

*AdvantagePlan*  
from Medical Mutual of Ohio®

ABRIDGED FORMULARY 2007

MA-PD



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## **WHAT IS THE ADVANTAGE PLAN FROM MEDICAL MUTUAL OF OHIO® FORMULARY?**

A formulary is a list of covered drugs selected by Advantage Plan from Medical Mutual of Ohio® in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Advantage Plan from Medical Mutual of Ohio will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Advantage Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Advantage Plan from Medical Mutual of Ohio. For a complete listing of all prescription drugs covered by Advantage Plan, please visit our Web site at [MedMutual.com](http://MedMutual.com) or call 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231.

## **CAN THE FORMULARY CHANGE?**

Generally, if you are taking a drug on our 2007 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2007 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing amount for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or improve the safety of your drugs.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2007. To get updated information about the drugs covered by Advantage Plan, please visit our Web site at [MedMutual.com](http://MedMutual.com) or call Customer Service at 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231.

## HOW DO I USE THE FORMULARY?

There are two ways to find your drug within the formulary:

### Medical Condition

The formulary begins on page 11. The drugs in this formulary are grouped into categories according to type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular Agents.” If you know what your drug is used for, look for the category name in the list that begins on page 7. Then look under the category name for your drug.

### Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 32. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

### What are generic drugs?

Advantage Plan from Medical Mutual of Ohio covers both brand-name drugs and generic drugs. A generic drug has the same active-ingredient as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are approved by the Food and Drug Administration (FDA).

## ARE THERE ANY RESTRICTIONS ON MY COVERAGE?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

**Prior Authorization:** Advantage Plan from Medical Mutual of Ohio requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Advantage Plan from Medical Mutual of Ohio before you fill your prescriptions. If you don't get approval, Advantage Plan from Medical Mutual of Ohio may not cover the drug.

**Quantity Limits:** For certain drugs, Advantage Plan from Medical Mutual of Ohio limits the amount of the drug that Advantage Plan from Medical Mutual of Ohio will cover. For example, Advantage Plan from Medical Mutual of Ohio provides 34 tablets per prescription for LIPITOR.

**Step Therapy:** In some cases, Advantage Plan from Medical Mutual of Ohio requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Advantage Plan from Medical Mutual of Ohio may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Advantage Plan from Medical Mutual of Ohio will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11.

You can ask Advantage Plan from Medical Mutual of Ohio to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Advantage Plan from Medical Mutual of Ohio’s formulary?” on page 4 for information about how to request an exception.

### **WHAT IF MY DRUG IS NOT ON THE FORMULARY?**

If your drug is not included in this formulary, you should first contact our Customer Service department and ask if your drug is covered. This document includes only a partial list of covered drugs, so Advantage Plan from Medical Mutual of Ohio may cover your drug. You can contact our Customer Service at 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231.

If you learn that Advantage Plan from Medical Mutual of Ohio does not cover your drug, you have two options:

You can ask Customer Service for a list of similar drugs that are covered by Advantage Plan from Medical Mutual of Ohio. When you receive the list, show it to your doctor, and ask him or her to prescribe a similar drug that is covered by Advantage Plan from Medical Mutual of Ohio.

You can ask Advantage Plan from Medical Mutual of Ohio to make an exception and cover your drug. See below for information about how to request an exception.

### **NOTE:**

Due to a change in Medicare, most Medicare Drug Plans will no longer cover erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, and Caverject starting January 1, 2007. Call your Medicare Drug Plan for more information.

## HOW DO I REQUEST AN EXCEPTION TO THE ADVANTAGE PLAN FROM MEDICAL MUTUAL OF OHIO FORMULARY?

You can ask Advantage Plan from Medical Mutual of Ohio to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

You can ask us to cover your drug even if it is not on our formulary.

You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Advantage Plan from Medical Mutual of Ohio limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Tier 3, you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2 instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for specialty drugs that are in Tier 5.

Generally, Advantage Plan from Medical Mutual of Ohio will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. When you are requesting a formulary, tiering, or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

## WHAT DO I DO BEFORE I CAN TALK TO MY DOCTOR ABOUT CHANGING MY DRUGS OR REQUESTING AN EXCEPTION?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 34-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 34-day supply, we will not pay for these drugs.

If you are a resident of a long-term care facility, we will cover a temporary 34-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our Plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our Plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription written for fewer days) while you pursue a formulary exception.

Other times when we will cover a temporary 34-day transition supply (or less, if you have a prescription written for fewer days) include:

Advantage Plan from Medical Mutual of Ohio will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

#### **FOR MORE INFORMATION**

For more detailed information about your Advantage Plan from Medical Mutual of Ohio prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Advantage Plan from Medical Mutual of Ohio, please call Customer Service at 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231. Or visit [MedMutual.com](http://MedMutual.com).

If you have general questions about Medicare prescription drug coverage, please visit [Medicare.gov](http://Medicare.gov) or call Medicare at 800-MEDICARE (800/633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 877/486-2048.

**When you enter a long-term care facility**

**When you leave a long-term care facility**

**When you are discharged from a hospital**

**When you leave a skilled nursing facility**

**When you cancel hospice care**

# MEDICARE

## (1-800-633-4227)

## ADVANTAGE PLAN FROM MEDICAL MUTUAL OF OHIO'S FORMULARY

The formulary that begins on page 11 provides coverage information about some of the drugs covered by Advantage Plan from Medical Mutual of Ohio. If you have trouble finding your drug in the list, turn to the Index that begins on page 32. Remember: This is only a partial list of drugs covered by Advantage Plan from Medical Mutual of Ohio. If your prescription is not in this partial formulary, please visit our Web site at MedMutual.com or call Customer Service at 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231 for additional help.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., PRILOSEC) and generic drugs are listed in lower-case italics (e.g., omeprazole).

The information in the *Requirements/Limits* column tells you if Advantage Plan from Medical Mutual of Ohio has any special requirements for coverage of your drug.

The tier level refers to the level of coverage for each medication. The amount you pay at each tier level during your initial coverage period is explained below. After you reach your \$100 deductible, you are responsible for paying these amounts for your medications until the total medication costs\* reach \$2,400.

**NOTE:**

**Total medication costs means your out-of-pocket costs plus the Plan's costs for the drugs.**

**If you are not sure whether your drug is covered, please visit our Web site at Medco.com or call our Customer Service at 800/935-9952, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 800/716-3231.**

BRAND	RETAIL PHARMACY SUPPLY			MAIL-ORDER PHARMACY
	34-DAY	60-DAY	90-DAY	90-DAY
<b>Generic (Tier 1)</b>	\$5.00	\$10.00	\$15.00	\$10.00
<b>Preferred (Tier 2)</b>	\$33.00	\$66.00	\$99.00	\$80.00
<b>Non-preferred (Tier 3)</b>	75%	75%	75%	75%
<b>Specialty (Tier 5)</b>	33%	33%	33%	33%

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## COMMONLY PRESCRIBED THERAPEUTIC DRUG CATEGORIES

<b>ANTI - INFECTIVES</b>		
<b>Antifungal Agents</b>		
<b>DRUG NAME</b>	<b>DRUG TIER</b>	<b>REQ./ LIMITS</b>
<b>GENERICS</b>		
clotrimazole	1	
fluconazole	1	QL
fluconazole suspension	1	
nystatin	1	
<b>BRANDS</b>		
ERAXIS	5	
<b>ANTIVIRALS</b>		
<b>DRUG NAME</b>	<b>DRUG TIER</b>	<b>REQ./ LIMITS</b>
<b>GENERICS</b>		
zidovudine	1	
<b>BRANDS</b>		
AGENERASE	2	
COMBIVIR	2	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	2	
FAMVI	2	QL
INVIRASE	2	
LEXIVA	2	
PREZISTA	5	
RELENZA	2	QL
RETROVIR	2	
RETROVIR IV	2	
REYATAZ	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Req./ Limits</b>
SUSTIVA	2	
TRIZIVIR	2	
VALTREX	2	QL
VIDEX	2	
VIDEX EC	2	
ZERIT	2	
ZIAGEN	2	

<b>CEPHALOSPORINS</b>		
<b>Drug Name</b>	<b>Drug Tier</b>	<b>Req./ Limits</b>
<b>GENERICS</b>		
cefaclor	1	
cefadroxil	1	
ceftriaxone	1	
cefuroxime axetil	1	
cefuroxime sodium	1	
cephalexin	1	
<b>BRANDS</b>		
CEFTAZIDIME	2	
CEFTRIAXONE IV		
PIGGYBACK	2	
CEFUROXIME		
1.5GM/50ML	2	
CEFUROXIME SODIUM		
INTRAVENOUS BAG	2	
LORABID	2	
OMNICEF	2	
ROCEPHIN VIAL	2	

### KEY:

QL= Quantity Limitations may apply  
 PA = Prior Approval may be required  
 ST = Step Therapy rules may apply

DRUG NAME	DRUG TIER	REQ./LIMITS
<b>ERYTHROMYCINS &amp; OTHER MACROLIDES</b>		
<b>GENERICS</b>		
azithromycin	1	
azithromycin suspension	1	
clarithromycin	1	
erythromycin capsule	1	
<b>BRANDS</b>		
BIAXIN XL	2	
ERYTHROMYCIN TABLET	2	
ZITHROMAX PACKET	2	
<b>MISCELLANEOUS ANTI-INFECTIVES</b>		
<b>GENERICS</b>		
clindamycin HCl	1	
isoniazid	1	
mebendazole	1	
mefloquine HCl	1	
metronidazole	1	
neomycin sulfate	1	
quinine sulfate	1	
rifampin	1	
<b>BRANDS</b>		
ALINIA	2	QL
CLEOCIN PALMITATE	2	
ISONIAZID SYRUP	2	
KETEK	2	QL
MEPRON	2	
PRIMAXIN	2	
PRIMAXIN I.M.	2	
QUININE SULFATE 200MG	2	

Drug Name	Drug Tier	Req./Limits
TYGACIL	2	
ZYVOX	2	QL,PA
ZYVOX INJECTION	2	PA
<b>PENICILLINS</b>		
<b>GENERICS</b>		
amoxicillin	1	
<b>BRANDS</b>		
AUGMENTIN XR	2	
<b>QUINOLONES</b>		
<b>GENERICS</b>		
ciprofloxacin HCl	1	
<b>BRANDS</b>		
AVELOX	2	
LEVAQUIN	2	
<b>SULFA'S &amp; RELATED AGENTS</b>		
<b>GENERICS</b>		
sulfadiazine	1	
sulfamethoxazole/trimethoprim DS	1	
<b>KEY:</b>		
QL= Quantity Limitations may apply		
PA = Prior Approval may be required		
ST = Step Therapy rules may apply		

DRUG NAME	DRUG TIER	REQ./LIMITS
<b>TETRACYCLINES</b>		
<b>GENERICS</b>		
doxycycline hyclate	1	
tetracycline HCl	1	
<b>URINARY TRACT AGENTS</b>		
<b>GENERICS</b>		
methenamine	1	
nitrofurantoin	1	
<b>BRANDS</b>		
PRIMSOL	3	
<b>VANCOMYCIN</b>		
<b>GENERICS</b>		
vancomycin HCl	1	
<b>BRANDS</b>		
VANCOGIN HCl	2	
VANCOMYCIN HCl 10GMVIAL	2	
<b>ANTINEOPLASTIC &amp; IMMUNOSUPPRESSANT DRUGS</b>		
<b>Adjunctive Agents</b>		
<b>GENERICS</b>		
leucovorin calcium 100mg vial	1	
leucovorin calcium 200mg vial	1	
leucovorin calcium 25mg tablet	1	
leucovorin calcium 350mg vial	1	
leucovorin calcium 50mg vial	1	
leucovorin calcium 5mg tablet	1	

Drug Name	Drug Tier	Req./Limits
<b>BRANDS</b>		
LEUCOVORIN CALCIUM 10MG TABLET	2	
LEUCOVORIN CALCIUM 10MG/ML	2	
LEUCOVORIN CALCIUM 15MG TABLET	2	
LEUCOVORIN CALCIUM 500MG VIAL	2	
MESNEX	2	PA

**ANTINEOPLASTIC & IMMUNOSUPPRESSANT**

<b>GENERICS</b>		
bleomycin sulfate 30 unit	1	PA
carboplatin	1	PA
cisplatin	1	PA
cyclophosphamide	1	PA
cyclosporine	1	PA

**KEY:**

QL= Quantity Limitations may apply  
 PA = Prior Approval may be required  
 ST = Step Therapy rules may apply

DRUG NAME	DRUG TIER	Req./LIMITS
<b>GENERICIS</b>		
cytarabine	1	PA
dacarbazine	1	PA
daunorubicin HCl	1	PA
doxorubicin HCl	1	PA
flutamide	1	
hydroxyurea	1	
ifosfamide/mesna	1	PA
megestrol acetate	1	
mercaptopurine	1	
methotrexate	1	PA
mitomycin	1	PA
octreotide acetate 1000mcg/ml	1	PA
octreotide acetate 200mcg/ml	1	PA
tamoxifen citrate	1	
vinblastine sulfate	1	PA
vincristine sulfate	1	PA
<b>BRANDS</b>		
ARIMIDEX	2	
AROMASIN	2	
BICNU	3	PA
BLEOMYCIN SULFATE 15 UNIT	3	PA
CASODEX	2	
CELLCEPT	2	PA
CYCLOSPORINE AMPULE	2	PA
CYTARABINE 100MG/ML INJECTION	3	PA
ELIGARD	3	PA
FLOXURIDINE	3	PA
FLUOROURACIL	3	PA
GLEEVEC	5	PA
IFOSFAMIDE	3	PA
LEUKERAN	2	

Drug Name	DrugTier	Req./Limits
<b>METHOTREXATE</b>		
SODIUM 1GM VIA	3	PA
MUSTARGEN	3	PA
MYFORTIC	2	PA
MYLOTARG	3	PA
NEORAL	2	PA
OCTREOTIDE ACETATE 100MCG/ML	2	PA
OCTREOTIDE ACETATE 500MCG/ML	2	PA
<b>OCTREOTIDE ACETATE</b>		
50MCG/ML	2	PA
PACLITAXEL	3	PA
REVLIMID	5	PA
RITUXAN	3	PA
SANDIMMUNE	2	PA
SPRYCEL	5	QL,PA
SUTENT	5	QL,PA
TESLAC	3	
THIOTEPA	3	PA

**AUTONOMIC & CNS DRUGS,  
NEUROLOGY & PSYCH  
Anticonvulsants**

<b>GENERICIS</b>		
carbamazepine	1	
phenytoin	1	
valproic acid capsule	1	
valproic acid syrup	1	
<b>BRANDS</b>		
DEPAKOTE	2	
DEPAKOTE ER	2	

DRUG NAME	DRUG TIER	REQ./LIMITS
<b>GENERICS</b>		
KEPPRA	2	
LAMICTAL	2	
LYRICA	2	QL
PHENYTEK	3	
TEGRETOL XR	2	
TOPAMAX	2	
VALPROIC ACID LIQUID	2	
<b>ANTIPARKINSONISM AGENTS</b>		
<b>GENERICS</b>		
carbidopa/levodopa	1	
selegiline HCl	1	
<b>BRANDS</b>		
APOKYN	2	QL,PA
COMTAN	2	
MIRAPEX	2	
REQUIP	2	
STALEVO	2	
<b>MIGRAINE &amp; CLUSTER HEADACHE THERAPY</b>		
<b>GENERICS</b>		
ergotamine-caffeine	1	
<b>BRANDS</b>		
AMERGE	2	QL
IMITREX	2	QL
IMITREX INJECTION	2	QL
IMITREX NASAL SPRAY	2	QL
IMITREX STATDOSE	2	QL
MAXALT	2	QL
MAXALT MLT	2	QL

Drug Name	Drug Tier	Req./Limits
RELPAK	2	QL
ZOMIG	2	QL
ZOMIG NASA SPRAY	2	QL
ZOMIG ZMT	2	QL

### MISCELLANEOUS NEUROLOGICAL THERAPY

<b>BRANDS</b>		
ARICEPT	2	QL,PA
COPAXONE	2	QL,PA
EXELON	2	QL,PA
EXELON SOLUTION	2	PA
RAZADYNE	2	QL,PA
RAZADYNE ER	2	QL,PA
RAZADYNE SOLUTION	2	PA

### MUSCLE RELAXANTS & ANTISPASMODIC THERAPY

<b>GENERICS</b>		
baclofen	1	
neostigmine methylsulfate	1	
pyridostigmine bromide	1	
tizanidine HCl	1	

### Narcotic Analgesics

<b>GENERICS</b>		
acetaminophen /codeine	1	
acetaminophen/ hydrocodone	1	
acetaminophen /oxycodone	1	

DRUG NAME	DRUG TIER	REQ./LIMITS
<b>GENERICS</b>		
codeine sulfate	1	
methadone HCl	1	
morphine sulfate	1	
morphine sulfate ER	1	
oxycodone HCl	1	
oxycodone HCl extended release	1	
<b>BRANDS</b>		
ACTIQ	2	QL,PA
AVINZA	2	
METHADONE HCl SOLUTION	2	
MORPHINE SULFATE 10MG/ML AMPULE	2	
MORPHINE SULFATE 250MG/10ML VIAL	2	
MORPHINE SULFATE HYPODERMIC TABLET	2	
MORPHINE SULFATE SOLUTION	2	
OXYCONTIN	2	
<b>Non-Narcotic Analgesics</b>		
<b>GENERICS</b>		
butorphanol tartrate	1	QL,PA
choline magnesium trisalicylate	1	
diclofenac sodium	1	
diflunisal	1	
ibuprofen suspension	1	
meloxicam	1	
naloxone HCl	1	
salsalate	1	
tramadol HCl	1	

Drug Name	Drug Tier	Req./Limits
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**BRANDS**

CELEBREX 2 QL  
SUBOXONE 2

**PROPOXYPHENE**

**GENERICS**

propoxyphene HCl 1  
propoxyphene hcl/acetaminophen 1

**PSYCHOTHERAPEUTIC DRUGS**

**GENERICS**

tranylcypromine sulfate 1

**ANTIDEPRESSANT AGENTS**

**GENERICS**

amitriptyline HCl	1	
bupropion HCl	1	
bupropion HCl ER	1	QL
citalopram hydrobromide	1	QL
citalopram hydrobromide solution	1	
doxepin HCl	1	
fluoxetine HCl	1	QL
fluoxetine HCl solution	1	
paroxetine HCl	1	QL
sertraline concentrate	1	
sertraline HCl	1	QL
trazodone HCl	1	

**BRANDS**

CYMBALTA	2	QL
NARDIL	2	

DRUG NAME	DRUG TIER	REQ./LIMITS
PAXIL	2	
PAXIL CR	2	QL
WELLBUTRIN XL	2	QL
<b>ANTIPSYCHOTICS</b>		
<b>GENERICS</b>		
chlorpromazine HCl	1	PA
haloperidol	1	
<b>BRANDS</b>		
ABILIFY	3	QL
GEODON	2	QL
SEROQUEL	2	QL
SEROQUEL 400MG	2	
SEROQUEL 50MG	2	
ZYPREXA	2	QL
ZYPREXA ZYDIS	2	QL
<b>ANXIOLYTICS</b>		
<b>GENERICS</b>		
bupirone HCl	1	
<b>HYPNOTIC AGENTS</b>		
<b>BRANDS</b>		
AMBIEN	2	QL
SONATA	3	QL
<b>MISCELLANEOUS PSYCHOTHERAPEUTIC AGENTS</b>		
<b>BRANDS</b>		
FOCALIN	2	PA
PROVIGIL	2	QL,PA
RITALIN LA	2	PA
STRATTERA	2	PA

Drug Name	Drug Tier	Req./Limits
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**CARDIOVASCULAR,  
HYPERTENSION & LIPIDS  
Antiarrhythmic Agents**

**GENERICS**

mexiletine HCl	1	
procainamide HCl	1	
quinidine sulfate	1	

**BRANDS**

PROCAINAMIDE HCl SUSTAINED RELEASE	2	
RYTHMOL SR	2	

**ANTIHYPERTENSIVE THERAPY**

**GENERICS**

amiloride HCl	1	
captopril	1	QL
clonidine HCl	1	
diltiazem HCl	1	
doxazosin mesylate	1	QL
enalapril maleate	1	QL
felodipine ER	1	
fosinopril sodium	1	QL
furosemide	1	
hydralazine HCl	1	
hydrochlorothiazide	1	
labetalol HCl	1	
lisinopril	1	QL
lisinopril/ hydrochlorothiazide	1	QL

**KEY:**

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>GENERIC</b>		
metolazone	1	
metoprolol tartrate	1	
minoxidil	1	
nifedipine	1	
nifedipine ER	1	
quinapril	1	QL
terazosin HCl	1	QL
timolol maleate	1	
verapamil HCl	1	
<b>BRANDS</b>		
ACEON	2	QL
ALTACE	2	QL
ATACAND	2	QL
ATACAND HCT	2	QL
AVALIDE	2	QL
AVAPRO	2	QL
BIDIL	2	QL
CARDIZEM LA	2	
COREG	2	
COZAAR	2	QL
DILTIAZEM HCl VIAL	2	
DIOVAN	2	QL
DIOVAN HCT	2	QL
DYNACIRC CR	2	
FUROSEMIDE SOLUTION	2	
HYDRALAZINE HCl VIAL	2	
HYZAAR	2	QL
INNOPRAN XL	2	
LOTREL	2	QL
MAVIK	2	QL
METOPROLOL TARTRATE INJECTION	2	

Drug Name	Drug Tier	Req./Limits
MICARDIS	2	QL
MICARDIS HCT	2	QL
NORVASC	2	
SULAR	2	
TARKA	2	QL
TOPROL XL	2	
UNIRETIC	2	QL
UNIVASC	2	QL
VERELAN PM	2	

### CARDIAC GLYCOSIDES

<b>GENERIC</b>		
digoxin	1	

<b>BRANDS</b>		
LANOXIN	2	

### COAGULATION THERAPY

<b>GENERIC</b>		
cilostazol	1	QL
dipyridamole	1	
jantoven	1	
ticlopidine HCl	1	QL
warfarin sodium	1	

<b>BRANDS</b>		
AGGRENEX	2	QL
ARIXTRA	2	
FRAGMIN	2	
LOVENOX	2	

**KEY:**  
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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>HEMOSTATICS</b>		
<b>BRANDS</b>		
CYKLOKAPRON	3	
<b>LIPID/CHOLESTEROL LOWERING AGENTS</b>		
<b>GENERIC</b>		
gemfibrozil	1	
lovastatin	1	QL
pravastatin	1	QL
simvastatin	1	QL
<b>BRANDS</b>		
ADVICOR	3	
ALTOPREV	2	QL
ANTARA	2	
CADUET	2	QL
COLESTID	2	
CRESTOR	2	QL
LIPITOR	2	QL
NIASPAN	2	
OMACOR	2	QL
TRICOR	2	
VYTORIN	2	QL
ZETIA	2	QL

Drug Name	Drug Tier	Req./Limits
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**MISCELLANEOUS  
CARDIOVASCULAR AGENTS**

**BRANDS**  
RANEXA 2

**NITRATES**

**GENERIC**

nitro-bid	1
nitroglycerin	1
nitroglycerin injection	1
nitroglycerin patch	1

**BRANDS**  
NITROLINGUAL 2

**DERMATOLOGICALS/TOPICAL  
THERAPY**  
Antipsoriatic / Antiseborrheic

**GENERIC**

anthralin	1
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**BRANDS**  
CAPITROL 2  
DOVONEX 2  
SORIATANE 2

**KEY:**

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>BURN THERAPY</b>		
<b>GENERICS</b>		
silver sulfadiazine	1	
<b>MISCELLANEOUS DERMATOLOGICALS</b>		
<b>GENERICS</b>		
allanfil	1	
fluorouracil	1	
sulfacetamide sodium	1	
<b>BRANDS</b>		
CARAC	2	
CARMOL HC	2	
EFUDEX	2	
ELIDEL	2	PA
OXSORALEN 2		
OXSORALEN ULTRA	2	
PANAFIL	2	
SOLARAZE	2	
ZONALON	2	
<b>THERAPY FOR ACNE</b>		
<b>GENERICS</b>		
clindamycin phosphate	1	
erythromycin	1	
metronidazole	1	
<b>BRANDS</b>		
EVOCLIN	2	
FINACEA	2	

Drug Name	Drug Tier	Req./Limits
METROGEL	2	
TAZORAC	2	

### TOPICAL ANESTHETICS

<b>GENERICS</b>		
lidocaine	1	

### TOPICAL ANTIBACTERIALS

<b>GENERICS</b>		
mupirocin	1	

<b>BRANDS</b>		
KLARON	2	

### TOPICAL ANTIFUNGALS

<b>GENERICS</b>		
clotrimazole	1	
econazole nitrate	1	
nystatin	1	

<b>BRANDS</b>		
ERTACZO	2	
LOPROX	2	

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>TOPICAL ANTIVIRALS</b>		
<b>BRANDS</b>		
DENAVIR	3	
ZOVIRAX	2	
<b>TOPICAL CORTICOSTEROID</b>		
<b>GENERICS</b>		
betamethasone valerate	1	
fluocinolone acetonide	1	
fluocinonide	1	
hydrocortisone	1	
triamcinolone acetonide	1	
<b>Brands</b>		
DIPROLENE	3	
LUXIQ	2	
OLUX	2	
PANDEL	2	
<b>TOPICAL ENZYMES</b>		
<b>GENERICS</b>		
allanzyme	1	
<b>BRANDS</b>		
ACCUZYME	2	
XENADERM	2	

Drug Name	Drug Tier	Req./Limits
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**TOPICAL SCABICIDES / PEDICULICIDES**

<b>GENERICS</b>		
permethrin	1	

<b>BRANDS</b>		
EURAX	2	

**DIAGNOSTICS & MISCELLANEOUS AGENTS**  
Miscellaneous Agents

<b>GENERICS</b>		
anagrelide hydrochloride	1	QL

<b>BRANDS</b>		
ACTONEL 30MG	2	QL,PA
EVOXAC	2	
FOSAMAX 40MG	2	QL,PA
FOSRENOL	2	
INCRELEX	5	PA
PANAFIL	2	
PROLASTIN	2	PA
RENAGEL	2	
THALOMID	5	PA

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>SMOKING DETERRENT</b>		
<b>GENERICS</b>		
buproban	1	QL,PA
<b>BRANDS</b>		
NICOTROL	3	QL,PA
<b>EAR, NOSE &amp; THROAT MEDICATIONS</b>		
Miscellaneous Agents		
<b>GENERICS</b>		
triamcinolone acetonide	1	
<b>BRANDS</b>		
BACTROBAN NASAL	2	
PREVIDENT	3	
<b>MISCELLANEOUS OTIC PREPARATIONS</b>		
<b>BRANDS</b>		
FLOXIN	2	
<b>OTIC STEROID / ANTIBIOTIC</b>		
<b>GENERICS</b>		
neomycin/polymyxin /hydrocortiso	1	
<b>ENDOCRINE/DIABETES</b>		
Adrenal Hormones		
<b>GENERICS</b>		
dexamethasone	1	
hydrocortisone	1	

Drug Name	DrugTier	Req./Limits
<b>BRANDS</b>		
DEXAMETHASONE 1MG TABLET	2	
DEXAMETHASONE 2MG TABLET	2	
DEXAMETHASONE SOLUTION	2	
<b>ANTITHYROID AGENTS</b>		
<b>GENERICS</b>		
methimazole	1	

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>DIABETES THERAPY</b>		
<b>GENERICS</b>		
glimepiride	1	QL
glipizide	1	QL
glyburide	1	
metformin HCl	1	QL
metformin HCl ER	1	QL
tolazamide	1	
<b>BRANDS</b>		
ACTOPLUS MET	2	QL
ACTOS	2	QL
APIDRA	2	
AVANDAMET	2	QL
AVANDARYL	2	QL
AVANDIA	2	QL
BYETTA	2	QL
FORTAMET	2	QL
GLUCAGON		
EMERGENCY KIT	2	
HUMALOG	2	
HUMALOG MIX 75/25	2	
HUMULIN N	2	
HUMULIN R	2	
ILETIN II LENTE/PORK	3	
LANTUS	2	
LEVEMIR	2	
NOVOLIN 70/30	2	
NOVOLIN N	2	
NOVOLIN R	2	
NOVOLOG	2	
NOVOLOG MIX 70/30	2	
PRANDIN	2	QL
PRECOSE	2	QL

Drug Name	Drug Tier	Req./Limits
STARLIX	2	QL
SYMLIN	2	QL,PA

### DIABETIC SUPPLIES, MISC

#### BRANDS

ALCOHOL SWABS 2

### MISCELLANEOUS HORMONES

#### GENERICS

fortical 1 QL

#### BRANDS

ANDRODERM 2 QL,PA  
 ANDROGEL 2 QL,PA  
 CEREZYME 5 PA  
 CYTADREN 2  
 DEPO-TESTOSTERONE 2 PA  
 HECTOROL 2  
 STRIANT 2 QL,PA  
 TESTIM 2 QL,PA  
 ZEMPLAR 2

### THYROID HORMONES

#### GENERICS

levothyroxine sodium 1

#### BRANDS

CYTOMEL 2

#### KEY:

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>GASTROENTEROLOGY</b>		
<b>Antidiarrheals &amp; Antispasmodics</b>		
<b>GENERICS</b>		
colytrol	1	
diphenoxylate/atropine	1	
glycopyrrolate	1	
hyoscyamine sulfate	1	
<b>MISCELLANEOUS GASTROINTESTINAL AGENTS</b>		
<b>GENERICS</b>		
lipram	1	
lipram-cr	1	
lipram-pn	1	
lipram-ul	1	
prochlorperazine edisylate	1	PA
prochlorperazine maleate tablet	1	PA
prochlorperazine suppository	1	PA
ursodio	1	
<b>BRANDS</b>		
CANASA	2	
COLAZAL	2	
CREON	2	
EMEND	2	QL,PA
HALFLYTELY	3	
LOTRONEX	2	QL,PA
NULYTELY	3	
PENTASA	2	
PROCTOCREAM-HC	2	
PROCTOFOAM-HC	2	
REMICADE	5	PA

Drug Name	Drug Tier	Req./Limits
ULTRASE	2	
URSO	2	
URSO FORTE	2	
ZOFRAN	2	QL,PA
ZOFRAN SOLUTION	2	PA
ZOFRAN VIAL	2	

### ULCER THERAPY

<b>GENERICS</b>		
famotidine	1	QL
famotidine injection	1	
misoprostol	1	
omeprazole	1	QL
ranitidine HCl	1	QL
sucralfate	1	

<b>BRANDS</b>		
NEXIUM	2	QL
NEXIUM I.V.	2	
PREVACID	2	QL
PREVACID IV	2	
PREVACID SUSPENSION	2	
PREVPAC	3	
PRILOSEC 40MG	3	QL
ZANTAC INJECTION	2	
ZANTAC SYRUP	2	
ZEGERID	3	QL

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>IMMUNOLOGY, VACCINES &amp; BIOTECHNOLOGY</b>		
<b>Biotechnology Drugs</b>		
<b>BRANDS</b>		
ARANESP	5	QL,PA
BETASERON	5	QL,PA
EPOGEN	5	QL,PA
LEUKINE	5	PA
NEULASTA	5	QL,PA
NEUMEGA	5	QL,PA
NORDITROPIN	2	PA
PEGASYS	2	QL,PA
PEG-INTRON	2	QL,PA
PROCRIT	5	QL,PA
PROLEUKIN	5	
REBIF	2	QL,PA
TEV-TROPIN	2	PA
<b>VACCINES &amp; MISCELLANEOUS</b>		
<b>Immunologicals</b>		
<b>BRANDS</b>		
ACTHIB	2	
ENGERIX-B	2	
GARDASIL	2	
TETANUS DIPHTHERIA		
TOXOIDS	2	
VARIVAX	2	
ZOSTAVAX	2	

Drug Name	Drug Tier	Req./Limits
<b>MUSCULOSKELETAL &amp; RHEUMATOLOGY</b>		
<b>Gout Therapy</b>		
<b>GENERICS</b>		
allopurinol	1	
colchicine	1	
<b>BRANDS</b>		
COLCHICINE VIAL	2	
<b>OSTEOPOROSIS THERAPY</b>		
<b>BRANDS</b>		
ACTONEL	2	QL
BONIVA	2	QL
BONIVA SYRINGE	2	
EVISTA	2	QL
FORTEO	2	QL
FOSAMAX	2	QL
FOSAMAX PLUS D	2	QL
<b>OTHER RHEUMATOLOGICALS</b>		
<b>GENERICS</b>		
leflunomide	1	QL,PA
<b>BRANDS</b>		
ENBREL	2	QL,PA
HUMIRA	2	QL,PA
RIDAURA	2	
<b>KEY:</b>		
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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>OBSTETRICS &amp; GYNECOLOGY</b>		
Estrogens & Progestins		
<b>GENERICS</b>		
medroxyprogesterone acetate	1	
norethindrone acetate	1	
<b>BRANDS</b>		
ACTIVELLA	2	QL
ALORA	2	QL
CENESTIN	2	QL
CLIMARA	3	QL
CLIMARA PRO	2	QL
COMBIPATCH	2	QL
ENJUVIA	2	QL
ESTRING	2	QL
FEMHRT	3	QL
PREFEST	3	QL
PREMARIN	3	QL
PREMARIN CREAM	3	
VAGIFEM	2	
VIVELLE	3	QL
<b>MISCELLANEOUS OB/GYN</b>		
<b>GENERICS</b>		
clindamycin phosphate	1	
nystatin	1	
terconazole	1	
<b>BRANDS</b>		
NUVARING	2	
ORTHO EVRA	3	

Drug Name	Drug Tier	Req./Limits
<b>ORAL CONTRACEPTIVES &amp; RELATED AGENTS</b>		
<b>GENERICS</b>		
aranelle	1	
cesia	1	
enpresse	1	
junel	1	
junel FE	1	
leena	1	
levora-28	1	
low-ogestrel	1	
microgestin	1	
microgestin FE	1	
mononessa	1	
necon	1	
nortrel	1	
nortrel 1/35 (21)	1	
previfem	1	
sprintec	1	
sronyx	1	
trinessa	1	
tri-previfem	1	
tri-sprintec	1	
velivet	1	
zovia 1/35e	1	
zovia 1/50e	1	
<b>BRANDS</b>		
PLAN B	2	QL

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>OXYTOCICS</b>		
<b>BRANDS</b>		
METHERGINE	2	
<b>OPHTHALMOLOGY</b>		
<b>Antibiotics</b>		
<b>GENERICS</b>		
ciprofloxacin HCl	1	
erythromycin	1	
<b>BRANDS</b>		
CILOXAN	2	
VIGAMOX	2	
ZYMAR	2	
<b>ANTIVIRALS</b>		
<b>GENERICS</b>		
trifluridine	1	
<b>BETA-BLOCKERS</b>		
<b>GENERICS</b>		
timolol maleate	1	
<b>BRANDS</b>		
BETOPTIC S	2	
ISTALOL	2	

Drug Name	Drug Tier	Req./Limits
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TIMOPTIC SINGLE USE DROPPERETTE	2	
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### CYCLOPLEGIC MYDRIATICS

#### BRANDS

ISOPTO		
HOMATROPINE	2	

### DIRECT ACTING MIOTICS

#### GENERICS

pilocarpine HCl	1	
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### MISCELLANEOUS OPTHALMOLOGICS

#### BRANDS

ALOCRIAL	3	
ELESTAT	2	
OPTIVAR	2	
PATANOL	2	
RESTASIS	2	QL,PA

### NON-STEROIDAL ANTI-INFLAMMATORY AGENTS

#### BRANDS

ACULAR	2	
VOLTAREN	2	
XIBROM	2	

#### KEY:

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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>ORAL DRUGS FOR GLAUCOMA</b>		
<b>GENERICS</b>		
acetazolamide sodium	1	
<b>OTHER GLAUCOMA DRUGS</b>		
<b>BRANDS</b>		
AZOPT	2	
COSOPT	2	
LUMIGAN	2	
TRAVATAN	2	
TRUSOPT	2	
XALATAN	2	
<b>STEROID-ANTIBIOTIC COMBINATIONS</b>		
<b>BRANDS</b>		
TOBRADEX	2	
ZYLET	2	
<b>STEROIDS</b>		
<b>GENERICS</b>		
fluorometholone	1	
<b>BRANDS</b>		
ALREX	2	
INFLAMASE MILD	2	
LOTEMAX	2	
<b>STEROID-SULFONAMIDE COMBINATIONS</b>		
<b>GENERICS</b>		
sulfacetamide/ prednisolone	1	
<b>BRANDS</b>		
BLEPHAMIDE	2	

Drug Name	Drug Tier	Req./Limits
<b>SULFONAMIDES</b>		
<b>GENERICS</b>		
sulfacetamide sodium	1	
<b>SYMPATHOMIMETICS</b>		
<b>GENERICS</b>		
dipivefrin HCl	1	
<b>BRANDS</b>		
ALPHAGAN P	2	
<b>VASOCONSTRICTOR DECONGESTANTS</b>		
<b>GENERICS</b>		
phenylephrine HCl	1	
<b>KEY:</b>		
QL= Quantity Limitations may apply		
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DRUG NAME	DRUG TIER	REQ./LIMITS
<b>RESPIRATORY AND ALLERGY</b>		
<b>ANTIHISTAMINE &amp; ANTIALLERGENIC AGENTS</b>		
<b>ADRENERGICS</b>		
<b>GENERICS</b>		
adrenalin chloride	1	
<b>BRANDS</b>		
EPIPEN	2	
<b>ANTIHISTAMINES</b>		
<b>GENERICS</b>		
fexofenadine HCl	1	QL
<b>BRANDS</b>		
CLARINEX	2	QL
CLARINEX 2.5MG	2	
CLARINEX SYRUP	2	
ZYRTEC	2	QL
ZYRTEC 5MG	2	QL
ZYRTEC SYRUP	2	
<b>ANTIHISTAMINES</b>		
<b>BRANDS</b>		
ALLEGRA-D	2	QL
ZYRTEC-D	2	QL

Drug Name	DrugTier	Req./Limits
<b>PULMONARY AGENTS</b>		
<b>ADRENERGICS</b>		
<b>BRANDS</b>		
ADRENALIN CHLORIDE		
NASAL	2	
<b>INHALED BETA AGONISTS</b>		
<b>GENERICS</b>		
albuterol inhaler	1	QL
albuterol sulfate for nebulization		
0.83mg/ml	1	PA
<b>BRANDS</b>		
ALBUTEROL SULFATE		
FOR NEBULIZATION		
0.42MG/ML	2	PA
FORADIL		
AEROLIZER	2	QL
PROVENTIL HFA	2	QL
SEREVENT DISKUS	2	QL
VENTOLIN HFA	2	QL
XOPENEX HFA	2	QL
<b>INHALED CORTICOSTEROIDS</b>		
<b>BRANDS</b>		
ASMANEX	2	QL
FLOVENT	2	QL
FLOVENT		
ROTADISK	2	QL
PULMICORT FOR		
NEBULIZATION	2	PA
PULMICORT		
INHALER	2	QL

DRUG NAME	DRUGTIER	REQ./LIMITS
<b>INTRANASAL STERIODS</b>		
<b>GENERICS</b>		
flunisolide	1	QL
<b>BRANDS</b>		
NASACORT AQ	2	QL
NASONEX	2	QL
RHINOCORT AQUA	2	QL
<b>MISCELLANEOUS PULMONARY AGENTS</b>		
<b>GENERICS</b>		
terbutaline sulfate	1	
<b>BRANDS</b>		
ADVAIR DISKUS	2	QL
ADVAIR HFA	2	QL
COMBIVENT	2	QL
DUONEB	2	PA
INTAL	2	QL
REVATIO	5	QL
SINGULAIR	2	QL
SPIRIVA	2	QL
TILADE	2	QL
<b>ORAL BETA AGONISTS</b>		
<b>GENERICS</b>		
albuterol sulfate	1	
<b>XANTHINES</b>		
<b>GENERICS</b>		
dyphylline	GG	

Drug Name	DrugTier	Req./Limits
<b>UROLOGICALS</b>		
<b>Anticholinergics &amp; Antispasmodics</b>		
<b>GENERICS</b>		
oxybutynin chloride	1	QL
<b>BRANDS</b>		
DETROL	2	QL
DETROL LA	2	QL
DITROPAN XL	2	QL
ENABLEX	2	QL
OXYTROL	2	QL
SANCTURA	2	QL
VESICARE	2	QL
<b>BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY</b>		
<b>GENERICS</b>		
finasteride	1	QL
<b>BRANDS</b>		
AVODART	2	QL
FLOMAX	2	QL
UROXATRAL	2	QL
<b>CHOLINERGIC STIMULANTS</b>		
<b>GENERICS</b>		
bethanechol chloride	1	
<b>KEY:</b>		
QL= Quantity Limitations may apply		
PA = Prior Approval may be required		
ST = Step Therapy rules may apply		

DRUG NAME	DRUG TIER	REQ./LIMITS
<b>MISCELLANEOUS UROLOGICALS</b>		
<b>BRANDS</b>		
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<b>URINARY ANESTHETICS</b>		
<b>GENERICS</b>		
phenazopyridine HCl	1	
<b>VITAMINS, HEMATINICS &amp; ELECTROLYTES</b>		
<b>Electrolytes</b>		
<b>GENERICS</b>		
potassium bicarbonate	1	
potassium chloride	1	
<b>BRANDS</b>		
PHOSLO	2	
POTASSIUM CHLORIDE IV		
PIGGYBACK	3	
POTASSIUM CHLORIDE 15MEQ TABLET	3	
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<b>VITAMINS &amp; HEMATINICS</b>		
<b>GENERICS</b>		
prenatal plus 1		
prenatal RX 1		

**KEY:**

QL= Quantity Limitations may apply  
PA = Prior Approval may be required  
ST = Step Therapy rules may apply

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