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Use of generic drugs can save both you and your health plan money. This list is not all-inclusive and is not a guarantee of coverage. Plan Benefit design is the final determinate of coverage.

Certain drugs (*) may be subject to Prior Authorization (PA), Quantity Limits (QL), Step Therapy (ST), or Reference Based Pricing (RBP) requirements according to Benefit Design. Unless noted, multisource brand drugs (brand drugs with generic equivalent) are covered at 100% copay.

If you have any questions about these requirements or other formulary questions, please contact a MedImpact Healthcare customer service representative at 800-788-2949.

This list represents brand products in CAPS, branded generics in upper- and lowercase Italics, and generic products in lowercase italics.

Drug Type	Tier 1	Tier 2	Tier 3
Anti-Infectives			
Antibiotics – Cephalosporins (Quantity Limit)	*cefaclor, cefadroxil, cefdinir, cefpodoxime, cefprozil, cefditoren,cefuroxime, cephalexin*		CEFTIN susp, SUPRAX 400mg only* (QL) Note: all other Suprax strengths are 100% copay
Antibiotics - Macrolides	*azithromycin, clarithromycin, clarithromycin ext-rel, erythromycin delayed-rel, erythromycin ethylsuccinate, erythromycin stearate*	ERY-TAB, PCE	ZMAX susp
Antibiotics - Fluoroquinolones	*ciprofloxacin, ciprofloxacin ext-rel, levofloxacin ,moxifloxacin*	FACTIVE	
Antibiotics - Penicillins	*amoxicillin, amoxicillin-clavulanate, dicloxacillin, penicillin VK*		
Antibiotics – Other* (Prior Authorization)	*clindamycin HCl, doxycycline hyclate, linezolid* (PA), minocycline, tetracycline*		ZYVOX susp*(PA)
Antifungals* (Prior Authorization) (Quantity Limit)	*fluconazole, itraconazole* (QL), ketoconazole, terbinafine tabs , voriconazole*		NOXAFIL
Antivirals - Influenza* (Quantity Limit)	*amantadine, rimantadine*	TAMIFLU	RELENZA* (QL)
Antivirals - Herpes	*acyclovir, famciclovir, valacyclovir, valganciclovir tab*		VALCYTE susp
Antivirals - Other - Interferons/Interferon Combinations (Prior Authorization)	*ribasphere, ribavirin*	HARVONI*(PA), PEGASYS* (PA), PEGINTRON* (PA), REBETOL susp, SOVALDI*(PA)	DAKLINZA* (PA), TECHINIVIE* (PA)
Cardiovascular			
Anti-Adrenergic Blockers Peripherally Acting	*doxazosin, prazosin, terazosin*		
Anticoagulants/Antiplatelet Agents (Quantity Limits)	*cilostazol, clopidogrel, dipyridamole, ticlopidine, warfarin*	AGGRENOX, ELIQUIS (QL), PRADAXA (QL), XARELTO (QL)	
Antihyperlipidemics - HMG (Statins) REFERENCE BASED PRICING PROGRAM (RBP)	*atorvastatin,lovastatin, pravastatin, simvastatin*	RBP: PLAN WILL PAY $0.50/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE ADVICOR, ALTOPREV, CRESTOR, LIVALO, SIMCOR, VYTORIN	
Other Antihyperlipidemic Agents	*cholestyramine, colestipol, gemfibrozil*	LIPOCHOL PLUS	WELCHOL

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Drug Type	Tier 1	Tier 2	Tier 3
ACE Inhibitors and ACE Inhibitor Combinations	*captopril, captopril-HCTZ, enalapril, fosinopril, fosinopril-hydrochlorothiazide, lisinopril, lisinopril-HCTZ, quinapril, quinapril HCTZ, ramipril, trandolapril*		
Angiotensin II Receptor Antagonists* (Step Therapy)	*candesartan/-HCTZ (ST), eprosartan*(ST),irbesartan (ST)/-HCTZ (ST),losartan, losartan-HCTZ, telmisartan/-HCTZ, valsartan/-HCTZ*		BENICAR* (ST), BENICAR HCT* (ST), (ST), TEVETEN HCT* (ST)
Antihypertensive Combinations (Step Therapy)	*amlodipine-benazepril, amlodipine-valsartan(ST) ,nadolol-bendroflumethiazide, trandolapril/verapamil*		AZOR*(ST), TRIBENZOR*(ST), TEKAMLO*(ST)
Antihypertensive - Others	*eplerenone*		
Beta-blockers* (Quantity Limit)	*atenolol, carvedilol, carvedilol ext-rel, metoprolol, metoprolol ext-rel, propranolol, propranolol ext-rel*	LEVATOL	BYSTOLIC, COREG CR* (QL),
Calcium Channel Blockers	*amlodipine, diltiazem ext-rel, isradipine, nimodipine, nisoldipine, verapamil ext-rel*		
Chronic Angina* (Prior Authorization)			RANEXA* (PA)
Direct Renin Inhibitors/Combo* (Step Therapy)			AMTURNIDE*(ST),TEKTURNA* (ST), TEKTURNA HCT* (ST)
Diuretics	*furosemide, hydrochlorothiazide, metolazone, spironolactone/-HCTZ, triamterene-HCTZ, torsemide*		
Paroxysmal Nocturnal Hemoglobinuria Agents* (Prior Authorization)		SOLIRIS* (PA)	
Pulmonary Arterial Hypertension (Prior Authorization)	*sildenafil (PA)*		ADCIRCA* (PA), ADEMPAS* (PA), LETAIRIS, TRACLEER
Central Nervous System			
ADHD Medications* (Prior Authorization) (Quantity Limit) (Step Therapy) **EFFECTIVE 1/1/13** - Extended-Release ADHD medications will not be covered for members who are 26 years and older. Regular release ADHD drugs will continued to be covered at existing tiers.	*dexmethylphenidate, dexmethylphenidate ext-rel, dextroamphetamine, methylphenidate, methylphenidate ext-rel, modafinil (PA),* ADDERALL XR	STRATTERA	DAYTRANA* (ST), VYVANSE* (QL)
Alzheimer's Disease* (age edit)	*donepezil/-ODT*(age), galantamine,memantine* (age), rivastigmine*		
Analgesics - Narcotic* (Quantity Limit)(Prior Authorization)	*butalbital-APAP-caffeine, codeine-APAP, fentanyl transdermal/- buccal*(QL), hydrocodone-APAP, hydromorphone, morphine/-ER, morphine supp, oxycodone-/APAP ER, oxycodone ibuprofen, propoxyphene, propoxyphene napsylate-APAP, tramadol/-ER*	KADIAN (200mg), OXYCONTIN* (QL),	ABSTRAL, , FENTORA* (QL), KADIAN (40mg,70mg, 130mg, 150mg), SUBOXONE* (PA)

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Drug Type	Tier 1	Tier 2	Tier 3
Analgesics - Anti-Inflammatory/ NSAIDs	*choline magnesium trisalicylate, diclofenac, etodolac, ibuprofen, indomethacin ext-rel, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, sulindac*		
Anticonvulsants (Prior Authorization)	*carbamazepine, clonazepam, clonazepam ODT, diazepam (rectal), divalproex sodium,ethosuximide, gabapentin, lamotrigine, levetiracetam/-XR, oxcarbazepine, phenobarbital, phenytoin, primidone, valproic acid, zonisamide*	CELONTIN, GABITRIL (12mg,16mg), STAVZOR	BANZEL* (PA), DEPAKENE, DEPAKOTE, DEPAKOTE ER, DILANTIN, FYCOMPA, LYRICA (PA), ONFI (PA), OXTELLAR XR VIMPAT
Antianxiety	*alprazolam/- ext-rel, buspirone, diazepam, lorazepam, oxazepam*		
Antidepressants - Other* (Quantity Limit)	*amitriptyline, bupropion/-ext-rel, clomipramine, desipramine, doxepin, mirtazapine, nortriptyline, trazodone*		EMSAM* (QL)
Antidepressants - SSRIs	*citalopram, escitalopram ,fluoxetine, paroxetine/-ER, sertraline*		
Antidepressants - SNRIs	*duloxetine, venlafaxine/-ER*		
Antiparkinsonian Agents	*amantadine, benztropine, bromocriptine, cabergoline, carbidopa-levodopa, carbidopa-levodopa ext-rel, entacapone, pramipexole, ropinirole/-XL, selegiline, tolcapone, trihexyphenidyl*		AZILECT, MIRAPEX ER, ZELAPAR
Antimanic Agents	*lithium carbonate*		
Antipsychotic Agents* (Prior Authorization)	*aripiprazole* (PA), chlorpromazine, clozapine, fluphenazine, haloperidol, olanzapine, perphenazine, paliperidone tabs, quetiapine (IR), risperidone, thioridazine, trifluoperazine,ziprasidone*	MOBAN, NAVANE 20mg only, SEROQUEL XR	
Migraine Products* (Quantity Limit)	*almotriptan* (QL), dihydroergotamine inj, ergotamine-caffeine tabs, naratriptan (QL), rizatriptan (QL), sumatriptan (QL), zolmitriptan (QL)*		CAFERGOT, RELPAX* (ST,QL), ZOMIG NS* (QL)
Multiple Sclerosis Drugs (Prior Authorizatiion)(Quantity Limit)	*Glatopa*	REBIF* (QL)	AVONEX, AUBAGIO (PA), BETASERON, GILENYA*(PA)(QL), TECFIDERA (PA)
Sedative Hypnotics – Benzodiazepines (BZD)	*flurazepam, temazepam (except 7.5mg and 22.5mg), triazolam*		
Sedative Hypnotics* - Non-Benzodiazepine (Quantity Limit) REFERENCE BASED PRICING PROGRAM (RBP)	*zaleplon* (QL), zolpidem* (QL)*	RBP: PLAN WILL PAY $0.19/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *zolpidem tartrate ER** (QL,RBP), EDLUAR*(QL,RBP),eszopiclone (QL,RBP)INTERMEZZO*(RBP),ROZEREM* (QL,RBP), SILENOR*(QL,RBP), ZOLPIMIST*(RBP)	

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Drug Type	Tier 1	Tier 2	Tier 3
Skeletal Muscle Relaxants REFERENCE BASED PRICING PROGRAM (RBP)	*baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, tizanidine*	RBP: PLAN WILL PAY $0.09/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *orphenadrine* (RBP), *orphenadrine compound* (RBP), *metaxalone* (RBP), AMRIX (RBP),	
Dermatologicals			
Other Dermatologicals*(Prior Authorization)	*fluorouracil, spinosad*(PA)*		ALTABAX
Rectal Preparations	*lidocaine HC*		ANAMANTLE HC (0.5 %-3 %)
Endocrine			
Diabetes - Insulin		HUMALOG, HUMALOG MIX, HUMULIN, LANTUS/-SOLOSTAR, NOVOLIN, NOVOLOG	APIDRA, LEVEMIR
Diabetes - Insulin Sensitizing Agents*(Prior Authorization)	*metformin/-XR, pioglitazone*		
Diabetes - Insulin Secreting Agents	*chlorpropamide, glimepiride, glipizide, glipizide ext-rel, glyburide, tolazamide*		DIABETA
Diabetes - Combinations	*glyburide-metformin, glipizide-metformin, pioglitazone-metformin, metformin ext-rel, pioglitazone-glimepiride*	GLYSET	AVANDIA* (PA), AVANDAMET* (PA), AVANDARYL* (PA), JANUVIA, JANUMET/-XR
Diabetes - Other Medications (Step Therapy)	*acarbose*	GLYSET, GLUCAGON EMERGENCY KIT* (QL)	BYETTA*(ST), ,SYMLIN
Diabetic - Supplies	*$0 copay for ABBOTT and BAYER Test Strips, Lancets, Alcohol Swabs, Insulin Needles, and Syringes.*		GLUCOMETER**, HUMAPEN MEMOIR, LIFESCAN TEST STRIPS, ROCHE TEST STRIP and all other NON-ABBOTT/NON-BAYER Test strips
Thyroid Agents	*levothyroxine*		
Gastrointestinal/Urinary			
Antispasmodic/GI Motility	*belladonna alkaloids-phenobarbital, chlordiazepoxide-clidinium, dicyclomine, diphenoxylate-atropine, glycopyrrolate, hyoscyamine/-ext rel, loperamide,methscopolamine*		
Bowel Evacuants	*lactulose, peg 3350-electrolytes, polyethylene glycol*	KRISTALOSE	GOLYTELY, MOVIEPREP, SUPREP
Digestive Aids	*pancrelipase*	VIOKASE	CREON, PANCREAZE, ULTRESA, ZENPEP (EXCEPT ZENPEP 5K-17K-27K CAPS)
Gallstone Solubilizing Agents	*ursodiol*		
H_2-Antagonists	*cimetidine, famotidine, nizatidine, ranitidine*		

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Drug Type	Tier 1	Tier 2	Tier 3
Genitourinary Medications REFERENCE BASED PRICING PROGRAM (RBP)	*bethanechol, oxybutynin chloride, phenazopyridine, potassium citrate* ***oxybutynin ext-rel (2nd Tier Copay)***	RBP: PLAN WILL PAY $0.30/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *tolterodine/-XL (RBP), trospium* (RBP), GELNIQUE (RBP), MYRBETRIQ (RBP), OXYTROL (RPB), TOVIAZ (RBP), VESICARE (RBP)	
Inflammatory Bowel* (Quantity Limit) (Step Therapy)	*balsalazide, budesonide, mesalamine, sulfasalazine, sulfasalazine delayed-rel*	APRISO*(QL), DELZICOL*(QL),	CANASA, DIPENTUM, ENTOCORT EC, GIAZO, UCERIS* (ST)
Immunosuppressive Agents			
Immunosuppressive* (Prior Authorization)	*azathioprine, cyclosporine, cyclosporine modified, Gengraf,mycophenolate (caps/tabs), tacrolimus caps*		AZASAN, RAPAMUNE, ZORTRESS*(PA)
Men's Health			
Erectile Dysfunction* (Prior Authorization) (Quantity Limit)		MUSE* (PA) (QL), VIAGRA* (PA) (QL)	CIALIS* (PA) (QL), LEVITRA* (PA) (QL), STENDRA*(PA), STAXYN* (PA)
Hormone Replacement * (Prior Authorization)	*testosterone cyprionate, testosterone enanthate*	EFFECTIVE ON 1/1/15 – TOPICAL TESTOSTERONES ARE COVERED AT 100% COPAY	
Prostate Health	*alfluzosin, dutasteride, finasteride, tamsulosin*		RAPAFLO
Ophthalmics			
Anti-Allergic Agents	*azelastine,cromolyn, epinastine*		ALAMAST, ALOCRIL, ALOMIDE, EMADINE, LASTACAFT, PATADAY
Anti-Infective/Antiviral Agents	*bacitracin, ciprofloxacin, erythromycin, gentamicin, neomycin-polymyxin B-gramicidin, ofloxacin, levofloxacin, polymyxin B-bacitracin, polymyxin B-trimethoprim, sulfacetamide, tobramycin, trifluridine*	NATACYN	AZASITE, VIGAMOX
Anti-Glaucoma Agents/ Beta-blockers (Quantity Limit)	*betaxolol, brimonidine, dipivefrin, latanoprost, levobunolol, metipranolol, pilocarpine, timolol, Carboptic*	AZOPT	ALPHAGAN P (0.10%), BETIMOL, BETOPTIC S, COMBIGAN, COSOPT PF,LUMIGAN (0.01%), RESCULA
Anti-Inflammatory Agents	*bromfenac, dexamethasone, diclofenac sodium, fluorometholone, ketotifen,ketorolac, prednisolone acetate, prednisolone phosphate*	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, NEVANAC, VEXOL, XIBROM	ACUVAIL, ALREX, LOTEMAX
Respiratory			
Nasal Products* (Quantity Limit) REFERENCE BASED PRICING PROGRAM (RBP)	*azelastine*(QL), flunisolide, fluticasone* (QL)*	RBP: PLAN WILL PAY $22.42/inhaler; REMAINING COST WILL BE APPLIED TO MEMBER SHARE *budesonide spray/pump (QL,RBP), triamcinolone** (QL,RBP), BECONASE AQ* (QL,RBP), DYMISTA (RBP), NASONEX* (QL,RBP), OMNARIS* (QL,RBP), QNASL* (RBP), VERAMYST* (QL,RBP), ZETONNA (RBP)	

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Drug Type	Tier 1	Tier 2	Tier 3
Asthma -Leukotriene Modulators* (Step Therapy)	montelukast, zafirlukast* (ST)		
Asthma - Steroid Inhalants	*budesonide neb soln*	FLOVENT DISKUS/-HFA QVAR	AEROBID, AEROBID-M, ALVESCO, ASMANEX, AZMACORT, DULERA
Asthma - Beta Agonists Short Acting	*Albuterol/-ER albuterol inhalation soln, metaproterenol, terbutaline*	PROAIR HFA, PROVENTIL HFA VENTOLIN HFA	VOSPIRE ER
Asthma - Beta Agonists - Long Acting		FORADIL, SEREVENT	BROVANA, PERFOROMIST
Asthma - Other* (Prior Autorization)	*ipratropium soln, theophylline anhydrous*	ADVAIR DISKUS, ADVAIR HFA, ANORO ELLIPTA, ATROVENT HFA, COMBIVENT, SPIRIVA/-RESPIMAT	BREO ELLIPTA, DALIRESP* (PA), STRIVERDI RESPIMAT, SYMBICORT,TUDORZA, XOLAIR* (PA)
Topical			
Ears	*acetic acid, acetic acid-aluminum acetate, acetic acid-hydrocortisone, ciprofloxacin, fluocinolone, neomycin-polymyxin B-hydrocortisone, ofloxacin otic*	COLY-MYCIN S, CORTISPORIN-TC	CIPRODEX
Miscellaneous	*ciclopirox soln*		
Skin - All	*betamethasone dipropionate 0.05% gel/oint/cream/lotion, betamethasone valerate 0.1% lot/cream/oint, calcipotriene soln, clobetasol 0.05% sol/cream, , clotrimazole-betamethasone, fluocinolone, lidocaine, mometasone furoate, triamcinolone 0.1%, 0.25% cream/oint/lotion or 0.5% cream/oint*	ELIDEL, CORTISPORIN	CORDRAN, FINACEA (15%) gel , fluocinolone scalp oil, triamcinolone spray,
Skin – Acne* (Prior Authorization)	*adapalene, benzoyl peroxide, clindamycin, metronidazole, sulfacetamide-sulfur, isotretinoin*(PA), tretinoin*	ALA-QUIN, AZELEX	NORITATE
Women's Health			
Antineoplastic - Hormonal Agents	*tamoxifen*		
Contraceptives* (All Contraceptives subject to Quantity Limit)	*$0 copay for contraceptives nclude: generic oral contraceptives such as ethinyl estradiol-drospirenone, medroxyprogesterone acetate, Apri, Kariva, Levora, Low-Ogestrel, Necon Sprintec, Trinessa,* ORTHO-EVRA patch, NUVARING		
Combination HRT	*estradiol-norethindrone*	CLIMARA PRO, COMBIPATCH, PREFEST, PREMPHASE, PREMPRO, PREMPRO LOW DOSE	ANGELIQ
Hormone Replacement Therapy (HRT) *NOTE: If a product may be used to treat infertility prior authorization will be required.*	*estradiol,estradiol patches estropipate,progesterone micronized*(PA)*	ALORA, CENESTIN, MENEST, MENOSTAR, MINIVELLE, PREMARIN	CLIMARA PRO, DIVIGEL, ELESTRIN, ENJUVIA, ESTRACE vaginal cream, ESTRING, FEMRING, FEMTRACE

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Drug Type	Tier 1	Tier 2	Tier 3
Osteoporosis REFERENCE BASED PRICING PROGRAM (RBP)	*alendronate*	RBP: PLAN WILL PAY $0.26/PILL; REMAINING COST WILL BE APPLIED TO MEMBER SHARE ACTONEL (RBP), ATELVIA (RBP), ibandronate 150mg (RBP)	
Osteoporosis	*etidronate, Fortical,raloxifene,zoledronic acid*		
Prenatal Vitamins	*generics*		
Vaginal Products* (Quantity Limit)	*clindamycin, clotrimazole, fluconazole* (QL on 150mg), metronidazole, terconazole*		,
Miscellaneous			
Antiemetics* (Quantity Limit)	*granisetron* (QL), ondansetron* (QL), trimethobenzamide caps*	EMEND caps* (QL)	ANZEMET* (QL), CESAMET* (PA), SANCUSO* (QL),
Antineoplastic Enzyme Inhibitors* (Prior Authorization)		NEXAVAR* (PA), SPRYCEL* (PA), SUTENT* (PA)	
Antineoplastic Immunomodulator Agents* (Prior Authorization)			REVLIMID* (PA)
Growth Hormone (Prior Authorization)		GENOTROPIN* (PA), NORDITROPIN* (PA), NUTROPIN* (PA), NUTROPIN AQ* (PA)	HUMATROPE* (PA), OMNITROPE* (PA), SAIZEN* (PA), SEROSTIM* (PA), TEV-TROPIN * (PA)
Hematopoietic Growth Factors		ARANESP * (PA), EPOGEN* (PA), PROCRIT* (PA)	
Insulin-Like Growth Factors* (Prior Authorization)			INCRELEX* (PA)
Miscellaneous	*cevimeline*		CUVPOSA,NASCOBAL, NARCAN
Neurological Disease, misc (Prior Authorization)			NUEDEXTA*(PA),TYSABRI*(PA)
Rheumatoid Arthritis (Prior Authorization)	*methotrexate*	HUMIRA* (PA), TREXALL	ACTEMRA SC* (PA), ENBREL* (PA), ORENCIA* (PA), REMICADE* (PA), SIMPONI* (PA)
Smoking Cessation	*bupropion ext-rel, nicotine transdermal*	CHANTIX, NICOTROL INHALER	

FOR YOUR INFORMATION: Generics should be considered the first line of prescribing. This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage. Specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. The plan participant's prescription benefit plan may have a different copay for specific products on the list. Unless specifically indicated, drug list products will include all dosage forms. This list represents brand products in CAPS, branded generics in upper- and lowercase Italics, and generic products in lowercase italics. Generics listed in therapeutic categories are for representational purposes only. This is not an all-inclusive list. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to **www.medimpact.com** to check coverage and copay information for a specific medicine.

[1] Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

[2] Atacand should be reserved for plan participants who meet CHARM (Candesartan in Heart Failure – Assessment of Reduction in Mortality and Morbidity) trial criteria.

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This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber.