

ICHP

Inter-County
Hospitalization Plan, Inc.
Health Plan, Inc.

PRESCRIPTION DRUG PROGRAM FORMULARY
EFFECTIVE APRIL 1, 2012

www.myichp.com

Dear Plan Member:

In an effort to continue our commitment to provide you with comprehensive prescription drug coverage, a formulary feature is included in your prescription drug benefit. A formulary is a list of selected drugs that are approved by the U.S. Food and Drug Administration (FDA) and reviewed by our Pharmacy and Therapeutics Committee. These prescription drugs have been selected for their reported medical effectiveness, safety, and value while providing you with the highest level of coverage under your prescription drug benefits.

Our pharmacy benefits manager, FutureScripts®, continuously monitors the effectiveness and safety of drugs and drug prescribing patterns. Several procedures support safe prescribing patterns for our prescription drug programs, such as:

- prior authorization;
- age and gender limits;
- quantity limits;
- 96-Hour Temporary Supply Program.

These procedures are designed to optimize your prescription drug benefits by promoting appropriate utilization. They are based on FDA guidelines, and the criteria are endorsed by our Pharmacy and Therapeutics Committee.

A detailed description of the procedures that support safe prescribing is included at the end of the formulary list.

Please note: Because prescription drug benefits vary by group, the inclusion of a drug in this formulary does not imply coverage. This formulary was current at the time of printing and is subject to change. Please call 1-888-678-7013 if you have any questions about your prescription drug benefits. Please discuss any questions or concerns about your drug therapy with your physician or pharmacist. Prescription Drug Program Formulary information can also be obtained on our website at www.myichp.com.

Brand drugs with a “3” in the immediate column to the right are available at the highest level of cost-sharing. It is displayed next to the equivalent formulary generic drug, that is available at the lowest level of cost-sharing. For example: amoxicillin is the formulary generic drug available at the lowest level of copay. Amoxil is the non-formulary brand available at the highest level of cost-sharing. In most cases when brand drugs have a generic equivalent, the generic version is formulary and the brand version is non-formulary.

- Covered generic drugs not listed are formulary and are available at the lowest level of cost-sharing.
- Covered brand drugs not listed are non-formulary and are available at the highest level of cost-sharing.

Dear Physician:

This is a listing of formulary drugs to be considered for your patient, a Prescription Drug Program Formulary participant. Please refer to this formulary guide in order to choose a drug. Because prescription drug benefits vary by group, the inclusion of a drug in this formulary does not imply coverage.

This formulary was current at the time of printing and is subject to change. Please understand that this formulary is not intended as a substitute for your independent, professional judgment. Rather, it is offered as a tool to help plan members recognize formulary drugs. We hope that you will refer to the formulary as a guide to prescribing formulary drugs.

1. ANTIBIOTICS & OTHER DRUGS USED FOR INFECTION

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Adoxa	3	<i>doxycycline monohydrate</i>	1	Yes	
Agenerase	2				
Amoxil	3	<i>amoxicillin</i>	1	Yes	
Ancobon	3	<i>flucytosine</i>	1	Yes	
Aralen	3	<i>chloroquine phosphate</i>	1	Yes	
Atripla	2				
Augmentin	3	<i>amoxicillin/clavulanate</i>	1	Yes	
Augmentin XR	3	<i>amoxicillin/clavulanate extended-release</i>	1	Yes	
Bactrim, Bactrim DS, Septra DS	3	<i>sulfamethoxazole/tmp</i>	1	Yes	
Biaxin	3	<i>clarithromycin</i>	1	Yes	
Biaxin XL	3	<i>clarithromycin SR</i>	1	Yes	
Ceclor	3	<i>cefaclor</i>	1	Yes	
Ceftin	3	<i>cefuroxime axetil</i>	1	Yes	
Cellcept	3	<i>mycophenolate</i>	1	Yes	
Cipro	3	<i>ciprofloxacin tabs</i>	1	Yes	
Cipro oral suspension	2				
Cipro XR	3	<i>ciprofloxacin ER tabs</i>	1	Yes	
Cleocin	3	<i>clindamycin</i>	1	Yes	
Combivir	3	<i>lamivudine/zidovudine</i>	1	Yes	
Complera	2				
Crixivan	2				
Cytovene	3	<i>ganciclovir</i>	1	Yes	
Dapsone	2				
Daraprim	2				
Declomycin	3	<i>demeclocycline</i>	1	Yes	
Diflucan	3	<i>fluconazole</i>	1	Yes	
Doryx	3	<i>doxycycline</i>	1	Yes	
Duricef	3	<i>cefadroxil</i>	1	Yes	
EES, EryPed	3	<i>erythromycin ethylsuccinate</i>	1	Yes	
Edurant	2				
Emtriva	2				
Epivir	3	<i>lamivudine</i>	1	Yes	
Epzicom	2				
Eryc, Ery-Tab	3	<i>erythromycin delayed release</i>	1	Yes	
Erythrocin	3	<i>erythromycin stearate</i>	1	Yes	
Famvir	3	<i>famciclovir</i>	1	Yes	
Fansidar	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

1. ANTIBIOTICS & OTHER DRUGS USED FOR INFECTION

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Flagyl	3	<i>metronidazole</i>	1	Yes	
Floxin	3	<i>ofloxacin</i>	1	Yes	
Flumadine	3	<i>rimantadine</i>	1	Yes	
Fortovase	2				
Fuzeon	2				
Grifulvin V susp	3	<i>griseofulvin microsize susp</i>	1	Yes	
Grifulvin V tabs	2				
Gris-PEG	2				
Hepsera	2				
Hiprex, Urex	3	<i>methenamine hippurate</i>	1	Yes	
HIVID	2				
Isentress	2				
Incivek	2				PA
Keflex	3	<i>cephalexin</i>	1	Yes	
Lamisil tabs	3	<i>terbinafine tabs</i>	1	Yes	
Lariam	3	<i>mefloquine</i>	1	Yes	
Levaquin	3	<i>levofloxacin</i>	1	Yes	
Lexiva	2				
Macrochantin	3	<i>nitrofurantoin macrocrystals</i>	1	Yes	
Malarone	3	<i>atovaquone/proguanil</i>	1	Yes	
Mepron	2				
Minocin, Dynacin	3	<i>minocycline caps</i>	1	Yes	
Monodox	3	<i>doxycycline monohydrate</i>	1	Yes	
Myambutol	3	<i>ethambutol</i>	1	Yes	
Mycelex	3	<i>clotrimazole troches</i>	1	Yes	
Mycobutin	2				
Mycostatin	3	<i>nystatin</i>	1	Yes	
Nizoral tabs	3	<i>ketoconazole tabs</i>	1	Yes	
Norvir	2				
Omnicef	3	<i>cefdinir</i>	1	Yes	
Oracea	2				
Pediazole	3	<i>erythromycin susp w/sulfa</i>	1	Yes	
Plaquenil	3	<i>hydroxychloroquine</i>	1	Yes	
Prezista	2				
Principen	3	<i>ampicillin</i>	1	Yes	
Pyridium	3	<i>phenazopyridine</i>	1	Yes	
Rebetol	3	<i>ribavirin</i>	1	Yes	PA
Rescriptor	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

1. ANTIBIOTICS & OTHER DRUGS USED FOR INFECTION

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Retrovir	3	<i>zidovudine</i>	1	Yes	
Reyataz	2				
Rifadin	3	<i>rifampin</i>	1	Yes	
Selzentry	2				
Spectracef	3	<i>cefditoren</i>	1	Yes	
Sporanox	3	<i>itraconazole</i>	1	Yes	
Sumycin	3	<i>tetracycline</i>	1	Yes	
Sustiva	2				
Symmetrel	3	<i>amantadine</i>	1	Yes	
Tamiflu	2				QL
Tindamax	3	<i>tinidazole</i>	1	Yes	
Tobi	2				
Trizivir	2				
Truvada	2				
Valcyte	2				
Valtrex	3	<i>valacyclovir tab</i>	1	Yes	
Veetids	3	<i>penicillin VK</i>	1	Yes	
Vermox	3	<i>mebendazole</i>	1	Yes	
Vfend	3	<i>voriconazole</i>	1	Yes	
Vibramycin, Periostat	3	<i>doxycycline hyclate</i>	1	Yes	
Vitreolis	2				PA
Videx	2				
Videx EC	3	<i>didanosine</i>	1	Yes	
Viracept	2				
Viramune	2				
Viramune XR	2				
Viread	2				
Xifaxan	2				
Zerit	3	<i>stavudine</i>	1	Yes	
Ziagen	2				
Zithromax	3	<i>azithromycin</i>	1	Yes	
Zovirax	3	<i>acyclovir</i>	1	Yes	
		<i>cefaclor ER</i>	1	Yes	
		<i>dicloxacillin</i>	1	Yes	
		<i>isoniazid</i>	1	Yes	
		<i>minocycline tabs</i>	1	Yes	
		<i>primaquine phosphate</i>	1	Yes	
		<i>pyrazinamide</i>	1	Yes	
		<i>sulfisoxazole tabs</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

2. CANCER & ORGAN TRANSPLANT DRUGS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Alkeran	2				
Arimidex	3	<i>anastrozole</i>	1	Yes	
Aromasin	3	<i>exemestane</i>	1	Yes	
Casodex	3	<i>bicalutamide</i>	1	Yes	
CeeNU	2				
Cellcept	3	<i>mycophenolate</i>	1	Yes	
Cytosan	3	<i>cyclophosphamide</i>	1	Yes	
Danocrine	3	<i>danazol</i>	1	Yes	
Deltasone	3	<i>prednisone</i>	1	Yes	
Emcyt	2				
Eulexin	3	<i>flutamide</i>	1	Yes	
Fareston	2				
Femara	3	<i>letrozole</i>	1	Yes	
Gleevec	2				PA
Hexalen	2				
Hydrea	3	<i>hydroxyurea</i>	1	Yes	
Imuran	3	<i>azathioprine</i>	1	Yes	
Leukeran	2				
Lysodren	2				
Matulane	2				
Megace	3	<i>megestrol</i>	1	Yes	
Myleran	2				
Nolvadex	3	<i>tamoxifen</i>	1	Yes	
Prograf	3	<i>tacrolimus</i>	1	Yes	
Purinethol	3	<i>mercaptopurine</i>	1	Yes	
Rapamune	2				
Rheumatrex, Trexall	3	<i>methotrexate</i>	1	Yes	
Sandimmune, Neoral	3	<i>cyclosporine</i>	1	Yes	
Tabloid	3	<i>thioguanine</i>	1	Yes	
Targretin	2				
Temodar	2				
VePesid	3	<i>etoposide</i>	1	Yes	
Xeloda	2				
		<i>leucovorin calcium</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

3. PAIN, NERVOUS SYSTEM, & PSYCH

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Abilify	2				
Abilify Discmelt	2				
Actiq	3	<i>fentanyl citrate OTFC</i>	1	Yes	QL, PA
Adderall	3	<i>amphetamine aspartate/ amphetamine sulfate/ dextroamphetamine</i>	1	Yes	QL
Adderall XR	3	<i>amphetamine aspartate/ amphetamine sulfate/ dextroamphetamine ER</i>	1	Yes	QL
Alsuma	3	<i>sumatriptan succinate</i>	1	Yes	
Ambien	3	<i>zolpidem tartrate</i>	1	Yes	QL
Ambien CR	3	<i>zolpidem tartrate controlled release</i>	1	Yes	PA
Amerge	3	<i>naratriptan</i>	1	Yes	QL, PA
Amrix	3	<i>cyclobenzaprine</i>	1	Yes	
Anafranil	3	<i>clomipramine HCl</i>	1	Yes	
Anaprox DS	3	<i>naproxen sodium</i>	1	Yes	
Ansaid	3	<i>flurbiprofen</i>	1	Yes	
Aricept	3	<i>donepezil hydrochloride</i>	1	Yes	
Ativan	3	<i>lorazepam</i>	1	Yes	
Avinza	2				QL
Azilect	2				
BuSpar	3	<i>buspirone</i>	1	Yes	
Cafergot	3	<i>ergotamine tartrate/caffeine</i>	1	Yes	
Cafergot	3	<i>migergot</i>	1	Yes	
Cataflam	3	<i>diclofenac potassium</i>	1	Yes	
Celexa	3	<i>citalopram</i>	1	Yes	
Celontin	2				
Clinoril	3	<i>sulindac</i>	1	Yes	
Clozaril	3	<i>clozapine</i>	1	Yes	
Combunox	3	<i>ibuprofen/oxycodone HCl</i>	1	Yes	
Concerta	3	<i>methylphenidate</i>	1	Yes	QL
Cymbalta	2				
Darvocet-N	3	<i>propoxyphene napsylate/apap</i>	1	Yes	QL
Daypro	3	<i>oxaprozin</i>	1	Yes	
Demerol	3	<i>meperidine HCl</i>	1	Yes	QL
Depakene	3	<i>valproic acid</i>	1	Yes	
Depakote	3	<i>divalproex sodium</i>	1	Yes	
Depakote ER	3	<i>divalproex sodium ER</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

3. PAIN, NERVOUS SYSTEM, & PSYCH

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Depakote Sprinkle Caps	3	<i>divalproex sprinkle cap</i>	1	Yes	
Desoxyn	3	<i>methamphetamine</i>	1	Yes	QL
Desyrel	3	<i>trazodone</i>	1	Yes	
Diastat	3	<i>diazepam rectal gel</i>	1	Yes	
Diastat AcuDial	3	<i>diazepam rectal gel</i>	1	Yes	
Dilaudid	3	<i>hydromorphone HCl</i>	1	Yes	QL
Dolobid	3	<i>diflunisal</i>	1	Yes	
Dolophine	3	<i>methadone</i>	1	Yes	
Duragesic	3	<i>fentanyl transdermal</i>	1	Yes	QL
Effexor	3	<i>venlafaxine</i>	1	Yes	
Effexor XR	3	<i>venlafaxine ER</i>	1	Yes	
Eldepryl	3	<i>selegiline HCl</i>	1	Yes	
Eskalith	3	<i>lithium carbonate</i>	1	Yes	
Eskalith CR, Lithobid	3	<i>lithium carbonate SR</i>	1	Yes	
Exelon	3	<i>rivastigmine</i>	1	Yes	
Felbatol	3	<i>felbamate</i>	1	Yes	
Feldene	3	<i>piroxicam</i>	1	Yes	
Fexmid	3	<i>cyclobenzaprine</i>	1	Yes	
Fioricet	3	<i>butalbital/apap/caffeine</i>	1	Yes	QL
Fiorinal	3	<i>butalbital/aspirin/caffeine</i>	1	Yes	
Focalin	3	<i>dexmethylphenidate</i>	1	Yes	QL
Geodon	2				
Imitrex	3	<i>sumatriptan</i>	1	Yes	QL, PA
Indocin SR	3	<i>indomethacin</i>	1	Yes	
Kadian	3	<i>morphine extended release</i>	1	Yes	QL
Keppra	3	<i>levetiracetam</i>	1	Yes	
Keppra XR	3	<i>levetiracetam</i>	1	Yes	
Klonopin	3	<i>clonazepam</i>	1	Yes	
Lamictal	3	<i>lamotrigine</i>	1	Yes	
Lexapro	2				
Lodine XL	3	<i>etodolac</i>	1	Yes	
Lortab	3	<i>hydrocodone/acetaminophen elixir</i>	1	Yes	QL
Loxitane	3	<i>loxapine</i>	1	Yes	
Lunesta	2				
Maxalt, Maxalt-MLT	2				QL, PA
Mestinon	3	<i>pyridostigmine</i>	1	Yes	
Midrin	3	<i>isometheptene/ dichloralphenazone/apap</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

3. PAIN, NERVOUS SYSTEM, & PSYCH

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Mirapex	3	<i>pramipexole</i>	1	Yes	
Mirapex ER	2				
MS Contin	3	<i>morphine sulfate, extended release</i>	1	Yes	QL
MSIR	3	<i>morphine sulfate</i>	1	Yes	QL
Mysoline	3	<i>primidone</i>	1	Yes	
Nalfon	3	<i>fenoprofen calcium</i>	1	Yes	
Namenda	2				
Naprelan	3	<i>naproxen sodium SA</i>	1	Yes	
Naprosyn	3	<i>naproxen</i>	1	Yes	
Nardil	3	<i>phenelzine</i>	1	Yes	
Navane	3	<i>thiothixene</i>	1	Yes	
Neurontin	3	<i>gabapentin</i>	1	Yes	
Neurontin solution	3	<i>gabapentin solution</i>	1	Yes	
Norpramin	3	<i>desipramine</i>	1	Yes	
Opana	3	<i>oxymorphone</i>	1	Yes	QL
Oruvail, Orudis	3	<i>ketoprofen</i>	1	Yes	
OxyContin	2				QL
OxyIR	3	<i>oxycodone</i>	1	Yes	QL
Pamelor	3	<i>nortriptyline</i>	1	Yes	
Parcopa	3	<i>carbidopa/levodopa ODT</i>	1	Yes	
Parlodel	3	<i>bromocriptine mesylate</i>	1	Yes	
Parnate	3	<i>tranycypromine sulfate</i>	1	Yes	
Paxil	3	<i>paroxetine</i>	1	Yes	
Paxil CR	3	<i>paroxetine HCl ext-release</i>	1	Yes	
Percodan	3	<i>oxycodone/aspirin</i>	1	Yes	QL
Phenytek	3	<i>phenytoin sodium</i>	1	Yes	
Prodrin	3	<i>isometheptene/APAP/caffeine</i>	1	Yes	
Prostigmin	2				
Prozac	3	<i>fluoxetine</i>	1	Yes	
Razadyne	3	<i>galantamine</i>	1	Yes	
Razadyne ER	3	<i>galantamine ER</i>	1	Yes	
Relafen	3	<i>nabumetone</i>	1	Yes	
Remeron	3	<i>mirtazapine</i>	1	Yes	
Remeron SolTab	3	<i>mirtazapine rapid dissolve tabs</i>	1	Yes	
Requip	3	<i>ropinirole</i>	1	Yes	
Restoril	3	<i>temazepam</i>	1	Yes	QL
Risperdal, Risperdal M-Tab	3	<i>risperidone</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

3. PAIN, NERVOUS SYSTEM, & PSYCH

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Ritalin LA	3	<i>methylphenidate ER</i>	1	Yes	QL
Ritalin SR	3	<i>methylphenidate SR</i>	1	Yes	QL
RMS	3	<i>morphine sulfate supp</i>	1	Yes	
Roxicet, Percocet, Tylox	3	<i>oxycodone/apap</i>	1	Yes	QL
Ryzolt	3	<i>tramadol ER</i>	1	Yes	
Serax	3	<i>oxazepam</i>	1	Yes	
Seroquel	2				
Seroquel XR	2				
Sinemet	3	<i>carbidopa/levodopa</i>	1	Yes	
Sinemet CR	3	<i>carbidopa/levodopa CR</i>	1	Yes	
Sinequan	3	<i>doxepin</i>	1	Yes	
Sonata	3	<i>zaleplon</i>	1	Yes	QL
Strattera	2				QL
Surmontil	3	<i>trimipramine</i>	1	Yes	
Symmetrel	3	<i>amantadine</i>	1	Yes	
Tegretol	3	<i>carbamazepine</i>	1	Yes	
Tegretol XR	3	<i>carbamazepine XR</i>	1	Yes	
Tofranil	3	<i>imipramine</i>	1	Yes	
Topamax	3	<i>topiramate</i>	1	Yes	
Topamax Sprinkle Capsules	3	<i>topiramate sprinkle cap</i>	1	Yes	
Toradol oral	3	<i>ketorolac</i>	1	Yes	
Treximet	2				QL, PA
Trileptal	3	<i>oxcarbazepine</i>	1	Yes	
Ultram	3	<i>tramadol</i>	1	Yes	
Ultram ER	3	<i>tramadol ER</i>	1	Yes	PA(brand only)
Valium	3	<i>diazepam</i>	1	Yes	
Vicodin ES	3	<i>hydrocodone/acetaminophen ES</i>	1	Yes	QL
Vicodin, Norco, Maxidone	3	<i>hydrocodone/acetaminophen</i>	1	Yes	QL
Vicoprofen	3	<i>hydrocodone/ibuprofen</i>	1	Yes	QL
Voltaren XR	3	<i>diclofenac sodium</i>	1	Yes	
Wellbutrin	3	<i>bupropion</i>	1	Yes	
Wellbutrin SR	3	<i>bupropion SR</i>	1	Yes	
Wellbutrin XR	3	<i>bupropion XR</i>	1	Yes	
Xanax	3	<i>alprazolam</i>	1	Yes	
Zarontin	3	<i>ethosuximide</i>	1	Yes	
Zoloft	3	<i>sertraline</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

3. PAIN, NERVOUS SYSTEM, & PSYCH

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Zyprexa	3	<i>olanzapine</i>	1	Yes	
Zyprexa Zydys	3	<i>olanzapine ODT</i>	1	Yes	
		<i>acetaminophen/butalbital</i>	1	Yes	
		<i>acetaminophen/codeine</i>	1	Yes	QL
		<i>acetazolamide</i>	1	Yes	
		<i>amitriptyline</i>	1	Yes	
		<i>amoxapine</i>	1	Yes	
		<i>aspirin with codeine</i>	1	Yes	QL
		<i>benztropine</i>	1	Yes	
		<i>chlorpromazine HCl</i>	1	Yes	
		<i>choline magnesium trisalicylate</i>	1	Yes	
		<i>codeine tabs</i>	1	Yes	QL
		<i>fluphenazine</i>	1	Yes	
		<i>fluvoxamine</i>	1	Yes	
		<i>haloperidol</i>	1	Yes	
		<i>maprotiline</i>	1	Yes	
		<i>meclofenamate</i>	1	Yes	
		<i>nefazodone</i>	1	Yes	
		<i>perphenazine</i>	1	Yes	
		<i>phenobarbital</i>	1	Yes	
		<i>phenytoin</i>	1	Yes	
		<i>propoxyphene HCl/apap</i>	1	Yes	QL
		<i>salsalate</i>	1	Yes	
		<i>thioridazine</i>	1	Yes	
		<i>tolmetin sodium</i>	1	Yes	
		<i>trifluoperazine</i>	1	Yes	
		<i>trihexyphenidyl</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

4. HEART, BLOOD PRESSURE, & CHOLESTEROL

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Accupril	3	<i>quinapril HCl</i>	1	Yes	
Accuretic	3	<i>quinapril/HCTZ</i>	1	Yes	
Aceon	3	<i>perindopril</i>	1	Yes	
Adalat CC, Procardia XL	3	<i>nifedipine ER</i>	1	Yes	
Agrylin	3	<i>anagrelide</i>	1	Yes	
Aldactazide	3	<i>spironolactone/HCTZ</i>	1	Yes	
Aldactone	3	<i>spironolactone</i>	1	Yes	
Altace	3	<i>ramipril</i>	1	Yes	
Amicar	3	<i>aminocaproic acid</i>	1	Yes	
Azor	2				
Benicar	2				
Benicar HCT	2				
Betapace AF	3	<i>sotalol HCl</i>	1	Yes	
Blocadren	3	<i>timolol</i>	1	Yes	
Bumex	3	<i>bumetanide</i>	1	Yes	
Bystolic	2				
Caduet	3	<i>atorvastatin/amlodipine</i>	1	Yes	
Calan, Verelan	3	<i>verapamil HCl</i>	1	Yes	
Capoten	3	<i>captopril</i>	1	Yes	
Capozide	3	<i>captopril/HCTZ</i>	1	Yes	
Cardizem	3	<i>diltiazem</i>	1	Yes	
Cardizem CD, Dilacor XR	3	<i>diltiazem extended release</i>	1	Yes	
Cardizem LA	3	<i>diltiazem HCL</i>	1	Yes	
Cardizem SR	3	<i>diltiazem SR</i>	1	Yes	
Cardura	3	<i>doxazosin mesylate</i>	1	Yes	
Catapres tablets	3	<i>clonidine</i>	1	Yes	
Catapres-TTS	3	<i>clonidine patch</i>	1	Yes	
Colestid	3	<i>colestipol HCl</i>	1	Yes	
Cordarone	3	<i>amiodarone HCl</i>	1	Yes	
Coreg	3	<i>carvedilol</i>	1	Yes	
Corgard	3	<i>nadolol</i>	1	Yes	
Corzide	3	<i>nadolol-bendroflume thiazide</i>	1	Yes	
Coumadin	3	<i>warfarin</i>	1	Yes	
Cozaar	3	<i>losartan</i>	1	Yes	PA (Brand only)
Crestor	2				
Demadex	3	<i>toremide</i>	1	Yes	
Dilatrate-SR	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

4. HEART, BLOOD PRESSURE, & CHOLESTEROL

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Diovan	2				
Diovan HCT	2				
Dyazide, Maxzide	3	<i>triamterene/HCTZ</i>	1	Yes	
DynaCirc	3	<i>isradipine</i>	1	Yes	
Edecrin	2				
Fibricor	3	<i>fenofibric acid</i>	1	Yes	
Hytrin	3	<i>terazosin</i>	1	Yes	
Hyzaar	3	<i>losartan-HCTZ</i>	1	Yes	PA (Brand only)
Imdur	3	<i>isosorbide mononitrate ER</i>	1	Yes	
Inderal, Inderal LA	3	<i>propranolol</i>	1	Yes	
Inderide	3	<i>propranolol/HCTZ</i>	1	Yes	
Inspra	3	<i>eplerenone</i>	1	Yes	
Ismo	3	<i>isosorbide mononitrate</i>	1	Yes	
Isordil tabs	3	<i>isosorbide dinitrate</i>	1	Yes	
Kerlone	3	<i>betaxolol</i>	1	Yes	
Lanoxin	2	<i>digoxin</i>	1	Yes	
Lasix	3	<i>furosemide</i>	1	Yes	
Lipitor	1				
Lofibra	3	<i>fenofibrate</i>	1	Yes	
Loniten	3	<i>minoxidil</i>	1	Yes	
Lopid	3	<i>gemfibrozil</i>	1	Yes	
Lopressor	3	<i>metoprolol tartrate</i>	1	Yes	
Lotensin	3	<i>benazepril</i>	1	Yes	
Lotensin HCT	3	<i>benazepril/HCTZ</i>	1	Yes	
Lotrel	3	<i>amlodipine/benazepril</i>	1	Yes	
Lovaza	2				
Lozol	3	<i>indapamide</i>	1	Yes	
Mavik	3	<i>trandolapril</i>	1	Yes	
Mephyton	2				
Mevacor	3	<i>lovastatin</i>	1	Yes	
Mexitil	3	<i>mexiletine HCl</i>	1	Yes	
Microzide	3	<i>hydrochlorothiazide</i>	1	Yes	
Midamor	3	<i>amiloride</i>	1	Yes	
Minipress	3	<i>prazosin</i>	1	Yes	
Moduretic	3	<i>amiloride/HCTZ</i>	1	Yes	
Monopril	3	<i>fosinopril</i>	1	Yes	
Multaq	2				
Niaspan	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

4. HEART, BLOOD PRESSURE, & CHOLESTEROL

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Nimotop	2				
Nitro-Bid	2				
Nitro-Dur	3	<i>nitroglycerin patches</i>	1	Yes	
Nitrostat SL	3	<i>nitroglycerin SL</i>	1	Yes	
Norpace	3	<i>disopyramide</i>	1	Yes	
Norpace CR	3	<i>disopyramide CR 150mg</i>	1	Yes	
Norvasc	3	<i>amlodipine</i>	1	Yes	
Persantine	3	<i>dipyridamole</i>	1	Yes	
Plendil	3	<i>felodipine ER</i>	1	Yes	
Pletal	3	<i>cilostazol</i>	1	Yes	
Pravachol	3	<i>pravastatin</i>	1	Yes	
Prinivil	3	<i>lisinopril</i>	1	Yes	
Prinzide	3	<i>lisinopril/HCTZ</i>	1	Yes	
Pronestyl	3	<i>procainamide</i>	1	Yes	
Questran Light	3	<i>cholestyramine</i>	1	Yes	
Rythmol	3	<i>propafenone</i>	1	Yes	
Rythmol SR	3	<i>propafenone SR</i>	1	Yes	
Sectral	3	<i>acebutolol</i>	1	Yes	
Sular	3	<i>nisoldipine</i>	1	Yes	
Tambocor	3	<i>flecainide</i>	1	Yes	
Tarka	3	<i>trandolapril-verapamil extended-release</i>	1	Yes	
Tenex	3	<i>guanfacine</i>	1	Yes	
Tenoretic	3	<i>atenolol/chlorthalidone</i>	1	Yes	
Tenormin	3	<i>atenolol</i>	1	Yes	
Teveten	3	<i>eprosartan</i>	1	Yes	
Tiazac	3	<i>diltiazem ER 24 hour</i>	1	Yes	
Ticlid	3	<i>ticlopidine HCl</i>	1	Yes	
Toprol XL	3	<i>metoprolol succinate</i>	1	Yes	
Trandate	3	<i>labetalol HCl</i>	1	Yes	
Trental	3	<i>pentoxifylline</i>	1	Yes	
Tribenzor	2				
Tricor	2				
Trilipix	2				
Uniretic	3	<i>moexipril/HCTZ</i>	1	Yes	
Valturna	3				
Vaseretic	3	<i>enalapril/HCTZ</i>	1	Yes	
Vasotec	3	<i>enalapril</i>	1	Yes	
Visken	3	<i>pindolol</i>	1	Yes	
Zaroxolyn	3	<i>metolazone</i>	1	Yes	
Zetia	2				
Ziac	3	<i>bisoprolol/HCTZ</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

4. HEART, BLOOD PRESSURE, & CHOLESTEROL

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Zocor	3	<i>simvastatin</i>	1	Yes	
		<i>chlorothiazide</i>	1	Yes	
		<i>chlorthalidone</i>	1	Yes	
		<i>guanfacine HCl</i>	1	Yes	
		<i>hydralazine</i>	1	Yes	
		<i>isosorbide dinitrate ER</i>	1	Yes	
		<i>methyldopa</i>	1	Yes	
		<i>nitroglycerin ER</i>	1	Yes	

5. SKIN MEDICATIONS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Accutane	3	<i>isotretinoin</i>	1	Yes	
Aclovate	3	<i>alclometasone dipropionate cream</i>	1	Yes	
Aldara	3	<i>imiquimod cream</i>	1	Yes	
Bactroban ointment	3	<i>mupirocin ointment</i>	1	Yes	
Bactroban cream	2				
BenzaClin	3	<i>clindamycin-benzoyl peroxide gel</i>	1	Yes	
Benzamycin gel	3	<i>benzoyl peroxide/erythromycin</i>	1	Yes	
Beta-Val	3	<i>betamethasone valerate</i>	1	Yes	
Biafine	3	<i>prulect topical emulsion</i>	1	Yes	
Brevoxyl gel	3	<i>benzoyl peroxide gel</i>	1	Yes	
Carmol scalp lotion	3	<i>sulfacetamide sodium/urea lotion</i>	1	Yes	
Cleocin T	3	<i>clindamycin</i>	1	Yes	
Clobex lotion, shampoo, spray	2				
Condylox	3	<i>podofilox soln</i>	1	Yes	
Cutivate	3	<i>fluticasone propionate</i>	1	Yes	
Cyclocort	3	<i>amcinonide</i>	1	Yes	
Dermatop	3	<i>prednicarbate ointment</i>	1	Yes	
Differin	3	<i>adapalene gel</i>	1	Yes	
Diprolene, Diprolene AF	3	<i>betamethasone dipropionate augmented</i>	1	Yes	
Diprosone	3	<i>betamethasone dipropionate</i>	1	Yes	
Dovonex Soln	3	<i>calcipotriene soln</i>	1	Yes	
Efudex	3	<i>fluorouracil solution</i>	1	Yes	
Efudex cream	2				
Elimite	3	<i>permethrin</i>	1	Yes	
Elocon	3	<i>mometasone cream</i>	1	Yes	
Emla cream	3	<i>prilocaine/lidocaine</i>	1	Yes	
Epiduo	2				
Erycette	3	<i>erythromycin swabs</i>	1	Yes	
Erygel, Emgel	3	<i>erythromycin gel</i>	1	Yes	
Evoclin	3	<i>clindamycin phosphate</i>	1	Yes	
Fluoroplex	2				
Hytone	3	<i>hydrocortisone 2.5%</i>	1	Yes	
Kenalog	3	<i>triamcinolone</i>	1	Yes	
Keralac cream	3	<i>urea cream</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

5. SKIN MEDICATIONS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Klaron	3	<i>sodium sulfacetamide lotion</i>	1	Yes	
Lidex, Lidex E	3	<i>fluocinonide gel, oint, cream</i>	1	Yes	
Locoid	3	<i>hydrocortisone butyrate 0.1%</i>	1	Yes	
Loprox	3	<i>ciclopirox cream, susp</i>	1	Yes	
Loprox gel	2				
Loprox shampoo	3	<i>ciclopirox shampoo</i>	1	Yes	
Lotrisone	3	<i>betamethasone/clotrimazole</i>	1	Yes	
MetroCream	3	<i>metronidazole cream</i>	1	Yes	
Metrolotion	3	<i>metronidazole lotion</i>	1	Yes	
Mycolog II	3	<i>nystatin/triamcinolone</i>	1	Yes	
Mycostatin	3	<i>nystatin</i>	1	Yes	
Nizoral cream	3	<i>ketoconazole cream</i>	1	Yes	
Nizoral shampoo	3	<i>ketoconazole shampoo</i>	1	Yes	
Ovide	3	<i>malathion lotion</i>	1	Yes	
Oxsoralen lotion 1%	2				
Oxsoralen Ultra	2				
Penlac	3	<i>ciclopirox solution</i>	1	Yes	
Psorcon	3	<i>diflorasone diacetate</i>	1	Yes	
Psoriatec	3	<i>anthralin</i>	1	Yes	
Regranex	2				
Retin-A, Avita	3	<i>tretinoin</i>	1	Yes	
Sebizon	3	<i>sulfacetamide sodium</i>	1	Yes	
Selsun Rx	3	<i>selenium sulfide</i>	1	Yes	
Senatec HC	3	<i>HC acetate/lidocaine HCl</i>	1	Yes	
Silvadene	3	<i>silver sulfadiazine</i>	1	Yes	
Spectazole	3	<i>econazole</i>	1	Yes	
Sulfacet-R, Plexion	3	<i>sodium sulfacetamide/sulfur</i>	1	Yes	
Synalar	3	<i>fluocinolone acetonide cream, soln</i>	1	Yes	
Temovate	3	<i>clobetasol</i>	1	Yes	
Topicort	3	<i>desoximetasone</i>	1	Yes	
Vanoxide-HC	3	<i>bencort lotion kit</i>	1	Yes	
Vectical	2				
Westcort	3	<i>hydrocortisone valerate 0.2%</i>	1	Yes	
Xylocaine	3	<i>lidocaine</i>	1	Yes	
Zoderm	3	<i>benzoyl peroxide/urea cream</i>	1	Yes	
Zovirax oint	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

5. SKIN MEDICATIONS

BRAND	Formulary Tier	<i>GENERIC</i>	Formulary Tier	<i>Generic Available</i>	Additional Requirements
		<i>erythromycin solution</i>	1	Yes	
		<i>gentamicin topical cream, oint</i>	1	Yes	
		<i>lindane lotion</i>	1	Yes	

6. EAR, NOSE, THROAT MEDICATIONS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Acetasol HC	3	<i>acetic acid HC</i>	1	Yes	
Astepro	2				
Atrovent nasal spray	3	<i>ipratropium</i>	1	Yes	
Bactroban nasal oint	2				
Benzotic	3	<i>benzocaine/antipyrine</i>	1	Yes	
Cipro HC Otic	2				
Cortisporin Otic	3	<i>neomycin/polymyxin/hydrocortisone</i>	1	Yes	
Flonase	3	<i>fluticasone propionate nasal susp</i>	1	Yes	PA (Brand only)
Floxin Otic	3	<i>ofloxacin otic</i>	1	Yes	
Kenalog in Orabase	3	<i>triamcinolone</i>	1	Yes	
Nasarel	3	<i>flunisolide</i>	1	Yes	
Nasonex	2				
Peridex	3	<i>chlorhexidine gluconate</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

7. DIABETES, THYROID, STEROIDS, & OTHER MISCELLANEOUS HORMONES

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Actos	2				
Actosplus Met	2				
Amaryl	3	<i>glimepiride</i>	1	Yes	
Androgel	2				
Ascensia Autodisc Test Strips	2				
Ascensia Breeze 2 Test Strips	2				
Ascensia Glucometer	2				
Ascensia Contour Test Strips	2				
Ascensia Contour Test Strips	2				
BD Insulin Syringe Micro-Fine	2				
Byetta	2				PA
Cortef	3	<i>hydrocortisone</i>	1	Yes	
Cytomel	3	<i>liothyronine</i>	1	Yes	
Danocrine	3	<i>danazol</i>	1	Yes	
DDAVP	3	<i>desmopressin acetate</i>	1	Yes	
Decadron	3	<i>dexamethasone</i>	1	Yes	
Deltasone	3	<i>prednisone tabs</i>	1	Yes	
Diabeta, Micronase	3	<i>glyburide</i>	1	Yes	
Florinef	3	<i>fludrocortisone acetate</i>	1	Yes	
Fortamet	3	<i>metformin ER</i>	1	Yes	
FreeStyle Lite Glucometer	2				
FreeStyle Lite Test Strips	2				
FreeStyle Meter	2				
FreeStyle Test Strips	2				
Glucagon emergency kit	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

7. DIABETES, THYROID, STEROIDS, & OTHER MISCELLANEOUS HORMONES

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Glucophage	3	<i>metformin</i>	1	Yes	
Glucophage XR	3	<i>metformin ER</i>	1	Yes	
Glucotrol	3	<i>glipizide</i>	1	Yes	
Glucotrol XL	3	<i>glipizide ER</i>	1	Yes	
Glucovance	3	<i>metformin/glyburide</i>	1	Yes	
Glynase	3	<i>glyburide micronized</i>	1	Yes	
Humatrope	2				PA
Insulin syringes	2				
Janumet	2				
Januvia	2				
Juvisync	2				
Kombiglyze XR	2				
Lancets	2				
Levemir	2				
Levoxyl, Synthroid	3	<i>levothyroxine</i>	1	Yes	
Medrol	3	<i>methylprednisolone</i>	1	Yes	
Norditropin	2				PA
Novolin	2				
Novolog	2				
Novolog mix	2				
Onglyza	2				
Oxandrin	3	<i>oxandrolone</i>	1	Yes	
Pediapred, Orapred	3	<i>prednisolone sodium phosphate</i>	1	Yes	
Prandin	2				
Precision XTRA Glucometer	2				
Precision XTRA Test Strips	2				
Precose	3	<i>acarbose</i>	1	Yes	
Preлоне	3	<i>prednisolone syrup</i>	1	Yes	
Rocaltrol capsules	3	<i>calcitriol capsules</i>	1	Yes	
Sensipar	2				
Starlix	3	<i>nateglinide</i>	1	Yes	
Symlin	2				PA
Tapazole	3	<i>methimazole</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

7. DIABETES, THYROID, STEROIDS, & OTHER MISCELLANEOUS HORMONES

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Zavesca	2				
		<i>propylthiouracil</i>	1	Yes	
		<i>tolbutamide</i>	1	Yes	

8. STOMACH, ULCER, & BOWEL MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Actigall	3	<i>ursodiol</i>	1	Yes	
Analpram E Kit	3	<i>hydrocortisone/pramoxine kit</i>	1	Yes	
Anusol-HC	3	<i>hydrocortisone</i>	1	Yes	
Asacol	2				
Avonex	2				
Axid	3	<i>nizatidine</i>	1	Yes	
Azulfidine	3	<i>sulfasalazine</i>	1	Yes	
Bentyl	3	<i>dicyclomine</i>	1	Yes	
Canasa supp	2				
Carafate tabs	3	<i>sucralfate tabs</i>	1	Yes	
Carafate susp	2				
Colazal	3	<i>balsalazide</i>	1	Yes	
Colocort	3	<i>hydrocortisone retention enema</i>	1	Yes	
Compazine	3	<i>prochlorperazine</i>	1	Yes	
Copaxone	2				
Cytotec	3	<i>misoprostol</i>	1	Yes	
Donnatal	3	<i>phenobarb/hyoscyamine/atropine/scopolamine</i>	1	Yes	
Emend	2				QL
Entocort EC	3	<i>budesonide</i>	1	Yes	
Fragmin	2				
Gastrocrom	2				
Kristalose	2				
Kytril	3	<i>granisetron</i>	1	Yes	
Levsin, Levsinex, Levbid	3	<i>hyoscyamine</i>	1	Yes	
Lomotil	3	<i>diphenoxylate HCl/atropine</i>	1	Yes	
Marinol	3	<i>dronabinol</i>	1	Yes	
Nexium	2				QL
Nulytely	3	<i>PEG 3350 & electrolytes</i>	1	Yes	
Pancrease, Pancrease MT	3	<i>pancrelipase EC/SA</i>	1	Yes	
Peg-Intron	2				PA
Pentasa	2				
Pepcid	3	<i>famotidine 40mg</i>	1	Yes	
Pepcid suspension	3	<i>famotidine suspension</i>	1	Yes	
Phenergan	3	<i>promethazine</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

8. STOMACH, ULCER, & BOWEL MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Prevacid	3	<i>lansoprazole</i>	1	Yes	PA (Brand only), QL
Prevacid SoluTab	3	<i>lansoprazole ODT</i>	1	Yes	PA (Brand only), QL
Prilosec	3	<i>omeprazole</i>	1	Yes	QL
Proctofoam-HC	2				
Protonix	3	<i>pantoprazole</i>	1	Yes	PA (Brand only), QL
Reglan	3	<i>metoclopramide</i>	1	Yes	
Rowasa	3	<i>mesalamine rectal susp</i>	1	Yes	
Tagamet	3	<i>cimetidine</i>	1	Yes	
Tigan	3	<i>trimethobenzamide</i>	1	Yes	
Zantac	3	<i>ranitidine 300mg</i>	1	Yes	
Zegerid	3	<i>omeprazole-sodium bicarbonate</i>	1	Yes	PA (Brand only), QL
Zofran	3	<i>ondansetron HCl</i>	1	Yes	
		<i>chlordiazepoxide/clidinium</i>	1	Yes	
		<i>lactulose soln</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

9. BIOTECHNOLOGY

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Arixtra	3	<i>fondaparinux</i>	1	Yes	
Avonex	2				
Copaxone	2				
Fragmin	2				
Lovenox	3	<i>enoxaparin</i>	1	Yes	
Peg-Intron	2				PA
Procrit	2				
Sylatron	3				PA

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

10. BONE, JOINT, & MUSCLE

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Actonel	2				QL
Anaprox DS	3	<i>naproxen sodium</i>	1	Yes	
Ansaid	3	<i>flurbiprofen</i>	1	Yes	
Arava	3	<i>leflunomide</i>	1	Yes	
Azulfidine	3	<i>sulfasalazine</i>	1	Yes	
Cataflam	3	<i>diclofenac potassium</i>	1	Yes	
Clinoril	3	<i>sulfinpyrazone sulindac</i>	1	Yes	
Colcrys	2				
Cortef	3	<i>hydrocortisone</i>	1	Yes	
Daypro	3	<i>oxaprozin</i>	1	Yes	
Decadron	3	<i>dexamethasone</i>	1	Yes	
Deltasone	3	<i>prednisone tabs</i>	1	Yes	
Dolobid	3	<i>diflunisal</i>	1	Yes	
Enbrel kit, disp syr	2				
Evista	2				
Feldene	3	<i>piroxicam</i>	1	Yes	
Flexeril	3	<i>cyclobenzaprine</i>	1	Yes	
Fosamax	3	<i>alendronate</i>	1	Yes	QL
Humira	2				PA
Imuran	3	<i>azathioprine</i>	1	Yes	
Indocin	3	<i>indomethacin</i>	1	Yes	
Indocin SR	3	<i>indomethacin SR</i>	1	Yes	
Lodine XL	3	<i>etodolac</i>	1	Yes	
Medrol	3	<i>methylprednisolone</i>	1	Yes	
Miacalcin	3	<i>calcitonin-salmon (rDNA origin) nasal spray</i>	1	Yes	
Mobic	3	<i>meloxicam</i>	1	Yes	PA (Brand only)
Motrin	3	<i>ibuprofen</i>	1	Yes	
Nalfon	3	<i>fenoprofen calcium</i>	1	Yes	
Naprelan	3	<i>naproxen sodium SA</i>	1	Yes	
Naprosyn	3	<i>naproxen</i>	1	Yes	
Orudis	3	<i>ketoprofen</i>	1	Yes	
Oruvail	3	<i>ketoprofen SR</i>	1	Yes	
Parafon Forte	3	<i>chlorzoxazone</i>	1	Yes	
Pediapred, Orapred	3	<i>prednisolone sodium phosphate</i>	1	Yes	
Plaquenil	3	<i>hydroxychloroquine</i>	1	Yes	
Prezone	3	<i>prednisolone syrup</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

10. BONE, JOINT, & MUSCLE

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Relafen	3	<i>nabumetone</i>	1	Yes	
Robaxin	3	<i>methocarbamol</i>	1	Yes	
Skelaxin	3	<i>metaxalone</i>	1	Yes	
Soma	3	<i>carisoprodol</i>	1	Yes	
Toradol oral	3	<i>ketorolac</i>	1	Yes	
Valium	3	<i>diazepam</i>	1	Yes	
Voltaren XR	3	<i>diclofenac sodium</i>	1	Yes	
Zanaflex	3	<i>tizanidine</i>	1	Yes	
Zyloprim	3	<i>allopurinol</i>	1	Yes	
		<i>baclofen</i>	1	Yes	
		<i>choline magnesium trisalicylate</i>	1	Yes	
		<i>colchicine</i>	1	Yes	
		<i>meclofenamate</i>	1	Yes	
		<i>methotrexate</i>	1	Yes	
		<i>probenecid</i>	1	Yes	
		<i>salsalate</i>	1	Yes	
		<i>tolmetin</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

11. FEMALE, HORMONE REPLACEMENT, & BIRTH CONTROL

The Injectable Fertility Agents in this section are covered only under certain benefits programs.
Please check your handbook to determine coverage.

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Aygestin	3	<i>norethindrone acetate</i>	1	Yes	
Bravelle	2				
Cenestin	2				
Cleocin	3	<i>clindamycin cream</i>	1	Yes	
Climara	3	<i>estradiol transdermal</i>	1	Yes	
Depo SubQ Provera	2				
Depo-Provera	2				
Diflucan	3	<i>fluconazole 150mg</i>	1	Yes	
Estrace	3	<i>estradiol</i>	1	Yes	
Estraderm	2				
Estratest HS	2				
Estring	2				
Estrostep FE	3	<i>norethindrone acetate/ethinyl estradiol/ferrous fumarate</i>	1	Yes	
Femcon Fe	3	<i>ethinyl estradiol/norethindrone</i>	1	Yes	
Femhrt	3	<i>norethindrone acetate/ethinyl estradiol</i>	1	Yes	
Follistim	2				
Follistim AQ	2				
LoSeasonique	3	<i>amethia lo/camrese lo</i>	1	Yes	
Lunelle	2				
Menopur	2				
Methergine	3	<i>methylergonovine maleate</i>	1	Yes	
Metrogel	3	<i>metronidazole vaginal gel</i>	1	Yes	
Metrogel Combo Pack	2				
Novarel	2				
Nuvaring	2				
Ogen	3	<i>estropipate</i>	1	Yes	
Ortho Evra	2				
Ortho Tri-Cyclen Lo	3	<i>tri-lo-sprintec</i>	1	Yes	
Premarin	2				
Premarin vaginal cream	2				
Premphase	2				
Prempro	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

11. FEMALE, HORMONE REPLACEMENT, & BIRTH CONTROL

The Injectable Fertility Agents in this section are covered only under certain benefits programs.
Please check your handbook to determine coverage.

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Prometrium	2				
Provera	3	<i>medroxyprogesterone acetate</i>	1	Yes	
Repronex	2				
Seasonale, Triphasil	3	<i>levonorgestrel/ethinyl estradiol</i>	1	Yes	
Seasonique	3	<i>amethia</i>	1	Yes	
Terazol 3	3	<i>terconazole cream</i>	1	Yes	
Vivelle, Vivelle Dot	2				
Yasmin	3	<i>ethinyl estradiol/drospirenone</i>	1	Yes	
YAZ	3	<i>Gianvi</i>	1	Yes	
		<i>desogestrel/ethinyl estradiol</i>	1	Yes	
		<i>esterified estrogens/ methyltestosterone</i>	1	Yes	
		<i>norethindrone</i>	1	Yes	
		<i>norethindrone/ethinyl estradiol</i>	1	Yes	
		<i>norethindrone/ethinyl estradiol, Fe</i>	1	Yes	
		<i>norethindrone/mestranol</i>	1	Yes	
		<i>norgestimate/ethinyl estradiol</i>	1	Yes	
		<i>norgestrel/ethinyl estradiol</i>	1	Yes	
		<i>nystatin</i>	1	Yes	

12. EYE MEDICATIONS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Acular/Acular LS	3	<i>ketorolac oph soln</i>	1	Yes	
Alphagan P	3	<i>brimonidine tartrate</i>	1	Yes	
Alrex	2				
Azopt	2				
Besivance	2				
Betagan	3	<i>levobunolol</i>	1	Yes	
Betimol	2				
Betoptic S	2				
Bleph 10	3	<i>sulfacetamide</i>	1	Yes	
Blephamide	2				
Ciloxan	3	<i>ciprofloxacin</i>	1	Yes	
Cosopt	3	<i>dorzolamide-timolol</i>	1	Yes	
Crolom	3	<i>cromolyn ophth</i>	1	Yes	
Cyclogyl	3	<i>cyclopentolate HCl</i>	1	Yes	
Diamox Sequels	3	<i>acetazolamide ER</i>	1	Yes	
Econopred Plus, Pred-Forte	3	<i>prednisolone acetate</i>	1	Yes	
Elestat	3	<i>epinastine HCl</i>	1	Yes	
FML, Liquifilm	3	<i>fluorometholone</i>	1	Yes	
Gentak	3	<i>gentamicin ophth</i>	1	Yes	
HMS	2				
Inflamase Forte	3	<i>prednisolone sodium phosphate</i>	1	Yes	
Isopto Atropine	3	<i>atropine sulfate</i>	1	Yes	
Isopto Carbachol 3%	3	<i>carbachol 3%</i>	1	Yes	
Isopto Homatropine	3	<i>homatropine 5%</i>	1	Yes	
Lotemax	2				
Lumigan	2				
Maxitrol	3	<i>neomycin/polymyxin B/ dexamethasone</i>	1	Yes	
Mydracil	3	<i>tropicamide</i>	1	Yes	
Neosporin oint	3	<i>polymyxin B/neo/bacitracin</i>	1	Yes	
Neosporin soln	3	<i>polymyxin B/neo/gramicidin</i>	1	Yes	
Ocuflox	3	<i>ofloxacin</i>	1	Yes	
Optivar	3	<i>azelastine HCL drops</i>	1	Yes	
Patanol	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

12. EYE MEDICATIONS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Phospholine Iodide	2				
Pilocar, Isopto Carpine	3	<i>pilocarpine</i>	1	Yes	
Pilopine HS gel	2				
Polysporin	3	<i>bacitracin/polymyxin B ophth oint</i>	1	Yes	
Polytrim	3	<i>trimethoprim sulfate/polymyxin B</i>	1	Yes	
Propine	3	<i>dipivefrin HCl</i>	1	Yes	
Timoptic	3	<i>timolol ophth</i>	1	Yes	
Timoptic XE	3	<i>timolol XE</i>	1	Yes	
Tobradex	3	<i>tobramycin-dexamethasone</i>	1	Yes	
Tobrex	3	<i>tobramycin</i>	1	Yes	
Trusopt	3	<i>dorzolamide HCl 2%</i>	1	Yes	
Vasocidin oint	3	<i>prednisolone/sodium sulfacetamide</i>	1	Yes	
Vexol	2				
Vigamox	2				
Viroptic	3	<i>trifluridine</i>	1	Yes	
Voltaren	3	<i>diclofenac sodium</i>	1	Yes	
Xalatan	3	<i>latanoprost</i>	1	Yes	
		<i>acetazolamide</i>	1	Yes	
		<i>bacitracin ophth</i>	1	Yes	
		<i>betaxolol</i>	1	Yes	
		<i>carteolol</i>	1	Yes	
		<i>dexamethasone ophth</i>	1	Yes	
		<i>erythromycin</i>	1	Yes	
		<i>methazolamide</i>	1	Yes	

13. ALLERGY, COUGH & COLD, LUNG MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Accolate	3	<i>zafirlukast</i>	1	Yes	
AdrenaClick	3	<i>epinephrine pen injector</i>	1	Yes	
Advair Diskus	2				
Advair HFA	2				
Alupent aerosol	2				
Astelin Nasal Spray	3	<i>azelastine nasal spray</i>	1	Yes	
Atrovent HFA	2				
Atrovent soln	3	<i>ipratropium inhalation soln</i>	1	Yes	
Brethine	3	<i>terbutaline sulfate tabs</i>	1	Yes	
Brovex D	3	<i>brompheniramine/phenylephrine</i>	1	Yes	
Brovex HC	3	<i>pseudoephedrine/ brompheniramine/hydrocodone liquid</i>	1	Yes	
Combivent MDI	2				
Cortef	3	<i>hydrocortisone</i>	1	Yes	
Decadron	3	<i>dexamethasone</i>	1	Yes	
Deltasone	3	<i>prednisone tabs</i>	1	Yes	
Duoneb	3	<i>ipratropium-albuterol</i>	1	Yes	
Duratuss HD elixir	3	<i>guaifenesin/phenylephrine/ hydrocodone</i>	1	Yes	
Elixophyllin	2				
EpiPen	2				
EpiPen Jr. Auto-Injector/ E*Z	2				
Extendryl	3	<i>chlorpheniramine/phenylephrine/ methscopolamine chewable tabs, syrup</i>	1	Yes	
Extendryl SR	2				
Flovent Diskus	2				
Flovent HFA	2				
Flutuss HC liquid	3	<i>phenylephrine/hydrocodone/ BPM</i>	1	Yes	
Foradil	2				
Guiatuss AC	3	<i>guaifenesin/codeine</i>	1	Yes	
Guiatuss DAC	3	<i>guaifenesin/pseudoephedrine/ codeine</i>	1	Yes	
Guiatuss DAC, Novahistine	3	<i>guaifenesin/pseudoephedrine/ codeine</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

13. ALLERGY, COUGH & COLD, LUNG MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Hista-Vent DA	3	<i>chlorpheniramine/phenylephrine/methscopolamine extended release</i>	1	Yes	
Histussin-HC	3	<i>phenylephrine/cpm/hydrocodone</i>	1	Yes	
Hycodan	3	<i>hydrocodone/homatropine syrup</i>	1	Yes	
Intal soln	3	<i>cromolyn inhalation soln</i>	1	Yes	
Kronofed-A Jr.	3	<i>pseudoephedrine/chlorpheniramine</i>	1	Yes	
Max HC	3	<i>phenylephrinecarbinoxamine w/hydrocodone liquid</i>	1	Yes	
Maxair	2				
Maxituss HC	3	<i>phenylephrine/hydrocodone/CP</i>	1	Yes	
Medrol	3	<i>methylprednisolone</i>	1	Yes	
Mucomyst	3	<i>acetylcysteine</i>	1	Yes	
Nasacort AQ	3	<i>triamcinolone acetonide</i>	1	Yes	
Nasarel	3	<i>flunisolide</i>	1	Yes	
Nasonex	2				
Novahistine DH	3	<i>pseudoephedrine/cpm/codeine</i>	1	Yes	
Pediapred, Orapred	3	<i>prednisolone sodium phosphate</i>	1	Yes	
Phenergan	3	<i>promethazine</i>	1	Yes	
Phenergan VC w/codeine	3	<i>phenylephrine HCl/COD/promethazine</i>	1	Yes	
Preлоне	3	<i>prednisolone syrup</i>	1	Yes	
ProAir HFA	2				
Proventil HFA	2				
Proventil, Ventolin	3	<i>albuterol inhaler</i>	1	Yes	
Pulmicort Flexhaler	2				
Pulmicort Respules	3	<i>budesonide</i>	1	Yes	
Pulmozyme	2				
Qvar	2				
Rynatan	3	<i>chlorpheniramine/phenylephrine</i>	1	Yes	
Serevent Diskus	2				
Singulair	2				
Spiriva	2				
Symbicort	2				
Tessalon Perles	3	<i>benzonatate</i>	1	Yes	
Theo-24	2				

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

13. ALLERGY, COUGH & COLD, LUNG MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Theochron, Uniphyll	3	<i>theophylline extended release</i>	1	Yes	
Tilade	2				
Tracleer	2				
Tussionex	3	<i>hydrocodone-chlorpheniramine susp</i>	1	Yes	
Vistaril	3	<i>hydroxyzine pamoate</i>	1	Yes	
Vospire ER	2				
Xopenex inhalation solution)	3	<i>levalbuterol inhalation solution</i>	1	Yes	
Xyzal	3	<i>levocetirizine dihydrochloride</i>	1	Yes	PA (Brand only)
Zephrex LA	3	<i>pseudoephedrine/guaifenesin extended release</i>	1	Yes	
		<i>albuterol soln</i>	1	Yes	
		<i>aminophylline tabs</i>	1	Yes	
		<i>cyproheptadine</i>	1	Yes	
		<i>guaifenesin/hydrocodone</i>	1	Yes	
		<i>hydroxyzine HCl</i>	1	Yes	
		<i>metaproterenol tabs, syrup, inh soln</i>	1	Yes	
		<i>promethazine/codeine</i>	1	Yes	
		<i>promethazine/dextromethorphan</i>	1	Yes	
		<i>promethazine/phenylephrine/codeine</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

14. URINARY & PROSTATE MEDS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Cardura	3	<i>doxazosin mesylate</i>	1	Yes	
Ditropan	3	<i>oxybutynin</i>	1	Yes	
Ditropan XL	3	<i>oxybutynin ER</i>	1	Yes	
Enablex	2				
Flomax	3	<i>tamsulosin</i>	1	Yes	
Hytrin	3	<i>terazosin</i>	1	Yes	
Muse	2				QL, PA
Proscar	3	<i>finasteride</i>	1	Yes	
Prosed EC tab	3	<i>methenamine/methylene blue/ benzoic acid/salicylic acid/ atropine</i>	1	Yes	
Pyridium	3	<i>phenazopyridine</i>	1	Yes	
Rapaflo	2				
Urecholine	3	<i>bethanechol</i>	1	Yes	
Urised	3	<i>methenamine/phenylsalicylate/ atropine/hyoscyamine/benzoic acid/methylene blue</i>	1	Yes	
Urispas	3	<i>flavoxate</i>	1	Yes	
Urocit-K	3	<i>potassium citrate</i>	1	Yes	
Uroxatral	3	<i>alfuzosin</i>	1	Yes	
VESIcare	2				
Viagra	2				QL, PA

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

15. VITAMINS & ELECTROLYTES

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Calciferol	3	<i>ergocalciferol</i>	1	Yes	
Chromagen	3	<i>Multigen</i>	1	Yes	
Chromagen Forte	3	<i>Multigen Plus</i>	1	Yes	
Icar	3	<i>iron, carbonyl 15mg</i>	1	Yes	
Klor-Con, Kaon-CL, Klotrix, K-Tab, K-Dur, Micro-K	3	<i>potassium chloride</i>	1	Yes	
K-Lyte	3	<i>potassium bicarbonate/potassium citrate effervescent</i>	1	Yes	
Luride drops	3	<i>sodium fluoride drops</i>	1	Yes	
Tri-Vi-Flor, Poly-Vi-Flor with and without iron	3	<i>multivitamin with fluoride drops, tabs</i>	1	Yes	
		<i>fluoride</i>	1	Yes	
		<i>folic acid</i>	1	Yes	

16. DIAGNOSTICS & MISCELLANEOUS AGENTS

BRAND	Formulary Tier	GENERIC	Formulary Tier	Generic Available	Additional Requirements
Campral	2				
Chemet	2				
Didronel	3	<i>etidronate disodium</i>	1	Yes	
PhosLo	3	<i>calcium acetate</i>	1	Yes	
ProAmatine	3	<i>midodrine HCl</i>	1	Yes	
Salagen	3	<i>pilocarpine HCl</i>	1	Yes	
Suboxone	2				QL, PA
Suboxone Sublingual Film	2				QL, PA
Subutex	3	<i>buprenorphine</i>	1	Yes	QL, PA
		<i>benzoyl peroxide</i>	1	Yes	

PA = Prior authorization must be requested by the physician.

QL = Quantity limits apply.

PROCEDURES THAT SUPPORT SAFE PRESCRIBING

Inter-County Hospitalization Plan, Inc. and Inter-County Health Plan, Inc. group health plan (Inter-County) utilizes an independent pharmacy benefits management (PBM) company, FutureScripts, to manage the administration of its commercial prescription drug programs. As our PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our members and providers.

Prior authorization

Prior authorization is a requirement that your physician obtain approval from your health plan for coverage of, or payment for, prescription drugs. Inter-County requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary, and appropriate, and is being prescribed according to FDA guidelines. The approval criteria were developed and endorsed by the Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the member's prescribing physician, and the member's available prescription drug therapy history. Their review includes a determination that there are no drug interactions or contraindications, that dosing and length of therapy are appropriate, and that other drug therapies, if necessary, were utilized.

Without prior authorization, the plan member's prescription will not be covered at the retail or mail-order pharmacy. The prior authorization process may take up to two business days once complete information from the prescribing physician has been received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Prior authorization applies to all formulations of specific drugs, including but not limited to, tablet, capsule, and oral suspension.*

PTSSP	Ferriprox [®]	Orencia [®] SQ	Taclonex [®]
Prior Authorized Drugs	Firazyr [®]	Peg-Intron [®]	Taclonex Scalp [®]
Abstral [®]	Flector [®] patch	Pegasys [®]	Tarceva [®]
AcipHex [®]	Flonase [®]	Pegasys ProClick [®]	Tasigna [®]
Actiq [®]	Forteo [™]	Pradaxa [®]	Tekamlo [™]
Adcirca [™]	Fortesta [™]	PrandiMet [™]	Tekturna [®] /Tekturna HCT [®]
Afinitor [®]	Frova [®]	Prevacid [®]	Temodar [®] Oral
Alodox [™]	Genotropin [®]	Prevacid/NapraPAC [®]	Testim [®]
Altabax [™]	Gilenya [®]	Prilosec [®] suspension	Teveten [®] /Teveten HCT [®]
Ambien CR [®]	Gleevec [®]	Pristiq [™]	Tev-Tropin [®]
Amerge [®]	Gralise [™]	Protonix [®]	Thalomid [®]
Ampyra [™]	Glumetza [™]	Provigil [®]	Toviaz [™]
AMRIX [®]	Horizant [™]	Pylera [™]	Tradjenta [™]
Amturnide [™]	Humalog [®]	Qualaquin [®]	Treximet [™]
Androderm [®]	Humatrope [®]	Rebetol [®]	Twynsta [®]
Apidra [®]	Humira [®]	ReliOn [®] /Novolin [®]	Tykerb [®]
Apidra [®] SoloSTAR [®]	Humulin [®]	Relpax [®]	Uloric [®]
Aplenzin [™]	HYCAMTIN [®] capsules	Renvela [®]	Ultram [®] ER
Atacand [®] /Atacand HCT [®]	Imitrex [®]	Requip [®] XL [™]	Valturna [®]
Avapro [®] /Avalide [®]	Incivek [™]	Revatio [™]	Veramyst [™]
Avidoxy [™] DK	Intuniv [™]	Revlimid [®]	Viagra [®]
Axert [®]	Invega [™]	RibaPak [®]	Victoza [®]
Axiron [®]	Jakafi [™]	Ribasphere [®]	Victrelis [™]
Banzel [™]	Kineret [®]	RibaTab [®]	Vimovo [™]
Beconase AQ [®]	Lantus [®]	ribavirin	Vimpat [™]
Bepreve [™]	Lazanda [®]	Rhinocort Aqua [®]	Voltaren [®] Gel
BiDiI [®]	Levitra [®]	Rozerem [™]	Votrient [™]
Byetta [®]	Livalo [®]	Rybix [™] ODT	Vytorin [®]
Caprelsa [®]	Lyrica [®]	Ryzolt [™]	Vyvanse [®]
Caverject [®]	Magnacet [™]	Sabril [®]	Xalkori [®]
Cayston [™]	Maxalt [®]	Saizen [®]	Xarelto [®]
Celebrex [®]	Micardis [®] /Micardis HCT [®]	Samsca [™]	Xenazine [™]
Cesamet [®]	Mobic [®]	Savella [™]	Xifaxan [®] 550mg
Cialis [®]	MUSE [®]	Serostim [®]	Xyzal [®]
Cimzia [®]	Nasacort [®] AQ	Silenor [®]	Zegerid [®]
Copegus [®]	Nexavar [®]	Simponi [™]	Zelboraf [®]
Cozaar [®] /Hyzaar [®]	Nexiclon [™] XR	Sprycel [®]	Zipsor [™]
Daytrana [™]	Norditropin [®]	Staxyn [™]	Zmax [™]
Dexilant [™]	Noxafil [®]	Striant [®]	Zolinza [®]
Diabetic test strips*	Nucynta [™]	Suboxone [®]	Zolpimist [™]
Edarbi [™]	Nuedexta [™]	Suboxone [®] Sublingual	Zomig [®]
Edex [®]	NutriDox [™]	Subutex [®]	Zorbtive [™]
Edluar [™]	Nutropin [®] /Nutropin AQ [®]	Sumavel [™]	Zortress [®]
Enbrel [®]	Nuvigil [®]	Sutant [®]	Zytiga [™]
Exforge [®] /Exforge HCT [®]	Oforta [™]	Sylatron [™]	Zyvox [®]
Exjade [®]	Omnaris [®]	Symlin [®]	
Fanapt [™]	Omnitrope [®]	Synagis [®] (<i>applies to AHA/IA/ICHP only</i>)	
Fentora [®]	Onsolis [™]		

* All diabetic test strips require prior authorization except the following: Autodisc[®], Ascencia[®], Breeze[®] 2, Contour[®], Elite[®], FreesStyle[®], FreeStyle Lite[®], and Precision XTRA[®]

Age and gender limits

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and to ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age 14 and older, such as ciprofloxacin, or prescribed only for females, such as prenatal vitamins. The pharmacist's computer provides up-to-date information about FDA rules. If the plan member's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request consideration for preapproval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the Pharmacy and Therapeutics Committee. The plan member should contact the prescribing physician to request that he or she initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age or gender limit, call FutureScripts at 1-888-678-7013.

Quantity limits

Quantity limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. We have several different types of quantity limits that are explained in detail below.

Rolling 30-day period

This quantity limit is based on dosing guidelines over a rolling 30-day period. For example, if a plan member went to the pharmacy on July 1, 2011, for one of these medications, the computer system would have looked back 30 days to June 1, 2011, to see how much medication was dispensed. The purpose of these limits is to make certain that these drugs are being used appropriately and to guard against overuse or stockpiling.

Examples of quantity limits per rolling 30-day period are:

- **Emend® (four 125mg capsules + eight 80mg capsules or four trifold packs [one 125mg capsule + two 80mg capsules]); Boniva® (two 150mg tablets); Avonex® (one kit, four injections); Betaseron® (15 vials); Copaxone® (32 vials); Fosamax Plus D™ (five tablets); and Rebif® (12 injections);**
- **migraine drugs, such as Amerge® (nine 2.5mg tablets), Imitrex® (36 50mg tablets), Maxalt® (12 10mg tablets), Migranal® (eight 4mg nasal spray units), Stadol NS® (four 10mg units), and Zomig® (nine 5mg tablets);**
- **sedative hypnotic drugs, such as Sonata® (14 capsules) and Ambien® (14 tablets);**
- **oral narcotic drugs, such as OxyContin® (90 units), Percocet® (180 units), and Percodan® (180 units).**

Refill too soon

With this quantity limit, if a plan member used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the drug is being taken in accordance with the prescribed dose and frequency of administration.

Therapeutic drug class

This quantity limit applies to some classes of drugs, such as narcotics (i.e., short-acting and long-acting). If a plan member uses more than one drug within the same class, he or she may be unsafely duplicating drugs and would be affected by the total quantity limits for a therapeutic drug class. Members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

If a physician requires that a member uses a drug therapy that exceeds any of the quantity limits described above, the physician must request consideration for a quantity limit override. The member is required to contact the prescribing physician to initiate a preapproval request for an override.

Some drugs may have a time period for quantity limit exceptions of 6 to 12 months. If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy that exceeds a quantity limit after the expiration date, a new request for a quantity limit exception will need to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity limit, call FutureScripts at 1-888-678-7013.

96-Hour Temporary Supply Program

The 96-Hour Temporary Supply Program applies to the following covered drugs:

- most drugs that require prior authorization;
- drugs that are subject to age limits (pre-approval required for ages outside of recommended ranges);
- migraine drugs with quantity limits, such as Amerge[®], Imitrex[®], Maxalt[®], Migranal[®], Stadol NS[®], and Zomig[®] (preapproval of quantity override required for amounts over the quantity limits).

Under the 96-Hour Temporary Supply Program, if a member's physician writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication, and prior authorization has not been obtained by the physician, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the member with no out-of-pocket cost-sharing (i.e., no cost to the member) at that time.*
2. By the next business day, FutureScripts will contact the member's physician to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by FutureScripts, the review will be completed, and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled, and the appropriate prescription drug out-of-pocket cost-sharing will be applied.*
5. If denied, notification will be sent to both the physician and the member.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. Some drugs are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations such as Retin-A[®] (tube), Enbrel[®] (two-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs. Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually purchased at the pharmacy and must be special-ordered; therefore, they are not eligible under the 96-Hour Temporary Supply Program.

**Members with an integrated drug benefit (e.g., Comprehensive Major Medical and Major Medical) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved) at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures.*

The process for requesting a prior authorization/preapproval or override is as follows:

- The physician prescribing the drug completes a prior authorization form or writes a letter of medical necessity and submits it to FutureScripts by fax at 1-888-671-5285. The forms are available online at: www.futurescripts.com/for_health_care_professionals/prior_authorization. The form must be completed and submitted by the physician, not the plan member.
- FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing physician will be notified of approval via fax or telephone, and the claims system will be coded with the approval. The member may call the Customer Service phone number on his or her ID card to determine if the prescription is approved.
- If denied, the prescribing physician will be notified via letter, fax, or telephone. The plan member is also notified of all denied requests via letter. The appeals process will be detailed within the denial letters sent to the plan member and physician.

Coverage for drugs not on the formulary (specific to Select Drug Program plan members only)

Providers may request consideration for formulary coverage of a covered non-formulary medication when all formulary alternatives have been exhausted or there are contraindications to using the formulary alternatives. The provider should complete the covered non-formulary appeal form, providing detail to support use of the covered non-formulary medication, and should fax the request to 1-888-671-5285. If the non-formulary exception request is approved, the drug will be paid at the appropriate formulary level of cost-sharing. If the request is denied, the plan member and provider will receive a denial letter with the appropriate appeals language. Whether an appeal is filed, the plan member may always obtain benefits for the covered non-formulary drug at the appropriate non-formulary level of cost-sharing. Out-of-pocket expenses for non-formulary drugs are higher than for formulary drugs.

Appealing a decision

If a request for prior authorization/preapproval or exception results in a denial, the plan member, or physician on the plan member's behalf, may file an appeal. Both the plan member and his or her physician will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. In all cases, the physician needs to be involved in the appeals process to provide the required medical information for the basis of the appeal.

ICHP
Inter-County
Hospitalization Plan, Inc.
Health Plan, Inc.

FutureScripts® is an independent company that performs pharmacy benefits manager (PBM) services for AmeriHealth Administrators.

©2012 Inter-County Hospitalization Plan, Inc. and Inter-County Health Plan, Inc. All rights reserved.
No part of this publication may be reproduced or distributed without the prior written permission of Inter-County Hospitalization Plan, Inc. and Inter-County Health Plan, Inc.