

CMSP DRUG FORMULARY

Administered by MedImpact

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INTRODUCTION

Foreword

Members with the CMSP Standard Benefit are eligible for covered prescriptions without a copayment after meeting a monthly share of cost (SOC). CMSP members who additionally have coverage under the CMSP Primary Care Benefit should use their CMSP Primary Care Benefit (CMSP-PCB) as the primary pharmacy benefit.

The below table describes CMSP prescription coverage:

	CMSP Primary Care Benefit	CMSP Standard Benefit	CMSP Emergency Services Only Benefit
When to use the benefit	<ul style="list-style-type: none"> Primary benefit for CMSP Aid Codes 89 and 50 	<ul style="list-style-type: none"> Primary benefit for CMSP Aid Code 88 Secondary benefit for CMSP Aid Code 89. Use when CMSP Primary Care Benefit does not provide coverage (e.g., prescription cost exceeds maximum cost of \$500/claim, drug is excluded from Primary Care Benefit, or patient exceeds \$1500 maximum benefit per CMSP-PCB enrollment period). 	<ul style="list-style-type: none"> Secondary benefit for CMSP Aid Code 50 Use when CMSP Primary Care Benefit does not provide coverage (e.g., prescription cost exceeds maximum cost of \$500/claim or patient exceeds \$1500 maximum benefit per CMSP-PCB enrollment period.) <u>if prescribed following an emergency medical service.</u>
Patient out-of-pocket cost	<ul style="list-style-type: none"> \$5 copayment per prescription No monthly share of cost requirement 	<ul style="list-style-type: none"> Monthly share of cost must be met before prescription coverage No copayment per prescription 	<ul style="list-style-type: none"> Monthly share of cost must be met before prescription coverage No copayment per prescription
Benefit maximums	<ul style="list-style-type: none"> \$500 per prescription claim \$1500 maximum benefit per CMSP-PCB enrollment period 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Limited to prescriptions associated with an emergency medical service.
Drug exclusions	<ul style="list-style-type: none"> Specialty drugs excluded. See “<i>Prescription Coverage of Select Drug Classes</i>” section of the CMSP Primary Care Benefit formulary for additional information about excluded drugs. 	<ul style="list-style-type: none"> Specialty drugs generally covered. See “<i>Prescription Coverage of Select Drug Classes</i>” section of the CMSP Standard Benefit formulary for additional information about excluded drugs. 	<ul style="list-style-type: none"> Specialty drugs excluded. Limited to prescriptions associated with an emergency medical service.

This document represents the efforts of MedImpact and the County Medical Services Program (CMSP) Governing Board to provide physicians and pharmacists with a method to evaluate the various drug products available under the CMSP Standard Benefit. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage

must be developed. The goal of the CMSP Standard Benefit Drug Formulary is to enhance the ability of physicians and pharmacists participating in CMSP to provide optimal cost effective drug therapy for CMSP members.

The development, maintenance, and improvement of the CMSP Standard Benefit Drug Formulary are evolutionary and require on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The CMSP Standard Benefit Drug Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to the CMSP Governing Board.

CMSP uses the following criteria in the evaluation of product selection for the CMSP Standard Benefit Drug Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Standard Benefit Drug Formulary is a list of covered and preferred drug agents for CMSP members. All products are listed by their generic names and most common proprietary (branded) name. The Standard Benefit Drug Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by the CMSP Governing Board shall be considered a Non-Formulary Drug.

Coverage Limitations

The Standard Benefit Drug Formulary does not provide information regarding the specific coverage or limitations an individual member may have. CMSP members may have specific limitations, such as share of cost, which are not reflected in this Drug Formulary. This Drug Formulary contains only FDA-approved outpatient drugs for eligible members and does not apply to non-FDA approved drugs or medications used in in-patient settings. If a CMSP member has any specific questions regarding coverage, they should contact the CMSP Governing Board at (916) 649-2631 for further explanation of benefits.

CMSP members are not eligible to receive prescription drug services outside of California and the designated board state areas of Oregon, Nevada and Arizona.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the CMSP pharmacy and therapeutics review process.

CMSP approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by CMSP Governing Board for efficacy and safety.

- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - ◇ Coumadin
 - ◇ Dilantin
 - ◇ Lanoxin
 - ◇ Premarin
 - ◇ Neoral Oral Solution
 - ◇ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Experimental Drugs

The experimental nature or use of drug products will be determined by CMSP using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

Prior Authorization

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by CMSP, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Request Process for Non-Formulary Agents

Coverage for non-formulary agents may be requested in advance by physicians. When a CMSP member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of CMSP Standard Benefit Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the CMSP Standard Benefit Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- 4) The use of a CMSP Standard Benefit Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

CMSP recognizes that not all medical needs can be met with agents listed in this document and encourages inquires about optional therapies.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per CMSP guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL) will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or CMSP members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court, San Diego, CA 92131
Attention: Appeals Coordinator
or
Fax (858) 790-6060

Formulary Process and Communication

The CMSP Standard Benefit Drug Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. CMSP welcomes input on the formulary from physicians and pharmacists providing services to CMSP clients. Suggestions and comments should be submitted to the CMSP Governing Board at the following address:

CMSP Governing Board
ATTN: Pharmacy and Therapeutics Panel
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631

Prescription Coverage of Select Drug Classes

Drug Class	CMSP Primary Care Benefit	CMSP Standard Benefit Coverage
HIV Antiretroviral Agents	<p>Antiretroviral drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Antiretroviral agents for the treatment of HIV are not covered unless the member is ineligible for the AIDS Drug Assistance Program (ADAP). Evidence of ADAP ineligibility for antiretroviral coverage is required. Contact ADAP at (888) 311-7632 or (888) 575-2327 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: www.cmspcounties.org. Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org.</p> <p><u>For patients who also have the CMSP Emergency Services Only Benefit:</u> This benefit only provides coverage of covered prescriptions following an emergency medical service once the monthly share of cost is met.</p>	<p>Antiretroviral agents for the treatment of HIV are not covered unless the member is ineligible for the AIDS Drug Assistance Program (ADAP).</p> <p>Evidence of ADAP ineligibility for antiretroviral coverage is required. Contact ADAP at (888) 311-7632 or (888) 575-2327 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p> <p>Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org.</p>
Contraceptives	<p>Contraceptives are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Contraceptives are not covered unless the member is not eligible for Family PACT. Evidence of Family PACT ineligibility for contraceptive coverage is required. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for contraceptive coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p> <p><u>For patients who also have the CMSP Emergency Services Only Benefit:</u> This benefit only provides coverage of covered prescriptions following an emergency medical service once the monthly share of cost is met.</p>	<p>Contraceptives are not covered unless the member is not eligible for Family PACT.</p> <p>Evidence of Family PACT ineligibility for contraceptive coverage is required. Contact Family PACT at (800) 942-1054 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for contraceptive coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p>

<p>Cystic Fibrosis Agents: Kalydeco, Orkambi, Symdeko</p>	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Cystic Fibrosis therapies otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p> <p><u>For patients who also have the CMSP Emergency Services Only Benefit:</u> This benefit only provides coverage of covered prescriptions following an emergency medical service once the monthly share of cost is met.</p>	<p>Cystic Fibrosis therapies otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP.</p> <p>Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p>
<p>Hemophilia Agents</p>	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p> <p><u>For patients who also have the CMSP Emergency Services Only Benefit:</u> This benefit only provides coverage of covered prescriptions following an emergency medical service once the monthly share of cost is met.</p>	<p>Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP.</p> <p>Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.</p>
<p>Hepatitis C: Ribavirin and Pegylated Interferons</p>	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> These agents are not a covered benefit unless the member is ineligible for the drug manufacturer's patient assistance program and clinical prior authorization requirements are met. Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MedImpact.</p> <p><u>For patients who also have the CMSP Emergency Services Only Benefit:</u> These</p>	<p>These agents are not a covered benefit unless the member is ineligible for the drug manufacturer's patient assistance program and clinical prior authorization requirements are met.</p> <p>Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MedImpact.</p>

	drugs are excluded under this benefit.	
Hepatitis C: Daklinza, Harvoni, Olysio, Sovaldi, Technivie, Viekira Pak, Viekira XR, Zepatier, Epclusa, Mavyret, Vosevi		These agents are not a covered benefit. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org .

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

Aspirin	ASPIRIN
Aspirin EC	ECOTRIN
Celecoxib	CELEBREX
Diclofenac Sodium	VOLTAREN
Etodolac	LODINE
Ibuprofen	MOTRIN (INCLUDES OTC)
Indomethacin	INDOCIN
Ketoprofen	ORUVAIL, 200MG STRENGTH NON-FORMULARY
Indomethacin, Sustained Release	INDOCIN SR
Meloxicam Tablets	MOBIC (TABLETS ONLY), SUSPENSION NON-FORMULARY
Nabumetone	RELAFEN
Naproxen	NAPROSYN
Naproxen Sodium	ANAPROX
	ANAPROX DS
Salsalate	DISALCID
Sulindac	CLINORIL
Piroxicam	FELDENE

SECOND LINE AGENTS

SE	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
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Miscellaneous Arthritis Agents

Leflunomide	ARAVA
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Migraine Agents

	APAP/Dichloralphenazone/Isomethep	MIDRIN
	Butalbital/APAP/Caffeine	ESGIC
		ESGIC PLUS
		FIORICET
	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
QL	Ergotamine/Caffeine	CAFERGOT
	Naratriptan	AMERGE, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Rizatriptan	MAXALT, MAXALT MLT, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH, SUMAVEL NON-FORMULARY
SE, QL	Eletriptan	RELPAK, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
SE, QL	Zolmitriptan	ZOMIG, ZOMIG ZMT STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
PA, QL	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH

Opiate Agonists

QL	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; ORAL SUSPENSION AND VOPAC NON-FORMULARY
QL	Acetaminophen/Hydrocodone	NORCO 5/325, LIMITED TO #240/MONTH
QL		NORCO 7.5/325, LIMITED TO #180/MONTH
QL		NORCO 10/325, LIMITED TO #150/MONTH
		ALL OTHER HYDROCODONE/APAP STRENGTHS NON-FORMULARY
QL	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL	Oxycodone	OXYIR, LIMITED TO #240/MONTH
QL	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
QL	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH; MAGNACET AND PRIMALEV NON-FORMULARY
QL		TYLOX, LIMITED TO #240/MONTH
QL	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH
PA, QL	Oxycodone	OXYCONTIN, PA REQ , LIMITED TO #60/MONTH
	Narcotic Withdrawal Therapy Agents	
	Naloxone Spray and Syringes	NARCAN; EVZIO NON-FORMULARY
	Opiate Antagonists	
	Naltrexone	REVIA
	Miscellaneous Analgesics	
	Acetaminophen	TYLENOL
	Tramadol	ULTRAM ; ULTRAM ER NON-FORMULARY
PA, QL	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH
	Miscellaneous Central Nervous System Agents	
	Donepezil	ARICEPT
	Anticonvulsant Agents	
	Barbiturate Anticonvulsants	
	Mephobarbital	MEBARAL
	Phenobarbital	PHENOBARBITAL
	Primidone	MYSOLINE
	Benzodiazepine Anticonvulsants	
QL	Clonazepam	KLONOPIN, LIMITED TO #90/MONTH; RAPDIS TABLETS NON-FORMULARY
	Hydantoin Anticonvulsants	
	Phenytoin	DILANTIN, PHENYTEK
	Miscellaneous Anticonvulsants	
	Carbamazepine	TEGRETOL; EQUETRO NON-FORMULARY
	Carbamazepine Extended Release	TEGRETOL XR
	Divalproex Sodium	DEPAKOTE
	Divalproex Sodium Extended Release	DEPAKOTE ER
	Gabapentin	NEURONTIN
	Levetiracetam	KEPPRA
	Oxcarbazepine	TRILEPTAL
	Tiagabine	GABITRIL
	Valproic Acid	DEPAKENE
	Zonisamide	ZONEGRAN
QL	Lamotrigine	LAMICTAL, LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG

QL	Topiramate	TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS
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Antiparkinsonian Agents

Amantadine Benztropine Mesylate Bromocriptine Carbidopa/Levodopa Carbidopa/Levodopa CR Pramipexole Ropinirole Selegiline Trihexyphenidyl	SYMMETREL COGENTIN PARLODEL SINEMET; PARCOPA NON-FORMULARY SINEMET CR MIRAPEX REQUIP; REQUIP XL NON-FORMULARY SELEGILINE, ZELAPAR AND EMSAM NON-FORMULARY ARTANE
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Muscle Relaxant Agents

Skeletal Muscle Relaxants

QL	Baclofen Carisoprodol Chlorzoxazone Cyclobenzaprine Dantrolene Sodium Methocarbamol Orphenadrine Citrate Orphenadrine/Aspirin/Caffeine	LIORESAL SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY PARAFON DSC FLEXERIL DANTRIUM ROBAXIN NORFLEX NORGESIC
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Psychotherapeutic Agents

Tricyclic Antidepressant Agents

Amitriptyline Amoxapine Desipramine Doxepin Imipramine Maprotiline Nortriptyline Protriptyline	ELAVIL ASENDIN NORPRAMIN SINEQUAN TOFRANIL, TOFRANIL PM NON-FORMULARY LUDIOMIL PAMELOR VIVACTIL
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S.S.R.I. Agents

Citalopram Fluoxetine Capsules Fluvoxamine Paroxetine Sertraline	CELEXA PROZAC CAPSULES (10MG, 20MG ONLY), TABLETS NON-FORMULARY LUVOX PAXIL ZOLOFT
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S.N.R.I. Agents

QL	Duloxetine	CYMBALTA , LIMITED TO #60/MONTH
QL	Venlafaxine	EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
QL	Venlafaxine Extended Release	EFFEXOR XR, LIMITED TO #30/MONTH VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY

M.A.O. Inhibitor Agents

Phenelzine Tranylcypromine	NARDIL PARNATE
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Miscellaneous Antidepressant Agents

	Bupropion	WELLBUTRIN, ALENZIN NON-FORMULARY
	Bupropion SR	WELLBUTRIN SR, ALENZIN NON-FORMULARY
	Bupropion XL	WELLBUTRIN XL, ALENZIN NON-FORMULARY
	Clomipramine	ANAFRANIL
	Mirtazapine	REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
MD, QL	Trazodone	DESYREL
	Nefazodone	SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH
Antimanic Agents		
	Lithium Carbonate	ESKALITH LITHOBID
Benzodiazepines		
QL	Alprazolam	XANAX, LIMITED TO #90/MONTH; XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY
QL	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	Diazepam	VALIUM, LIMITED TO #90/MONTH, DIASTAT NON-FORMULARY
QL	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; LORAZEPAM ORAL CONCENTRATE NON-FORMULARY
QL	Temazepam	RESTORIL, LIMITED TO #30/MONTH; 22.5MG STRENGTH NON-FORMULARY
QL	Triazolam	HALCION, LIMITED TO #30/MONTH
Antipsychotic Agents		
QL	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH DISCMELOTS NON-FORMULARY
	Chlorpromazine	THORAZINE
	Clozapine	CLOZARIL
	Fluphenazine	PROLIXIN
	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	Loxapine	LOXITANE
	Molindone	MOBAN
QL	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL		ZYPREXA ZYDIS, LIMITED TO #60/MONTH
		ZYPREXA INJECTION
		ZYPREXA RELPREVV
	Perphenazine	TRILAFON
	Pimozide	ORAP
QL	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, 25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMITPA FOR OTHER INDICATIONS.
QL	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
	Thioridazine	MELLARIL
	Thiothixene	NAVANE
	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH
Antipsychotic/SSRI Combination Agents		
QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
Miscellaneous Anxiolytics, Sedatives, and Hypnotics		
	Buspirone	BUSPAR 7.5MG STRENGTH NON-FORMULARY
	Chloral Hydrate	NOCTEC
	Hydroxyzine	ATARAX

QL	Hydroxyzine Pamoate Promethazine Zolpidem	VISTARIL PHENERGAN AMBIEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY
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CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

Amiodarone	CORDARONE; 100MG STRENGTH NON-FORMULARY
Disopyramide	NORPACE
Disopyramide CR	NORPACE CR
Flecainide	TAMBOCOR
Mexiletine	MEXITIL
Procainamide	PRONESTYL
Procainamide SR	PROCAN SR
	PROCANBID
Propafenone	RYTHMOL
Quinidine Gluconate	QUINAGLUTE
Quinidine Polygalacturonate	CARDIOQUIN
Quinidine Sulfate	CIN-QUIN
Quinidine Sulfate SR	QUINIDEX
Sotalol	BETAPACE

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

Atenolol	TENORMIN
Metoprolol Succinate	TOPROL XL
Metoprolol Tartrate	LOPRESSOR
Nadolol	CORGARD
Pindolol	VISKEN
Propranolol	INDERAL
Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

Carvedilol	COREG; COREG CR NON-FORMULARY
Labetalol	NORMODYNE
	TRANDATE

Angiotensin Converting Enzyme Inhibitor Agents

Benazepril	LOTENSIN
Captopril	CAPOTEN
Enalapril	VASOTEC
Lisinopril	PRINIVIL
	ZESTRIL

Angiotensin Receptor Blocker Agents

	Irbesartan	AVAPRO
	Losartan	COZAAR
SE, QL	Telmisartan	MICARDIS
	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan	DIOVAN, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

Amlodipine	NORVASC, LIMITED TO #30/MONTH
Diltiazem	CARDIZEM
Diltiazem SR	CARDIZEM SR; CARDIZEM LA NON-FORMULARY
Diltiazem CD	CARTIA XT
Felodipine	PLENDIL, LIMITED TO #30/MONTH
Nifedipine, Sustained Release	ADALAT CC
Verapamil	CALAN
Verapamil LA Tablets	CALAN SR; COVERA-HS NON-FORMULARY
Verapamil SR Capsules	VERELAN

Centrally Acting Antihypertensive Agents

Clonidine	CATAPRES
Guanfacine	TENEX
Methyldopa	ALDOMET

Combination Antihypertensive Agents

	Atenolol/Chlorthalidone	TENORETIC
	Benazepril/HCTZ	LOTENSIN HCT
	Bisoprolol/HCTZ	ZIAC
	Captopril/HCTZ	CAPOZIDE
	Enalapril/HCTZ	VASORETIC
	Lisinopril/HCTZ	ZESTORETIC
	Losartan/HCTZ	PRINZIDE
SE, QL	Olmesartan/HCTZ	HYZAAR, BENICAR HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS
SE, QL	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

PA	Phenoxybenzamine	DIBENZYLINE, PA REQUIRED
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Potassium-Sparing Diuretics

	Spironolactone	ALDACTONE
	Spironolactone/HCTZ	ALDACTAZIDE
	Triamterene	DYRENIUM
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50

Loop Diuretics

	Bumetanide	BUMEX
	Furosemide	LASIX

Thiazide and Related Diuretics

	Chlorthalidone	HYGROTON
	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
	Indapamide	LOZOL
	Metolazone	ZAROXOLYN

Vasodilator Antihypertensive Agents

	Doxazosin Mesylate	CARDURA; CARDURAL XL NON-FORMULARY
	Hydralazine	APRESOLINE
	Minoxidil	LONITEN
	Prazosin	MINIPRESS
	Terazosin	HYTRIN

Antilipemic Agents

Atorvastatin	LIPITOR
Cholestyramine/Aspartame	QUESTRAN LIGHT
Cholestyramine/Sucrose	QUESTRAN
Gemfibrozil	LOPID
Lovastatin	MEVACOR
Niacin	NIACIN
Pravastatin	PRAVACHOL
Niacin, Delayed Release	NIASPAN
Niacin/Lovastatin	ADVICOR
Simvastatin	ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF 80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS FORMULARY

Blood Agents

Coagulants and Anticoagulants

QL	Enoxaparin	LOVENOX, LIMITED TO #20/FILL TIMES 3
	Warfarin Sodium	COUMADIN

Hemophilia Agents

Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.

Hemorheologic Agents

Pentoxifylline	TRENTAL
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Cardiac Glycoside Agents

Digoxin	LANOXIN; LANOXICAPS NON-FORMULARY
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Antiplatelet Agents

Cilostazole	PLETAL
Clopidogrel	PLAVIX
Dipyridamole	PERSANTINE
Pasugrel	EFFIENT

Vasodilating Agents

Isosorbide Dinitrate	ISORDIL; CHEW TABLETS NON-FORMULARY
Isosorbide Dinitrate SR	DILATRATE SR
Isosorbide Mononitrate	ISOSORBIDE MONONITRATE
Isosorbide Dinitrate ER	ISOSORBIDE MONONITRATE
Nitroglycerin Ointment	NITROL
Nitroglycerin Patches	NITRO-DUR
Nitroglycerin Spray	NITROLINGUAL SPRAY
Nitroglycerin Sublingual	NITROSTAT SL
SE	IMDUR, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

Attapulgite	PAREPECTOLIN
Bismuth Subsalicylate	PEPTO BISMOL
Diphenoxylate/Atropine	LOMOTIL
Kaolin/Pectin	KAOPECTATE
Loperamide	IMODIUM

Antiemetic Agents

Meclizine	ANTIVERT
Metoclopramide	REGLAN
Ondansetron ODT Tablets	ZOFRAN ODT
Ondansetron Tablets	ZOFRAN TABLETS
Ondansetron Solution	ZOFRAN SOLUTION
Prochlorperazine Maleate	COMPAZINE
	COMPAZINE SPANSULES NOT COVERED
Promethazine	PHENERGAN
Trimethobenzamide	TIGAN

Antimuscarinic/Antispasmodic Agents

Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)	DONNATAL
Chlordiazepoxide/Clidinium	CHLORDIAZEPOXIDE/CLIDINIUM
Dicyclomine	BENTYL
Hyoscyamine Sulfate	LEVVID
	LEVSIN
	LEVSIN SL

Antiulcer/Antipeptic Agents

Antacid Mg OH/Al OH	MAALOX, TC
Antacid Mg OH/Al OH/Simethicone	MYLANTA I, II
Lansoprazole 15mg OTC	PREVACID 24HR, LEGEND LANSOPRAZOLE NON-FORMULARY
Misoprostol	CYTOTEC
Omeprazole 20mg and 40mg	PRILOSEC 20MG AND 40MG, OTHER STRENGTHS NON-FORMULARY
Omeprazole Magnesium	PRILOSEC OTC
Pantoprazole Tablets	PROTONIX
Simethicone	MYLICON
Sucralfate	CARAFATE

Bowel Evacuant Agents

QL	Bowel Evacuation Prep Kits	FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
QL	Enema	FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR

QL	Oral Colon Lavage Solution Oral Saline Laxative	COLYTE FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR
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Digestive Enzymes

Amylase/Lipase/Protease	PANCRELIPASE 5,000
Amylase/Lipase/Protease	CREON
Amylase/Lipase/Protease	PANCREAZE

Gallstone Solubilizing Agents

Ursodiol	ACTIGALL
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Gastrointestinal Stimulant Agents

Metoclopramide	REGLAN
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H₂ Antagonist Agents

Cimetidine	TAGAMET
Famotidine	PEPCID
Ranitidine	ZANTAC (TABLETS ONLY)

Laxative Agents

QL	Bisacodyl Suppositories	DULCOLAX, LIMITED TO #30/MONTH
	Docusate Sodium Capsules	COLACE
QL	Lactulose	CEPHULAC, LIMITED TO 4L/MONTH
QL		CHRONULAC, LIMITED TO 4L/MONTH
	Sennosides	SENNA

Miscellaneous Gastrointestinal Supplies

Ostomy Supplies

Miscellaneous Gastrointestinal Agents

	Mesalamine	DELZICOL ROWASA
	Olsalazine	DIPENTUM
	Sulfasalazine	AZULFIDINE
PA	Budesonide	ENTOCORT EC, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

Metronidazole	FLAGYL; FLAGYL ER NON-FORMULARY
Iodoquinol (Diiodohydroxyquin)	YODOXIN

Antihelmintic Agents

Albendazole	ALBENZA
Furazolidone	FUROXONE
Mebendazole	VERMOX
Praziquantel	BILTRICIDE

Antibiotic Agents

Aminoglycosides

Neomycin Sulfate

MYCIFRADIN

Cephalosporins

Cefaclor

CECLOR

Cefadroxil

DURICEF

Cefdinir

OMNICEF

QL

Cefixime

SUPRAX, LIMITED TO #1 X 400MG/FILL

Cefuroxime Tablets

CEFTIN

Cephalexin

KEFLEX; **750MG STRENGTH NON-FORMULARY**

Macrolide Antibiotic Agents

QL

Azithromycin

ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; **ZMAX NON-FORMULARY**

Erythromycin Base

ERY-TAB

PCE

ERYPED SUSPENSION

Erythromycin Stearate

ERYTHROCIN

Erythromycin Ethylsuccinate

EES

Erythromycin/Sulfisoxazole

PEDIAZOLE

PA

Clarithromycin

BIAXIN, **PA REQ**

Miscellaneous Antibiotic Agents

Clindamycin

CLEOCIN

Metronidazole

FLAGYL

Penicillins

Amoxicillin

AMOXIL

TRIMOX

Amoxicillin/Potassium Clavulanate

AUGMENTIN

Ampicillin

PRINCIPEN

Dicloxacillin

DYNAPEN

Penicillin VK (125mg Tablets Not Covered)

PEN VK

Quinolones

QL

Ciprofloxacin tablets

CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; **CIPRO XR AND PROQUIN XR NONFORMULARY**

QL

Moxifloxacin

AVELOX, LIMITED TO 21-DAY SUPPLY

Sulfonamide Agents

Erythromycin/Sulfisoxazole

PEDIAZOLE

Sulfamethoxazole/Trimethoprim (SMZ/TMP)

BACTRIM

Sulfisoxazole

SEPTRA

Sulfadiazine

GANTRISIN

Trimethoprim

SULFADIAZINE

TRIMPEX

Tetracyclines

Doxycycline

VIBRAMYCIN

VIBRA-TABS

DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY

Minocycline

MINOCIN

Tetracycline

ACHROMYCIN V

SUMYCIN

Antifungal Agents

Clotrimazole

MYCELEX TROCHE

Fluconazole

DIFLUCAN

Griseofulvin Ultramicrosized	GRIS-PEG FULVICIN P/G
Ketoconazole	NIZORAL
Nystatin (Oral Powder Not Covered)	MYCOSTATIN
Terbinafine Tablets	LAMISIL TABLETS

Antimalarial Agents

Atovaquone/Proguanil	MALARONE
Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
Hydroxychloroquine	PLAQUENIL
Iodoquinol	YODOXIN
Mefloquine	LARIAM
Primaquine	PRIMAQUINE
Pyrimethamine	DARAPRIM
Quinine (260mg Not Covered)	QUININE

Antituberculosis Agents

Ethambutol	MYAMBUTOL
Isoniazid	ISONIAZID
Pyrazinamide	PYRAZINAMIDE
Rifabutin	MYCOBUTIN
Rifampin	RIFADIN

Anti-Ulcer Eradication Agents

QL	Amoxicillin/Clarithromycin/Lansoprazole	PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL	Tetracycline/Bismuth/Metronidazole	HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Hepatitis C Antiviral Agents

PA	Ribavirin	COPEGUS, REBETOL, PA REQ
PA	Peginterferon Alfa 2b	PEG-INTRON, PA REQ, PEGASYS NON-FORMULARY

The following Hepatitis C agents are not a covered benefit for CMSP members: Daklinza, Harvoni, Olysio, Sovaldi, Technivie, Zepatier, Viekira Pak, Viekira XR, Mavyret, Vosevi, and Epclusa. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at <http://www.pparx.org/>.

HIV Antiretroviral Agents

CMSP requires evidence of ADAP ineligibility for antiretroviral coverage for the treatment of HIV infection. Contact ADAP at (888) 311-7632 or (888) 575-2327 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: www.cmspcounties.org

Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at www.pparx.org.

Other Antiviral Agents

Amantadine	SYMMETREL
Acyclovir Oral	ZOVIRAX ORAL
Oseltamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
Rimantadine	FLUMADINE

	Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS
	Valacyclovir	VALTREX
SE	Famciclovir	FAMVIR, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS

Leprostatic Agents

	Clofazimine	LAMPRENE
	Dapsone	DAPSONE; ACZONE NON-FORMULARY

ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

	Altretamine	HEXALEN
	Anastrozole	ARIMIDEX
	Bexarotene	TARGRETIN
	Bicalutamide	CASODEX
	Busulfan	MYLERAN
	Capecitabine	XELODA
	Chlorambucil	LEUKERAN
	Cyclophosphamide	CYTOXAN
	Estramustine	EMCYT
	Etoposide	VEPESID
	Flutamide	EULEXIN
	Hydroxyurea	HYDREA
PA	Imatinib	GLEEVEC, PA REQ
	Letrozole	FEMARA
	Levamisole	ERGAMISOL
	Lomustine	CEENU
	Megestrol	MEGACE
	Melphalan	ALKERAN
	Mercaptopurine	PURINETHOL
	Methotrexate	RHEUMATREX
	Mitotane	LYSODREN
	Nilutamide	NILANDRON
	Procarbazine	MATULANE
	Tamoxifen Citrate	NOLVADEX
	Testolactone	TESLAC
	Thioguanine	THIOGUANINE
	Tretinoin	VESANOID

Blood Colony Stimulating Factors

PA	Darbepoetin	ARANESP, PA REQ
PA	Erythropoietin	EPOGEN, PA REQ
PA		PROCRIT, PA REQ
PA	Filgrastim	NEUPOGEN, PA REQ
PA	Oprelvekin	NEUMEGA, PA REQ
PA	Pegfilgrastim	NEULASTA, PA REQ
PA	Sargramostim	LEUKINE, PA REQ

Multiple Sclerosis Agents

PA	Glatiramer	COPAXONE, PA REQ
PA	Interferon Beta 1a	AVONEX, PA REQ
PA		REBIF, PA REQ
PA	Interferon Beta 1b	BETASERON, PA REQ

Miscellaneous Agents

PA	Adalimumab	HUMIRA, PA REQ
PA	Anakinra	KINERET, PA REQ
PA	Etanercept	ENBREL, PA REQ
PA	Interferon Alfa 2a	ROFERON A, PA REQ
PA	Interferon Alfa 2b	INTRON A, PA REQ
PA	Interferon Alfa N3	ALFERON N, PA REQ
PA	Interferon Alfacon 1	INFERGEN, PA REQ
PA	Interferon Gamma 1b	ACTIMMUNE, PA REQ
PA	Leuprolide	LUPRON, PA REQ

Immunosuppressant Agents

Azathioprine	IMURAN; AZASAN NON-FORMULARY
Cyclosporine	NEORAL
	SANDIMMUNE
Leucovorin	WELLCOVORIN
Mycophenolate Mofetil	CELLCEPT ; MYFORTIC NON-FORMULARY
Sirolimus	RAPAMUNE
Tacrolimus (Oral only)	PROGRAF

RESPIRATORY/EENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

Chlorpheniramine	CHLORTRIMETON
Dexchlorpheniramine	POLARAMINE

Single Entity Ethanolamine Agents

Cyproheptadine	PERIACTIN
Diphenhydramine	BENADRYL

Non-Sedating Single Entity Agents

Cetirizine, OTC	CETIRIZINE, OTC
Fexofenadine	FEXOFENADINE
Loratadine, OTC	LORATADINE, OTC

Miscellaneous Antihistamine Agents

Hydroxyzine	ATARAX
Hydroxyzine Pamoate	VISTARIL
Promethazine	PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

Bromphen/Pseudoephedrine	BROMFED
	BROMFED PD
Guaifenesin/Pseudoephedrine	GUAIFED-PD
Pseudoephedrine/Chlorpheniramine	DECONAMINE SR

Antitussive Agents

Non-Narcotic Antitussive Agents

Benzonatate	TESSALON
Dextromethorphan	TUSSIN PEDIATRIC
Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

Narcotic Antitussive Agents

Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
Guaifenesin/Codeine	ROBITUSSIN A-C
Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT
	ROBITUSSIN DAC
Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC
Promethazine/Codeine	ENDAL-HD
Promethazine/Phenylephrine/Codeine	PHENERGAN/CODEINE
Terpin Hydrate/Codeine	PHENERGAN VC/CODEINE
Tripolidine/Pseudoephedrine/Codeine	TERPIN HYDRATE/CODEINE
	ACTIFED/CODEINE

Decongestants

Pseudoephedrine	SUDAFED
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Asthma/COPD Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.
QL	Albuterol/Ipratropium	COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
QL	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	Ipratropium	ATROVENT HFA
QL	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH
QL	Salmeterol	MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
SE, QL	Mometasone/Formoterol	SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	Salmeterol/Fluticasone	DULERA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA), ANTICHOLINERGIC, OR ANTICHOLINERGIC/LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
		ADVAIR DISKUS 250/50 STRENGTH ONLY, STEP THERAPY , RESTRICTED TO COPD AFTER A TRIAL ANTICHOLINERGIC OR LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH

Oral Sympathomimetic (Adrenergic) Agents

Albuterol	PROVENTIL
Albuterol E.R.	PROVENTIL REPETABS
	VOLMAX
Metaproterenol Oral	ALUPENT
Terbutaline Sulfate	BRETHINE
	BRICANYL

Inhaled Oral Corticosteroid Agents

QL	Beclomethasone Inhaler	QVAR REDHALER, LIMITED TO #2 INHALERS/MONTH
QL	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH

Leukotriene Receptor Antagonists

QL	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
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Respiratory Smooth Muscle Relaxant Agents

Aminophylline 150mg/5ml	
Aminophylline Suppositories	
Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80

Theophylline
Theophylline, Sustained Release

SLO-PHYLLIN
THEO-DUR, SLO-BID, UNIPHYL

Cystic Fibrosis Therapy

Cystic Fibrosis therapy (Orkambi, Kalydeco) otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (800) 639-0597 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.

Expectorant Agents

Guaifenesin	ROBITUSSIN
Guaifenesin/Dextromethorphan	ROBITUSSIN DM
Guaifenesin/Phenylephrine	ENDAL
Guaifenesin/Pseudoephedrine	ZEPHREX LA
Phenylephrine/Promethazine	PHENERGAN VC
Phenylephrine/Guaifenesin	RESCON GC
Potassium Iodide	SSKI

Mucolytic Agents

Acetylcysteine	MUCOMYST
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Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

Bacitracin	BACITRACIN
Dexamethasone/Polymyxin/Neomycin	MAXITROL
Erythromycin Base	ILOTYCIN
Gentamicin	GARAMYCIN
Gentamicin/Prednisolone	PRED-G
Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
Ofloxacin	OCUFLOX
Polymixin B Sulfate/TMP	POLYTRIM
Tobramycin	TOBREX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

Fluorometholone	EFLONE
	FML
	FML FORTE
Prednisolone Acetate	PRED MILD OPHTHALMIC
	PRED FORTE
Prednisolone Phosphate	INFLAMASE
	INFLAMASE FORTE

Ophthalmic Anti-Inflammatory Agents, NSAIDs

Flurbiprofen Sodium	OCUFEN
Diclofenac Sodium	VOLTAREN
Ketorolac Tromethamine	ACULAR

Ophthalmic Antiviral Agents

Trifluridine Ophthalmic Solution	VIROPTIC
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Ophthalmic Beta Blockers

Levobunolol	BETAGAN
Timolol	TIMOPTIC

Ophthalmic Miotic Agents

Brimonidine

Dorzolamide

Dorzolamide/Timolol

Echothiophate Iodide

Pilocarpine

ALPHAGAN

ALPHAGAN P

TRUSOPT

COSOPT

PHOSPHOLINE IODIDE

PILOCAR

OCUSERT NOT COVERED

Ophthalmic Mydriatic Agents

Atropine Sulfate

Dipivefrin

Tropicamide

ISOPTO ATROPINE

PROPINE

MYDRIACYL

Ophthalmic Sulfonamide Agents

Sulfacetamide

Sulfacetamide 10%/Prednisolone 0.2%

Sulfacetamide 10%/Prednisolone 0.5%

BLEPH-10

SODIUM SULAMYD

BLEPHAMIDE

METIMYD

Miscellaneous Ophthalmic Agents

Ketotifen

Latanoprost

Naphazoline

Naphazoline/Pheniramine

ZADITOR OTC, ALAWAY

XALATAN

ALBALON

NAPHCON-A

Otic Anti-Infective Agents

Acetic Acid

Acetic Acid 2%

Acetic Acid 2%/Hydrocortisone 1%

Hydrocortisone/Neomycin/Polymyxin

Ofloxacin

VOSOL

DOMEBORO

VOSOL HC

CORTISPORIN

FLOXIN OTIC

Miscellaneous Otic Agents

Benzocaine/Antipyrine

Carbamide Peroxide/Glycerin

AURALGAN

DEBROX

Inhaled/Oral EENT Agents

Inhaled Nasal Agents

Fluticasone, Nasal

Triamcinolone, Nasal

Ipratropium, Nasal

QL

FLONASE

NASACORT

ATROVENT, LIMITED TO #2 DEVICES/MONTH

Carbonic Anhydrase Inhibitor Agents

Acetazolamide

Acetazolamide SA

Methazolamide

DIAMOX

DIAMOX SEQUELS

NEPTAZANE

Local Anesthetic Agents

Benzocaine/Antipyrine Otic

Lidocaine Solution

Lidocaine, Viscous

Triamcinolone 0.1% in Orabase

AURALGAN

XYLOCAINE

VISCOUS XYLOCAINE

KENALOG IN ORABASE

Miscellaneous EENT Agents

Carbachol

Chlorhexidine Gluconate

Cromolyn Ophthalmic Solution

Epinephrine Injection

Optichamber

Sodium Chloride for Inhalation

Triethanolamine

QL

ISOPTO CARBACHOL

PERIDEX

CROLOM

EPIPEN

OPTICHAMBER, LIMITED TO #2/YEAR

GENERIC

CERUMENEX

DIABETES AND THYROID AGENTS

Oral Diabetes Agents

Sulfonylureas

Glipizide	GLUCOTROL
Glipizide L.A.	GLUCOTROL XL
Glyburide	DIABETA, GLYNASE
	MICRONASE
Glimepiride	AMARYL
Chlorpropamide	DIABINESE
Tolazamide	TOLINASE
Tolbutamide	ORINASE

Non-Sulfonylureas

	Acarbose	PRECOSE
	Metformin	GLUCOPHAGE
	Metformin ER	GLUCOPHAGE XR
SE, QL	Pioglitazone	ACTOS
	Alogliptin	NESINA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH
SE, QL	Sitagliptin	JANUVIA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

Combination Diabetes Agents

	Glipizide/Metformin	METAGLIP
SE, QL	Glyburide/Metformin	GLUCOVANCE
	Alogliptin/Metformin	KAZANO, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR ALOGLIPTIN IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin	JANUMET, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin Extended Release	JANUMET XR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH

Insulin Agents

Insulin	ALL LILLY INSULINS, VIALS ONLY
Insulin Lispro	HUMALOG, HUMALOG MIX, VIALS AND PENS
Insulin Glargine	LANTUS, VIALS ONLY

Miscellaneous Diabetes Agents

Glucagon	GLUCAGON
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Thyroid Agents

Levothyroxine	LEVOTHROID
Liotrix	THYROLAR
Liothyronine	CYTOMEL
Thyroid, Desiccated	ARMOUR THYROID
	LEVOXYL

Antithyroid Agents

Methimazole
Propylthiouracil

SYNTHROID

TAPAZOLE
PROPYLTHIOURACIL

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

Cortisone Acetate
Dexamethasone
Fludrocortisone Acetate
Hydrocortisone Oral
Methylprednisolone
Prednisone

CORTONE
DECADRON
FLORINEF
CORTEF
MEDROL
DELTASONE
ORASONE
MEDROL DOSEPAK
PEDIAPRED
PRELONE

Prednisolone

Androgen Agents

Danazol
Fluoxymesterone
Methyltestosterone

DANOCRINE
HALOTESTIN
ANDROID
METANDREN

Bone Resorption Inhibitors

QL Alendronate

FOSAMAX,
70MG AND 35MG LIMITED TO #4/MONTH;
5MG, 10MG, AND 40MG LIMITED TO #30/MONTH;
SOLUTION LIMITED TO #300ML/MONTH
FOSAMAX PLUS D NONFORMULARY
MIACALCIN NS, **PA REQ**

PA Calcitonin

Parathyroid Hormone

PA, QL Teriparatide

FORTEO, **PA REQ**, LIMITED TO 1 PEN/MONTH

Estrogen Agents

Conjugated Estrogens
Conjugated Estrogens, Vaginal
Estradiol
Estradiol Patches

PREMARIN
PREMARIN VAGINAL CREAM
ESTRACE
ALORA
CLIMARA
ESTRADERM
VIVELLE
VIVELLE DOT
PREMPRO, PREMPRO LOW DOSE
PREMPHASE

Estrogen/Medroxyprogesterone

ESTRATEST, ESTRATEST HS
ESTRING, **STEP THERAPY**, RESTRICTED TO USE AFTER A
TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

SE

Esterified Estrogens/ Methyltestosterone
Estradiol/Vaginal Ring

Estrogen Agonist-Antagonists

Raloxifene

EVISTA

Oral Contraceptive Agents

CMSP requires evidence of Family PACT ineligibility for contraceptive coverage. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to MedImpact for contraceptive coverage. This form can be obtained on the CMSP website: www.cmspcounties.org.

Oxytocic Agents

Ergonovine Maleate	ERGOTRATE
Methylergonovine Maleate	METHERGINE

Pituitary Agents

Desmopressin	DDAVP
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Progestin Agents

Medroxyprogesterone	CYCRIN
	PROVERA
Norethindrone Acetate	AYGESTIN
	NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

Meth/Me Blue/PA/Salol/ATP/Hyos Nitrofurantoin (Tablets, Suspension Only)	URISED FURADANTIN
Trimethoprim	TRIMPEX

Urinary Anti-Spasmodic Agents

Pentosan	ELMIRON
Phenazopyridine	PYRIDIUM

Genitourinary Smooth Muscle Relaxant Agents

	Belladonna/Methylene Blue Oxybutynin	URISED DITROPAN DITROPAN XL NOT COVERED
ST, QL	Tolterodine	DETROL, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS
ST, QL		DETROL LA, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS

Parasympathomimetic (Cholinergic) Agents

Bethanechol	URECHOLINE
Neostigmine	PROSTIGMIN
Pyridostigmine	MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

Anthralin	DRITHOCREME
Podofilox	DRITHO-SCALP CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

Aluminum Acetate	BURROWS SOLUTION
Aluminum Chloride Hexahydrate	DRYSOL
Benzoyl Peroxide, OTC Generic	BENZOYL PEROXIDE, OTC GENERIC
Calamine	CALAMINE LOTION
Calcipotriene	DOVONEX
Fluorouracil	EFUDEX
Hydrocortisone 1% Rectal	PROCTOCORT
Masoprocol	ACTINEX
PA Becaplermin	REGRANEX, PA REQ
PA Isotretinoin	ACUTANE, PA REQ

Topical Antibiotic Agents

Bacitracin	BACITRACIN
Bacitracin/Polymixin/Neomycin	NEOSPORIN
Clindamycin Solution	CLEOCINT
Erythromycin Topical	ERYGEL EMGEL
Erythromycin/Benzoyl Peroxide	T-STAT
Gentamicin Sulfate	BENZAMYCIN
Mupirocin	GARAMYCIN
Silver Sulfadiazine	BACTROBAN SILVADENE

Topical Antifungal Agents

Clotrimazole	LOTTRIMIN
Clotrimazole/Betamethasone	LOTTRISONE
Ciclopirox	LOPROX
Ketoconazole	NIZORAL
Miconazole Nitrate	MONISTAT-DERM
Nystatin	MYCOSTATIN
Terbinafine	LAMISIL
Tolnaftate	TINACTIN
Triamcinolone/Nystatin	MYCOLOG II

Vaginal Antifungal Agents

Butoconazole	FEMSTAT
Clotrimazole Cream/Vaginal Tablets	MYCELEX MYCELEX G
Nystatin	MYCOSTATIN
Miconazole Cream/Vaginal Tablets	MONISTAT MONISTAT 3
Triple Sulfa Cream	SULTRIN
Tioconazole	VAGISTAT-1

Vaginal Anti-Infective Agents

Metronidazole

METROGEL-VAGINAL

Topical Contraceptive Agents

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Topical Anti-Inflammatory Agents

LOW POTENCY

Fluocinolone 0.025%

Desonide

Hydrocortisone

Hydrocortisone Enema

Hydrocortisone Acetate

Hydrocortisone/Pramoxine

MEDIUM POTENCY

Betamethasone Dipropionate

Betamethasone Valerate 0.01%

Betamethasone Valerate 0.1%

Desoximetasone Cream/Gel 0.05%

Flurandrenolide

Hydrocortisone Valerate

Mometasone Furoate Cream

Triamcinolone

HIGH POTENCY

Betamethasone Dipropionate

Desoximetasone 0.25%

Fluocinonide

Fluocinolone Acetonide 0.2%

VERY HIGH POTENCY

Augmented Betamethasone

Dipropionate

Clobetasol Cream, Gel, Solution,

Ointment

Diflorasone Diacetate

SYNALAR

TRIDESILON

HYTONE

CORTENEMA

CORTIFOAM

PROCTOCREAM-HC

DIPROSONE

MAXIVATE

VALISONE REDUCED STRENGTH

VALISONE

TOPICORT LP

CORDRAN

WESTCORT

ELOCON

ARISTOCORT

ARISTOCORT A NOT COVERED

KENALOG

DIPROLENE

TOPICORT

LIDEX

LIDEX E

SYNALAR

DIPROLENE AF

TEMOVATE

FLORONE

FLORONE-E

PSORCON

Topical Antipruritic and Local Anesthetic Agents

Lidocaine (Viscous and Spray Only)

Pramoxine/Hydrocortisone

Pramoxine

Pimecrolimus

Tacrolimus

XYLOCAINE

PROCTOFOAM HC

EPIFOAM

ELIDEL, **PA REQ**

PROTOPIC, **PA REQ**

PA

PA

Topical Antiviral Agents

Acyclovir Topical

ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents

Selenium Sulfide 2.5%

EXSEL

SELSUN

Sulfacetamide Lotion

SEBIZON

Scabicide/Pediculicide Agents

Crotamiton

EURAX

Malathion

OVIDE

Permethrin

ELIMITE

NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

Calcium Acetate

PHOS LO

Calcium Carbonate

TUMS

Magnesium Oxide, OTC Generic

MAGNESIUM OXIDE, OTC GENERIC

Potassium Agents

Potassium Chloride 8mEq

Potassium Chloride

MICRO-K

Potassium Chloride 10mEq

Potassium Chloride

KAON-CL 10

K-DUR

MICRO-K 10

Potassium Chloride 20mEq

Potassium Chloride

K-DUR

<i>Potassium Chloride Effervescent Tablets</i>	
Potassium Chloride Tablets	K-LYTE
Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>	
Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>	
Potassium Chloride Liquid	KAON-CL
<i>Potassium-Removing Resins</i>	
Sodium Polystyrene Sulfonate	KAYEXALATE

Heavy Metal Antagonist Agents

Penicillamine	CUPRIMINE
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Vitamin Agents

Vitamin B-Complex Agents

Cyanocobalamin	VITAMIN B ₁₂ (ORAL FORMULATIONS ONLY)
Folic Acid	FOLIC ACID
Niacin	NIACIN
Pyridoxine	VITAMIN B ₆
Thiamine	VITAMIN B ₁

Vitamin D

Calcitriol	ROCALTROL
Ergocalciferol	DRISDOL

Vitamin K Activity Agents

Phytonadione	MEPHYTON
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Iron Agents

Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL
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Diagnostic Testing

Blood Glucose Supplies

QL	Alcohol Swabs	LIMITED TO 200/MONTH
	Blood Glucose Monitoring Control Solution	BLOOD GLUCOSE MONITORING CONTROL SOLUTION, ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY
QL	Blood Glucose Test Strips	BLOOD GLUCOSE TEST STRIPS, ROCHE STRIPS (E.G., ACCU-CHEK) ONLY , LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS. MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH. LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION
	Glucometers	GLUCOMETERS, ROCHE METERS (E.G., ACCU-CHEK) ONLY
	Lancets	

Alcohol And Smoking Deterrent Agents

PA	Bupropion SR	ZYBAN, PA REQ
	Disulfiram	ANTABUSE
PA	Nicotine	NICORETTE GUM, PA REQ
PA		NICOTINE PATCH, PA REQ (OTC PATCHES ONLY)
PA		NICOTROL NASAL SPRAY, PA REQ

Gout Agents

Allopurinol	ZYLOPRIM
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QL	Colchicine	COLCRYS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1 TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.
	Probenecid	BENEMID

Other Medical Supplies

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. CMSP does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms) unless the member is ineligible for Family PACT. Call Family PACT (800) 942-1054. If ineligible, call MedImpact at (800) 788-2949.

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