



Aetna Medicare
2012 Formulary
(List of Covered Drugs)

PLEASE READ:
This document contains
information about the drugs
we cover in this plan

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

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

This document includes The Aetna Medicare Plan's partial formulary as of July 22, 2011. For a complete, updated formulary, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748.

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

A Medicare Advantage organization with a Medicare contract

A Medicare-approved Part D sponsor

This information is available for free in other languages. Please contact our customer service number at **1-877-238-6211** (TTY/TDD: 1-888-760-4748) for additional information. Hours of operation: 7 days per week, 8 a.m. till 8 p.m. Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-877-238-6211** (TTY/TDD: 1-888-760-4748). Horario de atención: los 7 días de la semana, de 8 a.m. a 8 p.m. This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number listed above for more information.

Formulary ID: 00012369, Version 9

What is the Aetna Medicare formulary?

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

This document is a partial formulary and includes only some of the drugs covered by Aetna Medicare. For a complete listing of all prescription drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748.

Can the formulary change?

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

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of July 22, 2011. To get updated information about the drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748.

In the event of any CMS-approved, mid-year non-maintenance formulary changes, you will be mailed an addendum to this printed formulary.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 8. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents -- Heart, Blood Pressure and Cholesterol Drugs.” If you know what your drug is used for, look for the category name in the list that begins on page number 8. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the index that begins on page 31. The index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the index. Look in the index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Aetna Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Aetna Medicare before you fill your prescriptions. If you don't get approval, Aetna Medicare may not cover the drug.
- **Quantity Limits:** For certain drugs, Aetna Medicare limits the amount of the drug that Aetna Medicare will cover. For example, Aetna Medicare provides 1 tablet per day per prescription for simvastatin. This may be in addition to a standard one month or three month supply.
- **Step Therapy:** In some cases, Aetna Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Aetna Medicare may not cover drug B unless you try Drug A first. If Drug A does not work for you, Aetna Medicare will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 8. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.aetnamedicare.com.

You can ask Aetna Medicare to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Aetna Medicare formulary?” on page 4, below, for information about how to request an exception.

What if my drug is not on the formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Aetna Medicare may cover your drug. You can contact Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748.

If you learn that Aetna Medicare does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Aetna Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Aetna Medicare.
- You can ask Aetna Medicare to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Aetna Medicare formulary?

You can ask Aetna Medicare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Aetna Medicare limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in a non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in a preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the high cost/specialty drug tier.

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

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 93-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility), your physician or pharmacy can request a one-time prescription override. This one-time override will provide you with temporary coverage (up to a 31-day supply) for the applicable drug(s).

For more information

For more detailed information about your Aetna Medicare prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Aetna Medicare, please call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748. Or, visit www.aetnamedicare.com.

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

Aetna Medicare’s formulary

The abridged formulary that begins on page 8 provides coverage information about some of the drugs covered by Aetna Medicare. If you have trouble finding your drug in the list, turn to the index that begins on page 31. Remember: This is only a partial list of drugs covered by Aetna Medicare. If your prescription is not in this partial formulary, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748 for additional help.

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

The information in the Requirements/Limits column tells you if Aetna Medicare has any special requirements for coverage of your drug. The following abbreviations are used:

QL	Quantity limits
PA	Prior authorization
ST	Step therapy
LA	Limited Availability
MO	Mail order delivery
B/D	Part B vs D prior authorization
ED	Excluded Drug

QL: Quantity Limits. For certain drugs, Aetna Medicare limits the amount of the drug that we will cover. For example, Aetna Medicare provides 1 tablet per day per prescription for simvastatin. This may be in addition to a standard one month or three month supply.

PA: Prior Authorization. Aetna Medicare requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from Aetna Medicare before you fill your prescriptions. If you don't get approval, we may not cover the drug.

ST: Step Therapy. In some cases, the Aetna Medicare plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Aetna Medicare may not cover drug B unless you try Drug A first. If Drug A does not work for you, Aetna Medicare will then cover Drug B.

LA: Limited Availability. These prescriptions may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748 for additional help.

MO: Mail Order. For certain kinds of drugs, you can use Aetna Medicare network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan’s mail-order service are marked as “**mail-order**” drugs in our Drug List or MO. For more information consult your Pharmacy Directory or

call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 am to 8 pm, 7 days a week. TTY/TDD users should call 1-888-760-4748 for additional help.

B/D: Part B versus Part D. This prescription drug has a Part B versus Part D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

ED: Excluded Drug. These prescription drugs are not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

Note: The Aetna Medicare Premiere Rx plan includes coverage for generic benzodiazepines and barbiturates as an enhanced benefit. These drugs are listed as Excluded Drugs (ED).

Drug tier copay levels

This 2012 abridged formulary is a partial listing of brand name and generic drugs. Aetna Medicare's 2012 formulary covers most drugs identified by Medicare as Part D drugs, and your copay may differ depending upon the tier at which the drug resides.

The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna Medicare plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and coinsurance amounts.

Copay tier	Type of drug
Tier 1* (<i>Lowest Copay Amount</i>)	Preferred generic prescription drugs
Tier 2*	Non-preferred generic prescription drugs
Tier 3	Preferred brand name prescription drugs
Tier 4	Non-preferred brand name prescription drugs
Tier 5	Specialty tier brand and generic prescription drugs

* Note: Some Aetna Medicare Advantage and PDP plans provide additional coverage for drugs in tier 1 and/or tier 2 in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

KEY	Drug Tier	Requirements/Limits
Drug Name UPPERCASE = Brand name prescription drugs <i>Lower case italics</i> = Generic medications	1,2,3,4,5 = Copay tier level	QL= Quantity Limit ST = Step Therapy PA = Prior Authorization LA = Limited Availability MO = Mail order delivery B/D = Part B vs. Part D ED = Excluded Drug

Drug Name	Drug Tier	Requirements/Limits
Analgesics/Anesthetics/ Nonsteroidal Anti-inflammatory Agents		
<i>acetaminophen/codeine</i>	1	QL (13 per 1 day) MO
<i>acetaminophen/codeine #3</i>	1	QL (13 per 1 day) MO
<i>acetaminophen/codeine #4</i>	1	QL (13 per 1 day) MO
<i>fentanyl</i>	2	QL (15 per 30 days) MO
<i>flurbiprofen sodium</i>	1	MO
<i>hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg</i>	1	QL (13 per 1 day) MO
<i>hydrocodone bitartrate/acetaminophen tablet 750mg; 10mg</i>	1	QL (5 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (12 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 750mg; 7.5mg</i>	1	QL (5 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 650mg; 10mg, 650mg; 7.5mg, 660mg; 10mg</i>	1	QL (6 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 500mg; 10mg, 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg</i>	1	QL (8 per 1 day) MO
<i>hydrocodone/ibuprofen</i>	1	QL (5 per 1 day) MO
<i>ibuprofen</i>	1	MO
<i>lidocaine viscous</i>	1	MO
LIDODERM	4	QL (3 per 1 day) ST PA MO

*ED - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug

Drug Name	Drug Tier	Requirements/Limits
<i>meloxicam</i>	1	MO
<i>morphine sulfate er</i>	1	QL (3 per 1 day) MO
<i>morphine sulfate tablet</i>	1	QL (6 per 1 day) MO
<i>morphine sulfate solution</i>	2	QL (60 per 1 day) MO
NEVANAC	4	MO
NUCYNTA	3	QL (6 per 1 day) ST MO
OPANA ER TABLET EXTENDED RELEASE 12 HOUR 10MG, 20MG, 30MG, 5MG	4	QL (2 per 1 day) ST MO
OPANA ER TABLET EXTENDED RELEASE 12 HOUR 40MG	4	QL (4 per 1 day) ST MO
<i>oxycodone hcl tablet 5mg</i>	2	QL (12 per 1 day) MO
<i>oxycodone hcl tablet 30mg</i>	2	QL (6 per 1 day) MO
<i>oxycodone/acetaminophen capsule</i>	1	QL (8 per 1 day) MO
<i>oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (12 per 1 day) MO
<i>oxycodone/acetaminophen tablet 650mg; 10mg</i>	1	QL (6 per 1 day) MO
<i>oxycodone/acetaminophen tablet 500mg; 7.5mg</i>	1	QL (8 per 1 day) MO
VIMOVO	3	QL (2 per 1 day) MO
VOLTAREN	3	QL (34 per 1 day) MO
Anti-Addiction/Substance Abuse Treatment Agents		
ANTABUSE	4	MO
<i>buprenorphine hcl</i>	2	PA MO
<i>buproban</i>	1	QL (2 per 1 day) MO
CHANTIX PAK	4	QL (1.76 per 1 day) ST MO
CHANTIX TABLET 0.5MG, 1MG	4	QL (2 per 1 day) ST MO
<i>naloxone hcl injection 1mg/ml</i>	1	
<i>naloxone hcl injection 0.4mg/ml</i>	1	MO
<i>naltrexone hcl</i>	1	MO
Antibacterials		
<i>amoxicillin/clavulanate potassium</i>	1	MO
<i>amoxicillin capsule, suspension reconstituted, tablet</i>	1	MO
<i>amoxicillin tablet chewable 200mg</i>	1	
<i>amoxicillin tablet chewable 125mg, 250mg</i>	1	MO
AZASITE	3	MO

*ED - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug

Drug Name	Drug Tier	Requirements/Limits
<i>azithromycin suspension reconstituted, tablet</i>	1	MO
<i>azithromycin injection</i>	2	MO
<i>aztreonam</i>	2	
<i>bacitracin/polymyxin b</i>	1	MO
<i>cefaclor</i>	1	MO
<i>cefotetan</i>	2	
<i>cephalexin</i>	1	MO
<i>ciprofloxacin er</i>	1	MO
<i>ciprofloxacin hcl tablet</i>	1	MO
<i>clarithromycin er</i>	2	MO
<i>clarithromycin suspension reconstituted</i>	2	MO
<i>clarithromycin tablet 250mg</i>	2	MO
<i>clindamycin hcl capsule 150mg</i>	1	MO
<i>doxycycline monohydrate</i>	2	PA MO
<i>gentamicin sulfate/0.9% sodium chloride</i>	1	
<i>gentamicin sulfate/sodium chloride</i>	1	
<i>gentamicin sulfate injection 10mg/ml</i>	1	
<i>gentamicin sulfate injection 40mg/ml</i>	1	MO
<i>isotonic gentamicin injection 0.6mg/ml; 0.9%</i>	1	
<i>isotonic gentamicin injection 0.8mg/ml; 0.9%</i>	1	MO
LEVAQUIN TABLET	4	MO
<i>metronidazole vaginal</i>	1	MO
<i>metronidazole tablet</i>	1	MO
MOXEZA	4	MO
<i>mupirocin</i>	1	MO
<i>neomycin/polymyxin/bacitracin/hydrocortis one</i>	1	MO
<i>neomycin/polymyxin/dexamethasone suspension</i>	1	MO
<i>neomycin/polymyxin/hydrocortisone suspension</i>	1	MO
PRIMAXIN I.M.	4	MO
PRIMAXIN IV	4	MO
<i>silver sulfadiazine</i>	1	MO
<i>sodium sulfacetamide</i>	1	MO
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
<i>sulfadiazine</i>	2	MO
<i>sulfamethoxazole/trimethoprim ds</i>	1	MO
<i>sulfamethoxazole/trimethoprim suspension, tablet</i>	1	MO
TEFLARO	4	
<i>tetracycline hcl</i>	1	PA MO
<i>tobramycin sulfate/sodium chloride</i>	2	
<i>tobramycin sulfate ophthalmic solution</i>	1	MO
<i>tobramycin sulfate injection 10mg/ml</i>	2	
<i>tobramycin sulfate injection 80mg/2ml</i>	2	MO
<i>vancomycin hcl injection 10gm</i>	2	B/D
<i>vancomycin hcl injection 1000mg, 500mg</i>	2	B/D MO
VIGAMOX	4	MO
Anticonvulsants		
<i>carbamazepine tablet</i>	1	MO
<i>clonazepam odt tablet dispersible 0.25mg, 0.5mg, 2mg</i>	1	QL (2 per 1 day) MO ED*
<i>clonazepam odt tablet dispersible 0.125mg</i>	1	QL (3 per 1 day) MO ED*
<i>clonazepam odt tablet dispersible 1mg</i>	1	QL (4 per 1 day) MO ED*
<i>clonazepam tablet 2mg</i>	1	QL (10 per 1 day) MO ED*
<i>clonazepam tablet 0.5mg</i>	1	QL (3 per 1 day) MO ED*
<i>clonazepam tablet 1mg</i>	1	QL (4 per 1 day) MO ED*
<i>divalproex sodium</i>	1	MO
<i>divalproex sodium er</i>	1	MO
<i>gabapentin capsule 100mg, 300mg</i>	1	QL (6 per 1 day) MO
<i>gabapentin capsule 400mg</i>	1	QL (9 per 1 day) MO
<i>gabapentin tablet 800mg</i>	1	QL (4.5 per 1 day) MO
<i>gabapentin tablet 600mg</i>	1	QL (6 per 1 day) MO
LAMICTAL ODT	4	ST MO
<i>lamotrigine</i>	2	MO
<i>levetiracetam tablet</i>	1	MO
LYRICA CAPSULE 225MG, 300MG	4	QL (2 per 1 day) ST MO
LYRICA CAPSULE 100MG, 150MG, 200MG, 25MG, 50MG, 75MG	4	QL (3 per 1 day) ST MO
<i>phenytoin sodium extended capsule 100mg</i>	1	MO
<i>topiramate tablet</i>	2	MO
<i>zonisamide</i>	1	MO
Antidementia Agents		
ARICEPT TABLET 23MG	3	QL (1 per 1 day) ST MO
<i>donepezil hcl</i>	2	QL (1 per 1 day) MO

*ED - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug

Drug Name	Drug Tier	Requirements/Limits
<i>ergoloid mesylates</i>	2	MO
EXELON PATCH 24 HOUR	3	MO
NAMENDA	3	MO
NAMENDA TITRATION PAK	3	MO
<i>rivastigmine tartrate</i>	2	MO
Antidepressants		
<i>bupropion hcl</i>	1	QL (6 per 1 day) MO
<i>bupropion hcl sr tablet extended release 12 hour 100mg, 200mg</i>	1	QL (2 per 1 day) MO
<i>citalopram hydrobromide tablet</i>	1	QL (1 per 1 day) MO
<i>doxepin hcl</i>	1	MO
EMSAM	4	QL (1 per 1 day) ST PA MO
<i>nefazodone hcl tablet 250mg, 50mg</i>	1	QL (2 per 1 day) MO
<i>nefazodone hcl tablet 100mg, 150mg, 200mg</i>	1	QL (3 per 1 day) MO
<i>nortriptyline hcl</i>	1	MO
<i>paroxetine hcl tablet 10mg, 20mg</i>	1	QL (1 per 1 day) MO
<i>paroxetine hcl tablet 30mg, 40mg</i>	1	QL (2 per 1 day) MO
<i>phenelzine sulfate</i>	2	MO
VIIBRYD	4	QL (1 per 1 day) ST MO
Antidotes, Deterrents, and Toxicologic Agents		
CHEMET	4	MO
<i>fomepizole</i>	5	
Antiemetics		
<i>granisetron hcl tablet</i>	2	QL (2 per 1 day) B/D MO
<i>meclizine hcl</i>	1	MO
<i>ondansetron hcl tablet 8mg</i>	1	QL (3 per 1 day) B/D MO
<i>ondansetron hcl tablet 24mg</i>	1	QL (5 per 30 days) B/D MO
<i>ondansetron hcl tablet 4mg</i>	1	QL (6 per 1 day) B/D MO
<i>ondansetron odt tablet dispersible 8mg</i>	2	QL (3 per 1 day) B/D MO
<i>ondansetron odt tablet dispersible 4mg</i>	2	QL (6 per 1 day) B/D MO
<i>trimethobenzamide hcl capsule</i>	1	PA MO
Antifungals		
<i>clotrimazole cream, solution</i>	1	MO
<i>fluconazole tablet 100mg, 200mg, 50mg</i>	1	MO
<i>fluconazole tablet 150mg</i>	1	QL (0.14 per 1 day) MO
<i>ketoconazole cream, tablet</i>	1	MO
<i>nystatin cream, ointment</i>	1	MO
<i>terbinafine hcl</i>	1	QL (1 per 1 day) PA MO

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Drug Name	Drug Tier	Requirements/Limits
Antigout Agents		
<i>allopurinol</i>	1	MO
COLCRYS	3	QL (4 per 1 day) MO
ULORIC	3	MO
Antimigraine Agents		
<i>dihydroergotamine mesylate</i>	2	MO
<i>ergotamine tartrate/caffeine</i>	1	MO
MAXALT	4	QL (12 per 30 days) MO
MAXALT-MLT	4	QL (12 per 30 days) MO
<i>sumatriptan succinate tablet</i>	2	QL (9 per 30 days) MO
<i>sumatriptan succinate injection 4mg/0.5ml</i>	2	QL (4 per 30 days)
<i>sumatriptan succinate injection 6mg/0.5ml</i>	2	QL (4 per 30 days) MO
Antimyasthenic Agents		
<i>guanidine hcl</i>	1	
<i>pyridostigmine bromide</i>	1	MO
Antimycobacterials		
<i>dapsone</i>	1	MO
<i>isoniazid tablet</i>	1	MO
MYCOBUTIN	4	MO
<i>rifampin capsule</i>	1	MO
Antineoplastics		
<i>anastrozole</i>	2	QL (1 per 1 day) MO
<i>bleomycin sulfate</i>	2	B/D
CEENU	4	MO
<i>cyclophosphamide</i>	2	B/D MO
EMCYT	4	MO
<i>exemestane</i>	2	MO
GLEEVEC TABLET 400MG	5	QL (2 per 1 day) PA
GLEEVEC TABLET 100MG	5	QL (3 per 1 day) PA
<i>hydroxyurea</i>	1	MO
<i>leucovorin calcium tablet</i>	1	MO
<i>leucovorin calcium injection 350mg</i>	1	B/D
MOZOBIL	5	PA
PANRETIN	5	MO
REVLIMID	5	QL (1 per 1 day) PA LA
RITUXAN	5	PA
SUTENT CAPSULE 50MG	5	QL (1 per 1 day) PA
SUTENT CAPSULE 25MG	5	QL (2 per 1 day) PA
SUTENT CAPSULE 12.5MG	5	QL (3 per 1 day) PA
<i>tamoxifen citrate</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
TARCEVA TABLET 25MG	5	QL (2 per 1 day) PA
TARCEVA TABLET 100MG, 150MG	5	QL (3 per 1 day) PA
TARGRETIN	5	PA
THALOMID	5	QL (28 per 28 days) PA
ZOLINZA	5	QL (4 per 1 day) PA
Antiparasitics		
ALBENZA	4	MO
<i>chloroquine phosphate</i>	2	MO
<i>lindane</i>	2	QL (2 per 1 day) MO
<i>mebendazole</i>	1	MO
<i>permethrin</i>	1	MO
<i>primaquine phosphate</i>	1	MO
Antiparkinson Agents		
<i>amantadine hcl capsule, tablet</i>	1	MO
<i>amantadine hcl syrup</i>	2	MO
AZILECT	3	MO
<i>benztropine mesylate tablet</i>	1	MO
<i>carbidopa/levodopa</i>	1	MO
<i>carbidopa/levodopa cr</i>	2	MO
<i>carbidopa/levodopa odt</i>	1	MO
<i>carbidopa/levodopa sr</i>	2	MO
COMTAN	3	MO
<i>pramipexole dihydrochloride</i>	2	MO
<i>ropinirole hcl</i>	1	MO
<i>selegiline hcl</i>	1	MO
STALEVO 100	3	MO
STALEVO 125	3	MO
STALEVO 150	3	MO
STALEVO 200	3	MO
STALEVO 50	3	MO
STALEVO 75	3	MO
<i>trihexyphenidyl hcl</i>	1	MO
Antipsychotics		
ABILIFY DISCMELT	4	QL (2 per 1 day) MO
ABILIFY INJECTION	4	MO
ABILIFY TABLET	4	QL (1 per 1 day) MO
ABILIFY ORAL SOLUTION	4	QL (30 per 1 day) MO
<i>clozapine tablet 25mg, 50mg</i>	2	QL (3 per 1 day)
<i>clozapine tablet 200mg</i>	2	QL (4 per 1 day)
<i>clozapine tablet 100mg</i>	2	QL (9 per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
FAZACLO TABLET DISPERSIBLE 12.5MG	4	QL (2 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 25MG	4	QL (3 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 200MG	4	QL (4 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 150MG	4	QL (6 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 100MG	4	QL (9 per 1 day) ST
<i>fluphenazine hcl tablet</i>	1	MO
<i>haloperidol tablet</i>	1	MO
SAPHRIS	4	QL (2 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150MG, 200MG	3	QL (1 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300MG, 400MG	3	QL (2 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50MG	3	QL (6 per 1 day) MO
SEROQUEL TABLET 300MG, 400MG	4	QL (2 per 1 day) MO
SEROQUEL TABLET 100MG, 50MG	4	QL (3 per 1 day) MO
SEROQUEL TABLET 200MG	4	QL (4 per 1 day) MO
SEROQUEL TABLET 25MG	4	QL (6 per 1 day) MO
Antivirals		
ATRIPLA	5	MO
BARACLUDE SOLUTION	3	QL (21 per 1 day) PA MO
BARACLUDE TABLET	5	QL (1 per 1 day) PA MO
CRIXIVAN CAPSULE 100MG	3	
CRIXIVAN CAPSULE 200MG, 400MG	3	MO
DENAVIR	4	MO
EPIVIR HBV	4	MO
<i>famciclovir tablet 125mg, 250mg</i>	2	QL (2 per 1 day) MO
<i>famciclovir tablet 500mg</i>	2	QL (30 per 10 days) MO
<i>foscarnet sodium</i>	2	B/D
FUZEON	5	
<i>ganciclovir capsule 250mg</i>	2	
<i>ganciclovir injection</i>	2	
PREZISTA TABLET 75MG	4	
PREZISTA TABLET 150MG	4	MO
PREZISTA TABLET 400MG, 600MG	5	MO

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Drug Name	Drug Tier	Requirements/Limits
RELENZA DISKHALER	4	QL (120 per 365 days) MO
RESCRIPTOR	3	MO
SELZENTRY	5	MO
<i>stavudine</i>	2	MO
TAMIFLU SUSPENSION RECONSTITUTED	4	QL (525 per 365 days) MO
TAMIFLU CAPSULE 30MG	4	QL (168 per 365 days) MO
TAMIFLU CAPSULE 45MG, 75MG	4	QL (84 per 365 days) MO
TRUVADA	5	MO
<i>valacyclovir hcl</i>	1	MO
ZIRGAN	4	MO
ZOVIRAX OINTMENT	4	MO
Anxiolytics		
<i>alprazolam er</i>	1	QL (1 per 1 day) MO ED*
<i>alprazolam intensol</i>	1	QL (5 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 0.5mg, 2mg</i>	1	QL (3 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 0.25mg</i>	1	QL (4 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 1mg</i>	1	QL (5 per 1 day) MO ED*
<i>alprazolam tablet 0.5mg, 2mg</i>	1	QL (3 per 1 day) MO ED*
<i>alprazolam tablet 0.25mg</i>	1	QL (4 per 1 day) MO ED*
<i>alprazolam tablet 1mg</i>	1	QL (5 per 1 day) MO ED*
<i>bupirone hcl</i>	1	MO
<i>chlordiazepoxide hcl</i>	1	QL (4 per 1 day) MO ED*
<i>clorazepate dipotassium tablet 15mg</i>	1	QL (1 per 1 day) MO ED*
<i>clorazepate dipotassium tablet 3.75mg, 7.5mg</i>	1	QL (3 per 1 day) MO ED*
<i>diazepam intensol</i>	1	QL (8 per 1 day) MO ED*
<i>diazepam tablet</i>	1	QL (4 per 1 day) MO ED*
<i>diazepam solution</i>	1	QL (40 per 1 day) MO ED*
<i>lorazepam concentrate, tablet</i>	1	QL (3 per 1 day) MO ED*
<i>lorazepam injection</i>	1	QL (4 per 1 day) MO ED*
<i>meprobamate</i>	2	PA MO
<i>oxazepam</i>	1	QL (4 per 1 day) MO ED*

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Drug Name	Drug Tier	Requirements/Limits
Attention Deficit Hyperactivity Disorder Agents		
<i>amphetamine/dextroamphetamine tablet</i> 1.25mg; 1.25mg; 1.25mg; 1.25mg, 1.875mg; 1.875mg; 1.875mg; 1.875mg, 2.5mg; 2.5mg; 2.5mg; 2.5mg, 3.125mg; 3.125mg; 3.125mg; 3.125mg, 3.75mg; 3.75mg; 3.75mg; 3.75mg, 7.5mg; 7.5mg; 7.5mg; 7.5mg	1	QL (2 per 1 day) PA MO
<i>amphetamine/dextroamphetamine tablet</i> 5mg; 5mg; 5mg; 5mg	1	QL (3 per 1 day) PA MO
<i>dexmethylphenidate hcl</i>	1	QL (2 per 1 day) PA MO
<i>methamphetamine hcl</i>	2	QL (5 per 1 day) PA MO
<i>methylphenidate hcl</i>	1	QL (3 per 1 day) PA MO
<i>methylphenidate hcl sr</i>	1	QL (3 per 1 day) PA MO
Bipolar Agents		
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100MG	4	QL (4 per 1 day) MO
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300MG	4	QL (5 per 1 day) MO
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200MG	4	QL (8 per 1 day) MO
<i>lithium carbonate</i>	1	MO
<i>lithium carbonate er</i>	1	MO
<i>lithium citrate</i>	1	MO
Blood Glucose Regulators		
<i>acarbose</i>	1	QL (3 per 1 day) MO
ACTOPLUS MET	3	QL (3 per 1 day) MO
ACTOS	3	QL (1 per 1 day) MO
ALCOHOL PREPS	4	MO
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	4	ST
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	4	ST MO
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	4	ST MO
BD PEN NEEDLE/ULTRAFINE/29G X 12.7MM	4	ST MO
BYETTA INJECTION 5MCG/0.02ML	3	QL (0.04 per 1 day) MO
BYETTA INJECTION 10MCG/0.04ML	3	QL (0.08 per 1 day) MO
CURITY GAUZE PADS 2"X2"	4	MO

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Drug Name	Drug Tier	Requirements/Limits
DUETACT	3	QL (1 per 1 day) MO
<i>glipizide er tablet extended release 24 hour 2.5mg, 5mg</i>	1	QL (1 per 1 day) MO
<i>glipizide er tablet extended release 24 hour 10mg</i>	1	QL (2 per 1 day) MO
<i>glipizide/metformin hcl tablet 2.5mg; 500mg, 5mg; 500mg</i>	1	QL (4 per 1 day) MO
<i>glipizide/metformin hcl tablet 2.5mg; 250mg</i>	1	QL (8 per 1 day) MO
<i>glipizide tablet 10mg</i>	1	QL (4 per 1 day) MO
<i>glipizide tablet 5mg</i>	1	QL (8 per 1 day) MO
GLUCAGON EMERGENCY KIT	3	QL (2 per 1 day) MO
<i>glyburide tablet 1.25mg, 2.5mg</i>	1	QL (3 per 1 day) MO
<i>glyburide tablet 5mg</i>	1	QL (4 per 1 day) MO
JANUMET	3	QL (2 per 1 day) MO
JANUVIA	3	QL (1 per 1 day) MO
LANTUS	4	MO
LANTUS SOLOSTAR	4	MO
LEVEMIR	3	MO
LEVEMIR FLEXPEN	3	MO
<i>metformin hcl er tablet extended release 24 hour 750mg</i>	1	QL (2 per 1 day) MO
<i>metformin hcl er tablet extended release 24 hour 500mg</i>	1	QL (4 per 1 day) MO
<i>metformin hcl tablet 1000mg, 850mg</i>	1	QL (3 per 1 day) MO
<i>metformin hcl tablet 500mg</i>	1	QL (5 per 1 day) MO
NOVOLIN 70/30	3	MO
NOVOLIN N	3	MO
NOVOLIN R	3	MO
NOVOLOG	3	MO
NOVOLOG FLEXPEN	3	MO
NOVOLOG MIX 70/30	3	MO
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	MO
PROGLYCEM	4	MO
VICTOZA	3	QL (1.8 per 1 day) MO
WELCHOL	4	MO
Blood Products/Modifiers/ Volume Expanders		
AGGRENOX	3	QL (2 per 1 day) MO

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Drug Name	Drug Tier	Requirements/Limits
ARANESP ALBUMIN FREE INJECTION 100MCG/ML, 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML, 60MCG/ML	3	PA
ARANESP ALBUMIN FREE INJECTION 100MCG/0.5ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML	5	PA
<i>cilostazol</i>	1	MO
CYKLOKAPRON	4	MO
<i>enoxaparin sodium injection 30mg/0.3ml, 40mg/0.4ml</i>	2	MO
LYSTEDA	3	QL (30 per 5 days) PA MO
NEUPOGEN	5	PA
PLAVIX TABLET 75MG	4	QL (1 per 1 day) MO
PLAVIX TABLET 300MG	4	QL (2 per 365 days)
PRADAXA	3	QL (2 per 1 day) PA MO
PROCRIT INJECTION 10000UNIT/ML	3	PA
PROCRIT INJECTION 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	QL (12 per 30 days) PA
PROCRIT INJECTION 20000UNIT/ML, 40000UNIT/ML	5	PA
<i>warfarin sodium</i>	1	MO
Cardiovascular Agents		
<i>acetazolamide</i>	1	MO
<i>amiloride hcl</i>	1	MO
<i>amiloride/hydrochlorothiazide</i>	1	MO
<i>amlodipine besylate tablet 10mg</i>	1	MO
<i>amlodipine besylate tablet 2.5mg, 5mg</i>	1	QL (1 per 1 day) MO
AMTURNIDE	3	QL (1 per 1 day) MO
<i>atenolol</i>	1	MO
BENICAR HCT TABLET 12.5MG; 40MG, 25MG; 40MG	4	MO
BENICAR HCT TABLET 12.5MG; 20MG	4	QL (1 per 1 day) MO
BENICAR TABLET 40MG	4	MO
BENICAR TABLET 20MG, 5MG	4	QL (1 per 1 day) MO
<i>carvedilol</i>	1	MO
<i>chlorothiazide</i>	1	MO
<i>chlorthalidone</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
<i>clonidine hcl tablet</i>	1	MO
<i>clonidine hcl patch weekly</i>	2	QL (8 per 28 days) MO
<i>colestipol hcl granules</i>	2	MO
CRESTOR	3	QL (1 per 1 day) MO
DEMSER	5	MO
<i>digoxin</i>	1	MO
<i>diltiazem cd capsule extended release 24 hour 240mg, 300mg</i>	1	MO
<i>diltiazem cd capsule extended release 24 hour 120mg</i>	1	QL (1 per 1 day) MO
<i>diltiazem hcl er</i>	1	MO
<i>diltiazem hcl injection</i>	1	
<i>diltiazem hcl tablet</i>	1	MO
DIOVAN HCT TABLET 12.5MG; 320MG, 25MG; 320MG	3	MO
DIOVAN HCT TABLET 12.5MG; 160MG, 12.5MG; 80MG, 25MG; 160MG	3	QL (1 per 1 day) MO
DIOVAN TABLET 320MG	3	MO
DIOVAN TABLET 160MG, 40MG, 80MG	3	QL (2 per 1 day) MO
<i>doxazosin mesylate</i>	1	MO
<i>enalapril maleate</i>	1	MO
<i>enalapril maleate/hydrochlorothiazide</i>	1	MO
EXFORGE	3	QL (1 per 1 day) MO
EXFORGE HCT TABLET 10MG; 25MG; 320MG	3	MO
EXFORGE HCT TABLET 10MG; 12.5MG; 160MG, 10MG; 25MG; 160MG, 5MG; 12.5MG; 160MG, 5MG; 25MG; 160MG	3	QL (1 per 1 day) MO
<i>fenofibrate</i>	1	MO
<i>fenofibrate micronized</i>	1	MO
<i>flecainide acetate</i>	1	MO
<i>fosinopril sodium</i>	1	MO
<i>furosemide</i>	1	MO
<i>gemfibrozil</i>	1	MO
<i>hydralazine hcl tablet</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO
<i>isosorbide dinitrate</i>	1	MO
<i>isosorbide dinitrate er</i>	1	MO
<i>isosorbide mononitrate</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
<i>isosorbide mononitrate er</i>	1	MO
LIPITOR	3	QL (1 per 1 day) MO
<i>lisinopril</i>	1	MO
<i>lovastatin</i>	1	QL (2 per 1 day) MO
LOVAZA	3	QL (4 per 1 day) MO
<i>methazolamide</i>	1	MO
<i>methyldopa</i>	1	MO
<i>methyldopa/hydrochlorothiazide</i>	1	MO
<i>metolazone</i>	1	MO
<i>metoprolol succinate er</i>	1	MO
<i>metoprolol tartrate</i>	1	MO
MICARDIS HCT TABLET 12.5MG; 80MG, 25MG; 80MG	3	MO
MICARDIS HCT TABLET 12.5MG; 40MG	3	QL (1 per 1 day) MO
MICARDIS TABLET 80MG	3	MO
MICARDIS TABLET 20MG, 40MG	3	QL (1 per 1 day) MO
<i>minoxidil</i>	1	MO
MULTAQ	3	MO
NIASPAN TABLET EXTENDED RELEASE 1000MG, 750MG	3	QL (2 per 1 day) MO
NIASPAN TABLET EXTENDED RELEASE 500MG	3	QL (3 per 1 day) MO
<i>nifediac cc tablet extended release 24 hour 90mg</i>	1	MO
<i>nifediac cc tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifediac cc tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO
<i>nifedical xl tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifedical xl tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO
<i>nifedipine</i>	1	MO
<i>nifedipine er tablet extended release 24 hour 90mg</i>	1	MO
<i>nifedipine er tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifedipine er tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO

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Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin transdermal</i>	1	MO
<i>nitroglycerin patch 24 hour</i>	1	MO
NITROSTAT	4	MO
RANEXA TABLET EXTENDED RELEASE 12 HOUR 1000MG	4	QL (2 per 1 day) ST MO
RANEXA TABLET EXTENDED RELEASE 12 HOUR 500MG	4	QL (3 per 1 day) ST MO
<i>reserpine</i>	1	MO
SIMCOR TABLET EXTENDED RELEASE 24 HOUR 1000MG; 40MG, 500MG; 40MG	3	QL (1 per 1 day) MO
SIMCOR TABLET EXTENDED RELEASE 24 HOUR 500MG; 20MG, 750MG; 20MG	3	QL (2 per 1 day) MO
<i>simvastatin</i>	1	QL (1 per 1 day) MO
<i>sotalol hcl</i>	1	MO
<i>spironolactone</i>	1	MO
<i>spironolactone/hydrochlorothiazide</i>	1	MO
TEKAMLO	3	QL (1 per 1 day) MO
TEKTURNA HCT TABLET 300MG; 12.5MG, 300MG; 25MG	3	MO
TEKTURNA HCT TABLET 150MG; 12.5MG, 150MG; 25MG	3	QL (1 per 1 day) MO
TEKTURNA TABLET 300MG	3	MO
TEKTURNA TABLET 150MG	3	QL (1 per 1 day) MO
<i>terazosin hcl</i>	1	MO
<i>toremide tablet</i>	1	MO
<i>toremide injection</i>	2	
<i>triamterene/hydrochlorothiazide</i>	1	MO
TRICOR	3	MO
TRILIPIX	3	MO
VALTURNA TABLET 300MG; 320MG	3	MO
VALTURNA TABLET 150MG; 160MG	3	QL (1 per 1 day) MO
<i>verapamil hcl</i>	1	MO
<i>verapamil hcl er</i>	1	MO
VYTORIN	3	QL (1 per 1 day) MO
ZETIA	4	QL (1 per 1 day) MO
Central Nervous System Agents		
AVONEX	5	QL (4 per 28 days) PA
<i>baclofen</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
COPAXONE	5	QL (1 per 1 day) PA
<i>cyclobenzaprine hcl</i>	1	QL (3 per 1 day) PA MO
<i>dantrolene sodium</i>	2	MO
EXTAVIA	5	QL (0.53 per 1 day) PA
<i>methocarbamol</i>	1	PA MO
NUEDEXTA	4	QL (2 per 1 day) PA MO
RILUTEK	5	PA MO
SAVELLA	3	QL (2 per 1 day) MO
SAVELLA TITRATION PACK	3	QL (55 per 365 days) MO
<i>tizanidine hcl</i>	1	MO
Dental and Oral Agents		
<i>chlorhexidine gluconate oral rinse</i>	1	MO
<i>periogard</i>	1	MO
<i>triamcinolone in orabase</i>	1	MO
Dermatological Agents		
<i>doxycycline hyclate capsule delayed release particles 100mg</i>	1	PA
<i>doxycycline hyclate capsule delayed release particles 75mg</i>	1	PA MO
<i>doxycycline hyclate capsule, tablet</i>	1	PA MO
<i>fluorouracil</i>	2	MO
TAZORAC	4	MO
<i>tretinoin cream</i>	1	PA MO
<i>tretinoin gel</i>	2	PA MO
Enzyme Replacement/ Modifying Agents		
CREON	3	MO
ZENPEP	3	MO
Gastrointestinal Agents		
AMITIZA CAPSULE 24MCG	3	QL (2 per 1 day) ST MO
AMITIZA CAPSULE 8MCG	3	QL (2 per 1 day) ST PA MO
APRISO	3	QL (4 per 1 day) MO
<i>atropine sulfate</i>	1	PA
CANASA	4	MO
DEXILANT	3	QL (1 per 1 day) MO
<i>dicyclomine hcl</i>	1	PA MO
<i>famotidine tablet</i>	1	MO
<i>lactulose</i>	1	MO
LIALDA	4	QL (4 per 1 day) MO
<i>loperamide hcl</i>	1	MO
LOTRONEX	5	QL (2 per 1 day) PA MO

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Drug Name	Drug Tier	Requirements/Limits
<i>metoclopramide hcl</i>	1	MO
<i>misoprostol</i>	2	MO
NEXIUM I.V.	3	
NEXIUM PACKET	3	QL (1 per 1 day) MO
NEXIUM CAPSULE DELAYED RELEASE 20MG	3	QL (1 per 1 day) MO
NEXIUM CAPSULE DELAYED RELEASE 40MG	3	QL (2 per 1 day) MO
<i>omeprazole capsule delayed release 10mg, 40mg</i>	1	QL (1 per 1 day) MO
<i>omeprazole capsule delayed release 20mg</i>	1	QL (3 per 1 day) MO
PENTASA CAPSULE EXTENDED RELEASE 250MG	4	QL (20 per 1 day) MO
PENTASA CAPSULE EXTENDED RELEASE 500MG	4	QL (8 per 1 day) MO
<i>polyethylene glycol 3350</i>	1	MO
<i>ranitidine hcl capsule, tablet</i>	1	MO
<i>sucralfate</i>	1	MO
<i>ursodiol</i>	1	MO
Genitourinary Agents		
AVODART	3	QL (1 per 1 day) PA MO
<i>bethanechol chloride</i>	1	MO
<i>calcium acetate</i>	2	MO
ELMIRON	4	MO
ENABLEX	3	QL (1 per 1 day) MO
<i>finasteride</i>	1	QL (1 per 1 day) PA MO
FOSRENOL	4	MO
GELNIQUE	3	QL (1 per 1 day) MO
JALYN	3	QL (1 per 1 day) PA MO
<i>nitrofurantoin</i>	2	MO
<i>oxybutynin chloride</i>	1	MO
<i>oxybutynin chloride er tablet extended release 24 hour 5mg</i>	2	QL (1 per 1 day) MO
<i>oxybutynin chloride er tablet extended release 24 hour 10mg, 15mg</i>	2	QL (2 per 1 day) MO
PHOSLO	3	MO
RAPAFLO CAPSULE 8MG	3	QL (1 per 1 day) PA MO
RAPAFLO CAPSULE 4MG	3	QL (2 per 1 day) PA MO
RENVELA	3	MO
<i>tamsulosin hcl</i>	1	QL (2 per 1 day) MO

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Drug Name	Drug Tier	Requirements/Limits
VESICARE	3	QL (1 per 1 day) MO
Glucocorticoid/ Mineralocorticoid Agents		
ALREX	3	MO
<i>clobetasol propionate</i>	1	MO
<i>clobetasol propionate e</i>	1	MO
DERMOTIC	4	MO
<i>desonide</i>	1	MO
DUREZOL	3	MO
<i>fludrocortisone acetate</i>	1	MO
<i>fluocinolone acetonide</i>	1	MO
<i>fluocinonide</i>	1	MO
<i>fluocinonide emollient base</i>	1	MO
<i>fluorometholone</i>	1	MO
<i>fluticasone propionate</i>	1	MO
<i>halobetasol propionate</i>	1	MO
<i>hydrocortisone</i>	1	MO
LOTEMAX	3	MO
<i>methylprednisolone</i>	1	MO
<i>mometasone furoate</i>	1	MO
<i>prednisone</i>	1	MO
<i>triamcinolone acetonide</i>	1	MO
<i>triamcinolone acetonide in absorbbase</i>	1	MO
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
ANDROGEL PUMP	3	QL (5.87 per 1 day) MO
<i>zeosa</i>	2	MO
Hormonal Agents		
ANDRODERM PATCH 24 HOUR 5MG/24HR	3	QL (1 per 1 day) MO
ANDRODERM PATCH 24 HOUR 2.5MG/24HR	3	QL (2 per 1 day) MO
ANDROGEL	3	QL (10 per 1 day) MO
<i>bicalutamide</i>	1	QL (1 per 1 day) MO
CHORIONIC GONADOTROPIN	4	PA
<i>desmopressin acetate</i>	2	MO
ELIGARD	4	PA
<i>estradiol tablet</i>	1	MO
<i>estradiol patch weekly</i>	1	QL (4 per 28 days) MO
EVISTA	3	QL (1 per 1 day) MO
<i>flutamide</i>	2	MO

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Drug Name	Drug Tier	Requirements/Limits
INCRELEX	5	PA
<i>leuprolide acetate</i>	1	PA
<i>levothyroxine sodium</i>	1	MO
<i>liothyronine sodium</i>	1	MO
LYSODREN	3	MO
<i>medroxyprogesterone acetate</i>	1	MO
<i>megestrol acetate</i>	1	PA MO
<i>methimazole</i>	1	MO
NORDITROPIN FLEXPRO	5	PA
NORDITROPIN NORDIFLEX PEN	5	PA
<i>octreotide acetate</i>	2	PA
PREMARIN	4	PA MO
PREMARIN W/APPLICATOR	4	MO
<i>propylthiouracil</i>	1	MO
SENSIPAR TABLET 30MG	3	QL (2 per 1 day) MO
SENSIPAR TABLET 60MG	5	QL (2 per 1 day) MO
SENSIPAR TABLET 90MG	5	QL (4 per 1 day) MO
SOMAVERT	5	ST PA
<i>sprintec 28</i>	1	MO
<i>testosterone cypionate</i>	2	MO
<i>tri-sprintec</i>	1	QL (28 per 28 days) MO
Immunological Agents		
<i>azathioprine</i>	1	PA MO
<i>cyclosporine capsule</i>	2	PA MO
ENBREL INJECTION 25MG/0.5ML	5	QL (0.15 per 1 day) PA
ENBREL INJECTION 50MG/ML	5	QL (0.29 per 1 day) PA
ENBREL INJECTION 25MG	5	QL (14.3 per 28 days) PA
GAMASTAN S/D	3	PA
GAMMAGARD LIQUID	5	PA
HUMIRA PEN-CROHNS DISEASESTARTER	5	QL (6 per 28 days) PA
HUMIRA INJECTION 20MG/0.4ML	5	QL (2 per 28 days) PA
HUMIRA INJECTION 40MG/0.8ML	5	QL (6 per 28 days) PA
INTRON-A W/DILUENT	5	PA
INTRON-A INJECTION 6000000UNIT/ML	4	PA
INTRON-A INJECTION 10MU/0.2ML, 3MU/0.2ML, 5MU/0.2ML	5	PA
<i>leflunomide</i>	1	MO
<i>methotrexate</i>	1	MO

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Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate sodium injection 25mg/ml</i>	1	B/D MO
PEG-INTRON	5	PA
PEG-INTRON REDIPEN	5	PA
PEGASYS	5	PA
SIMPONI	5	QL (0.02 per 1 day) PA
SIMULECT	5	PA
SYNAGIS	5	PA
<i>tacrolimus capsule 0.5mg, 1mg</i>	2	PA MO
THYMOGLOBULIN	4	PA
VARIVAX	3	
ZOSTAVAX	4	QL (1 per 999 days) PA
Metabolic Bone Disease Agents		
ACTONEL TABLET 30MG, 5MG	3	QL (1 per 1 day) MO
ACTONEL TABLET 150MG	3	QL (1 per 28 days) MO
ACTONEL TABLET 35MG	3	QL (4 per 28 days) MO
<i>alendronate sodium tablet 10mg, 40mg, 5mg</i>	1	QL (1 per 1 day) MO
<i>alendronate sodium tablet 35mg, 70mg</i>	1	QL (4 per 28 days) MO
ATELVIA	3	QL (4 per 28 days) MO
<i>calcitriol capsule</i>	1	B/D MO
FORTEO	5	QL (2.4 per 28 days) ST
ZEMPLAR	3	B/D MO
Nutrients/ Minerals/ Electrolytes		
CUPRIMINE	4	MO
EXJADE TABLET SOLUBLE 125MG	4	PA
EXJADE TABLET SOLUBLE 250MG, 500MG	5	PA
<i>klor-con 10</i>	1	MO
<i>klor-con 8</i>	1	MO
KLOR-CON M15	4	MO
<i>klor-con m20</i>	1	MO
<i>potassium chloride er</i>	1	MO
<i>potassium citrate extended-release</i>	1	MO
PRENATAL TABLETS	4	
<i>sodium polystyrene sulfonate</i>	2	MO
Ophthalmic Agents		
<i>ak-con</i>	1	MO
ALPHAGAN P	3	MO
<i>apraclonidine</i>	2	MO
AZOPT	3	MO

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Drug Name	Drug Tier	Requirements/Limits
COMBIGAN	4	MO
<i>cromolyn sodium</i>	1	MO
<i>dorzolamide hcl</i>	1	MO
<i>epinastine hcl</i>	2	MO
LACRISERT	4	MO
<i>latanoprost</i>	2	MO
LUMIGAN	3	MO
<i>parcaine</i>	1	
PATADAY	4	MO
PATANOL	4	MO
PHOSPHOLINE IODIDE	4	
PILOPINE HS	3	MO
RESTASIS	3	MO
<i>timolol maleate</i>	1	MO
TRAVATAN Z	3	MO
<i>tropicamide</i>	1	MO
Respiratory Tract Agents		
<i>acetylcysteine</i>	1	B/D MO
ADVAIR DISKUS	3	QL (2 per 1 day) MO
ADVAIR HFA	3	QL (0.48 per 1 day) MO
<i>albuterol sulfate er</i>	2	MO
<i>albuterol sulfate nebulization solution</i>	1	B/D MO
<i>albuterol sulfate tablet</i>	1	MO
<i>aminophylline tablet</i>	1	MO
ASMANEX 120 METERED DOSES	3	QL (0.24 per 25 days) MO
ASMANEX 14 METERED DOSES	3	QL (0.48 per 25 days) MO
ASMANEX 30 METERED DOSES AEROSOL POWDER BREATH ACTIVATED 110MCG/INH	3	QL (0.14 per 25 days) MO
ASMANEX 30 METERED DOSES AEROSOL POWDER BREATH ACTIVATED 220MCG/INH	3	QL (0.24 per 25 days) MO
ASMANEX 60 METERED DOSES	3	QL (0.24 per 25 days) MO
ASTEPRO	3	MO
<i>cromolyn sodium</i>	2	QL (8 per 1 day) B/D MO
DULERA	3	QL (0.52 per 1 day) MO
EPIPEN 2-PAK	4	MO
EPIPEN-JR 2-PAK	4	MO
<i>fexofenadine hcl tablet 180mg</i>	1	QL (1 per 1 day) MO
<i>fexofenadine hcl tablet 30mg, 60mg</i>	1	QL (2 per 1 day) MO

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Drug Name	Drug Tier	Requirements/Limits
FLOVENT DISKUS	3	QL (4 per 1 day) MO
FLOVENT HFA AEROSOL 44MCG/ACT	3	QL (0.85 per 1 day) MO
FLOVENT HFA AEROSOL 110MCG/ACT, 220MCG/ACT	3	QL (0.96 per 1 day) MO
FORADIL AEROLIZER	3	QL (2 per 1 day) MO
GASTROCROM	4	PA MO
<i>ipratropium bromide solution 0.03%</i>	1	QL (1 per 1 day) MO
<i>ipratropium bromide solution 0.06%</i>	1	QL (1.5 per 1 day) MO
LETAIRIS	5	QL (1 per 1 day) PA
NASONEX	3	MO
PATANASE	4	MO
PROAIR HFA	3	MO
PROVENTIL HFA	3	MO
SINGULAIR	3	QL (1 per 1 day) MO
SPIRIVA HANDIHALER	3	QL (1 per 1 day) MO
SYMBICORT AEROSOL 160MCG/ACT; 4.5MCG/ACT	3	QL (0.41 per 1 day) MO
SYMBICORT AEROSOL 80MCG/ACT; 4.5MCG/ACT	3	QL (0.55 per 1 day) MO
<i>theophylline er</i>	1	MO
TRACLEER	5	QL (2 per 1 day) PA LA
TYZINE	4	MO
TYZINE PEDIATRIC NASAL DROPS	4	MO
VENTOLIN HFA	4	MO
XOLAIR	5	QL (900 per 28 days) PA
<i>zafirlukast</i>	2	QL (2 per 1 day) MO
Sedatives/Hypnotics		
<i>butisol sodium</i>	1	QL (20 per 1 day) MO ED*
<i>estazolam tablet 2mg</i>	1	QL (1 per 1 day) MO ED*
<i>estazolam tablet 1mg</i>	1	QL (2 per 1 day) MO ED*
<i>flurazepam hcl</i>	1	QL (1 per 1 day) MO ED*
<i>midazolam hcl injection</i>	1	QL (1 per 1 day) MO ED*
<i>midazolam hcl syrup</i>	1	QL (10 per 1 day) MO ED*
<i>phenobarbital sodium injection 65mg/ml</i>	1	QL (4 per 1 day) MO ED*
<i>phenobarbital sodium injection 130mg/ml</i>	1	QL (5 per 1 day) MO ED*
<i>phenobarbital elixir</i>	1	QL (40 per 1 day) MO ED*
<i>phenobarbital tablet 64.8mg</i>	1	QL (3 per 1 day) MO ED*
<i>phenobarbital tablet 15mg, 16.2mg, 30mg, 32.4mg</i>	1	QL (4 per 1 day) MO ED*
<i>temazepam capsule 22.5mg, 30mg</i>	1	QL (1 per 1 day) MO ED*

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Drug Name	Drug Tier	Requirements/Limits
<i>temazepam capsule 7.5mg</i>	1	QL (2 per 1 day) MO ED*
<i>triazolam</i>	1	QL (2 per 1 day) MO ED*
Sleep Disorder Agents		
PROVIGIL	3	QL (2 per 1 day) PA MO
XYREM	5	QL (18 per 1 day) PA LA
<i>zaleplon capsule 10mg</i>	2	QL (2 per 1 day) MO
<i>zaleplon capsule 5mg</i>	2	QL (3 per 1 day) MO
<i>zolpidem tartrate er</i>	2	QL (1 per 1 day) MO
<i>zolpidem tartrate tablet 10mg</i>	1	QL (1 per 1 day) MO
<i>zolpidem tartrate tablet 5mg</i>	1	QL (2 per 1 day) MO
Therapeutic Nutrients/Minerals/ Electrolytes		
INTRALIPID	4	
<i>lactated ringers</i>	2	
<i>premasol injection 56meq/l; 320mg/100ml; 730mg/100ml; 190mg/100ml; 3meq/l; 20mg/100ml; 300mg/100ml; 220mg/100ml; 290mg/100ml; 490mg/100ml; 840mg/100ml; 490mg/100ml; 200mg/100ml; 290mg/100ml; 410mg/100ml; 230mg/100ml; 5meq/l; 15mg/100ml; 250mg/100ml; 120mg/100ml; 140mg/100ml; 470mg/100ml</i>	2	B/D
<i>ringers injection</i>	1	

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