

PATH TO HEALTH DRUG FORMULARY

Administered by MedImpact

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INTRODUCTION

Foreword

The below table describes Path to Health prescription coverage:

Patient out-of-pocket cost	<ul style="list-style-type: none">• \$5 copayment per prescription• No monthly share of cost requirement
Benefit maximums	<ul style="list-style-type: none">• \$500 per prescription claim• \$1500 maximum benefit per Path to Health enrollment period
Drug exclusions	<ul style="list-style-type: none">• Specialty drugs and contraceptives are excluded

This document represents the efforts of MedImpact and Path to Health to provide physicians and pharmacists with a method to evaluate the various drug products available under the Path to Health Benefit. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Path to Health Formulary is to enhance the ability of physicians and pharmacists participating in Path to Health to provide optimal cost effective drug therapy for Path to Health members.

The development, maintenance, and improvement of the Path to Health Formulary are evolutionary and require on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The Path to Health Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to Path to Health.

Path to Health uses the following criteria in the evaluation of product selection for the Path to Health Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Path to Health Formulary is a list of covered and preferred drug agents for Path to Health members. All products are listed by their generic names and most common proprietary (branded) name. The Path to Health Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing shall be considered a Non-Formulary Drug.

Coverage Limitations

The Path to Health Formulary does not provide information regarding the specific coverage or limitations an individual member may have. Path to Health members may have specific limitations which are not reflected in this Drug Formulary. This Drug Formulary contains only FDA-approved outpatient drugs for eligible members and does not apply to non-FDA approved drugs or medications used in in-patient settings. If a Path to Health member has any specific questions regarding coverage, they should contact Path to Health at (916) 649-2631 for further explanation of benefits.

Path to Health members are not eligible to receive prescription drug services outside of California and the designated border state areas of Oregon, Nevada and Arizona.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the Path to Health pharmacy and therapeutics review process.

Path to Health approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by Path to Health for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - ◊ Coumadin
 - ◊ Dilantin
 - ◊ Lanoxin
 - ◊ Premarin
 - ◊ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Experimental Drugs

The experimental nature or use of drug products will be determined by Path to Health using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

Prior Authorization

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or

- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by Path to Health, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Request Process for Non-Formulary Agents

Coverage for non-formulary agents may be requested in advance by physicians. When a Path to Health member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of Path to Health Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the Path to Health Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- 4) The use of a Path to Health Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

Path to Health recognizes that not all medical needs can be met with agents listed in this document and encourages inquires about optional therapies.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per Path to Health guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL) will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or Path to Health members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court, San Diego, CA 92131
Attention: Appeals Coordinator
or
Fax (858) 790-6060

Formulary Process and Communication

The Path to Health Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. Path to Health welcomes input on the formulary from physicians and pharmacists providing services to Path to Health clients. Suggestions and comments should be submitted to the Path to Health at the following address:

Path to Health
ATTN: Pharmacy and Therapeutics Panel
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

Aspirin	ASPIRIN
Aspirin EC	ECOTRIN
Celecoxib	CELEBREX
Diclofenac Sodium	VOLTAREN
Etodolac	LODINE
Ibuprofen	MOTRIN (INCLUDES OTC)
Indomethacin	INDOCIN
Ketoprofen	ORUVAIL, 200MG STRENGTH NON-FORMULARY
Indomethacin, Sustained Release	INDOCIN SR
Meloxicam Tablets	MOBIC (TABLETS ONLY), SUSPENSION NON-FORMULARY
Nabumetone	RELAFEN
Naproxen	NAPROSYN
Naproxen Sodium	ANAPROX
	ANAPROX DS
Salsalate	DISALCID
Sulindac	CLINORIL
Piroxicam	FELDENE

SECOND LINE AGENTS

SE	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
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Miscellaneous Arthritis Agents

Leflunomide	ARAVA
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Migraine Agents

	APAP/Dichloralphenazone/Isomethep	MIDRIN
	Butalbital/APAP/Caffeine	ESGIC
		ESGIC PLUS
		FIORICET
	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
	Ergotamine/Caffeine	CAFERGOT
QL	Naratriptan	AMERGE, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Rizatriptan	MAXALT, MAXALT MLT, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH, SUMAVEL NON-FORMULARY
SE, QL	Eletriptan	RELPAK, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
SE, QL	Zolmitriptan	ZOMIG, ZOMIG ZMT STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
PA, QL	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH

Opiate Agonists

QL	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; ORAL SUSPENSION AND VOPAC NON-FORMULARY
QL	Acetaminophen/Hydrocodone	NORCO 5/325, LIMITED TO #240/MONTH
QL		NORCO 7.5/325, LIMITED TO #180/MONTH
QL		NORCO 10/325, LIMITED TO #150/MONTH
		ALL OTHER HYDROCODONE/APAP STRENGTHS NON-FORMULARY
QL	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL	Oxycodone	OXYIR, LIMITED TO #240/MONTH
QL	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
QL	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH; MAGNACET AND PRIMALEV NON-FORMULARY
QL		TYLOX, LIMITED TO #240/MONTH
QL	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH
PA, QL	Oxycodone	OXYCONTIN, PA REQ , LIMITED TO #60/MONTH
	Narcotic Withdrawal Therapy Agents	
	Naloxone Spray and Syringes	NARCAN; EVZIO NON-FORMULARY
	Opiate Antagonists	
	Naltrexone	REVIA
	Miscellaneous Analgesics	
	Acetaminophen	TYLENOL
	Tramadol	ULTRAM ; ULTRAM ER NON-FORMULARY
PA, QL	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH
	Miscellaneous Central Nervous System Agents	
	Donepezil	ARICEPT
	Anticonvulsant Agents	
	Barbiturate Anticonvulsants	
	Mephobarbital	MEBARAL
	Phenobarbital	PHENOBARBITAL
	Primidone	MYSOLINE
	Benzodiazepine Anticonvulsants	
QL	Clonazepam	KLONOPIN, LIMITED TO #90/MONTH; RAPDIS TABLETS NON-FORMULARY
	Hydantoin Anticonvulsants	
	Phenytoin	DILANTIN, PHENYTEK
	Miscellaneous Anticonvulsants	
	Carbamazepine	TEGRETOL; EQUETRO NON-FORMULARY
	Carbamazepine Extended Release	TEGRETOL XR
	Divalproex Sodium	DEPAKOTE
	Divalproex Sodium Extended Release	DEPAKOTE ER
	Gabapentin	NEURONTIN
	Levetiracetam	KEPPRA
	Oxcarbazepine	TRILEPTAL
	Tiagabine	GABITRIL
	Valproic Acid	DEPAKENE
	Zonisamide	ZONEGRAN
QL	Lamotrigine	LAMICTAL, LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG

QL	Topiramate	TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS
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Antiparkinsonian Agents

Amantadine Benztropine Mesylate Bromocriptine Carbidopa/Levodopa Carbidopa/Levodopa CR Pramipexole Ropinirole Selegiline Trihexyphenidyl	SYMMETREL COGENTIN PARLODEL SINEMET; PARCOPA NON-FORMULARY SINEMET CR MIRAPEX REQUIP; REQUIP XL NON-FORMULARY SELEGILINE, ZELAPAR AND EMSAM NON-FORMULARY ARTANE
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Muscle Relaxant Agents

Skeletal Muscle Relaxants

QL	Baclofen Carisoprodol Chlorzoxazone Cyclobenzaprine Dantrolene Sodium Methocarbamol Orphenadrine Citrate Orphenadrine/Aspirin/Caffeine	LIORESAL SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY PARAFON DSC FLEXERIL DANTRIUM ROBAXIN NORFLEX NORGESIC
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Psychotherapeutic Agents

Tricyclic Antidepressant Agents

Amitriptyline Amoxapine Desipramine Doxepin Imipramine Maprotiline Nortriptyline Protriptyline	ELAVIL ASENDIN NORPRAMIN SINEQUAN TOFRANIL, TOFRANIL PM NON-FORMULARY LUDIOMIL PAMELOR VIVACTIL
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S.S.R.I. Agents

Citalopram Fluoxetine Capsules Fluvoxamine Paroxetine Sertraline	CELEXA PROZAC CAPSULES (10MG, 20MG ONLY), TABLETS NON-FORMULARY LUVOX PAXIL ZOLOFT
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S.N.R.I. Agents

QL	Duloxetine	CYMBALTA , LIMITED TO #60/MONTH
QL	Venlafaxine	EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
QL	Venlafaxine Extended Release	EFFEXOR XR, LIMITED TO #30/MONTH VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY

M.A.O. Inhibitor Agents

Phenelzine Tranylcypromine	NARDIL PARNATE
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Miscellaneous Antidepressant Agents

	Bupropion	WELLBUTRIN, APLENZIN NON-FORMULARY
	Bupropion SR	WELLBUTRIN SR, APLENZIN NON-FORMULARY
	Bupropion XL	WELLBUTRIN XL, APLENZIN NON-FORMULARY
	Clomipramine	ANAFRANIL
	Mirtazapine	REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
MD, QL	Trazodone	DESYREL
	Nefazodone	SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH

Antimanic Agents

	Lithium Carbonate	ESKALITH
		LITHOBID

Benzodiazepines

QL	Alprazolam	XANAX, LIMITED TO #90/MONTH; XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY
QL	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	Diazepam	VALIUM, LIMITED TO #90/MONTH, DIASTAT NON-FORMULARY
QL	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; LORAZEPAM ORAL CONCENTRATE NON-FORMULARY
QL	Temazepam	RESTORIL, LIMITED TO #30/MONTH; 22.5MG STRENGTH NON-FORMULARY
QL	Triazolam	HALCION, LIMITED TO #30/MONTH

Antipsychotic Agents

QL	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH DISCMELTS NON-FORMULARY
	Chlorpromazine	THORAZINE
	Clozapine	CLOZARIL
	Fluphenazine	PROLIXIN
	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	Loxapine	LOXITANE
	Molindone	MOBAN
QL	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL		ZYPREXA ZYDIS, LIMITED TO #60/MONTH
		ZYPREXA INJECTION
		ZYPREXA RELPREVV

	Perphenazine	TRILAFON
	Pimozide	ORAP
QL	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, 25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMIT PA FOR OTHER INDICATIONS.
QL	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
	Thioridazine	MELLARIL
	Thiothixene	NAVANE
	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH

Antipsychotic/SSRI Combination Agents

QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
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Miscellaneous Anxiolytics, Sedatives, and Hypnotics

	Buspirone	BUSPAR 7.5MG STRENGTH NON-FORMULARY
	Chloral Hydrate	NOCTEC
	Hydroxyzine	ATARAX

QL	Hydroxyzine Pamoate Promethazine Zolpidem	VISTARIL PHENERGAN AMBIEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY
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CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

Amiodarone	CORDARONE; 100MG STRENGTH NON-FORMULARY
Disopyramide	NORPACE
Disopyramide CR	NORPACE CR
Flecainide	TAMBOCOR
Mexiletine	MEXITIL
Procainamide	PRONESTYL
Procainamide SR	PROCAN SR
	PROCANBID
Propafenone	RYTHMOL
Quinidine Gluconate	QUINAGLUTE
Quinidine Polygalacturonate	CARDIOQUIN
Quinidine Sulfate	CIN-QUIN
Quinidine Sulfate SR	QUINIDEX
Sotalol	BETAPACE

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

Atenolol	TENORMIN
Metoprolol Succinate	TOPROL XL
Metoprolol Tartrate	LOPRESSOR
Nadolol	CORGARD
Pindolol	VISKEN
Propranolol	INDERAL
Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

Carvedilol	COREG; COREG CR NON-FORMULARY
Labetalol	NORMODYNE
	TRANDATE

Angiotensin Converting Enzyme Inhibitor Agents

Benazepril	LOTENSIN
Captopril	CAPOTEN
Enalapril	VASOTEC
Lisinopril	PRINIVIL
	ZESTRIL

Angiotensin Receptor Blocker Agents

	Irbesartan	AVAPRO
	Losartan	COZAAR
	Telmisartan	MICARDIS
SE, QL	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan	DIOVAN, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

Amlodipine	NORVASC, LIMITED TO #30/MONTH
Diltiazem	CARDIZEM
Diltiazem SR	CARDIZEM SR; CARDIZEM LA NON-FORMULARY
Diltiazem CD	CARTIA XT
Felodipine	PLENDIL, LIMITED TO #30/MONTH
Nifedipine, Sustained Release	ADALAT CC
Verapamil	CALAN
Verapamil LA Tablets	CALAN SR; COVERA-HS NON-FORMULARY
Verapamil SR Capsules	VERELAN

Centrally Acting Antihypertensive Agents

Clonidine	CATAPRES
Guanfacine	TENEX
Methyldopa	ALDOMET

Combination Antihypertensive Agents

	Atenolol/Chlorthalidone	TENORETIC
	Benazepril/HCTZ	LOTENSIN HCT
	Bisoprolol/HCTZ	ZIAC
	Captopril/HCTZ	CAPOZIDE
	Enalapril/HCTZ	VASORETIC
	Lisinopril/HCTZ	ZESTORETIC
	Losartan/HCTZ	PRINZIDE
SE, QL	Olmesartan/HCTZ	HYZAAR, BENICAR HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

PA	Phenoxybenzamine	DIBENZYLINE, PA REQUIRED
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Potassium-Sparing Diuretics

	Spirolactone	ALDACTONE
	Spirolactone/HCTZ	ALDACTAZIDE
	Triamterene	DYRENIUM
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50

Loop Diuretics

	Bumetanide	BUMEX
	Furosemide	LASIX

Thiazide and Related Diuretics

	Chlorthalidone	HYGROTON
	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
	Indapamide	LOZOL
	Metolazone	ZAROXOLYN

Vasodilator Antihypertensive Agents

	Doxazosin Mesylate	CARDURA; CARDURAL XL NON-FORMULARY
	Hydralazine	APRESOLINE
	Minoxidil	LONITEN
	Prazosin	MINIPRESS
	Terazosin	HYTRIN

Antilipemic Agents

Atorvastatin
Cholestyramine/Aspartame
Cholestyramine/Sucrose
Gemfibrozil
Lovastatin
Niacin
Pravastatin
Niacin, Delayed Release
Niacin/Lovastatin
Simvastatin

LIPITOR
QUESTRAN LIGHT
QUESTRAN
LOPID
MEVACOR
NIACIN
PRAVACHOL
NIASPAN
ADVICOR
ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF 80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS FORMULARY

Blood Agents

Coagulants and Anticoagulants

QL Enoxaparin
Warfarin Sodium

LOVENOX, LIMITED TO #20/FILL TIMES 3
COUMADIN

Hemorheologic Agents

Pentoxifylline

TRENTAL

Cardiac Glycoside Agents

Digoxin

LANOXIN; LANOXICAPS NON-FORMULARY

Antiplatelet Agents

Cilostazole
Clopidogrel
Dipyridamole
Pasugrel

PLETAL
PLAVIX
PERSANTINE
EFFIENT

Vasodilating Agents

Isosorbide Dinitrate
Isosorbide Dinitrate SR
Isosorbide Mononitrate
Isosorbide Dinitrate ER
Nitroglycerin Ointment
Nitroglycerin Patches
Nitroglycerin Spray
Nitroglycerin Sublingual
Isosorbide Mononitrate

ISORDIL; CHEW TABLETS NON-FORMULARY
DILATRATE SR
ISOSORBIDE MONONITRATE
ISOSORBIDE MONONITRATE
NITROL
NITRO-DUR
NITROLINGUAL SPRAY
NITROSTAT SL
IMDUR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS

SE

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

Attapulgite
Bismuth Subsalicylate

PAREPECTOLIN
PEPTO BISMOL

Diphenoxylate/Atropine
Kaolin/Pectin

LOMOTIL
KAOPECTATE

Loperamide

IMODIUM

Antiemetic Agents

Meclizine
Metoclopramide
Ondansetron ODT Tablets
Ondansetron Tablets
Ondansetron Solution
Prochlorperazine Maleate

ANTIVERT
REGLAN
ZOFTRAN ODT
ZOFTRAN TABLETS
ZOFTRAN SOLUTION
COMPAZINE
COMPAZINE SPANSULES NOT COVERED
PHENERGAN
TIGAN

Promethazine
Trimethobenzamide

Antimuscarinic/Antispasmodic Agents

Belladonna/Phenobarbital
(Extentabs, Capsules Not Covered)
Chlordiazepoxide/Clidinium
Dicyclomine
Hyoscyamine Sulfate

DONNATAL

CHLORDIAZEPOXIDE/CLIDINIUM
BENTYL
LEVBID
LEVSIN
LEVSIN SL

Antiulcer/Antipeptic Agents

Antacid Mg OH/Al OH
Antacid Mg OH/Al OH/Simethicone
Lansoprazole 15mg OTC

Misoprostol
Omeprazole 20mg and 40mg

Omeprazole Magnesium
Pantoprazole Tablets
Simethicone
Sucralfate

MAALOX, TC
MYLANTA I, II
PREVACID 24HR,
LEGEND LANSOPRAZOLE NON-FORMULARY
CYTOTEC
PRILOSEC 20MG AND 40MG, OTHER STRENGTHS NON-FORMULARY
PRILOSEC OTC
PROTONIX
MYLICON
CARAFATE

Bowel Evacuant Agents

QL Bowel Evacuation Prep Kits

FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR

QL Enema

FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR

QL Oral Colon Lavage Solution
Oral Saline Laxative

COLYTE
FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR

Digestive Enzymes

Amylase/Lipase/Protease
Amylase/Lipase/Protease

PANCRELIPASE 5,000
CREON

Amylase/Lipase/Protease

PANCREAZE

Gallstone Solubilizing Agents

Ursodiol

ACTIGALL

Gastrointestinal Stimulant Agents

Metoclopramide

REGLAN

H₂ Antagonist Agents

Cimetidine

TAGAMET

Famotidine

PEPCID

Ranitidine

ZANTAC (TABLETS ONLY)

Laxative Agents

QL

Bisacodyl Suppositories

DULCOLAX, LIMITED TO #30/MONTH

Docusate Sodium Capsules

COLACE

QL

Lactulose

CEPHULAC, LIMITED TO 4L/MONTH

QL

Sennosides

CHRONULAC, LIMITED TO 4L/MONTH

SENNA

Miscellaneous Gastrointestinal Supplies

Ostomy Supplies

Miscellaneous Gastrointestinal Agents

Mesalamine

DELZICOL

ROWASA

Olsalazine

DIPENTUM

Sulfasalazine

AZULFIDINE

PA

Budesonide

ENTOCORT EC, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

Metronidazole

FLAGYL; FLAGYL ER NON-FORMULARY

Iodoquinol (Diiodohydroxyquin)

YODOXIN

Anthelmintic Agents

Albendazole

ALBENZA

Furazolidone

FUROXONE

Mebendazole

VERMOX

Praziquantel

BILTRICIDE

Antibiotic Agents

Aminoglycosides

Neomycin Sulfate

MYCIFRADIN

Cephalosporins

Cefaclor

CECLOR

	Cefadroxil	DURICEF
	Cefdinir	OMNICEF
QL	Cefixime	SUPRAX, LIMITED TO #1 X 400MG/FILL
	Cefuroxime Tablets	CEFTIN
	Cephalexin	KEFLEX; 750MG STRENGTH NON-FORMULARY
	Macrolide Antibiotic Agents	
QL	Azithromycin	ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; ZMAX NON-FORMULARY
	Erythromycin Base	ERY-TAB
	Erythromycin Stearate	PCE
	Erythromycin Ethylsuccinate	ERYPED SUSPENSION
	Erythromycin/Sulfisoxazole	ERYTHROCIN
PA	Clarithromycin	EES
	Miscellaneous Antibiotic Agents	PEDIAZOLE
	Clindamycin	BIAXIN, PA REQ
	Metronidazole	CLEOCIN
	Penicillins	FLAGYL
	Amoxicillin	AMOXIL
	Amoxicillin/Potassium Clavulanate	TRIMOX
	Ampicillin	AUGMENTIN
	Dicloxacillin	PRINCIPEN
	Penicillin VK (125mg Tablets Not Covered)	DYNAPEN
	Quinolones	PEN VK
QL	Ciprofloxacin tablets	CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; CIPRO XR AND PROQUIN XR NONFORMULARY
QL	Moxifloxacin	AVELOX, LIMITED TO 21-DAY SUPPLY
	Sulfonamide Agents	
	Erythromycin/Sulfisoxazole	PEDIAZOLE
	Sulfamethoxazole/Trimethoprim (SMZ/TMP)	BACTRIM
	Sulfisoxazole	SEPTRA
	Sulfadiazine	GANTRISIN
	Trimethoprim	SULFADIAZINE
	Tetracyclines	TRIMPEX
	Doxycycline	VIBRAMYCIN
	Minocycline	VIBRA-TABS
	Tetracycline	DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY
	Antifungal Agents	MINOCIN
	Clotrimazole	ACHROMYCIN V
	Fluconazole	SUMYCIN
	Griseofulvin Ultramicrosized	MYCELEX TROCHE
	Ketoconazole	DIFLUCAN
	Nystatin (Oral Powder Not Covered)	GRIS-PEG
	Terbinafine Tablets	FULVICIN P/G
		NIZORAL
		MYCOSTATIN
		LAMISIL TABLETS

Antimalarial Agents

Atovaquone/Proguanil
Chloroquine Phosphate
Hydroxychloroquine
Iodoquinol
Mefloquine
Primaquine
Pyrimethamine
Quinine (260mg Not Covered)

MALARONE
CHLOROQUINE PHOSPHATE
PLAQUENIL
YODOXIN
LARIAM
PRIMAQUINE
DARAPRIM
QUININE

Antituberculosis Agents

Ethambutol
Isoniazid
Pyrazinamide
Rifabutin
Rifampin

MYAMBUTOL
ISONIAZID
PYRAZINAMIDE
MYCOBUTIN
RIFADIN

Anti-Ulcer Eradication Agents

QL Amoxicillin/Clarithromycin/Lansoprazole PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL Tetracycline/Bismuth/Metronidazole HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Other Antiviral Agents

Amantadine SYMMETREL
Acyclovir Oral ZOVIRAX ORAL
Oseltamivir TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT
OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
Rimantadine FLUMADINE
Zanamivir RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT
OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS
Valacyclovir VALTREX
SE Famciclovir FAMVIR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL
OF ACYCLOVIR IN THE PAST 90 DAYS

Leprostatic Agents

Clofazimine
Dapsone

LAMPRENE
DAPSONE; **ACZONE NON-FORMULARY**

RESPIRATORY/EENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

Chlorpheniramine
Dexchlorpheniramine

CHLORTRIMETON
POLARAMINE

Single Entity Ethanolamine Agents

Cyproheptadine
Diphenhydramine

PERIACTIN
BENADRYL

Non-Sedating Single Entity Agents

Cetirizine, OTC
Fexofenadine
Loratadine, OTC

CETIRIZINE, OTC
FEXOFENADINE
LORATADINE, OTC

Miscellaneous Antihistamine Agents

Hydroxyzine	ATARAX
Hydroxyzine Pamoate	VISTARIL
Promethazine	PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

Bromphen/Pseudoephedrine	BROMFED BROMFED PD
Guaifenesin/Pseudoephedrine	GUAIFED-PD
Pseudoephedrine/Chlorpheniramine	DECONAMINE SR

Antitussive Agents

Non-Narcotic Antitussive Agents

Benzonatate	TESSALON
Dextromethorphan	TUSSIN PEDIATRIC
Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

Narcotic Antitussive Agents

Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
Guaifenesin/Codeine	ROBITUSSIN A-C
Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC ENDAL-HD
Promethazine/Codeine	PHENERGAN/CODEINE
Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE
Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
Triprolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE

Decongestants

Pseudoephedrine	SUDAFED
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Asthma/COPD Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.
QL	Albuterol/Ipratropium	COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
QL	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	Ipratropium	ATROVENT HFA
QL	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
QL	Salmeterol	SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	Mometasone/Formoterol	DULERA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA), ANTICHOLINERGIC, OR ANTICHOLINERGIC/LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
SE, QL	Salmeterol/Fluticasone	ADVAIR DISKUS 250/50 STRENGTH ONLY, STEP THERAPY , RESTRICTED TO COPD AFTER A TRIAL ANTICHOLINERGIC OR LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH

Oral Sympathomimetic (Adrenergic) Agents

Albuterol	PROVENTIL
Albuterol E.R.	PROVENTIL REPETABS VOLMAX

Metaproterenol Oral	ALUPENT
Terbutaline Sulfate	BRETHINE
	BRICANYL

Inhaled Oral Corticosteroid Agents

QL	Beclomethasone Inhaler	QVAR REDIHALER, LIMITED TO #2 INHALERS/MONTH
QL	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH

Leukotriene Receptor Antagonists

QL	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
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Respiratory Smooth Muscle Relaxant Agents

	Aminophylline 150mg/5ml	
	Aminophylline Suppositories	
	Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80
	Theophylline	SLO-PHYLLIN
	Theophylline, Sustained Release	THEO-DUR, SLO-BID, UNIPHYL

Expectorant Agents

	Guaifenesin	ROBITUSSIN
	Guaifenesin/Dextromethorphan	ROBITUSSIN DM
	Guaifenesin/Phenylephrine	ENDAL
	Guaifenesin/Pseudoephedrine	ZEPHREX LA
	Phenylephrine/Promethazine	PHENERGAN VC
	Phenylephrine/Guaifenesin	RESCON GC
	Potassium Iodide	SSKI

Mucolytic Agents

	Acetylcysteine	MUCOMYST
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Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

	Bacitracin	BACITRACIN
	Dexamethasone/Polymyxin/Neomycin	MAXITROL
	Erythromycin Base	ILOTYCIN
	Gentamicin	GARAMYCIN
	Gentamicin/Prednisolone	PRED-G
	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
	Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
	Ofloxacin	OCUFLOX
	Polymixin B Sulfate/TMP	POLYTRIM
	Tobramycin	TOBREX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

	Fluorometholone	EFLONE
		FML
		FML FORTE
	Prednisolone Acetate	PRED MILD OPHTHALMIC
		PRED FORTE
	Prednisolone Phosphate	INFLAMASE
		INFLAMASE FORTE

Ophthalmic Anti-Inflammatory Agents, NSAIDs

	Flurbiprofen Sodium	OCUFEN
	Diclofenac Sodium	VOLTAREN
	Ketorolac Tromethamine	ACULAR

Ophthalmic Antiviral Agents

	Trifluridine Ophthalmic Solution	VIROPTIC
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Ophthalmic Beta Blockers

Levobunolol
Timolol

Ophthalmic Miotic Agents

Brimonidine

Dorzolamide
Dorzolamide/Timolol
Echothiophate Iodide
Pilocarpine

Ophthalmic Mydriatic Agents

Atropine Sulfate
Dipivefrin
Tropicamide

Ophthalmic Sulfonamide Agents

Sulfacetamide

Sulfacetamide 10%/Prednisolone 0.2%
Sulfacetamide 10%/Prednisolone 0.5%

Miscellaneous Ophthalmic Agents

Ketotifen
Latanoprost
Naphazoline
Naphazoline/Pheniramine

Otic Anti-Infective Agents

Acetic Acid
Acetic Acid 2%
Acetic Acid 2%/Hydrocortisone 1%
Hydrocortisone/Neomycin/Polymyxin
Ofloxacin

Miscellaneous Otic Agents

Benzocaine/Antipyrine
Carbamide Peroxide/Glycerin

BETAGAN
TIMOPTIC

ALPHAGAN
ALPHAGAN P
TRUSOPT
COSOPT
PHOSPHOLINE IODIDE
PILOCAR
OCUSERT NOT COVERED

ISOPTO ATROPINE
PROPINE
MYDRIACYL

BLEPH-10
SODIUM SULAMYD
BLEPHAMIDE
METIMYD

ZADITOR OTC, ALAWAY
XALATAN
ALBALON
NAPHCON-A

VOSOL
DOMEBORO
VOSOL HC
CORTISPORIN
FLOXIN OTIC

AURALGAN
DEBROX

Inhaled/Oral EENT Agents

Inhaled Nasal Agents

Fluticasone, Nasal
Triamcinolone, Nasal
Ipratropium, Nasal

QL

Carbonic Anhydrase Inhibitor Agents

Acetazolamide
Acetazolamide SA
Methazolamide

Local Anesthetic Agents

Benzocaine/Antipyrine Otic
Lidocaine Solution
Lidocaine, Viscous
Triamcinolone 0.1% in Orabase

FLONASE
NASACORT
ATROVENT, LIMITED TO #2 DEVICES/MONTH

DIAMOX
DIAMOX SEQUELS
NEPTAZANE

AURALGAN
XYLOCAINE
VISCIOUS XYLOCAINE
KENALOG IN ORABASE

Miscellaneous EENT Agents

Carbachol
Chlorhexidine Gluconate
Cromolyn Ophthalmic Solution
Epinephrine Injection
Optichamber

QL

ISOPTO CARBACHOL
PERIDEX
CROLOM
EPIPEN
OPTICHAMBER, LIMITED TO #2/YEAR

Sodium Chloride for Inhalation
Triethanolamine

GENERIC
CERUMENEX

DIABETES AND THYROID AGENTS

Oral Diabetes Agents

Sulfonylureas

Glipizide
Glipizide L.A.
Glyburide

GLUCOTROL
GLUCOTROL XL
DIABETA, GLYNASE
MICRONASE
AMARYL
DIABINESE
TOLINASE
ORINASE

Glimepiride
Chlorpropamide
Tolazamide
Tolbutamide

Non-Sulfonylureas

Acarbose
Metformin
Metformin ER
Pioglitazone
Alogliptin

PRECOSE
GLUCOPHAGE
GLUCOPHAGE XR
ACTOS
NESINA, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH
JANUVIA, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

SE, QL

SE, QL

Sitagliptin

Combination Diabetes Agents

Glipizide/Metformin
Glyburide/Metformin
Alogliptin/Metformin

METAGLIP
GLUCOVANCE
KAZANO, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR ALOGLIPTIN IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
JANUMET, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
JANUMET XR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH

SE, QL

SE, QL

Sitagliptin/Metformin

SE, QL

Sitagliptin/Metformin Extended Release

Insulin Agents

Insulin
Insulin Lispro
Insulin Glargine

ALL LILLY INSULINS, VIALS ONLY
HUMALOG, HUMALOG MIX, VIALS AND PENS
LANTUS, VIALS ONLY

Miscellaneous Diabetes Agents

Glucagon

GLUCAGON

Thyroid Agents

Levothyroxine
Liotrix
Liothyronine

LEVOTHROID
THYROLAR
CYTOMEL

Thyroid, Desiccated

ARMOUR THYROID
LEVOXYL
SYNTHROID

Antithyroid Agents

Methimazole
Propylthiouracil

TAPAZOLE
PROPYLTHIOURACIL

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

Cortisone Acetate
Dexamethasone
Fludrocortisone Acetate
Hydrocortisone Oral
Methylprednisolone
Prednisone

CORTONE
DECADRON
FLORINEF
CORTEF
MEDROL
DELTASONE
ORASONE
MEDROL DOSEPAK
PEDIAPRED
PRELONE

Prednisolone

Androgen Agents

Danazol
Fluoxymesterone
Methyltestosterone

DANOCRINE
HALOTESTIN
ANDROID
METANDREN

Bone Resorption Inhibitors

QL Alendronate

FOSAMAX,
70MG AND 35MG LIMITED TO #4/MONTH;
5MG, 10MG, AND 40MG LIMITED TO #30/MONTH;
SOLUTION LIMITED TO #300ML/MONTH
FOSAMAX PLUS D NONFORMULARY
MIACALCIN NS, **PA REQ**

PA Calcitonin

Parathyroid Hormone

PA, QL Teriparatide

FORTEO, **PA REQ**, LIMITED TO 1 PEN/MONTH

Estrogen Agents

Conjugated Estrogens
Conjugated Estrogens, Vaginal
Estradiol
Estradiol Patches

PREMARIN
PREMARIN VAGINAL CREAM
ESTRACE
ALORA
CLIMARA
ESTRADERM
VIVELLE
VIVELLE DOT
PREMPRO, PREMPRO LOW DOSE
PREMPHASE

Estrogen/Medroxyprogesterone

ESTRATEST, ESTRATEST HS
ESTRING, **STEP THERAPY**, RESTRICTED TO USE AFTER A
TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

SE Esterified Estrogens/ Methyltestosterone
Estradiol/Vaginal Ring

Estrogen Agonist-Antagonists

Raloxifene EVISTA

Contraceptives

Contraceptives are not a covered benefit.

Oxytocic Agents

Ergonovine Maleate ERGOTRATE
Methylergonovine Maleate METHERGINE

Pituitary Agents

Desmopressin DDAVP

Progestin Agents

Medroxyprogesterone CYCRIN
PROVERA
Norethindrone Acetate AYGESTIN
NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

Meth/Me Blue/PA/Salol/ATP/Hyos URISED
Nitrofurantoin (Tablets, Suspension FURADANTIN
Only)
Trimethoprim TRIMPEX

Urinary Anti-Spasmodic Agents

Pentosan ELMIRON
Phenazopyridine PYRIDIUM

Genitourinary Smooth Muscle Relaxant Agents

Belladonna/Methylene Blue URISED
Oxybutynin DITROPAN
DITROPAN XL NOT COVERED
ST, QL Tolterodine DETROL, **STEP THERAPY**, LIMITED TO #60/MONTH,
RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE
PAST 90 DAYS
ST, QL DETROL LA, **STEP THERAPY**, LIMITED TO #30/MONTH,
RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE
PAST 90 DAYS

Parasympathomimetic (Cholinergic) Agents

Bethanechol URECHOLINE
Neostigmine PROSTIGMIN
Pyridostigmine MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

Anthralin	DRITHOCREME
	DRITHO-SCALP
Podofilox	CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

	Aluminum Acetate	BURROWS SOLUTION
	Aluminum Chloride Hexahydrate	DRYSOL
	Benzoyl Peroxide, OTC Generic	BENZOYL PEROXIDE, OTC GENERIC
	Calamine	CALAMINE LOTION
	Calcipotriene	DOVONEX
	Fluorouracil	EFUDEX
	Hydrocortisone 1% Rectal	PROCTOCORT
	Masoprocol	ACTINEX
PA	Becaplermin	REGRANEX, PA REQ
PA	Isotretinoin	ACCUTANE, PA REQ

Topical Antibiotic Agents

	Bacitracin	BACITRACIN
	Bacitracin/Polymixin/Neomycin	NEOSPORIN
	Clindamycin Solution	CLEOCIN T
	Erythromycin Topical	ERYGEL
		EMGEL
		T-STAT
	Erythromycin/Benzoyl Peroxide	BENZAMYCIN
	Gentamicin Sulfate	GARAMYCIN
	Mupirocin	BACTROBAN
	Silver Sulfadiazine	SILVADENE

Topical Antifungal Agents

	Clotrimazole	LOTRIMIN
	Clotrimazole/Betamethasone	LOTRISONE
	Ciclopirox	LOPROX
	Ketoconazole	NIZORAL
	Miconazole Nitrate	MONISTAT-DERM
	Nystatin	MYCOSTATIN
	Terbinafine	LAMISIL
	Tolnaftate	TINACTIN
	Triamcinolone/Nystatin	MYCOLOG II

Vaginal Antifungal Agents

	Butoconazole	FEMSTAT
	Clotrimazole Cream/Vaginal Tablets	MYCELEX
		MYCELEX G
	Nystatin	MYCOSTATIN
	Miconazole Cream/Vaginal Tablets	MONISTAT
		MONISTAT 3
	Triple Sulfa Cream	SULTRIN
	Tioconazole	VAGISTAT-1

Vaginal Anti-Infective Agents

Metronidazole

METROGEL-VAGINAL

Topical Anti-Inflammatory Agents

LOW POTENCY

Fluocinolone 0.025%

Desonide

Hydrocortisone

Hydrocortisone Enema

Hydrocortisone Acetate

Hydrocortisone/Pramoxine

SYNALAR

TRIDESILON

HYTONE

CORTENEMA

CORTIFOAM

PROCTOCREAM-HC

MEDIUM POTENCY

Betamethasone Dipropionate

Betamethasone Valerate 0.01%

Betamethasone Valerate 0.1%

Desoximetasone Cream/Gel 0.05%

Flurandrenolide

Hydrocortisone Valerate

Mometasone Furoate Cream

Triamcinolone

DIPROSONE

MAXIVATE

VALISONE REDUCED STRENGTH

VALISONE

TOPICORT LP

CORDRAN

WESTCORT

ELOCON

ARISTOCORT

ARISTOCORT A NOT COVERED

KENALOG

HIGH POTENCY

Betamethasone Dipropionate

Desoximetasone 0.25%

Fluocinonide

Fluocinolone Acetonide 0.2%

VERY HIGH POTENCY

Augmented Betamethasone

Dipropionate

Clobetasol Cream, Gel, Solution,

Ointment

Diflorasone Diacetate

DIPROLENE

TOPICORT

LIDEX

LIDEX E

SYNALAR

DIPROLENE AF

TEMOVATE

FLORONE

FLORONE-E

PSORCON

Topical Antipruritic and Local Anesthetic Agents

Lidocaine (Viscous and Spray Only)

Pramoxine/Hydrocortisone

Pramoxine

Pimecrolimus

Tacrolimus

XYLOCAINE

PROCTOFOAM HC

EPIFOAM

ELIDEL, PA REQ

PROTOPIC, PA REQ

PA

PA

Topical Antiviral Agents

Acyclovir Topical

ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents

Selenium Sulfide 2.5%

Sulfacetamide Lotion

EXSEL

SELSUN

SEBIZON

Scabicide/Pediculicide Agents

Crotamiton
Malathion
Permethrin

EURAX
OVIDE
ELIMITE
NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

Calcium Acetate
Calcium Carbonate
Magnesium Oxide, OTC Generic

PHOS LO
TUMS
MAGNESIUM OXIDE, OTC GENERIC

Potassium Agents

Potassium Chloride 8mEq
Potassium Chloride
Potassium Chloride 10mEq
Potassium Chloride

MICRO-K

Potassium Chloride 20mEq
Potassium Chloride

KAON-CL 10
K-DUR
MICRO-K 10
K-DUR

<i>Potassium Chloride Effervescent Tablets</i>	
Potassium Chloride Tablets	K-LYTE
Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>	
Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>	
Potassium Chloride Liquid	KAON-CL
<i>Potassium-Removing Resins</i>	
Sodium Polystyrene Sulfonate	KAYEXALATE

Heavy Metal Antagonist Agents

Penicillamine	CUPRIMINE
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Vitamin Agents

Vitamin B-Complex Agents

Cyanocobalamin	VITAMIN B ₁₂ (ORAL FORMULATIONS ONLY)
Folic Acid	FOLIC ACID
Niacin	NIACIN
Pyridoxine	VITAMIN B ₆
Thiamine	VITAMIN B ₁

Vitamin D

Calcitriol	ROCALTROL
Ergocalciferol	DRISDOL

Vitamin K Activity Agents

Phytonadione	MEPHYTON
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Iron Agents

Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL
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Diagnostic Testing

Blood Glucose Supplies

QL	Alcohol Swabs	LIMITED TO 200/MONTH
	Blood Glucose Monitoring Control Solution	BLOOD GLUCOSE MONITORING CONTROL SOLUTION, ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY
QL	Blood Glucose Test Strips	BLOOD GLUCOSE TEST STRIPS, ROCHE STRIPS (E.G., ACCU-CHEK) ONLY , LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS. MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH. LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION
	Glucometers	GLUCOMETERS, ROCHE METERS (E.G., ACCU-CHEK) ONLY
	Lancets	

Alcohol And Smoking Deterrent Agents

PA	Bupropion SR	ZYBAN, PA REQ
	Disulfiram	ANTABUSE
PA	Nicotine	NICORETTE GUM, PA REQ
PA		NICOTINE PATCH, PA REQ (OTC PATCHES ONLY)
PA		NICOTROL NASAL SPRAY, PA REQ

Gout Agents

Allopurinol	ZYLOPRIM
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QL	Colchicine	COLCRYS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1 TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.
	Probenecid	BENEMID

Other Medical Supplies

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. Path to Health does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms).

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