



Aetna Medicare
2012 Formulary
(List of Covered Drugs)

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

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Partial
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WE COVER IN THIS PLAN**

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

This document includes The Aetna Medicare Plan's partial formulary as of December 6, 2011. For a complete, updated formulary, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711.

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

A Medicare Advantage organization with a Medicare contract
A Medicare-approved Part D sponsor

This information is available for free in other languages. Please contact our customer service number at **1-877-238-6211** (TTY/TDD: 1-888-760-4748 or 711) for additional information. Hours of operation: 7 days per week, 8 a.m. till 8 p.m. Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-877-238-6211** (TTY/TDD: 1-888-760-4748 or 711). Horario de atención: los 7 días de la semana, de 8 a.m. a 8 p.m. This document may be available in an alternate format such as Braille, larger print or audio. Please contact our Customer Service number listed above for more information.

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What is the Aetna Medicare formulary?

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

This document is a partial formulary and includes only some of the drugs covered by Aetna Medicare. For a complete listing of all prescription drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711.

Can the formulary change?

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

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of December 6, 2011. To get updated information about the drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com/formulary or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711.

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

How do I use the formulary?

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

Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents -- Heart, Blood Pressure and Cholesterol Drugs.” If you know what your drug is used for, look for the category name in the list that begins on page 9. Then look under the category name for your drug.

Alphabetical Listing

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

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.aetnamedicare.com/formulary.

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

What if my drug is not on the formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Aetna Medicare may cover your drug. You can contact Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711.

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

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

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

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

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

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

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

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

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

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

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

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

For more information

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

If you have questions about Aetna Medicare, please call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711. Or, visit www.aetnamedicare.com.

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

Aetna Medicare's formulary

The abridged formulary that begins on page 9 provides coverage information about some of the drugs covered by Aetna Medicare. If you have trouble finding your drug in the list, turn to the index that begins on page 31. Remember: This is only a partial list of drugs covered by Aetna Medicare. If your prescription is not in this partial formulary, please visit our website at www.aetnamedicare.com or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711 for additional help.

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

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

QL	Quantity Limits
PA	Prior Authorization
ST	Step Therapy
LA	Limited Availability
MO	Mail Order Delivery
B/D	Part B vs. D Prior Authorization
ED	Excluded Drug

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

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

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

LA: Limited Availability. These prescriptions may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711 for additional help.

MO: Mail Order. For certain kinds of drugs, you can use Aetna Medicare network mail order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail order service are marked as "**mail order**" drugs in our Drug List or MO. For more information consult your Pharmacy Directory or call Member Services at the toll-free number on the back of your Aetna Medicare member ID card, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-888-760-4748 or 711 for additional help.

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

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

Note: The Aetna Medicare Premier Rx plan includes coverage for generic benzodiazepines and barbiturates as an enhanced benefit. These drugs are listed separately in the chart beginning on page 38.

Drug tier copay levels

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

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

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

Tier 4

Non-preferred brand name prescription drugs

Tier 5

Specialty tier prescription drugs

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

KEY**Drug Name**

UPPERCASE =

Brand name prescription drugs

Lower case italics =

Generic medications

Drug Tier**1,2,3,4,5 =****Copay tier level****Requirements/Limits**

QL= Quantity Limit

ST = Step Therapy

PA = Prior Authorization

LA = Limited Availability

MO = Mail Order Delivery

B/D = Part B vs. Part D

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS/ANESTHETICS/ NONSTEROIDAL ANTI-INFLAMMATORY AGENTS		
<i>acetaminophen/codeine #3</i>	1	QL (13 per 1 day) MO
<i>acetaminophen/codeine #4</i>	1	QL (13 per 1 day) MO
<i>acetaminophen/codeine tablet 300mg; 15mg</i>	1	QL (13 per 1 day) MO
<i>fentanyl</i>	2	QL (15 per 30 days) MO
<i>flurbiprofen sodium</i>	1	MO
<i>hydrocodone bitartrate/acetaminophen tablet 750mg; 10mg</i>	1	QL (5 per 1 day) MO
<i>hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg</i>	1	QL (13 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 750mg; 7.5mg</i>	1	QL (5 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 650mg; 10mg, 650mg; 7.5mg, 660mg; 10mg</i>	1	QL (6 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 500mg; 10mg, 500mg; 2.5mg, 500mg; 5mg, 500mg; 7.5mg</i>	1	QL (8 per 1 day) MO
<i>hydrocodone/acetaminophen tablet 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (12 per 1 day) MO
<i>hydrocodone/ibuprofen</i>	1	QL (5 per 1 day) MO
<i>ibuprofen tablet 400mg, 600mg, 800mg</i>	1	MO
<i>lidocaine viscous</i>	1	MO
LIDODERM	4	QL (3 per 1 day) ST PA MO
<i>meloxicam tablet</i>	1	MO
<i>morphine sulfate er tablet extended release 12 hour</i>	1	QL (3 per 1 day) MO
<i>morphine sulfate oral solution 10mg/5ml</i>	2	QL (60 per 1 day) MO
<i>morphine sulfate tablet</i>	1	QL (6 per 1 day) MO
NEVANAC	4	MO
NUCYNTA	3	QL (6 per 1 day) ST MO
OPANA ER TABLET EXTENDED RELEASE 12 HOUR 10MG, 20MG, 30MG, 5MG	4	QL (2 per 1 day) ST MO

Drug Name	Drug Tier	Requirements/Limits
OPANA ER TABLET EXTENDED RELEASE 12 HOUR 40MG	4	QL (4 per 1 day) ST MO
<i>oxycodone hcl tablet 30mg</i>	2	QL (6 per 1 day) MO
<i>oxycodone hcl tablet 5mg</i>	2	QL (12 per 1 day) MO
<i>oxycodone/acetaminophen capsule</i>	1	QL (8 per 1 day) MO
<i>oxycodone/acetaminophen tablet 650mg; 10mg</i>	1	QL (6 per 1 day) MO
<i>oxycodone/acetaminophen tablet 500mg; 7.5mg</i>	1	QL (8 per 1 day) MO
<i>oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	QL (12 per 1 day) MO
VIMOVO	3	QL (2 per 1 day) MO
VOLTAREN GEL	3	QL (34 per 1 day) MO
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ANTABUSE	4	MO
<i>buprenorphine hcl tablet sublingual</i>	2	PA MO
<i>buproban</i>	1	QL (2 per 1 day) MO
CHANTIX PAK	4	QL (1.76 per 1 day) ST MO
CHANTIX TABLET 0.5MG, 1MG	4	QL (2 per 1 day) ST MO
<i>naloxone hcl injection 1mg/ml</i>	1	
<i>naloxone hcl injection 0.4mg/ml</i>	1	MO
<i>naltrexone hcl</i>	1	MO
ANTIBACTERIALS		
<i>amoxicillin capsule</i>	1	MO
<i>amoxicillin suspension reconstituted</i>	1	MO
<i>amoxicillin tablet</i>	1	MO
<i>amoxicillin tablet chewable 200mg</i>	1	
<i>amoxicillin tablet chewable 125mg, 250mg</i>	1	MO
<i>amoxicillin/clavulanate potassium suspension reconstituted</i>	1	MO
<i>amoxicillin/clavulanate potassium tablet 250mg; 125mg</i>	1	MO
<i>amoxicillin/clavulanate potassium tablet chewable</i>	1	MO
<i>amoxicillin/potassium clavulanate tablet</i>	1	MO
AZASITE	3	MO
<i>azithromycin injection 500mg</i>	2	MO
<i>azithromycin suspension reconstituted</i>	1	MO
<i>azithromycin tablet</i>	1	MO
<i>aztreonam injection 1gm</i>	2	
<i>bacitracin/polymyxin b</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>cefaclor capsule</i>	1	MO
<i>cefotetan</i>	2	
<i>cephalexin</i>	1	MO
<i>ciprofloxacin er tablet extended release 24 hour 1000mg</i>	1	MO
<i>ciprofloxacin hcl tablet</i>	1	MO
<i>clarithromycin er</i>	2	MO
<i>clarithromycin suspension reconstituted</i>	2	MO
<i>clarithromycin tablet 250mg</i>	2	MO
<i>clindamycin hcl capsule 150mg</i>	1	MO
<i>doxycycline monohydrate tablet 150mg, 50mg, 75mg</i>	2	PA MO
<i>gentamicin sulfate injection 10mg/ml</i>	1	
<i>gentamicin sulfate injection 40mg/ml</i>	1	MO
<i>gentamicin sulfate/0.9% sodium chloride injection 0.9mg/ml; 0.9%, 1.4mg/ml; 0.9%, 1.6mg/ml; 0.9%, 1mg/ml; 0.9%</i>	1	
<i>gentamicin sulfate/sodium chloride injection 1.2mg/ml; 0.9%</i>	1	
<i>isotonic gentamicin injection 0.6mg/ml; 0.9%</i>	1	
<i>isotonic gentamicin injection 0.8mg/ml; 0.9%</i>	1	MO
LEVAQUIN TABLET	4	MO
<i>metronidazole tablet</i>	1	MO
<i>metronidazole vaginal</i>	1	MO
MOXEZA	4	MO
<i>mupirocin</i>	1	MO
<i>neomycin/polymyxin/bacitracin/hydrocortisone</i>	1	MO
<i>neomycin/polymyxin/dexamethasone suspension</i>	1	MO
<i>neomycin/polymyxin/hydrocortisone ophthalmic suspension</i>	1	MO
PRIMAXIN I.M.	4	MO
PRIMAXIN IV	4	MO
<i>silver sulfadiazine</i>	1	MO
<i>sodium sulfacetamide ophthalmic solution</i>	1	MO
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	MO
<i>sulfadiazine</i>	2	MO
<i>sulfamethoxazole/trimethoprim ds</i>	1	MO
<i>sulfamethoxazole/trimethoprim suspension</i>	1	MO
<i>sulfamethoxazole/trimethoprim tablet</i>	1	MO
TEFLARO	4	

Drug Name	Drug Tier	Requirements/Limits
<i>tetracycline hcl</i>	1	PA MO
<i>tobramycin sulfate injection 10mg/ml</i>	2	
<i>tobramycin sulfate injection 80mg/2ml</i>	2	MO
<i>tobramycin sulfate ophthalmic solution</i>	1	MO
<i>tobramycin sulfate/sodium chloride</i>	2	
<i>vancomycin hcl injection 10gm</i>	2	B/D
<i>vancomycin hcl injection 1000mg, 500mg</i>	2	B/D MO
VIGAMOX	4	MO
ANTICONVULSANTS		
<i>carbamazepine tablet</i>	1	MO
<i>divalproex sodium capsule sprinkle</i>	1	MO
<i>divalproex sodium er</i>	1	MO
<i>divalproex sodium tablet delayed release</i>	1	MO
<i>gabapentin capsule 100mg, 300mg</i>	1	QL (6 per 1 day) MO
<i>gabapentin capsule 400mg</i>	1	QL (9 per 1 day) MO
<i>gabapentin tablet 800mg</i>	1	QL (4.5 per 1 day) MO
<i>gabapentin tablet 600mg</i>	1	QL (6 per 1 day) MO
LAMICTAL ODT TABLET DISPERSIBLE	4	ST MO
<i>lamotrigine</i>	2	MO
<i>levetiracetam tablet</i>	1	MO
LYRICA CAPSULE 225MG, 300MG	4	QL (2 per 1 day) MO
LYRICA CAPSULE 100MG, 150MG, 200MG, 25MG, 50MG, 75MG	4	QL (3 per 1 day) MO
<i>phenytoin sodium extended capsule 100mg</i>	1	MO
<i>topiramate tablet</i>	2	MO
<i>zonisamide</i>	1	MO
ANTIDEMENTIA AGENTS		
ARICEPT TABLET 23MG	3	QL (1 per 1 day) ST MO
<i>donepezil hcl</i>	2	QL (1 per 1 day) MO
<i>ergoloid mesylates</i>	2	MO
EXELON PATCH 24 HOUR	3	MO
NAMENDA	3	MO
NAMENDA TITRATION PAK	3	MO
<i>rivastigmine tartrate</i>	2	MO
ANTIDEPRESSANTS		
<i>bupropion hcl</i>	1	QL (6 per 1 day) MO
<i>bupropion hcl sr tablet extended release 12 hour 100mg, 200mg</i>	1	QL (2 per 1 day) MO
<i>citalopram hydrobromide tablet</i>	1	QL (1 per 1 day) MO
<i>doxepin hcl</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
EMSAM	4	QL (1 per 1 day) ST PA MO
<i>nefazodone hcl tablet 250mg, 50mg</i>	1	QL (2 per 1 day) MO
<i>nefazodone hcl tablet 100mg, 150mg, 200mg</i>	1	QL (3 per 1 day) MO
<i>nortriptyline hcl</i>	1	MO
<i>paroxetine hcl tablet 10mg, 20mg</i>	1	QL (1 per 1 day) MO
<i>paroxetine hcl tablet 30mg, 40mg</i>	1	QL (2 per 1 day) MO
<i>phenelzine sulfate</i>	2	MO
VIIBRYD	4	QL (1 per 1 day) MO
ANTIDOTES, DETERRENTS, AND TOXICOLOGIC AGENTS		
CHEMET	4	MO
<i>fomepizole</i>	2	
ANTIEMETICS		
<i>granisetron hcl tablet</i>	2	QL (2 per 1 day) B/D MO
<i>meclizine hcl</i>	1	MO
<i>ondansetron hcl tablet 8mg</i>	1	QL (3 per 1 day) B/D MO
<i>ondansetron hcl tablet 24mg</i>	1	QL (5 per 30 days) B/D MO
<i>ondansetron hcl tablet 4mg</i>	1	QL (6 per 1 day) B/D MO
<i>ondansetron odt tablet dispersible 8mg</i>	2	QL (3 per 1 day) B/D MO
<i>ondansetron odt tablet dispersible 4mg</i>	2	QL (6 per 1 day) B/D MO
<i>trimethobenzamide hcl capsule 300mg</i>	1	PA MO
ANTIFUNGALS		
<i>clotrimazole external cream</i>	1	MO
<i>clotrimazole external solution</i>	1	MO
<i>fluconazole tablet 100mg, 200mg, 50mg</i>	1	MO
<i>fluconazole tablet 150mg</i>	1	QL (0.14 per 1 day) MO
<i>ketoconazole cream</i>	1	MO
<i>ketoconazole tablet</i>	1	MO
<i>nystatin cream</i>	1	MO
<i>nystatin ointment</i>	1	MO
<i>terbinafine hcl tablet</i>	1	QL (1 per 1 day) PA MO
ANTIGOUT AGENTS		
<i>allopurinol</i>	1	MO
COLCRYS	3	QL (4 per 1 day) MO
ULORIC	3	MO
ANTIMIGRAINE AGENTS		
<i>dihydroergotamine mesylate</i>	2	MO
<i>ergotamine tartrate/caffeine</i>	1	MO
MAXALT	4	QL (12 per 30 days) MO
MAXALT-MLT	4	QL (12 per 30 days) MO

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate injection 4mg/0.5ml</i>	2	QL (4 per 30 days)
<i>sumatriptan succinate injection 6mg/0.5ml</i>	2	QL (4 per 30 days) MO
<i>sumatriptan succinate tablet</i>	2	QL (9 per 30 days) MO
ANTIMYASTHENIC AGENTS		
<i>guanidine hcl</i>	1	
<i>pyridostigmine bromide</i>	1	MO
ANTIMYCOBACTERIALS		
<i>dapsone</i>	1	MO
<i>isoniazid tablet</i>	1	MO
MYCOBUTIN	4	MO
<i>rifampin capsule</i>	1	MO
ANTINEOPLASTICS		
<i>anastrozole</i>	2	QL (1 per 1 day) MO
<i>bleomycin sulfate injection 30unit</i>	2	B/D
CEENU CAPSULE 100MG, 10MG, 40MG	4	MO
<i>cyclophosphamide tablet</i>	2	B/D MO
EMCYT	4	MO
<i>exemestane</i>	2	MO
GLEEVEC TABLET 400MG	5	QL (2 per 1 day) PA
GLEEVEC TABLET 100MG	5	QL (3 per 1 day) PA
<i>hydroxyurea</i>	1	MO
<i>leucovorin calcium injection 350mg</i>	1	B/D
<i>leucovorin calcium tablet</i>	1	MO
MOZOBIL	5	PA
PANRETIN	5	MO
REVLIMID	5	QL (1 per 1 day) PA LA
RITUXAN	5	PA
SUTENT CAPSULE 50MG	5	QL (1 per 1 day) PA
SUTENT CAPSULE 25MG	5	QL (2 per 1 day) PA
SUTENT CAPSULE 12.5MG	5	QL (3 per 1 day) PA
<i>tamoxifen citrate</i>	1	MO
TARCEVA TABLET 25MG	5	QL (2 per 1 day) PA
TARCEVA TABLET 100MG, 150MG	5	QL (3 per 1 day) PA
TARGRETIN	5	PA
THALOMID	5	QL (28 per 28 days) PA
ZOLINZA	5	QL (4 per 1 day) PA
ANTIPARASITICS		
ALBENZA	4	MO
<i>chloroquine phosphate</i>	2	MO
<i>lindane</i>	2	QL (2 per 1 day) MO

Drug Name	Drug Tier	Requirements/Limits
<i>mebendazole</i>	1	MO
<i>permethrin cream</i>	1	MO
<i>primaquine phosphate</i>	1	MO
ANTIPARKINSON AGENTS		
<i>amantadine hcl capsule</i>	1	MO
<i>amantadine hcl syrup</i>	2	MO
<i>amantadine hcl tablet</i>	1	MO
AZILECT	3	MO
<i>benztropine mesylate tablet</i>	1	MO
<i>carbidopa/levodopa</i>	1	MO
<i>carbidopa/levodopa cr</i>	2	MO
<i>carbidopa/levodopa odt</i>	1	MO
<i>carbidopa/levodopa sr tablet extended release 50mg; 200mg</i>	2	MO
COMTAN	3	MO
<i>pramipexole dihydrochloride</i>	2	MO
<i>ropinirole hcl</i>	1	MO
<i>selegiline hcl</i>	1	MO
STALEVO 100	3	MO
STALEVO 125	3	MO
STALEVO 150	3	MO
STALEVO 200	3	MO
STALEVO 50	3	MO
STALEVO 75	3	MO
<i>trihexyphenidyl hcl</i>	1	MO
ANTIPSYCHOTICS		
ABILIFY DISCMELT	4	QL (2 per 1 day) MO
ABILIFY INJECTION	4	MO
ABILIFY ORAL SOLUTION	4	QL (30 per 1 day) MO
ABILIFY TABLET	4	QL (1 per 1 day) MO
<i>clozapine tablet 25mg, 50mg</i>	2	QL (3 per 1 day)
<i>clozapine tablet 200mg</i>	2	QL (4 per 1 day)
<i>clozapine tablet 100mg</i>	2	QL (9 per 1 day)
FAZACLO TABLET DISPERSIBLE 12.5MG	4	QL (2 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 25MG	4	QL (3 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 200MG	4	QL (4 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 150MG	4	QL (6 per 1 day) ST
FAZACLO TABLET DISPERSIBLE 100MG	4	QL (9 per 1 day) ST
<i>fluphenazine hcl tablet</i>	1	MO
<i>haloperidol tablet</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
SAPHRIS	4	QL (2 per 1 day) MO
SEROQUEL TABLET 300MG, 400MG	4	QL (2 per 1 day) MO
SEROQUEL TABLET 100MG, 50MG	4	QL (3 per 1 day) MO
SEROQUEL TABLET 200MG	4	QL (4 per 1 day) MO
SEROQUEL TABLET 25MG	4	QL (6 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150MG, 200MG	3	QL (1 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300MG, 400MG	3	QL (2 per 1 day) MO
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50MG	3	QL (6 per 1 day) MO
ANTIVIRALS		
ATRIPLA	5	MO
BARACLUDE ORAL SOLUTION	3	QL (21 per 1 day) PA MO
BARACLUDE TABLET	5	QL (1 per 1 day) PA MO
CRIXIVAN CAPSULE 100MG	3	
CRIXIVAN CAPSULE 200MG, 400MG	3	MO
DENAVIR	4	MO
EPIVIR HBV	4	MO
<i>famciclovir tablet 125mg, 250mg</i>	2	QL (2 per 1 day) MO
<i>famciclovir tablet 500mg</i>	2	QL (30 per 10 days) MO
<i>foscarnet sodium</i>	2	B/D
FUZEON	5	
<i>ganciclovir capsule 250mg</i>	2	
<i>ganciclovir injection</i>	2	
PREZISTA TABLET 75MG	4	
PREZISTA TABLET 150MG	4	MO
PREZISTA TABLET 400MG, 600MG	5	MO
RELENZA DISKHALER	4	QL (120 per 365 days) MO
RESCRIPTOR	3	MO
SELZENTRY	5	MO
<i>stavudine</i>	2	MO
TAMIFLU CAPSULE 45MG, 75MG	4	QL (84 per 365 days) MO
TAMIFLU CAPSULE 30MG	4	QL (168 per 365 days) MO
TAMIFLU SUSPENSION RECONSTITUTED 12MG/ML	4	QL (525 per 365 days) MO
TRUVADA	5	MO
<i>valacyclovir hcl</i>	1	MO
ZIRGAN	4	MO
ZOVIRAX OINTMENT	4	MO

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

Drug Name	Drug Tier	Requirements/Limits
<i>glipizide er tablet extended release 24 hour 2.5mg, 5mg</i>	1	QL (1 per 1 day) MO
<i>glipizide er tablet extended release 24 hour 10mg</i>	1	QL (2 per 1 day) MO
<i>glipizide tablet 10mg</i>	1	QL (4 per 1 day) MO
<i>glipizide tablet 5mg</i>	1	QL (8 per 1 day) MO
<i>glipizide/metformin hcl tablet 2.5mg; 500mg, 5mg; 500mg</i>	1	QL (4 per 1 day) MO
<i>glipizide/metformin hcl tablet 2.5mg; 250mg</i>	1	QL (8 per 1 day) MO
GLUCAGON EMERGENCY KIT	3	QL (2 per 1 day) MO
<i>glyburide tablet 1.25mg, 2.5mg</i>	1	QL (3 per 1 day) MO
<i>glyburide tablet 5mg</i>	1	QL (4 per 1 day) MO
JANUMET	3	QL (2 per 1 day) MO
JANUVIA	3	QL (1 per 1 day) MO
LANTUS	4	MO
LANTUS SOLOSTAR	4	MO
LEVEMIR	3	MO
LEVEMIR FLEXPEN	3	MO
<i>metformin hcl er tablet extended release 24 hour 750mg</i>	1	QL (2 per 1 day) MO
<i>metformin hcl er tablet extended release 24 hour 500mg</i>	1	QL (4 per 1 day) MO
<i>metformin hcl tablet 1000mg, 850mg</i>	1	QL (3 per 1 day) MO
<i>metformin hcl tablet 500mg</i>	1	QL (5 per 1 day) MO
NOVOLIN 70/30	3	MO
NOVOLIN N	3	MO
NOVOLIN R	3	MO
NOVOLOG	3	MO
NOVOLOG FLEXPEN	3	MO
NOVOLOG MIX 70/30	3	MO
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	MO
PROGLYCEM	4	MO
VICTOZA	3	QL (1.8 per 1 day) MO
WELCHOL	4	MO
BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS		
AGGRENOX	3	QL (2 per 1 day) MO
ARANESP ALBUMIN FREE INJECTION 100MCG/ML, 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML, 60MCG/ML	3	PA

Drug Name	Drug Tier	Requirements/Limits
ARANESP ALBUMIN FREE INJECTION 100MCG/0.5ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML	5	PA
<i>cilostazol</i>	1	MO
CYKLOKAPRON	4	MO
<i>enoxaparin sodium injection 30mg/0.3ml, 40mg/0.4ml</i>	2	MO
LYSTEDA	3	QL (30 per 5 days) PA MO
NEUPOGEN INJECTION 300MCG/0.5ML, 480MCG/0.8ML, 480MCG/1.6ML	5	PA
PLAVIX TABLET 75MG	4	QL (1 per 1 day) MO
PLAVIX TABLET 300MG	4	QL (2 per 365 days)
PRADAXA	3	QL (2 per 1 day) PA MO
PROCRIT INJECTION 10000UNIT/ML	3	PA
PROCRIT INJECTION 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	QL (12 per 30 days) PA
PROCRIT INJECTION 20000UNIT/ML, 40000UNIT/ML	5	PA
<i>warfarin sodium</i>	1	MO
CARDIOVASCULAR AGENTS		
<i>acetazolamide</i>	1	MO
<i>acetazolamide er</i>	1	MO
<i>amiloride hcl</i>	1	MO
<i>amiloride/hydrochlorothiazide</i>	1	MO
<i>amlodipine besylate tablet 10mg</i>	1	MO
<i>amlodipine besylate tablet 2.5mg, 5mg</i>	1	QL (1 per 1 day) MO
AMTURNIDE	3	QL (1 per 1 day) MO
<i>atenolol</i>	1	MO
BENICAR HCT TABLET 12.5MG; 40MG, 25MG; 40MG	4	MO
BENICAR HCT TABLET 12.5MG; 20MG	4	QL (1 per 1 day) MO
BENICAR TABLET 40MG	4	MO
BENICAR TABLET 20MG, 5MG	4	QL (1 per 1 day) MO
<i>carvedilol</i>	1	MO
<i>chlorothiazide</i>	1	MO
<i>chlorthalidone tablet 25mg, 50mg</i>	1	MO
<i>clonidine hcl patch weekly</i>	2	QL (8 per 28 days) MO
<i>clonidine hcl tablet</i>	1	MO
<i>colestipol hcl granules</i>	2	MO
CRESTOR	3	QL (1 per 1 day) MO
DEMSER	5	MO

Drug Name	Drug Tier	Requirements/Limits
<i>digoxin</i>	1	MO
<i>diltiazem cd capsule extended release 24 hour 240mg, 300mg</i>	1	MO
<i>diltiazem cd capsule extended release 24 hour 120mg</i>	1	QL (1 per 1 day) MO
<i>diltiazem hcl er capsule extended release 12 hour</i>	1	MO
<i>diltiazem hcl er capsule extended release 24 hour 360mg, 420mg</i>	1	MO
<i>diltiazem hcl injection 100mg, 25mg/5ml</i>	1	
<i>diltiazem hcl tablet</i>	1	MO
DIOVAN HCT TABLET 12.5MG; 320MG, 25MG; 320MG	3	MO
DIOVAN HCT TABLET 12.5MG; 160MG, 12.5MG; 80MG, 25MG; 160MG	3	QL (1 per 1 day) MO
DIOVAN TABLET 320MG	3	MO
DIOVAN TABLET 160MG, 40MG, 80MG	3	QL (2 per 1 day) MO
<i>doxazosin mesylate</i>	1	MO
<i>enalapril maleate</i>	1	MO
<i>enalapril maleate/hydrochlorothiazide</i>	1	MO
EXFORGE	3	QL (1 per 1 day) MO
EXFORGE HCT TABLET 10MG; 25MG; 320MG	3	MO
EXFORGE HCT TABLET 10MG; 12.5MG; 160MG, 10MG; 25MG; 160MG, 5MG; 12.5MG; 160MG, 5MG; 25MG; 160MG	3	QL (1 per 1 day) MO
<i>fenofibrate</i>	1	MO
<i>fenofibrate micronized</i>	1	MO
<i>flecainide acetate</i>	1	MO
<i>fosinopril sodium</i>	1	MO
<i>furosemide</i>	1	MO
<i>gemfibrozil</i>	1	MO
<i>hydralazine hcl tablet</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO
<i>isosorbide dinitrate</i>	1	MO
<i>isosorbide dinitrate er</i>	1	MO
<i>isosorbide mononitrate</i>	1	MO
<i>isosorbide mononitrate er</i>	1	MO
LIPITOR	3	QL (1 per 1 day) MO
<i>lisinopril</i>	1	MO
<i>lovastatin</i>	1	QL (2 per 1 day) MO
LOVAZA	3	QL (4 per 1 day) MO

Drug Name	Drug Tier	Requirements/Limits
<i>methazolamide</i>	1	MO
<i>methyldopa</i>	1	MO
<i>methyldopa/hydrochlorothiazide</i>	1	MO
<i>metolazone</i>	1	MO
<i>metoprolol succinate er</i>	1	MO
<i>metoprolol tartrate</i>	1	MO
MICARDIS HCT TABLET 12.5MG; 80MG, 25MG; 80MG	3	MO
MICARDIS HCT TABLET 12.5MG; 40MG	3	QL (1 per 1 day) MO
MICARDIS TABLET 80MG	3	MO
MICARDIS TABLET 20MG, 40MG	3	QL (1 per 1 day) MO
<i>minoxidil tablet</i>	1	MO
MULTAQ	3	MO
NIASPAN TABLET EXTENDED RELEASE 1000MG, 750MG	3	QL (2 per 1 day) MO
NIASPAN TABLET EXTENDED RELEASE 500MG	3	QL (3 per 1 day) MO
<i>nifediac cc tablet extended release 24 hour 90mg</i>	1	MO
<i>nifediac cc tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifediac cc tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO
<i>nifedical xl tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifedical xl tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO
<i>nifedipine</i>	1	MO
<i>nifedipine er tablet extended release 24 hour 90mg</i>	1	MO
<i>nifedipine er tablet extended release 24 hour 30mg</i>	1	QL (1 per 1 day) MO
<i>nifedipine er tablet extended release 24 hour 60mg</i>	1	QL (2 per 1 day) MO
<i>nitroglycerin patch 24 hour</i>	1	MO
<i>nitroglycerin transdermal patch 24 hour 0.1mg/hr</i>	1	MO
NITROSTAT	4	MO
RANEXA TABLET EXTENDED RELEASE 12 HOUR 1000MG	4	QL (2 per 1 day) ST MO
RANEXA TABLET EXTENDED RELEASE 12 HOUR 500MG	4	QL (3 per 1 day) ST MO
<i>reserpine</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
SIMCOR TABLET EXTENDED RELEASE 24 HOUR 1000MG; 40MG, 500MG; 40MG	3	QL (1 per 1 day) MO
SIMCOR TABLET EXTENDED RELEASE 24 HOUR 500MG; 20MG, 750MG; 20MG	3	QL (2 per 1 day) MO
<i>simvastatin</i>	1	QL (1 per 1 day) MO
<i>sotalol hcl</i>	1	MO
<i>spironolactone</i>	1	MO
<i>spironolactone/hydrochlorothiazide</i>	1	MO
TEKAMLO	3	QL (1 per 1 day) MO
TEKTRNA HCT TABLET 300MG; 12.5MG, 300MG; 25MG	3	MO
TEKTRNA HCT TABLET 150MG; 12.5MG, 150MG; 25MG	3	QL (1 per 1 day) MO
TEKTRNA TABLET 300MG	3	MO
TEKTRNA TABLET 150MG	3	QL (1 per 1 day) MO
<i>terazosin hcl</i>	1	MO
<i>toremide injection 20mg/2ml</i>	2	
<i>toremide tablet</i>	1	MO
<i>triamterene/hydrochlorothiazide</i>	1	MO
TRICOR	3	MO
TRILIPIX	3	MO
VALTRNA TABLET 300MG; 320MG	3	MO
VALTRNA TABLET 150MG; 160MG	3	QL (1 per 1 day) MO
<i>verapamil hcl</i>	1	MO
<i>verapamil hcl er</i>	1	MO
VYTORIN	3	QL (1 per 1 day) MO
ZETIA	4	QL (1 per 1 day) MO
CENTRAL NERVOUS SYSTEM AGENTS		
AVONEX	5	QL (4 per 28 days) PA
<i>baclofen</i>	1	MO
COPAXONE	5	QL (1 per 1 day) PA
<i>cyclobenzaprine hcl tablet 10mg, 5mg</i>	1	QL (3 per 1 day) PA MO
<i>dantrolene sodium capsule</i>	2	MO
EXTAVIA	5	QL (0.53 per 1 day) PA
<i>methocarbamol</i>	1	PA MO
NUEDEXTA	4	QL (2 per 1 day) PA MO
RILUTEK	5	PA MO
SAVELLA	3	QL (2 per 1 day) MO
SAVELLA TITRATION PACK	3	QL (55 per 365 days) MO
<i>tizanidine hcl</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
DENTAL AND ORAL AGENTS		
<i>chlorhexidine gluconate oral rinse</i>	1	MO
<i>periogard</i>	1	MO
<i>triamcinolone in orabase</i>	1	MO
DERMATOLOGICAL AGENTS		
<i>doxycycline hyclate capsule</i>	1	PA MO
<i>doxycycline hyclate capsule delayed release particles 100mg</i>	1	PA
<i>doxycycline hyclate capsule delayed release particles 75mg</i>	1	PA MO
<i>doxycycline hyclate tablet 20mg</i>	1	PA MO
<i>fluorouracil cream</i>	2	MO
<i>fluorouracil external solution</i>	2	MO
TAZORAC	4	MO
<i>tretinoin cream</i>	1	PA MO
<i>tretinoin gel</i>	2	PA MO
ENZYME REPLACEMENT/ MODIFYING AGENTS		
CREON CAPSULE DELAYED RELEASE PARTICLES 120000UNIT; 24000UNIT; 76000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	MO
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 109000UNIT; 20000UNIT; 68000UNIT, 27000UNIT; 5000UNIT; 17000UNIT, 55000UNIT; 10000UNIT; 34000UNIT, 82000UNIT; 15000UNIT; 51000UNIT	3	MO
GASTROINTESTINAL AGENTS		
AMITIZA CAPSULE 24MCG	3	QL (2 per 1 day) ST MO
AMITIZA CAPSULE 8MCG	3	QL (2 per 1 day) ST PA MO
APRISO	3	QL (4 per 1 day) MO
<i>atropine sulfate injection 0.05mg/ml, 0.1mg/ml</i>	1	PA
CANASA	4	MO
DEXILANT	3	QL (1 per 1 day) MO
<i>dicyclomine hcl</i>	1	PA MO
<i>famotidine tablet 20mg, 40mg</i>	1	MO
<i>lactulose</i>	1	MO
LIALDA	4	QL (4 per 1 day) MO
<i>loperamide hcl capsule</i>	1	MO
LOTRONEX	5	QL (2 per 1 day) PA MO
<i>metoclopramide hcl injection</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>metoclopramide hcl oral solution 5mg/5ml</i>	1	MO
<i>metoclopramide hcl tablet</i>	1	MO
<i>misoprostol</i>	2	MO
NEXIUM CAPSULE DELAYED RELEASE 20MG	3	QL (1 per 1 day) MO
NEXIUM CAPSULE DELAYED RELEASE 40MG	3	QL (2 per 1 day) MO
NEXIUM I.V.	3	
NEXIUM PACKET	3	QL (1 per 1 day) MO
<i>omeprazole capsule delayed release 10mg, 40mg</i>	1	QL (1 per 1 day) MO
<i>omeprazole capsule delayed release 20mg</i>	1	QL (3 per 1 day) MO
PENTASA CAPSULE EXTENDED RELEASE 500MG	4	QL (8 per 1 day) MO
PENTASA CAPSULE EXTENDED RELEASE 250MG	4	QL (20 per 1 day) MO
<i>polyethylene glycol 3350 powder</i>	1	MO
<i>ranitidine hcl capsule</i>	1	MO
<i>ranitidine hcl tablet</i>	1	MO
<i>sucrafate</i>	1	MO
<i>ursodiol</i>	1	MO
GENITOURINARY AGENTS		
AVODART	3	QL (1 per 1 day) PA MO
<i>bethanechol chloride</i>	1	MO
<i>calcium acetate capsule</i>	2	MO
ELMIRON	4	MO
ENABLEX	3	QL (1 per 1 day) MO
<i>finasteride</i>	1	QL (1 per 1 day) PA MO
FOSRENOL TABLET CHEWABLE 1000MG, 500MG, 750MG	4	MO
GELNIQUE	3	QL (1 per 1 day) MO
JALYN	3	QL (1 per 1 day) PA MO
<i>nitrofurantoin</i>	2	MO
<i>oxybutynin chloride</i>	1	MO
<i>oxybutynin chloride er tablet extended release 24 hour 5mg</i>	2	QL (1 per 1 day) MO
<i>oxybutynin chloride er tablet extended release 24 hour 10mg, 15mg</i>	2	QL (2 per 1 day) MO
PHOSLO	3	MO
RAPAFLO CAPSULE 8MG	3	QL (1 per 1 day) PA MO
RAPAFLO CAPSULE 4MG	3	QL (2 per 1 day) PA MO
RENVELA	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>tamsulosin hcl</i>	1	QL (2 per 1 day) MO
VESICARE	3	QL (1 per 1 day) MO
GLUCOCORTICOID/ MINERALOCORTICOID AGENTS		
ALREX	3	MO
<i>clobetasol propionate e</i>	1	MO
<i>clobetasol propionate external solution</i>	1	MO
<i>clobetasol propionate gel</i>	1	MO
<i>clobetasol propionate ointment</i>	1	MO
DERMOTIC	4	MO
<i>desonide</i>	1	MO
DUREZOL	3	MO
<i>fludrocortisone acetate</i>	1	MO
<i>fluocinolone acetonide cream</i>	1	MO
<i>fluocinolone acetonide external solution</i>	1	MO
<i>fluocinolone acetonide ointment</i>	1	MO
<i>fluocinonide emollient base</i>	1	MO
<i>fluocinonide external solution</i>	1	MO
<i>fluocinonide gel</i>	1	MO
<i>fluocinonide ointment</i>	1	MO
<i>fluorometholone</i>	1	MO
<i>fluticasone propionate cream</i>	1	MO
<i>fluticasone propionate ointment</i>	1	MO
<i>halobetasol propionate</i>	1	MO
<i>hydrocortisone cream 1%, 2.5%</i>	1	MO
<i>hydrocortisone lotion 2.5%</i>	1	MO
<i>hydrocortisone ointment 1%, 2.5%</i>	1	MO
LOTEMAX SUSPENSION	3	MO
<i>methylprednisolone</i>	1	MO
<i>mometasone furoate</i>	1	MO
<i>prednisone</i>	1	MO
<i>triamcinolone acetonide cream</i>	1	MO
<i>triamcinolone acetonide in absorbbase</i>	1	MO
<i>triamcinolone acetonide lotion</i>	1	MO
<i>triamcinolone acetonide ointment</i>	1	MO
HORMONAL AGENTS		
ANDRODERM PATCH 24 HOUR 5MG/24HR	3	QL (1 per 1 day) MO
ANDRODERM PATCH 24 HOUR 2.5MG/24HR	3	QL (2 per 1 day) MO
ANDROGEL GEL 50MG/5GM	3	QL (10 per 1 day) MO

Drug Name	Drug Tier	Requirements/Limits
<i>bicalutamide</i>	1	QL (1 per 1 day) MO
<i>chorionic gonadotropin</i>	2	PA
<i>desmopressin acetate nasal solution</i>	2	MO
<i>desmopressin acetate tablet</i>	2	MO
ELIGARD	4	PA
<i>estradiol patch weekly</i>	1	QL (4 per 28 days) MO
<i>estradiol tablet</i>	1	MO
EVISTA	3	QL (1 per 1 day) MO
<i>flutamide</i>	2	MO
INCRELEX	5	PA
<i>leuprolide acetate</i>	1	PA
<i>levothyroxine sodium tablet</i>	1	MO
<i>liothyronine sodium tablet</i>	1	MO
LYSODREN	3	MO
<i>medroxyprogesterone acetate tablet</i>	1	MO
<i>megestrol acetate tablet</i>	1	PA MO
<i>methimazole</i>	1	MO
NORDITROPIN FLEXPRO	5	PA
NORDITROPIN NORDIFLEX PEN	5	PA
<i>octreotide acetate injection 50mcg/ml</i>	2	PA
PREMARIN TABLET	4	PA MO
PREMARIN W/APPLICATOR	4	MO
<i>propylthiouracil</i>	1	MO
SENSIPAR TABLET 30MG	3	QL (2 per 1 day) MO
SENSIPAR TABLET 60MG	5	QL (2 per 1 day) MO
SENSIPAR TABLET 90MG	5	QL (4 per 1 day) MO
SOMAVERT	5	ST PA
<i>sprintec 28</i>	1	MO
<i>testosterone cypionate injection 100mg/ml</i>	2	MO
<i>tri-sprintec</i>	1	QL (28 per 28 days) MO
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
ANDROGEL PUMP GEL 1.62%	3	QL (5.87 per 1 day) MO
<i>zeosa</i>	2	MO
IMMUNOLOGICAL AGENTS		
<i>azathioprine</i>	1	PA MO
<i>cyclosporine capsule</i>	2	PA MO
ENBREL INJECTION 25MG/0.5ML	5	QL (0.15 per 1 day) PA
ENBREL INJECTION 50MG/ML	5	QL (0.29 per 1 day) PA
ENBREL INJECTION 25MG	5	QL (14.3 per 28 days) PA

Drug Name	Drug Tier	Requirements/Limits
GAMASTAN S/D	3	PA
GAMMAGARD LIQUID	5	PA
HUMIRA INJECTION 20MG/0.4ML	5	QL (2 per 28 days) PA
HUMIRA INJECTION 40MG/0.8ML	5	QL (6 per 28 days) PA
HUMIRA PEN-CROHNS DISEASESTARTER	5	QL (6 per 28 days) PA
INTRON-A INJECTION 10MU/0.2ML, 3MU/0.2ML, 5MU/0.2ML	5	PA
INTRON-A INJECTION 6000000UNIT/ML	4	PA
INTRON-A W/DILUENT INJECTION 10MU	5	PA
<i>leflunomide</i>	1	MO
<i>methotrexate</i>	1	MO
<i>methotrexate sodium injection 25mg/ml</i>	1	B/D MO
PEG-INTRON INJECTION 50MCG/0.5ML	5	PA
PEG-INTRON REDIPEN	5	PA
PEGASYS	5	PA
SIMPONI	5	QL (0.02 per 1 day) PA
SIMULECT INJECTION 20MG	5	PA
SYNAGIS INJECTION 50MG/0.5ML	5	PA
<i>tacrolimus capsule 0.5mg, 1mg</i>	2	PA MO
THYMOGLOBULIN	4	PA
VARIVAX	3	
ZOSTAVAX	4	QL (1 per 365 days)
METABOLIC BONE DISEASE AGENTS		
ACTONEL TABLET 30MG, 5MG	3	QL (1 per 1 day) MO
ACTONEL TABLET 150MG	3	QL (1 per 28 days) MO
ACTONEL TABLET 35MG	3	QL (4 per 28 days) MO
<i>alendronate sodium tablet 10mg, 40mg, 5mg</i>	1	QL (1 per 1 day) MO
<i>alendronate sodium tablet 35mg, 70mg</i>	1	QL (4 per 28 days) MO
AELVIA	3	QL (4 per 28 days) MO
<i>calcitriol capsule</i>	1	B/D MO
FORTEO	5	QL (2.4 per 28 days) ST
ZEMPLAR	3	B/D MO
NUTRIENTS/ MINERALS/ ELECTROLYTES		
CUPRIMINE CAPSULE 250MG	4	MO
EXJADE TABLET SOLUBLE 125MG	4	PA
EXJADE TABLET SOLUBLE 250MG, 500MG	5	PA
<i>klor-con 10</i>	1	MO
<i>klor-con 8</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
KLOR-CON M15	4	MO
<i>klor-con m20</i>	1	MO
<i>potassium chloride er capsule extended release</i>	1	MO
<i>potassium chloride er tablet extended release 10meq, 20meq</i>	1	MO
<i>potassium citrate er</i>	1	MO
PRENATAL TABLETS	4	
<i>sodium polystyrene sulfonate powder</i>	2	MO
OPHTHALMIC AGENTS		
<i>ak-con</i>	1	MO
ALPHAGAN P	3	MO
<i>apraclonidine</i>	2	MO
AZOPT	3	MO
COMBIGAN	4	MO
<i>cromolyn sodium ophthalmic solution</i>	1	MO
<i>dorzolamide hcl</i>	1	MO
<i>epinastine hcl</i>	2	MO
LACRISERT	4	MO
<i>latanoprost</i>	2	MO
LUMIGAN	3	MO
<i>parcaine</i>	1	
PATADAY	4	MO
PATANOL	4	MO
PHOSPHOLINE IODIDE	4	
PILOPINE HS	3	MO
RESTASIS	3	MO
<i>timolol maleate ophthalmic solution</i>	1	MO
TRAVATAN Z	3	MO
<i>tropicamide</i>	1	MO
RESPIRATORY TRACT AGENTS		
<i>acetylcysteine</i>	1	B/D MO
ADVAIR DISKUS	3	QL (2 per 1 day) MO
ADVAIR HFA	3	QL (0.48 per 1 day) MO
<i>albuterol sulfate er</i>	2	MO
<i>albuterol sulfate nebulization solution</i>	1	B/D MO
<i>albuterol sulfate tablet</i>	1	MO
<i>aminophylline tablet</i>	1	MO
ASMANEX 120 METERED DOSES	3	QL (0.24 per 25 days) MO
ASMANEX 14 METERED DOSES	3	QL (0.48 per 25 days) MO

Drug Name	Drug Tier	Requirements/Limits
ASMANEX 30 METERED DOSES AEROSOL POWDER BREATH ACTIVATED 110MCG/INH	3	QL (0.14 per 25 days) MO
ASMANEX 30 METERED DOSES AEROSOL POWDER BREATH ACTIVATED 220MCG/INH	3	QL (0.24 per 25 days) MO
ASMANEX 60 METERED DOSES	3	QL (0.24 per 25 days) MO
ASTEPRO NASAL SOLUTION 0.15%	3	MO
<i>cromolyn sodium nebulization solution</i>	2	QL (8 per 1 day) B/D MO
DULERA	3	QL (0.52 per 1 day) MO
EPIPEN 2-PAK	4	MO
EPIPEN-JR 2-PAK	4	MO
<i>fexofenadine hcl tablet 180mg</i>	1	QL (1 per 1 day) MO
<i>fexofenadine hcl tablet 30mg, 60mg</i>	1	QL (2 per 1 day) MO
FLOVENT DISKUS	3	QL (4 per 1 day) MO
FLOVENT HFA AEROSOL 44MCG/ACT	3	QL (0.85 per 1 day) MO
FLOVENT HFA AEROSOL 110MCG/ACT, 220MCG/ACT	3	QL (0.96 per 1 day) MO
FORADIL AEROLIZER	3	QL (2 per 1 day) MO
GASTROCROM	4	PA MO
<i>ipratropium bromide nasal solution 0.03%</i>	1	QL (1 per 1 day) MO
<i>ipratropium bromide nasal solution 0.06%</i>	1	QL (1.5 per 1 day) MO
LETAIRIS	5	QL (1 per 1 day) PA
NASONEX	3	MO
PATANASE	4	MO
PROAIR HFA	3	MO
PROVENTIL HFA	3	MO
SINGULAIR	3	QL (1 per 1 day) MO
SPIRIVA HANDIHALER	3	QL (1 per 1 day) MO
SYMBICORT AEROSOL 160MCG/ACT; 4.5MCG/ACT	3	QL (0.41 per 1 day) MO
SYMBICORT AEROSOL 80MCG/ACT; 4.5MCG/ACT	3	QL (0.55 per 1 day) MO
<i>theophylline er tablet extended release 12 hour</i>	1	MO
<i>theophylline er tablet extended release 24 hour</i>	1	MO
TRACLEER	5	QL (2 per 1 day) PA LA
TYZINE	4	MO
TYZINE PEDIATRIC NASAL DROPS	4	MO
VENTOLIN HFA	4	MO
XOLAIR	5	QL (900 per 28 days) PA
<i>zafirlukast</i>	2	QL (2 per 1 day) MO

Drug Name	Drug Tier	Requirements/Limits
SLEEP DISORDER AGENTS		
PROVIGIL	3	QL (2 per 1 day) PA MO
XYREM	5	QL (18 per 1 day) PA LA
<i>zaleplon capsule 10mg</i>	2	QL (2 per 1 day) MO
<i>zaleplon capsule 5mg</i>	2	QL (3 per 1 day) MO
<i>zolpidem tartrate er</i>	2	QL (1 per 1 day) MO
<i>zolpidem tartrate tablet 10mg</i>	1	QL (1 per 1 day) MO
<i>zolpidem tartrate tablet 5mg</i>	1	QL (2 per 1 day) MO
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES		
<i>intralipid injection 2.25%; 20%</i>	2	
INTRALIPID INJECTION 1.7%; 30%	4	
<i>lactated ringers</i>	2	
<i>premasol injection 56meq/l; 320mg/100ml; 730mg/100ml; 190mg/100ml; 3meq/l; 20mg/100ml; 300mg/100ml; 220mg/100ml; 290mg/100ml; 490mg/100ml; 840mg/100ml; 490mg/100ml; 200mg/100ml; 290mg/100ml; 410mg/100ml; 230mg/100ml; 5meq/l; 15mg/100ml; 250mg/100ml; 120mg/100ml; 140mg/100ml; 470mg/100ml</i>	2	B/D
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Excluded Drug Coverage for Aetna Medicare Rx Premier[®] Plan Only

KEY	Requirements/Limits
Drug Name	QL= Quantity Limit
<i>Lower case italics</i> = Generic medications	ED = Excluded Drug

Drug Name	Drug Tier	Requirements/Limits
ANTICONVULSANTS		
<i>clonazepam odt tablet dispersible 0.25mg, 0.5mg, 2mg</i>	1	QL (2 per 1 day) MO ED*
<i>clonazepam odt tablet dispersible 0.125mg</i>	1	QL (3 per 1 day) MO ED*
<i>clonazepam odt tablet dispersible 1mg</i>	1	QL (4 per 1 day) MO ED*
<i>clonazepam tablet 0.5mg</i>	1	QL (3 per 1 day) MO ED*
<i>clonazepam tablet 1mg</i>	1	QL (4 per 1 day) MO ED*
<i>clonazepam tablet 2mg</i>	1	QL (10 per 1 day) MO ED*
ANXIOLYTICS		
<i>alprazolam er</i>	1	QL (1 per 1 day) MO ED*
<i>alprazolam intensol</i>	1	QL (5 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 0.5mg, 2mg</i>	1	QL (3 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 0.25mg</i>	1	QL (4 per 1 day) MO ED*
<i>alprazolam odt tablet dispersible 1mg</i>	1	QL (5 per 1 day) MO ED*
<i>alprazolam tablet 0.5mg, 2mg</i>	1	QL (3 per 1 day) MO ED*
<i>alprazolam tablet 0.25mg</i>	1	QL (4 per 1 day) MO ED*
<i>alprazolam tablet 1mg</i>	1	QL (5 per 1 day) MO ED*
<i>chlordiazepoxide hcl</i>	1	QL (4 per 1 day) MO ED*
<i>clorazepate dipotassium tablet 15mg</i>	1	QL (1 per 1 day) MO ED*
<i>clorazepate dipotassium tablet 3.75mg, 7.5mg</i>	1	QL (3 per 1 day) MO ED*
<i>diazepam injection 5mg/ml</i>	1	QL (8 per 1 day) MO ED*
<i>diazepam intensol</i>	1	QL (8 per 1 day) MO ED*
<i>diazepam oral solution</i>	1	QL (40 per 1 day) MO ED*
<i>diazepam tablet</i>	1	QL (4 per 1 day) MO ED*

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

Drug Name	Drug Tier	Requirements/Limits
<i>lorazepam concentrate</i>	1	QL (3 per 1 day) MO ED*
<i>lorazepam injection</i>	1	QL (4 per 1 day) MO ED*
<i>lorazepam tablet</i>	1	QL (3 per 1 day) MO ED*
<i>oxazepam</i>	1	QL (4 per 1 day) MO ED*
SEDATIVES/HYPNOTICS		
<i>butisol sodium elixir</i>	1	QL (20 per 1 day) MO ED*
<i>estazolam tablet 2mg</i>	1	QL (1 per 1 day) MO ED*
<i>estazolam tablet 1mg</i>	1	QL (2 per 1 day) MO ED*
<i>flurazepam hcl</i>	1	QL (1 per 1 day) MO ED*
<i>midazolam hcl injection 10mg/10ml, 10mg/2ml, 1mg/ml, 25mg/5ml, 2mg/2ml, 5mg/ml</i>	1	QL (1 per 1 day) MO ED*
<i>midazolam hcl syrup</i>	1	QL (10 per 1 day) MO ED*
<i>phenobarbital elixir</i>	1	QL (40 per 1 day) MO ED*
<i>phenobarbital sodium injection 65mg/ml</i>	1	QL (4 per 1 day) MO ED*
<i>phenobarbital sodium injection 130mg/ml</i>	1	QL (5 per 1 day) MO ED*
<i>phenobarbital tablet 100mg, 60mg, 64.8mg, 97.2mg</i>	1	QL (3 per 1 day) MO ED*
<i>phenobarbital tablet 15mg, 16.2mg, 30mg, 32.4mg</i>	1	QL (4 per 1 day) MO ED*
<i>temazepam capsule 22.5mg, 30mg</i>	1	QL (1 per 1 day) MO ED*
<i>temazepam capsule 15mg, 7.5mg</i>	1	QL (2 per 1 day) MO ED*
<i>triazolam</i>	1	QL (2 per 1 day) MO ED*

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

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Notes

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

This material is for informational purposes only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In general, beneficiaries must use network pharmacies to access their prescription drug benefit, except in non routine circumstances. Pharmacy clinical programs such as prior authorization, step therapy, and quantity limits may apply to your prescription drug coverage. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.