



Welcome to your guide to the Maryland Physicians Care (MPC) drug coverage for prescription medications. This booklet will provide you with information on the medications that are covered under the MPC formulary.

The formulary was developed by the MPC Pharmacy and Therapeutics Committee (P&T Committee) that is comprised of physicians from various medical specialties. The P&T Committee reviews new and existing medications to ensure the formulary remains responsive to the needs of our members and providers, as well as monitoring the safety, effectiveness and cost associated with all drug categories.

The formulary is the cornerstone of drug therapy quality assurance and cost containment efforts. The review process has been successfully used by hospitals and managed care organizations to provide a comprehensive and cost-effective formulary. As you use the formulary, we invite your suggestions to improve the format or content.

Formulary Medications

The formulary is a listing of medications marketed at the time of printing and intended for use by the health plan physicians and pharmacy providers. The first column of the chart lists the drug that is covered by the plan. Brand name drugs are capitalized (e.g., AMOXIL). Generic drugs are listed in lower case (e.g., amoxicillin). The second column serves as a reference for providing the brand name of the drug when a generic is covered by the plan. The third column lists any requirements for the drug such as prior authorization (PA), quantity limits (QLL), step therapy (ST). Unless exceptions are noted, all forms (tablet, capsule, liquid, topical) and strengths of a drug product are included in the formulary and will be covered by MPC. Injectable medications are only covered when noted on the formulary.

The formulary applies only to medications dispensed to outpatients by participating pharmacies. The formulary does not apply to inpatient medications or to medications obtained from and administered by a physician.

Epocrates

The Maryland Physicians Care formulary and formulary status information can be found online through Epocrates. Registration is free and is available at www.epocrates.com.

HIV Medications

HIV medications are carved out for MPC and are payable as fee-for-service through Maryland Medical Assistance.

Mental Health Medications



Certain mental health medications are carved out for MPC and are payable as fee-for-service through Maryland Medical Assistance. Please refer to the following website for a list of medications that are carved out and those that must be covered by MPC:

http://www.mdmahealthchoicercx.com/healthchoice_docs/mmmh_form.pdf

Over-the-Counter, Non-prescription Medications Policy

Some over-the-counter (OTC) products are covered according to the MPC OTC list and will require a prescription.

Generic Drug Policy

Specific drugs, which have generic equivalents are covered at a generic reimbursement level and should be prescribed and dispensed in the generic form. Providers are reminded of the following:

1. When generic substitution conflicts with state regulations or restrictions, the pharmacist must gain approval from the prescribing physician to use the generic equivalent.
2. If a physician indicates "Dispense As Written" (DAW) and completes a MedWatch form to document any adverse effects caused by previous experience with at least 2 of the generic alternatives, MPC will pay for the brand name drug.

Unapproved Use of Medications

The member's benefit handbook states medications will be eligible for coverage only if they are FDA approved medications used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA-approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion.

Experimental and investigational drugs, and drugs used for cosmetic purposes are not eligible for coverage.

Drugs, which have Drug Efficiency Studies Implementation (DESI) status, are not covered by MPC.

Prescriptions for Non-Formulary Medications

The MPC P&T Committee has attempted to include medications from all therapeutic needs. If a patient requires medication that is not listed on the formulary, the physician may request an exception to allow payment for the medication. It is anticipated that such exceptions will be rare and physicians should be able to find a medication on the formulary for most therapeutic needs. However, if a health care provider wishes that a member receive a medication not covered, he/she must submit a letter explaining the necessity, past therapeutic failures, and patient identification (name, address, and member id number). The P&T Committee will



monitor prescriptions written in a non-conformance with the formulary and contact physicians who prescribe non-formulary products to request compliance.

Specialty Medications

Most Specialty Medications require prior authorization. Specialty drugs are available through CVS Caremark Specialty Pharmacy for delivery to a patient's home or to a provider's office. Providers can call the Maryland Physicians Care Pharmacy Prior Authorization department at 1-800-953-8854 to request prior authorization, or fax a PA request form to 1-866-207-7231. Prior authorization forms can be downloaded from the MPC website at:

<http://www.marylandphysicianscare.com/approved-drug-benefits.aspx>

Oncology Medications

MPC will no longer prior authorize oncology/chemotherapy & radiation oncology services without an Eviti code. Your office should have received notification to sign up for training. If you have not had training, please go to the website www.welcometoeviti.com and sign up for training in order to receive your pin# and learn how to access the web based system, eviti®. If you have any additional questions, please call ITA Partners, our oncology vendor, @ 1-888-678-0990 (toll free).

Prior Authorization (PA)

Certain medications on the MPC formulary require pre-authorization. Drugs that require Prior Authorization are identified on the formulary in the third column with PA. In order for a member to receive coverage for a medication requiring Prior Authorization a provider must:

- Call the MPC Pharmacy Prior Authorization department at 1-800-953-8854, or
- Fax a Pharmacy Prior Authorization Request Form to the MPC Pharmacy Prior Authorization Department at 1-866-207-7231.

Pharmacy Prior Authorization Request forms can be downloaded from the MPC website at <http://www.marylandphysicianscare.com/approved-drug-benefits.aspx>

If you need to have a Prior Authorization form sent to you, you can contact the MPC Pharmacy Prior Authorization department at 1-800-953-8854.

Quantity Limits (QL)

Certain formulary drugs may be prescribed only in limited quantities. Quantity limits are based on clinically approved prescribing guidelines to ensure safe and proper use. Drugs that have quantity limits are identified on the formulary in the third column with QL. In order to receive an override for a medication that has a quantity limit, please call the MPC Pharmacy Prior Authorization department at 1-800-953-8854, or complete a Prior Authorization form and fax to MPC Pharmacy Prior Authorization at 1-866-207-7231. Prior Authorization forms can be



downloaded from the MPC website at <http://www.marylandphysicianscare.com/approved-drug-benefits.aspx>

Step Therapy (ST)

The ST program requires certain first-line drugs (generic drugs or other formulary drugs) be prescribed prior to approval of specific second-line drugs. If the prerequisite first-line agents have been filled, the member will be able to fill the prescription automatically, without requiring prior authorization. The ST requirements document can be downloaded from the MPC website at: <http://www.marylandphysicianscare.com/approved-drug-benefits.aspx>

Formulary Additions

If there is a new or existing medication that you would like to have added to the formulary, you will need to complete the Drug Formulary Change Request Form and send to MPC for presentation to the P&T Committee. Forms are located in the MPC Provider Manual or you can call Provider Services at (800) 953-8854, option 5 to request a form. You will be notified in writing of the decision taken at the P&T Committee. The MPC P&T Committee meets on a quarterly basis.

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANESTHETICS		
TOPICAL ANESTHETICS		
Lidocaine topical 2% jelly, 2.5% and 4% solution, 3% cream/lotion, 5% ointment	Xylocaine	
Lidocaine 2% hcl viscous	Xylocaine	
Lidocaine-HC 3-0.5% cream		
Lidocaine 5% patch	Lidoderm	
ANTIINFECTIVES		
CEPHALOSPORINS		
cefaclor	Ceclor	
cefaclor er	Ceclor	
cefadroxil	Duricef	
cefdinir	Omnicef	
cefuroxime tablets, suspension	Ceftin	
cefuroxime Sodium injection	Ceftin	PA
cephalexin	Keflex	
ceftriaxone	Rocephin	QL=2 grams/Rx
SUPRAX		QL= 1 tab/Rx
CLINDAMYCINS		
Clindamycin hcl	Cleocin	
ERYTHROMYCINS		
erythromycin ethylsuccinate	E.E.S.	
erythromycin w/sulfisoxazole	Pediazole	
OTHER MACROLIDES		
azithromycin	Zithromax	QL= 250mg, zpack, suspension – 2 Rxs/60 days
clarithromycin, er	Biaxin, Biaxin XL	QL = 250 mg and 500 mg - combined 28/30 days 500 mg extended-release- 28/30 days oral suspension- 1RX/month
PENICILLINS		
amox tr-potassium clavulanate tablets, suspension	Augmentin	QL: 2 Rxs/60days
amoxicillin	Amoxil	
Amox TR-K CLV 600		
ampicillin	Principen	
penicillin v potassium	Veetids	
SULFONAMIDES		
sulfamethoxazole/trimethoprim	Septra	
erythromycin w/Sulfisoxazole		
TETRACYCLINES		
doxycycline hyclate, hyclate DR, monohydrate	Adoxa, Doryx, Periostat, Vibramycin	
minocycline hcl	Dynacin	
tetracycline hcl	Sumycin	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
URINARY ANTIINFECTIVES		
Macrobid		
nitrofurantoin macrocrystal	Macrochantin	
trimethoprim		
QUINOLONES		
ciprofloxacin hcl	Cipro	
ofloxacin	Floxin	
levofloxacin	Levaquin	
TOPICAL ANTIBACTERIAL DRUGS		
mupirocin ointment, cream	Bactroban	
neomycin/bacitracin/polymyxin B	Neosporin	
silver sulfadiazine	Silvadene	
ORAL ANTIFUNGAL DRUGS		
clotrimazole	Mycelex	
fluconazole	Diflucan	
GRIFULVIN V 500mg tablets		
Griseofulvin 125 mg/ 5 ml Suspension		
GRIS-PEG		
itraconazole	Sporanox	PA
ketoconazole	Nizoral	
nystatin	Mycostatin	
SPORANOX (ORAL SOLUTION)		PA
terbinafine	Lamisil	QLL #84/365 days
OTHER TOPICAL ANTIFUNGALS		
ciclopirox	Loprox/Penlac	
OTC clotrimazole	Lotrimin	
econazole nitrate	Spectazole	
ketoconazole shampoo	Nizoral	
OTC miconazole		
nystatin	Mycostatin	
Nystop		
terbinafine	Lamisil	
TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.		
clotrimazole/betamethasone	Lotrisone	
nystatin w/triamcinolone	Mycolog II	
OTHER ANTIINFECTIVE DRUGS		
vancomycin capsules	Vancocin pulvules	PA, QL=40 caps/30 days
dapsone		
OTHER ANTIVIRAL DRUGS		
Acyclovir tablets, capsules, suspension	Zovirax	QL=60 caps or tabs/30 days Oral suspension: 300ml/month
acyclovir 5% ointment	Zovirax ointment	
amantadine hcl	Symmetrel	
famciclovir	Famvir	QL: 125 mg,500mg – 21/month 250 mg – 60/month

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
INCIVEK		PA
INTRON A		PA
PEGINTRON		PA
PEGINTRON REDIPEN		PA
PEGASYS		PA
rimantadine	Flumadine	QL=14 tabs/90days
RELENZA		QL: 3 packs/6months
ribavirin		PA; MUST BE ON INTERFERON QL: 2 packs/month
TAMIFLU		QL= 30mg: 20 capsules/Rx 45mg: 10 capsules /Rx 75mg: 10 capsules /Rx 6mg/ml oral susp: 3 bottles (180 ml)/Rx
TYZEKA		PA
valacyclovir	Valtrex	
VALCYTE		PA
VICTRELIS		PA
ZOVIRAX (5% CREAM)		
ANTITUBERCULOSIS DRUGS		
ethambutol	Myambutol	
isoniazid	Nydrazid	
ISONARIF CAPSULE		
pyrazinamide		
rifampin	Rifadin	
AMEBICIDES		
paromomycin		
PLASMODICIDES		
chloroquine phosphate	Aralen	
DARAPRIM		
hydroxychloroquine sulfate	Plaquenil	
mefloquine	Lariam	
primaquine		
TRICHOMONOCIDES		
metronidazole	Flagyl	
ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS		
anastrozole	Arimidex	PA
azathioprine	Imuran	
bicalutamide	Casodex	PA
CELLCEPT INJECTION		PA
Cometriq		PA
cyclosporine	Neoral	
Degarelix		PA

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ELIGARD (INJ)		PA
exemestane	Aromasin	PA
flutamide		PA
hydroxyurea	Hydrea	PA
leflunomide	Arava	
megestrol acetate, Megace ES 625mg/5ml	Megace, Megace ES	
mercaptopurine	Purinethol	PA
MESNEX		PA
methotrexate 2.5mg tablet	Trexall	
mycophenolate mofetil 250mg capsule, 500mg tablet	Cellcept	
mycophenolic Acid 180mg & 360mg Delayed-Release Tablet	Myfortic	
Nulojix		
octreotide	Sandostatin	PA
REVLIMID		PA
Somatuline		PA
TABLOID		PA
tacrolimus	Prograf	
tamoxifen citrate	Nolvadex	PA
Tykerb		PA
VOTRIENT		PA
XALKORI		PA
XELODA		PA
ZELBORAF		PA
AUTONOMIC AND CNS MEDICATIONS		
ANALGESICS		
Acetaminophen tablets, infant drops, elixir	Tylenol OTC	QL = 4grams APAP/day
OTC aspirin, enteric-coated aspirin		
diflunisal		
tramadol hcl	Ultram	QL=240 tabs/30 days
tramadol hcl-acetaminophen	Ultracet	QL= 4 grams APAP/day
CLASS II NARCOTICS		
fentanyl patches	Duragesic	QL=15 patches/30 days
hydromorphone hcl	Dilaudid	QL = 2mg, 4mg =180 tabs/30 days 8mg=120 tabs/30 days
meperidine	Demerol	QL=56 tabs/30 days
methadone hcl	Dolophine	QL=540 tabs/30 days
morphine sulfate		
morphine sulfate ER tablets	MS Contin	
Oramorph		
oxycodone-acetaminophen (5/325 mg, 7.5/325 mg, 10/325 mg, 5/500 mg, 7.5/500 mg, 10/650 mg)	Percocet	QL=10-650mg – 180/30 days. Other strengths – 240 tabs/30 days
oxycodone hcl	Oxyir	QL = 240/month for 5mg

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		150/month for 10mg,15mg,20mg,30mg
OXYCONTIN		PA/QL=90 tabs/30 days
Roxicet 5-325mg/5ml solution		
CLASS III NARCOTICS		
acetaminophen-codeine	Tylenol #3	QL= 240/30days
buprenorphine	Subutex	QL 2mg=360/month (24mg per day) 8mg=90/month(24mg per day)
Buprenorphine-naloxone	Suboxone	QL 2 mg=360/month (24 mg per day) 4 mg=180/month (24 mg per day) 8 mg=90/month(24 mg per day) 12 mg= 60/month (24 mg per day)
hydrocodone-acetaminophen	Vicodin, Lortab	QL: 2.5/500mg, 7.5/325mg, 7.5/500mg, 5/325mg, 5/500, 10/325mg, 10/500mg =240/30 days. 7.5/650mg, 10/650mg, 10/660mg=180/30 days 7.5/750mg 10/750mg=150/30 days
hydrocodone bit-ibuprofen	Vicoprofen	QL=240 tabs/30 days
Norco		QL
Suboxone Film		QL 2 mg=360/month (24 mg per day) 4 mg=180/month (24 mg per day) 8 mg=90/month(24 mg per day) 12 mg= 60/month (24 mg per day)
DRUGS TO PREVENT AND TREAT HEADACHES		
butalbital/acetaminophen/caffeine	Esgic/Fioricet/Triad	QL: 240 tabs / 30days
butalbital/aspirin/caffeine (butalbital compound)	Fiorinal, Fortabs	QL: 240 tabs / 30days
Butorphanol		QL: 1 pkg / 30days (2.5ml/30days)
sumatriptan	Imitrex	QL =Nasal Spray 6/month Tablets: 9 tabs/month
sumatriptan (inj)	Imitrex	QL=2 kits or 4 vials or syringes/30 days;
MIGRANAL		QL=8 units/30 days
RELPAK		QL=6 tabs/30 days
Zolmitriptan tabs, ODT	Zomig, Zomig ZMT	QL: 6 tabs/30days
Zomig nasal spray		QL: Nasal spray: 6/month
HYDANTOINS		
phenytoin sodium, extended	Dilantin, ER	
phenytoin infatabs 50mg chew	Dilantin Infatabs	
DILANTIN 30 MG EXTENDED RELEASE		
PHENYTEK		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
SUCCINIMIDES		
ethosuximide		
ANTICONVULSANT BARBITURATES		
phenobarbital		
primidone	Mysoline	
ANTIVERTIGO AND ANTIEMETIC DRUGS		
granisetron	Kytril	PA
meclizine		
ondansetron, -ODT 4mg, 8mg, oral solution	Zofran, -ODT	QL=30 tabs/30 days oral solution QL=150ml/30 days
prochlorperazine maleate	Compazine	
trimethobenzamide	Tigan	
OTHER ANTIPARKINSON DRUGS		
bromocriptine mesylate	Parlodel	
carbidopa/levodopa, extended-release	Sinemet, Sinemet CR	
entacapone	Comtan	
ropinirole	Requip	QL=90 tabs/30 days
selegiline		
ALCOHOL ANTAGONIST		
Antabuse		
Campral		PA
ANTIDEMENTIA DRUGS		
EXELON solution, patch		PA
galantamine, -ER	Razadyne, Razadyne ER	QL=60 tabs/30 days galantamine ER QL=30 caps/30 days
rivastigmine capsules	Exelon	
SMOKING CESSATION DRUGS		
buproban	Zyban	QL = 90day supply/year
CHANTIX		
nicotine patch OTC		QL = 90day supply/year
NICOTINE INHALER SYSTEM		
NICOTROL NASAL SPRAY		QL = 90day supply/year MONTHLY QLL=15 bottle/30 days
nicotine lozenge OTC		QL = 90day supply/year MONTHLY QLL=324 lozenges/30 days
nicotine gum OTC		QL = 90day supply/year MONTHLY QLL 2 MG=660 pieces/30 days; MONTHLY QLL 4 MG=330 pieces/30 days
OTHER DRUGS FOR ADHD		
Intuniv Extended Release		PA for <6 and >17 For recipients 6 – 17 years old, Intuniv is part of the mental health formulary and billed fee-for-service. For individuals not

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		in this age range, Intuniv continues to be part of the MCO pharmacy benefit
Kapvay Extended Release		PA for <6 and >17 For recipients 6 – 17 years old, Kapvay is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Kapvay continues to be part of the MCO pharmacy benefit
OTHER CNS DRUGS		
naltrexone		
Savella		PA QL = 60/month
CARDIOVASCULAR MEDICATIONS		
CARDIAC GLYCOSIDES		
digoxin	Lanoxin	
LANOXIN		
CALCIUM ANTAGONISTS		
amlodipine	Norvasc	QL= 30 tabs/30 days
cartia xt	Cardizem CD	QL=60 caps/30 days
diltiazem er	Tiazac/Taztia XT	QL=60 caps or tabs/30 days
diltiazem hcl	Cardizem	QL=120 tabs/30 days
felodipine er	Plendil	
isradipine	Dynacirc	
nicardipine hcl	Cardene	
nifediac cc		
nifedipine, er	Procardia Procardia XL	Extended Release QL=90/30 days
Nisoldipine	Sular	QL=60 tabs/30 days
verapamil, er	Verelan/Calan/Calan SR	QL for Immediate Release=120 units/30days; QL for Extended Release=60 units/30 days
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide, -ER	Diamox	
LOOP DIURETICS		
bumetanide	Bumex	
furosemide	Lasix	
toremide	Demadex	
THIAZIDE AND RELATED DRUGS		
chlorothiazide		
Diuril oral suspension		
hydrochlorothiazide	Microzide	
indapamide	Lozol	
metolazone	Zaroxolyn	
methyclothiazide	Aquatensen, Enduron	
POTASSIUM SPARING DIURETICS		
amiloride hcl w/hctz	Midamor	
spironolactone	Aldactone	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
spironolactone w/hctz	Aldactazide	
triamterene w/hctz	Maxzide/Diazide	
BETA-ADRENERGIC ANTAGONIST DRUGS		
acebutolol		
atenolol	Tenormin	
bisoprolol fumarate	Zebeta	
carvedilol	Coreg	
labetalol hcl	Normodyne/Trandate	
metoprolol succinate	Toprol XL	QL: 60/month
metoprolol tartrate	Lopressor	
nadolol	Corgard	
pindolol		
propranolol, er	Inderal/LA	
VASODILATOR ANTIHYPERTENSIVES		
doxazosin mesylate	Cardura	QL 1mg, 2mg, 4mg = 30 tabs/30 days QL 8mg= 60/30days
hydralazine hcl	Apresoline	
prazosin hcl	Minipress	
terazosin hcl	Hytrin	QL 1mg, 2mg, 5mg=30/30 days; QL 10 mg=60/30 days
CENTRALLY ACTING ANTIHYPERTENSIVES		
clonidine patches	Catapres TTS	QL: 5/month
clonidine tablets	Catapres	
guanfacine hcl	Tenex	
methyldopa		
ANGIOTENSIN CONVERTING ENZYME INHIBITORS		
benazepril hcl	Lotensin	
captopril	Capoten	
enalapril maleate	Vasotec	
fosinopril sodium	Monopril	
lisinopril	Prinivil/Zestril	
moexipril hcl	Univasc	
perindopril	Aceon	
ramipril	Altace	
trandolapril	Mavik	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
BENICAR, BENICAR HCT		STEP; QL=30 tabs/30 days
DIOVAN, valsartan HCTZ		STEP; QL=60 tabs/30 days;
irbesartan	Avapro	
losartan, losartan/HCTZ	Cozaar	
OTHER ANTIHYPERTENSIVES		
amlodipine/benazepril	Lotrel	
atenolol w/chlorthalidone	Tenoretic	
benazepril hcl w/hctz	Lotensin HCT	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
bisoprolol fumarate w/hctz	Ziac	
captopril w/hctz	Capozide	
enalapril maleate w/hctz	Vaseretic	
fosinopril w/hctz	Monopril HCT	
lisinopril w/hctz	Prinzide/Zestoretic	
NITRATES		
isosorbide dinitrate	Isochron/Isordil	
isosorbide mononitrate	Imdur/Ismo/Monoket	
nitro-bid ointment		
nitroglycerin (patch, sublingual tablet)	Nitro-Dur/Nitrostat	
NITROSTAT		
CLASS 1A ANTIARRHYTHMICS		
quinidine gluconate		
quinidine sulfate		
CLASS 1B ANTIARRHYTHMICS		
mexiletine	Mexitil	
CLASS 1C ANTIARRHYTHMICS		
flecainide acetate	Tambocor	
propafenone hcl, - SR	Rythmol, -SR	
OTHER ANTIARRHYTHMICS		
amiodarone	Pacerone	
MULTAQ		PA
sotalol	Betapace	
HYPOLIPOPROTEINEMICS		
Cholestyramine	Questran	
colestipol hcl	Colestid	
Fenofibrate 54mg, 67mg, 134mg, 160mg, 200mg	Lofibra	
fenofibrate 48 mg, 145 mg	Tricor	
OTC Fish Oil		
gemfibrozil	Lopid	QL: 60/month
OTC niacin		
fenofibric acid	Trilipix	
HMG-COA REDUCTASE INHIBITORS		
atorvastatin	Lipitor	QL=30 tabs/30 days
lovastatin	Mevacor	QL=30 tabs/30 days
pravastatin	Pravachol	QL=30 tabs/30 days
simvastatin	Zocor	QL=30 tabs/30 days
Vytorin		QL=30 tabs/30 days
OTHER CARDIOVASCULAR DRUGS		
pentoxifylline	Trental	
DERMATOLOGICAL MEDICATIONS		
TOPICAL CORTICOSTEROID DRUGS		
alclometasone dipropionate	Aclovote	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
amcinonide		
betamethasone dipropionate	Diprolene	
clobetasol propionate	Clobevate/Temovate	
desonide	Desowen/Lokara	
desoximetasone	Topicort	
diflorasone diacetate	Apexicon/Maxiflor/Psorcon	
fluocinolone cream, ointment, solution, shampoo	Synalar	
fluocinolone body oil, scalp oil	Derma-Smoothe FS Oil	
fluocinonide		
Hydrocortisone (includes OTC dosage forms)	Ala-Cort/Cetacort/Hytone	
mometasone furoate	Elocon	
Prednicarbate	Dermatop	
triamcinolone acetonide	Kenalog	
ANTIPRURITIC DRUGS		
hydroxyzine hcl		
hydroxyzine pamoate		
ANTIACNE DRUGS		
adapalene cream, gel	Differin	
amnesteem	Accutane	
benzoyl peroxide 2.5, 5% gel, lotion, cream		
benzoyl peroxide-erythromycin 5%-3% gel	Benzamycin	
claravis	Accutane	
clindamycin phosphate (1% solution, gel, topical pledget, lotion, foam)	Cleocin T/Clindamax	
Erythromycin base	A/T/S / Emgel/Erycette	
Finacea		
metronidazole cream, gel, lotion	Metrocream, Metrogel, Metro lotion	
salicylic acid cream, gel, liquid, lotion		
sod.sulfacetamide/sulfur	Avar/Plexion	
sotret	Accutane	
tretinoin	Avita/Retin-A	PA required age >30 years QL= 20gm/30days
KERATOLYTIC DRUGS		
CONDYLOX GEL		
podofilox solution	Condylox	
Salicylic Acid 26%, 27.5% (wart removal products)		
ANTIPSORIASIS AND ANTIECZEMA DRUGS		
calcipotriene cream, ointment, scalp solution	Dovonex	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
Coal tar		
Salicylic acid cream, gel, liquid, lotion		
selenium sulfide	Selseb	
sulfacetamide sodium 10%	Carmol Scalp	
VECTICAL OINTMENT		
TOPICAL DERMATOLOGICAL DRUGS		
ammonium lactate OTC lotion, cream	Lac-Hydrin	
capsaicin OTC		
CARAC		
DRYSOL 20%	aluminum chloride	
ELIDEL		PA required age > 12 year QL=30 gm/30 days
HYPERCARE 20%	aluminum chloride	
imiquimod 5% cream	Aldara	
urea 40% cream, 50% ointment		
SCABICIDES/PEDICULICIDES		
malathion 0.5% lotion	Ovide	
OTC permethrin lotion		
permethrin 5% cream	Elimite	
pyrethrin 0.33% OTC shampoo		
ULESFIA 5% LOTION		
EAR-NOSE-THROAT MEDICATIONS		
DRUGS AFFECTING THE EAR		
Acetasol- HC otic		
acetic acid, -HC otic		
A/B Otic		
CIPRO HC		
CIPRODEX OTIC		
ofloxacin		
DRUGS AFFECTING THE NOSE		
azelastine	Astelin	
flunisolide	Nasarel	QL: 2 bottles/month
fluticasone propionate	Flonase	QL: 2 bottles/month
ipratropium bromide	Atrovent	QL: 2 bottles/month
NASONEX		STEP/QL=2 bottles/month
OTC oxymetazoline nasal spray		
triamcinolone acetonide nasal spray		STEP/QL=2 bottles/month
DRUGS AFFECTING THE THROAT AND MOUTH		
chlorhexidine gluconate 0.12% rinse	Peridex	
DENAVIR		
ENDOCRINE MEDICATIONS		
ORAL HYPOGLYCEMIC DRUGS		
acarbose	Precose	
glimepiride	Amaryl	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
glimepiride-pioglitazone	Duetact	QL: 30/month
glipizide, er	Glucotrol, XL	
glyburide, -micro	Diabeta/Micronase	
glyburide-metformin	Glucovance	
JANUMET, JANUMET XR		STEP
JANUVIA		STEP
metformin metformin ER 500mg, 750mg (generics for Glucophage XR only)	Glucophage Glucophage XR	
nateglinide	Starlix	
PRANDIMET		
repaglinide		
INSULIN SENSITIZERS		
pioglitazone	Actos	QL=30 tabs/30 days
pioglitazone-metformin	Actoplus Met	QL=90 tabs/30 days
GLUCOSE ELEVATING DRUGS		
GLUCAGON		
glucose chewable tablets OTC		
INSULIN (VIALS ONLY)		
Humalog		
Humalog Mix 75/25		
OTC HUMULIN 50/50		
OTC HUMULIN 70/30		
OTC Humulin N		
OTC Humulin R		
LANTUS		
LEVEMIR		
OTC NOVOLIN 70/30		
OTC NOVOLIN R		
OTC NOVOLIN N		
NOVOLOG		
NOVOLOG MIX 70/30		
OTHER GLUCOSE-LOWERING DRUGS		
BYETTA		STEP
GLUCOCORTICOID DRUGS		
cortisone		
dexamethasone		
hydrocortisone	Cortef	
methylprednisolone	Medrol	
prednisolone	Prelone	
prednisone	Sterapred	
MINERALOCORTICOID DRUGS		
fludrocortisone acetate	Florinef	
THYROID SUPPLEMENTS		
ARMOUR THYROID		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
levothroid		
levothyroxine sodium	Synthroid	
levoxyl	Synthroid	
liothyronine	Cytomel	
thyroid, dessicated	Armour Thyroid	
unithroid	Synthroid	
ANTITHYROID DRUGS		
propylthiouracil		
OTHER ENDOCRINE DRUGS		
alendronate sodium	Fosamax	QL 35 mg or 70 mg=4 tabs/30 days; QL 5 mg,10 mg, 40 mg=30 tabs/30 days
cabergoline	Dostinex	
calcitonin nasal spray, injection	Miacalcin	
desmopressin acetate	DDAVP/Minirin	
etidronate	Didronel	
fortical nasal spray		
INCRELEX		PA
MIACALCIN (INJ)		PA
GASTROINTESTINAL MEDICATIONS		
ANTIDIARRHEAL DRUGS		
bismuth subsalicylate	Pepto Bismol	
diphenoxylate w/atropine	Lomotil	
OTC loperamide hcl	Imodium	
ANTISPASMODICS/DRUGS AFFECT GI MOTILITY		
dicyclomine hcl	Bentyl	
glycopyrrolate tablets	Robinul	
hyoscyamine	Nulev/Levbrel	
metoclopramide hcl	Reglan	
NULEV		
ANTIULCER DRUGS		
cimetidine	Tagamet	
famotidine	Pepcid	
nizatidine	Axid	
Ranitidine, OTC ranitidine	Zantac	
OTHER ANTIULCER DRUGS		
Carafate oral suspension		
misoprostol	Cytotec	
sucralfate	Carafate	
PROTON PUMP INHIBITORS		
omeprazole RX, omeprazole OTC	Prilosec, OTC Prilosec	omeprazole 10mg QL=30 caps/30 days, omeprazole 20mg QL=120 caps or tabs/30 days, omeprazole 40mg QL= 60 caps/30 days.
FIRST Omeprazole Suspension		
pantoprazole	Protonix	STEP QL=30 tabs/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
HELICOBACTER PYLORI DRUGS		
PREVPAC		QL: 1 per 90days
LAXATIVES AND CATHARTICS		
constulose		
docusate	Colace	
OTC FLEET BISACODYL ENEMA		
Golytely		
MIRALAX OTC		QL=510 gm/30 days
polyethylene glycol 3350 powder for solution		
psyllium OTC		
SENOKOT OTC (brand and generic OTC dosage forms covered)		
SORBITOL OTC 70% ORAL SOLN		
OTHER GI DRUGS		
OTC aluminum hydroxide gel	Alternagel	
AMITIZA		QL=60 caps/30 days
Analpram-HC 1%		
ASACOL, ASACOL HD		
CANASA suppository		
CORTIFOAM		
CREON LIPASE 3,000; 6,000; 12,000; 24,000 UNITS		
Delzicol		
Hydrocortisone 1%, 2.5% rectal cream	Proctocort 1%,Procto Pak, Proctocream-HC, Proctosol-HC, Proctozone-HC	
hydrocortisone rectal enema suspension	Colocort/ Cortenema	
Lidocaine-hydrocortisone rectal cream, gel		
mesalamine enema	Rowasa	
NULYTELY		
PANCREAZE		
PANCRELIPASE 5,000 UNITS		
PEG 3350 ELECTROLYTE SOLUTION		
sulfasalazine	Azulfidine	
ULTRASE, ULTRASE MT12, MT18, MT20		
ursodiol	Actigall	
VIOKASE 8, 16		
ZENPEP 5,000U; 10,000U, 15,000U, 20,000U		
IMMUNOLOGICALS AND VACCINES		
CERVARIX (available through medical)		PA <10 and >25 Females only

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
		QL 3 syringes and vials/lifetime
FLUMIST		PA FOR AGES <2 OR >49
GARDASIL		PA <9 and >26 QL 3 doses per lifetime Specialty pharmacy ships to provider office only
ZOSTAVAX		PA Specialty Pharmacy Ships to provider office only
MYELOID STIMULANTS		
LEUKINE		PA
NEULASTA		PA
NEUPOGEN		PA
ERYTHROID STIMULANTS		
EPOGEN		PA
PROCRIT		PA
INTERFERONS		
AVONEX		PA
BETASERON		PA QL: 15 syringes/month
INTRON A		PA
PEGASYS		PA
PEG-INTRON		PA
REBIF		PA QL: 15 syringes/month
GROWTH HORMONES AND RELATED AGENTS		
NORDITROPIN		PA
NUTROPIN		PA
NUTROPIN AQ		PA
INTERLEUKINS		
NEUMEGA		PA QL:21/month
IMMUNOGLOBULIN ANTIBODIES		
SOLIRIS		PA
HEMATOPOIETIC AGENTS		
Mozobil		PA
MUSCULOSKELETAL MEDICATIONS		
SALICYLATES AND RELATED DRUGS		
diflunisal	Dolobid	
salsalate	Disalcid	
NON-STEROIDAL ANTIINFLAMMATORY AGENTS		
CELEBREX		STEP QL 50mg, 100mg, 200mg : 60/30days 400mg: 30/30days
diclofenac sodium	Voltaren	
etodolac	Lodine/Lodine XL	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
Ibuprofen rx, OTC and 100mg/5ml Susp	Motrin, Advil	
indomethacin	Indocin SR	
ketoprofen	Orudis/Oruvail	
meloxicam	Mobic	
nabumetone	Relafen	
naproxen	Naprosyn, Aleve	
oxaprozin	Daypro	
DRUGS TO PREVENT AND TREAT GOUT		
allopurinol	Zyloprim	
COLCRYS		
probenecid		
ULORIC		PA
DIRECT MUSCLE RELAXANTS		
baclofen		
tizanidine hcl tablets	Zanaflex tablets	
CNS MUSCLE RELAXANTS		
carisoprodol	Soma	QL=120 tabs/30 days
cyclobenzaprine hcl	Flexeril	
methocarbamol	Robaxin	
metaxalone	Skelaxin	
NUTRITION, BLOOD MODIFIERS, ELECTROLYTES		
THERAPEUTIC VITAMINS & MINERALS		
calcitriol	Calcijex/Rocaltrol	
calcium acetate capsules, tablets, gelcap	Phoslo	
calcium carbonate	Tums	
calcium citrate	Citracal	
OTC cholecalciferol, ergocalciferol, calciferol drops	Vitamin D3	
ferrous gluconate		
ferrous sulfate		
folic acid		
Hectorol capsules		
levocarnitine		
Mephyton		QL: 10 tabs / 30days
multivitamin with fluoride		
multivitamin with iron		
NEPHROCAPS		
sodium fluoride drops, chewable tablets, tablets, drops		
POTASSIUM SUPPLEMENTS		
citric acid/sodium citrate oral soln	Bicitra	
klor con, klor con m, klor con effervescent		
K-Phos		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
potassium chloride, -CR, ER, oral solution, powder packets Potassium Citrate ER	K-Dur/Klotrix	
ORAL ANTICOAGULANTS		
warfarin sodium	Coumadin	
PRADAXA		PA
XARELTO		PA
HEPARINS		
heparin sodium (heparin lock flush solution not covered)		
LOW-MOLECULAR WEIGHT HEPARINS (LMWH)		
enoxaparin [inj]	Lovenox	20 SYRINGES PER YEAR
Fondaparinux		PA
FRAGMIN [inj]		10 SYRINGES PER YEAR
ANTIPLATELET DRUGS		
anagrelide		
clopidogrel	Plavix	
ticlopidine hcl	Ticlid	
HEMOSTATICS		
aminocaproic acid	Amicar	
MEPHYTON		
BLOOD DETOXICANTS		
enulose		
generlac		
lactulose		
RENAGEL		
RENVELA		
OBSTETRICAL & GYNECOLOGICAL MEDICATIONS		
PRENATAL VITAMINS		
<i>QL (single) = 100tabs/90days</i>		
<i>(combo pack) = 60/month</i>		
complete natal DHA		QL
CONCEPT DHA		QL
Prenafirst		QL
Prenatabs FA		QL
Prenatabs RX		QL
Prenatal AD		QL
Prenate Advance		QL
Prenate GT		QL
SELECT-OB, SELECT-OB + DHA		QL
Ultra Natalcare		QL
vinate II		QL
vinate az		QL
vinate calcium		QL
vinate gt		QL

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
vinate one		QL
vinate m		QL
vinate ultra		QL
vitafol-ob		QL
vitafol-pn		QL
SPECIALIZED OB/GYN DRUGS		
Lupron		PA
OB/GYN TOPICAL ANTIINFECTIVES		
CLEOCIN 100mg vaginal suppositories		
clindamycin 2% vaginal cream	Clindamax	
metronidazole 0.75% vaginal gel	MetroGel	
miconazole vaginal cream, combination pack, suppositories		
ANDROGEN DRUGS		
Androxy		
Danazol		
Methitest		
Testosterone Cypionate		
ESTROGEN DRUGS		
estradiol tablets	Estrace	
estradiol transdermal patch	Climara	QL=4 patches/30 days
estropiate	Ogen/Ortho-Est	
ESTRACE VAGINAL CREAM		
PREMARIN		
PREMARIN CREAM		
VAGIFEM		
ESTROGEN/PROGESTIN COMBINATIONS		
COMBIPATCH		
PREMPHASE		
PREMPRO		
SELECTIVE ESTROGEN RECEPTOR MODULATOR		
EVISTA		
PROGESTIN DRUGS		
medroxyprogesterone acetate	Provera	
norethindrone acetate	Aygestin	
CONTRACEPTIVES		
Apri	Desogen	
Altavera-28	Nordette-28	
Alyacen		
Amethia, - Lo		
Amethyst	LYBREL	
Aranelle	TRI-NORINYL	
Aubra		
Aviane	ALESSE-28	
Azurette		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
BEYAZ		
Balziva	OVCON	
Briellyn	OVCON	
Camila	NOR-Q-D	
Camrese, - Lo		
Caziant-28	CYCLESSA	
Cesia	CYCLESSA	
Chateal		
Cryelle	LO/OVRAL-28	
Cyclafem	ORTHO-NOVUM 1/35	
Daysee		
Dasetta		
Ella		QL: 1 pkg/1 month; 3 pkgs/year
Elinest		
Emoquette	DESOGEN	
Enpresse	TRI-LEVLEN 28	
Enskyce		
Errin		
Estarylla		
Falmina		
Generess FE chew		
Gianvi		
Gildagia	OVCON	
Gildess		
Heather		
Implanon		
Introvale		
Jencycla		
Jolessa		
Jolivette	NOR-Q-D	
Junel	LOESTRIN	
Junel Fe	LOESTRIN FE	
Kariva	MIRCETTE	
Kelnor 1/35	DEMULEN 1/35-28	
Kurvelo		
Larin FE		
Leena	TRI-NORINYL	
Lessina	ALESSE-28	
Levonest		
Levonorgestrel 0.75mg (Next Choice, Plan B)	PLAN B	QL: 1 pkg/1 month; 3 pkgs/year
Levnorgestrel 1.5mg (Next Choice, My Way)	PLAN B	QL: 1 pkg/1 month; 3 pkgs/year
Levora-28	NORDETTE-28	
Loryna	YAZ	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
Low-Ogestrel	LO/OVRAL-28	
Lo Loestrin		
Lo Minastrin FE		
Lutera	ALESSE-28	
Lyza		
Marlissa		
Medroxyprogesterone AC Inj 150mg/ml		
Microgestin	LOESTRIN	
Microgestin Fe	LOESTRIN FE	
Minastrin 24 FE		
Mirena		
Mono-Linyah		
Mononessa	ORTHO-CYCLEN	
Myzilra	TRI-LEVLEN 28	
NATAZIA		
Necon	MODICON	
Nexplanon		
Next Choice One Dose		QL: 1 pkg/1 month; 3 pkgs/year
Nora-Be	NOR-Q-D	
Nortrel	ORTHO-NOVUM	
NuvaRing		QL: 1 ring/month
Ocella 28	Yasmin	
Ogestrel	OVRAL-28	
Orsythia		
Ortho Evra		QL: 3 patches/month
Ortho Tri Cyclen Lo		
Paragard		
Philith	OVCON	
Pimtrea		
Pirmella 1/35		
Plan B One Step		
Portia	NORDETTE-28	
Previfem	ORTHO-CYCLEN	
Quartette		
Quasense		
Reclipsen	DESOGEN	
SAFYRAL		
Solia	DESOGEN	
Sprintec	ORTHO-CYCLEN	
Sronyx	ALESSE-28	
Skyla		
Syeda	YASMIN	
Tilia-FE		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
Tri-Estaryll		
Tri-Legest-FE		
Trinessa	ORTHO TRI-CYCLEN	
Tri-Linyah		
Tri-Previfem	ORTHO TRI-CYCLEN	
Tri-Sprintec	ORTHO TRI-CYCLEN	
Trivora-28	TRI-LEVLEN 28	
Velivet	CYCLESSA	
Vestura	YAZ	
Viorele		
Wera		
Wymzya FE		
Zarah	YASMIN	
Zenchent, - FE		
Zovia	DEMULEN 1/35-28	
OPHTHALMIC MEDICATIONS		
OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS		
bacitracin/polymyxin ophth ointment	AK-Poly Bac	
ciprofloxacin hcl (ophth drops)	Ciloxan	
CILOXAN OPTHALMIC OINTMENT		
erythromycin		
gatifloxacin	Zymaxid	
levofloxacin 0.5% ophth soln	Quixin	
neomycin/polymyxin/bacitracin	Neosporin	
ofloxacin	Ocuflox	
polymyxin/trimethoprim	Polytrim	
sulfacetamide sodium	Bleph-10	
tobramycin sulfate	Tobrex	
TOBREX OINTMENT		
VIGAMOX		
OPHTHALMIC CORTICOSTEROID DRUGS		
dexamethasone 0.1%		
fluorometholone 0.1%		
PRED MILD 0.12%		
prednisolone acetate 1%	Omnipred/Pred Forte	
Prednisolone sodium phosphate 1%		
Vexol 1%		
OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS		
Bacitracin/neomycin/polymyxin B/hydrocortisone ophthalmic ointment		
neomycin/polymyxin/dexamethasone	Methadex/Maxitrol	
Sulfacetamide w/ prednisolone		
TOBRADEX OINTMENT		
tobramycin/dexamethasone susp	Tobradex	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANTIGLAUCOMA DRUGS		
brimonidine tartrate	Alphagan, Alphagan P	
carteolol hcl		
COMBIGAN		
dorzolamide	Trusopt	
dorzolamide/timolol	Cosopt	
latanoprost	Xalatan	
levobunolol hcl	Betagan	
LUMIGAN		
pilocarpine hcl	Isopto Carpine	
timolol maleate	Timoptic/Timoptic-XE	
Timoptic Ocudose		
travoprost	Travatan	
TRAVATAN Z		
OTHER OPHTHALMIC DRUGS		
cromolyn sodium	Crolom	
ketorolac tromethamine	Acular, Acular LS	
OTC ketotifen		
REFRESH TEARS, LIQUIGEL (5ML, 15 ML AND 30 ML BOTTLE ONLY)		
tropicamide	Tropicacyl	
ZADITOR OTC		
RESPIRATORY MEDICATIONS		
BETA-2 ADRENERGIC DRUGS		
albuterol sulfate (inhalation soln, syrup, tablet)		QL=375 ml/30 days for inhalation soln 0.5% solution: 60ml/month
FORADIL		PA
metaproterenol		
PROAIR HFA		QL= 2 inhalers/30 days
PROVENTIL HFA		QL= 2 inhalers/30 days
SEREVENT DISKUS		QL= 1 x 60 / 30days
VENTOLIN HFA		QL= 2 inhalers/30 days
INHALED CORTICOSTEROIDS		
ADVAIR DISKUS		QL= 60 blisters/month
ADVAIR HFA		QL = 2 inhalers/30 days
budesonide respules 0.25 mg/2 ml, 0.50 mg/2 ml	Pulmicort Respules	QL=120 ml/30 days (60 respules/30 days)
FLOVENT DISKUS		QL: 50 mcg – 1x60/month
FLOVENT HFA		QL: 44 mcg, 110 mcg – 2 month; 220 mcg – 3/month
PULMICORT 1 MG/2 ML RESPULES		QL=120 ml/30 days (60 respules/30 days)
PULMICORT FLEXHALER/INHALER		QL=1 inhaler or flexhaler/30 days

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
SYMBICORT		
LEUKOTRIENE MODIFIERS		
montelukast 4mg, 5mg 10mg tablets, 4mg granules	Singulair	QL: 30/30days
zafirlukast	Accolate	QL 60/30days Please note: No ST required for members with use of an asthma medication within the past 6 months; zafirlukast is currently not FDA-approved for allergic rhinitis
METHYL XANTHINE DRUGS		
Theophylline anhydrous		
Theochron		
OTHER DRUGS FOR ASTHMA		
ATROVENT		QL: 2 / month
COMBIVENT MDI, RESPIMAT		QL: 3/month
cromolyn sodium nebulizer soln		
EIPEN, EIPEN JR		
ipratropium bromide		
OTHER RESPIRATORY DRUGS		
SPIRIVA		STEP QL=1 pack of 30 / month
ANTI-HISTAMINES AND DECONGESTANTS		
Bromax ER tablets	brompheniramine maleate	
cetirizine, cetirizine-D OTC	OTC Zyrtec	cetirizine-D12hr tabs QL=60 tabs/30 days cetirizine syrup/solution: Age < 6 yrs = 150ml/month Age ≥ 6 yrs = 300ml/month
OTC chlorpheniramine maleate		
cycloheptadine hcl	Periactin	
OTC diphenhydramine hcl	Benadryl	
OTC fexofenadine, fexofenadine-D OTC	Allegra, Allegra-D	
Allegra 30 mg/5 ml suspension		
loratadine, loratadine-D OTC	OTC Claritin, Claritin D	QL: Loratadine: 30 tabs/month oral solution/syrup – 300 ml/month QL: Loratadine-D 12 hr tab - 60/month 24 hr tab - 30/month
promethazine		
ANTI-HISTAMINE/DECONGESTANT COMBINATIONS		
LoHist D Syrup	chlorpheniramine-pseudoephedrine	
promethazine vc plain syrup (promethazine-phenylephrine)	Phenergan VC	
Sildec syrup (brompheniramine/pseudoephedrine)	Rondec, Cardec syrup	
R-Tanna pediatric suspension (chlorpheniramine/phenylephrine)	Rondec drops	

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
ANTITUSSIVE AND EXPECTORANT DRUGS		
benzonatate	Tessalon	
CHERATUSSIN AC OTC (guaifensin-codeine)		
guaifenesin w/codeine syrup	Tussi-Organidin NR	
Hydrocodone w/ chlorpheniramine		
OTC Mucinex ER, Mucinex D ER, Mucinex DM ER, Mucinex Fast-Max DM Max, Mucinex Fast- Max Cold & Sinus		
promethazine-codeine	Phenergan w/Codeine	
promethazine vc w/codeine syrup (promethazine-phenylephrine- codeine)	Phenergan VC w/Codeine	
promethazine-dm	Phenergan DM	
TOXICOLOGY MEDICATIONS		
acetylcysteine		
UROLOGICAL MEDICATIONS		
ANTICHOLINERGIC ANTISPASMODICS DRUGS		
flavoxate	Urispas	
oxybutynin chloride	Ditropan	
oxybutynin chloride er	Ditropan XL	
tropium	Sanctura	STEP
tropium ER	Sanctura XR	STEP QL = 30 tabs/30 days
URINARY ANESTHETICS		
phenazopyridine hcl	Pyridium/Urodol	
OTHER GENITOURINARY PRODUCTS		
alfuzosin	Uroxatral	
finasteride	Proscar	
tamsulosin	Flomax	QL=60 caps/30 days
MEDICAL (MISCELLANEOUS) SUPPLIES		
DIABETIC SUPPLIES		
TEST STRIPS COMBINED QL=204 TEST STRIPS/30 DAYS		
ACCU-CHEK AVIVA GLUCOMETER/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK ACTIVE GLUCOMETER/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK ADVANTAGE GLUCOMETER/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK COMPACT PLUS GLUCOMETER/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK NANOSMARTVIEW GLUOCMETER/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK COMFORT CURVE TEST STRIPS		Combined QL for test strips= 204 strips/30 days
ACCU-CHEK FASTCLIX LANCET		

COVERED DRUG	REFERENCE DRUG NAME	REQUIREMENTS/LIMITS
DEVICE /LANCETS		
ACCU-CHEK MULTICLIX LANCET DEVICE/LANCETS		
ACCU-CHEK SOFTCLIX LANCET DEVICE/LANCETS		
ACCU-CHEK SOFT TOUCH LANCETS		
MICROLET LANCING DEVICE/LANCETS		
ONE TOUCH DELICA LANCET DEVICE/ LANCETS		
ONE TOUCH ULTRA SOFT LANCET DEVICE/ LANCETS		
ONE TOUCH ULTRA CONTROL SOLUTION		
ONE TOUCH BASIC, ULTRA, ULTRA2, ULTRALINK, ULTRAMINI, ULTRASMART, VERIO GLUCOMETERS/TEST STRIPS		Combined QL for test strips= 204 strips/30 days
OTHER SUPPLIES		
AEROCHAMBER, MICROCHAMBER		QL=1 spacer/ 365days
OTC ALCOHOL PREP PADS		
ASSESS, MICROLIFE, PERSONAL BEST PEAK FLOW METER		QL: 1 peak flow meter/365 days
OTC CHEMSTRIP TEST STRIPS		
OTC KETOSTIX URINE TEST STRIPS		
OTC LATEX CONDOMS		