Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ALLERGY AGENTS

Intranasal Antihistamines

Preferred Drug Covered		Non-preferred	
Azelastine	Astelin®	Azelastine	Astepro®
Olopatadine	Patanase®		

Non-Sedating Antihistamines

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Cetirizine	Zyrtec® Zyrtec Syrup®	Desloratadine	Clarinex®
Loratadine	Claritin® Claritin 24-hr Allergy® Claritin® Syrup	Desloratadine/ Pseudoephedrine	Clarinex-D 12-hour® Clarinex-D 24-hour® **KBH only**
		Fexofenadine	Allegra® Allegra ODT®
		Fexofenadine / Pseudoephedrine	Allegra-D® **KBH only** Allegra-D24® **KBH only**
		Levocetirizine	Xyzal®
		Non-preferred	
		Loratadine	Claritin Hives Relief® Claritin RediTabs®

Ophthalmic Antihistamine/Mast Cell Stabilizer Combos

Preferred Drug Covered		Non-preferred	
Ketotifen	Zaditor® Alaway® Refresh®	Alcaftadine	Lastacaft®
		Azelastine	Optivar®
		Bepotastine	Bepreve®
		Epinastine	Elestat®
		Olopatadine	Pataday® Patanol®

ANALGESICS

Long Acting Opioids

Preferred Drug Covered		Non-preferred	
Morphine sulfate ER	generic only	Fentanyl (patch)	Duragesic®
Oxycodone SR	OxyContin®	Hydromorphone HCl ER	Exalgo®
		Morphine sulfate ER	Avinza® Kadian® MS Contin®
		Morphine/Naltrexone	Embeda®
		Oxymorphone	Opana ER®
		Tramadol ER	Ryzolt® Tramadol ER® Ultram ER®

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANALGESICS (CONT)

Muscle Relaxants (Skeletal)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Chlorzoxazone	Parafon Forte DSC®	Cyclobenzaprine 5mg	Flexeril® 5mg
Methocarbamol	Robaxin® Robaxin-750®	Cyclobenzaprine 7.5mg	Fexmid® 7.5mg
		Cyclobenzaprine 7.5mg Cyclobenzaprine XR Metaxalone	Fexmid® 7.5mg Amrix® Skelaxin®
Methocarbamol /Aspirin	Robaxisal®		
Cyclobenzaprine 10mg	Flexeril® 10mg	Orphenadrine	Norflex®
		Orphenadrine/Aspirin /Caffeine	Norgesic® Norgesic Forte®

Muscle Relaxants (Spasticity)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Tizanidine tablets	Zanaflex® tablets	Tizanidine capsules	Zanaflex® capsules
Baclofen	Lioresal®	**Non-preferred**	
		Dantrolene	Dantrium®

Oral - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Diclofenac Potassium	Cataflam®	Nabumetone	Relafen®
Diclofenac Sodium, Oral	Voltaren® Voltaren XR®	**Non-preferred**	
		Diclofenac Potassium	Cambia® Pwd Packets
Diclofenac Sodium/ Misoprostol	Arthrotec®	Diclofenac Sodium	Zipsor®
Etodolac	Lodine®	Diflunisal	Dolobid®
Fenoprofen	Nalfon®	Etodolac	Lodine XL®
Flurbiprofen	Ansaid®	Indomethacin	Indocin SR®
Ibuprofen	Motrin®	Naproxen/Esomeprazole	Vimovo®
Indomethacin	Indocin®	Naproxen Sodium	Naprelan CR® Dosepak
		Piroxicam	Generics only
Ketoprofen	Orudis®		
Ketorolac (limit 5 day supply)	Toradol®		
Meclofenamate	Meclomen®		
Mefenamic Acid	Ponstel®		
Meloxicam	Mobic®		
Naproxen	Aleve®		
Naproxen Sodium	Anaprox® Anaprox DS® Naprelan®		
Oxaprozin	Daypro®		
Piroxicam	Feldene®		
Sulindac	Clinoril®		
Tolmetin	Tolectin 600® Tolectin DS®		

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANALGESICS (CONT)

Ophthalmic - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred	
Diclofenac Sodium, Ophth	Voltaren®	Bromfenac, Ophth	Bromday® Xibrom®
Flurbiprofen, Ophth	Ocufen®		
Ketorolac, Ophth	Acular® Acular LS® Acuvail®		
Nepafenac, Ophth	Nevanac®		

Topical - Non-Steroidal Anti-Inflammatory (NSAIDs)

Preferred Drug Covered		Non-preferred	
Diclofenac Sodium, Topical	Voltaren®	Diclofenac Epolamine	Flector®
Diclofenac Sodium	Pennsaid®	Ketorolac Tromethamine	Sprix®

Triptans

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Eletriptan	Relpax®	Frovatriptan	Frova®
Naratriptan	Amerge®	Zolmitriptan	Zomig® Zomig-ZMT®
Sumatriptan	Imitrex® All generics	**Non-preferred**	
		Almotriptan	Axert®
		Sumatriptan	Alsuma®
		Sumatriptan	Sumavel®
		Rizatriptan	Maxalt® Maxalt-MLT®

ANTIHYPERLIPIDEMICS

Bile Acid Sequestrants

Preferred Drug Covered		Non-preferred	
Cholestyramine	Questran®	Colesevelam	Welchol®
Cholestyramine Light	Questran Light®		
Cholestyramine Light	Prevalite®		
Colestipol	Colestid®		

Fibric Acid Derivatives

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Fenofibrate	TriCor® and all generics	Fenofibrate	Lofibra® Lipofen®
Fenofibric acid	Trilipix®	**Non-preferred**	
Gemfibrozil	Lopid®	Fenofibrate	Fenoglide™
		Fenofibrate	Triglide®

HMG-CoA Reductase Inhibitors (Statins)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Atorvastatin	Lipitor®	Fluvastatin	Lescol® Lescol XL®
Simvastatin	Zocor®	Lovastatin	Mevacor® Altoprev
		Pravastatin	Pravachol®
		Non-preferred	
		Pitavastatin Ca	Livalo®
		Rosuvastatin	Crestor®

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

ANTI-INFECTIVES

Antiherpes Virus Agents

Preferred Drug Covered		Non-preferred	
Acyclovir (Acycloguanosine) *Oral Dose forms Only*	Zovirax®	Famciclovir	Famvir®
		Valacyclovir	Valtrex®

BIOLOGICS

Adult Rheumatoid Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Abatacept	Orencia®
Etanercept	Enbrel®	Anakinra	Kineret®
		Certolizumab	Cimzia®
		Golimumab	Simponi®
		Infliximab	Remicade®
		Rituximab	Rituxan®
		Tocilizumab	Actemra®

Ankylosing Spondylitis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Infliximab	Remicade®
Etanercept	Enbrel®	Golimumab	Simponi®

Crohn's Disease **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Certolizumab	Cimzia®
Infliximab	Remicade®	Natalizumab	Tysabri®

Juvenile Idiopathic Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Abatacept	Orencia®
Etanercept	Enbrel®	Tocilizumab	Actemra®

Plaque Psoriasis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Alefacept	Amevive®
Etanercept	Enbrel®	Infliximab	Remicade®
		Ustekinumab	Stelara®

Psoriatic Arthritis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Adalimumab	Humira®	Golimumab	Simponi®
Etanercept	Enbrel®	Infliximab	Remicade®

Ulcerative Colitis **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required
Infliximab	Remicade®	

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

CARDIOVASCULAR AGENTS

ACE Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Benazepril	Lotensin®	Moexipril	Univasc®
Captopril	Capoten®	Perindopril	Aceon®
Enalapril	Vasotec®	Ramipril	Altace®
Fosinopril	Monopril®	Trandolapril	Mavik®
Lisinopril	Zestril® Prinivil®		
Quinapril	Accupril®		

ACE Inhibitors/Calcium Channel Blocker Combos

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Benazepril/Amlodipine	Lotrel®	Enalapril/Felodipine	Lexxel®
		Trandolapril/Verapamil	Tarka®

ARBs

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Losartan	Cozaar®	Candesartan	Atacand®
Losartan/HCTZ	Hyzaar®	Candesartan/HCTZ	Atacand HCT®
Olmesartan	Benicar®	Eprosartan	Teveten®
Olmesartan/HCTZ	Benicar HCT®	Eprosartan/HCTZ	Teveten HCT®
Telmisartan	Micardis®	**Non-preferred**	
Telmisartan/HCTZ	Micardis HCT®	Azilsartan Medoxomil	Edarbi®
Valsartan	Diovan®	Irbesartan	Avapro®
Valsartan/HCTZ	Diovan HCT®	Irbesartan/HCTZ	Avalide®

ARBs / Calcium Channel Blocker Combos

Preferred Drug Covered		Non-preferred	
Amlodipine/Olmesartan	Azor®	Amlodipine/Telmisartan	Twynsta®
Amlodipine/Valsartan	Exforge®		

Beta-Blockers

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Acebutolol	Sectral®	Bisoprolol	Zebeta®
Atenolol	Tenormin®	Penbutolol	Levatol®
Betaxolol	Kerlone®	Propranolol XL	Inderal LA®
Carvedilol	Coreg®	**Non-preferred**	
Carvedilol CR	Coreg CR®	Nebivolol	Bystolic®
Metoprolol Tartrate	Lopressor®		
Metoprolol Succinate	Toprol XL®		
Nadolol	Corgard®		
Pindolol	Visken®		
Propranolol	Inderal® Propranolol Intensol®		
Propranolol XL	InnoPran XL®		
Sotalol	Betapace®		
Sotalol AF	Betapace AF®		
Timolol	Blocadren®		

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

CARDIOVASCULAR AGENTS (CONT)

Calcium Channel Blockers (Dihydropyridines)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Amlodipine	Norvasc®	Felodipine	Plendil®
Isradipine CR	DynaCirc CR®	Nicardipine SR	Cardene SR®
Isradipine IR	DynaCirc®	Nifedipine IR	Adalat®
Nicardipine IR	Cardene®	Nisoldipine	Sular®
Nifedipine (Extended Release)	Adalat CC® Procardia XL®		

Calcium Channel Blockers (Non-Dihydropyridines)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Diltia XT®	& AB-Rated Generics	Dilacor XR®	
Diltiazem IR	Cardizem®	Cardizem CD®	& AB-Rated Generics
Tiazac®	& AB-Rated Generics	Cardizem LA®	& AB-Rated Generics
Verapamil IR	Calan®	Cardizem SR®	& AB-Rated Generics
Covera HS® Only		Verelan PM®	& AB-Rated Generics
Verapamil (Sustained Release)	Calan SR® Isoptin SR® Verelan®		

CENTRAL NERVOUS SYSTEM

Adjunct Antiepileptics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Gabapentin	Neurontin®	Clobazam	Onfi®
Levetiracetam	Keppra®	Lacosamide	Vimpat®
Levetiracetam XR	Keppra XR®	Rufinamide	Banzel®
Pregabalin	Lyrica®		
Tiagabine	Gabitril®		
Zonisamide	Zonegran®		

Non-Benzodiazepine Sedative Hypnotics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Zolpidem	Generic only	Zaleplon	Sonata®
		Zolpidem (brand)	Ambien® Edluar®
		Zolpidem CR	Ambien CR®
		Zolpidem sublingual	Intermezzo®
		Non-preferred	
		Eszopiclone	Lunesta®

Non-Scheduled Novel Sleep Agents

Preferred Drug Covered		Non-preferred
Ramelteon	Rozerem®	

DIABETIC AGENTS

Alphaglucosidase Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Miglitol	Glyset®	Acarbose	Precose®

Biguanides

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Metformin	Glucophage®	Metformin (Extended Release) (brands)	Glucophage XR® Fortamet®
Metformin (Extended Release)	generic only		

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

DIABETIC AGENTS (CONT)

Dipeptidyl Peptidase-4 Inhibitors (DPP- 4 Inhibitors)

Preferred Drug Covered		Non-preferred	
Linagliptin	Tradjenta®		
Saxagliptin	Onglyza®		
Sitagliptin	Januvia®		

Meglitinides

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Nateglinide	Starlix®	Repaglinide	Prandin®

Incretin Mimetics **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Exenatide	Byetta®	Exenatide extended-release	Bydureon®

Insulin (Delivery Systems)

Preferred Drug Covered		Non-preferred Prior Authorization Required	
All Multi-dose vials	Humalog®	Cartridges, Syringes, Pens	Humalog®
	Humalog Mix®	and any other alternative	Humalog Mix®
	NovoLog®	delivery device	NovoLog® Excluding Pens
	NovoLog Mix®		NovoLog Mix® Excluding Pens
	Novolin R®		Novolin R®
	Novolin N®		Novolin N®
	Humulin R®		Humulin R®
	Humulin N®		Humulin N®
	Humulin 70/30®		Humulin 70/30®
	Novolin 70/30®		Novolin 70/30®
	Velosulin BR®		Velosulin BR®
Pens	NovoLog®		
	NovoLog Mix®		

Insulin - Long Acting (Vials Only)

Preferred Drug Covered		Non-preferred	
Insulin Glargine	Lantus®	Insulin Detemir	Levemir®

2nd Generation Sulfonylureas

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Glimepiride	Amaryl®	Glipizide/Metformin	Metaglip®
Glipizide	Glucotrol®		
Glipizide XL	Glucotrol XL®		
Glyburide	DiaBeta® Micronase®		
Glyburide/Metformin	Glucovance®		
Glyburide Micronized	Glynase PresTab®		

Thiazolidinediones

Preferred Drug Covered		Non-preferred	
Pioglitazone	Actos®	Pioglitazone/Glimepiride HCl	Duetact ™
Pioglitazone/Metformin	ACTOplus Met®	Rosiglitazone/ Metformin	Avandamet®
Pioglitazone/Metformin	ACTOplus Met XR®	Rosiglitazone/Glimepiride	Avandaryl®
Rosiglitazone	Avandia®		

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

GASTROINTESTINAL AGENTS

H2 Antagonists

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Famotidine	Pepcid®	Nizatidine	Axid®
Ranitidine	Zantac ® Zantac EFFERdose®	**Non-preferred**	
		Cimetidine	Tagamet®

Pancreatic Enzyme Replacement Products

Preferred Drug Covered		Non-preferred	
Pancrelipase	Creon ®	Pancrelipase	Pancreaze®
Pancrelipase	Zenpep ®		

Proton Pump Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Omeprazole	Prilosec®	Dexlansoprazole	Dexilant®
Pantoprazole	Protonix®	Esomeprazole	Nexium®
		Esomeprazole Suspension	Nexium® Suspension
		Lansoprazole Suspension	Prevacid® Suspension
		Omeprazole Suspension	Prilosec® Suspension
		Rabeprazole	AcipHex®
		Non-preferred	
		Lansoprazole	Prevacid®
		Lansoprazole SoluTab™	Prevacid® SoluTab™

Serotonin 5HT3 Antagonists

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Ondansetron	Zofran® Zofran ODT®	Dolasetron	Anzemet®
		Granisetron Oral & Inj	Kytril®
		Granisetron, Oral	Granisol®
		Granisetron, Topical	Sancuso®
		Non-preferred	
		Ondansetron	Zuplenz®

INJECTABLES

Erythropoiesis - Stimulating Agents

Preferred Drug Covered		Non-preferred	
Epoetin alfa	Procrit®	Darbepoetin alfa	Aranesp®
Epoetin alfa	Epogen®		

Growth Hormone **Clinical Prior Authorization is still required for all Growth Hormones*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Somatropin	Genotropin® Genotropin MiniQuick® Saizen® Tev-Tropin® Omnitrope®	Somatropin	Humatrope® Norditropin® Norditropin FlexPro® Norditropin Nordiflex® Nutropin® Nutropin AQ® Nutropin AQ NuSpin®

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

Nasal Agents

Intranasal Corticosteroids

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Fluticasone	Flonase® Veramyst®	Beclomethasone	Beconase® Beconase AQ® Vancenase® Vancenase AQ®
Mometasone	Nasonex®	Ciclesonide	Omnaris® Zetonna™
Triamcinolone	Nasacort AQ® (brand only)	Flunisolide	Bausch & Lomb
		Flunisolide	Nasarel®
		Non-preferred	
		Budesonide	Rhinocort AQ®
		Triamcinolone	generic products only

Ophthalmic Agents

Ophthalmic Prostaglandin Analogs

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Latanoprost	Xalatan®	Bimatoprost	Lumigan®
Travoprost	Travatan Z®		

Osteoporosis Agents

Bisphosphonates

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Alendronate	Fosamax®	Risedronate	Actonel®
Alendronate/Cholecalciferol	Fosamax Plus D®	Risedronate/Calcium	Actonel® with Calcium
		Risedronate	Atelvia®
		Non-preferred	
		Ibandronate	Boniva®

Respiratory

Inhaled Corticosteroids

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Beclomethasone	QVAR®	Budesonide Inhaled Susp.	Pulmicort Respules® ****7 and Over**
Budesonide Inhaled Susp.	Pulmicort Respules® ***6 and Under ONLY**	**Non-preferred**	
Fluticasone	Flovent HFA® Flovent Diskus®	Budesonide Inhaled Powder	Pulmicort Flexhaler®
		Ciclesonide	Alvesco®
Mometasone	Asmanex®		

Inhaled Beta 2 Agonists/Corticosteroid – Long - Acting

Preferred Drug Covered		Non-preferred	
Budesonide/Formoterol	Symbicort®	Formoterol/Mometasone	Dulera®
Fluticasone/Salmeterol	Advair® Advair HFA®		

Preferred Drug List

Unless otherwise indicated, the chemical name includes branded products

RESPIRATORY (CONT)

Inhaled Beta 2 Agonists – Long – Acting **Clinical Prior Authorization may apply*

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Formoterol	Foradil®	Formoterol solution	Perforomist®
Salmeterol	Serevent®	**Non-preferred**	
		Arformoterol	Brovana®
		Indacaterol	Arcapta®

Inhaled Beta 2 Agonists – Short - Acting

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Albuterol solution 0.5%	Proventil® Ventolin®	Albuterol solution 0.021%	AccuNeb®
		Albuterol solution 0.042%	AccuNeb®
Albuterol solution 0.083%	Proventil® Ventolin®	Levalbuterol solution	Xopenex®
		Non-preferred	
Albuterol inhalers HFA	ProAir HFA® Ventolin HFA®	Albuterol inhalers HFA	Proventil HFA®
		Levalbuterol inhalers	Xopenex HFA®
		Pirbuterol inhalers	Maxair®

UROLOGIC AGENTS

Anticholinergics

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Fesoterodine	Toviaz®	Flavoxate	Urispas®
Oxybutynin, Oral	Ditropan®	Oxybutynin XL, Oral	Ditropan XL®
Tolterodine	Detrol®	Oxybutynin, Topical	Oxytrol®
Tolterodine LA	Detrol LA®	Trospium	Sanctura®
Solifenacin	Vesicare®	Trospium XR	Sanctura XR®
		Non-preferred	
		Darifenacin	Enablex®
		Oxybutynin, Topical	Gelnique®

GOUT AGENTS

Xanthine Oxidase Inhibitors

Preferred Drug Covered		Non-preferred Prior Authorization Required	
Allopurinol	Zyloprim®	Febuxostat	Uloric®

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