

Community Health Group Medi-Cal Drug Formulary

October 2016



Community Health Group Medi-Cal Drug Formulary Administered by MedImpact

October 2016

Forward

This document represents the efforts of the Community Health Group (CHG) Pharmacy and Therapeutics (P&T) Committee to provide physicians and pharmacists with a method to begin to evaluate the various drug products available. The medical treatment of patients is frequently relative to the practical application of drug therapy. Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the CHG Medi-Cal Drug Formulary is to enhance the physician's and pharmacist's abilities to provide optimal cost effective drug therapy for patients.

The development, maintenance, and improvement of this process are evolutionary and require constant attention. This is accomplished by the CHG P&T Committee, which is comprised of plan providers and pharmacists. The Formulary is a continually reviewed and revised list of drug products, which mirror the prevailing clinical opinion within the medical community. Unfortunately, this dynamic process does not allow this document to be completely accurate at all times. To accommodate the necessary changes of this document, updates are to be sent to providers regularly. As you use this Formulary, you are encouraged to review the information and provide your input and comments to the CHG P&T Committee.

The CHG P&T Committee uses the following criteria in the evaluation of product selection for the CHG Drug Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate a therapeutic outcome.
- The drug product must be accepted for use by the medical community.
- The drug product must have an equitable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Drug Formulary is a list of covered and preferred drug agents for CHG members. All products are listed by their generic names, and a proprietary (branded) name. The Drug Formulary may be accessed by using the index, either by generic or proprietary name (in small capital letters) or by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by CHG shall be considered a Nonformulary drug.

All drugs are listed in each category in ascending order of cost. This is denoted by the relative dollar scale, described as follows:

\$	Least expensive
\$\$	Slightly more expensive
\$\$\$	More expensive
\$\$\$\$	Significantly more expensive
\$\$\$\$\$	Most expensive

The prices used to calculate the relative dollar scale are based on the monthly cost of therapy or cost of treatment course to allow for dosing interval differences between various products. The number of dollar signs is a relative indication of cost and does not represent the true cost of the drug. For example, two dollar signs do not mean that a product is twice as expensive as a product with one dollar sign. They are intended only to provide general information regarding cost. Economics should not be the only factor involved with any therapeutic and clinical decision process. Price comparisons are reflective of pricing and contracts available through MedImpact. While this document can provide you with good information which can be used for non-health plan patients, it may not accurately reflect the drug cost for non-health plan patients.

Coverage Limitations

The Drug Formulary applies only to outpatient drugs dispensed to members, and does not apply to medications used in inpatient or outpatient treatment settings. If a member has any specific questions regarding their coverage, they should contact CHG at (619) 498-6464 or MedImpact at (800) 788-2949.

All injectable drugs, with the exception of insulin, are subject to prior authorization to determine treatment setting and administration of drug (self vs. provider).

The following general exclusions pertain to all covered individuals:

- Drug Products not listed in the Drug Formulary, or specifically listed as not covered are not covered except per Medi-Cal guidelines or approved medical exception request.
- Any drug products used for cosmetic purposes are not covered.
- Experimental drug products, or any drug product used in an experimental manner are not covered, except per Medi-Cal guidelines.
- Agents for the treatment of sexual or erectile dysfunction.

Formulary Designations & Definitions

Abbreviated designations and definitions used in the formulary are explained as follows:

Age Restriction (AGE)

Drugs marked with an age restriction (AGE) are available as formulary agents for patients meeting age criteria. Members who do not meet age criteria may be approved for the age-restricted formulary item if prior authorization criteria are met. Drugs used to treat CCS-eligible conditions may have an age restriction to review for CCS eligibility.

Age & Specialty Restriction (AGE, MD)

Drugs marked with age and physician specialty restrictions (AGE, MD) are available as formulary agents for patients meeting both age criteria and physician specialty criteria. Members who do not meet age and/or physician specialty criteria may be approved if prior authorization criteria are met. For drugs used to treat CCS-eligible conditions, the members less than 21 years of age must be reviewed for CCS eligibility even if the prescriber meets the physician specialty restriction.

Age & Step Therapy Restriction (AGE, STEP)

Drugs marked with age and step therapy restrictions (AGE, STEP) are available as formulary agents for patients meeting both age criteria and step therapy criteria. Members who do not meet age and/or step therapy criteria may be approved if prior authorization criteria are met. For drugs used to treat CCS-eligible conditions, the members less than 21 years of age must be reviewed for CCS eligibility even if the member meets the step therapy criteria.

Medi-Cal Fee-For-Service (Bill State EDS)

Drugs marked "Bill State EDS" are covered by Medi-Cal Fee-For-Service. For medication reimbursement, items with this notation need to be billed through the Medi-Cal fiscal intermediary, Electronic Data System (EDS), rather than through Community Health Group.

Medi-Cal List of Contract Drugs (CD1)

Drugs marked “Code 1” (CD1) require prior authorization in accordance with Section 51003 of Medi-Cal regulations unless used under the conditions specified on the Medi-Cal List of Contract Drugs, and are subject to the prescription documentation requirements in Section 51476c (see California Code of Regulations [CCR], Title 22, Section 51313.3[b]). However, CHG has modified the Medi-Cal Code 1 requirements in some instances and these modifications are indicated within the formulary.

Physician Specialty Restriction (MD)

Drugs marked with a physician specialty restriction (MD) are available as formulary agents for certain medical specialists. For other practitioners, the restricted formulary item may be approved if prior authorization criteria are met.

Step Therapy (STEP)

Medications with this notation require a previous trial with a first-line agent. Members with a claims history in the system, which meets these criteria, will receive automatic approval for the second-line agent. Claims that are not automatically approved will be processed by the standard Medical Exception Request process. Please refer to the Medical Exception Request section for procedures.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only, and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. The inclusion of a drug product for generic substitution is subject to:

- A minimum of two sources of the product.
- A FDA Rating for generic equivalency.
- Review by the P&T Committee for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic index (NTI) or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - Dilantin®
 - Neoral® Solution
 - Premarin®
 - Synthroid®
 - Tegretol XR®

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products.

If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medical exception process.

Preferred Branded Interchange

Certain dual-licensed branded drug products may be excluded from coverage.

Experimental Drugs

The experimental nature or use of drug products will be determined by the P&T Committee using current medical literature. Any drug product or use of an existing product, which is determined to be experimental will be subject to Medi-Cal guidelines and current, accepted medical practice.

Prior Authorization Process

Either the prescriber or pharmacy provider may request nonformulary drugs and medical supplies. Prior authorization requests may be made by faxing a completed Medication Request Form (MRF) to MedImpact Healthcare Systems, Inc. at (858) 790-7100. Requests may also be processed over the telephone by calling a MedImpact Customer Service representative at (800) 788-2949.

The following general criteria are used to evaluate requests for nonformulary drugs:

1. The use of formulary drug(s) is contraindicated in the patient.
2. The patient has failed an appropriate trial of formulary drugs or related agents.
3. The choices available on the drug formulary are not suited for the present patient care need and/or the requested drug is required for patient safety.
4. The use of a formulary drug may exacerbate an underlying condition that would be detrimental to patient care.
5. The patient has been maintained on requested drug by CHG or previous insurance immediately prior to enrollment date (documentation required).

CHG requests that MRFs be filled out completely and legibly. This will help to expedite the review process. All requests will be processed within 24 hours or one business day. However, a determination may be deferred pending additional medical documentation for up to 30 days from the date of the initial request. If the requested documentation is not provided within this time frame, the request will be denied.

If MedImpact cannot make a determination based on the information provided and/or the request does not meet the criteria established by the P & T committee, the request will be forwarded to CHG for a secondary review. If the request is not approved by CHG, the member and prescriber will be notified in writing. A reason for the denial of the nonformulary request and notification of alternative drugs or treatments offered by CHG will be provided in the notice. The notice will also indicate that the member may file a grievance with CHG if the member objects to the denial.

Pharmacist and Physician Communication

The Drug Formulary is a tool to promote cost-effective prescription drug use. The P&T Committee has made every attempt to create a document which meets all therapeutic needs; however, the art of medicine makes this a formidable task. CHG welcomes the participation of physicians, pharmacists, and ancillary medical providers in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions, comments or formulary additions to CHG at the address following:

Chairman, Pharmacy & Therapeutics Committee
Community Health Group
2420 Fenton Street, Suite 100
Chula Vista, CA 91914

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ANTI-INFECTIVE AGENTS

Amebicide Agents

	\$	Metronidazole	FLAGYL
	\$\$\$	Paromomycin	HUMATIN

Antibacterial Agents

<i>Aminoglycosides</i>			
	\$	Neomycin Sulfate	MYCIFRADIN
<i>Cephalosporins</i>			
	\$	Cephalexin (Tablets Nonformulary)	KEFLEX (KEFLEX 750MG STRENGTH NONFORMULARY)
	\$	Cefuroxime Axetil	CEFTIN
AGE	\$\$	Cefdinir	OMNICEF, SUSPENSION ONLY (FOR MEMBERS ≤ 12 YEARS OF AGE)
<i>Macrolide Antibiotics</i>			
	\$	Erythromycin Base	ERY-TAB ERYPED SUSPENSION
	\$\$	Erythromycin/Sulfisoxazole	PEDIAZOLE
AGE	\$\$	Azithromycin	ZITHROMAX SUSPENSION, RESTRICTED TO MEMBERS 12 YEARS AND YOUNGER
PA			ZITHROMAX POWDER PACKET (ZMAX NONFORMULARY)
AGE, STEP			ZITHROMAX TABLETS, AGE & STEP THERAPY RESTRICTIONS (MEMBERS LESS THAN 18 OR OVER 64 YEARS OLD ARE EXEMPT FROM STEP THERAPY RESTRICTION)
QL	\$\$	Clarithromycin	BIAXIN,
PA			BIAXIN XL 500MG, PA REQ
<i>Penicillins</i>			
	\$	Amoxicillin	AMOXIL TRIMOX
	\$	Ampicillin	PRINCIPEN
	\$	Dicloxacillin	DYNAPEN
	\$	Penicillin VK	PEN VK
AGE	\$\$	Amoxicillin/Potassium Clavulanate	AUGMENTIN TABLETS, (FOR OTITIS MEDIA < 18 YEARS OF AGE; LOWER RESPIRATORY TRACT INFECTION ≥ 50 YEARS OF AGE) (EFFECTIVE 5/1/09)
			AUGMENTIN SUSPENSION
PA			AUGMENTIN XR, PA REQ
<i>Quinolones</i>			
	\$	Ciprofloxacin	CIPRO
CD1	\$\$	Ciprofloxacin Extended Release	CIPRO XR, CODE 1 (OVERRIDE IF UTI OR PYELONEPHRITIS); 500MG LIMITED TO 3 TABLETS/FILL & 2 FILLS/MONTH; 1000MG LIMITED TO 10 TABLETS/FILL & 2 FILLS/MONTH (PROQUIN XR NONFORMULARY)
	\$\$	Norfloxacin	NOROXIN
PA	\$\$	Ofloxacin	FLOXIN, PA REQ

CD1	\$\$\$	Ciprofloxacin Suspension	CIPRO SUSPENSION, CODE 1 (OVERRIDE IF CYSTIC FIBROSIS, LOWER RESP INFECTION IN PATIENTS ≥50 YRS, OR OSTEOMYELITIS)
QL	\$\$\$	Levofloxacin	LEVAQUIN, LIMITED TO #10 PER FILL
Tetracyclines			
	\$	Doxycycline Monohydrate	MONODOX CAPSULES (VIBRAMYCIN, ADOXA, DORYX, ORACEA NONFORMULARY)
	\$\$	Minocycline Capsules	MINOCIN CAPSULES (EFFECTIVE 12/17/09) OTHER MINOCYCLINE DOSAGE FORMS NON-FORMULARY
MD	\$\$\$	Doxycycline 20mg Tablets	PERIOSTAT, SPECIALTY RESTRICTION

Antifungal Agents

	\$	Fluconazole Tablets	DIFLUCAN TABLETS
	\$	Ketoconazole	NIZORAL
	\$	Nystatin	MYCOSTATIN (ORAL POWDER NONFORMULARY)
	\$\$	Clotrimazole	MYCELEX
QL	\$\$	Terbinafine Tablets	LAMISIL TABLETS, (LAMISIL GRANULES NONFORMULARY)
	\$\$	Griseofulvin Tablets	GRISPEG GRIFULVIN V TABLETS FULVICIN U/F
AGE	\$\$\$	Fluconazole Suspension	DIFLUCAN SUSPENSION , MEMBERS > 12 YEARS OF AGE REQUIRE PA
AGE	\$\$\$	Griseofulvin Suspension	GRIFULVIN V SUSPENSION, MEMBERS > 12 YEARS OF AGE REQUIRE PA
PA	\$\$\$\$	Itraconazole	SPORANOX, PA REQ

Antihelmintic Agents

	\$	Mebendazole	VERMOX
	\$	Pyrantel Pamoate	PIN-RID
	\$	Thiabendazole	MINTEZOL
	\$\$	Furazolidone	FUOXONE

Antimalarial Agents

	\$	Primaquine	PRIMAQUINE
	\$	Hydroxychloroquine	PLAQUENIL
	\$	Pyrimethamine	DARAPRIM
	\$\$\$	Paromomycin	HUMATIN

Antituberculosis Agents

	\$	Isoniazid	ISONIAZID
	\$\$	Cycloserine	SEROMYCIN
	\$\$	Ethambutol	MYAMBUTOL
	\$\$	Pyrazinamide	PYRAZINAMIDE
	\$\$	Rifampin	RIFADIN
	\$\$\$	Ethionamide	TRECTOR-SC
	\$\$\$\$	Rifabutin	MYCOBUTIN
	\$\$\$\$	Rifapentine	PRIFTIN
PA	\$\$\$\$	Streptomycin	STREPTOMYCIN, PA REQ

Antiviral Agents

PA	\$\$\$\$\$	Elbasvir/Grazoprevir	ZEPATIER, PA REQ
	\$	Amantadine	SYMMETREL, BILL STATE EDS

	\$	Acyclovir Oral	ZOVIRAX ORAL
PA	\$\$\$	Famciclovir	FAMVIR, PA REQ
QL	\$\$\$	Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS. TAMIFLU SYRUP, QL OF #120ML PER 180 DAYS.(EFFECTIVE 2/15/12)
PA	\$\$\$	Ribavirin (200mg strength only)	COPEGUS, PA REQ
PA			REBETOL, PA REQ
PA	\$\$\$	Valacyclovir	VALTREX, PA REQ
	\$\$\$	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS (EFFECTIVE 10/1/09)
AGE	\$\$\$\$	Didanosine (ddl)	VIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Lamivudine	EPIVIR, BILL STATE EDS
	\$\$\$\$	Stavudine	ZERIT, BILL STATE EDS
AGE	\$\$\$\$	Zidovudine (AZT)	RETROVIR, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Abacavir	ZIAGEN, BILL STATE EDS
	\$\$\$\$\$	Abacavir/Lamivudine	EPZICOM, BILL STATE EDS
AGE, MD	\$\$\$\$\$	Adefovir Dipivoxil	HEPSERA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE, STEP THERAPY FOR BARACLUDE
	\$\$\$\$\$	Amprenavir/Vitamin E	AGENERASE, BILL STATE EDS
	\$\$\$\$\$	Atazanavir	REYATAZ, BILL STATE EDS
PA	\$\$\$\$\$	Cidofovir	VISTIDE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Darunavir	PREZISTA, BILL STATE EDS
	\$\$\$\$\$	Delavirdine	RESCRIPTOR, BILL STATE EDS
	\$\$\$\$\$	Efavirenz	SUSTIVA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine	EMTRIVA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine/Tenofovir	TRUVADA, BILL STATE EDS
	\$\$\$\$\$	Emtricitabine/Tenofovir/Efavirenz	ATRIPLA, BILL STATE EDS
	\$\$\$\$\$	Enfuvirtide	FUZEON, BILL STATE EDS
AGE, MD	\$\$\$\$\$	Entecavir	BARACLUDE, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Fosamprenavir	LEXIVA, BILL STATE EDS
PA	\$\$\$\$\$	Ganciclovir	CYTOVENE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Indinavir	CRIXIVAN, BILL STATE EDS
	\$\$\$\$\$	Lamivudine/Zidovudine	COMBIVIR, BILL STATE EDS
	\$\$\$\$\$	Nelfinavir	VIRACEPT, BILL STATE EDS
	\$\$\$\$\$	Nevirapine	VIRAMUNE, BILL STATE EDS
CD1	\$\$\$\$\$	Pentamidine, Aerosolized	NEBUPENT, CODE 1 (OVERRIDE IF HIV PATIENT WITH PNEUMOCYSTIS)
	\$\$\$\$\$	Ritonavir	NORVIR, BILL STATE EDS
	\$\$\$\$\$	Ritonavir/Lopinavir	KALETRA, BILL STATE EDS
	\$\$\$\$\$	Saquinavir	INVIRASE, BILL STATE EDS
AGE, MD, STEP	\$\$\$\$\$	Telbivudine	TYZEKA, RESTRICTED TO GASTROENTEROLOGISTS, MEMBERS <21 MAY BE CCS-ELIGIBLE, REQUIRES TRIAL OF BARACLUDE
	\$\$\$\$\$	Tenofovir	VIREAD, BILL STATE EDS
	\$\$\$\$\$	Tipranavir	APTIVUS, BILL STATE EDS
PA	\$\$\$\$\$	Valganciclovir	VALCYTE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$\$	Zidovudine/Lamivudine/Abacavir	TRIZIVIR, BILL STATE EDS

Immunization

	\$\$	Influenza Virus Vaccine	VARIOUS (E.G. FLUBLOK, MANY OTHERS)
PA	\$\$\$\$	Immune Globulin Vaccine	VARIOUS

AGE	\$\$\$	Pneumococcal Vaccine	PNEUMOVAX, PRENVAR
AGE	\$\$\$	Meningococcal Vaccines	MENACTRA, MENOMUNE, BEXSERO, MENVEO NOTE:
AGE	\$\$\$	Rabies Vaccines	IMOVAX ETC
AGE	\$\$\$	Tetanus and Diptheria Vaccine	DECAVAC ETC
AGE	\$\$\$	Varicella Virus Vaccine	VARIVAX ETC
AGE	\$\$\$	Zoster Vaccine	ZOSTAVAX
AGE	\$\$\$	Hepatitis A Vaccine	HAVRIX, VAQTA
AGE	\$\$\$	Hepatitis B Vaccine	RECOMBIVAX HB
AGE	\$\$\$	Hepatitis A&B Vaccine	TWINRX
AGE	\$\$\$	Measles, Mumps, and Rubella Vaccine	MMR NOTE
AGE	\$\$\$	Human Papillomavirus Vaccine	GARDASIL, CERVARIX

Leprostic Agents

	\$	Clofazimine	LAMPRENE
	\$	Dapsone	DAPSONE (ACZONE IS NONFORMULARY)

Sulfonamide Agents

	\$	Sulfamethoxazole/Trimethoprim (SMX/TMP)	BACTRIM
			SEPTRA
AGE	\$	Sulfasalazine	AZULFIDINE, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 5/1/09)
	\$	Sulfisoxazole	GANTRISIN
	\$	Trimethoprim	TRIMPEX

Miscellaneous Antibiotics

	\$	Metronidazole	FLAGYL (FLAGYL ER AND CAPSULES NONFORMULARY)
	\$\$	Clindamycin Capsules	CLEOCIN CAPSULES
AGE	\$\$\$	Clindamycin Oral Solution	CLEOCIN ORAL SOLUTION, LIMITED TO USE IN PATIENTS 6 YEARS OF AGE AND YOUNGER
STEP	\$\$\$\$\$	Atovaquone	MEPRON, STEP THERAPY (TRIAL OF TRIMETHOPRIM/SULFAMETHOXAZOLE)
PA	\$\$\$\$\$	Linezolid	ZYVOX, PA REQ

ANTINEOPLASTIC AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

AGE		Aldesleukin	PROLEUKIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Altretamine	HEXALEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Anastrozole	ARIMIDEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Asparaginase	ELSPAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Bevacizumab	AVASTIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Bexarotene	TARGRETIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Bicalutamide	CASODEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Bleomycin Sulfate	BLENOXANE, PA REQ, MEMBERS <21 MAY BE CCS- ELIGIBLE

PA	Bortezomib	VELCADE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Busulfan	MYLERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Capecitabine	XELODA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Carboplatin	PARAPLATIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Carmustine	BICNU, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Chlorambucil	LEUKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Cisplatin	PLATINOL-AQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Cladribine	LEUSTATIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Cyclophosphamide	CYTOXAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Cytarabine	CYTOSAR-U, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Dacarbazine	DTIC-DOME, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Dactinomycin	COSMEGEN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Dasatinib	SPRYCEL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Daunorubicin Citrate Liposome	DAUNOXOME, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Daunorubicin HCl	DAUNORUBICIN HCL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Docetaxel	TAXOTERE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Doxorubicin HCl	RUBEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Doxorubicin HCl Liposome	DOXIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Epirubicin	ELLENCE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Erlotinib	TARCEVA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Estramustine	EMCYT, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Etoposide	VEPESID, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Everolimus	AFINITOR, AFINITOR DISPERZ, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Exemestane	AROMASIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Floxuridine	FUDR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Fludarabine Phosphate	FLUDARA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Fluorouracil	ADRUCIL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Flutamide	EULEXIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Fulvestrant	FASLODEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Gefitinib	IRESSA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Gemcitabine HCl	GEMZAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Gemtuzumab Ozogamicin	MYLOTARG, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Goserelin Acetate	ZOLADEX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Hydroxyurea	HYDREA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Ifosfamide	IFEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Imatinib	GLEEVEC, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Interferon Alfa-2b	INTRON-A, PA REQ
AGE	Irinotecan	CAMPTOSAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lapatinib	TYKERB, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Lenalidomide	REVLIMID, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Letrozole	FEMARA, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Leucovorin	WELLCOVORIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Leuprolide Acetate	LUPRON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Lomustine	CEENU, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	Mechlorethamine HCl	MUSTARGEN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	Megestrol	MEGACE (MEGACE ES NONFORMULARY)
AGE	Melphalan	ALKERAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Mercaptopurine	PURINETHOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Methotrexate Tablets	RHEUMATREX, MEMBERS <21 MAY BE CCS-ELIGIBLE, 2.5MG TABLETS ONLY (OTHER STRENGTHS AND DOSE PACKS NONFORMULARY) (EFFECTIVE 5/1/09)
AGE	Methotrexate Injection	METHOTREXATE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	Mitomycin	MUTAMYCIN, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE		Mitotane	LYSODREN, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Mitoxantrone	NOVANTRONE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Nilotinib	TASIGNA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Nilutamide	NILANDRON 50MG, 150MG, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Ofatumumab	ARZERRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Oprelvekin	NEUMEGA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Oxaliplatin	ELOXATIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Paclitaxel	TAXOL, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Panitumumab	VECTIBIX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Pazopanib	VOTRIENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Pegaspargase	ONCASPAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Peginterferon Alfa-2b	PEGINTRON, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
AGE		Pentostatin	NIPENT, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Porfimer	PHOTOFRIN, PA REQ MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Pralatrexate	FOLOTYN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Procarbazine	MATULANE, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Romidepsin	ISTODAX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Sorafenib	NEXAVAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Streptozocin	ZANOSAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Sunitinib	SUTENT, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Tamoxifen Citrate	NOLVADEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Temozolomide	TEMODAR, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Teniposide	VUMON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA		Thalidomide	THALOMID, PA REQ
AGE		Thioguanine	THIOGUANINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Thiotepa	THIOPLEX, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Topotecan HCl	HYCAMTIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Toremifene	FARESTON, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Trastuzumab	HERCEPTIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Tretinoin	VESANOID, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Triptorelin	TRELSTAR, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
AGE		Valrubicin	VALSTAR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Vinblastine Sulfate	VELBAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Vincristine Sulfate	ONCOVIN, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Vinorelbine Tartrate	NAVELBINE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Vorinostat	ZOLINZA, MEMBERS <21 MAY BE CCS-ELIGIBLE

Immunosuppressant Agents

AGE	\$\$	Azathioprine	IMURAN, MEMBERS <21 MAY BE CCS-ELIGIBLE (AZASAN NONFORMULARY)
MD, AGE	\$\$\$\$	Cyclosporine Capsules	NEORAL CAPSULES, SPECIALTY RESTRICTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
MD, AGE			SANDIMMUNE CAPSULES, SPECIALTY RESTRICTION, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$\$\$	Mycophenolate	CELLCEPT, MEMBERS <21 MAY BE CCS-ELIGIBLE (MYFORTIC NONFORMULARY) (EFFECTIVE 11/1/09)
PA	\$\$\$\$\$	Sirolimus	RAPAMUNE, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/10)

CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

AGE	\$	Amiodarone 200mg	CORDARONE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10) (OTHER AMIODARONE STRENGTHS NONFORMULARY)
AGE	\$	Mexiletine	MEXITIL MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Procainamide	PRONESTYL MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Procainamide SR	PROCAN SR MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Quinidine Sulfate	QUINIDINE SULFATE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Quinidine Gluconate	QUINAGLUTE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$	Sotalol	BETAPACE MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Flecainide	TAMBOCOR MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE	\$\$	Sotalol	BETAPACE AF MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensives			
	\$	Reserpine	SERPASIL
Angiotensin Converting Enzyme Inhibitors			
	\$	Captopril	CAPOTEN
	\$	Enalapril	VASOTEC
	\$	Benazepril	LOTENSIN
	\$	Lisinopril	ZESTRIL
	\$	Ramipril	ALTACE
	\$	Trandolapril	MAVIK
	\$	Quinapril	ACCUPRIL
Angiotensin Receptor Blockers			
QL	\$	Losartan	COZAAR QL OF #1/DAY
QL	\$	Losartan/HCTZ	HYZAAR QL OF #1/DAY
QL,ST	\$\$	Valsartan	DIOVAN QL OF #1/DAY
QL,ST	\$\$	Valsartan/HCTZ	DIOVAN HCT QL OF #1/DAY
QL	\$	Irbesartan	AVAPRO QL OF #1/DAY
QL	\$	Irbesartan/HCTZ	AVALIDE QL OF #1/DAY
Beta-Adrenergic Antagonists			
	\$	Acebutolol	SECTRAL
	\$	Atenolol	TENORMIN
	\$	Timolol	BLOCADREN
	\$	Metoprolol Tartrate	LOPRESSOR
	\$	Nadolol	CORGARD
	\$	Pindolol	VISKEN
	\$	Propranolol	INDERAL
	\$\$	Betaxolol	KERLONE
	\$\$	Bisoprolol	ZEBETA

	\$\$	Metoprolol Succinate	TOPROL XL
Combination Alpha-Beta Antagonists			
	\$	Labetalol	NORMODYNE
			TRANDATE
	\$\$	Carvedilol	COREG
			(COREG CR NONFORMULARY)
Calcium Channel Blockers			
QL	\$	Amlodipine	NORVASC: QL of #60
QL	\$	Diltiazem	CARDIZEM:
	\$	Nifedipine	ADALAT
			PROCARDIA
	\$	Verapamil	CALAN
	\$\$	Diltiazem ER (24 hr)	Diltiazem ER 24hr (QL OF #1 / DAY) Cardizem CD (QL OF #1 / DAY) Diltia XT(QL OF #1 / DAY) (Cardizem LA – Nonformulary) (Effective 4/1/12)
	\$\$	Diltiazem ER (12 hr)	Diltiazem ER 12hr (QL of #2 / day) Cardizem SR (QL of #2 / day) (Effective 4/1/12)
	\$\$	Felodipine	PLENDIL
	\$\$	Nifedipine, Sustained Release	ADALAT CC
			PROCARDIA XL
	\$\$	Verapamil SR Tablets	CALAN SR (COVERA-HS NONFORMULARY)
STEP	\$\$\$	Amlodipine/Benazepril	LOTREL, STEP THERAPY (TRIAL OF AMLODIPINE AND BENAZEPRIL)
	\$\$\$	Verapamil LA Capsules	VERELAN VERELAN PM
Centrally Acting Antihypertensives			
	\$	Clonidine	CATAPRES
	\$	Methyldopa	ALDOMET
	\$	Guanfacine	TENEX (INTUNIV NONFORMULARY)
Combination Antihypertensives			
	\$	Hydralazine/HCTZ	HYDRA-ZIDE
	\$	Benazepril/HCTZ	LOTENSIN HCT
	\$	Bisoprolol/HCTZ	ZIAC
	\$	Captopril/HCTZ	CAPOZIDE
	\$	Enalapril/HCTZ	VASERETIC
	\$	Methyldopa/HCTZ	ALDORIL
	\$\$	Metoprolol/HCTZ	LOPRESSOR HCT
	\$	Quinapril/HCTZ	ACCURETIC
Potassium-Sparing Diuretics			
	\$	Spironolactone	ALDACTONE
	\$	Spironolactone/HCTZ	ALDACTAZIDE
	\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
			MAXZIDE 25
	\$\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50
	\$\$	Triamterene	DYRENIUM
Loop Diuretics			
	\$	Furosemide	LASIX
STEP	\$	Bumetanide	BUMEX (REQUIRES TRIAL OF FUROSEMIDE IN PREVIOUS 12 DAYS)
	\$\$	Ethacrynic Acid	EDECIN
Thiazide and Related Diuretics			

	\$	Chlorothiazide	DIURIL
	\$	Chlorthalidone	HYGROTON
	\$	Hydrochlorothiazide Tablets (HCTZ)	HYDRODIURIL (SOLUTION NONFORMULARY)
PA	\$	Hydrochlorothiazide Capsules	MICROZIDE, PA REQ
	\$	Indapamide	LOZOL
	\$\$	Metolazone	ZAROXOLYN
Vasodilator Antihypertensives			
AGE	\$	Doxazosin Mesylate	CARDURA MEMBERS <21 MAY BE CCS-ELIGIBLE (CARDURA XL NONFORMULARY)
	\$	Hydralazine	APRESOLINE
AGE	\$	Prazosin	MINIPRESS MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Terazosin	HYTRIN MEMBERS <21 MAY BE CCS-ELIGIBLE

Antilipidemic Agents

	\$	Fish Oil, over-the-counter	FISH OIL, OVER-THE-COUNTER (EFFECTIVE 4/1/12)
	\$	Cholestyramine	QUESTRAN
			QUESTRAN LIGHT
	\$	Gemfibrozil	LOPID
	\$	Lovastatin	MEVACOR
	\$	Simvastatin	ZOCOR
	\$\$	Pravastatin	PRAVACHOL
	\$	Pravastatin	PRAVACHOL
QL	\$\$	Atorvastatin	LIPITOR
ST QL	\$\$\$	Rosuvastatin	CRESTOR ST REQUIRED (TRIAL OF SIMVASTATIN 40MG AND ATORVASTATIN) FOR 5MG; ST REQUIRED (TRIAL OF ATORVASTATIN) FOR 10MG AND 20MG; TABLET SPLITTING REQUIRED (USE 1/2 40MG FOR 20MG DOSE; USE 1/2 20MG FOR 10MG DOSE; USE 1/2 10MG FOR 5MG DOSE) (EFFECTIVE 7/15/12)
ST	\$\$	Fenofibrate	LOFIBRA, STEP THERAPY (TRIAL OF GEMFIBROZIL OR CONCURRENT STATIN REQUIRED) (TRICOR, TRIGLIDE, LIPOFEN, FENOGLIDE, ANTARA, TRILIPIX NONFORMULARY) (EFFECTIVE 8/15/09)
PA	\$\$\$	Ezetimibe	ZETIA, PA REQ

Coagulants and Anticoagulants

	\$	Warfarin Sodium	COUMADIN
	\$	Heparin Sodium	HEPARIN
	\$\$	Anagrelide	AGRYLIN
	\$\$	Cilostazol	PLETAL
	\$\$	Ticlopidine	TICLID
ST	\$\$	Aspirin/dipyridamole	AGGRENOX STEP THERAPY OF A TRIAL OF ASPIRIN (EFFECTIVE 12/28/11)
AGE	\$	Clopidogrel	PLAVIX <21 MAY BE CCS-ELIGIBLE
QL	\$\$\$	Rivaroxaban	XARELTO
	\$\$\$\$	Dalteparin Syringes	FRAGMIN SYRINGES; SYRINGES ONLY, LIMITED TO 10 SYRINGES/FILL & 2 FILLS/YEAR
	\$\$\$\$	Enoxaparin Syringes	LOVENOX SYRINGES, SYRINGES ONLY, LIMITED TO 20 SYRINGES/FILL & 2 FILLS/YEAR
	\$\$\$\$	Fondaparinux	ARIXTRA, MAXIMUM OF 10 SYRINGES /FILL & 2 FILLS/YEAR
	\$\$\$\$	Tinzaparin	INNOHEP, MAXIMUM OF 10 VIALS/FILL & 2 FILLS/YEAR

Cardiac Glycoside Agents			
	\$	Digoxin	LANOXIN (LANOXICAPS NONFORMULARY)
Hemorheologic Agents			
	\$	Pentoxifylline	TRENTAL
Vasodilating Agents			
	\$	Isosorbide Dinitrate	ISORDIL (CHEW TABLETS NONFORMULARY)
	\$	Nitroglycerin Sublingual	NITROSTAT SL
	\$	Nitroglycerin Ointment	NITROL
	\$\$	Isosorbide Mononitrate	IMDUR
PA			ISOTRATE ER, PA REQ
	\$\$	Nitroglycerin Patches	NITRODUR
Agents for Pulmonary Hypertension			
PA, AGE		Sildenafil Citrate	REVATIO, PA REQ , CCS AGE EDIT (MEMBERS <21 MAY BE CCS ELGIBLE) (EFFECTIVE 6/1/11)
PA, AGE		Tadalafil Tablets	ADCIRCA, PA REQ , CCS AGE EDIT (MEMBERS <21 MAY BE CCS ELGIBLE) (EFFECTIVE 6/1/11)
CENTRAL NERVOUS SYSTEM AGENTS			
Analgesic and Anti-Inflammatory Agents			
	<i>Analgesics</i>		
	\$	Acetaminophen	TYLENOL
AGE	\$	Tramadol	ULTRAM; MAXIMUM OF 8 TABLETS/DAY (EFFECTIVE 10/15/09)
			(ULTRAM ER NONFORMULARY)
	<i>Migraine Agents</i>		
	\$	APAP/Dichloralphenazone/ Isometheptene	MIDRIN
	\$	Butalbital/ASA/Caffeine/Codeine	FIORINAL W/CODEINE #3, MAXIMUM #45/RX, 3 RXS/75 DAYS
	\$	Butalbital/APAP/Caffeine	ESGIC FIORICET
	\$	Butalbital/ASA/Caffeine	FIORINAL
	\$\$	Ergotamine/Caffeine	CAFERGOT
	\$\$	Sumatriptan Tablets	IMITREX TABLETS, TRIAL OF TRIPTAN(EFFECTIVE 12/17/09)
STEP	\$\$\$\$	Sumatriptan Injection	IMITREX INJECTION, STEP THERAPY (TRIAL OF SUMATRIPTAN TABLETS), QUANTITY LIMIT OF 2 INJECTIONS PER MONTH (EFFECTIVE 12/17/09)
STEP	\$\$\$\$	Sumatriptan Nasal	IMITREX NASAL, STEP THERAPY (TRIAL OF SUMATRIPTAN TABLETS), QUANTITY LIMIT OF 6 NASAL SPRAYS PER MONTH (EFFECTIVE 12/17/09)

Opiate Agonists			
QL	\$	Acetaminophen/Codeine	TYLENOL #2, MAXIMUM #120/30 DAYS TYLENOL #3, MAXIMUM #120/30 DAYS TYLENOL #4, MAXIMUM #120/30 DAYS
QL	\$	Acetaminophen/Hydrocodone	NORCO MEDI-CAL QUANTITY RESTRICTION, 3 RXS / 75 DAYS, GENERICS ONLY . QL OF MAXIMUM #6/DAY. FILL LIMIT OF #3/75DAYS. SOLUTION QL OF MAXIMUM #1770 ML/MO. FILL LIMIT OF #3/75DAYS VICOPROFEN QL OF #90/30
	\$	Codeine/Aspirin	EMPIRIN #2, MAXIMUM #60/RX, 3 RXS/75 DAYS EMPIRIN #3, MAXIMUM #45/RX, 3 RXS/75 DAYS
QL, MD	\$	Methadone	METHADONE, MAXIMUM #120/RX FOR 5MG, #240/RX FOR 10MG 3RXS/75 DAYS. SPECIALIST PRESCRIBERS ONLY: PAIN MANAGEMENT, ANESTHESIOLOGY, HEMATOLOGY, AND ONCOLOGY
QL	\$	Oxycodone/Acetaminophen	PERCOCET (7.5MG/500MG NONFORMULARY) TYLOX, MAXIMUM #120/RX, 3RXS/75 DAYS
QL	\$	Oxycodone/Aspirin	PERCODAN MAXIMUM #120/RX, 3RXS/75 DAYS
QL	\$\$	Hydromorphone	DILAUDID, MAXIMUM #180/RX, 3RXS/75 DAYS (DILAUDID SYRUP NONFORMULARY)
	\$\$	Meperidine	DEMEROL
QL	\$\$	Morphine	MSIR, MAXIMUM #90/RX, 3 RX/75 DAYS
	\$\$	Morphine SR	MS CONTIN, MAXIMUM #60/MONTH (KADIAN AND AVINZA NONFORMULARY)
PA	\$\$\$\$	Fentanyl Transdermal Patch	DURAGESIC, PA REQ
PA	\$\$\$\$	Oxycodone	OXYCONTIN, PA REQ
PA	\$\$\$\$	Fentanyl Lozenge	ACTIQ, PA REQ
Anti-Inflammatory Agents			
First Line Agents			
	\$	Aspirin	ECOTRIN
	\$	Diclofenac Potassium	CATAFLAM (ZIPSOR NONFORMULARY)
	\$	Flurbiprofen	ANSAID
	\$	Ibuprofen	MOTRIN
	\$	Indomethacin	INDOCIN (INDOCIN SUPPOSITORY, INDOCIN SR NONFORMULARY)
	\$	Naproxen	NAPROSYN, ANAPROX (NAPROXEN SODIUM SUSTAINED-ACTION NONFORMULARY)
	\$	Salsalate	DISALCID
	\$	Sulindac	CLINORIL
	\$\$	Choline Mag. Trisalicylate	TRILISATE
	\$\$	Diclofenac Sodium	VOLTAREN
	\$\$	Diflunisal	DOLOBID
	\$\$	Etodolac	LODINE (LODINE XL NONFORMULARY)
	\$\$	Fenoprofen	NALFON (NALFON CAPSULES NONFORMULARY)
	\$\$	Tolmetin Sodium	TOLECTIN
Second Line Agents			
QL	\$\$	Ketoprofen	ORUVAIL, QL OF #4 / DAY (EFFECTIVE 2/15/12) (COMPOUNDED KETOPROFEN NONFORMULARY). QL OF #4/DAY.
	\$\$	Leflunomide	ARAVA (EFFECTIVE 5/15/10)
	\$\$\$\$	Auranofin (Gold)	RIDAURA
QL	\$\$	Meloxicam	MOBIC, QL OF #1 / DAY (EFFECTIVE 2/15/12) (MELOXICAM SUSPENSION NONFORMULARY). QL OF #1/DAY

QL	\$\$	Nabumetone	RELAFEN, QL OF #2 / DAY (EFFECTIVE 2/15/12). QL OF #2/DAY
QL	\$\$	Ketorolac	TORADOL, LIMITED TO 5 DAYS TREATMENT (EFFECTIVE 2/15/12). QL OF #20/5 DAYS SUPPLY
AGE, STEP	\$\$\$\$	Celecoxib	CELEBREX, STEP THERAPY AND AGE EDITS (RESTRICTED TO PATIENTS WITH GI RISK [60 YEARS AND OLDER OR ON WARFARIN], SUBMIT PA FOR OTHER GI RISK FACTORS. PATIENTS <21 YEARS MAY BE CCS ELIGIBLE) (CELEBREX 400MG NONFORMULARY)
PA	\$\$\$\$	Diclofenac/Misoprostol	ARTHROTEC, PA REQ
PA	\$\$\$\$	Adalimumab	HUMIRA, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)
PA	\$\$\$\$	Etanercept	ENBREL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 4/1/10)
NOTE: NSAID COMPOUNDS ARE NOT A COVERED PLAN BENEFIT			

Anticonvulsant Agents

AGE	\$	Carbamazepine	TEGRETOL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
QL	\$	Clonazepam	KLONOPIN, QUANTITY LIMIT OF #90 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (EFFECTIVE 3/1/2011) (KLONOPIN WAFERS NONFORMULARY)
AGE	\$	Phenobarbital	PHENOBARBITAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$	Phenytoin	DILANTIN, PHENYTEK, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$	Primidone	MYSOLINE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$	Valproic Acid	DEPAKENE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Divalproex Sodium	DEPAKOTE, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Ethosuximide	ZARONTIN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Gabapentin	NEURONTIN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
AGE	\$\$	Lamotrigine Tablets	LAMICTAL TABLETS, HALF TABLET EDITS, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 8/1/09) (LAMICTAL DOSE PACK, LAMICTAL XR, LAMICTAL ODT, & LAMOTRIGINE DISPERSIBLE TABLETS NONFORMULARY)
AGE	\$\$	Levetiracetam	KEPPRA, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 11/1/09)
PA	\$\$	Topiramate	TOPAMAX, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EFFECTIVE 8/1/10) (TOPAMAX SPRINKLE CAP ON FORMULARY WITH PA)
	\$\$	Zonisamide	ZONEGRAN, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
PA	\$\$\$	Carbamazepine SR Capsules	CARBATROL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE (EQUETRO NONFORMULARY)
	\$\$\$	Oxcarbazepine	TRILEPTAL, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE

PA	\$\$\$	Tiagabine	GABITRIL, PA REQ, MEMBERS <21 YEARS THAT ARE ON 2 OR MORE ANTICONVULSANTS MAY BE CCS ELIGIBLE
Antiparkinsonian Agents			
	\$	Trihexyphenidyl	ARTANE, BILL STATE EDS
	\$	Benzotropine Mesylate	COGENTIN, BILL STATE EDS
	\$\$	Amantadine	SYMMETREL, BILL STATE EDS
AGE	\$\$	Carbidopa/Levodopa	SINEMET, MEMBERS <21 MAY BE CCS-ELIGIBLE (PARCOPA NONFORMULARY)
	\$\$	Procyclidine HCl	KEMADRIN, BILL STATE EDS
	\$\$	Selegiline	ELDEPRYL
			EMSAM
			ZELAPAR
AGE	\$\$\$	Bromocriptine	PARLODEL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Carbidopa/Levodopa CR	SINEMET CR, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Pramipexole	MIRAPEX, MEMBERS <21 MAY BE CCS-ELIGIBLE (MIRAPEX ER NONFORMULARY)
AGE	\$\$\$	Ropinirole	REQUIP, MEMBERS <21 MAY BE CCS-ELIGIBLE
			(REQUIP STARTER KIT NONFORMULARY, REQUIP XR NONFORMULARY)
AGE	\$\$\$\$	Entacapone	COMTAN, MEMBERS <21 MAY BE CCS-ELIGIBLE
Muscle Relaxant Agents			
Skeletal Muscle Relaxants			
	\$\$	Tizanadine	ZANAFLEX (TABS ONLY)
	\$	Cyclobenzaprine	FLEXERIL
	\$	Methocarbamol	ROBAXIN
	\$\$	Baclofen	LIORESAL
	\$\$\$	Dantrolene Sodium	DANTRIUM
Psychotherapeutic Agents			
Antimanics			
	\$	Lithium Carbonate	ESKALITH, BILL STATE EDS
			LITHOBID, BILL STATE EDS
Antipsychotics			
	\$	Chlorpromazine	THORAZINE, BILL STATE EDS
	\$	Fluphenazine	PROLIXIN, BILL STATE EDS
	\$	Haloperidol	HALDOL, BILL STATE EDS
	\$	Perphenazine	TRILAFON, BILL STATE EDS
	\$	Thioridazine	MELLARIL, BILL STATE EDS
	\$	Thiothixene	NAVANE, BILL STATE EDS
	\$	Trifluoperazine	STELAZINE, BILL STATE EDS
	\$\$	Loxapine	LOXITANE, BILL STATE EDS
	\$\$\$	Clozapine	CLOZARIL, BILL STATE EDS
	\$\$\$	Molindone	MOBAN, BILL STATE EDS
	\$\$\$	Quetiapine	SEROQUEL, BILL STATE EDS
	\$\$\$	Risperidone	RISPERDAL, BILL STATE EDS
			RISPERDAL CONSTA, BILL STATE EDS
			RISPERDAL-M, BILL STATE EDS
	\$\$\$\$	Aripiprazole	ABILIFY, BILL STATE EDS
	\$\$\$\$	Olanzapine	ZYPREXA, BILL STATE EDS

	\$\$\$\$	Olanzapine/Fluoxetine	SYMBYAX, BILL STATE EDS
	\$\$\$\$	Paliperidone	INVEGA, BILL STATE EDS
Miscellaneous Anxiolytics, Hypnotics and Sedatives			
	\$	Chloral Hydrate	NOCTEC
	\$	f HCl	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
QL	\$	Zolpidem	AMBIEN, QUANTITY LIMIT TO #30 PER MONTH (Effective 3/1/11) (AMBIEN CR, EDLUAR NONFORMULARY)
	\$\$	Buspirone	BUSPAR
QL	\$\$\$	Zaleplon	SONATA, QUANTITY LIMIT TO #30 PER MONTH (Effective 3/1/11)
Benzodiazepines			
QL	\$	Diazepam	VALIUM (DIAZEPAM SOLUTION AND ORAL CONCENTRATE NONFORMULARY), QUANTITY LIMIT OF #90 PER MONTH
QL	\$	Alprazolam	XANAX QUANTITY LIMIT TO #90 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (2MG STRENGTH, ORAL CONCENTRATE, XANAX XR & NIRAVAM ARE NONFORMULARY)
	\$	Flurazepam	DALMANE
	\$	Temazepam	RESTORIL (7.5MG & 22.5MG STRENGTHS NONFORMULARY)
	\$	Triazolam	HALCION
QL	\$	Lorazepam	ATIVAN, QUANTITY LIMIT OF #60 PER MONTH; FILL LIMITS OF #3 IN 75 DAYS (LORAZEPAM ORAL CONCENTRATE NONFORMULARY)
Cholinesterase Inhibitors			
QL	\$	Donepezil	ARICEPT, QL OF #1 / DAY (ARICEPT ODT - PA REQUIRED)
PA	\$\$\$	Galantamine	RAZADYNE, PA REQ
PA	\$\$\$	Rivastigmine	EXELON, PA REQ (EXELON PATCHES NONFORMULARY)
SSRIs			
	\$	Fluoxetine	PROZAC (USE 2 X 20MG FOR 40MG DOSE) RAPIFLUX
	\$	Citalopram	CELEXA
	\$	Paroxetine	PAXIL
	\$	Sertraline	ZOLOFT TAB AND SOLN
MD	\$\$	Fluvoxamine	LUVOX, SPECIALTY RESTRICTION (LUVOX CR NONFORMULARY)
PA	\$\$\$	Paroxetine CR	PAXIL CR, PA REQ
	\$\$	Escitalopram Oxalate	LEXAPRO
Tricyclic Antidepressants			
	\$	Amitriptyline	ELAVIL
	\$	Desipramine	NORPRAMIN
	\$	Doxepin	SINEQUAN
	\$	Imipramine	TOFRANIL (TOFRANIL PM NONFORMULARY)
	\$	Nortriptyline	PAMELOR
			AVENTYL
	\$\$\$	Protriptyline	VIVACTIL
Miscellaneous Antidepressants			

MD	\$	Clomipramine	ANAFRANIL, SPECIALTY RESTRICTION
	\$	Trazodone	DESYREL
	\$\$	Mirtazapine Tablets	REMERON TABLETS, (7.5MG TABLETS NONFORMULARY, SOLTABS NONFORMULARY)
	\$\$	Nefazodone	SERZONE
	\$\$\$	Bupropion	WELLBUTRIN
			WELLBUTRIN SR
QL			WELLBUTRIN XL (LIMITED TO 1 TAB PER DAY)
			(APLENZIN NON-FORMULARY)
	\$	Venlafaxine	EFFEXOR
			EFFEXOR XR CAPSULES, QL OF #1 / DAY
QL	\$\$	Duloxetine	Cymbalta QL of #1/day for 60mg. 2/day of 20mg/30mg
ADHD Agents (Not covered as appetite suppressants)			
	\$	Methylphenidate	RITALIN, 60 DAY SUPPLY ALLOWED
AGE, STEP	\$\$	Dexmethylphenidate	FOCALIN, MEMBERS ≤18 REQUIRE STEP THERAPY (METHYLPHENIDATE AND MIXED AMPHETAMINE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Dextroamphetamine	DEXEDRINE, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Dextroamphetamine/Amphetamine	ADDERALL, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	METADATE CD, MEMBERS > 18 YEARS REQUIRE PA
AGE AGE	\$\$	Methylphenidate	METADATE ER, MEMBERS > 18 YEARS REQUIRE PA METHYLIN ER, MEMBERS > 18 YEARS REQUIRE PA RITALIN SR MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$	Methylphenidate	RITALIN LA, MEMBERS > 18 YEARS REQUIRE PA
AGE, STEP	\$\$\$	Dexmethylphenidate	FOCALIN XR, MEMBERS ≤18 REQUIRE STEP THERAPY (METHYLPHENIDATE AND MIXED AMPHETAMINE PREFERRED), MEMBERS > 18 YEARS REQUIRE PA
AGE, STEP	\$\$\$	Lisdexamfetamine	VYVANSE, MEMBERS ≤18 REQUIRE STEP THERAPY (METHYLPHENIDATE AND MIXED AMPHETAMINE PREFERRED) MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$\$	Methylphenidate	CONCERTA, MEMBERS > 18 YEARS REQUIRE PA
AGE	\$\$\$	Dextroamphetamine/Amphetamine	ADDERALL XR, MEMBERS > 18 YEARS REQUIRE PA
PA	\$\$\$\$	Atomoxetine	STRATTERA, PA REQ
Substance Abuse Agents			
	\$\$	Naltrexone	REVIA, BILL STATE EDS
	\$\$\$	Buprenorphine HCl	SUBUTEX, BILL STATE EDS
	\$\$\$	Buprenorphine HCl/Naloxone HCl	SUBOXONE, BILL STATE EDS
	\$\$\$\$	Naltrexone Microspheres	VIVITROL, BILL STATE EDS

DIABETIC AND THYROID AGENTS

Diabetic Agents

(May be eligible for CCS Coverage for members < 21 years of age)

Non-Sulfonylureas			
AGE	\$	Metformin	GLUCOPHAGE, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$	Metformin XR	GLUCOPHAGE XR
AGE	\$\$	Acarbose	PRECOSE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, PA	\$\$	Miglitol	GLYSET, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE	\$\$\$	Glucagon	GLUCAGON, MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Nateglinide	STARLIX, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Pioglitazone	ACTOS, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Pioglitazone/Glimepiride	DUETACT, STEP THERAPY (TRIAL OF ACTOS AND GLIMEPIRIDE REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Pioglitazone/Metformin	ACTOPLUS MET, STEP THERAPY (TRIAL OF ACTOS AND METFORMIN REQUIRED), MEMBERS <21 MAY BE CCS-ELIGIBLE
PA	\$\$\$	Repaglinide	PRANDIN, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone	AVANDIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone/Glimepiride	AVANDARYL, STEP THERAPY (TRIAL OF AVANDIA AND GLIMEPIRIDE), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Rosiglitazone/Metformin	AVANDAMET, STEP THERAPY (TRIAL OF AVANDIA AND METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Saxagliptin	ONGLYZA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 2/1/10)
AGE, STEP	\$\$\$	Sitagliptin	JANUVIA, STEP THERAPY (TRIAL OF METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Sitagliptin/Metformin	JANUMET, JANUMET XR, STEP THERAPY (TRIAL METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$	Sitagliptin/Simvastatin	JUVISYNC STEP THERAPY (TRIAL OF JANUVIA OR METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$\$\$	Exenatide XR	BYDUREON STEP THERAPY (TRIAL METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
Sulfonylureas			
AGE	\$	Chlorpropamide	DIABINESE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glimepiride	AMARYL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glipizide	GLUCOTROL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glipizide LA	GLUCOTROL XL, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Glyburide	DIABETA, MEMBERS <21 MAY BE CCS-ELIGIBLE MICRONASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolazamide	TOLINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$	Tolbutamide	ORINASE, MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE, STEP	\$\$	Glyburide/Metformin	GLUCOVANCE, STEP THERAPY (TRIAL OF GLYBURIDE OR METFORMIN), MEMBERS <21 MAY BE CCS-ELIGIBLE
Insulin Agents			
NOTE: PA REQUIRED FOR INSULIN PRE-FILLED SYRINGES.			
AGE	\$\$	Insulin	NOVO-NORDISK INSULINS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Human Insulin	NOVOLIN (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart	NOVOLOG (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Aspart Protamine/Insulin Aspart	NOVOLOG MIX (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Glargine	LANTUS (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE	\$\$\$	Insulin Lispro	HUMALOG (VIALS ONLY), MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)

AGE	\$\$\$	Human Insulin	HUMULIN N AND HUMULIN R (VIALS ONLY, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)
AGE	\$\$\$\$	Insulin NPL/Insulin Lispro	HUMALOG MIX 75/25, HUMULIN MIX (VIALS ONLY, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 6/1/11)

Thyroid Agents

	\$	Levothyroxine	LEVOTHROID
			LEVOXYL
		Antithyroids	
	\$	Propylthiouracil	PROPYLTHIOURACIL
	\$	Methimazole	TAPAZOLE
		Thyroid Hormones	
	\$\$	Liothyronine Sodium	CYTOMEL, MD SPECIALTY OF ENDOCRINOLOGY OR PSYCHIATRY

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

	\$	Bismuth Subsalicylate	PEPTO BISMOL
	\$	Diphenoxylate/Atropine	LOMOTIL
	\$	Kaolin/Pectin	KAOPECTATE
	\$	Loperamide	IMODIUM
	\$	Paregoric	PAREGORIC

Antiemetic Agents

	\$	Dimenhydrinate	DRAMAMINE
	\$	Meclizine	ANTIVERT
	\$	Metoclopramide	REGLAN (METOCLOPRAMIDE INTENSOL NONFORMULARY) (METOZOLV ODT NONFORMULARY)
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$	Prochlorperazine Maleate	COMPazine
	\$	Trimethobenzamide	TIGAN
AGE, QL	\$\$	Ondansetron Tablets and ODT	ZOFRAN TABLETS AND ODT, QUANTITY LIMIT OF #90 PER FILL AND 1 FILL PER MONTH, ONDANSETRON SOLUTION PA REQUIRED
PA	\$\$\$\$	Dronabinol	MARINOL, PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE
	\$\$\$\$	Aprepitant	EMEND, MEMBERS <21 MAY BE CCS-ELIGIBLE

Antimuscarinic/Antispasmodic Agents

	\$	Dicyclomine	BENTYL
	\$	Hyoscyamine	LEVSIN, LEVSIN SL

Anti-ulcer/Antipeptic Agents

\$	Aluminum Carbonate	BASALJEL
		TITRALAC
\$	Aluminum Hydroxide	ALTERNAGEL
\$	Calcium Carbonate	TUMS
\$	Cimetidine	TAGAMET
\$	Famotidine	PEPCID
\$	Magaldrate	RIOPAN

	\$	Magnesium Carbonate/Aluminum Hydroxide/Alginic Acid	GAVISCON
	\$	Magnesium Hydroxide/Aluminum Hydroxide	MAALOX
	\$	Magnesium Hydroxide/Aluminum Hydroxide/Simethicone	GELUSIL
QL	\$	Misoprostol	CYTOTEC, USE ½ OF 200MCG FOR 100MCG DOSE
	\$	Omeprazole	PRILOSEC; QL OF #1 / DAY (OTC VERSIONS NON-FORMULARY) (EFFECTIVE 4/1/12).
	\$	Ranitidine	ZANTAC (ZANTAC EFFERDOSE NONFORMULARY)
AGE			ZANTAC LIQUID, AGE RESTRICTION (MEMBERS >12 YEARS OF AGE REQUIRE PA)
	\$\$	Sucralfate	CARAFATE
ST	\$\$	Lansoprazole OTC 15mg Capsules	PREVACID 24HR, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE). (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
ST	\$\$	Lansoprazole 30mg Capsules	PREVACID 30MG CAPSULES, STEP THERAPY (TRIAL OF OMEPRAZOLE) (EFFECTIVE 2/1/10) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE). (FEDERAL LEGEND LANSOPRAZOLE 15MG CAPSULES NONFORMULARY, OTC IS PREFERRED FOR 15MG STRENGTH)
AGE, STEP	\$\$\$	Lansoprazole Solutabs	PREVACID SOLUTABS, AGE RESTRICTION & STEP THERAPY (RESTRICTED TO MEMBERS <6 YEARS OF AGE AND A HISTORY OF A TRIAL OF RANITIDINE IN THE PREVIOUS 120 DAYS, MEMBERS THAT DO NOT MEET BOTH CRITERIA REQUIRE PA) , PREVACID OTC 15MG AND PREVACID 30MG CAPSULES PREFERRED OVER SOLUTABS FOR PATIENTS WHO ARE ABLE TO SWALLOW CAPSULES (EFFECTIVE 2/1/10) (5DAYS SUPPLY IN THE PAST 120 DAYS. GRANDFATHER EXISTING MEMBERS THAT ARE ALREADY TAKING LANSOPRAZOLE).
AGE, STEP	\$\$\$	Mesalamine	ASACOL, STEP THERAPY (TRIAL OF SULFASALAZINE), MEMBERS <21 MAY BE CCS ELIGIBLE (EFFECTIVE 5/1/09)
QL	\$	Pantoprazole	PROTONIX, QL OF #1 PER DAY

Miscellaneous Gastrointestinal Agents

AGE	\$	Metoclopramide	REGLAN
AGE	\$\$\$	Amylase/Lipase/Protease	CREON, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
AGE			PANCREAZE, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
AGE			ZENPEP, MEMBERS <21 MAY BE CCS-ELIGIBLE (EFFECTIVE 8/1/10)
PA	\$\$\$	Mesalamine Suppository	CANASA, PA REQ, MEMBERS <21 MAY BE CCS ELIGIBLE
	\$\$\$	Pilocarpine	SALAGEN
	\$\$\$	Ursodiol	ACTIGALL (URSO FORTE NONFORMULARY)
PA	\$\$\$\$	Alosetron	LOTROXEX, PA REQ
ST	\$\$	Balsalazide	COLAZAL, REQUIRES TRIAL OF SULFASALAZINE

Laxative Agents

\$	Bisacodyl	DUCOLAX
\$	Docusate Sodium	COLACE
\$	Magnesium Hydroxide	MILK OF MAGNESIA
\$	Docusate Calcium	SURFAK
\$	Psyllium	METAMUCIL
\$	Sennosides	SENNA, (EFFECTIVE 10/1/09)
\$\$	Lactulose	CEPHULAC
		CHRONULAC
\$\$	Polyethylene Glycol 3350	MIRALAX

HEMATOLOGICAL DISORDERS

Hematinics, Other

PA, AGE	Epoetin Alfa	EPOGEN PA REQ AND CCS AGE EDIT. MEMBERS <21 MAY BE CCS ELIGIBLE (EFFECTIVE 6/1/11)
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GENITOURINARY AGENTS

Analgesics, Urinary Tract

\$	Phenazopyridine	PYRIDIUM
\$\$\$\$	Pentosan Polysulfate	ELMIRON

Anti-Infective Agents, Urinary

\$	Trimethoprim	TRIMPEX
\$\$	Methenamine	UREX
\$\$	Nitrofurantoin Macrocrystals	MACRODANTIN
		MACROBID
\$\$\$	Nitrofurantoin	FURADANTIN

Genitourinary Smooth Muscle Relaxant Agents

\$	Oxybutynin	DITROPAN
STEP \$	Oxybutynin Patch	OXYTROL, STEP THERAPY (TRIAL OF OXYBUTININ IMMEDIATE-RELEASE)
STEP \$	Oxybutynin SR	DITROPAN XL, STEP THERAPY (OXYBUTININ IMMEDIATE- RELEASE PREFERRED)
STEP \$	Tolterodine	DETROL, STEP THERAPY (OXYBUTININ IMMEDIATE- RELEASE PREFERRED IF AGE LESS THAN 65)
STEP \$\$\$	Tolterodine	DETROL LA, STEP THERAPY (OXYBUTININ IMMEDIATE- RELEASE PREFERRED IF AGE LESS THAN 65)
STEP \$	Trospium	SANCTURA, STEP THERAPY (OXYBUTININ IMMEDIATE- RELEASE PREFERRED IF AGE LESS THAN 65)

Parasympathomimetic (Cholinergic) Agents

\$	Bethanechol	URECHOLINE
\$\$	Neostigmine	PROSTIGMIN
\$\$	Pyridostigmine	MESTINON

Miscellaneous Genitourinary Agents

\$\$	Finasteride	PROSCAR, SPECIALTY RESTRICTION
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\$\$ Tamsulosin

FLOMAX, **STEP THERAPY (TRIAL OF TERAZOSIN OR DOXAZOSIN IF AGE LESS THAN 65)**

\$\$ Alfuzosin

UROXATRAL,

HORMONE AND CONTRACEPTIVE AGENTS

Adrenal Cortical Steroid Agents, Oral

\$	Dexamethasone	DECADRON (DEXPAK IS NONFORMULARY)
\$	Fludrocortisone Acetate	FLORINEF
\$	Hydrocortisone Oral	CORTEF
\$	Methylprednisolone	MEDROL
\$	Prednisone	DELTASONE ORASONE
\$	Prednisolone	PEDIAPRED PRELONE
AGE \$\$\$	Prednisolone Sodium Phosphate 10mg ODT	ORAPRED ODT -10MG STRENGTH ONLY, RESTRICTED TO PATIENTS 6 YEARS OF AGE AND YOUNGER (EFFECTIVE 2/1/10)

Androgen Agents

PA \$\$\$	Testosterone Gel	ANDROGEL, PA REQ
\$\$\$	Testosterone Injectable	TESTOSTERONE INJECTION
PA \$\$\$\$	Oxandrolone	OXANDRIN 2.5MG, PA REQ

Bisphosphonate Agents

\$\$	Alendronate Tablets	FOSAMAX (TABLETS ONLY) (FOSAMAX SOLUTION AND FOSAMAX PLUS D ARE NONFORMULARY),
PA \$\$\$\$	Pamidronate Injection	AREDIA, PA REQ
PA \$\$\$\$\$	Zoledronic Acid Injection	ZOMETA, PA REQ

HRT - Oral Estrogen Tablets

STEP \$	Estradiol Transdermal	CLIMARA PATCHSTEP THERAPY OF PREMARIN OR VIVELLE-DOT. QL OF #4 PATCHES/MONTH
QL	Estradiol	ESTRACE
\$	Estropipate	OGEN, ORTHO-EST, QL OF #1 / DAY (EFFECTIVE 2/15/12)
\$	Estradiol acetate	FEMTRACE, QL OF #1 / DAY (EFFECTIVE 2/15/12)
\$	Estrogens, Synthetic Conjugated	ENJUVA, QL OF #1 / DAY (EFFECTIVE 2/15/12)
PA \$	Synthetic Conjugated Estrogen	CENESTIN, PA REQ

HRT - Oral Estrogen / Progestin Tablets

\$\$	Estradiol/Norethindrone	ACTIVELLA, QL OF #1 / DAY
\$\$	Estradiol/Norgestimate	ORTHO-PREFEST (EFFECTIVE 10/15/11)
\$\$	Ethinyl Estradiol/Norethindrone	FEMHRT (EFFECTIVE 10/15/11)
\$\$	Estrogen, conjugated/Medroxyprogesterone	PREMPRO PREMPHASE

HRT- Oral Estrogen / Testosterone Tablets

\$	Sodium Estrone (Estropiate)	ORTHO-EST (EFFECTIVE 10/15/11)
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HRT - Transdermal Estrogen System

\$	Estradiol Patches	CLIMARA; QL OF # 4 PATCHES / MO (EFFECTIVE 2/15/12)
\$\$	Estradiol Patches	VIVELLE-DOT; QL OF #8 PATCHES / MO (EFFECTIVE 2/15/12)

HRT - Intravaginal Estrogen System

	\$	Estradiol Vaginal Tablet	VAGIFEM
	\$\$	Estradiol Vaginal Cream	ESTRACE (EFFECTIVE 2/15/12)
	\$\$	Estradiol Vaginal Cream	PREMARIN (EFFECTIVE 2/15/12)
STEP	\$\$\$	Estradiol Vaginal Ring	ESTRING, STEP THERAPY (VAGIFEM, ESTRACE, OR PREMARIN CREAM PREFERRED; EFFECTIVE 2/15/12)
STEP	\$\$\$	Estradiol Vaginal Ring	FEMRINGSTEP THERAPY (VAGIFEM, ESTRACE, OR PREMARIN CREAM PREFERRED; EFFECTIVE 2/15/12)

Selective Estrogen Receptor Modulator

\$\$	Raloxifene	EVISTA
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Contraceptive Agents

Monophasic Oral Contraceptives

\$	Desogestrel/Ethinyl Estradiol	DESOGEN
\$	Ethinodiol/Ethinyl Estradiol	DEMULEN
\$	Levonorgestrel/Ethinyl Estradiol	ALESSE
		NORDETTE
\$	Norethindrone	NOR QD
\$	Norethindrone Acetate/Ethinyl Estradiol	LOESTRIN
		LOESTRIN FE
		(LOESTRIN 24 FE NONFORMULARY)
\$	Norethindrone/Ethinyl Estradiol	JENEST-28
		MODICON
		NELOVA
		NORINYL
\$	Norethindrone/Mestranol	NORINYL 1/50
\$	Norgestimate/Ethinyl Estradiol	ORTHO CYCLEN
\$	Norgestrel/Ethinyl Estradiol	LO/OVRAL
		OVRAL

Triphasic Oral Contraceptives

\$	Desogestrel/Ethinyl Estradiol	CYCLESSA
\$	Levonorgestrel/Ethinyl Estradiol	TRIPHASIL
\$	Norethindrone/Ethinyl Estradiol	TRI-NORINYL
		ORTHO-NOVUM
\$	Norgestimate/Ethinyl Estradiol	ORTHO TRI-CYCLEN

Miscellaneous Contraceptives

\$	Latex Condoms	VARIOUS
\$	Nonoxynol 9	CONCEPTROL
		ENCARE
		KOROMEX
\$	Levonorgestrel	PLAN B, , NEXT CHOICE: FEMALE ONLY; QL OF #2 IN 30 DAYS; #6 DISPENSINGS IN ANY 12 MONTH PERIOD; PLAN B ONE STEP, NEXT CHOICE ONE STEP; QL OF #1 IN 30 DAYS; #6 DISPENSINGS IN ANY 12 MONTH PERIOD.
\$	Diaphragms, Coil Spring,	ORTHO-DIAPHRAGM
\$	Medroxyprogesterone	DEPO-PROVERA 150MG/ML STRENGTH ONLY
\$\$	Etonogestrel/Ethinyl Estradiol	NUVARING
\$\$	Norelgestromin/Ethinyl Estradiol	ORTHO EVRA

Growth Hormone Agents

PA \$\$\$\$\$ Somatropin
PA

SEROSTIM, **PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE**
TEV-TROPIN, **PA REQ, MEMBERS <21 MAY BE CCS-ELIGIBLE**
(OTHER GROWTH HORMONES ARE NONFORMULARY)

Oxytocic Agents

 \$ Methylergonovine Maleate
 \$\$ Ergonovine Maleate

METHERGINE
ERGOTRATE

Pituitary Agents

AGE \$\$\$ Desmopressin
AGE

DDAVP TABLET, **MEMBERS <21 MAY BE CCS-ELIGIBLE**
DDAVP NASAL SPRAY,, **MEMBERS <21 MAY BE CCS-ELIGIBLE**

Progestin Agents

 \$ Medroxyprogesterone
PA \$\$\$\$ Hydroxyprogesterone Caproate

PROVERA
MAKENA, **PA REQ**

Miscellaneous Hormone Agents

 \$\$\$ Calcitonin Salmon

MIACALCIN

NEOPLASTIC DISEASE

Antineoplastic Systemic Enzyme Inhibitors

PA \$\$\$\$ Crizotinib

XALKORI, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 10/1/11)**

PA \$\$\$\$ Vandetanib

CAPRELSA, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 8/15/11)**

PA \$\$\$\$ Vemurafenib

ZELBORAF, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 5/1/12)**

Antineoplastic – Hedgehog Pathway Inhibitor

PA \$\$\$\$ Vismodegib
AGE

Erivedge, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 5/1/12)**

Antineoplastic – Halichondrin B Analogs

PA, \$\$\$ Eribulin Mesylate
AGE

HALAVEN, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 6/1/11)**

Antiandrogenic Agents

PA \$\$\$\$ Abiraterone acetate
AGE

ZYTIGA, **PA REQ; CCS AGE EDIT. MEMBERS <21 YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE 8/15/11)**

CYTOTOXIC T-LYMPHOCYTE ANTIGEN(CTLA-4)RMC ANTIBODY

PA \$\$\$\$ Ipilimumab
AGE

YERVOY, PA REQ; CCS AGE EDIT. MEMBERS <21
YEARS OLD MAY BE ELIGIBLE FOR CCS (EFFECTIVE
11/1/11)

NEUROLOGICAL DISEASE – MISCELLANEOUS

Agent to treat Multiple Sclerosis

PA \$\$\$ Glatiramer Acetate
PA \$\$\$ Interferon beta-1a

COPAXONE PA REQ (EFFECTIVE 3/1/2011)
REBIF PA REQ (EFFECTIVE 3/1/2011)

Amyotrophic Lateral Sclerosis Agent (ALS)

\$\$ Riluzole

RILUTEK

RESPIRATORY/ENT AGENTS

Adrenal Cortical Steroid Agents, Inhaled

\$\$ Beclomethasone
\$\$\$ Budesonide
\$\$\$ Budesonide
\$\$\$ Fluticasone Propionate
\$\$\$ Fluticasone Propionate
\$\$\$ Mometasone
\$\$\$ Flunisolide

QVAR
PULMICORT
PULMICORT RESPULES
FLOVENT HFA
FLOVENT DISKUS (EFFECTIVE 6/1/11)
ASMANEX
AEROSPAN

Antihistamine/Decongestant Agents

Antihistamine/Decongestant Combinations

AGE \$ Brompheniramine/Pseudoephedrine
AGE \$ Phenylephrine/Promethazine

DRIXORAL
PHENERGAN VC, USE CONTRAINDICATED IN MEMBERS <2
YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
BENADRYL ALLERGY DECONGESTANT
ACTIFED
DECONAMINE
CLARITIN-D

\$ Pseudoephedrine/Diphenhydramine
\$ Pseudoephedrine/Tripolidine
\$ Pseudoephedrine/Chlorpheniramine
\$\$ Pseudoephedrine/Loratadine

Antihistamines/Low or Non-Sedating

\$ Cetirizine

\$ Loratadine

PA \$\$\$ Fexofenadine

ZYRTEC TABLETS (EFFECTIVE 3/1/09)
ZYRTEC SYRUP (EFFECTIVE 3/1/09)
(ZYRTEC CHEWABLE TABLETS NONFORMULARY)
(EFFECTIVE 3/1/09)
CLARITIN
CLARITIN REDI-TABS
ALLEGRA TABLETS, PA REQ
(ALLEGRA SUSPENSION AND ALLEGRA ODT
NONFORMULARY)

Antihistamines

\$ Brompheniramine

\$ Chlorpheniramine
\$ Cyproheptadine
\$ Dexchlorpheniramine

DIMETAPP
(DIMETAPP SOLUTION NONFORMULARY)
CHLORTRIMETON
PERIACTIN
POLARAMINE

	\$	Diphenhydramine	BENADRYL
	\$	Hydroxyzine HCL	ATARAX
	\$	Hydroxyzine Pamoate	VISTARIL
AGE	\$	Promethazine	PHENERGAN, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
Decongestants			
	\$	Pseudoephedrine	SUDAFED KIDCARE DROPS
Expectorants			
	\$	Guaifenesin	ROBITUSSIN
	\$	Guaifenesin, Sustained Release	HUMBID LA
AGE	\$	Guaifenesin/Dextromethorphan	ANTITUSSIVE DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE			CHERACOL-D
			ROBITUSSIN DM. PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
	\$	Guaifenesin/Pseudoephedrine	ZEPHREX LA
	\$\$	Guaifenesin/Phenylephrine	GUAIFED
	\$\$	Potassium Iodide	ENTEX LA SSKI

Antitussive Agents

Narcotic Antitussives

	\$	Guaifenesin/Codeine	ROBITUSSIN AC
AGE, QL	\$	Promethazine/Codeine	PHENERGAN/CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
AGE	\$	Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE, USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
	\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
	\$	Triprolidine/Pseudoephedrine/ Codeine	TRIACIN-C

Non-Narcotic Antitussives

AGE	\$	Dextromethorphan HBr	TUSSIN PEDIATRIC, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Dextromethorphan/Pseudoephedrine/ Chlorpheniramine	KIDCARE COUGH AND COLD LIQUID, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Phenylephrine/Chlorpheniramine/ Dextromethorphan	CEROSE DM, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
AGE	\$	Promethazine/Dextromethorphan	PHENERGAN WITH DEXTROMETHORPHAN, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE, PROMETHAZINE USE CONTRAINDICATED IN MEMBERS <2 YEARS DUE TO RISK OF RESPIRATORY DEPRESSION
AGE	\$	Pseudoephedrine/Guaifenesin/ Dextromethorphan	BRONCOT, PA REQUIRED FOR ALL COUGH & COLD PRODUCTS CONTAINING DEXTROMETHORPHAN FOR PATIENTS LESS THAN 2 YEARS OF AGE
	\$\$	Benzonatate	TESSALON

Bronchodilator Agents

Inhaled Bronchodilator Agents

	\$	Terbutaline	BRETHINE
	\$\$	Albuterol	PROAIR HFA AND RESPICLICK
	\$\$	Ipratropium	ATROVENT HFA
	\$\$	Pirbuterol Acetate	MAXAIR AUTOHALER
	\$\$\$	Albuterol/Ipratropium	COMBIVENT RESPIMAT
	\$\$	Albuterol/Ipratropium	DUONEB
STEP	\$\$	Levalbuterol for Nebulization	XOPENEX FOR NEBULIZATION, STEP THERAPY (ALBUTEROL PREFERRED) (XOPENEX HFA NONFORMULARY)
AGE,	\$\$\$	Salmeterol	SEREVENT DISKUS, AGE RESTRICTION (MEMBERS LESS THAN 12 YEARS OF AGE REQUIRE PRIOR AUTHORIZATION)
	\$\$\$	Tiotropium	SPIRIVA HANDIHALER AND RESPIMAT
	\$\$\$	Aclidinium	TUDORZA PRESSAIR

Oral Sympathomimetics (Adrenergics)

AGE	\$	Albuterol Tablets Albuterol Syrup	PROVENTIL PROVENTIL SYRUP, ALBUTEROL SYRUP RESTRICTED TO MEMBERS ≤5 YEARS OF AGE
	\$	Metaproterenol Oral	ALUPENT
	\$	Terbutaline Sulfate	BRETHINE
	\$\$	Albuterol ER	BRICANYL PROVENTIL REPETABS VOLMAX

Beta-Adrenergic and Glucocorticoid Combinations

	\$\$\$	Mometasone/Formoterol	DULERA
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Inhaled/Oral EENT Agents

Carbonic Anhydrase Inhibitors

	\$	Acetazolamide	DIAMOX
	\$	Methazolamide	NEPTAZANE
	\$\$\$	Acetazolamide SA	DIAMOX SEQUELS

Inhaled Agents

	\$	Sodium Chloride	SALINE NOSE SPRAY
	\$\$	Flunisolide	FLUNISOLIDE
	\$\$	Fluticasone	FLONASE
AGE	\$\$\$	Mometasone	NASONEX RESTRICTED TO MEMBERS LESS THAN 4 YEARS OF AGE (EFF 7/1/09)

Miscellaneous EENT Agents

	\$	Sodium Chloride Solution for Inhalation	SODIUM CHLORIDE SOLUTION FOR INHALATION
	\$\$	Azelastine Nasal Spray	ASTELIN (ASTEPRO NONFORMULARY)
STEP	\$\$\$	Montelukast	SINGULAIR, STEP THERAPY (ASTHMA: TRIAL OF ANY COMMON ASTHMA MEDICATION SUCH AS BETA AGONIST, INHALED CORTICOSTEROID OR COMBO, ALLERGIC RHINITIS: TRIAL OF A NASAL STEROID OR NSA)
	\$\$\$	Zafirlukast	ACCOLATE

Local Anesthetics

	\$	Benzocaine/Antipyrine Otic	AURALGAN
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Mucolytic Agents

\$ Acetylcysteine MUCOMYST

Ophthalmic Agents

Ophthalmic Anti-Allergics

\$ Cromolyn Sodium Ophthalmic OPTICROM
 \$ Ketotifen Ophthalmic OTC ALAWAY, ZADITOR OTC, (FEDERAL LEGEND KETOTIFEN NONFORMULARY)
 \$ Naphazoline Ophthalmic VASOCON
 \$ Naphazoline/Pheniramine Ophthalmic NAPHCN-A
 MD \$\$ Lodoxamide Ophthalmic ALOMIDE, **RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY**
 MD \$\$ Nedocromil Sodium Ophthalmic ALOCRI, **RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY**
 STEP \$\$ Olopatadine Ophthalmic PATANOL, **STEP THERAPY (TRIAL OF OTC KETOTIFEN OPHTHALMIC)**
 MD \$\$ Pemirolast Ophthalmic ALAMAST, **RESTRICTED TO OPHTHALMOLOGY AND OPTOMETRY**

Ophthalmic Antibiotics

\$ Bacitracin Ophthalmic BACITRACIN
 \$ Bacitracin/Polymyxin Ophthalmic POLYSPORIN
 \$ Bacitracin/Polymyxin/Neosporin Ophthalmic OCUTRICIN
 \$ Ciprofloxacin Ophthalmic CILOXAN
 \$ Dexamethasone/Neomycin Ophthalmic NEO-DECADRON
 \$ Dexamethasone/Poly/Neomycin Ophthalmic MAXITROL
 \$ Erythromycin Base Ophthalmic ILOTYCIN
 \$ Gentamicin Ophthalmic GARAMYCIN
 \$ Neomycin/Gramicidin/Polymyxin Ophthalmic NEOSPORIN OPHTHALMIC
 \$ Ofloxacin Ophthalmic OCUFLOX
 \$ Polymixin B Sulfate/TMP Ophthalmic POLYTRIM
 \$ Tetracycline Ophthalmic ACHROMYCIN
 \$ Tobramycin Ophthalmic TOBREX
 MD \$\$ Levofloxacin Ophthalmic Ophthalmic QUIXIN, **SPECIALTY RESTRICTION (RESTRICTED TO OPHTHALMOLOGY)**
 ST \$\$ Moxifloxacin VIGAMOX, **STEP THERAPY (OPHTHALMIC CIPROFLOXACIN, OFLOXACIN, OR GENERIC POLYTRIM PREFERRED, OPHTHALMOLOGISTS EXEMPT FROM STEP THERAPY RESTRICTION) (EFFECTIVE 11/1/09)**
 \$\$ Tobramycin/Dexamethasone Ophthalmic TOBRADEX

Ophthalmic Anti-Inflammatories

\$ Dexamethasone Ophthalmic DEXASOL
 \$ Diclofenac Sodium Ophthalmic VOLTAREN (EFFECTIVE 3/1/09)
 \$ Fluorometholone Ophthalmic FML FORTE (FML S.O.P. NONFORMULARY)
 \$ Flurbiprofen Ophthalmic OCUFEN
 \$ Prednisolone Acetate Ophthalmic PRED MILD
 OMNIPRED
 PRED FORTE
 STEP \$\$ Loteprednol Ophthalmic LOTEMAX, **STEP THERAPY (PREDNISOLONE OR DEXAMETHASONE PREFERRED)**
 PA \$\$ Rimexolone Ophthalmic VEXOL, PA REQ

Ophthalmic Antiviral Agents

\$\$\$ Trifluridine Ophthalmic VIROPTIC

Ophthalmic Beta Blockers

\$ Carteolol Ophthalmic OCUPRESS

\$	Levobunolol Ophthalmic	BETAGAN
\$	Metipranolol Ophthalmic	OPTIPRANOLOL
\$	Timolol Ophthalmic	BETIMOL
		TIMOPTIC
\$\$\$	Betaxolol Ophthalmic	BETOPTIC S
	Ophthalmic Miotics	
\$	Carbachol Ophthalmic	ISOPTO
		CARBACHOL
\$	Pilocarpine Ophthalmic	PILOCAR
\$\$	Brimonidine Ophthalmic	ALPHAGAN P
\$\$	Demecarium Ophthalmic	HUMORSOL
\$\$	Echothiophate Iodide Ophthalmic	PHOSPHOLINE IODIDE
	Ophthalmic Mydriatics	
\$	Atropine Sulfate Ophthalmic	ISOPTO ATROPINE
\$	Cyclopentolate Ophthalmic	CYCLOGYL
\$	Dipivefrin Ophthalmic	PROPINE
\$	Phenylephrine Ophthalmic	MYDRIN
\$	Tropicamide Ophthalmic	MYDRIACYL
	Ophthalmic Sulfonamides	
\$	Sulfacetamide Ophthalmic	BLEPH-10
		SODIUM
		SULAMYD
		VASOCIDIN
\$	Sulfacetamide 10%/Prednisolone 0.25% Ophthalmic	
	Miscellaneous Ophthalmics	
\$	Polyvinyl Alcohol Ophthalmic	ARTIFICIAL TEARS
\$	Sodium Chloride Ophthalmic	MURO-128
\$\$	Brinzolamide	AZOPT
\$\$	Latanoprost	XALATAN
PA	\$\$\$ Cyclosporine Ophthalmic	RESTASIS, PA REQ
	\$\$\$ Dorzolamide/Timolol Ophthalmic	COSOPT

Otic Agents

Otic Anti-Infectives

\$	Acetic Acid 2% Otic	DOMEBORO
\$	Acetic Acid 2%/Hydrocortisone 1% Otic	VOSOL HC
\$	Neomycin/HC Otic	NEO-CORT-DOME
\$	Neomycin/Polymyxin Otic	POLY OTIC
\$	Neomycin/Polymyxin/HC Otic	CORTISPORON
\$\$	Neomycin/Colistin/HC Otic	COLY-MYCIN S
\$\$\$	Ciprofloxacin/Dexamethasone Otic	CIPRODEX
\$\$\$	Ciprofloxacin/Hydrocortisone	CIPRO HC
\$\$\$	Ofloxacin Otic	FLOXIN OTIC

Respiratory Smooth Muscle Relaxants

\$	Aminophylline 105mg/5cc	
\$	Theophylline	THEOLAIR
\$\$	Theophylline, 80mg/15cc (Alcohol Free)	ELIXOPHYLLIN
\$\$	Theophylline, Sustained Release	SLO-BID
		UNIPHYL

TOPICAL/MUCOUS MEMBRANE AGENTS

Anti-Acne Agents

	\$	Benzoyl Peroxide Gel	BENZAGEL
	\$	Benzoyl Peroxide 10% Wash	BENZAC AC DESQUAM-X
	\$	Clindamycin Topical Solution	CLEOCIN (CLINDAMYCIN PLEDGETS NONFORMULARY)
	\$	Erythromycin 2% Solution	T-STAT
AGE	\$\$	Tretinoin Cream and Tretinoin Gel	RETIN-A, AGE RESTRICTION < 25 YEARS OF AGE
STEP	\$\$\$	Benzoyl Peroxide/Clindamycin Gel	BENZAFLIN, STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED). QL OF #50GM IN 30DAYS
QL			
STEP			DUAC, STEP THERAPY (TOPICAL CLINDAMYCIN OR BENZOYL PEROXIDE PREFERRED)
MD	\$\$\$\$	Isotretinoin	AC CUTANE, SPECIALTY RESTRICTION

Keratolytic Agents

	\$\$\$	Podofilox	CONDYLOX
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Scabicide/Pediculicide Agents

	\$	Piperonyl butoxide/pyrethrins	RID
	\$	Piperonyl butoxide/pyrethrins	TRIPLE X
	\$	Permethrin	ELIMITE NIX
	\$\$	Malathion	OVIDE
	\$\$\$	Crotamiton	EURAX

Miscellaneous Skin/Mucous Membrane Agents

	\$	Aluminum Acetate	BURROW'S SOLUTION
	\$	Ammonium Lactate 12% Lotion	AMLACTIN
	\$	Calamine Lotion	CALAMINE
	\$	Capsaicin	CAPSAICIN
	\$	Coal Tar	FOTOTAR
	\$	Lidocaine, Viscous	XYLOCAINE
	\$	Mineral Oil	LUBAFAX
	\$	Vitamin A & D Cream	CLOCREAM
	\$\$	Fluorouracil	EFUDEX (EFUDEX OCCLUSION PACK NONFORMULARY)
	\$\$	Metronidazole 0.75% Cream	METROCREAM, (EFFECTIVE 11/1/09) (OTHER STRENGTHS NON-FORMULARY)
	\$\$	Metronidazole 0.75% Gel	METROGEL (OTHER STRENGTHS NON-FORMULARY) (METROGEL/SKIN CLENSER KIT AND METROGEL 1% NONFORMULARY)
PA	\$\$	Papain/Urea	ACCUZYME, PA REQ
PA	\$\$	Papain/Urea/Chlorophyllin	PANAFIL, PA REQ
	\$\$\$	Imiquimod	ALDARA, QUANTITY LIMIT OF 12 PER MONTH (EFFECTIVE 5/1/09)
PA	\$\$\$	Papain/Urea	PANAFIL WHITE, PA REQ
STEP	\$\$\$	Pimecrolimus	ELIDEL, STEP THERAPY (TOPICAL STEROID PREFERRED)
STEP	\$\$\$	Tacrolimus	PROTOPIC, STEP THERAPY (TOPICAL STEROID PREFERRED)
MD	\$\$\$	Tazarotene	TAZORAC, SPECIALTY RESTRICTION

MD	\$\$\$\$	Calcipotriene
PA	\$\$\$\$\$	Alitretinoin
	\$	Chlorhexidine
	\$	Sodium Chloride Irrigation Solution

DOVONEX, **SPECIALTY RESTRICTION**
 PANRETIN, **PA REQ**
 PERIDEX
 SEA-CLENSMI

Topical Antibiotic Agents

\$	Bacitracin Ointment
\$	Bacitracin/Polymyxin
\$	Bacitracin/Polymyxin/Neomycin
\$	Isopropyl Alcohol
\$	Povidone/Iodine
\$	Selenium Sulfide 2.5%
\$	Silver Sulfadiazine
\$	Tetracycline Ointment
\$	neomy sulf/bacitrac zn/poly
\$	neomycin/baci zn/pmyx bs/pramox
\$	neomycin/baci zn/pmyx bs/pramox
\$\$	Mupirocin Ointment

BACITRACIN
 POLYSPORIN
 NEOSPORIN
 ISOPROPYL ALCOHOL
 BETADINE
 SELSUN
 SILVADENE
 ACHROMYCIN
 NEOSPORIN
 TRIPLE ANTIBIOTIC PLUS
 NEOSPORIN
 BACTROBAN OINTMENT
 (BACTROBAN CREAM AND BACTROBAN NASAL
 NONFORMULARY)

Topical Antifungal Agents

	\$	Clotrimazole
	\$	clotrimazole/betamet diprop
	\$	Miconazole Nitrate
	\$	Nystatin
	\$	Tolnaftate
	\$	Econazole
	\$	Selenium sulfide 2.5% shampoo
	\$	Terbinafine 1% cream
	\$\$	Ketoconazole Cream
	\$\$	Ketoconazole Shampoo
PA	\$\$\$	Ciclopirox

LOTRIMIN
 LOTRISONE CREAM
 MONISTAT-DERM
 MYCOSTATIN
 TINACTIN
 SPECTAZOLE
 SELENIUM SULFIDE, QL OF #240ML / MO
 LAMISIL AT – OTC (**EFFECTIVE 8/15/11**)
 NIZORAL CREAM (**EFFECTIVE 2/15/12**)
 NIZORAL A-D SHAMPOO (**EFFECTIVE 2/15/12**)
 LOPROX, **PA REQ**
 (LOPROX SHAMPOO NONFORMULARY)

Topical Anti-Inflammatory Agents

Low Potency

	\$	Fluocinolone 0.025%
	\$	Hydrocortisone
	\$	Hydrocortisone Suppository
	\$	Hydrocortisone Acetate
ST	\$	Desonide
STEP	\$\$	Alclometasone Dipropionate
	\$\$	Hydrocortisone/Pramoxine
	\$\$\$	Hydrocortisone Enema
	\$	Betamethasone Dipropionate
	\$	Betamethasone Valerate
	\$	Triamcinolone

Medium Potency

SYNALAR
 HYTONE
 PROCTOSOL HC
 HEMORRHOIDAL HC
 CORTIFOAM
 PROCTOCORT
 DESOWEN
 ACLOVATE, **STEP THERAPY (TRIAL OF TOPICAL
 FLUOCINOLONE OR HYDROCORTISONE)**
 PROCTOCREAM-HC
 PROCTOFOAM HC
 CORTENEMA
 DIPROSONE
 MAXIVATE
 BETA-VAL
 KENALOG
 (TRIAMCINOLONE TOPICAL AEROSOL NONFORMULARY)

AGE	\$\$	Mometasone Furoate Cream	ELOCON , QUANTITY RESTRICTION OF 15GM AND FOR CHILDREN < 12 YEARS OF AGE
	\$\$\$	Flurandrenolide High Potency	CORDRAN
ST	\$	Clobetasol 0.05% Cream, Solution, Ointment, Gel	TEMOVATE CREAM, SOLUTION, OINTMENT, GEL (OTHER DOSAGE FORMS NON-FORMULARY)
ST	\$	Fluocinonide	LIDEX

Vaginal Antifungal Agents

	\$	Clotrimazole	MYCELEX-7&3
	\$	Miconazole	MONISTAT-7
	\$\$	Butoconazole	FEMSTAT
PA			GYNAZOLE-1, PA REQ
	\$\$	Miconazole (200mg Vaginal Suppository)	MONISTAT-3
STEP	\$\$	Terconazole	TERAZOL, STEP THERAPY (VAGINAL CLOTRIMAZOLE OR MICONAZOLE PREFERRED)

Vaginal Anti-Infective Agents

	\$\$	Clindamycin Vaginal Cream	CLEOCIN VAGINAL CREAM (CLINDESSE NONFORMULARY)
	\$\$	Metronidazole	METROGEL-VAGINAL

UNCLASSIFIED/MISCELLANEOUS AGENTS

Alcohol/Smoking Deterrents

	\$\$	Bupropion SR	ZYBAN
QL	\$	Nicotine Gum	NICORETTE GUM
QL	\$	Nicotine 24 Hour Patch	NICODERM CQ PATCH
PA	\$\$	Nicotine Lozenge	COMMIT LOZENGE, PA REQ
PA	\$\$	Nicotine 16 Hour Patch	NICOTROL PATCH, PA REQ
PA	\$\$\$	Nicotine Nasal Spray	NICOTROL NS, PA REQ
PA	\$\$\$	Nicotine Inhaler	NICOTROL CARTRIDGE INHALER, PA REQ
	\$\$\$	Disulfiram	ANTABUSE
PA	\$\$\$	Varenicline	CHANTIX, PA REQ

Weight Loss Agents

PA	\$\$	Phentermine	IONAMIN, PA REQ
PA	\$\$\$	Sibutramine	MERIDIA, PA REQ
PA	\$\$\$\$	Orlistat	XENICAL, PA REQ

Diagnostic Testing

Blood Glucose Test Strips

(* Ascensia Test Strips are preferred. Other test strips are nonformulary.)

AGE		Blood Glucose Testing Strips	ALL ASCENSIA (FORMERLY BAYER) TEST STRIPS (E.G. CONTOUR, CONTOUR NEXT, BREEZE 2) MEMBERS <21 MAY BE CCS-ELIGIBLE
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Urine Test Strips

AGE		Urine Acetone	CHEMSTRIP K MEMBERS <21 MAY BE CCS-ELIGIBLE
AGE		Urine Glucose	CHEMSTRIP UG MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE Urine Multiple Test

CHEMSTRIP-9 MEMBERS <21 MAY BE CCS-ELIGIBLE
KETO-DIASTIX MEMBERS <21 MAY BE CCS-ELIGIBLE

Electrolyte Agents

Potassium Agents

\$ Potassium Chloride Liquids

KAON-CL

\$\$ Potassium Chloride 10mEq

KAON-CL 10

\$\$ Potassium Chloride 20mEq

K-DUR

K-DUR

Misellaneous Electrolyte Agents

\$ Electrolytes, Oral Solution

PEDIALYTE

AGE \$\$\$\$ Sevelamer

RENAGEL, RENVELA MEMBERS <21 MAY BE CCS-ELIGIBLE

\$\$\$\$\$ Cinacalcet

SENSIPAR

Enzyme Agent

Gout Agents

\$ Allopurinol

ZYLOPRIM

\$ Colchicine

COLCHICINE

\$\$ Colchicine/Probenecid

COL-BENEMID

\$\$ Probenecid

BENEMID

Vitamin and Fluoride Agents

Calcium Agents

AGE \$ Calcium Acetate

PHOSLO, MEMBERS <21 MAY BE CCS-ELIGIBLE

AGE

PHOSLO GELCAP 667MG, MEMBERS <21 MAY BE CCS-ELIGIBLE

\$ Calcium Carbonate

OS-CAL 500

\$ Calcium Gluconate

CALCIUM

\$ Calcium Lactate

CALCIUM LACTATE

\$ Calcium Phosphate

DICALCIUM PHOSPHATE

Fluoride Agents

\$ Sodium Fluoride (Drops and Tablets)

LURIDE

Iron Agents

\$ Ferrous Sulfate

FERROUS SULFATE

Magnesium Agents

\$ Magnesium Lactate

MAGTAB-SR

\$ Magnesium Oxide

MAGOX, (EFFECTIVE 10/1/09)

Metabolic Deficiency Agents

\$\$ Levocarnitine

CARNITOR

Multivitamin Agents

\$ Fluoride/Polyvitamins (With and Without Iron; Drops and Tablets)

POLY-VI-FLOR

\$ Fluoride/Vitamins A,D,C, (With and Without Iron; Drops and Tablets)

TRI-VI-FLOR

\$ Multivitamin

DALY VITE

\$ Multivitamin with Iron

DALY VITE WITH IRON

\$ Multivitamin with Minerals

GERIATRIC

Prenatal Vitamin Agents

QL \$ Prenatal Multivitamins

CARENATE
MATERNITY-90

PRENAVITE

PRENATAL

Vitamin A

\$ Beta-Carotene

\$ Vitamin A

Vitamin B-Complex Agents

\$ Cyanocobalamin

\$ Folic Acid

\$ Folic Acid/Multivitamins with Minerals

\$ Niacin

\$ Pyridoxine

\$ Riboflavin

\$ Thiamine

\$ Vitamin B Complex/C

Vitamin C

\$ Ascorbic Acid

Vitamin D

\$ Ergocalciferol

\$ Cholecalciferol

\$\$ Calcitriol

\$\$\$ Dihydroxycholecalciferol

\$\$\$ Doxercalciferol

Vitamin E

\$ Vitamin E

Vitamin K Activity Agents

\$\$ Phytonadione

PRENATAL PLUS

PRENAPLUS

SOLATENE

AQUASOL-A

VITAMIN B-12

FOLIC ACID

VICON FORTE

NICOTINIC ACID

VITAMIN B-6

VITAMIN B-2

VITAMIN B-1

BEE WITH C

VITAMIN C

DRISDOL

VITAMIN D₃ (EFFECTIVE 11/1/10)

ROCALTROL

HYTAKEROL

HECTOROL

VITAMIN E

MEPHYTON

Anaphylaxis Kits

\$\$ Epinephrine

EIPEN

EIPEN JR

Metal Overload

\$\$\$ Succimer

CHEMET

Medical Devices

\$ Peak Flow Meter

\$ Tablet Splitter

\$\$ Inhaler Assistant Device Without Mask
(Spacer Without Mask)

PEAK FLOW METER

TABLET SPLITTER

VARIOUS, LIMIT OF 1 DEVICE PER YEAR IF OVER 18, 2

DEVICES PER YEAR IF UNDER 18

AEROCHAMBER (WITHOUT MASK) NONFORMULARY, ALL

OTHER SPACER BRANDS PREFERRED OVER

AEROCHAMBER (EFFECTIVE 8/1/09)

VARIOUS, LIMIT OF 2 DEVICE PER YEAR IF UNDER 18

AEROCHAMBER WITH MASK RESTRICTED TO PATIENTS

<6 YEARS OF AGE, OTHER BRANDS OF SPACERS WITH

MASKS HAVE NO AGE RESTRICTIONS (EFFECTIVE 8/1/09)

AGE \$\$ Inhaler Assistant Device With Mask (Spacer
With Mask)

Recent Changes to the Formulary

Drug Name	Formulary Change	Effective Date
Alprazolam 2mg	Removed from formulary. GRA existing users.	10/01/2016
Zepatier	Added to formulary with PA	10/01/2016
Sovaldi	Removed from formulary	10/01/2016
Harvoni	Removed from formulary	10/01/2016
Methadone	New starts restricted to the following specialist prescribers: Pain Management, Anesthesiology, Hematology and Oncology	7/01/2016
Proparacaine Opth solution	Add to formulary	07/01/16
Vaccines	Remove PA restriction	07/01/16
Miacalcin	Remove PA restriction	07/01/16
Emend	Remove PA restriction	07/01/16
Testosterone Injectable	Remove PA restriction	07/01/16
Hyaluronidase	Remove from formulary to match removal from FFS CDL.	04/01/16
Cyclophosphamide	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Zoster Vaccine	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Varicella Virus Vaccine	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Tetanus and Diphtheria Vacc	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Rabies Vaccine	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Diphtheria/Pertussis/Tetanus Vaccine	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
HPV vaccines	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Hepatitis A, B and A&B Vaccines	Add to formulary with age edit and PA to ensure CDC guideline use	04/01/16
Clotrimazole 2% Vag cream	Add to formulary	04/01/16
Carisoprodol	Remove from formulary	02/01/16
Duloxetine	Increase QL to #60/30 for 20mg and 30mg	01/27/16
Spiriva Respimat 1.25	Add to formulary	01/11/16
Bydureon	Add with ST	01/11/16
Aerospan	Add to formulary	01/11/16
Fragmin	Remove from formulary	01/11/16
Tramadol	Add age restriction	01/11/16
Afulzosin	Remove ST	01/11/16
Liothyronine	Add psychiatry to specialist edit	01/11/16
Terbinafine	Remove DS limit	01/11/16
Cyanocobalamin	Remove PA restriction	01/11/16
Tizanadine	Add to formulary with QL	01/11/16
Amlodipine	Increase QL to 2/day	11/17/15
Lovastatinva	Increase QL to 2/day	11/17/15
Rentavite	Add to formulary	11/03/15
Phenytek	Add to formulary	11/07/15
Lactulose	Increase QL to 1800ml	11/09/15
Valsartan/Valsartan+HCTZ	Add to formulary with ST	11/09/15
Diastat	Add to formulary with fill limit	11/09/15
Quinapril/Quinapril HCTZ	Add to formulary	11/09/15
Sodium Chloride Irrigation Soln	Add to formulary	10/01/15
Influenza Vaccines	Add Flu Vaccines to formulary with PA – may be part of medical svcs	10/01/15
Immune Globulin Vaccines	Add various agents to formulary with PA – may be part of medical svcs	10/01/15
Pneumococcal Vaccines	Add to formulary with PA – may be part of medical svcs	10/01/15
Carnitor	Add Levocarnitine to formulary	10/01/15
Riluzole	Add to formulary	10/01/15
Succimer	Add to formulary	10/01/15
Hyaluronidase	Add to formulary with PA – may be part of medical services	10/01/15
Auranofin	Add to formulary	10/01/15

Vicoprofen	Add to formulary with QL	06/16/15
Valium	Increase QL and remove fill limit	06/16/15
Trileptal	Remove PA restriction	06/16/15
Desowen, Temovate and Lidex	Add ST for high cost generic agents	06/16/15
Erythromycin Products	Remove all PO except Ery-Tab formulation	06/16/15
Proair Respiclick	Add to formulary with same QL as Proair HFA	06/01/15
Spiriva Respimat	Add to formulary to match Spiriva Handihaler	06/01/15
Methadone 40mg disperstab	Remove from formulary as no longer available at pharmacies	06/01/15
Lortab Elixer 7.5/500	Remove obsolete product from formulary	06/01/15
Testred, Android and Methitest	Remove from formulary due to cost and safety concerns	06/01/15
Nitromist	Remove from formulary	06/01/15
NitroDur Patch	Remove ST	06/01/15
Glucophage XR	Remove ST	06/01/15
Tylenol with Codiene	Increase QL and remove fill restriction	06/01/15
Zonegran	Remove PA	06/01/15
Venlafaxine ER Tablets	Remove from formulary Capsules are preferred	06/01/15
Effexor IR Tablets	Remove ST	06/01/15
Peridex	Add to formulary with QL	05/08/15
Plan B One Step	Add to formulary	05/04/15
Toprol XL	Removes ST	05/04/15
Incivek	Remove obsolete drug from formulary	05/04/15
Zofran ODT	Increase QL to #90	05/01/15
Simethicone	Add low cost formulations to formulary	02/17/15
Voltaren Gel	Add to formulary with double ST and QL	02/17/15
Estradiol	Remove gender edit	02/17/15
Menest	Remove from formulary	02/17/15
Premarin	Remove from formulary	02/17/15
Biaxin	Remove PA restriction	02/02/15
Augmentin	Remove PA restriction on tablets	02/02/15
Zofran	Increased QL to #90	02/05/15
Avapro/Avalide	Add to formulary	02/02/15
Cymbalta	Add to formulary with QL	02/02/15
Makena	Add to formulary with PA	01/01/15
Harvoni	Add to formulary with PA	01/01/15
Sovaldi	Add to formulary with PA	01/01/15
Sivextro	Add to formulary with PA	11/24/14
Proscar	Removed MD restriction	11/24/14
Lamictal	QL increased	11/24/14
Drysol	Add to formulary	11/24/14
Zydelig	Add to formulary with PA	11/19/14
Nilandron	Add to formulary with PA	11/19/14
Nicotrol Nasal Spray	Add to formulary with PA	11/01/14
Nicotrol Patch	Add to formulary with PA	11/01/14
Commit Lozenge	Add to formulary with PA	11/01/14
Nicotrol Cartridge Inhaler	Add to formulary with PA	11/01/14
Nicoderm CQ	Remove PA restriction	11/01/14
Nicorette	Remove PA restriction	11/01/14
Xarelto	Add to formulary with QL	06/01/14
Vicodin, Vicodin ES	5/500 and 7.5/750 formulations are obsolete. New strengths NF	04/01/14
Welchol	Remove from formulary	04/01/14
Tetracycline	Remove from formulary	04/01/14
Lexapro	Half Tab Program removed, QL now 30 per 30	01/01/14
Lipitor	Half Tab Program removed, QL now 30 per 30	01/01/14
Vyvanse	Step Therapy Addition	10/28/13
Depakote ER	Remove from formulary	10/22/13
Nystatin/Triamcinolone	Remove from formulary	10/22/13

Doxycycline Hyclate	Hyclate removed and replaced with Monohydrate	10/22/13
Niaspan	Remove from formulary	10/22/13
Serevent	Step therapy removal	09/19/13
Afinitor Disperz	Add to formulary with PA and CCS age restriction	06/01/13
Eldepryl, Emsam, Zelapar	Remove selegeline products from EDS carve out list	06/01/13
Renvela	Add to formulary with CCS age edit	06/15/13
Levsin SL	Add to formulary	06/15/13
Combivent Respimat	Add to formulary with QL of 1 unit every 30 days	06/15/13
Hepsera	Add ST for Baraclude	05/01/13
Tyzeka	Add ST for Baraclude	05/01/13
Zoloft Solution	Add to formulary with QL of 300ml/30 days	05/01/13
Colazal	Remove PA and add ST for sulfasalazine	05/01/13
Altace	Remove PA requirement	05/02/13
Dulera	Remove ST requirement	04/01/13
Levaquin	Remove PA and add QL of #10/10 days	03/01/13
Duoneb	Add to formulary	02/15/13
Janumet XR	Add to formulary with ST for trial of metformin	01/15/13
Next Choice One step	Add to formulary with QL of #1/30 and 6 fills in 12 months	01/15/13
Wellbutrin XL	Add to formulary with QL of 1/day	01/15/13
Spiriva	ST removal	01/15/13
Tudorza	Add to formulary with QL of 1 unit per 30 days	12/20/12
Spacers	Revise fill limit to 2 per year for patients under 18	01/01/13
Bumex	Add to formulary with ST for furosemide	01/01/13
Flomax	Revise ST to apply to only members under 65	12/26/12
Uroxatral	Add to formulary with ST for terazosin and doxazosin if age less than 65	12/26/12
Sanctura	Add to formulary with ST for oxybutynin IR if age less than 65	12/26/12
Ditropan	Revise ST to apply only to members under age 65	12/26/12
Singulair	Revision of step therapy to include beta agonists, ICS combo agents and theophylline to allow payment at POS.	12/26/12
Juvisync	Add to formulary with ST for metformin or Januvia. QL #1/day and CCS age edit.	10/24/12
Oxycodone/ASA	Add QL of 120/30 and fill restriction of 3 fills every 75 days	10/24/12
Armour Thyroid	Remove all strengths from formulary	8/15/12
atorvastatin	10mg/20mg: F with ST of simvastatin 40mg, QL of #1 in 2 days 40mg: F with no ST requirement, QL of #1 in 2 days 80mg: F with no ST requirement, QL of #1 in 1 day	7/15/12
Crestor	5mg: F with ST of a trial of generic simvastatin 40mg AND generic atorvastatin, QL of #1 in 1 days remain 10mg/20mg: F with ST of a trial of generic atorvastatin, QL of #1 in 2 days remain 40mg: F with no ST requirement. QL of #1 in 1 day remain	7/15/12
pravastatin	F with no ST requirement, remove tablet splitting, QL of #1 in 1 day	7/15/12
Vyvanse	Remove PA restriction for patients less than < 18yo. For members who are > 18 years old requires PA.	5/1/12
Advair / Symbicort	Remove from formulary; grandfather existing members	5/1/12
Vismodegib	Add to F with PA	5/1/12
Zelboraf	Add to F with PA	5/1/12
Yervoy	Add to F with PA	5/1/12
Plan B One-Step	Remove from F. Have Next Choice as the alternative on F with POS message "Generic Next Choice is the formulary alternative."	5/1/12
Prenatal Vitamins that are on formulary (ex. Prenavite, Prenatal, Prenatal Plus, Prenaplus)	Add QL of #1 / day and gender edit "limited to females only" to formulary prenatal vitamins. No change to current formulary statues.	5/1/12
Fish Oils OTC	Add to F	5/1/12

Diltiazem 24hr ER/Diltia XT	Add to F with QL of #1/day	4/1/12
Diltiazem 12hr ER	Add to F with QL of #2/day	4/1/12
Omeprazole 40mg	Add to F with QL of #1/day; fill limit of #1 in 21 days	4/1/12
Omeprazole 20mg	Change QL of #2/day to #1/day; drug remains on F with fill limit of #1 in 21days	4/1/12
Benzaclin Gel	Update QL to #50gm in 30 days	4/1/12
Tamiflu 6mg/ml suspension	Add to F with QL of #120ml per 180 days. Fill Limit of 1 in 180 days.	2/15/12
Enjuvia	Add to F; QL of #1 / day	2/15/12
Femtrace	Add to F; QL of #1 / day	2/15/12
Menest	Add to F; QL of # 1 / day	2/15/12
Estropipate	Add to F; QL of #1 / day	2/15/12
Climara patch	Remove current ST (Per formulary lookup, it currently has a ST of premarin or Vivelle-dot, please verify); drug remains F; add QL of #4 patches / month	2/15/12
Vivelle-Dot patch	Add to F; QL of #8 / month	2/15/12
Premarin cream	Add to F	2/15/12
Estrace cream	Drug remains F; remove ST	2/15/12
Vagifem	Add to F	2/15/12
Estring / Femring	Revise current ST to include ST of a trial of either Premarin cream, Estrace cream, or Vagifem 5 days supply in the past 120 days period. Drug remains F.	2/15/12
generic hydrocodone/APAP oral tablets/capsules	Add to F with QL of maximum #6 / day. Fill limit of #3 / 75 days	2/15/12
generic hydrocodone/APAP 7.5-500/15 Solution	Add to F with QL of maximum #1770 ml / mo. Fill limit of #3/75 days.	2/15/12
generic losartan	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic losartan – hctz	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
geneirc atorvastatin 80mg	Add to F with QL of #1 / day	2/15/12
Crestor 5mg, 10mg, and 20mg	Remove 5mg, 10mg, and 20mg from Formulary. Grandfather all current users. No change to Crestor 40mg and it remains F with QL of #1 / day.	2/15/12
generic meloxicam	Remove current ST; Drug should be on F with QL of #1 / day	2/15/12
generic nabumetone	Remove current ST; Drug should be on F with QL of #2 / day	2/15/12
generic ketorolac	Add drug to formulary with QL of #20 / 5 days supply	2/15/12
generic ketoprofen	Remove current PA; Drug should be on F with QL of #4 / day	2/15/12
generic piroxicam	Remove from formulary; grandfather current users	2/15/12
generic ketoconazole cream and ketoconazole shampoo	Remove current ST; Drugs should be F without restrictions	2/15/12
generic venlafaxine ER capsules only	Remove current ST; Drug should be F with QL #1 / day; venlafaxine ER tablets should still be F with ST.	2/15/12
generic donepezil	Remove current PA; Drug should be F with QL #1 / day	2/15/12
Aggrenox	Add to F with ST of aspirin 5 days supply in the past 120 days	12/28/11
Humalog Mix 75/50	Add to F; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	11/1/11
Incivek	Add to F with PA	11/1/11
Zytiga	Add to F with PA	11/1/11
Cytomel	Add to F with specialty edit of Endocrinology	11/1/11
Vagifem	Remove current PA	[Pending]
Menest	Remove current PA	10/15/11
Ortho-Prefest / Prefest	Remove current PA	10/15/11
Estring Vaginal Ring	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11
Femring Vagina Ring	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11
Estrace Vaginal cream	Remove current PA; add ST of trial of Vagifem 5 days supply in 120 days period	10/15/11

Premarin Vaginal cream	Remove from formulary	10/15/11
Femhrt	Add to formulary	10/15/11
Ortho-Est	Add to formulary	10/15/11
Benlysta	NF with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Yervoy	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Vandetanib	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Zytiga	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Xalkori	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	10/1/11
Crestor 5mg, 10mg, 20mg	Revised current ST of Crestor from ST of simvastatin 80mg to ST of simvastatin 40mg.	8/15/11
Vandetanib	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	8/15/11
Abiraterone acetate	Add to F with PA; Add CCS Age Edit Members < 21 years of age may be CCS-Eligible	8/15/11
Lumigan	Remove from formulary	8/15/11
Travatan and Travatan Z	Remove from formulary	8/15/11
bupropion (Wellbutrin), bupropion SR (Wellbutrin SR)	Remove MD physician specialty Edit	8/15/11
nefazodone (Serzone)	Remove MD physician specialty Edit	8/15/11
Dulera	Add to F with ST of a trial of inhaled corticosteroid 5 days supply in the past 120 days period.	8/15/11
Symbicort	Remove PA; add ST of a trial of inhaled corticosteroids 5 days supply in the past 120 days period.	8/15/11
Generic terbinafine 1% cream	Add to formulary.	8/15/11
Generic pantoprazole	Remove prior authorization of pantoprazole. Add QL of #1 per day.	6/15/11
Generic lansoprazole	Revise existing ST to step on both omeprazole and pantoprazole 5 days supply in the past 120 days. Grandfather existing members that are already taking lansoprazole.	6/15/11
Diovan, Diovan HCT	Remove from formulary	6/1/11
Benicar, Benicar HCT	Remove from formulary	6/1/11
Micardis, Micardis HCT	Remove from formulary	6/1/11
Eribulin Mesylate	Formulary with PA; add CCS age edit. Members <21 years old may be eligible for CCS, PA required for all other members.	6/1/11
Plan B, Next Choice, Plan B One Step	Add fills limit of maximum of #6 dispensings in any 12 month period;	6/1/11
Epogen	Add drug to formulary with PA and CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Procrit	Remove drug from formulary	6/1/11
Pegintron	Add drug to formulary with PA and CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Pegasys	Remove drug from formulary; grandfather existing Pegasys members (lookback period 3 months)	6/1/11
Levemir	Remove drug from formulary; grandfather existing Levemir members (lookback period 3 months)	6/1/11
Humalog, Humulin N, Humulin R, Humulin Mix, Humalog Mix	Add drugs to formulary; Add CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Revatio	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Adcirca	Add drug to formulary with PA required; CCS Age Edit (members < 21 may be CCS eligible)	6/1/11
Flovent Diskus	Add to formulary; Current QL of #60 / mo remains.	6/1/11

Rituxan	Remove from formulary	6/1/11
Amlodipine 5mg	Remove PA required. Drug remains in Formulary. No change to existing QL of #30 in 21 days	4/1/11
losartan	Added to formulary; ST of a trial of ACEI	4/1/11
losartan - hctz	Added to formulary; ST of a trial of ACEI-hctz	4/1/11
Copaxone	Add to F with PA	3/1/11
Rebif	Add to F with PA	3/1/11
Alprazolam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Clonazepam	QL restriction to #90 / mo; fill limits of #3 in 75 days	3/1/11
Diazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Lorazepam	QL restriction to #60 / mo; fill limits of #3 in 75 days	3/1/11
Zolpidem	Modified QL restriction to #30 / mo	3/1/11
Zaleplon	Modified QL restriction to #30 / mo	3/1/11
Desonide cream	Added to formulary.	11/1/10
Cholecalciferol (Vitamin D3)	Added to formulary.	11/1/10
Creon, Pancreaze, Zenpep	Added to formulary. Patients less than 21 years may be CCS eligible.	8/1/10
Trelstar	Added to formulary with PA restriction. Patients less than 21 years may be CCS eligible.	8/1/10
Topiramate	PA restriction removed for tablets. PA required remains for sprinkles capsules. Patient <21 years that are on 2 or more anticonvulsants may be CCS eligible	8/1/10
Hydromorphone	QL restrictions of #240 / Rx and fill limit of 3 in 75days	8/1/10
Methadone	QL restrictions to #120 / Rx for 5mg and QL of #240 / Rx for 10mg; fill limit of 3 in 75days	8/1/10
Morphine sulfate, SA	QL restrictions to #90 / month; fill limits of 3 in 75 days	8/1/10
Oxycodone and APAP	QL to #120 / month; fill limits of 3 in 75 days	8/1/10
OTC omeprazole	Removed from formulary. Federal legend omeprazole preferred.	6/15/10
Rapamune	Added to formulary with PA restrictions. . Patients less than 21 years may be CCS eligible.	6/1/10
Nabumetone	PA restrictions removed. Step therapy restriction added (trial of unrestricted NSAID).	5/15/10
Leflunomide	PA restrictions removed.	5/15/10
Advair	Step therapy criteria modified. Trial of inhaled steroid (if asthma), anticholinergic (if COPD) or LABA (if COPD) required.	4/15/10
Enbrel, Humira	Added to formulary with a PA restriction. Preferred TNF agents.	4/1/10
Prevacid 24HR (OTC)	Added to formulary with a step therapy restriction (omeprazole preferred)	2/1/10
Lansoprazole 15mg Capsules (Federal Legend)	Removed from formulary. (OTC lansoprazole preferred for patients using lansoprazole 15mg)	2/1/10
Lansoprazole 30mg	Added to formulary with a step therapy restriction (omeprazole preferred)	2/1/10
Prevacid Solutabs	Restricted to patients less than 6 years of age who have failed a trial of ranitidine. Lansoprazole capsules (OTC 15mg or legend 30mg) preferred for patients able to swallow capsules.	2/1/10
Antiarrhythmics	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Plavix, Ticlopidine, Cilostazole	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Prazosin, Terazosin, Doxazosin	Patients less than 21 years of age may be eligible for CCS.	2/1/10
Generic Climara Patches	Step therapy removed.	2/1/10
Onglyza	Added to formulary with age and step therapy restrictions. Patients must fail a trial of metformin. Patients less than 21 years of age may be eligible for CCS.	2/1/10
Orapred ODT 10mg	Added to formulary, restricted to patients 6 years of age and younger.	2/1/10

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