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:

<table>
<thead>
<tr>
<th>CMSP Primary Care Benefit</th>
<th>CMSP Standard Benefit</th>
<th>CMSP Emergency Services Only Benefit</th>
</tr>
</thead>
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<tr>
<td>When to use the benefit</td>
<td>• Primary benefit for CMSP Aid Codes 89 and 50</td>
<td>• Primary benefit for CMSP Aid Code 88&lt;br&gt; • Secondary benefit for CMSP Aid Code 89.&lt;br&gt; • 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).</td>
</tr>
<tr>
<td>Patient out-of-pocket cost</td>
<td>• $5 copayment per prescription&lt;br&gt; • No monthly share of cost requirement</td>
<td>• Monthly share of cost must be met before prescription coverage&lt;br&gt; • No copayment per prescription</td>
</tr>
<tr>
<td>Benefit maximums</td>
<td>• $500 per prescription claim&lt;br&gt; • $1500 maximum benefit per CMSP-PCB enrollment period</td>
<td>None</td>
</tr>
<tr>
<td>Drug exclusions</td>
<td>• Specialty drugs excluded.&lt;br&gt; • See “Prescription Coverage of Select Drug Classes” section of the CMSP Primary Care Benefit formulary for additional information about excluded drugs.</td>
<td>• Specialty drugs generally covered. See “Prescription Coverage of Select Drug Classes” section of the CMSP Standard Benefit formulary for additional information about excluded drugs.</td>
</tr>
</tbody>
</table>

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 CMS 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 inquiries 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

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>CMSP Primary Care Benefit</th>
<th>CMSP Standard Benefit Coverage</th>
</tr>
</thead>
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<tr>
<td>HIV Antiretroviral Agents</td>
<td>Antiretroviral drugs are excluded under the CMSP Primary Care Benefit.</td>
<td>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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>. 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 <a href="http://www.pparx.org">www.pparx.org</a>.</td>
</tr>
<tr>
<td></td>
<td>For patients who also have the CMSP Standard Benefit: 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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>. 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 <a href="http://www.pparx.org">www.pparx.org</a>.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For patients who also have the CMSP Emergency Services Only Benefit: This benefit only provides coverage of covered prescriptions following an emergency medical service once the monthly share of cost is met. The benefit is not covered unless the member is ineligible 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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>. 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 <a href="http://www.pparx.org">www.pparx.org</a>.</td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Contraceptives are excluded under the CMSP Primary Care Benefit.</td>
<td>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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>. 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 <a href="http://www.pparx.org">www.pparx.org</a>.</td>
</tr>
<tr>
<td></td>
<td>For patients who also have the CMSP Standard Benefit: 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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>. 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 <a href="http://www.pparx.org">www.pparx.org</a>.</td>
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<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Specialty drugs are excluded under the CMSP Primary Care Benefit.</td>
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</tr>
<tr>
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<td>------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Cystic Fibrosis Agents: Kalydeco, Orkambi, Symdeko</strong></td>
<td>For patients who also have the CMSP Standard Benefit: 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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>.</td>
<td>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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>.</td>
</tr>
<tr>
<td><strong>Hemophilia Agents</strong></td>
<td>For patients who also have the CMSP Standard Benefit: 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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>.</td>
<td>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: <a href="http://www.cmspcounties.org">www.cmspcounties.org</a>.</td>
</tr>
<tr>
<td><strong>Hepatitis C: Ribavirin and Pegylated Interferons</strong></td>
<td>For patients who also have the CMSP Standard Benefit: 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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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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- Etodolac
- Ibuprofen
- Indomethacin
- Ketoprofen
- Indomethacin, Sustained Release
- Meloxicam Tablets
- Nabumetone
- Naproxen
- Naproxen Sodium
- Salsalate
- Sulindac
- Piroxicam

SECOND LINE AGENTS

- Etodolac Extended Release

Miscellaneous Arthritis Agents

Leflunomide

Migraine Agents

- APAP/Dichloralphenazone/Isomethep
- Butalbital/APAP/Caffeine
- Butalbital/Aspirin/Caffeine (Tablets Only)
- Ergotamine/Caffeine
- Naratriptan
- Rizatriptan
- Sumatriptan
- Eletriptan
- Zolmitriptan

Opiate Agonists

Dihydroergotamine
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 Acetaminophen/Hydrocodone NORCO 7.5/325, LIMITED TO #180/MONTH
QL Acetaminophen/Hydrocodone 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 EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL Hydromorphone DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL Morphine MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL Morphine SR OXYCONTIN, PA REQ, LIMITED TO #60/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 Oxycodone TYLOX, LIMITED TO #240/MONTH
QL Oxycodone/Percodan OXYCONTIN, PA REQ, LIMITED TO #240/MONTH
PA, QL Oxycodone

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
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 MYSONE

Benzodiazepine Anticonvulsants
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 NEUROTIN
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
Antiparkinsonian Agents

- Amantadine
- Benztropine Mesylate
- Bromocriptine
- Carbidopa/Levodopa
- Carbidopa/Levodopa CR
- Pramipexole
- Ropinirole
- Selegiline
- Trihexyphenidyl

Muscle Relaxant Agents

Skeletal Muscle Relaxants

- Baclofen
- Carisoprodol
- Chlorzoxazone
- Cyclobenzaprine
- Dantrolene Sodium
- Methocarbamol
- Orphenadrine Citrate
- Orphenadrine/Aspirin/Caffeine

Psychotherapeutic Agents

Tricyclic Antidepressant Agents

- Amitriptyline
- Amoxapine
- Desipramine
- Doxepin
- Imipramine
- Maprotiline
- Nortriptyline
- Protriptyline

S.S.R.I. Agents

- Citalopram
- Fluoxetine Capsules
- Fluvoxamine
- Paroxetine
- Sertraline

S.N.R.I. Agents

- Duloxetine
- Venlafaxine
- Venlafaxine Extended Release

M.A.O. Inhibitor Agents

- Phenelzine
- Tranylcypromine

Miscellaneous Antidepressant Agents

- QL Topiramate

TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS

SYMMETREL

COGENTIN

PARLODEL

SINEMET; PARCOPA NON-FORMULARY

SINEMET CR

MIRAPEX

REQUIP; REQUIP XL NON-FORMULARY

SELEGILINE, ZELAPAR AND EMSAM NON-FORMULARY

ARTANE

LIORESAL

SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY

PARAFON DSC

FLEXERIL

DANTRIUM

ROBAXIN

NORFLEX

NORGESIC

ELAVIL

ASENDIN

NORPRAMIN

SINEQUAN

TOFRANIL, TOFRANIL PM NON-FORMULARY

LUDIOMIL

PAMELOR

VIVACTIL

CELEXA

PROZAC CAPSULES (10MG, 20MG ONLY), TABLETS NON-FORMULARY

LUVOX

PAXIL

ZOLOFT

CYMBALTA, LIMITED TO #60/MONTH

EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY

EFFEXOR XR, LIMITED TO #30/MONTH VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY

NARDIL

PARNATE
Bupropion WELLBUTRIN, APLENZIN NON-FORMULARY
Bupropion SR WELLBUTRIN SR, APLENZIN NON-FORMULARY
Bupropion XL WELLBUTRIN XL, APLENZIN NON-FORMULARY
Clomipramine ANAFRANIL
Mirtazapine REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
Trazodone DESYREL
MD, QL
Nefazodone SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH

**Antimanic Agents**
Lithium Carbonate ESKALITH

**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 DISCMELTS NON-FORMULARY
QL Chlorpromazine THORAZINE
QL Clozapine CLOZARIL
QL Fluphenazine PROLIXIN
QL Haloperidol HALDOL, HALDOL DECANOATE-VIALS ONLY
QL Loxapine LOXITANE
QL Molindone MOBAN
QL Olanzapine ZYPREXA, LIMITED TO #60/MONTH
QL Quetiapine ZYPREXA ZYDIS, LIMITED TO #60/MONTH
QL Risperidone RISPERDAL, LIMITED TO #60/MONTH
QL Thioridazine MELLARIL
QL Thiothixene NAVANE
QL 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
Chloral Hydrate 7.5MG STRENGTH NON-FORMULARY
Hydroxyzine NOCTEC

16
Hydroxyzine Pamoate
Promethazine QL
Zolpidem

VISTARIL
PHENERGAN
AMBEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY

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
Procainamide 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

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

Angiotensin Converting Enzyme Inhibitor Agents
Benazepril LOTENSIN
Captopril CAPOTEN
Enalapril VASOTEC
Lisinopril PRINIVIL

Angiotensin Receptor Blocker Agents
Irbesartan AVAPRO
Losartan COZAAR
Telmisartan MICARDIS
Olmesartan

SE, QL 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 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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amlodipine</td>
<td>NORVASC, LIMITED TO #30/MONTH</td>
</tr>
<tr>
<td>Diltiazem</td>
<td>CARDIZEM</td>
</tr>
<tr>
<td>Diltiazem SR</td>
<td>CARDIZEM SR; CARDIZEM LA NON-FORMULARY</td>
</tr>
<tr>
<td>Diltiazem CD</td>
<td>CARTIA XT</td>
</tr>
<tr>
<td>Felodipine</td>
<td>PLENDIL, LIMITED TO #30/MONTH</td>
</tr>
<tr>
<td>Nifedipine, Sustained Release</td>
<td>ADALAT CC</td>
</tr>
<tr>
<td>Verapamil</td>
<td>CALAN</td>
</tr>
<tr>
<td>Verapamil LA Tablets</td>
<td>CALAN SR; COVERA-HS NON-FORMULARY</td>
</tr>
<tr>
<td>Verapamil SR Capsules</td>
<td>VERELAN</td>
</tr>
</tbody>
</table>

### Centrally Acting Antihypertensive Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine</td>
<td>CATAPRES</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>TENEX</td>
</tr>
<tr>
<td>Methylidopa</td>
<td>ALDOMET</td>
</tr>
</tbody>
</table>

### Combination Antihypertensive Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atenolol/Chlorthalidone</td>
<td>TENORETIC</td>
</tr>
<tr>
<td>Benazepril/HCTZ</td>
<td>LOTENSIN HCT</td>
</tr>
<tr>
<td>Bisoprolol/HCTZ</td>
<td>ZIAC</td>
</tr>
<tr>
<td>Captopril/HCTZ</td>
<td>CAPOZIDE</td>
</tr>
<tr>
<td>Enalapril/HCTZ</td>
<td>VASORETIC</td>
</tr>
<tr>
<td>Lisinopril/HCTZ</td>
<td>ZESTORETIC</td>
</tr>
<tr>
<td>Losartan/HCTZ</td>
<td>HYZAR,</td>
</tr>
<tr>
<td>Olmesartan/HCTZ</td>
<td>BENICAR HCT, STEP THERAPY, LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS</td>
</tr>
<tr>
<td>Valsartan/HCTZ</td>
<td>DIOVAN HCT, STEP THERAPY, LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS</td>
</tr>
</tbody>
</table>

### Potassium-Sparing Diuretics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spironolactone</td>
<td>ALDACTONE</td>
</tr>
<tr>
<td>Spironolactone/HCTZ</td>
<td>ALDACTAZIDE</td>
</tr>
<tr>
<td>Triamterene</td>
<td>DYRENIUM</td>
</tr>
<tr>
<td>Triamterene 37.5mg/HCTZ 25mg</td>
<td>DYAZIDE</td>
</tr>
<tr>
<td>Triamterene 75mg/HCTZ 50mg</td>
<td>MAXZIDE 50</td>
</tr>
</tbody>
</table>

### Loop Diuretics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bumetanide</td>
<td>BUMEX</td>
</tr>
<tr>
<td>Furosemide</td>
<td>LASIX</td>
</tr>
</tbody>
</table>

### Thiazide and Related Diuretics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorthalidone</td>
<td>HYGROTON</td>
</tr>
<tr>
<td>Hydrochlorothiazide (HCTZ)</td>
<td>HYDRODIURIL</td>
</tr>
<tr>
<td>Indapamide</td>
<td>LOZOL</td>
</tr>
<tr>
<td>Metolazone</td>
<td>ZAROXOLYN</td>
</tr>
</tbody>
</table>

### Vasodilator Antihypertensive Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxazosin Mesylate</td>
<td>CARDURA; CARDURAL XL NON-FORMULARY</td>
</tr>
<tr>
<td>Hydralazine</td>
<td>APRESOLINE</td>
</tr>
<tr>
<td>Minoxidil</td>
<td>LONITEN</td>
</tr>
<tr>
<td>Prazosin</td>
<td>MINIPRESS</td>
</tr>
<tr>
<td>Terazosin</td>
<td>HYTRIN</td>
</tr>
</tbody>
</table>
**Antilipemic Agents**

- Atorvastatin, Lipitor
- Cholestyramine/Aspartame, Questran Light
- Cholestyramine/Sucrose, Questran
- Gemfibrozil
- Lovastatin, Mevacor
- 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

**Cardiac Glycoside Agents**

- Digoxin, Lanoxin; Lanoxicaps non-formulary

**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 Dinitrate ER
- Nitroglycerin Ointment, Nitrol
- Nitroglycerin Patches, Nitro-Dur
- Nitroglycerin Spray, Nitrolingual Spray
- Nitroglycerin Sublingual, Nitrostat SL
- SE: Isosorbide Mononitrate, 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
- Bismuth Subsalicylate
- Diphenoxylate/Atropine
- Kaolin/Pectin
- Loperamide

**Antiemetic Agents**
- Meclizine
- Metoclopramide
- Ondansetron ODT Tablets
- Ondansetron Tablets
- Ondansetron Solution
- Prochlorperazine Maleate
- Promethazine
- Trimethobenzamide

**Antimuscarinic/Antispasmodic Agents**
- Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)
- Chlordiazepoxide/Clidinium
- Dicyclomine
- Hyoscyamine Sulfate

**Antulcer/Antipeptic Agents**
- Antacid Mg OH/Al OH
- Antacid Mg OH/Al OH/Simethicone
- Lansoprazole 15mg OTC
- Misoprostol
- Omeprazole 20mg and 40mg
- Omeprazole Magnesium
- Pantoprazole Tablets
- Simethicone
- Sucralfate

**Bowel Evacuant Agents**
- QL Bowel Evacuation Prep Kits
- QL Enema
Oral Colon Lavage Solution: COLYTE
Oral Saline Laxative: FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR

**Digestive Enzymes**
- Amylase/Lipase/Pro tease: PANCRELIPASE 5,000
- Amylase/Lipase/Pro tease: CREON
- Amylase/Lipase/Pro tease: PANCREAZ

**Gallstone Solubilizing Agents**
- Ursodiol: ACTIGALL

**Gastrointestinal Stimulant Agents**
- Metoclopramide: REGLAN

**H2 Antagonist Agents**
- Cimetidine: TAGAMET
- Famotidine: PEPCID
- Ranitidine: ZANTAC (TABLETS ONLY)

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

**Miscellaneous Gastrointestinal Supplies**
- Ostomy Supplies

**Miscellaneous Gastrointestinal Agents**
- Mesalamine: DELZICOL
- Olsalazine: ROWASA
- Sulfasalazine: DIPENTUM
- PA Budesonide: AZULFIDINE
- PA Budesonide: ENTOCORT EC, PA REQ

**ANTI-INFECTIVE AGENTS**

**Amebicides**
- Metronidazole: FLAGYL
- Iodoquinol (Diiodohydroxyquin): YODOXIN

**Antihelmintic Agents**
- Albendazole: ALBENZA
- Furazolidone: FUROXONE
- Mebendazole: VERMOX
- Praziquantel: BILTRICIDE
Antibiotic Agents

Aminoglycosides
Neomycin Sulfate

Cephalosporins
Cefaclor
Cefadroxil
Cefdinir
Cefixime
Cefuroxime Tablets
Cephalexin

QL

Cephalosporins
Cefadroxil
DURICEF
Cefdinir
OMNICEF

Macrolide Antibiotic Agents
Azithromycin
ERY-TAB
ERYPED SUSPENSION
ERYTHROCIN
EES
PEDIAZOLE

PA

Miscellaneous Antibiotic Agents
Clindamycin
CLEOCIN
Metronidazole
FLAGYL

Penicillins
Amoxicillin
AMOXIL
Amoxicillin/Potassium Clavulanate
TRIMOX
Ampicillin
PRINCIPEN
Dicloxacillin
DYNAPEX
Penicillin VK (125mg Tablets Not Covered)
PEN VK

Quinolones
Ciprofloxacin tablets
CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; CIPRO XR AND PROQUIN XR NON-FORMULARY

QL

Moxifloxacin
AVELOX, LIMITED TO 21-DAY SUPPLY

QL

Sulfonamide Agents
Erythromycin/Sulfisoxazole
PEDIAZOLE
Sulfamethoxazole/Trimethoprim
BACTRIM
(SEM/TMP)
SEPTRA
Sulfisoxazole
GANTRISIN
Sulfadiazine
SULFADIAZINE
Trimethoprim
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 Ultramicromized
Ketoconazole
Nystatin (Oral Powder Not Covered)
Terbinafine Tablets

**Antimalarial Agents**
Atovaquone/Proguanil
Chloroquine Phosphate
Hydroxychloroquine
Iodoquinol
Mefloquine
Primaquine
Pyrimethamine
Quinine (260mg Not Covered)

**Antituberculosis Agents**
Ethambutol
Isoniazid
Pyrazinamide
Rifabutin
Rifampin

**Anti-Ulcer Eradication Agents**
QL Amoxicillin/Clarithromycin/Lansoprazole
QL Tetracycline/Bismuth/Metronidazole

**Hepatitis C Antiviral Agents**
PA Ribavirin
PA Peginterferon Alfa 2b

The following Hepatitis C agents are not a covered benefit for CMSP members: Daklinza, Harvoni, Olysio, Sovaldi, Technivie, Zepetier, 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](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](http://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](http://www.pparx.org).

**Other Antiviral Agents**
Amantadine
Acyclovir Oral
Oseltamivir
Rimantadine

SYMMETREL
ZOVIRAX ORAL
TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
FLUMADINE
Zanamivir  
Valacyclovir  
Famciclovir  

RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS 

VALTREX  
FAMVIR, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS

**Leprostatic Agents**

Clofazimine  
Dapsone  

LAMPRENE  
DAPSONE; ACZONE NON-FORMULARY

**ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS**

**Antineoplastic Agents**

Altretamine  
Anastrozole  
Bexarotene  
Bicalutamide  
Busulfan  
Capecitabine  
Chlorambucil  
Cyclophosphamide  
Estramustine  
Etoposide  
Flutamide  
Hydroxyurea

**PA**

Imatinib  
Letrozole  
Levamisole  
Lomustine  
Megestrol  
Melphalan  
Mercaptopurine  
Methotrexate  
Mitotane  
Nilutamide  
Procarbazine  
Tamoxifen Citrate  
Testolactone  
Thioguanine  
Tretinoin

**Blood Colony Stimulating Factors**

**PA**

Darbepoetin  
Erythropoietin  
Filgrastim  
Oprelvekin  
Pegfilgrastim  
Sargramostim

ARANESP, PA REQ  
EPOGEN, PA REQ  
PROCRIT, PA REQ  
NEUPOGEN, PA REQ  
NEUMEGA, PA REQ  
NEULASTA, PA REQ  
LEUKINE, PA REQ
### Multiple Sclerosis Agents

| PA | Glatiramer | COPAXONE, PA REQ |
| PA | Interferon Beta 1a | AVONEX, 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 | ACTIMMUNE, PA REQ |
| PA | Leuprolide | LUPRON, PA REQ |

### Immunosuppressant Agents

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

### RESPIRATORY/EENT AGENTS

#### Antihistamine Agents

- **Single Entity Alkylamine Agents**
  - Chlorpheniramine
  - Dexchlorpheniramine

- **Single Entity Ethanolamine Agents**
  - Cyproheptadine
  - Diphenhydramine

- **Non-Sedating Single Entity Agents**
  - Cetirizine, OTC
  - Fexofenadine
  - Loratadine, OTC

- **Miscellaneous Antihistamine Agents**
  - Hydroxyzine
  - Hydroxyzine Pamoate
  - Promethazine

#### Antihistamine/Decongestant Combination Agents

- **Antihistamine/Decongestant Agents**
  - Bromphen/Pseudoephedrine
  - Guaifenesin/Pseudoephedrine
  - Pseudoephedrine/Chlorpheniramine
## Antitussive Agents

### Non-Narcotic Antitussive Agents
- Benzonatate: TESSALON
- Dextromethorphan: TUSSIN PEDIATRIC
- Promethazine/Dextromethorphan: PHENERGAN W/DEXTROMETHORPHAN

### Narcotic Antitussive Agents
- Codeine/Chlorpheniramine: NOVAHISTINE DH
- Guaifenesin/Codeine: ROBITUSSIN A-C
- Phenylephrine/Hydrocodone: HISTUSSIN HC
- Guaifenesin/Codeine/Pseudoephedrine: NOVAHISTINE EXPECTORANT
- Triprolidine/Pseudoephedrine/Codeine: ACTIFED/CODEINE

### Decongestants
- Pseudoephedrine: SUDAFED

## 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.
  - Albuterol/Ipratropium: COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
  - Formoterol: FORADIL, LIMITED TO #60/MONTH
  - Ipratropium: ATROVENT HFA
  - Pirbuterol Acetate: MAXAIR, LIMITED TO #2 INHALERS/MONTH
  - Salmeterol: SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
- **SE, QL**
  - Mometasone/Formoterol: 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
  - Salmeterol/Fluticasone: 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
- Metaproterenol Oral: ALUPENT
- Terbutaline Sulfate: BRETHINE
- Salmeterol: BRICANYL

### Inhaled Oral Corticosteroid Agents
- **QL**
  - Beclomethasone Inhaler: QVAR REDIHALER, LIMITED TO #2 INHALERS/MONTH
  - Mometasone Inhaler: ASMANEX, LIMITED TO #2 INHALERS/MONTH

### Leukotriene Receptor Antagonists
- **QL**
  - Montelukast: SINGULAIR, LIMITED TO #30/MONTH

### Respiratory Smooth Muscle Relaxant Agents
- Aminophylline 150mg/5ml
- Aminophylline Suppositories
- Theophylline, 80mg/15cc (Alcohol Free): SLO-PHYLLIN
Theophylline, Sustained Release

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
- Guaiifenesin
- Guaiifenesin/Dextromethorphan
- Guaiifenesin/Phenylephrine
- Guaiifenesin/Pseudoephedrine
- Phenylephrine/Promethazine
- Phenylephrine/Guaifenesin
- Potassium Iodide

Mucolytic Agents
- Acetylcysteine

Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents
- Bacitracin
- Dexamethasone/Polymyxin/Neomycin
- Erythromycin Base
- Gentamicin
- Gentamicin/Prednisolone
- Hydrocortisone/Neomycin/Polymyxin
- Neomycin/Gramicidin/Polymyxin
- Ofloxacin
- Polymyxin B Sulfate/TMP
- Tobramycin

Ophthalmic Anti-Inflammatory Agents, Corticosteroid
- Fluorometholone
- Prednisolone Acetate
- Prednisolone Phosphate

Ophthalmic Anti-Inflammatory Agents, NSAIDs
- Flurbiprofen Sodium
- Diclofenac Sodium
- Ketorolac Tromethamine

Ophthalmic Antiviral Agents
- Trifluridine Ophthalmic Solution

Ophthalmic Beta Blockers
- Levobunolol
- Timolol

Ophthalmic Miotic Agents
Brimonidine
Dorzolamide
Dorzolamide/Timolol
Echinothiopate Iodide
Pilocarpine

**Ophthalmic Mydriatic Agents**
Atropine Sulfate
Dipivefrin
Tropicamide

**Ophthalmic Sulfonamide Agents**
Sulfacetamide
Sulfacetamide 10%/Prednisolone 0.2%
Sulfacetamide 10%/Prednisolone 0.5%

**Miscellaneous Ophthalmic Agents**
Ketotifen
Latanoprost
Naphazoline
Naphazoline/Pheniramine

**Otic Anti-Infective Agents**
Acetic Acid
Acetic Acid 2%
Acetic Acid 2%/Hydrocortisone 1%
Hydrocortisone/Neomycin/Polymyxin
Oftoxacin

**Miscellaneous Otic Agents**
Benzocaine/Antipyrine
Carbamide Peroxide/Glycerin

**Inhaled/Oral EENT Agents**

**Inhaled Nasal Agents**
Fluticasone, Nasal
Triamcinolone, Nasal
Ipratropium, Nasal

**Carbonic Anhydrase Inhibitor Agents**
Acetazolamide
Acetazolamide SA
Methazolamide

**Local Anesthetic Agents**
Benzocaine/Antipyrine Otic
Lidocaine Solution
Lidocaine, Viscous
Triamcinolone 0.1% in Orabase

**Miscellaneous EENT Agents**
Carbachol
Chlorhexidine Gluconate
Cromolyn Ophthalmic Solution
Epinephrine Injection
Optichamber
Sodium Chloride for Inhalation
Triethanolamine

**Otic Anti-Infective Agents**
Acetic Acid
Acetic Acid 2%
Acetic Acid 2%/Hydrocortisone 1%
Hydrocortisone/Neomycin/Polymyxin
Oftoxacin

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Acetazolamide SA
Methazolamide

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Benzocaine/Antipyrine Otic
Lidocaine Solution
Lidocaine, Viscous
Triamcinolone 0.1% in Orabase

**Miscellaneous EENT Agents**
Carbachol
Chlorhexidine Gluconate
Cromolyn Ophthalmic Solution
Epinephrine Injection
Optichamber
Sodium Chloride for Inhalation
Triethanolamine
## DIABETES AND THYROID AGENTS

### Oral Diabetes Agents

#### Sulfonylureas

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glipizide</td>
<td>GLUCOTROL</td>
</tr>
<tr>
<td>Glipizide L.A.</td>
<td>GLUCOTROL XL</td>
</tr>
<tr>
<td>Glyburide</td>
<td>DIABETA, GLYNASE</td>
</tr>
<tr>
<td>Glimepiride</td>
<td>MICRONASE</td>
</tr>
<tr>
<td>Chlorpropamide</td>
<td>AMARYL</td>
</tr>
<tr>
<td>Tolazamide</td>
<td>DIABINESE</td>
</tr>
<tr>
<td>Tolbutamide</td>
<td>TOLINASE</td>
</tr>
</tbody>
</table>

#### Non-Sulfonylureas

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acarbose</td>
<td>PRECOSE</td>
</tr>
<tr>
<td>Metformin</td>
<td>GLUCOPHAGE</td>
</tr>
<tr>
<td>Metformin ER</td>
<td>GLUCOPHAGE XR</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>ACTOS</td>
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</table>

### Combination Diabetes Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glipizide/Metformin</td>
<td>METAGLIP</td>
</tr>
<tr>
<td>Glyburide/Metformin</td>
<td>GLUCOVANCE</td>
</tr>
<tr>
<td>Alogliptin/Metformin</td>
<td>KAZANO, STEP THERAPY, LIMITED TO 60 TABLETS/MONTH</td>
</tr>
<tr>
<td>SE, QL</td>
<td></td>
</tr>
<tr>
<td>Sitagliptin/Metformin</td>
<td>JANUMET, STEP THERAPY, LIMITED TO 60 TABLETS/MONTH</td>
</tr>
<tr>
<td>SE, QL</td>
<td></td>
</tr>
<tr>
<td>Sitagliptin/Metformin Extended Release</td>
<td>JANUMET XR, STEP THERAPY, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH</td>
</tr>
<tr>
<td>SE, QL</td>
<td></td>
</tr>
</tbody>
</table>

### Insulin Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>ALL LILLY INSULINS, VIALS ONLY</td>
</tr>
<tr>
<td>Insulin Lispro</td>
<td>HUMALOG, HUMALOG MIX, VIALS AND PENS</td>
</tr>
<tr>
<td>Insulin Glargine</td>
<td>LANTUS, VIALS ONLY</td>
</tr>
</tbody>
</table>

### Miscellaneous Diabetes Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucagon</td>
<td>GLUCAGON</td>
</tr>
</tbody>
</table>

### Thyroid Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levothyroxine</td>
<td>LEVOTHROID</td>
</tr>
<tr>
<td>Liotrix</td>
<td>THYROLAR</td>
</tr>
<tr>
<td>Liothyronine</td>
<td>CYTOMEL</td>
</tr>
<tr>
<td>Thyroid, Desiccated</td>
<td>ARMOUR THYROID</td>
</tr>
<tr>
<td></td>
<td>LEVOXYL</td>
</tr>
</tbody>
</table>
### HORMONE AGENTS

#### Oral Adrenal Corticosteroid Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cortisone Acetate</td>
<td>CORTONE</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>DECADRON</td>
</tr>
<tr>
<td>Fludrocortisone Acetate</td>
<td>FLORINEF</td>
</tr>
<tr>
<td>Hydrocortisone Oral</td>
<td>CORTEF</td>
</tr>
<tr>
<td>Methylprednisolone</td>
<td>DELTASONE</td>
</tr>
<tr>
<td>Prednisone</td>
<td>ORASONE</td>
</tr>
<tr>
<td>Prednisolone</td>
<td>MEDROL DOSEP</td>
</tr>
</tbody>
</table>

#### Androgen Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danazol</td>
<td>DANOCRINE</td>
</tr>
<tr>
<td>Fluoxymesterone</td>
<td>HALOTESTIN</td>
</tr>
<tr>
<td>Methyltestosterone</td>
<td>ANDROID</td>
</tr>
<tr>
<td></td>
<td>METANDREN</td>
</tr>
</tbody>
</table>

#### Bone Resorption Inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alendronate</td>
<td>FOSAMAX</td>
</tr>
<tr>
<td></td>
<td>70MG AND 35MG LIMITED TO #4/MONTH; 5MG, 10MG, AND 40MG LIMITED TO #30/MONTH; SOLUTION LIMITED TO #300ML/MONTH</td>
</tr>
<tr>
<td>Calcitonin</td>
<td>MIACALCIN NS, PA REQ</td>
</tr>
</tbody>
</table>

#### Parathyroid Hormone

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teriparatide</td>
<td>FORTEO, PA REQ, LIMITED TO 1 PEN/MONTH</td>
</tr>
</tbody>
</table>

#### Estrogen Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjugated Estrogens</td>
<td>PREMARIN</td>
</tr>
<tr>
<td>Conjugated Estrogens, Vaginal</td>
<td>PREMARIN VAGINAL CREAM</td>
</tr>
<tr>
<td>Estradiol</td>
<td>ESTRACE</td>
</tr>
<tr>
<td>Estradiol Patches</td>
<td>ALORA</td>
</tr>
<tr>
<td>Estradiol Patches</td>
<td>CLIMARA</td>
</tr>
<tr>
<td>Estradiol Patches</td>
<td>VIVELLE</td>
</tr>
<tr>
<td>Estradiol Patches</td>
<td>VIVELLE DOT</td>
</tr>
<tr>
<td>Estradiol/Vaginal Ring</td>
<td>ESTRING, STEP THERAPY, RESTRICTED TO USE AFTER A TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS</td>
</tr>
<tr>
<td>Esterified Estrogens/Methyltestosterone</td>
<td>ESTRATTEST, ESTRATTEST HS</td>
</tr>
</tbody>
</table>

#### Estrogen Agonist-Antagonists

<table>
<thead>
<tr>
<th>Drug</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raloxifene</td>
<td>EVISTA</td>
</tr>
</tbody>
</table>
**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
- Methylergonovine Maleate

**Pituitary Agents**
- Desmopressin

**Progestin Agents**
- Medroxyprogesterone
- Norethindrone Acetate

**GENITOURINARY AGENTS**

**Urinary Anti-Infective Agents**
- Meth/Me Blue/PA/Salol/ATP/Hyos
- Nitrofurantoin (Tablets, Suspension Only)
- Trimethoprim

**Urinary Anti-Spasmodic Agents**
- Pentosan
- Phenazopyridine

**Genitourinary Smooth Muscle Relaxant Agents**
- Belladonna/Methylene Blue
- Oxybutynin
- Tolterodine

**Parasympathomimetic (Cholinergic) Agents**
- Bethanechol
- Neostigmine
- Pyridostigmine
TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

Anthralin
Podofiloax

Miscellaneous Skin/Mucous Membrane Agents

Aluminum Acetate
Aluminum Chloride Hexahydrate
Benzoyl Peroxide, OTC Generic
Calamine
Calcipotriene
Fluorouracil
Hydrocortisone 1% Rectal
Masoprocol
PA Pacifier
PA Adhesive
PA Tape
PA Wipes
PA Alcohol Pads

Topical Antibiotic Agents

Bacitracin
Bacitracin/Polymixin/Neomycin
Clindamycin Solution
Erythromycin Topical
Erythromycin/Benzoyl Peroxide
Gentamicin Sulfate
Mupirocin
Silver Sulfadiazine

Topical Antifungal Agents

Clotrimazole
Clotrimazole/Betamethasone
Ciclopirox
Ketoconazole
Miconazole Nitrate
Nystatin
Terbinafine
Tolnaftate
Triamcinolone/Nystatin

Vaginal Antifungal Agents

Butoconazole
Clotrimazole Cream/Vaginal Tablets
Nystatin
Miconazole Cream/Vaginal Tablets
Triple Sufa Cream
Tioconazole
**Vaginal Anti-Infective Agents**

Metronidazole

**Topical 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.

**Topical Anti-Inflammatory Agents**

<table>
<thead>
<tr>
<th>LOW POTENCY</th>
<th>MEDIUM POTENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluocinolone 0.025%</td>
<td>SYNALAR</td>
</tr>
<tr>
<td>Desonide</td>
<td>TRIDESILON</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td>HYTONE</td>
</tr>
<tr>
<td>Hydrocortisone Enema</td>
<td>CORTENEMA</td>
</tr>
<tr>
<td>Hydrocortisone Acetate</td>
<td>CORTIFOAM</td>
</tr>
<tr>
<td>Hydrocortisone/Pramoxine</td>
<td>PROCTOCREAM-HC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOW POTENCY</th>
<th>MEDIUM POTENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betamethasone Dipropionate</td>
<td>DIPROSONE</td>
</tr>
<tr>
<td>Betamethasone Valerate 0.01%</td>
<td>MAXIVATE</td>
</tr>
<tr>
<td>Betamethasone Valerate 0.1%</td>
<td>VALISONE REDUCED STRENGTH</td>
</tr>
<tr>
<td>Desoximetasone Cream/Gel 0.05%</td>
<td>TOPICORT LP</td>
</tr>
<tr>
<td>Flurandrenolide</td>
<td>CORDRAN</td>
</tr>
<tr>
<td>Hydrocortisone Valerate</td>
<td>WESTCORT</td>
</tr>
<tr>
<td>Mometasone Furoate Cream</td>
<td>ELOCON</td>
</tr>
<tr>
<td>Triamcinolone</td>
<td>ARISTOCORT</td>
</tr>
<tr>
<td></td>
<td>ARISTOCORT A NOT COVERED</td>
</tr>
<tr>
<td></td>
<td>KENALOG</td>
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</table>

<table>
<thead>
<tr>
<th>HIGH POTENCY</th>
<th>VERY HIGH POTENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Betamethasone Dipropionate</td>
<td>DIPROLENE</td>
</tr>
<tr>
<td>Desoximetasone 0.25%</td>
<td>TOPICORT</td>
</tr>
<tr>
<td>Fluocinonide</td>
<td>LIDEX</td>
</tr>
<tr>
<td>Fluocinolone Acetonide 0.2%</td>
<td>LIDEX E</td>
</tr>
<tr>
<td></td>
<td>SYNALAR</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH POTENCY</th>
<th>VERY HIGH POTENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augmented Betamethasone Dipropionate</td>
<td>DIPROLENE AF</td>
</tr>
<tr>
<td></td>
<td>TEMOVATE</td>
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<table>
<thead>
<tr>
<th>TOPICAL ANTI-PRURITIC AND LOCAL ANESTHETIC AGENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lidocaine (Viscous and Spray Only)</td>
</tr>
<tr>
<td>Pramoxine/Hydrocortisone</td>
</tr>
<tr>
<td>Pramoxine</td>
</tr>
<tr>
<td>PA Pimecrolimus</td>
</tr>
<tr>
<td>PA Tacrolimus</td>
</tr>
</tbody>
</table>
Topical Antiviral Agents
Acyclovir Topical ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents
Selenium Sulfide 2.5% EXSEL
Sulfacetamide Lotion SELSUN 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 MICRO-K
Potassium Chloride
Potassium Chloride 10mEq KAON-CL 10 K-DUR MICRO-K 10
Potassium Chloride
Potassium Chloride 20mEq K-DUR
Potassium Chloride Effervescent Tablets
Potassium Chloride Tablets
Potassium Chloride Tablets
Potassium Chloride Powders
Potassium Chloride Powder
Potassium Chloride Liquids
Potassium Chloride Liquid
Potassium-Removing Resins
Sodium Polystyrene Sulfonate

Heavy Metal Antagonist Agents
Penicillamine

Vitamin Agents
Vitamin B-Complex Agents
Cyanocobalamin
Folic Acid
Niacin
Pyridoxine
Thiamine
Vitamin D
Calcitriol
Ergocalciferol
Vitamin K Activity Agents
Phytonadione
Iron Agents
Ferrous Sulfate (Tablets, Liquid, Drops)

Diagnostic Testing
Blood Glucose Supplies
QL
Alcohol Swabs
Blood Glucose Monitoring Control Solution
QL
Blood Glucose Test Strips

Alcohol And Smoking Deterrent Agents
PA
Bupropion SR
Disulfiram
Nicotine

Gout Agents
Allopurinol
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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