

Community Health Group Healthy Families Drug Formulary

February 2010



Community Health Group Drug Formulary

Healthy Families Plan

Administered by MedImpact
February 2010
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 criterion 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 Community Health Group

Healthy Families

February 2010

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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 inquires 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>Patient DOB (required):</u>	<u>Physician License #:</u>
<u>Diagnosis (required):</u>	<u>Physician Area Code and Telephone Number:</u> () -
<u>Pharmacy used by Member:</u>	<u>Physician Area Code and Fax Number (required):</u> () -
<u>Drug Requested:</u>	<u>Pharmacy Area Code and Telephone Number:</u> () -
<u>Dose:</u>	<u>Quantity (per month):</u>
<u>Strength:</u>	<u>Length of Treatment (please be specific):</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):	

TABLE OF CONTENTS

FOREWORD.....	2
HOW TO USE THE DRUG FORMULARY	2
COVERAGE LIMITATIONS	3
AGE RESTRICTION (AGE)	3
AGE & SPECIALTY RESTRICTION (AGE, MD)	3
STEP THERAPY	3
PHYSICIAN SPECIALTY RESTRICTION (MD).....	3
GENERIC SUBSTITUTION	3
EXPERIMENTAL DRUGS	4
MEDICAL EXCEPTION PROCESS.....	4
PRIOR AUTHORIZATION	4
CENTRAL NERVOUS SYSTEM AGENTS.....	11
ANALGESIC AND ANTI-INFLAMMATORY AGENTS	11
<i>Non-Steroidal Anti-Inflammatory Agents</i>	11
<i>Miscellaneous Arthritis Agents</i>	11
<i>Migraine Agents</i>	11
<i>Opiate Agonists</i>	11
<i>Opiate Antagonists</i>	12
<i>Miscellaneous Analgesics</i>	12
<i>Miscellaneous Central Nervous System Agents</i>	12
ANTICONVULSANT AGENTS	12
ANTIPARKINSONIAN AGENTS	13
MUSCLE RELAXANT AGENTS.....	13
<i>Skeletal Muscle Relaxants</i>	13
PSYCHOTHERAPEUTIC AGENTS	13
<i>Tricyclic Antidepressant Agents</i>	13
<i>S.S.R.I. Agents</i>	14
<i>S.N.R.I. Agents</i>	14
<i>M.A.O. Inhibitor Agents</i>	14
<i>Miscellaneous Antidepressant Agents</i>	14
<i>Antimanic Agents</i>	14
<i>Benzodiazepines</i>	14
<i>Antipsychotic Agents</i>	14
<i>Miscellaneous Anxiolytics, Sedatives, and Hypnotics</i>	15
ADHD AGENTS.....	15
CARDIOVASCULAR/BLOOD AGENTS	15
ANTIARRHYTHMIC AGENTS.....	15
ANTIHYPERTENSIVE AGENTS	16
<i>Alpha-Adrenergic Antagonist Antihypertensive Agents</i>	16
<i>Beta-Adrenergic Antagonist Agents</i>	16
<i>Combination Alpha-Beta Antagonist Agents</i>	16
<i>Angiotensin Converting Enzyme Inhibitor Agents</i>	16
<i>Angiotensin Receptor Blocker Agents</i>	16
<i>Calcium Channel Blocking Agents</i>	16
<i>Centrally Acting Antihypertensive Agents</i>	17
<i>Potassium-Sparing Diuretics</i>	17
<i>Loop Diuretics</i>	17
<i>Thiazide and Related Diuretics</i>	17
<i>Vasodilator Antihypertensive Agents</i>	17
ANTILIPIDEMIC AGENTS	17
BLOOD AGENTS	17

<i>Anticoagulants</i>	17
HEMORRHOLOGIC AGENTS	18
CARDIAC GLYCOSIDE AGENTS.....	18
ANTIPLATELET AGENTS.....	18
VASODILATING AGENTS.....	18
MISCELLANEOUS CARDIOVASCULAR AGENTS	18
GASTROINTESTINAL AGENTS.....	18
ANTIDIARRHEAL AGENTS.....	18
ANTI-EMETIC AGENTS.....	18
ANTIMUSCARINIC/ANTISPASMODIC AGENTS.....	19
ANTI-ULCER/ANTIPEPTIC AGENTS.....	19
BOWEL EVACUANT AGENTS.....	19
DIGESTIVE ENZYMES.....	20
GALLSTONE SOLUBILIZING AGENTS.....	20
GASTROINTESTINAL STIMULANT AGENTS.....	20
LAXATIVE AGENTS.....	20
ULCER ERADICATION AGENTS.....	20
ANTI-INFECTIVE AGENTS.....	20
AMEBICIDES.....	20
ANTHELMINTIC AGENTS.....	20
ANTIBIOTIC AGENTS.....	20
<i>Aminoglycosides</i>	20
<i>Cephalosporins</i>	20
<i>Macrolide Antibiotic Agents</i>	20
<i>Miscellaneous Antibiotic Agents</i>	21
<i>Penicillins</i>	21
<i>Quinolones</i>	21
<i>Tetracyclines</i>	21
ANTIFUNGAL AGENTS.....	21
ANTIMALARIAL AGENTS.....	21
ANTITUBERCULOSIS AGENTS.....	22
ANTIVIRAL AGENTS.....	22
LEPROSTATIC AGENTS.....	23
SULFONAMIDE AGENTS.....	23
ANTINEOPLASTIC AND IMMUNOSUPPRESSANT AGENTS.....	23
ANTINEOPLASTIC AGENTS.....	23
IMMUNOSUPPRESSANT AGENTS.....	24
RESPIRATORY/EENT AGENTS.....	24
ANTIHISTAMINE AGENTS.....	24
ANTIHISTAMINE/DECONGESTANT COMBINATION AGENTS.....	24
ANTITUSSIVE AGENTS.....	24
<i>Non-Narcotic Antitussive Agents</i>	24
<i>Narcotic Antitussive Agents</i>	25
BRONCHODILATING AGENTS.....	25
<i>Inhaled Sympathomimetic (Adrenergic) Agents</i>	25
<i>Oral Sympathomimetic (Adrenergic) Agents</i>	25
EXPECTORANT AGENTS.....	25
INHALED ADRENAL CORTICAL STEROID AGENTS.....	26
MUCOLYTIC AGENTS.....	26
EYE, EAR, NOSE AND THROAT (EENT) PREPARATIONS.....	26
<i>Ophthalmic Antibiotic Agents</i>	26

<i>Ophthalmic Anti-Inflammatory Agents</i>	26
<i>Ophthalmic Antiviral Agents</i>	27
<i>Ophthalmic Beta Blockers</i>	27
<i>Ophthalmic Miotic Agents</i>	27
<i>Carbonic Anhydrase Inhibitors</i>	27
<i>Ophthalmic Mydriatic Agents</i>	27
<i>Ophthalmic Sulfonamide Agents</i>	27
<i>Ophthalmic Antiallergic Agents</i>	27
<i>Ophthalmic Miscellaneous Agents</i>	27
<i>Otic Anti-Infective Agents</i>	27
INHALED/ORAL EENT AGENTS.....	28
<i>Inhaled Agents, Nasal</i>	28
<i>Carbonic Anhydrase Inhibitor Agents</i>	28
<i>Local Anesthetic Agents</i>	28
LEUKOTRIENE RECEPTOR ANTAGONISTS.....	28
MISCELLANEOUS EENT AGENTS.....	28
RESPIRATORY SMOOTH MUSCLE RELAXANT AGENTS.....	28
DIABETIC AND THYROID AGENTS.....	28
DIABETIC AGENTS.....	28
<i>Sulfonylureas</i>	28
<i>Non-Sulfonylureas</i>	29
INSULIN AGENTS.....	29
THYROID AGENTS.....	29
<i>Antithyroid Agents</i>	29
HORMONE AND CONTRACEPTIVE AGENTS.....	29
ORAL ADRENAL CORTICAL STEROID AGENTS.....	29
ANDROGEN AGENTS.....	30
BISPHOSPHONATE AGENTS.....	30
ESTROGEN AGENTS.....	30
GROWTH AGENTS.....	30
CONTRACEPTIVE AGENTS.....	30
<i>Monophasic Oral Contraceptives</i>	30
<i>Biphasic Oral Contraceptives</i>	31
<i>Triphasic Oral Contraceptives</i>	31
<i>Miscellaneous Contraceptives</i>	31
OXYTOCIC AGENTS.....	31
PITUITARY AGENTS.....	31
PROGESTIN AGENTS.....	31
GENITOURINARY AGENTS.....	31
URINARY ANTI-INFECTIVE AGENTS.....	31
URINARY TRACT ANALGESICS.....	31
GENITOURINARY SMOOTH MUSCLE RELAXANT AGENTS.....	31
PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS.....	31
TOPICAL/MUCOUS MEMBRANE AGENTS.....	32
ANTI-ACNE AGENTS.....	32
KERATOLYTIC AGENTS.....	32
MISCELLANEOUS SKIN/MUCOUS MEMBRANE AGENTS.....	32
PIGMENTING AND MISCELLANEOUS AGENTS.....	32
TOPICAL ANTIBIOTIC AGENTS.....	32
TOPICAL ANTIFUNGAL AGENTS.....	33
VAGINAL ANTI-INFECTIVE AGENTS.....	33

TOPICAL ANTI-INFLAMMATORY AGENTS	33
TOPICAL ANTIPRURITIC AND LOCAL ANESTHETIC AGENTS	33
TOPICAL ANTIVIRAL AGENTS	34
TOPICAL MISCELLANEOUS ANTI-INFECTIVE AGENTS	34
SCABICIDE/PEDICULICIDE AGENTS	34
MISCELLANEOUS/UNCLASSIFIED AGENTS.....	34
ELECTROLYTE AGENTS	34
<i>Potassium Agents</i>	34
<i>Potassium-Removing Resins</i>	34
HEAVY METAL ANTAGONIST AGENTS	34
VITAMIN AND FLUORIDE AGENTS	34
<i>Fluoride Agents</i>	34
<i>Vitamin A</i>	34
<i>Vitamin B-Complex Agents</i>	34
<i>Vitamin D</i>	35
<i>Vitamin K Activity Agents</i>	35
<i>Multivitamin Agents</i>	35
<i>Prenatal Vitamin Agents</i>	35
DIAGNOSTIC TESTING.....	35
<i>Blood Glucose Meters</i>	35
<i>Blood Glucose Testing Strips</i>	35
WEIGHT LOSS AGENTS	35
ALCOHOL DETERRENTS.....	35
GOUT AGENTS	35
SMOKING DETERRENTS.....	35
MEDICAL DEVICES	35
ANAPHYLAXIS KITS	36

CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

\$	Diclofenac Potassium	CATAFLAM
\$	Diclofenac Sodium	VOLTAREN
\$	Flurbiprofen	ANSAID
\$	Ibuprofen	MOTRIN
\$	Indomethacin	INDOCIN

\$	Naproxen	(INDOCIN SUPP NONFORMULARY)
\$		NAPROSYN
\$\$	Choline Mag. Trisalicylate	TRILISATE
\$	Naproxen Sodium	ANAPROX
		ANAPROX DS

\$	Piroxicam	FELDENE
\$	Salsalate	DISALCID
\$	Sulindac	CLINORIL
\$\$	Etodolac	LODINE
\$\$	Fenoprofen	NALFON
\$\$	Indomethacin, Sustained Release	INDOCIN SR
\$\$	Meclofenamate	MECLOMEN

SECOND LINE AGENTS

	\$\$	Ketoprofen	ORUVAIL
	\$\$	Ketorolac	TORADOL, LIMITED TO 5 DAYS TREATMENT
STEP	\$\$	Meloxicam	MOBIC, STEP THERAPY (FAILURE OF AN UNRESTRICTED FORMULARY NSAID)
			MELOXICAM SUSPENSION NONFORMULARY)
	\$\$	Nabumetone	RELAFEN
	\$\$\$	Etodolac, Sustained Release	LODINE XL
	\$\$\$	Oxaprozin	DAYPRO
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

PA	\$\$\$	Leflunomide	ARAVA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
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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
		IMITREX NASAL, QUANTITY LIMIT OF 6 NASAL SPRAYS PER MONTH
\$\$\$\$	Sumatriptan Nasal	
\$\$\$\$\$	Dihydroergotamine	D.H.E. 45
		MIGRANAL, LIMITED TO 1 KIT PER MONTH

Opiate Agonists

\$	Acetaminophen/Codeine (Capsules & VOPAC® Nonformulary)	TYLENOL #2, #3, #4
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	\$	Acetaminophen/Hydrocodone	VICODIN VICODIN ES LORCET LORCET PLUS
	\$	Codeine/Aspirin	EMPIRIN #2, #3, #4
	\$	Oxycodone/Acetaminophen	PERCOCET TYLOX
	\$	Oxycodone/Aspirin	PERCODAN
	\$	Propoxyphene Napsylate/APAP	DARVOCET-N 100 (DARVOCET A 500 & TRYCET NONFORMULARY)
	\$\$	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE
	\$\$	Butalbital/Aspirin/Codeine	FIORINAL/CODEINE
	\$\$	Dihydrocodeine/APAP/Caffeine	DHC PLUS
	\$\$	Hydromorphone	DILAUDID (DILAUDID SYRUP NONFORMULARY)
	\$\$	Meperidine	DEMEROL
PA	\$\$	Oxycodone	OXYIR, PA REQ
	\$\$\$	Morphine	MSIR
	\$\$\$	Morphine SR	MS CONTIN
		Opiate Antagonists	
	\$\$\$	Naltrexone	REVIA
		Miscellaneous Analgesics	
	\$	Tramadol	ULTRAM (ULTRAM ER NONFORMULARY)
		Miscellaneous Central Nervous System Agents	
PA	\$\$\$	Donepezil	ARICEPT, PA REQ
PA			ARICEPT ODT, PA REQ

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 (KLONOPIN WAFERS NONFORMULARY)
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

AGE	\$\$\$	Oxycarbazepine	(EQUETRO NONFORMULARY)
PA	\$\$\$	Tiagabine	TRILEPTAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$	Zonisamide	GABITRIL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$\$	Levetiracetam	ZONEGRAN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$\$\$	Topiramate	KEPPRA, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
			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)
AGE	\$\$	Procyclidine	KEMADRIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Carbidopa/Levodopa CR	SINEMET CR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Bromocriptine	PARLODEL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Pramipexole	MIRAPEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
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
\$	Diazepam	VALIUM
		VALRELEASE NOT COVERED
\$	Methocarbamol	ROBAXIN
\$\$	Baclofen	LIORESAL
\$\$	Carisoprodol/Aspirin	SOMA COMPOUND
\$\$	Chlorzoxazone	PARAFON DSC
\$\$	Orphenadrine/Aspirin/Caffeine	NORGESIC
		NORGESIC FORTE
\$\$	Tizanidine	ZANAFLEX TABLETS (ZANAFLEX CAPSULES NONFORMULARY)
\$\$\$	Dantrolene Sodium	DANTRIUM
\$\$\$	Metaxalone	SKELAXIN
\$\$\$	Orphenadrine Citrate	NORFLEX

Psychotherapeutic Agents

Tricyclic Antidepressant Agents

\$	Amitriptyline	ELAVIL
\$\$\$	Amoxapine	ASENDIN
\$	Desipramine	NORPRAMIN
\$	Doxepin	SINEQUAN
\$	Imipramine	TOFRANIL (TOFRANIL PM NONFORMULARY)
		LUDIOMIL

\$ Nortriptyline

PAMELOR
AVENTYL

S.S.R.I. Agents

\$ Citalopram

\$ Fluoxetine

CELEXA
PROZAC (40MG STRENGTH NONFORMULARY; USE 2 X 20MG
FOR 40MG DOSE)

\$ Paroxetine

RAPIFLUX

PAXIL

PAXIL CR

\$\$ Sertraline

ZOLOFT TABLETS(USE 1/2 OF 100MG TABLET FOR 50MG
DOSE),
(USE 1/2 OF 50MG FOR 25MG DOSE)

S.N.R.I. Agents

ST \$\$\$ Venlafaxine

EFFEXOR STEP THERAPY (TRIAL OF FORMULARY SSRI)
(EFFECTIVE 5/1/09)

EFFEXOR XR CAPSULES STEP THERAPY (TRIAL OF
FORMULARY SSRI) (EFFECTIVE 5/1/09)

VENLAFAXINE XR TABLETS STEP THERAPY (TRIAL OF
FORMULARY SSRI) (EFFECTIVE 5/1/09)

M.A.O. Inhibitor Agents

\$\$ Phenezine

\$\$ Tranylcypromine

NARDIL

PARNATE

Miscellaneous Antidepressant Agents

\$ Clomipramine

\$ Trazodone

\$\$ Mirtazapine Tablets

ANAFRANIL

DESYREL

REMORON TABLETS (7.5MG TABLETS NONFORMULARY,
SOLTABS NONFORMULARY)

\$\$ Nefazodone

\$\$\$ Bupropion

SERZONE

WELLBUTRIN

MD

WELLBUTRIN SR, **RESTRICTED**

(WELLBUTRIN XL, APLENZIN NON-FORMULARY)

Antimanic Agents

\$ Lithium Carbonate (All Forms)

ESKALITH

LITHOBID

Benzodiazepines

\$ Alprazolam

XANAX

(XANAX XR & NIRAVAM NONFORMULARY)

\$ Chlordiazepoxide

LIBRIUM

\$ Diazepam

VALIUM

(VALRELEASE NONFORMULARY)

\$ Flurazepam

DALMANE

\$ Lorazepam

ATIVAN

\$ 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
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
	\$	Zolpidem	AMBIEN, LIMITED TO #14/30 DAYS (AMBIEN CR, EDLUAR NON-FORMULAY)
	\$\$	Buspirone	BUSPAR
	\$\$\$	Zaleplon	SONATA, LIMITED TO #14/30 DAYS

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, STEP	\$\$	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, STEP	\$\$\$	Dexmethylphenidate	FOCALIN XR, MEMBERS ≤ 18 REQUIRE STEP THERAPY (METHYLPHENIDATE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
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

PA	\$	Amiodarone 200mg	CORDARONE, PA REQ (OTHER AMIODARONE STRENGTHS NONFORMULARY)
PA	\$	Mexiletine	MEXITIL, PA REQ
PA	\$	Procainamide	PRONESTYL, PA REQ
PA	\$	Procainamide SR	PROCAN SR, PA REQ
PA			PROCANBID, PA REQ
PA	\$	Quinidine Sulfate	QUINIDINE SULFATE, PA REQ

PA	\$	Sotalol	BETAPACE, PA REQ
PA	\$\$	Disopyramide	NORPACE, PA REQ
PA	\$\$	Disopyramide CR	NORPACE CR, PA REQ
PA	\$\$	Flecainide	TAMBOCOR, PA REQ
PA	\$\$	Quinidine Gluconate	QUINAGLUTE, PA REQ
PA	\$\$\$	Quinidine Sulfate SR	QUINIDEX, PA REQ
PA	\$\$\$\$	Dofetilide	TIKOSYN, PA REQ
PA	\$\$\$\$	Propafenone	RYTHMOL, PA REQ (RYTHMOL SR NONFORMULARY)

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

PA	\$	Reserpine	SERPASIL, PA REQ
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Beta-Adrenergic Antagonist Agents

PA	\$	Atenolol	TENORMIN, PA REQ
PA	\$	Atenolol/Chlorthalidone	TENORETIC, PA REQ
PA	\$	Bisoprolol/HCTZ	ZIAC, PA REQ
PA	\$	Metoprolol	LOPRESSOR, PA REQ
PA	\$	Nadolol	CORGARD, PA REQ
PA	\$	Pindolol	VISKEN, PA REQ
PA	\$	Propranolol	INDERAL, PA REQ
PA	\$\$	Metoprolol Succinate	TOPROL XL, PA REQ
PA	\$\$	Propranolol LA	INDERAL LA, PA REQ

Combination Alpha-Beta Antagonist Agents

PA	\$	Labetalol	NORMODYNE, PA REQ
PA			TRANDATE, PA REQ
PA	\$\$	Carvedilol	COREG, PA REQ (COREG CR NONFORMULARY)

Angiotensin Converting Enzyme Inhibitor Agents

PA	\$	Benazepril	LOTENSIN, PA REQ
PA	\$	Benazepril/HCTZ	LOTENSIN HCT, PA REQ
PA	\$	Captopril	CAPOTEN, PA REQ
PA	\$	Captopril/HCTZ	CAPOZIDE, PA REQ
PA	\$	Enalapril	VASOTEC, PA REQ
PA	\$	Lisinopril	ZESTRIL, PA REQ
PA	\$	Lisinopril/HCTZ	ZESTORETIC, PA REQ
PA	\$\$	Ramipril	ALTACE (10MG STRENGTH ONLY), PA REQ

Angiotensin Receptor Blocker Agents

PA	\$\$	Olmesartan	BENICAR, PA REQ
PA	\$\$	Olmesartan/HCTZ	BENICAR HCT, PA REQ
PA	\$\$	Valsartan	DIOVAN, PA REQ
PA	\$\$	Valsartan/HCTZ	DIOVAN HCT, PA REQ

Calcium Channel Blocking Agents

PA	\$	Diltiazem	CARDIZEM, PA REQ
PA	\$	Nifedipine	ADALAT, PA REQ
PA			PROCARDIA, PA REQ
PA	\$	Verapamil	CALAN, PA REQ
PA	\$\$	Amlodipine	NORVASC, PA REQ
PA	\$\$	Diltiazem CD	CARDIZEM CD, PA REQ (CARDIZEM CD 360MG NONFORMULARY)
PA	\$\$	Diltiazem SR	CARDIZEM SR, PA REQ (CARDIZEM LA NONFORMULARY)

PA	\$\$	Diltiazem SA Capsules	DILACOR XR, PA REQ
PA			TIAZAC, PA REQ
PA	\$\$	Felodipine	PLENDIL, PA REQ
PA	\$\$	Nifedipine, Sustained Release	ADALAT CC, PA REQ
PA	\$\$	Verapamil SR Tablets	CALAN SR, PA REQ
			(COVERA-HS NONFORMULARY)
PA	\$\$	Verapamil LA Capsules	VERELAN, PA REQ

Centrally Acting Antihypertensive Agents

PA	\$	Clonidine	CATAPRES, PA REQ
PA	\$	Guanfacine	TENEX, PA REQ
PA	\$	Methyldopa	ALDOMET, PA REQ

Potassium-Sparing Diuretics

PA	\$	Spirolactone	ALDACTONE, PA REQ
PA	\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE, PA REQ
PA	\$	Triamterene 37.5mg/HCTZ 25mg	MAXZIDE 25, PA REQ
PA	\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50, PA REQ

Loop Diuretics

PA	\$	Furosemide	LASIX, PA REQ
PA	\$\$	Bumetanide	BUMEX, PA REQ

Thiazide and Related Diuretics

PA	\$	Chlorthalidone	HYGROTON, PA REQ
PA	\$	Hydrochlorothiazide (HCTZ)	HYDRODIURIL, PA REQ
PA	\$	Indapamide	LOZOL, PA REQ
PA	\$\$	Metolazone	ZAROXOLYN, PA REQ

Vasodilator Antihypertensive Agents

PA	\$	Doxazosin Mesylate	CARDURA, PA REQ (CARDURA XL NONFORMULARY)
PA	\$	Hydralazine	APRESOLINE, PA REQ
PA	\$	Prazosin	MINIPRESS, PA REQ
PA	\$	Terazosin	HYTRIN, PA REQ

Antilipidemic Agents

	\$	Cholestyramine	QUESTRAN QUESTRAN LIGHT
	\$	Gemfibrozil	LOPID
	\$	Lovastatin	MEVACOR
	\$	Simvastatin	ZOCOR
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)
ST	\$\$\$	Rosuvastatin	CRESTOR (USE ½ 10MG FOR 5MG DOSE;USE ½ 20MG FOR 10MG DOSE;USE ½ 40MG FOR 20MG DOSE) STEP THERAPY REQUIRED ON ALL STRENGTHS EXCEPT 40MG TABLETS (TRIAL OF SIMVASTATIN 80MG REQUIRED) (EFFECTIVE 7/15/09)

Blood Agents

Anticoagulants

PA	\$	Warfarin Sodium	COUMADIN, PA REQ
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\$\$\$\$\$ Dalteparin syringes
 \$\$\$\$\$ Enoxaparin Syringes
 \$\$\$\$\$ Fondaparinux
 \$\$\$\$\$ Tinzaparin

FRAGMIN SYRINGES, LIMITED TO 10 SYRINGES/FILL AND 2
 FILLS/YEAR
 LOVENOX SYRINGES, LIMITED TO 10 SYRINGES/FILL AND 2
 FILLS/YEAR
 ARIXTRA, LIMITED TO 20 SYRINGES/FILL AND 2 FILLS/YEAR
 INNOHEP, LIMITED TO 10 VIALS/FILL AND 2 FILLS/YEAR

Hemorrhologic Agents

PA \$ Pentoxifylline
 PA \$\$ Cilostazol

TRENTAL, PA REQ
 PLETAL, PA REQ

Cardiac Glycoside Agents

PA \$ Digoxin

LANOXIN, PA REQ
 (LANOXICAP NONFORMULARY)

Antiplatelet Agents

PA \$ Dipyridamole
 PA \$\$ Anagrelide
 PA \$\$ Ticlopidine
 PA \$\$\$ Clopidogrel

PERSANTINE, PA REQ
 AGRYLIN, PA REQ
 TICLID, PA REQ
 PLAVIX, PA REQ

Vasodilating Agents

PA \$ Isosorbide Dinitrate (Chew Tablets Not Covered)
 PA \$ Nitroglycerin Sublingual
 PA \$ Nitroglycerin Ointment
 PA \$\$ Isosorbide Dinitrate SR
 PA \$\$ Isosorbide Mononitrate
 PA
 PA \$\$ Nitroglycerin Oral
 PA \$\$ Nitroglycerin Patches
 PA \$\$\$ Nitroglycerin Spray

ISORDIL, PA REQ
 NITROSTAT SL, PA REQ
 NITROL, PA REQ
 DILATRATE SR, PA REQ
 IMDUR - PREFERRED, PA REQ
 MONOKET, PA REQ
 (ISMO NONFORMULARY)
 NITROGLYN E-R, PA REQ
 NITRODUR - PREFERRED, PA REQ
 NITROLINGUAL SPRAY, PA REQ

Miscellaneous Cardiovascular Agents

PA \$\$ Midodrine

PROAMATINE, PA REQ

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

\$ Diphenoxylate/Atropine

LOMOTIL

Anti-emetic Agents

\$ Meclizine
 \$ Metoclopramide
 \$ Prochlorperazine Maleate
 AGE \$ Promethazine
 \$ Trimethobenzamide

ANTIVERT
 REGLAN (METOCLOPRAMIDE INTENSOL NONFORMULARY)
 COMPAZINE
 PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS
 DUE TO RISK OF RESPIRATORY DEPRESSION
 TIGAN

AGE, QL	\$\$	Ondansetron Tablets and ODT	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)
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Antimuscarinic/Antispasmodic Agents

\$	Belladonna/Phenobarbital (Extentab Not Covered)	DONNATAL
\$	Dicyclomine	BENTYL
\$	Hyoscyamine Sulfate	LEVSIN LEVBID

Anti-ulcer/Antipeptic Agents

\$	Cimetidine	TAGAMET	
\$	Famotidine	PEPCID	
\$	Misoprostol	CYTOTEC	
\$	Omeprazole OTC	PRILOSEC OTC	
\$	Omeprazole (Federal Legend) 20mg capsules	PRILOSEC (FEDERAL LEGEND) 20MG CAPSULES (EFFECTIVE 3/1/09) (ZEGERID AND OMEPRAZOLE 40MG NONFORMULARY)	
\$	Ranitidine	ZANTAC (ZANTAC EFFERDOSE NONFORMULARY)	
\$\$	Omeprazole (Federal Legend) 10mg capsules	PRILOSEC (FEDERAL LEGEND) 10MG CAPSULES LIMIT OF #30 CAPSULES (PATIENTS REQUIRING DOSE GREATER THAN 10MG SHOULD USE OMEPRAZOLE 20MG) (ZEGERID AND OMEPRAZOLE 40MG NONFORMULARY)	
ST	\$\$\$	Sucralfate	CARAFATE
ST	\$\$\$	Lansoprazole OTC 15mg Capsules	PREVACID 24HR, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (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) (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)
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)
	\$\$\$\$	Pantoprazole	PROTONIX

Bowel Evacuant Agents

\$	Oral Colon Lavage Solution	COLYTELY GOLYTELY
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Digestive Enzymes

AGE \$\$\$ Amylase/Lipase/Protease/Pancreatin
AGE \$\$\$\$ Amylase/Lipase/Protease
AGE
AGE

CREON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PANCREAZE, MEMBERS <21 MAY BE CCS-ELIGIBLE
ULTRASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
VIOKASE, MEMBERS <21 MAY BE CCS-ELIGIBLE

Gallstone Solubilizing Agents

\$\$\$ Ursodiol

ACTIGALL
(URSO FORTE NONFORMULARY)

Gastrointestinal Stimulant Agents

\$ Metoclopramide

REGLAN

Laxative Agents

\$\$ Lactulose

CEPHULAC
CHRONULAC
MIRALAX

\$\$ Polyethylene Glycol 3350

Ulcer Eradication Agents

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

TRITEC
HELIDAC

ANTI-INFECTIVE AGENTS

Amebicides

\$ Metronidazole Tablets

FLAGYL TABLETS (FLAGYL ER AND METRONIDAZOLE
CAPSULES NONFORMULARY)

\$\$ Iodoquinol (Diodohydroxyquin)
\$\$\$ Paromomycin

YODOXIN
HUMATIN

Antihelmintic Agents

\$ Mebendazole
\$ Thiabendazole
\$\$ Furazolidone
\$\$\$\$ Praziquantel

VERMOX
MINTEZOL
FUROXONE
BILTRICIDE

Antibiotic Agents

Aminoglycosides

\$ Neomycin Sulfate

NEOMYCIN

Cephalosporins

\$ Cephalexin

KEFLEX
(KEFLEX 750MG STRENGTH NONFORMULARY)

\$\$ Cefdinir
\$\$ Cefuroxime Axetil
\$\$\$ Cefadroxil
\$\$\$ Cefprozil

OMNICEF
CEFTIN
DURICEF
CEFZIL

Macrolide Antibiotic Agents

\$ Erythromycin Base

ERY-TAB

	\$	Erythromycin Stearate	ERYTHROCIN
	\$	Erythromycin Ethylsuccinate	EES
	\$\$	Azithromycin	ERYPED SUSPENSION 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	VANCOGIN, 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
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\$	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	\$\$\$	Oseltamivir	REBETOL, PA REQ
	\$\$\$	Valacyclovir	TAMIFLU, QTY LIMITED TO 1 COURSE OF TREATMENT PER 6 MONTHS (EFFECTIVE 8/1/09)
	\$\$\$	Zanamivir	VALTREX
	\$\$\$\$	Rimantadine	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS (EFFECTIVE 10/1/09)
AGE	\$\$\$\$	Zidovudine (AZT)	FLUMADINE
AGE	\$\$\$\$	Abacavir	RETROVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, MD	\$\$\$\$	Adefovir Dipivoxil	ZIAGEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Amprenavir	HEPSERA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Delavirdine	AGENERASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Didanosine (DDI)	RESCRIPTOR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Efavirenz	VIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, MD	\$\$\$\$	Entecavir	VIDEX EC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Ganciclovir	SUSTIVA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Indinavir	BARACLUDE, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Interferon Alpha 2a	CYTOVENE
PA	\$\$\$\$	Interferon Alpha 2b	CRIXIVAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Lamivudine (3TC)	ROFERON-A, PA REQ
AGE, MD	\$\$\$\$	Lamivudine HBV	INTRON A, PA REQ
AGE	\$\$\$\$	Nelfinavir	EPIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$	Nevirapine	EPIVIR HBV, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Peginterferon Alfa-2a	VIRACEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Pentamidine, Aerosolized	VIRAMUNE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Ribavirin, Aerosolized	PEGASYS, PA REQ
AGE	\$\$\$\$	Ritonavir	NEBUPENT, PA REQ
			VIRAZOLE, PA REQ
			NORVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE	\$\$\$\$\$	Saquinavir
AGE	\$\$\$\$\$	Stavudine (d4T)
AGE, MD	\$\$\$\$\$	Telbivudine
AGE	\$\$\$\$\$	Tenofovir
AGE	\$\$\$\$\$	Zalcitabine (ddC)
AGE	\$\$\$\$\$	Zidovudine/Lamivudine
AGE	\$\$\$\$\$	Zidovudine/Lamivudine/Abacavir

INVIRASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 ZERIT, MEMBERS <21 MAY BE CCS-ELIGIBLE
 TYZEKA, RESTRICTED TO GASTROENTEROLOGISTS,
 MEMBERS <21 MAY BE CCS-ELIGIBLE
 VIREAD, MEMBERS <21 MAY BE CCS-ELIGIBLE
 HIVID, MEMBERS <21 MAY BE CCS-ELIGIBLE
 COMBIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
 TRIZIVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE

Leprostatic Agents

\$	Clofazimine
\$	Dapsone

LAMPRENE
 DAPSONE
 (ACZONE IS NONFORMULARY)

Sulfonamide Agents

\$	Sulfamethoxazole/Trimethoprim (SMZ/TMP)
AGE	\$ Sulfasalazine(Enteric Coated Not Covered)
\$	Sulfisoxazole
\$	Trimethoprim
\$\$	Erythromycin/Sulfisoxazole
\$\$\$	Sulfadiazine

BACTRIM
 SEPTRA
 AZULFIDINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 (EFFECTIVE 5/1/09) (AZULFIDINE EN-TABS NONFORMULARY)
 GANTRISIN
 TRIMPEX
 PEDIAZOLE
 SULFADIAZINE

ANTINEOPLASTIC AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

AGE	Altretamine
AGE	Anastrozole
AGE	Bicalutamide
AGE	Busulfan
AGE	Capecitabine
AGE	Chlorambucil
AGE	Cyclophosphamide
AGE	Estramustine
AGE	Etoposide
AGE	Flutamide
AGE	Hydroxyurea
AGE	Letrozole
AGE	Leucovorin
AGE	Levamisole
AGE	Lomustine
AGE	Megestrol
AGE	Melphalan
AGE	Mercaptopurine
AGE	Methotrexate 2.5mg Tablets
AGE	Mitotane

HEXALEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 ARIMIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
 CASODEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
 MYLERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 XELODA, MEMBERS <21 MAY BE CCS-ELIGIBLE
 LEUKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 CYTOXAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 EMCYT, MEMBERS <21 MAY BE CCS-ELIGIBLE
 VEPESID, MEMBERS <21 MAY BE CCS-ELIGIBLE
 EULEXIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 HYDREA, MEMBERS <21 MAY BE CCS-ELIGIBLE
 FEMARA, MEMBERS <21 MAY BE CCS-ELIGIBLE
 WELLCOVORIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 ERGAMISOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
 CEENU, MEMBERS <21 MAY BE CCS-ELIGIBLE
 MEGACE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 (MEGACE ES NONFORMULARY)
 ALKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
 PURINETHOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
 RHEUMATREX 2.5 MG TABLETS, MEMBERS <21 MAY BE CCS-ELIGIBLE OTHER STRENGTHS AND DOSE PACKS
 NONFORMULARY
 LYSODREN, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE	Nilutamide	NILANDRON, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Procarbazine	MATULANE, 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
AGE	Testolactone	TESLAC, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Thioguanine	THIOGUANINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Tretinoin	VESANOID, 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
PA	\$\$\$\$\$	Glatiramer	COPAXONE, PA REQ
AGE	\$\$\$\$\$	Mycophenolate	CELLCEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE

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
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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

	\$	Metaproterenol	ALUPENT
	\$\$	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)
PA	\$\$\$\$	Formoterol/Budesonide	SYMBICORT, PA REQ
STEP	\$\$\$\$	Salmeterol/Fluticasone	ADVAIR DISKUS, STEP THERAPY ADVAIR HFA, STEP THERAPY (TRIAL OF ORAL INHALED STEROID)

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

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
\$\$	Triamcinolone Oral Inhaled	AZMACORT
\$\$\$	Fluticasone Oral Inhaled	FLOVENT HFA
\$\$\$	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

\$\$\$	Ketorolac Tromethamine Ophthalmic	ACULAR ACULAR LS ACULAR PF	
Ophthalmic Antiviral Agents			
\$\$\$	Trifluridine Ophthalmic Solution	VIROPTIC	
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)	
MD	\$\$\$	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			
\$\$\$\$	Bimatoprost	LUMIGAN	
\$\$\$\$	Latanoprost	XALATAN	
\$\$\$\$	Travoprost	TRAVATAN	
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)
	\$\$\$\$	Cromolyn Sodium	INTAL INHALER

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	\$	Glipizide	GLUCOTROL, MEMBERS <21 MAY BE CCS-ELIGIBLE

Community Health Group

Healthy Families

February 2010

Revised: 1/5/10

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	\$	Glyburide/Metformin	GLUCOVANCE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolazamide	TOLINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolbutamide	ORINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
Non-Sulfonylureas			
AGE	\$	Metformin	GLUCOPHAGE, MEMBERS <21 MAY BE CCS-ELIGIBLE (GLUCOPHAGE XR NONFORMULARY)
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	\$\$\$	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	\$\$\$	Pioglitazone	ACTOS, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Repaglinide	PRANDIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Rosiglitazone	AVANDIA, MEMBERS <21 MAY BE CCS-ELIGIBLE

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

Thyroid Agents

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

Antithyroid Agents

\$	Propylthiouracil	PROPYLTHIOURACIL
\$\$	Methimazole	TAPAZOLE

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
	\$\$	Cortisone Acetate	PEDIAPRED
	\$\$\$	Betamethasone Oral	PRELONE
AGE	\$\$\$	Prednisolone Sodium Phosphate 10mg ODT	CORTONE
			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

Estrogen Agents

	\$	Diethylstilbestrol	DES
	\$	Estradiol	ESTRACE
	\$	Estropipate	OGEN (ORTHO-EST NONFORMULARY)
	\$\$	Conjugated Estrogens	PREMARIN PREMARIN VAGINAL CREAM
	\$\$	Estrogen/Medroxyprogesterone	PREMPRO
	\$\$	Esterified Estrogens/ Methyltestosterone	ESTRATEST
	\$\$	Ethinyl Estradiol/Norethindrone	FEMHRT

Growth Agents

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

Contraceptive Agents

Monophasic Oral Contraceptives

	\$	Desogestrel/Ethinyl Estradiol	DESOGEN
	\$	Ethinodiol/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
		PLAN B ONE-STEP (EFFECTIVE 11/1/09)
\$	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
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\$\$ Pyridostigmine
\$\$ Neostigmine

MESTINON
PROSTIGMIN

TOPICAL/MUCOUS MEMBRANE AGENTS

Anti-Acne Agents

\$	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

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

\$	Nystatin	MYCOSTATIN
\$	Triamcinolone/Nystatin	MYCOLOG II
\$\$	Clotrimazole/Betamethasone	LOTRISONE
\$\$	Ketoconazole	NIZORAL
\$\$\$	Ciclopirox	LOPROX (LOPROX SHAMPOO NONFORMULARY)
\$\$\$	Naftifine	NAFTIN
\$\$\$	Sulconazole	EXELDERM

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
\$\$	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)
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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
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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
\$\$	Calcitriol	ROCALTROL
\$\$	Dihydrotachysterol	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

\$	Prenatal Multivitamins	CHROMAGEN OB PRENATE ULTRA PRENATE ADVANCE
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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
AGE		ASCENSIA, MEMBERS <21 MAY BE CCS-ELIGIBLE

Weight Loss Agents

PA	\$\$	Phentermine	IONAMIN, PA REQ
PA	\$\$\$\$	Orlistat	XENICAL, PA REQ
PA	\$\$\$\$	Sibutramine	MERIDIA, PA REQ

Alcohol Deterrents

\$\$	Disulfiram	ANTABUSE
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Gout Agents

\$	Allopurinol	ZYLOPRIM
\$\$	Colchicine	COLCHICINE
\$\$	Probenecid	BENEMID
\$\$\$	Colchicine/Probenecid	COL-BENEMID

Smoking Deterrents

PA	\$\$	Nicotine	NICOTROL INHALER, PA REQ
PA	\$\$\$	Bupropion SR	ZYBAN, PA REQ

Medical Devices

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

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

EPIPEN, EPIPEN JR

Recent Changes to the Formulary

Drug Name	Formulary Change	Effective Date
Prevacid 24HR (OTC)	Added to formulary with a step therapy restriction (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 step therapy restriction (omeprazole preferred)	2/1/10
Prevacid Solutabs	Restricted to patients less than 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
Nuvaring	Added to formulary	2/1/10
Quixin	Added to formulary, restricted to Ophthalmology	2/1/10
Onglyza	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
Orapred ODT 10mg	Added to formulary, restricted to patients 6 years of age and younger.	2/1/10
Axert	Removed from formulary. Sumatriptan preferred.	12/17/09
Zomig, Zomig ZMT	Removed from formulary. Sumatriptan preferred.	12/17/09
Plan B One-Step	Added to formulary.	11/1/09
Metronidazole 0.75% Cream and Gel	Added to formulary. Other strengths non-formulary.	11/1/09
Vigamox	Step therapy restriction added. Ophthalmic ciprofloxacin, ofloxacin, or generic Polytrim preferred. Ophthalmologists exempt from step therapy restriction.	11/1/09
Thyroid Agents	CCS restriction removed.	10/15/09
Metoprolol 25mg	Added to formulary with PA restrictions. Patients less than 21 years of age may be eligible for CCS.	10/1/09
Relenza	PA restriction removed. Patient may receive a 5-day course of either Relenza or Tamiflu in 180 day period)	10/1/09
Metformin XR	Added to formulary with step therapy restrictions (trial of metformin)	9/15/09
Fenofibrate	Generic fenofibrate added to formulary. Brand fenofibrate will remain nonformulary.	8/15/09

INDEX

—A—

- Abacavir, 22
- Acarbose, 29
- ACCOLATE, 28
- ACCUTANE, 32
- Acetaminophen/Codeine, 11
- Acetaminophen/Codeine Capsules, 11
- Acetaminophen/Hydrocodone, 12
- Acetazolamide, 28
- Acetazolamide SA, 28
- Acetic Acid, 27
- Acetic Acid 2%, 27
- Acetic Acid 2%/Hydrocortisone 1%, 27
- Acetylcysteine, 26
- ACHROMYCIN V, 21
- ACTIGALL, 20
- ACTOS, 29
- ACULAR, 27
- ACULAR LS, 27
- ACULAR PF, 27
- Acyclovir Oral, 22
- Acyclovir Topical, 34
- ADALAT, 16
- ADALAT CC, 17
- ADDERALL, 15
- ADDERALL XR, 15
- Adefovir Dipivoxil, 22
- ADHD Agents, 15
- ADVAIR DISKUS, 25
- ADVAIR HFA,, 25
- AGENERASE, 22
- AGRYLIN, 18
- ALAMAST, 27
- ALAVERT, 24
- ALAWAY, 27
- Albuterol, 25
- Albuterol E.R., 25
- Albuterol HFA, 25
- Albuterol/Ipratropium, 25
- Alcohol Deterrents, 35
- ALDACTONE, 17
- ALDARA, 32
- ALDOMET, 17
- Alendronate, 30
- ALESSE, 30
- ALKERAN, 23
- ALLEGRA, 24
- Allopurinol, 35
- ALOCRIL, 27
- ALOMIDE, 27
- Alpha-Adrenergic Antagonist Antihypertensive Agents, 16
- ALPHAGAN P, 27
- Alprazolam, 14
- ALTACE, 16
- Altretamine, 23
- Aluminum Chloride Hexahydrate, 32
- ALUPENT, 25
- Amantadine, 13, 22
- AMBIEN, 15
- Amebicides, 20
- Aminoglycosides, 20
- Aminophylline, 28
- Amiodarone 200mg, 15
- Amitriptyline, 13
- Amlodipine, 16
- Amoxapine, 13
- Amoxicillin, 21
- Amoxicillin/Potassium Clavulanate, 21
- AMOXIL, 21
- Amphetamine Aspartate/Amphetamine/Dextro-amphetamine, 15
- Ampicillin, 21
- Amprenavir, 22
- Amylase/Lipase/Protease, 20
- Amylase/Lipase/Protease/Pancreatin, 20
- ANAFRANIL, 14
- Anagrelide, 18
- Analgic and Anti-Inflammatory Agents, 11
- Anaphylaxis Kits, 36
- ANAPROX, 11
- ANAPROX DS, 11
- Anastrozole, 23
- Androgen Agents, 30
- Angiotensin Converting Enzyme Inhibitor Agents, 16
- Angiotensin Receptor Blocker Agents, 16
- ANSAID, 11
- ANTABUSE, 35
- Anthralin, 32, 34
- Anti-Acne Agents, 32
- Antiarrhythmic Agents, 15
- Antibiotic Agents, 20
- Anticoagulants, 17
- Anticonvulsant Agents, 12
- Antidiarrheal Agents, 18
- Anti-emetic Agents, 18
- Antifungal Agents, 21
- Antihelmintic Agents, 20
- Antihistamine Agents, 24
- Antihistamine/Decongestant Combination Agents, 24
- Antihypertensive Agents, 16
- ANTI-INFECTIVE AGENTS, 20
- Antilipidemic Agents, 17
- Antimalarial Agents, 21
- Antimanic Agents, 14
- Antimuscarinic/Antispasmodic Agents, 19

Antineoplastic Agents, 23
 ANTINEOPLASTIC AND IMMUNOSUPPRESSANT
 AGENTS, 23
 Antiparkinsonian Agents, 13
 Antiplatelet Agents, 18
 Antipsychotic Agents, 14
 Antithyroid Agents, 29
 Antituberculosis Agents, 22
 Antitussive Agents, 24
 Anti-ulcer/Antipeptic Agents, 19
 ANTIVERT, 18
 Antiviral Agents, 22
 ANUSOL HC 2.5%, 32
 APAP/Dichloralphenazone/Isometh, 11
 APRESOLINE, 17
 AQUASOL A, 34
 ARALEN, 22
 ARAVA, 11
 ARICEPT, 12
 ARICEPT ODT, 12
 ARIMIDEX, 23
 ARISTOCORT, 33
 ARIXTRA, 18
 ARMOUR THYROID, 29
 ARTANE, 13
 ASCENSIA, 35
 ASENDIN, 13
 ASMANEX, 26
 ASTELIN, 28
 ATABRINE, 22
 ATARAX, 15, 24
 Atenolol, 16
 Atenolol/Chlorthalidone, 16
 ATIVAN, 14
 Atomoxetine, 15
 Atropine Sulfate, 27
 ATROVENT HFA, 28
 Augmented Betamethasone Dipropionate, 33
 AUGMENTIN, 21
 AURALGAN, 28
 AVANDIA, 29
 AVC CREAM, 34
 AVENTYL, 14
 AYGESTIN, 31
 Azathioprine, 24
 Azelastine Nasal Spray, 28
 Azithromycin, 21
 AZMACORT, 26
 AZOPT, 27
 AZULFIDINE, 23

—B—

BACITRACIN, 26
 Bacitracin, 26
 Bacitracin/Polymyxin, 26
 Baclofen, 13

BACTRIM, 23
 BACTROBAN, 32
 BARACLUDE, 22
 Becaplermin, 32
 Beclomethasone, Oral Inhaled, 26
 Belladonna/Phenobarbital, 19
 Benazepril, 16
 Benazepril/HCTZ, 16
 BENEMID, 35
 BENICAR, 16
 BENICAR HCT, 16
 BENTYL, 19
 BENZAMYCIN, 32
 Benzocaine/Antipyrine Otic, 28
 Benzodiazepines, 14
 Benzonatate, 24
 Benztropine Mesylate, 13
 Beta-Adrenergic Antagonist Agents, 16
 Beta-Carotene, 34
 BETAGAN, 27
 Betamethasone Dipropionate, 33
 Betamethasone Oral, 30
 Betamethasone Valerate 0.1%, 33
 BETAPACE, 16
 BETA-VAL, 33
 Betaxolol, 27
 Bethanechol, 31
 BETIMOL, 27
 BETOPTIC S, 27
 BIAXIN, 21
 Bicalutamide, 23
 BILTRICIDE, 20
 Bimatoprost, 27
 Biphasic Oral Contraceptives, 31
 Bisoprolol/HCTZ, 16
 Bisphosphonate Agents, 30
 BLEPH-10, 27
 BLEPHAMIDE, 27
 Blood Agents, 17
 Blood Glucose Meters, 35
 Blood Glucose Testing Strips, 35
 Bowel Evacuant Agents, 19
 BRETHINE, 25
 Brimonidine, 27
 Brinzolamide, 27
 BROMFED, 24
 BROMFED PD, 24
 Bromocriptine, 13
 Bromphen/Pseudoephedrine, 24
 Bronchodilating Agents, 25
 Budesonide, Oral Inhaled, 26
 Bumetanide, 17
 BUMEX, 17
 Bupropion, 14
 Bupropion SR, 35
 BUSPAR, 15
 Bupirone, 15

Busulfan, 23
Butalbital/APAP/Caffeine, 11
Butalbital/APAP/Caffeine/Codeine, 12
Butalbital/Aspirin/Caffeine, 11
Butalbital/Aspirin/Codeine, 12

—C—

CAFERGOT, 11
CALAN, 16
CALAN SR, 17
Calcipotriene, 32
Calcitriol, 35
Calcium Channel Blocking Agents, 16
Capecitabine, 23
CAPOTEN, 16
CAPOZIDE, 16
Captopril, 16
Captopril/HCTZ, 16
CARAFATE, 19
Carbachol, 27, 28
Carbamazepine, 12
Carbamazepine SR, 12
Carbidopa/Levodopa, 13
Carbidopa/Levodopa CR, 13
Carbonic Anhydrase Inhibitor Agents, 28
Carbonic Anhydrase Inhibitors, 27
Cardiac Glycoside Agents, 18
CARDIOVASCULAR/BLOOD AGENTS, 15
CARDIZEM, 16
CARDIZEM CD, 16
CARDIZEM SR, 16
CARDURA, 17
Carisoprodol, 13
Carisoprodol/Aspirin, 13
Carteolol, 27
Carvedilol, 16
CASODEX, 23
CATAFLAM, 11
CATAPRES, 17
CEENU, 23
Cefadroxil, 20
Cefdinir, 20
Cefprozil, 20
CEFTIN, 20
Cefuroxime Axetil, 20
CEFZIL, 20
CELEBREX, 11
Celecoxib, 11
CELESTONE, 30
CELEXA, 14
CELLCEPT, 24
CENTRAL NERVOUS SYSTEM AGENTS, 11
Centrally Acting Antihypertensive Agents, 17
Cephalexin, 20
Cephalosporins, 20
CEPHULAC, 20

CERUMENEX, 28
Cetirizine (OTC only), 24
Chloral Hydrate, 15
Chlorambucil, 23
Chlordiazepoxide, 14
Chlorhexidine Gluconate, 28
Chloroquine, 22
CHLOROQUINE PHOSPHATE, 21
Chloroquine Phosphate, 21
Chlorpromazine, 14
Chlorpropamide, 28
Chlorthalidone, 17
Chlorzoxazone, 13
Cholestyramine, 17
Choline Mag. Trisalcylate, 11
CHROMAGEN OB, 35
CHRONULAC, 20
Ciclopirox, 33
Cilostazol, 18
CILOXAN, 26
Cimetidine, 19
CIPRO, 21
CIPRO HC, 27
CIPRO XR, 21
CIPRODEX, 27
Ciprofloxacin, 26
Ciprofloxacin, 21
Ciprofloxacin/Dexamethasone, 27
Ciprofloxacin/Hydrocortisone, 27
Citalopram, 14
Clarithromycin, 21
CLARITIN OTC, 24
CLARITIN-D OTC, 24
CLEOCIN, 21
CLEOCIN T, 32
Clindamycin, 21
Clindamycin Lotion/Gel, 32
Clindamycin Topical Solution, 32
CLINORIL, 11
Clobetasol, 33
Clocortolone Pivalate, 33
CLODERM, 33
Clofazimine, 23
Clomipramine, 14
Clonazepam, 12
Clonidine, 17
Clopidogrel, 18
Clorazepate, 14
Clotrimazole, 21
Clotrimazole/Betamethasone, 33
Codeine/Aspirin, 12
Codeine/Chlorpheniramine/Pseudoephedrine, 25
Codeine/Guaifenesin/Pseudoephed, 25
COGENTIN, 13
COL-BENEMID, 35
COLCHICINE, 35
Colchicine, 35

Colchicine/Probenecid, 35
COLY-MYCIN S, 27
COLYTE, 19
Combination Alpha-Beta Antagonist Agents, 16
COMBIVENT, 25
COMBIVIR, 23
COMPAZINE, 18
COMTAN, 13
CONCERTA, 15
CONDYLOX, 32
Conjugated Estrogens, 30
Contraceptive Agents, 30
COPAXONE, 24
COPEGUS, 22
CORDARONE, 15
CORDRAN, 33
COREG, 16
CORCARD, 16
CORTEF, 29
CORTENEMA, 33
CORTIFOAM, 33
Cortisone Acetate, 30
CORTISPORIN, 27
CORTISPORIN OPHTHALMIC, 26
CORTONE, 30
COSOPT, 27
COUMADIN, 17
CREON, 20
CRESTOR, 17
CRIXIVAN, 22
CROLOM, 27
Cromolyn Ophthalmic, 27
Cromolyn Sodium, 28
Crotamiton, 34
CUPRIMINE, 34
CUTIVATE, 33
CYCLESSA, 31
Cyclobenzaprine, 13
Cyclophosphamide, 23
Cyclosporine, 24
Cyproheptadine, 24
CYTOTEC, 19
CYTOVENE, 22
CYTOXAN, 23

—D—

D.H.E. 45, 11
DALMANE, 14
Dalteparin syringes, 18
Danazol, 30
DANOCRINE, 30
DANTRIUM, 13
Dantrolene Sodium, 13
DAPSONE, 23
Dapsone, 23
DARAPRIM, 22

Community Health Group
Healthy Families
February 2010
Revised: 1/5/10

DARVOCET-N 100, 12
DAYPRO, 11
DDAVP, 31
DECADRON, 29
DECONAMINE SR, 24
Delavirdine, 22
DELTASONE, 30
Demecarium, 27
DEMEROL, 12
DEMULEN, 30
DEPAKENE, 12
DEPAKOTE, 12
DEPO-PROVERA, 31
DES, 30
Desipramine, 13
Desmopressin, 31
DESOGEN, 30
Desogestrel/Ethinyl Estradiol, 30, 31
Desonide, 33
Desoximetasone Cream/Gel 0.05%, 33
Desoxymetasone 0.25%, 33
DESYREL, 14
Dexamethasone, 26, 29
Dexamethasone/Neomycin, 26
Dexamethasone/Polymyxin/Neomycin, 26
DEXASOL, 26
Dexchlorpheniramine, 24
DEXEDRINE, 15
Dexmethylphenidate, 15
DEXPAK IS NON-FORMUARY, 29
Dextroamphetamine, 15
DHC PLUS, 12
DIABETA, 29
Diabetic Agents, 28
DIABETIC AND THYROID AGENTS, 28
DIABINESE, 28
Diagnostic Testing, 35
DIAMOX, 28
DIAMOX SEQUELS, 28
Diazepam, 13, 14
Diclofenac Potassium, 11
Diclofenac Sodium, 11, 26
Dicloxacillin, 21
Dicyclomine, 19
Didanosine (DDI), 22
DIDRONEL, 30
Diethylstilbestrol, 30
Diflorasone Diacetate, 33
DIFLUCAN SUSPENSION, 21
DIFLUCAN TABLETS, 21
Digestive Enzymes, 20
Digoxin, 18
Dihydrocodeine/APAP/Caffeine, 12
Dihydroergotamine, 11
Dihydrotachysterol, 35
DILACOR XR, 17
DILANTIN, 12

DILATRATE SR, 18
DILAUDID, 12
Diltiazem, 16
Diltiazem CD, 16
Diltiazem SA Capsules, 17
Diltiazem SR, 16
DIOVAN, 16
DIOVAN HCT, 16
DIPENTUM, 19
Diphenoxylate/Atropine, 18
Dipivefrin, 27
DIPROLENE, 33
DIPROLENE AF, 33
DIPROSONE, 33
Dipyridamole, 18
DISALCID, 11
Disopyramide, 16
Disopyramide CR, 16
Disulfiram, 35
DITROPAN, 31
Divalproex Sodium, 12
Dofetilide, 16
DOMEBORO, 27
Donepezil, 12
DONNATAL, 19
Dorzolamide, 27
Dorzolamide/Timolol, 27
DOVONEX, 32
Doxazosin Mesylate, 17
Doxepin, 13
Doxycycline, 21
DRISDOL, 35
DRITHOCREME, 32, 34
DRITHOSCALP, 32
DRYSOL, 32
DURICEF, 20
DYAZIDE, 17
DYNAPEN, 21

—E—

Echothiophate Iodide, 27
EES, 21
Efavirenz, 22
EFFEXOR, 14
EFFEXOR XR, 14
EFUDEX, 32
ELAVIL, 13
Electrolyte Agents, 34
ELIDEL, 32
ELIMITE, 34
ELIXOPHYLLIN, 28
ELMIRON, 31
ELOCON, 33
EMCYT, 23
EMGEL, 32
EMPIRIN #2, #3, #4, 12

Community Health Group
Healthy Families
February 2010
Revised: 1/5/10

Enalapril, 16
ENDAL, 25
Enoxaparin Syringes, 18
Entacapone, 13
Entecavir, 22
ENTEX, 26
ENTEX LA, 26
EPIFOAM, 33
Epinephrine, 36
EPIPEN, 36
EPIVIR, 22
EPIVIR HBV, 22
ERGAMISOL, 23
Ergocalciferol, 35
Ergonovine Maleate, 31
Ergotamine/Caffeine, 11
ERGOTRATE, 31
ERYGEL, 32
ERYPED SUSPENSION, 21
ERY-TAB, 20
ERYTHROCIN, 21
Erythromycin Base, 20, 26
Erythromycin Estolate, 21
Erythromycin Ethylsuccinate, 21
Erythromycin Stearate, 21
Erythromycin Topical, 32
Erythromycin/Benzoyl Peroxide, 32
Erythromycin/Sulfisoxazole, 21, 23
ESGIC, 11
ESGIC PLUS, 11
ESKALITH, 14
Esterified Estrogens/Methyltestosterone, 30
ESTRACE, 30
Estradiol, 30
Estramustine, 23
ESTRATEST, 30
Estrogen Agents, 30
Estrogen/Medroxyprogesterone, 30
Estropipate, 30
Ethambutol, 22
Ethinyl Estradiol/Norethindrone, 30
Ethinodiol/Ethinyl Estradiol, 30
Etidronate, 30
Etodolac, 11
Etodolac, Sustained Release, 11
Etonogestrel/Ethinyl Estradiol, 31
Etoposide, 23
EULEXIN, 23
EURAX LOTION, 34
EXELDERM, 33
Expectorant Agents, 25
EXSEL, 34
Eye, Ear, Nose and Throat (EENT) Preparations, 26

—F—

Famotidine, 19

FANSIDAR, 22
 FELDENE, 11
 Felodipine, 17
 FEMARA, 23
 FEMHRT, 30
 Fenofibrate, 17
 Fenoprofen, 11
 Fexofenadine, 24
 FIORICET/CODEINE, 12
 FIORINAL, 11
 FIORINAL/CODEINE, 12
 FLAGYL, 20, 21
 Flavoxate, 31
 Flecainide, 16
 FLEXERIL, 13
 FLONASE, 28
 FLORINEF, 29
 FLORONE, 33
 FLORONE-E, 33
 FLOVENT HFA, 26
 Fluconazole Suspension, 21
 Fluconazole Tablets, 21
 Fludrocortisone Acetate, 29
 FLUMADINE, 22
 FLUNISOLIDE, 28
 Flunisolide, Nasal, 28
 Fluocinolone, 33
 Fluocinolone 0.025%, 33
 Fluocinolone Acetonide 0.2%, 33
 Fluoride Agents, 34
 Fluoride/Polyvitamins, 35
 Fluoride/Vitamins A,D,C, 35
 Fluorometholone, 26
 Fluorouracil, 32
 Fluoxetine, 14
 Fluoxymesterone, 30
 Fluphenazine, 14
 Flurandrenolide, 33
 Flurazepam, 14
 Flurbiprofen, 11
 Flurbiprofen Sodium, 26
 Flutamide, 23
 Fluticasone, 33
 Fluticasone Propionate, Nasal, 28
 Fluticasone, Oral Inhaled, 26
 FML, 26
 FML FORTE, 26
 FOCALIN, 15
 FOCALIN XR, 15
 FOLIC ACID, 34
 Folic Acid, 34
 Folic Acid/Multivitamins with Minerals, 34
 Fondaparinux, 18
 Formoterol/Budesonide, 25
 FOSAMAX, 30
 FRAGMIN SYRINGES, 18
 FURADANTIN, 31

Community Health Group
 Healthy Families
 February 2010
 Revised: 1/5/10

Furazolidone, 20
 Furosemide, 17
 FUROXONE, 20

—G—

Gabapentin, 12
 GABITRIL, 13
 Gallstone Solubilizing Agents, 20
 Ganciclovir, 22
 GANTRISIN, 23
 GARAMYCIN, 26, 32
 GASTROINTESTINAL AGENTS, 18
 Gastrointestinal Stimulant Agents, 20
 Gemfibrozil, 17
 GENITOURINARY AGENTS, 31
 Genitourinary Smooth Muscle Relaxant Agents, 31
 Gentamicin, 26
 Gentamicin Sulfate, 32
 Gentamicin/Prednisolone, 26
 Glatiramer, 24
 Glipizide, 28
 Glipizide L.A., 29
 GLUCAGON, 29
 Glucagon, 29
 GLUCOMETER, 35
 GLUCOPHAGE, 29
 GLUCOPHAGE XR, 29
 GLUCOTROL, 28
 GLUCOTROL XL, 29
 GLUCOVANCE, 29
 Glyburide, 29
 Glyburide/Metformin, 29
 GOLYTELY, 19
 Gout Agents, 35
 GRIFULVIN V SUSPENSION, 21
 GRIFULVIN V TABLETS, 21
 Griseofulvin Suspension, 21
 Griseofulvin Tablets, 21
 GRISPEG, 21
 Growth Agents, 30
 GUAIFED, 25
 GUAIFED-PD, 24
 Guaifenesin/Codeine, 25
 Guaifenesin/Codeine Phosphate, 25
 Guaifenesin/Dextromethorphan HBr, 24
 Guaifenesin/Phenylephrine, 25
 Guaifenesin/Pseudoephedrine, 24, 25
 Guanfacine, 17

—H—

HALDOL, 14
 Haloperidol, 14
 HALOTESTIN, 30
 Heavy Metal Antagonist Agents, 34
 HELIDAC, 20

Hemorrhologic Agents, 18
 HEPSERA, 22
 HEXALEN, 23
 HISTENEX HC, 25
 HIVID, 23
 HORMONE AND CONTRACEPTIVE AGENTS, 29
 HUMATIN, 20, 22
 HUMORSOL, 27
 Hydralazine, 17
 HYDREA, 23
 Hydrochlorothiazide (HCTZ), 17
 Hydrocodone/Chlorpheniramine, 25
 Hydrocortisone, 33
 Hydrocortisone Acetate, 33
 Hydrocortisone Enema, 33
 Hydrocortisone Oral, 29
 Hydrocortisone Rectal Cream, 32
 Hydrocortisone Valerate, 33
 Hydrocortisone/Neomycin/Polymyxin, 26, 27
 Hydrocortisone/Pramoxine, 33
 HYDRODIURIL, 17
 Hydromorphone, 12
 Hydroxychloroquine, 22
 Hydroxyurea, 23
 Hydroxyzine, 15, 24
 Hydroxyzine Pamoate, 15, 24
 HYGROTON, 17
 Hyoscyamine Sulfate, 19
 HYTAKEROL, 35
 HYTONE, 33
 HYTRIN, 17

—I—

Ibuprofen, 11
 ILOSONE SUSPENSION, 21
 ILOTYCIN, 26
 IMDUR, 18
 Imipramine, 13
 Imiquimod, 32
 IMITREX INJECTION, 11
 IMITREX NASAL, 11
 IMITREX TABLETS, 11
 Immunosuppressant Agents, 24
 IMURAN, 24
 Indapamide, 17
 INDERAL, 16
 INDERAL LA, 16
 Indinavir, 22
 INDOCIN, 11
 INDOCIN SR, 11
 Indomethacin, 11
 Indomethacin, Sustained Release, 11
 INFLAMASE, 26
 INFLAMASE FORTE, 26
 Inhaled Adrenal Cortical Steroid Agents, 26
 Inhaled Agents, Nasal, 28

Community Health Group
 Healthy Families
 February 2010
 Revised: 1/5/10

Inhaled Sympathomimetic (Adrenergic) Agents, 25
 Inhaled/Oral EENT Agents, 28
 Inhaler Assistant Device Without Mask, 35, 36
 INNOHEP, 18
 Insulin, 29
 Insulin Agents, 29
 Insulin Aspart, 29
 Insulin Aspart Pretamine/Insulin Aspart, 29
 Insulin Glargine, 29
 INTAL INHALER, 28
 Interferon Alpha 2a, 22
 Interferon Alpha 2b, 22
 INTRON A, 22
 INVIRASE, 23
 Iodoquinol, 22
 Iodoquinol (Diiodohydroxyquin), 20
 IONAMIN, 35
 IOPHEN - C NR, 25
 IOPHEN DM, 24
 Ipratropium, 28
 ISONIAZID, 22
 Isoniazid, 22
 ISOPTO ATROPINE, 27
 ISOPTO CARBACHOL, 27, 28
 ISORDIL, 18
 Isosorbide Dinitrate, 18
 Isosorbide Dinitrate SR, 18
 Isosorbide Mononitrate, 18
 Isotretinoin, 32

—J—

JANUMET, 29
 JANUVIA, 29

—K—

KAON-CL, 34
 KAON-CL 10, 34
 KAYEXALATE, 34
 K-DUR, 34
 K-DUR, 34
 KEFLEX, 20
 KEMADRIN, 13
 KENALOG, 33
 KENALOG IN ORABASE, 28
 KEPPRA, 13
 Keratolytic Agents, 32
 Ketoconazole, 21, 33
 Ketoprofen, 11
 Ketorolac, 11
 Ketorolac Tromethamine, 27
 Ketotifen Ophthalmic OTC, 27
 KLARON 10%, 34
 KLONOPIN, 12
 K-LOR, 34
 K-LYTE, 34

K-LYTE CL DS, 34
K-TABS, 34

—L—

Labetalol, 16
Lactulose, 20
LAMICTAL TABLETS, 12
LAMISIL TABLETS, 21
Lamivudine (3TC), 22
Lamivudine HBV, 22
Lamotrigine Tablets, 12
LAMPRENE, 23
LANOXIN, 18
Lansoprazole 30mg Capsules, 19
Lansoprazole OTC, 19
Lansoprazole Solutabs, 19
LANTUS, 29
LARIAM, 22
LASIX, 17
Latanoprost, 27
Laxative Agents, 20
Leflunomide, 11
Leprostatic Agents, 23
Letrozole, 23
Leucovorin, 23
LEUKERAN, 23
Leukotriene Receptor Antagonists, 28
Levalbuterol for Nebulization, 25
Levamisole, 23
LEVAQUIN, 21
LEVBID, 19
Levetiracetam, 13
LEVLEN, 30
Levobunolol, 27
Levofloxacin, 21, 26
Levonorgestrel, 31
Levonorgestrel/Ethin Estradiol, 31
Levonorgestrel/Ethinyl Estradiol, 30
LEVOTHROID, 29
Levothyroxine, 29
LEVSIN, 19
LIBRIUM, 14
LIDEX, 33
LIDEX E, 33
Lidocaine Viscous, 33
Lidocaine, Viscous, 28
Linezolid, 21
LIORESAL, 13
Liotrix, 29
Lisdexamfetamine, 15
Lisinopril, 16
Lisinopril/HCTZ, 16
Lithium Carbonate, 14
LITHOBID, 14
LO/OVRAL, 30
Local Anesthetic Agents, 28

Community Health Group
Healthy Families
February 2010
Revised: 1/5/10

LODINE, 11
LODINE XL, 11
Lodoxamide Ophthalmic, 27
LOESTRIN, 30
LOESTRIN FE, 30
LOFIBRA, 17
LOMOTIL, 18
Lomustine, 23
Loop Diuretics, 17
LOPID, 17
LOPRESSOR, 16
LOPROX, 33
Loratadine OTC, 24
Loratadine/Pseudoephedrine OTC, 24
Lorazepam, 14
LORCET, 12
LORCET PLUS, 12
LOTENSIN, 16
LOTENSIN HCT, 16
LOTRISONE, 33
Lovastatin, 17
LOVENOX SYRINGES, 18
Loxapine, 15
LOXITANE, 15
LOZOL, 17
LUDIOMIL, 13
LUMIGAN, 27
LURIDE, 34
LYSODREN, 23

—M—

M.A.O. Inhibitor Agents, 14
MACROBID, 31
MACRODANTIN, 31
Macrolide Antibiotic Agents, 20
Malathion, 34
Maprotiline, 13
MATULANE, 24
MAXAIR AUTOHALER, 25
MAXITROL, 26
MAXITROL OPHTHALMIC OINTMENT, 26
MAXIVATE, 33
MAXZIDE 25, 17
MAXZIDE 50, 17
MEBARAL, 12
Mebendazole, 20
Meclizine, 18
Meclofenamate, 11
MECLOMEN, 11
Medical Devices, 35
MEDROL, 29
MEDROL DOSEPAK, 29
Medroxyprogesterone, 31
Mefloquine, 22
MEGACE, 23
Megestrol, 23

MELLARIL, 14
 Meloxicam, 11
 Melphalan, 23
 Meperidine, 12
 Mephobarbitol, 12
 MEPHYTON, 35
 Mercaptopurine, 23
 MERIDIA, 35
 Mesalamine, 19
 MESTINON, 32
 METADATE CD, 15
 METADATE ER, 15
 METANDREN, 30
 Metaproterenol, 25
 Metaproterenol Oral, 25
 Metaxalone, 13
 Metformin, 29
 Metformin XR, 29
 Meth/Me Blue/PA/Salol/ATP/Hyos, 31
 Methazolamide, 28
 METHERGINE, 31
 Methimazole, 29
 Methocarbamol, 13
 Methotrexate 2.5mg Tablets, 23
 Methoxsalen, 32
 Methylidopa, 17
 Methylergonovine Maleate, 31
 METHYLIN ER, 15
 Methylphenidate, 15
 Methylprednisolone, 29
 Methyltestosterone, 30
 Metipranolol, 27
 Metoclopramide, 18, 20
 Metolazone, 17
 Metoprolol, 16
 Metoprolol Succinate, 16
 METROCREAM, 32
 METROGEL, 32
 METROGEL-VAGINAL, 33
 Metronidazole, 20, 21, 33
 Metronidazole 0.75% Cream, 32
 Metronidazole Gel, 32
 MEVACOR, 17
 Mexiletine, 15
 MEXITIL, 15
 MICRO-K, 34
 MICRO-K 10, 34
 MICRONASE, 29
 Midodrine, 18
 MIDRIN, 11
 Migraine Agents, 11
 MIGRANAL, 11
 MINIPRESS, 17
 MINOCIN CAPSULES, 21
 Minocycline Capsules, 21
 MINTEZOL, 20
 MIRALAX, 20

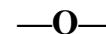
MIRAPEX, 13
 MIRCETTE, 31
 Mirtazapine, 14
 Miscellaneous Antibiotic Agents, 21
 Miscellaneous Antidepressant Agents, 14
 Miscellaneous Anxiolytics, Sedatives, and Hypnotics,
 15
 Miscellaneous Arthritis Agents, 11
 Miscellaneous Cardiovascular Agents, 18
 Miscellaneous Contraceptives, 31
 Miscellaneous EENT Agents, 28
 Miscellaneous Skin/Mucous Membrane Agents, 32
 MISCELLANEOUS/UNCLASSIFIED AGENTS, 34
 Miscellaneous Analgesics, 12
 Miscellaneous Central Nervous System Agents, 12
 Misoprostol, 19
 Mitotane, 23
 MOBIC, 11
 MODICON, 30
 Mometasone Furoate Cream, 33
 Mometasone, Nasal, 28
 Mometasone, Oral Inhaled, 26
 MONOKET, 18
 Monophasic Oral Contraceptives, 30
 Montelukast, 28
 Morphine, 12
 Morphine SR, 12
 MOTRIN, 11
 Moxifloxacin, 26
 MS CONTIN, 12
 MSIR, 12
 Mucolytic Agents, 26
 MUCOMYST, 26
 Multivitamin Agents, 35
 Mupirocin, 32
 Muscle Relaxant Agents, 13
 MYAMBUTOL, 22
 MYCELEX TROCHE, 21
 MYCOLOG II, 33
 Mycophenolate, 24
 MYCOSTATIN, 21, 33
 MYDRIACYL, 27
 MYLERAN, 23
 MYSOLINE, 12

—N—

Nabumetone, 11
 Nadolol, 16
 Naftifine, 33
 NAFTIN, 33
 NALFON, 11
 Naltrexone, 12
 NAPROSYN, 11
 Naproxen, 11
 Naproxen Sodium, 11
 Narcotic Antitussive Agents, 25

NARDIL, 14
 NASACORT AQ, 28
 NASONEX, 28
 Nateglinide, 29
 NAVANE, 14
 NEBUPENT, 22
 Nedocromil Ophthalmic, 27
 Nefazodone, 14
 Nelfinavir, 22
 NEO-DECADRON, 26
 NEOMYCIN, 20
 Neomycin Sulfate, 20
 Neomycin/Colist/HC, 27
 Neomycin/Gramicidin/Polymyxin, 26
 Neomycin/Polymyxin/Dexamethasone, 26
 Neomycin/Polymyxin/Prednisone, 26
 NEORAL, 24
 NEOSPORIN OPHTHALMIC, 26
 Neostigmine, 32
 NEPTAZANE, 28
 NEURONTIN, 12
 Nevirapine, 22
 NEXAVAR, 24
 NIACIN, 34
 Niacin, 17, 34
 NIASPAN, 17
 Nicotine, 35
 NICOTROL INHALER, 35
 Nifedipine, 16
 Nifedipine, Sustained Release, 17
 NILANDRON, 24
 Nilutamide, 24
 NITRODUR, 18
 Nitrofurantoin Macrocrystals, 31
 Nitrofurantoin Suspension, 31
 Nitroglycerin Ointment, 18
 Nitroglycerin Oral, 18
 Nitroglycerin Patches, 18
 Nitroglycerin Spray, 18
 Nitroglycerin Sublingual, 18
 NITROGLYN E-R, 18
 NITROL, 18
 NITROLINGUAL SPRAY, 18
 NITROSTAT SL, 18
 NIZORAL, 21, 33
 NOCTEC, 15
 NOLVADEX, 24
 Non-Narcotic Antitussive Agents, 24
 Non-Steroidal Anti-Inflammatory Agents, 11
 Non-Sulfonylureas, 29
 NOR QD, 31
 NORDETTE, 30
 Norelgestromin/Ethinyl Estradiol, 31
 Norethindrone, 31
 Norethindrone Acetate, 31
 Norethindrone Acetate/Ethinyl Estradiol, 30
 Norethindrone/Ethinyl Estradiol, 31

Norethindrone/Ethinyl Estradiol, 30
 Norethindrone/Mestranol, 30
 NORFLEX, 13
 Norfloxacin, 21
 NORGESIC, 13
 NORGESIC FORTE, 13
 Norgestrel/Ethinyl Estradiol, 30
 NORINYL 1/35, 30
 NORINYL 1/50, 30
 NORLUTATE, 31
 NORMODYNE, 16
 NOROXIN, 21
 NORPACE, 16
 NORPACE CR, 16
 NORPRAMIN, 13
 Nortriptyline, 14
 NORVASC, 16
 NORVIR, 22
 NOVAHISTINE EXPECT, 25
 NOVOLOG, 29
 NOVOLOG MIX, 29
 NOVO-NORDISK INSULINS, 29
 NUVARING, 31
 Nystatin, 21, 33
 Nystatin Oral Powder, 21



OCUFEN, 26
 OCUFLOX, 26
 OCUPRESS, 27
 Ofloxacin, 26
 OGEN, 30
 Olanzapine, 15
 Olmesartan, 16
 Olmesartan/HCTZ, 16
 Olopatadine Ophthalmic, 27
 Olsalazine, 19
 Omeprazole (Federal Legend) 10mg capsules, 19
 Omeprazole (Federal Legend) 20mg capsules, 19
 Omeprazole OTC, 19
 OMNICEF, 20
 Ondansetron Tablets and ODT, 19
 ONGLYZA, 29
 Ophthalmic Antiallergic Agents, 27
 Ophthalmic Antibiotic Agents, 26
 Ophthalmic Anti-Inflammatory Agents, 26
 Ophthalmic Antiviral Agents, 27
 Ophthalmic Beta Blockers, 27
 Ophthalmic Miotic Agents, 27
 Ophthalmic Miscellaneous Agents, 27
 Ophthalmic Mydriatic Agents, 27
 Ophthalmic Sulfonamide Agents, 27
 Opiate Agonists, 11
 Opiate Antagonists, 12
 OPTIPRANOLOL, 27
 Oral Adrenal Cortical Steroid Agents, 29

Oral Colon Lavage Solution, 19
Oral Sympathomimetic (Adrenergic) Agents, 25
ORAPRED ODT -10MG STRENGTH ONLY, 30
ORASONE, 30
ORINASE, 29
Orlistat, 35
Orphenadrine Citrate, 13
Orphenadrine/Aspirin/Caffeine, 13
ORTHO EVRA, 31
ORTHO-NOVUM 7/7/7, 31
ORUVAIL, 11
Oseltamivir, 22
Otic Anti-Infective Agents, 27
OVIDE, 34
OVRAL, 30
Oxaprozin, 11
Oxazepam, 14
OXSORALEN, 32
Oxybutynin, 31
Oxycarbazepine, 13
Oxycodone, 12
Oxycodone/Acetaminophen, 12
Oxycodone/Aspirin, 12
OXYIR, 12
Oxytocic Agents, 31

—P—

PAMELOR, 14
PANCREASE, 20
Pantoprazole, 19
PARAFON DSC, 13
Parasympathomimetic (Cholinergic) Agents, 31
PARLODEL, 13
PARNATE, 14
Paromomycin, 20, 22
Paroxetine, 14
PATANOL, 27
PAXIL, 14
PAXIL CR, 14
PEAK FLOW METER, 35
Peak Flow Meter, 35
PEDIAPRED, 30
PEDIAZOLE, 21, 23
PEGASYS, 22
Peginterferon Alfa-2a, 22
Pemirolast Ophthalmic, 27
PEN VK, 21
Penicillamine, 34
Penicillin VK, 21
Penicillins, 21
Pentamidine, Aerosolized, 22
PENTASA, 19
Pentosan, 31
Pentoxifylline, 18
PEPCID, 19
PERCOCET, 12

PERCODAN, 12
PERIACTIN, 24
PERIDEX, 28
Permethrin, 34
Perphenazine, 14
PERSANTINE, 18
Phenazopyridine, 31
Phenelzine, 14
PHENERGAN, 15, 18, 24
PHENERGAN VC, 25
PHENERGAN VC CODEINE, 25
PHENERGAN W/DM, 25
PHENERGAN/CODEINE, 25
PHENOBARBITAL, 12
Phenobarbital, 12
Phentermine, 35
Phenylephrine/Hydrocodone/Chlorpheniramine, 25
Phenylephrine/Promethazine, 25
PHENYLHISTINE DH, 25
Phenytoin, 12
PHOSPHOLINE IODIDE, 27
Phytonadione, 35
Pigmenting and Miscellaneous Agents, 32
PILOCAR, 27
Pilocarpine, 27
Pimecrolimus, 32
Pindolol, 16
Pioglitazone, 29
Pirbuterol Acetate, 25
Piroxicam, 11
Pituitary Agents, 31
PLAN B, 31
PLAN B ONE-STEP, 31
PLAQUENIL, 22
PLAVIX, 18
PLENDIL, 17
PLETAL, 18
Podofilox, 32
POLARAMINE, 24
Polyethylene Glycol 3350, 20
Polymixin B Sulfate/TMP, 26
POLY-PRED, 26
POLYSPORIN OPHTHALMIC, 26
POLYTRIM, 26
POLY-VI-FLOR, 35
Potassium Agents, 34
Potassium Chloride 10mEq, 34
Potassium Chloride 20mEq, 34
Potassium Chloride 8mEq, 34
Potassium Chloride Effervescent Tablets, 34
Potassium Chloride Effervescent Tablets, 34
Potassium Chloride Liquid, 34
Potassium Chloride Powder, 34
Potassium Iodide, 26
Potassium-Removing Resins, 34
Potassium-Sparing Diuretics, 17
Pramipexole, 13

PRAMOSONE HC, 33
 Pramoxone HC 1%, 33
 Pramoxine/HC, 33
 Pramoxine/Hydrocortisone, 33
 PRANDIN, 29
 PRAVACHOL, 17
 Pravastatin, 17
 Praziquantel, 20
 Prazosin, 17
 PRECOSE, 29
 PRED FORTE, 26
 PRED MILD OPHTHALMIC, 26
 PRED-G, 26
 Prednisolone, 30
 Prednisolone Acetate, 26
 Prednisolone Phosphate, 26
 Prednisolone Sodium Phosphate 10mg ODT, 30
 Prednisone, 30
 PRELONE, 30
 PREMARIN, 30
 PREMARIN VAGINAL CREAM, 30
 PREMPRO, 30
 Prenatal Multivitamins, 35
 Prenatal Vitamin Agents, 35
 PRENATE ADVANCE, 35
 PRENATE ULTRA, 35
 PREVACID 24HR, 19
 PREVACID 30MG CAPSULES, 19
 PREVACID SOLUTABS, 19
 PREVEN, 31
 PRILOSEC (FEDERAL LEGEND) 10MG CAPSULES, 19
 PRILOSEC (FEDERAL LEGEND) 20MG CAPSULES, 19
 PRILOSEC OTC, 19
 PRIMAQUINE, 22
 Primaquine, 22
 Primidone, 12
 PRINCIPEN, 21
 PROAMATINE, 18
 Probenecid, 35
 Procainamide, 15
 Procainamide SR, 15
 PROCAN SR, 15
 PROCANBID, 15
 Procarbazine, 24
 PROCARDIA, 16
 Prochlorperazine Maleate, 18
 PROCTOCORT 1%, 32
 PROCTOCREAM-HC, 33
 PROCTOFOAM HC, 33
 Procyclidine, 13
 Progesterone, 31
 Progestin Agents, 31
 PROLIXIN, 14
 Promethazine, 15, 18, 24
 Promethazine/Codeine, 25
 Promethazine/Dextromethorphan, 25
 Promethazine/Phenylephrine/Codeine, 25

PROMETRIUM, 31
 PRONESTYL, 15
 Propafenone, 16
 PROPINE, 27
 Propoxyphene Napsylate/APAP, 12
 Propranolol, 16
 Propranolol LA, 16
 PROPYLTHIOURACIL, 29
 Propylthiouracil, 29
 PROSTIGMIN, 32
 PROTONIX, 19
 PROTOPIC, 32
 PROVENTIL, 25
 PROVENTIL REPETABS, 25
 PROVERA, 31
 PROZAC, 14
 PROZAC 40MG, 14
 Pseudoephedrine/Chlorpheniramine, 24
 PSORCON, 33
 Psychotherapeutic Agents, 13
 PULMICORT, 26
 PULMICORT RESPULES, 26
 PURINETHOL, 23
 PYRAZINAMIDE, 22
 Pyrazinamide, 22
 PYRIDIUM, 31
 Pyridostigmine, 32
 Pyrimethamine, 22

—Q—

QUESTRAN, 17
 QUESTRAN LIGHT, 17
 Quetiapine, 15
 Quinacrine, 22
 QUINAGLUTE, 16
 QUINIDEX, 16
 Quinidine Gluconate, 16
 Quinidine Sulfate, 15
 Quinidine Sulfate SR, 16
 Quinolones, 21
 QUIXIN, 26
 QVAR, 26

—R—

Ramipril, 16
 Ranitidine, 19
 Ranitidine/Bismuth Citrate, 20
 RAPIFLUX, 14
 REBETOL, 22
 REGLAN, 18, 20
 REGRANEX, 32
 RELAFEN, 11
 RELENZA, 22
 REMERON, 14
 Repaglinide, 29

REQUIP, 13
RESCRIPTOR, 22
Reserpine, 16
Respiratory Smooth Muscle Relaxant Agents, 28
RESPIRATORY/EENT AGENTS, 24
RESTORIL, 14
RETIN A, 32
RETROVIR, 22
REVIA, 12
RHEUMATREX, 23
Ribavirin, 22
Ribavirin, Aerosolized, 22
RIFADIN, 22
Rifampin, 22
Rimantadine, 22
RISPERDAL, 15
Risperidone, 15
RITALIN, 15
RITALIN LA, 15
RITALIN SR, 15
Ritonavir, 22
ROBAXIN, 13
ROBITUSSIN AC, 25
ROBITUSSIN DAC, 25
ROCALTROL, 35
ROFERON-A, 22
Ropinirole, 13
Rosiglitazone, 29
Rosuvastatin, 17
RYTHMOL, 16

—S—

S.N.R.I. Agents, 14
S.S.R.I. Agents, 14
Salmeterol, 25
Salmeterol/Fluticasone, 25
Salsalate, 11
SANDIMMUNE, 24
Saquinavir, 23
Saxagliptin, 29
Scabicide/Pediculicide Agents, 34
Selenium Sulfide 2.5%, 34
SELSUN, 34
SEPTRA, 23
SERAX, 14
SEREVENT DISKUS, 25
SEROQUEL, 15
SEROSTIM, 30
SERPASIL, 16
Sertraline, 14
SERZONE, 14
Sibutramine, 35
SILVADENE, 32
Silver Sulfadiazine, 32
Simvastatin, 17
SINEMET, 13

SINEMET CR, 13
SINEQUAN, 13
SINGULAIR, 28
Sitagliptin, 29
Sitagliptin/Metformin, 29
SKELAXIN, 13
Skeletal Muscle Relaxants, 13
SLO-BID, 28
SLOW K, 34
Smoking Deterrents, 35
SODIUM CHLORIDE SOLUTION, 28
Sodium Chloride Solution (for Inhalation), 28
Sodium Fluoride, 34
Sodium Polystyrene Sulfonate, 34
SODIUM SULAMYD, 27
SOLATENE, 34
SOMA, 13
SOMA COMPOUND, 13
Somatropin, 30
SONATA, 15
Sorafenib, 24
Sotalol, 16
Spironolactone, 17
SSKI, 26
STARLIX, 29
Stavudine (d4T), 23
STELAZINE, 15
STRATTERA, 15
Sucralfate, 19
Sulconazole, 33
Sulfacetamide, 27
Sulfacetamide 10%/Prednisolone 0.2%, 27
Sulfacetamide 10%/Prednisolone 0.25%, 27
Sulfacetamide Lotion, 34
SULFADIAZINE, 23
Sulfadiazine, 23
Sulfadoxine/Pyrimethamine, 22
Sulfamethoxazole/Trimethoprim (SMZ/TMP), 23
Sulfanilamide Compound, 34
Sulfasalazine, 23
Sulfisoxazole, 23
Sulfonamide Agents, 23
Sulfonylureas, 28
Sulindac, 11
SULTRIN, 34
Sumatriptan Injection, 11
Sumatriptan Nasal, 11
Sumatriptan Tablets, 11
SUMYCIN, 21
Sunitinib, 24
SUSTIVA, 22
SUTENT, 24
SYMBICORT, 25
SYMMETREL, 13, 22
SYNALAR, 33

—T—

Tacrolimus, 32
 TAGAMET, 19
 TAMBOCOR, 16
 TAMIFLU, 22
 Tamoxifen Citrate, 24
 TAPAZOLE, 29
 Tazarotene, 32
 TAZORAC, 32
 TEGRETOL, 12
 TEGRETOL XR, 12
 Telbivudine, 23
 Temazepam, 14
 TEMOVATE, 33
 TENEX, 17
 Tenofovir, 23
 TENORETIC, 16
 TENORMIN, 16
 Terazosin, 17
 Terbinafine Tablets, 21
 Terbutaline Sulfate, 25
 TERPIN HYDRATE/COD, 25
 Terpin Hydrate/Codeine, 25
 TESLAC, 24
 TESSALON PERLE, 24
 Testolactone, 24
 Tetracycline, 21
 Tetracycline/Bismuth/Metronidazole, 20
 Tetracyclines, 21
 TEV-TROPIN, 30
 THEOLAIR, 28
 Theophylline, 28
 Theophylline, 80mg/15cc, 28
 Theophylline, Sustained Release, 28
 Thiabendazole, 20
 Thiazide and Related Diuretics, 17
 THIOGUANINE, 24
 Thioguanine, 24
 Thioridazine, 14
 Thiothixene, 14
 THORAZINE, 14
 Thyroid Agents, 29
 Thyroid, Desiccated, 29
 THYROLAR, 29
 Tiagabine, 13
 TIAZAC, 17
 TICLID, 18
 Ticlopidine, 18
 TIGAN, 18
 TIKOSYN, 16
 Timolol, 27
 TIMOPTIC, 27
 Tinzaparin, 18
 Tizanidine, 13
 Tobramycin, 26
 TOBEX, 26

TOFRANIL, 13
 Tolazamide, 29
 Tolbutamide, 29
 TOLINASE, 29
 TOPAMAX, 13
 Topical Antibiotic Agents, 32
 Topical Antifungal Agents, 33
 Topical Anti-Inflammatory Agents, 33
 Topical Antipruritic and Local Anesthetic Agents, 33
 Topical Antiviral Agents, 34
 Topical Miscellaneous Anti-Infective Agents, 34
 TOPICAL/MUCOUS MEMBRANE AGENTS, 32
 TOPICORT, 33
 TOPICORT LP, 33
 Topiramate, 13
 TOPROL XL, 16
 TORADOL, 11
 T-PHYL, 28
 Tramadol, 12
 TRANDATE, 16
 TRANXENE, 14
 Tranylcypromine, 14
 TRAVATAN, 27
 Travoprost, 27
 Trazodone, 14
 TRENTAL, 18
 Tretinoin, 24, 32
 Triamcinolone, 33
 Triamcinolone 0.1% in Orabase, 28
 Triamcinolone Acetonide, Nasal, 28
 Triamcinolone, Oral Inhaled, 26
 Triamcinolone/Nystatin, 33
 Triamterene 37.5mg/HCTZ 25mg, 17
 Triamterene 75mg/HCTZ 50mg, 17
 Tricyclic Antidepressant Agents, 13
 TRIDESILON, 33
 Triethanolamine, 28
 Trifluoperazine, 15
 Trifluridine Ophthalmic Solution, 27
 Trihexyphenidyl, 13
 TRILAFON, 14
 TRILEPTAL, 13
 TRI-LEVELLEN, 31
 TRILISATE, 11
 Trimethobenzamide, 18
 Trimethoprim, 23, 31
 TRIMOX, 21
 TRIMPEX, 23, 31
 TRI-NORINYL, 31
 Triphasic Oral Contraceptives, 31
 TRIPHASIL, 31
 Triple Sulfa Vaginal, 34
 TRITEC, 20
 TRI-VI-FLOR, 35
 TRIZIVIR, 23
 Tropicamide, 27
 TRUSOPT, 27

T-STAT, 32
TUSSIONEX, 25
TYLENOL/CODEINE, 11
TYLOX, 12
TYZEKA, 23

—U—

Ulcer Eradication Agents, 20
ULTRAM, 12
ULTRASE, 20
UNIPHYL, 28
URECHOLINE, 31
Urinary Anti-Infective Agents, 31
Urinary Tract Analgesics, 31
URISED, 31
URISPAS, 31
Ursodiol, 20

—V—

Vaginal Anti-Infective Agents, 33
Valacyclovir, 22
VALIUM, 13, 14
Valproic Acid, 12
VALRELEASE, 13
Valsartan, 16
Valsartan/HCTZ, 16
VALTREX, 22
VANCOCIN, 21
Vancomycin, 21
VASOCIDIN, 27
Vasodilating Agents, 18
Vasodilator Antihypertensive Agents, 17
VASOTEC, 16
Venlafaxine, 14
VENLAFAXINE XR TABLETS, 14
VENTOLIN HFA, 25
VEPESID, 23
Verapamil, 16
Verapamil LA Capsules, 17
Verapamil SR Tablets, 17
VERELAN, 17
VERMOX, 20
VESANOID, 24
VIBRAMYCIN, 21
VIBRA-TABS, 21
VICODIN, 12
VICODIN ES, 12
VICON FORTE, 34
VIDEX, 22
VIDEX EC, 22
VIGAMOX, 26
VIKASE, 20
VIRACEPT, 22
VIRAMUNE, 22
VIRAZOLE, 22

Community Health Group
Healthy Families
February 2010
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VIREAD, 23
VIROPTIC, 27
VISCIOUS XYLOCAINE, 28
VISKEN, 16
VISTARIL, 15, 24
Vitamin A, 34
Vitamin and Fluoride Agents, 34
Vitamin B-Complex Agents, 34
Vitamin D, 35
Vitamin K Activity Agents, 35
VOLMAX, 25
VOLTAREN, 11, 26
VOPAC, 11
VOSOL, 27
VOSOL HC, 27
VYVANSE, 15

—W—

Warfarin Sodium, 17
Weight Loss Agents, 35
WELLBUTRIN, 14
WELLBUTRIN SR, 14
WELLCOVORIN, 23
WESTCORT, 33

—X—

XALATAN, 27
XANAX, 14
XELODA, 23
XENICAL, 35
XOPENEX FOR NEBULIZATION, 25
XYLOCAINE, 33

—Y—

YODOXIN, 20, 22

—Z—

ZADITOR, 27
Zafirlukast, 28
Zalcitabine (ddC), 23
Zaleplon, 15
ZANAFLEX TABLET, 13
Zanamivir, 22
ZANTAC, 19
ZAROXOLYN, 17
ZEPHREX LA, 25
ZERIT, 23
ZESTORETIC, 16
ZESTRIL, 16
ZIAC, 16
ZIAGEN, 22
Zidovudine (AZT), 22
Zidovudine/Lamivudine, 23
Zidovudine/Lamivudine/Abacavir, 23

ZITHROMAX, 21
ZOCOR, 17
ZOFRAN TABLETS AND ODT, 19
ZOLOFT TABLETS, 14
Zolpidem, 15
ZONEGRAN, 13
Zonisamide, 13
ZOVIRAX OINTMENT, 34

ZOVIRAX ORAL, 22
ZYBAN, 35
ZYLOPRIM, 35
ZYPREXA, 15
ZYPREXA ZYDIS, 15
ZYRTEC TABLETS AND SYRUP (OTC ONLY), 24
ZYVOX, 21