



## Santa Clara Family Health Plan

### 2011-2012 *Drug Formulary Listing*

#### **Introduction**

The Santa Clara Family Health Plan (SCFHP) *Drug Formulary* provides a list of preferred medications in various therapeutic classes for use in complying with the prescription medication needs of the health plan members. The Drug Formulary list applies only to prescriptions dispensed to outpatient and does not include inpatient medications and drugs administered in a physician's office or clinic. The following formulary applies to **Medi-Cal, Healthy Kids and Healthy Families**.

#### **Overview**

The SCFHP Pharmacy and Therapeutics (P&T) Committee composed of physicians and pharmacists determine the content of the *Drug Formulary*. The principal consideration in the selection of drugs for inclusion in the formulary is to provide the safest, most effective, and most economical medications for all possible disease states.

#### **Formulary Updates**

The P&T Committee meets every quarter to review new drugs and existing drugs including trends in drug therapy. They provide clinical recommendations based on similarities and differences compared with other drugs that treat the same condition.

Notification of revisions to the SCFHP *Drug Formulary* will be disseminated via periodic distributions to providers. A complete and updated formulary will be posted on the SCFHP website [www.scfhp.com](http://www.scfhp.com) to reflect any P&T approved changes.

#### **Over-the Counter and Therapeutically Equivalent Medications**

Medications listed in the *Drug Formulary* with over-the-counter (OTC) equivalents are covered for Medi-Cal members unless otherwise specified. A prescription written by a licensed prescriber is required for reimbursement with the prescriber's DEA and NPI number. The hardcopy of the prescription should be filed and must be labeled in accordance with legend prescription requirements. Over-the-counter medications are not a covered drug benefit for Healthy Families and Healthy Kids.

#### **Generic Medications**

The appropriate use of generic drugs is one method of providing cost-conscious drug therapy. A generic drug is the pharmaceutical equivalent of brand-name drug that has been approved by the Food and Drug Administration (FDA) meeting the same standards of safety, purity, and effectiveness of the brand-name drug. SCFHP Pharmacy Network providers will dispense available generic equivalent drugs if the prescribed drug is medically appropriate and safe.

#### **Specialty Drug Program**

Specialty drugs are high-cost drugs that may be used to treat complex medical health conditions. They are either oral specialty medications or self-administered drugs. Prior Authorization is required prior to filling the medication. A one-time fill may be obtained at a local retail pharmacy and subsequent refills will be obtained through a contracted Specialty Pharmacy Network Provider. For more information, please call SCFHP Pharmacy Department at 408-874-1796.

#### **Drugs administered by Physician/Clinics**

Any drug administered by a physician or clinic, including injectable anti-neoplastic medications, needs to be billed as a medical claim by the physician or clinic and not by the dispensing pharmacy providing the drug for such administration.

### **Formulary Exclusions**

Certain medications are not eligible for coverage under the member's pharmacy benefit. These include the following:

- All drugs bearing a label: "Caution – limited by federal law to investigational use." Or experimental drugs.
- Fertility drugs, oral, injectable or vaginal
- Products used for cosmetic indications
- OTC products (not a covered benefit for **Healthy Kids** and **Healthy Families**)
- Any drug used for erectile dysfunction
- Alcohol, heroine detoxification and dependency treatment drugs (ie.Suboxone)
- Medi-Cal "Carve-Out" Drugs
  - HIV-AIDS drugs
  - Atypical Anti-Psychotics

### **Price Restrictions**

Non-compound claims with dollar amounts greater than \$500 and compound claims with dollar amounts greater than \$50 will reject with messaging "Max Claim Pay Exceeded." These claims will require an operational prior authorization for review of correct claim submission, dosing and pricing which justifies the high-cost claim. The dispensing pharmacy may call MedImpact at 800-788-2949. MedImpact staff will ensure that the pharmacy is billing correctly and enter a prior authorization if appropriate.

### **Up to 5-Day Emergency Supply Policy**

**At any time, the pharmacy may utilize the Emergency Supply Plan.** If a contracted pharmacy cannot fill a prescription upon the time of service, and the medication is urgently needed, Santa Clara Family Health Plan allows the dispensing of up to 5-day supply of non-covered medication. This policy has been created to ensure members receive medication in appropriate situations to cover temporary delays that might prevent prescriptions from being filled at the time of service. The dispensing pharmacist will use his/her clinical judgment to determine whether the situation is an emergency. **Please call the MedImpact Customer Service Center at 1-800-788-2949 in order in order to request an up to 5-day supply override.**

### **Prior Authorization Process**

SCFHP encourages providers to prescribe formulary medications whenever possible. However, when a provider elects to prescribe a drug requiring prior authorization (PA) a PA request form must be completed by the pharmacy or physician and **faxed to Santa Clara Family Health Plan at 408-874-1444.** Determinations of approval or denial for prior authorization requests are provided within 24 business hours as long as all of the information required to make a decision is included. **Prior authorization hours are Monday through Friday 8:30a.m. to 5:00 p.m. PST (Pacific Standard Time) excluding holidays.** Note: For **urgent prior authorization requests**, please check the "urgent" box on the PA Form.

The following claims situations require prior authorization:

- Non-formulary drugs
- Formulary drugs for which the limitations and/or restrictions listed have not been met or are exceeded such as step therapy or quantity limit restrictions.

For a copy of the PA form, please email [pharmacy@scfhp.com](mailto:pharmacy@scfhp.com) or call the SCFHP Pharmacy Department at 408-874-1796.

All required fields of the Drug PA form should be completed to avoid delay on the review of the request. Incomplete or illegible forms will be returned or pended for clarification or additional information.

The required fields are as follows:

- Patient name and SCFHP ID number
- Diagnosis – for the requested drug
- Name, strength, size of medication and NDC number
- Quantity
- Days Supply

- Expected total duration of therapy
- Pharmacy name, fax and phone number
- Physician name and phone number
- Physician's medical specialty (board certification)
- Medical justification
- Other drugs tried and failed and their reasons for failure
- Any supporting lab values/documentation (e.g. C&S reports, lipid panel results, chemistry panels, weight/height or growth chart, etc.)
- Any specialty consult recommendations, including medical procedures (e.g. Psychiatry, GI, Neurology consultation)

If a prior authorization request is approved, the pharmacy may adjudicate the claim on-line as directed by the PA fax-back message from SCFHP. There is no need for a prior authorization number. For all other related PA status or questions, please call the SCFHP Pharmacy Department at **408-874-1796 during regular business hours.**

### **Copay**

Healthy Families and Healthy Kids do have \$5 or \$10 copay for their prescriptions. No out-of-pocket payment for medically necessary prescription medications may be requested from Medi-Cal members.

### **Formulary Legend**

**B/ G** = Brand and generic indicators. Indicates if the drug is available as a brand or generic agent. In some cases certain strengths are only available as brands while other strengths are available generically. In these cases the designation is dependent on whether more strength is available as brands or generics.

**Representative Brand** = In some cases there is more than one brand name for the generic equivalent. In these cases one brand name is used to represent multiple products.

**QL** = Indicates the medication has a quantity restriction. Requests for quantities higher than the indicated amount require prior authorization.

**Age** = Indicates that there is an age restriction when obtaining this medication.

**ST** = Step therapy. Step therapies indicate that another drug is requested to be tried first before the 2<sup>nd</sup> line agent will approve online. If the provider feels the first line agent is inappropriate then a prior authorization can be requested.

**Day Supply** = Indicates the medication can be dispensed for more than a month's supply.

### **Formulary Addition Request**

A participating physician or pharmacist provider may suggest the addition of a medication to the Drug Formulary. To request a formulary addition, please complete the "*Formulary Addition Request Form*" and submit to the address listed below no later than 4 weeks prior to the next P&T Committee meeting:

Santa Clara Family Health Plan  
210 East Hacienda Ave  
Campbell, CA 95008  
**ATTN: Pharmacy Department**

**OR email: [pharmacy@scfhp.com](mailto:pharmacy@scfhp.com)**

For your convenience, a copy of this form is located on page v.

### **Disclaimer**

Our formulary is updated by a group of community physicians and pharmacists periodically and therefore the status for any medication may change throughout the year. The benefits are subject to the plan provisions in effect when services are given including patient eligibility and any plan limitations or exclusions. For clarification on coverage of any medication, please contact SCFHP Member Services at 1-800-260-2055.



**Santa Clara  
Family Health Plan**

## Pharmacy & Therapeutics Committee Formulary Addition Request Form

**Note: This form must be completed and signed by the requestor. All requests must be received by the SCFHP Pharmacy Department no later than 4 weeks prior to the next P & T Committee meeting. A written response will be provided to the requestor with the P&T decision after the review.**

<b>REQUESTED DRUG INFORMATION</b>	<b>DATE:</b>
<b>Generic Name:</b>	<b>Brand Name:</b>
<b>Dosage Form:</b>	<b>Strength:</b>
<b>FDA Approved Indications:</b>	
<b>Other indications for which the drug is being used:</b>	
<b>For which of the SCFHP Drug Formulary drugs (if any) may the requested drug be therapeutically substituted. Name of the Drug(s) :</b>	
<b>Please provide rationale for addition of the drug to the formulary.</b>	
<b>REFERENCE:</b> Cite or furnish published peer reviewed literature which demonstrates therapeutic advantages of the requested drug over the comparable drug currently on the Drug Formulary list.	
<b>Conflict of Interest Disclosure: (Circle and attach comments if applicable):</b>	
1. Do you now or have you in the past have received research/financial support from the manufacturer of the requested drug? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
2. Do you have a consulting agreement with the manufacturer of the requested drug? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
3. Do you <b>OR</b> your immediate members of your family have any financial interests in the manufacturer of the requested drug? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
4. Have you received gifts or any monetary benefits worth an annual total of greater than \$50 from the manufacturer of the requested drug? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)	
<b>Printed Name:</b>	<b>Phone Number:</b>
	<b>Fax Number:</b>
<b>Specialty:</b>	<b>E-mail address:</b>
<b>SCFHP Network :</b>	<b>Mailing Address:</b>

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please Submit Your Request to:*  
**Santa Clara Family Health Plan, ATTN: Pharmacy Department**  
**210 E Hacienda Ave, Campbell, CA 95008 OR Fax to: (408) 874-1444**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
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**ALLERGY**

**2ND GEN ANTIHISTAMINE & DECONGESTANT COMBINATIONS**

B	SEMPREX-D Limit of 2 tabs per day.	PSEUDOEPHEDRINE HCL/ACRIVAS	X			
B	ZYRTEC-D Limit of 2 per day. Requires history of loratadine or nasal steroid in past 120 days.	P-EPHED HCL/CETIRIZINE HCL	X		X	

**ANTIHISTAMINES - 1ST GENERATION**

G	ATARAX	HYDROXYZINE HCL				
G	BENADRYL	DIPHENHYDRAMINE HCL				
G	CHLOR-TRIMETON	CHLORPHENIRAMINE MALEATE				
G	LODRANE	BROMPHENIRAMINE MALEATE				
G	PEDIATAN	CHLORPHENIRAMINE TANNATE				
G	PERIACTIN	CYPROHEPTADINE HCL				
G	PHENERGAN	PROMETHAZINE HCL				
G	VISTARIL	HYDROXYZINE PAMOATE				
G	ZYMINE	TRIPROLIDINE HCL				

**ANTIHISTAMINES - 2ND GENERATION**

B	ALLEGRA	FEXOFENADINE HCL	X			
G	CHILDREN'S ALLEGRA ALLERGY Formulary for <= 12 y.o.	FEXOFENADINE		X		
G	CLARITIN	LORATADINE				
G	ZYRTEC	CETIRIZINE HCL				

**NASAL ANTIHISTAMINE**

B	ASTELIN	AZELASTINE HCL				
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**NASAL ANTI-INFLAMMATORY STEROIDS**

B	BECONASE AQ	BECLOMETHASONE DIPROPIONATE				<= 90
G	FLONASE	FLUTICASONE PROPIONATE				<= 90
B	NASACORT AQ	TRIAMCINOLONE ACETONIDE				<= 90
B	NASONEX	MOMETASONE FUROATE				
B	RHINOCORT AQUA	BUDESONIDE				<= 90

**NASAL MAST CELL STABILIZERS AGENTS**

G	NASALCROM	CROMOLYN SODIUM				
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**ANTIEMESIS/ANTIVERTIGO****ANTIEMETIC/ANTIVERTIGO AGENTS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G ANTIVERT	MECLIZINE HCL				
G COMPAZINE	PROCHLORPERAZINE MALEATE				
G EMETROL Limit of 240mls per month.	PHOSP AC,DIL/DEXTROSE/FRUCTOSE				
G PHENERGAN	PROMETHAZINE HCL				
G TIGAN Limit of 4 per day.	TRIMETHOBENZAMIDE HCL/B-CAINE	X			
G ZOFRAN	ONDANSETRON				

Representative Brand	Generic Name	QL	Age	ST	Day Supply
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## **ASTHMA**

### **BETA-ADRENERGIC AGENTS**

G	ACCUNEB	ALBUTEROL SULFATE				<= 90
G	ALUPENT	METAPROTERENOL SULFATE				<= 90
G	BRETHINE Requires history of oral albuterol sulfate.	TERBUTALINE SULFATE			X	<= 90
B	COMBIVENT	ALBUTEROL SULFATE/IPRATROPIUM				
G	DUONEB Requires trial of albuterol-ipratropium or ipratropium in the last 90 days.	ALBUTEROL SULFATE/IPRATROPIUM			X	
B	FORADIL Requires history of an inhaled corticosteroid.	FORMOTEROL FUMARATE			X	<= 90
B	PROAIR HFA Limit of 2 inhalers per month.	ALBUTEROL SULFATE	X			<= 90
B	SEREVENT DISKUS Requires history of an inhaled corticosteroid. Limit of 1 package per month.	SALMETEROL XINAFOATE	X		X	<= 90

### **BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS**

B	DULERA Requires history of an inhaled corticosteroid or short acting beta agonist.	MOMETASONE/FORMOTEROL			X	
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### **BETA-ADRENERGICS AND GLUCOCORTICIDS COMBINATION**

B	ADVAIR DISKUS Requires history of an inhaled corticosteroid or short acting beta agonist.	FLUTICASONE/SALMETEROL			X	<= 90
B	ADVAIR HFA Requires history of an inhaled corticosteroid or short acting beta agonist.	FLUTICASONE/SALMETEROL			X	<= 90
B	SYMBICORT Requires history of an inhaled corticosteroid or short acting beta agonist.	BUDESONIDE/FORMOTEROL FUMARATE			X	

### **GENERAL BRONCHODILATOR AGENTS**

G	ATROVENT	IPRATROPIUM BROMIDE				<= 90
B	ATROVENT HFA	IPRATROPIUM BROMIDE				<= 90
B	BRONCAP	GUAIFENESIN/THEOPHYLLINE				<= 90
B	BRONCODUR	GUAIFENESIN/THEOPHYLLINE				<= 90
B	DIFIL-G	GUAIFENESIN/DYPHYLLINE				
B	DILEX-G 200	GUAIFENESIN/DYPHYLLINE				
B	DILEX-G 400	GUAIFENESIN/DYPHYLLINE				
G	ED-BRON G	GUAIFENESIN/THEOPHYLLINE				<= 90
B	ELIXOPHYLLIN GG	GUAIFENESIN/THEOPHYLLINE				<= 90
G	LUFYLLIN-GG	GUAIFENESIN/DYPHYLLINE				
B	QUIBRON	GUAIFENESIN/THEOPHYLLINE				<= 90
B	SPIRIVA Requires history of ipratropium bromide or Combivent. Limit of 1 per day.	TIOTROPIUM BROMIDE	X		X	<= 90

**ASTHMA****LEUKOTRIENE RECEPTOR ANTAGONISTS**

B	ACCOLATE Requires history of an inhaled corticosteroid, nasal corticosteroid, short acting beta agonist, or cromolyn.	ZAFIRLUKAST			X	<= 90
B	SINGULAIR Requires history of an inhaled corticosteroid, nasal corticosteroid, or cromolyn.	MONTELUKAST SODIUM			X	<= 90
G	ZAFIRLUKAST	ZAFIRLUKAST			X	X

**MAST CELL STABILIZERS**

B	INTAL	CROMOLYN SODIUM				
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**ORAL INHALED CORTICOSTEROIDS(DOSAGE FORM 408 ONLY)**

B	AEROBID	FLUNISOLIDE				<= 90
B	AEROBID-M Requires a history of a formulary inhaled nasal corticosteroid.	FLUNISOLIDE/MENTHOL			X	<= 90
B	ASMANEX Requires a history of a formulary inhaled nasal corticosteroid.	MOMETASONE FUROATE			X	
B	AZMACORT Requires a history of a formulary inhaled nasal corticosteroid.	TRIAMCINOLONE ACETONIDE			X	<= 90
B	FLOVENT HFA Requires history of Flovent HFA or Trial of QVAR	FLUTICASONE PROPIONATE			X	<= 90
B	PULMICORT INHALER Requires a history of a formulary inhaled nasal corticosteroid.	BUDESONIDE			X	<= 90
B	PULMICORT NEBS Limit of 120 per month. PA required if age > 8.	BUDESONIDE	X	X		
B	QVAR	BECLOMETHASONE DIPROPIONATE				<= 90

**RESPIRATORY AIDS,DEVICES,EQUIPMENT**

	NEBULIZER (VARIOUS BRANDS) Limited to 2 per year.	NEBULIZER	X			
	PEAK FLOW METER (VARIOUS BRANDS) Limit of 1 per year.	PEAK FLOW METER	X			
	SPACER (VARIOUS BRANDS) Limit of 2 per year. Preferred products: Optichamber; Microspacer; Vortex; Microchamber. PA required: Aerochamber.	INHALER, ASSIST DEVICES	X			

**XANTHINES**

G	AMINOPHYLLINE	AMINOPHYLLINE				<= 90
B	THEO-24	THEOPHYLLINE ANHYDROUS				<= 90
G	THEOPHYLLINE	THEOPHYLLINE ANHYDROUS				<= 90
B	UNIPHYL	THEOPHYLLINE ANHYDROUS				<= 90

**AUTONOMIC NERVOUS SYSTEM DISORDERS****CHOLINESTERASE INHIBITORS**

B	ARICEPT Limit of 1 per day.	DONEPEZIL HCL	X				<= 90
B	ARICEPT ODT Limit of 1 per day.	DONEPEZIL HCL	X				<= 90
G	DONEPEZIL HCL	DONEPEZIL HCL	X				X
G	MESTINON	PYRIDOSTIGMINE BROMIDE					
B	PROSTIGMIN	NEOSTIGMINE BROMIDE					

**BEHAVIORAL HEALTH - ANTIDEPRESSANTS****ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS**

G	REMERON	MIRTAZAPINE				
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**MAOIS - NON-SELECTIVE & IRREVERSIBLE**

B	MARPLAN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ISOCARBOXAZID				
B	NARDIL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	PHENELZINE SULFATE				
G	PARNATE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	TRANLYCPROMINE SULFATE				

**MONOAMINE OXIDASE(MAO) INHIBITORS**

B	EMSAM	SELEGILINE				
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**NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)**

G	BUPROPION XL Quantity limit of 1 per 1 day applies	BUPROPION HCL	X			
G	WELLBUTRIN (SR) Wellbutrin XL = history of Wellbutrin (SR); Wellbutrin SR = PA Required	BUPROPION HCL				

**SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)**

G	CELEXA 10mg, 20mg and 40mg limit of 1 per day. Oral solution = PA required.	CITALOPRAM HYDROBROMIDE	X			
G	FLUVOXAMINE MALEATE	FLUVOXAMINE MALEATE				
B	LEXAPRO Tabs: limit 15 per month. Requires history of fluoxetine, paroxetine, sertraline, or citalopram in the last 90 days.	ESCITALOPRAM OXALATE	X		X	
G	PAXIL Paxil CR = PA required.	PAROXETINE HCL				
G	PROZAC 40mg caps limit of 2 per day. Oral solution = PA required.	FLUOXETINE HCL	X			
B	PROZAC WEEKLY Limit of 4 caps per month.	FLUOXETINE HCL	X			
B	SARAFEM	FLUOXETINE HCL				
G	ZOLOFT 25mg and 50mg tabs limit of 1 tab per day. 100mg limit of 2 tabs per day.	SERTRALINE HCL	X			

**SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)**

G	DESYREL	TRAZODONE HCL				
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**SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)**

B	CYMBALTA Patients must try and fail an antidepressant, gabapentin, or 2 urinary incontinence drugs to receive Cymbalta. Limit of 1 per day.	DULOXETINE HCL	X		X	
G	EFFEXOR Limit of 3 tabs per day	VENLAFAXINE HCL	X			
G	EFFEXOR XR Please use Capusles; Tablets = PA required	VENLAFAXINE HCL				

**BEHAVIORAL HEALTH - ANTIDEPRESSANTS****TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G PERPHENAZINE-AMITRIPTYLINE	AMITRIPTYLINE HCL/PERPHENAZINE				
G TRIAVIL	AMITRIPTYLINE HCL/PERPHENAZINE				

**TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB**

G ANAFRANIL	CLOMIPRAMINE HCL				
G ELAVIL	AMITRIPTYLINE HCL				
G NORPRAMIN	DESIPRAMINE HCL				
G PAMELOR	NORTRIPTYLINE HCL				
G SINEQUAN	DOXEPIN HCL				
G TOFRANIL	IMIPRAMINE HCL				
B VIVACTIL	PROTRIPTYLINE HCL				

**BEHAVIORAL HEALTH - OTHER****ADRENERGICS, AROMATIC, NON-CATECHOLAMINE**

B	ADDERALL (XR) PA Required if age > 17. Limit of 2 caps per day.	AMPHET ASP/AMPHET/D-AMPHET	X	X			<= 90
G	DEXEDRINE PA Required if age > 17.	D-AMPHETAMINE SULFATE		X			<= 90

**ANTI-ALCOHOLIC PREPARATIONS**

B	ANTABUSE	DISULFIRAM					
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**ANTI-ANXIETY DRUGS**

G	ATIVAN	LORAZEPAM					
G	BUSPAR	BUSPIRONE HCL					
G	CHLORDIAZEPOXIDE HCL	CHLORDIAZEPOXIDE HCL					
G	SERAX	OXAZEPAM					
G	VALIUM	DIAZEPAM					
G	XANAX Limit of 3 tabs per day. Xanax XR = PA Required.	ALPRAZOLAM	X				

**ANTI-MANIA DRUGS**

G	ESKALITH Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LITHIUM CARBONATE					
B	LITHIUM CARBONATE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LITHIUM CARBONATE					
G	LITHIUM CITRATE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LITHIUM CITRATE					

**ANTIPSYCH,DOPAMINE ANTAG.,DIPHENYLBUTYLPIPERIDINES**

B	ORAP Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	PIMOZIDE					
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**ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED**

B	ABILIFY Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ARIPIRAZOLE					
B	ABILIFY DISCMELT Carve out drug - Bill EDS/Medi-Cal Fee For Service. (PA for HF/HK).	ARIPIRAZOLE					

**ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS**

G	LOXITANE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LOXAPINE SUCCINATE					
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**BEHAVIORAL HEALTH - OTHER****ANTIPSYCHOTICS, ATYPICAL, DOPAMINE, & SEROTONIN ANTAG**

G	CLOZARIL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	CLOZAPINE				
B	FAZACLO Carve out drug - Bill EDS/Medi-Cal Fee For Service. (PA for HF/HK).	CLOZAPINE				
B	GEODON Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ZIPRASIDONE HCL				
B	INVEGA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (ST for HF/HK. History of risperdal, clozapine, and quetiapine. QL 1/day).	PALIPERIDONE			X	
B	RISPERDAL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	RISPERIDONE				
B	RISPERDAL CONSTA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	RISPERIDONE MICROSPHERES				
B	SEROQUEL (XR) Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	QUETIAPINE FUMARATE				
B	ZYPREXA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	OLANZAPINE				
B	ZYPREXA ZYDIS Carve out drug - Bill EDS/Medi-Cal Fee For Service. (PA for HF/HK).	OLANZAPINE				

**ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES**

G	NAVANE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	THIOTHIXENE				
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**ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES**

G	HALDOL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	HALOPERIDOL				
B	HALOPERIDOL LACTATE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	HALOPERIDOL LACTATE				

**ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES**

B	MOBAN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	MOLINDONE HCL				
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**ANTI-PSYCHOTICS, PHENOTHIAZINES**

G	MELLARIL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	THIORIDAZINE HCL				
G	PERPHENAZINE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	PERPHENAZINE				
G	PROLIXIN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	FLUPHENAZINE HCL				
G	PROLIXIN DECANOATE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	FLUPHENAZINE DECANOATE				
G	STELAZINE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	TRIFLUOPERAZINE HCL				
G	THORAZINE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	CHLORPROMAZINE HCL				
G	TRILAFON Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	PERPHENAZINE				

**BEHAVIORAL HEALTH - OTHER****BARBITURATES**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G PHENOBARBITAL	PHENOBARBITAL				<= 90

**SEDATIVE-HYPNOTICS, NON-BARBITURATE**

G AMBIEN Limit of 1 per day. Requires history of temazepam in the last 120 days.	ZOLPIDEM TARTRATE	X		X	
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G CHLORAL HYDRATE	CHLORAL HYDRATE				
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G DALMANE	FLURAZEPAM HCL				
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G HALCION Limit of 15 per month.	TRIAZOLAM	X			
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B LUNESTA Requires history of both temazepam and zolpidem in the last 120 days.	ESZOPICLONE			X	
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G RESTORIL 22.5mg caps = PA Required.	TEMAZEPAM				
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G SOMINEX	DIPHENHYDRAMINE HCL				
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G SOMNOTE	CHLORAL HYDRATE				
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G UNISOM	DOXYLAMINE SUCCINATE				
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**SSRI & ANTIPSYCH, ATYP, DOPAMINE & SEROTONIN ANTAG COMB**

B SYMBYAX Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	OLANZAPINE/FLUOXETINE HCL				
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**TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY**

B CONCERTA PA required if age > 17.	METHYLPHENIDATE HCL		X		<= 90
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B METADATE CD Requires history of methylphenidate hcl in the last 90 days.	METHYLPHENIDATE HCL			X	<= 90
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G METADATE ER PA required if age > 17.	METHYLPHENIDATE HCL		X		<= 90
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G RITALIN	METHYLPHENIDATE HCL				<= 90
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B RITALIN LA Requires history of methylphenidate hcl in the last 90 days.	METHYLPHENIDATE HCL			X	<= 90
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**TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE**

B STRATTERA Limit of 1 cap per day.	ATOMOXETINE HCL	X			<= 90
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**CARDIOVASCULAR DISEASE - ARRHYTHMIA****ANTIARRHYTHMICS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G FLECAINIDE ACETATE	FLECAINIDE ACETATE				
G MEXITIL 150mg & 200mg QL 180 per month. 250mg QL 120 per month.	MEXILETINE HCL	X			<= 90
B PROCAINAMIDE	PROCAINAMIDE HCL				<= 90
G PRONESTYL Pronestyl 375mg = PA required.	PROCAINAMIDE HCL				<= 90
G QUINAGLUTE	QUINIDINE GLUCONATE				<= 90
G QUINIDEX	QUINIDINE SULFATE				<= 90
G QUINIDINE GLUCONATE	QUINIDINE GLUCONATE				<= 90
G RYTHMOL IR	PROPAPENONE				

**CARDIOVASCULAR DISEASE - CARDIAC STIMULANT****DIGITALIS GLYCOSIDES**

G DIGOXIN	DIGOXIN				<= 90
B LANOXICAPS	DIGOXIN				<= 90

**CARDIOVASCULAR DISEASE - HYPERTENSION****ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION**

B	LEXXEL	ENALAPRIL MALEATE/FELODIPINE					<= 90
B	TARKA	TRANDOLAPRIL/VERAPAMIL HCL			X		<= 90
Requires history of another ACE inhibitor in the last 120 days.							

**ALPHA/BETA-ADRENERGIC BLOCKING AGENTS**

G	COREG	CARVEDILOL					<= 90
Coreg CR = PA Required.							
G	NORMODYNE	LABETALOL HCL	X				<= 90
Limit of 8 per day.							

**ALPHA-ADRENERGIC BLOCKING AGENTS**

G	CARDURA	DOXAZOSIN MESYLATE					<= 90
G	HYTRIN	TERAZOSIN HCL					<= 90
G	MINIPRESS	PRazosin HCL					<= 90

**ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB**

G	LOSARTAN-HYDROCHLOROTHIAZIDE	LOSARTAN/HYDROCHLOROTHIAZIDE					
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**ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST**

G	LOSARTAN POTASSIUM	LOSARTAN POTASSIUM					
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**ANTIHYPERTENSIVES, SYMPATHOLYTIC**

G	CATAPRES-TTS 1	CLONIDINE					
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**BETA-ADRENERGIC BLOCKING AGENTS**

G	BETAPACE (AF)	SOTALOL HCL					<= 90
G	BLOCADREN	TIMOLOL MALEATE					<= 90
G	CORGARD	NADOLOL					<= 90
G	INDERAL (LA)	PROPRANOLOL HCL	X				<= 90
Sustained release: QL 1 per day.							
G	LOPRESSOR	METOPROLOL TARTRATE					<= 90
G	SECTRAL	ACEBUTOLOL HCL			X		<= 90
Requires history of a beta blocker in the last 120 days.							
G	TENORMIN	ATENOLOL					<= 90
G	TOPROL XL	METOPROLOL SUCCINATE					<= 90

**CARDIOVASCULAR DISEASE - HYPERTENSION****CALCIUM CHANNEL BLOCKING AGENTS**

B	CARDIZEM CD	DILTIAZEM HCL	X				<= 90
B	CARDIZEM LA	DILTIAZEM HCL	X				<= 90
G	DILTIAZEM Limit of 1 per day.	DILTIAZEM HCL	X				<= 90
G	DILTIAZEM 24HR ER Quantity limit of 1 per 1 day applies	DILTIAZEM HCL	X				
G	NORVASC Limit of 1 per day.	AMLODIPINE BESYLATE	X				<= 90
G	PLENDIL Limit of 1 per day.	FELODIPINE	X				<= 90
G	PROCARDIA (XL) 10mg caps: QL 3/day. 20mg caps: QL 4 per day. 30mg, 60mg, & 90mg SR tabs: QL 2 per day.	NIFEDIPINE	X				
G	VERAPAMIL (SR) Sustained release: QL 2 per day.	VERAPAMIL HCL	X				

**HYPOTENSIVES, ACE INHIBITORS**

G	ACCUPRIL Limit of 1 per day.	QUINAPRIL HCL	X				<= 90
G	ACCURETIC Limit of 1 per day.	QUINAPRIL/HYDROCHLOROTHIAZIDE	X				<= 90
B	ALTACE Requires history of another ACE inhibitor in the last 120 days.	RAMIPRIL				X	<= 90
G	CAPOTEN	CAPTOPRIL					<= 90
G	CAPOZIDE	CAPTOPRIL/HYDROCHLOROTHIAZIDE					<= 90
G	LOTENSIN	BENAZEPRIL HCL					<= 90
G	LOTENSIN HCT	BENAZEPRIL/HYDROCHLOROTHIAZIDE					<= 90
G	MAVIK Requires history of another ACE inhibitor in the last 120 days.	TRANDOLAPRIL				X	<= 90
G	MONOPRIL Limit of 1 per day.	FOSINOPRIL SODIUM	X				<= 90
G	MONOPRIL HCT Limit of 1 per day.	FOSINOPRIL/HYDROCHLOROTHIAZIDE	X				<= 90
G	PRINIVIL	LISINOPRIL					<= 90
G	PRINZIDE	LISINOPRIL/HYDROCHLOROTHIAZIDE					<= 90
G	VASERETIC	ENALAPRIL/HYDROCHLOROTHIAZIDE					<= 90
G	VASOTEC	ENALAPRIL MALEATE					<= 90

**HYPOTENSIVES, MISCELLANEOUS**

G	TENORETIC	ATENOLOL/CHLORTHALIDONE					<= 90
G	ZIAC	BISOPROLOL/HYDROCHLOROTHIAZIDE					<= 90

**CARDIOVASCULAR DISEASE - HYPERTENSION****HYPOTENSIVES, SYMPATHOLYTIC**

G	ALDOMET	METHYLDOPA					<= 90
G	ALDORIL-15	METHYLDOPA/HYDROCHLOROTHIAZIDE					<= 90
B	ALDORIL-D50	METHYLDOPA/HYDROCHLOROTHIAZIDE					<= 90
G	CATAPRES	CLONIDINE HCL					<= 90
G	GUANABENZ ACETATE Limit of 1 per day.	GUANABENZ ACETATE	X				<= 90
G	HYDROCHLOROTHIAZIDE/RESERPINE	RESERPINE/HYDROCHLOROTHIAZIDE					
G	METHYLDOPA	METHYLDOPA					<= 90
G	TENEX	GUANFACINE HCL					<= 90

**HYPOTENSIVES, VASODILATORS**

G	APRESOLINE	HYDRALAZINE HCL					<= 90
G	HYDRALAZINE HCL	HYDRALAZINE HCL					<= 90

**LOOP DIURETICS**

G	BUMEX	BUMETANIDE					<= 90
B	EDECIN	ETHACRYNIC ACID					<= 90
G	LASIX	FUROSEMIDE					<= 90

**POTASSIUM SPARING DIURETICS**

G	ALDACTONE	SPIRONOLACTONE					<= 90
B	INSPIRA Requires history of spironolactone in the last 90 days.	EPLERENONE				X	<= 90
G	MIDAMOR	AMILORIDE HCL					<= 90

**POTASSIUM SPARING DIURETICS IN COMBINATION**

G	ALDACTAZIDE	SPIRONOLACT/HYDROCHLOROTHIAZID					<= 90
G	DYAZIDE	TRIAMTERENE/HYDROCHLOROTHIAZID					<= 90
G	MODURETIC	AMILORIDE/HYDROCHLOROTHIAZIDE					<= 90

**THIAZIDE AND RELATED DIURETICS**

G	CHLORTHALIDONE	CHLORTHALIDONE					<= 90
G	DIURIL	CHLOROTHIAZIDE					<= 90
G	HYDROCHLOROTHIAZIDE	HYDROCHLOROTHIAZIDE					<= 90
G	LOZOL	INDAPAMIDE					<= 90
B	SALURON	HYDROFLUMETHIAZIDE					
G	ZAROXOLYN Limit of 1 per day.	METOLAZONE	X				<= 90

**CARDIOVASCULAR DISEASE - LIPID IRREGULARITY****BILE SALT SEQUESTRANTS**

G	COLESTID 5gm granules: limit of 500gm/month. 1gm tablet: limit of 4 per day. 5gm packet = PA Required.	COLESTIPOL HCL	X				<= 90
G	QUESTRAN Limit of 2 packets per day or 378gm/month.	CHOLESTYRAMINE/SUCROSE	X				
G	QUESTRAN LIGHT Limit of 2 packets per day or 240gm/month.	CHOLESTYRAMINE/ASPARTAME	X				<= 90

**LIPOTROPICS**

B	ALTOPREV	LOVASTATIN	X				<= 90
B	ANTARA	FENOFIBRATE,MICRONIZED				X	<= 90
G	FENOFIBRATE Limit 1 tablet per day.	FENOFIBRATE	X				
G	FISH OIL Quantity limit 6 tablets per day.	OMEGA-3 FATTY ACIDS	X				
G	LOPID	GEMFIBROZIL					<= 90
G	MEVACOR Limited to 1 per day.	LOVASTATIN	X				<= 90
G	NIACIN Limit of 3 per day.	NIACIN	X				<= 90
B	NIACOR Limit of 3 per day.	NIACIN	X				<= 90
B	NIASPAN Limit of 2 per day.	NIACIN	X				<= 90
B	VIGOREX	NIA/CAPSI/YHBK/GIN/GNK/DAM/OAT					
B	VYTORIN History of Zetia in past year. Limit of 1 per day.	EZETIMIBE/SIMVASTATIN				X	<= 90
B	ZETIA History of any statin in the past 120 days.	EZETIMIBE				X	
G	ZOCOR Limit of 1/2 tablet per day on all strengths except 80mg.	SIMVASTATIN	X				<= 90

**CARDIOVASCULAR DISEASE - MISCELLANEOUS AGENTS****ADRENERGIC VASOPRESSOR AGENTS**

G	PROAMATINE Limit of 90 per month.	MIDODRINE HCL	X				
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**CARDIOVASCULAR DISEASE - VASODILATION****VASODILATORS,CORONARY**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G AMYL NITRITE	AMYL NITRITE				
B DILATRATE-SR	ISOSORBIDE DINITRATE				<= 90
G ISMO	ISOSORBIDE MONONITRATE				<= 90
G ISORDIL	ISOSORBIDE DINITRATE				<= 90
B NITRO-BID	NITROGLYCERIN				<= 90
G NITRO-DUR	NITROGLYCERIN				<= 90
G NITROSTAT	NITROGLYCERIN				

**VASODILATORS,PERIPHERAL**

G ERGOLOID MESYLATES	ERGOLOID MESYLATES				
G ISOVEX	ETHAVERINE HCL				
G NYLIDRIN HCL	NYLIDRIN HCL				
G PAPAVERINE HCL	PAPAVERINE HCL				<= 90
G VASODILAN	ISOXSUPRINE HCL				<= 90

**CONTRACEPTION/OXYTOCICS****CONTRACEPTIVES,INJECTABLE**

G	DEPO-PROVERA Limit of 1 per 90 days.	MEDROXYPROGESTERONE ACET	X				<= 90
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**CONTRACEPTIVES,INTRAVAGINAL**

G	NONOXYNOL 9 (VARIOUS BRANDS)	NONOXYNOL 9					
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**CONTRACEPTIVES,ORAL**

G	DEMULEN 1/50	ETHYNODIOL D-ETHINYL ESTRADIOL					<= 90
G	DESOGEN	DESOGESTREL-ETHINYL ESTRADIOL					<= 90
B	ESTROSTEP FE	NORETH A-ET ESTRA/FE FUMARATE					<= 90
G	LOESTRIN	NORETHINDRONE A-E ESTRADIOL					<= 90
G	LOESTRIN FE	NORETH A-ET ESTRA/FE FUMARATE					<= 90
G	MIRCETTE	DESOG-ET ESTRA/ETHIN ESTRA					<= 90
G	MODICON	NORETHINDRONE-ETHINYL ESTRAD					<= 90
G	NORDETTE	LEVONORGESTREL-ETH ESTRA					<= 90
G	ORTHO MICRONOR	NORETHINDRONE					<= 90
B	ORTHO TRI-CYCLEN LO	NORGESTIMATE-ETHINYL ESTRADIOL					<= 90
G	ORTHO-CYCLEN	NORGESTIMATE-ETHINYL ESTRADIOL					<= 90
G	ORTHO-NOVUM	NORETHINDRONE-MESTRANOL					
B	OVCON	NORETHINDRONE-ETHINYL ESTRAD					<= 90
G	OVRAL	NORGESTREL-ETHINYL ESTRADIOL					<= 90
B	PLAN B Limit 2 tablets per month.	LEVONORGESTREL	X				

**CONTRACEPTIVES,TRANSDERMAL**

B	ORTHO EVRA Ortho Evra Patch: Must have filled prescription in past 120 days, or trial of three formulary alternatives.	ETHINYL ESTRADIOL/NORELGEST					<= 90
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**DIAPHRAGMS/CERVICAL CAP**

	FEMCAP Limit 1 per year.	CERVICAL CAP	X				
	KORO-FLEX ARCING Limit 1 per year.	DIAPHRAGMS, ARC-SPRING	X				
	KOROMEX COIL SPRING Limit 1 per year.	DIAPHRAGMS, COIL SPRING	X				
	ORTHO-DIAPHRAGM Limit 1 per year.	DIAPHRAGMS, ARC-SPRING	X				
	WIDE SEAL DIAPHRAGM Limit 1 per year.	DIAPHRAGMS, WIDE SEAL	X				

**CONTRACEPTION/OXYTOCICS****OXYTOCICS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
B CERVIDIL	DINOPROSTONE				
B HEMABATE	CARBOPROST TROMETHAMINE				
B METHERGINE	METHYLERGONOVINE MALEATE				
B PREPIDIL	DINOPROSTONE				
B PROSTIN E2 VAGINAL SUPPOSITORY	DINOPROSTONE				

**COUGH AND COLD****1ST GEN ANTIHISTAMINE & DECONGESTANT COMBINATIONS**

G	ACCUHIST DROPS Limit of 120 per month.	P-EPHED HCL/BROMPHENIRAMIN	X			
G	ACTIFED Tablets limit of 2 per day. Liquid limit of 480mls per month.	P-EPHED HCL/TRIPROLDINE HCL	X			
G	ALLERTAN Limit of 480mls per month.	PHENYLEPHRINE/PYRIL TAN/CP	X			
B	A-PHEDRIN Tablets limit of 2 per day. Liquid (Zymine-D) limit of 480mls per month.	P-EPHED HCL/TRIPROLDINE HCL	X			
G	BENADRYL-D Tablets limit of 2 per day. Liquid limit of 480mls per month.	P-EPHED HCL/DP-HYDRAM HCL	X			
B	COMHIST Tablets limit of 2 per day. Liquid (Nalex-A) limit of 480mls per month.	PHENYLEPHRINE/P-TLOX CI/CP	X			
G	DALLERGY-JR Limit of 2 caps per day.	PHENYLEPHRINE HCL/CHLOR-MAL	X			
G	ED A-HIST Limit of 2 per day.	PHENYLEPHRINE HCL/CHLOR-MAL	X			
G	FRIALLERGIA Limit of 480mls per month.	P-EPHED HCL/BROMPHENIRAMIN	X			
G	HISTEX Limit of 480mls per month.	PSEUDOEPHEDRINE HCL/CHLOR-MAL	X			
B	HISTEX SR Limit of 2 per day.	P-EPHED HCL/BROMPHENIRAMIN	X			
G	LOHIST-PEB	PHENYLEPHRINE/BROMPHENIRAMINE	X			
G	LOHIST-PSB	P-EPHED HCL/BROMPHENIRAMIN	X			
G	POLY HIST FORTE Limit of 2 per day.	PHENYLEPHRINE/PYRIL MAL/CP	X			
B	POLY TAN D Limit of 473ml per month.	PE TAN/PYRIL MAL/DEXBROMPH TAN	X			
B	PREHIST	PHENYLEPHRINE HCL/CHLOR-MAL				
G	PROMETHAZINE VC	PHENYLEPHRINE HCL/PROMETH HCL				
G	QDALL Limit of 2 per day.	PSEUDOEPHEDRINE HCL/CHLOR-MAL	X			
G	RYNA-12 S Limit of 480mls per month.	PHENYLEPHRINE/PYRILAMINE TAN	X			
B	TRI ACTING Limit of 480mls per month.	PSEUDOEPHEDRINE HCL/CHLOR-MAL	X			
G	WEST-DECON M Limit of 2 per day.	PHENYLEPHRINE/P-TLOX CI/CP				

**COUGH AND COLD****1ST GEN ANTIHISTAMINE-DECONGESTANT-ANALGESIC COMB**

G	CHILDREN'S TYLENOL COLD Limit of 480mls per month.	P-EPHED HCL/ACETAMINOPHN/CP	X			
B	DRIXORAL Limit of 2 per day.	P-EPHED HCL/ACETAMINOPHN/D-BP	X			
B	ONSET FORTE Limit of 2 per day.	PHENYLEPHRINE/ACETAMINOPHN/CP	X			
B	PROTID Limit of 2 per day.	PHENYLEPHRINE/ACETAMINOPHN/CP	X			
G	SINADRIN PLUS Limit of 2 per day.	P-EPHED HCL/ACETAMINOPHN/D-BP	X			
B	THERAFLU Limit of 60 per month.	P-EPHED HCL/ACETAMINOPHN/CP	X			
G	TYLENOL ALLERGY COMPLETE Limit of 2 per day.	P-EPHED HCL/ACETAMINOPHN/CP	X			
G	TYLENOL ALLERGY MULTI-SYMP TOM Limit of 2 per day.	PHENYLEPHRINE/ACETAMINOPHN/CP	X			
G	TYLENOL FLU NIGHTTIME Limit of 2 per day.	P-EPHED HCL/ACETAMINOPHN/DPHA	X			
B	TYLENOL SINUS NIGHTTIME Limit of 2 per day.	P-EPHED HCL/APAP/DOXYLAM	X			

**1ST GEN ANTIHISTAMINE-DECONGESTANT-EXPECTORANT CMB**

G	DONATUSSIN Limit of 120 per month.	GUAIFEN/PHENYLEPHRINE/CP	X			
G	LEMOHIST PLUS Limit of 480mls per month.	GUAIFEN/P-EPHED HCL/CP	X			

**1ST GEN ANTIHIST-DECON-ANALGESIC, SALICYLATE**

G	EFFERVESCENT COLD RELIEF Limit of 2 per day.	P-EPHED HCL/ASA/CHLORPHENIR	X			
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**1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB**

B	DALLERGY Limit of 2 per day.	PHENYLEPHRINE/CHLOR-MAL/SCOP	X			
G	EXTENDRYL	PHENYLEPHRINE/CHLOR-MAL/SCOP				
B	EXTENDRYL JR	PHENYLEPHRINE/CHLOR-MAL/SCOP				
G	RU-TUSS Limit of 2 per day.	P-EPHED HCL/CHLOR-MAL/BELL ALK	X			

**1ST GEN ANTIHIST-DECON-NSAID,COX NONSPEC**

B	ADVIL MULTI-SYMP TOM Limit of 2 per day.	IBUPROFEN/P-EPHED HCL/CP	X			
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**COUGH AND COLD****ANALGESIC, NON-SAL.- 1ST GENERATION ANTIHISTAMINE**

G	CORICIDIN Limit of 2 per day.	ACETAMINOPHEN/CHLOR-MAL	X			
G	EXCEDRIN PM	ACETAMINOPHEN/DP-HYDRAMINE				
G	TYLENOL P.M. Limit of 2 per day.	ACETAMINOPHEN/DP-HYDRAM HCL	X			
G	VISTRA 650-60mg QL 6 per day.	ACETAMINOPHEN/PHENYLTOLX CIT	X			

**ANALGESIC/ANTIPYRETICS, NON-SALICYLATE**

G	PEDIACARE Drops limit of 240ml per month. 30mg tabs (Sudafed) limit of 100 per month. 120mg sustained release tabs = PA required.	PSEUDOEPHEDRINE HCL	X			
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**ANTITUSSIVES, NON-NARCOTIC**

B	DELSYM Limit of 480mls per month.	DEXTROMETHORPHAN POLISTIREX	X			
G	ROBITUSSIN PEDIATRIC Limit of 480mls per month.	DEXTROMETHORPHAN HBR	X			
B	SCOT-TUSSIN Limit of 480mls per month.	DEXTROMETHORPHAN HBR	X			
B	SIMPLY COUGH Limit of 480mls per month.	DEXTROMETHORPHAN HBR	X			
G	TESSALON PERLE Limit of 3 per day.	BENZONATATE	X			

**COUGH AND/OR COLD PREPARATIONS**

G	CHILDREN'S TYLENOL COLD Limit of 2 per day.	P-EPHED HCL/ACETAMINOPHN/CP	X			
G	CHILDREN'S TYLENOL FLU Limit of 2 per day.	DM HB/P-EPD HCL/APAP/CP	X			
G	PEDIACARE Limit of 480mls per month.	D-METHORPHAN HB/P-EPHED HCL	X			
G	PEDIACARE COUGH-COLD Limit of 240mls per month.	D-METHORPHAN HB/P-EPHED HCL/CP	X			

**DECON-ANALGESIC, NON-SALICYLATE-XANTHINE**

B	MEDI-GRAINE Limit of 2 per day.	PHENYLEPHRINE/APAP/CAFFEIN	X			
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**DECONGEST-ANALGESIC, NON-SALICYLATE COMB.**

G	TYLENOL SINUS	P-EPHED HCL/ACETAMINOPHEN				
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**DECONGESTANT-EXPECTORANT COMBINATIONS**

B	CONPEC Limit of 480mls per month.	GUAIFENESIN/PHENYLEPHRINE HCL	X			
B	MARDROPS-EX Limit of 120mls per month.	GUAIFENESIN/P-EPHED HCL	X			

Representative Brand	Generic Name	QL	Age	ST	Day Supply
<b><u>COUGH AND COLD</u></b>					
<b>EXPECTORANTS</b>					
G ALLFEN (JR) Allfen JR Limit of 2 per day.	GUAIFENESIN	X			
G ROBITUSSIN Limit of 480mls per month.	GUAIFENESIN	X			
<b>NARCOTIC ANTITUSS-1ST GEN. ANTIHISTAMINE-DECONGEST</b>					
G PROMETHAZINE VC W/CODEINE	PHENYLEPHRINE HCL/COD/PROMETH				
<b>NARCOTIC ANTITUSS-DECONGESTANT-EXPECTORANT COMB</b>					
G CHERATUSSIN DAC Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
G COPHENE XP Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
G GUIATUSS-DAC Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
G NOVAGEST Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
G PHENYLHISTINE Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
G RYNA-CX Limit of 480mls per month.	GUAIFENESIN/P-EPHED HCL/COD	X			
<b>NARCOTIC ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE</b>					
G PHENERGAN W/CODEINE	CODEINE/PROMETHAZINE HCL				
<b>NARCOTIC ANTITUSSIVE-EXPECTORANT COMBINATION</b>					
G TUSSI-ORGANIDIN-S NR Limit of 480mls per month.	GUAIFENESIN/CODEINE PHOS	X			
<b>NON-NARC ANTITUS-1ST GEN ANTIHIST-DECON-ANALGES CB</b>					
G COMTRES Tabs limit of 2 per day. Liquid and solution limit of 480mls per month.	DM HB/PSEUDOEPHED/ACETAMIN/CP	X			
G THERAFLU Limit of 2 packets per day.	DM HB/PSEUDOEPHED/ACETAMIN/CP	X			
<b>NON-NARC ANTITUS-1ST GEN ANTIHIST-DECONGEST-EXPECT</b>					
G DONATUSSIN 15-10-2/5 liquid and 7.5-10-2/5 syrup limit of 480mls per month. 100-15-5-2 syrup = PA required.	GUAIFEN/D-METHORPHAN HB/PE/CP	X			
<b>NON-NARC ANTITUSS-1ST GEN ANTIHIST-ANALGESIC COMB.</b>					
G CORICIDIN HBP Limit of 2 per day.	D-METHORPHAN HB/APAP/CP	X			

**COUGH AND COLD****NON-NARC ANTITUSS-1ST GEN. ANTIHISTAMINE-DECONGEST**

G	DIMETAPP DM 15-45-4/5 syrup, 5-15-1MG/5 elixer,4-15-1MG/1 drops,10-30-2/5 syrup limit of 480mls per month.	D-METHORPHAN HB/P-EPD HCL/BPM	X			
B	POLY TAN DM Limit of 473ml per month.	DM TAN/PE TAN/PYRIL/D-BROM TAN	X			
G	PROHIST DM Limit of 60ml per month.	D-METHORPHAN HB/P-EPD HCL/BPM	X			
G	TANDUR DM Limit of 946ml per month.	D-METHORP TAN/P-EPD TAN/D-CP	X			

**NON-NARC ANTITUSS-DECONGESTANT-ANALGESIC-EXPECT CB**

G	TYLENOL COLD Tabs and caps limit of 2 per day. Liquid and expectorant limit of 480mls per month.	GUAIFEN/DM HB/P-EPHEDRINE/APAP	X			
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**NON-NARC ANTITUSSIVE-1ST GEN ANTIHISTAMINE COMB.**

B	CORICIDIN HBP Limit of 2 tabs per day.	DEXTROMETHORPHAN HBR/CHLOR-MAL	X			
G	COUGH & RUNNY NOSE Tabs limit of 2 per day. Oral liquid limit of 480mls per month.	DEXTROMETHORPHAN HBR/CHLOR-MAL	X			
G	NITE TIME Solution limit of 480mls per month.	D-METHORPHAN HB/DOXYLAMINE	X			
G	PROMETHAZINE DM	D-METHORPHAN HB/PROMETH HCL				
G	TUSSI-12 Tablet limit of 2 per day. Oral susp limit of 480mls per month.	CAR-B-PEN TA/CHLOR-TAN	X			

**NON-NARCOTIC ANTITUSS-DECONGESTANT-EXPECTORANT CMB**

B	DESPEC DM Syrup limit of 480mls per month. Tabs limit of 2 per day.	GUAIFEN/D-METHORPHAN HB/PE	X			
G	ROBITUSSIN COUGH & COLD CF Limit of 30ml per month.	GUAIFEN/D-METHORPHAN HB/PE	X			

**NON-NARCOTIC ANTITUSSIVE AND EXPECTORANT COMB.**

G	NALDECON DX Tabs limit of 2 per day. Liquid limit of 480mls per month.	GUAIFENESIN/D-METHORPHAN HB	X			
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**NON-NARCOTIC ANTITUSSIVE-ANALGESIC COMBINATIONS**

B	DRIXORAL Limit of 2 per day.	D-METHORPHAN HB/ACETAMINOPHEN	X			
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**NON-NARCOTIC ANTITUSSIVE-DECONGESTANT COMBINATIONS**

G	PEDIACARE 2.5-7.5/0.8ml drops and 7.5-15mg/5 syrup limit of 240mls per month. 10-20/5 elixer and 15-30/5 liquid limit of 480mls per month	D-METHORPHAN HB/P-EPHED HCL	X			
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**NON-NARCOTIC ANTITUSSIVE-DECONGESTANT-ANALGESIC CB**

G	TRIAMINIC Packet limit of 60 per month. Caps and tabs limit of 2 per day. Drops limit of 240mls per month. Solution limit of 480mls per month. 7.5-15-160 liquid = PA Required.	D-METHORPHAN HB/P-EPD HCL/APAP	X			
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**COUGH AND COLD**

**SYMPATHOMIMETIC AGENTS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G PHENYLEPHRINE HCL 10mg tabs = formulary.	PHENYLEPHRINE HCL				
G SUDAFED Drops, liquid and syrup limit of 240mls per month. 30mg and 60mg tabs limit of 100 per month. 120mg SA tabs = PA required.	PSEUDOEPHEDRINE HCL		X		

**DERMATOLOGY - ACNE****ACNE AGENTS, SYSTEMIC**

G	ACUTANE Limit 2 per day. Limit 5 months.	ISOTRETINOIN	X			
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**ACNE AGENTS, TOPICAL**

G	KLARON Requires history of erythromycin solution or gel or benzoyl peroxide in the last 60 days.	SULFACETAMIDE SODIUM			X	
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**ASTRINGENTS**

B	A-MANTLE	ALUMINUM ACETATE				
B	BURO-SOL	ALUMINUM ACETATE				
G	HYDROSAL	ALUMINUM ACETATE				

**KERATOLYTICS**

B	ACNOMEL	RESORCINOL/SULFUR				
G	ALA-SEB-T Limit 120mls per month.	SALICYLIC ACID/COAL TAR/SULFUR	X			
G	BENZOYL PEROXIDE (VARIOUS) 10% liquid, lotion, or gel QL 240ml/mo. 2.5% gel or liquid QL 240ml/mo. 3% cleanser QL 341ml/mo. 4% gel QL 42.5ml/mo. 5% gel QL 240ml/mo. 5% liquid QL 240/mo. 5% lotion QL 297ml/mo.	BENZOYL PEROXIDE	X			
B	BREVOXYL-4 Gel - Limit 43gm/month; Brevoxyl-8 = PA Required.	BENZOYL PEROXIDE	X			
G	CONDYLOX Soluton = Limit of 3.5gm per month. Gel = PA Required.	PODOFILOX	X			
B	FOSTEX	SALICYLIC ACID/SOAP/SULFUR				
B	FREEZONE	SALICYLIC ACID/COLLODION				
G	MOSCO LIQ CALLUS/CORN REMOVER	SALICYLIC ACID/COLLODION				
G	PHISOAC BP	RESORCINOL/SULFUR				
G	PODOFILOX	PODOFILOX				
B	REZAMID	RESORCINOL/SULFUR/CL-XYLENOL				
G	SALACTIC FILM	SALICYLIC ACID/COLLODION				
G	SALICYLIC ACID Shampoo - Limit 120 per month. 0.5% & 2% pads = formulary.	SALICYLIC ACID	X			
G	TISEB-T Liquid and Shampoo = Limit 120mls per month.	SALICYLIC ACID/COAL TAR	X			
G	WART LIQUID 17% liquid = formulary.	SALICYLIC ACID/COLLODION				
G	WART-OFF	SALICYLIC ACID/COLLODION				

**ROSACEA AGENTS, TOPICAL**

G	METROCREAM, METROLOTION Metrocream limit 45gm/month; Metro lotion limit 59ml/month.	METRONIDAZOLE	X			
B	METROGEL Metrogel limit 60gm/month	METRONIDAZOLE	X			
B	NORITATE	METRONIDAZOLE				

**DERMATOLOGY - ACNE****TOPICAL PREPARATIONS,ANTIBACTERIALS**

G	1 + 1-F	CLIOQUINOL/HYDROCORTISONE/PRAM				
G	HIBICLENS Limit of 5 fills per year.	CHLORHEXIDINE GLUCONATE	X			
G	SILVER NITRATE Limit 100 per month.	SILVER NITRATE	X			

**VITAMIN A DERIVATIVES**

G	RETIN-A PA required if age > 21. Limit of 45gm per month. Retin A Micro = PA required for all ages.	TRETINOIN	X	X		
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**DERMATOLOGY - ANTIINFECTIVE****TOPICAL ANTIBIOTICS**

G	BACITRACIN	BACITRACIN				
G	BACITRACIN ZINC	BACITRACIN ZINC				
B	BACTROBAN	MUPIROCIN				
B	CAMPHO-PHENIQUE MAX ANTIBIOTIC	NEOMY SULF/BACITRACIN/POLY/DPD				
G	CLEOCIN PHOSPHATE Limit of 60mls per month.	CLINDAMYCIN PHOSPHATE	X			
B	CLINDAGEL Limit of 40gm per month.	CLINDAMYCIN PHOSPHATE	X			
G	ERYGEL	ERYTHROMYCIN BASE/ETHANOL				
G	FIRST AID OINTMENT	NEOMY SULF/BACITRA/POLY/LIDO				
G	GENTAMICIN SULFATE	GENTAMICIN SULFATE				
G	LANABIOTIC	NEOMY SULF/BACITRA/POLY/LIDO				
G	MULTI-ANTIBIOTIC	NEOMY SULF/POLYMYXIN B SULFATE				
G	NEOMYCIN-POLYMYXIN B	NEOMY SULF/POLYMYXIN B SULFATE				
G	NEOSPORIN	NEOMY SULF/BACITRA/POLYMYXIN B				
G	NEOSPORIN G.U. IRRIGANT	NEOMY SULF/POLYMYXIN B SULFATE				
G	NEOSPORIN PLUS	NEOMY SULF/POLYMYX B SULF/PRAM				
G	POLYSPORIN	BACITRACIN/POLYMYXIN B SULFATE				
G	TRIPLE ANTIBIOTIC	NEOMY SULF/BACI ZN/POLY/PRAM				

**TOPICAL ANTIFUNGALS**

G	ANTI-FUNGAL	UNDECYLENIC ACID				
G	CLOTRIMAZOLE-BETAMETHASONE Quantity limit of 100gm/30 days	CLOTRIMAZOLE/BETAMET DIPROP	X			
G	DESENEX	TERBINAFINE				
G	ECONAZOLE NITRATE Quantity limit of 100gm/30 days	ECONAZOLE NITRATE	X			
G	LOTRIMIN	CLOTRIMAZOLE				
G	LOTRIMIN AF	CLOTRIMAZOLE				
G	MICATIN	MICONAZOLE NITRATE				
G	MYCOLOG II	NYSTATIN/TRIAMCIN				
G	MYCOSTATIN	NYSTATIN				
G	NIZORAL CREAM Limit of 60gm per month.	KETOCONAZOLE	X			
G	NIZORAL SHAMPOO Limit of 120ml per month.	KETOCONAZOLE	X			
B	OXISTAT Requires history of 2 of the following: clotrimazole, miconazole, or ketoconazole.	OXICONAZOLE			X	
G	SPECTAZOLE Requires history of 2 of the following: clotrimazole, miconazole, or ketoconazole.	ECONAZOLE NITRATE			X	
G	TINACTIN Cream and powder = PA Required. Packet and solution = formulary. Soln QL 20ml/month. Packets QL 96/month.	TOLNAFTATE	X			
B	VUSION	MICONAZOLE NITRATE/ZINC OXIDE				
B	ZEASORB-AF	MICONAZOLE NITRATE				

**DERMATOLOGY - ANTIINFECTIVE****TOPICAL ANTIPARASITICS**

G	ELIMITE Limit of 120 per month. Limit of 2 fills per month.	PERMETHRIN	X			
B	EURAX	CROTAMITON				
G	LICE EGG REMOVER Limit 2 fills (120ml) per month.	POTASS HYD/GLYCO/PQ10/HE-CELL	X			
G	LICE TREATMENT Kit QL 2/month. Spray QL 284gm/month. Gel QL 24gm or 60gm/month (depending on package size). Shampoo QL 2 fills (120gm)/month. Foam QL 2 fills (312gm)/month.	PIP BUTOX/PYRETHRINS/PERMETH	X			
B	LICEOUT	ME-PARABEN/PELE/CARBOM/H2O				
B	OVIDE Limit of 2 fills (120ml) per month.	MALATHION	X			

**TOPICAL ANTIVIRALS**

B	DENAVIR Limit 3gm per month.	PENCICLOVIR	X			
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**TOPICAL SULFONAMIDES**

G	SILVADENE	SILVER SULFADIAZINE				
G	SULFACET-R Limit 25gm or 30gm depending on package size.	SULFACETAMIDE SODIUM/SULFUR	X			

**DERMATOLOGY - ANTIINFLAMMATORY****TOPICAL ANTI-INFLAMMATORY STEROIDAL**

G	ACLOVATE	ALCLOMETASONE DIPROPIONATE				
G	BETAMETHASONE DIPROPIONATE Quantity limit of 100gm/30 days	BETAMETHASONE DIPROPIONATE	X			
B	CORTAID	HYDROCORTISONE				
B	DERMA-SMOOTH/FS Limit 119ml per month.	FLUOCINOLONE ACETONIDE	X			
G	DERMATOP Limit of 60gm per month.	PREDNICARBATE	X			
G	DESOWEN Ointment & Cream limit 60gm/mo; Lotion limit 118ml/mo	DESONIDE				
B	DIPROLENE History of fluocinonide 0.05% or triamcinolone 0.5% in last 120 days.	BETAMET DIPROP/PROP GLY			X	
G	DIPROLENE AF History of fluocinonide 0.05% or triamcinolone 0.5% in last 120 days.	BETAMET DIPROP/PROP GLY			X	
G	ELOCON Cream and ointment limit of 45gm per month. Solution = PA Required.	MOMETASONE FUROATE	X			
B	FIRST-HYDROCORTISONE	HYDROCORTISONE				
B	INSTACORT-10	HYDROCORTISONE				
G	KENALOG 0.5% cream, 0.5% ointment & 0.025% lotion limit 60gm/mo; 0.025% cream, 0.1% cream, 0.25% ointment & 0.01% ointment limit 80gm/mo; 0.1% lotion limit 120ml/mo	TRIAMCINOLONE ACETONIDE	X			
G	LIDEX Limit 60gm per month.	FLUOCINONIDE	X			
G	LIDEX-E Limit 60gm per month.	FLUOCINONIDE/EMOLLIENT	X			
B	OLUX History of fluocinonide 0.05% or triamcinolone acetone 0.5% in the last 120 days.	CLOBETASOL PROPIONATE			X	
G	SYNALAR Oil limit of 118.28ml per month.	FLUOCINOLONE ACETONIDE	X			
G	TEMOVATE History of fluocinonide 0.05% or triamcinolone 0.5% in last 120 days.	CLOBETASOL PROPIONATE			X	
B	TEXACORT	HYDROCORTISONE				

**DERMATOLOGY - ANTIPRURITIC DRUGS****ANTIPRURITICS, TOPICAL**

G	ANTI-ITCH Limit 56gm per month.	PRAMOXINE HCL/MENTHOL	X			
G	BENADRYL Limit 120gm per month	DIPHENHYDRAMINE HCL	X			
B	BENADRYL ITCH RELIEF Gel: QL 120gm per month. Cream QL 56.8gm/month. Soln QL 28gm/month.	DIPHENHYDRAMINE HCL/ZINC ACET	X			
G	CALADRYL Limit 180ml per month.	PRAMOXINE HCL/CALAMINE	X			
G	CALADRYL CLEAR Limit 180ml per month.	PRAMOXINE HCL/CAMPH/ZINC ACET	X			
G	CALDYPHEN Limit 177ml per month	DIPHENHYDRAMINE HCL/CALAMINE	X			
G	CALOHIST Limit of 180ml per month.	DIPHENHYDRAMINE HCL/CALAMINE	X			
G	DERMAGESIC Limit 120ml per month.	PYRIL MAL/BENZOCAINE/ZNOX	X			
G	SARNA Limit 222ml per month.	MENTHOL/CAMPHOR	X			

**DERMATOLOGY - MISCELLANEOUS****ANTISEBORRHEIC AGENTS**

G	SELSUN RX	SELENIUM SULFIDE				
G	ZINCON DANDRUFF	PYRITHIONE ZINC				

**CATHETERS AND RELATED DEVICES**

	SODIUM CHLORIDE Limit of 2 per year.	SODIUM CL IRRIG SOLN	X			
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**IRRIGANTS**

G	NEOMYCIN-POLYMYXIN B	NEOMY SULF/POLYMYXIN B SULFATE				
G	NEOSPORIN G.U. IRRIGANT	NEOMY SULF/POLYMYXIN B SULFATE				
G	SODIUM CHLORIDE	SODIUM CL 0.45PC IRRIG. SOLN				
B	SORBITOL-MANNITOL	MANNITOL/SORBITOL SOLUTION				

**IRRITANTS/COUNTER-IRRITANTS**

G	ARTHRITIS HOT PAIN RELIEF	METHYL SALICYLATE/MENTHOL				
G	BENGAY	METHYL SALICYLATE/MENTHOL				
G	MEDICATED CHEST RUB	EUCALYPT/MEN/CAMP/TURP/PET,WH				
G	MEDOTAR	COAL TAR/ZINC OXIDE				
B	MENTHOLATUM DEEP HEATING	METHYL SALICYLATE/MENTHOL				
G	ZOSTRIX	CAPSAICIN				
B	ZOSTRIX-HP	CAPSAICIN				

**PROTECTIVES**

G	CALAMINE	CALAMINE				
G	CALAMINE PHENOLATED	CALAMINE/PHENOL LIQUID				

**TOPICAL PREPARATIONS,MISCELLANEOUS**

G	BLUBORO	CALCIUM ACETATE/AL SULFATE				
	SILVASORB	SILVER				
	SILVERMED	SILVER				

Representative Brand	Generic Name	QL	Age	ST	Day Supply
<b><u>DIABETES</u></b>					
<b>ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)</b>					
B BYETTA	EXENATIDE				
<b>ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>					
B SYMLIN	PRAMLINTIDE ACETATE				
<b>BLOOD SUGAR DIAGNOSTICS</b>					
TEST STRIPS - VARIOUS Limit of 100 per month. Truetrack and One Touch brands only.	TEST STRIPS	X			
<b>DIABETIC SUPPLIES</b>					
DIABETIC METERS - VARIOUS Limit 1 per year. Truetrack and One Touch brands only.	BLOOD-GLUCOSE METER	X			
LANCETS Limit of 200 per month.	DIABETIC SUPPLIES,MISCELL	X			
LANCING DEVICE	DIABETIC SUPPLIES,MISCELL				
<b>HYPERGLYCEMICS</b>					
B GLUCAGEN Limit 1 per 90 days.	GLUCAGON,HUMAN RECOMBINANT	X			
B GLUCAGON EMERGENCY KIT Limit 1 per 90 days.	GLUCAGON,HUMAN RECOMBINANT	X			
<b>HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIB TYPE (N-S)</b>					
B GLYSET Limit of 300 per 90 days.	MIGLITOL	X			<= 90
B PRECOSE Limit of 300 per 90 days.	ACARBOSE	X			<= 90
<b>HYPOGLYCEMICS, BIGUANIDE TYPE (NON-SULFONYLUREAS)</b>					
B FORTAMET	METFORMIN HCL				<= 90
G GLUCOPHAGE (XR)	METFORMIN HCL				<= 90
B RIOMET	METFORMIN HCL				<= 90
<b>HYPOGLYCEMICS, INSULIN-RELEASE STIMULANT TYPE</b>					
G AMARYL	GLIMEPIRIDE				<= 90
B DIABETA	GLYBURIDE				<= 90
G DIABINESE	CHLORPROPAMIDE				<= 90
G GLUCOTROL XL	GLIPIZIDE				<= 90
G GLUCOVANCE Limit of 2 tablets per day.	GLYBURIDE/METFORMIN HCL	X			<= 90
G GLYNASE	GLYBURIDE,MICRONIZED				<= 90
G METAGLIP Limit of 3 per day. History of metformin in the past 120 days.	GLIPIZIDE/METFORMIN HCL	X		X	
G MICRONASE	GLYBURIDE				<= 90
G TOLBUTAMIDE	TOLBUTAMIDE				<= 90
G TOLINASE	TOLAZAMIDE				<= 90

Representative Brand	Generic Name	QL	Age	ST	Day Supply
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## DIABETES

### HYPOGLYCEMICS, INSULIN-RESPONSE ENHANCER (N-S)

B	ACTOPLUS MET	PIOGLITAZONE HCL/METFORMIN HCL				
B	ACTOS Limited to 1 per day.	PIOGLITAZONE HCL	X			
B	AVANDAMET	ROSIGLITAZONE/METFORMIN HCL				
B	AVANDIA Requires history of metformin in the last 120 days. Limited to 1 per day.	ROSIGLITAZONE MALEATE	X		X	

### INSULINS

B	APIDRA PA required for pen/cartridge.	INSULIN GLULISINE				<= 90
B	HUMALOG Limit of 20ml's per month. (60ml's per 100 days). PA required for pen/cartridge.	INSULIN LISPRO,HUMAN REC.ANLOG	X			<= 90
B	HUMALOG MIX 50/50 PA required for pen/cartridge.	INSULIN NPL/INSULIN LISPRO				<= 90
B	HUMALOG MIX 75/25 PA required for pen/cartridge.	INSULIN NPL/INSULIN LISPRO				<= 90
B	HUMULIN 50/50 PA required for pen/cartridge.	HUM INSULIN NPH/REG INSULIN HM				<= 90
B	HUMULIN 70/30 PA required for pen/cartridge.	HUM INSULIN NPH/REG INSULIN HM				<= 90
B	HUMULIN N Limit of 20ml's per month. (60ml's per 100 days). PA required for pen/cartridge.	INSULIN NPH HUMAN RECOM	X			<= 90
B	HUMULIN R 500 units/ml - Limit of 20ml's per month. (60ml's per 100 days). PA required for pen/cartridge.	INSULIN REGULAR HUMAN REC				<= 90
B	LANTUS Limit of 20ml's per month. (60ml's per 100 days). PA required for pen/cartridge.	INSULIN GLARGINE ,HUM.REC.ANLOG	X			<= 90
B	NOVOLIN 70/30 INNOLET PA required for pen/cartridge.	HUM INSULIN NPH/REG INSULIN HM				<= 90
B	NOVOLIN N Limit of 20ml's per month. (60ml's per 100 days). PA required for pen/cartridge.	INSULIN NPH HUMAN RECOM	X			<= 90
B	NOVOLIN R PA required for pen/cartridge.	INSULIN REGULAR HUMAN REC				<= 90
B	NOVOLOG MIX 70/30 PA required for pen/cartridge.	INSULN ASP PRT/INSULIN ASPART				<= 90

### SYRINGES AND ACCESSORIES

BD	INSULIN SYRINGE Limit of 100 per month. All increments (0.3ml, 0.5ml, 1ml) on formulary.	SYRING W-NDL,DISP,INSUL	X			<= 90
	MONOJECT Limit of 100 per month. All increments (0.3ml, 0.5ml, 1ml) on formulary.	SYRING W-NDL,DISP,INSUL	X			<= 90

### URINE GLUCOSE TEST AIDS

	CLINISTIX REAGENT	URINE GLUCOSE TEST,STRIP				
	DIASCREEN 1G REAGENT	URINE GLUCOSE TEST,STRIP				
	DIASTIX REAGENT	URINE GLUCOSE TEST,STRIP				

**EAR - GENERAL DISORDERS****EAR PREPARATIONS, MISC. ANTI-INFECTIVES**

B	STAR-OTIC	ACETIC AC/AL ACETATE/BOR AC/PG				
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**EAR PREPARATIONS, MISCELLANEOUS (OTC)**

B	EAR DRY	BORIC ACID/ISOPROPYL ALCOHOL				
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B	SWIM EAR	ISOPROPYL ALCOHOL/GLYCERIN				
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**EAR PREPARATIONS,ANTIBIOTICS**

G	ACETIC ACID Limit of 15ml per month.	ACETIC ACID	X			
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G	CORTISPORIN Limit of 10ml per month.	NEOMY SULF/POLYMYX B SULF/HC	X			
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G	DOMEBORO Limit of 60ml per month.	ACETIC ACID/ALUMINUM ACETATE	X			
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G	FLOXIN Limited to 10ml in 14 days.	OFLOXACIN	X			
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G	VOSOL HC Limit of 10ml per month.	ACETIC ACID/HYDROCHLOROTHIAZIDE	X			
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**EAR PREPARATIONS,EAR WAX REMOVERS**

G	GLY-OXIDE Limit of 15ml per month.	CARBAMIDE PEROXIDE	X			
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**EAR PREPARATIONS,LOCAL ANESTHETICS**

G	A/B OTIC Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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G	ANTIPYRINE-BENZOCAINE Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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G	AUROGUARD Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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G	BALAGAN Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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G	OTRA NR Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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G	PRO-OTIC Limit of 15ml per month.	ANTIPYRINE/BENZOCAINE/GLYCERIN	X			
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**ELECTROLYTE REGULATION****ELECTROLYTE DEPLETERS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G KAYEXALATE	SODIUM POLYSTYRENE SULFONATE				
B PHOSLO	CALCIUM ACETATE				<= 90

**ELECTROLYTE MAINTENANCE**

G PEDIALYTE Limit of 4000ml in 32 days.	ELECTROLYTE, ORAL	X			
G REHYDRALYTE Limit of 4000ml in 32 days.	ELECTROLYTE, ORAL	X			
B SALIVA SUBSTITUTE Limit 120ml in 30 days.	LYTES/CARBOXYMETHYLCELLULOSE	X			

**POTASSIUM REPLACEMENT**

G KAON	POTASSIUM GLUCONATE				
G K-LOR	POTASSIUM CHLORIDE				<= 90
G MICRO-K Limit of 2 per day.	POTASSIUM CHLORIDE	X			<= 90
B QUIC-K	POTASSIUM BICARBONATE				<= 90
B RUM-K	POTASSIUM CHLORIDE				<= 90

**ENDOCRINE DISORDER - OTHER****ANTIDIURETIC AND VASOPRESSOR HORMONES**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G DDAVP Vials and ampuls = PA Required.	DESMOPRESSIN ACETATE				

**BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE**

B FORTEO Limit of 3 per month.. Step therapy requires history of Fosamax.	TERIPARATIDE	X		X	
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**BONE RESORPTION INHIBITOR & CALCIUM COMBINATIONS**

B ACTONEL WITH CALCIUM	RISEDRON SOD/CALCIUM CARBONATE				
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**BONE RESORPTION INHIBITOR & VITAMIN D COMBINATIONS**

B FOSAMAX PLUS D Limit of 4 per month.	ALENDRONATE SODIUM/VITAMIN D3	X			
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**BONE RESORPTION INHIBITORS**

B ACTONEL Limit of 2 per month. Step therapy requires history of Fosamax.	RISEDRONATE SODIUM	X		X	
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B BONIVA 150mg tabs: Limit of 3 per 90 days. Injection = PA required. Step therapy requires history of Fosamax.	IBANDRONATE SODIUM	X		X	
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G DIDRONEL	ETIDRONATE DISODIUM				
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B EVISTA Limited to 1 per day.	RALOXIFENE HCL	X			
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B FORTICAL Spray pump: Limited to 1 package per month.	CALCITONIN,SALMON,SYNTHETIC	X			
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B FOSAMAX Tabs: Limit of 4 per month. Solution: limit of 150ml per month.	ALENDRONATE SODIUM	X			
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B MIACALCIN Spray pump: Limited to 1 package per month.	CALCITONIN,SALMON,SYNTHETIC	X			
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B SKELID	TILUDRONATE DISODIUM				
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**HYPERPARATHYROID TX AGENTS VITAMIN D ANALOG TYPE**

B ZEMPLAR Step therapy requires history of calcitriol.	PARICALCITOL			X	
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**ENDOCRINE DISORDER - THYROID****ANTITHYROID PREPARATIONS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G METHIMAZOLE	METHIMAZOLE				<= 90
G PROPYLTHIOURACIL	PROPYLTHIOURACIL				<= 90
G TAPAZOLE	METHIMAZOLE				

**IODINE CONTAINING AGENTS**

G LUGOL'S	POTASSIUM IODIDE/IODINE				
B PIMA	POTASSIUM IODIDE				
G SSKI	POTASSIUM IODIDE				
G STRONG IODINE	POTASSIUM IODIDE/IODINE				
B THYROSHIELD	POTASSIUM IODIDE				

**THYROID HORMONES**

G ARMOUR THYROID	THYROID				<= 90
B CYTOMEL	LIOTHYRONINE SODIUM				
G NATURE-THROID	THYROID,PORK				
G NP THYROID	THYROID,PORK				
G SYNTHROID / LEVOXYL	LEVOTHYROXINE SODIUM				<= 90
G THYROID,PORK	THYROID,PORK				<= 90
B THYROLAR	LIOTRIX				

**EYE - GENERAL DISORDERS****EYE ANTIBIOTIC-CORTICOID COMBINATIONS**

G	MAXITROL Limited to 3.5g (1 package) per month	NEO/POLYMYX B SULF/DEXAMETH	X			
G	NEODECADRON	NEOMYCIN SULFATE/DEX NA PH				
G	NEOMYCIN-POLYMYXIN-HC Limited to 7.5ml (1 package) per month	NEOMYCIN-POLYMYXIN-HC	X			
B	POLY-PRED Limited to 3.5g (1 package) per month	NEOMY SULF/POLYMYX B SULF/PRED	X			
B	PRED-G	GENTAMICIN/PREDNISOL AC				
B	TOBRADEX Ointment: Limited to 3.5g (1 package) per month. Suspension: Limited to 10ml (1 package) per month.	TOBRAMYCIN SULFATE/DEXAMETH	X			

**EYE ANTIHISTAMINES**

B	BEPREVE History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days. Limited to 10ml (1 package) per month.	BEPOTASTINE BESILATE	X		X	
B	ELESTAT History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days. Limited to 5ml (1 package) per month.	EPINASTINE HCL	X		X	
B	EMADINE History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days. Limited to 5ml (1 package) per month.	EMEDASTINE DIFUMARATE	X		X	
G	OPTIVAR Limited to 6ml (1 package) per month.	AZELASTINE HCL	X			
B	PATADAY History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days. Limited to 10ml (1 package) per month.	OLOPATADINE HCL	X		X	
B	PATANOL History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days. Limited to 5ml (1 package) per month.	OLOPATADINE HCL	X		X	
G	ZADITOR (OTC/RX) Limited to 5 mL (1 package) per month.	KETOTIFEN FUMARATE	X			

**EYE ANTIINFLAMMATORY AGENTS**

G	ACULAR (LS, PF)	KETOROLAC TROMETHAMINE				
G	DECADRON	DEXAMETHASONE SOD PHOSPHATE				
G	FML	FLUOROMETHOLONE				
B	FML FORTE	FLUOROMETHOLONE				
B	FML S.O.P.	FLUOROMETHOLONE				
B	INFLAMASE MILD	PREDNISOLONE SOD PHOSPHATE				
G	OCUFEN	FLURBIPROFEN SODIUM				
G	PEDIAPRED	PREDNISOLONE SOD PHOSPHATE				
G	PRED FORTE	PREDNISOLONE ACETATE				
G	PREDNISOLONE SODIUM PHOSPHATE	PREDNISOLONE SOD PHOSPHATE				
G	VOLTAREN	DICLOFENAC SODIUM				

**EYE - GENERAL DISORDERS****EYE ANTIVIRALS**

G	TRIFLURIDINE	TRIFLURIDINE				
G	VIROPTIC	TRIFLURIDINE				

**EYE LOCAL ANESTHETICS**

G	FLUORACAINE	PROPARAC HCL/FLUORESCEIN NA				
G	PARCAINE	PROPARACAINE HCL				

**EYE SULFONAMIDES**

G	BLEPH-10	SULFACETAMIDE SODIUM				
B	BLEPHAMIDE (S.O.P.)	NA SULFACETM/PREDNISOL AC				
B	OPTIMYD	NA SULFACETM/PREDNIS SP				
G	VASOCIDIN	NA SULFACETM/PREDNIS SP				

**EYE VASOCONSTRICTORS**

G	AK-NEFRIN	PHENYLEPHRINE HCL				
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**EYE VASOCONSTRICTORS (OTC ONLY)**

G	ALL CLEAR	NAPHAZOLINE HCL/PEG 300				
B	ALL CLEAR AR	NAPHAZOLINE HCL/HYPROMELLOSE				
G	EYE DROPS	TETRAHYDROZOLINE HCL/PEG'S				
G	EYE DROPS EXTRA	TETRAHYDROZOLINE HCL/PEG'S				
G	EYE MOISTURIZING RELIEF	TETRAHYDROZOLINE HCL/PEG'S				
G	EYE-SED	TETRAHYDROZOLINE HCL/ZN SULF				
G	NAPHCON	NAPHAZOLINE HCL				
G	NAPHCON-A	NAPHAZOLINE HCL/PHENIR MAL				
G	NEO-SYNEPHRINE 12 HOUR	OXYMETAZOLINE HCL				
B	OPCON-A	NAPHAZOLINE HCL/PHENIR MAL				
G	REDNESS RELIEF	TETRAHYDROZOLINE HCL/PEG'S				
G	RELIEF EYE DROPS	TETRAHYDROZOLINE HCL/PEG'S				
G	STERILE EYE DROPS	TETRAHYDROZOLINE HCL/PEG'S				
G	VISINE	TETRAHYDROZOLINE HCL				

**EYE VASOCONSTRICTORS (RX ONLY)**

G	AK-DILATE	PHENYLEPHRINE HCL				
G	NAPHCON	NAPHAZOLINE HCL				

**EYE - GENERAL DISORDERS****OPHTHALMIC ANTIBIOTICS**

G	BACITRACIN STERILE	BACITRACIN				
G	CILOXAN Limit of 10ml per month.	CIPROFLOXACIN HCL	X			
G	GARAMYCIN	GENTAMICIN SULFATE				
G	ILOTYCIN	ERYTHROMYCIN BASE				
B	NATACYN	NATAMYCIN				
G	NEOCIDIN	NEOMY SULF/GRAMICID D/POLY				
G	NEOMYCIN-BACITRACIN-POLYMYXIN	NEOMY SULF/BACITRA/POLYMYXIN B				
G	NEOSPORIN	NEOMYCIN/GRAMICIDIN/POLYMYXN B				
G	POLYTRIM	POLYMYXIN B SULFATE/TMP				
B	QUIXIN	LEVOFLOXACIN				
B	TERAK	OXY-TCN HCL/POLYMYX B SULF				
B	TOBREX OINTMENT	TOBRAMYCIN SULFATE				
G	TOBREX SOLUTION	TOBRAMYCIN SULFATE				
B	ZYMAR History of bacitracin, erythromycin, gentamicin, neomycin/bacitracin/polymyxin, neomycin/polymyxin/gramicidin, norfloxacin, polymycin/bacitracin, tobramycin, or polytrim in the past 120 days.	GATIFLOXACIN			X	
B	ZYMAXID History of bacitracin, erythromycin, gentamicin, neomycin/bacitracin/polymyxin, neomycin/polymyxin/gramicidin, norfloxacin, polymycin/bacitracin, tobramycin, or polytrim in the past 120 days.	GATIFLOXACIN	X		X	

**OPHTHALMIC MAST CELL STABILIZERS**

B	ALAMAST History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days.	PEMIROLAST POTASSIUM			X	
B	ALOCRIAL History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days.	NEDOCROMIL SODIUM			X	
B	ALOMIDE History of Zaditor AND one of the following: Naphcon, Naphcon-A, Vasocon-A, Opcon-A, All-Clear, Albalon, Visine, Visine LR, Mydrin, or itself in the past 120 days.	LODOXAMIDE TROMETHAMINE			X	
G	CROLOM	CROMOLYN SODIUM				

**OPHTHALMIC PREPARATIONS, MISCELLANEOUS**

G	SODIUM CHLORIDE	SODIUM CHLORIDE				
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**EYE - MISCELLANEOUS****ARTIFICIAL TEARS**

B	CELLUVISC	CARBOXYMETHYLCELLULOSE SODIUM				
B	HYPOTEARs-PF	POLYVINYL ALCOHOL				
G	LIQUID TEARS	POLYVINYL ALCOHOL				
G	REFRESH	POLYVINYL ALCOHOL/POVIDONE				
B	REFRESH LIQUIGEL	CARBOXYMETHYLCELLULOSE SODIUM				
G	REFRESH P.M.	PETROLAT,WHT/MIN OIL/SOD CHL				
B	REFRESH PLUS	CARBOXYMETHYLCELLULOSE SODIUM				
G	REFRESH TEARS	CARBOXYMETHYLCELLULOSE SODIUM				
G	TEARGEN II	HYPROMELLOSE				
G	TEARS NATURALE FORTE	DEXTRAN/HYPROMELLOSE/GLYCERIN				
G	TEARS NATURALE-II	DEXTRAN 70/HYPROMELLOSE				
B	THERA TEARS	CARBOXYMETHYLCELLULOSE SODIUM				

**EYE IRRIGATIONS**

G	BALANCED SALT	BALANCED SALT IRRIG SOLN COMB2				
G	EYE WASH	SOD BORATE/BORIC AC/H2O/NACL				
G	EYE-STREAM	BALANCED SALT SOLN NON-SURG #3				
G	IRIGATE	SODIUM/POTASSIUM/SOD CHL				
B	MEDIWASH	BORIC ACID				
G	OCUSOFT	SODIUM/POTASSIUM/SOD CHL				
B	OPTICS EYE WASH	SODIUM CHLORIDE				
G	VISUAL-EYES	SODIUM/POTASSIUM/SOD CHL				

**EYE PREPARATIONS, MISCELLANEOUS (OTC)**

B	ADVANCED EYE RELIEF	PETROLATUM,WHITE/MINERAL OIL				
G	HYPOTEARs	MINERAL OIL/PETROLATUM,WHITE				
G	LACRI-LUBE S.O.P.	LANOLIN/MIN OIL/PETROLAT,WHT				
B	PURALUBE	PETROLATUM,WHITE				
B	SOOTHE	MINERAL OIL, LIGHT/MINERAL OIL				

**GOUT AND RELATED DISEASES****COLCHICINE**

G	COLCHICINE	COLCHICINE				
G	COL-PROBENECID	OLCHICINE/PROBENECID				

**HYPERURICEMIA TX - PURINE INHIBITORS**

G	ZYLOPRIM	ALLOPURINOL				<= 90
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**URICOSURIC AGENTS**

G	PROBENECID	PROBENECID				<= 90
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**HEMATOLOGICAL DISORDERS****ANTICOAGULANTS, COUMARIN TYPE**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G COUMADIN	WARFARIN SODIUM				<= 90

**HEMATINICS, OTHER**

B EPOGEN Limit 12 per fill.	EPOETIN ALFA	X			
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B PROCRT Limit 12 per fill.	EPOETIN ALFA	X			
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**HEMORRHOLOGIC AGENTS**

G TRENTAL	PENTOXIFYLLINE				<= 90
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**HEPARIN AND RELATED PREPARATIONS**

B LOVENOX Limit of 7 per 14 days and 2 fills per year.	ENOXAPARIN SODIUM	X			
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**PLATELET AGGREGATION INHIBITORS**

B AGGRENEX History of Aspirin, Plavix, or Aggrenox in the past 120 days.	ASPIRIN/DIPYRIDAMOLE			X	<= 90
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G PERSANTINE	DIPYRIDAMOLE				<= 90
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B PLAVIX	CLOPIDOGREL BISULFATE				<= 90
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**TOPICAL HEMOSTATICS**

G GELFOAM	GELATIN SPONGE, ABSORBABLE				
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B OXYCEL	CELLULOSE, OXIDIZED				
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B RAPHON	RACEPINEPHRINE HCL				
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**VITAMIN K PREPARATIONS**

B MEPHYTON	PHYTONADIONE				
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**HORMONAL DEFICIENCY****ESTROGEN/ANDROGEN COMBINATIONS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G ESTRATEST H.S.	ESTROGEN,ESTER/ME-TESTOSTERONE				<= 90

**ESTROGENIC AGENTS**

B ACTIVELLA	ESTRADIOL/NORETH AC				<= 90
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B ALORA	ESTRADIOL				<= 90
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B ESTRADERM	ESTRADIOL				<= 90
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B GYNODIOL	ESTRADIOL				<= 90
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B MENEST	ESTROGENS,ESTERIFIED				<= 90
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G OGEN	ESTROPIPATE				<= 90
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B PREMARIN	ESTROGENS,CONJUGATED				<= 90
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B PREMPHASE	ESTROGEN,CON/M-PROGEST ACET				<= 90
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B PREMPRO	ESTROGEN,CON/M-PROGEST ACET				<= 90
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G VIVELLE-DOT	ESTRADIOL				<= 90
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**PROGESTATIONAL AGENTS**

G PROVERA	MEDROXYPROGESTERONE ACET				<= 90
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**IMMUNOSUPPRESSION/MODULATION****IMMUNOMODULATORS**

B ALDARA	IMIQUIMOD			X	
Requires trial of podofilox in the last 90 days.					

G IMIQUIMOD	IMIQUIMOD	X			
QL of #24 packets/30 days					

**IMMUNOSUPPRESSIVES**

G IMURAN	AZATHIOPRINE				<= 90
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G MYCOPHENOLATE MOFETIL	MYCOPHENOLATE MOFETIL	X	X		
Formulary for => 21 y.o. Quantity limit of 8 tabs/day					

**INFECTIOUS DISEASE - BACTERIAL****ABSORBABLE SULFONAMIDES**

G	BACTRIM (DS)	SULFAMETHOXAZOLE/TRIMETHOPRIM				
B	GANTRISIN	SULFISOXAZOLE ACETYL				
G	SULFADIAZINE	SULFADIAZINE				

**CEPHALOSPORINS - 1ST GENERATION**

G	KEFLEX	CEPHALEXIN MONOHYDRATE				
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**CEPHALOSPORINS - 2ND GENERATION**

G	CECLOR	CEFACTOR				
G	CEFZIL	CEFPROZIL				

**CEPHALOSPORINS - 3RD GENERATION**

G	OMNICEF	CEFDINIR				
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**CHEMOTHERAPEUTICS, ANTIBACTERIAL, MISC.**

G	HIPREX	METHENAMINE HIPPURATE				
G	MANDELAMINE	METHENAMINE MANDELATE				
G	PROLOPRIM	TRIMETHOPRIM				
G	TRIMETHOPRIM	TRIMETHOPRIM				
B	URO BLUE	METHENAMINE/HYOSCYAMINE				
B	UTA	MTH/ME BLUE/SALICY/NA PHOS/HYO				

**MACROLIDES**

G	BIAXIN Limit 30 tabs per 14 days. Suspension PA required.	CLARITHROMYCIN	X			
B	E.E.S.	ERYTHROMYCIN ETHYLSUCCINATE				
B	ERYPED	ERYTHROMYCIN ETHYLSUCCINATE				
B	ERY-TAB	ERYTHROMYCIN BASE				
B	ERYTHROCIN STEARATE	ERYTHROMYCIN STEARATE				
G	PEDIAZOLE	ERY E-SUCC/SULFISOXAZOLE				
G	ZITHROMAX 1gm packet limit of 2 per fill. 250mg tab limit of 6 per fill. 100mg/5ml limit of 75ml per fill. 200mg/5ml limit of 45ml per fill. 600mg tab limit of 10 per month.	AZITHROMYCIN	X			
G	ZITHROMAX TRI-PAK 500mg limit of 3 tabs per fill.	AZITHROMYCIN	X			

**NITROFURAN DERIVATIVES**

B	FURADANTIN	NITROFURANTOIN				
B	FUROXONE	FURAZOLIDONE				
G	MACROBID	NITROFURANTOIN/NITROFURAN MAC				
G	MACRODANTIN	NITROFURANTOIN MACROCRYSTAL				

**INFECTIOUS DISEASE - BACTERIAL****PENICILLINS**

G	AMOXIL	AMOXICILLIN TRIHYDRATE				
G	AUGMENTIN (ES) PA for Augmentin 250-62.5/5 suspension.	AMOX TR/POTASSIUM CLAVULANATE Please substitute with Augmentin 200-28.5/5.				
B	AUGMENTIN XR	AMOX TR/POTASSIUM CLAVULANATE				
G	BACTOCILL 250mg caps formulary. 500mg caps PA required.	OXACILLIN SODIUM				
G	DICLOXACILLIN SODIUM	DICLOXACILLIN SODIUM				
G	DYNAPEN	DICLOXACILLIN SODIUM				
B	GEOCILLIN	CARBENICILLIN INDANYL SODIUM				
G	PRINCIPEN	AMPICILLIN TRIHYDRATE				
G	VEETIDS	PENICILLIN V POTASSIUM				

**QUINOLONES**

G	CIPRO Ciprofloxacin tabs = no restrictions. Cipro Suspension and Cipro XR = PA Required.	CIPROFLOXACIN HCL				
G	NEGRAM	NALIDIXIC ACID				

**TETRACYCLINES**

G	TETRACYCLINE	TETRACYCLINE HCL				
B	VIBRAMYCIN 25mg/ml suspension = formulary. Other doxycycline monohydrate products = PA required.	DOXYCYCLINE HYCLATE				

**INFECTIOUS DISEASE - FUNGAL****ANTIFUNGAL AGENTS**

B	ANCOBON	FLUCYTOSINE				
G	DIFLUCAN 150mg limit of 3 per month. 10mg/ml and 40mg/ml suspension limit of 70ml in 30 days.	FLUCONAZOLE	X			
G	MYCELEX	CLOTRIMAZOLE				
G	NIZORAL	KETOCONAZOLE				

**ANTIFUNGAL ANTIBIOTICS**

B	FULVICIN U/F	GRISEOFULVIN,MICROSIZED				
G	GRIFULVIN V	GRISEOFULVIN,MICROSIZED				
G	GRIS-PEG	GRISEOFULVIN ULTRAMICROSIZED				
G	MYCOSTATIN	NYSTATIN				

**INFECTIOUS DISEASE - MISCELLANEOUS****AMINOGLYCOSIDES**

G	NEOMYCIN SULFATE	NEOMYCIN SULFATE				
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**ANTIBACTERIAL AGENTS,MISCELLANEOUS**

B	IRRIGATING SOLUTION G	UROLOGIC SOLUTION-G				
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**ANTILEPTOTICS**

B	DAPSONE	DAPSONE				
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**ANTI-MYCOBACTERIUM AGENTS**

G	ISONIAZID	ISONIAZID				<= 90
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G	MYAMBUTOL	ETHAMBUTOL HCL				<= 90
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G	PYRAZINAMIDE	PYRAZINAMIDE				<= 90
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B	TRECTOR	ETHIONAMIDE				
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**ANTITUBERCULAR ANTIBIOTICS**

G	RIFADIN	RIFAMPIN				<= 90
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G	RIFAMATE	RIFAMPIN/ISONIAZID				<= 90
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B	SEROMYCIN	CYCLOSERINE				
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**LINCOSAMIDES**

G	CLEOCIN HCL	CLINDAMYCIN HCL				
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B	CLEOCIN PALMITATE	CLINDAMYCIN PALMITATE				
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**INFECTIOUS DISEASE - PARASITIC****ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS**

G	FLAGYL	METRONIDAZOLE				
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**ANTHELMINTICS**

G	LICE TREATMENT Limit of 2 fills per month. Limit of 120ml per month.	PIPERONYL BUTOXIDE/PYRETHRINS	X			
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G	REESE PINWORM	PYRANTEL PAMOATE				
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G	VERMOX	MEBENDAZOLE				
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**ANTIMALARIAL DRUGS**

G	ARALEN PHOSPHATE	CHLOROQUINE PHOSPHATE				
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B	DARAPRIM	PYRIMETHAMINE				
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G	PLAQUENIL	HYDROXYCHLOROQUINE SULFATE				
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B	PRIMAQUINE	PRIMAQUINE PHOSPHATE				
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G	QUININE SULFATE	QUININE SULFATE				
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**INFECTIOUS DISEASE - VIRAL****ANTIVIRAL MONOCLONAL ANTIBODIES**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
B SYNAGIS Specialty Pharmacy Only	PALIVIZUMAB				

**ANTIVIRALS, GENERAL**

B TAMIFLU 1 per year.	OSELTAMIVIR PHOSPHATE		X			X
G ZOVIRAX Oral suspension limit of 960ml per fill.	ACYCLOVIR		X			

**ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB**

B PREZISTA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	DARUNAVIR ETHANOLATE					
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**ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG**

B TRUVADA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	EMTRICITABINE/TENOFOVIR					
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**ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB**

B COMBIVIR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LAMIVUDINE/ZIDOVUDINE					
B TRIZIVIR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ABACAVIR/LAMIVUDINE/ZIDOVUDINE					

**ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS**

B FUZEON Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ENFUVRTIDE					
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**ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI**

B RESCRIPTOR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	DELAVIRDINE MESYLATE					
B SUSTIVA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	EFAVIRENZ					
B VIRAMUNE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	NEVIRAPINE					

**INFECTIOUS DISEASE - VIRAL****ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI**

B	EMTRIVA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	EMTRICITABINE				
B	EPIVIR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	LAMIVUDINE				
B	HIVID Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ZALCITABINE				
G	RETROVIR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ZIDOVUDINE				
B	VIDEX Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	DIDANOSINE				
G	VIDEX EC Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	DIDANOSINE				
B	ZERIT Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	STAVUDINE				
B	ZIAGEN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ABACAVIR SULFATE				

**ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI**

B	VIREAD Mcal [Dx: HIV. Carve out drug - Bill EDS/Medi-Cal Fee For Service. Dx: Hepatitis B. PA required.] (Covered for HF/HK).	TENOFOVIR DISOPROXIL FUMARATE				
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**ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB**

B	KALETRA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	RITONAVIR/LOPINAVIR				
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**ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS**

B	AGENERASE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	AMPRENAVIR/VITAMIN E				
B	CRIXIVAN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	INDINAVIR SULFATE				
B	INVIRASE Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	SAQUINAVIR MESYLATE				
B	LEXIVA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	FOSAMPRENAVIR CALCIUM				
B	NORVIR Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	RITONAVIR				
B	REYATAZ Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	ATAZANAVIR SULFATE				
B	VIRACEPT Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	NELFINAVIR MESYLATE				

**ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI**

B	ATRIPLA Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	EFAVIRENZ/EMTRICITAB/TENOFOVIR				
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**HEPATITIS B TREATMENT AGENTS**

B	HEPSERA Requires history of Hep B product in last 120 days; otherwise PA Required..	ADEFOVIR DIPIVOXIL				X
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**INFLAMMATORY DISEASE****ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
B RHEUMATREX	METHOTREXATE SODIUM				

**FENOPROFEN CALCIUM**

G NALFON	FENOPROFEN				
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600 mg on formulary. Other strengths PA required.

**GLUCOCORTICOIDS**

G CORTEF	HYDROCORTISONE				
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G CORTISONE ACETATE	CORTISONE ACETATE				
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G DECADRON	DEXAMETHASONE				
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B DEXPAK	DEXAMETHASONE				
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G MEDROL	METHYLPREDNISOLONE				
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2mg, 8mg, 16mg & 32mg = PA Required. 4mg tabs & prednisone are formulary.

G ORAPRED	PREDNISOLONE SOD PHOSPHATE				
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G PEDIAPRED	PREDNISOLONE SOD PHOSPHATE				
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G PREDNISONE	PREDNISONE				
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G PRELONE	PREDNISOLONE				
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**MINERALOCORTICOIDS**

G FLORINEF ACETATE	FLUDROCORTISONE ACETATE				
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**INFLAMMATORY DISEASE****NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE**

G	ANAPROX DS	NAPROXEN SODIUM					<= 90
G	ANSAID	FLURBIPROFEN					<= 90
B	ARTHROTEC Requires history of 2 NSAIDS in the last 365 days.	DICLOFENAC SODIUM/MISOPROSTOL				X	
G	CATAFLAM	DICLOFENAC POTASSIUM					<= 90
B	CELEBREX PA Required if age < 55. 50mg caps limit of 1 per day.	CELECOXIB	X	X			<= 90
G	CLINORIL	SULINDAC					<= 90
G	DAYPRO	OXAPROZIN					<= 90
G	FELDENE	PIROXICAM					<= 90
G	INDOCIN Suppositories = PA Required.	INDOMETHACIN					<= 90
G	LODINE	ETODOLAC					<= 90
G	LODINE XL Requires history of 2 NSAIDS in the last 365 days.	ETODOLAC SR				X	
G	MOBIC	MELOXICAM					
G	MOTRIN 100mg chewables: Limited to ages 4 to 11.	IBUPROFEN		X			<= 90
G	NALFON	FENOPROFEN CALCIUM					<= 90
G	NAPROSYN 125mg/5ml solution: Limited to 600ml per month.	NAPROXEN	X				<= 90
G	ORUVAIL	KETOPROFEN					<= 90
G	RELAFEN	NABUMETONE					<= 90
G	TOLECTIN Requires history of 2 NSAIDS in the last 365 days.	TOLMETIN				X	
G	TOLECTIN DS	TOLMETIN SODIUM					<= 90
G	TORADOL Limit of 20 per month. Limit of 4 per day.	KETOROLAC TROMETHAMINE	X				
G	VOLTAREN (XR)	DICLOFENAC SODIUM					<= 90

**LOCAL ANESTHESIA****LOCAL ANESTHETICS**

B	ORASEP	B-CAINE/TAN AC/MENTH/CPYRD					
G	XYLOCAINE Lidocaine 2% jelly: Limit of 30ml per month. Lidocaine Viscous: Limit of 200ml per month.	LIDOCAINE HCL	X				

**LOWER GASTROINTESTINAL DISORDERS - BOWEL INFLAMMAT****BOWEL ANTIINFLAMATORY AGENTS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G AZULFIDINE	SULFASALAZINE				<= 90

**RECTAL PREPARATIONS**

G ANUSOL-HC	HYDROCORTISONE ACETATE				
G PROCTOCORT	HYDROCORTISONE				
B PROCTO-KIT	HYDROCORTISONE				

**RECTAL/LOWER BOWEL PREP.,GLUCOCORT. (NON-HEMORR)**

G HYDROCORTISONE ENEMA	HYDROCORTISONE				
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**LOWER GASTROINTESTINAL DISORDERS - OTHER****AMMONIA INHIBITORS**

G	ENULOSE Limit of 2700ml per month.	LACTULOSE	X			
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**ANTIDIARRHEALS**

G	IMODIUM A-D	LOPERAMIDE HCL				
G	LOMOTIL	DIPHENOXYLATE HCL/ATROP SULF				
G	PEPTO-BISMOL Oral suspension = formulary. Tablets = PA Required.	BISMUTH SUBSALICYLATE				

**BILE SALTS**

G	ACTIGALL Limit of 3 per day.	URSODIOL	X			
B	URSO Limit of 3 per day.	URSODIOL	X			

**LOWER GASTROINTESTINAL DISORDERS - OTHER****LAXATIVES AND CATHARTICS**

G	BENEFIBER	GUAR GUM				
B	CASCARA SAGRADA	CASCARA SAGRADA				
G	CITRUCEL	METHYLCELLULOSE				
G	COLYTE Limit 4000ml per month.	SOD SULF/SOD/NAHCO3/KCL/PEG'S	X			
G	DULCOLAX	BISACODYL				
G	FIBER OFF	FIBER				
G	FIBERCON	CALCIUM POLYCARBOPHIL				
G	FLEET PHOSPHO-SODA	NA PHOS,M-B/NA PHOS,DI-BA				
B	FLEET PREP KIT	BISACODYL/NAPH,MB-DB				
B	GOLYTELY Limit 4000ml per month.	SOD SULF/SOD/NAHCO3/KCL/PEG'S	X			
B	HALFLYTELY	BISAC/NACL/NAHCO3/KCL/PEG 3350				
G	KAOPECTATE	DOCUSATE CALCIUM				
B	KONDREMUL	MINERAL OIL/CARRAGEENAN				
G	MAGNESIUM CITRATE	MAGNESIUM CITRATE				
G	MAGNESIUM SULFATE	MAGNESIUM SULFATE				
G	METAMUCIL	PSYLLIUM HUSK				
G	METAMUCIL PLUS CALCIUM	PSYLLIUM HUSK/CA CARBONATE				
G	MILK OF MAGNESIA	MAGNESIUM HYDROXIDE				
G	MILK OF MAGNESIA W/CASCARA	CASCARA SAGRADA/MAG HYDROX				
G	MINERAL OIL	MINERAL OIL				
G	MIRALAX Requires history of any 2 laxatives. Limit of 527gm per month.	POLYETHYLENE GLYCOL 3350	X		X	
G	NATURAL FIBER	PSYLLIUM SEED/ASPARTAME				
B	OSMOPREP Limit 20 tabs per month.	NAPHOS M-B M-H/NA PHOS,DI-BA	X			
G	PERI-COLACE 30-100mg caps limit of 100 per month.	CASANTHRANOL/DOCUSATE SODIUM	X			
G	PURGE Limit of 1 fill per 120 days.	CASTOR OIL	X			
G	SENNA 8.6mg caps and 15mg tabs = formulary. Fill limit of 1 per 120 days.	SENNOSIDES	X			
G	SENNA PLUS 8.6 - 50mg tabs = formulary	SENNA/DOCUSATE SODIUM				
G	SOF-LAX Caps and tabs limit of 100 per month. Liquid limit of 960ml per month.	DOCUSATE SODIUM	X			
G	TRILYTE WITH FLAVOR PACKETS	SOD CHLORIDE/NAHCO3/KCL/PEG'S				
B	UNIFIBER	CELLULOSE				
B	VISICOL Limit 20 tabs per month.	NA PHOS MONO&DIBASIC/CELLULOSE	X			

**LOWER GASTROINTESTINAL DISORDERS - OTHER****LAXATIVES, LOCAL/RECTAL**

G	DULCOLAX Tablets limit of 50 per month. Kit limit 1 fill per 120 days.	BISACODYL	X			
G	ENEMEEZ	DOCUSATE SODIUM/BENZOCAINE				
B	FLEET BABYLAX	GLYCERIN				
B	FLEET BISACODYL	BISACODYL				
G	FLEET PHOSPHO-SODA	NA PHOS,M-B/NA PHOS,DI-BA				
G	GLYCERIN	GLYCERIN				
G	MINERAL OIL	MINERAL OIL				
G	SOF-LAX	DOCUSATE SODIUM				

**MEDICAL SUPPLIES****DURABLE MEDICAL EQUIPMENT**

	BP MONITOR (VARIOUS BRANDS)	BLOOD PRESSURE MONITOR/KIT				
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**MISCELLANEOUS AGENTS****ANAPHYLAXIS THERAPY AGENTS**

B	ADRENALICK Limit of 1 syringe per 90 days.	EPINEPHRINE	X			
B	EPIPEN Limit of 1 syringe per 90 days.	EPINEPHRINE	X			
B	EPIPEN JR. Limit of 1 syringe per 90 days.	EPINEPHRINE	X			

**NEOPLASTIC DISEASE****ALKYLATING AGENTS**

B	ALKERAN	MELPHALAN				
B	CEENU	LOMUSTINE				
G	CYTOXAN	CYCLOPHOSPHAMIDE				
B	HEXALEN	ALTRETAMINE				
G	HYDREA	HYDROXYUREA				
B	LEUKERAN	CHLORAMBUCIL				
B	MYLERAN	BUSULFAN				

**ANTIANDROGENIC AGENTS**

B	CASODEX	BICALUTAMIDE				
G	EULEXIN	FLUTAMIDE				
B	NILANDRON	NILUTAMIDE				

**ANTIBIOTIC ANTINEOPLASTICS**

B	MITHRACIN	PLICAMYCIN				
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**ANTIMETABOLITES**

G	METHOTREXATE	METHOTREXATE SODIUM				
G	PURINETHOL	MERCAPTOPYRINE				
B	THIOGUANINE	THIOGUANINE				
B	XELODA	CAPECITABINE				

**ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS**

B	IRESSA	GEFITINIB				
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**ANTINEOPLASTICS,MISCELLANEOUS**

B	ARIMIDEX	ANASTROZOLE				
B	AROMASIN	EXEMESTANE				<= 90
B	FEMARA	LETROZOLE				<= 90
B	LYSODREN	MITOTANE				
B	MATULANE	PROCARBAZINE HCL				
G	VEPESID	ETOPOSIDE				
B	VESANOID	TRETINOIN				

**CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS**

G	LEUCOVORIN	LEUCOVORIN CALCIUM				
B	MESNEX	MESNA				

**SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM)**

G	NOLVADEX	TAMOXIFEN CITRATE				<= 90
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**NEOPLASTIC DISEASE****STEROID ANTINEOPLASTICS**

B	EMCYT	ESTRAMUSTINE PHOSPHATE SODIUM				
G	MEGACE	MEGESTROL ACETATE				
B	TESLAC	TESTOLACTONE				

**ORAL/PHARYNGEAL DISORDERS****NOSE PREPARATIONS ANTIBIOTICS**

B	BACTROBAN NASAL Limit of 10gm per month.	MUPIROICIN CALCIUM	X			
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**NOSE PREPARATIONS, MISCELLANEOUS (RX)**

G	ATROVENT 21mcg: limit of 30ml per month. 42mcg: limit of 15ml per month.	IPRATROPIUM BROMIDE	X			
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**PERIODONTAL COLLAGENASE INHIBITORS**

G	PERIOSTAT Limit of 90 days supply.	DOXYCYCLINE HYCLATE				
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**OTHER DRUGS****ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR**

B	ISENTRESS Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	RALTEGRAVIR				
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**NOSE PREPARATIONS, MISCELLANEOUS (OTC)**

G	NEILMED SINUS	SODIUM CHLORIDE/SOD BICARB				
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**URINE ACETONE TEST AIDS**

B	KETOSTIX REAGENT Formulary for => 21 y.o.	URINE ACETONE TEST, STRIPS		X		
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**OTHER DRUGS/SUPPLIES****CONDOMS**

CONDOMS (VARIOUS)  
Limit of 24 per month.

CONDOMS, LATEX, LUBRICATED

X

**GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS**

B BARICON

BARIUM SULFATE

B BAR-TEST

BARIUM SULFATE

B ENTERO VU

BARIUM SULFATE/METHYLCELLULOSE

B E-Z-CAT

BARIUM SULFATE

B GASTROMARK

FERUMOXASIL

B READI-CAT

BARIUM SULFATE

B TAGITOL

BARIUM SULFATE

**INSECTICIDES**

G ELIMITE

PERMETHRIN

Limit 120gm per month. Limit 2 fills per month.

X

G RID

RESMETHRIN

Limit 120gm per month. Limit 2 fills per month.

X

**PROTEIN REPLACEMENT**

G L-CARNITINE

LEVOCARNITINE

**OTHER RESPIRATORY DISORDERS****MUCOLYTICS**

G MUCOMYST

ACETYLCYSTEINE

**PAIN MANAGEMENT - ANALGESICS****ANALGESIC/ANTIPYRETICS, SALICYLATES**

G	ALKA-SELTZER Limit of 100 per month.	ASPIRIN/SOD BICARB/CITRIC ACID	X			
G	ASCRIPTIN Limit of 100 per month.	ASA/CALCIUM CARB/MAG/AL HYDROX	X			
G	ASPIRIN Limit of 100 per month.	ASPIRIN	X			
G	BACK PAIN-OFF	MG SALICYLATE/ACETAMINOPH/CAFF				
G	BUFFERED ASPIRIN Limit of 100 per month.	ASPIRIN/MAG CARB/AL AMINOACET	X			
G	DISALCID	SALSALATE				
G	DURABAC	SAL-AMIDE/ACETAMIN/P-TLOX/CAFF				
G	EXCEDRIN	ASPIRIN/ACETAMINOPHEN/CAFFEINE				
G	FIORINAL	ASPIRIN/CAFFEINE/BUTALBITAL				
G	FRENADOL	SALICYLAMIDE/ACETAMINOPHEN				
B	LEVACET	ASA/SALICYLAM/ACETAMINOPH/CAFF				
G	PAIN RELIEF	ASA/SALICYLAM/ACETAMINOPH/CAFF				
G	SALETO	ASA/SALICYLAM/ACETAMINOPH/CAFF				
B	SUPAC	ASA/ACETAMINOPHEN/CAFFEINE/CAL				
G	TRILISATE	CHOL SAL/MAGNESIUM SALICYLATE				
B	VANQUISH	ASA/ACETAMINOPHN/MAG/ALH/CAFF				

**ANALGESIC/ANTIPYRETICS, NON-SALICYLATE**

G	EXCEDRIN ASPIRIN FREE	ACETAMINOPHEN/CAFFEINE				
G	FIORICET	ACETAMINOPHEN/CAFFEINE/BUTALB				
B	FLEXTRA	ACETAMINOPHEN/PHENYLTOLOX/CAFF				
G	MENSTRUAL RELIEF	ACETAMINOPHEN/PAMABROM				
G	PHRENILIN	ACETAMINOPHEN/BUTALBITAL				
G	TYLENOL Tabs: QL 100 per month. Suppositories QL 24 per month. Suspension QL 240ml per month. Drops QL 60ml per month.	ACETAMINOPHEN	X			

**ANALGESICS, NARCOTIC AGONIST AND NSAID COMBINATION**

G	HYDROCODONE BIT-IBUPROFEN	HYDROCODONE/IBUPROFEN				
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**PAIN MANAGEMENT - ANALGESICS****ANALGESICS, NARCOTICS**

G	ASPIRIN W/CODEINE 60-325mg Limit of 6 per day. 30-325mg limit of 12 per day. Limit of 90 days supply.	CODEINE PHOS/ASPIRIN	X				<= 90
B	CODEINE PHOSPHATE 60mg limit of 6 per day. 30mg limit of 12 per day.	CODEINE PHOSPHATE	X				<= 90
G	CODEINE SULFATE 60mg limit of 6 per day. 30mg limit of 12 per day. 15mg limit of 24 per day.	CODEINE SULF	X				<= 90
G	DARVO CET-N 100 Limit of 6 tabs per day.	PROPOXYPHENE/ACETAMINOPHEN	X				<= 90
G	DARVON Limit of 12 tabs per day.	PROPOXYPHENE HCL	X				<= 90
G	DEMEROL 50mg limit 5 per day. 100mg limit 10 per day. 50mg/5ml limit 50ml per day.	MEPERIDINE HCL	X				<= 90
G	DILAUDID 2mg limit 6 per day. 4mg limit of 3 per day. 8mg limit of 45 per month.; Liquid = PA required	HYDROMORPHONE HCL	X				<= 90
G	DOLOPHINE HCL	METHADONE HCL					
G	LEVO-DROMORAN Limit of 4 tabs per day.	LEVORPHANOL TARTRATE	X				
G	MSIR, MS CONTIN Suppositories & soluble tabs = PA Required. SR tabs: 10mg & 20mg QL 60 per month. 15mg, 30mg & 60mg QL 90 per month.	MORPHINE SULFATE	X				
G	OXYCODONE 5mg/5ml solution limit of 80ml/day. 20mg/ml oral concentrate limit of 4ml per day. 5mg tab limit 16 per day. 15mg tab limit of 5 per day. 30mg tab limit of 2 per day.	OXYCODONE HCL	X				<= 90
G	PERCOCET 5mg/325mg tabs limit of 12 per day. 5mg/500mg caps limit of 8 per day. Other strengths = PA Required.	OXYCODONE HCL/ACETAMINOPHEN	X				<= 90
G	PERCODAN Limit 6 tablets per day.	OXYCODONE HCL/ASPIRIN	X				<= 90
G	TYLENOL W/CODEINE NO.3	CODEINE PHOS/ACETAMINOPHEN	X				
G	ULTRAM	TRAMADOL HCL					
G	VICODIN 5/500 & 10/500: Limit 8 tablets per day.	HYDROCODONE BIT/ACETAMINOPHEN	X				

**PAIN MANAGEMENT - ANALGESICS****ANTIMIGRAINE PREPARATIONS**

B	AMERGE Requires history of Imitrex tablets. Limit of 9 tabs per month.	NARATRIPTAN HCL	X			
G	CAFERGOT Limited to 6 per month.	ERGOTAMINE TARTRATE/CAFFEINE	X			
B	FROVA Requires history of Imitrex tablets. Limit 9 tablets per month.	FROVATRIPTAN SUCCINATE	X			
B	IMITREX NASAL SPRAY Requires history of Imitrex tablets. Limit of 1 nasal spray unit per month.	SUMATRIPTAN	X		X	
B	IMITREX TABLETS Limit of 9 tabs per month.	SUMATRIPTAN SUCCINATE	X			
B	MAXALT (MLT) Requires history of Imitrex tablets. Limit of 9 tabs per month.	RIZATRIPTAN BENZOATE	X			
G	MIDRIN Limited to 8 per month Limited to 8 per month	ISOMETHEPT/ACETAMINOP/DICHLPHN	X			
B	RELPAK Requires history of Imitrex tablets. Limit of 6 tabs per month.	ELETRIPTAN HYDROBROMIDE	X			
B	ZOMIG Requires history of Imitrex tablets. Limit of 6 tabs or nasal spray unit per month.	ZOLMITRIPTAN	X			
B	ZOMIG ZMT Requires history of Imitrex or Zomig nasal spray in the last 90 days. Limit of 6 per month.	ZOLMITRIPTAN	X		X	

**NARCOTIC & SALICYLATE ANALGESICS, BARB.& XANTHINE**

G	BUTALBITAL COMPOUND-CODEINE	CODEINE/BUTALBITAL/ASA/CAFFEIN				
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**PARKINSONS DISEASE****ANTIPARKINSONISM**

G	ROPINOROLE HCL	ROPINOROLE HCL				
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**ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC**

G	COGENTIN Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	BENZTROPINE MESYLATE				<= 90
G	TRIHEXYPHENIDYL HCL	TRIHEXYPHENIDYL HCL				<= 90

**ANTIPARKINSONISM DRUGS,OTHER**

G	ELDEPRYL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	SELEGILINE HCL				<= 90
G	PERMAX	PERGOLIDE MESYLATE				<= 90
G	PRAMIPEXOLE DIHYDROCHLORIDE	PRAMIPEXOLE				<= 90
G	SINEMET (CR)	CARBIDOPA/LEVODOPA				<= 90
B	STALEVO Requires history of carbidopa/levodopa in the last 120 days.	CARBIDOPA/LEVODOPA/ENTACAPONE			X	<= 90
B	STALEVO 200 History of carbidopa/levodopa.	ARBIDOPA/LEVODOPA/ENTACAPONE			X	
G	SYMMETREL Carve out drug - Bill EDS/Medi-Cal Fee For Service. (Covered for HF/HK).	AMANTADINE HCL				<= 90

**PITUITARY SUPPRESSIVE AGENTS**

G	PARLODEL	BROMOCRIPTINE MESYLATE				<= 90
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**SEIZURE DISORDER****ANTICONVULSANTS**

B	CARBATROL Requires history of anticonvulsant agent in the last 120 days.	CARBAMAZEPINE			X	<= 90
B	CELONTIN	METHSUXIMIDE				<= 90
B	DEPAKOTE 125mg limit of 3 per day.	DIVALPROEX SODIUM	X			<= 90
B	DEPAKOTE ER	DIVALPROEX SODIUM				<= 90
B	DEPAKOTE SPRINKLE	DIVALPROEX SODIUM				<= 90
B	DIASTAT Limit of 4 fills per year.	DIAZEPAM	X			
B	DIASTAT ACUDIAL Limit of 4 fills per year.	DIAZEPAM	X			
B	DILANTIN	PHENYTOIN				<= 90
B	EQUETRO Requires history of anticonvulsant agent in the last 120 days.	CARBAMAZEPINE			X	<= 90
G	FELBAMATE	FELBAMATE				
B	FELBATOL Requires history of an antiepileptic agent in the last 120 days. 600mg/5ml oral susp limit of 300ml per month. 600mg limit of 6 per day. 400mg limit of 9 per day.	FELBAMATE	X		X	<= 90
B	GABITRIL Step therapy requires history of anticonvulsant in the last 120 days. 2mg, 4mg, & 12mg limit 4 tabs per day. 16mg limit 3 tabs per day.	TIAGABINE HCL	X		X	<= 90
G	KEPPRA	LEVETIRACETAM	X			
G	KLONOPIN Wafers PA required.	CLONAZEPAM				<= 90
B	LAMICTAL Requires history of an antiepileptic agent in the last 120 days. 5mg limit of 7 per day. 25mg limit of 6 per day. 100mg and 150mg limit of 3 per day.	LAMOTRIGINE	X		X	<= 90
G	MYSOLINE	PRIMIDONE				<= 90
G	NEURONTIN 100mg tabs & caps limit of 4 per day. 300mg and 400mg tab or caps limit of 3 per day. 600mg tab limit of 6 per day. 800mg tab limit of 4 per day. 250mg/5ml oral soln limit of 2100ml per month.	GABAPENTIN	X			<= 90
B	PHENYTEK	PHENYTOIN SODIUM EXTENDED				<= 90
G	PRIMIDONE	PRIMIDONE				<= 90
G	TEGRETOL	CARBAMAZEPINE				<= 90
B	TEGRETOL XR Requires history of anticonvulsant agent in the last 120 days. Limit of 2 tabs per day.	CARBAMAZEPINE			X	<= 90
B	TRILEPTAL Requires history of an antiepileptic agent in the last 120 days. Tablets limit of 4 per day. Oral susp limit of 1000ml per month.	OXCARBAZEPINE	X		X	<= 90
G	ZARONTIN	ETHOSUXIMIDE				<= 90
G	ZONEGRAN Requires history of an antiepileptic agent in the last 120 days. 25mg and 50mg limit of 2 per day. 100mg limit of 6 per day.	ZONISAMIDE	X		X	<= 90

**SKELETAL MUSCLE DISORDER****SKELETAL MUSCLE RELAXANTS**

G	DANTRIUM	DANTROLENE SODIUM				
G	FLEXERIL	CYCLOBENZAPRINE HCL				
G	LIORESAL	BACLOFEN				<= 90
G	METHOCARBAMOL	METHOCARBAMOL				
G	PARAFON FORTE DSC	CHLORZOXAZONE				
G	ROBAXIN	METHOCARBAMOL				
B	SKELAXIN	METAXALONE			X	
Requires history of 2 of the following agents: carisprodol, methocarbamol, cyclobenzaprine, baclofen in the last 120 days.						
G	SOMA	CARISOPRODOL	X		X	
Requires history of cyclobenzaprine or baclofen in the last 120 days. Quantity limit of 90 per 30 days.						
G	ZANAFLEX	TIZANIDINE HCL			X	<= 90
Requires history of cyclobenzaprine or baclofen in the last 120 days. Capsules are PA required. Please use 2mg or 4mg tablets.						

**SMOKING CESSATION****SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)**

G	NICODERM CQ	NICOTINE	X			
Limit of 90 days per year.						

**SMOKING DETERRENTS, OTHER**

G	ZYBAN	BUPROPION HCL				
Limit of 84 days per year.						

**UPPER GASTROINTESTINAL DISORDERS - SPASTIC DISEASE****ANTICHOLINERGICS, QUATERNARY AMMONIUM**

G	LIBRAX	CLIDINIUM BR/CHLORDIAZEPOXIDE				
G	PROPANTHELINE BROMIDE	PROPANTHELINE BROMIDE				
G	ROBINUL	GLYCOPYRROLATE				

**ANTISPASMODIC AGENTS**

G	BELLAMINE	ERGOTAMINE TART/BELLAD ALK/PB				
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**BELLADONNA ALKALOIDS**

G	CYSTOSPAZ	HYOSCYAMINE				
B	DONNAMAR	HYOSCYAMINE SULFATE				
G	DONNATAL	BELLADONNA ALKALOIDS/PHENOBARB				
G	NULEV	HYOSCYAMINE SULFATE				
G	SPACOL	BELLADONNA ALKALOIDS				
Tincture and elixer = PA required. Tablets = formulary.						

**UPPER GASTROINTESTINAL DISORDERS - ULCER DISEASE****ANTACIDS**

G	ACID RELIEF	DIHYDROXYALUMINUM SODIUM CARB					<= 90
G	ALAMAG	MAGNESIUM HYDROXIDE/AL HYDROX					
B	ALKA-AID	POT BICARB/SODIUM BICARBONATE					
B	ALKA-MINT	CALCIUM CARBONATE					
G	ALTERNAGEL	ALUMINUM HYDROXIDE					
G	ANTACID	DIHYDROXYALUMINUM SODIUM CARB					<= 90
G	ANTACID P/MINT	DIHYDROXYALUMINUM SODIUM CARB					<= 90
G	CITROCARBONATE ANTACID	SODIUM BICARBONATE/SODIUM CIT					
G	GAVISCON	MAG CARB/AL HYDROX/ALGINIC AC					<= 90
G	GAVISCON-2	MG TRISILICATE/ALH/NAHCO3/AA					<= 90
B	HEARTBURN	MG TRISILICATE/AL HYDROX/AA					
G	MAALOX MS Limit of 120 per month.	MAG HYDROX/AL HYDROX/SIMETH	X				<= 90
B	MAG-AL	MAGNESIUM HYDROXIDE/AL HYDROX					
G	MILK OF MAGNESIA	MAGNESIUM HYDROXIDE					
B	MYLANTA	CALCIUM CARBONATE/MAG CARB					<= 90
G	MYLANTA ULTRA	CALCIUM CARBONATE/MAG HYDROX					<= 90
G	RIOPAN PLUS	MAGALDRATE/SIMETHICONE					
B	ROLAIDS	CALCIUM CARBONATE					
G	RON-ACID	MAGALDRATE					
G	RULOX	MAGNESIUM HYDROXIDE/AL HYDROX					
G	SB ANTACID	DIHYDROXYALUMINUM SODIUM CARB					
G	SODIUM BICARBONATE	SODIUM BICARBONATE					
B	TITRALAC	CALCIUM CARBONATE/GLYCINE					

**ANTI-ULCER PREPARATIONS**

G	CARAFATE	SUCRALFATE					
G	CYTOTEC	MISOPROSTOL					
G	PRILOSEC Omeprazole 20 covered product. OTC version not covered. Quantity limit 2 per day.	OMEPRAZOLE	X				
B	ZEGERID 20mg-1680mg packet = formulary. Other strengths & dosage forms = PA required.	OMEPRAZOLE/SODIUM BICARBONATE					

**HISTAMINE H2-RECEPTOR INHIBITORS**

G	PEPCID Limit 1 tablet per day.	FAMOTIDINE	X				
G	TAGAMET	CIMETIDINE					
G	ZANTAC	RANITIDINE HCL					

**INTESTINAL MOTILITY STIMULANTS**

G	REGLAN	METOCLOPRAMIDE HCL					
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**URINARY TRACT - FUNCTIONAL DISORDERS****BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
B AVODART	DUTASTERIDE				<= 90
G FLOMAX	TAMSULOSIN HCL				<= 90
G PROSCAR	FINASTERIDE				<= 90
B UROXATRAL	ALFUZOSIN HCL				<= 90

**KIDNEY STONE AGENTS**

B CALCIBIND	CELLULOSE SODIUM PHOSPHATE				
B CYSTAGON	CYSTEAMINE BITARTRATE				

**PARASYMPATHETIC AGENTS**

G BETHANECHOL CHLORIDE	BETHANECHOL CHLORIDE				
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**URINARY PH MODIFIERS**

G BICITRA	CITRIC ACID/SODIUM CITRATE				
B K-PHOS M.F.	NA PHOS,M-B/K PHOS,MONOB				
B K-PHOS NO.2	NA PHOS,M-B/K PHOS,MONOB				
B ORACIT	CITRIC ACID/SODIUM CITRATE				
G POLYCITRA-K Packets = formulary.	CITRIC ACID/POTASSIUM CITRATE				
B RENACIDIN	MAG CARB/CITRIC ACID/G-LACTONE				
B SHOHL'S MODIFIED	CITRIC ACID/SODIUM CITRATE				
G UROCIT-K	POTASSIUM CITRATE				
B UROQID-ACID NO.2	METHEN MAND/NAPHOS M-B M-H				

**URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)**

G PYRIDIUM	PHENAZOPYRIDINE HCL				
G PYRIDIUM PLUS	PHENAZOPY HCL/HYOSCY/BUTABARB				

**URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT**

B DETROL	TOLTERODINE TARTRATE				<= 90
G OXYBUTYNIN CHLORIDE ER	OXYBUTYNIN CHLORIDE				
G URISPAS	FLAVOXATE HCL				<= 90

Representative Brand	Generic Name	QL	Age	ST	Day Supply
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## VAGINAL DISORDERS

### VAGINAL ANTIBIOTICS

B	CLEOCIN SUPP	CLINDAMYCIN PHOSPHATE				
G	CLEOCIN W/ APPL	CLINDAMYCIN PHOSPHATE				
G	FLAGYL	METRONIDAZOLE				

### VAGINAL ANTIFUNGALS

B	FEMSTAT 3	BUTOCONAZOLE NITRATE				
B	GYNE-LOTRIMIN 3	CLOTRIMAZOLE				
B	MONISTAT (1, 3, 7) 200mg suppositories = PA required.	MICONAZOLE NITRATE				
B	MYCELEX-3	BUTOCONAZOLE NITRATE				
G	MYCELEX-7	CLOTRIMAZOLE				
G	TERAZOL (3, 7) History of nystatin, clotrimazole, miconazole, butaconazole in the past 120 days. 80mg suppositories = PA Required.	TERCONAZOLE			X	
G	VAGISTAT-1	TIOCONAZOLE				

### VAGINAL ANTISEPTICS

B	TRIMO-SAN	OXYQUINOLINE/BORIC ACID				
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### VAGINAL ESTROGEN PREPARATIONS

B	ESTRACE	ESTRADIOL				<= 90
B	PREMARIN	ESTROGENS,CONJUGATED				<= 90

### VAGINAL SULFONAMIDES

B	AVC	SULFANILAMIDE				
G	DAYTO-SULF	SULFATHIAZ/SULFACET/S-BENZ/URE				

**VITAMIN AND/OR MINERAL DEFICIENCY****CALCIUM REPLACEMENT**

B	BLEND 15	CALCIUM GLUCONATE				
G	CALCIUM	CALCIUM				<= 90
G	CALCIUM GLUCONATE	CALCIUM GLUCONATE				<= 90
G	CALTRATE-600	CALCIUM CARBONATE				<= 90
G	CALTRATE-600 PLUS	CALCIUM CARB/VIT D3/MINERALS				<= 90
B	CITRACAL	CALCIUM CITRATE/VITAMIN D3				<= 90
G	DOLOMITE	CALCIUM/MAGNESIUM				
B	OYSTER SHELL + D	CALCIUM CARBONATE/VITAMIN D3				<= 90

**FLUORIDE PREPARATIONS**

B	FLUORABON Must be <= 12 y.o.	SODIUM FLUORIDE		X		<= 90
G	PEDIAFLOR Must be <= 12 y.o.	SODIUM FLUORIDE		X		<= 90
B	SODIUM FLUORIDE Must be <= 12 y.o.	SODIUM FLUORIDE		X		<= 90

**FOLIC ACID PREPARATIONS**

G	FOLIC ACID	FOLIC ACID				<= 90
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**IRON REPLACEMENT**

B	FEOSOL	IRON,CARBONYL				
B	FEOSTAT	FERROUS FUMARATE				<= 90
B	FERATAB	FERROUS SULFATE				<= 90
G	FERGON	FERROUS GLUCONATE				<= 90
B	FERRIMIN 150	FERROUS FUMARATE				<= 90
B	FERROMAR 324mg tabs = PA required.	FERROUS FUMARATE				<= 90
G	FERROUS FUMARATE	FERROUS FUMARATE				<= 90
B	FERROUS GLUCONATE	FERROUS GLUCONATE				<= 90
G	ICAR	IRON,CARBONYL				
B	IRCON	FERROUS FUMARATE				<= 90
B	MOL-IRON	FERROUS SULFATE				<= 90
G	NIFEREX-150	IRON POLYSACCHARIDES COMPLEX				
G	SLOW FE	FERROUS SULFATE				<= 90

**MAGNESIUM SALTS REPLACEMENT**

G	MAGOX	MAGNESIUM OXIDE				
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**VITAMIN AND/OR MINERAL DEFICIENCY****MULTIVITAMIN PREPARATIONS**

B	ADEKS If age > 12 PA required.	MULTIVITAMINS/ZINC GLUCONATE		X			<= 90
G	CENTRUM KIDS If age > 12 PA required.	FOLIC ACID/MV,FE,OTHER MIN		X			<= 90
G	MULTIVITAMINS If age > 12 PA required.	MULTIVITAMINS		X			<= 90
G	MULTIVITAMINS W-IRON If age > 12 PA required.	MULTIVITAMINS W-IRON		X			<= 90

**PEDIATRIC VITAMIN PREPARATIONS**

B	ADEFLO M If age > 12 PA required.	FLUORIDE/CAL/MULTIVITS W-FE		X			<= 90
B	ADEKS If age > 12 PA required.	MULTIVITAMINS/ZINC SULFATE		X			<= 90
G	CENTRUM KIDS If age > 12 PA required.	FOLIC ACID/MV,FE,OTHER MIN		X			<= 90
G	FLINTSTONES PLUS CALCIUM If age > 12 PA required.	CALCIUM CARBONATE/MULTIVIT		X			<= 90
B	KIDSTART If age > 12 PA required.	AMINO ACIDS/MULTIVITS-MIN		X			<= 90
G	POLY-VI-FLOR If age > 12 PA required. Limited to 1 per day.	FLUORIDE ION/MULTIVITAMINS	X	X			<= 90
G	POLY-VI-FLOR W/IRON If age > 12 PA required.	FLUORIDE ION/MULTIVITS W-FE		X			<= 90
B	SOURCECF	MULTIVITAMINS/ZINC GLUCONATE		X			<= 90
G	TRI-VI-FLOR If age > 12 PA required.	FLUORIDE ION/VIT A,C&D		X			<= 90
G	TRI-VI-FLOR W/IRON If age > 12 PA required.	FLUORIDE ION/IRON/VIT A,C&D		X			<= 90
G	TRI-VI-SOL If age > 12 PA required.	VITAMINS A,C,AND D		X			<= 90
B	TRI-VI-SOL W/IRON If age > 12 PA required.	IRON/VITAMINS A,C,AND D		X			<= 90
G	TRI-VITAMIN If age > 12 PA required.	VITAMINS A,C,AND D		X			<= 90
G	VI-DAYLIN If age > 12 PA required.	MULTIVITAMINS		X			<= 90
G	VI-DAYLIN + IRON If age > 12 PA required.	MULTIVITAMINS W-IRON		X			<= 90

**VITAMIN AND/OR MINERAL DEFICIENCY****PRENATAL VITAMIN PREPARATIONS**

B	ATABEX	PRENATAL VIT/IRON,CARBONYL/FA				<= 90
B	CHEWABLE PRENATAL	PRENATAL VITS W-CA,FE,FA(<1MG)				<= 90
B	CITRACAL PRENATAL + DHA	PNV4/IRON CBN&GLUC/FA/DOSS/DHA				<= 90
G	CITRACAL PRENATAL 90+DHA	PNV COMB 13/IRON CB/FA/DSS/DHA				<= 90
G	CITRACAL PRENATAL RX	PNV NO.4/IRON CBN&GLUC/FA/DOSS				<= 90
G	LACTOCAL-F	PRENATAL VIT/FE FUMARATE/FA				<= 90
B	LIQUID PRENATAL VITAMIN	PRENATAL VITAMINS/FE SULF/FA				<= 90
B	MARNATAL-F PLUS	P-NAT VIT/FE P/DHA/EPA/OM-3/FA				<= 90
G	MATERNA	PRENATAL VIT/FE FUMARATE/FA/SE				<= 90
B	MAXINATE	PNV COMB.NO3/FE FM-FE GLU/FA				<= 90
G	MISSION PRENATAL	PRENATAL VIT/FE GLUCONATE/FA				<= 90
G	MISSION PRENATAL FA	PRENATAL VIT/FE GLUCONATE/FA				<= 90
G	MISSION PRENATAL HP	PV W-O CAL/FE GLUCONATE/FA				<= 90
B	M-VIT	PV W-O CAL/FERROUS FUMARATE/FA				<= 90
B	NATAFORT	PV W-O CAL/FE CARB-FESO4/FA				<= 90
B	NATELLE C	PNV W-O CA.1/FE BISGLY/FA				<= 90
B	NATELLE-EZ	PRENATAL VITAMINS/FE BISGLY/FA				<= 90
G	NESTABS RX	PRENATAL VIT/IRON,CARBONYL/FA				<= 90
G	NIFEREX-PN	PRENATAL VIT/FE PS CMLX/FA				<= 90
B	NUTRACARE	PRENATAL VITAMINS/IRON/FA				<= 90
B	NUTRICION PORVIDA	PRENATAL VIT/FE SULF/FA/MIN AA				<= 90
B	OBSTETRIX-100	PRENATAL VIT/IRON,CARB/DOSS/FA				<= 90
B	PRECARE	PV W-O VIT A/FE FUMARATE/FA				<= 90
B	PRECARE CONCEIVE	PV W-O VIT A/FECBN-FEFM/FA				<= 90
B	PRECARE PREMIER	PNV7/FE ASP GLY/DOCUSATE/FA				<= 90
B	PREMESIS RX	CA CARBONATE/VIT B12/FA/VIT B6				<= 90
B	PRENAFORT	PRENATAL VIT/FE CARB-FESO4/FA				<= 90
G	PRENATAL ADVANTAGE	PRENATAL VIT/IRON,CARB/DOSS/FA				<= 90
G	PRENATAL FORMULA	PRENATAL VITS W-CA,FE,FA(<1MG)				<= 90
G	PRENATAL Z	PRENATAL VITS W-CA,FE,FA(1MG)				<= 90
B	TANDEM OB	PRENATAL VITS CMB W-O CA NO.2				
G	ULTRA-NATAL	PNV COMB.NO1/IRON,CARB/DOSS/FA				<= 90
G	VITAFOL-OB	PRENATAL VIT COMB.10/IRON/FA				<= 90
G	VITAFOL-PN	PRENATAL VIT COMBO.11/IRON/FA				<= 90

**VITAMIN B PREPARATIONS**

G	DIALYVITE	FOLIC ACID/VIT BCOMP&C/ZINC				
G	NEPHROCAPS	FOLIC ACID/VITAMIN B COMP W-C				

**VITAMIN B1 PREPARATIONS**

G	THIAMINE HCL	THIAMINE HCL				
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**VITAMIN AND/OR MINERAL DEFICIENCY****VITAMIN B12 PREPARATIONS**

Representative Brand	Generic Name	QL	Age	ST	Day Supply
G CYANOCOBALAMIN INJECTION	CYANOCOBALAMIN (VITAMIN B-12)				

**VITAMIN D PREPARATIONS**

B DHT	DIHYDROTACHYSTEROL				
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G DRISDOL	ERGOCALCIFEROL				
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G ROCALTROL Solution limited to 960mls per fill.	CALCITRIOL	X			
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G VITAMIN D	CHOLECALCIFEROL				
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