

#### What is Coverage Management?

Coverage Management is a review of certain prescribed drugs, or drug quantities to verify that they are covered according to plan rules. Plan rules are based on FDA approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe and effective. Please note that this program is not intended to limit the doctor's ability to treat his/her patient's healthcare needs, but rather to ensure the coverage of medications based on accepted medical uses.

Refer to the accompanying list of prescription drugs that require prior authorization, or visit **www.guardianlife.com** and select the "Prescription Drug" link under the Resources heading. Or, speak with a Member Services representative by calling 800-417-1783 for assistance. The list of prescription drugs requiring prior authorization may be updated periodically, so be sure to visit the site occasionally to stay informed of any changes.

### **Obtaining Prior Authorization for your prescription**

#### Save time — get the process started early!

To initiate the process, ask your doctor to call Medco at 800-753-2851 before you leave his or her office. Medco will review the information with your doctor. In certain cases, a Utilization Review Agent, other than Medco, may also review the information with your doctor. Based on the review outcome, coverage for your prescription will be approved or denied.

If your doctor has *not* previously contacted Medco, the process of initiating the review will vary, depending on how you choose to fill your prescription. This is described in more detail below.

#### Medco By Mail

Depending on the prior authorization your prescription is subject to, either a mail-order pharmacist will perform the review before filling the prescription, or you will receive up to the maximum amount allowed by your plan. When your medication is not subject to dispensing limits, the mail-order pharmacist will initiate the review with your doctor. When your medication is subject to dispensing limits, your prescription will be filled up to the allowable quantity and you will be asked to call your doctor to begin a coverage review for the remaining amount. If the remaining amount is approved, you should submit a new prescription for the full quantity to avoid paying an additional cost-share for the remaining amount.

#### Participating retail pharmacy

The pharmacist will tell you if a prescription needs prior authorization. Either you or the pharmacist may call your doctor to initiate the process.

#### Nonparticipating retail pharmacy

The pharmacist will fill your prescription. When you submit your claim for reimbursement and your prescription requires prior authorization, you will be notified to initiate the process and resubmit your claim. If coverage is limited to a smaller quantity or shorter duration, you will only be reimbursed for the authorized amount and you will be asked to contact your doctor to initiate the authorization process for the non-authorized amount. If coverage is approved, you must submit a claim for the additional amount to be reimbursed, less your cost-share.

### **Additional Information**

You and your doctor will be informed if coverage for your prescription is approved or denied. If coverage is denied, you will have the right to appeal.

For additional information on Coverage Management, refer to the Coverage Management FAQ.

If you have questions on Coverage Management or how to file an appeal, please contact Medco Member Services at 800-417-1783. Representatives are available to assist you 24 hours a day, 7 days a week.



Drug Class	Brand Name	Chemical Name	Generic Available
Androgens & Anabolic Steroids	Androgef <sup>®</sup> Testim <sup>®</sup>	testosterone gel	No
	Androderm <sup>®</sup>	testosterone transdermal system	No
	Striant <sup>®</sup>	testosterone buccal system	No
	First <sup>IM</sup> -testosterone ointment First <sup>TM</sup> -testosterone Moisturizing Cream	testosterone propionate	No
	Methitest <sup>®</sup>	methyltestosterone tablets	No
	Testred <sup>®</sup> Android <sup>®</sup>	methyltestosterone capsules	No
	Androxy <sup>®</sup>	fluoxymesterone	Yes
	Tesamone <sup>®</sup>	testosterone aqueous injection	No
	Depo-Testosterone®	testosterone cypionate injection	No
	Delatestryl <sup>®</sup>	testosterone enanthate injection	No
	Testopel <sup>®</sup>	testosterone pellets	No
	Anadrol-50®	oxymetholone	No
	Winstrol <sup>®</sup>	stanozolol	No
	Oxandrin <sup>®</sup>	oxandrolone	Yes
	Nandrolone decanoate	nandrolone decanoate	Yes
70	Testosterone propionate	testosterone propionate	Yes
Anticonvulsants* <sup>(2)</sup>	Lyrica <sup>®</sup>	pregabalin	No
Anti-Narcoleptic Agents (1) used to promote wakefulness)	Provigil <sup>®</sup>	modafinil	No
	Nuvigil®	armodafinil	No
Antipsychotic Agents* <sup>(3)</sup>	Abilify <sup>®</sup>	aripiprazole	No
	Invega <sup>®</sup>	paliperidone	No
	Saphris <sup>®</sup>	asenapine maleate	No
Antiviral Agents* (used to treat hepatitis B and C)	Copegus®, Rebetol®,	ribavirin	Yes

<sup>(1) \*</sup> Prior claim history is used to initiate the coverage evaluation process in this drug class. If the claim history meets the review criteria, coverage consideration is not subject to prior authorization. All medications in this class are subject to the dispensing limitations rules listed on page 15 in this document.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(2)</sup> This medication is subject to dispensing limitation rules listed on page 12 of this document.

<sup>(3)</sup> This medication is subject to dispensing limitation rules listed on page 13 of this document.



Drug Class	Brand Name	Chemical Name	Generic Available
Appetite Suppressants and Weight Loss	Didrex <sup>®</sup>	benzphetamine	Yes
Agents	Tenuate <sup>®</sup> , Tenuate <sup>®</sup> Dospan <sup>®</sup>	diethylpropion	Yes
	Bontril <sup>®</sup>	phendimetrazine	Yes
	Adipex-P <sup>®</sup> , Fastin <sup>®</sup>	phentermine	Yes
	Ionamin®	phentermine	No
	Meridia <sup>®</sup>	sibutramine	No
	Xenical <sup>®</sup>	orlistat	No
Asthmatic Agents (used to treat allergic asthma caused by mmunoglobulin type E (IgE) only)	Xolair <sup>®</sup>	omalizumab	No
Calcium Regulators used to lower parathyroid hormone levels)	Sensipar <sup>®</sup>	cinacalcet hydrochloride	No
Cancer Therapy	Gleevec <sup>®</sup>	imatinib mesylate	No
	Nexavar <sup>®</sup>	sorafenib tosylate	No
	Sprycel <sup>®</sup>	dasatinib	No
	Sutent®	sunitinib malate	No
	Tarceva <sup>®</sup>	erlotinib	No
	Tasigna <sup>®</sup>	nilotinib hydrochloride	No
	Temodar <sup>®</sup>	temozolomide	No
	Tykerb <sup>®</sup>	lapatinib ditosylate	No
CNS Stimulant-type Agents (attention deficit or ADHD)	Adderall®	amphetamine/ dextroamphetamine	Yes
	Adderall XR®	amphetamine/ dextroamphetamine	No
	Cylert®	pemoline	Yes
	Dexedrine®, Dexedrine® Spansules®, DextroStat®	dextroamphetamine	Yes
	Desoxyn <sup>®</sup>	methamphetamine	Yes
	Focalin®	dexmethylphenidate	Yes
	Focalin XR®	dexmethylphenidate	No

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

consideration is not subject to prior authorization.



<b>Prescription Drugs Requiring</b>	Prior Authorization		
Drug Class	Brand Name	Chemical Name	Generic Available
CNS stimulant-type Agents (attention deficit or ADHD)	ProCentra™	dextroamphetamine	No
(continued)	Ritalin®	methylphenidate	Yes
	Daytrana™	methylphenidate transdermal patch	No
	Ritalin-LA <sup>®</sup> , Metadate <sup>®</sup> CD, Concerta <sup>®</sup>	methylphenidate extended release	No
	Methylin <sup>®</sup> ER, Metadate® ER	methylphenidate extended release	Yes
	Ritalin-SR®	methylphenidate sustained release	No
	Intuniv®	guanfacine extended- release tablet	No
	Strattera®	atomoxetine	No
	Vyvanse®	lisdexamfetamine dimesylate	No
Constipation Agents	Relistor®	methylnaltrexone bromide	No
Cosmetic Agents	Botox®	onabotulinumtoxinA	No
	Myobloc®	rimabotulinumtoxinB	No
COX-2 inhibitors* (commonly used for arthritis pain and inflammation)	Celebrex®	celecoxib	No
Crohn's Disease	Cimzia®	certolizumab	No
Cystic Fibrosis	Pulmozyme®	dornase alfa	No
	Cayston®	aztreonam lysine	No
	Tobi®	tobramycin	No
Dermatologicals	Amnesteem®, Claravis®, Sotret®	isotretinoin	Yes
(used to treat diseases of the skin)	Penlac®	ciclopirox	Yes
	Elidel®	pimecrolimus	No
	Protopic®	tacrolimus	No
	Regranex®	becaplermin	No
	Retin-A®, Avita®, Tretin-X®, Atralin®, Altinac®	tretinoin	Yes
	Solodyn®	minocycline HCl	Yes
	Tazorac®	tazarotene	No
Diabetic Agents	Fortamet®, Glucophage XR	metformin hydrochloride extended release	Yes
	Byetta®* <sup>(1)</sup>	exenatide	No
	Symlin® <sup>(1)</sup>	pramlintide	No
Erythroid Stimulants	Procrit®, Epogen®	erythropoietin (epoetin)	No
(to boost red blood cell count)	Aranesp®	darbepoetin	No
	-	•	-

<sup>\*</sup>Prior claim history is used to initiate the coverage evaluation process in this drug class. If the claim history meets the review criteria, coverage consideration is not subject to prior authorization.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(1)</sup> This medication is subject to dispensing limitation rules listed on page 20 of this document.



Drug Class	Brand Name	Chemical Name	Generic Available	
Fertility Agents	Clomid® Serophene®	clomiphene citrate	Yes	
	Pergonal® Humegon® Repronex®	menotropin	No	
	Fertinex® Bravelle®	urofollitropin	No	
	Gonal-F®	follitropin alfa	No	
	Follistim® AQ	follitropin beta	No	
	Luveris®	lutropin alfa	No	
	Profasi®, Profasi HP®, Chorex- 5®, Chorex-10®, Gonic®, Pregnyl®. Ovidrel®	human chorionic gonadotropin	No	
	Factrel®	gonadorelin hydrochloride	No	
	Lupron®	leuprolide	Yes	
	Synarel®	nafarelin acetate	No	
	FollistimAntagon Kit®	follitropin beta/ganirelix acetate	No	
	Cetrotide®	cetrorelix acetate	No	
	Ganirelix acetate	ganirelix acetate	No	
	Crinone® Prochieve®	progesterone	No	
	progesterone	progesterone	Yes	
<b>Growth Hormones</b> ** (used to treat hormone deficiencies in children)	Genotropin®, Humatrope® Norditropin®, Nutropin®, Saizen®, Tev-Tropin®, Zorbtive®, Omnitrope®, Serostim®	somatropin	No	
	Geref®	sermorelin	No	
	Increlex®	mecasermin (rDNA origin)	No	
Growth Hormone Receptor Antagonists** (used to treat conditions caused by excessive growth hormone production)	Somavert®	pegvisomant	No	
HIV Agents	Selzentry®	maraviroc	No	
Immunomodulatory Agents	Thalomid®	thalidomide	No	
(used to treat certain cancers and blood cell disorders)	Revlimid®	lenalidomide	No	

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



#### **Prescription Drugs Requiring Prior Authorization Drug Class Brand Name Chemical Name** Generic **Available** Interferons Alferon-N® interferon alpha-n3 (used to treat hepatitis and certain cancers) Actimmune® interferon gamma-1b No Intron A® interferon alpha-2b No Infergen® interferon alpha-con No Pegasys<sup>®</sup> pegylated Interferon alpha-2a No Pegintron<sup>®</sup> peginterferon alpha-2b No Leukotriene Receptor Antagonist Singulair montelukast No Agents\* (1) (allergy and asthma relief) zafirlukast No Accolate<sup>®</sup> Zyflo CR® zileuton No Zyflo zileuton No Multiple Sclerosis No *Ampyra*<sup>®</sup> dalfampridine Avonex<sup>®</sup> interferon beta-1a No Rebif interferon beta-1a No Gilenya® fingolimod HCI No Betaseron® interferon beta-1b No glatiramer acetate Copaxone<sup>®</sup> No Tysabrí natalizumab No Myeloid Stimulants filgrastim No Neupogen<sup>®</sup> (to boost white blood cell counts) Neulasta<sup>®</sup> pegfilgrastim No Leukine No sargramostim Neumega<sup>®</sup> oprelvekin No Nplate® romiplostim No Promacta® No eltrombopag Narcotic Analgesics\* Actiq<sup>®</sup> fentanyl Yes (used to treat breakthrough pain) Fentora<sup>®</sup> fentanyl No Opthalmic Therapy Restasis® Νo cyclosporine

<sup>\*\*</sup> Accredo is the preferred specialty pharmacy to dispense growth hormones.

<sup>(1)</sup> All medications in this class are subject to the dispensing limitations rules listed on page 22 in this document

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Drug Class	Brand Name	Chemical Name	Generic Available
Osteoporosis Therapy*	Forteo <sup>®</sup>	teriparatide	No
Pain Management	Voltaren Gel®	diclofenac	No
	Onsolis <sup>®</sup>	fentanyl citrate	No
	Flector Patch®	diclofenac epolamine	No
Parkinson's Therapy	Apokyn <sup>®</sup>	apomorphine hydrochloride	No
Pulmonary Arterial Hypertension	Revatio <sup>®</sup>	sildenafil	No
Therapy* (treats pulmonary arterial hypertension)	Tracleer <sup>®</sup>	bosentan	No
	Ventavis <sup>®</sup>	iloprost	No
	Letairis <sup>®</sup>	ambrisentan	No
Rheumatoid Arthritis Agents*	Arava <sup>®</sup>	leflunomide	Yes
used to treat rheumatoid arthritis and other specific types of arthritis)	Enbrel®	etanercept	No
	Actemra <sup>®</sup>	tocilizumab	No
	Humira <sup>®</sup>	adalimumab	No
	Kineret <sup>®</sup>	anakinra	No
	Orencia <sup>®</sup>	abatacept	No
	Remicade <sup>™</sup>	Infliximab	No
	Rituxan <sup>®</sup>	rituximab	No
	Simponi <sup>®</sup>	golimumab	No
despiratory Syncytial Virus (RSV) gents o prevent lower respiratory tract disease aused by respiratory syncytial virus)	Synagis <sup>™</sup>	palivizumab	No
Smoking Deterrents	Nicotine® Transdermal, Nicotrol® NS, Nicotrol® Inhaler,	nicotine	No
	Zyban <sup>®</sup>	bupropion	Yes
	Chantix <sup>®</sup>	varenicline	No

L Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



### **Prescription Drugs Subject to Coverage Review**

The drugs listed below as "Covered brand" or "Covered generic" are covered without coverage review. "Targeted brand" drugs require a review and may or may not be covered depending on the outcome of the review and may be subject to a higher copay. The targeted drugs listed may or may not be covered depending on the outcome of the review. All medications listed below are subject to the existing coverage management rules for that particular drug class listed elsewhere in this document. If you are prescribed a targeted medication, your doctor should contact Medco at 800-753-2851 to initiate a review. **This telephone number is for your doctor's use only.** 

Drug Class	Brand Name	Chemical Name	Generic Available	Drug Status
Angiotensin II Receptor	Micardis <sup>®</sup>	telmisartan	No	Covered brand
Blockers (ARB's) (blood pressure)	Micardis HCT®	telmisartan hydrochlorothiazde	No	Covered brand
	Diovan <sup>®</sup>	valsartan	No	Covered brand
	Diovan HCT®	valsartan hydrochorothiazide	No	Covered brand
	losartan	losartan	Yes	Covered generic
	losartan hydrochorothiazide	losartan hydrochorothiazide	Yes	Covered generic
	Atacand <sup>®</sup>	candesartan	No	Targeted brand
	Atacand HCT®	candesartan hydrochlorothiazide	No	Targeted brand
	Avalide <sup>®</sup>	irbesartan hydrochlorothiazide	No	Targeted brand
	Avapro <sup>®</sup>	irbesartan	No	Targeted brand
	Benicar <sup>®</sup>	olmesartan	No	Targeted brand
	Benicar HCT®	olmesartan hydrochlorothiazide	No	Targeted brand
	Teveten <sup>®</sup>	eprosartan	No	Targeted brand
	Teveten HCT®	eprosartan hydrochorothiazide	No	Targeted brand
	Tekturna <sup>®</sup>	aliskiren	No	Targeted brand
	Tekturna HCT®	aliskiren hydrochorothiazde	No	Targeted brand
Antisecretory Agents-	omeprazole	omeprazole	Yes	Covered generic
Proton Pump Inhibitors (ulcer) <sup>(1)</sup>	Nexium <sup>®</sup>	esomeprazole	No	Covered brand
	Aciphex <sup>®</sup>	rabeprazole	No	Targeted brand
	Zegerid <sup>®</sup>	omeprazole	No	Targeted brand
	Prevacid <sup>®</sup>	lansoprazole	Yes	Targeted brand
	Protonix <sup>®</sup>	pantoprazole	Yes	Targeted brand
	Dexilant®	dexlansoprazole	No	Targeted brand
	Prilosec® packets	omeprazole	No	Targeted brand

<sup>&</sup>quot;Generic omeprazole and branded Nexium" are covered Proton Pump Inhibitors; members that have active claims for Plavix® in history will not be targeted. All medications in this class are subject to the dispensing limitations rules listed on page 14 in this document.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



orug Class	Brand Name	Chemical Name	Generic Available	Drug Status				
Antidepressants (depression and other	SSRI	SSRI						
mental health disorders) (2)	fluvoxamine	fluvoxamine	Yes	Covered generic				
	fluoxetine	fluoxetine	Yes	Covered generic				
	paroxetine	paroxetine	Yes	Covered generic				
	sertraline	sertraline	Yes	Covered generic				
	Lexapro®	escitalopram	No	Targeted brand				
	Luvox CR®	fluvoxamine	No	Targeted brand				
	SNRI							
	venlafaxine	venlafaxine	Yes	Covered generic				
	Wellbutrin XL®	bupropion extended release (24-hour)	Yes	Covered generic				
	Wellbutrin SR®	bupropion extended release (12-hour)	Yes	Covered generic				
	Cymbalta®	duloxetine	No	Covered brand				
	Pristiq®	desvenlafaxine	No	Targeted brand				
	Effexor XR®	venlafaxine extended release capsules	No	Targeted brand				

<sup>(2)</sup> Generics and branded Cymbalta® are the covered Antidepressants; Applies to new users only. SSRIs in this class are subject to the dispensing limitations rules listed on page 13 in this document.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Prescription Drugs	Subject to Coverage	<u>ge neview</u>		
Drug Class	Brand Name	Chemical Name	Generic Available	Drug Status
Hypnotic Agents (used to treat insomnia,	zolpidem	zolpidem	Yes	Covered generic
short term) <sup>(3)</sup>	zaleplon	zaleplon	Yes	Covered generic
	Ambien CR®	zolpidem	No	Targeted brand
	Lunesta <sup>™</sup>	eszopiclone	No	Targeted brand
	Rozerem <sup>™</sup>	ramelteon	No	Targeted brand
	Sonata <sup>®</sup>	zaleplon	Yes	Targeted brand
tranasal Steroids	flunisolide	flunisolide	Yes	Targeted generic
used to treat allergic ninitis)	fluticasone	fluticasone	Yes	Targeted generic
	Beconase® AQ	beclomethasone	No	Targeted brand
	Nasacort® AQ	triamcinolone	No	Targeted brand
	Nasonex <sup>®</sup>	mometasone	No	Targeted brand
	Omnaris <sup>®</sup>	ciclesonide	No	Targeted brand
	Rhinocort Aqua®	budesonide	No	Targeted brand
	Veramyst <sup>®</sup>	fluticasone furoate	No	Targeted brand
ligraine Therapy <sup>(5)</sup>	sumatriptan	sumatriptan	Yes	Covered generic
	Relpax <sup>®</sup>	eletriptan	No	Covered Brand
	Amerge <sup>®</sup>	naratriptan	No	Targeted Brand
	Axert <sup>®</sup>	almotriptan	No	Targeted brand
	Frova <sup>®</sup>	frovatriptan	No	Targeted brand
	Maxalt <sup>®</sup> / Maxalt-MLT <sup>®</sup>	rizatriptan	No	Targeted brand
	Sumavel <sup>®</sup>	sumatriptan	Yes	Targeted brand
	Treximet <sup>®</sup>	Sumatriptan/naproxen	No	Targeted brand
	Zomig <sup>®</sup> / Zomig <sup>®</sup> ZMT	zolmatriptan	No	Targeted brand
Osteoporosis Therapy	alendronate	alendronate	Yes	Covered generic
<b>Bisphosphonates)</b> used to treat bone loss) (4)	Boniva <sup>®</sup>	ibandronate	No	Covered brand
	Actonel®	risedronate	No	Targeted brand
	Actonel® with Calcium	risedronate wih calcium	No	Targeted brand
	Fosamax D®	alendronate with vitamin D	No	Targeted brand

<sup>(3)</sup> Generic zolpidem, zaleplon and branded Ambien are covered hypnotics. All medications in this class are subject to the dispensing limitations rules listed on page 16 in this document.

(4) Generic alendronate and branded Boniva® are covered bisphosphonates

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(5)</sup> All medications in this class are subject to the dispensing limitations rules listed on page 17 in this document



### Prescription Drugs Subject to Dispensing Limitations

There are quantity limitations on the medications listed below. If your doctor prescribes a medication from this list, for a quantity above the limit, they should contact Medco at 800-753-2851 to initiate a review. This telephone number is for your doctor's use only.

Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
ACE Inhibitors (1)	Accupril®	quinapril	Yes	60 tablets/ prescription (1)
	Altace®	ramipril	Yes	60 tablets/ prescription (1)
	Capoten®	captopril	Yes	90 tablets/ prescription
	Lotensin®	benazepril	Yes	60 tablets/ prescription (1)
	Mavik®	trandolapril	Yes	60 tablets/ prescription (1
	Monopril®	fosinopril	Yes	60 tablets/ prescription (1
	Prinivil® 2.5mg, 5mg, 10mg, 20mg, 40mg Zestril® 2.5mg, 5mg,	lisinopril	Yes	(60) 40mg tablets/ prescription (1)
	10mg, 20mg, 30mg, 40mg			(30) 10mg, 20mg, 30mg tablets/ prescription
	Univasc®	moexipril	Yes	60 tablets/ prescription (1)
	Vasotec®	enalapril	Yes	60 tablets/ prescription (1)
	Aceon®	perindopril	Yes	60 tablets/ prescription (1)
ACE Inhibitors (2) Combination	Accuretic®	quinapril/ HCTZ	Yes	(30) 10-12.5mg, 20- 12.5mg 20-25mg tablets/ prescription
	Capozide®	Captopril/ HCTZ	Yes	30 tablets/ prescription
	Lotensin HCT®	benazepril/ HCTZ	Yes	30 tablets/ prescription
	Lotrel® 2.5-10mg, 5- 40mg	amlodipine/HCTZ	Yes	30 tablets/ prescription (2
	Monopril HCT®	fosinopril/ HCTZ	Yes	(30) 10-12.5mg, 20- 12.5mg tablets/ prescription
	Prinzide® Zestorectic®	lisinopril/HCTZ	Yes	(30) 10-12.5mg, 20- 12.5mg tablets/ prescription (60) 20-25mg tablets/ prescription (2)
	Tarka®	Trandolapril/ HCTZ	No	(30) 2-80mg, 1-240mg, 2-240mg tablets/ prescription (60) 4-240mg tablets/ prescription <sup>(2)</sup>
	Uniretic®	moexipril/ HCTZ	Yes	(30) 7.5-12.5mg, 15- 12.5mg tablets/ prescription (60) 15-25mg tablets/ prescription (2)
	Vaseretic®	enalapril/ HCTZ	Yes	(30) 5-12.5mg tablets/ prescription (60) 10-25mg tablets/ prescription

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information (1) Additional quantities of Accupril 40mg, Altace 10mg, Lotensin 40mg, Mavik 4mg, Monopril 40mg, Prinivil/ Zestril 40mg, Univasc 15mg,

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

Vasotec 20mg, and Aceon 4mg are not available through coverage review

<sup>(2)</sup> Additional quantities of Lotrel 5-10mg, 5-20mg, 10-20mg, 10-40mg, Prinzide 20-25mg, Zestoretic 20-25mg, Unirectic15-25mg, and Tarka 4-240mg are not available through coverage review.



Prescription Dru	ugs Subject t	o Dispensing Limitations		
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
ARBs/Renin Inhibitor <sup>(1)</sup>	Atacand®	candesartan	No	(60) 16mg tablets/ prescription (30) 4mg, 8mg, 32mg tablets/ prescription
	Avapro®	irbesartan	No	30 tablets/ prescription
	Benicar®	olmesartan	No	(30) 20mg, 40mg tablets/ prescription
				(60) 5mg tablets/ prescription
	Cozaar®	losartan	Yes	(60) 25mg, 50mg tablets/ prescription
	Diovan®	valaartas	No	(30) 100mg tablets/ prescription (60) 40mg, 160mg tablets/
	Diovane	valsartan	No	prescription
				(30) 80mg, 320mg tablets/ prescription
	Micardis®	telmisartan	No	30 tablets/ prescription
	Teveten®	eprosartan	No	(60) 400mg tablets/ prescription (30) 600mg tablets/ prescription
	Tekturna®	aliskiren	No	30 tablets/ prescription (1)
ARB Combination (2)	Atacand	candesartan/ HCTZ	No	30 tablets/ prescription
	HCT®			(2)
	Avalide®	irbesartan/ HCTZ	No	30 tablets/ prescription (2)
	Benicar HCT®	olmesartan/HCTZ	No	30 tablets/ prescription (2)
	Hyzaar®	losartan/ HCTZ	Yes	30 tablets/ prescription (2)
	Diovan HCT®	valsartan/HCTZ	No	30 tablets/ prescription
	Micardis HCT®	telmisartan/ HCTZ	No	(30) 40-12.5mg, 80-25mg tablets/ prescription
				(60) 80-12.5mg tablets/ prescription (2)
	Tekamlo®	aliskiren/amlodipine	No	30 tablets/ prescription (2)
	Tribenzor®	amlodipine/olmesartan/hydrochlorothiazide	No	30 tablets/ prescription (2)
	Teveten HCT®	eprosartan I/ HCTZ	No	30 tablets/ prescription (2)
Anti-Infectives	Alinia®	nitazoxanide	No	(6) 500mg tablets/ prescription at retail and mail
				(3 bottles) 100mg/ 5ml suspension/ prescription at retail and mail
	Xifaxan	rifaximin	No	(9) 200mg tab;ets per 23 days or (27) 200mg tablets per 69 days
	Zyvox	linezolid	No	Maximum of 14 days of therapy per 30 days
	Noxafil	posaconazole	No	Maximum of 10 days of therapy per 30 days
Anticonvulsant (3)	Lyrica®	pregabalin	No	(90) 25mg, 50mg, 100mg, 150mg, 200mg tablets/ prescription
				(60) 75mg, 225mg, 300mg tablets/ prescription

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

(1) Additional quantities of Tekturna are not available through coverage review

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(2)</sup> Additional quantities of Atacand HCT 32-12.5mg, Avalide 300-12.5mg, Benicar HCT, Hyzaar 100-25mg, 100-12.5mg, Micardis HCT 80-12.5mg, 80-25mg, Teveten HCT are not available through coverage review

Additional quantities of Lyrica 25mg, 150mg, 200mg, 225mg, 300mg are not available through coverage review.



Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Antidepressants	Celexa <sup>®</sup>	citalopram	Yes	(60) 10mg or, (90) 20mg or,
(depression and other mental				(30) 40mg tablets/ prescription
nealth disorders)	Lexapro®	escitalopram	No	30 tablets/ prescription
	Luvox CR®	fluvoxamine	No	60 tablets/ prescription
	Paxil®	paroxetine	Yes	(60) 10mg or, (30) 20mg or, (60) 30mg or, (30) 40mg tablets/ prescription
	Paxil CR®	paroxetine	Yes	(60) 12.5mg or, (90) 25mg or, (60) 37.5mg tablets/ prescription
	Pexeva <sup>®</sup>	paroxetine mesylate	No	(60) 10mg or, (30) 20mg or, (60) 30mg or, (30) 40mg tablets/ prescription
	Prozac <sup>®</sup>	fluoxetine	Yes	(60) 10mg or, (90) 20mg or, (60) 40mg tablets/ prescription
	Zoloft®	sertraline	Yes	(60) 25mg or, (90) 50mg or, (60) 100mg tablets/ prescription
	Prozac <sup>®</sup> Weekly <sup>™</sup>	fluoxetine	No	4 capsules/ prescription
	Sarafem <sup>®</sup>	fluoxetine	No	14 capsules/ prescription
Atypical Antipsychotics (1)	Symbyax <sup>®</sup>	olanzapine/ fluoxetine	No	30 tablets/ prescription (1)
	Fanapt <sup>®</sup>	iloperidone	No	(2) 1mg, 2mg, 4mg tablets/ prescription (60) 6mg, 8mg, 10mg, 12mg tablets/ prescription (1) Titration pack/ prescription
	Zyprexa® Zyprexa Zydis®	olanzapine	No	30 tablets/ prescription (1)
	Seroquel® Seroquel XR®	quetiapine	No	(60) 400mg, 25mg, 150mg, 300mg tablets/ prescription (
				(90) 50mg, 100mg, 200mg tablets/ prescription
	Risperdal®	risperidone	Yes	60 tablets/ prescription
	Risperdal M- Tab®			8 bottles oral solution
	Geodon®	ziprasidone	No	60 tablets/ prescription (1)
	Saphris®	asenapine maleate	No	(60) 5mg, 10mg, 15mg tablets/ prescription <sup>(1)</sup>
	Abilify® Abilify	aripirazole	No	(42) 5mg, 10mg, 15mg tablets/ prescription (1)
	Discmelt®			(30) 20mg, 30mg tablets/ prescription
	Invega®	paliperidone	No	(30) 3mg, 9mg tablets/ prescription (60) 1.5mg, 6mg tablets/ prescription
Antiplatelet (2)	Pletal®	cilostazol	Yes	60 tablets/ prescription (2)
	Effient®	prasugrel	No	(30) 5mg tablets/ prescription (36) 10mg tablets/ prescription
	Plavix®	clopidogrel	No	37 tablets/ prescription
	Ticlid®	ticlopidine	Yes	60 tablets/ prescription (2)
	Aggrenox®	dipyridamole/ aspirin	No	60 capsules/ prescription (2)
	Agrylin®	anagrelide	Yes	120 capsules/ prescription (2)

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

(1) Additional quantities of Fanapt 6mg, 8mg, 10mg, 12mg, and Titration pack, Symbyax 6/50mg, 12/25mg, 12/50mg, Zyprexa/Zyprexa Zydis 15mg,

<sup>(1)</sup> Additional quantities of Fanapt 6mg, 8mg, 10mg, 12mg, and Titration pack, Symbyax 6/50mg, 12/25mg, 12/50mg, Zyprexa/Zyprexa Zydis 15mg 20mg, Seroquel/ Seroquel XR 300mg, 400mg, Geodon 40mg, 60mg, 80mg, and Invega are not available through coverage review (2) Additional quantities of Pletal, Ticlid, Aggrenox, Agrylin 0.5mg are not available through coverage review.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Prescription Drugs S	ubject to Dispens	sing Limitations		
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Antidiabetic Agents (1)	Avandia® (1)	rosiglitazone	No	(30) 8mg tablets/ prescription
_				(60) 2mg, 4mg tablets/ prescription
	Actos® (1)	pioglitazone	No	30 tablets/ prescription
	Avandamet® (1)	rosiglitazone/metformin	No	(60) 4-500mg, 2-1000mg, 4-1000mg tablets/ prescription
				(60) 1-500mg, 2-500mg tablets/ prescription
	Metaglip®	glipizide/ metformin	Yes	(60) 2.5-250mg tablets/ prescription
	-/1)			(60) 2.5-500mg, 5-500mg tablets/ prescription
	Glucovance® <sup>1)</sup>	glyburide/ metformin	Yes	(60) 1.25-250mg, 2.5-500mg tablets/ prescription
	(1)			(120) 5-500mg tablets/ prescription
	Glucophage XR® (1)	metformin extended	Yes	(60) 750mg tablets/ prescription
	(4)	release		(120) 500mg tablets/ prescription
	Fortamet® (1)	metformin extended	Yes	(150) 500mg tablets/ prescription
		release		(60) 1000mg tablets/ prescription
	Glucotrol XL®	glipizide	Yes	(30) 2.5mg, 5mg tablets/ prescription
				(60) 10mg <sup>(1)</sup> tablets/ prescription
	Amaryl®	glimepiride	Yes	(30) 1mg, 2mg (1) tablets/ prescription
				(60) 4mg tablets/ prescription
	Glynase Prestab®	glyburide, micronized	Yes	(30) 1.5mg, 3mg tablets/ prescription
	(4)			(60) 6mg (1) tablets/ prescription
	Prandin® <sup>(1)</sup>	repaglinide	No	(120) 0.5mg, 1mg tablets/ prescription
	(4)			(240) 2mg (1) tablets/ prescription
	Starlix® (1)	nateglinide	Yes	90 tablets/ prescription
	Symlin® (1)	pramlintide	No	4 vials/ prescription
	Duetact® (1)	glimepiride/pioglitazone	No	30 tablets/ prescription
	Januvia® (1)	sitagliptin	No	30 tablets/ prescription
Antisecretory Agents- Proton Pump Inhibitors <sup>(2)</sup> and H <sub>2</sub> Antagonists (ulcer)	Prilosec <sup>®</sup>	omeprazole	Yes	Ulcer healing doses for first 90 days of therapy H2 Antagonists: > 800mg/ day of Tagamet
	Zegerid <sup>®,</sup>	amanyazala	No	> 300mg/day of Axid/ Zantac
	Aciphex <sup>®</sup>	omeprazole rabeprazole	No No	> 40mg/day of Pepcid
	Nexium <sup>®</sup>	esomeprazole	No	PPIs:
	Prevacid <sup>®</sup>	lansoprazole	Yes	> 20 mg/day of Aciphex
	Protonix <sup>®</sup>	pantoprazole	Yes	> 40 mg/day of Nexium
	Tagamet®	cimetidine	Yes	> 30 mg/day of Prevacid
	Zantac <sup>®</sup>	ranitidine	Yes	> 20 mg/day of Prilosec (includes packets)
	Pepcid <sup>®</sup>	famotidine	Yes	> 40 mg/day of Protonix
	Axid <sup>®</sup>	nizatidine	Yes	> 20mg/day of Zegerid
	AXIU	HIZALIUIHE	162	> 30 mg/day of Dexilant

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

(1) Additional quantities of Avandia, Actos, Avandamet, Metaglip, Glucovance, Glucophage XR, Fortamet, Glucotrol XL 10mg, Amaryl 2mg, Glynase

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

Prestab 6mg, Prandin, Starlix, Symlin, Duetact, Januvia are not available through coverage review.

<sup>(2)</sup> Certain drugs in this class maybe subject to Coverage Review rules. See page 8 for specific details.



Prescription Drugs Subject to Dispensing Limitations					
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**	
Antiemetic Agents (used to treat nausea and vomiting)	Anzemet <sup>®</sup>	ondansetron	No	Quantities sufficient for seven (7) treatment days	
	Emend <sup>®</sup>	aprepitant	No	per 30 day period  Anzemet: 700 mg in 30 days or 2100 mg in 90 days  Emend 125 mg: 2 capsule in 26 days or 4 capsules in 84 days  Emend 40mg: 1 capsule in 30 days or 2 capsules in 90 days  Emend 80mg: 8 capsules in 26 days or 16 capsules in 84 days  Emend trifold pack: 2 pack (6 caps) in 26 days or 4 packs (12 caps) in 84 days	
	Kytril <sup>®</sup>	granisetron	Yes	Kytril: 14 mg in 30 days or 42 mg in 90 days	
	Zofran <sup>®</sup> , Zuplenz <sup>®</sup>	ondansetron	Yes	Zofran (all forms): 168 mg in 30 days or 504 mg in 90 days	
	Sancuso®	granisetron	No	2 patches in 30 days or 6 patches in 90 days	
Antifungal Agents (1)	Diflucan®	fluconazole	Yes	(30) 50mg, 100mg tablets/ prescription (1) (2) 150mg tablets/ prescription (60) 200mg tablets/ prescription	
	Lamisil® (1)	terbinafine	Yes	(30) 250mg (60) 125mg packets/ prescription (30) 187.5mg packets/ prescription	
	Sporanox® (1)	itraconazole	Yes	120 capsules/ prescription	
Antiviral Agents (used to treat herpes infections)	Famvir <sup>®</sup>	famciclovir	Yes	Quantities sufficient to treat one (1) acute episode or three (3) preventative regimens per 90 day period Famvir: 50,000 mgs in any 90 day period	
	Valtrex <sup>®</sup>	valacyclovir	Yes	Valtrex: 100,000 mgs in any 90 day period	
	Zovirax <sup>®</sup>	acyclovir	Yes	Zovirax: 80,000 mgs in any 90 day period For recurrent genital herpes, quantities greater than approved suppression regimens and 1 acute treatment in 90 days require prior authorization.	
Anti-Narcoleptic Agents (used to promote	Provigil <sup>®</sup>	modafinil	No	6000 mg in 23 days or 18000 mg in 68 days	
wakefulness) (2)	Nuvigil®	armodafinil	No	7500 mg in 23 days or 22500 mg in 68 days	

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

(1) Additional quantities of Diflucan 50mg, 100mg, Lamisil, Sporanox are not available through coverage review

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(2)</sup> This class of medications is subject to prior authorization. See page 2 for specific details.



Drug Class	Brand Name	Chemical	Generic	Dispensing Limit**
		Name	Available	
Calcium Regulators (used to lower parathyroid hormone levels)	Sensipar <sup>®</sup>	cinacalcet hydrochloride	No	5400 mg in 23 days or 16200 mg in 69 days
Cancer Agents	Sprycef <sup>®</sup>	dasatinib	No	4200 mg in 23 days or 12600 mg in 68 days
	Sutent <sup>®</sup>	sunitinib malate	No	1500 mg in 23 days or 4500 mg in 69 days
	Tarceva <sup>®</sup>	erlotinib	No	4500 mg in 23 days or 13500 mg in 69 days
	Tasigna <sup>®</sup>	nilotinib hydrochloride	No	22400mg in 21 days or 67200 mg in 63 days *based on 28-day regimen
	Tykerb <sup>®</sup>	lapatinib ditosylate	No	45000mg in 23 days or 135000mg in 68 days
Constipation Agents	Relistor®	methylnaltrexone bromide	No	15 vials in 23 days or 45 vials in 69 days
Cystic Fibrosis	Cayston <sup>®</sup>	aztreonam lysine	No	84ml(1 kit) in 56 days or 168ml(2 kits) in 112 days
Fertility Agents	Clomid®, Serophene®	clomiphene citrate	Yes	4500 units in 30 days or 13500 units in 90 days
	Pergonal® Humegon® , Repronex®	menotropin	No	4500 units in 30 days or 13500 units in 90 days
	Fertinex®, Bravelle®	urofollitropin	No	4500 units in 30 days or 13500 units in 90 days
	Gonal-F®	follitropin alfa	No	4500 units in 30 days or 13500 units in 90 days
	Follistim AQ®	follitropin beta	No	4500 units in 30 days or 13500 units in 90 days
	Luveris®	lutropin alfa	No	4500 units in 30 days or 13500 units in 90 days
	Profasi®, Profasi HP®, Chorex-5®, Chorex-10®, Gonic®, Pregnyl®. Ovidrel®	human chorionic gonadotropin	No	4500 units in 30 days or 13500 units in 90 days
	Factrel®	gonadorelin hydrochloride	No	4500 units in 30 days or 13500 units in 90 days
	Lupron®	leuprolide	Yes	4500 units in 30 days or 13500 units in 90 days
	Synarel®	nafarelin acetate	No	4500 units in 30 days or 13500 units in 90 days
	FollistimAntagon Kit®	follitropin beta/ganirelix acetate	No	4500 units in 30 days or 13500 units in 90 days
	Cetrotide®	cetrorelix acetate	No	4500 units in 30 days or 13500 units in 90 days
	Ganirelix Acetate	ganirelix acetate	No	4500 units in 30 days or 13500 units in 90 days
	Crinone®, Prochieve®	progesterone	No	4500 units in 30 days or 13500 units in 90 days
	progesterone	progesterone	Yes	4500 units in 30 days or 13500 units in 90 days
Hypnotic Agents	Ambien <sup>®</sup>	zolpidem	Yes	Doses consistent with the treatment of short term
(used to treat insomnia,	Ambien CR®	zolpidem	Yes	insomnia
short term) (3)	Edluar®	zolpidem	No	Ambien, Ambien CR, Edluar, Lunesta, Rozerem,
	Lunesta <sup>™</sup>	eszopiclone	No	Silenor, Sonata, Zolpimist: 60 days supply in 90
	Rozerem <sup>™</sup>	ramelteon	No	days
	Silenor <sup>®</sup>	doxepin Hcl	No	,-
	Sonata <sup>®</sup>	zaleplon	Yes	
	Zolpimist <sup>®</sup>	zolpidem	No	

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

(3) Certain drugs in this class may be subject to Coverage Review rules. See page 10 for specific details.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Inhaled Corticosteroids (1)	Qvar®	beclomethasone	No	3 inhalers/ prescription
	Pulmicor Flexhalert®	budesonide	No	2 inhalers/ prescription
	Dulera®	mometasone furoate/ formoterol fumarate	No	1 inhaler/ prescription
	Aerobid® Aerobid-M®	flunisolide	No	3 inhalers at retail and 8 inhalers at mail
	Flovent® Flovent HFA®	fluticasone propionate	No	2 inhalers/ prescription
	Flovent Rotadisk®			240 doses (16 blisters)
	Advair HFA®	fluticasone/ salmeterol	No	1 inhaler/ prescription
	Azmacort®	triamcinolone	No	2 inhalers/ prescription
	Symbicort® (1)	budesonide/ formoterol	No	1 inhaler/ prescription
Migraine Therapy (headache treatment)	Alsuma <sup>®</sup> , Imitrex <sup>®</sup> , Sumavel <sup>®</sup>	sumatriptan	Yes	900mg/ 30 days
	Zomig <sup>®</sup> ,	zolmitriptan	No	40mg/ 30 days
	Zomig-ZMT <sup>®</sup>			
	Amerge <sup>®</sup>	naratriptan	No	20mg/ 30 days
	Maxalt <sup>®</sup> ,	rizatriptan	No	120mg/ 30 days
	Maxalt-MLT®	1		
	Axert®	almotriptan	No	100mg/ 30 days
	Frova®	frovatriptan	No	30mg/ 30 days
	Treximet <sup>®</sup>	sumatriptan/naproxen		900mg(sumatriptan)/ 30 days
	Relpax®	eletriptan	No	320mg/ 30 days
	Migranal® NS	dihydroergotamine nasal	No	8 amps/ 30 days
Misc Hormones	Acthar Gel		No	Maximum quantity of 5 ml (1 vial) in 30 days or 15 ml (3 vials) in 90 days

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(1)</sup> Additional quantities of Symbicort are not available through coverage review.

<sup>&</sup>lt;sup>(2)</sup> Drugs in this class may be subject to Coverage Review rules. See page 10 for specific details.



Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Oral Estrogens (estrogen replacement)	Prempro <sup>™</sup> , Premphase <sup>®</sup>	conjugated estrogens, medroxyprogesterone	No	28 day pack/ prescription
	Activella®1-0.5mg	estradiol,norethindrone	Yes	7
	Activella®0.5mg-0.1mg	estradiol,norethindrone	No	7
	Cenestin <sup>®</sup>	conjugated estrogen	No	(30) 0.625mg or (30) 0.3mg or 0.9mg tablets/prescription
	Menest <sup>®</sup>	esterified estrogen	No	30 tablets/ prescription
	Premarin <sup>®</sup> , Enjuvia <sup>®</sup>	conjugated estrogens	No	
	Femtrace <sup>®</sup>	estradiol acetate	No	30 tablets/ prescription
	Ortho-Prefest®	estradiol, norgestimate	No	7
	Estratest®, Estratest®HS	esterified estrogens, methyltestosterone	Yes	
	Ortho-Est <sup>®</sup> , Ogen <sup>®</sup>	estropipate	Yes	
	Estrace®	estradiol	Yes	7
	Femhrt®	ethinyl estradiol,norethindrone	No	
	Syntest <sup>®</sup> DS, Syntest <sup>®</sup> HS	esterified estrogen, methyltestosterone	Yes	
Pain Management	Actiq <sup>®</sup>	fentanyl citrate	Yes	120 units in 23 days or 360 units in 68 days
	Fentora <sup>®</sup>	fentanyl citrate	No	Fentora 300,400,600,800 mcg: 120 tabs in 23 days or 360 tabs in 68 days
	Onsolis <sup>®</sup>	fentanyl citrate	No	Onsolis 400, 600, 800, 1200 mcg: 120 units in 23 days or 360 units in 68 days
	Stadol® Nasal Spray	butorphanol	Yes	10 ml in 30 days or 30 ml in 90 days
	Voltaren <sup>®</sup> Gel	diclofenac	No	500gm in 23 days or 1500gm in 68 days
Parkinson's Therapy	Apokyn <sup>®</sup>	apomorphine hydrochloride	No	60ml (20 cartridges) in 23 days or 180ml (60 cartridges) in 68 days
Psoriatic Therapy (2)	Enbrel <sup>®</sup>	etanercept	No	200 mg/ 30 days
(used to treat psoriasis)	Raptiva <sup>®</sup>	efalizumab	No	4 kits/ 30 days
	Amevive <sup>®</sup>	alefacept	No	60 mg/ 30 days <sup>(2)</sup>
Pulmonary Arterial Hypertension	Adcirca <sup>®</sup>	tadalafil	No	60 tablets in 23 days or 180 tablets in 68 days
	Revatio <sup>®</sup>	sildenafil citrate	No	90 tablets in 23 days or 270 tablets in 68 days
	Tyvaso <sup>®</sup>	treprostinil	No	1

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.

<sup>(2)</sup> Additional quantities of Amevive are not available through coverage review.



Prescription Drugs Subject to Dispensing Limitations					
Brand Name	Chemical Name	Generic Available	Dispensing Limit**		
Enbrel <sup>®</sup>	etanercept	No	Enbrel 50 mg prefilled SureClick autoinjector (Carton of 4): 1 carton (4 doses) in 30 days or 3 cartons (12 doses) in 90 days  Enbrel 50 mg pre-filled syringe (carton of 4) 1 carton (4 doses) in 30 days or 3 cartons (12 doses) in 90 days		
Cimzia <sup>®</sup>	certolizumab pegol	No	1 carton contains #2 200 mg vials 1 carton/ 30 days 3 cartons/ 90 days		
Humira <sup>®</sup>	adalimumab	No	Humira Syringe carton (2 prefilled syringes; 40 mg/0.8 ml):  1 syringe carton (2 pre-filled syringes) in 30 days or  3 syringe carton (6 pre-filled syringes) in 90 days  Humira Pediatric prefilled syringe carton (2 prefilled 20 mg syringes):  1 syringe carton (2 pre-filled syringes) in 30 days or  3 syringe carton (6 pre-filled syringes) in 90 days  Humira Pen carton: each kit contains 2 - single use pens providing 40 mg (0.8mL) of Humira:  1 kit in 30 days or		
	Enbrel®  Cimzia®	Brand Name     Chemical Name       Enbrel®     etanercept       Cimzia®     certolizumab pegol	Brand Name         Chemical Name         Generic Available           Enbrel®         etanercept         No           Cimzia®         certolizumab pegol         No		

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



### Prescription Drugs Subject to Dispensing Limitations – no review

Quantities are subject to the dispensing limit shown. Refills may be obtained for these quantities in accordance with the days-supply listed for each prescribed drug.

Prescription Drug	Prescription Drugs Subject to Dispensing Limitations – no review					
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**		
Leukotriene Receptor Antagonist Agents (Allergy & Asthma)	Xolair®	omalizumab	No	6 vials in 23 days or 18 vials in 68 days		
Alpha1 Blockers	Minipress®	prazosin	Yes	(120) 1mg, 2mg, 5mg capsules/ prescription		
	Hytrin®	terazosin	Yes	60 capsules/ prescription		
	Cardura®	doxazosin	Yes	60 tablets/ prescription		
	Cardura XL®	doxazosin	Yes	30 tablets/ prescription		
	Flomax®	tamsulosin	No	60 capsules/ prescription		
	Jalyn®	dutasteride/tamsulosin	No	30 tablets/ prescription		
	Rapaflo®	silodosin	No	30 tablets/ prescription		
Antihistamines	Clarinex® Clarinex-D®	desloratadine desloratadine/ pseudoephedrine	No	(30) 2.5mg, 5mg, 5-240mg tablets/ prescription (60) 2.5-120mg tablets/ prescription		
	Allegra®	fexofenadine	Yes	(60) 30-60mg tablets/ prescription (60) 60mg capsules/ prescription (30) 180mg tablets/ prescription		
	Allegra-D®	fexofenadine/ pseudoephedrine	Yes	(60) 60-120mg tablets/ prescription (30) 180-240mg tablets/ prescription		
	Xyzal®	levocetirizine	No	30 tablets/ prescription		
BPH Agents	Proscar®	finasteride	Yes	30 tablets/ prescription		
	Avodart®	dutasteride	No	30 tablets/ prescription		
	Uroxatral®	alfuzosin	No	30 tablets/ prescription		
Cancer Therapy	Gleevec®	imatinib mesylate	No	24000mg in 23 days or 72000mg in 68 days		
	Nexavar®	sorafenib tosylate	No	24000 mg in 23 days or 72000 mg in 68 days		
Cholesterol Lowering Agents	Omacor® (Lovaza®)	omega-3-acid ethyl esters	No	120 capsules in 23 days or 360 capsules in 69 days		
Diabetic Agents	Byetta®	exenatide	No	3 ml in 23 days or 8 ml in 68 days		
	Symlin®	pramlintide acetate	No	12000mcg in 23 days or 33000mcg in 68 days		
Erectile Dysfunction	Viagra <sup>®</sup>	sildenafil	No	6 tablets(or units)/30 days		
Agents	Levitra <sup>®</sup>	vardenafil	No			
	Cialis <sup>®</sup> (10mg, 20mg)	tadalafil	No			
	Muse <sup>®</sup> , Edex <sup>®</sup> , Caverject <sup>®</sup>	alprostadil	No			
	Cialis 2.5mg®  Cialis 5.mg®	tadalafil	No	15 tablets/ 60 days		
		1				

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Estrogens - Topical	Vivelle®, Vivelle-Dot® Alora® Esclim® Estraderm®	estradiol	No	8 systems/ prescription
	Climara®	estradiol	Yes	A such as a function of the su
	Climara-Pro®	estradiol/ levonorgestrel	No	4 systems/ prescription
	CombiPatch®	estradiol/ norethrindone	No	8 systems/ prescription
	Menostar®	estradiol	No	4 systems/ prescription
	Estrogel®	estradiol	No	93gm – 1 at retail and mail 50gm – 1 at retail; 3 at mail
	Elestrin®	estradiol	No	1 pump at retail; 2 pumps at mail
	Divigel®	estradiol	No	30
Estrogen Receptor Modulator (selective)	Evista®	raloxifene	No	30 tablets/ prescription
Bronchodilators	Ventolin®, Ventolin HFA® Proventil®, Proventil HFA® ProAir®	albuterol	No	2 inhalers/ prescription
	Atrovent®	ipratropium	Yes	2 inhalers/ prescription
	Atrovent HFA®		No	
	Combivent®	albuterol/ ipratropium	No	2 inhalers/ prescription
	Maxair Autohaler®	pirbuterol	No	2 inhalers/ prescription
	Serevent®			2 inhalers/ prescription
	Serevent Diskus®	salmeterol	No	56 blisters or 60 blisters based on package size
	Foradil®	formoterol	No	60 blisters/ prescription
	Spiriva®	tiotropium	No	30 units in 23 days or 90 units in 68 days
HIV Agents	Selzentry®	maraviroc	No	36000mg in 23 days and 108000mg in 68 days
Immunomodulatory Agents (used to treat certain cancers and blood cell disorders)	Revlimid®	lenalidomide	No	Revlimid 5mg, 10mg, & 15mg: 28 capsules in 23 days at both retail and ma Revlimid 25 mg: 21 capsules in 21 days a both retail and mail

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Intranasal	Nasarel®	flunisolide	Yes	3 inhalers at retail and 8 inhalers at mail
Corticosteroids	Beconase AQ®	beclomethasone	No	2 inhalers at retail and 4 inhalers at mail
	Nasacort AQ®	triamcinolone	No	2 inhalers/ prescription
	Rhinocort Aqua®	budesonide	No	2 inhalers/ prescription
	Flonase®	fluticasone	Yes	1 inhaler/ prescription
	Nasonex®	mometasone	No	1 inhaler/ prescription
	Omnaris®	ciclesonide	No	1 inhaler/ prescription
	Veramyst®	fluticasone	No	1 inhaler/ prescription
eukotriene Antagonists	Accolate®	zafirlukast	No	60 tablets/ prescription
	Singulair®	montelukast	No	30 tablets/ prescription
	Zyflo®, Zyflo CR®	zileuton	No	120 tablets/ prescription
HMG-CoA Inhibitors cholesterol-lowering)	Mevacor <sup>®</sup>	lovastatin	Yes	(30) 10mg tablets/ prescription or,
3,				(60) 20mg or 40-mg tablets/ prescription
	Zocor®	simvastatin	Yes	(30) tablets/ prescription
	Lipitor <sup>®</sup>	atorvastatin	No	
	Pravachol <sup>®</sup>	pravastatin	Yes	
	Altoprev <sup>™</sup>	lovastatin	No	
	Lescol®	fluvastatin	No	
	Crestor <sup>®</sup>	rosuvastatin	No	
	Zetia <sup>®</sup>	ezetimibe	No	
	Vytorin <sup>™</sup>	simvastatin/ ezetimibe	No	
	Caduet®	amlodipine/ atorvastatin	No	
Pain Management	Fentora <sup>®</sup>	fentanyl citrate	No	Fentora 100mcg, 200mcg: 240 tabs in 23 days or 720 tabs in 68 days
	Flector <sup>®</sup> Patch	diclofenac epolamine	No	60 patches in 30 days or 180 patches in 90 days
	Lidoderm <sup>®</sup> Patch	lidocaine	No	90 patches in 30 days or 270 patches in 90 days.
	Pennsaid <sup>®</sup>	diclofenac sodium	No	300 ml per 23 days or 900 ml in 68 days
soriatic Therapy used to treat psoriasis)	Amevive <sup>®</sup>	alefacept	No	60 mg/ 30 days
Pulmonary Arterial lypertension	Letairis <sup>®</sup>	ambrisentan	No	30 tablets in 23 days or 90 tablets in 68 days

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.



<b>Prescription Drugs</b>	Subject to Dispe	ensing Limitation	ns – no review	
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Rheumatoid Arthritis Agents	Arava <sup>®</sup>	leflunomide	Yes	30 tablets in 23 days or 90 tablets in 69 days
	Enbrel <sup>®</sup>	etanercept	No	Enbrel 25 mg prefilled syringe (Carton of 4): 2 cartons (8 doses) in 30 days or 6 cartons (24 doses) in 90 days
				Enbrel 25 mg Multiple use vial carton (4 doses per carton): 2 cartons (8 doses) in 30 days or 6 cartons (24 doses) in 90 days
	Humira <sup>®</sup>	adalimumab	No	Crohn's Disease or Psoriasis Starter Kit (6 pens; 40 mg/0.8 ml) 1 starter kit in 30 days or 1 starter kit in 90 days
	Kineret <sup>®</sup>	anakinra	No	21ml (31 syringes) in 23 days or 61ml (91 syringes) in 69 days
	Simponi <sup>®</sup>	golimumab	No	1 vial in 30 days or 3 vials in 90 days
Smoking Deterrents	Nicotrol NS®	nicotine	No	90 days supply in any 365 day period
	Nicotrol Inhaler®	nicotine	No	90 days supply in any 365 day period
	Zyban <sup>®</sup>	buproprion	Yes	90 days supply in any 365 day period
	Chantix <sup>®</sup>	varenicline	No	180 days supply in any 365 day period
Urinary Antispasmodics	Detrol®	tolterondine	No	60 tablets/ prescription
	Detrol LA®	tolterondine extended release	No	30 tablets/ prescription
	Ditropan XL®	oxybutynin	Yes	(30) 5mg tablets/ prescription
	Ditropan XL®	oxybutynin	Yes	(60) 10mg, 15mg tablets/ prescription
	Oxytrol®	oxybutynin	No	10 patches/ prescription
	Enablex®	darifenacin	No	30 tablets/ prescription
	Sanctura®	trospium	No	60 tablets/ prescription
	Sanctura XR®	trospium chloride	No	30 tablets/ prescription
	Vesicare®	solifenacin	No	30 tablets/ prescription

<sup>\*\*</sup>Quantities reflect limits available at a retail pharmacy. Mail order quantities are generally available at 3 times the retail pharmacy limit (max. 90-day supply). State and plan variations apply. See your Certificate of Coverage for benefit information.

Some drug classes may not be covered by your plan. See your Certificate of Coverage for benefit information.