# 2016 BlueChoice® HealthPlan Prescription Drug List

## Important Information About This List

This is **not** a comprehensive list of all drugs covered under your prescription drug benefit. Not all benefit plans cover all drugs listed here. To find more information about a drug *not* on this list or to verify how coverage of a certain drug applies to you, please log into My Health Toolkit® and use the Drug Coverage and Cost Tool. You can also refer to your plan materials for more information about coverage exceptions, limitations, etc.

**Drug Exclusions:** We cover most drugs under your pharmacy benefit. For information about excluded drugs, please see the Excluded Drug List. The list of excluded drugs is subject to change at any time. Your benefit plan may include the right for you, your doctor or another person of your choosing to request that we cover an excluded drug based on medical necessity. To begin the exception process, ask your doctor to request the formulary exception by calling Health Care Services at 800-950-5387 or faxing 800-610-5685. You (or your designated representative) may also initiate a request for a formulary exception by calling Customer Service at 800-868-2528. Additionally, your pharmacy benefit also may not cover certain categories of drugs, such as those for weight loss or drugs to treat impotence. Please check your plan materials for more details about coverage for a specific drug category.

**Copayments**
Pharmacy benefits cover prescription drugs at three levels. They are generic (Tier 1), preferred (Tier 2) and non-preferred (Tier 3). ***Generic*** drugs typically have the lowest copayment. This category includes most generic drugs and covered over-the-counter (OTC) drugs. Many members have a two-tier generic benefit. Generic drugs costing more than $15 have a low “Standard” generic copayment. Generic drugs that cost less than $15 and OTC drugs have the lowest “Value” generic copayment. ***Preferred*** drugs are generally brand drugs that have the middle copayment. ***Non-preferred*** drugs are brand-name drugs and occasionally, high-priced generic drugs, which have the highest copayment.

We assign these levels based on cost, availability of a generic substitute and clinical value. Drugs may change levels at any time during the year without prior notice. These changes usually occur when new drugs become available.

We do not cover specific “lifestyle” medications under the pharmacy benefit. Some examples of these types of drugs include those for:

- The treatment of hair loss
- Sexual dysfunction
- Weight loss
- Skin pigmentation treatments

Members can get these types of drugs at a discounted price by presenting their prescription and member ID cards at network pharmacies.

**Quantity Limitations**
The BlueChoice® Pharmacy and Therapeutics Committee is made up of doctors and pharmacists. The Committee sets maximum-allowed amounts for certain prescription drugs. It bases the amounts on U.S. Food and Drug Administration (FDA) prescribing guidelines and available package sizes. As a result, we limit coverage for some drugs to a certain quantity within a certain period of time. In this drug list, you will see “QL” next to drugs with quantity limits. Unless otherwise noted, one month equals a 31-day supply.

**Prior Authorization**
Doctors must get prior authorization for certain drugs. This helps make sure the drugs are used according to their product labeling. We base the need for prior authorization on current FDA guidelines. We also base it on clinical decisions from the BlueChoice Pharmacy and Therapeutics Committee. Before a doctor prescribes a prior authorization drug, he or she should call Caremark at 800-294-5979. Caremark is an independent company that administers prescription drug benefits on behalf of BlueChoice. In this drug list, you will see "PA" next to drugs that require prior authorization.

**Medical Necessity Prior Authorization**
We will not cover some medications without prior authorization for medical necessity (MN). Before a doctor prescribes an MN prior authorization drug, he or she should call Caremark at 800-294-5979. In this drug list, you will see "MN" next to drugs that require medical necessity prior authorization.

**Step Therapy**
Some drugs require members to satisfy certain step therapy criteria before they can get the drug. Before a doctor prescribes a step therapy drug, he or she should call BlueChoice at 800-950-5387. We will decide if we can approve the drug based on the step therapy criteria for that drug. In this drug list, you will see "ST" next to drugs that have a step therapy requirement. Unless otherwise noted, the requirement only applies to brand medications, not the generic version if there is one available.

**Specialty Pharmaceuticals**
Specialty pharmaceuticals are drugs that treat complex or chronic medical conditions and that are usually very expensive. We cover some of these drugs under the pharmacy benefit (oral and self-injectable drugs) and we cover others under the medical benefit. Specialty drugs ***are not*** included in this Prescription Drug List. For information about specialty drugs, please see the **Specialty Drug** list.


**Legend**

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **ABILIFY** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone or Seroquel XR in the last 365 days |
| ABSTRAL | | NP | PA, QL. QL is 120 doses per month. | Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain |
| **ACCOLATE** | **G** | NP | | |
| ACCU-CHEK kits and test strips | | NP | MN | Alternatives that do not require PA for medical necessity are OneTouch products |
| **ACCUPRIL** | **G** | NP | | |
| **ACCURETIC** | **G** | NP | | |
| **acetazolamide** | | Tier 1 | | |
| **ACIPHEX** | **G** | NP | ST, QL | Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, and OTC PPI. PA required for more than once-daily dosing. |
| ACTICLATE | | NP | PA | Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review. |
| **ACTIGALL** | **G** | NP | | |
| **ACTIQ** | **G** | NP | PA, QL. QL is 120 doses per month. | Coverage provided for members 16 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain. PA is required for both brand and generic. |
| **ACTIVELLA** | **G** | NP | | |
| **ACTONEL** (daily dose) | **G** | NP | QL | QL of 31 tabs per month |
| **ACTONEL** (weekly dose) | **G** | NP | QL | QL of 4 tabs per month |
| **ACTONEL 150 mg** (monthly dose) | **G** | NP | QL | QL of 1 tab per month or 3 tabs per 3 months |
| **ACTOPLUS MET** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| ACTOPLUS MET XR | | NP | | |
| **ACTOS** | **G** | NP | | |
| **ACULAR** | **G** | NP | | |
| **ADALAT CC** | **G** | NP | | |
| **ADDERALL** | **G** | NP | QL | Quantity Limits:<br>5mg-10mg: 90 per month<br>15mg-20mg: 60 per month<br>30mg: 60 per month |
| **ADDERALL XR** | **G** | NP | QL | QL of 30 caps per month |
| **ADOXA** | **G** | NP | PA | Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review. |
| ADVAIR DISKUS | | P | QL | QL of 1 inhaler per month |
| ADVAIR HFA | | P | QL | QL of 1 inhaler per month |
| ADVICOR | | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin, Simcor |
| **ALAVERT OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **ALAVERT-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **albuterol inhalation solution, syrup, tabs** | | Tier 1 | QL | |
| **ALDACTAZIDE** | **G** | NP | | |
| **ALDACTONE** | **G** | NP | | |
| **ALLEGRA OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **ALLEGRA-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| ALPHAGAN P 0.1% | | P | | |
| **ALTACE** | **G** | NP | | |
| ALTOPREV | | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| ALVESCO | | P | QL | QL of 2 inhalers per month at retail or 6 units per 3 months by mail order |
| **amantadine** | | Tier 1 | | |
| **AMARYL** | **G** | NP | | |
| **AMBIEN** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order. |
| **AMBIEN CR** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| **AMERGE** | **G** | NP | QL | QL of 8 tabs per month, all strengths. Additional quantities require PA. |
| **amiloride/ hydrochlorothiazide** | | Tier 1 | | |
| AMITIZA | | NP | MN | Alternative that does not require PA for medical necessity is Linzess. |
| **amitriptyline** | | Tier 1 | | |
| **AMNESTEEM** | | Tier 1 | | |
| **amoxicillin** | | Tier 1 | | |
| **ampicillin** | | Tier 1 | | |
| AMRIX | | NP | MN | Alternative that does not require PA for medical necessity is cyclobenzaprine |
| ANADROL-50 | | NP | PA | Coverage provided for treatment of anemias caused by deficient red blood cell production. |
| **ANAFRANIL** | **G** | NP | | |
| **ANAPROX** | **G** | NP | | |
| ANDRODERM | | P | PA | Coverage provided for male members who need replacement therapy in conditions associated with deficiency or absence of endogenous testosterone |
| ANDROGEL | **G** | NP | MN | If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations. |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| ANORO ELLIPTA | | P | QL | QL of 1 inhaler per month |
| **ANTARA** | **G** | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| **ANTIVERT** | **G** | NP | | |
| **ANUSOL HC** | **G** | NP | | |
| APIDRA | | NP | MN | Alternatives that do not require PA for medical necessity are Novolin, Novolog |
| APRISO | | P | | |
| APTENSIO XR | | NP | QL | Quantity Limit:<br>10mg-30mg; 60 caps per month<br>40mg-60mg: 30 caps per month |
| APTIVUS | | P | | |
| **ARALEN** | **G** | NP | | |
| **ARTHROTEC** | **G** | NP | | |
| ASACOL HD | | P | | |
| ASMANEX | | P | QL | QL varies by strength. Retail: Asmanex 7 – 2 inhalers; Asmanex 14 – 4 inhalers; Asmanex 30 – 2 inhalers (220mcg/inhaler) or Asmanex 30 – 1 inhaler (110mcg/inhaler); Asmanex 60 – 1 inhaler; Asmanex 120 – 1 inhaler at retail. Multiply each strength by 3 for mail order. |
| **ASTEPRO** | **G** | NP | QL | QL of 1 inhaler per month at retail or 3 inhalers per 3 months by mail order |
| **ATACAND** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **ATACAND HCT** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **ATIVAN** | **G** | NP | | |
| ATRIPLA | | P | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **ATROVENT INHAL SOLN** | **G** | NP | | |
| ATROVENT HFA | | P | QL | QL of 2 inhalers per month |
| **ATROVENT NASAL** | **G** | NP | QL | |
| **AUGMENTIN** | **G** | NP | | |
| **AUGMENTIN XR** | **G** | NP | | |
| **AVALIDE** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **AVAPRO** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **AVELOX** | **G** | NP | | |
| | | | | |
| **AXERT** | **G** | NP | QL | QL of 8 tabs per month, all strengths. Additional quantities require PA. |
| **AXID** | **G** | NP | | |
| AXIRON | | P | PA | Coverage provided for male members who need replacement therapy in conditions associated with deficiency or absence of endogenous testosterone |
| **azathioprine** | | Tier 1 | | |
| **azelastine nasal spray** | | Tier 1 | QL | QL 1 inhaler per month at retail or 3 inhalers per 3 months by mail order |
| AZOPT | | P | | |
| AZOR | | P | | |
| **AZULFIDINE** | **G** | NP | | |
| **bacitracin ophthalmic ointment** | | Tier 1 | | |
| **baclofen** | | Tier 1 | | |
| **BACTROBAN** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| BACTROBAN NASAL | | NP | | |
| BANZEL | | P | | |
| **BARACLUDE** | **G** | NP | | |
| BECONASE AQ | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 2 inhalers per month at retail or 6 inhalers per 3 months by mail order |
| BELSOMRA | | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| BENICAR | | P | | |
| BENICAR HCT | | P | | |
| **BENTYL** | **G** | NP | | |
| **benztropine** | | Tier 1 | | |
| **BETAGAN** | **G** | NP | | |
| **betamethasone dipropionate crm, gel, lotion, oint 0.05%** | | Tier 1 | | |
| **BETAPACE** | **G** | NP | | |
| **BETAPACE AF** | **G** | NP | | |
| BETIMOL | | NP | | |
| **BIAXIN** | **G** | NP | | |
| **BIAXIN XL** | **G** | NP | | |
| **bimatoprost 0.03%** | | Tier 1 | | |
| **BLEPH-10** | **G** | NP | | |
| BLEPHAMIDE SOP | | P | | |
| **BONIVA 150 mg TABS** | **G** | NP | QL | QL of 1 tab per month |
| BREO ELLIPTA | | P | QL | QL of 1 inhaler per month |
| **BREVICON** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **brimonidine 0.15%, 0.2%** | | Tier 1 | | |
| BUNAVAIL | | NP | MN, QL | Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program. Alternatives that do not require PA for medical necessity are generic buprenorphine-naloxone sublingual tablets and Suboxone film. |
| **buprenorphine** | | Tier 1 | PA, QL | Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program |
| **buprenorphine/naloxone sublingual tabs** | | Tier 1 | PA, QL | Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program |
| **bupropion 150 mg extended release** | | | PA, QL | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials<br>Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period. |
| **buspirone** | | Tier 1 | | |
| BUTRANS | | NP | QL | QL of 4 patches per month |
| **butorphanol nasal spray** | | Tier 1 | QL, PA | QL of 2 units per month. Additional quantities require PA. |
| BYDUREON | | P | | |
| BYETTA | | NP | MN | Alternatives that do not require PA for medical necessity are Bydureon, Victoza |
| BYSTOLIC | | P | | |
| CAFERGOT | | NP | | |
| **CALAN** | **G** | NP | | |
| **CALAN SR** | **G** | NP | | |
| CAMBIA | | NP | QL | QL of 4 packets per month |
| CANASA SUPPOSITORY | | P | | |
| **captopril** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **CARAFATE** | **G** | NP | | |
| **CARDIZEM CD** | **G** | NP | | |
| **CARDIZEM LA** | **G** | NP | | |
| **CARDURA** | **G** | NP | | |
| **CATAPRES** | **G** | NP | | |
| CAYSTON, inhalation | | NP | | |
| **cefdinir** | | Tier 1 | | |
| **CEFTIN** | **G** | NP | | |
| **cefprozil** | | Tier 1 | | |
| **CELEBREX** | **G** | NP | ST, QL, PA | Requires step thru generic DMARDs, NSAIDs, or GI drugs. QL of 62 of 100 mg or 31 of 200 mg per month. PA required for doses > 200 mg daily. ST and PA are required for both brand and generic formulations. |
| **CELEXA** | **G** | NP | | |
| **cetirizine OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| **cetirizine-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| CHANTIX | | $0 | PA, QL | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period. |
| **chlorthalidone** | | Tier 1 | | |
| CIALIS | | NP | See limitations | Check member drug benefit for coverage of oral erectile dysfunction drugs |
| **ciclopirox** | | Tier 1 | | |
| **cimetidine** | | Tier 1 | | |
| CIPRO HC OTIC | | P | | |
| **CIPRO** | **G** | NP | | |
| **ciprofloxacin ext-rel tabs** | | Tier 1 | | |
| CITRANATAL VITAMINS | | P | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **CLARINEX** | **G** | NP | ST | Requires 21-day trial of OTC non-sedating/mildly sedating antihistamine in the last 12 months |
| CLARINEX D | | NP | ST | Requires 21-day trial of OTC non-sedating/mildly sedating antihistamine in the last 12 months |
| **CLARITIN OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **CLARITIN-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **CLARAVIS** | | Tier 1 | | |
| **CLEOCIN** | **G** | NP | | |
| CLEOCIN VAG SUPP | | NP | | |
| **CLEOCIN T** | **G** | NP | | |
| **CLIMARA** | **G** | NP | | |
| **CLOZARIL** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| **COLAZAL** | **G** | NP | | |
| **COLCRYS** | **G** | NP | QL | QL of 60 tabs per month |
| **COLOCORT** | **G** | Tier 1 | | |
| COMBIGAN | | P | | |
| COMBIVENT RESPIMAT | | P | QL | QL of 2 inhalers per month |
| **COMBIVIR** | **G** | NP | | |
| COMPLERA | | P | | |
| **COMTAN** | **G** | NP | | |
| **CONCERTA** | **G** | NP | QL | Quantity Limit:<br>18mg-36mg: 60 per month<br>54mg: 30 per month |
| CONDYLOX GEL | | NP | | |
| **CONDYLOX SOLN** | **G** | NP | | |
| **COPEGUS** | **G** | NP | | |
| **CORDARONE** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **COREG** | **G** | NP | | |
| **CORGARD** | **G** | NP | | |
| **CORTEF** | **G** | NP | | |
| CORTIFOAM | | P | | |
| **CORTISPORIN OTIC** | **G** | NP | | |
| **COSOPT** | **G** | NP | | |
| **COUMADIN** | **G** | NP | | |
| **COZAAR** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| CREON | | P | | |
| **CRESTOR** | **G** | NP | MN | Alternative that does not require PA for medical necessity is atorvastatin |
| CRIXIVAN | | P | | |
| **cromolyn inhalation, ophthalmic** | | Tier 1 | | |
| **CYCLESSA** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **cyclobenzaprine** | | Tier 1 | | |
| **cyclosporine, modified** | | Tier 1 | | |
| **CYMBALTA** | **G** | NP | ST, QL | Requires 30-day trial of generic SSRI/SNRI in last 180 days. QL of 62 per month for 20 mg, 31 per month for 30 mg, 62 per month for 60 mg. |
| **cyproheptadine** | | Tier 1 | | |
| **CYTOTEC** | **G** | NP | | |
| **DANTRIUM** | **G** | NP | | |
| **dapsone** | | Tier 1 | | |
| **DAYPRO** | **G** | NP | | |
| **DDAVP SPRAY** | **G** | NP | QL | QL of 2 bottles per month |
| **DEMADEX** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **demeclocycline** | | Tier 1 | | |
| DENAVIR | | NP | QL | QL of 1 – 5gm tube per month |
| **DEPAKENE** | **G** | NP | | |
| **DEPAKOTE** | **G** | NP | | |
| **DEPAKOTE ER** | **G** | NP | | |
| **DEPAKOTE SPRINKLES** | **G** | NP | | |
| **DESOGEN** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| DESVENLAFAXINE ER | | NP | ST, QL | Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month. |
| **DETROL** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare |
| **DETROL LA** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare |
| **dexamethasone** | | Tier 1 | | |
| **dexamethasone sodium phosphate** | | Tier 1 | | |
| **DEXEDRINE** | **G** | NP | QL | Quantity Limit:<br>5mg-10mg: 90 per month<br>15mg:60 per month |
| DEXILANT | | NP | ST, QL | Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| **dextroamphetamine** | | Tier 1 | QL | Quantity Limit:<br>2.5mg-10mg: 90 per month<br>15mg-20mg: 60 per month<br>30mg: 30 per month |
| **diclofenac sodium delayed-rel tabs** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **diclofenac sodium ophthalmic** | | Tier 1 | | |
| **dicloxacillin** | | Tier 1 | | |
| **DIFLUCAN TABS** | **G** | NP | | |
| **DILANTIN 100 mg CAPS** | **G** | NP | | |
| **DILANTIN 125/5 SUSP** | **G** | NP | | |
| DILANTIN 30 mg CAPS | | P | | |
| **DILANTIN 50 mg CHEW** | **G** | NP | | |
| **DILAUDID** | **G** | NP | QL | QL of 180 tabs per month at retail |
| **DIOVAN** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **DIOVAN HCT** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **diphenhydramine** | | Tier 1 | | |
| **DITROPAN XL** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare |
| DORYX | | NP | PA | Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review. |
| **DOVONEX** | **G** | NP | | |
| **doxepin** | | Tier 1 | | |
| **DUAC** | **G** | NP | | |
| DULERA | | NP | MN, QL | Alternatives that do not require PA for medical necessity are Advair, Advair HFA, Symbicort. QL of 1 inhaler per month |
| **DURAGESIC** | **G** | NP | QL | QL of 10 patches per month. Additional quantities require PA. |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| DUREZOL | | P | | |
| DYANAVEL XR | | NP | QL | QL of 240 mL per month |
| **DYAZIDE** | **G** | NP | | |
| DYMISTA | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month at retail or 3 inhalers per 3 months by mail order |
| EDARBI | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| EDARBYCLOR | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| EDLUAR | | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| EDURANT | | P | | |
| **E.E.S.** | **G** | NP | | |
| **EFFEXOR XR** | **G** | NP | QL | QL of 31 per month for 37.5 mg, 75 mg XR, or 150 mg XR. |
| **EFUDEX** | **G** | NP | | |
| ELIDEL CREAM | | P | | Coverage for 2 years of age and up. If less than 2 years old, call BlueChoice at 800-950-5387. |
| ELIQUIS | | P | | |
| EMEND 40 mg | | NP | QL, PA | QL of 4 of 40 mg per month. Additional quantities require PA. |
| EMEND 80 mg, 125 mg | | NP | QL, PA | QL of 2 of 80 mg or 125 mg per month. Additional quantities require PA. |
| EMTRIVA | | P | | |
| ENJUVIA TABS | | P | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| EPANOVA | | NP | PA | Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet |
| EPIPEN | | P | | |
| EPIPEN JR. | | P | | |
| **EPIVIR TABS** | **G** | NP | | |
| **EPIVIR SOLUTION** | **G** | NP | | |
| EPZICOM | | P | | |
| ERY-TAB | | Tier 1 | | |
| **erythromycin** | | Tier 1 | | |
| **erythromycin stearate** | | Tier 1 | | |
| **ESTRACE TABS** | **G** | NP | | |
| ESTRING | | NP | | Packaged as 90-day supply for two times the applicable copayment |
| **etodolac** | | Tier 1 | | |
| **etoposide** | | Tier 1 | | |
| EVEKEO | | NP | PA, QL | Coverage provided for ADHD or narcolepsy after trial of 2 generic amphetamine products. QL of 60 per month. |
| **EVISTA** | **G** | NP | | |
| **EXALGO** | **G** | NP | QL | Coverage provided for treatment of opioid-tolerant patients who require continuous, around-the-clock analgesia for an extended timeframe. QL applies based on dosing. PA is required for both brand and generic formulations. |
| **EXELON CAPS** | **G** | NP | | |
| **EXFORGE** | **G** | P | | |
| **EXFORGE HCT** | **G** | P | | |
| FABIOR | | NP | ST | Requires 30-day trial of generic tretinoin product in the last 365 days |
| **FAMVIR** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| FANAPT | | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| FARXIGA | | P | | |
| **FAZACLO** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| **FELDENE** | **G** | NP | | |
| **FEMHRT 0.5/2.5** | G | NP | | |
| FEMRING | | P | | Packaged as 90-day supply for 2 times the applicable copayment |
| **FENOGLIDE** | **G** | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| FENTORA | | NP | PA, QL<br>QL is 120 doses per month. | Coverage provided for members 16 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain |
| FETZIMA | | NP | ST, QL | Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month. |
| **fexofenadine OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| **fexofenadine-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| **FIBRICOR** | **G** | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **finasteride 5 mg** | | Tier 1 | PA | Coverage provided for the treatment of symptomatic benign prostatic hypertrophy in males over age 40. PA is required for both brand and generic formulations. |
| **FIORICET** | **G** | NP | | |
| **FIORINAL** | **G** | NP | | |
| FIRST-LANSOPRAZOLE | | NP | ST, QL | Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| FIRST-OMEPRAZOLE | | NP | ST, QL | Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| **FLAGYL** | **G** | NP | | |
| FLAGYL ER | | NP | | |
| **fludrocortisone** | | Tier 1 | | |
| **FLOMAX** | **G** | NP | | |
| FLOVENT DISKUS | | P | QL | QL of 1 inhaler per month |
| FLOVENT HFA | | P | QL | QL of 2 inhalers per month |
| **flunisolide nasal** | | Tier 1 | QL | QL of 1 inhaler per month |
| **fluocinonide crm, gel, oint, soln 0.05%** | | Tier 1 | | |
| FLUOROPLEX | | P | | |
| **fluphenazine** | | Tier 1 | | |
| **fluticasone** | | Tier 1 | QL | QL of 1 inhaler per month |
| **FML OPHTH DROP** | **G** | NP | | |
| FOCALIN | **G** | NP | QL | QL of 60 per month |
| FOCALIN XR | **G** | NP | QL | Quantity Limit:<br>5mg-20mg: 60 per month<br>25mg-40mg: 30 per month |
| FORTAMET | | NP | MN | Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **FORTESTA** | **G** | NP | MN | If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations. |
| **FOSAMAX (daily dose)** | **G** | NP | QL | QL of 31 tabs per month |
| **FOSAMAX (weekly dose)** | **G** | NP | QL | QL of 4 tabs per month |
| FOSAMAX PLUS D (weekly dose) | | NP | QL | QL of 4 tabs per month |
| **FROVA** | **G** | NP | QL | QL of 8 tabs per month. Additional quantities require PA. |
| GELNIQUE | | P | | |
| **gentamicin ophthalmic, topical** | | Tier 1 | | |
| **GEODON** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| **GIANVI** | | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| GLUCAGON | | P | | |
| **GLUCOPHAGE** | **G** | NP | | |
| **GLUCOPHAGE XR** | **G** | NP | | |
| **GLUCOTROL** | **G** | NP | | |
| **GLUCOTROL XL** | **G** | NP | | |
| **GLUCOVANCE** | **G** | NP | | |
| **GLUMETZA** | **G** | NP | MN | Brand and generic require MN PA. Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel (generic Glucophage) |
| **GOLYTELY** | **G** | NP | | |
| GRALISE | | NP | PA | Coverage requires that members have tried at least a 30-day supply of gabapentin immediate-release at a dose of 1800 mg daily without adequate response |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **granisetron tabs** | | Tier 1 | QL, PA | QL of 4 tabs per month. Additional quantities require PA. |
| **GRIS-PEG** | **G** | NP | | |
| **haloperidol** | | Tier 1 | | |
| HUMALOG (ALL FORMS) | | NP | MN | Alternatives that do not require PA for medical necessity are Novolin, Novolog |
| HUMULIN (ALL FORMS except R U-500) | | NP | MN | Alternatives that do not require PA for medical necessity are Novolin, Novolog |
| HUMULIN R U-500 | | P | | |
| **hydralazine** | | Tier 1 | | |
| **HYDREA** | **G** | NP | | |
| **hydrochlorothiazide** | | Tier 1 | | |
| **hydrocortisone crm 2.5%** | | Tier 1 | | |
| **HYZAAR** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **IMITREX INJECTION** | **G** | NP | QL | QL of 3 kits or 5 vials per month. Additional quantities require PA. |
| **IMITREX NASAL** | **G** | NP | QL | QL of 3 boxes (20 mg) or (5 mg) per month. Additional quantities require PA. |
| **IMITREX TABS** | **G** | NP | QL | QL of 8 tabs per month, all strengths. Additional quantities require PA. |
| INCRUSE ELLIPTA | | NP | QL | QL of 1 inhaler per month |
| **INDERAL LA** | **G** | NP | | |
| INTELENCE | | P | | |
| **INTERMEZZO** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| **INVEGA** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| INVIRASE | | P | | |
| INVOKAMET | | NP | MN | Alternatives that do not require PA for medical necessity are Farxiga, Jardiance, Synjardy, and Xigduo XR |
| INVOKANA | | NP | MN | Alternatives that do not require PA for medical necessity are Farxiga, Jardiance, Synjardy, and Xigduo XR |
| **ipratropium/albuterol inhalation** | | Tier 1 | | |
| IRENKA | | NP | ST, QL | Requires 30-day trial of generic SSRI/SNRI in last 180 days. QL of 30 per month. |
| ISENTRESS | | P | | |
| **isoniazid** | | Tier 1 | | |
| **ISOPTO CARPINE** | **G** | NP | | |
| **ISORDIL** | **G** | NP | | |
| JANUMET | | P | | |
| JANUMET XR | | P | | |
| JANUVIA | | P | | |
| JARDIANCE | | P | | |
| JENTADUETO | | NP | MN | Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza |
| KALETRA | | P | | |
| **KAPVAY** | **G** | NP | QL | QL of 120 tablets per month |
| KAZANO | | NP | MN | Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza |
| **KEFLEX** | **G** | NP | | |
| **KEPPRA** | **G** | NP | | |
| **KEPPRA XR** | **G** | NP | | |
| **ketoconazole tabs** | | Tier 1 | | |
| **ketoprofen** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| KHEDEZLA | | NP | ST, QL | Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month. |
| **KLONOPIN** | **G** | NP | | |
| KOMBIGLYZE XR | | P | | |
| **labetalol** | | Tier 1 | | |
| **lactulose** | | Tier 1 | | |
| **LAMICTAL CHEW TABS** | **G** | NP | | |
| **LAMICTAL TABS** | **G** | NP | | |
| **LAMICTAL XR** | **G** | NP | | |
| **LAMISIL TABS** | **G** | NP | | |
| **LANOXIN** | **G** | NP | | |
| **lansoprazole delayed-rel OTC** | | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month. |
| **lansoprazole delayed-rel (Rx)** | | Tier 1 | QL | PA required for more than once-daily dosing |
| LANTUS (ALL FORMS) | | P | | |
| **LASIX** | **G** | NP | | |
| LATUDA | | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| LAZANDA | | NP | PA, QL. QL is 8 bottles at retail per month. | Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain |
| **LESCOL** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |
| **LESCOL XL** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |
| **LEVAQUIN** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| LEVEMIR | | NP | MN | Alternative that does not require PA for medical necessity is Lantus |
| LEVITRA | | NP | See limitations | Check member drug benefit for coverage of oral erectile dysfunction drugs |
| **LEVORA** | | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **LEVOXYL** | | Tier 1 | | |
| **LEVSIN** | **G** | NP | | |
| **LEXAPRO** | **G** | NP | | |
| LEXIVA | | P | | |
| **lidocaine viscous** | | Tier 1 | | |
| LINZESS | | P | | |
| **LIPITOR** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |
| LIPOFEN | | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| LIPTRUZET | | NP | MN | Alternative that does not require PA for medical necessity is atorvastatin |
| **lithium carbonate** | | Tier 1 | | |
| **LITHOBID** | **G** | NP | | |
| LIVALO | | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |
| **LOFIBRA** | **G** | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) to align with Tricor, TriGlide, Trilipix |
| LO LOESTRIN | | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **LOMOTIL** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **loperamide** | | Tier 1 | | |
| **LOPID** | **G** | NP | | |
| **LOPRESSOR** | **G** | NP | | |
| **LOPROX GEL, LOTION** | **G** | NP | | |
| **loratadine OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| **loratadine-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription for OTC formulation |
| LOTEMAX | | P | | |
| **LOTENSIN** | **G** | NP | | |
| **LOTENSIN HCT** | **G** | NP | | |
| **LOTREL** | **G** | NP | | |
| **LOTRONEX** | **G** | NP | PA | Coverage provided to female members with severe diarrhea-predominant irritable bowel syndrome (IBS) who have chronic IBS symptoms (generally lasting six months or longer), had anatomic or biochemical abnormalities of the gastrointestinal tract excluded, and not responded adequately to conventional therapy. PA is required for both brand and generic formulations. |
| **LOVAZA** | **G** | NP | PA | Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet. PA is required for both brand and generic formulations. |
| **LOVENOX** | **G** | | QL, PA | QL of maximum 35-day supply at retail pharmacy. Additional quantities require PA through preferred specialty pharmacy. |
| **LOW-OGESTREL** | | Tier 1 | | |
| LUMIGAN 0.01% | | NP | MN | Alternatives that do not require PA for medical necessity are latanoprost, travoprost, Travatan Z, Zioptan |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **LUNESTA** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| **LURIDE** | **G** | NP | | |
| **LURIDE LOZI-TABS** | **G** | NP | | |
| LYRICA | | NP | QL | QL for doses ≤ 200 mg, 90 caps per 30 days. QL for doses ≥ 225 mg, 60 caps per 30 days. Lyrica solution QL 900 mL per 30 days. |
| **MACRODANTIN** | **G** | NP | | |
| **MALARONE** | **G** | NP | | |
| **MAVIK** | **G** | NP | | |
| **MAXALT/MAXALT-MLT** | **G** | NP | QL | QL of 8 tabs per month. Additional quantities require PA. |
| **MAXITROL** | **G** | NP | | |
| **MAXZIDE** | **G** | NP | | |
| MENEST | | NP | | |
| **MESTINON 60 mg** | **G** | NP | | |
| MESTINON SYRUP | | P | | |
| **MESTINON TIMESPAN** | **G** | NP | | |
| **METADATE CD** | **G** | NP | QL | Quantity Limit:<br>10mg-30mg: 60 per month<br>40mg-60mg: 30 per month |
| METAGLIP | | NP | | |
| **methazolamide** | | Tier 1 | | |
| **methotrexate 2.5 mg, oral** | | Tier 1 | | |
| **methyldopa** | | Tier 1 | | |
| **METROGEL TOPICAL** | **G** | NP | | |
| **METROGEL VAG 0.75% GEL** | **G** | NP | | |
| **MEVACOR** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **MIACALCIN SPRAY** | **G** | NP | QL | QL of 2 units per month |
| **MICARDIS** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **MICARDIS HCT** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **MICRO-K** | **G** | NP | | |
| **MIGRANAL NASAL** | **G** | NP | QL | QL of 8 units per month |
| **MINIPRESS** | **G** | NP | | |
| **MINOCIN** | **G** | NP | | |
| **minocycline ext-rel** | | Tier 1 | ST | Coverage requires that members be 12 years or older and must have tried at least 30 days of a generic immediate-release minocycline **and** a 30-day supply of one of these generics (doxycycline, erythromycin or tetracycline) within the previous 365 days |
| **MIRAPEX** | **G** | NP | | |
| **MIRCETTE** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **MODICON** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **MONODOX** | **G** | NP | PA | Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review. |
| **morphine sulfate immediate release** | | Tier 1 | QL | QL of 150 tabs per month |
| **morphine suppository** | | Tier 1 | | |
| MOVIPREP | | P | | |
| **MS CONTIN** | **G** | NP | QL | QL of 90 tabs per month |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **MYAMBUTOL** | **G** | NP | | |
| **mycophenolate mofetil** | | Tier 1 | | |
| **mycophenolic acid** | | Tier 1 | | |
| MYRBETRIQ | | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare |
| **MYSOLINE** | **G** | NP | | |
| **nabumetone** | | Tier 1 | | |
| **NAMENDA SOLUTION** | **G** | NP | | |
| NAMENDA XR | | NP | | |
| **NAPRELAN** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are generic NSAIDs |
| **NAPROSYN** | **G** | NP | | |
| **NARDIL** | **G** | NP | | |
| **NASACORT AQ** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month |
| **NASONEX** | **G** | P | QL | QL of 2 inhalers per month |
| NATESTO | | NP | MN | If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options |
| NECON 10/11 | | NP | | |
| **NEOSPORIN** | **G** | NP | | |
| NESINA | | NP | MN | Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza |
| **NEURONTIN** | **G** | NP | | |
| NEXIUM (Rx) | **G** | NP | MN, ST, QL | PA for medical necessity requires trial/failure of both Nexium 24HR (OTC) **and** a generic PPI (lansoprazole, omeprazole, rabeprazole or pantoprazole). QL of 31 caps or granule packets per month. PA required for more than once-daily dosing. |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **NEXIUM 24HR (OTC)** | | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 84 per month. |
| **NIASPAN** | **G** | NP | | |
| **nicotine transdermal patches OTC** | | Tier 1 | | Check member drug benefit for coverage of smoking cessation drugs. OTC preparation available at Tier 1 copayment with prescription. |
| **NICOTROL INHALER** | | $0 | PA, QL | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials<br>Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period. |
| **NICOTROL NS** | | $0 | PA, QL | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials<br>Limit of 30-day supply for each prescription; maximum therapy of 180 days per each 365 period. |
| **NIMOTOP** | **G** | NP | | |
| **NITRO-DUR** | **G** | NP | | |
| **nitroglycerin transdermal patches** | | Tier 1 | | |
| NITROSTAT | | NP | | |
| **NORCO** | **G** | NP | QL | Max 3 grams acetaminophen (APAP) per day |
| **NORPRAMIN** | **G** | NP | | |
| **NORVASC** | **G** | NP | | |
| NORVIR | | P | | |
| NOVOFINE | | P | | |
| NOVOLIN (ALL FORMS) | | P | | |
| NOVOLOG (ALL FORMS) | | P | | |
| NOXAFIL | | NP | | |

**Legend**

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| NUVARING | | | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials. Packaged as 90-day supply for 2 times the applicable copayment |
| NUVIGIL | | NP | PA, QL | Coverage provided for members with a diagnosis of narcolepsy, multiple sclerosis-related fatigue, persistent sleepiness due to obstructive sleep apnea refractory to traditional treatments (i.e., CPAP, etc.) and sleepiness associated with diagnosed shift work sleep disorder |
| **nystatin** | | Tier 1 | | |
| **OCUFLOX** | **G** | NP | | |
| **ofloxacin otic** | | Tier 1 | | |
| **OLUX-E FOAM** | **G** | NP | MN | Alternative that does not require PA for medical necessity is clobetasol propionate foam 0.05% |
| **omeprazole caps (Rx)** | | Tier 1 | QL | QL of 31-caps-per month. PA required for more than once-daily dosing. |
| **omeprazole OTC** | | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month. |
| OMNARIS | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month. |
| OMTRYG | | NP | PA | Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet |
| ONE TOUCH kits and test strips | | P | | |
| ONGLYZA | | P | | |
| ONMEL | | NP | PA | Coverage provided to members who have diagnosis of onychomycosis of the toenail. |
| **ORTHO-CYCLEN** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **ORTHO EVRA** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ORTHO MICRONOR** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ORTHO TRI-CYCLEN** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ORTHO TRI-CYCLEN LO** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ORTHO-NOVUM** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| OSENI | | NP | MN | Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza |
| **OVIDE** | **G** | NP | | |
| OXANDRIN | | NP | PA | Coverage provided for adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma. |
| **oxazepam** | | Tier 1 | | |
| **oxybutynin** | | Tier 1 | | |
| OXYCONTIN | | P | QL | QL of 120 tabs per month. Additional quantities require PA. |
| OXYTROL | | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel, trospium, trospium ext-rel, Gelnique, Vesicare |
| **PAMELOR** | **G** | NP | | |
| PANCREAZE | | P | | |
| PANRETIN | | NP | | |
| PATADAY | | P | | |
| **PATANASE** | **G** | NP | QL | QL of 1 inhaler per month |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **pantoprazole** | | Tier 1 | QL | QL of 31 caps per month. PA required for more than once-daily dosing. |
| **PARLODEL** | **G** | NP | | |
| **PARNATE** | **G** | NP | | |
| **PAXIL** | **G** | NP | | |
| **PAXIL CR** | **G** | NP | | |
| PCE | | NP | | |
| **penicillin VK** | | Tier 1 | | |
| PENNSAID 2% | | NP | MN | Alternatives that do not require PA for medical necessity are generic NSAIDs |
| **PEPCID (Rx)** | **G** | NP | | |
| **PERCOCET** | **G** | NP | QL | |
| **PERIDEX** | **G** | NP | | |
| **perphenazine** | | Tier 1 | | |
| **PERSANTINE** | **G** | NP | | |
| **phenobarbital** | | Tier 1 | | |
| **PHOSLO** | **G** | NP | | |
| **pindolol** | | Tier 1 | | |
| **PLAQUENIL** | **G** | NP | | |
| **PLAVIX** | **G** | NP | | |
| **POLYTRIM** | **G** | NP | | |
| **potassium chloride ext-rel, liquid** | | Tier 1 | | |
| PRADAXA | | NP | | |
| **PRANDIN** | **G** | NP | | |
| **PRAVACHOL** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin |
| **PRECOSE** | **G** | NP | | |
| **PRED FORTE** | **G** | NP | | |
| PRED MILD | | P | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **prednisolone acetate 1%** | | Tier 1 | | |
| **prednisone** | | Tier 1 | | |
| PREFERAOB VITAMINS | | P | | |
| **PRELONE** | **G** | NP | | |
| PREMARIN | | P | | |
| PREMPHASE | | P | | |
| PREMPRO | | P | | |
| **PREVACID (Rx)** | **G** | NP | ST, QL | Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| **PREVACID 24HR OTC** | | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month. |
| PREZISTA | | P | | |
| **PRILOSEC (Rx)** | **G** | NP | ST, QL | Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| PRILOSEC OTC | | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month. |
| PRISTIQ | | NP | ST, QL | Requires 30-day trial of generic SNRI in last 180 days. QL of 31 per month. |
| PROAIR HFA, Respiclick | | P | QL | QL of 2 inhalers per month |
| **probenecid** | | Tier 1 | | |
| **PROCARDIA XL** | **G** | NP | | |
| **prochlorperazine** | | Tier 1 | | |
| **promethazine** | | Tier 1 | | |
| **promethazine w/ codeine** | | Tier 1 | | |
| **promethazine w/ dextromethorphan** | | Tier 1 | | |
| **propranolol tabs** | | Tier 1 | | |
| **propylthiouracil** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **PROSCAR** | **G** | NP | PA | Coverage provided for the treatment of symptomatic benign prostatic hypertrophy in males over age 40. PA is required for both brand and generic formulations. |
| **PROTONIX** | **G** | NP | ST, QL | Require step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. |
| **PROTOPIC** | **G** | NP | | Coverage for 2 years of age and up for 0.03%, 16 years and up for 0.1%. Outside of these ages, call BlueChoice at 800-950-5387. |
| PROVENTIL HFA | | NP | QL | QL of 2 inhalers per month |
| **PROVERA** | **G** | NP | | |
| **PROVIGIL** | **G** | NP | PA, QL | Coverage requires members try and fail at least a 30-day trial of Nuvigil in the last 365 days and meet PA requirement for indications. QL of 60 per month. |
| **PROZAC** | **G** | NP | | |
| **PROZAC WEEKLY** | **G** | NP | QL | QL of 4 per month at retail or 12 per 3 months by mail order |
| PULMICORT FLEXHALER | | NP | QL | QL of 2 inhalers per month |
| **PULMICORT RESPULES** | **G** | NP | QL | QL of 1 box per month |
| **pyrazinamide** | | Tier 1 | | |
| **PYRIDIUM** | **G** | NP | | |
| QUILLICHEW ER | | NP | QL | Quantity Limit:<br>20mg-30mg: 60 per month<br>40mg: 30 per month |
| QUILLIVANT XR | | NP | QL | QL of 360 mL per month |
| QNASL | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month at retail or 3 inhalers per 90 days by mail order. |
| **QUALAQUIN** | **G** | NP | QL, PA | QL of 42 caps per year. Additional quantities require PA. |

**Legend**

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **QUESTRAN/QUESTRAN-LIGHT** | **G** | NP | | |
| QVAR | | P | QL | QL of 2 inhalers per month |
| **ramipril** | | Tier 1 | | |
| RAYOS | | NP | MN | Alternative that does not require PA for medical necessity is prednisone |
| **RAZADYNE** | **G** | NP | | |
| **REGLAN TABS** | **G** | NP | | |
| RELPAX | | NP | QL | QL of 8 tabs per month, all strengths. Additional quantities require PA. |
| **REMERON** | **G** | NP | | |
| **REMERON SOLTAB** | **G** | NP | | |
| RENAGEL | | NP | | |
| RENVELA | | P | | |
| **REQUIP** | **G** | NP | | |
| **REQUIP XL** | **G** | NP | | |
| RESCRIPTOR | | P | | |
| **RESTORIL** | **G** | NP | QL | QL of 31 per month |
| **RETIN-A CREAM, GEL** | **G** | NP | ST | Coverage up to age 25 for acne. If over 25 yrs, PA required. |
| **RETIN-A MICRO GEL** | **G** | NP | ST | Coverage up to age 25 for acne. If over 25 yrs, PA required. |
| **RETROVIR** | **G** | NP | | |
| REYATAZ | | P | | |
| **RHINOCORT AQ** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 2 inhalers per month. |
| **ribasphere tabs & caps** | | Tier 1 | | |
| **ribavirin tabs & caps** | | Tier 1 | | |
| **RIFADIN** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| RIOMET | | NP | MN | Alternatives that do not require PA for medical necessity are metformin, metformin ext-rel |
| **RISPERDAL/RISPERDAL M** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| **RITALIN** | **G** | NP | QL | QL of 90 per month |
| **RITALIN-LA** | | NP | QL | Quantity Limit:<br>10mg-30mg:60 per month<br>40mg-60mg: 30 per month |
| **ROBAXIN** | **G** | NP | | |
| **ROCALTROL** | **G** | NP | | |
| **ROWASA ENEMA** | **G** | NP | | |
| **ROXICODONE** | **G** | NP | QL | QL of 90 per month |
| ROZEREM | | P | QL | QL of 31 per month at retail or 93 per 3 months by mail order |
| **RYTHMOL** | **G** | NP | | |
| **RYTHMOL SR** | **G** | NP | | |
| SANCUSO | | NP | QL, PA | QL of 2 patches per month, all strengths. Additional quantities require PA. |
| SAPHRIS | | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| SAVELLA | | P | QL | QL of 62 caps per month |
| **SEASONIQUE** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials<br>Packaged as 90-day supply for 2 times the applicable copayment |
| SEEBRI NEOHALER | | NP | QL | QL of 1 inhaler per month. |
| **selegiline tabs** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **selenium sulfide shampoo 2.5%** | | Tier 1 | | |
| SELZENTRY | | P | | |
| SENSIPAR | | P | | |
| SEREVENT DISKUS | | P | QL | QL of 1 inhaler per month |
| **SEROQUEL** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| SEROQUEL XR | | P | | |
| SILENOR | | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 per month at retail or 93 per 3 months by mail order. |
| **SILVADENE** | **G** | NP | | |
| SIMCOR | | P | | |
| **SINEMET** | **G** | NP | | |
| **SINEMET CR** | **G** | NP | | |
| **SINGULAIR** | **G** | NP | | |
| **sirolimus** | | Tier 1 | | |
| **SOLODYN** | **G** | NP | ST | Coverage requires that members be 12 years or older and must have tried at least 30 days of a generic immediate-release minocycline **and** a 30-day supply of one of these generics (doxycycline, erythromycin or tetracycline) within the previous 365 days. ST is required for brand and generic. |
| **SOMA** | **G** | NP | | |
| **SONATA** | **G** | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order. |
| **SORIATANE CAPS** | **G** | NP | PA | PA for treatment of severe psoriasis in adults |
| SPIRIVA HANDIHALER | | P | QL | QL of 1 inhaler per month |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| SPIRIVA RESPIMAT | | P | QL | QL of 1 inhaler per month |
| **SPORANOX CAPS** | **G** | NP | PA, QL | Coverage provided to members for treatment of onychomycosis. QL of 31 caps per month. Max 3 months of therapy per year. PA is required for both brand and generic formulations. |
| SPORANOX SOLUTION | | NP | PA, QL | Coverage provided for members for treatment of oropharyngeal and esophageal candidiasis. QL of 600mL per month, with max 1800mL per year. |
| SPRIX | | NP | MN | Alternatives that do not require PA for medical necessity are generic NSAIDs |
| STAXYN | | NP | See limitations | Check member drug benefit for coverage of oral erectile dysfunction drugs |
| STRATTERA | | P | QL | Quantity Limit:<br>10mg-40mg: 60 per month<br>60mg-100mg: 30 per month |
| SUBOXONE sublingual film | | P | PA, QL | Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program |
| SUBSYS | | NP | PA, QL<br>QL is 120 doses per month. | Coverage provided for members 18 years and older for the management of breakthrough cancer pain in patients with cancer who are already receiving and are tolerant of opioid therapy for their underlying persistent cancer pain |
| **sulfamethoxazole-trimethoprim** | | Tier 1 | | |
| SUMAVEL DOSEPRO | | NP | ST, QL | Coverage requires that members must have filled 14 days of generic sumatriptan injection in the last 180 days. QL of 6 per month. Additional quantities require PA. |
| SUSTIVA | | P | | |
| SYMBICORT | | P | QL | QL of 2 inhalers per month |
| SYMLINPEN | | NP | | |
| SYNJARDY | | P | | |
| **SYNTHROID** | **G** | NP | | |
| **tacrolimus** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| TAMIFLU | | NP | QL | QL of 10 caps (1 blister pack) per year |
| **tamoxifen** | | Tier 1 | | |
| TANZEUM | | NP | MN, QL | QL of 4 pens per month. Alternatives that do not require PA for medical necessity are Bydureon and Victoza |
| **TAPAZOLE** | **G** | NP | | |
| TARGADOX | | NP | PA | Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review. |
| TARKA | | NP | | |
| TAZORAC | | NP | ST | Requires 30-day trial of generic tretinoin product in the last 365 days |
| **TEGRETOL** | **G** | NP | | |
| **TEGRETOL XR** | **G** | NP | | |
| TEKTURNA | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| TEKTURNA HCT | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **TEMOVATE** | **G** | NP | | |
| **TENORMIN** | **G** | NP | | |
| **terazosin** | | Tier 1 | | |
| **terbutaline** | | Tier 1 | | |
| **TESSALON** | **G** | NP | | |
| TEST STRIPS (except ONETOUCH) | | NP | MN | Alternatives that do not require PA for medical necessity are OneTouch products |
| **TESTIM** | **G** | NP | MN | If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations. |
| **tetracycline** | | Tier 1 | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| TEVETEN | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| TEVETEN HCT | | NP | MN | Alternatives that do not require PA for medical necessity are candesartan, candesartan-HCT, eprosartan, irbesartan, irbesartan-HCT, losartan, losartan-HCT, telmisartan, telmisartan HCT, valsartan, valsartan-HCT, Benicar, Benicar HCT |
| **THEOCHRON** | **G** | NP | | |
| **theophylline ext-rel (12 hr)** | | Tier 1 | | |
| **thiothixene** | | Tier 1 | | |
| **TIMOPTIC** | **G** | NP | | |
| TOBRADEX ST | | P | | |
| **tobramycin-dexamethasone 0.3-0.1%** | | Tier 1 | | |
| **TOBREX** | **G** | NP | | |
| **TOFRANIL** | **G** | NP | | |
| **TOPAMAX** | **G** | NP | | |
| **TOPROL XL** | **G** | NP | | |
| TOUJEO | | NP | MN | Alternative that does not require PA for medical necessity is Lantus. |
| TOVIAZ | | NP | MN | Alternatives that do not require PA for medical necessity are oxybutynin ext-rel, tolterodine, tolterodine ext rel. trospium, trospium ext-rel, Gelnique, Vesicare |
| TRADJENTA | | NP | MN | Alternatives that do not require PA for medical necessity are Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza |
| TRAVATAN Z | | P | | |
| **travoprost** | | Tier 1 | | |
| **trazodone** | | Tier 1 | | |
| TREXIMET | | NP | QL | QL of 9 tabs per month. Additional quantities require PA. |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **triamcinolone crm 0.5%** | | Tier 1 | | |
| **triamcinolone crm, lotion 0.025%** | | Tier 1 | | |
| **triamcinolone crm, lotion, oint 0.1%** | | Tier 1 | | |
| **triamcinolone paste** | | Tier 1 | | |
| TRIBENZOR | | P | | |
| **TRICOR** | **G** | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| TRIGLIDE | | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| **trihexyphenidyl** | | Tier 1 | | |
| **TRILEPTAL** | **G** | NP | | |
| TRILIPIX | | NP | ST | Coverage requires a 30-day trial of a generic fenofibrate before an NP brand fenofibrate (Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, TriGlide, Trilipix) |
| **trimethoprim** | | Tier 1 | | |
| **TRI-NORINYL** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **TRIVORA** | | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **TRIZIVIR** | **G** | NP | | |
| **trospium** | | Tier 1 | | |
| **trospium ext-rel** | | Tier 1 | | |
| **TRULICITY** | | NP | MN, QL | QL of 4 pens per month. Alternatives that do not require PA for medical necessity are Bydureon and Victoza. |
| **TRUSOPT** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| TRUVADA | | P | | |
| TUDORZA PRESSAIR | | NP | QL | QL of 1 inhaler per month |
| **TWYNSTA** | **G** | NP | | |
| **TYLENOL w/ CODEINE** | **G** | NP | QL | QL of 300 per month |
| ULORIC | | NP | ST | Coverage requires a 30-day trial of allopurinol in the past 180 days |
| **ULTRAM** | **G** | NP | QL | QL of 240 per month |
| **ULTRAM ER** | **G** | NP | QL | QL of 30 per month |
| **UNIRETIC** | **G** | NP | | |
| **URECHOLINE** | **G** | NP | | |
| **URSO** | **G** | NP | | |
| UTIBRON NEOHALER | | NP | QL | QL of 1 inhaler per month. |
| **VALCYTE** | **G** | NP | | |
| **VALIUM** | **G** | NP | | |
| **VALTREX** | **G** | NP | QL | QL of 42 caps of 500 mg per fill or 84 caps per month; QL of 31 caps of 1000 mg per month. |
| VASCEPA | | NP | PA | Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA-approved therapy to lower triglycerides along with diet |
| **VASERETIC** | **G** | NP | | |
| **VASOTEC** | **G** | NP | | |
| **venlafaxine** | | Tier 1 | | |
| **venlafaxine ext-rel** | | Tier 1 | QL | QL of 31 of 37.5 mg, 75 mg, 150 mg. QL of 31 of 225 mg or use (31 of 150 mg + 31 of 75 mg) = 1 copayment. |
| VENTOLIN HFA | | P | QL | QL of 2 inhalers per month |
| VERAMYST | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex. QL of 1 inhaler per month. |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| VERSACLOZ | | NP | ST | Requires 30-day trial of clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| VESICARE | | P | | |
| **VFEND** | **G** | NP | | |
| VIAGRA | | NP | See limitations | Check member drug benefit for coverage of oral erectile dysfunction drugs |
| **VIBRAMYCIN** | **G** | NP | | |
| **VICODIN ES** | **G** | NP | QL | Max 3 grams acetaminophen (APAP) per day |
| VICTOZA | | P | | |
| **VIDEX EC** | **G** | NP | | |
| VIDEX SOLN | | P | | |
| VIGAMOX | | P | | |
| VIRACEPT | | P | | |
| **VIRAMUNE** | **G** | NP | | |
| **VIRAMUNE XR** | **G** | P | | |
| VIREAD | | P | | |
| **VIROPTIC** | **G** | NP | | |
| **vitamin B-12 inj** | | Tier 1 | | |
| **VIVELLE-DOT** | **G** | NP | | |
| **VOGELXO** | **G** | NP | MN | If initial PA criteria is met (see Androderm or Axiron), MN applies to non-preferred options. PA is required for both brand and generic formulations. |
| VYTORIN | | NP | MN | Alternative that does not require PA for medical necessity is atorvastatin. |
| VYVANSE | | NP | QL | Quantity Limit:<br>10mg-30mg: 60 per month<br>40mg-70mg: 30 per month |
| WELCHOL | | P | | |
| **WELLBUTRIN** | **G** | NP | | |
| **WELLBUTRIN SR** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **WELLBUTRIN XL** | **G** | NP | QL | QL of 31 per month for 150 mg or 300 mg. |
| **XALATAN** | **G** | NP | | |
| **XANAX** | **G** | NP | | |
| XARELTO | | P | | |
| XARTEMIS XR | | NP | QL | Max 3 grams acetaminophen (APAP) per day |
| XIGDUO XR | | P | | |
| **XYZAL** | **G** | NP | ST | Coverage requires a trial of OTC non-sedating/mildly sedating antihistamine for 21 days in the last 12 months |
| **YASMIN** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **YAZ** | **G** | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ZANTAC (Rx)** | **G** | NP | | |
| **ZARONTIN** | **G** | NP | | |
| **ZAROXOLYN** | **G** | NP | | |
| **ZEGERID** | **G** | NP | ST, QL | Requires step thru generic esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole, or OTC PPI. PA required for more than once-daily dosing. ST is required for brand and generic. |
| **ZEGERID OTC** | **G** | Tier 1 | QL | OTC preparation available at Tier 1 copayment with prescription. QL of 128 per month. |
| **ZEMPLAR** | **G** | NP | | |
| **ZERIT** | **G** | NP | | |
| **ZESTORETIC** | **G** | NP | | |
| **ZESTRIL** | **G** | NP | | |
| ZETIA | | NP | | |
| ZETONNA | | NP | MN, QL | Alternatives that do not require PA for medical necessity are budesonide spray, flunisolide spray, fluticasone spray, triamcinolone spray, Nasonex |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| **ZIAGEN tabs** | **G** | P | | |
| ZIAGEN SOLUTION | | P | | |
| ZIOPTAN | | P | | |
| ZIPSOR | | NP | MN | Alternatives that do not require PA for medical necessity are generic NSAIDs |
| **ZITHROMAX** | **G** | NP | | |
| **ZOCOR** | **G** | NP | MN | Alternatives that do not require PA for medical necessity are atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin. |
| **ZOFRAN** | **G** | NP | QL, PA | QL of 9 per month for 4 mg, 6 per month for 8 mg, 50 mL per month for solution. Additional quantities require PA. |
| ZOHYDRO ER | | NP | QL | Coverage provided for members with pain severe enough to require daily, around-the-clock, long-term treatment and for which alternative treatment options are inadequate. QL of 120 per month for 10, 15 and 20 mg. QL of 60 per month for 30, 40 and 50 mg. |
| **ZOLOFT** | **G** | NP | | |
| ZOLPIMIST | | NP | MN, QL | Alternatives that do not require PA for medical necessity are eszopiclone, zaleplon, zolpidem, zolpidem ext-rel. QL of 31 tabs per month at retail or 93 per 3 months by mail order. |
| ZOMIG NASAL | | NP | QL | QL of 1 package (6 units) per month |
| **ZOMIG/ZOMIG-ZMT** | **G** | NP | QL | QL of 6 per month. Additional quantities require PA. |
| **ZONEGRAN** | **G** | NP | | |
| ZORTRESS | | NP | QL | QL of 62 per month for 0.25 mg. QL of 124 for 0.5 mg and 0.75 mg. |
| ZORVOLEX | | NP | MN | Alternatives that do not require PA for medical necessity are generic NSAIDs |
| **ZOVIA** | | $0 | | Coverage varies based on your benefit plan – see Health Care Reform section at end of document and your plan materials |
| **ZOVIRAX CAPS, OINT, SUSP, TABS** | **G** | NP | | |

## Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| Drug | Generic Available | Formulary Status | Usage Guidelines | Limitations |
|---|---|---|---|---|
| ZOVIRAX CREAM | | NP | | |
| ZUBSOLV | | NP | MN, QL | Coverage provided for members who are confirmed to be receiving treatment for opioid dependence in a valid opioid-addiction treatment program. Alternatives that do not require PA for medical necessity are generic buprenorphine-naloxone sublingual tablets and Suboxone film. |
| ZUPLENZ | | NP | QL, PA | QL of 10 per month. Additional quantities require PA. |
| ZYLET | | P | | |
| **ZYLOPRIM** | **G** | NP | | |
| **ZYMAXID** | **G** | NP | | |
| **ZYPREXA** | **G** | NP | ST | Requires 30-day trial of aripiprazole, clozapine immediate release, clozapine orally disintegrating tabs (ODT), olanzapine, paliperidone, quetiapine, risperidone, ziprasidone or Seroquel XR in the last 365 days |
| **ZYRTEC OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **ZYRTEC-D OTC** | | Tier 1 | | OTC preparation available at Tier 1 copayment with prescription |
| **ZYVOX** | **G** | NP | | |

## Health Care Reform Coverage

The Affordable Care Act (ACA) requires health insurance plans to cover certain drugs such as aspirin, female contraceptives, folic acid, iron supplements, oral fluoride agents, vaccines and tobacco cessation products at $0 (no charge.) **Covered OTC products require a prescription to have coverage under your pharmacy benefit.** These ACA benefits apply to most, but not all, employer groups. Check your plan documents or log into My Health Toolkit and use the Drug Coverage and Cost Tool.

| MISCELLANEOUS |
|---|
| **Aspirin:** Coverage is for OTC generics only for members aged 12-79. Maximum of one dose per day of 81mg, 162 mg or 325mg tablets or capsules. No coverage for buffered aspirin, powders, suppositories or effervescent tablets. |
| **Bowel Preparations for colonoscopy:** Halflytely, Moviprep, Prepopik, Suprep<br>(Only those aged 50-75 have $0 coverage) |
| **Breast Cancer Prevention:** We cover generic tamoxifen and raloxifene for females aged 35 and older. |

### Legend

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| |
|---|
| **Folic Acid:** We cover prescription generics or OTC products for females only. Max one dose per day of 0.4 and 0.8mg strength. We do not cover OTC prenatal vitamins or combination products. |
| **Iron Supplements:** Oral liquid dosage forms on single-ingredient only. We cover OTC generics and brands for those up to age 1 only. |
| **Oral Fluorides:** We cover only single-ingredient prescription generics. There is a maximum daily dose limit. Only ages zero to 17 years old have $0 coverage. |
| **Tobacco Cessation:** We cover prescription products (bupropion 150mg, Chantix, Nicotrol nasal spray, Nicotrol inhaler) with prior authorization. We cover OTC products (nicotine patches, gum and lozenges) with prescription. Limit of 30-day supply for each prescription filled. Maximum therapy of 180 days per each 365 period. |
| **Vitamin D:** Only those aged 65 and older have $0 coverage. Includes OTC with prescription. |

| VACCINES | |
|---|---|
| DIPHTHERIA-TETANUS TOXOID & PERTUSSIS VACCINE | MEASLES, MUMPS & RUBELLA VIRUS VACCINES |
| DIPHTHERIA-TETANUS TOXOIDS (DT) | MENINGOCOCCAL |
| DIPHTHERIA, PERTUSSIS & TETANUS | PNEUMOCOCCAL |
| HAEMOPHILUS B POLYSACCHARIDE CONJUGATE | POLIO VACCINE |
| HEPATITIS A (INACTIVATED) - HEPATITIS B (RECOMB) | RECOMBIVAX HB |
| HEPATITIS A VACCINE | ROTAVIRUS VACCINE |
| HEPATITIS B VACCINE (RECOMB) | TETANUS TOXOID |
| HUMAN PAPILLOMAVIRUS (HPV) | TETANUS-DIPHTHERIA TOXOIDS (TD) |
| INFLUENZA | VARICELLA VIRUS VACCINE LIVE |
| MEASLES-MUMPS-RUBELLA-VARICELLA VIRUS VACCINE | ZOSTER VACCINE LIVE |

| FEMALE CONTRACEPTIVES |
|---|
| **Oral Contraceptives** |
| All generic oral contraceptives (birth control pills) are available at $0 if your plan has ACA benefits. The only brand oral contraceptive we cover at $0 is Lo Loestrin. |
| **Other Female Contraceptives** |
| **Cervical Cap:** FEMCAP, PRENTIF, PRENTIF FITTING KIT |
| **Diaphragms**: OMNIFLEX DIAPHRAGM, ORTHO COIL SPRING KIT, ORTHO FLAT SPRING KIT, ORTHO FLEX, WIDE-SEAL |
| **Emergency Contraception:** ELLA, NEXT CHOICE |

**Legend**

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |

| |
|---|
| **Female Condom:** FC2 FEMALE CONDOM |
| **Implantable Rod:** NEXPLANON |
| **Intrauterine Device (IUD):** MIRENA, PARAGARD |
| **Patch:** XULANE |
| **Shot/Injection:** MEDROXYPROGESTERONE AC (generic Depo-Provera) |
| **Spermicide:** CONCEPTROL GEL ,GYNOL II GEL, ENCARE SUPPOSITORIES, SHUR-SEAL GEL, VCF VAGINAL CONTRACEPTIVE FILM, VCF VAGINAL FOAM |
| **Sponge:** TODAY SPONGE |
| **Vaginal Contraceptive Ring:** NUVARING |



**Legend**

| | | | |
|---|---|---|---|
| **Bold** | Generic available at tier 1 | P | Preferred available at tier 2 |
| NP | Non-preferred available at tier 3 | ST | Step Therapy |
| QL | Quantity Limit | PA | Prior Authorization Required |
| MN | Medical Necessity Prior Authorization | $0 | See Health Care Reform section for more information |