



# **Preferred Drug List 2009**

## THE DRUG BENEFIT PROGRAM OF THE VENTURA COUNTY HEALTH PLAN

The Ventura County Health Care Plan (VCHCP) offers its members an outpatient prescription medication benefit that includes generic and brand-name medications.

VCHCP provides an open drug plan or open formulary. In addition to the generic and brand name drugs on its Preferred Drug List (previously referred to as the Drug Formulary), VCHCP also covers many other medications that are classified as “non-preferred.” Members usually pay a much higher copayment for these non-preferred medications.

VCHCP utilizes a four-tier drug classification system to determine the amount of the patient’s cost share, or copayment. Drugs classified as either Tier 1, Tier 2, or Tier 4 constitute VCHCP’s Preferred Drug List (PDL). A description of the four medication classification tiers follows:

**Tier 1** includes all covered generic medications available at the lowest copayment to the patient. When appropriate, physicians are encouraged to prescribe generic medications to help patients save money and to help control health care costs. If the patient or physician requests a brand-name medication when a generic is available, in addition to the copay, the patient pays the difference in cost between the brand-name medication and the generic.

**Tier 2** includes brand-name medications for which there is generally only a single manufacturing or distributing source. These medications are described in the industry as “single source brands.” The patient pays a higher copayment for these than for Tier 1 generic medications.

**Tier 3** includes those covered medications considered to be non-preferred. Generally a medication is considered non-preferred if VCHCP’s Pharmacy Benefit Manager (PBM) has determined that there are one or more therapeutically-equivalent drug alternatives available to the patient on either Tier 1 or Tier 2. The patient pays the highest copayment amount for these medications.

**Tier 4** Includes “Specialty Medications” – Specialty pharmaceuticals, primarily injectibles represent a relatively new area of prescription medications, one with a small market in terms of patient populations. Yet it is the single most explosive market in terms of growth and cost. In 2009, VCHCP will implement an integrated approach to managing today’s most sophisticated pharmaceuticals. Some of the components will include:

- Specialty pharmacy management program, including delivery, pharmacy partnerships and home infusion network coordination cover all delivery options.
- Utilization analysis and care management ensure appropriate treatment initiation and continuation.
- Single source for specialty pharmacy efforts simplifies and standardizes billing.

2009 MEMBER COST-SHARE		
PREFERRED DRUGS		NON-PREFERRED DRUGS
Tier 1	Tier 2	Tier 3
GENERIC	SINGLE-SOURCE BRAND	MULTI-SOURCE BRAND
\$10 Retail Copay	\$27 Retail Copay	\$45 Retail Copay
\$20 Mail-Order Copay	\$45 Mail-Order Copay	\$75 Mail-Order Copay
<b>Tier 4 – Specialty drugs:</b> 20% of drug cost to \$150 / Rx, \$300 monthly maximum		

EXAMPLES		
PREFERRED DRUGS		NON-PREFERRED DRUGS
Tier 1	Tier 2	Tier 3
GENERIC	SINGLE-SOURCE BRAND	MULTI-SOURCE BRAND
lovastatin	Crestor	Lipitor
lisinopril	Diovan	Cozaar
omeprazole	Nexium	Aciphex
<b>Tier 4 – Specialty drugs:</b> Enbrel, Copaxone, Ribavirin, Pegasys, et. al.		

***This tiered copay structure pertains to commercial benefit plan members only. Other programs, such as Healthy Families, have a different structure.***

The Ventura County Health Care Plan Pharmacy and Therapeutics Committee (P&T Committee) has reviewed and accepted the DRUG BENEFIT PROGRAM. This Committee comprised of physicians from various medical specialties, reviews reports and recommendations from expert physician and pharmacist panels. The Committee in turn bases its recommendations on these sources of information, while making modifications to reflect local practice patterns and preferences.

### **NON-PRESCRIPTION MEDICATION (OTC) POLICY**

With the exception of Prilosec OTC, over-the-counter (OTC) products are not covered, although some may be listed here for informational purposes only. Absent those exceptions, if an OTC product equivalent to a prescription product is available, then neither the prescription product nor the OTC product will be covered by the Plan. Physicians and pharmacists should refer members to the OTC equivalent product, which is then to be purchased over-the-counter by the member.

If an OTC product is available, and if that product exists in a different dose or in another form, and if that alternative product can **only** be obtained with a prescription, then that medicine is to be considered covered, and the usual rules for providing the prescription are in effect. (See **Copay Determination # 5** below.)

If the member or physician insists on the prescription equivalent product to the OTC drug, and the two preparations are equivalent, the member must pay the entire cost of the prescription, regardless of the cost, even if the prescribed medication would be less expensive than the OTC product.

### **GENERIC DRUG POLICY**

Specified drugs which have generic equivalents are covered at a generic reimbursement level (Tier 1) and should be prescribed and dispensed in the generic form. These drugs are indicated by **bold print** in the drug formulary. Providers are reminded of the following:

1. When generic substitution conflicts with state regulations or restrictions, the pharmacist must obtain approval from the prescribing medical care professional to use the generic equivalent.
2. Pharmacists are reminded that a drug in **bold print** indicates that one or more (but not necessarily all) forms of the drug are subject to a "Maximum Allowable Cost" or "MAC". In such a case, the pharmacist should consult the MAC list.
3. If a physician indicates "Dispense As Written" ("DAW"), or "Do Not Substitute" ("DNS"), or if a member insists on the brand named product for which an equivalent generic product is available, then the patient must pay the applicable copay plus the cost difference between the brand-name product and the MAC amount.

### **UNAPPROVED USE OF FORMULARY MEDICATIONS**

Medications are generally covered only if they are FDA-approved medications, and are used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA-approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion. This so-called "off-label" use may place the medication in a higher tier for purposes of determining the copay, or it may be that such use is not a covered treatment, under any conditions, in which case the member will bear the entire cost of the prescription. Finally, drugs used for cosmetic purposes are not eligible for coverage, under any conditions.

## QUANTITY LIMITS (QLs)

Some formulary medications have a Quantity Limit or QL statement, which is applied against the written prescription. If, for instance, the number of doses of a certain drug exceeds the QL, then the member will receive only the allowed number, as shown in the QL list. With some exceptions, QLs are generally the amount allowed over a thirty (30) day period when purchased at a participating pharmacy, or for ninety (90) days if purchased by mail order. (It should be noted that not all drugs are available through mail order. In particular, **injectable drugs and drugs for insomnia, erectile dysfunction, and headaches may not be available by mail order.**)

## EXCLUDED MEDICATIONS

Certain medications are specifically excluded from coverage, as noted in the EVIDENCE OF COVERAGE. These include appetite suppressants (with rare exceptions), dietary supplements, cosmetics or medications used for cosmetic purposes (i.e. retinoic acid for wrinkles), and medications to treat baldness.

A few drugs are specifically excluded because they are not included in a competitive pricing category (CPC). In each case alternative drugs are available in that therapeutic category. These excluded drugs are therefore not covered by the plan.

## COPAY DETERMINATION

The table below describes the copay which will be charged to the patient when filling a prescription. (See above "Generic Drug Policy" for additional conditions and payments which apply when certain non-generic drugs are provided.) For Healthy Families and AIM members, the maximum copay for any Tier 1, 2, or 3 drug is \$5. Tier 3 drugs will require prior authorization.

	Type of Prescription	Member's Co-Pay	Comments
1.	Generic formulation is available and furnished by a network pharmacy.	Tier 1 \$10	\$20 (if a 3 mo. supply by mail)
2.	Preferred Drug but only brand-name or single-source is available.	Tier 2 \$27 or more	\$45 (if a 3 mo. supply by mail) or more
3.	Non-Preferred Drug except if excluded. (See excluded drugs.) Certain drugs must be prior authorized before the prescription will be covered by the Plan.	Tier 3 \$45 or more	\$75 (if a 3 mo. supply by mail) or more
4.	Brand Drug for which a generic preparation is available, but physician and/or member insist on a brand name drug.	Member pays, in addition to copay, difference in cost between generic and brand drug, up to 100% of cost of brand drug	Tier 3 copay
5.	Over the counter (OTC) preparation when the equivalent drug is available as a prescription drug and is equal in dosage.	Member pays full cost if the OTC strength of the drug and the strength of the drug by prescription are the same	Although a physician may have written the prescription, this is not a covered benefit if the drug is available OTC at the same strength.
6.	Drugs for treatment of non-	Member pays full cost	Regardless of a drug being on or off the PDL,

	Type of Prescription	Member's Co-Pay	Comments
	covered conditions.		if a drug is prescribed for a non-covered condition, the member pays full cost.
7.	Investigational Drugs: FDA approved for retail sales, but investigation is for treatment of medical diagnoses not otherwise approved by the FDA (or not supported by informed medical opinion or the peer reviewed medical literature).	Tier 3 copay or actual drug cost	Can only be prescribed for the specific investigation of a condition(s) covered under the Plan; requires prior authorization.
8.	<u>Not</u> FDA approved for retail sales, but is in a formally approved study, (phase II or greater).	Tier 3 copay or actual drug cost	Requires prior authorization.
9.	All "specialty" medications, including injectables (with the exception of insulin and epinephrine) used for the treatment of chronic conditions (other than diabetes), such as hepatitis C, multiple sclerosis, rheumatoid arthritis, migraine, and HIV/AIDS.	20%% of the cost of each individual drug up to \$150, not to exceed a <b>global cost of \$300</b> per month for <b>all injectable</b> drugs prescribed for use in a single month	All injectables, other than insulin and epinephrine, require prior authorization and may also be subject to certain Quantity Limits or QLs. (Does not include injectable(s) given during an office visit.) For the current QL list (at the time of publication) please see the PAR/QL/ST list on each page.

### MEDICATIONS REQUIRING PRIOR AUTHORIZATION

Using the 3 tier system described above, most medications are available by proper prescription. However, the Pharmacy & Therapeutics Committee may designate any preferred or non-preferred medication as requiring prior authorization (PAR). Generally these are high cost medications or medications for which medical necessity must be demonstrated. In general, the prior authorization list includes all injectables (with the exception of insulins, epinephrine, and medroxyprogesterone acetate); all approved immunization products; all growth hormones; all infertility drugs; and all antivirals/protease inhibitors. This list is not all inclusive. For the most current list of PAR drugs, please see the PAR/QL/ST column on each page. In addition, all Tier 3 drugs for Healthy Families and AIM members require prior authorization. From time to time, additional drugs may be added to the prior authorization list. Physicians will receive updates on these additions.

For those medications requiring prior authorization, the Plan should be notified by the prescribing physician who will submit medical justification for using the drug.

### STEP THERAPY (ST)\*

VCHCP has implemented step therapy programs for Angiotensin Receptor Blockers (ARBs), COX 2 inhibitors, Proton Pump Inhibitors (PPIs), Selective Serotonin Reuptake Inhibitors (SSRIs), Other Antidepressants (SNRIs), and Cholesterol Lowering medications (statins).

**ARB** step therapy requires a trial of two (2) different ACE Inhibitors, unless an unacceptable cough is present, or receipt of a prescription for an ARB within 130 days of the current prescription before authorization for an ARB will be approved.

Unless a member has previously received a prescription for a **COX 2 inhibitor** within 130 days of the current prescription, or has a contraindication to the use of conventional NSAIDs (such as prior adverse reaction; history of peptic ulcer, perforation, GI bleed, or obstruction; age >65, anti-coagulant or corticosteroid use) or is being treated for rheumatoid arthritis, the member must have received courses of treatment with 2 different conventional NSAIDs before a COX 2 inhibitor will be authorized.

A brand **PPI** will not be authorized unless the member has received and failed a course of treatment with omeprazole or Prilosec OTC, or the member has received a prescription for a brand PPI within 130 days of the current prescription.

**SSRI** step therapy requires a trial of two (2) different generic SSRIs or receipt of a prescription for an SSRI within 130 days of the current prescription before an authorization for Lexapro will be approved. The subsequent options will include other brand SSRIs.

**Other Antidepressants** step therapy requires a trial of a generic SSRI or receipt of a prescription for Effexor XR or Cymbalta within 130 days before receiving Effexor XR or Cymbalta. It also requires a trial of bupropion SR or receipt of a prescription for Wellbutrin XL within 130 days before receiving Wellbutrin XL.

The **statin** step therapy requires the following: If a low dose statin is requested and the member has not had receipt of a prescription for a brand statin within 130 days of the current prescription, a trial of a generic HMG CoA reductase inhibitor is required before authorization for Crestor (5 or 10mg) or Vytorin (10/10 or 10/20mg) will be approved. The subsequent options will include Lipitor 10 or 20mg or another low dose brand statin. If a high dose statin is requested and the member has not had receipt of a prescription for a brand statin within 130 days of the current prescription, a trial of Crestor (20 or 40mg) or Vytorin (10/40 or 10/80mg) is required before authorization for Lipitor 40 or 80mg or another high dose statin will be approved.

\*If exemption from the step therapy protocol is sought, prior authorization should be obtained. If a physician or member insists on non-authorized use of a step therapy drug, the member will be responsible for 100% of the prescription cost.

## **REVISING THE PREFERRED DRUG LIST**

In the case that a physician desires that a product, presently non-preferred, be placed on the preferred drug list, an application should be made to the Pharmacy & Therapeutics Committee (P&T) of the Plan. Description and explanation of such items as the nature of the drug and the therapeutic benefits to be derived from using it, the presence or absence of alternatives, the cost-benefit ratio of the drug, the general use of the drug by the medical community, etc., will help the P&T Committee make recommendations to the Pharmacy Benefits Manager.

All inquiries or requests should be directed to:

Ventura County Health Care Plan  
Attn: Utilization Department  
2220 E. Gonzales Road #210-B  
Oxnard, CA 93036

Telephone: (805) 981-5050  
Facsimile: (805) 981-5026  
E-mail to [VCHCP.Admin@ventura.org](mailto:VCHCP.Admin@ventura.org)

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>CHAPTER 1: ANESTHETICS</b>						
<b>1.2 TOPICAL ANESTHETICS</b>						
lidocaine hcl viscous						
lidocaine hcl						
LIDODERM						
<b>CHAPTER 2: ANTIINFECTIVES</b>						
<b>2.1.1 CEPHALOSPORINS</b>						
cefaclor						
cefaclor er						
cefadroxil						
cefdinir						
cefepodoxime proxetil						
cefuroxime (tab)						
cephalexin						
CEFTIN (SUSP)						cefepodoxime suspension
OMNICEF						cefdinir
<b>The following drugs are not covered by the Plan:</b>						
CEDAX		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
CEFZIL		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
LORABID		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
SPECTRACEF		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
SUPRAX (SUSP)		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
VANTIN		N/A	N/A	N/A	N/A	amoxicillin/clavulante, cefdinir
<b>2.1.3 CLINDAMYCINS</b>						
clindamycin hcl						
<b>2.1.4 ERYTHROMYCINS</b>						
erythrocin stearate						
erythromycin ethylsuccinate						
PCE						clarithromycin, erythromycin
<b>2.1.4.1 OTHER MACROLIDES</b>						
azithromycin	QL= 8 tabs/30 days (250mg); 4 tabs/30 days (500mg); 15ml suspension (100mg/5ml) - 2 bottles; 15, 22.5, 30ml susp 200mg/5ml - 3 bottles					
clarithromycin						
BIAXIN						clarithromycin
BIAXIN XL						clarithromycin
DYNABAC						clarithromycin, erythromycin
ZITHROMAX	QL= 8 tabs/30 days (250mg); 4 tabs/30 days (500mg); 15ml suspension (100mg/5ml) - 2 bottles; 15, 22.5, 30ml susp 200mg/5ml - 3 bottles					clarithromycin, erythromycin
<b>2.1.5 PENICILLINS</b>						
amox tr/potassium clavulanate (susp)						
amoxicillin						
penicillin v potassium						
trimox						
AUGMENTIN XR						amox/clavulanate (immed release)
<b>2.1.6 SULFONAMIDES</b>						
erythromycin w/sulfisoxazole						
sulfamethoxazole/trimethoprim						
<b>2.1.7 TETRACYCLINES</b>						
doxycycline hyclate						
minocycline hcl						
tetracycline hcl						
<b>2.1.8 URINARY ANTIINFECTIVES</b>						
nitrofurantoin macrocrystal (100 mg)						

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>2.1.9 QUINOLONES</b>						
<b>ciprofloxacin hcl</b>						
<b>ofloxacin (tabs)</b>						
AVELOX						
AVELOX ABC PACK						
CIPROFLOXACIN						
LEVAQUIN (SOLN)						
CIPRO XR						
FACTIVE	QL = 7 tablets					<b>ciprofloxacin, AVELOX</b>
LEVAQUIN (inj)	PAR w/ injectable copay					<b>ciprofloxacin, AVELOX</b>
MAXAQUIN						<b>ciprofloxacin, AVELOX</b>
NOROXIN						<b>ciprofloxacin, AVELOX</b>
<b>2.2 TOPICAL ANTIBACTERIAL DRUGS</b>						
<b>gentamicin sulfate</b>						
<b>mupirocin</b>						
<b>mupirocin 2% ointment</b>						
<b>silver sulfadiazine</b>						
BACTROBAN						
CHLORHEXIDINE GLUCONATE						
<b>2.3 ORAL ANTIFUNGAL DRUGS</b>						
<b>clotrimazole</b>						
<b>fluconazole</b>	PAR; QL = 2 tabs					
<b>itraconazole</b>	PAR; QL = 34 caps (100mg)					
<b>ketoconazole</b>	PAR					
<b>nystatin</b>						
<b>terbinafine tablet</b>						
NOXAFIL						
LAMISIL tab	PAR					<b>terbinafine</b>
SPORANOX	PAR; QL = 34 caps (100mg)					<b>itraconazole</b>
<b>2.4.1 VAGINAL ANTIFUNGALS</b>						
<b>terconazole</b>						
GYNAZOLE-1						
<b>2.4.2 OTHER TOPICAL ANTIFUNGALS</b>						
<b>ciclopirox (cream)</b>						
<b>ciclopirox (lotion)</b>						
<b>econazole nitrate</b>						
<b>ketoconazole</b>						
<b>nystatin</b>						
<b>The following drugs are not covered by the Plan:</b>						
ERTACZO		N/A	N/A	N/A	N/A	generic OTC antifungal
EXELDERM		N/A	N/A	N/A	N/A	generic OTC antifungal
LAMISIL cream		N/A	N/A	N/A	N/A	OTC LAMISIL
LOPROX		N/A	N/A	N/A	N/A	generic OTC antifungal
MENTAX		N/A	N/A	N/A	N/A	OTC LOTRIMIN ULTRA
NAFTIN		N/A	N/A	N/A	N/A	generics
OXISTAT		N/A	N/A	N/A	N/A	generic OTC antifungal
PENLAC		N/A	N/A	N/A	N/A	generic OTC antifungal
<b>2.4.3 TOPICAL ANTIFUNGAL-CORTICOSTEROID COMB.</b>						
<b>clotrimazole/betamethasone</b>						
<b>nystatin w/triamcinolone</b>						
<b>2.5.1 ANTIRETROVIRALS &amp; PROTEASE INHIBITORS</b>						
EMTRIVA	PAR					
INTELENCE	PAR					
REYATAZ	PAR					
TRUVADA	PAR					
FUZEON	PAR					

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>2.5.2 OTHER ANTIVIRAL DRUGS</b>						
acyclovir						
amantadine hcl						
DENAVIR						
TAMIFLU	QL=10 caps, 25 ml oral susp=3 bottles					
TYZEKA						
FLUMIST	PAR					
ribasphere	PAR					
ribavirin	PAR					
COPEGUS	PAR					ribasphere, ribavirin 200mg
<b>The following drugs are not covered by the Plan:</b>						
FAMVIR		N/A	N/A	N/A	N/A	acyclovir
FLUMADINE		N/A	N/A	N/A	N/A	amantadine hcl
RELENZA		N/A	N/A	N/A	N/A	rimantadine, TAMIFLU
VALTREX		N/A	N/A	N/A	N/A	acyclovir
<b>2.7.2 ANTITUBERCULOSIS DRUGS</b>						
isoniazid						
rifampin						
<b>2.7.3 PLASMODICIDES</b>						
hydroxychloroquine sulfate						
quinine sulfate						
<b>2.7.5 TRICHOMONOCIDES</b>						
metronidazole						
<b>2.8.2 AMINOGLYCOSIDES</b>						
GENTAMICIN SULFATE	PAR w/injectable copay					
<b>CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS</b>						
<b>3.0 ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS</b>						
azathioprine						
cyclosporine softgel						
megestrol acetate						
mercaptopurine						
methotrexate tablet						
tamoxifen citrate						
ARIMIDEX	PAR					
CASODEX	PAR					
DEPO-PROVERA	PAR w/ injectable copay QL = 1 vial/syringe					
FEMARA	PAR					
MYFORTIC	PAR					
cyclosporine injection	PAR w/ injectable copay					
methotrexate injection	PAR w/ injectable copay					
CELLCEPT	PAR w/injectable copay					
ELIGARD	PAR w/ injectable copay					
ENBREL	PAR w/ injectable copay 50mg QL = 5 syringes 25mg QL = 10 syringes					
HUMIRA	PAR, QL = 3 syringes w/injectable copay					
IRESSA	PAR					
REVLIMID	PAR					
SUTENT	PAR					
TREANDA						
TYKERB						
ZOLADEX						
ZOLINZA						
TRELSTAR DEPOT	PAR w/ injectable copay					ELIGARD
TRELSTAR LA	PAR w/ injectable copay					ELIGARD
<b>CHAPTER 4: CARDIOVASCULAR MEDICATIONS</b>						
<b>4.1 CARDIAC GLYCOSIDES</b>						
digitek						
digoxin						

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>4.2 CALCIUM ANTAGONISTS</b>						
amlodipine besylate						
cartia xt						
diltiazem er						
diltiazem hcl						
diltiazem xr						
felodipine er						
nicardipine hcl						
nifedipine						
nifedipine er						
verapamil hcl						
SULAR						
<b>The following drugs are not covered by the Plan:</b>						
CARDENE SR		N/A	N/A	N/A	N/A	felodipine er, nifedipine er, SULAR
CARDIZEM LA		N/A	N/A	N/A	N/A	diltiazem er
COVERA-HS		N/A	N/A	N/A	N/A	verapamil hcl
DYNACIRC		N/A	N/A	N/A	N/A	felodipine er, nifedipine er, SULAR
DYNACIRC CR		N/A	N/A	N/A	N/A	felodipine er, nifedipine er, SULAR
NORVASC		N/A	N/A	N/A	N/A	felodipine er, nifedipine er, SULAR
VERELAN PM		N/A	N/A	N/A	N/A	verapamil hcl
<b>4.3.1 LOOP DIURETICS</b>						
bumetanide						
furosemide						
toremide						
<b>4.3.2 THIAZIDE AND RELATED DRUGS</b>						
hydrochlorothiazide						
indapamide						
metolazone						
<b>4.3.3 POTASSIUM SPARING DIURETICS</b>						
amiloride hcl w/hctz						
spironolactone						
spironolactone w/hctz						
triamterene w/hctz						
INSPRA						spironolactone
<b>4.4 BETA-ADRENERGIC ANTAGONIST DRUGS</b>						
atenolol						
bisoprolol fumarate						
labetalol hcl						
labetalol hcl	PAR w/ injectable copay					
metoprolol succ er						
metoprolol tartrate						
nadolol						
propranolol hcl						
COREG						
INNOPRAN XL						propranolol hcl
TOPROL XL						metoprolol succ er
<b>4.5.1 VASODILATOR ANTIHYPERTENSIVES</b>						
doxazosin mesylate						
hydralazine hcl						
prazosin hcl						
terazosin hcl						
CARDURA XL						
<b>4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES</b>						
clonidine hcl						
guanfacine hcl						
methyldopa						
<b>4.5.4.1 ANGIOTENSIN CONVERTING ENZYME INHIBITORS</b>						
benazepril hcl						
captopril						
enalapril maleate						
fosinopril sodium						
lisinopril						
quinapril						
quinapril hcl						

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>The following drugs are not covered by the Plan:</b>						
ACCUPRIL		N/A	N/A	N/A	N/A	quinapril
ACEON		N/A	N/A	N/A	N/A	generic ACE inhibitor
ALTACE		N/A	N/A	N/A	N/A	generic ACE inhibitor
MAVIK		N/A	N/A	N/A	N/A	generic ACE inhibitor
UNIVASC		N/A	N/A	N/A	N/A	generic ACE inhibitor
<b>4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>						
BENICAR	ST					
DIOVAN	ST					
ATACAND	ST					BENICAR, DIOVAN
AVAPRO	ST					BENICAR, DIOVAN
COZAAR	ST					BENICAR, DIOVAN
MICARDIS	ST					BENICAR, DIOVAN
TEVETEN	ST					BENICAR, DIOVAN
<b>4.5.6 OTHER ANTIHYPERTENSIVES</b>						
<b>atenolol w/chlorthalidone</b>						
<b>benazepril hcl-hctz</b>						
<b>bisoprolol fumarate/hctz</b>						
<b>captopril/hydrochlorothiazide</b>						
<b>enalapril maleate/hctz</b>						
<b>fosinopril-hydrochlorothiazide</b>						
<b>lisinopril-hctz</b>						
<b>moexepiril-hctz</b>						
<b>quinaretic</b>						
AZOR	ST					
BENICAR HCT	ST					
DIOVAN HCT	ST					
EXFORGE	ST					
LOTREL	ST					
ATACAND HCT	ST					BENICAR HCT, DIOVAN HCT
AVALIDE	ST					BENICAR HCT, DIOVAN HCT
HYZAAR	ST					BENICAR HCT, DIOVAN HCT
LEXXEL	ST					LOTREL
MICARDIS HCT	ST					BENICAR HCT, DIOVAN HCT
TARKA	ST					VERAPAMIL+ACE INHIBITOR, LOTREL
TEVETEN HCT	ST					BENICAR HCT, DIOVAN HCT
UNIRETIC	ST					quinaretic, BENAZ/HCT, ENAL/HCT
<b>4.6.1 NITRATES</b>						
<b>isosorbide dinitrate</b>						
<b>isosorbide mononitrate</b>						
<b>nitroglycerin</b>						
<b>4.6.3 ENDOTHELIN RECPTR ANTAGONIST</b>						
LETAIRIS						
TRACLEER						
<b>4.7.1.1 CLASS 1A</b>						
<b>quinidine gluconate</b>						
<b>4.7.1.3 CLASS 1C</b>						
<b>flecainide acetate</b>						
<b>propafenone hcl</b>						
<b>4.7.3 AMIODARONES</b>						
<b>amiodarone hcl</b>						
PACERONE (200mg only)						
PACERONE						amiodarone hcl
<b>4.7.5 OTHER ANTIARRHYTHMICS</b>						
<b>sotalol</b>						
<b>4.8.1 HYPOLIPOPROTEINEMICS</b>						
<b>cholestyramine</b>						
<b>colestipol</b>						
<b>gemfibrozil</b>						
LOVAZA						
NIASPAN						
OMACOR						
TRICOR						
ZETIA						
COLESTID						colestipol
LOFIBRA						gemfibrozil, TRICOR
WELCHOL						cholestyramine, COLESTID

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>4.8.2 HMG-COA REDUCTASE INHIBITORS</b>						
lovastatin						
pravastatin						
simvastatin						
CRESTOR	ST					
ALTOPREV	ST					
LESCOL	ST					lovastatin, CRESTOR, ZOCOR
LESCOL XL	ST					lovastatin, CRESTOR, ZOCOR
LIPITOR	ST					lovastatin, CRESTOR, ZOCOR, VYTORIN
PRAVACHOL	ST					lovastatin, CRESTOR, ZOCOR
ZOCOR	ST					
<b>4.8.2.1 HMG-COA COMBINATIONS</b>						
ADVICOR						
SIMCOR						
VYTORIN	ST					
CADUET						
PRAVIGARD PAK						
<b>4.9 OTHER CARDIOVASCULAR DRUGS</b>						
pentoxifylline						
<b>CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS</b>						
<b>5.1.1 ANALGESICS</b>						
tramadol hcl						
tramadol hcl-acetaminophen						
<b>5.1.1.1 CLASS II NARCOTICS</b>						
fentanyl	PAR w/ injectable copay					
hydromorphone hcl	QL = 100tabs/30days					
meperidine hcl	PAR w/ injectable copay					
morphine sulfate	QL = 100tabs/30days					
oxycodone apap	QL = 100tabs/30days					
oxycodone hcl	QL = 100tabs/30days					
oxycodone w/acetaminophen	QL = 100tabs/30days					
OPANA ER						
OXYCONTIN	QL = 100tabs/30days					
ACTIQ	PAR QL = 4/day					fentanyl citrate
AVINZA	QL = 100tabs/30days					generics
KADIAN	QL = 100tabs/30days					generics
METHADONE HCL (PWD)	QL = 100tabs/30days					
MS CONTIN	QL = 100tabs/30days					morphine sulfate
MSIR	QL = 100tabs/30days					generics
OXYIR	QL = 100tabs/30days					oxycondone hcl
<b>5.1.1.2 CLASS III NARCOTICS</b>						
acetaminophen w/codeine	QL = 100tabs/30days					
acetaminophen w/hydrocodone	QL = 100tabs/30days					
hydrocodone bit-ibuprofen	QL = 100tabs/30days					
<b>5.1.1.3 CLASS IV NARCOTICS</b>						
propoxyphene hcl	QL = 100tabs/30days					
propoxyphene hcl w/acetaminophen	QL = 100tabs/30days					
propoxyphene napsylate w/acetaminophen	QL = 100tabs/30days					
<b>5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES</b>						
butalbital compound						
butalbital/acetaminophen/caffeine						
sumatriptan	QL= 1 kit/30 days (2 syringes); 2 vials/30 days; 6 devices/30 days (5mg & 20mg spray); 9 tabs/30 days (25mg, 50mg, & 100mg) Injectable copay applies for injectable dosage form.					
MAXALT	QL= 12 tabs/30 days					
MAXALT MLT	QL = 12 tabs/30 days					
ZOMIG	QL= 6 tabs/30 days					
ZOMIG NASAL SPRAY	QL=6 devices/30 days					
ZOMIG ZMT	QL= 6 tabs/30 days					
AMERGE	QL= 9 tabs/30 days (1mg & 2.5mg)					sumatriptan, MAXALT, ZOMIG

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
AXERT	QL= 6 tabs/30 days 6.25mg & 12 tablets/30 days 12.5 mg)					sumatriptan, MAXALT, ZOMIG
FROVA	QL= 9 tabs/30 days					sumatriptan, MAXALT, ZOMIG
IMITREX	QL= 1 kit/30 days (2 syringes); 2 vials/30 days; 6 devices/30 days (5mg & 20mg spray); 9 tabs/30 days (25mg, 50mg, & 100mg) Injectable copay applies for injectable dosage form.					sumatriptan
RELPAK	QL= 6 tabs/30 days					sumatriptan, MAXALT, ZOMIG
<b>5.2.1 ANXIOLYTICS</b>						
alprazolam						
bupirone hcl						
chlordiazepoxide hcl						
clorazepate dipotassium						
diazepam						
lorazepam						
<b>5.2.2 SEDATIVE/HYPNOTIC DRUGS</b>						
flurazepam hcl						
temazepam						
triazolam						
zaleplon	QL= 30 tabs (5mg); 60 tabs (10mg)					
zolpidem	QL = 30 tabs/30 days					
AMBIEN CR	QL = 30 tabs/30 days					
AMBIEN	QL = 30 tabs/30 days					
AMBIEN PAK						zolpidem
RESTORIL						zolpidem
SONATA	QL= 30 tabs (5mg); 60 tabs (10mg)					temazepam
<b>5.3 ANTIMANIA DRUGS</b>						
lithium carbonate, -er						
lithium citrate						
ESKALITH, -CR						lithium carbonate, -er
<b>5.4.1 CARBAMAZEPINES</b>						
carbamazepine						
CARBATROL						
TEGRETOL XR						
TRILEPTAL						
<b>5.4.2 ANTICONVULSANT BENZODIAZEPINES</b>						
clonazepam						
<b>5.4.3 HYDANTOINS</b>						
phenytoin						
phenytoin sodium, extended						
DILANTIN						phenytoin sodium, extended
PHENYTEK						phenytoin sodium, extended
<b>5.4.4 VALPROIC ACID AND DERIVATIVES</b>						
DEPAKOTE						
DEPAKOTE ER						
<b>5.4.6 ANTICONVULSANT BARBITURATES</b>						
phenobarbital						
primidone						
<b>5.4.7 OTHER ANTICONVULSANTS</b>						
gabapentin						
zonisamide						
KEPPRA						
LAMICTAL						
LYRICA						
TOPAMAX						
NEURONTIN						gabapentin
ZONEGRAN						zonisamide

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>5.5.1.1 TERTIARY AMINES</b>						
amitriptyline hcl						
doxepin hcl						
imipramine hcl						
TOFRANIL-PM						imipramine hcl
<b>5.5.1.2 SECONDARY AMINES</b>						
desipramine hcl						
nortriptyline hcl						
<b>5.5.1.3 SELECTIVE SEROTONIN REUPTAKE INHIBITORS</b>						
citalopram (soln)						
citalopram hbr						
fluoxetine hcl						
fluvoxamine maleate						
paroxetine hcl						
sertraline						
LEXAPRO	ST					
CELEXA	ST					citalopram
PAXIL	ST					paroxetine hcl
PAXIL CR	ST					paroxetine, LEXAPRO
PROZAC WEEKLY	ST					fluoxetine hcl
ZOLOFT	ST					generics, LEXAPRO
<b>5.5.1.4 OTHER ANTIDEPRESSANTS</b>						
budeprion sr (150 mg)						
budeprion xl						
bupropion hcl						
bupropion sr						
mirtazapine						
nefazodone hcl						
trazodone hcl						
venlafaxine						
CYMBALTA	ST					
EFFEXOR XR	ST					
WELLBUTRIN XL	ST					
EFFEXOR	ST					venlafaxine
REMERON (M tab)						mirtazapine
<b>5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS</b>						
granisetron hcl						
ondansetron hcl, -odt						
prochlorperazine maleate						
trimethobenzamide hcl						
EMEND	PAR, QL = 1 cap 40 & 125mg; 2 caps 80mg, 1 pkg trifold pack					
ANZEMET	PAR, QL= 1 tab					ondansetron hcl, -odt
KYTRIL	PAR, QL= 2 tab; 30ml soln					ondansetron hcl, -odt
ZOFRAN IN DEXTROSE	PAR w/ injectable copay					ondansetron in dextrose
ZOFRAN ODT	PAR, QL= 12 tabs, 4mg & 8mg					ondansetron hcl, -odt
ZOFRAN	PAR, QL= 12 tabs (4mg & 8mg); 1 tab (24mg)					ondansetron hcl, -odt
<b>5.7.1 ANTIPARKINSON ANTICHOLINERGIC DRUGS</b>						
benztropine mesylate						
<b>5.7.2 OTHER ANTIPARKINSON DRUGS</b>						
bromocriptine mesylate						
carbidopa/levodopa						
ropinirole						
MIRAPEX						
STALEVO						
REQUIP						ropinirole

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>5.8 ANTIPSYCHOTIC DRUGS</b>						
clozapine						
haloperidol						
thioridazine hcl						
ABILIFY						
RISPERDAL						
RISPERDAL CONSTA	PAR with injectable copay					
SEROQUEL						
ZYPREXA	PAR 10mg vial; with injectable copay					
GEODON						ABILIFY,RISPERDAL,SEROQUEL,ZYPREXA
ZYPREXA ZYDIS	PAR					ZYPREXA (NON-ZYDIS)
<b>5.9.1 CNS STIMULANT DRUGS</b>						
amphetamine salt combo	PAR age >18					
methamphetamine hcl	PAR age >18					
methylin	PAR age >18					
methylin er	PAR age >18					
methylphenidate er	PAR age >18					
methylphenidate hcl	PAR age >18					
ADDERALL XR	PAR age >18					
CONCERTA	PAR age >18					
PROVIGIL	PAR age >18					
FOCALIN	PAR age >18					methylphenidate, CONCERTA
METADATE CD	PAR age >18					
METADATE ER	PAR age >18					
RITALIN LA	PAR age >18					methylphenidate, CONCERTA
<b>5.9.3 ANTIDEMENTIA DRUGS</b>						
ARICEPT, -ODT						
EXELON						
NAMENDA						
REMINYL						
<b>5.9.4 DRUGS TO TREAT MULTIPLE SCLEROSIS</b>						
COPAXONE	PAR w/ injectable copay QL = 1 kit					
<b>5.9.6 OTHER DRUGS FOR ADHD</b>						
STRATTERA						
<b>CHAPTER 6: DERMATOLOGICAL MEDICATIONS</b>						
<b>6.1 TOPICAL CORTICOSTEROID DRUGS</b>						
alclometasone dipropionate						
betamethasone dipropionate						
betamethasone dp augmented						
clobetasol propionate						
desonide						
desoximetasone						
diflorasone diacetate						
fluocinonide						
fluticasone propionate (oint)						
mometasone furoate						
mometasone furoate (cream)						
triamcinolone acetonide						
<b>The following drugs are not covered by the Plan:</b>						
HALOG		N/A	N/A	N/A	N/A	betamethasone dp, desoximetasone
HALOG-E		N/A	N/A	N/A	N/A	betamethasone dp, desoximetasone
HYDROCORTISONE		N/A	N/A	N/A	N/A	HYCORT
LOCOID		N/A	N/A	N/A	N/A	HYDROCORTISONE 0.1% SOLUTION
PRAMOSONE		N/A	N/A	N/A	N/A	LIDOCAINE-HC
<b>6.2 ANTIPRURITIC DRUGS</b>						
hydroxyzine hcl						
hydroxyzine pamoate						

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>6.3 ANTIACNE DRUGS</b>						
clindamycin phosphate						
erythromycin base						
metronidazole (0.75%)						
sod.sulfacetamide/sulfur tf						
tretinoin	PAR age >34					
DIFFERIN						
FINACEA						
ROZEX						
AVITA	PAR age >34					tretinoin
AZELEX						tretinoin
BENZACLIN						benzoyl peroxide + clindamycin
BENZAMYCIN						erythromycin/benzoyl peroxide
DUAC						benzoyl peroxide + clindamycin
METROGEL						metronidazole (0.75%)
METROLOTION						metronidazole (0.75%)
NORITATE						metronidazole (0.75%)
PLEXION						sod.sulfacetamide/sulfur tf
PLEXION SCT						sod.sulfacetamide/sulfur tf
PLEXION TS						sod.sulfacetamide/sulfur tf
RETIN-A MICRO	PAR age >34					tretinoin
<b>6.7 KERATOLYTIC DRUGS</b>						
CONDYLOX						GENERIC PODOFILOX SOLUTION
<b>6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS</b>						
calcipotriene solution						
selenium sulfide						
TAZORAC						
DOVONEX						calcipotriene solution
KLARON						generic
<b>6.9.2 TOPICAL DERMATOLOGICAL DRUGS</b>						
ALDARA						
CARAC						
PROTOPIC						
ELIDEL						generic topical corticosteroid
<b>6.9.3 SCABICIDES</b>						
LINDANE						
<b>CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS</b>						
<b>7.1 DRUGS AFFECTING THE EAR</b>						
a/b otic						
CIPRODEX						
CIPRODEX OTIC						
FLOXIN (OPHTH DROPS)						
CERUMENEX						OTC DEBROX, MURINE EAR
CIPRO HC						
<b>7.2 DRUGS AFFECTING THE NOSE</b>						
fluticasone propionate						
ipratropium bromide	QL= 0.03%, 2 bottles; 0.6%, 2 bottles					
ASTELIN	QL= 2 bottles					
NASONEX	QL= 2 bottles					
BECONASE AQ	QL= 2 bottles					fluticasone, NASONEX
FLONASE	QL= 2 bottles					fluticasone
NASACORT AQ	QL= 2 bottles					fluticasone, NASONEX
NASAREL	QL= 3 bottles					fluticasone, NASONEX
RHINOCORT AQUA	QL=3 bottles					fluticasone, NASONEX
VERAMYST	QL= 2 bottles					fluticasone, NASONEX
<b>7.3 DRUGS AFFECTING THE THROAT AND MOUTH</b>						
chlorhexidine gluconate						
<b>CHAPTER 8: ENDOCRINE MEDICATIONS</b>						

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>8.1.1 INSULIN</b>						
HUMALOG (vial only)			Yellow			
HUMALOG MIX 75/25 (vial only)			Yellow			
HUMULIN 50/50 (vial only)			Yellow			
HUMULIN 70/30 (vial only)			Yellow			
HUMULIN L (vial only)			Yellow			
HUMULIN N (vial only)			Yellow			
HUMULIN R (vial only)			Yellow			
HUMULIN U (vial only)			Yellow			
LANTUS			Yellow			
LEVEMIR (vial only)			Yellow			
NOVOLIN 70/30 (vial only)			Yellow			
NOVOLIN L (vial only)			Yellow			
NOVOLIN N (vial only)			Yellow			
NOVOLIN R (vial only)			Yellow			
NOVOLOG (vial only)			Yellow			
NOVOLOG MIX 70/30 (vial only)			Yellow			
APIDRA				Red		Humalog / Novolog
<b>8.1.2 ORAL HYPOGLYCEMIC DRUGS</b>						
acarbose		Green				
glipizide		Green				
glipizide er		Green				
glyburide		Green				
glyburide-metformin		Green				
metformin er		Green				
metformin hcl		Green				
PRANDIN			Yellow			
STARLIX			Yellow			
PRECOSE				Red		acarbose
AMARYL				Red		glipizide, glyburide
GLUCOPHAGE XR				Red		metformin er
GLYSET				Red		PRECOSE
METAGLIP				Red		glipizide + metformin
<b>8.1.3 INSULIN SENSITIZERS</b>						
ACTOS	QL= 34 tabs		Yellow			
ACTOPLUS MET	QL= 34 tabs		Yellow			
DUETACT			Yellow			
AVANDAMET	QL=68 tabs			Red		ACTOPLUS MET
AVANDARYL	QL = 68 tabs 4mg/2mg); 34 tabs (4m/4mg)			Red		DUETACT
AVANDIA	QL= 68 tabs (2mg & 4mg); 34 tabs (8mg)			Red		ACTOS
<b>8.1.4 AMYLIN ANALOGUES</b>						
SYMLIN/SYMLINPEN			Yellow			
<b>8.1.5.1 INCRETIN MIMETICS</b>						
BYETTA			Yellow			
<b>8.1.5.2 DIPEPTIDYL PEPTIDASE - IV INHIB</b>						
JANUMET	QL= 68 tabs		Yellow			
JANUVIA	QL= 34 tabs		Yellow			
<b>8.2 GLUCOSE ELEVATING DRUGS</b>						
GLUCAGEN			Yellow			
<b>8.3.1 GLUCOCORTICOID DRUGS</b>						
dexamethasone		Green				
hydrocortisone		Green				
methylprednisolone		Green				
prednisolone		Green				
prednisone		Green				
ORAPRED				Red		prednisolone
<b>8.3.2 MINERALOCORTICOID DRUGS</b>						
fludrocortisone acetate		Green				

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>8.4.1 THYROID SUPPLEMENTS</b>						
levothroid						
levothyroxine sodium						
levoxyl						
unithroid						
thyroid						
ARMOUR THYROID						thyroid, unithroid
CYTOMEL						levothyroxine sodium
SYNTHROID						levothyroxine sodium
<b>8.4.2 ANTITHYROID DRUGS</b>						
methimazole						
propylthiouracil						
<b>8.6 OTHER ENDOCRINE DRUGS</b>						
alendronate sodium						
desmopressin tab	PAR					
ACTONEL, -WITH CALCIUM	QL= 34 tabs (5mg & 30mg); 5 tabs (35mg)					
MIACALCIN Injection	PAR injectable copay					
SENSIPAR						
BONIVA tablets						alendronate tablet
DIDRONEL						ACTONEL, FOSAMAX/PLUS D
FOSAMAX	QL= 34 tabs (5mg, 10mg & 40mg); 5 tabs (35 & 70mg)					alendronate tablet
FOSAMAX PLUS D						alendronate tablet
MIACALCIN Nasal Spray						ACTONEL, FOSAMAX/PLUS D
SKELID						ACTONEL, FOSAMAX/PLUS D
desmopressin injection	PAR w/injectable copay					
BONIVA injection	PAR w/injectable copay					RECLAST
DDAVP	PAR w/injectable copay					desmopressin
DIDRONEL inj	PAR w/injectable copay					ACTONEL, FOSAMAX/PLUS D
FORTEO	PAR w/injectable copay					
RECLAST Injection	PAR w/injectable copay					
<b>CHAPTER 9: GASTROINTESTINAL MEDICATIONS</b>						
<b>9.2 ANTIDIARRHEAL DRUGS</b>						
diphenoxylate w/atropine						
loperamide hcl						
<b>9.3 ANTISPASMODICS/DRUGS AFFECT GI MOTILITY</b>						
dicyclomine hcl						
hyoscyamine sulfate						
metoclopramide hcl						
NULEV						hyoscyamine sulfate
<b>9.4 ANTIULCER DRUGS</b>						
cimetidine						
famotidine						
nizatidine						
ranitidine hcl						
<b>9.4.1 OTHER ANTIULCER DRUGS</b>						
misoprostol						
sucralfate						
<b>9.4.2 PROTON PUMP INHIBITORS</b>						
omeprazole	QL = 34 (10mg)					
PRILOSEC OTC	QL = 34 tabs					
NEXIUM	QL=34 caps, ST					
ACIPHEX	ST					PriLOSEC OTC, omeprazole, NEXIUM
PREVACID	QL=34 caps, ST					PriLOSEC OTC, omeprazole, NEXIUM
PRILOSEC	QL= 34caps, ST					PriLOSEC OTC, omeprazole, NEXIUM
PROTONIX	QL= 34 caps, ST					PriLOSEC OTC, omeprazole, NEXIUM
ZEGERID	QL=34 pcks or caps, ST					PriLOSEC OTC, omeprazole, NEXIUM
<b>9.4.3 HELICOBACTER PYLORI DRUGS</b>						
PREVPAC	QL= 1 pkg					
HELIDAC						PREVPAC
<b>9.5 LAXATIVES AND CATHARTICS</b>						
glycolax						

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>9.6 OTHER GI DRUGS</b>						
<b>balsalazide disodium</b>						
<b>hydrocortisone</b>						
<b>sulfasalazine</b>						
ANALPRAM-HC						
ANALPRAM-HC (1% cream)						
ASACOL						
CANASA						
CREON						
LIALDA						
PENTASA						
ULTRASE						
ULTRASE MT						
URSO, -FORTE						
COLAZAL						
DIPENTUM						
GOLYTELY						
NULYTELY						
NULYTELY WITH FLAVOR PACKS						
<b>CHAPTER 10: IMMUNOLOGICALS AND VACCINES</b>						
<b>10.0 IMMUNOLOGICALS AND VACCINES</b>						
BAYHEP B	PAR w/ injectable copay					
BAYRHO-D	PAR w/ injectable copay					
GAMMAGARD S/D	PAR w/ injectable copay					
GAMUNEX	PAR w/ injectable copay					
CARIMUNE	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
CARIMUNE NF NANOFILTERED	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
FLEBOGAMMA	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
GAMIMUNE N	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
GAMMAR-P I.V.	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
IVEEGAM EN	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
MICRHOGAM	PAR w/ injectable copay					BAYRHO-D
NABI-HB	PAR w/ injectable copay					BAYHEP B
PANGLOBULIN NF	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
POLYGAM S/D	PAR w/ injectable copay					GAMMAGARD S/D, GAMUNEX
RHOGAM	PAR w/ injectable copay					BAYRHO-D
RHOPHYLAC	PAR w/ injectable copay					BAYRHO-D
WINRHO SD	PAR w/ injectable copay					BAYRHO-D
WINRHO SDF	PAR w/ injectable copay					BAYRHO-D
<b>10.2.1 MYELOID STIMULANTS</b>						
NEUPOGEN	PAR w/ injectable copay					
NEULASTA	PAR w/ injectable copay					
<b>10.2.2 ERYTHROID STIMULANTS</b>						
ARANESP	PAR w/ injectable copay					
PROCRIT	PAR w/ injectable copay					
EPOGEN	PAR w/ injectable copay					ARANESP, PROCRIT
<b>10.2.3 INTERFERONS</b>						
AVONEX	PAR with injectable copay; QL = 4 vials/4 syringes					
AVONEX ADMINISTRATION PACK	PAR with injectable copay; QL = 4 vials/4 syringes					
BETASERON	PAR with injectable copay; QL = 15 vials with prefilled diluent syringe					
INFERGEN	PAR with injectable copay					
INTRON A	PAR with injectable copay					
PEGASYS	PAR with injectable copay; QL = 5 vials; Convenience Pack = 1 box					
REBIF	PAR with injectable copay; QL = 15 syringes; Titration Pack = 1 package					

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
PEG-INTRON	PAR with injectable copay; QL = 5 packages				•	ribasphere, ribavirin 200mg, PEGASYS
PEG-INTRON REDIPEN	PAR with injectable copay; QL = 5 pens				•	ribasphere, ribavirin 200mg, PEGASYS
<b>10.2.4 GROWTH HORMONES AND RELATED DRUGS</b>						
GENOTROPIN	PAR with injectable copay				•	
NUTROPIN	PAR with injectable copay				•	
NUTROPIN AQ	PAR with injectable copay				•	
TEV-TROPIN	PAR with injectable copay				•	
HUMATROPE	PAR with injectable copay				•	TEV-TROPIN, GENOTROPIN, NUTROPIN/AQ
NORDITROPIN	PAR with injectable copay				•	TEV-TROPIN, GENOTROPIN, NUTROPIN/AQ
NUTROPIN DEPOT	PAR with injectable copay				•	TEV-TROPIN, GENOTROPIN, NUTROPIN/AQ
PROTROPIN	PAR with injectable copay				•	TEV-TROPIN, GENOTROPIN, NUTROPIN/AQ
SAIZEN	PAR with injectable copay				•	TEV-TROPIN, GENOTROPIN, NUTROPIN/AQ
<b>10.2.5 INTERLEUKINS</b>						
NEUMEGA	PAR w/ injectable copay QL = 21 vials				•	
<b>CHAPTER 11: MUSCULOSKELETAL MEDICATIONS</b>						
<b>11.1.1 SALICYLATES AND RELATED DRUGS</b>						
diffunisal						
salsalate						
<b>11.1.2 NON-STEROIDAL ANTIINFLAMMATORY AGENTS</b>						
diclofenac sodium						
etodolac						
ibuprofen						
indomethacin						
ketoprofen						
nabumetone						
naproxen						
oxaprozin						
piroxicam						
sulindac						
CELEBREX	ST					
MOBIC	QL = 34 Tabs, ST					generic NSAID
PREVACID NAPRAPAC	ST					naproxen + omeprazole
<b>11.1.4 OTHER DRUGS FOR ARTHRITIS</b>						
supartz	PAR w/injectable copay				•	
EUFLEXXA	PAR w/injectable copay				•	
HYALGAN	PAR w/injectable copay				•	supartz, EUFLEXXA
ORTHOVISC	PAR w/injectable copay				•	supartz, EUFLEXXA
SYNVISC	PAR w/injectable copay				•	supartz, EUFLEXXA
<b>11.2 DRUGS TO PREVENT AND TREAT GOUT</b>						
allopurinol						
colchicine						
probenecid						
<b>11.3.1 DIRECT MUSCLE RELAXANTS</b>						
baclofen						
tizanidine hcl						
<b>11.3.2 CNS MUSCLE RELAXANTS</b>						
carisoprodol						
cyclobenzaprine hcl						
methocarbamol						
orphenadrine citrate						
orphenadrine citrate injectable	PAR w/injectable copay					
SKELAXIN						
<b>CHAPTER 12: NUTRITION, BLOOD</b>						
<b>12.1.2 VITAMINS &amp; MINERALS &amp; RELATED PRODUCTS</b>						
FOLTX						
METANX						
CEREFOLIN						generic vitamin supplement

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>12.1.3 THERAPEUTIC VITAMINS &amp; MINERALS</b>						
<b>calcitriol</b>	PAR w/ injectable copay					
<b>folic acid</b>						
PHOSLO						
<b>12.2 POTASSIUM SUPPLEMENTS</b>						
<b>klor-con</b>						
<b>potassium chloride</b>	PAR w/ injectable copay					
<b>12.3.1 ORAL ANTICOAGULANTS, VITAMIN K</b>						
<b>warfarin sodium</b>						
COUMADIN						warfarin sodium
<b>12.3.2 HEPARIN AND HEPARIN ANTAGONISTS</b>						
ARIXTRA	PAR w/ injectable copay					
FRAGMIN	PAR w/ injectable copay					
INNOHEP	PAR w/ injectable copay					
LOVENOX	PAR w/ injectable copay					
<b>12.4 ANTIPLATELET DRUGS</b>						
<b>cilostazol</b>						
<b>dipyridamole</b>						
<b>ticlopidine hcl</b>						
PLAVIX	PAR					
AGGRENOX	PAR					aspirin + dipyridamole
<b>12.5 HEMOSTATICS</b>						
ADVATE	PAR w/ injectable copay					
ALPHANATE	PAR w/ injectable copay					
BEBULIN VH IMMUNO	PAR w/ injectable copay					
BENEFIX	PAR w/ injectable copay					
HELIXATE FS	PAR w/ injectable copay					
HUMATE-P	PAR w/ injectable copay					
KOATE-DVI	PAR w/ injectable copay					
PROFILNINE SD	PAR w/ injectable copay					
PROPLEX T	PAR w/ injectable copay					
RECOMBINATE	PAR w/ injectable copay					
ALPHANINE SD	PAR w/ injectable copay					BEBULN,BENEFX,PROFILNNE,PROPLX
HEMOPIL-M	PAR w/ injectable copay					ADVATE, ALPHANATE, HUMATE-P
KOGENATE FS	PAR w/ injectable copay					ADVATE, ALPHANATE, HUMATE-P
MONARC-M	PAR w/ injectable copay					ADVATE, ALPHANATE, HUMATE-P
MONOCLATE-P	PAR w/ injectable copay					ADVATE, ALPHANATE, HUMATE-P
MONONINE	PAR w/ injectable copay					BEBULN,BENEFX,PROFILNNE,PROPLX
REFACTO	PAR w/ injectable copay					ADVATE, ALPHANATE, HUMATE-P
<b>12.7 BLOOD DETOXICANTS</b>						
<b>lactulose</b>						
RENAGEL						
REVELA						
KRISTALOSE						lactulose
<b>CHAPTER 13: OBSTETRICAL &amp; GYNECOLOGICAL MEDICATIONS</b>						
<b>13.1.1 PRENATAL VITAMINS</b>						
<b>natacare plus</b>						
<b>prenatal rx</b>						
PRENATE ADVANCE						generic prenatal vitamins
PRENATE ELITE						ADVANCED-RF NATALCARE
PRENATE GT						generic prenatal vitamins
<b>13.1.2 SPECIALIZED OB/GYN DRUGS</b>						
ANTAGON	PAR w/ infertility copay					
<b>novarel</b>	PAR w/ infertility copay; QL = 3 vials					
CETROTIDE	PAR w/ infertility copay					
ELIGARD	PAR w/ infertility copay					
GANIRELIX ACETATE	PAR w/ infertility copay					
PREGNYL	PAR w/ infertility copay					ch.gonadotropin, novarel
LUPRON	PAR w/ infertility copay					leuprolide acetate
LUPRON DEPOT	PAR w/ infertility copay					ELIGARD
OVIDREL	PAR w/ infertility copay					ch.gonadotropin, novarel

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>13.2 OVULATORY STIMULANTS</b>						
<b>clomiphene citrate</b>	PAR >150MG w/ infertility copay					
BRAVELLE	PAR w/ infertility copay					FOLLISTIM AQ, GONAL F/ RFF
FERTINEX	PAR w/ infertility copay					FOLLISTIM AQ, GONAL F/ RFF
FOLLISTIM	PAR w/ infertility copay					FOLLISTIM AQ, GONAL F/ RFF
FOLLISTIM AQ	PAR w/ infertility copay					
GONAL-F	PAR w/ infertility copay					
GONAL-F RFF	PAR w/ infertility copay					
MENOPUR	PAR w/ infertility copay					
REPRONEX	PAR w/ infertility copay					MENOPUR
<b>13.3 ANDROGEN DRUGS</b>						
ANDRODERM						
ANDROGEL						
TESTIM						ANDRODERM, ANDROGEL
TESTODERM						ANDRODERM, ANDROGEL
<b>13.4 ESTROGEN DRUGS</b>						
<b>estradiol</b>						
<b>estradiol transdermal patch</b>	QL= 5 patches					
<b>estropipate</b>						
ALORA	QL= 10 patches					
MENEST						
PREMARIN						
VAGIFEM						
CENESTIN						MENEST, PREMARIN
CLIMARA	QL= 5 patches					<b>estradiol</b>
ENJUVA						
ESTRADERM	QL= 10 patches					<b>generic patches, ALORA</b>
ESTRASORB						<b>generic patches, ALORA</b>
ESTRATEST						SYNTEST
ESTRATEST H.S.						SYNTEST
ESTROGEL	QL= 1 pump bottle					<b>generic patches, ALORA</b>
MENOSTAR						<b>generic patches, ALORA</b>
VIVELLE	QL= 10 patches					<b>generic patches, ALORA</b>
VIVELLE-DOT	QL= 10 patches					<b>generic patches, ALORA</b>
<b>13.4.1 ESTROGEN/PROGESTIN COMBINATIONS</b>						
<b>estradiol-norethindrone acetat</b>						
ACTIVELLA						
CLIMARA PRO	Ql = 5 patches					
ORTHO-PREFEST						
PREMPHASE						
PREMPRO						
COMBIPATCH						CLIMARA PRO
FEMHRT						PREMPRO/PREMPHASE
PREFEST						
<b>13.4.3 SELECTIVE ESTROGEN RECEPTOR MODULATOR</b>						
EVISTA						
<b>13.5 PROGESTIN DRUGS</b>						
<b>camila</b>						
<b>errin</b>						
<b>jolivette</b>						
<b>medroxyprogesterone acetate</b>	w/injectable copay					
<b>nora-be</b>						
<b>norethindrone acetate</b>						
CRINONE						
PROCHIEVE						
PROMETRIUM						
DEPO-PROVERA	PAR (Brand Only) w/injectable copay					<b>medroxyprogesterone acetate</b>
NOR-Q-D						CAMILA,ERRIN,JOLIVETTE,NORA-BE
ORTHO MICRONOR						CAMILA,ERRIN,JOLIVETTE,NORA-BE

Ventura County Health Care Plan  
Preferred Drug List (Index in back)

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>13.7 CONTRACEPTIVES</b>						
apri						
aranelle						
aviane						
cesia						
cryselle						
enpresse						
junel fe						
kariva						
kelnor 1/35						
lessina						
levora-28						
low-ogestrel						
lutera						
microgestin						
microgestin fe						
mononessa						
necon						
nortrel						
previfem						
solia						
sprintec						
trinessa						
tri-previfem						
tri-sprintec tablet						
trivora-28						
velivet 28 day						
zovia 1/35e						
ORTHO TRI-CYCLEN LO						
YASMIN						
YAZ						
ALESSE						aviane, lessina
CYCLESSA						cesia, velivet
DEMULEN 1/35						zovia 1/35e
DEMULEN 1/50						zovia 1/50e
DESOGEN						apri
ESTROSTEP FE						
LEVLEN						levora, portia
LEVLITE						aviane, lessina
LO/OVRAL						cryselle, low-ogestrel
LOESTRIN						junel fe, microgestin
LOESTRIN FE						junel fe, microgestin
MIRCETTE						kariva
MODICON						brevicon, necon, nortrel
NORDETTE						levora, portia
NORINYL 1/35						necon, nortrel
NORINYL 1/50						necon
NUVARING						generics, ORTHO TRI-CYCLEN LO, YASMIN, YAZ
ORTHO EVRA						ORTHO TRI-CYCLEN LO, YASMIN, YAZ
ORTHO TRI-CYCLEN						trinessa, trisprintec
ORTHO-CEPT						apri
ORTHO-CYCLEN						mononessa, sprintec
ORTHO-NOVUM						necon, nortrel
OVCON						necon, nortrel
SEASONALE						levora, portia
TRI-LEVLEN						enpresse, trivora
TRI-NORINYL						aranelle, leena
TRIPHASIL						levonorgestrel-eth estra

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>CHAPTER 14: OPHTHALMIC MEDICATIONS</b>						
<b>14.1.1 OPHTHALMIC TOPICAL ANTIBACTERIAL DRUGS</b>						
<b>ciprofloxacin hcl (ophth drops)</b>						
<b>erythromycin</b>						
<b>gentamicin sulfate</b>						
<b>ofloxacin (eye drops)</b>						
<b>polymyxin b sul/trimethoprim</b>						
<b>sulfacetamide sodium</b>						
<b>tobramycin sulfate</b>						
VIGAMOX						
ZYMAR						
CILOXAN						<b>ciprofloxacin hcl (ophth drops)</b>
QUIXIN						<b>ciprofloxacin, VIGAMOX, ZYMAR</b>
<b>14.2 OPHTHALMIC CORTICOSTEROID DRUGS</b>						
<b>prednisolone acetate</b>						
ALREX						<b>generic ophthalmic steroids</b>
FML FORTE						<b>generic ophthalmic steroids</b>
LOTEMAX						<b>generic ophthalmic steroids</b>
VEXOL						<b>generic ophthalmic steroids</b>
<b>14.3 OPHTHALMIC ANTIINFECTIVE/CORTICOSTEROIDS</b>						
<b>neomycin/polymyxin/dexameth</b>						
ZYLET						
TOBRADEX						ZYLET
<b>14.5 ANTIGLAUCOMA DRUGS</b>						
<b>brimonidine tartrate</b>						
<b>levobunolol hcl</b>						
<b>pilocarpine hcl</b>						
<b>timolol maleate</b>						
ALPHAGAN P						
LUMIGAN						
TRUSOPT						
XALATAN						
AZOPT						<b>generics, ALPHAGAN P, TRUSOPT</b>
BETIMOL						<b>betaxolol, timolol maleate</b>
COSOPT						<b>generics, ALPHAGAN P, TRUSOPT</b>
IOPIDINE						<b>generics, ALPHAGAN P, TRUSOPT</b>
ISTALOL						<b>timolol maleate</b>
TRAVATAN						LUMIGAN, XALATAN
<b>14.6 OTHER OPHTHALMIC DRUGS</b>						
<b>cromolyn sodium</b>						
<b>diclofenac</b>						
LIVOSTIN						
PATADAY						
PATANOL						
RESTASIS						
ZADITOR						
ACULAR						<b>diclofenac sodium eye drops</b>
ACULAR LS						<b>diclofenac sodium eye drops</b>
ACULAR PF						<b>diclofenac sodium eye drops</b>
ALAMAST						<b>cromolyn sodium, ZADITOR</b>
ALOCRIAL						<b>cromolyn sodium, ZADITOR</b>
ALOMIDE						<b>cromolyn sodium, ZADITOR</b>
ELESTAT						<b>cromolyn sodium, ZADITOR</b>
EMADINE						<b>cromolyn sodium, ZADITOR</b>
OPTIVAR						<b>cromolyn sodium, ZADITOR</b>
VOLTAREN						<b>diclofenac sodium eye drops</b>

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>CHAPTER 15: RESPIRATORY MEDICATIONS</b>						
<b>15.1.1 BETA-2 ADRENERGIC DRUGS</b>						
<b>albuterol</b>	QL=3 inhs					
<b>albuterol sulfate</b>						
FORADIL	QL= 12 caps/12pk; 36 caps/18pk; 120 caps/60pk					
PERFOROMIST						
PROAIR HFA						
PROVENTIL HFA	QL= 3 inhs/7pk					
SEREVENT DISKUS	QL= 1 pkg/28 blisters; 2 pkgs/60 blisters					
VENTOLIN HFA	QL =3 inhs					
MAXAIR AUTOHALER	QL=2 inhs					generic, VENTOLIN HFA
XOPENEX HFA	QL =3 inhs					albuterol
<b>15.1.2 METHYL XANTHINE DRUGS</b>						
<b>theophylline, -er</b>						
<b>theophylline anhydrous</b>						
UNIPHYL						theophylline er
<b>15.1.3 OTHER DRUGS FOR ASTHMA</b>						
<b>ipratropium bromide</b>						
ADVAIR DISKUS	QL= 120 ins/60pk; 28 inhs/28pk					
ADVAIR HFA						
ATROVENT	QL= 2 inhalers HFA					
COMBIVENT	QL= 3 inhalers					
DUONEB	QL= 205 vials (package size 3)					
EPIPEN	QL= 3 units (package size 1); 2 units (package size 2), w/injectable copay					
EPIPEN JR.	QL= 3 units (package size 1); 2 units (package size 2) w/injectable copay					
FLOVENT DISKUS	QL = 44mcg - 2 inhalers; 110 mcg - 1 inhaler; 220 mcg - 3 inhalers					
FLOVENT HFA	QL = 44mcg - 2 inhalers; 110 mcg - 1 inhaler; 220 mcg - 3 inhalers					
FLOVENT ROTADISK	QL (50mg & 120mg) 120 inhs; (250mg) 300 inhs					
INTAL	QL= 2 inhalers					
PULMICORT	QL= 140 nebs; 2 inhs					
PULMICORT FLEXHALER	QL= 140 nebs; 2 inhs					
QVAR	QL= 3 inhalers					
SPIRIVA	QL= 1 package (6 capsules); 2 packages (30 capsules)					
SYMBICORT	QL = 2 inhalers					
TILADE	QL= 3 inhalers					
TWINJECT						
AEROBID	QL= 3 inhalers					FLOVENT, PULMICORT, QVAR
AEROBID-M	QL= 3 inhalers					FLOVENT, PULMICORT, QVAR
AZMACORT	QL= 3 inhalers					FLOVENT, PULMICORT, QVAR
<b>15.1.4 LEUKOTRIENE MODIFIERS</b>						
SINGULAIR						
ACCOLATE						SINGULAIR
<b>15.2.1 ANTIHISTAMINES</b>						
<b>cyproheptadine hcl</b>						
<b>promethazine hcl</b>						
ALLEGRA	QL=68 tabs/caps (30mg & 60mg); 34 tabs (180mg)					fexofenadine
CLARINEX	QL= 34 tabs					fexofenadine
ZYRTEC	QL= 34 tabs					fexofenadine

DRUG NAME	PA/QL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
<b>15.2.3 ANTIHISTAMINE/DECONGESTANT COMBINATIONS</b>						
<b>promethazine vc</b>						
ALLEGRA-D						
RYNATAN						ALLEGRA-D 12 HOUR
SEMPREX-D						OTC ANTIHISTAMINE/DECONGESTANT
ZYRTEC-D	QL= 68 tablets					ALLEGRA-D 12 HOUR
<b>15.3 ANTITUSSIVE AND EXPECTORANT DRUGS</b>						
<b>benzonate</b>						
<b>guaifenesin w/codeine</b>						
<b>guaifenes pse</b>						
<b>hydone</b>						
<b>hydrocodone w/guaifenesin</b>						
<b>prolex dh</b>						
<b>promethazine w/codeine</b>						
<b>promethazine w/dm</b>						
<b>promethazine vc w/codeine</b>						
TUSSIONEX						
ENTUSS						prolex dh, hydone
<b>CHAPTER 16: UROLOGICAL MEDICATIONS</b>						
<b>16.1.1 ANTICHOLINERGIC ANTISPASMODICS</b>						
<b>oxybutynin chloride</b>						
OXYTROL	QL= 10 patches					
DETROL						oxybutynin
DETROL LA						oxybutynin
DITROPAN XL	QL= 34 tabs					
SANCTURA						oxybutynin
<b>16.1.3 URINARY ANESTHETICS</b>						
<b>phenazopyridine hcl</b>						
<b>16.1.4 OTHER GENITOURINARY PRODUCTS</b>						
<b>finasteride</b>						
CAVERJECT	PAR, w/ injectable copay QL= 12 vials					
FLOMAX						
LEVITRA	PAR, QL= 6/30 days					
AVODART						finasteride, FLOMAX, UROXATROL
EDEX	PAR, w/ injectable copay QL= 12 cartridges					LEVITRA
PROSCAR						
<b>The following drugs are not covered by the Plan:</b>						
CIALIS		N/A	N/A	N/A	N/A	LEVITRA
MUSE		N/A	N/A	N/A	N/A	EDEX, LEVITRA
UROXATRAL		N/A	N/A	N/A	N/A	FLOMAX
VIAGRA		N/A	N/A	N/A	N/A	LEVITRA
<b>CHAPTER 17: DIAGNOSTIC &amp; MISCELLANEOUS MEDICATIONS</b>						
<b>17.1 DIAGNOSTIC PRODUCTS</b>						
PRECISION XTRA						
<b>17.3.1 APPETITE SUPPRESSANTS</b>						
MERIDIA	PAR					
<b>17.3.2 OTHER WEIGHT LOSS PRODUCTS</b>						
XENICAL	PAR					
<b>CHAPTER 18: MEDICAL (MISCELLANEOUS) SUPPLIES</b>						
<b>18.1 DIABETIC SUPPLIES</b>						
ACCU-CHEK						
ACCU-CHEK III						
ACCU-CHEK INSTANTPLUS						
ACCU-CHEK SIMPLICITY						
ASCENSIA AUTODISC						
ASCENSIA AUTODISC (SOLN)						
ASCENSIA BREEZE						
ASCENSIA CONTOUR						
ASCENSIA DEX2						
ASCENSIA ELITE						
ASCENSIA ELITE (SOLN)						
ASCENSIA ELITE XL						
ASCENSIA MICROFILL						
CHEMSTRIP BG						
GLUCOMETER DEX						
GLUCOMETER ELITE						

Ventura County Health Care Plan  
Preferred Drug List (Index in back)

DRUG NAME	PA/QLL/ST	TIER				SUGGESTED PREFERRED ALTERNATIVES
		1 \$10	2 \$27	3 \$45	4 Spec	
GLUCOMETER ENCORE						
NOVOFINE 32						
PRECISION						
PRECISION XTRA						
<b>The following drugs/supplies are not covered by the Plan:</b>						
FAST TAKE		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FAST TAKE MONITORING SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE FLASH SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE FLASH SYSTEM KIT		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE SIDEKICK II		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE TEST STRIPS		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE TRACKER		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
FREESTYLE TRACKER SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH BASIC SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH INDUO		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH PROFILE SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH TEST STRIPS		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH ULTRA SMART		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH ULTRA SYSTEM		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
ONE TOUCH ULTRA TEST STRIPS		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
PRECISION PCX		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
PRECISION PCX PLUS		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
PRECISION Q-I-D		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
PRECISION SOF-TACT		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
SOF-TACT		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER
SURESTEP		N/A	N/A	N/A	N/A	ACCU-CHEK, ASCENSIA/GLUCOMETER

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

a/b otic	7.1
ABILIFY	5.8
acarbose	8.1.2
ACCOLATE	15.1.4
ACCU-CHEK	18.1
ACCU-CHEK III	18.1
ACCU-CHEK INSTANTPLUS	18.1
ACCU-CHEK SIMPLICITY	18.1
ACCUPRIL	4.5.4.1
ACEON	4.5.4.1
acetaminophen w/codeine	5.1.1.2
acetaminophen w/hydrocodone	5.1.1.2
ACIPHEX	9.4.2
ACTIQ	5.1.1.1
ACTIVELLA	13.4.1
ACTONEL, -WITH CALCIUM	8.6
ACTOPLUS MET	8.1.3
ACTOS	8.1.3
ACULAR	14.6
ACULAR LS	14.6
ACULAR PF	14.6
acyclovir	2.5.2
ADDERALL XR	5.9.1
ADVAIR DISKUS	15.1.3
ADVAIR HFA	15.1.3
ADVATE	12.5
ADVICOR	4.8.2.1
AEROBID	15.1.3
AEROBID-M	15.1.3
AGGRENOLX	12.4
ALAMAST	14.6
albuterol	15.1.1
albuterol sulfate	15.1.1
alclometasone dipropionate	6.1
ALDARA	6.9.2
alendronate sodium	8.6
ALESSE	13.7
ALLEGRA	15.2.1
ALLEGRA-D	15.2.3
allopurinol	11.2
ALOCRIAL	14.6
ALOMIDE	14.6
ALORA	13.4
ALPHAGAN P	14.5
ALPHANATE	12.5
ALPHANINE SD	12.5
alprazolam	5.2.1
ALREX	14.2
ALTACE	4.5.4.1
ALTOPREV	4.8.2
amantadine hcl	2.5.2
AMARYL	8.1.2
AMBIEN	5.2.2
AMBIEN CR	5.2.2
AMBIEN PAK	5.2.2
AMERGE	5.1.2
amiloride hcl w/hctz	4.3.3
amiodarone hcl	4.7.3
amitriptyline hcl	5.5.1.1
amlodipine besylate	4.2

amox tr/potassium clavulanate (susp)	2.1.5
amoxicillin	2.1.5
amphetamine salt combo	5.9.1
ANALPRAM-HC	9.6
ANALPRAM-HC (1% cream)	9.6
ANDRODERM	13.3
ANDROGEL	13.3
ANTAGON	13.1.2
ANZEMET	5.6
APIDRA	8.1.1
apri	13.7
aranelle	13.7
ARANESP	10.2.2
ARICEPT, -ODT	5.9.3
ARIMIDEX	3
ARIXTRA	12.3.2
ARMOUR THYROID	8.4.1
ASACOL	9.6
ASCENSIA AUTODISC	18.1
ASCENSIA AUTODISC (SOLN)	18.1
ASCENSIA BREEZE	18.1
ASCENSIA CONTOUR	18.1
ASCENSIA DEX2	18.1
ASCENSIA ELITE	18.1
ASCENSIA ELITE (SOLN)	18.1
ASCENSIA ELITE XL	18.1
ASCENSIA MICROFILL	18.1
ASTELIN	7.2
ATACAND	4.5.4.2
ATACAND HCT	4.5.6
atenolol	4.4
atenolol w/chlorthalidone	4.5.6
ATROVENT	15.1.3
AUGMENTIN XR	2.1.5
AVALIDE	4.5.6
AVANDAMET	8.1.3
AVANDARYL	8.1.3
AVANDIA	8.1.3
AVAPRO	4.5.4.2
AVELOX	2.1.9
AVELOX ABC PACK	2.1.9
aviane	13.7
AVINZA	5.1.1.1
AVITA	6.3
AVODART	16.1.4
AVONEX	10.2.3
AVONEX ADMINISTRATION PACK	10.2.3
AXERT	5.1.2
azathioprine	3
AZELEX	6.3
azithromycin	2.1.4.1
AZMACORT	15.1.3
AZOPT	14.5
AZOR	4.5.6
baclofen	11.3.1
BACTROBAN	2.2
balsalazide disodium	9.6
BAYHEP B	10
BAYRHO-D	10
BEBULIN VH IMMUNO	12.5

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

BECONASE AQ	7.2
benazepril hcl	4.5.4.1
benazepril hcl-hctz	4.5.6
BENEFIX	12.5
BENICAR	4.5.4.2
BENICAR HCT	4.5.6
BENZAACLIN	6.3
BENZAMYCIN	6.3
benzonatate	15.3
benztropine mesylate	5.7.1
betamethasone dipropionate	6.1
betamethasone dp augmented	6.1
BETASERON	10.2.3
BETIMOL	14.5
BIAXIN	2.1.4.1
BIAXIN XL	2.1.4.1
bisoprolol fumarate	4.4
bisoprolol fumarate/hctz	4.5.6
BONIVA injection	8.6
BONIVA tablets	8.6
BRAVELLE	13.2
brimonidine tartrate	14.5
bromocriptine mesylate	5.7.2
budeprion sr (150 mg)	5.5.1.4
budeprion xl	5.5.1.4
bumetanide	4.3.1
bupropion hcl	5.5.1.4
bupropion sr	5.5.1.4
buspirone hcl	5.2.1
butalbital compound	5.1.2
butalbital/acetaminophen/caffeine	5.1.2
BYETTA	8.1.5.1
CADUET	4.8.2.1
calcipotriene solution	6.8
calcitriol	12.1.3
camila	13.5
CANASA	9.6
captopril	4.5.4.1
captopril/hydrochlorothiazide	4.5.6
CARAC	6.9.2
carbamazepine	5.4.1
CARBATROL	5.4.1
carbidopa/levodopa	5.7.2
CARDENE SR	4.2
CARDIZEM LA	4.2
CARDURA XL	4.5.1
CARIMUNE	10
CARIMUNE NF NANOFILTERED	10
carisoprodol	11.3.2
cartia xt	4.2
CASODEX	3
CAVERJECT	16.1.4
CEDAX	2.1.1
cefaclor	2.1.1
cefaclor er	2.1.1
cefadroxil	2.1.1
cefdinir	2.1.1
cefepodoxime proxetil	2.1.1
CEFTIN (SUSP)	2.1.1
cefuroxime (tab)	2.1.1

CEFZIL	2.1.1
CELEBREX	11.1.2
CELEXA	5.5.1.3
CELLCEPT	3
CENESTIN	13.4
cephalexin	2.1.1
CEREFOLIN	12.1.2
CERUMENEX	7.1
cesia	13.7
CETROTIDE	13.1.2
CHEMSTRIP BG	18.1
chlordiazepoxide hcl	5.2.1
CHLORHEXIDINE GLUCONATE	2.2
chlorhexidine gluconate	7.3
cholestyramine	4.8.1
CIALIS	16.1.4
ciclopirox (cream)	2.4.2
ciclopirox (lotion)	2.4.2
cilostazol	12.4
CILOXAN	14.1.1
cimetidine	9.4
CIPRO HC	7.1
CIPRO XR	2.1.9
CIPRODEX	7.1
CIPRODEX OTIC	7.1
CIPROFLOXACIN	2.1.9
ciprofloxacin hcl	2.1.9
ciprofloxacin hcl (ophth drops)	14.1.1
citalopram (soln)	5.5.1.3
citalopram hbr	5.5.1.3
CLARINEX	15.2.1
clarithromycin	2.1.4.1
CLIMARA	13.4
CLIMARA PRO	13.4.1
clindamycin hcl	2.1.3
clindamycin phosphate	6.3
clobetasol propionate	6.1
clomiphene citrate	13.2
clonazepam	5.4.2
clonidine hcl	4.5.2
clorazepate dipotassium	5.2.1
clotrimazole	2.3
clotrimazole/betamethasone	2.4.3
clozapine	5.8
COLAZAL	9.6
colchicine	11.2
COLESTID	4.8.1
colestipol	4.8.1
COMBIPATCH	13.4.1
COMBIVENT	15.1.3
CONCERTA	5.9.1
CONDYLOX	6.7
COPAXONE	5.9.4
COPEGUS	2.5.2
COREG	4.4
COSOPT	14.5
COUMADIN	12.3.1
COVERA-HS	4.2
COZAAR	4.5.4.2
CREON	9.6

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

CRESTOR	4.8.2
CRINONE	13.5
cromolyn sodium	14.6
cryselle	13.7
CYCLESSA	13.7
cyclobenzaprine hcl	11.3.2
cyclosporine	3
CYMBALTA	5.5.1.4
cyproheptadine hcl	15.2.1
CYTOMEL	8.4.1
DDAVP	8.6
DEMULEN 1/35	13.7
DEMULEN 1/50	13.7
DENAVIR	2.5.2
DEPAKOTE	5.4.4
DEPAKOTE ER	5.4.4
DEPO-PROVERA	3
DEPO-PROVERA	13.5
desipramine hcl	5.5.1.2
desmopressin	8.6
DESOGEN	13.7
desonide	6.1
desoximetasone	6.1
DETROL	16.1.1
DETROL LA	16.1.1
dexamethasone	8.3.1
diazepam	5.2.1
diclofenac	14.6
diclofenac sodium	11.1.2
dicyclomine hcl	9.3
DIDRONEL	8.6
DIFFERIN	6.3
diflorasone diacetate	6.1
diflunisal	11.1.1
digitek	4.1
digoxin	4.1
DILANTIN	5.4.3
diltiazem er	4.2
diltiazem hcl	4.2
diltiazem xr	4.2
DIOVAN	4.5.4.2
DIOVAN HCT	4.5.6
DIPENTUM	9.6
diphenoxylate w/atropine	9.2
dipyridamole	12.4
DITROPAN XL	16.1.1
DOVONEX	6.8
doxazosin mesylate	4.5.1
doxepin hcl	5.5.1.1
doxycycline hyclate	2.1.7
DUAC	6.3
DUETACT	8.1.3
DUONEB	15.1.3
DYNABAC	2.1.4.1
DYNACIRC	4.2
DYNACIRC CR	4.2
econazole nitrate	2.4.2
EDEX	16.1.4
EFFEXOR	5.5.1.4
EFFEXOR XR	5.5.1.4

ELESTAT	14.6
ELIDEL	6.9.2
ELIGARD	13.1.2
ELIGARD	3
EMADINE	14.6
EMEND	5.6
EMTRIVA	2.5.1
enalapril maleate	4.5.4.1
enalapril maleate/hctz	4.5.6
ENBREL	3
ENJUVA	13.4
enpresse	13.7
ENTUSS	15.3
EPIPEN	15.1.3
EPIPEN JR.	15.1.3
EPOGEN	10.2.2
errin	13.5
ERTACZO	2.4.2
erythrocin stearate	2.1.4
erythromycin	14.1.1
erythromycin base	6.3
erythromycin ethylsuccinate	2.1.4
erythromycin w/sulfisoxazole	2.1.6
ESKALITH, -CR	5.3
ESTRADERM	13.4
estradiol	13.4
estradiol transdermal patch	13.4
estradiol-norethindrone acetat	13.4.1
ESTRASORB	13.4
ESTRATEST	13.4
ESTRATEST H.S.	13.4
ESTROGEL	13.4
estropiate	13.4
ESTROSTEP FE	13.7
etodolac	11.1.2
EUFLEXXA	11.1.4
EVISTA	13.4.3
EXELDERM	2.4.2
EXELON	5.9.3
EXFORGE	4.5.6
FACTIVE	2.1.9
famotidine	9.4
FAMVIR	2.5.2
FAST TAKE	18.1
FAST TAKE MONITORING SYSTEM	18.1
felodipine er	4.2
FEMARA	3
FEMHRT	13.4.1
fentanyl	5.1.1.1
FERTINEX	13.2
FINACEA	6.3
finsteride	16.1.4
FLEBOGAMMA	10
flecainide acetate	4.7.1.3
FLOMAX	16.1.4
FLONASE	7.2
FLOVENT DISKUS	15.1.3
FLOVENT HFA	15.1.3
FLOVENT ROTADISK	15.1.3
FLOXIN (OPHTH DROPS)	7.1

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

fluconazole	2.3
fludrocortisone acetate	8.3.2
FLUMADINE	2.5.2
FLUMIST	2.5.2
fluocinonide	6.1
fluoxetine hcl	5.5.1.3
flurazepam hcl	5.2.2
fluticasone propionate	7.2
fluticasone propionate (oint)	6.1
fluvoxamine maleate	5.5.1.3
FML FORTE	14.2
FOCALIN	5.9.1
folic acid	12.1.3
FOLLISTIM	13.2
FOLLISTIM AQ	13.2
FOLTX	12.1.2
FORADIL	15.1.1
FORTEO	8.6
FOSAMAX	8.6
FOSAMAX PLUS D	8.6
fosinopril sodium	4.5.4.1
fosinopril-hydrochlorothiazide	4.5.6
FRAGMIN	12.3.2
FREESTYLE	18.1
FREESTYLE FLASH SYSTEM	18.1
FREESTYLE FLASH SYSTEM KIT	18.1
FREESTYLE SIDEKICK II	18.1
FREESTYLE SYSTEM	18.1
FREESTYLE TEST STRIPS	18.1
FREESTYLE TRACKER	18.1
FREESTYLE TRACKER SYSTEM	18.1
FROVA	5.1.2
furosemide	4.3.1
FUZEON	2.5.1
gabapentin	5.4.7
GAMIMUNE N	10
GAMMAGARD S/D	10
GAMMAR-P I.V.	10
GAMUNEX	10
GANIRELIX ACETATE	13.1.2
gemfibrozil	4.8.1
GENOTROPIN	10.2.4
gentamicin sulfate	2.2
gentamicin sulfate	14.1.1
GENTAMICIN SULFATE	2.8.2
GEODON	5.8
glipizide	8.1.2
glipizide er	8.1.2
GLUCAGEN	8.2
GLUCOMETER DEX	18.1
GLUCOMETER ELITE	18.1
GLUCOMETER ENCORE	18.1
GLUCOPHAGE XR	8.1.2
glyburide	8.1.2
glyburide-metformin	8.1.2
glycolax	9.5
GLYSET	8.1.2
GOLYTELY	9.6
GONAL-F	13.2
GONAL-F RFF	13.2

granisetron hcl	5.6
guaifenesin w/codeine	15.3
guaifenesin pse	15.3
guanfacine hcl	4.5.2
GYNAZOLE-1	2.4.1
HALOG	6.1
HALOG-E	6.1
haloperidol	5.8
HELIDAC	9.4.3
HELIXATE FS	12.5
HEMOPIL-M	12.5
HUMALOG (vial only)	8.1.1
HUMALOG MIX 75/25 (vial only)	8.1.1
HUMATE-P	12.5
HUMATROPE	10.2.4
HUMIRA	3
HUMULIN 50/50 (vial only)	8.1.1
HUMULIN 70/30 (vial only)	8.1.1
HUMULIN L (vial only)	8.1.1
HUMULIN N (vial only)	8.1.1
HUMULIN R (vial only)	8.1.1
HUMULIN U (vial only)	8.1.1
HYALGAN	11.1.4
hydnone	15.3
hydralazine hcl	4.5.1
hydrochlorothiazide	4.3.2
hydrocodone bit-ibuprofen	5.1.1.2
hydrocodone w/guaifenesin	15.3
HYDROCORTISONE	6.1
hydrocortisone	9.6
hydrocortisone	8.3.1
hydromorphone hcl	5.1.1.1
hydroxychloroquine sulfate	2.7.3
hydroxyzine hcl	6.2
hydroxyzine pamoate	6.2
hyoscyamine sulfate	9.3
HYZAAR	4.5.6
ibuprofen	11.1.2
imipramine hcl	5.5.1.1
IMITREX	5.1.2
indapamide	4.3.2
indomethacin	11.1.2
INFERGEN	10.2.3
INNOHEP	12.3.2
INNOPRAN XL	4.4
INSPIRA	4.3.3
INTAL	15.1.3
INTELENCE	2.5.1
INTRON A	10.2.3
IOPIDINE	14.5
ipratropium bromide	7.2
ipratropium bromide	15.1.3
IRESSA	3
isoniazid	2.7.2
isosorbide dinitrate	4.6.1
isosorbide mononitrate	4.6.1
ISTALOL	14.5
itraconazole	2.3
IVEEGAM EN	10
JANUMET	8.1.5.2

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

JANUVIA	8.1.5.2
jolivet	13.5
junel fe	13.7
KADIAN	5.1.1.1
kariva	13.7
kelnor 1/35	13.7
KEPPRA	5.4.7
ketoconazole	2.3
ketoconazole	2.4.2
ketoprofen	11.1.2
KLARON	6.8
klor-con	12.2
KOATE-DVI	12.5
KOGENATE FS	12.5
KRISTALOSE	12.7
KYTRIL	5.6
labetalol hcl	4.4
labetalol hcl	4.4
lactulose	12.7
LAMICTAL	5.4.7
LAMISIL cream	2.4.2
LAMISIL tab	2.3
LANTUS	8.1.1
LESCOL	4.8.2
LESCOL XL	4.8.2
lessina	13.7
LETAIRIS	4.6.3
LEVAQUIN (inj)	2.1.9
LEVAQUIN (SOLN)	2.1.9
LEVEMIR (vial only)	8.1.1
LEVITRA	16.1.4
LEVLEN	13.7
LEVLITE	13.7
levobunolol hcl	14.5
levora-28	13.7
levothroid	8.4.1
levothyroxine sodium	8.4.1
levoxyl	8.4.1
LEXAPRO	5.5.1.3
LEXXEL	4.5.6
LIALDA	9.6
lidocaine hcl	1.2
lidocaine hcl viscous	1.2
LIDODERM	1.2
LINDANE	6.9.3
LIPITOR	4.8.2
lisinopril	4.5.4.1
lisinopril-hctz	4.5.6
lithium carbonate, -er	5.3
lithium citrate	5.3
LIVOSTIN	14.6
LO/OVRAL	13.7
LOCID	6.1
LOESTRIN	13.7
LOESTRIN FE	13.7
LOFIBRA	4.8.1
loperamide hcl	9.2
LOPROX	2.4.2
LORABID	2.1.1
lorazepam	5.2.1

LOTEMAX	14.2
LOTREL	4.5.6
lovastatin	4.8.2
LOVAZA	4.8.1
LOVENOX	12.3.2
low-ogestrel	13.7
LUMIGAN	14.5
LUPRON	13.1.2
LUPRON DEPOT	13.1.2
lutea	13.7
LYRICA	5.4.7
MAVIK	4.5.4.1
MAXAIR AUTOHALER	15.1.1
MAXALT	5.1.2
MAXALT MLT	5.1.2
MAXAQUIN	2.1.9
medroxyprogesterone acetate	13.5
megestrol acetate	3
MENEST	13.4
MENOPUR	13.2
MENOSTAR	13.4
MENTAX	2.4.2
meperidine hcl	5.1.1.1
mercaptopurine	3
MERIDIA	17.3.1
METADATE CD	5.9.1
METADATE ER	5.9.1
METAGLIP	8.1.2
METANX	12.1.2
metformin er	8.1.2
metformin hcl	8.1.2
METHADONE HCL (PWD)	5.1.1.1
methamphetamine hcl	5.9.1
methimazole	8.4.2
methocarbamol	11.3.2
methotrexate injection	3
methotrexate tablet	3
methyl dopa	4.5.2
methylin	5.9.1
methylin er	5.9.1
methylphenidate er	5.9.1
methylphenidate hcl	5.9.1
methylprednisolone	8.3.1
metoclopramide hcl	9.3
metolazone	4.3.2
metoprolol succ er	4.4
metoprolol tartrate	4.4
METROGEL	6.3
METROLOTION	6.3
metronidazole	2.7.5
metronidazole (0.75%)	6.3
MIACALCIN Injection	8.6
MIACALCIN Nasal Spray	8.6
MICARDIS	4.5.4.2
MICARDIS HCT	4.5.6
MICRHOGAM	10
microgestin	13.7
microgestin fe	13.7
minocycline hcl	2.1.7
MIRAPEX	5.7.2

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

MIRCETTE	13.7
mirtazapine	5.5.1.4
misoprostol	9.4.1
MOBIC	11.1.2
MODICON	13.7
moexepiril-hctz	4.5.6
mometasone furoate	6.1
mometasone furoate (cream)	6.1
MONARC-M	12.5
MONOCLATE-P	12.5
mononessa	13.7
MONONINE	12.5
morphine sulfate	5.1.1.1
MS CONTIN	5.1.1.1
MSIR	5.1.1.1
mupirocin	2.2
mupirocin 2% ointment	2.2
MUSE	16.1.4
MYFORTIC	3
NABI-HB	10
nabumetone	11.1.2
nadolol	4.4
NAFTIN	2.4.2
NAMENDA	5.9.3
naproxen	11.1.2
NASACORT AQ	7.2
NASAREL	7.2
NASONEX	7.2
natacare plus	13.1.1
necon	13.7
nefazodone hcl	5.5.1.4
neomycin/polymyxin/dexameth	14.3
NEULASTA	10.2.1
NEUMEGA	10.2.5
NEUPOGEN	10.2.1
NEURONTIN	5.4.7
NEXIUM	9.4.2
NIASPAN	4.8.1
nicardipine hcl	4.2
nifedipine	4.2
nifedipine er	4.2
nitrofurantoin macrocrystal (100 mg)	2.1.8
nitroglycerin	4.6.1
nizatidine	9.4
nora-be	13.5
NORDETTE	13.7
NORDITROPIN	10.2.4
norethindrone acetate	13.5
NORINYL 1/35	13.7
NORINYL 1/50	13.7
NORITATE	6.3
NOROXIN	2.1.9
NOR-Q-D	13.5
nortrel	13.7
nortriptyline hcl	5.5.1.2
NORVASC	4.2
novarel	13.1.2
NOVOFINE 32	18.1
NOVOLIN 70/30 (vial only)	8.1.1
NOVOLIN L (vial only)	8.1.1

NOVOLIN N (vial only)	8.1.1
NOVOLIN R (vial only)	8.1.1
NOVOLOG (vial only)	8.1.1
NOVOLOG MIX 70/30 (vial only)	8.1.1
NOXAFIL	2.3
NULEV	9.3
NULYTELY	9.6
NULYTELY WITH FLAVOR PACKS	9.6
NUTROPIN	10.2.4
NUTROPIN AQ	10.2.4
NUTROPIN DEPOT	10.2.4
NUVARING	13.7
nystatin	2.3
nystatin	2.4.2
nystatin w/triamcinolone	2.4.3
ofloxacin (eye drops)	14.1.1
ofloxacin (tabs)	2.1.9
OMACOR	4.8.1
omeprazole	9.4.2
OMNICEF	2.1.1
ondansetron hcl, -odt	5.6
ONE TOUCH BASIC SYSTEM	18.1
ONE TOUCH INDUO	18.1
ONE TOUCH PROFILE SYSTEM	18.1
ONE TOUCH TEST STRIPS	18.1
ONE TOUCH ULTRA SMART	18.1
ONE TOUCH ULTRA SYSTEM	18.1
ONE TOUCH ULTRA TEST STRIPS	18.1
OPANA ER	5.1.1.1
OPTIVAR	14.6
ORAPRED	8.3.1
orphenadrine citrate	11.3.2
orphenadrine citrate injectable	11.3.2
ORTHO EVRA	13.7
ORTHO MICRONOR	13.5
ORTHO TRI-CYCLEN	13.7
ORTHO TRI-CYCLEN LO	13.7
ORTHO-CEPT	13.7
ORTHO-CYCLEN	13.7
ORTHO-NOVUM	13.7
ORTHO-PREFEST	13.4.1
ORTHOVISC	11.1.4
OVCON	13.7
OVIDREL	13.1.2
oxaprozin	11.1.2
OXISTAT	2.4.2
oxybutynin chloride	16.1.1
oxycodone apap	5.1.1.1
oxycodone hcl	5.1.1.1
oxycodone w/acetaminophen	5.1.1.1
OXYCONTIN	5.1.1.1
OXYIR	5.1.1.1
OXYTROL	16.1.1
PACERONE	4.7.3
PACERONE (200mg only)	4.7.3
PANGLOBULIN NF	10
paroxetine hcl	5.5.1.3
PATADAY	14.6
PATANOL	14.6
PAXIL	5.5.1.3

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

PAXIL CR	5.5.1.3
PCE	2.1.4
PEGASYS	10.2.3
PEG-INTRON	10.2.3
PEG-INTRON REDIPEN	10.2.3
penicillin v potassium	2.1.5
PENLAC	2.4.2
PENTASA	9.6
pentoxifylline	4.9
PERFOROMIST	15.1.1
phenazopyridine hcl	16.1.3
phenobarbital	5.4.6
PHENYTEK	5.4.3
phenytoin	5.4.3
phenytoin sodium, extended	5.4.3
PHOSLO	12.1.3
pilocarpine hcl	14.5
piroxicam	11.1.2
PLAVIX	12.4
PLEXION	6.3
PLEXION SCT	6.3
PLEXION TS	6.3
POLYGAM S/D	10
polymyxin b sul/trimethoprim	14.1.1
potassium chloride	12.2
PRAMOSONE	6.1
PRANDIN	8.1.2
PRAVACHOL	4.8.2
pravastatin	4.8.2
PRAVIGARD PAK	4.8.2.1
prazosin hcl	4.5.1
PRECISION	18.1
PRECISION PCX	18.1
PRECISION PCX PLUS	18.1
PRECISION Q-I-D	18.1
PRECISION SOF-TACT	18.1
PRECISION XTRA	17.1
PRECISION XTRA	18.1
PRECOSE	8.1.2
prednisolone	8.3.1
prednisolone acetate	14.2
prednisone	8.3.1
PREFEST	13.4.1
PREGNYL	13.1.2
PREMARIN	13.4
PREMPHASE	13.4.1
PREMPRO	13.4.1
prenatal rx	13.1.1
PRENATE ADVANCE	13.1.1
PRENATE ELITE	13.1.1
PRENATE GT	13.1.1
PREVACID	9.4.2
PREVACID NAPRAPAC	11.1.2
previfem	13.7
PREVPAC	9.4.3
PRILOSEC	9.4.2
PRILOSEC OTC	9.4.2
primidone	5.4.6
PROAIR HFA	15.1.1
probenecid	11.2

PROCHIEVE	13.5
prochlorperazine maleate	5.6
PROCRIT	10.2.2
PROFILNINE SD	12.5
prolex dh	15.3
promethazine hcl	15.2.1
promethazine vc	15.2.3
promethazine vc w/codeine	15.3
promethazine w/codeine	15.3
promethazine w/dm	15.3
PROMETRIUM	13.5
propafenone hcl	4.7.1.3
PROPLEX T	12.5
propoxyphene hcl	5.1.1.3
propoxyphene hcl w/acetaminophen	5.1.1.3
propoxyphene napsylate w/acetaminophen	5.1.1.3
propranolol hcl	4.4
propylthiouracil	8.4.2
PROSCAR	16.1.4
PROTONIX	9.4.2
PROTOPIC	6.9.2
PROTROPIN	10.2.4
PROVENTIL HFA	15.1.1
PROVIGIL	5.9.1
PROZAC WEEKLY	5.5.1.3
PULMICORT	15.1.3
PULMICORT FLEXHALER	15.1.3
quinapril	4.5.4.1
quinapril hcl	4.5.4.1
quinaretic	4.5.6
quinidine gluconate	4.7.1.1
quinine sulfate	2.7.3
QUIXIN	14.1.1
QVAR	15.1.3
ranitidine hcl	9.4
REBIF	10.2.3
RECLAST Injection	8.6
RECOMBINATE	12.5
REFACTO	12.5
RELENZA	2.5.2
RELPAK	5.1.2
REMERON (M tab)	5.5.1.4
REMINYL	5.9.3
RENAGEL	12.7
REVELA	12.7
REPRONEX	13.2
REQUIP	5.7.2
RESTASIS	14.6
RESTORIL	5.2.2
RETIN-A MICRO	6.3
REVLIMID	3
REYATAZ	2.5.1
RHINOCORT AQUA	7.2
RHOGAM	10
RHOPHYLAC	10
ribasphere	2.5.2
ribavirin	2.5.2
rifampin	2.7.2
RISPERDAL	5.8

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

RISPERDAL CONSTA	5.8
RITALIN LA	5.9.1
ropinirole	5.7.2
ROZEX	6.3
RYNATAN	15.2.3
SAIZEN	10.2.4
salsalate	11.1.1
SANCTURA	16.1.1
SEASONALE	13.7
selenium sulfide	6.8
SEMPREX-D	15.2.3
SENSIPAR	8.6
SEREVENT DISKUS	15.1.1
SEROQUEL	5.8
sertraline	5.5.1.3
silver sulfadiazine	2.2
SIMCOR	4.8.2.1
simvastatin	4.8.2
SINGULAIR	15.1.4
SKELAXIN	11.3.2
SKELID	8.6
sod.sulfacetamide/sulfur tf	6.3
SOF-TACT	18.1
solia	13.7
SONATA	5.2.2
sotalol	4.7.5
SPECTRACEF	2.1.1
SPIRIVA	15.1.3
spironolactone	4.3.3
spironolactone w/hctz	4.3.3
SPORANOX	2.3
sprintec	13.7
STALEVO	5.7.2
STARLIX	8.1.2
STRATTERA	5.9.6
sucralfate	9.4.1
SULAR	4.2
sulfacetamide sodium	14.1.1
sulfamethoxazole/trimethoprim	2.1.6
sulfasalazine	9.6
sulindac	11.1.2
sumatriptan	5.1.2
supartz	11.1.4
SUPRAX (SUSP)	2.1.1
SURESTEP	18.1
SUTENT	3
SYMBICORT	15.1.3
SYMLIN/SYMLINPEN	8.1.4
SYNTHROID	8.4.1
SYNVISC	11.1.4
TAMIFLU	2.5.2
tamoxifen citrate	3
TARKA	4.5.6
TAZORAC	6.8
TEGRETOL XR	5.4.1
temazepam	5.2.2
terazosin hcl	4.5.1
terbinafine tablet	2.3
terconazole	2.4.1
TESTIM	13.3

TESTODERM	13.3
tetracycline hcl	2.1.7
TEVETEN	4.5.4.2
TEVETEN HCT	4.5.6
TEV-TROPIN	10.2.4
theophylline anhydrous	15.1.2
theophylline, -er	15.1.2
thioridazine hcl	5.8
thyroid	8.4.1
ticlopidine hcl	12.4
TILADE	15.1.3
timolol maleate	14.5
tizanidine hcl	11.3.1
TOBRADEX	14.3
tobramycin sulfate	14.1.1
TOFRANIL-PM	5.5.1.1
TOPAMAX	5.4.7
TOPROL XL	4.4
torsemide	4.3.1
TRACLEER	4.6.3
tramadol hcl	5.1.1
tramadol hcl-acetaminophen	5.1.1
TRAVATAN	14.5
trazodone hcl	5.5.1.4
TREANDA	3
TRELSTAR DEPOT	3
TRELSTAR LA	3
tretinoin	6.3
triamcinolone acetonide	6.1
triamterene w/hctz	4.3.3
triazolam	5.2.2
TRICOR	4.8.1
TRILEPTAL	5.4.1
TRI-LEVELN	13.7
trimethobenzamide hcl	5.6
trimox	2.1.5
trinessa	13.7
TRI-NORINYL	13.7
TRIPHASIL	13.7
tri-previfem	13.7
tri-sprintec tablet	13.7
trivora-28	13.7
TRUSOPT	14.5
TRUVADA	2.5.1
TUSSIONEX	15.3
TWINJECT	15.1.3
TYKERB	3
TYZEKA	2.5.2
ULTRASE	9.6
ULTRASE MT	9.6
UNIPHYL	15.1.2
UNIRETIC	4.5.6
unithroid	8.4.1
UNIVASC	4.5.4.1
UROXATRAL	16.1.4
URSO, -FORTE	9.6
VAGIFEM	13.4
VALTREX	2.5.2
VANTIN	2.1.1
velivet 28 day	13.7

Ventura County Health Care Plan  
Preferred Drug List (Numbers Refer to Therapeutic Class Section)

venlafaxine	5.5.1.4
VENTOLIN HFA	15.1.1
verapamil hcl	4.2
VERELAN PM	4.2
VEXOL	14.2
VIAGRA	16.1.4
VIGAMOX	14.1.1
VIVELLE	13.4
VIVELLE-DOT	13.4
VOLTAREN	14.6
VYTORIN	4.8.2.1
warfarin sodium	12.3.1
WELCHOL	4.8.1
WELLBUTRIN XL	5.5.1.4
WINRHO SD	10
WINRHO SDF	10
XALATAN	14.5
XENICAL	17.3.2
XOPENEX HFA	15.1.1
YASMIN	13.7
YAZ	13.7
ZADITOR	14.6
zaleplon	5.2.2
ZEGERID	9.4.2
ZETIA	4.8.1
ZITHROMAX	2.1.4.1
ZOCOR	4.8.2
ZOFRAN	5.6
ZOFRAN IN DEXTROSE	5.6
ZOFRAN ODT	5.6
ZOLADEX	3
ZOLINZA	3
ZOLOFT	5.5.1.3
zolpidem	5.2.2
ZOMIG	5.1.2
ZOMIG NASAL SPRAY	5.1.2
ZOMIG ZMT	5.1.2
ZONEGRAN	5.4.7
zonisamide	5.4.7
zovia 1/35e	13.7
ZYLET	14.3
ZYMAR	14.1.1
ZYPREXA	5.8
ZYPREXA ZYDIS	5.8
ZYRTEC	15.2.1
ZYRTEC-D	15.2.3