2014
Drug Formulary

MOLINA® HEALTHCARE | Your Extended Family.

Medi-Cal/Healthy Families
Drug Formulary • 2014

TABLE OF CONTENTS

MOLINA HEALTHCARE MEDI-CAL/HEALTHY FAMILIES DRUG FORMULARY

The Molina Healthcare Medi-Cal/Healthy Families Drug Formulary was created to help manage the quality of our members' pharmacy benefit. The Formulary is the cornerstone for a progressive program of managed care pharmacotherapy. Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The Formulary was created to ensure that Molina members receive high quality, cost-effective, rational drug therapy.

The Molina Healthcare Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for Formulary consideration. This assures that the Formulary remains responsive to physician and patient needs. The Committee is composed of physicians and pharmacists representing various medical specialties. With a primary consideration to provide a safe, effective and comprehensive Formulary, the Committee evaluated all therapeutic categories and has selected the most cost-effective agent(s) in each class.

The Committee also uses reference materials from the CVS/Caremark Pharmacy and Therapeutics Advisory Panel. In addition, the Molina Healthcare Pharmacy and Therapeutics Committee reviews prior authorization procedures to ensure medications are used safely, following manufacturer's guidelines and current medical practices. Please familiarize yourself with the Drug Formulary as you prescribe medications for Molina members. Thank you for your cooperation.

PRESCRIPTION CLAIMS PROCESSOR

Molina Healthcare has selected CVS/Caremark as the Pharmacy Benefit Management (PBM) Company to manage the prescription benefit for Molina members.

- Questions on processing claims, formulary status or rejected claims may be directed to the CVS/Caremark Help Desk at (800) 770-8014.
- Membership and eligibility concerns may be addressed by calling the Molina Membership Services at (888) 665-4621.
- Provider-related questions may be addressed by calling the Molina Provider Services Help Desk at (888) 665-4621.

PREFACE

USING THE MOLINA MEDI-CAL/HEALTHY FAMILIES DRUG FORMULARY

The Molina Medi-Cal/Healthy Families Drug Formulary is a listing of preferred drug products eligible for reimbursement by Molina. All medications are listed by brand and generic name. The medications are organized by therapeutic classes. For your convenience, an index by both brand and generic names is located at the end of the Drug Formulary. The brand names listed are for reference only, and do not denote coverage unless specifically noted. New dosage forms/line extensions of Formulary products are considered non-Formulary, unless otherwise indicated in this listing.

CLINICAL CONSIDERATIONS

The Molina Healthcare Pharmacy and Therapeutics Committee have developed clinical considerations for many categories of medications and several specific drugs. The clinical considerations should not be considered prescribing guidelines or restrictions on the provider's use of certain medications. As these drugs are evaluated for inclusion in the patient's drug-therapy plan, the clinical considerations are important, key reminders related to cautions, drug-interactions, adverse effects or patient monitoring.

INDIVIDUAL PRESCRIPTIONS

Each prescription must legally be prescribed for one individual only. If prescribing for a family, each family member must receive a prescription. For a member to receive a covered over the counter medication, a written prescription is required.

GENERIC MEDICATIONS

Selected medications have FDA-approved generic equivalents available. The Molina drug endorsement states that generic drugs will be dispensed whenever available. If the use of a particular brand-name becomes medically necessary as determined by the physician, the physician must contact Molina for prior authorization. Molina encourages the use of quality generic products. Physicians are encouraged to write "Brand Only" or "DNS" only when medically necessary.

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. The physician may fax a completed "Medication Prior Authorization Request" form to Molina. The forms may be obtained by accessing Molina Healthcare of California's website at **http://www.molinahealthcare.com/medicaid/providers/ca/drug/Pages/formulary.aspx** or by calling the Molina Pharmacy Prior Authorization Department at (888) 665-4621.

STEP THERAPY PROCEDURE

Step-Therapy requires a trial of one or more "prerequisite" medications before a "Step-Therapy" medication will be covered. If it is medically necessary for a member to use a Step-Therapy medication as initial therapy, the treating physician can request coverage of such drug by submitting a Prior Authorization Request form.

PRESCRIPTION QUANTITY

Prescriptions should be written for a therapeutic supply of medications (the amount to appropriately treat a medical condition) up to a maximum of a 60-day supply. Trial quantities may be used when trying new treatments, if appropriate.

URGENT AND AFTER-HOURS MEDICATION POLICY

To prevent a member's condition from worsening in an urgent situation, it may be necessary to dispense a 72-hour supply of an acute medication before prior authorization may be obtained from Molina. (e.g., a member is discharged from a hospital after regular business hours with a special antibiotic prescription). Pharmacies are instructed to use their professional judgment. Molina will reimburse pharmacies for a 72-hour supply of an acute medication at contracted rates for these prescriptions. Pharmacies may contact CVS/Caremark Help Desk at (800) 770-8014 to obtain an override for a 72-hour supply.

Pharmacies may call Molina at (888) 665-4621 on the following business day to obtain authorization to allow the urgent or after-hours prescription to process on-line. It is advised and expected that the pharmacy will provide reasonable documentation of cases where medications were dispensed under these urgent circumstances.

TELEPHONE PRESCRIPTIONS

Whenever possible, the member should be given the prescription in writing. This will allow the member to make use of the most convenient network pharmacy and enable the pharmacy to fill the prescription after normal office hours.

MOLINA® HEALTHCARE

DRUG FORMULARY

Generic Available	Generic Name	Common Brand Name

Chapter 1 ANALGESICS

1.1 Non-Narcotic Analgesics

	Acetaminophen (Chew Tab, Soln, Supp, & Dispersible Tab)	TYLENOL – OTC*
	Aspirin	ASPIRIN – OTC*
	Butalbital/APAP/Caffeine Tab (Limited to age <65; Limited to #6/day)	FIORICET
	Butalbital/ASA/Caffeine (Limited to age <65)	FIORINAL
	Ketorolac Tromethamine (Limited to age <65; Limited to #5 day supply)	TORADOL
	Choline & Magnesium Salicylate	TRILISATE
	Salsalate	DISALCID
	Tramadol HCl (Limited to #8/day)	ULTRAM
PRIOR AUTHORIZATION REQUIRED		
	Butorphanol (PA)	STADOL Nasal Spray

1.2 Narcotic Analgesics

- Limited to 4 gram of Acetaminophen per day.

	Acetaminophen/Codeine 300/15mg, 300/30mg, 300/60mg Tab, Soln & Susp (Soln & Susp: Limited to age ≤12; 240mL/mo)	TYLENOL/CODEINE
	Hydrocodone/APAP 5/500mg, 7.5/500mg, 10/500mg, 7.5/750mg Tab	VICODIN, VICODIN ES, LORCET, LORTAB
	Hydrocodone/APAP 5/325mg, 10/325mg (Limited to #12/day, max of 3 dispensing in 75-day period)	NORCO
	Hydromorphone 2mg and 4mg Tab	DILAUDID
	Methadone	DOLOPHINE, METHADOSE
	Morphine Sulfate CR Tab (Generic only; 30mg CR: Limited to #4/day)	MS CONTIN, ORAMORPH SR
	Morphine Sulfate IR	MS IR

Generic Available	Generic Name	Common Brand Name
	Oxycodone IR (5mg Cap & Tab: Limited to #8/day, 15mg & 30mg Tab: Limited to #4/day)	Oxy IR
	Oxycodone/APAP 5/325mg Tab (5/325mg Tab: Limited to #12/day)	PERCOCET

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

	Fentanyl Transdermal (ST) (ST for failure of Morphine Sulfate ER or Methadone; Limited to #10/mo)	DURAGESIC
	Oxycodone HCl, CR (PA)	OXYCONTIN
	Oxycodone/APAP 2.5/325mg, 7.5/500mg & 10/650mg (PA)	PERCOCET
	Oxycodone/APAP 7.5/325mg, 10/325mg (ST) (ST for failure or intolerant to Oxycodone/APAP 5/325mg)	PERCOCET
	Oxycodone/ASA (ST) (ST for failure of Oxycodone/APAP 5/325mg)	PERCODAN

1.3 Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

- NSAID use in the following conditions deserves special consideration of potential risks: History of GI bleeding or ulcer; chronic anticoagulation, asthma, aspirin allergy, renal failure, hypertension or congestive heart failure.

	Diclofenac (25mg Tab: Limited to #3/day)	VOLTAREN
	Etodolac (Tab: Limited to #2/day; Cap: Limited to #4/day)	LODINE
	Flurbiprofen (50mg Tab: Limited to #4/day)	ANSAID
	Ibuprofen (Cap & Tab: Limited to #4/day; Chewable Tab & Susp; 40mg/mL, 100mg/5ml Susp: Limited to 240mL/mo)	MOTRIN – OTC*
	Indomethacin (25mg Cap: Limited to #4/day)	INDOCIN
	Meloxicam	MOBIC
	Naproxen (Limited to #3/day)	NAPROSYN – OTC*
	Naproxen Sodium (Limited to #3/day; 550mg Tab #4/day)	ANAPROX, ANAPROX DS – OTC*
	Piroxicam	FELDENE
	Sulindac	CLINORIL

Generic Available	Generic Name	Common Brand Name
	PRIOR AUTHORIZATION REQUIRED	
	Diclofenac/Misoprostol (PA)	ARTHROTEC
	Etodolac CR (PA)	LODINE XL
	Oxaprozin (PA)	DAYPRO
	Ketoprofen CR Cap (PA)	ORUVAIL
	Nabumetone (PA)	RELAFEN
	1.4 Antirheumatics	
	Hydroxychloroquine	PLAQUENIL
	Methotrexate	METHOTREXATE
	1.5 Gout Agents	
	Allopurinol	ZYLOPRIM
	(100mg: Limited to #3/day; 60 day supply available)	
	Indomethacin	INDOCIN
	Probenecid	BENEMID
	(60 day supply available)	
	PRIOR AUTHORIZATION REQUIRED	
	Colchicine (PA)	COLCRYS
	1.6 Anti-TNF-Alpha – Monoclonoal Antibodies	
	PRIOR AUTHORIZATION REQUIRED	
	Etanercept (PA)	ENBREL
	(Rx Limited to CVS/Caremark Specialty Pharmacy)	
	Adalimumab (PA)	HUMIRA
	(Rx Limited to CVS/Caremark Specialty Pharmacy)	
	1.7 Migraine	
	APAP/ASA/Caffeine	EXCEDRINE MIGRAINE – OTC*
	Divalproex ER	DEPAKOTE ER
	(250mg: Limited to #4/day; 500mg: Limited to #8/day)	
	Ergotamine/Caffeine	CAFERGOT
	Isometheptene/ Dichloralphenazone/APAP	MIDRIN
	Sumatriptan Tablet	IMITREX
	(Limited to #9/month)	

Generic Available	Generic Name	Common Brand Name

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Dihydroergotamine (PA)	MIGRANAL Nasal Spray
Eletriptan (ST)	RELPAX
(ST for failure or intolerant to Imitrex Tab, Limited to #9/45 day)	
Sumatriptan(PA)	IMITREX Nasal Spray, Injection
Zolmitriptan (ST)	ZOMIG
(ST for failure or intolerant to Imitrex Tab, Limited to #9/45 day)	

Chapter 2 ANTIDIABETIC AGENTS

2.1 Sulfonylureas

Glimepiride	AMARYL
(4mg: Limited to #2/day; 60 day supply available)	
Glipizide	GLUCOTROL
(60 day supply available)	
Glipizide Extended Release	GLUCOTROL XL
(10mg: Limited to #2/day; 60 day supply available)	
Glyburide	DIABETA, GLYNASE
(Limited to #2/day; 5mg #4/day; 60 day supply available)	
Glyburide/Metformin	GLUCOVANCE
(Limited to #2/day; 2.5/500mg #4/day; 60 day supply available)	

PRIOR AUTHORIZATION REQUIRED

Chlorpropamide (PA)	DIABINESE
Tolazamide (PA)	TOLINASE
Tolbutamide (PA)	ORINASE

2.2 Alpha-Glucosidase Inhibitors

Acarbose	PRECOSE
(Limited to #3/day; 60 day supply available)	

2.3 Biguanides

Metformin, SR	GLUCOPHAGE, XR
(1000mg: Limited to #2/day; 500mg SR: Limited to #4/day; 750mg SR: Limited to #3/day; 60 day supply available)	

2.4 Meglitinides

PRIOR AUTHORIZATION REQUIRED

Repaglinide (PA)	PRANDIN

2.5 Thiazolidinediones & Thiazolidinediones Combinations

PRIOR AUTHORIZATION/STEP THERAPY REQUIRED

Pioglitazone (ST)	ACTOS
(ST for concurrent use with Sulfonylurea, Metformin, or Basal insulin)	
Pioglitazone/Metformin (PA)	ACTOPLUS MET

Generic Available	Generic Name	Common Brand Name

2.6 Dipeptidyl Peptidase IV Inhibitor

PRIOR AUTHORIZATION REQUIRED

Sitagliptin (PA)	JANUVIA
Sitagliptin/Metformin (PA)	JANUMET
Saxagliptin (PA)	ONGLYZA
Saxagliptin/Metformin (PA)	KOMBIGLYZA

2.7 Insulins

- **Limited to vials only. Prefilled insulin pens and cartridges are PA required.**
- **All vial formulations of Humulin, Humalog, and Novo-Nordisk agents are formulary.**
- **Humulin, Humalog and Novo Nordisk agents are Limited to 4 vials per month.**

Insulin Glulisine (Limited to 4 vials/mo)	APIDRA
Insulin Glargine (Limited to 3 vials/mo)	LANTUS

STEP THERAPY REQUIRED

Insulin Detemir (ST) (ST for failure or intolerance to Lantus)	LEVEMIR

2.8 Glucagon

PRIOR AUTHORIZATION REQUIRED

Glucagon Injection (PA)	GLUCAGON KIT

2.9 Diabetic Supplies

Blood Glucose Meter (Limited to 1 meter/yr)	TRUERESULTS
Test Strips (Limited to #50/mo with oral diabetic medication; Limited to #150/mo for use with insulin or gestational diabetes)	TRUETEST
Syringes	Various
Lancets (Limited to #150/mo for use with insulin, gestational diabetes)	LANCETS, Various

Generic Available	Generic Name	Common Brand Name

Chapter 3 ANTIHISTAMINES AND COMBINATIONS

3.1 Single-Entity Products

Chlorpheniramine (Limited to age ≥3 and <65)	CHLOR-TRIMETON – OTC*
Clemastine Tab, Syrup (Tab: Limited to age ≥3 and <65; Syrup: Limited to age ≥3 and ≤12)	TAVIST– OTC*
Cyproheptadine (Limited to for age <65)	PERIACTIN – OTC*
Diphenhydramine (Liquid: Limited to age ≤12; 25mg Tab & Cap: Limited to age <65, #2/day; 50mg Tab & Cap: Limited to age <65, #6/day)	BENADRYL– OTC*
Hydroxyzine HCl (Limited to age <65; Tab #4/day; Syrup: Limited to age ≥12; 60mL/day)	ATARAX
Hydroxyzine Pamoate Cap (Limited to age <65, #4/day)	VISTARIL

Less Sedating Antihistamines:

Cetirizine (Syrup: Limited to age ≤10)	ZYRTEC
Loratadine Tab, Syrup (Syrup: Limited to age ≤10)	CLARITIN– OTC*

3.2 Combination Products

All antihistamine combination products require a prior authorization for age <4.

Brompheniramine/Decongestant	CONTAC Tab – OTC*
Chlortrimeton/Decongestant Tab, Elixir, Syrup	DIMETAPP, RONDEC – OTC*
Pyril/Phenyltolox/Pheniramine	POLY-HISTINE – OTC*
Triprolidine/Pseudoephedrine Tab, Syrup	ACTIFED– OTC*

Less Sedating Combination Products

Certirizine/Pseudoephedrine	ZYRTEC-D
Loratadine/Pseudoephedrine	CLARITIN-D – OTC*

Generic Available	Generic Name	Common Brand Name

Chapter 4 ANTI-INFECTIVE AGENTS

4.1 Penicillins

	Ampicillin	PRINCIPEN
	(Susp: Limited to age ≤12 and 400mL/10 day)	
	Amoxicillin	TRIMOX
	(Chewable Tab & Susp; Susp: Limited to 300mL/10 day; Chewable Tab: Limited to #3/day)	
	Dicloxacillin	DYNAPEN
	Penicillin	VK VEETIDS
	(Susp: Limited to age ≤12)	
	Amoxicillin/Clavulanate Potassium	AUGMENTIN
	(Chewable Tab & Susp; Limited to 300mL/mo; 500mg Tab: Limited to #3/day; 750mg Tab: Limited to #2/day)	

4.2 Cephalosporins

	Cefaclor	CECLOR
	(Susp: Limited to age ≤12; Limited to 300mL/10 day)	
	Cefdinir	OMNICEF
	(Cap: Limited to #2/day; Susp: Limited to age ≤12; Limited to 100mL/mo)	
	Cefixime 400mg	SUPRAX
	(Limited to #1 tab/fill and diagnosis of STD)	
	Cefuroxime Susp	CEFTIN
	(Limited to age ≤12; Limited to 200mL/10 day)	
	Cephalexin	KEFLEX
	(Susp: Limited to 400mL/mo)	
	Cephradrine	VELOSEF
PRIOR AUTHORIZATION REQUIRED		
	Cefadroxil (PA)	DURICEF
	Cefpodoxime (PA)	
	Cefprozil (PA)	CEFZIL

4.3 Macrolides

	Azithromycin	ZITHROMAX
	(Limited to #6/mo for 250mg Tab, #3/mo for Tri-Pak 500mg Tab, 1 pack/90 days for Powder Pack, Susp: Limited to 30mL/mo)	
	Clarithromycin	BIAXIN
	250mg, 500mg Tab (Limited to #28/14 days)	
	Erythromycin Base	ERY-TAB Enteric Coated

Generic Available	Generic Name	Common Brand Name
	Erythromycin Ethylsuccinate Tab & Liquid (Susp: Limited to age ≤12 and 400mL/mo)	E.E.S.
	Erythromycin Stearate	ERYTHROCIN
4.4 Tetracyclines		
	- Contraindicated for children less than 8 years old or pregnant and nursing mothers.	
	Doxycycline Hyclate Cap 50mg &100mg, Tab 100mg (Limited to age ≥8 and #2/day)	VIBRATAB
	Tetracycline Cap & Tab (Limited to age ≥8)	SUMYCIN
	Minocycline Cap 50mg, 100mg	MINOCIN
4.5 Quinolones		
	Ciprofloxacin 250mg, 500mg & 750mg Tab (Limited to #28/mo)	CIPRO
	PRIOR AUTHORIZATION REQUIRED	
	Levofloxacin (PA)	LEVAQUIN
	Ofloxacin (PA)	FLOXIN
4.6 Aminoglycosides		
	Neomycin	NEOMYCIN
4.7 Sulfonamides		
	SMZ/TMP	BACTRIM, SEPTRA
	Sulfisoxazole	GRANTRISIN
	Sulfisoxazole/Erythromycin Susp	PEDIAZOLE
4.8 Antituberculosis		
	Ethambutol	MYAMBUTOL
	Isoniazid (100mg: Limited to #3/day; Syrup: Limited to age ≤12; 900mL/mo)	ISONIAZID
	Pyrazinamide	PYRAZINAMIDE
	Pyridoxine	VITAMIN B-6
	Rifampin (Limited to #4/day)	RIFADIN

Generic Available	Generic Name	Common Brand Name
4.9 Antifungal – Oral		
	Clotrimazole (Troches only)	MYCELEX
	Fluconazole 150mg (Limited to female, #1/mo)	DIFLUCAN
	Fluconazole 50mg, 100mg, 200mg Tablet; 70mg Suspension (Tablet Limited to #1/day, Suspension Limited to 70mL/fill)	DIFLUCAN
	Ketoconazole 200mg (Limited to #1/day)	NIZORAL
	Nystatin	MYCOSTATIN
	Terbinafine	LAMISIL
	PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
	Griseofulvin (ST) (ST, Failure to fluconazole)	FULVICIN UF, FULVICIN P/G
	Itraconazole (PA)	SPORANOX
	Posaconazole (PA)	NOXAFIL
	Voriconazole (PA)	VFEND
4.10 Antiviral		
	Acyclovir	ZOVIRAX
	Docosanol	ABREVA
	Oseltamivir (Capsule: Limited to #10/ fill; Suspension: Limited to 75mL/ fill)	TAMIFLU
	Zamanivir Inhalation (Limited to 1 inhaler/ 28 days)	RELENZA
	PRIOR AUTHORIZATION REQUIRED	
	Boceprevir (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	VICTRELIS
	Peginterferon Alfa-2A (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	PEGASYS Inj
	Peginterferon Alfa-2B (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	PEG-INTRON Inj
4.11 Antimalarial		
	Primaquine Phosphate	PRIMAQUINE
	Pyrimethamine	DARAPRIM
4.12 Antihelminitics		
	Pyrantel Pamoate	

Generic Available	Generic Name	Common Brand Name

4.13 Anti retrovirals
(See Carved-out List, Bill Medi-Cal Fee For Service)

4.14 Misc. Anti-Infectives

Clindamycin	CLEOCIN
Metronidazole	FLAGYL
Nitrofurantoin (Limited to age <65)	MACRODANTIN
Nitrofurantoin Monohydrate Macrocrystals LA (Limited to age <65, Limited to #2/day)	MACROBID
Trimethoprim	TRIMPEX

PRIOR AUTHORIZATION REQUIRED

Chloroquine (PA)	
Dapsone (PA)	

Chapter 5 ANTILIPIDEMICS

5.1 HMG CoA Reductase Inhibitors (Statins)

Lovastatin (Limited to #1/day; 40mg Limited to #2/day; 60 day supply available)	MEVACOR
Pravastatin (Limited to #1/day; 60 day supply available)	PRAVACHOL
Simvastatin 5mg, 10mg, 20mg, 40mg (Limited to #1/day; 60 day supply available)	ZOCOR
Atorvastatin (ST) (ST failure to simvastatin 40mg, pravastatin/lovastatin 80mg)	LIPITOR

PRIOR AUTHORIZATION REQUIRED

Simvastatin 80mg (PA) (PA: Limited to prior use)	ZOCOR
Rosuvastatin (PA)	CRESTOR

5.1.1 HMG CoA Reductase Inhibitor Combinations

PRIOR AUTHORIZATION REQUIRED

Lovastatin/Niacin Extended Release (PA)	ADVICOR
Ezetimibe/Simvastatin (PA)	VYTORIN
Simvastatin/Niacin (PA)	SIMCOR

Generic Available	Generic Name	Common Brand Name
5.2 Fibrates		
	Micro Cap 67mg &134mg, Tab 54mg & 160mg	LOFIBRA, TRICOR
	Gemfibrozil (60 day supply available)	LOPID
5.3 Other Cholesterol Lowering Agents		
	Cholestyramine, Light (Limited to 1 can/mo)	QUESTRAN, LIGHT
	Niacin, Niacin SR	NIACIN, SLO-NIACIN
	Niacin Timed Released (750mg SR: Limited to #2/day; 60 day supply available)	NIASPAN
STEP THERAPY REQUIRED		
	Colesevelam (ST) (ST for failure or intolerant to Cholestyramine)	WELCHOL
Chapter 6 ANTINEOPLASTICS AND IMMUNOSUPPRESSANTS		
6.1 Antineoplastics		
	Altretamine	HEXALEN
	Anastrozole	ARIMIDEX
	Bexarotene	TARGRETIN
	Bicalutamide C	ASODEX
	Busulfan	MYLERAN
	Chlorambucil	LEUKERAN
	Cyclophosphamide	CYTOXAN
	Diethylstilbestrol	STILPHOSTROL
	Estramustine	EMCYT
	Etoposide	VEPESID
	Exemestane	AROMASIN
	Flutamide	EULEXIN
	Hydroxyurea	HYDREA
	Letrozole	FEMARA
	Levamisole	ERGAMISOL
	Lomustine	CEENU
	Megestrol	MEGACE
	Melphalan	ALKERAN
	Mercaptopurine	PURINETHOL
	Methotrexate	RHEUMATREX
	Mitotane	LYSODREN
	Procarbazine	MATULANE
	Tamoxifen	NOLVADEX
	Teremefine	FARESTON
	Tretinoin	VESANOID

Generic Available	Generic Name	Common Brand Name
	PRIOR AUTHORIZATION REQUIRED	
	(All Rx Limited to CVS/Caremark Specialty Pharmacy)	
	Capecitabine (PA)	XELODA
	Erlotinib (PA)	TARCEVA
	Imatinib (PA)	GLEEVEC
	Sunitinib (PA)	SUTENT
	Temozolomide (PA)	TEMODAR
	6.2 Immunosuppressants	
	Azathioprine	IMURAN
	PRIOR AUTHORIZATION REQUIRED	
	(All Rx Limited to CVS/Caremark Specialty Pharmacy)	
	Cyclosporine (PA)	SANDIMMUNE, NEORAL
	Mycophenolate Mofetil (PA)	CELLCEPT
	Sirolimus (PA)	RAPAMUNE
	Tacrolimus (PA)	PROGRAF
	Chapter 7 CARDIOVASCULAR MEDICATIONS	
	7.1 Cardiac Glycosides	
	Digoxin (60 day supply available)	LANOXIN
	7.2 Nitrates	
	Isosorbide Dinitrate Tab & SL (Limited to #4/day; 60 day supply available)	DILATRATE SR
	Isosorbide Mononitrate, SR (Limited to #1/day; 10mg Tab: #2/day; 60 day supply available)	IMDUR, MONOKET, ISMO, ISORDIL
	Nitroglycerin Oint	NITROL
	Nitroglycerin Patch (60 day supply available)	NITRO-DUR
	Nitroglycerin 0.4mg Pump Spray	NITROLINGUAL
	Nitroglycerin SR Cap (Limited to age ≥12; 2.5mg & 9mg Cap: #4/day; 60 day supply available)	NITRO-BID CR
	Nitroglycerin SL Tab (60 day supply available)	NITROSTAT

Generic Available	Generic Name	Common Brand Name
7.3 Beta-Blockers		
7.3.1 Beta-1 Specific		
	Atenolol	TENORMIN
	(60 day supply available)	
	Bisoprolol Fumerate	ZEBETA
	(60 day supply available)	
	Metoprolol	LOPRESSOR
	(Limited to #5/day; 60 day supply available)	
	Metoprolol ER	TOPROL XL
	(60 day supply available)	
7.3.2 Non-Selective		
	Carvedilol	COREG
	(Limited to #2/day; 60 day supply available)	
	Labetalol	NORMODYNE
	(60 day supply available)	
	Nadolol	CORGARD
	(120mg: Limited to #2/day; 60 day supply available)	
	Propranolol	INDERAL
	(80mg: Limited to #6/day)	
7.3.3 Beta-Blockers Combinations		
	Atenolol/Chlorthalidone	TENORETIC
	(50/25mg & 100/25mg: Limited to #1/day; 60 day supply available)	
	Bisoprolol/HCTZ	ZIAC
	(2.5/6.25mg & 5.6/25mg: Limited to #2/day; 60 day supply available)	
7.4 Calcium Antagonists		
	Amlodipine	NORVASC
	(60 day supply available)	
	Nifedipine Cap	PROCARDIA
	(Limited to age <65)	
	Nifedipine SR	ADALAT CC
	(60 day supply available)	
	Diltiazem, ER	DILACOR XR, TIAZAC,
	(60 day supply available)	CARDIZEM SR
	Verapamil, SR	CALAN, SR
	(60 day supply available)	
STEP THERAPY REQUIRED		
	Felodipine (ST)	PLENDIL
	(ST for failure or intolerance to Amlodipine)	

Generic Available	Generic Name	Common Brand Name
7.5 Antiarrhythmic Drugs		
	Amiodarone (60 day supply available)	CORDARONE, PACERONE
	Flecainide (60 day supply available)	TAMBOCOR
	Procainamide, SR (60 day supply available)	PRONESTYL, PROCANBID
	Propafenone (60 day supply available)	RYTHMOL
	Quinidine Gluconate (60 day supply available)	QUINAGLUTE
	Qunidine Sulfate, SR (SR: Limited to #6/day; 60 day supply available)	QUINIDEX
	Sotalol, AF (60 day supply available)	BETAPACE, AF
7.6 Angiotensin Converting Enzyme (ACE) Inhibitor **- Combination therapy with ARB requires prior authorization.**		
	Benazepril (Limited to #2/day; 60 day supply available)	LOTENSIN
	Captopril (Limited to #3/day; 60 day supply available)	CAPOTEN
	Enalapril (Limited to #2/day; 60 day supply available)	VASOTEC
	Lisinopril (Limited to #2/day; 60 day supply available)	ZESTRIL
	Quinapril (Limited to #2/day; 60 day supply available)	ACCUPRIL
7.6.1 Angiotensin Converting Enzyme Inhibitor / Diuretic Combination		
	Captopril/HCTZ (Limited to #2/day; 60 day supply available)	CAPOZIDE
	Lisinopril/HCTZ (60 day supply available)	ZESTORETIC
7.7 Angiotensin II Receptor Blockers		
	Losartan Potassium (Limited to #1/day; 60 day supply available)	COZAAR
7.7.1 ARB / Diuretic Combination		
	Losartan Potassium/ Hydrochlorothiazide (Limited to #1/day; 60 day supply available)	HYZAAR

Generic Available	Generic Name	Common Brand Name
	7.8 Antiadrenergic Agents-Centrally Acting	
	Clonidine Tab	CATAPRES
	(Limited to age <65; Tab: Limited to #8/day; 60 day supply available)	
	Methyldopa	ALDOMET
	(60 day supply available)	
	7.9 Antiadrenergic Agents-Peripheral Acting	
	Doxazosin	CARDURA
	(60 day supply available)	
	Prazosin	MINIPRESS
	(Limited to #3/day; 5mg #8/day; 60 day supply available)	
	Terazosin	HYTRIN
	(Limited to #2/day; 60 day supply available)	
	7.10 Diuretics	
	7.10.1 Loop Diuretics	
	Bumetanide	BUMEX
	(60 day supply available)	
	Furosemide	LASIX
	(60 day supply available)	
	7.10.2 Thiazide & Related Diuretics	
	Hydrochlorothiazide	HYDRODIURIL
	(60 day supply available)	
	Indapamide	LOZOL
	(60 day supply available)	
	Metolazone	ZAROXOLYN
	(Limited to #2/day; 60 day supply available)	
	7.10.3 Potassium Sparing Diuretics	
	Spironolactone	ALDACTONE
	(Limited to #2/day; 60 day supply available)	
	Triamterene/HCTZ	DYAZIDE, MAXZIDE 25 & 50
	(60 day supply available)	
	7.10.4 Carbonic Anhydrase Inhibitors	
	Acetazolamide	DIAMOX
	(Tab: Limited to #2/day)	
	Methazolamide	NEPTAZANE
	7.11 Vasodilators	
	Hydralazine	APRESOLINE
	(Limited to #4/day; 60 day supply available)	
	PRIOR AUTHORIZATION REQUIRED	
	Minoxidil (PA)	

Generic Available	Generic Name	Common Brand Name

Chapter 8 CENTRAL NERVOUS SYSTEM AGENTS

8.1 Antianxiety Agents

Alprazolam — XANAX
(Limited to #3/day; 2mg #5/day, Age < 65)

Buspirone — BUSPAR
(Limited to #2/day)

Chlordiazepoxide — LIBRIUM
(Limited to age <65)

Diazepam — VALIUM
(Limited to age <65; Tab: Limited to #4/day; Soln: Limited to maximum of 300mL/mo)

Lorazepam — ATIVAN
(Limited to #3/day; 2mg #5/day)

Oxazepam — SERAX
(Limited to #4/day, Age < 65)

8.2 Antidepressants

8.2.1 Tricyclics

Amitriptyline — ELAVIL
(Limited to #3/day; 150mg #2/day; 60 day supply available)

Amoxapine — ASCENDIN
(Limited to #3/day; 60 day supply available)

Clomipramine — ANAFRANIL
(Limited to #4/day; 75mg #3/day; 60 day supply available)

Desipramine — NORPRAMIN
(Limited to #3/day; 150mg #2/day; 60 day supply available)

Doxepin — SINEQUAN
(Limited to #3/day; 150mg #2/day; 60 day supply available)

Imipramine — TOFRANIL
(Limited to #3/day; 50mg #6/day; 60 day supply available)

Nortriptyline — PAMELOR
(Limited to #4/day; 60 day supply available)

8.2.2. Tetracyclics

Mirtazapine (regular tab) — REMERON
(60 day supply available)

8.2.3 Triazolopyridines/Phenylpiperazines

Nefazodone — SERZONE
(Limited to #2/day)

Trazodone 150mg — DESYREL
(Limited to #2/day; 60 day supply available)

Generic Available	Generic Name	Common Brand Name
	8.2.4 SSRIs	
	Citalopram (60 day supply available)	CELEXA
	Fluoxetine Cap (40mg Cap: Limited to #2/day; 60 day supply available)	PROZAC
	Paroxetine (60 day supply available)	PAXIL
	Sertraline (60 day supply available)	ZOLOFT
	PRIOR AUTHORIZATION/STEP THERAPY REQUIRED	
	Escitalopram (PA)	LEXAPRO
	Fluvoxamine (ST)	LUVOX
	8.2.6 SNRIs	
	Venlafaxine, XR (Tab: Limited to #3/day)	EFFEXOR, XR
	8.3 Miscellaneous Agents	
	Bupropion (Limited to #3/day)	WELLBUTRIN
	Bupropion SR (100mg, 150mg & 200mg Tab; Limited to #2/day)	WELLBUTRIN SR
	8.4 Antipsychotics ***(See Carve-out List, Bill Medi-Cal Fee For Service)***	
	8.5 Sedatives & Hypnotics (Limited to age <65)	
	- Flurazepam is not recommended for elderly patients due to its very long duration of action (> 24 hrs) from active metabolites.	
	Chloral Hydrate	NOCTEC
	Flurazepam	DALMANE
	Temazepam Cap 15mg & 30mg	RESTORIL
	Triazolam	HALCION
	Zolpidem	AMBIEN
	PRIOR AUTHORIZATION REQUIRED	
	Estazolam (PA)	PROSOM
	Zaleplon (PA)	SONATA

Generic Available	Generic Name	Common Brand Name
8.6 ADHD Agents (Age ≥6 through ≤ 18)		
	Amphetamine, Mixed Salts, Extended Release	ADDERALL, XR
	Atomoxetine (Limited to #1 cap, for monotherapy only)	STRATTERA
	Dextroamphetamine	DEXEDRINE
	Guanfacine	TENEX
	Methylphenidate	RITALIN, SR
	Methylphenidate ER	METADATE CD
PRIOR AUTHORIZATION REQUIRED		
	Guanfacine SR (PA)	INTUNIV
	Clonidine SR (PA)	KAPVAY
8.7 Smoking Cessation Agents		
	Bupropion SR	ZYBAN
PRIOR AUTHORIZATION REQUIRED		
	Nicotine Inhaler (PA)	NICOTROL Inhaler
	Nicotine Polacrilex (PA)	NICORETTE Gum – OTC
	Nicotine Transdermal (PA)	NICODERM CQ, NICOTROL (15mg) - OTC
	Varenicline (PA)	CHANTIX
8.8 Other CNS Agents		
	Disulfiram Tab	ANTABUSE
Chapter 9 CONTRACEPTIVES & SEX HORMONES		
9.1 Contraceptives *(Limited to female; age 12 to 45)*		
9.1.1 Mono-Phasic Oral Contraceptives		
	Desogestrel & Ethinyl Estradiol Tab 0.15mg-30mcg	DESOGEN-28, ORTHO-CEPT
	Desogest-Eth Estrad & Eth Estrad Tab 0.15-.02/.01mg (21/5)	MIRCETTE
	Drospirenone-Ethinyl Estradiol Tab 3-0.03mg	YASMIN
	Norethindrone & Ethinyl Estradiol Tab 0.5mg-35mcg	MODICON

Generic Available	Generic Name	Common Brand Name
	Norethindrone Ace & Ethinyl Estradiol Tab 1mg-20mcg	LOESTRIN 1/20-21
	Norethindrone Ace & Ethinyl Estradiol Tab 1.5mg-30mcg	LOESTRIN 1.5/30-21
	Norgestimate & Ethinyl Estradiol Tab 0.25mg-35mcg	ORTHO-CYCLEN
	Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1mg-20mcg	LOESTRIN FE 1/20
	Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5mg-30mcg	LOESTRIN FE 1.5/30
	9.1.2 Bi-Phasic Oral Contraceptives (PA)	
	9.1.3 Tri-Phasic Oral Contraceptives (PA)	
	Norethindrone/Ethinyl Estradiol	ESTROSTEP, ORTHO-NOVUM 7/7/7
	Norgestimate/Esthinyl Estradiol	ORTHO TRI-CYCLEN
	9.1.4 Progestin Oral Contraceptives (PA)	
	Norethindone	MICRONOR, NOR-QD
	9.2 Androgens (Limited to male)	
	PRIOR AUTHORIZATION REQUIRED	
	Testosterone Cypionate Injection (PA)	
	Testoterone gel (PA)	ANDROGEL, TESTIM
	9.3 Estrogens	
	(60 day supply available. Limited to for age <65)	
	Estradiol	ESTRACE
	Estradiol Transdermal	ESTRADERM, CLIMARA, VIVELLE
	Estrogens, Esterified	ESTRATAB
	Estrogens, Conjugated	PREMARIN

Generic Available	Generic Name	Common Brand Name
	9.3.1 Estrogen/Progesterone Combination (All estrogen/progesterone combination are Limited to female; 60 day supply available. Limited to for age <65)	
	Estrogen, Conjugated, Medroxyprogesterone	PREMPRO, PREMPRO LOW-DOSE, PREMPHASE
	Estradiol/Norethindrone Transdermal (Limited to #8/mo)	COMBIPATCH
	Ethinyl Estradiol/ Norethindrone (60 day supply available)	FEMHRT
	9.4 Progestins (All Progestins are Limited to female; 60 day supply available)	
	Medroxyprogesterone	PROVERA, CYCRIN
	Norethindrone Acetate	AYGESTIN
	9.5 Endometriosis Agents	
	Danazol	DANOCRINE
	Nafarelin	SYNAREL
	9.6 Uterine Stimulants	
	Methylergonovine	METHERGINE
	Chapter 10 DERMATOLOGICALS & MUCOUS MEMBRANE AGENTS	
	10.1 Acne Medications	
	Benzoyl Peroxide, Gel	BENZOYL PEROXIDE
	Clindamycin 1% Topical Gel, Solution (Limited to 60gm/mo)	CLEOCIN-T
	Erythromycin Topical Gel, Soln (Limited to 60gm/mo)	ERYGEL, ERYCETTE
	Tretinoin Cream & Gel (Limited to age 12 to 30, max 20gm/mo; Microgel is not covered)	RETIN A
	PRIOR AUTHORIZATION REQUIRED	
	Sulfacetamide Sodium/Sulfur Lotion, Emulsion (PA)	CERISA WASH, AVAR

Generic Available	Generic Name	Common Brand Name
10.2 Topical Anti-Infectives		
	Bacitracin, Zinc Ointment	BACITRACIN – OTC
	Bacitracin/Polymyxin B Oint	POLYSPORIN
	Gentamicin Cream, Oint	GARAMYCIN
	Mupirocin Oint (Limited to 22 gm/mo)	BACTROBAN
	Neomycin/Bacitracin/ Polymyxin Oint	NEOSPORIN - OTC
	Silver Sulfadiazine	SILVADENE
	Metronidazole 0.75% Cream, Gel (Limited to 45gm/mo)	METROCREAM 0.75%, METROGEL 0.75%
PRIOR AUTHORIZATION REQUIRED		
	Metronidazole Gel 1% (PA)	METROGEL 1%
10.3 Topical Antifungals		
	Clotrimazole Cream, Soln	MYCELEX – OTC
	Miconazole Cream	MONISTAT – OTC
	Nystatin Cream, Oint, Powder	MYCOSTATIN, NYSTAT-RX, NYAMYC
	Tolnaftate Cream	TINACTIN - OTC
	Ketoconazole 1%, 2% Shampoo (Limited to 120mL/mo)	NIZORAL A-D, NIZORAL
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED		
	Ciclopirox (PA)	LOPROX
	Clotrimazole/Betamethasone (PA)	LOTRISONE
	Ketoconazole 2% Cream (ST)	NIZORAL
	(ST for Miconazole & Clotrimazole Cream; Limited to 60gm/mo)	
10.4 Topical Corticosteroids		
GROUP IV (LOW POTENCY)		
	Aclometasone Dipropionate 0.05% Cream, Oint (Limited to 60gm/mo)	ACLOVATE
	Desonide Cream, Oint	TRIDESILON
	Hydrocortisone Cream, Oint, Lotion	HYTONE
PRIOR AUTHORIZATION REQUIRED		
	Desonide Lotion 0.05% (PA)	DESOWEN
	Lidocaine-Hydrocortisone Acetate 3-0.5% Cream, Lotion (PA)	LIDAMANTLE

Generic Available	Generic Name	Common Brand Name
	GROUP III (MEDIUM POTENCY)	
	Fluocinolone	SYNALAR
	Fluocinolone Acetonide Oil (age <6, QL #118ml/month)	DERMA-SMOOTH OIL / FS BODY, DERMA-SMOOTH OIL/FS SCALP
	Hydrocortisone Valerate Cream, Oint 0.2%	WESTCORT
	Mometasone Furoate Cream, Oint	ELOCON
	Triamcinolone Acetonide Cream, Oint	KENALOG
	PRIOR AUTHORIZATION REQUIRED	
	Prednicarbate (PA)	DERMATOP
	Pramoxine-HC Aerosol Foam (PA)	EPIFOAM AER 1%
	Triamcinolone Acetonide Aerosol Soln (PA)	KENALOG AER SPRAY
	Triamcinolone Acetonide Lotion 0.025%, 0.1% (PA)	ARISTOCORT, KENALOG
	GROUP II (HIGH POTENCY)	
	Fluocinonide	LIDEX
	Betamethasone Dipropionate 0.05% Cream, Lotion	DIPROSONE
	Betamethasone Valerate 0.1% Cream, Oint	VALISONE
	PRIOR AUTHORIZATION REQUIRED	
	Halcinonide (PA)	HALOG, HALOG-E
	Desoximetasone 0.05%, 0.25% Cream, 0.05% Gel, 0.25% Oint (PA)	TOPICORT
	GROUP 1 (VERY HIGH POTENCY)	
	Augmented Betamethasone Dipropionate	DIPROLENE
	Clobetasol Propionate 0.05% Cream, Oint, Soln	TEMOVATE
	PRIOR AUTHORIZATION REQUIRED	
	Diflorasone Diacetate (PA)	FLORONE, FLORONE E, PSORCON
	Halobetasol (PA)	ULTRAVATE

Generic Available	Generic Name	Common Brand Name
10.5 Topical Corticosteroids in Combinations		
	HydrocortisonePramoxine	EPIFOAM
10.6 Scabicides/Pediculocides		
	Permethrin	NIX – OTC
	Permethrin	ELIMITE
	Permethrin Combinations	RID, A-200 - OTC
	Benzyl Alcohol Lotion	ULESFIA
PRIOR AUTHORIZATION/STEP THERAPY REQUIRED		
	Spinosad Suspension (PA)	NATROBA
	Malathion (ST) (ST for failure of OTC Nix or Rid)	OVIDE
10.7 Anorectal		
	Hydrocortisone Rectal Crm	PROCTOCREAM HC 2.5%
	Hydrocortisone Acetate	ANUSOL HC Supp
10.8 Anti-Psoriatics		
	Anthralin	DITHROCREME
PRIOR AUTHORIZATION REQUIRED		
	Calcipotriene (PA)	DOVONEX
	Tazarotene Topical Gel (PA)	TAZORAC
10.9 Misc. Topicals		
	Calamine Lotion	CALAMINE – OTC
	Selenium Sulfide	SELSUN Shampoo- RX
PRIOR AUTHORIZATION REQUIRED		
	Imiquimod (PA)	ALDARA
	Fluorouracil Topical (PA)	EFUDEX 5%
	Pimecrolimus Ointment (PA)	ELIDEL
	Tacrolimus Ointment (PA)	PROTOPIC
10.10 Mucous Membrane Agents		
	Clotrimazole Troche	MYCELEX
	Lidocaine Viscous	XYLOCAINE
	Nystatin Susp	MYCOSTATIN

Generic Available	Generic Name	Common Brand Name

Chapter 11 ENDOCRINE AGENTS

11.1 Systemic Corticosteroids

11.1.1 Glucocorticoids

Hydrocortisone	CORTEF
Dexamethasone	DECADRON
Methylprednisolone	MEDROL
Prednisolone Tab 5mg, Syrup, Powder	PRELONE
Prednisone Tab, Sol (Tablet: 60 day supply available)	ORASONE

11.1.2 Mineralocorticoids

Fludrocortisone Tab	FLORINEF

11.2 Osteoporosis Agents

Alendronate 5mg, 10mg, 35mg, 70mg (Limited to age =/>50; Limited to #1/day for 5mg and10mg; and #4/month for 70mg)	FOSAMAX
Calcitonin Salmon (Limited to age =/>50; 1 bottle/mo)	MIACALCIN Nasal Spray

PRIOR AUTHORIZATION REQUIRED

Ibandronate (PA)	BONIVA
Raloxifene (PA)	EVISTA
Risedronate (PA)	ACTONEL

11.3 Thyroid Agents

11.3.1 Antithyroid Agents

Methimazole (60 day supply available)	TAPAZOLE
Propylthiouracil (60 day supply available)	PTU

11.3.2 Thyroid Hormones

Levothyroxine (60 day supply available)	LEVOXYL, SYNTHROID
Thyroid Dessicated (Limited to age <65; 60 day supply available)	ARMOUR THYROID

11.4 Other Endocrine Agents

Bromocriptine (5mg Cap: Limited to #6/day)	PARLODEL
Desmopressin	DDAVP
Ergocalciferol	CALCIFEROL

Generic Available	Generic Name	Common Brand Name

11.5 Growth Hormone

PRIOR AUTHORIZATION REQUIRED

Somatropin (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	TEV-TROPIN

Chapter 12 GASTROINTESTINAL AGENTS

12.1 Helicobacter Pylori Agents

Bismuth Subsalicylate/ Metronidazole/TCN (Limited to 1 fill/lifetime)	HELIDAC

12.2 Histamine-2 Antagonists

Cimetidine Tab, Syrup (Syrup Limited to age <12, max 300mL/mo)	TAGAMET
Famotidine	PEPCID AC - OTC
Ranitidine Tab, Syrup (Tab: Limited of #2/day, Syrup: Limited to age ≤10 and 600mL/mo)	ZANTAC

12.3 Proton Pump Inhibitors (Limited to 6 months use per year)

Lansoprazole Cap Delayed Release 15mg, 30mg (Limited to #2/day)	PREVACID 24 HR– OTC
Lansoprazole Cap 30mg (Limited to #1/day)	PREVACID
Omeprazole Cap 10mg & 20mg	PRILOSEC
Pantoprazole (Limited to #1/day)	PROTONIX

12.4 Antacids
(Limited to 4 fills/year)

Alum/Mag Hydroxide	MAALOX, MAALOX TC – OTC*
Alum/Mag Hydroxide /Simethicone	MYLANTA, MYLANTA II – OTC*
Calcium Carbonate Tab, Chewable Tab	TUMS, ROLAIDS – OTC*

Generic Available	Generic Name	Common Brand Name
12.5 Miscellaneous Agents		
	Simethicone (Limited to 4 fills/year)	MYLICON – OTC*
	Sucralfate	CARAFATE
STEP THERAPY REQUIRED		
	Misoprostol (ST) (ST for concurrent use with an NSAIDs and age > 55, Limited to #4/day)	CYTOTEC
12.6 Antiemetics		
	Meclizine Tab & Chewable Tab (Limited to age <65 and #2/day)	ANTIVERT
	Ondansetron Tab, ODT (Limited to #9/21 day)	ZOFRAN
	Prochlorperazine (5mg Tab: Limited to #4/day; 10mg Tab: Limited to #2/day; Supp: Limited to 12/fill)	COMPAZINE
	Promethazine (Limited to age ≥3 and <65; Supp: QL 12/fill, 2 fills/mo)	PHENERGAN
	Trimethobenzamide (Limited to age <65; Limited to #2/day)	TIGAN
12.7 Gastrointestinal Anticholinergic/Antispasmodics		
	Belladonna Alkaloids/Phenobarbital (Limited to age <65; Tab: Limited to #8/day; Elixir: Limited to 12mL/day)	DONNATAL
	CDZ/Clindinium (Limited to age <65, Limited to #8/day)	LIBRAX
	Dicyclomine (Limited to age <65; 10mg Cap: Limited to #16/day; 20mg Tab: Limited to #8/day; Soln: Limited to 40mL/day)	BENTYL
	L-Hyoscyamine Sulfate Tab, SL, SR, and Soln (Limited to age <65; SR: Limited to #4/day)	LEVSIN, LEVSINEX
	Metoclopramide (10mg Tab: Limited to #4/day; Soln: Limited to age ≤12)	REGLAN
	Probanthelene (Limited to age <65)	PRO-BANTHINE

Generic Available	Generic Name	Common Brand Name
12.8 Inflammatory Bowel Agents		
	Balsalazide Disodium Cap	COLAZAL
	(Formulary for age =/>21. Max #9/day)	
	Sulfasalazine	AZULFIDINE
	(Delayed Release: Limited to #4/day)	
PRIOR AUTHORIZATION REQUIRED		
	Mesalamine Cap (PA)	PENTASA
12.9 Laxatives		
(Limited to 4 fills/year)		
	Bisacodyl	DULCOLAX – OTC*
	Docusate Sodium	COLACE – OTC*
	Polyethylene Glycol 3350 Powder (can)	MIRALAX
	(Limited to 527gm/30 days, no fill limit)	
	Lactulose	CONSTULOSE, ENULOSE
	Senna	SENNA – OTC*
	Sennosides/Docusate	SENOKOT S – OTC*
12.10 Antidiarrheals		
(Limited to 4 fills/year)		
	Attapulgite	KAOPECTATE – OTC*
	Bismuth Subsalicylate	PEPTO BISMOL – OTC*
	Diphenoxylate/Atropine	LOMOTIL
	Loperamide	IMMODIUM – OTC*
12.11 Digestive Enzymes		
PRIOR AUTHORIZATION REQUIRED		
	Amylase/Lipase/Protease (PA)	ACREASE, VIOKASE, COTAZYME, CREON, PANCREAZE, ZENPEP
12.12 GI Preparations		
(Limited to 4 fills/year)		
	Barium Enema Prep Kit	FLEET PREP KIT
	PEG Solution	COLYTE, Flavored

Generic Available	Generic Name	Common Brand Name
	Chapter 13 GENITOUINARY AGENTS	
	13.1 Vaginal Anti-Infectives (Limited to female)	
	Butoconazole	FEMSTAT 3 – OTC*
	Clindamycin	CLEOCIN VAG Cream
	Clotrimazole	GYNE-LOTRIMIN – OTC*
	Fluconazole 150mg (Limited to #1/mo)	DIFLUCAN
	Metronidazole Vag Cream	METROGEL VAGINAL
	Miconazole Cream, Supp	MONISTAT 3, 7 – OTC*
	Nystatin Vaginal Tab	MYCOSTATIN
	Triple Sulfa Vag Cream	GYNE SULF – OTC*
	13.2 Anticholinergics	
	Oxybutynin (Tab: Limited to #4/day; Syrup: Limited to age ≤12)	DITROPAN
	PRIOR AUTHORIZATION REQUIRED	
	Tolterodine LA (PA)	DETROL LA
	13.3 Cholinergic Drugs	
	Bethanechol (Limited to #4/day)	URECHOLINE
	13.4 Urinary Analgesics	
	Phenazopyridine 100mg & 200mg (Limited to #12/mo)	PYRIDIUM
	13.5 Vaginal Estrogens (Limited to female)	
	Conjugated Estrogen Vaginal Cream	PREMARIN
	Estradiol Vaginal Cream	VAGIFEM
	13.6 Peripheral Antiadrenergic Agents (Limited to male)	
	Doxazosin	CARDURA
	Terazosin Cap	HYTRIN
	13.7 Prostatic Hypertrophy Agents (Limited to male age ≥ 50)	
	Finasteride 5mg tablet (Limited to #1/day)	PROSCAR
	Tamsulosin (Limited to #1/day)	FLOMAX
	PRIOR AUTHORIZATION REQUIRED	
	Alfuzosin (PA)	UROXATRAL

Generic Available	Generic Name	Common Brand Name

Chapter 14 HEMATOLOGICAL AGENTS

14.1 Hematopoeitic Agents

14.1.1 Erythropoiesis-Stimulating Agents

PRIOR AUTHORIZATION REQUIRED

Epoetin Alfa, Recombinant (PA) — PROCRIT
(Rx Limited to CVS/Caremark Specialty Pharmacy)

14.2 Anticoagulants

Warfarin Sodium — COUMADIN
(60 day supply available)

PRIOR AUTHORIZATION REQUIRED

Enoxaparin (PA) — LOVENOX
(Limited to max of 14/7 day at retail; limit 2 fills per year, PA required for >7 day supply or more than 2 fills per year)

14.3 Antiplatelets

Aspirin — ASPIRIN – OTC*
(60 day supply available)
Clopidogrel — PLAVIX
Dipyridamole — PERSANTINE
(Limited to age <65; 60 day supply available)

14.4 Hemorrheologic Agents

Pentoxifylline — TRENTAL
(60 day supply available)

Chapter 15 NASAL AGENTS

15.1 Nasal Corticosteroids

(All nasal corticosteroids are Limited to 4 fills per year. Members with Asthma are excluded from the 4 fill limit.)

Flunisolide — NASAREL, NASALIDE
(Fills >4 per year Limited to those with Asthma; Limited to 25gm/mo)
Fluticasone — FLONASE
(Fills >4 per year Limited to those with Asthma; Limited to 16gm/mo)

PRIOR AUTHORIZATION REQUIRED

Mometasone (PA) — NASONEX
(Limited to age ≤4. Fills >4 per year Limited to those with Asthma; Limited to 17gm/mo)

Generic Available	Generic Name	Common Brand Name

15.2 Miscellaneous Nasal Products

	Cromolyn	NASALCROM – OTC*

Chapter 16 NEURO-MUSCULAR AGENTS

16.1 Anticonvulsants

	Carbamazepine, SR (SR: Limited to #2/day; 60 day supply available)	TEGRETOL, XR
	Clonazepam (Limited to #4/day)	KLONOPIN
	Divalproex Sodium (Sprinkle: Limited to #8/day; 250mg ER #4/day; 500mg ER #8/day; 60 day supply available)	DEPAKOTE, ER
	Ethosuximide (60 day supply available)	ZARONTIN
	Gabapentin (Limited to #6/day; 800mg Tab: #4/day)	NEURONTIN
	Phenobarbital (Tab: Limited to age <65; Limited to #3/day, 100mg Tab #4/day; Soln: Age ≤12)	PHENOBARBITAL
	Phenytoin (Limited to #6/day; 60 day supply available)	DILANTIN
	Primidone (60 day supply available)	MYSOLINE
	Lamotrigine 25mg, 100mg, 150mg, 200mg (Limited to Neurologist or Psychiatrist; PA for other prescribers; 25mg, 100mg, 150mg max #2/day, 200mg max #3/day)	LAMICTAL
	Levetiracetam 250mg, 500mg, 750mg & 1000mg (250mg & 500mg, max #2/day, 750mg max #4/day, 1000mg max #3/day)	KEPPRA
	Oxcarbazepine 150mg, 300mg & 600mg (Limited to Neurologist or Psychiatrist; PA for other prescribers; 150mg & 300mg max #2/day, 600mg max #3/day)	TRILEPTAL
	Zonisamide 25mg, 50mg & 100mg (Limited to Neurologist or Psychiatrist; PA for other prescribers; 25mg & 50mg max #3/day, 100mg max #6/day)	ZONEGRAN
	Valproic Acid (60 day supply available)	DEPAKENE

Generic Available	Generic Name	Common Brand Name
	PRIOR AUTHORIZATION REQUIRED	
	Carbamazepine Cap SR (PA)	CARBATROL
	Diazepam Rectal Gel Delivery System (PA)	DIASTAT
	Tiagabine (PA)	GABITRIL
	Topiramate (PA)	TOPAMAX
	Valproic Acid Delayed Release (PA)	STAVZOR
	16.2 Antiparkinson Agents	
	(Limited to #3/day)	
	Biperiden HCl	AKINETON
	Bromocriptine	PARODEL
	Carbidopa/Levodopa, CR (60 day supply available)	SINEMET, CR
	Carbidopa/Levodopa/ Entacapone (Limited to #8/day; 50-200-200mg Tab #6/day)	STALEVO
	PRIOR AUTHORIZATION REQUIRED	
	Entacapone (PA)	COMTAN
	Pramipexole (PA)	MIRAPEX
	Ropinirole (PA)	REQUIP
	16.3 Skeletal Muscle Relaxants	
	Baclofen (Limited to #4/day)	LIORESAL
	Carisoprodol Tab 350mg (Limited to age <65; Limited to #4/day)	SOMA
	Cyclobenzaprine Tab 10mg (Limited to age <65; Limited to #3/day)	FLEXERIL
	Methocarbamol (Limited to age <65; Limited to #4/day)	ROBAXIN
	PRIOR AUTHORIZATION REQUIRED	
	Orphenadrine Citrate (PA)	NORFLEX
	Orphenadrine/ASA/Caffeine (PA)	NORGESIC, FORTE

Generic Available	Generic Name	Common Brand Name

16.4 Viscosupplements

PRIOR AUTHORIZATION REQUIRED

	Sodium Hyaluronate Intra-Articular (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	SUPARTZ

16.5 Others

	Pyridostigmine	MESTINON

16.6 Multiple Sclerosis Agents – Interferons

PRIOR AUTHORIZATION REQUIRED

	Glatiramer Acetate Inj Kit (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	COPAXONE
	Interferon Beta-1B IM Inj Kit (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	EXTAVIA
	Interferon Beta-1A IM Inj Kit (PA) (Rx Limited to CVS/Caremark Specialty Pharmacy)	AVONEX

Chapter 17 NUTRITIONAL PRODUCTS

17.1 Vitamins

	Calcitriol	ROCALTROL
	Folic Acid 1mg (Limited to #2/day)	FOLVITE
	Folic Acid/B-12/Iron (Limited to female, age 12 to 50; 60 day supply available)	NIFEREX-150 FORTE
	Multi-Vitamin & Fluoride, FE Tab & Drops (Limited to children age ≤5; 60 day supply available)	POLY-VI-FLOR, FE, TRI-VI-FLOR, FE
	Vitamin A	AQUASOL A
	Vitamin K	MEPHYTON

17.2 Prenatal Vitamins

(Limited to females, age 12 to 50; #1/day, 60 day supply available)

	Prenatal Vitamin FE	PRENAVITE, PRENATAL-S, NIFEREX ON, PN FORTE

Generic Available	Generic Name	Common Brand Name
17.3 Potassium Supplement		
	Potassium Chloride Tab, Cap, Liquid (15mEq: Limited to #5/day; 60 day supply available)	K-DUR, K-TABS, KLOTRIX, KLOR-CON
17.4 Others		
	Calcium Acetate (Limited to #12/day)	PHOSLO
	Calcium Carbonate	OS-CAL, TUMS – OTC*
	Ferrous Gluconate	FERGON – OTC*
	Ferrous Sulfate Tab, Soln, Drops (Drops: Limited to age ≤5)	FEOSOL
	Levocarnitine	CARNITOR
	Magnesium Chloride	SLOW MAG
	Magnesium Oxide	MAG OXIDE
	Pediatric Electrolyte Soln	PEDIALYTE – OTC*
	Sodium Fluoride Tab & Drops (60 day supply available)	LURIDE
STEP THERAPY REQUIRED		
	Sevelamer (ST) (ST for failure or intolerant to Phos-Lo)	RENVELA, RENAGEL

Chapter 18 OPHTHALMIC AGENTS

18.1 Anti-Infectives

18.1.1 Antibiotics and Combinations		
	Bacitracin	AK-TRACIN
	Chloramphenicol	CHLOROPTIC
	Erythromycin Ophth Oint	ILOTYCIN
	Gentamicin (Limited to 5mL/mo)	GENOPTIC
	Neomycin/Polymyxin B/ Gramicidin	NEOSPORIN
	Ofloxacin (Limited to 5mL/mo)	OCUFLOX
	Polymycin/TMP (Limited to 10mL/mo)	POLYTRIM
	Sulfacetamide (Limited to 15mL/mo)	BLEPH-10, SODIUM SULAMYD
	Tobramycin (Limited to 5mL/mo)	TOBREX
PRIOR AUTHORIZATION REQUIRED		
	Gatifloxacin (PA)	ZYMAR
	Moxifloxacin (PA)	VIGAMOX

Generic Available	Generic Name	Common Brand Name
	18.1.2 Antibiotics-Corticosteroid Combinations	
	Hydrocortisone/Neomycin Polymyxin B	CORTISPORIN
	Prednisolone 1%/Gentamicin	PRED-G
	Prednisolone 0.5%/ Neomycin/Polymyxin B	POLYPRED
	Prednisolone 0.6%/ Tobramycin/Dexamethasone (Limited to 5mL/mo)	TOBRADEX
	Sulfacetamide/Prednisolone	BLEPHAMIDE
	18.1.3 Antifungals	
	Natamycin 5%	NATACYN
	18.1.4 Antivirals	
	Trifluridine	VIROPTIC
	18.2 Anti-Inflammatory Agents	
	18.2.1 Corticosteroids	
	Dexamethasone 0.1%	DECADRON, AK-DEX
	Fluorometholone 0.1%	FML, FML FORTE
	Prednisolone 0.12%, 1%	PRED MILD, PRED FORTE
	18.2.2 NSAIDs	
	Diclofenac 0.1%	VOLTAREN
	Flurbiprofen	OCUFEN
	Ketorolac	ACULAR, LS
	18.3 Anti-Allergic Agents	
	18.3.1 Others	
	Ketotifen	ZADITOR – OTC*
	STEP THERAPY REQUIRED	
	Olapatadine HCl Ophth Soln (ST) (ST for Zaditor/Alaway and age ≤18; Limited to 5mL/30 day)	PATANOL
	18.4 Dilating Agents	
	18.4.1 Anticholinergics	
	Atropine	ISOPTO ATROPINE
	Cyclopentolate	CYCLOGYL
	Homatropine	ISOPTO HOMATROPINE
	Scopolamine	ISOPTO HYOSCINE
	Tropicamide	MYDRIACIL

Generic Available	Generic Name	Common Brand Name
18.5 Glaucoma Agents		
	18.5.1 Alpha-2 Adrenergic Agonists	
	Brimonidine 0.1%, 0.2%	ALPHAGAN
	Brimonidine/Timolol	COMBIGAN
	18.5.2 Symathomimetics	
	Dipivefrin	PROPINE
	Epinephrine HCl	EPIFRIN
	18.5.3 Beta-Adrenergic Antagonists	
	Levobunolol	BETAGAN
	Timolol Maleate 0.25% & 0.5% Soln, XE Gel	TIMOPTIC, TIMOPTIC XE, TIMOPTIC OCUDOSE
	PRIOR AUTHORIZATION REQUIRED	
	Betaxolol 0.25% & 0.5% (PA)	BETOPTIC S, BETOPIC
	18.5.4 Miotics, Direct Acting	
	Pilocarpine HCl	PILOCAR
	18.5.5 Carbonic Anhydrase Inhibitors	
	Dorzolamide HCl 1%	TRUSOPT
	18.5.6 Prostaglandin Agonists	
	Latanoprost Ophth Soln (Limited to 2.5ml/30 days, 5ml/60 days; Limited to age > 21)	XALATAN
	PRIOR AUTHORIZATION REQUIRED	
	Bimatoprost Ophth Soln (PA)	LUMIGAN
	Travoprost Ophth Soln (PA)	TRAVATAN Z
Chapter 19 OTIC PREPARATION		
19.1 Otic Anti-infectives and Combinations		
	Hydrocortisone/Neomycin/ Polymyxin B Otic	CORTISPORIN
	Ofloxacin Otic (Limited to 7mL/mo)	FLOXIN
	PRIOR AUTHORIZATION REQUIRED	
	Ciprofloxacin/Dexamethasone (PA)	CIPRODEX

Generic Available	Generic Name	Common Brand Name
19.2 Miscellaneous Otic Products		
	Acetic Acid	VOSOL
	Benzocaine/Antipyrine	AURALGAN
	Carbamide Peroxide	DEBROX – OTC*
	Triethanolamine/ Chlorobutanol	CERUMENEX
PRIOR AUTHORIZATION REQUIRED		
	Hydrocortisone/Acetic Acid (PA)	VOSOL HC

Chapter 20 RESPIRATORY AGENTS

20.1 Cough/Cold Products

- **All Cough/cold products requires a prior authorization for age <4 and are limited to 4 fills per year.**
- **All Promethazine products are limited to age ≥ 6 to <65**

20.1.1 Cough/Cold Combinations		
	Brompheniramine/Decongestant Tab, Elixir	DIMETAPP– OTC*
	Brompheniramine/ Pseudoephedrine Tab, Syrup	BROMDEC
	Chlorpheniramine/Decongestant Cap	CONTACT 12 Hr – OTC*
	Pyril/Phenyltolox/Pheniramine	POLY-HISTINE
	Triprolidine/Pseudoephedrine Tab, Syrup	ACTIFED – OTC*
20.1.3 Decongestants		
	Pseudoephedrine Tab, Syrup (Limited to age ≥2)	SUDAFED – OTC*
20.1.4 Antitussives & Expectorants		
	Benzonatate (Limited to #60/10 day)	TESSALON PERLES
	Codeine/Promethazine	PHENERGAN/CODEINE
	Codeine/Promethazine/ Phenylephrine	PHENERGAN VC/CODEINE
	Dextromethorphan/ Hydrocodone/Phenyl/CTM	HISTUSSIN HC, HISTINEX HC
	Guaifenesin/Codeine	TUSSI-ORGANIDIN NR, ROBITUSSIN AC

Generic Available	Generic Name	Common Brand Name
20.2 Beta Adrenergic Agonist		
20.2.1 Inhalers		
	Albuterol	PROAIR HFA, VENTOLIN
	Metaproterenol	ALUPENT
	Pirbuterol	MAXAIR AUTOHALER
20.2.2 Solutions		
	Albuterol 0.083% nebulized solution (Limited to #300/30days)	PROVENTIL
20.2.3 Oral Tablets		
	Albuterol	PROVENTIL
	Albuterol Extended Release	VOLMAX
	Terbutaline	BRETHINE
20.3 Long-Acting Beta Agonist		
PRIOR AUTHORIZATION REQUIRED		
	Formoterol Fumarate (PA)	FORADIL
	Salmeterol (PA)	SEREVENT, DISKUS
20.4 Xanthine Derivatives		
	Theophylline	UNIPHYL
	Theophylline 8-12 Hr SR	SLO-BID GYROCAPS
	Theophylline 8-24 Hr SR (400mg Tab: Limited to #2/day)	THEO-DUR
20.5 Corticosteroids Inhalation		
	Beclomethasone	QVAR
	Budesonide	PULMICORT FLEXHALER
	Budesonide Inh Soln (Limited to age ≤6; Limited to 60 vials/mo)	PULMICORT RESPULES
	Mometasone Furoate	ASMANEX

Generic Available	Generic Name	Common Brand Name

20.6 Corticosteroids/ Long-Acting Beta Agonist Combinations

Fluticasone/Salmeterol — ADVAIR DISKUS 100/50
(Limited to age <12; Limited to #1/mo)

STEP THERAPY REQUIRED

Mometasone Furoate/Formoterol Fumarate (ST) — DULERA
(ST for inhaled corticosteroid (ICS) in last 90 days; Limited to 13gm/mo)

Budesonide/Formoterol (ST) — SYMBICORT
(ST for inhaled corticosteroid (ICS) in last 90 days)

20.7 Leukotriene Inhibitors

Montelukast 4mg chew, 5mg chew, 10mg tab — SINGULAIR

PRIOR AUTHORIZATION REQUIRED

Zafirlukast (PA) — ACCOLATE

20.8 Anticholinergics

Ipratropium Inhaler & Neb Soln — ATROVENT
Aclidinium — TUDORZA

20.8.1 Anticholinergic/Beta Agonist combination

Ipratropium/Albuterol Aerosol — COMBIVENT RESPIMAT
(Limited to age ≥12; Limited to 4gm, 1 box/month)

20.9 Mast Cell Stabilizers

Cromolyn Neb Soln — INTAL
Nedocromil Sodium Inhaler — TILADE

20.10 Respiratory Devices

Inhaler Enhancement Device (Limited to 1 space device/yr) — AEROCHAMBER, E-Z SPACER, MICROCHAMBER, OPTICHAMBER, INSPIREASE EASIVENT

Spacers consistently increase the delivery of inhaled medications in all age groups, regardless of technique, and are strongly recommended.

Generic Available	Generic Name	Common Brand Name
Chapter 21 MISCELLANEOUS		
	Condoms	CONDOMS – Various OTC*
	Diaphragm	DIAPHRAGM - Various
	Epinephrine Inj Device (Epipen/Epipen JR Limited to 2/mo)	EPIPEN, EPIPEN JR, TWINJECT
	Spermicidal Jelly, Foam, Film	SPERMICIDAL – Various OTC*
PRIOR AUTHORIZATION REQUIRED		
	Epinephrine Inj (PA)	TWINJECT INJECTABLE

Generic Name/Common Brand Name
PA = Prior Authorization Required
ST = Step Therapy Restriction applied

CARVED –OUT DRUGS

The Department of Health Services through the Medi-Cal Fee for Service Program has assumed financial responsibility for select psychiatric, HIV, and detoxification medications listed below. This list may not be inclusive. Pharmacies must bill these medications directly to Medi-Cal Fee for Service. Prior Authorization from the plan is not required.

PSYCHIATRIC DRUGS (Listed by Generic Name) * list may not be inclusive	
Amantadine HCl (SYMMETREL)	Olanzapine/Fluoxetine (SYMBYAX)
Aripiprazole (ABILIFY)	Olanzapine Pamoate Monohydrate
Asenapine (SAPHRIS)	(Zyprexa Relprevv)
Benztropine Mesylate (COGENTIN)	Paliperidone (INVEGA)
Biperiden HCl (AKINETON)	Paliperidone Palmitate
Biperiden Lactate (AKINETON)	(Invega Sustenna)
Chlorpromazine HCl (THORAZINE)	Perphenazine (TRILAFON)
Chlorprothixene	Phenelzine Sulfate (NARDIL)
Clozapine (CLOZARIL)	Pimozide (ORAP)
Fluphenazine Decanoate	Procyclidine HCl (KEMADRIN)
(PROLIXIN)	Promazine HCl (SPARINE)
Fluphenazine Enanthate (PROLIXIN)	Quetiapine (SEROQUEL XR,
Fluphenazine HCl (PERMITIL,	SEROQUEL)
PROLIXIN)	Risperidone, Risperidone
Haloperidol (HALDOL)	Microspheres (RISPERDAL,
Haloperidol Decanoate (HALDOL-D)	RISPERDAL CONSTA)
Haloperidol Lactate (HALDOL)	Selegiline Transdermal (EMSAM)
Iloperidone (FANAPT)	Thioridazine HCl (MELLARIL)
Isocarboxazid (MARPLAN)	Thiothixene HCl (NAVANE)
Lithium Carbonate (LITHOBID,	Tranylcypromine Sulfate
LITHONATE, ESKALITH)	(VESPERIN)
Lithium Citrate (various generic)	Trifluroperazine HCl (STELAZINE)
Loxapine HCl (LOXITANE)	Triflupromazine HCl (VESPERIN)
Loxapine Succinate (LOXITANE)	Trihexyphenidyl HCl (ARTANE,
Lurasidone HCL (LATUDA)	TRIHEXY-5)
Mesoridazine Mesylate (SERENTIL)	Ziprasidone, Ziprasidone Mesylate
Molindone HCl (MOBAN)	(GEODON, GEODON IM)
Olanzapine (ZYPREXA)	

HIV DRUGS (Listed by Generic Name) *list may not be inclusive	
Abacavir/Lamivudine/Zidovudine Combination (TRIZIVIR)	Etravirine (INTELENCE)
Abacavir Sulfate (ZIAGEN)	Fosamprenavir Calcium (LEXIVA)
Abacavir/Lamivudine (EPZICOM)	Indinavir Sulfate (CRIXIVAN)
Amprenavir (AGENERASE)	Lamivudine (EPIVIR)
Atazanavir (REYATAZ)	Lopinavir/Ritonavir (KALETRA)
Darunavir Ethanolate (PREZISTA)	Maraviroc (SELZENTRY)
Delavirdine Mesylate (RESCRIPTOR)	Nevirapine (VIRAMUNE)
Efavirenz (SUSTIVA)	Nelfinavir Mesylate (VIRACEPT)
Efavirenz/Emtricitabine/ Tenofovir Disoproxil Fumarate (ATRIPLA)	Raltegravir Potassium (ISENTRESS)
Elvitegravir/Cobicistat/Emtricitabine/ Tenofovir Disoproxil Fumarate (STRIBILD)	Rilpivirine HCl (Edurant)
Emtricitabine (EMTRIVA)	Ritonavir (NORVIR)
Emtricitabine/Rilpivirine/Tenofovir Disoproxil Fumarate (COMPLERA)	Saquinavir (INVIRASE, FORTOVASE)
Enfuvirtide (FUZEON)	Stavudine (ZERIT)
	Tenofovir Disoproxil-Emtricitabine (TRUVADA)
	Tenofovir Disoproxil (VIREAD)
	Tipranavir (APTIVUS)
	Zidovudine/Lamivudine (COMBIVIR)

DETOXIFICATION AGENTS (Listed by Generic Name) * list may not be inclusive	
Acamprosate Calcium (CAMPRAL)	Buprenorphine Transdermal Patch (BUTRANS)
Buprenorphine/Naloxone HCl (SUBOXONE)	Naltrexone Microsphere Injectable Suspension (VIVITROL)
Buprenorphine HCl (SUBUTEX, BUPRENEX)	Naltrexone (oral) (REVIA)

INDEX

A

INDEX

INDEX

INDEX

INDEX

E

F

INDEX

G

H

INDEX

INDEX

M

INDEX

N

INDEX

O

P

INDEX

INDEX

Q

R

S

INDEX

T

INDEX

U

V

W

X

INDEX

Y

Z

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