

2012 Prescription Drug List

Our goal is to help you make informed drug choices. Since pharmacy benefits can be confusing, we have designed this brochure to explain your benefits and answer your questions. **This brochure is an abbreviated version of the BlueChoice HealthPlan Prescription Drug List.** For a complete list, visit our website at www.BlueChoiceSC.com or contact Member Services (Mon. – Fri. 8:30 a.m. to 8:30 p.m. EST) toll free at 800-868-2528.



About the Prescription Drug List

The 2012 **Prescription Drug List** includes many commonly prescribed drugs used to treat a variety of medical conditions. It was developed by the physicians and pharmacists on our Pharmacy and Therapeutics (P&T) Committee. These professionals work in our community and advise us on drug-related decisions, including what copayments are assigned to each drug. CVS Caremark is the pharmacy benefit management company responsible for administration of the BlueChoice HealthPlan Prescription Drug List. CVS Caremark is an independent company. Because new drugs come to the market and older drugs become available generically throughout the year, the list is subject to change at any time with or without prior notice to members or health care providers. If you don't see a drug listed in this brochure, please review the complete list on our website.

SAVE \$\$\$ Using the Web

To find the most current version of the Prescription Drug List, go to www.BlueChoiceSC.com, select Members and then Find Out More under Prescription Drug Information. Then choose BlueChoice HealthPlan Prescription Drug List. Also, we have created a **Prescription Drugs** section of My Health Toolkit[®], an interactive part of our website where you can easily find out more about your pharmacy benefits.

To enter the **Prescription Drugs** portion of our website, go to www.BlueChoiceSC.com, select Members then the link for My Health Toolkit. You will need a username and password to access this part of our website. Once you have entered My Health Toolkit, select Benefits and choose one of the options under **Prescription Drugs**. You will be able to:

- Check your drug claims information and history
- See your copayments and out-of-pocket expenses
- Find the nearest network pharmacy
- Find out about drug interactions, recalls and warnings
- Refill mail-service prescriptions

SAVE \$\$\$ with Generic Drugs

Generic drugs are medications that contain the same active ingredients as the corresponding brand-name drugs, but generally cost less. The Food & Drug Administration (FDA) requires testing of generic drugs before they are sold to make sure they are of the same quality and effectiveness as their brand-name counterparts. We've designed a program, called **GENERICS NOWSM**, to encourage you to use generic drugs. How does it work? Get a prescription from your doctor and take it to a network pharmacy. If your doctor writes the prescription to say that it must be filled with a brand-name drug **that has a generic option** — or if you simply choose to get the brand-name drug instead of the generic option — you will pay a higher copayment plus the price difference between the generic and the brand-name drug. At no time will you be charged more than the retail price.

SAVE \$\$\$ with Over-the-Counter Medications

In general, over-the-counter (OTC) medications are available from your local pharmacy without a prescription. Your BlueChoice HealthPlan benefits will cover certain over-the-counter drugs if your doctor writes a prescription for you.

- Antihistamines (Alavert OTC, Allegra OTC, Claritin OTC, Zyrtec OTC or OTC store brands)
- Acid reflux medications (Prilosec OTC, Prevacid 24HR, Zegerid OTC or OTC store brands)

Frequently Asked Questions

What is a Prescription Drug List?

When you have pharmacy benefits with BlueChoice HealthPlan, you can get most oral prescription drugs that your doctor orders. The main exceptions are Lifestyle Medications (see page 2). The Prescription Drug List includes all the drugs covered under the pharmacy benefit and divides them into three categories: Generic, Preferred and Non-preferred.

How does my prescription benefit work?

When you get a prescription from your health care provider, take it to a participating network pharmacy along with your BlueChoice HealthPlan ID card. You will receive up to a month's supply of your medication for one copayment. If you have mail-service benefits, you can also fill some prescriptions for up to a 90-day supply, by mail. Mail-service is a convenient way to get your medications AND it may also save you money. See the **Save \$\$\$ with Mail-Service Prescriptions** section on this page.

Are there special situations?

Most drugs are covered under your pharmacy benefit. Some drugs, however, may have additional requirements — **Prior Authorization, Quantity Limits, Step Therapy** — before you get them filled. See pages 2-3 for more information.

What will I have to pay for my prescriptions?

See your Schedule of Benefits for your plan's exact copayment structure and cost for each level. Here is an overview of the various copayment levels:

Copayment Level	What you will pay
Generic/Tier 1	<ul style="list-style-type: none"> • Plans with one generic copayment: Most generic drugs are available at the lowest copayment.* • Plans with a two-tier generic copayment: <ul style="list-style-type: none"> <i>Value generics:</i> Generic drugs that cost less than \$15 (and select over-the-counter drugs) are available at the lowest copayment. <i>Standard generics:</i> Generic drugs that cost more than \$15 are available for a low copayment.* <p>* A few high-priced generics are available at the non-preferred (highest) level.</p>
Preferred/Tier 2	These are select brand drugs that are available at the middle copayment.
Non-preferred/Tier 3	These are select brand drugs (and occasionally some high-priced generic drugs) that are available at the highest copayment.

Note: A specialty pharmacy copayment applies to a certain list of drugs that are used to treat complex medical conditions. See **Specialty Pharmaceuticals** on page 3.

What do I do when I have questions?

You can find the answers to many of your questions on our website. Look at the **Save \$\$\$ Using the Web** section for tips on getting the information you need. If you still have questions, please call **Member Services toll free at 800-868-2528**.

- Smoking cessation patches (Nicoderm CQ, etc. — refer to the **Lifestyle Medications** section for benefit specifics).

These medications are covered at the lowest generic copayment level under your pharmacy benefit and require a doctor's prescription.

SAVE \$\$\$ with Mail-Service Prescriptions

You may have mail service available as part of your pharmacy benefits. With our mail-service program, you get the convenience of having your prescriptions delivered by mail directly to your home in plain, tamper-evident packaging. When you order by mail, you can get up to a three-month supply of medication, typically for less than the cost of three monthly retail copayments. Ordering your drugs through mail service can also save you money when filling drugs you take routinely. Please refer to your Schedule of Benefits for more information about this service.

Getting Started with Mail Service: Get written prescription(s) from your doctor for a three-month supply of your medication, with up to three refills, if appropriate. Remember, it's important that your

doctor write your mail-service prescription(s) for a three-month supply. Go to www.BlueChoiceSC.com to get a mail-service order form. Select Members and go to Forms. Under Forms, select Pharmacy Mail Order Form. Print and complete the form and mail it with your original prescription(s) and copayment(s) to the address on the form. You can pay by check, money order or major credit card.

We can also contact your physician for a new prescription under the **FastStart** program. Please call CVS Caremark toll free at 800-875-0867 for details.

Refills Are Simple: You have the option of requesting refills via the Internet (See **Save \$\$\$ Using the Web** section) or by phone toll free at 888-963-7290. Both are available 24 hours a day, seven days a week. To refill your prescription, you will need your prescription number, five-digit ZIP code, and credit card number with expiration date. Please allow up to 14 days for home delivery by mail from the time you place your refill order.

Coverage Exclusions

These types of medication may not be covered under your pharmacy benefit. Please refer to your Certificate of Coverage for more information.

- Contraceptives¹
- Cosmetic agents
- Drugs considered investigational or not approved by the FDA
- Fertility
- Impotence
- Injectables²
- Over-the-Counter (OTC)³
- Smoking cessation⁴
- Weight loss

¹ Oral contraceptives are covered as outlined in your Schedule of Benefits. Other non-covered contraceptives may be available under the Lifestyle Medication discount (i.e., Depo-Provera injections).

² Injectables covered under the pharmacy benefit include B yetta, enoxaparin, epinephrine, glucagon, insulin, Lovenox, sumatriptan, Symlin, Victoza and Vitamin B-12.

³ OTC antihistamines and some OTC acid reflux products may be covered with a prescription. See the **Save \$\$\$ with Over-the-Counter Medications** section on page 1 for more information.

⁴ Chantix, generic Zyban and OTC smoking cessation patches may be covered by some benefit plans. See the **Lifestyle Medications** section for more information.

Some drugs in the categories listed above are available at a discount through participating pharmacies. See the **Lifestyle Medications** section for more information.

Lifestyle Medications

Certain Lifestyle Medications are available to you at a discounted price under your pharmacy benefits. To receive the discount, present your prescription and member ID card to a participating pharmacy. You will be charged the discounted price at the time of purchase. Drugs that fall under the Lifestyle Medication benefit are:

- Weight loss agents
- Contraceptive agents or products
- Cosmetic agents
- Erectile dysfunction agents
- Male pattern baldness agents
- Skin depigmenting agents
- Smoking cessation agents*

*Smoking Cessation Agents

Although smoking cessation agents are considered Lifestyle Medications, we believe in encouraging members to quit smoking. For that reason, we cover some smoking cessation agents under your pharmacy benefits. We cover bupropion ext-rel (generic for Zyban) and OTC transdermal nicotine (patches) at the generic copayment level. We cover Chantix at the Preferred copayment level. Nicotrol, Nicotrol NS and Zyban will remain covered under the Lifestyle Medications discount price. If you have another smoking cessation benefit provided by your employer such as Free & Clear®, please consult that benefit regarding coverage for smoking cessation medications. On behalf of BlueChoice HealthPlan, Free & Clear administers a smoking cessation program. Free & Clear is an independent company that provides smoking cessation services.

Quantity Limits

The BlueChoice HealthPlan P&T Committee sets limits on the amount of certain medications you can get at one time based on FDA prescribing guidelines and/or available package sizes. Some medications are also limited to certain quantities you are allowed to fill at one time.

As you go through the Prescription Drug List, you will see the letters “**QL**” beside drugs with quantity limits. If you have a question about quantity limits, please call Member Services toll free at 800-868-2528.

Step Therapy

BlueChoice HealthPlan requires that certain drugs covered under your prescription benefits satisfy specific step therapy criteria. You will see the letters “**ST**” beside drugs requiring step therapy. “Step therapy criteria” simply means that before you can fill a medication listed on the Step Therapy Drug List, you must first have tried one or more prerequisite drugs that are also appropriate to treat your condition. Step therapy can also help prevent or alert you to any adverse reactions between drugs that could cause serious health problems or have potential drug interactions. All step therapy criteria are based on current FDA guidelines and clinical decisions made by the BlueChoice HealthPlan P&T Committee.

The current step therapy medications are listed here, followed by a summary of the step therapy criteria. If your particular situation does not meet the criteria, please forward your request to BlueChoice HealthPlan for further review. This list is subject to change with or without prior notice. For a complete list, please visit our website at www.BlueChoiceSC.com or call Member Services toll free at 800-868-2528. (Note: For drugs with an “ST” in the Generic column, only the BRAND drug must meet the step requirements, not the generic, unless otherwise noted.)

Atypical Antipsychotics: Coverage requires that members must have filled at least a 30-day supply in the previous 365 days of risperidone, Geodon, Seroquel, Seroquel XR or Zyprexa before Abilify, Fanapt, Invega, Latuda or Saphris.

Celebrex: Coverage requires that members 60 years or younger must have filled at least a 30-day supply in the previous 120 days for one of these medications or have one of these risk factors:

1. Tried and failed at least one traditional generic nonsteroidal anti-inflammatory agent (NSAID)
2. Have at least one pharmacological indicator of a risk factor for developing gastrointestinal (GI) adverse events
3. Filled at least one GI medication
4. Filled at least one oral disease-modifying anti-rheumatic drug (DMARD) medication in the previous 12 months

Cymbalta, Pristiq: Coverage requires that members must have filled at least a 14-day supply in the previous 180 days of an available generic Selective Serotonin Reuptake Inhibitor (SSRI), Selective Norepinephrine Reuptake Inhibitor (SNRI) or Lexapro before Cymbalta or Pristiq.

Elidel, Protopic: Coverage requires that members 16 years of age or older must have tried at least one prescription topical steroid (any potency) for at least 14 days within the previous six months. No requirement for members 2 years of age through 15 years of age.

Fibrates: Coverage requires that members must have filled a generic fenofibrate (triglyceride-lowering drug) for at least a 30-day supply in the previous 180 days before Antara, Fenoglide, Fibricor, Lipofen, Lofibra, Tricor, Triglide or Trilipix.

Nonbenzodiazepine Hypnotics: Coverage requires that members must have filled at least a 30-day supply in the previous 365 days of generic zolpidem or zaleplon before Ambien, Ambien CR, Edluar, Lunesta, Rozerem, Silenor, Sonata or Zolpimist.

Prescription Antihistamines: Coverage requires members to have had a 21-day trial of an available OTC oral non-sedating/mildly sedating antihistamine (Alavert OTC, Allegra OTC, Claritin OTC, Zyrtec OTC or OTC label store brand) in the previous 12 months from the time of fill before Clarinex, levocetirizine or Xyzal. (Note: Proof of a trial of an OTC drug must be found in the member’s medication history.)

Proton Pump Inhibitors (PPIs): Coverage requires that members must have filled at least a 30-day supply in the previous 180 days of generic lansoprazole, omeprazole, pantoprazole, an OTC PPI or Nexium before filling Aciphex, Dexilant, omeprazole-sodium bicarbonate (generic Zegerid), Prevacid, Prilosec, Protonix or Zegerid.

Singulair: Coverage for asthma requires that members 2 years and older use Singulair as a second-line medication in addition to inhaled corticosteroids or in the rare circumstance of steroid unresponsiveness or inability to use a steroid inhaler correctly. If the member has not filled a one-month supply of an inhaled corticosteroid or combination corticosteroid in the three months prior to the date of fill for Singulair, the request will be forwarded to the CVS Caremark Prior Authorization (PA) center for further review. See the **Prior Authorization** section for more information. Members less than 2 years old are exempt. Coverage for members with allergic rhinitis will be provided after attempt and failure of a minimum 21-day trial of an available OTC (Alavert OTC, Allegra OTC, Claritin OTC, Zyrtec OTC or OTC label store brand) or prescription oral non-sedating/mildly sedating antihistamine and a one-month trial of an intranasal corticosteroid in the previous four months. (Note: Proof of a trial of an OTC drug must be found in the member’s medication history.) Requests for Exercise-Induced Bronchospasm (EIB) should be forwarded to the CVS Caremark PA center.

Solodyn: Coverage requires that members be 12 years or older, must have tried at least 30 days of a generic minocycline AND a 30-day supply of one of the following generics (tetracycline, erythromycin or doxycycline) within the previous 365 days.

Sumavel DosePro: Coverage requires that the member must have tried at least 14 days of generic sumatriptan injectable in the last 180 days before Sumavel DosePro.

Topical Acne Treatments: Coverage requires that members 22 years of age and older must have filled at least a 30-day supply in the previous 365 days of a benzoyl peroxide product before Atralin, Avita, Differin, Retin-A, Retin-A Micro, Tazorac, Tretin-X or Ziana.

Vytorin 10/80 mg, Zocor (simvastatin) 80 mg: Coverage requires that members must have filled at least a 290-day supply of the 10/80 mg strength of Vytorin or the 80 mg strength of simvastatin within the previous 365 days.

Prior Authorization

BlueChoice HealthPlan asks doctors to get prior authorization before prescribing certain drugs to you to ensure these drugs are prescribed within FDA clinical guidelines. You will see the letters “**PA**” beside drugs requiring prior authorization. The decision to require prior authorization for a drug is based on current FDA guidelines and recommendations from the BlueChoice HealthPlan P&T Committee.

Before your doctor prescribes a drug that requires prior authorization, he or she should call the CVS Caremark PA center toll free at 800-294-5979 to begin the prior authorization process.

These medications, and their generics, if available, currently require prior authorization. The medications are listed first followed by a summary of prior authorization criteria.

Abstral, Lazanda, Onsolis: Coverage provided for members 18 years and older for the management of breakthrough cancer pain who are already receiving opioid therapy.

Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix, Zegerid: (Please Note: This PA does not apply to prescriptions for OTC reflux medications.)

- After satisfying initial step criteria, prior authorization is required to continue therapy after eight weeks of initial therapy.
- Coverage provided after a trial of a prescription or OTC version of lansoprazole, omeprazole or pantoprazole when treating reflux (GERD).
- Coverage provided for twice-daily dosing for treatment of reflux (GERD) only after failure of full-strength once-daily dosing.
- Coverage for other disorders (Barrett’s esophagus, erosive esophagitis and Zollinger-Ellison syndrome) has less restrictive treatment and dosing guidelines.

Actiq, Fentora: Coverage provided for members 16 years and older for the management of breakthrough cancer pain who are already receiving opioid therapy.

Adoxa, Doryx, Monodox: Coverage allows up to 14 days of therapy in 365 days. Requests for additional days of therapy for acne diagnoses require medical review.

Anti-emetic Agents (Anzemet, granisetron, Granisol, Sancuso, Zofran, Zuplenz): Coverage provided for treatment of nausea and vomiting associated with chemotherapy or pregnancy (granisetron, Granisol, Sancuso or Zofran).

Celebrex: After satisfying initial step criteria, coverage provided for members at doses greater than 200 mg total per day only for treatment of acute pain, ankylosing spondylitis, dysmenorrhea or rheumatoid arthritis.

Exalgo: Coverage provided for management of moderate to severe pain in patients who are opioid tolerant and require around-the-clock pain therapy for an extended period of time.

Lovaza: Coverage provided to members 18 years and older who have elevated triglycerides above 500 mg/dl and have failed on previous FDA approved therapy to lower triglycerides along with diet.

Namenda: Coverage provided for members with mild to severe Alzheimer’s disease based on widely accepted standard medical testing guidelines for diagnosis of dementia of the Alzheimer’s type.

Nuvigil: Coverage provided for members with a diagnosis of narcolepsy, multiple sclerosis-related fatigue, persistent sleepiness due to obstructive sleep apnea despite traditional treatments (CPAP, etc.), and sleepiness associated with diagnosed shift work sleep disorder.

Pradaxa: Coverage requires that members have a diagnosis of non-valvular atrial fibrillation and risk factors for thromboembolism. It is requested that the physician not use in patients over 75 years of age.

Proscar: Coverage provided for the treatment of symptomatic benign prostatic hypertrophy in males over 40 years old.

Provigil: Coverage provided for members with a diagnosis of multiple sclerosis-related fatigue or an FDA-approved indication that have tried and failed at least a 30-day trial of Nuvigil in the last 365 days.

Revlimid: Coverage provided for the treatment of patients with transfusion dependent anemia due to Low- or Intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.

Soriatane: Coverage provided for the treatment of keratinization disorder, lichen planus, pityriasis rubra pilaris or severe psoriasis in adults.

Suboxone, Subutex: Coverage provided for members who are confirmed to be receiving treatment of opioid dependence in a valid opioid-addiction treatment program.

Symlin: Coverage provided for patients with Type I or Type II diabetes who have failed to achieve adequate glycemic control despite optimal insulin therapy.

In general, PA drugs will require you to pay a Non-preferred (highest) copayment for your prescriptions. The exceptions are:

1. lansoprazole, omeprazole and pantoprazole (Generic copayment)
2. Nexium (Preferred copayment)
3. Abstral, Actiq, Fentora, Gilenya, Onsolis and Revlimid (Specialty Pharmaceutical copayment)

As new drugs come out and indications change we may add or remove drugs from this list at any time with or without notice. For a complete list of drugs requiring prior authorization, please view the Prescription Drug List on our website at www.BlueChoiceSC.com.

Specialty Pharmaceuticals

Some prescription drugs are covered under the Specialty Pharmaceuticals benefit, which is a separate benefit from your pharmacy benefit. These are drugs used to treat complex medical conditions. These medications include, but are not limited to, intravenous (IV) drugs, injectable and self-injectable medications, inhaled, topical and certain oral drugs used to treat chronic or rare disease. Go to our website at www.BlueChoiceSC.com for a complete list of these drugs.

If you are prescribed a drug covered under the Specialty Pharmaceuticals benefit, your doctor will arrange to do one of the following:

1. Give specialty pharmaceutical drugs requiring administration in his or her office.
2. Arrange for home delivery of specialty pharmaceuticals that are typically self-injected.
3. Write a prescription for one of the specialty pharmaceutical drugs listed in the next column.

These specialty medications and their generic versions, if available, are covered under the Specialty Pharmaceuticals benefit:

Brand Name	Generic Name
Abstral PA	fentanyl sublingual
Actiq PA	fentanyl lozenge
Ancobon	flucytosine
Exjade	deferasirox
Fentora PA	fentanyl buccal
Ganciclovir	ganciclovir
Gilenya PA	fingolimod
Gleevec	imatinib
Hycamtin	topotecan
Incivek	telaprevir
Iressa	gefitinib
Jakafi	ruxolitinib
Kuvan	sapropterin
Letairis	ambrisentan
Nexavar	sorafenib tosylate
Nimotop	nimodipine
Noxafil	posaconazole
Onsolis PA	fentanyl buccal
Promacta	eltrombopag
Rapamune	sirolimus
Revatio	sildenafil citrate
Revlimid PA	lenalidomide
Sprycel	dasatinib
Sucraid	sacrosidase
Sutent	sunitinib
Synarel	nafarelin
Tarceva	erlotinib
Tasigna	nilotinib
Temodar	temozolomide
Thalomid	thalidomide
Tracleer	bosentan
Tykerb	lapatinib
Valcyte	valganciclovir

Vesanoid caps	tretinoin caps
Vfend	voriconazole
Victrelis	boceprevir
Votrient	pazopanib
Xalkori	crizotinib
Xeloda	capecitabine
Xenazine	tetrabenazine
Zelboraf	vemurafenib
Zolanza	vorinostat
Zytiga	abiraterone
Zyvox	linezolid

Currently, all specialty drugs are available only from retail pharmacies in the BlueChoice HealthPlan/CVS Caremark pharmacy network. **Effective April 1, 2012, these products will only be available through a specialty pharmaceutical vendor and not through retail pharmacies.** When you fill one of these medications, you will be charged the required specialty pharmaceutical copayment per 31-day supply as outlined in your Schedule of Benefits. If you have any further questions about Specialty Pharmaceuticals, please contact Member Services by visiting us at www.BlueChoiceSC.com or by calling toll free at 800-868-2528.

Legend	
delayed-rel	Delayed-release (also known as enteric-coated)
ext-rel	Extended-release (also known as sustained-release)
#	Requires a prescription
OTC	Over the Counter
PA	Prior Authorization
QL	Quantity Limit
ST	Step Therapy criteria applies (Note: For drugs with an "ST" in the Generics column, only the BRAND drug must meet the step requirements, not the generic, unless otherwise noted)
*	Step Therapy required only for brand or generic products containing 80 mg of simvastatin
†	Step Therapy applies to both brand and generic product

BlueChoice HealthPlan 2012 Prescription Drug List

Generics Tier 1	Preferred Tier 2	Non-Preferred Tier 3
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Cardiovascular (Heart and Hypertensive)

amlodipine (NORVASC)	AZOR	ATACAND
amlodipine-benazepril (LOTREL)	BENICAR	ATACAND HCT
atenolol (TENORMIN)	BENICAR HCT	AVALIDE
lisinopril (ZESTRIL)	DIOVAN	AVAPRO
losartan (COZAAR)	DIOVAN HCT	
losartan-hydrochlorothiazide (HYZAAR)	EXFORGE	
metoprolol succinate ext-rel (TOPROL XL)	EXFORGE HCT	
propranolol	TRIBENZOR	
propranolol ext-rel (INDERAL LA)	TWYNSTA	
quinapril (ACCUPRIL)		
ramipril (ALTACE)		

Lipid Lowering Agents

FIBRATES

fenofibrate, micronized (LOFIBRA) ST		ANTARA ST
fenofibric acid (FIBRICOR) ST		FENOGLIDE ST
gemfibrozil (LOPID)		LIPOFEN ST
		TRICOR ST
		TRIGLIDE ST
		TRILIPIX ST

HMG-CoA REDUCTASE INHIBITORS

atorvastatin (LIPITOR)	CRESTOR	
lovastatin (MEVACOR)		
pravastatin (PRAVACHOL)		
simvastatin (ZOCOR) ST *		

LIPID LOWERING COMBINATIONS

SIMCOR	
VYTORIN ST *	

Generics Tier 1	Preferred Tier 2	Non-Preferred Tier 3
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LIPID LOWERING, MISCELLANEOUS

cholestyramine	NIASPAN	LOVAZA PA ZETIA
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Depression

bupropion (WELLBUTRIN)	LEXAPRO	CYMBALTA QL ST
bupropion ext-rel (WELLBUTRIN XL) QL		PRISTIQ QL ST
citalopram (CELEXA)		
fluoxetine (PROZAC)		
fluoxetine delayed-rel (PROZAC WEEKLY) QL		
mirtazapine (REMERON)		
paroxetine (PAXIL)		
paroxetine ext-rel (PAXIL CR)		
phenelzine (NARDIL)		
sertraline (ZOLOFT)		
venlafaxine		
venlafaxine ext-rel caps (EFFEXOR XR) QL		
venlafaxine ext-rel tabs (VENLAFAXINE ER) QL		

Diabetes

acarbose (PRECOSE)	ACTOPLUS MET	KOMBIGLYZE ER
glimepiride (AMARYL)	ACTOPLUS MET XR	ONGLYZA
glipizide (GLUCOTROL)	ACTOS	SYMLIN PA
glipizide ext-rel (GLUCOTROL XL)	BYETTA	VICTOZA
glipizide-metformin (METAGLIP)	JANUMET	
glyburide (DIABETA)	JANUVIA	
glyburide, micronized (GLYNASE)	PRANDIN	
glyburide-metformin (GLUCOVANCE)		
metformin (GLUCOPHAGE)		
metformin ext-rel (GLUCOPHAGE XR)		

Generics Tier 1	Preferred Tier 2	Non-Preferred Tier 3
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Insulin and Monitoring Products

ACCU-CHEK lancets	HUMALOG
LANTUS	HUMULIN
LEVEMIR	
NOVOLIN	
NOVOLOG	
ONETOUGH	

Gastrointestinal (Stomach)

PREVACID 24HR OTC # QL	NEXIUM PA QL	ACIPHEX PA QL ST
PRILOSEC OTC OTC # QL		DEXILANT PA QL ST
ZEGERID OTC OTC # QL		
cimetidine		
lansoprazole (PREVACID) PA QL ST		
metoclopramide (REGLAN)		
omeprazole (PRILOSEC) PA QL ST		
omeprazole-sodium bicarbonate (ZEGERID) PA QL ST †		
pantoprazole (PROTONIX) PA QL ST		
ranitidine (ZANTAC)		
sucralfate (CARAFATE)		

Infectious Disease

acyclovir (ZOVIRAX)	AVELOX
amoxicillin-clavulanate (AUGMENTIN)	ERY-TAB
atovaquone-proguanil (MALARONE)	
azithromycin (ZITHROMAX)	
ciprofloxacin (CIPRO)	
ciprofloxacin ext-rel	
clarithromycin ext rel (BIAXIN XL)	
dapsone	
fluconazole (DIFLUCAN)	
itraconazole (SPORANOX) QL	
levofloxacin (LEVAQUIN)	
metronidazole tabs (FLAGYL) QL	
minocycline ext-rel (SOLODYN) ST	
sulfamethoxazole-trimethoprim (SEPTA)	
terbinafine tabs (LAMISIL) QL	
valacyclovir (VALTREX) QL	

Migraine

ergotamine-caffeine (CAFERGOT)	MAXALT QL	ALSUMA QL
ibuprofen (MOTRIN)	MAXALT-MLT QL	AXERT QL
naproxen sodium (ANAPROX)	RELPAK QL	FROVA QL
naratriptan (AMERGE) QL		SUMAVEL
sumatriptan (IMITREX) QL		DOSEPRO QL ST
		TREXIMET QL
		ZOMIG/ZOMIG-ZMT/
		ZOMIG NS QL

Ophthalmic (Eye)

brimonidine 0.15%, 0.2%	ALPHAGAN P 0.1%
cromolyn sodium	AZOPT
dorzolamide (TRUSOPT)	BETIMOL
dorzolamide-timolol (COSOPT)	LUMIGAN
latanoprost (XALATAN)	
polymyxin B-trimethoprim (POLYTRIM)	
timolol maleate (TIMOPTIC)	
tobramycin (TOBREX)	

NSAIDs

diclofenac sodium delayed-rel	CELEBREX PA QL ST
ibuprofen (MOTRIN)	
meloxicam (MOBIC)	
naproxen (NAPROSYN)	
piroxicam (FELDENE)	

Opioids

codeine-acetaminophen (TYLENOL w/CODEINE) QL	OXYCONTIN QL
hydrocodone-acetaminophen (LORTAB) QL	
hydromorphone (DILAUDID) QL	
morphine sulfate (MS CONTIN) QL	
oxycodone-acetaminophen (PERCOCET) QL	

Generics Tier 1	Preferred Tier 2	Non-Preferred Tier 3
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Respiratory

ALLERGY

cetirizine (ZYRTEC) OTC #	ASTEPRO QL	CLARINEX ST
cetirizine-pseudoephedrine (ZYRTEC-D) OTC #	NASONEX QL	OMNARIS QL
fexofenadine (ALLEGRA) OTC #	VERAMYST QL	PATANASE QL
fexofenadine-pseudoephedrine (ALLEGRA-D) OTC #		RHINOCORT AQUA QL
loratadine (ALAVERT, CLARITIN) OTC #		
loratadine-pseudoephedrine (ALAVERT-D, CLARITIN-D) OTC #		
azelastine (ASTELIN) QL		
fluticasone nasal spray (FLONASE) QL		
ipratropium nasal spray (ATROVENT) QL		
levocetirizine (XYZAL) ST		
triamcinolone nasal spray (NASACORT AQ) QL		

ASTHMA/COPD

albuterol ext-rel tabs QL	ADVAIR QL	BROVANA QL
albuterol soln QL	ASMANEX QL	PERFORMIST QL
albuterol tabs	ATROVENT HFA QL	PULMICORT
budesonide susp (PULMICORT RESPULES) QL	COMBIVENT QL	FLEXHALER QL
cromolyn soln QL	DULERA QL	
ipratropium soln	FLOVENT QL	
ipratropium-albuterol soln (DUONEB)	FORADIL QL	
terbutaline	PROAIR HFA QL	
theophylline ext-rel	QVAR QL	
	SEREVENT QL	
	SINGULAIR ST	
	SPIRIVA QL	
	SYMBICORT QL	
	VENTOLIN HFA QL	

Thyroid Replacement

levothyroxine (LEVOXYL)
levothyroxine (SYNTHROID)
methimazole (TAPAZOLE)
propylthiouracil

Kidney and Bladder

bethanechol (URECHOLINE)	VESICARE	DETROL
doxazosin (CARDURA)		DETROL LA
finasteride (PROSCAR) PA		
oxybutynin		
oxybutynin ext-rel (DITROPAN XL)		
phenazopyridine (PYRIDIUM)		
tamsulosin (FLOMAX)		
terazosin		

Women's Health

HORMONAL THERAPY

estradiol	ENJUVIA
estropipate	PREMPHASE
medroxyprogesterone acetate	PREMPRO
	VIVELLE-DOT

ORAL CONTRACEPTIVES

Gianvi	ORTHO TRI-CYCLEN LO
Levora	
Low-Ogestrel	
Trivora	
Zovia	

OSTEOPOROSIS

alendronate (FOSAMAX) QL	BONIVA TABS QL	ACTONEL QL
	EVISTA	FOSAMAX PLUS D QL