



**Blue Cross Blue Shield
of Michigan and
Blue Care Network**

**Custom
Formulary
2012**

BCBSM and BCN Custom Formulary

January 2012

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Introduction

We are pleased to provide the *BCBSM and BCN Custom Formulary* (January 2012 update) as a useful reference and educational tool for prescribers, pharmacists and members. Our formulary is a regularly updated list of medications approved by the U.S. Food and Drug Administration and reviewed by the BCBSM and BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and the promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. The *BCBSM and BCN Custom Formulary* will help in maintaining the quality of care for our members and containing costs for our clients.

Physicians, pharmacists and members should regularly refer to the *BCBSM and BCN Custom Formulary* for information regarding drug coverage and therapeutic options for BCBSM and BCN members. Physicians are encouraged to prescribe formulary medications whenever possible. The *BCBSM and BCN Custom Formulary* is divided into major therapeutic categories by chapter for easy use. Products approved for more than one therapeutic indication may be included in more than one chapter. Within each chapter, drugs are identified according to whether they are formulary preferred (Tier 1), formulary options (Tier 2) or nonformulary (Tier 3).

Formulary preferred (Tier 1): These drugs have a proven record of safety and effectiveness, and offer the best value for members. Because they are Tier 1, they require the lowest copayment, making them your most cost-effective option for treatment. Most generic drugs are formulary preferred.

Formulary options (Tier 2): Our Tier 2 drugs also have a record of safety and effectiveness. However, because more cost-effective therapies or generic alternatives to these drugs are usually available, most Tier 2 drugs require a higher copayment.

Nonformulary (Tier 3): Nonformulary drugs are not formulary preferred options. These drugs may not have a proven record for safety, or their clinical value may not be as high as the drugs in Tier 1 and Tier 2. Depending on the drug coverage, the member may pay a higher copayment or even the entire cost of these drugs.

Specialty — Formulary* This tier applies to specialty drugs on the custom formulary (Tiers 1 and 2).

Specialty — Nonformulary* This tier applies to nonformulary specialty drugs (Tier 3).

Note: When a generic version of a Tier 2 or Tier 3 drug becomes available, the generic versions are generally added to Tier 1. The original branded version may be moved or kept as nonformulary status (Tier 3).

BCBSM and BCN respect the judgment of the dispensing pharmacist. Pharmacists are expected to contact the prescriber when presented with a prescription for a drug or dose that may not be appropriate for a patient. We encourage pharmacists to also contact the prescriber to suggest an alternative when a BCBSM or BCN member's prescription is written for a nonformulary drug.

Drug coverage

Coverage and applicable copayment amounts for drugs on the *BCBSM and BCN Custom Formulary* are based on a member's drug plan. Not all drugs included in the *BCBSM and BCN Custom Formulary* are necessarily covered by each patient's plan. Most BCN members do not have coverage for nonformulary drugs unless a BCN-affiliated provider certifies that the prescription is medically necessary and BCN agrees. Similarly, BCBSM members with a closed (managed) formulary option do not have coverage for nonformulary drugs.

Some BCBSM and BCN plans may require a different copayment amount or may not cover certain lifestyle drugs. These may include weight-loss products and drugs to treat sexual dysfunction or infertility. BCN's coverage for drugs used to treat infertility is based on the member's BCN medical plan. Coverage

for contraceptives is based on the member's BCBSM or BCN drug plan. Some BCN drug plans do not include coverage for proton pump inhibitors.

Members should consult their prescription drug benefit packet or contact a customer service representative to determine specific coverage.

Approved medications

In general, only FDA-approved prescription medications are eligible for coverage under a member's policy. When a drug is available in the identical strength and dosage in either a prescription or a nonprescription medication, the prescription medication is usually not covered. In these cases, prescribers should refer the patient to the equivalent over-the-counter product. Certain OTC products, such as loratadine (Claritin[®]), are covered for BCN members and for some BCBSM members with a prescription. Other exceptions are identified in the *BCBSM and BCN Custom Formulary*.

Certain medications may be excluded from a BCBSM and BCN member's pharmacy benefits, but may be covered under the medical benefits. Such medications include serums, vaccines and other medications that are generally administered in a physician's office under the supervision of appropriate health care personnel and not normally dispensed to the patient for self-administration.

Prior authorization and step therapy

Prior authorization may be necessary for coverage of certain medications. In these cases, clinical criteria must be met based on current medical information and approved by the BCBSM and BCN Pharmacy and Therapeutics Committee, or other information must be provided before coverage is approved. Drugs subject to step therapy may require previous treatment with one or more drugs on the formulary before coverage is approved.

The Blue Care Network Quality Interchange Program (Pages 7 to 23) and the BCBSM Prior Authorization and Step-Therapy Program (Pages 24 to 39) provide a list of drugs that require prior authorization or must meet step-therapy requirements prior to coverage. A description of the BCN quality interchange program and the BCBSM prior authorization and step-therapy program are included in this *BCBSM and BCN Custom Formulary*. To view the most recent version, please go to bcbsm.com/provider/pharmacy_services/index.shtml.

For BCBSM members:

Members should consult their prescription drug benefit packet for information on how to obtain prior authorization, or call the Customer Service number on the back of their Blues member ID card for additional information. Physicians can access the medication request forms on web-DENIS or contact the Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy Services Clinical Help Desk at 1-800-437-3803 and select option 1 for more information and to request coverage.

For BCN members:

The physician or office designee should call the Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy Services Clinical Help Desk at 1-800-437-3803 and select option 2 to request prior authorization or a benefit exception. This is the preferred and most efficient method to generate a medication coverage request. Alternatively, physicians can access the medication request forms through web-DENIS.

Urgent requests should be identified when initiated. The authorization request form must be completed in its entirety and returned to the Pharmacy Services Clinical Help Desk for review. The physician is notified of approved requests, and the member's claim will process accordingly. If the request is not approved, written notification is provided to both the member and practitioner. The notification includes the reason for the denial and an explanation of the appeal rights and the appeals process.

As part of our 2012 focus on efficient service, drugs are listed alphabetically within each tier. **The *BCBSM and BCN Custom Formulary* is current at the time of publication (January and July) and is subject to change.**

Blue Care Network

Quality Interchange Program January 2012

Blue Care Network Quality Interchange Program January 2012

The Blue Care Network Quality Interchange Program helps ensure that safe, high-quality cost-effective drug therapy is prescribed prior to the use of more expensive agents that may not have proven value over current formulary medications. This program makes use of drug utilization management tools including prior authorization and step therapy. If a drug requires prior authorization, certain clinical criteria must be met, or other information must be provided, before coverage is approved. Drugs subject to step therapy require previous treatment with one or more formulary agents prior to coverage. The criteria for approval are based on current medical information and are approved by the BCBSM/BCN Pharmacy and Therapeutics Committee.

Most BCN members do not have coverage for *nonformulary drugs*. Requests for these *nonformulary drugs* will only be considered when the following criteria have been met:

- The member has tried and failed to respond to an adequate trial of the available formulary agents from the same drug class, or the available formulary agents would pose unnecessary risk to the member.
- The prescriber and BCN agree that it is medically necessary.

Authorization requests that do not include documentation of medical necessity and failure of formulary alternatives will be denied.

Brand-name drugs that physicians prescribe or members request to be dispensed as written (DAW), but are available as generics, are covered only when determined to be medically necessary by the physician and approved by BCN (the physician must submit a completed MedWatch form to the FDA with a copy to BCN to document serious adverse events or a quality issue with the covered generic). Information regarding the FDA MedWatch program and online forms are available at **www.accessdata.fda.gov/scripts/medwatch**. If a DAW prescription is not authorized, BCN members are required to pay the difference in cost between the brand-name and generic versions in addition to their usual brand-name copay amount.

Quantity limits may also apply to certain drugs. Please visit us online at **MiBCN.com** for more information.

This information applies to members with a BCN commercial drug benefit. Criteria for BCN AdvantageSM and BlueCaid[®] members can be viewed on our Web site: **MiBCN.com**.

(g)=generic available

ANTI-INFECTIVES	
Anti-Fungals Approval duration: up to 3 months	
Nonformulary: Lamisil [®] Granules	Requires documentation that the member has experienced treatment failure of or intolerance to at least three months of treatment with griseofulvin (Grifulvin V (g)) suspension.
Miscellaneous Anti-infectives Approval duration: up to 3 months	
Nonformulary: Cayston [®]	Coverage is provided for the treatment of pneumonia in patients with cystic fibrosis.
Quinolones Approval duration: up to 1 month	
Formulary: Cipro [®] XR (g) (ciprofloxacin-extended release)	Formulary agents: Cipro XR(g): Approved only for uncomplicated urinary tract infection (cystitis). Alternatives include Cipro (g) 100-250mg BID x 3 days and Bactrim DS [®] (g) BID x 3-5 days.

ANTI-INFECTIVES (Cont.)

Tetracyclines		Approval duration: up to 1 year
<p>Formulary: Adoxa[®](g), Doryx[®](g), Monodox[®](g), Solodyn[®](g)</p> <p>Nonformulary: Oracea[®], Solodyn</p>	<p>Formulary agents: Adoxa(g): Requires documentation that the member has experienced treatment failure of or intolerance to generic doxycycline monohydrate (Monodox (g)). Doryx(g), Monodox(g): Requires documentation that the member has experienced treatment failure of or intolerance to generic immediate release doxycycline hyclate.</p> <p>Nonformulary agents: Oracea: Requires documentation that the member has experienced treatment failure of or intolerance to generic doxycycline monohydrate (Monodox (g)). Solodyn: Requires documentation that the member has experienced treatment failure of or intolerance to generic minocycline immediate release (Minocyn (g), Dynacin (g)).</p> <p>Approved if above criteria are met, and a copy of the completed MedWatch form (that has been submitted to the FDA) has been submitted to the plan to document treatment failure of or intolerance to a formulary agent.</p>	

ANTINEOPLASTICS & IMMUNOSUPPRESSANTS

Hormonal Agents		Approval duration: up to 1 year
<p>Formulary: Arimidex[®](g) (anastrozole), Aromasin[®](g) (exemestane), Femara[®](g) (letrozole)</p>	PA required for males: Approved only for ER-positive breast cancer treatment.	
Immunomodulators		Approval duration: up to 1 year
<p>Formulary: Arcalyst[™] (rilonacept)</p> <p>Nonformulary: Revlimid[®]</p>	<p>Formulary agent: Arcalyst: Approved for the treatment of cryopyrin-associated periodic syndrome in members ≥12 years of age.</p> <p>Nonformulary agent: Revlimid: Approved for treatment of transfusion-dependent anemia due to low or intermediate-1 risk myelodysplastic syndromes (MDS) with deletion 5q abnormality; multiple myeloma in members whom have experienced treatment failure of or intolerance to or have a contraindication to thalidomide; or members with documentation of enrollment in a Phase II-IV investigative study approved by an appropriate Investigational Review Board (IRB). MDS must be confirmed by FISH analysis or other genetic testing.</p>	

Kinase Inhibitors & Molecular Target Inhibitors		Approval duration: up to 1 year
<p>Formulary: Afinitor[®] (everolimus), Caprelsa[®] (vandetanib), Hycamtin[®] (topotecan), Iressa[®] (gefitinib), Nexavar[®] (sorafenib), Sprycel[®] (dasatinib), Sutent[®] (sunitinib)</p> <p>Cont. next page...</p>	<p>Formulary agents*: Afinitor: Approved for the treatment of advanced renal cell carcinoma in members who have experienced disease progression or recurrence following treatment with Sutent or Nexavar, OR requires documentation. Caprelsa: Approved for the treatment of symptomatic or progressive medullary thyroid cancer (MTC) in patients with unresectable, locally advanced or metastatic disease. Hycamtin: Approved for treatment of relapsed small cell lung cancer. Iressa: Approved only for members continuing existing therapy prior to the 09/2005 FDA label revisions. Nexavar: Approved for treatment of advanced or recurrent renal cell carcinoma or hepatocellular carcinoma. Sprycel: Approved for treatment of chronic myelogenous leukemia in members who have experienced resistance or intolerance to Gleevec; treatment of Philadelphia chromosome-positive acute lymphoblastic leukemia in members who have experienced resistance or intolerance to Gleevec or cytotoxic chemotherapy. Sutent: Approved for treatment of advanced renal cell carcinoma or gastrointestinal stromal tumor. Evidence of disease progression or intolerance to Gleevec must be provided for members with gastrointestinal stromal tumor.</p>	

ANTINEOPLASTICS & IMMUNOSUPPRESSANTS (Cont.)	
Kinase Inhibitors & Molecular Target Inhibitors (cont.) Approval duration: up to 1 year	
<p>Formulary: Tarceva® (erlotinib), Tasigna® (nilotinib), Tykerb® (lapatinib), Votrient™ (pazopanib), Xalkori™ (crizotinib), Zelboraf™ (vemurafenib)</p> <p>Nonformulary: Zytiga® (abiraterone)</p>	<p>Formulary agents*: Tarceva: Approved for treatment of non-small cell lung cancer in members who have experienced treatment failure with at least one chemotherapy regimen or treatment of pancreatic cancer in members who will be receiving Tarceva in combination with gemcitabine. Tasigna: Requires documentation that the member has been newly diagnosed with chronic phase Philadelphia chromosome-positive chronic myeloid (Ph+ CML), or accelerated or chronic phase in situations where the member has experienced resistance or intolerance to prior therapy with imatinib mesylate (Gleevec). Tykerb: Approved only for treatment of HER2 or HER2/neu positive advanced or metastatic breast cancer. Evidence of disease progression following treatment with an anthracycline, a taxane, and trastuzumab (Herceptin) must be provided. The member must be receiving Tykerb in combination with Xeloda. Xalkori: Approved for treatment of advanced or metastatic non-small cell lung cancer that is anaplastic lymphoma kinase positive. Votrient: Approved for treatment of advanced renal cell carcinoma. Zelboraf: Approved for the treatment of unresectable or metastatic melanoma with a BRAF V600E mutation.</p> <p>Nonformulary*: Zytiga: Requires a diagnosis of metastatic castration-resistant prostate cancer (CRPC) in patients who have previously received chemotherapy treatment with docetaxel. Also requires members to receive concurrent therapy with oral prednisone.</p> <p><i>*Approved if above criteria are met, or requires documentation of enrollment in a Phase II-IV investigative study approved by an appropriate IRB.</i></p>
Miscellaneous Antineoplastic Agents Approval duration: up to 1 year	
<p>Formulary: Zolinza™ (vorinostat)</p>	<p>Approved for treatment of cutaneous manifestation of cutaneous T-cell lymphoma and requires documentation of persistent progressive or recurrent disease after trial with two systemic therapies, such as oral bexarotene (Targretin), α-interferon (Intron-A, Pegasys, PEG-Intron), denileukin diftitox (Ontak), photochemotherapy (Psoralen plus ultraviolet A (PUVA)), or systemic chemotherapy, OR requires documentation of enrollment in a Phase II-IV investigative study approved by an appropriate IRB.</p>
CARDIOVASCULAR, HYPERTENSION, CHOLESTEROL	
Alpha-adrenergic Agents Approval duration: up to 10 years	
<p>Nonformulary: Nexiclon™ XR</p>	<p>Requires documentation that member has experienced failure of or intolerance to Catapres(g) or Catapres-TTS(g).</p>
Angiotensin Converting Enzyme Inhibitors (ACE-Inhibitor) Approval duration: up to 10 years	
<p>Nonformulary: Altace® Tablets</p>	<p>Requires documentation that member has experienced failure of or intolerance to Altace(g) capsules.</p>
Angiotensin II Receptor Blockers (ARBs) Approval duration: up to 10 years	
<p>Formulary: Benicar® (olmesartan medoxomil), HCT</p> <p>Nonformulary: Atacand®, HCT; Avapro®, Avalide®; Azor®, Diovan®, HCT; Edarbi®, Exforge®, HCT; Micardis®, HCT; Teveten®, HCT; Tribenzor™, Twynsta®, Valturna®</p>	<p>Formulary agents: Benicar, HCT: Requires documentation that the member has experienced intolerance to an ACE inhibitor such as Prinivil/Zestril(g), Monopril(g), Lotensin(g), Vasotec(g), Accupril(g), etc.</p> <p>Nonformulary agents: Atacand, HCT; Avapro, Avalide; Diovan, HCT; Edarbi, Micardis, HCT; Teveten, HCT: Requires documentation that the member has experienced intolerance to an ACE inhibitor and experienced treatment failure of or intolerance to a formulary ARB (Cozaar(g), Hyzaar(g); Benicar, HCT) Azor, Exforge, Tribenzor, Twynsta, Valturna: Requires successful treatment of at least three months of therapy with the individual agents contained in the requested medication at the prescribed dosage. Exforge HCT: Requires inadequate response with at least three months of therapy with Exforge.</p>

CARDIOVASCULAR, HYPERTENSION, CHOLESTEROL (cont.)	
Beta Blockers Approval duration: up to 10 years	
Nonformulary: Bystolic [®] , Coreg CR [™]	Bystolic: Requires documentation that the member has experienced treatment failure of or intolerance to at least two unique formulary beta blockers, such as betaxolol, atenolol, acebutolol, metoprolol, or bisoprolol. Coreg CR: Requires documentation that the member experienced treatment failure of or intolerance to both carvedilol immediate-release (Coreg(g)) AND metoprolol succinate (Toprol XL(g)).
Cardiovascular Treatment Approval duration: up to 10 years	
Nonformulary: Ranexa [®]	Ranexa: Requires documentation that the member has experienced treatment failure of or intolerance to both a beta-blocker and a nitrate. The member must have no history of or high risk for cancer.
Cholesterol-Lowering Agents Approval duration: up to 10 years	
Formulary: Caduet [®] (g) (atorvastatin/amlodipine), Crestor [®] (rosuvastatin), Lipitor [®] (g) (atorvastatin), Zetia [®] (ezetimibe), Zocor [®] (g) (simvastatin) 80mg Nonformulary: Advicor [®] , Altoprev [®] , Lescol [®] , XL; Livalo [®] , Simcor [®] , TriLipix [®] , Vytorin [®]	Formulary agents: Caduet(g): Requires documentation that member has experienced treatment failure of or intolerance to at least one high dose (>=40mg) generic statin AND at least one formulary brand agent (Crestor or Zetia). Crestor: Requires documentation that member has experienced failure of or intolerance to at least <u>one</u> high dose (>=40mg) generic statin. Lipitor(g): Requires documentation that member has experienced treatment failure of or intolerance to at least one high dose (>=40mg) generic statin or Crestor. Zetia: Requires documentation that member has experienced failure of or intolerance to at least <u>two</u> generic statins <u>OR</u> approved when added to a high dose (>=40mg) generic statin. Zocor(g) 80mg: Requires prior authorization for any member starting on 80mg dose. Nonformulary agents: Altoprev, Lescol, XL, Livalo, Vytorin: Requires documentation that member has experienced treatment failure of or intolerance to at least one high dose (>=40mg) generic statin AND at least one formulary brand agent (Crestor or Zetia). Advicor, Simcor: Requires successful treatment of at least three months of therapy with the individual agents contained in the requested medication at the prescribed dosage. TriLipix: Requires documentation that the member has experienced treatment failure of or intolerance to ALL generic fenofibrates, such as Lofibra(g) and Lopid(g), AND supporting evidence for the use of this agent. Concomitant use of a statin does not satisfy criteria.
Miscellaneous Antihypertensives Approval duration: up to 10 years	
Nonformulary: Amturnide [®] , Tekamlo [™] , Tekturna [®] , HCT	Amturnide: Requires successful treatment of at least three months of therapy with the individual agents contained in the requested medication at the prescribed dosage. Tekamlo: Requires successful treatment of at least three months of therapy with the individual agents contained in the requested medication at the prescribed dosage. Tekturna, HCT: Approved for the treatment of hypertension AND requires documentation that the member has experienced treatment failure of or intolerance to ALL of the following drug classes: diuretics, beta-blockers, ACE inhibitors, and angiotensin II receptor blockers (ARBs).
CENTRAL NERVOUS SYSTEM	
Anticonvulsants Approval duration: up to 10 years	
Nonformulary: Gralise [™] Cont. next page...	Gralise: Requires documentation that the member has: <ul style="list-style-type: none"> • Diagnosis of neuropathic pain associated with post-herpetic neuralgia AND the member has experienced treatment failure of or intolerance to: <ul style="list-style-type: none"> o Members ≥ 65 years of age: gabapentin 1200 mg per day o Members < 65 years: gabapentin 1200 mg per day AND a tricyclic antidepressant. • An explanation why gabapentin extended release is expected to work if gabapentin immediate release has not.

CENTRAL NERVOUS SYSTEM (Cont.)	
Anticonvulsants (cont.) Approval duration: up to 10 years	
<p>Nonformulary: Lyrica®</p>	<p>Lyrica: Requires documentation that the member has at least one of the three listed diagnoses:</p> <ul style="list-style-type: none"> • Seizure disorder that is being treated concurrently with other anticonvulsants • Neuropathic pain associated with either diabetic peripheral neuropathy or post-herpetic neuralgia AND the member has experienced treatment failure of or intolerance to: <ul style="list-style-type: none"> o Members ≥ 65 years of age: gabapentin 1200 mg per day o Members < 65 years: gabapentin 1200 mg per day, AND a tricyclic antidepressant. • Fibromyalgia and documentation that the member has experienced intolerance to gabapentin or inadequate relief from gabapentin 1200 mg per day, AND treatment failure of or intolerance to at least three of the following: a tricyclic antidepressant, an SSRI, an SNRI, cyclobenzaprine, or tramadol. <p>Additional criteria:</p> <ul style="list-style-type: none"> • Approvals are granted only at the specific strength requested. • Approved dosage is limited to < 300 mg per day for initial treatment and will not exceed 600 mg per day if 300 mg/day is tolerated. • Any previous authorizations are discontinued when a new strength is approved.
Antidepressants Approval duration: up to 10 years	
<p>Formulary: Serzone®(g) (nefazodone), Lexapro® (escitalopram)</p> <p>Nonformulary: Aplenzin™, Cymbalta®, Luvox CR®, Oleptro™,</p> <p>Cont. next page...</p>	<p>Formulary agents:</p> <p>Serzone(g): Requires documentation that member has experienced treatment failure of or intolerance to at least three of the following antidepressants (Prozac(g), Celexa(g), Paxil/CR(g), Luvox(g), Zoloft(g), Effexor, XR(g), or Wellbutrin SR, XL(g)). Approval Duration: Up to 1 year</p> <p>Lexapro: Requires documentation that member has experienced treatment failure of or intolerance to at least one generic antidepressant (Prozac(g), Celexa(g), Paxil(g), Zoloft(g), Effexor, XR(g), or Wellbutrin SR, XL(g)).</p> <p>Nonformulary agents:</p> <p>Aplenzin: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants AND documentation that continued use of Wellbutrin SR/XL(g) will adversely affect the member's mental health.</p> <p>Cymbalta:</p> <ul style="list-style-type: none"> • Depression and/or anxiety: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants, once of which is a generic SNRI. • Post-herpetic neuralgia or diabetic peripheral neuropathy: If older than 65 years, requires treatment failure of or intolerance to gabapentin 1200 mg per day. If under 65 years, requires treatment failure of or intolerance to gabapentin 1200 mg per day and a tricyclic antidepressant. • Fibromyalgia: Documentation is required to show that the member has experienced intolerance to gabapentin OR inadequate relief from gabapentin 1200 mg per day AND treatment failure of or intolerance to at least three of the following: a tricyclic antidepressant, an SSRI, an SNRI, cyclobenzaprine, or tramadol. • Chronic musculoskeletal pain: Requires documentation of treatment failure or intolerance of two generic formulary medications from any three drug classes (NSAID, centrally acting analgesics, or antidepressants). <p>Luvox CR: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants AND documentation that continued use of Luvox(g) will adversely affect the member's mental health.</p> <p>Oleptro: Approved for major depressive disorder in members who have experienced treatment failure of or intolerance to at least three formulary antidepressants one of which is Desyrel®(g) AND documentation that continued use of Desyrel(g) will adversely affect the member's mental health.</p>

CENTRAL NERVOUS SYSTEM (Cont.)	
Approval duration: up to 10 years	
Antidepressants (cont.)	
Nonformulary: Pexeva [®] , Pristiq [®] , Savella [®] , Viibryd [™]	Nonformulary agents: Pexeva: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants AND documentation that continued use of Paxil(g) will adversely affect the member's mental health. Pristiq: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants, one of which is a generic SNRI, AND documentation that continued use of Effexor(g) or Effexor XR(g) will adversely affect the member's mental health. Savella: Approved for treatment of fibromyalgia AND requires documentation that the member has experienced intolerance to gabapentin or inadequate relief from gabapentin 1200 mg per day and treatment failure of or intolerance to at least three of the following: a tricyclic antidepressant, an SSRI, an SNRI, cyclobenzaprine, or tramadol. Viibryd: Requires documentation that the member has experienced treatment failure of or intolerance to at least three generic antidepressants.
Approval duration: up to 10 years	
Antipsychotics	
Nonformulary: Invega [®] , Saphris [®] , Seroquel XR [®]	Requires documentation that the member has experienced treatment failure of or intolerance to all formulary atypical antipsychotic agents. Maximum dose of Invega is limited to 12 mg per day.
Approval duration: up to 1 year	
CNS Stimulants	
Formulary: Adderall XR [®] (amphet asp/ amphet/d-amphet)(g), Procentra [™] (dextroamphetamine), Provigil [®] (modafinil)	Formulary agents: Adderall XR(g): Requires documentation that member has experienced treatment failure of or intolerance to brand name Adderall XR. Procentra: Requires documentation that member has experienced treatment failure of or intolerance to both Metadate CD and Adderall XR; both of which may be sprinkled on food. Provigil: Approved only for members with narcolepsy, or obstructive sleep apnea. Dosage limited to a maximum of 400mg per day. Shift-work sleep disorder is not covered since treatment is not medically necessary. Approval duration: up to 10 years
Nonformulary: Nuvigil [®] , Strattera [™] , Vyvanse [™]	Nonformulary agents: Nuvigil: Approved for treatment of narcolepsy or obstructive sleep apnea and requires documentation that member has experienced treatment failure of or intolerance to Provigil. Strattera: Approvable when stimulants are contraindicated by medical history OR the following criteria by age: <ul style="list-style-type: none"> • For BCN members age 5 to 20: Requires documentation that the member has experienced treatment failure of or intolerance to both a methylphenidate (such as Ritalin(g) or Concerta(g)) AND an amphetamine (such as Adderall(g)). • For BCN members age 21 and older: Requires documentation that the member has experienced treatment failure of or intolerance to either a methylphenidate OR an amphetamine. • Note: The use of Strattera in members ≤ 4 years of age is not recommended or supported by literature. Vyvanse: Requires documentation that the member has experienced treatment failure of or intolerance to both a methylphenidate (such as Ritalin(g) or Concerta(g)) AND an amphetamine (such as Adderall(g)).
Approval duration: up to 1 year	
Migraine Therapy	
Formulary: Amerge [®] (g) (naratriptan), Maxalt [®] , MLT [®] (rizatriptan)	Formulary agents: Amerge(g): Requires documentation that member has experienced treatment failure of or intolerance to sumatriptan (Imitrex(g)). Maxalt, MLT: Requires documentation that member has experienced treatment failure of or intolerance to sumatriptan (Imitrex(g)).
Cont. next page...	

CENTRAL NERVOUS SYSTEM (Cont.)	
Approval duration: up to 1 year	
Migraine Therapy (cont.)	
<p>Nonformulary: Alsuma[®], Axert[®], Frova[®], Relpax[®], Sumavel™ DosePro™, Treximet[®], Zomig[®], ZMT[®], nasal spray</p>	<p>Nonformulary agents: Alsuma, Axert, Frova, Relpax, Sumavel DosePro; Zomig, ZMT, nasal spray: Requires documentation that member has experienced failure of or intolerance to both sumatriptan (Imitrex^(g)) and Maxalt. Treximet: Requires documentation that the member has experienced treatment failure of or intolerance to a combination of sumatriptan (Imitrex^(g)) or Maxalt AND naproxen. Documentation as to why sumatriptan (Imitrex^(g)) or Maxalt and naproxen as individual agents do not work for and/or may be harmful to the member must be provided.</p>
Approval duration: up to 1 year	
Miscellaneous CNS	
<p>Formulary: Zanaflex[®](tizanadine) (g)</p> <p>Nonformulary: Aricept[®] 23mg, Intuniv™, Kapvay™, Nuedexta™, Zanaflex capsules[®]</p>	<p>Formulary Agents: Zanaflex(g): Requires patient has had trial failure of or intolerance to baclofen and Flexeril^(g).</p> <p>Nonformulary Agents: Aricept 23mg: Requires documentation for a progressive-type dementia AND requires successful treatment with Aricept 10mg for three months. Intuniv, Kapvay: Approved for treatment of ADHD and requires documentation that the member has experienced treatment failure of or intolerance to both a methylphenidate (such as Ritalin^(g) or Concerta^(g)), an amphetamine (such as Adderall^(g)), generic guanfacine immediate-release, and clonidine. Nuedexta: Requires documentation that member has a diagnosis of pseudobulbar affect. Zanaflex capsules: Requires patient has had trial failure of or intolerance to both baclofen and Flexeril^(g), and documentation must be provided as to why continued use of generic Zanaflex will adversely affect the member's health.</p>
Approval duration: up to 1 year	
Narcotics	
<p>Formulary: Actiq[®] (g) (fentanyl citrate) Opana[®] (oxymorphone)(g), Opana[®] ER(oxymorphone)(g) 7.5, 15mg</p> <p>Nonformulary: Abstral™, Butrans™, Exalgo™, Fentora[®], Lazanda[®], Onsolis[®]</p> <p>Cont. next page...</p>	<p>Formulary agents: Actiq(g): Approved for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and is currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of other oral immediate-release narcotics for the management of breakthrough pain. Opana (g): Requires documentation that the member has experienced treatment failure of or intolerance to morphine sulfate 20mg/mL (Roxanol^(g)) or morphine sulfate immediate-release (MSIR^(g)). Opana ER 7.5, 15mg(g): Requires documentation that the member has experienced treatment failure of or intolerance to ALL of the following long-acting formulary agents: methadone, morphine sulfate extended-release (Oramorph^(g), MS Contin^(g)), and fentanyl transdermal patch (Duragesic^(g)).</p> <p>Nonformulary agents: Abstral, Fentora, Lazanda, Onsolis: Approved for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and who are currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of Actiq^(g) and other oral immediate-release narcotics for the management of breakthrough pain. Lazanda also requires treatment failure of or intolerance to buccal fentanyl product. Butrans: Coverage is provided for a diagnosis of moderate to severe chronic pain AND documentation that the member has experienced treatment failure of or intolerance to methadone, Duragesic^(g) AND morphine sulfate (MS Contin^(g) or Oramorph SR^(g)). Exalgo: Coverage is provided for the management of moderate to severe pain in opioid tolerant patients requiring continuous around the clock analgesia for an extended period of time AND requires documentation that the member has experienced treatment failure of or intolerance to ALL of the following long-acting formulary agents: methadone, morphine sulfate extended-release (Oramorph^(g), MS Contin^(g)), and fentanyl transdermal patch (Duragesic^(g)).</p>

CENTRAL NERVOUS SYSTEM (Cont.)	
Approval duration: up to 1 year	
Narcotics (cont.)	
<p>Nonformulary: Nucynta®, Nucynta ER, Opana® ER; Oxecta®, Oxycontin®</p>	<p>Nonformulary agents: Nucynta: Requires documentation that member has experienced treatment failure of or intolerance to a generic immediate-release tramadol or tramadol/acetaminophen AND three formulary immediate-release narcotics. If use is to exceed 30 days, Nucynta must be used in combination with a long-acting narcotic, such as methadone, morphine sulfate extended-release (Oramorph(g), MS Contin(g)), and fentanyl transdermal patch (Duragesic(g)). Nucynta ER: Requires documentation that member has experienced treatment failure of or intolerance to Ultram ER(g) AND two of the following formulary alternatives: morphine sulfate extended-release (Oramorph(g), MS Contin(g)), fentanyl transdermal patch (Duragesic(g)) OR methadone. Opana ER, Oxycontin: Requires documentation that the member has experienced treatment failure of or intolerance to ALL of the following long-acting formulary agents: methadone, morphine sulfate extended-release (Oramorph(g), MS Contin(g)), and fentanyl transdermal patch (Duragesic(g)). Oxecta: Requires documentation that the member has experienced treatment failure of or intolerance to at least three of the following immediate-release narcotics MS-IR(g), Opana IR(g), oxycodone IR. If use is to exceed 30 days, Nucynta must be used in combination with a long-acting narcotic, such as methadone, morphine sulfate extended-release (Oramorph(g), MS Contin(g)), and fentanyl transdermal patch (Duragesic(g)).</p>
Narcotic Mixed Agonist/Antagonist	
Approval duration: up to 1 year	
<p>Formulary: Suboxone® (buprenorphine HCl/ naloxone HCl)</p> <p>Nonformulary: Rybix® ODT</p>	<p>Formulary agents: Suboxone: Approved only for the treatment of clinically diagnosed opioid dependence. Requires documentation of validated screening tools used to identify the opioid use problem.</p> <p>Nonformulary: Rybix ODT: Requires documentation that the member cannot swallow ANY oral tramadol tablets OR the member has exhibited intolerance to at least two different manufacturer's brands of generic tramadol.</p>
Non-Steroidal Anti-Inflammatory Drugs	
<p>Nonformulary: Arthrotec®, Celebrex®, Flector® Patch, Pennsaid™, Voltaren® Gel,</p> <p>Cont. next page...</p>	<p>Arthrotec: Approved for members >60 years of age, receiving anticoagulant or antiplatelet therapy, receiving chronic treatment with oral corticosteroids (≥ 60 days duration), or a history of or current diagnosis of peptic ulcer disease, clinically significant gastrointestinal bleeding, and/or alcoholism. Approval duration: up to 10 years Celebrex: <i>Approved for members >60 years of age</i> who are not at high risk for cardiovascular events, and do not have a previous history of stroke, myocardial infarction (MI), coronary heart disease, or blood clots. The member must not be receiving concomitant anticoagulant or an antiplatelet therapy. <i>Approved for members ≤ 60 years of age</i> who are receiving chronic treatment with oral corticosteroids (≥ 60 days duration) or have a history of or current diagnosis of peptic ulcer disease, clinically significant gastrointestinal bleeding, and/or alcoholism. The member must not be receiving concomitant anticoagulant or antiplatelet therapy AND have no previous history or evidence of cardiovascular and thromboembolic disease. Note: Lodine®(g) is more selective than Celebrex for the COX-2 enzyme. Approval duration: up to 10 years Flector Patch: Approved only for the treatment of acute sprains AND requires treatment failure of or intolerance to Voltaren(g)/XR(g) tablets AND an OTC topical analgesic (Myoflex OR Aspercreme). Approval duration: up to 1 month Pennsaid, Voltaren Gel: Requires documentation of treatment failure of or intolerance to Voltaren(g)/XR(g) tablets AND an OTC topical analgesic (Myoflex OR Aspercreme). Approval duration: up to 3 months</p>

CENTRAL NERVOUS SYSTEM (Cont.)	
Non-Steroidal Anti-Inflammatory Drugs (cont.)	
Nonformulary: Vimovo™	Vimovo: Requires documentation that member has had treatment failure of or intolerance to Prilosec(g), Protonix(g) and Prevacid(g) AND meets any one of the following criteria: •Greater than 60 years of age •Receiving anticoagulant or antiplatelet therapy •Receiving chronic treatment with oral corticosteroids (>= 60 days duration) •A history of peptic ulcer disease, clinically significant gastrointestinal bleeding, and/or alcoholism. Approval duration: up to 10 years
Parkinson's Disease and Related Disorders Approval duration: up to 10 years	
Nonformulary: Horizant™, Mirapex ER®	Horizant: Requires a diagnosis of restless legs syndrome and treatment failure or intolerance to Requip(g), Mirapex(g), and Neurontin(g), and an explanation why gabapentin extended release is expected to work if gabapentin immediate release has not. Mirapex ER: Requires a diagnosis of Parkinson's Disease. Must also try and fail Mirapex IR(g) AND documentation that the continued use will adversely affect the member's condition.
Sedatives/Hypnotics Approval duration: up to 1 year	
Formulary: Ambien CR® (g) (zolpidem)	Requires documentation that member has experienced treatment failure of or intolerance to an adequate trial of both zolpidem (Ambien®(g)) and zaleplon (Sonata®(g)).
Nonformulary: Edluar™, Lunesta®, Rozerem®, Silenor™, ZolpiMist™	Silenor: Requires documentation that member has experienced treatment failure of or intolerance to Sinequan®(g), Ambien(g), Sonata(g) AND Desyre®(g).
DERMATOLOGY	
Acne Treatment Approval duration: up to 1 year	
Nonformulary: Ziana™ gel	Requires documentation of medical necessity to identify why individual agents [Cleocin-T®(g) plus Retin-A®(g)] cannot be used.
Antipsoriatic/Antiseborrheic Approval duration: up to 1 year	
Formulary: Enbrel® (etanercept), Humira® (adalimumab)	Formulary agents: Enbrel, Humira: Moderate to Severe Psoriasis: Requires 3 months of previous treatment with topical corticosteroids and 3 months treatment with PUVA.
Nonformulary: Taclonex, Scalp®	Nonformulary agent: Taclonex: Requires documentation that the member has experienced treatment failure of or intolerance to at least 30 days of treatment with the combination of a very high potency corticosteroid [Diprolene ointment(g), Temovate(g), Psorcon(g)] AND Dovonex(g).
Miscellaneous Dermatologicals Approval duration: up to 1 year	
Formulary: Elidel® (pimecrolimus)	Formulary agents: Elidel: Approved for members ≥2 years of age with a diagnosis of atopic dermatitis or eczema.
Nonformulary: Protopic®	Nonformulary agent: Protopic: Approved for members ≥2 years of age with a diagnosis of atopic dermatitis or eczema and documentation that the member has experienced treatment failure of or intolerance to Elidel®. For members ages 2 to 15, only the 0.03% strength may be used.
Wound & Burn Therapy Approval duration: up to 1 year	
Nonformulary: Regranex®	Requires documentation that the member has a diagnosis of lower extremity diabetic neuropathic ulcers that have an adequate blood supply and extend into the subcutaneous tissue or beyond (must be a full thickness – for example, Stage III to the muscle or Stage IV to the bone). Members must be participating in a comprehensive wound care program which includes treatment such as surgical removal of tissue, pressure relief (for example, non-weight bearing), and infection control.

DIAGNOSTICS & OTHER MISCELLANEOUS

Diagnostic & Other Miscellaneous

Formulary:

Kuvan® (sapropterin dihydrochloride);
Xenazine® (tetrabenazine)

Nonformulary:

Campral®, Exjade®, Firazyr®

Formulary agents:

Kuvan: Requires documentation that member has a diagnosis of phenylketonuria (PKU) and will be following a phenylalanine-restricted diet in conjunction with Kuvan.

Approval duration: up to 1 year

Xenazine: Requires documentation that member has a diagnosis of chorea associated with Huntington's disease.

Approval duration: up to 10 years

Nonformulary agents:

Campral: Approved for the treatment of alcohol dependence, to maintain abstinence from alcohol in members who have been abstinent at treatment initiation for at least 5 days post-detoxification. Members must be enrolled in a comprehensive alcohol management program that includes psychosocial support.

Approval duration: up to 1 year

Exjade: Approved for members ≥12 years of age with a diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis) and documentation that the member has experienced treatment failure of or intolerance to Desferal®(g) OR requires documentation that the member is enrolled in a Phase II-IV investigative study approved by an appropriate IRB.

Approval duration: up to 1 year

Firazyr: Approved for members ≥18 years of for the treatment of acute attacks of hereditary angioedema (HAE).

Approval duration: up to 1 year

ENDOCRINOLOGY

Growth Hormone & Related Products

Formulary:

Genotropin® (somatropin),
Nutropin®, AQ (somatropin)

Nonformulary:

Humatrope®, Norditropin®,
Omnitrope®, Saizen®, Serostim®,
Tev-Tropin®, Valtropin®, Zorbtive™
Increlex™

Formulary agents:

Children (<18 years of age): Requires a diagnosis of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering >40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses.

Initial treatment: For growth hormone deficiency, two growth hormone stimulation tests OR one GH stimulation test along with a subnormal IGF-1 level and IGFBP-3 level must be provided. The member's height must be below the 5th percentile.

To continue: The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented.

Approval duration: up to 1 year

Adults (≥18 years of age): Approved for treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome, and Short Bowel Syndrome (SBS). The diagnosis must be made by an endocrinologist or a nephrologist. Initial diagnosis must be based on two growth hormone stimulation tests, three or more pituitary hormone deficiencies with an IGF-1 below 80ng/ml OR one growth hormone and at least one pituitary hormone deficiency

Approval duration: up to 10 years (exception SBS 1 month)

Nonformulary agents: Also requires documentation that the member has experienced treatment failure of or intolerance to formulary agents.

Increlex: Approved for treatment of severe IGF-1 deficiency, growth hormone gene deletion, and Laron's syndrome in members <18 years of age, with open epiphyses, and height below the 3rd percentile. Member must have a normal or elevated growth hormone level with an IGF-1 level 3 or more standard deviations below normal. The prescriber must be a pediatric endocrinologist.

Approval duration: Initial approval is granted for 1 year and renewal can be obtained if member has clinical response with therapy, as demonstrated by an annual growth velocity of ≥ 2.5 cm

ENDOCRINOLOGY (Cont.)	
Non-Insulin Hypoglycemic Agents Approval duration: up to 10 years	
<p>Formulary: Actos® (pioglitazone); Actoplus Met® (pioglitazone/ metformin), Duetact® (pioglitazone/glimepiride)</p> <p>Nonformulary: Avandamet®, Avandaryl®, Avandia®, Byetta®, Cycloset®, Januvia®, Janumet®, Kombiglyze™ XR, Onglyza™, Tradjenta™, Prandimet®, Symlin®, Victoza®</p>	<p>Formulary agents: Actos: Requires documentation that the member has experienced failure with metformin. If the member cannot tolerate metformin or if metformin is contraindicated, physicians are encouraged to prescribe a sulfonylurea, unless contraindicated, prior to treatment with a TZD. Actoplus Met, Duetact: Requires documentation that the member has experienced successful treatment with at least three months of therapy with the individual agents that are in the combination product.</p> <p>Nonformulary agents: Actoplus Met XR, Avandamet, Avandaryl, Janumet, Kombiglyze XR, Prandimet: Requires documentation that the member has experienced successful treatment with at least three months of therapy with the individual agents that are in the combination product. Avandamet, Avandaryl coverage subject to enrollment in REMS. Avandia: Requires documentation that the member has had treatment failure of or intolerance to both Glucophage(g) and Actos. Coverage is subject to enrollment in REMS. Byetta, Victoza: Approved for treatment of type 2 diabetes in members with a contraindication to or have experienced treatment failure of or intolerance to metformin. The member must currently be taking either metformin, a sulfonylurea, a thiazolidinedione, a combination of metformin and a sulfonylurea, or a combination of metformin and a thiazolidinedione. The member must also have tried and failed to achieve desired glucose control with at least TWO types of oral agents and insulin. Insulin must be discontinued. Cycloset, Januvia, Onglyza, Tradjenta: Requires documentation that member has experienced treatment failure of or intolerance to the use of three of the following: metformin, basal insulin, sulfonylurea, and a TZD. Symlin: Approved for members ≥18 years of age for the treatment of type 1 or 2 diabetes who are receiving insulin therapy and has not achieved desired glucose control (Hgb A1C >7%) despite good compliance with optimal insulin therapy.</p>
Miscellaneous	
<p>Nonformulary: Egrifta®</p>	<p>Approved for members ≥ 18 years of age for the reduction of excess abdominal fat in HIV-associated lipodystrophy, receiving antiretroviral therapy, with gender-specific measures when other weight loss efforts have been ineffective and there is functional impairment in activities of daily living. Renewal coverage is provided for the reduction of excess abdominal fat in HIV-associated lipodystrophy when clinical documentation is provided indicating a decrease in waist circumference and continuation of functional impairment in activities of daily living. Approval duration: Initial approval length up to 6 months, renewal up to 1 year.</p>
GASTROINTESTINAL AGENTS	
Antiemetics Approval duration: up to 1 year	
<p>Nonformulary: Sancuso®, Zuplenz®</p>	<p>Requires documentation that the member has experienced treatment failure of or intolerance to oral granisetron (Kytril(g)) AND ondansetron (Zofran(g)).</p>
Hematopoietic Agents	
<p>Formulary: Procrit® (epoetin alfa)</p> <p>Cont. next page...</p>	<p>Procrit: Requires documentation that the member has one of the following conditions: anemia secondary to chronic renal failure, chronic renal insufficiency, HIV infection, HIV therapy, chemotherapy, myelodysplasia, or chronic hepatitis C therapy, OR prophylaxis prior to surgery to reduce need for allogenic blood transfusions. A Hgb level of less than 10 g/dL is required for initial therapy. For continued coverage dose adjustments are required to maintain Hgb between 10 to 12 g/dL. Duration of approval is dependent on the indication. Approval duration: Initial approval up to 6 months to 1 year Promacta: Approved for treatment of thrombocytopenia with chronic immune thrombocytopenic purpura, has a platelet count of <400 x 10⁹/L if continuing therapy, and inadequate response to, intolerance to, or is not a candidate for standard first-line treatments, such as corticosteroids, immunoglobulins, or splenectomy. Approval duration: up to 6 months</p>

GASTROINTESTINAL AGENTS (Cont.)	
Hematopoietic Agents (cont.)	
<p>Nonformulary: Aranesp®, Epopgen®</p>	<p>Nonformulary agents: Also requires documentation that member has experienced failure of or intolerance to formulary epoetin alfa (Procrit). Approval duration: up to 6 months to 1 year</p>
Miscellaneous Gastrointestinal Agents Approval duration: up to 1 year	
<p>Formulary: Relistor® (methylnaltrexone)</p> <p>Nonformulary: Amitiza®, Chenodal™, Cimzia®, Lotronex®, Xifaxan 550®</p>	<p>Formulary agent: Relistor: Approved for the treatment of opioid-induced constipation in members with advanced illness whom are receiving palliative care and requires documentation that the member has experienced inadequate response to at least 3 of the following laxatives: bulk laxatives (polycarbophil, psyllium, methylcellulose), saline laxatives (milk of magnesia/magnesium hydroxide), osmotic laxatives (Miralax(g)), or stimulant (Dulcolax(g), Senna(g)).</p> <p>Nonformulary agents: Amitiza: Approved for the treatment of chronic idiopathic constipation (fewer than 3 bowel movements/week) or constipation predominant IBS (females only) in members 18 to 65 years of age whom have tried and failed ALL of the following: dietary advice, trials of bulk laxatives, stool softeners, and a short course of stimulant laxatives and are NOT taking medications causing constipation. A total of 12 weeks can be approved, with renewal, only if improvement in bowel frequency is seen with initial trial. Approval duration: Initial up to 3 months, renewal is 1 year Chenodal: Approved for dissolution of gallstones only in patients where surgery is not appropriate. In addition, member must have experience treatment failure of or have an intolerance to Actigall(g). Member cannot have history of hepatocellular disease. Approval duration: up to 2 years Cimzia: Approved for the treatment of Crohn's disease in members ≥18 years of age whom have experienced treatment failure of or intolerance to Humira. Lotronex: Approved for the treatment of severe, diarrhea-predominant irritable bowel syndrome in women at least 18 years of age who have failed to respond to conventional diarrhea therapy including one OTC product (loperamide, bismuth subsalicylate) and one prescription agent (diphenoxylate/atropine (Lomotil(g))). Xifaxan 550: Requires diagnosis of hepatic encephalopathy AND documentation that the member has had treatment failure of or intolerance to lactulose.</p>
Proton Pump Inhibitors Approval duration: up to 1 year	
<p>Formulary: Prevacid®(g) capsule (lansoprazole), Prevacid Solutab™(g), Zegerid®(g) capsule (omeprazole/ sodium bicarbonate)</p> <p>Nonformulary: Aciphex®, Dexilant™, Nexium®, Prilosec suspension, Protonix suspension, Zegerid® Packet</p> <p>Cont. next page...</p>	<p>Formulary agent: Prevacid(g), Solutab(g): Requires documentation that the member has experienced failure of or intolerance to Prilosec OTC(g) or Prilosec(g), AND Protonix(g). Zegerid(g): Requires documentation that member has experienced failure of or intolerance to Prilosec OTC(g) or Prilosec(g) AND Protonix(g), AND Prevacid(g) or Prevacid Solutab.</p> <p>Nonformulary agents: Aciphex, Zegerid Packet: Requires documentation that the member has experienced treatment failure of or intolerance to Prilosec OTC or Prilosec(g) AND Protonix(g), AND Prevacid(g) or Prevacid Solutab. Dexilant, Nexium: Requires documentation that the member has experienced treatment failure of or intolerance to all BCN formulary alternatives [either Prilosec OTC or Prilosec(g), Protonix(g), AND Prevacid(g)], one of which is at a twice daily, high dose regimen. Prilosec suspension, Protonix suspension: Requires documentation that member has experienced treatment failure of or intolerance to Prevacid Solutab.</p>

GASTROINTESTINAL AGENTS (Cont.)	
Proton Pump Inhibitors (cont.) Approval duration: up to 1 year	
Nonformulary: Vimovo™	Vimovo: Requires documentation that member has had treatment failure of or intolerance to Prilosec(g), Protonix(g) and Prevacid(g) AND meets any one of the following criteria: <ul style="list-style-type: none"> •Greater than 60 years of age •Receiving anticoagulant or antiplatelet therapy •Receiving chronic treatment with oral corticosteroids (>= 60 days duration) •A history of peptic ulcer disease, clinically significant gastrointestinal bleeding, and/or alcoholism. Approval duration: up to 10 years
IMMUNOLOGY & HEMATOLOGY	
Hepatitis B & C Therapy	
Formulary: Incivek™ (telaprevir), Infergen (interferon alfacon-1), Intron-A (interferon alfa-2B), Pegasys (peginterferon alfa 2-A), Peg-Intron (peginterferon alfa-2B), Ribavirin, VICTRELIS™ (boceprevir)	Incivek: Requires a diagnosis of Hepatitis C genotype 1. Patients taking Incivek must be receiving triple therapy along with a peg interferon and ribavirin for the appropriate duration of the treatment. Approval duration: Initial approval: up to 6 weeks. Renewal: up to 6 weeks if viral load is 1000 IU/mL or less at treatment week 4. Infergen: Approved for the treatment of Hepatitis B. Approval duration: up to 1 year Intron-A: Approved for the treatment of Hepatitis B, condyloma acuminata, essential thrombocythemia, hairy cell leukemia, Kaposi's sarcoma, malignant melanoma, multiple myeloma, non-Hodgkin's lymphoma, Philadelphia chromosome (Ph) positive chronic phase myelogenous leukemia (CML), and renal cell carcinoma. Approval duration: up to 1 year Peg-Intron, Pegasys: Approved for the treatment of Hepatitis B and Hepatitis C. For hepatitis C, approved for members naïve to pegylated interferon therapy only. Genotype, HIV status, previous therapy and duration must also be provided. The member must receive pegylated interferon in combination with ribavirin unless contraindicated. Approval duration: <ul style="list-style-type: none"> • For genotypes 2, 3: Approval is for a total of 24 weeks duration. • For non-genotypes 2,3 receiving dual therapy with ribavirin: Initial approval is 16 weeks, renewal is 32 weeks if the members achieves >_ 2 log decrease in viral load after 12 weeks of treatment. • For genotype 1 receiving triple therapy: Initial and renewal approval durations depend on patient's viral loads at all futility points and treatment duration as indicated in the prescribing information. Ribavirin: Approved for the treatment of Hepatitis C. Genotype, HIV status, previous therapy and duration must also be provided. VICTRELIS: Requires a diagnosis of Hepatitis C genotype 1, and treatment failure of or intolerance to Incivek. Patients taking VICTRELIS must be receiving triple therapy along with a peg interferon and ribavirin for the appropriate duration of the treatment. Approval duration: Initial and renewal approval durations depend on patient's viral loads at all futility points and treatment duration as indicated in the prescribing information.
Interferons and MS Therapy	
Nonformulary: Ampyra™ Cont. next page...	Ampyra: Initial treatment: Requires a diagnosis of multiple sclerosis and documentation of difficulty walking resulting in significant limitations of instrumental activities of daily living. Also requires two timed 25-foot walk (T25FW) measurements that must be within 10% variability and demonstrates that the patient is able to walk 25 feet in 8-45 seconds. To continue: Requires documentation of improvement in walking speed by at least 10% as assessed by the T25FW AND that limitations of instrumental activities of daily living has improved as a result of increased walking speed within the first 2 months of therapy. Approval duration: initial approval is 2 months, renewal up to 12 months

IMMUNOLOGY & HEMATOLOGY (Cont.)	
Interferons and MS Therapy (cont.)	
<p>Nonformulary: Betaseron®, Gilenya™</p>	<p>Betaseron: Requires documentation that member has experienced failure of or intolerance to Extavia®. Approval duration: up to 10 years</p> <p>Gilenya: Requires diagnosis of relapsing-remitting, secondary-progressive, and progressive-relapsing types of multiple sclerosis, where the member has experienced failure or intolerance to an interferon beta product (for example, Avonex®, Extavia® or Rebif®) AND Copaxone®. Treatment failure is defined by a documented relapse or the presence of new and/or newly enlarged MRI lesions in the previous year. Approval duration: up to 1 year</p>
LIFESTYLE MODIFICATION PRODUCTS	
Impotence Approval duration: up to 1 year	
<p>Formulary: Caverject® (alprostadil), Cialis® (tadalafil), Muse® (alprostadil), Viagra® (sildenafil citrate)</p> <p>Nonformulary: Edex®, Levitra®, Staxyn®</p>	<p>For men under the age of 18, and for women; not covered</p> <p>For men 18 to 34 years old: requires a diagnosis of erectile dysfunction (ED) secondary to a medical cause such as multiple sclerosis, spinal cord injury, Parkinson's disease, radiation for prostate or bladder cancer, and other indications deemed appropriate. The member must not be using nitrates concomitantly and avoid use of alpha blockers with oral ED agents. Maximum of 6 doses per 28 days.</p> <p>For men over the age of 34: requires a diagnosis of ED.</p>
Weight Loss Products Approval duration: up to 1 year	
<p>Formulary: phentermine and related products</p> <p>Nonformulary: Suprenza™, Xenical®</p>	<p>Formulary agents: Requires verification that member's Body Mass Index (BMI) is ≥ 30 kg/m² or >27 kg/m² with co-morbidities, and concurrent lifestyle modification plan. Coverage for all anorexiant and related drugs is limited to 3 months. Additional coverage requires documentation of weight loss of at least 2 pounds per month. Maximum benefit is 12 months of treatment per lifetime; 24 months of treatment per lifetime for Xenical.</p> <p>Nonformulary agent: Suprenza: Requires trial and failure of generic phenteramine, and documentation as to why continued verification that member's Body Mass Index (BMI) is ≥ 30 kg/m² or >27 kg/m² with co-morbidities, and concurrent lifestyle modification plan. Coverage for all anorexiant and related drugs is limited to 3 months. Additional coverage requires documentation of weight loss of at least 2 pounds per month. Maximum benefit is 12 months of treatment per lifetime. Documentation must also be provided as to why continued use of generic phenteramine will adversely affect the member's health.</p>
Miscellaneous	
Compounds	<p>Coverage criteria include:</p> <ul style="list-style-type: none"> • The compound is medically necessary for the member's condition • The compound contains only FDA-approved drugs. • There are no appropriate FDA-approved commercial formulations of the compound available. <p>U6W's (bulk powders) are not covered. Approval duration: up to 6 months</p>

OBSTETRICS AND GYNECOLOGY	
Infertility treatment Approval duration: up to 1 year	
<p>Formulary: Bravelle® (urofollitropin), Cetrotide® (cetorelix acetate), Fertinex™ (urofollitropin), Ganirelix acetate® (ganirelix acetate), Gonal-F®, RFF (follitropin alfa, recomb), Ovidrel® (HCG alfa, recomb), Novarel®/Pregnyl®/Profasi® (gonadotropin, chorionic, human), Repronex® (menotropins)</p> <p>Nonformulary: Follistim® AQ, Luveris®, Menopur®</p>	<p>Coverage is provided for most BCN female members with an infertility benefit and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), gamete in vitro fertilization transfer (GIFT). Authorization will be provided for one year. Additional coverage will be based on documentation that the member is being treated according to accepted medical practice. Requests are not considered for men.</p> <p>Nonformulary: Also Requires treatment failure of or intolerance to formulary agents.</p>
OTIC & NASAL PREPARATIONS	
Intranasal Steroids Approval duration: up to 1 year	
<p>Formulary: Nasacort AQ® (g) (triamcinolone acetoneide)</p> <p>Nonformulary: Beconase AQ®, Nasonex®, Omnaris™, Rhinocort Aqua®, Veramyst™</p>	<p>Formulary agent: Nasacort AQ(g): Requires documentation that member has experienced treatment failure of or intolerance to fluticasone (Flonase(g)) or flunisolide (Nasalide(g)/Nasarel(g)).</p> <p>Nonformulary agents: Requires documentation that member has experienced treatment failure of or intolerance to fluticasone (Flonase(g)) or flunisolide (Nasalide(g)/Nasarel(g)) AND Nasacort AQ (g).</p>
RESPIRATORY COUGH & COLD	
Antihistamines and Combinations Approval duration: up to 1 year	
<p>Formulary: Xyzal® (g)</p> <p>Nonformulary: Clarinex® (Rx-Only), Clarinex-D® (Rx-Only), Clarinex Reditabs® (Rx-Only), Clarinex Syrup® (Rx-Only), Semprex-D®</p>	<p>Formulary agent: Xyzal(g): Requires documentation that the member has experienced treatment failure of or intolerance to OTC loratadine and OTC cetirizine.</p> <p>Nonformulary agents: Requires documentation that the member has experienced treatment failure of or intolerance to OTC loratadine and OTC cetirizine.</p>
Inhaled Beta-Agonists Approval duration: up to 10 years	
<p>Nonformulary: Arcapta® Neohaler, Brovana®, Perforomist™</p>	<p>Requires documentation that the member has experienced treatment failure of or intolerance to both Serevent® and Foradil®.</p>
Miscellaneous Approval duration: up to 1 year	
<p>Nonformulary: Daliresp™</p>	<p>Daliresp: Requires documentation that the member has a diagnosis of severe chronic obstructive pulmonary disorder (COPD) associated with chronic bronchitis and a history of exacerbations despite therapy with a long acting beta agonist, an anticholinergic and a formulary inhaled steroid.</p>
Pulmonary Arterial Hypertension Approval duration: up to 1 year	
<p>Formulary: Letairis™ (ambrisentan), Revatio® (sildenafil), Tracleer® (bosentan), Tyvaso™ (treprostinil), Ventavis® (iloprost)</p> <p>Cont. next page...</p>	<p>Formulary agents: Letairis, Revatio, Tracleer, Tyvaso, Ventavis: Approved for the treatment of pulmonary arterial hypertension (PAH) WHO Class III or IV symptoms.</p>

RESPIRATORY COUGH & COLD (Cont.)	
Pulmonary Arterial Hypertension (cont.) Approval duration: up to 1 year	
Nonformulary: Adcirca™	Nonformulary agent: Adcirca: Approved for the treatment of pulmonary arterial hypertension (PAH), WHO Class III or IV symptoms AND requires documentation that member has experienced treatment failure of or intolerance to Revatio.
RHEUMATOLOGY & MUSCULOSKELETAL	
Gout Therapy Approval duration: up to 10 years	
Formulary: Uloric® (febuxostat)	Approved for the treatment of gout in members that have experienced treatment failure of or intolerance to generic allopurinol. Uloric 80mg requires documentation that the member has had an inadequate response to the 40mg dose.
Miscellaneous Rheumatologic Agents Approval duration: up to 1 year	
Formulary: Enbrel®(etanercept), Humira® (adalimumab)	Formulary agents: Enbrel, Humira: Requires a three month trial with two concurrent oral disease modifying antirheumatic drugs (one must be methotrexate unless contraindicated). Examples of DMARDs include: methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine.
Nonformulary: Cimzia®, Kineret®, Orencia® SC, Simponi™	Nonformulary agent: Cimzia, Kineret, Orencia SC, Simponi: Requires that the member has experienced treatment failure of or intolerance to Enbrel and Humira.
Osteoporosis/Bone Resorption Inhibitors Approval duration: up to 10 years	
Formulary: Actonel® (risedronate); Actonel® plus Calcium	Formulary agents: Actonel, Actonel plus Calcium: Requires documentation that member has experienced treatment failure of or intolerance to alendronate (Fosamax(g)).
Nonformulary: Atelvia™, Boniva®, Fosamax D™, Forteo™	Nonformulary agents: Atelvia, Boniva, Fosamax D: Requires documentation that member has experienced treatment failure of or intolerance to both alendronate (Fosamax(g)) and Actonel. Forteo: Approved for the treatment of osteoporosis (T-score <= -2.5) AND requires documentation that the member has a contraindication to or experienced treatment failure of or intolerance to a bisphosphonate. Approval duration: up to 2 years
UROLOGY	
BPH Treatment Approval duration: up to 1 year	
Formulary: Jalyn™ (dutasteride/tamsulosin)	Requires successful treatment of at least three months of therapy of either an alpha blocker, 5-alpha-reductase inhibitor or Jalyn.

Blue Cross Blue Shield of Michigan

Prior Authorization and Step Therapy Program January 2012

Blue Cross Blue Shield of MI

Prior Authorization and Step Therapy Program

January 2012

BCBSM monitors the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization** for these drugs means that certain clinical criteria must be met before coverage is provided. In the case of drugs requiring **step therapy**, for example, previous treatment with one or more formulary drugs may be required. Drugs that must meet clinical criteria are identified in the formulary list with (PA) or (ST). Your physician can contact our pharmacy help desk to request prior authorization for these drugs.

The criteria for authorization are based on current medical information and the recommendations of the Blues' Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts. You may be required to pay the full cost of the drug if your physician does not obtain prior authorization.

When your doctor prescribes a brand-name drug that's nonformulary, requires prior authorization or is not covered under your drug rider, it may not be a covered benefit. BCBSM reviews all physician and member requests to determine if the drug is medically necessary and that there aren't equally effective alternative drugs on the formulary.

Please call the Customer Service number on the back of your BCBSM ID card if you have questions about your drug coverage, a drug claim or filing a benefit exception.

Prior Authorization and Step Therapy Drug Categories (CUSTOM FORMULARY)

MEDICATION/DRUG CLASS	CRITERIA
Adcirca[®] (tadalafil) <i>Nonformulary</i>	Approved for members with documentation of a diagnosis of Pulmonary Arterial Hypertension (PAH). Coverage is NOT provided for Adcirca [®] in situations where the patient is receiving nitrate therapy.
Amitiza[®] (lubiprostone) <i>Nonformulary</i>	Patient must be 18 years or older and have a diagnosis of constipation predominant Irritable Bowel Syndrome (IBS) (female only) OR Chronic idiopathic constipation with documented failure with one fiber laxative and either a stimulant or osmotic laxative. Drug induced constipation must also be ruled out.
Ampyra[®] (dalfampridine) <i>Nonformulary</i>	Coverage may be provided in patients ≥ 18 years of age when the criteria below are met: <ul style="list-style-type: none"> Diagnosis of multiple sclerosis. Prescribing physician is a neurologist. Patient has documented difficulty walking, resulting in significant limitations of instrumental activities of daily living. Clinical notes are provided documenting two measurements with variability within 10% demonstrating the patient is able to walk 25 feet in 8-45 seconds. The faster time of the two measurements will serve as the baseline value. Ambulatory function assessed with the timed 25-foot walk (T25FW). Patient does not have a history of seizure. Patient does not have moderate to severe renal impairment (CrCl ≤ 50 ml/min). <p>Initial approval length is for 3 months</p> Coverage may be renewed for 12 months when the following criteria are met: <ul style="list-style-type: none"> Clinical notes are provided documenting improvement in walking speed by at least 10% as assessed by the timed 25-foot walk. Indication that the significant limitations of instrumental activities of daily living have improved/resolved as a result of increased speed of ambulation. Coverage may be renewed annually thereafter (12 month intervals) when clinical notes document no deterioration in walking speed, compared to the previous walking speed measured for renewal of therapy, as assessed by the timed 25-foot walk.

MEDICATION/DRUG CLASS	CRITERIA
Amrix® [g] (cyclobenzaprine) <i>Nonformulary</i>	Approval requires previous trial and failure of generic immediate-release cyclobenzaprine.
<u>Anabolic Steroids:</u> <i>Formulary:</i> Oxandrin® [g] (oxandrolone) <i>Nonformulary:</i> Anadrol-50® (oxymetholone) Deca-Durabolin® (nandrolone decanoate)	Oxandrin® [g]: Approved when used as an adjunct therapy to promote weight gain in patients who have had extensive surgery, chronic infection, or severe trauma OR for therapy to offset protein catabolism associated with prolonged use of corticosteroids OR for bone pain associated with osteoporosis OR if prophylactic therapy is needed in patients with hereditary angioedema. <u>Anadrol-50® (oxymetholone) and Deca-Durabolin® (nandrolone decanoate):</u> Approved for the treatment of clinically diagnosed anemia (documentation must support the trial of standard supportive measures for treating anemia including: transfusion, correction of iron, folic acid, vitamin B12, or pyridoxine deficiency, antibacterial therapy and the appropriate use of corticosteroids) OR for the treatment of HIV-associated wasting OR if prophylactic therapy is needed in patients with hereditary angioedema.
<u>Angiotensin II Receptor Blockers (ARBs):</u> <i>Formulary:</i> Benicar®/HCT (olmesartan) <i>Nonformulary:</i> Atacand®/HCT (candesartan) Avapro®/Avalide® (irbesartan) Diovan®/HCT (valsartan) Edarbi™ (azilsartan medoxomil) Micardis®/HCT (telmisartan) Teveten®/HCT (eprosartan)	Benicar®/HCT requires documentation that the member has experienced failure of or intolerance to Cozaar® (losartan)/Hyzaar® [g]. Approval of nonformulary agents require documentation that the member has experienced failure of or intolerance to Cozaar® (losartan)/Hyzaar® [g] AND Benicar®/HCT (olmesartan).
<u>Antidepressants:</u> <i>Formulary:</i> Lexapro® (escitalopram) <i>Nonformulary:</i> Aplenzin® (bupropion hydrobromide) Cymbalta® (duloxetine) Luvox® CR (fluvoxamine) Pexeva® (paroxetine) Pristiq® (desvenlafaxine) Viibryd™ (vilazodone)	Lexapro® requires step therapy with at least one of the following generic formulary alternatives: Celexa® [g], Effexor®/XR® [g], Luvox® [g], Paxil/CR® [g], Prozac® [g], Remeron® [g], venlafaxine XR, Wellbutrin/SR® [g], Wellbutrin XL® [g] or Zoloft® [g]. <u>Nonformulary agents:</u> Aplenzin® requires trial/failure of at least two formulary antidepressant agents, one of which must be generic bupropion. Luvox® CR requires trial/failure of at least two formulary antidepressant agents, one of which must be generic fluvoxamine. Pexeva® requires trial/failure of at least two formulary antidepressant agents, one of which must be generic paroxetine. Cymbalta® for diagnosis of major depression requires trial and failure with two formulary antidepressant agents. Pristiq® requires trial/failure of at least two formulary antidepressant agents, one of which must be Effexor® [g], Effexor XR® [g] or venlafaxine ER. Viibryd™ requires trial/failure of at least two formulary antidepressant agents.
Arcalyst® (rilonacept) <i>Formulary</i>	Only FDA-approved for treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years and older.

MEDICATION/DRUG CLASS	CRITERIA
Aricept® 23 mg (donepezil) <i>Nonformulary</i>	Requires 3 month trial of Aricept® [g] (donepezil) 10 mg tablets within the last year.
<u>Aromatase Inhibitors:</u> <i>Formulary:</i> Arimidex® [g] (anastrozole) Aromasin® [g] (exemestane) Femara® [g] (letrozole)	Coverage review required for males only. Approved only for ER-positive breast cancer treatment and other literature supported cancer therapies.
Betaseron® (Interferon beta-1b) <i>Nonformulary</i>	Requires trial and failure or intolerance of Extavia®.
<u>Bisphosphonates:</u> <i>Formulary:</i> Actonel® (risedronate) Actonel® with Calcium <i>Nonformulary:</i> Atelvia™ (risedronate) Boniva® (ibandronate) Fosamax Plus D®	Actonel® (risedronate) requires documentation that the member has tried and failed/not tolerated treatment with Fosamax® [g]. Atelvia™ requires documentation that the member has tried and failed/not tolerated treatment with Fosamax® [g]. Boniva® (ibandronate) and Fosamax Plus D® require documentation that the member has tried and failed/not tolerated treatment with both Fosamax® [g] AND Actonel® (risedronate) or Atelvia™ (risedronate).
<u>Brand Tetracyclines:</u> <i>Formulary:</i> Adoxa® (doxycycline) Doryx® (doxycycline) Solodyn® (minocycline) <i>Nonformulary:</i> Dynacin® (minocycline) Oracea® (doxycycline)	<u>Adoxa®, Doryx® and Oracea®</u> Requires documentation that the member has experienced treatment failure of generic doxycycline. <u>Dynacin® and Solodyn®</u> Requires documentation that the member has experienced treatment failure of generic minocycline.
Butrans® (buprenorphine) <i>Nonformulary</i>	Coverage will be provided for the management of moderate to severe chronic pain in patients requiring around the clock opioid analgesia for an extended period of time. Criteria also require trial and failure or intolerance of two of the following: extended release morphine, fentanyl patch or methadone. Coverage will not be provided for use as an “as needed” analgesic or for acute pain or postoperative pain.
Byetta® (exenatide) <i>Nonformulary</i>	Approved as adjunctive therapy in combination with at least one of the following medications: metformin, sulfonylurea or a thiazolidinedione AND being used to improve glycemic control in patients who have a diagnosis of type II diabetes mellitus AND have tried at least 2 of the following: metformin, a sulfonylurea or a thiazolidinedione (unless contraindicated) AND the patient must have documentation of an A1c greater than 7%. Byetta® is NOT covered for the primary indication of weight loss in patients with or without diabetes.
Bystolic® (nebivolol) <i>Nonformulary</i>	Approval requires documentation that the patient has tried and failed/intolerant to at least TWO of the formulary cardioselective beta blockers: Kerlone® [g], Sectral® [g], Tenormin® [g], Zebeta® [g], Lopressor® [g] OR Toprol XL® [g].

MEDICATION/DRUG CLASS	CRITERIA
Cambia™ (diclofenac potassium) <i>Nonformulary</i>	Approval requires documentation that the patient has tried and failed or is intolerant to generic oral diclofenac AND one oral generic NSAID (Non-steroidal anti-inflammatory drug).
Carbaglu® (carglumic acid) <i>Formulary</i>	Covered for the treatment of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS).
Cayston® (aztreonam lysine) <i>Nonformulary</i>	Covered for the improvement of respiratory symptoms in cystic fibrosis patients with <i>Pseudomonas aeruginosa</i> .
Celebrex® (celecoxib) <i>Nonformulary</i>	Requires one of the following: <ul style="list-style-type: none"> • Age > 60 OR • Concomitant use of anticoagulants OR • Oral steroids OR • Risk of GI bleed (history of PUD, previous GI bleed, alcoholism).
Chenodal™ (chenodeoxycholic acid) <i>Nonformulary</i>	Coverage approved for patients with radiolucent stones in well-opacifying gallbladders in whom selective surgery would be undertaken except for the presence of increased surgical risk because of systemic disease or age. Requires: <ol style="list-style-type: none"> 1. Trial and failure or intolerance of ursodiol 2. Patient is not a candidate for surgery 3. Patient has no history of hepatocellular disease 4. If the patient is a woman, required that they are not pregnant and may not become pregnant. Coverage is limited to 24 months total of ursodiol plus Chenodal™.
<u>Cholesterol lowering Agents:</u> <i>Formulary:</i> Crestor® (rosuvastatin) <i>Nonformulary:</i> Altoprev® (lovastatin ER) Lescol®/XL® (fluvastatin) Livalo® (pitavastatin) Vytorin® (simvastatin/ezetimibe) Advicor® (lovastatin/niacin ER) Simcor® (simvastatin/niacin ER)	Crestor® requires documentation that member has experienced failure of or intolerance to at least one generic statin (Mevacor [g], Zocor [g], Pravachol [g] or Lipitor [g]). Nonformulary agents: Altoprev®, Lescol®, Lescol XL®, Livalo®, Vytorin®: Requires documentation that member has experienced failure of or intolerance to at least one generic statin (Mevacor [g], Zocor [g], Pravachol [g] or Lipitor [g]) AND one formulary brand agent (Crestor® or Zetia®). Advicor®: Requires documentation that member has had at least 3 months of treatment with lovastatin and niacin extended release as individual agents when used concomitantly. Simcor®: Requires documentation that member has had at least 3 months of treatment with simvastatin and niacin extended release as individual agents when used concomitantly.
Cialis® (tadalafil) <i>Formulary</i>	Requires diagnosis of Benign Prostatic Hyperplasia (BPH) AND trial and failure or intolerance of an alpha-blocker AND a 5-alpha reductase inhibitor. May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions.
Clarinet-D® (desloratadine/ pseudoephedrine) <i>Nonformulary</i>	Coverage for Clarinet/Clarinet-D® requires failure of or intolerance to loratadine/loratadine-D AND cetirizine/cetirizine-D AND fexofenadine/fexofenadine-D AND Xyzal® [g] (levocetirizine).

MEDICATION/DRUG CLASS	CRITERIA
Cycloset[®] (bromocriptine) <i>Nonformulary</i>	<p>Approved as adjunctive therapy in combination with at least one of the following medications: metformin, sulfonylurea or a thiazolidinedione AND being used to improve glycemic control in patients who have a diagnosis of type II diabetes mellitus AND have tried at least 2 of the following: metformin, a sulfonylurea or a thiazolidinedione (unless contraindicated) AND the patient must have documentation of an A1c greater than 7%.</p> <p>Cycloset[®] is NOT covered for the primary indication of weight loss in patients with or without diabetes.</p>
Cymbalta[®] (duloxetine) <i>Nonformulary</i>	<p>Coverage for Cymbalta[®] will be provided for:</p> <p><u>Treatment of major depression</u> Approval requires trial and failure with two formulary antidepressants.</p> <p>OR</p> <p><u>Treatment of diabetic neuropathic pain</u></p> <ul style="list-style-type: none"> ➤ If patient equal to or greater than 65 years of age: After a 30-day trial of gabapentin. ➤ If patient less than 65 years of age: After a 30-day trial of gabapentin AND a tricyclic antidepressant, such as amitriptyline, desipramine or imipramine. <p>OR</p> <p><u>Treatment of Fibromyalgia</u> Fibromyalgia characterized by pain in all 4 body quadrants, for at least 3 months, with or without fatigue and sleep disturbance AND the patient has tried and experienced intolerance to gabapentin OR had inadequate pain relief at doses of 1200 mg or above AND has tried and experienced intolerance or inadequate pain relief to three of the following: tricyclic antidepressant, SSRI, SNRI, cyclobenzaprine and tramadol.</p> <p>OR</p> <p><u>Treatment of Chronic Musculoskeletal Pain</u> Approval requires failure or intolerance of two generic formulary alternatives from any of the following three drug classes: antidepressants, NSAIDs and centrally acting analgesics. Examples of centrally acting analgesics include: codeine, hydrocodone, morphine, meperidine, oxycodone and tramadol.</p> <p>OR</p> <p><u>Treatment of Generalized Anxiety Disorder</u> Approval requires trial and failure of two formulary antidepressants.</p>
Daliresp[®] (roflumilast) <i>Nonformulary</i>	<p>Coverage for Daliresp[®] will be approved for use in patients with severe COPD associated with chronic bronchitis AND a history of exacerbations despite maximal therapy with a LABA (long-acting beta agonist), an anticholinergic and an inhaled corticosteroid. Supporting documentation will be required for processing.</p>
Duexis[®] (ibuprofen/famotidine) <i>Nonformulary</i>	<p>Coverage for Duexis[®] requires trial and failure of individual generic agents ibuprofen and famotidine taken concurrently AND explanation of why the combination product is expected to work if the individual agents have not.</p>

MEDICATION/DRUG CLASS	CRITERIA
<p>Egrifta[®] (tesamorelin) <i>Nonformulary</i></p>	<p>Coverage for Egrifta[®] will be provided for the FDA approved indication only. The reduction of excess abdominal fat in HIV-infected patients with lipodystrophy AND supporting documentation will be required for the following criteria:</p> <ul style="list-style-type: none"> A. Patient is infected with human immunodeficiency virus (HIV). B. Patient is receiving antiretroviral therapy (ART). C. Weight loss efforts (dietary modification and exercise) have been ineffective in reducing the excess abdominal fat due to lipodystrophy. D. Documentation of the medical complication(s) caused by excess abdominal fat. E. The medical complication(s) due to excess abdominal fat are unresponsive to conventional therapy. <p>Initial approval is for 6 months.</p> <p>Coverage may be renewed for 12 months when the following criteria are met:</p> <ul style="list-style-type: none"> A. Clinical documentation indicating a decrease in waist circumference (decrease in lipodystrophy). B. Reduction of complication(s) provided in the initial request caused by excess abdominal fat. <p>Coverage is <u>NOT</u> provided for weight loss management in patients with HIV infection.</p>
<p><u>Erythropoiesis Stimulating Agents (ESAs):</u></p> <p><i>Formulary:</i> Procrit[®] (epoetin alfa)</p> <p><i>Nonformulary:</i> Aranesp[®] (darbepoetin alfa) Epogen[®] (epoetin alfa)</p>	<p>Information may need to be submitted describing the use and setting of the drug to make the determination.</p> <p>Approved for use in members with hemoglobin less than 12 g/dL and one of the following conditions: anemia secondary to chronic renal failure, chronic renal insufficiency, HIV infection, HIV therapy, chemotherapy, myelodysplasia or chronic hepatitis C therapy OR prophylaxis prior to major surgery. Duration of approval is dependent on the indication.</p> <p>Nonformulary agent(s): Coverage for nonformulary agents also requires documentation that the member has experienced failure of or intolerance to formulary epoetin alfa (Procrit[®]).</p> <p>Coverage duration = 3 months</p>
<p>Exalgo[®] (hydromorphone ER) <i>Nonformulary</i></p>	<p>Coverage will be provided for management of moderate to severe pain in opioid tolerant patients requiring continuous, around the clock opioid analgesia for an extended period of time. Criteria also require trial and failure or intolerance of two of the following: extended release morphine, fentanyl patch or methadone.</p> <p>Coverage will not be provided for use as an “as needed” analgesic or for acute pain or postoperative pain.</p>
<p>Firazyr[®] (icatibant) <i>Nonformulary</i></p>	<p>Coverage for Firazyr[®] will be provided for a diagnosis of hereditary angioedema (HAE) established by an immunologist or hematologist. Supporting documentation will be required for processing.</p>
<p>Flector[®] (diclofenac patch) <i>Nonformulary</i></p>	<p>For FDA approved indications only. Member must have tried and failed or demonstrated intolerance to oral diclofenac AND at least two other oral, traditional NSAIDs unless the patient is unable to take any oral medications.</p> <p>AND</p> <p>Coverage will NOT be provided in the presence of concurrent therapy with oral NSAIDs or a COX II inhibitor.</p>

MEDICATION/DRUG CLASS	CRITERIA
Forteo® (teriparatide) <i>Nonformulary</i>	Forteo® will be provided for the following guidelines: 1. For patients with a history of fracture. OR 2. For the treatment of postmenopausal women with osteoporosis who are at high risk of fracture or men with primary or hypogonadal osteoporosis who are at high risk for fracture and meet the following criteria (a and b): a) Have a bone mineral density (BMD) that is 2.5 standard deviations or more below the mean (T-score at or below -2.5). b) Patient has tried and failed a bisphosphonate (formulary agents include Fosamax® [g] and Actonel®) for a 24 month period except when: 1. Contraindication to a bisphosphonate (such as a stricture or achalasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration). OR 2. Documented intolerance to a bisphosphonate Forteo will be approved for a maximum of two years.
Gilenya™ (fingolimod) <i>Nonformulary</i>	Approval for Gilenya™ requires (1,2,3 and 4): 1. That the patient is 18 years of age or older with a relapsing form of multiple sclerosis 2. The prescribing physician must be a neurologist 3. Trial of at least one interferon beta product (e.g. Avonex®, Betaseron®, Extavia®, Rebif®) OR Copaxone® has demonstrated clinical failure or intolerance, unless all products are contraindicated based on clinical documentation. <ul style="list-style-type: none"> • Treatment failure is demonstrated by the following: <ul style="list-style-type: none"> - Documented clinical relapse - The presence of new and/or newly enlarged MRI lesions in the previous year. 4. Will not be used in combination with other disease-modifying treatments of multiple sclerosis.
Gralise™ (gabapentin CR) <i>Nonformulary</i>	Covered for the treatment of post-herpetic neuralgia with the following criteria: ➤ If patient equal to or greater than 65 years of age: After a 30-day trial of gabapentin. ➤ If patient less than 65 years of age: After a 30-day trial of gabapentin AND a tricyclic antidepressant, such as amitriptyline, desipramine or imipramine.
<u>Growth Hormone:</u> <i>Formulary:</i> Genotropin® (somatotropin) Nutropin® (somatotropin) <i>Nonformulary:</i> Humatrope® Norditropin® Omnitrope® Saizen® Serostim® Tev-Tropin® Zorbtive™	Coverage will be provided for: <u>Pediatric Growth Hormone Deficiency</u> <i>Children (M < 16 years old, F < 15 years old):</i> <i>Initial Treatment:</i> Req. ≥ 6 months of initial height measurements, Ht < 5 th percentile for age (based on initial evaluation), abnormal growth velocity based on ≥ 6 mo. of measurement, < 50 th percentile for age with growth hormone therapy, initial subnormal blood test for growth hormone. <i>To continue treatment:</i> must have a documented growth velocity of ≥ 2.5 cm/year during the first 6 mo. of therapy & documented growth of ≥ 4.5 cm/year for each succeeding 6 month review period. Treatment may continue until final height or epiphyseal closure has been documented or patient has reached age 16 years (M) or 15 years (F). <u>Adults:</u> Diagnosis of growth hormone deficiency confirmed by laboratory testing (e.g. provocative stimulation), known indication for pituitary disease and multiple pituitary hormone deficiencies. Multiple stimulation tests may be required in certain clinical circumstances. May be approved for AIDS-wasting cachexia and Turner's Syndrome.

MEDICATION/DRUG CLASS	CRITERIA
	<p>Growth hormone therapy is NOT covered for anti-aging, obesity or athletic enhancement.</p> <p>Nonformulary agents require that the member has experienced treatment failure of or intolerance to formulary agents.</p>
<p><u>Hepatitis C Protease Inhibitors</u></p> <p><i>Formulary:</i> Incivek™ (telaprevir) Victrelis™ (boceprevir)</p>	<p>Incivek™ (telaprevir) Coverage will be provided for adult patients (18 years or older) with Chronic hepatitis C genotype 1 infection AND</p> <ol style="list-style-type: none"> 1. Compensated liver disease (including cirrhosis) AND with recent HCV-RNA level. 2. Used in combination with peg interferon alfa (PegIntron or Pegasys) and ribavirin (Rebetol, Copegus). <p>Victrelis™ Coverage will be provided for adult patients (18yo or older) with Chronic hepatitis C genotype 1 infection AND</p> <ol style="list-style-type: none"> 1. Compensated liver disease (including cirrhosis) AND with recent HCV-RNA level. 2. Used in combination with peg interferon alfa (PegIntron or Pegasys) and ribavirin (Rebetol, Copegus) AND 3. Therapy must be initiated for 4 weeks with peg interferon alfa and ribavirin (Victrelis therapy starts at treatment week 5) AND 4. Treatment with telaprevir (Incivek™) is contraindicated or not recommended: <ol style="list-style-type: none"> a. History of severe skin reactions or dermatologic conditions b. Moderate to severe hepatic impairment (Child-Pugh B or C) c. Drug-drug interactions not also associated with boceprevir <p>**Renewal criteria for both Incivek™ and Victrelis™ require updated viral load**</p>
<p>Horizant™ (gabapentin ER) <i>Nonformulary</i></p>	<p>Approval of Horizant™ requires trial and failure of Mirapex® [g], Neurontin® [g] and Requip® [g].</p>
<p>H.P. Acthar Gel® (repository corticotropin) <i>Nonformulary</i></p>	<p>Coverage will be provided for the treatment of infantile spasms OR for the diagnostic testing of adrenocortical function only if use of cosyntropin is contraindicated.</p> <p>Use of H.P. Acthar Gel® is NOT considered medically necessary as treatment of steroid-responsive conditions, unless there are medical contraindications or intolerance to corticosteroids that are not also expected to occur with use of H.P. Acthar Gel®.</p>
<p><u>Human Chorionic Gonadotropin:</u></p> <p><i>Formulary:</i> Novarel® Pregnyl®</p>	<p>Coverage for Novarel® or Pregnyl® will be provided in accordance with infertility benefit and policy for both males and females and for FDA approved indications.</p>
<p><u>Immune Globulin:</u></p> <p><i>Nonformulary:</i> Gammagard™ Gammaked™ Gamunex-C® Hizentra®</p>	<p>Requires appropriate diagnosis for coverage and other criteria may apply depending on diagnosis.</p>

MEDICATION/DRUG CLASS	CRITERIA
Increlex[®] (mecasermin) <i>Nonformulary</i>	Approval will require all of the following (1, 2, 3, 4, 5 and 6.): <ol style="list-style-type: none"> 1. Medication to be prescribed by a pediatric endocrinologist 2. Diagnosis of one of the following: <ul style="list-style-type: none"> o Severe primary IGF-1 deficiency or growth hormone gene deletion or o genetic mutation of growth hormone receptor (Laron Syndrome) 3. Current height measurement at less than 3rd percentile for age and sex 4. IGF-1 level greater than or equal to 3 standard deviations below normal 5. Normal or elevated growth hormone levels based on at least one growth hormone stimulation test 6. Open growth plates <p>Authorizations shall be reviewed <u>at least annually</u> to confirm that current medical necessity criteria are met and that the medication is effective. Continued authorization in children may be given for up to 12 months until any one of the following conditions occurs:</p> <ol style="list-style-type: none"> 1. Growth velocity is less than 2.5 cm/year OR 2. Bone age in males exceeds 16^{0/12} years of age OR 3. Bone age in females exceeds 14^{0/12} years of age
<u>Intranasal Steroids:</u> <i>Formulary:</i> Nasacort AQ[®] [g] (triamcinolone) <i>Nonformulary:</i> Beconase[®] AQ (beclomethasone) Nasonex[®] (mometasone) Omnaris[®] (ciclesonide) Rhinocort AQ[®] (budesonide) Veramyst[®] (fluticasone)	Approval of triamcinolone (Nasacort AQ [®]) requires trial and failure/intolerance to (Flonase [®]) OR generic flunisolide (Nasarel [®]). Approval of nonformulary agents requires trial and failure/intolerance of 2 of the following intranasal steroids: generic fluticasone (Flonase [®]), generic flunisolide (Nasarel [®]) or generic triamcinolone (Nasacort AQ [®]).
Intuniv[®] (guanfacine extended-release) <i>Nonformulary</i>	Covered for the members 6 years of age and older with the appropriate diagnosis who have experienced therapeutic failure or intolerance to BOTH an amphetamine-type product AND a methylphenidate product.
Kapvay[™] (clonidine ER) <i>Nonformulary</i>	Covered for the members 6 years of age and older with the appropriate diagnosis who have experienced therapeutic failure or intolerance to BOTH an amphetamine-type product AND a methylphenidate product.
Lotronex[®] (alosetron hydrochloride) <i>Nonformulary</i>	Approved for treatment of women ≥ 18 years old with severe, diarrhea-predominant Irritable Bowel Syndrome (IBS) who have failed to respond to conventional IBS therapy.

MEDICATION/DRUG CLASS	CRITERIA
<p>Lyrica® (pregabalin) Nonformulary</p>	<p>Coverage of Lyrica® will be provided for:</p> <p><u>Adjunctive treatment for adult patients with partial onset of seizures</u></p> <p>OR</p> <p><u>Treatment of diabetic neuropathic pain or post-herpetic neuralgia</u></p> <ul style="list-style-type: none"> ➤ If patient equal to or greater than 65 years of age: After a 30-day trial of gabapentin. ➤ If patient less than 65 years of age: After a 30-day trial of gabapentin AND a tricyclic antidepressant, such as amitriptyline, desipramine or imipramine. <p>OR</p> <p><u>Treatment of Fibromyalgia</u></p> <p>Fibromyalgia characterized by pain in all 4 body quadrants for at least 3 months with or without fatigue and sleep disturbance AND the patient has tried and experienced intolerance to gabapentin OR had inadequate pain relief at doses of 1200 mg or above AND has tried and experienced intolerance or inadequate pain relief to three of the following: tricyclic antidepressant, SSRI, SNRI, cyclobenzaprine, tramadol.</p>
<p>Mirapex® ER (pramipexole ER) Nonformulary</p>	<p>Coverage approved for the treatment of Parkinson's. Requires trial and failure of Mirapex® [g].</p>
<p>Narcotics:</p> <p><i>Formulary:</i> Actiq® [g] (fentanyl citrate)</p> <p><i>Nonformulary:</i> Abstral® (fentanyl citrate) Fentora® (fentanyl citrate) Onsolis® (fentanyl citrate) Lazanda® (fentanyl citrate)</p>	<p>Requires appropriate diagnosis for coverage and tolerance to high doses of narcotics and current use of long-acting narcotic. Approved for breakthrough pain only.</p> <p>Nonformulary agents: (Abstral®, Fentora® and Onsolis®) require that the member has experienced treatment failure of or intolerance to formulary agents.</p> <p>Coverage for Lazanda® will only be provided when members have meet ALL of the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of breakthrough cancer pain OR treatment for breakthrough cancer pain 2. Patient is opioid tolerant and is currently being treated with a long acting opioid analgesic 3. Previous trial and failure of generic short acting fentanyl products (fentanyl citrate buccal lollipop and buccal tablet)
<p>Nexiclon™ XR (clonidine ER) Nonformulary</p>	<p>Requires appropriate diagnosis for coverage and trial and failure of generic clonidine tablet or generic clonidine patch.</p>
<p>Nucynta® ER (tapentadol) Nonformulary</p>	<p>Coverage for Nucynta ER requires documented trial and failure or intolerance to Ultram® ER [g] AND trial and failure of TWO of the following generic formulary alternatives: extended-release morphine, fentanyl patch or methadone.</p>
<p>Nuedexta® (dextromethorphan/ quinidine) Nonformulary</p>	<p>Requires appropriate diagnosis for coverage. Coverage approved for the treatment of PBA (pseudobulbar affect) secondary to ALS and/or MS.</p>
<p>Oleptro™ (trazodone ER) Nonformulary</p>	<p>Coverage approved for the treatment of major depressive disorder. Requires trial and failure of Desyrel [g] and documentation why the long acting would be more efficacious.</p>
<p>Pennsaid® (diclofenac sodium) Nonformulary</p>	<p>For FDA approved indications only. Member must have tried and failed or demonstrated intolerance to oral diclofenac AND at least two other oral, traditional NSAIDs unless the patient is unable to take any oral medications.</p> <p>AND</p> <p>Coverage will NOT be provided in the presence of concurrent therapy with oral NSAIDs or a COX II inhibitor.</p>

MEDICATION/DRUG CLASS	CRITERIA
Promacta[®] (eltrombopag) <i>Formulary</i>	Initial approval for coverage requires all of the following: <ol style="list-style-type: none"> 1. Age greater than 18 years old AND 2. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 150,000 mcL) for \geq 2 months AND 3. Prescribed by a hematologist or in consultation with a hematologist AND 4. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins or splenectomy AND 5. Current platelet count is < 50, 000 mcL AND 6. Dose is \leq 75 mg/day Renewal approval for Promacta [®] requires recent platelet count of 30,000-150, 000 mcL AND dose is \leq 75 mg/day.
Proton Pump Inhibitors (PPI's): <i>Nonformulary:</i> Aciphex[®] (rabeprazole) Dexilant[™] (dexlansoprazole) Nexium[®] (esomeprazole) Zegerid[®] powder for oral suspension (omeprazole/sodium bicarbonate)	Approval of nonformulary medications requires failure of or intolerance to all formulary alternatives: Prilosec [®] [g] OR Prilosec OTC [®] [g] AND Protonix [®] [g] AND Prevacid [®] /Prevacid [®] SoluTab [™] [g]
Relistor[®] (methylnaltrexone bromide) <i>Formulary</i>	Coverage of Relistor [®] will be provided for: <ol style="list-style-type: none"> 1. The treatment of opioid-induced constipation in patients with advanced illnesses who are receiving palliative care when response to laxative therapy has not been sufficient. 2. Patients shall be on stable doses of opioids for greater than 2 weeks. 3. Duration of methylnaltrexone therapy shall be limited to 3 months. 4. Previous history of treatment for constipation shall include fluids, stool softeners, bulk laxatives, saline laxatives and osmotic laxatives. Laxatives trials shall be of at least 5 days duration. 5. Maximum initial regimen shall be 1 box (7 doses). 6. Monthly doses shall not exceed 14. Patients experiencing withdrawal symptoms while taking methylnaltrexone should consider using an alternate form of therapy.
Revatio[®] (sildenafil citrate) <i>Formulary</i>	Approved for members with documentation of a diagnosis of Pulmonary Arterial Hypertension (PAH). Coverage is NOT provided for sildenafil (Revatio [®]) in situations where patients are receiving nitrate therapy.
Sancuso[®] (granisetron) <i>Nonformulary</i>	Coverage of Sancuso [®] will be provided for: <ol style="list-style-type: none"> 1. Indication for prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy AND 2. Documented treatment/failure with generic ondansetron (Zofran[®]) AND generic granisetron (Kytril[®]) AND 3. Not a candidate for IV granisetron therapy

MEDICATION/DRUG CLASS	CRITERIA
<p>Sandostatin® [g] (octreotide) Sandostatin LAR® <i>Formulary</i></p>	<p>Sandostatin® [g] Approval requires one of the following (1, 2 or 3):</p> <ol style="list-style-type: none"> 1. Clinically diagnosed acromegaly AND one of the following (a, b or c) <ol style="list-style-type: none"> a. Failure to respond to surgery or radiation OR b. Not a candidate for surgery or radiation OR c. Use to shrink tumor prior to surgery 2. Diagnosis of metastatic carcinoid tumor 3. Diagnosis of vasoactive intestinal peptide tumors (VIPomas) <p>Sandostatin LAR - Approval requires member to have previously tried, responded and tolerated immediate-release octreotide injection in addition to the diagnosis requirement listed under Sandostatin [g].</p>
<p>Savella® (milnacipran) <i>Nonformulary</i></p>	<p>Requires diagnosis of fibromyalgia characterized by pain in all 4 body quadrants for at least 3 months with or without fatigue and sleep disturbance AND the patient has tried and experienced intolerance to gabapentin OR had inadequate pain relief at doses of 1200 mg or above AND has tried and experienced intolerance or inadequate pain relief to three of the following: tricyclic antidepressant, SSRI, SNRI, cyclobenzaprine, tramadol.</p>
<p>Sedative/Hypnotics: <i>Nonformulary:</i> Edluar™ (zolpidem tartrate SL) Zolpimist® (zolpidem tartrate)</p>	<p>Edluar™ and Zolpimist® require trial and failure, or intolerance, to the formulary alternatives Ambien® (zolpidem) AND Sonata® (zaleplon) AND documentation of medical necessity.</p>
<p>Silenor® (doxepin) <i>Nonformulary</i></p>	<p>Requires trial and failure of the formulary alternatives Ambien [g] AND Sonata [g].</p>
<p>Somavert® (pegvisomant) <i>Formulary</i></p>	<p>For the treatment of acromegaly in patients who have had an inadequate response to surgery and/or radiation therapy and/or other medical therapies or for whom these therapies are not appropriate.</p>
<p>Suprenza™ (phentermine HCl) <i>Nonformulary</i></p>	<p>Coverage for Suprenza™ requires trial and failure of generic phentermine AND explanation of why Suprenza™ is expected to work if generic phentermine has not.</p>
<p>Tekturna® (aliskiren) <i>Nonformulary</i></p>	<p>Requires documentation that the member has tried standard effective doses and not reached therapeutic goals or could not tolerate therapy with ALL of the following drug classes:</p> <ol style="list-style-type: none"> 1. Diuretic 2. Beta-blocker 3. ACE-Inhibitor 4. Angiotension II Receptor Blocker (ARB)
<p>TNF-alpha agents and related products: <i>Formulary:</i> Enbrel® (etanercept) Humira® (adalimumab) <i>Nonformulary:</i> Cimzia® (certolizumab pegol) Kineret® (anakinra) Simponi® (golimumab) Orencia® SC (abatacept)</p>	<p>Enbrel® and Humira®:</p> <ul style="list-style-type: none"> • Rheumatoid arthritis, juvenile RA or psoriatic arthritis: Requires three-month trial with two concurrent DMARDs (one must be methotrexate unless contraindicated). Examples of DMARDs include: methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine. • Ankylosing spondylitis: requires therapy is being supervised by a Rheumatologist. • Moderate to severe psoriasis: Requires 3 months of previous treatment with topical corticosteroids AND 3 months treatment with PUVA (unless PUVA is contraindicated) AND therapy must be supervised by a Dermatologist. • Crohn's Disease: Coverage for patients age 18 years and older with a diagnosis of moderately to severely active Crohn's disease with a history of inadequate response to conventional therapy. Applies to Humira® only. <p>Orencia® SC: Coverage will be provided for adults with Rheumatoid Arthritis after a three-month trial with two concurrent DMARDs (one must be methotrexate unless contraindicated)</p>

MEDICATION/DRUG CLASS	CRITERIA
	<p>AND treatment failure or intolerance to Enbrel[®] and Humira[®].</p> <p>Cimzia[®]: The following criteria are used in reviewing medical exceptions for Cimzia[®]</p> <p>A. OR B.</p> <p>A. Age 18 or older and for the treatment of acute exacerbation of moderate to severe Crohn's disease when the following criteria are met (1 AND 2):</p> <ol style="list-style-type: none"> 1) Treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated or patient has been unable to taper or patient is experiencing breakthrough disease while stabilized on an immunomodulatory medication for at least 2 months. <p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 2) Previous trial/failure/contraindication of Humira[®]. <p>OR</p> <p>B. Age 18 or older and for the treatment of rheumatoid arthritis when the following criteria are met (1 AND 2)</p> <ol style="list-style-type: none"> 1) Treatment failure with a three month trial with two concurrent DMARDs (one must be methotrexate unless contraindicated) <p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 2) Treatment failure or documented intolerance to Adalimumab (Humira[®]) and Etanercept (Enbrel[®]) <p>Kineret[®]: <u>Rheumatoid arthritis in adults:</u> Requires three-month trial with two concurrent DMARDs (one must be methotrexate unless contraindicated) AND treatment failure or intolerance to Enbrel[®] and Humira[®]. Examples of DMARDs include: methotrexate, sulfasalazine, azothioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine.</p> <p>Simponi[®]: 18 years of age or older and A OR B</p> <p>A. <u>Rheumatoid arthritis and psoriatic arthritis:</u> Requires a 3-month trial on two concurrent Disease Modifying Anti-Rheumatic Drugs (DMARDs), one of which must be methotrexate unless contraindicated, AND treatment failure or contraindication to both Enbrel[®] AND Humira[®].</p> <p>OR</p> <p>B. <u>Ankylosing spondylitis:</u> Requires a treatment failure or contraindication to both Enbrel[®] AND Humira[®]</p>
Tradjenta[™] (linagliptin) <i>Nonformulary</i>	Approval for Tradjenta [™] requires trial and failure of Januvia [®] .
Treximet[®] (sumatriptan/naproxen sodium) <i>Nonformulary</i>	Requires prior use of Imitrex [®] [g] and Naprosyn [®] [g] in combination AND documentation indicating why use of the individual agents is harmful to the member AND documentation of trial and failure of formulary option Maxalt [®] .
TriLipix[®] (fenofibric acid) <i>Nonformulary</i>	Requires trial and failure of gemfibrozil [g] AND fenofibrate [g].

MEDICATION/DRUG CLASS	CRITERIA
<p><u>Triptans:</u></p> <p><i>Formulary:</i> Maxalt®/MLT (rizatriptan)</p> <p><i>Nonformulary:</i> Alsuma™ (sumatriptan) Axert® (almotriptan) Frova® (frovatriptan) Relpax® (eletriptan) Sumavel® DosePro® (sumatriptan injection) Zomig® (zolmitriptan)</p>	<p>Maxalt®/MLT requires trial and failure of the generic formulary alternative Imitrex® [g].</p> <p>Axert®, Frova®, Relpax® and Zomig® will require trial and failure of both the formulary options Imitrex® [g] AND Maxalt®.</p> <p>Alsuma™ and Sumavel® DosePro® will require trial and failure of both formulary options Imitrex [g] injection AND Maxalt MLT®.</p>
<p>Uloric® (februxostat) <i>Formulary</i></p>	<p>Requires treatment failure, intolerance or contraindication with formulary alternative generic allopurinol.</p>
<p>Victoza® (liraglutide) <i>Nonformulary</i></p>	<p>Approved as adjunctive therapy in combination with at least one of the following medications: metformin, sulfonylurea or a thiazolidinedione AND being used to improve glycemic control in patients who have a diagnosis of type II diabetes mellitus AND have tried at least 2 of the following: metformin, a sulfonylurea or a thiazolidinedione (unless contraindicated) AND the patient must have documentation of an A1c greater than 7%.</p> <p>Victoza® is NOT covered for the primary indication of weight loss in patients with or without diabetes.</p>
<p>Vimovo® (naproxen/ esomeprazole) <i>Nonformulary</i></p>	<p>Approval requires trial and failure of Prilosec [g] AND Protonix [g] AND Prevacid [g] AND one of the following criteria:</p> <p>Member is > 60 years of age or</p> <p>Receiving anticoagulant or antiplatelet therapy or</p> <p>Receiving chronic treatment with oral corticosteroids (>60 days duration) or</p> <p>Has a history of or current diagnosis of peptic ulcer disease, clinically significant gastrointestinal bleeding and/or alcoholism.</p>
<p>Voltaren Gel® (diclofenac) <i>Nonformulary</i></p>	<p>For FDA approved indications only. Member must have tried and failed or demonstrated intolerance to oral diclofenac AND at least two other oral, traditional NSAIDs unless the patient is unable to take any oral medications.</p> <p>AND</p> <p>Coverage will NOT be provided in the presence of concurrent therapy with oral NSAIDs or a COX II inhibitor.</p>
<p>Vyvanse® (lisdexamfetamine) <i>Nonformulary</i></p>	<p>Covered for members 6 years of age and older with the appropriate diagnosis who have experienced therapeutic failure or intolerance to BOTH an amphetamine-type product AND a methylphenidate product. Maximum dose approved per day will be 70 mg.</p>
<p>Xalkori® (crizotinib) <i>Formulary</i></p>	<p>Coverage for Xalkori® will be provided for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by a FDA approved test.</p>

MEDICATION/DRUG CLASS	CRITERIA
Xenazine® (tetrabenazine) <i>Formulary</i>	Approval will require diagnosis of chorea associated with Huntington's disease AND , for doses above 50 mg per day, documentation of the CYP2D6 genotype of the patient will be required. Tetrabenazine is considered investigational when used for all other conditions, including, but not limited to: <ol style="list-style-type: none"> A. Chorea not associated with Huntington's disease B. Tardive dyskinesia C. Dystonia, tics and other dyskinesias D. Hyperkinetic or involuntary movement disorders E. Tourette's syndrome F. Athetoid cerebral palsy
Xyrem® (sodium oxybate) <i>Nonformulary</i>	Requires a diagnosis of narcolepsy and A OR B: <ol style="list-style-type: none"> A. Cataplexy demonstrated by supporting chart documentation or sleep studies OR <ol style="list-style-type: none"> B. Excessive daytime sleepiness demonstrated by supporting chart documentation or sleep studies when (1 AND 2): <ol style="list-style-type: none"> 1. Modafinil in doses up to 400 mg daily has been ineffective, not tolerated or contraindicated. <p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 2. At least one other formulary/preferred treatment, such as methylphenidate or dextroamphetamine, has been ineffective, not tolerated or is contraindicated. Xyrem® will NOT be approved if: <ol style="list-style-type: none"> 1. Patient is being treated with sedative hypnotic agents, other CNS depressants or using alcohol 2. Patient has a history of drug abuse 3. Patient has succinic semialdehyde dehydrogenase deficiency Xyrem® is NOT considered medically necessary for the following condition(s): <ol style="list-style-type: none"> 1. Alcohol dependence and withdrawal 2. Fibromyalgia Xyrem® is considered investigational for all other conditions or applications, including, but not limited to, the treatment of: <ol style="list-style-type: none"> 1. Opioid dependence and withdrawal 2. Parkinsonism 3. Night eating syndrome 4. Myoclonus and essential tremor
Zelboraf® (vemurafenib) <i>Formulary</i>	Coverage for Zelboraf® will be provided for patients with unresectable or metastatic melanoma with BRAF ^{V600E} mutation as detected by an FDA-approved test.
Zuplenz® oral soluble film (ondansetron) <i>Nonformulary</i>	Requires documentation that the member has experienced treatment failure or intolerance to Zofran ODT [g] AND oral Kyrtril [g]. Documentation must be provided as to why continued use of Zofran ODT will harm the patient.

Generic substitution and formulary alternatives

Generic drug substitution

Generic drug substitution occurs when a generic equivalent is dispensed rather than the brand-name product. Products designated in the formulary with “(g)” after the name are available as generics approved by the U.S. Food and Drug Administration. BCN members are required to use generic substitution. For BCN members, if a brand-name drug is requested when a generic version is available, members will pay their Tier 2 copayment plus the difference in cost between the brand and generic versions. Prescribers may request authorization for the brand-name version, based on medical necessity. A completed MedWatch form is required.

BCBSM members are encouraged to receive the generic equivalent, if available, or they may be required to pay the difference in cost between the brand dispensed and the generic equivalent, in addition to the applicable copay.

The maximum allowable cost list sets ceiling prices for reimbursement of certain generic prescription drugs. The drugs on the MAC list are commonly prescribed and dispensed, and have undergone the FDA’s review and approval process, which ensures:

- Generic drugs contain the same active ingredients and are the same strengths and dosage forms as their brand-name counterparts.
- The FDA has given the generics an “A” rating and has determined they are the equivalent of their brand-name counterparts. Or the BCBSM and BCN Pharmacy and Therapeutics Committee has reviewed the products and found them to be acceptable generic substitutes.

When the above two criteria are met, generics can be substituted with the full expectation that they will produce the same clinical effects and have the same safety profiles as the prescribed brand-name products.

Possible brand alternatives

There are some medications that are identical in strength and formulation, that are produced by multiple manufacturers, but are marketed as brand-name products with different brand names. Some of these brand name products are included in the formulary, and others are not covered or are nonformulary. We encourage prescribers to select the formulary product to help patients save on their out-of-pocket costs.

Possible brand alternatives	
Nonformulary	Formulary alternative
Epogen [®]	Procrit [®]
Follistim [®]	Gonal-F [®]
Humatrope [®] , Norditropin [®] , Omnitrope [®] , Saizen [®] , Serostim [®] , Tev-Tropin [®] , Zorbitive [®]	Genotropin [®] , Nutropin [®]
Ritalin LA [®]	Metadate CD [®]

Possible therapeutic alternatives

The *BCBSM/BCN Formulary Alternatives — January 2012* list represents possible alternatives to nonformulary drugs. These alternative medications can generally be prescribed without approval from BCBSM or BCN, and can be dispensed with lesser copayments for members. Therapeutic alternatives may represent a different drug class, contain different ingredients or may be available in strengths or dosage forms that differ from the prescribed branded products. Pharmacists must obtain authorization from a patient’s physician to dispense an alternative product.

Listed below are examples of the therapeutic alternatives a patient’s physician should consider when determining appropriate treatment for the patient. The physician should consider individual drug product characteristics and patient factors such as coexisting disease states, contraindications, therapeutic history, concurrent medications and other relevant circumstances. This list is also available at bcbsm.com/provider/pharmacy_services/index.shtml.

BCBSM/BCN Formulary Alternatives - January 2012

NonFormulary	Formulary Alternative
ABSTRAL	Actiq(g)*, MSIR(g), MS Contin(g), Oramorph SR(g), Roxanol(g)
ACANYA	Individual Agents (BPO and Clindamycin)
ACIPHEX	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g), Zegerid(g)*
ACTOPLUS MET XR	Glucophage(g) plus Actos*; ActoPlus Met*
ACUVAIL	Acular, LS(g); Voltaren(g)
ACZONE	Topical OTC benzoyl peroxide, clindamycin, erythromycin
ADCIRCA	Revatio*
ADVICOR	Lipitor(g)*, Mevacor(g), Pravachol(g), Zocor(g), Crestor*; plus Niaspan
AGGRENOX	Persantine(g) plus ASA OTC, Plavix
AKNE-MYCIN	Erythromycin topical solution & gel(g)
ALAMAST	Alomide, Patanol, Zaditor OTC(g)
ALREX	Decadron ophth(g), Pred Forte(g), Pred Mild
ALTABAX	Triple Antibiotic OTC, Bactroban(g)
ALTACE TABLETS	Altace capsules(g)
ALTOPREV	Lipitor(g)*, Mevacor(g), Pravachol(g), Zocor(g), Crestor*, Zetia*
AMITIZA	OTC laxatives and stool softeners, Glycolax(g), Lactulose(g)
AMTURNIDE	Lotrel(g), Generic ACE Inhibitor (lisinopril, benazepril, etc.), Benicar*, or Cozaar(g) PLUS Norvasc(g) and HCTZ
ANADROL-50	Androgel, Androxy(g), Depo- testosterone(g), Androderm, Delatestryl
ANGELIQ	FemHRT, Prempro/Premphase, or Estradiol plus Progestin
ANTARA	Lofibra(g), Lopid(g), Tricor
ANZEMET	Kytril(g); Zofran(g), ODT(g)
APHTHASOL	Kenalog in Orabase(g)
APLENZIN	Generic SSRI/SNRI (Celexa(g), Prozac(g), Zoloft(g), Effexor(g), Effexor XR(g); Wellbutrin, SR, XL(g), etc.)
APRISO	Azulfidine(g), Azulfidine En-Tab(g), Asacol, HD; Pentasa

NonFormulary	Formulary Alternative
ARANESP	Procrit*
ARCAPTA NEOHALER	Foradil, Serevent, Spiriva
ARICEPT 23MG	Aricept(g)
ARMOUR THYROID	Synthroid(g)
ARTHROTEC	Lodine(g), Mobic(g), Motrin(g), Naprosyn(g), Voltaren(g), etc. plus Cytotec(g)
ATACAND, HCT	Cozaar(g), Hyzaar(g), Benicar*, HCT*
ATELVIA	Fosamax(g), Actonel*
AVALIDE, AVAPRO	Cozaar(g), Hyzaar(g), Benicar*, HCT*
AVANDAMET	ActoPlus Met*, Glucophage, Actos*
AVANDARYL	Duetact*, Actos*, Amaryl
AVANDIA	Glucophage(g); Insulin or a sulfonylurea (Glucotrol, XL(g); Micronase(g), Amaryl(g)), Actos*
AVC	Diflucan(g) oral, Terazol(g) vaginal
AVINZA	Duragesic(g), Methadone(g), MSIR(g), MS Contin(g), Oramorph SR(g)
AXERT	Amerge(g)*, Imitrex(g); Maxalt*, MLT*
AXIRON	Androgel, Androderm
AZASITE	Ciloxan(g), Ocuflax(g), Vigamox(g)
AZELEX	Retin-A(g)
AZOR	Generic ACE (lisinopril, benazepril, etc.), Benicar*, or Cozaar(g) PLUS Norvasc(g)
BECONASE AQ	Flonase(g), Nasalide(g), Nasarel(g), Nasacort AQ*(g)
BENZACLIN	Individual agents (BPO and clindamycin)
BEPREVE	Zaditor OTC(g), Patanol
BESIVANCE	Ciloxan(g), Ocuflax(g), Vigamox
BETASERON	Avonex, Copaxone, Rebif
BETIMOL	Betagan(g), Betoptic(g), Timoptic(g)
BEYAZ	Yasmin(g), Yaz(g) PLUS Folic Acid 1MG
BONIVA	Fosamax(g), Actonel*
BRILINTA	Effient, Plavix
BROMDAY	Acular(g), Xibrom(g), Voltaren(g), Ocufen(g)

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

Most BCN members and some BCBSM members do not have coverage for nonformulary agents. Please use this list as a guide when selecting alternatives.

<i>NonFormulary</i>	<i>Formulary Alternative</i>
BROVANA	Foradil, Serevent Diskus
BUTISOL SODIUM	Ambien(g), Prosom(g), Restoril(g), Sonata(g)
BUTRANS	Duragesic(g), Methadone(g), MS Contin(g), Oramorph(g)
BYETTA	Insulin, Glucophage(g), Sulfonylurea's, Actos*
BYSTOLIC	Blocadren(g), Lopressor(g), Tenormin(g), Toprol XL(g), etc.
CAMPRAL	Revia(g), Antabuse
CANTIL	Bentyl(g), Donnatal(g), Robinul(g)
CARAC	Efudex(g)
CARDENE SR	Cardene(g), Norvasc(g), Procardia XL(g)
CARDURA XL	Cardura(g), Flomax(g), Hytrin(g), Avodart, Uroxatral(g)
CARMOL HC	Hydrocortisone plus Aquaphor OTC, Hydrocortisone plus Eucerin OTC
CAYSTON	Tobi
CEDAX	Ceclor(g), Ceftin(g), Duricef(g), Keflex(g), Omnicef(g)
CELEBREX	Lodine(g), Mobic(g), Motrin(g), Naprosyn(g), Voltaren(g), etc.
CENESTIN	Estrace(g), Ogen(g), Enjuvia, Premarin
CESAMET	Kytril(g); Zofran(g), ODT(g)
CHENODAL	Actigall(g), Urso(g)
CIMZIA SYRINGE	Enbrel*, Humira*
CLARIFOAM EF	Plexion(g), Sulfacet-R(g)
CLARINEX (ALL)	Claritin OTC(g)**, Zyrtec OTC(g)**, Astelin(g), Xyzal(g)*
CLEOCIN VAGINAL OVULES	Cleocin Vaginal Cream(g)
CLIMARA PRO	Climara(g), Vivelle-DOT, or Estraderm plus a progestin
CLINDESSE	Cleocin vaginal cream(g)
CLOBEX, SPRAY	Diprolene(g), Psorcon(g), Temovate(g), Ultravate(g)
COGNEX	Razadyne, ER(g); Aricept, ODT(g); Namenda
COLESTID FLAVORED	Colestid(g), Questran(g), Questran Light(g)
COLY-MYCIN S	Cortisporin(g), Floxin(g) Otic, Cipro HC
COMBIPATCH	Climara(g), Vivelle-DOT, Estraderm plus Progestin

<i>NonFormulary</i>	<i>Formulary Alternative</i>
CONZIP	Ultram(g)
COREG CR	Coreg(g), Toprol XL(g)
CORTISPORIN-TC	Cortisporin(g), Floxin(g) Otic, Cipro Otic HC
CYMBALTA	Generic SSRI/SNRI (Celexa(g), Effexor(g), Effexor XR(g), Prozac(g), Zoloft(g), etc.)
DALIRESP	Foradil, Serevent, Spiriva
DAYTRANA	Adderall, XR(g)*; Ritalin, SR(g); Concerta(g), Metadate CD
DENAVIR	Zovirax 5% cream/ointment
DEPEN	Cuprimine
DESONATE	Elocon(g), Locoid(g), Synalar solution(g), Capex
DEXILANT	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g), Zegerid(g)*
DIFICID	Flagyl(g), Vancocin
DIOVAN, HCT	Cozaar(g), Hyzaar(g), Benicar*, HCT*
DIPENTUM	Azulfidine(g), Azulfidine En-Tab(g), Asacol, HD; Pentasa
DONNATAL EXTENTABS	Bentyl(g), Donnatal(g), Robinul(g)
DORAL	Ambien(g), Halcion(g), Prosom(g), Restoril(g), Sonata(g)
DUAC CS	Individual agents (Cleocin(g) topical and OTC BPO)
DUEXIS	Motrin(g), Pepsid(g)
DUREZOL	Decadron ophth(g); Inflamase, Forte(g); Pred Forte(g), etc.
DYNACIRC CR	Cardene(g), Dynacirc(g), Norvasc(g), Procardia XL(g)
EDARBI	Cozaar(g), Hyzaar(g), Benicar*, HCT*
EDEX	Caverject*, Cialis*, Muse*, Viagra*
EDLUAR	Ambien(g), Sonata(g)
EFUDEX OCCLUSION	Efudex(g)
ELESTAT	Zaditor OTC(g), Alomide, Patanol
ELESTRIN	Climara(g), Estrace(g), Ogen(g), Vivelle-DOT, Estraderm
ELIGARD	Lupron, Depot; Trelstar, Depot
ELLA	Plan B(g)
EMADINE	Zaditor OTC(g), Alomide, Patanol
EMBEDA	Methadone(g), MSIR(g), MS Contin(g), Oramorph SR(g)

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

Most BCN members and some BCBSM members do not have coverage for nonformulary agents. Please use this list as a guide when selecting alternatives.

<i>NonFormulary</i>	<i>Formulary Alternative</i>
EMSAM	Celexa(g), Effexor(g), Effexor XR(g), Paxil(g), Prozac(g), Wellbutrin, SR, XL(g); Lexapro*
ENABLEX	Ditropan(g), XL(g), Detrol, LA
EPIDUO	Individual agents: Differin(g) plus OTC BPO
EPOGEN	Procrit*
EQUETRO	Tegretol, XR(g)
ERTACZO	Lamisil AT(g) OTC; Lotrimin(g), Ultra OTC; Monistat-Derm(g), Nizoral cream(g), Spectazole(g)
ESTRACE VAGINAL CREAM	Premarin Vaginal Cream, Vagifem
ESTRASORB	Climara(g), Estrace(g), Ogen(g), Estraderm, Vivelle-DOT
ESTROGEL	Climara(g), Estrace(g), Ogen(g), Estraderm, Vivelle-DOT
EVAMIST	Climara(g), Estrace(g), Ogen(g), Estraderm, Vivelle-DOT
EVOXAC	Bethanechol(g), Salagen(g)
EXALGO	Duragesic(g), Methadone(g), MS Contin(g), Oramorph(g)
EXFORGE	Lotrel(g), Generic ACE Inhibitor (lisinopril, benazepril, etc.), Benicar*, or Cozaar(g) PLUS Norvasc(g)
EXFORGE HCT	Benicar HCT*, Hyzaar(g), Lotrel(g) plus HCTZ(g)
EXJADE	Desferal(g)
EXTAVIA	Avonex, Betaseron, Copaxone, Rebif
EXTINA	Nizoral(g)
FACTIVE	Erythromycin(g), Vibramycin(g), Zithromax(g), Avelox
FANAPT	Clozaril(g), Risperdal(g), Abilify, Geodon, Seroquel, Zyprexa(g)
FAZACLO	Clozaril(g), Risperdal(g), Abilify, Geodon, Seroquel, Zyprexa(g)
FEMCON FE	Loestrin Fe(g) [NOT 24], Estrostep Fe(g)
FEMRING	Estring
FEMTRACE	Estrace(g), Ogen(g), Enjuvia, Premarin
FENOGLIDE	Lofibra(g), Lopid(g), Tricor
FENTORA	Actiq(g)*, MSIR(g), MS Contin(g), Oramorph SR(g), Roxanol(g)
FEXMID	Flexeril(g)

<i>NonFormulary</i>	<i>Formulary Alternative</i>
FINACEA, PLUS	Metrogel topical(g), Metroloction(g), Retin-A(g)
FLECTOR PATCH	Topical OTC analgesic balms, i.e. trolamine salicylate; Voltaren oral(g)
FOCALIN XR	Adderall, XR(g)*, Focalin(g); Ritalin(g), SR(g); Concerta(g), Metadate CD
FOLLISTIM AQ	Gonal-F, Gonal RFF
FORTEO	Fosamax(g), Miacalcin Nasal Spray(g), Actonel*
FORTESTA	AndroGel, AndroDerm
FOSAMAX PLUS D	Fosamax(g) plus OTC Vitamin D
FOSRENOL	Tums OTC, Phoslo(g), Renagel, 2.4g
FRAGMIN	Lovenox(g)
FROVA	Amerge(g)*, Imitrex(g); Maxalt*, MLT*
GALZIN	OTC zinc supplements
GELNIQUE	Ditropan, XL(g); Detrol, LA
GILENYA	Avonex, Copaxone, Extavia, Rebif
GLUMETZA	Glucophage(g), Glucophage XR(g)
GLYSET	Precose(g)
GRALISE	Effexor(g), Effexor XR(g), Flexeril(g), Neurontin(g), SSRI's(g), TCA's(g), Ultram(g)
GYNAZOLE-1	Lotrimin OTC, Monistat OTC, Diflucan 150mg(g), Terazol(g)
HALFLYTELY	Colyte(g) plus bisacodyl OTC
HECTOROL	Rocaltrol(g)
HORIZANT	Mirapex, Neurontin(g)
HUMATROPE	Genotropin*; Nutropin*, AQ*
INNOPRAN XL	Inderal(g), Inderal LA(g), Inderide(g)
INTUNIV	Catapres(g), Tenex(g)
INVEGA	Clozaril(g), Risperdal(g), Abilify, Geodon, Seroquel, Zyprexa(g)
IOPIDINE	Alphagan(g), Alphagan P .15%(g), .1%
IQUIX	Ciloxan(g), Ocuflax(g), Vigamox
JANUMET (BCN ONLY)	Glucophage(g); Insulin or a Sulfonylurea (Glucotrol, XL(g); Micronase(g), Amaryl(g)), Actos*
JANUVIA (BCN ONLY)	Glucophage(g); Insulin or a Sulfonylurea (Glucotrol, XL(g); Micronase(g), Amaryl(g)), Actos*
KAOCHLOR-EFF	Potassium Chloride(g) liquid, capsules or tablets

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<i>NonFormulary</i>	<i>Formulary Alternative</i>
KAPVAY	Clonidine(g); Guanfacine(g), Strattera*
KEFLEX 750MG	Keflex(g)
KETEK	Erythromycin(g), Zithromax(g)
KINERET	Enbrel*, Humira*
LAMICTAL ODT, XR	Lamictal(g), Disper tabs(g), Tegretol(g)
LAMISIL GRANULES	Lamisil(g)
LASTACAFT	Patanol, Alomide
LATUDA	Risperdal(g), Clozaril(g), Abilify, Geodon, Seroquel, Zyprexa(g)
LAZANDA	Actiq(g)*, MSIR(g), MS Contin(g), Oramorph SR(g), Roxanol(g)
LESCOL, XL	Lipitor(g)*, Mevacor(g), Pravachol(g), Zocor(g), Crestor*, Zetia*
LEVATOL	Inderal(g), Inderal LA(g), Lopressor(g), Sectral(g), Tenormin(g), Toprol XL(g)
LEVITRA	Cialis*, Viagra*
LIALDA	Azulfidine(g); Asacol, HD; Pentasa
LIDODERM PATCH	Topical lidocaine, EMLA(g)
LIPOFEN	Lofibra(g), Lopid(g), Tricor
LIVALO	Lipitor(g)*, Mevacor(g), Pravachol(g), Zocor(g), Crestor*, Zetia*
LO LOESTRIN FE	Generic monophasic contraceptives
LOCROID LIPOCREAM	Aristocort(g), Elocon(g), Locoid(g), Synalar(g), Topicort(g)
LOESTRIN 24 FE	Loestrin(g), Loestrin Fe(g)
LORZONE	Parafon Forte(g)
LOTEMAX	Decadron ophth(g), Pred Forte(g), Pred Mild
LOTRONEX	OTC Anti-diarrheals; Levbid(g); Levsin, SL(g); Levsinex(g); Lomotil(g)
LOVAZA	OTC Omega products, Lofibra(g), Lopid(g), Tricor
LUNESTA	Ambien(g), Halcion(g), Prosom(g), Restoril(g), Sonata(g)
LUVERIS	Repronex
LUVOX CR	Luvox(g) immediate release
LUXIQ	Aristocort(g), Elocon(g), Locoid(g), Synalar(g), Topicort(g), Valisone(g)
LYRICA	Effexor(g), Effexor XR(g), Flexeril(g), Neurontin(g), SSRI's(g), TCA's(g), Ultram(g)

<i>NonFormulary</i>	<i>Formulary Alternative</i>
MAGNACET	Percocet(g), Tylox(g)
MARPLAN	Parnate(g), Nardil
MAXIDEX	Decadron ophth(g)
MEGACE ES	Megace(g)
MENEST	Estradiol (various), Ogen(g)
MENOPUR	Repronex
MENOSTAR	Climara(g), Estrace(g), Ogen(g), Vivelle-DOT, Estraderm
MENTAX	Lamisil AT(g), OTC; Lotrimin(g), Ultra OTC; Monistat-Derm(g), Nizoral cream(g), Spectazole(g)
METHITEST	Androgel, Androxy(g), Depo-Testosterone(g), Oxandrin(g), Androderm, Delatestryl
METHYLIN CHEW	Adderall XR(g)*, Metadate CD (Both of which may be "sprinkled" on food), Methylin Solution(g)
METZOZOLV ODT	Reglan(g)
MICARDIS, HCT	Cozaar(g), Hyzaar(g), Benicar*, HCT*
MIRAPEX ER	Mirapex(g)
MONUROL	Bactrim(g), DS(g); Macrobid(g), Cipro(g), Levaquin(g)
MOVIPREP	Colyte(g), Nulytely(g)
MOXATAG	Amoxil capsules(g)
MYFORTIC	Cellcept(g)
MYTELASE	Mestinon(g), Prostigmin
NAFTIN	Lotrimin(g), Monistat(g), Nystatin(g)
NAPRELAN	Mobic(g); Motrin(g); Naprosyn, EC(g); etc*
NASCOBAL SPRAY	Cyanocobalamin tabs OTC, Cyanocobalamin injection
NASONEX	Flonase(g), Nasalide(g), Nasarel(g), Nasacort AQ*(g)
NATAZIA	Yasmin(g), Yaz(g)
NEULASTA	Neupogen
NEVANAC	Ocufen(g), Voltaren ophth(g)
NEXICLON XR	Catapres-TTS(g), Catapres(g)
NEXIUM	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g)
NICOTROL, NS	Nicotine gum(g), lozenge(g), patch(g)
NORDITROPIN, NORDIFLEX	Genotropin*; Nutropin*, AQ*
NORITATE	MetroCream(g)

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

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<i>NonFormulary</i>	<i>Formulary Alternative</i>
NOROXIN	Bactrim DS/Septra DS(g); Cipro(g), XR(g)*, Levaquin(g)
NUCYNTA, ER	Methadone, Ultram(g); MSIR(g), oxycodone IR(g)
NUVARING	Oral contraceptives, Ortho Evra
NUVIGIL	Provigil*
OLEPTRO	Desyrel(g)
OLUX-E	Diprolene(g), Psorcon(g), Temovate(g), Ultravate(g)
OMNARIS	Flonase(g), Nasalide(g), Nasarel(g), Nasacort AQ*(g)
OMNITROPE	Genotropin*, Nutropin*, AQ*
ONGLYZA	Glucophage(g); Insulin or a Sulfonylurea (Glucotrol, XL(g); Micronase(g), Amaryl(g)), Actos*
ONSOLIS	Actiq(g)*, MSIR(g), MS Contin(g), Oramorph SR(g), Roxanol(g)
OPANA ER	Duragesic(g), Methadone(g), Morphine(g), MS Contin(g), Oramorph SR(g)
ORACEA	Monodox(g), Vibramycin(g)
ORAPRED ODT	Orapred(g)
ORAXYL	Vibramycin(g)
ORENCIA SC	Humira*, Enbrel*, Methotrexate(g)
ORTHO-PREFEST	Use FemHRT, Prempro/Premphase, or Estradiol plus progestin
OSMOPREP	Colyte(g), Nulytely(g)
OVCON-50, FE	Modicon(g), Ortho-Cyclen(g), Ortho-Novum(g), Ovcon-35(g)
OXECTA	Duragesic(g), Methadone(g), MS Contin(g), Oramorph(g)
OXISTAT	Lamisil AT(g), OTC; Lotrimin(g), Ultra OTC; Monistat-Derm(g), Nizoral cream(g), Spectazole(g)
OXYCONTIN	Duragesic(g), Methadone(g), MS Contin(g), Oramorph(g)
OXYTROL	Ditropan, XL(g); Detrol, LA
PANCRECARB MS - 16	Pancrease MT - 16(g), Viokase
PANCRECARB MS - 4	Pancrease MT - 4(g), Pancrelipase EC
PANDEL	Aristocort(g), Elocon(g), Locoid(g), Synalar(g), Topicort(g), Cloderm, Cordran
PAREMYD	Atropine(g), Cyclogyl(g), Mydraciy(g)

<i>NonFormulary</i>	<i>Formulary Alternative</i>
PATADAY	Zaditor OTC(g), Alocril, Alomide, Patanol
PATANASE	Flonase(g), Nasalide(g), Nasarel(g), Astelin(g), Nasacort AQ*(g)
PCE	Biaxin(g), Erythromycin(g), Zithromax(g)
PENNSAID	Topical OTC analgesic balms, i.e. trolamine salicylate; Voltaren oral(g)
PERANEX HC	Anusol HC(g), Proctocream HC(g)
PERFOROMIST	Serevent Diskus, Foradil MDI
PEXEVA	Generic SSRI/SNRI (Celexa(g), Prozac(g), Paxil(g), Zoloft(g), etc.)
PHOSLYRA	Phoslo(g), Renvela, 2.4g
PLAN B ONE-STEP	Plan B(g)
POTIGA	Valium(g), Diastat(g), Dilantin(g)
PRANDIMET	Individual agents: Prandin and Glucophage(g)
PRED-G	Garamycin(g), Pred Forte(g)
PRILOSEC SUSPENSION	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g)
PRISTIQ	Generic SSRI/SNRI (Celexa(g), Prozac(g), Zoloft(g), Effexor(g), Effexor XR(g), etc.)
PROTONIX SUSP	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g)
PROTOPIC	Topical corticosteroids, Elidel*
PROVENTIL HFA	Proair HFA, Ventolin HFA
PYLERA	Use Tetracycline(g) plus Flagyl(g) plus Bismuth; or Helidac or PREVPAC
QUALAQUIN	Aralen(g), Lariam(g), Plaquenil(g), Malarone(g)
QUIXIN	Ciloxan(g), Vigamox
RANEXA	Long-acting nitrate, plus a beta-blocker or calcium channel blocker
RANICLOR	Ceclor(g), Ceftin(g), Duricef(g), Keflex(g), Omnicef(g)
RAPAFLO	Cardura(g), Flomax(g), Hytrin(g), Avodart, Uroxatral(g), Jalyn
REGRANEX	Ethezyme(g), Granulex(g)
RELPAK	Amerge(g)*, Imitrex(g); Maxalt*, MLT*
REQUIP XL	Requip(g)
REVLIMID	Thalomid
RHINOCORT AQUA	Flonase(g), Nasalide(g), Nasarel(g), Nasacort AQ*(g)

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

Most BCN members and some BCBSM members do not have coverage for nonformulary agents. Please use this list as a guide when selecting alternatives.

<i>NonFormulary</i>	<i>Formulary Alternative</i>
RIOMET	Glucophage(g)
RITALIN LA	Adderall, XR(g)*; Ritalin(g), Concerta(g), Metadate CD
ROZEREM	Ambien(g), Halcion(g), Prosom(g), Restoril(g), Sonata(g)
RYBIX ODT	Ultram(g)
RYZOLT	Ultram(g)
SAFYRAL	Generic tri-cyclic birth control plus an OTC vitamin
SAIZEN	Genotropin*; Nutropin*, AQ*
SANCTURA XR	Ditropan, XL(g); Sanctura(g); Detrol, LA
SANCUSO PATCH	Kytril(g); Zofran, ODT(g)
SAPHRIS	Clozaril(g), Risperdal(g), Abilify, Geodon, Seroquel, Zyprexa(g)
SARAFEM TABLET	Fluoxetine capsule(g)
SAVELLA	Effexor(g), Effexor XR(g), Flexeril(g), Neurontin(g), SSRI(g), TCA's(g), Ultram(g)
SEMPREX D	Claritin OTC(g)**, Zyrtec OTC(g)**, Astelin(g)
SEROQUEL XR	Clozaril(g), Risperdal(g), Abilify, Geodon, Zyprexa(g), Seroquel(IR)
SEROSTIM	Genotropin*, Nutropin*, AQ*
SERZONE(g)	Generic SSRI/SNRI (Celexa(g), Prozac(g), Paxil(g), Zoloft(g), etc.)
SILENOR	Ambien(g), Desyrel(g), Doxepin, Sonata(g)
SIMCOR	Individual agents (Zocor(g) PLUS Niaspan)
SIMPONI	Enbrel*, Humira*
SOLARAZE	Efudex(g)
SOLTAMOX	Tamoxifen
SOMA 250	Soma(g)
STAXYN	Cialis*, Viagra*
STRATTERA	Adderall, XR(g)*; Focalin(g), Ritalin(g), Concerta(g), Metadate CD
STRIANT	Androgel, Androxy(g), Depo-testosterone(g), Oxandrin(g), Androderm, Delatestryl
SUMAVEL DOSEPRO	Amerge(g)*, Imitrex(g); Maxalt*, MLT*
SUPRAX	Ceclor(g), Ceftin(g), Duricef(g), Keflex(g), Omnicef(g)
SUPRENZA	Alli OTC, Bontril(g)*, Didrex(g)*, Phentermine(g)*, Tenuate(g)*
SUPREP	Colyte(g), Nulytely(g)

<i>NonFormulary</i>	<i>Formulary Alternative</i>
SYMBYAX	Use Zyprexa(g) plus Prozac(g)
SYMLIN	Insulin
TACLONEX, SCALP	Use Dovonex(g) plus Diprosone/Diprolene(g)
TASMAR	Comtan
TEKAMLO	Lotrel(g), Generic ACE Inhibitor (lisinopril, benazepril, etc.), Benicar*, or Cozaar(g) PLUS Norvasc(g)
TEKTURNA, HCT	Generic ACE Inhibitors (benazapril, enalapril, lisinopril, etc.), Benicar*, HCT*; Cozaar(g), Hyzaar(g)
TESTIM	Androgel, Androderm
TESTRED, ANDROID	Androgel, Androxy(g), Depo-testosterone(g), Oxandrin(g), Androderm, Delatestryl
TEVETEN, HCT	Cozaar(g), Hyzaar(g), Benicar*, HCT*
TEV-TROPIN	Genotropin*; Nutropin*, AQ*
TIROSINT	Synthroid(g)
TOVIAZ	Ditropan, XL(g); Detrol, LA
TRADJENTA	Glucophage(g); Insulin or a Sulfonylurea (Glucotrol, XL(g); Micronase(g), Amaryl(g)), Actos*
TRANXENE SD	Ativan(g), Buspar(g), Serax(g), Tranxene(g), Valium(g), Xanax(g)
TREXIMET	Individual agents (Imitrex(g) PLUS naproxen); Amerge(g)*; Maxalt, MLT*
TRIBENZOR	Cozaar(g), HCTZ(g), Hyzaar(g), PLUS Norvasc(g)
TRIGLIDE	Lofibra(g), Lopid(g), Tricor
TRILIPIX	Lofibra(g), Lopid(g), Tricor
TWYNSTA	Lotrel(g), Generic ACE Inhibitor (lisinopril, benazepril, etc.), Benicar*, or Cozaar(g) PLUS Norvasc(g)
TYZEKA	Baraclude, Epivir HBV, Hepsera
VALTURNA	Generic ACE Inhibitors (benazapril, enalapril, lisinopril, etc.), Benicar*, Cozaar(g)
VANOS 0.1% CR	Diprolene(g), Psorcon(g), Temovate(g), Ultravate(g)
VECTICAL	Dovonex(g)
VERAMYST	Flonase(g), Nasalide(g), Nasarel(g), Nasacort AQ*(g)
VERDESO	Elocon(g), Locoid(g), Synalar solution(g), Capex
VEREGEN	Condylox Solution(g), Gel

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

Most BCN members and some BCBSM members do not have coverage for nonformulary agents. Please use this list as a guide when selecting alternatives.

<i>NonFormulary</i>	<i>Formulary Alternative</i>
VESICARE	Ditropan, XL(g); Detrol, LA
VICTOZA	Insulin, Glucophage(g), Sulfonylurea's, Actos*
VIIBRYD	Generic SSRI/SNRI (Celexa(g), Prozac(g), Zoloft(g), Effexor(g), Effexor XR(g); Wellbutrin, SR, XL(g), etc.)
VIRAMUNE XR	Viramune
VISICOL	Colyte(g), Nulytely(g)
VOLTAREN GEL	Topical OTC analgesic balms, i.e. trolamine salicylate; Voltaren oral(g)
VUSION	OTC diaper rash products
VYTORIN	Lipitor(g)*, Mevacor(g), Pravachol(g), Zocor(g), Crestor*; plus Zetia*
VYVANSE	Adderall, XR(g)*; Ritalin, SR(g); Concerta(g), Metadate CD
XENICAL	Alli OTC, Bontril(g)*, Didrex(g)*, Phentermine(g)*, Tenuate(g)*
XERESE	Zovirax cream PLUS HC cream
XIBROM	Ocufen(g), Voltaren (ophthalmic)(g)
XIFAXAN 220MG	Bactrim DS(g), Vibramycin(g)
XIFAXAN 550MG	Lactulose
XOLEGEL	Nizoral(g)
XOPENEX, HFA	Albuterol(g); Maxair; Proair HFA, Ventolin HFA
XYREM	Ambien(g), Halcion(g), Prosom(g), Restoril(g)
ZANAFLEX(g)	Baclofen, Flexeril(g)
ZANTAC EFFERDOSE	Zantac(g) (RX only); Pepcid(g)
ZAVESCA	Ceredase, Cerezyme (medical benefit)
ZEGERID PACKET	Prilosec(g)/Prilosec OTC**; Prevacid(g)*, Solutab(g)*; Protonix(g), Zegerid(g)*
ZELAPAR	Eldepryl(g)
ZEMPLAR	Rocaltrol(g)
ZIANA GEL	Individual agents: Cleocin topical(g) and Retin-A(g)*
ZIPSOR	Mobic(g), Motrin(g), Naprosyn, EC(g); Voltaren(g), etc*
ZMAX	Zithromax(g)
ZOLPIMIST	Ambien(g), Sonata(g)
ZOMIG	Amerge(g)*, Imitrex(g); Maxalt*, MLT*
ZORBTIVE	Genotropin*; Nutropin*, AQ*

<i>NonFormulary</i>	<i>Formulary Alternative</i>
ZUPLENZ	Kytril(g); Zofran, ODT(g)
ZYCLARA	Aldara(g)
ZYDONE	Lortab(g), Tylenol with Codeine(g), Vicodin(g)
ZYFLO CR	Accolate(g), Inhaled Steroids, Singulair
ZYLET	Maxitrol(g), Tobradex(g), Vasocidin(g)
ZYMAR	Ciloxan(g), Vigamox
ZYMAXID	Ciloxan(g), Ocuflax(g)

* Prior Authorization or Step Therapy may be required.

** Covered with a prescription for BCN members and certain BCBSM members.

Most BCN members and some BCBSM members do not have coverage for nonformulary agents. Please use this list as a guide when selecting alternatives.

Dose optimization and quantity limits

The Blue Cross Blue Shield of Michigan and Blue Care Network dose optimization programs encourage appropriate prescribing of medications intended for once-daily administration. Quantities of these medications are limited to single daily doses of appropriate strengths. Michigan Blues pharmacists work closely with physicians and community pharmacists to achieve this goal, which promotes patient compliance and more cost-effective therapy. Examples of some drugs include certain cholesterol-lowering, diabetes, antidepressant and anti-hypertensive medications.

Quantity limits also apply to both BCBSM and BCN for other medications, based on manufacturer recommendations, available package size and other criteria. These drugs are identified with a quantity limit (#) indicator. A complete list of medications subject to quantity limits is available at:

bcbsm.com/provider/pharmacy_services/index.shtml.

Copayments

A member's benefit plan design determines applicable copayments for covered prescriptions.

Symbols used throughout the document

- (g) Generic equivalent covered. Brand not covered or requires higher copay.
- (#) Quantity limits may apply
- [PA] Prior authorization required for some members
- [ST] Step therapy required prior to use for some members
- <s> Specialty drug
- BE Drugs offered a Tier 0 copayment for BCN Blue EssentialsSM Rx benefit

Editor's note:

Please send us your comments and suggestions regarding the *BCBSM and BCN Custom Formulary*. Your input is vital to its continued success. We review and consider all responses. Please send your comments to:

Drug Information Services — Mail Code 512C
Blue Cross Blue Shield of Michigan
600 E. Lafayette Boulevard
Detroit, MI 48226-2998

or

Pharmacy Services — Mail Code C303
Blue Care Network of Michigan
20500 Civic Center Drive
Southfield, MI 48076-5043

1. ANTI-INFECTIVES

1A. Penicillins

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AMOXIL (g)	AMOXICILLIN TRIHYDRATE	
AMPICILLIN (g)	AMPICILLIN TRIHYDRATE	
AUGMENTIN, ES, XR (g)	AMOX TR/POTASSIUM CLAVULANATE	
DICLOXACILLIN (g)	DICLOXACILLIN SODIUM	
PENICILLIN VK (g)	PENICILLIN V POTASSIUM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
MOXATAG	AMOXICILLIN TRIHYDRATE	

1B. Cephalosporins

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CECLOR (g)	CEFACLOR	
CECLOR ER (g)	CEFACLOR	
CEFTIN (g)	CEFUROXIME AXETIL	
CEFZIL (g)	CEFPROZIL	
DURICEF (g)	CEFADROXIL HYDRATE	
KEFLEX (g)	CEPHALEXIN MONOHYDRATE	
OMNICEF (g)	CEFDINIR	
SPECTRACEF (g)	CEFDITOREN PIVOXIL	[QL]
VANTIN (g)	CEFPODOXIME PROXETIL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
CEDAX	CEFTIBUTEN DIHYDRATE	
KEFLEX 750MG	CEPHALEXIN MONOHYDRATE	
RANICLOR	CEFACLOR	
SUPRAX	CEFIXIME	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

1C. Tetracyclines

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ADOXA (g)	DOXYCYCLINE MONOHYDRATE	[PA]
DORYX (g)	DOXYCYCLINE HYCLATE	[PA] [QL]
MINOCIN, DYNACIN (g)	MINOCYCLINE HCL	
MONODOX (g)	DOXYCYCLINE MONOHYDRATE	[PA] [QL]
PERIOSTAT (g)	DOXYCYCLINE HYCLATE	
SOLODYN 45, 90, 135MG (g)	MINOCYCLINE HCL	[PA]
TETRACYCLINE (g)	TETRACYCLINE HCL	
VIBRAMYCIN, VIBRATABS (g)	DOXYCYCLINE HYCLATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
DORYX 150MG	DOXYCYCLINE HYCLATE	[PA]
ORACEA	DOXYCYCLINE MONOHYDRATE	[PA]
ORAXYL	DOXYCYCLINE HYCLATE	
SOLODYN 55, 65, 80, 105, 115MG	MINOCYCLINE HCL	[PA]

1D. Macrolides

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BIAXIN, XL (g)	CLARITHROMYCIN	
ERYTHROMYCIN (g)	ERYTHROMYCIN ETHYLSUCCINATE	
ERYTHROMYCIN STEARATE (g)	ERYTHROMYCIN STEARATE	
PEDIAZOLE (g)	ERY E-SUCC/SULFISOXAZOLE	
ZITHROMAX (g)	AZITHROMYCIN	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
DIFICID	FIDAXOMICIN	[QL]
KETEK	TELITHROMYCIN	
PCE	ERYTHROMYCIN BASE	
ZMAX	AZITHROMYCIN	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

1E. Quinolones

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CIPRO (g)	CIPROFLOXACIN HCL	
CIPRO XR (g)	CIPROFLOXACIN HCL-BETAINE COMB	[PA] [QL]
FLOXIN (g)	OFLOXACIN	
LEVAQUIN (g)	LEVOFLOXACIN	
Formulary Options		
Trade Name	Generic Name	Utilization Management
AVELOX, ABC	MOXIFLOXACIN HCL	
Nonformulary		
Trade Name	Generic Name	Utilization Management
FACTIVE	GEMIFLOXACIN MESYLATE	
NOROXIN	NORFLOXACIN	

1F. Sulfonamides and Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BACTRIM, DS, SEPTA, DS (g)	SULFAMETHOXAZOLE/TRIMETHOPRIM	
PEDIAZOLE (g)	ERY E-SUCC/SULFISOXAZOLE	
SULFADIAZINE (g)	SULFADIAZINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

1G. Urinary Tract Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
HIPREX/UREX (g)	METHENAMINE HIPPURATE	
MACROBID (g)	NITROFURANTOIN	
MACRODANTIN (g)	NITROFURANTOIN MACROCRYSTAL	
MANDELAMINE (g)	METHENAMINE MANDELATE	
PYRIDIUM (g)	PHENAZOPYRIDINE HCL	
TRIMETHOPRIM (g)	TRIMETHOPRIM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
MONUROL	FOSFOMYCIN TROMETHAMINE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

1H. Antifungals

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ANCOBON (g)	FLUCYTOSINE	
DIFLUCAN (g)	FLUCONAZOLE	
GRIFULVIN V SUSP (g)	GRISEOFULVIN,MICROSIZE	
LAMISIL TABLETS (g)	TERBINAFINE HCL	
MYCELEX TROCHE (g)	CLOTRIMAZOLE	
NIZORAL (g)	KETOCONAZOLE	
NYSTATIN (g)	NYSTATIN	
SPORANOX CAPS (g)	ITRACONAZOLE	
VFEND (g)	VORICONAZOLE	

Formulary Options

Trade Name	Generic Name	Utilization Management
GRIFULVIN V 500MG	GRISEOFULVIN,MICROSIZE	
GRIS PEG	GRISEOFULVIN ULTRAMICROSIZE	
NOXAFIL	POSACONAZOLE	
SPORANOX SOLN	ITRACONAZOLE	
VFEND SUSP	VORICONAZOLE	

Nonformulary

Trade Name	Generic Name	Utilization Management
LAMISIL GRANULES	TERBINAFINE HCL	[PA]
ORAVIG	MICONAZOLE	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

11. Antivirals

Formulary Preferred

Trade Name	Generic Name	Utilization Management
COPEGUS (g)	RIBAVIRIN	[PA] <s>
CYTOVENE (g)	GANCICLOVIR	
FAMVIR (g)	FAMCICLOVIR	[QL]
FLUMADINE (g)	RIMANTADINE HCL	
REBETOL (g)	RIBAVIRIN	[PA] <s>
RIBAPAK	RIBAVIRIN	<s>
RIBASPHERE	RIBAVIRIN	<s>
RIBATAB (g)	RIBAVIRIN	<s>
SYMMETREL (g)	AMANTADINE HCL	
VALTREX (g)	VALACYCLOVIR HCL	[QL]
ZOVIRAX (g)	ACYCLOVIR	

Formulary Options

Trade Name	Generic Name	Utilization Management
BARACLUDE	ENTECAVIR	<s>
EPIVIR HBV	LAMIVUDINE	
HEPSERA	ADEFOVIR DIPIVOXIL	<s>
INCIVEK	TELAPREVIR	[PA] [QL] <s>
REBETOL SOLUTION	RIBAVIRIN	[PA] <s>
RELENZA	ZANAMIVIR	[QL]
TAMIFLU CAP, SUSP	OSELTAMIVIR PHOSPHATE	[QL]
VALCYTE	VALGANCICLOVIR HYDROCHLORIDE	
VICTRELIS	BOCEPREVIR	[PA] [ST] [QL] <s>

Nonformulary

Trade Name	Generic Name	Utilization Management
TYZEKA	TELBIVUDINE	<s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

1J. Antiretrovirals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
EPIVIR (g)	LAMIVUDINE	
RETROVIR (g)	ZIDOVUDINE	
VIDEX EC (g)	DIDANOSINE	
ZERIT (g)	STAVUDINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
APTIVUS(MUST BE USED WITH NORVIR)	TIPRANAVIR	
ATRIPLA	EFAVIRENZ/EMTRICITAB/TENOFOVIR	
COMBIVIR	LAMIVUDINE/ZIDOVUDINE	
COMPLERA	EMTRICITAB/RILPIVIRINE/TENOFOV	[QL]
CRIXIVAN	INDINAVIR SULFATE	
EDURANT	RILPIVIRINE HYDROCHLORIDE	[QL]
EMTRIVA	EMTRICITABINE	
EPZICOM	ABACAVIR SULFATE/LAMIVUDINE	
FUZEON	ENFUVRTIDE	<s>
INTELENCE	ETRAVIRINE	
INVIRASE	SAQUINAVIR MESYLATE	
ISENTRESS	RALTEGRAVIR POTASSIUM	
KALETRA	RITONAVIR/LOPINAVIR	
LEXIVA	FOSAMPRENAVIR CALCIUM	
NORVIR	RITONAVIR	
PREZISTA(MUST BE USED WITH NORVIR)	DARUNAVIR ETHANOLATE	
RESCRIPTOR	DELAVIRDINE MESYLATE	
REYATAZ	ATAZANAVIR SULFATE	
SELZENTRY	MARAVIROC	
SUSTIVA	EFAVIRENZ	
TRIZIVIR	ABACAVIR/LAMIVUDINE/ZIDOVUDINE	
TRUVADA	EMTRICITABINE/TENOFOVIR	
VIDEX	DIDANOSINE	
VIRACEPT	NELFINAVIR MESYLATE	
VIRAMUNE	NEVIRAPINE	
VIREAD	TENOFOVIR DISOPROXIL FUMARATE	
ZIAGEN	ABACAVIR SULFATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
VIRAMUNE XR	NEVIRAPINE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

1K. Antimalarials

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ARALEN (g)	CHLOROQUINE PHOSPHATE	
LARIAM (g)	MEFLOQUINE HCL	
MALARONE (g)	ATOVAQUONE/PROGUANIL HCL	
PLAQUENIL (g)	HYDROXYCHLOROQUINE SULFATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
COARTEM	ARTEMETHER/LUMEFANTRINE	[QL]
DARAPRIM	PYRIMETHAMINE	
PRIMAQUINE	PRIMAQUINE PHOSPHATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
QUALAQUIN	QUININE SULFATE	

1L. Antituberculars

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ETHAMBUTOL (g)	ETHAMBUTOL HCL	
ISONIAZID (g)	ISONIAZID	
PYRAZINAMIDE (g)	PYRAZINAMIDE	
RIFADIN (g)	RIFAMPIN	
RIFAMATE (g)	RIFAMPIN/ISONIAZID	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DAPSONE	DAPSONE	
MYCOBUTIN	RIFABUTIN	
SEROMYCIN	CYCLOSERINE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
PRIFTIN	RIFAPENTINE	
RIFATER	RIFAMPIN/INH/PYRAZINAMIDE	
TRECTOR	ETHIONAMIDE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

1M. Antiparasitics/Anthelmintics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
FLAGYL (g)	METRONIDAZOLE	
HUMATIN (g)	PAROMOMYCIN SULFATE	
VERMOX (g)	MEBENDAZOLE	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALINIA	NITAZOXANIDE	
BILTRICIDE	PRAZIQUANTEL	
FLAGYL ER	METRONIDAZOLE	
MEPRON	ATOVAQUONE	
NEBUPENT AEROSOL	PENTAMIDINE ISETHIONATE	
STROMEKTROL - SINGLE DOSE	IVERMECTIN	[QL]
TINDAMAX	TINIDAZOLE	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
ALBENZA	ALBENDAZOLE	

1N. Miscellaneous Anti-infectives

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLEOCIN (g)	CLINDAMYCIN HCL	
NEOMYCIN (g)	NEOMYCIN SULFATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
TOBI	TOBRAMYCIN/0.25 NORMAL SALINE	[QL] <s>
VANCOGIN HCL	VANCOMYCIN HCL	
ZYVOX	LINEZOLID	
Nonformulary		
Trade Name	Generic Name	Utilization Management
CAYSTON	AZTREONAM LYSINE	[PA] [QL] <s>
XIFAXAN 200MG	RIFAXIMIN	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2. CARDIOVASCULAR, HYPERTENSION, CHOLESTEROL

2A. Lipid-lowering Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CADUET (g)	AMLODIPINE/ATORVAST CAL	[PA] [QL]
COLESTID (g)	COLESTIPOL HCL	
FIBRICOR (g)	FENOFIBRIC ACID	
LIPITOR (g)	ATORVASTATIN CALCIUM	[ST] [QL]
LOFIBRA (g)	FENOFIBRATE,MICRONIZED	BE
LOPID (g)	GEMFIBROZIL	BE
MEVACOR (g)	LOVASTATIN	[QL] BE
PRAVACHOL (g)	PRAVASTATIN SODIUM	[QL] BE
QUESTRAN, QUESTRAN LIGHT (g)	CHOLESTYRAMINE	
ZOCOR (g)	SIMVASTATIN	[QL] BE
ZOCOR 80mg (g)	SIMVASTATIN	[PA] [QL] BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
CRESTOR	ROSUVASTATIN CALCIUM	[ST] [QL]
NIASPAN	NIACIN	BE
TRICOR	FENOFIBRATE NANOCRYSTALLIZED	[QL]
WELCHOL	COLESEVELAM HCL	
ZETIA	EZETIMIBE	[ST] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
ADVICOR	NIACIN/LOVASTATIN	[PA] [QL]
ALTOPREV	LOVASTATIN	[PA] [QL]
ANTARA	FENOFIBRATE,MICRONIZED	
COLESTID FLAVORED	COLESTIPOL HCL	
FENOGLIDE	FENOFIBRATE	
LESCOL, XL	FLUVASTATIN SODIUM	[PA] [QL]
LIPOFEN	FENOFIBRATE	[QL]
LIVALO	PITAVASTATIN CALCIUM	[ST] [QL]
LOVAZA	OMEGA-3 ACID ETHYL ESTERS	
SIMCOR	NIACIN/SIMVASTATIN	[ST]
TRIGLIDE	FENOFIBRATE NANOCRYSTALLIZED	
TRILIPIX	FENOFIBRIC ACID	[PA] [QL]
VYTORIN	EZETIMIBE/SIMVASTATIN	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2B. Beta Blockers and Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BETAPACE, AF (g)	SOTALOL HCL	BE
BLOCADREN (g)	TIMOLOL MALEATE	BE
COREG (g)	CARVEDILOL	BE
CORGARD (g)	NADOLOL	BE
CORZIDE (g)	NADOLOL/BENDROFLUMETHIAZIDE	BE
INDERAL (g)	PROPRANOLOL HCL	BE
INDERAL LA (g)	PROPRANOLOL HCL	[QL] BE
INDERIDE (g)	PROPRANOLOL/HYDROCHLOROTHIAZIDE	BE
KERLONE (g)	BETAXOLOL HCL	BE
LOPRESSOR (g)	METOPROLOL TARTRATE	BE
LOPRESSOR HCT (g)	METOPROLOL/HYDROCHLOROTHIAZIDE	BE
NORMODYNE (g)	LABETALOL HCL	BE
PINDOLOL (g)	PINDOLOL	BE
SECTRAL (g)	ACEBUTOLOL HCL	BE
TENORETIC (g)	ATENOLOL/CHLORTHALIDONE	BE
TENORMIN (g)	ATENOLOL	BE
TOPROL XL (g)	METOPROLOL SUCCINATE	BE
ZEBETA (g)	BISOPROLOL FUMARATE	BE
ZIAC (g)	BISOPROLOL/HYDROCHLOROTHIAZIDE	BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
BYSTOLIC	NEBIVOLOL HCL	[PA] [QL]
COREG CR	CARVEDILOL PHOSPHATE	[PA] [QL]
INNOPRAN XL	PROPRANOLOL HCL	
LEVATOL	PENBUTOLOL SULFATE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2C. ACE-Inhibitors and Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACCUPRIL (g)	QUINAPRIL HCL	BE
ACCURETIC (g)	QUINAPRIL/HYDROCHLOROTHIAZIDE	BE
ACEON (g)	PERINDOPRIL ERBUMINE	
ALTACE CAPSULE (g)	RAMIPRIL	BE
CAPOTEN (g)	CAPTOPRIL	BE
CAPOZIDE (g)	CAPTOPRIL/HYDROCHLOROTHIAZIDE	BE
LOTENSIN (g)	BENAZEPRIL HCL	BE
LOTENSIN HCT (g)	BENAZEPRIL/HYDROCHLOROTHIAZIDE	BE
LOTREL (g)	AMLODIPINE BESYLATE/BENAZEPRIL	BE
LOTREL 5/40, 10/40mg (g)	AMLODIPINE BESYLATE/BENAZEPRIL	[QL]
MAVIK (g)	TRANDOLAPRIL	BE
MONOPRIL (g)	FOSINOPRIL SODIUM	BE
MONOPRIL HCT (g)	FOSINOPRIL/HYDROCHLOROTHIAZIDE	BE
PRINIVIL, ZESTRIL (g)	LISINOPRIL	BE
PRINZIDE, ZESTORETIC (g)	LISINOPRIL/HYDROCHLOROTHIAZIDE	BE
TARKA (g)	TRANDOLAPRIL/VERAPAMIL HCL	[QL]
UNIRETIC (g)	MOEXIPRIL/HYDROCHLOROTHIAZIDE	BE
UNIVASC (g)	MOEXIPRIL HCL	BE
VASERETIC (g)	ENALAPRIL/HYDROCHLOROTHIAZIDE	BE
VASOTEC (g)	ENALAPRIL MALEATE	BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ALTACE TABLET	RAMIPRIL	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2D. Angiotensin II Receptor Blockers and Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
COZAAR (g)	LOSARTAN POTASSIUM	[QL] BE
HYZAAR (g)	LOSARTAN/HYDROCHLOROTHIAZIDE	[QL] BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
BENICAR	OLMESARTAN MEDOXOMIL	[ST] [QL]
BENICAR HCT	OLMESARTAN/HYDROCHLOROTHIAZIDE	[ST] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
ATACAND	CANDESARTAN CILEXETIL	[PA] [QL]
ATACAND HCT	CANDESARTAN/HYDROCHLOROTHIAZIDE	[PA]
AVALIDE	IRBESARTAN/HYDROCHLOROTHIAZIDE	[PA] [QL]
AVAPRO	IRBESARTAN	[PA] [QL]
AZOR	AMLODIPINE BES/OLMESARTAN MED	[PA] [QL]
DIOVAN	VALSARTAN	[PA]
DIOVAN HCT	VALSARTAN/HYDROCHLOROTHIAZIDE	[PA] [QL]
EDARBI	AZILSARTAN MEDOXOMIL	[PA] [QL]
EXFORGE	AMLODIPINE/VALSARTAN	[PA]
EXFORGE HCT	AMLODIPINE/VALSARTAN/HCTZ	[PA] [QL]
MICARDIS	TELMISARTAN	[PA] [QL]
MICARDIS HCT	TELMISARTAN/HYDROCHLOROTHIAZIDE	[PA] [QL]
TEVETEN	EPROSARTAN MESYLATE	[PA]
TEVETEN HCT	EPROSARTAN/HYDROCHLOROTHIAZIDE	[PA]
TRIBENZOR	OLMESARTAN MED/AMLODIPINE/HCTZ	[ST] [QL]
TWYNSTA	TELMISARTAN/AMLODIPINE	[PA] [QL]
VALTURNA	ALISKIREN/VALSARTAN	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2E. Calcium Channel Blockers and Combinations

Formulary Preferred

Trade Name	Generic Name	Utilization Management
CADUET (g)	AMLODIPINE/ATORVAST CAL	[PA] [QL]
CALAN SR/ISOPTIN SR (g)	VERAPAMIL HCL	
CARDENE (g)	NICARDIPINE HCL	
CARDIZEM, SR, CD, LA (g)	DILTIAZEM HCL	
DYNACIRC (g)	ISRADIPINE	
LOTREL (g)	AMLODIPINE BESYLATE/BENAZEPRIL	BE
LOTREL 5/40, 10/40mg (g)	AMLODIPINE BESYLATE/BENAZEPRIL	[QL]
NORVASC (g)	AMLODIPINE BESYLATE	BE
PLENDIL (g)	FELODIPINE	
PROCARDIA, XL;ADALAT CC (g)	NIFEDIPINE	[QL]
SULAR (g)	NISOLDIPINE	
TARKA (g)	TRANDOLAPRIL/VERAPAMIL HCL	[QL]
TIAZAC (g)	DILTIAZEM HCL	
VERELAN (g)	VERAPAMIL HCL	
VERELAN PM (g)	VERAPAMIL HCL	

Formulary Options

Trade Name	Generic Name	Utilization Management
COVERA-HS	VERAPAMIL HCL	

Nonformulary

Trade Name	Generic Name	Utilization Management
AZOR	AMLODIPINE BES/OLMESARTAN MED	[PA] [QL]
CARDENE SR	NICARDIPINE HCL	
CARDIZEM LA 120MG	DILTIAZEM HCL	
DYNACIRC CR	ISRADIPINE	
EXFORGE	AMLODIPINE/VALSARTAN	[PA]
EXFORGE HCT	AMLODIPINE/VALSARTAN/HCTZ	[PA] [QL]
TEKAMLO	ALISKIREN/AMLODIPINE	[ST] [QL]
TRIBENZOR	OLMESARTAN MED/AMLODIPINE/HCTZ	[ST] [QL]
TWYNSTA	TELMISARTAN/AMLODIPINE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2F. Diuretics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALDACTAZIDE (g)	SPIRONOLACT/HYDROCHLOROTHIAZID	BE
ALDACTONE (g)	SPIRONOLACTONE	BE
BUMEX (g)	BUMETANIDE	BE
DEMADEX (g)	TORSEMIDE	BE
DIAMOX (g)	ACETAZOLAMIDE	
DIAMOX SEQUELS (g)	ACETAZOLAMIDE	
DIURIL (g)	CHLOROTHIAZIDE	BE
HYDRODIURIL, MICROZIDE (g)	HYDROCHLOROTHIAZIDE	BE
HYGROTON, THALITONE (g)	CHLORTHALIDONE	BE
INSPRA (g)	EPLERENONE	BE
LASIX (g)	FUROSEMIDE	BE
LOZOL (g)	INDAPAMIDE	BE
MAXZIDE, DYAZIDE (g)	TRIAMTERENE/HYDROCHLOROTHIAZID	BE
MIDAMOR (g)	AMILORIDE HCL	BE
MODURETIC (g)	AMILORIDE/HYDROCHLOROTHIAZIDE	BE
ZAROXOLYN (g)	METOLAZONE	BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
DYRENIUM	TRIAMTERENE	
EDECIN	ETHACRYNIC ACID	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

2G. Cardiovascular Treatment

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BETAPACE, AF (g)	SOTALOL HCL	BE
CORDARONE (g)	AMIODARONE HCL	
DIGOXIN (g)	DIGOXIN	
MEXITIL (g)	MEXILETINE HCL	
NORPACE (g)	DISOPYRAMIDE PHOSPHATE	
PROAMATINE (g)	MIDODRINE HCL	
QUINIDEX (g)	QUINIDINE SULFATE	
QUINIDINE GLUCONATE SA (g)	QUINIDINE GLUCONATE	
RYTHMOL, SR (g)	PROPAFENONE HCL	
TAMBOCOR (g)	FLECAINIDE ACETATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
MULTAQ	DRONEDARONE HYDROCHLORIDE	[QL]
NORPACE CR	DISOPYRAMIDE PHOSPHATE	
TIKOSYN	DOFETILIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
RANEXA	RANOLAZINE	[PA]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2H. Nitrates and Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
IMDUR (g)	ISOSORBIDE MONONITRATE	
ISMO, MONOKET (g)	ISOSORBIDE MONONITRATE	
ISORDIL (g)	ISOSORBIDE DINITRATE	
NITROGLYCERIN PATCH (g)	NITROGLYCERIN	
NITROGLYCERIN SA CAP (g)	NITROGLYCERIN	
NITROGLYCERIN SPRAY	NITROGLYCERIN	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
DILATRATE-SR	ISOSORBIDE DINITRATE	
NITRO-BID OINTMENT	NITROGLYCERIN	
NITROSTAT	NITROGLYCERIN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NITROMIST	NITROGLYCERIN	

2I. Anticoagulants and Hemostasis Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AGRYLIN (g)	ANAGRELIDE HCL	
AMICAR (g)	AMINOCAPROIC ACID	
ARIXTRA (g)	FONDAPARINUX SODIUM	<s>
COUMADIN (g)	WARFARIN SODIUM	BE
HEPARIN (g)	HEPARIN SODIUM,PORCINE	<s>
LOVENOX (g)	ENOXAPARIN SODIUM	<s>
PERSANTINE (g)	DIPYRIDAMOLE	
PLETAL (g)	CILOSTAZOL	
TICLID (g)	TICLOPIDINE HCL	
TRENTAL (g)	PENTOXIFYLLINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
EFFIENT	PRASUGREL HYDROCHLORIDE	[QL]
IPRIVASK	DESIRUDIN INJECTION	<s>
LOVENOX 300MG/3ML	ENOXAPARIN SODIUM	<s>
MEPHYTON	PHYTONADIONE	
PLAVIX	CLOPIDOGREL BISULFATE	
PRADAXA	DABIGATRAN ETEXILATE MESYLATE	[QL]
XARELTO	RIVAROXABAN	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
AGGRENOX	ASPIRIN/DIPYRIDAMOLE	
BRILINTA	TICAGRELOR	[ST] [QL]
FRAGMIN	DALTEPARIN SODIUM,PORCINE	<s>
INNOHEP	TINZAPARIN SODIUM,PORCINE	<s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

2J. Alpha-adrenergic Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALDOMET (g)	METHYLDOPA	
ALDORIL (g)	METHYLDOPA/HYDROCHLOROTHIAZIDE	
CARDURA (g)	DOXAZOSIN MESYLATE	
CATAPRES, TTS (g)	CLONIDINE HCL	
HYTRIN (g)	TERAZOSIN HCL	
MINIPRESS (g)	PRAZOSIN HCL	
RESERPINE (g)	RESERPINE	
TENEX (g)	GUANFACINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NEXICLON XR	CLONIDINE HCL	[PA] [QL]

2K. Miscellaneous Antihypertensives

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
APRESOLINE (g)	HYDRALAZINE HCL	
LONITEN (g)	MINOXIDIL	
PAPAVERINE CAPS (g)	PAPAVERINE HCL	
VASODILAN (g)	ISOXSUPRINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
AMTURNIDE	ALISKIREN/AMLODIPINE/HCTZ	[ST] [QL]
TEKAMLO	ALISKIREN/AMLODIPINE	[ST] [QL]
TEKTURNA	ALISKIREN HEMIFUMARATE	[PA]
TEKTURNA HCT	ALISKIREN/HYDROCHLOROTHIAZIDE	[PA]
VALTURNA	ALISKIREN/VALSARTAN	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3. CENTRAL NERVOUS SYSTEM

3A. Antidepressants

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ANAFRANIL (g)	CLOMIPRAMINE HCL	BE
ASENDIN (g)	AMOXAPINE	
CELEXA (g)	CITALOPRAM HYDROBROMIDE	BE
DESYREL (g)	TRAZODONE HCL	BE
EFFEXOR (g)	VENLAFAXINE HCL	BE
EFFEXOR XR (g)	VENLAFAXINE HCL	[QL] BE
ELAVIL (g)	AMITRIPTYLINE HCL	BE
ETRAFON (g)	AMITRIPTYLINE HCL/PERPHENAZINE	
FLUVOXAMINE MALEATE (g)	FLUVOXAMINE MALEATE	BE
LIMBITROL, DS (g)	AMITRIP HCL/CHLORDIAZEPOXIDE	
MAPROTILINE HCL (g)	MAPROTILINE HCL	BE
NARDIL (g)	PHENELZINE SULFATE	
NORPRAMIN (g)	DESIPRAMINE HCL	BE
PAMELOR, AVENTYL (g)	NORTRIPTYLINE HCL	BE
PARNATE (g)	TRANLYCYPROMINE SULFATE	
PAXIL (g)	PAROXETINE HCL	BE
PAXIL CR (g)	PAROXETINE HCL	[QL]
PROZAC WEEKLY (g)	FLUOXETINE HCL	[PA] [QL]
PROZAC, SARAFEM CAPSULES (g)	FLUOXETINE HCL	BE
REMERON, SOLTAB (g)	MIRTAZAPINE	BE
SERZONE (g)	NEFAZODONE HCL	[PA]
SINEQUAN, ADAPIN (g)	DOXEPIN HCL	BE
SURMONTIL (g)	TRIMIPRAMINE MALEATE	
TOFRANIL (g)	IMIPRAMINE HCL	BE
TOFRANIL-PM (g)	IMIPRAMINE PAMOATE	
VENLAFAXINE HCL ER (g)	VENLAFAXINE HCL	[QL] BE
VIVACTIL (g)	PROTRIPTYLINE HCL	
WELLBUTRIN XL (g)	BUPROPION HCL	[QL]
WELLBUTRIN, SR (g)	BUPROPION HCL	BE
ZOLOFT (g)	SERTRALINE HCL	BE

Formulary Options

Trade Name	Generic Name	Utilization Management
LEXAPRO	ESCITALOPRAM OXALATE	[ST] [QL]

Nonformulary

Trade Name	Generic Name	Utilization Management
APLENZIN	BUPROPRION HBR	[PA]
CYMBALTA	DULOXETINE HCL	[PA] [QL]
EMSAM	SELEGILINE	[QL]
FLUOXETINE 60mg	FLUOXETINE HCL	
LUVOX CR	FLUVOXAMINE MALEATE	[ST] [QL]
MARPLAN	ISOCARBOXAZID	
OLEPTRO	TRAZODONE HCL	[PA] [QL]
PEXEVA	PAROXETINE MESYLATE	[PA] [QL]
PRISTIQ	DESVENLAFAXINE SUCCINATE	[ST] [QL]
SARAFEM TABLET	FLUOXETINE HCL	
VIIBRYD	VILAZODONE HYDROCHLORIDE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3B. Antipsychotics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLOZARIL (g)	CLOZAPINE	BE
HALDOL (g)	HALOPERIDOL	BE
LOXITANE (g)	LOXAPINE SUCCINATE	
MELLARIL (g)	THIORIDAZINE HCL	BE
NAVANE (g)	THIOTHIXENE	
PERPHENAZINE (g)	PERPHENAZINE	
PROLIXIN (g)	FLUPHENAZINE HCL	BE
RISPERDAL M-TAB (g)	RISPERIDONE	BE
RISPERDAL(g) (TIER 0-BCN ONLY)	RISPERIDONE	BE
STELAZINE (g)	TRIFLUOPERAZINE HCL	BE
THORAZINE (g)	CHLORPROMAZINE HCL	BE
ZYPREXA, ZYDIS (g)	OLANZAPINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ABILIFY, DISCMELT, SOLUTION	ARIPIPIRAZOLE	
GEODON	ZIPRASIDONE HCL	
ORAP	PIMOZIDE	
SEROQUEL	QUETIAPINE FUMARATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
FANAPT	ILOPERIDONE	
FAZACLO	CLOZAPINE	
INVEGA	PALIPERIDONE	[PA] [QL]
LATUDA	LURASIDONE HCL	
SAPHRIS	ASENAPINE	[PA] [QL]
SEROQUEL XR	QUETIAPINE FUMARATE	[PA] [QL]
SYMBYAX	OLANZAPINE/FLUOXETINE HCL	

3C. Anxiolytics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ATIVAN (g)	LORAZEPAM	
BUSPAR (g)	BUSPIRONE HCL	
LIBRIUM (g)	CHLORDIAZEPOXIDE HCL	
MILTOWN, EQUANIL (g)	MEPROBAMATE	
NIRAVAM (g)	ALPRAZOLAM	
SERAX (g)	OXAZEPAM	
TRANXENE (g)	CLORAZEPATE DIPOTASSIUM	
VALIUM (g)	DIAZEPAM	
XANAX, XR (g)	ALPRAZOLAM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
TRANXENE SD	CLORAZEPATE DIPOTASSIUM	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3D. Sedative/Hypnotics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AMBIEN (g)	ZOLPIDEM TARTRATE	[QL]
AMBIEN CR (g)	ZOLPIDEM TARTRATE	[PA] [QL]
CHLORAL HYDRATE (g)	CHLORAL HYDRATE	
DALMANE (g)	FLURAZEPAM HCL	[QL]
HALCION (g)	TRIAZOLAM	[QL]
PROSOM (g)	ESTAZOLAM	[QL]
RESTORIL (g)	TEMAZEPAM	[QL]
SONATA (g)	ZALEPLON	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
BUTISOL SODIUM	BUTABARBITAL SODIUM	
DORAL	QUAZEPAM	[QL]
EDLUAR	ZOLPIDEM TARTRATE	[PA] [QL]
LUNESTA	ESZOPICLONE	[PA] [QL]
ROZEREM	RAMELTEON	[PA] [QL]
SILENOR	DOXEPIN HCL	[PA] [QL]
ZOLPIMIST	ZOLPIDEM TARTRATE	[PA] [QL]

3E. CNS Stimulants

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ADDERALL (g)	AMPHET ASP/AMPHET/D-AMPHET	[QL]
ADDERALL XR (BRAND BCN-ONLY)	AMPHET ASP/AMPHET/D-AMPHET	[QL]
ADDERALL XR (g)	AMPHET ASP/AMPHET/D-AMPHET	[QL]
CONCERTA (g)	METHYLPHENIDATE HCL	[QL]
DESOXYN (g)	METHAMPHETAMINE HCL	[QL]
DEXEDRINE (g)	D-AMPHETAMINE SULFATE	[QL]
FOCALIN (g)	DEXMETHYLPHENIDATE HCL	[QL]
METHYLIN SOLN (g)	METHYLPHENIDATE HCL	[QL]
PROCENTRA	D-AMPHETAMINE SULFATE	[PA]
RITALIN, SR; METHYLIN, ER (g)	METHYLPHENIDATE HCL	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
METADATE CD	METHYLPHENIDATE HCL	[QL]
PROVIGIL	MODAFINIL	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
DAYTRANA	METHYLPHENIDATE	[QL]
FOCALIN XR	DEXMETHYLPHENIDATE HCL	[QL]
METHYLIN CHEW	METHYLPHENIDATE HCL	[QL]
NUVIGIL	ARMODAFINIL	[PA] [QL]
RITALIN LA	METHYLPHENIDATE HCL	[QL]
STRATTERA	ATOMOXETINE HCL	[PA] [QL]
VYVANSE	LISDEXAMFETAMINE DIMESYLATE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3F. Nonsteroidal Anti-inflammatory Drugs

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ANAPROX, DS (g)	NAPROXEN SODIUM	
ANSAID (g)	FLURBIPROFEN	
CATAFLAM (g)	DICLOFENAC POTASSIUM	
CLINORIL (g)	SULINDAC	
EC-NAPROSYN (g)	NAPROXEN	
FELDENE (g)	PIROXICAM	
INDOCIN, SR (g)	INDOMETHACIN	
KETOPROFEN (g)	KETOPROFEN	
LODINE, XL (g)	ETODOLAC	
MECLOMEN (g)	MECLOFENAMATE SODIUM	
MOBIC (g)	MELOXICAM	
MOTRIN (g)	IBUPROFEN	
NAPROSYN (g)	NAPROXEN	
PONSTEL (g)	MEFENAMIC ACID	
RELAFEN (g)	NABUMETONE	
TOLECTIN, DS (g)	TOLMETIN SODIUM	
TORADOL (g)	KETOROLAC TROMETHAMINE	[QL]
VOLTAREN, XR (g)	DICLOFENAC SODIUM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DAYPRO	OXAPROZIN	
INDOCIN SUPPOSITORY	INDOMETHACIN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ARTHROTEC	DICLOFENAC SODIUM/MISOPROSTOL	[PA]
CAMBIA	DICLOFENAC POTASSIUM	[PA] [QL]
CELEBREX	CELECOXIB	[PA] [QL]
DUEXIS	IBUPROFEN/FAMOTIDINE	[PA] [QL]
FLECTOR PATCH	DICLOFENAC EPOLAMINE	[PA] [QL]
NAPRELAN	NAPROXEN SODIUM	
PENNSAID	DICLOFENAC SODIUM	[PA] [QL]
SPRIX	KETOROLAC TROMETHAMINE	[QL]
VIMOVO	NAPROXEN/ESOMEPRAZOLE MAG	[PA] [QL]
VOLTAREN GEL	DICLOFENAC SODIUM	[PA] [QL]
ZIPSOR	DICLOFENAC POTASSIUM	

3G. Salicylates

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DISALCID, SALFLEX (g)	SALSALATE	
DOLOBID (g)	DIFLUNISAL	
TRILISATE (g)	CHOLINE MAGNESIUM TRISALICYLATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE	NONE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3H. Narcotics

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ACTIQ (g)	FENTANYL CITRATE	[PA] [QL]
CODEINE SULFATE (g)	CODEINE SULFATE(g)	
DEMEROL (g)	MEPERIDINE HCL	
DILAUDID (g)	HYDROMORPHONE HCL	
DURAGESIC (g)	FENTANYL	[QL]
KADIAN (g)	MORPHINE SULFATE	
METHADONE (g)	METHADONE HCL	
MS CONTIN/ORAMORPH SR (g)	MORPHINE SULFATE	
MSIR (g)	MORPHINE SULFATE	
OPANA (g)	OXYMORPHONE HCL	[PA] [QL]
OPANA ER 7.5, 15mg (g)	OXYMORPHONE HCL	[PA] [QL]
OXYCODONE IMMEDIATE RELEASE (g)	OXYCODONE HCL	
RMS SUPPOSITORY (g)	MORPHINE SULFATE	
ROXANOL (g)	MORPHINE SULFATE	

Formulary Options

Trade Name	Generic Name	Utilization Management
NONE		

Nonformulary

Trade Name	Generic Name	Utilization Management
ABSTRAL	FENTANYL CITRATE	[PA] [QL]
AVINZA	MORPHINE SULFATE	[QL]
EMBEDA	MORPHINE SULFATE/NALTREXONE	[QL]
EXALGO	HYDROMORPHONE HCL	[PA] [QL]
FENTORA	FENTANYL CITRATE	[PA] [QL]
KADIAN 10, 200mg	MORPHINE SULFATE	
LAZANDA	FENTANYL CITRATE	[PA] [QL]
NUCYNTA, ER	TAPENTADOL HYDROCHLORIDE	[PA] [QL]
ONSOLIS	FENTANYL CITRATE	[PA] [QL]
OPANA ER	OXYMORPHONE HCL	[PA] [QL]
OXECTA	OXYCODONE HCL	[PA] [QL]
OXYCONTIN	OXYCODONE HCL	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3I. Narcotic/Analgesic Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ASPIRIN W/CODEINE (g)	CODEINE PHOS/ASPIRIN	
FIORICET W/CODEINE (g)	CODEINE/BUTALBUT/ACETAMIN/CAFF	
FIORICET; ESGIC, PLUS (g)	BUTALB/ACETAMINOPHEN/CAFFEINE	
FIORINAL (g)	BUTALBITAL/ASPIRIN/CAFFEINE	
FIORINAL W/CODEINE (g)	CODEINE/BUTALBITAL/ASA/CAFFEIN	
PERCOCET (g)	OXYCODONE HCL/ACETAMINOPHEN	
PERCODAN (g)	OXYCODONE HCL/ASPIRIN	
PHRENILIN (g)	BUTALBITAL/ACETAMINOPHEN	
TYLENOL W/CODEINE (g)	CODEINE PHOS/ACETAMINOPHEN	
TYLOX (g)	OXYCODONE HCL/ACETAMINOPHEN	
VICODIN, LORTAB (g)	HYDROCODONE BIT/ACETAMINOPHEN	
VICOPROFEN (g)	HYDROCODONE/IBUPROFEN	
XODOL (g)	HYDROCODONE BIT/ACETAMINOPHEN	
ZEBUTAL (g)	BUTALB/ACETAMINOPHEN/CAFFEINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
PHRENILIN FORTE	BUTALBITAL/ACETAMINOPHEN	
SYNALGOS-DC	DIHYDROCODEINE/ASPIRIN/CAFFEIN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
MAGNACET	OXYCODONE HCL/ACETAMINOPHEN	
ZYDONE	HYDROCODONE BIT/ACETAMINOPHEN	

3J. Narcotic Mixed Agonist/Antagonist

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
STADOL NS (g)	BUTORPHANOL TARTRATE	
TALACEN (g)	PENTAZOCINE HCL/ACETAMINOPHEN	
TALWIN NX (g)	PENTAZOCINE HCL/NALOXONE HCL	
ULTRACET (g)	TRAMADOL HCL/ACETAMINOPHEN	
ULTRAM, ER (g)	TRAMADOL HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
SUBOXONE FILM	BUPRENORPHINE HCL/NALOXONE HCL	[PA]
SUBOXONE TABS	BUPRENORPHINE HCL/NALOXONE HCL	[PA]
Nonformulary		
Trade Name	Generic Name	Utilization Management
BUTRANS	BUPRENORPHINE	[PA] [QL]
CONZIP	TRAMADOL HCL	[QL]
RYBIX ODT	TRAMADOL HCL	[PA] [QL]
RYZOLT	TRAMADOL HCL	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3K. Narcotic Antagonists

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
REVIA (g)	NALTREXONE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
RELISTOR	METHYLNALTREXONE	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

3M. Migraine Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALSUMA (g)	SUMATRIPTAN SUCCINATE	[ST] [QL]
AMERGE (g)	NARATRIPTAN HCL	[ST] [QL]
BUPAP (g)	BUTALBITAL/ACETAMINOPHEN	
D.H.E.45 (g)	DIHYDROERGOTAMINE MESYLATE	[QL]
FIORICET; ESGIC, PLUS (g)	BUTALB/ACETAMINOPHEN/CAFFEINE	
FIORINAL (g)	BUTALBITAL/ASPIRIN/CAFFEINE	
FIORINAL W/CODEINE (g)	CODEINE/BUTALBITAL/ASA/CAFFEIN	
IMITREX (ALL FORMS) (g)	SUMATRIPTAN SUCCINATE	[QL]
MIDRIN (g)	ISOMETHEPTENE/APAP/DICHLPHEN	
PHRENILIN (g)	BUTALBITAL/ACETAMINOPHEN	
STADOL NS (g)	BUTORPHANOL TARTRATE	
ZEBUTAL (g)	BUTALB/ACETAMINOPHEN/CAFFEINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CAFERGOT	ERGOTAMINE TARTRATE/CAFFEINE	[QL]
ERGOMAR	ERGOTAMINE TARTRATE	[QL]
MAXALT, MLT	RIZATRIPTAN BENZOATE	[ST] [QL]
MIGRANAL	DIHYDROERGOTAMINE MESYLATE	[QL]
PHRENILIN FORTE	BUTALBITAL/ACETAMINOPHEN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
AXERT	ALMOTRIPTAN MALATE	[ST] [QL]
CAMBIA	DICLOFENAC POTASSIUM	[PA] [QL]
FROVA	FROVATRIPTAN SUCCINATE	[ST] [QL]
RELPAX	ELETRIPTAN HYDROBROMIDE	[ST] [QL]
SUMAVEL DOSEPRO	SUMATRIPTAN SUCCINATE	[PA] [QL]
TREXIMET	SUMATRIPTAN SUCC/NAPROXEN SOD	[PA] [QL]
ZOMIG	ZOLMITRIPTAN	[ST] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

30. Parkinsons Disease and Related Disorders

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ARTANE (g)	TRIHEXYPHENIDYL HCL	
COGENTIN (g)	BENZTROPINE MESYLATE	
DOSTINEX (g)	CABERGOLINE	
MIRAPEX (g)	PRAMIPEXOLE DI-HCL	
PARCOPA (g)	CARBIDOPA/LEVODOPA	
PARLODEL (g)	BROMOCRIPTINE MESYLATE	
REQUIP (g)	ROPINIROLE HCL	
SINEMET, CR (g)	CARBIDOPA/LEVODOPA	
SYMMETREL (g)	AMANTADINE HCL	

Formulary Options

Trade Name	Generic Name	Utilization Management
APOKYN	APOMORPHINE HCL	<s>
AZILECT	RASAGILINE MESYLATE	
COMTAN	ENTACAPONE	
ELDEPRYL	SELEGILINE HCL	
STALEVO	CARBIDOPA/LEVODOPA/ENTACAPONE	

Nonformulary

Trade Name	Generic Name	Utilization Management
MIRAPEX ER	PRAMIPEXOLE DI-HCL	[PA] [QL]
REQUIP XL	ROPINIROLE HCL	[QL]
TASMAR	TOLCAPONE	
ZELAPAR	SELEGILINE HCL	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3P. Anticonvulsants

Formulary Preferred

Trade Name	Generic Name	Utilization Management
CARBATROL (g)	CARBAMAZEPINE	
DEPAKENE (g)	VALPROATE SODIUM	
DEPAKOTE, ER, SPRINKLES (g)	DIVALPROEX SODIUM	
DIAMOX (g)	ACETAZOLAMIDE	
DIASTAT 2.5MG (g)	DIAZEPAM	
DILANTIN (g)	PHENYTOIN SODIUM EXTENDED	
FELBATOL (g)	FELBAMATE	
KEPPRA, XR (g)	LEVETIRACETAM	
KLONOPIN, WAFER (g)	CLONAZEPAM	
LAMICTAL TABS, DISPERTABS (g)	LAMOTRIGINE	
MEBARAL (g)	MEPHOBARBITAL	
MYSOLINE (g)	PRIMIDONE	
NEURONTIN (g)	GABAPENTIN	
PHENOBARBITAL (g)	PHENOBARBITAL	
TEGRETOL, XR (g)	CARBAMAZEPINE	
TOPAMAX, SPRINKLE (g)	TOPIRAMATE	
TRILEPTAL, SUSP (g)	OXCARBAZEPINE	
ZARONTIN (g)	ETHOSUXIMIDE	
ZONEGRAN (g)	ZONISAMIDE	

Formulary Options

Trade Name	Generic Name	Utilization Management
BANZEL	RUFINAMIDE	
CELONTIN	METHSUXIMIDE	
DIASTAT	DIAZEPAM	
DILANTIN CHEW TABS	PHENYTOIN	
GABITRIL	TIAGABINE HCL	
PEGANONE	ETHOTOIN	
SABRIL	VIGABATRIN	<s>
TEGRETOL XR 100MG	CARBAMAZEPINE	
VIMPAT	LACOSAMIDE	

Nonformulary

Trade Name	Generic Name	Utilization Management
EQUETRO	CARBAMAZEPINE	
GRALISE	GABAPENTIN	[PA] [QL]
LAMICTAL ODT	LAMOTRIGINE	[QL]
LAMICTAL, XR	LAMOTRIGINE	[QL]
LYRICA	PREGABALIN	[PA] [QL]
POTIGA	EZOAGABINE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3Q. Skeletal Muscle Relaxants

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AMRIX (g)	CYCLOBENZAPRINE HCL	[PA] [QL]
BACLOFEN, LIORESAL (g)	BACLOFEN	
DANTRIUM (g)	DANTROLENE SODIUM	
FLEXERIL (g)	CYCLOBENZAPRINE HCL	
NORFLEX (g)	ORPHENADRINE CITRATE	
NORGESIC, FORTE (g)	ORPHENADRINE/ASPIRIN/CAFFEINE	
PARAFLEX, PARAFON FORTE DSC (g)	CHLORZOXAZONE	
ROBAXIN (g)	METHOCARBAMOL	
SKELAXIN (g)	METAXALONE	
SOMA (g)	CARISOPRODOL	
SOMA COMPOUND (g)	CARISOPRODOL/ASPIRIN	
SOMA COMPOUND W/CODEINE (g)	CODEINE PHOS/CARISOPRODOL/ASA	
VALIUM (g)	DIAZEPAM	
ZANAFLEX TABS (g)	TIZANIDINE HCL	[PA]
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
FEXMID	CYCLOBENZAPRINE HCL	
ZANAFLEX CAPS	TIZANIDINE HCL	[PA]

3R. Myesthenia Gravis

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
MESTINON (g)	PYRIDOSTIGMINE BROMIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
MESTINON TIMESPAN, SYRUP	PYRIDOSTIGMINE BROMIDE	
PROSTIGMIN	NEOSTIGMINE BROMIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
MYTELASE	AMBENONIUM CHLORIDE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

3S. Miscellaneous CNS

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ARICEPT, ODT (g)	DONEPEZIL HCL	
ESKALITH, CR (g)	LITHIUM CARBONATE	
EXELON (g)	RIVASTIGMINE TARTRATE	[QL]
LITHIUM CITRATE (g)	LITHIUM CITRATE	
LITHOBID (g)	LITHIUM CARBONATE	
NIMOTOP (g)	NIMODIPINE	
RAZADYNE, ER, SOLUTION (g)	GALANTAMINE HYDROBROMIDE	

Formulary Options

Trade Name	Generic Name	Utilization Management
EXELON PATCH	RIVASTIGMINE TARTRATE	[QL]
NAMENDA, SOLN	MEMANTINE HCL	
NUDEXTA	DEXTROMETHORPHAN HBR/QUINIDINE	[PA]
RILUTEK	RILUZOLE	

Nonformulary

Trade Name	Generic Name	Utilization Management
ARICEPT 23MG	DONEPEZIL HCL	[ST] [QL]
COGNEX	TACRINE HCL	
HORIZANT	GABAPENTIN ENACARBIL	[PA] [QL]
INTUNIV	GUANFACINE HCL	[PA] [QL]
KAPVAY	CLONIDINE HCL	[PA] [QL]
SAVELLA	MILNACIPRAN HCL	[PA] [QL]
XYREM	SODIUM OXYBATE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

4. GASTROINTESTINAL AGENTS

4A. H2-Receptor Antagonists

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AXID (RX ONLY) (g)	NIZATIDINE	
PEPCID (RX ONLY) (g)	FAMOTIDINE	
TAGAMET (RX ONLY) (g)	CIMETIDINE	
ZANTAC (RX ONLY) (g)	RANITIDINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ZANTAC EFFERDOSE	RANITIDINE HCL	

4B. Proton Pump Inhibitors

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
OMEPRAZOLE OTC (g)	OMEPRAZOLE	
PREVACID (g)	LANSOPRAZOLE	[ST]
PREVACID SOLUTAB (g)	LANSOPRAZOLE	[PA]
PRILOSEC (g)	OMEPRAZOLE	
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM	
PROTONIX (g)	PANTOPRAZOLE SODIUM	
ZEGERID RX (g)	OMEPRAZOLE/SODIUM BICARBONATE	[PA]
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ACIPHEX	RABEPRAZOLE SODIUM	[PA]
DEXILANT	DEXLANSOPRAZOLE	[ST] [QL]
NEXIUM	ESOMEPRAZOLE MAG TRIHYDRATE	[PA]
PRILOSEC SUSPENSION	OMEPRAZOLE MAGNESIUM	[PA]
PROTONIX SUSPENSION	PANTOPRAZOLE SODIUM	[ST]
VIMOVO	NAPROXEN/ESOMEPRAZOLE MAG	[PA] [QL]
ZEGERID PACKET	OMEPRAZOLE/SODIUM BICARBONATE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

4C. Other Ulcer Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CARAFATE, SUSP (g)	SUCRALFATE	
CYTOTEC (g)	MISOPROSTOL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
HELIDAC	TETRACYC HCL/BIS SS/METRONID	
PREVPAC	LANSOPRAZOLE/AMOX TR/CLARITH	
Nonformulary		
Trade Name	Generic Name	Utilization Management
PYLERA	BISMUTH/METRONID/TETRACYCLINE	

4D. Antidiarrheals and Antispasmodics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BELLAMINE/BELLASPAS (g)	ERGOTAMINE TART/BELLAD ALK/PB	
BENTYL (g)	DICYCLOMINE HCL	
DONNATAL (g)	BELLADONNA ALKALOIDS/PHENOBARB	
LEVBID (g)	HYOSCYAMINE SULFATE	
LEVSIN, SL (g)	HYOSCYAMINE SULFATE	
LEVSINEX (g)	HYOSCYAMINE SULFATE	
LIBRAX (g)	CLIDINIUM BR/CHLORDIAZEPOXIDE	
LOMOTIL (g)	DIPHENOXYLATE HCL/ATROP SULF	
PAREGORIC (g)	PAREGORIC	
PRO-BANTHINE 15MG (g)	PROPANTHELINE BROMIDE	
ROBINUL, FORTE (g)	GLYCOPYRROLATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
CANTIL	MEPENZOLATE BROMIDE	
DONNATAL EXTENTABS	BELLADONNA ALKALOIDS/PHENOBARB	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

4E. Antiemetics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ANTIVERT (g)	MECLIZINE HCL	
COMPAZINE (g)	PROCHLORPERAZINE MALEATE	
KYTRIL (g)	GRANISETRON HCL	[QL]
MARINOL (g)	DRONABINOL	[QL]
PHENERGAN (g)	PROMETHAZINE HCL	
TIGAN (g)	TRIMETHOBENZAMIDE HCL	
ZOFRAN, ODT (g)	ONDANSETRON	
Formulary Options		
Trade Name	Generic Name	Utilization Management
EMEND 80,125MG CAPSULES	APREPITANT	[QL]
TRANSDERM-SCOP	SCOPOLAMINE HYDROBROMIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ANZEMET	DOLASETRON MESYLATE	[QL]
CESAMET	NABILONE	
SANCUSO	GRANISETRON	[ST] [QL]
ZUPLENZ	ONDANSETRON	[ST] [QL]

4F. Bile Acids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACTIGALL (g)	URSODIOL	
URSO, URSO FORTE (g)	URSODIOL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
CHENODAL	CHENODIOL	[PA]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

4G. Digestive Enzymes

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DYGASE (g)	AMYLASE/LIPASE/PROTEASE	
LAPASE (g)	AMYLASE/LIPASE/PROTEASE	
PANCREASE MT 10, 16, 20 (g)	LIPASE/PROTEASE/AMYLASE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CREON	AMYLASE/LIPASE/PROTEASE	
LIPRAM-UL20	AMYLASE/LIPASE/PROTEASE	
PANCREASE MT 4	LIPASE/PROTEASE/AMYLASE	
PANCREAZE	LIPASE/PROTEASE/AMYLASE	
PANCRECARB MS (Tier 3 - BCN ONLY)	AMYLASE/LIPASE/PROTEASE	
PANGESTYME UL 12	AMYLASE/LIPASE/PROTEASE	
ULTRASE MT	AMYLASE/LIPASE/PROTEASE	
VIOKASE	AMYLASE/LIPASE/PROTEASE	
ZENPEP	AMYLASE/LIPASE/PROTEASE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

4H. Miscellaneous Gastrointestinal Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ANALPRAM HC (g)	HYDROCORTISONE/PRAMOXINE HCL	
ANAMANTLE HC (g)	LIDOCAINE HCL/HC	
ANNUSOL HC, PROCTOCREAM HC (g)	HYDROCORTISONE	
AZULFIDINE, EN-TAB (g)	SULFASALAZINE	
COLAZAL (g)	BALSALAZIDE DISODIUM	
CORTENEMA (g)	HYDROCORTISONE ACETATE	
GLYCOLAX (g)	POLYETHYLENE GLYCOL 3350	
HC ACETATE/PRAMOXINE HCL	HC ACETATE/PRAMOXINE HCL	
LACTULOSE (g)	LACTULOSE	
PROCTOCORT SUPPOSITORY (g)	HYDROCORTISONE ACETATE	
REGLAN TAB, SOLUTION (g)	METOCLOPRAMIDE HCL	
ROWASA ENEMA (g)	MESALAMINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ASACOL	MESALAMINE	
ASACOL HD	MESALAMINE	
CANASA	MESALAMINE	
CORTIFOAM	HYDROCORTISONE ACETATE	
PENTASA	MESALAMINE	
RELISTOR	METHYLNALTREXONE	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
AMITIZA	LUBIPROSTONE	[PA] [QL]
APRISO	MESALAMINE	
CIMZIA SYRINGE	CERTOLIZUMAB	[PA] [QL] <s>
CUVPOSA	GLYCOPYRROLATE	
DIPENTUM	OLSALAZINE SODIUM	
LIALDA	MESALAMINE	[QL]
LOTRONEX	ALOSETRON HCL	[PA] [QL]
METZOLV ODT	METOCLOPRAMIDE HCL	
PERANEX HC	HC ACETATE/LIDOCAINE HCL	
PRAMOSONE	HC ACETATE/PRAMOXINE HCL	
RECTIV	NITROGLYCERIN	[QL]
XIFAXAN 550MG	RIFAXIMIN	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

5. OBSTETRICS AND GYNECOLOGY

5A. Contraceptives-Monophasic

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALESSE (g), LEVLITE (g)	LEVONORGESTREL-ETH ESTRA	
DEMULEN (g)	ETHYNODIOL D-ETHINYL ESTRADIOL	
DESOGEN (g), ORTHO-CEPT (g)	DESOGESTREL-ETHINYL ESTRADIOL	
FEMCON FE (g)	NORETH-ETHINYL ESTRADIOL/IRON	
LO/OVRAL (g)	NORGESTREL-ETHINYL ESTRADIOL	
LOESTRIN, FE (g)	NORETH A-ET ESTRA/FE FUMARATE	
LYBREL (g)	LEVONORGESTREL-ETH ESTRA	
MODICON (g)	NORETHINDRONE-ETHINYL ESTRAD	
NORDETTE, LEVLEN (g)	LEVONORGESTREL-ETH ESTRA	
NORINYL 1/35 (g), ORTHO-NOVUM 1/35 (g)	NORETHINDRONE-MESTRANOL	
NORINYL 1/50 (g), ORTHO-NOVUM 1/50 (g)	NORETHINDRONE-ETHINYL ESTRAD	
ORTHO-CYCLEN (g)	NORGESTIMATE-ETHINYL ESTRADIOL	
OVCON 35 (g)	NORETHINDRONE-ETHINYL ESTRAD	
OVRAL (g)	NORGESTREL-ETHINYL ESTRADIOL	
SEASONALE (g)	LEVONORGESTREL-ETH ESTRA	[QL]
YASMIN 28 (g)	ETHINYL ESTRADIOL/DROSPIRENONE	
YAZ (g)	ETHINYL ESTRADIOL/DROSPIRENONE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
LO LOESTRIN FE	NORETH A-ET ESTRA/FE FUMARATE	
LOESTRIN 24 FE	NORETH A-ET ESTRA/FE FUMARATE	
NATAZIA	ESTRADIOL VALERATE/DIENOGEST	
OVCON-50, FE	NORETHINDRONE-ETHINYL ESTRAD	

5B. Contraceptives-Biphasic

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
LOSEASONIQUE (g)	L-NORGEST-ETH ESTR/ETHIN ESTRA	[QL]
MIRCETTE (g)	DESOG-ET ESTRA/ETHIN ESTRA	
NECON 10/11 (g)	NORETHINDRONE-ETHINYL ESTRAD	
SEASONIQUE (g)	L-NORGEST-ETH ESTR/ETHIN ESTRA	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

5C. Contraceptives-Triphasic

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CYCLESSA (g)	DESOGESTREL-ETHINYL ESTRADIOL	
ESTROSTEP FE (g)	NORETH A-ET ESTRA/FE FUMARATE	
ORTHO TRI-CYCLEN (g)	NORGESTIMATE-ETHINYL ESTRADIOL	
ORTHO-NOVUM 7/7/7 (g)	NORETHINDRONE-ETHINYL ESTRAD	
TRI-NORINYL (g)	NORETHINDRONE-ETHINYL ESTRAD	
TRIPHASIL, TRILEVLEN (g)	LEVONORGESTREL-ETH ESTRA	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ORTHO TRI-CYCLEN LO	NORGESTIMATE-ETHINYL ESTRADIOL	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

5D. Contraceptives-Misc.

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ORTHO MICRONOR (g), NOR-QD (g)	NORETHINDRONE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ORTHO EVRA	ETHINYL ESTRADIOL/NORELGEST	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
BEYAZ	DROSPIR/ETH ESTRA/LEVOMEFOL CA	
NUVARING	ETONOGESTREL/ETHINYL ESTRADIOL	[QL]
SAFYRAL	DROSPIR/ETH ESTRA/LEVOMEFOL CA	

5E. Contraceptives-Postcoital

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
PLAN B (g)	LEVONORGESTREL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ELLA	ULIPRISTAL ACETATE	[QL]
PLAN B ONE-STEP	LEVONORGESTREL	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

5F. Progestins

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
AYGESTIN (g)	NORETHINDRONE ACETATE	
DEPO-PROVERA 150MG (g)	MEDROXYPROGESTERONE ACET	
PROGESTERONE IN OIL (INJ) (g)	PROGESTERONE	
PROVERA (g)	MEDROXYPROGESTERONE ACET	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CRINONE	PROGESTERONE,MICRONIZED	[PA]
DEPO-SUBQ PROVERA 104	MEDROXYPROGESTERONE ACET	
ENDOMETRIN	PROGESTERONE, MICRONIZED	[PA]
PROCHIEVE	PROGESTERONE,MICRONIZED	
PROMETRIUM	PROGESTERONE,MICRONIZED	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

5G. Estrogens

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLIMARA (g)	ESTRADIOL	[QL]
ESTRACE (g)	ESTRADIOL	
OGEN, ORTHO-EST (g)	ESTROPIPATE	
VIVELLE (g)	ESTRADIOL	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALORA	ESTRADIOL	[QL]
ENJUVA	ESTROGENS,CONJ.,SYNTHETIC B	[QL]
ESTRADERM	ESTRADIOL	[QL]
ESTRING	ESTRADIOL	[QL]
PREMARIN CREAM	ESTROGENS,CONJUGATED	
PREMARIN, PREMARIN LOW DOSE	ESTROGENS,CONJUGATED	
VAGIFEM	ESTRADIOL	[QL]
VIVELLE-DOT	ESTRADIOL	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
CENESTIN	ESTROGENS,CONJ.,SYNTHETIC A	
DIVIGEL	ESTRADIOL	[QL]
ELESTRIN	ESTRADIOL	[QL]
ESTRACE VAGINAL CREAM	ESTRADIOL	
ESTRASORB	ESTRADIOL	[QL]
ESTROGEL	ESTRADIOL	[QL]
EVAMIST	ESTRADIOL TRANSDERMAL SPRAY	[QL]
FEMRING	ESTRADIOL ACETATE	[QL]
FEMTRACE	ESTRADIOL ACETATE	
MENEST	ESTROGENS,ESTERIFIED	
MENOSTAR	ESTRADIOL	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

5H. Estrogen/Progestin Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACTIVELLA (g)	ESTRADIOL/NORETH AC	
ESTRATEST, H.S. (g)	ESTROGEN,ESTER/ME-TESTOSTERONE	
FEMHRT (g)	ETHINYL ESTRADIOL/NORETH AC	
Formulary Options		
Trade Name	Generic Name	Utilization Management
FEMHRT 0.5MG-2.5MCG	ETHINYL ESTRADIOL/NORETH AC	
PREMPRO, LOW DOSE/PREMPHASE	ESTROGEN,CON/M-PROGEST ACET	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ANGELIQ	ESTRADIOL/DROSPIRENONE	
CLIMARA PRO	ESTRADIOL/LEVONORGESTREL	[QL]
COMBIPATCH	ESTRADIOL/NORETH AC	[QL]
ORTHO-PREFEST	ESTRADIOL/NORGESTIMATE	

5J. Infertility Treatment

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLOMID (g)	CLOMIPHENE CITRATE	
LUPRON (g)	LEUPROLIDE ACETATE	<s>
Formulary Options		
Trade Name	Generic Name	Utilization Management
BRAVELLE	UROFOLLITROPIN (FSH)	[PA] <s>
CETROTIDE	CETRORELIX ACETATE	[PA] <s>
FERTINEX	UROFOLLITROPIN (FSH)	[PA] <s>
GANIRELIX ACETATE	GANIRELIX ACETATE	[PA] <s>
GONAL-F, RFF	FOLLITROPIN ALPHA,RECOMB	[PA] <s>
NOVAREL, PREGNYL, PROFASI	GONADOTROPIN,CHORIONIC,HUMAN	[PA] <s>
OVIDREL	HCG ALPHA,RECOMBINANT	[PA] <s>
REPRONEX	MENOTROPINS	[PA] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
FOLLISTIM AQ	FOLLITROPIN BETA,RECOMB	[PA] <s>
LUVERIS	LUTROPIN ALPHA	[PA] <s>
MENOPUR	MENOTROPINS	[PA] <s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

5K. Vaginal Anti-infective/Antifungal

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLEOCIN VAG CREAM (g)	CLINDAMYCIN PHOSPHATE	
DIFLUCAN (g)	FLUCONAZOLE	
METROGEL-VAGINAL (g)	METRONIDAZOLE	
NYSTATIN (g)	NYSTATIN	
TERAZOL- 3, 7 (g)	TERCONAZOLE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
AVC	SULFANILAMIDE	
CLEOCIN VAGINAL OVULES	CLINDAMYCIN PHOSPHATE	
CLINDESSE	CLINDAMYCIN PHOSPHATE	
GYNAZOLE-1	BUTOCONAZOLE NITRATE	

5L. Miscellaneous OB-GYN

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
METHERGINE (g)	METHYLERGONOVINE MALEATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
LUPRON DEPOT	LEUPROLIDE ACETATE	<S>
SYNAREL	NAFARELIN ACETATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
LYSTEDA	TRANEXAMIC ACID	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<S> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

6. RHEUMATOLOGY AND MUSCULOSKELETAL

6A. Salicylates

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
SALICYLATES AND NSAIDS	SEE CHAPTERS 3F & 3G	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

6B. Gout Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
COLBENEMID (g)	COLCHICINE/PROBENECID	
PROBENECID (g)	PROBENECID	
ZYLOPRIM (g)	ALLOPURINOL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
COLCRYS	COLCHICINE	
ULORIC	FEBUXOSTAT	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

6C. Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CORTICOSTEROIDS	SEE CHAPTER 7C	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

6D. Miscellaneous Rheumatologic Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ARAVA (g)	LEFLUNOMIDE	[QL]
AZULFIDINE, EN-TAB (g)	SULFASALAZINE	
IMURAN (g)	AZATHIOPRINE	
METHOTREXATE (g)	METHOTREXATE SODIUM	
PLAQUENIL (g)	HYDROXYCHLOROQUINE SULFATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CUPRIMINE	PENICILLAMINE	[QL]
ENBREL	ETANERCEPT	[PA] [QL] <s>
HUMIRA	ADALIMUMAB	[PA] [QL] <s>
RHEUMATREX, TREXALL	METHOTREXATE SODIUM	
RIDAURA	AURANOFIN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
CIMZIA SYRINGE	CERTOLIZUMAB	[PA] [QL] <s>
DEPEN	PENICILLAMINE	
KINERET	ANAKINRA	[PA] [QL] <s>
ORENCIA SC	ABATACEPT	[PA] [QL] <s>
SIMPONI	GOLIMUMAB	[PA] [QL] <s>

6E. Osteoporosis/Hormonal Treatment

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLIMARA (g)	ESTRADIOL	[QL]
ESTRACE (g)	ESTRADIOL	
ESTRATEST, H.S. (g)	ESTROGEN,ESTER/ME-TESTOSTERONE	
FEMHRT (g)	ETHINYL ESTRADIOL/NORETH AC	
OGEN, ORTHO-EST (g)	ESTROPIPATE	
VIVELLE (g)	ESTRADIOL	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALORA	ESTRADIOL	[QL]
ENJUVA	ESTROGENS,CONJ.,SYNTHETIC B	[QL]
ESTRADERM	ESTRADIOL	[QL]
FEMHRT 0.5MG-2.5MCG	ETHINYL ESTRADIOL/NORETH AC	
PREMARIN CREAM	ESTROGENS,CONJUGATED	
PREMARIN, PREMARIN LOW DOSE	ESTROGENS,CONJUGATED	
PREMPRO, LOW DOSE/PREMPHASE	ESTROGEN,CON/M-PROGEST ACET	
VIVELLE-DOT	ESTRADIOL	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
CENESTIN	ESTROGENS,CONJ.,SYNTHETIC A	
FORTEO	TERIPARATIDE	[PA] [QL] <s>
MENEST	ESTROGENS,ESTERIFIED	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

6F. Osteoporosis/Bone Resorption

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DIDRONEL (g)	ETIDRONATE DISODIUM	[QL]
ESTROGENS	FIRST-LINE THERAPY WHEN APPROPRIATE	
FOSAMAX, WEEKLY (g)	ALENDRONATE SODIUM	[QL] BE
MIACALCIN NASAL SPRAY (g)	CALCITONIN,SALMON,SYNTHETIC	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ACTONEL WITH CALCIUM	RISEDRON SOD/CALCIUM CARBONATE	[ST] [QL]
ACTONEL, WEEKLY, 150MG	RISEDRONATE SODIUM	[ST] [QL]
EVISTA	RALOXIFENE HCL	
MIACALCIN INJECTION	CALCITONIN,SALMON,SYNTHETIC	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ATELVIA	RISEDRONATE SODIUM	[PA] [QL]
BONIVA	IBANDRONATE SODIUM	[ST] [QL]
FOSAMAX PLUS D	ALENDRONATE SODIUM/VITAMIN D3	[ST] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

7. ENDOCRINOLOGY

7A. Antithyroid Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
PROPYLTHIOURACIL (g)	PROPYLTHIOURACIL	
SSKI (g)	POTASSIUM IODIDE	
TAPAZOLE (g)	METHIMAZOLE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

7B. Thyroid Hormones

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CYTOMEL (g)	LIOthyRONINE SODIUM	
SYNTHROID (g)	LEVOTHYROXINE SODIUM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
THYROLAR	LIOTRIX	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ARMOUR THYROID	THYROID	
TIROSINT	LEVOTHYROXINE SODIUM	

7C. Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CORTEF, HYDROCORTISONE (g)	HYDROCORTISONE	
CORTISONE ACETATE (g)	CORTISONE ACETATE	
DECADRON (g)	DEXAMETHASONE	
ENTOCORT EC (g)	BUDESONIDE	
FLORINEF (g)	FLUDROCORTISONE ACETATE	
MEDROL, DOSEPAK (g)	METHYLPREDNISOLONE	
ORAPRED (g)	PREDNISOLONE SOD PHOSPHATE	
PREDNISOLONE, TABS, SYRUP (g)	PREDNISOLONE	
PREDNISON (g)	PREDNISON	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ORAPRED ODT	PREDNISOLONE SOD PHOSPHATE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

7D. Androgens

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ANDROXY 10MG (g)	FLUOXYMESTERONE	
DANOCRINE (g)	DANAZOL	
DELATESTRYL (g)	TESTOSTERONE ENANTHATE	
DEPO-TESTOSTERONE (g)	TESTOSTERONE CYPIONATE	
OXANDRIN (g)	OXANDROLONE	[PA]
Formulary Options		
Trade Name	Generic Name	Utilization Management
ANDRODERM	TESTOSTERONE	[QL]
ANDROGEL	TESTOSTERONE	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
ANADROL-50	OXYMETHOLONE	
AXIRON	TESTOSTERONE	[PA] [QL]
FORTESTA	TESTOSTERONE	[PA] [QL]
METHITEST	METHYLTESTOSTERONE	
STRIANT	TESTOSTERONE	[PA] [QL]
TESTIM	TESTOSTERONE	[PA] [QL]
TESTRED, ANDROID	METHYLTESTOSTERONE	[PA]

7E. Miscellaneous Endocrine

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CALCIFEROL (g)	ERGOCALCIFEROL	
DDAVP TABS, SPRAY (g)	DESMOPRESSIN ACETATE	
DOSTINEX (g)	CABERGOLINE	
MIACALCIN NASAL SPRAY (g)	CALCITONIN,SALMON,SYNTHETIC	
PROSCAR (g)	FINASTERIDE	
ROCALTROL (g)	CALCITRIOL	
SANDOSTATIN (g)	OCTREOTIDE ACETATE	[PA] <s>
Formulary Options		
Trade Name	Generic Name	Utilization Management
GLUCAGON EMERGENCY KIT	GLUCAGON,HUMAN RECOMBINANT	
LUPRON DEPOT-PED	LEUPROLIDE ACETATE	<s>
MIACALCIN INJECTION	CALCITONIN,SALMON,SYNTHETIC	
SANDOSTATIN LAR	OCTREOTIDE ACETATE	[PA] <s>
SENSIPAR	CINACALCET HCL	<s>
SOMATULINE DEPOT	LANREOTIDE ACETATE	<s>
SOMAVERT	PEGVISOMANT	[PA] <s>
STIMATE	DESMOPRESSIN ACETATE	
SYNAREL	NAFARELIN ACETATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
EGRIFTA	TESAMORELIN ACETATE	[PA] [QL] <s>
HECTOROL	DOXERCALCIFEROL	
ZEMPLAR	PARICALCITOL	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

7F. Insulins

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
APIDRA (PEN/CARTRIDGE)	INSULIN GLULISINE	
APIDRA (VIAL)	INSULIN GLULISINE	
HUMALOG, MIX (PEN/CARTRIDGE)	INSULIN LISPRO,HUMAN REC.ANLOG	
HUMALOG, MIX (VIAL)	INSULIN NPL/INSULIN LISPRO	BE
HUMULIN 70/30 (PEN/CARTRIDGE)	HUMULIN	
HUMULIN 70/30 (VIAL)	HUMULIN	BE
HUMULIN N (PEN/CARTRIDGE)	NPH, HUMAN INSULIN ISOPHANE	
HUMULIN N (VIAL)	NPH, HUMAN INSULIN ISOPHANE	BE
HUMULIN R (VIAL)	INSULIN REGULAR HUMAN REC	BE
LANTUS (PEN/CARTRIDGE)	INSULIN GLARGINE,HUM.REC.ANLOG	
LANTUS (VIAL)	INSULIN GLARGINE,HUM.REC.ANLOG	
LEVEMIR (PEN)	INSULIN DETEMIR	
LEVEMIR (VIAL)	INSULIN DETEMIR	
NOVOLIN (PEN/CARTRIDGE)	INSULIN REGULAR HUMAN REC	
NOVOLIN (VIAL)	INSULIN REGULAR HUMAN REC	BE
NOVOLOG (PEN/CARTRIDGE)	INSULIN ASPART	
NOVOLOG (VIAL)	INSULIN ASPART	BE
NOVOLOG MIX (PEN/CARTRIDGE)	INSULN ASP PRT/INSULIN ASPART	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

7G. Non-insulin Hypoglycemic Agents

Formulary Preferred

Trade Name	Generic Name	Utilization Management
AMARYL (g)	GLIMEPIRIDE	BE
DIABETA, MICRONASE (g)	GLYBURIDE	BE
DIABINESE (g)	CHLORPROPAMIDE	BE
FORTAMET (g)	METFORMIN HCL	
GLUCOPHAGE, XR (g)	METFORMIN HCL	BE
GLUCOTROL, XL (g)	GLIPIZIDE	BE
GLUCOVANCE (g)	GLYBURIDE/METFORMIN HCL	BE
GLYNASE (g)	GLYBURIDE, MICRONIZED	BE
METAGLIP (g)	GLIPIZIDE/METFORMIN HCL	BE
ORINASE (g)	TOLBUTAMIDE	
PRECOSE (g)	ACARBOSE	
STARLIX (g)	NATEGLINIDE	
TOLINASE (g)	TOLAZAMIDE	

Formulary Options

Trade Name	Generic Name	Utilization Management
ACTOPLUS MET	PIOGLITAZONE HCL/METFORMIN HCL	[ST] [QL]
ACTOS	PIOGLITAZONE HCL	[ST] [QL]
DUETACT	PIOGLITAZONE/GLIMEPIRIDE	[ST] [QL]
JANUMET (TIER 3 - BCN ONLY)	SITAGLIPTIN PHOS/METFORMIN HCL	[PA] [QL]
JANUVIA (TIER 3 - BCN ONLY)	SITAGLIPTIN PHOSPHATE	[PA] [QL]
PRANDIN	REPAGLINIDE	

Nonformulary

Trade Name	Generic Name	Utilization Management
ACTOPLUS MET XR	PIOGLITAZONE HCL/METFORMIN HCL	[ST] [QL]
AVANDAMET	ROSIGLITAZONE/METFORMIN HCL	[ST] [QL]
AVANDARYL	ROSIGLITAZONE MALEATE/GLIMEPIR	[ST]
AVANDIA	ROSIGLITAZONE MALEATE	[ST] [QL]
BYETTA	EXENATIDE	[PA] [QL]
CYCLOSET	BROMOCRIPTINE MESYLATE	[PA] [QL]
GLUMETZA	METFORMIN HCL	
GLYSET	MIGLITOL	
KOMBIGLIYZE XR	SAXAGLIPTIN HCL/METFORMIN HCL	[ST] [QL]
ONGLYZA	SAXAGLIPTIN HYDROCHLORIDE	[PA] [QL]
PRANDIMET	REPAGLINIDE/METFORMIN HCL	[PA]
RIOMET	METFORMIN HCL	
SYMLIN	PRAMLINTIDE ACETATE	[ST] [QL]
TRADJENTA	LINAGLIPTIN	[PA] [QL]
VICTOZA	LIRAGLUTIDE	[PA] [QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

7H. Growth Hormone and Related Products

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
GENOTROPIN	SOMATROPIN	[PA] <s>
NUTROPIN	SOMATROPIN	[PA] <s>
NUTROPIN AQ	SOMATROPIN	[PA] <s>
NUTROPIN AQ NUSPIN	SOMATROPIN	[PA] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
HUMATROPE	SOMATROPIN	[PA] <s>
INCRELEX	MECASERMIN	[PA] <s>
NORDITROPIN (ALL)	SOMATROPIN	[PA] <s>
OMNITROPE	SOMATROPIN	[PA] <s>
SAIZEN	SOMATROPIN	[PA] <s>
SEROSTIM	SOMATROPIN	[PA] <s>
TEV-TROPIN	SOMATROPIN	[PA] <s>
ZORBTIVE	SOMATROPIN	[PA] <s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

8. ANTINEOPLASTICS AND IMMUNOSUPPRESSANTS

8A. Alkylating Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CYTOXAN (g)	CYCLOPHOSPHAMIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALKERAN	MELPHALAN	
CEENU	LOMUSTINE	
LEUKERAN	CHLORAMBUCIL	
MYLERAN	BUSULFAN	
TEMODAR	TEMOZOLOMIDE	<s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

8B. Antimetabolites

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
METHOTREXATE TABS (g)	METHOTREXATE SODIUM	
PURINETHOL (g)	MERCAPTOPYRINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
OFORTA	FLUDARABINE PHOSPHATE	[QL] <s>
THIOGUANINE	THIOGUANINE	
XELODA	CAPECITABINE	<s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

8C. Immunomodulators

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CELLCEPT (g)	MYCOPHENOLATE MOFETIL	<s>
GENGRAF, NEORAL (g)	CYCLOSPORINE, MODIFIED	<s>
IMURAN (g)	AZATHIOPRINE	
PREDNISONE (g)	PREDNISONE	
PROGRAF (g)	TACROLIMUS ANHYDROUS	<s>
Formulary Options		
Trade Name	Generic Name	Utilization Management
ARCALYST	RILONACEPT	[PA] <s>
CELLCEPT SUSPENSION	MYCOPHENOLATE MOFETIL	<s>
RAPAMUNE TABS, SOLUTION	SIROLIMUS	<s>
SANDIMMUNE	CYCLOSPORINE	<s>
THALOMID	THALIDOMIDE	<s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
MYFORTIC	MYCOPHENOLATE SODIUM	<s>
REVLIMID	LENALIDOMIDE	[PA] [QL] <s>

8D. Hormonal Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ARIMIDEX (g)	ANASTROZOLE	[PA]
AROMASIN (g)	EXEMESTANE	[PA]
CASODEX (g)	BICALUTAMIDE	
EULEXIN (g)	FLUTAMIDE	
FEMARA (g)	LETROZOLE	[PA]
LUPRON (g)	LEUPROLIDE ACETATE	<s>
MEGACE (g)	MEGESTROL ACETATE	
TAMOXIFEN CITRATE (g)	TAMOXIFEN CITRATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DEPO-PROVERA 400MG	MEDROXYPROGESTERONE ACET	
FARESTON	TOREMIFENE CITRATE	
LUPRON DEPOT	LEUPROLIDE ACETATE	<s>
NILANDRON	NILUTAMIDE	
TRELSTAR DEPOT, LA	TRIPTORELIN PAMOATE	<s>
ZOLADEX	GOSERELIN ACETATE	[QL] <s>
ZYTIGA (TIER 3 - BCN ONLY)	ABIRATERONE ACETATE	[PA] [QL] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
ELIGARD	LEUPROLIDE ACETATE	<s>
FASLODEX	FULVESTRANT	
MEGACE ES	MEGESTROL ACETATE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

8E. Miscellaneous Antineoplastic Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
HYDREA (g)	HYDROXYUREA	
SANDOSTATIN (g)	OCTREOTIDE ACETATE	[PA] <s>
VEPESID (g)	ETOPOSIDE	
VESANOID (g)	TRETINOIN	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DROXIA	HYDROXYUREA	
EMCYT	ESTRAMUSTINE PHOSPHATE SODIUM	
HEXALEN	ALTRETAMINE	
HYCANTIN	TOPOTECAN HCL	[PA] <s>
LYSODREN	MITOTANE	
MATULANE	PROCARBAZINE HCL	
SANDOSTATIN LAR	OCTREOTIDE ACETATE	[PA] <s>
ZOLINZA	VORINOSTAT	[PA] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
SYLATRON	PEGINTERFERON ALFA-2B	[PA] <s>
TARGRETIN ORAL	BEXAROTENE	<s>

8F. Adjuvant Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
LEUCOVORIN (g)	LEUCOVORIN CALCIUM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
LEUKINE	SARGRAMOSTIM	<s>
MESNEX TABS	MESNA	
NEUPOGEN	FILGRASTIM	<s>
PROCRIT	EPOETIN ALFA	[PA] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
ARANESP	DARBEPOETIN ALFA IN ALBUMN SOL	[PA] <s>
EPOGEN	EPOETIN ALFA	[PA] <s>
NEULASTA	PEGFILGRASTIM	[QL] <s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

8G. Kinase Inhibitors and Molecular Target Inhibitors

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
AFINITOR	EVEROLIMUS	[PA] [QL] <s>
CAPRELSA	VANDETANIB	[PA] [QL] <s>
GLEEVEC	IMATINIB MESYLATE	<s>
IRESSA	GEFITINIB	[PA] <s>
NEXAVAR	SORAFENIB TOSYLATE	[PA] [QL] <s>
SPRYCEL	DASATINIB	[PA] [QL] <s>
SUTENT	SUNITINIB MALATE	[PA] [QL] <s>
TARCEVA	ERLOTINIB HCL	[PA] <s>
TASIGNA	NILOTINIB HYDROCHLORIDE	[PA] <s>
TYKERB	LAPATINIB DITOSYLATE	[PA] <s>
VOTRIENT	PAZOPANIB HYDROCHLORIDE	[PA] <s>
XALKORI	RIVAROXABAN	[PA] [QL] <s>
ZELBORAF	VEMURAFENIB	[PA] [QL] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
ZORTRESS	EVEROLIMUS	[QL] <s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

9. IMMUNOLOGY AND HEMATOLOGY

9B. Hematopoietic Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
LEUKINE	SARGRAMOSTIM	<s>
NEUMEGA	OPRELVEKIN	<s>
NEUPOGEN	FILGRASTIM	<s>
PROCRIT	EPOETIN ALFA	[PA] <s>
PROMACTA	ELTROMBOPAG OLAMINE	[PA] [QL] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
ARANESP	DARBEPOETIN ALFA IN ALBUMN SOL	[PA] <s>
EPOGEN	EPOETIN ALFA	[PA] <s>
NEULASTA	PEGFILGRASTIM	[QL] <s>

9C. Interferons and MS Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
REBETOL (g)	RIBAVIRIN	[PA] <s>
Formulary Options		
Trade Name	Generic Name	Utilization Management
ACTIMMUNE	INTERFERON GAMMA-1B,RECOMB.	<s>
ALFERON N	INTERFERON ALFA-N3	
AVONEX	INTERFERON BETA-1A	<s>
COPAXONE	GLATIRAMER ACETATE	<s>
INFERGEN	INTERFERON ALFACON-1	[PA] <s>
INTRON A	INTERFERON ALFA-2B,RECOMB.	[PA] <s>
PEGASYS	PEGINTERFERON ALFA-2A	[PA] [QL] <s>
PEG-INTRON, REDIPEN	PEGINTERFERON ALFA-2B	[PA] [QL] <s>
REBIF	INTERFERON BETA-1A/ALBUMIN	<s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
AMPYRA	FAMPRIDINE (4-AMINOPYRIDINE)	[PA] [QL] <s>
BETASERON	INTERFERON BETA-1B	[PA] <s>
EXTAVIA	INTERFERON BETA-1B	<s>
GILENYA	FINGOLIMOD HYDROCHLORIDE	[PA] [QL] <s>

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10. DERMATOLOGY

10A. Very High Potency Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DIPROLENE OINTMENT (g)	BETAMET DIPROP/PROP GLY	
OLUX (g)	CLOBETASOL PROPIONATE	
PSORCON, FLORONE (g)	DIFLORASONE DIACETATE	
TEMOVATE (g), CLOBEVATE (g)	CLOBETASOL PROPIONATE	
ULTRAVATE (g)	HALOBETASOL PROPIONATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
CLOBEX, SPRAY	CLOBETASOL PROPIONATE	
OLUX-E	CLOBETASOL PROPIONATE/EMOLL	
VANOS 0.1% CR	FLUOCINONIDE	

10B. High Potency Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ARISTOCORT, KENALOG 0.5% CR (g)	TRIAMCINOLONE ACETONIDE	
CYCLOCORT (g)	AMCINONIDE	
DIPROLENE AF, GEL, CR, LOT (g)	BETAMET DIPROP/PROP GLY	
DIPROSONE (g), MAXIVATE (g)	BETAMETHASONE DIPROPIONATE	
LIDEX, E (g)	FLUOCINONIDE	
PSORCON, FLORONE (g)	DIFLORASONE DIACETATE	
TOPICORT CR, GEL, OINT (g)	DESOXIMETASONE	
VALISONE CR, LOTION, OINT (g)	BETAMETHASONE VALERATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
APEXICON E	DIFLORASONE DIACETATE/EMOLL	
HALOG	HALCINONIDE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10C. Medium Potency Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ARISTOCORT, KENALOG (g)	TRIAMCINOLONE ACETONIDE	
CUTIVATE (g)	FLUTICASONE PROPIONATE	
DERMATOP (g)	PREDNICARBATE	
ELOCON (g)	MOMETASONE FUROATE	
LOCOID CR, OINT, SOLN (g)	HYDROCORTISONE BUTYRATE	
LOCOID LIPOCREAM (g)	HYDROCORTISONE BUTYRATE/EMOLL	
SYNALAR 0.025% CREAM, OINT (g)	FLUOCINOLONE ACETONIDE	
TOPICORT LP (g)	DESOXIMETASONE	
VALISONE CR, LOTION, OINT (g)	BETAMETHASONE VALERATE	
WESTCORT (g)	HYDROCORTISONE VALERATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CLODERM	CLOCORTOLONE PIVALATE	
CORDRAN, TAPE, SP	FLURANDRENOLIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
CUTIVATE LOTION	FLUTICASONE PROPIONATE	
LOCOID LOTION	HYDROCORTISONE BUTYRATE	
LUXIQ	BETAMETHASONE VALERATE	
PANDEL	HYDROCORTISONE PROBUTATE	

10D. Low Potency Corticosteroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACLOVATE (g)	ALCLOMETASONE DIPROPIONATE	
DERMACORT, HYTONE (Rx Only) (g)	HYDROCORTISONE	
DERMA-SMOOTHIE/FS (g)	FLUOCINOLONE ACETONIDE	
DESOWEN, TRIDESILON (g)	DESONIDE	
SYNALAR CREAM, SOLN (g)	FLUOCINOLONE ACETONIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CAPEX SHAMPOO	FLUOCINOLONE ACETONIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
DESONATE	DESONIDE	[ST]
VERDESO	DESONIDE	[ST]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10E. Topical Anesthetics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
EMLA (g)	LIDOCAINE/PRILOCAINE	
XYLOCAINE (Rx Only) (g)	LIDOCAINE HCL	
XYLOCAINE VISCOUS (g)	LIDOCAINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
LIDODERM PATCH	LIDOCAINE	

10F. Acne Treatment

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACUTANE (g)	ISOTRETINOIN	(REQ DERM CONSULT)
BENZAMYCIN (g)	ERYTHROMYCIN BASE/BENZ PER	
BENZOYL PEROXIDE-RX (g)	BENZOYL PEROXIDE	
BREVOXYL GEL (g)	BENZOYL PEROXIDE	
CLEOCIN T (g)	CLINDAMYCIN PHOSPHATE	
DIFFERIN 0.1% CREAM, GEL (g)	ADAPALENE	
ERYTHROMYCIN TOPICAL SOLN, GEL (g)	ERYTHROMYCIN BASE/ETHANOL	
EVOCLIN FOAM (g)	CLINDAMYCIN PHOSPHATE	
METROCREAM, GEL, LOTION (g)	METRONIDAZOLE	
PLEXION, TS (g)	SULFACETAMIDE SODIUM/SULFUR	
RETIN-A, AVITA (g)	TRETINOIN	
ROSULA CLEANSER (g)	SULFACETAMIDE SOD/SULFUR/UREA	
SULFACET-R (g)	SULFACETAMIDE SODIUM/SULFUR	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DIFFERIN 0.3% GEL	ADAPALENE	
METROGEL TOPICAL 1%	METRONIDAZOLE	
RETIN-A MICRO	TRETINOIN MICROSPHERES	
TAZORAC	TAZAROTENE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ACANYA	CLINDAMYCIN PHOS/BENZOYL PEROX	
ACZONE	DAPSONE	[QL]
AKNE-MYCIN	ERYTHROMYCIN BASE	
ALTABAX	RETAPAMULIN	
AZELEX	AZELAIC ACID	
BENZAACLIN	CLINDAMYCIN PHOSPHATE/BENZ PER	
CLINAC BPO	BENZOYL PEROXIDE	
DIFFERIN 0.1% LOTION	ADAPALENE	
DUAC, CS	CLINDAMYCIN PHOSPHATE/BENZ PER	
EPIDUO	ADAPALENE/BENZOYL PEROXIDE	
FINACEA	AZELAIC ACID	
NORITATE	METRONIDAZOLE	
ROSULA FOAM	SULFACETAMIDE SODIUM/SULFUR	
ZIANA GEL	CLINDAMYCIN/TRETINOIN	[PA]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10G. Topical Antibacterials

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BACTROBAN OINTMENT (g)	MUPIROICIN	
GENTAMICIN CR, OINT (g)	GENTAMICIN SULFATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
BACTROBAN CREAM, NASAL	MUPIROICIN CALCIUM	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ALTABAX	RETAPAMULIN	

10H. Topical Antifungals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
LOPROX CR, LOTION(g)	CICLOPIROX OLAMINE	
LOPROX GEL, SHAMPOO (g)	CICLOPIROX	
LOTRIMIN (g)	CLOTRIMAZOLE	
LOTRISONE CR, LOTION (g)	CLOTRIMAZOLE/BETAMET DIPROP	
MONISTAT-DERM (g)	MICONAZOLE NITRATE	
MYCOSTATIN (g)	NYSTATIN	
NIZORAL CR, SHAMPOO 2% (g)	KETOCONAZOLE	
NYSTATIN W/TRIAMCINOLONE (g)	NYSTATIN/TRIAMCIN	
PENLAC (g)	CICLOPIROX	
SPECTAZOLE (g)	ECONAZOLE NITRATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ERTACZO	SERTACONAZOLE NITRATE	
EXELDERM SOLN, CR	SULCONAZOLE NITRATE	
EXTINA	KETOCONAZOLE	
MENTAX	BUTENAFINE HCL	
NAFTIN	NAFTIFINE HCL	
OXISTAT	OXICONAZOLE NITRATE	
VUSION	MICONAZOLE NITRATE/ZINC OXIDE	
XOLEGEL	KETOCONAZOLE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10I. Topical Antivirals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
ZOVIRAX CREAM, OINT	ACYCLOVIR	
Nonformulary		
Trade Name	Generic Name	Utilization Management
DENAVIR	PENCICLOVIR	
XERESE	ACYCLOVIR/HYDROCORTISONE	

10J. Wound and Burn Therapy

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACCUZYME, ETHEZYME, GLADASE (g)	PAPAIN/UREA	
GRANULEX (g)	TRYPSIN/BALSAM PERU/CASTOR OIL	
SILVADENE (g)	SILVER SULFADIAZINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
SANTYL	COLLAGENASE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
REGRANEX	BECAPLERMIN	[PA]

10K. Antipsoriatic/Antiseborrheic

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DOVONEX OINT, SOLUTION (g)	CALCIPOTRIENE	
DRITHOCREME HP (g)	ANTHRALIN	
SELSUN RX (g)	SELENIUM SULFIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DOVONEX CREAM	CALCIPOTRIENE	
DRITHO-SCALP	ANTHRALIN	
ENBREL	ETANERCEPT	[PA] [QL] <s>
HUMIRA	ADALIMUMAB	[PA] [QL] <s>
OXSORALEN, ULTRA	METHOXSALEN, RAPID	
SORIATANE	ACITRETIN	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
TACLONEX, SCALP	BETAMET DIPROP/CALCIPOTRIENE	[PA]
VECTICAL	CALCITRIOL	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

10L. Scabicides/Pediculicides

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ELIMITE (g)	PERMETHRIN	
LINDANE (g)	LINDANE	
OVIDE (g)	MALATHION	
Formulary Options		
Trade Name	Generic Name	Utilization Management
EURAX	CROTAMITON	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NATROBA	SPINOSAD	[QL]

10M. Miscellaneous Dermatologicals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALDARA (g)	IMIQUIMOD	[QL]
CONDYLOX SOLN (g)	PODOFILOX	
DRYSOL (g)	ALUMINUM CHLORIDE	
EFUDEX (g)	FLUOROURACIL	
ZONALON (g)	DOXEPIN HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CONDYLOX GEL	PODOFILOX	
ELIDEL	PIMECROLIMUS	[PA]
PANRETIN	ALITRETINOIN	
Nonformulary		
Trade Name	Generic Name	Utilization Management
CARAC	FLUOROURACIL	
CARMOL HC	HYDROCORTISONE ACETATE/UREA	
EFUDEX OCCLUSION	FLUOROURACIL/ADHESIVE BANDAGE	
PROTOPIC	TACROLIMUS	[ST]
SOLARAZE	DICLOFENAC SODIUM	
TARGRETIN GEL	BEXAROTENE	<s>
VEREGEN	SINECATECHINS	
ZYCLARA	IMIQUIMOD	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

11. OPHTHALMOLOGY

11A. Ophthalmic Beta Blockers

Formulary Preferred

Trade Name	Generic Name	Utilization Management
BETAGAN (g)	LEVOBUNOLOL HCL	
BETOPTIC SOLN (g)	BETAXOLOL HCL	
OCUPRESS (g)	CARTEOLOL HCL	
OPTIPRANOLOL (g)	METIPRANOLOL	
TIMOPTIC - XE (g)	TIMOLOL MALEATE	
TIMOPTIC (g)	TIMOLOL MALEATE	

Formulary Options

Trade Name	Generic Name	Utilization Management
BETOPTIC S	BETAXOLOL HCL	

Nonformulary

Trade Name	Generic Name	Utilization Management
BETIMOL	TIMOLOL	
ISTALOL	TIMOLOL MALEATE	

11B. Other Glaucoma Agents

Formulary Preferred

Trade Name	Generic Name	Utilization Management
ALPHAGAN, P 0.15% (g)	BRIMONIDINE TARTRATE	
COSOPT (g)	TIMOLOL MALEATE/DORZOLAM HCL	
IOPIDINE DROPS (g)	APRACLONIDINE HCL	
PILOCAR, ISOPTO-CARPINE (g)	PILOCARPINE HCL	
TRUSOPT (g)	DORZOLAMIDE HCL	
XALATAN (g)	LATANOPROST	

Formulary Options

Trade Name	Generic Name	Utilization Management
ALPHAGAN P 0.1%	BRIMONIDINE TARTRATE	
AZOPT	BRINZOLAMIDE	
ISOPTO CARBACHOL	CARBACHOL	
LUMIGAN	BIMATOPROST	
PHOSPHOLINE IODIDE	ECHOTHIOPHATE IODIDE	
PILOPINE HS	PILOCARPINE HCL	
TRAVATAN Z	TRAVOPROST	

Nonformulary

Trade Name	Generic Name	Utilization Management
COMBIGAN	BRIMONIDINE TARTRATE/TIMOLOL	
IOPIDINE DROPERETTE	APRACLONIDINE HCL	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

11C. Cycloplegic Mydriatics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CYCLOGYL (g)	CYCLOPENTOLATE HCL	
ISOPTO ATROPINE (g)	ATROPINE SULFATE	
ISOPTO HOMATROPINE (g)	HOMATROPINE HBR	
MYDRIACYL (g)	TROPICAMIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ISOPTO HYOSCINE	SCOPOLAMINE HYDROBROMIDE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
PAREMYD	HYDROXYAMPHETAMINE/TROPICAMIDE	

11D. Ophthalmic Anti-inflammatory Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACULAR, LS (g)	KETOROLAC TROMETHAMINE	
OCUFEN (g)	FLURBIPROFEN SODIUM	
VOLTAREN (g)	DICLOFENAC SODIUM	
XIBROM (g)	BROMFENAC SODIUM	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
ACUVAIL	KETOROLAC TROMETHAMINE	
BROMDAY	BROMFENAC SODIUM	
NEVANAC	NEPAFENAC	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

11E. Ophthalmic Anti-infectives

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BACITRACIN (g)	BACITRACIN	
BLEPH-10, SODIUM SULAMYDE (g)	SULFACETAMIDE SODIUM	
CILOXAN DROPS (g)	CIPROFLOXACIN HCL	
GARAMYCIN (g)	GENTAMICIN SULFATE	
ILOTYCIN (g)	ERYTHROMYCIN BASE	
NEOSPORIN OPHTH SOLN (g)	NEOMYCIN/GRAMICIDIN/POLYMYXIN B	
NEOSPORIN OPTH OINT (g)	NEOMY SULF/BACITRA/POLYMYXIN B	
OCUFLOX (g)	OFLOXACIN	
POLYSPORIN (g)	BACITRACIN/POLYMYXIN B SULFATE	
POLYTRIM (g)	POLYMYXIN B SULFATE/TMP	
QUIXIN (g)	LEVOFLOXACIN	
TOBREX (g)	TOBRAMYCIN SULFATE	
VIROPTIC (g)	TRIFLURIDINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CILOXAN OINT	CIPROFLOXACIN HCL	
MOXEZA	MOXIFLOXACIN HCL	
NATACYN	NATAMYCIN	
VIGAMOX	MOXIFLOXACIN HCL	
ZIRGAN	GANCICLOVIR	
Nonformulary		
Trade Name	Generic Name	Utilization Management
AZASITE	AZITHROMYCIN	
BESIVANCE	BESIFLOXACIN HYDROCHLORIDE	
IQUIX	IQUIX	
ZYMAXID	GATIFLOXACIN	

11F. Ophthalmic Steroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
DECADRON OPTH (g)	DEXAMETHASONE SOD PHOSPHATE	
FML (g)	FLUOROMETHOLONE	
INFLAMASE, FORTE (g)	PREDNISOLONE SOD PHOSPHATE	
PRED FORTE (g)	PREDNISOLONE ACETATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
FML FORTE, S.O.P.	FLUOROMETHOLONE	
PRED MILD	PREDNISOLONE ACETATE	
VEXOL	RIMEXOLONE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ALREX	LOTEPREDNOL ETABONATE	
DUREZOL	DIFLUPREDNATE	
LOTEMAX	LOTEPREDNOL ETABONATE	
MAXIDEX	DEXAMETHASONE	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

11G. Ophthalmic Anti-infective/Steroid Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CORTISPORIN (g)	NEOMY SULF/POLYMYX B SULF/HC	
MAXITROL (g)	NEO/POLYMYX B SULF/DEXAMETH	
TOBRADEX SUSP (g)	TOBRAMYCIN SULFATE/DEXAMETH	
VASOCIDIN (g)	NA SULFACETM/PREDNIS SP	
Formulary Options		
Trade Name	Generic Name	Utilization Management
BLEPHAMIDE DROPS, OINT	NA SULFACETM/PREDNISOL AC	
POLY-PRED	NEOMY SULF/POLYMYX B SULF/PRED	
TOBRADEX OINT	TOBRAMYCIN SULFATE/DEXAMETH	
Nonformulary		
Trade Name	Generic Name	Utilization Management
PRED-G	GENTAMICIN/PREDNISOL AC	
ZYLET	TOBRAMYCIN/LOTEPRED ETAB	

11H. Miscellaneous Ophthalmic Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALBALON (g)	NAPHAZOLINE HCL	
ELESTAT (g)	EPINASTINE HCL	
NEO-SYNEPHRINE (g)	PHENYLEPHRINE HCL	
OPTICROM (g)	CROMOLYN SODIUM	
OPTIVAR (g)	AZELASTINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALOCRIIL	NEDOCROMIL SODIUM	
ALOMIDE	LODOXAMIDE TROMETHAMINE	
LACRISERT	HYDROXYPROPYL CELLULOSE	
PATANOL	OLOPATADINE HCL	
RESTASIS	CYCLOSPORINE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ALAMAST	PEMIROLAST POTASSIUM	
BEPREVE	BEPOTASTINE BESILATE	
EMADINE	EMEDASTINE DIFUMARATE	
LASTACFT	ALCAFTADINE	
PATADAY	OLOPATADINE HCL	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

12. OTIC & NASAL PREPARATIONS

12A. Nasal Preparations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ASTELIN NASAL SPRAY (g)	AZELASTINE HCL	[QL]
ATROVENT NASAL SPRAY (g)	IPRATROPIUM BROMIDE	[QL]
FLONASE (g)	FLUTICASONE PROPIONATE	[QL]
NASACORT AQ (g)	TRIAMCINOLONE ACETONIDE	[ST] [QL]
NASALIDE (g)	FLUNISOLIDE 0.025% SPRAY	[QL]
NASAREL (g)	FLUNISOLIDE	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
ASTEPRO NASAL SPRAY	AZELASTINE HCL	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
BECONASE AQ	BECLOMETHASONE DIPROPIONATE	[ST] [QL]
NASONEX	MOMETASONE FUROATE	[ST] [QL]
OMNARIS	CICLESONIDE	[ST] [QL]
PATANASE	OLOPATADINE HCL	[QL]
RHINOCORT AQUA	BUDESONIDE	[ST] [QL]
VERAMYST	FLUTICASONE FUROATE	[ST] [QL]

12B. Otic Preparations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACETASOL, HC/VOSOL, HC (g)	ACETIC ACID/HYDROCORTISONE	
AURALGAN (g)	AA/ANTPY/BCAINE/POLICO/AL ACET	
CORTISPORIN (g)	NEOMY SULF/POLYMYX B SULF/HC	
DOMEBORO OTIC (g)	ACETIC ACID/ALUMINUM ACETATE	
FLOXIN OTIC (g)	OFLOXACIN	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CIPRO HC	CIPROFLOXACIN HCL/HC	
CIPRODEX	CIPROFLOXACIN HCL/DEXAMETH	
Nonformulary		
Trade Name	Generic Name	Utilization Management
COLY-MYCIN S	NEOMYCIN SULFATE/COLIST SUL/HC	
CORTISPORIN-TC	NEOMY SULF/COLIST SUL/HC/THONZ	
FLOXIN OTIC SINGLES	OFLOXACIN	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

13. RESPIRATORY, COUGH & COLD

13A. Antihistamines

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ASTELIN NASAL SPRAY (g)	AZELASTINE HCL	
ATARAX, VISTARIL (g)	HYDROXYZINE	
BENADRYL (g)	DIPHENHYDRAMINE HCL	
CLARITIN, ALAVERT(OTC) (g)	LORATADINE	
PERIACTIN (g)	CYPROHEPTADINE HCL	
PHENERGAN (g)	PROMETHAZINE HCL	
POLARAMINE (g)	DEXCHLORPHENIRAMINE MALEATE	
XYZAL (g)	LEVOCETIRIZINE DIHYDROCHLORIDE	[ST] [QL]
ZYRTEC (OTC) (g)	CETIRIZINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ASTEPRO NASAL SPRAY	AZELASTINE HCL	
Nonformulary		
Trade Name	Generic Name	Utilization Management
CLARINEX (ALL)	DESLORATADINE	[PA] [QL]
PATANASE	OLOPATADINE HCL	

13B. Antihistamine/Decongestant Combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CLARITIN-D 12HR, 24HR(OTC) (g)	P-EPHED SUL/LORATADINE	
ZYRTEC-D(OTC) (g)	P-EPHED HCL/CETIRIZINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
CLARINEX-D	P-EPHED SUL/DESLORATADINE	[PA] [QL]
SEMPREX-D	PSEUDOEPHEDRINE HCL/ACRIVAS	[ST]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

13C. Antitussive combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
PHENERGAN DM (g)	D-METHORPHAN HB/PROMETH HCL	
PHENERGAN W/CODEINE (g)	CODEINE/PROMETHAZINE HCL	
TESSALON, PERLES (g)	BENZONATATE	
TUSSIONEX (g)	HYDROCODONE/CHLORPHEN POLIS	
Formulary Options		
Trade Name	Generic Name	Utilization Management
TUSSICAPS	HYDROCODONE/CHLORPHEN POLIS	
Nonformulary		
Trade Name	Generic Name	Utilization Management
REZIRA	HYDROCODONE AND PSEUDOEPHEDRINE	[QL]
ZUTRIPRO	CHLORPHENIRAMINE, HYDROCODONE/PSEne	[QL]

13D. Expectorant combinations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
PHENERGAN VC (g)	PHENYLEPHRINE HCL/PROMETH HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

13F. Oral Beta-Agonists

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ALUPENT (g)	METAPROTERENOL SULFATE	
BRETHINE (g)	TERBUTALINE SULFATE	
PROVENTIL SOLUTION (g)	ALBUTEROL SULFATE	
VOSPIRE ER (g)	ALBUTEROL SULFATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

13G. Inhaled Beta-Agonists

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACCUNEB (g)	ALBUTEROL SULFATE	
ALBUTEROL NEBULIZER SOLN (g)	ALBUTEROL SULFATE	
METAPROTERENOL SOLN (g)	METAPROTERENOL SULFATE	
XOPENEX 1.25MG/0.5ML (g)	LEVALBUTEROL HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
FORADIL	FORMOTEROL FUMARATE	[QL]
MAXAIR AUTOHALER	PIRBUTEROL ACETATE	[QL]
PROAIR HFA, VENTOLIN HFA	ALBUTEROL	[QL]
SEREVENT DISKUS	SALMETEROL XINAFOATE	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
ARCAPTA NEOHALER	INDACATEROL MALEATE	[QL]
BROVANA	ARFORMOTEROL TARTRATE	[PA] [QL]
PERFOROMIST	FORMOTEROL FUMARATE	[PA] [QL]
PROVENTIL HFA	ALBUTEROL	[QL]
XOPENEX HFA	LEVALBUTEROL TARTRATE	[QL]
XOPENEX SOLUTION	LEVALBUTEROL HCL	

13H. Inhaled Steroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
PULMICORT 0.25MG, 0.5MG/2ML (g)	BUDESONIDE	[QL] BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
ALVESCO (TIER 1-BCN ONLY)	CICLESONIDE	[QL] BE
ASMANEX (TIER 1-BCN ONLY)	MOMETASONE FUROATE	[QL] BE
FLOVENT HFA, DISKUS (TIER 1-BCN ONLY)	FLUTICASONE PROPIONATE	[QL] BE
PULMICORT 1MG/2ML (TIER 1-BCN ONLY)	BUDESONIDE	[QL] BE
PULMICORT INH (TIER 1-BCN ONLY)	BUDESONIDE	[QL]
QVAR (TIER 1-BCN ONLY)	BECLOMETHASONE DIPROPIONATE	[QL] BE
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

13I. Intranasal Steroids

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
FLONASE (g)	FLUTICASONE PROPIONATE	[QL]
NASACORT AQ (g)	TRIAMCINOLONE ACETONIDE	[ST] [QL]
NASALIDE (g)	FLUNISOLIDE 0.025% SPRAY	[QL]
NASAREL (g)	FLUNISOLIDE	[QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
BECONASE AQ	BECLOMETHASONE DIPROPIONATE	[ST] [QL]
NASONEX	MOMETASONE FUROATE	[ST] [QL]
OMNARIS	CICLESONIDE	[ST] [QL]
RHINOCORT AQUA	BUDESONIDE	[ST] [QL]
VERAMYST	FLUTICASONE FUROATE	[ST] [QL]

13J. Theophyllines

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
THEOPHYLLINE ANHYDROUS (g)	THEOPHYLLINE ANHYDROUS	
UNIPHYL (g)	THEOPHYLLINE ANHYDROUS	
Formulary Options		
Trade Name	Generic Name	Utilization Management
THEO-24	THEOPHYLLINE ANHYDROUS	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

13K. Epinephrine

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
NONE		
Formulary Options		
Trade Name	Generic Name	Utilization Management
EPIPEN, JR	EPINEPHRINE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

13L. Miscellaneous Pulmonary Agents

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ACCOLATE (g)	ZAFIRLUKAST	[QL]
ATROVENT NASAL SPRAY (g)	IPRATROPIUM BROMIDE	
ATROVENT SOLN (g)	IPRATROPIUM BROMIDE	
DUONEB (g)	IPRATROPIUM/ALBUTEROL SULFATE	
INTAL SOLUTION (g)	CROMOLYN SODIUM	
MUCOMYST (g)	ACETYLCYSTEINE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ADVAIR	FLUTICASONE/SALMETEROL	[QL]
ATROVENT INHALER	IPRATROPIUM BROMIDE	[QL]
COMBIVENT	ALBUTEROL SULFATE/IPRATROPIUM	[QL]
DULERA	MOMETASONE/FORMOTEROL	[QL]
LETAIRIS	AMBRISENTAN	[PA] [QL] <s>
PULMOZYME	DORNASE ALFA	<s>
REVATIO	SILDENAFIL CITRATE	[PA] [QL] <s>
SINGULAIR	MONTELUKAST SODIUM	[QL]
SPIRIVA	TIOTROPIUM BROMIDE	[QL]
SYMBICORT	BUDESONIDE/FORMOTEROL FUMARATE	[QL]
TRACLEER	BOSENTAN	[PA] <s>
TYVASO	TREPROSTINIL	[PA] [QL] <s>
VENTAVIS	ILOPROST	[PA] [QL] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
ADCIRCA	TADALAFIL	[PA] [QL] <s>
DALIRESP	ROFLUMILAST	[PA] [QL]
ZYFLO, CR	ZILEUTON	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

14. UROLOGY

14A. Urinary Antispasmodics

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
BENTYL (g)	DICYCLOMINE HCL	
DITROPAN, XL (g)	OXYBUTYNIN CHLORIDE	
LEVBID (g)	HYOSCYAMINE SULFATE	
LEVSIN, SL (g)	HYOSCYAMINE SULFATE	
LEVSINEX (g)	HYOSCYAMINE SULFATE	
PRO-BANTHINE 15MG (g)	PROPANTHELINE BROMIDE	
SANCTURA (g)	TROSPIUM CHLORIDE	
URISPAS (g)	FLAVOXATE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
DETROL	TOLTERODINE TARTRATE	
DETROL LA	TOLTERODINE TARTRATE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
ENABLEX	DARIFENACIN HYDROBROMIDE	
GELNIQUE	OXYBUTYNIN CHLORIDE	[QL]
OXYTROL	OXYBUTYNIN	[QL]
SANCTURA XR	TROSPIUM CHLORIDE	[QL]
TOVIAZ	FESOTERODINE FUMARATE	[QL]
VESICARE	SOLIFENACIN SUCCINATE	

14B. Miscellaneous Urologicals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CYTRA-2, 3, K (g)	CITRIC ACID/POTASSIUM CITRATE	
K-PHOS NEUTRAL (g)	PHOSPHORUS #1	
POLYCITRA (g)	SOD/POTASS/K CIT/SOD CIT/CA	
PYRIDIUM (g)	PHENAZOPYRIDINE HCL	
URECHOLINE (g)	BETHANECHOL CHLORIDE	
UROCIT-K (g)	POTASSIUM CITRATE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
ELMIRON	PENTOSAN POLYSULFATE SODIUM	
RENACIDIN	MAG CARB/CITRIC ACID/G-LACTONE	
URETRON D-S	MTH/ME BLUE/BA/SALICY/ATP/HYOS	
Nonformulary		
Trade Name	Generic Name	Utilization Management
NONE		

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

14C. BPH Treatment

Formulary Preferred

Trade Name	Generic Name	Utilization Management
CARDURA (g)	DOXAZOSIN MESYLATE	
FLOMAX (g)	TAMSULOSIN HCL	
HYTRIN (g)	TERAZOSIN HCL	
PROSCAR (g)	FINASTERIDE	
UROXATRAL (g)	ALFUZOSIN HCL	

Formulary Options

Trade Name	Generic Name	Utilization Management
AVODART	DUTASTERIDE	
CIALIS 2.5, 5MG	TADALAFIL	[PA] [QL]
JALYN	DUTASTERIDE/TAMSULOSIN HCL	[ST] [QL]

Nonformulary

Trade Name	Generic Name	Utilization Management
CARDURA XL	DOXAZOSIN MESYLATE	
RAPAFLO	SILODOSIN	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

[PA] Prior authorization may be required

[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

BE – Drugs offered at a zero dollar copayment with the BCN “Blue Essentials” Rx benefit

15. VITAMINS AND SUPPLEMENTS

15A. Vitamins and Minerals

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
CALCIFEROL (g)	ERGOCALCIFEROL	
CYANOCOBALAMIN INJ (g)	CYANOCOBALAMIN	
FOLVITE (g)	FOLIC ACID	
LURIDE (g)	SODIUM FLUORIDE	
POLY-VI-FLOR (g)	FLUORIDE ION/MULTIVITAMINS	
PRENATAL VITS (g)	PRENATAL VIT/IRON,CARB/DOSS/FA	
PREVIDENT (g)	SODIUM FLUORIDE	
ROCALTROL (g)	CALCITRIOL	
TRI-VI-FLOR (g)	FLUORIDE ION/VIT A,C&D	
Formulary Options		
Trade Name	Generic Name	Utilization Management
MEPHYTON	PHYTONADIONE	
Nonformulary		
Trade Name	Generic Name	Utilization Management
GALZIN	ZINC ACETATE	
HECTOROL	DOXERCALCIFEROL	
NASCOBAL SPRAY	CYANOCOBALAMIN	
NIFEREX GOLD	IRON ASPGLY&PS/C/B12/FA/CA/SUC	
SUPERVITE	LYSINE HCL/VIT B COMP/FA/ZINC	
ZEMPLAR	PARICALCITOL	

15B. Potassium Replacement

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
KAYCIEL, KAON-CL, KAON LIQUID (g)	POTASSIUM CHLORIDE	
K-LOR, KLOR-CON (g)	POTASSIUM CHLORIDE	
K-LYTE, KLOR-CON/EF (g)	POTASSIUM BICARBONATE/CIT AC	
K-TAB, K-DUR, SLOW-K, KAON CL (g)	POTASSIUM CHLORIDE	
MICRO-K (g)	POTASSIUM CHLORIDE	
Formulary Options		
Trade Name	Generic Name	Utilization Management
NONE		
Nonformulary		
Trade Name	Generic Name	Utilization Management
KAOCHLOR-EFF	POTASSIUM CHLORIDE/POT BICARB	

(g) Generic equivalent covered. Brand not covered or requires higher copay.

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[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

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16. DIAGNOSTIC AND OTHER MISCELLANEOUS

16A. Diagnostics and Other Miscellaneous

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ANTABUSE (g)	DISULFIRAM	
CARNITOR (g)	LEVOCARNITINE	
COLYTE (g)	SOD SULF/SOD/NAHCO3/KCL/PEG'S	
DEFERAL (g)	DEFEROXAMINE MESYLATE	
GOLYTELY (g)	PEG 3350/NA SULF,BICARB,CL/KCL	
KAYEXALATE (g)	SODIUM POLYSTYRENE SULFONATE	
NULYTELY (g)	SOD SULF/SOD/NAHCO3/KCL/PEG'S	
PERIDEX (g)	CHLORHEXIDINE GLUCONATE	
PHOSLO (g)	CALCIUM ACETATE	
RE VIA (g)	NALTREXONE HCL	
SALAGEN (g)	PILOCARPINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CARBAGLU	CARGLUMIC ACID	[PA] <s>
CUPRIMINE	PENICILLAMINE	[QL]
GOLYTELY PACKET	PEG 3350/NA SULF,BICARB,CL/KCL	
KUVAN	SAPROPTERIN DIHYDROCHLORIDE	[PA] <s>
RADIOGARDASE	PRUSSIAN BLUE	[QL]
RENAGEL	SEVELAMER HCL	
RENVELA PACKET 2.4G	SEVELAMER CARBONATE	
RENVELA TABLET	SEVELAMER CARBONATE	
SAMSCA	TOLVAPTAN	<s>
XENAZINE	TETRABENAZINE	[PA] [QL] <s>
Nonformulary		
Trade Name	Generic Name	Utilization Management
APHTHASOL	AMLEXANOX	
CAMPRAL	ACAMPROSATE CALCIUM	[PA]
EVOXAC	CEVIMELINE HCL	
EXJADE	DEFERASIROX	[PA] <s>
FIRAZYR	ICATIBANT ACETATE	[PA] [QL] <s>
FOSRENOL	LANTHANUM CARBONATE	
HALFLYTELY	BISAC/NACL/NAHCO3/KCL/PEG 3350	[QL]
MOVIPREP	PEG3350/SOD SUL/NACL/ASB/C/KCL	
ORFADIN	NITISINONE	<s>
OSMOPREP, VISICOL	NAPHOS M-B M-H/NA PHOS,DI-BA	
PHOSLYRA	CALCIUM ACETATE	
RENVELA PACKET 0.8G	SEVELAMER CARBONATE	
SUPREP	SODIUM,POTASSIUM,&MAG SULFATES	
SYPRINE	TRIENTINE HCL	<s>
ZAVESCA	MIGLUSTAT	

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[ST] Step therapy may be required

[QL] Quantity limits may apply

<s> Specialty Drug

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17. LIFESTYLE MODIFICATION

17A. Impotence

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
YOHIMBINE HCL (g)	YOHIMBINE HCL	
Formulary Options		
Trade Name	Generic Name	Utilization Management
CAVERJECT	ALPROSTADIL	[PA] [QL]
CIALIS	TADALAFIL	[PA] [QL]
MUSE	ALPROSTADIL	[PA] [QL]
VIAGRA	SILDENAFIL CITRATE	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
EDEX	ALPROSTADIL	[PA] [QL]
LEVITRA	VARDENAFIL HCL	[PA] [QL]
STAXYN	VARDENAFIL HCL	[PA] [QL]

17B. Weight Loss Preparations

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
ADIPEX-P (g)	PHENTERMINE HCL	[PA] [QL]
BONTRIL (g)	PHENDIMETRAZINE TARTRATE	[PA] [QL]
DIDREX (g)	BENZPHETAMINE HCL	[PA] [QL]
TENUATE (g)	DIETHYLPROPION HCL	[PA] [QL]
Formulary Options		
Trade Name	Generic Name	Utilization Management
IONAMIN	PHENTERMINE RESIN	[PA] [QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
SUPRENZA	PHENTERMINE HCL	[PA] [QL]
XENICAL	ORLISTAT	[PA] [QL]

17C. Smoking Cessation

Formulary Preferred		
Trade Name	Generic Name	Utilization Management
COMMIT LOZENGE OTC(g) (BCN ONLY)	NICOTINE POLACRILEX	[QL] BE
NICOTINE GUM, NICORETTE(g) (BCN ONLY)	NICOTINE POLACRILEX	[QL] BE
NICOTINE PATCH(g) (BCN ONLY)	NICOTINE	[QL] BE
ZYBAN (g)	BUPROPION HCL	BE
Formulary Options		
Trade Name	Generic Name	Utilization Management
CHANTIX	VARENICLINE TARTRATE	[QL]
Nonformulary		
Trade Name	Generic Name	Utilization Management
NICOTROL, NS	NICOTINE	[QL]

(g) Generic equivalent covered. Brand not covered or requires higher copay.

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[ST] Step therapy may be required

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<s> Specialty Drug

BE - Drugs offered at a zero dollar copayment with the BCN "Blue Essentials" Rx benefit

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FIORICET; ESGIC, PLUS(g)	71	GLYNASE(g)	92
FIORINAL W/CODEINE(g)	70	GLYSET	92
FIORINAL W/CODEINE(g)	71	GOLYTELY PACKET	118
FIORINAL(g)	70	GOLYTELY(g)	118
FIORINAL(g)	71	GONAL-F, RFF	84
FIRAZYR	118	GRALISE	73
FLAGYL ER	56	GRANULEX(g)	103
FLAGYL(g)	56	GRIFULVIN V 500MG	52
FLECTOR PATCH	68	GRIFULVIN V SUSP(g)	52
FLEXERIL(g)	74	GRIS PEG	52
FLOMAX(g)	116	GYNAZOLE-1	85
FLONASE(g)	109	HALCION(g)	67
FLONASE(g)	113	HALDOL(g)	66
FLORINEF(g)	89	HALFLYTELY	118
FLOVENT HFA, DISKUS (TIER 1-BCN ONLY)	112	HALOG	99
FLOXIN OTIC SINGLES	109	HC ACETATE/PRAMOXINE HCL	80
FLOXIN OTIC(g)	109	HECTOROL	90
FLOXIN(g)	51	HECTOROL	117
FLUMADINE(g)	53	HELIDAC	77
FLUOXETINE 60mg	65	HEPARIN(g)	63
FLUVOXAMINE MALEATE(g)	65	HEPSERA	53
FML FORTE, S.O.P.	107	HEXALEN	96
FML(g)	107	HIPREX/UREX(g)	51
FOCALIN XR	67	HORIZANT	75
FOCALIN(g)	67	HUMALOG, MIX (PEN/CARTRIDGE)	91
FOLLISTIM AQ	84	HUMALOG, MIX (VIAL)	91
FOLVITE(g)	117	HUMATIN(g)	56
FORADIL	112	HUMATROPE	93
FORTAMET (g)	92	HUMIRA	87
FORTEO	87	HUMIRA	103
FORTESTA	90	HUMULIN 70/30 (PEN/CARTRIDGE)	91
FOSAMAX PLUS D	88	HUMULIN 70/30 (VIAL)	91
FOSAMAX, WEEKLY(g)	88	HUMULIN N (PEN/CARTRIDGE)	91
FOSRENOL	118	HUMULIN N (VIAL)	91
FRAGMIN	63	HUMULIN R (VIAL)	91
FROVA	71	HYCANTIN	96
FUZEON	54	HYDREA(g)	96
GABITRIL	73	HYDRODIURIL, MICROZIDE(g)	62
GALZIN	117	HYGROTON, THALITONE(g)	62
GANIRELIX ACETATE	84	HYTRIN(g)	64
GARAMYCIN(g)	107	HYTRIN(g)	116

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ILOTYCIN(g)	107	KINERET	87
IMDUR(g)	63	KLONOPIN, WAFER(g)	73
IMITREX (ALL FORMS)(g)	71	K-LOR, KLOR-CON(g)	117
IMURAN(g)	87	K-LYTE, KLOR-CON/EF(g)	117
IMURAN(g)	95	KOMBIGLIYZE XR	92
INCIVEK	53	K-PHOS NEUTRAL(g)	115
INCRELEX	93	K-TAB, K-DUR, SLOW-K, KAON CL(g)	117
INDERAL LA(g)	58	KUVAN	118
INDERAL(g)	58	KYTRIL(g)	78
INDERIDE(g)	58	LACRISERT	108
INDOCIN SUPPOSITORY	68	LACTULOSE(g)	80
INDOCIN, SR(g)	68	LAMICTAL ODT	73
INFERGEN	98	LAMICTAL TABS, DISPERTABS(g)	73
INFLAMASE, FORTE(g)	107	LAMICTAL, XR	73
INNOHEP	63	LAMISIL GRANULES	52
INNOPRAN XL	58	LAMISIL TABLETS(g)	52
INSPRA(g)	62	LANTUS (PEN/CARTRIDGE)	91
INTAL SOLUTION(g)	114	LANTUS (VIAL)	91
INTELENCE	54	LAPASE(g)	79
INTRON A	98	LARIAM(g)	55
INTUNIV	75	LASIX(g)	62
INVEGA	66	LASTACAFT	108
INVIRASE	54	LATUDA	66
IONAMIN	119	LAZANDA	69
IOPIDINE DROPERETTE	105	LESCOL, XL	57
IOPIDINE DROPS(g)	105	LETAIRIS	114
IPRIVASK	63	LEUCOVORIN(g)	96
IQUIX	107	LEUKERAN	94
IRESSA	97	LEUKINE	96
ISENTRESS	54	LEUKINE	98
ISMO, MONOKET(g)	63	LEVAQUIN(g)	51
ISONIAZID(g)	55	LEVATOL	58
ISOPTO ATROPINE(g)	106	LEVBID(g)	77
ISOPTO CARBACHOL	105	LEVBID(g)	115
ISOPTO HOMATROPINE(g)	106	LEVEMIR (PEN)	91
ISOPTO HYOSCINE	106	LEVEMIR (VIAL)	91
ISORDIL(g)	63	LEVITRA	119
ISTALOL	105	LEVSIN, SL(g)	77
JALYN	116	LEVSIN, SL(g)	115
JANUMET (TIER 3 - BCN ONLY)	92	LEVSINEX(g)	77
JANUVIA (TIER 3 - BCN ONLY)	92	LEVSINEX(g)	115
KADIAN 10, 200mg	69	LEXAPRO	65
KADIAN(g)	69	LEXIVA	54
KALETRA	54	LIALDA	80
KAOCHLOR-EFF	117	LIBRAX(g)	77
KAPVAY	75	LIBRIUM(g)	66
KAYCIEL, KAON-CL, KAON LIQUID(g)	117	LIDEX, E(g)	99
KAYEXALATE(g)	118	LIDODERM PATCH	101
KEFLEX 750MG	49	LIMBITROL, DS(g)	65
KEFLEX(g)	49	LINDANE(g)	103
KEPPRA, XR(g)	73	LIPITOR(g)	57
KERLONE(g)	58	LIPOFEN	57
KETEK	50	LIPRAM-UL20	79

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LITHOBID(g)	75	MAPROTILINE HCL(g)	65
LIVALO	57	MARINOL(g)	78
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LO/OVRAL(g)	81	MATULANE	96
LOCOID CR, OINT, SOLN(g)	100	MAVIK(g)	59
LOCOID LIPOCREAM(g)	100	MAXAIR AUTOHALER	112
LOCOID LOTION	100	MAXALT, MLT	71
LODINE, XL(g)	68	MAXIDEX	107
LOESTRIN 24 FE	81	MAXITROL(g)	108
LOESTRIN, FE(g)	81	MAXZIDE, DYAZIDE(g)	62
LOFIBRA(g)	57	MEBARAL(g)	73
LOMOTIL(g)	77	MECLOMEN(g)	68
LONITEN(g)	64	MEDROL, DOSEPAK(g)	89
LOPID(g)	57	MEGACE ES	95
LOPRESSOR HCT(g)	58	MEGACE(g)	95
LOPRESSOR(g)	58	MELLARIL(g)	66
LOPROX CR, LOTIONg)	102	MENEST	83
LOPROX GEL, SHAMPOO(g)	102	MENEST	87
LOSEASONIQUE(g)	81	MENOPUR	84
LOTEMAX	107	MENOSTAR	83
LOTENSIN HCT(g)	59	MENTAX	102
LOTENSIN(g)	59	MEPHYTON	63
LOTREL 5/40, 10/40mg(g)	59	MEPHYTON	117
LOTREL 5/40, 10/40mg(g)	61	MEPRON	56
LOTREL(g)	59	MESNEX TABS	96
LOTREL(g)	61	MESTINON TIMESPAN, SYRUP	74
LOTRIMIN(g)	102	MESTINON(g)	74
LOTRISONE CR, LOTION(g)	102	METADATE CD	67
LOTRONEX	80	METAGLIP(g)	92
LOVAZA	57	METAPROTERENOL SOLN(g)	112
LOVENOX 300MG/3ML	63	METHADONE(g)	69
LOVENOX(g)	63	METHERGINE(g)	85
LOXITANE(g)	66	METHITEST	90
LOZOL(g)	62	METHOTREXATE TABS(g)	94
LUMIGAN	105	METHOTREXATE(g)	87
LUNESTA	67	METHYLIN CHEW	67
LUPRON DEPOT	85	METHYLIN SOLN(g)	67
LUPRON DEPOT	95	METZOLV ODT	80
LUPRON DEPOT-PED	90	METROCREAM, GEL, LOTION(g)	101
LUPRON(g)	84	METROGEL TOPICAL 1%	101
LUPRON(g)	95	METROGEL-VAGINAL(g)	85
LURIDE(g)	117	MEVACOR(g)	57
LUVERIS	84	MEXITIL(g)	62
LUVOX CR	65	MIACALCIN INJECTION	88
LUXIQ	100	MIACALCIN INJECTION	90
LYBREL(g)	81	MIACALCIN NASAL SPRAY(g)	88
LYRICA	73	MIACALCIN NASAL SPRAY(g)	90
LYSODREN	96	MICARDIS	60
LYSTEDA	85	MICARDIS HCT	60
MACROBID(g)	51	MICRO-K(g)	117
MACRODANTIN(g)	51	MIDAMOR(g)	62
MAGNACET	70	MIDRIN(g)	71
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MINIPRESS(g)	64	NEULASTA	96
MINOCIN, DYNACIN(g)	50	NEULASTA	98
MIRAPEX ER	72	NEUMEGA	98
MIRAPEX(g)	72	NEUPOGEN	96
MIRCETTE(g)	81	NEUPOGEN	98
MOBIC(g)	68	NEURONTIN(g)	73
MODICON(g)	81	NEVANAC	106
MODURETIC(g)	62	NEXAVAR	97
MONISTAT-DERM(g)	102	NEXICLON XR	64
MONODOX(g)	50	NEXIUM	76
MONOPRIL HCT(g)	59	NIASPAN	57
MONOPRIL(g)	59	NICOTINE GUM, NICORETTE(g) (BCN ONLY)	119
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MOTRIN(g)	68	NICOTROL, NS	119
MOVIPREP	118	NIFEREX GOLD	117
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MS CONTIN/ORAMORPH SR(g)	69	NIRAVAM(g)	66
MSIR(g)	69	NITRO-BID OINTMENT	63
MUCOMYST(g)	114	NITROGLYCERIN PATCH(g)	63
MULTAQ	62	NITROGLYCERIN SA CAP(g)	63
MUSE	119	NITROGLYCERIN SPRAY	63
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MYCOBUTIN	55	NITROSTAT	63
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MYFORTIC	95	NORDETTE, LEVLEN(g)	81
MYLERAN	94	NORDITROPIN (ALL)	93
MYSOLINE(g)	73	NORFLEX(g)	74
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NARDIL(g)	65	NOROXIN	51
NASACORT AQ(g)	109	NORPACE CR	62
NASACORT AQ(g)	113	NORPACE(g)	62
NASALIDE(g)	109	NORPRAMIN(g)	65
NASALIDE(g)	113	NORVASC(g)	61
NASAREL(g)	109	NORVIR	54
NASAREL(g)	113	NOVAREL, PREGNYL, PROFASI	84
NASCOBAL SPRAY	117	NOVOLIN (PEN/CARTRIDGE)	91
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NASONEX	113	NOVOLOG (PEN/CARTRIDGE)	91
NATACYN	107	NOVOLOG (VIAL)	91
NATAZIA	81	NOVOLOG MIX (PEN/CARTRIDGE)	91
NATROBA	103	NOXAFIL	52
NAVANE(g)	66	NUCYNTA, ER	69
NEBUPENT AEROSOL	56	NUEDEXTA	75
NECON 10/11(g)	81	NULYTELY(g)	118
NEOMYCIN(g)	56	NUTROPIN	93
NEOSPORIN OPHTH SOLN(g)	107	NUTROPIN AQ	93
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OLEPTRO	65	PARAFLEX, PARAFON FORTE DSC(g)	74
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OMEPRAZOLE OTC(g)	76	PAREMYD	106
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OMNARIS	113	PARNATE(g)	65
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ORACEA	50	PEGASYS	98
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PLAQUENIL(g)	87	PROCRIT	98
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STRATTERA	67	TENORMIN(g)	58
STRIANT	90	TENUATE(g)	119
STROMECTROL - SINGLE DOSE	56	TERAZOL- 3, 7(g)	85
SUBOXONE FILM	70	TESSALON, PERLES(g)	111
SUBOXONE TABS	70	TESTIM	90
SULAR(g)	61	TESTRED, ANDROID	90
SULFACET-R(g)	101	TETRACYCLINE(g)	50
SULFADIAZINE(g)	51	TEVETEN	60
SUMAVEL DOSEPRO	71	TEVETEN HCT	60
SUPERVITE	117	TEV-TROPIN	93
SUPRAX	49	THALOMID	95
SUPRENZA	119	THEO-24	113
SUPREP	118	THEOPHYLLINE ANHYDROUS(g)	113
SURMONTIL(g)	65	THIOGUANINE	94
SUSTIVA	54	THORAZINE(g)	66
SUTENT	97	THYROLAR	89
SYMBICORT	114	TIAZAC(g)	61
SYMBYAX	66	TICLID(g)	63
SYMLIN	92	TIGAN(g)	78
SYMMETREL(g)	53	TIKOSYN	62
SYMMETREL(g)	72	TIMOPTIC - XE(g)	105
SYNALAR 0.025% CREAM, OINT(g)	100	TIMOPTIC(g)	105
SYNALAR CREAM, SOLN(g)	100	TINDAMAX	56
SYNALGOS-DC	70	TIROSINT	89
SYNAREL	85	TOBI	56
SYNAREL	90	TOBRADEX OINT	108
SYNTHROID (g)	89	TOBRADEX SUSP(g)	108
SYPRINE	118	TOBREX(g)	107
TACLONEX, SCALP	103	TOFRANIL(g)	65
TAGAMET (RX ONLY)(g)	76	TOFRANIL-PM(g)	65
TALACEN(g)	70	TOLECTIN, DS(g)	68
TALWIN NX(g)	70	TOLINASE(g)	92
TAMBOCOR(g)	62	TOPAMAX, SPRINKLE(g)	73
TAMIFLU CAP, SUSP	53	TOPICORT CR, GEL, OINT(g)	99
TAMOXIFEN CITRATE(g)	95	TOPICORT LP(g)	100

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TOPROL XL(g)	58	VALIUM(g)	66
TORADOL(g)	68	VALIUM(g)	74
TOVIAZ	115	VALTREX(g)	53
TRACLEER	114	VALTURNA	60
TRADJENTA	92	VALTURNA	64
TRANSDERM-SCOP	78	VANCOCIN HCL	56
TRANXENE SD	66	VANOS 0.1% CR	99
TRANXENE(g)	66	VANTIN(g)	49
TRAVATAN Z	105	VASERETIC(g)	59
TRECATOR	55	VASOCIDIN(g)	108
TRELSTAR DEPOT, LA	95	VASODILAN(g)	64
TRENTAL(g)	63	VASOTEC(g)	59
TREXIMET	71	VECTICAL	103
TRIBENZOR	60	VENLAFAXINE HCL ER(g)	65
TRIBENZOR	61	VENTAVIS	114
TRICOR	57	VEPESID(g)	96
TRIGLIDE	57	VERAMYST	109
TRILEPTAL, SUSP(g)	73	VERAMYST	113
TRILIPIX	57	VERDESO	100
TRILISATE(g)	69	VEREGEN	104
TRIMETHOPRIM(g)	51	VERELAN PM(g)	61
TRI-NORINYL(g)	82	VERELAN(g)	61
TRIPHASIL, TRILEVLEN(g)	82	VERMOX(g)	56
TRI-VI-FLOR(g)	117	VESANOID(g)	96
TRIZIVIR	54	VESICARE	115
TRUSOPT(g)	105	VEXOL	107
TRUVADA	54	VFEND SUSP	52
TUSSICAPS	111	VFEND(g)	52
TUSSIONEX(g)	111	VIAGRA	119
TWYNSTA	60	VIBRAMYCIN, VIBRATABS(g)	50
TWYNSTA	61	VICODIN, LORTAB(g)	70
TYKERB	97	VICOPROFEN(g)	70
TYLENOL W/CODEINE(g)	70	VICTOZA	92
TYLOX(g)	70	VICTRELIS	53
TYVASO	114	VIDEX	54
TYZEKA	53	VIDEX EC(g)	54
ULORIC	86	VIGAMOX	107
ULTRACET(g)	70	VIIBRYD	65
ULTRAM, ER(g)	70	VIMOVO	68
ULTRASE MT	79	VIMOVO	76
ULTRAVATE(g)	99	VIMPAT	73
UNIPHYL(g)	113	VIOKASE	79
UNIRETIC(g)	59	VIRACEPT	54
UNIVASC(g)	59	VIRAMUNE	54
URECHOLINE(g)	115	VIRAMUNE XR	54
URETRON D-S	115	VIREAD	54
URISPAS(g)	115	VIROPTIC(g)	107
UROCIT-K(g)	115	VIVACTIL(g)	65
UROXATRAL(g)	116	VIVELLE(g)	83
URSO, URSO FORTE(g)	78	VIVELLE(g)	87
VAGIFEM	83	VIVELLE-DOT	83
VALCYTE	53	VIVELLE-DOT	87
VALISONE CR, LOTION, OINT(g)	99	VOLTAREN GEL	68
VALISONE CR, LOTION, OINT(g)	100	VOLTAREN(g)	106

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VOTRIENT	97	ZIRGAN	107
VUSION	102	ZITHROMAX(g)	50
VYTORIN	57	ZMAX	50
VYVANSE	67	ZOCOR 80mg(g)	57
WELCHOL	57	ZOCOR(g)	57
WELLBUTRIN XL (g)	65	ZOFRAN, ODT(g)	78
WELLBUTRIN, SR(g)	65	ZOLADEX	95
WESTCORT(g)	100	ZOLINZA	96
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XALKORI	97	ZOLPIMIST	67
XANAX, XR(g)	66	ZOMIG	71
XARELTO	63	ZONALON(g)	104
XELODA	94	ZONEGRAN(g)	73
XENAZINE	118	ZORBTIVE	93
XENICAL	119	ZORTRESS	97
XERESE	102	ZOVIRAX CREAM, OINT	102
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XIFAXAN 200MG	56	ZUPLENZ	78
XIFAXAN 550MG	80	ZUTRIPRO	111
XODOL(g)	70	ZYBAN(g)	119
XOLEGEL	102	ZYCLARA	104
XOPENEX 1.25MG/0.5ML(g)	112	ZYDONE	70
XOPENEX HFA	112	ZYFLO, CR	114
XOPENEX SOLUTION	112	ZYLET	108
XYLOCAINE (Rx Only)(g)	101	ZYLOPRIM(g)	86
XYLOCAINE VISCOUS(g)	101	ZYMAXID	107
XYREM	75	ZYPREXA, ZYDIS(g)	66
XYZAL(g)	110	ZYRTEC (OTC)(g)	110
YASMIN 28(g)	81	ZYRTEC-D(OTC)(g)	110
YAZ(g)	81	ZYTIGA (TIER 3 - BCN ONLY)	95
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ZANTAC (RX ONLY)(g)	76		
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ZARONTIN(g)	73		
ZAROXOLYN(g)	62		
ZAVESCA	118		
ZEBETA(g)	58		
ZEBUTAL(g)	70		
ZEBUTAL(g)	71		
ZEGERID PACKET	76		
ZEGERID RX(g)	76		
ZELAPAR	72		
ZELBORAF	97		
ZEMPLAR	90		
ZEMPLAR	117		
ZENPEP	79		
ZERIT(g)	54		
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