

# Oregon Rx Plus Pharmacy Benefit Guide

*For Oregon Groups and Individual Plan members*

1. Review your Supplemental Prescription Benefit Schedule and determine the copayment and/or coinsurance amounts that you could pay for medications on this plan. There are several different copayment and/or coinsurance options available, including three tiers, oral anticancer (AC) and a Specialty Pharmacy provision.

Effective 8/1/12, some plans will cover most female prescription contraceptives and other preventive medications, as recommended by the United States Preventive Services Task Force (USPSTF) and/or the Health Resources and Services Administration (HRSA) guidelines at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents<sup>1</sup> and Health Net's Preferred Drug List for coverage, cost-share and tier information.

2. Take a look at the following alphabetical list, called a Preferred Drug List or PDL, for any medications that you are currently taking. The tier (1, 2, 3, AC or SP) corresponds to the copayment and/or coinsurance that you will be responsible for. A lower tier generally indicates a lower copayment and/or coinsurance. For example, a Tier 1 drug would generally have the lowest plan copayment and/or coinsurance. Please take special note of any comments that accompany the medication.
3. If your medication is not on this list or there are comments that you do not understand, please call the Health Net Customer Contact Center at your earliest convenience at **1-888-802-7001** to help avoid interruption of a prescription. The representatives will answer your questions, suggest alternative medications if your drug is not on this list, or explain the steps you need to take if your drug requires prior authorization. Generally, drugs not listed are subject to your Tier 3 copayment and/or coinsurance, unless excluded by your pharmacy benefit.

### *Important pharmacy benefits tips*

- By using generic versions of most medications, you will generally save money and get an equivalent result. Ask your pharmacist, physician or a Health Net Pharmacy Services representative if you aren't sure if your drug has a generic version.
- In most cases, you must obtain the generic when it first becomes available or choose to pay a higher copayment and/or coinsurance for the brand-name drug.
- The PDL is updated quarterly. The latest version is always available on our website at **[www.healthnet.com](http://www.healthnet.com)**.

Please contact the Health Net Customer Contact Center at 1-888-802-7001 if you have any questions about a drug, your copayment and/or coinsurance or a required prior authorization. These representatives are an excellent resource.

<sup>1</sup>Evidence of Coverage (EOC) or Certificate of Insurance (COI) are legal binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.



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# Oregon Rx Plus Preferred Drug List

Effective October 1, 2013  
(Published September 15, 2013)

<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
abacavir sulfate	1	
Abilify	2	
Abilify Discmelt	3	
Abilify solution	2	
Absorica	3	Prior authorization required otherwise not covered.
Abstral SL tablet	3	Limited to 3 tablets per day.
acamprosate	3	Prior authorization required otherwise not covered. Not available through mail order.
acarbose	1	
Accu-Chek test strips	3	Prior authorization required otherwise not covered.
acebutolol	1	
acetaminoph/dichloralphen/isomethep	1	
acetazolamide	1	
acetylcysteine	1	
Aciphex	2	Limited to 1 tablet per day.
acitretin	1	
aclometasone	1	
Actonel	3	
Actonel with Calcium	3	Limited to 1 package of 28 tablets per month.
ACTOplus met XR	3	
acyclovir ointment, capsule	1	
adapalene cream, gel 0.1%	1	Limited to 45gm per fill.
Adcirca	2	Prior authorization required otherwise not covered.
Advair Diskus	2	Limited to 2 inhalations per day.
Advair HFA	2	Limited to 4 inhalations per day.
Advicor	2	
Afinitor	AC	Prior authorization required otherwise not covered. Not available through mail order. Limited to 1 tablet per day.
Afinitor Disperz	AC	Prior authorization required otherwise not covered. Not available through mail order.
Agenerase	2	
Albenza	2	
albuterol er	1	
albuterol tablet, syrup, nebulizing soln	1	
albuterol-ipratropium nebulizing solution	1	
alendronate	1	
alendronate solution	3	Limited to 4 bottles per month.
Alinia suspension	3	Limited to 60ml per month.
Alinia tablet	3	Limited to 6 tablets per month.
Alkeran	AC	Not available through mail order.
allopurinol	1	
Alomide	2	
Alora	3	Limited to 8 patches per month.
Alphagan P	2	
alprazolam	1	
Alsuma	3	Limited to 4 syringes per fill and up to 2 fills per month.
altavera	1*	Limited to 1 package per copay.
aluminum chloride	1	
Alvesco	3	Limited to 1 inhaler per month.
amantadine	1	
amcinonide cream	1	
amethia	1*	Limited to 1 package per 91 days for 3 copays.
amethia lo	1*	Limited to 1 package per 91 days for 3 copays.
amethyst	3*	
amiloride	1	
amiloride/hydrochlorothiazide	1	
aminophylline	1	
amiodarone	1	
Amitiza	2	
amitriptyline	1	
amlodipine	1	Limited to 1 tablet per day.
amoxapine	2	
amoxicillin	1	
amoxicillin/clavulanate	1	
amoxicillin/clavulanate SR	1	
amphetamine/dextroamphetamine	1	
amphetamine/dextroamphetamine SR cap	1	Limited to 1 capsule per day.
ampicillin	1	

\*Effective 8/1/2012 some plans will cover these medications and other preventive medications at \$0 cost share

<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
Ampyra	2	
Amturnide	2	
anagrelide	1	
anastrozole	AC	Not available through mail order.
Androderm	3	Limited to 1 patch per day.
AndroGel	2	Up to 10gm per day.
AndroGel Pump 1.62%	2	Up to 4 bottles per month.
Apidra	3	Up to 2 vials or boxes per month.
Aplenzin	3	Limited to 1 tablet per day.
apri	1*	Limited to 1 package per copay.
Aptivus	2	
aranelle	1*	Limited to 1 package per copay.
Arcapta Neohaler	3	Limited to one capsule per day.
Asacol	2	
Asacol HD	2	
Asmanex	2	Limited to 1 inhaler per month.
Astepro	2	
Atelvia	3	Limited to 1 tablet per week.
atenolol	1	
atenolol/chlorthalidone	1	
atorvastatin	1	Limited to 1 tablet per day.
atovaquone-proguanil	1	
Atralin Gel	3	Limited to 45gm per month.
Atripla	2	
Atrovent HFA	2	Up to 2 inhalers per month.
Aubagio	3	Prior authorization required otherwise not covered.
Auvi-Q	2	Limited to 4 syringes per fill. Not available through mail order.
Avandamet	2	Effective 11/18/2011, only available through a restricted access program in which the physician and patient must be enrolled.
Avandaryl	2	Effective 11/18/2011, only available through a restricted access program in which the physician and patient must be enrolled.
Avandia	2	Effective 11/18/2011, only available through a restricted access program in which the physician and patient must be enrolled.
Avelox	2	Limited to 14 tablets per fill.
aviane	1*	Limited to 1 package per copay.
Avinza	2	
Axert	3	Limited to 6 tablets per month.
Axiron	3	Prior authorization required otherwise not covered. Limited to one bottle per month.
azathioprine	1	
azelastine nasal spray	1	
Azelex	2	
Azilect	2	Limited to 1 tablet per day.
azithromycin 250mg tablet	1	Limited to 6 tablets per fill.
azithromycin 500mg tablet	1	Limited to 3 tablets per fill.
azithromycin 600mg tablet	1	Limited to 8 tablets per month.
azithromycin suspension	1	Limited to 60ml per fill.
Azopt	2	
Azor	2	
bacitracin	1	
baclofen	1	
balsalazide	1	
balziva	1*	Limited to 1 package per copay.
Banzel	2	
Baraclude 0.5,1mg tablet	2	Limited to 1 tablet per day.
Baraclude solution	2	Up to 3 bottles per month.
belladonna alkaloids/pb	1	
benazepril	1	
benazepril/hydrochlorothiazide	1	
Benicar	2	
Benicar HCT	2	
benzocaine/antipyrine	1	
benzonatate	1	
benzoyl peroxide/erythromycin	1	
benztropine	1	
betamethasone dipropionate	1	
betamethasone valerate	1	
betamethasone valerate foam	3	
betaxolol	1	
bethanechol	1	
Betimol	2	
Betoptic S	2	
Beyaz	2*	Limited to 1 package per copay.
bicalutamide	AC	Not available through mail order.
Biltricide	2	
Binosto	3	Limited to 4 tablets per month.
bisoprolol fumarate	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
bisoprolol/hydrochlorothiazide	1	
Blephamide ophthalmic susp	2	
Blephamide SOP ophthalmic ointment	2	
Bosulif	AC	Not available through mail order.
Breo Ellipta	2	Limited to 1 inhaler per month.
briellyn	1*	Limited to 1 package per copay.
Brilinta	2	
brimonidine	1	
bromocriptine	1	
budesonide 0.25mg/2ml suspension	1	Up to 240ml per month.
budesonide 0.5mg/2ml suspension	1	Up to 120ml per fill.
budesonide 3mg	3	
bumetanide	1	
buprenorphine SL tablet	3	Prior authorization required otherwise not covered.
buprenorphine-naloxone tablet	3	Prior authorization required otherwise not covered.
bupropion	1	
bupropion hcl tab SR 150mg (smoking deterrent)	3	Prior authorization required otherwise not covered. Not available through mail order.
bupropion SR	1	Limited to 2 tablets per day.
bupropion XL 300mg	1	Limited to 1 tablet per day.
bupirone	1	
butalbital/apap/caffeine	1	
butalbital/apap/caffeine/codeine	1	
butalbital/asa/caffeine	1	
butalbital/asa/caffeine/codeine	1	
butorphanol nasal spray	1	Limited to 1 package per month.
Butrans	3	Limited to 4 patches per 28 days.
cabergoline	1	Limited to 8 tablets per fill.
Cafergot	2	
calcipotriene cream, ointment	1	Limited to 60gm per fill.
calcitonin nasal spray	1	
calcitriol	1	
calcium acetate phosphate binder	1	
camila	1*	Limited to 1 package per copay.
camrese	1*	Limited to 1 package per 91 days for 3 copays.
camrese lo	1*	Limited to 1 package per 91 days for 3 copays.
Canasa	2	
candesartan cilexetil tablet	3	
Capitol	2	
Caprelsa	AC	Not available through mail order.
captopril	1	
captopril/hydrochlorothiazide	1	
Carafate suspension	2	
Carbaglu	2	
carbamazepine	1	
carbamazepine SR 200,400mg	1	
carbidopa/levodopa	1	
carbidopa/levodopa sust rel	1	
carbidopa/levodopa/entacapone	1	
Cardura XL	3	Limited to 1 tablet per day.
carisoprodol	1	
carvedilol	1	
cefaclor	1	
cefadroxil	1	
cefdinir	1	
cefpodoxime	1	
cefprozil	1	
cefuroxime	1	
Celebrex	3	Up to 2 capsules per day.
Cellcept oral suspension	2	
cephalexin	1	
cephradine	1	
Cesamet	3	Up to 10 capsules per fill.
cesia	1*	Limited to 1 package per copay.
Chantix	3	Prior authorization required otherwise not covered. Not available through mail order.
Chemet	2	
chloral hydrate	1	
chlordiazepoxide	1	
chlordiazepoxide/clidinium	1	
chloroquine	1	
chlorothiazide	1	
chlorpromazine	1	
chlorpropamide	1	
chlorthalidone	1	
cholestyramine	1	
choline fenofibrate	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
choline magnesium salicylate	1	
Ciloxan ophthalmic ointment	2	
cimetidine	1	
Ciprodex otic	2	
ciprofloxacin	1	Limited to 28 tablets per fill.
ciprofloxacin ophthalmic solution	1	
ciprofloxacin otic solution 0.2%	3	
ciprofloxacin XR 500,1000mg	3	Limited to 14 tablets per fill.
citalopram 10mg	1	Limited to 3 tablets per day.
citalopram 20,40mg	1	Limited to 1 tablet per day.
citalopram solution 10mg/5ml	1	Limited to 600ml per month.
Clarinet-D	3	Limited to 1 tablet per day.
clarithromycin tablet	1	Limited to 28 tablets per fill.
clarithromycin XL	1	Limited to 14 tablets per fill.
clemastine	1	
Climara Pro	2	Limited to 4 patches per month.
clindamax vaginal cream	1	
clindamycin	1	
clindamycin phos-benzoyl peroxide gel	1	
clobetasol	1	
clobetasol propionate foam	3	
Clobex spray	2	
clomipramine	1	
clonazepam	1	
clonazepam ODT	3	
clonidine	1	
clopidogrel	1	Limited to 1 tablet per day.
clorazepate	1	
clotrimazole troche	1	
clotrimazole/betamethasone	1	
clozapine	1	
clozapine ODT	3	
Coartem	2	
codeine	1	
codeine/acetaminophen	1	
codeine/ASA	1	
Colcrys	2	
colestipol	1	
Combivir	2	
Cometriq	AC	Not available through mail order.
Compazine syrup	2	
Complera	2	
Condylox gel	2	
Cordran	2	
Coreg CR	3	Carvedilol (generic Coreg) available for Tier 1 copay.
Creon	2	
Crestor	3	Limited to 1 tablet per day.
Crixivan	2	
cromolyn	1	
cryselle	1*	Limited to 1 package per copay.
Cuvposa	2	
cyclafem 1/35	1*	Limited to 1 package per copay.
cyclafem 7/7/7	1*	Limited to 1 package per copay.
cyclobenzaprine tablet	1	
cyclopentolate 1%, 2%	1	
cyclophosphamide	AC	Not available through mail order.
cyclosporine 25,100mg	1	
cyclosporine 50mg	3	
Cymbalta	2	Limited to 1 capsule per day.
cyproheptadine	1	
Cystaran	3	Up to 4 bottles per month.
Cytadren	2	
danazol	1	
dantrolene	1	
Dapsone	2	
Daraprim	2	
Daytrana	3	Limited to 1 patch per day.
Delzicol	2	
Denavir	3	Limited to 1.5gm per fill.
Derma-Smoother/FS	2	
desipramine	1	
desloratadine	3	Limited to 1 tablet per day.
desmopressin solution, tablet	1	
desonide	1	
Detrol LA	2	Limited to 1 capsule per day.
dexameth/polymyxin/neomycin	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
dexamethasone	1	
dexamethasone/neomycin	1	
dexchlorpheniramine	1	
Dexilant	3	Prior authorization required otherwise not covered. Limited to 1 capsule per day.
dexmethylphenidate	3	Limited to 2 tablets per day.
dextroamphetamine	1	
dextroamphetamine solution	3	Limited to 1 bottle (473ml) per month.
Diaphragms	3*	Not available through mail order.
diazepam concentrate, solution	2	
diazepam gel	1	Limited to 1 kit per fill.
diazepam tablet	1	
Diclegis	3	Limited to 4 tablets per day.
diclofenac tablet, ophth. sol.	1	
diclofenac XR	1	
dicloxacillin	1	
dicyclomine	1	
didanosine	1	
Differin gel 0.3%	2	Limited to 45gm per fill.
Differin Lotion	3	Limited to 59ml per month.
diflorasone	1	
diflunisal	1	
digoxin	1	
dihydroergotamine 1mg injection	3	Limited to 10ml per prescription fill and 2 fills per month.
Dilantin Infatabs	2	
diltiazem	1	
diltiazem ext rel	1	
Diovan	2	
diphenoxylate/atropine	1	
dipivefrin	1	
dipyridamole	1	
disopyramide	1	
disulfiram	1	
divalproex	1	
divalproex ER	1	
donepezil 23mg	3	Limited to 1 tablet per day.
donepezil 5,10mg	1	Limited to 1 tablet per day.
donepezil ODT 5,10mg	1	Limited to 1 tablet per day.
Doryx 200mg	3	
dorzolamide ophthalmic solution 2%	1	
dorzolamide/timolol ophthalmic solution	1	
Dovonex solution	2	Limited to 60ml per fill.
doxazosin	1	
doxepin	1	
doxycycline hyclate capsule, tablet	1	
doxycycline hyclate DR capsule 75mg	3	
doxycycline hyclate DR tablet	3	
doxycycline monohydrate capsule, tablet	1	
dronabinol	1	
Dulera	2	Limited to 1 inhaler per month.
Dymista	3	Limited to 1 bottle per month.
Dyrenium	2	
econazole cream	1	
Edarbi	3	
Edarbyclor	3	
Eduar	3	Limited to 1 tablet per day.
Edurant	2	
Effient	2	
Ella	3*	
Elmiron	2	
Emcyt	AC	Not available through mail order.
Emend 125mg	3	Limited to 1 capsule per fill.
Emend 40mg	3	Limited to 1 capsule per fill.
Emend 80mg	3	Limited to 2 capsules per fill.
Emend pack	3	Limited to 1 pack per fill.
emoquette	1*	Limited to 1 package per copay.
Emsam	3	Limited to 1 patch per day.
Emtriva	2	
Emtriva solution	2	Up to 4 bottles per month.
enalapril	1	
enalapril/hydrochlorothiazide	1	
enpresse	1*	Limited to 1 package per copay.
Epiduo Gel	3	Limited to 45gm per month.
epinephrine inj (Adrenaclick)	3	Limited to 4 syringes per fill. Not available through mail order.
Epipen injection	2	Limited to 4 syringes per fill. Not available through mail order.
Epipen JR injection	2	Limited to 4 syringes per fill. Not available through mail order.
Epivir HBV	2	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
Epivir solution	2	
eplerenone 25mg	3	Limited to 1 tablet per day.
eplerenone 50mg	3	Limited to 2 tablets per day.
Epzicom	2	
Equetro	3	
Erivedge	AC	Not available through mail order.
errin	1*	Limited to 1 package per copay.
Ertaczo	3	Limited to 60gm per month.
Ery-tab	2	
erythromycin	1	
erythromycin estolate	1	
erythromycin/sulfisoxazole	1	
escitalopram	1	
Esomeprazole	3	Prior authorization required otherwise not covered.
estazolam	1	
esterified estrogens & methyltestosterone	1	
Estrace vaginal cream	2	
Estraderm	2	Limited to 8 patches per month.
estradiol & norethindrone acetate 1-0.5mg	1	
estradiol patch	1	Limited to 4 patches per month.
estradiol tablet	1	
Estring	3	Limited to 1 ring per 90 days for 3 copays.
Estrogel	3	Limited to 50gm per month.
estropipate	1	
ethambutol	1	
Ethmozine	2	
ethosuximide	1	
etidronate	1	
etodolac	1	
etoposide	AC	Not available through mail order.
Eurax cream, lotion	2	Limited to 60ml per fill.
Evista	2	Limited to 1 tablet per day.
Exalgo	3	Limited to 4 tablets per day.
Exalgo 32mg	3	Limited to 2 tablets per day.
Exelon patch	2	
Exelon solution	2	
exemestane	AC	Not available through mail order.
Exforge	2	
Exforge HCT	2	
Exjade	2	
Factive	3	Limited to 7 tablets per fill.
famciclovir	1	
famotidine 20,40mg	1	
Fareston	AC	Not available through mail order.
Fazacllo 150,200mg	3	
felbamate	1	
felodipine SR	1	
Femring	3	Limited to 1 ring per 90 days for 3 copays.
fenofibrate capsule/tablet	1	
fenofibrate micronized capsule 43,130mg	3	
fentanyl OT lozenges	3	Up to 3 lozenges per day.
fentanyl patch	1	Limited to 1 patch every 48 hours.
Fentora	3	Limited to 3 tablets per day.
Finacea	2	Limited to 50gm per fill.
finasteride	1	Patient must be 50 years of age or older otherwise prior authorization is required.
Fioricet 50-300-40 with Codeine 30mg capsule	3	
flavoxate	1	
flecainide	1	
Flovent 100mcg Diskus	2	Up to 10 inhalers per month.
Flovent 250mcg Diskus	2	Up to 4 inhalers per month.
Flovent 50mcg Diskus	2	Up to 20 inhalers per month.
Flovent HFA 110,220mcg	2	Limited to 2 inhalers per month.
Flovent HFA 44mcg	2	Limited to 1 inhaler per month.
fluconazole	1	
fludrocortisone	1	
flunisolide nasal 0.025% solution	1	Limited to 1 bottle per month.
fluocinolone	1	
fluocinonide	1	
fluoride/polyvitamins	1	
Fluoroplex	2	
fluorouracil cream, solution	1	
fluoxetine	1	
Fluoxetine 60mg	3	Limited to 1 tablet per day.
fluphenazine tablet, solution	1	
flurazepam	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
flurbiprofen ophth, tablet	1	
flutamide	AC	Not available through mail order.
fluticasone nasal spray	1	Limited to 1 bottle per month.
fluvastatin	3	Limited to 1 capsule per day.
fluvoxamine	1	
fluvoxamine SR	3	Limited to 1 capsule per day.
Focalin XR	3	Limited to 1 capsule per day.
folic acid	1	
Foradil	3	Limited to 60 capsules per fill.
ForFivo XL	3	Limited to 1 tablet per day.
Fortesta	3	Prior authorization required otherwise not covered. Limited to 2 bottles per month.
Fortovase	2	
Fosamax Plus D	3	Limited to 1 tablet per week.
fosinopril	1	
fosinopril/hydrochlorothiazide	1	
Freestyle Lite test strips	2	
Freestyle test strips	2	
Frova	3	Limited to 9 tablets per month.
Fulyzaq	3	Prior authorization required otherwise not covered. Limited to 2 tablets per day.
Furadantin suspension	2	
furosemide	1	
gabapentin	1	
galantamine	1	
galantamine ER	1	
ganciclovir	1	
gemfibrozil	1	
Generess FE Chew	3*	Limited to 1 package per copay.
gentamicin	1	
gianvi	1*	Limited to 1 package per copay.
Giazo	3	Prior authorization required otherwise not covered. Limited to 6 tablets per day.
gildess FE	1*	Limited to 1 package per copay.
Gilenya	3	Prior authorization required otherwise not covered.
Gilotrif	AC	Not available through mail order.
Gleevec	AC	Not available through mail order.
glimepiride	1	
glipizide	1	
glipizide/metformin 2.5-250mg	1	Up to 2 tablets per day.
glipizide/metformin 2.5-500mg,5-500mg	1	
Glucagon injection	2	
glyburide	1	
glyburide/metformin	1	
Golytely solution	2	
granisetron hcl oral solution	3	Limited to 30ml per fill.
granisetron tablet	3	Limited to 6 tablets per fill.
griseofulvin	1	
guaifenesin, sust rel	1	
guaifenesin/codeine	1	
guaifenesin/dextromethorphan sust rel	1	
guanabenz	1	
guanfacine	1	
halobetasol	1	
Halog	2	
haloperidol	1	
heather	1*	Limited to 1 package per copay.
Helidac	2	
Hepsera	2	
Hexalen	AC	Not available through mail order.
Hivid	2	
Horizant	3	Limited to 2 tablets per day.
Humalog injection	2	Up to 2 vials or boxes per month.
Humulin injection	2	Up to 2 vials or boxes per month.
Hycamtin capsule	AC	Not available through mail order.
hydralazine	1	
hydralazine/hydrochlorothiazide	1	
hydrochlorothiazide	1	
hydrocodone/acetaminophen	1	
hydrocodone/guaifenesin syrup	1	
hydrocodone/homatropine	1	
hydrocortisone cream	1	
hydrocortisone enema	1	
hydrocortisone suppository	1	
hydrocortisone tablet	1	
hydrocortisone valerate	1	
hydrocortisone/pramoxine cream 1-1%	1	
hydromorphone	1	
hydroxychloroquine	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
hydroxyurea	AC	Not available through mail order.
hydroxyzine	1	
hyoscyamine	1	
ibandronate 150mg	3	Limited to 1 tablet per month.
ibuprofen	1	
lclusig	AC	Prior authorization required otherwise not covered. Not available through mail order.
imipramine	1	
imiquimod	1	
Incivek	3	Prior authorization required otherwise not covered.
indapamide	1	
indomethacin	1	
indomethacin sust rel	1	
Inlyta	AC	Prior authorization required otherwise not covered. Not available through mail order.
Insulin syringes and needles	2	
Intelence	2	
Intermezzo	3	Limited to 1 tablet per day.
introvale	3*	Limited to 1 package per 91 days for 3 copays.
Intuniv	3	Limited to 1 tablet per day.
Invega tablet	3	
Invirase	2	
Invokana	2	
ipratropium 0.02% solution	1	
ipratropium nasal spray	1	
irbesartan	1	
irbesartan/hydrochlorothiazide	1	
Iressa	AC	Not available through mail order.
Isentress	2	
isonarif	1	
isoniazid	1	
isosorbide dinitrate	1	
isosorbide dinitrate sust rel	1	
isosorbide mononitrate	1	
isotretinoin	3	Limited to 5 months treatment. Not available through mail order.
isoxsuprine	1	
itraconazole capsule	1	Prior authorization required otherwise not covered. Not covered for nail fungus.
Jakafi	AC	Not available through mail order.
Janumet	2	
Janumet XR	2	
Januvia	2	
Jentadueto	2	
jolessa	3*	Limited to 1 package per 91 days for 3 copays.
jolivette	1*	Limited to 1 package per copay.
junel, junel FE	1*	Limited to 1 package per copay.
Juvisync	2	
Juvisync 100-40mg, 50-40mg	2	Limited to 1 tablet per day.
Juxtapid	3	Prior authorization required otherwise not covered.
Kadian 10mg	3	Limited to 2 capsules per day.
Kadian 40,70,130,150,200mg	3	
Kaletra	2	
Kalydeco	2	Prior authorization required otherwise not covered.
Kapvay	3	Limited to 4 tablets per day.
kariva	1*	Limited to 1 package per copay.
kelnor	1*	Limited to 1 package per copay.
Ketek	3	Limited to 10 tablets per fill.
ketoconazole	1	
ketoprofen	1	
ketoprofen sust rel	1	
ketorolac	1	Limited to 20 tablets per fill.
ketorolac ophthalmic	1	
ketotifen ophthalmic	1	
Kombiglyze XR	2	
Kuvan	2	Prior authorization required otherwise not covered.
labetalol	1	
lactulose	1	
Lamictal chewable tablet 2mg	2	
Lamisil oral granules packet	2	Prior authorization required otherwise not covered. Not covered for the treatment of nail fungus.
lamivudine 150,300mg tablet	1	
lamotrigine	1	
Lancets	2	
lansoprazole	1	Limited to 1 capsule per day.
Lantus cartridge	2	Up to 3 boxes per fill.
Lantus Solostar	2	Up to 3 boxes per fill.
Lantus vial	2	Up to 4 vials per fill.
Lastacaft	2	
latanoprost ophthalmic solution	1	
Lazanda	3	Prior authorization required otherwise not covered.

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
leena	1*	Limited to 1 package per copay.
leflunomide	3	Limited to 1 tablet per day.
Lescol XL	3	Limited to 1 tablet per day.
lessina	1*	Limited to 1 package per copay.
Letairis	2	Limited to 1 tablet per day.
letrozole	AC	Not available through mail order.
leucovorin oral	AC	Not available through mail order.
Leukeran	AC	Not available through mail order.
levalbuterol nebulizing solution	1	
Levemir Flexpen	2	Up to 2 boxes per fill.
Levemir vial	2	Up to 2 vials per fill.
levetiracetam	1	
levobunolol	1	
levofloxacin	1	Limited to 14 tablets per fill.
levonorgestrel 1.5mg tablet	3*	Limited to 1 tablet per month.
levora	1*	Limited to 1 package per copay.
Levothroid	1	
levothyroxine	1	
Levoxyl	1	
Lexiva	2	
Lialda	2	
lidocaine	1	
Limbrel	3	
lindane	1	Limited to 60ml per fill.
lithyronine	1	
Liptruzet	2	Limited to 1 tablet per day.
lisinopril	1	
lisinopril/hydrochlorothiazide	1	
lithium carbonate	1	
lithium carbonate CR	1	
Lo Loestrin FE	3*	Limited to 1 package per copay.
Lo Minastrin FE	3*	Limited to 1 package per copay.
Loestrin FE 24	3*	Limited to 1 package per copay.
lomustine	AC	Not available through mail order.
lorazepam	1	
loryna	1*	Limited to 1 package per copay.
losartan	1	
losartan/hydrochlorothiazide	1	
Lotemax ophthalmic ointment, gel	3	
Lotemax ophthalmic suspension	2	
Lotronex	3	Not available through mail order.
lovastatin 10,20mg	1	Limited to 1.5 tablets per day.
lovastatin 40mg	1	
low-ogestrel	1*	Limited to 1 package per copay.
loxapine	1	
l-thyroxine	1	
Lumigan	2	
Lunesta	3	Limited to 1 tablet per day.
lutera	1*	Limited to 1 package per copay.
Lyrica 225,300mg	3	Prior authorization required otherwise not covered. Up to 2 tablets per day.
Lyrica 25,50,75,100,150,200mg	3	Prior authorization required otherwise not covered. Up to 3 tablets per day.
Lyrica solution	3	Prior authorization required otherwise not covered. Limited to 30ml per day.
Lysodren	AC	Not available through mail order.
maprotiline	1	
Matulane	AC	Not available through mail order.
mebendazole	1	Limited to 6 tablets per fill.
meclofenamate	1	
medroxyprogesterone	1	
medroxyprogesterone acetate 150mg inj	1*	Limited to 1 injection per 90 days for 3 copays.
mefenamic acid	1	
mefloquine	1	
megestrol suspension	1	Not available through mail order.
megestrol tablet	AC	Not available through mail order.
Mekinist	AC	Not available through mail order.
meloxicam suspension	1	
meloxicam tablet	1	Limited to 1 tablet per day.
Menest	2	
Menostar	3	Limited to 4 patches per month.
meperidine	1	
mephobarbital	1	
Mephyton	2	
meprobamate	1	
Mepron	2	
mercaptopurine	AC	Not available through mail order.
mesalamine enema	1	
Mesnex	AC	Not available through mail order.

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
metaproterenol	1	
metaxalone	1	
metformin	1	
metformin XR	1	
methadone	1	
methazolamide	1	
methen/phenylsalicy/atropine	1	
methimazole 5,10mg	1	
methocarbamol	1	
methocarbamol/asa	1	
methotrexate tablet	1	
methyl dopa	1	
methyl dopa/hydrochlorothiazide	1	
methylergonovine	1	
methylphenidate	1	
methylphenidate hcl CD capsule	3	Limited to 1 capsule per day.
methylphenidate SA OSM 18,27,54mg tablet	1	Limited to 1 tablet per day.
methylphenidate SA OSM 36mg tablet	1	Limited to 2 tablets per day.
methylphenidate SR 24 HR 20,40mg capsule	1	Limited to 1 capsule per day.
methylphenidate SR 24 HR 30mg capsule	1	Limited to 2 capsules per day.
methylprednisolone	1	
methyltestosterone	1	
metipranolol	1	
metoclopramide	1	
metolazone	1	
metoprolol	1	
metoprolol XL	1	
metronidazole cream, gel, lotion	1	
metronidazole oral tablet	1	
mexiletine	1	
microgestin	1*	Limited to 1 package per copay.
microgestin FE	1*	Limited to 1 package per copay.
Minastrin 24FE	3*	Limited to 1 package per copay.
minocycline capsule	1	
minocycline tab SR 24hr 45,90,135mg	3	Prior authorization required otherwise not covered.
minoxidil	1	
Mintezol	2	
mirtazapine	1	
misoprostol	1	
modafinil	3	Prior authorization required otherwise not covered. Limited to 1 tablet per day.
moexipril	1	
moexipril/hydrochlorothiazide	1	
mometasone	1	
mononessa	1*	Limited to 1 package per copay.
montelukast 4,5,10mg tablet	1	Limited to 1 tablet per day.
montelukast granules	1	Limited to 1 packet per day.
morphine sulfate	1	
morphine sulfate sust rel	1	
Motofen	2	
Moxeza	2	
Multaq	2	
mupirocin	1	
mycophenolate	1	
Myleran	AC	Not available through mail order.
Myrbetriq	3	Limited to 1 tablet per day.
nabumetone	1	
nadolol	1	
Naftin	2	
naltrexone 50mg	1	
Namenda 5,10mg	3	Limited to 2 tablets daily.
naproxen	1	
naratriptan	1	Limited to 9 tablets per month.
Nasonex	2	Limited to 1 bottle per month.
Natazia	2*	Limited to 1 package per copay.
nateglinide	1	
necon 0.5/35	1*	Limited to 1 package per copay.
necon 1/35	1*	Limited to 1 package per copay.
Necon 10/11	2*	Limited to 1 package per copay.
necon 7/7/7	1*	Limited to 1 package per copay.
nefazodone	1	
neomycin	1	
neomycin/bacitracin/polymyxin ophthalmic	1	
neomycin/gramacidin/polymyxin ophthalmic	1	
neomycin/polymyxin/HC otic	1	
nevirapine	1	
Nexavar	AC	Not available through mail order.

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
Nexium	3	Prior authorization required otherwise not covered. Limited to 1 capsule per day.
Nexium oral suspension	3	Prior authorization required otherwise not covered. Limited to 1 packet per day.
Niaspan	2	
Nicotrol inhaler, spray	3	Prior authorization required otherwise not covered. Not available through mail order.
nifedipine	1	
nifedipine CR 30,90mg	1	Limited to 1 tablet per day.
nifedipine CR 60mg	1	Limited to 2 tablets per day.
Nilandron	AC	Not available through mail order.
nimodipine	1	
nisoldipine	1	
nitrofurantoin	1	
nitroglycerin	1	
Nitrolingual spray	2	Limited to 1 package per fill.
nizatidine	1	
Non-preferred test strips	3	Prior authorization required otherwise not covered.
nora-BE	1*	Limited to 1 package per copay.
norethindrone 0.35mg	1*	Limited to 1 package per copay.
norethindrone acetate 5mg	1	
norgestrel-eth estradiol 0.3mg-30mcg	1*	Limited to 1 package per copay.
nortrel 0.5/35	1*	Limited to 1 package per copay.
nortrel 1/35	1*	Limited to 1 package per copay.
nortrel 7/7/7	1*	Limited to 1 package per copay.
nortriptyline	1	
Norvir	2	
Nucynta 100mg	2	Up to 6 tablets per day. Maximum of 150 per 25 days.
Nucynta 50mg	2	Up to 12 tablets per day. Maximum of 300 per 25 days.
Nucynta 75mg	2	Up to 8 tablets per day. Maximum of 200 per 25 days.
Nucynta ER	2	Limited to 2 tablets per day.
Nuedexta	2	
NuvaRing	2*	Limited to 1 ring per fill.
Nuvigil	3	Prior authorization required otherwise not covered.
nystatin	1	
ocella	1*	Limited to 1 package per copay.
ofloxacin ophthalmic, otic	1	
ofloxacin tablet	3	
Oforta	AC	Not available through mail order.
ogestrel	3*	Limited to 1 package per copay.
olanzapine	1	
olanzapine orally disintegrating tablet	3	
omeprazole 10,40mg	1	Limited to 1 capsule per day.
omeprazole 20mg	1	
ondansetron	1	Up to 20 tablets per fill.
ondansetron ODT	1	Up to 20 tablets per fill.
ondansetron solution	1	Up to 100ml per fill.
One Touch test strips	2	
Onglyza	2	
Onsolis	3	Prior authorization required otherwise not covered.
Opana ER 5,10,20,30,40mg	2	Limited to 2 tablets per day.
Oracea	3	Prior authorization required otherwise not covered.
Orap	2	
Oravig	3	Limited to 14 tablets per fill.
Ortho Evra	2*	Limited to 3 patches per fill.
Ortho Tri-Cyclen Lo	2*	Limited to 1 package per copay.
Osmoglyn	2	
Ovcon	3*	Limited to 1 package per copay.
oxaprozin	1	
oxazepam	1	
oxcarbazepine	1	
Oxecta	3	Limited to 4 tablets per day.
Oxsoralen Ultra	2	
oxybutynin	1	
oxycodone	1	
oxycodone/acetaminophen	1	
oxycodone/asa	1	
OxyContin	3	Limited to 3 tablets per day.
oxymorphone ER 7.5,15mg	1	Limited to 2 tablets per day.
Pancrelipase 5,000	2	
pantoprazole	1	Limited to 1 tablet per day.
paregoric	1	
paroxetine	1	
paroxetine CR	1	
paroxetine suspension	1	
Pataday	2	
Patanase	3	Limited to 1 bottle per month.
Patanol	3	
PCE	2	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
penicillin	1	
Pennsaid	3	Limited to 150ml per month.
Pentasa	3	
pentoxifylline	1	
perindopril	1	
permethrin cream	1	
perphenazine	1	
perphenazine/amitriptyline	1	
phenazopyridine	1	
phenelzine	1	
phenobarbital	1	
phenobarbital & belladonna alk CR	1	
phenytoin capsule	1	
phenytoin suspension	1	
Picato	3	
pilocarpine	1	
pindolol	1	
pioglitazone	1	
pioglitazone/glimepiride	1	
pioglitazone-metformin	1	
piroxicam	1	
polymyxin/trimethoprim	1	
Poly-Pred	2	
Pomalyst	AC	Not available through mail order.
portia	1*	Limited to 1 package per copay.
pot citrate/citric acid	1	
potassium chloride	1	
potassium citrate CR	1	
Pradaxa	2	
pramipexole	1	
Pramosone 1% lotion, ointment	2	
Pramosone 2.5% lotion	2	
pravastatin	1	Limited to 1 tablet per day.
Pravigard	3	Limited to 1 dose per day.
prazosin	1	
Precision QID test strips	2	
Precision Xtra test strips	2	
Pred Mild	2	
Pred-G	2	
prednicarbate	1	
prednisolone sod phos ophthalmic	1	
prednisolone syrup, tablet	1	
prednisone	1	
Prednisone oral solution	2	
Premarin 0.3,0.45,0.625,0.9mg	2	Limited to 1 tablet per day.
Premarin 1.25mg	2	Limited to 2 tablets per day.
Premarin vaginal cream	2	
Premphase	2	
Prempro	2	Limited to 1 tablet per day.
Prevacid solutab	3	Prior authorization required otherwise not covered. Limited to 1 tablet per fill.
previfem	1*	Limited to 1 package per copay.
Prevpac	3	Limited to 14 capsules per fill.
Prezista	2	
Primaquine	2	
primidone	1	
Pristiq	3	
Proair HFA inhaler	3	Up to 2 inhalers per month.
probenecid	1	
probenecid/colchicine	1	
procainamide	1	
procainamide sust rel	1	
prochlorperazine	1	
Proctofoam HC	2	
progesterone micronized	3	Up to 2 capsules per day.
Promacta	3	Prior authorization required otherwise not covered.
promethazine	1	
promethazine VC/codeine	1	
promethazine/codeine	1	
promethazine/dextromethorphan	1	
promethazine/phenylephrine	1	
propafenone	1	
propafenone SR	1	Up to 2 capsules per day.
propantheline	1	
propranolol	1	
propranolol LA	1	
propranolol/hydrochlorothiazide	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
propylthiouracil	1	
Prostigmin	2	
protriptyline	1	
Proventil HFA	2	Up to 2 inhalers per month.
Pulmicort 180mcg Flexhaler	2	Up to 2 inhalers per month.
Pulmicort 1mg/2ml suspension	2	Up to 60ml per month.
Pulmicort 90mcg Flexhaler	2	Up to 8 inhalers per month.
Pulmozyme	2	
pyrazinamide	1	
Qnasl	3	Limited to 1 canister per month.
Quartette	3*	Limited to 1 package per 91 days for 3 copays.
quasense	3*	Limited to 1 package per 91 days for 3 copays.
quetiapine	1	
Quillivant XR	3	Up to 2 bottles per month.
quinapril	1	
quinaretic	1	
quinidine gluconate	1	
quinidine sulf sust rel	1	
quinidine sulfate	1	
QVAR 40mcg inhaler	2	Limited to 2 inhalers per month.
QVAR 80mcg inhaler	2	Limited to 1 inhaler per month.
ramipril	1	Limited to 1 capsule per day.
ranitidine	1	Limited to 2 tablets/capsules per day.
Rapamune	2	
Ravicti	3	Prior authorization required otherwise not covered.
Rebetol solution	2	Prior authorization required otherwise not covered.
reclipsen	1*	Limited to 1 package per copay.
Relpax	3	Limited to 6 tablets per month.
repaglinide	1	
Rescriptor	2	
Rescula	3	Limited to 5ml per month.
reserpine	1	
reserpine/hydrochlorothiazide	1	
Retin-A Micro	2	Limited to 20gm per fill.
Retin-A Micro gel pump	2	Limited to 50gm per fill.
Revlimid	AC	Prior authorization required otherwise not covered. Not available through mail order.
Reyataz	2	
Rhinocort AQ	3	Limited to 1 bottle per month.
Ribapak 600	3	Prior authorization required otherwise not covered.
ribavirin 200mg	1	Prior authorization required otherwise not covered.
ribavirin 400,600mg	3	Prior authorization required otherwise not covered.
Rifamate	2	
rifampin	1	
rimantadine	1	
risperidone	1	
Ritalin LA 10mg	2	Limited to 1 capsule per day.
rivastigmine capsule	1	Limited to 2 capsules per day.
rizatriptan	1	Limited to 12 tablets per fill and 2 fills per month.
rizatriptan MLT	1	Limited to 12 tablets per fill and 2 fills per month.
ropinirole	1	
ropinirole XL	3	Limited to 1 tablet per day.
rosanil	1	
Rozerem	3	Limited to 1 tablet per day.
Rybix ODT	3	
Sabril	2	
Safyral	2*	Limited to 1 package per copay.
salsalate	1	
Samsca	2	Limited to 1 tablet per day.
Sancuso	3	Limited to 1 patch per fill.
Saphris	2	
Savella	3	Prior authorization required otherwise not covered. Limited to 2 tablets per day.
Seconal	2	
selegiline	1	
selenium sulfide	2	
Selzentry	2	
Serevent Diskus	2	Limited to 60 inhalations per month.
Seroquel XR	3	
sertraline tablet, concentrate	1	
Signifor	3	Prior authorization required otherwise not covered.
sildenafil 20mg tablet	3	Prior authorization required otherwise not covered.
Silenor	3	Limited to 1 tablet per day.
silver sulfadiazine	1	
Simcor 500-20,750-20,1000-20mg	2	Limited to 2 tablets per day.
Simcor 500-40,1000-40mg	2	Limited to 1 tablet per day.
simvastatin	1	Limited to 1 tablet per day.
Sirturo	3	Not available through mail order.

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
Solia	1*	Limited to 1 package per copay.
Solodyn	3	Prior authorization required otherwise not covered.
Soltamox		Not available through mail order.
Sorilux	3	Limited to 120gm per month.
sotalol	1	
sotalol AF	1	
Spiriva	2	Limited to 1 capsule per day.
spironolactone	1	
spironolactone/hydrochlorothiazide	1	
Sporanox oral solution	2	Prior authorization required otherwise not covered. Not covered for nail fungus.
sprintec	1*	Limited to 1 package per copay.
Sprix	3	Limited to 1 bottle per day for up to a maximum of 5 days per fill.
Sprycel	AC	Not available through mail order.
sronyx	1*	Limited to 1 package per copay.
stavudine	1	
Stivarga	AC	Not available through mail order.
Strattera	3	Limited to 1 capsule daily.
Striant	3	Limited to 2 units per day.
Stribild	2	
Suboxone film	3	Prior authorization required otherwise not covered.
Subsys Sublingual Spray	3	Prior authorization required otherwise not covered.
sucralfate tablet	1	
sulfacetamide 10%	1	
sulfacetamide/prednisolone	1	
sulfadiazine	1	
sulfamethoxazole/trimethoprim	1	
sulfasalazine	1	
sulfinpyrazone	1	
sulfisoxazole	1	
Sulfoxyl	2	
sulindac	1	
sumatriptan injection kit	1	Limited to 4 syringes per prescription fill and 2 fills per month.
sumatriptan nasal spray	1	Limited to 6 units per prescription fill and 2 fills per month.
sumatriptan tablet	1	Limited to 9 tablets per prescription fill and 2 fills per month.
Sumavel	3	Limited to 6 syringes per month.
Sustiva	2	
Sutent	AC	Not available through mail order.
syeda	1*	Limited to 1 package per copay.
Symbicort	2	Limited to 1 inhaler per month.
Synarel	2	
Tabloid	AC	Not available through mail order.
tacrolimus capsules	1	
Tafinlar	AC	Not available through mail order.
Tamiflu capsules, 30,45mg	3	Limited to 10 capsules per 6 month period. Not available through mail order.
Tamiflu capsules, 75mg	3	Not available through mail order.
Tamiflu suspension	3	Limited to one fill of up to 180ml per 6 month period. Not available through mail order.
tamoxifen	AC	Not available through mail order.
tamsulosin	1	
Tarceva	AC	Prior authorization required otherwise not covered. Not available through mail order.
Targretin capsule	AC	Not available through mail order.
Targretin gel	3	
Tasigna	AC	Prior authorization required otherwise not covered. Not available through mail order.
Tazorac	2	Limited to 30gm per fill.
Tecfidera	3	Prior authorization required otherwise not covered.
Tegretol XR 100mg	2	
Tekamlo	2	
Tekturna	2	
Tekturna HCT	2	
temazepam	1	
temozolomide	AC	Limited to 5 tablets per month. Not available through mail order.
terazosin	1	
terbinafine tablet	1	Prior authorization required otherwise not covered. Not covered for the treatment of nail fungus.
terbutaline	1	
Testim	3	Prior authorization required otherwise not covered. Up to 10gm per day.
testosterone cypionate injection	1	Not available through mail order.
testosterone enanthate injection	1	Not available through mail order.
tetracycline	1	
Thalomid	AC	Not available through mail order.
theophylline	1	
thioridazine	1	
thiothixene	1	
Thyrolar	2	
tiagabine	1	
Tikosyn	2	
tilia FE	3*	Limited to 1 package per copay.
timolol maleate ophthalmic	1	

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<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
tizanidine tablet	1	
Tobradex ophthalmic ointment	3	
Tobradex ST ophthalmic susp	3	
tobramycin ophthalmic	1	
tobramycin-dexamethasone ophth susp	1	
tolazamide	1	
tolbutamide	1	
tolterodine	1	
Topicort Spray	3	Prior authorization required otherwise not covered.
topiramate	1	
Torecan tablet	2	
torsemide	1	
Toviaz	2	
Tracleer	2	Limited to 2 tablets per day.
Tradjenta	2	
tramadol	1	
tramadol ER	3	
trandolapril	1	
tranexamic acid	3	Up to 30 tablets per month.
Travatan Z	2	
trazodone	1	
tretinoin capsule	AC	Not available through mail order.
tretinoin cream, gel	1	
Tretin-X	3	Limited to 35gm per month.
Treximet	3	Prior authorization required otherwise not covered. Limited to 9 tablets per prescription fill and 2 fills per month.
triamcinolone 0.1% in orabase	1	
triamcinolone acetonide	1	
triamcinolone nasal spray	3	Limited to 1 bottle per month.
triamcinolone/nystatin	1	
triamterene/hydrochlorothiazide	1	
triazolam	1	
Tribenzor	2	
trifluoperazine	1	
trifluridine	1	
trihexyphenidyl	1	
tri-legest FE	3*	Limited to 1 package per copay.
trilyte solution	1	
trimethobenzamide	1	
trimethoprim	1	
trimipramine	1	
trinessa	1*	Limited to 1 package per copay.
tri-previfem	1*	Limited to 1 package per copay.
tri-sprintec	1*	Limited to 1 package per copay.
trivora	1*	Limited to 1 package per copay.
Trizivir	2	
tropicamide	1	
tropium XR	3	Limited to 1 capsule per day.
Truvada	2	
Tudorza Pressair	2	Limited to 1 inhaler per month.
Tykerb	AC	Not available through mail order.
Tyvaso	3	Prior authorization required otherwise not covered.
Uloric	2	
Unithroid	1	
ursodiol	1	
valacyclovir	1	
Valcyte solution	2	Limited to 21ml per day.
Valcyte tablet	2	
valproic acid	1	
valsartan/hydrochlorothiazide	1	
vancomycin capsule	1	
velivet	1*	Limited to 1 package per copay.
Veltin Gel	3	Limited to 30gm per month.
venlafaxine ER tablet	1	Limited to 1 tablet per day.
venlafaxine tablet	1	
venlafaxine XR 150mg capsule	1	
venlafaxine XR 37.5,75mg capsule	1	Limited to 1 capsule per day.
Ventolin HFA inhaler	3	Up to 2 inhalers per month.
Veramyst	2	Limited to 1 bottle per month.
verapamil	1	
Vfend suspension	2	
Victrelis	3	Prior authorization required otherwise not covered.
Videx Solution	2	
Vigamox	2	
Vimovo	3	Prior authorization required otherwise not covered. Limited to 2 tablets per day.
Vimpat	2	

\*Effective 8/1/2012 some plans will cover these medications and other preventive medications at \$0 cost share.



<i>Medication</i>	<i>Tier</i>	<i>Comments</i>
Viracept	2	
Viramune XR	3	
Viread	2	
Vivelle	2	Limited to 8 patches per month.
Vivelle Dot	2	Limited to 8 patches per month.
voriconazole	1	
Votrient	AC	Not available through mail order.
Vytorin 10-10mg,10-20mg,10-40mg	2	Limited to 1 tablet per day.
Vyvanse	2	Limited to 1 capsule per day.
warfarin	1	
wymzya FE	3*	Limited to 1 package per copay.
Xalkori	AC	Prior authorization required otherwise not covered. Not available through mail order.
Xarelto 10mg	2	Limited to 1 tablet per day.
Xarelto 15,20mg	2	
Xeljanz	3	Prior authorization required otherwise not covered.
Xeloda	AC	Not available through mail order.
Xifaxan 200mg	3	Limited to 9 tablets per fill.
Xifaxan 550mg	3	Limited to 2 tablets per day.
Xopenex HFA inhaler	2	Up to 2 inhalers per month.
Xtandi	AC	Prior authorization required otherwise not covered. Not available through mail order.
Xyrem	3	Prior authorization required otherwise not covered.
zafirlukast	1	
zaleplon	1	Limited to 1 capsule per day.
zarah	1*	Limited to 1 package per copay.
Zavesca	3	
Zelboraf	AC	Prior authorization required otherwise not covered. Not available through mail order.
zenchent	1*	Limited to 1 package per copay.
zenchent FE	3*	Limited to 1 package per copay.
Zenpep	2	
zeosa	3*	Limited to 1 package per copay.
Zetonna	3	Limited to 1 inhaler per month.
Ziana gel	3	Limited to 30 gm per month.
zidovudine	1	
Zioptan	3	Limited to 1 single-use container per day.
ziprasidone	1	
Zmax	2	Limited to 1 bottle per fill.
Zolinza	AC	Prior authorization required otherwise not covered. Not available through mail order.
zolmitriptan 2.5mg tablet	3	Limited to 6 tablets per fill and 2 fills per month.
zolmitriptan 5mg tablet	3	Limited to 9 tablets per fill and 2 fills per month.
zolmitriptan orally disintegrating 2.5mg tablet	3	Limited to 6 tablets per fill and 2 fills per month.
zolmitriptan orally disintegrating 5mg tablet	3	Limited to 9 tablets per fill and 2 fills per month.
zolpidem	1	Limited to 1 tablet per day.
zolpidem CR	3	Limited to 1 tablet per day.
Zolpimist spray	3	Limited to 1 bottle per month.
Zomig 5mg nasal spray	3	Limited to 6 units per fill, and 2 fills per month.
zonisamide	1	
Zortress	2	
zovia	1*	Limited to 1 package per copay.
Zovirax cream	3	
Zubsolv	3	Prior authorization required otherwise not covered.
Zuplenz	3	Limited to 20 oral soluble films per 30 days.
Zyclara Pump 2.5%, 3.75%	3	Limited to 1 bottle per month.
Zylet	2	
Zytiga	AC	Prior authorization required otherwise not covered. Not available through mail order.
Zyvox	2	

Specialty Pharmacy Medication List

- For members with the Specialty Pharmacy Provision only.
- Available through Health Net's preferred Specialty pharmacies only.
- All Specialty Provision medications require prior authorization.
- SP= Specialty Pharmacy Provision co-insurance listed on your pharmacy rider.

Medication	Comments
Actimmune	SP Prior authorization required otherwise not covered.
Apokyn	SP Prior authorization required otherwise not covered.
Aranesp	SP Prior authorization required otherwise not covered.
Arcalyst	SP Prior authorization required otherwise not covered.
Arixtra	SP Prior authorization required otherwise not covered. The first fill of up to 10 syringes per year will process at retail without prior authorization.
Avonex	SP Prior authorization required otherwise not covered. Limited to 4 per month.
Berinert	SP Prior authorization required otherwise not covered.
Betaseron	SP Prior authorization required otherwise not covered.
Bydureon	SP Prior authorization required otherwise not covered.
Byetta	SP Prior authorization required otherwise not covered.
Cimzia	SP Prior authorization required otherwise not covered.
Copaxone	SP Prior authorization required otherwise not covered. Limited to 1 kit per month.
Enbrel	SP Prior authorization required otherwise not covered.
enoxaparin	SP Prior authorization required otherwise not covered. The first fill of up to 20 syringes per year will process at retail without prior authorization.
Extavia	SP Prior authorization required otherwise not covered.
Firazyr	SP Prior authorization required otherwise not covered.
fondaparinux	SP Prior authorization required otherwise not covered. The first fill of up to 10 syringes per year will process at retail without prior authorization.
Forteo	SP Prior authorization required otherwise not covered.
Fragmin	SP Prior authorization required otherwise not covered. The first fill of up to 20 syringes per year will process at retail without prior authorization.
Fuzeon	SP Prior authorization required otherwise not covered.
Gattex	SP Prior authorization required otherwise not covered.
Genotropin	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.
Humatrope	SP Prior authorization required otherwise not covered.
Humira	SP Prior authorization required otherwise not covered.
Infergen	SP Prior authorization required otherwise not covered.
Innohep	SP Prior authorization required otherwise not covered. The first fill of up to 10 syringes per year will process at retail without prior authorization.
Intron A	SP Prior authorization required otherwise not covered.
Iprivask	SP Prior authorization required otherwise not covered. The first fill of up to 20 vials per year will process at retail without prior authorization.
Kineret	SP Prior authorization required otherwise not covered.
Kynamro	SP Prior authorization required otherwise not covered.
Leukine	SP Prior authorization required otherwise not covered.
Lovenox	SP Prior authorization required otherwise not covered. The first fill of up to 20 syringes per year will process at retail without prior authorization.
Neulasta	SP Prior authorization required otherwise not covered.
Neumega	SP Prior authorization required otherwise not covered.
Neupogen	SP Prior authorization required otherwise not covered.
Norditropin	SP Prior authorization required otherwise not covered.
Nutropin	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.
octreotide acetate injection	SP Prior authorization required otherwise not covered.
Omnitrope	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.
Orencia	SP Prior authorization required otherwise not covered.
Pegasys	SP Prior authorization required otherwise not covered.
Peg-Intron	SP Prior authorization required otherwise not covered.
Procrit/Epogen	SP Prior authorization required otherwise not covered.
Rebif	SP Prior authorization required otherwise not covered.
Relistor	SP Prior authorization required otherwise not covered.
Saizen	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.
Sandostatin	SP Prior authorization required otherwise not covered.
Sandostatin LAR	SP Prior authorization required otherwise not covered.
Serostim	SP Prior authorization required otherwise not covered.
Signifor	SP Prior authorization required otherwise not covered.
Simponi	SP Prior authorization required otherwise not covered.
Somavert	SP Prior authorization required otherwise not covered.
Sylatron	SP Prior authorization required otherwise not covered.
Symlin	SP Prior authorization required otherwise not covered.
Tev-Tropin	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.
Victoza	SP Prior authorization required otherwise not covered.
Zorbtive	SP Prior authorization required otherwise not covered. Humatrope and Norditropin preferred.

\*Effective 8/1/2012 some plans will cover these medications and other preventive medications at \$0 cost share

## Preventive Medications

Effective August 1, 2012, some plans will cover the following preventive medications as recommended by the United States Preventive Services Task Force (USPSTF) and/or the Health Resources and Services Administration (HRSA) guidelines at \$0 cost share under the conditions listed below. Note, we require a prescription for these items to be administered under pharmacy benefits.

Medication	Comments
Folic Acid	400mcg or 800mcg for women under 65 years of age.
Aspirin	75mg to 325mg for those 45-79 years of age.
Fluoride	For children ages 6 months to 6 years of age.
Iron	For children 6 to 12 months of age.
Prescription Contraceptives	
Diaphragms	
Intrauterine Devices (IUD's)	
Over the counter female contraceptive products such as:	Female condoms (FC, FC2), vaginal spermicides (aerosol foam, gel, film, suppository), contraceptive sponge and emergency contraceptive tablets.

# Frequently Asked Questions

## *Oregon pharmacy benefits*

**1. *How do I know what my copayment and/or coinsurance will be?***

There are several different copayment and/or coinsurance options available including three tiers, oral anticancer (AC) and a Specialty Pharmacy provision. The tier (1, 2, 3, AC or SP) on the Preferred Drug List (PDL) corresponds to the copayment and/or coinsurance that you will be responsible for. A lower tier generally indicates a lower copayment and/or coinsurance.

**2. *How can I work with my provider to get the best benefit from the PDL?***

Your physician, pharmacist or other medical provider can be a valuable partner in helping you get the best benefit. Here are some tips:

- Ask your provider to prescribe generic products from the PDL whenever possible.
- If a medication you need is not available generically, or is non-preferred, ask your provider to choose a brand-name product that is on the PDL.
- Take your PDL with you when you go to the provider for an office visit.
- Tell your provider if it is important to you to pay the lowest copayment and/or coinsurance possible for your medication as long as the medication is right for your medical condition.

**3. *Where can I fill my prescription?***

You may access pharmacies in the following chain stores anywhere in the United States: Albertsons, Costco, CVS, Fred Meyer, Kmart, Rite Aid, Safeway, Sav-on, Shopko, Target, The Medicine Shoppe, Walgreens and Walmart. You may also access the following pharmacies in the Northwest: Bartell Drugs, Bi-Mart and Hi-School Pharmacy. Health Net has a number of other contracted pharmacies. To inquire if a specific pharmacy is a Health Net participating pharmacy, please call the Health Net Pharmacy Department or visit our website at [www.healthnet.com](http://www.healthnet.com). Specialty Pharmacy drugs must be obtained from one of Health Net's designated Specialty Pharmacy Providers.

Fill all non-emergency prescriptions at a Health Net participating pharmacy to ensure your prescription will be covered.

**4. *How do I know if my medication has a generic version and why should I take the generic?***

If you are already taking a particular medication, the generic name should be listed on the label for that medication, even if you were prescribed the brand name. Generic drugs are therapeutically equivalent to brand-name drugs, but are typically less expensive. Generic drugs undergo the same strict regulation and quality control by the Food and Drug Administration to ensure that they are as safe and effective as brand-name drugs.

**5. *What should I do if my medication needs prior authorization?***

If your medication has a comment on the PDL indicating that it requires prior authorization, Health Net recommends you talk with your physician or medical provider as soon as possible about the prescribed medication and alternatives available. If your physician decides to request prior authorization, we need to obtain information directly from the provider (this information may not come from the patient). The provider may fax a prior authorization request using our Prior Authorization/Medication Exception Request Form to **1-800-255-9198**. If urgent, the physician may call **1-888-802-7001**.

If the criteria for prior authorization are met, then the drug is approved at the applicable copayment and/or coinsurance. If not, the drug is not approved for coverage. If you decide to purchase the medication without authorization, you will be responsible for the total cost of the medication unless otherwise noted in the PDL.

**6. *What does it mean if my drug has a quantity limit?***

Some drugs may be subject to a dosage or quantity limit, which means that there is a set amount of the medication you can receive within a specific period. If your prescription has a quantity limit, but you have been prescribed a dose that exceeds the quantity limit, your physician must obtain prior authorization for the quantity requested. The prior authorization will not be approved if: medical necessity criteria are not met, there is a less costly alternative, or the medication is not a covered benefit. If you decide to purchase the medication without prior authorization, you will be responsible for the total cost.

**7. *How often can I refill my prescription?***

You may refill prescriptions written for a 10-day or less supply after 50 percent of the medication has been used according to the directions. Prescriptions for more than a 10-day supply of medication are eligible for refill after 74 percent of the medication has been used as directed. If your physician has increased your dose, the physician needs to notify your pharmacy of the change in directions. Your pharmacy may contact Health Net for an override if this change will result in an early refill request.

**8. *How do I use my mail-order benefit?***

CVS Caremark Mail Order Pharmacy is Health Net's mail-order provider. In order to take advantage of this service, you will need to obtain new written prescriptions from your physician that allow up to a 90-day supply for each new prescription. You should contact the Health Net Pharmacy Department prior to your initial order to verify that the prescription is eligible for coverage through mail-order and what the copayment and/or coinsurance amount will be. Mail-order forms are available on our website at [www.healthnet.com](http://www.healthnet.com) or you may contact the Health Net Customer Contact Center to request an order form. You should allow two weeks for delivery of the initial order.

**9. *Are injectable medications covered?***

Injectable medications other than those that appear on the main PDL are excluded from the pharmacy benefit. Specific medications listed on the Specialty Pharmacy medication list are covered through the pharmacy benefit if you have Specialty Pharmacy coverage. Please refer to the Specialty Pharmacy drug list to verify which medications are included. If you have questions about a Specialty drug, please call Health Net Pharmacy Services at **1-888-802-7001**.

**10. *How are compounded prescriptions covered?***

Compounded prescriptions are subject to your Tier 3 copayment and/or coinsurance and require prior authorization for coverage. Please contact the Pharmacy Services Department for information on participating pharmacies that may prepare the medication for you. If you have any questions about a compounded prescription, please call Health Net Pharmacy Services at **1-888-802-7001**.

**11. *What if I am on a medication that was covered by my previous health insurance?***

Under the Continuity of Care Policy, within the first 90 days of Health Net coverage, members will receive authorization for any existing medication requiring prior authorization that was covered under their previous health insurance company.

This policy excludes the following:

- injectables
- compounded medications
- pharmacy benefit exclusions
- overrides on quantity or dosage limits

The health plan will require verification that the medication was covered by the previous insurance company.

**12. *Is Sudafed or any product containing pseudoephedrine covered under my pharmacy benefit?***

Effective July 1, 2006, the state of Oregon requires a prescription for pseudoephedrine (Sudafed) and all over-the-counter products containing pseudoephedrine. Your pharmacy benefit does not cover any drug for which there is an over-the-counter therapeutic equivalent available. The over-the-counter therapeutic equivalent for Sudafed is Sudafed PE. The over-the-counter therapeutic equivalent for Claritin-D is loratadine with Sudafed PE. The over-the-counter therapeutic equivalent for Allegra D is fexofenadine plus Sudafed PE.

**Email the Customer Contact Center through the Contact Us feature on Healthnet.com, contact Health Net Pharmacy Services at 1-888-802-7001 if you have any questions that are not answered on this list, or visit our website at [www.healthnet.com](http://www.healthnet.com).**