

Community Health Group Medi-Cal Drug Formulary

May 2012



Community Health Group Medi-Cal Drug Formulary Administered by MedImpact

May 2012

Forward

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 Medi-Cal Drug Formulary is to enhance the physician's and pharmacist's abilities to provide optimal cost effective drug therapy for patients.

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

The CHG P&T Committee uses the following criteria in the evaluation of product selection for the CHG 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 Drug Formulary applies only to outpatient drugs dispensed to members, and does not apply to medications used in inpatient or outpatient treatment settings. If a member has any specific questions regarding their coverage, they should contact CHG at (619) 498-6464 or **MedImpact** at (800) 788-2949.

All injectable drugs, with the exception of insulin, are subject to prior authorization to determine treatment setting and administration of drug (self vs. provider).

The following general exclusions pertain to all covered individuals:

- Drug Products not listed in the Drug Formulary, or specifically listed as not covered are not covered except per Medi-Cal guidelines or approved medical exception request.
- Any drug products used for cosmetic purposes are not covered.
- Experimental drug products, or any drug product used in an experimental manner are not covered, except per Medi-Cal guidelines.
- Agents for the treatment of sexual or erectile dysfunction.

Formulary Designations & Definitions

Abbreviated designations and definitions used in the formulary are explained as follows:

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.

Age & Step Therapy Restriction (AGE, STEP)

Drugs marked with age and step therapy restrictions (AGE, STEP) are available as formulary agents for patients meeting both age criteria and step therapy criteria. Members who do not meet age and/or step therapy 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 member meets the step therapy criteria.

Medi-Cal Fee-For-Service (Bill State EDS)

Drugs marked "Bill State EDS" are covered by Medi-Cal Fee-For-Service. For medication reimbursement, items with this notation need to be billed through the Medi-Cal fiscal intermediary, Electronic Data System (EDS), rather than through Community Health Group.

Medi-Cal List of Contract Drugs (CD1)

Drugs marked “Code 1” (CD1) require prior authorization in accordance with Section 51003 of Medi-Cal regulations unless used under the conditions specified on the Medi-Cal List of Contract Drugs, and are subject to the prescription documentation requirements in Section 51476c (see California Code of Regulations [CCR], Title 22, Section 51313.3[b]). However, CHG has modified the Medi-Cal Code 1 requirements in some instances and these modifications are indicated within the formulary.

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.

Step Therapy (STEP)

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.

Generic Substitution

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

- 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 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.

Preferred Branded Interchange

Certain dual-licensed branded drug products may be excluded from coverage.

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, which is determined to be experimental will be subject to Medi-Cal guidelines and current, accepted medical practice.

Prior Authorization Process

Either the prescriber or pharmacy provider may request nonformulary drugs and medical supplies. Prior authorization requests may be made by faxing a completed Medication Request Form (MRF) to MedImpact Healthcare Systems, Inc. at (858) 790-7100. Requests may also be processed over the telephone by calling a MedImpact Customer Service representative at (800) 788-2949.

The following general criteria are used to evaluate requests for nonformulary drugs:

1. The use of formulary drug(s) is contraindicated in the patient.
2. The patient has failed an appropriate trial of formulary drugs or related agents.
3. The choices available on the drug formulary are not suited for the present patient care need and/or the requested drug is required for patient safety.
4. The use of a formulary drug may exacerbate an underlying condition that would be detrimental to patient care.
5. The patient has been maintained on requested drug by CHG or previous insurance immediately prior to enrollment date (documentation required).

CHG requests that MRFs be filled out completely and legibly. This will help to expedite the review process. All requests will be processed within 24 hours or one business day. However, a determination may be deferred pending additional medical documentation for up to 30 days from the date of the initial request. If the requested documentation is not provided within this time frame, the request will be denied.

If MedImpact cannot make a determination based on the information provided and/or the request does not meet the criteria established by the P & T committee, the request will be forwarded to CHG for a secondary review. If the request is not approved by CHG, the member and prescriber will be notified in writing. A reason for the denial of the nonformulary request and notification of alternative drugs or treatments offered by CHG will be provided in the notice. The notice will also indicate that the member may file a grievance with CHG if the member objects to the denial.

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 address following:

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

Medication Request Form (MRF)
COMMUNITY HEALTH GROUP
c/o MedImpact Healthcare Systems, Inc.

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

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

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

Instructions:

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

Review Criteria:

The following criteria is used in reviewing medical exceptions:

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

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

DATE OF REQUEST: _____

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

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ANTI-INFECTIVE AGENTS

Amebicide Agents

\$	Metronidazole	FLAGYL
\$\$\$	Paromomycin	HUMATIN

Antibacterial Agents

Aminoglycosides

\$	Neomycin Sulfate	MYCIFRADIN
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Cephalosporins

\$	Cephalexin (Tablets Nonformulary)	KEFLEX (KEFLEX 750MG STRENGTH NONFORMULARY)
\$	Cefuroxime Axetil	CEFTIN
AGE	Cefdinir	OMNICEF, SUSPENSION ONLY (FOR MEMBERS ≤ 12 YEARS OF AGE)

Macrolide Antibiotics

\$	Erythromycin Stearate	ERYTHROCIN
\$	Erythromycin Base	ERY-TAB
\$	Erythromycin Ethylsuccinate	PCE
\$	Erythromycin Ethylsuccinate	EES
\$	Erythromycin/Sulfisoxazole	ERYPED SUSPENSION
AGE	Azithromycin	PEDIAZOLE
PA		ZITHROMAX SUSPENSION, RESTRICTED TO MEMBERS 12 YEARS AND YOUNGER
AGE, STEP		ZITHROMAX POWDER PACKET (ZMAX NONFORMULARY)
PA		ZITHROMAX TABLETS, AGE & STEP THERAPY RESTRICTIONS (MEMBERS LESS THAN 49 YEARS MUST HAVE A TRIAL OF AN UNRESTRICTED ORAL ANTIBIOTIC, MEMBERS 49 YEARS AND OLDER EXEMPT FROM STEP THERAPY RESTRICTION)
PA	Clarithromycin	BIAXIN, PA REQ
PA		BIAXIN XL 500MG, PA REQ

Penicillins

\$	Amoxicillin	AMOXIL
\$	Ampicillin	TRIMOX
\$	Dicloxacillin	PRINCIPEN
\$	Penicillin VK	DYNAPEN
AGE	Amoxicillin/Potassium Clavulanate	PEN VK
PA		AUGMENTIN TABLETS, (FOR OTITIS MEDIA < 18 YEARS OF AGE; LOWER RESPIRATORY TRACT INFECTION ≥ 50 YEARS OF AGE) (EFFECTIVE 5/1/09)
		AUGMENTIN SUSPENSION
		AUGMENTIN XR, PA REQ

Quinolones

\$	Ciprofloxacin	CIPRO
CD1	Ciprofloxacin Extended Release	CIPRO XR, CODE 1 (OVERRIDE IF UTI OR PYELONEPHRITIS); 500MG LIMITED TO 3 TABLETS/FILL & 2 FILLS/MONTH; 1000MG LIMITED TO 10 TABLETS/FILL & 2 FILLS/MONTH (PROQUIN XR NONFORMULARY)
\$	Norfloxacin	NOROXIN

PA	\$\$	Ofloxacin	FLOXIN, PA REQ
CD1	\$\$\$	Ciprofloxacin Suspension	CIPRO SUSPENSION, CODE 1 (OVERRIDE IF CYSTIC FIBROSIS, LOWER RESP INFECTION IN PATIENTS ≥50 YRS, OR OSTEOMYELITIS)
PA	\$\$\$	Levofloxacin	LEVAQUIN, PA REQ
		Tetracyclines	
	\$	Tetracycline	ACHROMYCIN-V SUMYCIN
	\$	Doxycycline	VIBRAMYCIN VIBRA-TABS (ADOXA, DORYX, ORACEA NONFORMULARY)
	\$\$	Minocycline Capsules	MINOCIN CAPSULES (EFFECTIVE 12/17/09) OTHER MINOCYCLINE DOSAGE FORMS NON-FORMULARY
MD	\$\$\$	Doxycycline 20mg Tablets	PERIOSTAT, SPECIALTY RESTRICTION

Antifungal Agents

	\$	Fluconazole Tablets	DIFLUCAN TABLETS
	\$	Ketoconazole	NIZORAL
	\$	Nystatin	MYCOSTATIN (ORAL POWDER NONFORMULARY)
	\$\$	Clotrimazole	MYCELEX
QL	\$\$	Terbinafine Tablets	LAMISIL TABLETS, LIMITED TO 90 TABLETS PER 9 MONTHS (LAMISIL GRANULES NONFORMULARY)
	\$\$	Griseofulvin Tablets	GRISPEG GRIFULVIN V TABLETS
AGE	\$\$\$	Fluconazole Suspension	FULVICIN U/F DIFLUCAN SUSPENSION, MEMBERS > 12 YEARS OF AGE REQUIRE PA
AGE	\$\$\$	Griseofulvin Suspension	GRIFULVIN V SUSPENSION, MEMBERS > 12 YEARS OF AGE REQUIRE PA
PA	\$\$\$\$	Itraconazole	SPORANOX, PA REQ

Anthelmintic Agents

\$	Mebendazole	VERMOX
\$	Pyrantel Pamoate	PIN-RID
\$	Thiabendazole	MINTEZOL
\$\$	Furazolidone	FUROXONE

Antimalarial Agents

\$	Primaquine	PRIMAQUINE
\$	Hydroxychloroquine	PLAQUENIL
\$	Pyrimethamine	DARAPRIM
\$\$\$	Paromomycin	HUMATIN

Antituberculosis Agents

\$	Isoniazid	ISONIAZID	
\$\$	Cycloserine	SEROMYCIN	
\$\$	Ethambutol	MYAMBUTOL	
\$\$	Pyrazinamide	PYRAZINAMIDE	
\$\$	Rifampin	RIFADIN	
\$\$\$	Ethionamide	TRECTOR-SC	
\$\$\$\$	Rifabutin	MYCOBUTIN	
\$\$\$\$\$	Rifapentine	PRIFTIN	
PA	\$\$\$\$\$	Streptomycin	STREPTOMYCIN, PA REQ

Antiviral Agents

	\$	Amantadine	SYMMETREL, BILL STATE EDS
	\$	Acyclovir Oral	ZOVIRAX ORAL
PA	\$\$\$	Famciclovir	FAMVIR, PA REQ
QL	\$\$\$	Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS. TAMIFLU SYRUP, QL OF #120ML PER 180 DAYS.(EFFECTIVE 2/15/12)
PA	\$\$\$	Ribavirin (200mg strength only)	COPEGUS, PA REQ
PA			REBETOL, PA REQ
PA	\$\$\$	Valacyclovir	VALTREX, PA REQ
	\$\$\$	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS (EFFECTIVE 10/1/09)
AGE	\$\$\$\$	Didanosine (ddl)	VIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Lamivudine	EPIVIR, BILL STATE EDS
AGE, MD	\$\$\$\$	Lamivudine HBV	EPIVIR HBV, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Stavudine	ZERIT, BILL STATE EDS
AGE	\$\$\$\$	Zidovudine (AZT)	RETROVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Abacavir	ZIAGEN, BILL STATE EDS
	\$\$\$\$\$	Abacavir/Lamivudine	EPZICOM, BILL STATE EDS
AGE, MD	\$\$\$\$\$	Adefovir Dipivoxil	HEPSERA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Amprenavir/Vitamin E	AGENERASE, BILL STATE EDS
	\$\$\$\$\$	Atazanavir	REYATAZ, BILL STATE EDS
PA	\$\$\$\$\$	Cidofovir	VISTIDE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Darunavir	PREZISTA, BILL STATE EDS
	\$\$\$\$\$	Delavirdine	RESCRIPTOR, BILL STATE EDS
	\$\$\$\$\$	Efavirenz	SUSTIVA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine	EMTRIVA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine/Tenofovir	TRUVADA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine/Tenofovir/Efavirenz	ATRIPLA, BILL STATE EDS
	\$\$\$\$\$	Enfuvirtide	FUZEON, BILL STATE EDS
AGE, MD	\$\$\$\$\$	Entecavir	BARACLUDE, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Fosamprenavir	LEXIVA, BILL STATE EDS
PA	\$\$\$\$\$	Ganciclovir	CYTOVENE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Indinavir	CRIXIVAN, BILL STATE EDS
	\$\$\$\$\$	Lamivudine/Zidovudine	COMBIVIR, BILL STATE EDS
	\$\$\$\$\$	Nelfinavir	VIRACEPT, BILL STATE EDS
	\$\$\$\$\$	Nevirapine	VIRAMUNE, BILL STATE EDS
CD1	\$\$\$\$\$	Pentamidine, Aerosolized	NEBUPENT, CODE 1 (OVERRIDE IF HIV PATIENT WITH PNEUMOCYSTIS)
	\$\$\$\$\$	Ritonavir	NORVIR, BILL STATE EDS
	\$\$\$\$\$	Ritonavir/Lopinavir	KALETRA, BILL STATE EDS
	\$\$\$\$\$	Saquinavir	INVIRASE, BILL STATE EDS
AGE, MD	\$\$\$\$\$	Telbivudine	TYZEKA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Tenofovir	VIREAD, BILL STATE EDS
	\$\$\$\$\$	Tipranavir	APTIVUS, BILL STATE EDS
PA	\$\$\$\$\$	Valganciclovir	VALCYTE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Zidovudine/Lamivudine/Abacavir	TRIZIVIR, BILL STATE EDS

PA, AGE	Cyclophosphamide	CYTOXAN, PA REQ FOR INJECTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Cytarabine	CYTOSAR-U, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Dacarbazine	DTIC-DOME, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Dactinomycin	COSMEGEN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA PA	Dasatinib Daunorubicin Citrate Liposome	SPRYCEL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE DAUNOXOME, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Daunorubicin HCl	DAUNORUBICIN HCL, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Docetaxel	TAXOTERE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Doxorubicin HCl	RUBEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Doxorubicin HCl Liposome	DOXIL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Epirubicin	ELLENC, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Erlotinib	TARCEVA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Estramustine	EMCYT, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA, AGE	Etoposide	VEPESID, PA REQ FOR INJECTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Everolimus	AFINITOR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Exemestane	AROMASIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Floxuridine	FUDR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Fludarabine Phosphate	FLUDARA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Fluorouracil	ADRUCIL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Flutamide	EULEXIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Fulvestrant	FASLODEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Gefitinib	IRESSA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Gemcitabine HCl	GEMZAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Gemtuzumab Ozogamicin	MYLOTARG, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Goserelin Acetate	ZOLADEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Hydroxyurea	HYDREA, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Ifosfamide	IFEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
MD, AGE	Imatinib	GLEEVEC, RESTRICTED TO ONCOLOGY, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Interferon Alfa-2a	ROFERON-A, PA REQ
PA	Interferon Alfa-2b	INTRON-A, PA REQ
PA	Interferon Alfacon-1	INFERGEN, PA REQ
AGE	Irinotecan	CAMPTOSAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lapatinib	TYKERB, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lenalidomide	REVLIMID, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Letrozole	FEMARA, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Leucovorin	WELLCOVORIN, PA REQ FOR INJECTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Leuprolide Acetate	LUPRON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Lomustine	CEENU, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Mechlorethamine HCl	MUSTARGEN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	Megestrol	MEGACE (MEGACE ES NONFORMULARY)
PA, AGE	Melphalan	ALKERAN, PA REQ FOR INJECTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Mercaptopurine	PURINETHOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Methotrexate Tablets	RHEUMATREX, MEMBERS <21 MAY BE CCS-ELIGIBLE, 2.5MG TABLETS ONLY (OTHER STRENGTHS AND DOSE PACKS NONFORMULARY) (EFFECTIVE 5/1/09)
PA, AGE	Methotrexate Injection	METHOTREXATE, PA REQ FOR INJECTION, MEMBERS <21 MAY BE CCS-ELIGIBLE

PA	Mitomycin	MUTAMYCIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Mitotane	LYSODREN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Mitoxantrone	NOVANTRONE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Nilotinib	TASIGNA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Nilutamide	NILANDRON 50MG, 150MG, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Ofatumumab	ARZERRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Oprelvekin	NEUMEGA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Oxaliplatin	ELOXATIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Paclitaxel	TAXOL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Panitumumab	VECTIBIX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Pazopanib	VOTRIENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Pegaspargase	ONCASPAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Peginterferon Alfa-2b	PEGINTRON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
PA	Pentostatin	NIPENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Porfimer	PHOTOFRIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Pralatrexate	FOLOTYN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Procarbazine	MATULANE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Romidepsin	ISTODAX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Sorafenib	NEXAVAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Streptozocin	ZANOSAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Sunitinib	SUTENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Tamoxifen Citrate	NOLVADEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Temozolomide	TEMODAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Teniposide	VUMON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Thalidomide	THALOMID, PA REQ
AGE	Thioguanine	THIOGUANINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Thiotepa	THIOPLEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Topotecan HCl	HYCAMTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Toremifene	FARESTON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Trastuzumab	HERCEPTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Tretinoin	VESANOID, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Triptorelin	TRELSTAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
PA	Valrubicin	VALSTAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Vinblastine Sulfate	VELBAN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Vincristine Sulfate	ONCOVIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Vinorelbine Tartrate	NAVELBINE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Vorinostat	ZOLINZA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

Immunosuppressant Agents

AGE	\$\$	Azathioprine	IMURAN, MEMBERS <21 MAY BE CCS-ELIGIBLE (AZASAN NONFORMULARY)
MD, AGE	\$\$\$\$	Cyclosporine Capsules	NEORAL CAPSULES, SPECIALTY RESTRICTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
MD, AGE			SANDIMMUNE CAPSULES, SPECIALTY RESTRICTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$\$	Mycophenolate	CELLCEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE (MYFORTIC NONFORMULARY) (EFFECTIVE 11/1/09)
PA	\$\$\$\$\$	Sirolimus	RAPAMUNE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/10)

CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

AGE	\$	Amiodarone 200mg	CORDARONE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10) (OTHER AMIODARONE STRENGTHS NONFORMULARY)
AGE	\$	Mexiletine	MEXITIL MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Procainamide	PRONESTYL MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Procainamide SR	PROCAN SR MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Quinidine Sulfate	QUINIDINE SULFATE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Quinidine Gluconate	QUINAGLUTE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Sotalol	BETAPACE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Flecainide	TAMBOCOR MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Sotalol	BETAPACE AF MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensives

\$ Reserpine SERPASIL

Angiotensin Converting Enzyme Inhibitors

	\$	Captopril	CAPOTEN
	\$	Enalapril	VASOTEC
	\$	Benazepril	LOTENSIN
	\$	Lisinopril	ZESTRIL
PA	\$\$	Ramipril	ALTACE ,PA REQ
	\$\$	Trandolapril	MAVIK

Angiotensin Receptor Blockers

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

Beta-Adrenergic Antagonists

	\$	Acebutolol	SECTRAL
	\$	Atenolol	TENORMIN
	\$	Timolol	BLOCADREN
	\$	Metoprolol Tartrate	LOPRESSOR
	\$	Nadolol	CORGARD
	\$	Pindolol	VISKEN
	\$	Propranolol	INDERAL
	\$\$	Betaxolol	KERLONE
	\$\$	Bisoprolol	ZEBETA
STEP	\$\$	Metoprolol Succinate	TOPROL XL, STEP THERAPY (METOPROLOL IMMEDIATE-RELEASE PREFERRED. SUBMIT PA IF CHF)

Combination Alpha-Beta Antagonists

	\$	Labetalol	NORMODYNE
	\$\$	Carvedilol	TRANDATE COREG (COREG CR NONFORMULARY)

Calcium Channel Blockers

QL	\$	Amlodipine	NORVASC: QL of #30 / Rx (EFFECTIVE 4/1/11)
QL	\$	Diltiazem	CARDIZEM:
	\$	Nifedipine	ADALAT
	\$	Verapamil	PROCARDIA
	\$\$	Diltiazem ER (24 hr)	CALAN
			Diltiazem ER 24hr (QL OF #1 / DAY)
			Cardizem CD (QL OF #1 / DAY)
			Diltia XT(QL OF #1 / DAY)
			(Cardizem LA – Nonformulary) (Effective 4/1/12)
	\$\$	Diltiazem ER (12 hr)	Diltiazem ER 12hr (QL of #2 / day)
			Cardizem SR (QL of #2 / day) (Effective 4/1/12)
	\$\$	Felodipine	PLENDIL
	\$\$	Nifedipine, Sustained Release	ADALAT CC
			PROCARDIA XL
	\$\$	Verapamil SR Tablets	CALAN SR
			(COVERA-HS NONFORMULARY)
STEP	\$\$\$	Amlodipine/Benazepril	LOTREL, STEP THERAPY (TRIAL OF AMLODIPINE AND BENAZEPRIL)
	\$\$\$	Verapamil LA Capsules	VERELAN
			VERELAN PM
		Centrally Acting Antihypertensives	
	\$	Clonidine	CATAPRES
	\$	Methyldopa	ALDOMET
	\$	Guanfacine	TENEX
			(INTUNIV NONFORMULARY)
		Combination Antihypertensives	
	\$	Hydralazine/HCTZ	HYDRA-ZIDE
	\$	Benazepril/HCTZ	LOTENSIN HCT
	\$	Bisoprolol/HCTZ	ZIAC
	\$	Captopril/HCTZ	CAPOZIDE
	\$	Enalapril/HCTZ	VASERETIC
	\$	Methyldopa/HCTZ	ALDORIL
	\$\$	Metoprolol/HCTZ	LOPRESSOR HCT
		Potassium-Sparing Diuretics	
	\$	Spironolactone	ALDACTONE
	\$	Spironolactone/HCTZ	ALDACTAZIDE
	\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
			MAXZIDE 25
	\$\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50
	\$\$	Triamterene	DYRENIUM
		Loop Diuretics	
	\$	Furosemide	LASIX
	\$\$	Ethacrynic Acid	EDECRIN
		Thiazide and Related Diuretics	
	\$	Chlorothiazide	DIURIL
	\$	Chlorthalidone	HYGROTON
	\$	Hydrochlorothiazide Tablets (HCTZ)	HYDRODIURIL
			(SOLUTION NONFORMULARY)
PA	\$	Hydrochlorothiazide Capsules	MICROZIDE, PA REQ
	\$	Indapamide	LOZOL
	\$\$	Metolazone	ZAROXOLYN
		Vasodilator Antihypertensives	
AGE	\$	Doxazosin Mesylate	CARDURA MEMBERS <21 MAY BE CCS-ELIGIBLE
			(CARDURA XL NONFORMULARY)
	\$	Hydralazine	APRESOLINE
AGE	\$	Prazosin	MINIPRESS MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Terazosin	HYTRIN MEMBERS <21 MAY BE CCS-ELIGIBLE

Antilipidemic Agents

	\$	Cholestyramine	QUESTRAN QUESTRAN LIGHT
	\$	Gemfibrozil	LOPID
	\$	Lovastatin	MEVACOR
	\$	Simvastatin	ZOCOR
PA QL	\$\$	Atorvastatin	LIPITOR, PA REQUIRED ON ALL STRENGTHS EXCEPT 80MG TABLETS; TABLET SPLITTING REQUIRED (USE ½ 80MG FOR 40MG DOSE; USE ½ 40MG FOR 20MG DOSE; USE ½ 20MG FOR 10MG DOSE) (EFFECTIVE 2/15/12) QL OF #1/DAY
ST QL	\$\$\$	Rosuvastatin	CRESTOR STEP THERAPY REQUIRED ON ALL STRENGTHS EXCEPT 40MG TABLETS (TRIAL OF SIMVASTATIN 40MG AND ATORVASTATIN REQUIRED) (EFFECTIVE 2/15/12). GRANDFATHER ALL CURRENT USERS. QL OF #1/DAY
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 (USE ½ 20MG FOR 10MG DOSE, USE ½ 40MG FOR 20MG DOSE, USE ½ 80MG FOR 40MG DOSE) (EFFECTIVE 3/1/09)
PA	\$\$\$	Colesevelam	WELCHOL
	\$\$\$	Ezetimibe	ZETIA, PA REQ
	\$	Fish Oil, over-the-counter	FISH OIL, OVER-THE-COUNTER (EFFECTIVE 4/1/12)

Coagulants and Anticoagulants

	\$	Warfarin Sodium	COUMADIN
	\$	Heparin Sodium	HEPARIN
	\$\$	Anagrelide	AGRYLIN
	\$\$	Cilostazol	PLETAL
	\$\$	Ticlopidine	TICLID
ST	\$\$	Aspirin/dipyridamole	AGGRENOX STEP THERAPY OF A TRIAL OF ASPIRIN (EFFECTIVE 12/28/11)
AGE	\$\$\$	Clopidogrel	PLAVIX <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Dalteparin Syringes	FRAGMIN SYRINGES; SYRINGES ONLY, LIMITED TO 10 SYRINGES/FILL & 2 FILLS/YEAR
	\$\$\$\$	Enoxaparin Syringes	LOVENOX SYRINGES, SYRINGES ONLY, LIMITED TO 20 SYRINGES/FILL & 2 FILLS/YEAR
	\$\$\$\$	Fondaparinux	ARIXTRA, MAXIMUM OF 10 SYRINGES /FILL & 2 FILLS/YEAR
	\$\$\$\$	Tinzaparin	INNOHEP, MAXIMUM OF 10 VIALS/FILL & 2 FILLS/YEAR

Cardiac Glycoside Agents

	\$	Digoxin	LANOXIN (LANOXICAPS NONFORMULARY)
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Hemorheologic Agents

	\$	Pentoxifylline	TRENTAL
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Vasodilating Agents

	\$	Isosorbide Dinitrate	ISORDIL (CHEW TABLETS NONFORMULARY)
	\$	Nitroglycerin Sublingual	NITROSTAT SL
	\$	Nitroglycerin Ointment	NITROL
	\$\$	Isosorbide Mononitrate	IMDUR
PA			ISOTRATE ER, PA REQ
STEP	\$\$	Nitroglycerin Patches	NITRODUR, STEP THERAPY (ISOSORBIDE DINITRATE PREFERRED)
	\$\$\$	Nitroglycerin Spray	NITROLINGUAL SPRAY

Agents for Pulmonary Hypertension

PA, AGE		Sildenafil Citrate	REVIATIO, PA REQ , CCS AGE EDIT (MEMBERS <21 MAY BE CCS ELGIBLE) (EFFECTIVE 6/1/11)
PA, AGE		Tadalafil Tablets	ADCIRCA, PA REQ , CCS AGE EDIT (MEMBERS <21 MAY BE CCS ELGIBLE) (EFFECTIVE 6/1/11)

CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Analgesics

\$	Acetaminophen
\$	Tramadol

TYLENOL
ULTRAM; **MAXIMUM OF 8 TABLETS/DAY (EFFECTIVE 10/15/09)**
(ULTRAM ER NONFORMULARY)

Migraine Agents

\$	APAP/Dichloralphenazone/ Isometheptene
\$	Butalbital/ASA/Caffeine/Codeine
\$	Butalbital/APAP/Caffeine
\$	Butalbital/ASA/Caffeine
\$\$	Ergotamine/Caffeine
\$\$	Sumatriptan Tablets

MIDRIN
FIORINAL W/CODEINE #3, **MAXIMUM #45/RX, 3 RXS/75 DAYS**
ESGIC
FIORICET
FIORINAL
CAFERGOT
IMITREX TABLETS, **TRIAL OF TRIPTAN(EFFECTIVE 12/17/09)**

STEP	\$\$\$	Divalproex ER
	\$\$\$\$	Sumatriptan Injection

DEPAKOTE ER
IMITREX INJECTION, **STEP THERAPY (TRIAL OF SUMATRIPTAN TABLETS), QUANTITY LIMIT OF 2 INJECTIONS PER MONTH (EFFECTIVE 12/17/09)**
IMITREX NASAL, **STEP THERAPY (TRIAL OF SUMATRIPTAN TABLETS), QUANTITY LIMIT OF 6 NASAL SPRAYS PER MONTH (EFFECTIVE 12/17/09)**

STEP	\$\$\$\$	Sumatriptan Nasal
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Opiate Agonists

\$	Acetaminophen/Codeine
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TYLENOL #2, **MAXIMUM #60/RX, 3 RXS/75 DAYS**
TYLENOL #3, **MAXIMUM #45/RX, 3 RXS/75 DAYS**
TYLENOL #4, **MAXIMUM #45/RX, 3 RXS/75 DAYS**
(VOPAC NONFORMULARY)

QL	\$	Acetaminophen/Hydrocodone	VICODIN, VICODIN ES, NORCO, LORCET, LORCET PLUS MEDI-CAL QUANTITY RESTRICTION, 3 RXS / 75 DAYS, GENERICS ONLY . QL OF MAXIMUM #6/DAY. FILL LIMIT OF #3/75DAYS. SOLUTION QL OF MAXIMUM #1770 ML/MO. FILL LIMIT OF #3/75DAYS
	\$	Codeine/Aspirin	EMPIRIN #2, MAXIMUM #60/RX, 3 RXS/75 DAYS EMPIRIN #3, MAXIMUM #45/RX, 3 RXS/75 DAYS
QL	\$	Methadone	METHADONE, MAXIMUM #120/RX FOR 5MG, #240/RX FOR 10MG 3RXS/75 DAYS
QL	\$	Oxycodone/Acetaminophen	PERCOCET (7.5MG/500MG NONFORMULARY) TYLOX, MAXIMUM #120/RX, 3RXS/75 DAYS
	\$	Oxycodone/Aspirin	PERCODAN
	\$	Propoxyphene Napsylate/APAP	DARVOCET N-100, MAXIMUM #45/RX, 3RXS/75 DAYS (DARVOCET A 500 & TRYCET NONFORMULARY)
QL	\$\$	Hydromorphone	DILAUDID, MAXIMUM #240/RX, 3RXS/75 DAYS (DILAUDID SYRUP NONFORMULARY)
	\$\$	Meperidine	DEMEROL
QL	\$\$	Morphine	MSIR, MAXIMUM #90/RX, 3 RX/75 DAYS
	\$\$	Morphine SR	MS CONTIN, MAXIMUM #60/MONTH (KADIAN AND AVINZA NONFORMULARY)
PA	\$\$\$\$	Fentanyl Transdermal Patch	DURAGESIC, PA REQ
PA	\$\$\$\$	Oxycodone	OXYCONTIN, PA REQ
PA	\$\$\$\$	Fentanyl Lozenge	ACTIQ, PA REQ
Anti-Inflammatory Agents			
First Line Agents			
	\$	Aspirin	ECOTRIN
	\$	Diclofenac Potassium	CATAFLAM (ZIPSOR NONFORMULARY)
	\$	Flurbiprofen	ANSAID
	\$	Ibuprofen	MOTRIN
	\$	Indomethacin	INDOCIN (INDOCIN SUPPOSITORY, INDOCIN SR NONFORMULARY)
	\$	Naproxen	NAPROSYN, ANAPROX (NAPROXEN SODIUM SUSTAINED-ACTION NONFORMULARY)
	\$	Salsalate	DISALCID
	\$	Sulindac	CLINORIL
	\$\$	Choline Mag. Trisalicylate	TRILISATE
	\$\$	Diclofenac Sodium	VOLTAREN
	\$\$	Diflunisal	DOLOBID
	\$\$	Etodolac	LODINE (LODINE XL NONFORMULARY)
	\$\$	Fenoprofen	NALFON (NALFON CAPSULES NONFORMULARY)
	\$\$	Tolmetin Sodium	TOLECTIN
Second Line Agents			
QL	\$\$	Ketoprofen	ORUVAIL, QL OF #4 / DAY (EFFECTIVE 2/15/12) (COMPOUNDED KETOPROFEN NONFORMULARY). QL OF #4/DAY.
	\$\$	Leflunomide	ARAVA (EFFECTIVE 5/15/10)
QL	\$\$	Meloxicam	MOBIC, QL OF #1 / DAY (EFFECTIVE 2/15/12) (MELOXICAM SUSPENSION NONFORMULARY). QL OF #1/DAY
QL	\$\$	Nabumetone	RELAFEN, QL OF #2 / DAY (EFFECTIVE 2/15/12). QL OF #2/DAY
QL	\$\$	Ketorolac	TORADOL, LIMITED TO 5 DAYS TREATMENT (EFFECTIVE 2/15/12). QL OF #20/5 DAYS SUPPLY

AGE, STEP	\$\$\$\$	Celecoxib	CELEBREX, STEP THERAPY AND AGE EDITS (RESTRICTED TO PATIENTS WITH GI RISK [60 YEARS AND OLDER OR ON WARFARIN], SUBMIT PA FOR OTHER GI RISK FACTORS. PATIENTS <21 YEARS MAY BE CCS ELIGIBLE) (CELEBREX 400MG NONFORMULARY)
PA	\$\$\$\$	Diclofenac/Misoprostol	ARTHROTEC, PA REQ
PA	\$\$\$\$\$	Adalimumab	HUMIRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)
PA	\$\$\$\$\$	Etanercept	ENBREL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)

NOTE: NSAID COMPOUNDS ARE NOT A COVERED PLAN BENEFIT

Anticonvulsant Agents

AGE	\$	Carbamazepine	TEGRETOL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
QL	\$	Clonazepam	KLONOPIN, QUANTITY LIMIT OF #90 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (EFFECTIVE 3/1/2011) (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	\$	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	\$\$	Divalproex Sodium	DEPAKOTE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Ethosuximide	ZARONTIN, 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	\$\$	Levetiracetam	KEPPRA, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 11/1/09)
PA	\$\$	Topiramate	TOPAMAX, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 8/1/10) (TOPAMAX SPRINKLE CAP ON FORMULARY WITH PA)
PA	\$\$	Zonisamide	ZONEGRAN, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
PA	\$\$\$	Carbamazepine SR Capsules	CARBATROL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EQUETRO NONFORMULARY)
PA	\$\$\$	Oxcarbazepine	TRILEPTAL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
PA	\$\$\$	Tiagabine	GABITRIL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE

Antiparkinsonian Agents

\$	Trihexyphenidyl	ARTANE, BILL STATE EDS
\$	Benzotropine Mesylate	COGENTIN, BILL STATE EDS

AGE	\$\$	Amantadine	SYMMETREL, BILL STATE EDS
	\$\$	Carbidopa/Levodopa	SINEMET, MEMBERS <21 MAY BE CCS-ELIGIBLE (PARCOPA NONFORMULARY)
	\$\$	Procyclidine HCl	KEMADRIN, BILL STATE EDS
	\$\$	Selegiline	ELDEPRYL, BILL STATE EDS EMSAM, BILL STATE EDS ZELAPAR, BILL STATE EDS
AGE	\$\$\$	Bromocriptine	PARLODEL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Carbidopa/Levodopa CR	SINEMET CR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Pramipexole	MIRAPEX, MEMBERS <21 MAY BE CCS-ELIGIBLE (MIRAPEX ER NONFORMULARY)
AGE	\$\$\$	Ropinirole	REQUIP, MEMBERS <21 MAY BE CCS-ELIGIBLE (REQUIP STARTER KIT NONFORMULARY, REQUIP XR NONFORMULARY)
AGE	\$\$\$\$	Entacapone	COMTAN, MEMBERS <21 MAY BE CCS-ELIGIBLE

Muscle Relaxant Agents

Skeletal Muscle Relaxants

\$	Carisoprodol	SOMA (250MG TABLET NONFORMULARY)
\$	Cyclobenzaprine	FLEXERIL
\$	Methocarbamol	ROBAXIN
\$\$	Baclofen	LIORESAL
\$\$\$	Dantrolene Sodium	DANTRIUM

Psychotherapeutic Agents

Antimanics

\$	Lithium Carbonate	ESKALITH, BILL STATE EDS LITHOBID, BILL STATE EDS
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Antipsychotics

\$	Chlorpromazine	THORAZINE, BILL STATE EDS
\$	Fluphenazine	PROLIXIN, BILL STATE EDS
\$	Haloperidol	HALDOL, BILL STATE EDS
\$	Perphenazine	TRILAFON, BILL STATE EDS
\$	Thioridazine	MELLARIL, BILL STATE EDS
\$	Thiothixene	NAVANE, BILL STATE EDS
\$	Trifluoperazine	STELAZINE, BILL STATE EDS
\$\$	Loxapine	LOXITANE, BILL STATE EDS
\$\$\$	Clozapine	CLOZARIL, BILL STATE EDS
\$\$\$	Molindone	MOBAN, BILL STATE EDS
\$\$\$	Quetiapine	SEROQUEL, BILL STATE EDS
\$\$\$	Risperidone	RISPERDAL, BILL STATE EDS RISPERDAL CONSTA, BILL STATE EDS RISPERDAL-M, BILL STATE EDS
\$\$\$\$	Aripiprazole	ABILIFY, BILL STATE EDS
\$\$\$\$	Olanzapine	ZYPREXA, BILL STATE EDS
\$\$\$\$	Olanzapine/Fluoxetine	SYMBYAX, BILL STATE EDS
\$\$\$\$	Paliperidone	INVEGA, BILL STATE EDS

Miscellaneous Anxiolytics, Hypnotics and Sedatives

\$	Chloral Hydrate	NOCTEC	
\$	f HCl	ATARAX	
\$	Hydroxyzine Pamoate	VISTARIL	
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
QL	\$	Zolpidem	AMBIEN, QUANTITY LIMIT TO #30 PER MONTH (Effective 3/1/11) (AMBIEN CR, EDLUAR NONFORMULARY)

QL	\$\$	Buspirone	BUSPAR
	\$\$\$	Zaleplon	SONATA, QUANTITY LIMIT TO #30 PER MONTH (Effective 3/1/11)
<i>Benzodiazepines</i>			
QL	\$	Diazepam	VALIUM (DIAZEPAM SOLUTION AND ORAL CONCENTRATE NONFORMULARY), QUANTITY LIMIT OF #60 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (3/1/11)
QL	\$	Alprazolam	XANAX QUANTITY LIMIT TO #90 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (Effective 3/1/11) (ALPRAZOLAM ORAL CONCENTRATE, XANAX XR & NIRAVAM NONFORMULARY)
	\$	Flurazepam	DALMANE
	\$	Temazepam	RESTORIL (7.5MG & 22.5MG STRENGTHS NONFORMULARY)
	\$	Triazolam	HALCION
QL	\$	Lorazepam	ATIVAN, QUANTITY LIMIT OF #60 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (Effective 3/1/11) (LORAZEPAM ORAL CONCENTRATE NONFORMULARY)
<i>Cholinesterase Inhibitors</i>			
QL	\$	Donepezil	ARICEPT, QL OF #1 / DAY (ARICEPT ODT - PA REQUIRED)
PA	\$\$\$	Galantamine	RAZADYNE, PA REQ
PA	\$\$\$	Rivastigmine	EXELON, PA REQ (EXELON PATCHES NONFORMULARY)
<i>SSRIs</i>			
	\$	Fluoxetine	PROZAC (USE 2 X 20MG FOR 40MG DOSE) RAPIFLUX
	\$	Citalopram	CELEXA
	\$	Paroxetine	PAXIL
	\$	Sertraline	ZOLOFT
MD	\$\$	Fluvoxamine	LUVOX, SPECIALTY RESTRICTION (LUVOX CR NONFORMULARY)
PA	\$\$\$	Paroxetine CR	PAXIL CR, PA REQ
PA	\$\$\$	Escitalopram Oxalate	LEXAPRO, PA REQ
<i>Tricyclic Antidepressants</i>			
	\$	Amitriptyline	ELAVIL
	\$	Desipramine	NORPRAMIN
	\$	Doxepin	SINEQUAN
	\$	Imipramine	TOFRANIL (TOFRANIL PM NONFORMULARY)
	\$	Nortriptyline	PAMELOR
	\$\$\$	Protriptyline	AVENTYL VIVACTIL
<i>Miscellaneous Antidepressants</i>			
MD	\$	Clomipramine	ANAFRANIL, SPECIALTY RESTRICTION
	\$	Trazodone	DESYREL
	\$\$	Mirtazapine Tablets	REMERON TABLETS, (7.5MG TABLETS NONFORMULARY, SOLTABS NONFORMULARY)
	\$\$	Nefazodone	SERZONE
	\$\$\$	Bupropion	WELLBUTRIN WELLBUTRIN SR (WELLBUTRIN XL, APLENZIN NON-FORMULARY)
QL	\$\$\$	Venlafaxine	EFFEXOR QL OF #1/DAY; EFFEXOR XR CAPSULES, QL OF #1 / DAY VENLAFAXINE XR TABLETS STEP THERAPY (TRIAL OF FORMULARY SSRI)

ADHD Agents

(Not covered as appetite suppressants)

AGE, STEP	\$	Methylphenidate	RITALIN, 60 DAY SUPPLY ALLOWED
	\$\$	Dexmethylphenidate	FOCALIN, MEMBERS ≤18 REQUIRE STEP THERAPY (METHYLPHENIDATE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Dextroamphetamine	DEXEDRINE, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Dextroamphetamine/Amphetamine	ADDERALL, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METADATE CD, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METADATE ER, MEMBERS > 18 YEARS REQUIRE PA
AGE			METHYLIN ER, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	RITALIN SR, MEMBERS > 18 YEARS REQUIRE PA
	\$\$\$	Dexmethylphenidate	RITALIN LA, MEMBERS > 18 YEARS REQUIRE PA
AGE, STEP			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
AGE	\$\$\$	Dextroamphetamine/Amphetamine	ADDERALL XR, MEMBERS > 18 YEARS REQUIRE PA
PA	\$\$\$\$	Atomoxetine	STRATTERA, PA REQ
Substance Abuse Agents			
	\$	Naltrexone	REVIA, BILL STATE EDS
	\$\$\$	Buprenorphine HCl	SUBUTEX, BILL STATE EDS
	\$\$\$	Buprenorphine HCl/Naloxone HCl	SUBOXONE, BILL STATE EDS
	\$\$\$\$	Naltrexone Microspheres	VIVITROL, BILL STATE EDS

DIABETIC AND THYROID AGENTS

Diabetic Agents

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

Non-Sulfonylureas

AGE	\$	Metformin	GLUCOPHAGE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$	Metformin XR	GLUCOPHAGE XR, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$	Acarbose	PRECOSE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, PA	\$\$	Miglitol	GLYSET, PA REQ, 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	\$\$\$	Pioglitazone	ACTOS, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Pioglitazone/Glimepiride	DUETACT, STEP THERAPY (TRIAL OF ACTOS AND GLIMEPIRIDE REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Pioglitazone/Metformin	ACTOPLUS MET, STEP THERAPY (TRIAL OF ACTOS AND METFORMIN REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Repaglinide	PRANDIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone	AVANDIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone/Glimepiride	AVANDARYL, STEP THERAPY (TRIAL OF AVANDIA AND GLIMEPIRIDE), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone/Metformin	AVANDAMET, STEP THERAPY (TRIAL OF AVANDIA AND METFORMIN), 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
AGE, STEP	\$\$\$	Sitagliptin/Metformin

Sulfonylureas

AGE	\$	Chlorpropamide
AGE	\$	Glimepiride
AGE	\$	Glipizide
AGE	\$	Glipizide LA
AGE	\$	Glyburide
AGE	\$	Tolazamide
AGE	\$	Tolbutamide
AGE, STEP	\$\$	Glyburide/Metformin

Insulin Agents

NOTE: PA REQUIRED FOR INSULIN PRE-FILLED SYRINGES.

AGE	\$\$	Insulin
AGE	\$\$\$	Human Insulin
AGE	\$\$\$	Insulin Aspart
AGE	\$\$\$	Insulin Aspart Protamine/Insulin Aspart
AGE	\$\$\$	Insulin Glargine
AGE	\$\$\$	Insulin Lispro
AGE	\$\$\$	Human Insulin
AGE	\$\$\$\$	Insulin NPL/Insulin Lispro

JANUVIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
 JANUMET, STEP THERAPY (TRIAL OF JANUVIA AND METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE

DIABINESE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 AMARYL, MEMBERS <21 MAY BE CCS-ELIGIBLE
 GLUCOTROL, MEMBERS <21 MAY BE CCS-ELIGIBLE
 GLUCOTROL XL, MEMBERS <21 MAY BE CCS-ELIGIBLE
 DIABETA, MEMBERS <21 MAY BE CCS-ELIGIBLE
 MICRONASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 TOLINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 ORINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
 GLUCOVANCE, STEP THERAPY (TRIAL OF GLYBURIDE OR METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE

NOVO-NORDISK INSULINS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
 NOVOLIN (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
 NOVOLOG (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
 NOVOLOG MIX (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
 LANTUS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
 HUMALOG (VIALS ONLY, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
 HUMULIN N AND HUMULIN R (VIALS ONLY, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
 HUMALOG MIX 75/25, HUMULIN MIX (VIALS ONLY, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)

Thyroid Agents

\$	Thyroid, Desiccated
\$	Levothyroxine

ARMOUR
 THYROID
 LEVOTHROID
 LEVOXYL

Antithyroids

\$	Propylthiouracil
\$	Methimazole

PROPYLTHIOURACIL
 TAPAZOLE

Thyroid Hormones

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

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

\$	Bismuth Subsalicylate
\$	Diphenoxylate/Atropine
\$	Kaolin/Pectin
\$	Loperamide
\$	Paregoric

PEPTO BISMOL
 LOMOTIL
 KAOPECTATE
 IMODIUM
 PAREGORIC

Antiemetic Agents

	\$	Dimenhydrinate	DRAMAMINE
	\$	Meclizine	ANTIVERT
	\$	Metoclopramide	REGLAN (METOCLOPRAMIDE INTENSOL NONFORMULARY) (METOZOLV ODT NONFORMULARY)
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$	Prochlorperazine Maleate	COMPAZINE
	\$	Trimethobenzamide	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)
PA	\$\$\$\$	Dronabinol	MARINOL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Aprepitant	EMEND, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

Antimuscarinic/Antispasmodic Agents

	\$	Belladonna/Phenobarbital (Extentabs Nonformulary)	DONNATAL
	\$	Dicyclomine	BENTYL
	\$	Hyoscyamine	LEVSIN

Anti-ulcer/Antipeptic Agents

	\$	Aluminum Carbonate	BASALJEL
	\$	Aluminum Hydroxide	TITRALAC
	\$	Calcium Carbonate	ALTERNAGEL
	\$	Cimetidine	TUMS
	\$	Famotidine	TAGAMET
	\$	Magaldrate	PEPCID
	\$	Magnesium Carbonate/Aluminum Hydroxide/Alginic Acid	RIOPAN
	\$	Magnesium Hydroxide/Aluminum Hydroxide	GAVICON
	\$	Magnesium Hydroxide/Aluminum Hydroxide/Simethicone	MAALOX
	\$	Misoprostol	GELUSIL
QL	\$	Omeprazole	CYTOTEC, USE 1/2 OF 200MCG FOR 100MCG DOSE PRILOSEC; QL OF #1 / DAY (OTC VERSIONS NON-FORMULARY) (EFFECTIVE 4/1/12).
	\$	Ranitidine	ZANTAC (ZANTAC EFFERDOSE NONFORMULARY)
AGE			ZANTAC LIQUID, AGE RESTRICTION (MEMBERS >12 YEARS OF AGE REQUIRE PA)
	\$\$	Sucralfate	CARAFATE
ST	\$\$	Lansoprazole OTC 15mg Capsules	PREVACID 24HR, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE). (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)

ST \$\$ Lansoprazole 30mg Capsules

PREVACID 30MG CAPSULES, **STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE).**
(FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)

AGE, \$\$\$ Lansoprazole Solutabs
STEP

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) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE).**

AGE, \$\$\$ Mesalamine
STEP

ASACOL, **STEP THERAPY (TRIAL OF SULFASALAZINE), MEMBERS <21 MAY BE CCS ELIGIBLE (EFFECTIVE 5/1/09)**
PROTONIX, **QL OF #1 PER DAY**

QL \$ Pantoprazole

Miscellaneous Gastrointestinal Agents

AGE \$ Metoclopramide
AGE \$\$\$ Amylase/Lipase/Protease

REGLAN
CREON, **MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)**

AGE

PANCREAZE, **MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)**

AGE

ZENPEP, **MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)**

PA \$\$\$ Mesalamine Suppository
 \$\$\$ Pilocarpine
 \$\$\$ Ursodiol

CANASA, **PA REQ, MEMBERS <21 MAY BE CCS ELIGIBLE**
SALAGEN
ACTIGALL
(URSO FORTE NONFORMULARY)

PA \$\$\$\$ Alosetron
PA \$\$\$\$ Balsalazide

LOTROXEX, **PA REQ**
COLAZAL, **PA REQ**

Laxative Agents

\$ Bisacodyl
\$ Docusate Sodium
\$ Magnesium Hydroxide
\$ Docusate Calcium
\$ Psyllium
\$ Sennosides
\$\$ Lactulose

\$\$ Polyethylene Glycol 3350

DUCOLAX
COLACE
MILK OF MAGNESIA
SURFAK
METAMUCIL
SENNA, **(EFFECTIVE 10/1/09)**
CEPHULAC
CHRONULAC
MIRALAX

HEMATOLOGICAL DISORDERS

Hematinics, Other

PA, Epoetin Alfa
AGE

EPOGEN **PA REQ** AND CCS AGE EDIT. MEMBERS <21 MAY BE CCS ELIGIBLE **(EFFECTIVE 6/1/11)**

GENITOURINARY AGENTS

Analgesics, Urinary Tract

\$	Phenazopyridine	PYRIDIUM
\$\$\$\$	Pentosan Polysulfate	ELMIRON

Anti-Infective Agents, Urinary

\$	Trimethoprim	TRIMPEX
\$\$	Methenamine	UREX
\$\$	Nitrofurantoin Macrocrystals	MACRODANTIN
		MACROBID
\$\$\$	Nitrofurantoin	FURADANTIN

Genitourinary Smooth Muscle Relaxant Agents

	\$	Oxybutynin	DITROPAN
STEP	\$\$	Oxybutynin Patch	OXYTROL, STEP THERAPY (TRIAL OF OXYBUTININ IMMEDIATE-RELEASE)
STEP	\$\$	Oxybutynin SR	DITROPAN XL, STEP THERAPY (OXYBUTININ IMMEDIATE-RELEASE PREFERRED)
STEP	\$\$\$	Tolterodine	DETROL, STEP THERAPY (OXYBUTININ IMMEDIATE-RELEASE PREFERRED)
STEP	\$\$\$	Tolterodine	DETROL LA, STEP THERAPY (OXYBUTININ IMMEDIATE-RELEASE PREFERRED)

Parasympathomimetic (Cholinergic) Agents

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

Miscellaneous Genitourinary Agents

MD	\$\$	Finasteride	PROSCAR, SPECIALTY RESTRICTION
STEP	\$\$	Tamsulosin	FLOMAX, STEP THERAPY (TRIAL OF TERAZOSIN OR DOXAZOSIN)

HORMONE AND CONTRACEPTIVE AGENTS

Adrenal Cortical Steroid Agents, Oral

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

Androgen Agents

	\$\$	Methyltestosterone	ANDROID METANDREN HALOTESTIN
	\$\$\$	Fluoxymesterone	ANDROGEL, PA REQ
PA	\$\$\$	Testosterone Gel	TESTOSTERONE, INJECTABLE, PA REQ
PA	\$\$\$	Testosterone	OXANDRIN 2.5MG, PA REQ
PA	\$\$\$\$	Oxandrolone	

Bisphosphonate Agents

	\$\$	Alendronate Tablets	FOSAMAX (TABLETS ONLY) (FOSAMAX SOLUTION AND FOSAMAX PLUS D ARE NONFORMULARY), AREDIA, PA REQ ZOMETA, PA REQ
PA	\$\$\$\$	Pamidronate Injection	
PA	\$\$\$\$\$	Zoledronic Acid Injection	

HRT - Oral Estrogen Tablets

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

HRT - Oral Estrogen / Progestin Tablets

	\$\$	Estradiol/Norethindrone	ACTIVELLA, QL OF #1 / DAY
	\$\$	Estradiol/Norgestimate	ORTHO-PREFEST (EFFECTIVE 10/15/11)
	\$\$	Ethinyl Estradiol/Norethindrone	FEMHRT (EFFECTIVE 10/15/11)
	\$\$	Estrogen, conjugated/Medroxyprogesterone	PREMPRO PREMPHASE

HRT- Oral Estrogen / Testosterone Tablets

	\$	Sodium Estrone (Estropiate)	ORTHO-EST (EFFECTIVE 10/15/11)
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HRT - Transdermal Estrogen System

	\$	Estradiol Patches	CLIMARA; QL OF # 4 PATCHES / MO (EFFECTIVE 2/15/12)
	\$\$	Estradiol Patches	VIVELLE-DOT; QL OF #8 PATCHES / MO (EFFECTIVE 2/15/12)

HRT - Intravaginal Estrogen System

	\$	Estradiol Vaginal Tablet	VAGIFEM
	\$\$	Estradiol Vaginal Cream	ESTRACE (EFFECTIVE 2/15/12)
	\$\$	Estradiol Vaginal Cream	PREMARIN (EFFECTIVE 2/15/12)
STEP	\$\$\$	Estradiol Vaginal Ring	ESTRING, STEP THERAPY (VAGIFEM, ESTRACE, OR PREMARIN CREAM PREFERRED; EFFECTIVE 2/15/12)
STEP	\$\$\$	Estradiol Vaginal Ring	FEMRINGSTEP THERAPY (VAGIFEM, ESTRACE, OR PREMARIN CREAM PREFERRED; EFFECTIVE 2/15/12)

Selective Estrogen Receptor Modulator

	\$\$	Raloxifene	EVISTA
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Contraceptive Agents

Monophasic Oral Contraceptives

	\$	Desogestrel/Ethinyl Estradiol	DESOGEN
	\$	Ethinodiol/Ethinyl Estradiol	DEMULEN

\$	Levonorgestrel/Ethinyl Estradiol	ALESSE
\$	Norethindrone	NORDETTE
\$	Norethindrone Acetate/Ethinyl Estradiol	NOR QD
		LOESTRIN
		LOESTRIN FE
		(LOESTRIN 24 FE NONFORMULARY)
\$	Norethindrone/Ethinyl Estradiol	JENEST-28
		MODICON
		NELOVA
		NORINYL
\$	Norethindrone/Mestranol	NORINYL 1/50
\$	Norgestimate/Ethinyl Estradiol	ORTHO CYCLEN
\$	Norgestrel/Ethinyl Estradiol	LO/OVRAL
		OVRAL
<i>Triphasic Oral Contraceptives</i>		
\$	Desogestrel/Ethinyl Estradiol	CYCLESSA
\$	Levonorgestrel/Ethinyl Estradiol	TRIPHASIL
\$	Norethindrone/Ethinyl Estradiol	TRI-NORINYL
		ORTHO-NOVUM
\$	Norgestimate/Ethinyl Estradiol	ORTHO TRI-CYCLEN
<i>Miscellaneous Contraceptives</i>		
\$	Latex Condoms	VARIOUS
\$	Nonoxynol 9	CONCEPTROL
		ENCARE
		KOROMEX
\$	Levonorgestrel	PLAN B, NEXT CHOICE: FEMALE ONLY; QL OF #2 IN 30 DAYS; #6 DISPENSINGS IN ANY 12 MONTH PERIOD (PLAN B ONE-STEP IS NON-FORMULARY) (EFFECTIVE 5/1/2012)
\$	Diaphragms, Coil Spring,	ORTHO-DIAPHRAGM
\$	Medroxyprogesterone	DEPO-PROVERA 150MG/ML STRENGTH ONLY
\$\$	Etonogestrel/Ethinyl Estradiol	NUVARING
\$\$	Norelgestromin/Ethinyl Estradiol	ORTHO EVRA

Growth Hormone Agents

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

Oxytocic Agents

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

Pituitary Agents

AGE	\$\$\$	Desmopressin	DDAVP TABLET, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE			DDAVP NASAL SPRAY,, MEMBERS <21 MAY BE CCS-ELIGIBLE

Progestin Agents

\$	Medroxyprogesterone	PROVERA
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Miscellaneous Hormone Agents

PA \$\$\$ Calcitonin Salmon

MIACALCIN, PA REQ

NEOPLASTIC DISEASE

Antineoplastic Systemic Enzyme Inhibitors

PA \$\$\$\$ Crizotinib
AGE

XALKORI, PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 10/1/11)

PA \$\$\$\$ Vandetanib
AGE

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

PA \$\$\$\$ Vemurafenib
AGE

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

Antineoplastic – Hedgehog Pathway Inhibitor

PA \$\$\$\$ Vismodegib
AGE

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

Antineoplastic – Halichondrin B Analogs

PA, \$\$\$ Eribulin Mesylate
AGE

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

Antiandrogenic Agents

PA \$\$\$\$ Abiraterone acetate
AGE

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

CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY

PA \$\$\$\$ Ipilimumab
AGE

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

NEUROLOGICAL DISEASE – MISCELLANEOUS

Agent to treat Multiple Sclerosis

PA \$\$\$ Glatiramer Acetate
PA \$\$\$ Interferon beta-1a

COPAXONE PA REQ (EFFECTIVE 3/1/2011)
REBIF PA REQ (EFFECTIVE 3/1/2011)

RESPIRATORY/EENT AGENTS

Adrenal Cortical Steroid Agents, Inhaled

\$\$ Beclomethasone
\$\$\$ Budesonide
\$\$\$ Budesonide
\$\$\$ Fluticasone Propionate
\$\$\$ Fluticasone Propionate

QVAR
PULMICORT
PULMICORT RESPULES
FLOVENT HFA
FLOVENT DISKUS (EFFECTIVE 6/1/11)

\$\$\$ Mometasone

ASMANEX

Antihistamine/Decongestant Agents

Antihistamine/Decongestant Combinations

AGE	\$	Brompheniramine/Pseudoephedrine	DRIXORAL
	\$	Phenylephrine/Promethazine	PHENERGAN VC, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$	Pseudoephedrine/Diphenhydramine	BENADRYL ALLERGY DECONGESTANT
	\$	Pseudoephedrine/Tripolidine	ACTIFED
	\$	Pseudoephedrine/Chlorpheniramine	DECONAMINE
	\$\$	Pseudoephedrine/Loratadine (OTC only)	CLARITIN-D (OTC ONLY)

Antihistamines/Low or Non-Sedating

	\$	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)
	\$	Loratadine (OTC only)	CLARITIN (OTC ONLY) CLARITIN REDI-TABS (OTC ONLY)
PA	\$\$\$	Fexofenadine	ALLEGRA TABLETS, PA REQ (ALLEGRA SUSPENSION AND ALLEGRA ODT NONFORMULARY)

Antihistamines

	\$	Brompheniramine	DIMETAPP (DIMETAPP SOLUTION NONFORMULARY)
	\$	Chlorpheniramine	CHLORTRIMETON
	\$	Cyproheptadine	PERIACTIN
	\$	Dexchlorpheniramine	POLARAMINE
	\$	Diphenhydramine	BENADRYL
	\$	Hydroxyzine HCL	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION

Decongestants

	\$	Pseudoephedrine	SUDAFED KIDCARE DROPS
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Expectorants

	\$	Guaifenesin	ROBITUSSIN
	\$	Guaifenesin, Sustained Release	HUMIBID LA
AGE	\$	Guaifenesin/Dextromethorphan	ANTITUSSIVE DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE			CHERACOL-D ROBITUSSIN DM. PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
	\$	Guaifenesin/Pseudoephedrine	ZEPHREX LA
	\$\$	Guaifenesin/Phenylephrine	GUAIFED
	\$\$	Potassium Iodide	ENTEX LA SSKI

Antitussive Agents

Narcotic Antitussives

	\$	Guaifenesin/Codeine	ROBITUSSIN AC
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AGE	\$	Promethazine/Codeine	PHENERGAN/CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
AGE	\$	Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
	\$	Tripolidine/Pseudoephedrine/ Codeine	TRIACIN-C
		Non-Narcotic Antitussives	
AGE	\$	Dextromethorphan HBr	TUSSIN PEDIATRIC, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Dextromethorphan/Pseudoephedrine/ Chlorpheniramine	KIDCARE COUGH AND COLD LIQUID, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Phenylephrine/Chlorpheniramine/ Dextromethorphan	CEROSE DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Promethazine/Dextromethorphan	PHENERGAN WITH DEXTROMETHORPHAN, 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
AGE	\$	Pseudoephedrine/Guaifenesin/ Dextromethorphan	BRONCOT, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
	\$\$	Benzonatate	TESSALON

Bronchodilator Agents

Inhaled Bronchodilator Agents

	\$	Terbutaline	BRETHINE
	\$\$	Albuterol	PROAIR HFA
	\$\$	Ipratropium	ATROVENT HFA
	\$\$	Pirbuterol Acetate	MAXAIR AUTOHALER
	\$\$\$	Albuterol/Ipratropium	COMBIVENT
STEP	\$\$\$	Levalbuterol for Nebulization	XOPENEX FOR NEBULIZATION, STEP THERAPY (ALBUTEROL PREFERRED) (XOPENEX HFA NONFORMULARY)
AGE, STEP	\$\$\$	Salmeterol	SEREVENT DISKUS, AGE RESTRICTION (MEMBERS LESS THAN 12 YEARS OF AGE REQUIRE PRIOR AUTHORIZATION), STEP THERAPY (TRIAL OF ORAL INHALED STEROID REQUIRED FOR MEMBERS 12 YEARS AND OLDER) (EFFECTIVE 3/1/09)
STEP	\$\$\$	Tiotropium	SPIRIVA, STEP THERAPY (TRIAL OF IPRATROPIUM)
		Oral Sympathomimetics (Adrenergics)	
AGE	\$	Albuterol Tablets	PROVENTIL
		Albuterol Syrup	PROVENTIL SYRUP, ALBUTEROL SYRUP RESTRICTED TO MEMBERS ≤5 YEARS OF AGE
	\$	Metaproterenol Oral	ALUPENT
	\$	Terbutaline Sulfate	BRETHINE
			BRICANYL
	\$\$	Albuterol ER	PROVENTIL REPETABS
			VOLMAX

Beta-Adrenergic and Glucocorticoid Combinations

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

Carbonic Anhydrase Inhibitors

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

Inhaled Agents

\$	Sodium Chloride	SALINE NOSE SPRAY	
\$\$	Flunisolide	FLUNISOLIDE	
\$\$	Fluticasone	FLONASE	
AGE	\$\$\$	Mometasone	NASONEX RESTRICTED TO MEMBERS LESS THAN 4 YEARS OF AGE (EFF 7/1/09)

Miscellaneous EENT Agents

\$	Sodium Chloride Solution for Inhalation	SODIUM CHLORIDE SOLUTION FOR INHALATION	
\$\$	Azelastine Nasal Spray	ASTELIN (ASTEPRO NONFORMULARY)	
STEP	\$\$\$	Montelukast	SINGULAIR, STEP THERAPY (ASTHMA: TRIAL OF AN ORAL INHALED STEROID, ALLERGIC RHINITIS: TRIAL OF A NASAL STEROID AND NSA)
\$\$\$	Zafirlukast	ACCOLATE	

Local Anesthetics

\$	Benzocaine/Antipyrine Otic	AURALGAN
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Mucolytic Agents

\$	Acetylcysteine	MUCOMYST
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Ophthalmic Agents

Ophthalmic Anti-Allergics

\$	Cromolyn Sodium Ophthalmic	OPTICROM	
\$	Ketotifen Ophthalmic OTC	ALAWAY, ZADITOR OTC, (FEDERAL LEGEND KETOTIFEN NONFORMULARY)	
\$	Naphazoline Ophthalmic	VASOCON	
\$	Naphazoline/Pheniramine Ophthalmic	NAPHCON-A	
MD	\$\$\$	Lodoxamide Ophthalmic	ALOMIDE, RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY
MD	\$\$	Nedocromil Sodium Ophthalmic	ALOCRI, RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY
STEP	\$\$	Olopatadine Ophthalmic	PATANOL, STEP THERAPY (TRIAL OF OTC KETOTIFEN OPTHALMIC)
MD	\$\$	Pemirolast Ophthalmic	ALAMAST, RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY

Ophthalmic Antibiotics

\$	Bacitracin Ophthalmic	BACITRACIN
\$	Bacitracin/Polymyxin Ophthalmic	POLYSPORIN
\$	Bacitracin/Polymyxin/Neosporin Ophthalmic	OCUTRICIN
\$	Ciprofloxacin Ophthalmic	CILOXAN
\$	Dexamethasone/Neomycin Ophthalmic	NEO-DECADRON

	\$	Dexamethasone/Poly/Neomycin Ophthalmic	MAXITROL
	\$	Erythromycin Base Ophthalmic	ILOTYCIN
	\$	Gentamicin Ophthalmic	GARAMYCIN
	\$	Neomycin/Gramicidin/Polymyxin Ophthalmic	NEOSPORIN OPHTHALMIC
	\$	Ofloxacin Ophthalmic	OCUFLOX
	\$	Polymixin B Sulfate/TMP Ophthalmic	POLYTRIM
	\$	Tetracycline Ophthalmic	ACHROMYCIN
	\$	Tobramycin Ophthalmic	TOBREX
MD	\$\$	Levofloxacin Ophthalmic Ophthalmic	QUIXIN, SPECIALTY RESTRICTION (RESTRICTED TO OPHTHALMOLOGY)
ST	\$\$	Moxifloxacin	VIGAMOX, STEP THERAPY (OPHTHALMIC CIPROFLOXACIN, OFLOXACIN, OR GENERIC POLYTRIM PREFERRED, OPHTHALMOLOGISTS EXEMPT FROM STEP THERAPY RESTRICTION) (EFFECTIVE 11/1/09)
	\$\$	Tobramycin/Dexamethasone Ophthalmic	TOBRADEX
		Ophthalmic Anti-Inflammatories	
	\$	Dexamethasone Ophthalmic	DEXASOL
	\$	Diclofenac Sodium Ophthalmic	VOLTAREN (EFFECTIVE 3/1/09)
	\$	Fluorometholone Ophthalmic	FML FORTE (FML S.O.P. NONFORMULARY)
	\$	Flurbiprofen Ophthalmic	OCUFEN
	\$	Prednisolone Acetate Ophthalmic	PRED MILD OMNIPRED PRED FORTE
STEP	\$\$	Loteprednol Ophthalmic	LOTEMAX, STEP THERAPY (PREDNISOLONE OR DEXAMETHASONE PREFERRED)
PA	\$\$	Rimexolone Ophthalmic	VEXOL, PA REQ
		Ophthalmic Antiviral Agents	
	\$\$\$	Trifluridine Ophthalmic	VIROPTIC
		Ophthalmic Beta Blockers	
	\$	Carteolol Ophthalmic	OCUPRESS
	\$	Levobunolol Ophthalmic	BETAGAN
	\$	Metipranolol Ophthalmic	OPTIPRANOLOL
	\$	Timolol Ophthalmic	BETIMOL TIMOPTIC
	\$\$\$	Betaxolol Ophthalmic	BETOPTIC S
		Ophthalmic Miotics	
	\$	Carbachol Ophthalmic	ISOPTO CARBACHOL
	\$	Pilocarpine Ophthalmic	PILOCAR
	\$\$	Brimonidine Ophthalmic	ALPHAGAN P
	\$\$	Demecarium Ophthalmic	HUMORSOL
	\$\$	Echothiophate Iodide Ophthalmic	PHOSPHOLINE IODIDE
		Ophthalmic Mydriatics	
	\$	Atropine Sulfate Ophthalmic	ISOPTO ATROPINE
	\$	Cyclopentolate Ophthalmic	CYCLOGYL
	\$	Dipivefrin Ophthalmic	PROPINE
	\$	Phenylephrine Ophthalmic	MYDFRIN
	\$	Tropicamide Ophthalmic	MYDRIACYL
		Ophthalmic Sulfonamides	
	\$	Sulfacetamide Ophthalmic	BLEPH-10 SODIUM SULAMYD
	\$	Sulfacetamide 10%/Prednisolone 0.25% Ophthalmic	VASOCIDIN
		Miscellaneous Ophthalmics	
	\$	Polyvinyl Alcohol Ophthalmic	ARTIFICIAL TEARS

	\$	Sodium Chloride Ophthalmic	MURO-128
	\$\$	Brinzolamide	AZOPT
	\$\$	Latanoprost	XALATAN
PA	\$\$\$	Cyclosporine Ophthalmic	RESTASIS, PA REQ
	\$\$\$	Dorzolamide/Timolol Ophthalmic	COSOPT

Otic Agents

Otic Anti-Infectives

\$	Acetic Acid 2% Otic	DOMEBORO
\$	Acetic Acid 2%/Hydrocortisone 1% Otic	VOSOL HC
\$	Neomycin/HC Otic	NEO-CORT-DOME
\$	Neomycin/Polymyxin Otic	POLY OTIC
\$	Neomycin/Polymyxin/HC Otic	CORTISPORON
\$\$	Neomycin/Colistin/HC Otic	COLY-MYCIN S
\$\$\$	Ciprofloxacin/Dexamethasone Otic	CIPRODEX
\$\$\$	Ciprofloxacin/Hydrocortisone	CIPRO HC
\$\$\$	Ofloxacin Otic	FLOXIN OTIC

Respiratory Smooth Muscle Relaxants

\$	Aminophylline 105mg/5cc	
\$	Theophylline	THEOLAIR
\$\$	Theophylline, 80mg/15cc (Alcohol Free)	ELIXOPHYLLIN
\$\$	Theophylline, Sustained Release	SLO-BID UNIPHYL

TOPICAL/MUCOUS MEMBRANE AGENTS

Anti-Acne Agents

	\$	Benzoyl Peroxide Gel	BENZAGEL
	\$	Benzoyl Peroxide 10% Wash	BENZAC AC DESQUAM-X
	\$	Clindamycin Topical Solution	CLEOCIN (CLINDAMYCIN PLEDGETS NONFORMULARY)
	\$	Erythromycin 2% Solution	T-STAT
AGE	\$\$	Tretinoin Cream and Tretinoin Gel	RETIN-A, AGE RESTRICTION < 25 YEARS OF AGE
STEP	\$\$\$	Benzoyl Peroxide/Clindamycin Gel	BENZAACLIN, STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED). QL OF #50GM IN 30DAYS
QL			
STEP			DUAC, STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED)
MD	\$\$\$\$	Isotretinoin	ACCUTANE, SPECIALTY RESTRICTION

Keratolytic Agents

\$\$\$	Podofilox	CONDYLOX
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Scabicide/Pediculicide Agents

\$	Piperonyl butoxide/pyrethrins	RID
\$	Piperonyl butoxide/pyrethrins	TRIPLE X
\$	Permethrin	ELIMITE NIX
\$\$	Malathion	OVIDE
\$\$\$	Crotamiton	EURAX

Miscellaneous Skin/Mucous Membrane Agents

	\$	Aluminum Acetate	BURROW'S SOLUTION
	\$	Ammonium Lactate 12% Lotion	AMLACTIN
	\$	Calamine Lotion	CALAMINE
	\$	Capsaicin	CAPSAICIN
	\$	Coal Tar	FOTOTAR
	\$	Lidocaine, Viscous	XYLOCAINE
	\$	Mineral Oil	LUBAFAX
	\$	Vitamin A & D Cream	CLOCREAM
	\$\$	Fluorouracil	EFUDEX
			(EFUDEX OCCLUSION PACK NONFORMULARY)
	\$\$	Metronidazole 0.75% Cream	METROCREAM, (EFFECTIVE 11/1/09) (OTHER STRENGTHS NON-FORMULARY)
	\$\$	Metronidazole 0.75% Gel	METROGEL (OTHER STRENGTHS NON-FORMULARY) (METROGEL/SKIN CLENSER KIT AND METROGEL 1% NONFORMULARY)
PA	\$\$	Papain/Urea	ACCUZYME, PA REQ
PA	\$\$	Papain/Urea/Chlorophyllin	PANAFIL, PA REQ
	\$\$\$	Imiquimod	ALDARA, QUANTITY LIMIT OF 12 PER MONTH (EFFECTIVE 5/1/09)
PA	\$\$\$	Papain/Urea	PANAFIL WHITE, PA REQ
STEP	\$\$\$	Pimecrolimus	ELIDEL, STEP THERAPY (TOPICAL STEROID PREFERRED)
STEP	\$\$\$	Tacrolimus	PROTOPIC, STEP THERAPY (TOPICAL STEROID PREFERRED)
MD	\$\$\$	Tazarotene	TAZORAC, SPECIALTY RESTRICTION
MD	\$\$\$\$	Calcipotriene	DOVONEX, SPECIALTY RESTRICTION
PA	\$\$\$\$\$	Alitretinoin	PANRETIN, PA REQ

Topical Antibiotic Agents

	\$	Bacitracin Ointment	BACITRACIN
	\$	Bacitracin/Polymyxin	POLYSPORIN
	\$	Bacitracin/Polymyxin/Neomycin	NEOSPORIN
	\$	Isopropyl Alcohol	ISOPROPYL ALCOHOL
	\$	Povidone/Iodine	BETADINE
	\$	Selenium Sulfide 2.5%	SELSUN
	\$	Silver Sulfadiazine	SILVADENE
	\$	Tetracycline Ointment	ACHROMYCIN
	\$	neomy sulf/bacitrac zn/poly	NEOSPORIN
	\$	neomycin/baci zn/pmyx bs/pramox	TRIPLE ANTIBIOTIC PLUS
	\$	neomycin/baci zn/pmyx bs/pramox	NEOSPORIN
	\$\$	Mupirocin Ointment	BACTROBAN OINTMENT
			(BACTROBAN CREAM AND BACTROBAN NASAL NONFORMULARY)

Topical Antifungal Agents

	\$	Clotrimazole	LOTRIMIN
	\$	clotrimazole/betamet diprop	LOTRISONE CREAM
	\$	Miconazole Nitrate	MONISTAT-DERM
	\$	Nystatin	MYCOSTATIN
	\$	Tolnaftate	TINACTIN
	\$	Triamcinolone/Nystatin	MYCOLOG II
	\$	Econazole	SPECTAZOLE
	\$	Selenium sulfide 2.5% shampoo	SELENIUM SULFIDE, QL OF #240ML / MO
	\$	Terbinafine 1% cream	LAMISIL AT – OTC (EFFECTIVE 8/15/11)
	\$\$	Ketoconazole Cream	NIZORAL CREAM (EFFECTIVE 2/15/12)
	\$\$	Ketoconazole Shampoo	NIZORAL A-D SHAMPOO (EFFECTIVE 2/15/12)

PA	\$\$\$	Ciclopirox	LOPROX, PA REQ (LOPROX SHAMPOO NONFORMULARY)
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Topical Anti-Inflammatory Agents

Low Potency

	\$	Fluocinolone 0.025%	SYNALAR
	\$	Hydrocortisone	HYTONE
	\$	Hydrocortisone Suppository	PROCTOSOL HC
	\$	Hydrocortisone Acetate	HEMORRHOIDAL HC
	\$	Desonide	CORTIFOAM
STEP	\$\$	Alclometasone Dipropionate	PROCTOCORT
	\$\$	Hydrocortisone/Pramoxine	TRIDESILON (EFFECTIVE 11/1/10)
	\$\$\$	Hydrocortisone Enema	ACLOVATE, STEP THERAPY (TRIAL OF TOPICAL FLUOCINOLONE OR HYDROCORTISONE)
	\$	Betamethasone Dipropionate	PROCTOCREAM-HC
	\$	Betamethasone Valerate	PROCTOFOAM HC
	\$	Triamcinolone	CORTENEMA
AGE	\$\$	Mometasone Furoate Cream	DIPROSONE
	\$\$\$	Flurandrenolide	MAXIVATE
	\$	Clobetasol 0.05% Cream, Solution, Ointment, Gel	BETA-VAL
	\$	Fluocinonide	KENALOG
			(TRIAMCINOLONE TOPICAL AEROSOL NONFORMULARY)
			ELOCON, QUANTITY RESTRICTION OF 15GM AND FOR CHILDREN < 12 YEARS OF AGE
			CORDRAN
			TEMOVATE CREAM, SOLUTION, OINTMENT, GEL (OTHER DOSAGE FORMS NON-FORMULARY) (EFFECTIVE 11/1/09)
			LIDEX
			(VANOS NONFORMULARY)

High Potency

Vaginal Antifungal Agents

	\$	Clotrimazole	MYCELEX-7
	\$	Miconazole	MONISTAT-7
PA	\$\$	Butoconazole	FEMSTAT
	\$\$	Miconazole (200mg Vaginal Suppository)	GYNAZOLE-1, PA REQ
STEP	\$\$	Terconazole	MONISTAT-3
			TERAZOL, STEP THERAPY (VAGINAL CLOTRIMAZOLE OR MICONAZOLE PREFERRED)

Vaginal Anti-Infective Agents

	\$\$	Clindamycin Vaginal Cream	CLEOCIN VAGINAL CREAM (CLINDESSE NONFORMULARY)
	\$\$	Metronidazole	METROGEL-VAGINAL

UNCLASSIFIED/MISCELLANEOUS AGENTS

Alcohol/Smoking Deterrents

PA	\$\$	Bupropion, Slow Release	ZYBAN, PA REQ
PA	\$\$	Nicotine Gum	NICORETTE, PA REQ
PA	\$\$	Nicotine Patch	NICOTINE PATCH, PA REQ
	\$\$\$	Disulfiram	ANTABUSE
PA	\$\$\$	Varenicline	CHANTIX, PA REQ

Weight Loss Agents

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

Diagnostic Testing

Blood Glucose Test Strips

(* Glucometer and Ascensia are the preferred test strips for new patients. Other test strips are nonformulary.)

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

Urine Test Strips

AGE		Urine Acetone	CHEMSTRIP K MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Urine Glucose	CHEMSTRIP UG MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Urine Multiple Test	CHEMSTRIP-9 MEMBERS <21 MAY BE CCS-ELIGIBLE KETO-DIASTIX MEMBERS <21 MAY BE CCS-ELIGIBLE

Electrolyte Agents

Potassium Agents

\$	Potassium Chloride Liquids	KAON-CL
\$\$	Potassium Chloride 10mEq	KAON-CL 10
		K-DUR
\$\$	Potassium Chloride 20mEq	K-DUR

Misellaneous Electrolyte Agents

\$	Electrolytes, Oral Solution	PEDIALYTE	
AGE	\$\$\$\$	Sevelamer	RENAGEL MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Cinacalcet	SENSIPAR

Gout Agents

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

Vitamin and Fluoride Agents

Calcium Agents

AGE	\$	Calcium Acetate	PHOSLO, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE			PHOSLO GELCAP 667MG, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$	Calcium Carbonate	OS-CAL 500
	\$	Calcium Gluconate	CALCIUM
	\$	Calcium Lactate	CALCIUM LACTATE
	\$	Calcium Phosphate	DICALCIUM PHOSPHATE

Fluoride Agents

\$	Sodium Fluoride (Drops and Tablets)	LURIDE
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Iron Agents

\$	Ferrous Sulfate	FERROUS SULFATE
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Magnesium Agents

\$	Magnesium Lactate	MAGTAB-SR
\$	Magnesium Oxide	MAGOX, (EFFECTIVE 10/1/09)

Multivitamin Agents

\$	Fluoride/Polyvitamins (With and Without Iron; Drops and Tablets)	POLY-VI-FLOR
\$	Fluoride/Vitamins A,D,C, (With and Without Iron; Drops and Tablets)	TRI-VI-FLOR
\$	Multivitamin	DALY VITE
\$	Multivitamin with Iron	DALY VITE WITH IRON
\$	Multivitamin with Minerals	GERIATRIC

Prenatal Vitamin Agents

QL	\$	Prenatal Multivitamins	CARENATE MATERNITY-90 PRENAVITE PRENATAL PRENATAL PLUS PRENAPLUS
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Vitamin A

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

Vitamin B-Complex Agents

\$	Cyanocobalamin	VITAMIN B-12
\$	Folic Acid	FOLIC ACID
\$	Folic Acid/Multivitamins with Minerals	VICON FORTE
\$	Niacin	NICOTINIC ACID
\$	Pyridoxine	VITAMIN B-6
\$	Riboflavin	VITAMIN B-2
\$	Thiamine	VITAMIN B-1
\$	Vitamin B Complex/C	BEE WITH C

Vitamin C

\$	Ascorbic Acid	VITAMIN C
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Vitamin D

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

Vitamin E

\$	Vitamin E	VITAMIN E
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Vitamin K Activity Agents

\$\$	Phytonadione	MEPHYTON
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Anaphylaxis Kits

\$\$	Epinephrine	EPIPEN EPIPEN JR
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Medical Devices

	\$	Peak Flow Meter	PEAK FLOW METER
	\$	Tablet Splitter	TABLET SPLITTER
	\$\$	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 <u>With</u> 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)

Recent Changes to the Formulary

Drug Name	Formulary Change	Effective Date
Advair / Symbicort	Remove from formulary; grandfather existing members	5/1/12
Vismodegib	Add to F with PA	5/1/12
Zelboraf	Add to F with PA	5/1/12
Yervoy	Add to F with PA	5/1/12
Plan B One-Step	Remove from F. Have Next Choice as the alternative on F with POS message "Generic Next Choice is the formulary alternative."	5/1/12
Prenatal Vitamins that are on formulary (ex. Prenavite, Prenatal, Prenatal Plus, Prenaplus)	Please ensure that there is QL of #1 / day and gender edit "limited to females only" to formulary prenatal vitamins. No change to current formulary statuses	5/1/12
Fish Oils OTC	Please add drugs to formulary.	5/1/12
Diltiazem 24hr ER/Diltia XT	Please add drugs to formulary with QL of #1/day	4/1/12
Diltiazem 12hr ER	Please add drugs to formulary with QL of #2/day	4/1/12
Omeprazole 40mg	Add to F with QL of #1/day; fill limit of #1 in 21 days	4/1/12
Omeprazole 20mg	Change QL of #2/day to #1/day; drug remains on F with fill limit of #1 in 21days	4/1/12
Benzaclin Gel	Please change current QL to #50gm in 30 days	4/1/12
Tamiflu 6mg/ml suspension	Add to F with QL of #120ml per 180 days. Fill Limit of 1 in 180 days.	2/15/12
Enjuvia	Add to F; QL of #1 / day	2/15/12
Femtrace	Add to F; QL of #1 / day	2/15/12
Menest	Add to F; QL of # 1 / day	2/15/12
Estropipate	Add to F; QL of #1 / day	2/15/12
Climara patch	Remove current ST (Per formulary lookup, it currently has a ST of premarin or Vivelle-dot, please verify); drug remains F; add QL of #4 patches / month	2/15/12
Vivelle-Dot patch	Add to F; QL of #8 / month	2/15/12
Premarin cream	Add to F	2/15/12
Estrace cream	Drug remains F; remove ST	2/15/12
Vagifem	Add to F	2/15/12
Estring / Femring	Revise current ST to include ST of a trial of either Premarin cream, Estrace cream, or Vagifem 5 days supply in the past 120 days period. Drug remains F.	2/15/12
generic hydrocodone/APAP oral tablets/capsules	Add to F with QL of maximum #6 / day. Fill limit of #3 / 75 days	2/15/12
generic hydrocodone/APAP 7.5-500/15 Solution	Add to F with QL of maximum #1770 ml / mo. Fill limit of #3/75 days.	2/15/12
generic losartan	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic losartan – hctz	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
geneirc atorvastatin 80mg	Add to F with QL of #1 / day	2/15/12
Crestor 5mg, 10mg, and 20mg	Remove 5mg, 10mg, and 20mg from Formulary. Grandfather all current users. No change to Crestor 40mg and it remains F with QL of #1 / day.	2/15/12
generic meloxicam	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic nabumetone	Remove current ST; Drug should be on F with QL of #2 / day	2/15/12
generic ketorolac	Add drug to formulary with QL of #20 / 5 days supply	2/15/12
generic ketoprofen	Remove current PA; Drug should be on F with QL of #4 / day	2/15/12
generic piroxicam	Remove from formulary; grandfather current users	2/15/12
generic ketoconazole cream and ketoconazole shampoo	Remove current ST; Drugs should be F without restrictions	2/15/12
generic venlafaxine ER capsules only	Remove current ST; Drug should be F with QL #1 / day; venlafaxine ER tablets should still be F with ST.	2/15/12
generic donepezil	Remove current PA; Drug should be F with QL #1 / day	2/15/12
Aggrenox	Add to F with ST of aspirin 5 days supply in the past 120 days	12/28/11

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

Pegintron	Add drug to formulary with PA and CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Pegasys	Remove drug from formulary; grandfather existing Pegasys members (lookback period 3 months)	6/1/11
Levemir	Remove drug from formulary; grandfather existing Levemir members (lookback period 3 months)	6/1/11
Humalog, Humulin N, Humulin R, Humulin Mix, Humalog Mix	Add drugs to formulary; Add CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Revatio	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Adcirca	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Flovent Diskus	Add to formulary; Current QL of #60 / mo remains.	6/1/11
Rituxan	Remove from formulary	6/1/11
Amlodipine 5mg	Remove PA required. Drug remains in Formulary. No change to existing QL of #30 in 21 days	4/1/11
losartan	Added to formulary; ST of a trial of ACEI	4/1/11
losartan - hctz	Added to formulary; ST of a trial of ACEI-hctz	4/1/11
Copaxone	Add to F with PA	3/1/11
Rebif	Add to F with PA	3/1/11
Alprazolam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Clonazepam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Diazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Lorazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Zolpidem	Modified QL restriction to #30 / mo	3/1/11
Zaleplon	Modified QL restriction to #30 / mo	3/1/11
Desonide cream	Added to formulary.	11/1/10
Cholecalciferol (Vitamin D3)	Added to formulary.	11/1/10
Creon, Pancreaze, Zenpep	Added to formulary. Patients less than 21 years may be CCS eligible.	8/1/10
Trelstar	Added to formulary with PA restriction. Patients less than 21 years may be CCS eligible.	8/1/10
Topiramate	PA restriction removed for tablets. PA required remains for sprinkles capsules. Patient <21 years that are on 2 or more anticonvulsants may be CCS eligible	8/1/10
Hydromorphone	QL restrictions of #240 / Rx and fill limit of 3 in 75days	8/1/10
Methadone	QL restrictions to #120 / Rx for 5mg and QL of #240 / Rx for 10mg; fill limit of 3 in 75days	8/1/10
Morphine sulfate, SA	QL restrictions to #90 / month; fill limits of 3 in 75 days	8/1/10
Oxycodone and APAP	QL to #120 / month; fill limits of 3 in 75 days	8/1/10
OTC omeprazole	Removed from formulary. Federal legend omeprazole preferred.	6/15/10
Rapamune	Added to formulary with PA restrictions. . Patients less than 21 years may be CCS eligible.	6/1/10
Nabumetone	PA restrictions removed. Step therapy restriction added (trial of unrestricted NSAID).	5/15/10
Leflunomide	PA restrictions removed.	5/15/10
Advair	Step therapy criteria modified. Trial of inhaled steroid (if asthma), anticholinergic (if COPD) or LABA (if COPD) required.	4/15/10
Enbrel, Humira	Added to formulary with a PA restriction. Preferred TNF agents.	4/1/10
Prevacid 24HR (OTC)	Added to formulary with a step therapy 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	2/1/10

	trial of ranitidine. Lansoprazole capsules (OTC 15mg or legend 30mg) preferred for patients able to swallow capsules.	
Antiarrhythmics	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Plavix, Ticlopidine, Cilostazole	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Prazosin, Terazosin, Doxazosin	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Generic Climara Patches	Step therapy removed.	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

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