PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Medi-Cal/Healthy Kids/Healthy Families

FORMULARY GUIDE*

January 2011

FAX Lines:

(707) 419-7900 (Providers using ONLINE/POS billing ONLY)

(707) 863-4330 (Providers using PAPER CLAIMS/HAND billing ONLY)

***Partnership*Advantage* (Part D):**
Formulary is available at www.partnershiphp.org

PHC Contact Information:

360 Campus Lane, Suite 100, Fairfield, CA 94534

Phone Directory:

PHC Member Services Call Center . . . . (800) 863-4155
(707) 863-4120
PHC Member Services Automated Eligibility. . . . . (707) 863-4140

PHC Provider Relations (Prescribers) . . . . (707) 863-4100

PHC Pharmacy Services (Pharmacies & Prescribers). . . . (707) 863-4414

Web:

Partnership Healthplan of California: www.partnershiphp.org

PHC Formularies: www.partnershiphp.org/Pharmacy/Formularies.htm

PHC Prior Authorization Forms: www.partnershiphp.org/Pharmacy/Prior_Auth.html

Epocrates (Formularies): www.epocrates.com
Download “Epocrates Rx” for your smartphone, or “Epocrates Online” for your computer.

FAX Numbers:

TARs for PHARMACY ONLINE BILLING/POS SERVICES: (707) 419-7900

TARs for PAPER/HANDBILL ONLY (such as in-office services): (707) 863-4330

PHC FORMULARY GUIDE
2011

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

PHC Pharmacy Information

The Partnership HealthPlan of California (PHC), with direction from the Pharmacy & Therapeutics (P&T) Committee and Physician Advisory Committee (PAC), has developed formularies for its four lines of business to be used by HealthPlan clinicians and pharmacists. These committees will continue to update and revise the formularies based on quality of care considerations and sound pharmacoeconomic principles. As coverage & criteria are subject to change, please refer to quarterly formulary updates for updated formulary information. In 2006, PHC added the Healthy Kids commercial line of business, in 2007, PHC added Partnership*Advantage*, a Medicare D plan for dual eligible PHC members, and in 2010 added Healthy Families commercial line of business. This guide only includes the Formulary for the Medi-Cal line of business. Healthy Kids & Healthy Families follow the same formulary, with some exceptions, as noted within this document. The Partnership Advantage Formulary is not included is this guide, although there are many similarities. **A complete Partnership*Advantage* Formulary is available at www.partnershiphp.org.**

Drugs included in the formulary are listed by their brand names in most cases, rather than by their generic names, for convenience only. **PHC requires generic substitution when an equivalent generic product is available.** However, clinicians may prescribe a brand name drug with a "do not substitute" order when there is clinical justification for doing so. In this case, submission of a Treatment Authorization Request (TAR) is necessary, along with a MedWatch form (clinical information to be completed by physician, product info may be completed by pharmacy).

ABOUT THE 2011 PHC FORMULARY GUIDE:

This guide is intended to help providers know formulary status of products, criteria for TAR authorization, and to help determine appropriate formulary alternatives. This document does not contain all the formulary agents for all 3 lines of business, only those most commonly encountered in the outpatient setting. Additional formulary information can be obtained using *Epocrates Online* for your desktop/laptop or *Epocrates Rx* for your mobile device (available at *www.epocrates.com*) or by calling PHC Pharmacy Services at (707)863-4414. A PDF version of this document is available online at *www.partnershiphp.org.* The guide is divided into 4 main sections:

1. Therapeutic Class/Price List: This section can help providers find formulary alternatives based on what problem is being treated; it primarily contains PHC's most commonly used Medi-Cal ("MC") formulary items.
2. 2011 Formulary Status:
   Note: Products are listed by the trade (brand) name only for convenience—brand name drugs are not covered when there are A/B rated generics available. Generic substitution is required unless otherwise stated.
   a. Rx Outpatient Formulary (PO, PR, PV, Topical, Inhaled, Ophthalmic, & a few injectables commonly dispensed by retail pharmacies)
   b. OTC's
   c. Medical Supplies, DME (strips, monitors, bandages, etc)
   d. Injectables
3. Medication Class Comparison Tables – These compare cost of both formulary & some non-formulary treatment choices.
4. Drug-specific Prior Authorization Criteria – Includes prerequisite therapy, dx's, labs or other information needed by PHC reviewers to make a determination. Referring to this section & gathering the necessary information for inclusion with the first fax of the TAR will greatly reduce the need for additional communication with providers.

TERMS, ACRONYMS & SYMBOLS USED BY PHC:

AWP: "Average Wholesale Price". Despite the name, the AWP is not the wholesale price; it more closely resembles a "sticker price" or manufacturer's list/retail price. In the pharmacy insurance industry, payments are typically based on AWP minus some percentage. PHC's reimbursement rate for brand items is AWP minus 16% (or pharmacy's "usual & customary", whichever is less) plus a dispensing fee.

BRAND NAMES: Trade name/patent drugs. Unless otherwise stated, **THE BRAND NAMES SHOWN IN THE FORMULARY GUIDE ARE NON-FORMULARY WHEN AN AB-RATED GENERIC IS APPROVED BY THE FDA.** Brand names used in this formulary guide are *representative only*, for ease of drug recognition by providers. Generic products must be dispensed whenever possible, as required by the Formulary Utilization Management Initiative (refer to State's Medi-Cal program). TAR consideration for brand names may require any or all of the following: Prescriber's evaluation & assessment of signs/symptoms of generic failure, documentation that generic has actually been dispensed (e.g., copy of pharmacy profile), completion of FDA MedWatch form to document problem with a generic product, trial of more than one generic source product, trial of alternate product in same therapeutic category.

CARVE-OUT DRUGS: Prescription services not included in PHC's scope of coverage, but are covered by other state payers such as State Med-Cal & CCS. These drugs remain a potential benefit for eligible PHC members but PHC is not financially responsible and all claims for these drugs (including secondary copays) must be reimbursed through the State Medi-Cal/ CCS programs. Indicated by the symbols shown below:

- ✔ = HIV/AIDS products
- ♠ = Psychotherapeutic & Addiction products
- ♥ = Drugs used to treat CCS eligible conditions

CCS: California Children's Services-- a state program for children up to 21 years old with certain health problems. CCS claims for Healthy Kids, Healthy Families, Mendocino &Sonoma Medi-Cal members are billed through the state/CCS procedures rather than to PHC due to "Carve-Out" status (see above). Claims for agents that are commonly used to treat CCS eligible conditions may be screened for CCS eligibility via the TAR process. Please submit CCS Screening TARs to PHC, with a patient-specific diagnosis *as provided by the prescriber*. CCS programs in Napa, Solano & Yolo counties are administered by PHC, thus claims & TARs are processed through PHC. Note: Including CCS SAR's with TAR's for PHC in Napa, Solano & Yolo counties will help facilitate the TAR review, even though CCS is not carved-out in these counties. Eligible agents are designated by "♥".

CCS ELIGIBLE PHARMACY SERVICES: CCS covered prescriptions include agents in the following treatment categories: cardiology, neurology, endocrinology, oncology, hematology, metabolism disorders, gastroenterology, ophthalmology, rheumatology & other connective tissue/musculoskeletal disorders, pulmonology, nephrology, immunology and severe skin/subcutaneous conditions. Disabling injuries may also be eligible for CCS services.

CDF: Coverage Determination Form. This is the CMS Medicare Part D term for a prior authorization request form for medication/DME service. A CDF is used in lieu of the standard TAR form for PHC's Part D plan, Partnership*Advantage*.

CMS: Centers for Medicare & Medicaid Services. The US Federal agency which administers Medicare (A, B & D), Medicaid/Medi-Cal and the Children's Health Insurance programs.

CODE 1 MEDICATIONS: Indicated by the symbol ©. Formulary use of the medication is restricted to a specific medical condition, failure/intolerance to 1st line therapy or member's place of residence. Although Code 1 restricted drugs do not require a TAR, pharmacy providers must maintain documentation that the drug is being dispensed according to the Code 1 restriction. Any other use of the drug is considered non-formulary and

requires a TAR. To facilitate filling of a Code 1 prescription, **prescribers should write the member's diagnosis, and any other Code 1 criteria if met, on the prescription**.

DEFERRED: AKA "Pending": A TAR that is on hold, waiting for additional information requested by PHC. *This is not the same as a denial – a "deferred" TAR is not denied, but additional information needs to be submitted in a timely manner for completion of the review.* An administrative denial will occur if the requested information is not received by PHC within 14 business days of the date of deferral.

DESI: Drug Efficacy Study Implementation. A program started in the 1960's by the FDA with the goal of evaluating all medications for efficacy as well as safety. The program was intended to classify all drugs placed on the market prior to 1962, which had been in use without any prior efficacy studies. A DESI drug is any drug that lacks substantial evidence of effectiveness. DESI drugs are excluded from Medicare Part D benefits per CMS – see "Excluded Drugs" for more information.

DISPENSING LIMITS: Indicated by the symbol Ψ. Formulary use of the medication is limited to the specified dispensing quantity, duration of use or member age. An approved TAR or CDF is required for dispensing of a drug that exceeds the designated limit.

DOLLAR LIMITS: PHC's Medi-Cal, Healthy Kids & Healthy Families plans have an online adjudication limit of $500 for any single claim. Claims submitted for more than $500 will require a TAR, regardless of formulary status, unless otherwise indicated by the symbol #. Partnership*Advantage* has an online adjudication limit of $1000. Compounded prescriptions have a $50 limit (see PHC's Pharmacy Procedure Manual for instructions on submitting compound claims & TARs).

DUAL ELIGIBLE: Member with both Medi-Cal and Medicare. Medi-Cal is always secondary to Medicare, thus if pt has eligible coverage through either Medicare B or Medicare D, the Medicare plan is responsible for Medicare B or D covered items. Excluded & DESI drugs may be submitted to PHC for Medi-Cal coverage (TAR may be needed); drugs that are non-formulary on pt's Part D (not excluded per CMS) must go through the prior authorization procedures with the Part D plan rather than PHC. Pharmacies may submit a TAR to PHC for consideration of Part B copays & deductibles; PHC is federally prohibited from paying any Part D copays or deductibles.

eCOB: Electronic coordination of benefits. The ability to transmit & adjudicate electronically (online) the portion of the primary insurance claim that is the patient's responsibility, to the secondary insurance. Co-pays over $50 require a TAR when PHC is the secondary payer; please note on the TAR the copay and submit with an eCOB form, including any/all known reason(s) for the high copay (deductibles, non-formulary w/ primary, etc). If Rx is non-formulary or non-preferred with the primary, prior auth should be sought with the primary before submitting a TAR to PHC. PHC formulary restrictions may be applied. If Rx is "refill too soon" or "M/I days supply" or any other administrative denial with the primary, those issues must be resolved with the primary before submitting claim to PHC. Per CMS Federal regulations, PHC is *not* responsible for any Part D copays, deductibles or "donut hole" amounts.

EXCLUDED DRUGS: These are agents that have been excluded from Part D by Federal CMS regulation, and are typically not a covered benefit by Medicare D plans. Excluded Drugs include: drugs covered exclusively by Part A or B, drugs with "less than effective" DESI status, OTC's, Rx vitamin & minerals supplements (except niacin, prenatal & fluoride products), cough & cold agents, fertility agents, agents for weight gain/loss (except megestrol), agents for cosmetic use, barbiturates, benzodiazepines. *Drugs which are excluded from PART D coverage per CMS may be eligible for coverage through the member's secondary Medi-Cal (PHC) coverage***.**

Note: "Excluded" is NOT the same as being non-formulary or "Formulary Exempt". An agent may be non-formulary on a specific Part D plan, but not CMS excluded. Conversely, a drug may be a CMS excluded drug, but a Part D plan may *choose* to include it on the formulary. Since Medicare is primary over

Medicaid/Medi-Cal programs, PHC requires that prior auth (CDF) be sought with the member's primary Part D insurance, including any necessary appeals *before* submitting a TAR to PHC.

F: Formulary. Note that additional restrictions may apply. A formulary agent may be subject to dollar limit, age, qty, dosage form, code 1, specific NDC requirement, CCS referral, or other limitations which necessitate a TAR despite formulary status.

HF: Healthy Families, a state sponsored low-cost insurance for children & teens, up to age 19. PHC is only one of several entities offering a Healthy Families plan. It provides coverage to children/teens who do not have insurance & do not qualify for free Medi-Cal. Excluded Benefits: most OTC's and treatment of chronic CCS eligible conditions (carved out to State/CCS). Exceptions to the exclusion from benefits are indicated with the diamond symbol ♦.

HK: Healthy Kids, PHC's low-cost commercial line of business for children in Solano County. This is a locally developed insurance program, administered by PHC. Available for purchase by low-income families for children up to age 19, who do not qualify for free cost Medi-Cal or Healthy Families. Excluded from benefits: most OTC's and treatment of chronic CCS eligible conditions (carved out to State/CCS). Exceptions to the exclusion from benefits are indicated with the diamond symbol ♦.

MAC: Maximum Allowable Cost. Used to calculate reimbursement rates for generically available products. Third party payers utilize MAC pricing for many generics rather than the manufacturers' AWPs. MAC lists are not standardized – each PBM or insurer determines its own MAC. MAC pricing is used by both commercial & state/federally funded insurance programs.

MC: Medi-Cal. Used to disgnate **PHC's Medi-Cal line of business**; also referred to as "regular Partnership" (as opposed to Partnership*Advantage*). PHC contracts with the STATE to provide medical services to the Medi-Cal eligible population in certain counties (Marin, Mendocino, Napa, Solano, Sonoma & Yolo). PHC is a separate entity from "State Medi-Cal". PHC utilizes its own formulary & criteria derived from evidenced-based medicine and approved by both a Pharmacy & Therapeutics Committee and a Physicians' Advisory Committee.

NEW STARTS: Initial Rx

NF: Non-Formulary. A TAR (Treatment Authorization Form, aka prior authorization) is required for coverage.

OVER-THE-COUNTER MEDICATION (OTC's) & Medical Supplies: PHC's Medi-Cal formulary offers a large selection of covered OTC items & medical supplies. A prescription is required for both formulary OTC claims and non-formulary OTC requests. OTC coverage is generally not a covered benefit for Healthy Kids or Healthy Families, but exceptions have been made as noted in the OTC section. PHC's Medi-Cal formulary includes "wrap benefit" coverage for dual eligible members (members with both Medi-Cal and Medi-Care) – this allows Medi-Cal members to obtain formulary OTC products at no charge if the product is excluded from Medi-Care.

OTC manufacturers change/add/discontinue UPC's, NDC's & GPIDS frequently, and new product identifiers are not always recognized by MedImpact. A rejected claim does not necessarily mean an OTC will not be covered; please submit a TAR if the prescribed product is medically necessary. PHC staff will help find a formulary equivalent &/or refer the TAR to the appropriate PHC staff for review.

PBM: Pharmacy Benefits Manager. A PBM is a third party administrator of prescription drug plans. The PBM for PHC is MedImpact. The PBM is primarily responsible for processing and paying drug claims. MedImpact is a separate entity from PHC, contracted by PHC for online claims adjudication & support.

PDP: Part D Plan-- *e.g.*, "This member's PDP is Partnership*Advantage".* Examples of other PDP's include Healthnet Orange, AARP, Blue Cross Medicare Rx, etc.

QL: Quantity limits apply. A drug may be limited to a maximum daily, monthly, yearly or lifetime usage.

SECONDARY INSURANCE: When patients have more than one medical &/or prescription insurance, one is assigned as the primary and the other is secondary—meaning reimbursement for services is the responsibility of the primary insurance first. The secondary is billed only after the primary. The secondary insurance may utilize its own formulary restrictions. State funded programs (Medi-Cal, PHC, CCS, etc) are always secondary to any private or federal insurance plans—*i.e.*, they are the payers of last resort. All reimbursement issues should be resolved with the primary insurance before submitting a TAR to PHC – this includes using the allowed day's supply, using the primary's formulary preferred agents, obtaining prior auth from the primary for non-preferred or non-formulary items, *etc.*

STEP AGENT, OR STEP THERAPY EDIT: Online approval without a TAR requires specific "step" treatment. Drugs with this limitation are designated by STE. Member must have had a previous trial of one or more designated 1st line agent(s) *paid by MedImpact* within the last 120 – 180 days (depending on specific agent) in order for claim to adjudicate without a TAR. TARs submitted for STEP agents should include documentation of previous trial & failure of (or contraindication to) the prerequisite step therapy.

TREATMENT AUTHORIZATION REQUEST (TAR): A prior authorization request form for PHC services. The following are examples of claims which require prior authorization (TAR or CDF) before reimbursement can be made:

- Drugs not listed in the 2011 Formulary Guide
- Drugs listed as NF or NF
- Drugs listed as needing CCS screening for eligibility (applies to Mendocino, Sonoma County & Healthy Kids/Families)
- Brand name drugs when an equivalent generic is available
- Prescriptions not meeting a Code 1 restriction
- Prescriptions exceeding a designated dispensing limit
- Any single claim that exceeds plan dollar limits and is ***not*** designated with a "#" ($500 exempt footnote)
- Non-formulary agents with prior auths that were previously approved by another plan (including State Medi-Cal)
- Agents that are STEP with no claims for the prerequisite step therapies on member's PHC profile within the allotted time frame
- Agents designated as "Specialty Pharmacy Item" when being dispensed by any pharmacy other than PHC's contracted specialty pharmacy

Prior authorizations must be requested by the provider (pharmacy or prescriber) by sending a completed TAR to PHC, preferably by FAX. Retroactive **TAR's must be received by PHC within fifteen (15) business days of the requested start date of service.** To facilitate prompt completion of the TAR, and to minimize the need for communication between the prescriber, the pharmacist, and PHC staff, prescribers are encouraged to include the following information, as appropriate, on the back of the written prescription or as additional faxed info to pt's pharmacy for medications requiring a TAR:

- **D**iagnosis (ICD-9, DSM# optional—may use to maintain pt confidentiality).
  TARs must have an accurate Dx provided by the physician, for the specific patient & drug in question. Ancillary pharmacy staff is asked NOT to complete this section on TAR without checking with the prescriber, as many drugs have multiple indications & the dx should not be assumed. An incorrect dx may cause further delay of the review process.
- **O**ther Formulary Medications tried and nature of the failure
- **C**linical Justification for the use of a non-formulary drug, including relevant lab results & medical history.

*(Remember "DOC" – **D**iagnosis, **O**thers tried & **C**linical justification)*

TAR's may be deferred by PHC for further information and placed in "Pended" status, awaiting response from provider. Responses to deferred/pended TAR's must be received within 14 calendar days or the TAR will be subject to administrative denial.

Emergency authorizations for TAR's outside of PHC's normal business hours may be requested from MedImpact (PHC's contracted PBM) at (800) 788-2949. MedImpact may authorize up to a 5 day supply of medication, pending further authorization by PHC. When both PHC and MedImpact are unavailable, PHC will authorize a retroactive TAR allowing the pharmacy to dispense up to a 5 day supply of a non-formulary drug in an emergency situation. PHC does not require that the situation meet any *legal* (i.e., pharmacy law) definition of "emergency" -- it is the judgment of the dispensing pharmacist that determines the need for emergency authorization in order to avoid pain, suffering, severe emotional distress, or worsening of any medical condition that could result in the need for emergency medical treatment.

$500 TAR EXEMPTION: Indicated by the symbol "**#**". This indicates that the specified agent does not require a dollar override when the total claim is $500 or more.

TO SUBMIT A TAR OR CDF for online claims, PLEASE FAX THE APPROPRIATE COMPLETED FORM TO PHC AT (707) 419-7900.

For hand billed claims (such as in-office drug procedures using J or X billing codes) FAX to 707-863-4330.

- TARS & CDF forms are available at www.partnershiphp.org, www.covermymeds.com, or by calling PHC pharmacy services dept.
- Complete TARs carefully & neatly. Use the form specific for the plan to which member belongs (PHC Medi-Cal, Healthy Kids, Healthy Families, Partnership *Advantage*). Incomplete TARs may be returned to the pharmacy (or other provider) if any of the following are missing or illegible: Member Name, ID#, Date of Birth, Diagnosis, Justification, Drug Name/Strength/Sig, NDC, prescriber DEA & contact info.
- You may fax multiple sheets of paper if additional writing space is needed – make sure the patient's last name &/or TAR # is included on all additional sheets to help ensure they get attached to the correct TAR.
- Pharmacies: Please include the prescriber's full contact info -- name, DEA #, specialty, phone & fax. Include the Rx Sig in either standard English or standard Latin based pharmacy abbreviations. Please do NOT use the pharmacy's unique internal abbreviation codes assigned by the pharmacy's computer software, as they are usually not industry standard & may cause delay in the TAR review process.
- Providers submitting TARs for manual billing to PHC Claims Dept: To help expedite TAR review, please include ***on the TAR form*** not only the current billing code, drug, provider & pt info, but also the # of billing units needed per dose, the number of doses requested, and the strength & admin directions for the drug. Expected duration of treatment is also helpful.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

THERAPEUTIC CLASS/PRICE LIST

PHC FORMULARY

I) ANTI-INFECTIVES: ORAL
II) ANTI-INFECTIVES: TOPICAL
III) IMMUNE-MODULATING
IV) CARDIOVASCULAR
V) AUTONOMIC/CNS
VI) ANALGESICS
VII) DERMATOLOGICS
VIII) OTICS
IX) OPHTHALMICS
X) NASAL
XI) ENDOCRINE
XII) OB/GYN
XIII) UROLOGICS
XIV) GASTROINTESTINALS
XV) RESPIRATORY
XVI) ALLERGY/COUGH/COLD
XVII) NUTRITIONALS
XVIII) ELECTROLYTE-RELATED
XIX) HABIT-ABATEMENT
XX) INJECTABLES
XXI) MISCELLANEOUS
XXII) MEDICAL SUPPLIES / DME

Symbol Key:

Symbol		Meaning
♦	=	Covered benefit (in an otherwise excluded benefit category such as OTC) for HK & HF members –PHC's commercial line of business.
©	=	Code 1 Restricted Medication
Ψ	=	Quantity, Duration or Age Limit
✔	=	Carve-Out: HIV/AIDS Carve-Out drug. *Pharmacy must submit any claims or TARs to STATE Medi-Cal.*
♠	=	Carve-Out: Psychotherapeutic/Addiction Carve-Out drug. *Provider must submit any claims & TARS to STATE Medi-Cal.*
♥	=	Carve-Out: Potential carve-out to CCS. TARS sent to PHC will include screening for CCS eligible condition/tx and referral to CCS if applicable. This applies to HK, HF, Mendocino and Sonoma MC only.
STE	=	Step Therapy Edit
#	=	Exempt from $500 claim limit
SP	=	Specialty Pharmacy item. TAR required for non-specialty pharmacy dispensing.
F	=	Formulary; restrictions may apply
HF	=	Healthy Families
HK	=	Healthy Kids
MC	=	PHC's Medi-Cal
NF	=	Non-formulary, submit TAR for review

Remember: BRAND NAMES are shown throughout this guide for ease of drug recognition only. *Generic substitution is required*

Price Information:

- Based on Average Wholesale Price (AWP) for single-source brand name and MAC (Maximum Allowable Cost) for generically available drugs.
- A month supply of an average regimen is used for pricing, except where otherwise indicated.
- Prices are for oral forms unless otherwise specified.
- Ophthalmics, otics, topicals and most oral liquids are priced according to the smallest available container, unless otherwise stated.
- Prices are approximate and rounded to the nearest $5.
- For some agents, a price range is given when broad dose/cost variability exists.

I) ANTI-INFECTIVES: ORAL

Price estimates for oral anti-infectives are based on a 10 day supply unless otherwise stated.

ANTI-BACTERIALS

Cephalosporins

$15 cefpodoxime (VANTIN)Ψ - per 2 tablet limit
$20-40 cefaclor (CECLOR)
$25 cefixime (SUPRAX) © Ψ - per 2 tablet limit
$35-120 cefuroxime (CEFTIN)Ψ
$45-90 cefdinir (OMNICEF) Liquid
$5-15 cephalexin (KEFLEX)

Macrolides

$5 erythromycin base
$5 erythromycin ethyl succinate
$5 erythromycin stearate
$10 EES/sulfisoxazole (PEDIAZOLE)
$10 azithromycin (ZITHROMAX)Ψ - per 5day course

Penicillins

$5 amoxicillin (AMOXIL)
$5 ampicillin (PRINCIPEN)
$5 penicillin VK (PEN V K)
$5-10 dicloxacillin (DYNAPEN)
$40-90 amox/clav (AUGMENTIN)

Quinolones

$10 ciprofloxacin (CIPRO)Ψ
$95-120 levofloxacin (LEVAQUIN)Ψ
$110-120 ofloxacin (FLOXIN) Ψ

Tetracyclines

$5 doxycycline (VIBRAMYCIN, VIBRA-TABS))
$5 tetracycline (ACHROMYCIN)

Urinary Tract Anti-Infectives

$5 trimethoprim (PROLOPRIM)
$10 methenamine mand. (MANDELAMINE)
$25 methenamine hipp. (HIPREX/UREX)
$25 nitrofurantoin (MACRODANTIN)
$40 nitrofurantoin SR (MACROBID)

Other Anti-Bacterials

$5 TMP/SMX (SEPTRA, BACTRIM)
$5 metronidazole (FLAGYL)
$15-30 clindamycin (CLEOCIN)
$20 sulfisoxazole (GANTRISIN)
$40 neomycin (NEOMYCIN)
$775 atovaquone (MEPRON)

ANTI-FUNGALS

$5 nystatin (MYCOSTATIN)
$5 fluconazole (DIFLUCAN) 150mg Ψ (price shown for qty limit 2 tabs)
$15 griseofulvin (FULVICIN P/G)
$20-60 fluconazole (DIFLUCAN) 100, 200mg
$25 ketoconazole (NIZORAL)
$40 clotrimazole (MYCELEX)
$150-295 flucytosine (ANCOBON)

ANTI-MALARIALS

$10 hydroxychloroquine (PLAQUENIL)
$10 primaquine (PRIMAQUINE)
$10 pyrimethamine (DARAPRIM)
$25 chloroquine (ARALEN)

ANTI-MYCOBACTERIALS

$5 clofazimine (LAMPRENE)
$5 isoniazid (INH)
$5-10 dapsone (DAPSONE)
$110 rifampin (RIMACTANE)
$120 pyrazinamide (PZA)
$130 rifampin/isoniazid (RIFAMATE)
$135 ethambutol (MYAMBUTOL)
$215 rifabutin (MYCOBUTIN)
$230 cycloserine (SEROMYCIN)
$285 rifampin/isoniazid/pyrazine (RIFATER)

ANTI-RETROVIRALS

NOTE: Anti-HIV products are CARVE-OUT drugs (i.e., payable via State Medi-Cal for PHC/MC members rather than PHC), with the exception of Epivir-HBV, Retrovir, Videx and Videx-HC.

Non- Nucleoside Reverse Transcriptase Inhibitors

$320 delavirdine (RESCRIPTOR) ✔
$370 nevirapine (VIRAMUNE) ✔
$435 efavirenz (SUSTIVA) ✔

Nucleoside Reverse Transcriptase Inhibitors

$160 lamivudine (Epivir-HBV)
$260 zalcitabine (HIVID)
$270 didanosine (VIDEX)
$305 emtricitabine (EMTRIVA) ✔
$305 lamivudine (EPIVIR) ✔
$335 stavudine (ZERIT) ✔
$335 zidovudine (RETROVIR)
$410 abacavir (ZIAGEN) ✔
$2085 enfuvirtide (FUZEON) ✔

Nucleotide Reverse Transcriptase Inhibitors

$435 tenofovir (VIREAD) ✔

Protease Inhibitors

$580 indinavir (CRIXIVAN) ✔
$675 saquinavir mesylate (INVIRASE) ✔
$680 nelfinavir (VIRACEPT) ✔
$815 ritonavir (NORVIR) ✔
$1065 atazanavir (REYATAZ) ✔

Combinations

$620 lamivudine/zidovudine (COMBIVIR) ✔
$705 lopinavir/Ritonivir (KALETRA) ✔

I) ANTI-INFECTIVES: ORAL, continued

Combination anti-retrovirals, continued

$780 abacavir/tenofovir (EPZICOM) ✔
$815 emtrictabine/tenofovir (TRUVADA) ✔
$1065 abacavir/lamivudine/zidovudine (TRIZIVIR) ✔

ANTI-VIRALS

$20-50 acyclovir (ZOVIRAX) tablets
$70 zanamivir (RELENZA) ©Ψ
$95 oseltamivir (TAMIFLU) ©Ψ
$720-1440 ganciclovir (CYTOVENE)

ANTIHELMINTICS

$5 thiabendazole (MINTEZOL)
$10 pyrantel pamoate (ANTIMINTH)
$30 mebendazole (VERMOX)
$30-60 praziquantel (BILTRICIDE)Ψ

II) ANTI-INFECTIVES: TOPICAL

Price estimates are based on 30g supply unless otherwise stated.

TOPICAL ANTI-BACTERIALS

$5 bacitracin oint (BACITRACIN)
$5 poly/bac oint (POLYSPORIN)
$5 neo/poly/bac oint (NEOSPORIN)
$5 silver sulfadiazine cr (SILVADENE)
$15 mupirocin oint (BACTROBAN) (22g tube)
$25 metronidazole gel 0.75% (METROGEL)

TOPICAL ANTI-FUNGALS

$5 nystatin (MYCOSTATIN)
$5 selenium sulfide (SELSUN, 120ml)
$5 tolnaftate (TINACTIN)
$5 miconazole (MICATIN)
$10 terbinafine (LAMISIL AT)
$10 clotrimazole (LOTRIMIN)
$15 econazole (SPECTAZOLE)
$20 ketoconazole (NIZORAL)
$70 oxiconazole (OXISTAT)

TOPICAL ANTI-FUNGAL COMBINATIONS

$5 nystatin/triamcinolone (MYCOLOG II)

TOPICAL PEDICULOCIDES / SCABICIDES

Price per 2 fluid oz (liquids) or 60g (creams)

$10 pyrethrins (RID, *etc*.)
$10 permethrin (NIX) Ψ
$15 crotamiton (EURAX)
$35 permethrin (ELIMITE)
$140 malathion (OVIDE) Ψ

OTHER ANTI-INFECTIVE TOPICALS

$250 podofilox gel (CONDYLOX, 3.5g)
$625 imiquimod (ALDARA)

III) IMMUNE MODULATORS

Regardless of formulary status, TARs are required for: (1) claims exceeding $ limit and (2) local pharmacies seeking to dispense products that are limited to dispensing by contract specialty pharmacy. Screening for CCS eligibility is required via TAR for ages 0-20 in Mendocino, Sonoma County & Healthy Kids/Families (all counties).

ANTI-NEOPLASTICS

Any FDA approved cancer therapy prescribed for the FDA approved condition (TAR may be required to ensure reimbursement due to PHC dx or $ limits). Dispensing limits may apply (specialty pharmacy, qty limits).

IMMUNOSUPPRESSANTS

$40-110 azathioprine (IMURAN)
$4 -730 mycophenolate mofetil (CELLCEPT)
$575-1440 tacrolimus (PROGRAF)
$800-1500 cyclosporine (SANDIMMUNE, NEORAL)

IV) CARDIOVASCULAR

Claims for cardiovascular agents requires a TAR for ages 0-20 to facilitate screening for CCS eligibility in Sonoma & Mendocino counties and all Healthy Kids/Families.

ACE INHIBITORS

$5 captopril (CAPOTEN)
$10 enalapril (VASOTEC)
$10 benazepril (LOTENSIN)
$10 lisinopril (PRINIVIL/ZESTRIL)
$60-80 ramipril (ALTACE)

ADRENERGICS

$5 methyldopa (ALDOMET)
$5 clonidine oral (CATAPRES)
$15 guanfacine (TENEX)

ALPHA BLOCKERS

$15 prazosin (MINIPRESS)
$15 terazosin (HYTRIN)
$15-20 doxazosin (CARDURA)

ALPHA/BETA BLOCKERS

$40 carvedilol (COREG)

ANGIOTENSIN-II RECEPTOR ANTAGONIST(ARB)

$10 losartan (Cozaar) STE
$10 losartan/HCTZ (Hyzaar) STE
$45 irbesartan (AVAPRO) © Ψ

ANTI-PLATELET/ANTI-COAGULANT

$5-10 dipyridamole (PERSANTINE)
$10-15 warfarin (COUMADIN)
$145 clopidogrel 75MG (PLAVIX)

IV) CARDIOVASCULAR, continued

ANTI-ARRHYTHMICS

$5-15	quinidine sulfate (QUINIDINE)
$10-20	procainamide (PRONESTYL)
$35-70	quinidine gluconate (QUINAGLUTE)
$40-50	mexiletine (MEXITIL)
$75-150	procainamide SR (PROCANBID)
$85-170	procainamide SR (PRONESTYL-SR)
$105-310	amiodarone (CORDARONE)
$110-205	propafenone (RYTHMOL)

BETA BLOCKERS

$5	atenolol (TENORMIN)
$5-10	propranolol (INDERAL)
$5-10	metoprolol (LOPRESSOR)
$15	labetalol (TRANDATE)
$35	acebutolol (SECTRAL)
$35	metoprolol XL (TOPROL XL)
$45-65	propranolol SR (INDERAL LA)
$45-50	sotalol (BETAPACE)

CALCIUM-CHANNEL BLOCKERS

$5	diltiazem (CARDIZEM)
$5-15	verapamil (CALAN, ISOPTIN)
$10	verapamil SR (CALAN SR, etc)
$20	amlodipine (NORVASC)Ψ
$20-55	diltiazem SR (CARDIZEM CD, CARDIZEM SR, DILACOR XR)
$30	felodipine (PLENDIL)
$40	nifedipine SR (ADALAT CC)Ψ
$45-55	nisoldipine (SULAR)

CARDIAC GLYCOSIDES

$5-10	digoxin (LANOXIN)

COMBINATION AGENTS

$10-15	benazepril HCT (LOTENSIN-HCT)
$10-30	atenolol/chlorthalidone (TENORETIC)
$15-25	lisinopril/HCT (PRINZIDE)
$35-65	bisoprolol HCT (ZIAC)
$65	benazepril/amlodipine (LOTREL)Ψ (Only generically available strengths are formulary)

DIURETICS

Carbonic Anhydrase Inhibitors

$10-15	acetazolamide (DIAMOX)
$20-60	methazolamide (NEPTAZANE)

Diuretic Combinations

$10	triamterene/HCT (MAXZIDE, DYAZIDE)
$10-15	spironolactone/HCT (ALDACTAZIDE)

Loop

$5	furosemide (LASIX)
$15	bumetanide (BUMEX)

Potassium-Sparing

$15	spironolactone (ALDACTONE)

Thiazides

$5	chlorthalidone (HYGROTON)
$5	hydrochlorothiazide (HYDRODIURIL)
$5	chlorothiazide (DIURIL)
$5-10	indapamide (LOZOL)
$25-40	metolazone (ZAROXOLYN)

LIPID-LOWERING AGENTS

Resins

$55-60	cholestyramine bulk pwd (QUESTRAN)

Statins

$5	simvastatin (ZOCOR)
$10	pravastatin (PRAVACOL) Ψ
$10	lovastatin (MEVACOR) Ψ
$55-70	fluvastatin (LESCOL)
$70	rosuvastatin (CRESTOR) Ψ **STE**

Other Lipid-Lowering Agents

$5-15	niacin (OTC)
$20	gemfibrozil (LOPID)
$35	micronized fenofibrate (LOFIBRA)
$90	Ezetimibe (ZETIA) **STE**
$120	Niacin, Rx product (NIASPAN)

NITRATES

$5	nitroglycerin SL (NITROSTAT)
$5-15	isosorbide dinitrate (ISORDIL)
$10-15	isosorbide mononitrate ER (IMDUR)
$10-15	nitroglycerin topical (NITROBID)
$15	nitroblycerin patch (NITRODUR)
$50	nitroglycerin spray (NITROLINGUAL)

VASODILATORS

$5	hydralazine (APRESOLINE)
$15	minoxidil tablets (LONITEN)

V) AUTONOMIC/CNS

ANTI-ANXIETY AGENTS

$5	chlordiazepoxide (LIBRIUM)Ψ
$5	diazepam (VALIUM)Ψ
$5-15	alprazolam (XANAX)Ψ
$5-15	hydroxyzine pamoate (VISTARIL)
$15-30	lorazepam (ATIVAN)Ψ
$15-30	buspirone (BUSPAR)

ANTI-CONVULSANTS *–TARs needed for CCS screening in Sonoma & Mendocino counties & HK/HF members up to age 21.*

$5	phenobarbital (PHENOBARBITAL)
$5-45	valproic acid (DEPAKENE)
$10-25	clonazepam (KLONOPIN)
$10-105	primidone (MYSOLINE)
$20-40	phenytoin Extended (PHENYTEK)

$25-100	carbamazepine (TEGRETOL, TEGRETOL-XR)
$25-50	phenytoin (DILANTIN)

ANTI-CONVULSANTS, continued

$30-100	methsuximide (CELONTIN)
$50	topiramate (TOPAMAX)
$50-150	ethosuximide (ZARONTIN)
$50-380	divalproex DR (DEPAKOTE, non-ER only)
$60-260	zonisamide (ZONEGRAN)
$75-210	gabapentin (NEURONTIN)Ψ
$80 – 160	lamotrigine (LAMICTAL) Ψ
$115-230	tiagabine (GABITRIL)
$120-600	levetiracetam (KEPPRA)
$185-370	oxcarbazepine (TRILEPTAL)
$430	diazepam rectal gel (DIASTAT-price per twin pack, 2 doses)

ANTI-DEPRESSANTS

Tricyclics

$5-10	amitriptyline (ELAVIL)
$5-50	desipramine (NORPRAMIN)
$10	imipramine (TOFRANIL)
$10-15	nortriptyline (PAMELOR)
$15	doxepin (SINEQUAN)
$25-215	protriptyline (VIVACTIL)

SSRIs

$5-10	fluoxetine (PROZAC)Ψ
$20-55	citalopram (CELEXA)
$20	fluvoxamine (LUVOX)
$30-90	paroxetine (PAXIL)Ψ
$40	sertraline (ZOLOFT)

Other Anti-Depressants

$10	trazodone (DESYREL)
$25	bupropion (WELLBUTRIN, reg)Ψ
$25	mirtazapine (REMERON) Ψ
$40	bupropion SR (WELLBUTRIN-SR) Ψ
$100	venlafaxine tabs (EFFEXOR) STE
$135	venlafaxine XR caps (EFFEXOR XR) STE

ANTI-PARKINSON AGENTS

NOTE: For PHC/Medi-Cal, Cogentin, Artane & Symmetrel are carve-out drugs (♠): claims & TARs must be sent to State Medi-Cal (EDS) instead of PHC in all counties.

Anticholinergics

$5-10	benztropine (COGENTIN)♠
$10-15	triyphenidyl (ARTANE)♠

Dopaminergics

$20-30	amantadine (SYMMETREL)♠
$50	ropinirole (REQUIP)
$20-300	levodopa (LARODOPA)
$60-100	carbidopa/levodopa (SINEMET)
$95-145	bromocriptine (PARLODEL)

ANTI-PSYCHOTICS:

For PHC/Medi-Cal, these items are carve-out drugs (♠)--claims & TARs must be sent to State Medi-Cal (EDS) *instead of PHC* in all counties. The following list is included only to provide examples of carve-out anti-psychotic agents; it is not all-inclusive. See State provider manual & list of contract drugs for more information. Covered benefit for HK/HF members, (TAR may be required).

Formulary on State Medi-Cal, restrictions may apply:

$5-10	fluphenazine tabs, oral liquid (PROLIXIN) ♠
$10-20	thiothixene caps (NAVANE) ♠
$15-35	trifluoperazine tabs (STELAZINE) ♠
$20	thioridazine tabs (MELLARIL) ♠
$20-30	chlorpromazine (THORAZINE) ♠
$30	haloperidol tablets (HALDOL) ♠
$50	loxapine capsules (LOXITANE) ♠
$50-100	haloperidol decanoate IM (HALDOL) ♠
$60	perphenazine tabs, oral soln (TRILAFON) ♠
$200	molindone tabs (MOBAN) ♠
$275	risperidone tabs (RISPERDAL) ♠
$700	olanzapine (ZYPREXA) ♠

TAR needed for STATE Medi-Cal (do not send to PHC):

$115	clozapine (CLOZARIL) ♠
$430	paliperidone (INVEGA) ♠
$600	asenapine sl tabs (SAPHRIS) ♠
$630	iloperidone (FANAPT) ♠

ANTI-VERTIGO/ANTI-EMETICS

$10	meclizine (ANTIVERT)
$20-30	prochlorperazine (COMPAZINE)
$15	ondansetron (ZOFRAN) ©Ψ (30 tablets)
$30	promethazine (PHENERGAN)

CNS STIMULANTS

$20	dextroamphetamine (DEXEDRINE tabs)Ψ
$25-80	methylphenidate (RITALIN)Ψ
$35	methylphenidate ER tabs (RITALIN SR)Ψ
$60	mixed amphet. tabs (ADDERALL)Ψ
$60	dextroamphetamine XR(Dexedrine Spansules)Ψ
$130	mixed amphet. XR cap (ADDERALL XR) Ψ

MANIA AGENTS ♠

NOTE: For PHC/Medi-Cal, these agents (*e.g.*, lithium) are carve-out drugs (♠): claims & TARs must be sent to State Medi-Cal (EDS) instead of PHC in all counties. Covered benefit HK/HF members, restrictions may apply.

MISCELLANEOUS PSYCOTHERAPEUTIC AGENTS

$60-125	ergoloid mesylates (HYDERGINE)

OBSESSIVE-COMPULSIVE DISORDER

$30-70	clomipramine (ANAFRANIL)

See also: SSRI's indicated for OCD (sertraline, paroxetine, fluoxetine.)

V) AUTONOMIC/CNS, continued

SEDATIVE HYPNOTICS

$5	chloral hydrate (NOCTEC)
$5	flurazepam (DALMANE)Ψ
$5	temazepam 15-30mg only (RESTORIL) Ψ
$5	zolpidem (AMBIEN)Ψ
$20	zaleplon (SONATA) STE Ψ

See also other therapeutic category agents generally considered effective for insomnia: Antihistamines (Atarax, Benadryl, Unisom), Anti-Anxiety (Vistaril, Ativan), Antidepressants (Elavil, Trazodone, Sinequan).

VI) ANALGESIC/MUSCULOSKELETAL

ANALGESICS

$5	acetaminophen (TYLENOL)
$5	aspirin
$5-45	butal/apap/caff tablets (FIORICET)Ψ
$5-45	butal/asa/caff capsules (FIORINAL)Ψ
$30	tramadol (ULTRAM)Ψ

ANTI-RHEUMATICS

$10	hydroxychloroquine (PLAQUENIL)
$10	methotrexate tablets (RHEUMATREX)

GOUT MEDICATIONS

NOTE: generic colchicine tablets are no longer available. Prescribers please replace colchicine Rx's with generic Colbenemid or NSAIDS as appropriate.

$5-10	allopurinol (ZYLOPRIM)
$5-10	probenecid (BENEMID)
$5-10	probenecid/colchicine (COLBENEMID)
$5-25	sulfinpyrazone (ANTURANE)

MIGRAINE AGENTS – Cost per dose

$5	ergot/caffeine (CAFERGOT)
$5	ergot/caff/pent/bella (ERGO-CAFF-PB)
$5-10	isomethep/dichloral/apap (MIDRIN)
$15	ergotamine tartrate (ERGOMAR)
$20-60	sumatriptan tabs/nasal/sub-q (IMITREX) Ψ

MYASTHENIA GRAVIS AGENTS

$30-75	pyridostigmine (MESTINON)
$60-115	neostigmine (PROSTIGMIN)

NARCOTICS

$10-35	methadone (DOLOPHINE)
$30-120	oxycodone short-acting (OXY-IR, ROXICODONE) Ψ
$35-70	morphine sulfate tabs (immediate release)
$35-120	hydromorphone (DILAUDID)
$45-90	levorphanol (LEVODROMORAN)
$100	morphine SR (MS CONTIN)Ψ

NARCOTIC COMBINATIONS

Hydrocodone combinations, priced per #120 tabs:

$5	hydrocodone/apap 5/500mg (VICODIN)Ψ
$7	hydrocod/apap 7.5/650mg (LORCET PLUS) Ψ
$8	hydrocodone/apap 7.5/750 (VICODIN-ES) Ψ
$9	hydrocodon/apap 7.5//500 (LORTAB 7.5) Ψ
$9	hydrocod/apap 10/650 (LORCET) Ψ
$20	hydrocod/apap 10/500 (LORTAB-10) Ψ
$25	hydrocodon/apap 10/325 (NORCO 10)Ψ
$25	hydrocodon/apap 10/660 (VICODIN-HP) Ψ

Other narcotic combinations, per #120 tablets

$10	codeine/apap (TYLENOL #2, #3, #4)Ψ
$10	oxycodone/apap (PERCOCET 5/325)
$15	oxycodone/apap caps 5/500 (TYLOX)
$40	codeine/asa (EMPIRIN #2, #3)Ψ

NSAIDS

$5	ibuprofen (MOTRIN)
$5	indomethacin (INDOCIN)
$5	piroxicam (FELDENE)
$10	naproxen (NAPROSYN)
$10	ketoprofen (ORUDIS 50 & 75MG)
$12	salsalate (DISALCID)
$15	naproxen sodium (ANAPROX)
$15	sulindac (CLINORIL)
$20	meloxicam (MOBIC)
$20	oxaprozin (DAYPRO)
$25	diclofenac (VOLTAREN)
$25	nabumetone (RELAFEN)
$30-45	etodolac (LODINE)
$55	diflunisal (DISALCID)

SKELETAL MUSCLE RELAXANTS

$10	methocarbamol (ROBAXIN)Ψ
$25	cyclobenzaprine (FLEXERIL)Ψ
$25-35	baclofen (LIORESAL)
$25	tizanidine (ZANAFLEX)
$100-160	dantrolene (DANTRIUM)

VII) DERMATOLOGICS

Price based on 30g supply unless otherwise stated.

ACNE PREPARATIONS

$10 (1.5oz)	benzoyl peroxide solution (PANOXYL)
$10 (60ml)	erythromycin 2% soln. (ERTHRA-DERM)
$20 (60ml)	clindamycin 1% soln., gel (CLEOCIN-T)
$30	tretinoin gel (RETIN A)

ANTI-PSORIATIC AGENTS

$100 (50g)	anthralin (DRITHOCREME)
$250 (60g)	calcipotriene (DOVONEX Cr)

VII) DERMATOLOGICS, continued

RETINOID (ORAL)

Priced for #30. TAR required for claims over $500 and for quantity supply exceeding 20 weeks per lifetime.

$190 isotretinoin 10mg capsules (ACCUTANE) Ψ
$215 isotretinoin 20mg capsules (ACCUTANE) Ψ
$245 isotretinoin 40mg capsules (ACCUTANE) Ψ
$500 isotretinoin 30mg capsules (CLARAVIS) Ψ

ROSACEA

$10 metronidazole 0.75% gel (METROGEL)

TOPICAL ANTI-FUNGAL

$5 clotrimazole (LOTRIMIN AF)
$5 miconazole (MICATIN)
$10 ketoconazole (NIZORAL)
$10 econazole (SPECTAZOLE)
$10 terbinafine (LAMISIL AT)

TOPICAL STEROIDS

$5 betamethasone dip. (DIPROSONE)
$5 betamethasone valerate (VALISONE)
$5 desonide (TRIDESILON)
$5 fluocinonide (LIDEX)
$5 fluocinolone (SYNALAR)
$5 hydrocortisone (HYDROCORTISONE)
$5 triamcinolone (ARISTOCORT, KENALOG)
$5 triamcinolone dental paste (KENALOG in ORABASE)
$20 clobetasol (TEMOVATE)
$20 alclometasone (ACLOVATE)
$20 prednicarbate (DERMATOP)
$20 mometasone furoate (ELOCON)

TOPICAL IMMUNOMODULATOR

$90 pimecrolimus (ELIDEL, 30g)Ψ

WOUND PRODUCTS

$45 papain/urea (ACCUZYME)
$50 papain/urea/chlorophyllin (PANAFIL)
$60 collagenase (SANTYL)

OTHER DERMATOLOGICALS

$5 calamine (CALAMINE)
$5 salicyclic acid 17% (WART REMOVER)
$10 sunscreen /sunblock ©
$15 aluminum acetate (DOMEBORO)
$226 Aldara (imiquimod 5%) Brand exception: qty 12 NDC allowed as brand until generic 12 pack available.

VIII) OTIC PREPARATIONS

$5 antipyrine /benzocaine (AURODEX)*
$5-10 acetic acid (VOSOL)
$5-10 carbamide (DEBROX)
$5-20 hc/polymix/neo (CORTISPORIN)
$20 acetic acid/alum acet (DOMEBORO OTIC)
$75 ofloxacin (FLOXIN) Ψ
$115 ciprofloxacin/dexamethasone (CIPRODEX)

*NOTE: The new formula of AURALGAN is Non-Formulary; there is no longer an A/B rated generic due to the change in formula. To avoid delays, please write Rx's for antipyrine/ benzocaine as either "generic Aurodex", "A/B Otic" or just generically as "antipyrine/ benzocaine otic".

IX) OPHTHALMICS

CYCLOPLEGIC MYDRIATICS

$5 cyclopentolate (CYCLOGYL)
$5 atropine (ISOPTO ATROPINE)
$25 homatropine HBR (ISOPTO HOMATROPINE)

GLAUCOMA AGENTS

Beta Blockers

$5 levobunolol (BETAGAN)Ψ
$20 timolol (TIMOPTIC, TIMOPTIC–XE)Ψ
$20 metipranolol (OPTIPRANOLOL)Ψ
$45 betaxolol (BETOPTIC)Ψ

Carbonic Anhydrase-Inhibitors

$50 dorzolamide (TRUSOPT)
$95 brinzolamide (AZOPT)Ψ

Combination

$80 timolol/dorzolamide (COSOPT) Ψ

Miotics

$10 pilocarpine (ISOPTO CARPINE)
$35 carbachol (ISOPTO CARBACHOL)

Prostaglandin Analogues (2.5ml)

$85 bimatoprost (LUMIGAN) ©
$90 travoprost (TRAVATAN)
$90 latanoprost (XALATAN)

Sympathomimetics

$25 dipivefrin (PROPINE)Ψ
$35-55 brimonidine .15, .2% (ALPHAGAN, ALPHAGAN P)
$45 epinephrine (EPIFRIN)
$70 apraclonidine (IOPIDINE)Ψ

IX) OPHTHALMICS, continued

OPHTHALMIC ANTI-BACTERIALS

$5	erythromycin (ILOTYCIN)
$5	sulfacetamide (SODIUM SULAMYD)
$5	tobramycin (TOBREX)
$10	gentamicin (GARAMYCIN)
$15	neo/bacit/polymix (NEOSPORIN OINT)
$15	neo/polymix/gram (NEOSPORIN SOLN)
$15	polymix/bacit (POLYSPORIN)
$45	ofloxacin (OCUFLOX) Ψ
$50	ciprofloxacin (CILOXAN)

OPHTHALMIC ANTI-INFLAMMATORY

$5	fluorometholone (FLAREX, FML)
$5	prednisolone (PRED-MILD, PRED-FORTE)
$10	diclofenac 0.1% (VOLTAREN)
$40	rimexolone (VEXOL)
$65	ketorolac 0.5% (ACULAR)

OPHTHALMIC ANTI-VIRALS

$115	trifluridine (VIROPTIC)

OPHTHALMIC COMBINATIONS

$5	dexa/neo/polymix (MAXITROL)
$5	naphaz/phenir (NAPHCON-A)
$5	polymix/trimethoprim (POLYTRIM)
$20	dexa/neo (NEODECADRON)
$30	prednis/neo/polymix (POLY-PRED)
$60	prednis/sulfacetamide (BLEPHAMIDE)
$80	dexa/tobra (TOBRADEX)

OTHER OPHTHALMICS

$10	artificial tears (TEARS NATURALE II, FORTE)
$10	naphazoline (NAPHCON)
$10	petrolatum (LACRI-LUBE)
$10	ketotifen (ZADITOR-OTC) ♦
$15	sodium chloride (ADSORBONAC)
$95	lodoxamide (ALOMIDE) STE
$95	olopatadine (PATANOL) STE

X) NASAL PREPARATIONS

$5	sodium chloride (VARIOUS)
$15	fluticasone prop. (FLONASE)
$20	flunisolide (NASAREL)

XI) ENDOCRINE MEDICATIONS

ANDROGENS

$60-255	fluoxymesterone (HALOTESTIN)

ORAL HYPOGLYCEMICS

$5	glimepiride (AMARYL)
$10	tolbutamide (ORINASE)
$10	glyburide (MICRONASE, DIABETA)
$10	glipizide (GLUCOTROL)
$10	tolazamide (TOLINASE)
$10	chlorpropamide (DIABINESE)
$10	metformin (GLUCOPHAGE)
$10	metformin ER (GLUCOPHAGE XR)
$50	acarbose (PRECOSE)
$110	miglitol (GLYSET)
$155	nateglinide (STARLIX)
$155	rosiglit./glimepiride (AVANDARYL) STE
$165	rosiglit./metformin (AVANDAMENT) STE
$205	sitagliptin (JANUVIA) STE
$205	sitagliptin/metformin (JANUMET) STE
$240	pioglitazone/met. (ACTOPLUS MET) STE
$240	pioglitazone/glimepiride (DUETACT) STE
$245	pioglitazone (ACTOS) STE

ANTI-THYROID AGENTS

$10	potassium iodide (SSKI)
$15	propylthiouracil (PTU)
$15-40	methimazole (TAPAZOLE)

CORTICOSTEROIDS

$5	prednisone (PREDNISONE)
$5-15	dexamethasone (DECADRON)
$5-25	hydrocortisone (CORTEF)
$15-30	prednisolone (PEDIAPRED)
$15-65	methylprednisolone (MEDROL)

ESTROGENS

$5	estradiol micronized (ESTRACE)Ψ
$35	estradiol transdermal (CLIMARA, ALORA, VIVELLE)

ESTROGENS COMBINATIONS

$40-50	estrogens, est/methyltest (ESTRATEST, ESTRATEST HS)
$55	estradiol /norethindrone (COMBIPATCH)
$60	estrogens/med (PREMPRO, PREMPHASE)
$60	ethinyl estradiol/norethindrone (FEMHRT, ACTIVELLA)
$75	etonogestrel/ethinyl est. ring (NUVARING)

GLUCOSE ELEVATING AGENTS

$5-15	glucose gel, tablets

INSULIN

Vials priced per 10ml, cartridges per 15ml

$40-115	Insulin, vials Ψ ♦
$115-225	Insulin, PFS, Pen or CRT Ψ ♦

MINERALOCORTICOIDS

$20-35	fludrocortisone (FLORINEF)

OSTEOPOROSIS AGENTS

$20	alendronate (FOSAMAX)
$80	calcitonin-salmon (MIACALCIN)

Calcium & vitamin D products—See OTC section

XI) ENDOCRINE MEDICATIONS, continued

PROGESTINS

$10	medroxyprogesterone acet (PROVERA)
$35	norethindrone acetate (AYGESTIN)
$40	megestrol acetate tablets (MEGACE)

THYROID AGENTS

$10	levothyroxine (SYNTHROID, LEVOXYL, LEVOTHROID)
$25-50	liothyronine (CYTOMEL)

OTHER HORMONES

$90	desmopressin (DDAVP TABLETS)Ψ

XII) OBSTETRICAL/GYNECOLOGIC

CONTRACEPTIVE HORMONES
All FDA Approved Dosage Forms

$10	IMPLANT SYSTEM
$15-80	ORAL
$30	INJECTION
$35	INTRAUTERINE SYSTEM
$50	VAGINAL RING
$60	TRANSDERMAL
$800 +	MIRENA IUD

EMERGENCY CONTRACEPTIVES

$30	L-norgestrel 0.75mg (PLAN B/NEXT CHOICE)Ψ

OXYTOCICS

$20	methylergonovine (METHERGINE)

VAGINAL ANTI-INFECTIVES

$10	clotrimazole (GYNE-LOTRIMIN)
$15	miconazole (MONISTAT)
$15	tioconazole (MONISTAT 1, VAGISTAT 1)
$30	terconazole (TERAZOL)
$35	metronidazole (METROGEL)
$50-55	clindamycin vag. cr. (CLEOCIN, CLINDESSE)

VAGINAL HORMONES

$40	estradiol hemihydrate (VAGIFEM)
$75	dienestrol (ORTHO DIENESTROL)
$80	estrogens, conjugated (PREMARIN CREAM)

XIII) UROLOGICS

ANTISPASMODICS

$10-20	oxybutynin (DITROPAN, DITROPAN XL)Ψ
$95	bethanechol (URECHOLINE)
$130	tolterodine tartrate ER (DETROL LA) Ψ

BPH AGENTS

$15	terazosin (HYTRIN)
$15-20	doxazosin (CARDURA)
$55	finasteride (PROSCAR)

GU IRRIGANTS

$10-20	acetic acid
$10-90	neo/polymix irrig (NEOSPORIN GU)

OTHER UROLOGICS

$5	phenazopyridine (PYRIDIUM)--priced for qty 30 tabs, short-term use)

URINARY ACIDIFIERS

$10-40	potassium & sodium acid phosphate (K-PHOS)

XIV) GASTROINTESTINALS

ACID REDUCING /PUD AGENTS

$10	cimetidine Rx tabs (TAGAMET)
$10	famotidine Rx tabs (PEPCID)
$10	ranitidine Rx tabs (ZANTAC)
$15	omeprazole (PRILOSEC OTC) ♦
$20	omeprazole Rx 20mg caps (PRILOSEC)
$20	lansoprazole OTC 15mg (PREVACID 24H) ♦
$30	sucralfate tablets (CARAFATE)
$85	misoprostol (CYTOTEC)Ψ

ANTACIDS / ANTIFLATULENTS

$5	ALTERNAGEL
$5	ALUDROX
$5	AMPHOJEL
$5	BASALJEL
$5	GAVISCON
$5	GELUSIL
$5	MAALOX
$5	MYLANTA
$5	MILK OF MAGNESIA
$5	MYLICON
$5	RIOPAN
$5	SODIUM BICARBONATE

ANTICHOLINERGICS / ANTISPASMODICS

Priced per #90:

$5	PB/hyoscy/atropine tabs (DONNATAL)
$5	chlordiazepoxide/clidinium (LIBRAX)
$10	dicyclomine tabs, caps (BENTYL)
$35	propantheline (PROBANTHINE)
$60	glycopyrrolate (ROBINUL)
$90	hyoscyamine 0.125 tabs, reg & SL (LEVSIN)

ANTI-DIARRHEALS

Priced per #90:

$5	loperamide Rx 2mg caps (IMODIUM)
$5	bismuth (PEPTO BISMOL)
$10	diphenoxylate/atropine (LOMOTIL)

XIV) GASTROINTESTINALS, continued

HELIOBACTER PYLORI

Write Rx's for each component of chosen therapy:

TRIPLE THERAPY, 10 DAY DURATION:

$30
- omeprazole 20mg (PRILOSEC OTC/Rx) ♦ #20
- clarithromycin 500mg (BIAXIN) #20 Ψ©
- amoxicillin 500mg #40

$40
- lansoprazole OTC 15mg (PREVACID 24H) ♦ #40
- clarithromycin 500mg (BIAXIN) #20 Ψ©
- amoxicillin 500mg, 2 caps BID

DUAL THERAPY, 14 DAY DURATION::

$40
- omeprazole 20mg (PRILOSEC OTC/Rx) ♦ #28
- clarithromycin 500mg (BIAXIN) #42 Ψ©

$60
- lansoprazole OTC 15mg (PREVACID 24H) ♦ #84
- amoxicillin 500mg #84

LAXATIVES

$5	bisacodyl (DULCOLAX)
$5	citrate of magnesia
$5	glycerin supps
$5	phosphates (FLEET)
$5-10	docusate calcium (SURFAK)
$5-10	docusate sodium (COLACE)
$5-10	docusate /phenolphth (DOXIDAN)
$5-20	docusate /casan (PERI-COLACE)
$10	psyllium bulk powder (METAMUCIL)
$10-20	senna (SENOKOT)
$15-30	polyethylene glycol (MIRALAX, MIRALAX OTC) Ψ
$20-40	lactulose (DUPHALAC)

MOTILITY AGENTS

$10	metoclopramide (REGLAN)

MOUTH AND THROAT PRODUCTS

$140	pilocarpine HCL (SALAGEN)

RECTAL PREPARATIONS

$10-20	hydrocortisone (suppositories, cream, foam, enema)
$50	pramoxine/HC (PROCTOFOAM – HC)

OTHER GI AGENTS

$10-15	polyethyl glycol-electrolyte (CO-LYTE)
$20	sulfasalazine (AZULFIDINE)
$60	ursodiol (ACTIGALL)
$185	mesalamine (ASACOL)
$200-1000	amylase-lipase-protease (CREON, PANCREAZE, ZENPEP)

Reminder: TAR is required for Rx claims >$500 on formulary agents.

XV) RESPIRATORY

For inhalers, price is per MDI unit for the most common strength dispensed in 2009; for unit dose soln, price is per smallest pkg size.

BRONCHODILATORS

Inhaled Beta-Agonists (Long–Acting)

$165	formoterol (FORADIL)Ψ
$165	salmeterol (SEREVENT DISKUS)Ψ

Inhaled Beta-Agonists (Short-Acting)

$15	albuterol nebulizer unit dose (PROVENTIL)
$35	albuterol HFA (VENTOLIN HFA) Ψ

Note: Only the BRAND name VENTOLIN HFA is formulary at this time; ProAir & Proventil HFA are non-formulary.

Oral Beta-Agonists

$5-10	albuterol tabs, syr (PROVENTIL)Ψ
$35	metaproterenol tabs, syr (ALUPENT)
$40	terbutaline tabs (BRETHINE)

INHALED ANTI-CHOLINERGICS

$145	ipratropium MDI (ATROVENT HFA) Ψ
$155	ipratropium /albuterol MDI (COMBIVENT)Ψ
$220	tiotropium bromide (SPIRIVA)

INHALED ANTI-INFLAMMATORY AGENTS

$105 (80 mcg)	beclomethasone MDI (QVAR)Ψ
$100	flunisolide MDI (AEROBID, AEROBID-M)
$150 (110mcg)	fluticasone MDI (FLOVENT HFA)Ψ
$160 (90 mcg)	budesonide (PULMICORT FLEXHALER)Ψ
$155 (220mcg)	mometasone (ASMANEX)
$160 (0.5mg)	budesonide sol (PULIMCORT RESPULES)Ψ

LEUKOTRIENE MODIFIERS

$110	zafirlukast (ACCOLATE) STE
$130	montelukast (SINGULAIR) STE

MAST CELL STABILIZERS

$80-140	cromolyn (INTAL)Ψ

MUCOLYTICS

$70-240	acetylcysteine (MUCOMYST)

RESPIRATORY INHALANT COMBINATIONS:

$230 (160/4.5)	formoterol/budesonide (SYMBICORT) STE
$240 (250/50)	salmeterol/fluticasone (ADVAIR DISKUS) STE

XANTHINES

$5	aminophylline (AMINOPHYLLINE)
$20-45	theophylline (THEO-DUR, THEO-24)

XVI) ALLERGY /COUGH /COLD

ANTIHISTAMINES

$5	chlorpheniramine (CHLORTRIMETRON)
$5	diphenhydramine (BENADRYL)
$10	certirizine OTC (ZYRTEC OTC) Ψ♦
$10	clemastine (TAVIST)
$10	loratadine (OTC CLARITIN) Syrup♦
$15	loratadine (ALAVERT/CLARITIN OTC) Ψ♦
$25	cyproheptadine (PERIACTIN)
$40	hydroxyzine HCL (ATARAX)
$50	fexofenadine 60mg, 180mg (ALLEGRA) STE (30mg currently requires a TAR)

ANTIHISTAMINE /DECONGESTANT

$5	pseudo/bromphen (DIMETAPP) Ψ
$5	pseudo/triprolidine (APRODINE*) Ψ
$5	phenyl/prometh (PHENERGAN-VC) Ψ
$20	pseudo/dexbrom (DRIXORAL C/Allergy)Ψ

* Formerly available as Actifed (original formula).

ANTITUSSIVES/EXPECTORANTS/DECONGESTANTS

Notes: Age restriction (Ψ) on OTC & RX cough/cold products, following FDA & CHPA recommendations for avoiding use in ages 3 yrs & younger. Liquids priced per 120ml unless otherwise stated. Tabs/caps priced per qty 30 for short-term/prn use.

$5	guiafenesin/DM (ROBITUSSIN DM, DIABETIC TUSS DM) Ψ
$5	promethazine/DM (PHENERGAN DM) Ψ
$5	cod/triprol/pseu (ACTIFED w/COD) Ψ
$5	promethazine/codeine (PHENERGAN/COD) Ψ
$5	guaifenesin/codeine (ROBITUSSIN-AC) Ψ
$5	promethazine/p-e/codeine (PHENERGAN VC/CODEINE) Ψ
$5	guaifenesin (ROBITUSSIN) Ψ
$10	dextromethorphan polystirex (DELSYM) Ψ
$35	potassium iodide (SSKI)
$20	benzonatate (TESSALON) Ψ

DECONGESTANTS

$5	pseudoephedrine (SUDAFED) Ψ
$5	phenylephrine (SUDAFED PE) Ψ

XVII) NUTRITIONALS

MINERALS

$5	ferrous gluconate
$5	ferrous sulfate
$5	sodium fluoride

MULTIVITAMINS

$5	prenatal vitamins (various generic OTC & Rx) ©
$5	vitamin A/D/C drops(TRI-VI-SOL)Ψ
$5	vitamin A/D/C/Fe drops (TRI-VI-SOL w/Fe)Ψ
$5	vitamin A/D/C/fluoride drops (TRI-VI-Flor)Ψ
$5	vitamin multi drops +/- FE (POLY-VI-SOL) Ψ
$5	vitamin multi/Fl drops +/- FE (POLY-VI-FLOR) Ψ
$5	vitamin multi/Fl chew (POLY-VI-FLOR) Ψ
$15	renal multivitamins (NEPHRO-VITE, NEPHROVITE RX, NEPHROCAPS)

VITAMINS

$5	Ergocalciferol (DRISDOL)Ψ
$5	pyridoxine (VITAMIN B-6)
$5	alpha-tocopherol (VITAMIN E) ©
$5	folic acid (FOLATE)
$10	phytonadione (MEPHYTON)
$30-140	calcitriol (ROCALTROL)
$35	dihydrotachysterol (DHT)
$70-220	folinic acid (LEUCOVORIN)
$70-220	leucovorin calcium (WELLCOVORIN)

OTHER NUTRITIONAL

$30-85	levocarnitine (CARNITOR, w/ sugar)

XVIII) ELECTROLYTES & RELATED

$5	calcium salts
$5-10	magnesium oxide (MAG-OX)
$5-10	Potassium Chloride
$5-10	potassium CI (KCL)
$10	I.V. hydration solution
$15	aluminum hydroxide (DIALUME)
$15-35	citrate solution (BICITRA)
$20-80	SPS (KAYEXALATE)
$40-55	phosphorus/potassium/sodium (NEUTRA-PHOS, NEUTRA PHOS K)
$150-300	calcium acetate (PHOS-LO)

XIX) HABIT-ABATEMENT

ALCOHOL DETERRENTS

$40-80	disulfiram (ANTABUSE)

NOTE: Campral is a Carve-Out drug, submit TAR to STATE Medi-Cal.

SMOKING DETERRENTS

$60	bupropion SR (ZYBAN)Ψ
$80-95	nicotine patch (HABITROL, NICODERM)Ψ♦
$100-115	nicotine polacr gum (NICORETTE GUM)Ψ ♦
$125	varenicline (CHANTIX) Ψ

XX) INJECTABLES

See Injectable Section in Formulary, pg 66 - 67.

XXI) MEDICAL SUPPLIES /DME

See Medical Supplies/DME Section in Formulary, pg 65.

XII) MISCELLANEOUS

$5	lidocaine viscous (XYLOCAINE)
$5	saliva substitute (SALIVART)
$5-10	chloridine (PERIOGARD)
$10	lidocaine 5% oint (price per 35g tube)
$10	lidocaine 2% gel (price per 30ml)
$20	lidocaine/prilocaine 2.5/2.5% cr. (EMLA) ©
$45	caffeine, citrated (CAFCIT)

2011 Partnership HealthPlan of California Formulary Status

This is a listing of commonly used drugs with formulary status. Drugs are listed by BRAND name, even though generic substitution is required. To find a drug by generic name, refer to index (pages 115 - 125) or PHC website at http://www.partnershiphp.org. This guide includes PHC's Medi-Cal, Healthy Kids & Healthy Families lines of business. The Partnership*Advantage* formulary can be found at www.partnershiphp.org

Brand Name	Generic Name & Dosage Forms	Formulary Status	Qualifiers	Notes
ABILIFY	*Aripiprazole Tabs: 2, 5, 10, 15, 20, & 30mg Discmelt: 10 & 15mg Oral Soln: 1mg/ml (150ml) Injection: 9.75mg single-dose vial*	**NF**	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
ACCOLATE	*Zafirlukast Tablets: 10mg, 20mg*	F	♥, STE	**STEP Edit:** requires claim for inhaled corticosteroid in last 120 days. Potentially eligible for CCS, see ♥ footnote.
ACCUNEB	*Albuterol Sulfate nebulizer soln. 0.63mg/3ml & 1.25mg/3ml Packaged as 25x3ml ud, (25 doses per box =75ml billing qty).*	F	♥	**MC "Dual Eligible":** Dx's related to COPD must be billed to Medicare Part B *before* MC. May submit TAR for Part B *copay* only. Potentially eligible for CCS, see ♥ footnote.
ACCUTANE	*Isotretinoin 10, 20, 30 & 40mg capsules*	F	Ψ	**Limit:** Maximum of 20 weeks of treatment for life. (TARs are needed for claims > $500).
ACHROMYCIN	*Tetracycline Capsules: 250mg, 500mg*	F		
ACIPHEX	*Rabeprazole Tablets: 20mg EC tablets: 20mg*	**NF**		**See TAR Criteria,** in back of formulary.
ACLOVATE	*Alclometasone Dipropionate 0.05% Cream, Ointment Packaged in 15, 45 & 60g*	F		
ACTIGALL	*Ursodiol 300mg capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ACTIQ	*Fentanyl Citrate Oral Transmucosal Lozenge*	**NF**		**See TAR Criteria**, in back of formulary – for cancer patients only.
ACTIVELLA	*Estradiol/Norethindrone Tablets: 0.5/0.1mg & 1.0/0.5mg*	F		
ACTONEL	*Risedronate Tablets: 5mg, 30mg, 75mg*	**NF**		**See TAR Criteria**, in back of formulary.
ACTOPLUS MET	*Pioglitazone HCL/Metformin Tablets: 15/500mg & 15/850mg*	F	♥, Ψ, STE	**STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met. Potentially eligible for CCS, see ♥ footnote.

F = Formulary
NF = Non-Formulary
STE = Step Therapy Edit required, see notes
Ψ = Qty, Duration or Age limit applies
SP = TAR required for dispensing by pharmacies other than contract specialty pharmacy(ies).

\# = Exempt from $500 limit on MC
© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

♥ = Drug is in a therapeutic class used to treat a CCS eligible condition. Because CCS is carved out for HK, HF, MC Sonoma & MC Mendocino, a TAR is required for PHC determination of CCS eligibility & referral (members age 0-20).

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Brand Name	Generic Name & Dosage Forms	Formulary Status	Qualifiers	Notes
ACTOS	*Pioglitazone HCL Tablets: 15, 30 & 45mg*	F	♥, Ψ, STE	**Limit:** 1 tab/day. **STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met. Potentially eligible for CCS, see ♥ footnote.
ACULAR	*Ketorolac Tromethamine 0.5% ophth. soln.*	F		Acular LS is non-formulary; please use formulary Acular.
ADALAT CC	*Nifedipine CC, ER, XR Tablets: 30, 60, 90mg*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ADDERALL, ADDERALL XR	*Amphetamine Mixture Tablets*	F	Ψ	**Limit:** Ages 3-16 years. **Adults**: See TAR Criteria, in back of formulary.
ADVAIR DISKUS	*Fluticasone/Salmeterol Diskus (powder inhalation)*	F	♥, Ψ, STE	**STEP Edit:** Prior use of an orally inhaled corticosteroid on PHC profile within the previous 180 days. Limited to 1 unit per month. If step edit not met, see TAR Criteria, in back of formulary. Potentially eligible for CCS, see ♥ footnote.
AEROBID, AEROBID-M	*Flunisolide MDI*	F	♥	Potentially eligible for CCS, see ♥ footnote.
AGENERASE	*Amprenavir*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary, TAR needed for claims >$500.
AGGRENOX	*Aspirin/Dipyridamole 25/200mg*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: Plavix, ASA, dipyridamole.***
AKINETON	*Biperiden HCL*	**NF**	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, TAR required.
ALBALON, AK-CON	*Naphazoline 0.1% o/s*	F		
ALDACTAZIDE	*Spironolactone/HCTZ tabs*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ALDACTONE	*Spironolactone tabs*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ALDARA	*Imiquimod (topical) Topical Cream: 5%*	F		TAR required for claims over $500. Brand (Graceway) is now making a 12 pack, which has been added to formulary (*ie,* brand name 12-pack OK until generic 12-pack is available).

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STE = Step Therapy Edit required, see notes
Ψ = Qty, Duration or Age limit applies
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© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

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Brand Name	Generic Name & Dosage Forms	Formulary Status	Qualifiers	Notes
ALDOMET	*Methyldopa tablets*	F	♥	
ALLEGRA	*Fexofenadine Tablets: 60mg, 180mg*	F	STE	**STEP Edit:** Previous use of loratidine or cetirizine in the last 120 days.
ALOMIDE	*Lodoxamide Tromethamine Ophthalmic Drops: 0.1%*	F	STE	**STEP Edit:** Previous use of Naphcon A, Vasocon A, or ketotifen-OTC in the last 120 days.
ALORA	*Estradiol TD Patch 0.025, 0.075, 0.05, 0.1mg/day*	F		
ALPHAGAN	*Brimonidine Tartrate Ophth. Drops: 0.2%*	F		
ALPHAGAN P	*Brimonidine Tartrate Ophth. Drops: 0.15% only*	F		0.1% strength is non- formulary, please use formulary 0.15%.
ALTACE	*Ramipril Capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ALUPENT	*Metaproterenol Sulfate tablets, syrup*	F		
AMARYL	*Glimepiride 1, 2, 4mg tablets*	F		
AMBIEN	*Zolpidem Tartrate 5, 10mg tablets*	F	Ψ	**Limit:** 1 tablet per day without a TAR.
AMERGE	*Naratriptan HCL*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternative: Sumatriptan.***
AMOXIL	*Amoxicillin Trihydrate*	F		
AMPICILLIN	*Ampicillin*	F		
ANAFRANIL	*Clomipramine HCL*	F		
ANAPROX	*Naproxen Sodium 275mg tablets*	F		
ANAPROX-DS	*Naproxen Sodium 550mg tablets*	F		
ANCOBON	*Flucytosine*	F		
ANSAID	*Flurbiprofen*	F		
ANTABUSE	*Disulfiram*	F		
ANTIMINTH	*Pyrantel Pamoate*	F		
ANTIVERT	*Meclizine HCL 12.5, 25, 50mg tablets, 25 mg chewable*	F		**HK/HF:** OTC formulations are not a covered benefit.
ANTURANE	*Sulfinpyrazone*	F		
ANUSOL-HC	*Hydrocortisone Rectal 2.5% cream, 25mg supp.*	F		
APRESOLINE	*Hydralazine*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ARALEN	*Chloroquine*	F		
ARICEPT	*Donepezil HCL*	**NF**		**See TAR Criteria,** in back of formulary.

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© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

♥ = Drug is in a therapeutic class used to treat a CCS eligible condition. Because CCS is carved out for HK, HF, MC Sonoma & MC Mendocino, a TAR is required for PHC determination of CCS eligibility & referral (members age 0-20).

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Brand Name	Generic Name & Dosage Forms	Formulary Status	Qualifiers	Notes
ARIMIDEX	*Anastrozole*	F	SP, #	TAR required for dispensing by pharmacy other than contracted specialty pharmacy.
ARISTOCORT	*Triamcinolone Acetonide Lotion: 0.025%, 0.1% Cream: 0.025, 0.1 & 0.5% Ointment: 0.025, 0.1, 0.5%*	F		
ARIXTRA	*Fondaparinux Injection Disp. Syringe: 2.5, 5, 7.5 & 10mg*	F	Ψ, ♥, #	Qty limited to a 10 day supply per Rx, 2 Rx's per year without a TAR. Potentially eligible for CCS, see ♥ footnote.
ARMOUR THYROID	*Thyroid (pork) tablets 30, 60, 90, 120, 180 mg*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ARTANE	*Triyphenidyl*	See notes	♠, ♥	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary but potentially eligible for CCS, see ♥ footnote.
ASACOL	*Mesalamine*	F		
ASMANEX	*Mometasone MDI 220mcg*	F	Ψ, ♥	**Limit:** 1 unit/ month. Potentially eligible for CCS, see ♥ footnote.
ASTELIN NASAL SPRAY	*Azelastine HCL*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: fluticasone, oral antihistamines.***
ATABRINE	*Quinacrine*	F		
ATARAX	*Hydroxyzine HCL*	F		
ATIVAN	*Lorazepam tablets, injection*	F	Ψ	**Limits:** 90 per month, 3 per day.
ATROVENT	*Ipratropium Bromide Neb. Soln: 0.02% (0.2mg/ml) 1 unit dose = 2.5ml* Available in boxes of 25, 30 or 60 unit doses	F		**Limits:** 600ml per month. **MC "Dual Eligible":** Dx's related to COPD must be billed to Medicare Part B *before* MC. May submit TAR for Part B *copays* only (not Part D).
ATROVENT HFA	*Ipratropium Bromide HFA*	F	Ψ, ♥	**Limit:** 2 units/month. Potentially eligible for CCS, see ♥ footnote.
AUGMENTIN, AUGMENTIN ES-600	*Amoxicillin Potassium Clavulanate Tablets, Chewable & Susp: 125-31.25, 200-28.5, 250-62.5MG, 250-125MG 500-125 MG, 400-57MG 600-42.9, 875-125*	F		Augmentin XR is non-formulary, please use formulary strengths.
AURALGAN – New Formula	*Antipyrine/Benzocaine Otic*	**NF**		New formulation BRAND is non-formulary. ***Formulary alternative* = Aurodex (Old formula)**

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Brand Name	Generic Name & Dosage Forms	Formulary Status	Qualifiers	Notes
AURALGAN – Old Formula, AKA AURODEX	*Antipyrine/Benzocaine Otic*	F		To avoid unnecessary TARS for brand Auralgan, please write Rx's as either generic "Aurodex", "A/B Otic" or "antipyrine/ benzocaine otic".
AVANDAMET	*Rosiglitazone/Metformin HCL*	F	♥, STE	**STEP Edits: STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met. Potentially eligible for CCS, see ♥ footnote.
AVANDARYL	*Rosiglitazone/ Glimepiride*	F	♥, STE	**STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met. Potentially eligible for CCS, see ♥ footnote.
AVANDIA	*Rosiglitazone*	**NF**		**See TAR Criteria**, in back of formulary.
AVAPRO	*Irbesartan*	F	♥, Ψ, ©	**Code 1:** Tried and failed an ACE as add on and stand alone for diabetic nephropathy. **Limit:** ½ tablet dosing. Potentially eligible for CCS, see ♥ footnote.
AXERT	*Almotriptan Malate*	**NF**		**See TAR Criteria**, in back of formulary.
AYGESTIN	*Norethindrone*	F		
AZILECT	*Rasagiline Mesylate*	**NF**		**See TAR Criteria**, in back of formulary.
AZOPT 1%	*Brinzolamide*	F	Ψ	**Limit:** 10 mls per month
AZULFIDINE	*Sulfasalazine*	F		
BACITRACIN	*Bacitracin ophthalmic oint.*	F		
BACTRIM BACTRIM DS	*Trimethoprim/ Sulfamethoxazole Suspension & Tablets (DS & SS)*	F		
BACTROBAN	*Mupirocin topical cream, topical ointment*	F		**Note:** Nasal ointment is non-formulary, please use topical when appropriate.

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BARACLUDE	*Entecavir tablets, solution*	**NF**		**See TAR Criteria**, in back of formulary.
BENADRYL	*Diphenhydramine Capsules, Liquid*	F		**HK/HF:** OTC formulations are not a covered benefit.
BENEMID	*Probenecid*	F		
BENICAR	*Olmesartan Medoxomil 5, 20, 40mg tablets*	**NF**		Removed from formulary, effective 7/1/11. **See PA Criteria,** in back of formulary.
BENICAR HCT	*Olmesartan/HCTZ* 40/12.5mg, 40/25mg *tablets*	**NF**		Removed from formulary, effective 7/1/11. **See PA Criteria,** in back of formulary.
BENTYL	*Dicyclomine HCL tablets, capsules, syrup*	F		
BENZAC AC, W	*Benzoyl Peroxide liquid, gel & wash: 2.5, 5, 10%*	F		
BENZASHAVE	*Benzoyl Peroxide 10% Cr.*	F		
BEPREVE	*Bepotastine besilate 2% ophth sol.*	F	STE	**STEP Edit:** Use of Zaditor-OTC and Patanol in the last 120 days.
BETAGAN	*Levobunolol ophthal. drops*	F	Ψ	**Limit:** 10 ml/ month.
BETAPACE	*Sotalol tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
BETOPTIC	*Betaxolol HCL ophth. susp.*	F	Ψ	**Limit:** 10 ml/ month.
BIAXIN	*Clarithromycin 500mg tablets*	F	Ψ, ©	Code 1 for H. pylori, limited to 500mg bid #28.
BICITRA	*Sodium Citrate soln.*	F	♥	Potentially eligible for CCS, see ♥ footnote.
BILTRICIDE	*Praziquantel*	F	Ψ	**Limit:** 3 tablets per fill.
BLEPHAMIDE	*Sod Sulfacetm/Prednisolone*	F		
BLEPHAMIDE S.O.P.	*Sod Sulfacetm/Prednisolone Ophthalmic ointment*	F		
BRETHINE	*Terbutaline Sulfate tablets*	F		
BUMEX	*Bumetanide tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
BUPRENEX	*Buprenorphine Injection*	See notes		**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
BUSPAR	*Buspirone tablets*	F		
BYETTA	*Exenatide injection*	**NF**		**See TAR Criteria**, in back of formulary.
BYSTOLIC	*Nebivolol tablets*	**NF**		**See TAR Criteria**, in back of formulary.
CAFATINE PB	*Ergot/Caff/Pentobarb/ Belladonna tablets*	F		

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CAFCIT	*Caffeine Citrated, powder & 20mg/ml vial*	F		
CAFERGOT	*Ergotamine Tartrate/Caffeine tablets*	F		
CALAN	*Verapamil (Short Acting) tablets*	F,	♥	Potentially eligible for CCS, see ♥ footnote.
CALAN SR	*Verapamil (Long Acting) caplets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CAMPRAL	*Acamprosate Calcium tablets*	**NF**	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, submit TAR.
CAPOTEN	*Captopril tablets*	F		
CARAFATE	*Sucralfate tablets, suspension*	F		
CARDIZEM	*Diltiazem tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CARDIZEM CD	*Diltiazem CD capsules (24H)*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CARDURA	*Doxazosin tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CARNITOR	*Levocarnitine tablets, solution*	F		**Note:** Sugar-free solution is non-formulary, use generic Carnitor w/ sugar when possible.
CASODEX	*Bicalutamide tablets*	F	SP, #	TAR required for dispensing by pharmacy other than contracted specialty pharmacy.
CATAFLAM	*Diclofenac Potassium*	F		
CATAPRES	*Clonidine Tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CATAPRES TTS	*Clonidine TTS Patches*	**NF**		**See TAR Criteria,** in back of formulary.
CECLOR	*Cefaclor*	F		
CEFTIN	*Cefuroxime Axetil susp,tabs*	F	Ψ	**Limits:** Tablets have qty limit of 20/mo.
CELEBREX	*Celecoxib Capsules*	**NF**		**See TAR Criteria**, in back of formulary.
CELEXA	*Citalopram HBr tablets*	F		
CELLCEPT	*Mycophenolate Mofetil*	F	#	
CELONTIN	*Methsuximide capsules*	F		
CEPHULAC	*Lactulose solution*	F		
CHANTIX	*Varenicline Tartrate tablets*	F	Ψ	**Limit:** 12 wk treatment duration; prior auth. needed for continued use.
CILOXAN	*Ciprofloxacin HCL o/s*	F		
CIMZIA	*Certolizumab injection kit*	**NF**		**See TAR Criteria,** in back of formulary.
CIPRO	*Ciprofloxacin tablets (not XR)*	F		

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CIPRODEX OTIC	*Ciprofloxacin HCL/Dexameth otic susp*	F		
CLARITIN OTC	*Loratidine tablets, syrup*	F	Ψ	**Limit:** 1/day.
CLEOCIN HCL	*Clindamycin HCL capsules*	F		
CLEOCIN T	*Clindamycin Phosphate Gel: 1% Solution: 1% Pledgette/Swab: 1%*	F		Lotion & foam are non-formulary, please use formulary dosage forms.
CLIMARA	*Estradiol TTS/Patch*	F		
CLINDESSE	*Clindamycin 2% vaginal*	F		
CLINORIL	*Sulindac tablets*	F		
CLOZARIL	*Clozapine tablets*	See notes	♠, #	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
COGENTIN	*Benztropine Mesylate tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
COLAZAL	*Balsalazide Disodium tablets*	**NF**		***Formulary alternative:* sulfasalazine**
COLBENEMID	*Probenecid/Colchicine 500/0.6mg tablets*	F		
COLCRYS	*Colchicine 0.6mg tablets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: Allopurinol, Probenecid, Colbenemid, NSAIDS.***
COLESTID	*Colestipol HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternative: Questran bulk pwd.***
COLYTE	*Polyethylene Glycol PEG 3350*	F		
COMBIPATCH	*Estradiol/ Norethindrone TTS/ Patch*	F		
COMBIVENT	*Albuterol Sulfate/Ipratropium MDI*	F	♥, Ψ	**Limit:** 2 units/month. Potentially eligible for CCS, see ♥ footnote.
COMBIVIR	*Zidovudine/Lamivudine tablets*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
COMPAZINE	*Prochlorperazine tablets, capsules, suppositories, syrup, injection*	F		
CONCERTA	*Methylphenidate ER (OSM) Tablets: 18, 27, 36, 54mg*	**NF**		**See TAR Criteria,** in back of formulary. ***Pediatric formulary alternatives: generic Ritalin SR, Adderall, Adderall XR, Dexedrine; Adult formulary alternative: Strattera***
CONDYLOX	*Podofilox (Topical) gel*	F		

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CONTRACEPTIVE HORMONES	*All Forms*	F		OCP's: All single-source brands and generic multi-source products
CORDARONE	*Amiodarone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
COREG	*Carvedilol tablets*	F	♥	Note that the CR form is non-formulary, please use generic carvedilol. Potentially eligible for CCS, see ♥ footnote.
CORTEF	*Hydrocortisone tablets*	F		
CORTENEMA	*Hydrocortisone enema*	F		
CORTISPORIN OTIC	*Neomy Sul/Polymyx B Sulf/Hc OTIC suspension, soln*	F		
COSOPT	*Timolol Maleate Dorzolam HCL ophth. Sol.*	F	Ψ	**Limit:** 10 mls/month.
COUMADIN	*Warfarin Sodium tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
COZAAR	*Losartan tablets*	F	♥,Ψ, STE	**STEP Edit:** ACE inhibitor filled in the last 365 days. **Limit:** ½ tablet dosing Note: Effective 4/1/11, ½ tab dose limit removed.
CREON 6,000 12,000 24,000	*Lipase/Protease/Amylase DR Capsules*	F	♥	TAR needed for claims > $500 Potentially eligible for CCS, see ♥ footnote
CRESTOR	*Rosuvastatin tablets*	F	Ψ, STE	**STEP Edit:** Prior fill of simvastatin 40mg or 80mg of other formulary statin (fluvastatin, lovastatin, pravastatin). **Limit:** ½ tablet dosing
CRIXIVAN	*Indinavir capsules*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
CROLOM 4%	*Cromolyn Sodium Ophth sol.*	F		
CYCLOGYL	*Cyclopentolate 0.5%, 1%, 2% ophth. drops*	F		
CYMBALTA	*Duloxetine HCL capsules*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: SSRI's, TCA's, bupropion, mirtazapine, &/or gabapentin, depending on diagnosis for use.***
CYTOMEL	*Liothyroxine Sodium tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
CYTOTEC	*Misoprostol tablets*	F	♥, Ψ	**Limit:** 90 days/year max Potentially eligible for CCS, see ♥ footnote.
CYTOVENE	*Ganciclovir capsules, vial*	F	♥, #	Potentially eligible for CCS, see ♥ footnote.
DALMANE	*Flurazepam capsules*	F	Ψ	**Limit:** 1 capsule per day dosing.

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DANTRIUM	*Dantrolene Sodium capsules*	F		
DAPSONE	*Dapsone tablets*	F		
DARAPRIM	*Pyrimethamine tablets*	F		
DAYPRO	*Oxaprozin tablets*	F		
DAYTRANA	*Methylphenidate Transdermal Patch*	**NF**		**See TAR Criteria,** in back of formulary.
DDAVP	*Desmopressin tablets*	F	Ψ	**Limit:** Age >/= 15 yrs. All others see TAR Criteria in back of formulary.
DDAVP INTRANASAL	*Desmopressin 0.1mg/ml Nasal Spray*	**NF**		**See TAR Criteria,** in back of formulary.
DECADRON	*Dexamethasone tablets, dose pack, drops, vials*	F		
DEPAKENE	*Valproic Acid capsules, syrup*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DEPAKOTE ER	*Divalproex Sodium ER (Extended Release) tablets*	**NF**		**See TAR Criteria**, in back of formulary.
DEPAKOTE DR	*Divalproex Sodium DR (Delayed Release) tablets, sprinkle caps*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DERMA-SMOOTHE/FS	*Fluocinolone Acetonide 0.01% Body Oil, Scalp Oil*	**NF**		***Formulary alternative = fluocinolone solution***
DERMATOP	*Prednicarbate 0.1% cream & ointment*	F		
DES	*Diethylstilbestrol tablets*	F		
DESOWEN 0.05%	*Desonide 0.05% cream, oint.*	F		
DESOWEN 0.05% LOTION	*Desonide lotion*	**NF**		***Formulary alternatives = HC, TAC lotions, or desonide cr/ung.***
DESYREL	*Trazodone HCL 50, 100, 150mg tablets*	F		300mg tablet is non-formulary, use 2 tabs of 150mg for a 300mg dose.
DETROL	*Tolterodine tartrate tablets*	**NF**		**See TAR Criteria**, in back of formulary.
DETROL LA	*Tolterodine tartrate LA capsules*	F	Ψ	**Limit:** Members age 65 or greater.
DEXEDRINE	*Dextroamphetamine tablets, Spansules*	F,	Ψ	**Limit:** Members age 4-16 yrs.
DHT	*Dihydrotachysterol tablets, capsules, solution*	F		
DIABETA	*Glyburide tablets*	F		
DIABINESE	*Chlorpropamide tablets*	F		
DIAMOX	*Acetazolamide capsules (Sequels), tablets, vials*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DIASTAT	*Diazepam Rectal*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DIFLUCAN	*Fluconazole 150mg tablets*	F	Ψ	**Limit:** 2 tablets/month.
DIFLUCAN	*Fluconazole 100, 200mg tablets, suspension*	F	#	

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DILACOR XR	*Diltiazem capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DILANTIN	*Phenytoin tablets, capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DILAUDID	*Hydromorphone HCL tablets, suppositories, iinjection*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DIOVAN	*Valsartan tablets*	**NF**		**See TAR Criteria**, in back of formulary. ***Formulary alternatives: losartan, olmesartan (step)***
DIPROLENE, DIPROLENE AF	*Betamethasone Dipropionate Augmented 0.05% ointment, gel & lotion*	**NF**		***Formulary alternatives = Diprosone, Temovate, Lidex, Elocon***
DIPROSONE	*Betamethasone Dipropionate 0.05% oint., cream, lotion*	F		
DISALCID	*Salsalate tablets*	F		
DITROPAN	*Oxybutynin tablets, solution (immediate release only)*	F		
DITROPAN XL	*Oxybutynin XL tablets*	F	Ψ	**Limit:** Members age 55 or greater.
DIURIL	*Chlorothiazide tablets*	F		
DOLOPHINE	*Methadone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DOMEBORO OTIC	*Acetic Acid/Aluminum Acetate otic solution*	F		
DONNATAL	*Belladonna Alkaloids/PB tablets*	F		
DOVONEX	*Calcipotriene 0.005% cream, ointment, solution*	F		TAR needed for qty > 60g due to
DRISDOL	*Ergocalciferol (Vitamin D_2) Capsules: 1.25mg (50,000 iu)*	F	Ψ	**Limit:** Once weekly dosing, 4 capsules per month.
DRITHOCREAM	*Anthralin, Psoriatec 1% cr.*	F		
DRITHO-SCALP	*Anthralin 0.5% cream*	F		
DRYSOL	*Aluminum Chloride 20% soln*	F		
DUETACT	*Pioglitazone/Glimepiride tablets*	F	STE	**Limit:** 1 tab/day. **STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met.

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DUONEB	*Albuterol Sulf / Ipratropium neb. soln. 0.5/3.0 mg/dose* *Packaged as 30x3ml (90ml) and 60x 3ml (180ml)*	**NF**		***Formulary alternative: separate rx's for albuterol unit dose & ipratropium unit dose, used in nebulizer together.*** **MC Dual Eligibles:** Dx's related to COPD must be billed to Medicare Part B before MC. (PHC pays Part B copay only, not Part D).
DURAGESIC	*Fentanyl transdermal 12, 25, 50, 75 & 100 mcg/hr*	**NF**		**See TAR Criteria,** in back of formulary.
DYAZIDE	*Triamterene/HCTZ casules 50/25 mg & 37.5/25mg*	F	♥	Potentially eligible for CCS, see ♥ footnote.
DYNAPEN	*Dicloxacillin suspension, capsules*	F		
EASPRIN	*Aspirin, 975mg delayed release tablets*	F		
E.E.S.	*Erythromycin Ethylsuccinate tablets, chewables, susp, drops*	F		
EFFEXOR	*Venlafaxine HCL tablets (immediate release)*	F	Ψ, STE	**STEP Edit:** Requires prior use of formulary SSRI in the last 120 days. Limited to 3/day.
EFFEXOR XR	*Venlafaxine XR capsules*	F	Ψ, STE	**STEP Edit:** Requires prior use of formulary SSRI in the last 120 days. Limited to 1/day of 37.5 and 75mg, 2/day of 150mg.
EFUDEX	*Fluorouracil 2%, 5% solution, 5% cream*	F		
ELAVIL	*Amitriptyline tablets*	F		
ELIDEL	*Pimecrolimus 1% cream*	F	Ψ	**Limit:** Age 5 and younger and maximum of 30g/Rx.
ELIMITE	*Permethrin 5% cream*	F		
ELMIRON	*Pentosan Polysulfate Sodium capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
ELOCON	*Mometasone topical 0.1% cream, ointment, solution*	F		
EMEND	*Aprepitant tablets*	F	©, Ψ	**Code 1:** Given with chemo **Limit:** 3 tablets per fill
EMLA	*Lidocaine/Prilocaine 2.5/2.5% Cream*	F	©	**Code 1:** IV/Port injections
EMPIRIN W/ CODEINE	*Aspirin/Codeine tablets*	F	Ψ	**Limit:** 240 tablets per month.
EMTRIVA	*Emtricitabine capsules*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal.' **HK/HF:** Formulary

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EPIFRIN	*Epinephrine o/s*	F		
EPIVIR	*Lamivudine tablets, soln.*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
EPIVIR HBV	*Lamivudine tablets, soln.*	F	♥	Potentially eligible for CCS, see ♥ footnote.
EPZICOM	*Abacavir/Tenofovir*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
ERGOMAR	*Ergotamine Tartrate sublingual tablets*	F		
ERY-TAB	*Erythromycin base tablets*	F		
ERYC	*Erythromycin base capsules*	F		
ERYTHROCIN	*Erythromycin Stearate tablets*	F		
ERYTHROMYCIN BASE	*Erythromycin base tablets, DR tablets, capsules*	F		
ESTRACE	*Estradiol, micronized tablets and vaginal cream 0.01%*	F	Ψ	**Limit, tablets:** 1 tablet per day.
ESTRADERM	*Estradiol, transdermal*	F		
ESTRATEST, ESTRATEST HS	*Estrogens, Esterified/ Methyltestosterone tablets*	F		**Limit:** 1 tablet per day.
EURAX	*Crotamiton 10% cream, lotion*	F		
EVISTA	*Raloxifene HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary.
EXELON	*Rivastigmine Tartrate capsules*	**NF**		**See TAR Criteria,** in back of formulary.
FANAPT	*Iloperidone tablets (including titration pack)*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
FELDENE	*Piroxicam capsules*	F		
FEMARA	*Letrozole tablets*	F	SP	TAR required for dispensing by pharmacy other than contracted specialty pharmacy.
FEMHRT	*Ethinyl Estradiol/ Norethindrone tablets*	F		
FIORICET	*Butalb/Caffeine/APAP tablets*	F	Ψ	**Limit:** 50 tablets per month.
FIORINAL	*Butalb/Caffeine/ASA capsules*	F	Ψ	**Limit:** 50 tablets per month.
FLAGYL	*Metronidazole tablets*	F		
FLEXERIL	*Cyclobenzaprine 10mg tablets*	F	Ψ	**Limit:** 120 tablets per month

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FLOMAX	*Tamsulosin HCL capsules*	**NF**		**See TAR Criteria** in back of formulary. ***Formulary alternatives = doxazosin, terazosin.***
FLONASE	*Fluticasone Nasal Spray*	F	Ψ	**Limit:** 1 unit per month
FLORINEF	*Fludrocortisone Acetate tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
FLOVENT HFA	*Fluticasone HFA Propionate MDI*	F	Ψ	**Limit:** 1 unit per month
FLOXIN	*Ofloxacin tablets*	F	Ψ	**Limit:** 28 tablets per month.
FLOXIN OTIC	*Ofloxacin Otic susp*	F		
FLUMIST	*Influenza Vaccine, live trivalent nasal spray*	F	Ψ	**Limits:** (1) Ages 2-49, (2) vaccination network pharmacies only. Injection forms (formulary), included in injectable section.
FML FML FML S.O.P.	*Fluorometholone .0.1%, 0.25% ophth. susp. 0.1% opth.oint.*	F		
FOLIC ACID	*Folic Acid 1mg tablets*	F		
FORADIL	*Formoterol Fumarate MDI*	F	Ψ	**Limit:** 1 unit per month
FOSAMAX	*Alendronate Sodium 5, 10mg, 35, 70mg tablets*	F	Ψ, ♥	**Limit, 35 & 70mg:** 4 tablets in 28 days. Potentially eligible for CCS, see ♥ footnote.
FOSRENOL	*Lanthanum Carbonate chewable tablets*	**NF**		**See TAR Criteria,** in back of formulary.
FROVA	*Frovatriptan Succinate tablets*	**NF**		**See TAR Criteria,** in back of formulary.
GABITRIL	*Tiagabine HCL tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
GANTRISIN	*Sulfisoxazole susp.*	F		
GARAMYCIN	*Gentamicin 0.3% o/o, o/s*	F		
GEODON	*Ziprasidone HCL capsules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
GEODON IM	*Ziprasidone Mesylate IM injection*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
GLEEVEC	*Imatinib Mesylate capsules*	F	#, SP, ♥	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. **Limits:** 400mg tabs limited to 14 tabs per fill; 100mg tabs limited to 28 tabs per fill. Potentially eligible for CCS, see ♥ footnote.

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GLUCOPHAGE	*Metformin, immediate release tablets*	F		
GLUCOPHAGE XR	*Metformin extended release tablets*	F		
GLUCOTROL	*Glipizide, regular release tablets*	F		Non XL Only.
GLYSET	*Miglitol tablets*	F		
GOLYTELY	*Polyethylene Glycol powder for reconstitution*	**NF**		***Formulary alternative = PEG 3350/electrolytes (generic Colyte)***
GRIFULVIN V	*Griseofulvin, Microsize tablets, suspension*	F		
GRIS-PEG	*Griseofulvin, Ultramicrosize tablets*	F		
HALDOL	*Haloperidol tablets, oral solution, injection*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
HALOTESTIN	*Fluoxymesterone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
HECTORAL	*Doxercalciferol capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
HEPSERA	*Adefovir Dipivoxil tablets*	**NF**		**See TAR Criteria,** in back of formulary.
HIPREX	*Methenamine tablets*	F		
HIVID	*Zalcitabine tablets*	F	#	
HYALGAN	*Hyaluronate sodium injection*	**NF**		**See TAR Criteria,** in back of formulary.
HYDERGINE	*Ergoloid Mesylates oral & sl tablets*	F		Note that the FDA indication is for ages >60yrs.
HYDREA	*Hydroxyurea 500mg tablets*	F	SP, ♥	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote.
HYDRODIURIL	*Hydrochlorothiazide 25, 50, 100mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
HYGROTON	*Chlorthalidone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
HYTRIN	*Terazosin capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
HYZAAR	*Losartan/Hydrochlorothiazide 12.5/50, 12.5/100, 25/100mg tablets*	F	♥,Ψ, STE	**STEP Edit:** ACE inhibitor filled in the last 365 days. **Limit:** ½ tablet dosing Potentially eligible for CCS, see ♥ footnote.
ILOTYCIN	*Erythromycin o/o*	F		
IMDUR	*Isosorbide Mononitrate, extended release 24 hr 30, 60, 120mg tablets*	F	♥	

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IMITREX	*Sumatriptan tablets, injection, nasal spray*	F	Ψ	**Limits:** Nasal Spray – 1 unit/month. Syringes – 4/month Tablets – 9/month.
IMODIUM	*Loperamide HCL 2mg capsules*	F		
IMODIUM A-D	*Loperamide HCL 2mg tablets, 1mg/5ml liquid 1mg/7.5ml liquid*	F		
IMURAN	*Azathioprine 50mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
INDERAL	*Propranolol HCL tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
INDERAL LA	*Propranolol HCL capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
INDOCIN	*Indomethacin 25 & 50mg regular release capsules*	F		
INFLAMASE MILD	*Prednisolone Sod Phosphate 0.125% o/s*	F		
INFLAMSE FORTE	*Prednisolone Sod Phosphate 1% o/s*	F		
INH	*Isoniazid tablets, syrup, vials*	F		
INSPRA	*Eplerenone*	**NF**		**See TAR Criteria,** in back of formulary.
INSULIN (All Forms)	*Insulin*	F	♥, Ψ	**Limits:** Vials – 4 vials (40ml) per month Cartridges – 5 cartridges (15ml) per month. Potentially eligible for CCS, see ♥ footnote.
INTAL	*Cromolyn sod. MDI*	F	Ψ	Limit 2 units per month.
INVEGA	*Paliperidone ER tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF: See TAR Criteria,** in back of formulary.
INVEGA IM injection	*Paliperidone Palmitate Inj.*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary
INVIRASE	*Saquinavir Mesylate*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
IOPIDINE	*Apraclonidine HCL 0.5%, 1% o/s*	F	Ψ	**Limit:** 10 ml/month.
ISOPTO ATROPINE	*Atropine 0.5% & 1% o/s 1% o/o*	F		

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ISOPTO CARBACHOL	*Carbachol 1.5% & 3% o/s*	F		
ISOPTO CARPINE	*Pilocarpine o/s*	F		
ISOPTO HOMATROPINE	*Homatropine HBr 2%, 5% o/s*	F		
ISORDIL	*Isosorbide Dinitrate tablets*	F	♥	
JANUVIA	*Sitagliptin tablets*	F	STE	**STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met.
JANUMET	*Sitagliptin/Metformin tablets*	F	STE	**STEP Edits:** (1) Prior claims exist for both metformin and insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met.
KADIAN	*Morphine Sulfate, DR capsules (pelleted)*	**NF**		**See TAR Criteria,** in back of formulary.
KALETRA	*Lopinavir/Ritonavir solution, tablets*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
KAYEXELATE	*Sodium Polystyrene Sulfonate powder, susp.*	F		
K-Dur, K-Tab	*Potassium Chloride ER tablets*	F		
KEFLEX	*Cephalexin Monohydrate capsules, susp.*	F		
KENALOG	*Triamcinolone Acetonide 0.025, 0.1, 0.5% cream 0.025m 0.1, 0.5% oint. 0.025, 0.1% lotions*	F		
KENALOG IN ORABASE	*Triamcinolone in Orabase ("Dental Paste")*	F		
KEPPRA	*Levetiracetam Tablets, solution*	F	♥	Potentially eligible for CCS, see ♥ footnote.
KLONOPIN	*Clonazepam 0.5, 1, 2mg oral tablets (ODT not covered)*	F		**Limit:** Oral (swallow) tablets only, not ODT.
K-PHOS (M.F., NO.2, Neutral, Original)	*Na Phos, M-B/K Phos,Monobasic tablets*	F		

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LAMICTAL	*Lamotrigine 5 & 25mg chewable, 25, 100, 150, 200mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LAMISIL-AT	*Terbinafine HCL 1% cream, solution*	F		
LAMISIL	*Terbinafine HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary.
LAMPRENE	*Clofazimine capsules*	F		
LANOXICAPS	*Digoxin capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LANOXIN	*Digoxin tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LARODOPA	*Levodopa tablets*	F		
LASIX	*Furosemide tablets, solution*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LESCOL	*Fluvastatin Sodium Capsules: 20mg, 40mg*	F	Ψ	**Limit:** 1 tablet daily
LESCOL XL	*Fluvastatin Sod. Extended Release Tablets: 80mg*	F	Ψ	**Limit:** 1 tablet daily
LEUCOVORIN	*Folinic acid tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LEUKERAN	*Chlorambucil tablets*	F	SP, ♥	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote.
LEVAQUIN	*Levofloxacin tablets, vial*	F	Ψ	**Limit:** tablets limited to #10 per Rx.
LEVO-DROMORAN	*Levorphanol Tartrate tablets, injection*	F		
LEVSIN 0.125	*Hyoscyamine*	F		
LEXAPRO	*Escitalopram Oxalate*	**NF**		**See TAR Criteria,** in back of formulary.
LIBRAX	*Chlordiazepoxide/Clidinium bromide*	F		
LIBRIUM	*Chlordiazepoxide*	F	Ψ	**Limit:** 90 tablets/month.
LIDEX 0.05% cr, gel, ung, soln	*Fluocinonide*	F		
LIDODERM	*Lidocaine 5% Patch*	**NF**		**See TAR Criteria,** in back of formulary.
LIORESAL	*Baclofen*	F		
LITHIUM	*Lithium Carbonate, Lithium Citrate*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary

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LODINE	*Etodolac 300mg capsules 400 & 500mg tablets 400 & 500mg XL tablets*	F		
LOFIBRA	*Micronized Fenofibrate 67, 134, 200mg capsules, 54, 160mg tablets*	F		**Note:** Addition of 54 & 160mg tablets goes into effect 4/1/11.
LOMOTIL	*Diphenoxylate/Atropine Tablets: 2.5/0.05mg Soln: 2.5/0.05mg/5ml*	F		
LONITEN	*Minoxidil tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LOPID	*Gemfibrozil tablets*	F		
LOPRESSOR	*Metoprolol Tartrate tablets, ampules*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LORCET	*Hydrocodone/APAP 10/650mg tablets*	F	Ψ	**Limit:** 120/month or 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
LORCET PLUS	*Hydrocodone/APAP 7.5/650mg tablets*	F	Ψ	**Limit:** 120/month or 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
LORTAB	*Hydrocodone/APAP 5/500mg Hydrocodone/APAP 7.5/500mg Hydrocodone/APAP 10/500mg tablets*	F	Ψ	**Limit:** 120/month or 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
LOTENSIN	*Benazepril tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LOTENSIN HCT	*Benazepril HCT tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
LOTREL 2.5/10, 5/10, 5/20, 10/20	*Amlodipine Besylate/Benazepril capsules*	F	♥	**Limit:** limited to the stated strengths. Please use 2 of the 5/20mg to achieve a 10/40mg dose. Potentially eligible for CCS, see ♥ footnote.
LOTRONEX	*Alosetron HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary.
LOVAZA	*Omega-3 Acid Ethyl Esters capsules*	**NF**		**See TAR Criteria,** in back of formulary.
LOVENOX injection	*Enoxaparin Sodium Prefilled syringes*	F	SP, Ψ, #, ♥	**Limits:** 20 doses/Rx, 2 Rx's/yr. TAR required for > qty limit and for dispensing by non-specialty pharmacy. Potentially eligible for CCS, see ♥ footnote.
LOXITANE	*Loxapine Succinate capsules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
LOZOL	*Indapamide tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.

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LUMIGAN	*Bimatoprost 0.03% o/s*	F	©	**Code 1:** Dx of open angle glaucoma or ocular hypertension.
LUNESTA	*Eszopiclone tablets*	**NF**		**See TAR Criteria,** in back of formulary.
LURIDE	*Sodium Fluoride drops, tablets*	F		
LUVOX	*Fluvoxamine tablets*	F		
LYRICA	*Pregabalin capsules*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives = gabapentin, TCA's***
MACROBID	*Nitrofurantoin slow-release capsules (Monohydrate/ macrocrystal blend)*	F		
MACRODANTIN	*Nitrofurantoin Macrocrystal tablets*	F		
MAG-OX 400	*Magnesium Oxide 400mg tablets*	F		
MANDELAMINE	*Methenamine Mandelate tablets*	F		
MARINOL	*Dronabinol capsules*	**NF**		**See TAR Criteria,** in back of formulary.
MAXALT, reg & MLT	*Rizatriptan Benzoate tablets & MLT*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternative: sumatriptan.***
MAXITROL	*Dexamethasone/Neomycin Polymyxin o/s, o/o*	F		
MAXZIDE	*HCTZ/Triamterene 50/75mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
MAXZIDE-25	*HCTZ/Triamterene 25/37.5mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote.
MEDROL, MEDROL DOSEPAK	*Methylprednisolone tablets*	F		
MEGACE suspension	*Megestrol Acetate 40mg/ml susp.*	**NF**		**See TAR Criteria,** in back of formulary.
MEGACE (tablets)	*Megestrol Acetate tabs*	F	SP, ♥	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote.
MELLARIL	*Thioridazine Tablets, oral soln.*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
MEPHYTON	*Phytonadione tablets, injection*	F	♥	Potentially eligible for CCS, see ♥ footnote.
MEPRON	*Atovaquone 750mg/5ml susp.*	F	#	

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MESTINON	*Pyridostigmine Bromide*	F	♥	Potentially eligible for CCS, see ♥ footnote.
METADATE CD Capsules	*Methylphenidate HCL ER Capsules*	**NF**		**See TAR Criteria,** in back of formulary. ***Pediatric formulary alternatives: generic Ritalin SR, Adderall, Adderall XR, Dexedrine; Adult formulary alternative: Strattera***
METADATE ER Tablets	*Methylphenidate ER Tablets*	F	Ψ	**Limit:** Ages 6-16.
METHERGINE	*Methylergonovine Maleate tablets, ampules*	F		
METHITEST	*Methyltestosterone*	**NF**		**See TAR Criteria,** in back of formulary (listed under "testosterone", not individual brand names).
METHOTREXATE	*Methotrexate tablets, injection*	F	SP, ♥	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote
METROGEL	*Metronidazole gel topical & vaginal 0.75%*	F		Note: Effective 4/1/11, 1% gel is NF.
MEVACOR	*Lovastatin tablets*	F	Ψ	**Limit:** 1 tablet per day
MEXITIL	*Mexiletine capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote
MIACALCIN	*Calcitonin, Salmon, Synthetic, nasal spray*	F	Ψ	**Limit:** 3.7ml/31 days.
MICRONASE	*Glyburide tablets*	F		
MICROZIDE	*Hydrochlorothiazide 12.5mg capsules*	F		
MICRO-K 8 MEQ	*Potassium Chloride SA caps*	F		
MICRO-K 10 MEQ	*Potassium Chloride SA caps*	F		
MIDRIN	*Isometheptene/ Dichloralphenazone/APAP capsules*	F		
MINIPRESS	*Prazosin capsules*	F	♥	
MINTEZOL	*Thiabendazole chewable tablets, susp.*	F		
MINOCIN	*Minocycline 50, 100mg capsules*	F	STE	**STEP Edit:** Use of doxycycline in the last 90 days.
MIRALAX	*Polyethylene Glycol powder*	F	Ψ	**Limit:** 2 week supply (255g Rx or 238g OTC) without a TAR.
MIRAPEX	*Pramipexole tablets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives = carbidopa/l-dopa, clonazepam, ropinirole.***

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MOBAN	*Molindone HCL tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
MOBIC	*Meloxicam 7.5mg, 15mg tablets*	F		
MONISTAT vaginal products	*Miconazole, tioconazole*	F		See OTC section for specific product info.
MONISTAT-DERM	*Miconazole 2% topical cream*	F		
MOTOFEN	*Difenoxin HCL/Atropine Sulfate*	**NF**		
MOTRIN	*Ibuprofen tablets and susp 100mg/5ml*	F		
MS CONTIN	*Morphine Sulfate LA tablets (long-acting)*	F		
MSIR	*Morphine Sulfate IR tablets (immediate release) and solution*	F		
MUCINEX EXP	*Guaifenesin 600mg ER tablets*	F		
MUCOMYST	*Acetylcysteine vials, neb.*	F	♥	Potentially eligible for CCS, see ♥ footnote
MYAMBUTOL	*Ethambutol tablets*	F		
MYCELEX	*Clotrimazole oral troches*	F		
MYCOBUTIN	*Rifabutin capsules*	F	**#**	
MYCOLOG II	*Nystatin-Triamcinolone cream, ointment*	F		
MYCOSTATIN	*Nystatin tablets, ointment, suspension, cream, powder*	F		
MYFORTIC	*Mycophenolate Sodium tablets*	F	♥, #	Potentially eligible for CCS, see ♥ footnote
MYSOLINE	*Primidone tablets, suspension*	F	♥	Potentially eligible for CCS, see ♥ footnote
NAMENDA	*Memantine HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary.
NAPHCON A	*Naphazoline/pheniramine maleate o/s Visine A*	See notes		**MC:** Formulary **HK/HF:** OTC, not a covered benefit
NAPROSYN	*Naproxen tablet (regular & EC), susp.*	F		
NARDIL	*Phenelzine Sulfate*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
NASAREL	*Flunisolide nasal spray*	F		

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NAVANE	*Thiothixene capsules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
NEMBUTAL	*Pentobarbital 41 suppositories*	F		
NEO-DECADRON	*Dexamethasone/Neomycin o/s, o/o*	F		
NEORAL	*Cyclosporine capsules, oral solution*	F	SP, ♥, #	TAR required for dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote
NEOSPORIN GU	*Neomycin/Polymixin irrig.*	F		
NEOSPORIN o/o	*: Neomycin/Bacitracin/ Polymyxin B o/o*	F		
NEOSPORIN o/s	*Neomycin/Gramicidin/ Polymyxin B o/s*	F		
NEPHROCAPS	*Renal multivitamins (B's, C, Folate)* *Nephronex, Renal caps*	F		
NEPHRO-VITE	*Renal multivitamins (B's, C, Folate)* *Dialyvite, Rena-Vite tablets*	F		
NEPHROVITE–RX	*Renal multivitamin (B's, C, 1mg Folate)* *Rena-Vite RX tablets*	F		
NEPTAZANE	*Methazolamide tablets*	F		
NEURONTIN	*Gabapentin* *Capsules in 100, 300, 400mg* *Tablets in 600, 800 mg*	F	♥, Ψ	**Limit:** 3600mg/day. Potentially eligible for CCS, see ♥ footnote
NEURONTIN	*Gabapentin* *Tablets in 100, 300, 400mg*	**NF**		***Formulary Alternative: Use CAPSULES.***
NEUTRA PHOS	*Phosphorus, Potassium, Sodium powder, capsules*	F		
NEXAVAR	*Sorafenib tablets*	F	SP, ♥, Ψ	**Limits:** (1) Limited to dispensing by a specialty pharmacy, other pharmacies require a TAR; (2) Limited to #56/fill (2 week supply) for the first 2 months of treatment. Potentially eligible for CCS, see ♥ footnote
NEXIUM	*Esomeprazole DR capsules, powder for suspension*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: omeprazole (Rx & OTC), lansoprazole (OTC only), H-2 blockers (Rx & OTC)***

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NIACIN	*Nicotinic Acid, B3 tablets, OTC capsules, ER & IR forms.*	F		
NIASPAN ER	*Niacin, RX extended release tablets*	F		
NICODERM	*Nicotine Patch 7, 14, 21mg/24hr*	F	Ψ	**Limits:** 180 patches within a year period, 1 strength per fill up to qty #42.
NICORETTE	*Nicotine Polacrilex gum*	F	Ψ	**Limit:** Maximum of 810 pieces within a 1 year period.
NICOTROL Inhaler	*Nicotine oral inhaler*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: nicotine patch, nicotine gum, Chantix.***
NICOTROL NS	*Nicotine nasal spray*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: nicotine patch, nicotine gum, Chantix.***
NICOTROL PATCH	*Nicotine Patch 15mg/16hrs*	F	Ψ	**Limits:** 180 patches within a year period.
NITRO-BID	*Nitroglycerin 2% Ointment*	F	♥	Potentially eligible for CCS, see ♥ footnote
NITRO-DUR	*Nitroglycerin Patch*	F		
NITROLINGUAL	*Nitroglycerin Spray*	F		
NITROSTAT	*Nitroglycerin sl tabs*	F	♥	Potentially eligible for CCS, see ♥ footnote
NIZORAL	*Ketoconazole 200mg tablets, 2% shampoo, 2% cream*	F		
NOCTEC	*Chloral Hydrate 250mg/5ml syrup, 500mg capsules & supp.*	F		
NOLVADEX	*Tamoxifen tablets*	F	SP	TAR required for dispensing by pharmacy other than contracted specialty pharmacy.
NORCO-10	*Hydrocodone/APAP 10/325mg*	F	Ψ	**Limit:** 120/month or 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
NORMAL SALINE Irrigation	*Sodium Chloride irrigation*	F		
NORMAL SALINE Inhalation for nebulizer	*Sodium Chloride nebulizer*	F		
NORPRAMIN	*Desipramine HCL*	F		
NORVASC	*Amlodipine Besylate*	F	♥, Ψ	**Limit:** 1 per day Potentially eligible for CCS, see ♥ footnote

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NORVIR	*Ritonavir*	See notes	🗸	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
NULYTELY	*PEG/electrolytes*	F		
NUMORPHAN	*Oxymorphone HCL Supp.*	F		
NUVARING	*Etonogestrel/Ethinyl Estradiol*	F		
OCEAN Nasal Spray/Drops	*0.65% Sodium Chloride Nasal spray/drops*	See notes		**MC:** Formulary **HK/HF:** OTC, not a covered benefit
OCUFLOX	*Ofloxacin 0.3% ophth. drops*	F	Ψ	**Limit:** 5 ml per Rx
OMNICEF	*Cefdinir Suspension: 125mg/5ml, 250mg/5ml*	F	Ψ	**Limit:** Oral suspension only. Tablets are non-formulary.
ONGLYZA	*Saxagliptin tablets*	F	♥, Ψ, STE	Limited to 1 tab/day. **STEP Edits:** (1) Prior claims exist for both metformin, sitagliptin AND insulin in the last 120 days, or (2) Prescriber is on file as a board-certified endocrinologist. See TAR Criteria in back of formulary for additional information if step edit not met. Potentially eligible for CCS, see ♥ footnote.
OPTIPRANOLOL	*Metipranolol 0.3% Ophth. drops*	F	Ψ	**Limit:** 10ml/month.
ORAP	*Pimozide tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
ORAPRED	*Prednisolone Sodium Phos. 15mg/5ml oral solution*	F		
ORINASE	*Tolbutamide tablets*	F		
ORUDIS	*Ketotifen 50 & 75mg capsules*	F		
OVIDE	*Malathion 0.5% lotion*	F	Ψ	**Limit:** 60ml/90days.
OXANDRIN	*Oxandrolone tablets*	**NF**		**See TAR Criteria,** in back of formulary.
OXISTAT	*Oxiconazole Nitrate Cream: 1%, available in 15, 30 & 60g tubes*	F		Note: Lotion is non-formulary.
OXSORALEN	*Methoxsalen 1% lotion*	**NF**		
OXY IR	*Oxycodone 5mg immediate release capsules*	F	Ψ	**Limit:** 100/30 days

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Brand	Generic	Status	Code	Notes
OXYCONTIN	*Oxycodone extended-release tablets*	**NF**	#	**See TAR Criteria,** in back of formulary.
PAMELOR	*Nortriptyline HCL Capsules, solution*	F		
PANAFIL	*Papain/Urea/Chlorophyllin ointment*	F		
PANCREAZE	*Lipase/Protease/Amylase DR capsules*	F	♥	TAR needed for claims over $500. Potentially eligible for CCS, see ♥ footnote
PARLODEL	*Bromocriptine Mesylate 2.5mg tablets, 5mg capsules*	F		
PATANASE	*Olopatadine 0.6% nasal spray*	**NF**		**See TAR Criteria,** in back of formulary.
PATANOL	*Olopatadine 0.1% opth drops*	F	STE	**STEP Edit:** Prior use of Zaditor-OTC or cromolyn in the last 120 days.
PAXIL	*Paroxetine HCL immediate release tablets*	F	Ψ	**Limit:** ½ tablet substitution. Effective 4/1/11, ½ tab restriction removed.
PEDIAPRED	*Prednisolone Sodium Phos. 5mg/5ml & 6.7mg/5ml oral solution*	F		
PEDIAZOLE	*Enthryomycin/Sulfisoxazole susp.*	F		
PEN VK	*Penicillin V Potassium susp, tablets*	F		
PENICILLIN G	*Penicillin G Potassium Susp, tablets, injection*	F		
PENLAC 8% nail lacquer	*Ciclopirox nail soln.*	**NF**		**See TAR Criteria,** in back of formulary.
PENTAM 300	*Pentamidine isetionate Inhalation, injection*	F		
PEPCID	*Famotidine*	F, Ψ		**Limit:** #60/mo.
PERCOCET 5/325	*Oxycodone HCL/ Acetaminophen tablets 5mg/325mg*	F		**Note:** 10/325mg is non-formulary. Use 2 tabs of 5/325 for a 10mg dose of oxycodone.
PERCODAN 5/325	*Oxycodone/ASA tablets 5/325mg*	F		
PERIACTIN	*Cyproheptadine tablets, syrup*	F		
PERIDEX, PERIOGARD	*Chlorhexidine Gluconate 0.12% solution*	F		
PERSANTINE	*Dipyridamole tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PHENERGAN	*Promethazine tablets, suppositories, syrup*	F	Ψ	**Limit:** Syrup limited to ages 4yr & up
PHENERGAN DM	*Promethazine/ Dextromethorphan syrup*	F	Ψ	**Limit:** Ages 4yr & up

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PHENERGAN VC	*Promethazine/Phenylephrine syrup*	F	Ψ	**Limit:** Ages 4yr & up
PHENERGAN VC w/CODEINE	*Codeine/Promethazine/ Phenylephrine syrup*	F	Ψ	**Limit:** Ages 4yr & up
PHENERGAN w/CODEINE	*Promethazine w/Codeine syrup*	F	Ψ	**Limit:** Ages 4yr & up
PHENOBARBITAL	*Phenobarbital tablets, solution*	F	♥	Potentially eligible for CCS, see ♥ footnote
PHENYTEK	*Phenytoin Sodium 200 & 300mg ER capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote
PHOSLO gelcaps	*Calcium Acetate*	F	♥	Potentially eligible for CCS, see ♥ footnote
PHOSPHOLINE IODIDE	*Echothiophate iodide ophthalmic*	F		
PILOCAR	*Pilocarpine o/s*	F		
PILOPINE 4%	*Pilocarpine ophth. gel*	F		
PLAN B 0.75mg (NEXT CHOICE)	*Levonorgestrel Tablets: 0.75mg/tab, 2 tab pack* Available in generic from Watson, "Next Choice 0.75mg"	F	Ψ	**Limit:** 3 fills of 1 pack (2 tabs) in 3 months. Use generic. Plan B 1-Step (1.5mg) is non-formulary; please use 2 tabs of 0.75mg.
PLAQUENIL	*Hydroxychloroquin tablets*	F	SP, ♥	Potentially eligible for CCS, see ♥ footnote
PLAVIX 75mg	*Clopidogrel Bisulfate tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PLENDIL	*Felodipine tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
POLY VI FLOR	*Multi-Vitamin/Sodium Flouride chewable tablets, drops*	F	Ψ	**Limit:** Age < 8 yrs
POLY-PRED	*Neomy Sulf/Polymyx B Sulf/Pred o/s*	F		
POLYSPORIN	*Polymyxin B/Bacitracin o/o*	F		Generic is found as "AK-Poly"
POLYTRIM	*Polymixin B/Trimethoprim o/s*	F		
PRADAXA	*Dabigatran capsules*	**NF**		**See TAR Criteria,** in back of formulary.
PRAVACHOL	*Pravastatin tablets, 10 & 20mg only*	F	Ψ	**Note:** Formulary addition effective 4/1/11: Limited to 10 & 20mg only on formulary. For 40mg dose or higher, use multiples of 20mg tablets.
PRECOSE	*Acarbose tablets*	F		
PRED MILD 0.12%	*Prednisolone Acetate o/s*	F		
PRED FORTE 1%	*Prednisolone Acetate o/s*	F		
PREDNISONE	*Prednisone tablets, syrup, solution*	F		

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PRELONE	*Prednisolone 15mg/5ml & 5mg/5ml oral solution*	F		
PREMARIN	*Estrogens, Conjugated, vaginal cream*	F		
PREMARIN tablets	*Estrogens, Conjugated tablets*	**NF**		***Formulary alternatives = transdermal or oral estradiol; also combination estrogen/ progesterone products***
PREMPHASE	*Estrogens, Conjugated/ Medroxyprogesterone acetate tablets*	F		
PREMPRO	*Estrogens, Conjugated/ Medroxyprogesterone acetate tablets*	F		
PRENATAL VITAMINS	*Prenatal vitamins* Generic multi-source products are covered, OTC and Rx.	F	©	**Code 1:** restricted to women who are pregnant or lactating. Not all formulations are covered, must use a generic product.
PREVACID **Rx**	*Lansoprazole DR Capsules: 15mg & 30mg*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives = omeprazole, Prevacid 24H (OTC), H-2 blockers.***
PREVACID 24H **OTC**	*Lansoprazole DR Capsules: 15mg*	F	♥	NOTE: The OTC product is identical to the 15mg Rx product, no change in composition was made for OTC status per FDA & mfg. No limit, can use multiple capsules for 30mg doses. Potentially eligible for CCS, see ♥ footnote
PREVIDENT (original, not 5000)	*Sodium Fluoride Gel: 1.1%*	F		
PREVPAC	*Lansoprazole/Amoxicillin/ Clarithromycin*	**NF**		***Formulary alternatives = separate Rx's, 1 each for Prevacid 24H/OTC, amoxicillin, & clarithromycin. See page 16.***
PRILOSEC-**OTC**	*Omeprazole Magnesium 20mg tablets*	F	♥, Ψ	**Limit:** 2/day; up to 4/day allowed with prior authorization. Potentially eligible for CCS, see ♥ footnote
PRILOSEC RX	*Omeprazole 10mg & 20mg capsules*	F	♥	**Limit:** 10 and 20 mg strengths only are formulary; for 40mg dose, use 2 capsules of 20mg. Potentially eligible for CCS, see ♥ footnote
PRINIVIL	*Lisinopril tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote

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PRINZIDE	*Lisinopril/HCTZ tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PROAIR HFA	*Albuterol HFA MDI*	NF		***Formulary Alternative: Ventolin HFA***
PRO-BANTHINE	*Propantheline Bromide tablets*	F		
PROCAN SR	*Procainamide SA (SR) tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PROCANBID	*Procainamide HCL SR tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PROCARDIA, PROCARDIA XL	*Nifedipine Immediate release capsules & XL tablets*	F		
PROCTOFOAM-HC	*HC Acetate/Pramoxine HCL*	F		
PROCTO-KIT	*Hydrocortisone 1%, 2% Rectal cream w/ applicator*	F		
PROCTOSOL HC	*Hydrocortisone 2.5% Rectal cream & supp.*	F		
PROGRAF	*Tacrolimus Anhydrous capsules, injection*	F	♥, #	TAR required for claims >$500, part B copays, & brand DAW 1. Part B copays: Part B eligible for renal transplants for 3 yrs and all other organ transplants. Renal transplant > 3 yrs old is Medicare Part D eligible. Potentially eligible for CCS, see ♥ footnote
PROLIXIN	*Fluphenazine tablets, elixir, concentrate, injection*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
PROLOPRIM	*Trimethoprim tablets*	F		
PROMETRIUM 200mg capsules	*Progesterone, Micronized*	**NF**		
PRONESTYL	*Procainamide HCL*	F	♥	Potentially eligible for CCS, see ♥ footnote
PROPINE 0.1% ophth sol	*Dipivefrin*	F	Ψ	**Limit:** 10 ml/month
PROSCAR	*Finasteride*	F	♥	Potentially eligible for CCS, see ♥ footnote
PROSTIGMIN	*Neostigmine Bromide*	F		
PROTONIX	*Pantoprazole Sodium*	F		Added to formulary, effective 7/1/11.
PROTOPIC	*Tacrolimus oint.*	**NF**		**See TAR Criteria,** in back of formulary.

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PROVENTIL neb soln, for dilution	*Albuterol Sulfate Nebulizer Solution: 5mg/ml* Available in 20ml dropper bottle, to be mixed with NS	F	Ψ	**Limit:** 40ml (2 bottles) /month.
PROVENTIL neb soln. unit dose	*Albuterol Sulfate Nebulizer Unit Dose Soln: 0.83mg/ml* Available in 25, 30 & 60 dose boxes, 3ml per dose (pre-mixed w/NS)	F	Ψ	**Limit:** 225ml/month (75 doses or 3 boxes @ 25 doses, 75ml each).
PROVENTIL HFA - *use Ventolin-HFA*	*Albuterol HFA*	**NF**		**Use Ventolin HFA only.** Proventil-HFA requires brand justification.
PROVENTIL Syrup	*Albuterol Syrup 2mg/5ml*	F		
PROVERA, including DEPO PROVERA	*Medroxyprogesterone tablets, IM injection*	F		
PROVIGIL	*Modafinil*	**NF**		**See TAR Criteria,** in back of formulary.
PROZAC	*Fluoxetine HCL 10 & 20mg capsules*	F	Ψ	**Limit:** 10mg & 20mg only – up to 80mg/day. (Tablets are also formulary, generic for Sarafem).
PROZAC 40mg	*Fluoxetine HCL capsules*	**NF**		***Formulary alternative: 20mg, 2 caps (up to 80mg/day).***
PTU	*Propylthiouracil tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
PULMICORT FLEXHALER	*Budesonide MDI 90mcg/dose (containing 60 doses) & 180mcg/dose (containing 120 doses)*	F	Ψ	**Limit:** 1 MDI per month
PULMICORT RESPULES	*Budesonide nebulizer soln. 0.25mg/2ml & 0.5mg/2ml* Packaged in 30 x 2ml boxes, billing qty is 60ml per 30 doses.	F	Ψ	**Limits:** Ages 9 yrs & younger; Qty limited to 60 doses (120ml) per month.
PYRIDIUM	*Phenazopyridine tablets*	F		
PZA	*PZA Pyrazinamide tablets*	F		
QUESTRAN, QUESTRAN LIGHT	*Cholestyramine/Sucrose Powder for Oral Suspension: Cans only, not packets. Regular 378g Light 210g*	F		Packets are non-formulary, must use bulk powder (can).
QUINAGLUTE DURATABS	*Quinidine Gluconate tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
QVAR	*Beclomethasone Dipropionate MDI 40mcg/dose & 80mcg/dose* MDI's contain 7.3g & 100 doses each (both strengths)	F	Ψ	**Limit:** 1 MDI per month.
REBETOL	*Ribavirin capsules, soln.*	**NF**		**See TAR Criteria,** in back of formulary.
REGLAN	*Metoclopramide tablets, soln.*	F		

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REGRANEX	*Becaplermin 0.01% gel*	**NF**		**See TAR Criteria,** in back of formulary.
RELAFEN	*Nabumetone tablets*	F		
RELENZA	*Zanamivir inhalation (Diskhaler)*	F	©, Ψ	**Code 1:** Cases in which current CDC guidelines for *treatment* are met; **Limit:** 5 day treatment supply, one fill per year.
RELPAX	*Eletriptan HBr tablets*	**NF**		**Limit:** 6 tablets of 1 strength/month.
REMERON	*Mirtazapine tablets (excluding ODT)*	F	Ψ	**Limit:** 1 tablet/day.
RENAGEL	*Sevelamer HCL tablets*	**NF**	#	**See TAR Criteria,** in back of formulary.
RENVELA	*Sevelamer Carbonate powder, tablets*	**NF**		**See TAR Criteria,** in back of formulary.
REQUIP	*Ropinirole tablets*	F	Ψ	**Limit:** 1 tablet per day
RESCRIPTOR	*Delavirdine Mesylate tablets, ODT*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
RESTASIS	*Cyclosporine ophth.drops*	**NF**		**See TAR Criteria,** in back of formulary.
RESTORIL 7.5	*Temazepam 7.5mg capsules*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives include: temazepam 15-30mg, flurazepam, lorazepam, zolpidem, TCA's, trazodone, doxepin, doxylamine, diphenhydramine, zaleplon (Step).***
RESTORIL 15mg, 30mg	*Temazepam 15, 30mg capsules*	F	Ψ	**Limit:** 1 capsule/day dosing.
RETIN-A	*Tretinoin gel* *0.01, 0.025% in 15 & 45 g* *Tretinoin cream* *0.025, 0.05, 0.1% in 20 & 45g*	F	Ψ	**Limit:** Ages < 40 yrs
RETIN-A MICRO	*Tretinoin Microspheres cream*	**NF**		***Formulary alternative: tretinoin cream or gel, non-micronized.***
RETROVIR	*Zidovudine capsules, syrup, vials*	F		Formulary on HK/HF & PHC/MC (an exception to the usual carve-out rule for anti-retrovirals).
REVATIO	*Sildenafil Citrate solution, tablets*	**NF**		**See TAR Criteria,** in back of formulary.
REVIA	*Naltrexone 50mg tablet*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary

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REYATAZ	*Atazanavir Sulfate capsules*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HF/HK:** Formulary
RHEUMATREX	*Methotrexate Sodium tablets*	F	SP, ♥	
RIFATER	*Rifampin/Inh/Pyrazinamide tablets*	F		
RIMACTANE	*Rifampin/Isoniazid capsules*	F		
RISPERDAL	*Risperidone tablets, ODT*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, **See TAR Criteria,** in back of formulary.
RISPERDAL CONSTA	*Risperidone Long-acting Injection*	See notes	♠	**MC:** Submit TAR to State MediCal/EDS. **HK/HF:** Non-formulary, **See TAR Criteria,** in back of formulary.
RITALIN, RITALIN SR	*Methylphenidate HCL, Methylphenidate ER (Methylin, Methylin ER, Metadate ER) tablets*	F	Ψ	Age restriction (6-16). **See TAR Criteria,** in back of formulary.
ROBAXIN	*Methocarbamol tablets*	F	Ψ	**Limit:** 120/mo.
ROBINUL, ROBINUL FORTE	*Glycopyrrolate 1 & 2mg tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
ROBITUSSIN DAC	*Guaifen/Pseudoephed/Cod. syrup*	F	Ψ	**Limit:** Ages 4yr & up. Generic can be found as "Mytussin DAC".
ROBITUSSIN AC	*Guaifenesin w/Codeine syrup*	F	Ψ	**Limit:** Ages 4yr & up
ROCALTROL	*Calcitriol Capsules: 0.25 & 0.5mcg*	F		Note that oral solution is excluded (non-formulary).
ROXANOL	*Morphine Sulfate 20mg/ml oral solution (100mg/5ml)*	F		
ROXICET	*Oxycodone HCL/APAP 5/325 & 5/500 tablets*	F		
ROXICODONE	*Oxycodone IR 5, 15, 30mg tablets*	F	Ψ	**Limits:** 100/month. IR tablets only, liquid is non-formulary.
ROZEREM	*Ramelteon tablets*	**NF**		**See TAR Criteria,** in back of formulary.
RYTHMOL	*Propafenone HCL tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
SALAGEN	*Pilocarpine HCL tablets*	F		
SANTYL	*Collagenase ointment*	F		
SAPHRIS	*Asenapine tablets*	See notes	♠	**MC:** Carve-out. Submit TAR to State MediCal/EDS. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
SARAFEM	*Fluoxetine HCL 10 & 20mg tablets*	F	Ψ	**Limit:** Qty limited to total daily dose of 80mg.

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SAVELLA	*Milnacipran HCL tablet*	**NF**		**See TAR Criteria,** in back of formulary.
SECTRAL	*Acebutolol capsules*	F	♥	Potentially eligible for CCS, see ♥ footnote
SELSEB 2.25%	*Selenium Sulfide 2.25% shampoo*	**NF**		***Formulary alternative = selenium sulfide 2.5% (generic Selsun Rx, see next line below)***
SELSUN RX 2.5%	*Selenium Sulfide 2.5% lotion/shampoo*	F		Product is a scalp "lotion" that is shampooed into scalp, & is indicated for treatment of scalp seborrhea & other dx's.
SENSIPAR	*Cinacalcet HCL tablets*	**NF**		**See TAR Criteria,** in back of formulary.
SEPTRA SEPTRA DS	*Trimethoprim/ Sulfamethoxazole SS & DS tablets, Oral suspension*	F		
SERAX	*Oxazepam capsules*	F	Ψ	**Limit:** 90 tablets per month
SERENTIL	*Mesoridazine tablets, oral conc., ampules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
SEREVENT DISKUS	*Salmeterol Xinafoate MDI*	F	Ψ	**Limit:** 1 unit/month.
SEROMYCIN	*Cycloserine capsules*	F		
SEROQUEL	*Quetiapine Fumarate tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
SILVADENE	*Silver Sulfadiazine 1% cream*	F		
SINEQUAN	*Doxepin capsules*	F		
SINGULAIR	*Montelukast Sodium Chewable & oral tablets*	F	STE	**STEP Edit:** Prior use of an orally inhaled cortico-steroid on PHC profile within the previous 180 days.
SLOW-K 8 MEQ	*Potassium Chloride ER tabs*	F		
SODIUM CHLORIDE neb.	*NaCl 0.9% Nebulizer soln.*	F		
SODIUM CHLORIDE Irrig.	*NaCl 0.9% Irrigation*	F		
SODIUM CHLORIDE Nasal spray/drops	*NaCl 0.65%, 0.4% Nasal spray/drops*	F		**HK/HF:** OTC, not a covered benefit.
SODIUM SULAMYD	*Sulfacetamide Sodium 30% Ophth. drops*	F		
SODIUM SULFA-CETAMIDE	*Sulfacetamide Sodium 10% opht. drops*			

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SOMA 350mg	*Carisoprodol tablets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: methocarbamol, cyclobenzaprine, baclofen, diazepam, tizanidine.***
SONATA	*Zaleplon capsules*	F	STE	**STEP Edit:** Use of temazepam and zolpidem in the last 90 days.
SPECTAZOLE	*Econazole Nitrate 1% cream*	F		
SPIRIVA	*Tiotropium Bromide capsules w/ inhalation device*	F		
SSKI	*Potassium Iodide Saturated Solution*	F	♥	Potentially eligible for CCS, see ♥ footnote
STARLIX	*Nateglinide tablets*	F		
STELAZINE	*Trifluoperazine tablets, oral conc., vials*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
STIMATE	*Desmopressin Acetate 150mcg Nasal Spray*	**NF**		**See TAR Criteria,** in back of formulary.
STRATTERA	*Atomoxetine HCL 10, 18, 25, 40, 60, 80, 100mg capsules*	F (Adults)	Ψ	**Limits:** Formulary for ages >/= 17 yrs. Ages < 17 see TAR Criteria in back of formulary. Limited to one capsule per day of a single strength; please consolidate dosing to an available strength given once a day.
SUBOXONE	*Buprenorphine/Naloxone tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
SUBUTEX	*Buprenorphine tablets*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
SULAR	*Nisoldipine SR tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
SUMYCIN	*Tetracycline HCL capsules, suspension*	F		
SUPRAX	*Cefixime tablets*	F	©, Ψ	**Code 1:** Treatment of gonorrhea. Limit of 2 tablets.
SUSTIVA	*Efavirenz tablets, capsules*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HF/HK:** Formulary
SUTENT	*Sunitinib Capsules*	F	SP, ♥, Ψ	**Limits:** (1) Limited to dispensing by a specialty pharmacy, other pharmacies require a TAR; (2) Limited to #14/fill (2 week supply) for the first 2 months of treatment. Potentially eligible for CCS, see ♥ footnote

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SYMBICORT	*Budesonide/Formoterol Fumerate HFA*	F	Ψ, STE	**STEP Edit:** Prior use of an orally inhaled corticosteroid on PHC profile within the previous 180 days. Limited to 1 unit per month. If step edit not met, **See TAR Criteria,** in back of formulary.
SYMBYAX	*Olanzapine/Fluoxetine HCL capsules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary
SYMMETREL	*Amantadine capsules*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
SYNALAR	*Fluocinolone .01%, .025% cream, .025% ung, .01% soln.*	F		
SYNTHROID	*Levothyroxine tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
SYPRINE	*Trientine HCL capsules*	**NF**		**See TAR Criteria,** in back of formulary.
TAGAMET	*Cimetidine Rx & OTC tablets, Oral solution*	F		
TAMIFLU	*Oseltamivir Phosphate Tablets: 30, 45 & 75mg Susp: 12mg/ml* Tablets available in unit-of-use packages of 10 tabs; Susp. available in 25ml	F	©, Ψ	**Code 1:** Cases in which current CDC guidelines for *treatment* are met. **Limits:** 5 day treatment supply, one fill per year. Compounded susp – submit compound pricing worksheet with TAR (see Pharmacy Provider Manual). **Compounds**: Submit TAR with completed compound worksheet.
TAPAZOLE	*Methimazole tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
TARCEVA	*Erlotinib tablets*	F	SP, ♥, Ψ	**Limits:** (1) Limited to dispensing by a specialty pharmacy, other pharmacies require a TAR; (2) Limited to #14/fill (2 week supply) for the first 2 months of treatment. Potentially eligible for CCS, see ♥ footnote
TEGRETOL, TEGRETOL XR	*Carbamazepine chewable, IR & XR tablets, suspension.*	F	♥	Potentially eligible for CCS, see ♥ footnote
TEMOVATE	*Clobetasol 0.05% cr, ung, scalp & soln.*	F		*Note that gel is excluded (non-formulary).*
TENEX	*Guanfacine tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
TENORETIC	*Atenolol/Chlorthalidone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote

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TENORMIN	*Atenolol tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
TERAZOL 3	*Terconazole vaginal cream, supp.*	F		
TERAZOL 7	*Terconazole vaginal cream*	F		
TESSALON PERLES	*Benzonatate capsules*	F		
TESTOPEL	*Testosterone implant*	**NF**		**See TAR Criteria,** in back of formulary (listed under "testosterone", not individual brand names).
THEODUR	*Theophylline tablets*	F		
THORAZINE	*Chlorpromazine tablets,capsules, syrup, conc., supp, injection*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
TILADE	*Nedocromil Sodium MDI*	F	Ψ	**Limit:** of 2/month.
TIMOPTIC, TIMOPTIC-XE	*Timolol Maleate ophth. solution, gel forming drops*	F	Ψ	**Limit:** 10ml/month.
TOBRADEX	*Tobramycin Sulfate/Dexameth ophth. soln, ointment*	F		
TOBREX	*Tobramycin Sulfate ophth. soln, ointment*	F		
TOFRANIL	*Imipramine HCl tablets, injection*	F		
TOLINASE	*Tolazamide tablets*	F		
TOPAMAX	*Topiramate Sprinkle Caps: 15, 25mg Tablets: 25, 50, 100, 200mg*	F	♥	Potentially eligible for CCS, see ♥ footnote
TOPROL XL	*Metoprolol Succinate XL tablets*	F	♥	
TRACLEER	*Bosentan*	**NF**		**See TAR Criteria,** in back of formulary.
TRANDATE	*Labetalol 100, 200, 300mg tablets*	F		
TRANXENE	*Clorazepate*	F	Ψ, STE	**STEP Edit:** Use of other BDZ in the last 120 days. **Limit:** 90 per month
TRAVATAN, TRAVATAN-Z	*Travoprost ophth. soln.*	F		
TRI VI FLOR chew tabs, drops	*Vitamins A,D and C/ Sodium Fluoride chewable tablets, drops*	F	Ψ	**Limit:** Ages less than 8 years old.
TRIAVIL	*Amitriptyline/Perphenazine tablets*	F		

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TRICOR	*Fenofibrate nanocrystals tablets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternative = micronized fenofibrate capsules (LOFIBRA).***
TRILIPIX	*Fenofibric Acid (Choline fenofibrate) 45, 135mg capsules*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternative = micronized fenofibrate capsules (LOFIBRA).***
TRIDESILON	*Desonide 0.05% cream, ointment*	F		
TRILAFON	*Perphenazine tablets, oral concentrate, injection*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
TRILEPTAL	*Oxcarbazepine tablets, oral susp.*	F	♥	Potentially eligible for CCS, see ♥ footnote
TRIZIVIR	*Abacavir/Lamivudine/ Zidovudine tablets*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
TRUSOPT	*Dorzolamide HCL 2% o/s*	F		
TRUVADA	*Emtricitabine/Tenofovir tablets*	See notes	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
TYLENOL w/ CODEINE	*Acetaminophen/Codeine No. 2 tablets: 300mg/15mg No. 3 tablets: 300mg/30mg No. 4 tablets: 300mg/60mg Liquid: 12mg codeine, 120mg APAP per 5ml*	F	Ψ	Tylenol 4 (60mg) added to formulary, effective 7/1/11. **Limit:** 240 tablets/month and 480ml/mo of the liquid.
TYLOX	*Oxycodone/Acetaminophen 5/500mg capsule*	F		
ULORIC	*Febuxostat tablets*	**NF**		**See TAR Criteria,** in back of formulary.
ULTRAM	*Tramadol HCL 50mg tablets*	F	Ψ	**Limit:** 240 per month, immediate release tabs only.
URECHOLINE	*Bethanechol tablets, injection*	F		
URSO, URSO FORTE	*Ursodiol 250 & 500mg tablets*	**NF**		***Formulary alternative = generic Actigall (ursodiol 300mg caps)***
VAGIFEM	*Estradiol 10 & 25mcg vaginal tablets*	F		
VALISONE	*Betamethasone Valerate 0.1% cr., ung, lotion*	F		
VALIUM	*Diazepam tablets, injection*	F	Ψ	**Limit:** 90 tabs/month, 3 per day.
VALTREX	*Valacyclovir HCL tablets*	**NF**		*Formulary alternative: acyclovir*

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VANCOCIN, ORAL	*Vancomycin HCL capsules*	**NF**		**See TAR Criteria,** in back of formulary. Indicated for C. diff. only, not for systemic infections. ***Formulary alternative: metronidazole.***
VANOS	*Fluocinonide 0.1% cream*	**NF**		***Formulary alternative: clobetasol, fluocinonide 0.05%***
VANTIN	*Cefpodoxime Proxetil 200mg tablets*	F	Ψ	**Limit:** 2 tablets per fill.
VASOTEC	*Enalapril tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
VENTOLIN	*Albuterol Syrup 2mg/5ml*	F		
VENTOLIN HFA	*Albuterol HFA MDI*	F	Ψ	**Limit:** 2 per month. Formulary is limited to Glaxo brand Ventolin HFA; Proventil HFA & ProAir are non-formulary.
VERMOX	*Mebendazole chewable*	F		
VESANOID	*Tretinoin capsules*	F	SP, ♥	Note: Indicated induction of APL remission. Potentially eligible for CCS, see ♥ footnote
VEXOL O/S	*Rimexolone ophth. susp.*	F		
VIBRAMYCIN, VIBRATABS	*Doxycycline Hyclate 50 & 100mg capsules, 100mg tablets, injection*	F		
VICODIN	*Hydrocodone/APAP 5/500mg tablets*	F	Ψ	**Limit:** 240/month, 8/day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
VICODIN ES	*Hydrocodone/APAP 7.5/750mg tablets*	F	Ψ	**Limit:** 120/month, 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
VICODIN HP	*Hydrocodone/APAP 10/660mg tablets*	F	Ψ	**Limit:** 120/month, 4 per day. **See TAR Criteria,** in back of formulary, for claims exceeding formulary limit.
VICTOZA	*Liraglutide injection*	**NF**		**See PA Criteria,** in back of formulary
VIDEX	*Didanosine Powder for Oral Suspension: 2g/120ml, for preparation of 10mg/ml admixture*	F	#	Formulary on HK/HF & PHC/MC (an exception to the usual carve-out rule for anti-retrovirals).
VIDEX EC	*Didanosine DR capsules w/enteric-coated beadlets: 125, 200, 250 & 400mg*	F	#	Formulary on HK/HF & PHC/MC (an exception to the usual carve-out rule for anti-retrovirals).
VIGAMOX	*Moxifloxacin ophth. drops*	F		
VIRACEPT	*Nelfinavir Mesylate tablets, powder*	F	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
VIRAMUNE	*Nevirapine tablets, suspension*	F	✔	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary

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VIREAD	*Tenofovir Disoproxil Fumarate tablets*	F	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
VIROPTIC	*Trifluridine 1% o/soln*	F		
VISTARIL	*Hydroxyzine Pamoate capsules and Hydroxyzine HCL injection*	F		
VITAMIN D-2	*Ergocalciferol 50,000 unit capsules*	F	Ψ	**Limit:** 4 per month, once weekly dosing.
VITAMIN E	*Vitamin E capsules*	F	©	**Code 1:** Restricted to the treatment of tardive dyskinesia.
VIVACTIL	*Protriptyline HCL tablets*	F		
VIVELLE -DOT	*Estradiol TDS/Patch*	F		
VIVITROL	*Naltrexone Microspheres*	See notes	♠	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary
VOLTAREN tablets	*Diclofenac Sodium 50mg, 75mg tablets, 0.1% ophth. soln.*	F		
VOSOL	*Acetic acid otic soln.*	F		
VOSPIRE ER	*Albuterol Sulfate ER tablets*	F		
VYTORIN	*Ezetimibe/Simvastatin tablets*	**NF**		**See TAR Criteria,** in back of formulary.
VYVANSE	*Lisdexamfetamine Dimesylate capsules*	**NF**		**See TAR Criteria,** in back of formulary.
WELLBUTRIN (TID formula)	*Bupropion HCL 75 & 100mg immediate release*	F	Ψ	**Limit:** 3/day.
WELLBUTRIN SR (BID formula)	*Bupropion HCL SR 100, 150 & 200mg sustained release tablets (12 hr)*	F	Ψ	**Limit:** 2/day.
WELLBUTRIN XL (QD formula)	*Bupropion HCL XL 150 & 300mg extended release tablets (24 hr)*	**NF**		***Formulary alternatives: bupropion, bupropion SR***
WIGRAINE	*Ergotamine tartrate/Caffeine tablets, suppositories*	F		
XALATAN	*Latanoprost ophth. soln.*	F		
XANAX	*Alprazolam tablets*	F	Ψ	**Limit:** 3 tabs/day & 90 tabs/mo.
XELODA	*Capecitabine tablets: 150, 500mg*	F	SP, ♥, #	TAR needed when claim exceeds plan $ limits or dispensing by pharmacy other than contracted specialty pharmacy. Potentially eligible for CCS, see ♥ footnote

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XENICAL, ALLI	*Orlistat* *Rx: 120mg capsules* *OTC: 60mg capsules*	**NF**		**See TAR Criteria,** in back of formulary. Recommendation: Submit TAR for Alli 60mg TID as initial trial, to assess effectiveness & tolerability before trying the higher strength. Note: If 120mg is required, it is less expensive to use 2 capsules of Alli than 1 capsule of Xenical.
XIBROM	*Bromfenac Sodium* *ophth drops*	F		
XOPENEX HFA & Soln.	*Levalbuterol neb & MDI*	**NF**		**See TAR Criteria,** in back of formulary.
XYLOCAINE oral	*Lidocaine Viscous Soln: 2%*	F		
XYLOCAINE topical	*Lidocaine* *Topical Jel: 2%* *Topical Ointment: 5%*	F		
XYZAL	*Levocetirizine* *tablets, oral soln.*	**NF**		***Formulary alternatives: cetirizine (Zyrtec), loratadine (Claritin), fexofenadine (Allegra, Step required), and 1st generation antihistamines (Benadryl, Atarax)***
ZADITOR-OTC	*Ketotifen ophth. soln.*	F		
ZANAFLEX Tablets	*Tizanidine* *2 & 4mg tablets*	F	Ψ	**Limit:** Tablet dosage form only on formulary, in doses not to exceed 36mg/day.
ZANTAC	*Ranitidine HCL* *Rx & OTC tablets,syrup*	F		
ZARONTIN	*Ethosuximide* *capsules, syrup*	F	♥	Potentially eligible for CCS, see ♥ footnote
ZAROXOLYN	*Metolazone tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
ZEGERID	*Omeprazole / Sod. Bicarb.* *capsules & powder packets*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives: Omeprazole 10 & 20mg (either Rx or OTC, whole pills or compounded into suspension), Lansoprazole 15mg 24h (OTC only), Ranitidine Syrup.***
ZENPEP	*Lipase/Protease/Amylase*	F	♥	TAR needed for claims >$500 Potentially eligible for CCS, see ♥ footnote
ZERIT	*Stavudine* *capsules, solution*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
ZESTRIL	*Lisinopril tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote
ZETIA	*Ezetimibe tablets*	F	STE	**STEP Edit:** Prior use of formulary statin, atorvastatin, Zetia or Vytorin in the last 120 days.
ZIAC	*Bisoprolol/HCTZ tablets*	F	♥	Potentially eligible for CCS, see ♥ footnote

F = Formulary
NF = Non-Formulary
STE = Step Therapy Edit required, see notes
Ψ = Qty, Duration or Age limit applies
SP = TAR required for dispensing by pharmacies other than contract specialty pharmacy(ies).

\# = Exempt from $500 limit on MC
© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

♥ = Drug is in a therapeutic class used to treat a CCS eligible condition. Because CCS is carved out for HK, HF, MC Sonoma & MC Mendocino, a TAR is required for PHC determination of CCS eligibility & referral (members age 0-20).

ZIAGEN	*Abacavir Sulfate tablets, soln.*	See notes	✓	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Formulary
ZITHROMAX	*Azithromycin tablets, suspension, powder packet*	F	Ψ	**Limits:** 250mg tab 6/Rx 500mg tab 3/Rx 600mg tab 8/Rx
ZOCOR	*Simvastatin tablets*	F		
ZOFRAN	*Ondansetron HCL tablets & ODT*	F	©, Ψ, ♥	**Code 1:** Treatment of N/V caused by cancer chemotherapy or radiation. **Limit:** 30 per month. Submit TAR if additional dosing is required. Potentially eligible for CCS, see ♥ footnote
ZOLOFT	*Sertraline tablets, oral conc.*	F	Ψ	Limit: For 25mg dose use ½ of 50mg tab; for 50mg dose, use ½ of 100mg tab. (50mg dose limits removed on 50 & 100mg, effective 4/1/11).
ZOMIG	*Zolmitriptan tablets, nasal spray*	**NF**		**See TAR Criteria,** in back of formulary.
ZONEGRAN	*Zonisamide capsules*	F	♥	
ZOVIRAX	*Acyclovir tabs, caps, susp*	F	#	
ZYBAN	*Bupropion HCL SR tablets*	F	Ψ	**Limit:** 180 tablets within a 1 year period. *Use this product only if indication is smoking cessation. For all other indications, use generic Wellbutrin SR.*
ZYFLO ZYFLO CR	*Zileuton tablets (IR & ER)*	**NF**		**See TAR Criteria,** in back of formulary.
ZYLOPRIM	*Allopurinol tablets*	F		
ZYPREXA, ZYDIS (ODT)	*Olanzapine tablets & ODT*	See notes	♠, #	**MC:** "Carve-Out" –submit TAR &/or claim to STATE Medi-Cal. **HK/HF:** Non-formulary, see TAR Criteria in back of formulary.
ZYRTEC OTC	*Cetirizine HCL oral & chewable tablets, oral solution*	F	Ψ	**Limits: Syrup only --** (1) Ages 5 and under; (2) 300ml per month. No restriction on tabs/chews.

F = Formulary
NF = Non-Formulary
STE = Step Therapy Edit required, see notes
Ψ = Qty, Duration or Age limit applies
SP = TAR required for dispensing by pharmacies other than contract specialty pharmacy(ies).

= Exempt from $500 limit on MC
© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

♥ = Drug is in a therapeutic class used to treat a CCS eligible condition. Because CCS is carved out for HK, HF, MC Sonoma & MC Mendocino, a TAR is required for PHC determination of CCS eligibility & referral (members age 0-20).

ZYVOX	*Linezolid oral tablets, suspension. injection*	**NF**		**See TAR Criteria,** in back of formulary. ***Formulary alternatives, depending on diagnosis/c&s: clindamycin, vancomycin, Bactrim DS, tetracyclines, cefazolin, daptomycin, fluoroquinolones, rifampin (usually as adjunct).*** *Reference: "Clinical Practice Guidelines by the Infectious Diseases Society of America for the Treatment of MRSA infections in Adults & Children",* Clin Infect Dis. (2011) doi: 10.1093/cid/ciq146 First published online: January 4, 2011

F = Formulary
NF = Non-Formulary
STE = Step Therapy Edit required, see notes
Ψ = Qty, Duration or Age limit applies
SP = TAR required for dispensing by pharmacies other than contract specialty pharmacy(ies).

\# = Exempt from $500 limit on MC
© = Code 1 requirement
✓ = HIV/AIDS Carve Out Drug, bill to State
♠ = Psychotherapeutic Carve Out Drug, submit claim &/or TAR to State.

♥ = Drug is in a therapeutic class used to treat a CCS eligible condition. Because CCS is carved out for HK, HF, MC Sonoma & MC Mendocino, a TAR is required for PHC determination of CCS eligibility & referral (members age 0-20).

OVER-THE-COUNTER DRUG FORMULARY
MEDI-CAL & EXCLUDED DRUG COVERAGE FOR PART D ONLY

Over-the-counter (OTC) drugs are included in the per-diem rate for recipients in nursing facilities, including subacute patients. Except for insulin, providers cannot separately bill any OTC drugs for recipients in these facilities.

OTC Medications are not a covered benefit for members under PHC's commercial lines of business (Healthy Kids, Healthy Families), unless an exception is notated. The following medications are exceptions and are covered for PHC's commercial line of business:

- Cetirizine (ZYRTEC OTC)
- Insulin
- Ketotifen OTC (ZADITOR)
- Loratadine tablets and liquid (CLARITIN, ALAVERT)
- Nicotine Patches (NICODERM)
- Omeprazole 20mg ER tablets (PRILOSEC OTC)
- Lansoprazole 15mg ER capsules (PREVACID 24H OTC)

♦	=	Covered benefit for Commercial Lines of Business (Healthy Kids, Healthy Families)
Ψ	=	Quantity, Duration or Age Limit

As with the Rx formulary, generic substitution is preferred when a generic NDC is available. Many formulary OTC's have a "MAC" price (maximum allowable cost), and reimbursement will be at the MAC rate, regardless of brand dispensed. Note: Private label (aka House Brand, Store Brand) NDC's are often not in MedImpact's data base, and if not, claims will not process even with a TAR. Using a nationally recognized generic source (Major, GNP, Qualitest, etc) will help minimize delays in processing. As an alternative, pharmacies can contact MedImpact directly to request an NDC addition, but the process takes a few days.

The following products are payable without prior authorization (TAR) when a prescription has been provided to the pharmacy. Generic substitution may be required in some cases to ensure adequate reimbursement.

ANALGESICS

ACETAMINOPHEN (TYLENOL)
- **Junior strength tablets (160mg chewable)**
- **Liquid 160mg/5ml**
- **Drops 80mg/0.8ml dropper**
- **Suppositories 80mg, 120mg, 325mg, 650mg**
- **500mg, 325mg tablets or caplets**
- **650mg SA tablets**

ASPIRIN:
- **Lo-dose (81mg)**
- **Suppositories**
- **Tablets, regular & enteric coated**
- **Tablets, Buffered**

IBUPROFEN (MOTRIN, PEDIAPROFEN)
- **Liquid 100mg/5ml**
- **Tablets 50, 100 & 200mg**
- **Drops 50mg/1.25ml**

ANTACIDS/ANTIFLATULENTS

Note: Formulations with simethicone also are covered.

ALTERNAGEL
- **Liquid**
- **Tablets**

ALUDROX
- **Liquid**
- **Tablets**

AMPHOJEL
- **Liquid**
- **Tablets**

BASALJEL
- **Liquid**
- **Tablets**

GAS-X
- **125MG Capsules, 80 & 125mg chewables**

GAVISCON
- **Liquid**
- **Tablets**

GELUSIL
- **Liquid**
- **Tablets**

MAALOX
- **Liquid**
- **Tablets**

MILK OF MAGNESIA
- **Liquid Tablets**

MYLANTA
- **Liquid (Regular and Maximum strength)**
- **Tablets (Ultra and DS)**

MYLICON
- **Liquid and drops**
- **Tablets**

RIOPAN
- **Liquid**
- **Tablets**

SODIUM BICARBONATE
- **Tablets**

OVER-THE-COUNTER DRUG FORMULARY
MEDI-CAL & EXCLUDED DRUG COVERAGE FOR PART D ONLY

ANTIDIARRHEALS/ANTIEMETICS

EMETROL
- Liquid

IMODIUM AD
- Liquid
- Tablets

KAOPECTATE
- Liquid
- Tablets

PEPTO BISMOL
- Liquid
- Tablets

ANTIHISTAMINES

ALAVERT (Loratadine) ♦Ψ
- Tablets

Ψ***Limit: Limited to a maximum of 1 tablet per day dosing.***

BENADRYL (diphenhydramine)
- 25mg, 50mg caps
- Liquid

CHLOR-TRIMETRON (Chlorpheniramine)
- 4mg, 8mg, 12mg tabs/caps
- Liquid

CLARITIN (Loratadine) ♦Ψ
- Syrup
- Tablets

Ψ***Limit: Tablets limited to a maximum of 1 tablet per day dosing.***

TAVIST (Clemastine)
- Liquid
- Tablets

ZYRTEC OTC (Cetirizine) ♦Ψ
- Syrup
- Tablets

Ψ***Limit: Syrup limited to ages <6 years.***

CONTRACEPTIVE ITEMS

Condoms (Male and Female)
Creams, foams, jelly
Suppositories

COUGH AND COLD

Saline nasal spray/drops

<u>Guaifenesin, dextromethorphan products:</u> Non-formulary for ages ≤ 3. Generally covered for ages ≥ 4.

<u>Pseudoephedrine:</u> 30 and 60mg immediate release tablets only on formulary. Non-formulary for ages ≤ 3.

DIABETIC SUPPLIES*

see MEDICAL SUPPLIES / DME

*** Not covered for Members with a Part D plan other than Partnership*Advantage*, due to other primary Part B/D eligibility.**

G/I AGENTS

PEPCID AC, PEPCID MAX – 10 & 20mg tablets

PRILOSEC – OTC 20mg DR tablets ♦

PREVACID 24H – OTC 15mg ER capsules ♦

ZANTAC – 150 & 75mg tablets

♦HABIT ABATEMENT

NICODERM, NICOTROL ♦Ψ
- 7mg, 14mg, 21mg Patch

Ψ***Limit: Limited to a maximum of 180 patches within a 1 year period.***

NICORETTE GUM ♦Ψ
- Chewing Gum

Ψ***Limit: Limited to a maximum of 180 pieces within a 1 year period.***

♦INSULIN

All types ♦

Ψ ***Limit: 4 vials per month or 5 pen cartridges without a TAR***

LAXATIVES, STOOL SOFTENERS

CITRATE OF MAGNESIA
- Liquid

COLACE
- Liquid
- Tablets

♦	=	Covered benefit for Commercial Lines of Business (Healthy Kids, Healthy Families)
Ψ	=	Quantity, Duration or Age Limit

LAXATIVES, STOOL SOFTENERS, continued

DOXIDAN
- Tablets

DULCOLAX
- Suppositories
- Tablets

FLEETS DISPOSABLE ENEMA

METAMUCIL (Psyllium)
- Powder (Bulk Only)

MIRALAX OTC – 14 Day

GLYCERIN
- Suppositories

PERI-COLACE
- Liquid
- Tablets

SENOKOT
- Liquid
- Tablets

SURFAK
- Capsules

OPHTHALMICS/OTICS/NASAL

DEBROX OTIC
- Drops

LACRI LUBE, PURALUBE
- Ointment

NAPHCON
- Drops

NAPHCON A, OPCON A
- Drops

SODIUM CHLORIDE NASAL
- Drops
- Mist
- Spray

TEARS NATURALE Reg & Forte
- Drops

ZADITOR-OTC ♦
- Drops

TOPICALS

BACITRACIN
- Ointment

CALAMINE
- Lotion

CETAPHIL MOISTURIZER
- Lotion

DOMEBORO
- Tablets
- Powder packets

EUCERIN ORIGINAL
- Cream: 2oz tube, 4oz jar
- Lotion: Brand dc'd by mfg, generic available as "Dry Skin Moisturizing Lotion", by Major

HYDROCORTISONE 0.5% and 1%
- Cream
- Lotion

LAMISIL AT
- Cream
- Solution

LOTRIMIN AF
- Topical Cream
- Topical Lotion
- Topical Solution

MICATIN
- Cream
- Powder
- Spray

NEOSPORIN
- Ointment

NIX CREAM RINSE Ψ

ΨLimit: Limited to a max of 60 mls/ 90 days.

POLYSPORIN Ointment

RID SHAMPOO

SUNSCREEN / SUNBLOCK ©
- Lotion

©Code 1: Restricted to use by members on maintenance photo sensitive drugs or members with a history of skin cancer. Limit one Rx per month, maximum $8 per container.

TINACTIN
- Cream
- Powder
- Spray

WART REMOVER (17% SALICYLIC ACID)
- Liquid

VAGINAL ANTI-INECTIVES

GYNE-LOTRIMIN (Clotrimazole)
- Combo pack: 100mg/1%
- Tablets: 100mg
- Cream: 1%

GYNE-LOTRIMIN 3 (Clotrimazole)
- Tablets: 200mg

MONISTAT 1 (Tioconazole)
- Cream/appl.

MONISTAT 1 (Miconazole)
- Combo pack: 1200mg /2%cr

MONISTAT 3 (Miconazole)
- Combo pack: 200mg/2%cr
- Suppositories 200mg
- Cream 4%

♦	=	Covered benefit for Commercial Lines of Business (Healthy Kids, Healthy Families)
Ψ	=	Quantity, Duration or Age Limit

VAGINAL ANTI-INECTIVES, continued

MONISTAT 7 (Miconazole)
- Cream 2%
- Suppositories 100mg

VAGISTAT 1 (Tioconazole)
- Tablets

VITAMINS & MINERALS

ALUMINUM HYDROXIDE (ALUCAPS)
- Capsules

CALCIUM SUPPLEMENTS
- Calcium carbonate 500mg, 600mg (CALTRATE, OS-CAL, TUMS, OYSTER SHELL)
- Calcium citrate 950mg (CITRICAL)
- Calcium gluconate 500mg
- Calcium lactate 10gr/650mg
- Calcium w/vitamin D 500/200mg (OS-CAL + D)

FERROUS GLUCONATE
- Tablets and liquid

FERROUS SULFATE
- Tablets, liquid and drops

MAGNESIUM OXIDE (MAG-OX) 400mg
- Tablets

NEUTRO-PHOS, NEUTRO-PHOS K
- Capsules
- Powder

NIACIN
- Tablets and capsules
- Immediate & slow-release

POLY VI SOL (MULTI-VITE), with or without iron) Ψ
-- Limited to ages under 8 yrs. Tablets DC'd by mfg; may substitute other children's multivite/mineral. Submit TAR for NDC's that won't adjudicate as paid.
- Chewable tablets
- Drops

PYRIDOXINE (VIT B-6)
- Tablets

PRENATAL VITAMINS (Non-prescription) ©
- Tablets or capsules ***©Code 1: Restricted to women who are pregnant or lactating.***

TRI VI SOL (A,D,C), with or without iron Ψ
- Chewable tablets
- Drops

ΨLimit: Limited to use in children under 8 years old.

VITAMIN D-3 (Cholecalciferol)
- Tablets: 200, 400, 1000 iu
- Soft Gels: 2000 iu
- Chewable: 400iu
- Drops: 400 iu/ml
- Liquid: 5000 iu/ml

VITAMIN E ©
- Capsules

©Code 1: Restricted for treatment of tardive dyskinesia.

MISCELLANEOUS

DERIFIL (CHLOROPHYLL DERIVATIVE)
- Tablets

ELECTROLYTE REPLACEMENT (PEDIALYTE)
- Liquid

GLUCOSE
- Chewable tablets
- Gels
- Tablets

MECLIZINE
- Tablets
- Chewable

OCEAN NASAL SPRAY

SALIVA SUBSTITUTE
- Solution

♦	=	Covered benefit for Commercial Lines of Business (Healthy Kids, Healthy Families)
Ψ	=	Quantity, Duration or Age Limit

MEDICAL SUPPLIES / DURABLE MEDICAL EQUIPMENT (DME) (MEDI-CAL ONLY)

Pharmacy claims for medical supply and DME prescriptions not listed below will require an approved TAR for payment. Formulary medical supply and DME items and non-formulary products approved by TAR (excluding incontinence supplies, disposable gloves, and ostomy supplies) with a National Drug Code (NDC) number must be billed to PHC's Pharmacy Benefit Manager (PBM). Items without an NDC number, all incontinence supplies, disposable gloves, and ostomy supplies, must be billed directly to the PHC Claims Department.

If a member has Medicare Part B, the provider must bill Medicare as the primary insurer for Part B covered medical supply and DME items.

Medical Supplies are not covered under Healthy Kids, except when marked with a ♦.

COVERED MEDICAL SUPPLY / DME ITEMS

DIABETIC SUPPLIES

- **Blood Glucose Test Strips ♦Ψ**
  Formulary limited to: TrueTrack and limited to a maximum of 100 per 25 days for patients on insulin, 50 per 25 days for those not on insulin.
- **Blood Glucose Monitors ♦Ψ**
  Formulary limited to: TrueTrack
- **Lancets ♦Ψ**
  Limited to a Maximum of 100 per 25 days for patients on insulin, #50/25d for those not on insulin.
- **Lancet Auto Injectors**
- **Novopen Injectors**
- **Urine Test Strips**
  -Diastix - Clinistix
  -Ketostix - Ketodiastix
- **Insulin Syringes –** *Part D eligible item*

OTHER

- **Bandages (non-medicated)**
  Gauze, Pad, Sponge type
- **Bedwetting Alarm ♦Ψ**
  Limited to members age 7 and older.
- **Blood pressure monitoring devices/cuffs ©Ψ**
  Code 1 for HTN. Claim limit: $55 or less. Submit TAR for NDCs < $55 but excluded per POS response.
- **Diaphragms**
- **Injection supplies other than Insulin syringes**
  Disposable Syringes ♦
  Disposable Needles ♦
  Disposable Syringe w/ Needle ♦
- **Eye Patches**
- **Inhaler Assist Devices ("Spacers") Ψ**
  Limited to $20 reimbursement per spacer
- **Peak Flow Meters**
- **Pill Cutters ♦Ψ**
  Formulary Limit: 1 every 180 days
- **Humidifiers, Vaporizers**

♦	=	Covered benefit for Commercial Lines of Business (Healthy Kids, Healthy Families)
Ψ	=	Quantity, Duration or Age Limit

OSTOMY SUPPLIES:
All ostomy supplies must be billed to the PHC Claims Department. A TAR is required if monthly cumulative cost for all related supplies exceeds $150.00.

INCONTINENCE SUPPLIES:
All incontinence supplies must be billed to the PHC Claims Department. A TAR is required if monthly cumulative cost for all related supplies exceeds $50.00. Washes and creams will only be authorized if the physician indicates medical necessity such as skin breakdown.

DISPOSABLE GLOVES:
All disposable gloves must be billed to the PHC claims department. Maximum dispensing is 100 gloves per month.

NUTRITIONAL SUPPLEMENTS (Ensure, Glucerna, Boost, Proteinex, *etc.*)
A TAR is required for all nutritional supplements to be used on an out-patient basis. All requests must be accompanied by a completed Nutritional Supplement form documenting medical necessity. Supplements for members currently in an acute care hospital or LTC/ICF facility are included in the per diem rate or capitation paid to the facility, thus are not eligible for TAR consideration.

INJECTABLE DRUG FORMULARY*
(MEDI-CAL ONLY)

The following drugs (in the original container) are covered when dispensed by a pharmacy, home infusion company, when administered in a physician's office, licensed clinic, hospital outpatient facility or a licensed Long Term Care (LTC) facility and do not require an approved TAR for payment*. **As this is not a complete listing of all injectable drugs that may be a covered benefit when administered in a physician's office, clinic or outpatient facility, please contact the PHC Claims Department with the appropriate billing code for formulary status of drugs not listed here.** IV infusion compound claims may be billed directly to PHC claims (hand bill) or billed electronically via MedImpact. TAR & compound worksheet required for electronic claims > $50. Pharmacy claims for drugs dispensed in the original container should be billed on-line to PHC's Pharmacy Benefit Manager.

Inclusive Categories:

Injectables included in the following therapeutic categories generally can be billed without a TAR (may be subject to limitations such as specialty pharmacy, $ limits, dx limits, or carve-out status for MC or CCS): Adrenocorticosteroids, Anti-infectives, Cancer chemotherapeutics, Local anesthetics, and Narcotic analgesics.

Specific Drugs:

Acetazolamide (Diamox)
Alteplase (Cathflo Activase – 2mg)
Aminophyllin
Amphotericin B (Fungizone)
Atracurium (Tracrium)
Atropine sulfate
Aurothioglucose (Solganal)
Benztropine mesylate (Cogentin) ♠
Bumetanide (Bumex)
Buprenorphine
Calcitonin-Salmon (Calcimar)
Calcitriol (Calcijex)
Chlordiazepoxide (Librax)
Chlorpromazine (Thorazine) ♠
Cyanocobalamin (Vit. B-12)
Cytovene (Ganciclovir DHPG)
Deferoxamine mesylate (Desferal)
Diazepam (Valium)
Dicyclomine (Bentyl)
Digoxin (Lanoxin)
Dihydroergotamine mesylate (DHE 45)
Diphenhydramine (Benadryl)
Dobutamine (Dobutrex)
Dopamine (Intropin)
Doxapram (Dopram)
Droperidol (Inapsine)
Edrophonium chloride (Tensilon)
Enoxaparin (Lovenox) #, Ψ *Limit of 20 syringes maximum per fill and maximum of 2 fills per year.*
Ephedrine sulfate
Epinephrine (Adrenalin Chloride, Susphrine)
Epinephrine (Epi-Pen, Ana-Kit)
Estradiol Cypionate in Oil (Depo-Estradiol)
Flumazenil (Romazicon)
Fluphenazine (Prolixin) ♠
Folic acid (Folvite)
Fondaparinux (Arixtra) *Limit of 10 doses/10 days per fill and maximum of 2 fills per year.*
Furosemide (Lasix)
Glucagon Emergency Kit
Glycopyrrolate (Robinul)
Goserelin acetate (Zoladex)
Haloperidol (Haldol) ♠
Heparin
Heparin flush
Hydralazine (Apresoline)
Hydroxyzine (Vistaril)
Insulin (All forms) Ψ
Ketamine (Ketalar)
Ketorolac (Toradol)
Leucovorin calcium (Wellcovorin)
Levonorgestrel (Norplant System)
Lidocaine (Xylocaine)
Lorazepam (Ativan)
M.V.I.
Magnesium sulfate
Mannitol
Medroxyprogesterone acetate (Depo-Provera)
Medroxyprogesterone/Estradiol Cypionate (Lunelle)
Methohexital (Brevital)
Methotrexate
Methylergonovine maleate (Methergine)
Metoclopramide (Reglan)
Midazolam (Versed)
Narcan (Naloxone)
Neostigmine (Prostigmin)
Oxytocin (Pitocin)
Pamidronate (Aredia)
Phenobarbital
Phenylephrine (Neo-Synephrine)
Phenytoin (Dilantin)
Physostigmine Salicylate (Antilirium)
Phytonadione (Vit. K, Aqua-Mephyton)
Porfimer Sodium (Photofrin) Prochlorperazine (Compazine)
Promethazine (Phenergan)
Propofol (Diprivan)
Propranolol (Inderal) Protamine sulfate
Rocuronium (Zemuron)
Sodium Chloride Sodium hyaluronate (Ophthalmic, Healon)

**Formulary items may be subject to online billing limitations (QL, $, Age, Code 1, duration, B vs D, specialty pharmacy dispensing requirement, carve-out status, etc). Submit TAR if unable to process online.*

INJECTABLE DRUG FORMULARY
(MEDI-CAL ONLY)

Succinylcholine chloride (Quelicin)
Sumatriptan Succinate (Imitrex) Ψ *Limit of 4/mo.*
Terbutaline (Brethine)
Thiopental sodium (Pentothal)
Tubocurarine chloride
Urokinase (Abbokinase)
Vasopressin (Pitressin)
Vecuronium (Norcuron)
Verapamil
Ziprasidone Mesylate (Geodon) ♠
Water for Injection

Covered Biologicals
Diphtheria/Pertussis/Tetanus Toxoid
Diphtheria/Tetanus Toxoid
Diphtheria Toxoid
Haemophilus b / Hepatitis b (Comvax)
Hepatitis A vaccine (Havrix)
Hepatitis A & B (Twinrix) Vaccine
Hepatitis B Immune Globulin (HBIG)
Hepatitis B vaccine (Engerix-B/Recombivax)
Influenza vaccine
Measles/Mumps/Rubella vaccine
Measles/Rubella vaccine
Measles (Rubella) vaccine
Meningococcal Polysaccharide Vaccine (Menomune)
Mumps vaccine
Pediatrix (Dip, Tet, Pertussis, Hep B, Polio)
Pneumococcal vaccine (PNU–Immune, Pneumovax 23 Prevnar)
Poliomyelitis vaccine
Rabies vaccine
Rho Immune Globulin (RhoGAM)
Rubella vaccine
Rubella/Mumps vaccine
Staphylococcus Toxoid
Tetanus Toxoid
Tetanus/Diphtheria/Pertussis
Tuberculin PPD
Typhoid vaccine
Varicella vaccine
Zoster vaccine, live (Zostavax) *Limit: age >60*
Zoster vaccine live (Zostavax) Ψ age >60

♠ = **Psychotherapeutic Carve-out drug**
Ψ = **Quantity, Duration or Age Limit**
= **$500 TAR exemption**

RESTRICTED INJECTABLE DRUGS:

The following injectable drugs are only covered when the listed restriction has been met; otherwise, a TAR must be submitted to PHC.

DRUG	RESTRICTION
Epoetin Alfa (Aranesp, Epogen, Procrit)	Supplied & administered in a Dialysis Center.
Glucagon	Supplied & administered in a physician's office or outpatient facility.
Human Papilloma Virus Quadrivalent (Gardasil)	Supplied & administered in a physician's office. PHC benefit age 19-26. Ages 9-18 supplied by Vaccines For Children program.
Ondansetron(Zofran)	Supplied & administered in a physician's office or outpatient facility in conjunction with chemotherapy.

NON-FORMULARY (TAR REQUIRED):

The following list of drugs, the above listed Restricted Injectable Drugs, as well as other injectable drugs not listed under Covered Injectable Drugs, require an approved TAR in order for payment to be made.

Adalimumab (Humira)
Etanercept (Enbrel)
Glatiramer (Copaxone)
Granisetron (Kytril)
Human Growth Hormone
Immune Globulin IM (Gammar)
Immune Globulin IV (IGIV)
Infliximab (Remicade)
Interferon Alpha 1B (Intron A)
Interferon Alpha 2A (Roferon A)
Interferon Alpha 2B+Ribavairin (Rebetron)
Interferon Beta 1A (Avonex, Rebif)
Interferon Beta 1B (Betaseron)
Leflunomide (Arava)
Leuprolide acetate (Lupron, Lupron Depot)
Omalizumab (Xolair)
Palivizumab (Synagis)
Peginterferon Alfa-2A (Pegasys)
Peginterferon Alfa-2B (Peg-Intron)
Repository Corticotropin (Acthar)
RSV-IGIV (RespiGam)
Somatropin (Serostim)
Varicella zoster immune globulin (VZIG)

MEDICATION CLASS

COMPARISON TABLES

NOTE: Inclusion in the Cost Comparison Tables does not indicate an item is a formulary agent. Formulary status & restrictions are indicated in each table for the Medi-Cal, Healthy Kids & Healthy Families lines of business. For a listing of Partnership*Advantage* formulary agents, please refer to www.partnershiphp.org.

PHC
COMMON ANTIDEPRESSANT AGENTS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL STARTING DOSE	COST/ MONTH †	USUAL MAXIMUM DAILY DOSE	COST/ MONTH †
TRICYCLICS (TCAs)						
Nortriptyline	Pamelor	F	10mg – 25mg QHS	$5	150mg	$10
Amitriptyline	Elavil	F	25mg – 50mg QHS	$5	300mg	$10
Doxepin	Sinequan	F	25mg – 50mg QHS	$5	300mg	$30
Desipramine	Norpramin	F	25mg – 50mg QHS	$30	300mg	$18
Imipramine	Tofranil	F	25mg – 50mg QHS	$40	300mg	$180
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)						
Fluoxetine	Prozac	Limited to 10 & 20mg	20mg QAM	$5	80mg	$10
Citalopram	Celexa	F	20mg QD	$5	60mg	$10
Paroxetine	Paxil	F	20mg QD	$10(1)	60mg	$10
Escitalopram	Lexapro	NF	10mg QD	$55(1)	20mg	$110
Fluvoxamine	Luvox	F	50mg HS	$20	300mg	$65
Sertraline	Zoloft	QL	50mg QD	$10(1)	200mg	$45
Paroxetine CR	Paxil CR	NF	25mg QAM	$70	62.5mg	$145
SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)						
Venlafaxine SR	Effexor-XR	STE	75mg QD	$85	225mg given as 75mg 3/d	$250
					225mg given as 150mg+75mg	$195
Venlafaxine	Effexor	STE	37.5mg BID	$75	375mg	$170
Duloxetine	Cymbalta	NF	20mg BID	$290	60mg	$170
OTHERS						
Trazodone	Desyrel	F	50mg QHS	$5	600mg	$20
Mirtazapine	Remeron	F	15mg QHS	$10	45mg	$15
Nefazodone	Serzone	NF	50mg - 100mg BID	$25	600mg	$35
Bupropion	Wellbutrin	F	75mg TID	$15	400mg	$30
Bupropion SR	Wellbutrin-SR	F	100mg BID	$42	400mg	$110
Bupropion	Wellbutrin XL	NF	150mg	$100	300mg	$35

*F=Formulary; NF=Non-Formulary; QL= Quantity Limit; STE=Step Therapy Edit: Claim for fluoxetine, paroxetine, sertraline or citalopram with the last 120 days with PHC. †=Cost based on AWP for single-source brands & MAC for generics as of January 2011, rounded to the nearest $5. (1)=Based on ½ tablet therapy.

PHC
COMMON ANTIHISTAMINE AGENTS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL STARTING DOSE	SEDATIVE EFFECTS†	COST PER MONTH††
ORAL ANTIHISTAMINES					
Chlorpheniramine	Chlor-Trimeton	F	4mg Q6H	+	$5
Diphenhydramine	Benadryl	F	25mg Q6H	+++	$5
Clemastine	Tavist	F	1.34mg Q12H	++	$10
Cyproheptadine	Periactin	F	4mg Q8H	+	$20
Cetirizine	Zyrtec Syrup OTC	Age limit	5-10mg Q24H	+	$5
Cetirizine	Zyrtec Tablets OTC	F	5-10mg Q24H	+	$10
Hydroxyzine HCL	Atarax	F	25mg Q8h	+++	$25
Promethazine	Phenergan	F	25mg Q8H	+++	$30
Xyzal	Levocetirizine tab	NF	5mg QD	+	$90
ORAL ANTIHISTAMINES: NON-SEDATING					
Loratadine	OTC - Alavert Claritin	QL	10mg Q24H	±	$5
Loratadine	OTC - Claritin Syrup	F	5mg Q24H	±	$10
Fexofenadine	Allegra	STE	60mg Q12H	±	$50
			180mg QD	±	$35
INTRANASAL ANTIHISTAMINES					
Azelastine HCL	Astelin Nasal Spray	NF	2 Sprays each nostril Q12h	±	$130

*F=Formulary; NF=Non-Formulary; QL= Quantity Limit; STE=Step Therapy Edit: Previous claim for loratadine or cetirizine on PHC profile in the last 120 days.

†=Sedative Effects: +++=high, ++=moderate, +=low, ±=low/none,-=stimulation possible

††=Cost based on usual dose; AWP for single-source brands & MAC for generics as of January 2011, rounded to the nearest $5.

OTC = Over-The Counter (Requires Rx from prescriber for PHC coverage)

PHC
COMMON ANTIHYPERTENSION AGENTS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL STARTING DOSE	MAXIMUM DAILY DOSE	COST/ MONTH†
ACE INHIBITORS					
Captopril	Capoten	F	25mg BID	300mg	$5
Enalapril	Vasotec	F	5mg QD	40mg	$5
Lisinopril	Prinivil, Zestril	F	10mg QD	40mg	$5
Ramipril	Altace	F	2.5mg QD	20mg	$5
Quinapril	Accupril	NF	10mg QD	80mg	$5
Benazepril	Lotensin	F	10mg QD	80mg	$10
Fosinopril	Monopril	NF	10mg QD	80mg	$10
Trandolapril	Mavik	NF	1mg QD	8mg	$45-90
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)					
Olmesartan	Benicar	NF	20 QD	40 mg	$55-115 (1)
Losartan	Cozaar	STE	50mg QD	100mg	$15
Valsartan	Diovan	NF	80mg QD	320mg	$80-115
BETA-BLOCKERS					
Beta-1 Selective					
Atenolol	Tenormin	F	50mg QD	100mg	$5
Metoprolol tartrate	Lopressor	F	50mg BID	400mg	$5
Acebutolol	Sectral	F	200mg BID	1200mg	$10
Metoprolol succinate XL	Toprol XL	F	50mg QD	400mg	$20
Nebivolol	Bystolic	NF	5mg QD	40mg	$60-120
Beta-1/Beta-2 Non-Selective					
Propranolol	Inderal	F	40mg BID	640mg	$5
Nadolol	Corgard	NF	40mg QD	320mg	$5
Propranolol SR	Inderal LA	F	80mg QD	640mg	$25
Sotalol	Betapace	F	80mg BID	320mg	$15
Alpha-1/Beta-1/Beta-2 Non-Selective					
Labetalol	Normodyne Trandate	F	100mg BID	2400mg	$10
Carvedilol	Coreg	F	3.125mg BID	40mg	$10
Carvedilol phos., ER	Coreg CR	NF	10mg QD	80mg	$140
COMBINATION PRODUCTS					
Lisinopril/hctz	Prinzide	F	10/12.5mg QD	40/25mg	$5
Benazepril/hctz	Lotensin-HCT	F (generic strengths only)	5/6.25mg QD	40/25mg	$5
Bisoprolol/hctz	Ziac	F	5/6.25mg QD	20/12.5mg	$5
Benazepril/amlodipine	Lotrel	F	10/2.5 mg QD	20/5mg	$55
Losartan/hctz	Hyzaar	STE	50/12.5mg QD	100/25mg	$15
Valsartan/hctz	Diovan-HCT	NF	80/12.5mg QD	320/25mg	$85

*F=Formulary; NF=Non-Formulary; QL= Quantity Limit. (1) =using ½ tablet substitution; †=Cost based on usual starting dose; AWP for single-source brands or MAC for generics as of January 2011, rounded to the nearest $5.

PHC COMMON ANTIHYPERTENSION AGENTS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL STARTING DOSE	MAXIMUM DAILY DOSE	COST/ MONTH†
CALCIUM-CHANNEL BLOCKERS					
Dihydropyridines					
Nifedipine CC, XL	Adalat , Procardia XL	F	30mg QD	120mg	$20
Amlodipine	Norvasc	F	5mg QD	10mg	$20
Felodipine	Plendil	F	5mg QD	10mg	$25
Nisoldipine	Sular	NF	20mg QD	60mg	$100-200
Non-Dihydropyridines					
Diltiazem	Cardizem	F	30mg QID	360mg	$5
Verapamil	Calan, Isoptin	F	80mg TID	480mg	$5
Verapamil SR tabs	Calan SR, Isoptin SR	F	240mg QD	480mg	$10
Diltiazem ER	Dilacor-XR	F	180mg QD	540mg	$15
Verapamil SR caps	Verelan	F	240mg QD	480mg	$15
Diltiazem CD	Cardizem CD	F	180mg QD	360mg	$20
Diltiazem SR	Cardizem SR	F	60mg BID	360mg	$25
Verapamil SR tabs	Covera-HS	NF	240mg QD	480mg	$90
DIURETICS					
Thiazides					
Chlorothiazide	Diuril	F	500mg QD	2g	$5
Chlorthalidone	Hygroton	F	25mg QD	100mg	$5
Hydrochlorothiazide	HydroDIURIL	F	25mg QD	50mg	$5
Indapamide	Lozol	F	1.25mg QD	5mg	$5
Metolazone	Zaroxolyn	F	2.5mg QD	20mg	$20
Loop					
Bumetanide	Bumex	F	0.5mg QD	40mg	$5
Furosemide	Lasix	F	20mg BID	240mg	$5
Potassium-Sparing					
Spironolactone	Aldactone	F	50mg QD	200mg	$10
Combination					
Triamterene/hctz	Maxzide, Diazide (new)	F	37.5/25mg QD	2 caps/tabs	$5
Spironolactone/hctz	Aldactazide	F	25mg/125mg QD	100mg	$10
Triamterene/hctz	Dyazide (old formula)	F	50mg/25mg QD	2 caps	$20
CENTRALLY-ACTING ADRENERGICS					
Clonidine tablets	Catapres	F	0.1 mg BID	2.4 mg	$5
Methyldopa	Aldomet	F	250mg BID	3g	$5
Guanfacine	Tenex	F	1mg QHS	3mg	$5
Clonidine TD patch	Catapres-TTS	NF	TTS-1 QWEEK	0.6mg/day	$80-200
ALPHA-BLOCKERS					
Doxazosin	Cardura	F	1mg QD	16mg	$10
Prazosin	Minipres	F	1mg TID	20mg	$5
Terazosin	Hytrin	F	1mg QHS	20mg	$5
Tamsulosin	Flomax	NF	1mg QD	0.4mg	$90
VASODILATORS					
Minoxidil	Loniten	F	5mg QD	100mg	$10
Hydralazine	Apresoline	F	10mg QID	300mg	$20

*F=Formulary; NF=Non-Formulary; †=Cost based on usual starting dose; AWP for single-source brands & MAC for generics as of January 2011, rounded to the nearest $5.

PHC

COMMON ASTHMA MEDICATIONS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL DOSE	# INH/ UNIT	COST/ MONTH (1)
INHALED BETA-2 AGONISTS: SHORT-ACTING					
Albuterol Nebulizer Solution 5mg/ml	Proventil	F	**ADULT:** 1.25-5 mg (0.25-1ml) in 2-3 ml of saline Q 4-8 hours **CHILD:** 0.05 mg/kg (min 1.25mg, max 2.5 mg) in 2-3 ml of saline Q 4-6 hours	25 Nebules Per Box	$20
Albuterol MDI 90mcg/puff	Ventolin-HFA	F	**ADULT:** 2 puffs TID-QID OR 2 puffs 5 minutes prior to exercise **CHILD:** 2 puffs TID-QID OR 1-2 puffs 5 minutes prior to exercise	200/17g	$35
Levalbuterol MDI 45mcg/puff	Xopenex-HFA	NF	**ADULT & CHILD ≥ 4:** 2 puffs q 4-6 hrs	200/15g, 80/8.4g	$55
BETA-2 AGONIST: LONG ACTING					
Albuterol SR 4mg tablet	Proventil	F	**ADULT:** 4 mg q 12 hours **CHILD:** 0.3-0.6 mg/kg, not to exceed 8 mg/day	---	$5
Formoterol Aerolizer	Foradil	F	**ADULT:** 1 puff q 12 hrs **CHILD:** 1 puff q 12 hrs	60/ blister-pack	$170
Salmeterol 50mcg/blister	Serevent Diskus	F	**ADULT:** 1 puff q 12 hours **CHILD:** 1 puff q 12 hours	60/ blister-pack	$175
MAST CELL STABILIZERS					
Cromolyn Nebulizer Soln, 20mg/amp	Intal Neb. Soln. (Brand & most generics discontinued; 1 generic remains in market)	F	**ADULT:** 1 amp QID **CHILD:** 1 amp QID	120 x 2ml Ampules Per Box	$140
LEUKOTRIENE MODIFIERS					
Montelukast 5mg,10mg tablet	Singulair	STE	**ADULT:** 10mg po QPM **CHILD:** 5mg po QPM	N/A	$140
Zafirlukast10mg, 20mg tablet	Accolate	STE	**ADULT:** 20mg po BID ac **CHILD:** 10mg po BID ac	N/A	$120
COMBINATION PRODUCTS					
Fluticasone/ Salmeterol Diskus	Advair Diskus 100mcg/50mcg 250mcg/50mcg 500mcg/50mcg	STE	**ADULT:** 1 puff BID (100/50 – 250/50mcg) **CHILD ≥ 4:** 1 puff BID (100/50mcg)	60/ blister-pack	$195
Budesonide/ Formoterol HFA	Symbicort 80/4.5mcg, 160/4.5mcg	STE	**Ages 12yrs & older:** 2 puffs BID	120/10.2g	$200

*F=Formulary; NF=Non-Formulary; QL= Quantity Limit; STE=Step Edit=Must have claim for an inhaled corticosteroid on PHC profile in the last 120 days.

(1)=Cost/month is for the lowest recommended adult dose, based on AWP for single-source brands & MAC for generics, as of January 2011, rounded to the nearest $5.

PHC

COMMON ASTHMA MEDICATIONS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL DOSE	# INH/ UNIT	COST/ MONTH (1)
ANTICHOLINERGICS					
Ipratropium Nebulizer Solution 0.5mg/vial (.02%)	Various generic, Atrovent	F	**ADULT:** 0.5 mg q 6 hours **CHILD:** 0.25 mg q 6 hours	25 vials per box	$70
Ipratropium MDI 18mcg/puff	Atrovent HFA	F	**ADULT:** 2-3 puffs q 6 hrs **CHILD:** 1-2 puffs q 6 hrs	200/12.9	$145
Ipratropium 18mcg with Albuterol 103mcg MDI	Combivent	F	**ADULT:** 2-3 puffs q 6 hrs **CHILD:** 1-2 puffs q 6 hrs	200/14.7g	$155
Tiotropium 18mcg HH cap/inhalation	Spiriva	F	**(for COPD use, not indicated for asthma)** **ADULT:** 1 capsule (2 inhalations from 1 cap) QD	30 capsules providing 60 inhalations	$220
XANTHINES					
Theophylline Liquid, capsules, sustained-release tablets & capsules	Various generic	F	**ADULT:** Starting dose 10mg/kg/day not to exceed 300mg/day initially; max 800mg/day **CHILD:** Starting dose 10mg/kg/day; Usual max: 16mg/kg/day	N/A	$10
SYSTEMIC CORTICOSTEROIDS					
Methylprednisolone 2,4,8,16,32mg tabs Prednisolone 5mg/5cc,15mg/5cc liquid	Various generic	F	**ADULT:** 7.5-60 mg daily in a single dose or QOD as needed for control. **CHILD:** 0.25-2mg/kg daily in a single dose or QOD as needed for control.	N/A	$5
Prednisone 1,5,10,20, 50mg tabs; 5mg/5cc5mg/cc liquid	Various generic	F	**ADULT:** Short-course "burst" to achieve control: 40-60 mg per day as single or 2 divided doses for 3-10 days. **CHILD:** Short-course "burst": 1-2 mg/kg/day, max 60 mg/day for 3-10 days. **Short-course or "bursts" are effective for establishing control when initiating therapy or during a period of gradual deterioration & should be continued until patient achieves 80% PEF personal best or symptoms resolve.**	N/A	$5

*F=Formulary; (1) =Cost/month is for the lowest recommended adult dose, based on AWP for single-source brands & MAC for generic, as of January 2011, rounded to the nearest $5.

PHC

COMMON ASTHMA MEDICATIONS

GENERIC NAME	BRAND NAME	PHC MEDI-CAL FORMULARY STATUS*	LOW DAILY DOSE‡	MEDIUM DAILY DOSE‡	HIGH DAILY DOSE‡	COST/ MONTH (1)
INHALED CORTICOSTEROIDS (ORAL)						
Beclomethasone dipropionate	QVAR 40mcg/puff	F	**ADULT:** 4-12 puffs/ day given BID-QID **CHILD:** 2-8 puffs/ day given BID-QID	**ADULT:** 12-20 puffs/ day given BID-QID **CHILD:** 8-16 puffs/ day given BID-QID	**ADULT:** >20 puffs/ day given BID-QID **CHILD:** >16 puffs/ day given BID-QID	$160
	QVAR 80mcg/puff	F	**ADULT:** 2-6 puffs/day given BID **CHILD:** 1-4 puffs/day given BID	**ADULT:** 6-10 puffs/day given BID **CHILD:** 4-8 puffs/day given BID	**ADULT:** >10 puffs/day given BID **CHILD:** >8 puffs/day given BID	$200
Budesonide	Pulmicort Flexhaler 180mcg/puff	F	**ADULT:** 1-2 puffs/day given QD-BID **CHILD:** 1 puff/day given QD-BID	**ADULT:** 2-3 puffs/day given BID **CHILD:** 1-2 puffs/day given BID	**ADULT:** > 3 puffs/day given BID **CHILD:** > 2 puffs/day given BID	$150
Budesonide Respules	Pulmicort Respules 0.25 mg/AMP; 0.5 mg/AMP	F, Age limit (9 & younger)	**ADULT:** N/A **CHILD:** 0.25 mg BID or 0.5 mg QD	**ADULT:** N/A **CHILD:** 0.5 mg BID or 1 mg QD	**ADULT:** N/A **CHILD:** 1 mg QD	$160
Flunisolide	AeroBid, AeroBid-M 250mcg/puff	F	**ADULT:** 2-4 puffs/day given BID **CHILD:** 2-3 puffs/day	**ADULT:** 4-8 puffs/ day given BID **CHILD:** >4-5 puffs/day	**ADULT:** >8 puffs/ day given BID **CHILD:** >5 puffs/day	$200
Fluticasone	Flovent-HFA 44 mcg/puff	F	**ADULT:** 2-6 puffs/d given BID **CHILD:** 2-4 puffs/day, given BID	**ADULT:** N/A, use higher strength MDI **CHILD:** 4-10 puffs/day, given BID	**ADULT:** N/A, use higher strength MDI **CHILD:** N/A, use higher strength MDI	$110 (dosed @ 4 puffs/d)
	Flovent-HFA 110 mcg/puff	F	**ADULT:** 2 puffs/d, given BID **CHILD:** N/A	**ADULT:** 2-6 puffs/ day, given BID **CHILD:** 2-4 puffs/day, given BID	**ADULT:** N/A **CHILD:** > 4 puffs/day, given BID	$150 (dosed @ 4 puffs/d)
	Flovent-HFA 220 mcg/puff	F	**ADULT:** N/A **CHILD:** N/A	**ADULT:** 1-3 puffs/day, given BID **CHILD:** 2 puffs/ day, given BID	**ADULT:** >3 puffs/day, given BID **CHILD:** >2 puffs/day, given BID	$230[2]
Mometasone	Asmanex 220mcg/puff	F	**ADULT/ CHILD > 12 yrs old:** 1 puff/day	**ADULT/ CHILD > 12 yrs old:** 2 puff/day	**ADULT:** N/A **CHILD:** N/A	$130

*F=Formulary. ‡Comparative daily dosages are based on the National Heart, Lung & Blood Institute Expert Panel: Guidelines for the Diagnosis & Mgmt of Asthma and may exceed those recommended by the manufacturer. High doses of inhaled corticosteroids can result in significant systemic absorption with resultant adverse effects and should be tapered to the lowest dose possible to control asthma symptoms.

(1) Cost/month is for low – medium recommended adult dosage, based on AWP for single-source brands & MAC for generics as of January 2011, unless otherwise specified, rounded to the nearest $5.

(2) Cost is per MDI unit, which contains 120 puffs, lasting > 1 month at doses less than 2 puffs BID; the monthly cost for moderate dosing (1 puff BID) is thus $115 since one unit would last 2 months.

PHC

COMMON TYPE II DIABETES AGENTS

CLASS	GENERIC	TRADE		USUAL DOSE	PHC Medi-Cal FORMULARY STATUS*	Cost (1)
ORAL AGENTS						
Alpha Glucosidase Inhibitors	Acarbose	Precose		150-300mg/d	F	$50
	Miglitol	Glyset		150-300mg/d	F	$110
Biguanide	Metformin	Glucophage		1500-2550mg/d	F	$10
	Metformin XR	Glucophage XR		1500-2000mg/d	F	$10
Meglitinides	Repaglinide	Prandin		1.5-12mg/d	NF	$190
D-phenylalanine	Nateglinide	Starlix		180-360mg/d	F	$105
Sulfonylureas	Chlorpropamide	Diabinese		100-500mg/d	F	$10
	Glimepiride	Amaryl		1-8mg/d	F	$5
	Glipizide	Glucotrol		5-20mg/d	F	$10
	Glipizide (extended Release)	Various		5-20 mg/day	NF	$10
	Glyburide	DiaBeta		1.25-20mg/d	F	$10
		Micronase		1.25-20mg/d	F	$10
		Glynase		1.5-12mg/d	NF	$10
	Tolazamide	Tolinase		100-1000mg/d	F	$10
	Tolbutamide	Orinase		500-3000mg/d	F	$10
Dipeptidyl Peptidase-4 Inhibitor	Sitagliptin	Januvia		25-100 mg/day	F(STE)	$140
Combination Products	Glyburide + Metformin	Glucovance		10mg/1000mg/d	NF	$15
	Glipizide + Metformin	Various		2.5 /250mg-20/2000mg/d	NF	$30
	Rosiglitazone + Metformin	Avandamet		2/1000mg-8/2000mg/d	F(STE)	$165
	Rosiglitazone + Glimepiride	Avandaryl		4/1mg – 4/4mg/d	F(STE)	$155
	Pioglitazone + Metformin	ActoPlus Met		15/500mg -45 /2550 mg/d	F(STE)	$240
	Pioglitazone + Glimepiride	Duetact		30mg/2mg- 30 mg/4mg	F(STE)	$240
Thiazolidinediones	Pioglitazone	Actos		15-45mg/d	F (STE)	$245
	Rosiglitazone	Avandia		4-8mg/d	NF	$255
INSULIN						**Cost per 10ml vial**
Rapid Acting	Lispro	Humalog		Individualized to Member	F (QL)	$130
	Aspart	Novolog		“	F (QL)	$130
	Glulisine	Apidra		“	F (QL)	$110
	Human	Humulin R		“	F (QL)	$65
		Novolin R		“	F (QL)	$65
	Human	Humulin N		“	F (QL)	$65
		Novolin N		“	F (QL)	$65
	Human	Humulin L		(Discontinued by Mfg)	--	--
		Novolin L		(Discontinued by Mfg)	--	--
Long Acting	Ultralente	Humulin U		(Discontinued by Mfg)	--	--
	Glargine	Lantus		Individualized to Member	F (QL)	$120
	Detemir	Levemir		“	F (QL)	$120
Pre-Mixed	NPH/Regular (70/30)	Humulin 70/30		“	F (QL)	$65
		Novolin 70/30		“	F (QL)	$65
	NPH/Regular (50/50)	Humulin 50/50		(Discontinued by Mfg)	--	--
	Lispro protamine suspension/Lispro (75/25)	Humalog Mix 75/25		Individualized to Member	F (QL)	$120
GLP-1 Agonist						
Incretin Mimetic	Exenatide	Byetta	5mcg/ 1.2ml	5mcg bid	NF	$300/ CRT
			10mcg/ 2.4ml	10 mcg bid	NF	$330/ CRT

*F=Formulary; NF=Non-Formulary; STE=Step Therapy Edit: Member must have had previous use on profile 1st line agent metformin, with or without a sulfonylurea, AND insulin in the last 120days. PA=Prior Authorization Required. (1)=Average cost for 30 days treatment with the lowest daily dosage, based on AWP for single-source brands & MAC for generics as of January 2011, rounded to the nearest $5

PHC

GASTRO-ESOPHAGEAL REFLUX DISEASE (GERD) AGENTS

GENERIC NAME	BRAND NAME	MEDI-CAL FORMULARY STATUS*	USUAL DOSE	MAXIMUM DAILY DOSE**	COST/ MONTH(1)
H-2 ANTAGONISTS (H2RAs)					
Cimetidine Tablets, RX & OTC	Tagamet, Tagamet HB	F	400mg bid	2400mg	$10
Famotidine Tablets, RX & OTC	Pepcid, Pepcid AC	F (QL)	20mg bid	80mg	$10
Ranitidine Tablets, RX & OTC	Zantac, Zantac 75/150	F	150mg bid	600mg	$10
Cimetidine Oral Soln, 300mg/5ml	Tagamet	F	300mg bid	2400mg	$20
Ranitidine Syrup, 75mg/5ml	Zantac	F	150mg bid	600mg	$60
PROTON PUMP INHIBITORS (PPIs)					
Omeprazole Mg DR Tablets	Prilosec OTC	F (QL)	20mg qd	40mg	$15
Omeprazole DR Capsules	Prilosec Rx	F (QL)	20mg qd	40mg	$5
Lansoprazole DR Capsules	Prevacid	NF	15mg qd	30mg	$60
	Prevacid ***24H*** (OTC)	F	15mg qd	30mg	$20
Pantoprazole Sod. DR Tablets	Protonix	F	40mg qd	40mg	$20
Rabeprazole Sodium DR Tablets	Aciphex	NF	20mg qd	40mg	$250
Esomeprazole Magnesium DR Capsules	Nexium	NF	20mg qd	40mg	$200
Lansoprazole DR orally disintegrating tablets	Prevacid Solu Tab	NF	15mg qd	30mg	$105
Omeprazole/ Sod. Bicarb Capsules	Zegerid	NF	20mg qd	40mg	$195
	Zegerid OTC	NF	20mg qd	40mg	$20
Omeprazole / Sod. Bicarb pwd for oral susp.	Zegerid Oral Suspension	NF	20mg qd	40mg	$205

*F=Formulary; NF=Non-Formulary; QL=Quantity Limit

**=Higher doses may be used for pathological hypersecretory conditions

(1)=Cost based on usual dose; AWP for single-source brands & MAC for generics as of January 2011; rounded to the nearest $5

PHC

COMMON HYPERLIPIDEMIA AGENTS (STATINS)

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	% LDL REDUCTION(1)	DOSE	COST/ DOSE (2)	COST/ MONTH (2)
Fluvastatin	Lescol	F	17%	20mg QD	3.63	$110
			23%	40mg QD	3.63	$110
			33%	80mg QD	4.66	$140
Atorvastatin	Lipitor	NF	38%	10mg QD	4.04	$120
			46%	20mg QD	5.76	$170
			51%	40mg QD	5.76	$170
			54%	80mg QD	5.76	$170
Atorvastatin	Lipitor ½ Tab Substitution	NF	38%	10mg QD	2.88	$85
			46%	20mg QD	2.88	$85
			51%	40mg QD	2.88	$85
Lovastatin	Mevacor	F	20%	10mg QD	0.41	$10
			29%	20mg QD	0.32	$10
			31%	40mg QD	0.61	$20
			48%	40mg BID	1.22	$40
Pravastatin	Pravachol	F	19%	10mg QD	0.11	$5
			24%	20mg QD	0.11	$5
		NF	34%	40mg QD	0.71	$20
			40%	80mg QD	1.58	$50
Simvastatin	Zocor	F	20-25%	5mg QD	0.05	$5
			28%	10mg QD	0.05	$5
			35%	20mg QD	0.06	$5
			40%	40mg QD	0.08	$5
			48%	80mg QD	0.64	$20
Rosuvastatin	Crestor	STE	43%	5mg QD	5.23	$155
			50%	10mg QD	5.23	$155
			53%	20mg QD	5.23	$155
			62%	40mg QD	5.23	$155
Rosuvastatin	Crestor ½ Tab Substitution	STE	43%	5mg QD	2.62	$80
			50%	10mg QD	2.62	$80
			53%	20mg QD	2.62	$80

*F=Formulary; NF=Non-Formulary; STE=Step Edit requirement: PHC member profile must include claim for fluvastatin, lovastatin or simvastatin in the previous 120 days.

(1)=Based in US product labeling and relevant studies.

(2)=Cost based on AWP for single-source brands or MAC for generics as of Jan. 2011; rounded to the nearest $5.

PHC

OTHER HYPERLIPIDEMIA AGENTS

GENERIC NAME	BRAND NAME	MEDI-CAL FORMULARY STATUS	DOSE	COST/DAY (2)	COST/ MONTH (2)
Fenofibrate capsules, micronized	Lofibra capsules	F	67mg, 1QD 134mg, 1 QD 200mg, 1 QD	$0.67 $1.22 $2.15	$15 $35 $55
Fenofibrate tablets, non-micronized	Lofibra tablets	F	54mg, 1QD 160mg, 1QD	$0.71 $1.88	$20 $55
Fenofibrate tabs, nanocrystals	Tricor	NF	48mg, 1 QD 145 mg, 1 QD	$1.72 $5.16	$50 $155
Ezetimibe	Zetia	STE	10 mg, 1QD	$4.35	$130
Ezetimibe/ Simvastatin	Vytorin	NF	1 QD (10/10, 10/20, 10/40, 10/80mg all have same AWP)	$4.41	$130
Omega – 3 Acid Ethyl Esters	Lovaza	NF	4g (4 caps) per day, given as 4 QD or 2 BID.	$6.49	$195
Niacin, slow release OTC	Slo-Niacin (tabs), Nicobid (caps)	F	Titrated to 1000mg BID	$0.15	$5
Niacin, immediate release OTC	Niacin tabs	F	Titrated to 1000mg TID (500mg, 2 tabs TID)	$1.00	$30
Niacin ER tabs (RX only)	Niaspan	F	Titrated to 2000mg HS	$10.00	$300

*F=Formulary; NF= Non-Formulary, STE=Step Therapy Edit: Prior claim for a formulary statin must be on member's PHC profile in the previous 120 days.

(1)=Based in US product labeling and relevant studies.

(2)=Cost based on AWP for single-source brands & MAC for generic as of January 2011, rounded to the nearest $5.

PHC

MIGRAINE AGENTS

(SEROTONIN 5-HT 1 RECEPTOR AGONIST)

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL DOSE	MAXIMUM DAILY DOSE	COST(1)
Sumatriptan (oral)	Imitrex	QL	50-100mg Q2H prn	200mg	$1
Eletriptan (oral)	Relpax	NF	20-40mg Q 2Hprn	80mg	$30
Frovatriptan (oral)	Frova	NF	2.5mg Q2H prn	7.5mg	$30
Zolmitriptan (oral)	Zomig	NF	2.5mg Q2Hprn	10mg	$30
Rizatriptan (oral)	Maxalt	NF	5-10mg Q2H prn	30mg	$30
Almotriptan (oral)	Axert	NF	6.25mg-12.5mg Q2H prn	25mg	$30
Naratriptan (oral)	Amerge	NF	1-2.5mg Q4H prn	5mg	$5
Zolmitriptan (nasal)	Zomig	NF	5mg Q2H prn	10mg	$40
Sumatriptan (nasal)	Imitrex Nasal	QL	20mg Q2H prn	40mg	$5
Sumatriptan (inj)	Imitrex Inj.	QL	6mg SC Q1 H prn	12mg	$60

*QL=Quantity Limit, NF=Non-Formulary
(1)=Cost is for a single dose of the lower strength if dose range given, using AWP for single-source brands & MAC for generics as of January 2011, rounded to the nearest $5.

PHC

COMMON NASAL CORTICOSTEROIDS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	USUAL DOSE	MAXIMUM DAILY DOSE	# SPR/ UNIT	COST/ MONTH[1]
Fluticasone propionate	Flonase	F	2 spr each nostril QD	2 spr/nostril (4 sprays)	120/16g	$20
Flunisolide	Nasarel	F	2 spr each nostril BID	2 spr each nostril TID	200/25ml	$20
Triamcinolone acetonide aqueous	Nasacort AQ	NF	2 spr each nostril QD	2 spr each nostril QD	120/16.5g	$125
Mometasone furoate monohydrate	Nasonex	NF	2 spr each nostril QD	2 spr each nostril QD	120/17g	$125
Fluticasone furoate	Veramyst	NF	1 spr each nostril QD	2 spr/nostril QD	120/10g	$60[2]
Budesonide	Rhinocort AQ	NF	1 spr each nostril QD	2 spr/nostril QD	120/8.4g	$60[2]
Olopatadine	Patanase	NF	2 spr each nostril BID	2 spr/nostril BID	240/30.5g	$140
Beclomethasone dipropionate, monohydrate	Beconase AQ	NF	1-2 spr each nostril BID	2 spr/nostril BID	200/25g	$160

*F=Formulary; NF=Non-Formulary

(1) Cost is based on the dose in the “Usual Dose” column, using AWP for single-source brands & MAC for generics as of January 2011, based on usual dose, rounded to the nearest $5.

(2) $50-55 per month when dosed at 1 spray each nostril QD – each unit is $110-120, but will last 2 months at usual dose.

PHC

COMMON NSAIDS

GENERIC NAME	BRAND NAME	DYSPEPSIA/ GI DISTRESS INCIDENCE*	USUAL DOSE	MAXIMUM DAILY DOSE	COST/ MONTH(1)	CLASS**
FORMULARY						
Ibuprofen	Motrin	1-3%/1-3%	600mg QID	3200mg	$5	PA
Indomethacin	Indocin	3-9%/1-3%	25mg TID	200mg	$5	AA
Piroxicam	Feldene	1-10%/1-10%	20mg QD	20mg	$5	O
Naproxen	Naprosyn	1-3%/3-9%	500mg BID	1500mg	$5	PA
Salsalate	Disalcid	~3-9%/~3-9%†	1000mg TID	4000mg	$10	S
Naproxen Na+	Anaprox	1-3%/3-9%	550mg BID	1375mg	$10	PA
Sulindac	Clinoril	3-9%/10%	150mg BID	400mg	$10	AA
Etodolac	Lodine	10%/3-9%	400mg BID	1200mg	$15	AA
Ketoprofen	Orudis	11%/>3.9%	75mg TID	300mg	$15	PA
Meloxicam	Mobic	1-3%/1-3%	7.5-15mg QD	15mg	$20	O
Diclofenac Na+	Voltaren	3-9%/3-9%	50mg BID	200mg	$20	AA
Oxaprozin	Daypro	3-9%/1-3%	1200mg QD	1800mg	$20	PA
Flurbiprofen	Ansaid	3-9%/3-9%	50mg QID	300mg	$20	PA
Nabumetone	Relafen	13%/12%	1000mg QD	2000mg	$25	AA
NON-FORMULARY: TAR REQUIRED						
Diclofenac Sod. SR 100mg	Voltaren XR 100 mg	3-9%/3-9%	100mg QD	200mg	$20	AA
Fenoprofen	Nalfon	10.3%/2%	600mg TID	3200mg	$60	PA
Tolmetin	Tolectin	3-9%/3-9%	400mg TID	2000mg	$60	AA
Indomethacin ER	Indocin SR	3-9%/1-3%	75mg QD	150mg	$60	AA
Diclofenac Topical Gel	Voltaren Topical Gel	N/A	2-4g to affected joint QID	32g	$100 per 300g	AA
Fenoprofen	Nalfon	10.3%/2%	400mg TID	3200mg	$130	PA
Celecoxib	Celebrex	8.8%/4.1%	200mg QD	400mg‡	$145	C

*=Incidence reported by manufacturer' †=Estimate from manufacturer; no data available

**AA=Acetic Acid, PA=Propionic Acid, O=Oxicam, F=Fenamate, S=Salicylate, C=Cox-2 Specific

(1)=Cost based on dose in the "Usual Dose" column, using AWP for single-source brands & MAC for generics as of Jan. 2011, rounded to the nearest $5.

TOPICAL STEROID AGENTS

GENERIC NAME	BRAND NAME	*MEDI-CAL FORMULARY STATUS	DOSAGE FORM	STRENGTH	COST/ UNIT [1]
VERY HIGH POTENCY (I)					
Clobetasol propionate	Temovate	F	Cr, Ung, Scalp soln	0.05%	$10/15g; $10/25ml
Augmented Betamethasone dipropionate	Diprolene	NF	Gel, Lotion, Ointment	0.05%	$20/15 gel $40/30ml lot. $10/15g ung.
Clobetasol propionate	Olux	NF	Foam	0.05%	$90/50g
Clobetasol propionate	Olux-E	NF	Foam w/ emollient	0.05%	$210/50g
Clobetasol propionate	Clobex	NF	Lotion	0.05%	$300/60g
HIGH POTENCY (II)					
Betamethasone dipropionate	Diprosone	F	Cream, ointment	0.05%	$5/15g
Betamethasone valerate	Valisone	F	Ointment	0.1%	$5/15g
Fluocinonide	Lidex	F	Cr, Gel, Ung	0.05%	$5/15g
Triamcinolone acetonide	Kenalog	F	Cream, Ointment	0.5%	$5/15g
Augmented Betamethasone dipropionate	Diprolene AF	NF	Cream	0.05%	$15/15g
MEDIUM POTENCY (III)					
Betamethasone dipropionate	Diprosone lotion	F	Lotion	0.05%	$5/15ml
Betamethasone valerate	Valisone	F	Cream	0.1%	$5/15g
Fluocinolone acetonide	Synalar	F	Cr, Ung	0.025%	$5/15g
Mometasone furoate (+)	Elocon	F	Cr, Lot, Ung	0.1%	$10/15g or ml
Prednicarbate	Dermatop	F	Cr, Ung	0.1%	$10/15g
Triamcinolone acetonide	Kenalog	F	Cr, Lot, Ung	0.025%, 0.1%	$5/15g or ml
LOW POTENCY (IV)					

Alclometasone dipropionate	Aclovate	F	Cr, Ung	0.05%	$20/15g
Fluocinolone acetonide	Synalar	F	Cr, Sol	0.01%	$5/15g or ml
Hydrocortisone (+)	Various	F	Lotion	0.25%	$5/60ml
		F	Cr, Lot, Ung	0.5%	$5/15g or ml
		F	Cr, Lot, Ung	1.0%	$5/15g or ml
		F	Cr, Lot, Ung	2.5%	$5/15g or ml
Desonide (+)	Tridesilon	F	Cream	0.05%	$5/15g

*F=Formulary, NF=No-formulary; (+)=Non-fluorinated agent; (1) Cost based on smallest available package size, using AWP for single-source brands as of January 2011 & MAC for generics, rounded to the nearest $5.

PRIOR AUTHORIZATION

CRITERIA GUIDELINES

2011 PRIOR AUTHORIZATION CRITERIA GUIDELINES

These guidelines for prior approval are not inclusive of all non-formulary drugs and do not apply to all member-specific situations as all non-formulary drug requests are reviewed on a case by case basis.

BRAND NAME	GENERIC NAME	COVERED USES	CRITERIA
ABILIFY Tablets & ODT	*Aripiprazole*	Schizophrenia & Bipolar Disorders	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE, not PHC **HK/HF:** New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is tried & failed.
ABILIFY Injection	*Aripiprazole*	Agitation Associated with Schizophrenia & Bipolar Disorders	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE, not PHC **HK/HF:** New Starts -- T/F of, or contraindication to, injectable phenothiazine.
ACIPHEX Tablets	*Rabeprazole*	See Criteria	Treatment of erosive esophagitis, duodenal ulcer associated with H. pylori infection and pathological hypersecretory conditions including ZE syndrome. Treatment of GERD related conditions unresponsive to trials of both lansoprazole-OTC AND omeprazole (either Rx or OTC omeprazole).
ACTHAR Gel	*Corticotropin, Repository, injection*	Diagnostic	Diagnostic testing use: Trial & failure of cosyntropin. Situations responsive to corticosteroids with trial and failure to formulary corticosteroids (*e.g.*, cortisone, hydrocortisone, dexamethasone or prednisone).
ACTIQ Lozenge	*Fentanyl Citrate*	Cancer Pain	Treatment for the management of break-through cancer pain in members with malignancies who are already receiving and who are already tolerant to opioid therapy for their underlying cancer pain. There must also be documented evidence that other more appropriate and cost effective short-acting opioids have tried & failed. Limit of 4 doses per day. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with a PHC contracted pain management consultant may be required.

2011 PRIOR AUTHORIZATION CRITERIA GUIDELINES

ACTONEL Tablets	*Risedronate*	Osteoporosis	Trial and failure of formulary alendronate (Fosamax) or documented contraindication to the use of alendronate.
ACTOS Tablets	*Pioglitazone HCL*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
ACTOPLUS MET Tablets (regular tablets only, not XR)	*Pioglitazone/Metformin HCL*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
ADDERALL Tablets, ADDERALL XR Capsules	*Amphetamine Mixture Tablets*	ADHD, Narcolepsy	Use limited to members between 3 and 16 years of age. For Patients 16 years and greater with Adult ADHD diagnosis. Trial and failure of atomoxetine.
ADVAIR DISKUS	*Fluticasone/Salmeterol Diskus (powder inhalation*	Asthma, COPD	**If Step Therapy not met:** New Starts, Asthma: Limited to members with trial & failure of inhaled corticosteroid (ICS). New Starts, COPD: Limited to members with severe disease, as classified below: Stage summary/treatment criteria-- – mild: t/f short acting bronchodilator – moderate: t/f of long acting bronchodilator – severe: t/f of above and ICS
ADVICOR Tablets	*Niacin-ER/Lovastatin*	Hyperlipidemia	Not for initial therapy. Trial and failure of Lovastatin, Niacin, Fluvastatin or Atorvastatin.
AGGRENOX Capsules	*Aspirin/Dipyridamole 25/200mg*	Reduction of Stroke Risk	Prophylactic treatment for reduction of atherosclerotic events in member who have failed on or intolerant to generic dipyridamole and aspirin or Plavix.
AMERGE Tablets	*Naratriptan HCL*	Migraine	Trial and failure of formulary sumatriptan.
AMPHOTEC Injection	*Amphotericin B/ Cholesteryl sulfate*	Invasive Aspergillosis	Trial and failure of Amphotericin B desoxycholate or contraindication to use in patients with renal impairment.

<table>
<tr>
<td>ARANESP Injection (Specialty pharmacy item)</td>
<td>Darbepoetin</td>
<td colspan="2">Chronic Kidney Disease (CKD) in dialysis centers – No PA required: documentation must be submitted on the Clinical Justification Worksheet.

CKD – Darbepoetin not administered in dialysis center – PA required:
• Maintain Hgb/Hct between 11 and 12 g/Dl (33% and 36%) based on a recent measurement within the last month.
• Appropriate indications for administering darbepoetin if the Hgb/Hct is >12/36 include:
o Reduction of the dose by 25%
o A dose of 5 mcg or less.
-or-
o Co-Morbid conditions such as CHF/Pulmonary Disease

Oncology – Anemia associated with malignancy, chemotherapy or Myelo-dysplastic syndrome—PA required:
• For pts receiving cancer chemotherapy and for pts with low grade myelodysplasia not receiving chemotherapy:
o Hgb/Hct less than 10 g/dl (30%) within the previous month
• For pts with anemia associated with other hematologic malignancies in the absence of chemotherapy:
o trial and failure of conventional therapy for anemia
• Starting dosage: 2.25 mcg/kg per week.

Elective, noncardiac, nonvascular surgery when patient is unable or unwilling to donate autologous blood – PA required:
• Hgb/Hct between 10 and 12 g/dl (30-36%) and pt is unwilling or unable to donate autologous blood.

Anti-retroviral therapy for HIV infected patients – PA required:
• Case by case review. Co-morbid conditions.
• Hgb/Hct between 10 and 12 g/dl (30-36%) and a serum erythropoietin of less than 500 Mu/ml.
Note – In all cases the cause of the anemia is not due to correctable/treatable factors.
such as:
▪ Iron deficiency (it is recognized that patients on EPO may still require supplemental iron therapy.)
▪ Underlying infectious or inflammatory processes.
▪ Occult blood loss.
▪ Underlying hematologic diseases (i.e., thalassemia)
▪ Vitamin deficiencies: (i.e., folic acid or vitamin B12)
▪ Hemolysis</td>
</tr>
<tr>
<td>ARAVA Tablets</td>
<td>Leflunomide</td>
<td>RA</td>
<td>Treatment of active rheumatoid arthritis; failure/ intolerance to methotrexate & patient has been evaluated by a rheumatologist.</td>
</tr>
</table>

ARICEPT Tablets	*Donepezil HCL*	Alzheimer's Dementia	*All strengths:* Treatment of Alzheimer's Disease or related dementia . An updated MMSE or other assessment tool is required every 12 months. *5 & 10 mg*: Baseline MMSE 3-26 or evidence of Dementia with an alternate assessment tool. *23mg:* MMSE 3-14 and trial and failure of 10mg used for at least 3 months.
ASTELIN NASAL SPRAY	*Azelastine HCL*	Rhinitis	Trial and failure of first line therapy including oral antihistamines and nasal steroids for allergic or for non-allergic rhinitis.
AVANDAMET Tablets	*Rosiglitazone Metformin HCL*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
AVANDARYL Tablets	*Rosiglitazone/ Glimepiride*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
AVANDIA Tablets	*Rosiglitazone*	DM	Trial and failure of pioglitazone and either insulin or metformin with a HgA1C less than 9.0 in the last 90 days
AVONEX Injection *(Specialty Pharmacy Item)*	*Interferon beta-1a*	MS	Treatment of Multiple Sclerosis for members who have been evaluated by a neurologist. Requests which document that the member continues to benefit from therapy are approved on a yearly basis.
AXERT Tablets	*Almotriptan Malate*	Migraine	Trial and failure of formulary sumatriptan.
AZILECT Tablets	*Rasagiline Mesylate*	Parkinson's Disease	Trial and failure of first line adjunct therapy to carbidopa/levodopa treatment in Parkinson's Disease.
BARACLUDE Oral Solution and Tablets	*Entecavir*	Hepatitis B	Treatment of chronic Hepatitis B virus in adults who have been evaluated by a gastroenterologist, HIV or liver specialist with evidence of active viral replication, active disease or evidence of persistent elevation of ALT / AST.

BENICAR, BENICAR-HCT	*Olmesartan, Olmesartan-HCTZ*		Trial and failure of, or contraindication to, formulary ACE inhibitors and formulary ARB losartan.
BEPREVE	*Bepotastine besilate 2% ophth sol*	Allergic Conjunctivitis	Step edit for trial and failure of, or contraindication to, ketotifen OTC (Zaditor) and Olopatadine. If online step edit not met, submit TAR with above documentation. (Patanol/Pataday).
BETASERON Injection *(Specialty Pharmacy Item)*	*Interferon beta-1b*	MS	Treatment of Multiple Sclerosis for members who have been evaluated by a neurologist. Requests which document that the member continues to benefit from therapy are approved on a yearly basis.
BLOOD GLUCOSE MONITORS & STRIPS, Other than TrueTrack	*Blood Sugar Diagnostic*	BID blood sugar testing in NIDDM, QID testing in IDDM	Trial and failure of preferred system (TrueTrack) with medical justification why preferred system cannot be used. Same qty limits apply to other brands as to TrueTrack: Qty 50 w/BID testing for members not on insulin; Qty 100 w/ QID testing for members on insulin. (51 & 102 for Accu-Check Drums). Counts waived for pregnancy.
BONIVA Tablets	*Ibandronate*	Osteoporosis	Trial and failure of formulary alendronate (Fosamax) or documented contraindication to use of alendronate.
BOTOX	*OnabotulinumtoxinA*	See Criteria →	Treatment of: • Upper limb spasticity in adults • Cervical dystonia in adults to reduce the severity of abnormal head position and neck pain • Severe axillary hyperhidrosis, inadequately managed by topical agents • Blepharospasm with dystonia in patients > 12 yrs of age • Strabismus in patients > 12 yrs • Prophylaxis of headaches in adults with chronic migraine (15 or more per mo. & lasting 4 hrs or more). In addition, HA treatment requires: o Request must be from neurology o Trial & failure of at least 2 formulary agents: TCA, beta-blocker, valproate or calcium channel blocker.

BYETTA Injection (CRT)	*Exenatide*	DM	1. Prescribed by endocrinologist, ***or*** 2. HgA1C less than 9.0 in the last 90 days: trial & failure of metformin or insulin. 3. HgA1C equal to or greater than 9.0 in the last 90 days: trial & failure of metformin AND insulin.
BYSTOLIC	*Nebivolol*	HTN	Patient's with hypertension requiring 2 or more classes of antihypertensives AND trial and failure of 2 or more formulary beta-blockers.
CATAPRES-TTS Transdermal Patch	*Clonidine Patches*	HTN	Treatment for members with hypertension and have a documented trial and failure with oral clonidine.
CAVERJECT Vial, Kit	*Alprostadil*	none	The drug is not covered per Federal Regulation and State Operating Instruction letter as of 1/1/06.
CELEBREX Capsules	*Celecoxib*	OA, RA	Treatment for members who have a diagnosis of OA or RA who meet one of the following criteria: a documented history of peptic ulcer disease; GI bleeding; concurrent use of a chronic oral corticosteroid; concurrent use of warfarin therapy; age greater than or equal to 75 years old, a previous trial of two (2) formulary NSAIDs, one of which must have been salsalate, etodolac, diclofenac, or meloxicam. Mbr must also not be on concurrent ASA.
CIALIS Tablets	*Tadalafil*	none	The drug is not covered per Federal Regulation and State Operating Instruction letter as of 1/1/06.
CIMZIA PFS Kit	*Certolizumab*	RA, Crohn's Disease	Treatment of rheumatoid arthritis in members who have been evaluated by a rheumatologist and have had an incomplete or inadequate response to methotrexate. Treatment of Crohn's Disease in members who have had an inadequate response to conventional therapy.
COLAZAL caps	*Balsalazide Disodium*	Ulcerative Colitis	Trial and failure of Sulfasalazine.
COLCRYS Tablets	*Colchicine*	Gout	**Dx: Familial Mediterranean Fever** – approve as requested (up to max quantity of 4 tabs/day) **Acute gout:** Trial /failure or contra-indication to NSAIDs. Approve for 2 tabs at first sign of gout followed by 1 tablet 1 hour later. QL of 9/month (allows 3 acute attacks/month) unless med Hx shows higher frequency. **Chronic gout:** Trial and failure or contraindication with probenecid, Colbenemid and allopurinol. Require a trial of 1 tablet/day before approving 2 tablets/day.
COLESTID Tablets, Granules	*Colestipol HCL*	Hypercholesterolemia	Trial and failure of cholestyramine.

COPAXONE PFS Kit *(Specialty Pharmacy Item)*	*Glatiramer Acetate*	MS	Treatment of Multiple Sclerosis for members who have been evaluated by a neurologist. Requests which document that the member continues to benefit from therapy are approved on a yearly basis.
CONCERTA Tablets	*Methylphenidate ER (OSM) tablets*	ADD, ADHD	Pediatric use: Trial and failure of formulary stimulants for ADHD (one of which must include methylphenidate sustained release), or a documented need for less frequent dosing. Adult use: Same as pediatric criteria, and in addition, T/F of atomoxetine (Strattera).
CRESTOR Tablets	*Rosuvastatin*	Hyperlipidemia	**If Step not met in PHC profile:** Trial and failure of a formulary statin: simvastatin 40mg, fluvastatin 80mg, pravastatin 80mg or lovastatin 80mg. ½ tablet dosing required.
CYMBALTA Capsules	*Duloxetine HCL*	Depression, Neuropathic pain	New Starts, limited to treatment of: (1) DEPRESSION: For members who have had a trial and failure of two or more of the following: fluoxetine, paroxetine, citalopram, sertraline, bupropion, mirtazapine or Effexor/Effexor XR; (2) DIABETIC NEUROPATHY OR FIBROMYALGIA: For members who have tried and failed gabapentin AND tricyclic antidepressants. Approval limited to #60/month for 20mg, and #30 /month for 30mg & 60mg; requests exceeding limits will require additional documentation: (3) CHRONIC MUSCULOSKELETAL PAIN (OSTEOARTHRITIC PAIN OR LOW BACK PAIN). Trial and failure or contraindication to at least two or formulary NSAIDs AND 2 or more formulary antidepressants.
DAYTRANA Patch	*Methylphenidate Transdermal*	ADHD	Trial and failure with oral methylphenidate extended release. Age limit: children aged 6-16 yrs.
DDAVP tablets	*Desmopressin*	PNE	Treatment in members with diabetes insipidus or members age 7 to 14 with primary nocturnal enuresis (PNE) who have failed treatment with or have a contraindication to using bedwetting alarm. Continuation of therapy allowed for members on current treatment.
DDAVP INTRANASAL	*Desmopressin Nasal Spray*	Central Cranial Diabetes Insipidus	Intranasal formulation is no longer indicated for treatment of primary nocturnal enuresis (PNE). It is indicated for central cranial diabetes insipidus. For hemophilia A and Von Willebrand disease, see Stimate.

DEPAKOTE ER Tablets	*Divalproex Sodium ER (Extended Release)*	Behavioral	Approve for Behavioral indications &/or trial and failure of Depakote DR (divalproex DR/EC) or documented contraindication to trial use of DR formulation by prescribing physician.
DETROL Tablets	*Tolterodine tartrate*	OAB	Treatment of overactive bladder. Trial and failure of oxybutynin (Ditropan).
DEXEDRINE Tablets, Spansules	*Dextroamphetamine*	ADHD	Trial and failure of atomoxetine (Strattera) in patients 16 years of age and greater with Adult ADHD diagnosis.
DIOVAN Tablets	*Valsartan*	HTN, CHF	Trial and failure of ACE inhibitor and a formulary ARB (olmesartan, losartan).
DITROPAN XL Tablets	*Oxybutynin XL*	OAB	Treatment of overactive bladder. Limited to member's age 55 or greater who have failed regular release oxybutynin.
DUETACT Tablets	*Pioglitazone/ Glimepiride*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** Trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
DURAGESIC Patch	*Fentanyl transdermal*	Around-the-clock pain control *(Include primary diagnosis/cause of pain on TAR)*	Treatment of severe pain for members with cancer or those members with a demonstrated need for a non-oral route of administration. Other conditions require prescribing by a pain management specialist. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with pain management consultant may be required.
EFFEXOR Tablets, EFFEXOR-XR Capsules	*Venlafaxine HCL, Venlafaxine XR*	MDD, GAD, Panic Disorder, Social Anxiety Disorder	**Step Therapy Edit** – member must have had a trial of Fluoxetine, Paroxetine, Sertraline or Citalopram within the last 120 days. **TAR will be needed if step edit not met** – submit documentation of trial & failure of at least one formulary SSRI.
EMSAM Patch	*Selegiline transdermal*	MDD	Carve out drug.

ENBREL Kit, PFS, Syringe *(Specialty Pharmacy Item)*	*Etanercept*	RA, Psoriasis	Treatment of: 1) Rheumatoid Arthritis in members who have been evaluated by an appropriate specialist and have had an incomplete or inadequate response to methotrexate or 2) Plaque Psoriasis involving greater than 10% of body surface in members who have been evaluated by an appropriate specialist. Must follow FDA approved dosing of 50mg twice weekly for 3 months followed by a reduction to a maintenance dose of 50mg/week.
ENJUVIA Tablets	*Estrogens, synthetic conjugated B*	HRT	Treatment trial and failure of estradiol
ENTERAL NUTRITIONAL SUPPLEMENTS (BOOST, ENSURE, GLUCERNA etc.)	*Enteral nutritional supplements*	Medically necessary nutrition via G-tube, NG tube, PEG, J-tube	**MC:** Treatment for members with a functioning gastrointestinal tract who, due to pathology or nonfunction of the structures that normally permit food to reach the digestive tract, requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the member's general condition. Not a covered benefit for members residing in a LTC or ICF. **HK/HF:** OTC, not a covered benefit.

EPOGEN, PROCRIT Injection *(Specialty Pharmacy Item)*	*Epoetin Alpha*	Chronic Kidney Disease (CKD) in dialysis centers – No PA required: documentation must be submitted on the Clinical Justification Worksheet. CKD – Epoetin Alpha **not** administered in dialysis center – PA required: • Maintain Hgb/Hct between 11 and 12g/Dl (33% and 36%) based on a recent measurement within the last month. • Appropriate indications for administering Epoetin Alpha if the Hgb/Hct is >12/36 include: o Reduction of the dose by 25% o A dose of 1000 units or less. *-or-* o Co-Morbid conditions such as CHF/Pulmonary Disease Oncology – Anemia associated with malignancy, chemotherapy or myelodysplastic syndrome—PA required: • For pts receiving cancer chemotherapy and for pts with low grade myelodysplasia not receiving chemotherapy: o Hgb/Hct less than 10 g/dl (30%) within the previous month • For pts with anemia associated with other hematologic malignancies in the absence of chemotherapy: o trial and failure of conventional therapy for anemia • Starting dosage: 150u/kg per week. Elective, noncardiac, nonvascular surgery when patient is unable or unwilling to donate autologous blood – PA required: • Hgb/Hct between 10 and 12g/dl (30-39%) and pt is unwilling or unable to donate autologous blood; the recommended dose of recombinant human erythropoietin is 300 units/kg/day subcutaneously for 10 days prior to, on the day of, and for four days post-surgery. An alternate dose schedule is 600 units/kg of recombinant human erythropoietin subcutaneously in once-a-week doses (21, 14 and 7 days prior to surgery) plus a fourth dose given on the day of surgery. Anti-retroviral therapy for HIV infected patients – PA required: • Case by case review. Co-morbid conditions. • Hgb/Hct between 10 and 12g/dl (30-36%) and a serum erythropoietin of less than 500 Mu/ml. Note – In all cases the cause of the anemia is not due to correctable/treatable factors. such as: ▪ Iron deficiency (it is recognized that patients on EPO may still require supplemental iron therapy.) ▪ Underlying infectious or inflammatory processes. ▪ Occult blood loss. ▪ Underlying hematologic diseases (i.e., thalassemia) ▪ Vitamin deficiencies: (i.e., folic acid or vitamin B12) ▪ Hemolysis

EVISTA Tablets	*Raloxifene HCL*	Osteoporosis	For osteoporosis, trial & failure of formulary alendronate (Fosamax) or documented contraindication to use of alendronate. Prior authorization for FDA approved indication of reduction in risk of invasive breast cancer in postmenopausal women with osteoporosis or in postmenopausal women at high risk of invasive breast cancer.
EXELON Capsules	*Rivastigmine Tartrate*	Alzheimer's, Dementia	Treatment of Alzheimer's Disease or related dementia with a baseline MMSE score of between 10 and 26 or evidence of Alzheimer's Dementia with an alternate assessment tool. An updated MMSE or other assessment tool is required every 12 months.
FANAPT Tablets	*Iloperidone*	Schizophrenia, Bipolar disorder	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE, not PHC **HK/HF:** (1) TAR required for CCS screening. (2) If case is not CCS eligible, PHC criteria apply: New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
FERAHEME IV	*Ferumoxytol*		Iron Sucrose is the preferred choice for IV use. See prior authorization criteria for Iron Sucrose (Venofer).
FERRLECIT IV	*Sodium Ferric Gluconate Complex*		Iron Sucrose is the preferred choice for IV use. See prior authorization criteria for Iron Sucrose (Venofer).
FLECTOR Patch	*Diclofenac transdermal*	Acute pain (due to injury)	Trial & failure of 2 formulary agents for acute pain such as diclofenac, meloxicam, etodolac, salsalate, ibuprofen, naproxen and T/F of Voltaren gel. *Note: Not FDA approved for chronic use.*
FLOMAX Capsules	*Tamsulosin HCL*	BPH	Trial & failure of formulary agents: doxazosin (Cardura) or terazosin (Hytrin).
FORTEO Prefilled Injection Pen	*Teriparatide*	Osteoporosis	Treatment of post-menopausal female with Hx of osteoporosis with high risk for fracture. Male with primary or hypogonadal osteoporosis with high risk for fracture. T/F of oral formulary bisphosphonate alendronate (Fosamax).

FOSRENOL Chewable Tablets	*Lanthanum Carbonate*	Hyperphosphatemia	For control of hyperphosphatemia in dialysis members who are unresponsive to calcium based phosphate binder therapy (PhosLo) in amounts exceeding 2,000 mg total elemental calcium content; members with hypercalcemia: members with vascular or soft tissue calcifications or members with low PTH.
FROVA Tablets	*Frovatriptan Succinate*	Migraine	Trial and failure of sumatriptan.
GEODON Capsules, GEODON IM Injection	*Ziprasidone HCL, Ziprasidone Mesylate IM*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE. **HK/HF:** (1) TAR required for CCS screening. (2) If case is not CCS eligible, PHC criteria apply: New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
GROWTH HORMONE Injection (GENOTROPIN, HUMATROPE, NUTROPIN, OMNITROPE, PROTROPIN, SAIZEN) *(Specialty Pharmacy Item)*	*Somatropin, Somatrem*	Growth Hormone deficiency	Treatment of Growth Hormone Deficiency, Chronic Renal Insufficiency (CRI) and Non-mosaic Turner Syndrome (TS) in members under the age of 21. Requests for GHD must meet one of the following criteria: 1) A diminished peak serum GH response below 7ng/ml to at least 2 provocative stimuli: 2) A diminished peak serum GH response between 7-12ng/ml with a growth rate of 4.5cm or less per yr for girls 0-10 years & boys 0-12 years: 3) Growth less than 8-10cm per year at puberty.
HEPSERA Tablets	*Adefovir*	Hepatitis B	Treatment of chronic Hepatitis B virus in adults who have been evaluated by a gastroenterologist, HIV or liver specialist with evidence of active viral replication, active disease or evidence of persistent elevation of ALT / AST.
HERBALS	*All types*	none	Not a PHC covered benefit. Not approved by the FDA for safety, efficacy and purity standards.
HUMIRA PFS, Kit *(Specialty Pharmacy Item)*	*Adalimumab*	RA	Treatment of Rheumatoid Arthritis in members who have been evaluated by a rheumatologist have had an incomplete or inadequate response to methotrexate. Authorization for 40mg every week dosing requires that the member has tried and failed a 3 month trial of 40mg every other week.

HYALGAN Syringe *(Specialty Pharmacy Item)*	*Hyaluronate sodium*	OA	Treatment of Osteoarthritis of the knee in which the following are met: (1) members who have been evaluated by an appropriate specialist, (2) condition is not controlled with physical therapy, NSAIDs and steroid injections & (3) surgery is not contemplated.
HYDROCODONE w/APAP Combinations Tablets	Hydrocodone/APAP tablets 5/500 VICODIN 7.5/500 LORTAB 7.5/650 LORCET PLUS 7.5/750 VICODIN ES 10/325 NORCO-10 10/500 LORTAB 10/650 LORCET 10/660 VICODIN HP	Moderate to Moderately Severe Pain *(Include primary diagnosis /cause of pain on TAR)*	**MC, HK:** TAR review required when formulary quantity limit is exceeded. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with pain management consultant may be required. Limitations: 5/500 is limited to 8 tabs/day or 240 tabs per month. All other strengths are limited to 4 tabs/day or 120 tabs/month without a TAR.
HYDROXY-PROGESTERONE Injection	*Hydroxyprogesterone Injection*		Limited to use in reducing risk of preterm delivery in singleton pregnancy with history of spontaneous preterm delivery. Request for treatment should begin between 16-20 weeks of gestation, and continue until 37 weeks gestation or birth. Must be supplied by a compounding pharmacy rather than using Makena.
IMMUNE GLOBULIN IV	*IGIV*	See Criteria	Must be prescribed by a specialist or by the PCP in conjunction with a specialist consultation for treatment of the following conditions: Immunodeficiency Syndrome (supporting labs required), Idiopathic Thrombocytopenia, B-cell Chronic Lymphocytic Leukemia, Kawasaki Disease, Bone Marrow transplant, Guillain-Barre Syndrome or Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).
INCRELEX Subcutaneous injection	*Mecasermin*	See Criteria	For treatment of severe primary IGF-1 deficiency or growth hormone gene depletion with neutralizing antibiotics in a person less than 18 years old & confirmed by pediatric endocrinologist or nephrologist.
INFANT FORMULAS Powder, liquid	*Various Formula products*	See Criteria	Treatment of a medical condition for members unable to maintain adequate nutrition with contract formulas provided by the WIC Program: Similac Advance, Similac with iron, Similac Lactose Free, Similac Isomil, Similac Isomil Advance and Lacto-Free. For infants needing soy based formula such as Isomil, Prosobee or a specialty formula such as Alimentum, Nutramigen, Pregestimil or Pediasure. A completed Infant Formula Medical Justification form is required with each TAR.

InfeD, DexFerrum IM, IV	*Iron Dextran*		IV: Iron Sucrose in the preferred choice for IV use. See prior auth criteria for Iron Sucrose (Venofer). IM: For IM Iron Dextran requests, IV Iron Sucrose is preferred if criteria met. See prior auth criteria for Iron Sucrose (Venofer).
INSPRA Tablets	*Eplerenone*	HTN, CHF	HTN: Trial and failure of formulary antihypertensives. CHF: For post-MI use.
INVEGA Tablets	*Paliperidone ER tablets*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims & TARs to STATE. **HK:** (1) TAR required for CCS screening. (2) If case is not CCS eligible, PHC criteria apply: New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
JANUMET Tablets	*Sitagliptin/Metformin*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** Trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
JANUVIA Tablets	*Sitagliptin*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin *and* insulin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** Trial and failure of either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
KADIAN Capsules	*Morphine Sulfate, DR capsules (pelleted)*	Around-the-Clock pain control *(Include primary diagnosis / cause of pain on TAR)*	Trial and failure or contraindication to use of morphine sulfate sustained-release tablets (generic MS Contin) *and* methadone, at equianalgesic doses. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with pain management consultant may be required.

KINERET PFS injection	*Anakinra*	RA	Treatment of moderate to severe rheumatoid arthritis in members 18 yrs or older who have been evaluated by a rheumatologist and have failed one of more DMARDS (Imuran, Plaquenil, MTX, etc).
KYTRIL Tablets	*Granisetron*	Antiemetic	Restricted to use for prophylaxis of nausea and vomiting associated with cancer chemotherapy and radiation therapy. Limit of 9 tablets per fill and 2 fills per month; renewable every 6 mo.
LAMISIL Tablets	*Terbinafine HCL*	Antifungal	Treatment of onychomycosis, diagnosis confirmed by laboratory; member must be experiencing pain that interferes with normal activity or be immunocompromised; normal baseline LFTs required. Treatment is limited to 6 weeks of therapy for fingernail and 12 weeks of therapy for toenail.
LEUKINE Lyophilized & Liquid	*Sargramostim*	See Criteria	New Starts -- Use limited to FDA approved indications: following induction therapy in AML; transplantation of autologous peripheral blood progenitor cells; bone marrow transplant failure.
LEVITRA Tablets	*Vardenafil*	none	This drug is not covered per Federal Regulation and State Operating Instruction letter as of 1/1/06.
LEXAPRO Tablets	*Escitalopram Oxalate*	MDD	New Starts: For treatment in members who have failed or have contraindications to 2 agents: fluoxetine, paroxetine, sertraline or citalopram--one of which must have been citalopram. Half tablet substitution required.
LIDODERM Patch	*Lidocaine 5% Patch*	Postherpetic Neuralgia	Rx or recommendation from pain specialist/ pain clinic: Dx of postherpetic neuralgia, Hx of chemical/narcotic dependency, and treatment failure with three other formulary agents for pain: Limit 4 patches/day for 3 months initially: if repeat request, may approve for up to 6 months.
LIPITOR Tablets	*Atorvastatin*	Hyperlipidemia	Trial and failure of formulary statin: simvastatin 40mg, fluvastatin 80mg, rosuvastatin (step), pravastatin 80mg or lovastatin 80mg.
LOTRONEX Tablets	*Alosetron HCL*	Chronic IBS (diarrhea predominant)	Trial and failure of an antispasmodic agent, bulking agent.

LOVAZA Capsules	*Omega-3 Acid Ethyl Esters*	Triglycerides > 500	For Hypertriglyceridemia. Trial and failure of niacin and or formulary statins.
LUNESTA Tablets	*Eszopiclone*	Insomnia	Trial and failure of non-drug treatment of chronic insomnia and formulary agents zolpidem (Ambien), or benzodiazepines.
LYRICA Capsules	*Pregabalin*	Fibromyalgia, Neuralgia	Fibromyalgia or Postherpetic Neuralgia: Failure with trials of both gabapentin *and* a tricyclic antidepressant.
MARINOL Capsules	*Dronabinol*	Medically necessary appetite stimulant, Antiemetic	Treatment of anorexia associated with weight loss for members with HIV/AIDS or nausea and vomiting associated with cancer chemotherapy in members not responding to conventional antiemetic treatment.
MAXALT Tablets, MLT	*Rizatriptan Benzoate*	Migraine	Trial and failure of formulary sumatriptan.
MEGACE SUSPENSION 40mg/ml	*Megestrol Acetate susp*	Medically necessary appetite stimulant	Must not be eligible for coverage under Medicare Part D. Part D plans (PDP) must cover megestrol when used for cancer chemotherapy or for weight gain in patients with chronic diseases such as AIDS, CHF, lung, kidney or liver disease not responding to conventional treatment such as nutritional support and anti-emetic therapy.
MEPROBAMATE Tablets	*Meprobamate*	Anxiety disorder	Trial and failure of buspirone, hydroxyzine or failure with benzodiazepines.
METADATE CD Capsule	*Methylphenidate HCL ER Capsules*	ADD, ADHD	Pediatric use: Trial and failure of formulary stimulants for ADHD, a need for less frequent dosing or unable to swallow medications. Adult use: Same as pediatric criteria, and in addition, T/F of atomoxetine (Strattera).
METHYL-PHENIDATE ER & REG Tablets	"Branded" generics: *Methylin, Methylin ER, Metadate ER*, (substitutes for Ritalin, Ritalin SR	ADD, ADHD	Pediatric use: Use limited to members between 6 and 16 years of age. Adult use: Dx of ADD/ADHD, *and* T/F of atomoxetine (Strattera).
METROGEL 1%	*Metronidazole 1% topical gel*	Rosacea	Trial & failure of formulary metronidazole 0.75% gel.

MIRAPEX Tablets	*Pramipexole*	Parkinson's Disease, Restless Leg Syndrome	Use limited to Parkinson's Disease and moderate to severe primary RLS. For RLS, must have trial & failure of 2 (two) formulary agents (carbidopa/l-dopa, clonazepam, ropinirole), one of which must be ropinirole.
MULTAQ Tablets	*Dronedarone*	A-fib, A-flutter	Trial & failure or contraindication to amiodarone.
MUSE Pellet	*Alprostadil*	none	This drug is not covered per Federal Regulation and State Operating Instruction letter as of 1/1/06.
NAMENDA Tablet	*Memantine HCL*	Alzheimer's, Dementia	Treatment of moderate to severe Alzheimer's Disease or related dementia as single therapy or in combination with an ACE inhibitor. A baseline MMSE score of between 3 and 14 or evidence of Alzheimer's Dementia with an alternate assessment tool is required. An updated MMSE or other assessment tool is required every 12 months.
NANDROLONE Injection	*Nandrolone decanoate*	Anemia	Use limited to management of anemia of renal insufficiency.
NEUPOGEN Injection *(Specialty Pharmacy Item)*	*Filgrastim*	Neutropenia	Treatment in members with neutropenia secondary to chemotherapy when prescribed by an oncologist, and prophylaxis treatment in chemotherapy regimens and patient factors that are associated with a high risk of febrile neutropenia (>20%) as summarized in NCCN Practice Guidelines in Oncology-v.1.2007 and in members with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. Ref: *Myeloid Growth Factors: National Comprehensive Cancer Network (NCNN) practice guidelines in Oncology V.1.2008* For HCV treated members: Neutropenia defined as absolute neutrophil count (ANC) less than 500/mm^3 (Grade 4) associated with interferon treatment in HCV and a higher than average risk of infection (eg, cirrhosis, HIV?HCV co-infection and patients posttransplant on immunosuppressants). QTY limit of 1 week supply. *Ref: UpToDate Online 2010.*
NEULASTA Injection	*Pegfilgrastim*	Neutropenia	Same as Neupogen, see above.

NEXIUM Capsules	*Esomeprazole*	See Criteria	Treatment of erosive esophagitis, duodenal ulcer associated with H. pylori infection and pathological hypersecretory conditions including ZE syndrome. Treatment of GERD related conditions unresponsive to trials of both lansoprazole-OTC AND omeprazole (either Rx or OTC omeprazole).
NICODERM CQ Patch	*Nicotine Patch*	Smoking cessation	Requests exceeding two 90 day course per year (180d/yr) requires member to be currently enrolled in a in a smoking cessation program.
NICOTROL, NICOTROL NS	*Nicotine oral inhaler, Nicotine nasal spray*	Smoking cessation	Trial and failure of nicotine gum and nicotine patch.
NITRO-DUR PATCH	*Nitroglycerin Patch*	Angina	Trial and failure with nitroglycerin topical ointment (Nitro-BID 2%).
ONGLYZA Tablets	*Saxagliptin*	DM	**Step Edit (claim pays w/o TAR):** (1) Prior claims exist for both metformin, insulin *and* sitagliptin on profile in the last 120 days, or (2) prescriber is an endocrinologist. **TAR criteria if Step or Prescriber edits are not met:** Trial and failure of sitagliptin and either insulin or metformin with a HgA1C less than 9.0 in the last 90 days.
ORFADIN Capsules	*Nitisinone*	See Criteria	Use limited to Tyrosinemia; alkaptonuria.
ORAL NUTRITIONAL SUPPLEMENTS (ENSURE GLUCERNA, PROCEL, etc)	*Oral Nutritional Supplements*	Medically necessary nutrition	**MC:** Supplemental treatment of a medical condition for members who are malnourished or may be at risk for malnutrition and are unable to maintain adequate nutrition with ordinary foodstuffs. A completed Nutritional Supplement Medical Justification form is required with each TAR. Not a covered benefit for members residing in a LTC/ICF (see page 66). For dialysis patients, the albumin level continues to 3.9 or below and has been unresponsive to high protein diet & counseling recommendations by a Registered Dietitian. **HK/HF:** OTC products are not a covered benefit
ORTHOCLONE	*Muromonab-CD3 injection*	Graft vs. Host	Trial and failure of first line therapy (cyclosporine, methotrexate) for acute graft vs host reaction in allogenic bone marrow transplantation.

OXANDRIN Tablets	*Oxandrolone*		Trial and failure of megestrol.
OXYCONTIN Tablets	*Oxycodone extended-release*	Around-the-clock pain control *(Include primary diagnosis/cause of pain on TAR)*	Treatment of moderate-to-severe chronic pain for members who have a demonstrated ineffectiveness to maximum doses of long-acting (LA) morphine AND methadone; or for members who have a demonstrated intolerance (defined as hallucinations, delirium, nausea/vomiting or excessive sedation) to LA morphine AND methadone. Requests must be accompanied by documentation of an appropriate evaluation and management plan in the medical record. Consultation with pain management consultant may be required in patients without cancer pain.
PATANASE NASAL SPRAY	*Olopatadine 0.6% nasal spray*	Allergic or Non-Allergic Rhinitis	Trial and Failure of first-line therapy, including oral antihistamines and nasal steroids, for allergic or for non-allergic rhinitis.
PAXIL CR Tablets	*Paroxetine CR HCL*	MDD	New Starts: For treatment in members who have failed or have contraindications to 2 formulary SSRI's: fluoxetine, paroxetine, sertraline or citalopram.
PEGASYS Vial, Kit *(Specialty Pharmacy Item)*	*Peginterferon Alfa-2A*	Hepatitis C	Combination treatment with ribavirin for Chronic Hepatitis C in members who have been evaluated by a gastroenterologist &/or HIV specialist. Baseline labs/reports required. Treatment beyond 12 weeks for genotype 1 requires evidence of an early viral response (EVR) defined as a minimum 2 log decrease in viral load (HCV/RNA). Maximum duration of therapy is limited to 24 weeks for genotypes 2 and 3 and 48 weeks for genotype 1. Treatment for members beyond these limits or retreatment for members who were "nonresponders" with previous therapy must be clinically justified and supported by documentation from current medical literature.
PEG-INTRON Kit	*Peginterferon Alfa-2B*	Hepatitis C	Same as Pegasys, see above.

PENLAC NAIL LACQUER 8% solution	*Ciclopirox nail soln.*	Onychomycosis	Treatment of onychomycosis in members for whom oral Lamisil is contraindicated; member must be experiencing pain that interferes with normal activity or be immunocompromised. Treatment may be authorized up to 48 weeks with documentation of removal of the unattached, infected nail, as frequently as monthly, by a health care professional.
PERIOSTAT Tablets	*Doxycycline Hyclate 20mg*	Scaling and root planing	Treatment restricted to no longer than 9 months duration for use as an adjunct therapy to scaling and root planing in members with adult periodontitis.
PRADAXA Capsules	*Dabigatran*	See Criteria	Indicated for reduction of risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation. Trial & failure or contraindication to warfarin therapy.
PRAVACHOL Tablets	*Pravastatin*	Hyperlipidemia	Pravastatin 10 & 20mg on formulary as of 4/1/11. Please use multiples of 20mg for 40 & 80mg doses.
PREMARIN Tablets (High Dose Tx)	*Estrogens, Conjugated tabs*	Trans-gender	For trans-gender change: treatment authorized if it is prescribed for medically necessary reasons (not cosmetic use) & discontinuing would cause great psychological harm.
PREVACID (Rx) Capsules	*Lansoprazole DR Capsules*	See Criteria	Treatment of erosive esophagitis, duodenal ulcer associated with H. pylori infection and pathological hypersecretory conditions including ZE syndrome. Treatment of GERD related conditions unresponsive to trials of both lansoprazole-OTC AND omeprazole (either Rx or OTC omeprazole). Note: OTC lansoprazole is the same formulation as Rx lansoprazole; no product changes were required for FDA approval of OTC status. The OTC product is only available in 15mg. Please consider 2 of the 15mg OTC capsules to yield a 30mg dose.
PRISTIQ Tablets	*Desvenlafaxine*	MDD	New starts: Treatment of Depression for members who have had a trial and failure of a formulary SSRI (citalopram, fluoxetine, paroxetine, sertraline) AND venlafaxine-ER.
PROCRIT Injection	*Epoetin Alpha*		See EPOGEN

PROMETRIUM Capsules	*Progesterone, Micronized*	Endometrial hyperplasia, secondary amenorrhea	Trial & failure of, or contraindication to formulary medroxyprogesterone or formulary progesterone injection. (Rx Qty limit #12/month).
PROTONIX Tablets	*Pantoprazole Sodium*		Added to formulary effective 7/1/11.
PROTOPIC Ointment	*Tacrolimus oint.*	Atopic dermatitis (Eczema)	Treatment of moderate-to-severe atopic dermatitis for members who are intolerant to alternative conventional therapies, and for when alternative, conventional therapies are deemed inadvisable because of potential risks.
PROVIGIL Tablets	*Modafinil*	See Criteria	Treatment of narcolepsy or for daytime sleepiness due to sleep apnea unresponsive to 1st line therapy such as CPAP. Limit of 30 tablets per month.
RAZADYNE IR Tablets	*Galantamine*	Alzheimer's, Dementia	Treatment of Alzheimer's Disease or related dementia with a baseline MMSE score of between 10 and 26. An updated MMSE is required every 12 months.
REBETOL (also RIBAPAK, RIBASPHERE, COPEGUS) Tablets, Capsules *(Specialty Pharmacy Item)*	*Ribavirin*	Hepatitis C	Treatment of Chronic Hepatitis C for members who have been evaluated by a gastroenterologist &/or HIV specialist. Baseline labs/reports required. Treatment beyond 12 weeks for genotype 1 requires evidence of an early viral response (EVR) defined as a minimum 2 log decrease in viral load (HCV/RNA). Maximum duration of therapy is limited to 24 weeks for genotypes 2 and 3 and 48 weeks for genotype 1. Treatment for members beyond these limits or retreatment for members who were "nonresponders" with previous therapy must be clinically justified and supported by documentation from current medical literature.
REBETRON	*Ribavirin/ Interferon alfa-2b*	Hepatitis C	Same as REBETOL (above) *and in addition*, medical justification must also be provided supporting why member cannot be treated with the current 1st line therapy of peginterferon alfa 2-a, plus ribavirin.

REGRANEX Gel	*Becaplermin*	DM foot ulcer	Treatment of lower-extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond & have an adequate blood supply, in addition to debridement, pressure relief, & infection control. Must be prescribed by a specialist in wound care.
RELENZA Inhalation	*Zanamivir*	H1N1 infection	**Code 1:** Cases in which current CDC guidelines for *treatment* are met; **Limit:** 5 day treatment supply, one fill per year. TARs are reviewed on a case-by-case basis if Code 1/Limit restrictions are not met.
RELPAX Tablets	*Eletriptan Hydrobromide*	Migraine	Trial and failure of formulary sumatriptan.
REMICADE Vial	*Infliximab*	RA	Treatment of Rheumatoid Arthritis in members who have been evaluated by a rheumatologist and have had an incomplete or inadequate response to methotrexate.
RENAGEL Tablets	*Sevelamer HCL*	Hyperphosphatemia	For control of hyperphosphatemia in dialysis members who are unresponsive to calcium based phosphate binder therapy (PhosLo) in amounts exceeding 2,000 mg total elemental calcium content*; members with hypercalcemia; members with vascular or soft tissue calcifications; or members with low PTH. **PhosLo 667 = 169mg elemental calcium per capsule. 12 capsules = 2,028mg*
RENVELA Susp, Pwd, Tabs	*Sevelamer Carbonate*	Hyperphosphatemia	For control of hyperphosphatemia in dialysis members who are unresponsive to calcium based phosphate binder therapy (PhosLo) in amounts exceeding 2,000 mg total elemental calcium content*; members with hypercalcemia; members with vascular or soft tissue calcifications; or members with low PTH. **PhosLo 667 = 169mg elemental calcium per capsule. 12 capsules = 2,028mg*
RESTASIS Ophth. Soln.	*Cyclosporine ophth.*	See Criteria	For patients with keratoconjunctivitis sicca or dry eyes disease who have failed a trial of artificial tears and/or Lacrisert.

RESTORIL 7.5 mg Capsules	*Temazepam 7.5mg*	Insomnia	Trial and failure of non-drug treatment of chronic insomnia and formulary agents: zolpidem, benzodiazepines (temazepam 15-30mg, lorazepam, etc).
REVATIO Tablets	*Sildenafil Citrate*	Pulmonary Hypertension	Revatio, sildenafil 20mg tablets only: For Pulmonary Arterial Hypertension only. The drug is not covered for erectile dysfunction per Federal regulation and California State Operating Instruction date 1/1/06
RISPERDAL Tablets	*Risperidone*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE. **HK/HF:** New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
RISPERDAL CONSTA Injection	*Risperidone Long-acting Injection*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out Drug in all counties; send claims/TARs to STATE. **HK/HF:** New Starts -- T/F of, or contraindication to, injectable phenothiazine.
RITALIN RITALIN SR Tablets	*Methylphenidate HCL, Methylphenidate ER*	ADD, ADHD	**Pediatric use:** Use limited to members between 6 and 16 years of age. **Adult use:** T/F of atomoxetine (Strattera).
RITALIN LA Capsules	*Methylphenidate LA capsules*	ADD, ADHD	**Pediatric use:** Trial and failure of formulary stimulants for ADHD, a need for less frequent dosing or unable to swallow medications. **Adult use:** Same as pediatric criteria, and in addition, T/F of atomoxetine (Strattera).
ROZEREM Tablets	*Ramelteon*	Insomnia	Trial and failure of non-drug treatment of chronic insomnia and two formulary agents: zolpidem (Ambien) and a benzodiazepine.
SAVELLA Tablets, Titration Pack	*Milnacipran HCL tablet*	Fibromyalgia	Limited to the treatment of Fibromyalgia with trials and failures of a TCA, gabapentin *and* pregabalin.
SENSIPAR Tablets	*Cinacalcet HCL*	Secondary Hyperparathyroidism, Parathyroid Cancer	For dialysis members with uncontrolled severe secondary hyperparathyroidism despite maximal doses of vitamin D sterols who are either not candidates for parathyroidectomy, or who have failed parathyroidectomy; dialysis members with persistent hypercalcemia on vitamin D sterol and off all calcium-containing products and on low calcium dialysate; or for members with parathyroid cancer.

SEROQUEL Tablets (Immediate Release)	*Quetiapine Fumarate*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out drug in all counties; send claims & TARs to STATE. **HK/HF:** New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
SEROSTIM Injection	*Somatropin*	HIV Wasting	Treatment of HIV associated wasting in members who meet 1 of the following criteria: 5% BCM loss within the preceding 6 months; BCM less than 35% of total body weight for men or 23% for women & BMI less than 27kg/m2; BMI less than 25kg/m2 & a 10% unintentional weight loss within the preceding 12 months or 7.5% unintentional weight loss within the preceding 6 months. Treatment must be re-evaluated after 4 weeks & 8 weeks of therapy for a maximum duration of 12 weeks of initial therapy. A nutritional evaluation by a Registered Dietician is also required. For complete policy see HS Policy No. RC100435
SERZONE Tablets	*Nefazodone*	Depression	New starts -- Treatment of depression in members who do not have liver disease or elevated LFTs; have been evaluated by a psychiatrist; and have failed or have a contraindication to two formulary agents: fluoxetine, paroxetine, citalopram or sertraline.
SINGULAIR Tablets, Chewable, Granules	*Montelukast*		According to the NIH National Asthma Education and Prevention Program (NAEPP) 2007 Expert Panel Report (EPR)-3 national asthma guidelines, montelukast or other leukotriene receptor antagonists (LTRA) is either an appropriate preferred or alternative (depending on patient age) combination therapy with medium dose ICS at step 4 (severe persistent asthma). **For Age 0-4 yrs**: see summary of NAEPP EPR guidelines. For persistent asthma (step 2), use of montelukast as initial step therapy is an acceptable alternative to preferred low dose ICS. **For persistent asthma (step 4,5,6),** use of LABA or Montelukast in combination w/ICS is preferred initial step therapy. **For Ages 5-11** see summary of NAEPP EPR guidelines. Use of LTRA is an acceptable alternative component therapy for Step 2, 4,5,6. LTRA is a preferred component for Step 3 **For Age12 yrs and older,** see summary of NAEPP EPR guidelines. Use of LTRA is an acceptable alternative for Step 2,3, 4 persistent asthma Reference NAEPP EPR: www.nhlbi.nih.gov/guidelines/asthma
SOMA 350MG Tablets	*Carisoprodol*	Muscle spasms	Indicated for short term use only. Trial and failure of formulary muscle relaxants: baclofen, cyclobenzaprine, methocarbamol, tizanidine.
STIMATE Nasal Spray	*Desmopressin Acetate*	See Criteria	Limited to use in Hemophilia A (factor VIII def.) & Von Willebrand disease.

STRATTERA Capsules	*Atomoxetine HCL*	ADD, ADHD	**Pediatric use (< 17 yrs):** Trial and failure of formulary stimulant medication (e.g. short, intermediate and long acting methylphenidate, dextroamphetamine); children who do not want or parents who do not want their children to take controlled substances. Limited to max of once daily dosing on 1 strength capsule. Additional justification required for more than one capsule per day. **Adult use:** Formulary, limited to a maximum of once daily dosing of 1 strength capsule. Additional justification required for more than one capsule per day.
SYMBICORT MDI	*Budesonide/Formoterol Fumarate HFA*	Asthma, COPD	New Starts, Asthma: Limited to members with trial/failure of inhaled corticosteroid (ICS). New Starts, COPD: Limited to members with severe disease, as classified below: Stage summary/treatment criteria-- - mild: t/f short acting bronchodilator - moderate: t/f of long acting bronchodilator - severe: t/f of above and ICS
SYMLIN Vial, Pen	*Pramlintide*	DM	Use as adjunct in Type 1 diabetics who use mealtime insulin and who failed optimal insulin therapy. Use in Type 2 diabetics as an adjunct who use mealtime insulin and who failed optimal insulin therapy with or without oral agents..

SYNAGIS *(Specialty Pharmacy Item)* Injection	*Palivizumab*	RSV	Prevention of Respiratory Syncytial Virus (RSV) in children born at less than 29 weeks gestation and less than 12 months at the start of RSV season and children between 29 & 32 weeks gestation and less than 6 months at the start of RSV season. Children born between 32 and 35 weeks gestation and who are 3 months of age or less at the start of RSV season or during the RSV season, and have at least 1 of the following two risk factors, may be approved according to the American Academy of Pediatrics Guidelines: (1) attend childcare or (2) have sibling(s) younger than 5 years of age. For complete policy, see HS Policy Number MPRC4025. *Note: CCS criteria are applied for CCS clients, regardless of the CCS diagnosis.*
SYNVISC, SYNVISC-ONE *(Specialty Pharmacy Item)* Injection	*Hylan G-F 20*	OA	Treatment of Osteoarthritis of the knee in which the following are met: (1) members who have been evaluated by an appropriate specialist, (2) condition is not controlled with physical therapy, NSAIDs and steroid injections & (3) surgery is not contemplated.
SYPRINE Capsules	*Trientine HCL*	Wilson's Disease	Trial and failure of penicillamine.
TAMIFLU Tablets, Suspension	*Oseltamivir Phosphate*	H1N1 infection	**Code 1:** Cases in which current CDC guidelines for *treatment* are met; **Limit:** 5 day treatment supply, one fill per year. TARs are reviewed on a case-by-case basis if Code 1/Limit restrictions are not met. Compounded Suspension: Submit TAR with a compound worksheet (see Pharmacy Policy & Procedure Manual for current form).
TEKTURNA Tablets	*Aliskiren*	HTN	Use limited to inadequately controlled hypertension on three formulary medications. Quantity limit of 30 tabs/month.

TESTOSTERONE PRODUCTS, ALL FORMS Injection (Cypionate, Enanthate) Patch Gel	*Testosterone*	Primary or Secondary hypogonadism	Treatment for male members 18 years of age or older diagnosed with primary or secondary hypo-gonadism: ▪ Lab confirmed low testosterone level, *drawn before 9am*, within 90 days of request must be provided for initiation of new therapy. ▪ A baseline lab before treatment was started is required for those members new to PHC who are currently on therapy. Patches, gel, cream and pellet dosage forms require a trial & failure of, or contraindication to, injectable testosterone.
TRACLEER Tablets	*Bosentan*	PAHT	Limited to pulmonary arterial hypertension.
TRENTAL Tablets	*Pentoxifylline*	See Criteria	Treatment of intermittent claudication on the basis of chronic occlusive arterial disease of the limbs.
TRICOR Tablets	*Fenofibrate nanocrystals*	Hypercholesterolemia, Hypertriglyceridemia	Trial & failure of formulary fenofibrate—available as 67, 134 & 200mg micronized fenofibrate capsules and 54 & 160mg tablets (non-micronized).
TRILIPIX Capsules	*Fenofibric Acid (Choline fenofibrate)*	Hypercholesterolemia, Hypertriglyceridemia	Trial & failure of formulary micronized fenofibrate— available as 67, 134 & 200mg caps and 54 & 160mg tablets.
TYZEKA Tablets	*Telbivudine*	Hepatitis B	Evaluated by a gastroenterologist; use for treatment of chronic Hepatitis B.
ULESFIA Lotion	*Benzyl Alcohol 5% lotion*	Head Lice	Trial & failure or contraindication to OTC & Rx permethrin or malathion.
ULORIC Tablets	*Febuxostat*	Symptomatic Gout	Trial & failure of, or contraindication to, the use of maximum doses of allopurinol.
VANCOCIN Capsules	*Oral Vancomycin HCL*	C. difficile	Limited to use in gastrointestinal infections due to *Clostridium difficile* (C. diff.) with trial and failure of metronidazole. Note: not systemically absorbed.

Venofer IV iron	*Iron Sucrose*		Laboratory evidence of iron deficiency anemia (characterized by low levels of ferritin and serum iron, increased levels of transferrin, low percent saturation of transferrin and increased unsaturated iron binding capacity). Trial and failure of oral iron supplementation. Indication for parenteral iron in iron deficient patients whose level of continued bleeding (usually GI) exceeds the ability of the GI tract to absorb iron. Other indications include patients with inflammatory bowel disease and iron deficiency with Hx of severe GI intolerance, dialysis for reasons of ongoing blood loss associated with procedure, need for adequate iron to respond to administration of erythropoietin and the inability of these patients to utilize oral iron, and anemic cancer patients receiving treatment with erythropoiesis-stimulating agent. Requests for IV iron therapy in patients with HD-CKD on epoetin therapy should have transferrin saturation of less than 30%.
VIAGRA Tablets	*Sildenafil Citrate*	none	This drug is not covered per Federal Regulation and State Operating Instruction letter as of 1/1/06.
VICTOZA Injection	*Liraglutide*	DM	1. Prescribed by endocrinologist, ***or*** 2. HgA1C less than 9.0 in the last 90 days: trial & failure of metformin or insulin. 3. HgA1C equal to or greater than 9.0 in the last 90 days: trial & failure of metformin AND insulin.
VOLTAREN GEL	*Diclofenac sodium gel 1%*	OA	Trial & failure of 2 formulary agents (diclofenac, salsalate, ibuprofen, meloxicam or naproxen).
VYTORIN Tablets	*Ezetimibe/ Simvastatin*	Hyperlipidemia	Trial and failure of, or contraindication to, formulary statins: lovastatin, simvastatin, rosuvastatin (STEP), fluvastatin or pravastatin.
VYVANSE Capsules	*Lisdexamfetamine Dimesylate*	ADHD	Limited to use in children with ADHD who are 6-12 years of age and have had a trial & failure of, or contraindication to generic Adderall/Adderall XR: amphetamine aspartate/amphetamine sulfate/dextroamphetamine saccharate/ dextroamphetamine sulfate (aka “amphetamine mixture”, “amphetamine salts”, “mixed amphetamines”).

XENICAL Capsules	*Orlistat*	Obesity	Treatment for obese members with an initial body mass index (BMI) greater than or equal to 30 or for members with BMI greater than or equal to 27 who have concomitant risk factors (e.g., hypertension, diabetes, dyslipidemia, CHD, sleep apnea). Members must be participating in an exercise program and a supervised diet program. Weight updates are required for each TAR submittal.
XOLAIR Injection	*Omalizumab*	Allergy-mediated Asthma	Treatment of members 12 years of age and older with moderate to severe allergy related asthma inadequately controlled with high-dose inhaled corticosteroid in combination with a 2nd asthma controller (LA beta-agonist or leukotriene modifier) for at least 3 months. Must be prescribed by an allergy or pulmonary medicine specialist and member must have a documented positive skin prick or RAST test to a perennial aeroallergen.
XOPENEX HFA & Solution	*Levalbuterol HCL neb. soln., Levalbuterol Tartrate HFA*	Asthma	Rescue treatment of asthma in members who have tried and failed or have a contraindication to albuterol.
ZAVESCA Capsules	*Miglustat*	See Criteria	Use restricted to Gaucher disease.
ZEGERID Capsules, Powder	*Omeprazole / Sod. Bicarb.*	See Criteria	Treatment of erosive esophagitis, duodenal ulcer associated with H. pylori infection and pathological hypersecretory conditions including ZE syndrome. Treatment of GERD related conditions unresponsive to maximum doses of lansoprazole-OTC AND either omeprazole-Rx or omeprazole-OTC.
ZEMPLAR Capsules	*Paricalcitol*	Secondary Hyperparathyroidism	Trial & failure of formulary vitamin D sterols: doxercalciferol (Hectorol) or calcitriol (Rocaltrol).
ZOFRAN Tablets	*Ondansetron HCL*	Antiemetic	Code 1: Restricted to use for prophylaxis of nausea and vomiting associated with cancer chemotherapy and radiation therapy. Limit of 30 tablets per month without a TAR.
ZOFRAN Injection	*Ondansetron HCL*	Antiemetic	Supplied and administered in a physician's office or outpatient facility in conjunction with chemotherapy.

ZOMIG Tablets, ZMT, Nasal	*Zolmitriptan*	Migraine	Trial and failure of formulary sumatriptan.
ZOVIRAX Topical, Cream, Ointment	*Acyclovir Topical*	Herpes genitalis or mucocutaneous Herpes simplex	Trial and failure of, or contraindication to oral acyclovir; use limited to Herpes genitalis or mucocutaneous Herpes simplex infections.
ZYBAN Tablets	*Bupropion HCL SR*	Smoking cessation	Requests exceeding one 90 day course per year requires member to member to be currently enrolled in a smoking cessation program.
ZYFLO Tablets	*Zileuton*	Asthma	Treatment of asthma in adults and children who have tried & failed oral inhaled corticosteroids.
ZYPREXA Tablets, ODT	*Olanzapine*	Schizophrenia, Bipolar Disorder	**MC:** Psychotherapeutic Carve-out drug in all counties; send claims & TARs to STATE. **HK/HF:** New Starts – Limited to FDA approved indications of Bipolar Disorder & Schizophrenia with trial & failure of non-atypical antipsychotics. Other dx's considered when 1st line tx is T/F.
ZYVOX Tablets, suspension, injection	*Linezolid*	VRE	Use limited to VRE.

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