



2012

— Prescription Drug Guide —

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Humana Group Medicare Abbreviated Formulary

This is a partial list of covered drugs

Humana Group Medicare Plus

3

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT THE DRUGS WE COVER IN THIS PLAN.

*Instructions for getting information about all covered
drugs are inside.*

Welcome to Humana Group Medicare!

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

What is the formulary?

A formulary is a list of covered drugs selected by Humana Group Medicare who worked with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Humana Group Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Humana Group Medicare network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Humana Group Medicare. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com**. Simply select "Medicare Drug List" from the Humana Medicare Plans tab at the top left of the website. The Medicare Drug List search tool lets you search for your drug by name or drug type.

For help and information, prospective members please call the Customer Care number listed in your enrollment materials. Current members should call the number listed in your Annual Notice of Change or Evidence of Coverage or the number on the back of your membership card.

Can the formulary change?

Generally, if you take a drug on our 2012 formulary that was covered at the beginning of the year, we won't discontinue or reduce coverage of the drug during the 2012 coverage year except when a new, less-expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, won't affect members who currently take the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it's important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits, or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we'll immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2012. Our printed formularies will be updated each month and will be available on **Humana.com**.

How do I use the formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Drugs". If you know what your drug is used for, look for the category name in the list that begins on page 9. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 31. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

- **Tier 1 - Generic:** Drugs that have the same active ingredients as brand drugs and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity, and stability as brand drugs. Your cost for generic drugs is usually lower than your cost for brand drugs.
- **Tier 2 - Preferred Brand:** Drugs that Humana Group Medicare offers at a lower cost to you than non-preferred brand drugs.
- **Tier 3 - Non-Preferred Brand:** Drugs that Humana Group Medicare offers at a higher cost to you than preferred brands.
- **Tier 4 - Specialty Tier:** Some injectables and other high-cost drugs.

How much will I pay for Covered Drugs?

If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage or call Customer Care to find out what your costs are. Humana Group Medicare pays part of the costs for your covered drugs and you pay part of the costs, as well.

The amount you pay depends on which drug category your drug falls under in the formulary and whether you fill your prescription at a network pharmacy.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Humana Group Medicare requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval from Humana Group Medicare before you fill your prescriptions. If you don't get approval, Humana Group Medicare may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Humana Group Medicare limits the amount of the drug that we'll cover. Humana Group Medicare might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, Humana Group Medicare requires you to first try certain drugs to treat your medical condition before we'll cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Humana Group Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Humana Group Medicare will then cover Drug B.
- **Part B versus Part D (B vs D):** This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug so we can make the determination.

For drugs that require prior authorization, step therapy, or fall outside of the noted quantity limits, the doctor must fax the request to Humana Group Medicare at **1-877-486-2621**. Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9.

You also can get more information about the restrictions applied to specific covered drugs by visiting our website at **Humana.com**. Simply select "Medicare Drug List" from the Humana Medicare Plans tab at the top left of the website. The Medicare Drug List search tool lets you search for your drug by name or drug type.

You can ask Humana Group Medicare to make an exception to these restrictions or limits. See the section, "How do I request an exception to the formulary?" on page 5 for information about how to request an exception.

What if my drug is not on the formulary?

If your drug isn't included in this list of covered drugs, you should visit **Humana.com** to see if your drug is covered. Or contact Customer Care and ask if your drug is covered.

If you learn that Humana Group Medicare does not cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that are covered by Humana Group Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Humana Group Medicare.
- You can ask Humana Group Medicare to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the formulary?

You can ask Humana Group Medicare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it's not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Humana Group Medicare limits the amount of the drug that we'll cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is usually considered a non-preferred drug, you can ask us to cover it as a preferred instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, Humana Group Medicare will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions wouldn't be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier or utilization restriction exception. When you're requesting a formulary tier or utilization restriction exception you should submit a statement from your doctor supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing doctor's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing doctor's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that aren't on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we'll cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you're a member of our plan.

For each of your current Part D drugs that are not on our formulary or if your ability to get your drugs is limited, we'll cover a temporary 30-day supply (unless you have a prescription written for fewer days in which case we'll allow multiple fills to provide up to a total of 30 days of medication) when you go to a pharmacy. After your first 30-day supply, we won't pay for these drugs, even if you have been a member of the plan less than 90 days unless a formulary exception has otherwise been granted.

If you're a resident of a long-term care facility, we'll cover a temporary 102-day transition supply of your current drug therapy (unless you have a prescription written for fewer days). We'll cover more than one refill of these drugs for the first 90 days you're a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited and you're past the first 90 days of membership in our plan, we'll cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:

- Members who are discharged from a hospital or skilled nursing facility to a home setting.
- Members who are admitted to a hospital or skilled nursing facility from a home setting.
- Members who transfer from one skilled nursing facility to another and are served by a different pharmacy.
- Members who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to now use their Part D plan benefit.
- Members who give up Hospice Status and revert back to standard Medicare Part A and B coverage.
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens.

For these changes in treatment settings, Humana Group Medicare will cover up to a 34-day temporary supply of a Part D covered drug when your prescription is filled at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. Humana Group Medicare will review these requests for continuation of therapy on a case-by-case basis when you're on a stabilized drug regimen that, if altered, is known to have risks.

Transition Extension

Humana Group Medicare makes arrangements to continue to provide necessary drugs to you via an extension of the transition period, on a case-by case basis, when your exception request or appeal has not been processed by the end of your transition period.

A member Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Part D formulary is displayed.

For More Information

For more detailed information about your Humana Group Medicare prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Humana, please visit our website at **Humana.com**. Simply select "Medicare Drug List" from the Humana Medicare Plans tab at the top left of the website. The Medicare Drug List search tool lets you search for your drug by name or drug type.

If you have questions, prospective members please call the Customer Care number listed in your enrollment materials. For current members please call the number listed in your ANOC or EOC or the number on the back of your Membership card.

If you have general questions about Medicare prescription drug coverage, please call Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. Or, visit **www.medicare.gov**.

Humana Group Medicare Formulary

The formulary that begins on the next page provides coverage information about some of the drugs covered by Humana Group Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on page 31.

Remember: This is only a partial list of drugs covered by Humana. If your prescription is not listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

How to read your formulary

The first column of the chart lists categories of medical condition in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand name drugs are CAPITALIZED and generic drugs are listed in lower case. Next to the drug name you may see an indicator to tell you about additional coverage for that drug. The following indicators may be displayed:

GB - Select brand drugs that are covered in the gap.

GC - Tier 1 or Tier 2 medications that are covered in the gap.

HI - Home Infusion drugs that are covered in the gap.

SP - Drugs that are typically available through a specialty pharmacy. Please check with your specialty pharmacy to make sure your drug is available.

MO - Drugs that are typically available through mail-order. Please check with your mail-order pharmacy to make sure your drug is available.

The second column lists the tier of the drug. See page 4 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. Humana Group Medicare may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply is based on benefits and whether your doctor prescribes a 30-, 60-, or 90-day supply. The amount of any quantity limits will also be in this column (Example: QL - 30 for 30 days). See page 4 for more details on these requirements for your plan.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANTINEOPLASTIC AGENTS		
anastrozole 1 mg tablet GC,MO	1	QL (30 per 30 days)
fluorouracil 500 mg/10 ml vial GC,MO	1	B vs D
MEGACE ES 625 MG/5 ML ORAL SUSP MO	3	
MEGACE ORAL 400 MG/10 ML (40 MG/ML) ORAL SUSP MO	3	
methotrexate 2.5 mg tablet GC,MO	1	
TRELSTAR 22.5 MG IM SUSP SP	3	PA,QL (1 per 168 days)
AUTONOMIC DRUGS		
albuterol 5 mg/ml solution GC,MO	1	B vs D
albuterol sul 1.25 mg/3 ml sol GC,MO	1	B vs D
albuterol sulf 2 mg/5 ml syrup GC,MO	1	
albuterol sulfate 2 mg tab GC,MO	1	
ARICEPT 10 MG TAB MO	3	PA,QL (30 per 30 days)
ARICEPT 23 MG TAB MO	3	ST,QL (30 per 30 days)
ARICEPT 5 MG TAB MO	3	PA,QL (30 per 30 days)
ARICEPT ODT 10 MG TAB, RAPID DISSOLVE MO	3	PA,QL (30 per 30 days)
ARICEPT ODT 5 MG TAB, RAPID DISSOLVE MO	3	PA,QL (30 per 30 days)
COMBIVENT 18 MCG-103 MCG/ACTUATION AEROSOL INHALER MO	3	QL (30 per 28 days)
donepezil hcl 10 mg tablet GC,MO	1	QL (30 per 30 days)
donepezil hcl 5 mg tablet GC,MO	1	QL (30 per 30 days)
donepezil hcl odt 10 mg tablet GC,MO	1	QL (30 per 30 days)
donepezil hcl odt 5 mg tablet GC,MO	1	QL (30 per 30 days)
EPIPEN 0.3 MG/0.3 ML (1:1,000) IM INJECTOR GB,GC,MO	2	
EPIPEN JR 0.15 MG/0.3 ML (1:2,000) IM INJECTOR GB,GC,MO	2	
EXELON 4.6 MG/24 HOUR TRANSDERM 24 HR PATCH MO	3	QL (30 per 30 days)
EXELON 9.5 MG/24 HOUR TRANSDERM 24 HR PATCH MO	3	QL (30 per 30 days)
galantamine er 16 mg capsule GC,MO	1	QL (30 per 30 days)
galantamine er 24 mg capsule GC,MO	1	QL (30 per 30 days)
galantamine er 8 mg capsule GC,MO	1	QL (30 per 30 days)
galantamine hbr 12 mg tablet GC,MO	1	QL (60 per 30 days)
galantamine hbr 4 mg tablet GC,MO	1	QL (60 per 30 days)
galantamine hbr 8 mg tablet GC,MO	1	QL (60 per 30 days)
PROAIR HFA 90 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (36 per 30 days)
PROVENTIL HFA 90 MCG/ACTUATION AEROSOL INHALER MO	3	QL (36 per 30 days)
rivastigmine 1.5 mg cap GC,MO	1	QL (90 per 30 days)
rivastigmine 3 mg capsule GC,MO	1	QL (90 per 30 days)
rivastigmine 4.5 mg capsule GC,MO	1	QL (60 per 30 days)
rivastigmine 6 mg capsule GC,MO	1	QL (60 per 30 days)
SEREVENT DISKUS 50 MCG/DOSE FOR INHALATION GC,MO	2	QL (60 per 30 days)
SPIRIVA WITH HANDIHALER 18 MCG & INHALATION CAPS GC,MO	2	QL (30 per 30 days)
tamsulosin hcl 0.4 mg capsule GC,MO	1	QL (60 per 30 days)

Need more information about the indicators displayed by the drug names? Please refer to page 8.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
UROXATRAL 10 MG 24 HR TAB MO	3	QL (30 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (36 per 30 days)
BLOOD FORMATION, COAGULATION & THROMBOSIS		
ARIXTRA 10 MG/0.8 ML SUB-Q SYRINGE HI,MO	3	QL (14 per 30 days)
ARIXTRA 2.5 MG/0.5 ML SUB-Q SYRINGE HI,MO	3	QL (14 per 30 days)
ARIXTRA 5 MG/0.4 ML SUB-Q SYRINGE HI,MO	3	QL (14 per 30 days)
ARIXTRA 7.5 MG/0.6 ML SUB-Q SYRINGE HI,MO	3	QL (14 per 30 days)
cilostazol 100 mg tablet GC,MO	1	
cilostazol 50 mg tablet GC,MO	1	
enoxaparin 100 mg/ml syr GC,MO	1	QL (14 per 30 days)
enoxaparin 120 mg/0.8 ml syr GC,MO	1	QL (14 per 30 days)
enoxaparin 150 mg/ml syr GC,MO	1	QL (14 per 30 days)
enoxaparin 30 mg/0.3 ml syr GC,MO	1	QL (28 per 30 days)
enoxaparin 40 mg/0.4 ml syr GC,MO	1	QL (14 per 30 days)
enoxaparin 60 mg/0.6 ml syr HI,GC,MO	1	QL (14 per 30 days)
enoxaparin 80 mg/0.8 ml syr GC,MO	1	QL (14 per 30 days)
PRADAXA 150 MG CAP MO	3	QL (60 per 30 days)
PRADAXA 75 MG CAP MO	3	QL (60 per 30 days)
PROCRIT 10,000 UNIT/ML INJECTION SP	3	PA,QL (14 per 30 days)
PROCRIT 2,000 UNIT/ML INJECTION SP	3	PA,QL (14 per 30 days)
PROCRIT 20,000 UNIT/ML INJECTION SP	4	PA,QL (14 per 30 days)
PROCRIT 3,000 UNIT/ML INJECTION SP	3	PA,QL (14 per 30 days)
PROCRIT 4,000 UNIT/ML INJECTION SP	3	PA,QL (14 per 30 days)
PROCRIT 40,000 UNIT/ML INJECTION SP	4	PA,QL (4 per 30 days)
warfarin sodium 1 mg tablet GC,MO	1	
warfarin sodium 2 mg tablet GC,MO	1	
warfarin sodium 2.5 mg tablet GC,MO	1	
warfarin sodium 3 mg tablet GC,MO	1	
warfarin sodium 4 mg tablet GC,MO	1	
warfarin sodium 5 mg tablet GC,MO	1	
warfarin sodium 6 mg tablet GC,MO	1	
warfarin sodium 7.5 mg tablet GC,MO	1	
CARDIOVASCULAR DRUGS		
acebutolol 200 mg capsule GC,MO	1	
acebutolol 400 mg capsule GC,MO	1	
AGGRENOX 200 MG-25 MG 12 HR CAP GC,MO	2	
amiodarone hcl 400 mg tablet GC,MO	1	
amlodipine besylate 10 mg tab GC,MO	1	
amlodipine besylate 2.5 mg tab GC,MO	1	
amlodipine besylate 5 mg tab GC,MO	1	
amlodipine-benazepril 10-20 mg GC,MO	1	QL (60 per 30 days)

Need more information about the indicators displayed by the drug names? Please refer to page 8.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
amlodipine-benazepril 10-40 mg GC,MO	1	QL (30 per 30 days)
amlodipine-benazepril 2.5-10 GC,MO	1	QL (60 per 30 days)
amlodipine-benazepril 5-10 mg GC,MO	1	QL (60 per 30 days)
amlodipine-benazepril 5-20 mg GC,MO	1	QL (60 per 30 days)
amlodipine-benazepril 5-40 mg GC,MO	1	QL (30 per 30 days)
AMTURNIDE 150 MG-5 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
AMTURNIDE 300 MG-10 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
AMTURNIDE 300 MG-10 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
AMTURNIDE 300 MG-5 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
AMTURNIDE 300 MG-5 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
atenolol 25 mg tablet GC,MO	1	
AVALIDE 300 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
AVAPRO 150 MG TAB GC,MO	2	QL (30 per 30 days)
AVAPRO 300 MG TAB GC,MO	2	QL (30 per 30 days)
AVAPRO 75 MG TAB GC,MO	2	QL (30 per 30 days)
AZOR 10 MG-20 MG TAB MO	3	QL (30 per 30 days)
AZOR 10 MG-40 MG TAB MO	3	QL (30 per 30 days)
AZOR 5 MG-20 MG TAB MO	3	QL (30 per 30 days)
AZOR 5 MG-40 MG TAB MO	3	QL (30 per 30 days)
benazepril hcl 10 mg tablet GC,MO	1	
benazepril hcl 40 mg tablet GC,MO	1	
benazepril hcl 5 mg tablet GC,MO	1	
benazepril-hctz 10-12.5 mg tab GC,MO	1	
benazepril-hctz 20-12.5 mg tab GC,MO	1	
benazepril-hctz 20-25 mg tab GC,MO	1	
benazepril-hctz 5-6.25 mg tab GC,MO	1	
BENICAR 20 MG TAB MO	3	QL (30 per 30 days)
BENICAR 40 MG TAB MO	3	QL (30 per 30 days)
BENICAR 5 MG TAB MO	3	QL (30 per 30 days)
BENICAR HCT 20 MG-12.5 MG TAB MO	3	QL (30 per 30 days)
BENICAR HCT 40 MG-12.5 MG TAB MO	3	QL (30 per 30 days)
BENICAR HCT 40 MG-25 MG TAB MO	3	QL (30 per 30 days)
BIDIL 20 MG-37.5 MG TAB GC,MO	2	QL (180 per 30 days)
BYSTOLIC 10 MG TAB GC,MO	2	QL (120 per 30 days)
BYSTOLIC 2.5 MG TAB GC,MO	2	QL (30 per 30 days)
BYSTOLIC 20 MG TAB GC,MO	2	QL (60 per 30 days)
BYSTOLIC 5 MG TAB GC,MO	2	QL (30 per 30 days)
captopril 100 mg tablet GC,MO	1	
captopril 12.5 mg tablet GC,MO	1	
captopril 25 mg tablet GC,MO	1	
captopril 50 mg tablet GC,MO	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
captopril-hctz 25-15 mg tablet GC,MO	1	
captopril-hctz 25-25 mg tablet GC,MO	1	
captopril-hctz 50-15 mg tablet GC,MO	1	
captopril-hctz 50-25 mg tablet GC,MO	1	
cartia xt 120 mg 24 hr cap GC,MO	1	QL (60 per 30 days)
cartia xt 240 mg 24 hr cap GC,MO	1	QL (60 per 30 days)
cartia xt 300 mg 24 hr cap GC,MO	1	QL (30 per 30 days)
carvedilol 12.5 mg tablet GC,MO	1	
carvedilol 25 mg tablet GC,MO	1	
carvedilol 3.125 mg tablet GC,MO	1	
carvedilol 6.25 mg tablet GC,MO	1	
COREG CR 10 MG 24 HR CAP MO	3	QL (30 per 30 days)
COREG CR 20 MG 24 HR CAP MO	3	QL (30 per 30 days)
COREG CR 40 MG 24 HR CAP MO	3	QL (30 per 30 days)
COREG CR 80 MG 24 HR CAP MO	3	QL (30 per 30 days)
CRESTOR 10 MG TAB GC,MO	2	QL (30 per 30 days)
CRESTOR 20 MG TAB GC,MO	2	QL (30 per 30 days)
CRESTOR 40 MG TAB GC,MO	2	QL (30 per 30 days)
CRESTOR 5 MG TAB GC,MO	2	QL (30 per 30 days)
digoxin 125 mcg tablet GC,MO	1	
digoxin 250 mcg tablet GC,MO	1	
dilt-xr 180 mg cap GC,MO	1	QL (60 per 30 days)
diltiazem 120 mg tablet GC,MO	1	
DIOVAN 160 MG TAB GC,MO	2	QL (60 per 30 days)
DIOVAN 320 MG TAB GC,MO	2	QL (60 per 30 days)
DIOVAN 40 MG TAB GC,MO	2	QL (60 per 30 days)
DIOVAN 80 MG TAB GC,MO	2	QL (60 per 30 days)
DIOVAN HCT 160 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
DIOVAN HCT 160 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
DIOVAN HCT 320 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
DIOVAN HCT 320 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
DIOVAN HCT 80 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
dipyridamole 25 mg tablet GC,MO	1	PA
dipyridamole 50 mg tablet GC,MO	1	PA
dipyridamole 75 mg tablet GC,MO	1	PA
doxazosin mesylate 1 mg tab GC,MO	1	
doxazosin mesylate 4 mg tab GC,MO	1	
enalapril maleate 10 mg tab GC,MO	1	
enalapril-hctz 10-25 mg tablet GC,MO	1	
EXFORGE 10 MG-160 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE 10 MG-320 MG TAB GC,MO	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EXFORGE 5 MG-160 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE 5 MG-320 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE HCT 10 MG-160 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE HCT 10 MG-160 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE HCT 10 MG-320 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE HCT 5 MG-160 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
EXFORGE HCT 5 MG-160 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
felodipine er 10 mg tablet GC,MO	1	QL (30 per 30 days)
felodipine er 2.5 mg tablet GC,MO	1	QL (30 per 30 days)
felodipine er 5 mg tablet GC,MO	1	QL (30 per 30 days)
fenofibrate 134 mg capsule GC,MO	1	QL (30 per 30 days)
fenofibrate 200 mg capsule GC,MO	1	QL (30 per 30 days)
fenofibrate 54 mg tablet GC,MO	1	QL (60 per 30 days)
fenofibrate 67 mg capsule GC,MO	1	QL (60 per 30 days)
fosinopril sodium 10 mg tab GC,MO	1	
hydralazine 10 mg tablet GC,MO	1	
hydralazine 100 mg tablet GC,MO	1	
hydralazine 25 mg tablet GC,MO	1	
hydralazine 50 mg tablet GC,MO	1	
isosorbide mn 10 mg tablet GC,MO	1	
labetalol hcl 100 mg tablet GC,MO	1	
labetalol hcl 200 mg tablet GC,MO	1	
labetalol hcl 300 mg tablet GC,MO	1	
LESCOL 20 MG CAP GC,MO	2	QL (60 per 30 days)
LESCOL 40 MG CAP GC,MO	2	QL (60 per 30 days)
LESCOL XL 80 MG 24 HR TAB GC,MO	2	QL (30 per 30 days)
LETAIRIS 10 MG TAB SP	4	PA,QL (30 per 30 days)
LETAIRIS 5 MG TAB SP	4	PA,QL (30 per 30 days)
LIPITOR 10 MG TAB GC,MO	2	QL (30 per 30 days)
LIPITOR 20 MG TAB GC,MO	2	QL (30 per 30 days)
LIPITOR 40 MG TAB GC,MO	2	QL (30 per 30 days)
LIPITOR 80 MG TAB GC,MO	2	QL (30 per 30 days)
lisinopril 10 mg tablet GC,MO	1	
lisinopril 20 mg tablet GC,MO	1	
lisinopril 30 mg tablet GC,MO	1	
lisinopril 40 mg tablet GC,MO	1	
lisinopril-hctz 10-12.5 mg tab GC,MO	1	
lisinopril-hctz 20-12.5 mg tab GC,MO	1	
lisinopril-hctz 20-25 mg tab GC,MO	1	
LIVALO 1 MG TAB MO	3	ST,QL (30 per 30 days)
LIVALO 2 MG TAB MO	3	ST,QL (30 per 30 days)

Need more information about the indicators displayed by the drug names? Please refer to page 8.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LIVALO 4 MG TAB MO	3	ST,QL (30 per 30 days)
losartan potassium 100 mg tab GC,MO	1	QL (60 per 30 days)
losartan potassium 25 mg tab GC,MO	1	QL (60 per 30 days)
losartan potassium 50 mg tab GC,MO	1	QL (60 per 30 days)
losartan-hctz 100-12.5 mg tab GC,MO	1	QL (60 per 30 days)
losartan-hctz 100-25 mg tab GC,MO	1	QL (60 per 30 days)
losartan-hctz 50-12.5 mg tab GC,MO	1	QL (60 per 30 days)
lovastatin 10 mg tablet GC,MO	1	QL (60 per 30 days)
lovastatin 20 mg tablet GC,MO	1	QL (60 per 30 days)
lovastatin 40 mg tablet GC,MO	1	QL (60 per 30 days)
LOVAZA 1 GRAM CAP GC,MO	2	QL (120 per 30 days)
methyl dopa 250 mg tablet GC,MO	1	
methyl dopa 500 mg tablet GC,MO	1	
metoprolol succ er 200 mg tab GC,MO	1	QL (60 per 30 days)
metoprolol succ er 25 mg tab GC,MO	1	QL (60 per 30 days)
metoprolol tartrate 100 mg tab GC,MO	1	
metoprolol tartrate 25 mg tab GC,MO	1	
metoprolol tartrate 50 mg tab GC,MO	1	
metoprolol-hctz 100-25 mg tab GC,MO	1	
metoprolol-hctz 100-50 mg tab GC,MO	1	
metoprolol-hctz 50-25 mg tab GC,MO	1	
minoxidil 10 mg tablet GC,MO	1	
minoxidil 2.5 mg tablet GC,MO	1	
NIASPAN EXTENDED-RELEASE 1,000 MG 24 HR TAB GC,MO	2	
NIASPAN EXTENDED-RELEASE 500 MG 24 HR TAB GC,MO	2	
NIASPAN EXTENDED-RELEASE 750 MG 24 HR TAB GC,MO	2	
nifedipine 10 mg capsule GC,MO	1	PA
nifedipine 20 mg capsule GC,MO	1	PA
nisoldipine er 17 mg tablet GC,MO	1	QL (30 per 30 days)
nisoldipine er 20 mg tablet GC,MO	1	QL (30 per 30 days)
nisoldipine er 25.5 mg tablet GC,MO	1	QL (60 per 30 days)
nisoldipine er 30 mg tablet GC,MO	1	QL (60 per 30 days)
nisoldipine er 34 mg tablet GC,MO	1	QL (30 per 30 days)
nisoldipine er 40 mg tablet GC,MO	1	QL (30 per 30 days)
nisoldipine er 8.5 mg tablet GC,MO	1	QL (30 per 30 days)
nitroglycerin 0.2 mg/hr patch GC,MO	1	QL (30 per 30 days)
nitroglycerin 0.4 mg/hr patch GC,MO	1	QL (60 per 30 days)
nitroglycerin 0.6 mg/hr patch GC,MO	1	QL (30 per 30 days)
pravastatin sodium 10 mg tab GC,MO	1	QL (30 per 30 days)
pravastatin sodium 20 mg tab GC,MO	1	QL (30 per 30 days)
pravastatin sodium 40 mg tab GC,MO	1	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
pravastatin sodium 80 mg tab GC,MO	1	QL (30 per 30 days)
propafenone hcl er 225 mg cap GC,MO	1	
propafenone hcl sr 325 mg cap GC,MO	1	
propafenone hcl sr 425 mg cap GC,MO	1	
propranolol 80 mg tablet GC,MO	1	
ramipril 1.25 mg capsule GC,MO	1	
ramipril 2.5 mg capsule GC,MO	1	
ramipril 5 mg capsule GC,MO	1	
RYTHMOL SR 325 MG 12 HR CAP MO	3	PA
RYTHMOL SR 425 MG 12 HR CAP MO	3	PA
SIMCOR 1,000 MG-40 MG 24 HR TAB MO	3	QL (30 per 30 days)
SIMCOR 500 MG-20 MG 24 HR TAB MO	3	QL (60 per 30 days)
SIMCOR 500 MG-40 MG 24 HR TAB MO	3	QL (30 per 30 days)
SIMCOR 750 MG-20 MG 24 HR TAB MO	3	QL (60 per 30 days)
simvastatin 10 mg tablet GC,MO	1	QL (30 per 30 days)
simvastatin 20 mg tablet GC,MO	1	QL (30 per 30 days)
simvastatin 40 mg tablet GC,MO	1	QL (30 per 30 days)
simvastatin 5 mg tablet GC,MO	1	QL (30 per 30 days)
simvastatin 80 mg tablet GC,MO	1	QL (30 per 30 days)
sotalol 120 mg tablet GC,MO	1	
sotalol 160 mg tablet GC,MO	1	
sotalol 240 mg tablet GC,MO	1	
sotalol 80 mg tablet GC,MO	1	
spironolactone 100 mg tablet GC,MO	1	
spironolactone 25 mg tablet GC,MO	1	
spironolactone 50 mg tablet GC,MO	1	
TEKAMLO 150 MG-10 MG TAB GC,MO	2	QL (30 per 30 days)
TEKAMLO 150 MG-5 MG TAB GC,MO	2	QL (30 per 30 days)
TEKAMLO 300 MG-10 MG TAB GC,MO	2	QL (30 per 30 days)
TEKAMLO 300 MG-5 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA 150 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA 300 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA HCT 150 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA HCT 150 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA HCT 300 MG-12.5 MG TAB GC,MO	2	QL (30 per 30 days)
TEKTURNA HCT 300 MG-25 MG TAB GC,MO	2	QL (30 per 30 days)
timolol maleate 10 mg tablet GC,MO	1	
timolol maleate 20 mg tablet GC,MO	1	
timolol maleate 5 mg tablet GC,MO	1	
TRIBENZOR 20 MG-5 MG-12.5 MG TAB MO	3	QL (30 per 30 days)
TRIBENZOR 40 MG-10 MG-12.5 MG TAB MO	3	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TRIBENZOR 40 MG-10 MG-25 MG TAB MO	3	QL (30 per 30 days)
TRIBENZOR 40 MG-5 MG-12.5 MG TAB MO	3	QL (30 per 30 days)
TRIBENZOR 40 MG-5 MG-25 MG TAB MO	3	QL (30 per 30 days)
TRICOR 145 MG TAB GC,MO	2	QL (30 per 30 days)
TRICOR 48 MG TAB GC,MO	2	QL (60 per 30 days)
VALTURNA 150 MG-160 MG TAB GC,MO	2	QL (30 per 30 days)
VALTURNA 300 MG-320 MG TAB GC,MO	2	QL (30 per 30 days)
verapamil 120 mg tablet GC,MO	1	
verapamil 80 mg tablet GC,MO	1	
VYTORIN 10-10 10 MG-10 MG TAB MO	3	QL (30 per 30 days)
VYTORIN 10-20 10 MG-20 MG TAB MO	3	QL (30 per 30 days)
VYTORIN 10-40 10 MG-40 MG TAB MO	3	QL (30 per 30 days)
VYTORIN 10-80 10 MG-80 MG TAB MO	3	QL (30 per 30 days)
WELCHOL 625 MG TAB GC,MO	2	
ZETIA 10 MG TAB GC,MO	2	ST,QL (30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
ABILIFY 10 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY 15 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY 2 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY 20 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY 30 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY 5 MG TAB MO	3	PA,QL (30 per 30 days)
ABILIFY DISCMELT 10 MG MO	3	PA,QL (60 per 30 days)
ABILIFY DISCMELT 15 MG MO	3	PA,QL (60 per 30 days)
acetaminophen-cod #2 tablet GC,MO	1	QL (390 per 30 days)
amantadine 100 mg tablet GC,MO	1	
amitriptyline hcl 10 mg tab GC,MO	1	
amitriptyline hcl 100 mg tab GC,MO	1	
amitriptyline hcl 25 mg tab GC,MO	1	
amitriptyline hcl 50 mg tab GC,MO	1	
amoxapine 100 mg tablet GC,MO	1	
amoxapine 150 mg tablet GC,MO	1	
amoxapine 25 mg tablet GC,MO	1	
amoxapine 50 mg tablet GC,MO	1	
AVINZA 120 MG 24 HR CAP GC,MO	2	QL (60 per 30 days)
AVINZA 30 MG 24 HR CAP GC,MO	2	QL (30 per 30 days)
AVINZA 45 MG 24 HR CAP GC,MO	2	QL (30 per 30 days)
AVINZA 60 MG 24 HR CAP GC,MO	2	QL (60 per 30 days)
AVINZA 75 MG 24 HR CAP GC,MO	2	QL (60 per 30 days)
AVINZA 90 MG 24 HR CAP GC,MO	2	QL (60 per 30 days)
budeprion sr 100 mg tab GC,MO	1	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
budeprion sr 150 mg tab GC,MO	1	QL (120 per 30 days)
budeprion xl 300 mg 24 hr tab GC,MO	1	QL (90 per 30 days)
bupropion hcl sr 200 mg tab GC,MO	1	QL (60 per 30 days)
bupropion sr 150 mg tablet GC,MO	1	QL (120 per 30 days)
bupirone hcl 15 mg tablet GC,MO	1	
bupirone hcl 7.5 mg tablet GC,MO	1	
carbamazepine 100 mg tab chew GC,MO	1	
carbamazepine 200 mg tablet GC,MO	1	
carbamazepine xr 200 mg tablet GC,MO	1	
carbamazepine xr 400 mg tablet GC,MO	1	
carbidopa-leva 25-100 mg odt GC,MO	1	
carbidopa-leva 25-250 mg odt GC,MO	1	
carbidopa-leva er 25-100 tab GC,MO	1	
carbidopa-leva er 50-200 tab GC,MO	1	
carbidopa-levodopa 10-100 tab GC,MO	1	
carbidopa-levodopa 25-100 tab GC,MO	1	
carbidopa-levodopa 25-250 tab GC,MO	1	
CELEBREX 100 MG CAP GC,MO	2	ST,QL (60 per 30 days)
CELEBREX 200 MG CAP GC,MO	2	ST,QL (60 per 30 days)
CELEBREX 400 MG CAP GC,MO	2	ST,QL (60 per 30 days)
CELEBREX 50 MG CAP GC,MO	2	ST,QL (60 per 30 days)
citalopram hbr 10 mg tablet GC,MO	1	QL (30 per 30 days)
citalopram hbr 20 mg tablet GC,MO	1	QL (90 per 30 days)
citalopram hbr 40 mg tablet GC,MO	1	QL (45 per 30 days)
clozapine 100 mg tablet GC,MO	1	
clozapine 200 mg tablet GC,MO	1	
clozapine 25 mg tablet GC,MO	1	
clozapine 50 mg tablet GC,MO	1	
COMTAN 200 MG TAB GC,MO	2	QL (300 per 30 days)
CYMBALTA 20 MG CAP GC,MO	2	QL (60 per 30 days)
CYMBALTA 30 MG CAP GC,MO	2	QL (60 per 30 days)
CYMBALTA 60 MG CAP GC,MO	2	QL (60 per 30 days)
desipramine 10 mg tablet GC,MO	1	
desipramine 100 mg tablet GC,MO	1	
desipramine 25 mg tablet GC,MO	1	
desipramine 50 mg tablet GC,MO	1	
desipramine 75 mg tablet GC,MO	1	
EFFEXOR XR 150 MG 24 HR CAP MO	3	PA,QL (60 per 30 days)
EFFEXOR XR 37.5 MG 24 HR CAP MO	3	PA,QL (30 per 30 days)
EFFEXOR XR 75 MG 24 HR CAP MO	3	PA,QL (90 per 30 days)
EMBEDA 100-4 MG CAPSULE GC,MO	2	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EMBEDA 20-0.8 MG CAPSULE GC,MO	2	QL (60 per 30 days)
EMBEDA 30-1.2 MG CAPSULE GC,MO	2	QL (60 per 30 days)
EMBEDA 50-2 MG CAPSULE GC,MO	2	QL (60 per 30 days)
EMBEDA 60-2.4 MG CAPSULE GC,MO	2	QL (60 per 30 days)
EMBEDA 80-3.2 MG CAPSULE GC,MO	2	QL (60 per 30 days)
endocet 10 mg-325 mg tab GC,MO	1	QL (360 per 30 days)
endocet 10 mg-650 mg tab GC,MO	1	QL (180 per 30 days)
endocet 5 mg-325 mg tab GC,MO	1	QL (360 per 30 days)
endocet 7.5 mg-325 mg tab GC,MO	1	QL (360 per 30 days)
endocet 7.5 mg-500 mg tab GC,MO	1	QL (240 per 30 days)
EXALGO ER 12 MG 24 HR TAB MO	3	ST,QL (180 per 30 days)
EXALGO ER 16 MG 24 HR TAB MO	3	ST,QL (120 per 30 days)
EXALGO ER 8 MG 24 HR TAB MO	3	ST,QL (240 per 30 days)
fentanyl 100 mcg/hr patch GC,MO	1	QL (20 per 30 days)
fluoxetine hcl 20 mg tablet GC,MO	1	
fluoxetine hcl 40 mg capsule GC,MO	1	QL (60 per 30 days)
gabapentin 300 mg capsule GC,MO	1	QL (270 per 30 days)
gabapentin 400 mg capsule GC,MO	1	QL (270 per 30 days)
gabapentin 600 mg tablet GC,MO	1	QL (180 per 30 days)
gabapentin 800 mg tablet GC,MO	1	QL (180 per 30 days)
GEODON 20 MG CAP GC,MO	2	QL (60 per 30 days)
GEODON 40 MG CAP GC,MO	2	QL (60 per 30 days)
GEODON 60 MG CAP GC,MO	2	QL (60 per 30 days)
GEODON 80 MG CAP GC,MO	2	QL (60 per 30 days)
haloperidol 1 mg tablet GC,MO	1	
haloperidol 2 mg tablet GC,MO	1	
hydroxyzine hcl 10 mg tablet GC,MO	1	PA
hydroxyzine hcl 25 mg tablet GC,MO	1	PA
INVEGA SUSTENNA 117 MG/0.75 ML IM SYRINGE MO	4	QL (1 per 30 days)
INVEGA SUSTENNA 156 MG/ML (1 ML) IM SYRINGE MO	4	QL (1 per 30 days)
INVEGA SUSTENNA 234 MG/1.5 ML IM SYRINGE MO	4	QL (1 per 30 days)
INVEGA SUSTENNA 39 MG/0.25 ML IM SYRINGE MO	3	QL (1 per 30 days)
INVEGA SUSTENNA 78 MG/0.5 ML IM SYRINGE MO	3	QL (1 per 30 days)
KADIAN 10 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 100 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 20 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 200 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 30 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 50 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 60 MG CAP GC,MO	2	QL (60 per 30 days)
KADIAN 80 MG CAP GC,MO	2	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LAMICTAL XR 100 MG 24 HR TAB MO	3	QL (120 per 30 days)
LAMICTAL XR 200 MG 24 HR TAB MO	3	QL (90 per 30 days)
LAMICTAL XR 25 MG 24 HR TAB MO	3	QL (90 per 30 days)
LAMICTAL XR 50 MG 24 HR TAB MO	3	QL (90 per 30 days)
lamotrigine 100 mg tablet GC,MO	1	QL (150 per 30 days)
lamotrigine 150 mg tablet GC,MO	1	QL (90 per 30 days)
lamotrigine 200 mg tablet GC,MO	1	QL (90 per 30 days)
lamotrigine 25 mg disper tab GC,MO	1	
lamotrigine 25 mg tablet GC,MO	1	QL (120 per 30 days)
lamotrigine 5 mg disper tablet GC,MO	1	
LATUDA 40 MG TAB MO	3	PA,QL (30 per 30 days)
LATUDA 80 MG TAB MO	3	PA,QL (30 per 30 days)
levetiracetam 1,000 mg tablet GC,MO	1	QL (120 per 30 days)
levetiracetam 250 mg tablet GC,MO	1	QL (120 per 30 days)
levetiracetam 500 mg tablet GC,MO	1	QL (120 per 30 days)
levetiracetam 750 mg tablet GC,MO	1	QL (120 per 30 days)
LEXAPRO 10 MG TAB GC,MO	2	QL (30 per 30 days)
LEXAPRO 20 MG TAB GC,MO	2	QL (30 per 30 days)
LEXAPRO 5 MG TAB GC,MO	2	QL (30 per 30 days)
lithium carbonate 150 mg cap GC,MO	1	
lithium carbonate er 300 mg tb GC,MO	1	
meloxicam 7.5 mg tablet GC,MO	1	QL (60 per 30 days)
mirtazapine 15 mg odt GC,MO	1	QL (30 per 30 days)
mirtazapine 15 mg tablet GC,MO	1	QL (30 per 30 days)
mirtazapine 30 mg odt GC,MO	1	QL (30 per 30 days)
mirtazapine 30 mg tablet GC,MO	1	QL (30 per 30 days)
mirtazapine 45 mg odt GC,MO	1	QL (30 per 30 days)
mirtazapine 45 mg tablet GC,MO	1	QL (30 per 30 days)
mirtazapine 7.5 mg tablet GC,MO	1	
morphine sulf er 100 mg tablet GC,MO	1	
morphine sulf er 30 mg tablet GC,MO	1	
NAMENDA 10 MG TAB GC,MO	2	QL (60 per 30 days)
NAMENDA 10 MG/5 ML ORAL SOLN GC,MO	2	QL (360 per 30 days)
NAMENDA 5 MG TAB GC,MO	2	QL (60 per 30 days)
NAMENDA TITRATION PAK 5 MG-10 MG TABS IN A DOSE PACK GC,MO	2	QL (98 per 30 days)
naratriptan hcl 1 mg tablet GC,MO	1	QL (9 per 30 days)
naratriptan hcl 2.5 mg tablet GC,MO	1	QL (9 per 30 days)
nortriptyline hcl 75 mg cap GC,MO	1	
OLEPTRO ER 150 MG 24 HR TAB MO	3	PA,QL (30 per 30 days)
OLEPTRO ER 300 MG 24 HR TAB MO	3	PA,QL (30 per 30 days)
OPANA ER 10 MG 12 HR TAB GC,MO	2	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OPANA ER 20 MG 12 HR TAB GC,MO	2	QL (60 per 30 days)
OPANA ER 30 MG 12 HR TAB GC,MO	2	QL (60 per 30 days)
OPANA ER 40 MG 12 HR TAB GC,MO	2	QL (60 per 30 days)
OPANA ER 5 MG 12 HR TAB GC,MO	2	QL (60 per 30 days)
PENNSAID 1.5 % TOPICAL DROPS MO	3	
PHENYTEK 200 MG CAP GC,MO	1	
PHENYTEK 300 MG CAP GC,MO	1	
pramipexole 0.125 mg tablet GC,MO	1	
pramipexole 0.25 mg tablet GC,MO	1	
pramipexole 0.5 mg tablet GC,MO	1	
pramipexole 0.75 mg tablet GC,MO	1	
pramipexole 1 mg tablet GC,MO	1	
pramipexole 1.5 mg tablet GC,MO	1	
PRISTIQ 100 MG 24 HR TAB MO	3	QL (30 per 30 days)
PRISTIQ 50 MG 24 HR TAB MO	3	QL (30 per 30 days)
REQUIP XL 12 MG 24 HR TAB MO	3	QL (90 per 30 days)
REQUIP XL 2 MG 24 HR TAB MO	3	QL (90 per 30 days)
REQUIP XL 4 MG 24 HR TAB MO	3	QL (90 per 30 days)
REQUIP XL 6 MG 24 HR TAB MO	3	QL (90 per 30 days)
REQUIP XL 8 MG 24 HR TAB MO	3	QL (90 per 30 days)
RISPERDAL CONSTA 12.5 MG/2 ML IM SYRINGE MO	3	QL (2 per 28 days)
RISPERDAL CONSTA 25 MG/2 ML IM SYRINGE MO	3	QL (2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML IM SYRINGE MO	3	QL (4 per 28 days)
RISPERDAL CONSTA 50 MG/2 ML IM SYRINGE MO	4	QL (4 per 28 days)
risperidone 0.25 mg odt GC,MO	1	QL (60 per 30 days)
risperidone 0.25 mg tablet GC,MO	1	QL (60 per 30 days)
risperidone 0.5 mg odt GC,MO	1	QL (120 per 30 days)
risperidone 0.5 mg tablet GC,MO	1	QL (120 per 30 days)
risperidone 2 mg odt GC,MO	1	QL (60 per 30 days)
risperidone 2 mg tablet GC,MO	1	QL (60 per 30 days)
risperidone 3 mg odt GC,MO	1	QL (60 per 30 days)
risperidone 3 mg tablet GC,MO	1	QL (60 per 30 days)
risperidone 4 mg odt GC,MO	1	QL (60 per 30 days)
ropinirole hcl 0.25 mg tablet GC,MO	1	
ropinirole hcl 0.5 mg tablet GC,MO	1	
ropinirole hcl 1 mg tablet GC,MO	1	
ropinirole hcl 2 mg tablet GC,MO	1	
ropinirole hcl 4 mg tablet GC,MO	1	
ropinirole hcl 5 mg tablet GC,MO	1	
SEROQUEL 100 MG TAB GC,MO	2	QL (90 per 30 days)
SEROQUEL 200 MG TAB GC,MO	2	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SEROQUEL 25 MG TAB GC,MO	2	QL (120 per 30 days)
SEROQUEL 300 MG TAB GC,MO	2	QL (90 per 30 days)
SEROQUEL 400 MG TAB GC,MO	2	QL (90 per 30 days)
SEROQUEL 50 MG TAB GC,MO	2	QL (120 per 30 days)
SEROQUEL XR 150 MG 24 HR TAB GC,MO	2	QL (90 per 30 days)
SEROQUEL XR 200 MG 24 HR TAB GC,MO	2	QL (30 per 30 days)
SEROQUEL XR 300 MG 24 HR TAB GC,MO	2	QL (60 per 30 days)
SEROQUEL XR 400 MG 24 HR TAB GC,MO	2	QL (60 per 30 days)
SEROQUEL XR 50 MG 24 HR TAB GC,MO	2	QL (120 per 30 days)
sertraline hcl 100 mg tablet GC,MO	1	QL (60 per 30 days)
sertraline hcl 25 mg tablet GC,MO	1	QL (60 per 30 days)
sertraline hcl 50 mg tablet GC,MO	1	QL (60 per 30 days)
STALEVO 100 25 MG-100 MG-200 MG TAB GC,MO	2	
STALEVO 125 31.25 MG-125 MG-200 MG TAB GC,MO	2	
STALEVO 150 37.5 MG-150 MG-200 MG TAB GC,MO	2	
STALEVO 200 50 MG-200 MG-200 MG TAB GC,MO	2	
STALEVO 50 12.5 MG-50 MG-200 MG TAB GC,MO	2	
STALEVO 75 18.75 MG-75 MG-200 MG TAB GC,MO	2	
SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM MO	3	PA,QL (90 per 30 days)
SUBOXONE 8 MG-2 MG SUBLINGUAL FILM MO	3	PA,QL (90 per 30 days)
sumatriptan 4 mg/0.5 ml vial GC,MO	1	QL (6 per 30 days)
sumatriptan 6 mg/0.5 ml vial GC,MO	1	QL (6 per 30 days)
sumatriptan succ 100 mg tablet GC,MO	1	QL (9 per 30 days)
sumatriptan succ 25 mg tablet GC,MO	1	QL (9 per 30 days)
sumatriptan succ 50 mg tablet GC,MO	1	QL (9 per 30 days)
topiramate 100 mg tablet GC,MO	1	QL (120 per 30 days)
topiramate 15 mg sprinkle cap GC,MO	1	
topiramate 200 mg tablet GC,MO	1	QL (120 per 30 days)
topiramate 25 mg tablet GC,MO	1	QL (90 per 30 days)
topiramate 50 mg tablet GC,MO	1	QL (120 per 30 days)
trazodone 150 mg tablet GC,MO	1	
trazodone 300 mg tablet GC,MO	1	
TREXIMET 85 MG-500 MG TAB MO	3	QL (12 per 30 days)
venlafaxine hcl 100 mg tablet GC,MO	1	
venlafaxine hcl 25 mg tablet GC,MO	1	
venlafaxine hcl 37.5 mg tablet GC,MO	1	
venlafaxine hcl 50 mg tablet GC,MO	1	
venlafaxine hcl 75 mg tablet GC,MO	1	
venlafaxine hcl er 150 mg cap GC,MO	1	QL (60 per 30 days)
venlafaxine hcl er 37.5 mg cap GC,MO	1	QL (30 per 30 days)
venlafaxine hcl er 75 mg cap GC,MO	1	QL (90 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
VIMOVO 375 MG-20 MG MULTIPHASE, IMMEDIATE & DELAY RELEASE TAB GC,MO	2	ST,QL (60 per 30 days)
VIMOVO 500 MG-20 MG MULTIPHASE, IMMEDIATE & DELAY RELEASE TAB GC,MO	2	ST,QL (60 per 30 days)
VIMPAT 10 MG/ML ORAL SOLUTION MO	3	QL (1395 per 30 days)
VOLTAREN 1 % TOPICAL GEL MO	3	
ZIPSOR 25 MG CAP MO	3	QL (120 per 30 days)
zolpidem tartrate 12.5 mg tab GC,MO	1	ST,QL (30 per 30 days)
zolpidem tartrate 6.25 mg tab GC,MO	1	ST,QL (30 per 30 days)
zonisamide 25 mg capsule GC,MO	1	
ZYPREXA 10 MG IM MO	3	PA,QL (60 per 30 days)
ZYPREXA 10 MG TAB MO	3	PA,QL (30 per 30 days)
ZYPREXA 15 MG TAB MO	3	PA,QL (60 per 30 days)
ZYPREXA 2.5 MG TAB MO	3	PA,QL (30 per 30 days)
ZYPREXA 20 MG TAB MO	3	PA,QL (60 per 30 days)
ZYPREXA 5 MG TAB MO	3	PA,QL (30 per 30 days)
ZYPREXA 7.5 MG TAB MO	3	PA,QL (30 per 30 days)
ZYPREXA ZYDIS 10 MG TAB, RAPID DISSOLVE MO	3	PA,QL (30 per 30 days)
ZYPREXA ZYDIS 15 MG TAB, RAPID DISSOLVE MO	3	PA,QL (60 per 30 days)
ZYPREXA ZYDIS 20 MG TAB, RAPID DISSOLVE MO	3	PA,QL (60 per 30 days)
ZYPREXA ZYDIS 5 MG TAB, RAPID DISSOLVE MO	3	PA,QL (30 per 30 days)
ELECTROLYTIC, CALORIC, AND WATER BALANCE		
chlorothiazide 250 mg tablet GC,MO	1	
chlorothiazide 500 mg tablet GC,MO	1	
fexofenadine hcl 30 mg tablet GC,MO	1	QL (60 per 30 days)
fexofenadine hcl 60 mg tablet GC,MO	1	QL (60 per 30 days)
hydrochlorothiazide 25 mg tab GC,MO	1	
levocetirizine 5 mg tablet GC,MO	1	QL (30 per 30 days)
PHOSLO 667 MG CAP GC,MO	2	
promethazine 12.5 mg suppos GC,MO	1	PA
promethazine 25 mg suppository GC,MO	1	PA
RENVELA 0.8 GRAM ORAL PWPK GC,MO	2	QL (540 per 30 days)
RENVELA 2.4 GRAM ORAL PWPK GC,MO	2	QL (180 per 30 days)
RENVELA 800 MG TAB GC,MO	2	QL (540 per 30 days)
sodium lactate 1/6molar inj GC,MO	1	
sodium lactate 5 meq/ml vial GC,MO	1	
toremide 10 mg tablet GC,MO	1	
toremide 100 mg tablet GC,MO	1	
toremide 20 mg tablet GC,MO	1	
toremide 5 mg tablet GC,MO	1	
triamterene-hctz 37.5-25 mg cp GC,MO	1	
triamterene-hctz 37.5-25 mg tb GC,MO	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
triamterene-hctz 50-25 mg cap GC,MO	1	
triamterene-hctz 75-50 mg tab GC,MO	1	
EYE, EAR, NOSE AND THROAT (EENT) PREPS.		
acetazolamide 250 mg tablet GC,MO	1	
ACUVAIL 0.45 % EYE DROPPERETTE MO	3	
AZOPT 1 % EYE DROPS GC,MO	2	
dorzolamide hcl 2% eye drops GC,MO	1	QL (10 per 30 days)
dorzolamide-timolol eye drops GC,MO	1	QL (10 per 30 days)
LASTACFT 0.25 % EYE DROPS MO	3	
LUMIGAN 0.01 % EYE DROPS GC,MO	2	QL (3 per 25 days)
LUMIGAN 0.03 % EYE DROPS GC,MO	2	QL (3 per 25 days)
NASONEX 50 MCG/ACTUATION SPRAY GC,MO	2	QL (34 per 30 days)
PATADAY 0.2 % EYE DROPS GC,MO	2	
PATANASE 0.6 % NASAL SPRAY MO	3	QL (31 per 30 days)
PATANOL 0.1 % EYE DROPS MO	3	
RESTASIS 0.05 % EYE DROPPERETTE GC,MO	2	
timolol 0.25% eye drops GC,MO	1	
timolol 0.25% gfs gel-solution GC,MO	1	
timolol 0.5% eye drops GC,MO	1	
timolol 0.5% gfs gel-solution GC,MO	1	
TRAVATAN Z 0.004 % EYE DROPS GC,MO	2	QL (3 per 25 days)
VERAMYST 27.5 MCG/ACTUATION NASAL SPRAY GC,MO	2	QL (10 per 30 days)
VOLTAREN 0.1 % EYE DROPS MO	3	PA
ZYMAXID 0.5 % EYE DROPS MO	3	QL (3 per 25 days)
GASTROINTESTINAL DRUGS		
ASACOL 400 MG TAB MO	3	QL (360 per 30 days)
ASACOL HD 800 MG TAB MO	3	QL (180 per 30 days)
cimetidine 300 mg tablet GC,MO	1	
cimetidine 400 mg tablet GC,MO	1	
cimetidine 800 mg tablet GC,MO	1	
CIMZIA 400 MG/2 ML (200 MG/ML X 2) SUBQ SYRINGE KIT SP	4	PA,QL (6 per 30 days)
CIMZIA POWDER FOR RECONSTITUTION 400 MG (200 MG X 2) SUB-Q KIT SP	4	PA,QL (6 per 30 days)
DEXILANT 30 MG CAPSULE MO	3	QL (30 per 30 days)
DEXILANT 60 MG CAPSULE MO	3	QL (30 per 30 days)
GOLYTELY 227.1 G-21.5 G-6.36 G-5.53 G PACKET GC,MO	2	
GOLYTELY 236 G-22.74 G-6.74 G-5.86 G ORAL SOLUTION GB,GC,MO	2	
lansoprazole odt 15 mg tablet GC,MO	1	QL (30 per 30 days)
lansoprazole odt 30 mg tablet GC,MO	1	QL (30 per 30 days)
NEXIUM 20 MG CAP GC,MO	2	QL (30 per 30 days)
NEXIUM 40 MG CAP GC,MO	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NULYTELY WITH FLAVOR PACKS 420 G ORAL SOLUTION GB,GC,MO	2	
omeprazole dr 40 mg capsule GC,MO	1	QL (30 per 30 days)
omeprazole-bicarb 20-1,100 cap GC,MO	1	QL (30 per 30 days)
omeprazole-bicarb 40-1,100 cap GC,MO	1	QL (30 per 30 days)
PANCREAZE 10,500-25,000-43,750 UNIT CAP MO	3	
PANCREAZE 16,800-40,000-70,000 UNIT CAP MO	3	
PANCREAZE 21,000-37,000-61,000 UNIT CAP MO	3	
PANCREAZE 4,200-10,000-17,500 UNIT CAP MO	3	
pantoprazole sod dr 20 mg tab GC,MO	1	QL (30 per 30 days)
prochlorperazine 25 mg supp GC,MO	1	
ranitidine 150 mg capsule GC,MO	1	
SUPREP 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION MO	3	
ZENPEP 10,000-34,000-55,000 UNIT CAP GC,MO	2	
ZENPEP 15,000-51,000-82,000 UNIT CAP GC,MO	2	
ZENPEP 20,000-68,000-109,000 UNIT CAP GC,MO	2	
ZENPEP 5,000-17,000-27,000 UNIT CAP GC,MO	2	
ZUPLENZ 4 MG ORAL SOLUBLE FILM MO	3	PA,QL (90 per 30 days)
ZUPLENZ 8 MG ORAL SOLUBLE FILM MO	3	PA,QL (90 per 30 days)
HORMONES AND SYNTHETIC SUBSTITUTES		
acarbose 100 mg tablet GC,MO	1	
acarbose 50 mg tablet GC,MO	1	
ACTOPLUS MET 15 MG-500 MG TAB GC,MO	2	ST,QL (90 per 30 days)
ACTOPLUS MET 15 MG-850 MG TAB GC,MO	2	ST,QL (90 per 30 days)
ACTOPLUS MET XR 15 MG-1,000 MG 24 HR TAB MO	3	ST,QL (30 per 30 days)
ACTOPLUS MET XR 30 MG-1,000 MG 24 HR TAB MO	3	ST,QL (30 per 30 days)
ACTOS 15 MG TAB GC,MO	2	ST,QL (30 per 30 days)
ACTOS 30 MG TAB GC,MO	2	ST,QL (30 per 30 days)
ACTOS 45 MG TAB GC,MO	2	ST,QL (30 per 30 days)
ADVAIR DISKUS 100 MCG-50 MCG/DOSE FOR INHALATION GC,MO	2	QL (60 per 30 days)
ADVAIR DISKUS 250 MCG-50 MCG/DOSE FOR INHALATION GC,MO	2	QL (60 per 30 days)
ADVAIR DISKUS 500 MCG-50 MCG/DOSE FOR INHALATION GC,MO	2	QL (60 per 30 days)
ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (12 per 30 days)
ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (12 per 30 days)
ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (12 per 30 days)
ANDROGEL 1 % (50 MG/5 GRAM) TRANSDERMAL PACKET GC,MO	2	QL (300 per 30 days)
APIDRA 100 UNIT/ML SUB-Q MO	3	
APIDRA SOLOSTAR 100 UNIT/ML SUB-Q INSULIN PEN MO	3	
ASMANEX TWISTHALER 110 MCG (30 DOSES) BREATH ACTIVATED GC,MO	2	QL (7 per 30 days)
ASMANEX TWISTHALER 220 MCG (120 DOSES) BREATH ACTIVATED GC,MO	2	QL (53 per 30 days)
ASMANEX TWISTHALER 220 MCG (14 DOSES) BREATH ACTIVATED GC,MO	2	QL (6 per 30 days)
ASMANEX TWISTHALER 220 MCG (30 DOSES) BREATH ACTIVATED GC,MO	2	QL (13 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ASMANEX TWISTHALER 220 MCG (60 DOSES) BREATH ACTIVATED GC,MO	2	QL (26 per 30 days)
AVANDAMET 2 MG-1,000 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDAMET 2 MG-500 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDAMET 4 MG-1,000 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDAMET 4 MG-500 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDARYL 4 MG-1 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDARYL 4 MG-2 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDARYL 4 MG-4 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDARYL 8 MG-2 MG TAB MO	3	ST,QL (30 per 30 days)
AVANDARYL 8 MG-4 MG TAB MO	3	ST,QL (30 per 30 days)
AVANDIA 2 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDIA 4 MG TAB MO	3	ST,QL (60 per 30 days)
AVANDIA 8 MG TAB MO	3	ST,QL (30 per 30 days)
budesonide 0.25 mg/2 ml susp GC,MO	1	B vs D
budesonide 0.5 mg/2 ml susp GC,MO	1	B vs D
BYETTA 10 MCG/0.04 ML PER DOSE SUB-Q PEN INJECTOR MO	3	PA,QL (3 per 30 days)
BYETTA 5 MCG/0.02 ML PER DOSE SUB-Q PEN INJECTOR MO	3	PA,QL (3 per 30 days)
calcitonin-salmon 200 units sp GC,MO	1	QL (4 per 28 days)
CENESTIN 0.3 MG TAB MO	3	PA
CENESTIN 0.45 MG TAB GB,MO	3	PA
CENESTIN 0.625 MG TAB GB,MO	3	PA
CENESTIN 0.9 MG TAB GB,MO	3	PA
CENESTIN 1.25 MG TAB GB,MO	3	PA
danazol 100 mg capsule GC,MO	1	
danazol 50 mg capsule GC,MO	1	
DUETACT 30 MG-2 MG TAB GC,MO	2	ST,QL (30 per 30 days)
DUETACT 30 MG-4 MG TAB GC,MO	2	ST,QL (30 per 30 days)
DULERA 100 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER MO	3	ST,QL (13 per 30 days)
DULERA 200 MCG-5 MCG/ACTUATION HFA AEROSOL INHALER MO	3	ST,QL (13 per 30 days)
ENJUVIA 0.3 MG TAB GB,MO	3	PA
ENJUVIA 0.45 MG TAB GB,MO	3	PA
ENJUVIA 0.625 MG TAB GB,MO	3	PA
ENJUVIA 0.9 MG TAB GB,MO	3	PA
ENJUVIA 1.25 MG TAB GB,MO	3	PA
estradiol 0.05 mg/day patch GC,MO	1	QL (4 per 28 days)
estradiol 0.1 mg/day patch GC,MO	1	QL (4 per 28 days)
estradiol tds 0.025 mg/day GC,MO	1	QL (4 per 28 days)
estradiol tds 0.0375 mg/day GC,MO	1	QL (4 per 28 days)
estradiol tds 0.06 mg/day GC,MO	1	QL (4 per 28 days)
estradiol tds 0.075 mg/day GC,MO	1	QL (4 per 28 days)
estropipate 0.625(0.75 mg) tab GC,MO	1	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
estropipate 1.25(1.5 mg) tab GC,MO	1	PA
estropipate 2.5(3 mg) tab GC,MO	1	PA
EVISTA 60 MG TAB GC,MO	2	QL (30 per 30 days)
FLOVENT DISKUS 100 MCG/ACTUATION FOR INHALATION GC,MO	2	QL (60 per 30 days)
FLOVENT DISKUS 250 MCG/ACTUATION FOR INHALATION GC,MO	2	QL (60 per 30 days)
FLOVENT DISKUS 50 MCG/ACTUATION FOR INHALATION GC,MO	2	QL (60 per 30 days)
FLOVENT HFA 110 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (24 per 30 days)
FLOVENT HFA 220 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (1 per 30 days)
FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUB-Q PEN INJECTOR MO	3	ST,QL (2 per 28 days)
FORTICAL 200 UNIT/ACTUATION NASAL SPRAY AEROSOL MO	3	QL (4 per 28 days)
glimepiride 1 mg tablet GC,MO	1	
glimepiride 2 mg tablet GC,MO	1	
glimepiride 4 mg tablet GC,MO	1	
glipizide 10 mg tablet GC,MO	1	
glipizide er 2.5 mg tablet GC,MO	1	
glipizide-metformin 2.5-250 mg GC,MO	1	
glipizide-metformin 2.5-500 mg GC,MO	1	
glipizide-metformin 5-500 mg GC,MO	1	
GLUMETZA 500 MG 24 HR TAB GB,MO	3	QL (120 per 30 days)
glyburid-metformin 1.25-250 mg GC,MO	1	
glyburide 2.5 mg tablet GC,MO	1	
glyburide micro 1.5 mg tab GC,MO	1	
glyburide micro 3 mg tablet GC,MO	1	
glyburide micro 6 mg tablet GC,MO	1	
glyburide-metformin 2.5-500 mg GC,MO	1	
glyburide-metformin 5-500 mg GC,MO	1	
HUMALOG 100 UNIT/ML SUB-Q GC,MO	2	QL (240 per 30 days)
HUMALOG MIX 50-50 100 UNIT/ML (50-50) SUSP, SUB-Q INJ GC,MO	2	
HUMALOG MIX 75-25 100 UNIT/ML (75-25) SUSP, SUB-Q INJ GC,MO	2	
HUMULIN 70/30 100 UNIT/ML (70-30) SUSP, SUB-Q INJ GC,MO	2	
HUMULIN 70/30 PEN 100 UNIT/ML (70-30) SUBQ GC,MO	2	
HUMULIN N 100 UNIT/ML SUSP, SUB-Q INJ GC,MO	2	
HUMULIN N PEN 100 UNIT/ML (3 ML) SUBQ GC,MO	2	
HUMULIN R 100 UNIT/ML INJECTION GC,MO	2	
HUMULIN R U-500 "CONCENTRATED" INSULIN 500 UNIT/ML INJECTION GC,MO	2	
KOMBIGLYZE XR 2.5 MG-1,000 MG 24 HR TAB MO	3	ST,QL (60 per 30 days)
KOMBIGLYZE XR 5 MG-1,000 MG 24 HR TAB MO	3	ST,QL (30 per 30 days)
KOMBIGLYZE XR 5 MG-500 MG 24 HR TAB MO	3	ST,QL (30 per 30 days)
LANTUS 100 UNIT/ML SUB-Q GC,MO	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LEVEMIR 100 UNIT/ML SUB-Q GC,MO	2	
LEVEMIR FLEXPEN 100 UNIT/ML SUB-Q INSULIN PEN GC,MO	2	
levothyroxine 112 mcg tablet GC,MO	1	
levothyroxine 88 mcg tablet GC,MO	1	
LEVOXYL 100 MCG TAB GC,GB,MO	1	
LEVOXYL 112 MCG TAB GC,GB,MO	1	
LEVOXYL 125 MCG TAB GC,GB,MO	1	
LEVOXYL 137 MCG TAB GC,GB,MO	1	
LEVOXYL 150 MCG TAB GC,GB,MO	1	
LEVOXYL 175 MCG TAB GC,GB,MO	1	
LEVOXYL 200 MCG TAB GC,GB,MO	1	
LEVOXYL 25 MCG TAB GC,GB,MO	1	
LEVOXYL 50 MCG TAB GC,GB,MO	1	
LEVOXYL 75 MCG TAB GC,GB,MO	1	
LEVOXYL 88 MCG TAB GC,GB,MO	1	
metformin hcl 1,000 mg tablet GC,MO	1	
metformin hcl 500 mg tablet GC,MO	1	
metformin hcl er 500 mg tablet GC,MO	1	QL (120 per 30 days)
metformin hcl er 750 mg tablet GC,MO	1	QL (60 per 30 days)
nateglinide 120 mg tablet GC,MO	1	
nateglinide 60 mg tablet GC,MO	1	
NOVOLIN 70-30 INNOLET GC,MO	2	
NOVOLIN 70/30 100 UNIT/ML (70-30) SUSP, SUB-Q INJ GC,MO	2	
NOVOLIN N 100 UNIT/ML INNOLET GC,MO	2	
NOVOLIN N 100 UNIT/ML SUSP, SUB-Q INJ GC,MO	2	
NOVOLIN R 100 UNIT/ML INJECTION GC,MO	2	
NOVOLOG 100 UNIT/ML SUB-Q GC,MO	2	
NOVOLOG FLEXPEN 100 UNIT/ML SUB-Q GC,MO	2	
NOVOLOG MIX 70-30 100 UNIT/ML (70-30) SUB-Q GC,MO	2	
NOVOLOG MIX 70-30 FLEXPEN 100 UNIT/ML (70-30) SUB-Q GC,MO	2	
NUTROPIN AQ NUSPIN 5 MG/2 ML (2.5 MG/ML) SUBQ CARTRIDGE SP	4	PA,QL (28 per 30 days)
ONGLYZA 2.5 MG TAB MO	3	ST,QL (30 per 30 days)
ONGLYZA 5 MG TAB MO	3	ST,QL (30 per 30 days)
PREMARIN 0.3 MG TAB MO	3	PA
PREMARIN 0.45 MG TAB MO	3	PA
PREMARIN 0.625 MG TAB MO	3	PA
PREMARIN 0.625 MG/G VAGINAL CREAM GC,MO	2	
PREMARIN 0.9 MG TAB MO	3	PA
PREMARIN 1.25 MG TAB MO	3	PA
PREMARIN 25 MG SOLUTION FOR INJECTION MO	3	PA
PREMPHASE 0.625 MG(14)/0.625 MG-5MG(14) TAB MO	3	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PREMPRO 0.3 MG-1.5 MG TAB MO	3	PA
PREMPRO 0.45 MG-1.5 MG TAB MO	3	PA
PREMPRO 0.625 MG-2.5 MG TAB MO	3	PA
PREMPRO 0.625 MG-5 MG TAB MO	3	PA
QVAR 40 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (37 per 30 days)
QVAR 80 MCG/ACTUATION AEROSOL INHALER GC,MO	2	QL (22 per 30 days)
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER GC,MO	2	QL (11 per 30 days)
SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER GC,MO	2	QL (11 per 30 days)
VICTOZA 0.6 MG/0.1 ML (18 MG/3 ML) SUB-Q PEN INJECTOR MO	3	PA,QL (9 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
ACTONEL 150 MG TAB MO	3	QL (2 per 30 days)
ACTONEL 30 MG TAB MO	3	QL (30 per 30 days)
ACTONEL 35 MG TAB MO	3	QL (4 per 28 days)
ACTONEL 5 MG TAB MO	3	QL (30 per 30 days)
alendronate sodium 10 mg tab GC,MO	1	QL (30 per 30 days)
alendronate sodium 35 mg tab GC,MO	1	QL (4 per 28 days)
alendronate sodium 40 mg tab GC,MO	1	QL (30 per 30 days)
alendronate sodium 5 mg tablet GC,MO	1	QL (30 per 30 days)
alendronate sodium 70 mg tab GC,MO	1	QL (4 per 28 days)
allopurinol 300 mg tablet GC,MO	1	
AMPYRA 10 MG 12 HR TAB SP	4	PA,QL (60 per 30 days)
AVODART 0.5 MG CAP GC,MO	2	QL (30 per 30 days)
AVONEX 30 MCG IM KIT SP	4	PA,QL (4 per 28 days)
AVONEX ADMINISTRATION PACK 30 MCG/0.5 ML IM KIT SP	4	PA,QL (4 per 28 days)
azathioprine 50 mg tablet GC,MO	1	B vs D
BETASERON 0.3 MG SUB-Q KIT SP	4	PA,QL (15 per 30 days)
BONIVA 150 MG TAB MO	3	QL (1 per 28 days)
BONIVA 3 MG/3 ML IV SYRINGE MO	3	PA,QL (3 per 90 days)
COPAXONE 20 MG SUB-Q KIT SP	4	PA,QL (30 per 30 days)
ENBREL 25 MG SUB-Q KIT SP	4	PA,QL (8 per 28 days)
ENBREL 25 MG/0.5 ML (0.51 ML) SUB-Q SYRINGE SP	4	PA,QL (8 per 28 days)
ENBREL 50 MG/ML (0.98 ML) SUB-Q SYRINGE SP	4	PA,QL (8 per 28 days)
finasteride 5 mg tablet GC,MO	1	QL (30 per 30 days)
GILENYA 0.5 MG CAP SP	4	PA,QL (30 per 30 days)
HUMIRA 20 MG/0.4 ML SUB-Q KIT SP	4	PA,QL (6 per 28 days)
HUMIRA 40 MG/0.8 ML SUB-Q KIT SP	4	PA,QL (6 per 28 days)
HUMIRA CROHN'S DISEASE STARTER PACK 40 MG/0.8 ML SUBQ PEN KIT SP	4	PA,QL (6 per 28 days)
JALYN 0.5 MG-0.4 MG 24 HR CAP GC,MO	2	QL (30 per 30 days)
leflunomide 10 mg tablet GC,MO	1	QL (30 per 30 days)
mycophenolate 250 mg capsule GC,MO	1	B vs D

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PROLIA 60 MG/ML SUB-Q SYRINGE SP	3	PA,QL (60 per 180 days)
REBIF 22 MCG/0.5 ML SUB-Q SYRINGE SP	4	PA,QL (12 per 30 days)
REBIF 44 MCG/0.5 ML SUB-Q SYRINGE SP	4	PA,QL (12 per 30 days)
REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUB-Q SYRINGE SP	4	PA,QL (12 per 30 days)
REMICADE 100 MG IV SOLUTION SP	4	PA
SENSIPAR 30 MG TAB GC,MO	2	QL (60 per 30 days)
SENSIPAR 60 MG TAB MO	4	QL (60 per 30 days)
SENSIPAR 90 MG TAB MO	4	QL (120 per 30 days)
STELARA 45 MG/0.5 ML SUB-Q SYRINGE SP	4	PA,QL (3 per 84 days)
STELARA 90 MG/ML SUB-Q SYRINGE SP	4	PA,QL (3 per 84 days)
RESPIRATORY TRACT AGENTS		
cromolyn 20 mg/2 ml neb soln GC,MO	1	B vs D
zafirlukast 10 mg tablet GC,MO	1	QL (60 per 30 days)
zafirlukast 20 mg tablet GC,MO	1	QL (60 per 30 days)
SKIN AND MUCOUS MEMBRANE AGENTS		
adapalene 0.1% cream GC,MO	1	
adapalene 0.1% gel GC,MO	1	
ORAVIG 50 MG MUCO-ADHESIVE BUCCAL TAB MO	3	QL (14 per 30 days)
SORIATANE 17.5 MG CAP MO	4	
ZYCLARA 3.75 % TOPICAL CREAM PACKET MO	3	
SMOOTH MUSCLE RELAXANTS		
DETROL 1 MG TAB GC,MO	2	QL (60 per 30 days)
DETROL 2 MG TAB GC,MO	2	QL (60 per 30 days)
DETROL LA 2 MG 24 HR CAP GC,MO	2	QL (30 per 30 days)
DETROL LA 4 MG 24 HR CAP GC,MO	2	QL (30 per 30 days)
ENABLEX 15 MG 24 HR TAB MO	3	QL (30 per 30 days)
ENABLEX 7.5 MG 24 HR TAB MO	3	QL (30 per 30 days)
oxybutynin 5 mg tablet GC,MO	1	
oxybutynin cl er 10 mg tablet GC,MO	1	QL (60 per 30 days)
oxybutynin cl er 5 mg tablet GC,MO	1	QL (60 per 30 days)
SANCTURA XR 60 MG 24 HR CAP MO	3	QL (30 per 30 days)
tropium chloride 20 mg tablet GC,MO	1	
VESICARE 10 MG TAB GC,MO	2	QL (30 per 30 days)
VESICARE 5 MG TAB GC,MO	2	QL (30 per 30 days)
VITAMINS		
calcitriol 0.5 mcg capsule GC,MO	1	B vs D
HECTOROL 0.5 MCG CAP GC,MO	2	B vs D
HECTOROL 1 MCG CAP GC,MO	2	B vs D
HECTOROL 2.5 MCG CAP GC,MO	2	B vs D
ZEMPLAR 1 MCG CAP GC,MO	2	B vs D

Need more information about the indicators displayed by the drug names? Please refer to page 8.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ZEMPLAR 2 MCG CAP GC,MO	2	B vs D
ZEMPLAR 4 MCG CAP GC,MO	2	B vs D

Need more information about the indicators displayed by the drug names? Please refer to page 8.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

Index

A			
ABILIFY	16	ARICEPT	9
ABILIFY DISCMELT	16	ARICEPT ODT	9
acarbose	24	ARIXTRA	10
acebutolol	10	ASACOL	23
acetaminophen-codeine	16	ASACOL HD	23
acetazolamide	23	ASMANEX TWISTHALER	24, 25
ACTONEL	28	atenolol	11
ACTOPLUS MET	24	AVALIDE	11
ACTOPLUS MET XR	24	AVANDAMET	25
ACTOS	24	AVANDARYL	25
ACUVAIL	23	AVANDIA	25
adapalene	29	AVAPRO	11
ADVAIR DISKUS	24	AVINZA	16
ADVAIR HFA	24	AVODART	28
AGGRENOX	10	AVONEX	28
albuterol sulfate	9	AVONEX ADMINISTRATION PACK	28
alendronate	28	azathioprine	28
allopurinol	28	AZOPT	23
amantadine	16	AZOR	11
amiodarone	10	B	
amitriptyline	16	benazepril	11
amlodipine	10	benazepril-hydrochlorothiazide	11
amlodipine-benazepril	10, 11	BENICAR	11
amoxapine	16	BENICAR HCT	11
AMPYRA	28	BETASERON	28
AMTURNIDE	11	BIDIL	11
anastrozole	9	BONIVA	28
ANDROGEL	24	budeprion sr	16, 17
APIDRA	24	budeprion xl	17
APIDRA SOLOSTAR	24	budesonide	25
		bupropion hcl	17

buspirone	17	DEXILANT	23
BYETTA	25	digoxin	12
BYSTOLIC	11	dilt-xr	12
		diltiazem hcl	12
C			
calcitonin (salmon)	25	DIOVAN	12
calcitriol	29	DIOVAN HCT	12
captopril	11	dipyridamole	12
captopril-hydrochlorothiazide	12	donepezil	9
carbamazepine	17	dorzolamide	23
carbidopa-levodopa	17	dorzolamide-timolol	23
cartia xt	12	doxazosin	12
carvedilol	12	DUETACT	25
CELEBREX	17	DULERA	25
CENESTIN	25		
E			
chlorothiazide	22	EFFEXOR XR	17
cilostazol	10	EMBEDA	17, 18
cimetidine	23	ENABLEX	29
CIMZIA	23	enalapril maleate	12
CIMZIA POWDER FOR RECONST	23	enalapril-hydrochlorothiazide	12
citalopram	17	ENBREL	28
clozapine	17	endocet	18
COMBIVENT	9	ENJUVA	25
COMTAN	17	enoxaparin	10
COPAXONE	28	EPIPEN	9
COREG CR	12	EPIPEN JR	9
CRESTOR	12	estradiol	25
cromolyn	29	estropipate	25, 26
CYMBALTA	17	EVISTA	26
D			
danazol	25	EXALGO ER	18
desipramine	17	EXELON	9
DETROL	29	EXFORGE	12, 13
DETROL LA	29	EXFORGE HCT	13
F			

felodipine	13	HUMIRA CROHN'S DIS START PCK	28
fenofibrate	13	HUMULIN N	26
fenofibrate micronized	13	HUMULIN N PEN	26
fentanyl	18	HUMULIN R	26
fexofenadine	22	HUMULIN R U-500 "CONCENTRATED"	26
finasteride	28	HUMULIN 70/30	26
FLOVENT DISKUS	26	HUMULIN 70/30 PEN	26
FLOVENT HFA	26	hydralazine	13
fluorouracil	9	hydrochlorothiazide	22
fluoxetine	18	hydroxyzine hcl	18
FORTEO	26		
FORTICAL	26	I	
fosinopril	13	INVEGA SUSTENNA	18
		isosorbide mononitrate	13
	G		J
gabapentin	18	JALYN	28
galantamine	9		K
GEODON	18	KADIAN	18
GILENYA	28	KOMBIGLYZE XR	26
glimepiride	26		L
glipizide	26	labetalol	13
glipizide-metformin	26	LAMICTAL XR	19
GLUMETZA	26	lamotrigine	19
glyburide	26	lansoprazole	23
glyburide micronized	26	LANTUS	26
glyburide-metformin	26	LASTACAPT	23
GOLYTELY	23	LATUDA	19
	H	leflunomide	28
haloperidol	18	LESCOL	13
HECTOROL	29	LESCOL XL	13
HUMALOG	26	LETAIRIS	13
HUMALOG MIX 50-50	26	LEVEMIR	27
HUMALOG MIX 75-25	26	LEVEMIR FLEXPEN	27
HUMIRA	28	levetiracetam	19

PHENYTEK	20	S	
PHOSLO	22	SANCTURA XR	29
PRADAXA	10	SENSIPAR	29
pramipexole	20	SEREVENT DISKUS	9
pravastatin	14, 15	SEROQUEL	20, 21
PREMARIN	27	SEROQUEL XR	21
PREMPHASE	27	sertraline	21
PREMPRO	28	SIMCOR	15
PRISTIQ	20	simvastatin	15
PROAIR HFA	9	sodium lactate	22
prochlorperazine	24	SORIATANE	29
PROCRIT	10	sotalol	15
PROLIA	29	SPIRIVA WITH HANDIHALER	9
promethazine	22	spironolactone	15
propafenone	15	STALEVO 100	21
propranolol	15	STALEVO 125	21
PROVENTIL HFA	9	STALEVO 150	21
	Q	STALEVO 200	21
QVAR	28	STALEVO 50	21
	R	STALEVO 75	21
ramipril	15	STELARA	29
ranitidine hcl	24	SUBOXONE	21
REBIF	29	sumatriptan succinate	21
REBIF TITRATION PACK	29	SUPREP	24
REMICADE	29	SYMBICORT	28
RENVELA	22	T	
REQUIP XL	20	tamsulosin	9
RESTASIS	23	TEKAMLO	15
RISPERDAL CONSTA	20	TEKTURNA	15
risperidone	20	TEKTURNA HCT	15
rivastigmine	9	timolol maleate	15, 23
ropinirole	20	topiramate	21
RYTHMOL SR	15	toremide	22

TRAVATAN Z	23	ZIPSOR	22
trazodone	21	zolpidem	22
TRELSTAR	9	zonisamide	22
TREXIMET	21	ZUPLENZ	24
triamterene-hydrochlorothiazid	22, 23	ZYCLARA	29
TRIBENZOR	15, 16	ZYMAXID	23
TRICOR	16	ZYPREXA	22
tropium	29	ZYPREXA ZYDIS	22

U

UROXATRAL	10
-----------	----

V

VALTURNA	16
venlafaxine	21
VENTOLIN HFA	10
VERAMYST	23
verapamil	16
VESICARE	29
VICTOZA	28
VIMOVO	22
VIMPAT	22
VOLTAREN	22, 23
VYTORIN 10-10	16
VYTORIN 10-20	16
VYTORIN 10-40	16
VYTORIN 10-80	16

W

warfarin	10
WELCHOL	16

Z

zafirlukast	29
ZEMPLAR	29, 30
ZENPEP	24
ZETIA	16

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