



MEDICAID PREFERRED DRUG LIST 2014

The following is a list of medications or a formulary listing of medications covered for Medicaid recipients managed under the Hudson Health Plan Program. This list is not intended to be a complete and an all-inclusive list, but a representative list that is as comprehensive as possible. If there should ever be a question about medication coverage as part of this program please contact Hudson Health Plan directly at 1-800-339-4557 or MaxorPlus, the pharmacy benefit management company working with Hudson Health Plan to manage this prescription benefit at 1-800-687-0707.

Copay Tier

Tier 1 (Generic): \$1.00

Tier 2 (Preferred Brands) \$1.00

Tier 3 (Non-Preferred Brands): \$3.00

In addition; Certain restrictions, quantity limits, step therapy, and prior authorization requirements may apply. As brand name drugs become available generically, only the generic will be considered formulary.

HHP-MDC JUNE 2014

Anti-infective; Antifungal Agents:	Rx Only Coverage	Copay Tier
	<i>amphotericin B</i>	Generic
	<i>clotrimazole</i>	Generic
	<i>fluconazole</i>	Generic
	<i>griseofulvin</i>	Generic
	<i>itraconazole</i>	Generic
	<i>ketoconazole</i>	Generic
	<i>nystatin</i>	Generic
	<i>terbinafine HCl</i>	Generic
	<i>voriconazole</i>	Generic
	NOXAFIL	Non-preferred Brand
	SPORANOX ORAL SOL	Non-preferred Brand
Anti-infective; Antiviral HIV Specific:	Rx Only Coverage	Copay Tier
	<i>abacavir</i>	Generic
	<i>abacavir/lamivudine/zidovudine</i>	Generic
	<i>didanosine</i>	Generic
	<i>lamivudine</i>	Generic
	<i>lamivudine;zidovudine</i>	Generic
	<i>nevirapine IR</i>	Generic
	<i>stavudine</i>	Generic
	<i>zidovudine</i>	Generic
	AGENERASE	Preferred Brand
	APTIVUS	Preferred Brand
	ATRIPLA	Preferred Brand
	COMPLERA	Preferred Brand
	CRIXIVAN	Preferred Brand
	EDURANT	Preferred Brand
	EMTRIVA	Preferred Brand
	EPZICOM	Preferred Brand
	FUZEON	Preferred Brand
	INTELENCE	Preferred Brand
	INVIRASE	Preferred Brand

Anti-infective; Antiviral HIV Specific (Cont):	Rx Only Coverage	Copay Tier
	ISENTRESS	Preferred Brand
	KALETRA	Preferred Brand
	LEXIVA	Preferred Brand
	NORVIR	Preferred Brand
	PREZISTA	Preferred Brand
	RESCRIPTOR	Preferred Brand
	REYATAZ	Preferred Brand
	SELZENTRY	Preferred Brand
	STRIBILD	Preferred Brand
	SUSTIVA	Preferred Brand
	TIVICAY	Preferred Brand
	TRUVADA	Preferred Brand
	VIRACEPT	Preferred Brand
	VIRAMUNE XR	Preferred Brand
	VIREAD	Preferred Brand
Anti-infective; Antiviral Hepatitis B:	Rx Only Coverage	Copay Tier
	BARACLUDE	Preferred Brand
	EPIVIR HBV	Preferred Brand
	HEPSERA	Preferred Brand
	TYZEKA	Non-preferred Brand
Anti-infective; Antiviral Hepatitis C:	Rx Only Coverage	Copay Tier
	<i>ribavirin</i>	Generic
	PEGASYS	Preferred Brand
	INCIVEK	Preferred Brand
	VICTRELIS	Preferred Brand
	COPEGUS	Non-preferred Brand
	INFERGEN	Non-preferred Brand
	REBETOL	Non-preferred Brand
	RIBAPAK	Non-preferred Brand
	RIBASPHERE	Non-preferred Brand
Anti-infective; Antiviral General:	Rx Only Coverage	Copay Tier
Notes: <i>Synagis is subject to a prior authorization or clinical drug review to ensure proper use of this medication - if approved it is also limited to 5 doses or 5 months of treatment during the RSV season (October through March).</i>	<i>acyclovir sodium</i>	Generic
	<i>amantadine</i>	Generic
	<i>famciclovir</i>	Generic
	<i>foscarnet sodium</i>	Generic
	<i>ganciclovir</i>	Generic
	<i>ribavirin</i>	Generic
	<i>valacyclovir HCl</i>	Generic
	SYNAGIS	Preferred Brand
	TAMIFLU	Preferred Brand
	VALCYTE	Preferred Brand
Anti-infective; Antibacterial Cephalosporin 1st Generation:	Rx Only Coverage	Copay Tier
	<i>cefadroxil</i>	Generic
	<i>cefazolin sodium</i>	Generic
	<i>cephalexin</i>	Generic

Anti-infective; Antibacterial Cephalosporin 2nd Generation:	Rx Only Coverage	Copay Tier
	<i>cefaclor</i>	Generic
	<i>cefotetan</i>	Generic
	<i>cefoxitin sodium</i>	Generic
	<i>cefprozil</i>	Generic
	<i>cefuroxime</i>	Generic
Anti-infective; Antibacterial Cephalosporin 3rd Generation:	Rx Only Coverage	Copay Tier
	<i>cefdinir</i>	Generic
	<i>cefotaxime sodium</i>	Generic
	<i>cefpodoxime sodium</i>	Generic
	<i>ceftazidime</i>	Generic
	<i>ceftriaxone sodium</i>	Generic
	<i>ceftibuten</i>	Generic
	SUPRAX	Non-preferred Brand
Anti-infective; Antibacterial Cephalosporin 4th Generation:	Rx Only Coverage	Copay Tier
	<i>cefepime</i>	Generic
Anti-infective; Antibacterial Quinolone Antibiotic:	Rx Only Coverage	Copay Tier
	<i>ciprofloxacin</i>	Generic
	<i>levofloxacin</i>	Generic
	<i>moxifloxacin</i>	Generic
	<i>ofloxacin</i>	Generic
	NOROXIN	Preferred Brand
Anti-infective; Antibacterial Macrolide Antibiotic:	Rx Only Coverage	Copay Tier
	<i>azithromycin</i>	Generic
	<i>clarithromycin</i>	Generic
	<i>erythromycin base</i>	Generic
	<i>erythromycin ethylsuccinate</i>	Generic
	<i>erythromycin lactobionate</i>	Generic
Anti-infective; Antibacterial Penicillin Antibiotic:	Rx Only Coverage	Copay Tier
	<i>amoxicillin</i>	Generic
	<i>amoxicillin/clavulanate P</i>	Generic
	<i>ampicillin</i>	Generic
	<i>ampicillin-sulbactam</i>	Generic
	<i>dicloxacillin sodium</i>	Generic
	<i>nafacillin sodium</i>	Generic
	<i>penicillin G potassium</i>	Generic
	<i>penicillin G sodium</i>	Generic
	<i>piperacillin sodium</i>	Generic
	BICILLIN C-R	Non-preferred Brand
	BICILLIN L-A	Non-preferred Brand
Anti-infective; Antibacterial Sulfonamide Antibiotic:	Rx Only Coverage	Copay Tier
	<i>sulfamethoxazole/trimethoprim</i>	Generic
	<i>sulfadiazine</i>	Generic
	<i>sulfasalazine</i>	Generic
	<i>sulfazine</i>	Generic

Anti-infective; Antibacterial Tetracycline Antibiotic:	Rx Only Coverage	Copay Tier
Notes: <i>all extended release formulations for acne treatment are considered non-formulary, the immediate release formulations are covered.</i>	<i>demeclocycline HCl</i>	Generic
	<i>doxycycline hyclate</i>	Generic
	<i>doxycycline monohydrate</i>	Generic
	<i>minocycline HCl</i>	Generic
	<i>tetracycline HCl</i>	Generic
	<i>vibramycin</i>	Generic
Anti-infective; Anti-Mycobacterium Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>ethambutol HCL</i>	Exempt
	<i>isoniazid</i>	Exempt
	<i>pyrazinamide</i>	Exempt
	<i>rifabutin</i>	Exempt
	<i>rifampin</i>	Exempt
	TRECTOR	Exempt
Anti-infective; Miscellaneous Antibacterial Agents:	Rx Only Coverage	Copay Tier
	<i>colistimethate sodium</i>	Generic
	<i>furadantin</i>	Generic
	<i>macrodantin</i>	Generic
	<i>nitrofurantoin monohydrate</i>	Generic
	<i>vancomycin HCl</i>	Generic
	CAYSTON	Preferred Brand
Anti-infective; Antimalarial Agents:	Rx Only Coverage	Copay Tier
	<i>atovaquone/proguanil</i>	Generic
	<i>chloroquine phosphate</i>	Generic
	<i>hydroxychloroquine sulfate</i>	Generic
	<i>mefloquine HCl</i>	Generic
	DARAPRIM	Preferred Brand
Anti-infective Antiparasitic Agent:	Rx Only Coverage	Copay Tier
	<i>atovaquone</i>	Generic
	<i>mebendazole</i>	Generic
	<i>metronidazole</i>	Generic
	<i>paromomycin sulfate</i>	Generic
	<i>tinidazole</i>	Generic
	ALBENZA	Preferred Brand
	ALINIA	Preferred Brand
	NEBUPENT	Preferred Brand
YODOXIN	Preferred Brand	
Anti-infective; Lincosamide Antibiotic:	Rx Only Coverage	Copay Tier
	<i>clindamycin HCl</i>	Generic
	<i>clindamycin phosphate</i>	Generic
	LINCOCIN	Non-preferred Brand
Anti-infective; Aminoglycoside Antibiotic:	Rx Only Coverage	Copay Tier
	<i>amikacin sulfate</i>	Generic
	<i>gentamicin sulfate</i>	Generic
	<i>kanamycin sulfate</i>	Generic
	<i>neomycin sulfate</i>	Generic
	<i>streptomycin sulfate</i>	Generic

Anti-infective; Aminoglycoside Antibiotic (Cont):	Rx Only Coverage	Copay Tier
	<i>tobramycin sulfate</i>	Generic
	<i>tobramycin nebulizer solution</i>	Generic
	NEO-FRADIN	Non-preferred Brand
Anti-infective; Antiprotozoal Agents:	Rx Only Coverage	Copay Tier
	MEPRON	Preferred Brand
	NEBUPENT	Preferred Brand
Anti-infective; Antibacterial Miscellaneous:	Rx Only Coverage	Copay Tier
	<i>methenamine hippurate</i>	Generic
	<i>methenamine mandelate</i>	Generic
	<i>nitrofurantoin</i>	Generic
	<i>phenazopyridine</i>	Generic
	<i>trimethoprim</i>	Generic
	HIPREX	Non-preferred Brand
	MONUROL	Non-preferred Brand
	PRIMSOL	Non-preferred Brand
Antineoplastic Agents:	Rx Only Coverage	Copay Tier
	<i>anastrozole</i>	Generic
	<i>azacitidine inj</i>	Generic
	<i>bleomycin sulfate</i>	Generic
	<i>capecitabine</i>	Generic
	<i>cyclophosphamide</i>	Generic
	<i>cytarabine</i>	Generic
	<i>dacarbazine</i>	Generic
	<i>daunorubicin HCl</i>	Generic
	<i>decitabine</i>	Generic
	<i>docetaxel</i>	Generic
	<i>doxorubicin HCl</i>	Generic
	<i>etoposide</i>	Generic
	<i>exemestane</i>	Generic
	<i>fludarabine phosphate</i>	Generic
	<i>fluorouracil</i>	Generic
	<i>gemcitabine</i>	Generic
	<i>hydroxyurea</i>	Generic
	<i>irinotecan</i>	Generic
	<i>leucovorin calcium</i>	Generic
	<i>leuprolide acetate</i>	Generic
	<i>Letrozole</i>	Generic
	<i>lomustine</i>	Generic
	<i>mercaptopurine</i>	Generic
	<i>methotrexate</i>	Generic
	<i>mitoxantrone HCl</i>	Generic
	<i>octreotide acetate</i>	Generic
	<i>riluzole</i>	Generic
	<i>tamoxifen</i>	Generic
	<i>temozolomide</i>	Generic
	<i>teniposide</i>	Generic

Antineoplastic Agents (Cont):	Rx Only Coverage	Copay Tier
	<i>tretinoin</i>	Generic
	<i>vinblastine sulfate</i>	Generic
	<i>vincristine sulfate</i>	Generic
	<i>vinorelbine tartrate</i>	Generic
	EMCYT	Preferred Brand
	GILOTTRIF	Preferred Brand
	HYCAMTIN	Preferred Brand
	IMBRUVICA	Preferred Brand
	KADCYLA	Preferred Brand
	LUPRON DEPOT	Preferred Brand
	LYSODREN	Preferred Brand
	MARQIBO	Preferred Brand
	MATULANE	Preferred Brand
	MENKINIST	Preferred Brand
	TAFINLAR	Preferred Brand
	TYKERB	Preferred Brand
	ZOLADEX	Preferred Brand
	GAZYVA	Non-preferred Brand
	IRESSA	Non-preferred Brand
	TARGETIN	Non-preferred Brand
	TICE BCG	Non-preferred Brand
	VALCHLOR GEL	Non-preferred Brand
	XTANDI	Non-preferred Brand
	ZOLINZA	Non-preferred Brand
Immunosuppressant Therapy Agents:	Rx Only Coverage	Copay Tier
	<i>azathioprine</i>	Generic
	<i>cyclosporine</i>	Generic
	<i>HECORIA (tacrolimus)</i>	Generic
	<i>mycophenolate</i>	Generic
	<i>sirolimus</i>	Generic
	<i>tacrolimus</i>	Generic
	CELLCEPT Suspension	Preferred Brand
	RAPAMUNE	Preferred Brand
	SANDIMMUNE	Preferred Brand
	GENGRAF	Non-preferred Brand
	IMURAN	Non-preferred Brand
	PROGRAF	Non-preferred Brand
	ZORTRESS	Non-preferred Brand
Immune System Stimulant Agents:	Rx Only Coverage	Copay Tier
	GAMMAGARD S/D	Non-preferred Brand
	GAMMAGARD S/D IGA LESS TH	Non-preferred Brand
	GAMUNEX	Non-preferred Brand
	VIVAGLOBIN	Non-preferred Brand
Alzheimer's Medications:	Rx Only Coverage	Copay Tier
	<i>donepezil HCl</i>	Generic
	<i>galantamine hydrobromide</i>	Generic

Alzheimer's Medications (Cont):	Rx Only Coverage	Copay Tier
	<i>pyridostigmine bromide</i>	Generic
	<i>rivastigmine tartrate</i>	Generic
	NAMENDA	Preferred Brand
	XENAZINE	Preferred Brand
	COGNEX	Non-preferred Brand
Antiparkinson's Medications:	Rx Only Coverage	Copay Tier
	<i>amantadine</i>	Generic
	<i>benztropine HCl</i>	Generic
	<i>bromocriptine mesylate</i>	Generic
	<i>carbidopa</i>	Generic
	<i>carbidopa/levodopa</i>	Generic
	<i>carbidopa/levodopa/entacapone</i>	Generic
	<i>entacapone</i>	Generic
	<i>pramipexole dihydrochloride</i>	Generic
	<i>ropinirole HCl IR & XL</i>	Generic
	<i>selegiline HCl</i>	Generic
	<i>trihexyphenidyl HCl</i>	Generic
	APOKYN	Preferred Brand
	AZILECT	Preferred Brand
	MIRAPEX ER	Non-preferred Brand
	NEUPRO PATCH	Non-preferred Brand
	ZELAPAR	Non-preferred Brand
Antispasmodic Skeletal Muscle Relaxant:	Rx Only Coverage	Copay Tier
	<i>baclofen</i>	Generic
	<i>carisoprodol</i>	Generic
	<i>carisoprodol/aspirin</i>	Generic
	<i>chlozoxazone</i>	Generic
	<i>cyclobenzaprine HCl</i>	Generic
	<i>dantrolene sodium</i>	Generic
	<i>diazepam</i>	Generic
	<i>lioressal intrathecal</i>	Generic
	<i>metaxalone</i>	Generic
	<i>methocarbamol</i>	Generic
	<i>orphenadrine citrate</i>	Generic
	<i>tizanidine HCl</i>	Generic
	<i>trospium IR & XR</i>	Generic
	GELNIQUE	Preferred Brand
Osteoporosis Therapy Agents:	Rx Only Coverage	Copay Tier
	<i>alendronate sodium</i>	Generic
	<i>calcitonin salmon, synthetic</i>	Generic
	<i>estradiol/norethindrone acetate</i>	Generic
	<i>ibandronate</i>	Generic
	<i>zoledronic acid</i>	Generic
	EVISTA	Preferred Brand
	ACTONEL	Non-preferred Brand

Osteoporosis Therapy Agents (Cont):	Rx Only Coverage	Copay Tier
	BINOSTO	Non-preferred Brand
	MIACALCIN NASAL	Non-preferred Brand
Rheumatologicals; Rheumatoid Arthritis/Psoriasis Agents:	Rx Only Coverage	Copay Tier
	<i>leflunomide</i>	Generic
	ENBREL	Preferred Brand
	ENBREL SURECLICK	Preferred Brand
	HUMIRA	Preferred Brand
	HUMIRA PEN	Preferred Brand
	HUMIRA PEN-CROHNS DISEASE	Preferred Brand
	HUMIRA PEN-PSORIASIS STAR	Preferred Brand
	CIMZIA	Non-preferred Brand
	KINERET	Non-preferred Brand
	ORENCIA	Non-preferred Brand
	RIDAURA	Non-preferred Brand
	SIMPONI	Non-preferred Brand
	XELJANZ	Non-preferred Brand
Anticoagulant; Coumadin Type:	Rx Only Coverage	Copay Tier
	<i>warfarin sodium</i>	Generic
	<i>Jantoven</i>	Generic
	ELIQUIS	Preferred Brand
	XARELTO	Preferred Brand
	COUMADIN	Non-preferred Brand
Anticoagulant; Platelet Aggregation Inhibitors	Rx Only Coverage	Copay Tier
	<i>cilostazol</i>	Generic
	<i>clopidogrel</i>	Generic
	<i>dipyridamole</i>	Generic
	<i>ticlopidine HCl</i>	Generic
	AGGRENOX	Preferred Brand
	EFFIENT	Preferred Brand
	BRILINTA	Non-preferred Brand
Anticoagulant; Heparin and Related Agents:	Rx Only Coverage	Copay Tier
	<i>argatroban</i>	Generic
	<i>enoxaparin sodium</i>	Generic
	<i>fondaparinux</i>	Generic
	<i>heparin sodium</i>	Generic
	FRAGMIN	Non-preferred Brand
	INNOHEP	Non-preferred Brand
Antifibrotic Agents:	Rx Only Coverage	Copay Tier
	<i>aminocaproic acid</i>	Generic
	<i>cyklokapron</i>	Generic
Hematinic/Leukocyte Stimulants:	Rx Only Coverage	Copay Tier
	LEUKINE	Preferred Brand
	NEUPOGEN	Preferred Brand
	PROCRIT	Preferred Brand
	PROLEUKIN	Preferred Brand

Interferon Agents:	Rx Only Coverage	Copay Tier
	INTRON-A	Preferred Brand
	ALFERON N	Non-preferred Brand
Antiarrhythmic Agents	Rx Only Coverage	Copay Tier
	<i>amiodarone HCl</i>	Generic
	<i>disopyramide phosphate</i>	Generic
	<i>flecainide acetate</i>	Generic
	<i>lidocaine HCl</i>	Generic
	<i>mexiletine HCl</i>	Generic
	<i>procainamide HCl</i>	Generic
	<i>propafenone HCl</i>	Generic
	<i>quinidine gluconate</i>	Generic
	<i>quinidine sulfate</i>	Generic
	MULTAQ	Preferred Brand
	TIKOSYN	Preferred Brand
Cardiac Glycoside Agents:	Rx Only Coverage	Copay Tier
	<i>digoxin</i>	Generic
	LANOXICAPS	Non-preferred Brand
	LANOXIN	Non-preferred Brand
Lipotropic Agents; Triglyceride Reducers:	Rx Only Coverage	Copay Tier
	<i>cholestyramine/cholestyramine light</i>	Generic
	<i>fenofibrate</i>	Generic
	<i>fenofibric acid</i>	Generic
	<i>gemfibrozil</i>	Generic
	FENOGLIDE	Preferred Brand
	WELCHOL	Preferred Brand
	ZETIA	Preferred Brand
Lipotropic Agents; Cholesterol Reducers:	Rx Only Coverage	Copay Tier
Notes: <i>Step therapy is in place for the statin medications, requiring the use of generic statins and failure before a brand name agent will be allowed.</i>	<i>amlodipine/atorvastatin</i>	Generic
	<i>atorvastatin</i>	Generic
	<i>fluvastatin IR and ER</i>	Generic
	<i>lovastatin</i>	Generic
	<i>niacin</i>	Generic
	<i>niacin ER</i>	Generic
	<i>omega-3 OTC Agents</i>	Generic
	<i>pravastatin</i>	Generic
	<i>simvastatin</i>	Generic
	ALTOPREV	Preferred Brand
	CRESTOR	Preferred Brand
	SIMCOR	Preferred Brand
	VYTORIN	Preferred Brand
Antihypertensive; Sympatholytic Agents:	Rx Only Coverage	Copay Tier
	<i>clonidine HCl oral</i>	Generic
	<i>clonidine HCl patch</i>	Generic
	<i>doxazosin mesylate</i>	Generic
	<i>guanabenz acetate</i>	Generic
	<i>guanfacine</i>	Generic

Antihypertensive; Sympatholytic Agents (Cont):	Rx Only Coverage	Copay Tier
	<i>methyldopa</i>	Generic
	<i>methyldopa/HCTZ</i>	Generic
	<i>prazosin HCl</i>	Generic
	<i>reserpine</i>	Generic
	<i>terazosin HCl</i>	Generic
	CARDURA XL	Non-preferred Brand
	CATAPRES-TTS	Non-preferred Brand
	CLORPRES	Non-preferred Brand
	KAPVAY	Non-preferred Brand
Antihypertensive: Vasodilator Agents:	Rx Only Coverage	Copay Tier
	<i>hydralazine HCl</i>	Generic
	<i>isosorbide dinitrate</i>	Generic
	<i>isosorbide mononitrate</i>	Generic
	<i>minoxidil</i>	Generic
	<i>nitroglycerin</i>	Generic
	BIDIL	Preferred Brand
	DILATRATE SR	Preferred Brand
Antihypertensive; ACE Inhibitor and ACE Combinations:	Rx Only Coverage	Copay Tier
	<i>benazepril</i>	Generic
	<i>benazepril/HCTZ</i>	Generic
	<i>benazepril/amlodipine</i>	Generic
	<i>captopril</i>	Generic
	<i>captopril/HCTZ</i>	Generic
	<i>enalapril maleate</i>	Generic
	<i>enalapril maleate/HCTZ</i>	Generic
	<i>fosinopril sodium</i>	Generic
	<i>fosinopril sodium/HCTZ</i>	Generic
	<i>lisinopril</i>	Generic
	<i>lisinopril/HCTZ</i>	Generic
	<i>moexipril HCl</i>	Generic
	<i>moexipril HCl/HCTZ</i>	Generic
	<i>perindopril erbumine</i>	Generic
	<i>quinapril HCl</i>	Generic
	<i>quinapril HCl/HCTZ</i>	Generic
	<i>ramipril</i>	Generic
	<i>trandolapril</i>	Generic
Antihypertensive; Calcium Channel Blocker & Combinations:	Rx Only Coverage	Copay Tier
	<i>amlodipine besylate</i>	Generic
	<i>diltiazem</i>	Generic
	<i>felodipine</i>	Generic
	<i>isradipine</i>	Generic
	<i>nifedipine</i>	Generic
	<i>nisoldipine</i>	Generic
	DYNACIRC CR	Non-preferred Brand
Antihypertensive; Beta-Adrenergic Blocking and Combinations:	Rx Only Coverage	Copay Tier
	<i>acebutolol HCl</i>	Generic

Antihypertensive; Beta-Adrenergic Blocking and Combos (Cont):	Rx Only Coverage	Copay Tier
	<i>atenolol</i>	Generic
	<i>atenolol/chlorthalidone</i>	Generic
	<i>betaxolol HCl</i>	Generic
	<i>bisoprolol fumarate</i>	Generic
	<i>bisoprolol fumarate/HCTZ</i>	Generic
	<i>carvedilol</i>	Generic
	<i>labetalol</i>	Generic
	<i>metoprolol succinate</i>	Generic
	<i>metoprolol tartrate</i>	Generic
	<i>metoprolol/HCTZ</i>	Generic
	<i>nadolol</i>	Generic
	<i>nadolol/bendroflumethiazide</i>	Generic
	<i>pindolol</i>	Generic
	<i>propranolol</i>	Generic
	<i>propranolol/HCTZ</i>	Generic
	<i>sotalol HCl</i>	Generic
	<i>timolol maleate</i>	Generic
	BYSTOLIC	Preferred Brand
	COREG CR	Preferred Brand
Antihypertensive; Angiotensin Receptor Binding (ARB):	Rx Only Coverage	Copay Tier
	candesartan	Generic
	<i>candesartan/HCTZ</i>	Generic
	<i>irbesartan</i>	Generic
	<i>irbesartan/HCTZ</i>	Generic
	<i>losartan potassium</i>	Generic
	<i>losartan potassium/HCTZ</i>	Generic
	<i>telmisartan</i>	Generic
	<i>telmisartan/amlodipine</i>	Generic
	<i>telmisartan/HCTZ</i>	Generic
	<i>valsartan/HCTZ</i>	Generic
	DIOVAN	Preferred Brand
Antihypertensive; Pulmonary Agents:	Rx Only Coverage	Copay Tier
	<i>epoprostenol sodium</i>	Generic
	REMODULIN	Preferred Brand
	TYVASO	Preferred Brand
	VENTAVIS	Preferred Brand
Antihypertensive; Diuretic Agents:	Rx Only Coverage	Copay Tier
	<i>amiloride HCl</i>	Generic
	<i>amiloride HCl/HCTZ</i>	Generic
	<i>bumetanide</i>	Generic
	<i>chlorothiazide</i>	Generic
	<i>chlorthalidone</i>	Generic
	<i>eplerenone</i>	Generic
	<i>furosemide</i>	Generic
	<i>hydrochlorothiazide (HCTZ)</i>	Generic
	<i>indapamide</i>	Generic

Antihypertensive; Diuretic Agents (Cont):	Rx Only Coverage	Copay Tier
	<i>metolazone</i>	Generic
	<i>spironolactone</i>	Generic
	<i>spironolactone/HCTZ</i>	Generic
	<i>toremide</i>	Generic
	<i>triamterene/HCTZ</i>	Generic
Antihypertensive; Other and Other Combinations:	Rx Only Coverage	Copay Tier
	<i>amlodipine/benazepril</i>	Generic
	<i>trandolapril/verapamil HCl</i>	Generic
	DEMSEER	Non-preferred Brand
	TARKA	Non-preferred Brand
Cardiovascular; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
	<i>isoxsuprine</i>	Generic
	RANEXA	Preferred Brand
Analgesic; NSAID and Combinations	Rx and OTC Coverage	Copay Tier
	<i>diclofenac IR and ER</i>	Generic
	<i>diclofenac; misoprostil</i>	Generic
	<i>etodolac</i>	Generic
	<i>flurbiprofen</i>	Generic
	<i>ibuprofen</i>	Generic
	<i>indomethacin</i>	Generic
	<i>ketoprofen</i>	Generic
	<i>ketorolac</i>	Generic
	<i>meclofenamate sodium</i>	Generic
	<i>meloxicam</i>	Generic
	<i>nabumetone</i>	Generic
	<i>naproxen sodium</i>	Generic
	<i>oxaprozin</i>	Generic
	<i>piroxicam</i>	Generic
	<i>sulindac</i>	Generic
	<i>tolmetin sodium</i>	Generic
	CELEBREX	Preferred Brand
	VIMOVO	Preferred Brand
	CATAFLAM	Non-preferred Brand
	FLECTOR PATCH	Non-preferred Brand
	SAVELLA	Non-preferred Brand
Analgesic; Narcotic Agents:	Rx Only Coverage	Copay Tier
Notes: <i>All fentanyl buccal (oral) agents are subject to a prior authorization or clinical drug review for appropriate use of these medications.</i>	<i>buprenorphine HCl</i>	Generic
	<i>buprenorphine/naloxone SL</i>	Generic
	<i>butorphanol tartrate</i>	Generic
<i>There are strict quantity limits in place for all extended release narcotic medications as well as prior authorization requirements for all narcotics to ensure proper use.</i>	<i>codeine sulfate</i>	Generic
	<i>fentanyl citrate</i>	Generic
	<i>hydromorphone HCl</i>	Generic
	<i>levorphanol tartrate</i>	Generic
	<i>meperidine</i>	Generic
	<i>methadone HCl</i>	Generic
	<i>morphine sulfate IR and ER</i>	Generic

Analgesic; Narcotic Agents (Cont):	Rx Only Coverage	Copay Tier
<p>Notes: All fentanyl buccal (oral) agents are subject to a prior authorization or clinical drug review for appropriate use of these medications.</p> <p>There are strict quantity limits in place for all extended release narcotic medications as well as prior authorization requirements for all narcotics to ensure proper use.</p>	<i>oxycodone HCl</i>	Generic
	<i>oxymorphone</i>	Generic
	<i>oxymorphone ER</i>	Generic
	<i>tramadol/tramadol ER</i>	Generic
	OPANA ER	Preferred Brand
	OXYCONTIN	Preferred Brand
	SUBOXONE FILM	Preferred Brand
	ACTIQ	Non-preferred Brand
	AVINZA	Non-preferred Brand
	EXALGO	Non-preferred Brand
Analgesic; Narcotic Combination Agents:	Rx Only Coverage	Copay Tier
	<i>acetaminophen/butalbital</i>	Generic
	<i>acetaminophen/butalbital/caffeine</i>	Generic
	<i>acetaminophen/tramadol</i>	Generic
	<i>aspirin/butalbital/caffeine</i>	Generic
	<i>carisoprodol/aspirin/codeine</i>	Generic
	<i>codeine phosphate/acetaminophen</i>	Generic
	<i>codeine phosphate/aspirin</i>	Generic
	<i>codeine/APAP/butalbital/caffeine</i>	Generic
	<i>hydrocodone/acetaminophen</i>	Generic
	<i>hydrocodone/ibuprofen</i>	Generic
	<i>oxycodone HCl/acetaminophen</i>	Generic
	<i>oxycodone HCl/aspirin</i>	Generic
	<i>oxycodone/ibuprofen</i>	Generic
CAPITAL/CODEINE	Non-preferred Brand	
Analgesic; Non-Salicylate, Non-Narcotic Agents:	Rx and OTC Coverage	Copay Tier
	<i>acetaminophen</i>	Generic
	<i>clonidine</i>	Generic
	<i>ibuprofen</i>	Generic
Analgesic; Salicylate, Non-Narcotic Agents:	Rx and OTC Coverage	Copay Tier
	<i>aspirin</i>	Generic
	<i>aspirin buffered</i>	Generic
	<i>aspirin enteric coated</i>	Generic
	<i>butalbital</i>	Generic
	<i>butalbital/aspirin</i>	Generic
Analgesic; Gout Therapy Agents:	Rx Only Coverage	Copay Tier
	<i>allopurinol</i>	Generic
	ULORIC	Non-preferred Brand
Analgesic; Migraine Headache Pain:	Rx Only Coverage	Copay Tier
	<i>dihydroergotamine mesylate</i>	Generic
	<i>ergotamine tartrate/caffeine</i>	Generic
	<i>naratriptan HCl</i>	Generic
	<i>rizatriptan</i>	Generic
	<i>sumatriptan succinate</i>	Generic
	<i>zoledronic acid injection</i>	Generic

Analgesic; Migraine Headache Pain (Cont):	Rx Only Coverage	Copay Tier
	<i>zolmitriptan</i>	Generic
	ERGOMAR	Preferred Brand
	RELPAK	Preferred Brand
	TREMIMET	Preferred Brand
Anticonvulsant; Epilepsy & Neuropathic Pain Agents:	Rx Only Coverage	Copay Tier
<p>Notes: <i>This therapeutic category is exempt from copayments.</i></p> <p><i>There is a step therapy program in place for Lyrica, requiring the use of generic gabapentin for all indications other than seizure control.</i></p>	<i>benztropine HCl</i>	Exempt
	<i>carbamazepine</i>	Exempt
	<i>clonazepam</i>	Exempt
	<i>diazepam rectal gel</i>	Exempt
	<i>divalproex sodium</i>	Exempt
	<i>ethosuximide</i>	Exempt
	<i>felbamate</i>	Exempt
	<i>gabapentin</i>	Exempt
	<i>klonopin</i>	Exempt
	<i>lamotrigine</i>	Exempt
	<i>levetiracetam IR & ER</i>	Exempt
	<i>oxcarbazepine</i>	Exempt
	<i>phenobarbital</i>	Exempt
	<i>phenytoin sodium</i>	Exempt
	<i>primidone</i>	Exempt
	<i>tiagabine HCl</i>	Exempt
	<i>topiramate</i>	Exempt
	<i>trihexyphenidyl HCl</i>	Exempt
	<i>valproic acid</i>	Exempt
	<i>zonisamide</i>	Exempt
	BANZEL	Exempt
	CELONTIN	Exempt
	DIASTAT ACUDIAL	Exempt
	EQUETRO	Exempt
	FELBATOL	Exempt
	GABITRIL	Exempt
	LYRICA	Exempt
	OXTELLAR XR	Exempt
	POTIGA	Exempt
	TROKENDI	Exempt
	VIMPAT	Exempt
Multiple Sclerosis Agents:	Rx Only Coverage	Copay Tier
	AVONEX	Preferred Brand
	COPAXONE	Preferred Brand
	EXTAVIA	Preferred Brand
	GILENYA	Preferred Brand
	REBIF	Preferred Brand
	REBIF TITRATION PACK	Preferred Brand
	AUBAGIO	Non-preferred Brand
	BETASERON	Non-preferred Brand

Antidepressant; Tricyclic Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>amitriptyline</i>	Exempt
	<i>amitriptyline/chlordiazepoxide</i>	Exempt
	<i>amitriptyline/perphenazine</i>	Exempt
	<i>amoxapine</i>	Exempt
	<i>clomipramine HCl</i>	Exempt
	<i>desipramine HCl</i>	Exempt
	<i>doxepin HCl</i>	Exempt
	<i>imipramine HCl</i>	Exempt
	<i>imipramine pamoate</i>	Exempt
	<i>nortriptyline HCl</i>	Exempt
	<i>protriptyline HCl</i>	Exempt
	<i>trimipramine maleate</i>	Exempt
Antidepressant; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>budeprion</i>	Exempt
	<i>bupropion HCL</i>	Exempt
	<i>desvenlafaxine</i>	Exempt
	<i>duloxetine</i>	Exempt
	<i>mirtazapine</i>	Exempt
	<i>venlafaxine HCl</i>	Exempt
	PRISTIQ	Exempt
Antidepressant; MAO Inhibitor Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>phenelzine sulfate</i>	Exempt
	<i>tranylcypromine sulfate</i>	Exempt
	EMSAM	Exempt
	MARPLAN	Exempt
Antidepressant; Selective Serotonin Reuptake Inhibitor (SSRI):	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>citalopram hydrobromide</i>	Exempt
	<i>escitalopram</i>	Exempt
	<i>fluoxetine</i>	Exempt
	<i>fluoxetine; olanzapine</i>	Exempt
	<i>fluvoxamine maleate</i>	Exempt
	<i>paroxetine HCl</i>	Exempt
	<i>sertraline HCl</i>	Exempt
	PEXEVA	Exempt
	SARAFEM	Exempt
Antipsychotic; Phenothiazine Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>chlorpromazine HCl</i>	Exempt
	<i>fluphenazine deconate</i>	Exempt
	<i>fluphenazine HCl</i>	Exempt
	<i>perphenazine</i>	Exempt
	<i>thioridazine HCl</i>	Exempt
	<i>trifluoperazine HCl</i>	Exempt
Antipsychotic; Miscellaneous Antipsychotic Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>clozapine</i>	Exempt
	<i>haloperidol</i>	Exempt
	<i>lithium carbonate</i>	Exempt

Antipsychotic; Miscellaneous Antipsychotic Agents (Cont):	Rx Only Coverage	Copay Tier
<p>Notes: This therapeutic category is exempt from copayments.</p>	<i>lithium citrate</i>	Exempt
	<i>loxapine</i>	Exempt
	<i>olanzapine</i>	Exempt
	<i>olanzapine; fluoxetine</i>	Exempt
	<i>quetiapine IR</i>	Exempt
	<i>risperidone</i>	Exempt
	<i>thiothixene</i>	Exempt
	<i>ziprasidone</i>	Exempt
	ABILIFY	Exempt
	EQUETRO	Exempt
	FANAPT	Exempt
	INVEGA	Exempt
	LATUDA	Exempt
	ORAP	Exempt
	SEROQUEL XR	Exempt
	SYMBYAX	Exempt
	VIIBRYD	Exempt
	MOBAN	Non-preferred Brand
Psychotherapeutic; Hypnotic Agents:	Rx and OTC Coverage	Copay Tier
<p>Notes: This therapeutic category is exempt from copayments.</p> <p>All brand name agents in this class are considered non-formulary and generic medications are covered in this class.</p>	<i>chloral hydrate</i>	Exempt
	<i>diphenhydramine HCl</i>	Exempt
	<i>estazolam</i>	Exempt
	<i>flurazepam</i>	Exempt
	<i>hydroxyzine HCl</i>	Exempt
	<i>hydroxyzine pamoate</i>	Exempt
	<i>lorazepam</i>	Exempt
	<i>temazepam</i>	Exempt
	<i>triazolam</i>	Exempt
	<i>zaleplon</i>	Exempt
	<i>zolpidem tartrate</i>	Exempt
	GNP NIGHTTIME SLEEP AID	Exempt
Psychotherapeutic; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
<p>Notes: Xyrem is subject to a prior authorization or clinical drug review to help ensure appropriate utilization.</p>	<i>amphetamine/dextroamphetamine</i>	Generic
	<i>dexmethylphenidate HCl IR & ER</i>	Generic
	<i>dextroamphetamine sulfate</i>	Generic
	<i>lithium carbonate</i>	Generic
	<i>lithium citrate</i>	Generic
	<i>methamphetamine HCl</i>	Generic
	<i>methylphenidate HCl</i>	Generic
	<i>modafinil</i>	Generic
	DAYTRANA	Preferred Brand
	INTUNIV	Preferred Brand
	STRATTERA	Preferred Brand
	VYVANSE	Preferred Brand
	XYREM	Preferred Brand

Antianxiety; Anxiolytic Agents:	Rx Only Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>alprazolam</i>	Exempt
	<i>buspirone HCl</i>	Exempt
	<i>chlordiazepoxide HCl</i>	Exempt
	<i>clorazepate dipotassium</i>	Exempt
	<i>diazepam</i>	Exempt
	<i>diazepam rectal gel</i>	Exempt
	<i>lorazepam</i>	Exempt
	<i>oxazepam</i>	Exempt
Dermatologicals; Corticosteroid Topical Agents	Rx and OTC Coverage	Copay Tier
	<i>alclometasone dipropionate</i>	Generic
	<i>amcinonide</i>	Generic
	<i>betamethasone dipropionate</i>	Generic
	<i>betamethasone dipropionate/propylene glycol</i>	Generic
	<i>betamethasone valerate</i>	Generic
	<i>clobetasol propionate</i>	Generic
	<i>clobetasol propionate/emollient</i>	Generic
	<i>desonide</i>	Generic
	<i>desoximetasone</i>	Generic
	<i>desoximetasone</i>	Generic
	<i>diflorasone diacetate</i>	Generic
	<i>fluocinonide</i>	Generic
	<i>fluocinonide/emollient</i>	Generic
	<i>fluocinolone acetonide</i>	Generic
	<i>fluticasone propionate</i>	Generic
	<i>halobetasol propionate</i>	Generic
	<i>hydrocortisone</i>	Generic
	<i>mometasone furoate</i>	Generic
<i>triamcinolone acetonide</i>	Generic	
CORDRAN TAPE	Non-preferred Brand	
Dermatologicals; Topical Anesthetic Agents:	Rx Only Coverage	Copay Tier
Notes: <i>Lidoderm/lidocaine pad is subject to a prior authorization or clinical drug review to help ensure appropriate utilization.</i>	<i>hydrocortisone acetate/lidocaine HCl</i>	Generic
	<i>lidocaine HCl</i>	Generic
	<i>lidocaine Pad 5%</i>	Generic
Dermatologicals; Acne Therapy Agents:	Rx Only Coverage	Copay Tier
Notes: <i>All brand name topical tretinoin and clindamycin agents are considered as non-formulary, generic topical agents are covered in these categories.</i>	<i>benzoyl peroxide</i>	Generic
	<i>clindamycin phosphate</i>	Generic
	<i>erythromycin base/benzoyl peroxide</i>	Generic
	<i>erythromycin base/ethyl alcohol</i>	Generic
	<i>isotretinoin</i>	Generic
	<i>metronidazole cream</i>	Generic
	<i>sulfacetamide sodium</i>	Generic
	<i>sulfacetamide sodium/sulfur</i>	Generic
	<i>tretinoin topical</i>	Generic
	FINACEA	Preferred Brand
	METROGEL 1%	Preferred Brand
	TAZORAC	Preferred Brand

Dermatologicals; Acne Therapy Agents (Cont):	Rx Only Coverage	Copay Tier
Notes: <i>All brand name topical tretinoin and clindamycin agents are considered as non-formulary, generic topical agents are covered in these categories.</i>	AMNESTEEM (ORAL)	Non-preferred Brand
	CLARAVIS (ORAL)	Non-preferred Brand
	SOTRET (ORAL)	Non-preferred Brand
	ZODERM	Non-preferred Brand
Dermatologicals; Topical Antibacterial Agents:	Rx Only Coverage	Copay Tier
	<i>gentamicin sulfate</i>	Generic
	<i>mupirocin ointment</i>	Generic
	<i>sulfacetamide sodium</i>	Generic
	ALTABAX	Preferred Brand
	BACTROBAN NASAL	Preferred Brand
Dermatologicals; Topical Antifungal Agents:	Rx and OTC Coverage	Copay Tier
	<i>ciclopirox</i>	Generic
	<i>clotrimazole/betamethasone</i>	Generic
	<i>econazole nitrate</i>	Generic
	<i>ketoconazole</i>	Generic
	<i>nystatin</i>	Generic
	<i>nystatin/triamcinolone</i>	Generic
	CARRINGTON ANTIFUNGAL	Generic
	CLOTRIMAZOLE ANTI-FUNGAL	Generic
	CLOTRIMAZOLE/BETAMETHASON	Generic
	GNP ATHLETES FOOT	Generic
	GNP TERBINAFINE HYDROCHLO	Generic
	LAMISIL AF DEFENSE	Generic
	LAMISIL AT	Generic
	SM ANTIFUNGAL CLOTRIMAZOL	Generic
	SM ANTIFUNGAL TOLNAFTATE	Generic
	SM ATHLETES FOOT	Generic
	EXELDERM	Preferred Brand
	MENTAX	Preferred Brand
	ERTACZO	Non-preferred Brand
OXISTAT	Non-preferred Brand	
XOLEGEL	Non-preferred Brand	
Dermatologicals; Topical Antiviral Agents:	Rx and OTC Coverage	Copay Tier
	ABREVA	Generic
	<i>acyclovir</i>	Generic
	DENAVIR	Non-preferred Brand
Dermatologicals; Topical Burn Therapy Agents:	Rx Only Coverage	Copay Tier
	<i>silver sulfadiazine</i>	Generic
Dermatologicals; Topical Enzyme (Wound Healing) Agents:	Rx Only Coverage	Copay Tier
Notes: <i>Regranex is subject to a prior authorization or clinical drug review to help ensure appropriate utilization.</i>	<i>trypsin/balsam peru/castor oil</i>	Generic
	REGRANEX	Non-preferred Brand
	SANTYL	Non-preferred Brand
Dermatologicals; Antipsoriatic Agents:	Rx Only Coverage	Copay Tier
	<i>Acitretin</i>	Generic
	<i>calcipotriene</i>	Generic
	<i>hydrocortisone acetate/pramoxine HCl</i>	Generic

Dermatologicals; Antipsoriatic Agents (Cont):	Rx Only Coverage	Copay Tier
	<i>selenium sulfide</i>	Generic
	<i>sulfacetamide sodium</i>	Generic
	TAZORAC	Non-preferred Brand
Dermatologicals; Topical Scabicide Agents:	Rx and OTC Coverage	Copay Tier
	<i>lindane</i>	Generic
	<i>malathion</i>	Generic
	<i>permethrin</i>	Generic
	GNP LICE TREATMENT	Generic
	LICE KILLING	Generic
	LICE KILLING SHAMPOO MAXI	Generic
	LICE TREATMENT CREME RINS	Generic
	PERMETHRIN	Generic
	SM LICE TREATMENT	Generic
	EURAX	Preferred Brand
	ULESFIA	Preferred Brand
Dermatologicals; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
	<i>aluminum chloride</i>	Generic
	<i>ammonium lactate</i>	Generic
	<i>dibezyline/padimate O/hydroquinone</i>	Generic
	<i>diclofenac gel</i>	Generic
	<i>fluorouracil solution</i>	Generic
	<i>hydroquinone</i>	Generic
	<i>imiquimod</i>	Generic
	<i>podofilox</i>	Generic
	<i>urea</i>	Generic
	CARAC	Preferred Brand
	EFUDEX	Preferred Brand
	PANRETIN	Preferred Brand
Gastroenterology; Antivertigo/Antiemetic Agents:	Rx and OTC Coverage	Copay Tier
	<i>dimenhydrinate</i>	Generic
	<i>granisetron HCL</i>	Generic
	<i>meclizine HCl</i>	Generic
	<i>ondansetron HCl</i>	Generic
	<i>prochlorperazine</i>	Generic
	<i>promethazine HCl</i>	Generic
	<i>trimethobenzamide HCl</i>	Generic
	ANZEMET	Preferred Brand
	SANCUSO	Preferred Brand
	TRANSDERM-SCOP	Preferred Brand
Gastroenterology; Antacid Agents:	OTC Coverage	Copay Tier
	ACID GONE	Generic
	ANTACID ANTI-GAS MAXIMUM	Generic
	ANTACID ANTI-GAS REGULAR	Generic
	ANTACID/ANTI-GAS	Generic
	CALCIUM ANTACID EXTRA STR	Generic
	CHEWABLE ANTACID	Generic

Gastroenterology; Antacid Agents (Cont):	OTC Coverage	Copay Tier
	<i>GAVISCON EXTRA STRENGTH R</i>	Generic
	<i>MAALOX ADVANCED</i>	Generic
	<i>MAALOX ADVANCED MAXIMUM S</i>	Generic
	<i>MAALOX CHILDRENS</i>	Generic
	<i>MAALOX MAX</i>	Generic
	<i>MAALOX REGULAR STRENGTH</i>	Generic
	<i>SODIUM BICARBONATE</i>	Generic
	<i>TUMS</i>	Generic
	<i>TUMS CALCIUM FOR LIFE BON</i>	Generic
	<i>TUMS E-X 750</i>	Generic
	<i>TUMS KIDS</i>	Generic
	<i>TUMS SMOOTHIES</i>	Generic
	<i>TUMS ULTRA 1000</i>	Generic
Gastroenterology; Histamine 2 Reducing Agents:	Rx and OTC Coverage	Copay Tier
	<i>cimetidine HCl</i>	Generic
	<i>famotidine</i>	Generic
	<i>nizatidine</i>	Generic
	<i>ranitidine HCl</i>	Generic
Gastroenterology; Proton Pump Reducing Agents:	Rx and OTC Coverage	Copay Tier
Notes: <i>Effective 5-15-2013 all brand name agents in this class of medications are non-formulary, unless medical necessity can be demonstrated.</i>	<i>esomeprazole injection</i>	Generic
	<i>lansoprazole</i>	Generic
	<i>lansoprazole/amoxicillin/clarithromycin</i>	Generic
	<i>omeprazole</i>	Generic
	<i>omeprazole/sodium bicarbonate</i>	Generic
	<i>pantoprazole</i>	Generic
	<i>PREVACID 24HR</i>	Generic
	<i>PRILOSEC OTC</i>	Generic
	<i>rabeprazole</i>	Generic
Gastroenterology; Other Ulcer Therapy:	Rx Only Coverage	Copay Tier
	<i>misoprostol</i>	Generic
	<i>sucralfate</i>	Generic
	<i>CARAFATE</i>	Preferred Brand
	<i>PYLERA</i>	Preferred Brand
Gastroenterology; Antidiarrheal Agents:	Rx and OTC Coverage	Copay Tier
	<i>diphenoxylate/atropine sulfate</i>	Generic
	<i>loperamide HCl</i>	Generic
	<i>BISMATROL</i>	Generic
	<i>KAOPECTATE</i>	Generic
	<i>PINK BISMUTH</i>	Generic
Gastroenterology; Laxative/Cathartic Agents:	Rx and OTC Coverage	Copay Tier
	<i>docusate sodium</i>	Generic
	<i>BISACODYL EC</i>	Generic
	<i>CITRUCEL</i>	Generic
	<i>EX-LAX ULTRA</i>	Generic

Gastroenterology; Laxative/Cathartic Agents (Cont):	Rx and OTC Coverage	Copay Tier
	<i>FIBER TABS</i>	Generic
	<i>FIBERCON</i>	Generic
	<i>GENFIBER</i>	Generic
	<i>lactulose</i>	Generic
	<i>MILK OF MAGNESIA</i>	Generic
	<i>PEGYLAX POWDER</i>	Generic
	<i>SENNA CONCENTRATE</i>	Generic
	<i>STOOL SOFTENER</i>	Generic
	AMITIZA	Preferred Brand
	HALFLYTELY BOWEL PREP	Preferred Brand
Gastroenterology; Antispasmodic Agents:	Rx Only Coverage	Copay Tier
	<i>dicyclomine HCl</i>	Generic
	<i>glycopyrrolate</i>	Generic
	<i>hyoscyamine</i>	Generic
	<i>methscopolamine</i>	Generic
Gastroenterology; Bile Salts:	Rx Only Coverage	Copay Tier
	<i>ursodiol</i>	Generic
	ACTIGALL	Non-preferred Brand
	CHENODAL	Non-preferred Brand
	URSO FORTE	Non-preferred Brand
Gastroenterology; Digestive Enzymes:	Rx Only Coverage	Copay Tier
	<i>amylase/lipase/protease</i>	Generic
	CREON	Preferred Brand
	PANCREAZE DR	Preferred Brand
	PERTZYE	Preferred Brand
	ULTRASE	Preferred Brand
	VIOKACE	Preferred Brand
	ZENPEP	Preferred Brand
Gastroenterology; Irritable Bowel Syndrome & Miscellaneous:	Rx Only Coverage	Copay Tier
	<i>balsalazide disodium</i>	Generic
	<i>budesonide</i>	Generic
	<i>mesalamine</i>	Generic
	<i>sulfasalazine</i>	Generic
	APRISO	Preferred Brand
	ASACOL HD	Preferred Brand
	CANASA	Preferred Brand
	LOTRONEX	Preferred Brand
	PENTASA	Preferred Brand
	RELISTOR	Preferred Brand
Gastroenterology; Electrolyte Agents:	Rx and OTC Coverage	Copay Tier
	MAGNEBIND 300	Generic
	FOSRENOL	Preferred Brand
	REVELA	Preferred Brand
	RENAGEL	Non-preferred Brand

Obstetrics; Contraceptives, Oral, Injectable, Vaginal & Topical :
Notes:

This therapeutic category is exempt from copayments.

All brand name oral contraceptives are considered non-formulary requiring the use and failure of generics before a brand name agent will be considered for use.

Rx Only Coverage
Copay Tier

APRI	Exempt
ARANELLE	Exempt
AUBRA	Exempt
AVIANE	Exempt
AZURETTE	Exempt
BALZIVA	Exempt
BREVICON-28	Exempt
CAMILA	Exempt
CAMRESE	Exempt
CAZIANT	Exempt
CESIA	Exempt
CRYSSELLE-28	Exempt
CYCLESSA	Exempt
DESOGEN	Exempt
<i>drospirenone/ethinyl estradiol</i>	Exempt
ENPRESSE-28	Exempt
ENSKYCE	Exempt
ERRIN	Exempt
FALMINA	Exempt
GIANVI	Exempt
GILDESS FE 1.5/30	Exempt
GILDESS FE 1/20	Exempt
JENCYLA	Exempt
JOLESSA	Exempt
JOLIVETTE	Exempt
JUNEL 1.5/30	Exempt
JUNEL 1/20	Exempt
JUNEL FE 1.5/30	Exempt
JUNEL FE 1/20	Exempt
KARIVA	Exempt
KELNOR 1/35	Exempt
LARIN 1/20	Exempt
LARIN FE	Exempt
LESSINA-28	Exempt
LEVLEN CONTRACT PACK	Exempt
<i>levonorgestrel</i>	Exempt
LEVORA 0.15/30-28	Exempt
LUTERA	Exempt
LYZA	Exempt
MARLISSA	Exempt
MIRCETTE	Exempt
MONONESSA	Exempt
MY WAY	Exempt
MYZILRA	Exempt
NATAZIA	Exempt
NORGESTREL/ETHINYL ESTRAD	Exempt

Obstetrics; Contraceptives, Oral, Inj, Vaginal & Topical (Cont):	Rx Only Coverage	Copay Tier
<p>Notes: <i>This therapeutic category is exempt from copayments.</i></p> <p><i>All brand name oral contraceptives are considered non-formulary requiring the use and failure of generics before a brand name agent will be considered for use.</i></p>	NOR-QD	Exempt
	OCELLA	Exempt
	PIRMELLA 7/7/7 & 1/35	Exempt
	PORTIA-28	Exempt
	PREVIFEM	Exempt
	PIMTREA	Exempt
	QUASENSE	Exempt
	RECLIPSEN	Exempt
	SPRINTEC 28	Exempt
	TILIA FE	Exempt
	TRI-LEGEST FE	Exempt
	TRI-LINYAH	Exempt
	TRI-LO-SPRINTEC	Exempt
	VIORELE	Exempt
	VYFEMLA	Exempt
	WERA	Exempt
	ZENCHENT FE Chew	Exempt
	ZOVIA 1/35E	Exempt
	ZOVIA 1/50E	Exempt
	PLAN B	Exempt
	PLAN B ONE-STEP	Exempt
MEDROXYPROGESTERONE ACETA	Exempt	
NUVARING	Exempt	
ORTHO EVRA	Exempt	
ORTHO TRI-CYCLEN LO	Exempt	
Obstetrics; Estrogen & Progesterone Agents:	Rx Only Coverage	Copay Tier
	<i>estradiol</i>	Generic
	<i>estropipate</i>	Generic
	<i>medroxyprogesterone acetate</i>	Generic
	<i>norethindrone</i>	Generic
	<i>progesterone</i>	Generic
	CENESTIN	Preferred Brand
	CLIMARA	Preferred Brand
	CLIMARA PRO	Preferred Brand
	DIVIGEL	Preferred Brand
	ENJUVA	Preferred Brand
	ESTRACE VAGINAL CREAM	Preferred Brand
	EVAMIST	Preferred Brand
	PREMARIN	Preferred Brand
	PREMARIN VAGINAL	Preferred Brand
	Obstetrics; Estrogen Combination Agents:	Rx Only Coverage
	<i>estrogens, esterofied/methyltestosterone</i>	Generic
	<i>estradiol/norethindrone</i>	Generic
	COMBIPATCH	Preferred Brand
	PREMPHASE	Preferred Brand
	PREMPRO	Preferred Brand

Obstetrics; Vaginal Antibiotic/Antifungal Agents:	Rx and OTC Coverage	Copay Tier
	<i>clindamycin phosphate vaginal</i>	Generic
	<i>clotrimazole vaginal</i>	Generic
	GNP MICONAZOLE 7	Generic
	<i>metronidazole vaginal</i>	Generic
	<i>miconazole vaginal</i>	Generic
	MICONAZOLE 1	Generic
	MICONAZOLE 3	Generic
	MICONAZOLE 7	Generic
	<i>nystatin vaginal</i>	Generic
	AVC	Preferred Brand
	VAGIFEM	Preferred Brand
Obstetrics; Specialized OB/GYN Agents:	Rx Only Coverage	Copay Tier
	<i>leuprolide acetate</i>	Generic
	LUPRON DEPOT	Preferred Brand
	LUPRON DEPOT-PED	Preferred Brand
	SYNAREL	Preferred Brand
Ophthalmology; Beta-blocker Agents:	Rx Only Coverage	Copay Tier
	<i>betaxolol HCl</i>	Generic
	<i>carteolol HCl</i>	Generic
	<i>levobunolol HCl</i>	Generic
	<i>metipranolol</i>	Generic
	<i>timolol maleate</i>	Generic
	BETOPTIC-S	Preferred Brand
Ophthalmology; Cholinesterase Inhibitor Agents:	Rx Only Coverage	Copay Tier
	<i>phospholine iodide</i>	Generic
Ophthalmology; Direct Acting Miotic Agents:	Rx Only Coverage	Copay Tier
	<i>pilocarpine HCl</i>	Generic
	PILOPINE HS	Non-preferred Brand
Ophthalmology; Other Glaucoma Agents:	Rx Only Coverage	Copay Tier
	<i>dorzolamide HCl</i>	Generic
	<i>dorzolamide HCl/timolol maleate</i>	Generic
	<i>travaprost</i>	Generic
	AZOPT	Preferred Brand
	ISOPTO CARBACHOL	Preferred Brand
	LUMIGAN	Preferred Brand
	TRAVATAN Z	Preferred Brand
	SIMBRINZA	Non-preferred Brand
Ophthalmology; Cycloplegic Mydriatic Agents:	Rx Only Coverage	Copay Tier
	<i>atropine sulfate</i>	Generic
	<i>cyclopentolate HCl</i>	Generic
	<i>homatropine hydrobromide</i>	Generic
	<i>procarinamide</i>	Generic
Ophthalmology; Non-steroidal anti-inflammatory Agents:	Rx Only Coverage	Copay Tier
	<i>diclofenac sodium</i>	Generic
	<i>flurbiprofen sodium</i>	Generic
	<i>ketorolac tromethamine</i>	Generic

Ophthalmology; Non-steroidal anti-inflammatory Agents (Cont):	Rx Only Coverage	Copay Tier
	FML LIQUIFILM	Non-preferred Brand
	NEVANAC	Non-preferred Brand
	PROLENSA	Non-preferred Brand
Ophthalmology; Vasoconstrictor Agents:	Rx Only Coverage	Copay Tier
	<i>naphazoline HCl</i>	Generic
	<i>phenylephrine HCl</i>	Generic
	AK-CON	Non-preferred Brand
	MYDFRIN	Non-preferred Brand
Ophthalmology; Antibiotic Agents:	Rx Only Coverage	Copay Tier
	<i>bacitracin</i>	Generic
	<i>bacitracin/neomycin/polymyxin</i>	Generic
	<i>bacitracin/polymyxin B</i>	Generic
	<i>ciprofloxacin HCl</i>	Generic
	<i>erythromycin</i>	Generic
	<i>gatifloxacin</i>	Generic
	<i>gentamicin sulfate</i>	Generic
	<i>ofloxacin</i>	Generic
	<i>polymyxin B sulfate/trimethoprim</i>	Generic
	<i>sulfacetamide sodium</i>	Generic
	<i>tobramycin sulfate</i>	Generic
	BESIVANCE	Preferred Brand
	CILOXAN	Preferred Brand
	NATACYN	Preferred Brand
	TOBEX OINTMENT	Preferred Brand
	VIGAMOX	Preferred Brand
Ophthalmology; Sulfonamide Antibacterial Agents:	Rx Only Coverage	Copay Tier
	<i>sulfacetamide sodium</i>	Generic
	BLEPH-10	Non-preferred Brand
	BLEPHAMIDE	Non-preferred Brand
	BLEPHAMIDE S.O.P.	Non-preferred Brand
Ophthalmology; Steroid Agents:	Rx Only Coverage	Copay Tier
	<i>dexamethasone sodium phosphate</i>	Generic
	<i>fluorometholone</i>	Generic
	<i>prednisolone acetate</i>	Generic
	<i>prednisolone sodium phosphate</i>	Generic
	ALREX	Preferred Brand
	FML S.O.P.	Preferred Brand
	LOTEMAX	Preferred Brand
	OZURDEX	Preferred Brand
	PRED MILD	Preferred Brand
	RETISERT	Preferred Brand
Ophthalmology; Steroid Antibiotic Combination Agents:	Rx Only Coverage	Copay Tier
	<i>neomycin/bacitracin/polymyxin/hydrocortisone</i>	Generic
	<i>neomycin/polymyxin/hydrocortisone</i>	Generic
	<i>neomycin/polymyxin/dexamethasone</i>	Generic

Ophthalmology; Steroid Antibiotic Combination Agents (Cont):	Rx Only Coverage	Copay Tier
	<i>sulfacetamide/prednisolone sodium</i>	Generic
	<i>tobramycin sulfate/dexamethasone</i>	Generic
	TOBRADEX OINTMENT	Preferred Brand
	ZYLET	Preferred Brand
Ophthalmology; Sympathomimetic Agents:	Rx Only Coverage	Copay Tier
	<i>apraclonidine HCl</i>	Generic
	<i>Brimonidine tartrate</i>	Generic
	<i>dipivefrin HCl</i>	Generic
	ALPHAGAN P	Preferred Brand
Ophthalmology; Antiviral Agents:	Rx Only Coverage	Copay Tier
	<i>trifluridine</i>	Generic
	VIROPTIC	Non-preferred Brand
Ophthalmology; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
Notes: <i>There is a step therapy program in place for the antihistamine agents requiring the use of generics first. For Restasis the patient must have used and failed artificial tears and gels.</i>	<i>azelastine HCl</i>	Generic
	<i>cromolyn sodium</i>	Generic
	<i>epinastine</i>	Generic
	<i>ketotifen</i>	Generic
	LUCENTIS	Preferred Brand
	PATADAY	Preferred Brand
	PATANOL	Preferred Brand
	RESTASIS	Preferred Brand
Ophthalmology; Artificial Tears/Hydrating Agents:	Rx Only Coverage	Copay Tier
	AKWA TEARS	Generic
	ARTIFICIAL TEARS	Generic
	DRY EYES	Generic
	HYPOTEARs	Generic
	ISOPTO TEARS	Generic
	LIQUITEARS	Generic
	OPTIVE SENSITIVE	Generic
	REFRESH DRY EYE THERAPY	Generic
	TEARS NATURALE	Generic
	TEARS RENEWED	Generic
	LACRISERT	Preferred Brand
Otic Preparations; Steroid, Antibiotic & Miscellaneous:	Rx Only Coverage	Copay Tier
	<i>acetic acid solution</i>	Generic
	<i>acetic acid/aluminum acetate</i>	Generic
	<i>acetic acid/hydrocortisone</i>	Generic
	<i>antipyrine/benzocaine/glycerin</i>	Generic
	<i>benzocaine</i>	Generic
	<i>ofloxacin</i>	Generic
	<i>hydrocortisone/pramoxine/chloroxylonol</i>	Generic
	<i>neomycin/polymyxin/hydrocortisone</i>	Generic
	MURO 128	Generic
	SODIUM CHLORIDE	Generic
	CIPRODEX	Preferred Brand

Endocrine; Antithyroid Agents:	Rx Only Coverage	Copay Tier
	<i>methimazole</i>	Generic
	<i>propylthiouracil</i>	Generic
	TAPAZOLE	Non-preferred Brand
Endocrine; Thyroid Hormone Agents:	Rx Only Coverage	Copay Tier
	<i>levothyroxine sodium</i>	Generic
	<i>liothyronine sodium</i>	Generic
	<i>thyroid</i>	Generic
	LEVOXYL	Generic
	ARMOUR THYROID	Non-preferred Brand
	THYROLAR	Non-preferred Brand
	TIROSINT	Non-preferred Brand
Endocrine; Adrenal Hormone Agents:	Rx Only Coverage	Copay Tier
	<i>cortisone acetate</i>	Generic
	<i>dexamethasone</i>	Generic
	<i>fludrocortisone acetate</i>	Generic
	<i>hydrocortisone</i>	Generic
	<i>methylprednisolone</i>	Generic
	<i>prednisolone sodium phosphate</i>	Generic
	<i>prednisone</i>	Generic
	CELESTONE	Non-preferred Brand
	CORTEF	Non-preferred Brand
	DEPO-MEDROL	Non-preferred Brand
	KENALOG-10	Non-preferred Brand
	KENALOG-40	Non-preferred Brand
	PEDIAPRED	Non-preferred Brand
Endocrine; Androgens General:	Rx Only Coverage	Copay Tier
	<i>megestrol acetate</i>	Generic
	MEGACE ES	Non-preferred Brand
Endocrine; Antiandrogen Agents:	Rx Only Coverage	Copay Tier
	<i>bicalutamide</i>	Generic
	<i>flutamide</i>	Generic
	CASODEX	Non-preferred Brand
	EULEXIN	Non-preferred Brand
	NILANDRON	Non-preferred Brand
Endocrine; Androgen Hormone Agents:	Rx Only Coverage	Copay Tier
	<i>danazol</i>	Generic
	<i>testosterone cypionate</i>	Generic
	<i>testosterone propionate</i>	Generic
	ANDRODERM	Preferred Brand
	ANDROGEL	Preferred Brand
	AXIRON	Preferred Brand
	FORTESTA	Non-preferred Brand
	TESTIM	Non-preferred Brand
Endocrine; Ovulatory Stimulant Agents:	Rx Only Coverage	Copay Tier
	<i>clomiphene citrate</i>	Generic

Endocrine; Miscellaneous Agents:	Rx Only Coverage	Copay Tier
	<i>cabergoline</i>	Generic
	<i>calcitonin salmon, synthetic</i>	Generic
	<i>calcitriol</i>	Generic
	<i>desmopressin acetate</i>	Generic
	<i>desmopressin acetate/sodium phosphate</i>	Generic
	<i>doxercalciferol</i>	Generic
	<i>octreotide acetate</i>	Generic
	<i>paricalcitol</i>	Generic
	CEREZYME	Preferred Brand
	KUVAN	Preferred Brand
	SAMSCA	Preferred Brand
	SANDOSTATIN LAR DEPOT	Preferred Brand
	SENSIPAR	Preferred Brand
	STIMATE	Preferred Brand
	SYNREL	Preferred Brand
	VPRIV	Preferred Brand
Endocrine; Gonadotropin & Related Agents:	Rx Only Coverage	Copay Tier
	<i>chorionic gonadotropin</i>	Generic
Endocrine; Growth Hormone Replacement Agents:	Rx Only Coverage	Copay Tier
<p>Notes: <i>All growth hormone products are subject to a prior authorization or clinical drug review, especially if the patient is age 21 or older to help ensure proper use of these medications.</i></p> <p><i>Serostim is subject to a prior authorization or clinical drug review regardless of the patient's age.</i></p>	GENOTROPIN	Preferred Brand
	GENOTROPIN MINIQUICK	Preferred Brand
	HUMATROPE	Preferred Brand
	HUMATROPE COMBO PACK	Preferred Brand
	NORDITROPIN CARTRIDGE	Preferred Brand
	NORDITROPIN FLEXPRO	Preferred Brand
	NORDITROPIN NORDIFLEX PEN	Preferred Brand
	NUTROPIN	Non-preferred Brand
	OMNITROPE	Non-preferred Brand
	SAIZEN	Non-preferred Brand
	TEV-TROPIN	Non-preferred Brand
Endocrine; Diabetes - Insulin Therapy:	Rx and OTC Coverage	Copay Tier
	HUMALOG	Preferred Brand
	HUMALOG KWIKPEN	Preferred Brand
	HUMALOG MIX 50/50	Preferred Brand
	HUMALOG MIX 50/50 KWIKPEN	Preferred Brand
	HUMALOG MIX 50/50 PEN	Preferred Brand
	HUMALOG MIX 75/25	Preferred Brand
	HUMALOG MIX 75/25 KWIKPEN	Preferred Brand
	HUMALOG MIX 75/25 PEN	Preferred Brand
	HUMALOG PEN	Preferred Brand
	HUMULIN 70/30	Preferred Brand
	HUMULIN 70/30 PEN	Preferred Brand
	HUMULIN N	Preferred Brand
	HUMULIN N U-100 PEN	Preferred Brand
	HUMULIN R	Preferred Brand

Endocrine; Diabetes - Insulin Therapy (Cont):	Rx and OTC Coverage	Copay Tier
	HUMULIN R U-500 (CONCENTR	Preferred Brand
	LANTUS	Preferred Brand
	LANTUS FOR OPTICLIK	Preferred Brand
	LANTUS SOLOSTAR	Preferred Brand
	LEVEMIR	Preferred Brand
	LEVEMIR FLEXPEN	Preferred Brand
	APIDRA	Non-preferred Brand
	APIDRA SOLOSTAR	Non-preferred Brand
	NOVOLOG	Non-preferred Brand
	NOVOLOG FLEXPEN	Non-preferred Brand
	NOVOLOG MIX 70/30	Non-preferred Brand
	NOVOLOG MIX 70/30 PREFILL	Non-preferred Brand
	NOVOLOG PENFILL	Non-preferred Brand

Endocrine; Non-Insulin Diabetes Agents:	Rx Only Coverage	Copay Tier
Notes: <i>All oral brand name agents in this class are subject to a step therapy program requiring the use of generic medications rather than brand name agents when ever possible.</i>	<i>acarbose</i>	Generic
	<i>acetohexamide</i>	Generic
	<i>chlorpropamide</i>	Generic
	<i>glimepiride</i>	Generic
	<i>glipizide/glipizide ER</i>	Generic
	<i>glipizide/metformin HCl</i>	Generic
	<i>glyburide</i>	Generic
	<i>glyburide/metformin HCl</i>	Generic
	<i>metformin HCl</i>	Generic
	<i>nateglinide</i>	Generic
	<i>pioglitazone</i>	Generic
	<i>pioglitazone;metformin</i>	Generic
	<i>pioglitazone;glimepiride</i>	Generic
	<i>repaglinide</i>	Generic
	<i>tolazamide</i>	Generic
	<i>tolbutamide</i>	Generic
	BYDUREON	Preferred Brand
	BYETTA	Preferred Brand
	JANUMET/JANUMET XR	Preferred Brand
	JANUVIA	Preferred Brand
	KOMBIGLYZE	Preferred Brand
	ONGLYZA	Preferred Brand
	TRADJENTA	Preferred Brand
	AVANDAMET	Non-preferred Brand
	AVANDARYL	Non-preferred Brand
	AVANDIA	Non-preferred Brand
	INVOKANA	Non-preferred Brand
	JENTADUETO	Non-preferred Brand
	JUVISYNC	Non-preferred Brand
	KAZANO	Non-preferred Brand
	NESINA	Non-preferred Brand

Endocrine; Non-Insulin Diabetes Agents (Cont):	Rx Only Coverage	Copay Tier
Notes: <i>All oral brand agents in this class subject to step therapy requiring use of generic medications rather than brand name agents when possible.</i>	OSENI	Non-preferred Brand
	SYMLINPEN	Non-preferred Brand
	VICTOZA	Non-preferred Brand
Endocrine; Glucose Elevating Agents:	Rx Only Coverage	Copay Tier
	GLUCOSE	Generic
	GLUTOSE 15	Generic
	GLUTOSE 45	Generic
	INSTA-GLUCOSE	Generic
	SM GLUCOSE	Generic
	GLUCAGON EMERGENCY KIT	Preferred Brand
	GLUCAGEN	Non-preferred Brand
	GLUCAGEN HYPOKIT	Non-preferred Brand
	PROGLYCEM	Non-preferred Brand
Endocrine, Diabetes Testing; Insulin Syringes, etc.:	Rx and OTC Coverage	Copay Tier
	insulin Syringes - various	Generic
	lancets - various	Generic
	ONETOUCH METERS (ALL)	Preferred Brand
	ONETOUCH TEST STRIPS (ALL)	Preferred Brand
	NIPRO METERS (ALL)	Preferred Brand
	NIPRO TEST STRIPS (ALL)	Preferred Brand
	ACCU-CHEK METERS (ALL)	Non-preferred Brand
	ACCU-CHEK TEST STRIPS (ALL)	Non-preferred Brand
Respiratory; Antihistamine First Generation:	Rx and OTC Coverage	Copay Tier
	<i>carbinoxamine maleate</i>	Generic
	<i>chlorpheniramine maleate</i>	Generic
	<i>clemastine fumarate</i>	Generic
	<i>cyproheptadine HCl</i>	Generic
	<i>diphenhydramine HCl</i>	Generic
	<i>hydroxyzine HCl</i>	Generic
	<i>hydroxyzine pamoate</i>	Generic
Respiratory; Antihistamine Second Generation:	Rx and OTC Coverage	Copay Tier
	<i>cetirizine HCl</i>	Generic
	<i>desloratadine</i>	Generic
	<i>fexofenadine</i>	Generic
	<i>levocetirizine</i>	Generic
	<i>loratadine</i>	Generic
	ALLEGRA	Generic
Respiratory; Antihistamine & Decongestant First Generation:	Rx and OTC Coverage	Copay Tier
	APRODINE	Generic
	BROMALINE	Generic
	BROTAPP	Generic
	COMTrex FLU THERAPY MAXIM	Generic
	DIMETAPP COLD & ALLERGY	Generic
Respiratory; Antihistamine & Decongestant Second Generation:	Rx and OTC Coverage	Copay Tier
	<i>cetirizine/Pseudoephedrine</i>	Generic
	<i>fexofenadine/pseudoephedrine</i>	Generic

Respiratory; Antihistamine & Decongestant Second Gen (Cont):	Rx and OTC Coverage	Copay Tier
	<i>loratadine-D 24 hr</i>	Generic
	ALLERGY RELIEF D-24	Generic
Antihistamine Nasal Formulations:	Rx Only Coverage	Copay Tier
	<i>azelastine HCl</i>	Generic
	ASTEPRO	Preferred Brand
	PATANASE	Non-preferred Brand
Respiratory; Adrenergic Agents (Anaphylaxis):	Rx Only Coverage	Copay Tier
	<i>epinephrine inj 0.15mg & 0.3mg</i>	Generic
	EPIPEN	Preferred Brand
	EPIPEN JR.	Preferred Brand
Respiratory; Corticosteroid Agents (Oral):	Rx Only Coverage	Copay Tier
	<i>cortisone acetate</i>	Generic
	<i>dexamethasone</i>	Generic
	<i>hydrocortisone</i>	Generic
	<i>methylprednisolone</i>	Generic
	<i>prednisolone</i>	Generic
	<i>prednisone</i>	Generic
Respiratory; Antitusive Combination Agents:	Rx and OTC Coverage	Copay Tier
	<i>benzonatate</i>	Generic
	<i>dextromethorphan/PSE/brompheniramine</i>	Generic
	<i>guaifenesin/codeine phosphate</i>	Generic
	<i>guaifenesin/dextromethorphan</i>	Generic
	<i>hydrocodone/homatropine</i>	Generic
	<i>phenylephrine/brompheniramine</i>	Generic
	ALLFEN	Generic
	Q-TUSSIN	Generic
	ROBITUSSIN CHEST CONGESTION	Generic
	ROBITUSSIN PEDIATRIC	Generic
	SM TUSSIN	Generic
	TUSSICAPS	Preferred Brand
Respiratory; Xanthine Agents:	Rx Only Coverage	Copay Tier
	<i>aminophylline</i>	Generic
	<i>caffeine citrate</i>	Generic
	<i>theophylline</i>	Generic
	ELIXOPHYLLIN	Non-preferred Brand
	LUFYLLIN	Non-preferred Brand
	THEO-24	Non-preferred Brand
	UNIPHYL	Non-preferred Brand
Respiratory; Beta Agonists Oral:	Rx Only Coverage	Copay Tier
	<i>albuterol sulfate</i>	Generic
	<i>metaproterenol sulfate</i>	Generic
	<i>terbutaline sulfate</i>	Generic
	VOSPIRE ER	Non-preferred Brand
Respiratory; Beta Agonist Inhaler:	Rx Only Coverage	Copay Tier
	<i>albuterol inhalation solution</i>	Generic
	<i>isoetharine HCL inhalation solution</i>	Generic

Respiratory; Beta Agonist Inhaler (Cont):	Rx Only Coverage	Copay Tier
	<i>levalbuterol HCL inhalation solution</i>	Generic
	<i>metaproterenol sulfate inhaler</i>	Generic
	FORADIL AEROLIZER	Preferred Brand
	PROAIR HFA	Preferred Brand
	SEREVENT DISKUS	Preferred Brand
	VENTOLIN HFA	Preferred Brand
	XOPENEX HFA	Non-preferred Brand
Respiratory; Inhaled Corticosteroid Agents:	Rx Only Coverage	Copay Tier
	<i>budesonide</i>	Generic
	ASMANEX METERED INHALER	Preferred Brand
	PULMICORT FLEXHALER	Preferred Brand
	QVAR	Preferred Brand
	FLOVENT HFA	Non-preferred Brand
	FLOVENT DISKUS/ROTADISK	Non-preferred Brand
Respiratory; Intranasal Steroid Agents:	Rx Only Coverage	Copay Tier
Notes: <i>There is a step therapy program in place for the nasal steroids requiring the use and failure of generics before a brand name agent is allowed.</i>	<i>flunisolide</i>	Generic
	<i>fluticasone</i>	Generic
	Nasacort OTC	Generic
	<i>triamcinolone acetonide</i>	Generic
	NASONEX	Preferred Brand
	RHINOCORT AQUA	Non-preferred Brand
	VERAMYST	Non-preferred Brand
Respiratory; Miscellaneous Nasal Agents:	Rx and OTC Coverage	Copay Tier
	BABY AYR SALINE	Generic
	DEEP SEA NASAL SPRAY	Generic
	GNP NASAL DECONGESTANT	Generic
	<i>ipratropium bromide</i>	Generic
	NASAL SPRAY	Generic
	MUCINEX NASAL SPRAY MOIST	Generic
	NEO-SYNEPHRINE 12 HOUR EX	Generic
	PSEUDOEPHEDRINE HCL	Generic
	PULMOSAL	Generic
	SM NASAL SPRAY 12 HOUR	Generic
	BACTROBAN NASAL	Preferred Brand
Respiratory; Miscellaneous Pulmonary Agents:	Rx Only Coverage	Copay Tier
Notes: <i>All agents prescribed for pulmonary hypertension are subject to a prior authorization or clinical drug review to help ensure appropriate use of these medications.</i>	<i>acetylcysteine</i>	Generic
	<i>cromolyn sodium inhalation</i>	Generic
	<i>ipratropium/albuterol sulfate</i>	Generic
	<i>ipratropium bromide inhalation solution</i>	Generic
	montelukast	Generic
	<i>sildenafil (pulmonary hypertension)</i>	Generic
Examples = Adcirca, Letiris & Revatio	ADCIRCA	Preferred Brand
	ATROVENT HFA	Preferred Brand
	COMBIVENT	Preferred Brand
	DULERA	Preferred Brand
	LETAIRIS	Preferred Brand

Respiratory; Miscellaneous Pulmonary Agents (Cont):	Rx Only Coverage	Copay Tier
Notes: <i>All agents prescribed for pulmonary hypertension are subject to a prior authorization or clinical drug review to help ensure appropriate use of these medications.</i> Examples = Adcirca, Letiris & Revatio	PULMOZYME	Preferred Brand
	SPIRIVA HANDHALER	Preferred Brand
	SYMBICORT	Preferred Brand
	TRACLEER	Preferred Brand
	TYVASO	Preferred Brand
	VENTAVIS	Preferred Brand
	ADVAIR DISKUS	Non-preferred Brand
	ADVAIR HFA	Non-preferred Brand
	ANORO ELLIPTA	Non-preferred Brand
	XOLAIR	Non-preferred Brand
	ZYFLO	Non-preferred Brand
	ZYFLO CR	Non-preferred Brand
Urological; Cholenergic Stimulant Agents:	Rx Only Coverage	Copay Tier
	<i>bethanechol chloride</i>	Generic
Urological; Anticholinergic & Antispasmodic Agents:	Rx Only Coverage	Copay Tier
	<i>dicyclomine HCl</i>	Generic
	<i>flavoxate HCL</i>	Generic
	<i>hyoscyamine sulfate</i>	Generic
	<i>oxybutinin chloride</i>	Generic
	<i>tolterodine IR & ER</i>	Generic
	<i>trospium chloride IR & XR</i>	Generic
	MYRBETRIQ	Preferred Brand
Urological; Urinary Tract Anesthetic Agents:	Rx Only Coverage	Copay Tier
	<i>phenazopyridine HCl</i>	Generic
	ELMIRON	Preferred Brand
Urological; Benign Prostatic Hyperplasia (BPH) Agents:	Rx Only Coverage	Copay Tier
	<i>alfuzosin</i>	Generic
	<i>doxazosin mesylate</i>	Generic
	<i>finasteride</i>	Generic
	<i>terazosin HCl</i>	Generic
	<i>tamsulosin HCl</i>	Generic
	AVODART	Preferred Brand
	JALYN	Non-preferred Brand
Urological; Urinary Tract PH Modifier Agents:	Rx Only Coverage	Copay Tier
	<i>citric acid/sodium citrate</i>	Generic
	<i>potassium citrate</i>	Generic
	<i>potassium phosphate</i>	Generic
	K-PHOS NEUTRAL	Non-preferred Brand
	RENACIDIN	Non-preferred Brand
	UROCIT-K 10	Non-preferred Brand
	UROCIT-K 15	Non-preferred Brand
Vitamin & Hematinic Agents - Prenatal:	Rx and OTC Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	<i>folic acid</i>	Exempt
	CYTRANATAL	Exempt
	<i>prenatal vitamin (multiple)</i>	Exempt

Vitamin & Hematinic Agents - Prenatal (Cont):	Rx and OTC Coverage	Copay Tier
Notes: <i>This therapeutic category is exempt from copayments.</i>	NEEVO	Exempt
	NEEVO DHA	Exempt
	NIFEREX GOLD	Exempt
	NIFEREX-150 FORTE	Exempt
	NIFEREX-PN FORTE	Exempt
	PRENATE DHA	Exempt
	PRENATE ELITE	Exempt
	PRIMACARE	Exempt
	PRIMACARE ONE	Exempt
	REPLIVA 21/7	Exempt
	CONCEPT DHA	Exempt
	CONCEPT OB	Exempt
	MISSION PRENATAL	Exempt
	MISSION PRENATAL HP	Exempt
	MISSION PRENATAL/FOLIC AC	Exempt
	PNV-DHA	Exempt
	PNV-DHA PLUS	Exempt
	PNV-IRON	Exempt
	PNV-OMEGA	Exempt
	PNV-SELECT	Exempt
STUART PRENATAL	Exempt	

Vitamin & Hematinic Agents - General:	Rx and OTC Coverage	Copay Tier
Notes: <i>Vitamins shall be covered as either prescription only or as over-the-counter vitamin preparations with a valid prescription.</i> <i>Vitamins shall be provided as appropriate for the patient's age - Infant, Pediatric, Adult, Geriatric, etc.</i>	<i>cyanocobalamin (Vitamin B-12)</i>	Generic
	<i>ergocalciferol (Vitamin D)</i>	Generic
	<i>fluoride Iron/multiple vitamin</i>	Generic
	<i>vitamin A</i>	Generic
	<i>vitamin B1</i>	Generic
	<i>vitamin B6</i>	Generic
	<i>vitamin C</i>	Generic
	<i>vitamin D</i>	Generic
	<i>vitamin K1</i>	Generic
	<i>multiple vitamin formulation</i>	Generic
	<i>multiple vitamin with minerals</i>	Generic
	B-COMPLEX WITH B-12	Generic
	BIOTIN	Generic
	CENTRUM	Generic
	CENTRUM SILVER ULTRA MENS	Generic
	CENTURY SENIOR	Generic
	CEROVITE ADVANCED FORMULA	Generic
	COMPETE	Generic
	COMPLETE	Generic
	DAILY VITE	Generic
	DAILY-VITE/IRON	Generic
	FOLGARD	Generic
	FOLTX	Generic
	GERI-VITE	Generic

Vitamin & Hematinic Agents - General (Cont):	Rx and OTC Coverage	Copay Tier
	GLUTOFAC	Generic
	GOLDEN AGE VITAMIN/MINERA	Generic
	HAIRVITE	Generic
	HEXAVITAMIN	Generic
	ICAPS MV	Generic
	IROMIN-G	Generic
	MEPHYTON	Generic
	MERIBIN	Generic
	MULTI-DELYN	Generic
	MULTI-DELYN/IRON	Generic
	MULTILEX	Generic
	MULTILEX-T&M	Generic
	MULTIVITAMINS	Generic
	NEPHRO-VITE	Generic
	OCUVITE	Generic
	ONCE DAILY	Generic
	ONCE DAILY/IRON	Generic
	ONCOVITE	Generic
	ONE DAILY	Generic
	ONE DAILY MENS	Generic
	ONE DAILY W/IRON	Generic
	PYRIDOXINE HCL	Generic
	RENA-VITE	Generic
	THERAPEUTIC	Generic
	THERAPEUTIC-M	Generic
	THERA-PLUS	Generic
	VI-STRESS	Generic
	VITABEE W/C	Generic
	VITAMIN A	Generic
	VITAMIN B COMPLEX	Generic
	VITAMIN LIQUID	Generic
	VITAMINS & MINERALS	Generic

Vitamin & Hematinic; Iron Replacement Agents:	Rx & OTC Coverage	Copay Tier
	<i>ferrous fumarate</i>	Generic
	<i>ferrous gluconate</i>	Generic
	<i>ferrous sulfate</i>	Generic
	FERATAB	Generic
	FERATE	Generic
	FERGON	Generic
	FER-IN-SOL	Generic
	POLY-IRON 150	Generic
	POLYSACCHARIDE IRON COMPL	Generic
	SLOW FE	Generic
	SLOW RELEASE IRON	Generic
	DEXFERRUM	Non-preferred Brand
	FERRLECIT	Non-preferred Brand

Vitamin & Hematinic; Iron Replacement Agents (Cont):	Rx & OTC Coverage	Copay Tier
	INFED	Non-preferred Brand
	VENOFER	Non-preferred Brand
Electrolyte Replacement; Potassium Agents:	Rx Only Coverage	Copay Tier
	<i>potassium bicarbonate/citric acid</i>	Generic
	<i>potassium chloride</i>	Generic
	<i>potassium Cl/potassium bicarb/citric</i>	Generic
	EFFER-K	Non-preferred Brand
	KLOR-CON	Non-preferred Brand
Electrolyte Replacement; Other Agents:	Rx and OTC Coverage	Copay Tier
	<i>calcium</i>	Generic
	<i>calcium carbonate</i>	Generic
	<i>calcium citrate</i>	Generic
	<i>calcium lactate</i>	Generic
	<i>calcium/vitamin D</i>	Generic
	<i>potassium phosphate</i>	Generic
	<i>sodium phosphate</i>	Generic
	CALTRATE 600+D	Generic
	CALTRATE 600+D PLUS	Generic
	FOSFREE	Generic
	OYSTER SHELL CALCIUM	Generic
	OYSTER SHELL CALCIUM/D	Generic
	OYSTER SHELL CALCIUM/VITA	Generic
Smoking Cessation Agents:	Rx and OTC Coverage	Copay Tier
	<i>bupropion HCl SR</i>	Generic
	<i>nicotine gum</i>	Generic
	<i>nicotine lozenge</i>	Generic
	<i>nicotine patch</i>	Generic
	NICODERM CQ	Generic
	NICORETTE	Generic
	NICORETTE STARTER KIT	Generic
	NICOTROL INHALER	Generic
	NICOTROL NS	Generic
	CHANTIX	Preferred Brand
Miscellaneous Therapeutic Agents:	Rx Only Coverage	Copay Tier
	<i>Acampro Cal</i>	Generic
	<i>riluzole</i>	Generic
	ADAGEN	Preferred Brand
	ANTABUSE	Preferred Brand
	CHEMET	Preferred Brand
	EXJADE	Preferred Brand
	KALYDECO	Preferred Brand
	ORFADIN	Preferred Brand
	PROLASTIN	Preferred Brand
	XIFAXAN 200mg	Preferred Brand
	AGRYLIN	Non-preferred Brand
	AMPYRA	Non-preferred Brand

Miscellaneous Therapeutic Agents (Cont):	Rx Only Coverage	Copay Tier
	ANAGRELIDE HYDROCHLORIDE	Non-preferred Brand
	DEFEROXAMINE MESYLATE	Non-preferred Brand
	DEFERAL	Non-preferred Brand
	GALZIN	Non-preferred Brand
	JUXTAPID	Non-preferred Brand
	SIGNIFOR	Non-preferred Brand
	SYPRINE	Non-preferred Brand
	ZAVESCA	Non-preferred Brand



Certain restrictions, quantity limits, step therapy, and prior authorization requirements may apply. As brand name drugs become available generically, only the generic will be considered formulary.