

Blue Shield 65 Plus (HMO)
2012 Formulary
(list of covered drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT THE DRUGS WE COVER IN THIS PLAN

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

An HMO plan with a Medicare contract.

This information is available for free in other languages. Please contact Member Services at (800) 776-4466 [TTY: (800) 794-1099] 7 a.m. to 8 p.m., seven days a week, for additional information.

Esta información está disponible de forma gratuita en varios idiomas. Por favor, llame a Servicios para Miembros al (800) 776-4466 [TTY: (800) 794-1099] de 7 a.m. a 8 p.m., siete días a la semana para información adicional.

What is the Blue Shield 65 Plus (HMO) Formulary?

A formulary is a list of covered drugs selected by Blue Shield 65 Plus in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Blue Shield 65 Plus will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Blue Shield 65 Plus network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Generally, if you are taking a drug on our 2012 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2012 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. You may use this written notification as an update to your printed formulary. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of **February 24, 2012**. To get updated information about the drugs covered by Blue Shield 65 Plus, please visit our Web site on the Pharmacy section of www.blueshieldca.com or call Member Services at 1-800-776-4466, seven days a week, 7:00 a.m. - 8:00 p.m. TTY/TDD users should call 1-800-794-1099.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 36. The Index provides an alphabetical list of all of the drugs included in this document. Both

brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Blue Shield 65 Plus covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Blue Shield 65 Plus requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Blue Shield 65 Plus before you fill your prescriptions. If you don't get approval, Blue Shield 65 Plus may not cover the drug.
- **Quantity Limits:** For certain drugs, Blue Shield 65 Plus limits the amount of the drug that Blue Shield 65 Plus will cover. For example, Blue Shield 65 Plus provides 18 tablets per 30 days for *sumatriptan* (generic for IMITREX). This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, Blue Shield 65 Plus requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Blue Shield 65 Plus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Blue Shield 65 Plus will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.blueshieldca.com.

You can ask Blue Shield 65 Plus to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Blue Shield 65 Plus formulary?" on page iii for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that Blue Shield 65 Plus does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Blue Shield 65 Plus. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Blue Shield 65 Plus.

- You can ask Blue Shield 65 Plus to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Blue Shield 65 Plus Formulary?

You can ask Blue Shield 65 Plus to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue Shield 65 Plus limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Brand Drugs tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Drugs tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty tier.

Generally, Blue Shield 65 Plus will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's or prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 91-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Blue Shield of California has a transition process to provide coverage for members who are stabilized on Part D drugs, which are not included in their Part D plan's formulary. This transition process provides coverage for Part D drugs, within the first 90 days of enrollment, or until the member's physician has completed the exception process.

Our transition policy applies to Blue Shield of California's Medicare Advantage and Part D Plans (MAPDs) and standalone Part D Plans (PDPs). This document describes our Medicare Transitional Medication Process and applies to member categories listed below whom are stabilized on:

- Part D drugs not on Blue Shield's formulary
- Part D drugs on the Blue Shield formulary drugs with a prior authorization, step therapy or quantity limit requirement, or
- Part D drugs as listed above, where a distinction cannot be made at point of service whether it is a new or ongoing prescription drug
- And are members in any of the following scenarios:
 - new members at the beginning of a contract year,
 - newly eligible members transitioning from other coverage at the beginning of a contract year,
 - transitioning individuals who switch from one plan to another after the beginning of a contract year,
 - enrollees residing in long-term care (LTC) facilities, or
 - in some cases, current enrollees affected by formulary changes from one contract year to the next.

Members continuing coverage into a new plan year and experiencing negative formulary changes will have selected drugs, as determined by Blue Shield, and in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance for Part D drugs, grandfathered for continued coverage in the new plan year. Plan members on drugs that were not selected for grandfathering will have a similar transitional benefit. The transition policy will be extended across contract years if a member enrolls in a plan with an effective enrollment date of either November 1st or December 1st and needs access to a transition supply.

During the transitional stage, members may talk to their prescribers to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug, if it is not on our formulary or has restrictions such as step therapy or prior authorization. Members may contact Medicare Member Services for assistance. As necessary, Medicare Member Services will forward the call to Pharmacy Benefit Management to initiate a prior authorization or exception request. We will provide prior authorization or exception request forms upon request to both members and prescribers via mail, email or fax. Forms may also be found on our website at:

<https://www.blueshieldca.com/bsc/medicarepartdplans/formulary/faxforms.jhtml>

Per our transition policy, in conjunction with network pharmacies we can provide a temporary supply of non-formulary Part D drugs or formulary drugs with coverage restrictions in order to accommodate the immediate needs of a member, as well as to provide sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent formulary medication or to complete a formulary exception request to maintain coverage of an existing drug based on medical necessity reasons. Requests for prior authorization of formulary drugs are reviewed against the CMS-approved coverage criteria and formulary exception requests are reviewed for medical necessity by Blue Shield pharmacists and physicians. If a formulary exception request is denied, Blue Shield will provide information regarding therapeutically appropriate formulary alternatives.

The transitional supply is a one-time 30-day temporary supply (unless the prescription is written for fewer days in which case we will cover multiple fills to provide up to a total of 30 days of medication) of the non-formulary drug at a retail pharmacy during the first 90 days of new membership beginning on the member's effective date of coverage in any of our Medicare Part D Plans. Refills may be provided for transition prescriptions dispensed for less than the written amount, due to a plan quantity limit edit for safety, and for up to a total of a 30-day supply. If a current member is affected by a negative formulary change from one year to the next, we will provide up to a 30-day temporary supply of the non-formulary drug if the member needs a refill for the drug during the first 90 days of the new plan year.

Retail and LTC pharmacies have the ability to provide a point-of-sale override for coverage of a transition supply of a drug that is non-formulary, or that has coverage restrictions other than Part B vs. Part D determination, limits to prevent coverage of non-Part D drugs or limits that promote safe utilization of a Part D drug. We will cover a 30-day supply (unless the prescription is written for fewer days, in which case we will cover multiple fills to provide up to a total of 30 days of medication). Mail service transition supply overrides will be determined and entered by Blue Shield staff.

The cost-sharing for low-income subsidy (LIS) eligible members for a temporary supply of drugs provided under the transition process, will not exceed the statutory maximum co-payment amounts for LIS-eligible members. For all other members, cost-sharing will be based on approved cost-sharing tiers and be consistent with what the member would be charged for non-formulary drugs, approved under a coverage exception. Members will not be required to pay additional cost-sharing associated with multiple fills of lesser quantities of Part D drugs based upon quantity limits for safety once the originally prescribed doses of Part D drugs have been determined to be medically necessary after an exception process has been completed.

After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide the member a CMS-approved written notice via US First Class mail within three business days of the transitional fill after we cover the temporary supply. We will send the prescriber a fax with notification of the transitional supply. This notice will contain an explanation of the temporary nature of the transition supply received, instructions for working with us and the prescriber to identify appropriate therapeutic alternatives that are on our formulary, an explanation of the member's right to request a formulary exception and a description of the procedures for requesting a formulary exception. If a transition supply has been provided once and the member is currently in the process of receiving a coverage determination, the transition supply may be extended by one additional 30-day prescription fill beyond the initial 30 days supply, unless the member presents a prescription written for less than 30 days.

If a member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply (unless the prescription is written for fewer days) with multiple refills as necessary, up to a 93-day supply, during the first 90 days a new member is enrolled in our Plan beginning on the member's

effective date of coverage. If the resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a long-term care facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out-of-network, unless the member qualifies for out-of-network access.

For more information

For more detailed information about your Blue Shield 65 Plus prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Blue Shield 65 Plus, please call Member Services at 1-800-776-4466, seven days a week, 7:00 a.m. – 8:00 p.m. TTY/TDD users should call 1-800-794-1099. Or visit www.blueshieldca.com/findamedicareplan.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Blue Shield 65 Plus Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by Blue Shield 65 Plus. If you have trouble finding your drug in the list, turn to the Index that begins on page 36.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., CARBATROL) and generic drugs are listed in lower-case italics (e.g. *carbamazepine*).

The information in the Requirements/Limits column tells you if Blue Shield 65 Plus has any special requirements for coverage of your drug.

Key to Formulary Abbreviations

Drug Tiers

Tier	Supply	Blue Shield 65 Plus		
		Los Angeles County (Partial) & Orange County	Riverside County (Partial)	San Bernardino County (Partial)
1 Generic Drugs	Retail - in-network Preferred, Other Network pharmacy or out-of-network pharmacy (30-day supply)	\$5 Copay	\$6 Copay	\$6 Copay
	Retail - in-network Preferred or mail service pharmacy (90-day supply)	\$10 Copay	\$12 Copay	\$12 Copay
	Retail - Other Network pharmacy (90-day supply)	\$15 Copay	\$18 Copay	\$18 Copay
	Network Long-term Care Pharmacy - 34-day supply	\$5 Copay	\$6 Copay	\$6 Copay
2 Preferred Brand Drugs	Retail - in-network Preferred, Other Network pharmacy or out-of-network pharmacy (30-day supply)	\$40 Copay	\$45 Copay	\$45 Copay
	Retail - in-network Preferred or mail service pharmacy (90-day supply)	\$80 Copay	\$90 Copay	\$90 Copay
	Retail - Other Network pharmacy (90-day supply)	\$120 Copay	\$135 Copay	\$135 Copay
	Network Long-term Care Pharmacy - 34-day supply	\$40 Copay	\$45 Copay	\$45 Copay
3 Non-Preferred Brand Drugs	Retail - in-network Preferred, Other Network pharmacy or out-of-network pharmacy (30-day supply)	\$80 Copay	\$90 Copay	\$90 Copay
	Retail - in-network Preferred or mail service pharmacy (90-day supply)	\$160 Copay	\$180 Copay	\$180 Copay
	Retail - Other Network pharmacy (90-day supply)	\$240 Copay	\$270 Copay	\$270 Copay
	Network Long-term Care Pharmacy - 34-day supply	\$80 Copay	\$90 Copay	\$90 Copay

Tier	Supply	Blue Shield 65 Plus		
		Los Angeles County (Partial) & Orange County	Riverside County (Partial)	San Bernardino County (Partial)
4 Injectable Drugs	Retail - in-network Preferred pharmacy or Other Network pharmacy (30-day supply) Retail - in-network Preferred pharmacy, Other Network pharmacy or mail service pharmacy (90-day supply)	33% of Blue Shield's contracted rate	25% of Blue Shield's contracted rate	33% of Blue Shield's contracted rate
	Retail - out-of-network pharmacy (30-day supply)	33% of submitted cost	25% of submitted cost	33% of submitted cost
5 Specialty Drugs	Retail - in-network Preferred pharmacy or Other Network pharmacy (30-day supply) Retail - in-network Preferred pharmacy, Other Network pharmacy or mail service pharmacy (90-day supply)	33% of Blue Shield's contracted rate	25% of Blue Shield's contracted rate	33% of Blue Shield's contracted rate
	Retail - out-of-network pharmacy (30-day supply)	33% of submitted cost	25% of submitted cost	33% of submitted cost

Requirements/Limit Codes

Code	Definition
AG	This prescription drug has coverage limits based on age groups. The limits may be based upon how the U.S. Food and Drug Administration (FDA) approved the drug for use or special cautions for use by people in certain age groups. For new prescriptions, discuss alternatives with your physician. Your pharmacy or physician may call Blue Shield for assistance with coverage for ongoing use.
B/D	This prescription drug requires prior authorization review to determine whether coverage is under Part B or Part D of the Medicare benefit, based on Medicare coverage rules. Call Blue Shield to provide the necessary information to determine coverage.
ED	This prescription drug is not normally covered in a Medicare Prescription Drug Plan; however, Blue Shield covers this drug as a supplemental benefit. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help from Medicare or Social Security to pay for your prescriptions, you will not get any extra help to pay for this drug.
LA	This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 1-800-776-4466, seven days a week, 7:00 a.m. - 8:00 p.m. TTY/TDD users should call 1-800-794-1099.
QL	This medication has a dosing or prescription quantity limit. Maximum daily dose limits are defined by the FDA and listed in the drug package insert. Other quantity limits encourage consolidated dosing when possible.
PA	Coverage for this prescription requires prior authorization from Blue Shield. Call Blue Shield to provide the necessary information to determine coverage.
ST	Coverage for this prescription is provided when other first-line or preferred drug therapies have been tried (step therapy).
†	Medication is NOT available through Blue Shield's mail service pharmacy.

Form Codes

Abbreviation	Definition
AERS	Aerosol
CAPS	Capsule
CHEW	Chewable
CONC	Concentrate
CP24	Capsule - Extended Release 24-hour
CPDR	Capsule - Delayed-Release
CREA	Cream
ELIX	Elixir
FOAM	Foam
GEL	Gel
LOTN	Lotion
OIL	Oil
OINT	Ointment

Abbreviation	Definition
PACK	Pack
PTTW	Patch - Biweekly
PTWK	Patch - Weekly
SOLN	Solution
SOLR	Solution - Reconstituted
SUSP	Suspension
SUSR	Suspension - Reconstituted
SYRP	Syrup
TABS	Tablet
TB24	Tablet - Extended Release 24-hour
TBDP	Tablet - Dispersible
TBEC	Tablet - Enteric Coated
TBEF	Tablet - Effervescent

Drug Name	Drug Tier	Requirements/ Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
EQUAGESIC	3	
meclofenamate sodium	1	
mefenamic acid	1	
NALFON	3	
naproxen sodium	1	
Opioid Analgesics		
acetaminophen/codeine #3	1	QL (360 tabs per 30 days) †
acetaminophen/codeine soln	1	QL (2700 ml's per 30 days) †
acetaminophen/codeine tabs 300mg; 60mg	1	QL (270 tabs per 30 days) †
acetaminophen/codeine tabs 300mg; 15mg	1	QL (390 tabs per 30 days) †
ascomp/codeine	1	QL (270 tabs per 30 days) †
ASTRAMORPH	4	B/D †
AVINZA CP24 120MG	3	QL (390 caps per 30 days) †
AVINZA CP24 30MG, 45MG, 60MG, 75MG	3	QL (30 caps per 30 days) †
AVINZA CP24 90MG	3	QL (90 caps per 30 days) †
buprenorphine hcl subl	1	PA †
buprenorphine hcl inj	4	B/D †
butalbital/acetaminophen/caffeine/codeine	1	QL (270 tabs per 30 days) †
butorphanol tartrate nasal soln	1	QL (4-2.5ml bottles per 30 days) †
butorphanol tartrate inj	4	B/D †
CAPITAL/CODEINE	3	QL (2700 ml's per 30 days) †
co-gesic	1	QL (240 tabs per 30 days) †
codeine sulfate tabs 15mg	1	QL (1080 tabs per 30 days) †
codeine sulfate tabs 60mg	1	QL (270 tabs per 30 days) †
codeine sulfate tabs 30mg	1	QL (540 tabs per 30 days) †
DILAUDID-HP INJ 250MG	4	B/D †
DILAUDID INJ	4	B/D †
DURAMORPH	4	B/D †
endocet tabs 650mg; 10mg	1	QL (180 tabs per 30 days) †

Drug Name	Drug Tier	Requirements/ Limits
endocet tabs 500mg; 7.5mg	1	QL (240 tabs per 30 days) †
endocet tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg	1	QL (360 tabs per 30 days) †
fentanyl transdermal patches	1	QL (20 patches per 30 days) †
fentanyl citrate	4	B/D †
fentanyl citrate oral transmucosal	1	QL (120 lollipops per 30 days) PA †
HYCET	3	QL (5400 ml's per 30 days) †
hydrocodone bitartrate/acetaminophen tabs 750mg; 10mg	1	QL (150 tabs per 30 days) †
hydrocodone bitartrate/acetaminophen tabs 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg	1	QL (390 tabs per 30 days) †
hydrocodone/acetaminophen soln	1	QL (3600 ml's per 30 days) †
hydrocodone/acetaminophen tabs 750mg; 7.5mg	1	QL (150 tabs per 30 days) †
hydrocodone/acetaminophen tabs 650mg; 10mg, 650mg; 7.5mg, 660mg; 10mg	1	QL (180 tabs per 30 days) †
hydrocodone/acetaminophen tabs 500mg; 10mg, 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg	1	QL (240 tabs per 30 days) †
hydrocodone/acetaminophen tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg	1	QL (360 tabs per 30 days) †
hydrocodone/ibuprofen	1	QL (225 tabs per 30 days) †
hydromorphone hcl inj	4	B/D †
hydromorphone hcl tabs 2mg	1	QL (1800 tabs per 30 days) †
hydromorphone hcl tabs 8mg	1	QL (450 tabs per 30 days) †
hydromorphone hcl tabs 4mg	1	QL (900 tabs per 30 days) †
INFUMORPH 200	4	B/D †
KADIAN CP24 20MG	3	QL (135 caps per 30 days) †
KADIAN CP24 30MG	3	QL (180 caps per 30 days) †

Drug Name	Drug Tier	Requirements/Limits
KADIAN CP24 10MG	3	QL (270 caps per 30 days) †
KADIAN CP24 100MG, 200MG, 50MG, 60MG, 80MG	3	QL (90 caps per 30 days) †
levorphanol tartrate	1	QL (270 tabs per 30 days) †
margesic-h	1	QL (240 tabs per 30 days) †
meperidine hcl oral soln	1	QL (5400 ml's per 30 days) †
meperidine hcl inj 10mg/ml, 25mg/ml, 50mg/ml	4	B/D †
meperidine hcl tabs 50mg	1	QL (1080 tabs per 30 days) †
meperidine hcl tabs 100mg	1	QL (540 tabs per 30 days) †
methadone hcl conc	1	QL (540 ml's per 30 days) †
methadone hcl inj	4	B/D †
methadone hcl oral soln 10mg/5ml	1	QL (2700 ml's per 30 days) †
methadone hcl oral soln 5mg/5ml	1	QL (5400 ml's per 30 days) †
methadone hcl tabs 5mg	1	QL (1080 tabs per 30 days) †
methadone hcl tabs 10mg	1	QL (540 tabs per 30 days) †
methadose tabs 5mg	1	QL (1080 tabs per 30 days) †
methadose tabs 10mg	1	QL (540 tabs per 30 days) †
morphine sulfate add-vantage	4	B/D †
morphine sulfate er caps 20mg	1	QL (135 caps per 30 days) †
morphine sulfate er caps 30mg	1	QL (180 caps per 30 days) †
morphine sulfate er caps 50mg, 60mg, 80mg, 100mg	1	QL (90 caps per 30 days) †
morphine sulfate er tb12 60mg	1	QL (135 tabs per 30 days) †
morphine sulfate er tb12 15mg, 30mg	1	QL (180 tabs per 30 days) †
morphine sulfate er tb12 100mg, 200mg	1	QL (90 tabs per 30 days) †
morphine sulfate in dextrose 5%	4	B/D †
morphine sulfate inj 1mg/ml	4	B/D †

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate inj 1mg/ml	4	QL (5400 ml's per 30 days) B/D †
morphine sulfate inj 0.5mg/ml, 10mg/ml, 15mg/ml, 25mg/ml, 2mg/ml, 4mg/ml, 50mg/ml, 5mg/ml, 8mg/ml	4	B/D †
morphine sulfate oral soln 20mg/5ml	1	QL (2025 ml's per 30 days) †
morphine sulfate oral soln 20mg/ml	1	QL (405 ml's per 30 days) †
morphine sulfate oral soln 10mg/5ml	1	QL (4050 ml's per 30 days) †
morphine sulfate supp 5mg	1	QL (1620 suppositories per 30 days) †
morphine sulfate supp 30mg	1	QL (270 suppositories per 30 days) †
morphine sulfate supp 20mg	1	QL (405 suppositories per 30 days) †
morphine sulfate supp 10mg	1	QL (810 suppositories per 30 days) †
morphine sulfate tabs 30mg	1	QL (270 tabs per 30 days) †
morphine sulfate tabs 15mg	1	QL (540 tabs per 30 days) †
nalbuphine hcl	4	B/D †
NUCYNTA TABS 50MG	3	QL (180 tabs per 30 days) †
NUCYNTA TABS 100MG, 75MG	3	QL (210 tabs per 30 days) †
oxycodone hcl conc	1	QL (180 ml's per 30 days) †
oxycodone hcl caps	1	QL (360 caps per 30 days) †
oxycodone hcl tabs 30mg, 5mg	1	QL (360 tabs per 30 days) †
oxycodone hcl tabs 15mg	1	QL (720 tabs per 30 days) †
oxycodone/acetaminophen caps	1	QL (240 caps per 30 days) †
oxycodone/acetaminophen tabs 650mg; 10mg	1	QL (180 tabs per 30 days) †
oxycodone/acetaminophen tabs 500mg; 7.5mg	1	QL (240 tabs per 30 days) †

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (360 tabs per 30 days) †
<i>oxycodone/aspirin</i>	1	QL (360 tabs per 30 days) †
<i>oxycodone/ibuprofen</i>	1	QL (120 tabs per 30 days) †
OXYCONTIN TB12 80MG	2	QL (120 tabs per 30 days) †
OXYCONTIN TB12 15MG, 20MG, 30MG	2	QL (180 tabs per 30 days) †
OXYCONTIN TB12 10MG	2	QL (270 tabs per 30 days) †
OXYCONTIN TB12 60MG	2	QL (60 tabs per 30 days) †
OXYCONTIN TB12 40MG	2	QL (120 tabs per 30 days) †
<i>oxymorphone hydrochloride</i>	1	QL (360 tabs per 30 days) †
<i>oxymorphone hcl er tabs</i>	1	QL (60 tabs per 30 days) †
<i>pentazocine/acetaminophen</i>	1	QL (270 tabs per 30 days) †
<i>pentazocine/naloxone hcl</i>	1	QL (540 tabs per 30 days) †
REPREXAIN TABS 2.5MG; 200MG	3	QL (225 tabs per 30 days) †
REPREXAIN TABS 5MG; 200MG	3	QL (270 tabs per 30 days) †
<i>reprexain tabs 10mg; 200mg</i>	1	QL (225 tabs per 30 days) †
ROXICET SOLN	2	QL (1800 ml's per 30 days) †
ROXICET TABS 500MG; 5MG	3	QL (240 tabs per 30 days) †
<i>roxicet tabs 325mg; 5mg</i>	1	QL (360 tabs per 30 days) †
<i>roxicodone tabs 5mg</i>	1	QL (360 tabs per 30 days) †
<i>stagesic</i>	1	QL (240 caps per 30 days) †
SYNALGOS-DC	3	†
TALWIN	4	B/D †
<i>tramadol hcl</i>	1	†
<i>tramadol hcl er</i>	1	†
<i>tramadol hydrochloride/acetaminophen</i>	1	†

Drug Name	Drug Tier	Requirements/Limits
ULTRAM ER TB24 300MG	3	†
<i>zerlor</i>	1	QL (225 tabs per 30 days) †
ZYDONE	3	QL (300 tabs per 30 days) †
Anesthetics		
Local Anesthetics		
<i>lidocaine</i>	1	
<i>lidocaine hcl gel, external soln</i>	1	
<i>lidocaine hcl inj 2%</i>	4	B/D †
LIDOCAINE HCL INJ 2%	4	B/D †
<i>lidocaine hcl inj 0.5%, 1%, 1.5%, 10mg/ml, 20mg/ml</i>	4	B/D †
<i>lidocaine/epinephrine</i>	4	B/D †
<i>lidocaine/prilocaine</i>	1	
LIDODERM	3	QL (90 patches per 30 days)
XYLOCAINE INJ	4	B/D †
Anti-inflammatory Agents		
Nonsteroidal Anti-inflammatory Drugs		
ARTHROTEC 50	3	
ARTHROTEC 75	3	
CELEBREX	3	QL (60 caps per 30 days) PA
<i>diclofenac potassium</i>	1	
<i>diclofenac sodium</i>	1	
<i>diclofenac sodium dr</i>	1	
<i>diclofenac sodium ec</i>	1	
<i>diclofenac sodium er</i>	1	
<i>diclofenac sodium xr</i>	1	
<i>diflunisal</i>	1	
<i>etodolac</i>	1	
<i>etodolac er</i>	1	
<i>fenoprofen calcium</i>	1	
<i>flurbiprofen</i>	1	
<i>ibuprofen</i>	1	
INDOCIN	3	
<i>indomethacin</i>	1	
<i>indomethacin er</i>	1	
<i>ketoprofen</i>	1	
<i>ketoprofen er</i>	1	
<i>ketorolac tromethamine tabs</i>	1	
<i>ketorolac tromethamine inj 15mg/ml</i>	4	B/D †
<i>meloxicam</i>	1	
<i>nabumetone</i>	1	
NALFON	3	
NAPRELAN TB24 375MG	3	

Drug Name	Drug Tier	Requirements/ Limits
<i>naproxen</i>	1	
<i>naproxen dr</i>	1	
<i>oxaprozin</i>	1	
<i>piroxicam</i>	1	
<i>sulindac</i>	1	
<i>tolmetin sodium</i>	1	

Antibacterials

Aminoglycosides

<i>amikacin sulfate</i>	4	B/D †
CORTISPORIN	3	†
<i>gentamicin sulfate/0.9% sodium chloride</i>	4	B/D †
<i>gentamicin sulfate/sodium chloride</i>	4	B/D †
<i>gentamicin sulfate crea, oint, ophthalmic soln</i>	1	†
<i>gentamicin sulfate inj 10mg/ml</i>	4	B/D †
<i>gentamicin sulfate inj 40mg/ml</i>	4	B/D †
<i>isotonic gentamicin</i>	4	B/D †
<i>kanamycin sulfate</i>	4	B/D †
<i>neomycin sulfate</i>	1	†
<i>paromomycin sulfate</i>	1	†
<i>streptomycin sulfate</i>	4	B/D †
TOBI	2	QL (280 ml's per 30 days) PA †
<i>tobramycin sulfate add-vantage</i>	4	B/D †
<i>tobramycin sulfate/sodium chloride</i>	4	B/D †
<i>tobramycin sulfate ophthalmic soln</i>	1	†
<i>tobramycin sulfate inj</i>	4	B/D †

Antibacterials, Other

<i>baciim</i>	4	B/D †
<i>bacitracin</i>	4	B/D †
BACTROBAN NASAL	3	†
BACTROBAN CREA	3	†
<i>chloramphenicol sodium succinate</i>	4	B/D †
CLEOCIN GALAXY	4	B/D †
CLEOCIN PHOSPHATE	4	B/D †
INJ 150MG/ML		
CLEOCIN SUPP	2	†
CLEOCIN CAPS 75MG	2	†
<i>clindamycin hcl</i>	1	†
<i>clindamycin palmitate hcl</i>	1	†
<i>clindamycin phosphate crea</i>	1	†

Drug Name	Drug Tier	Requirements/ Limits
<i>clindamycin phosphate foam</i>	1	QL (1-100gram can per 30 days)
		†
<i>colistimethate sodium</i>	4	B/D †
CUBICIN	5	B/D †
HELIDAC	3	†
LINCOCIN	4	B/D †
MACRODANTIN CAPS 25MG	2	†
<i>methenamine hippurate</i>	1	†
METROGEL	2	†
<i>metronidazole</i>	1	†
<i>metronidazole in nacl 0.79%</i>	4	B/D †
MONUROL	3	†
<i>mupirocin</i>	1	†
<i>neomycin/bacitracin/polymyxin</i>	1	†
NEUTREXIN	4	B/D †
<i>nitrofurantoin</i>	1	†
<i>nitrofurantoin macrocrystalline</i>	1	†
<i>nitrofurantoin monohydrate</i>	1	†
NORITATE	3	†
<i>polymyxin b sulfate</i>	4	B/D †
PRIMSOL	3	†
<i>silver sulfadiazine</i>	1	†
<i>ssd</i>	1	†
<i>ssd af</i>	1	†
SULFAMYLON	3	†
SYNERCID	4	B/D †
<i>thermazene</i>	1	†
<i>trimethoprim</i>	1	†
TYGACIL	4	B/D †
VANCOCIN HCL	2	†
VANCOMYCIN HCL INJ 500MG	4	B/D †
<i>vancomycin hcl inj 1000mg, 10gm, 5000mg, 750mg</i>	4	B/D †
<i>vandazole</i>	1	†
XIFAXAN TABS 550MG	3	PA †
XIFAXAN TABS 200MG	3	QL (9 tabs per 30 days) PA †
ZYVOX SUSR, TABS	2	PA †
ZYVOX INJ	4	PA †

Beta-lactam, Cephalosporins

CEDAX	3	†
<i>cefaclor</i>	1	†
<i>cefaclor er</i>	1	QL (20 tabs per 10 days) †

Drug Name	Drug Tier	Requirements/ Limits
<i>cefadroxil</i>	1	†
CEFAZOLIN	4	B/D †
SODIUM/DEXTROSE		
<i>cefazolin sodium inj 1gm; 5%, 20gm, 500mg</i>	4	B/D †
<i>cefdinir</i>	1	†
<i>cefditoren pivoxil</i>	1	†
<i>cefepime</i>	4	B/D †
<i>cefotaxime sodium</i>	4	B/D †
<i>cefoxitin sodium inj 10gm, 1gm, 2gm</i>	4	B/D †
<i>cefpodoxime proxetil</i>	1	†
<i>cefprozil</i>	1	†
<i>ceftazidime/dextrose</i>	4	B/D †
<i>ceftriaxone in iso-osmotic dextrose</i>	4	B/D †
<i>ceftriaxone sodium</i>	4	B/D †
<i>cefuroxime axetil</i>	1	†
<i>cefuroxime sodium</i>	4	B/D †
<i>cefuroxime/dextrose</i>	4	B/D †
<i>cephalexin caps, susr</i>	1	†
CLAFORAN/D5W	4	B/D †
CLAFORAN INJ 2GM	4	B/D †
FORTAZ INJ 1GM/50ML; 5%, 2GM/50ML; 5%	4	B/D †
SUPRAX	3	†
<i>tazicef</i>	4	B/D †
TEFLARO	4	B/D †
ZINACEF IN ISO- OSMOTIC DEXTROSE	4	B/D †
ZINACEF IN ISO- OSMOTIC DILUENT	4	B/D †
Beta-lactam, Other		
AZACTAM	4	B/D †
AZACTAM IN ISO- OSMOTIC DEXTROSE	4	B/D †
<i>aztreonam</i>	4	B/D †
CAYSTON	5	QL (84 ml's per 30 days) PA †
<i>cilastatin sodium/imipenem</i>	4	B/D †
INVANZ	2	B/D †
<i>meropenem</i>	4	B/D †
MERREM	4	B/D †
PRIMAXIN I.M.	4	B/D †
PRIMAXIN IV	4	B/D †
PRIMAXIN IV ADD- VANTAGE	4	B/D †
Beta-lactam, Penicillins		
<i>amoxicillin</i>	1	†

Drug Name	Drug Tier	Requirements/ Limits
<i>amoxicillin/clavulanate potassium</i>	1	†
<i>amoxicillin/clavulanate potassium er</i>	1	†
<i>amoxicillin/potassium clavulanate</i>	1	†
<i>ampicillin</i>	1	†
<i>ampicillin sodium</i>	4	B/D †
<i>ampicillin-sulbactam</i>	4	B/D †
AUGMENTIN	2	†
BACTOCILL IN DEXTROSE	4	B/D †
BICILLIN C-R	4	B/D †
BICILLIN L-A	4	B/D †
<i>dicloxacillin sodium</i>	1	†
NAFCILLIN SODIUM	4	B/D †
NALLPEN ISO-OSMOTIC IN DEXTROSE	4	B/D †
NALLPEN/DEXTROSE	4	B/D †
<i>oxacillin sodium</i>	4	B/D †
<i>penicillin g potassium</i>	4	B/D †
PENICILLIN G POTASSIUM IN ISO- OSMOTIC DEXTROSE INJ 0; 60000UNIT/ML	4	B/D †
<i>penicillin g potassium in iso-osmotic dextrose inj 0; 20000unit/ml, 0; 40000unit/ml</i>	4	B/D †
<i>penicillin g procaine</i>	4	B/D †
<i>penicillin g sodium</i>	4	B/D †
<i>penicillin v potassium</i>	1	†
<i>piperacillin sodium</i>	4	B/D †
<i>piperacillin sodium/ tazobactam sodium</i>	4	B/D †
<i>piperacillin sodium/tazobactam sodium</i>	4	B/D †
PREVPAC	3	†
TIMENTIN	4	B/D †
UNASYN ADD- VANTAGE	4	B/D †
UNASYN INJ 2GM; 1GM	4	B/D †
UNASYN INJ 1GM; 0.5GM	4	B/D †
ZOSYN INJ 5%; 2GM/50ML; 0.25GM/50ML, 5%; 3GM/50ML; 0.375GM/50ML	4	B/D †
Macrolides		

Drug Name	Drug Tier	Requirements/ Limits
AKNE-MYCIN	3	†
<i>azithromycin susr</i>	1	†
<i>azithromycin inj</i>	4	B/D †
<i>azithromycin tabs 500mg</i>	1	QL (3 tabs per 3 days) †
<i>azithromycin tabs 250mg</i>	1	QL (6 tabs per 5 days) †
<i>azithromycin tabs 600mg</i>	1	QL (8 tabs per 30 days) †
<i>clarithromycin er</i>	1	QL (42 tabs per 14 days) †
<i>clarithromycin susr</i>	1	†
<i>clarithromycin tabs</i>	1	QL (42 tabs per 14 days) †
<i>ery</i>	1	†
ERY-TAB	2	†
ERYPED 200	2	†
ERYPED 400	2	†
<i>erythrocin lactobionate</i>	4	B/D †
ERYTHROCIN	2	†
STEARATE		
<i>erythromycin</i>	1	†
<i>erythromycin base</i>	1	†
<i>erythromycin ethylsuccinate</i>	1	†
<i>erythromycin/sulfisoxazole</i>	1	†
KETEK TABS 400MG	2	QL (20 tabs per 10 days) †
KETEK TABS 300MG	2	QL (20 tabs per 30 days) †
PCE	2	†
ZITHROMAX PACK	2	QL (2 packets per 1 days) †
ZITHROMAX INJ	4	B/D †
ZMAX	3	QL (1-60ml bottle per 30 days) †
Quinolones		
AVELOX ABC PACK	2	QL (2-5 tablet packs per 10 days) †
AVELOX TABS	2	QL (10 tabs per 10 days) †
AVELOX INJ	4	B/D †
CIPRO SUSR	2	†
<i>ciprofloxacin</i>	4	B/D †
<i>ciprofloxacin er</i>	1	QL (14 tabs per 14 days) †
<i>ciprofloxacin extended-release</i>	1	QL (3 tabs per 3 days) †
<i>ciprofloxacin hcl</i>	1	†

Drug Name	Drug Tier	Requirements/ Limits
FACTIVE	3	†
LEVAQUIN ORAL SOLN	3	QL (300 ml's per 14 days) †
LEVAQUIN TABS	3	QL (10 tabs per 10 days) †
LEVAQUIN INJ	4	B/D †
<i>levofloxacin inj</i>	4	B/D †
<i>levofloxacin oph soln</i>	1	†
<i>levofloxacin oral soln</i>	1	†
<i>levofloxacin tabs</i>	1	QL (10 tabs per 10 days) †
MOXEZA	2	†
NOROXIN	3	†
<i>ofloxacin</i>	1	†
ZYMAR	3	†
Sulfonamides		
<i>sodium sulfacetamide</i>	1	†
<i>sulfadiazine</i>	1	†
<i>sulfamethoxazole/trimethopr im ds</i>	1	†
<i>sulfamethoxazole/trimethopr im susp, tabs</i>	1	†
<i>sulfamethoxazole/trimethopr im inj</i>	4	B/D †
Tetracyclines		
<i>demeclocycline hcl</i>	1	†
DORYX TBEC 150MG	3	†
<i>doxycycline</i>	1	†
<i>doxycycline hyclate caps, tabs, tbec</i>	1	†
<i>doxycycline hyclate inj</i>	4	B/D †
<i>doxycycline monohydrate</i>	1	†
<i>minocycline hcl</i>	1	†
ORACEA	2	†
<i>tetracycline hcl</i>	1	†
VIBRAMYCIN SUSR	2	†
VIBRAMYCIN SYRP	3	†

Anticonvulsants

Anticonvulsants, Other		
BANZEL SUSP	2	QL (2400 ml's per 30 days) PA
BANZEL TABS 400MG	2	QL (240 tabs per 30 days) PA
BANZEL TABS 200MG	2	QL (60 tabs per 30 days) PA
<i>clonazepam tabs 0.5mg</i>	1	QL (1200 tabs per 30 days) ED
<i>clonazepam tabs 2mg</i>	1	QL (300 tabs per 30 days) ED

Drug Name	Drug Tier	Requirements/ Limits
<i>clonazepam tabs 1mg</i>	1	QL (600 tabs per 30 days) ED
<i>levetiracetam er 500mg tabs</i>	1	QL (180 tabs per 30 days)
<i>levetiracetam er 750mg tabs</i>	1	QL (120 tabs per 30 days)
<i>levetiracetam oral soln, tabs</i>	1	
<i>levetiracetam inj</i>	4	B/D †
<i>phenobarbital</i>	1	ED
VIMPAT ORAL SOLN	3	QL (1200 ml's per 30 days) PA
VIMPAT TABS	3	QL (60 tabs per 30 days) PA
VIMPAT INJ	4	PA †
Calcium Channel Modifying Agents		
CELONTIN	2	
<i>ethosuximide</i>	1	
LYRICA CAPS 200MG, 225MG, 300MG	3	QL (60 caps per 30 days) PA
LYRICA CAPS 100MG, 150MG, 25MG, 50MG, 75MG	3	QL (90 caps per 30 days) PA
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>divalproex sodium</i>	1	
<i>divalproex sodium er</i>	1	
<i>gabapentin</i>	1	
GABITRIL	3	PA
HORIZANT	3	QL (30 tabs per 30 days) PA
<i>primidone</i>	1	
SABRIL	5	QL (180 tabs per 30 days) †
STAVZOR	3	PA
<i>valproate sodium</i>	4	B/D †
<i>valproic acid</i>	1	
<i>zonisamide</i>	1	
Glutamate Reducing Agents		
<i>felbamate</i>	1	
FELBATOL	3	
LAMICTAL	2	
STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE		
LAMICTAL	2	
STARTER/TAKING VALPROATE		
<i>lamotrigine</i>	1	
<i>topiramate</i>	1	PA
Sodium Channel Inhibitors		

Drug Name	Drug Tier	Requirements/ Limits
<i>carbamazepine</i>	1	
<i>carbamazepine er</i>	1	
CARBATROL	2	
DILANTIN INFATABS	2	
DILANTIN CAPS 30MG	2	
<i>epitol</i>	1	
EQUETRO	3	
<i>fosphenytoin sodium</i>	4	B/D †
<i>oxcarbazepine</i>	1	PA
PEGANONE	2	
<i>phenytoin</i>	1	
<i>phenytoin sodium</i>	4	B/D †
<i>phenytoin sodium extended</i>	1	
TEGRETOL-XR TB12 100MG	2	
Antidementia Agents		
Antidementia Agents, Other		
<i>ergoloid mesylates</i>	1	
Cholinesterase Inhibitors		
ARICEPT TABS 23MG	2	QL (30 tabs per 30 days) ST
<i>donepezil hcl</i>	1	
EXELON PT24, SOLN	2	
<i>galantamine hydrobromide soln, tabs</i>	1	
<i>galantamine hydrobromide cp24</i>	1	QL (30 caps per 30 days)
<i>rivastigmine tartrate</i>	1	
Glutamate Pathway Modifiers		
NAMENDA TITRATION	2	QL (60 tabs per 30 days)
PAK		
NAMENDA SOLN	2	QL (360 ml's per 30 days)
NAMENDA TABS	2	QL (60 tabs per 30 days)
Antidepressants		
Antidepressants, Other		
<i>budeprion sr tb12 100mg</i>	1	QL (120 tabs per 30 days)
<i>budeprion sr tb12 150mg</i>	1	QL (90 tabs per 30 days)
<i>budeprion xl tb24 300mg</i>	1	QL (30 tabs per 30 days)
<i>budeprion xl tb24 150mg</i>	1	QL (90 tabs per 30 days)
<i>bupropion hcl sr tb12 100mg</i>	1	QL (120 tabs per 30 days)
<i>bupropion hcl sr tb12 200mg</i>	1	QL (60 tabs per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>bupropion hcl sr tb12</i>	1	QL (90 tabs per 30 days)
<i>bupropion hcl tabs 100mg</i>	1	QL (120 tabs per 30 days)
<i>bupropion hcl tabs 75mg</i>	1	QL (180 tabs per 30 days)
<i>mirtazapine</i>	1	
<i>mirtazapine odt</i>	1	
<i>nefazodone hcl</i>	1	
<i>trazodone hcl</i>	1	
Monoamine Oxidase Inhibitors		
EMSAM	3	PA
MARPLAN	2	
<i>phenelzine sulfate</i>	1	
<i>tranylcypromine sulfate</i>	1	
Serotonin/ Norepinephrine Reuptake Inhibitors		
<i>citalopram hydrobromide</i>	1	
CYMBALTA CPEP 60MG	2	QL (60 caps per 30 days)
CYMBALTA CPEP 20MG, 30MG	2	QL (90 caps per 30 days)
<i>fluoxetine dr</i>	1	QL (4 caps per 28 days)
<i>fluoxetine hcl</i>	1	
<i>fluvoxamine maleate</i>	1	
LEXAPRO SOLN	3	QL (720 ml's per 30 days) PA
LEXAPRO TABS 20MG, 5MG	3	QL (30 tabs per 30 days) PA
LEXAPRO TABS 10MG	3	QL (45 tabs per 30 days) PA
<i>paroxetine hcl</i>	1	
<i>paroxetine hcl er</i>	1	
PEXEVA	3	ST
PRISTIQ TB24 100MG	3	QL (120 tabs per 30 days) ST
PRISTIQ TB24 50MG	3	QL (30 tabs per 30 days) ST
<i>sertraline hcl</i>	1	
SYMBYAX	3	
<i>venlafaxine hcl</i>	1	
VENLAFAXINE HCL ER TB24	3	QL (30 tabs per 30 days) PA
<i>venlafaxine hcl er cp24 150mg, 37.5mg</i>	1	QL (60 caps per 30 days)
<i>venlafaxine hcl er cp24 75mg</i>	1	QL (90 caps per 30 days)
Tricyclics		
<i>amitriptyline hcl</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>amoxapine</i>	1	
<i>chlordiazepoxide/amitriptyline</i>	1	
<i>clomipramine hcl</i>	1	
<i>desipramine hcl</i>	1	
<i>doxepin hcl</i>	1	
<i>imipramine hcl</i>	1	
<i>imipramine pamoate</i>	1	
<i>maprotiline hcl</i>	1	
<i>nortriptyline hcl</i>	1	
<i>perphenazine/amitriptyline</i>	1	
<i>protriptyline hcl</i>	1	
SILENOR	3	QL (30 tabs per 30 days)
SURMONTIL	2	
Antidotes, Deterrents, and Toxicologic Agents		
Antidotes		
CHEMET	2	
CUPRIMINE	2	
DEPEN TITRATABS	2	
EXJADE	2	LA †
<i>kionex</i>	1	
RELISTOR	4	PA †
<i>sodium polystyrene sulfonate</i>	1	
<i>sps</i>	1	
SYPRINE	3	
Deterrents		
ANTABUSE	2	
<i>buproban</i>	1	QL (60 tabs per 30 days)
CAMPRAL	3	
CHANTIX	2	QL (60 tabs per 30 days)
<i>depade</i>	1	
<i>disulfiram</i>	1	
NICOTROL INHALER	2	
NICOTROL NS	2	
Toxicologic Agents		
FERRIPROX	5	QL (540 tabs per 30 days) †
<i>naloxone hcl</i>	4	B/D †
<i>naltrexone hcl</i>	1	
SUBOXONE SUBL 2MG; 0.5MG	3	QL (480 tabs per 30 days) PA
SUBOXONE SUBL 8MG; 2MG	3	QL (120 tabs per 30 days) PA
Antiemetics		
Antiemetics		
ALOXI	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
ANZEMET TABS	2	QL (1 tab per 5 days) PA †
ANZEMET INJ	4	PA †
<i>compro</i>	1	†
<i>dronabinol caps 2.5mg</i>	1	QL (1080 caps per 30 days) PA †
<i>dronabinol caps 10mg</i>	1	QL (270 caps per 30 days) PA †
<i>dronabinol caps 5mg</i>	1	QL (540 caps per 30 days) PA †
EMEND CAPS 125MG, DISP PACK	2	PA †
EMEND CAPS 40MG	3	PA †
<i>granisetron hcl tabs</i>	1	QL (60 tabs per 30 days) PA †
<i>granisetron hcl inj</i>	4	PA †
<i>granisol</i>	1	QL (300 ml's per 30 days) PA †
<i>metoclopramide hcl</i>	1	†
<i>ondansetron hcl oral soln</i>	1	QL (450 ml's per 30 days) B/D †
<i>ondansetron hcl inj</i>	4	B/D †
<i>ondansetron hcl tabs 24mg</i>	1	QL (30 tabs per 30 days) B/D †
<i>ondansetron hcl tabs 4mg, 8mg</i>	1	QL (90 tabs per 30 days) B/D †
<i>ondansetron odt</i>	1	QL (90 tabs per 30 days) B/D †
<i>phenadoz</i>	1	†
<i>prochlorperazine</i>	1	†
<i>prochlorperazine edisylate</i>	4	B/D †
<i>prochlorperazine maleate</i>	1	†
<i>promethazine hcl plain</i>	1	†
<i>promethazine hcl supp, syrup, tabs</i>	1	†
<i>promethazine hcl inj</i>	4	B/D †
<i>promethegan</i>	1	†
TRANSDERM-SCOP	3	†
<i>trimethobenzamide hcl inj</i>	4	B/D †
Antifungals		
<i>Antifungals</i>		
ABELCET	4	B/D †
AMBISOME	4	B/D †
AMPHOTEC	4	B/D †
<i>amphotericin b</i>	4	B/D †
ANCOBON	2	PA †
BIO-STATIN	3	†
CANCIDAS	4	PA †
<i>ciclopirox</i>	1	†

Drug Name	Drug Tier	Requirements/ Limits
<i>ciclopirox nail lacquer</i>	1	†
<i>ciclopirox olamine</i>	1	†
<i>clotrimazole</i>	1	†
<i>clotrimazole/betamethasone dipropionate</i>	1	†
<i>econazole nitrate</i>	1	†
EXELDERM	3	†
<i>fluconazole</i>	1	†
<i>fluconazole in dextrose</i>	4	B/D †
<i>fluconazole in nacl</i>	4	B/D †
<i>flucytosine</i>	1	†
GRIFULVIN V	2	†
GRIS-PEG	2	†
<i>griseofulvin microsize</i>	1	†
<i>itraconazole</i>	1	PA †
<i>ketoconazole</i>	1	†
LAMISIL SOLN	3	†
MENTAX	3	†
<i>miconazole 3</i>	1	†
MYCAMINE	4	B/D †
NAFTIN	3	†
NOXAFIL	2	PA †
<i>nyamyc</i>	1	†
<i>nystatin</i>	1	†
<i>nystatin vaginal</i>	1	†
<i>nystatin/triamcinolone</i>	1	†
<i>nystop</i>	1	†
OXISTAT	3	†
<i>pedi-dri</i>	1	†
<i>selenium sulfide</i>	1	†
SPORANOX SOLN	3	PA †
<i>terbinafine hcl</i>	1	QL (30 tabs per 30 days) †
<i>terconazole</i>	1	†
VFEND IV	4	B/D †
VFEND SUSR	2	PA †
<i>voriconazole</i>	1	PA †
<i>zazole</i>	1	†
Antigout Agents		
<i>Antigout Agents</i>		
<i>allopurinol</i>	1	
<i>allopurinol sodium</i>	4	B/D †
COLCRYS	2	
KRYSTEXXA	5	PA †
<i>probenecid</i>	1	
<i>probenecid/colchicine</i>	1	
ULORIC	2	QL (30 tabs per 30 days) ST
Antimigraine Agents		
<i>Abortive</i>		

Drug Name	Drug Tier	Requirements/ Limits
AXERT	3	QL (24 tabs per 30 days) †
<i>bupap</i>	1	ED †
<i>butalbital/acetaminophen</i>	1	ED †
<i>butalbital/acetaminophen/ca</i> <i>ffeine</i>	1	ED †
<i>dihydroergotamine mesylate</i>	4	PA †
ERGOMAR	3	†
<i>ergotamine tartrate/cafeine</i>	1	†
FROVA	3	QL (27 tabs per 30 days) †
<i>margesic</i>	1	†
MAXALT	2	QL (24 tabs per 30 days) †
MAXALT-MLT	2	QL (24 tabs per 30 days) †
<i>migergot</i>	1	†
MIGRANAL	2	QL (8 ml's per 30 days) †
<i>naratriptan hcl</i>	1	QL (18 tabs per 30 days) †
RELPAK	3	QL (18 tabs per 30 days) †
<i>sumatriptan nasal inhaler</i>	1	QL (3-6ml packages per 30 days) †
<i>sumatriptan succinate refill</i>	4	QL [4 packs (2 syringes/pack) per 15 days] †
<i>sumatriptan succinate tabs</i>	1	QL (18 tabs per 30 days) †
<i>sumatriptan succinate inj</i>	4	QL [4 packs (2 vials/pack) per 15 days] †
ZOMIG NASAL SOLN	3	QL (3-6ml inhalers per 30 days) †
ZOMIG TABS	3	QL (18 tabs per 30 days) †
ZOMIG ZMT	3	QL (18 tabs per 30 days) †

Antimyasthenic Agents

Parasympathomimetics

<i>bethanechol chloride</i>	1	
<i>guanidine hcl</i>	1	
MESTINON TIMESPAN	3	
MESTINON SYRP	3	
MYTELASE	3	
<i>pyridostigmine bromide</i>	1	
REGONOL	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
Antimycobacterials		
<i>Antimycobacterials, Other</i>		
<i>dapsone</i>	1	
MYCOBUTIN	2	
<i>Antituberculars</i>		
CAPASTAT SULFATE	4	B/D †
<i>cycloserine</i>	1	
<i>ethambutol hcl</i>	1	
<i>isonarif</i>	1	
ISONIAZID INJ	4	B/D †
<i>isoniazid syrp, tabs</i>	1	
PASER	3	
PRIFTIN	2	
<i>pyrazinamide</i>	1	
<i>rifampin caps</i>	1	
<i>rifampin inj</i>	4	B/D †
RIFATER	3	
SEROMYCIN	3	
TRECTOR	3	
Antineoplastics		
<i>Alkylating Agents</i>		
ALKERAN INJ	4	B/D †
BICNU	4	B/D †
BUSULFEX	4	B/D †
CEENU	2	
HEXALEN	2	
LEUKERAN	2	
MATULANE	2	
<i>melphalan hydrochloride</i>	4	B/D †
MUSTARGEN	4	B/D †
<i>thiotepa</i>	4	B/D †
TREANDA	5	B/D †
ZANOSAR	4	B/D †
<i>Antiangiogenic Agents</i>		
REVLIMID	5	PA LA †
THALOMID	5	PA †
VANDETANIB TABS 300MG	5	QL (30 tabs per 30 days) PA †
VANDETANIB TABS 100MG	5	QL (60 tabs per 30 days) PA †
VOTRIENT	5	QL (120 tabs per 30 days) PA †
<i>Antiestrogens/Modifiers</i>		
EMCYT	2	
FARESTON	2	
FASLODEX	4	B/D †
<i>tamoxifen citrate</i>	1	
<i>Antimetabolites</i>		
ALIMTA	4	B/D †
<i>cladribine</i>	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
DROXIA	2	
ELITEK	5	B/D †
<i>floxuridine</i>	4	B/D †
<i>fludarabine phosphate</i>	4	B/D †
FLUOROURACIL INJ	4	†
<i>gemcitabine hcl</i>	4	B/D †
<i>hydroxyurea</i>	1	
<i>mercaptopurine</i>	1	
TABLOID	2	
<i>Antineoplastics, Other</i>		
ABRAXANE	4	B/D †
<i>adriamycin inj 10mg, 20mg, 50mg</i>	4	B/D †
<i>amifostine</i>	4	B/D †
ARRANON	5	B/D †
AVASTIN	5	B/D †
<i>bleomycin sulfate</i>	4	B/D †
<i>carboplatin</i>	4	B/D †
<i>cisplatin</i>	4	B/D †
CLOLAR	4	B/D †
<i>cyclophosphamide tabs</i>	1	PA
<i>cyclophosphamide inj</i>	4	B/D †
<i>cytarabine</i>	4	B/D †
<i>cytarabine aqueous</i>	4	B/D †
<i>dacarbazine</i>	4	B/D †
DACOGEN	5	PA †
<i>dactinomycin</i>	4	B/D †
<i>daunorubicin hcl</i>	4	B/D †
<i>docetaxel</i>	4	B/D †
DOXIL	4	B/D †
<i>doxorubicin hcl</i>	4	B/D †
ELLENC	4	B/D †
ELSPAR	4	B/D †
EPIRUBICIN HCL INJ	4	B/D †
200MG, 50MG		
<i>epirubicin hcl inj 50mg/25ml</i>	4	B/D †
ETOPOPHOS	4	B/D †
<i>etoposide inj</i>	4	B/D †
HALAVEN	5	B/D †
IDAMYCIN PFS	4	B/D †
<i>idarubicin hcl</i>	4	B/D †
<i>ifosfamide</i>	4	B/D †
<i>ifosfamide/mesna</i>	4	B/D †
<i>irinotecan</i>	4	B/D †
ISTODAX	5	B/D †
IXEMPRA KIT	5	B/D †
JEVTANA	5	B/D †
<i>mesna</i>	4	B/D †
MESNEX TABS	2	

Drug Name	Drug Tier	Requirements/ Limits
<i>mitomycin</i>	4	B/D †
<i>mitoxantrone hcl</i>	4	B/D †
ONCASPAR	4	B/D †
ONTAK	5	B/D †
<i>oxaliplatin inj 100mg, 50mg</i>	4	B/D †
<i>oxaliplatin inj 100mg/20ml</i>	5	B/D †
<i>paclitaxel</i>	4	B/D †
<i>pentostatin</i>	4	B/D †
PHOTOFRIN	4	B/D †
PROLEUKIN	5	B/D †
SYLATRON	5	PA †
TAXOTERE	4	B/D †
<i>topotecan hcl</i>	4	B/D †
TORISEL	5	B/D †
TRISENOX	4	B/D †
TYKERB	5	PA †
VELCADE	5	B/D †
VIDAZA	5	B/D †
<i>vinblastine sulfate</i>	4	B/D †
<i>vincasar pfs</i>	4	B/D †
<i>vincristine sulfate</i>	4	B/D †
<i>vinorelbine tartrate</i>	4	B/D †
VUMON	4	B/D †
ZOLINZA	5	QL (120 caps per 30 days) PA †
<i>Aromatase Inhibitors, 3rd Generation</i>		
<i>anastrozole</i>	1	
<i>exemestane</i>	1	
<i>letrozole</i>	1	
<i>Molecular Target Inhibitors</i>		
AFINITOR TABS 2.5MG, 5MG	5	QL (30 tabs per 30 days) PA †
AFINITOR TABS 10MG	5	QL (60 tabs per 30 days) PA †
GLEEVEC	5	PA †
IRESSA	5	QL (30 tabs per 30 days) PA LA †
NEXAVAR	5	PA LA †
SPRYCEL	5	PA †
SUTENT	5	PA †
TARCEVA	5	PA †
TASIGNA	5	PA †
XALKORI	5	QL (60 caps per 30 days) PA †
ZELBORAF	5	QL (240 tabs per 30 days) PA †
<i>Monoclonal Antibodies</i>		
ARZERRA	5	PA †
CAMPATH	5	B/D †

Drug Name	Drug Tier	Requirements/ Limits
ERBITUX	5	B/D †
HERCEPTIN	5	B/D †
RITUXAN	5	PA †
VECTIBIX	5	B/D †
Retinoids		
PANRETIN	5	PA †
TARGRETIN	5	†
<i>tretinoin caps</i>	1	
Antiparasitics		
Anthelmintics		
ALBENZA	3	
BILTRICIDE	2	
<i>mebendazole</i>	1	
STROMEKTOL	3	
Antiprotozoals		
ALINIA SUSR	3	QL (180 ml's per 3 days) †
ALINIA TABS	3	QL (60 tabs per 30 days) †
<i>atovaquone/proguanil hcl 250mg/100mg tabs</i>	1	†
<i>chloroquine phosphate</i>	1	†
COARTEM	2	QL (24 tabs per 2 days) †
DARAPRIM	2	†
<i>hydroxychloroquine sulfate</i>	1	†
MALARONE	3	†
<i>mefloquine hcl</i>	1	†
MEPRON	2	PA †
NEBUPENT	2	B/D †
PENTAM 300	4	B/D †
<i>primaquine phosphate</i>	1	†
QUALAQUIN	2	QL (240 caps per 30 days) †
Pediculicides/ Scabicides		
<i>acticin</i>	1	
EURAX	2	
<i>lindane</i>	1	
<i>malathion</i>	1	
<i>permethrin</i>	1	
Antiparkinson Agents		
Antiparkinson Agents		
<i>amantadine hcl</i>	1	
APOKYN	4	PA †
AZILECT	2	QL (30 tabs per 30 days)
<i>benztropine mesylate tabs</i>	1	
<i>benztropine mesylate inj</i>	4	B/D †
<i>bromocriptine mesylate</i>	1	
<i>carbidopa/levodopa</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>carbidopa/levodopa cr</i>	1	
<i>carbidopa/levodopa er</i>	1	
<i>carbidopa/levodopa odt</i>	1	
<i>carbidopa/levodopa sr</i>	1	
COGENTIN	4	B/D †
COMTAN	2	
LODOSYN	3	
MIRAPEX ER	3	QL (30 tabs per 30 days)
<i>pramipexole dihydrochloride</i>	1	
<i>ropinirole hcl</i>	1	
<i>selegiline hcl</i>	1	
STALEVO 100	2	
STALEVO 125	2	
STALEVO 150	2	
STALEVO 200	2	
STALEVO 50	2	
STALEVO 75	2	
TASMAR	3	
<i>trihexyphenidyl hcl</i>	1	
Antipsychotics		
Atypicals		
ABILIFY DISCMELT	3	PA
ABILIFY ORAL SOLN, TABS	3	
ABILIFY INJ	4	B/D †
<i>clozapine</i>	1	
FANAPT	3	QL (60 tabs per 30 days)
FANAPT TITRATION PACK	3	QL (1-8 tablet pack per 30 days)
FAZACLO	3	
GEODON CAPS	3	
GEODON INJ	4	B/D †
INVEGA	3	PA
INVEGA SUSTENNA INJ	4	PA †
39MG/0.25ML, 78MG/0.5ML		
INVEGA SUSTENNA INJ	5	PA †
117MG/0.75ML, 156MG/ML, 234MG/1.5ML		
LATUDA	3	QL (30 tabs per 30 days)
<i>olanzapine</i>	1	
RISPERDAL CONSTA	4	B/D †
<i>risperidone</i>	1	
<i>risperidone odt</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
SAPHRIS	3	QL (60 tabs per 30 days)
SEROQUEL	2	
SEROQUEL XR	2	
SYMBYAX	3	
ZYPREXA ZYDIS	3	
ZYPREXA TABS	3	
ZYPREXA INJ	4	B/D †
Conventional		
<i>chlorpromazine hcl tabs</i>	1	
<i>chlorpromazine hcl inj</i>	4	B/D †
<i>fluphenazine decanoate</i>	4	B/D †
<i>fluphenazine hcl conc, elix, tabs</i>	1	
<i>fluphenazine hcl inj</i>	4	B/D †
<i>haloperidol</i>	1	
<i>haloperidol decanoate</i>	4	B/D †
<i>haloperidol lactate</i>	4	B/D †
<i>loxapine succinate</i>	1	
NAVANE CAPS 20MG	2	
ORAP	2	
<i>perphenazine</i>	1	
<i>thioridazine hcl</i>	1	
<i>thiothixene</i>	1	
<i>trifluoperazine hcl</i>	1	
Antispasticity Agents		
Antispasticity Agents		
<i>baclofen</i>	1	
<i>dantrolene sodium</i>	1	
<i>tizanidine hcl</i>	1	
ZANAFLEX CAPS 6MG	3	
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
<i>foscarnet sodium</i>	4	B/D †
<i>ganciclovir caps</i>	1	
<i>ganciclovir inj</i>	4	B/D †
VALCYTE	2	
VISTIDE	4	B/D †
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		
COMPLERA	2	
EDURANT	2	
INTELENCE	2	
RESCRIPTOR	2	
SUSTIVA	2	
VIRAMUNE	2	
VIRAMUNE XR	2	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		
ATRIPLA	5	†

Drug Name	Drug Tier	Requirements/ Limits
COMBIVIR	2	
<i>didanosine</i>	1	
EMTRIVA	2	
EPIVIR	2	
EPIVIR HBV	2	PA
EPZICOM	2	
<i>lamivudine</i>	1	
RETROVIR IV INFUSION	4	†
<i>stavudine</i>	1	
TRIZIVIR	2	
TRUVADA	2	
VIDEX PEDIATRIC	2	
VIREAD	2	
ZIAGEN	2	
<i>zidovudine</i>	1	
Anti-HIV Agents, Other		
FUZEON	5	†
ISENTRESS	2	
SELZENTRY	2	
Anti-HIV Agents, Protease Inhibitors		
APTIVUS	2	
CRIXIVAN	2	
INVIRASE	2	
KALETRA	2	
LEXIVA	2	
NORVIR	2	
PREZISTA TABS 150MG, 75MG	3	
PREZISTA TABS 400MG, 600MG	5	†
REYATAZ	2	
VICTRELIS	5	QL (336 caps per 28 days) PA †
VIRACEPT	2	
Anti-influenza Agents		
<i>amantadine hcl</i>	1	
RELENZA DISKHALER	2	QL (3 diskhalers per 180 days)
<i>rimantadine hcl</i>	1	
TAMIFLU 6MG/ML SUSR	2	QL (1080 ml's per 365 days)
TAMIFLU 12MG/ML SUSR	2	QL (525 ml's per 365 days)
TAMIFLU CAPS 75MG	2	QL (28 caps per 180 days)
TAMIFLU CAPS 45MG	2	QL (42 caps per 180 days)
TAMIFLU CAPS 30MG	2	QL (56 caps per 180 days)
Antihpatitis Agents		

Drug Name	Drug Tier	Requirements/ Limits
BARACLUDE TABS	2	QL (30 tabs per 30 days)
BARACLUDE SOLN	2	QL (630 ml's per 30 days)
HEPSERA	2	QL (30 tabs per 30 days)
INCIVEK	5	QL (168 tabs per 28 days) PA †
REBETOL SOLN	3	PA
<i>ribapak</i>	1	PA
<i>ribasphere</i>	1	PA
<i>ribavirin</i>	1	PA
TYZEKA	2	QL (30 tabs per 30 days)

Antitherpetic Agents

<i>acyclovir caps, tabs</i>	1	
<i>acyclovir sodium inj</i>	4	B/D †
DENAVIR	3	
<i>famciclovir</i>	1	
<i>valacyclovir hcl</i>	1	
ZOVIRAX CREA, OINT	3	

Anxiolytics

Anxiolytics, Other

<i>alprazolam er tb24 2mg</i>	1	QL (150 tabs per 30 days) ED
<i>alprazolam er tb24 1mg</i>	1	QL (300 tabs per 30 days) ED
<i>alprazolam er tb24 0.5mg</i>	1	QL (600 tabs per 30 days) ED
<i>alprazolam er tb24 3mg</i>	1	QL (90 tabs per 30 days) ED
<i>alprazolam intensol</i>	1	QL (120 ml's per 30 days) ED
<i>alprazolam xr</i>	1	QL (90 tabs per 30 days) ED
<i>alprazolam tabs 0.25mg</i>	1	QL (1200 tabs per 30 days) ED
<i>alprazolam tabs 2mg</i>	1	QL (150 tabs per 30 days) ED
<i>alprazolam tabs 1mg</i>	1	QL (300 tabs per 30 days) ED
<i>alprazolam tabs 0.5mg</i>	1	QL (600 tabs per 30 days) ED
<i>buspirone hcl</i>	1	
<i>chlordiazepoxide hcl caps 5mg</i>	1	QL (1800 caps per 30 days) ED
<i>chlordiazepoxide hcl caps 25mg</i>	1	QL (360 caps per 30 days) ED
<i>chlordiazepoxide hcl caps 10mg</i>	1	QL (900 caps per 30 days) ED

Drug Name	Drug Tier	Requirements/ Limits
<i>diazepam intensol</i>	1	QL (360 ml's per 30 days) ED
<i>diazepam soln</i>	1	QL (1800 ml's per 30 days) ED
<i>diazepam tabs 10mg</i>	1	QL (180 tabs per 30 days) ED
<i>diazepam tabs 5mg</i>	1	QL (360 tabs per 30 days) ED
<i>diazepam tabs 2mg</i>	1	QL (900 tabs per 30 days) ED
<i>lorazepam intensol</i>	1	QL (150 ml's per 30 days) ED
<i>lorazepam tabs 2mg</i>	1	QL (150 tabs per 30 days) ED
<i>lorazepam tabs 1mg</i>	1	QL (300 tabs per 30 days) ED
<i>lorazepam tabs 0.5mg</i>	1	QL (600 tabs per 30 days) ED
<i>meprobamate</i>	1	QL (180 tabs per 30 days)
<i>midazolam hcl</i>	1	ED
<i>oxazepam caps 30mg</i>	1	QL (120 caps per 30 days) ED
<i>oxazepam caps 15mg</i>	1	QL (240 caps per 30 days) ED
<i>oxazepam caps 10mg</i>	1	QL (360 caps per 30 days) ED

Bipolar Agents

Bipolar Agents

LAMICTAL	2	
STARTER/NOT TAKING		
CARBAMAZEPINE		
<i>lithium carbonate</i>	1	
<i>lithium carbonate er</i>	1	
<i>lithium citrate</i>	1	

Blood Glucose Regulators

Antidiabetic Agents

<i>acarbose</i>	1	
ACTOPLUS MET	2	ST
ACTOPLUS MET XR	2	ST
ACTOS	2	ST
BYETTA	4	PA †
<i>chlorthalidone</i>	1	
DUETACT	3	ST
<i>glimepiride</i>	1	
<i>glipizide</i>	1	
<i>glipizide er</i>	1	
<i>glipizide xl</i>	1	
<i>glipizide/metformin hcl</i>	1	
<i>glyburide</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>glyburide micronized</i>	1	
<i>glyburide/metformin hcl</i>	1	
GLYSET	3	
JANUMET	2	QL (60 tabs per 30 days) ST
JANUVIA	2	QL (30 tabs per 30 days) ST
JUVISYNC	2	QL (30 tabs per 30 days) ST
<i>metformin hcl</i>	1	
<i>metformin hcl er</i>	1	
<i>nateglinide tabs 60mg</i>	1	QL (180 tabs per 30 days)
<i>nateglinide tabs 120mg</i>	1	QL (90 tabs per 30 days)
PRANDIN TABS 0.5MG, 1MG	2	QL (120 tabs per 30 days)
PRANDIN TABS 2MG	2	QL (240 tabs per 30 days)
RIOMET	3	
SYMLIN	4	QL (4-5ml vials per 30 days) PA †
SYMLINPEN 120	4	QL (4-2.7ml pens per 30 days) PA †
SYMLINPEN 60	4	QL (8-1.5ml pens per 30 days) PA †
<i>tolazamide</i>	1	
<i>tolbutamide</i>	1	
Glycemic Agents		
GLUCAGEN HYPOKIT	2	QL (2 kits per 2 days)
GLUCAGON EMERGENCY KIT	2	QL (2 kits per 2 days)
PROGLYCEM	2	
Insulins		
APIDRA VIAL	3	
HUMALOG PEN	2	
HUMALOG VIAL	2	
HUMALOG MIX 50/50 PEN	2	
HUMALOG MIX 50/50 VIAL	2	
HUMALOG MIX 75/25 PEN	2	
HUMALOG MIX 75/25 VIAL	2	
HUMULIN 70/30 VIAL	2	

Drug Name	Drug Tier	Requirements/ Limits
HUMULIN N VIAL	2	
HUMULIN R VIAL	2	
HUMULIN R U-500 VIAL (CONCENTRATED)	2	
LANTUS SOLOSTAR	2	QL (15 pens per 30 days)
LANTUS VIAL	2	
LEVEMIR VIAL	2	
LEVEMIR FLEXPEN	2	
NOVOLIN 70/30 VIAL	3	
NOVOLIN N VIAL	3	
NOVOLIN R VIAL	3	
NOVOLOG VIAL	3	
NOVOLOG MIX 70/30 VIAL	3	
Blood Products/Modifiers/ Volume Expanders		
Anticoagulants		
ARIXTRA INJ 2.5MG/0.5ML	4	QL (30 syringes per 30 days) †
ARIXTRA INJ 5MG/0.4ML, 7.5MG/0.6ML, 10MG/0.8ML	5	QL (30 syringes per 30 days) †
COUMADIN TABS	3	
COUMADIN INJ	4	B/D †
<i>enoxaparin sodium inj 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml</i>	4	QL (28 syringes per 60 days) †
<i>enoxaparin sodium inj 100mg/ml, 120mg/0.8ml, 150mg/ml</i>	5	QL (28 syringes per 60 days) †
<i>fondaparinux sodium 2.5mg/0.5ml</i>	4	QL (30 syringes per 30 days) †
<i>fondaparinux sodium 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml</i>	5	QL (30 syringes per 30 days) †
FRAGMIN INJ 2500UNIT/0.2ML, 5000UNIT/0.2ML, 25000UNIT/ML	4	QL (28 syringes per 60 days) †
FRAGMIN INJ 10000UNIT/ML,	5	QL (14 syringes per 60 days) †
FRAGMIN INJ 7500UNIT/0.3ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNIT/0.72ML	5	QL (28 syringes per 60 days) †
<i>heparin sodium</i>	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
HEPARIN SODIUM/D5W INJ 5%; 40UNIT/ML, 5%; 50UNIT/ML	4	B/D †
<i>heparin sodium/d5w inj 5%; 100unit/ml</i>	4	B/D †
<i>heparin sodium/nacl 0.45%</i>	4	B/D †
<i>heparin sodium/nacl 0.9%</i>	4	B/D †
<i>heparin sodium/sodium chloride 0.9% premix</i>	4	B/D †
INNOHEP	4	PA †
<i>jantoven</i>	1	
<i>warfarin sodium</i>	1	
Blood Formation Products		
ARANESP ALBUMIN FREE INJ 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/ML	4	PA †
ARANESP ALBUMIN FREE INJ 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML, 60MCG/0.3ML	5	PA †
LEUKINE INJ 250MCG	5	PA †
NEULASTA	5	PA †
NEUMEGA	5	PA †
NEUPOGEN	5	PA †
PROCRIT INJ 2000UNIT/ML	2	PA
PROCRIT INJ 10000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA †
PROCRIT INJ 20000UNIT/ML, 40000UNIT/ML	5	PA †
Blood Products/Modifiers/ Volume Expanders		
CINRYZE	5	B/D †
PROMACTA TABS 50MG, 75MG	5	QL (30 tabs per 30 days) PA †
PROMACTA TABS 25MG	5	QL (90 tabs per 30 days) PA †
Coagulants		
CYKLOKAPRON	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
Platelet Aggregation Inhibitors		
AGGRENOX	3	
<i>cilostazol</i>	1	
<i>dipyridamole</i>	1	
EFFIENT TABS 5MG	3	QL (30 tabs per 30 days)
EFFIENT TABS 10MG	3	QL (36 tabs per 30 days)
PLAVIX TABS 75MG	2	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
<i>clonidine hcl patch, tabs</i>	1	
CLORPRES	2	
<i>guanabenz acetate</i>	1	
<i>guanfacine hcl</i>	1	
<i>methyldopa</i>	1	
<i>methyldopa/hydrochlorothiazide</i>	1	
<i>methyldopate hcl</i>	4	B/D †
<i>midodrine hcl</i>	1	
Alpha-adrenergic Blocking Agents		
<i>prazosin hcl</i>	1	
<i>reserpine</i>	1	
Antiarrhythmics		
<i>amiodarone hcl tabs</i>	1	
<i>amiodarone hcl inj</i>	4	B/D †
<i>disopyramide phosphate</i>	1	
<i>flecainide acetate</i>	1	
<i>mexiletine hcl</i>	1	
MULTAQ	2	QL (60 tabs per 30 days)
NORPACE CR	2	
PACERONE TABS 100MG	2	
<i>procainamide hcl</i>	4	B/D †
<i>propafenone hcl</i>	1	
<i>propafenone hcl er</i>	1	
<i>quinidine gluconate er</i>	1	
<i>quinidine sulfate</i>	1	
<i>quinidine sulfate er</i>	1	
<i>sorine</i>	1	
<i>sotalol hcl</i>	1	
<i>sotalol hcl (af)</i>	1	
TIKOSYN	2	
Beta-adrenergic Blocking Agents		
<i>acebutolol hcl</i>	1	
<i>atenolol</i>	1	
<i>atenolol/chlorthalidone</i>	1	
<i>betaxolol hcl</i>	1	
<i>bisoprolol fumarate</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>bisoprolol</i>	1	
<i>fumarate/hydrochlorothiazide</i>		
<i>carvedilol</i>	1	
COREG CR	3	ST
INNOPRAN XL	3	
<i>labetalol hcl tabs</i>	1	
<i>labetalol hcl inj</i>	4	B/D †
LEVATOL	3	
<i>metoprolol succinate er</i>	1	
<i>metoprolol tartrate tabs</i>	1	
<i>metoprolol tartrate inj</i>	4	B/D †
<i>metoprolol/ hydrochlorothiazide</i>	1	
<i>nadolol</i>	1	
<i>nadolol/bendroflumethiazide</i>	1	
<i>pindolol</i>	1	
<i>propranolol hcl er</i>	1	
<i>propranolol hcl oral soln, tabs</i>	1	
<i>propranolol hcl inj</i>	4	B/D †
<i>propranolol/ hydrochlorothiazide</i>	1	
<i>timolol maleate</i>	1	
Calcium Channel Blocking Agents		
<i>afeditab cr</i>	1	
<i>amlodipine besylate</i>	1	
<i>amlodipine besylate/benazepril hcl caps 10mg; 40mg</i>	1	QL (30 caps per 30 days)
<i>amlodipine besylate/benazepril hcl caps 5mg; 40mg</i>	1	QL (60 caps per 30 days)
CARDENE IV	4	B/D †
CARDIZEM CD CP24 360MG	3	
CARDIZEM LA TB24 120MG	3	
<i>cartia xt</i>	1	
COVERA-HS	3	
<i>dilt-xr cp24 180mg</i>	1	
<i>diltiazem cd</i>	1	
<i>diltiazem hcl er</i>	1	
<i>diltiazem hcl cp24, tabs</i>	1	
<i>diltiazem hcl inj</i>	4	B/D †
<i>diltzac cp24 120mg, 180mg, 300mg</i>	1	
DYNACIRC CR	3	

Drug Name	Drug Tier	Requirements/ Limits
EXFORGE HCT	3	QL (30 tabs per 30 days) ST
<i>felodipine er</i>	1	
<i>isradipine</i>	1	
<i>matzim la</i>	1	
<i>nicardipine hcl caps</i>	1	
<i>nifediac cc</i>	1	
<i>nifedical xl</i>	1	
<i>nifedipine</i>	1	
<i>nifedipine er</i>	1	
<i>nimodipine</i>	1	
<i>nisoldipine</i>	1	
<i>nisoldipine er</i>	1	
<i>taztia xt</i>	1	
<i>verapamil hcl er</i>	1	
<i>verapamil hcl sr</i>	1	
<i>verapamil hcl tabs</i>	1	
<i>verapamil hcl inj</i>	4	B/D †
Cardiovascular Agents, Other		
DEMSEER	3	
<i>digoxin oral soln, tabs</i>	1	
<i>digoxin inj</i>	4	B/D †
LANOXIN TABS	3	
LANOXIN INJ	4	B/D †
RANEXA	3	PA
Diuretics		
<i>acetazolamide</i>	1	
ACETAZOLAMIDE	4	B/D †
SODIUM		
<i>amiloride hcl</i>	1	
<i>amiloride/hydrochlorothiazide</i>	1	
<i>bumetanide tabs</i>	1	
<i>bumetanide inj</i>	4	B/D †
<i>chlorothiazide</i>	1	
<i>chlorothiazide sodium</i>	4	B/D †
<i>chlorthalidone</i>	1	
DIURIL	3	
DYRENIUM	3	
EDECRIN	3	
<i>furosemide oral soln, tabs</i>	1	
<i>furosemide inj</i>	4	B/D †
<i>hydrochlorothiazide</i>	1	
<i>indapamide</i>	1	
<i>methyclothiazide</i>	1	
<i>metolazone</i>	1	
SODIUM EDECRIN	4	B/D †
THALITONE	2	
<i>torsemide tabs</i>	1	
<i>torsemide inj</i>	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
<i>triamterene/ hydrochlorothiazide</i>	1	
<i>Dyslipidemics</i>		
ADVICOR TB24 20MG; 500MG, 40MG; 1000MG	2	QL (30 tabs per 30 days)
ADVICOR TB24 20MG; 1000MG, 20MG; 750MG	2	QL (60 tabs per 30 days)
ALTOPREV	3	
<i>amlodipine/atorvastatin</i>	1	QL (30 tabs per 30 days)
ANTARA	3	
<i>atorvastatin</i>	1	QL (30 tabs per 30 days)
<i>cholestyramine</i>	1	
<i>cholestyramine light</i>	1	
<i>colestipol hcl</i>	1	
<i>colestipol hcl for oral suspension</i>	1	
CRESTOR	3	QL (30 tabs per 30 days) PA
<i>fenofibrate</i>	1	
<i>fenofibrate micronized</i>	1	
<i>gemfibrozil</i>	1	
LESCOL	3	QL (60 caps per 30 days)
LESCOL XL	3	QL (30 tabs per 30 days)
LIPITOR	3	QL (30 tabs per 30 days) PA
<i>lovastatin</i>	1	QL (60 tabs per 30 days)
LOVAZA	3	PA
<i>niacor</i>	1	
NIASPAN	2	
<i>pravastatin sodium tabs 80mg</i>	1	QL (30 tabs per 30 days)
<i>pravastatin sodium tabs 10mg, 20mg, 40mg</i>	1	QL (60 tabs per 30 days)
<i>prevalite</i>	1	
SIMCOR TB24 1000MG; 40MG, 500MG; 20MG, 500MG; 40MG	2	QL (30 tabs per 30 days)
SIMCOR TB24 1000MG; 20MG, 750MG; 20MG	2	QL (60 tabs per 30 days)
<i>simvastatin</i>	1	QL (30 tabs per 30 days)
TRICOR	2	
TRIGLIDE	3	
TRILIPIX	2	QL (30 caps per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
VYTORIN	2	QL (30 tabs per 30 days) ST
WELCHOL	2	
ZETIA	3	QL (30 tabs per 30 days)
<i>Renin-angiotensin-aldosterone System Inhibitors</i>		
ALDACTAZIDE	3	
<i>amlodipine besylate/benazepril hydrochloride</i>	1	QL (30 tabs per 30 days)
AMTURNIDE	3	QL (30 tabs per 30 days) ST
ATACAND	3	QL (30 tabs per 30 days) ST
ATACAND HCT	3	QL (30 tabs per 30 days) ST
AVALIDE TABS 12.5MG; 300MG, 25MG; 300MG	3	QL (30 tabs per 30 days) ST
AVALIDE TABS 12.5MG; 150MG	3	QL (60 tabs per 30 days) ST
AVAPRO TABS 300MG	2	QL (30 tabs per 30 days) ST
AVAPRO TABS 150MG, 75MG	3	QL (30 tabs per 30 days) ST
<i>benazepril hcl/hydrochlorothiazide</i>	1	
<i>benazepril hcl tabs 10mg, 20mg, 5mg</i>	1	QL (30 tabs per 30 days)
<i>benazepril hcl tabs 40mg</i>	1	QL (60 tabs per 30 days)
BENICAR HCT	3	QL (30 tabs per 30 days) ST
BENICAR TABS 20MG, 40MG	3	QL (30 tabs per 30 days) ST
BENICAR TABS 5MG	3	QL (90 tabs per 30 days) ST
<i>captopril</i>	1	
<i>captopril/hydrochlorothiazide</i>	1	
DIOVAN HCT TABS 12.5MG; 320MG, 12.5MG; 80MG, 25MG; 160MG, 25MG; 320MG	2	QL (30 tabs per 30 days) ST
DIOVAN HCT TABS 12.5MG; 160MG	2	QL (60 tabs per 30 days) ST
DIOVAN TABS 320MG, 40MG	2	QL (30 tabs per 30 days) ST
DIOVAN TABS 160MG, 80MG	2	QL (60 tabs per 30 days) ST

Drug Name	Drug Tier	Requirements/ Limits
EDARBI	3	QL (30 tabs per 30 days) ST
<i>enalapril maleate</i>	1	
<i>enalapril maleate/hydrochlorothiazide</i>	1	
<i>eplerenone</i>	1	
<i>eprosartan 600mg tabs</i>	1	QL (30 tabs per 30 days) ST
EXFORGE	3	QL (30 tabs per 30 days) ST
<i>fosinopril sodium/hydrochlorothiazide</i>	1	QL (120 tabs per 30 days)
<i>fosinopril sodium tabs 10mg, 20mg</i>	1	QL (30 tabs per 30 days)
<i>fosinopril sodium tabs 40mg</i>	1	QL (60 tabs per 30 days)
<i>lisinopril</i>	1	QL (60 tabs per 30 days)
<i>lisinopril/hydrochlorothiazide tabs 12.5mg; 10mg</i>	1	QL (30 tabs per 30 days)
<i>lisinopril/hydrochlorothiazide tabs 12.5mg; 20mg, 25mg; 20mg</i>	1	QL (60 tabs per 30 days)
<i>losartan potassium</i>	1	QL (30 tabs per 30 days)
<i>losartan potassium/hydrochlorothiazide</i>	1	QL (30 tabs per 30 days)
MICARDIS HCT TABS 12.5MG; 40MG	3	QL (30 tabs per 30 days) ST
MICARDIS HCT TABS 12.5MG; 80MG, 25MG; 80MG	3	QL (60 tabs per 30 days) ST
MICARDIS TABS 20MG, 40MG	3	QL (30 tabs per 30 days) ST
MICARDIS TABS 80MG	3	QL (60 tabs per 30 days) ST
<i>moexipril hcl</i>	1	QL (60 tabs per 30 days)
<i>moexipril/hydrochlorothiazide tabs 12.5mg; 7.5mg</i>	1	QL (30 tabs per 30 days)
<i>moexipril/hydrochlorothiazide tabs 12.5mg; 15mg, 25mg; 15mg</i>	1	QL (60 tabs per 30 days)
<i>perindopril erbumine tabs 2mg, 4mg</i>	1	QL (30 tabs per 30 days)
<i>perindopril erbumine tabs 8mg</i>	1	QL (60 tabs per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>quinapril hcl</i>	1	QL (60 tabs per 30 days)
<i>quinapril/hydrochlorothiazide</i>	1	QL (30 tabs per 30 days)
<i>ramipril caps 10mg</i>	1	QL (60 caps per 30 days)
<i>ramipril caps 1.25mg, 2.5mg, 5mg</i>	1	QL (90 caps per 30 days)
<i>spironolactone</i>	1	
<i>spironolactone/hydrochlorothiazide</i>	1	
TARKA	3	
TEKTURNA	3	QL (30 tabs per 30 days) ST
TEKTURNA HCT	3	QL (30 tabs per 30 days) ST
TEVETEN HCT	3	QL (30 tabs per 30 days) ST
TEVETEN TABS 600MG	3	QL (30 tabs per 30 days) ST
TEVETEN TABS 400MG	3	QL (60 tabs per 30 days) ST
<i>trandolapril tabs 1mg, 2mg</i>	1	QL (30 tabs per 30 days)
<i>trandolapril tabs 4mg</i>	1	QL (60 tabs per 30 days)
VALTURNA	3	QL (30 tabs per 30 days) ST
Vasodilators		
BIDIL	3	QL (180 tabs per 30 days) PA
DILATRATE SR	3	
<i>hydralazine hcl tabs</i>	1	
<i>hydralazine hcl inj</i>	4	B/D †
ISORDIL TITRADOSE TABS 40MG	3	
<i>isosorbide dinitrate</i>	1	
<i>isosorbide dinitrate er</i>	1	
<i>isosorbide mononitrate</i>	1	
<i>isosorbide mononitrate er</i>	1	
<i>minitran</i>	1	
<i>minoxidil</i>	1	
NITRO-BID	2	
NITRO-DUR PT24 0.3MG/HR, 0.8MG/HR	2	
<i>nitroglycerin lingual</i>	1	
<i>nitroglycerin transdermal</i>	1	
<i>nitroglycerin pt24</i>	1	
<i>nitroglycerin inj</i>	4	B/D †
NITROSTAT	2	

Drug Name	Drug Tier	Requirements/Limits
<i>papaverine hcl</i>	4	B/D †
Central Nervous System Agents		
<i>Amphetamines, ADHD</i>		
ADDERALL XR CP24 5MG, 10MG, 20MG, 25MG, 30MG	2	QL (30 caps per 30 days)
ADDERALL XR CP24 15MG	2	QL (60 caps per 30 days)
<i>amphetamine/dextroamphetamine cp24 5mg, 10mg, 20mg, 25mg, 30mg</i>	1	QL (30 caps per 30 days)
<i>amphetamine/dextroamphetamine cp24 15mg</i>	1	QL (60 caps per 30 days)
<i>amphetamine/dextroamphetamine tabs</i>	1	
<i>dextroamphetamine sulfate</i>	1	
<i>dextroamphetamine sulfate er</i>	1	
<i>methamphetamine hcl</i>	1	
VYVANSE	2	
<i>Non-amphetamines, ADHD</i>		
CONCERTA	2	QL (30 tabs per 30 days)
<i>dexmethylphenidate hcl</i>	1	QL (60 tabs per 30 days)
FOCALIN XR 5MG, 10MG	3	QL (60 caps per 30 days)
FOCALIN XR 15MG, 20MG, 25MG, 30MG, 35MG, 40MG	3	QL (30 caps per 30 days)
METADATE CD	3	
<i>metadate er</i>	1	
<i>methylin er</i>	1	
METHYLIN CHEW	3	
<i>methylin tabs</i>	1	
<i>methylphenidate hcl</i>	1	
<i>methylphenidate hcl sr</i>	1	
<i>methylphenidate hydrochloride</i>	1	
RITALIN LA CP24 10MG, 20MG, 40MG	3	QL (30 caps per 30 days)
RITALIN LA CP24 30MG	3	QL (60 caps per 30 days)
STRATTERA CAPS 100MG, 60MG, 80MG	2	QL (30 caps per 30 days)
STRATTERA CAPS 10MG, 18MG, 25MG, 40MG	2	QL (60 caps per 30 days)
<i>Non-amphetamines, Other</i>		

Drug Name	Drug Tier	Requirements/Limits
AMPYRA	5	QL (60 tabs per 30 days) PA †
NUEDEXTA	2	QL (60 caps per 30 days)
NUVIGIL TABS 150MG, 250MG	2	QL (30 tabs per 30 days) PA
NUVIGIL TABS 50MG	2	QL (60 tabs per 30 days) PA
RILUTEK	2	
XYREM	5	QL (540 ml's per 30 days) PA LA †
Dental and Oral Agents		
<i>Dental and Oral Agents</i>		
APHTHASOL	3	
<i>chlorhexidine gluconate oral rinse</i>	1	
EVOXAC	2	
<i>periogard</i>	1	
<i>pilocarpine hcl tabs</i>	1	
<i>triamcinolone in orabase</i>	1	
Dermatological Agents		
<i>Dermatological Agents</i>		
8-MOP	3	
<i>adapalene</i>	1	PA
AMEVIVE	5	PA †
<i>ammonium lactate</i>	1	
<i>amnestem</i>	1	
AZELEX	3	
BENZACLIN WITH PUMP	3	
<i>calcipotriene</i>	1	
<i>calcitrene</i>	1	
CARAC	2	
<i>claravis</i>	1	
<i>clindamycin phosphate</i>	1	
<i>clindamycin/benzoyl peroxide</i>	1	
CONDYLOX	3	
DIFFERIN LOTN 0.1%	3	PA
DIFFERIN GEL 0.3%	3	PA
DOVONEX	2	
ELIDEL	2	QL (1-100 gram tube per 30 days) PA
<i>erythromycin/benzoyl peroxide</i>	1	
FINACEA	3	
FLUOROPLEX	2	
<i>fluorouracil</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>imiquimod</i>	1	QL (1-24 count pack per 30 days)
<i>lacloion</i>	1	
OXSORALEN	3	
OXSORALEN ULTRA	2	
<i>podofilox</i>	1	
PROTOPIC	3	QL (1-100 gram tube per 30 days)
		PA
REGRANEX	2	PA
RETIN-A MICRO	2	PA
SANTYL	2	
SOLARAZE	3	
SORIATANE	2	
<i>sotret</i>	1	
STELARA	5	PA †
TACLONEX	3	PA
TAZORAC	3	PA
<i>tretinoin</i>	1	PA
UVADEX	4	B/D †
ZONALON	3	QL (1-45 gram tube per 30 days)
ZYCLARA	2	QL (1-28 count pack per 30 days)

Enzyme Replacements/ Modifiers

<i>Enzyme Replacements/ Modifiers</i>		
ADAGEN	4	B/D †
ALDURAZYME	5	B/D †
BUPHENYL	5	PA †
CARBAGLU	5	PA †
CEREDASE	5	PA †
CEREZYME	5	PA †
CREON	2	
CYSTADANE	3	
CYSTAGON	3	
ELAPRASE	5	B/D †
FABRAZYME	5	B/D †
LUMIZYME	5	B/D †
MYOZYME	5	B/D †
NAGLAZYME	5	B/D †
ORFADIN	3	PA
PANCREAZE	2	
SUCRAID	5	QL (360ml's per 30 days) †
VPRIV	5	B/D †
ZAVESCA	2	PA
ZENPEP	2	

Gastrointestinal Agents

Drug Name	Drug Tier	Requirements/ Limits
<i>Antispasmodics, Gastrointestinal</i>		
<i>atropine sulfate</i>	4	B/D †
BENTYL INJ	4	B/D †
CANTIL	3	
<i>dicyclomine hcl caps, oral soln, tabs</i>	1	
<i>dicyclomine hcl inj</i>	4	B/D †
<i>glycopyrrolate tabs</i>	1	
<i>glycopyrrolate inj</i>	4	B/D †
<i>methscopolamine bromide</i>	1	
MOTOFEN	3	
<i>propantheline bromide</i>	1	
<i>Gastrointestinal Agents, Other</i>		
AMITIZA	3	QL (60 caps per 30 days) PA
<i>constulose</i>	1	
DIPENTUM	2	
<i>diphenoxylate/atropine</i>	1	
<i>enulose</i>	1	
GASTROCROM	3	
<i>gavilyte-c</i>	1	
<i>gavilyte-g</i>	1	
<i>gavilyte-n/ flavor pack</i>	1	
GOLYTELY SOLR	3	
227.1GM; 2.82GM; 6.36GM; 5.53GM; 21.5GM		
KRISTALOSE	3	
<i>lactulose</i>	1	
<i>lonox</i>	1	
<i>loperamide hcl</i>	1	
<i>metoclopramide hcl oral soln, tabs</i>	1	
<i>metoclopramide hcl inj</i>	4	B/D †
<i>peg 3350/electrolytes</i>	1	
<i>polyethylene glycol 3350</i>	1	
<i>trilyte</i>	1	
<i>ursodiol</i>	1	
VISICOL	3	
<i>Histamine2 (H2) Blocking Agents</i>		
<i>cimetidine</i>	1	
<i>cimetidine hcl oral soln</i>	1	
<i>cimetidine hcl inj</i>	4	B/D †
<i>famotidine premixed</i>	4	B/D †
<i>famotidine susr, tabs</i>	1	
<i>famotidine inj</i>	4	B/D †
<i>nizatidine</i>	1	
<i>ranitidine hcl caps, syrp, tabs</i>	1	
<i>ranitidine hcl inj</i>	4	B/D †
ZANTAC TBEF	3	

Drug Name	Drug Tier	Requirements/Limits
ZANTAC INJ 50MG/50ML; 0.45%	4	B/D †
Irritable Bowel Syndrome Agents		
LOTRONEX	2	PA
Protectants		
<i>misoprostol</i>	1	
<i>sucralfate</i>	1	
Proton Pump Inhibitors		
DEXILANT	2	QL (30 caps per 30 days) ST
<i>lansoprazole</i>	1	
<i>lansoprazole odt</i>	1	
NEXIUM I.V.	4	B/D †
<i>omeprazole</i>	1	
<i>omeprazole/sodium bicarbonate</i>	1	ST
<i>pantoprazole sodium</i>	1	
PRILOSEC PACK 10MG	3	QL (60 packets per 30 days) ST
PRILOSEC PACK 2.5MG	3	QL (90 packets per 30 days) ST
PROTONIX PACK	2	
PROTONIX INJ	4	B/D †
ZEGERID PACK	3	QL (30 packets per 30 days) ST
Genitourinary Agents		
Antispasmodics, Urinary		
DETROL	3	QL (60 tabs per 30 days) ST
DETROL LA	3	QL (30 caps per 30 days) ST
ENABLEX TB24 15MG	2	QL (30 tabs per 30 days) ST
ENABLEX TB24 7.5MG	2	QL (60 tabs per 30 days) ST
<i>flavoxate hcl</i>	1	
<i>oxybutynin chloride</i>	1	
<i>oxybutynin chloride er</i>	1	
OXYTROL	2	QL (8 patches per 28 days) ST
SANCTURA XR	3	QL (30 caps per 30 days) ST
TOVIAZ	3	QL (30 tabs per 30 days) ST
<i>tropium chloride</i>	1	QL (60 tabs per 30 days)
VESICARE TABS 10MG	2	QL (30 tabs per 30 days) ST
VESICARE TABS 5MG	2	QL (60 tabs per 30 days) ST

Drug Name	Drug Tier	Requirements/Limits
Benign Prostatic Hypertrophy Agents		
<i>alfuzosin hcl</i>	1	QL (30 tabs per 30 days)
AVODART	3	QL (30 caps per 30 days) ST
<i>doxazosin mesylate</i>	1	
<i>finasteride</i>	1	
RAPAFLO	3	QL (30 caps per 30 days) ST
<i>tamsulosin hcl</i>	1	QL (60 tabs per 30 days)
<i>terazosin hcl</i>	1	
UROXATRAL	3	QL (30 tabs per 30 days)
Genitourinary Agents, Other		
CLINDESSE	2	
ELMIRON	2	
Phosphate Binders		
<i>calcium acetate</i>	1	
FOSRENOL	3	
RENAGEL	2	
REVELA TABS	2	QL (540 tabs per 30 days)
REVELA PACK 0.8GM	2	QL (180 packets per 30 days)
REVELA PACK 2.4GM	2	QL (180 packets per 30 days)
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
Glucocorticoids/ Mineralocorticoids		
<i>a-hydrocort</i>	4	B/D †
<i>a-methapred</i>	4	B/D †
<i>ala cort</i>	1	
ALA SCALP	3	
<i>ala-cort</i>	1	
<i>alclometasone dipropionate</i>	1	
<i>amcinonide</i>	1	
ANUSOL-HC	3	
ARISTOSPAN	4	B/D †
INTRALESIONAL		
<i>augmented betamethasone dipropionate crea, gel, oint</i>	1	
<i>betamethasone dipropionate</i>	1	
<i>betamethasone valerate</i>	1	
CAPEX	3	
CELESTONE	3	
<i>clobetasol propionate</i>	1	
<i>clobetasol propionate e</i>	1	
<i>clobetasol propionate emollient</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
CLODERM	3	
CORDRAN	3	
CORDRAN SP	3	
CORDRAN TAPE	3	
cortisone acetate	1	
CUTIVATE LOTN	3	
DEPO-MEDROL INJ 20MG/ML	4	B/D †
DERMA-SMOOTH/FS BODY OIL	3	
DERMA-SMOOTH/FS SCALP OIL	3	
desonide	1	
desoximetasone	1	
dexamethasone	1	
dexamethasone intensol	1	
dexamethasone sodium phosphate	4	B/D †
dexpak 13 day	1	
diflorasone diacetate	1	
DIPROLENE LOTN	3	
fludrocortisone acetate	1	
fluocinolone acetonide	1	
fluocinonide	1	
fluocinonide emollient base	1	
fluocinonide-e	1	
fluticasone propionate	1	
halobetasol propionate	1	
HALOG	3	
hydrocortisone butyrate	1	
hydrocortisone in absorbase	1	
hydrocortisone valerate	1	
hydrocortisone crea, oint, tabs	1	
hydrocortisone lotn 2.5%	1	
KENALOG	3	
KENALOG-10	4	B/D †
KENALOG-40	4	B/D †
LOCOID LIPOCREAM	3	
lokara	1	
LUXIQ	3	
MEDROL TABS 2MG, 4MG	2	
methylprednisolone acetate	4	B/D †
methylprednisolone sodiumsuccinate	4	B/D †
methylprednisolone tabs 4mg	1	
methylprednisolone tabs 16mg, 32mg, 8mg	1	

Drug Name	Drug Tier	Requirements/ Limits
mometasone furoate	1	
ORAPRED ODT	3	
PANDEL	3	
prednicarbate	1	
prednisolone sodium phosphate	1	
prednisone	1	
prednisone intensol	1	
procto-pak	1	
proctocream hc	1	
proctosol hc	1	
proctozone-hc	1	
SOLU-MEDROL INJ 1000MG, 2GM, 500MG	4	B/D †
TEXACORT	3	
triamcinolone acetonide	1	
triamcinolone acetonide in absorbase	1	
triderm	1	
u-cort	1	
VANOS	3	PA
VERDESO	3	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>		
chorionic gonadotropin	4	B/D †
desmopressin acetate nasal soln, tabs	1	
desmopressin acetate inj	4	B/D †
EGRIFTA	5	QL (60 vials per 30 days) PA †
GENOTROPIN	5	PA †
GENOTROPIN	4	PA †
MINIQUICK INJ 0.2MG		
GENOTROPIN	5	PA †
MINIQUICK INJ 0.4MG, 0.6MG, 0.8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 1MG, 2MG		
HUMATROPE COMBO PACK	5	PA †
HUMATROPE INJ 6MG	4	PA †
HUMATROPE INJ 12MG, 24MG	5	PA †
INCRELEX	5	PA LA †
NORDITROPIN FLEXPPO	5	PA †
NORDITROPIN	5	PA †
NORDIFLEX PEN		
novarel	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
NUTROPIN	5	PA †
NUTROPIN AQ	5	PA †
NUTROPIN AQ NUSPIN 5	5	PA †
NUTROPIN AQ PEN	5	PA †
OMNITROPE INJ	4	PA †
10MG/1.5ML, 5MG/1.5ML		
OMNITROPE INJ 5.8MG	5	PA †
<i>pregnyl w/diluent benzyl alcohol/nacl</i>	4	B/D †
SAIZEN	5	PA †
SAIZEN CLICK.EASY	5	PA †
SEROSTIM	5	PA †
STIMATE	3	
ZORBTIVE	5	PA †

Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)

Anabolic Steroids

ANADROL-50	3	
<i>oxandrolone</i>	1	PA

Androgens

ANDRODERM	3	QL (60 patches per 30 days)
ANDROGEL	2	QL (60 packets per 30 days)
ANDROGEL PUMP 1.62% GEL	2	QL (2 metered dose pumps per 30 days)
ANDROGEL PUMP 1% GEL	2	QL (4 metered dose pumps per 30 days)
ANDROID	3	
<i>androxy</i>	1	
AXIRON	3	QL (2 metered dose pumps per 30 days)
<i>danazol</i>	1	
DEPO-TESTOSTERONE INJ 100MG/ML	4	B/D †
STRIANT	3	
TESTIM	3	QL (60 packets per 30 days)
<i>testosterone cypionate inj 200mg/ml</i>	4	B/D †
<i>testosterone enanthate</i>	4	B/D †
TESTRED	3	

Estrogens

ACTIVELLA TABS 0.5MG; 0.1MG	2	
ALORA	3	QL (8 patches per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>amethia 91 day</i>	1	
<i>amethyst 28 day</i>	1	
<i>briellyn 28 day</i>	1	
CENESTIN	3	
<i>cyclafem 1/35</i>	1	
<i>cyclafem 7/7/7</i>	1	
DELESTROGEN	4	B/D †
DEPO-ESTRADIOL	4	B/D †
<i>emoquette</i>	1	
ENJUVIA	2	
ESTRACE CREAM	2	
ESTRADERM	3	QL (8 patches per 28 days)
<i>estradiol valerate</i>	4	B/D †
<i>estradiol/norethindrone acetate</i>	1	
<i>estradiol tabs</i>	1	
<i>estradiol ptwk</i>	1	QL (16 patches per 30 days)
ESTRING	2	QL (1 ring per 84 days)
<i>estropipate</i>	1	
FEMRING	3	QL (1 ring per 84 days)
FEMTRACE	3	
<i>gianvi</i>	1	
<i>introvale 91 day</i>	1	
<i>jinteli</i>	1	
LYBREL	2	
MENOSTAR	3	QL (4 patches per 28 days)
<i>ocella</i>	1	
<i>orsythia 28 day</i>	1	
<i>ortho-est</i>	1	
PREMARIN CREAM W/APPLICATOR	2	
PREMARIN INJ	4	B/D †
<i>tri-legest fe</i>	1	
VAGIFEM	2	
VIVELLE-DOT PTTW 0.05MG/24HR	2	QL (16 patches per 28 days)
VIVELLE-DOT PTTW 0.025MG/24HR, 0.0375MG/24HR, 0.075MG/24HR, 0.1MG/24HR	2	QL (16 patches per 30 days)
<i>zeosa</i>	1	

Progestins

<i>apri</i>	1	
<i>aranelle</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>aviane</i>	1	
<i>balziva</i>	1	
<i>camila</i>	1	
<i>cesia</i>	1	
CLIMARA PRO	2	QL (4 patches per 28 days)
COMBIPATCH	2	QL (8 patches per 28 days)
CRINONE GEL 4%	3	PA
CRINONE GEL 8%	3	PA
<i>cryselle-28</i>	1	
DEPO-PROVERA	4	B/D †
DEPO-SUBQ PROVERA 104	4	B/D †
ENDOMETRIN	3	PA
<i>enpresse-28</i>	1	
<i>errin</i>	1	
FEMHRT LOW DOSE	3	
<i>jolivette</i>	1	
<i>junel 1.5/30</i>	1	
<i>junel 1/20</i>	1	
<i>junel fe 1.5/30</i>	1	
<i>junel fe 1/20</i>	1	
<i>kariva</i>	1	
<i>kelnor 1/35</i>	1	
<i>lessina-28</i>	1	
<i>levora 0.15/30-28</i>	1	
LOESTRIN 24 FE	3	
<i>low-ogestrel</i>	1	
<i>lutra</i>	1	
<i>medroxyprogesterone acetate tabs</i>	1	
<i>medroxyprogesterone acetate inj</i>	4	B/D †
MEGACE ES	3	PA
<i>megestrol acetate susp</i>	1	PA
<i>megestrol acetate tabs</i>	1	PA
<i>microgestin 1.5/30</i>	1	
<i>microgestin 1/20</i>	1	
<i>microgestin fe</i>	1	
<i>microgestin fe 1.5/30</i>	1	
<i>mononessa</i>	1	
<i>necon 0.5/35-28</i>	1	
<i>necon 1/35-28</i>	1	
<i>necon 1/50-28</i>	1	
NECON 10/11-28	2	
<i>necon 7/7/7</i>	1	
<i>next choice</i>	1	
<i>nora-be</i>	1	
<i>norethindrone acetate</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>nortrel 0.5/35 (28)</i>	1	
<i>nortrel 1/35 (21)</i>	1	
<i>nortrel 1/35 (28)</i>	1	
<i>nortrel 7/7/7</i>	1	
NUVARING	2	QL (1 ring per 28 days)
<i>ogestrel</i>	1	
ORTHO EVRA	2	
OVCON-50 28	3	
PLAN B	2	
<i>portia-28</i>	1	
PREFEST	3	
PREMPHASE	2	QL (1-28 tab pack per 28 days)
PREMPRO	2	QL (1-28 tab packet per 28 days)
<i>previfem</i>	1	
PROMETRIUM	2	
<i>quasense</i>	1	
<i>reclipsen</i>	1	
<i>solia</i>	1	
<i>sprintec 28</i>	1	
<i>tri-previfem</i>	1	
<i>tri-sprintec</i>	1	
<i>trinessa</i>	1	
<i>trivora-28</i>	1	
<i>velivet</i>	1	
<i>zovia 1/35e</i>	1	
<i>zovia 1/50e</i>	1	
Selective Estrogen Receptor Modifying Agents		
EVISTA	2	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
<i>levothroid</i>	1	
<i>levothyroxine sodium</i>	1	
<i>levoxyl</i>	1	
<i>liothyronine sodium tabs</i>	1	
<i>liothyronine sodium inj</i>	4	B/D †
SYNTHROID	3	
THYROLAR	2	
TIROSINT	3	
<i>unithroid</i>	1	
Hormonal Agents, Suppressant (Adrenal)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	2	

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Suppressant (Parathyroid)		
<i>Hormonal Agents, Suppressant (Parathyroid)</i>		
SENSIPAR	2	PA
Hormonal Agents, Suppressant (Pituitary)		
<i>Hormonal Agents, Suppressant (Pituitary)</i>		
cabergoline	1	QL (16 tabs per 30 days)
ELIGARD	4	B/D †
leuprolide acetate	4	B/D †
LUPRON DEPOT	4	B/D †
LUPRON DEPOT-PED	4	B/D †
octreotide acetate	4	PA †
SANDOSTATIN LAR DEPOT	4	PA †
SOMATULINE DEPOT	4	PA †
SOMAVERT	5	PA †
SYNAREL	5	†
TRELSTAR DEPOT MIXJECT	4	B/D †
TRELSTAR LA MIXJECT	4	B/D †
TRELSTAR MIXJECT	4	B/D †
ZOLADEX	4	B/D †
Hormonal Agents, Suppressant (Sex Hormones/Modifiers)		
<i>Antiandrogens</i>		
bicalutamide	1	
flutamide	1	
NILANDRON	2	
Hormonal Agents, Suppressant (Thyroid)		
<i>Antithyroid Agents</i>		
methimazole	1	
propylthiouracil	1	
Immunological Agents		
<i>Immune Suppressants</i>		
AZASAN	3	B/D
azathioprine	1	B/D
azathioprine sodium	4	B/D †
BENLYSTA	5	PA †
CELLCEPT	4	PA †
INTRAVENOUS CELLCEPT SUSR	2	PA
cyclosporine modified	1	B/D
cyclosporine caps	1	B/D
cyclosporine inj	4	B/D †
cyclosporine oral soln	5	B/D †
ENBREL	5	PA †
gengraf	1	B/D
HUMIRA	5	PA †
HUMIRA PEN	5	PA †

Drug Name	Drug Tier	Requirements/ Limits
HUMIRA PEN-CROHNS DISEASESTARTER	5	PA †
methotrexate	1	
methotrexate sodium	4	B/D †
mycophenolate mofetil	1	PA
MYFORTIC	2	PA
NULOJIX	5	B/D †
ORENCIA IV	5	PA †
ORENCIA PREFILLED SYRINGE	5	QL (4 doses per 28 days) PA †
ORTHOCLONE OKT3	5	B/D †
PROGRAF INJ	4	B/D †
RAPAMUNE	2	PA
REMICADE	5	PA †
SIMULECT	5	B/D †
tacrolimus	1	B/D
TREXALL	3	
ZORTRESS	2	QL (60 tabs per 30 days) B/D
<i>Immunizing Agents, Passive</i>		
ATGAM	5	B/D †
CARIMUNE	5	PA †
NANOFILTERED GAMASTAN S/D	4	PA †
GAMMAGARD LIQUID	5	PA †
GAMMAGARD S/D	5	PA †
GAMUNEX	5	PA †
GAMUNEX-C	5	PA †
PRIVIGEN	5	PA †
THYMOGLOBULIN	5	B/D †
VIVAGLOBIN	5	PA †
<i>Immunomodulators</i>		
ACTIMMUNE	5	PA †
ARCALYST	5	PA †
AVONEX	5	QL (4 doses per 28 days) †
BETASERON	5	QL (15 vials per 30 days) PA †
COPAXONE	5	QL (1 kit per 30 days) †
EXTAVIA	5	QL (15 vials per 30 days) PA †
GILENYA	5	QL (30 caps per 30 days) PA †
ILARIS	5	PA †
INFERGEN	5	PA †
INTRON-A W/DILUENT INJ 10MU	4	PA †
INTRON-A W/DILUENT INJ 18MU, 50MU	5	PA †

Drug Name	Drug Tier	Requirements/ Limits
INTRON-A INJ 3MU/0.2ML	4	PA †
INTRON-A INJ 10MU/0.2ML, 10MU/ML, 5MU/0.2ML, 6000000UNIT/ML	5	PA †
KINERET	5	PA †
<i>leflunomide</i>	1	
PEG-INTRON	5	PA †
PEG-INTRON REDIPEN	5	PA †
PEG-INTRON REDIPEN	5	PA †
PAK 4		
PEGASYS	5	PA †
REBIF	5	QL (12 syringes per 30 days) †
REBIF TITRATION PACK	5	QL (1 pack per 28 days) †
RIDAURA	2	
SYNAGIS	5	B/D †
TYSABRI	5	PA LA †
Vaccines		
ACTHIB	4	†
ADACEL	4	†
BIOTHRAX	4	†
BOOSTRIX	4	†
CERVARIX	4	†
COMVAX	4	†
DAPTACEL	4	†
DECAVAC	4	B/D †
DIPHThERIA/TETANUS TOXOID PEDIATRIC	4	B/D †
ENGRIX-B	4	B/D †
GARDASIL	4	†
HAVRIX	4	B/D †
IMOVAX RABIES (H.D.C.V.)	4	B/D †
INFANRIX	4	†
IPOL INACTIVATED IPV	4	†
IXIARO	4	†
JE-VAX	4	†
M-M-R II W/DILUENT 10 DOSE	4	†
MENACTRA	4	†
MENOMUNE-A/C/Y/W- 135	4	†
MENVEO	4	†
PEDIARIX	4	B/D †
PEDVAX HIB	4	†
PENTACEL	4	B/D †
PROQUAD	4	†

Drug Name	Drug Tier	Requirements/ Limits
RABAVERT	4	B/D †
RECOMBIVAX HB	4	B/D †
ROTARIX	3	B/D
ROTATEQ	2	
TETANUS TOXOID ADSORBED	4	B/D †
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	4	B/D †
THERACYS	4	B/D †
TICE BCG	4	B/D †
TRIIBIT	4	†
TRIPEDIA	4	†
TWINRIX	4	B/D †
TYPHIM VI	4	†
VAQTA	4	B/D †
VARIVAX	4	†
YF-VAX	4	†
ZOSTAVAX	4	†
Inflammatory Bowel Disease Agents		
Glucocorticoids		
<i>budesonide ec caps</i>	1	
<i>colocort</i>	1	
CORTIFOAM	2	
ENTOCORT EC	2	
<i>hydrocortisone millipred tabs</i>	1	
SOLU-CORTEF INJ 1000MG, 500MG	4	B/D †
<i>triamcinolone acetonide inj</i>	4	B/D †
Salicylates		
APRISO	2	QL (120 caps per 30 days)
ASACOL	2	
ASACOL HD	2	
<i>balsalazide disodium</i>	1	
CANASA	2	
<i>mesalamine</i>	1	
PENTASA	2	
Sulfonamides		
<i>sulfasalazine</i>	1	
<i>sulfazine</i>	1	
<i>sulfazine ec</i>	1	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
ACTONEL TABS 30MG	2	PA
ACTONEL TABS 150MG	3	QL (1 tab per 28 days) ST
ACTONEL TABS 5MG	3	QL (30 tabs per 30 days) ST

Drug Name	Drug Tier	Requirements/ Limits
ACTONEL TABS 35MG	3	QL (4 tabs per 28 days) ST
<i>alendronate sodium tabs 10mg, 40mg, 5mg</i>	1	QL (30 tabs per 30 days)
<i>alendronate sodium tabs 35mg, 70mg</i>	1	QL (4 tabs per 28 days)
ATELVIA	3	QL (4 tabs per 30 days) ST
BONIVA TABS	3	QL (1 tab per 28 days) ST
BONIVA INJ	4	PA †
<i>calcitonin-salmon</i>	1	QL (1 inhaler per 30 days)
<i>calcitriol caps, oral soln</i>	1	
<i>calcitriol inj</i>	4	B/D †
<i>etidronate disodium</i>	1	
FORTEO	4	PA †
FORTICAL	2	
FOSAMAX PLUS D TABS 70MG; 2800UNIT	2	QL (4 tabs per 28 days)
FOSAMAX PLUS D TABS 70MG; 5600UNIT	3	QL (4 tabs per 28 days)
FOSAMAX ORAL SOLN	3	QL (300 ml's per 28 days)
HECTOROL CAPS	2	
HECTOROL INJ	4	B/D †
MIACALCIN INJ	4	PA †
<i>pamidronate disodium</i>	4	B/D †
PROLIA	4	PA †
SKELID	3	
XGEVA	5	QL (1 vial per 28 days) PA †
ZEMPLAR CAPS	2	
ZEMPLAR INJ	4	B/D †
ZOMETA	4	PA †

Miscellaneous Therapeutic Agents

Miscellaneous Therapeutic Agents

<i>alcohol prep pads</i>	1	
<i>anagrelide hydrochloride</i>	1	
APLISOL	4	B/D †
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	2	
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	

Drug Name	Drug Tier	Requirements/ Limits
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	
BD PEN NEEDLE/ULTRAFINE/29 G X 12.7MM	2	
BOTOX	4	B/D †
<i>curity gauze pads 2"x2"</i>	1	
<i>dexrazoxane</i>	4	B/D †
FIRAZYR	5	QL (2 doses per rx) PA †
INTRALIPID	4	B/D †
KUVAN	5	PA
<i>levocarnitine tabs</i>	1	
LIPOSYN II	4	B/D †
LIPOSYN III INJ 1.2%; 2.5%; 10%, 1.2%; 2.5%; 20%	4	B/D †
<i>liposyn iii inj 1.8%; 2.5%; 30%</i>	4	B/D †
<i>methylergonovine maleate</i>	1	
<i>pentopak</i>	1	
<i>pentoxifylline er</i>	1	
XENAZINE	5	PA †
XEOMIN	4	B/D †

Ophthalmic Agents

Ophthalmic Agents, Other

<i>ak-con</i>	1	
<i>ak-poly-bac</i>	1	
<i>ak-tob</i>	1	
<i>atropine sulfate</i>	1	
<i>bacitracin</i>	1	
<i>bacitracin/polymyxin b</i>	1	
CILOXAN	2	
<i>gentasol</i>	1	
LACRISERT	3	
<i>mydral</i>	1	
NATACYN	2	
<i>neomycin/polymyxin/bacitracin/hydrocortisone</i>	1	
<i>neomycin/polymyxin/gramicidin</i>	1	
<i>ofloxacin</i>	1	
<i>polycin b</i>	1	
RESTASIS	2	QL (64 dropperettes per 30 days)
<i>romycin</i>	1	
<i>sulfacetamide sodium</i>	1	
<i>tobrasol</i>	1	

Drug Name	Drug Tier	Requirements/Limits
TOBREX OINT	2	
<i>trifluridine</i>	1	
<i>trimethoprim sulfate/polymyxin b sulfate</i>	1	
<i>tropicacyl</i>	1	
<i>tropicamide</i>	1	
VIGAMOX	2	
Ophthalmic Anti-allergy Agents		
ALAMAST	2	
ALOCRIAL	3	
ALOMIDE	2	
<i>azelastine hcl</i>	1	
BEPREVE	3	
<i>cromolyn sodium</i>	1	
EMADINE	3	ST
<i>epinastine hcl</i>	1	
LASTACAFT	3	QL (1 bottle per 30 days)
PATADAY	2	
PATANOL	2	QL (2 bottles per 30 days)
Ophthalmic Anti-inflammatories		
ALREX	2	
BLEPHAMIDE	2	
BLEPHAMIDE S.O.P.	2	
<i>bromfenac</i>	1	
<i>dexamethasone sodium phosphate</i>	1	
<i>diclofenac sodium oph soln</i>	1	
DUREZOL	3	
FLAREX	3	
<i>fluorometholone</i>	1	
<i>flurbiprofen sodium</i>	1	
FML	2	
FML FORTE	3	
<i>ketorolac tromethamine oph soln</i>	1	
LOTEMAX	2	
MAXIDEX	3	
<i>neomycin/polymyxin/dexamethasone</i>	1	
<i>neomycin/polymyxin/hydrocortisone</i>	1	
NEVANAC	3	
<i>poly-dex</i>	1	
POLY-PRED	3	
PRED MILD	3	
PRED-G	3	
PRED-G S.O.P.	3	
<i>prednisolone acetate</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone sodium phosphate oph soln</i>	1	
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	
TOBRADEX OINT	2	
<i>tobramycin/dexamethasone</i>	1	
VEXOL	3	
VOLTAREN OPTH SOLN	3	
ZYLET	2	
Ophthalmic Antiglaucoma Agents		
ALPHAGAN P SOLN 0.1%	2	
<i>apraclonidine</i>	1	
AZOPT	2	
<i>betaxolol hcl</i>	1	
BETIMOL	2	
BETOPTIC-S	2	
<i>brimonidine tartrate</i>	1	
<i>carteolol hcl</i>	1	
<i>dorzolamide hcl</i>	1	
<i>dorzolamide hcl/timolol maleate</i>	1	
ISOPTO CARPINE	3	
<i>levobunolol hcl</i>	1	
<i>methazolamide</i>	1	
<i>metipranolol</i>	1	
MIOSTAT	4	B/D †
PHOSPHOLINE IODIDE	3	
PILOPINE HS	2	
<i>timolol maleate</i>	1	
<i>timolol maleate ophthalmic gel forming</i>	1	
Ophthalmic Prostaglandin and Prostanoid Analogs		
<i>latanoprost</i>	1	
LUMIGAN SOLN 0.01%	2	QL (2.5 ml's per 30 days)
LUMIGAN SOLN 0.03%	2	QL (7.5 ml's per 30 days)
TRAVATAN Z	2	QL (5 ml's per 30 days)
Otic Agents		
Otic Agents		
<i>acetic acid</i>	1	
<i>acetic acid/aluminum acetate</i>	1	
<i>acetic acid/hydrocortisone</i>	1	
CIPRO HC	3	
CIPRODEX	3	

Drug Name	Drug Tier	Requirements/ Limits
COLY-MYCIN S	2	
CORTISPORIN-TC	2	
<i>cortomycin</i>	1	
DERMOTIC	3	
<i>fluocinolone acetonide</i> <i>0.1mg/ml</i>	1	
<i>neomycin/polymyxin/hc</i>	1	
<i>neomycin/polymyxin/hydroc</i> <i>ortisone</i>	1	

Respiratory Tract Agents

Anti-inflammatories, Inhaled

Corticosteroids

ADVAIR DISKUS	2	QL (1-60 count diskus/inhaler per 30 days)
ADVAIR HFA	2	QL (1-12 gram inhaler per 30 days)
ASMANEX 120 METERED DOSES	2	QL (1 inhaler per 30 days)
ASMANEX 14 METERED DOSES	2	QL (1 inhaler per 30 days)
ASMANEX 30 METERED DOSES AEPB	2	QL (1 inhaler per 30 days)
110MCG/INH		
ASMANEX 30 METERED DOSES AEPB	2	QL (1 inhaler per 30 days)
220MCG/INH		
ASMANEX 60 METERED DOSES	2	QL (2 inhalers per 30 days)
ASMANEX 7 METERED DOSES	2	QL (4 inhalers per 30 days)
BECONASE AQ	3	QL (2 inhalers per 30 days)
<i>budesonide</i>	1	QL (60 ampules per 30 days) B/D
FLOVENT DISKUS AEPB	2	QL (4 diskus/inhalers per 30 days)
250MCG/BLIST		
FLOVENT DISKUS AEPB	2	QL (1 diskus/inhaler per 30 days)
100MCG/BLIST, 50MCG/BLIST		
FLOVENT HFA AERO	2	QL (2 inhalers per 30 days)
44MCG/ACT		
FLOVENT HFA AERO	2	QL (2 inhalers per 30 days)
110MCG/ACT, 220MCG/ACT		
<i>flunisolide</i>	1	QL (2 inhalers per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>fluticasone propionate</i>	1	QL (1 inhaler per 30 days)
NASACORT AQ	3	QL (1 inhaler per 30 days)
NASONEX	2	QL (2 inhalers per 30 days)
OMNARIS	3	QL (1 inhaler per 30 days) ST
PULMICORT FLEXHALER	3	QL (2 inhalers per 30 days)
PULMICORT SUSP	2	QL (60 ampules per 30 days) B/D
0.25MG/2ML, 0.5MG/2ML		
PULMICORT SUSP	2	QL (30 ampules per 30 days) B/D
1MG/2ML		
QVAR AERS 80MCG/ACT	2	QL (2 inhalers per 30 days)
QVAR AERS 40MCG/ACT	2	QL (4 inhalers per 30 days)
RHINOCORT AQUA	3	QL (2 inhalers per 30 days) ST
SYMBICORT AERO	2	QL (1 inhaler per 30 days)
160MCG/ACT; 4.5MCG/ACT		
SYMBICORT AERO	2	QL (1 inhaler per 30 days)
80MCG/ACT; 4.5MCG/ACT		
<i>triamcinolone acetonide</i> <i>55mcg nasal spray</i>	1	
Antihistamines		
ANTIVERT	3	
ASTEPRO	2	QL (1 inhaler per 25 days)
<i>azelastine hcl</i>	1	QL (1 inhaler per 30 days)
<i>carbinoxamine maleate</i>	1	
CLARINEX REDITABS	3	QL (30 tabs per 30 days) ST
TBDP 5MG		
CLARINEX REDITABS	3	QL (60 tabs per 30 days) ST
TBDP 2.5MG		
CLARINEX-D 12 HOUR	3	QL (60 tabs per 30 days) ST
CLARINEX-D 24 HOUR	3	QL (30 tabs per 30 days) ST
CLARINEX TABS	3	QL (30 tabs per 30 days) ST
CLARINEX SYRP	3	QL (1-473ml bottle per 30 days) ST
<i>clemastine fumarate</i>	1	
<i>cypheptadine hcl</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>dexchlorpheniramine maleate</i>	1	
<i>diphenhydramine hcl caps, elix</i>	1	
<i>diphenhydramine hcl inj</i>	4	B/D †
<i>hydroxyzine hcl syrp, tabs</i>	1	
<i>hydroxyzine hcl inj</i>	4	B/D †
<i>hydroxyzine pamoate</i>	1	
<i>levocetirizine dihydrochloride</i>	1	
<i>meclizine hcl</i>	1	
<i>promethazine vc</i>	1	
SEMPREX-D	3	
XYZAL ORAL SOLN	3	PA
Antileukotrienes		
SINGULAIR	2	QL (30 tabs per 30 days)
<i>zafirlukast</i>	1	
ZYFLO CR	3	
Bronchodilators, Anticholinergic		
ATROVENT HFA	2	QL (4 inhalers per 30 days)
<i>ipratropium bromide/albuterol sulfate</i>	1	QL (180 ampules per 30 days) B/D
<i>ipratropium bromide inhalation soln</i>	1	QL (144 ampules per 30 days) B/D
<i>ipratropium bromide nasal soln 0.03%</i>	1	QL (1 inhaler per 28 days)
<i>ipratropium bromide nasal soln 0.06%</i>	1	QL (3 inhalers per 28 days)
SPIRIVA HANDIHALER	2	QL (1-30 count handihaler per 30 days)
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)		
<i>aminophylline tabs</i>	1	
<i>aminophylline inj</i>	4	B/D †
ELIXOPHYLLIN	3	
THEO-24	3	
<i>theochron</i>	1	
<i>theophylline er</i>	1	
Bronchodilators, Sympathomimetic		
ADRENACLICK	2	QL (2 pens per 2 days)
<i>albuterol sulfate nebu 1.25mg/3ml</i>	1	QL (60 vials per 30 days) B/D
<i>albuterol sulfate nebu 0.083%</i>	1	QL (120 vials per 30 days) B/D
<i>albuterol sulfate nebu 0.63mg/3ml</i>	1	QL (125 vials per 30 days) B/D

Drug Name	Drug Tier	Requirements/ Limits
<i>albuterol sulfate nebu 0.5%</i>	1	QL (2-20ml bottles per 30 days) B/D
COMBIVENT	3	QL (2 inhalers per 30 days)
<i>epinephrine pen</i>	1	QL (2 pens per 2 days)
<i>epinephrine hcl inj syringe</i>	4	†
EPIPEN-JR 2-PAK	2	QL (2 pens per 2 days)
FORADIL AEROLIZER	2	
ISUPREL	4	B/D †
<i>levalbuterol</i>	1	QL (90 vials per 30 days) PA
MAXAIR AUTOHALER	2	QL (1 inhaler per 30 days)
PROAIR HFA	2	QL (2 inhalers per 30 days)
SEREVENT DISKUS	2	QL (1-60 count diskus/inhaler per 30 days)
<i>terbutaline sulfate tabs</i>	1	
<i>terbutaline sulfate inj</i>	4	B/D †
TWINJECT	2	QL (2 pens per 2 days)
VENTOLIN HFA	2	QL (2 inhalers per 30 days)
XOPENEX	3	QL (96 vials per 30 days) PA
XOPENEX CONCENTRATE	3	QL (90 vials per 30 days) PA
XOPENEX HFA	3	QL (2 inhalers per 30 days)
Mast Cell Stabilizers		
<i>cromolyn sodium</i>	1	QL (120 ampules per 30 days) B/D
Pulmonary Antihypertensives		
ADCIRCA	2	PA
LETAIRIS	5	PA †
REVATIO TABS	5	PA †
TRACLEER	5	PA LA †
VENTAVIS	5	B/D †
Respiratory Tract Agents, Other		
<i>acetylcysteine</i>	1	B/D
ARALAST NP	5	B/D †
GLASSIA	5	B/D †
PROLASTIN	5	B/D †
PROLASTIN-C	5	B/D †
PULMOZYME	5	B/D †
TYZINE	2	

Drug Name	Drug Tier	Requirements/ Limits
TYZINE PEDIATRIC NASAL DROPS	2	
XOLAIR	5	PA †
ZEMAIRA	5	B/D †

Sedatives/Hypnotics

<i>Sedatives/Hypnotics</i>		
<i>estazolam tabs 2mg</i>	1	QL (30 tabs per 30 days) ED
<i>estazolam tabs 1mg</i>	1	QL (60 tabs per 30 days) ED
LUNESTA	3	QL (30 tabs per 30 days) ST
ROZEREM	3	QL (30 tabs per 30 days) ST
<i>temazepam caps 7.5mg</i>	1	QL (120 caps per 30 days) ED
<i>temazepam caps 22.5mg, 30mg</i>	1	QL (30 caps per 30 days) ED
<i>temazepam caps 15mg</i>	1	QL (60 caps per 30 days) ED
<i>triazolam tabs 0.125mg</i>	1	QL (120 tabs per 30 days) ED
<i>triazolam tabs 0.25mg</i>	1	QL (60 tabs per 30 days) ED
<i>zaleplon caps 5mg</i>	1	QL (120 caps per 30 days)
<i>zaleplon caps 10mg</i>	1	QL (60 caps per 30 days)
<i>zolpidem tartrate er tbcr 12.5mg</i>	1	QL (30 tabs per 30 days) ST
<i>zolpidem tartrate er tbcr 6.25mg</i>	1	QL (60 tabs per 30 days) ST
<i>zolpidem tartrate tabs 10mg</i>	1	QL (30 tabs per 30 days)
<i>zolpidem tartrate tabs 5mg</i>	1	QL (60 tabs per 30 days)

Skeletal Muscle Relaxants

<i>Skeletal Muscle Relaxants</i>		
<i>carisoprodol/aspirin</i>	1	
<i>carisoprodol/aspirin/codeine</i>	1	QL (360 tabs per 30 days)
<i>carisoprodol tabs 350mg</i>	1	
<i>carisoprodol tabs 250mg</i>	1	QL (120 tabs per 30 days)
<i>chlorzoxazone</i>	1	
<i>cyclobenzaprine hcl</i>	1	
<i>cyclobenzaprine hcl 7.5mg tabs</i>	1	QL (90 tabs per 30 days) ST
<i>cyclobenzaprine hcl er</i>	1	QL (30 caps per 30 days) ST

Drug Name	Drug Tier	Requirements/ Limits
<i>metaxalone</i>	1	
<i>methocarbamol</i>	1	
<i>orphenadrine citrate</i>	4	B/D †
<i>orphenadrine citrate er</i>	1	
<i>orphenadrine compound ds</i>	1	
<i>orphenadrine/asa/cafeine</i>	1	
ROBAXIN INJ	4	B/D †
SOMA TABS 250MG	2	QL (120 tabs per 30 days)

Therapeutic Nutrients/Minerals/ Electrolytes

<i>Electrolytes/Minerals</i>		
AMINOSYN	4	B/D †
AMINOSYN 7%/ELECTROLYTES	4	B/D †
AMINOSYN II	4	B/D †
AMINOSYN II 3.5%/DEXTROSE25%	4	B/D †
AMINOSYN II 3.5%/DEXTROSE5%	4	B/D †
AMINOSYN II 3.5/DEXTROSE 25%	4	B/D †
AMINOSYN II 4.25/DEXTROSE10%	4	B/D †
AMINOSYN II 4.25/DEXTROSE20%	4	B/D †
AMINOSYN II 4.25/DEXTROSE25%	4	B/D †
AMINOSYN II 5/DEXTROSE 25	4	B/D †
AMINOSYN II 8.5%/ELECTROLYTES	4	B/D †
AMINOSYN II M 4.25/DEXTROSE 10%	4	B/D †
AMINOSYN M	4	B/D †
AMINOSYN-HBC	4	B/D †
AMINOSYN-HF	4	B/D †
AMINOSYN-PF	4	B/D †
AMINOSYN-PF 7%	4	B/D †
CLINIMIX 2.75%/DEXTROSE 5%	4	B/D †
CLINIMIX 4.25%/DEXTROSE 10%	4	B/D †
CLINIMIX 4.25%/DEXTROSE 20%	4	B/D †
CLINIMIX 4.25%/DEXTROSE 25%	4	B/D †
CLINIMIX 4.25%/DEXTROSE 5%	4	B/D †
CLINIMIX 5%/DEXTROSE 15%	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
CLINIMIX	4	B/D †
5%/DEXTROSE 20%		
CLINIMIX	4	B/D †
5%/DEXTROSE 25%		
CLINIMIX E	4	B/D †
2.75%/DEXTROSE 10%		
CLINIMIX E	4	B/D †
2.75%/DEXTROSE 5%		
CLINIMIX E	4	B/D †
4.25%/DEXTROSE 25%		
CLINIMIX E	4	B/D †
4.25%/DEXTROSE 5%		
CLINIMIX E	4	B/D †
5%/DEXTROSE 15%		
CLINIMIX E	4	B/D †
5%/DEXTROSE 20%		
CLINIMIX E	4	B/D †
5%/DEXTROSE 25%		
<i>clinisol sf 15%</i>	4	B/D †
DELFLEX-LC/1.5%	4	B/D †
DEXTROSE		
DELFLEX-LC/2.5%	4	B/D †
DEXTROSE		
DELFLEX-LC/4.25%	4	B/D †
DEXTROSE		
DELFLEX-LM/1.5%	4	B/D †
DEXTROSE		
DELFLEX-LM/2.5%	4	B/D †
DEXTROSE		
DELFLEX-LM/4.25%	4	B/D †
DEXTROSE		
DELFLEX-SM/1.5%	4	B/D †
DEXTROSE		
DELFLEX-SM/2.5%	4	B/D †
DEXTROSE		
DELFLEX-SM/4.25%	4	B/D †
DEXTROSE		
<i>dextrose 10%/nacl 0.45%</i>	4	B/D †
DEXTROSE 2.5%	4	B/D †
<i>dextrose 5% /electrolyte</i>	4	B/D †
<i>#48 viaflex</i>		
<i>dextrose 10% flex container</i>	4	B/D †
<i>dextrose 10%/nacl 0.2%</i>	4	B/D †
<i>dextrose 2.5%/sodium</i>	4	B/D †
<i>chloride 0.45%</i>		
<i>dextrose 5%</i>	4	B/D †
<i>dextrose 5%/lactated</i>	4	B/D †
<i>ringers</i>		
<i>dextrose 5%/nacl 0.2%</i>	4	B/D †
<i>dextrose 5%/nacl 0.225%</i>	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
<i>dextrose 5%/nacl 0.33%</i>	4	B/D †
<i>dextrose 5%/nacl 0.45%</i>	4	B/D †
<i>dextrose 5%/nacl 0.9%</i>	4	B/D †
<i>dextrose 5%/potassium</i>	4	B/D †
<i>chloride 0.075%</i>		
DIANEAL LOW	4	B/D †
CALCIUM/2.5%		
DEXTROSE		
DIANEAL LOW	4	B/D †
CALCIUM/4.25%DEXTR		
OSE		
DIANEAL PD-2/2.5%	4	B/D †
DEXTROSE		
DIANEAL PD-2/4.25%	4	B/D †
DEXTROSE		
<i>ed k+10</i>	1	
<i>eliphos</i>	1	
<i>freamine iii</i>	4	B/D †
<i>hepatamine</i>	4	B/D †
HEPATASOL	4	B/D †
<i>inpersol-lm/1.5% dextrose</i>	4	B/D †
<i>inpersol/dextrose</i>	4	B/D †
IONOSOL-B/DEXTROSE	4	B/D †
5%		
IONOSOL-	4	B/D †
MB/DEXTROSE 5%		
IONOSOL-T/DEXTROSE	4	B/D †
5%		
ISOLYTE-H/DEXTROSE	4	B/D †
5%		
ISOLYTE-M/DEXTROSE	4	B/D †
5%		
ISOLYTE-P/DEXTROSE	4	B/D †
5%		
ISOLYTE-S	4	B/D †
ISOLYTE-S PH 7.4	4	B/D †
ISOLYTE-S/DEXTROSE	4	B/D †
5%		
<i>kcl 0.075%/d5w/nacl 0.2%</i>	4	B/D †
KCL 0.075%/D5W/NACL	4	B/D †
0.45%		
KCL 0.15%/D10W/NACL	4	B/D †
0.2%		
<i>kcl 0.15%/d5w/lr</i>	4	B/D †
<i>kcl 0.15%/d5w/nacl 0.2%</i>	4	B/D †
KCL 0.15%/D5W/NACL	4	B/D †
0.225%		
KCL 0.15%/D5W/NACL	4	B/D †
0.45%		

Drug Name	Drug Tier	Requirements/ Limits
KCL 0.15%/D5W/NACL 0.9%	4	B/D †
KCL 0.224%/D5W/NACL 0.2%	4	B/D †
<i>kcl 0.3%/d5w/lr</i>	4	B/D †
<i>kcl 0.3%/d5w/lr iv lac ring</i>	4	B/D †
<i>kcl 0.3%/d5w/nacl 0.2%</i>	4	B/D †
KCL 0.3%/D5W/NACL 0.45%	4	B/D †
<i>kcl 0.3%/d5w/nacl 0.9%</i>	4	B/D †
<i>klor-con m10</i>	1	
<i>klor-con m15</i>	1	
LACTATED RINGERS	4	B/D †
<i>lactated ringers dextrose 5% viaflex</i>	4	B/D †
<i>lactated ringers irrigation</i>	4	B/D †
<i>lactated ringers viaflex</i>	4	B/D †
<i>leucovorin calcium tabs</i>	1	
<i>leucovorin calcium inj</i>	4	B/D †
<i>magnesium sulfate</i>	4	B/D †
NEPHRAMINE	4	B/D †
<i>normosol -r</i>	4	B/D †
NORMOSOL-M IN D5W	4	B/D †
NORMOSOL-R	4	B/D †
NORMOSOL-R IN D5W	4	B/D †
<i>novamine</i>	4	B/D †
<i>physiolyte</i>	1	
<i>physiosol irrigation</i>	1	
PLASMA-LYTE 56	4	B/D †
PLASMA-LYTE A	4	B/D †
PLASMA-LYTE-148	4	B/D †
PLASMA-LYTE-148/D5W	4	B/D †
PLASMA-LYTE-56/D5W	4	B/D †
PLASMA-LYTE-R	4	B/D †
<i>potassium chloride</i>	4	B/D †
<i>potassium chloride 0.075%/d5w/nacl 0.225%</i>	4	B/D †
<i>potassium chloride 0.15% /nacl 0.45% viaflex</i>	4	B/D †
<i>potassium chloride 0.15% d5w/nacl 0.33%</i>	4	B/D †
<i>potassium chloride 0.15% d5w/nacl 0.45% viaflex</i>	4	B/D †
<i>potassium chloride 0.15% nacl 0.9%</i>	4	B/D †
POTASSIUM CHLORIDE 0.15%/D5W	4	B/D †
POTASSIUM CHLORIDE 0.22% D5W/NACL 0.45%	4	B/D †

Drug Name	Drug Tier	Requirements/ Limits
<i>potassium chloride 0.224%/d5w</i>	4	B/D †
POTASSIUM CHLORIDE 0.224%/D5W/NACL 0.45%	4	B/D †
<i>potassium chloride 0.224%d5w/nacl 0.33%</i>	4	B/D †
<i>potassium chloride 0.3%/nacl 0.9%</i>	4	B/D †
<i>potassium chloride 0.3%/d5w</i>	4	B/D †
<i>potassium chloride er</i>	1	
<i>potassium chloride sr</i>	1	
<i>potassium citrate extended-release</i>	1	
<i>premasol</i>	4	B/D †
PROCALAMINE	4	B/D †
<i>ringers injection</i>	4	B/D †
<i>ringers irrigation</i>	4	B/D †
<i>sodium bicarbonate</i>	4	B/D †
<i>sodium chloride</i>	4	B/D †
<i>sodium chloride 0.9%</i>	4	B/D †
<i>sodium chloride 0.45% viaflex</i>	4	B/D †
<i>sodium fluoride</i>	1	
<i>sodium lactate</i>	4	B/D †
<i>tis-u-sol</i>	4	B/D †
<i>tpn electrolytes fiv</i>	4	B/D †
TRAVASOL	4	B/D †
TROPHAMINE	4	B/D †
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ULTRABAG/DIANEAL LOW CALCIUM/4.25% DEXTROSE	4	B/D †
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contact us

Enrollment

If you are interested in enrolling, please call us at:

(800) 488-8000

TTY: (888) 595-0000

8 a.m. to 8 p.m., seven days a week

Member Assistance

If you are a member and need assistance, please call our
Member Services representatives at:

(800) 776-4466

TTY: (800) 794-1099

7 a.m. to 8 p.m., seven days a week