

Community Health Group Healthy Families Drug Formulary

May 2012



Community Health Group Drug Formulary

Healthy Families Plan

Administered by MedImpact
May 2012
INTRODUCTION

Foreword

This document represents the efforts of the Community Health Group (CHG) Pharmacy and Therapeutics (P&T) Committee to provide physicians and pharmacists with a method to begin to evaluate the various drug products available. The medical treatment of patients is frequently relative to the practical application of drug therapy. Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the CHG's Healthy Families Drug Formulary is to enhance the physician's and pharmacist's abilities to provide optimal cost effective drug therapy for patients.

The development, maintenance, and improvement of this process are evolutionary and require constant attention. This is accomplished by the CHG P&T Committee, which is comprised of plan providers and pharmacists. The Formulary is a continually reviewed and revised list of drug products, which mirror the prevailing clinical opinion within the medical community. Unfortunately, this dynamic process does not allow this document to be completely accurate at all times. To accommodate the necessary changes of this document, updates are to be sent to providers regularly. As you use this Formulary, you are encouraged to review the information and provide your input and comments to the CHG P&T Committee.

The CHG P&T Committee uses the following criteria in the evaluation of product selection for the CHG Healthy Families Drug Formulary:

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

How to Use the Drug Formulary

The Drug Formulary is a list of covered and preferred drug agents for CHG members. All products are listed by their generic names, and a proprietary (branded) name. The Drug Formulary may be accessed by using the index, either by generic or proprietary name (in small capital letters) or by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by CHG shall be considered a Nonformulary drug.

All drugs are listed in each category in ascending order of cost. This is denoted by the relative dollar scale, described as follows:

\$	least expensive
\$\$	slightly more expensive
\$\$\$	more expensive
\$\$\$\$	significantly more expensive
\$\$\$\$\$	most expensive

The prices used to calculate the relative dollar scale are based on the monthly cost of therapy or cost of treatment course to allow for dosing interval differences between various products. The number of dollar signs is a relative indication of cost and does not represent the true cost of the drug. For example, two dollar signs do not mean that a product is twice as expensive as a product with one dollar sign. They are intended only to provide general information regarding cost. Economics should not be the only factor involved with any therapeutic and clinical decision process. Price comparisons are reflective of pricing and contracts available through **MedImpact**. While this document can provide you with good information which can be used for non-health plan patients, it may not accurately reflect the drug cost for non-health plan patients.

Coverage Limitations

The formulary does not provide information regarding the specific coverage and limitations an individual member may have. Many members have specific exclusions, copays, or a lack of coverage that is not reflected in the Drug Formulary.

The Drug Formulary applies only to outpatient drugs provided to members, and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact their Health Plan or **MedImpact** at (800) 788-2949.

The following general exclusions pertain to all covered individuals:

- A. Over the Counter (OTC) medications or their equivalents are not covered, unless otherwise specified in the Formulary listing.
- B. Drug Products not listed in the Drug Formulary, or specifically listed as not covered are not covered.
- C. Any drug products used for cosmetic purposes are not covered.
- D. Experimental drug products, or any drug product used in an experimental manner are not covered.
- E. Injectable drug products, other than insulin or as otherwise noted, are not covered.

Age Restriction (AGE)

Drugs marked with an age restriction (AGE) are available as formulary agents for patients meeting age criteria. Members who do not meet age criteria may be approved for the age-restricted formulary item if prior authorization criteria are met. Drugs used to treat CCS-eligible conditions may have an age restriction to review for CCS eligibility.

Age & Specialty Restriction (AGE, MD)

Drugs marked with age and physician specialty restrictions (AGE, MD) are available as formulary agents for patients meeting both age criteria and physician specialty criteria. Members who do not meet age and/or physician specialty criteria may be approved if prior authorization criteria are met. For drugs used to treat CCS-eligible conditions, the members less than 21 years of age must be reviewed for CCS eligibility even if the prescriber meets the physician specialty restriction.

Step Therapy

Medications with this notation require a previous trial with a first-line agent. Members with a claims history in the system, which meets these criteria, will receive automatic approval for the second-line agent. Claims that are not automatically approved will be processed by the standard Medical Exception Request process. Please refer to the Medical Exception Request section for procedures.

Physician Specialty Restriction (MD)

Drugs marked with a physician specialty restriction (MD) are available as formulary agents for certain medical specialists. For other practitioners, the restricted formulary item may be approved if prior authorization criteria are met.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. *The brand names listed are for reference use only, and do not denote coverage, unless specifically noted.* Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state

statutes that may exist. All drugs that are or become available generically are subject to review by CHG's Pharmacy and Therapeutics Committee. MedImpact approves such multisource drugs for addition to the MAC list based on the following criteria:

- A minimum of two sources of the product.
- A FDA Rating for generic equivalency.
- Review by the P & T Committee for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic index (NTI), or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - ◊ Dilantin
 - ◊ Neoral Solution
 - ◊ Premarin
 - ◊ Synthroid
 - ◊ Tegretol XR

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products.

If a member or physician requests a brand name product in lieu of an approved generic, the member may be required to pay the difference in cost between the brand and the generic. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medical exception process.

Experimental Drugs

The experimental nature or use of drug products will be determined by the P & T Committee using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

Medical Exception Process

Coverage for nonformulary agents may be applied for in advance by physicians. When a member gives a prescription order for a nonformulary drug to a pharmacist, the pharmacist will evaluate the patient's drug history and contact the physician to determine if there is a legitimate medical need for a nonformulary drug. The physician or pharmacist will then call MedImpact at (800) 788-2949, to be given an authorization number. The following general criteria are used:

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

The P & T Committee recognizes that not all medical needs can be met with this document and encourages inquiries about alternative therapies.

Prior Authorization

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

- A. Fax a completed **Prior Authorization Request** to MedImpact at (858) 790-7100.
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by the P & T Committee, the request will be denied and alternative therapy will be recommended. Each request will be reviewed on individual patient need. Approval will be given if a documented medical need exists.

Once approved, MedImpact will provide the physician or pharmacist with a prior authorization number, specific for the medical need.

NOTE: Failure to submit a **Prior Authorization** for a listed drug will result in a denial of coverage for the health plan member.

Pharmacist and Physician Communication

The Drug Formulary is a tool to promote cost effective prescription drug use. The P & T Committee has made every attempt to create a document which meets all therapeutic needs; however, the art of medicine makes this a formidable task. CHG welcomes the participation of physicians, pharmacists, and ancillary medical providers, in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions, comments or formulary additions to CHG at the following address:

Chairman, Pharmacy & Therapeutics Committee
Community Health Group
740 Bay Boulevard
Chula Vista, CA 91910

COMMUNITY HEALTH GROUP

Medication Request Form (MRF)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

c/o MedImpact Healthcare Systems, Inc

Attn: Prior Authorization Department
10680 Treena Street, Suite 500
San Diego, CA 92131
Phone: 1-(800) 788-2949 Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:

This form is to be used by participating physicians and providers to obtain coverage for a nonformulary drug for which there is no suitable alternative available. Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

Review Criteria:

The following criteria is used in reviewing medical exceptions:

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

Medication Request Information (please complete each section of this form prior to transmittal):

DATE OF REQUEST: _____

<u>Patient Name (required):</u>	<u>Patient's Health Plan (required):</u>
<u>Patient ID # (required):</u>	<u>Physician Name/Specialty:</u>
	<u>Physician License #:</u>
<u>Patient DOB (required):</u>	<u>Physician Area Code and Telephone Number:</u> () -
<u>Diagnosis (required):</u>	<u>Physician Area Code and Fax Number (required):</u> () -
<u>Pharmacy used by Member:</u>	<u>Pharmacy Area Code and Telephone Number:</u> () -
<u>Drug Requested:</u>	<u>Quantity (per month):</u>
<u>Dose:</u>	<u>Length of Treatment (please be specific):</u>
<u>Strength:</u>	<u>Dosage Form (e.g. Oral, Injection)</u>
Reason for Medication Request (please be specific, give detail):	
Other Medications Tried and/or Failed (please be specific, give detail):	
Other Pertinent History (relative or pertaining to this request):	

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

\$	Diclofenac Potassium	CATAFLAM (ZIPSOR NONFORMULARY)
\$	Diclofenac Sodium	VOLTAREN
\$	Flurbiprofen	ANSAID
\$	Ibuprofen	MOTRIN
\$	Indomethacin	INDOCIN (INDOCIN SUPP NONFORMULARY)
\$	Naproxen	NAPROSYN
\$\$	Choline Mag. Trisalicylate	TRILISATE
\$	Naproxen Sodium	ANAPROX ANAPROX DS
\$	Salsalate	DISALCID
\$	Sulindac	CLINORIL
\$\$	Etodolac	LODINE
\$\$	Fenoprofen	NALFON (NALFON CAPSULES NONFORMULARY)
\$\$	Indomethacin, Sustained Release	INDOCIN SR
\$\$	Meclofenamate	MECLOMEN

SECOND LINE AGENTS

QL	\$\$	Ketoprofen	ORUVAIL, QL OF #4 / DAY (EFFECTIVE 2/15/12) (COMPOUNDED KETOPROFEN NONFORMULARY). QL OF #4/DAY.
QL	\$\$	Ketorolac	TORADOL, LIMITED TO 5 DAYS TREATMENT (EFFECTIVE 2/15/12) QL OF #20/5 DAYS SUPPLY
QL	\$\$	Meloxicam	MOBIC, QL OF #1 / DAY (EFFECTIVE 2/15/12) (MELOXICAM SUSPENSION NONFORMULARY). QL OF #1/DAY
QL	\$\$	Nabumetone	RELAFEN, QL OF #2 / DAY (EFFECTIVE 2/15/12). QL OF #2/DAY.
	\$\$\$	Etodolac, Sustained Release	LODINE (LODINE XL NONFORMULARY)
AGE, STEP	\$\$\$\$	Celecoxib	CELEBREX, RESTRICTED TO MEMBERS ≥60 YEARS OF AGE OR ON CONCURRENT WARFARIN, MEMBERS <21 YEARS MAY BE CCS ELIGIBLE (400MG STRENGTH NONFORMULARY),

Miscellaneous Arthritis Agents

	\$\$	Leflunomide	ARAVA (EFFECTIVE 5/15/10)
PA	\$\$\$\$\$	Adalimumab	HUMIRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)
PA	\$\$\$\$\$	Etanercept	ENBREL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)

Migraine Agents

\$	APAP/Dichloralphenazone/Isometh	MIDRIN
\$	Butalbital/APAP/Caffeine	ESGIC ESGIC PLUS
\$	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
\$\$	Ergotamine/Caffeine	CAFERGOT
\$\$	Sumatriptan Tablets	IMITREX TABLETS, QUANTITY LIMIT OF 9 TABLETS PER MONTH
\$\$\$\$	Sumatriptan Injection	IMITREX INJECTION, QUANTITY LIMIT OF 2 INJECTIONS PER MONTH

\$\$\$\$	Sumatriptan Nasal	IMITREX NASAL, QUANTITY LIMIT OF 6 NASAL SPRAYS PER MONTH
\$\$\$\$\$	Dihydroergotamine	D.H.E. 45 MIGRANAL, LIMITED TO 1 KIT PER MONTH

Opiate Agonists

\$	Acetaminophen/Codeine	TYLENOL #2, MAXIMUM #60/RX, 3 RXS/75 DAYS TYLENOL #3, MAXIMUM #45/RX, 3 RXS/75 DAYS TYLENOL #4, MAXIMUM #45/RX, 3 RXS/75 DAYS (Capsules and VOPAC NONFORMULARY)
QL	\$ Acetaminophen/Hydrocodone	VICODIN, VICODIN ES, NORCO, LORCET, LORCET PLUS MEDICAL QUANTITY RESTRICTION, 3 RXS / 75 DAYS, GENERICS ONLY. QL OF MAXIMUM #6/DAY. FILL LIMIT OF #3/75DAYS. SOLUTION QL OF MAXIMUM #1770 ML/MO. FILL LIMIT OF #3/75DAYS. LORCET LORCET PLUS EMPIRIN #2, #3, #4, QL LIMIT, FILL LIMIT 3 RXS / 75 DAYS PERCOCET TYLOX PERCODAN DARVOCET-N 100 (DARVOCET A 500 & TRYCET NONFORMULARY) FIORICET/CODEINE FIORINAL/CODEINE DHC PLUS DILAUDID (DILAUDID SYRUP NONFORMULARY) DEMEROL OXYIR, PA REQ MSIR, MAXIMUM #90/RX, 3 RX/75 DAYS (EFFECTIVE 5/1/10) MS CONTIN (KADIAN AND AVINZA NONFORMULARY) DURAGESIC, PA REQ (EFFECTIVE 8/1/10), MEMBERS <21 YEARS MAY BE CCS ELIGIBLE
\$	Codeine/Aspirin	
\$	Oxycodone/Acetaminophen	
\$	Oxycodone/Aspirin	
\$	Propoxyphene Napsylate/APAP	
\$\$	Butalbital/APAP/Caffeine/Codeine	
\$\$	Butalbital/Aspirin/Codeine	
\$\$	Dihydrocodeine/APAP/Caffeine	
\$\$	Hydromorphone	
PA	\$\$ Meperidine	
	\$\$ Oxycodone	
	\$\$\$ Morphine	
	\$\$\$ Morphine SR	
PA	\$\$\$\$ Fentanyl Transdermal Patch	

Opiate Antagonists

\$\$\$	Naltrexone	REVIA
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Miscellaneous Analgesics

\$	Tramadol	ULTRAM, LIMITED TO 8 TABLETS/DAY (ULTRAM ER NONFORMULARY)
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Miscellaneous Central Nervous System Agents

QL	\$ Donepezil	ARICEPT, QL OF #1 / DAY (ARICEPT ODT – PA REQUIRED)
PA	\$\$\$ Galantamine	RAZADYNE, PA REQ
PA	\$\$\$ Rivastigmine	EXELON, PA REQ (EXELON PATCHES NONFORMULARY)

Anticonvulsant Agents

AGE	\$ Carbamazepine	TEGRETOL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$ Clonazepam	KLONOPIN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE, QUANTITY LIMIT OF #90/MO; FILL LIMITS OF #3 IN 75DAYS (KLONOPIN WAFERS NONFORMULARY)
QL		
AGE	\$ Phenobarbital	PHENOBARBITAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$ Phenytoin	DILANTIN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE

AGE	\$\$	Divalproex Sodium	DEPAKOTE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Gabapentin	NEURONTIN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Lamotrigine Tablets	LAMICTAL TABLETS, HALF TABLET EDITS, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 8/1/09)
			(LAMICTAL DOSE PACK, LAMICTAL XR, LAMICTAL ODT, & LAMOTRIGINE DISPERSIBLE TABLETS NONFORMULARY)
AGE	\$\$	Mephobarbital	MEBARAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Primidone	MYSOLINE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Valproic Acid	DEPAKENE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$	Carbamazepine SR	TEGRETOL XR, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
			(EQUETRO NONFORMULARY)
AGE	\$\$\$	Oxycarbazepine	TRILEPTAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
PA	\$\$\$	Tiagabine	GABITRIL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$	Zonisamide	ZONEGRAN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$\$	Levetiracetam	KEPPRA, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$\$	Topiramate	TOPAMAX, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE

Antiparkinsonian Agents

AGE	\$	Benzotropine Mesylate	COGENTIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Trihexyphenidyl	ARTANE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Amantadine	SYMMETREL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Carbidopa/Levodopa	SINEMET, MEMBERS <21 MAY BE CCS-ELIGIBLE (PARCOPA NONFORMULARY)
			KEMADRIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Procyclidine	SINEMET CR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Carbidopa/Levodopa CR	PARLODEL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Bromocriptine	MIRAPEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(MIRAPEX ER NONFORMULARY)
AGE	\$\$\$	Ropinirole	REQUIP, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(REQUIP XL NONFORMULARY)
AGE	\$\$\$\$	Entacapone	COMTAN, MEMBERS <21 MAY BE CCS-ELIGIBLE

Muscle Relaxant Agents

Skeletal Muscle Relaxants

\$	Carisoprodol	SOMA (250MG TABLETS NONFORMULARY)
\$	Cyclobenzaprine	FLEXERIL VALRELEASE NOT COVERED
\$	Methocarbamol	ROBAXIN
\$\$	Baclofen	LIORESAL
\$\$	Carisoprodol/Aspirin	SOMA COMPOUND
\$\$	Chlorzoxazone	PARAFON DSC
\$\$	Orphenadrine/Aspirin/Caffeine	NORGESIC

\$\$	Tizanidine	NORGESIC FORTE ZANAFLEX TABLETS (ZANAFLEX CAPSULES NONFORMULARY)
\$\$\$	Dantrolene Sodium	DANTRIUM
\$\$\$	Metaxalone	SKELAXIN
\$\$\$	Orphenadrine Citrate	NORFLEX

Psychotherapeutic Agents

Tricyclic Antidepressant Agents

\$	Amitriptyline	ELAVIL
\$	Desipramine	NORPRAMIN
\$	Doxepin	SINEQUAN
\$	Imipramine	TOFRANIL (TOFRANIL PM NONFORMULARY)
\$	Nortriptyline	PAMELOR AVENTYL VIVACTIL
\$\$\$	Protriptyline	

S.S.R.I. Agents

\$	Citalopram	CELEXA
\$	Fluoxetine	PROZAC (USE 2 X 20MG FOR 40MG DOSE) RAPIFLUX
\$	Paroxetine	PAXIL
MD	Fluvoxamine	LUVOX, SPECIALTY RESTRICTION (EFFECTIVE 5/1/10) (LUVOX CR NONFORMULARY)
PA	Sertraline	ZOLOFT
PA	Paroxetine CR	PAXIL CR, PA REQ
PA	Escitalopram Oxalate	LEXAPRO, PA REQ

S.N.R.I. Agents

QL	Venlafaxine	EFFEXOR QL OF #1/DAY EFFEXOR ER CAPSULES, QL #1/DAY EFFEXOR XR CAPSULES, QL OF #1 / DAY VENLAFAXINE XR TABLETS STEP THERAPY (TRIAL OF FORMULARY SSRI)
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M.A.O. Inhibitor Agents

\$\$	Phenelzine	NARDIL
\$\$	Tranylcypromine	PARNATE

Miscellaneous Antidepressant Agents

\$	Clomipramine	ANAFRANIL
\$	Trazodone	DESYREL
\$\$	Mirtazapine Tablets	REMERON TABLETS (7.5MG TABLETS NONFORMULARY, SOLTABS NONFORMULARY)
\$\$	Nefazodone	SERZONE
\$\$\$	Bupropion	WELLBUTRIN WELLBUTRIN SR (WELLBUTRIN XL, APLENZIN NON-FORMULARY)

Antimanic Agents

\$	Lithium Carbonate (All Forms)	ESKALITH LITHOBID
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Benzodiazepines

QL	Alprazolam	XANAX QUANTITY LIMIT OF #90/MO; FILL LIMITS OF #3 IN 75DAYS (EFFECTIVE 3/1/11) (XANAX XR & NIRAVAM NONFORMULARY)
\$	Chlordiazepoxide	LIBRIUM

	\$	Diazepam	VALIUM QUANTITY LIMIT OF #60/MO; FILL LIMITS OF #3 IN 75DAYS (EFFECTIVE 3/1/11) (VALRELEASE NONFORMULARY)
	\$	Flurazepam	DALMANE
QL	\$	Lorazepam	ATIVAN, QUANTITY LIMIT OF #60/MO; FILL LIMITS OF #3 IN 75DAYS (EFFECTIVE 3/1/11)
	\$	Temazepam	RESTORIL (7.5MG & 22.5MG STRENGTHS NONFORMULARY)
	\$\$	Clorazepate	TRANXENE (TRANXENE SD NONFORMULARY)
	\$\$	Oxazepam	SERAX

Antipsychotic Agents

	\$	Chlorpromazine	THORAZINE (THORAZINE SPANSULE NONFORMULARY)
	\$	Fluphenazine	PROLIXIN
	\$	Haloperidol	HALDOL
	\$	Perphenazine	TRILAFON
	\$	Thioridazine	MELLARIL
	\$	Thiothixene	NAVANE
	\$	Trifluoperazine	STELAZINE
	\$\$	Loxapine	LOXITANE
	\$\$\$	Quetiapine	SEROQUEL
	\$\$\$	Risperidone	RISPERDAL (RISPERDAL-M NONFORMULARY)
MD	\$\$\$\$	Olanzapine	ZYPREXA, RESTRICTED
MD			ZYPREXA ZYDIS, RESTRICTED
PA	\$\$\$\$	Fanapt	ILOPERIDONE, PA Required
PA	\$\$\$\$	Saphris	ASENAPINE MALEATE, PA Required

Miscellaneous Anxiolytics, Sedatives, and Hypnotics

	\$	Chloral Hydrate	NOCTEC
	\$	Hydroxyzine	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
QL	\$	Zolpidem	AMBIEN, QUANTITY LIMITED TO #30 PER MONTH (AMBIEN CR, EDLUAR NON-FORMULAY)
	\$\$	Buspirone	BUSPAR
QL	\$\$\$	Zaleplon	SONATA, QUANTITY LIMITED TO #30 PER MONTH

ADHD Agents

		<i>(Not Covered as Appetite Suppressants)</i>	
	\$	Methylphenidate	RITALIN (EFFECTIVE 3/1/09)
AGE	\$\$	Amphetamine Aspartate/Amphetamine/ Dextro-amphetamine	ADDERALL, MEMBERS > 18 YEARS REQUIRE PA
AGE, STE P	\$\$	Dexmethylphenidate	FOCALIN, MEMBERS ≤ 18 REQUIRE STEP THERAPY (METHYLPHENIDATE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Dextroamphetamine	DEXEDRINE, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	RITALIN SR, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METADATE CD, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METADATE ER, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METHYLIN ER, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	RITALIN LA, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$\$	Amphetamine Aspartate/Amphetamine/ Dextro-amphetamine	ADDERALL XR, MEMBERS > 18 YEARS REQUIRE PA

AGE, \$\$\$	Dexmethylphenidate	FOCALIN XR, MEMBERS ≤ 18 REQUIRE STEP THERAPY (METHYLPHENIDATE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
STE		
P		
PA \$\$\$	Lisdexamfetamine	VYVANSE, PA REQ
AGE \$\$\$	Methylphenidate	CONCERTA, MEMBERS > 18 YEARS REQUIRE PA
PA \$\$\$\$	Atomoxetine	STRATTERA, PA REQ

CARDIOVASCULAR/BLOOD AGENTS (May be eligible for CCS coverage.)

Antiarrhythmic Agents

AGE \$	Amiodarone 200mg	CORDARONE, MEMBERS <21 MAY BE CCS-ELIGIBLE (OTHER AMIODARONE STRENGTHS NONFORMULARY)
AGE \$	Mexiletine	MEXITIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Procainamide	PRONESTYL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Procainamide SR	PROCAN SR, MEMBERS <21 MAY BE CCS-ELIGIBLE
		PROCANBID, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Quinidine Sulfate	QUINIDINE SULFATE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Sotalol	BETAPACE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Disopyramide	NORPACE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Disopyramide CR	NORPACE CR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Flecainide	TAMBOCOR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Quinidine Gluconate	QUINAGLUTE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Quinidine Sulfate SR	QUINIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$\$\$	Dofetilide	TIKOSYN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$\$\$	Propafenone	RYTHMOL, MEMBERS <21 MAY BE CCS-ELIGIBLE (RYTHMOL SR NONFORMULARY)

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

AGE \$	Reserpine	SERPASIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
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Beta-Adrenergic Antagonist Agents

AGE \$	Atenolol	TENORMIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Atenolol/Chlorthalidone	TENORETIC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Bisoprolol/HCTZ	ZIAC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Metoprolol	LOPRESSOR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Nadolol	CORGARD, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Pindolol	VISKEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Propranolol	INDERAL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Metoprolol Succinate	TOPROL XL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Propranolol LA	INDERAL LA, MEMBERS <21 MAY BE CCS-ELIGIBLE

Combination Alpha-Beta Antagonist Agents

AGE \$	Labetalol	NORMODYNE, MEMBERS <21 MAY BE CCS-ELIGIBLE
		TRANDATE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$\$	Carvedilol	COREG, MEMBERS <21 MAY BE CCS-ELIGIBLE (COREG CR NONFORMULARY)

Angiotensin Converting Enzyme Inhibitor Agents

AGE \$	Benazepril	LOTENSIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Benazepril/HCTZ	LOTENSIN HCT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Captopril	CAPOTEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE \$	Captopril/HCTZ	CAPOZIDE, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE	\$	Enalapril	VASOTEC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Lisinopril	ZESTRIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Lisinopril/HCTZ	ZESTORETIC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Ramipril	ALTACE (10MG STRENGTH ONLY) , MEMBERS <21 MAY BE CCS-ELIGIBLE

Angiotensin Receptor Blocker Agents

QL	\$	Losartan	COZAAR QL OF 1/DAY
QL	\$	Losartan/HCTZ	HYZAAR QL OF #1/DAY

Calcium Channel Blocking Agents

QL	\$	Diltiazem	CARDIZEM
AGE	\$	Nifedipine	ADALAT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Verapamil	PROCARDIA, MEMBERS <21 MAY BE CCS-ELIGIBLE
QL	\$\$	Amlodipine	CALAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$	Diltiazem ER (24 hr)	NORVASC, #30/RX IN 21 DAYS (EFFECTIVE 4/1/11)
			Diltiazem ER 24hr (QL OF #1 / DAY)
			Cardizem CD (QL OF #1 / DAY)
			Diltia XT(QL OF #1 / DAY)
			(Cardizem LA – Nonformulary) (Effective 4/1/12)
	\$\$	Diltiazem ER (12 hr)	Diltiazem ER 12hr (QL of #2 / day)
AGE	\$\$	Felodipine	Cardizem SR (QL of #2 / day) (Effective 4/1/12)
AGE	\$\$	Nifedipine, Sustained Release	PLENDIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Verapamil SR Tablets	ADALAT CC, MEMBERS <21 MAY BE CCS-ELIGIBLE
			CALAN SR, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(COVERA-HS NONFORMULARY)
AGE	\$\$	Verapamil LA Capsules	VERELAN, MEMBERS <21 MAY BE CCS-ELIGIBLE

Centrally Acting Antihypertensive Agents

AGE	\$	Clonidine	CATAPRES, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Guanfacine	TENEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(INTUNIV NONFORMULARY)
AGE	\$	Methyldopa	ALDOMET, MEMBERS <21 MAY BE CCS-ELIGIBLE

Potassium-Sparing Diuretics

AGE	\$	Spironolactone	ALDACTONE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Triamterene 37.5mg/HCTZ 25mg	MAXZIDE 25, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50, MEMBERS <21 MAY BE CCS-ELIGIBLE

Loop Diuretics

AGE	\$	Furosemide	LASIX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Bumetanide	BUMEX, MEMBERS <21 MAY BE CCS-ELIGIBLE

Thiazide and Related Diuretics

AGE	\$	Chlorthalidone	HYGROTON, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Hydrochlorothiazide (HCTZ)	HYDRODIURIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Indapamide	LOZOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Metolazone	ZAROXOLYN, MEMBERS <21 MAY BE CCS-ELIGIBLE

Vasodilator Antihypertensive Agents

AGE	\$	Doxazosin Mesylate	CARDURA, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(CARDURA XL NONFORMULARY)
AGE	\$	Hydralazine	APRESOLINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Prazosin	MINIPRESS, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Terazosin	HYTRIN, MEMBERS <21 MAY BE CCS-ELIGIBLE

Antilipidemic Agents

	\$	Cholestyramine	QUESTRAN
	\$	Gemfibrozil	QUESTRAN LIGHT
			LOPID

	\$	Lovastatin	MEVACOR
	\$	Simvastatin	ZOCOR
PA	\$\$	Atorvastatin	LIPITOR, PA REQUIRED ON ALL STRENGTHS EXCEPT 80MG TABLETS; TABLET SPLITTING REQUIRED (USE ½ 80MG FOR 40MG DOSE; USE ½ 40MG FOR 20MG DOSE; USE ½ 20MG FOR 10MG DOSE) (EFFECTIVE 2/15/12) QL OF #1/DAY
QL			
ST	\$\$\$	Rosuvastatin	CRESTOR STEP THERAPY REQUIRED ON ALL STRENGTHS EXCEPT 40MG TABLETS (TRIAL OF SIMVASTATIN 40MG AND ATORVASTATIN REQUIRED) (EFFECTIVE 2/15/12) GRANDFATHER ALL CURRENT USERS. QL OF #1/DAY
QL			
STEP	\$\$	Fenofibrate	LOFIBRA, STEP THERAPY (TRIAL OF GEMFIBROZIL OR CONCURRENT STATIN REQUIRED) (TRICOR, TRIGLIDE, LIPOFEN, FENOGLIDE, ANTARA, TRILIPIX NONFORMULARY) (EFFECTIVE 8/15/09)
	\$\$	Niacin, Delayed Release	NIASPAN
	\$\$	Pravastatin	PRAVACHOL, ½ TABLET (EFFECTIVE 3/1/09)
	\$	Fish Oil, over-the-counter	FISH OIL, OVER-THE-COUNTER (EFFECTIVE 4/1/12)

Blood Agents

Anticoagulants

AGE	\$	Warfarin Sodium	COUMADIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Dalteparin syringes	FRAGMIN SYRINGES, LIMITED TO 10 SYRINGES/FILL AND 2 FILLS/YEAR
	\$		
	\$\$\$\$	Enoxaparin Syringes	LOVENOX SYRINGES, LIMITED TO 10 SYRINGES/FILL AND 2 FILLS/YEAR
	\$		
	\$\$\$\$	Fondaparinux	ARIXTRA, LIMITED TO 20 SYRINGES/FILL AND 2 FILLS/YEAR
	\$		
	\$\$\$\$	Tinzaparin	INNOHEP, LIMITED TO 10 VIALS/FILL AND 2 FILLS/YEAR
	\$		

Hemorrhologic Agents

AGE	\$	Pentoxifylline	TRENTAL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Cilostazol	PLETAL, MEMBERS <21 MAY BE CCS-ELIGIBLE

Cardiac Glycoside Agents

AGE	\$	Digoxin	LANOXIN, MEMBERS <21 MAY BE CCS-ELIGIBLE (LANOXICAP NONFORMULARY)
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Antiplatelet Agents

AGE	\$\$	Anagrelide	AGRYLIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Ticlopidine	TICLID, MEMBERS <21 MAY BE CCS-ELIGIBLE
ST,	\$\$	Aspirin/dipyridamole	AGGRENOX STEP THERAPY OF A TRIAL OF ASPIRIN (EFFECTIVE 12/28/11); MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE			
AGE,	\$\$\$	Clopidogrel	PLAVIX, MEMBERS <21 MAY BE CCS-ELIGIBLE; QUANTITY LIMITED TO #30 IN 30 DAYS.
QL			

Vasodilating Agents

	\$	Isosorbide Dinitrate	ISORDIL
	\$	Nitroglycerin Sublingual	NITROSTAT SL
	\$	Nitroglycerin Ointment	NITROL
	\$\$	Isosorbide Mononitrate	IMDUR
			MONOKET
	\$\$	Nitroglycerin Oral	NITROGLYN E-R

PA \$\$ Nitroglycerin Patches
 PA \$\$\$ Nitroglycerin Spray

NITRODUR, **PA REQ**
 NITROLINGUAL SPRAY, **PA REQ**

Agents for Pulmonary Hypertension

PA, Sildenafil Citrate
 AGE
 PA, Tadalafil Tablets
 AGE

REVATIO, **PA REQ** CCS AGE EDIT (MEMBERS<21 MAY BE CCS ELGIBILE). **(EFFECTIVE 6/1/11)**
 ADCIRCA, **PA REQ** CCS AGE EDIT (MEMBERS<21 MAY BE CCS ELGIBILE). **(EFFECTIVE 6/1/11)**

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

\$ Diphenoxylate/Atropine

LOMOTIL

Anti-emetic Agents

\$ Meclizine
 \$ Metoclopramide
 \$ Prochlorperazine Maleate
 AGE \$ Promethazine
 \$ Trimethobenzamide
 AGE, \$\$ Ondansetron Tablets and ODT
 QL

ANTIVERT
 REGLAN (METOCLOPRAMIDE INTENSOL NONFORMULARY)
 (METOZOLV ODT NONFORMULARY)
 COMPAZINE
 PHENERGAN, **USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION**
 TIGAN
 ZOFRAN TABLETS AND ODT, **MEMBERS <21 MAY BE CCS-ELIGIBLE, QUANTITY LIMIT OF 72MG PER FILL AND 1 FILL PER MONTH, ONDANSETRON SOLUTION PA REQUIRED (ODT PREFERRED FOR PATIENTS UNABLE TO SWALLOW TABLETS) (EFFECTIVE 5/1/09)**

Antimuscarinic/Antispasmodic Agents

\$ Belladonna/Phenobarbital (Extentab
 Not Covered)
 \$ Dicyclomine
 \$ Hyoscyamine Sulfate

DONNATAL
 BENTYL
 LEVSIN
 LEVBID

Anti-ulcer/Antipeptic Agents

\$ Cimetidine
 \$ Famotidine
 \$ Misoprostol
 QL \$ Omeprazole
 \$ Ranitidine
 \$\$ Omeprazole (Federal Legend) 10mg
 capsules
 \$\$ Sucralfate

TAGAMET
 PEPCID
 CYTOTEC
 PRILOSEC; QL OF #1 / DAY (OTC VERSIONS NON-FORMULARY) (EFFECTIVE 4/1/12).
 ZANTAC
 (ZANTAC EFFERDOSE NONFORMULARY)
 PRILOSEC (FEDERAL LEGEND) 10MG CAPSULES LIMIT OF #30 CAPSULES (PATIENTS REQUIRING DOSE GREATER THAN 10MG SHOULD USE OMEPRAZOLE 20MG)
 (ZEGERID AND OMEPRAZOLE 40MG NONFORMULARY)
 CARAFATE

ST	\$\$	Lansoprazole OTC 15mg Capsules	PREVACID 24HR, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5 DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE). (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
ST	\$\$	Lansoprazole 30mg Capsules	PREVACID 30MG CAPSULES, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5 DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE). (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
AGE, STEP	\$\$\$	Lansoprazole Solutabs	PREVACID SOLUTABS, AGE RESTRICTION & STEP THERAPY (RESTRICTED TO MEMBERS <6 YEARS OF AGE AND A HISTORY OF A TRIAL OF RANITIDINE IN THE PREVIOUS 120 DAYS, MEMBERS THAT DO NOT MEET BOTH CRITERIA REQUIRE PA) , PREVACID OTC 15MG AND PREVACID 30MG CAPSULES PREFERRED OVER SOLUTABS FOR PATIENTS WHO ARE ABLE TO SWALLOW CAPSULES (EFFECTIVE 2/1/10) (5 DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE).
AGE	\$\$\$	Mesalamine	PENTASA, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/09)
AGE	\$\$\$	Olsalazine	DIPENTUM, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/09)
QL	\$\$\$	Pantoprazole	PROTONIX QL OF #1 PER DAY

Bowel Evacuant Agents

\$	Oral Colon Lavage Solution	COLYTELY GOLYTELY
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Digestive Enzymes

AGE	\$\$\$	Amylase/Lipase/Protease	CREON, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
AGE			PANCREAZE, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
AGE			ZENPEP, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)

Gallstone Solubilizing Agents

\$\$\$	Ursodiol	ACTIGALL (URSO FORTE NONFORMULARY)
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Gastrointestinal Stimulant Agents

\$	Metoclopramide	REGLAN
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Laxative Agents

\$\$	Lactulose	CEPHULAC CHRONULAC
\$\$	Polyethylene Glycol 3350	MIRALAX

Ulcer Eradication Agents

\$\$\$\$	Ranitidine/Bismuth Citrate	TRITEC
\$\$\$\$	Tetracycline/Bismuth/Metronidazole	HELIDAC

ANTI-INFECTIVE AGENTS

Amebicides

\$	Metronidazole Tablets	FLAGYL TABLETS (FLAGYL ER AND METRONIDAZOLE CAPSULES NONFORMULARY)
\$\$	Iodoquinol (Diiodohydroxyquin)	YODOXIN
\$\$\$	Paromomycin	HUMATIN

Antihelmintic Agents

\$	Mebendazole	VERMOX
\$	Thiabendazole	MINTEZOL
\$\$	Furazolidone	FUROXONE
\$\$\$\$	Praziquantel	BILTRICIDE

Antibiotic Agents

Aminoglycosides

\$	Neomycin Sulfate	NEOMYCIN
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Cephalosporins

\$	Cephalexin	KEFLEX (KEFLEX 750MG STRENGTH NONFORMULARY)
\$\$	Cefdinir	OMNICEF
\$\$	Cefuroxime Axetil	CEFTIN
\$\$\$	Cefadroxil	DURICEF
\$\$\$	Cefprozil	CEFZIL

Macrolide Antibiotic Agents

\$	Erythromycin Base	ERY-TAB
\$	Erythromycin Stearate	ERYTHROCIN
\$	Erythromycin Ethylsuccinate	EES ERYPED SUSPENSION
\$\$	Azithromycin	ZITHROMAX (ZMAX NONFORMULARY)
\$\$	Clarithromycin	BIAXIN
\$\$	Erythromycin Estolate (Suspension Only)	ILOSONE SUSPENSION
\$\$	Erythromycin/Sulfisoxazole	PEDIAZOLE

Miscellaneous Antibiotic Agents

	\$	Metronidazole	FLAGYL
	\$\$	Clindamycin Capsules	CLEOCIN CAPSULES
AGE	\$\$\$	Clindamycin Oral Solution	CLEOCIN ORAL SOLUTION, LIMITED TO USE IN PATIENTS 6 YEARS OF AGE AND YOUNGER
PA	\$\$\$\$	Linezolid	ZYVOX, PA REQ
	\$		
PA	\$\$\$\$	Vancomycin	VANCOCIN, PA REQ
	\$		

Penicillins

\$	Amoxicillin	AMOXIL TRIMOX
\$	Ampicillin	PRINCIPEN
\$	Dicloxacillin	DYNAPEN
\$	Penicillin VK (125mg Tablets Not Covered)	PEN VK
\$\$	Amoxicillin/Potassium Clavulanate	AUGMENTIN

Quinolones

\$	Ciprofloxacin	CIPRO
\$\$	Ciprofloxacin	CIPRO XR (PROQUIN XR NONFORMULARY)
\$\$	Norfloxacin	NOROXIN
\$\$\$	Levofloxacin	LEVAQUIN

Tetracyclines

\$	Doxycycline (Tablets, Capsules Only)	VIBRAMYCIN VIBRA-TABS (ORACEA, ADOXA, DORYX ARE NONFORMULARY)
\$	Tetracycline	ACHROMYCIN V SUMYCIN
\$\$	Minocycline Capsules	MINOCIN CAPSULES OTHER MINOCYCLINE DOSAGE FORMS NON-FORMULARY

Antifungal Agents

\$	Fluconazole Tablets	DIFLUCAN TABLETS	
\$	Ketoconazole	NIZORAL	
\$	Nystatin (Oral Powder Not Covered)	MYCOSTATIN	
\$\$	Clotrimazole	MYCELEX TROCHE	
\$\$	Griseofulvin Tablets	GRISPEG GRIFULVIN V TABLETS	
QL	Terbinafine Tablets	LAMISIL TABLETS, LIMITED TO 90 TABLETS PER 9 MONTHS (LAMISIL GRANULES NONFORMULARY)	
AGE	\$\$\$	Fluconazole Suspension	DIFLUCAN SUSPENSION, MEMBERS > 12 YEARS OF AGE REQUIRE PA
AGE	\$\$\$	Griseofulvin Suspension	GRIFULVIN V SUSPENSION, PA REQ FOR PATIENTS >12 YEARS OF AGE

Antimalarial Agents

\$	Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
\$	Hydroxychloroquine	PLAQUENIL
\$	Primaquine	PRIMAQUINE
\$	Pyrimethamine	DARAPRIM
\$\$	Iodoquinol	YODOXIN
\$\$	Quinacrine	ATABRINE
\$\$	Sulfadoxine/Pyrimethamine	FANSIDAR
\$\$\$	Paromomycin	HUMATIN
\$\$\$\$	Chloroquine	ARALEN
\$		
\$\$\$\$	Mefloquine	LARIAM
\$		

Antituberculosis Agents

\$	Isoniazid	ISONIAZID
\$\$	Ethambutol	MYAMBUTOL

\$\$	Pyrazinamide	PYRAZINAMIDE
\$\$	Rifampin	RIFADIN

Antiviral Agents

	\$	Acyclovir Oral	ZOVIRAX ORAL
	\$	Amantadine Capsules and Syrup	SYMMETREL CAPSULES AND SYRUP (TABLETS NONFORMULARY)
PA	\$\$\$	Ribavirin (200mg strength only)	COPEGUS, PA REQ
PA			REBETOL, PA REQ
QL	\$\$\$	Oseltamivir	TAMIFLU, QTY LIMITED TO 1 COURSE OF TREATMENT PER 6 MONTHS (EFFECTIVE 8/1/09). TAMIFLU SYRUP, QL OF #120ML PER 180 DAYS.(EFFECTIVE 2/15/12)
	\$\$\$	Valacyclovir	VALTREX
	\$\$\$	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS (EFFECTIVE 10/1/09)
	\$\$\$\$	Rimantadine	FLUMADINE
AGE	\$\$\$\$	Zidovudine (AZT)	RETROVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Abacavir	ZIAGEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE, MD	\$\$\$\$	Adefovir Dipivoxil	HEPSERA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Amprenavir	AGENERASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Delavirdine	RESCRIPTOR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Didanosine (DDI)	VIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$		VIDEX EC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Efavirenz	SUSTIVA, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE, MD	\$\$\$\$	Entecavir	BARACLUDE, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
	\$\$\$\$	Ganciclovir	CYTOVENE
	\$		
AGE	\$\$\$\$	Indinavir	CRIXIVAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
PA	\$\$\$\$	Interferon Alpha 2a	ROFERON-A, PA REQ
	\$		
PA	\$\$\$\$	Interferon Alpha 2b	INTRON A, PA REQ
	\$		
	\$\$\$\$	Lamivudine (3TC)	EPIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$		
AGE, MD	\$\$\$\$	Lamivudine HBV	EPIVIR HBV, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Nelfinavir	VIRACEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Nevirapine	VIRAMUNE, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
PA	\$\$\$\$	Pentamidine, Aerosolized	NEBUPENT, PA REQ
	\$		
PA	\$\$\$\$	Ribavirin, Aerosolized	VIRAZOLE, PA REQ
	\$		
AGE	\$\$\$\$	Ritonavir	NORVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Saquinavir	INVIRASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		

AGE	\$\$\$\$	Stavudine (d4T)	ZERIT, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE,	\$\$\$\$	Telvivudine	TYZEKA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS
MD	\$		<21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Tenofovir	VIREAD, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Zalcitabine (ddC)	HIVID, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Zidovudine/Lamivudine	COMBIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		
AGE	\$\$\$\$	Zidovudine/Lamivudine/Abacavir	TRIZIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$		

Hepatitis C Treatment Agents

Peginterferon alfa-2b

PEGINTRON. PA REQ ; CCS AGE EDIT. MEMBERS<21 MAY BE CCS ELIGIBLE. (EFFECTIVE 6/1/11)

HEPATITIS C VIRUS NS3/4A SERINE PROTEASE INHIB.

PA	\$\$\$\$	Telaprevir	INCIVEK, PA REQUIRED (EFFECTIVE 11/1/11)
	\$\$		

Leprostatic Agents

\$	Clofazimine	LAMPRENE
\$	Dapsone	DAPSONE
		(ACZONE IS NONFORMULARY)

Sulfonamide Agents

\$	Sulfamethoxazole/Trimethoprim (SMZ/TMP)	BACTRIM	
		SEPTRA	
AGE	\$	Sulfasalazine(Enteric Coated Not Covered)	AZULFIDINE, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/09) (AZULFIDINE EN-TABS NONFORMULARY)
	\$	Sulfisoxazole	GANTRISIN
	\$	Trimethoprim	TRIMPEX
	\$\$	Erythromycin/Sulfisoxazole	PEDIAZOLE
	\$\$\$	Sulfadiazine	SULFADIAZINE

ANTINEOPLASTIC AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

PA	Alemtuzumab	CAMPATH, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Altretamine	HEXALEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Anastrozole	ARIMIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Bexarotene	TARGRETIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Bevacizumab	AVASTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Bicalutamide	CASODEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Busulfan	MYLERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Capecitabine	XELODA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Chlorambucil	LEUKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Cyclophosphamide	CYTOXAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Dasatinib	SPRYCEL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

PA	Erlotinib	TARCEVA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Estramustine	EMCYT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Etoposide	VEPESID, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Everolimus	AFINITOR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Exemestane	AROMASIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Flutamide	EULEXIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Gefitinib	IRESSA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Hydroxyurea	HYDREA, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Imatinib Mesylate	,GLEEVEC, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lapatinib	TYKERB, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lenalidomide	REVLIMID, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Letrozole	FEMARA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Leucovorin	WELLCOVORIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Levamisole	ERGAMISOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Lomustine	CEENU, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Megestrol	MEGACE, MEMBERS <21 MAY BE CCS-ELIGIBLE (MEGACE ES NONFORMULARY)
AGE	Melphalan	ALKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Mercaptopurine	PURINETHOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Methotrexate 2.5mg Tablets	RHEUMATREX 2.5 MG TABLETS, MEMBERS <21 MAY BE CCS-ELIGIBLE OTHER STRENGTHS AND DOSE PACKS NONFORMULARY
AGE	Mitotane	LYSODREN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Nilotinib	TASIGNA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Nilutamide	NILANDRON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Ofatumumab	ARZERRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Panitumumab	VECTIBIX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Pazopanib	VOTRIENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Pralatrexate	FOLOTYN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Procarbazine	MATULANE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Romidepsin	ISTODAX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Sorafenib	NEXAVAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Sunitinib	SUTENT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Tamoxifen Citrate	NOLVADEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Temozolomide	TEMODAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Testolactone	TESLAC, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Thalidomide	THALOMID, PA REQ
AGE	Thioguanine	THIOGUANINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Toremifene	FARESTON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Topotecan	HYCANTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Trastuzumab	HERCEPTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Tretinoin	VESANOID, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Triptorelin	TRELSTAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
PA	Vorinostat	ZOLINZA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

Immunosuppressant Agents

AGE	\$\$	Azathioprine	IMURAN, MEMBERS <21 MAY BE CCS-ELIGIBLE (AZASAN NONFORMULARY)
AGE	\$\$\$\$	Cyclosporine	SANDIMMUNE, MEMBERS <21 MAY BE CCS-ELIGIBLE NEORAL, MEMBERS <21 MAY BE CCS-ELIGIBLE COPAXONE, PA REQ. (EFFECTIVE 3/1/11)
PA	\$\$\$\$	Glatiramer	
PA	\$		
PA	\$\$\$\$	Interferon beta-1a	REBIF, PA REQ. (EFFECTIVE 3/1/11)
PA	\$		
AGE	\$\$\$\$	Mycophenolate	CELLCEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$		

PA \$\$\$\$ Sirolimus
 \$

RAPAMUNE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
 (EFFECTIVE 6/1/10)

RESPIRATORY/EENT AGENTS

Antihistamine Agents

\$	Cetirizine (OTC only)	ZYRTEC TABLETS (OTC ONLY); (EFFECTIVE 3/1/09) ZYRTEC SYRUP (OTC ONLY) (EFFECTIVE 3/1/09) (ZYRTEC CHEWABLE TABLETS NONFORMULARY) (EFFECTIVE 3/1/09)
\$	Cyproheptadine	PERIACTIN
\$	Dexchlorpheniramine	POLARAMINE
\$	Hydroxyzine	ATARAX
\$	Hydroxyzine Pamoate	VISTARIL
\$	Loratadine OTC	ALAVERT CLARITIN OTC (FEDERAL LEGEND NONFORMULARY)
\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
PA	\$\$\$ Fexofenadine	ALLEGRA, PA REQUIRED (ALLEGRA ODT AND SUSPENSION NONFORMULARY)

Antihistamine/Decongestant Combination Agents

\$	Bromphen/Pseudoephedrine	BROMFED
\$	Guaifenesin/Pseudoephedrine	GUAIFED-PD
\$	Pseudoephedrine/Chlorpheniramine	DECONAMINE SR
\$\$	Loratadine/Pseudoephedrine OTC	CLARITIN-D OTC (FEDERAL LEGEND NONFORMULARY)
\$\$\$	Bromphen/Pseudoephedrine	BROMFED PD

Antitussive Agents

Non-Narcotic Antitussive Agents

\$	Benzonatate	TESSALON PERLE
AGE	\$ Guaifenesin/Dextromethorphan HBr	IOPHEN DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$ Promethazine/Dextromethorphan	PHENERGAN W/DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE, PROMETHAZINE USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION

Narcotic Antitussive Agents

\$	Codeine/Chlorpheniramine/Pseudoephedrine	PHENYLHISTINE DH
\$	Codeine/Guaifenesin/Pseudoephedrine	NOVAHISTINE EXPECT ROBITUSSIN DAC
\$	Guaifenesin/Codeine	ROBITUSSIN AC
\$	Phenylephrine/Hydrocodone/Chlorpheniramine	HISTENEX HC
AGE	\$ Promethazine/Codeine	PHENERGAN/CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
AGE	\$ Promethazine/Phenylephrine/Cod	PHENERGAN VC CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION

\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/COD
\$\$\$	Guaifenesin/Codeine Phosphate	IOPHEN – C NR
\$\$\$	Hydrocodone/Chlorpheniramine	TUSSIONEX

Bronchodilating Agents

Inhaled Sympathomimetic (Adrenergic) Agents

	\$\$	Albuterol HFA	PROAIR HFA
	\$\$	Pirbuterol Acetate	MAXAIR AUTOHALER
	\$\$\$	Albuterol/Ipratropium	COMBIVENT
STEP	\$\$\$	Levalbuterol for Nebulization	XOPENEX FOR NEBULIZATION, STEP THERAPY (ALBUTEROL PREFERRED) (EFFECTIVE 8/1/09) (XOPENEX HFA NONFORMULARY)
AGE, STEP	\$\$\$\$	Salmeterol	SEREVENT DISKUS, STEP THERAPY (TRIAL OF ORAL INHALED STEROID), PRIOR AUTHORIZATION REQUIRED FOR MEMBERS LESS THAN 12 YEARS OF AGE (EFFECTIVE 3/1/09)

Oral Sympathomimetic (Adrenergic) Agents

AGE	\$	Albuterol	PROVENTIL, ALBUTEROL SYRUP RESTRICTED TO MEMBERS 5 YEARS OF AGE OR YOUNGER
	\$	Metaproterenol Oral	ALUPENT
	\$	Terbutaline Sulfate	BRETHINE
	\$\$	Albuterol E.R.	PROVENTIL REPETABS VOLMAX

Beta-Adrenergic and Glucocorticoid Combinations

STEP	\$\$\$	Mometasone/Formoterol	DULERA, STEP THERAPY (TRAIL OF INHALED CORTICOSTEROID 5DAYS SUPPLY IN THE PAST 120 DAYS PERIOD) (EFFECTIVE 8/15/11).
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Expectorant Agents

	\$	Guaifenesin/Pseudoephedrine	ZEPHREX LA GUAIFED
AGE	\$	Phenylephrine/Promethazine	PHENERGAN VC, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$\$	Guaifenesin/Phenylephrine	ENDAL ENTEX ENTEX LA
	\$\$	Potassium Iodide	SSKI

Inhaled Adrenal Cortical Steroid Agents

	\$\$	Beclomethasone, Oral Inhaled	QVAR
	\$\$\$	Fluticasone Oral Inhaled	FLOVENT HFA
	\$\$\$	Fluticasone Propionate	FLOVENT DISKUS
	\$\$\$	Budesonide, Oral Inhaled	PULMICORT PULMICORT RESPULES
	\$\$\$	Mometasone, Oral Inhaled	ASMANEX

Mucolytic Agents

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

Ophthalmic Antibiotic Agents

	\$	Bacitracin Ophthalmic	BACITRACIN
	\$	Bacitracin/Polymyxin Ophthalmic	POLYSPORIN OPHTHALMIC
	\$	Ciprofloxacin Ophthalmic	CILOXAN
	\$	Dexamethasone/Neomycin Ophthalmic	NEO-DECADRON
	\$	Dexamethasone/Poly/Neomycin Ophthalmic	MAXITROL
	\$	Erythromycin Base Ophthalmic	ILOTYCIN
	\$	Gentamicin Ophthalmic	GARAMYCIN
	\$	Gentamicin/Prednisolone Ophthalmic	PRED-G
	\$	Hydrocortisone/Neomycin/Polymyxin Ophthalmic	CORTISPORIN OPHTHALMIC
	\$	Neomycin/Gramicidin/Polymyxin Ophthalmic	NEOSPORIN OPHTHALMIC
	\$	Neomycin/Polymyxin/Dexamethasone Ophthalmic	MAXITROL OPHTHALMIC OINTMENT
	\$	Neomycin/Polymyxin/Prednisone Ophthalmic	POLY-PRED
	\$	Ofloxacin Ophthalmic	OCUFLOX
	\$	Polymixin B Sulfate/TMP Ophthalmic	POLYTRIM
	\$	Tobramycin Ophthalmic	TOBREX
MD	\$\$	Levofloxacin Ophthalmic Ophthalmic	QUIXIN, SPECIALTY RESTRICTION (RESTRICTED TO OPHTHALMOLOGY) (EFFECTIVE 2/1/10)
ST	\$\$	Moxifloxacin	VIGAMOX, STEP THERAPY (OPHTHALMIC CIPROFLOXACIN, OFLOXACIN, OR GENERIC POLYTRIM PREFERRED, OPHTHALMOLOGISTS EXEMPT FROM STEP THERAPY RESTRICTION) (EFFECTIVE 11/1/09)

Ophthalmic Anti-Inflammatory Agents

	\$	Dexamethasone Ophthalmic	DEXASOL
	\$	Fluorometholone Ophthalmic	FML FML FORTE (FML S.O.P. NONFORMULARY)
	\$	Flurbiprofen Sodium Ophthalmic	OCUFEN
	\$	Prednisolone Acetate Ophthalmic	PRED MILD PRED FORTE
	\$	Prednisolone Phosphate Ophthalmic	INFLAMASE INFLAMASE FORTE
	\$\$	Diclofenac Sodium Ophthalmic	VOLTAREN
QL	\$\$\$	Ketorolac Tromethamine Ophthalmic	ACULAR. QL OF #20/5 DAYS SUPPLY ACULAR LS ACULAR PF

Ophthalmic Antiviral Agents

	\$\$\$	Trifluridine Ophthalmic Solution	VIROPTIC
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Ophthalmic Beta Blockers

	\$	Carteolol	OCUPRESS
	\$	Levobunolol	BETAGAN
	\$	Metipranolol	OPTIPRANOLOL
	\$	Timolol	BETIMOL TIMOPTIC
	\$\$\$	Betaxolol	BETOPTIC S

Ophthalmic Miotic Agents

	\$	Carbachol	ISOPTO CARBACHOL
	\$	Pilocarpine	PILOCAR (OCUSERT NONFORMULARY)
	\$\$	Demecarium	HUMORSOL
	\$\$	Echothiophate Iodide	PHOSPHOLINE IODIDE
	\$\$\$\$	Brimonidine	ALPHAGAN P

Carbonic Anhydrase Inhibitors

\$\$	Brinzolamide	AZOPT
\$\$\$	Dorzolamide	TRUSOPT
\$\$\$	Dorzolamide/Timolol	COSOPT

Ophthalmic Mydriatic Agents

\$	Atropine Sulfate	ISOPTO ATROPINE
\$	Dipivefrin	PROPINE
\$	Tropicamide	MYDRIACYL

Ophthalmic Sulfonamide Agents

\$	Sulfacetamide	BLEPH-10
		SODIUM SULAMYD
\$	Sulfacetamide 10%/Prednisolone 0.25%	VASOCIDIN
\$	Sulfacetamide 10%/Prednisolone 0.2%	BLEPHAMIDE

Ophthalmic Antiallergic Agents

\$	Ketotifen Ophthalmic OTC	ALAWAY
		ZADITOR
		(FEDERAL LEGEND KETOTIFEN NONFORMULARY)

	\$\$	Cromolyn Ophthalmic	CROLOM
MD	\$\$\$	Nedocromil Ophthalmic	ALOCRIL, RESTRICTED TO OPHTHALMOLOGY/OPTOMETRY
MD	\$\$\$	Pemirolast Ophthalmic	ALAMAST, RESTRICTED TO OPHTHALMOLOGY/OPTOMETRY
MD	\$\$\$\$	Lodoxamide Ophthalmic	ALOMIDE, RESTRICTED TO OPHTHALMOLOGY/OPTOMETRY
STEP	\$\$\$\$	Olopatadine Ophthalmic	PATANOL, STEP THERAPY (OTC OPHTHALMIC KETOTIFEN PREFERRED)

Ophthalmic Miscellaneous Agents

\$\$\$\$	Latanoprost	XALATAN
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Otic Anti-Infective Agents

\$	Acetic Acid	VOSOL
\$	Acetic Acid 2%/Hydrocortisone 1%	VOSOL HC
\$	Acetic Acid 2%	DOMEBORO
\$	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN
\$\$	Neomycin/Colist/HC	COLY-MYCIN S
\$\$\$	Ciprofloxacin/Dexamethasone	CIPRODEX
\$\$\$	Ciprofloxacin/Hydrocortisone	CIPRO HC

Inhaled/Oral EENT Agents

Inhaled Agents, Nasal

	\$\$	Flunisolide, Nasal	FLUNISOLIDE
	\$\$	Fluticasone Propionate, Nasal	FLONASE
AGE	\$\$\$	Mometasone, Nasal	NASONEX, RESTRICTED TO MEMBERS LESS THAN 4 YEARS OF AGE (EFF 9/1/09)
AGE	\$\$\$	Triamcinolone Acetonide, Nasal	NASACORT AQ, RESTRICTED TO MEMBERS LESS THAN 4 YEARS OF AGE (EFF 9/1/09)

Carbonic Anhydrase Inhibitor Agents

\$	Acetazolamide	DIAMOX
\$	Methazolamide	NEPTAZANE
\$\$\$	Acetazolamide SA	DIAMOX SEQUELS

Local Anesthetic Agents

\$	Benzocaine/Antipyrine Otic	AURALGAN
\$	Lidocaine, Viscous	VISCOUS XYLOCAINE

Leukotriene Receptor Antagonists

STEP	\$\$\$	Montelukast	SINGULAIR, STEP THERAPY (ASTHMA: TRIAL OF AN ORAL INHALED STEROID, ALLERGIC RHINITIS: TRIAL OF A NASAL STEROID AND NSA) (EFFECTIVE 8/1/09)
	\$\$\$	Zafirlukast	ACCOLATE

Miscellaneous EENT Agents

\$	Carbachol	ISOPTO CARBACHOL
\$	Sodium Chloride Solution (for Inhalation)	SODIUM CHLORIDE SOLUTION
\$\$	Chlorhexidine Gluconate	PERIDEX
\$\$\$	Ipratropium	ATROVENT HFA
\$\$\$	Triamcinolone 0.1% in Orabase	KENALOG IN ORABASE
\$\$\$	Triethanolamine	CERUMENEX
\$\$\$\$	Azelastine Nasal Spray	ASTELIN (ASTEPRO NONFORMULARY)

Respiratory Smooth Muscle Relaxant Agents

\$	Aminophylline – Suppositories Not Covered	
\$\$	Theophylline, 80mg/15cc (Alcohol Free)	ELIXOPHYLLIN
\$\$	Theophylline	THEOLAIR
\$\$	Theophylline, Sustained Release	SLO-BID T-PHYL UNIPHYL

DIABETIC AND THYROID AGENTS

Diabetic Agents

(May be eligible for CCS Coverage for Healthy Families members < 21 years of age)

AGE **Sulfonylureas**

AGE	\$	Chlorpropamide	DIABINESE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glimepiride	AMARYL, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE	\$	Glipizide	GLUCOTROL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glipizide L.A.	GLUCOTROL XL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glyburide	DIABETA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE			MICRONASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolazamide	TOLINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolbutamide	ORINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$	Glyburide/Metformin	GLUCOVANCE, STEP THERAPY (TRIAL OF GLYBURIDE OR METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)

Non-Sulfonylureas

AGE	\$	Metformin	GLUCOPHAGE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$	Metformin XR	GLUCOPHAGE XR, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 9/15/09)
AGE	\$\$	Acarbose	PRECOSE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, PA	\$\$	Miglitol	GLYSET, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE	\$\$\$	Glucagon	GLUCAGON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Nateglinide	STARLIX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE, STEP	\$\$\$	Saxagliptin	ONGLYZA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE, STEP	\$\$\$	Sitagliptin	JANUVIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE, STEP	\$\$\$	Sitagliptin/Metformin	JANUMET, STEP THERAPY (TRIAL OF JANUVIA AND METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE, STEP	\$\$\$	Pioglitazone	ACTOS, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE, STEP	\$\$\$	Pioglitazone/Glimepiride	DUETACT, STEP THERAPY (TRIAL OF ACTOS AND GLIMEPIRIDE REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE, STEP	\$\$\$	Pioglitazone/Metformin	ACTOPLUS MET, STEP THERAPY (TRIAL OF ACTOS AND METFORMIN REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
PA	\$\$\$	Repaglinide	PRANDIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone	AVANDIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE, STEP	\$\$\$	Rosiglitazone/Glimepiride	AVANDARYL, STEP THERAPY (TRIAL OF AVANDIA AND GLIMEPIRIDE), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)
AGE, STEP	\$\$\$	Rosiglitazone/Metformin	AVANDAMET, STEP THERAPY (TRIAL OF AVANDIA AND METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/10)

Insulin Agents

Note: Prior authorization is required for pre-filled pens and cartridges

AGE	\$\$	Insulin	NOVO-NORDISK INSULINS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart	NOVOLOG (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart Pretamine/Insulin Aspart	NOVOLOG MIX (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Glargine	LANTUS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Lispro	HUMALOG (VIALS ONLY), MEMBERS <21 MAY BE CCS ELIGIBLE (EFFECTIVE 6/1/11)
AGE	\$\$\$	Human Insulin	HUMULIN N AND HUMULIN R (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
AGE	\$\$\$	Insulin NPL/Insulin Lispro	HUMALOG MIX 75/25, HUMULIN MIX (VIALS ONLY), MEMBERS <21 MAY BE CCS ELIGIBLE (EFFECTIVE 6/1/11)

Thyroid Agents

\$	Thyroid, Desiccated	ARMOUR THYROID
\$	Levothyroxine	LEVOTHROID
\$\$	Liotrix	THYROLAR

Antithyroid Agents

\$	Propylthiouracil	PROPYLTHIOURACIL
\$\$	Methimazole	TAPAZOLE

Thyroid Hormones

\$\$	Liothyronine Sodium	CYTOMEL, MD SPECIALTY OF ENDOCRINOLOGY (EFFECTIVE 11/1/11)
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HEMATOLOGICAL DISORDERS

Hematinics, Other

PA, AGE	Epoetin Alfa	EPOGEN. PA REQ; CCS AGE EDIT. MEMBERS<21 MAY BE CCS ELIGIBLE. (EFFECTIVE 6/1/11)
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HORMONE AND CONTRACEPTIVE AGENTS

Oral Adrenal Cortical Steroid Agents

	\$	Dexamethasone	DECADRON DEXPAK IS NON-FORMUARY
	\$	Fludrocortisone Acetate	FLORINEF
	\$	Hydrocortisone Oral	CORTEF
	\$	Methylprednisolone	MEDROL MEDROL DOSEPAK
	\$	Prednisone	DELTASONE
	\$	Prednisolone	ORASONE PEDIAPRED
	\$\$	Cortisone Acetate	PRELONE
	\$\$\$	Betamethasone Oral	CORTONE
AGE	\$\$\$	Prednisolone Sodium Phosphate 10mg ODT	CELESTONE ORAPRED ODT -10MG STRENGTH ONLY, RESTRICTED TO PATIENTS 6 YEARS OF AGE AND YOUNGER (EFFECTIVE 2/1/10)

Androgen Agents

\$\$	Methyltestosterone	METANDREN
\$\$\$	Fluoxymesterone	HALOTESTIN
\$\$\$\$	Danazol	DANOCRINE

Bisphosphonate Agents

\$\$	Alendronate	FOSAMAX (FOSAMAX SOLUTION AND FOSAMAX PLUS D NONFORMULARY)
\$\$\$	Etidronate	DIDRONEL

HRT – Oral Estrogen Tablets

STEP	\$	Estradiol Transdermal	CLIMARA PATCH STEP THERAPY OF PREMARIN OR VIVELLE-DOT. QL OF #4 PATCHES/MONTH
QL	\$	Estradiol	ESTRACE
QL	\$	Estropipate	OGEN, ORTHO-EST, QL OF #1 / DAY (EFFECTIVE 2/15/12)
QL	\$\$	Estradiol acetate	FEMTRACE, QL OF #1 / DAY (EFFECTIVE 2/15/12)
QL	\$\$	Estrogens, Synthetic Conjugated	ENJUVIA, QL OF #1 / DAY (EFFECTIVE 2/15/12)
	\$\$	Estrogens, Conjugated	PREMARIN
QL	\$\$	Estrogens, Esterified	MENEST, QL OF #1 / DAY (EFFECTIVE 2/15/12)
PA	\$\$	Synthetic Conjugated Estrogen	CENESTIN, PA REQ

HRT – Oral Estrogen / Progestin Tablets

\$\$	Estradiol/Norethindrone	ACTIVELLA
\$\$	Estradiol/Norgestimate	ORTHO-PREFEST (EFFECTIVE 10/15/11)

\$\$ Ethinyl Estradiol/Norethindrone
 \$\$ Estrogen,
 conjugated/Medroxyprogesterone

FEMHRT (EFFECTIVE 10/15/11)
 PREMPRO
 PREMPHASE

HRT- Oral Estrogen / Testosterone Tablets

\$ Sodium Estrone (Estropiate)

ORTHO-EST (EFFECTIVE 10/15/11)

HRT – Transdermal Estrogen System

QL \$ Estradiol Patches

CLIMARA; QL OF # 4 PATCHES / MO (EFFECTIVE 2/15/12)

\$\$ Estradiol Patches

VIVELLE-DOT; QL OF #8 PATCHES / MO (EFFECTIVE 2/15/12)

HRT – Intravaginal Estrogen System

\$ Estradiol Vaginal Tablet

VAGIFEM

\$\$ Estradiol Vaginal Cream

ESTRACE (EFFECTIVE 2/15/12)

\$\$ Estradiol Vaginal Cream

PREMARIN (EFFECTIVE 2/15/12)

STEP \$\$\$ Estradiol Vaginal Ring

ESTRING, STEP THERAPY (VAGIFEM, ESTRACE, OR
 PREMARIN CREAM PREFERRED 5 DAYS SUPPLY IN THE PAST
 120 DAYS PERIOD; EFFECTIVE 2/15/12)

STEP \$\$\$ Estradiol Vaginal Ring

FEMRING, STEP THERAPY (VAGIFEM, ESTRACE, OR
 PREMARIN CREAM PREFERRED; EFFECTIVE 2/15/12)

Growth Agents

PA \$\$\$\$\$ Somatropin

PA

TEV-TROPIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
 SEROSTIM, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
 (ALL OTHER GROWTH HORMONES NONFORMULARY)

Contraceptive Agents

Monophasic Oral Contraceptives

\$ Desogestrel/Ethinyl Estradiol

DESOGEN

\$ Ethynodiol/Ethinyl Estradiol

DEMULEN

\$ Levonorgestrel/Ethinyl Estradiol

LEVLEN

ALESSE

NORDETTE

\$ Norethindrone Acetate/Ethinyl Estradiol

LOESTRIN

LOESTRIN FE

(LOESTRIN 24 FE NONFORMULARY)

\$ Norethindrone/Ethinyl Estradiol

MODICON

NORINYL 1/35

\$ Norethindrone/Mestranol

NORINYL 1/50

\$ Norgestrel/Ethinyl Estradiol

OVRAL

LO/OVRAL

\$ Norethindrone

NOR QD

Biphasic Oral Contraceptives

\$\$ Desogestrel/Ethinyl Estradiol

MIRCETTE

Triphasic Oral Contraceptives

\$ Desogestrel/Ethinyl Estradiol

CYCLESSA

\$ Levonorgestrel

PLAN B, NEXT CHOICE: FEMALE ONLY; QL OF #2 IN 30 DAYS;
 #6 DISPENSINGS IN ANY 12 MONTH PERIOD
 (PLAN B ONE-STEP IS NON-FORMULARY) (EFFECTIVE
 5/1/2012)

\$ Levonorgestrel/Ethin Estradiol

TRI-LEVLEN

TRIPHASIL

PREVEN, LIMITED TO 2 KITS PER MONTH

\$ Norethindrone/Ethin Estradiol

TRI-NORINYL

ORTHO-NOVUM 7/7/7

Miscellaneous Contraceptives

\$	Medroxyprogesterone	DEPO-PROVERA 150MG/ML STRENGTH ONLY
\$\$	Etonogestrel/Ethinyl Estradiol	NUVARING (EFFECTIVE 2/1/10)
\$\$	Norelgestromin/Ethinyl Estradiol	ORTHO EVRA

Oxytocic Agents

\$	Methylergonovine Maleate	METHERGINE
\$\$	Ergonovine Maleate	ERGOTRATE

Pituitary Agents

AGE	\$\$\$	Desmopressin	DDAVP, MEMBERS <21 MAY BE CCS-ELIGIBLE (STIMATE NONFORMULARY)
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Progestin Agents

\$	Medroxyprogesterone	PROVERA
\$\$	Progesterone	PROMETRIUM
\$\$\$	Norethindrone Acetate	AYGESTIN NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

\$	Trimethoprim	TRIMPEX
\$\$	Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
\$\$\$	Nitrofurantoin Macrocrystals	MACRODANTIN MACROBID
\$\$\$	Nitrofurantoin Suspension	FURADANTIN

Urinary Tract Analgesics

	\$	Phenazopyridine	PYRIDIUM
PA	\$\$\$\$	Pentosan	ELMIRON, PA REQ

Genitourinary Smooth Muscle Relaxant Agents

\$\$	Oxybutynin	DITROPAN
\$\$\$\$	Flavoxate	URISPAS

Parasympathomimetic (Cholinergic) Agents

\$	Bethanechol	URECHOLINE
\$\$	Pyridostigmine	MESTINON
\$\$	Neostigmine	PROSTIGMIN

NEOPLASTIC DISEASE

Antiandrogenic Agents

PA	\$\$\$\$	Abiraterone acetate	ZYTIGA, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 8/15/11)
AGE			

Antineoplastic – Halichondrin B Analogs

PA, \$\$\$\$ Eribulin Mesylate
AGE

HALAVEN, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 6/1/11)

Antineoplastic Systemic Enzyme Inhibitors

PA \$\$\$\$ Vandetanib
AGE
PA \$\$\$\$ Vemurafenib
AGE

CAPRELSA, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 8/15/11)
ZELBORAF, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 5/1/12)

Antineoplastic – Hedgehog Pathway Inhibitor

PA \$\$\$\$ Vismodegib
AGE

ERIVEDGE, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 5/1/12)

Cytotoxic T-Lymphocyte Antigen(CTLA-4) RMC Antibody

PA \$\$\$\$ Lpilimumab
AGE

YERVOY, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 5/1/12)

TOPICAL/MUCOUS MEMBRANE AGENTS

Anti-Acne Agents

\$	Benzoyl Peroxide 10% Wash (federal legend only)	DESQUAM-X 10% WASH DESQUAM-X 10% WASH, FEDERAL LEGEND ONLY
\$	Erythromycin Topical	ERYGEL EMGEL T-STAT
\$	Clindamycin Topical Solution	CLEOCIN T
\$\$	Tretinoin - Limited to Acne Only	RETIN A, LIMITED TO ACNE ONLY < 25 YEARS OF AGE
\$\$\$	Clindamycin Lotion/Gel	CLEOCIN T
\$\$\$	Erythromycin/Benzoyl Peroxide	BENZAMYCIN
MD \$\$\$\$\$	Isotretinoin	ACUTANE , RESTRICTED
STEP \$\$\$	Benzoyl Peroxide/Clindamycin Gel	BENZACLIN, STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED). QL OF #50GM IN 30DAYS
QL		

Keratolytic Agents

\$	Anthralin	DRITHOCREME DRITHOSCALP (ZITHRANOL-RR NONFORMULARY)
\$\$\$	Podofilox	CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

\$\$	Hydrocortisone Rectal Cream	PROCTOCORT 1% ANUSOL HC 2.5%
\$\$	Metronidazole 0.75% Cream	METROCREAM, (EFFECTIVE 11/1/09) (OTHER STRENGTHS NON-FORMULARY)
\$\$	Metronidazole 0.75% Gel	METROGEL 0.75%, (EFFECTIVE 11/1/09) (OTHER STRENGTHS NON-FORMULARY) (METROGEL/SKIN CLENSER KIT AND METROGEL 1% NONFORMULARY)

	\$\$\$	Aluminum Chloride Hexahydrate	DRYSOL
	\$\$\$	Fluorouracil	EFUDEX (EFUDEX OCCLUSION PACK NONFORMULARY)
	\$\$\$	Imiquimod	ALDARA, QUANTITY LIMIT OF 12 PER MONTH (EFFECTIVE 5/1/09)
STEP	\$\$\$	Pimecrolimus	ELIDEL, STEP THERAPY (TOPICAL STEROIDS PREFERRED)
STEP	\$\$\$	Tacrolimus	PROTOPIC, STEP THERAPY (TOPICAL STEROIDS PREFERRED)
	\$\$\$	Tazarotene	TAZORAC
	\$\$\$\$	Calcipotriene	DOVONEX
PA	\$\$\$\$\$	Becaplermin	REGRANEX, PA REQ

Pigmenting and Miscellaneous Agents

	\$\$\$\$\$	Methoxsalen	OXSORALEN
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Topical Antibiotic Agents

	\$	Gentamicin Sulfate	GARAMYCIN
	\$	Silver Sulfadiazine	SILVADENE
	\$\$	Mupirocin Ointment	BACTROBAN OINTMENT, RESTRICTED TO 1 TUBE PER MONTH (BACTROBAN NASAL AND BACTROBAN CREAM NONFORMULARY)

Topical Antifungal Agents

	\$	Clotrimazole	LOTRIMIN
	\$	clotrimazole/betamet diprop	LOTRISONE CREAM
	\$	Miconazole Nitrate	MONISTAT-DERM
	\$	Nystatin	MYCOSTATIN
	\$	Tolnaftate	TINACTIN
	\$	Triamcinolone/Nystatin	MYCOLOG II
	\$	Econazole	SPECTAZOLE
	\$	Terbinafine 1% cream	LAMISIL AT – OTC (EFFECTIVE 8/15/11)
	\$\$	Ketoconazole Cream and Ketoconazole shampoo	NIZORAL CREAM
PA	\$\$\$	Ciclopirox	LOPROX, PA REQ (LOPROX SHAMPOO NONFORMULARY)

Vaginal Anti-Infective Agents

	\$\$	Metronidazole	METROGEL-VAGINAL
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Topical Anti-Inflammatory Agents

		LOW POTENCY	
	\$	Fluocinolone 0.025%	SYNALAR
	\$	Hydrocortisone	HYTONE
	\$	Hydrocortisone Acetate	CORTIFOAM
	\$	Desonide	TRIDESILON (EFFECTIVE 11/1/10)
	\$\$	Hydrocortisone/Pramoxine	PROCTOCREAM-HC
	\$\$\$	Hydrocortisone Enema	CORTENEMA
		MEDIUM POTENCY	
	\$	Betamethasone Dipropionate	DIPROSONE
			MAXIVATE
	\$	Betamethasone Valerate 0.1%	BETA-VAL
	\$	Triamcinolone	ARISTOCORT
			KENALOG
			(ARISTOCORT NONFORMULARY)

\$\$	Flurandrenolide	CORDRAN
\$\$	Hydrocortisone Valerate	WESTCORT
\$\$	Mometasone Furoate Cream	ELOCON
\$\$\$	Clocortolone Pivalate	CLODERM
\$\$\$	Desoximetasone Cream/Gel 0.05%	TOPICORT
\$\$\$	Fluticasone	CUTIVATE
	HIGH POTENCY	
\$\$	Betamethasone Dipropionate	DIPROLENE
\$\$	Desoximetasone 0.25%	TOPICORT LP
\$\$	Fluocinonide	LIDEX
		LIDEX E
\$\$	Fluocinolone Acetonide 0.2%	SYNALAR
	VERY HIGH POTENCY	
\$\$\$\$	Augmented Betamethasone Dipropionate	DIPROLENE AF
\$\$\$\$	Clobetasol	TEMOVATE
		(CLOBETASOL LOTION AND SPRAY NONFORMULARY)
\$\$\$\$	Diflorasone Diacetate	FLORONE
		FLORONE-E
		PSORCON

Topical Antipruritic and Local Anesthetic Agents

\$	Lidocaine Viscous	XYLOCAINE
\$\$	Pramosone HC 1%	PRAMOSONE HC
\$\$	Pramoxine/Hydrocortisone	PROCTOFOAM HC
\$\$\$	Pramoxine/HC	EPIFOAM

Topical Antiviral Agents

\$\$\$\$	Acyclovir Topical	ZOVIRAX OINTMENT
		(ZOVIRAX CREAM NONFORMULARY)

Topical Miscellaneous Anti-Infective Agents

\$	Selenium Sulfide 2.5%	SELSUN
		EXSEL
\$	Sulfacetamide Lotion	KLARON 10%
\$	Triple Sulfa Vaginal	SULTRIN
\$\$\$	Anthralin	DRITHOCREME
\$\$\$	Sulfanilamide Compound	AVC CREAM

Scabicide/Pediculicide Agents

\$	Permethrin	ELIMITE
\$\$\$	Crotamiton	EURAX LOTION
\$\$\$	Malathion	OVIDE

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Potassium Agents

\$	Potassium Chloride Effervescent Tablets	K-LYTE
\$	Potassium Chloride Liquid	KAON-CL
\$\$	Potassium Chloride 8mEq	MICRO-K
		SLOW K

	\$\$	Potassium Chloride 10mEq	MICRO-K 10 KAON-CL 10 K-DUR K-TABS
	\$\$	Potassium Chloride 20mEq	K-DUR
	\$\$	Potassium Chloride Effervescent Tablets	K-LYTE CL DS
	\$\$	Potassium Chloride Powder	K-LOR
		Potassium-Removing Resins	
	\$\$\$\$	Sodium Polystyrene Sulfonate	KAYEXALATE
		Other Electrolyte Depletors	
AGE	\$	Calcium Acetate	PHOSLO, MEMBERS <21 MAY BE CCS-ELIGIBLE (FEDERAL LEGEND ONLY), (EFFECTIVE 5/1/10)

Heavy Metal Antagonist Agents

AGE	\$\$\$	Penicillamine	CUPRIMINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
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Vitamin and Fluoride Agents

Fluoride Agents

\$	Sodium Fluoride (Drops and Tablets)	LURIDE
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Vitamin A

\$	Beta-Carotene	SOLATENE
\$	Vitamin A	AQUASOL A

Vitamin B-Complex Agents

\$	Folic Acid	FOLIC ACID
\$	Folic Acid/Multivitamins with Minerals	VICON FORTE
\$	Niacin	NIACIN (NIACOR NONFORMULARY)

Vitamin D

\$	Ergocalciferol	DRISDOL
\$	Cholecalciferol	VITAMIN D ₃ (EFFECTIVE 11/1/10)
\$\$	Calcitriol	ROCALTROL
\$\$	Dihydroxycholesterol	HYTAKEROL

Vitamin K Activity Agents

\$\$	Phytonadione	MEPHYTON
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Multivitamin Agents

\$	Fluoride/Polyvitamins (Without Iron; Drops and Tablets)	POLY-VI-FLOR
\$	Fluoride/Vitamins A,D,C (With and Without Iron; Drops and Tablets)	TRI-VI-FLOR

Prenatal Vitamin Agents

QL	\$	Prenatal Multivitamins	CARENATE MATERNITY-90 PRENAVITE PRENATAL PRENATAL PLUS PRENAPLUS
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Diagnostic Testing

Blood Glucose Meters

PA	Blood Glucose Meters	GLUCOMETER, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
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Blood Glucose Testing Strips

AGE	Blood Glucose Testing Strips	GLUCOMETER, MEMBERS <21 MAY BE CCS-ELIGIBLE
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AGE

ASCENSIA, MEMBERS <21 MAY BE CCS-ELIGIBLE

Weight Loss Agents

PA	\$\$	Phentermine
PA	\$\$\$\$	Orlistat
PA	\$\$\$\$	Sibutramine

IONAMIN, PA REQ
 XENICAL, PA REQ
 MERIDIA, PA REQ

Alcohol Deterrents

\$\$	Disulfiram
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ANTABUSE

Gout Agents

\$	Allopurinol
\$\$	Colchicine
\$\$	Probenecid
\$\$\$	Colchicine/Probenecid

ZYLOPRIM
 COLCHICINE
 BENEMID
 COL-BENEMID

Smoking Deterrents

PA	\$\$	Nicotine
PA	\$\$\$	Bupropion SR

NICOTROL INHALER, PA REQ
 ZYBAN, PA REQ

Medical Devices

\$	Peak Flow Meter
\$\$	Inhaler Assistant Device <u>Without</u> Mask (Spacer Without Mask)

PEAK FLOW METER
 VARIOUS, LIMIT OF 1 DEVICE PER YEAR
**AEROCHAMBER (WITHOUT MASK) NONFORMULARY, ALL
 OTHER SPACER BRANDS PREFERRED OVER AEROCHAMBER
 (EFFECTIVE 8/1/09)**

AGE	\$\$	Inhaler Assistant Device <u>With</u> Mask (Spacer With Mask)
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VARIOUS, LIMIT OF 1 DEVICE PER YEAR
**AEROCHAMBER WITH MASK RESTRICTED TO PATIENTS <6
 YEARS OF AGE, OTHER BRANDS OF SPACERS WITH MASKS
 HAVE NO AGE RESTRICTIONS (EFFECTIVE 8/1/09)**

Anaphylaxis Kits

\$\$\$	Epinephrine
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EPIPEN, EPIPEN JR

Recent Changes to the Formulary

Drug Name	Formulary Change	Effective Date
Advair / Symbicort	Remove from formulary; grandfather existing members	5/1/12
Fish Oils OTC	Please add drugs to formulary.	5/1/12
Vismodegib	Add to F with PA	5/1/12
Zelboraf	Add to F with PA	5/1/12
Yervoy	Add to F with PA	5/1/12
Plan B One-Step	Remove from F. Have Next Choice as the alternative on F with POS message "Generic Next Choice is the formulary alternative."	5/1/12
Prenatal Vitamins that are on formulary (ex. Prenavite, Prenatal, Prenatal Plus, Prenaplus)	Please ensure that there is QL of #1 / day and gender edit "limited to females only" to formulary prenatal vitamins. No change to current formulary statuses	5/1/12
Diltiazem 24hr ER/Diltia XT	Please add drugs to formulary with QL of #1/day	4/1/12
Diltiazem 12hr ER	Please add drugs to formulary with QL of #2/day	4/1/12
Omeprazole 40mg	Add to F with QL of #1/day; fill limit of #1 in 21 days	4/1/12
Omeprazole 20mg	Change QL of #2/day to #1/day; drug remains on F with fill limit of #1 in 21days	4/1/12
Benzaclin Gel	Please change current QL to #50gm in 30 days	4/1/12
Tamiflu 6mg/ml suspension	Add to F with QL of #120ml per 180 days. Fill Limit of 1 in 180 days.	2/15/12
Enjuvia	Add to F; QL of #1 / day	2/15/12
Femtrace	Add to F; QL of #1 / day	2/15/12
Menest	Add to F; QL of # 1 / day	2/15/12
Estropipate	Add to F; QL of #1 / day	2/15/12
Climara patch	Remove current ST (Per formulary lookup, it currently has a ST of premarin or Vivelle-dot, please verify); drug remains F; add QL of #4 patches / month	2/15/12
Vivelle-Dot patch	Add to F; QL of #8 / month	2/15/12
Premarin cream	Add to F	2/15/12
Estrace cream	Drug remains F; remove ST	2/15/12
Vagifem	Add to F	2/15/12
Estring / Femring	Revise current ST to include ST of a trial of either Premarin cream, Estrace cream, or Vagifem 5 days supply in the past 120 days period. Drug remains F.	2/15/12
generic hydrocodone/APAP oral tablets/capsules	Add to F with QL of maximum #6 / day. Fill limit of #3 / 75 days	2/15/12
generic hydrocodone/APAP 7.5-500/15 Solution	Add to F with QL of maximum #1770 ml / mo. Fill limit of #3/75 days.	2/15/12
generic losartan	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic losartan – hctz	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
geneirc atorvastatin 80mg	Add to F with QL of #1 / day	2/15/12
Crestor 5mg, 10mg, and 20mg	Remove 5mg, 10mg, and 20mg from Formulary. Grandfather all current users. No change to Crestor 40mg and it remains F with QL of #1 / day.	2/15/12
generic meloxicam	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic nabumetone	Remove current ST; Drug should be on F with QL of #2 / day	2/15/12
generic ketorolac	Add drug to formulary with QL of #20 / 5 days supply	2/15/12
generic ketoprofen	Remove current PA; Drug should be on F with QL of #4 / day	2/15/12
generic piroxicam	Remove from formulary; grandfather current users	2/15/12
generic ketoconazole cream and ketoconazole shampoo	Remove current ST; Drugs should be F without restrictions	2/15/12
generic venlafaxine ER capsules only	Remove current ST; Drug should be F with QL #1 / day; venlafaxine ER tablets should still be F with ST.	2/15/12

generic donepezil	Remove current PA; Drug should be F with QL #1 / day	2/15/12
Aggrenox	Add to F with ST of aspirin 5 days supply in the past 120 days	12/28/11
Humalog Mix 75/50	Add to F; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	11/1/11
Incivek	Add to F with PA	11/1/11
Zytiga	Add to F with PA	11/1/11
Cytomel	Add to F with specialty edit of Endocrinology	11/1/11
Vagifem	Remove current PA	[Pending]
Menest	Remove current PA	10/15/11
Ortho-Prefest / Prefest	Remove current PA	10/15/11
Estring Vaginal Ring	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11
Femring Vagina Ring	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11
Estrace Vaginal cream	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11
Premarin Vaginal cream	Remove from formulary	10/15/11
Femhrt	Add to formulary	10/15/11
Ortho-Est	Add to formulary	10/15/11
Benlysta	NF with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Yervoy	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Vandetanib	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Zytiga	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Xalkori	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Crestor 5mg, 10mg, 20mg	Revised current ST of Crestor from ST of simvastatin 80mg to ST of simvastatin 40mg.	8/15/11
Vandetanib	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	8/15/11
Abiraterone acetate	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	8/15/11
Lumigan	Remove from formulary	8/15/11
Travatan and Travatan Z	Remove from formulary	8/15/11
bupropion (Wellbutrin), bupropion SR (Wellbutrin SR)	Remove MD physician specialty Edit	8/15/11
nefazodone (Serzone)	Remove MD physician specialty Edit	8/15/11
Dulera	Add to F with ST of a trial of inhaled corticosteroid 5 days supply in the past 120 days period.	8/15/11
Symbicort	Remove PA; add ST of a trial of inhaled corticosteroids 5 days supply in the past 120 days period.	8/15/11
Generic terbinafine 1% cream	Add to formulary.	8/15/11
Generic pantoprazole	Remove prior authorization of pantoprazole. Add QL of #1 per day.	6/15/11
Generic lansoprazole	Revise existing ST to step on both omeprazole and pantoprazole 5 days supply in the past 120 days. Grandfather existing members that are already taking lansoprazole.	6/15/11
Diovan, Diovan HCT	Remove from formulary	6/1/11
Benicar, Benicar HCT	Remove from formulary	6/1/11
Micardis, Micardis HCT	Remove from formulary	6/1/11
Eribulin Mesylate	Formulary with PA; add CCS age edit. Members <21 years old may be eligible for CCS, PA required for all other members.	6/1/11
Plan B, Next Choice, Plan B	Add fills limit of maximum of #6 dispensings in any 12 month	6/1/11

One Step	period; no change to current formulary statues and restrictions	
Epogen	Add drug to formulary with PA and CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Procrit	Remove drug from formulary	6/1/11
Pegintron	Add drug to formulary with PA and CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Pegasys	Remove drug from formulary; grandfather existing Pegasys members (lookback period 3 months)	6/1/11
Levemir	Remove drug from formulary; grandfather existing Levemir members (lookback period 3 months)	6/1/11
Humalog, Humulin N, Humulin R, Humulin Mix, Humalog Mix	Add drugs to formulary; Add CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Revatio	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Adcirca	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Flovent Diskus	Add to formulary; Current QL of #60 / mo remains.	6/1/11
Rituxan	Remove from formulary.	6/1/11
Amlodipine 5mg	Remove PA required. Drug remains in Formulary. No change to existing QL of #30 in 21 days	4/1/11
losartan	Added to formulary; ST of a trial of ACEI	4/1/11
losartan - hctz	Added to formulary; ST of a trial of ACEI-hctz	4/1/11
Copaxone	Add to F with PA	3/1/11
Rebif	Add to F with PA	3/1/11
Alprazolam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Clonazepam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Diazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Lorazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Zolpidem	Modified QL restriction to #30 / mo	3/1/11
Zaleplon	Modified QL restriction to #30 / mo	3/1/11
Fanapt	Added to F with PA	3/1/11
Saphris	Added to F with PA	3/1/11
Desonide cream	Added to formulary.	11/1/10
Cholecalciferol (Vitamin D3)	Added to formulary.	11/1/10
Fentanyl transdermal	Added to formulary with PA restriction. Patients less than 21 years may be CCS eligible.	8/1/10
Trelstar	Added to formulary with PA restriction. Patients less than 21 years may be CCS eligible.	8/1/10
Creon, Pancreaze, Zenpep	Added to formulary. Patients less than 21 years may be CCS eligible.	8/1/10
OTC omeprazole	Removed from formulary. Federal legend omeprazole preferred.	6/15/10
Rapamune	Added to formulary with PA restrictions. . Patients less than 21 years may be CCS eligible.	6/1/10
Leflunomide	PA restrictions removed.	5/15/10
Actos	Step therapy restriction added. Trial of metformin required.	5/1/10
Avandia	Step therapy restriction added. Trial of metformin required.	5/1/10
Miglitol	Added to formulary with PA restriction. Patients less than 21 years of age may be eligible for CCS.	5/1/10
Duetact	Added to formulary with age and step therapy restrictions. Patients less than 21 years of age may be eligible for CCS. Trial of glimepiride and pioglitazone required.	5/1/10
Avandaryl	Added to formulary with age and step therapy restrictions. Patients less than 21 years of age may be eligible for CCS. Trial of glimepiride and rosiglitazone required.	5/1/10
Avandamet	Added to formulary with age and step therapy restrictions.	5/1/10

	Patients less than 21 years of age may be eligible for CCS. Trial of metformin and rosiglitazone required.	
Actoplus met	Added to formulary with age and step therapy restrictions. Patients less than 21 years of age may be eligible for CCS. Trial of metformin and pioglitazone required.	5/1/10
Glimepiride	Added to formulary with age restrictions. Patients less than 21 years of age may be eligible for CCS.	5/1/10
Glyburide/metformin	Step therapy restriction added. Trial of metformin or glyburide required.	5/1/10
Morphine, IR tablets	Quantity restriction of 90 tablets/Rx and 3 Rx/75 days added.	5/1/10
Fluvoxamine	Added to formulary with physician specialty restriction.	5/1/10
Advair	Step therapy criteria modified. Trial of inhaled steroid (if asthma), anticholinergic (if COPD) or LABA (if COPD) required.	4/15/10
Enbrel, Humira	Added to formulary with a PA restriction. Preferred TNF agents.	4/1/10
Prevacid 24HR (OTC)	Added to formulary with a step therapy (omeprazole preferred)	2/1/10
Lansoprazole 15mg Capsules (Federal Legend)	Removed from formulary. (OTC lansoprazole preferred for patients using lansoprazole 15mg)	2/1/10
Lansoprazole 30mg	Added to formulary with a ST restriction (omeprazole preferred)	2/1/10
Prevacid Solutabs	Restricted to patients < 6 years of age who have failed a trial of ranitidine. Lansoprazole capsules (OTC 15mg or legend 30mg) preferred for patients able to swallow capsules.	2/1/10
Januvia	Added to formulary with age and step therapy restrictions. Patients must fail a trial of metformin. Patients less than 21 years of age may be eligible for CCS.	2/1/10
Janumet	Added to formulary with age and step therapy restrictions. Patients must fail a trial of metformin and Januvia. Patients less than 21 years of age may be eligible for CCS.	2/1/10

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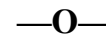
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