



GUARDIAN®

Guardian Coverage Management

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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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.

Prescription Drugs Requiring Prior Authorization			
Drug Class	Brand Name	Chemical Name	Generic Available
Anti-Narcoleptic Agents ⁽¹⁾ (used to promote wakefulness)	<i>Provigil</i> ®	modafinil	No
Antiviral Agents* (used to treat hepatitis B and C)	<i>Copegus</i> ®, <i>Rebetol</i> ®	ribavirin	Yes
Appetite suppressants and weight loss agents	<i>Didrex</i> ®	benzphetamine	Yes
	<i>Tenuate</i> ®, <i>Tenuate</i> ®, <i>Dospan</i> ®	diethylpropion	Yes
	<i>Bontril</i> ®	phendimetrazine	
	<i>Adipex-P</i> ®, <i>Fastin</i> ®	phentermine	Yes
	<i>Ionamin</i> ®	phentermine	No
	<i>Meridia</i> ®	sibutramine	No
	<i>Xenical</i> ®	orlistat	No
Asthmatic agents (used to treat allergic asthma caused by Immuno-globulin type E (IgE) only)	<i>Xolair</i> ®	omalizumab	No
CNS stimulants-type agents (attention deficit or ADHD)	<i>Adderall</i> ®,	amphetamine/ dextroamphetamine	Yes
	<i>Adderall XR</i> ®	amphetamine/ dextroamphetamine	No
	<i>Focalin</i> ®,	dexmethylphenidate	Yes
	<i>Focalin XR</i> ®	dexmethylphenidate	No
	<i>Dexedrine</i> ®, <i>Dexedrine</i> ®, <i>Spansules</i> ®, <i>DextroStat</i> ®,	dextroamphetamine	Yes

* 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.

⁽¹⁾ All medications in this class are subject to the dispensing limitations rules listed on page 11 in this document

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

Prescription Drugs Requiring Prior Authorization

CNS stimulants-type agents (continued)	<i>Liquadd</i> ®	dextroamphetamine	No
	<i>Desoxyn</i> ®	methamphetamine	Yes
	<i>Ritalin</i> ®, <i>Daytrana</i> ™	methylphenidate	Yes
	<i>Ritalin-LA</i> ®, <i>Metadate</i> ® CD, <i>Concerta</i> ®	methylphenidate sustained release	No
	<i>Ritalin-SR</i> ®, <i>Methylin</i> ® ER	methylphenidate sustained release	Yes
	<i>Cylert</i> ®	pemoline	Yes
	<i>Strattera</i> ®	atomoxetine	No
	<i>Vyvanse</i> ®	lisdexamfetamine dimesylate	No
COX-2 inhibitors* (commonly used for arthritis pain and inflammation)	<i>Celebrex</i> ®	celecoxib	No
Crohn's Disease	<i>Cimzia</i> ®	certolizumab	No
Erythroid stimulants (to boost red blood cell count)	<i>Procrit</i> ®, <i>Epogen</i> ®	erythropoietin (epoetin)	No
	<i>Aranesp</i> ®	darbepoetin	No
Growth hormones ** (to treat hormone deficiencies in children)	<i>Genotropin</i> ®, <i>Humatrope</i> ®, <i>Norditropin</i> ®, <i>Nutropin</i> ®, <i>Saizen</i> ®, <i>Tev-Tropin</i> ®, <i>Zorbtive</i> ®	somatropin	No
	<i>Omnitrope</i> ®	somatropin	Yes
	<i>Geref</i> ®, <i>Serostim</i> ®	somatrem	No
	<i>Increlex</i> ®	mecasermin (rDNA origin)	No
Interferons (used to treat hepatitis and certain cancers)	<i>Alferon-N</i> ®	interferon alpha-n3	No
	<i>Actimmune</i> ®	interferon gamma-1b	No
	<i>Intron A</i> ®	interferon alpha-2b	No
	<i>Infergen</i> ®	interferon alpha-con	No

* 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.

** Accredo is preferred specialty pharmacy to dispense growth hormones

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

Prescription Drugs Requiring Prior Authorization			
Drug Class	Brand Name	Chemical Name	Generic Available
Interferons (continued)	<i>Pegasys</i> ®	pegylated Interferon alpha-2a	No
	<i>Peg-Intron</i> ®	peginterferon alpha-2b	No
	<i>Rebetron</i> ®	interferon alpha-2b plus ribavirin	No
	<i>Roferon</i> ®	interferon alpha-2a	No
Leukotriene receptor antagonist agents* ⁽¹⁾ (allergy and asthma relief)	<i>Singulair</i> ®	montelukast	No
	<i>Accolate</i> ®	zafirlukast	No
	<i>Zyflo</i> ®	zileuton	No
Myeloid stimulants (to boost white blood cell counts)	<i>Neupogen</i> ®	filgrastim	No
	<i>Neulasta</i> ®	pegfilgrastim	No
	<i>Leukine</i> ®	sargramostim	No
	<i>Neumega</i> ®	oprelvekin	No
	<i>Nplate</i> ®	romiplostim	No
	<i>Promacta</i> ®	eltrombopag	No
Narcotic Analgesics* (used to treat breakthrough pain)	<i>Actiq</i> ®	fentanyl	Yes
	<i>Fentora</i> ®	entanyl	No
Pulmonary arterial hypertension therapy* (treats pulmonary arterial hypertension)	<i>Revatio</i> ®	sildenafil	No
	<i>Tracleer</i> ®	bosentan	No
	<i>Ventavis</i> ®	iloprost	No
	<i>Letairis</i> ®	ambrisentan	No
Rheumatoid arthritis agents* (used to treat rheumatoid arthritis and other specific types of arthritis)	<i>Arava</i> ®	leflunomide	Yes
	<i>Enbrel</i> ®	etanercept	No
	<i>Humira</i> ®	adalimumab	No
	<i>Kineret</i> ®	anakinra	No
	<i>Orencia</i> ®	abatacept	No
	<i>Remicade</i> ™	Infliximab	No
	<i>Rituxan</i> ®	rituximab	No
Respiratory Syncytial Virus (RSV) Agents (to prevent lower respiratory tract disease caused by respiratory syncytial virus)	Synagis™	palivizumab	No

* 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.

⁽¹⁾ 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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

Prescription Drugs Subject to Formulary Coverage Review

The covered generics and covered brands listed below are allowed without coverage review, but are subject to formulary copays (preferred and non-preferred). The targeted medications require a review and 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.**

Prescription Drugs Subject to Formulary Coverage Review				
Drug Class	Brand Name	Chemical Name	Generic Available	Drug Status
Antisecretory agents-proton pump inhibitors (ulcer) ⁽¹⁾	omeprazole	omeprazole	Yes	Covered generic
	<i>Nexium</i> ®	esomeprazole	No	Covered brand
	<i>Aciphex</i> ®	rabeprazole	No	Targeted brand
	<i>Zegerid</i> ®	omeprazole	No	Targeted brand
	<i>Prevacid</i> ®	lansoprazole	No	Targeted brand
	<i>Protonix</i> ®	pantoprazole	No	Targeted brand
	<i>Kapidex</i> ®	dexlansoprazole	No	Targeted brand
	<i>Prilosec</i> ® packets	omeprazole	No	Targeted brand
Antidepressants (depression and other mental health disorders) ⁽²⁾	SSRI			
	fluvoxamine	fluvoxamine	Yes	Covered generic
	fluoxetine	fluoxetine	Yes	Covered generic
	paroxetine	paroxetine	Yes	Covered generic
	sertraline	sertraline	Yes	Covered generic
	<i>Lexapro</i> ®	escitalopram	No	Targeted brand
	<i>Luvox CR</i> ®	fluvoxamine	No	Targeted brand
	SNRI			
	venlafaxine	venlafaxine	Yes	Covered generic
	bupropion XL	bupropion XL	Yes	Covered generic
	bupropion CR	bupropion CR	Yes	Covered generic
	<i>Cymbalta</i> ®	duloxetine	No	Covered brand
	<i>Pristiq</i> ®	desvenlafaxine	No	Targeted brand
	<i>Effexor XR</i> ®	venlafaxine XR	No	Targeted brand

⁽¹⁾ 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 10 in this document. ⁽²⁾ 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 9 in this document.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

Prescription Drugs Subject to Formulary Coverage Review				
Drug Class	Brand Name	Chemical Name	Generic Available	Drug Status
Hypnotic Agents (used to treat insomnia, short term) ⁽³⁾	zolpidem	zolpidem	Yes	Covered generic
	Ambien®	zolpidem	Yes	Covered brand
	zaleplon	zaleplon	Yes	Covered generic
	Ambien CR®	zolpidem	No	Targeted brand
	Lunesta™	eszopiclone	No	Targeted brand
	Rozerem™	ramelteon	No	Targeted brand
	Sonata®	zaleplon	Yes	Targeted brand
Osteoporosis Therapy (Bisphosphonates) (used to treat bone loss) ⁽⁴⁾	alendronate	alendronate	Yes	Covered generic
	Boniva®	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

⁽³⁾ generic zolpidem, zaleplon and branded Ambien® are covered hypnotics; All medications in this class are subject to the dispensing limitations rules listed on page 11 in this document. ⁽⁴⁾ generic alendronate and branded Boniva® are covered bisphosphonates

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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, 10mg, 20mg, 30mg, 40mg	lisinopril	Yes	(60) 30mg, 40mg tablets/ prescription ⁽¹⁾ (30) 10mg, 20mg tablets/ prescription
	Univasc®	moexipril	Yes	60 tablets/ prescription ⁽¹⁾
	Vasotec®	enalapril	Yes	60 tablets/ prescription ⁽¹⁾
Aceon®	perindopril	No	60 tablets/ prescription ⁽¹⁾	
ACE Inhibitors ⁽²⁾ Combination	Accuretic®	quinapril/ HCTZ	Yes	(30) 10-12.5mg, 20-25mg tablets/ prescription ⁽²⁾ (60) 20-12.5mg tablets/ prescription
	Capozide®	Captopril/ HCTZ	Yes	30 tablets/ prescription ⁽²⁾
	Lotensin HCT®	benazepril/ HCTZ	Yes	30 tablets/ prescription ⁽²⁾
	Lotrel®	amlodipine/HCTZ	Yes	30 tablets/ prescription ⁽²⁾
	Monopril HCT®	fosinopril/ HCTZ	Yes	(30) 10-12.5mg tablets/ prescription (60) 20-12.5mg tablets/ prescription
	Prinzide® Zestoretic®	lisinopril/HCTZ	Yes	(30) 10-12.5mg tablets/ prescription (60) 20-12.5mg, 20-25mg tablets/ prescription ⁽²⁾
	Tarka®	Trandolapril/ HCTZ	No	30 tablets/ prescription ⁽²⁾
	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

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

⁽²⁾ Additional quantities of Capozide, Lotensin HCT 20-12.5mg, 20-25mg Lotrel 5-10mg, 5-20mg, Prinzide 20-25mg, Zestoretic 20-25mg, Uniretic 15-25mg, and Tarka are not available through coverage review

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**
ARBs/ Renin Inhibitor ⁽¹⁾	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	No	(60) 25mg, 50mg tablets/ prescription (30) 100mg tablets/ prescription
	Diovan®	valsartan	No	(60) 40mg, 160mg tablets/ 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 HCT®	candesartan/ HCTZ	No	30 tablets/ prescription
	Avalide®	irbesartan/ HCTZ	No	30 tablets/ prescription ⁽²⁾
	Benicar HCT®	olmesartan/HCTZ	No	30 tablets/ prescription ⁽²⁾
	Hyzaar®	losartan/ HCTZ	No	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⁾
	Teveten HCT®	eprosartan / HCTZ	No	30 tablets/ prescription ⁽²⁾
Antibiotics	Alinia®	nitazoxanide	No	(6) 500mg tablets/ prescription at retail and mail (1 bottle) 100mg/ 5ml suspension/ prescription at retail and mail
Anticonvulsant ⁽³⁾	Lyrica®	pregabalin	No	(90) 25mg, 50mg, 100mg, 150mg, 200mg tablets/ prescription (60) 75mg, 225mg, 300mg tablets/ prescription

**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

⁽²⁾ 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

⁽³⁾ Additional quantities of Lyrica 25mg, 150mg, 200mg, 225mg, 300mg are not available through coverage review

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**
Antidepressants (depression and other mental health disorders)	Celexa®	citalopram	Yes	(60) 10mg or, (90) 20mg or, (30) 40mg tablets/ prescription
	Lexapro®	escitalopram	No	30 tablets/ prescription
	Luvox CR®	fluvoxamine	No	90 tablets/ prescription
	Paxil®	paroxetine hcl	Yes	(60) 10mg or, (30) 20mg or, (60) 30mg or, (30) 40mg tablets/ prescription
	Paxil CR®	paroxetine hcl	Yes	(60) 12.5mg or, (90) 25mg or, (60) 37.5mg tablets/ prescription
	Pexeva®	paroxetine mesylate	No	(60) 10mg or, (30) 20mg or, (60) 30mg or, (30) 40mg tablets/ prescription
	Prozac®	fluoxetine hcl	Yes	(60) 10mg or, (90) 20mg or, (60) 40mg tablets/ prescription
	Zoloft®	sertraline hcl	Yes	(60) 25mg or, (90) 50mg or, (60) 100mg tablets/ prescription
	Prozac® Weekly™	fluoxetine hcl	No	4 capsules/ prescription
Atypical Antipsychotics ⁽¹⁾	Symbyax®	olanzapine/ fluoxetine	No	30 tablets/ prescription ⁽¹⁾
	Zyprexa® Zyprexa Zydis®	olanzapine	No	30 tablets/ prescription ⁽¹⁾
	Seroquel® Seroquel XR®	quetiapine	No	(60) 400mg, 25mg, 300mg tablets/ prescription ⁽¹⁾ (90) 50mg, 100mg, 200mg tablets/ prescription
	Risperdal® Risperdal M-Tab®	risperidone	Yes	60 tablets/ prescription 8 bottles oral solution
	Geodon®	ziprasidone	No	60 tablets/ prescription ⁽¹⁾
	Abilify® Abilify Discmelt®	aripirazole	No	(42) 5mg, 10mg, 15mg tablets/ prescription ⁽¹⁾ (30) 20mg, 30mg tablets/ prescription
	Invega®		No	(30) 3mg, 9mg tablets/ prescription (60) 6mg tablets/ prescription
	Antiplatelet ⁽²⁾	Pletal®	cilostazol	Yes
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⁾

**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 Symbyax 6/50mg, 12/25mg, 12/50mg, Zyprexa/Zyprexa Zydis 15mg, 20mg, Seroquel/ Seroquel XR 300mg, 400mg, Geodon 40mg, 60mg, 80mg, Abilify/ Abilify Discmelt, 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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**
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 (120) 1-500mg, 2-500mg tablets/ prescription
	Metaglip® ⁽¹⁾	glipizide/ metformin	Yes	(60) 2.5-250mg tablets/ prescription (120) 2.5-500mg, 5-500mg tablets/ prescription
	Glucovance®	glyburide/ metformin	Yes	(60) 1.25-250mg, 2.5-500mg tablets/ prescription (120) 5-500mg tablets/ prescription
	Glucophage XR® ⁽¹⁾	metformin	Yes	(60) 750mg tablets/ prescription (120) 500mg tablets/ prescription
	Fortamet® ⁽¹⁾	metformin	No	(150) 500mg tablets/ prescription (60) 1000mg tablets/ prescription
	Glucotrol XL®	glipizide	Yes	(30) 2.5mg, 5mg tablets/ prescription (60) 10mg ⁽¹⁾ tablets/ prescription
	Amaryl®	glimepiride	Yes	(30) 1mg, 2mg ⁽¹⁾ tablets/ prescription (60) 4mg tablets/ prescription
	Glynae Prestab®	glyburide, micronized	Yes	(30) 1.5mg, 3mg tablets/ prescription (60) 6mg ⁽¹⁾ tablets/ prescription
	Prandin®	repaglinide	No	(120) 0.5mg, 1mg tablets/ prescription (240) 2mg ⁽¹⁾ tablets/ prescription
	Starlix® ⁽¹⁾	nateglinide	No	90 tablets/ prescription
	Symlin® ⁽¹⁾	pramlintide	No	4 vials/ prescription
	Duetact® ⁽¹⁾	gli mepiride/pioglitazone	No	30 tablets/ prescription
	Januvia® ⁽¹⁾	sitagliptin	No	30 tablets/ prescription
Antisecretory agents- proton pump inhibitors ⁽²⁾ and H ₂ antagonists (ulcer)	Prilosec®	omeprazole	Yes	Ulcer healing doses for first 90 days of therapy H2 Antagonists: > 800mg/ day of Tagamet > 300mg/day of Axid/ Zantac > 40mg/day of Pepcid
	Zegerid®	omeprazole	No	PPIs: > 20 mg/day of Aciphex > 40 mg/day of Nexium > 30 mg/day of Prevacid > 20 mg/day of Prilosec (includes packets) > 40 mg/day of Protonix > 20mg/day of Zegerid > 30 mg/day of Kapidex
	Aciphex®	rabeprazole	No	
	Nexium®	esomeprazole	No	
	Prevacid®	lansoprazole	No	
	Protonix®	pantoprazole	No	
	Tagamet®	cimetidine	Yes	
	Zantac®	ranitidine	Yes	
	Pepcid®	famotidine	Yes	
	Axid®	nizatidine	Yes	

**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, Glucophage XR, Fortamet, Glucotrol XL 10mg, Amaryl 2mg, Glynae Prestab 6mg, Prandin 2mg, Starlix, Symlin, Duetact, Januvia are not available through coverage review

⁽²⁾ Certain drugs in this class maybe subject to Preferred Step Therapy rules. See page 5 for specific details.

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**	
Antiemetic agents (used to treat nausea and vomiting)	<i>Anzemet</i> ®	ondansetron	No	Quantities sufficient for seven (7) treatment days 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	
	<i>Emend</i> ®	aprepitant	No		
	<i>Kytril</i> ®	granisetron	Yes		Kytril: 14 mg in 30 days or 42 mg in 90 days
	<i>Zofran</i> ®	ondansetron	Yes		Zofran (all forms): 168 mg in 30 days or 504 mg in 90 days
	<i>Sancuso</i> ®	granisetron	No		2 patches in 30 days or 6 patches in 90 days
Antifungal Agents ⁽¹⁾	<i>Diflucan</i> ®	fluconazole	Yes	(30) 50mg, 100mg tablets/ prescription ⁽¹⁾	
				(2) 150mg tablets/ prescription	
				(60) 200mg tablets/ prescription	
	<i>Lamisil</i> ® ⁽¹⁾	terbinafine	Yes	(30) 250mg (60) 125mg packets/ prescription (30) 187.5mg packets/ prescription	
<i>Sporanox</i> ® ⁽¹⁾	itraconazole	Yes	120 capsules/ prescription		
Antiviral agents (used to treat herpes infections)	<i>Famvir</i> ®	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	
	<i>Valtrex</i> ®	valacyclovir	No	Valtrex: 100,000 mgs in any 90 day period	
	<i>Zovirax</i> ®	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 wakefulness) ⁽²⁾	<i>Provigil</i> ®	modafinil	No	6000 mg in 23 days or 18000 mg in 68 days	
Hypnotic Agents (used to treat insomnia, short term) ⁽³⁾	<i>Ambien</i> ®	zolpidem	Yes	Doses consistent with the treatment of short term insomnia Ambien, Ambien CR, Lunesta, Rozerem, Sonata: 60 days supply in 90 days	
	<i>Ambien CR</i> ®	zolpidem	No		
	<i>Lunesta</i> ™	eszopiclone	No		
	<i>Rozerem</i> ™	ramelteon	No		
	<i>Sonata</i> ®	zaleplon	Yes		

**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

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

⁽³⁾ Certain drugs in this class may be subject to Preferred Step Therapy rules. See page 5 for specific details.

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**
Inhaled Corticosteroids (1)	Qvar®	Beclomethasone	No	3 inhalers/ prescription
	Pulmicor Flexhaler®	Budesonide	No	2 inhalers/ prescription
	Aerobid® Aerobid-M®	Flunisolide	No	3 inhalers at retail and 8 inhalers at mail
	Flovent® Flovent HFA® Flovent Rotadisk®	Fluticasone Propionate	No	2 inhalers/ prescription 240 doses (16 blisters)
	Advair HFA®	Fluticasone/ Salmeterol	No	1 inhalers/ prescription
	Azmacort®	Triamcinolone	No	2 inhalers/ prescription
	Symbicort® (1)	Budesonide/ Formoterol	No	1 inhalers/ prescription
Migraine therapy (headache treatment)	Imitrex®, Treximer®	sumatriptan	No	900mg/ 30 days
	Zomig®, Zomig-ZMT®	zolmitriptan	No	40mg/ 30 days
	Amerge®	naratriptan	No	20mg/ 30 days
	Maxalt®, Maxalt-MLT®	rizatriptan	No	120mg/ 30 days
	Axert®	almotriptan	No	100mg/ 30 days
	Frova®	frovatriptan	No	30mg/ 30 days
	Relpax®	eletriptan	No	320mg/ 30 days
	Migranal® NS	dihydroergotamine nasal	No	8 amps/ 30 days

**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 Symbicort are not available through coverage review

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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**
Oral estrogens (estrogen replacement)	Prempro™, Premphase®	conjugated estrogens, medroxyprogesterone	No	28 day pack/ prescription
	Activella® 1-0.5mg	estradiol,norethindrone	Yes	
	Activella® 0.5mg-0.1mg	estradiol,norethindrone	No	
	Cenestin®	conjugated estrogen	No	(60) 0.625mg or (30) 0.3mg or 0.9mg tablets/prescription
	Menes®	esterified estrogen	No	30 tablets/ prescription
	Premarin®, Enjuvia®	conjugated estrogens	No	
	Femtrace®	estradiol acetate	No	
	Ortho-Prefest®	estradiol, norgestimate	No	
	Estratest®, Estratest® HS	esterified estrogens, methyltestosterone	Yes	
	Ortho-Est®, Ogen®	estropipate	Yes	
	Estrace®	estradiol	Yes	
	Estinyl®	ethinyl estradiol	Yes	
	Femhrt®	ethinyl estradiol,norethindrone	Yes	
	Syntest® DS, Syntest® HS	esterified estrogen, methyltestosterone	Yes	
Psoriatic Therapy ⁽²⁾ (used to treat psoriasis)	Enbrel®	etanercept	No	200 mg/ 30 days
	Raptiva®	efalizumab	No	4 kits/ 30 days
	Amevive®	alefacept	No	60 mg/ 30 days ⁽²⁾

**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

⁽²⁾ Additional quantities of Amevive are not available through coverage review.

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

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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.				
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Alpha1 Blockers	<i>Minipress®</i>	prazosin	Yes	(90) 1mg capsules/ prescription (120) 2mg, 5mg capsules/ prescription
	<i>Hytrin®</i>	terazosin	Yes	60 capsules/ prescription
	<i>Cardura®</i>	doxazosin	Yes	60 tablets/ prescription
	<i>Flomax®</i>	tamsulosin	No	60 capsules/ prescription
Antihistamines	<i>Clarinet®</i> <i>Clarinet-D®</i>	desloratadine desloratadine/ pseudoephedrine	No	(30) 5mg, 5-240mg tablets/ prescription (60) 2.5-120mg tablets/ prescription
	<i>Allegra®</i>	fexofenadine	Yes	60 tablets/ prescription
	<i>Allegra-D®</i>	fexofenadine/ pseudoephedrine	No	(60) 60-120mg tablets/ prescription (30) 180-240mg tablets/ prescription
	<i>Xyzal®</i>	levocetirizine	No	30 tablets/ prescription
BPH Agents	<i>Proscar®</i>	finasteride	Yes	30 tablets/ prescription
	<i>Avodart®</i>	dutasteride	No	30 tablets/ prescription
	<i>Uroxatral®</i>	alfuzosin	No	30 tablets/ prescription
Erectile dysfunction agents	<i>Viagra®</i>	sildenafil	No	6 tablets(or units)/30 days
	<i>Levitra®</i>	vardeafil	No	
	<i>Cialis®</i>	tadalafil	No	
	<i>Muse®, Edex®, Caverject®</i>	alprostadiil	No	
	<i>Cialis 2.5mg®</i>	tadalafil	No	15 tablets/ 60 days
	<i>Cialis 5.mg®</i>			
Estrogens - Topical	<i>Vivelle®, Vivelle-Dot®</i> <i>Alora®</i> <i>Esclim®</i> <i>Estraderm®</i>	estradiol	No	8 systems/ prescription
	<i>Climara®</i>	estradiol	Yes	4 systems/ prescription
	<i>Climara-Pro®</i>	estradiol/ levonorgestrel	No	
	<i>CombiPatch®</i>	estradiol/ norethindone	No	8 systems/ prescription
	<i>Menostar®</i>	estradiol	No	4 systems/ prescription
	<i>Estroge®</i>	estradiol	No	93gm – 1 at retail and mail 50gm – 1 at retail; 3 at mail
	<i>Elestrin®</i>	estradiol	No	1 pump at retail; 2 pumps at mail
	<i>Divigel®</i>	estradiol	No	30
Evista	<i>Evista®</i>	raloxifene	No	30 tablets/ prescription

**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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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.				
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**
Bronchodilators	<i>Ventolin®</i> , <i>Ventolin HFA®</i> <i>Proventil®</i> , <i>Proventil HFA®</i> <i>ProAir®</i>	albuterol	Yes	2 inhalers/ prescription
	<i>Vetnolin Rotacaps®</i>	albuterol	Yes	240 capsules/ prescription
	<i>Atrovent®</i>	ipratropium	Yes	2 inhalers/ prescription
	<i>Atrovent HFA®</i>		No	
	<i>Combivent®</i>	albuterol/ ipratropium	No	2 inhalers/ prescription
	<i>Maxair Autohaler®</i>	pirbuterol	No	2 inhalers/ prescription
	<i>Serevent®</i>	salmeterol	No	2 inhalers/ prescription
	<i>Serevent Diskus®</i>			56 blisters or 60 blisters based on package size
	<i>Foradil®</i>	formoterol	No	60 blisters/ prescription
	<i>Spiriva®</i>	tiotropium	No	30 capsules/ prescription
Intranasal Corticosteroids	<i>Nasarel®</i>	flunisolide	Yes	3 inhalers at retail and 8 inhalers at mail
	<i>Beconase AQ®</i>	beclomethasone	No	2 inhalers at retail and 4 inhalers at mail
	<i>Nasacort AQ®</i>	triamcinolone	No	2 inhalers/ prescription
	<i>Rhinocort AQ®</i>	budesonide	No	2 inhalers/ prescription
	<i>Flonase®</i>	fluticasone	Yes	1 inhaler/ prescription
	<i>Nasonex®</i>	mometasone	No	1 inhaler/ prescription
	<i>Omnaris®</i>	ciclesonide	No	1 inhaler/ prescription
	<i>Veramyst®</i>	fluticasone	No	1 inhaler/ prescription
Leukotriene Antagonists	<i>Accolate®</i>	zafirlukast	No	60 tablets/ prescription
	<i>Singulair®</i>	montelukast	No	30 tablets/ prescription
	<i>Zyflo®</i> , <i>Zyflo CR®</i>	zileuton	No	120 tablets/ prescription
HMG-CoA Inhibitors (cholesterol-lowering)	<i>Mevacor®</i>	lovastatin	Yes	(30) 10mg tablets/ prescription or, (60) 20mg or 40-mg tablets/ prescription
	<i>Pravigard® PAC</i>	buffered aspirin and pravastatin	No	1 carton/ prescription
	<i>Zocor®</i>	simvastatin	Yes	(30) tablets/ prescription

**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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.



GUARDIAN®

Guardian Coverage Management

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.					
Drug Class	Brand Name	Chemical Name	Generic Available	Dispensing Limit**	
HMG-CoA Inhibitors (cholesterol-lowering) (continued)	<i>Lipitor</i> ®	atorvastatin	No	30 tablets/ prescription	
	<i>Pravachol</i> ®	pravastatin	Yes		
	<i>Altoprev</i> ™	lovastatin	No		
	<i>Lescol</i> ®	fluvastatin	No		
	<i>Crestor</i> ®	rosuvastatin	No		
	<i>Zetia</i> ®	ezetimibe	No		
	<i>Vytorin</i> ™	simvastatin/ ezetimibe	No		
	<i>Caduet</i> ®	amlodipine/ atorvastatin	No		
Psoriatic Therapy (used to treat psoriasis)	<i>Amevive</i> ®	alefacept	No	60 mg/ 30 days	
Urinary Antispasmodics	<i>Detrol</i> ®	tolterondine	No	60 tablets/ prescription	
	<i>Detrol LA</i> ®	tolterondine extended release	No	30 tablets/ prescription	
	<i>Ditropan XL</i> ®			Yes	(30) 5mg tablets/ prescription
					(60) 10mg, 15mg tablets/ prescription
	<i>Oxytrol</i> ®	oxybutynin	No	10 patches/ prescription	
	<i>Enablex</i> ®	darifenacin	No	30 tablets/ prescription	
	<i>Sanctura</i> ®	tropium	No	60 tablets/ prescription	
	<i>Sanctura XR</i> ®	tropium chloride	No	30 tablets/ prescription	
<i>Vesicare</i> ®	solifenacin	No	30 tablets/ prescription		

**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.

The list of medications requiring prior authorization is subject to change. Refer back to www.guardianlife.com and select the Prescription Drug link for the most recent list of medications, or call 800-417-1783 to speak with Member Services.