

**Gold Plan + Rx (Cost): Front Range**  
**Gold Plan + Rx (Cost): Denver/Boulder Metro**  
**Plus Plan + Rx (Cost): Western Slope**  
**Standard Plan + Rx (Cost): Front Range**  
**Standard Plan + Rx (Cost): Western Slope**  
**WINhealth Standard Plan + Rx (Cost)**  
**Qualified Part D Employer Groups**

**2010 Premier Medicare Formulary**

**(List of Covered Drugs)**

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Last Updated 09/01/09

## **What is the Rocky Mountain Health Plans Formulary?**

A formulary is a list of covered drugs selected by Rocky Mountain Health Plans (RMHP) in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. RMHP will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a RMHP network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

## **Can the Formulary change?**

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

The enclosed formulary is current as of January 1, 2010. To get updated information about the drugs covered by Rocky Mountain Health Plans, please visit our Web site at [www.rmhp.org](http://www.rmhp.org), or call Customer Services. We update the printed version of our formulary annually.

- RMHP Members residing in Colorado, call 970-244-7912 or 888-282-1420.
- WINhealth Partners Members residing in Wyoming, call 800-840-2211.
- If you are hearing impaired and use TTY equipment, call 800-704-6370.
- Para asistencia en español llame al 888-346-4643.

For Part D prescription drug benefit questions, please call between 8:00 a.m. and 8:00 p.m., Mountain Time, Monday through Friday. From November 15 through March 1, we are also available 8:00 a.m. to 8:00 p.m., Mountain Time, on weekends and most holidays.

## **How do I use the Formulary?**

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on page 7. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, <<"Cardiovascular Agents">. If you know what your drug is used for, look for the category name in the list that begins on page number 7. Then look under the category name for your drug.

## **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 68. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## **What are generic drugs?**

RMHP covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

## **Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** RMHP requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from RMHP before you fill your prescriptions. If you don't get approval, RMHP may not cover the drug.
- **Quantity Limits:** For certain drugs, RMHP limits the amount of the drug that RMHP will cover. For example, RMHP allows up to 12 tablets per month for Imitrex tablets.
- **Step Therapy:** In some cases, RMHP requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, RMHP may not cover Drug B unless you try Drug A first. If Drug A does not work for you, RMHP will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at [rmhp.org](http://rmhp.org).

You can ask RMHP to make an exception to these restrictions or limits. See the section, "How do I request an exception to the RMHP formulary?" on page 4 for information about how to request an exception.

## **What if my drug is not on the Formulary?**

If your drug is not included in this formulary, you should first contact Customer Services and confirm that your drug is not covered. If you learn that RMHP does not cover your drug, you have two options:

- You can ask Customer Services for a list of similar drugs that are covered by RMHP. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by RMHP.
- You can ask RMHP to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the RMHP Formulary?

You can ask RMHP to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, RMHP limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty tier.

Generally, RMHP will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

## What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

If you take any Part D drugs that are not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day

emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

## For more information

For more detailed information about your RMHP prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about RMHP please call Customer Services.

- RMHP Members residing in Colorado, call 970-244-7912 or 888-282-1420.
- WINhealth Partners Members residing in Wyoming, call 800-840-2211.
- If you are hearing impaired and use TTY equipment, call 800-704-6370.
- Para asistencia en español llame al 800-346-4643.

For Part D prescription drug benefit questions, please call between 8:00 a.m. and 8:00 p.m., Mountain Time, Monday through Friday. From November 15 through March 1, we are also available 8:00 a.m. to 8:00 p.m., Mountain Time, on weekends and most holidays. Or visit [www.rmhp.org](http://www.rmhp.org)

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit [www.medicare.gov](http://www.medicare.gov).

## RMHP Formulary

The formulary that begins on page 7 provides coverage information about some of the drugs covered by RMHP. If you have trouble finding your drug in the list, turn to the Index that begins on page 68.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., <ALLEGRA>) and generic drugs are listed in lower-case italics (e.g., <*amoxicillin*>).

The information in the Notes column tells you if RMHP has any special requirements for coverage of your drug.

The RMHP formulary key for the Notes column is as follows:

- Drug Tier = 1 Generic copayment (lowest)
- Drug Tier = 2 Preferred Brand copayment (midrange)
- Drug Tier = 3 Non-preferred Brand copayment (highest)
- Drug Tier = 4 Specialty coinsurance

See your Summary of Benefits or Evidence of Coverage to determine how much you will pay for prescription drugs in each tier. All formulary drugs are available from mail order pharmacies.

Drugs that appear with:

- italics* = Generic drugs
- CAPITALIZATION = Brand name drugs
- PA = Prior Authorization required
- QL = Quantity Limit applies
- ST = Step Therapy

\*\* = Limited Access Drug. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Customer Services at 888-282-1420. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643. Please call 8:00 a.m.- 8:00 p.m., Mtn. Time, Mon.- Fri. From Nov. 15 through March 1, we are also available 8:00 a.m. - 8:00 p.m., Mtn. Time, on weekends and most holidays.

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Tier	Notes
<b>Analgesics</b>		
<i>acetaminophen/codeine</i>	1	
<i>acetaminophen/codeine #3</i>	1	
<i>acetaminophen/codeine #4</i>	1	
ACTIQ	3	
<i>ascomp/codeine</i>	1	
<i>astramorph</i>	1	
AVINZA CAPSULE EXTENDED RELEASE 24 HOUR 120MG, 30MG, 60MG, 90MG	2	
BALACET 325	2	
BUPRENEX	3	
<i>buprenorphine hcl</i>	1	
<i>butalbital /apap /caffeine /codeine</i>	1	
<i>butorphanol tartrate</i>	1	
CAPITAL/CODEINE	2	
<i>co-gesic</i>	1	
COMBUNOX	3	
DARVOCET A500	3	
DARVOCET-N 100	3	
DARVOCET-N 50	3	
DARVON	3	
DARVON-N	2	
DEMEROL	3	
DILAUDID-5	2	
DILAUDID-HP	3	
DILAUDID TABLET	3	
DOLOPHINE	3	
DOLOPHINE HCL	3	
DURAGESIC	3	QL (15 per 30 days)
<i>duramorph</i>	1	
<i>endocet tablet 325mg; 5mg</i>	1	
EQUAGESIC	2	
<i>fentanyl</i>	1	QL (15 per 30 days)
<i>fentanyl citrate</i>	1	
FENTANYL CITRATE ORAL TRANSMUCOSAL	2	
FENTORA	2	
FIORICET /CODEINE	3	
FIORINAL/CODEINE #3	3	
HYCET	2	
<i>hydrocodone /acetaminophen-hs</i>	1	
<i>hydrocodone /acetaminophen tablet</i>	1	
<i>hydrocodone /acetaminophen solution 500mg/15ml; 7.5mg/15ml</i>	1	

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Drug Name	Drug Tier	Notes
<i>hydrocodone /ibuprofen</i>	1	
<i>hydrocodone bitartrate/acetaminophen</i>	1	
<i>hydromorphone hcl tablet</i>	1	
<i>hydromorphone hcl injection</i>	1	PA (Part B vs Part D only)
INFUMORPH 200	2	
INFUMORPH 500	2	
KADIAN	3	
LEVO DROMORAN	2	
<i>levorphanol tartrate</i>	1	
LORCET 10/650	3	
LORCET PLUS	3	
LORTAB	3	
LORTAB 10	3	
LORTAB 5	3	
LORTAB 7.5	3	
<i>margesic-h</i>	1	
MAXIDONE	3	
MEPERIDINE HCL ORAL SOLUTION	2	
<i>meperidine hcl tablet</i>	1	
<i>meperidine hcl injection 10mg/ml, 25mg/ml, 50mg/ml, 75mg/ml</i>	1	PA (Part B vs Part D only)
METHADONE HCL INJECTION, ORAL SOLUTION	2	
<i>methadone hcl concentrate, tablet</i>	1	
<i>methadose</i>	1	
<i>morphine sulfate er</i>	1	
MORPHINE SULFATE ORAL SOLUTION	2	
<i>morphine sulfate tablet</i>	1	
MORPHINE SULFATE INJECTION 5MG/ML	2	
<i>morphine sulfate injection 0.5mg/ml, 1mg/ml</i>	1	
MS CONTIN	3	
<i>nalbuphine hcl</i>	1	
NORCO	3	
OPANA	2	
OPANA ER	2	
ORAMORPH SR	3	
<i>oxycodone /acetaminophen capsule</i>	1	
<i>oxycodone /acetaminophen tablet 325mg; 5mg</i>	1	
<i>oxycodone /apap</i>	1	
<i>oxycodone /aspirin</i>	1	
<i>oxycodone /ibuprofen</i>	1	
<i>oxycodone hcl</i>	1	
<i>oxycodone hcl er</i>	1	
<i>oxycodone-apap</i>	1	

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Drug Name	Drug Tier	Notes
OXYCONTIN TABLET EXTENDED RELEASE 12 HOUR 40MG	2	
<i>oxycontin tablet extended release 12 hour 40mg</i>	1	
OXYCONTIN TABLET EXTENDED RELEASE 12 HOUR 10MG, 15MG, 20MG, 30MG, 60MG, 80MG	2	
PANLOR DC	3	
PANLOR SS	3	
<i>pentazocine /acetaminophen</i>	1	
<i>pentazocine/naloxone hcl</i>	1	
PERCOCET	3	
PERCODAN	3	
<i>propoxyphene /acetaminophen</i>	1	
<i>propoxyphene hcl</i>	1	
<i>propoxyphene-n /acetaminophen</i>	1	
ROXICET SOLUTION	2	
ROXICET TABLET 500MG; 5MG	2	
<i>roxicet tablet 325mg; 5mg</i>	1	
ROXICODONE	3	
<i>stagesic</i>	1	
SUBOXONE	2	
SUBUTEX	2	
SYNALGOS-DC	2	
TALACEN	3	
TALWIN	2	
TALWIN NX	3	
<i>tramadol hcl</i>	1	
<i>tramadol hydrochloride/acetaminophen</i>	1	
<i>trezix</i>	1	
TYLENOL/CODEINE #3	3	
TYLENOL/CODEINE #4	3	
TYLOX	3	
ULTRACET	3	
ULTRAM	3	
ULTRAM ER	2	
<i>vanacet</i>	1	
VICODIN	3	
VICODIN ES	3	
<i>vicodin hp</i>	1	
VICOPROFEN	3	
XODOL TABLET 300MG; 10MG	2	
ZAMICET	2	
ZYDONE	2	
<b>Anesthetics</b>		
EMLA	3	

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Drug Name	Drug Tier	Notes
<i>lidocaine</i>	1	
<i>lidocaine hcl jelly</i>	1	
<i>lidocaine hcl injection, external solution</i>	1	
<i>lidocaine/prilocaine</i>	1	
LIDODERM	2	
XYLOCAINE	3	
XYLOCAINE JELLY	3	
<b>Anti-inflammatory Agents</b>		
ANAPROX	3	
ANAPROX DS	3	
ARTHROTEC 50	3	
ARTHROTEC 75	3	
CATAFLAM	3	
CELEBREX	3	
CLINORIL	3	
DAYPRO	3	
<i>diclofenac potassium</i>	1	
<i>diclofenac sodium</i>	1	
DICLOFENAC SODIUM EC TABLET DELAYED RELEASE 25MG	2	
<i>diclofenac sodium ec tablet delayed release 50mg</i>	1	
<i>diclofenac sodium xr</i>	1	
DIFLUNISAL	2	
EC-NAPROSYN	3	
<i>etodolac</i>	1	
<i>etodolac er</i>	1	
FELDENE	3	
<i>fenoprofen calcium</i>	1	
<i>flurbiprofen</i>	1	
<i>ibu</i>	1	
<i>ibuprofen</i>	1	
INDOCIN	2	
INDOCIN SR	3	
<i>indomethacin</i>	1	
<i>indomethacin er</i>	1	
<i>ketoprofen</i>	1	
KETOPROFEN ER	2	
<i>ketorolac tromethamine</i>	1	
MECLOFENAMATE SODIUM	2	
MELOXICAM SUSPENSION	2	
<i>meloxicam tablet</i>	1	
MOBIC SUSPENSION	2	
MOBIC TABLET	3	
<i>nabumetone</i>	1	

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Drug Name	Drug Tier	Notes
NALFON	2	
NAPRELAN	3	
NAPROSYN	3	
<i>naproxen</i>	1	
<i>naproxen dr</i>	1	
<i>naproxen sodium</i>	1	
<i>oxaprozin</i>	1	
<i>piroxicam</i>	1	
PONSTEL	2	
PREVACID NAPRAPAC	3	
<i>sulindac</i>	1	
TOLMETIN SODIUM TABLET	2	
<i>tolmetin sodium capsule</i>	1	
VOLTAREN	3	
VOLTAREN-XR	3	
<b>Antibacterials</b>		
ADOXA	3	
ADOXA PAK 1/150	3	
ADOXA PAK 1/75	3	
AKNE-MYCIN	2	
<i>amikacin sulfate</i>	1	
AMIKIN	3	
<i>amoxicillin/clavulanate potassium</i>	1	
<i>amoxicillin/potassium clavulanate</i>	1	
<i>amoxicillin capsule, suspension reconstituted, tablet</i>	1	
AMOXICILLIN TABLET CHEWABLE 400MG	2	
<i>amoxicillin tablet chewable 125mg, 200mg, 250mg</i>	1	
<i>amoxil capsule</i>	1	
AMOXIL SUSPENSION RECONSTITUTED 400MG/5ML	3	
<i>amoxil suspension reconstituted 250mg/5ml</i>	1	
AMPICILLIN SODIUM INJECTION 125MG	2	
<i>ampicillin sodium injection 10gm, 1gm</i>	1	
<i>ampicillin-sulbactam</i>	1	
AMPICILLIN SUSPENSION RECONSTITUTED	2	
<i>ampicillin capsule</i>	1	
AUGMENTIN	3	
AUGMENTIN ES-600	3	
AUGMENTIN XR	3	
AVELOX	2	
AVELOX ABC PACK	2	
AZACTAM	2	
AZACTAM IN DEXTROSE	2	
<i>azithromycin</i>	1	

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Drug Name	Drug Tier	Notes
<i>baciim</i>	1	
BACITRACIN	3	
BACTOCILL IN DEXTROSE	2	
BACTRIM	3	
BACTRIM DS	3	
BACTROBAN NASAL	2	
BACTROBAN CREAM	2	
BACTROBAN OINTMENT	3	
BIAXIN	3	
BIAXIN XL	3	
BIAXIN XL PAC	3	
BICILLIN C-R	2	
BICILLIN L-A	2	
CEDAX	2	
CEFACLOR ER	2	
<i>cefaclor capsule</i>	1	
CEFACLOR SUSPENSION RECONSTITUTED 125MG/5ML, 250MG/5ML	2	
<i>cefaclor suspension reconstituted 375mg/5ml</i>	1	
<i>cefadroxil</i>	1	
CEFAZOLIN SODIUM INJECTION 1GM; 5%, 20GM, 500MG; 5%	2	
<i>cefazolin sodium injection 1gm, 500mg</i>	1	
<i>cefdinir</i>	1	
<i>cefepime</i>	1	
CEFIZOX IN DEXTROSE 5%	2	
<i>cefotaxime sodium</i>	1	
CEFOTETAN	2	
<i>cefoxitin sodium injection 10gm, 1gm, 2gm</i>	1	
<i>cefpodoxime proxetil</i>	1	
<i>cefprozil</i>	1	
CEFTIN	3	
<i>ceftriaxone sodium</i>	1	
CEFTRIAZONE/DEXTROSE	2	
<i>cefuroxime axetil</i>	1	
<i>cefuroxime sodium</i>	1	
CEFUROXIME/DEXTROSE	2	
CEPHALEXIN TABLET	2	
<i>cephalexin capsule, suspension reconstituted</i>	1	
CHLORAMPHENICOL SODIUM SUCCINATE	2	
CIPRO I.V.-IN D5W	3	
CIPRO SUSPENSION RECONSTITUTED	2	
CIPRO TABLET	3	
<i>ciprofloxacin</i>	1	

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Drug Name	Drug Tier	Notes
<i>ciprofloxacin er</i>	1	
<i>ciprofloxacin extended-release</i>	1	
<i>ciprofloxacin hcl</i>	1	
CLAFORAN/D5W	2	
CLAFORAN INJECTION 1GM	2	
CLAFORAN INJECTION 10GM, 2GM, 500MG	3	
<i>clarithromycin</i>	1	
<i>clarithromycin er</i>	1	
CLEOCIN GALAXY	2	
CLEOCIN PEDIATRIC GRANULES	2	
CLEOCIN PHOSPHATE	3	
CLEOCIN SUPPOSITORY	2	
CLEOCIN CREAM	3	
CLEOCIN CAPSULE 75MG	2	
CLEOCIN CAPSULE 150MG, 300MG	3	
<i>clindamycin hcl</i>	1	
<i>clindamycin phosphate</i>	1	
<i>clindamycin phosphate add-vantage</i>	1	
<i>colistimethate sodium</i>	1	
COLY-MYCIN M	3	
CORTISPORIN CREAM	2	
CORTISPORIN OINTMENT	2	QL (15 per 30 days)
CUBICIN	2	
DECLOMYCIN	3	
<i>demeclocycline hcl</i>	1	
<i>dicloxacillin sodium</i>	1	
DORIBAX	2	
DORYX TABLET DELAYED RELEASE 100MG, 75MG	2	
<i>doxy-caps</i>	1	
DOXYCYCLINE HYCLATE CAPSULE DELAYED RELEASE PARTICLES	2	
<i>doxycycline hyclate capsule, tablet</i>	1	
<i>doxycycline hyclate injection 100mg</i>	1	
<i>doxycycline monohydrate tablet 50mg, 75mg</i>	1	
DYNACIN	3	
<i>e.e.s. 400</i>	1	
E.E.S. GRANULES	3	
<i>ery</i>	1	
ERY-TAB	2	
ERYPED 200	3	
ERYPED 400	2	
ERYTHROCIN LACTOBIONATE	2	
<i>erythrocin stearate</i>	1	

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Drug Name	Drug Tier	Notes
<i>erythromycin</i>	1	
<i>erythromycin /sulfoxazole</i>	1	
ERYTHROMYCIN BASE	2	
FACTIVE	3	
FLAGYL	3	
FLAGYL ER	2	
FORTAZ INJECTION 1GM/50ML; 5%, 2GM/50ML; 5%	2	
FORTAZ INJECTION 1GM, 2GM, 6GM	3	
FURADANTIN	2	
GANTRISIN PEDIATRIC	2	
<i>gentamicin sulfate</i>	1	
GENTAMICIN SULFATE/0.9% SODIUM CHLORIDE INJECTION 0.9MG/ML; 0.9%, 1.4MG/ML; 0.9%	2	
<i>gentamicin sulfate/0.9% sodium chloride injection 1.6mg/ml; 0.9%, 1mg/ml; 0.9%</i>	1	
<i>gentamicin sulfate/sodium chloride</i>	1	
HELIDAC	2	
HIPREX	3	
INVANZ	2	
IQUIX	3	QL (20 per 30 days)
<i>isotonic gentamicin</i>	1	
KANAMYCIN SULFATE	2	
KEFLEX SUSPENSION RECONSTITUTED	3	
KEFLEX CAPSULE 750MG	2	
KEFLEX CAPSULE 250MG, 500MG	3	
KETEK	3	
KLARON	3	
LEVAQUIN	2	
LEVAQUIN PREMIX	2	
LINCOCIN	3	
MACROBID	3	
MACRODANTIN CAPSULE 25MG	2	
MACRODANTIN CAPSULE 100MG, 50MG	3	
MAXIPIME INJECTION 2GM	2	
MAXIPIME INJECTION 1GM	3	
MEFOXIN	3	
MEFOXIN ADD-VANTAGE	3	
MEFOXIN IN DEXTROSE 2.2%	2	
MEFOXIN IN DEXTROSE 3.9%	2	
MERREM	2	
<i>methenamine hippurate</i>	1	
METROCREAM	3	
METROGEL	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 14

Drug Name	Drug Tier	Notes
METROLOTION	3	
<i>metronidazole</i>	1	
<i>metronidazole in nacl 0.79%</i>	1	
<i>metronidazole vaginal</i>	1	
MINOCIN	3	
<i>minocycline hcl</i>	1	
MONODOX	3	
MONUROL	2	
<i>mupirocin</i>	1	
NAFCILLIN SODIUM	2	
NALLPEN/DEXTROSE	2	
NEO-FRADIN	2	
<i>neomycin /bacitracin /polymyxin</i>	1	
<i>neomycin sulfate</i>	1	
<i>neomycin/polymyxin b sulfates</i>	1	
NEUTREXIN	2	
<i>nitrofurantoin macrocrystalline</i>	1	
<i>nitrofurantoin monohydrate</i>	1	
NORITATE	2	
NOROXIN	3	
<i>ofloxacin</i>	1	
OMNICEF	3	
ORACEA	2	
OXACILLIN SODIUM	2	
<i>paromomycin sulfate</i>	1	
PCE	2	
<i>penicillin g potassium</i>	1	
PENICILLIN G POTASSIUM IN ISO-OSMOTIC DEXTROSE	2	
PENICILLIN G PROCAINE	2	
PENICILLIN G SODIUM	2	
<i>penicillin v potassium</i>	1	
PFIZERPEN-G INJECTION 20MU	3	
<i>pfizerpen-g injection 5mu</i>	1	
PHISOHEX	2	
PIPERACILLIN SODIUM	2	
<i>polymyxin b sulfate</i>	1	
PREVPAC	3	
PRIMAXIN I.M.	2	
PRIMAXIN IV	2	
PRIMSOL	2	
QUIXIN	3	
RANICLOR	2	
ROCEPHIN	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 15

Drug Name	Drug Tier	Notes
ROCEPHIN IN ISO-OSMOTIC DEXTROSE	3	
SEPTRA	3	
SEPTRA DS	3	
SILVADENE	3	
<i>silver sulfadiazine</i>	1	
<i>sodium sulfacetamide</i>	1	
<i>ssd</i>	1	
STREPTOMYCIN SULFATE	2	
SULFADIAZINE	2	
SULFAMETHOXAZOLE /TRIMETHOPRIM INJECTION	2	
<i>sulfamethoxazole /trimethoprim suspension, tablet</i>	1	
<i>sulfamethoxazole/trimethoprim ds</i>	1	
SULFAMYLON	2	
<i>sulfatrim</i>	1	
SUPRAX SUSPENSION RECONSTITUTED	2	
SYNERCID	2	
<i>tazicef</i>	1	
<i>tetracycline hcl</i>	1	
<i>thermazene</i>	1	
TIMENTIN	2	
<i>tobramycin /dexamethasone</i>	1	
<i>tobramycin sulfate</i>	1	
TOBRAMYCIN SULFATE/SODIUM CHLORIDE	2	
<i>trimethoprim</i>	1	
<i>trimox</i>	1	
TYGACIL	2	
UNASYN	3	
UNASYN BULK PACK	3	
UREX	3	
VANCOCIN HCL	2	
VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE	2	
VANCOMYCIN HCL INJECTION 10GM	2	
<i>vancomycin hcl injection 1000mg</i>	1	
<i>vandazole</i>	1	
VANTIN	3	
<i>veetids</i>	1	
VIBRAMYCIN	2	
VIBRATAB	3	
XIFAXAN	2	
ZINACEF IN ISO-OSMOTIC DEXTROSE	2	
ZINACEF IN ISO-OSMOTIC DILUENT	2	
ZINACEF INJECTION 1.5GM, 750MG	2	
<i>zinacef injection 7.5gm</i>	1	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 16

Drug Name	Drug Tier	Notes
ZITHROMAX	3	
ZITHROMAX TRI-PAK	3	
ZITHROMAX Z-PAK	3	
ZMAX	2	
ZOSYN	2	
ZYMAR	2	QL (10 per 30 days)
ZYVOX INJECTION	2	
ZYVOX SUSPENSION RECONSTITUTED, TABLET	4	
<b>Anticonvulsants</b>		
BANZEL	2	
<i>carbamazepine</i>	1	
CARBATROL	2	
CELONTIN	2	
DEPACON	3	
DEPAKENE	3	
DEPAKOTE	2	
DEPAKOTE ER	2	
DEPAKOTE SPRINKLES	2	
DILANTIN INFATABS	2	
DILANTIN SUSPENSION	3	
DILANTIN CAPSULE 30MG	2	
DILANTIN CAPSULE 100MG	3	
<i>divalproex sodium</i>	1	
<i>epitol</i>	1	
EQUETRO	2	
<i>ethosuximide</i>	1	
FELBATOL	2	
<i>fosphenytoin sodium</i>	1	
<i>gabapentin</i>	1	
GABITRIL	2	
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500MG	2	
KEPPRA INJECTION	2	
KEPPRA ORAL SOLUTION, TABLET	3	
LAMICTAL	3	
LAMICTAL CHEWABLE DISPERSIBLE	3	
LAMICTAL STARTER/NOT TAKING	2	
CARBAMAZEPINE		
LAMICTAL STARTER/TAKING	2	
CARBAMAZEPINE/NOT TAKING VALPROATE		
LAMICTAL STARTER/TAKING VALPROATE	2	
<i>lamotrigine</i>	1	
<i>levetiracetam</i>	1	
LYRICA	3	

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Drug Name	Drug Tier	Notes
MYSOLINE	3	
NEURONTIN	3	
<i>oxcarbazepine</i>	1	
PEGANONE	2	
PHENYTEK	2	
<i>phenytoin</i>	1	
<i>phenytoin sodium</i>	1	
<i>phenytoin sodium extended</i>	1	
<i>primidone</i>	1	
STAVZOR	2	
TEGRETOL	3	
TEGRETOL-XR	2	
TOPAMAX	2	
TOPAMAX SPRINKLE	2	
TRILEPTAL SUSPENSION	2	
TRILEPTAL TABLET	3	
<i>valproate sodium</i>	1	
<i>valproic acid</i>	1	
VIMPAT TABLET	2	
ZARONTIN	3	
ZONEGRAN	3	
<i>zonisamide</i>	1	
<b>Antidementia Agents</b>		
ARICEPT	2	
ARICEPT ODT	2	
COGNEX	2	
<i>ergoloid mesylates</i>	1	
EXELON CAPSULE, SOLUTION	2	
EXELON PATCH 24 HOUR	2	QL (30 per 30 days)
<i>galantamine hydrobromide</i>	1	
NAMENDA	2	
NAMENDA TITRATION PAK	2	
RAZADYNE ER	3	
RAZADYNE SOLUTION	2	
RAZADYNE TABLET	3	
<b>Antidepressants</b>		
<i>amitriptyline hcl</i>	1	
AMOXAPINE	2	
ANAFRANIL	3	
<i>budeprion sr</i>	1	
<i>budeprion xl tablet extended release 24 hour 300mg</i>	1	
<i>bupropion hcl</i>	1	
<i>bupropion hcl sr</i>	1	
CELEXA	3	

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Drug Name	Drug Tier	Notes
<i>chlordiazepoxide /amitriptyline</i>	1	
<i>citalopram hydrobromide</i>	1	
<i>clomipramine hcl</i>	1	
CYMBALTA	3	
<i>desipramine hcl</i>	1	
<i>doxepin hcl</i>	1	
EFFEXOR	3	
EFFEXOR XR	2	
EMSAM	2	
<i>fluoxetine hcl</i>	1	
<i>fluvoxamine maleate</i>	1	
<i>imipramine hcl</i>	1	
IMIPRAMINE PAMOATE	2	
LEXAPRO	2	
LIMBITROL	3	
MAPROTILINE HCL	2	
MARPLAN	2	
<i>mirtazapine</i>	1	
<i>mirtazapine odt</i>	1	
NARDIL	2	
<i>nefazodone hcl</i>	1	
NORPRAMIN	3	
<i>nortriptyline hcl</i>	1	
PAMELOR	3	
PARNATE	3	
<i>paroxetine hcl</i>	1	
<i>paroxetine hcl er</i>	1	
PAXIL	3	
PERPHENAZINE /AMITRIPTYLINE	2	
PRISTIQ	3	
<i>protriptyline hcl</i>	1	
PROZAC	3	
RAPIFLUX	3	
REMERON	3	
REMERON SOLTAB	3	
<i>sertraline hcl</i>	1	
SURMONTIL CAPSULE 100MG	2	
SURMONTIL CAPSULE 25MG, 50MG	3	
TOFRANIL	3	
TOFRANIL-PM	2	
<i>tranylcypromine sulfate</i>	1	
<i>trazodone hcl</i>	1	
<i>trimipramine maleate</i>	1	
<i>venlafaxine hcl</i>	1	

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Drug Name	Drug Tier	Notes
VIVACTIL	2	
WELLBUTRIN	3	
WELLBUTRIN SR	3	
WELLBUTRIN XL	3	
ZOLOFT	3	
<b>Antidotes, Deterrents, and Toxicologic Agents</b>		
ANTABUSE	2	
ANTIZOL	3	
CAMPRAL	2	
CHANTIX	2	QL (504 per 365 days)
CHEMET	2	
CUPRIMINE	2	
<i>depade</i>	1	
DEPEN TITRATABS	2	
EXJADE	3	PA
<i>fomepizole</i>	1	
KAYEXALATE	3	
<i>kionex</i>	1	
<i>naloxone hcl</i>	1	
<i>naltrexone hcl</i>	1	
NICOTROL INHALER	2	
NICOTROL NS	2	
RELISTOR	2	
REVIA	3	
<i>sodium polystyrene sulfonate</i>	1	
SUBOXONE	2	
SYPRINE	2	
ZYBAN	3	
<b>Antiemetics</b>		
ALOXI	2	
ANZEMET INJECTION	2	
ANZEMET TABLET	2	PA (Part B vs Part D only)
CESAMET	2	
<i>compro</i>	1	
EMEND	2	PA
<i>granisetron hcl injection</i>	1	
<i>granisetron hcl tablet</i>	1	PA (Part B vs Part D only)
<i>granisol</i>	1	PA (Part B vs Part D only)
KYTRIL INJECTION	3	
KYTRIL TABLET	3	PA (Part B vs Part D only)
MARINOL	2	
<i>metoclopramide hcl</i>	1	
<i>ondansetron hcl injection</i>	1	
<i>ondansetron hcl oral solution, tablet</i>	1	PA (Part B vs Part D only)

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Drug Name	Drug Tier	Notes
<i>ondansetron odt</i>	1	PA (Part B vs Part D only)
<i>phenadoz</i>	1	
PHENERGAN	3	
<i>prochlorperazine</i>	1	
<i>prochlorperazine edisylate</i>	1	
<i>prochlorperazine maleate</i>	1	
<i>promethazine hcl</i>	1	
<i>promethegan</i>	1	
TIGAN INJECTION	3	
TIGAN CAPSULE	3	PA (Part B vs Part D only)
TRANSDERM-SCOP	2	
<i>trimethobenzamide hcl injection</i>	1	
<i>trimethobenzamide hcl capsule</i>	1	PA (Part B vs Part D only)
ZOFRAN ODT	3	PA (Part B vs Part D only)
ZOFRAN INJECTION	3	
ZOFRAN ORAL SOLUTION, TABLET	3	PA (Part B vs Part D only)
<b>Antifungals</b>		
ABELCET	2	PA (Part B vs Part D only)
AMBISOME	2	PA (Part B vs Part D only)
AMPHOTEC	2	PA (Part B vs Part D only)
<i>amphotericin b</i>	1	PA (Part B vs Part D only)
ANCOBON	2	
CANCIDAS	2	
<i>ciclopirox olamine</i>	1	
<i>ciclopirox suspension</i>	1	
<i>clotrimazole</i>	1	
<i>clotrimazole/betamethasone dipropionate</i>	1	
DIFLUCAN	3	
DIFLUCAN IN NAACL	3	
<i>econazole nitrate</i>	1	
ERAXIS	2	
ERTACZO	2	
EXELDERM	2	
<i>fluconazole</i>	1	
<i>fluconazole in dextrose</i>	1	
GRIFULVIN V	3	
GRIS-PEG	2	
<i>griseofulvin microsized</i>	1	
<i>itraconazole</i>	1	
<i>ketoconazole</i>	1	
<i>kuric</i>	1	
LAMISIL SOLUTION	2	
LAMISIL PACKET, TABLET	3	
LOPROX	2	

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Drug Name	Drug Tier	Notes
LOPROX SHAMPOO	3	
LOTRISONE	3	
MENTAX	2	
MICONAZOLE 3	2	
MYCAMINE	4	
MYCOSTATIN	3	
NAFTIN	2	
NIZORAL	3	
NOXAFIL	4	
<i>nystatin</i>	1	
<i>nystatin/triamcinolone</i>	1	
<i>nystop</i>	1	
OXISTAT	2	
<i>pedi-dri</i>	1	
PENLAC NAIL LACQUER	3	
SELSUN SHAMPOO	3	
SPORANOX PULSEPAK	3	
SPORANOX SOLUTION	2	
SPORANOX CAPSULE	3	
TERAZOL 3 SUPPOSITORY	3	
TERAZOL 7	3	
<i>terbinafine hcl</i>	1	
<i>terconazole</i>	1	
VFEND	4	
VFEND IV	2	
<i>zazole</i>	1	
<b>Antigout Agents</b>		
<i>allopurinol</i>	1	
<i>allopurinol sodium</i>	1	
ALOPRIM	3	
<i>colchicine</i>	1	
<i>probenecid</i>	1	
<i>probenecid/colchicine</i>	1	
ULORIC	2	ST
ZYLOPRIM	3	
<b>Antimigraine Agents</b>		
AMERGE	3	QL (36 per 90 days)
AXERT	3	QL (36 per 90 days)
CAFERGOT	3	
D.H.E. 45	3	
<i>dihydroergotamine mesylate</i>	1	
ERGOMAR	2	
<i>ergotamine tartrate/caffeine</i>	1	
FROVA	3	QL (36 per 90 days)

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Drug Name	Drug Tier	Notes
IMITREX STATDOSE REFILL	2	QL (36 per 90 days)
IMITREX TABLET	2	
IMITREX INJECTION, NASAL SOLUTION	2	QL (36 per 90 days)
MAXALT	2	QL (36 per 90 days)
MAXALT-MLT	2	QL (36 per 90 days)
MIGERGOT	2	
MIGRANAL	2	
RELPAK	3	QL (36 per 90 days)
ZOMIG	3	QL (36 per 90 days)
ZOMIG ZMT	3	QL (36 per 90 days)
<b>Antimyasthenic Agents</b>		
<i>bethanechol chloride</i>	1	
GUANIDINE HCL	2	
MESTINON TIMESPAN	2	
MESTINON SYRUP	2	
MESTINON TABLET	3	
MYTELASE	2	
<i>pyridostigmine bromide</i>	1	
REGONOL	2	
<b>Antimycobacterials</b>		
CAPASTAT SULFATE	2	
DAPSONE	2	
<i>ethambutol hcl</i>	1	
<i>isonarif</i>	1	
ISONIAZID INJECTION, SYRUP	2	
<i>isoniazid tablet</i>	1	
MYAMBUTOL	3	
MYCOBUTIN	2	
PASER	2	
PRIFTIN	2	
<i>pyrazinamide</i>	1	
RIFADIN	3	
RIFAMATE	3	
<i>rifampin</i>	1	
RIFATER	2	
SEROMYCIN	2	
TRECTOR	2	
<b>Antineoplastics</b>		
ABRAXANE	2	
<i>adriamycin</i>	1	
ALIMTA	2	
ALKERAN	2	PA (Part B vs Part D only)
ARIMIDEX	2	
AROMASIN	2	

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Drug Name	Drug Tier	Notes
ARRANON	2	
AVASTIN	4	PA
BICNU	2	
<i>bleomycin sulfate</i>	1	
BUSULFEX	2	
CAMPATH	2	
CAMPTOSAR	3	
<i>carboplatin</i>	1	
CEENU	2	
CERUBIDINE	3	
<i>cisplatin</i>	1	
<i>cladribine</i>	1	
CLOLAR	2	
COSMEGEN	2	
<i>cyclophosphamide injection</i>	1	
<i>cyclophosphamide tablet</i>	1	PA (Part B vs Part D only)
<i>cytarabine</i>	1	
CYTARABINE AQUEOUS INJECTION 100MG/ML	3	
<i>cytarabine aqueous injection 20mg/ml</i>	1	
CYTOXAN INJECTION 2GM	3	
<i>dacarbazine</i>	1	
DACOGEN	2	
DAUNORUBICIN HCL	2	
DAUNOXOME	2	
DOXIL	2	
<i>doxorubicin hcl</i>	1	
DROXIA	2	
ELITEK	2	
ELLECE	3	
ELOXATIN	2	
ELSPAR	2	
EMCYT	2	
<i>epirubicin hcl</i>	1	
ERBITUX	2	PA
ETHYOL	3	
ETOPOPHOS	2	
<i>etoposide</i>	1	
FARESTON	2	
FASLODEX	2	PA
FEMARA	2	
FLUDARA	3	
FLUDARABINE PHOSPHATE INJECTION 50MG/2ML	3	
FLUOROURACIL	3	
GEMZAR	2	

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Drug Name	Drug Tier	Notes
GLEEVEC	4	PA
HERCEPTIN	2	
HEXALEN	2	
HYCAMTIN	2	
HYDREA	3	
<i>hydroxyurea</i>	1	
IDAMYCIN PFS	3	
<i>idarubicin hcl</i>	1	
IFEX	3	
<i>ifosfamide</i>	1	
<i>ifosfamide/mesna</i>	1	
IRESSA	4	PA
<i>irinotecan</i>	1	
IXEMPRA KIT	4	PA
LEUKERAN	2	
LEUSTATIN	3	
MATULANE	2	
<i>mercaptopurine</i>	1	
<i>mesna</i>	1	
MESNEX TABLET	2	
MESNEX INJECTION	3	
<i>mitomycin</i>	1	
<i>mitoxantrone hcl</i>	1	
MUSTARGEN	2	
MYLOTARG	2	
NAVELBINE	3	
NEXAVAR	4	PA
NIPENT	3	
NOVANTRONE	3	
ONCASPAR	2	
ONTAK	2	
<i>onxol</i>	1	
<i>paclitaxel</i>	1	
PANRETIN	2	
<i>pentostatin</i>	1	
PHOTOFRIN	2	
PLATINOL AQ	3	
PROLEUKIN	2	
PURINETHOL	3	
REVLIMID	4	PA ** Limited Access Drug. This prescription may be available only at certain pharmacies. For more information, consult your

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 25

Drug Name	Drug Tier	Notes
		Pharmacy Directory or call Member Services at 800-346-4643. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643. Please call 8:00 a.m. - 8:00 p.m., Mtn. Time, Mon. - Fri. From Nov. 15 through March 1, we are also available 8:00 a.m. - 8:00 p.m., Mtn. Time, on weekends and most holidays.
RITUXAN	2	
SPRYCEL TABLET 20MG, 50MG, 70MG	4	PA
SUTENT	4	PA
TABLOID	2	
<i>tamoxifen citrate</i>	1	
TARCEVA	4	PA
TARGRETIN	4	
TASIGNA	4	PA
TAXOTERE	2	
THALOMID	4	
<i>thiotepa</i>	1	
<i>toposar</i>	1	
TORISEL	2	PA
<i>tretinoin</i>	1	
TRISENOX	2	
TYKERB	4	PA
VECTIBIX	2	PA
VELCADE	4	
VESANOID	4	
VIDAZA	2	
VINBLASTINE SULFATE	2	
<i>vincasar pfs</i>	1	
<i>vincristine sulfate</i>	1	
<i>vinorelbine tartrate</i>	1	
ZANOSAR	2	
ZOLINZA	4	PA
<b>Antiparasitics</b>		
<i>acticin</i>	1	
ALBENZA	2	
ALINIA	2	
ARALEN	3	
BILTRICIDE	2	

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Drug Name	Drug Tier	Notes
<i>chloroquine phosphate</i>	1	
DARAPRIM	2	
ELIMITE	3	
EURAX	2	
FANSIDAR	2	
<i>hydroxychloroquine sulfate</i>	1	
LARIAM	3	
<i>lindane</i>	1	
MALARONE	2	
<i>mebendazole</i>	1	
<i>mefloquine hcl</i>	1	
MEPRON	4	
NEBUPENT	2	
OVIDE	2	
PENTAM 300	2	
<i>permethrin</i>	1	
PLAQUENIL	3	
PRIMAQUINE PHOSPHATE	2	
QUALAQUIN	2	
STROMEKTOL	2	
TINDAMAX	2	
<b>Antiparkinson Agents</b>		
AMANTADINE HCL TABLET	2	
<i>amantadine hcl capsule</i>	1	
APOKYN	2	PA
<i>atamet</i>	1	
AZILECT	2	
<i>benztropine mesylate</i>	1	
<i>bromocriptine mesylate</i>	1	
<i>carbidopa/levodopa</i>	1	
<i>carbidopa/levodopa cr</i>	1	
<i>carbidopa/levodopa odt</i>	1	
<i>carbidopa/levodopa sr</i>	1	
COGENTIN	2	
COMTAN	2	
ELDEPRYL	3	
LODOSYN	2	
MIRAPEX	2	
PARCOPA	2	
PARLODEL	3	
REQUIP	3	
REQUIP XL TABLET EXTENDED RELEASE 24 HOUR 12MG, 2MG, 4MG, 8MG	2	
<i>ropinirole hcl</i>	1	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 27

Drug Name	Drug Tier	Notes
SELEGILINE HCL TABLET	2	
<i>selegiline hcl capsule</i>	1	
SINEMET	3	
SINEMET CR	3	
STALEVO 100	2	
STALEVO 125	2	
STALEVO 150	2	
STALEVO 200	2	
STALEVO 50	2	
STALEVO 75	2	
TASMAR	2	
<i>trihexyphenidyl hcl</i>	1	
ZELAPAR	2	
<b>Antipsychotics</b>		
ABILIFY	2	
ABILIFY DISCMELT	2	
CHLORPROMAZINE HCL INJECTION	2	
<i>chlorpromazine hcl tablet</i>	1	
CLOZAPINE TABLET 200MG	2	
<i>clozapine tablet 100mg, 25mg, 50mg</i>	1	
CLOZARIL	3	
FAZACLO	2	
<i>fluphenazine decanoate</i>	1	
FLUPHENAZINE HCL CONCENTRATE, ELIXIR, INJECTION	2	
<i>fluphenazine hcl tablet</i>	1	
GEODON	2	
HALDOL	3	
HALDOL DECANOATE-100	3	
HALDOL DECANOATE-50	3	
<i>haloperidol</i>	1	
<i>haloperidol decanoate</i>	1	
<i>haloperidol lactate</i>	1	
INVEGA	2	
<i>loxapine succinate</i>	1	
LOXITANE	3	
MOBAN	2	
NAVANE	3	
ORAP	2	
<i>perphenazine</i>	1	
RISPERDAL	2	
RISPERDAL CONSTA	2	
RISPERDAL M-TAB	2	
<i>risperidone</i>	1	

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Drug Name	Drug Tier	Notes
SEROQUEL	2	
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200MG, 300MG, 400MG	2	
SYMBYAX	2	
<i>thioridazine hcl</i>	1	
<i>thiothixene</i>	1	
<i>trifluoperazine hcl</i>	1	
ZYPREXA	2	
ZYPREXA ZYDIS	2	
<b>Antispasticity Agents</b>		
<i>baclofen</i>	1	
DANTRIUM	3	
<i>dantrolene sodium</i>	1	
<i>tizanidine hcl</i>	1	
ZANAFLEX	2	
<b>Antivirals</b>		
<i>acyclovir</i>	1	
<i>acyclovir sodium</i>	1	
APTIVUS CAPSULE	2	
ATRIPLA	4	
BARACLUDE	2	
COMBIVIR	4	
COPEGUS	4	
CRIXIVAN	2	
CYTOVENE	2	
DENAVIR	2	
<i>didanosine</i>	1	
EMTRIVA	2	
EPIVIR	2	
EPIVIR HBV	2	
EPZICOM	2	
<i>famciclovir</i>	1	
FAMVIR	3	
FLUMADINE	3	
FUZEON	4	
GANCICLOVIR	4	
HEPSERA	2	
INTELENCE	4	
INVIRASE	2	
ISENTRESS	2	
KALETRA	4	
LEXIVA SUSPENSION	2	
LEXIVA TABLET	4	
NORVIR	2	

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Drug Name	Drug Tier	Notes
PREZISTA	2	
REBETOL	4	
RELENZA DISKHALER	2	
RESCRIPTOR	2	
RETROVIR	3	
RETROVIR IV INFUSION	2	
REYATAZ	4	
<i>ribapak tablet</i>	1	
<i>ribapak miscellaneous</i>	4	
<i>ribasphere</i>	1	
<i>ribavirin capsule</i>	1	
<i>ribavirin tablet 200mg</i>	1	
<i>rimantadine hcl</i>	1	
SELZENTRY	2	
<i>stavudine capsule</i>	1	
SUSTIVA	2	
TAMIFLU	2	
TRIZIVIR	4	
TRUVADA	4	
TYZEKA	2	
VALCYTE	4	
VALTREX	2	
VIDEX EC CAPSULE DELAYED RELEASE 125MG	2	
VIDEX EC CAPSULE DELAYED RELEASE 200MG, 250MG, 400MG	3	
VIDEX PEDIATRIC	2	
VIRACEPT	2	
VIRAMUNE	2	
VIRAZOLE	2	
VIREAD	2	
VISTIDE	2	
ZERIT	2	
ZIAGEN	2	
<i>zidovudine</i>	1	
ZOVIRAX CREAM, OINTMENT	2	
ZOVIRAX CAPSULE, SUSPENSION, TABLET	3	
<b>Anxiolytics</b>		
BUSPAR	3	
<i>bupirone hcl</i>	1	
<i>chlordiazepoxide /amitriptyline</i>	1	
<i>meprobamate</i>	1	
<i>paroxetine hcl er</i>	1	
VANSPAR	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 30

Drug Name	Drug Tier	Notes
<b>Bipolar Agents</b>		
<i>lithium carbonate er</i>	1	
LITHIUM CARBONATE TABLET	2	
LITHIUM CARBONATE CAPSULE 600MG	2	
<i>lithium carbonate capsule 150mg, 300mg</i>	1	
<i>lithium citrate</i>	1	
LITHOBID	3	
RISPERDAL M-TAB	2	
SYMBYAX	2	
<b>Blood Glucose Regulators</b>		
<i>acarbose</i>	1	
ACTOPLUS MET	2	
ACTOS	2	
AMARYL	3	
AVANDAMET	3	
AVANDARYL	3	
AVANDIA	3	
BYETTA	2	
<i>chlorpropamide</i>	1	
DIABETA	2	
DUETACT	2	
<i>glimepiride</i>	1	
<i>glipizide</i>	1	
<i>glipizide er</i>	1	
<i>glipizide xl</i>	1	
<i>glipizide/metformin hcl</i>	1	
GLUCAGEN HYPOKIT	2	
GLUCAGON EMERGENCY KIT	2	
GLUCOPHAGE	3	
GLUCOPHAGE XR	3	
GLUCOTROL	3	
GLUCOTROL XL	3	
GLUCOVANCE	3	
GLUMETZA	3	
<i>glyburide micronized</i>	1	
<i>glyburide/metformin hcl</i>	1	
GLYBURIDE TABLET 1.25MG, 5MG	2	
<i>glyburide tablet 2.5mg</i>	1	
GLYCRON TABLET 4.5MG	2	
<i>glycron tablet 1.5mg, 3mg, 6mg</i>	1	
GLYNASE	3	
GLYSET	3	
HUMALOG	2	
HUMALOG MIX 50/50	2	

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Drug Name	Drug Tier	Notes
HUMALOG MIX 75/25	2	
HUMULIN 50/50	2	
HUMULIN 70/30	2	
HUMULIN N	2	
HUMULIN R	2	
JANUMET	3	
JANUVIA	3	
LANTUS	2	
LEVEMIR	2	
METAGLIP	3	
<i>metformin hcl</i>	1	
<i>metformin hcl er</i>	1	
NOVOLIN 70/30	3	
NOVOLIN N	3	
NOVOLIN R	3	
NOVOLOG	3	
NOVOLOG MIX 70/30	3	
PRANDIMET	3	
PRANDIN	3	
PRECOSE	3	
PROGLYCEM	2	
RELION 70/30	3	
RELION N	3	
RELION R	3	
RIOMET	2	
STARLIX	3	
SYMLIN	2	
SYMLINPEN 60	2	
<i>tolazamide</i>	1	
TOLBUTAMIDE	2	
<b>Blood Products/Modifiers/ Volume Expanders</b>		
AGGRENEX	2	
ARANESP ALBUMIN FREE	2	PA (Part B vs Part D only)
ARIXTRA	2	
<i>cilostazol</i>	1	
COUMADIN INJECTION	2	
COUMADIN TABLET	3	
CYKLOKAPRON	2	
<i>dipyridamole</i>	1	
EPOGEN	2	PA (Part B vs Part D only)
FRAGMIN	2	
HEPARIN SODIUM DCU	2	
HEPARIN SODIUM/D5W INJECTION 5%; 50UNIT/ML	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 32

Drug Name	Drug Tier	Notes
<i>heparin sodium/d5w injection 5%; 100unit/ml, 5%; 40unit/ml</i>	1	
<i>heparin sodium/nacl 0.9%</i>	1	
HEPARIN SODIUM INJECTION 2000UNIT/ML, 2500UNIT/ML	2	
<i>heparin sodium injection 10000unit/ml, 1000unit/ml, 5000unit/ml</i>	1	
INNOHEP	2	
<i>jantoven</i>	1	
LEUKINE	2	
LOVENOX	2	
NEULASTA	2	
NEUMEGA	2	
NEUPOGEN	4	
PERSANTINE	3	
PLAVIX	2	
PLETAL	3	
PROCRIT	2	PA (Part B vs Part D only)
TICLID	3	
<i>ticlopidine hcl</i>	1	
<i>warfarin sodium</i>	1	
<b>Cardiovascular Agents</b>		
ACCUPRIL	3	
ACCURETIC	3	
<i>acebutolol hcl</i>	1	
ACEON	3	
<i>acetazolamide</i>	1	
ACETAZOLAMIDE SODIUM	2	
ADALAT CC	3	
ADVICOR	3	
<i>afeditab cr</i>	1	
ALDACTAZIDE TABLET 50MG; 50MG	2	
ALDACTAZIDE TABLET 25MG; 25MG	3	
ALDACTONE	3	
ALTACE CAPSULE	3	
<i>amiloride /hydrochlorothiazide</i>	1	
AMILORIDE HCL	2	
<i>amiodarone hcl</i>	1	
<i>amlodipine besylate</i>	1	
<i>amlodipine besylate/benazepril hydrochloride</i>	1	
ANTARA	3	
ATACAND	3	
ATACAND HCT TABLET 16MG; 12.5MG, 32MG; 12.5MG	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 33

Drug Name	Drug Tier	Notes
<i>atenolol</i>	1	
<i>atenolol/chlorthalidone</i>	1	
AVALIDE	3	
AVAPRO	3	
<i>benazepril hcl</i>	1	
<i>benazepril hcl/hydrochlorothiazide</i>	1	
BENICAR	2	
BENICAR HCT	2	
BETAPACE	3	
BETAPACE AF	3	
<i>betaxolol hcl</i>	1	
BIDIL	2	
<i>bisoprolol fumarate</i>	1	
<i>bisoprolol fumarate/hydrochlorothiazide</i>	1	
<i>bumetanide</i>	1	
BUMEX	3	
BYSTOLIC TABLET 10MG, 2.5MG, 5MG	2	
CADUET	3	
CALAN	3	
CALAN SR	3	
CAPOTEN TABLET 12.5MG, 25MG, 50MG	3	
<i>captopril</i>	1	
<i>captopril /hydrochlorothiazide</i>	1	
CARDENE I.V.	2	
CARDENE SR	3	
CARDIZEM	3	
CARDIZEM CD	3	
CARDIZEM LA	3	
<i>cartia xt</i>	1	
CARTROL	2	
<i>carvedilol</i>	1	
CATAPRES	3	
CATAPRES-TTS-1	2	QL (8 per 28 days)
CATAPRES-TTS-2	2	QL (8 per 28 days)
CATAPRES-TTS-3	2	QL (8 per 28 days)
<i>chlorothiazide</i>	1	
<i>chlorthalidone</i>	1	
<i>cholestyramine</i>	1	
<i>cholestyramine light powder</i>	1	
<i>clonidine hcl</i>	1	
CLORPRES	2	
COLESTID	3	
<i>colestipol hcl</i>	1	
CORDARONE	3	

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Drug Name	Drug Tier	Notes
COREG	3	
CORGARD	3	
CORZIDE	3	
COVERA-HS	2	
COZAAR	2	
CRESTOR	2	
DEMADEX INJECTION	2	
DEMADEX TABLET	3	
DEMSER	2	
DIAMOX	2	
DIGOXIN ORAL SOLUTION	2	
<i>digoxin injection, tablet</i>	1	
DILACOR XR	3	
DILATRATE SR	2	
<i>dilt-cd capsule extended release 24 hour 180mg</i>	1	
<i>dilt-xr capsule extended release 24 hour 240mg</i>	1	
<i>diltiazem cd</i>	1	
<i>diltiazem hcl er</i>	1	
<i>diltiazem hcl capsule extended release 24 hour, tablet</i>	1	
DILTIAZEM HCL INJECTION 100MG	2	
<i>diltiazem hcl injection 25mg/5ml</i>	1	
DIOVAN	3	
DIOVAN HCT	3	
<i>disopyramide phosphate</i>	1	
<i>disopyramide phosphate er</i>	1	
DIURIL	2	
DIURIL IV	2	
DYAZIDE	3	
DYNACIRC CR	3	
DYNACIRC-CR	3	
DYRENIUM	2	
EDECRIN	2	
<i>enalapril maleate</i>	1	
<i>enalapril maleate/hydrochlorothiazide</i>	1	
<i>eplerenone</i>	1	
<i>felodipine er</i>	1	
<i>fenofibrate</i>	1	
<i>fenofibrate micronized</i>	1	
FENOGLIDE	3	
<i>flecainide acetate</i>	1	
<i>fosinopril sodium</i>	1	
<i>fosinopril sodium/hydrochlorothiazide</i>	1	
<i>furosemide injection, tablet</i>	1	
FUROSEMIDE ORAL SOLUTION 8MG/ML	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 35

Drug Name	Drug Tier	Notes
<i>furosemide oral solution 10mg/ml</i>	1	
<i>gemfibrozil</i>	1	
GUANABENZ ACETATE	2	
<i>guanfacine hcl</i>	1	
<i>hydralazine hcl</i>	1	
<i>hydrochlorothiazide capsule</i>	1	
<i>hydrochlorothiazide tablet 25mg, 50mg</i>	1	
HYZAAR	2	
IMDUR	3	
<i>indapamide</i>	1	
INDERAL LA	3	
INNOPRAN XL	2	
INSPRA	2	
INVERSINE	2	
ISMO	3	
<i>isochron</i>	1	
ISOPTIN SR	3	
ISORDIL TITRADOSE	2	
<i>isosorbide dinitrate</i>	1	
<i>isosorbide dinitrate er</i>	1	
<i>isosorbide mononitrate</i>	1	
<i>isosorbide mononitrate er</i>	1	
<i>isradipine</i>	1	
KERLONE	3	
<i>labetalol hcl</i>	1	
LANOXIN TABLET	3	
LANOXIN INJECTION 0.1MG/ML	2	
LANOXIN INJECTION 0.25MG/ML	3	
LASIX	3	
LESCOL	3	
LESCOL XL	3	
LEVATOL	2	
LIPITOR	3	
LIPOFEN	3	
<i>lisinopril</i>	1	
<i>lisinopril /hydrochlorothiazide</i>	1	
LOFIBRA	3	
LOPID	3	
LOPRESSOR	3	
LOPRESSOR HCT	3	
LOTENSIN	3	
LOTENSIN HCT	3	
LOTREL CAPSULE 10MG; 40MG, 5MG; 40MG	2	

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Drug Name	Drug Tier	Notes
LOTREL CAPSULE 10MG; 20MG, 2.5MG; 10MG, 5MG; 10MG, 5MG; 20MG	3	
<i>lovastatin</i>	1	
LOVAZA	2	
MAVIK	3	
MAXZIDE	3	
MAXZIDE-25	3	
METHYCLOTHIAZIDE	2	
<i>methyldopa</i>	1	
METHYLDOPA /HYDROCHLOROTHIAZIDE	2	
METHYLDOPATE HCL	2	
<i>metolazone</i>	1	
<i>metoprolol /hydrochlorothiazide</i>	1	
<i>metoprolol succinate er</i>	1	
<i>metoprolol tartrate</i>	1	
MEVACOR	3	
MEXILETINE HCL	2	
MICARDIS	3	
MICARDIS HCT	3	
MICROZIDE	3	
<i>midodrine hcl</i>	1	
MINIPRESS	3	
<i>minitran</i>	1	
<i>minoxidil</i>	1	
<i>moexipril /hydrochlorothiazide</i>	1	
<i>moexipril hcl</i>	1	
MONOKET	3	
MONOPRIL	3	
MONOPRIL HCT	3	
<i>nadolol</i>	1	
<i>nadolol /bendroflumethiazide</i>	1	
<i>niacor</i>	1	
NIASPAN	2	
<i>nicardipine hcl capsule</i>	1	
<i>nifediac cc</i>	1	
<i>nifedical xl</i>	1	
<i>nifedipine er</i>	1	
NIFEDIPINE CAPSULE 20MG	2	
<i>nifedipine capsule 10mg</i>	1	
<i>nimodipine</i>	1	
NISOLDIPINE	2	
NITRO-DUR	3	
<i>nitroglycerin</i>	1	
<i>nitroglycerin transdermal</i>	1	

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Drug Name	Drug Tier	Notes
NITROLINGUAL PUMPSPRAY	2	
NITROSTAT	3	
NORPACE	3	
NORPACE CR CAPSULE EXTENDED RELEASE 12 HOUR 100MG	2	
NORPACE CR CAPSULE EXTENDED RELEASE 12 HOUR 150MG	3	
NORVASC	3	
PACERONE TABLET 100MG, 300MG	2	
PACERONE TABLET 400MG	3	
<i>pacerone tablet 200mg</i>	1	
PINDOLOL	2	
PRAVACHOL	3	
<i>pravastatin sodium</i>	1	
<i>prazosin hcl</i>	1	
<i>prevalite packet</i>	1	
PRINIVIL	3	
PRINZIDE	3	
PROAMATINE	3	
PROCAINAMIDE HCL	2	
PROCARDIA	3	
PROCARDIA XL	3	
<i>propafenone hcl</i>	1	
PROPRANOLOL /HYDROCHLOROTHIAZIDE TABLET 25MG; 80MG	2	
<i>propranolol /hydrochlorothiazide tablet 25mg; 40mg</i>	1	
<i>propranolol hcl er</i>	1	
PROPRANOLOL HCL ORAL SOLUTION	2	
<i>propranolol hcl injection, tablet</i>	1	
QUESTRAN	3	
QUESTRAN LIGHT	3	
<i>quinapril /hydrochlorothiazide</i>	1	
<i>quinapril hcl</i>	1	
<i>quinaretic</i>	1	
<i>quinidine gluconate cr</i>	1	
<i>quinidine sulfate</i>	1	
QUINIDINE SULFATE ER	2	
<i>ramipril</i>	1	
<i>reserpine tablet 0.25mg</i>	1	
RYTHMOL	3	
RYTHMOL SR	2	
SECTRAL	3	
SIMCOR	2	
<i>simvastatin</i>	1	

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Drug Name	Drug Tier	Notes
SODIUM EDECIN	2	
<i>sorine</i>	1	
<i>sotalol hcl</i>	1	
<i>spironolactone</i>	1	
<i>spironolactone /hydrochlorothiazide</i>	1	
SULAR	2	
TAMBOCOR	3	
TARKA	2	
<i>taztia xt</i>	1	
TEKTURNA	3	
TEKTURNA HCT	3	
TENEX	3	
TENORETIC 100	3	
TENORETIC 50	3	
TENORMIN	3	
TEVETEN	3	
TEVETEN HCT	3	
THALITONE	2	
TIAZAC	3	
TIKOSYN	2	
TIMOLIDE 10/25	2	
TIMOLOL MALEATE	2	
TOPROL XL	3	
<i>torse mide</i>	1	
TRANDATE	3	
<i>trandolapril</i>	1	
<i>triamterene /hydrochlorothiazide</i>	1	
TRICOR	3	
TRIGLIDE	3	
UNIRETIC	3	
UNIVASC	3	
VASERETIC	3	
VASOTEC	3	
<i>verapamil hcl</i>	1	
<i>verapamil hcl er</i>	1	
VERELAN	3	
VERELAN PM	3	
VYTORIN	2	
WELCHOL	2	
ZAROXOLYN	3	
ZEBETA	3	
ZESTORETIC	3	
ZESTRIL	3	
ZETIA	3	

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Drug Name	Drug Tier	Notes
ZIAC	3	
ZOCOR	3	
<b>Central Nervous System Agents</b>		
ADDERALL	3	
ADDERALL XR	3	
<i>amphetamine salt combo</i>	1	
CONCERTA	2	
DESOXYN	2	PA
DEXEDRINE	3	
<i>dexmethylphenidate hcl</i>	1	
<i>dextroamphetamine sulfate</i>	1	
<i>dextroamphetamine sulfate er</i>	1	
METADATE CD	2	
<i>metadate er</i>	1	
<i>methylin er</i>	1	
METHYLIN TABLET CHEWABLE, SOLUTION	2	
<i>methylin tablet</i>	1	
<i>methyphenidate hcl</i>	1	
<i>methyphenidate hcl sr</i>	1	
PROVIGIL	2	PA
RILUTEK	2	
RITALIN	3	
RITALIN LA	2	
RITALIN SR	3	
STRATTERA	3	
VYVANSE CAPSULE 30MG, 50MG, 70MG	3	
XYREM	2	** Limited Access Drug. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 800-346-4643. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643. Please call 8:00 a.m. - 8:00 p.m., Mtn. Time, Mon. - Fri. From Nov. 15 through March 1, we are also available 8:00 a.m. - 8:00 p.m., Mtn. Time, on weekends and most holidays.
<b>Dental and Oral Agents</b>		
APHTHASOL	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 40

Drug Name	Drug Tier	Notes
<i>chlorhexidine gluconate oral rinse</i>	1	
EVOXAC	2	
<i>pilocarpine hcl</i>	1	
<i>pilocarpine hydrochloride</i>	1	
SALAGEN	3	
<b>Dermatological Agents</b>		
8-MOP	2	
AC CUTANE	3	
ALDARA	2	
AMEVIVE	2	PA
<i>ammonium lactate</i>	1	
<i>amnesteem</i>	1	
ATRALIN	2	
<i>avita</i>	1	
AZELEX	2	
BENZA CLIN CARE KIT	2	
BENZAMYCIN	3	
<i>calcipotriene</i>	1	
CARAC	2	
<i>claravis</i>	1	
CLEOCIN-T	3	
CLINDAGEL	2	
<i>clindamycin phosphate</i>	1	
CONDYLOX GEL	2	
CONDYLOX SOLUTION	3	
DIFFERIN	2	
DOVONEX	2	
EFUDEX	3	
ELIDEL	3	
<i>erythromycin/benzoyl peroxide</i>	1	
EVOCLIN	2	
FINACEA	2	
FLUOROPLEX	2	
<i>fluorouracil</i>	1	
LAC-HYDRIN	3	
<i>laclotion</i>	1	
OXSORALEN	2	
OXSORALEN ULTRA	2	
<i>podofilox</i>	1	
PROTOPIC	3	
REGRANEX	2	
RETIN-A	3	
RETIN-A MICRO	2	
SANTYL	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 41

Drug Name	Drug Tier	Notes
<i>selenium sulfide</i>	1	
SOLARAZE	2	
SORIATANE CK	2	
<i>sotret</i>	1	
TAZORAC	2	
<i>tretinoin</i>	1	
UVADEX	2	
VEREGEN	2	
ZIANA	2	
ZONALON	3	
<b>Enzyme Replacements/ Modifiers</b>		
ADAGEN	2	
ALDURAZYME	2	
BUPHENYL	4	
CEREDASE	2	
CEREZYME	2	
CYSTADANE	2	
CYSTAGON	2	
ELAPRASE	4	
FABRAZYME	2	
KUVAN	4	PA
LIPRAM 4500	2	
LIPRAM-PN10	2	
LIPRAM-PN16	2	
LIPRAM-PN20	2	
LIPRAM-UL12	2	
LIPRAM-UL18	2	
LIPRAM-UL20	2	
NAGLAZYME	2	
ORFADIN	2	
PANCREASE MT 10	2	
PANCREASE MT 16	2	
PANCREASE MT 20	2	
PANCREASE MT 4	2	
PANCRECARB MS-16	2	
PANCRECARB MS-4	2	
PANCRECARB MS-8	2	
PANCRELIPASE	2	
PANCRELIPASE MST-16	2	
PANCRON 10	2	
PANCRON 20	2	
SUCRAID	2	
ULTRASE	2	
ULTRASE MT 12	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 42

Drug Name	Drug Tier	Notes
ULTRASE MT 18	2	
ULTRASE MT 20	2	
VIOKASE	2	
VIOKASE 16	2	
ZAVESCA	4	PA
<b>Gastrointestinal Agents</b>		
ACIPHEX	3	
ACTIGALL	3	
AMITIZA	3	
ATROPINE SULFATE INJECTION 0.05MG/ML	2	
<i>atropine sulfate injection 0.1mg/ml</i>	1	
AXID	3	
BENTYL	3	
CANTIL	2	
CARAFATE SUSPENSION	2	
CARAFATE TABLET	3	
<i>cimetidine</i>	1	
<i>cimetidine hcl</i>	1	
COLYTE	3	
<i>constulose</i>	1	
CYTOTEC	3	
<i>dicyclomine hcl</i>	1	
DIPENTUM	2	
<i>diphenoxylate/atropine</i>	1	
<i>enulose</i>	1	
<i>famotidine</i>	1	
<i>famotidine premixed</i>	1	
GASTROCROM	2	
<i>glycopyrrolate</i>	1	
GOLYTELY	2	
HALFLYTELY BOWEL PREP	2	
KRISTALOSE	2	
<i>lactulose</i>	1	
LOMOTIL	3	
<i>lonox</i>	1	
<i>loperamide hcl</i>	1	
LOTRONEX	2	
<i>methscopolamine bromide</i>	1	
<i>metoclopramide hcl</i>	1	
<i>misoprostol</i>	1	
MOTOFEN	2	
MOVIPREP	2	
NEXIUM I.V.	2	
NEXIUM CAPSULE DELAYED RELEASE	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 43

Drug Name	Drug Tier	Notes
NEXIUM PACKET 20MG, 40MG	3	
<i>nizatidine</i>	1	
NULYTELY/FLAVOR PACKS	2	
<i>omeprazole</i>	1	
PAMINE	3	
PAMINE FORTE	3	
<i>pantoprazole sodium</i>	1	
<i>peg 3350/electrolytes</i>	1	
PEPCID	3	
PEPCID PREMIXED	3	
<i>polyethylene glycol 3350</i>	1	
PREVACID	3	
PREVACID SOLUTAB	2	
PRILOSEC CAPSULE DELAYED RELEASE 10MG, 20MG	3	
PROPANTHELINE BROMIDE	2	
PROTONIX INJECTION	2	
PROTONIX PACKET, TABLET DELAYED RELEASE	3	
<i>ranitidine hcl</i>	1	
REGLAN	3	
ROBINUL	3	
ROBINUL FORTE	3	
<i>sucralfate</i>	1	
<i>trilyte</i>	1	
URSO 250	2	
URSO FORTE	2	
<i>ursodiol capsule</i>	1	
VISICOL	2	
ZANTAC PACKET, SYRUP, TABLET, TABLET EFFERVESCENT	3	
ZANTAC INJECTION 50MG/50ML; 0.45%	2	
ZANTAC INJECTION 25MG/ML	3	
<b>Genitourinary Agents</b>		
AVODART	2	
CARDURA	3	
CLINDESSE	2	
DETROL	2	
DETROL LA	2	
DITROPAN XL	3	
<i>doxazosin mesylate</i>	1	
ELMIRON	2	
<i>finasteride</i>	1	
<i>flavoxate hcl</i>	1	
FLOMAX	2	

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Drug Name	Drug Tier	Notes
FOSRENOL	2	
LITHOSTAT	2	
<i>oxybutynin chloride</i>	1	
<i>oxybutynin chloride er</i>	1	
OXYTROL	2	QL (8 per 28 days)
PHOSLO	2	
PROSCAR	3	
REVELA	2	
SANCTURA	3	
SANCTURA XR	3	
<i>terazosin hcl</i>	1	
THIOLA	2	
URECHOLINE	3	
UROXATRAL	2	
VESICARE	3	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)</b>		
<i>a-hydrocort</i>	1	
<i>a-methapred</i>	1	
ACLOVATE	3	
<i>ala-cort</i>	1	
ALA-SCALP	2	
<i>alclometasone dipropionate</i>	1	
AMCINONIDE LOTION, OINTMENT	2	
<i>amcinonide cream</i>	1	
ANUSOL-HC	3	
<i>augmented betamethasone dipropionate lotion</i>	1	
<i>beta-val</i>	1	
<i>betamethasone dipropionate</i>	1	
<i>betamethasone valerate</i>	1	
CAPEX	2	
CARMOL-HC	3	
CELESTONE	2	
<i>clobetasol propionate</i>	1	
<i>clobetasol propionate e</i>	1	
CLOBEX	2	
CLODERM	2	
CORDRAN	2	
CORDRAN SP	2	
CORDRAN TAPE	2	
<i>cormax</i>	1	
CORTEF	3	
CORTIFOAM	2	
<i>cortisone acetate</i>	1	
CUTIVATE	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 45

Drug Name	Drug Tier	Notes
<i>del-beta</i>	1	
DEPO-MEDROL INJECTION 20MG/ML	2	
DEPO-MEDROL INJECTION 40MG/ML, 80MG/ML	3	
DERMA-SMOOTHIE/FS BODY OIL	2	
DERMATOP	3	
DESONATE	2	
<i>desonide</i>	1	
DESOWEN CREAM/CETAPHIL LOTION	3	
DESOWEN LOTION/CETAPHIL CREAM	3	
DESOWEN OINTMENT/CETAPHIL LOTION	3	
<i>desoximetasone</i>	1	
DEXAMETHASONE INTENSOL	2	
<i>dexamethasone sodium phosphate</i>	1	
DEXAMETHASONE ELIXIR	2	
DEXAMETHASONE TABLET 0.5MG, 0.75MG, 1MG, 2MG	2	
<i>dexamethasone tablet 1.5mg, 4mg, 6mg</i>	1	
DEXPAK 13 DAY	2	
<i>diflorasone diacetate</i>	1	
DIPROLENE	3	
DIPROLENE AF	3	
ELOCON	3	
<i>fludrocortisone acetate</i>	1	
FLUOCINOLONE ACETONIDE OINTMENT, SOLUTION	2	
FLUOCINOLONE ACETONIDE CREAM 0.025%	2	
<i>fluocinolone acetonide cream 0.01%</i>	1	
<i>fluocinonide</i>	1	
<i>fluocinonide emollient base</i>	1	
<i>fluticasone propionate</i>	1	
<i>halobetasol propionate</i>	1	
HALOG	2	
<i>hydrocortisone</i>	1	
<i>hydrocortisone butyrate</i>	1	
<i>hydrocortisone in absorbase</i>	1	
<i>hydrocortisone valerate</i>	1	
<i>isovate</i>	1	
KENALOG	2	
LOCOID LIPOCREAM	2	
LOCOID LOTION	2	
LOCOID OINTMENT, SOLUTION	3	
<i>lokara</i>	1	
LUXIQ	2	
MEDROL DOSEPAK	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 46

Drug Name	Drug Tier	Notes
MEDROL TABLET 2MG	2	
MEDROL TABLET 16MG, 32MG, 4MG, 8MG	3	
<i>methylprednisolone acetate</i>	1	
<i>methylprednisolone sodiumsuccinate</i>	1	
<i>methylprednisolone tablet 4mg</i>	1	
<i>methylprednisolone tablet 16mg, 32mg, 8mg</i>	1	
MILLIPRED SOLUTION	2	
<i>mometasone furoate</i>	1	
OLUX-E	2	
ORAPRED	3	
ORAPRED ODT	2	
PANDEL	2	
PEDIAPRED	3	
<i>prednicarbate</i>	1	
<i>prednisolone sodium phosphate</i>	1	
PREDNISON INTENSOL	2	
PREDNISON SOLUTION	2	
PREDNISON TABLET 50MG	2	
<i>prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 5mg</i>	1	
PRELONE	3	
<i>procto-pak</i>	1	
PROCTOCORT	3	
<i>proctocream-hc</i>	1	
<i>proctosol hc</i>	1	
<i>proctozone-hc</i>	1	
SOLU-CORTEF INJECTION 250MG	2	
SOLU-CORTEF INJECTION 100MG	3	
SOLU-MEDROL INJECTION 2GM	2	
SOLU-MEDROL INJECTION 125MG, 40MG, 500MG	3	
STERAPRED 12 DAY	3	
STERAPRED DS 12 DAY	3	
TEMOVATE	3	
TEXACORT SOLUTION 2.5%	2	
<i>texacort solution 1%</i>	1	
TOPICORT	3	
TOPICORT LP	3	
<i>triamcinolone acetonide</i>	1	
TRIAMCINOLONE ACETONIDE IN ABSORBASE	2	
<i>triderm</i>	1	
<i>u-cort</i>	1	
ULTRAVATE	3	
VANOS	2	
VERDESO	2	
WESTCORT	3	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 47

Drug Name	Drug Tier	Notes
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</b>		
<i>chorionic gonadotropin</i>	1	
DDAVP INJECTION, TABLET	3	
DDAVP NASAL SOLUTION 0.01%	3	
<i>desmopressin acetate injection, tablet</i>	1	
<i>desmopressin acetate nasal solution 0.01%</i>	1	
GENOTROPIN	2	PA
GENOTROPIN MINIQUICK	2	PA
HUMATROPE	2	PA
HUMATROPE COMBO PACK	2	PA
INCRELEX	2	
NORDITROPIN NORDIFLEX PEN INJECTION 15MG/1.5ML, 5MG/1.5ML	2	PA
<i>novarel</i>	1	
NUTROPIN	2	PA
NUTROPIN AQ	2	PA
OMNITROPE	2	PA
<i>pregnyl w/diluent benzyl alcohol/nacl</i>	1	
SAIZEN	2	PA
SAIZEN CLICK.EASY	2	PA
SEROSTIM	2	
STIMATE	2	
TEV-TROPIN	2	PA
ZORBTIVE	2	PA
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)</b>		
ACTIVELLA	3	
ALORA	2	QL (8 per 28 days)
ANADROL-50	2	
ANDRODERM	2	QL (60 per 30 days)
ANDROGEL	2	QL (300 per 30 days)
ANDROID	2	
ANDROXY	2	
ANGELIQ	2	
<i>apri</i>	1	
<i>aranelle</i>	1	
<i>aviane</i>	1	
AYGESTIN	3	
<i>balziva</i>	1	
BREVICON-28	3	
<i>camila</i>	1	
CENESTIN	3	
<i>cesia</i>	1	
CLIMARA	2	QL (4 per 28 days)
CLIMARA PRO	2	QL (4 per 28 days)

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 48

Drug Name	Drug Tier	Notes
COMBIPATCH	2	QL (8 per 28 days)
CRINONE	2	
<i>cryselle-28</i>	1	
CYCLESSA	3	
<i>danazol</i>	1	
DELESTROGEN	3	
DEPO-ESTRADIOL	2	
DEPO-PROVERA	2	
DEPO-PROVERA CONTRACEPTIVE	3	
DEPO-SUBQ PROVERA 104	2	
DEPO-TESTOSTERONE	3	
DESOGEN	3	
ELESTRIN	2	QL (144 per 30 days)
ENDOMETRIN	2	
<i>enpresse-28</i>	1	
<i>errin</i>	1	
ESTRACE CREAM	2	
ESTRACE TABLET	3	
ESTRADERM	3	QL (8 per 28 days)
<i>estradiol valerate</i>	1	
<i>estradiol/norethindrone acetate</i>	1	
<i>estradiol tablet</i>	1	
<i>estradiol patch weekly 0.06mg/24hr, 37.5mcg/24hr</i>	1	
<i>estradiol patch weekly 0.025mg/24hr, 0.05mg/24hr, 0.075mg/24hr, 0.1mg/24hr</i>	1	QL (4 per 28 days)
ESTRASORB	2	
ESTRING	2	
<i>estropipate</i>	1	
ESTROSTEP FE	3	
EVAMIST	2	
EVISTA	2	
FEMHRT 1/5	3	
FEMHRT LOW DOSE	3	
FEMRING	2	
FEMTRACE	3	
GYNODIOL TABLET 1.5MG	2	
<i>gynodiol tablet 0.5mg, 1mg, 2mg</i>	1	
<i>jolivette</i>	1	
<i>junel 1.5/30</i>	1	
<i>junel 1/20</i>	1	
<i>junel fe 1.5/30</i>	1	
<i>junel fe 1/20</i>	1	
<i>kariva</i>	1	
<i>kelnor 1/35</i>	1	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 49

Drug Name	Drug Tier	Notes
<i>leena</i>	1	
<i>lessina-28</i>	1	
<i>levora 0.15/30-28</i>	1	
LO/OVRAL-28	3	
LOESTRIN 1.5/30-21	3	
LOESTRIN 1/20-21	3	
LOESTRIN 24 FE	2	
LOESTRIN FE 1.5/30	3	
LOESTRIN FE 1/20	3	
<i>low-ogestrel</i>	1	
<i>lutra</i>	1	
LYBREL	3	
<i>medroxyprogesterone acetate</i>	1	
MEGACE ES	2	
MEGACE ORAL	3	
<i>megestrol acetate</i>	1	
MENEST	2	
MENOSTAR	2	QL (4 per 28 days)
METHITEST	2	
<i>microgestin 1.5/30</i>	1	
<i>microgestin 1/20</i>	1	
<i>microgestin fe</i>	1	
<i>microgestin fe 1.5/30</i>	1	
MODICON-28	3	
<i>mononessa</i>	1	
<i>necon 0.5/35-28</i>	1	
<i>necon 1/35-28</i>	1	
<i>necon 1/50-28</i>	1	
NECON 10/11-28	2	
<i>necon 7/7/7</i>	1	
NOR-QD	3	
<i>nora-be</i>	1	
NORDETTE-28	3	
<i>norethindrone acetate</i>	1	
NORINYL 1+35	3	
<i>nortrel 0.5/35 (28)</i>	1	
<i>nortrel 1/35 (21)</i>	1	
<i>nortrel 1/35 (28)</i>	1	
<i>nortrel 7/7/7</i>	1	
NUVARING	2	
<i>ocella</i>	1	
OGEN	3	
OGESTREL	2	
ORTHO EVRA	2	QL (3 per 28 days)

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 50

Drug Name	Drug Tier	Notes
ORTHO MICRONOR	3	
ORTHO TRI-CYCLEN LO	3	
ORTHO-CEPT-28	3	
ORTHO-CYCLEN	3	
<i>ortho-est</i>	1	
ORTHO-NOVUM 7/7/7-28	3	
OVCON-35	3	
OVCON-50 28	2	
OXANDRIN	3	
<i>oxandrolone</i>	1	
PLAN B	2	
<i>portia-28</i>	1	
PREFEST	3	
PREMARIN	2	
PREMARIN W/APPLICATOR	2	
PREMPHASE	2	
PREMPRO	2	
<i>previfem</i>	1	
PROCHIEVE	2	
PROMETRIUM	2	
PROVERA	3	
<i>quasense</i>	1	
<i>reclipsen</i>	1	
SEASONALE	3	
SEASONIQUE	2	
<i>solia</i>	1	
<i>sprintec 28</i>	1	
<i>sronyx</i>	1	
STRIANT	2	
TESTIM	2	QL (300 per 30 days)
<i>testosterone cypionate</i>	1	
<i>testosterone enanthate</i>	1	
TESTRED	2	
<i>tri-legest fe</i>	1	
TRI-NORINYL 28	3	
<i>tri-previfem</i>	1	
<i>tri-sprintec</i>	1	
<i>trinessa</i>	1	
<i>trivora-28</i>	1	
VAGIFEM	2	
<i>velivet</i>	1	
VIVELLE-DOT	3	QL (8 per 28 days)
YASMIN 28	2	
YAZ	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 51

Drug Name	Drug Tier	Notes
<i>zovia 1/35e</i>	1	
<i>zovia 1/50e</i>	1	
<b>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</b>		
CYTOMEL	2	
<i>levothroid</i>	1	
<i>levothyroxine sodium</i>	1	
<i>levoxyl</i>	1	
<i>liothyronine sodium injection</i>	1	
SYNTHROID	3	
THYROLAR-1	2	
THYROLAR-1/2	2	
THYROLAR-1/4	2	
THYROLAR-2	2	
THYROLAR-3	2	
<i>unithroid</i>	1	
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
LYSODREN	2	
<b>Hormonal Agents, Suppressant (Parathyroid)</b>		
SENSIPAR	2	
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<i>cabergoline</i>	1	
ELIGARD	2	
<i>leuprolide acetate</i>	1	
LUPRON 2 WEEK SUPPLY	3	
LUPRON DEPOT	2	
LUPRON DEPOT-PED	2	
<i>octreotide acetate</i>	1	
SANDOSTATIN	3	
SANDOSTATIN LAR DEPOT	2	
SOMAVERT	2	
SYNAREL	2	
TRELSTAR DEPOT	2	
TRELSTAR LA	2	
<b>Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)</b>		
CASODEX	2	
<i>flutamide</i>	1	
NILANDRON	2	
<b>Hormonal Agents, Suppressant (Thyroid)</b>		
<i>methimazole</i>	1	
<i>propylthiouracil</i>	1	
TAPAZOLE	3	
<b>Immunological Agents</b>		
ACTHIB	2	
ACTIMMUNE	4	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 52

Drug Name	Drug Tier	Notes
ADACEL	2	
ALFERON N	2	
ARAVA	3	
ATGAM	2	
ATTENUVAX	2	
AVONEX	4	
AZASAN	2	PA (Part B vs Part D only)
<i>azathioprine</i>	1	PA (Part B vs Part D only)
AZATHIOPRINE SODIUM	2	
BETASERON	4	
BOOSTRIX	2	
CARIMUNE NANOFILTERED	2	PA
CELLCEPT	2	PA (Part B vs Part D only)
CELLCEPT INTRAVENOUS	2	
CIMZIA	4	PA
COMVAX	2	
COPAXONE	4	
<i>cyclosporine</i>	1	PA (Part B vs Part D only)
CYCLOSPORINE MODIFIED CAPSULE 50MG	2	PA (Part B vs Part D only)
<i>cyclosporine modified solution</i>	1	PA (Part B vs Part D only)
DAPTACEL	2	
DECAVAC	2	
DIPHTHERIA/TETANUS TOXOID PEDIATRIC	2	
ENBREL	4	PA
ENBREL SURECLICK	4	PA
ENGERIX-B	2	PA (Part B vs Part D only)
FLEBOGAMMA	2	PA
GAMASTAN S/D	2	PA
GAMMAGARD LIQUID	2	PA
GAMUNEX	2	PA
GARDASIL	2	
<i>gengraf</i>	1	PA (Part B vs Part D only)
HAVRIX	2	
HIBTITER	2	
HUMIRA	4	PA
HUMIRA PEN-CROHNS DISEASESTARTER	4	
IMOVAX RABIES (H.D.C.V.)	2	
IMURAN	3	PA (Part B vs Part D only)
INFANRIX	2	
INFERGEN	2	
INTRON-A	2	
INTRON-A W/DILUENT	2	
IPOL INACTIVATED IPV	2	
JE-VAX	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 53

Drug Name	Drug Tier	Notes
KINERET	4	PA
<i>leflunomide</i>	1	
M-M-R II W/DILUENT 10 DOSE	2	
MENACTRA	2	
MENOMUNE-A/C/Y/W-135	2	
MERUVAX II W/DILUENT 10 DOSE	2	
<i>methotrexate</i>	1	PA (Part B vs Part D only)
<i>methotrexate sodium</i>	1	
MYFORTIC	2	PA (Part B vs Part D only)
NEORAL	3	PA (Part B vs Part D only)
OCTAGAM	2	PA
ORENCIA	4	PA
ORTHOCLONE OKT3	2	PA (Part B vs Part D only)
PEDIARIX	2	PA (Part B vs Part D only)
PEDVAX HIB	2	
PEG-INTRON	2	
PEG-INTRON REDIPEN	2	
PEG-INTRON REDIPEN PAK 4	2	
PEGASYS	4	
POLYGAM S/D	2	PA
PROGRAF	2	PA (Part B vs Part D only)
PROQUAD	2	
RABAVERT	2	
RAPAMUNE	2	PA (Part B vs Part D only)
REBIF	4	
REBIF TITRATION PACK	4	
RECOMBIVAX HB	2	PA (Part B vs Part D only)
REMICADE	2	PA
RHEUMATREX	3	PA (Part B vs Part D only)
RIDAURA	2	
ROTATEQ	2	
SANDIMMUNE	3	PA (Part B vs Part D only)
SIMULECT	2	PA (Part B vs Part D only)
TETANUS TOXOID ADSORBED	2	
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	2	
THYMOGLOBULIN	2	
TREXALL	2	PA (Part B vs Part D only)
TRIHIBIT	2	
TRIPEDIA	2	
TWINRIX	2	
TYPHIM VI	2	
TYSABRI	2	PA ** Limited Access Drug. This prescription may be

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Drug Name	Drug Tier	Notes
		available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 800-346-4643. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643. Please call 8:00 a.m. - 8:00 p.m., Mtn. Time, Mon. - Fri. From Nov. 15 through March 1, we are also available 8:00 a.m. - 8:00 p.m., Mtn. Time, on weekends and most holidays.
VAQTA	2	
VARIVAX	2	
VIVAGLOBIN	2	PA
VIVOTIF BERNA	2	
YF-VAX	2	
ZENAPAX	2	PA (Part B vs Part D only)
ZOSTAVAX	2	
<b>Inflammatory Bowel Disease Agents</b>		
ASACOL	2	
AZULFIDINE	3	
AZULFIDINE EN-TABS	3	
<i>balsalazide disodium</i>	1	
CANASA	2	
COLAZAL	3	
<i>colocort</i>	1	
CORTENEMA	3	
ENTOCORT EC	3	
<i>hydrocortisone</i>	1	
LIALDA	2	
<i>mesalamine</i>	1	
PENTASA	2	
ROWASA	3	
<i>sulfasalazine</i>	1	
<i>sulfazine</i>	1	
<i>sulfazine ec</i>	1	
<b>Metabolic Bone Disease Agents</b>		
ACTONEL WITH CALCIUM	2	
ACTONEL TABLET 150MG, 30MG, 5MG	2	
ACTONEL TABLET 75MG	2	QL (2 per 28 days)

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 55

Drug Name	Drug Tier	Notes
ACTONEL TABLET 35MG	2	QL (4 per 28 days)
<i>alendronate sodium tablet 10mg, 40mg, 5mg</i>	1	
<i>alendronate sodium tablet 35mg, 70mg</i>	1	QL (4 per 28 days)
AREDIA	3	
BONIVA INJECTION	2	
BONIVA TABLET 2.5MG	3	
BONIVA TABLET 150MG	3	QL (1 per 28 days)
CALCIJEX	3	
<i>calcitonin-salmon</i>	1	
<i>calcitriol capsule, oral solution</i>	1	
CALCITRIOL INJECTION 2MCG/ML	2	
<i>calcitriol injection 1mcg/ml</i>	1	
DIDRONEL	3	
<i>etidronate disodium</i>	1	
FORTEO	4	PA
<i>fortical</i>	1	
FOSAMAX PLUS D	3	QL (4 per 28 days)
FOSAMAX SOLUTION	3	
FOSAMAX TABLET 10MG, 40MG, 5MG	3	
FOSAMAX TABLET 35MG, 70MG	3	QL (4 per 28 days)
HECTOROL	2	
MIACALCIN INJECTION	2	
MIACALCIN NASAL SOLUTION	3	
PAMIDRONATE DISODIUM INJECTION 6MG/ML	2	
<i>pamidronate disodium injection 30mg/10ml, 90mg/10ml</i>	1	
ROCALTROL	3	
SKELID	2	
ZEMPLAR	2	
ZOMETA	4	
<b>Miscellaneous Therapeutic Agents</b>		
AGRYLIN	3	
ALCOHOL 5%/DEXTROSE 5%	2	
ALCOHOL PREPS	2	
<i>anagrelide hydrochloride</i>	1	
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	2	
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	2	
BD INSULIN SYRINGE ULTRAFINE/1ML/31G X 5/16"	2	
BD ULTRA-FINE ORIGINAL PEN NEEDLES/29G X 12.7MM	2	

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Drug Name	Drug Tier	Notes
BOTOX	2	PA
CARNITOR TABLET	3	
CURITY GAUZE PADS 2"X2"	2	
<i>dexrazoxane</i>	1	
INTRALIPID INJECTION 1.7%; 30%	3	
<i>intralipid injection 2.25%; 20%</i>	1	
<i>levocarnitine</i>	1	
MYOBLOC	2	PA
<i>pentopak</i>	1	
<i>pentoxifylline er</i>	1	
<i>pentoxil</i>	1	
TRENTAL	3	
ZINECARD	3	
<b>Ophthalmic Agents</b>		
ACULAR	2	QL (10 per 30 days)
ACULAR LS	2	QL (10 per 30 days)
<i>ak-con</i>	1	QL (30 per 30 days)
<i>ak-poly-bac</i>	1	
<i>ak-tob</i>	1	
ALAMAST	2	QL (20 per 30 days)
ALCAINE	3	
ALOCRIL	2	QL (10 per 30 days)
ALOMIDE	2	QL (30 per 30 days)
ALPHAGAN P	2	QL (15 per 30 days)
ALREX	2	QL (20 per 30 days)
AZASITE	2	QL (5 per 30 days)
AZOPT	3	QL (15 per 30 days)
<i>bac /poly /neomy /hc</i>	1	
<i>bacitracin</i>	1	
<i>bacitracin/polymyxin b</i>	1	
BETAGAN	3	QL (15 per 30 days)
BETAGAN WITHOUT C CAP	3	QL (20 per 30 days)
BETAXOLOL HCL	2	QL (20 per 30 days)
BETIMOL	3	QL (10 per 30 days)
BETOPTIC-S	2	QL (20 per 30 days)
BLEPH-10	3	
BLEPHAMIDE	2	
BLEPHAMIDE S.O.P.	2	
<i>brimonidine tartrate</i>	1	QL (10 per 30 days)
<i>carteolol hcl</i>	1	QL (15 per 30 days)
CILOXAN SOLUTION	3	QL (20 per 30 days)
CILOXAN OINTMENT	3	QL (8 per 30 days)
COMBIGAN	2	QL (10 per 30 days)
COSOPT	2	QL (10 per 30 days)

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Drug Name	Drug Tier	Notes
CROLOM	3	QL (20 per 30 days)
<i>cromolyn sodium</i>	1	QL (50 per 30 days)
<i>dexamethasone sodium phosphate</i>	1	
<i>dexasporin</i>	1	
<i>diclofenac sodium</i>	1	QL (5 per 30 days)
<i>dipivefrin hcl</i>	1	QL (15 per 30 days)
<i>dorzolamide hcl</i>	1	
<i>dorzolamide hcl/timolol maleate</i>	1	
ELESTAT	2	QL (10 per 30 days)
EMADINE	2	QL (10 per 30 days)
FLAREX	2	
<i>fluor-op</i>	1	
<i>fluorometholone</i>	1	
<i>flurbiprofen sodium</i>	1	QL (3 per 30 days)
FML	2	
FML FORTE	2	
FML LIQUIFILM	3	QL (20 per 30 days)
<i>genoptic</i>	1	
<i>gentak</i>	1	
<i>gentasol</i>	1	
IOPIDINE SOLUTION 1%	3	
IOPIDINE SOLUTION 0.5%	3	QL (10 per 30 days)
ISTALOL	3	QL (5 per 30 days)
LACRISERT	2	QL (60 per 30 days)
<i>levobunolol hcl</i>	1	QL (10 per 30 days)
LOTEMAX	2	QL (20 per 30 days)
LUMIGAN	2	QL (8 per 30 days)
MAXIDEX	2	
MAXITROL	3	
<i>methazolamide</i>	1	
<i>metipranolol</i>	1	QL (10 per 30 days)
<i>mydral</i>	1	
MYDRIACYL	3	QL (15 per 30 days)
<i>naphazoline hcl</i>	1	QL (30 per 30 days)
NATACYN	2	
<i>neomycin /polymyxin /dexamethasone</i>	1	
<i>neomycin /polymyxin /gramicidin</i>	1	
<i>neomycin /polymyxin /hydrocortisone</i>	1	
NEOSPORIN	3	QL (20 per 30 days)
NEVANAC	2	QL (3 per 30 days)
OCUFEN	3	QL (3 per 30 days)
OCUFLOX	3	QL (10 per 30 days)
<i>ocusulf-10</i>	1	
<i>ofloxacin</i>	1	QL (10 per 30 days)

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 58

Drug Name	Drug Tier	Notes
OPTIPRANOLOL	3	QL (10 per 30 days)
OPTIVAR	2	QL (6 per 30 days)
<i>parcaine</i>	1	
PATADAY	2	QL (3 per 30 days)
PATANOL	2	QL (10 per 30 days)
PHOSPHOLINE IODIDE	2	
PILOPINE HS	2	
<i>poly-dex</i>	1	
POLY-PRED	2	
<i>polycin b</i>	1	
POLYTRIM	3	QL (10 per 30 days)
PRED FORTE	3	QL (20 per 30 days)
PRED MILD	2	
PRED-G	2	QL (20 per 30 days)
PRED-G S.O.P.	2	
<i>prednisolone acetate</i>	1	
PREDNISOLONE SODIUM PHOSPHATE	2	
<i>proparacaine hcl</i>	1	
PROPINE	3	QL (10 per 30 days)
RESTASIS	2	QL (64 per 30 days)
<i>romycin</i>	1	
<i>sodium sulfacetamide</i>	1	
<i>sulfacetamide sodium/prednisolone sodium phosphate</i>	1	
<i>timolol maleate solution 0.5%</i>	1	QL (10 per 30 days)
<i>timolol maleate solution 0.25%</i>	1	QL (15 per 30 days)
TIMOPTIC OCUDOSE	3	QL (60 per 30 days)
TIMOPTIC-XE	3	QL (5 per 30 days)
TOBRADEX OINTMENT	2	QL (4 per 30 days)
TOBRADEX SUSPENSION	3	QL (20 per 30 days)
<i>tobrasol</i>	1	
TOBREX OINTMENT	2	
TOBREX SOLUTION	3	
TRAVATAN Z	3	QL (6 per 30 days)
<i>trifluridine</i>	1	
<i>trimethoprim sulfate/polymyxin b sulfate</i>	1	
<i>tropicacyl</i>	1	
<i>tropicamide</i>	1	
TRUSOPT	2	QL (10 per 30 days)
VEXOL	2	
VIGAMOX	2	QL (6 per 30 days)
VIROPTIC	3	QL (16 per 30 days)
VOLTAREN	3	QL (5 per 30 days)
XALATAN	2	QL (5 per 30 days)
XIBROM	3	QL (5 per 30 days)

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Drug Name	Drug Tier	Notes
ZYLET	2	QL (20 per 30 days)
<b>Otic Agents</b>		
<i>acetazol hc</i>	1	
<i>acetic acid</i>	1	
<i>borofair</i>	1	
CIPRO HC	2	
CIPRODEX	2	QL (8 per 30 days)
COLY-MYCIN S	2	
CORTISPORIN	3	
CORTISPORIN-TC	2	
<i>cortomycin</i>	1	
DERMOTIC	2	
FLOXIN OTIC	3	
<i>neomycin /polymyxin /hc</i>	1	
<i>neomycin /polymyxin /hydrocortisone</i>	1	
PEDIOTIC	3	
<b>Respiratory Tract Agents</b>		
ACCOLATE	3	
ACCUNEB	3	
ACETADOTE	2	
<i>acetylcysteine</i>	1	
ADVAIR DISKUS	2	QL (60 per 30 days)
ADVAIR HFA	2	QL (12 per 30 days)
AEROBID-M	3	QL (14 per 30 days)
<i>albuterol sulfate</i>	1	
<i>albuterol sulfate er</i>	1	
ALLEGRA	3	
ALLEGRA-D 12 HOUR	3	
ALLEGRA-D 24 HOUR	3	
ALVESCO	2	
<i>aminophylline</i>	1	
ANTIVERT	3	
ARALAST	2	
<i>asmanex 120 metered doses</i>	1	QL (0.48 per 30 days)
<i>asmanex 14 metered doses</i>	1	QL (0.48 per 30 days)
<i>asmanex 30 metered doses</i>	1	QL (0.48 per 30 days)
<i>asmanex 60 metered doses</i>	1	QL (0.48 per 30 days)
ASTELIN	2	QL (2 per 30 days)
ASTEPRO	2	
ATROVENT HFA	2	QL (26 per 30 days)
ATROVENT SOLUTION 0.06%	3	QL (30 per 30 days)
ATROVENT SOLUTION 0.03%	3	QL (60 per 30 days)
AZMACORT	3	QL (40 per 30 days)
BECONASE AQ	3	QL (50 per 30 days)

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 60

Drug Name	Drug Tier	Notes
BRETHINE	3	
<i>clemastine fumarate</i>	1	
COMBIVENT	2	QL (30 per 30 days)
<i>cromolyn sodium</i>	1	
<i>cyproheptadine hcl</i>	1	
DEXCHLORPHENIRAMINE MALEATE	2	
<i>diphenhydramine hcl</i>	1	
DUONEB	3	
ELIXOPHYLLIN	2	
<i>epinephrine hcl</i>	1	
EIPEN 2-PAK	2	
EIPEN-JR 2-PAK	2	
<i>fexofenadine hcl</i>	1	
FLONASE	3	QL (32 per 30 days)
FLOVENT HFA AEROSOL 44MCG/ACT	2	QL (22 per 30 days)
FLOVENT HFA AEROSOL 110MCG/ACT, 220MCG/ACT	2	QL (24 per 30 days)
<i>flunisolide</i>	1	QL (50 per 30 days)
<i>fluticasone propionate</i>	1	QL (32 per 30 days)
FORADIL AEROLIZER	2	QL (60 per 30 days)
<i>hydroxyzine hcl</i>	1	
<i>hydroxyzine pamoate</i>	1	
INTAL INHALER	2	
<i>ipratropium bromide/albuterol sulfate</i>	1	
<i>ipratropium bromide inhalation solution</i>	1	
<i>ipratropium bromide nasal solution 0.06%</i>	1	QL (30 per 30 days)
<i>ipratropium bromide nasal solution 0.03%</i>	1	QL (60 per 30 days)
LETAIRIS	4	PA
LUFYLLIN	2	
<i>meclizine hcl</i>	1	
METAPROTERENOL SULFATE TABLET	2	
<i>metaproterenol sulfate syrup</i>	1	
NASACORT AQ	3	QL (34 per 30 days)
NASAREL	3	QL (50 per 30 days)
NASONEX	2	QL (34 per 30 days)
PALGIC TABLET	2	
PALGIC LIQUID	3	
PATANASE	2	
PERFOROMIST	2	
PROAIR HFA	2	QL (18 per 30 days)
PROLASTIN	2	PA
<i>promethazine vc</i>	1	
PROVENTIL HFA	3	QL (14 per 30 days)
PULMICORT FLEXHALER	2	QL (2 per 30 days)

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Drug Name	Drug Tier	Notes
PULMICORT SUSPENSION 1MG/2ML	2	
PULMICORT SUSPENSION 0.25MG/2ML, 0.5MG/2ML	2	QL (120 per 30 days)
QVAR	2	QL (24 per 30 days)
REVATIO	4	PA
RHINOCORT AQUA	3	QL (18 per 30 days)
SEMPREX-D	2	
SEREVENT DISKUS	2	QL (60 per 30 days)
SINGULAIR	2	
SPIRIVA HANDIHALER	2	QL (90 per 30 days)
SYMBICORT AEROSOL 160MCG/ACT; 4.5MCG/ACT	2	QL (11 per 30 days)
SYMBICORT AEROSOL 80MCG/ACT; 4.5MCG/ACT	2	QL (7 per 30 days)
<i>terbutaline sulfate</i>	1	
THEO-24	2	
<i>theochron</i>	1	
<i>theophylline cr</i>	1	
<i>theophylline er</i>	1	
TRACLEER	4	PA ** Limited Access Drug. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 800-346-4643. If you are hearing impaired and use TTY equipment, call 800-704-6370. Para asistencia en español llame al 800-346-4643. Please call 8:00 a.m. - 8:00 p.m., Mtn. Time, Mon. - Fri. From Nov. 15 through March 1, we are also available 8:00 a.m. - 8:00 p.m., Mtn. Time, on weekends and most holidays.
TWINJECT	2	
TYZINE	2	
TYZINE PEDIATRIC NASAL DROPS	2	
UNIPHYL	3	
VENTOLIN HFA	2	QL (36 per 30 days)
VERAMYST	3	QL (20 per 30 days)
VISTARIL	3	
VOSPIRE ER	3	
XOLAIR	2	PA
XOPENEX	3	

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Drug Name	Drug Tier	Notes
ZEMAIRA	2	
ZYFLO CR	3	
<b>Sedatives/Hypnotics</b>		
AMBIEN	3	
LUNESTA	3	
ROZEREM	3	
SONATA	3	
<i>zaleplon</i>	1	
<i>zolpidem tartrate</i>	1	
<b>Skeletal Muscle Relaxants</b>		
<i>carisoprodol</i>	1	
<i>carisoprodol /aspirin</i>	1	
<i>carisoprodol /aspirin /codeine</i>	1	
<i>chlorzoxazone</i>	1	
<i>cyclobenzaprine hcl</i>	1	
FLEXERIL	3	
<i>methocarbamol</i>	1	
NORFLEX	3	
<i>orphenadrine /asa /caffeine</i>	1	
<i>orphenadrine citrate</i>	1	
<i>orphenadrine citrate er</i>	1	
ORPHENADRINE COMPOUND DS	2	
PARAFON FORTE DSC	3	
ROBAXIN-750	3	
ROBAXIN INJECTION	2	
ROBAXIN TABLET	3	
SKELAXIN	2	
SOMA TABLET 350MG	3	
<b>Therapeutic Nutrients/Minerals/ Electrolytes</b>		
AMINESS	2	
AMINOSYN	2	
AMINOSYN 7%/ELECTROLYTES	2	
<i>aminosyn 8.5%/electrolytes</i>	1	
AMINOSYN II 3.5%/DEXTROSE25%	2	
AMINOSYN II 3.5/DEXTROSE 25%	2	
AMINOSYN II 4.25/DEXTROSE10%	2	
AMINOSYN II 4.25/DEXTROSE20%	2	
AMINOSYN II 4.25/DEXTROSE25%	2	
AMINOSYN II 5/DEXTROSE 25	2	
<i>aminosyn ii 8.5%/electrolytes</i>	1	
AMINOSYN II M 3.5%/DEXTROSE 5%	2	
AMINOSYN II INJECTION 50.3MEQ/L	2	
AMINOSYN II INJECTION 107.6MEQ/L	3	
AMINOSYN M	2	

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Drug Name	Drug Tier	Notes
AMINOSYN-HBC	2	
<i>aminosyn-hf</i>	1	
AMINOSYN-PF	2	
AMINOSYN-PF 7%	2	
CLINIMIX 2.75%/DEXTROSE 5%	2	
<i>clanimix 4.25%/dextrose 10%</i>	1	
<i>clanimix 4.25%/dextrose 20%</i>	1	
<i>clanimix 4.25%/dextrose 25%</i>	1	
CLINIMIX 4.25%/DEXTROSE 5%	2	
CLINIMIX 5%/DEXTROSE 15%	2	
CLINIMIX 5%/DEXTROSE 20%	2	
CLINIMIX 5%/DEXTROSE 25%	2	
CLINIMIX E 2.75%/DEXTROSE 10%	2	
CLINIMIX E 2.75%/DEXTROSE 5%	2	
CLINIMIX E 4.25%/DEXTROSE 25%	2	
CLINIMIX E 4.25%/DEXTROSE 5%	2	
CLINIMIX E 5%/DEXTROSE 15%	2	
CLINIMIX E 5%/DEXTROSE 20%	2	
CLINIMIX E 5%/DEXTROSE 25%	2	
CLINIMIX E 5%/DEXTROSE 35%	2	
<i>clinisol sf 15%</i>	1	
DEXTROSE 10%/NACL 0.45%	2	
DEXTROSE 5% /ELECTROLYTE #48 VIAFLEX	2	
<i>dextrose 10% flex container</i>	1	
<i>dextrose 10%/nacl 0.2%</i>	1	
<i>dextrose 2.5%/sodium chloride 0.45%</i>	1	
<i>dextrose 5%</i>	1	
<i>dextrose 5%/nacl 0.2%</i>	1	
DEXTROSE 5%/NACL 0.225%	2	
<i>dextrose 5%/nacl 0.33%</i>	1	
<i>dextrose 5%/nacl 0.45%</i>	1	
<i>dextrose 5%/nacl 0.9%</i>	1	
DEXTROSE 5%/POTASSIUM CHLORIDE 0.075%	2	
<i>ed k+10</i>	1	
FREAMINE HBC 6.9%	2	
<i>freamine iii</i>	1	
FREAMINE III 3%	2	
<i>hepatamine</i>	1	
HEPATASOL	2	
IONOSOL-B/DEXTROSE 5%	2	
IONOSOL-MB/DEXTROSE 5%	2	
IONOSOL-T/DEXTROSE 5%	2	
ISOLYTE-H/DEXTROSE 5%	2	
<i>isolyte-m/dextrose 5%</i>	1	

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Drug Name	Drug Tier	Notes
ISOLYTE-P/DEXTROSE 5%	2	
ISOLYTE-S	2	
ISOLYTE-S/DEXTROSE 5%	2	
K-TABS	3	
<i>kaon-cl-10</i>	1	
<i>kcl 0.075%/d5w/nacl 0.45%</i>	1	
KCL 0.15%/D10W/NACL 0.2%	2	
KCL 0.15%/D5W/LR	2	
<i>kcl 0.15%/d5w/nacl 0.2%</i>	1	
KCL 0.15%/D5W/NACL 0.225%	2	
<i>kcl 0.15%/d5w/nacl 0.9%</i>	1	
<i>kcl 0.224%/d5w/nacl 0.2%</i>	1	
KCL 0.3%/D5W/LR IV LAC RING	2	
<i>kcl 0.3%/d5w/nacl 0.2%</i>	1	
<i>kcl 0.3%/d5w/nacl 0.45%</i>	1	
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<i>klor-con 10</i>	1	
<i>klor-con 8</i>	1	
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<i>lactated ringer's viaflex</i>	1	
<i>leucovorin calcium injection</i>	1	
LEUCOVORIN CALCIUM TABLET 10MG, 15MG	2	
<i>leucovorin calcium tablet 25mg, 5mg</i>	1	
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PLASMA-LYTE-56/D5W	2	
<i>plasma-lyte-r</i>	1	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 65

Drug Name	Drug Tier	Notes
<i>potassium chloride 0.075%/d5w/nacl 0.225%</i>	1	
POTASSIUM CHLORIDE 0.15% /NACL 0.45% VIAFLEX	2	
<i>potassium chloride 0.15% d5w/nacl 0.33%</i>	1	
<i>potassium chloride 0.15% d5w/nacl 0.45% viaflex</i>	1	
<i>potassium chloride 0.15% nacl 0.9%</i>	1	
<i>potassium chloride 0.15%/d5w</i>	1	
<i>potassium chloride 0.22% d5w/nacl 0.45%</i>	1	
<i>potassium chloride 0.224%/d5w</i>	1	
POTASSIUM CHLORIDE 0.224%D5W/NACL 0.33%	2	
POTASSIUM CHLORIDE 0.3%/ NACL 0.9%	3	
<i>potassium chloride 0.3%/d5w</i>	1	
<i>potassium chloride cr</i>	1	
<i>potassium chloride er</i>	1	
POTASSIUM CHLORIDE INJECTION 10MEQ/50ML	2	
<i>potassium chloride injection 0.4meq/ml, 10meq/100ml, 2meq/ml, 30meq/100ml</i>	1	
<i>potassium citrate extended-release</i>	1	
PREMASOL INJECTION 52MEQ/L	2	
<i>premasol injection 56meq/l</i>	1	
<i>prenatabs obn</i>	1	
PROCALAMINE	2	
PROSOL	2	
RENAMIN	2	
<i>ringer's injection</i>	1	
<i>ringer's irrigation</i>	1	
<i>sodium bicarbonate</i>	1	
<i>sodium chloride</i>	1	
<i>sodium chloride 0.9%</i>	1	
<i>sodium chloride 0.45% viaflex</i>	1	
<i>sodium fluoride</i>	1	
SODIUM LACTATE INJECTION 167MEQ/L	2	
<i>sodium lactate injection 5meq/ml</i>	1	
<i>tis-u-sol</i>	1	
<i>tpn electrolytes ftv</i>	1	
TRAVASOL	2	
TRAVASOL 2.75%/DEXTROSE 10%	2	
TRAVASOL 2.75%/DEXTROSE 5%	2	
<i>travasol 3.5%/electrolytes</i>	1	
TRAVASOL 8.5%/DEXTROSE 10%	2	
TRAVASOL 8.5%/DEXTROSE 20%	2	
TRAVASOL 8.5%/DEXTROSE 50%	2	
<i>travasol 8.5%/electrolytes</i>	1	
TROPHAMINE INJECTION 97MEQ/L	2	

Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 66

Drug Name	Drug Tier	Notes
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Drugs that appear in lower-case *italics* are generic drugs. We provide coverage of this prescription drug in the coverage gap for Gold and Plus plans. Please refer to our Evidence of Coverage for more information about this coverage. 67

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<i>kcl 0.3%/d5w/nacl 0.2%</i>	65
<i>kcl 0.3%/d5w/nacl 0.45%</i>	65
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<i>ketoprofen</i>	10
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<i>lidocaine hcl jelly</i>	10
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