

## **CONNECT TO CARE**

### **DRUG FORMULARY**

**Administered by MedImpact**

*October 2024*

#### **INTRODUCTION**

### **Foreword**

The below table describes Connect to Care prescription coverage:

Patient out-of-pocket cost	<ul style="list-style-type: none"><li>• \$5 copayment per prescription</li><li>• No monthly share of cost requirement</li></ul>
Benefit maximums	<ul style="list-style-type: none"><li>• \$500 per prescription claim</li><li>• \$1500 maximum benefit per enrollment period</li></ul>
Drug exclusions	<ul style="list-style-type: none"><li>• Specialty drugs and contraceptives are excluded</li></ul>

This document represents the efforts of MedImpact and Connect to Care to provide physicians and pharmacists with a method to evaluate the various drug products available under the Connect to Care Benefits. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the Connect to Care Formulary is to enhance the ability of physicians and pharmacists participating in Connect to Care to provide optimal cost-effective drug therapy for Connect to Care members.

The development, maintenance, and improvement of the Connect to Care Formulary is evolutionary and requires on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The Connect to Care Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to Connect to Care.

Connect to Care uses the following criteria in the evaluation of product selection for the Connect to Care Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance, or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

### **How to Use the Drug Formulary**

The Connect to Care Formulary is a list of covered and preferred drug agents for Connect to Care members. All products are listed by their generic names and most common proprietary (branded) name. The Connect to Care Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing shall be considered a Non-Formulary Drug.

## ***Coverage Limitations***

The Connect to Care Formulary does not provide information regarding the specific coverage or limitations an individual member may have. Connect to Care members may have specific limitations which are not reflected in this Drug Formulary. This Drug Formulary contains only FDA-approved outpatient drugs for eligible members and does not apply to non-FDA approved drugs or medications used in inpatient settings. If a Connect to Care member has any specific questions regarding coverage, they should contact Connect to Care at (916) 649-2631 for further explanation of benefits.

Connect to Care members are not eligible to receive prescription drug services outside of California and the designated border state areas of Oregon, Nevada and Arizona.

## ***Generic Substitution***

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the Connect to Care pharmacy and therapeutics review process.

Connect to Care approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by Connect to Care for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
  - ◊ Coumadin
  - ◊ Dilantin
  - ◊ Lanoxin
  - ◊ Premarin
  - ◊ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

## ***Experimental Drugs***

The experimental nature or use of drug products will be determined by Connect to Care using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

## ***Prior Authorization***

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or

- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by Connect to Care, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

## ***Request Process for Non-Formulary Agents***

Coverage for non-formulary agents may be requested in advance by physicians. When a Connect to Care member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of Connect to Care Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the Connect to Care Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- 4) The use of a Connect to Care Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

Connect to Care recognizes that not all medical needs can be met with agents listed in this document and encourages inquires about optional therapies.

## ***Step Care Agents***

Drug products defined as step care will undergo an electronic pre-authorization process per Connect to Care guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

## ***Quantity Limits***

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL) will be subject to the prior authorization process.

## ***Appeals Process***

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or Connect to Care members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.  
10181 Scripps Gateway Court, San Diego, CA 92131  
Attention: Appeals Coordinator  
or  
Fax (858) 790-6060

## ***Formulary Process and Communication***

The Connect to Care Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. Connect to Care welcomes input on the formulary from physicians and pharmacists providing services to Connect to Care clients. Suggestions and comments should be submitted to the Connect to Care at the following address:

Connect to Care  
ATTN: Pharmacy and Therapeutics Panel  
1545 River Park Drive, Suite 435  
Sacramento, CA 95815  
(916) 649-2631

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# CENTRAL NERVOUS SYSTEM AGENTS

## *Analgesic and Anti-Inflammatory Agents*

### Non-Steroidal Anti-Inflammatory Agents

#### FIRST LINE AGENTS

Aspirin	ASPIRIN
Aspirin EC	ECOTRIN
Celecoxib	CELEBREX
Diclofenac Sodium	VOLTAREN
Etodolac	LODINE
Ibuprofen	MOTRIN (INCLUDES OTC)
Indomethacin	INDOCIN
Ketoprofen	ORUVAIL, <b>200MG STRENGTH NON-FORMULARY</b>
Indomethacin, Sustained Release	INDOCIN SR
Meloxicam Tablets	MOBIC (TABLETS ONLY), <b>SUSPENSION NON-FORMULARY</b>
Nabumetone	RELAFEN
Naproxen	NAPROSYN
Naproxen Sodium	ANAPROX ANAPROX DS
Salsalate	DISALCID
Sulindac	CLINORIL
Piroxicam	FELDENE

#### SECOND LINE AGENTS

SE	Etodolac Extended Release	LODINE XL, <b>STEP THERAPY</b> , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
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### Miscellaneous Arthritis Agents

Leflunomide	ARAVA
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### Migraine Agents

	APAP/Dichloralphenazone/Isomethep	MIDRIN
	Butalbital/APAP/Caffeine	ESGIC ESGIC PLUS FIORICET
	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
QL	Ergotamine/Caffeine	CAFERGOT
QL	Naratriptan	AMERGE, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Rizatriptan	MAXALT, MAXALT MLT, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH, SUMAVEL NON-FORMULARY
SE, QL	Eletriptan	RELPAX, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
SE, QL	Zolmitriptan	ZOMIG, ZOMIG ZMT <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
PA, QL	Dihydroergotamine	MIGRANAL, <b>PA REQ</b> , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH

### Opiate Agonists

QL	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; <b>ORAL SUSPENSION AND VOPAC NON-FORMULARY</b>
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QL	Acetaminophen/Hydrocodone	NORCO 5/325, LIMITED TO #240/MONTH
QL		NORCO 7.5/325, LIMITED TO #180/MONTH
QL		NORCO 10/325, LIMITED TO #150/MONTH
		<b>ALL OTHER HYDROCODONE/APAP STRENGTHS NON-FORMULARY</b>
QL	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL	Oxycodone	OXYIR, LIMITED TO #240/MONTH
QL	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
QL	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH; <b>MAGNACET AND PRIMALEV NON-FORMULARY</b>
QL		TYLOX, LIMITED TO #240/MONTH
QL	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH
PA, QL	Oxycodone	OXYCONTIN, <b>PA REQ</b> , LIMITED TO #60/MONTH

### **Narcotic Withdrawal Therapy Agents**

Naloxone Spray and Syringes

NARCAN; **EVZIO NON-FORMULARY**

### **Opiate Antagonists**

Naltrexone

REVIA

### **Miscellaneous Analgesics**

Acetaminophen

TYLENOL

Tramadol

ULTRAM ; **ULTRAM ER NON-FORMULARY**

PA, QL

Butorphanol NS

STADOL NS, **PA REQ**, LIMITED TO 2 BOTTLES/MONTH

### **Miscellaneous Central Nervous System Agents**

Donepezil

ARICEPT

## ***Anticonvulsant Agents***

### **Barbiturate Anticonvulsants**

Mephobarbital

MEBARAL

Phenobarbital

PHENOBARBITAL

Primidone

MYSOLINE

### **Benzodiazepine Anticonvulsants**

QL

Clonazepam

KLONOPIN, LIMITED TO #90/MONTH; **RAPDIS TABLETS NON-FORMULARY**

### **Hydantoin Anticonvulsants**

Phenytoin

DILANTIN, PHENYTEK

### **Miscellaneous Anticonvulsants**

Carbamazepine

TEGRETOL; **EQUETRO NON-FORMULARY**

Carbamazepine Extended Release

TEGRETOL XR

Divalproex Sodium

DEPAKOTE

Divalproex Sodium Extended Release

DEPAKOTE ER

Gabapentin

NEURONTIN

Levetiracetam

KEPPRA

Oxcarbazepine

TRILEPTAL

Tiagabine

GABITRIL

Valproic Acid

DEPAKENE

Zonisamide

ZONEGRAN

QL

Lamotrigine

LAMICTAL, LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG

QL

Topiramate

TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS

## Antiparkinsonian Agents

Amantadine  
Benztropine Mesylate  
Bromocriptine

Carbidopa/Levodopa  
Carbidopa/Levodopa CR  
Pramipexole  
Ropinirole  
Selegiline  
Trihexyphenidyl

SYMMETREL  
COGENTIN  
PARLODEL

SINEMET; **PARCOPA NON-FORMULARY**  
SINEMET CR  
MIRAPEX  
REQUIP; **REQUIP XL NON-FORMULARY**  
SELEGILINE, **ZELAPAR AND EMSAM NON-FORMULARY**  
ARTANE

## Muscle Relaxant Agents

### Skeletal Muscle Relaxants

QL Baclofen  
Carisoprodol  
  
Chlorzoxazone  
Cyclobenzaprine  
Dantrolene Sodium  
Methocarbamol  
Orphenadrine Citrate  
Orphenadrine/Aspirin/Caffeine

LIORESAL  
SOMA, LIMITED TO #120/MONTH; **250 STRENGTH NON-FORMULARY**  
PARAFON DSC  
FLEXERIL  
DANTRUM  
ROBAXIN  
NORFLEX  
NORGESIC

## Psychotherapeutic Agents

### Tricyclic Antidepressant Agents

Amitriptyline  
Amoxapine  
Desipramine  
Doxepin  
Imipramine  
Maprotiline  
Nortriptyline  
Protriptyline

ELAVIL  
ASENDIN  
NORPRAMIN  
SINEQUAN  
TOFRANIL, **TOFRANIL PM NON-FORMULARY**  
LUDIOMIL  
PAMELOR  
VIVACTIL

### S.S.R.I. Agents

Citalopram  
Fluoxetine Capsules

Fluvoxamine  
Paroxetine  
Sertraline

CELEXA  
PROZAC CAPSULES (10MG, 20MG ONLY), **TABLETS NON-FORMULARY**  
LUVOX  
PAXIL  
ZOLOFT

### S.N.R.I. Agents

QL Duloxetine  
QL Venlafaxine  
  
QL Venlafaxine Extended Release

CYMBALTA , LIMITED TO #60/MONTH  
EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY,  
LIMITED TO #90/MONTH OF DOSE > 200MG/DAY  
EFFEXOR XR, LIMITED TO #30/MONTH **VENLAFAXINE  
EXTENDED RELEASE TABLETS NON-FORMULARY**

### M.A.O. Inhibitor Agents

Phenelzine  
Tranylcypromine

NARDIL  
PARNATE

### Miscellaneous Antidepressant Agents

Bupropion  
Bupropion SR

WELLBUTRIN, **APLENZIN NON-FORMULARY**  
WELLBUTRIN SR, **APLENZIN NON-FORMULARY**

	Bupropion XL Clomipramine Mirtazapine	WELLBUTRIN XL, <b>APLENZIN NON-FORMULARY</b> ANAFRANIL REMERON TAB, <b>SOLTABS AND 7.5MG TABLETS NON-FORMULARY</b>
MD, QL	Trazodone Nefazodone	DESYREL SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH
<b>Antimanic Agents</b>		
	Lithium Carbonate	ESKALITH LITHOBID
<b>Benzodiazepines</b>		
QL	Alprazolam	XANAX, LIMITED TO #90/MONTH; <b>XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY</b>
QL	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	Diazepam	VALIUM, LIMITED TO #90/MONTH, <b>DIASTAT NON-FORMULARY</b>
QL	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; <b>LORAZEPAM ORAL CONCENTRATE NON-FORMULARY</b>
QL	Temazepam	RESTORIL, LIMITED TO #30/MONTH; <b>22.5MG STRENGTH NON-FORMULARY</b>
QL	Triazolam	HALCION, LIMITED TO #30/MONTH
<b>Antipsychotic Agents</b>		
QL	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH <b>DISCMELOTS NON-FORMULARY</b>
	Chlorpromazine	THORAZINE
	Clozapine	CLOZARIL
	Fluphenazine	PROLIXIN
	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	Loxapine	LOXITANE
	Molindone	MOBAN
QL	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL		ZYPREXA ZYDIS, LIMITED TO #60/MONTH
		ZYPREXA INJECTION
		ZYPREXA RELPREVV
	Perphenazine	TRILAFON
	Pimozide	ORAP
QL	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, <b>25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMIT PA FOR OTHER INDICATIONS.</b>
QL	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
	Thioridazine	MELLARIL
	Thiothixene	NAVANE
	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH
<b>Antipsychotic/SSRI Combination Agents</b>		
QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
<b>Miscellaneous Anxiolytics, Sedatives, and Hypnotics</b>		
	Buspirone	BUSPAR <b>7.5MG STRENGTH NON-FORMULARY</b>
	Chloral Hydrate	NOCTEC
	Hydroxyzine	ATARAX
	Hydroxyzine Pamoate	VISTARIL
	Promethazine	PHENERGAN

# CARDIOVASCULAR/BLOOD AGENTS

## Antiarrhythmic Agents

### Antidysrhythmic Drug Agents

Amiodarone	CORDARONE; <b>100MG STRENGTH NON-FORMULARY</b>
Disopyramide	NORPACE
Disopyramide CR	NORPACE CR
Flecainide	TAMBOCOR
Mexiletine	MEXITIL
Procainamide	PRONESTYL
Procainamide SR	PROCAN SR
	PROCANBID
Propafenone	RYTHMOL
Quinidine Gluconate	QUINAGLUTE
Quinidine Polygalacturonate	CARDIOQUIN
Quinidine Sulfate	CIN-QUIN
Quinidine Sulfate SR	QUINIDEX
Sotalol	BETAPACE

## Antihypertensive Agents

### Alpha-Adrenergic Antagonist Antihypertensive Agents

Reserpine	SERPASIL
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### Beta-Adrenergic Antagonist Agents

Atenolol	TENORMIN
Metoprolol Succinate	TOPROL XL
Metoprolol Tartrate	LOPRESSOR
Nadolol	CORGARD
Pindolol	VISKEN
Propranolol	INDERAL
Propranolol LA	INDERAL LA

### Combination Alpha-Beta Antagonist Agents

Carvedilol	COREG; <b>COREG CR NON-FORMULARY</b>
Labetalol	NORMODYNE
	TRANDATE

### Angiotensin Converting Enzyme Inhibitor Agents

Benazepril	LOTENSIN
Captopril	CAPOTEN
Enalapril	VASOTEC
Lisinopril	PRINIVIL
	ZESTRIL

### Angiotensin Receptor Blocker Agents

	Irbesartan	AVAPRO
	Losartan	COZAAR
	Telmisartan	MICARDIS
SE, QL	Olmesartan	BENICAR, <b>STEP THERAPY</b> , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan	DIOVAN, <b>STEP THERAPY</b> , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

### Calcium Channel Blocking Agents

Amlodipine  
Diltiazem  
Diltiazem SR  
Diltiazem CD  
Felodipine  
Nifedipine, Sustained Release  
Verapamil  
Verapamil LA Tablets  
Verapamil SR Capsules

NORVASC, LIMITED TO #30/MONTH  
CARDIZEM  
CARDIZEM SR; **CARDIZEM LA NON-FORMULARY**  
CARTIA XT  
PLENDIL, LIMITED TO #30/MONTH  
ADALAT CC  
CALAN  
CALAN SR; **COVERA-HS NON-FORMULARY**  
VERELAN

### **Centrally Acting Antihypertensive Agents**

Clonidine  
Guanfacine  
Methyldopa

CATAPRES  
TENEX  
ALDOMET

### **Combination Antihypertensive Agents**

Atenolol/Chlorthalidone  
Benazepril/HCTZ  
Bisoprolol/HCTZ  
Captopril/HCTZ  
Enalapril/HCTZ  
Lisinopril/HCTZ

TENORETIC  
LOTENSIN HCT  
ZIAC  
CAPOZIDE  
VASORETIC  
ZESTORETIC  
PRINZIDE

SE, QL  
Losartan/HCTZ  
Olmesartan/HCTZ

HYZAAR,  
BENICAR HCT, **STEP THERAPY**, LIMITED TO #30/MONTH,  
RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR  
LOSARTAN/HCTZ IN THE PAST 90 DAYS

SE, QL  
Valsartan/HCTZ

DIOVAN HCT, **STEP THERAPY**, LIMITED TO #30/MONTH,  
RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR  
LOSARTAN/HCTZ IN THE PAST 90 DAYS

### **Drugs for Pheochromocytoma**

PA  
Phenoxybenzamine

DIBENZYLINE, **PA REQUIRED**

### **Potassium-Sparing Diuretics**

Spirolactone  
Spirolactone/HCTZ  
Triamterene  
Triamterene 37.5mg/HCTZ 25mg  
Triamterene 37.5mg/HCTZ 25mg  
Triamterene 75mg/HCTZ 50mg

ALDACTONE  
ALDACTAZIDE  
DYRENIUM  
DYAZIDE  
DYAZIDE  
MAXZIDE 50

### **Loop Diuretics**

Bumetanide  
Furosemide

BUMEX  
LASIX

### **Thiazide and Related Diuretics**

Chlorthalidone  
Hydrochlorothiazide (HCTZ)  
Indapamide  
Metolazone

HYGROTON  
HYDRODIURIL  
LOZOL  
ZAROXOLYN

### **Vasodilator Antihypertensive Agents**

Doxazosin Mesylate  
Hydralazine  
Minoxidil  
Prazosin  
Terazosin

CARDURA; **CARDURAL XL NON-FORMULARY**  
APRESOLINE  
LONITEN  
MINIPRESS  
HYTRIN

## **Antilipemic Agents**

Atorvastatin  
Cholestyramine/Aspartame  
Cholestyramine/Sucrose

LIPITOR  
QUESTRAN LIGHT  
QUESTRAN

Gemfibrozil  
Lovastatin  
Niacin  
Pravastatin  
Niacin, Delayed Release  
Niacin/Lovastatin  
Simvastatin

LOPID  
MEVACOR  
NIACIN  
PRAVACHOL  
NIASPAN  
ADVICOR  
ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF  
80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS  
FORMULARY

## ***Blood Agents***

### **Coagulants and Anticoagulants**

QL Enoxaparin  
Warfarin Sodium

LOVENOX, LIMITED TO #20/FILL TIMES 3  
COUMADIN

## ***Hemorheologic Agents***

Pentoxifylline

TRENTAL

## ***Cardiac Glycoside Agents***

Digoxin

LANOXIN; LANOXICAPS NON-FORMULARY

## ***Antiplatelet Agents***

Cilostazole  
Clopidogrel  
Dipyridamole  
Pasugrel

PLETAL  
PLAVIX  
persantine  
EFFIENT

## ***Vasodilating Agents***

Isosorbide Dinitrate  
Isosorbide Dinitrate SR  
Isosorbide Mononitrate  
Isosorbide Dinitrate ER  
Nitroglycerin Ointment  
Nitroglycerin Patches  
Nitroglycerin Spray  
Nitroglycerin Sublingual  
Isosorbide Mononitrate

ISORDIL; **CHEW TABLETS NON-FORMULARY**  
DILATRATE SR  
ISOSORBIDE MONONITRATE  
ISOSORBIDE MONONITRATE  
NITROL  
NITRO-DUR  
NITROLINGUAL SPRAY  
NITROSTAT SL  
IMDUR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL  
OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN  
THE PAST 90 DAYS

SE

# **GASTROINTESTINAL AGENTS**

## ***Antidiarrheal Agents***

Attapulgite  
Bismuth Subsalicylate  
Diphenoxylate/Atropine  
Kaolin/Pectin

PAREPECTOLIN  
PEPTO BISMOL  
LOMOTIL  
KAOPECTATE

Loperamide

IMODIUM



## ***Antiemetic Agents***

Meclizine	ANTIVERT
Metoclopramide	REGLAN
Ondansetron ODT Tablets	ZOFRAN ODT
Ondansetron Tablets	ZOFRAN TABLETS
Ondansetron Solution	ZOFRAN SOLUTION
Prochlorperazine Maleate	COMPAZINE
	COMPAZINE SPANSULES NOT COVERED
Promethazine	PHENERGAN
Trimethobenzamide	TIGAN

## ***Antimuscarinic/Antispasmodic Agents***

Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)	DONNATAL
Chlordiazepoxide/Clidinium	CHLORDIAZEPOXIDE/CLIDINIUM
Dicyclomine	BENTYL
Hyoscyamine Sulfate	LEVBID
	LEVSIN
	LEVSIN SL

## ***Antiulcer/Antipeptic Agents***

Antacid Mg OH/Al OH	MAALOX, TC
Antacid Mg OH/Al OH/Simethicone	MYLANTA I, II
Lansoprazole 15mg OTC	PREVACID 24HR, LEGEND LANSOPRAZOLE NON-FORMULARY
Misoprostol	CYTOTEC
Omeprazole 20mg and 40mg	PRILOSEC 20MG AND 40MG, OTHER STRENGTHS NON-FORMULARY
Omeprazole Magnesium	PRILOSEC OTC
Pantoprazole Tablets	PROTONIX
Simethicone	MYLICON
Sucralfate	CARAFATE

## ***Bowel Evacuant Agents***

QL	Bowel Evacuation Prep Kits	FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
QL	Enema	FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR
QL	Oral Colon Lavage Solution	COLYTE
QL	Oral Saline Laxative	FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR

## ***Digestive Enzymes***

Amylase/Lipase/Protease	PANCRELIPASE 5,000
Amylase/Lipase/Protease	CREON
Amylase/Lipase/Protease	PANCREAZE

## ***Gallstone Solubilizing Agents***

Ursodiol	ACTIGALL
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## ***Gastrointestinal Stimulant Agents***

Metoclopramide REGLAN

## ***H<sub>2</sub> Antagonist Agents***

Cimetidine TAGAMET  
Famotidine PEPCID  
Ranitidine ZANTAC (TABLETS ONLY)

## ***Laxative Agents***

QL Bisacodyl Suppositories DULCOLAX, LIMITED TO #30/MONTH  
Docusate Sodium Capsules COLACE  
QL Lactulose CEPHULAC, LIMITED TO 4L/MONTH  
QL Sennosides CHRONULAC, LIMITED TO 4L/MONTH  
SENNA

## ***Miscellaneous Gastrointestinal Supplies***

Ostomy Supplies

## ***Miscellaneous Gastrointestinal Agents***

Mesalamine DELZICOL  
ROWASA  
Olsalazine DIPENTUM  
Sulfasalazine AZULFIDINE  
PA Budesonide ENTOCORT EC, PA REQ

# **ANTI-INFECTIVE AGENTS**

## ***Amebicides***

Metronidazole FLAGYL; FLAGYL ER NON-FORMULARY  
Iodoquinol (Diiodohydroxyquin) YODOXIN

## ***Antihelminthic Agents***

Albendazole ALBENZA  
Furazolidone FUROXONE  
Mebendazole VERMOX  
Praziquantel BILTRICIDE

## ***Antibiotic Agents***

### ***Aminoglycosides***

Neomycin Sulfate MYCIFRADIN

### ***Cephalosporins***

QL Cefaclor CECLOR  
Cefadroxil DURICEF  
Cefdinir OMNICEF  
Cefixime SUPRAX, LIMITED TO #1 X 400MG/FILL  
Cefuroxime Tablets CEFTIN

	Cephalexin	KEFLEX; <b>750MG STRENGTH NON-FORMULARY</b>
QL	<b>Macrolide Antibiotic Agents</b>	
	Azithromycin	ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; <b>ZMAX NON-FORMULARY</b>
	Erythromycin Base	ERY-TAB PCE ERYPED SUSPENSION
PA	Erythromycin Stearate	ERYTHROCIN
	Erythromycin Ethylsuccinate	EES
	Erythromycin/Sulfisoxazole	PEDIAZOLE
	Clarithromycin	BIAXIN, <b>PA REQ</b>
	<b>Miscellaneous Antibiotic Agents</b>	
	Clindamycin	CLEOCIN
	Metronidazole	FLAGYL
	<b>Penicillins</b>	
	Amoxicillin	AMOXIL TRIMOX
	Amoxicillin/Potassium Clavulanate	AUGMENTIN
	Ampicillin	PRINCIPEN
	Dicloxacillin	DYNAPEN
	Penicillin VK (125mg Tablets Not Covered)	PEN VK
	<b>Quinolones</b>	
QL	Ciprofloxacin tablets	CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; <b>CIPRO XR AND PROQUIN XR NONFORMULARY</b>
QL	Moxifloxacin	AVELOX, LIMITED TO 21-DAY SUPPLY
	<b>Sulfonamide Agents</b>	
	Erythromycin/Sulfisoxazole	PEDIAZOLE
	Sulfamethoxazole/Trimethoprim (SMZ/TMP)	BACTRIM
	Sulfisoxazole	SEPTRA
	Sulfadiazine	GANTRISIN
	Trimethoprim	SULFADIAZINE TRIMPEX
	<b>Tetracyclines</b>	
	Doxycycline	VIBRAMYCIN VIBRA-TABS DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY
	Minocycline	MINOCIN
	Tetracycline	ACHROMYCIN V SUMYCIN
	<b>Antifungal Agents</b>	
	Clotrimazole	MYCELEX TROCHE
	Fluconazole	DIFLUCAN
	Griseofulvin Ultramicrosized	GRIS-PEG FULVICIN P/G
	Ketoconazole	NIZORAL
	Nystatin (Oral Powder Not Covered)	MYCOSTATIN
	Terbinafine Tablets	LAMISIL TABLETS
	<b>Antimalarial Agents</b>	
	Atovaquone/Proguanil	MALARONE
	Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
	Hydroxychloroquine	PLAQUENIL
	Iodoquinol	YODOXIN

Mefloquine  
Primaquine  
Pyrimethamine  
Quinine (260mg Not Covered)

LARIAM  
PRIMAQUINE  
DARAPRIM  
QUININE

## ***Antituberculosis Agents***

Ethambutol  
Isoniazid  
Pyrazinamide  
Rifabutin  
Rifampin

MYAMBUTOL  
ISONIAZID  
PYRAZINAMIDE  
MYCOBUTIN  
RIFADIN

## ***Anti-Ulcer Eradication Agents***

QL Amoxicillin/Clarithromycin/Lansoprazole  
QL Tetracycline/Bismuth/Metronidazole

PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR  
HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

## ***Other Antiviral Agents***

Amantadine  
Acyclovir Oral  
Oseltamivir  
  
Rimantadine  
Zanamivir  
  
Valacyclovir  
Famciclovir  
  
Nirmatrelvir/Ritonavir  
Molnupiravir  
Tecovirimat Oral

SYMMETREL  
ZOVIRAX ORAL  
TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT  
OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS  
FLUMADINE  
RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT  
OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS  
VALTREX  
FAMVIR, **STEP THERAPY**, RESTRICTED TO USE AFTER A TRIAL  
OF ACYCLOVIR IN THE PAST 90 DAYS  
PAXLOVID (EUA)  
LAGEVRIO (EUA)  
TPOXX (NATIONAL STOCKPILE)

## ***Leprostatic Agents***

Clofazimine  
Dapsone

LAMPRENE  
DAPSONE; **ACZONE NON-FORMULARY**

# **RESPIRATORY/ENT AGENTS**

## ***Antihistamine Agents***

### **Single Entity Alkylamine Agents**

Chlorpheniramine  
Dexchlorpheniramine

CHLORTRIMETON  
POLARAMINE

### **Single Entity Ethanolamine Agents**

Cyproheptadine  
Diphenhydramine

PERIACTIN  
BENADRYL

### **Non-Sedating Single Entity Agents**

Cetirizine, OTC  
Fexofenadine  
Loratadine, OTC

CETIRIZINE, OTC  
FEXOFENADINE  
LORATADINE, OTC

### **Miscellaneous Antihistamine Agents**

Hydroxyzine  
Hydroxyzine Pamoate  
Promethazine

ATARAX  
VISTARIL  
PHENERGAN

## Antihistamine/Decongestant Combination Agents

### Antihistamine/Decongestant Agents

Bromphen/Pseudoephedrine	BROMFED BROMFED PD
Guaifenesin/Pseudoephedrine	GUAIFED-PD
Pseudoephedrine/Chlorpheniramine	DECONAMINE SR

## Antitussive Agents

### Non-Narcotic Antitussive Agents

Benzonatate	TESSALON
Dextromethorphan	TUSSIN PEDIATRIC
Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

### Narcotic Antitussive Agents

Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
Guaifenesin/Codeine	ROBITUSSIN A-C
Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC ENDAL-HD
Promethazine/Codeine	PHENERGAN/CODEINE
Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE
Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
Triprolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE

### Decongestants

Pseudoephedrine	SUDAFED
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## Asthma/COPD Agents

### Inhaled Sympathomimetic (Adrenergic) Agents

QL	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, <b>PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.</b>
QL	Albuterol/Ipratropium	COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
QL	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	Ipratropium	ATROVENT HFA
QL	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
QL	Salmeterol	SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	Mometasone/Formoterol	DULERA, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA), ANTICHOLINERGIC, OR ANTICHOLINERGIC/LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
SE, QL	Salmeterol/Fluticasone	ADVAIR DISKUS 250/50 STRENGTH ONLY, <b>STEP THERAPY</b> , RESTRICTED TO COPD AFTER A TRIAL ANTICHOLINERGIC OR LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH

### Oral Sympathomimetic (Adrenergic) Agents

Albuterol	PROVENTIL
Albuterol E.R.	PROVENTIL REPETABS
Metaproterenol Oral	VOLMAX
Terbutaline Sulfate	ALUPENT BRETHINE BRICANYL

### Inhaled Oral Corticosteroid Agents

QL	Beclomethasone Inhaler	QVAR REDHALER, LIMITED TO #2 INHALERS/MONTH
QL	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH
	<b>Leukotriene Receptor Antagonists</b>	
QL	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
	<b>Respiratory Smooth Muscle Relaxant Agents</b>	
	Aminophylline 150mg/5ml	
	Aminophylline Suppositories	
	Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80
	Theophylline	SLO-PHYLLIN
	Theophylline, Sustained Release	THEO-DUR, SLO-BID, UNIPHYL

## **Expectorant Agents**

Guaifenesin	ROBITUSSIN
Guaifenesin/Dextromethorphan	ROBITUSSIN DM
Guaifenesin/Phenylephrine	ENDAL
Guaifenesin/Pseudoephedrine	ZEPHREX LA
Phenylephrine/Promethazine	PHENERGAN VC
Phenylephrine/Guaifenesin	RESCON GC
Potassium Iodide	SSKI

## **Mucolytic Agents**

Acetylcysteine	MUCOMYST
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## **Eye, Ear, Nose and Throat (EENT) Preparations**

### **Ophthalmic Antibiotic Agents**

Bacitracin	BACITRACIN
Dexamethasone/Polymyxin/Neomycin	MAXITROL
Erythromycin Base	ILOTYCIN
Gentamicin	GARAMYCIN
Gentamicin/Prednisolone	PRED-G
Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
Ofloxacin	OCUFLOX
Polymixin B Sulfate/TMP	POLYTRIM
Tobramycin	TOBREX

### **Ophthalmic Anti-Inflammatory Agents, Corticosteroid**

Fluorometholone	EFLONE
	FML
	FML FORTE
Prednisolone Acetate	PRED MILD OPHTHALMIC
	PRED FORTE
Prednisolone Phosphate	INFLAMASE
	INFLAMASE FORTE

### **Ophthalmic Anti-Inflammatory Agents, NSAIDs**

Flurbiprofen Sodium	OCUFEN
Diclofenac Sodium	VOLTAREN
Ketorolac Tromethamine	ACULAR

### **Ophthalmic Antiviral Agents**

Trifluridine Ophthalmic Solution	VIROPTIC
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### **Ophthalmic Beta Blockers**

Levobunolol	BETAGAN
Timolol	TIMOPTIC

### **Ophthalmic Miotic Agents**

Brimonidine  
Dorzolamide  
Dorzolamide/Timolol  
Echothiophate Iodide  
Pilocarpine

ALPHAGAN  
ALPHAGAN P  
TRUSOPT  
COSOPT  
PHOSPHOLINE IODIDE  
PILOCAR  
OCUSERT NOT COVERED

### **Ophthalmic Mydriatic Agents**

Atropine Sulfate  
Dipivefrin  
Tropicamide

ISOPTO ATROPINE  
PROPINE  
MYDRIACYL

### **Ophthalmic Sulfonamide Agents**

Sulfacetamide

BLEPH-10  
SODIUM SULAMYD  
BLEPHAMIDE  
METIMYD

Sulfacetamide 10%/Prednisolone 0.2%  
Sulfacetamide 10%/Prednisolone 0.5%

### **Miscellaneous Ophthalmic Agents**

Ketotifen  
Latanoprost  
Naphazoline  
Naphazoline/Pheniramine

ZADITOR OTC, ALAWAY  
XALATAN  
ALBALON  
NAPHCN-A

### **Otic Anti-Infective Agents**

Acetic Acid  
Acetic Acid 2%  
Acetic Acid 2%/Hydrocortisone 1%  
Hydrocortisone/Neomycin/Polymyxin  
Ofloxacin

VOSOL  
DOMEBORO  
VOSOL HC  
CORTISPORIN  
FLOXIN OTIC

### **Miscellaneous Otic Agents**

Benzocaine/Antipyrine  
Carbamide Peroxide/Glycerin

AURALGAN  
DEBROX

## ***Inhaled/Oral EENT Agents***

### **Inhaled Nasal Agents**

Fluticasone, Nasal  
Triamcinolone, Nasal  
Ipratropium, Nasal

FLONASE  
NASACORT  
ATROVENT, LIMITED TO #2 DEVICES/MONTH

QL

### **Carbonic Anhydrase Inhibitor Agents**

Acetazolamide  
Acetazolamide SA  
Methazolamide

DIAMOX  
DIAMOX SEQUELS  
NEPTAZANE

### **Local Anesthetic Agents**

Benzocaine/Antipyrine Otic  
Lidocaine Solution  
Lidocaine, Viscous  
Triamcinolone 0.1% in Orabase

AURALGAN  
XYLOCAINE  
VISCIOUS XYLOCAINE  
KENALOG IN ORABASE

## ***Miscellaneous EENT Agents***

Carbachol  
Chlorhexidine Gluconate  
Cromolyn Ophthalmic Solution  
Epinephrine Injection  
Optichamber  
Sodium Chloride for Inhalation  
Triethanolamine

ISOPTO CARBACHOL  
PERIDEX  
CROLOM  
EPIPEN  
OPTICHAMBER, LIMITED TO #2/YEAR  
GENERIC  
CERUMENEX

QL

# DIABETES AND THYROID AGENTS

## Oral Diabetes Agents

### Sulfonylureas

Glipizide	GLUCOTROL
Glipizide L.A.	GLUCOTROL XL
Glyburide	DIABETA, GLYNASE
	MICRONASE
Glimepiride	AMARYL
Chlorpropamide	DIABINESE
Tolazamide	TOLINASE
Tolbutamide	ORINASE

### Non-Sulfonylureas

	Acarbose	PRECOSE
	Metformin	GLUCOPHAGE
	Metformin ER	GLUCOPHAGE XR
SE, QL	Pioglitazone	ACTOS
	Alogliptin	NESINA, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH
SE, QL	Sitagliptin	JANUVIA, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

### Combination Diabetes Agents

	Glipizide/Metformin	METAGLIP
SE, QL	Glyburide/Metformin	GLUCOVANCE
	Alogliptin/Metformin	KAZANO, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR ALOGLIPTIN IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin	JANUMET, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin Extended Release	JANUMET XR, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH

## Insulin Agents

### Rapid-Acting Insulins

Insulin Lispro	INSULIN LISPRO VIAL & KWIKPEN U-100
Insulin Lispro Protamine/Insulin Lispro	INSULIN LISPRO PROTAMINE MIX 75-25 PEN; HUMALOG MIX 75-25 VIAL; HUMALOG MIX 50-50 VIAL & KWIKPEN



Insulin Aspart  
Insulin Aspart Protamine/Insulin Aspart  
**Regular Insulins**  
Insulin Regular  
Insulin NPH  
Insulin NPH/ Insulin Regular  
**Long-Acting Insulins**  
Insulin Glargine  
Insulin Glargine-AGLR  
Insulin Glargine-YFGN

NOVOLOG VIAL & FLEXPEN  
INSULIN ASPART PROTAMINE/INSULIN ASPART MIX 70-30  
VIAL, NOVOLOG MIX 70-30 VIAL & FLEXPEN  
  
HUMULIN R VIAL  
HUMULIN N VIAL & KWIKPEN  
HUMULIN MIX 70-30 VIAL & KWIKPEN  
  
INSULIN GLARGINE VIAL, LANTUS VIAL & SOLOSTAR PEN  
REZVOGLAR KWIKPEN  
INSULIN GLARGINE-YFGN VIAL & PEN

## ***Miscellaneous Diabetes Agents***

Glucagon

GLUCAGON

## ***Thyroid Agents***

Levothyroxine  
Liotrix  
Liothyronine  
Thyroid, Desiccated

LEVOTHROID  
THYROLAR  
CYTOMEL  
ARMOUR THYROID  
LEVOXYL  
SYNTHROID

### **Antithyroid Agents**

Methimazole  
Propylthiouracil

TAPAZOLE  
PROPYLTHIOURACIL

# **HORMONE AGENTS**

## ***Oral Adrenal Corticosteroid Agents***

Cortisone Acetate  
Dexamethasone  
Fludrocortisone Acetate  
Hydrocortisone Oral  
Methylprednisolone  
Prednisone

CORTONE  
DECADRON  
FLORINEF  
CORTEF  
MEDROL  
DELTASONE  
ORASONE  
MEDROL DOSEPAK  
PEDIAPRED  
PRELONE

Prednisolone

## ***Androgen Agents***

Danazol  
Fluoxymesterone  
Methyltestosterone

DANOCRINE  
HALOTESTIN  
ANDROID  
METANDREN

## ***Bone Resorption Inhibitors***

QL Alendronate

FOSAMAX,  
70MG AND 35MG LIMITED TO #4/MONTH;  
5MG, 10MG, AND 40MG LIMITED TO #30/MONTH;  
SOLUTION LIMITED TO #300ML/MONTH  
**FOSAMAX PLUS D NONFORMULARY**

PA                      Calcitonin    MIACALCIN NS, **PA REQ**

## ***Parathyroid Hormone***

PA, QL                      Teriparatide    FORTEO, **PA REQ**, LIMITED TO 1 PEN/MONTH

## ***Estrogen Agents***

	Conjugated Estrogens	PREMARIN
	Conjugated Estrogens, Vaginal	PREMARIN VAGINAL CREAM
	Estradiol	ESTRACE
	Estradiol Patches	ALORA
		CLIMARA
		ESTRADERM
		VIVELLE
		VIVELLE DOT
	Estrogen/Medroxyprogesterone	PREMPRO, PREMPRO LOW DOSE
		PREMPHASE
	Esterified Estrogens/Methyltestosterone	ESTRATEST, ESTRATEST HS
SE	Estradiol/Vaginal Ring	ESTRING, <b>STEP THERAPY</b> , RESTRICTED TO USE AFTER A TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

## ***Estrogen Agonist-Antagonists***

Raloxifene    EVISTA

## ***Contraceptives***

Contraceptives are not a covered benefit.

## ***Oxytocic Agents***

Ergonovine Maleate	ERGOTRATE
Methylergonovine Maleate	METHERGINE

## ***Pituitary Agents***

Desmopressin    DDAVP

## ***Progestin Agents***

Medroxyprogesterone	CYCRIN
	PROVERA
Norethindrone Acetate	AYGESTIN
	NORLUTATE

# **GENITOURINARY AGENTS**

## ***Urinary Anti-Infective Agents***

Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
Nitrofurantoin (Tablets, Suspension Only)	FURADANTIN
Trimethoprim	TRIMPEX

## ***Urinary Anti-Spasmodic Agents***

Pentosan	ELMIRON
Phenazopyridine	PYRIDIUM

## ***Genitourinary Smooth Muscle Relaxant Agents***

	Belladonna/Methylene Blue Oxybutynin	URISED DITROPAN DITROPAN XL NOT COVERED
ST, QL	Tolterodine	DETROL, <b>STEP THERAPY</b> , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS
ST, QL		DETROL LA, <b>STEP THERAPY</b> , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS

## ***Parasympathomimetic (Cholinergic) Agents***

Bethanechol	URECHOLINE
Neostigmine	PROSTIGMIN
Pyridostigmine	MESTINON

# **TOPICAL/MUCOUS MEMBRANE AGENTS**

## ***Keratolytic Agents***

Anthralin	DRITHOCREME
	DRITHO-SCALP
Podofilox	CONDYLOX

## ***Miscellaneous Skin/Mucous Membrane Agents***

	Aluminum Acetate	BURROWS SOLUTION
	Aluminum Chloride Hexahydrate	DRYSOL
	Benzoyl Peroxide, OTC Generic	BENZOYL PEROXIDE, OTC GENERIC
	Calamine	CALAMINE LOTION
	Calcipotriene	DOVONEX
	Fluorouracil	EFUDEX
	Hydrocortisone 1% Rectal	PROCTOCORT
	Masoprocol	ACTINEX
PA	Becaplermin	REGGRANEX, <b>PA REQ</b>
PA	Isotretinoin	ACCUTANE, <b>PA REQ</b>

## ***Topical Antibiotic Agents***

Bacitracin	BACITRACIN
Bacitracin/Polymixin/Neomycin	NEOSPORIN
Clindamycin Solution	CLEOCIN T
Erythromycin Topical	ERYGEL
	EMGEL
	T-STAT
Erythromycin/Benzoyl Peroxide	BENZAMYCIN
Gentamicin Sulfate	GARAMYCIN
Mupirocin	BACTROBAN
Silver Sulfadiazine	SILVADENE

## ***Topical Antifungal Agents***

Clotrimazole	LOTRIMIN
Clotrimazole/Betamethasone	LOTRISONE

Ciclopirox  
Ketoconazole  
Miconazole Nitrate  
Nystatin  
Terbinafine  
Tolnaftate  
Triamcinolone/Nystatin

LOPROX  
NIZORAL  
MONISTAT-DERM  
MYCOSTATIN  
LAMISIL  
TINACTIN  
MYCOLOG II

## ***Vaginal Antifungal Agents***

Butoconazole  
Clotrimazole Cream/Vaginal Tablets

Nystatin  
Miconazole Cream/Vaginal Tablets

Triple Sulfa Cream  
Tioconazole

FEMSTAT  
MYCELEX  
MYCELEX G  
MYCOSTATIN  
MONISTAT  
MONISTAT 3  
SULTRIN  
VAGISTAT-1

## ***Vaginal Anti-Infective Agents***

Metronidazole

METROGEL-VAGINAL

## ***Topical Anti-Inflammatory Agents***

### **LOW POTENCY**

Fluocinolone 0.025%  
Desonide  
Hydrocortisone  
Hydrocortisone Enema  
Hydrocortisone Acetate  
Hydrocortisone/Pramoxine

### **MEDIUM POTENCY**

Betamethasone Dipropionate  
  
Betamethasone Valerate 0.01%  
Betamethasone Valerate 0.1%  
Desoximetasone Cream/Gel 0.05%  
Flurandrenolide  
Hydrocortisone Valerate  
Mometasone Furoate Cream  
Triamcinolone

### **HIGH POTENCY**

Betamethasone Dipropionate  
Desoximetasone 0.25%  
Fluocinonide

Fluocinolone Acetonide 0.2%

### **VERY HIGH POTENCY**

Augmented Betamethasone  
Dipropionate  
Clobetasol Cream, Gel, Solution,  
Ointment  
Diflorasone Diacetate

SYNALAR  
TRIDESILON  
HYTONE  
CORTENEMA  
CORTIFOAM  
PROCTOCREAM-HC

DIPROSONE  
MAXIVATE  
VALISONE REDUCED STRENGTH  
VALISONE  
TOPICORT LP  
CORDRAN  
WESTCORT  
ELOCON  
ARISTOCORT  
ARISTOCORT A NOT COVERED  
KENALOG

DIPROLENE  
TOPICORT  
LIDEX  
LIDEX E  
SYNALAR

DIPROLENE AF

TEMOVATE

FLORONE  
FLORONE-E  
PSORCON

## **Topical Antipruritic and Local Anesthetic Agents**

	Lidocaine (Viscous and Spray Only)	XYLOCAINE
	Pramoxine/Hydrocortisone	PROCTOFOAM HC
	Pramoxine	EPIFOAM
PA	Pimecrolimus	ELIDEL, <b>PA REQ</b>
PA	Tacrolimus	PROTOPIC, <b>PA REQ</b>

## **Topical Antiviral Agents**

Acyclovir Topical	ZOVIRAX OINTMENT
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## **Topical Miscellaneous Anti-Infective Agents**

Selenium Sulfide 2.5%	EXSEL
	SELSUN
Sulfacetamide Lotion	SEBIZON

## **Scabicide/Pediculicide Agents**

Crotamiton	EURAX
Malathion	OVIDE
Permethrin	ELIMITE
	NIX

# **MISCELLANEOUS/UNCLASSIFIED AGENTS**

## **Electrolyte Agents**

### **Miscellaneous Agents**

Calcium Acetate	PHOS LO
Calcium Carbonate	TUMS
Magnesium Oxide, OTC Generic	MAGNESIUM OXIDE, OTC GENERIC

### **Potassium Agents**

<i>Potassium Chloride 8mEq</i>	
Potassium Chloride	MICRO-K
<i>Potassium Chloride 10mEq</i>	
Potassium Chloride	KAON-CL 10
	K-DUR
	MICRO-K 10
<i>Potassium Chloride 20mEq</i>	
Potassium Chloride	K-DUR
<i>Potassium Chloride Effervescent Tablets</i>	
Potassium Chloride Tablets	K-LYTE
Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>	
Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>	
Potassium Chloride Liquid	KAON-CL
<i>Potassium-Removing Resins</i>	
Sodium Polystyrene Sulfonate	KAYEXALATE

## **Heavy Metal Antagonist Agents**

Penicillamine	CUPRIMINE
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## ***Vitamin Agents***

### **Vitamin B-Complex Agents**

Cyanocobalamin  
Folic Acid  
Niacin  
Pyridoxine  
Thiamine

VITAMIN B<sub>12</sub> (ORAL FORMULATIONS ONLY)  
FOLIC ACID  
NIACIN  
VITAMIN B<sub>6</sub>  
VITAMIN B<sub>1</sub>

### **Vitamin D**

Calcitriol  
Ergocalciferol

ROCALTROL  
DRISDOL

### **Vitamin K Activity Agents**

Phytonadione

MEPHYTON

### **Iron Agents**

Ferrous Sulfate (Tablets, Liquid, Drops)

FEOSOL

## ***Diagnostic Testing***

### **Blood Glucose Supplies**

QL Alcohol Swabs  
Blood Glucose Monitoring Control  
Solution  
QL Blood Glucose Test Strips

LIMITED TO 200/MONTH  
BLOOD GLUCOSE MONITORING CONTROL SOLUTION, **ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY**  
BLOOD GLUCOSE TEST STRIPS, **ROCHE STRIPS (E.G., ACCU-CHEK) ONLY**, LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS.  
MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH.  
LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION  
GLUCOMETERS, **ROCHE METERS (E.G., ACCU-CHEK) ONLY**

Glucometers  
Lancets

## ***Alcohol And Smoking Deterrent Agents***

PA Bupropion SR ZYBAN, **PA REQ**  
Disulfiram ANTABUSE  
PA Nicotine NICORETTE GUM, **PA REQ**  
PA NICOTINE PATCH, **PA REQ** (OTC PATCHES ONLY)  
PA NICOTROL NASAL SPRAY, **PA REQ**

## ***Gout Agents***

QL Allopurinol ZYLOPRIM  
Colchicine COLCRYS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1  
TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.  
Probenecid BENEMID

## Vaccinations

Immunizations covered at zero cost share to members for *routine* use or with shared clinical decision-making as defined by the Centers for Disease Control and Prevention (CDC), or the Advisory Committee on Immunization Practices (ACIP) recommended immunizations for all persons for the vaccines listed below.

QL, Age	Influenza	FLUBLOK, AGE ≥ 18 YO, LIMITED TO 1 DOSE/180 DAYS FLUZONE HIGH DOSE AND FLUAD, AGE ≥ 65 YO, LIMITED TO 1 DOSE/180 DAYS
QL, Age	COVID-19	COMIRNATY, NOVAVAX, SPIKEVAX, AGE ≥ 18 YO, LIMITED TO 1/FILL
QL, Age	Human Papillomavirus	GARDASIL 9, AGE 18-45 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Hepatitis A	VAQTA, HAVRIX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Hepatitis B	ENGERIX-B ADULT, AGE ≥ 18 YO, LIMITED TO 4 DOSES/365 DAYS HEPLISAV-B, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS PREHEVBRIO, RECOMBIVAX HB, AGE ≥ 18 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Hepatitis B/Hepatitis A Combo	TWINRIX, AGE ≥ 18 YO, LIMITED TO 4 DOSES/365 DAYS
QL, Age	Measles, Mumps, Rubella	MMR, PRIORIX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Meningococcal Serogroup B	BEXSERO, AGE 18-25 YO, LIMITED TO 2 DOSES/365 DAYS TRUMENBA, AGE 18-25 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Meningococcal Quadrivalent Conjugate	MENACWY [MENVEO, MENQUADFI], AGE 18-23 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Meningococcal ACWY-B	PENBRAYA, AGE 18-25 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Pneumococcal 15-Valent Conjugate	VAXNEUVANCE, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
	Pneumococcal 20-Valent Conjugate	PREVNAR 20, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
	Pneumococcal polysaccharide	PNEUMOVAX 23, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Poliovirus	IPOL, AGE ≥ 18 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Respiratory Syncytial Virus (RSV)	ABRYSVO, AREXVY, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS (FOR ABRYSVO ONLY: IF AGE < 60 YO AND PREGNANT, LIMITED TO 1 DOSE/365 DAYS)
QL, Age	Tetanus, Diphtheria, Pertussis	TDAP, AGE ≥ 18 YO, LIMITED TO 1 DOSE/365 DAYS
	Tetanus, Diphtheria	TD, AGE ≥ 18 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Varicella	VARIVAX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Zoster Vaccines, Recombinant	SHINGRIX, AGE ≥ 50 YO, LIMITED TO 2 DOSES/365 DAYS

## ***Other Medical Supplies***

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. Connect to Care does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms)



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