PREFERRED DRUG LIST

When a generic product is available, for a preferred or non-preferred agent, the pharmacy will receive a lower reimbursement rate for the branded product unless a DAW PA is obtained.

ALLERGY, ASTHMA, & COPD AGENTS

Inhaled Short-Acting Beta$_2$-Agonists

Preferred	Non-Preferred, Prior Authorization Required
AccuNeb® (albuterol) ProAir HFA® (albuterol) Proventil HFA® (albuterol) Proventil® Inhalation Solution (albuterol) Ventolin HFA® (albuterol) Ventolin® Inhalation Solution (albuterol)	Maxair® (pirbuterol) Xopenex® Inhaltion Solution (levalbuterol) Xopenex HFA® (levalbuterol)

Inhaled Long-Acting Beta$_2$-Agonists

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Foradil® (formeterol) Serevent® (salmeterol)	Arcapta® (indacaterol) Brovana® (arformoterol) Perforomist® (formoterol)

Inhaled Long-Acting Beta$_2$-Agonists/Corticosteroids

Preferred	Non-Preferred
Advair® Diskus (fluticasone/salmeterol) Advair® HFA (fluticasone/salmeterol) Symbicort® (budesonide/formoterol)	Dulera® (formoterol/mometasone)

Inhaled Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Asmanex® (mometasone) Flovent® Diskus (fluticasone) Flovent® HFA (fluticasone) Pulmicort Respules® (budesonide) ***≤ 6 years of age only** QVAR® (beclomethasone)	Pulmicort Respules® (budesonide) ***> 7 years of age**
	Non-Preferred
	Alvesco® (ciclesonide) Pulmicort Flexhaler® (budesonide)

Intranasal Corticosteroids

Preferred	Non-Preferred, Prior Authorization Required
Flonase® (fluticasone) Nasacort AQ® (triamcinolone) **(branded products only)** Nasonex® (mometasone) Veramyst® (fluticasone)	Beconase® (beclomethasone) Beconase AQ® (beclomethasone) Nasarel® (flunisolide) Omnaris® (ciclesonide) Vancenase® (beclomethasone) Vancenase AQ® (beclomethasone) Zetonna® (ciclesonide)
	Non-Preferred
	Rhinocort AQ® (budesonide) Triamcinolone Nasal Spray **(generic products only)**

Intranasal Antihistamines

Preferred	Non-Preferred
Astelin® (azelastine) Patanase® (olopatadine)	Astepro® (azelastine)

ALLERGY, ASTHMA, & COPD AGENTS (continued)

Non-Sedating Antihistamines

Preferred	Non-Preferred, Prior Authorization Required
Claritin® (loratadine) Claritin 24-hr Allergy® (loratadine) Claritin® Syrup (loratadine) Zyrtec® (cetirizine) Zyrtec® Syrup (cetirizine)	Allegra® (fexofenadine) Allegra® ODT (fexofenadine) Clarinex® (desloratadine) Xyzal® (levocetirizine) **The following drugs are covered for KBH only**: Allegra-D® (fexofenadine/pseudoephedrine) Allegra-D24® (fexofenadine/pseudoephedrine) Clarinex-D 12-hour® (desloratadine/pseudoephedrine) Clarinex-D 24-hour® (desloratadine/pseudoephedrine)
	Non-Preferred
	Claritin Hives Relief® (loratadine) Claritin RediTabs® (loratadine)

Ophthalmic Antihistamine/Mast Cell Stabilizer Combinations

Preferred	Non-Preferred
Alaway® (ketotifen) Refresh® (ketotifen) Zaditor® (ketotifen)	Bepreve® (bepotastine) Elestat® (epinastine) Lastacaft® (alcaftadine) Optivar® (azelastine) Pataday® (olopatadine) Patanol® (olopatadine)

ANALGESICS

Long-Acting Opioids

Preferred	Non-Preferred
Morphine Sulfate ER **(generic products only)** OxyContin® (oxycodone SR)	Avinza® (morphine sulfate ER) Duragesic® (fentanyl) Embeda® (morphine/naltrexone) Exalgo® (hydromorphone HCL ER) Kadian® (morphine sulfate ER) MS Contin® (morphine sulfate ER) Opana ER® (oxymorphone) Ryzolt® (tramadol ER) Ultram ER® (tramadol ER)

ANALGESICS (continued)

Muscle Relaxants (Skeletal)

Preferred	Non-Preferred, Prior Authorization Required
Flexeril® 10mg (cyclobenzaprine) Parafon Forte DSC® (chlorzoxazone) Robaxin® (methocarbamol) Robaxin-750® (methocarbamol) Robaxisal® (methocarbamol/aspirin)	Amrix® (cyclobenzaprine ER) Fexmid® 7.5mg (cyclobenzaprine) Flexeril® 5mg (cyclobenzaprine) Norflex® (orphenadrine) Norgesic® (orphenadrine/aspirin/caffeine) Norgesic® Forte (orphenadrine/aspirin/caffeine) Skelaxin® (metaxalone)

Muscle Relaxants (Spasticity)

Preferred	Non-Preferred, Prior Authorization Required
Lioresal® (baclofen) Zanaflex® Tablets (tizanidine)	Zanaflex® Capsules (tizanidine)
	Non-Preferred
	Dantrium® (dantrolene)

Non-Steroidal Anti-Inflammatory Drugs (Ophthalmic)

Preferred	Non-Preferred
Acular® (ketorolac) Acular LS® (ketorolac) Acuvail® (ketorolac) Nevanac® (nepafenac) Ocufen®(flurbiprofen) Voltaren® Ophthalmic (diclofenac)	Bromday® (bromfenac) Xibrom® (bromfenac)

Non-Steroidal Anti-Inflammatory Drugs (Topical)

Preferred	Non-Preferred
Pennsaid® (diclofenac) Voltaren® Gel (diclofenac)	Flector® Patch (diclofenac epolamine) Sprix® Nasal Spray (ketorolac tromethamine)

ANALGESICS (continued)

Non-Steroidal Anti-Inflammatory Drugs (Oral)

Preferred	Non-Preferred, Prior Authorization Required
Advil® (ibuprofen)	Relafen® (nabumetone)
Aleve® (naproxen)	**Non-Preferred**
Anaprox® (naproxen)	Cambia® (diclofenac)
Anaprox DS® (naproxen)	Dolobid® (diflunisal)
Ansaid® (flurbiprofen)	Indocin SR® (indomethacin)
Arthrotec® (diclofenac/misoprostol)	Lodine XL® (etodolac)
Cataflam® (diclofenac potassium)	Naprelan® CR Dosepak (naproxen)
Clinoril® (sulindac)	Piroxicam **(generic products only)**
Daypro® (oxaprozin)	Vimovo®(naproxen/esomeprazole)
EC-Naprosyn® (naproxen)	Zipsor® (diclofenac)
Feldene® (piroxicam)**(branded products only)**	
Indocin® (indomethacin)	
Lodine® (etodolac)	
Meclomen® (meclofenamate)	
Mobic® (meloxicam)	
Motrin® (ibuprofen)	
Motrin-IB® (ibuprofen)	
Nalfon® (fenoprofen)	
Naprelan® (naproxen)	
Naprosyn® (naproxen)	
Orudis® (ketoprofen)	
Orudis KT® (ketoprofen)	
Oruvail® (ketoprofen)	
Ponstel® (mefenamic acid)	
Tolectin DS® (tolmetin)	
Tolectin 600® (tolmetin)	
Toradol®(ketorolac) **(limited to a 5 day supply)**	
Voltaren®(diclofenac sodium oral)	
Voltaren XR ® (diclofenac sodium oral)	

Triptans

Preferred	Non-Preferred, Prior Authorization Required
Amerge® (naratriptan)	Frova® (frovatriptan)
Imitrex® (sumatriptan)	Zomig® (zolmitriptan)
Relpax® (eletriptan)	Zomig-ZMT® (zolmitriptan)
Sumatriptan generics	**Non-Preferred**
	Alsuma® (sumatriptan)
	Axert® (almotriptan)
	Maxalt® (rizatriptan)
	Maxalt-MLT® (rizatriptan)
	Sumavel DosePro® (sumatriptan)

ANTIHYPERLIPIDEMICS

Bile Acid Sequestrants

Preferred	Non-Preferred
Colestid® (colestipol) Prevalite® (cholestyramine light) Questran® (cholestyramine) Questran Light® (cholestyramine light)	Welchol® (colesevelam)

Fibric Acid Derivatives

Preferred	Non-Preferred, Prior Authorization Required
Fenofibrate generics Lopid® (gemfibrozil) Tricor® (fenofibrate) Trilipix® (fenofibric acid)	Lofibra® (fenofibrate) Lipofen® (fenofibrate)
	Non-Preferred
	Fenoglide® (fenofibrate) Triglide® (fenofibrate)

HMG-CoA Reductase Inhibitors (Statins)

Preferred	Non-Preferred, Prior Authorization Required
Lipitor® (atorvastatin) Lovastatin generics Mevacor® (lovastatin) Pravachol® (pravastatin) Zocor® (simvastatin)	Altoprev® (lovastatin) Lescol® (fluvastatin) Lescol XL® (fluvastatin) Livalo® (pitavastatin)
	Non-Preferred
	Crestor® (rosuvastatin)

ANTI-INFECTIVES

Antiherpes Virus Agents

Preferred	Non-Preferred
Zovirax® (acyclovir) **(oral dosage forms only)**	Famvir® (famiciclovir) Valtrex® (valacyclovir)

BIOLOGICS

Adult Rheumatoid Arthritis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept) Humira® (adalimumab)	Actemra® (tocilizumab) Cimzia® (certolizumab) Kineret® (anakinra) Orencia® (abatacept) Remicade® (infliximab) Rituxan® (rituximab) Simponi® (golimumab)

BIOLOGICS (continued)

Ankylosing Spondylitis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Remicade® (infliximab)
Humira® (adalimumab)	Simponi® (golimumab)

Crohn's Disease

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Humira® (adalimumab)	Cimzia® (certolizumab)
Remicade® (infliximab)	Tysabri® (natalizumab)

Juvenile Idiopathic Arthritis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Actemra® (tocilizumab)
Humira® (adalimumab)	Orencia® (abatacept)

Plaque Psoriasis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Amevive® (alefacept)
Humira® (adalimumab)	Remicade® (infliximab)
	Stelara® (ustekinumab)

Psoriatic Arthritis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Enbrel® (etanercept)	Remicade® (infliximab)
Humira® (adalimumab)	Simponi® (golimumab)

Ulcerative Colitis

**Clinical prior authorization may apply for all agents*

Preferred	Non-Preferred, Prior Authorization Required
Remicade® (infliximab)	

CARDIOVASCULAR AGENTS

ACE Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Accupril® (quinapril)	Aceon® (perindopril)
Capoten® (captopril)	Altace® (ramipiril)
Lotensin® (benazepril)	Mavik®(trandolapril)
Monopril® (fosinopril)	Univasc® (moexipril)
Prinivil® (lisinopril)	
Vasotec® (enalapril)	
Zestril® (lisinopril)	

CARDIOVASCULAR AGENTS (continued)

ACE Inhibitor/Calcium Channel Blocker Combinations

Preferred	Non-Preferred, Prior Authorization Required
Lotrel® (benazepril/amlodipine)	Lexxel® (enalapril/felodipine) Tarka® (trandolapril/verapamil)

ARBs

Preferred	Non-Preferred, Prior Authorization Required
Benicar® (olmesartan) Benicar HCT® (olmesartan/HCTZ) Cozaar® (losartan) Diovan® (valsartan) Diovan HCT® (valsartan/HCTZ) Hyzaar® (losartan/HCTZ) Micardis® (telmisartan) Micardis HCT® (telmisartan/HCTZ)	Atacand® (candesartan) Atacand HCT® (candesartan/HCTZ) Teveten® (eprosartan) Teveten HCT® (eprosartan/HCTZ) **Non-Preferred** Avalide® (irbesartan/HCTZ) Avapro® (irbesartan) Edarbi® (azilsartan medoxomil)

ARB/Calcium Channel Blocker Combinations

Preferred	Non-Preferred
Azor® (amlodipine/olmesartan) Exforge® (amlodipine/valsartan)	Twynsta® (amlodipine/telmisartan)

Beta-Blockers

Preferred	Non-Preferred, Prior Authorization Required
Betapace® (sotalol) Betapace AF® (sotalol AF) Blocadren® (timolol) Coreg® (carvedilol) Corgard® (nadolol) Inderal® (propranolol) InnoPran XL® (propranolol XL) Kerlone® (betaxolol) Lopressor® (metoprolol tartrate) Propranolol® Intensol (propranolol) Sectral® (acebutolol) Tenormin® (atenolol) Toprol XL® (metoprolol succinate) Visken® (pindolol)	Bystolic® (nebivolol) Inderal LA® (propranolol XL) Levatol® (penbutolol) Zebeta® (bisoprolol) **Non-Preferred** Coreg CR® (carvedilol CR)

Calcium Channel Blockers (Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Adalat CC® (nifedipine ER) Cardene® (nicardipine IR) DynaCirc® (isradipine IR) DynaCirc CR® (isradipine CR) Norvasc® (amlodipine) Procardia XL® (nifedipine ER)	Adalat® (nifedipine IR) Cardene SR® (nicardipine SR) Plendil® (felodipine) Sular® (nisoldipine)

CARDIOVASCULAR AGENTS (continued)

Calcium Channel Blockers (Non-Dihydropyridines)

Preferred	Non-Preferred, Prior Authorization Required
Calan® (verapamil IR) Calan SR® (verapamil SR) Cardizem® (diltiazem IR) Covera HS® (verapamil) **(branded products only)** Diltia XT® (diltiazem) **(brand & AB-rated generics)** Isoptin SR® (verapamil SR) Tiazac® (diltiazem) **(brand & AB-rated generics)** Verelan® (verapamil SR)	Cardizem CD® (diltiazem) **(brand & AB-rated generics)** Cardizem LA® (diltiazem) **(brand & AB-rated generics)** Cardizem SR® (diltiazem) **(brand & AB-rated generics)** Dilacor XR® (diltiazem) Verelan PM® (verapamil) **(brand & AB-rated generics)**

CENTRAL NERVOUS SYSTEM AGENTS

Adjunct Antiepileptics

Preferred	Non-Preferred, Prior Authorization Required
Gabitril® (tiagabine) Keppra® (levetiracetam) Keppra XR® (levetiracetam XR) Lyrica® (pregabalin) Neurontin® (gabapentin) Zonegran® (zonisamide)	Banzel® (rufinamide) Onfi® (clobazam) Vimpat® (lacosamide)

Non-Benzodiazepine Sedative Hypnotics

Preferred	Non-Preferred, Prior Authorization Required
Ambien® (zolpidem) Zolpidem generics	Ambien CR® (zolpidem CR) Edular® (zolpidem) Intermezzo® (zolpidem) Sonata® (zaleplon)
	Non-Preferred
	Lunesta® (eszopiclone)

Non-Scheduled Novel Sleep Agents

Preferred	Non-Preferred
Rozerem® (ramelteon)	

DIABETIC AGENTS

Alphaglucosidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Glyset® (miglitol)	Precose® (acarbose)

Biguanides

Preferred	Non-Preferred, Prior Authorization Required
Glucophage® (metformin) Metformin ER **(generic products only)**	Fortamet® (metformin ER) **(branded products only)** Glucophage XR® (metformin ER) **(branded products only)**

DIABETIC AGENTS (continued)

Dipeptidyl Peptidase-4 Inhibitors

Preferred	Non-Preferred
Januvia® (sitagliptin) Onglyza® (saxagliptin) Tradjenta® (linagliptin)	

Meglitinides

Preferred	Non-Preferred, Prior Authorization Required
Starlix® (nateglinide)	Prandin® (repaglinide)

Incretin Mimetics

**Clinical prior authorization may apply to all agents*

Preferred	Non-Preferred, Prior Authorization Required
Byetta® (exenatide)	Bydureon® (exenatide ER)

Insulin Delivery Systems

Preferred	Non-Preferred, Prior Authorization Required
Humalog® multi-dose vial Humalog® Mix multi-dose vial Humulin N® multi-dose vial Humulin R® multi-dose vial Humulin 70/30® multi-dose vial Novolin N® multi-dose vial Novolin R® multi-dose vial Novolin 70/30® multi-dose vial NovoLog® multi-dose vial, PenFill, & FlexPen NovoLog® Mix multi-dose vial, PenFill, & FlexPens Velosulin BR® multi-dose vial	Humalog® (excluding multi-dose vials) Humalog® Mix (excluding multi-dose vials) Humulin N® (excluding multi-dose vials) Humulin R® (excluding multi-dose vials) Humulin 70/30® (excluding multi-dose vials) Novolin N® (excluding multi-dose vials) Novolin R® (excluding multi-dose vials) Novolin 70/30® (excluding multi-dose vials) Velosulin BR® (excluding multi-dose vials)

Long-Acting Insulin (Vials Only)

Preferred	Non-Preferred
Lantus® (insulin glargine)	Levemir® (insulin detemir)

2nd Generation Sulfonylureas

Preferred	Non-Preferred, Prior Authorization Required
Amaryl® (glimepiride) DiaBeta® (glyburide) Glucotrol® (glipizide) Glucotrol XL® (glipizide XL) Glucovance® (glyburide/metformin) Glynase PresTab® (micronized glyburide) Micronase® (glyburide)	Metaglip® (glipizide/metformin)

DIABETIC AGENTS (continued)

Thiazolidinediones

Preferred	Non-Preferred
Actos® (pioglitazone) ACTOplus Met® (pioglitazone/metformin) ACTOplus Met XR® (pioglitazone/metformin) Avandia® (rosiglitazone)	Avandamet® (rosiglitazone/metformin) Avandaryl® (rosiglitazone/glimepiride) Duetact® (pioglitazone/glimepiride)

GASTROINTESTINAL AGENTS

H_2 Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Pepcid® (famotidine) Zantac® (ranitidine) Zantac EFFERdose® (ranitidine)	Axid® (nizatidine)
	Non-Preferred
	Tagamet® (cimetidine)

Pancreatic Enzyme Replacements

Preferred	Non-Preferred
Creon® (pancrelipase) Zenpep® (pancrelipase)	Pancreaze® (pancrelipase)

Proton Pump Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Prilosec® (omeprazole) Protonix® (pantoprazole)	AcipHex® (rabeprazole) Dexilant® (dexlansoprazole) Nexium® (esomeprazole) Nexium ®Suspension (esomeprazole) Prevacid® Suspension (lansoprazole) Prilosec® Suspension (omeprazole)
	Non-Preferred
	Prevacid® (lansoprazole) Prevacid SoluTab® (lansoprazole)

Serotonin $5HT_3$ Antagonists

Preferred	Non-Preferred, Prior Authorization Required
Zofran® (ondansetron) Zofran ODT® (ondansetron)	Anzemet® (dolasetron) Granisol® (granisetron) Kytril® (granisetron) Sancuso® (granisetron)
	Non-Preferred
	Zuplenz® (ondansetron)

GOUT AGENTS

Xanthine Oxidase Inhibitors

Preferred	Non-Preferred, Prior Authorization Required
Zyloprim® (allopurinol)	Uloric® (febuxostat)

INJECTABLES

Growth Hormones

**Clinical prior authorization may apply to all agents*

Preferred	Non-Preferred, Prior Authorization Required
Genotropin® (somatropin) Genotropin® MiniQuick (somatropin) Omnitrope® (somatropin) Saizen® (somatropin) Tev-Tropin® (somatropin)	Humatrope® (somatropin) Norditropin® (somatropin) Norditropin® FlexPro (somatropin) Norditropin® Nordiflex (somatropin) Nutropin® (somatropin) Nutropin® AQ (somatropin) Nutropin AQ NuSpin® (somatropin)

Erythropoiesis-Stimulating Agents

Preferred	Non-Preferred
Epogen® (epoetin alfa) Procrit® (epoetin alfa)	Aranesp® (darbepoetin alfa)

OPHTHALMIC AGENTS

Ophthalmic Prostaglandin Analogs

Preferred	Non-Preferred, Prior Authorization Required
Travatan Z® (travoprost) Xalatan ® (latanoprost)	Lumigan® (bimatoprost)

OSTEOPOROSIS AGENTS

Bisphosphonates

Preferred	Non-Preferred, Prior Authorization Required
Fosamax® (alendronate) Fosamax Plus D® (alendronate/cholecalciferol)	Actonel® (risedronate) Actonel® with Calcium (risedronate/calcium) Atelvia® (risedronate)
	Non-Preferred
	Boniva® (ibandronate)

UROLOGIC AGENTS

Anticholinergics

Preferred	Non-Preferred, Prior Authorization Required
Detrol® (tolterodine) Detrol LA® (tolterodine ER) Ditropan® (oxybutynin) Toviaz® (fesoterodine) Vesicare® (solifenacin)	Ditropan XL® (oxybutynin ER) Oxytrol® Patch (oxybutynin) Sanctura® (trospium) Sanctura XR® (trospium ER) Urispas® (flavoxate)
	Non-Preferred
	Enablex® (darifenacin) Gelnique® Gel (oxybutynin)