



**Meridian**  
*Health Plan*

**2012**

**Medicaid Formulary**

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## **Introduction**

Meridian Health Plan (MHP) is pleased to provide an updated 2013 Medicaid Formulary as a reference and informational tool for physicians, pharmacists and patients. The MHP Formulary is designed to assist practitioners in selecting clinically appropriate and cost-effective products for their patients.

## **The MeridianRx Pharmacy and Therapeutics Committee (P&T)**

The medications on this formulary have been reviewed by the MeridianRx P&T Committee. The Committee includes physicians, pharmacists and health professionals. The clinical information within the formulary is primarily derived from medical literature and is reviewed and approved by the P&T Committee.

## **Notice**

The information contained in this formulary is provided by MHP, solely for the convenience of medical providers. This formulary is not intended to be a substitute for the knowledge, expertise, skill and judgment of the medical provider in their choice of prescription drugs. Meridian Health Plan assumes no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

## **Preface**

The MHP formulary is organized by sections. Each section includes therapeutic groups identified by either drug class or disease state. Products are listed by generic name. Brand and common names are included as a reference to assist in product recognition. MHP will not cover prescription drugs that are prescribed for experimental, investigational or non FDA approved indications, dosages, or routes of administration. MHP does not cover any medication excluded by Michigan Medicaid.

## **Product Selection Criteria**

The MeridianRx P&T Committee considers clinical information on new to market drugs that are typically included in an outpatient pharmacy benefit. The primary goal of the MeridianRx P&T Committee is to preserve and evaluate the MHP formulary based upon an objective analysis of the safety, efficacy, approved indications, adverse effects, contraindications, patient administration/compliance considerations and cost effectiveness. When a new drug is considered for formulary inclusion, it will be reviewed relative to similar drugs currently included in the MHP Formulary. Formulary decisions are communicated quarterly on the MHP website.

## **Formulary Components**

The MHP Formulary contains the following components: Covered medications without authorization, medications that must meet Step Therapy Protocol, medications that require Prior Authorization, Specialty medications and medications that are subject to Quantity Limits. Members will not be charged a copay when MHP covers a medication.

## **Generic Substitution**

MHP is a mandatory generic plan. The brand and common names listed in the formulary are for reference only. Generic medication will be dispensed where available.

## **Covered Medications without Authorization**

MHP covers many medications without any authorization required. These medications include many prescription and over the counter medications. (When ordered by a physician.)

## **Non-Covered Benefits**

The following categories are not covered benefits: Medications used for cosmetic purposes, to promote fertility, for sexual dysfunction, to treat gender identity conditions, for experimental or investigational purposes, or medications that are not licensed for use in the United States.



**Prior Authorization**

Drugs indicated with "PA" require Prior Authorization for coverage. Details of the PA criteria are listed next to the drug name. Please call the MeridianRx Help Desk at 1-866-984-6462 or fax a completed Prior Authorization form to 1-877-355-8070. Non-Urgent requests are reviewed within 14 days. Urgent requests must be accompanied by pertinent clinical information and are reviewed within 72 hours.

**Step Therapy**

Drugs indicated with a "ST" require Step Therapy for coverage. The required step is listed next to the drug name.

**Specialty Medications**

All specialty medications noted as "SP" are handled by MeridianRx. To order a specialty medication by fax, send the prescription and a completed prior authorization form to 1-877-355-8070 or call MeridianRx's Help Desk at 1-866-984-6462.

**Quantity Limits**

Drugs indicated with a "QL" have a set quantity limit imposed. These limits are based on FDA recommended dosing guidelines. The quantity limit is listed next to the drug name. All medications are subject to a maximum of 30 days per prescription.

**Benefit Exception**

The process for requesting non formulary medication(s) requires faxing of a completed Formulary Exception form indicating the request for an exception to the formulary. This request will need to include pertinent clinical documentation showing trial and failure of all formulary agents. It should also contain information showing the medication is the standard of care for the indication provided (Peer reviewed journal articles may be required). Please call the MeridianRx Help Desk at 1-866-984-6462 or fax a completed Formulary Exception form to 1-877-355-8070.

**Pharmacy Benefit Management**

MHP utilizes MeridianRx to manage each member's pharmacy benefit. MeridianRx provides MHP with a pharmacy network, pharmacy claims management services, and claims adjudication. MeridianRx's Help Desk can be contacted at 1-866-984-6462.

## Step Therapy Information

Generic Name	Common Name	Drug Status	Criteria
<b>Antihistamines - 2nd Generation</b>			
FEXOFENADINE HCL	ALLEGRA	QL,ST	180 mg tablet limited to 1 tablet per day; 60 mg tablet limited to 2 tablets per day, Must have tried and failed three consecutive fills of Loratadine or Cetirizine tablets in the past 90 days
<b>Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>			
SITAGLIPTIN PHOSPHATE	JANUVIA	QL,ST	Limit of 1 tablet per day, Must have prior use of Metformin within the last 90 days; Maximal dose of metformin (1700 mg/day) or maximal dose of a sulfonylurea. Or if patient had renal or heart failure
<b>Asthma Therapy - Beta Adrenergic-Glucocorticoid Combinations</b>			
BUDESONIDE/FORMOTEROL FUMARATE	SYMBICORT	QL,ST	Limited to one inhaler per month, Must have tried and failed Qvar in the past 90 days
FLUTICASONE PROPIONATE/ SALMETEROL XINAFOATE	ADVAIR DISKUS	QL,ST	Limited to one inhaler per month; 500/50 mcg inhaler is not covered, Must have tried and failed Qvar in the past 90 days
MOMETASONE FUROATE/ FORMOTEROL FUMARATE	DULERA	QL,ST	Limited to one inhaler per month, Must have tried and failed Qvar in the past 90 days
<b>Asthma/COPD Therapy - Anticholinergics</b>			
TIOTROPIUM BROMIDE	SPIRIVA	QL,ST	Limited to one inhaler per month, Must have tried and failed Atrovent HFA in the past 90 days
<b>Cephalosporin Antibiotics - 1st Generation</b>			
CEFADROXIL HYDRATE	CEFADROXIL	ST	Must have prior use of a first line antibiotic (Cefaclor or Cephalexin) within the last 30 days
<b>Cephalosporin Antibiotics - 3rd Generation</b>			
CEFDINIR	OMNICEF	ST	Must have prior use of Amoxicillin in the past 60 days
CEFPODOXIME PROXETIL	CEFPODOXIME PROXETIL	ST	Must have prior use of a first line antibiotic (Cefaclor or Cephalexin) within the last 30 days
<b>Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)</b>			
LANSOPRAZOLE	PREVACID 24HR	ST	Must have tried and failed three consecutive fills of Omeprazole in the past 90 days
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM	ST	Must have tried and failed Omeprazole and Lansoprazole in the past 90 days
<b>Insulin Response Enhancers - Thiazolidinediones (PPAR-gamma agonists)</b>			
PIOGLITAZONE HCL	ACTOS	QL,ST	Limited to 1 tablet per day, Must have prior use of Metformin within the last 90 days; Maximal dose of metformin (1700 mg/day) or maximal dose of a sulfonylurea. Or if patient had renal or heart failure, Limit: 30 , Per 30 Days

## Step Therapy Information

Generic Name	Common Name	Drug Status	Criteria
<b>Migraine Therapy - Selective Serotonin Agonists 5-HT(1)</b>			
NARATRIPTAN HCL	NARATRIPTAN HCL	QL,ST	Limited to 9 tablets per 30 days, Must have tried and failed three consecutive fills of Sumatriptan Tablets in the past 90 days
<b>Prostatic Hypertrophy Agent - Type II 5-alpha Reductase Inhibitors</b>			
FINASTERIDE	PROSCAR	ST	Shows paid claim for Prazosin, Doxazosin, or Terazosin in the past 90 days
<b>Scabicide &amp; Pediculicide Single Agents</b>			
MALATHION	MALATHION	ST	Must have prior use of first line Pediculicides agent within the last 30 days
<b>Smoking Deterrents - Nicotinic Receptor Partial Agonist, alpha4beta2</b>			
VARENICLINE TARTRATE	CHANTIX	ST	Limited to 90 days therapy per rolling 365 days; Must have 6 months prior therapy with topical nicotine patches along with either nicotine polacrilex gum or lozenges
<b>Urinary Antispasmodic - Smooth Muscle Relaxants</b>			
TOLTERODINE TARTRATE	DETROL	ST	Must have prior use of Oxybutynin within past 90 days

## Prior Authorization Information

Generic Name	Common Name	Drug Status	Criteria
<b>Alkylating Agent - Nitrogen Mustards</b>			
CHLORAMBUCIL	LEUKERAN	PA,SP	PA Required
<b>Alzheimer's Disease Therapy - Cholinesterase Inhibitors</b>			
GALANTAMINE HBR	GALANTAMINE HBR	PA	Must show diagnosis of Alzheimer's Disease
<b>Alzheimer's Disease Therapy - Cholinesterase Inhibitors</b>			
RIVASTIGMINE TARTRATE	EXELON	PA	Must show diagnosis of Alzheimer's Disease
<b>Analgesic Narcotic Agonists</b>			
FENTANYL	FENTANYL	PA	Cancer related pain; end of life; unable to take oral medications; Limited to 10 patches per month
<b>Analgesic Narcotic Agonists</b>			
OXYCODONE HCL	OXYCODONE HCL	QL,PA	Must meet Pharmacy Approval Criteria to receive Oxycodone ER; Only 5 mg tablets and capsules are covered for Oxycodone IR and are limited to 4 tablets per day
<b>Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Selective</b>			
ETANERCEPT	ENBREL	PA,SP	Must meet Pharmacy Approval Criteria
<b>Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel</b>			
ADALIMUMAB	HUMIRA	PA,SP	Must meet Pharmacy Approval Criteria
<b>Antianginal and Anti-ischemic Agents, Non-hemodynamic</b>			
RANOLAZINE	RANEXA	PA	Must meet Pharmacy Approval Criteria
<b>Antiemetic - Cannabinoids</b>			
DRONABINOL	MARINOL	PA	Must meet Pharmacy Approval Criteria
<b>Antiemetic - Selective Serotonin 5-HT3 Antagonists</b>			
GRANISETRON HCL	KYTRIL	PA	PA Required; Must submit documentation showing trial and failure of Ondansetron
<b>Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type</b>			
EXENATIDE	BYETTA	PA	Must meet Pharmacy Approval Criteria
<b>Asthma Therapy - Glucocorticoids</b>			
BUDESONIDE	BUDESONIDE	PA,QL	Covered for patients up to age 8 without a prior authorization. Patients greater than age 8 must have tried and failed a steroid inhaler in the past 90 days or have documented inability to use an inhaler. Limited to 60 respules per 30 days
<b>Asthma Therapy - Glucocorticoids</b>			
FLUTICASONE PROPIONATE	FLOVENT HFA	PA	Only 44 mcg inhaler is covered for ages 17 and below without a prior authorization

## Prior Authorization Information

Generic Name	Common Name	Drug Status	Criteria
<b>Asthma Therapy - Leukotriene Receptor Antagonists</b>			
MONTELUKAST SODIUM	SINGULAIR	PA,QL	Limited to 1 tablet per day; PA Required for ages 15 and over, must submit documentation of trial and failure of Accolate
<b>Calcitonins</b>			
CALCITONIN,SALMON,SYNTHETIC	MIACALCIN	PA,SP	PA Required
<b>Cardiac Sympathomimetics</b>			
MIDODRINE HCL	MIDODRINE HCL	PA	Must be prescribed by a Cardiologist
<b>CNS Stimulant - Analeptics</b>			
CAFFEINE CITRATED	CAFFEINE CITRATE	PA	PA Required
<b>Dermatological - Antineoplastic Antimetabolites</b>			
FLUOROURACIL	EFUDEX	PA	Must show documented diagnosis of Basal Cell Carcinoma
<b>Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives</b>			
ACITRETIN	SORIATANE	PA	PA Required; Must submit documented failure of Methotrexate or Cyclosporine
<b>Digestive Enzyme Mixtures</b>			
LIPASE/PROTEASE/AMYLASE	ULTRASE MT 12	PA	PA Required
<b>DMARD - Antimetabolites</b>			
METHOTREXATE SODIUM	METHOTREXATE	PA	PA Required
<b>Erythropoietins</b>			
EPOETIN ALFA	EPOGEN	PA,SP	Must meet Pharmacy Approval Criteria
<b>Glycopeptide Antibiotics</b>			
VANCOMYCIN HCL	VANCOCIN HCL	PA	PA Required
<b>Gout Acute Therapy - Antimitotics</b>			
COLCHICINE	COLCHICINE	PA	PA Required
<b>Granulocyte Colony-Stimulating Factor (G-CSF)</b>			
FILGRASTIM	NEUPOGEN	PA,SP	Must meet Pharmacy Approval Criteria
<b>Growth Hormones</b>			
SOMATROPIN	HUMATROPE	PA,SP	PA Required
<b>Hepatitis C - Interferons</b>			
PEGINTERFERON ALFA-2B	PEGINTRON REDIPEN	PA,SP	Redipen is covered, Must meet Pharmacy Approval Criteria
<b>Hepatitis C - NS3/4A Serine Protease Inhibitors</b>			
BOCEPREVIR	VICTRELIS	PA,SP	PA Required
<b>Hepatitis C - Nucleoside Analogs</b>			
RIBAVIRIN	REBETOL	PA,SP	Must meet Pharmacy Approval Criteria
<b>Immune Globulin - Rho(D)</b>			
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	SP	
RHO(D) IMMUNE GLOBULIN/ MALTOSE	WINRHO SDF	SP	
<b>Immunosuppressive - Calcineurin Inhibitors</b>			
CYCLOSPORINE	SANDIMMUNE	PA,SP	PA Required
CYCLOSPORINE, MODIFIED	GENGRAF	PA,SP	PA Required

## Prior Authorization Information

Generic Name	Common Name	Drug Status	Criteria
<b>Immunosuppressive - Calcineurin Inhibitors</b>			
TACROLIMUS	TACROLIMUS	PA,SP	PA Required
<b>Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors</b>			
MYCOPHENOLATE MOFETIL	CELLCEPT	PA,SP	PA Required
<b>Interstitial Cystitis Agents</b>			
PENTOSAN POLYSULFATE SODIUM	ELMIRON	PA	Must have diagnosis of interstitial cystitis and be prescribed by a Urologist
<b>LHRH (GnRH) Agonist Analog Pit Suppres - Central Precocious Puberty</b>			
LEUPROLIDE ACETATE	LUPRON DEPOT-PED	PA,SP	Must meet Pharmacy Approval Criteria
<b>Low Molecular Weight Heparins</b>			
ENOXAPARIN SODIUM	LOVENOX	PA	Must meet Pharmacy Approval Criteria
<b>Multiple Sclerosis Agent - Interferons</b>			
INTERFERON BETA-1A	AVONEX	PA,SP	Must meet Pharmacy Approval Criteria
INTERFERON BETA-1A/ALBUMIN HUMAN	REBIF	PA,SP	Must meet Pharmacy Approval Criteria
<b>Multiple Sclerosis Agent - Others</b>			
GLATIRAMER ACETATE	COPAXONE	PA,SP	Must meet Pharmacy Approval Criteria
<b>Phosphate Binders</b>			
SEVELAMER CARBONATE	RENEVELA	PA	Must have trial and therapeutic failure, intolerance, or contraindication to Phoslo
<b>Platelet Aggregation Inhibitors - Thienopyridine Agents</b>			
CLOPIDOGREL BISULFATE	PLAVIX	PA	Must meet Pharmacy Approval Criteria
<b>Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.</b>			
TADALAFIL	ADCIRCA	PA,SP	Must meet Pharmacy Approval Criteria
<b>Tetracycline Antibiotics</b>			
DEMECLOCYCLINE HCL	DEMECLOCYCLINE HCL	PA	Must show documented diagnosis of syndrome of inappropriate antidiuretic hormone (SIADH)

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Generic Name	Common Name	Drug Status	Criteria
<b>1st Generation Antihistamine-Decongestant Combinations</b>			
PHENYLEPHRINE HCL/ PROMETHAZINE HCL	PROMETHAZINE VC		
PSEUDOEPHEDRINE HCL/ CHLORPHENIRAMINE MALEATE	PSEUDOEPHEDRINE- CHLORPHENIRAMI		
<b>ACE Inhibitor and Calcium Channel Blocker Combinations</b>			
AMLODIPINE BESYLATE/BENAZEPRIL HCL	LOTREL	QL	Limited to one tablet per day
<b>ACE Inhibitors</b>			
BENAZEPRIL HCL	LOTENSIN		
CAPTOPRIL	CAPTOPRIL		
ENALAPRIL MALEATE	ENALAPRIL MALEATE		
FOSINOPRIL SODIUM	FOSINOPRIL SODIUM		
LISINOPRIL	PRINIVIL		
MOEXIPRIL HCL	UNIVASC		
<b>ACE Inhibitors-Diuretic Combinations</b>			
BENAZEPRIL HCL/ HYDROCHLOROTHIAZIDE	LOTENSIN HCT	QL	Limited to one tablet per day
CAPTOPRIL/ HYDROCHLOROTHIAZIDE	CAPTOPRIL- HYDROCHLOROTHIAZIDE	QL	Limited to one tablet per day
ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE	ENALAPRIL- HYDROCHLOROTHIAZIDE	QL	Limited to one tablet per day
LISINOPRIL/HYDROCHLOROTHIAZIDE	PRINZIDE	QL	Limited to one tablet per day
<b>Acne Therapy Topical - Anti-infective</b>			
CLINDAMYCIN PHOSPHATE	CLEOCIN T		
ERYTHROMYCIN BASE/ETHYL ALCOHOL	ERYTHROMYCIN		
METRONIDAZOLE	METRONIDAZOLE		
<b>Acne Therapy Topical - Keratolytic</b>			
BENZOYL PEROXIDE	BENZAC AC		
<b>Acne Therapy Topical - Retinoids &amp; Derivatives</b>			
TRETINOIN	RETIN-A		
<b>Alkylating Agent - Nitrogen Mustards</b>			
CHLORAMBUCIL	LEUKERAN	PA,SP	PA Required
<b>Alpha-Beta Blockers</b>			
CARVEDILOL	COREG		
LABETALOL HCL	LABETALOL HCL		
<b>Alzheimer's Disease Therapy - Cholinesterase Inhibitors</b>			
DONEPEZIL HCL	ARICEPT		
GALANTAMINE HBR	GALANTAMINE HBR	PA	Must show diagnosis of Alzheimer's Disease
RIVASTIGMINE TARTRATE	EXELON	PA	Must show diagnosis of Alzheimer's Disease
<b>Aminoglycoside Antibiotic</b>			
NEOMYCIN SULFATE	NEOMYCIN SULFATE		

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Generic Name	Common Name	Drug Status	Criteria
<b>Aminopenicillin Antibiotic</b>			
AMOXICILLIN	AMOXICILLIN		
AMPICILLIN TRIHYDRATE	AMPICILLIN TRIHYDRATE		
<b>Aminopenicillin Antibiotic - Beta-lactamase Inhibitor Combinations</b>			
AMOXICILLIN/POTASSIUM CLAVULANATE	AUGMENTIN		Generic strengths covered only
<b>Analgesic Narcotic Agonists</b>			
CODEINE SULFATE	CODEINE SULFATE		
FENTANYL	FENTANYL	PA	Cancer related pain; end of life; unable to take oral medications; Limited to 10 patches per month
HYDROMORPHONE HCL	HYDROMORPHONE HCL	QL	Limited to 4 tablets per day
MEPERIDINE HCL	MEPERIDINE HCL		Limited to 6 tablets per day
METHADONE HCL	METHADONE HCL	QL	Limited to 4 tablets per day
MORPHINE SULFATE	MORPHINE SULFATE	QL	IR Tablets are limited to 4 per day; ER Tablets are limited to 2 per day; Solution is limited to 8 mL per day
OXYCODONE HCL	OXYCODONE HCL	QL,PA	Must meet Pharmacy Approval Criteria to receive Oxycodone ER; Only 5 mg tablets and capsules are covered for Oxycodone IR and are limited to 4 tablets per day
TRAMADOL HCL	TRAMADOL HCL	QL	Limited to 8 tablets per day
<b>Analgesic Narcotic Codeine Combinations</b>			
ACETAMINOPHEN WITH CODEINE PHOSPHATE	ACETAMINOPHEN-CODEINE	QL	Maximum of 4000 mg of Acetaminophen per day
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE PHOSPHATE	BUTALB-CAFF-ACETAMINOPH-CODEIN	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
CODEINE PHOSPHATE/BUTALBITAL/ASPIRIN/CAFFEINE	BUTALBITAL COMPOUND-CODEINE	QL	Limited to 6 tablets per day
<b>Analgesic Narcotic Hydrocodone Combinations</b>			
HYDROCODONE BIT/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
<b>Analgesic Narcotic Oxycodone Combinations</b>			
OXYCODONE HCL/ACETAMINOPHEN	OXYCODONE-ACETAMINOPHEN	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
<b>Analgesic or Antipyretic Non-Narcotic/Sedative Combinations</b>			
BUTALBITAL/ACETAMINOPHEN	PHRENILIN	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
BUTALBITAL/ACETAMINOPHEN/CAFFEINE	BUTALBITAL-ACETAMINOPHEN-CAFFE	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
<b>Androgen - Single Agents</b>			
TESTOSTERONE CYPIONATE	DEPO-TESTOSTERONE		
<b>Angiotensin II Receptor Blocker (ARB)-Diuretic Combinations</b>			
LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	HYZAAR		
<b>Angiotensin II Receptor Blockers (ARBs)</b>			
LOSARTAN POTASSIUM	COZAAR		



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Generic Name	Common Name	Drug Status	Criteria
<b>Anorectal - Glucocorticoids</b>			
HYDROCORTISONE	PROCTOCREAM-HC		
HYDROCORTISONE ACETATE	ANUCORT-HC		
<b>Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Selective</b>			
ETANERCEPT	ENBREL	PA,SP	Must meet Pharmacy Approval Criteria
<b>Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel</b>			
ADALIMUMAB	HUMIRA	PA,SP	Must meet Pharmacy Approval Criteria
<b>Antianginal - Coronary Vasodilators (Nitrates)</b>			
ISOSORBIDE DINITRATE	ISOSORBIDE DINITRATE		
ISOSORBIDE MONONITRATE	MONOKET		
NITROGLYCERIN	NITROGLYCERIN		Only sublingual tablets, capsules and patches are covered
<b>Antianginal and Anti-ischemic Agents, Non-hemodynamic</b>			
RANOLAZINE	RANEXA	PA	Must meet Pharmacy Approval Criteria
<b>Antianxiety Agent - Antihistamine Type</b>			
HYDROXYZINE HCL	HYDROXYZINE HCL		Only syrup is covered for ages 12 and under
HYDROXYZINE PAMOATE	HYDROXYZINE PAMOATE		
<b>Antiarrhythmic - Class Ia</b>			
DISOPYRAMIDE PHOSPHATE	NORPACE		
QUINIDINE SULFATE	QUINIDINE SULFATE		
<b>Antiarrhythmic - Class Ib</b>			
MEXILETINE HCL	MEXILETINE HCL		
<b>Antiarrhythmic - Class Ic</b>			
FLECAINIDE ACETATE	FLECAINIDE ACETATE		
PROPAFENONE HCL	RYTHMOL		
<b>Antiarrhythmic - Class II</b>			
SOTALOL HCL	SOTALOL		
<b>Antiarrhythmic - Class III</b>			
AMIODARONE HCL	CORDARONE		
<b>Antiarrhythmic - Class IV</b>			
VERAPAMIL HCL	CALAN		
<b>Antibacterial Folate Antagonist - Other Combinations</b>			
SULFAMETHOXAZOLE/ TRIMETHOPRIM	SULFAMETHOXAZOLE- TRIMETHOPRIM		
<b>Antibacterial Folate Antagonist Others</b>			
TRIMETHOPRIM	TRIMETHOPRIM		
<b>Anticoagulants - Coumarin</b>			
WARFARIN SODIUM	COUMADIN		
<b>Antidiarrheal - Antiperistaltic Agents</b>			
LOPERAMIDE HCL	LOPERAMIDE		
PAREGORIC	PAREGORIC		

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Generic Name	Common Name	Drug Status	Criteria
<b>Antidiarrheal Antiperistaltic-Anticholinergic Combinations</b>			
DIPHENOXYLATE HCL/ATROPINE SULFATE	DIPHENOXYLATE-ATROPINE	QL	Limited to two bottles per month
<b>Antidiuretic and Vasopressor Hormones</b>			
DESMOPRESSIN ACETATE	DDAVP	QL	Only tablets are covered, Limited to 6 tablets per day
<b>Antiemetic - Antihistamines</b>			
MECLIZINE HCL	ANTIVERT		
<b>Antiemetic - Cannabinoids</b>			
DRONABINOL	MARINOL	PA	Must meet Pharmacy Approval Criteria
<b>Antiemetic - Dopamine (D2)/5-HT3 Antagonists</b>			
TRIMETHOBENZAMIDE HCL	TRIMETHOBENZAMIDE HCL	QL	Limited to 4 capsules per day
<b>Antiemetic - Phenothiazines</b>			
PROCHLORPERAZINE MALEATE	COMPRO		
PROMETHAZINE HCL	PROMETHEGAN		
<b>Antiemetic - Selective Serotonin 5-HT3 Antagonists</b>			
GRANISETRON HCL	KYTRIL	PA	PA Required; Must submit documentation showing trial and failure of Ondansetron
ONDANSETRON	ONDANSETRON ODT	QL	Limited to 30 tablets per 30 days.
ONDANSETRON HCL	ONDANSETRON HCL	QL	Limited to 30 tablets per 30 days.
<b>Antifungal - Allylamines</b>			
TERBINAFINE HCL	LAMISIL		
<b>Antifungal - Amphoteric Polyene Macrolides</b>			
NYSTATIN	MYCOSTATIN		
<b>Antifungal - Imidazoles</b>			
KETOCONAZOLE	KETOCONAZOLE		
<b>Antifungal - Triazoles</b>			
FLUCONAZOLE	DIFLUCAN	QL	Limited to 1 tablet per day; Suspension is limited to ages 12 and under
<b>Antifungal other</b>			
GRISEOFULVIN,MICROSIZE	GRISEOFULVIN		
<b>Antihistamine - 1st Generation - Alkylamines</b>			
DEXCHLORPHENIRAMINE MALEATE	DEXCHLORPHENIRAMINE MALEATE		
<b>Antihistamine - 1st Generation - Ethanolamines</b>			
CLEMASTINE FUMARATE	CLEMASTINE FUMARATE		
DIPHENHYDRAMINE HCL	DIPHENHYDRAMINE HCL		
<b>Antihistamine - 1st Generation - Phenothiazines</b>			
PROMETHAZINE HCL	PROMETHAZINE HCL		
<b>Antihistamine - 1st Generation - Piperidines</b>			
CYPROHEPTADINE HCL	CYPROHEPTADINE HCL		
<b>Antihistamines - 2nd Generation</b>			
CETIRIZINE HCL	ZYRTEC		

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Generic Name	Common Name	Drug Status	Criteria
<b>Antihistamines - 2nd Generation</b>			
FEXOFENADINE HCL	ALLEGRA	QL,ST	180 mg tablet limited to 1 tablet per day; 60 mg tablet limited to 2 tablets per day, Must have tried and failed three consecutive fills of Loratadine or Cetirizine tablets in the past 90 days
<b>Antihyperglycemic - Alpha-Glucosidase Inhibitors</b>			
ACARBOSE	PRECOSE		
<b>Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>			
SITAGLIPTIN PHOSPHATE	JANUVIA	QL,ST	Limit of 1 tablet per day, Must have prior use of Metformin within the last 90 days; Maximal dose of metformin (1700 mg/ day) or maximal dose of a sulfonylurea. Or if patient had renal or heart failure
<b>Antihyperglycemic - Sulfonylurea Derivatives</b>			
CHLORPROPAMIDE	CHLORPROPAMIDE		
GLIMEPIRIDE	AMARYL		
GLIPIZIDE	GLUCOTROL		
GLYBURIDE	MICRONASE		
GLYBURIDE,MICRONIZED	GLYNASE		
TOLAZAMIDE	TOLAZAMIDE		
<b>Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type</b>			
EXENATIDE	BYETTA	PA	Must meet Pharmacy Approval Criteria
<b>Antihyperlipidemic - Bile Acid Sequestrants</b>			
CHOLESTYRAMINE (WITH SUGAR)	CHOLESTYRAMINE		
CHOLESTYRAMINE/ASPARTAME	CHOLESTYRAMINE LIGHT		
COLESTIPOL HCL	COLESTID		
<b>Antihyperlipidemic - Fibric Acid Derivatives</b>			
FENOFIBRATE	FENOFIBRATE		Generic tablets covered only
GEMFIBROZIL	LOPID		
<b>Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)</b>			
ATORVASTATIN CALCIUM	LIPITOR		
LOVASTATIN	MEVACOR	QL	Limited to 1 tablet per day
PRAVASTATIN SODIUM	PRAVACHOL	QL	Limited to 1 tablet per day
SIMVASTATIN	ZOCOR	QL	Limited to 1 tablet per day
<b>Antileprotic - Sulfone Agents</b>			
DAPSONE	DAPSONE		
<b>Antimalarials</b>			
HYDROXYCHLOROQUINE SULFATE	PLAQUENIL		
<b>Antimetabolite - Purine Analogs</b>			
MERCAPTOPURINE	MERCAPTOPURINE		
<b>Antimetabolite - Urea Derivatives</b>			
HYDROXYUREA	HYDREA		
<b>Antimyasthenic Agent - Reversible Cholinesterase Inhibitors</b>			
PYRIDOSTIGMINE BROMIDE	MESTINON		

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Generic Name	Common Name	Drug Status	Criteria
<b>Antineoplastic - Progestins</b>			
MEGESTROL ACETATE	MEGESTROL ACETATE		
<b>Antiparkinson - Dopaminerg-Peripheral Dopa-decarboxylase Inhibit Comb</b>			
CARBIDOPA/LEVODOPA	SINEMET 10-100		
<b>Antiparkinson Therapy - Ergot Alkaloids and Derivatives</b>			
BROMOCRIPTINE MESYLATE	PARLODEL		
<b>Antiparkinson Therapy - Monoamine Oxidase Inhibitor(MAO-B)</b>			
SELEGILINE HCL	SELEGILINE HCL		
<b>Antiparkinson Therapy - Non-ergot Dopamine Agonist Agents</b>			
PRAMIPEXOLE DI-HCL	PRAMIPEXOLE DIHYDROCHLORIDE		
ROPINIROLE HCL	REQUIP	QL	Limited to 30 tablets for 0.25, 0.5, 1, 2, 3 and 4 mg strengths per 30 days; Limited to 120 tablets for 5 mg strength per 30 days
<b>Antiprotozoal-Antibacterial 1st Generation 2-methyl-5-nitroimidazole</b>			
METRONIDAZOLE	FLAGYL		
<b>Antithyroid Agents, Thionamides - Imidazole Derivatives</b>			
METHIMAZOLE	METHIMAZOLE		
<b>Antithyroid Agents, Thionamides - Thiouracil Derivatives</b>			
PROPYLTHIOURACIL	PROPYLTHIOURACIL		
<b>Antitubercular - Isonicotinic Acid Derivatives</b>			
ISONIAZID	ISONIAZID		
<b>Antitubercular - Niacinamide Derivatives</b>			
PYRAZINAMIDE	PYRAZINAMIDE		
<b>Antitubercular - Rifamycin and Derivatives</b>			
RIFAMPIN	RIFADIN		
<b>Antitubercular Agents Other</b>			
ETHAMBUTOL HCL	ETHAMBUTOL HCL		
<b>Appetite Stimulants</b>			
MEGESTROL ACETATE	MEGACE		
<b>Asthma Therapy - Beta Adrenergic-Anticholinergic Combinations</b>			
IPRATROPIUM BROMIDE/ALBUTEROL SULFATE	COMBIVENT	QL	Limited to one inhaler per month
<b>Asthma Therapy - Beta Adrenergic-Glucocorticoid Combinations</b>			
BUDESONIDE/FORMOTEROL FUMARATE	SYMBICORT	QL,ST	Limited to one inhaler per month, Must have tried and failed Qvar in the past 90 days
FLUTICASONE PROPIONATE/SALMETEROL XINAFOATE	ADVAIR DISKUS	QL,ST	Limited to one inhaler per month; 500/50 mcg inhaler is not covered, Must have tried and failed Qvar in the past 90 days
MOMETASONE FUROATE/FORMOTEROL FUMARATE	DULERA	QL,ST	Limited to one inhaler per month, Must have tried and failed Qvar in the past 90 days
<b>Asthma Therapy - Glucocorticoids</b>			
BECLOMETHASONE DIPROPIONATE	QVAR	QL	Limited to one inhaler per month

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Generic Name	Common Name	Drug Status	Criteria
<b>Asthma Therapy - Glucocorticoids</b>			
BUDESONIDE	BUDESONIDE	PA,QL	Covered for patients up to age 8 without a prior authorization. Patients greater than age 8 must have tried and failed a steroid inhaler in the past 90 days or have documented inability to use an inhaler. Limited to 60 respules per 30 days
FLUTICASONE PROPIONATE	FLOVENT HFA	PA	Only 44 mcg inhaler is covered for ages 17 and below without a prior authorization
<b>Asthma Therapy - Leukotriene Receptor Antagonists</b>			
MONTELUKAST SODIUM	SINGULAIR	PA,QL	Limited to 1 tablet per day; PA Required for ages 15 and over, must submit documentation of trial and failure of Accolate
<b>Asthma Therapy - Mast Cell Stabilizers</b>			
CROMOLYN SODIUM	CROMOLYN SODIUM		
<b>Asthma Therapy - Xanthines</b>			
AMINOPHYLLINE	AMINOPHYLLINE		
THEOPHYLLINE ANHYDROUS	THEOPHYLLINE		
<b>Asthma/COPD Therapy - Anticholinergics</b>			
IPRATROPIUM BROMIDE	ATROVENT HFA	QL	Limited to one inhaler per month
TIOTROPIUM BROMIDE	SPIRIVA	QL,ST	Limited to one inhaler per month, Must have tried and failed Atrovent HFA in the past 90 days
<b>Asthma/COPD Therapy - Beta 2 Adrenergic Agents, Inhaled, Short Acting</b>			
ALBUTEROL SULFATE	VENTOLIN HFA	QL	Limited to one inhaler per month
METAPROTERENOL SULFATE	METAPROTERENOL SULFATE		
TERBUTALINE SULFATE	TERBUTALINE SULFATE		
<b>Beta Blockers Cardiac Selective</b>			
ATENOLOL	ATENOLOL		
METOPROLOL SUCCINATE	TOPROL XL	QL	Limited to one tablet per day
METOPROLOL TARTRATE	LOPRESSOR		
<b>Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity</b>			
ACEBUTOLOL HCL	ACEBUTOLOL HCL		
<b>Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity</b>			
PINDOLOL	PINDOLOL		
<b>Beta Blockers Non-Cardiac Selective</b>			
NADOLOL	NADOLOL		
PROPRANOLOL HCL	PROPRANOLOL HCL		
TIMOLOL MALEATE	TIMOLOL MALEATE		
<b>Bone Resorption Inhibitors - Bisphosphonates</b>			
ALENDRONATE SODIUM	FOSAMAX	QL	Limited to 4 tablets per 30 days
<b>Calcitonins</b>			
CALCITONIN,SALMON,SYNTHETIC	MIACALCIN	PA,SP	PA Required

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Generic Name	Common Name	Drug Status	Criteria
<b>Calcium Channel Blockers - Benzothiazepines</b>			
DILTIAZEM HCL	DILTIAZEM ER	QL	Limited to a Daily Dose of 2 (Cardizem SR); Limited to a Daily Dose of 1 (Cardizem CD) per 30 days
<b>Calcium Channel Blockers - Dihydropyridines</b>			
AMLODIPINE BESYLATE	AMLODIPINE BESYLATE	QL	Limited to 1 tablet per day
FELODIPINE	PLENDIL	QL	Limited to 1 tablet per day
NICARDIPINE HCL	NICARDIPINE HCL		
NIFEDIPINE	ADALAT CC	QL	Limited to 1 tablet per day
<b>Calcium Channel Blockers - Phenylalkylamines</b>			
VERAPAMIL HCL	CALAN SR	QL	Limited to 1 tablet per day
<b>Cardiac Selective Beta Blocker-Thiazide Diuretic &amp; Related Comb.</b>			
ATENOLOL/CHLORTHALIDONE	ATENOLOL-CHLORTHALIDONE		
BISOPROLOL FUMARATE/ HYDROCHLOROTHIAZIDE	BISOPROLOL- HYDROCHLOROTHIAZIDE		
<b>Cardiac Sympathomimetic - Anaphylaxis Therapy Single Agents</b>			
EPINEPHRINE	EPINEPHRINE	QL	Limited to 2 injections every 180 days.
EPINEPHRINE/PF	EPINEPHRINE	QL	Limited to 2 injections per 180 days
<b>Cardiac Sympathomimetics</b>			
MIDODRINE HCL	MIDODRINE HCL	PA	Must be prescribed by a Cardiologist
<b>Central Alpha-2 Agonists-Thiazide Diuretic &amp; Related Comb.</b>			
METHYLDOPA/ HYDROCHLOROTHIAZIDE	METHYLDOPA- HYDROCHLOROTHIAZIDE		
<b>Central Alpha-2 Receptor Agonists</b>			
CLONIDINE HCL	CLONIDINE HCL		
GUANFACINE HCL	GUANFACINE HCL		
METHYLDOPA	METHYLDOPA		
<b>Cephalosporin Antibiotics - 1st Generation</b>			
CEFADROXIL HYDRATE	CEFADROXIL	ST	Must have prior use of a first line antibiotic (Cefaclor or Cephalexin) within the last 30 days
CEPHALEXIN	CEPHALEXIN		
<b>Cephalosporin Antibiotics - 2nd Generation</b>			
CEFACLOL	CEFACLOL		
<b>Cephalosporin Antibiotics - 3rd Generation</b>			
CEFDINIR	OMNICEF	ST	Must have prior use of Amoxicillin in the past 60 days
CEFPODOXIME PROXETIL	CEFPODOXIME PROXETIL	ST	Must have prior use of a first line antibiotic (Cefaclor or Cephalexin) within the last 30 days
<b>CNS Stimulant - Analeptics</b>			
CAFFEINE CITRATED	CAFFEINE CITRATE	PA	PA Required
<b>Colonic Acidifier (Ammonia Inhibitor)</b>			
LACTULOSE	ENULOSE		

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Generic Name	Common Name	Drug Status	Criteria
<b>Contraceptive Injectable - Progestin</b>			
MEDROXYPROGESTERONE ACETATE	DEPO-PROVERA	QL	Limit of 1 injection per 90 days, Restricted to females only
<b>Contraceptive Oral - Biphasic</b>			
DESOGESTREL-ETHINYL ESTRADIOL/ETHINYL ESTRADIOL	KARIVA	QL	Limited to 1 tablet per day, Restricted to females only
<b>Contraceptive Oral - Monophasic</b>			
ETHYNODIOL D-ETHINYL ESTRADIOL	DEMULEN 1-50-21	QL	Limited to 1 tablet per day, Restricted to females only
LEVONORGESTREL-ETHINYL ESTRADIOL	LESSINA	QL	Limited to 1 tablet per day, Restricted to females only
NORETHINDRONE A-E ESTRADIOL	JUNEL	QL	Limited to 1 tablet per day, Restricted to females only
NORETHINDRONE A-E ESTRADIOL/FERROUS FUMARATE	JUNEL FE	QL	Limited to 1 tablet per day, Restricted to females only
NORETHINDRONE-ETHINYL ESTRADIOL	OVCON-35	QL	Limited to 1 tablet per day, Restricted to females only
NORGESTIMATE-ETHINYL ESTRADIOL	ORTHO-CYCLEN		
NORGESTREL-ETHINYL ESTRADIOL	OGESTREL	QL	Limited to 1 tablet per day, Restricted to females only
<b>Contraceptive Oral - Progestin</b>			
NORETHINDRONE	MICRONOR	QL	Limited to 1 tablet per day, Restricted to females only
<b>Contraceptive Oral - Triphasic</b>			
LEVONORGESTREL-ETHINYL ESTRADIOL	ENPRESSE	QL	Limited to 1 tablet per day, Restricted to females only
NORETHINDRONE-ETHINYL ESTRADIOL	ARANELLE	QL	Limited to 1 tablet per day, Restricted to females only
NORGESTIMATE-ETHINYL ESTRADIOL	ORTHO TRI-CYCLEN	QL	Limited to 1 tablet per day, Restricted to females only
<b>Dental Product - Fluoride Preparations</b>			
SODIUM FLUORIDE	SODIPHLUOR		Limited to ages 11 and below
<b>Dermatological - Antibacterial Other</b>			
MUPIROCIN	BACTROBAN		
<b>Dermatological - Antifungal Imidazole &amp; Related Agents</b>			
CLOTRIMAZOLE	DESENEX		
<b>Dermatological - Antifungal-Glucocorticoid Combinations</b>			
NYSTATIN/TRIAMCINOLONE ACETONIDE	NYSTATIN-TRIAMCINOLONE		
<b>Dermatological - Antineoplastic Antimetabolites</b>			
FLUOROURACIL	EFUDEX	PA	Must show documented diagnosis of Basal Cell Carcinoma
<b>Dermatological - Antiperspirants</b>			
ALUMINUM CHLORIDE	XERAC AC		

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Generic Name	Common Name	Drug Status	Criteria
<b>Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives</b>			
ACITRETIN	SORIATANE	PA	PA Required; Must submit documented failure of Methotrexate or Cyclosporine
<b>Dermatological - Antiseborrheic</b>			
SELENIUM SULFIDE	SELENIUM SULFIDE		
<b>Dermatological - Burn Products Anti-infective</b>			
SILVER SULFADIAZINE	THERMAZENE		
<b>Dermatological - Emollients</b>			
AMMONIUM LACTATE	LAC-HYDRIN		
<b>Dermatological - Glucocorticoid</b>			
BETAMETHASONE DIPROPIONATE	BETAMETHASONE DIPROPIONATE		
BETAMETHASONE DIPROPIONATE/ PROPYLENE GLYCOL	DIPROLENE AF		Cream and ointment covered only
BETAMETHASONE VALERATE	BETA-VAL		
CLOBETASOL PROPIONATE	CLOBETASOL PROPIONATE		
DESONIDE	DESONIDE		
DIFLORASONE DIACETATE	DIFLORASONE DIACETATE		
FLUOCINOLONE ACETONIDE	FLUOCINOLONE ACETONIDE		
FLUOCINONIDE	FLUOCINONIDE		
FLUOCINONIDE/EMOLLIENT	FLUOCINONIDE-E		
HYDROCORTISONE	HYDROCORTISONE		
HYDROCORTISONE VALERATE	WESTCORT		
<b>Dermatological - Glucocorticoid-Emollient Combinations</b>			
HYDROCORTISONE/MINERAL OIL/ PETROLATUM, WHITE	HYDROCORTISONE		
<b>Dermatological - Keratolytic-Antimitotic Single Agents</b>			
PODOFILOX	PODOFILOX		
<b>Dermatological - Local Anesthetic Combinations</b>			
LIDOCAINE/PRILOCAINE	LIDOCAINE-PRILOCAINE		Covered up to age 15
<b>Dermatological - Topical Local Anesthetic Amides</b>			
LIDOCAINE HCL	LIDOCAINE HCL		
<b>Digestive Enzyme Mixtures</b>			
LIPASE/PROTEASE/AMYLASE	ULTRASE MT 12	PA	PA Required
<b>Digitalis Glycosides</b>			
DIGOXIN	LANOXIN		
<b>Direct Acting Vasodilators</b>			
HYDRALAZINE HCL	HYDRALAZINE HCL		
MINOXIDIL	MINOXIDIL		
<b>Diuretic - Aldosterone Receptor Antagonist, Non-selective</b>			
SPIRONOLACTONE	ALDACTONE		
<b>Diuretic - Carbonic Anhydrase Inhibitors</b>			
ACETAZOLAMIDE	ACETAZOLAMIDE		
METHAZOLAMIDE	METHAZOLAMIDE		



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Generic Name	Common Name	Drug Status	Criteria
<b>Diuretic - Loop</b>			
BUMETANIDE	BUMEX		
FUROSEMIDE	FUROSEMIDE		
TORSEMIDE	DEMADEX		
<b>Diuretic - Potassium Sparing</b>			
AMILORIDE HCL	MIDAMOR		
<b>Diuretic - Potassium Sparing-Thiazide &amp; Related Combinations</b>			
AMILORIDE HCL/ HYDROCHLOROTHIAZIDE	AMILORIDE- HYDROCHLOROTHIAZIDE		
SPIRONOLACTONE/ HYDROCHLOROTHIAZIDE	ALDACTAZIDE		
TRIAMTERENE/ HYDROCHLOROTHIAZIDE	TRIAMTERENE-HCTZ		
<b>Diuretic - Thiazides and Related</b>			
CHLOROTHIAZIDE	CHLOROTHIAZIDE		
CHLORTHALIDONE	CHLORTHALIDONE		
HYDROCHLOROTHIAZIDE	HYDROCHLOROTHIAZIDE		
INDAPAMIDE	INDAPAMIDE		
METHYCLOTHIAZIDE	METHYCLOTHIAZIDE		
METOLAZONE	METOLAZONE		
<b>DMARD - Antimetabolites</b>			
METHOTREXATE SODIUM	METHOTREXATE	PA	PA Required
<b>Emergency Contraceptives</b>			
LEVONORGESTREL	PLAN B		
<b>Erythropoietins</b>			
EPOETIN ALFA	EPOGEN	PA,SP	Must meet Pharmacy Approval Criteria
<b>Estrogen-Progestin</b>			
ESTROGENS, CONJUGATED/ MEDROXYPROGESTERONE ACETATE	PREMPRO	QL	Limited to one tablet per day, Restricted to females only
NORETHINDRONE ACETATE/ETHINYL ESTRADIOL	FEMHRT	QL	Limited to one tablet per day, Restricted to females only
<b>Estrogens</b>			
ESTRADIOL	ESTRADIOL		Restricted to females only
ESTROGENS, CONJUGATED	PREMARIN		Restricted to females only, Only tablets are covered
ESTROGENS,ESTERIFIED	MENEST		Restricted to females only
ESTROPIPATE	ESTROPIPATE		Restricted to females only
<b>Fluoroquinolone Antibiotics</b>			
CIPROFLOXACIN HCL	CIPROFLOXACIN HCL		
LEVOFLOXACIN	LEVAQUIN		
<b>G.U. Irrigants</b>			
SODIUM CHLORIDE IRRIGATING SOLUTION	SODIUM CHLORIDE		
<b>Gallstone Solubilizing (Litholysis) Agents</b>			
URSODIOL	URSODIOL		

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Generic Name	Common Name	Drug Status	Criteria
<b>Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists</b>			
CIMETIDINE	HEARTBURN RELIEF		
CIMETIDINE HCL	CIMETIDINE		
FAMOTIDINE	PEPCID		Only generic tablets are covered
RANITIDINE HCL	RANITIDINE HCL		Suspension is limited to ages 11 and below
<b>Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)</b>			
LANSOPRAZOLE	PREVACID 24HR	ST	Must have tried and failed three consecutive fills of Omeprazole in the past 90 days
OMEPRAZOLE	OMEPRAZOLE	QL	20 mg capsule is limited to 4 per day; 40 mg capsule is limited to 2 per day. Limited to 6 months of therapy per rolling 365 days.
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM	ST	Must have tried and failed Omeprazole and Lansoprazole in the past 90 days
<b>Gastric Mucosa - Cytoprotective Prostaglandin Analogs</b>			
MISOPROSTOL	MISOPROSTOL		
<b>Gastrointestinal Prokinetic Agents - D2 Antagonist/5-HT4 Agonists</b>			
METOCLOPRAMIDE HCL	METOCLOPRAMIDE HCL		
<b>GI Antispasmodic - Belladonna Alkaloids</b>			
HYOSCYAMINE SULFATE	HYOSCYAMINE SULFATE		
METHSCOPOLAMINE BROMIDE	PAMINE		
<b>GI Antispasmodic - Quaternary Ammonium Compounds</b>			
GLYCOPYRROLATE	GLYCOPYRROLATE		
PROPANTHELINE BROMIDE	PROPANTHELINE BROMIDE		
<b>GI Antispasmodic - Synthetic Tertiary Amines</b>			
DICYCLOMINE HCL	DICYCLOMINE HCL		
<b>GI Antispasmodic Combinations Other</b>			
PHENOBARBITAL/HYOSCYAMINE SULF/ATROPINE SULF/SCOPOLAMINE HB	BELLADONNA-PHENOBARBITAL		
<b>Glucocorticoids</b>			
CORTISONE ACETATE	CORTISONE ACETATE		
DEXAMETHASONE	DEXAMETHASONE		
HYDROCORTISONE	CORTEF		
METHYLPREDNISOLONE	MEDROL		
PREDNISOLONE	PREDNISOLONE		
PREDNISOLONE SOD PHOSPHATE	PEDIAPRED		
PREDNISON	PREDNISON		
<b>Glycopeptide Antibiotics</b>			
VANCOMYCIN HCL	VANCOCIN HCL	PA	PA Required
<b>Gonadotropin Inhibitor Pituitary Suppressants</b>			
DANAZOL	DANAZOL		

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Generic Name	Common Name	Drug Status	Criteria
<b>Gout Acute Therapy - Antimitotics</b>			
COLCHICINE	COLCHICINE	PA	PA Required
<b>Granulocyte Colony-Stimulating Factor (G-CSF)</b>			
FILGRASTIM	NEUPOGEN	PA,SP	Must meet Pharmacy Approval Criteria
<b>Growth Hormones</b>			
SOMATROPIN	HUMATROPE	PA,SP	PA Required
<b>Hematorheologic Agents</b>			
PENTOXIFYLLINE	TRENTAL	QL	Limited to 3 tablets per day
<b>Heparins</b>			
HEPARIN SODIUM,PORCINE	HEPARIN LOCK		20,000 unit/mL strength is not covered
HEPARIN SODIUM,PORCINE IN 0.9 % SODIUM CHLORIDE	HEPARIN FLUSH		
HEPARIN SODIUM,PORCINE/PF	MONOJECT PREFILL ADVANCED		
<b>Hepatitis C - Interferons</b>			
PEGINTERFERON ALFA-2B	PEGINTRON REDIPEN	PA,SP	Redipen is covered, Must meet Pharmacy Approval Criteria
<b>Hepatitis C - NS3/4A Serine Protease Inhibitors</b>			
BOCEPREVIR	VICTRELIS	PA,SP	PA Required
<b>Hepatitis C - Nucleoside Analogs</b>			
RIBAVIRIN	REBETOL	PA,SP	Must meet Pharmacy Approval Criteria
<b>Herpes Antiviral Agent - Purine Analogs</b>			
ACYCLOVIR	ZOVIRAX		Only oral forms are covered
<b>Human Insulins - Short Acting</b>			
INSULIN REGULAR, HUMAN	HUMULIN R		Only vials will be covered
<b>Hyperglycemic Agents</b>			
GLUCAGON,HUMAN RECOMBINANT	GLUCAGON EMERGENCY KIT	QL	Limited to 2 kits per year
<b>Hyperuricemia Therapy - Uricosurics</b>			
PROBENECID	PROBENECID		
<b>Hyperuricemia Therapy - Xanthine Oxidase Inhibitors</b>			
ALLOPURINOL	ALLOPURINOL		
<b>Immune Globulin - Rho(D)</b>			
RHO(D) IMMUNE GLOBULIN	RHOGAM PLUS	SP	
RHO(D) IMMUNE GLOBULIN/ MALTOS	WINRHO SDF	SP	
<b>Immunosuppressive - Calcineurin Inhibitors</b>			
CYCLOSPORINE	SANDIMMUNE	PA,SP	PA Required
CYCLOSPORINE, MODIFIED	GENGRAF	PA,SP	PA Required
TACROLIMUS	TACROLIMUS	PA,SP	PA Required
<b>Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors</b>			
MYCOPHENOLATE MOFETIL	CELLCEPT	PA,SP	PA Required
<b>Immunosuppressive - Purine Analogs</b>			
AZATHIOPRINE	AZATHIOPRINE		
<b>Inflammatory Bowel Agent - Aminosalicylates and Related Agents</b>			
MESALAMINE	ROWASA		

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Generic Name	Common Name	Drug Status	Criteria
<b>Inflammatory Bowel Agent - Aminosalicylates and Related Agents</b>			
SULFASALAZINE	AZULFIDINE		
<b>Influenza Antiviral Agents - Neuraminidase Inhibitors</b>			
OSELTAMIVIR PHOSPHATE	TAMIFLU	QL	Must have documented Influenza. Limited to 10 capsules, unless institutional setting then 14 capsules can be approved; Suspension is limited to 3 bottles per 30 days
<b>Influenza-A Antiviral Agents</b>			
RIMANTADINE HCL	RIMANTADINE HCL		
<b>Insulin Analogs - Fixed Combinations</b>			
INSULIN ASPART PROTAMINE HUMAN/INSULIN ASPART	NOVOLOG MIX 70-30		Only vials will be covered
INSULIN LISPRO PROTAMINE & INSULIN LISPRO	HUMALOG MIX 75-25		Only vials will be covered
<b>Insulin Analogs - Long Acting</b>			
INSULIN GLARGINE, HUMAN RECOMBINANT ANALOG	LANTUS	QL	Vials are covered with no Prior Authorization. To receive cartridges or solostar, clinical documentation of a severe arthritic condition or blindness must be shown. Lantus is the preferred Long Acting Insulin
<b>Insulin Analogs - Rapid Acting</b>			
INSULIN GLULISINE	APIDRA	QL	Vials are covered with no Prior Authorization. To receive cartridges or solostar, clinical documentation of a severe arthritic condition or blindness must be shown. Apidra is the preferred Rapid Acting Insulin
<b>Insulin Response Enhancers - Biguanides</b>			
METFORMIN HCL	GLUCOPHAGE		
<b>Insulin Response Enhancers - Thiazolidinediones (PPAR-gamma agonists)</b>			
PIOGLITAZONE HCL	ACTOS	QL,ST	Limited to 1 tablet per day, Must have prior use of Metformin within the last 90 days; Maximal dose of metformin (1700 mg/day) or maximal dose of a sulfonylurea. Or if patient had renal or heart failure, Limit: 30 , Per 30 Days
<b>Interstitial Cystitis Agents</b>			
PENTOSAN POLYSULFATE SODIUM	ELMIRON	PA	Must have diagnosis of interstitial cystitis and be prescribed by a Urologist
<b>Laxative - Saline and Osmotic</b>			
LACTULOSE	LACTULOSE		
POLYETHYLENE GLYCOL 3350	CLEARLAX		
<b>Laxative - Saline/Osmotic Mixtures</b>			
PEG 3350/SOD SULF/SOD BICARBONATE/SOD CHLORIDE/ POTASSIUM CHL	COLYTE WITH FLAVOR PACKETS		

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Generic Name	Common Name	Drug Status	Criteria
<b>LHRH (GnRH) Agonist Analog Pit Suppres - Central Precocious Puberty</b>			
LEUPROLIDE ACETATE	LUPRON DEPOT-PED	PA,SP	Must meet Pharmacy Approval Criteria
<b>Lincosamide Antibiotics</b>			
CLINDAMYCIN HCL	CLEOCIN HCL		Solution is limited to 250 mL per 30 days
CLINDAMYCIN PALMITATE HCL	CLEOCIN PALMITATE	QL	Solution is limited to 250 mL per 30 days
<b>Low Molecular Weight Heparins</b>			
ENOXAPARIN SODIUM	LOVENOX	PA	Must meet Pharmacy Approval Criteria
<b>Luteal Phase Supporting, Progesterone-type</b>			
PROGESTERONE	FIRST-PROGESTERONE VGS 400		
<b>Macrolide - Sulfonamide Combinations</b>			
ERYTHROMYCIN ETHYLSUCCINATE/ SULFISOXAZOLE ACETYL	ERYTHROMYCIN-SULFISOXAZOLE		
<b>Macrolides</b>			
AZITHROMYCIN	ZITHROMAX	QL	Tablets are limited to 1.5 grams per 30 days
CLARITHROMYCIN	BIAXIN		
ERYTHROMYCIN BASE	ERYTHROMYCIN		
ERYTHROMYCIN ETHYLSUCCINATE	ERYTHROMYCIN ETHYLSUCCINATE		
ERYTHROMYCIN STEARATE	ERYTHROCIN STEARATE		
<b>Medical Supplies &amp; DME - Diaphragms</b>			
DIAPHRAGMS, ARC-SPRING	ORTHO ALL-FLEX		
<b>Medical Supplies &amp; DME - Insulin Needles-Syringes &amp; Admin. Supplies</b>			
SYRINGE WITH NEEDLE,DISPOSABLE, INSULIN 1 ML	MONOJECT INSULIN SYRINGE		
SYRINGE WITH NEEDLE,INSULIN DISPOSABLE,0.3 ML	INSULIN SYRINGE		
SYRINGE WITH NEEDLE,INSULIN DISPOSABLE,0.5 ML	MONOJECT		
<b>Medical Supplies &amp; DME - Respiratory Therapy Supplies</b>			
INHALER, ASSIST DEVICES	INSPIREASE	QL	Limited to 1 per year
<b>Migraine Therapy - Ergot Combinations</b>			
ERGOTAMINE TARTRATE/CAFFEINE	ERGOTAMINE-CAFFEINE		
<b>Migraine Therapy - Selective Serotonin Agonists 5-HT(1)</b>			
NARATRIPTAN HCL	NARATRIPTAN HCL	QL,ST	Limited to 9 tablets per 30 days, Must have tried and failed three consecutive fills of Sumatriptan Tablets in the past 90 days
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE	QL	Limited to 9 tablets or 2 injections per month
<b>Mineralocorticoids</b>			
FLUDROCORTISONE ACETATE	FLUDROCORTISONE ACETATE		
<b>Minerals &amp; Electrolytes - Potassium, Oral</b>			
POTASSIUM CHLORIDE	KLOR-CON		
<b>Minerals &amp; Electrolytes - Zinc</b>			
ZINC SULFATE	ZINC SULFATE		

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Generic Name	Common Name	Drug Status	Criteria
<b>Mouth and Throat - Glucocorticoids</b>			
TRIAMCINOLONE ACETONIDE	TRIAMCINOLONE ACETONIDE	QL	Limited to 1 tube per month
<b>Mouth and Throat - Local Anesthetic Amides</b>			
LIDOCAINE HCL	LIDOCAINE HCL VISCOUS		
<b>Mouth and Throat - Saliva Stimulants</b>			
CEVIMELINE HCL	EVOXAC		
PILOCARPINE HCL	PILOCARPINE HCL		
<b>Multiple Sclerosis Agent - Interferons</b>			
INTERFERON BETA-1A	AVONEX	PA,SP	Must meet Pharmacy Approval Criteria
INTERFERON BETA-1A/ALBUMIN HUMAN	REBIF	PA,SP	Must meet Pharmacy Approval Criteria
<b>Multiple Sclerosis Agent - Others</b>			
GLATIRAMER ACETATE	COPAXONE	PA,SP	Must meet Pharmacy Approval Criteria
<b>Narcotic Antitussive-1st Gen. Antihistamine-Decongestant Combinations</b>			
PHENYLEPHRINE HCL/CODEINE/PROMETHAZINE	PROMETHAZINE VC-CODEINE		
<b>Narcotic Antitussive-1st Generation Antihistamine Combinations</b>			
CODEINE/PROMETHAZINE HCL	PROMETHAZINE-CODEINE		
<b>Narcotic Antitussive-Expectorant Combinations</b>			
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE		
<b>Nasal Anticholinergics</b>			
IPRATROPIUM BROMIDE	IPRATROPIUM BROMIDE	QL	Limited to 1 inhaler per month
<b>Nasal Corticosteroids</b>			
FLUNISOLIDE	FLUNISOLIDE	QL	Limited to 1 inhaler per month
FLUTICASONE PROPIONATE	FLUTICASONE PROPIONATE	QL	Limited to 1 inhaler per month
<b>Non-Cardiac Selective Beta Blocker-Thiazide Diuretic &amp; Related Comb.</b>			
NADOLOL/BENDROFLUMETHIAZIDE	NADOLOL-BENDROFLUMETHIAZIDE		
<b>Non-Narcotic Antitussive-Antihistamine Combinations</b>			
DEXTROMETHORPHAN HBR/PROMETHAZINE HCL	PROMETHAZINE-DM		
<b>NSAID Analgesics (COX Non-Specific) - Anthranilic Acid Derivatives</b>			
MECLOFENAMATE SODIUM	MECLOFENAMATE SODIUM		
<b>NSAID Analgesics (COX Non-Specific) - Other</b>			
KETOROLAC TROMETHAMINE	KETOROLAC TROMETHAMINE		
SULINDAC	SULINDAC		
TOLMETIN SODIUM	TOLMETIN SODIUM		
<b>NSAID Analgesics (COX Non-Specific) - Oxicam Derivatives</b>			
MELOXICAM	MELOXICAM		
PIROXICAM	FELDENE		
<b>NSAID Analgesics (COX Non-Specific) - Phenylacetic Acid Derivatives</b>			
DICLOFENAC POTASSIUM	CATAFLAM		
DICLOFENAC SODIUM	DICLOFENAC SODIUM		
<b>NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives</b>			
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM		

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Generic Name	Common Name	Drug Status	Criteria
<b>NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives</b>			
FLURBIPROFEN	ANSAID		
IBUPROFEN	IBUPROFEN	QL	Maximum limit of 3200 mg of Ibuprofen per day
KETOPROFEN	KETOPROFEN		Only immediate release capsules are covered
NAPROXEN	NAPROSYN		
NAPROXEN SODIUM	ANAPROX		
<b>NSAID Analgesics, (COX Non-specific) - Indole Acetic Acid Derivatives</b>			
ETODOLAC	ETODOLAC		
INDOMETHACIN	INDOMETHACIN		Only immediate release capsules are covered
<b>Ophthalmic - Anti-inflammatory, Glucocorticoids</b>			
DEXAMETHASONE SOD PHOSPHATE	DEXAMETHASONE SODIUM PHOSPHATE		
PREDNISOLONE ACETATE	OMNIPRED		
PREDNISOLONE SOD PHOSPHATE	PREDNISOLONE SODIUM PHOSPHATE		
<b>Ophthalmic - Anti-inflammatory, NSAIDs</b>			
DICLOFENAC SODIUM	VOLTAREN		
FLURBIPROFEN SODIUM	OCUFEN		
KETOROLAC TROMETHAMINE	ACULAR		
<b>Ophthalmic - Antibacterial-Glucocorticoid Combinations</b>			
NEOMYCIN SULFATE/BACITRACIN ZINC/POLYMYXIN B/HYDROCORTISONE	CORTOMYCIN		
NEOMYCIN SULFATE/POLYMYXIN B SULFATE/HYDROCORTISONE	CORTISPORIN		
NEOMYCIN/POLYMYXIN B SULFATE/DEXAMETHASONE	MAXITROL		
TOBRAMYCIN/DEXAMETHASONE	TOBRADEX		
<b>Ophthalmic - Anticholinergics</b>			
CYCLOPENTOLATE HCL	CYCLOGYL		
TROPICAMIDE	TROPICAMIDE		
<b>Ophthalmic - Carbonic Anhydrase Inhibitors</b>			
DORZOLAMIDE HCL	TRUSOPT		
<b>Ophthalmic - Decongestants</b>			
NAPHAZOLINE HCL	NAPHAZOLINE HCL		
PHENYLEPHRINE HCL	MYDRIN		
<b>Ophthalmic - Intraocular Pressure Reducing Agents, Beta-blockers</b>			
BETAXOLOL HCL	BETAXOLOL HCL		
CARTEOLOL HCL	CARTEOLOL HCL		
LEVOBUNOLOL HCL	BETAGAN		
METIPRANOLOL	OPTIPRANOLOL		
TIMOLOL MALEATE	TIMOPTIC		

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Generic Name	Common Name	Drug Status	Criteria
<b>Ophthalmic - Local Anesthetic Esters</b>			
PROPACARCAINE HCL	ALCAINE		
<b>Ophthalmic Antibacterial Mixtures</b>			
BACITRACIN/POLYMYXIN B SULFATE	BACITRACIN-POLYMYXIN		
NEOMYCIN SULFATE/BACITRACIN/ POLYMYXIN B	NEOMYCIN-BACITRACIN- POLYMYXIN		
NEOMYCIN SULFATE/POLYMYXIN B SULFATE/GRAMICIDIN D	NEOMYCIN-POLYMYXIN- GRAMICIDIN		
POLYMYXIN B SULFATE/ TRIMETHOPRIM	POLYTRIM		
<b>Ophthalmic Antibiotic - Aminoglycosides</b>			
GENTAMICIN SULFATE	GENTAK		
<b>Ophthalmic Antibiotic - Dehydropeptidase Inhibitors</b>			
BACITRACIN	BACITRACIN		
<b>Ophthalmic Antibiotic - Fluoroquinolones</b>			
CIPROFLOXACIN HCL	CILOXAN		Only 5 mL bottle is covered
OFLOXACIN	OCUFLOX		
<b>Ophthalmic Antibiotic - Sulfonamides</b>			
SULFACETAMIDE SODIUM	BLEPH-10		
<b>Ophthalmic Antivirals</b>			
TRIFLURIDINE	VIROPTIC		
<b>Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists</b>			
APRACLOMIDINE HCL	IOPIDINE		
BRIMONIDINE TARTRATE	BRIMONIDINE TARTRATE		
<b>Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs</b>			
LATANOPROST	XALATAN		
<b>Otic - Anti-infective Mixtures</b>			
ACETIC ACID/ALUMINUM ACETATE	BOROFAR		
<b>Otic - Anti-infective-Glucocorticoid Combinations</b>			
NEOMYCIN SULFATE/POLYMYXIN B SULFATE/HYDROCORTISONE	NEOMYCIN-POLYMYXIN- HYDROCORT		
<b>Otic - Anti-infectives other</b>			
ACETIC ACID	VOSOL		
<b>Otic - Fluoroquinolones</b>			
OFLOXACIN	OFLOXACIN		
<b>Oxytocic - Ergot Alkaloids</b>			
METHYLERGONOVINE MALEATE	METHERGINE		
<b>Pediatric Vitamins with Fluoride and Minerals Combinations</b>			
FLUORIDE/IRON/VITAMINS A,C,AND D	TRI-VIT WITH FLUORIDE-IRON		
MULTIVITAMINS WITH IRON & FLUORIDE	MULTIVITAMINS W-FLUORIDE- IRON		
<b>Pediatric Vitamins with Fluoride Combinations</b>			
FLUORIDE/VITAMINS A,C,AND D	TRI-VITAMIN WITH FLUORIDE		Limited to ages 10 and under
MULTIVITAMINS WITH FLUORIDE	POLY-VITAMINS W/FLUORIDE		Limited to ages 10 and under



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Generic Name	Common Name	Drug Status	Criteria
<b>Pediatric Vitamins with Fluoride Combinations</b>			
PEDIATRIC MULTIVIT #37/SODIUM FLUORIDE/IRON BISGLYCINATE HCL	POLY-VI-FLOR WITH IRON		Limited to ages 10 and under
PEDIATRIC MULTIVITAMIN NO.26 WITH IRON & SODIUM FLUORIDE	ESCAVITE		Limited to ages 10 and under
PEDIATRIC MULTIVITAMIN NO.47 WITH IRON & SODIUM FLUORIDE	TL-FLUORIVITE		Limited to ages 10 and under
PEDIATRIC MULTIVITAMINS A,C,& D3 NO.21 WITH SODIUM FLUORIDE	TRI-VITAMIN WITH FLUORIDE		Limited to ages 10 and under
PEDIATRIC MULTIVITAMINS A,C,& D3 NO.38 WITH SODIUM FLUORIDE	TRI-VI-FLOR		Limited to ages 10 and under
PEDIATRIC MULTIVITAMINS NO.16 WITH SODIUM FLUORIDE	MULTIVITAMINS WITH FLUORIDE		Limited to ages 10 and under
PEDIATRIC MULTIVITAMINS NO.17 WITH SODIUM FLUORIDE	MULTIVITAMINS WITH FLUORIDE		Limited to ages 10 and under
<b>Penicillin Antibiotic - Natural (i.e. Pen G, Pen V)</b>			
PENICILLIN V POTASSIUM	PENICILLIN V POTASSIUM		
<b>Penicillin Antibiotic - Penicillinase-resistant</b>			
DICLOXACILLIN SODIUM	DICLOXACILLIN SODIUM		
<b>Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives</b>			
SUCRALFATE	SUCRALFATE		
<b>Peripheral Alpha-1 Receptor Blockers</b>			
DOXAZOSIN MESYLATE	CARDURA		
PRAZOSIN HCL	MINIPRESS		
TERAZOSIN HCL	TERAZOSIN HCL		
<b>Peripheral Vasodilators, Single Agents</b>			
ISOXSUPRINE HCL	ISOXSUPRINE HCL		
PAPAVERINE HCL	PAPAVERINE HCL		
<b>Phosphate Binders</b>			
CALCIUM ACETATE	CALCIUM ACETATE		
SEVELAMER CARBONATE	REVELA	PA	Must have trial and therapeutic failure, intolerance, or contraindication to Phoslo
<b>Platelet Aggregation Inhib - PDEsterase &amp; Adenosine deaminase Inhibitor</b>			
DIPYRIDAMOLE	DIPYRIDAMOLE		
<b>Platelet Aggregation Inhibitors - Phosphodiesterase III Inhibitors</b>			
CILOSTAZOL	CILOSTAZOL		
<b>Platelet Aggregation Inhibitors - Thienopyridine Agents</b>			
CLOPIDOGREL BISULFATE	PLAVIX	PA	Must meet Pharmacy Approval Criteria
<b>Prenatal Vitamins and Minerals</b>			
PRENATAL VIT WITH CALCIUM #34/IRON/FOLIC ACID	TARON-EC CAL	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMIN 27 WITH CALCIUM/FERROUS FUMARATE/FOLIC ACID	TRINATAL RX 1	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMIN NO.15/IRON, CARBONYL/FOLIC ACID/DOCUSATE SOD	TRIADVANCE	QL	Limited to 1 tablet per day, Restricted to females only

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Generic Name	Common Name	Drug Status	Criteria
<b>Prenatal Vitamins and Minerals</b>			
PRENATAL VITAMIN NO.18/IRON, CARBONYL/FOLIC ACID/DOCUSATE SOD	VINATE ULTRA	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS COMB NO.71/ FERROUS FUMARATE/FOLIC ACID	VOL-PLUS	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS COMB NO.72/ FERROUS FUMARATE/FOLIC ACID	PRENATAL PLUS	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS COMB NO.74/ FERROUS FUMARATE/FOLIC ACID	PRENATAL LOW IRON	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS COMBO NO.14/ FERROUS FUMARATE/FOLIC ACID	NATACHEW	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS/FERROUS FUMARATE/FOLIC ACID	PRENATAL PLUS	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL WITHOUT IRON/FOLIC ACID/CALCIUM CARB/PYRIDOXINE/ B12	TRIMESIS RX	QL	Limited to 1 tablet per day, Restricted to females only
<b>Progestins</b>			
HYDROXYPROGESTERONE CAPROATE	HYDROXYPROGESTERONE CAPROATE		
MEDROXYPROGESTERONE ACETATE	PROVERA		Restricted to females only
NORETHINDRONE ACETATE	NORETHINDRONE ACETATE	QL	Limited to 1 tablet per day, Restricted to females only
<b>Prostatic Hypertrophy Agent - alpha-1-Adrenoceptor Antagonists</b>			
TAMSULOSIN HCL	TAMSULOSIN HCL		
<b>Prostatic Hypertrophy Agent - Type II 5-alpha Reductase Inhibitors</b>			
FINASTERIDE	PROSCAR	ST	Shows paid claim for Prazosin, Doxazosin, or Terazosin in the past 90 days
<b>Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.</b>			
TADALAFIL	ADCIRCA	PA,SP	Must meet Pharmacy Approval Criteria
<b>Salicylate Analgesic and Sedative Combinations</b>			
BUTALBITAL/ASPIRIN/CAFFEINE	BUTALBITAL-ASPIRIN-CAFFEINE	QL	Limited to 13 tablets per day
<b>Salicylate Analgesic Combinations, Other</b>			
CHOLINE SALICYLATE/MAGNESIUM SALICYLATE	CHOLINE MAG TRISALICYLATE		
<b>Salicylate Analgesics</b>			
ASPIRIN	ASPIRIN EC		
SALSALATE	SALSALATE		
<b>Scabicide &amp; Pediculicide Single Agents</b>			
MALATHION	MALATHION	ST	Must have prior use of first line Pediculicides agent within the last 30 days
PERMETHRIN	ACTICIN		
<b>Skeletal Muscle Relaxant - Central Muscle Relaxants</b>			
BACLOFEN	BACLOFEN		
CARISOPRODOL	SOMA		

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Generic Name	Common Name	Drug Status	Criteria
<b>Skeletal Muscle Relaxant - Central Muscle Relaxants</b>			
CHLORZOXAZONE	PARAFON FORTE DSC		
CYCLOBENZAPRINE HCL	CYCLOBENZAPRINE HCL		
METHOCARBAMOL	ROBAXIN		
TIZANIDINE HCL	TIZANIDINE HCL		
<b>Smoking Deterrents - NE &amp; Dopamine Reuptake Inhibitor (NDRI)-Type</b>			
BUPROPION HCL	BUPROBAN		
<b>Smoking Deterrents - Nicotinic Receptor Partial Agonist, alpha4beta2</b>			
VARENICLINE TARTRATE	CHANTIX	ST	Limited to 90 days therapy per rolling 365 days; Must have 6 months prior therapy with topical nicotine patches along with either nicotine polacrilex gum or lozenges
<b>Sodium Chloride, Parenteral</b>			
0.9 % SODIUM CHLORIDE	SODIUM CHLORIDE		
<b>Sulfonamide Antibiotic</b>			
SULFADIAZINE	SULFADIAZINE		
<b>Systemic Sympathomimetic Decongestants</b>			
PSEUDOEPHEDRINE HCL	PSEUDOEPHEDRINE HCL	QL	Limited to 4 tablets per day
<b>Tetracycline Antibiotics</b>			
DEMECLOCYCLINE HCL	DEMECLOCYCLINE HCL	PA	Must show documented diagnosis of syndrome of inappropriate antidiuretic hormone (SIADH)
DOXYCYCLINE HYCLATE	VIBRAMYCIN		
MINOCYCLINE HCL	MINOCYCLINE HCL		
TETRACYCLINE HCL	TETRACYCLINE HCL		
<b>Thyroid Hormones - Animal Source (Porcine)</b>			
THYROID,PORK	ARMOUR THYROID		
<b>Thyroid Hormones - Synthetic T4 (Thyroxine)</b>			
LEVOTHYROXINE SODIUM	SYNTHROID		
<b>Urinary Alkalinizer - Citrates</b>			
CITRIC ACID/SODIUM CITRATE	SODIUM CITRATE & CITRIC ACID		
POTASSIUM CITRATE/CITRIC ACID	POTASSIUM CITRATE-CITRIC ACID		
<b>Urinary Analgesics</b>			
PHENAZOPYRIDINE HCL	PHENAZOPYRIDINE HCL		
<b>Urinary Antibacterial - Methenamine &amp; Salts</b>			
METHENAMINE HIPPURATE	HIPREX		
<b>Urinary Antibacterial - Nitrofurantoin Derivatives</b>			
NITROFURANTOIN MACROCRYSTAL	NITROFURANTOIN		
NITROFURANTOIN MONOHYDRATE/ MACROCRYSTALS	MACROBID		
<b>Urinary Antispasmodic - Smooth Muscle Relaxants</b>			
FLAVOXATE HCL	FLAVOXATE HCL		
OXYBUTYNIN CHLORIDE	OXYBUTYNIN CHLORIDE		

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Generic Name	Common Name	Drug Status	Criteria
<b>Urinary Antispasmodic - Smooth Muscle Relaxants</b>			
TOLTERODINE TARTRATE	DETROL	ST	Must have prior use of Oxybutynin within past 90 days
<b>Urinary Retention Therapy - Parasympathomimetic Agents</b>			
BETHANECHOL CHLORIDE	BETHANECHOL CHLORIDE		
<b>Vaginal Antibacterial - Lincosamides</b>			
CLINDAMYCIN PHOSPHATE	CLEOCIN		
<b>Vaginal Antifungal - Amphoteric Polyene Macrolides</b>			
NYSTATIN	NYSTATIN		
<b>Vaginal Antifungal - Triazoles</b>			
TERCONAZOLE	TERAZOL 7		
<b>Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives</b>			
METRONIDAZOLE	VANDAZOLE		
<b>Vitamins - B-12, Cyanocobalamin and derivatives</b>			
CYANOCOBALAMIN (VITAMIN B-12)	CYANOCOBALAMIN INJECTION		
<b>Vitamins - D Derivatives</b>			
CALCITRIOL	CALCITRIOL		
ERGOCALCIFEROL (VITAMIN D2)	DRISDOL	QL	Limited to 4 capsules per month
<b>Vitamins - Folic Acid and Derivatives</b>			
FOLIC ACID	FOLIC ACID		

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Generic Name	Common Name	Drug Status	Criteria
<b>1st Generation Antihistamine-Decongestant Combinations</b>			
PSEUDOEPHEDRINE HCL/ TRIPROLIDINE HCL	ALLERFRIM		
<b>Acne Therapy Topical - Keratolytic</b>			
BENZOYL PEROXIDE	BENZAC AC		
<b>Analgesic or Antipyretic Non-Narcotic</b>			
ACETAMINOPHEN	ACETAMINOPHEN	QL	Maximum of 4000 mg of Acetaminophen is allowed per day
<b>Antacid - Bicarbonate</b>			
SODIUM BICARBONATE	SODIUM BICARBONATE		
<b>Antacid - Calcium</b>			
CALCIUM CARBONATE	ANTACID		
<b>Antacid - Simethicone Combinations</b>			
MAGNESIUM HYDROXIDE/ALUMINUM HYDROXIDE/SIMETHICONE	MAALOX ADVANCED		
<b>Antidiarrheal - Antiperistaltic Agents</b>			
LOPERAMIDE HCL	LOPERAMIDE		
<b>Antidiarrheal - Bismuth Agents</b>			
BISMUTH SUBSALICYLATE	KAOPECTATE		
<b>Antidiarrheal GI Adsorbent Mixtures</b>			
KAOLIN/PECTIN	KAOLIN PECTIN		
<b>Antiemetic - Antihistamines</b>			
DIMENHYDRINATE	DIMENHYDRINATE		
MECLIZINE HCL	ANTIVERT		
<b>Antihistamine - 1st Generation - Alkylamines</b>			
CHLORPHENIRAMINE MALEATE	CHLOR-TRIMETON		
<b>Antihistamine - 1st Generation - Ethanolamines</b>			
CLEMASTINE FUMARATE	TAVIST-1		
DIPHENHYDRAMINE HCL	ALLERGY RELIEF		
<b>Antihistamines - 2nd Generation</b>			
CETIRIZINE HCL	ZYRTEC		
LORATADINE	WAL-ITIN		
<b>Antiseptic - Alcohols</b>			
ALCOHOL ANTISEPTIC PADS	ALCOHOL SWABS		
<b>Artificial Tears and Lubricant Combinations</b>			
DEXTRAN 70/HYPROMELLOSE/PF	TEARS NATURALE FREE		
<b>Artificial Tears and Lubricant Single Agents</b>			
POLYVINYL ALCOHOL	ARTIFICIAL TEARS		
<b>B-Complex Vitamin Combinations</b>			
B COMPLEX WITH VITAMIN C	SURBEX W-C		
FOLIC ACID/VITAMIN B COMPLEX & C/ RICE BRAN	VITAMIN B-COMPLEX WITH VIT C		
MULTIVITS,STRESS FORMULA	STRESS		
<b>B-Complex Vitamins</b>			
VITAMIN B COMPLEX	VITAMIN B COMPLEX		

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Generic Name	Common Name	Drug Status	Criteria
<b>Contact Lens Preparation - Soft Lens Products</b>			
SODIUM CHLORIDE	SALINE WOUND WASH		
<b>Dermatological - Antibacterial Mixtures</b>			
NEOMYCIN SULFATE/BACITRACIN ZINC/POLYMYXIN B	TRIPLE ANTIBIOTIC		
<b>Dermatological - Antibacterial Other</b>			
POVIDONE-IODINE	POVIDONE-IODINE		
<b>Dermatological - Antibacterial Polymyxins and Derivatives</b>			
BACITRACIN	BACITRACIN		
BACITRACIN ZINC	BACITRACIN ZINC		
<b>Dermatological - Antifungal Imidazole &amp; Related Agents</b>			
CLOTRIMAZOLE	DESENE		
MICONAZOLE NITRATE	ANTIFUNGAL CREAM		
<b>Dermatological - Antifungal Thiocarbamate</b>			
TOLNAFTATE	TINACTIN		
<b>Dermatological - Antifungals Other</b>			
UNDECYLENIC ACID	ANTI-FUNGAL		
<b>Dermatological - Antiviral</b>			
DOCOSANOL	ABREVA		
<b>Dermatological - Emollient Mixtures</b>			
MINERAL OIL/PETROLATUM,WHITE	MOISTURIN		
<b>Dermatological - Emollients</b>			
AMMONIUM LACTATE	LAC-HYDRIN		
<b>Dermatological - Glucocorticoid</b>			
HYDROCORTISONE	HYDROCORTISONE		
HYDROCORTISONE ACETATE	HYDROCORTISONE ACETATE		
<b>Dermatological - Glucocorticoid-Emollient Combinations</b>			
HYDROCORTISONE ACETATE/ALOE VERA	HYDROCORTISONE WITH ALOE		
HYDROCORTISONE/ALOE VERA	HYDROCORTISONE PLUS		
HYDROCORTISONE/COLLOIDAL OATMEAL/ALOE/VITAMIN E	AVEENO		
<b>Dermatological - Keratolytic-Antimitotic Combinations</b>			
SALICYLIC ACID/COLLODION, FLEXIBLE	WART REMOVER		
<b>Dermatological - Keratolytic-Antimitotic Single Agents</b>			
SALICYLIC ACID	WART REMOVER		
<b>Dermatological - Keratoplastic Tar Products</b>			
COAL TAR	DHS TAR		
<b>Dermatological Irritants-Counter-Irritant Single Agents</b>			
CAPSAICIN	CAPSAICIN		
<b>Expectorants - Single Agents, General</b>			
GUAIFENESIN	ORGANIDIN NR		
<b>Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists</b>			
CIMETIDINE	HEARTBURN RELIEF		

## 2013 Meridian Health Plan Medicaid OTC Formulary

Generic Name	Common Name	Drug Status	Criteria
<b>Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists</b>			
FAMOTIDINE	PEPCID		Only generic tablets are covered
RANITIDINE HCL	RANITIDINE HCL		
<b>Gastrointestinal Antiflatulents</b>			
SIMETHICONE	SIMETHICONE		
<b>Human Insulins - Fixed Combinations</b>			
NPH, HUMAN INSULIN ISOPHANE/ INSULIN REGULAR, HUMAN	HUMULIN 70-30		Only vials will be covered
<b>Human Insulins - Intermediate Acting</b>			
NPH, HUMAN INSULIN ISOPHANE	HUMULIN N		Only vials will be covered
<b>Human Insulins - Short Acting</b>			
INSULIN REGULAR, HUMAN	HUMULIN R		Only vials will be covered
<b>Laxative - Bulk Forming</b>			
CALCIUM POLYCARBOPHIL	FIBERCON		
PSYLLIUM HUSK (WITH SUGAR)	NATURAL VEGETABLE FIBER		
PSYLLIUM HUSK/ASPARTAME	WAL-MUCIL		
PSYLLIUM SEED	KONSYL		
PSYLLIUM SEED (WITH DEXTROSE)	KONSYL-D		
PSYLLIUM SEED (WITH SUGAR)	KONSYL		
PSYLLIUM SEED/ASPARTAME	KONSYL		
<b>Laxative - Saline and Osmotic</b>			
POLYETHYLENE GLYCOL 3350	CLEARLAX		
<b>Laxative - Stimulant</b>			
BISACODYL	GENTLE LAXATIVE		
<b>Laxative - Surfactant</b>			
DOCUSATE SODIUM	STOOL SOFTENER		
<b>Medical Supplies &amp; DME - Glucose Monitoring Test Supplies</b>			
LANCETS	UNILET GP LANCET		
LANCING DEVICE/LANCETS	GLUCOLET 2		
<b>Medical Supplies &amp; DME - Insulin Needles-Syringes &amp; Admin. Supplies</b>			
SYRING W-NDL,DISP,INSUL,0.3ML/ CONTAINER,EMPTY	ULTICARE		
SYRING W-NDL,DISP,INSUL,0.5ML/ CONTAINER,EMPTY	ULTICARE		
SYRING W-O NDL,DISP,INSUL, 1ML	LUER-LOK SYRINGE		
SYRINGE WITH NEEDLE, INSULIN,1 ML AND SHARPS CONTAINER	ULTICARE		
SYRINGE WITH NEEDLE,DISPOSABLE, INSULIN	ULTRA COMFORT		
SYRINGE WITH NEEDLE,DISPOSABLE, INSULIN 1 ML	MONOJECT INSULIN SYRINGE		
SYRINGE WITH NEEDLE,INSULIN DISPOSABLE,0.3 ML	MONOJECT INSULIN SYRINGE		
SYRINGE WITH NEEDLE,INSULIN DISPOSABLE,0.5 ML	MONOJECT INSULIN SYRINGE		
SYRINGE,NEEDLE,INSULIN,SAFETY, DISPOSAL UNIT, 1 ML	SAFESNAP INSULIN SYRINGE		

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Generic Name	Common Name	Drug Status	Criteria
<b>Medical Supplies &amp; DME - Insulin Needles-Syringes &amp; Admin. Supplies</b>			
SYRINGE,NEEDLE,INSULIN,SAFETY, DISPOSAL UNIT,0.3 ML	SAFESNAP INSULIN SYRINGE		
SYRINGE,NEEDLE,INSULIN,SAFETY, DISPOSAL UNIT,0.5 ML	SAFESNAP INSULIN SYRINGE		
<b>Medical Supplies &amp; DME - Male Condoms</b>			
CONDOMS, LATEX, LUBRICATED	CONDOMS		
CONDOMS, LATEX, NON-LUBRICATED	TRUSTEX-RIA		
<b>Minerals &amp; Electrolytes - Calcium Replacement</b>			
CALCIUM CARBONATE	CALCIUM CARBONATE		
<b>Minerals &amp; Electrolytes - Calcium Replacement Combinations</b>			
CALCIUM CARBONATE/ ERGOCALCIFEROL (VITAMIN D2)	OYSTER SHELL CALCIUM W- VIT D		
<b>Minerals &amp; Electrolytes - Calcium Replacement/Vitamin D Combinations</b>			
CALCIUM CARBONATE/ CHOLECALCIFEROL (VITAMIN D3)	CALCIUM 500 + VITAMIN D		
<b>Minerals &amp; Electrolytes - Iron</b>			
FERROUS GLUCONATE	FERGON		
FERROUS SULFATE	FERROUS SULFATE		
<b>Minerals &amp; Electrolytes - Magnesium</b>			
MAGNESIUM	MAGNESIUM		
MAGNESIUM OXIDE	MAGNESIUM OXIDE		
<b>Minerals &amp; Electrolytes - Oral Electrolytes</b>			
ELECTROLYTE,ORAL	PEDIALYTE		
<b>Minerals &amp; Electrolytes - Zinc</b>			
ZINC SULFATE	ZINC SULFATE		
<b>Multiple Vitamins and Mineral Combinations</b>			
FOLIC ACID/MULTIVITAMIN W- MINERALS	ONE DAILY WOMENS 50 PLUS		
FOLIC ACID/MULTIVITS W-FE,OTHER MIN	ONE DAILY MAXIMUM		
MULTIVITAMIN WITH MINERALS	ICAPS PLUS		
MULTIVITAMINS WITH IRON	DAILY VITE WITH IRON		
MULTIVITS W-CA,FE,OTHER MIN	TAB A VITE		
MULTIVITS,CA,IRON,MINERALS/FOLIC ACID/PHYTOSTEROL	CENTRUM CARDIO		
<b>Multivitamins</b>			
MULTIVITAMIN	MULTIPLE VITAMINS		
MULTIVITAMIN/FERROUS FUMARATE/ FOLIC ACID	CENTRUM COMPLETE		
MULTIVITAMINS,THERAPEUTIC	THERADEX		
<b>Narcotic Antitussive-Expectorant Combinations</b>			
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE		
<b>Nasal Mast Cell Stabilizers</b>			
CROMOLYN SODIUM	NASAL ALLERGY SPRAY		



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Generic Name	Common Name	Drug Status	Criteria
<b>Non-Narcotic Antitussive-Decongestant-Expectorant Combinations</b>			
GUAIFENESIN/ DEXTROMETHORPHAN HBR/ PSEUDOEPHEDRINE	TUSSIN CF		
<b>Non-Narcotic Antitussive-Expectorant Combinations</b>			
GUAIFENESIN/ DEXTROMETHORPHAN HBR	ULTRA DM FREE & CLEAR		
<b>NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives</b>			
IBUPROFEN	MOTRIN IB	QL	Maximum limit of 3200 mg of Ibuprofen per day
NAPROXEN SODIUM	ALL DAY PAIN RELIEF		
<b>Ophthalmic - Antihistamine-Decongestant Combinations</b>			
NAPHAZOLINE HCL/PHENIRAMINE MALEATE	NAPHCON-A		
<b>Pediatric Vitamins</b>			
MULTIVITAMIN	FRUITY CHEWS		
PEDIATRIC MULTIVITAMINS A,C,& D3 NO.21	TRI-VI-SOL		Limited to ages 10 and under
<b>Pediatric Vitamins and Mineral Combinations</b>			
FOLIC ACID/MULTIVITS W-FE,OTHER MIN	CENTRUM KIDS		
MULTIVITAMIN WITH IRON AND OTHER MINERALS	CEROVITE JR		
MULTIVITAMINS WITH IRON	MULTIVITAMINS WITH IRON		
<b>Prenatal Vitamins and Minerals</b>			
PRENATAL VITAMINS COMB NO.21/ IRON/FOLIC ACID	PRENATAL COMPLETE	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS COMB NO.59/ FERROUS SULFATE/FOLIC ACID/DHA	PRENATAL PLUS DHA	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITAMINS/FERROUS FUMARATE/FOLIC ACID	PRENATAL S	QL	Limited to 1 tablet per day, Restricted to females only
PRENATAL VITS W-CA,FE,FA(<1MG)	P-D NATAL PLUS	QL	Limited to 1 tablet per day, Restricted to females only
<b>Salicylate Analgesics</b>			
ASPIRIN	ASPIRIN		
<b>Salicylate Analgesics, Buffered</b>			
ASPIRIN/CALCIUM CARBONATE/ MAGNESIUM	BUFFERIN		
<b>Scabicide &amp; Pediculicide Combinations</b>			
PIPERONYL BUTOXIDE/PYRETHRINS	LICE KILLING		
<b>Scabicide &amp; Pediculicide Single Agents</b>			
PERMETHRIN	PERMETHRIN		
<b>Sedative-Hypnotic - Antihistamines</b>			
DIPHENHYDRAMINE HCL	SLEEP AID		

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Generic Name	Common Name	Drug Status	Criteria
<b>Smoking Deterrents - Nicotine-Type</b>			
NICOTINE	NICOTINE PATCH	QL	Patches are limited to 1 patch per day. Gum is limited to 336 pieces per month. Lozenges are limited to 360 per month. All are limited to 6 months therapy per 365 days. Inhaler is not covered
NICOTINE POLACRILEX	THRIVE NICOTINE	QL	Patches are limited to 1 patch per day. Gum is limited to 336 pieces per month. Lozenges are limited to 360 per month. All are limited to 6 months therapy per 365 days. Inhaler is not covered
<b>Spermicides</b>			
NONOXYNOL 9	VCF		
<b>Systemic Sympathomimetic Decongestants</b>			
PSEUDOEPHEDRINE HCL	SUDAFED	QL	Limited to 8 tablets per day
<b>Vaginal Antifungal - Imidazoles</b>			
CLOTRIMAZOLE	GYNE-LOTRIMIN		
MICONAZOLE NITRATE	MONISTAT 7		
<b>Vitamins - A</b>			
VITAMIN A	VITAMIN A		
<b>Vitamins - B-1, Thiamine and Derivatives</b>			
THIAMINE HCL	VITAMIN B-1		
<b>Vitamins - B-12, Cyanocobalamin and derivatives</b>			
CYANOCOBALAMIN/COBAMAMIDE	B-12		
<b>Vitamins - B-3, Niacin and Derivatives</b>			
NIACIN	NIACIN		
<b>Vitamins - B-6, Pyridoxine and Derivatives</b>			
PYRIDOXINE HCL	VITAMIN B-6		
<b>Vitamins - Folic Acid and Derivatives</b>			
FOLIC ACID	FOLIC ACID		