2013

BlueMedicare℠

Comprehensive Formulary

BlueMedicare Rx (PDP)
BlueMedicare HMO
BlueMedicare PPO
BlueMedicare Regional PPO

BlueMedicare Group Rx (Employer PDP)
BlueMedicare Group PPO

Y0011_30838 0812R1 CMS Accepted
Y0011_30838 0812R1 EGWP C: 08/2012

Florida Blue
In the pursuit of health®

Health insurance is offered by Blue Cross and Blue Shield of Florida, D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO

2013 Formulary

(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2014.

Florida Blue is a Medicare Advantage organization with a Medicare contract.

Florida Blue HMO is a Medicare Advantage organization with a Medicare contract.

A Medicare-approved Part D sponsor.

Please call Member Services at 1-800-926-6565 if you would like to receive this document in an alternate format or language. You will be able to speak to someone from 8:00 a.m. – 9:00 p.m. ET, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on Saturdays and Sundays. We will return your call within one business day. TTY users should call 1-800-955-8771.

Formulary ID: 00013173 PDP Version <7>
Formulary ID: 00013177 HMO Version <7>
Formulary ID: 00013182 PPO Version <7>
Formulary ID: 00013186 RPPO Version <7>

Y0011_30838 0812R1 CMS Accepted

Y0011_30838 0812R1 EGWP C: 08/2012

What is the BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO Formulary?

A formulary is a list of covered drugs selected by BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Generally, if you are taking a drug on our 2013 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2013 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2013. To get updated information about the drugs covered by BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO, please visit our Web site at www.BlueMedicareFL.com or call Member Services at 1-800-926-6565. You will be able to speak to someone from 8:00 a.m. – 9:00 p.m. ET, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on federal holidays, Saturdays and Sundays. We will return your call within one business day. TTY users should call 1-800-955-8771.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 50. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO before you fill your prescriptions. If you don't get approval, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO may not cover the drug.

- **Quantity Limits:** For certain drugs, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO limit the amount of the drug that BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO will cover. For example, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO provide 31 tablets per prescription for JANUVIA. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO may not cover Drug B unless you try Drug A first. If Drug A does not work for you, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.BlueMedicareFL.com.

You can ask BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO to make an exception to these restrictions or limits. See the section, "How do I request an exception to the BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO formulary?" on page iii for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and confirm that your drug is not covered. If you learn that BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO do not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO.

- You can ask BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the BlueMedicare Rx (PDP), HMO, PPO & Regional PPO and BlueMedicare Group Rx (Employer PDP), HMO & PPO Formulary?

You can ask BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Tier 4: Non-Preferred Brand Drugs tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Tier 3: Preferred Brand Drugs tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Tier 5: Specialty tier.

Generally, BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.**

Generally, we must make our decision within 72 hours of getting your prescriber's or prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 93-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Circumstances exist in which unplanned transitions for current members could arise and in which prescribed drug regimens may not be on the formulary. These circumstances usually involve level of care changes in which a member is changing from one treatment setting to another. For these unplanned transitions, you must use our exceptions and appeals process. Coverage determinations and redeterminations will be processed as expeditiously as your health condition requires.

When a member is admitted to or discharged from a Long Term Care (LTC) facility, he or she does not have access to the remainder of the previously dispensed prescription. We will ensure you have a refill upon admission or discharge. A one-time override of the "refill too soon" edits, are provided, for each medication which would be impacted due to a member being admitted to or discharged from an LTC facility. Early refill edits are not used to limit appropriate and necessary access to a member's Part D benefit, and such members are allowed to access a refill upon admission or discharge.

If you are a member of our plan, you could have an unexpected transition if you experience a level-of-care change. You may have been prescribed drugs that are not on our formulary, and you are changing from one treatment setting to another. For these unplanned transitions, you must use our exceptions and appeals process. Coverage determinations and appeals will be processed as quickly as your health condition requires.

For more information

For more detailed information about your BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO, please visit www.BlueMedicareFL.com or call Member Services at 1-800-926-6565. You will be able to speak to someone from 8:00 a.m. – 9:00 p.m. ET, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on federal holidays, Saturdays and Sundays. We will return your call within one business day. TTY users should call 1-800-955-8771.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO. If you have trouble finding your drug in the list, turn to the Index that begins on page 50.

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

The information in the Requirements/Limits column tells you if BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO have any special requirements for coverage of your drug.

Below is additional information to help you understand the formulary:

DOSAGE FORM ABBREVIATIONS KEY	
caps	capsules
chew tabs	chewable tablets
conc	concentrate
crm	cream
DR	delayed-release
ER	extended-release
g	gram
hr	hour
IM	intramuscular
inhal	inhalation
inj	injection
IR	immediate-release
IV	intravenous
liq	liquid
lotn	lotion
mcg	microgram
mEq	milliequivalent
mg	milligram
mL	milliliter
NF	non-formulary
ODT	orally disintegrating tablets
oint	ointment
SL	sublingual
soln	solution
supp	suppositories
susp	suspension
tabs	tablets

- The information in the second column of the chart tells you at what level (tier) your drug is covered.

- Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstances are indicated by an “X” in the third column of the chart.

- The last three columns of the chart, “Prior Authorization,” “Quantity Limits” and “Step Therapy,” indicate if BlueMedicare Rx, HMO, PPO & Regional PPO and BlueMedicare Group Rx & PPO have any special requirements for coverage of a drug.

- If Quantity Limits apply to a drug, the restriction amounts are shown in the listing beginning on page 35.

- Limited distribution drugs are indicated by an asterisk (*) in the drug list. These drugs may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 1-800-926-6565. You will be able to speak to someone from 8:00 a.m. – 9:00 p.m. ET, seven days a week from October 1 through February 14. However, from February 15 to September 30, you will have to leave a message on federal holidays, Saturdays and Sundays. We will return your call within one business day. TTY users should call 1-800-955-8771.

- For BlueMedicare Rx (PDP) - Option 2, BlueMedicare Group Rx (Employer Group PDP) - Option 3 and BlueMedicare HMO: We provide coverage of Tier 1: Preferred Generic Drugs, Tier 2: Non-Preferred Generic Drugs and Tier 5: Generic Specialty Drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage. (Does not apply to members of BlueMedicare HMO in Duval and Brevard counties).

- For BlueMedicare Group Rx (Employer Group PDP) – Options 1 & 2: We provide coverage of Tier 1: Preferred Generic Drugs, Tier 2: Non-Preferred Generic Drugs, Tier 3: Preferred Brands, Tier 4: Non-Preferred Brands and Tier 5: Specialty Drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

The copayment/coinsurance amounts that you pay for a one-month (31-day) supply of drugs in each Drug Tier are shown on the next two pages.

For BlueMedicare Rx – Options 1 & 2, HMO, PPO and Regional PPO:

	Pharmacy Type	Drug Tier 1 Preferred Generics	Drug Tier 2 Non-Preferred Generics	Drug Tier 3 Preferred Brand	Drug Tier 4 Non-Preferred Brand	Drug Tier 5 Specialty
BlueMedicare Rx Option 1 (PDP)	**Preferred Retail**	$6 copay	$16 copay	$32 copay	$90 copay	33% of the cost
	Non-Preferred Retail	$10 copay	$21 copay	$37 copay	$95 copay	
	Mail Order (90-day supply)	$0 copay	$24 copay	$96 copay	$270 copay	
BlueMedicare Rx Option 2 (PDP)	**Preferred Retail**	$2 copay	$6 copay	$35 copay	$85 copay	33% of the cost
	Non-Preferred Retail	$9 copay	$13 copay	$42 copay	$94 copay	
	Mail Order (90-day supply)	$0 copay	$15 copay	$105 copay	$255 copay	
BlueMedicare HMO (Miami-Dade County)	**Retail**	$0 copay	$0 copay	$25 copay	$50 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$0 copay	$75 copay	$150 copay	
BlueMedicare HMO (Broward, Hillsborough, Palm Beach, Pasco, Pinellas, Polk, Orange, Osceola and Seminole counties)	**Retail**	$0 copay	$0 copay	$45 copay	$95 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$0 copay	$135 copay	$285 copay	
BlueMedicare HMO (Brevard and Duval counties)	**Retail**	$10 copay	$20 copay	$45 copay	$95 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$0 copay	$135 copay	$285 copay	

	Pharmacy Type	Drug Tier 1 Preferred Generics	Drug Tier 2 Non-Preferred Generics	Drug Tier 3 Preferred Brand	Drug Tier 4 Non-Preferred Brand	Drug Tier 5 Specialty
BlueMedicare HMO (Lake and Sumter counties)	**Retail**	$0 copay	$0 copay	$30 copay	$80 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$0 copay	$90 copay	$240 copay	
BlueMedicare PPO	**Retail**	$10 copay	$17 copay	$45 copay	$95 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$24 copay	$135 copay	$285 copay	
BlueMedicare Regional PPO	**Preferred Retail**	$6 copay	$10 copay	$45 copay	$95 copay	33% of the cost
	Mail Order (90-day supply)	$0 copay	$15 copay	$135 copay	$285 copay	

For BlueMedicare Group Rx - Options 1, 2 & 3:

	Pharmacy Type	Drug Tier 1 Preferred Generics	Drug Tier 2 Non-Preferred Generics	Drug Tier 3 Preferred Brand	Drug Tier 4 Non-Preferred Brand	Drug Tier 5 Specialty
BlueMedicare Group Rx Option 1 (Employer PDP)	**Retail**	$10 copay	$10 copay	$40 copay	$70 copay	25% of the cost
	Mail Order (90-day supply)	$0 copay	$0 copay	$80 copay	$140 copay	
BlueMedicare Group Rx Option 2 (Employer PDP)	**Retail**	$15 copay	$15 copay	$45 copay	$85 copay	25% of the cost
	Mail Order (90-day supply)	$8 copay	$8 copay	$135 copay	$255 copay	
BlueMedicare Group Rx Option 3 (Employer PDP)	**Retail**	$10 copay	$10 copay	$45 copay	$95 copay	33% of the cost
	Mail Order (90-day supply)	$20 copay	$20 copay	$135 copay	$285 copay	

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
Analgesics					
acetaminophen/codeine oral soln	1			•	
acetaminophen/codeine tabs	2			•	
ANAPROX	4				
ANAPROX DS	4				
AVINZA	3			•	
butorphanol	2				
CELEBREX	3			•	
CODEINE SULFATE tabs	4				
DILAUDID tabs	4				
DILAUDID-HP inj, 10 mg/mL	4	X			
DOLOPHINE	4				
etodolac	2				
fentanyl transdermal	2			•	
fentanyl citrate oral lozenges	5		•	•	
hydrocodone/acetaminophen caps; oral soln, 7.5-325 mg/15 mL, 7.5-500 mg/15 mL	2			•	
hydrocodone/acetaminophen tabs, 2.5-500 mg, 5-300 mg, 5-325 mg, 5-500 mg, 7.5-300 mg, 7.5-325 mg, 7.5-500 mg, 7.5-650 mg, 7.5-750 mg, 10-300 mg, 10-325 mg, 10-500 mg, 10-650 mg, 10-660 mg, 10-750 mg	2			•	
hydrocodone/ibuprofen	2			•	
hydromorphone inj, 10 mg/mL	2	X			
hydromorphone liq, tabs	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ibuprofen	1				
ketoprofen	2				
ketorolac tabs	2			•	
LEVORPHANOL	4				
methadone tabs, 5 mg, 10 mg	2				
morphine sulfate inj, 0.5 mg/mL, 1 mg/mL	2	X			
morphine sulfate oral soln	2				
MORPHINE SULFATE tabs	4				
morphine sulfate ER tabs	2			•	
NAPROSYN	4				
naproxen susp	2				
naproxen tabs	1				
naproxen sodium tabs	1				
NUCYNTA ER	3			•	
oxycodone tabs, 5 mg, 15 mg, 30 mg	2				
oxycodone/acetaminophen	1			•	
oxycodone/aspirin	2			•	
OXYCONTIN	3			•	
PENNSAID	3			•	•
PERCODAN	4			•	
ROXICODONE tabs	4				
tramadol	2			•	
tramadol ER (Generic for Ultram ER)	2			•	
tramadol/acetaminophen	2			•	
ULTRACET	4			•	
ULTRAM	4			•	
VICOPROFEN	4			•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
VOLTAREN gel	3			•	•
Anes e ics					
EMLA	4				
lidocaine local inj, 0.5 , 1 ; topical soln,	2				
lidocaine iscous	1				
lidocaine/prilocaine	2				
LIDODERM	3				
XYLOCAINE local inj, 0.5 , 1 topical soln, 4	4				
An i A ic i n s ance A se ea en Agen s					
ANTABUSE	4				
buprenorphine L tabs	2			•	
bupropion hcl ER, 12 hr (smoking deterrent)	2				
CHANTIX	3			•	
disulfiram	2				
NALOXONE inj, 0.4 mg/mL	4				
naloxone inj, 1 mg/mL	2				
naltrexone	2				
NICOTROL INHALER	4				
NICOTROL NS nasal spray	4				
SUBOXONE	4			•	
SUBUTEX	4			•	
VIVITROL	5				
ZYBAN	4				
An i ac e ials					
AMI ACIN inj, 100 mg/2 mL	4				
amikacin inj, 500 mg/2 mL, 1 g/ mL	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
amoxicillin caps; che tabs, 250 mg; for susp; tabs	1				
AMOXICILLIN chew tabs, 125 mg	4				
amoxicillin/potassium cla ulanate che tabs, tabs	2				
amoxicillin/potassium cla ulanate for susp, 200 mg/5 mL, 00 mg/5 mL, 600 mg/5 mL	2				
ampicillin caps	2				
AMPICILLIN for susp	4				
ampicillin sodium for inj, 125 mg, 250 mg, 500 mg, 1 g, 2 g; for , 10 g	2				
AMPICILLIN SODIUM for IV, 1 g, 2 g	4				
AUGMENTIN tabs, 500 mg, 5 mg	4				
AVELOX	3				
AZACTAM	4				
azithromycin for , for susp, tabs	2				
AZITHROMYCIN powder pac for susp	3				
aztreonam for inj	2				
BACTRIM	4				
BACTRIM DS	4				
BIAXIN	4				
BIAXIN XL	4				
cefaclor caps	2				
cefadroxil	2				
cefazolin for inj, 500 mg, 1 g, 10 g, 20 g	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
cefdinir	2				
cefepime for inj	2				
cefotaxime for inj, 500 mg, 1 g, 2 g, 10 g	2				
cefoxitin for inj	2				
cefpodoxime	2				
cefprozil	2				
ceftazidime for inj, 500 mg, 1 g, 2 g, 6 g; for , 1 g, 2 g	2				
CEFTIN for susp, 125 mg/5 mL tabs	4				
ceftriaxone for inj, for	2				
CEFTRIAXONE for IV in de trose, inj in de trose	4				
cefuroxime axetil	2				
cefuroxime sodium for inj, 750 mg, 1.5 g, 7.5 g; for , 1.5 g	2				
cephalexin caps, for susp	1				
CHLORAMPHENICOL	4				
CIPRO	4				
ciprofloxacin for , 200 mg, 00 mg; for in dextrose	2				
ciprofloxacin tabs, 250 mg, 500 mg, 750 mg	1				
ciprofloxacin ER	2				
CLAFORAN for inj, IV in de trose	4				
clarithromycin	2				
clarithromycin ER	2				
CLEOCIN caps, for IV, inj, IV in de trose, vaginal cream	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
clindamycin caps	1				
clindamycin inj; soln, 600 mg/ mL, 00 mg/6 mL; aginal crm	2				
colistimethate sodium	2				
CUBICIN	5	X			
demeclocycline	2				
dicloxacillin	2				
DIFICID	5				
doxycycline hyclate caps, tabs	1				
doxycycline hyclate for inj	2				
doxycycline monohydrate	2				
E.E.S. GRANULES	4				
ERY-TAB	4				
ERYPED	4				
ERYTHROCIN	4				
FLAGYL	4				
FORTAZ	4				
GENTAMICIN inj in saline, 0. mg/mL, 1.4 mg/mL	4				
gentamicin inj; inj in saline, 0. mg/mL, 1 mg/mL, 1.2 mg/ mL, 1.6 mg/mL; soln	2				
HIPREX	4				
imipenem/cilastatin	2				
INVANZ	4				
ANAMYCIN	4				
EFLEX caps, 250 mg, 500 mg	4				
LEVAQUIN oral soln	4				
le ofloxacin	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
MACROBID	4				
MACRODANTIN caps, 50 mg, 100 mg	4				
MEFOXIN	4				
meropenem	2				
MERREM	4				
methenamine hippurate	2				
METRO IV	4				
METROGEL VAGINAL	4				
metronidazole caps, soln, aginal gel	2				
metronidazole tabs	1				
MINOCIN caps	4				
minocycline	2				
MONODOX	4				
nafcillin for inj	2				
NAFCILLIN for IV	4				
neomycin sulfate tabs	2				
nitrofurantoin susp	2				
nitrofurantoin macrocrystalline caps	2				
nitrofurantoin monohydrate/ macrocrystalline caps	2				
ofloxacin	2				
penicillin g potassium for inj	2				
PENICILLIN G POTASSIUM inj in de trose	4				
PENICILLIN G SODIUM for inj	4				
penicillin potassium	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PFIZERPEN-G for inj, 20 million units	4				
piperacillin/tazobactam for inj, 2-0.25 g, 3-0.375 g, -0.5 g	2				
PREVPAC	3				
ROCEPHIN	4				
STREPTOMYCIN	4				
SULFADIAZINE	4				
SULFAMETHOXAZOLE/ TRIMETHOPRIM inj	4				
sulfamethoxazole/trimethoprim susp	2				
sulfamethoxazole/trimethoprim tabs	1				
SUPRAX tabs	4				
SYNERCID	5				
TEFLARO	4				
TETRACYCLINE caps, 250 mg	4				
tetracycline caps, 500 mg	1				
TIMENTIN	4				
TOBI	5	X			
tobramycin for inj, inj	2				
TOBRAMYCIN inj in saline	4				
trimethoprim tabs	1				
TYGACIL	4				
VANCOCIN caps	5				
ancomycin caps	5				
ancomycin for inj, 500 mg, 1 g, 5 g	2	X			
VANCOMYCIN inj in de trose	4	X			

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
VIBRAMYCIN caps	4				
XIFAXAN tabs, 550 mg	3				
ZINACEF inj in de trose, inj in sterile water	4				
ZITHROMAX for IV, for susp, tabs	4				
ZOSYN for inj, 2-0.25 g, 3-0.3 5 g, 4-0.5 g IV in de trose	4				
ZYVOX	5				
An ic n lsan s					
BANZEL susp tabs, 400 mg	5				
BANZEL tabs, 200 mg	4				
carbamazepine	1				
carbamazepine ER caps; ER tabs, 200 mg, 00 mg	2				
CARBATROL	4				
CELONTIN	4				
clonazepam , tabs	2		•	•	
clorazepate	2		•	•	
DEPACON	4				
DEPA ENE	4				
DEPA OTE	4				
DEPA OTE ER	4				
DEPA OTE SPRIN LES	4				
DIAZEPAM oral conc, oral soln	4		•	•	
DIAZEPAM rectal gel	4			•	
diazepam tabs	2		•	•	
DILANTIN	4				
di alproex sprinkle caps	2				
di alproex R tabs	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
di alproex ER	1				
ethosuximide caps	2				
ethosuximide oral soln	1				
felbamate	2				
FELBATOL	4				
fosphenytoin	2				
gabapentin caps	1				
gabapentin oral soln, tabs	2				
GABITRIL	4				
EPPRA	4				•
LAMICTAL chew tabs, 5 mg, 25 mg tabs	4				•
LAMICTAL ODT	4				•
lamotrigine che tabs, 5 mg, 25 mg	2				
lamotrigine tabs	1				
le etiracetam inj, oral soln	2				
LEVETIRACETAM IV in saline	4				
le etiracetam tabs	1				
LYRICA	3				
MYSOLINE	4				
NEURONTIN	4				
ONFI	4		•	•	
oxcarbazepine susp	2				
oxcarbazepine tabs	1				
PEGANONE	4				
phenobarbital tabs, 16.2 mg, 30 mg, 32. mg	2		•		
PHENOBARBITAL tabs, 4. mg, .2 mg	4		•		

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PHENYTE	4				
phenytoin susp	1				
phenytoin sodium ER caps, 100 mg, 200 mg, 300 mg	1				
POTIGA	4				•
primidone	1				
SABRIL	4				
TEGRETOL	4				
TEGRETOL-XR	4				
TOPAMAX	4				•
TOPAMAX SPRIN LES	4				•
topiramate sprinkle caps	2				
topiramate tabs	1				
TRILEPTAL	4				•
alproate inj	2				
alproic acid	1				
VIMPAT	4				•
ZARONTIN caps	4				
ZONEGRAN	4				
zonisamide	1				
An i e en ia Agen s					
ARICEPT tabs, 5 mg, 10 mg	4			•	
ARICEPT ODT	4			•	
donepezil	2			•	
EXELON caps	4			•	
EXELON oral soln, transdermal	3			•	
galantamine	2			•	
galantamine ER	2			•	
NAMENDA	3			•	

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
RAZADYNE	4			•	
RAZADYNE ER	4			•	
ri astigmine caps	2			•	
An i e essan s					
ABILIFY	3			•	
ABILIFY DISCMELT	3			•	
amitriptyline	1				
AMOXAPINE	4				
ANAFRANIL	4				
bupropion hcl	1			•	
bupropion hcl ER, 12 hr	1			•	
bupropion hcl ER, 2 hr	1			•	
CELEXA	4			•	•
citalopram oral soln	2			•	
citalopram tabs	1			•	
clomipramine	1				
CYMBALTA	3			•	•
desipramine	2				
doxepin caps, 10 mg, 25 mg, 50 mg, 75 mg, 100 mg; oral conc	1				
DOXEPIN caps, 150 mg	4				
EFFEXOR XR	4			•	•
EMSAM	4				
escitalopram	2			•	
fluoxetine caps; oral soln; tabs, 10 mg, 20 mg	1			•	
fluoxetine R	2			•	
flu oxamine	1			•	
imipramine hcl	1				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
imipramine pamoate	2				
LEXAPRO	4			•	•
MAPROTILINE	4			•	•
MARPLAN	4				
mirtazapine tabs	1			•	
mirtazapine	2			•	
NARDIL	4				
NEFAZODONE	4				
NORPRAMIN	4				
nortriptyline caps	1				
OLEPTRO	4			•	•
PARNATE	4				
paroxetine hcl tabs	1			•	
paroxetine hcl ER	2			•	
PAXIL	4			•	•
PAXIL CR	4			•	•
phenelzine	2				
PRISTIQ	4			•	•
protriptyline	2				
PROZAC	4			•	•
PROZAC EE LY	4			•	•
quetiapine	1		•	•	
REMERON	4			•	•
REMERON SOLTAB	4			•	•
SEROQUEL	4		•	•	
SEROQUEL XR	3			•	
sertraline oral conc	2			•	
sertraline tabs	1			•	
SURMONTIL	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
tranylcypromine	2				
trazodone	1				
trimipramine	1				
enlafaxine	1			•	
enlafaxine ER caps	1			•	
enlafaxine ER tabs, 37.5 mg, 75 mg, 150 mg	2			•	
VIIBRYD	4			•	•
ELLBUTRIN	4			•	•
ELLBUTRIN SR	4			•	•
ELLBUTRIN XL	4			•	•
ZOLOFT	4			•	•
An ie e ics					
ALOXI	4				
ANTIVERT tabs, 12.5 mg, 25 mg	4				
CHLORPROMAZINE inj	4		•		
chlorpromazine tabs	1		•		
diphenhydramine caps, elixir	1				
diphenhydramine inj	2				
dronabinol	2	X			
EMEND caps	3	X			
EMEND for IV	4				
granisetron tabs	2	X			
hydroxyzine hcl syrup, tabs	2				
meclizine tabs, 12.5 mg, 25 mg	2				
metoclopramide oral soln, tabs	2				
ondansetron inj	2				
ondansetron , oral soln, tabs	2	X			
perphenazine	1		•		

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PROCHLORPERAZINE inj	4				
prochlorperazine supp, tabs	1				
promethazine supp, syrup, tabs	2				
REGLAN tabs	4				
ZOFRAN oral soln, tabs	4	X			
ZOFRAN ODT	4	X			
An i ngals					
AMPHOTERICIN B	4	X			
ANCOBON	4				
CANCIDAS	5				
clotrimazole troche	2				
DIFLUCAN	4				
fluconazole for susp; inj in dextrose; inj in normal saline, 200 mg/100 mL, 00 mg/200 mL	2				
FLUCONAZOLE inj in normal saline, 100 mg/50 mL	4				
fluconazole tabs	1				
flucytosine	2				
GRIS-PEG	3				
griseoful in	2				
itraconazole caps	2				
ketoconazole tabs	2				
LAMISIL tabs	4				
MYCAMINE	5				
NOXAFIL	5		•		
nystatin susp, tabs	2				
SPORANOX caps	4				
TERAZOL 3	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
TERAZOL	4				
terbinafine	1				
terconazole	2				
VFEND susp	5		•		
VFEND IV	4		•		
oriconazole for inj	2		•		
oriconazole tabs	5		•		
An ig Agen s					
allopurinol for inj	2				
allopurinol tabs	1				
ALOPRIM	4				
COLCRYS	3				
probenecid	2				
probenecid/colchicine	2				
ULORIC	3				
ZYLOPRIM	4				
An i n la a Agen s					
ANAPROX	4				
ANAPROX DS	4				
ARTHROTEC	4				
CATAFLAM	4				
CELEBREX	3			•	
CLINORIL	4				
DAYPRO	4				
diclofenac potassium	2				
diclofenac sodium R	2				
diclofenac sodium ER	2				
EC-NAPROSYN	4				
etodolac	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
etodolac ER	2				
FELDENE	4				
flurbiprofen	2				
ibuprofen	1				
indomethacin caps	1				
indomethacin ER	2				
ketoprofen	2				
meloxicam tabs	1				
MOBIC tabs	4				
nabumetone	2				
NAPROSYN	4				
naproxen susp	2				
naproxen tabs	1				
naproxen R	2				
naproxen sodium tabs	1				
oxaprozin	1				
PENNSAID	3			•	•
piroxicam	2				
sulindac	2				
tolmetin sodium caps, 00 mg	2				
VIMOVO	3			•	
VOLTAREN gel	3			•	•
VOLTAREN-XR	4				
An i ig aine Agen s					
AMERGE	4			•	•
DEPA OTE	4				
DEPA OTE ER	4				
DEPA OTE SPRIN LES	4				
di alproex sprinkle caps	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
di alproex R tabs	1				
di alproex ER	1				
ergotamine/caffeine	2				
IMITREX inj	4				•
IMITREX nasal spray, tabs	4			•	•
INDERAL LA	4				
MAXALT	4			•	•
MAXALT-MLT	4			•	•
MIGERGOT	4				
MIGRANAL	3				
naratriptan	2			•	
propranolol tabs	1				
propranolol ER caps	2				
sumatriptan inj	2				
SUMATRIPTAN nasal spray	4			•	
sumatriptan tabs	1			•	
TIMOLOL tabs	4				
TOPAMAX	4				•
TOPAMAX SPRIN LES	4				•
topiramate sprinkle caps	2				
topiramate tabs	1				
An i as enic Agen s					
MESTINON syrup, tabs	4				
pyridostigmine	2				
An i c ac e ials					
CAPASTAT	4				
CYCLOSERINE	4				
DAPSONE	3				
ethambutol	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ISONIAZID inj	4				
isoniazid tabs	1				
isoniazid/rifampin	2				
MYCOBUTIN	4				
PASER	4				
PRIFTIN	4				
pyrazinamide	2				
RIFADIN	4				
rifampin	2				
SEROMYCIN	4				
TRECATOR	4				
An ine las ics					
ABRAXANE	5				
ADRIAMYCIN for inj, 20 mg	4	X			
AFINITOR	5		•	•	
ALIMTA	5				
amifostine	5				
anastrozole	1				
ARIMIDEX	4				
AROMASIN	4				
ARRANON	5				
ARZERRA	5				
AVASTIN*	5				
BICNU	4				
bleomycin	2	X			
BUSULFEX	5				
CAMPATH	5				
CAPRELSA*	5		•	•	
carboplatin soln	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
CEENU	4				
CISPLATIN inj, 200 mg/200 mL	4				
cisplatin inj, 50 mg/50 mL, 100 mg/100 mL	2				
cladribine	5	X			
CLOLAR	5				
COSMEGEN	5				
CYCLOPHOSPHAMIDE for inj	4				
CYCLOPHOSPHAMIDE tabs	4	X			
CYTARABINE for inj, 100 mg	4	X			
cytarabine for inj, 500 mg, 1 g, 2 g; inj	2	X			
DACARBAZINE for inj, 100 mg	4				
dacarbazine for inj, 200 mg	2				
DACOGEN	5				
daunorubicin	2				
DAUNOXOME	5				
dexrazoxane	5				
DOCEFREZ	5				
DOCETAXEL for inj, 20 mg/mL, 0 mg/4 mL for IV	5				
DOXIL	4	X			
doxorubicin	2	X			
ELITE	5				
ELSPAR	4				
EMCYT	4				
epirubicin inj	2				
ERBITUX	5				
ERIVEDGE	5		•	•	
ETOPOPHOS	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits: B or D	Prior Authorization	Quantity Limits †	Step Therapy
etoposide inj	2				
exemestane	2				
FARESTON	4				
FASLODEX	5				
FEMARA	4				
fludarabine	2				
fluorouracil inj	2	X			
gemcitabine for inj	5				
GEMCITABINE inj	5				
GLEEVEC	5		•	•	
HALAVEN	5				
HERCEPTIN	5				
HEXALEN	5		•		
HYDREA	4				
hydroxyurea	1				
idarubicin	5				
IFEX for inj, 3 g	4				
ifosfamide for inj, 1 g	2				
IFOSFAMIDE for inj, 3 g IV	4				
IFOSFAMIDE/MESNA	4				
INLYTA	5		•	•	
INTRON-A 10 million units, 25 million units	4				
INTRON-A 1 million units, 50 million units	5				
IRESSA*	5				
irinotecan	2				
ISTODAX	5				
IXEMPRA	5				

Drug Name	Drug Tier	Requirements/ Limits: B or D	Prior Authorization	Quantity Limits †	Step Therapy
A AFF	5		•	•	
EVTANA	5				
letrozole	2				
leuco orin calcium for inj, 100 mg, 200 mg, 350 mg	2				
LEUCOVORIN CALCIUM for inj, 50 mg, 500 mg inj, 10 mg/mL tabs, 10 mg, 15 mg	4				
leuco orin calcium tabs, 5 mg, 25 mg	1				
LEU ERAN	3				
MATULANE	5		•		
melphalan	5				
mercaptopurine	1				
mesna	2				
MESNEX tabs	4				
methotrexate for inj, inj	2				
methotrexate tabs	1	X			
mitomycin	2				
mitoxantrone	2				
MUSTARGEN	4				
NEXAVAR*	5		•	•	
ONCASPAR	5				
ONTA	5				
oxaliplatin	5				
paclitaxel , 30 mg/5 mL, 100 mg/16.7 mL, 300 mg/50 mL	2				
PANRETIN	5				
pentostatin	5				
PER ETA	5				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PROLEU IN	5				
PURINETHOL	4				
REVLIMID*	5		•	•	
RITUXAN*	5		•		
SPRYCEL	5		•	•	
SUTENT	5		•	•	
SYLATRON	5		•		
TABLOID	4				
tamoxifen	1				
TARCEVA	5		•	•	
TARGRETIN caps	5		•		
TARGRETIN gel	5				
TASIGNA	5		•	•	
TAXOTERE	5				
TEMODAR for IV	5				
THALOMID	5		•	•	
THIOTEPA	4				
topotecan for inj	5				
TOPOTECAN inj	5				
TORISEL	5				
TREANDA	5				
TRETINOIN caps	5		•		
TRISENOX	4				
TY ERB*	5		•	•	
UVADEX	4				
VANDETANIB*	5		•	•	
VECTIBIX	5				
VELCADE	5				
VIDAZA	5				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
VINBLASTINE	4	X			
incristine	2				
inorelbine	2				
VOTRIENT	5		•	•	
XAL ORI	5		•	•	
YERVOY	5				
ZANOSAR	5				
ZELBORAF	5		•	•	
ZOLINZA	5		•	•	
ZYTIGA	5		•	•	
An i a asi ics					
ALBENZA	4				
ALINIA	4				
ato aquone/proguanil tabs, 250-100 mg	2				
BILTRICIDE	4				
chloroquine phosphate	2				
COARTEM	4				
DARAPRIM	4				
hydroxychloroquine	1				
lindane lotn, shampoo	2				
MALARONE	4				
malathion	2				
mefloquine	2				
MEPRON	5				
OVIDE	4				
paromomycin	2				
PENTAM 300	4	X			
permethrin	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PLAQUENIL	4				
PRIMAQUINE	4				
STROMECTOL	3				
ULESFIA	4				
An i a ins n Agen s					
amantadine caps, syrup	2				
AMANTADINE tabs	4				
APO YN*	5				
AZILECT	3				
benztropine tabs	1				
bromocriptine	2				
carbidopa/le odopa	2				
carbidopa/le odopa ER	2				
COMTAN	4				
diphenhydramine caps, elixir	1				
diphenhydramine inj	2				
ELDEPRYL	4				
MIRAPEX	4				
PARCOPA	4				
PARLODEL	4				
pramipexole	1				
REQUIP	4				
ropinirole	2				
selegiline	2				
SINEMET	4				
SINEMET CR	4				
STALEVO	3				
TASMAR	5				
trihexyphenidyl	2				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
An i s c ics					
ABILIFY	3			•	
ABILIFY DISCMELT	3			•	
CHLORPROMAZINE inj	4		•		
chlorpromazine tabs	1		•		
clozapine	2		•	•	
CLOZARIL	4		•	•	
FANAPT	4		•	•	
FAZACLO	4		•	•	
FLUPHENAZINE DECANOATE	4		•		
FLUPHENAZINE HCL eli ir, inj, oral conc	4		•		
fluphenazine hcl tabs	1		•		
GEODON	4		•	•	
HALDOL	4		•		
HALDOL DECANOATE	4		•		
haloperidol inj	2		•		
haloperidol oral conc, tabs	1		•		
haloperidol decanoate	2		•		
INVEGA tabs, 1.5 mg, 3 mg, mg	4		•	•	
INVEGA tabs, mg	5		•	•	
INVEGA SUSTENNA inj, 11 mg, 15 mg, 234 mg	5		•	•	
INVEGA SUSTENNA inj, 3 mg, mg	4		•	•	
LATUDA	4		•	•	
loxapine	1		•		
NAVANE caps, 2 mg, 10 mg	4		•		
olanzapine	2		•	•	
ORAP	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
perphenazine	1		•		
PROCHLORPERAZINE inj	4				
prochlorperazine supp, tabs	1				
quetiapine	1		•	•	
RISPERDAL	4		•	•	
RISPERDAL CONSTA	4		•	•	
RISPERDAL M-TAB	4		•	•	
risperidone , 0.5 mg, 1 mg, 2 mg, 3 mg, mg; oral soln	2		•	•	
risperidone tabs	1		•	•	
RISPERIDONE ODT, 0.25 mg	4		•	•	
SAPHRIS	4		•	•	
SEROQUEL	4		•	•	
SEROQUEL XR	3			•	
thioridazine	2		•		
thiothixene	1		•		
trifluoperazine	1		•		
ziprasidone	1		•	•	
ZYPREXA	4		•	•	
ZYPREXA RELPREVV*	5		•	•	
ZYPREXA ZYDIS	4		•	•	
An is as ici Agen s					
baclofen tabs	1				
DANTRIUM caps	4				
dantrolene caps	2				
tizanidine	2				
ZANAFLEX tabs	4				
An i i als					
acyclo ir caps, tabs	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
acyclo ir susp	2				
ACYCLOVIR SODIUM for inj, 1000 mg IV soln	4	X			
acyclo ir sodium for inj, 500 mg	2	X			
amantadine caps, syrup	2				
AMANTADINE tabs	4				
APTIVUS	4			•	
ATRIPLA	4			•	
BARACLUDE oral soln	4				
BARACLUDE tabs	5				
COMPLERA	4			•	
CRIXIVAN	4			•	
CYTOVENE	4	X			
didanosine R	2			•	
EDURANT	4			•	
EMTRIVA	4			•	
EPIVIR oral soln	3			•	
EPIVIR tabs	4			•	
EPIVIR-HBV	3				
EPZICOM	3			•	
famciclo ir	2				
FAMVIR	4				
FOSCARNET	4	X			
FUZEON	5			•	
GANCICLOVIR caps	3				
ganciclo ir for inj	2	X			
HEPSERA	5				
INCIVE	5		•		
INTELENCE	4			•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
INTRON-A 10 million units, 25 million units	4				
INTRON-A 1 million units, 50 million units	5				
INVIRASE	4			•	
ISENTRESS	3			•	
ALETRA	4			•	
lami udine	2			•	
lami udine/zido udine	1			•	
LEXIVA	3			•	
ne irapine tabs	2			•	
NORVIR	4			•	
PREZISTA	4			•	
REBETOL oral soln	4				
RESCRIPTOR	4			•	
RETROVIR	4			•	
RETROVIR IV	4				
REYATAZ	3			•	
RIBAPA 00, 1200	5				
RIBASPHERE tabs, 400 mg	4				
RIBASPHERE tabs, 00 mg	5				
riba irin caps; tabs, 200 mg	2				
rimantadine	2				
SELZENTRY	4			•	
sta udine	2			•	
SUSTIVA	3			•	
TAMIFLU	4				
TRIZIVIR	3			•	
TRUVADA	4			•	

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
TYZE A	4				
alacyclo ir	2				
VALCYTE	5				
VALTREX	4				
VICTRELIS	5		•		
VIDEX	4			•	
VIDEX EC	4			•	
VIRACEPT	4			•	
VIRAMUNE	4			•	
VIRAMUNE XR	4			•	
VIREAD	4			•	
VISTIDE	4				
ZERIT	4			•	
ZIAGEN	3			•	
zido udine	1			•	
ZOVIRAX caps, susp, tabs	4				
An i l ics					
buspirone tabs, 5 mg, 10 mg, 15 mg, 30 mg	1				
BUSPIRONE tabs, .5 mg	4				
clorazepate	2		•	•	
CYMBALTA	3			•	•
DIAZEPAM oral conc, oral soln	4		•	•	
diazepam tabs	2		•	•	
doxepin caps, 10 mg, 25 mg, 50 mg, 75 mg, 100 mg; oral conc	1				
DOXEPIN caps, 150 mg	4				
EFFEXOR XR	4			•	•
escitalopram	2			•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
hydroxyzine hcl syrup, tabs	2				
LEXAPRO	4			•	•
paroxetine hcl tabs	1			•	
paroxetine hcl ER	2			•	
PAXIL	4			•	•
PAXIL CR	4			•	•
sertraline oral conc	2			•	
sertraline tabs	1			•	
enlafaxine ER caps	1			•	
enlafaxine ER tabs, 37.5 mg, 75 mg, 150 mg	2			•	
ZOLOFT	4			•	•
i la Agen s					
ABILIFY	3			•	
ABILIFY DISCMELT	3			•	
DEPA ENE	4				
DEPA OTE	4				
DEPA OTE ER	4				
DEPA OTE SPRIN LES	4				
di alproex sprinkle caps	2				
di alproex R tabs	1				
di alproex ER	1				
EQUETRO	4				
GEODON	4		•	•	
LAMICTAL chew tabs, 5 mg, 25 mg tabs	4				•
LAMICTAL ODT	4				•
lamotrigine che tabs, 5 mg, 25 mg	2				
lamotrigine tabs	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
lithium carbonate caps, tabs	1				
LITHIUM CARBONATE caps, 150 mg, 00 mg	4				
lithium carbonate ER	1				
LITHIUM CITRATE	4				
LITHOBID	4				
olanzapine	2		•	•	
quetiapine	1		•	•	
RISPERDAL	4		•	•	
RISPERDAL CONSTA	4		•	•	
RISPERDAL M-TAB	4		•	•	
risperidone , 0.5 mg, 1 mg, 2 mg, 3 mg, mg; oral soln	2		•	•	
risperidone tabs	1		•	•	
RISPERIDONE ODT, 0.25 mg	4		•	•	
SEROQUEL	4		•	•	
SEROQUEL XR	3			•	
alproic acid	1				
ziprasidone	1		•	•	
ZYPREXA	4		•	•	
ZYPREXA ZYDIS	4		•	•	
l l c se eg la s					
acarbose	2			•	
ACTOS	4			•	•
ALCOHOL S ABS	3				
AMARYL	4			•	
DIABETA	4			•	
GAUZE PADS 2 X 2	3				
glimepiride	1			•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
glipizide	1			•	
glipizide ER	1			•	
glipizide/metformin	2			•	
GLUCAGEN IT	3				
GLUCAGON EMERGENCY IT	3				
GLUCOPHAGE	4			•	
GLUCOPHAGE XR	4			•	
GLUCOTROL	4			•	
GLUCOTROL XL	4			•	
GLUCOVANCE	4			•	
glyburide	1			•	
GLYBURIDE (distributor of Diabeta)	3			•	
glyburide micronized	1			•	
glyburide/metformin	1			•	
GLYNASE	4			•	
HUMALOG	3	X			
HUMALOG MIX	3				
HUMULIN N	3				
HUMULIN R	3				
HUMULIN 0/30	3				
INSULIN IN ECTION DEVICE	3				
INSULIN IN ECTION DEVICE/ NOVOLIN	3				
INSULIN SYRINGE/NEEDLE	3				
ANUMET	3			•	•
ANUMET XR	3			•	•
ANUVIA	3			•	•
ENTADUETO	4			•	•

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
UVISYNC	3			•	•
OMBIGLYZE XR	3			•	•
LANTUS	3				
LEVEMIR	3				
METAGLIP	4			•	
metformin	1			•	
metformin ER (Generic for Glucophage R)	1			•	
nateglinide	2			•	
NOVOLIN N	3				
NOVOLIN R	3				
NOVOLIN 0/30	3				
NOVOLOG	3	X			
NOVOLOG MIX	3				
ONGLYZA	3			•	•
PRANDIN	4			•	
PRECOSE	4			•	
PROGLYCEM	4				
STARLIX	4			•	
SYMLINPEN	4				
TRAD ENTA	4			•	•
VICTOZA	3			•	•
ELCHOL	3				
l c s i ie s l e an e s					
AGGRENOX	4				
AGRYLIN	4				
anagrelide	2				
ARANESP inj, 100 mcg, 150 mcg, 200 mcg, 300 mcg, 500 mcg	5	X	•		

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ARANESP inj, 25 mcg, 40 mcg, 0 mcg	3	X	•		
cilostazol	2				
clopidogrel tabs, 75 mg	2				
COUMADIN tabs	4				
CY LO APRON	4				
dipyridamole tabs	2				
EFFIENT	3				
enoxaparin	2			•	
EPOGEN	4	X	•		
fondaparinux	2			•	
heparin inj in dextrose, 20,000 units/500 mL	2	X			
heparin inj, 1000 units/mL, 5000 units/mL, 10,000 units/mL, 20,000 units/mL	2	X			
LEU INE	5				
LOVENOX	4			•	
NEULASTA	5				
NEUMEGA	5				
NEUPOGEN	5				
pentoxifylline ER tabs	2				
PERSANTINE	4				
PLAVIX tabs, 5 mg	4				
PLETAL	4				
PRADAXA	3			•	
PROCRIT inj, 20,000 units/mL, 40,000 units/mL	5	X	•		
PROCRIT inj, 2000 units/mL, 3000 units/mL, 4000 units/mL, 10,000 units/mL	4	X	•		

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PROMACTA*	5		•	•	
tranexamic acid inj	2				
TRENTAL	4				
arfarin tabs	1				
XARELTO	3			•	
a i asc la Agen s					
ACCUPRIL	4				
ACCURETIC	4				
acebutolol	1				
ACEON	4				
acetazolamide tabs	1				
acetazolamide ER caps	2				
ADALAT CC	4				
ADCIRCA	5		•	•	
ALDACTAZIDE tabs, 25-25 mg	4				
ALDACTONE	4				
ALTACE	4				
amiloride	2				
amiloride/hydrochlorothiazide	1				
amiodarone tabs	1				
amlodipine	1				
amlodipine/benazepril	2				
ATACAND	4			•	•
ATACAND HCT	4			•	•
atenolol	1				
atenolol/chlorthalidone	1				
ator astatin	1			•	
AVALIDE	4			•	•
AVAPRO	4			•	•

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
AZOR	3			•	•
benazepril	1				
benazepril/hydrochlorothiazide	1				
BENICAR	3			•	•
BENICAR HCT	3			•	•
BETAPACE	4				
BETAPACE AF	4				
betaxolol tabs	2				
bisoprolol	1				
bisoprolol/hydrochlorothiazide	1				
bumetanide inj	2				
bumetanide tabs	1				
BYSTOLIC	3				
CALAN	4				
CALAN SR	4				
captopril	1				
CARDIZEM	4				
CARDIZEM CD	4				
CARDIZEM LA	4				
CARDURA	4			•	
car edilol	1				
CATAPRES	4				
CATAPRES-TTS	4				
chlorothiazide tabs	1				
chlorthalidone tabs, 25 mg, 50 mg	1				
cholestyramine	1				
cholestyramine light packets	2				
cholestyramine light po der	1				
clonidine tabs	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
clonidine transdermal	2				
COLESTID	4				
colestipol	1				
CORDARONE	4				
COREG	4				
CORGARD	4				
COZAAR	4			•	•
CRESTOR	3			•	
DEMADEX	4				
DIAMOX SEQUELS	4				
DIBENZYLINE	4				
DIGOXIN oral soln	4				
digoxin tabs	1				
diltiazem tabs	1				
diltiazem ER	2				
DIOVAN	4			•	•
DIOVAN HCT	4			•	•
disopyramide	2				
doxazosin	1			•	
DYAZIDE	4				
DYNACIRC CR	4				
enalapril	1				
enalapril/hydrochlorothiazide	1				
eplerenone	2				
eprosartan	2			•	
EXFORGE	3			•	•
EXFORGE HCT	3			•	•
felodipine ER	2				
fenofibrate	1			•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
fenofibrate micronized	1			•	
FIRAZYR	5			•	
flecainide	2				
fosinopril	1				
fosinopril/hydrochlorothiazide	2				
furosemide inj	2				
furosemide oral soln, 10 mg/mL; tabs	1				
gemfibrozil	1			•	
hydralazine tabs	1				
hydrochlorothiazide	1				
HYZAAR	4			•	•
indapamide	1				
INDERAL LA	4				
INSPRA	4				
irbesartan	1			•	
irbesartan/hydrochlorothiazide	1			•	
ISOPTIN SR	4				
ISORDIL tabs, 5 mg	4				
ISOSORBIDE DINITRATE SL tabs	4				
isosorbide dinitrate tabs	1				
isosorbide dinitrate ER tabs	2				
isosorbide mononitrate	2				
isosorbide mononitrate ER tabs	1				
ISRADIPINE	4				
labetalol tabs	1				
LANOXIN tabs	4				
LASIX	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
LETAIRIS*	5		•	•	
LIDOCAINE IV, 10 mg/mL	4				
LIPITOR	4			•	
LIPOFEN	4			•	
lisinopril	1				
lisinopril/hydrochlorothiazide	1				
LOPID	4			•	
LOPRESSOR tabs	4				
LOPRESSOR HCT	4				
losartan	1			•	
losartan/hydrochlorothiazide	1			•	
LOTENSIN	4				
LOTENSIN HCT	4				
LOTREL	4				
lo astatin	1			•	
LOVAZA	3				
MAVI	4				
MAXZIDE	4				
MAXZIDE-25	4				
methazolamide	2				
methyldopa	1				
metolazone	1				
metoprolol succinate ER	1				
metoprolol tartrate tabs	1				
metoprolol/hydrochlorothiazide tabs, 50-25 mg, 100-25 mg	2				
MEVACOR	4			•	
MEXILETINE	4				
MICARDIS	4			•	•

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
MICARDIS HCT	4			•	•
MICROZIDE	4				
midodrine	2				
minoxidil	2				
moexipril	2				
moexipril/hydrochlorothiazide	1				
MONO ET	4				
MULTAQ	3				
nadolol	1				
NIASPAN	3			•	
nicardipine caps	2				
nifedipine ER tabs	2				
NISOLDIPINE ER tabs, 25.5 mg	4				
nisoldipine ER tabs, .5 mg, 17 mg, 3 mg	2				
NITRO-BID	4				
nitroglycerin transdermal, 0.1 mg/ hr, 0.2 mg/hr, 0. mg/hr, 0.6 mg/hr	2				
NITROMIST	4				
NITROSTAT	3				
NORPACE	4				
NORPACE CR	4				
NORVASC	4				
perindopril	2				
PINDOLOL	4				
PRAVACHOL	4			•	
pra astatin	1			•	
prazosin	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PRINIVIL	4				
PRINZIDE	4				
PROCARDIA XL	4				
propafenone	2				
propafenone ER	2				
propranolol tabs	1				
propranolol ER caps	2				
quinapril	1				
quinapril/hydrochlorothiazide	2				
quinidine gluconate ER	2				
quinidine sulfate	2				
ramipril	1				
RANEXA	3				
REMODULIN*	5	X			
RYTHMOL	4				
RYTHMOL SR	4				
SECTRAL	4				
sim astatin	1			•	
sotalol tabs	1				
sotalol tabs	1				
spironolactone	1				
spironolactone/ hydrochlorothiazide	1				
SULAR	4				
TAMBOCOR	4				
TE TURNA	3			•	•
TE TURNA HCT	3			•	•
TENORETIC	4				
TENORMIN	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
terazosin	1			•	
TEVETEN	4			•	•
TEVETEN HCT	4			•	•
TIAZAC	4				
TI OSYN	4				
TIMOLOL tabs	4				
TOPROL XL	4				
torsemide tabs	1				
TRACLEER*	5		•	•	
TRANDATE tabs, 100 mg, 200 mg	4				
trandolapril	1				
triamterene/hydrochlorothiazide	1				
TRILIPIX	3			•	
UNIRETIC	4				
UNIVASC	4				
VASERETIC	4				
VASOTEC	4				
erapamil tabs	1				
erapamil ER	1				
VERELAN	4				
VERELAN PM	4				
VYTORIN	3			•	
ELCHOL	3				
ZAROXOLYN	4				
ZEBETA	4				
ZESTORETIC	4				
ZESTRIL	4				
ZETIA	3			•	•

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ZIAC	4				
ZOCOR	4			•	
en al e s s e Agen s					
ADDERALL XR	4			•	
amphetamine/ dextroamphetamine ER caps	2			•	
AMPYRA	5		•	•	
AVONEX	5		•	•	
BETASERON	5		•	•	
caffeine citrate oral soln	2				
COPAXONE	5		•	•	
CYMBALTA	3			•	•
DEXEDRINE SPANSULE	4			•	
dexmethylphenidate tabs	2			•	
dextroamphetamine tabs	2			•	
dextroamphetamine ER caps	2			•	
FOCALIN	4			•	
INTUNIV	3			•	
LYRICA	3				
methylphenidate tabs, 5 mg, 10 mg, 20 mg	2			•	
methylphenidate ER tabs, 20 mg	2			•	
mitoxantrone	2				
NUEDEXTA	4				
RILUTE	5				
RITALIN	4			•	
RITALIN SR	4			•	
TYSABRI*	5		•	•	
XENAZINE*	3		•	•	
en al an al Agen s					

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
chlorhexidine gluconate oral rinse, 0.12	1				
doxycycline hyclate tabs, 20 mg	1				
EPIVANCE	5				
pilocarpine tabs	2				
SALAGEN	4				
triamcinolone acetonide paste	2				
e a l gical Agen s					
ACLOVATE	4				
alclometasone	2				
amcinonide crm	2				
ammonium lactate crm; lotn, 12	2				
AZELEX crm	4				
BACTROBAN oint	4				
BENZAMYCIN gel	4				
betamethasone dipropionate crm, lotn, oint	2				
betamethasone dipropionate, augmented; crm, gel, lotn, oint	2				
betamethasone alerate crm, lotn	1				
BETAMETHASONE VALERATE oint	4				
CALCIPOTRIENE oint	4				
calcipotriene soln	2				
CALCITRENE oint	4				
CARAC crm	4				
ciclopirox crm, gel, shampoo, susp	2				
ciclopirox soln (nail lacquer)	1				
CLEOCIN-T gel, lotn, soln, swabs	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
clindamycin gel, lotn, soln, s abs	2				
clindamycin/benzoyl peroxide gel	2				
clobetasol crm, crm (emollient), gel, oint, soln	2				
clotrimazole crm	1				
clotrimazole/betamethasone crm, lotn	2				
CORTIFOAM rectal foam	4				
CUTIVATE crm	4				
DENAVIR crm	4				
DERMATOP	4				
desonide crm, lotn, oint	2				
desoximetasone crm, gel, oint	2				
diflorasone oint	2				
DIPROLENE lotn, oint	4				
DIPROLENE AF	4				
DOVONEX crm	4				
DOVONEX SCALP soln	4				
econazole crm	2				
ELOCON	4				
erythromycin pads, soln	2				
erythromycin/benzoyl peroxide gel	2				
FINACEA gel	4				
fluocinolone crm, 0.01	2				
fluocinonide crm (emollient)	1				
fluocinonide crm, gel, oint, soln	2				
FLUOROPLEX crm	4				
fluorouracil crm, soln	2				
fluticasone crm, oint	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
GENTAMICIN crm, oint	4				
halobetasol crm, oint	2				
hydrocortisone crm, oint, rectal crm	1				
hydrocortisone lotn, 2.5	2				
hydrocortisone butyrate crm, oint, soln	2				
hydrocortisone alerate crm, oint	2				
isotretinoin caps	2				
ketoconazole crm, shampoo	2				
LARON	4				
LAC-HYDRIN	4				
lactic acid crm; lotn, 12	2				
lidocaine gel, 2 ; oint, 5	2				
LOCOID crm, oint, soln	4				
LOPROX gel, shampoo	4				
LOTRISONE crm	4				
METROCREAM	4				
METROGEL 1	4				
METROLOTION	4				
metronidazole crm, gel, lotn	2				
mometasone crm, lotn, oint	2				
mupirocin oint	2				
NIZORAL shampoo	4				
nystatin crm, oint, topical po der	2				
NYSTATIN/TRIAMCINOLONE	4				
ORACEA caps	4				
OXSORALEN ULTRA caps	5				
PANRETIN gel	5				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PENNSAID	3			•	•
PICATO	3				
podofilox soln	2				
prednicarbate	2				
PROTOPIC	3				•
PRUDOXIN crm	4				
RETIN-A crm, gel	4				
SANTYL	3				
selenium sulfide lotn, shampoo	1				
SILVADENE	4				
sil er sulfadiazine crm	2				
sodium chloride irrigation, 0.	2				
SOLARAZE gel	3				
SORIATANE caps	5				
sulfacetamide sodium lotn	2				
TARGRETIN gel	5				
TAZORAC crm, gel	4				
TEMOVATE soln	4				
tretinoin crm, gel	2				
triamcinolone crm; lotn; oint, 0.025 , 0.1	2				
TRIAMCINOLONE oint, 0.5	4				
ULTRAVATE crm, oint	4				
urea/hydrocortisone acetate crm	2				
VECTICAL oint	3				
VOLTAREN gel	3			•	•
ater for irrigation	2				
ESTCORT oint	4				
XYLOCAINE soln	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ZONALON	4				
ZOVIRAX oint	4				
n e e lace en s i ie s					
ADAGEN*	5				
ALDURAZYME*	5				
BUPHENYL	5				
CEREZYME*	5				
CREON	3				
CYSTADANE	5				
CYSTAGON*	4				
ELAPRASE	5				
FABRAZYME*	5				
UVAN*	5		•		
MYOZYME	5				
NAGLAZYME*	5				
ORFADIN*	5				
VPRIV	5				
ZAVESCA*	5				
ZENPEP	3				
as in es inal Agen s					
ACIPHEX DR tabs	4			•	•
ACTIGALL	4				
AMITIZA	3		•		
CARAFATE	4				
CHENODAL	5				
cimetidine inj, oral soln, tabs	2				
COLYTE for soln, 240 g	4				
cromolyn sodium oral conc	2				
CYTOTEC	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
famotidine for susp, inj	2				
famotidine tabs	1				
GASTROCROM	4				
glycopyrrolate tabs	2				
GOLYTELY	4				
lactulose	2				
lansoprazole R	2			•	
loperamide	2				
LOTRONEX	5				
methscopolamine	2				
metoclopramide oral soln, tabs	2				
misoprostol	2				
MOVIPREP	3				
NEXIUM	3			•	
NEXIUM I.V.	3				
nizatidine caps	2				
NULYTELY	4				
omeprazole R caps	1			•	
PAMINE	4				
PAMINE FORTE	4				
pantoprazole R tabs	1			•	
peg 3350/kcl/sod bicarb/nacl for soln	2				
peg 3350/kcl/sod bicarb/nacl/sod sulf for soln	2				
PEPCID tabs	4				
polyethylene glycol 3350 oral po der	2				
PREVACID DR caps	4			•	•
PREVACID SOLUTAB	4			•	•

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
PREVPAC	3				
PRILOSEC DR caps	4			•	•
PROTONIX DR tabs	4			•	•
PYLERA	3				
ranitidine caps, syrup	2				
ranitidine tabs	1				
REGLAN tabs	4				
RELISTOR	4		•		
ROBINUL tabs	4				
ROBINUL FORTE	4				
sucralfate tabs	2				
ursodiol caps	2				
ZANTAC syrup, tabs	4				
eni ina Agen s					
alfuzosin ER tabs	2			•	
AVODART	3			•	
bethanechol	2				
calcium acetate	2				
CARDURA	4			•	
CUPRIMINE	3				
DEPEN TITRATABS	4				
DETROL	4			•	
DETROL LA	3			•	
DITROPAN XL	4			•	
doxazosin	1			•	
finasteride	1			•	
FLOMAX	4			•	
FOSRENOL	3				
METHERGINE tabs	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
methylergono ine tabs	2				
MINIPRESS	4				
neomycin/polymyxin GU irrigation soln	2				
oxybutynin syrup	2			•	
oxybutynin tabs	1			•	
oxybutynin ER	2			•	
PHOSLO	4				
potassium citrate ER	2				
prazosin	1				
PROSCAR	4			•	
RAPAFLO	3			•	
RENVELA	3				
SANCTURA	4			•	
SANCTURA XR	4			•	
tamsulosin	1			•	
terazosin	1			•	
TOVIAZ	3			•	
trospium	2			•	
VESICARE	3			•	
nal Agen s i lan e lace en i ing A enal					
ACTHAR HP	5		•		
CORTEF	4				
CORTISONE	4				
dexamethasone elixir, taper pack	2				
dexamethasone tabs, 0.5 mg, 0.75 mg, 1.5 mg, mg, 6 mg	1				
DEXAMETHASONE tabs, 1 mg, 2 mg	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
dexamethasone sodium phosphate inj, mg/mL	2				
fludrocortisone	2				
hydrocortisone tabs	2				
MEDROL 4 mg, mg, 1 mg, 32 mg	4	X			
methylprednisolone tabs, mg, mg, 16 mg, 32 mg	2	X			
methylprednisolone sodium succinate for inj	2				
PEDIAPRED	4	X			
prednisolone syrup	2	X			
prednisolone sodium phosphate oral soln	2	X			
prednisone dose-pack, 5 mg, 10 mg	2				
PREDNISONE oral soln, 5 mg/5 mL tabs, 50 mg	4	X			
prednisone tabs, 1 mg, 2.5 mg, 5 mg, 10 mg, 20 mg	1	X			
SOLU-MEDROL for inj	4				
nal Agen s i lan e lace en i ing i i a					
chorionic gonadotropin	2				
DDAVP nasal spray, tabs	4				
desmopressin nasal soln, nasal spray, tabs	2				
INCRELEX*	5				
OMNITROPE	4		•		
STIMATE	4				
nal Agen s i lan e lace en i ing e nes i ie s					

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ACTIVELLA	4				
ANADROL-50	5		•		
ANDRODERM	3		•	•	
ANDROGEL	3		•	•	
ANDROXY	4		•		
AYGESTIN	4				
CLIMARA	4				
COMBIPATCH	3				
danazol	2		•		
DELATESTRYL	4		•	•	
DEPO-PROVERA	4				
DEPO-TESTOSTERONE	4		•	•	
DIVIGEL	3				
ELLA	4				
ESTRACE vaginal crm	4				
estradiol tabs	1				
estradiol transdermal	2				
estradiol/norethindrone acetate	2				
estropipate	2				
EVISTA	3				
FORTESTA	4		•	•	
medroxyprogesterone inj, 150 mg/mL	2				
medroxyprogesterone tabs	1				
MEGACE	4				
megestrol	1				
MENEST	4				
norethindrone acetate	2				
oral contracepti es all generics	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ORAL CONTRACEPTIVES multi-source brands	4				
OXANDRIN tabs, 2.5 mg	4		•		
oxandrolone tabs, 10 mg	5		•		
oxandrolone tabs, 2.5 mg	2		•		
PREMARIN tabs	3				
PREMARIN vaginal crm	3				
PREMPHASE	3				
PREMPRO	3				
PROVERA	4				
testosterone cypionate	2		•	•	
testosterone enanthate	2		•	•	
VAGIFEM vaginal tabs, 10 mg	3				
VIVELLE-DOT	3				
nal Agen s i lan e lace en i ing i					
CYTOMEL	4				
le othyroxine tabs (Le oxyl)	1				
Le oxyl	1				
liothyronine tabs	2				
SYNTHROID	4				
nal Agen s essan A enal					
LYSODREN	3				
nal Agen s essan a a i					
SENSIPAR	3		•		
nal Agen s essan i i a					
bromocriptine	2				
cabergoline	2				
ELIGARD 45 mg	5				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ELIGARD .5 mg, 22.5 mg, 30 mg	4				
FIRMAGON 120 mg	5				
FIRMAGON 0 mg	4				
leuprolide acetate	2				
LUPRON DEPOT	5				
LUPRON DEPOT-PED	5				
octreotide inj, 50 mcg/mL, 100 mcg/mL, 200 mcg/mL	2		•		
octreotide inj, 500 mcg/mL, 1000 mcg/mL	5		•		
PARLODEL	4				
SOMATULINE DEPOT	5		•		
SOMAVERT*	5		•		
SYNAREL	5				
TRELSTAR DEPOT	4				
TRELSTAR DEPOT MIX ECT	4				
TRELSTAR LA	5				
TRELSTAR LA MIX ECT	5				
TRELSTAR MIX ECT	5				
nal Agen s essan e nes i ie s					
AVODART	3			•	
bicalutamide	1				
CASODEX	4				
finasteride	1			•	
flutamide	2				
NILANDRON	4				
PROSCAR	4			•	
ZYTIGA	5		•	•	

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
nal Agen s essan i					
methimazole	1				
propylthiouracil	1				
n l gical Agen s					
ACTHIB	4				
ACTIMMUNE*	5				
ADACEL	4				
ALDARA	4		•	•	
AMEVIVE*	5		•		
ARCALYST*	5		•		
ATGAM	5	X			
AVONEX	5		•	•	
AZASAN	4	X			
AZATHIOPRINE for inj	4	X			
azathioprine tabs, 50 mg	2	X			
BETASERON	5		•	•	
BOOSTRIX	4				
CELLCEPT caps, for IV, tabs	4	X			
CELLCEPT for susp	5	X			
CERVARIX	4				
COMVAX	4				
CUPRIMINE	3				
cyclosporine	2	X			
cyclosporine modified caps, 25 mg, 100 mg; oral soln	2	X			
CYCLOSPORINE modified caps, 50 mg	4	X			
DAPTACEL	4				
DECAVAC	3				
DEPEN TITRATABS	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
DIPHTHERIA/TETANUS ADSORBED pediatric	4				
ENBREL	5		•		
ENGERIX-B	4	X			
GAMMAGARD	5	X	•		
GAMMAGARD S/D	5	X	•		
GARDASIL	4				
HAVRIX	4				
HIBERIX	4				
HUMIRA	5		•		
imiquimod	2		•	•	
IMURAN	4	X			
INFANRIX	4				
INFERGEN	5				
IPOL	4				
IXIARO	4				
E-VAX	4				
INRIX	4				
leflunomide	2				
M-M-R II /DILUENT	4				
MENACTRA	4				
MENOMUNE	4				
MENVEO	4				
methotrexate for inj, inj	2				
methotrexate tabs	1	X			
mycophenolate mofetil	2	X			
MYFORTIC	4	X			
NEORAL	4	X			
NULO IX	5	X			

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ORTHOCLONE O T3	5	X			
PEDVAX HIB	4				
PEG-INTRON	5		•		
PEGASYS	5		•		
PENTACEL	4				
PROGRAF	4	X			
PROQUAD	4				
PROTOPIC	3				•
RABAVERT	4	X			
RAPAMUNE	3	X			
RECOMBIVAX HB	4	X			
REMICADE	5		•		
RIDAURA	4				
ROTARIX	4				
ROTATEQ	4				
SANDIMMUNE	4	X			
SIMULECT	5	X			
SYNAGIS	5				
tacrolimus	2	X			
TENIVAC	3				
TETANUS/DIPHTHERIA ADSORBED adult	3				
THALOMID	5		•	•	
THYMOGLOBULIN	5	X			
TRIPEDIA	4				
T INRIX	4				
TYPHIM VI	4				
TYSABRI*	5		•	•	
VAQTA	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
VARIVAX	4				
XOLAIR	5		•		
YF-VAX	4				
ZORTRESS tabs, 0.25 mg	4	X			
ZORTRESS tabs, 0.5 mg, 0. 5 mg	5	X			
ZOSTAVAX	4			•	
n la a el isease Agen s					
APRISO	3				
ASACOL	3				
ASACOL HD	3				
AZULFIDINE	4				
AZULFIDINE EN-TABS	4				
balsalazide	2				
budesonide ER	2				
CANASA	3				
COLAZAL	4				
DIPENTUM	4				
hydrocortisone enema	2				
LIALDA	3				
mesalamine enema	2				
PENTASA	3				
SFRO ASA	4				
sulfasalazine	2				
sulfasalazine R	2				
e a lic ne isease Agen s					
ACTONEL	4			•	•
alendronate tabs	1			•	
ATELVIA	3			•	•

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
BONIVA inj	4	X		•	•
CALCI EX	4	X			
calcitonin nasal spray	2				
calcitriol caps	1	X			
calcitriol inj, oral soln	2	X			
DIDRONEL	4				
ETIDRONATE tabs, 200 mg	4				
etidronate tabs, 00 mg	2				
FORTEO	5		•		
FORTICAL	4				
FOSAMAX tabs	4			•	•
ibandronate tabs	2	X		•	
MIACALCIN nasal spray	4				
PROLIA	4		•		
ROCALTROL	4	X			
ZEMPLAR	3	X			
ZOMETA	5				
al ic Agen s					
ACULAR	4				
ACULAR LS	4				
ALPHAGAN P	4				
azelastine	2				
AZOPT	4				
bacitracin/polymyxin	2				
BESIVANCE	4				
BETAGAN	4				
betaxolol soln, 0.5	2				
BETOPTIC-S	4				
brimonidine	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
BROMFENAC	4				
carteolol	2				
CILOXAN soln	4				
ciprofloxacin	1				
COMBIGAN	3				
COSOPT	4				
cromolyn sodium	2				
dexamethasone sodium phosphate	1				
diclofenac sodium	2				
dorzolamide	2				
dorzolamide/timolol	2				
DUREZOL	3				
epinastine	2				
erythromycin	2				
fluorometholone	1				
flurbiprofen soln	1				
FML LIQUIFILM	4				
gentamicin oint, soln	2				
ISTALOL	4				
ketorolac	2				
LACRISERT	4				
latanoprost	1				
LEVOBUNOLOL soln, 0.25	4				
le obunolol soln, 0.5	2				
LOTEMAX	3				
LUMIGAN	3				
MAXITROL oint	4				
metipranolol	2				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
MOXEZA	4				
MYDRIACYL	4				
NAPHAZOLINE	4				
NATACYN	4				
neomycin/polymyxin /bacitracin oint	2				
neomycin/polymyxin /bacitracin/ hydrocortisone oint	2				
neomycin/polymyxin / dexamethasone oint, susp	2				
neomycin/polymyxin /gramicidin soln	2				
NEVANAC	4				
OCUFLOX	4				
ofloxacin	1				
OMNIPRED	4				
OPTIPRANOLOL	4				
OPTIVAR	4				
PATADAY	3				
PATANOL	4				
PHOSPHOLINE IODIDE	4				
pilocarpine	2				
PILOPINE HS	4				
polymyxin /trimethoprim	1				
POLYTRIM	4				
PRED FORTE	4				
prednisolone acetate	1				
RESTASIS	4				
sulfacetamide sodium soln	1				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
sulfacetamide sodium/ prednisolone soln	1				
timolol maleate gel-forming soln	2				
timolol maleate soln	1				
TIMOPTIC	4				
TIMOPTIC OCUDOSE	4				
TIMOPTIC-XE	4				
TOBRADEX oint	3				
TOBRADEX susp	4				
tobramycin	1				
tobramycin/dexamethasone	2				
TRAVATAN Z	3				
trifluridine	2				
tropicamide	2				
TRUSOPT	4				
VIGAMOX	3				
VIROPTIC	4				
VOLTAREN	4				
ic Agen s					
acetic acid soln	2				
acetic acid/aluminum acetate soln	2				
CIPRODEX	4				
CORTISPORIN soln	4				
DERMOTIC oil	4				
fluocinolone acetonide oil	2				
hydrocortisone/acetic acid soln	2				
neomycin/polymyxin / hydrocortisone soln, susp	2				
ofloxacin soln	2				
es i a ac Agen s					

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
ACCOLATE	4				•
acetylcysteine inhal soln	2	X			
ADVAIR DIS US	3			•	
ADVAIR HFA	3			•	
albuterol sulfate syrup, tabs	1				
albuterol sulfate ER	2				
albuterol sulfate inhal soln	2	X			
ASMANEX	3			•	
ASTELIN	4			•	
ASTEPRO	3			•	
ATROVENT	4			•	
ATROVENT HFA	4			•	
azelastine nasal spray, 137 mcg/ spray	2			•	
caffeine citrate oral soln	2				
COMBIVENT	4			•	
cromolyn sodium inhal soln	2	X			
diphenhydramine caps, elixir	1				
diphenhydramine inj	2				
EPIPEN	3				
EPIPEN- R	3				
FLONASE	4			•	
FLOVENT DIS US	3			•	
FLOVENT HFA	3			•	
fluticasone nasal spray	2			•	
FORADIL AEROLIZER	3			•	
hydroxyzine hcl syrup, tabs	2				
ipratropium nasal soln	2			•	
ALYDECO	5		•	•	

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
le ocetirizine tabs	2				
LUFYLLIN	4				
NASACORT AQ	4			•	
NASONEX	3			•	
PATANASE	4			•	
PROAIR HFA	3			•	
PROLASTIN*	5				
promethazine supp, syrup, tabs	2				
PULMOZYME	5	X			
QVAR	3			•	
SEREVENT DIS US	3			•	
SINGULAIR	4				•
SPIRIVA HANDIHALER	3			•	
SYMBICORT	3			•	
terbutaline tabs	2				
theophylline ER tabs, 100 mg, 200 mg, 300 mg, 50 mg	1				
theophylline ER tabs, 00 mg, 600 mg	2				
triamcinolone nasal spray	2			•	
TYZINE	4				
TYZINE PEDIATRIC	4				
VENTOLIN HFA	3			•	
zafirlukast	2				•
lee is e Agen s					
AMBIEN	4			•	•
doxepin caps, 10 mg, 25 mg, 50 mg, 75 mg, 100 mg; oral conc	1				
DOXEPIN caps, 150 mg	4				

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
LUNESTA	4			•	•
NUVIGIL	4		•	•	
PROVIGIL	4		•	•	
SONATA	4			•	•
XYREM*	5		•	•	
zaleplon	2			•	
zolpidem	1			•	
ele al scle ela an s					
cyclobenzaprine	2				
FLEXERIL	4				
methocarbamol	2				
ROBAXIN tabs	4				
e a e ic ien s ine als lec l es					
amino acid	2	X			
AMINOSYN II, 15	4	X			
CARNITOR oral soln, tabs	4	X			
CHEMET	4				
CUPRIMINE	3				
DEPEN TITRATABS	4				
EX ADE* tabs for oral susp, 125 mg	4				
EX ADE* tabs for oral susp, 250 mg, 500 mg	5				
fat emulsion , 20 , 30	2	X			
fomepizole	5				
INTRALIPID 30	4	X			
i fluids - generics	2				
IV FLUIDS - CL/D5 / LACTATED RINGERS inj	4				
-TABS	4				

Drug Name	Drug Tier	Requirements/ Limits			
		B or D	Prior Authorization	Quantity Limits †	Step Therapy
AYEXALATE	4				
le ocarnitine oral soln, tabs	2	X			
LIPOSYN 10 , 20	4	X			
MICRO-	4				
potassium chloride ER caps	2				
potassium chloride ER tabs, mEq, 10 mEq, 20 mEq	2				
potassium citrate ER	2				
sodium polystyrene sulfonate	2				
SYPRINE	5				
TROPHAMINE,	4	X			

1 = Preferred Generic Drugs
2 = Non-Preferred Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
• = Utilization Management (UM)
* = Limited Distribution Drug

X = Drugs that may be covered by Medicare Part B or Medicare Part D depending on the circumstance
† = Quantity limit restrictions for these drugs are listed beginning on page 35

For some of our prescription drug plans, we provide additional coverage of all formulary generic and/or brand drugs in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.

an i i i s

g a e	**n l i i** (unless otherwise noted)
ABILIFY DISCMELT all strengths	0 tablets
ABILIFY injection	0 vials
ABILIFY oral solution	50 mL
ABILIFY tablets all strengths	30 tablets
acarbose 25 mg, 50 mg, 100 mg	0 tablets
acetaminophen /codeine solution 120 mg/12 mg/5 mL	2 00 mL
acetaminophen /codeine 300-15 mg, 300-30 mg	3 0 tablets
acetaminophen /codeine 300-60 mg	1 0 tablets
ACIPHEX 20 mg	30 tablets
ACTONEL 150 mg	1 tablet
ACTONEL 35 mg	4 tablets per 2 days
ACTONEL 5 mg, 30 mg	30 tablets
ACTOS 15 mg, 30 mg, 45 mg	30 tablets
ADCIRCA 20 mg	0 tablets
ADDERALL XR 5 mg, 10 mg, 15 mg, 20 mg, 25 mg, 30 mg	30 capsules
ADVAIR DIS US	1 pac age of 0
ADVAIR HFA	1 canister
AFINITOR 2.5 mg, 5 mg, .5 mg, 10 mg	30 tablets
ALDARA	12 pac ets
alendronate 35 mg, 70 mg	4 tablets per 2 days
alendronate 5 mg, 10 mg, 0 mg	30 tablets
alfuzosin ER 10 mg	30 tablets
AMARYL 1 mg, 2 mg	30 tablets
AMARYL 4 mg	0 tablets
AMBIEN 5 mg, 10 mg	30 tablets
AMERGE all strengths	1 tablets
amphetamine/dextroamphetamine ER 5 mg, 10 mg, 15 mg, 20 mg, 25 mg, 30 mg	30 capsules
AMPYRA 10 mg	0 tablets
ANDRODERM 24 hr patch 2 mg, 4 mg, 5 mg	30 patches
ANDRODERM 24 hr patch 2.5 mg	0 patches
ANDROGEL PUMP 1	4 pumps
ANDROGEL 1. 2	2 pumps
ANDROGEL 1 25 mg/2.5 gm, 50 mg/5 gm	0 pac ets
APTIVUS 100 mg/mL	4 bottles
APTIVUS 250 mg	120 capsules
ARICEPT/ARICEPT ODT 5 mg, 10 mg	30 tablets
ASMANEX	1 canister
ASTELIN	2 bottles

g a e	n l i i (unless otherwise noted)
ASTEPRO	2 bottles
ATACAND HCT 1 -12.5 mg, 32-12.5 mg, 32-25 mg	30 tablets
ATACAND 32 mg	30 tablets
ATACAND 4 mg, mg, 1 mg	0 tablets
ATELVIA 35 mg	4 tablets per 2 days
ator astatin 10 mg, 20 mg, 0 mg	45 tablets
ator astatin 0 mg	30 tablets
ATRIPLA 00-200-300 mg	30 tablets
ATROVENT HFA INHALER	2 canisters
ATROVENT NASAL 0.03	2 bottles
ATROVENT NASAL 0.0	3 bottles
AVALIDE 150-12.5 mg, 300-12.5 mg, 300-25 mg	30 tablets
AVAPRO 5 mg, 150 mg, 300 mg	30 tablets
AVINZA SR 30 mg, 45 mg, 0 mg, 5 mg, 0 mg, 120 mg	30 capsules
AVODART 0.5 mg	30 capsules
AVONEX PEN	4 pens per 2 days
AVONEX 30 mcg, 30 mcg/0.5 mL	4 vials/syringes per 2 days
azelastine hcl 0.1	2 bottles
AZOR 5-20 mg, 5-40 mg, 10-20 mg, 10-40 mg	30 tablets
BENICAR HCT 20-12.5 mg, 40-12.5 mg, 40-25 mg	30 tablets
BENICAR 20 mg, 40 mg	30 tablets
BENICAR 5 mg	0 tablets
BETASERON 0.3 mg	15 vials/syringes
BONIVA injection	3mL per 0 days
budeprion R (12 hr) 100 mg, 150 mg	0 tablets
budeprion L (2 hr) 150 mg, 300 mg	30 tablets
buprenorphine hcl 2 mg, mg	15 tablets per 0 days
bupropion hcl ER (12 hr) 100 mg, 150 mg, 200 mg	0 tablets
bupropion hcl L (2 hr) 150 mg, 300 mg	30 tablets
bupropion hcl 100 mg	120 tablets
bupropion hcl 75 mg	0 tablets
CAPRELSA 100 mg	0 tablets
CAPRELSA 300 mg	30 tablets
CARDURA 1 mg, 2 mg, 4 mg	30 tablets
CARDURA mg	0 tablets
CELEBREX 400 mg	30 capsules
CELEBREX 50 mg, 100 mg, 200 mg	0 capsules
CELEXA 10 mg, 20 mg, 40 mg	30 tablets

g a e	n l i i (unless otherwise noted)
CHANTIX	1 days of therapy
citalopram 10 mg/5 mL	00 mL
citalopram 10 mg, 20 mg, 0 mg	30 tablets
clonazepam 0.125 mg, 0.25 mg	0 tablets
clonazepam/clonazepam 0.5 mg, 1 mg	0 tablets
clonazepam/clonazepam 2 mg	300 tablets
clorazepate 15 mg	1 0 tablets
clorazepate 3.75 mg, 7.5 mg	0 tablets
clozapine 100 mg	2 0 tablets
clozapine 200 mg	120 tablets
clozapine 25 mg, 50 mg	0 tablets
CLOZARIL 100 mg	2 0 tablets
CLOZARIL 25 mg	0 tablets
co-gesic 5-500 mg	240 tablets
COMBIVENT	2 canisters
COMPLERA 200-25-300 mg	30 tablets
COPAXONE 20 mg/mL	30 syringes
COZAAR 100 mg	30 tablets
COZAAR 25 mg, 50 mg	0 tablets
CRESTOR 40 mg	30 tablets
CRESTOR 5 mg, 10 mg, 20 mg	45 tablets
CRIXIVAN 100 mg	0 capsules
CRIXIVAN 200 mg	2 0 capsules
CRIXIVAN 400 mg	1 0 capsules
CYMBALTA 20 mg, 30 mg, 0 mg	0 capsules
DELATESTRYL 200 mg/mL	1 vial per 2 days
DEPO TESTOSTERONE 100 mg/mL	1 vial per 2 days
DEPO TESTOSTERONE 200 mg/mL - 1 mL vial	4 vials per 2 days
DEPO TESTOSTERONE 200 mg/mL - 10 mL multidose vial	1 vial per 2 days
DETROL all strengths	0 tablets
DETROL LA all strengths	30 capsules
DEXEDRINE 10 mg, 15 mg	120 capsules
DEXEDRINE 5 mg	0 capsules
dexmethylphenidate 2.5 mg, 5 mg, 10 mg	0 tablets
dextroamphetamine ER 10 mg, 15 mg	120 capsules
dextroamphetamine ER 5 mg	0 capsules
dextroamphetamine 10 mg	1 0 tablets
dextroamphetamine 5 mg	0 tablets
DIABETA 1.25 mg, 2.5 mg	30 tablets
DIABETA 5 mg	120 tablets

g a e	n l i i (unless otherwise noted)
DIAZEPAM gel 2.5 mg, 10 mg, 20 mg	5 twin pac s
DIAZEPAM 1 mg/mL	1200 mL
diazepam 2 mg, 5 mg, 10 mg	0 tablets
DIAZEPAM 5 mg/mL	240 mL
didanosine 125 mg, 200 mg, 250 mg, 00 mg	30 capsules
DIOVAN HCT 0-12.5 mg, 1 0-12.5 mg, 1 0-25 mg, 320-12.5 mg, 320-25 mg	30 tablets
DIOVAN 320 mg	30 tablets
DIOVAN 40 mg, 0 mg, 1 0 mg	0 tablets
DITROPAN XL 10 mg, 15 mg	0 tablets
DITROPAN XL 5 mg	30 tablets
donepezil/donepezil 5 mg, 10 mg	30 tablets
doxazosin 1 mg, 2 mg, mg	30 tablets
doxazosin mg	0 tablets
EDURANT 25 mg	30 tablets
EFFEXOR XR 3 .5 mg, 150 mg	30 capsules
EFFEXOR XR 5 mg	0 capsules
EMTRIVA 10 mg/mL	5 bottles
EMTRIVA 200 mg	30 capsules
endocet 10-325 mg, 10-650 mg	1 0 tablets
endocet 5-325 mg	3 0 tablets
endocet 7.5-325 mg, 7.5-500 mg	240 tablets
endodan . -325 mg	3 0 tablets
enoxaparin, 30 syringes	10 vials per 0 days
EPIVIR 10 mg/mL	0 mL
EPIVIR 150 mg, 300 mg	30 tablets
eprosartan 600 mg	30 tablets
EPZICOM 00-300 mg	30 tablets
ERIVEDGE 150 mg	30 capsules
escitalopram 5 mg/5 mL	00 mL
escitalopram 5 mg, 10 mg, 20 mg	30 tablets
EXELON 1.5 mg, 3 mg, 4.5 mg, mg	0 capsules
EXELON 4. mg/24 hr, .5 mg/24 hr	30 patches
EXELON 2 mg/mL	240 mL
EXFORGE HCT 5-1 0-12.5 mg, 5-1 0-25 mg, 10-1 0-12.5 mg, 10-1 0-25 mg, 10-320-25 mg	30 tablets
EXFORGE 5-1 0 mg, 5-320 mg, 10-1 0 mg, 10-320 mg	30 tablets
FANAPT TITRATION PA	1 it/4 days
FANAPT 1 mg, 2 mg, 4 mg, mg, mg, 10 mg, 12 mg	0 tablets

g a e	n l i i (unless otherwise noted)
FAZACLO 12.5 mg, 100 mg	0 tablets
FAZACLO 150 mg	1 0 tablets
FAZACLO 200 mg	120 tablets
FAZACLO 25 mg	2 0 tablets
fenofibrate micronized 67 mg, 13 mg, 200 mg	30 capsules
fenofibrate 160 mg	30 tablets
fenofibrate 5 mg	0 tablets
fentanyl citrate oral lozenges 200 mcg, 00 mcg, 600 mcg, 00 mcg, 1200 mcg, 1600 mcg	120 lozenges
fentanyl transdermal all strengths	15 patches
finasteride 5 mg	30 tablets
FIRAZYR	3 syringes
FLOMAX 0.4 mg	0 capsules
FLONASE	1 bottle
FLOVENT DIS US 250 mcg	4 cartons of 0
FLOVENT DIS US 50 mcg, 100 mcg	1 carton of 0
FLOVENT HFA 220 mcg	2 canisters
FLOVENT HFA 44 mcg, 110 mcg	1 canister
fluoxetine eekly R 0 mg	4 capsules per 2 days
fluoxetine 10 mg	30 capsules or tablets
fluoxetine 20 mg	120 capsules or tablets
fluoxetine 20 mg/5 mL	00 mL
fluoxetine 0 mg	0 capsules
fluticasone nasal	1 bottle
flu oxamine 100 mg	0 tablets
flu oxamine 25 mg, 50 mg	30 tablets
fondaparinux solution 2.5 mg/0.5 mL, 5.0 mg/0. mL, 7.5 mg/0.6 mL, 10 mg/0. mL	30 syringes per 0 days
FORADIL	1 pac age of 0
FORTESTA 10 mg/act	2 bottles
FOSAMAX 35 mg, 0 mg	4 tablets per 2 days
FOSAMAX 5 mg, 10 mg, 40 mg	30 tablets
FUZEON 0 mg	1 it
galantamine ER mg, 16 mg, 2 mg	30 capsules
galantamine oral solution mg/mL	200 mL
galantamine mg, mg, 12 mg	0 tablets
gemfibrozil 600 mg	0 tablets
GEODON capsules - all strengths	0 capsules
GEODON injection	0 vials
GLEEVEC 100 mg	0 tablets

g a e	n l i i (unless otherwise noted)
GLEEVEC 400 mg	0 tablets
glimepiride 1 mg, 2 mg	30 tablets
glimepiride mg	0 tablets
glipizide ER 10 mg	0 tablets
glipizide ER 2.5 mg, 5 mg	30 tablets
glipizide L 10 mg	120 tablets
glipizide L 2.5 mg, 5 mg	30 tablets
glipizide 10 mg	120 tablets
glipizide 5 mg	30 tablets
glipizide/metformin 2.5-250 mg	240 tablets
glipizide/metformin 2.5-500 mg, 5-500 mg	120 tablets
GLUCOPHAGE XR 500 mg	120 tablets
GLUCOPHAGE XR 50 mg	0 tablets
GLUCOPHAGE 1000 mg	0 tablets
GLUCOPHAGE 500 mg, 50 mg	0 tablets
GLUCOTROL XL 10 mg	0 tablets
GLUCOTROL XL 2.5 mg, 5 mg	30 tablets
GLUCOTROL 10 mg	120 tablets
GLUCOTROL 5 mg	30 tablets
GLUCOVANCE 1.25-250 mg	0 tablets
GLUCOVANCE 2.5-500 mg, 5-500 mg	120 tablets
glyburide micronized 1.5 mg, 3 mg	30 tablets
glyburide micronized 6 mg	0 tablets
glyburide 1.25 mg, 2.5 mg	30 tablets
GLYBURIDE 1.25 mg, 2.5 mg	30 tablets
glyburide 5 mg	120 tablets
GLYBURIDE 5 mg	120 tablets
glyburide/metformin 1.25-250 mg	0 tablets
glyburide/metformin 2.5-500 mg, 5-500 mg	120 tablets
GLYCRON 1.5 mg, 3 mg	30 tablets
GLYCRON mg	0 tablets
GLYNASE 1.5 mg, 3 mg	30 tablets
GLYNASE mg	0 tablets
hydrocodone/acetaminophen 10-660 mg	1 0 tablets
hydrocodone/acetaminophen 2.5-500 mg, 5-500 mg	240 tablets
hydrocodone/acetaminophen 5-300 mg, 5-325 mg	3 0 tablets
hydrocodone/acetaminophen 7.5 mg/500 mg/15 mL	2 00 mL
hydrocodone/acetaminophen 7.5-300 mg, 7.5-325 mg, 7.5-500 mg, 7.5-650 mg, 10-300 mg, 10-325 mg, 10-500 mg, 10-650 mg	1 0 tablets

g a e	n l i i (unless otherwise noted)
hydrocodone/acetaminophen 7.5-325 mg/15 mL	3 00 mL
hydrocodone/acetaminophen 7.5-750 mg, 10-750 mg	150 tablets
hydrocodone/ibuprofen all strengths	150 tablets
hydrogesic 5-500 mg	240 capsules
HYZAAR 50-12.5 mg, 100-12.5 mg, 100-25 mg	30 tablets
ibandronate 150 mg	1 tablet
ibudone 5-200 mg	150 tablets
imiquimod	12 pac ets
IMITREX NASAL	12 units/2 pac ages
IMITREX tablets - all strengths	1 tablets
INLYTA 1 mg	1 0 tablets
INLYTA 5 mg	120 tablets
INTELENCE 100 mg. 200 mg	0 tablets
INTELENCE 25 mg	120 tablets
INTUNIV 1 mg, 2 mg, 3 mg, 4 mg	30 tablets
INVEGA SUSTENNA	1 it
INVEGA 1.5 mg, 3 mg, mg	30 tablets
INVEGA mg	0 tablets
INVIRASE 200 mg	300 capsules
INVIRASE 500 mg	120 tablets
ipratropium nasal 0.03	2 bottles
ipratropium nasal 0.06	3 bottles
irbesartan 75 mg, 150 mg, 300 mg	30 tablets
irbesartan/ 150-12.5 mg, 300-12.5 mg	30 tablets
ISENTRESS 400 mg	0 tablets
A AFF all strengths	0 tablets
ANUMET all strengths	0 tablets
ANUMET XR 50-1000 mg	0 tablets
ANUMET XR 50-500 mg, 100-1000 mg	30 tablets
ANUVIA all strengths	30 tablets
ENTADUETO 2.5-500 mg, 2.5- 50 mg, 2.5-1000 mg	0 tablets
UVISYNC 100-10 mg, 100-20 mg, 100-40 mg	30 tablets
ALETRA 100-25 mg	300 tablets
ALETRA 200-50 mg	120 tablets
ALETRA 400-100mg/5mL	2 bottles
ALYDECO 150 mg	0 tablets
ketorolac 10 mg	21 tablets
OMBIGLYZE XR 2.5-1000 mg	0 tablets
OMBIGLYZE XR 5-500 mg, 5-1000 mg	30 tablets
lami udine 150 mg, 300 mg	30 tablets

g a e	n l i i (unless otherwise noted)
lami udine/zido udine 150-300 mg	0 tablets
lansoprazole/lansoprazole 15 mg, 30 mg	30 capsules or tablets
LATUDA all strengths	30 tablets
LETAIRIS 5 mg, 10 mg	30 tablets
LEXAPRO 5 mg/5 mL	00 mL
LEXAPRO 5 mg, 10 mg, 20 mg	30 tablets
LEXIVA 50 mg/mL	1 00 mL
LEXIVA 00 mg	120 tablets
LIPITOR 10 mg, 20 mg, 40 mg	45 tablets
LIPITOR 0 mg	30 tablets
LIPOFEN 150 mg	30 capsules
LIPOFEN 50 mg	0 capsules
LOPID 00 mg	0 tablets
losartan 100 mg	30 tablets
losartan 25 mg, 50 mg	0 tablets
losartan/ 50-12.5 mg, 100-12.5 mg, 100-25 mg	30 tablets
lo astatin all strengths	0 tablets
LOVENOX 30 mg/0.3 mL, 40 mg/0.4 mL, 0 mg/0. mL, 0 mg/0. mL, 100 mg/mL, 120 mg/0. mL, 150 mg/mL	30 syringes per 0 days
LOVENOX 300 mg/3 mL	10 vials per 0 days
LUNESTA 1 mg, 2 mg, 3 mg	30 tablets
MAPROTILINE 25 mg, 50 mg, 5 mg	0 tablets
MAXALT/MAXALT MLT all strengths	1 tablets
metadate ER 20 mg	0 tablets
METAGLIP 2.5-250 mg	240 tablets
metformin ER 500 mg	120 tablets
metformin ER 750 mg	0 tablets
metformin 1000 mg	0 tablets
metformin 500 mg, 50 mg	0 tablets
methylin ER 10 mg, 20 mg	0 tablets
methylin 5 mg, 10 mg, 20 mg	0 tablets
methylphenidate ER 20 mg	0 tablets
methylphenidate 5 mg, 10 mg, 20 mg	0 tablets
MEVACOR all strengths	0 tablets
MICARDIS HCT 40-12.5 mg, 0-25 mg	30 tablets
MICARDIS HCT 0-12.5 mg	0 tablets
MICARDIS 20 mg, 40 mg, 0 mg	30 tablets
mirtazapine 7.5 mg	30 tablets
mirtazapine/mirtazapine 15 mg, 30 mg, 5 mg	30 tablets

g a e	n l i i (unless otherwise noted)
morphine sulfate R 15 mg, 30 mg, 60 mg, 100 mg, 200 mg	0 tablets
NAMENDA TITRATION PAC	4 tablets per 2 days
NAMENDA 10 mg/5 mL	3 0 mL
NAMENDA 5 mg, 10 mg	0 tablets
naratriptan all strengths	1 tablets
NASACORT AQ	1 bottle
NASONEX	2 bottles
nateglinide 60 mg, 120 mg	0 tablets
ne irapine 200 mg	0 tablets
NEXAVAR 200 mg	120 tablets
NEXIUM all strengths	30 capsules or pac ets
NIASPAN ER 500 mg	30 tablets
NIASPAN ER 50 mg, 1000 mg	0 tablets
NORVIR 100 mg	3 0 capsules or tablets
NORVIR 0 mg/mL	2 bottles
NUCYNTA ER 50 mg, 100 mg, 150 mg, 200 mg, 250 mg	0 tablets
NUVIGIL all strengths	30 tablets
olanzapine injection, 10 mg	0 vials
olanzapine 5 mg, 10 mg, 15 mg, 20 mg	30 tablets
olanzapine 2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg	30 tablets
OLEPTRO 150 mg	45 tablets
OLEPTRO 300 mg	30 tablets
omeprazole 10 mg, 20 mg, 0 mg	30 capsules
ONFI 5 mg, 10 mg, 20 mg	0 tablets
ONGLYZA 2.5 mg, 5 mg	30 tablets
oxybutynin ER 10 mg, 15 mg	0 tablets
oxybutynin ER 5 mg	30 tablets
oxybutynin syrup 5 mg/mL	00 mL
oxybutynin 5 mg	120 tablets
oxycodone /acetaminophen 10-325 mg, 10-650 mg	1 0 tablets
oxycodone /acetaminophen 2.5-325 mg, 5-325 mg	3 0 tablets
oxycodone /acetaminophen 5-500 mg	240 capsules
oxycodone /acetaminophen 7.5-325 mg, 7.5-500 mg	240 tablets
oxycodone/aspirin full strength	3 0 tablets
OXYCONTIN 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	0 tablets
OXYCONTIN 0 mg, 0 mg	120 tablets
pantoprazole tablets - all strengths	30 tablets
paroxetine hcl ER 12.5 mg	30 tablets
paroxetine hcl ER 25 mg, 37.5 mg	0 tablets
paroxetine hcl 10 mg/5 mL	00 mL

g a e	n l i i (unless otherwise noted)
paroxetine hcl 10 mg, 20 mg, 0 mg	30 tablets
paroxetine hcl 30 mg	0 tablets
PATANASE	1 bottle
PAXIL CR 12.5 mg	30 tablets
PAXIL CR 25 mg, 3 .5 mg	0 tablets
PAXIL 10 mg/5 mL	00 mL
PAXIL 10 mg, 20 mg, 40 mg	30 tablets
PAXIL 30 mg	0 tablets
PENNSAID 1.5	300 mL
PERCODAN 4. -325 mg	3 0 tablets
polygesic 5-500 mg	240 capsules
PRADAXA all strengths	0 capsules
PRANDIN 0.5 mg, 1 mg	120 tablets
PRANDIN 2 mg	240 tablets
PRAVACHOL 10 mg, 20 mg, 40 mg	45 tablets
PRAVACHOL 0 mg	30 tablets
pra astatin 10 mg, 20 mg, 0 mg	45 tablets
pra astatin 0 mg	30 tablets
PRECOSE 25 mg, 50 mg, 100 mg	0 tablets
PREVACID SOLUTAB 15 mg, 30 mg	30 tablets
PREVACID 15 mg, 30 mg	30 capsules
PREZISTA 150 mg	1 0 tablets
PREZISTA 400 mg, 00 mg	0 tablets
PREZISTA 5 mg	30 tablets
PRILOSEC 10 mg 20 mg, 40 mg	30 capsules
PRISTIQ all strengths	30 tablets
PROAIR HFA	2 canisters
PROMACTA 12.5 mg, 50 mg, 5 mg	30 tablets
PROMACTA 25 mg	0 tablets
PROSCAR 5 mg	30 tablets
PROTONIX all strengths	30 tablets
PROVIGIL all strengths	30 tablets
PROZAC EE LY 0 mg	4 capsules per 2 days
PROZAC 10 mg	30 capsules
PROZAC 20 mg	120 capsules
PROZAC 40 mg	0 capsules
quetiapine 25 mg, 50 mg, 100 mg, 200 mg	0 tablets
quetiapine 300 mg, 00 mg	0 tablets

g a e	n l i i (unless otherwise noted)
QVAR 40 mcg	1 canister
QVAR 0 mcg	2 canisters
RAPAFLO 4 mg, mg	30 capsules
RAZADYNE ER mg, 1 mg, 24 mg	30 capsules
RAZADYNE oral solution 4 mg/mL	200 mL
RAZADYNE 4 mg, mg, 12 mg	0 tablets
REMERON/REMERON SOLTAB 15 mg, 30 mg, 45 mg	30 tablets
REPREXAIN 10-200 mg	150 tablets
RESCRIPTOR 100 mg	0 tablets
RESCRIPTOR 200 mg	1 0 tablets
RETROVIR 10 mg/mL	1 20 mL
RETROVIR 100 mg	1 0 capsules
RETROVIR 300 mg	0 tablets
REVLIMID 15 mg, 25 mg	21 capsules per 2 days
REVLIMID 2.5 mg, 5 mg, 10 mg	30 capsules
REYATAZ 100 mg, 150 mg, 300 mg	30 capsules
REYATAZ 200 mg	0 capsules
RISPERDAL CONSTA injection	2 vials per 2 days
RISPERDAL M-TAB 0.5 mg, 1 mg, 2 mg, 3 mg	0 tablets
RISPERDAL M-TAB 4 mg	120 tablets
RISPERDAL oral solution	4 0 mL
RISPERDAL 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	0 tablets
RISPERDAL 4 mg	120 tablets
RISPERIDONE ODT 0.25 mg	0 tablets
risperidone 0.5 mg, 1 mg, 2 mg, 3 mg	0 tablets
risperidone mg	120 tablets
risperidone oral solution	4 0 mL
risperidone 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	0 tablets
risperidone mg	120 tablets
RITALIN SR 20 mg	0 tablets
RITALIN 5 mg, 10 mg, 20 mg	0 tablets
ri astigmine 1.5 mg, 3 mg, .5 mg, 6 mg	0 capsules
roxicet 5-325 mg	3 0 tablets
SANCTURA XR 0 mg	30 capsules
SANCTURA 20 mg	0 tablets
SAPHRIS 5 mg, 10 mg	0 tablets
SELZENTRY 150 mg	0 tablets
SELZENTRY 300 mg	120 tablets
SEREVENT DIS US	1 pac age of 0
SEROQUEL XR 150 mg, 200 mg	30 tablets

g a e	n l i i (unless otherwise noted)
SEROQUEL XR 50 mg, 300 mg, 400 mg	0 tablets
SEROQUEL 25 mg, 50 mg, 100 mg, 200 mg	0 tablets
SEROQUEL 300 mg, 400 mg	0 tablets
sertraline 100 mg	0 tablets
sertraline 20 mg/mL	300 mL
sertraline 25 mg, 50 mg	30 tablets
sim astatin 20 mg	0 tablets
sim astatin 5 mg, 10 mg, 0 mg	45 tablets
sim astatin 0 mg	30 tablets
SONATA 5 mg, 10 mg	30 capsules
SPIRIVA	30 capsules
SPRYCEL 20 mg	0 tablets
SPRYCEL 50 mg, 0 mg, 0 mg, 100 mg, 140 mg	30 tablets
stagesic 5-500 mg	240 capsules
STARLIX 0 mg, 120 mg	0 tablets
sta udine 1 mg/mL	2400 mL
sta udine 15 mg, 20 mg, 30 mg, 0 mg	0 capsules
SUBOXONE MIS 2-0.5 mg, -2 mg	0 tablets
SUBOXONE SUB 2-0.5 mg, -2 mg	0 tablets
SUBUTEX 2 mg, mg	15 tablets per 0 days
SUMATRIPTAN NASAL	12 units/2 pac ages
sumatriptan tablets - all strengths	1 tablets
SUSTIVA 200 mg	0 capsules
SUSTIVA 50 mg	0 capsules
SUSTIVA 00 mg	30 tablets
SUTENT 12.5 mg	0 capsules
SUTENT 25 mg, 50 mg	30 capsules
SYMBICORT	1 canister
tamsulosin 0. mg	0 capsules
TARCEVA 100 mg, 150 mg	30 tablets
TARCEVA 25 mg	0 tablets
TASIGNA 150 mg, 200 mg	120 capsules
TE TURNA HCT 150-12.5 mg, 150-25 mg, 300-12.5 mg, 300-25 mg	30 tablets
TE TURNA 150 mg, 300 mg	30 tablets
terazosin 1 mg, 2 mg, 5 mg	30 capsules
terazosin 10 mg	0 capsules
testosterone cypionate 100 mg/mL	1 vial per 2 days
testosterone cypionate 200 mg/mL - 1 mL ial	4 vials per 2 days

g a e	n l i i (unless otherwise noted)
testosterone cypionate 200 mg/mL - 10 mL multidose ial	1 vial per 2 days
TEVETEN HCT 00-12.5 mg, 00-25 mg	30 tablets
TEVETEN 00 mg	30 tablets
THALOMID 150 mg, 200 mg	0 capsules
THALOMID 50 mg, 100 mg	30 capsules
TOVIAZ all strengths	30 tablets
TRACLEER 2.5 mg, 125 mg	0 tablets
TRAD ENTA	30 tablets
tramadol hcl ER 100 mg, 200 mg, 300 mg	30 tablets
tramadol hcl 50 mg	240 tablets
tramadol/acetaminophen 37.5-325 mg	240 tablets
triamcinolone nasal inhaler	1 bottle
TRILIPIX 135 mg	30 tablets
TRILIPIX 45 mg	0 tablets
TRIZIVIR 300-150-300 mg	0 tablets
trospium	0 tablets
TRUVADA 200-300 mg	30 tablets
TY ERB 250 mg	1 0 tablets
TYSABRI 300 mg/15 mL	1 vial per 2 days
ULTRACET 3 .5-325 mg	240 tablets
ULTRAM 50 mg	240 tablets
VANDETANIB 100 mg	0 tablets
VANDETANIB 300 mg	30 tablets
enlafaxine ER capsules 37.5 mg, 150 mg	30 capsules
enlafaxine ER capsules 75 mg	0 capsules
enlafaxine ER tablets 37.5 mg, 150 mg	30 tablets
enlafaxine ER tablets 75 mg	0 tablets
enlafaxine 25 mg, 37.5 mg, 50 mg, 75 mg, 100 mg	0 tablets
VENTOLIN HFA	2 canisters
VESICARE all strengths	30 tablets
icodin 10-660 mg	1 0 tablets
VICOPROFEN .5-200 mg	150 tablets
VICTOZA 1 mg/3 mL 2 Pen Pac age	1 pac age of 2 pens
VICTOZA 1 mg/3 mL 3 Pen Pac age	1 pac age of 3 pens
VIDEX EC 125 mg, 200 mg, 250 mg, 400 mg	30 capsules
VIDEX 2 gm, 4 gm	1200 mL
VIIBRYD	30 tablets
VIIBRYD starter it	1 it per 2 days
VIMOVO 3 5-20 mg, 500-20 mg	0 tablets
VIRACEPT 250 mg	2 0 tablets

g a e	n l i i (unless otherwise noted)
VIRACEPT 25 mg	120 tablets
VIRAMUNE XR 400 mg	30 tablets
VIRAMUNE 200 mg	0 tablets
VIRAMUNE 50 mg/5 mL	1200 mL
VIREAD 150 mg, 200 mg, 250 mg, 300 mg	30 tablets
VIREAD 40 mg/gm	240 gm
VOLTAREN gel 1	10 tubes
VOTRIENT 200 mg	120 tablets
VYTORIN 10-10 mg, 10-20 mg, 10-40 mg	45 tablets
VYTORIN 10- 0 mg	30 tablets
ELLBUTRIN SR 100 mg, 150 mg, 200 mg	0 tablets
ELLBUTRIN XL 150 mg, 300 mg	30 tablets
ELLBUTRIN 100 mg	120 tablets
ELLBUTRIN 5 mg	0 tablets
XAL ORI	0 capsules
XARELTO 10 mg	35 tablets per 0 days
XARELTO 15 mg, 20 mg	30 tablets
XENAZINE 12.5 mg	240 tablets
XENAZINE 25 mg	120 tablets
XYREM 500 mg/mL	540 mL
zaleplon 5 mg, 10 mg	30 capsules
ZELBORAF	240 tablets
ZERIT 1 mg/mL	2400 mL
ZERIT 15 mg, 20 mg, 30 mg, 40 mg	0 capsules
ZETIA 10 mg	30 tablets
ZIAGEN 20 mg/mL	0 mL
ZIAGEN 300 mg	0 tablets
zido udine syrup 10 mg/mL	1 20 mL
zido udine 100 mg	1 0 capsules
zido udine 300 mg	0 tablets
ziprasidone capsules - all strengths	0 capsules
ZOCOR 20 mg	0 tablets
ZOCOR 5 mg, 10 mg, 40 mg	45 tablets
ZOCOR 0 mg	30 tablets
ZOLINZA 100 mg	120 capsules
ZOLOFT 100 mg	0 tablets
ZOLOFT 20 mg/mL	300 mL
ZOLOFT 25 mg, 50 mg	30 tablets

g a e	n l i i (unless otherwise noted)
zolpidem 5 mg, 10 mg	30 tablets
ZOSTAVAX	1 vaccine per lifetime
ZYPREXA injection	0 vials
ZYPREXA RELPREVV 210 mg, 300 mg	2 vials per 2 days
ZYPREXA RELPREVV 405 mg	1 vial per 2 days
ZYPREXA tablets - all strengths	30 tablets
ZYPREXA ZYDIS tablets - all strengths	30 tablets
ZYTIGA	120 tablets

A

ABILIFY.....
ABILIFY.....13
ABILIFY.....1
ABILIFY DISCMELT.....
ABILIFY DISCMELT.....13
ABILIFY DISCMELT.....1
ABRAXANE.....10
acarbose.....1
ACCOLATE.....33
ACCUPRIL.....1
ACCURETIC.....1
acebutolol.....1
ACEON.....1
acetaminophen/codeine oral soln.....1
acetaminophen/codeine tabs.....1
acetazolamide ER caps.....1
acetazolamide tabs.....1
acetic acid/aluminum acetate ear soln.....32
acetic acid ear soln.....32
acetylcysteine inhal soln.....33
ACIPHEX DR tabs.....25
ACLOVATE.....23
ACTHAR HP.....2
ACTHIB.....2
ACTIGALL.....25
ACTIMMUNE*.....2
ACTIVELLA.....2
ACTONEL.....30
ACTOS.....1
ACULAR eye soln.....31
ACULAR LS eye soln.....31
acyclo ir caps, tabs.....14
acyclo ir sodium for inj.....14
ACYCLOVIR SODIUM for inj, IV soln.....14
acyclo ir susp.....14
ADACEL.....2
ADAGEN*.....25
ADALAT CC.....1
ADCIRCA.....1
ADDERALL XR.....22
ADRIAMYCIN for inj.....10
ADVAIR DIS US.....33
ADVAIR HFA.....33
AFINITOR.....10
AGGRENOX.....1
AGRYLIN.....1
ALBENZA.....12
albuterol sulfate ER.....33
albuterol sulfate inhal soln.....33
albuterol sulfate syrup, tabs.....33
alclometasone.....23
ALCOHOL S ABS.....1
ALDACTAZIDE tabs.....1
ALDACTONE.....1
ALDARA.....2
ALDURAZYME*.....25
alendronate tabs.....30
alfuzosin ER tabs.....2
ALIMTA.....10
ALINIA.....12
allopurinol for inj.....
allopurinol tabs.....
ALOPRIM.....
ALOXI.....
ALPHAGAN P eye soln.....31
ALTACE.....1
amantadine caps, syrup.....13
amantadine caps, syrup.....14
AMANTADINE tabs.....13
AMANTADINE tabs.....14
AMARYL.....1
AMBIEN.....33
amcinonide crm.....23
AMERGE.....
AMEVIVE*.....2
amifostine.....10
amikacin inj.....2
AMI ACIN inj.....2
amiloride.....1
amiloride/hydrochlorothiazide.....1
amino acid 34
AMINOSYN II.....34
amiodarone tabs.....1
AMITIZA.....25
amitriptyline.....
amlodipine.....1
amlodipine/benazepril.....1
ammonium lactate crm, lotn.....23
AMOXAPINE.....
amoxicillin/potassium cla ulanate che tabs, tabs.....2
amoxicillin/potassium cla ulanate for susp.....2
amoxicillin caps, che tabs, for susp, tabs.....2
AMOXICILLIN chew tabs.....2
amphetamine/dextroamphetamine ER caps.....22
AMPHOTERICIN B.....

ampicillin caps.....2
AMPICILLIN for susp.....2
ampicillin sodium for inj, for 2
AMPICILLIN SODIUM for IV.....2
AMPYRA.....22
ANADROL-50.....2
ANAFRANIL.....
anagrelide.....1
ANAPROX.....1
ANAPROX.....
ANAPROX DS.....1
ANAPROX DS.....
anastrozole.....10
ANCOBON.....
ANDRODERM.....2
ANDROGEL.....2
ANDROXY.....2
ANTABUSE.....2
ANTIVERT tabs.....
APO YN*.....13
APRISO.....30
APTIVUS.....14
ARANESP inj.....1
ARANESP inj.....1
ARCALYST*.....2
ARICEPT ODT.....
ARICEPT tabs.....
ARIMIDEX.....10
AROMASIN.....10
ARRANON.....10
ARTHROTEC.....
ARZERRA.....10
ASACOL.....30
ASACOL HD.....30
ASMANEX.....33
ASTELIN.....33
ASTEPRO.....33
ATACAND.....1
ATACAND HCT.....1
ATELVIA.....30
atenolol.....1
atenolol/chlorthalidone.....1
ATGAM.....2
ator astatin.....1
ato aquone/proguanil tabs.....12
ATRIPLA.....14
ATROVENT.....33
ATROVENT HFA.....33
AUGMENTIN tabs.....2
AVALIDE.....1
AVAPRO.....1
AVASTIN*.....10
AVELOX.....2
AVINZA.....1
AVODART.....2
AVODART.....2
AVONEX.....22
AVONEX.....2
AYGESTIN.....2
AZACTAM.....2
AZASAN.....2
AZATHIOPRINE for inj.....2
azathioprine tabs.....2
azelastine eye soln.....31
azelastine nasal spray.....33
AZELEX crm.....23
AZILECT.....13
azithromycin for , for susp, tabs.....2
AZITHROMYCIN powder pac for susp.....2
AZOPT eye susp.....31
AZOR.....1
aztreonam for inj.....2
AZULFIDINE.....30
AZULFIDINE EN-TABS.....30

bacitracin/polymyxin eye oint.....31
baclofen tabs.....14
BACTRIM.....2
BACTRIM DS.....2
BACTROBAN oint.....23
balsalazide.....30
BANZEL susp, tabs.....5
BANZEL tabs.....5
BARACLUDE oral soln.....14
BARACLUDE tabs.....14
benazepril.....1
benazepril/hydrochlorothiazide.....1
BENICAR.....1
BENICAR HCT.....1
BENZAMYCIN gel.....23
benztropine tabs.....13
BESIVANCE eye susp.....31
BETAGAN eye soln.....31
betamethasone dipropionate, augmented; crm, gel, lotn, oint.....23
betamethasone dipropionate crm, lotn, oint.....23
betamethasone alerate crm, lotn.....23
BETAMETHASONE VALERATE oint.....23
BETAPACE.....1

BETAPACE AF.....1
BETASERON.....22
BETASERON.....2
betaxolol eye soln.....31
betaxolol tabs.....1
bethanechol.....2
BETOPTIC-S eye susp.....31
BIAXIN.....2
BIAXIN XL.....2
bicalutamide.....2
BICNU.....10
BILTRICIDE.....12
bisoprolol.....1
bisoprolol/hydrochlorothiazide.....1
bleomycin.....10
BONIVA inj.....31
BOOSTRIX.....2
brimonidine eye soln.....31
BROMFENAC eye soln.....31
bromocriptine.....13
bromocriptine.....2
budesonide ER.....30
bumetanide inj.....1
bumetanide tabs.....1
BUPHENYL.....25
buprenorphine L tabs.....2
bupropion hcl.....
bupropion hcl ER, 12 hr.....
bupropion hcl ER, 12 hr (smoking deterrent).....2
bupropion hcl ER, 2 hr.....
buspirone tabs.....15
BUSPIRONE tabs.....15
BUSULFEX.....10
butorphanol.....1
BYSTOLIC.....1

cabergoline.....2
caffeine citrate oral soln.....22
caffeine citrate oral soln.....33
CALAN.....1
CALAN SR.....1
CALCI EX.....31
CALCIPOTRIENE oint.....23
calcipotriene soln.....23
calcitonin nasal spray.....31
CALCITRENE oint.....23
calcitriol caps.....31
calcitriol inj, oral soln.....31
calcium acetate.....2
CAMPATH.....10
CANASA.....30
CANCIDAS.....
CAPASTAT.....
CAPRELSA*.....10
captopril.....1
CARAC crm.....23
CARAFATE.....25
carbamazepine.....5
carbamazepine ER caps, ER tabs.....5
CARBATROL.....5
carbidopa/le odopa.....13
carbidopa/le odopa ER.....13
carboplatin soln.....10
CARDIZEM.....1
CARDIZEM CD.....1
CARDIZEM LA.....1
CARDURA.....1
CARDURA.....2
CARNITOR oral soln, tabs.....34
carteolol eye soln.....31
car edilol.....1
CASODEX.....2
CATAFLAM.....
CATAPRES.....1
CATAPRES-TTS.....1
CEENU.....10
cefaclor caps.....2
cefadroxil.....2
cefazolin for inj.....2
cefdinir.....3
cefepime for inj.....3
cefotaxime for inj.....3
cefoxitin for inj.....3
cefpodoxime.....3
cefprozil.....3
ceftazidime for inj, for 3
CEFTIN for susp, tabs.....3
ceftriaxone for inj, for 3
CEFTRIAXONE for IV in de trose, inj in de trose.....3
cefuroxime axetil.....3
cefuroxime sodium for inj, for 3
CELEBREX.....1
CELEBREX.....
CELEXA.....
CELLCEPT caps, for IV, tabs.....2
CELLCEPT for susp.....2
CELONTIN.....5
cephalexin caps, for susp.....3
CEREZYME*.....25

CERVARIX....2
CHANTIX....2
CHEMET....34
CHENODAL....25
CHLORAMPHENICOL....3
chlorhexidine gluconate oral rinse....23
chloroquine phosphate....12
chlorothiazide tabs....1
CHLORPROMAZINE inj....
CHLORPROMAZINE inj....13
chlorpromazine tabs....
chlorpromazine tabs....13
chlorthalidone tabs....1
cholestyramine....1
cholestyramine light packets....1
cholestyramine light po der....1
chorionic gonadotropin....2
ciclopirox crm, gel, shampoo, susp....23
ciclopirox soln (nail lacquer)....23
cilostazol....1
CILOXAN eye soln....31
cimetidine inj, oral soln, tabs....25
CIPRO....3
CIPRODEX ear susp....32
ciprofloxacin ER....3
ciprofloxacin eye soln....31
ciprofloxacin for , for in dextrose....3
ciprofloxacin tabs....3
cisplatin inj....10
CISPLATIN inj....10
citalopram oral soln....
citalopram tabs....
cladribine....10
CLAFORAN for inj, IV in de trose....3
clarithromycin....3
clarithromycin ER....3
CLEOCIN caps, for IV, inj, IV in de trose, vaginal cream....3
CLEOCIN-T gel, lotn, soln, swabs....23
CLIMARA....2
clindamycin/benzoyl peroxide gel....23
clindamycin caps....3
clindamycin gel, lotn, soln, s abs....23
clindamycin inj, soln, aginal crm....3
CLINORIL....
clobetasol crm, crm (emollient), gel, oint, soln....23
CLOLAR....10
clomipramine....
clonazepam , tabs....5
clonidine tabs....1
clonidine transdermal....1
clopidogrel tabs....1
clorazepate....5
clorazepate....15
clotrimazole/betamethasone crm, lotn....23
clotrimazole crm....23
clotrimazole troche....
clozapine....13
CLOZARIL....13
COARTEM....12
CODEINE SULFATE tabs....1
COLAZAL....30
COLCRYS....
COLESTID....1
colestipol....1
colistimethate sodium....3
COLYTE for soln....25
COMBIGAN eye soln....31
COMBIPATCH....2
COMBIVENT....33
COMPLERA....14
COMTAN....13
COMVAX....2
COPAXONE....22
CORDARONE....1
COREG....1
CORGARD....1
CORTEF....2
CORTIFOAM rectal foam....23
CORTISONE....2
CORTISPORIN ear soln....32
COSMEGEN....10
COSOPT eye soln....31
COUMADIN tabs....1
COZAAR....1
CREON....25
CRESTOR....1
CRIXIVAN....14
cromolyn sodium eye soln....31
cromolyn sodium inhal soln....33
cromolyn sodium oral conc....25
CUBICIN....3
CUPRIMINE....2
CUPRIMINE....2
CUPRIMINE....34
CUTIVATE crm....23
cyclobenzaprine....34
CYCLOPHOSPHAMIDE for inj....10
CYCLOPHOSPHAMIDE tabs....10
CYCLOSERINE....

cyclosporine.....2
CYCLOSPORINE modified caps.....2
cyclosporine modified caps, oral soln.....2
CY LO APRON.....1
CYMBALTA.....
CYMBALTA.....15
CYMBALTA.....22
CYSTADANE.....25
CYSTAGON*.....25
CYTARABINE for inj.....10
cytarabine for inj, inj.....10
CYTOMEL.....2
CYTOTEC.....25
CYTOVENE.....14

dacarbazine for inj.....10
DACARBAZINE for inj.....10
DACOGEN.....10
danazol.....2
DANTRIUM caps.....14
dantrolene caps.....14
DAPSONE.....
DAPTACEL.....2
DARAPRIM.....12
daunorubicin.....10
DAUNOXOME.....10
DAYPRO.....
DDAVP nasal spray, tabs.....2
DECAVAC.....2
DELATESTRYL.....2
DEMADEX.....1
demeclocycline.....3
DENAVIR crm.....23
DEPACON.....5
DEPA ENE.....5
DEPA ENE.....1
DEPA OTE.....5
DEPA OTE.....
DEPA OTE.....1
DEPA OTE ER.....5
DEPA OTE ER.....
DEPA OTE ER.....1
DEPA OTE SPRIN LES.....5
DEPA OTE SPRIN LES.....
DEPA OTE SPRIN LES.....1
DEPEN TITRATABS.....2
DEPEN TITRATABS.....2
DEPEN TITRATABS.....34
DEPO-PROVERA.....2
DEPO-TESTOSTERONE.....2
DERMATOP.....23
DERMOTIC ear oil.....32
desipramine.....
desmopressin nasal soln, nasal spray, tabs.....2
desonide crm, lotn, oint.....23
desoximetasone crm, gel, oint.....23
DETROL.....2
DETROL LA.....2
dexamethasone elixir, taper pack.....2
dexamethasone sodium phosphate eye soln.....31
dexamethasone sodium phosphate inj.....2
dexamethasone tabs.....2
DEXAMETHASONE tabs.....2
DEXEDRINE SPANSULE.....22
dexmethylphenidate tabs.....22
dexrazoxane.....10
dextroamphetamine ER caps.....22
dextroamphetamine tabs.....22
DIABETA.....1
DIAMOX SEQUELS.....1
DIAZEPAM oral conc, oral soln.....5
DIAZEPAM oral conc, oral soln.....15
DIAZEPAM rectal gel.....5
diazepam tabs.....5
diazepam tabs.....15
DIBENZYLINE.....1
diclofenac potassium.....
diclofenac sodium R.....
diclofenac sodium ER.....
diclofenac sodium eye soln.....31
dicloxacillin.....3
didanosine R.....14
DIDRONEL.....31
DIFICID.....3
diflorasone oint.....23
DIFLUCAN.....
DIGOXIN oral soln.....1
digoxin tabs.....1
DILANTIN.....5
DILAUDID-HP inj.....1
DILAUDID tabs.....1
diltiazem ER.....1
diltiazem tabs.....1
DIOVAN.....1
DIOVAN HCT.....1
DIPENTUM.....30
diphenhydramine caps, elixir.....
diphenhydramine caps, elixir.....13
diphenhydramine caps, elixir.....33

diphenhydramine inj.....
diphenhydramine inj.....13
diphenhydramine inj.....33
DIPHTHERIA/TETANUS ADSORBED pediatric.....2
DIPROLENE AF.....23
DIPROLENE lotn, oint.....23
dipyridamole tabs.....1
disopyramide.....1
disulfiram.....2
DITROPAN XL.....2
di alproex R tabs.....5
di alproex R tabs.....
di alproex R tabs.....1
di alproex ER.....5
di alproex ER.....
di alproex ER.....1
di alproex sprinkle caps.....5
di alproex sprinkle caps.....
di alproex sprinkle caps.....1
DIVIGEL.....2
DOCEFREZ.....10
DOCETAXEL for inj, for IV.....10
DOLOPHINE.....1
donepezil.....
dorzolamide/timolol maleate eye soln.....31
dorzolamide eye soln.....31
DOVONEX crm.....23
DOVONEX SCALP soln.....23
doxazosin.....1
doxazosin.....2
DOXEPIN caps.....
DOXEPIN caps.....15
DOXEPIN caps.....33
doxepin caps, oral conc.....
doxepin caps, oral conc.....15
doxepin caps, oral conc.....33
DOXIL.....10
doxorubicin.....10
doxycycline hyclate caps, tabs.....3
doxycycline hyclate for inj.....3
doxycycline hyclate tabs.....23
doxycycline monohydrate.....3
dronabinol.....
DUREZOL.....31
DYAZIDE.....1
DYNACIRC CR.....1

E.E.S. GRANULES.....3
EC-NAPROSYN.....
econazole crm.....23
EDURANT.....14
EFFEXOR XR.....
EFFEXOR XR.....15
EFFIENT.....1
ELAPRASE.....25
ELDEPRYL.....13
ELIGARD.....2
ELIGARD.....2
ELITE 10
ELLA.....2
ELOCON.....23
ELSPAR.....10
EMCYT.....10
EMEND caps.....
EMEND for IV.....
EMLA.....2
EMSAM.....
EMTRIVA.....14
enalapril.....1
enalapril/hydrochlorothiazide.....1
ENBREL.....2
ENGERIX-B.....2
enoxaparin.....1
epinastine eye soln.....31
EPIPEN.....33
EPIPEN- R.....33
epirubicin inj.....10
EPIVIR-HBV.....14
EPIVIR oral soln.....14
EPIVIR tabs.....14
eplerenone.....1
EPOGEN.....1
eprosartan.....1
EPZICOM.....14
EQUETRO.....1
ERBITUX.....10
ergotamine/caffeine.....
ERIVEDGE.....10
ERYPED.....3
ERY-TAB.....3
ERYTHROCIN.....3
erythromycin/benzoyl peroxide gel.....23
erythromycin eye oint.....31
erythromycin pads, soln.....23
escitalopram.....
escitalopram.....15
ESTRACE vaginal crm.....2
estradiol/norethindrone acetate.....2
estradiol tabs.....2

estradiol transdermal.....2
estropipate.....2
ethambutol.....
ethosuximide caps.....5
ethosuximide oral soln.....5
etidronate tabs.....31
ETIDRONATE tabs.....31
etodolac.....1
etodolac.....
etodolac ER.....
ETOPOPHOS.....10
etoposide inj.....11
EVISTA.....2
EXELON caps.....
EXELON oral soln, transdermal.....
exemestane.....11
EXFORGE.....1
EXFORGE HCT.....1
EX ADE* tabs for oral susp.....34
EX ADE* tabs for oral susp.....34

FABRAZYME*.....25
famciclo ir.....14
famotidine for susp, inj.....25
famotidine tabs.....25
FAMVIR.....14
FANAPT.....13
FARESTON.....11
FASLODEX.....11
fat emulsion 34
FAZACLO.....13
felbamate.....5
FELBATOL.....5
FELDENE.....
felodipine ER.....1
FEMARA.....11
fenofibrate.....1
fenofibrate micronized.....20
fentanyl citrate oral lozenges.....1
fentanyl transdermal.....1
FINACEA gel.....23
finasteride.....2
finasteride.....2
FIRAZYR.....20
FIRMAGON.....2
FIRMAGON.....2
FLAGYL.....3
flecainide.....20
FLEXERIL.....34
FLOMAX.....2
FLONASE.....33
FLOVENT DIS US.....33
FLOVENT HFA.....33
fluconazole for susp, inj in dextrose, inj in normal saline.....
FLUCONAZOLE inj in normal saline.....
fluconazole tabs.....
flucytosine.....
fludarabine.....11
fludrocortisone.....2
fluocinolone acetonide ear oil.....32
fluocinolone crm.....23
fluocinonide crm, gel, oint, soln.....23
fluocinonide crm (emollient).....23
fluorometholone eye susp.....31
FLUOROPLEX crm.....23
fluorouracil crm, soln.....23
fluorouracil inj.....11
fluoxetine caps, oral soln, tabs.....
fluoxetine R.....
FLUPHENAZINE DECANOATE.....13
FLUPHENAZINE HCL eli ir, inj, oral conc.....13
fluphenazine hcl tabs.....13
flurbiprofen.....
flurbiprofen eye soln.....31
flutamide.....2
fluticasone crm, oint.....23
fluticasone nasal spray.....33
flu oxamine.....
FML LIQUIFILM eye susp.....31
FOCALIN.....22
fomepizole.....34
fondaparinux.....1
FORADIL AEROLIZER.....33
FORTAZ.....3
FORTEO.....31
FORTESTA.....2
FORTICAL.....31
FOSAMAX tabs.....31
FOSCARNET.....14
fosinopril.....20
fosinopril/hydrochlorothiazide.....20
fosphenytoin.....5
FOSRENOL.....2
furosemide inj.....20
furosemide oral soln, tabs.....20
FUZEON.....14

gabapentin caps.....5
gabapentin oral soln, tabs.....5
GABITRIL.....5
galantamine.....
galantamine ER.....
GAMMAGARD..... 2
GAMMAGARD S/D..... 2
GANCICLOVIR caps.....14
ganciclo ir for inj.....14
GARDASIL.....2
GASTROCROM.....25
GAUZE PADS 2 X 2 1
gemcitabine for inj.....11
GEMCITABINE inj.....11
gemfibrozil.....20
GENTAMICIN crm, oint.....24
gentamicin eye oint, soln..... 31
gentamicin inj, inj in saline, soln.....3
GENTAMICIN inj in saline.....3
GEODON.....13
GEODON.....1
GLEEVEC.....11
glimepiride.....1
glipizide..... 1
glipizide/metformin.....1
glipizide ER..... 1
GLUCAGEN IT.....1
GLUCAGON EMERGENCY IT.....1
GLUCOPHAGE.....1
GLUCOPHAGE XR.....1
GLUCOTROL.....1
GLUCOTROL XL.....1
GLUCOVANCE.....1
glyburide.....1
glyburide/metformin.....1
GLYBURIDE (distributor of Diabeta)..... 1
glyburide micronized..... 1
glycopyrrolate tabs..... 25
GLYNASE.....1
GOLYTELY.....25
granisetron tabs.....
griseoful in.....
GRIS-PEG.....

HALAVEN..... 11
HALDOL.....13
HALDOL DECANOATE.....13
halobetasol crm, oint.....24
haloperidol decanoate.....13
haloperidol inj.....13
haloperidol oral conc, tabs.....13
HAVRIX.....2
heparin inj.....1
heparin sodium inj in dextrose..... 1
HEPSERA.....14
HERCEPTIN.....11
HEXALEN..... 11
HIBERIX.....2
HIPREX..... 3
HUMALOG.....1
HUMALOG MIX..... 1
HUMIRA.....2
HUMULIN 0/30..... 1
HUMULIN N..... 1
HUMULIN R..... 1
hydralazine tabs.....20
HYDREA..... 11
hydrochlorothiazide..... 20
hydrocodone/acetaminophen caps, oral soln..... 1
hydrocodone/acetaminophen tabs..... 1
hydrocodone/ibuprofen..... 1
hydrocortisone/acetic acid ear soln..... 32
hydrocortisone butyrate crm, oint, soln..... 24
hydrocortisone crm, oint, rectal crm..... 24
hydrocortisone enema..... 30
hydrocortisone lotn.....24
hydrocortisone tabs.....2
hydrocortisone alerate crm, oint.....24
hydromorphone inj.....1
hydromorphone liq, tabs.....1
hydroxychloroquine..... 12
hydroxyurea.....11
hydroxyzine hcl syrup, tabs.....
hydroxyzine hcl syrup, tabs..... 1
hydroxyzine hcl syrup, tabs..... 33
HYZAAR.....20

ibandronate tabs.....31
ibuprofen..... 1
ibuprofen.....
idarubicin.....11
IFEX for inj..... 11
IFOSFAMIDE/MESNA..... 11
ifosfamide for inj..... 11
IFOSFAMIDE for inj, IV.....11
imipenem/cilastatin..... 3
imipramine hcl.....
imipramine pamoate.....

imiquimod.....2
IMITREX inj.....
IMITREX nasal spray, tabs.....
IMURAN.....2
INCIVE 14
INCRELEX*.....2
indapamide.....20
INDERAL LA.....
INDERAL LA.....20
indomethacin caps.....
indomethacin ER.....
INFANRIX.....2
INFERGEN.....2
INLYTA.....11
INSPRA.....20
INSULIN IN ECTION DEVICE.....1
INSULIN IN ECTION DEVICE/NOVOLIN.....1
INSULIN SYRINGE/NEEDLE.....1
INTELENCE.....14
INTRALIPID.....34
INTRON-A.....11
INTRON-A.....11
INTRON-A.....15
INTRON-A.....15
INTUNIV.....22
INVANZ.....3
INVEGA SUSTENNA inj.....13
INVEGA SUSTENNA inj.....13
INVEGA tabs.....13
INVEGA tabs.....13
INVIRASE.....15
IPOL.....2
ipratropium nasal soln.....33
irbesartan.....20
irbesartan/hydrochlorothiazide.....20
IRESSA*.....11
irinotecan.....11
ISENTRESS.....15
isoniazid/rifampin.....10
ISONIAZID inj.....10
isoniazid tabs.....10
ISOPTIN SR.....20
ISORDIL tabs.....20
isosorbide dinitrate ER tabs.....20
ISOSORBIDE DINITRATE SL tabs.....20
isosorbide dinitrate tabs.....20
isosorbide mononitrate.....20
isosorbide mononitrate ER tabs.....20
isotretinoin caps.....24
ISRADIPINE.....20
ISTALOL eye soln.....31
ISTODAX.....11
itraconazole caps.....
i fluids - generics.....34
IV FLUIDS - CL/D5 /LACTATED RINGERS inj.....34
IXEMPRA.....11
IXIARO.....2

A AF.....11
ANUMET.....1
ANUMET XR.....1
ANUVIA.....1
ENTADUETO.....1
E-VAX.....2
EVTANA.....11
UVISYNC.....1

ALETRA.....15
ALYDECO.....33
ANAMYCIN.....3
AYEXALATE.....34
EFLEX caps.....3
EPIVANCE.....23
EPPRA.....5
ketoconazole crm, shampoo.....24
ketoconazole tabs.....
ketoprofen.....1
ketoprofen.....
ketorolac eye soln.....31
ketorolac tabs.....1
INRIX.....2
LARON.....24
OMBIGLYZE XR.....1
-TABS.....34
UVAN*.....25

labetalol tabs.....20
LAC-HYDRIN.....24
LACRISERT eye insert.....31
lactic acid crm, lotn.....24
lactulose.....25
LAMICTAL chew tabs, tabs.....5
LAMICTAL chew tabs, tabs.....1
LAMICTAL ODT.....5
LAMICTAL ODT.....1
LAMISIL tabs.....
lami udine.....15
lami udine/zido udine.....15

lamotrigine che tabs.....5
lamotrigine che tabs.....1
lamotrigine tabs.....5
lamotrigine tabs.....1
LANOXIN tabs.....20
lansoprazole R.....25
LANTUS.....1
LASIX.....20
latanoprost eye soln.....31
LATUDA.....13
leflunomide.....2
LETAIRIS*.....20
letrozole.....11
leuco orin calcium for inj.....11
LEUCOVORIN CALCIUM for inj, inj, tabs.....11
leuco orin calcium tabs.....11
LEU ERAN.....11
LEU INE.....1
leuprolide.....2
LEVAQUIN oral soln.....3
LEVEMIR.....1
le etiracetam inj, oral soln.....5
LEVETIRACETAM IV in saline.....5
le etiracetam tabs.....5
le obunolol eye soln.....31
LEVOBUNOLOL eye soln.....31
le ocarnitine oral soln, tabs.....34
le ocetirizine tabs.....33
le ofloxacin.....3
LEVORPHANOL.....1
le othyroxine tabs (Le oxyl).....2
Le oxyl.....2
LEXAPRO.....
LEXAPRO.....1
LEXIVA.....15
LIALDA.....30
lidocaine/prilocaine.....2
lidocaine gel, oint.....24
LIDOCAINE IV.....20
lidocaine local inj, topical soln.....2
lidocaine iscous.....2
LIDODERM.....2
lindane lotn, shampoo.....12
liothyronine tabs.....2
LIPITOR.....20
LIPOFEN.....20
LIPOSYN.....34
lisinopril.....20
lisinopril/hydrochlorothiazide.....20
LITHIUM CARBONATE caps.....1
lithium carbonate caps, tabs.....1
lithium carbonate ER.....1
LITHIUM CITRATE.....1
LITHOBID.....1
LOCOID crm, oint, soln.....24
loperamide.....25
LOPID.....20
LOPRESSOR HCT.....20
LOPRESSOR tabs.....20
LOPROX gel, shampoo.....24
losartan.....20
losartan/hydrochlorothiazide.....20
LOTEMAX eye susp.....31
LOTENSIN.....20
LOTENSIN HCT.....20
LOTREL.....20
LOTRISONE crm.....24
LOTRONEX.....25
lo astatin.....20
LOVAZA.....20
LOVENOX.....1
loxapine.....13
LUFYLLIN.....33
LUMIGAN eye soln.....31
LUNESTA.....34
LUPRON DEPOT.....2
LUPRON DEPOT-PED.....2
LYRICA.....5
LYRICA.....22
LYSODREN.....2

MACROBID.....4
MACRODANTIN caps.....4
MALARONE.....12
malathion.....12
MAPROTILINE.....
MARPLAN.....
MATULANE.....11
MAVI 20
MAXALT.....
MAXALT-MLT.....
MAXITROL eye oint.....31
MAXZIDE.....20
MAXZIDE-25.....20
meclizine tabs.....
MEDROL.....2
medroxyprogesterone inj.....2
medroxyprogesterone tabs.....2
mefloquine.....12

MEFOXIN....4
MEGACE....2
megestrol.... 2
meloxicam tabs....
melphalan....11
MENACTRA....2
MENEST.... 2
MENOMUNE.... 2
MENVEO....2
MEPRON.... 12
mercaptopurine.... 11
meropenem....4
MERREM.... 4
mesalamine enema....30
mesna....11
MESNEX tabs....11
MESTINON syrup, tabs....
METAGLIP....1
metformin.... 1
metformin ER.... 1
methadone tabs.... 1
methazolamide....20
methenamine hippurate.... 4
METHERGINE tabs.... 2
methimazole.... 2
methocarbamol.... 34
methotrexate for inj, inj....11
methotrexate for inj, inj....2
methotrexate tabs....11
methotrexate tabs....2
methscopolamine....25
methyldopa.... 20
methylergono ine tabs....2
methylphenidate ER tabs.... 22
methylphenidate tabs....22
methylprednisolone sodium succinate for inj....2
methylprednisolone tabs....2
metipranolol eye soln....31
metoclopramide oral soln, tabs....
metoclopramide oral soln, tabs.... 25
metolazone.... 20
metoprolol/hydrochlorothiazide tabs.... 20
metoprolol succinate ER.... 20
metoprolol tartrate tabs....20
METROCREAM.... 24
METROGEL....24
METROGEL VAGINAL.... 4
METRO IV.... 4
METROLOTION....24
metronidazole caps, soln, aginal gel....4
metronidazole crm, gel, lotn.... 24
metronidazole tabs.... 4
MEVACOR....20
MEXILETINE.... 20
MIACALCIN nasal spray.... 31
MICARDIS.... 20
MICARDIS HCT....21
MICRO- 34
MICROZIDE....21
midodrine.... 21
MIGERGOT....
MIGRANAL....
MINIPRESS....2
MINOCIN caps....4
minocycline.... 4
minoxidil.... 21
MIRAPEX....13
mirtazapine ....
mirtazapine tabs....
misoprostol....25
mitomycin....11
mitoxantrone....11
mitoxantrone....22
M-M-R II /DILUENT....2
MOBIC tabs....
moexipril....21
moexipril/hydrochlorothiazide....21
mometasone crm, lotn, oint.... 24
MONODOX....4
MONO ET....21
morphine sulfate ER tabs....1
morphine sulfate inj....1
morphine sulfate oral soln....1
MORPHINE SULFATE tabs....1
MOVIPREP....25
MOXEZA eye soln....32
MULTAQ.... 21
mupirocin oint....24
MUSTARGEN.... 11
MYCAMINE....
MYCOBUTIN....10
mycophenolate mofetil....2
MYDRIACYL eye soln.... 32
MYFORTIC....2
MYOZYME....25
MYSOLINE....5

nabumetone....
nadolol....21

nafcillin for inj.... 4
NAFCILLIN for IV.... 4
NAGLAZYME*....25
naloxone inj.... 2
NALOXONE inj....2
naltrexone.... 2
NAMENDA....
NAPHAZOLINE eye soln.... 32
NAPROSYN....1
NAPROSYN....
naproxen R....
naproxen sodium tabs.... 1
naproxen sodium tabs....
naproxen susp....1
naproxen susp....
naproxen tabs.... 1
naproxen tabs....
naratriptan....
NARDIL....
NASACORT AQ....33
NASONEX.... 33
NATACYN eye susp.... 32
nateglinide....1
NAVANE caps....13
NEFAZODONE....
neomycin/polymyxin /bacitracin/hydrocortisone eye oint.... 32
neomycin/polymyxin /bacitracin eye oint.... 32
neomycin/polymyxin /dexamethasone eye oint, susp.... 32
neomycin/polymyxin /gramicidin eye soln.... 32
neomycin/polymyxin /hydrocortisone ear soln, susp.... 32
neomycin/polymyxin GU irrigation soln.... 2
neomycin sulfate tabs.... 4
NEORAL.... 2
NEULASTA....1
NEUMEGA....1
NEUPOGEN....1
NEURONTIN.... 5
NEVANAC eye susp....32
ne irapine tabs....15
NEXAVAR*.... 11
NEXIUM.... 25
NEXIUM I.V....25
NIASPAN.... 21
nicardipine caps....21
NICOTROL INHALER....2
NICOTROL NS nasal spray....2
nifedipine ER tabs.... 21
NILANDRON.... 2
nisoldipine ER tabs.... 21
NISOLDIPINE ER tabs....21
NITRO-BID....21
nitrofurantoin macrocrystalline caps.... 4
nitrofurantoin monohydrate/macrocrystalline caps.....4
nitrofurantoin susp.... 4
nitroglycerin transdermal.... 21
NITROMIST....21
NITROSTAT.... 21
nizatidine caps.... 25
NIZORAL shampoo....24
norethindrone acetate....2
NORPACE.... 21
NORPACE CR....21
NORPRAMIN....
nortriptyline caps....
NORVASC.... 21
NORVIR.... 15
NOVOLIN 0/30....1
NOVOLIN N....1
NOVOLIN R....1
NOVOLOG....1
NOVOLOG MIX.... 1
NOXAFIL....
NUCYNTA ER....1
NUEDEXTA.... 22
NULO IX....2
NULYTELY.... 25
NUVIGIL....34
NYSTATIN/TRIAMCINOLONE.... 24
nystatin crm, oint, topical po der.... 24
nystatin susp, tabs....

octreotide inj....2
octreotide inj....2
OCUFLOX eye soln....32
ofloxacin.... 4
ofloxacin ear soln.... 32
ofloxacin eye soln....32
olanzapine....13
olanzapine....1
OLEPTRO....
omeprazole R caps.... 25
OMNIPRED eye susp....32
OMNITROPE....2
ONCASPAR....11
ondansetron inj....
ondansetron , oral soln, tabs....

ONFI....5
ONGLYZA....1
ONTA 11
OPTIPRANOLOL eye soln....32
OPTIVAR eye soln....32
ORACEA caps....24
oral contracepti es all generics....2
ORAL CONTRACEPTIVES multi-source brands...2
ORAP....13
ORFADIN*....25
ORTHOCLONE O T3....30
OVIDE....12
oxaliplatin....11
OXANDRIN tabs....2
oxandrolone tabs....2
oxandrolone tabs....2
oxaprozin....
oxcarbazepine susp....5
oxcarbazepine tabs....5
OXSORALEN ULTRA caps....24
oxybutynin ER....2
oxybutynin syrup....2
oxybutynin tabs....2
oxycodone/acetaminophen....1
oxycodone/aspirin....1
oxycodone tabs....1
OXYCONTIN....1

paclitaxel 11
PAMINE....25
PAMINE FORTE....25
PANRETIN....11
PANRETIN gel....24
pantoprazole R tabs....25
PARCOPA....13
PARLODEL....13
PARLODEL....2
PARNATE....
paromomycin....12
paroxetine hcl ER....
paroxetine hcl ER....1
paroxetine hcl tabs....
paroxetine hcl tabs....1
PASER....10
PATADAY eye soln....32
PATANASE....33
PATANOL eye soln....32
PAXIL....
PAXIL....1
PAXIL CR....
PAXIL CR....1
PEDIAPRED....2
PEDVAX HIB....30
peg 3350/kcl/sod bicarb/nacl/sod sulf for soln....25
peg 3350/kcl/sod bicarb/nacl for soln....25
PEGANONE....5
PEGASYS....30
PEG-INTRON....30
penicillin g potassium for inj....4
PENICILLIN G POTASSIUM inj in de trose....4
PENICILLIN G SODIUM for inj....4
penicillin potassium....4
PENNSAID....1
PENNSAID....
PENNSAID....24
PENTACEL....30
PENTAM 300....12
PENTASA....30
pentostatin....11
pentoxifylline ER tabs....1
PEPCID tabs....25
PERCODAN....1
perindopril....21
PER ETA....11
permethrin....12
perphenazine....
perphenazine....14
PERSANTINE....1
PFIZERPEN-G for inj....4
phenelzine....
phenobarbital tabs....5
PHENOBARBITAL tabs....5
PHENYTE ....
phenytoin sodium ER caps....
phenytoin susp....
PHOSLO....2
PHOSPHOLINE IODIDE eye soln....32
PICATO....24
pilocarpine eye soln, gel....32
pilocarpine tabs....23
PILOPINE HS eye gel....32
PINDOLOL....21
piperacillin/tazobactam for inj....4
piroxicam....
PLAQUENIL....13
PLAVIX tabs....1
PLETAL....1
podofilox soln....24
polyethylene glycol 3350 oral po der....25

polymyxin /trimethoprim eye soln.....32
POLYTRIM eye soln.....32
potassium chloride ER caps.....34
potassium chloride ER tabs.....34
potassium citrate ER.....2
potassium citrate ER.....34
POTIGA.....
PRADAXA.....1
pramipexole.....13
PRANDIN.....1
PRAVACHOL.....21
pra astatin.....21
prazosin.....21
prazosin.....2
PRECOSE.....1
PRED FORTE eye susp.....32
prednicarbate.....24
prednisolone acetate eye susp.....32
prednisolone sodium phosphate oral soln.....2
prednisolone syrup.....2
prednisone dose-pack.....2
PREDNISONE oral soln, tabs.....2
prednisone tabs.....2
PREMARIN tabs.....2
PREMARIN vaginal crm.....2
PREMPHASE.....2
PREMPRO.....2
PREVACID DR caps.....25
PREVACID SOLUTAB.....25
PREVPAC.....4
PREVPAC.....2
PREZISTA.....15
PRIFTIN.....10
PRILOSEC DR caps.....2
PRIMAQUINE.....13
primidone.....
PRINIVIL.....21
PRINZIDE.....21
PRISTIQ.....
PROAIR HFA.....33
probenecid.....
probenecid/colchicine.....
PROCARDIA XL.....21
PROCHLORPERAZINE inj.....
PROCHLORPERAZINE inj.....14
prochlorperazine supp, tabs.....
prochlorperazine supp, tabs.....14
PROCRIT inj.....1
PROCRIT inj.....1
PROGLYCEM.....1
PROGRAF.....30
PROLASTIN*.....33
PROLEU IN.....12
PROLIA.....31
PROMACTA*.....1
promethazine supp, syrup, tabs.....
promethazine supp, syrup, tabs.....33
propafenone.....21
propafenone ER.....21
propranolol ER caps.....
propranolol ER caps.....21
propranolol tabs.....
propranolol tabs.....21
propylthiouracil.....2
PROQUAD.....30
PROSCAR.....2
PROSCAR.....2
PROTONIX DR tabs.....2
PROTOPIC.....24
PROTOPIC.....30
protriptyline.....
PROVERA.....2
PROVIGIL.....34
PROZAC.....
PROZAC EE LY.....
PRUDOXIN crm.....24
PULMOZYME.....33
PURINETHOL.....12
PYLERA.....2
pyrazinamide.....10
pyridostigmine.....

quetiapine.....
quetiapine.....14
quetiapine.....1
quinapril.....21
quinapril/hydrochlorothiazide.....21
quinidine gluconate ER.....21
quinidine sulfate.....21
QVAR.....33

RABAVERT.....30
ramipril.....21
RANEXA.....21
ranitidine caps, syrup.....2
ranitidine tabs.....2
RAPAFLO.....2
RAPAMUNE.....30

RAZADYNE.....
RAZADYNE ER.....
REBETOL oral soln.....15
RECOMBIVAX HB..... 30
REGLAN tabs.....
REGLAN tabs.....2
RELISTOR.....2
REMERON.....
REMERON SOLTAB.....
REMICADE.....30
REMODULIN*..... 21
RENVELA..... 2
REQUIP.....13
RESCRIPTOR.....15
RESTASIS eye emulsion..... 32
RETIN-A crm, gel.....24
RETROVIR..... 15
RETROVIR IV..... 15
REVLIMID*.....12
REYATAZ.....15
RIBAPA 15
RIBASPHERE tabs..... 15
RIBASPHERE tabs..... 15
riba irin caps, tabs..... 15
RIDAURA.....30
RIFADIN.....10
rifampin.....10
RILUTE 22
rimantadine..... 15
RISPERDAL..... 14
RISPERDAL..... 1
RISPERDAL CONSTA..... 14
RISPERDAL CONSTA..... 1
RISPERDAL M-TAB.....14
RISPERDAL M-TAB.....1
RISPERIDONE ODT.....14
RISPERIDONE ODT.....1
risperidone , oral soln.....14
risperidone , oral soln.....1
risperidone tabs..... 14
risperidone tabs..... 1
RITALIN.....22
RITALIN SR.....22
RITUXAN*.....12
ri astigmine caps.....
ROBAXIN tabs.....34
ROBINUL FORTE..... 2
ROBINUL tabs..... 2
ROCALTROL.....31
ROCEPHIN..... 4
ropinirole..... 13
ROTARIX.....30
ROTATEQ.....30
ROXICODONE tabs.....1
RYTHMOL..... 21
RYTHMOL SR..... 21

SABRIL.....
SALAGEN.....23
SANCTURA.....2
SANCTURA XR.....2
SANDIMMUNE.....30
SANTYL..... 24
SAPHRIS..... 14
SECTRAL.....21
selegiline..... 13
selenium sulfide lotn, shampoo.....24
SELZENTRY..... 15
SENSIPAR.....2
SEREVENT DIS US..... 33
SEROMYCIN.....10
SEROQUEL.....
SEROQUEL.....14
SEROQUEL.....1
SEROQUEL XR.....
SEROQUEL XR.....14
SEROQUEL XR.....1
sertraline oral conc.....
sertraline oral conc.....1
sertraline tabs.....
sertraline tabs.....1
SFRO ASA.....30
SILVADENE.....24
sil er sulfadiazine crm..... 24
SIMULECT.....30
sim astatin..... 21
SINEMET..... 13
SINEMET CR.....13
SINGULAIR..... 33
sodium chloride irrigation..... 24
sodium polystyrene sulfonate..... 34
SOLARAZE gel.....24
SOLU-MEDROL for inj..... 2
SOMATULINE DEPOT.....2
SOMAVERT*.....2
SONATA..... 34
SORIATANE caps.....24
sotalol tabs.....21
sotalol tabs..... 21

SPIRIVA HANDIHALER..... 33
spironolactone..... 21
spironolactone/hydrochlorothiazide.....21
SPORANOX caps.....
SPRYCEL..... 12
STALEVO.....13
STARLIX..... 1
sta udine.....15
STIMATE.....2
STREPTOMYCIN.....4
STROMECTOL..... 13
SUBOXONE.....2
SUBUTEX..... 2
sucralfate tabs.....2
SULAR.....21
sulfacetamide sodium/prednisolone eye soln.....32
sulfacetamide sodium eye soln..... 32
sulfacetamide sodium lotn.....24
SULFADIAZINE.....4
SULFAMETHOXAZOLE/TRIMETHOPRIM inj.....4
sulfamethoxazole/trimethoprim susp..... 4
sulfamethoxazole/trimethoprim tabs..... 4
sulfasalazine.....30
sulfasalazine R.....30
sulindac.....
sumatriptan inj.....
SUMATRIPTAN nasal spray.....
sumatriptan tabs.....
SUPRAX tabs.....4
SURMONTIL.....
SUSTIVA.....15
SUTENT.....12
SYLATRON..... 12
SYMBICORT..... 33
SYMLINPEN.....1
SYNAGIS..... 30
SYNAREL..... 2
SYNERCID.....4
SYNTHROID..... 2
SYPRINE..... 34

TABLOID.....12
tacrolimus.....30
TAMBOCOR.....21
TAMIFLU.....15
tamoxifen.....12
tamsulosin.....2
TARCEVA..... 12
TARGRETIN caps..... 12
TARGRETIN gel..... 12
TARGRETIN gel..... 24
TASIGNA..... 12
TASMAR..... 13
TAXOTERE..... 12
TAZORAC crm, gel..... 24
TEFLARO.....4
TEGRETOL.....
TEGRETOL-XR.....
TE TURNA..... 21
TE TURNA HCT.....21
TEMODAR for IV.....12
TEMOVATE soln..... 24
TENIVAC.....30
TENORETIC.....21
TENORMIN.....21
TERAZOL 3.....
TERAZOL .....
terazosin.....22
terazosin.....2
terbinafine.....
terbutaline tabs..... 33
terconazole.....
testosterone cypionate.....2
testosterone enanthate..... 2
TETANUS/DIPHTHERIA ADSORBED adult..... 30
tetracycline caps..... 4
TETRACYCLINE caps..... 4
TEVETEN.....22
TEVETEN HCT.....22
THALOMID..... 12
THALOMID..... 30
theophylline ER tabs.....33
theophylline ER tabs.....33
thioridazine.....14
THIOTEPA..... 12
thiothixene.....14
THYMOGLOBULIN..... 30
TIAZAC.....22
TI OSYN..... 22
TIMENTIN..... 4
timolol maleate eye soln.....32
timolol maleate gel-forming eye soln.....32
TIMOLOL tabs.....
TIMOLOL tabs..... 22
TIMOPTIC eye soln..... 32
TIMOPTIC OCUDOSE eye soln..... 32
TIMOPTIC-XE eye soln.....32
tizanidine..... 14
TOBI.....4

TOBRADEX eye oint..... 32
TOBRADEX eye susp..... 32
tobramycin/dexamethasone eye susp..... 32
tobramycin eye soln..... 32
tobramycin for inj, inj..... 4
TOBRAMYCIN inj in saline..... 4
tolmetin sodium caps.....
TOPAMAX.....
TOPAMAX.....
TOPAMAX SPRIN LES.....
TOPAMAX SPRIN LES.....
topiramate sprinkle caps.....
topiramate sprinkle caps.....
topiramate tabs.....
topiramate tabs.....
topotecan for inj..... 12
TOPOTECAN inj..... 12
TOPROL XL..... 22
TORISEL..... 12
torsemide tabs..... 22
TOVIAZ..... 2
TRACLEER*..... 22
TRAD ENTA..... 1
tramadol..... 1
tramadol/acetaminophen..... 1
tramadol ER..... 1
TRANDATE tabs..... 22
trandolapril..... 22
tranexamic acid inj..... 1
tranylcypromine.....
TRAVATAN Z eye soln..... 32
trazodone.....
TREANDA..... 12
TRECATOR..... 10
TRELSTAR DEPOT..... 2
TRELSTAR DEPOT MIX ECT..... 2
TRELSTAR LA..... 2
TRELSTAR LA MIX ECT..... 2
TRELSTAR MIX ECT..... 2
TRENTAL..... 1
TRETINOIN caps..... 12
tretinoin crm, gel..... 24
triamcinolone acetonide paste..... 23
triamcinolone crm, lotn, oint..... 24
triamcinolone nasal spray..... 33
TRIAMCINOLONE oint..... 24
triamterene/hydrochlorothiazide..... 22
trifluoperazine..... 14
trifluridine eye soln..... 32
trihexyphenidyl..... 13
TRILEPTAL.....
TRILIPIX..... 22
trimethoprim tabs..... 4
trimipramine.....
TRIPEDIA..... 30
TRISENOX..... 12
TRIZIVIR..... 15
TROPHAMINE..... 34
tropicamide eye soln..... 32
trospium..... 2
TRUSOPT eye soln..... 32
TRUVADA..... 15
T INRIX..... 30
TYGACIL..... 4
TY ERB*..... 12
TYPHIM VI..... 30
TYSABRI*..... 22
TYSABRI*..... 30
TYZE A..... 15
TYZINE..... 33
TYZINE PEDIATRIC..... 33

ULESFIA..... 13
ULORIC.....
ULTRACET..... 1
ULTRAM..... 1
ULTRAVATE crm, oint..... 24
UNIRETIC..... 22
UNIVASC..... 22
urea/hydrocortisone acetate crm..... 24
ursodiol caps..... 2
UVADEX..... 12

VAGIFEM vaginal tabs..... 2
alacyclo ir..... 15
VALCYTE..... 15
alproate inj.....
alproic acid.....
alproic acid..... 1
VALTREX..... 15
VANCOCIN caps..... 4
ancomycin caps..... 4
ancomycin for inj..... 4
VANCOMYCIN inj in de trose..... 4
VANDETANIB*..... 12
VAQTA..... 30
VARIVAX..... 30
VASERETIC..... 22

VASOTEC....22
VECTIBIX....12
VECTICAL oint....24
VELCADE.... 12
enlafaxine....
enlafaxine ER caps....
enlafaxine ER caps.... 1
enlafaxine ER tabs....
enlafaxine ER tabs.... 1
VENTOLIN HFA....33
erapamil....22
erapamil tabs....22
VERELAN.... 22
VERELAN PM....22
VESICARE....2
VFEND IV....
VFEND susp....
VIBRAMYCIN caps....5
VICOPROFEN....1
VICTOZA....1
VICTRELIS.... 15
VIDAZA.... 12
VIDEX....15
VIDEX EC....15
VIGAMOX eye soln....32
VIIBRYD....
VIMOVO....
VIMPAT....
VINBLASTINE.... 12
incristine.... 12
inorelbine....12
VIRACEPT....15
VIRAMUNE....15
VIRAMUNE XR....15
VIREAD....15
VIROPTIC eye soln....32
VISTIDE.... 15
VIVELLE-DOT....2
VIVITROL....2
VOLTAREN eye soln....32
VOLTAREN gel....2
VOLTAREN gel....
VOLTAREN gel....24
VOLTAREN-XR....
oriconazole for inj....
oriconazole tabs....
VOTRIENT....12
VPRIV....25
VYTORIN.... 22

arfarin tabs....1
ater for irrigation.... 24
ELCHOL.... 1
ELCHOL.... 22
ELLBUTRIN....
ELLBUTRIN SR....
ELLBUTRIN XL....
ESTCORT oint.... 24

XAL ORI....12
XARELTO.... 1
XENAZINE*.... 22
XIFAXAN tabs....5
XOLAIR.... 30
XYLOCAINE local inj, topical soln.... 2
XYLOCAINE soln.... 24
XYREM*.... 34

YERVOY.... 12
YF-VAX.... 30

zafirlukast....33
zaleplon.... 34
ZANAFLEX tabs.... 14
ZANOSAR....12
ZANTAC syrup, tabs....2
ZARONTIN caps....
ZAROXOLYN.... 22
ZAVESCA*....25
ZEBETA.... 22
ZELBORAF....12
ZEMPLAR....31
ZENPEP....25
ZERIT.... 15
ZESTORETIC....22
ZESTRIL.... 22
ZETIA....22
ZIAC....22
ZIAGEN....15
zido udine....15
ZINACEF inj in de trose, inj in sterile water.... 5
ziprasidone....14
ziprasidone....1
ZITHROMAX for IV, for susp, tabs.... 5
ZOCOR.... 22
ZOFRAN ODT....

ZOFRAN oral soln, tabs.....
ZOLINZA.....12
ZOLOFT.....
ZOLOFT.....1
zolpidem.....34
ZOMETA.....31
ZONALON.....25
ZONEGRAN.....
zonisamide.....
ZORTRESS tabs.....30
ZORTRESS tabs.....30
ZOSTAVAX.....30
ZOSYN for inj, IV in de trose.....5
ZOVIRAX caps, susp, tabs.....15
ZOVIRAX oint.....25
ZYBAN.....2
ZYLOPRIM.....
ZYPREXA.....14
ZYPREXA.....1
ZYPREXA RELPREVV*.....14
ZYPREXA ZYDIS.....14
ZYPREXA ZYDIS.....1
ZYTIGA.....12
ZYTIGA.....2
ZYVOX.....5

a e a es i n c n ac
in a i n an s e a i n a e
c n aine in is la

www.BlueMedicareFL.com

Last Updated: August 2012