

# Community Health Group Medi-Cal Drug Formulary



February 2010

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## Administered by MedImpact

February 2010  
INTRODUCTION

### **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 criterion 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>
<b>Reason for Medication Request (please be specific, give detail):</b>	
<b>Other Medications Tried and/or Failed (please be specific, give detail):</b>	
<b>Other Pertinent History (relative or pertaining to this request):</b>	

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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, <b>SUSPENSION ONLY</b> <b>(FOR MEMBERS ≤ 12 YEARS OF AGE)</b>

### *Macrolide Antibiotics*

\$	Erythromycin Stearate	ERYTHROCIN
\$	Erythromycin Base	ERY-TAB
\$	Erythromycin Ethylsuccinate	PCE
\$	Erythromycin/Sulfisoxazole	EES
AGE	Azithromycin	ERYPED SUSPENSION
PA		PEDIAZOLE
AGE, STEP		ZITHROMAX SUSPENSION, <b>RESTRICTED TO MEMBERS 12 YEARS AND YOUNGER</b>
		ZITHROMAX POWDER PACKET (ZMAX NONFORMULARY)
		ZITHROMAX TABLETS, <b>AGE &amp; 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)</b>
PA	Clarithromycin	BIAXIN, <b>PA REQ</b>
PA		BIAXIN XL 500MG, <b>PA REQ</b>

### *Penicillins*

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

### *Quinolones*

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

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

## Antifungal Agents

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

## 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, <b>PA REQ</b>

## Antiviral Agents

	\$	Amantadine	SYMMETREL, BILL STATE EDS
	\$	Acyclovir Oral	ZOVIRAX ORAL
PA	\$\$\$	Famciclovir	FAMVIR, PA REQ
	\$\$\$	Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
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	BARACLUD, 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

## Leprostatic Agents

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

## Sulfonamide Agents

\$	Sulfamethoxazole/Trimethoprim (SMX/TMP)	BACTRIM SEPTRA
AGE	Sulfasalazine	AZULFIDINE, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/09)
\$	Sulfisoxazole	GANTRISIN
\$	Trimethoprim	TRIMPEX

## Miscellaneous Antibiotics

\$	Metronidazole	FLAGYL (FLAGYL ER AND CAPSULES NONFORMULARY)
AGE	Clindamycin Capsules	CLEOCIN CAPSULES
AGE	Clindamycin Oral Solution	CLEOCIN ORAL SOLUTION, LIMITED TO USE IN PATIENTS 6 YEARS OF AGE AND YOUNGER
STEP	Atovaquone	MEPRON, STEP THERAPY (TRIAL OF TRIMETHOPRIM/SULFAMETHOXAZOLE)
PA	Linezolid	ZYVOX, PA REQ

# ANTINEOPLASTIC AND IMMUNOSUPPRESSANT AGENTS

## Antineoplastic Agents

PA	Aldesleukin	PROLEUKIN, PA REQ
PA	Alemtuzumab	CAMPATH, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Altretamine	HEXALEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Anastrozole	ARIMIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Arsenic Trioxide	TRISENOX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Asparaginase	ELSPAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Bexarotene	TARGRETIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Bicalutamide	CASODEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Bleomycin Sulfate	BLENOXANE, PA REQ, MEMBERS <21 MAY BE CCS- ELIGIBLE
PA	Bortezomib	VELCADE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Busulfan	MYLERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Capecitabine	XELODA, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Carboplatin	PARAPLATIN, PA REQ, MEMBERS <21 MAY BE CCS- ELIGIBLE
PA	Carmustine	BICNU, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Chlorambucil	LEUKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Cisplatin	PLATINOL-AQ, PA REQ, MEMBERS <21 MAY BE CCS- ELIGIBLE
PA	Cladribine	LEUSTATIN, PA REQ, MEMBERS <21 MAY BE CCS- ELIGIBLE
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	Daunorubicin Citrate Liposome	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	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	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
AGE	Nilutamide	NILANDRON 50MG, 150MG, 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	Pegaspargase	ONCASPAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Peginterferon Alfa-2a	PEGASYS, PA REQ
PA	Pentostatin	NIPENT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Porfimer	PHOTOFRIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Procarbazine	MATULANE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Rituximab	RITUXAN, 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	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	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)

## CARDIOVASCULAR/BLOOD AGENTS

### Antiarrhythmic Agents

AGE	\$	Amiodarone 200mg	CORDARONE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10) (OTHER AMIODARONE STRENGTHS NONFORMULARY)
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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**

STEP	\$\$	Olmesartan	BENICAR, STEP THERAPY (TRIAL OF ACE INHIBITOR)
STEP	\$\$	Olmesartan/HCTZ	BENICAR HCT, STEP THERAPY (TRIAL OF ACE INHIBITOR)
STEP	\$\$	Telmisartan	MICARDIS, STEP THERAPY (TRIAL OF ACE INHIBITOR)
STEP	\$\$	Telmisartan/HCTZ	MICARDIS HCT, STEP THERAPY (TRIAL OF ACE INHIBITOR)
STEP	\$\$	Valsartan	DIOVAN, STEP THERAPY (TRIAL OF ACE INHIBITOR)
STEP	\$\$	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY (TRIAL OF ACE INHIBITOR)

### **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**

	\$	Amlodipine	NORVASC (USE 1/2 OF 10MG TABLET FOR 5MG DOSE)
	\$	Diltiazem	CARDIZEM
	\$	Nifedipine	ADALAT

	\$	Verapamil	PROCARDIA
	\$\$	Diltiazem SA Capsules	CALAN
	\$\$	Diltiazem CD	CARDIZEM SR (CARDIZEM LA NONFORMULARY)
	\$\$	Felodipine	DILACOR XR
	\$\$	Nifedipine, Sustained Release	TIAZAC
	\$\$	Verapamil SR Tablets	PLENDIL
STEP	\$\$\$	Amlodipine/Benazepril	ADALAT CC
	\$\$\$	Verapamil LA Capsules	PROCARDIA XL
			CALAN SR (COVERA-HS NONFORMULARY)
			LOTREL, <b>STEP THERAPY (TRIAL OF AMLODIPINE AND BENAZEPRIL)</b>
			VERELAN
			VERELAN PM

### **Centrally Acting Antihypertensives**

\$	Clonidine	CATAPRES
\$	Methyldopa	ALDOMET
\$	Guanfacine	TENEX

### **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
\$\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 25
\$\$	Triamterene	MAXZIDE 50
		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, <b>PA REQ</b>
	\$	Indapamide	LOZOL
	\$\$	Metolazone	ZAROXOLYN

### **Vasodilator Antihypertensives**

AGE	\$	Doxazosin Mesylate	CARDURA <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b> (CARDURA XL NONFORMULARY)
	\$	Hydralazine	APRESOLINE
AGE	\$	Prazosin	MINIPRESS <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
AGE	\$	Terazosin	HYTRIN <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>

### **Antilipidemic Agents**

	\$	Cholestyramine	QUESTRAN
	\$	Gemfibrozil	QUESTRAN LIGHT LOPID

	\$	Lovastatin	MEVACOR
	\$	Simvastatin	ZOCOR
STEP	\$\$	Fenofibrate	LOFIBRA, <b>STEP THERAPY (TRIAL OF GEMFIBROZIL OR CONCURRENT STATIN REQUIRED)</b>
	\$\$	Niacin, Delayed Release	<b>(TRICOR, TRIGLIDE, LIPOFEN, FENOGLIDE, ANTARA, TRILIPIX NONFORMULARY) (EFFECTIVE 8/15/09)</b>
	\$\$	Pravastatin	NIASPAN
	\$\$\$	Colesevelam	PRAVACHOL (USE ½ 20MG FOR 10MG DOSE, USE ½ 40MG FOR 20MG DOSE, USE ½ 80MG FOR 40MG DOSE) <b>(EFFECTIVE 3/1/09)</b>
PA	\$\$\$	Ezetimibe	WELCHOL
ST	\$\$\$	Rosuvastatin	ZETIA, <b>PA REQ</b>
			CRESTOR (USE ½ 10MG FOR 5MG DOSE;USE ½ 20MG FOR 10MG DOSE;USE ½ 40MG FOR 20MG DOSE) <b>STEP THERAPY REQUIRED ON ALL STRENGTHS EXCEPT 40MG TABLETS (TRIAL OF SIMVASTATIN 80MG REQUIRED) (EFFECTIVE 7/15/09)</b>

## Coagulants and Anticoagulants

	\$	Warfarin Sodium	COUMADIN
	\$	Heparin Sodium	HEPARIN
	\$\$	Anagrelide	AGRYLIN
	\$\$	Cilostazol	PLETAL
	\$\$	Ticlopidine	TICLID
	\$\$\$	Clopidogrel	PLAVIX
	\$\$\$\$\$	Dalteparin Syringes	FRAGMIN SYRINGES; <b>SYRINGES ONLY, LIMITED TO 10 SYRINGES/FILL &amp; 2 FILLS/YEAR</b>
	\$\$\$\$\$	Enoxaparin Syringes	LOVENOX SYRINGES, <b>SYRINGES ONLY, LIMITED TO 20 SYRINGES/FILL &amp; 2 FILLS/YEAR</b>
	\$\$\$\$\$	Fondaparinux	ARIXTRA, <b>MAXIMUM OF 10 SYRINGES /FILL &amp; 2 FILLS/YEAR</b>
	\$\$\$\$\$	Tinzaparin	INNOHEP, <b>MAXIMUM OF 10 VIALS/FILL &amp; 2 FILLS/YEAR</b>

## 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, <b>PA REQ</b>
STEP	\$\$	Nitroglycerin Patches	NITRODUR, <b>STEP THERAPY (ISOSORBIDE DINITRATE PREFERRED)</b>
	\$\$\$	Nitroglycerin Spray	NITROLINGUAL SPRAY

## Miscellaneous Blood Modifiers

PA	\$\$\$\$\$	Erythropoietin	PROCRIT, <b>PA, REQ, MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
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# 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

MIDRIN  
FIORINAL W/CODEINE #3, **MAXIMUM #45/RX, 3 RXS/75 DAYS**

\$ Butalbital/APAP/Caffeine

ESGIC

\$ Butalbital/ASA/Caffeine

FIORICET

\$\$ Ergotamine/Caffeine

FIORINAL

\$\$ Sumatriptan Tablets

CAFERGOT

IMITREX TABLETS, **QUANTITY LIMIT OF 9 TABLETS PER MONTH (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)**

STEP \$\$\$\$ Sumatriptan Nasal

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

### **Opiate Agonists**

\$ Acetaminophen/Codeine

TYLENOL #2, **MAXIMUM #60/RX, 3 RXS/75 DAYS**

TYLENOL #3, **MAXIMUM #45/RX, 3 RXS/75 DAYS**

TYLENOL #4, **MAXIMUM #45/RX, 3 RXS/75 DAYS**

(VOPAC NONFORMULARY)

\$ Acetaminophen/Hydrocodone

VICODIN, VICODIN ES, **MEDI-CAL QUANTITY RESTRICTION**

\$ Codeine/Aspirin

EMPIRIN #2, **MAXIMUM #60/RX, 3 RXS/75 DAYS**

EMPIRIN #3, **MAXIMUM #45/RX, 3 RXS/75 DAYS**

\$ Methadone

METHADONE

\$ Oxycodone/Acetaminophen

PERCOCET (7.5MG/500MG NONFORMULARY)

\$ Oxycodone/Aspirin

TYLOX, **MAXIMUM #90/RX, 3RXS/75 DAYS**

\$ Propoxyphene Napsylate/APAP

PERCODAN

DARVOCET N-100, **MAXIMUM #45/RX, 3RXS/75 DAYS**

(DARVOCET A 500 & TRYCET NONFORMULARY)

\$\$ Hydromorphone

DILAUDID

(DILAUDID SYRUP NONFORMULARY)

\$\$ Meperidine

DEMEROL

\$\$ Morphine

MSIR, **MAXIMUM #90/RX, 3 RX/75 DAYS**

\$\$ Morphine SR

MS CONTIN, **MAXIMUM #60/MONTH**

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  
\$ Diclofenac Potassium  
\$ Diclofenac Sodium  
\$ Flurbiprofen

ECOTRIN  
CATAFLAM  
VOLTAREN  
ANSAID

	\$	Ibuprofen	MOTRIN
	\$	Indomethacin	INDOCIN (INDOCIN SUPPOSITORY, INDOCIN SR NONFORMULARY)
	\$	Naproxen	NAPROSYN, ANAPROX (NAPROXEN SODIUM SUSTAINED-ACTION NONFORMULARY)
	\$	Piroxicam	FELDENE
	\$	Salsalate	DISALCID
	\$	Sulindac	CLINORIL
	\$\$	Choline Mag. Trisaliclylate	TRILISATE
	\$\$	Diflunisal	DOLOBID
	\$\$	Etodolac	(LODINE XL NONFORMULARY)
	\$\$	Fenoprofen	NALFON
	\$\$	Tolmetin Sodium	TOLECTIN
<b>Second Line Agents</b>			
PA	\$\$	Ketoprofen	ORUVAIL, <b>PA REQ</b> (COMPOUNDED KETOPROFEN NONFORMULARY)
STEP	\$\$	Meloxicam	MOBIC, <b>STEP THERAPY (FAILURE OF AN UNRESTRICTED FORMULARY NSAID)</b> MELOXICAM SUSPENSION NONFORMULARY)
PA	\$\$	Nabumetone	RELAFEN, <b>PA REQ</b>
AGE, STEP	\$\$\$	Celecoxib	CELEBREX, <b>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 &lt;21 YEARS MAY BE CCS ELIGIBLE)</b> (CELEBREX 400MG NONFORMULARY)
PA	\$\$\$	Diclofenac/Misoprostol	ARTHROTEC, <b>PA REQ</b>
PA	\$\$\$	Leflunomide	ARAVA, <b>PA REQ, MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>

**NOTE: NSAID COMPOUNDS ARE NOT A COVERED PLAN BENEFIT**

## Anticonvulsant Agents

AGE	\$	Carbamazepine	TEGRETOL, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$	Clonazepam	KLONOPIN, <b>LIMITED TO 90 DAYS, MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b> (KLONOPIN WAFERS NONFORMULARY)
AGE	\$	Phenobarbital	PHENOBARBITAL, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$	Phenytoin	DILANTIN, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$	Primidone	MYSOLINE, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$	Valproic Acid	DEPAKENE, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$\$	Divalproex Sodium	DEPAKOTE, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$\$	Ethosuximide	ZARONTIN, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$\$	Gabapentin	NEURONTIN, <b>MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE</b>
AGE	\$\$	Lamotrigine Tablets	LAMICTAL TABLETS, <b>HALF TABLET EDITS, MEMBERS &lt;21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 8/1/09)</b> (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, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
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
	\$\$	Amantadine	SYMMETREL, BILL STATE EDS
AGE	\$\$	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
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
\$	Diazepam	VALIUM
\$	Methocarbamol	ROBAXIN
\$\$	Baclofen	LIORESAL
\$\$\$	Dantrolene Sodium	DANTRium

## Psychotherapeutic Agents

### Antimanic

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

### 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, <b>BILL STATE EDS</b>
	\$\$\$	Clozapine	CLOZARIL, <b>BILL STATE EDS</b>
	\$\$\$	Molindone	MOBAN, <b>BILL STATE EDS</b>
	\$\$\$	Quetiapine	SEROQUEL, <b>BILL STATE EDS</b>
	\$\$\$	Risperidone	RISPERDAL, <b>BILL STATE EDS</b> RISPERDAL CONSTA, <b>BILL STATE EDS</b> RISPERDAL-M, <b>BILL STATE EDS</b>
	\$\$\$\$	Aripiprazole	ABILIFY, <b>BILL STATE EDS</b>
	\$\$\$\$	Olanzapine	ZYPREXA, <b>BILL STATE EDS</b>
	\$\$\$\$	Olanzapine/Fluoxetine	SYMBYAX, <b>BILL STATE EDS</b>
	\$\$\$\$	Paliperidone	INVEGA, <b>BILL STATE EDS</b>
		<b>Miscellaneous Anxiolytics, Hypnotics and Sedatives</b>	
	\$	Chloral Hydrate	NOCTEC
	\$	Hydroxyzine HCl	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
AGE	\$	Promethazine	PHENERGAN, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b> AMBIEN, MAXIMUM #14/30 DAYS (AMBIEN CR, EDLUAR NONFORMULARY)
	\$	Zolpidem	AMBIEN, MAXIMUM #14/30 DAYS (AMBIEN CR, EDLUAR NONFORMULARY)
	\$\$	Buspirone	BUSPAR
	\$\$\$	Zaleplon	SONATA, MAXIMUM #14/30 DAYS
		<b>Benzodiazepines</b>	
	\$	Diazepam	VALIUM (DIAZEPAM SOLUTION AND ORAL CONCENTRATE NONFORMULARY)
MD	\$	Alprazolam	XANAX, <b>SPECIALTY RESTRICTION</b> (ALPRAZOLAM ORAL CONCENTRATE, XANAX XR & NIRAVAM NONFORMULARY)
	\$	Flurazepam	DALMANE
	\$	Temazepam	RESTORIL (7.5MG & 22.5MG STRENGTHS NONFORMULARY)
	\$	Triazolam	HALCION
	\$	Lorazepam	ATIVAN, <b>QUANTITY LIMIT OF #30 PER RX</b> (LORAZEPAM ORAL CONCENTRATE NONFORMULARY)
		<b>Cholinesterase Inhibitors</b>	
PA	\$\$\$	Donepezil	ARICEPT, <b>PA REQ</b>
PA			ARICEPT ODT, <b>PA REQ</b>
PA	\$\$\$	Galantamine	RAZADYNE, <b>PA REQ</b>
PA	\$\$\$\$	Rivastigmine	EXELON, <b>PA REQ</b> (EXELON PATCHES NONFORMULARY)
		<b>SSRIs</b>	
	\$	Fluoxetine	PROZAC (USE 2 X 20MG FOR 40MG DOSE) RAPIFLUX
	\$	Citalopram	CELEXA TABLETS (USE 1/2 OF 20MG FOR 10MG DOSE; USE 1/2 OF 40MG FOR 20MG DOSE)
	\$	Paroxetine	PAXIL TABLETS (USE 1/2 20MG FOR 10MG DOSE; USE 1/2 40MG FOR 20MG DOSE)
	\$	Sertraline	ZOLOFT (USE 1/2 OF 100MG TABLET FOR 50MG DOSE), (USE 1/2 OF 50MG FOR 25MG DOSE)
MD	\$\$	Fluvoxamine	LUVOX, <b>SPECIALTY RESTRICTION</b>
PA	\$\$\$	Paroxetine CR	PAXIL CR, <b>PA REQ</b>
		<b>Tricyclic Antidepressants</b>	
	\$	Amitriptyline	ELAVIL
	\$	Desipramine	NORPRAMIN
	\$	Doxepin	SINEQUAN

	\$	Imipramine	TOFRANIL (TOFRANIL PM NONFORMULARY)
	\$	Nortriptyline	PAMELOR AVENTYL VIVACTIL
	\$\$\$	Protriptyline	
		<b>Miscellaneous Antidepressants</b>	
	\$	Amitriptyline/Perphenazine	TRIAVIL
MD	\$	Clomipramine	ANAFRANIL, <b>SPECIALTY RESTRICTION</b>
	\$	Trazodone	DESYREL
	\$\$	Mirtazapine Tablets	REMERNON TABLETS, (7.5MG TABLETS NONFORMULARY, SOLTABS NONFORMULARY)
MD	\$\$	Nefazodone	SERZONE, <b>SPECIALTY RESTRICTION</b>
MD	\$\$\$	Bupropion	WELLBUTRIN, <b>SPECIALTY RESTRICTION</b>
MD			WELLBUTRIN SR, <b>SPECIALTY RESTRICTION</b> (WELLBUTRIN XL, APLENZIN NON-FORMULARY)
ST	\$\$\$	Venlafaxine	EFFEXOR, <b>STEP THERAPY (TRIAL OF FORMULARY SSRI)</b> <b>(EFFECTIVE 5/1/09)</b> EFFEXOR XR CAPSULES <b>STEP THERAPY (TRIAL OF</b> <b>FORMULARY SSRI) (EFFECTIVE 5/1/09)</b> VENLAFAXINE XR TABLETS <b>STEP THERAPY (TRIAL OF</b> <b>FORMULARY SSRI) (EFFECTIVE 5/1/09)</b>

### **ADHD Agents**

*(Not covered as appetite suppressants)*

	\$	Methylphenidate	RITALIN, <b>60 DAY SUPPLY ALLOWED</b>
AGE, STEP	\$\$	Dexmethylphenidate	FOCALIN, <b>MEMBERS ≤18 REQUIRE STEP THERAPY</b> <b>(METHYLPHENIDATE PREFERRED), MEMBERS &gt; 18 YEARS</b> <b>REQUIRE PA</b>
AGE	\$\$	Dextroamphetamine	DEXEDRINE, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE	\$\$	Dextroamphetamine/Amphetamine	ADDERALL, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE	\$\$	Methylphenidate	METADATE CD, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE	\$\$	Methylphenidate	METADATE ER, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE			METHYLIN ER, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE	\$\$	Methylphenidate	RITALIN LA, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE, STEP	\$\$\$	Dexmethylphenidate	FOCALIN XR, <b>MEMBERS ≤18 REQUIRE STEP THERAPY</b> <b>(METHYLPHENIDATE PREFERRED), MEMBERS &gt; 18 YEARS</b> <b>REQUIRE PA</b>
PA	\$\$\$	Lisdexamfetamine	VYVANSE, <b>PA REQ</b>
AGE	\$\$\$	Methylphenidate	CONCERTA, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
AGE	\$\$\$	Dextroamphetamine/Amphetamine	ADDERALL XR, <b>MEMBERS &gt; 18 YEARS REQUIRE PA</b>
PA	\$\$\$\$	Atomoxetine	STRATTERA, <b>PA REQ</b>

### **Substance Abuse Agents**

	\$\$	Naltrexone	REVIA, <b>BILL STATE EDS</b>
	\$\$\$	Buprenorphine HCl	SUBUTEX, <b>BILL STATE EDS</b>
	\$\$\$	Buprenorphine HCl/Naloxone HCl	SUBOXONE, <b>BILL STATE EDS</b>
	\$\$\$\$	Naltrexone Microspheres	VIVITROL, <b>BILL STATE EDS</b>

## **DIABETIC AND THYROID AGENTS**

### **Diabetic Agents**

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

#### **Non-Sulfonylureas**

AGE	\$	Metformin	GLUCOPHAGE, <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
AGE, STEP	\$	Metformin XR	GLUCOPHAGE XR, <b>STEP THERAPY (TRIAL OF METFORMIN),</b> <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>

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	JANUVIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Sitagliptin/Metformin	JANUMET, STEP THERAPY (TRIAL OF JANUVIA AND METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE

### ***Sulfonylureas***

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

### ***Insulin Agents***

*NOTE: PA REQUIRED FOR INSULIN PRE-FILLED SYRINGES.*

AGE	\$\$	Insulin	NOVO-NORDISK INSULINS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Human Insulin	NOVOLIN (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart	NOVOLOG (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart Protamine/Insulin Aspart	NOVOLOG MIX (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Detemir	LEVEMIR (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Glargine	LANTUS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Insulin Lispro	HUMALOG (VIALS ONLY), PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$\$	Insulin NPL/Insulin Lispro	HUMALOG MIX 75/25 (VIALS ONLY), PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

## Thyroid Agents

\$	Thyroid, Desiccated	ARMOUR THYROID
\$	Levothyroxine	LEVOTHROID LEVOXYL

### Antithyroids

\$	Propylthiouracil	PROPYLTHIOURACIL,
\$	Methimazole	TAPAZOLE,

## GASTROINTESTINAL AGENTS

### Antidiarrheal Agents

\$	Bismuth Subsalicylate	PEPTO BISMOL
\$	Diphenoxylate/Atropine	LOMOTIL
\$	Kaolin/Pectin	KAOPECTATE
\$	Loperamide	IMODIUM
\$	Paregoric	PAREGORIC

### Antiemetic Agents

\$	Dimenhydrinate	DRAMAMINE
\$	Meclizine	ANTIVERT
\$	Metoclopramide	REGLAN (METOCLOPRAMIDE INTENSOL NONFORMULARY)
AGE	\$ Promethazine	PHENERGAN, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>
\$	Prochlorperazine Maleate	COMPazine
\$	Trimethobenzamide	TIGAN
AGE, QL	\$\$\$ Ondansetron Tablets and ODT	ZOFRAN TABLETS AND ODT, <b>MEMBERS &lt;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)</b>
PA	\$\$\$\$ Dronabinol	MARINOL, <b>PA REQ, MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
PA	\$\$\$\$ Aprepitant	EMEND, <b>PA REQ, MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>

### Antimuscarinic/Antispasmodic Agents

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

### Anti-ulcer/Antipeptic Agents

\$	Aluminum Carbonate	BASALJEL TITRALAC
\$	Aluminum Hydroxide	ALTERNAGEL
\$	Calcium Carbonate	TUMS
\$	Cimetidine	TAGAMET
\$	Famotidine	PEPCID
\$	Magaldrate	RIOPAN
\$	Magnesium Carbonate/Aluminum Hydroxide/Alginic Acid	GAVISCON
\$	Magnesium Hydroxide/Aluminum Hydroxide	MAALOX

	\$	Magnesium Hydroxide/Aluminum Hydroxide/Simethicone	GELUSIL
	\$	Misoprostol	CYTOTEC, USE ½ OF 200MCG FOR 100MCG DOSE
	\$	Omeprazole 10mg and 20mg	PRILOSEC PRILOSEC OTC (10MG AND 20MG STRENGTH ONLY, OTHER STRENGTHS NONFORMULARY); <b>10MG LIMITED TO 1 UNIT/DAY, 20MG LIMITED TO 2 UNITS PER DAY (EFFECTIVE 11/1/09)</b>
AGE	\$	Ranitidine	ZANTAC (ZANTAC EFFERDOSE NONFORMULARY) ZANTAC LIQUID, <b>AGE RESTRICTION ( MEMBERS &gt;12 YEARS OF AGE REQUIRE PA)</b>
	\$\$	Sucralfate	CARAFATE
ST	\$\$	Lansoprazole OTC 15mg Capsules	PREVACID 24HR, <b>STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10)</b> (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
ST	\$\$	Lansoprazole 30mg Capsules	PREVACID 30MG CAPSULES, <b>STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10)</b> (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
AGE, STEP	\$\$\$	Lansoprazole Solutabs	PREVACID SOLUTABS, <b>AGE RESTRICTION &amp; STEP THERAPY (RESTRICTED TO MEMBERS &lt;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)</b>
AGE, STEP	\$\$\$	Mesalamine	ASACOL, <b>STEP THERAPY (TRIAL OF SULFASALAZINE), MEMBERS &lt;21 MAY BE CCS ELIGIBLE (EFFECTIVE 5/1/09)</b>
PA	\$\$\$	Pantoprazole	PROTONIX, <b>PA REQ</b>

## Miscellaneous Gastrointestinal Agents

	\$	Metoclopramide	REGLAN
AGE	\$\$\$	Amylase/Lipase/Protease	ULTRASE, <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
AGE			VIOKASE, <b>MEMBERS &lt;21 MAY BE CCS-ELIGIBLE</b>
PA	\$\$\$	Mesalamine Suppository	CANASA, <b>PA REQ, MEMBERS &lt;21 MAY BE CCS ELIGIBLE</b>
	\$\$\$	Pilocarpine	SALAGEN
	\$\$\$	Ursodiol	ACTIGALL (URSO FORTE NONFORMULARY)
PA	\$\$\$\$	Alosetron	LOTROXEX, <b>PA REQ</b>
PA	\$\$\$\$	Balsalazide	COLAZAL, <b>PA REQ</b>

## Laxative Agents

	\$	Bisacodyl	DUCOLAX
	\$	Docosate Sodium	COLACE
	\$	Magnesium Hydroxide	MILK OF MAGNESIA
	\$	Docosate Calcium	SURFAK
	\$	Psyllium	METAMUCIL
	\$	Sennosides	SENNA, <b>(EFFECTIVE 10/1/09)</b>
	\$\$	Lactulose	CEPHULAC CHRONULAC

\$\$ Polyethylene Glycol 3350

MIRALAX

## GENITOURINARY AGENTS

### Analgesics, Urinary Tract

\$ Phenazopyridine  
\$\$\$\$ Pentosan Polysulfate

PYRIDIUM  
ELMIRON

### Anti-Infective Agents, Urinary

\$ Trimethoprim  
\$\$ Methenamine  
\$\$ Nitrofurantoin Macrocrystals  
  
\$\$\$ Nitrofurantoin

TRIMPEX  
UREX  
MACRODANTIN  
MACROBID  
FURADANTIN

### Genitourinary Smooth Muscle Relaxant Agents

STEP \$ Oxybutynin  
STEP \$\$ Oxybutynin Patch

DITROPAN  
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  
\$\$ Neostigmine  
\$\$ Pyridostigmine

URECHOLINE  
PROSTIGMIN  
MESTINON

### Miscellaneous Genitourinary Agents

MD \$\$ Finasteride  
STEP \$\$ Tamsulosin

PROSCAR, **SPECIALTY RESTRICTION**  
FLOMAX, **STEP THERAPY (TRIAL OF TERAZOSIN OR DOXAZOSIN)**

## HORMONE AND CONTRACEPTIVE AGENTS

### Adrenal Cortical Steroid Agents, Oral

\$ Dexamethasone  
  
\$ Fludrocortisone Acetate  
\$ Hydrocortisone Oral  
\$ Methylprednisolone  
\$ Prednisone  
  
\$ Prednisolone

DECADRON  
(DEXPAK IS NONFORMULARY )  
FLORINEF  
CORTEF  
MEDROL  
DELTASONE  
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, <b>PA REQ</b>
PA	\$\$\$	Testosterone Gel	TESTOSTERONE, <b>INJECTABLE, PA REQ</b>
PA	\$\$\$	Testosterone	OXANDRIN 2.5MG, <b>PA REQ</b>
PA	\$\$\$\$	Oxandrolone	

## Bisphosphonate Agents

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

## Estrogen Agents

	\$	Estradiol (Oral)	ESTRACE
PA	\$	Estradiol (Vaginal)	VAGIFEM, <b>PA REQ</b>
	\$\$	Conjugated Estrogens (Oral)	PREMARIN
	\$\$	Conjugated Estrogens (Vaginal)	PREMARIN VAGINAL CREAM
PA	\$\$		MENEST, <b>PA REQ</b>
	\$\$	Estradiol/Norethindrone	ACTIVELLA
PA	\$\$	Estradiol/Norgestimate	ORTHO-PREFEST, <b>PA REQ</b>
	\$\$	Estrogen/Medroxyprogesterone	PREMPRO PREMPHASE
PA	\$\$	Estradiol Vaginal Ring	ESTRING, <b>PA REQ</b>
	\$\$	Esterified Estrogens/ Methyltestosterone	MENOGEN ESTRATEST ESTRATEST H.S. CLIMARA ( <b>EFFECTIVE 2/1/10</b> ) ESTRADERM, <b>STEP THERAPY (PREMARIN PREFERRED)</b> CENESTIN, <b>PA REQ</b>
	\$\$	Estradiol Patches	
STEP			
PA	\$\$	Synthetic Conjugated Estrogen	

## 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 NORDETTE
\$	Norethindrone	NOR QD
\$	Norethindrone Acetate/Ethinyl Estradiol	LOESTRIN LOESTRIN FE (LOESTRIN 24 FE NONFORMULARY)
\$	Norethindrone/Ethinyl Estradiol	JENEST-28 MODICON NELOVA NORINYL NORINYL 1/50
\$	Norethindrone/Mestranol	
\$	Norgestimate/Ethinyl Estradiol	ORTHO CYCLEN

\$	Norgestrel/Ethinyl Estradiol	LO/OVRAL OVRAL
<b>Triphasic Oral Contraceptives</b>		
\$	Desogestrel/Ethinyl Estradiol	CYCLESSA
\$	Levonorgestrel/Ethinyl Estradiol	TRIPHASIL
\$	Norethindrone/Ethinyl Estradiol	TRI-NORINYL ORTHO-NOVUM ORTHO TRI-CYCLEN
\$	Norgestimate/Ethinyl Estradiol	
<b>Miscellaneous Contraceptives</b>		
\$	Latex Condoms	VARIOUS
\$	Nonoxynol 9	CONCEPTROL ENCARE KOROMEX
\$	Levonorgestrel	PLAN B PLAN B ONE-STEP (EFFECTIVE 11/1/09)
\$	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
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# RESPIRATORY/EENT AGENTS

## Adrenal Cortical Steroid Agents, Inhaled

\$\$	Beclomethasone	QVAR
\$\$	Triamcinolone	AZMACORT
\$\$\$	Budesonide	PULMICORT PULMICORT RESPULES
\$\$\$	Fluticasone	FLOVENT HFA
\$\$\$	Mometasone	ASMANEX

## Antihistamine/Decongestant Agents

### **Antihistamine/Decongestant Combinations**

	\$	Brompheniramine/Pseudoephedrine	DRIXORAL
AGE	\$	Phenylephrine/Promethazine	PHENERGAN VC, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>
	\$	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); <b>(EFFECTIVE 3/1/09)</b> ZYRTEC SYRUP (OTC ONLY) <b>(EFFECTIVE 3/1/09)</b> (ZYRTEC CHEWABLE TABLETS NONFORMULARY) <b>(EFFECTIVE 3/1/09)</b>
	\$	Loratadine (OTC only)	CLARITIN (OTC ONLY) CLARITIN REDI-TABS (OTC ONLY)
PA	\$\$\$	Fexofenadine	ALLEGRA TABLETS, <b>PA REQ</b> (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, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>

### **Decongestants**

	\$	Pseudoephedrine	SUDAFED KIDCARE DROPS
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### **Expectorants**

	\$	Guaifenesin	ROBITUSSIN
	\$	Guaifenesin, Sustained Release	HUMIBID LA
AGE	\$	Guaifenesin/Dextromethorphan	ANTITUSSIVE DM, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
AGE			CHERACOL-D ROBITUSSIN DM. <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
	\$	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, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>
AGE	\$	Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE, <b>USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>
	\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
	\$	Triprolidine/Pseudoephedrine/ Codeine	TRIACIN-C
<b>Non-Narcotic Antitussives</b>			
AGE	\$	Dextromethorphan HBr	TUSSIN PEDIATRIC, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
AGE	\$	Dextromethorphan/Pseudoephedrine/ Chlorpheniramine	KIDCARE COUGH AND COLD LIQUID, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
AGE	\$	Phenylephrine/Chlorpheniramine/ Dextromethorphan	CEROSE DM, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
AGE	\$	Promethazine/Dextromethorphan	PHENERGAN WITH DEXTROMETHORPHAN, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE, PROMETHAZINE USE CONTRAINDICATED IN MEMBERS &lt;2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION</b>
AGE	\$	Pseudoephedrine/Guaifenesin/ Dextromethorphan	BRONCOT, <b>PA REQUIRED FOR ALL COUGH &amp; COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE</b>
	\$\$	Benzonatate	TESSALON

## Bronchodilator Agents

### *Inhaled Bronchodilator Agents*

	\$	Metaproterenol	ALUPENT
	\$	Terbutaline	BRETHINE
	\$\$	Albuterol	PROAIR HFA
	\$\$	Ipratropium	ATROVENT HFA
	\$\$	Pirbuterol Acetate	MAXAIR AUTOHALER
	\$\$\$	Albuterol/Ipratropium	COMBIVENT
STEP	\$\$\$	Levalbuterol for Nebulization	XOPENEX FOR NEBULIZATION, <b>STEP THERAPY (ALBUTEROL PREFERRED)</b> (XOPENEX HFA NONFORMULARY)
AGE, STEP	\$\$\$	Salmeterol	SEREVENT DISKUS, <b>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)</b>
STEP	\$\$\$	Tiotropium	SPIRIVA, <b>STEP THERAPY (TRIAL OF IPRATROPIUM)</b>
PA	\$\$\$\$	Formoterol/Budesonide	SYMBICORT, <b>PA REQ</b>
STEP	\$\$\$\$	Salmeterol/Fluticasone	ADVAIR DISKUS, <b>STEP THERAPY (TRIAL OF ORAL INHALED STEROID)</b> ADVAIR HFA, <b>STEP THERAPY (TRIAL OF ORAL INHALED STEROID)</b>

### *Oral Sympathomimetics (Adrenergics)*

\$	Albuterol Tablets	PROVENTIL
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AGE	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

## Inhaled/Oral EENT Agents

### **Carbonic Anhydrase Inhibitors**

\$	Acetazolamide
\$	Methazolamide
\$\$\$	Acetazolamide SA

DIAMOX  
NEPTAZANE  
DIAMOX SEQUELS

### **Inhaled Agents**

	\$ Sodium Chloride
	\$\$ Flunisolide
	\$\$ Fluticasone
AGE	\$\$\$ Mometasone

SALINE NOSE SPRAY  
FLUNISOLIDE  
FLONASE  
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)
	\$\$\$ Cromolyn Sodium Inhaler	INTAL INHALER
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 OPHTHALMIC)
MD	\$\$ Pemirolast Ophthalmic	ALAMAST, RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY

### **Ophthalmic Antibiotics**

\$	Bacitracin Ophthalmic	BACITRACIN
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	\$	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, <b>SPECIALTY RESTRICTION (RESTRICTED TO OPTHALMOLOGY)</b>
ST	\$\$	Moxifloxacin	VIGAMOX, <b>STEP THERAPY (OPHTHALMIC CIPROFLOXACIN, OFLOXACIN, OR GENERIC POLYTRIM PREFERRED, OPTHALMOLOGISTS EXEMPT FROM STEP THERAPY RESTRICTION) (EFFECTIVE 11/1/09)</b>
	\$\$	Tobramycin/Dexamethasone Ophthalmic	TOBRADEX
		<b>Ophthalmic Anti-Inflammatories</b>	
	\$	Dexamethasone Ophthalmic	DEXASOL
	\$	Diclofenac Sodium Ophthalmic	VOLTAREN ( <b>EFFECTIVE 3/1/09</b> )
	\$	Fluorometholone Ophthalmic	FML FORTE (FML S.O.P. NONFORMULARY)
	\$	Flurbiprofen Ophthalmic	OCUFEN
	\$	Prednisolone Acetate Ophthalmic	PRED MILD OMNIPRED PRED FORTE
STEP	\$\$	Loteprednol Ophthalmic	LOTEMAX, <b>STEP THERAPY (PREDNISOLONE OR DEXAMETHASONE PREFERRED)</b>
PA	\$\$	Rimexolone Ophthalmic	VEXOL, <b>PA REQ</b>
		<b>Ophthalmic Antiviral Agents</b>	
	\$\$\$	Trifluridine Ophthalmic	VIROPTIC
		<b>Ophthalmic Beta Blockers</b>	
	\$	Carteolol Ophthalmic	OCUPRESS
	\$	Levobunolol Ophthalmic	BETAGAN
	\$	Metipranolol Ophthalmic	OPTIPRANOLOL
	\$	Timolol Ophthalmic	BETIMOL TIMOPTIC
	\$\$\$	Betaxolol Ophthalmic	BETOPTIC S
		<b>Ophthalmic Miotics</b>	
	\$	Carbachol Ophthalmic	ISOPTO CARBACHOL
	\$	Pilocarpine Ophthalmic	PILOCAR
	\$\$	Brimonidine Ophthalmic	ALPHAGAN P
	\$\$	Demecarium Ophthalmic	HUMORSOL
	\$\$	Echothiophate Iodide Ophthalmic	PHOSPHOLINE IODIDE
		<b>Ophthalmic Mydriatics</b>	
	\$	Atropine Sulfate Ophthalmic	ISOPTO ATROPINE
	\$	Cyclopentolate Ophthalmic	CYCLOGYL
	\$	Dipivefrin Ophthalmic	PROPINE
	\$	Phenylephrine Ophthalmic	MYDFRIN
	\$	Tropicamide Ophthalmic	MYDRIACYL
		<b>Ophthalmic Sulfonamides</b>	
	\$	Sulfacetamide Ophthalmic	BLEPH-10 SODIUM SULAMYD

	\$	Sulfacetamide 10%/Prednisolone 0.25% Ophthalmic	VASOCIDIN
		<b>Miscellaneous Ophthalmics</b>	
	\$	Polyvinyl Alcohol Ophthalmic	ARTIFICIAL TEARS
	\$	Sodium Chloride Ophthalmic	MURO-128
	\$\$	Bimatoprost	LUMIGAN
	\$\$	Brinzolamide	AZOPT
	\$\$	Latanoprost	XALATAN
	\$\$	Travoprost	TRAVATAN TRAVATAN Z
PA	\$\$\$	Cyclosporine Ophthalmic	RESTASIS, <b>PA REQ</b>
	\$\$\$	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
	\$	Clindamycin Topical Solution	CLEOCIN (CLINDAMYCIN PLEDGETS NONFORMULARY)
	\$	Erythromycin 2% Solution	T-STAT
AGE	\$\$	Tretinoin Cream and Tretinoin Gel	RETIN-A, <b>AGE RESTRICTION &lt; 25 YEARS OF AGE</b>
STEP	\$\$\$	Benzoyl Peroxide/Clindamycin Gel	BENZACLIN, <b>STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED)</b>
STEP			DUAC, <b>STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED)</b>
MD	\$\$\$\$	Isotretinoin	ACCUTANE, <b>SPECIALTY RESTRICTION</b>

## Keratolytic Agents

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

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

## 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, <b>(EFFECTIVE 11/1/09)</b> (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, <b>PA REQ</b>
PA	\$\$\$	Papain/Urea/Chlorophyllin	PANAFIL, <b>PA REQ</b>
	\$\$\$	Imiquimod	ALDARA, <b>QUANTITY LIMIT OF 12 PER MONTH (EFFECTIVE 5/1/09)</b>
PA	\$\$\$	Papain/Urea	PANAFIL WHITE, <b>PA REQ</b>
STEP	\$\$\$	Pimecrolimus	ELIDEL, <b>STEP THERAPY (TOPICAL STEROID PREFERRED)</b>
STEP	\$\$\$	Tacrolimus	PROTOPIC, <b>STEP THERAPY (TOPICAL STEROID PREFERRED)</b>
MD	\$\$\$	Tazarotene	TAZORAC, <b>SPECIALTY RESTRICTION</b>
MD	\$\$\$\$	Calcipotriene	DOVONEX, <b>SPECIALTY RESTRICTION</b>
PA	\$\$\$\$\$	Alitretinoin	PANRETIN, <b>PA REQ</b>

## 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
\$\$	Mupirocin Ointment	BACTROBAN OINTMENT (BACTROBAN CREAM AND BACTROBAN NASAL NONFORMULARY)

## Topical Antifungal Agents

\$	Clotrimazole	LOTRIMIN	
\$	Miconazole Nitrate	MONISTAT-DERM	
\$	Nystatin	MYCOSTATIN	
\$	Tolnaftate	TINACTIN	
\$	Triamcinolone/Nystatin	MYCOLOG II	
STEP	\$\$\$	Econazole	SPECTAZOLE
STEP	\$\$\$	Ketoconazole Cream	NIZORAL CREAM, <b>STEP THERAPY (CLOTRIMAZOLE, MICONAZOLE, NYSTATIN PREFERRED)</b>
PA	\$\$\$	Ciclopirox	LOPROX, <b>PA REQ</b> (LOPROX SHAMPOO NONFORMULARY)





\$	Magnesium Lactate	MAGTAB-SR
\$	Magnesium Oxide	MAGOX, (EFFECTIVE 10/1/09)
<b>Multivitamin Agents</b>		
\$	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
<b>Prenatal Vitamin Agents</b>		
\$	Prenatal Multivitamins	CARENATE MATERNITY-90
<b>Vitamin A</b>		
\$	Beta-Carotene	SOLATENE
\$	Vitamin A	AQUASOL-A
<b>Vitamin B-Complex Agents</b>		
\$	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
<b>Vitamin C</b>		
\$	Ascorbic Acid	VITAMIN C
<b>Vitamin D</b>		
\$	Ergocalciferol	DRISDOL
\$\$	Calcitriol	ROCALTROL
\$\$	Dihydrotachysterol	HYTAKEROL
\$\$\$	Doxercalciferol	HECTOROL
<b>Vitamin E</b>		
\$	Vitamin E	VITAMIN E
<b>Vitamin K Activity Agents</b>		
\$\$	Phytonadione	MEPHYTON

## 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 <b>AEROCHAMBER (WITHOUT MASK) NONFORMULARY, ALL OTHER SPACER BRANDS PREFERRED OVER AEROCHAMBER (EFFECTIVE 8/1/09)</b>	
AGE	\$\$	Inhaler Assistant Device <u>With</u> Mask (Spacer With Mask)	VARIOUS, LIMIT OF 1 DEVICE PER YEAR <b>AEROCHAMBER WITH MASK RESTRICTED TO PATIENTS &lt;6 YEARS OF AGE, OTHER BRANDS OF SPACERS WITH MASKS HAVE NO AGE RESTRICTIONS (EFFECTIVE 8/1/09)</b>

## 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
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
Sumatriptan Tablets	Step therapy restrictions removed. Preferred triptan.	12/17/09
Sumatriptan Nasal and Injection	Step therapy criteria changed to trial of sumatriptan tablets.	12/17/09
Zomig, Zomig ZMT	Removed from formulary. Sumatriptan tablets preferred.	12/17/09
Minocycline Capsules	Added to formulary. Other dosage forms remain non-formulary.	12/17/09
Omeprazole 10mg	Added to formulary with a quantity limit of 1 unit/day.	11/1/09
Mycophenolate	PA restriction removed. Patients less than 21 years of age may be eligible for CCS. Myfortic remains non-formulary.	11/1/09
Clobetasol 0.05% Cream, Solution, Gel, and Ointment	Added to formulary. Other dosage forms non-formulary.	11/1/09
Levetiracetam Tablets	PA restriction removed. Patients less than 21 years of age who are on 2 or more anticonvulsants may be eligible for CCS. Solution and XR tablets non-formulary.	11/1/09
Plan B One-Step	Added to formulary.	11/1/09
Metronidazole 0.75% Cream	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

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