



**JAI MEDICAL SYSTEMS**

A blue ECG (heart rate) line graphic positioned below the text "JAI MEDICAL SYSTEMS".

2014  
Therapeutic Formulary



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# ***BioScrip/Jai Medical Systems Managed Care Organization 2014 Therapeutic Formulary***

This formulary describes the circumstances under which pharmacies participating in a particular medical benefit program will be reimbursed for medications dispensed to patients covered by the program. This formulary does not:

- a) Require or prohibit the prescribing or dispensing of any medication.
- b) Substitute for the independent professional judgment of the physician or pharmacist.
- c) Relieve the physician or pharmacist of any obligation to the patient or others.

## **I. Non-Prescription Medication Policy**

This program does not cover most over-the-counter medications (OTC). The only exceptions to this policy are listed within the program formulary. Furthermore, all OTC medications with the exception of OTC emergency contraception can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription; see page 5 of the formulary for limitations.

## **II. Unapproved Use of Formulary Medication**

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications, which are accepted as safe and effective by the balance of current medical opinion and available scientific evidence, may also be covered. BioScrip, utilizing the procedures outlined in section IV, will make decisions about reimbursement for these other indications. Experimental, investigational drugs, and drugs used for cosmetic purposes are not eligible for coverage.

### **III. Prior Authorization Procedure**

To promote the most appropriate utilization of selected high risk and/or high cost medication, a prior authorization procedure has been created. The criteria for this system has been established by the BioScrip/Jai Medical Systems Managed Care Organization program with input from pharmacists and physician practitioners and in consideration of the available medical literature. The Pharmacy and Therapeutics Committee will have final approval responsibility for this list. In order for a dispensed prior authorization medication to be reimbursed to the pharmacy, the patient's prescribing physician must apply for pre-authorization for a specific patient and drug. The physician may phone or fax BioScrip to request prior authorization:

**BioScrip  
Prior Authorization Desk  
2787 Charter Street  
Columbus, Ohio 43228  
(800) 555-8513  
(800) 583-6010 (fax)**

**Please have patient information, including member I.D. number, complete diagnosis, medication history, and current medications readily available.**

These phone lines are dedicated to physicians making requests for prior authorization medication and non-formulary items. Members cannot be assisted if they call the prior-authorization toll-free number. For emergent requests for drugs requiring prior-authorization, a response will be made within 24 hours. For Non-Emergent requests for drugs requiring prior-authorization, a response will be provided within 2 business days of receipt of information. If the necessary information is not received, this process could take up to 7 calendar days. If the request is approved, information in the on-line pharmacy claims processing system will be changed to allow the specific patient to receive this specific drug. A prior authorization number will be issued to the prescribing physician and is to be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP.

In addition to those products that require prior authorization all injectables (except Depo-Provera, Insulin, Glucagon Kit, and Epi-Pen) require prior approval. Questions about injectable drugs administered by homehealth or healthcare providers should be directed to BioScrip at 800-555-8513.

Our prior authorization criteria can be found on our website: [www.jaimedicalsystems.com](http://www.jaimedicalsystems.com) as well as in this formulary. Any updates made to our criteria will be posted on the website above within 30 days.

#### **IV. Unique Patient Needs Non-Formulary Medication**

This formulary attempts to provide appropriate and cost effective drug therapy to all participants in the BioScrip/Jai Medical Systems Managed Care Organization program. If a patient requires medication that is not covered by the formulary, a request can be made for payment for the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. Requests for non-formulary medications should be made in writing (on the “Medical Necessity form” if possible) and mailed or faxed to:

**BioScrip  
Medical Necessity Desk  
2787 Charter Street  
Columbus, Ohio 43228  
(800) 555-8513  
(800) 583-6010 (fax)**

Appropriate documentation must be provided to support the request. For emergent requests for drugs requiring prior-authorization, a response will be made within 24 hours. For Non-Emergent requests for drugs requiring prior-authorization, a response will be provided within 2 business days of receipt of information. If the necessary information is not received, this process could take up to 7 calendar days. Approval of non-formulary items will be based upon criteria developed by the Pharmacy and Therapeutics Committee of Jai Medical Systems Managed Care Organization and BioScrip.

Physicians are expected to comply with this formulary when prescribing medication for those patients covered by the BioScrip/Jai Medical Systems Managed Care Organization plan. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist should attempt to contact

the prescribing physician to request a change to a product included in this formulary guide.

The pharmacy will not be reimbursed for non-formulary medications. **In an emergency situation outside of BioScrip's regular business hours, where the physician cannot be contacted, the pharmacist is authorized to dispense a 72 hour emergency supply of a medication, unless the medication is classified as a DESI, LTE or specifically excluded drug category (see section VI) product.**

**The pharmacist should contact BioScrip's Help Desk at (800) 213-5640 during regular business hours to arrange for reimbursement for the emergency supply.**

## **V. Newly Marketed Products**

Newly marketed drug products will not normally be placed on the formulary during their first year on the market. Exceptions to this rule will be made on a case by case basis using the medical necessity procedure.

## **VI. Specific Exclusions**

The following drug categories are not part of the BioScrip/Jai Medical Systems Managed Care Organization formulary and are not covered by the 72-hour emergency supply reimbursement policy:

- Antiobesity products
- Blood and blood plasma
- Cosmetic drugs
- Cough and cold products (except those listed in formulary)
- DESI drugs
- Diagnostic products (except those listed in formulary)
- Erectile Dysfunction agents
- Medical supplies and durable medical equipment (except certain diabetic supplies)
- Most vitamins
- Nutritional and dietary supplements
- Research drugs
- Topical minoxidil

## **VII. Fee-For-Service Carve-outs**

In addition to the above exclusions, the following are also excluded from the formulary, and are covered by the Maryland Department of Health and Mental Hygiene:

HIV drugs

Mental Health drugs (refer to Section VIII. Behavioral Health Medication Policy)

## **VIII. Behavioral Health Medication Policy**

Please refer to the Maryland Department of Health and Mental Hygiene's Mental Health Formulary for a complete listing of behavioral health medications. Any behavioral health medications that are covered by Jai Medical Systems Managed Care Organization are listed in the prescription formulary.

- Kapvay – For recipients 6 -17 years old, Kapvay is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Kapvay continues to be a part of the MCO pharmacy benefit.
- Intuniv – For recipients 6 -17 years old, Intuniv is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Intuniv continues to be a part of the MCO pharmacy benefit.

## **IX. Mandatory Generic Substitution & Therapeutic Interchange**

Generic substitution is mandatory when a generic equivalent is available. All branded products that have 3 or more generic equivalents available will be reimbursed at the maximum allowable cost. No other therapeutic interchange is permitted.



## **X. Specialty Medications**

**Effective 02/01/2010**, specialty medications will be covered under the pharmacy benefit for Jai Medical Systems. All requests will undergo prior authorization review when available drug specific prior authorization criteria will apply. When prior authorization criteria does not exist the request will be reviewed for FDA approved indications according to Jai Medical Systems' approved medical necessity review process. All specialty drug requests should contain the following:

- Drug name, strength, dose and quantity requested
- Diagnosis for use
- Any previous drug therapies tried and failed
- Any additional clinical information pertinent to the drug review

For emergent specialty drug requests, a decision will be made within 24 hours. For non-emergent specialty drug requests, a response will be provided within 2 business days of receipt of the clinical information. If the necessary information is not received, this process could take up to 7 calendar days.

## **XI. General Parameters**

- Valid DEA and NPI numbers are required. Physicians without numbers should contact BioScrip at 1-800-230-8189.
- Refill too soon - 75% of the day's supply must elapse before the prescription can be refilled.
- Maximum allowable quantity is a 30 days supply. The quantity limit on most medications is a 400-unit maximum limit per month. Most narcotics have individualized quantity and dosage form limitations, which are listed on page 13 of the formulary. If necessary, a healthcare provider may request a quantity override by contacting BioScrip's Prior Authorization Department. Prior authorization is also required for concomitant therapy of an opioid and Suboxone. The Prior Authorization procedure can be found on page I-2.
- All generic oral contraceptives (including emergency contraceptives) along with brand oral contraceptives that do not have a generic version available are formulary. Examples are listed on page 4 and 5.
- Covered smoking cessation agents are listed on page 17.
- No vacation fills are allowed.
- No overrides for lost or stolen prescriptions are allowed.

## **XII. Where to Call?**

### **PHYSICIANS**

Formulary Questions:

BioScrip (800) 555-8513

Medical Necessity:

BioScrip (800) 555-8513

Prior Authorization:

BioScrip (800) 555-8513

Provider Relations:

Jai Medical Systems

Managed Care Organization, Inc. (888) JAI-1999

### **PHARMACISTS**

Provider Network Questions:

BioScrip (800) 230-8187

Provider Relations:

BioScrip (800) 213-5640

## **XIII. Abbreviations**

Providers are encouraged to prescribe generically available drugs whenever possible and to prescribe first-line lower cost options when appropriate. Drugs are ranked by cost with the following abbreviations:

*	=	This product has a MAC price attached to some or all strengths.
\$	=	Cost per Rx is <\$20
\$\$	=	Cost per Rx is <\$40
\$\$\$	=	Cost per Rx is \$40 - \$80
\$\$\$\$	=	Cost per Rx is \$80 - \$160
\$\$\$\$\$	=	Cost per Rx is >\$160

## **XIV. Reference**

The formulary is now available online at e-pocrates. This is updated monthly and will have the most up-to-date information. Registration is free and available at:

[www.epocrates.com](http://www.epocrates.com)

Links to pdf copies of the most recent printed versions of all Maryland Medicaid Managed Care Organization's formularies can be found on the website listed below:

[www.mdmahealthchoicerox.com](http://www.mdmahealthchoicerox.com)

A link to a pdf copy of the Jai Medical Systems formulary is also available in the Providers section of our homepage:

[www.jaimedicalsystems.com](http://www.jaimedicalsystems.com)

## **XV. Copays**

Currently, there is no copay for active members of Jai Medical Systems Members Managed Care Organization, Inc.'s HealthChoice Program.

## **XVI. Step Therapy**

Jai Medical Systems offers Step therapy for Advair and Symbicort. For members with a current approved prior authorization, claims will continue to process as long as the member has filled for that medication within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of that medication within the last 3 months.



# Prescription Formulary

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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**I. ANTI-INFECTIVE AGENTS**

**PENICILLINS**

\$ Amoxicillin*	AMOXIL	<i>no chewables</i>
\$ Ampicillin*	AMPICILLIN	
\$ Penicillin G Benzathine	BICILLIN	
\$ Penicillin V Potassium*	PEN VEE K	

*Penicillinase-resistant*

\$ Dicloxacillin Sodium*	DICLOXACILLIN SODIUM	
\$ Oxacillin*	OXACILLIN	

\$ Cloxacillin Sodium*	CLOXACILLIN SODIUM	
<b>Prior Authorization Required</b>		

*Penicillin Combinations*

\$\$\$ Amox & K Clav*	AUGMENTIN	<i>no chewables</i>
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**CEPHALOSPORINS**

*Cephalosporins - 1st Generation*

\$ Cephalexin*	KEFLEX	<i>no tablets</i>
\$ Cephradine*	CEPHRADINE	

*Cephalosporins - 2nd Generation*

\$\$ Cefaclor*	CEFACTOR	
\$\$\$ Cefprozil*	CEFZIL	
\$\$\$ Cefuroxime*	CEFTIN	<i>oral tablets only covered for children under 12 yrs old</i>
\$\$\$ Loracarbef	LORABID SUSPENSION	

*Cephalosporins - 3rd Generation*

\$ Cefixime	SUPRAX	<i>QL = 1 tab</i>
\$\$\$ Ceftriaxone*	ROCEPHIN	

\$\$\$ Cefdinir*	OMNICEF	<i>suspension only</i>
<b>Prior Authorization Required</b>		

**MACROLIDE ANTIBIOTICS**

*Erythromycins*

\$ Erythromycin Base*	ERY-TAB	
\$ Erythromycin Estolate*	ERYTHROMYCIN ESTOLATE	
\$ Erythromycin Ethylsuccinate*	E.E.S.	
\$ Erythromycin Stearate*	ERYTHROCIN	

*Lincomycins*

\$\$ Clindamycin*	CLEOCIN	
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*Misc. Macrolide Antibiotics*

\$\$ Azithromycin*	ZITHROMAX	
\$\$\$ Azithromycin suspension*	ZITHROMAX	<i>QL = 1 single dose packet</i>

\$\$\$ Clarithromycin*	BIAXIN	
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**TETRACYCLINES**

\$\$\$ Doxycycline*	VIBRAMYCIN	
\$ Tetracycline*	SUMYCIN	<i>no tablets</i>

**FLUOROQUINOLONES**

\$\$\$ Ciprofloxacin*	CIPRO	
\$\$\$\$ Levofloxacin*	LEVAQUIN	
\$\$\$\$ Moxifloxacin	AVELOX	<i>QL 14 per 30 days</i>

<b>Prior Authorization Required</b>		
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<b><u>ANTIMALARIAL</u></b>		
\$ Chloroquine*	ARALEN	<i>no 500mg tabs</i>
\$ Hydroxychloroquine*	PLAQUENIL	
\$ Pyrimethamine	DARAPRIM	
<b><u>ANTHELMINTIC</u></b>		
\$\$ Albendazole	ALBENZA	<i>OTC product</i>
\$\$ Mebendazole*	MEBENDAZOLE	
\$\$\$\$ Pyrantel Pamoate*	PIN - X	
<b><u>AMINOGLYCOSIDES</u></b>		
\$ Gentamicin Sulfate*	GARAMYCIN	<i>tablets only</i>
\$ Neomycin Sulfate*	NEOMYCIN	
<b><u>SULFONAMIDES</u></b>		
\$ Erythromycin/Sulfisoxazole*	ERYTHROMYCIN/SULFISOXAZOLE	<i>no EN tabs</i>
\$ Sulfadiazine*	SULFADIAZINE	
\$ Sulfasalazine*	AZULFIDINE	
\$ Sulfisoxazole*	GANTRISIN	
\$ Trimethoprim/Sulfamethoxazole*	BACTRIM / DS	
<b><u>ANTIMYCOBACTERIAL AGENTS</u></b>		
\$\$\$\$ Cycloserine	SEROMYCIN	
\$\$\$ Ethambutol*	MYAMBUTOL	
\$\$\$ Ethionamide	TRECTOR	
\$ Isoniazid*	ISONIAZID	
\$\$\$ Pyrazinamide*	PYRAZINAMIDE	
\$\$\$\$ Rifabutin	MYCOBUTIN	
\$\$\$\$ Rifampin*	RIFADIN	
<b><u>MISC. ANTIINFECTIVES</u></b>		
\$ Metronidazole*	FLAGYL	<i>0.12% oral rinse</i>
\$ Trimethoprim*	PROLOPRIM	
\$\$ Chlorhexidine	PERIOGARD	
<i>Leprostatics</i>		
\$ Dapsone*	DAPSONE	
<b><u>ANTIFUNGALS</u></b>		
\$ Griseofulvin Microsize	GRIFULVIN V	
\$ Griseofulvin Ultramicronsize	GRIS-PEG	
\$ Nystatin*	MYCOSTATIN	
<i>Imidazole-Related Antifungals</i>		
\$ Ketoconazole*	NIZORAL	<i>OTC product</i>
\$ Miconazole*	MONISTAT	
\$\$ Terbinafine*	LAMISIL	
\$\$ Itraconazole*	SPORANOX	
<b>Prior Authorization Required</b>		
<i>Triazoles</i>		
\$ Fluconazole*	DIFLUCAN	
<b>Prior Authorization Required (requires PA after 1 x 150mg dispensed)</b>		
<b><u>ANTIVIRAL</u></b>		
<i>Neuraminidase Inhibitors</i>		
\$\$ Oseltamivir Phosphate	TAMIFLU	<i>QL=1 course of treatment per calendar year</i>
\$\$ Zanamivir	RELENZA	<i>QL=1 course of treatment per calendar year</i>
<i>CMV Agents</i>		
\$\$\$\$ Ganciclovir*	CYTOVENE	

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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*Hepatic Agents*

\$\$\$\$\$ Boceprevir	VICTRELIS	
\$\$\$\$\$ Peginterferon	PEG-INTRON, PEGASYS	
\$\$\$\$\$ Ribavirin*	REBETOL	
\$\$\$\$\$ Telaprevir	INCIVEK	
<b>Prior Authorization Required</b>		

*Herpes Agents*

\$\$ Amantadine*	SYMMETREL	
\$\$\$ Acyclovir*	ZOVIRAX	<i>PA for ointment</i>

**II. BIOLOGICALS**

**ANTISERA**

*Antiviral Monoclonal Antibodies*

\$\$\$\$\$ Palivizumab	SYNAGIS	
<b>Prior Authorization Required</b>		

**III. ANTINEOPLASTICS**

**ANTINEOPLASTICS**

*Alkylating Agents*

\$\$\$\$\$ Busulfan	MYLERAN	
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*Nitrogen Mustards*

\$\$\$\$\$ Chlorambucil	LEUKERAN	
\$\$\$\$\$ Cyclophosphamide*	CYTOXAN	
\$\$\$\$\$ Melphalan	ALKERAN	

*Nitrosoureas*

\$\$\$\$\$ Lomustine	CEENU	
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*Antimetabolites*

\$\$\$\$\$ Capecitabine	XELODA	
\$\$\$\$\$ Fluorouracil*	EFUDEX	<i>2% and 5% cream only</i>
\$\$\$\$\$ Mercaptopurine*	PURINETHOL	
\$\$\$\$\$ Methotrexate*	RHEUMATREX	
\$\$\$\$\$ Thioguanine	TABLOID	

*Progestins-Antineoplastic*

\$\$\$\$ Megestrol*	MEGACE	
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*Antiandrogens*

\$\$\$\$\$ Flutamide*	FLUTAMIDE	
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*Aromatase Inhibitors*

\$\$\$\$\$ Letrozole*	FEMARA	
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*Antineoplastic Hormones Misc.*

\$\$\$\$\$ Tamoxifen*	NOLVADEX	
\$\$\$\$\$ Leuprolide	LUPRON	
<b>Prior Authorization Required</b>		

*Mitotic Inhibitors*

\$\$\$\$ Etoposide*	VEPESID	
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Antineoplastics Misc.</i>		
\$\$\$\$ Erlotinib	TARCEVA	
\$\$\$ Hydroxyurea*	HYDREA	
\$\$\$\$ Mitotane	LYSODREN	
\$ Procarbazine	MATULANE	
\$\$\$\$ Sorafenib	NEXAVAR	
\$\$\$\$ Interferon Alfa-2A	ROFERON-A	
\$\$\$\$ Interferon Alfa-2B	INTRON-A	
\$\$\$\$ Interferon Alfa-n3	ALFERON N	
\$\$\$\$ Interferon Beta-1a	AVONEX	
\$\$\$\$ Interferon Beta-1a	REBIF	
\$\$\$\$ Interferon Beta-1b	BETASERON	
\$\$\$\$ Glatiramer acetate	COPAXONE	
<b>Prior Authorization Required</b>		

**IV. ENDOCRINE & METABOLIC DRUGS**

**CORTICOSTEROIDS**

<i>Glucocorticosteroids</i>		
\$ Cortisone*	CORTISONE	
\$ Dexamethasone*	DEXAMETHASONE	<i>no dose paks</i>
\$ Hydrocortisone*	CORTEF	
\$ Methylprednisolone*	MEDROL	<i>no dose paks</i>
\$ Prednisone*	PREDNISONE	
\$ Prednisolone*	PRELONE	
\$\$ Prednisolone Na Phosphate*	PEDIAPRED	
<i>Mineralocorticoids</i>		
\$ Fludrocortisone*	FLORINEF	

**ANDROGEN-ANABOLIC**

<i>Androgens</i>		
\$\$\$ Methyltestosterone	ANDROID	
\$\$\$ Danazol*	DANAZOL	
\$\$\$ Testosterone Gel	ANDROGEL, TESTIM	<i>Male only</i>
<b>Priorauthorization Required</b>		

**ESTROGENS**

\$ Estradiol*	ESTRACE	
\$\$ Esterified Estrogens	MENEST	
\$\$ Estrogens, Conjugated	PREMARIN	
\$\$\$ Estradiol Patch*	CLIMARA	
<i>Estrogen Combinations</i>		
\$\$ Conjugated Estrogens & Medroxyprogesterone*	PREMPRO	

**CONTRACEPTIVES**

\*\*\*All generic oral contraceptives are formulary\*\*\*

<i>Progestin</i>		
\$\$\$ Norethindrone*	NOR-QD, ORTHO MICRON	<i>Females only</i>
<i>Combinations</i>		
\$\$ Desogestral & Ethinyl Estradiol*	DESOGEN, ORTHO-CEPT	<i>Females only</i>
\$\$ Drospirenone & Ethinyl Estradiol*	YASMIN, YAZ	<i>Females only</i>
\$\$ Drospirenone-Eth Estrad Levomefolate	SAFYRAL, BEYAZ	<i>Females only</i>
\$\$ Ethynodiol Diacet & Eth Estrad*	ZOVIA	<i>Females only</i>
\$\$\$ Etonogestrel-Ethinyl Estradiol	NUVARING	<i>Females only</i>
\$\$ Levonorgestrel & Eth Estradiol*	NORDETTE, AVIANE	<i>Females only</i>
\$\$ Norethindrone & Eth Estradiol*	MODICON, BREVICON	<i>Females only</i>
\$\$ Norethindrone Ace-Ethinyl Estrad	LOESTRIN	<i>Females only</i>
\$\$ Norgestrel & Ethinyl Estradiol*	CRYSSELLE, OGESTREL	<i>Females only</i>
\$\$ Norgestimate & Ethinyl Estradiol*	ORTHO-CYCLLEN	<i>Females only</i>
\$\$ Norethindrone & Ethinyl Estrad FE	FEMCON FE	<i>Females only</i>
\$\$ Norethindrone Ace-Ethinyl Estrad FE	LOESTRIN FE	<i>Females only</i>
\$\$\$ Norelgestromin-Ethinyl Estradiol	ORTHO EVRA PATCH	<i>Females only</i>

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Biphasic</i>		
\$\$ Desogest-Eth Estrad & Eth Estrad	MIRCETTE	Females only
\$\$ Norethindrone & Mestranol	NORINYL, NECON	Females only
\$\$ Norethin-Eth Estrad-FE	LO LOESTRIN FE	Females only
<i>Triphasic</i>		
\$\$ Desogest-Ethin Est	CYCLESSA	Females only
\$\$ Levonorgestrel-Eth Estradiol*	TRIVORA	Females only
\$\$ Norethindrone-Ethinyl Estrad*	ORTHO NOVUM 7/ 7/ 7	Females only
\$\$ Norgestimate-Ethinyl Estradiol*	ORTHO TRI-CYCLEN / LO	Females only
\$\$\$ Norethindrone Ac-Ethinyl Estrad FE	ESTROSTEP FE	Females only
<i>Four Phase</i>		
\$\$ Estradiol Valerate-Dienogest	NATAZIA	Females only
<i>Extended</i>		
\$\$ Levonorgestrel & Ethinyl Estradiol	SEASONIQUE,QUARTETTE LOSEASONIQUE	Females only
<i>Continuous</i>		
\$\$ Levonorgestrel-Ethinyl Estradiol	AMETHYST	Females only
<b><u>PROGESTINS</u></b>		
\$ Medroxyprogesterone*	PROVERA	tabs only / females only
\$\$\$ Medroxyprogesterone Acetate Susp/IM	DEPO-PROVERA DEPO-SQ PROVERA 104	Females only
\$ Norethindrone*	AYGESTIN	
<b><u>EMERGENCY CONTRACEPTIVE</u></b>		
\$\$ Levonorgestrel*	PLAN B ONE STEP PLAN B	1 kit / month / 3 kits / yr Females only No prescription required for OTC formulation
<b><u>ANTIDIABETIC</u></b>		
<i>Thiazolidinediones/Combination</i>		
\$\$ Pioglitazone*	ACTOS	QL = 30 tabs / month
\$\$\$ Pioglitazone-Glimepiride	DUETACT	QL = 30 tabs / month
\$\$\$ Pioglitazone-Metformin	ACTOPLUS MET/XR	QL = 30 tabs / month
\$ Rosiglitazone Maleate	AVANDIA	QL = 30 tabs / month
\$\$ Rosiglitazone Maleate-Metformin	AVANDAMET	QL = 30 tabs / month
\$\$ Rosiglitazone Maleate-Glimperide	AVANDARYL	QL = 30 tabs / month
<b>Prior Authorization Required</b>		
<i>Human Insulin</i>		
\$ Insulin Aspart	NOVOLOG	
\$ Insulin Isophane	HUMULIN N	
\$ Insulin Isophane	NOVOLIN N	
\$ Insulin Lispro	HUMALOG	
\$ Insulin Reg & Isophane	HUMULIN 50/50	
\$ Insulin Reg & NPH	HUMULIN 70/30	
\$ Insulin Reg & NPH	NOVOLIN 70/30	
\$ Insulin Regular	HUMULIN R	
\$ Insulin Regular	NOVOLIN R	
\$\$ Insulin Glargine	LANTUS	
<i>Sulfonylureas</i>		
\$ Glimepiride*	AMARYL	
\$\$ Glipizide*	GLUCOTROL/XL	
\$\$ Glyburide*	DIABETA, GLYNASE	
<i>Alpha-Glucosidase Inhibitors</i>		
\$\$ Acarbose*	PRECOSE	QL = 90 tabs / month
<b>Prior Authorization Required</b>		
<i>Incretin Mimetic</i>		
\$\$\$\$ Exenatide	BYETTA	
\$\$\$\$ Liraglutide	VICTOZA	
<b>Prior Authorization Required</b>		
<i>Diabetic Other</i>		
\$ Metformin*	GLUCOPHAGE	
\$\$\$ Glucagon	GLUCAGON	

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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**THYROID**

*Thyroid Hormones*

\$ Levothyroxine*	LEVOXYL, SYNTHROID	
\$ Liothyronine*	CYTOMEL	
\$ Thyroid*	THYROID	

*Antithyroid Agents*

\$ Methimazole*	TAPAZOLE	
\$ Propylthiouracil*	PROPYLTHIOURACIL	

**OXYTOCICS**

\$ Methylergonovine*	METHERGINE	
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**MISC. ENDOCRINE**

*Calcium Regulators*

\$\$\$\$ Calcitonin (Salmon)	MIACALCIN INJ	
\$\$\$\$ Calcitonin (Salmon)*	MIACALCIN NASAL	
<b>Prior Authorization Required</b>		

*Hormone Receptor Modulators*

\$\$\$ Raloxifene	EVISTA	
<b>Prior Authorization Required</b>		

*Gonadotropin Releasing Hormones*

\$\$\$\$\$ Nafarelin	SYNAREL	
<b>Prior Authorization Required</b>		

*Growth Hormone*

\$\$\$\$\$\$ Somatropin	HUMATROPE ONLY	
<b>Prior Authorization Required</b>		

*Posterior Pituitary*

\$\$\$ Alendronate*	FOSAMAX	
\$\$\$\$ Alendronate + Cholecalciferol	FOSAMAX PLUS D	
\$\$\$\$ Ibandronate*	BONIVA	
\$\$\$\$ Risedronate	ACTONEL	
\$\$\$\$\$ Desmopressin*	DDAVP	<i>(all dosage forms)</i>
<b>Prior Authorization Required</b>		

*Parathyroid Hormone*

\$\$\$\$\$ Teriparatide	FORTEO	
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**V. CARDIOVASCULAR AGENTS**

**CARDIOTONICS**

*Digitalis*

\$ Digoxin*	LANOXIN	<i>no caps</i>
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**ANTIANGINAL AGENTS**

*Nitrates*

\$ Isosorbide Dinitrate*	ISORDIL, ISORDIL TEMBIDS	
\$ Nitroglycerin (oral)*	NITROSTAT	
\$\$\$ Nitroglycerin (topical)*	NITRODUR, NITROBID	
\$\$ Isosorbide Mononitrate*	IMDUR	
<b>Prior Authorization Required</b>		

*Antianginals-Other*

\$ Dipyridamole*	PERSANTINE	
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<b><u>BETA BLOCKERS</u></b>		
<i>Beta Blockers Non-Selective</i>		
\$ Propranolol*	INDERAL/LA	
\$ Timolol*	TIMOLOL	
\$\$\$ Sotalol*	BETAPACE	
\$\$\$ Carvedilol*	COREG	
<i>Beta Blockers Cardio-Selective</i>		
\$ Atenolol*	TENORMIN	
\$ Metoprolol Tartrate*	LOPRESSOR	
\$\$\$ Metoprolol Succinate*	TOPROL XL	
<i>Alpha-Beta Blockers</i>		
\$\$\$ Labetalol*	TRANDATE	
<b><u>CALCIUM BLOCKERS</u></b>		
\$\$\$ Amlodipine*	NORVASC	
\$\$\$ Amlodipine & Benazepril*	LOTREL	
\$\$\$ Diltiazem*	CARDIZEM/CD, DILACOR/XR	
\$\$ Felodipine*	PLENDIL	
\$\$\$ Nifedipine*	ADALAT CC, PROCARDIA XL	
\$\$ Verapamil*	CALAN, SR	
<b><u>ANTIARRHYTHMIC</u></b>		
\$\$\$ Amiodarone*	CORDARONE	
\$ Disopyramide*	NORPACE, CR	
\$\$\$ Flecainide*	TAMBOCOR	
\$ Procainamide*	PRONESTYL, PROCANBID	
\$ Quinidine Sulfate*	QUINIDINE SULFATE	
\$\$\$\$ Mexiletine*	MEXILETINE	
\$\$\$\$ Propafenone*	RYTHMOL	
<b><u>ANTIHYPERTENSIVE</u></b>		
<i>ACE Inhibitors</i>		
\$ Captopril*	CAPOTEN	
\$\$ Benazepril*	LOTENSIN	
\$\$ Enalapril*	VASOTEC	
\$\$ Fosinopril*	MONOPRIL	
\$\$ Lisinopril*	ZESTRIL	
\$\$ Quinapril*	ACCUPRIL	
\$\$ Ramipril*	ALTACE	
<i>ACE II Inhibitors</i>		
\$\$\$ Irbesartan*	AVAPRO	QL = 30 tabs / month
\$\$ Losartan potassium*	COZAAR	QL = 30 tabs / month
\$\$\$ Valsartan	DIOVAN	QL = 30 tabs / month
<i>Adrenolytics - Central</i>		
\$ Clonidine*	CATAPRES	no patches
\$ Guanfacine*	TENEX	
\$ Methyldopa*	METHYLDOPA	
<i>Adrenolytics - Peripheral</i>		
\$ Reserpine*	RESERPINE	
<i>Alpha Blockers</i>		
\$\$ Doxazosin*	CARDURA	
\$ Prazosin*	MINIPRESS	
\$\$\$\$ Tamsulosin*	FLOMAX	
\$\$\$ Terazosin*	HYTRIN	
<i>Vasodilators</i>		
\$ Hydralazine*	APRESOLINE	
\$ Minoxidil*	MINOXIDIL	

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Beta Blocker Combinations</i>		
\$ Atenolol & Chlorthalidone*	TENORETIC	
\$\$\$ Metoprolol & HCTZ*	LOPRESSOR HCT	
\$ Propranolol & HCTZ*	INDERIDE	no LA
<i>ACE and ACE II Inhibitors &amp; Diazines</i>		
\$\$\$\$ Irbesartan & HCTZ*	AVALIDE	QL = 30 tabs / month
\$ Lisinopril & HCTZ*	ZESTORETIC	
\$\$\$ Losartan potassium/HCTZ*	HYZAAR	QL = 30 tabs / month
\$\$\$\$ Valsartan & HCTZ*	DIOVAN HCT	QL = 30 tabs / month
<i>Adrenolytics-Central &amp; Thiazides</i>		
\$ Methyldopa & HCTZ*	METHYLDOPA & HCTZ	
\$\$ Clonidine & Chlorthalidone*	CLORPRES	
<i>Vasodilators &amp; Thiazides</i>		
\$ Hydralazine & HCTZ*	HYDRALAZINE & HCTZ	

**DIURETICS**

<i>Carbonic Anhydrase Inhibitors</i>		
\$ Acetazolamide*	DIAMOX	no sequeis
\$\$\$ Methazolamide*	METHAZOLAMIDE	
<i>Loop Diuretics</i>		
\$ Furosemide*	LASIX	
<i>Potassium Sparing Diuretics</i>		
\$ Spironolactone*	ALDACTONE	
<i>Thiazides</i>		
\$ Chlorothiazide*	DIURIL	
\$ Chlorthalidone*	CHLORTHALIDONE	
\$ Hydrochlorothiazide*	HYDROCHLOROTHIAZIDE	
\$ Methyclothiazide*	METHYCLOTHIAZIDE	
\$ Metolazone*	ZAROXOLYN	
\$ Indapamide*	INDAPAMIDE	
<i>Combination Diuretics</i>		
\$ Spironolactone & HCTZ*	ALDACTAZIDE	
\$ Triamterene & HCTZ*	MAXZIDE	
<i>Osmotic Diuretics</i>		
\$ Glycerin Supp.*	GLYCERIN	adult, infant, child

**PRESSORS**

<i>Emergency Kits</i>		
\$\$\$\$ Epinephrine	EPI-PEN, EPI-PEN JR	

**ANTIHYPERLIPEMIC**

<i>Bile Sequestrants</i>		
\$\$\$ Cholestyramine*	QUESTRAN, LIGHT	cans only
\$\$\$ Colestipol*	COLESTID	cans only
<i>Misc.</i>		
\$ Niacin*	NIACIN	OTC (slow release)
\$ Niacin CR*	NIASPAN	
\$\$\$ Fenofibrate*	LOFIBRA	54mg and 160mg
\$\$\$ Fenofibrate*	TRICOR	48mg and 145mg
\$\$ Gemfibrozil*	LOPID	
\$\$\$\$ Omega-3-acid ethyl esters	LOVAZA	
\$\$\$\$ Fenofibrate	LIPOFEN, TRIGLIDE	
\$\$\$\$ Fenofibrate acid*	TRILIPIX	
\$\$\$\$ Fenofibrate micronized	ANTARA	
\$\$\$\$ Ezetimibe	ZETIA	

**Prior Authorization Required**

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>HMG CoA Reductase Inhibitors</i>		
\$\$\$\$ Amlodipine & Atorvastatin	CADUET	
\$\$\$\$ Atorvastatin*	LIPITOR	QL = 30 tabs / month
\$\$\$\$ Fluvastatin*	LESCOL	QL = 30 tabs / month
\$\$ Lovastatin*	MEVACOR	QL = 30 tabs / month
\$\$\$\$ Niacin & Lovastatin	ADVICOR	
\$ Pravastatin*	PRAVACHOL	QL = 30 tabs / month
\$ Simvastatin*	ZOCOR	QL = 30 tabs / month
\$\$\$ Simvastatin*	ZOCOR	80mg only / QL = 30 tabs / month
\$\$\$\$ Ezetimibe + Simvastatin	VYTORIN	
\$\$\$\$ Rosuvastatin Calcium	CRESTOR	QL = 30 tabs / month
<b>Prior Authorization Required</b>		

**VI. RESPIRATORY AGENTS**

**ANTI-HISTAMINES**

<i>Antihistamines - Ethanolamines</i>		
\$ Diphenhydramine*	BENADRYL	OTC product
<i>Antihistamines - Non Sedating</i>		
\$\$ Loratadine*	ALAVERT, CLARITIN	OTC product
\$\$ Loratadine / Pseudoephedrine*	CLARITIN-D 12hr, 24hr	OTC product
\$\$ Cetirizine*	ZYRTEC	chew tabs/liquid AL ≤ 18
\$\$ Cetirizine tabs*	ZYRTEC	
\$\$ Fexofenadine*	ALLEGRA OTC	30 or 60 per 30 days
\$\$ Fexofenadine / Pseudoephedrine*	ALLEGRA-D OTC 12hr, 24hr	30 or 60 per 30 days
<i>Antihistamines - Phenothiazines</i>		
\$ Promethazine*	PROMETHAZINE	tabs only AL ≥ 2 years

**SYSTEMIC AND TOPICAL NASAL PRODUCTS**

<i>Nasal Antihistamines</i>		
\$\$\$\$ Azelastine*	ASTELIN	
<b>Prior Authorization Required</b>		
<i>Nasal Steroids</i>		
\$\$ Flunisolide*	NASALIDE	
\$\$ Triamcinolone*	NASACORT AQ	
\$\$\$ Fluticasone*	FLONASE	
\$\$\$\$ Mometasone furoate	NASONEX	
<i>Steroid Inhalants</i>		
\$\$\$\$ Fluticasone	FLOVENT HFA	
\$\$\$ Triamcinolone	AZMACORT	
\$\$\$\$ Budesonide	PULMICORT FLEXHALER	
\$\$\$\$ Budesonide*	PULMICORT RESPULES	AL = 4 years and under QL = 1 box / 30 days
\$\$\$\$ Beclomethasone Dipropionate	QVAR	
<i>Mucolytics</i>		
\$\$ Acetylcysteine*	MUCOMYST	
<b><u>ANTI-ASTHMATIC</u></b>		
<i>Anticholinergics</i>		
\$\$ Ipratropium*	ATROVENT/NASAL	
\$\$\$\$ Ipratropium	ATROVENT HFA	
\$\$\$\$ Tiotropium	SPIRIVA	
\$\$\$\$\$ Acridinium Bromide	TUDORZA PRESSAIR	QL = 1 inh / 30 days
<b>Prior Authorization Required</b>		
<i>Anti-Inflammatory Agents</i>		
\$\$\$ Cromolyn (inhalation)*	INTAL	
\$ Cromolyn (nasal)*	NASALCROM	

## BioScrip/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Beta Adrenergics</i>		
\$\$ Albuterol	PROVENTIL/VENTOLIN HFA	
\$\$ Albuterol*	ALBUTEROL NEBULIZER SOLUTION	0.5% (5mg/mL) and 0.083% (2.5mg/3ml)
\$\$\$ Pirbuterol	MAXAIR AUTOHALER	
\$\$ Albuterol	PROAIR HFA	
\$\$\$ Salmeterol	SEREVENT DISKUS	
<b>Prior Authorization Required</b>		
<i>Adrenergic Combinations</i>		
\$\$\$\$ Ipratropium-Albuterol	COMBIVENT RESPIMAT	
\$\$\$\$ Albuterol-Ipratropium*	DUONEB	
\$\$\$\$ Salmeterol-Fluticasone	ADVAIR / ADVAIR HFA	Step therapy
\$\$\$\$ Budesonide-Formoterol	SYMBICORT	Step therapy
<b>Prior Authorization Required</b>		
<i>Sympathomimetic Agents</i>		
\$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	OTC product
<i>Mixed Adrenergics</i>		
\$\$\$\$ Epinephrine	EPI-PEN, EPI-PEN JR	
<i>Xanthines</i>		
\$ Aminophylline*	AMINOPHYLLINE	
\$ Theophylline*	THEO-24, UNIPHYL	
<i>Leukotriene Receptor Antagonists</i>		
\$\$\$ Montelukast Sodium*	SINGULAIR	

### COUGH/COLD/ALLERGY

<i>Expectorants</i>		
\$ Guaifenesin*	GUAIFENESIN	OTC product
\$ Guaifenesin/DM*	GUAIFENESIN DM	OTC product
<i>Cough/Cold/Allergy Combinations</i>		
\$ Brompheniramine / Pseudoephedrine*	CVS COLD ALLERGY ELIXIR	
\$ Pseudoephedrine HCL soln*	PEDIACARE INFANT	
\$ Pseudoephedrine-Bromphen-DM*	CVS COLD ALLERGY DM ELIXIR	
\$ Pseudoephedrine-Chlorphen-DM*	CVS TRIACTING MULTI-SYMPATOM LIQUID	
\$ Pseudoephedrine-DM liquid*	CVS COUGH FORMULA D	
\$ Pseudoephedrine-DM soln*	CVS INFANT DECONGESTANT AND COUGH DROPS	
\$ GG/Codeine sol	CHERATUSSIN SYP AC	
\$ Benzonatate*	TESSALON, TESSALON PERLES	
\$\$ Hydrocodone-GG*	HYCOTUSS	
\$\$ Pseudoephedrine-GG*	DURATUSS	

## VII. GASTROINTESTINAL AGENTS

### LAXATIVES

<i>Surfactant Laxatives</i>		
\$ Docusate Sodium*	COLACE	OTC product
<i>Stimulant Laxatives</i>		
\$ Bisacodyl*	DULCOLAX	OTC product
<i>Bulk Laxatives</i>		
\$ Polycarbophil Calcium*	FIBERCON	OTC product
<i>Miscellaneous Laxatives</i>		
\$ Glycerin*	GLYCERIN	OTC product
\$ Lactulose*	LACTULOSE	
\$ PEG-Electrolyte*	GOLYTELY	

### ANTIDIARRHEALS

<i>Antiperistaltic Agents</i>		
\$ Diphenoxylate w/ Atropine*	LOMOTIL	
\$ Loperamide*	IMODIUM	OTC product

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Misc Antidiarrheal Agents</i>		
\$ Bismuth Subsalicylate*	PEPTO-BISMOL	<i>no tabs, OTC</i>
\$\$\$ Octreotide Acetate*	SANDOSTATIN	
<b>Prior Authorization Required</b>		

**ANTACIDS**

<i>Antacids - Aluminum Salts</i>		
\$ Aluminum Hydroxide Gel*	ALUMINUM HYDROXIDE	<i>OTC product</i>
<i>Antacids - Calcium Salts</i>		
\$ Calcium Carbonate*	OS-CAL	<i>OTC product</i>
<i>Antacid Combinations</i>		
\$ Al Hydrox-Mag Carb*	MAALOX	<i>no tabs, OTC</i>
\$ Aluminum & Magnesium Hydroxide*	MYLANTA	<i>no tabs, OTC</i>

**ULCER DRUGS**

<i>Belladonna Alkaloids</i>		
\$ Hyoscyamine Sulfate*	LEVSIN	
<i>Quaternary Anticholinergics</i>		
\$ Propantheline Bromide*	PRO-BANTHINE	
<i>Antispasmodics</i>		
\$ Dicyclomine*	BENTYL	
<i>H-2 Antagonists</i>		
\$ Famotidine*	PEPCID	<i>tabs only</i>
\$ Ranitidine*	ZANTAC	<i>no caps</i>
<i>Proton Pump Inhibitors</i>		
\$\$ Omeprazole*	PRIOSEC OTC	<i>OTC</i>
\$\$ Lansoprazole*	PREVACID	<i>OTC</i>
\$\$\$ Lansoprazole*	PREVACID	<i>RX</i>
\$\$\$ Pantoprazole	PROTONIX	
<b>Prior Authorization Required</b>		

<i>Misc. Anti-Ulcer</i>		
\$\$ Sucralfate*	CARAFATE TABLETS	
\$\$\$ Sucralfate*	CARAFATE SUSPENSION	
<b>Prior Authorization Required</b>		

**ANTIEMETICS**

<i>Antiemetics - Anticholinergic</i>		
\$ Meclizine*	ANTIVERT	
\$\$ Prochlorperazine*	PROCHLORPERAZINE	<i>no SR</i>
<i>5-HT3 Receptor Antagonists</i>		
Ondansetron*	ZOFRAN	<i>tablets only</i>
		<i>QL = 10 tabs per fill</i>
\$\$ Ondansetron*	ZOFRAN	<i>ODT: QL = 10 tabs per fill</i>
		<i>Suspension: QL = 50mls per fill</i>
<b>Prior Authorization Required</b>		

**DIGESTIVE AIDS**

<i>Digestive Aids - Mixtures</i>		
\$\$\$\$ Pancrelipase (Lip-Prot-Amyl)	VIOKACE	
\$\$\$\$ Pancrelipase (Lip-Prot-Amyl) DR	CREON	

**MISC. GI**

<i>GI Stimulants</i>		
\$ Metoclopramide*	REGLAN	<i>no 5mg tabs</i>



**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Inflammatory Bowel Agents</i>		
\$\$\$\$ Mesalamine	ASACOL	400mg tabs
\$\$\$\$ Mesalamine	PENTASA	
\$\$\$\$ Mesalamine*	ROWASA	
\$ Sulfasalazine*	AZULFIDINE	no EN tabs

**VIII. GENITOURINARY**

**URINARY ANTIINFECTIVES**

\$ Methenamine Mandelate*	MANDELAMINE	
\$\$\$ Nitrofurantoin*	FURADANTIN	
\$\$ Nitrofurantoin Macrocrystals*	MACROBID	
\$ Trimethoprim*	PROLOPRIM	

**URINARY ANTISPASMODICS**

\$ Bethanechol*	URECHOLINE	
\$\$\$ Finasteride*	PROSCAR	
\$\$\$ Flavoxate*	URISPAS	
\$ Hyoscyamine*	LEVSINEX	
\$ Oxybutynin*	DITROPAN	

**VAGINAL PRODUCTS**

*Vaginal Antiinfectives*

\$\$ Clindamycin*	CLEOCIN	
\$ Nystatin*	NYSTATIN	
\$\$ Sulfanilamide	AVC	
\$\$ Metronidazole*	METROGEL-VAGINAL	

**Prior Authorization Required**

*Imidazole-Related Antifungals*

\$ Butoconazole Nitrate*	GYNAZOLE-1	OTC product
\$ Clotrimazole*	MYCELEX	OTC product
\$ Miconazole*	MONISTAT	OTC product

*Vaginal Antiinfective Combinations*

\$ Triple Sulfas Vaginal*	TRIPLE SULFAS VAGINAL	
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**MISCELLANEOUS GENITOURINARY PRODUCTS**

*Citrates*

\$ Sodium Citrate & Citric Acid*	ORACIT	
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*Urinary Analgesics*

\$ Phenazopyridine*	PYRIDIUM	
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**IX. CENTRAL NERVOUS SYSTEM DRUGS**

**ANTIPSYCHOTICS**

*Phenothiazines*

\$\$ Prochlorperazine*	PROCHLORPERAZINE	no SR
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**HYPNOTICS**

*Barbiturate Hypnotics*

\$ Butabarbital	BUTISOL	
\$ Mephobarbital	MEBARAL	
\$ Phenobarbital*	PHENOBARBITAL	

*Antihistamine Hypnotics*

\$ Diphenhydramine*	BENADRYL	OTC product
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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**X. ANALGESICS & ANESTHETICS**

**ANALGESICS - NonNarcotic**

*Salicylates*

\$ Aspirin zero order*	ZORPRIN	
\$\$ Salsalate*	AMIGESIC	

*Salicylate Combinations*

\$ Aspirin Enteric Coated*	ECOTRIN	OTC product
\$ Aspirin with Buffers*	ASPIRIN BUFFERED	OTC product
\$\$ Choline & Mag Salicylate*	CHOLINE & MAG SALICYLATE	

*Analgesics Other*

\$ Acetaminophen*	TYLENOL	OTC product
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*Analgesics - Sedatives*

\$ APAP/Caffeine/Butalbital*	FIORICET	50/325/40 mg only
\$ Aspirin/Caffeine/Butalbital*	FIORINAL	50/325/40 mg only

**ANALGESICS - Narcotic**

*Narcotic Agonists*

\$ Codeine Phosphate*	CODEINE PHOSPHATE	
\$ Codeine Sulfate*	CODEINE SULFATE	
\$\$\$ Hydromorphone*	DILAUDID	
\$ Meperidine*	DEMEROL	
\$ Methadone*	METHADONE	
\$\$\$ Morphine Sulfate*	MSIR	
\$\$\$\$ Morphine Sulfate SR*	MS CONTIN	QL = 90 tabs / 30 days
\$\$\$\$ Naltrexone*	REVIA	
\$\$\$ Oxycodone*	XYRIN	5mg caps
\$\$\$ Oxycodone*	ROXICODONE	5mg, 15mg, 30mg tabs and 20mg/mL oral soln
\$\$\$ Tramadol*	ULTRAM	QL = 240 tabs / 30 days
\$\$\$\$ Tramadol/APAP*	ULTRACET	QL = 240 tabs / 30 days
\$\$\$\$\$ Tramadol ER*	ULTRAM ER	QL = 30 tabs / 30 days
\$\$\$\$\$ Fentanyl*	DURAGESIC	QL = 10 patches/ 30 days
\$\$\$\$\$ Oxycodone CR*	OXYCONTIN	QL = 60 tabs / 30 days

**Prior Authorization Required**

*Narcotic Agonist-Antagonist*

\$\$\$\$\$ Buprenorphine HCL-Naloxone HCL	SUBOXONE	QL = 90 / 30 days Film and Generic tabs
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*Opiate Partial Agonist*

\$\$\$\$ Buprenorphine HCL*	BUPRENORPHINE HCL	QL = 1 fill / 6 months
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*Narcotic Combinations*

\$ Oxycodone w/ Acetaminophen*	PERCOCET	QL = 120 / 30 days 5/500 tabs and caps 5/325 tabs and soln
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*Codeine Combinations*

\$ Acetaminophen w/ Codeine*	TYLENOL / CODEINE	
\$ Aspirin w/ Codeine*	ASPIRIN / CODEINE	

*Hydrocodone Combinations*

\$\$ Acetaminophen w/ Hydrocodone*	VICODIN, LORTAB, NORCO XODOL	QL = 180 tabs / 30 days 5/500, 5/325 and 5/300 mg tabs
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*Propoxyphene Combinations*

\$ Propoxyphene w/ APAP*	PROPOXYPHENE W/ APAP	100mg tabs
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<b><u>ANTI-RHEUMATIC</u></b>		
<i>NSAID's</i>		
\$\$ Diclofenac*	VOLTAREN	
\$\$ Etodolac*	ETODOLAC	
\$\$ Fenoprofen*	NALFON	
\$\$\$ Flurbiprofen*	ANSAID	
\$ Ibuprofen*	MOTRIN	
\$ Indomethacin*	INDOCIN	<i>no SR or supp.</i>
\$ Meloxicam*	MOBIC	
\$ Naproxen*	NAPROSYN	<i>no EC</i>
\$ Naproxen Sodium*	ANAPROX	
\$ Piroxicam*	FELDENE	
\$\$ Sulindac*	CLINORIL	
<i>COX-2 Inhibitor</i>		
\$\$\$\$ Celecoxib	CELEBREX	
<b>Prior Authorization Required</b>		
<i>Anti-Rheumatic Antimetabolite</i>		
\$\$\$\$ Methotrexate*	RHEUMATREX	
<b><u>GOUT</u></b>		
\$ Allopurinol*	ZYLOPRIM	
\$\$\$\$ Colchicine	COLCRYS	
<i>Uricosurics</i>		
\$ Probenecid*	PROBENECID	
<b><u>LOCAL ANESTHETICS</u></b>		
\$ Lidocaine*	LIDOCAINE	<i>2% gel only</i>
\$\$\$\$ Lidocaine*	LIDODERM PATCHES	<i>QL = 90 patches /30days</i>
<b><u>MIGRAINE PRODUCTS</u></b>		
\$\$\$ Ergoloid mesylates*	HYDERGINE	
\$\$\$\$ Ergotamine tartrate	ERGOMAR	
\$\$\$\$ Sumatriptan tablets*	IMITREX	<i>QL = 9 tabs / 30 days</i>
\$\$\$\$ Sumatriptan injection*	IMITREX	<i>QL = 2 injections/30days</i>
		<i>(no nasal sprays)</i>
\$\$\$\$\$ Sumatriptan-naproxen	TREXIMET	<i>QL = 9 tabs / 30 days</i>
\$\$\$\$\$ Rizatriptan tablets*	MAXALT	<i>QL = 6 tabs / 30 days</i>
\$\$\$\$ Zolmitriptan tablets*	ZOMIG	<i>QL = 6 tabs / 30 days</i>
		<i>tabs only</i>
<b>Prior Authorization Required</b>		
<i>Migraine Combinations</i>		
\$\$ Ergotamine w/ Caffeine	CAFERGOT	
<b>XI. NEUROMUSCULAR AGENTS</b>		
<b><u>ANTICONVULSANT</u></b>		
<i>Hydantoins</i>		
\$\$ Phenytoin*	DILANTIN	
<i>Succinimides</i>		
\$\$ Ethosuximide*	ZARONTIN	
<i>Miscellaneous Anticonvulsants</i>		
\$\$\$ Primidone*	MYSOLINE	

**BioScrip/Jai Medical Systems Therapeutic Formulary**

Generic Name

Brand Name

Annotation

**ANTIPARKINSONIAN**

*COMT Inhibitors*

\$\$\$ Entacapone*	COMTAN	
<b>Prior Authorization Required</b>		

*Dopaminergic*

\$ Amantadine\*

SYMMETREL

\$\$\$ Bromocriptine\*

PARLODEL

*no postpartum use*

\$\$ Ropinirole\*

REQUIP

<b>Prior Authorization Required</b>		
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*Levodopa Combinations*

\$\$\$ Carbidopa-Levodopa\*

SINEMET, CR

*no 100-25 CR*

*Monoamine Oxidase Inhibitor*

\$\$\$\$ Selegiline\*

ELDEPRYL

**MUSCULOSKELETAL THERAPY AGENTS**

*Central Muscle Relaxants*

\$\$ Baclofen\*

BACLOFEN

\$ Cyclobenzaprine\*

FLEXERIL

\$ Methocarbamol\*

ROBAXIN

*Direct Muscle Relaxants*

\$\$\$\$ Dantrolene*	DANTRIUUM	
<b>Prior Authorization Required</b>		

*Fibromyalgia*

\$\$\$\$\$ Milnacipran	SAVELLA	
<b>Prior Authorization Required</b>		

*Muscle Relaxant Combinations*

\$ Methocarbamol w/ Aspirin\*

METHOCARBAMOL w/ASA

**ANTIMYASTHENIC AGENTS**

*Antimythsthenic Agents*

\$\$\$\$ Pyridostigmine\*

MESTINON

*Benzothiazoles*

\$\$\$\$\$ Riluzole*	RILUTEK	
<b>Prior Authorization Required</b>		

**XII. NUTRITIONAL PRODUCTS**

**VITAMINS**

*Water Soluble Vitamins*

\$ Niacin\*

NIACIN

*Oil Soluble Vitamins*

\$ Vitamin A\*

VITAMIN A

*Vitamin D*

\$\$ Calcitriol\*

ROCALTROL

*Vitamin D3*

\$\$ Ergocalciferol\*

DRISDOL

*Vitamin D2*

*Vitamin K*

\$\$ Mephyton

VITAMIN K

*QL = 5 tabs / 30 days*

## BioScrip/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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### MULTIVITAMINS

\$ Folic Acid & Vitamin B Complex*	NEPHROCAPS	
\$ Multiple Vitamin*	ONE-A-DAY	OTC product
\$ Multiple Vitamin w/ Minerals*	BEROCCA PLUS	
\$ Pediatric Vitamins*	CHILDS COMPLETE	OTC product
\$ Pediatric Multivitamins w/Fluoride*	POLY-VI-FLOR	6mos to 16 years only
\$ Pediatric Multivitamins w/Iron*	ONE-A-DAY KIDS COMPLETE	
\$ Prenatal MV & Min w/FE-FA*	PRENATAL-1	
\$ Prenatal Vitamins*	PRENATABS RX	

### CITRATES

\$ Sodium Citrate & Citric Acid*	ORACIT	
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### MINERALS & ELECTROLYTES

#### *Calcium*

\$ Calcium Acetate*	PHOSLO	caps only
\$ Calcium Carbonate*	OS-CAL	OTC product

#### *Fluoride*

\$ Sodium Fluoride*	LURIDE	
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#### *Potassium*

\$ Potassium Chloride Capsule*	MICRO-K	
\$ Potassium Chloride Liquid*	POTASSIUM CHLORIDE LIQUID	
\$ Potassium Chloride Tablet*	KLOR-CON	

#### *Electrolyte Mixtures*

\$ Oral Electrolytes*	PEDIALYTE	OTC product
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### DIETARY PRODUCTS

\$\$ Infant Foods	LOFENALAC	OTC product
\$\$ Phenyl-Free*	PHENYL-FREE	OTC product

### MISCELLANEOUS NUTRITIONAL PRODUCTS

\$\$ Nutritional Supplements	ENSURE, PEDIASURE, BOOST, VIVONEX	
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**Prior Authorization Required  
For enteral access only  
(Nutritional Supplements are not limited to this list)**

## XIII. HEMATOLOGICAL AGENTS

### HEMATOPOIETIC AGENTS

#### *Cobalamines*

\$ Folic Acid*	FOLIC ACID	
\$\$\$ Leucovorin Calcium*	LEUCOVORIN	
\$ Cyanocobalamin*	VITAMIN B-12	
\$ Hydroxocobalamin*	HYDROXOCOBALAMIN	

**Prior Authorization Required**

#### *Iron*

\$ Ferrous Gluconate*	FERGON	OTC product
\$ Ferrous Sulfate*	FEOSOL	OTC product

#### *Hematopoietic Growth Factors*

\$\$\$\$ Darbepoetin	ARANESP	4 injections / month
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**Prior Authorization Required**

#### *Erythropoietins*

\$\$\$\$\$ Epoetin Alfa	EPOGEN, PROCRIT	2,000U, 3,000U, 4,000U, 10,000 - QL = 12 injections / month
		20,000U, 40,000U - QL = 4 injections / month

**Prior Authorization Required**

#### *Leukocytes*

\$\$\$\$\$ Filgrastim	NEUPOGEN	QL = 30 injections / month
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**Prior Authorization Required**

**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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**ANTICOAGULANTS**

<i>Coumarin Anticoagulants</i> \$\$ Warfarin Sodium*	COUMADIN
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<i>Heparin Agents</i> \$\$\$\$\$ Enoxaparin*	LOVENOX
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<i>Thrombin Inhibitors</i> \$\$\$\$\$ Dabigatran	PRADAXA
<b>Prior Authorization Required</b>	

**HEMOSTATICS**

<i>Hemostatics - Topical</i> \$\$\$\$ Thrombin	THROMBIN
<b>Prior Authorization Required</b>	

**MISC. HEMATOLOGICAL**

<i>Antihemophilic Products</i>	
\$\$\$\$\$ Antihemophilic Factor (Human)	ALPHANATE
\$\$\$\$\$ Antihemophilic Factor (Recombinate)	RECOMBINATE
\$\$\$\$\$ Antinhibitor Coagulant Complex	FEIBA VH
\$\$\$\$\$ Antithrombin III (Human)	THROMBATE III
<b>Prior Authorization Required</b>	

<i>Platelet Aggregation Inhibitors</i> \$\$ Clopidogrel*	PLAVIX
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<i>Hematorheological</i> \$\$ Pentoxifylline*	TRENAL
<b>Prior Authorization Required</b>	

**XIV. BEHAVIORAL HEALTH AGENTS**

**MISCELLANEOUS**

<i>Smoking Deterrents</i>		
\$\$\$ Nicotine Patches*	NICODERM CQ	QL = 30 patches / 30 days
	NICODERM	6 months / 365 days
\$\$\$ Nicotine Gum*	NICORETTE	QL = 336 pieces / 30 days
		6 months / 365 days
\$\$\$\$ Nicotine Lozenges*	NICORETTE	QL = 360 pieces / 30 days
	COMMIT	6 months / 365 days
\$\$\$\$\$ Nicotine Nasal Spray	NICOTROL NS	QL = 18 / 6 months
\$\$\$\$\$ Nicotine Inhaler	NICOTROL INF	QL = 336 / 6 months
\$\$\$\$ Varenicline Tartrate	CHANTIX	
<b>Prior Authorization Required</b>		

<i>Reversible Acetylcholinesterase inhibitor</i>		
\$\$\$\$ Donepezil*	ARICEPT	
\$\$\$ Galantamine*	RAZADYNE / RAZADYNE ER	
\$\$\$ Rivastigmine*	EXELON	
<b>Prior Authorization Required</b>		

<i>Miscellaneous</i>		
\$\$\$ Disulfiram*	ANTABUSE	
\$\$\$\$ Acamprosate*	CAMPRAL	
\$\$\$\$\$ Clonidine*	KAPVAY	Please refer to Introduction page I-5
\$\$\$\$\$ Guanfacine	INTUNIV	Please refer to Introduction page I-5
\$\$\$ Memantine	NAMENDA	
<b>Prior Authorization Required</b>		

**ANTICONSULSANT**

<i>Misc. Anticonvulsants</i> \$\$\$ Primidone*	MYSOLINE
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
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**XV. TOPICAL AGENTS**

**OPHTHALMIC**

*Antibiotics*

\$\$\$ Bacitracin*	AK-TRACIN	
\$\$\$ Ciprofloxacin*	CILOXAN	
\$ Erythromycin*	ROMYCIN	
\$ Gentamicin Sulfate*	GENTAK	
\$ Polymyxin B-Trimethoprim*	POLYTRIM	
\$\$\$ Moxifloxacin Hydrochloride	VIGAMOX	AL = 18 years
\$\$\$ Gatifloxacin	ZYMAXID	

<b>Prior Authorization Required</b>		
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*Anti Allergic*

\$\$\$ Lodoxamine	ALOMIDE	QL = 20 mls / 30 days
\$\$\$\$ Olopatadine	PATANOL	QL = 20 mls / 30 days

*Sulfonamides*

\$ Sodium Sulfacetamide*	BLEPH-10	
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*Antivirals*

\$\$\$ Trifluridine*	VIROPTIC	
\$ Vidarabine	VIRA-A	

*Antiinfective Combinations*

\$ Bacitracin-Polymyxin B*	POLYSPORIN	
\$ Neomycin-Bac Zn-Polymyxin*	NEOMYCIN-BAC ZN-POLYMXIN	
\$ Neomycin-Polymy-Gramicidin*	NEOSPORIN	

*Beta-Blockers*

\$\$\$\$ Betaxolol*	BETOPTIC, BETOPTIC S	
\$ Timolol*	BETIMOL, TIMOPTIC	no XE

*Steroids*

\$\$ Dexamethasone*	DEXAMETHASONE	
\$\$ Prednisolone Acetate*	PRED FORTE, MILD	

*Steroid Combinations*

\$ Bacitracin-Polymyxin-Neomycin-HC*	BACITRACIN-POLYMXIN-NEOMYCIN-HC	
\$ Neomycin-Polymyxin-Dexamethasone*	MAXITROL	
\$\$\$ Neomycin-Polymyxin-HC*	CORTISPORIN	
\$\$\$ Sulfacetamide Sod-Prednisolone*	BLEPHAMIDE	

*Cycloplegics*

\$ Atropine Sulfate*	ISOPTO ATROPINE	
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*Decongestants*

\$ Naphazoline*	NAPHCON	
\$\$ Phenylephrine*	MYDRIN	

*Ophthalmic NSAID's*

\$\$ Flurbiprofen*	OCUFEN	
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*Miotics - Direct Acting*

\$ Pilocarpine*	ISOPTO-CARPINE	no Ocuser
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*Prostaglandins*

\$\$\$ Latanoprost*	XALATAN	
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*Carbonic Anhydrase Inhibitors*

\$\$ Dorzolamide*	TRUSOPT	
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**OTIC**

*Steroids*

\$ Hydrocortisone w/Acetic Acid*	ACETASOL HC	QL = 20 mls / 30 days
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**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Antibiotics &amp; Steroid-Antibiotic Combinations</i> \$ Neomycin-Polymyxin-HC*	CORTISPORIN	QL = 20 mls / 30 days
<i>Antibiotics</i> \$\$\$ Ofloxacin*	FLOXIN	QL = 20 mls / 30 days
<i>Anti Infective</i> \$ Carbamide Peroxide*	DEBROX	
<i>Analgesic Combinations</i> \$ Benzocaine & Antipyrine*	A/B OTIC	
<b><u>MOUTH &amp; THROAT (Local)</u></b>		
<i>Antiinfectives - Throat</i> \$\$\$ Clotrimazole* \$ Nystatin*	MYCELEX TROCHE NYSTATIN	
<b><u>ANORECTAL</u></b>		
<i>Rectal Steroids</i> \$ Hydrocortisone* \$\$ Hydrocortisone*	ANUSOL-HC PROCTOCREAM	2.5% cream 2.5% cream
<b><u>DERMATOLOGICAL</u></b>		
<i>Antibiotics - Topical</i> \$\$ Bacitracin* \$ Gentamicin Sulfate* \$\$\$ Metronidazole \$\$\$ Mupirocin* \$ Neomycin Sulfate*	BACITRACIN GENTAMICIN METROGEL BACTROBAN NEOMYCIN	OTC product
<i>Antibiotic Mixtures Topical</i> \$ Neomycin-Bacitracin-Polymyxin*	NEOSPORIN	OTC product
<i>Antibiotic Steroid Combinations</i> \$\$ Neomycin-Polymyxin-HC*	CORTISPORIN	
<i>Imidazole-Related Antifungals (Topical)</i> \$\$ Clotrimazole* \$ Miconazole*	LOTRIMIN MONISTAT	OTC product OTC product
<i>Antifungals</i> \$ Nystatin*	NYSTATIN	no powder
<i>Antifungals - Topical Combinations</i> \$\$ Nystatin-Triamcinolone*	NYSTATIN-TRIAMCINOLONE	
<i>Antipsoriatics</i> \$\$\$\$ Calcipotriene*	DOVONEX	
<i>Antiseborrheic Products</i> \$ Sulfacetamide Sodium*	SULFACETAMIDE SODIUM	
<i>Bum Products</i> \$ Silver Sulfadiazine*	SILVADENE	
<i>Tar Products</i> \$ Coal Tar*	COAL TAR SHAMPOO	1% only
<i>Enzymes - Topical</i> \$\$\$ Collagenase	SANTYL	
<i>Keratolytics/Antimitotics</i> \$\$\$ Podofilox* \$\$\$\$ Urea 35% \$\$\$\$ Urea 50%	CONDYLOX KERALAC KERALAC NAILSTIK	



**BioScrip/Jai Medical Systems Therapeutic Formulary**

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Local Anesthetics - Topical</i>		
\$ Lidocaine viscous*	XYLOCAINE VISCOUS	
<i>Scabicides &amp; Pediculocides</i>		
\$ Lindane*	LINDANE	
\$\$ Permethrin*	ELIMITE	OTC product
\$\$ Permethrin*	NIX	
<i>Misc. Topical</i>		
\$\$ Ammonium Lactate	LAC-HYDRIN	cream & lotion
\$\$\$ Fluorouracil*	EFUDEX	2% and 5% cream only
\$\$\$ Pimecrolimus	ELIDEL	
<b>Prior Authorization Required</b>		
<i>Antiviral Topical</i>		
\$\$\$\$ Acyclovir	ZOVIRAX	
<b>Prior Authorization Required</b>		
<i>Corticosteroids - Topical</i>		
\$ Betamethasone Dipropionate*	BETAMETHASONE DIPROPIONATE	
\$ Betamethasone Valerate*	BETAMETHASONE VALERATE	
\$ Clobetasol Propionate*	TEMOVATE	
\$ Desonide*	DESOWAN	
\$ Fluocinonide*	LIDEX	
\$ Fluocinonide Acetonide*	SYNALAR	
\$ Hydrocortisone*	HYTONE	OTC product
\$ Triamcinolone Acetonide*	KENALOG	
\$ Triamcinolone Acetonide in Orabase*	TRIAM. ACET. IN ORABASE	
<i>Acne Products</i>		
\$ Benzoyl Peroxide*	BENZAC W	
\$\$\$ Tretinoin*	RETIN-A	Ages 0-21 only / no Micro
<i>Acne Antibiotics</i>		
\$\$ Clindamycin Phosphate*	CLEOCIN	
\$\$ Erythromycin Gel*	ERYGEL	
<b>XVI. MISCELLANEOUS PRODUCTS</b>		
<b><u>ANTIDOTES</u></b>		
\$ Ipecac*	IPECAC	OTC product
<b><u>DIAGNOSTIC PRODUCTS</u></b>		
<i>Diagnostic Reagents</i>		
\$ Acetone Tablets	ACETEST	
\$ Acetone Test*	KETOSTIX	
\$ Glucose Urine Test*	CLINITEST	
\$\$ Glucose Blood*	GLUCOFILM	
<b><u>MEDICAL DEVICES</u></b>		
<i>Parenteral Therapy Supplies</i>		
\$ Disposable Needles & Syringes*	B-D INSULIN SYRINGE	
\$ Insulin Pen Needles	Insulin Pen Needles	
<i>Diabetic Supplies</i>		
\$\$ Blood Glucose Monitoring Tests*	GLUCOMETER	Only Bayer Contour Ascensia Glucometer
\$ Calibration Solution*	CALIBRATION SOLUTION	
\$ Lancet Device	HYPOLET	
\$ Lancets*	LANCETS	
<i>Misc. Devices</i>		
\$ Alcohol Swabs*	ALCOHOL PADS	

**BioScrip/Jai Medical Systems Therapeutic Formulary**

Generic Name

Brand Name

Annotation

**CONTRACEPTIVES**

§ Condoms

**ASSORTED CLASSES**

*Chelating Agents*

\$\$\$\$ Penicillamine CUPRIMINE

\$\$\$\$ Succimer CHEMET

**Prior Authorization Required**

*Immunosuppressive Agents*

\$\$\$\$\$ Cyclosporine Microsize\* NEORAL

\$\$\$\$\$ Sirolimus\* RAPAMUNE

\$\$\$\$\$ Tacrolimus\* PROGRAF

*Inosine Monophosphate Dehydrogenase Inhibitors*

\$\$\$\$\$ Mycophenolate Mofetil\* CELLCEPT

\$\$\$\$\$ Mycophenolate Sodium\* MYFORTIC

*Multiple Sclerosis - Adjuvants*

\$\$\$\$\$ Teriflunomide AUBAGIO QL = 60 tabs / 30 days

\$\$\$\$\$ Dimethyl Fumarate TECFIDERA QL = 60 tabs / 30 days

\$\$\$\$\$ Dalfampridine AMPYRA QL = 60 tabs / 30 days

**Prior Authorization Required**

*Purine Analogs*

\$\$\$ Azathioprine\* IMURAN

*K Removing Resin*

\$\$\$\$ Sodium Polystyrene Sulfonate\* KAYEXALATE

*Rheumatology Biologics*

\$\$\$\$\$ Adalimumab HUMIRA

\$\$\$\$\$ Etanercept ENBREL

**Prior Authorization Required**

# Prior Authorization Guidelines

## Prior Authorization Guidelines

**GENERIC:** ACAMPROSATE

**BRAND:** CAMPRAL<sup>®</sup>

**INDICATION:**

- (1) Maintenance of abstinence for alcohol-dependent patients who are abstinent at treatment initiation.

**Criteria:**

- (a) Patient must be abstinent at treatment initiation; **and**
- (b) Treatment must be part of a comprehensive management program that includes psychosocial support; **and**
- (c) Patient must be opiate dependent.

**GENERIC:** ACARBOSE

**BRAND:** PRECOSE<sup>®</sup>

**INDICATION:**

- (1) Type 2 diabetes mellitus

**Criteria:**

- (a) Failure of maximal doses of *one* oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c > 7.0.

**GENERIC:** ACLIDINIUM BROMIDE AEROSOL POWDER

**BRAND:** TUDORZA PRESSAIR<sup>®</sup>

**INDICATION:**

- (1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

**Criteria:**

- (a) Diagnosis of COPD **and**
- (b) Must be greater than 18 years of age **and**
- (c) Documented inadequate response or intolerance to Spiriva

## Prior Authorization Guidelines

**GENERIC:** ACYCLOVIR TOPICAL OINTMENT

**BRAND:** ZOVIRAX<sup>®</sup> 5%<sup>®</sup>

**INDICATIONS:**

- (1) Herpes genitalis
- (2) Oral herpes infection

**Criteria:**

- (a) Herpes genitalis – for initial episode only; **or**
- (b) Oral herpes infection – for immunocompromised patients *only*.

**GENERIC:** ADALIMUMAB

**BRAND:** HUMIRA<sup>®</sup>

**INDICATIONS:**

- (1) Moderate to severely active rheumatoid arthritis
- (2) Psoriatic arthritis
- (3) Ankylosing spondylitis
- (4) Moderate to severely active Crohn's disease

**Criteria:**

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Humira therapy; **and**
- (b) The patient does not have a clinically important active infection

**Additional Criteria for RA:**

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

**Additional Criteria for Crohn's:**

- (a) The patient has failed or is intolerant to infliximab;**or**
- (b) The patient has failed or is intolerant to mesalamine or sulfasalazine;**and**
- (c) The patient has failed or is intolerant to corticosteroids;**and**
- (d) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate, 6-mercaptopurine or azathioprine)

## Prior Authorization Guidelines

**GENERIC:** ALBUTEROL SULFATE INHALER

**BRAND:** PROAIR HFA<sup>®</sup>

**INDICATION:**

Asthma

- (1) Symptomatic management of prevention of bronchospasms in patient 4 years of age and older with reversible obstructive airway disease
- (2) Prevent of exercise-induced bronchospasm in patients 4 years of age and older
- (3) COPD- Symptomatic management of reversible bronchospasm associated with COPD in patients who continue to have evidence of bronchospasm despite regular use of an orally inhaled bronchodilator and who require a second bronchodilator

**Criteria:**

- (a) Failure or contraindication of Ventolin HFA or Proventil HFA

**GENERIC:** ANTIHEMOPHILIC FACTORS

**BRAND:** ALPHANATE<sup>®</sup>, FEIBA VH<sup>®</sup>, RECOMBIMATE<sup>®</sup>,  
THROMBATE III<sup>®</sup>

**INDICATION:**

- (1) Hemophilia A

**Criteria:**

- (a) Diagnosis of Hemophilia A

**GENERIC:** AZELASTINE

**BRAND:** ASTELIN<sup>®</sup>

**INDICATIONS:**

- (1) Allergic conjunctivitis
- (2) Perennial allergic rhinitis
- (3) Seasonal allergic rhinitis

**Criteria:**

- (a) Patient is  $\geq 5$  years of age with one of the above diagnoses;  
**and**
- (b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

## Prior Authorization Guidelines

**GENERIC:** BOCEPREVIR

**BRAND:** VICTRELIS<sup>®</sup>

**INDICATION:**

- (1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin in patients with compensated liver disease.

**Criteria:**

- (a) Diagnosis of chronic hepatitis C genotype 1; **and**
- (b) Diagnosis of compensated liver disease; **and**
- (c) No previous treatment (full or partial course) of Incivek or Victrelis; **and**
- (d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
- (e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
- (f) HCV-RNA levels must be drawn at treatment weeks 8, 12, and 24 (Victrelis week 4, 8, and 20); **and**
- (g) Females of child bearing potential must meet the following additional parameters:
  - a. A recent negative pregnancy test; **and**
  - b. Been counseled on the teratogenic effects of triple therapy; **and**
  - c. Is willing to practice contraception during and for 6 months after completion of therapy

**GENERIC:** BUDESONIDE/FORMOTEROL

**BRAND:** SYMBICORT<sup>®</sup>

**INDICATION:**

- (1) Maintenance treatment of asthma in patients 12 years of age and older

## Prior Authorization Guidelines

### **Criteria:**

- (a) Currently on, but not adequately controlled by an inhaled corticosteroid; **or**
- (b) Maintenance treatment of airflow obstruction in patients with chronic bronchitis and emphysema
- (c) Patients must be reevaluated after 6 months

*\*For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy, or with no claims history of Symbicort within the last 3 months.*

**GENERIC:** CALCITONIN-SALMON

**BRAND:** MIACALCIN<sup>®</sup>

### **INDICATIONS:**

- (1) Mild to moderate Paget's disease of bone
- (2) Osteoporosis

### **Criteria:**

- (a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; **and**

One of the following:

- (1) Bone density measurement  $\geq 2.5$  standard deviations below the mean for normal, young adults of same gender (T-score  $\leq -2.5$ ); **or**
  - (2) History of an osteoporotic vertebral fracture; **or**
  - (3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:
    - (a) Thinness or low body mass index defined by weight  $< 127$  lb (57.7 kg) or BMI  $< 21$  kg/m<sup>2</sup>
    - (b) History of fragility fracture since menopause
    - (c) History of hip fracture in a parent
  - (4) Diagnosis of Paget's disease of bone
- (b) Patients receiving glucocorticoids in daily dosages of  $\geq 7.5$ mg prednisone daily (see table) AND who have bone density measurement  $> 1$  standard deviations below the mean for normal, young adults of same gender (T-score  $< -1.0$ )



## Prior Authorization Guidelines

<b>Glucocorticoid Potency Equivalencies</b>			
<b>Glucocorticoid</b>	<b>Approximate equivalent dose (mg)</b>	<b>Relative anti-inflammatory (glucocorticoid) potency</b>	<b>Relative mineralocorticoid potency</b>
<i>Short-acting</i>			
Cortisone	25	0.8	2
Hydrocortisone	20	1	2
<i>Intermediate-acting</i>			
Prednisone	5	4	1
Prednisolone	5	4	1
Triamcinolone	4	5	0
Methylprednisolone	4	5	0
<i>Long-acting</i>			
Dexamethasone	0.75	20-30	0
Betamethasone	0.6-0.75	20-30	0

Table adapted from Facts and Comparisons® 1999:122

*\* For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*

*\* If documentation of osteoporosis is available, please submit with PA request.*

**GENERIC:** CEFDINIR SUSPENSION

**BRAND:** OMNICEF<sup>®</sup>

**INDICATIONS:**

- (1) CAP
- (2) Acute exacerbations of chronic bronchitis
- (3) Acute maxillary sinusitis
- (4) Pharyngitis / Tonsillitis
- (5) Uncomplicated skin and skin structure infections
- (6) Acute bacterial otitis media – pediatrics only

**Criteria:**

- (a) Recent failure (within 30 days) of at least one standard first-line formulary antibiotic in absence of culture; **or**
- (b) Documentation of cultured organism with sensitivity to only cefdinir, other third generation cephalosporin OR contraindications to all other sensitive antibiotics.

## Prior Authorization Guidelines

**GENERIC:** CELECOXIB

**BRAND:** CELEBREX<sup>®</sup>

**INDICATIONS:**

- (1) Relief of signs and symptoms of rheumatoid arthritis (RA) in adults
- (2) Relief of signs and symptoms of osteoarthritis (OA)
- (3) Relief of signs and symptoms of ankylosing spondylitis
- (4) Management of acute pain in adults
- (5) Treatment of primary dysmenorrhea
- (6) To reduce the number of adenomatous polyps in familial adenomatous polyposis, as an adjunct to usual care

**Criteria:**

- (a) Failure, intolerance, or contraindication to at least 2 formulary NSAIDs; **and**
- (b) One of the following:
  - (1) Age greater than 65; **or**
  - (2) Concomitant use of warfarin or other antiplatelet therapy; **or**
  - (3) Concomitant use of chronic systemic corticosteroid therapy; **or**
  - (4) Documented history of ulcer disease or GI bleed; **or**
  - (5) Documented history of significant GI disease requiring therapy with an H2 antagonist or proton pump inhibitor; **or**
  - (6) Documented history of nonselective NSAID-induced GI adverse effects; **and**
- (c) For OA, therapeutic failure ( $\geq 21$  day trial), intolerance of, or contraindication to at least 1 of the following: acetaminophen or opiod analgesics or topical analgesics (capsaicin, etc.)

**GENERIC:** CHOLINE FENOFIBRATE

**BRAND:** TRILIPIX<sup>®</sup>

**INDICATION:**

- (1) Hypercholesterolemia, Hypertriglyceridemia

**Criteria:**

- (a) Failure of generic fenofibrate 48, 54, 154 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

## Prior Authorization Guidelines

**GENERIC:** CLOXACILLIN SODIUM

**INDICATION:**

- (1) Treatment of infections due to penicillinase-producing staphylococci

**Criteria:**

- (a) Diagnosis of staphylococcal infection; **and**
- (b) Failure of dicloxacillin sodium.

**GENERIC:** CYANOCOBALAMIN (HYDROXOCOBALAMIN)

**BRAND:** VITAMIN B-12<sup>®</sup>

**INDICATION:**

- (1) Vitamin B-12 deficiency

**Criteria:**

- (a) Patients who lack intrinsic factor; **or**
- (b) Patients who are on long-term PPI therapy; **or**
- (c) Patients with a partial or complete gastrectomy.

*\* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

**GENERIC:** DABIGATRAN ETEXILATE MESYLATE

**BRAND:** PRADAXA<sup>®</sup>

**INDICATION:**

- (1) Reduce the risk of stroke and systemic embolism in patients with non-vascular atrial fibrillation.

**Criteria:**

- (a) Diagnosis of non-vascular atrial fibrillation; **and**
- (b) Must have recent CrCl levels or Scr and current patient weight; **and**
- (c) No active pathological bleeding; **and**

- (d) Must have tried and failed or intolerant to Warfarin

**NOTE:** Conversion to Pradaxa:

- (a) From Warfarin: discontinue warfarin and start pradaxa when INR < 2.0
- (b) From Parenteral Anticoagulants: start Pradaxa 0-2 hrs prior to next scheduled dose of parenteral anticoagulant, or at the time of discontinuation of continuous parenteral drug (e.g. heparin)

## Prior Authorization Guidelines

**GENERIC:** DALFAMPRIDINE

**BRAND:** AMPYRA<sup>®</sup>

**INDICATION:**

(1) Improved walking speed in patients with multiple sclerosis

**Criteria:**

- (a) Diagnosis of multiple sclerosis; **and**
- (b) Prescribed by a neurologist; **and**
- (c) Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)

*\*Renewals will require documented improvement in walking speed (demonstrated improvement in timed 25 foot walk)*

**GENERIC:** DANTROLENE

**BRAND:** DANTRIUM<sup>®</sup>

**INDICATION:**

(1) Spasticity resulting from upper motor neuron disorders

**Criteria:**

- (a) Demonstrated failure of, or intolerance to, Baclofen (Lioresol<sup>®</sup>).

**GENERIC:** DARBEPOETIN ALFA

**BRAND:** ARANESP<sup>®</sup>

**INDICATIONS:**

(1) Anemia with cancer chemotherapy (nonmyeloid)

(2) Anemia due to chronic renal failure

**Criteria:**

(a) Ensure patient's iron stores are adequate (Ferritin  $\geq$  100 ng/mL and/or Transferrin saturation  $\geq$  20%) or patient is being treated with iron; **and**

(b) Adequate blood pressure control; **and**

**Chronic kidney disease patients:**

(a) Initiate treatment when hemoglobin is  $<10\text{g/dL}$ ; **or**

**Anemia due to chemotherapy in cancer:**

(a) Initiate treatment only if hemoglobin is  $<10\text{g/dL}$ ; **and**

(b) Anticipated duration of myelosuppressive chemotherapy is  $\geq$  2 months

## Prior Authorization Guidelines

### **For renewals:**

- (a) **Chronic kidney disease patients:**
  - (1) With dialysis Hbg <11; or
  - (2) Without dialysis Hbg <10
- (b) **Anemia due to chemotherapy in cancer patients:**
  - (1) Hbg <11

**GENERIC:** DESMOPRESSIN

**BRAND:** DDAVP<sup>®</sup>

### **INDICATIONS:**

- (1) Central cranial diabetes insipidus (CCDI)
- (2) Primary nocturnal enuresis

### **Criteria:**

- (a) Diagnosis of CCDI; **or**
- (b) For the treatment of enuresis, age 6 to 18 years; **and**
- (c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers etc.).

*\* Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.*

**GENERIC:** DIMETHYL FUMERATE

**BRAND:** TECFIDERA<sup>®</sup>

### **INDICATION:**

- (1) Diagnosis of a relapsing form of Multiple Sclerosis;

### **Criteria:**

- (a) Prescribed by neurologist; and
- (b) Not requesting combination of any 2 agents together:  
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

**GENERIC:** DONEPEZIL

**BRAND:** ARICEPT<sup>®</sup>

### **INDICATION:**

- (1) Alzheimer's disease: for the treatment of dementia.

### **Criteria:**

- (a) Dementia must be confirmed by clinical evaluation

## Prior Authorization Guidelines

**GENERIC:** ENTACAPONE

**BRAND:** COMTAN<sup>®</sup>

**INDICATION:**

- (1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease

**Criteria:**

- (a) Diagnosis of idiopathic Parkinson's disease; **and**
- (b) Patient is receiving concomitant levodopa/carbidopa therapy.

**GENERIC:** EPOETIN ALFA

**BRAND:** PROCRIT<sup>®</sup>, EPOGEN<sup>®</sup>

**INDICATIONS:**

- (1) Anemia with cancer chemotherapy (nonmyeloid)
- (2) Anemia due to chronic renal failure
- (3) Anemia of HIV infection associated with zidovudine
- (4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

**Criteria:**

- (a) Patient's iron stores are adequate (Ferritin  $\geq$  100 ng/mL and/or Transferrin saturation  $\geq$  20%) or patient is being treated with iron; **and**
- (b) Adequate blood pressure control

**Chronic kidney disease patients:**

- (a) Initiate treatment when hemoglobin is  $<10$  g/dL (3 month approval)

**Anemia due to chemotherapy in cancer patients:**

- (a) Initiate treatment only if hemoglobin  $<10$  g/dL and anticipated duration of myelosuppressive chemotherapy is  $\geq$  2 months

**Anemia due to zidovudine in HIV-infected patients:**

- (a) Initiate treatment when hemoglobin is  $<10$  g/dL

**Surgical procedure - Transfusion of blood product, Allogenic; Prophylaxis:**

- (a) Patient's pre-operative Hgb  $>10$  to  $\leq 13$  g/dL (14 day approval)

**For renewals:**

**Chronic kidney disease patients:**

- (a) With dialysis Hgb  $<11$
- (b) Without dialysis Hgb  $<10$

**Anemia due to chemotherapy in cancer patients:**

- (a) Hgb  $<11$

**Anemia due to zidovudine in HIV-infected patients:**

- (a) Hgb  $<11$

## Prior Authorization Guidelines

**GENERIC:** ETANERCEPT

**BRAND:** ENBREL<sup>®</sup>

**INDICATIONS:**

- (1) Moderate to severely active rheumatoid arthritis
- (2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
- (3) Psoriatic spondylitis
- (4) Ankylosing spondylitis
- (5) Plaque psoriasis

**Criteria:**

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; **and**
- (b) The patient does not have a clinically important active infection

**Additional Criteria for RA:**

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

**Additional Criteria for Plaque Psoriasis:**

- (a) Involvement of  $\geq 10\%$  body surface area (BSA)

**GENERIC:** EXENATIDE

**BRAND:** BYETTA<sup>®</sup>

**INDICATION:**

- (1) Adjunctive therapy of type 2 diabetes mellitus

**Criteria:**

- (a) Diagnosis of type 2 diabetes; **and**
- (b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c  $\geq 7.0$ ; **and**
- (c) Patient  $\geq 18$  years of age

## Prior Authorization Guidelines

**GENERIC:** EZETIMIBE

**BRAND:** ZETIA<sup>®</sup>

**INDICATIONS:**

- (1) Hypercholesterolemia
- (2) Sitosterolemia

**Criteria:**

- (a) Diagnosis of sitosterolemia; **or**
- (b) For the diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

**GENERIC:** EZETIMIBE/SIMVASTATIN

**BRAND:** VYTORIN<sup>®</sup>

**INDICATION:**

- (1) Hypercholesterolemia

**Criteria:**

- (a) The diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

**GENERIC:** FENOFIBRATE

**BRAND:** LIPOFEN<sup>®</sup>, TRIGLIDE<sup>®</sup>

**INDICATION:**

- (1) Hypercholesterolemia, Hypertriglyceridemia

**Criteria:**

- (a) Failure of generic fenofibrate 48, 54, 154, or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

**GENERIC:** FENOFIBRATE MICRONIZED

**BRAND:** ANTARA<sup>®</sup>

**INDICATION:**

- (1) Hypercholesterolemia, Hypertriglyceridemia

**Criteria:**

- (a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.



## Prior Authorization Guidelines

**GENERIC:** FENOFIBRIC ACID

**BRAND:** TRILIPIX<sup>®</sup>

**INDICATION:**

- (1) Hypercholesterolemia, Hypertriglyceridemia

**Criteria:**

- (a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

**GENERIC:** FENTANYL TRANSDERMAL PATCH

**BRAND:** DURAGESIC<sup>®</sup>

**INDICATION:**

- (1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time

**Criteria:**

- (a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opioid administration for an extended period of time; **and**
- (b) Patient unable to take medications by mouth; **or**
- (c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)

**GENERIC:** FILGRASTIM

**BRAND:** NEUPOGEN<sup>®</sup>

**INDICATIONS:**

- (1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for non-myeloid malignancies
- (2) Patients undergoing peripheral blood progenitor cell collection and therapy
- (3) Patients with severe chronic neutropenia

## Prior Authorization Guidelines

### **Criteria:**

- (a) The patient is undergoing peripheral blood progenitor cell collection and therapy; **or**
  - (b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; **or**
  - (c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given to prophylax for all future chemo cycles.
- \* For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*
- \* Please indicate estimated duration of therapy.*

**GENERIC:** FLUCONAZOLE

**BRAND:** DIFLUCAN<sup>®</sup>

(PA required after 1x 150mg tablet dispensed)

### **INDICATIONS:**

- (1) Vaginal candidiasis
- (2) Cryptococcal meningitis
- (3) Serious systemic candidal infections
- (4) Oropharyngeal and esophageal candidiasis

### **Criteria:**

- (a) Any of the above diagnoses; **except**
- (b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; **and**
- (c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

**GENERIC:** GALANTAMINE HYDROBROMIDE

**BRAND:** RAZADYNE<sup>®</sup>, RAZADYNE ER<sup>®</sup>

### **INDICATION:**

- (1) Alzheimer’s disease: for the treatment of dementia

### **Criteria:**

- (a) Confirmation by clinical evaluation

## Prior Authorization Guidelines

**GENERIC:** GATIFLOXACIN

**BRAND:** ZYMAXID<sup>®</sup>

**INDICATION:**

- (1) Bacterial conjunctivitis

**Criteria:**

- (a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

**GENERIC:** GLATIRAMER ACETATE

**BRAND:** COPAXONE<sup>®</sup>

**INDICATIONS:**

- (1) Relapsing-remitting Multiple Sclerosis
- (2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

**Criteria:**

- (a) Prescribed by neurologist; and
- (b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

**GENERIC:** INTERFERON ALPHA

**BRAND:** ROFERON-A<sup>®</sup>, INTRON-A<sup>®</sup>, and ALFERON N<sup>®</sup>

**INDICATIONS:**

- (1) Hairy cell leukemia
- (2) AIDS-related Kaposi's sarcoma
- (3) Chronic hepatitis B or C
- (4) Malignant melanoma

**Criteria:**

- (a) Any of the above diagnoses.

*\*For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

## Prior Authorization Guidelines

**GENERIC:** INTERFERON BETA

**BRAND:** AVONEX<sup>®</sup>, BETASERON<sup>®</sup>, REBIF<sup>®</sup>

**INDICATIONS:**

- (1) Diagnosis of a relapsing form of Multiple Sclerosis; **or**
- (2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

**Criteria:**

- (a) Prescribed by neurologist; **and**
- (b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
- (c) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

*\* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

**GENERIC:** ISOSORBIDE MONONITRATE

**BRAND:** IMDUR<sup>®</sup>

**INDICATION:**

- (1) Prevention of angina pectoris

**Criteria:**

- (a) Failure of formulary nitrates.

**GENERIC:** ITRACONAZOLE

**BRAND:** SPORANOX<sup>®</sup>

**INDICATIONS:**

- (1) Histoplasmosis infections
- (2) Aspergillosis infections
- (3) Blastomycosis

**Criteria:**

- (a) Any of the above diagnoses.

## Prior Authorization Guidelines

**GENERIC:** LEUPROLIDE

**BRAND:** LUPRON<sup>®</sup>

**INDICATIONS:**

- (1) Advanced prostate cancer
- (2) Central precocious puberty
- (3) Endometriosis
- (4) Uterine leiomyomata (fibroids)

**Criteria:**

- (a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; **or**
- (b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.

*\*Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

**GENERIC:** LIRAGLUTIDE

**BRAND:** VICTOZA<sup>®</sup>

**INDICATION:**

- (1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

**Criteria:**

- (a) Diagnosis of type II diabetes mellitus; **and**
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; **and**
- (d) Must have tried and failed or intolerant to treatment with Byetta; **and**
- (e) NO personal or family history of medullary thyroid carcinoma

## Prior Authorization Guidelines

**GENERIC:** MEMANTINE

**BRAND:** NAMENDA<sup>®</sup>

**INDICATION:**

- (1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia

**Criteria:**

- (a) Dementia must be confirmed by clinical evaluation; **and**
- (b) Documented dementia is either moderate or severe

**GENERIC:** METRONIDAZOLE VAGINAL GEL

**BRAND:** METROGEL<sup>®</sup>

**INDICATION:**

- (1) Bacterial vaginosis

**Criteria:**

- (a) Pregnancy; **or**
- (b) Intolerance to oral metronidazole

**GENERIC:** MILNACIPRAN

**BRAND:** SAVELLA<sup>®</sup>

**INDICATION:**

- (1) Moderate to severe fibromyalgia

**Criteria:**

- (a) Trial of two of the three below agents after a period of at least two months on the maximum dose appropriate and tolerated by the patient:
  - (1) gabapentin
  - (2) venlafaxine
  - (3) one other evidence based effective agent (TCA therapy, SSRIs, tramadol, NSAIDs, cyclobenzaprine)

## Prior Authorization Guidelines

**GENERIC:** MOXIFLOXACIN

**BRAND:** AVELOX<sup>®</sup>

**INDICATION:**

- (1) Acute bacterial sinusitis
- (2) Acute bacterial exacerbations of chronic bronchitis
- (3) Mild to moderate pelvic inflammatory disease
- (4) Complicated/Uncomplicated skin and skin structure infections
- (5) Community-acquired pneumonia
- (6) Complicated intra-abdominal infections

**Criteria:**

In patients  $\geq 18$  years of age with any of the above listed indications when:

- (a) Cultures show sensitivity to Avelox<sup>®</sup> only; **or**
- (b) Patient discharged on Avelox<sup>®</sup> from the hospital and needs to complete regimen on an outpatient basis

**GENERIC:** NAFARELIN+

**BRAND:** SYNAREL<sup>®</sup>

**INDICATIONS:**

- (1) Central precocious puberty
- (2) Endometriosis

**Criteria:**

- (a) Diagnosis of central precocious puberty; **or**
- (b) For the diagnosis of endometriosis in patients  $\geq 18$  years of age, failure of NSAIDs **and** oral contraceptives, **or** endometriosis diagnosed by laparoscopy.

**GENERIC:** NICOTINE INHALER

**BRAND:** NICOTROL INHALER<sup>®</sup>

**INDICATION:**

- (1) Smoking cessation

**Criteria:**

- (a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

## Prior Authorization Guidelines

**GENERIC:** NICOTINE NASAL SPRAY

**BRAND:** NICOTROL NASAL SPRAY<sup>®</sup>

**INDICATION:**

- (1) Smoking cessation

**Criteria:**

- (a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

**GENERIC:** NUTRITIONAL SUPPLEMENTS

**BRAND:** ENSURE<sup>®</sup>, PEDIASURE<sup>®</sup>, BOOST<sup>®</sup>, VIVONEX<sup>®</sup>

**INDICATION:**

- (1) Nutritional supplementation

**Criteria:**

- (a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

*To obtain nutritional supplements (e.g. Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.*

**GENERIC:** OCTREOTIDE

**BRAND:** SANDOSTATIN<sup>®</sup>

**INDICATIONS:**

- (1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
- (2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
- (3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly

**Criteria:**

- (a) Any of the above diagnoses; **and**
- (b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or can not be treated with surgical resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

*For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*



## Prior Authorization Guidelines

**GENERIC:** ONDANSETRON ODT AND SOLUTION

**BRAND:** ZOFRAN<sup>®</sup>

**INDICATIONS:**

- (1) Chemotherapy induced nausea and vomiting
- (2) Post-operative nausea and vomiting
- (3) Radiation induced nausea and vomiting

**Criteria:**

- (a) For patients who have a contraindication or failure of regular release ondansetron tablets

**GENERIC:** OXYCODONE, CONTROLLED-RELEASE

**BRAND:** OXYCONTIN<sup>®</sup>

**INDICATION:**

- (1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

**Criteria:**

- (a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-the-clock analgesia for an extended period of time; **and**
- (b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics
- (c) For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others)

**GENERIC:** PALIVIZUMAB

**BRAND:** SYNAGIS<sup>®</sup>

**INDICATION:**

- (1) Prevention of serious lower respiratory disease caused by respiratory syncytial virus (RSV)

**Criteria:**

- (a) Administration within RSV season (Nov-Apr); **and**
- (b) Pt < 2 yrs of age at start of RSV season with chronic lung disease that has required treatment (supplemental oxygen, bronchodilator, diuretic or corticosteroid) within prior 6 months **or**
- (c) Pt born  $\leq$  28 weeks gestation and is  $\leq$  12 months at the start of the RSV season **or**
- (d) Pt born between 29-32 weeks gestation and is  $\leq$  6 months at the start of the RSV season **or**

## **Prior Authorization Guidelines**

- (e) Pt  $\leq$  24 months of age at the start of the RSV season with hemodynamically significant congenital heart disease, including one of the following:
  - (1) Receiving medication to control congestive heart failure; **or**
  - (2) With moderate to severe pulmonary artery hypertension; **or**
  - (3) With cyanotic congenital heart disease; **or**
- (f) Pt born between 32-35 weeks gestation, and is  $\leq$  3 months at the start of the RSV season **and** has one of the following risk factors:
  - (1) Child care attendance; **or**
  - (2) Siblings less than 5 years **and** children born between 32-35 weeks receive a maximum of 3 doses; **or**
- (g) Is the patient born before 35 weeks of gestation and has either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions during the first year of life?

**Once the prior authorization is received, please contact the Synagis line below:**

**Phone** = 866-230-8102

**Fax** =888-325-6544

**GENERIC:** PANTOPRAZOLE

**BRAND:** PROTONIX<sup>®</sup>

### **INDICATIONS:**

- (1) Gastric hypersecretion, pathological conditions including Zollinger-Ellison Syndrome
- (2) Erosive esophagitis - gastroesophageal reflux disease
- (3) Erosive esophagitis, maintenance therapy - gastroesophageal reflux disease

### **Criteria:**

- (a) Failure, intolerance, or contraindication to at least 1 formulary PPI after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

## Prior Authorization Guidelines

**GENERIC:** PEGINTERFERON ALFA-2A

**BRAND:** PEGASYS<sup>®</sup>

**INDICATIONS:**

- (1) Use in combination with ribavirin for the treatment of chronic hepatitis C
- (2) Treatment of chronic hepatitis C in patients coinfecting with HIV whose HIV is clinically stable.
- (3) Treatment of patients with HBeAg positive and HBeAg negative chronic hepatitis B

**Criteria:**

**(In combination with ribavirin)**

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age  $\geq$  3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.

**(For chronic Hepatitis B)**

- (a) Documented HBeAg positive or negative chronic hepatitis B
- (b) Compensated liver disease
- (c) Evidence of viral replication
- (d) Evidence of liver inflammation
- (e) Not contraindicated

**GENERIC:** PEGINTERFERON ALFA-2B

**BRAND:** PEG-INTRON<sup>®</sup>

**INDICATIONS:**

- (1) Use in combination with ribavirin for the treatment of chronic hepatitis C
- (2) Treatment of chronic hepatitis C in patients coinfecting with HIV whose HIV is clinically stable.

**Criteria:**

**(In combination with ribavirin)**

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age  $\geq$  3 years

## **Prior Authorization Guidelines**

- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.

**GENERIC:** PENTOXIFYLLINE

**BRAND:** TRENTAL<sup>®</sup>

**INDICATION:**

- (1) Intermittent claudication

**Criteria:**

- (a) Pain on walking **or** ABI < 0.8; **or**
- (b) Diabetic foot ulcer; **or**
- (c) Gangrene; **or**
- (d) Risk of, or existing, amputation.

**GENERIC:** PIMECROLIMUS

**BRAND:** ELIDEL<sup>®</sup>

**INDICATION:**

- (1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

**Criteria:**

- (a) Documented failure of optimal dosing/adequate duration; **or**
- (b) Intolerance or contraindication to at least one formulary topical corticosteroid; **and**
- (c) Diagnosis of mild to moderate atopic dermatitis; **and**
- (d) Using for short-term and non-continuous treatment.

**GENERIC:** RALOXIFENE

**BRAND:** EVISTA<sup>®</sup>

**INDICATION:**

- (1) Treatment and prevention of osteoporosis in postmenopausal women

**Criteria:**

- (a) Personal or family history of breast cancer; **or**
- (b) Intolerable side effects to at least one formulary estrogen.

## Prior Authorization Guidelines

**GENERIC:** RIBAVIRIN

**BRAND:** REBETOL<sup>®</sup>

**INDICATION:**

- (1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product for the treatment of chronic hepatitisC.

**Criteria:**

- (a) Diagnosis of chronic hepatitis C; **and**
- (b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy.

**GENERIC:** RILUZOLE

**BRAND:** RILUTEK<sup>®</sup>

**INDICATION:**

- (1) Amyotrophic lateral sclerosis (ALS)

**Criteria:**

- (a) Diagnosis of ALS.

**GENERIC:** RIVASTIGMINE TARTRATE

**BRAND:** EXELON<sup>®</sup>

**INDICATION:**

- (1) Alzheimer's disease: for the treatment of dementia

**Criteria:**

- (a) Confirmation by clinical evaluation

**GENERIC:** RIZATRIPTAN

**BRAND:** MAXALT<sup>®</sup>

**INDICATION:**

- (1) Acute treatment of migraine headache

**Criteria:**

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT<sub>1</sub> Receptor Agonist.

## Prior Authorization Guidelines

**GENERIC:** ROPINROLE

**BRAND:** REQUIP<sup>®</sup>

**INDICATIONS:**

- (1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
- (2) Moderate to severe primary Restless Leg Syndrome.

**Criteria:**

- (a) Diagnosis of idiopathic Parkinson's disease; **or**
- (b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron-binding saturation)

**GENERIC:** ROSIGLITAZONE MALEATE

**BRAND:** AVANDIA<sup>®</sup>

**INDICATION:**

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

**Criteria:**

- (a) Blood sugar not controlled with any other antidiabetic medications;**and**
- (b) Failure or contraindication to use an Actos-containing regimen.

**GENERIC:** ROSIGLITAZONE MALEATE/GLIMEPIRIDE

**BRAND:** AVANDARYL<sup>®</sup>

**INDICATION:**

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

**Criteria:**

- (a) Blood sugar not controlled with any other antidiabetic medications**and**
- (b) Failure or contraindication to use an Actos-containing regimen.

**GENERIC:** ROSIGLITAZONE MALEATE/METFORMIN

**BRAND:** AVANDAMET<sup>®</sup>

**INDICATION:**

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

## Prior Authorization Guidelines

### **Criteria:**

- (a) Blood sugar not controlled with any other antidiabetic medications **and**
- (b) Failure or contraindication to use an Actos-containing regimen.

**GENERIC:** ROSUVASTATIN CALCIUM

**BRAND:** CRESTOR<sup>®</sup>

### **INDICATION:**

- (1) Primary prevention of CV disease in patients with multiple risk factors for CHD, diabetes, peripheral vascular disease, history of stroke, or other cerebrovascular disease.

### **Criteria:**

- (a) Failure of at least two generic formulary statins after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

**GENERIC:** SALMETEROL/FLUTICASON

**BRAND:** ADVAIR/ADVAIR HFA<sup>®</sup>

### **INDICATION:**

- (1) Long-term, twice-daily maintenance treatment of asthma in patients 4 years of age and older.

### **Criteria:**

- (a) Currently on, but not controlled by an inhaled corticosteroid
- (b) Twice daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

### **Criteria for the 250/50mg Strength:**

- (a) The 250/50mg strength is the only approved strength for COPD **and**
- (b) The patient must be reevaluated after 6 months

*\*For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 3 months.*

## Prior Authorization Guidelines

**GENERIC:** SALMETEROL XINAFOATE

**BRAND:** SEREVENT DISKUS®

**INDICATIONS:**

- (1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
- (2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
- (3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

**Criteria:**

- (a) Currently on but not controlled by an inhaled corticosteroid

**GENERIC:** SIMVASTATIN 80mg

**BRAND:** ZOCOR®

**INDICATIONS:**

- (1) Heterozygous or homozygous familial hypercholesterolemia
- (2) Familial type 3 hyperlipoproteinemia
- (3) Hypertriglyceridemia
- (4) Primary hypercholesterolemia, or mixed hyperlipidemia
- (5) Decrease cardiovascular event risk in patients with high coronary event risk
- (6) Cerebrovascular accident prophylaxis

**Criteria:**

- (a) Age ≤ 65 years
- (b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
- (c) Controlled hypothyroidism
- (d) Normal renal function
- (e) Documentation of all cholesterol lowering agents tried and failed must be provided.



## Prior Authorization Guidelines

**GENERIC:** SOMATROPIN

**BRAND:** HUMATROPE<sup>®</sup>

### **INDICATIONS:**

- (1) Growth failure in children due to inadequate growth hormone (GH) secretion
- (2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
- (3) Short stature in children associated with Turner syndrome

### **Criteria:**

- (a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
- (b) Medication prescribed by an endocrinologist; **and**
- (c) Patient meets one of the following criteria:
  - (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
    - i. Severe short stature defined as patient's height at  $\geq 2$  SD below the population mean
    - ii. Patient's height  $\geq 1.5$  SD below the midparental height (average of mother's and father's heights)
    - iii. Patient's height  $\geq 2$  SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
    - iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)
    - v. Signs indicative of an intracranial lesion
    - vi. Signs of multiple pituitary hormone deficiencies
    - vii. Neonatal symptoms and signs of GHD

## **Prior Authorization Guidelines**

- (2) Idiopathic short stature with patient's height at  $\geq 2.25$  SD below the mean height for normal children of the same age and gender
- (3) Short stature associated with Turner syndrome and height below the 5<sup>th</sup> percentile of normal growth curve

\* *To continue therapy, requests will be reviewed every six months. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

**GENERIC:** SUCCIMER

**BRAND:** CHEMET®

### **INDICATIONS:**

- (1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl
- (2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

### **Criteria:**

- (a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
- (b) Child is hospitalized; **or**
- (c) Child was started on the medication in the hospital and needs to continue upon discharge.

**GENERIC:** SUCRALFATE SUSPENSION

**BRAND:** CARAFATE®

### **INDICATIONS:**

- (1) Gastric ulcers
- (2) Duodenal ulcers
- (3) Gastritis
- (4) GERD

### **Criteria:**

- (a) For patients who have a contraindication or failure of sucralfate tablets

## Prior Authorization Guidelines

**GENERIC:** TELAPREVIR

**BRAND:** INCIVEK®

**INDICATION:**

- (1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin

**Criteria:**

- (a) Diagnosis of chronic hepatitis C genotype 1; **and**
- (b) Diagnosis of compensated liver disease; **and**
- (c) No previous treatment (full or partial course) of Incivek or Victrelis; **and**
- (d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
- (e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
- (f) HCV-RNA levels must be drawn at treatment weeks 4, 12, and 24
- (g) Females of child bearing potential must meet the following parameters:
  - (1) A recent negative pregnancy test; **and**
  - (2) Been counseled on the teratogenic effects of triple therapy; **and**
  - (3) Is willing to practice contraception during and for 6 months after completion of therapy

**GENERIC:** TERIFLUNOMIDE

**BRAND:** AUBAGIO®

**INDICATION:**

- (1) Diagnosis of a relapsing form of Multiple Sclerosis

**Criteria:**

- (a) Prescribed by neurologist; and
- (b) Not requesting combination of any 2 agents together:  
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.

## Prior Authorization Guidelines

**GENERIC:** TESTOSTERONE

**BRAND:** ANDROGEL<sup>®</sup>, TESTIM<sup>®</sup>

**INDICATION:**

(1) Hypogonadism

**Criteria:**

- (a) Must be prescribed by an Endocrinologist
- (b) Initial therapy: The patient has documented low testosterone concentration
- (c) Renewal: The patient has documented therapeutic concentration to confirm response

**GENERIC:** THROMBIN

**BRAND:** THROMBIN

**INDICATION:**

(1) Hemostasis

**Criteria:**

- (a) Diagnosis of a bleeding disorder

**GENERIC:** TRAMADOL ER

**BRAND:** ULTRAM ER<sup>®</sup>

**INDICATION:**

(1) Pain, chronic (moderate to severe)

**Criteria:**

- (a) For patients who have a contraindication or failure of tramadol regular release tablets

**GENERIC:** VARENCLINE

**BRAND:** CHANTIX<sup>®</sup>

**INDICATION:**

(1) Management of smoking cessation

**Criteria:**

- (a) Physician has confirmed that the patient has no history of psychiatric illness (including, but not limited to, depression).
- (b) Physician has counseled the patient to self-monitor mood and behavior while on Chantix, and to contact their physician immediately if they experience any changes in mood or behavior.
- (c) Physician must provide evidence that patient has completed smoking cessation class.

**Quantity Limit of 12 weeks of therapy per 12-month period**

## **Prior Authorization Guidelines**

**GENERIC:** ZOLMITRIPTAN TABLETS

**BRAND:** ZOMIG®

**INDICATION:**

(1) Acute treatment of migraine headache

**Criteria:**

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT<sub>1</sub> Receptor Agonist



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GLYNASE	5	Insulin Isophane	5
GOLYTELY	10	Insulin Lispro	5
GRIFULVIN V	2	Insulin Pen Needles	20
Griseofulvin Microsize	2	Insulin Reg & Isophane	5
Griseofulvin Ultramicrosize	2	Insulin Reg & NPH	5
GRIS-PEG	2	Insulin Regular	5
Guaifenesin*	10	INTAL	9
Guaifenesin/DM*	10	Interferon Alfa-2A	4
Guanfacine	17	Interferon Alfa-2B	4
Guanfacine*	7	Interferon Alfa-n3	4
GYNAZOLE-1	12	Interferon Beta-1a	4
HUMALOG	5	Interferon Beta-1b	4
HUMATROPE	6	INTRON-A	4
HUMIRA	21	INTUNIV	17
HUMULIN 50/50	5	Ipecac*	20
HUMULIN 70/30	5	Ipratropium-Albuterol	10
HUMULIN N	5	Ipratropium*	9
HUMULIN R	5	Irbesartan & HCTZ	8
HYCOTUSS	10	Irbesartan*	7
HYDERGINE	14	Isoniazid*	2

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ISOPTO ATROPINE	18	LO LOESTRIN	5
ISOPTO-CARPINE	18	Lodoxamine	18
ISORDIL/ISORDIL TEMBIDS	6	LOESTRIN	4
Isosorbide Dinitrate*	6	LOESTRIN FE	4
Isosorbide Mononitrate*	6	LOFENALAC	16
Itraconazole*	2	LOFIBRA	8
KAPVAY	17	LOMOTIL	10
KAYEXALATE	21	Lomustine	3
KEFLEX	1	Loperamide*	10
KENALOG	20	LOPID	8
KERALAC	19	LOPRESSOR	7
KERALAC NAILSTIK	19	LOPRESSOR HCT	8
Ketoconazole*	2	LORABID	1
KETOSTIX	20	Loracarbef	1
KLOR-CON	16	Loratadine / Pseudoephedrine*	9
Labetalol*	7	Loratadine*	9
LAC-HYDRIN	20	LORTAB	13
Lactulose*	10	losartan potassium & HCTZ*	8
LAMISIL	2	losartan potassium*	7
Lancet Device	20	LOSEASONIQUE	5
Lancets*	20	LOTENSIN	7
LANOXIN	6	LOTREL	7
Lansoprazole*	11	LOTRIMIN	19
LANTUS	5	lovastatin*	9
LASIX	8	LOVAZA	8
Latanoprost*	18	LOVENOX	17
LESCOL	9	LUPRON	3
Letrozole*	3	LURIDE	16
LEUCOVORIN	16	LYSODREN	4
Leucovorin Calcium*	16	MAALOX	11
LEUKERAN	3	MACROBID	12
Leuprolide	3	MANDELAMINE	12
LEVAQUIN	1	MATULANE	4
Levofloxacin*	1	MAXAIR AUTOHALER	10
Levonorgestrel & Ethinyl Estradiol	5	MAXALT	14
Levonorgestrel*	5	MAXITROL	18
Levonorgestrel-Eth Estradiol	4	MAXZIDE	8
Levonorgestrel-Eth Estradiol*	5	MEBARAL	12
Levonorgestrel-Ethinyl Estradiol	5	Mebendazole*	2
Levothyroxine*	6	Meclizine*	11
LEVOXYL	6	MEDROL	4
LEVSIN	11	Medroxyprogesterone Acetate	5
LEVSINEX	12	Medroxyprogesterone*	5
LIDEX	20	MEGACE	3
Lidocaine viscous*	20	Megestrol*	3
Lidocaine*	14	Meloxicam*	14
LIDODERM PATCHES	14	Melphalan	3
Lindane*	20	Memantine	17
Liothyronine*	6	MENEST	4
LIPITOR	9	Meperidine*	13
LIPOFEN	8	Mephobarbital	12
Liraglutide	5	Mephyton	15
Lisinopril & HCTZ*	8	Mercaptopurine*	3
Lisinopril*	7	Mesalamine	12

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Methadone*	13	Multiple Vitamin w/ Minerals*	16
Methazolamide*	8	Multiple Vitamin*	16
Methenamine Mandelate*	12	Mupirocin*	19
METHERGINE	6	MYAMBUTOL	2
Methimazole*	6	MYCELEX	12
Methocarbamol w/Aspirin*	15	MYCELEX TROCHE	19
Methocarbamol*	15	MYCOBUTIN	2
Methotrexate*	3	Mycophenolate Mofetil*	21
Methotrexate*	14	Mycophenolate Sodium*	21
Methyclothiazide*	8	MYCOSTATIN	2
Methyldopa & HCTZ*	8	MYDFRIN	18
Methyldopa*	7	MYFORTIC	21
Methylergonovine*	6	MYLANTA	11
Methylprednisolone*	4	MYLERAN	3
Methyltestosterone	4	MYSOLINE	14
Metoclopramide*	11	MYSOLINE	17
Metolazone*	8	Nafarelin	6
Metoprolol & HCTZ*	8	NALFON	14
Metoprolol Succinate*	7	Naltrexone*	13
Metoprolol Tartrate*	7	NAMENDA	17
METROGEL	19	Naphazoline*	18
METROGEL-VAGINAL	12	NAPHCOSY	18
Metronidazole	19	NAPROSYN	14
Metronidazole*	2	Naproxen Sodium*	14
Metronidazole*	12	Naproxen*	14
MEVACOR	9	NASACORT AQ	9
Mexiletine*	7	NASALCROM	9
MIACALCIN INJ	6	NASALIDE	9
MIACALCIN NASAL	6	NASONEX	9
Miconazole*	2	NATAZIA	5
Miconazole*	12	NECON	5
Miconazole*	19	Neomycin Sulfate topical*	19
MICRO-K	16	Neomycin Sulfate*	2
Milnacipran	15	Neomycin-Bac Zn-Polymyxin*	18
MINIPRESS	7	Neomycin-Bacitracin-Polymyxin*	19
Minoxidil*	7	Neomycin-Poly-Dexamethasone*	18
MIRCETTE	5	Neomycin-Polymy-Gramicidin*	18
Mitotane	4	Neomycin-Polymyxin-HC Opth*	18
MOBIC	14	Neomycin-Polymyxin-HC Otic*	19
MODICON	4	Neomycin-Polymyxin-HC Topical*	19
Mometasone furoate	9	NEORAL	21
MONISTAT	2	NEOSPORIN	18
MONISTAT	12	NEOSPORIN	19
MONISTAT	19	NEPHROCAPS	16
MONOPRIL	7	NEUPOGEN	16
Montelukast Sodium*	10	NEXAVAR	4
Morphine Sulfate SR*	13	Niacin & Lovastatin	9
Morphine Sulfate*	13	Niacin CR*	8
MOTRIN	14	Niacin*	8
Moxifloxacin	1	Niacin*	15
Moxifloxacin HCL	18	NIASPAN	8
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NICORETTE LOZENGES	17	OGESTREL	4
Nicotine Gum*	17	Olopatadine	18
Nicotine Inhaler	17	Omega-3-acid ethyl esters	8
Nicotine Lozenges*	17	Omeprazole*	11
Nicotine Nasal Spray	17	OMNICEF	1
Nicotine Patches*	17	Ondansetron	11
NICOTROL INH	17	ONE-A-DAY	16
NICOTROL NS	17	ONE-A-DAY KIDS COMPLETE	16
Nifedipine*	7	ORACIT	12
NITROBID	6	ORACIT	16
NITRODUR	6	Oral Electrolytes*	16
Nitrofurantoin Macrocrystals*	12	ORTHO EVRA PATCH	4
Nitrofurantoin*	12	ORTHO MICRON	4
Nitroglycerin (oral)*	6	ORTHO TRI-CYCLEN / LO	5
Nitroglycerin (topical)*	6	ORTHO-CEPT	4
NITROSTAT	6	ORTHO-CYCLEN	4
NIX	20	ORTHO-NOVUM 7 / 7 / 7	5
NIZORAL	2	OS-CAL	11
NOLVADEX	3	OS-CAL	16
NORCO	13	Oseltamivir phosphate	2
NORDETTE	4	Oxacillin*	1
Norelgestromin-Ethinyl Estradiol	4	Oxybutynin*	12
Norethindrone & Mestranol	5	Oxycodone CR*	13
Norethindrone Ace-Ethinyl Estrad	4	Oxycodone w/ Acetaminophen*	13
Norethindrone Ace-Ethinyl Estrad FE	4	Oxycodone*	13
Norethindrone Ac-Ethinyl Estrad FE	5	OXYCONTIN	13
Norethindrone Ethinyl Estrad FE	4	OXYIR	13
Norethindrone*	4	Palivizumab	3
Norethindrone*	5	Pancrelipase (Lip-Prot-Amyl)	11
Norethindrone-Ethinyl Estrad	4	Pancrelipase (Lip-Prot-Amyl) DR	11
Norethindrone-Ethinyl Estradiol*	5	Pantoprazole*	11
Norethin-Eth Estrad-FE	5	PARLODEL	15
Norethin-Eth Estradiol-Fe	5	PATANOL	18
Norgestimate & Ethinyl Estradiol*	4	PEDIACARE INFANT	10
Norgestimate-Ethinyl Estradiol*	5	PEDIALYTE	16
Norgestrel & Ethinyl Estradiol*	4	PEDIAPRED	4
NORINYL	5	PEDIASURE	16
NORPACE/CR	7	Pediatric Multivitamins w/Fluoride*	16
NOR-QD	4	Pediatric Multivitamins w/Iron*	16
NORVASC	7	Pediatric Vitamins*	16
NOVOLIN 70/30	5	PEGASYS	3
NOVOLIN N	5	PEG-Electrolyte*	10
NOVOLIN R	5	Peginterferon	3
NOVOLOG	5	PEG-INTRON	3
Nutritional Supplements	16	PEN VEE K	1
NUVARING	4	Penicillamine	21
Nystatin (local)*	19	Penicillin G Benzathine	1
Nystatin (vaginal)*	12	Penicillin V Potassium*	1
Nystatin*	2	PENTASA	12
Nystatin*	19	Pentoxifylline*	17
Nystatin-Triamcinolone*	19	PEPCID	11
Octreotide Acetate*	11	PEPTO-BISMOL	11
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Permethrin*	20	PROCANBID	7
PERSANTINE	6	Procarbazine	4
Phenazopyridine*	12	PROCARDIA XL	7
Phenobarbital*	12	Prochlorperazine*	11
Phenylephrine*	18	Prochlorperazine*	12
Phenyl-Free*	16	PROCRIT	16
Phenytoin*	14	PROCTOCREAM	19
PHOSLO	16	PROGRAF	21
Pilocarpine*	18	PROLOPRIM	2
Pimecrolimus	20	PROLOPRIM	12
PIN-X	2	Promethazine*	9
Pioglitazone*	5	PRONESTYL	7
Pioglitazone-Glimpiride	5	Propafenone*	7
Pioglitazone-Metformin	5	Propranetheline Bromide*	11
Pirbuterol	10	Propoxyphene w/ APAP*	13
Piroxicam*	14	Propranolol & HCTZ*	8
PLAN B, PLAN B ONE STEP	5	Propranolol*	7
PLAQUENIL	2	Propylthiouracil*	6
PLAVIX	17	PROSCAR	12
PLENDIL	7	PROTONIX	11
Podofilox*	19	PROVENTIL HFA	10
Polycarbophil Calcium*	10	PROVERA	5
Polymixin B-Trimethoprim*	18	Pseudoephed/Brompheniramine-DM*	10
POLYSPORIN	18	Pseudoephedrine HCL soln*	10
POLYTRIM	18	Pseudoephedrine HCL*	10
POLY-VI-FLOR	16	Pseudoephedrine/Chlorphen-DM*	10
Potassium Chloride Capsule*	16	Pseudoephedrine-DM*	10
Potassium Chloride Liquid*	16	Pseudoephedrine-GG*	10
Potassium Chloride Tablet*	16	PULMICORT FLEXHALER	9
PRADAXA	17	PULMICORT RESPULES	9
PRAVACHOL	9	PURINETHOL	3
Pravastatin*	9	Pyrantel Pamoate*	2
Prazosin*	7	Pyrazinamide*	2
PRECOSE	5	PYRIDIDIUM	12
PRED FORTE/MILD	18	Pyridostigmine*	15
Prednisolone Acetate*	18	Pyrimethamine	2
Prednisolone Na Phosphate*	4	QUARTETTE	5
Prednisolone*	4	QUESTRAN/LIGHT	8
Prednisone*	4	Quinapril*	7
PRELONE	4	Quinidine Sulfate*	7
PREMARIN	4	QVAR	9
PREMPRO	4	Raloxifene	6
PRENATABS RX	16	Ramipril*	7
Prenatal MV & Min w/FE-FA*	16	Ranitidine*	11
Prenatal Vitamins*	16	RAPAMUNE	21
PRENATAL-1	16	RAZADYNE	17
PREVACID, OTC	11	RAZADYNE ER	17
PRILOSEC OTC	11	REBETOL	3
Primidone*	14	REBIF	4
Primidone*	17	RECOMBINATE	17
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RETIN-A	20	Spirolactone*	8
REVIA	13	SPORANOX	2
RHEUMATREX	3	SUBOXONE	13
RHEUMATREX	14	Succimer	21
Ribavirin*	3	Sucralfate*	11
Rifabutin	2	Sulfacetamide Sodium*	19
RIFADIN	2	Sulfacetamide Sod-Prednisolone*	18
Rifampin*	2	Sulfadiazine*	2
RILUTEK	15	Sulfanilamide	12
Riluzole	15	Sulfasalazine*	12
Risedronate	6	Sulfasalazine*	2
Rivastigmine*	17	Sulfisoxazole*	2
Rizatriptan tablets*	14	Sulindac*	14
ROBAXIN	15	Sumatriptan*	14
ROBITUSSIN AC	10	Sumatriptan-Naproxen	14
ROCALTROL	15	SUMYCIN	1
ROCEPHIN	1	SUPRAX	1
ROFERON-A	4	SYMBICORT	10
ROMYCIN	18	SYMMETREL	3
Ropinirole*	15	SYMMETREL	15
Rosiglitazone Maleate	5	SYNAGIS	3
Rosiglitazone Maleate-Glimperide	5	SYNALAR	20
Rosiglitazone Maleate-Metformin	5	SYNAREL	6
Rosuvastatin Calcium	9	SYNTHROID	6
ROWASA	12	TABLOID	3
ROXICODONE	13	Tacrolimus*	21
RYTHMOL	7	TAMBOCOR	7
SAFYRAL	4	TAMIFLU	2
Salmeterol	10	Tamoxifen*	3
Salmeterol-Fluticasone	10	Tamsulosin*	7
Salsalate*	13	TAPAZOLE	6
SANDOSTATIN	11	TARCEVA	4
SANTYL	19	TECFIDERA	21
SAVELLA	15	Telaprevir	3
SEASONIQUE	5	TEMOVATE	20
Selegiline*	15	TENEX	7
SEROMYCIN	2	TENORETIC	8
SERVENT DISKUS	10	TENORMIN	7
SILVADENE	19	Terazosin*	7
Silver Sulfadiazine*	19	Terbinafine*	2
Simvastatin*	9	Teriflunomide	21
SINEMET/CR	15	Teriparatide	6
SINGULAIR	10	TESSALON, TESSALON PERLES	10
Sirolimus*	21	TESTIM	4
Sodium Citrate & Citric Acid*	12	Testosterone Gel	4
Sodium Citrate & Citric Acid*	16	Tetracycline*	1
Sodium Fluoride*	16	THEO-24	10
Sodium Polystyrene Sulfonate*	21	Theophylline*	10
Sodium Sulfacetamide*	18	Thioguanine	3
Somatropin	6	THROMBAT III	17
Sorafenib	4	THROMBIN	17
Sotalol*	7	Thyroid*	6
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Tramadol*	13	XALATAN	18
TRANDATE	7	XELODA	3
TRECATOR	2	XODOL	13
TRENTAL	17	XYLOCAINE VISCOUS	20
Tretinoin*	20	YASMIN	4
TREXIMET	14	YAZ	4
Triamcinolone Ace. In Orabase*	20	Zanamivir	2
Triamcinolone Acetonide*	20	ZANTAC	11
Triamcinolone*	9	ZARONTIN	14
Triamterene & HCTZ*	8	ZAROXOLYN	8
TRICOR	8	ZESTORETIC	8
Trifluridine	18	ZESTRIL	7
TRIGLIDE	8	ZETIA	8
TRILIPIX	8	ZITHROMAX	1
Trimethoprim / Sulfamethoxazole*	2	ZOCOR	9
Trimethoprim*	2	ZOFRAN	11
Trimethoprim*	12	Zolmitriptan tablets*	14
Triple Sulfas Vaginal*	12	ZOMIG	14
TRIVORA	5	ZORPRIN	13
TRUSOPT	18	ZOVIA	4
TUDORZA PRESSAIR	9	ZOVIRAX	3
TYLENOL	13	ZOVIRAX TOPICAL	20
TYLENOL / CODEINE	13	ZYLOPRIM	14
ULTRACET	13	ZYMAXID	18
ULTRAM	13	ZYRTEC	9
ULTRAM ER	13		
UNIPHYL	10		
Urea 35%	19		
Urea 50%	19		
URECHOLINE	12		
URISPAS	12		
Valsartan	7		
Valsartan & HCTZ*	8		
Varenicline Tartarate	17		
VASOTEC	7		
VENTOLIN HFA	10		
VEPESID	3		
Verapamil*	7		
VIBRAMYCIN	1		
VICODIN	13		
VICTOZA	5		
VICTRELIS	3		
Vidarabine	18		
VIGAMOX	18		
VIOKACE	11		
VIRA-A	18		
VIROPTIC	18		
Vitamin A*	15		