

CIGNA Medicare Select Plus Rx® (HMO)

A Medicare Advantage HMO Medical Plan with Part D Prescription Drug Coverage

CIGNA Medicare Select Plus Rx® (HMO)

2012 Formulary

(List of Covered Drugs)

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

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.

This document includes the CIGNA Medicare Select Plus Rx) partial formulary as of January 1, 2012. For a complete, updated formulary, please visit our website at:

www.cignamedicare.com or call 1-800-627-7534, 8 am to 8 pm local time, seven days a week. Hours apply Monday – Friday, February 15 – October 14 (a voicemail system is available on weekends and holidays). TTY/TDD users should call 1-800-987-8816.

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

CIGNA HealthCare of Arizona, Inc. is a Medicare Advantage Organization with a Medicare contract that offers various individual plans (including the CIGNA Medicare Select Plus Rx – Dual (HMO SNP) plan, which is a Coordinated Care plan offered without a contract with the Arizona Medicaid program).

This information is available in a different format, including Spanish and Braille. Please call Customer Service at the number listed above if you need plan information in another format or language.

Esta información está disponible en un formato diferente, incluso en español y braille. Si necesita información sobre el plan en otro formato o idioma, llame al Servicio de Atención al Cliente al número antes mencionado.



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What is the CIGNA Medicare Rx Select Plus Rx Formulary?

A formulary is a list of covered drugs selected by CIGNA Medicare Select Plus Rx in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. CIGNA Medicare Select Plus Rx will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CIGNA Medicare Select Plus Rx 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 CIGNA Medicare Select Plus Rx. For a complete listing of all prescription drugs covered by CIGNA Medicare Select Plus Rx, please visit our website at cignamedicare.com or call 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

Can the Formulary change?

Generally, if you are taking a drug on our 2012 formulary that was covered at the beginning of the year, we will not 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, will not affect members who are currently taking 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 is 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 and/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 will 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. To get updated information about the drugs covered by CIGNA Medicare Select Plus Rx, please visit our website at www.cignamedicare.com or call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

Our plan's printed formulary document will be updated for any mid-year, non maintenance changes via errata sheets in the event that we 1) remove a drug from our formulary, 2) increase the cost share of a formulary drug, or 3) add utilization management edits to a formulary drug **and** no new alternate drug is offered by our plan as a possible replacement for any of the previously described formulary changes. All affected members currently taking a formulary drug which will have one or more of the previously described formulary changes will be exempt from the formulary change(s) for the remainder of the coverage year.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 6. 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 Agents – Blood Pressure/Cholesterol/Heart Medications. If you know what your drug is used for, look for the category name in the list that begins on page 6. Then look under the category name for your 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 20. 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.

What are generic drugs?

CIGNA Medicare Select Plus Rx covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

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:** CIGNA Medicare Select Plus Rx requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from CIGNA Medicare Select Plus Rx before you fill your prescriptions. If you don't get approval, CIGNA Medicare Select Plus Rx may not cover the drug.

- **Quantity Limits:** For certain drugs, CIGNA Medicare Select Plus Rx limits the amount of the drug that CIGNA Medicare Select Plus Rx will cover. For example, CIGNA Medicare Select Plus Rx provides coverage for up to 1 tablet per day per prescription for Crestor 10 mg tablets. This may be in addition to a standard one month or three month supply.

- **Step Therapy:** In some cases, CIGNA Medicare Select Plus Rx requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, CIGNA Medicare Select Plus Rx may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CIGNA Medicare Select Plus Rx will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 6. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.cignamedicare.com.

You can ask CIGNA Medicare Select Plus Rx to make an exception to these restrictions or limits. See the section, "How do I request an exception to the CIGNA Medicare Select Plus Rx formulary?" on page 3 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this list of covered drugs, you should first contact Customer Service and ask if your drug is covered. This document includes only a partial list of covered drugs, so CIGNA Medicare Select Plus Rx may cover your drug. You can contact Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

If you learn that CIGNA Medicare Select Plus Rx does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by CIGNA Medicare Select Plus Rx. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by CIGNA Medicare Select Plus Rx.
- You can ask CIGNA Medicare Select Plus Rx 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 CIGNA Medicare Select Plus Rx Formulary?

You can ask CIGNA Medicare Select Plus Rx 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 is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, CIGNA Medicare Select Plus Rx limits the amount of the drug that we will 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 contained in our Non-Preferred Brand Drugs Tier 3, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Drugs Tier 2 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. Also you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Tier Drugs Tier 4.

Generally, CIGNA Medicare Select Plus Rx 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 would not 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, tiering or utilization restriction exception. **When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician'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 physician'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 are not 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 will 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 are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply (unless you

have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 102-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are 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, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

An extended transition process is provided to circumstances involving level of care changes in which a beneficiary is changing from one treatment setting to another. An override for refill too soon edit would be provided to allow appropriate coverage. Since there may exist some period of time in which beneficiaries with level of care changes have a temporary gap in coverage while going through a process, our transition policy would allow coverage for one fill with up to a 31-day supply of medication.

For more information

For more detailed information about your CIGNA Medicare Select Plus Rx prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about CIGNA Medicare Select Plus Rx, please call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816. Or, visit www.cignamedicare.com.

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/TDD users should call 1-877-486-2048. Or, visit medicare.gov.

CIGNA Medicare Select Plus Rx's Formulary

The abridged formulary that begins on page 6 provides coverage information about some of the drugs covered by CIGNA Medicare Select Plus Rx. If you have trouble finding your drug in the list, turn to the Index that begins on page 20. Remember: This is only a partial list of drugs covered by CIGNA Medicare Select Plus Rx. If your prescription is not in this partial formulary, please visit our website at www.cignamedicare.com or call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816 for additional help.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., NEXIUM) and generic drugs are listed in lower-case italics (e.g., *omeprazole*).

The information in the Requirements/Limits column tells you if CIGNA Medicare Select Plus Rx has any special requirements for coverage of your drug.

2012 Abridged Formulary Copay/Coinsurance Tables

CIGNA Medicare Select Plus Rx® – Standard (HMO) CIGNA Medicare Select Plus Rx® – Premium (HMO)

State	Initial Coverage Level Copays/Coinsurance						
	Tiers	30-Day Retail	90-Day Retail	30-Day Preferred Mail Order	90-Day Preferred Mail Order	30-Day Out-of-Network	31-Day LTC
AZ	1*	\$5.00	\$15.00	\$5.00	\$12.50	\$5.00	\$5.00
	2	\$45.00	\$135.00	\$45.00	\$112.50	\$45.00	\$45.00
	3	\$75.00	\$225.00	\$75.00	\$187.50	\$75.00	\$75.00
	4	25%	25%	25%	25%	25%	25%

*We provide coverage of this prescription drug in the coverage gap. Please refer to the Evidence of Coverage for more information about this coverage.

CIGNA Medicare Select Plus Rx® – Dual (HMO SNP)

State	Initial Coverage Level Copays						
	Tiers	30-Day Retail	90-Day Retail	30-Day Preferred Mail Order	90-Day Preferred Mail Order	30-Day Out-of-Network	31-Day LTC
AZ	1	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60	\$0 – \$2.60
	2	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50
	3	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50
	4	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50	\$0 – \$6.50

Cost-sharing is based on your level of Medicaid eligibility.

2012 Abridged Formulary

Cost-Sharing Tier Description. Please refer to page 5 for applicable copay/cost-share amounts.

Tier 1: Generic Drugs. This grouping represents the lowest cost-sharing.

Tier 2: Preferred Brand Drugs.

Tier 3: Non-Preferred Brand Drugs.

Tier 4: Specialty Tier Drugs. This grouping represents the highest cost-sharing.

Symbol Key – Utilization Management Requirements/Limits

B vs D: Coverage determination for Part B or Part D required. Note: Inhalant solutions used in a nebulizer are only covered under Part D when the member is located in a long term care (LTC) setting.

GC: Gap coverage. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

PA: Prior authorization is required.

QL: Quantity limits apply.

RA : Restricted Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-800-627-7534, seven days a week, 8 am – 8 pm, (hours apply Monday – Friday, February 15 – October 14). TTY/TDD users should call 1-800-987-8816.

ST: Step therapy is required.

Generally all medications on the formulary are available through mail order except when special circumstances or situations prohibit mailing a particular medication to your home.

Drug Name	Drug Tier	Requirements/ Limits
Analgesics – Pain Medications		
<i>acetaminophen/codeine</i>	1	GC
CAPITAL/CODEINE	2	
EMBEDA	3	QL (60 per 30 days)
<i>endocet</i>	1	GC
<i>fentanyl patch</i>	1	QL (20 per 30 days) GC
<i>hydrocodone/ acetaminophen</i>	1	GC
<i>hydrocodone/ibuprofen</i>	1	GC
<i>hydromorphone hcl</i>	1	GC
KADIAN	2	QL (60 per 30 days)
<i>methadone hcl tablet</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>morphine sulfate er tablet 15mg, 30mg</i>	1	QL (180 per 30 days) GC
<i>morphine sulfate er 60mg, 100mg, 200mg</i>	1	QL (120 per 30 days) GC
<i>morphine sulfate tablet</i>	1	GC
ONSOLIS	4	QL (120 per 30 days) PA
OPANA ER 5MG, 10MG, 20MG, 30MG	2	QL (60 per 30 days)
OPANA ER 40MG	2	QL (120 per 30 days)
<i>oxycodone hcl</i>	1	GC
<i>oxycodone hcl/acetaminophen</i>	1	GC
OXYCONTIN 10MG, 15MG, 20MG, 30MG, 40MG, 60MG	2	QL (90 per 30 days)

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HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday February 15 – October 14). TTY/TTD users should all 1-800-987-8816.

2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
OXYCONTIN 80MG	2	QL (120 per 30 days)
<i>roxicet tablet</i>	1	GC
<i>tramadol hcl</i>	1	GC
<i>tramadol hcl/ acetaminophen</i>	1	GC
Anesthetics – Topical Pain Medications		
<i>lidocaine hcl jelly</i>	1	GC
<i>lidocaine hcl viscous</i>	1	GC
<i>lidocaine/prilocaine</i>	1	B vs D GC
LIDODERM	2	QL (90 per 30 days)
Antibacterials – Antibiotic/Infection		
<i>amoxicillin</i>	1	GC
<i>amoxicillin/potassium clavulanate</i>	1	GC
AVELOX TABLET	2	QL (30 per 30 days)
<i>azithromycin tablet 250mg</i>	1	QL (12 per 30 days) GC
<i>azithromycin tablet 500mg, 600mg</i>	1	GC
<i>cefdinir</i>	1	GC
<i>cefuroxime axetil</i>	1	GC
<i>cephalexin</i>	1	GC
<i>ciprofloxacin hcl</i>	1	GC
<i>clarithromycin</i>	1	GC
<i>clindamycin hcl</i>	1	GC
<i>doxycycline hyclate</i>	1	GC
<i>erythromycin base</i>	1	GC
FACTIVE	3	QL (30 per 30 days)
<i>levofloxacin tablet</i>	1	QL (30 per 30 days) GC
<i>metronidazole</i>	1	GC
<i>neomycin sulfate</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>nitrofurantoin macrocrystalline</i>	1	GC
<i>nitrofurantoin monohydrate</i>	1	GC
<i>penicillin v potassium</i>	1	GC
<i>polycin b</i>	1	GC
<i>sulfamethoxazole/ trimethoprim</i>	1	GC
<i>tetracycline hcl</i>	1	GC
ZYVOX	4	PA
Anticonvulsants – Epilepsy/Seizures		
<i>carbamazepine</i>	1	GC
<i>divalproex sodium</i>	1	GC
<i>gabapentin capsule, tablet</i>	1	GC
LAMICTAL TABLET, ODT & XR	2	
<i>lamotrigine</i>	1	GC
<i>levetiracetam</i>	1	GC
LYRICA	2	QL (60 per 30 days)
<i>oxcarbazepine</i>	1	GC
PHENYTEK	2	
<i>phenytoin sodium extended</i>	1	GC
<i>primidone</i>	1	GC
<i>topiramate</i>	1	GC
<i>valproic acid</i>	1	GC
VIMPAT	3	
Antidementia Agents – Alzheimer's		
ARICEPT TABLET 23MG	2	QL (30 per 30 days)
<i>donepezil hcl</i>	1	QL (30 per 30 days) GC
EXELON PATCH	2	QL (30 per 30 days)
NAMENDA SOLUTION	2	QL (300 per 30 days)
NAMENDA TABLET	2	QL (60 per 30 days)

GC: Gap coverage. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday February 15 – October 14). TTY/TTD users should all 1-800-987-8816.

2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
Antidepressants – Depression		
<i>amitriptyline hcl</i>	1	GC
<i>budeprion sr</i>	1	QL (60 per 30 days) GC
<i>budeprion xl</i>	1	QL (30 per 30 days) GC
<i>bupropion hcl</i>	1	GC
<i>bupropion hcl sr</i>	1	QL (60 per 30 days) GC
<i>citalopram hydrobromide solution</i>	1	QL (900 per 30 days) GC
<i>citalopram hydrobromide tablet 10mg, 40mg</i>	1	QL (30 per 30 days) GC
<i>citalopram hydrobromide tablet 20mg</i>	1	QL (90 per 30 days) GC
CYMBALTA	2	QL (60 per 30 days)
<i>doxepin hcl</i>	1	GC
<i>fluoxetine hcl</i>	1	GC
LEXAPRO TABLET	3	QL (60 per 30 days)
MARPLAN	3	
<i>mirtazapine</i>	1	GC
<i>nortriptyline hcl</i>	1	GC
<i>paroxetine hcl tablet</i>	1	QL (30 per 30 days) GC
PRISTIQ	2	QL (30 per 30 days)
SAVELLA	2	QL (60 per 30 days)
<i>sertraline hcl 25mg, 50mg</i>	1	QL (30 per 30 days) GC
<i>sertraline hcl 100mg</i>	1	QL (60 per 30 days) GC
<i>trazodone hcl</i>	1	GC
<i>venlafaxine hcl</i>	1	GC
<i>venlafaxine hcl er capsule 37.5mg, 75mg</i>	1	QL (30 per 30 days) GC

Drug Name	Drug Tier	Requirements/ Limits
<i>venlafaxine hcl er capsule 150mg</i>	1	QL (60 per 30 days) GC
Antidotes, Deterrents, and Toxicologic Agents – Smoking Cessation/Addiction		
<i>buproban</i>	1	QL (60 per 30 days) GC
CHANTIX STARTING MONTH PAK	3	QL (106 per 365 days) ST
CHANTIX 0.5MG, 1MG	3	QL (336 per 365 days) ST
SUBOXONE	2	
Antiemetics – Nausea/Vomiting		
EMEND 40MG	2	QL (2 per 30 days) B vs D
EMEND 80MG	2	QL (8 per 30 days) B vs D
EMEND 125MG	2	QL (4 per 30 days) B vs D
EMEND TRIFOLD PACK	2	QL (12 per 30 days) B vs D
<i>ondansetron hcl tablet & odt 4mg</i>	1	QL (60 per 30 days) B vs D GC
<i>ondansetron hcl tablet & odt 8mg</i>	1	QL (90 per 30 days) B vs D GC
<i>phenadoz</i>	1	GC
<i>prochlorperazine maleate</i>	1	GC
<i>promethazine hcl</i>	1	GC
SANCUSO	3	QL (4 per 30 days) PA
TRANSDERM-SCOP	2	
Antifungals – Fungal Infection		
<i>clotrimazole/betamethasone dipropionate</i>	1	GC
<i>clotrimazole troche</i>	1	GC
<i>econazole nitrate</i>	1	GC

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HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday February 15 – October 14). TTY/TTD users should all 1-800-987-8816.

2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
EXELDERM	2	
<i>fluconazole tablet</i>	1	GC
GRIFULVIN V	2	
<i>itraconazole</i>	1	GC
<i>ketoconazole</i>	1	GC
<i>nystatin</i>	1	GC
<i>nystatin/triamcinolone</i>	1	GC
<i>nystop</i>	1	GC
OXISTAT	2	
<i>terbinafine hcl tablet</i>	1	QL (90 per 270 days) GC
Antigout Agents – Gout		
<i>allopurinol</i>	1	GC
COLCRYS	2	
ULORIC	2	QL (30 per 30 days) ST
Anti-inflammatory Agents – Pain/Inflammation (NSAIDs)		
CELEBREX	2	QL (60 per 30 days)
<i>diclofenac potassium</i>	1	GC
<i>diclofenac sodium</i>	1	GC
<i>diflunisal</i>	1	GC
<i>etodolac</i>	1	GC
FLECTOR	3	
<i>ibuprofen</i>	1	GC
<i>indomethacin</i>	1	GC
<i>ketorolac tromethamine tablet</i>	1	QL (20 per 30 days) GC
<i>meloxicam</i>	1	GC
<i>nabumetone</i>	1	GC
<i>naproxen</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>piroxicam</i>	1	GC
<i>salsalate</i>	1	GC
<i>sulindac</i>	1	GC
VIMOVO	2	QL (60 per 30 days)
Antimigraine Agents – Migraine		
<i>dihydroergotamine mesylate</i>	1	GC
MAXALT & MAXALT-MLT 5MG	2	QL (27 per 30 days)
MAXALT & MAXALT-MLT 10MG	2	QL (18 per 30 days)
MIGRANAL	3	QL (8 per 30 days)
<i>naratriptan hcl 1mg</i>	1	QL (18 per 30 days) ST GC
<i>naratriptan hcl 2.5mg</i>	1	QL (9 per 30 days) ST GC
RELPAK 20MG	3	QL (12 per 30 days) ST
RELPAK 40MG	3	QL (6 per 30 days) ST
<i>sumatriptan succinate 25mg</i>	1	QL (36 per 30 days) GC
<i>sumatriptan succinate 50mg</i>	1	QL (18 per 30 days) GC
<i>sumatriptan succinate 100mg</i>	1	QL (9 per 30 days) GC
TREXIMET	2	QL (9 per 30 days)
ZOMIG & ZOMIG ZMT 2.5MG	3	QL (12 per 30 days)
ZOMIG & ZOMIG ZMT 5MG	3	QL (6 per 30 days)
ZOMIG SOLUTION	3	QL (6 per 30 days)
Antimyasthenic Agents – Myasthenia Gravis		
<i>guanidine hcl</i>	1	GC
MESTINON TIMESPAN	2	
<i>pyridostigmine bromide</i>	1	GC

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
Antimycobacterials – Tuberculosis		
<i>ethambutol hcl</i>	1	GC
<i>isoniazid tablet</i>	1	GC
<i>rifampin capsule</i>	1	GC
Antineoplastics – Cancer		
<i>anastrozole</i>	1	QL (30 per 30 days) GC
FEMARA	3	
<i>tamoxifen citrate</i>	1	GC
Antiparasitics – Parasite Infection		
<i>hydroxychloroquine sulfate</i>	1	GC
<i>mebendazole</i>	1	GC
<i>mefloquine hcl</i>	1	GC
Antiparkinson Agents – Parkinson's		
<i>amantadine hcl</i>	1	GC
APOKYN	4	
AZILECT	2	QL (30 per 30 days)
<i>benztropine mesylate</i>	1	GC
<i>carbidopa/levodopa</i>	1	GC
<i>carbidopa/levodopa sr</i>	1	GC
LODOSYN	2	
MIRAPEX ER	2	
<i>pramipexole dihydrochloride</i>	1	GC
REQUIP XL	2	
<i>ropinirole hcl</i>	1	GC
STALEVO	2	
TASMAR	2	
ZELAPAR	3	

Drug Name	Drug Tier	Requirements/ Limits
Antipsychotics – Schizophrenia/Mental Disorders		
ABILIFY DISCMELT 10MG	3	QL (60 per 30 days)
ABILIFY DISCMELT 15MG	4	QL (60 per 30 days)
ABILIFY TABLET 2MG, 5MG, 10MG, 15MG	3	QL (30 per 30 days)
ABILIFY TABLET 20MG, 30MG	4	QL (30 per 30 days)
FANAPT	3	QL (60 per 30 days)
GEODON CAPSULE	2	QL (60 per 30 days)
LATUDA	3	QL (30 per 30 days)
<i>risperidone tablet 0.25mg, 0.5mg, 1mg, 2mg, 3mg</i>	1	QL (60 per 30 days) GC
<i>risperidone tablet 4mg</i>	1	QL (120 per 30 days) GC
SAPHRIS	3	
SEROQUEL 25MG, 50MG, 100MG, 200MG	3	QL (120 per 30 days)
SEROQUEL 300MG, 400MG	3	QL (60 per 30 days)
SEROQUEL XR 50MG, 300MG, 400MG	2	QL (60 per 30 days)
SEROQUEL XR 150MG, 200MG	2	QL (30 per 30 days)
ZYPREXA INJECTION	2	
ZYPREXA TABLET 2.5MG, 5MG, 7.5MG, 10MG	2	QL (30 per 30 days)
ZYPREXA TABLET 15MG, 20MG	4	QL (30 per 30 days)
ZYPREXA ZYDIS TABLET 5MG, 10MG	2	QL (30 per 30 days)
ZYPREXA ZYDIS TABLET 15MG, 20MG	4	QL (30 per 30 days)

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
Antispasticity Agents - Spasticity		
<i>baclofen</i>	1	GC
<i>tizanidine hcl</i>	1	GC
Antivirals – Viral Infections/Hepatitis/HIV		
<i>acyclovir capsule, tablet</i>	1	GC
CRIXIVAN	2	
EPIVIR	2	
EPIVIR HBV	2	
<i>famciclovir</i>	1	GC
NORVIR	3	
RESCRIPTOR	2	
SELZENTRY	2	
TAMIFLU CAPSULE 75MG	2	QL (56 per 365 days)
TRUVADA	4	
<i>valacyclovir hcl</i>	1	GC
VIRACEPT	2	
ZIAGEN	2	
ZOVIRAX OINTMENT	3	
Anxiolytics – Anxiety/Nerves		
<i>bupirone hcl</i>	1	GC
LEXAPRO TABLET	3	QL (60 per 30 days)
Bipolar Agents – Manic-Depression		
<i>divalproex sodium er</i>	1	GC
EQUETRO	3	
<i>lithium carbonate</i>	1	GC
Blood Glucose Regulators – Diabetes		
<i>acarbose</i>	1	GC
ACTOPLUS MET	2	QL (90 per 30 days)
ACTOS	2	QL (30 per 30 days)
ALCOHOL PREP PADS	2	

Drug Name	Drug Tier	Requirements/ Limits
APIDRA	2	
AVANDIA 2MG, 4MG	3	QL (60 per 30 days)
AVANDIA 8MG	3	QL (30 per 30 days)
BYETTA	2	QL (3 per 30 days)
DUETACT	2	QL (30 per 30 days)
<i>glimepiride</i>	1	GC
<i>glipizide</i>	1	GC
<i>glipizide er</i>	1	GC
<i>glipizide/metformin hcl</i>	1	GC
GLUCAGEN HYPOKIT	2	QL (2 per 1 day)
<i>glyburide</i>	1	GC
<i>glyburide/metformin hcl</i>	1	GC
HUMALOG	3	ST
INSULIN SYRINGES & NEEDLES	2	
JANUMET	2	QL (60 per 30 days)
JANUVIA	2	QL (30 per 30 days)
KOMBIGLYZE XR 500MG/5MG, 1000MG/5MG	2	QL (30 per 30 days)
KOMBIGLYZE XR 1000MG/2.5MG	2	QL (60 per 30 days)
LANTUS	2	
LEVEMIR	2	
<i>metformin hcl</i>	1	GC
<i>metformin hcl er</i>	1	GC
NOVOLIN	2	
NOVOLOG	2	
ONGLYZA	2	QL (30 per 30 days)
VICTOZA	2	QL (9 per 30 days)

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
Blood Products/Modifiers/Volume Expanders – Blood Thinners/Antiplatelet Medications/ Others		
AGGRENOX	2	QL (60 per 30 days)
ARANESP 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML, 60MCG/ML	2	PA
ARANESP 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML	4	PA
ARIXTRA 2.5MG/0.5ML	2	QL (32 per 365 days)
ARIXTRA 5MG/0.4ML	4	QL (12 per 365 days)
ARIXTRA 7.5MG/0.6ML	4	QL (18 per 365 days)
ARIXTRA 10MG/0.8ML	4	QL (24 per 365 days)
<i>cilostazol</i>	1	GC
EFFIENT 5MG	2	QL (42 per 30 days)
EFFIENT 10MG	2	QL (36 per 30 days)
<i>enoxaparin sodium 30mg/0.3ml</i>	1	QL (18 per 365 days) GC
<i>enoxaparin sodium 40mg/0.4ml</i>	1	QL (24 per 365 days) GC
<i>enoxaparin sodium 60mg/0.6ml</i>	1	QL (36 per 365 days) GC
<i>enoxaparin sodium 80mg/0.8ml</i>	1	QL (48 per 365 days) GC
<i>enoxaparin sodium 100mg/ml, 150mg/ml</i>	4	QL (60 per 365 days)
<i>enoxaparin sodium 120mg/0.8ml</i>	4	QL (48 per 365 days)
<i>jantoven</i>	1	GC
<i>pentoxifylline er</i>	1	GC
PLAVIX 75MG	2	

Drug Name	Drug Tier	Requirements/ Limits
PRADAXA	2	QL (60 per 30 days)
PROCRIT 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	2	QL (12 per 28 days) PA
PROCRIT 10000UNIT/ML	2	PA
PROCRIT 20000UNIT/ML, 40000UNIT/ML	4	PA
<i>warfarin sodium</i>	1	GC
Cardiovascular Agents – Blood Pressure/ Cholesterol/Heart Medications		
<i>afeditab cr</i>	1	GC
<i>amiodarone hcl</i>	1	GC
<i>amlodipine besylate</i>	1	QL (30 per 30 days) GC
<i>amlodipine besylate/ benazepril hydrochloride</i>	1	QL (30 per 30 days) GC
AMTURNIDE	3	QL (30 per 30 days)
<i>atenolol</i>	1	GC
<i>benazepril hcl</i>	1	GC
BENICAR/BENICAR HCT	3	QL (30 per 30 days)
<i>bumetanide</i>	1	GC
BYSTOLIC TABLET 2.5MG, 5MG	2	QL (90 per 30 days)
BYSTOLIC TABLET 10MG	2	QL (120 per 30 days)
BYSTOLIC TABLET 20MG	2	QL (60 per 30 days)
<i>captopril</i>	1	GC
<i>cartia xt</i>	1	GC
<i>carvedilol</i>	1	GC
<i>chlorthalidone</i>	1	GC
<i>clonidine hcl tablet</i>	1	GC
COREG CR	2	QL (30 per 30 days)
CRESTOR	2	QL (30 per 30 days)
<i>digoxin</i>	1	GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>dilt-cd</i>	1	GC
<i>dilt-xr</i>	1	GC
<i>diltiazem cd</i>	1	GC
<i>diltiazem hcl er</i>	1	GC
<i>diltzac</i>	1	GC
DIOVAN/DIOVAN HCT	2	QL (30 per 30 days)
<i>enalapril maleate</i>	1	GC
<i>enalapril maleate/ hydrochlorothiazide</i>	1	GC
EXFORGE/EXFORGE HCT	2	QL (30 per 30 days)
<i>felodipine er</i>	1	QL (30 per 30 days) GC
<i>fenofibrate micronized</i>	1	QL (30 per 30 days) GC
<i>fenofibrate tablet 54mg</i>	1	QL (60 per 30 days) GC
<i>fenofibrate tablet 160mg</i>	1	QL (30 per 30 days) GC
<i>flecainide acetate</i>	1	GC
<i>furosemide</i>	1	GC
<i>gemfibrozil</i>	1	GC
<i>hydralazine hcl</i>	1	GC
<i>hydrochlorothiazide</i>	1	GC
<i>indapamide</i>	1	GC
<i>isosorbide dinitrate</i>	1	GC
<i>isosorbide dinitrate er</i>	1	GC
<i>isosorbide mononitrate er</i>	1	GC
<i>labetalol hcl</i>	1	GC
LANOXIN	2	
LESCOL 20MG	2	QL (30 per 30 days)
LESCOL 40MG	2	QL (60 per 30 days)
LESCOL XL 80MG	2	QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
LIPITOR	1	QL (30 per 30 days) GC
<i>lisinopril</i>	1	GC
<i>lisinopril/ hydrochlorothiazide</i>	1	GC
<i>losartan potassium</i>	1	QL (30 per 30 days) GC
<i>losartan potassium/ hydrochlorothiazide</i>	1	QL (30 per 30 days) GC
<i>lovastatin 10mg, 20mg</i>	1	QL (30 per 30 days) GC
<i>lovastatin 40mg</i>	1	QL (60 per 30 days) GC
LOVAZA	2	
<i>metolazone</i>	1	GC
<i>metoprolol succinate er 25mg, 50mg, 100mg</i>	1	QL (90 per 30 days) GC
<i>metoprolol succinate er 200mg</i>	1	QL (60 per 30 days) GC
<i>metoprolol tartrate tablet</i>	1	GC
MICARDIS/MICARDIS HCT	2	QL (30 per 30 days)
MULTAQ	2	QL (60 per 30 days)
<i>nadolol</i>	1	GC
NIASPAN 500MG	2	QL (30 per 30 days)
NIASPAN 750MG, 1000MG	2	QL (60 per 30 days)
<i>nifediac cc</i>	1	GC
<i>nifedical xl</i>	1	GC
<i>nifedipine er</i>	1	GC
<i>nitroglycerin patch</i>	1	GC
NITROLINGUAL PUMPSPRAY	2	
NITROSTAT	2	
<i>pravastatin sodium</i>	1	QL (30 per 30 days) GC

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Drug Name	Drug Tier	Requirements/ Limits
<i>propranolol hcl</i>	1	GC
<i>propranolol hcl er</i>	1	GC
<i>quinapril hcl</i>	1	GC
<i>ramipril</i>	1	QL (60 per 30 days) GC
RANEXA	2	
SIMCOR 500MG/20MG, 500MG/40MG, 1000MG/40MG	2	QL (30 per 30 days)
SIMCOR 750MG/20MG, 1000MG/20MG	2	QL (60 per 30 days)
<i>simvastatin 5mg, 10mg, 20mg</i>	1	QL (90 per 30 days) GC
<i>simvastatin 40mg</i>	1	QL (45 per 30 days) GC
<i>simvastatin 80mg</i>	1	QL (30 per 30 days) GC
<i>sotalol hcl</i>	1	GC
<i>spironolactone</i>	1	GC
<i>spironolactone/ hydrochlorothiazide</i>	1	GC
<i>taztia xt</i>	1	GC
TEKAMLO	3	QL (30 per 30 days)
TEKTURNA/TEKTURNA HCT	3	QL (30 per 30 days)
<i>triamterene/ hydrochlorothiazide</i>	1	GC
TRICOR 48MG	3	QL (60 per 30 days)
TRICOR 145MG	3	QL (30 per 30 days)
TRILIPIX 45MG	2	QL (60 per 30 days)
TRILIPIX 135MG	2	QL (30 per 30 days)
TWYNSTA	2	QL (30 per 30 days)
VALTURNA	3	QL (30 per 30 days)
<i>verapamil hcl er</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
VYTORIN	2	QL (30 per 30 days)
WELCHOL PACKET	2	QL (30 per 30 days)
WELCHOL TABLET	2	
ZETIA	2	QL (30 per 30 days)
Central Nervous System Agents – ADD/ADHD		
<i>amphetamine/ dextroamphetamine tablet</i>	1	GC
<i>methylphenidate hcl</i>	1	GC
<i>methylphenidate hcl sr</i>	1	GC
STRATTERA 10MG, 18MG, 25MG, 40MG	2	QL (60 per 30 days)
STRATTERA 60MG, 80MG, 100MG	2	QL (30 per 30 days)
Dental and Oral Agents – Mouth Conditions		
<i>chlorhexidine gluconate</i>	1	GC
<i>pilocarpine hcl</i>	1	GC
<i>triamcinolone in orabase</i>	1	GC
Dermatological Agents – Skin Conditions		
<i>augmented betamethasone dipropionate</i>	1	GC
<i>betamethasone dipropionate</i>	1	GC
<i>betamethasone valerate</i>	1	GC
CARAC	3	
<i>clobetasol propionate</i>	1	GC
CLODERM	2	
CUTIVATE LOTION	3	
<i>desonide</i>	1	GC
DIFFERIN	2	
DOVONEX CREAM	3	
EFUDEX	3	
<i>fluocinonide</i>	1	GC

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
<i>fluorouracil cream</i>	1	GC
<i>hydrocortisone cream, lotion, ointment</i>	1	GC
<i>hydrocortisone valerate</i>	1	GC
<i>imiquimod</i>	1	GC
METROGEL	2	
<i>mometasone furoate</i>	1	GC
<i>mupirocin</i>	1	GC
OXSORALEN ULTRA	2	
PANDEL	2	
<i>proctosol hc</i>	1	GC
SANTYL	2	
<i>silver sulfadiazine</i>	1	GC
SOLARAZE	2	
<i>triamcinolone acetonide</i>	1	GC
<i>triderm</i>	1	GC
ZONALON	2	
ZYCLARA	3	
Enzyme Replacements/ Modifiers – Enzymes		
CREON	2	
CYSTAGON	2	
ZENPEP	2	
Gastrointestinal Agents – Stomach/Ulcer Medications		
ACIPHEX	3	QL (60 per 30 days)
AMITIZA	2	QL (60 per 30 days)
CARAFATE SUSPENSION	3	
<i>cimetidine</i>	1	GC
DEXILANT	3	QL (60 per 30 days)
<i>dicyclomine hcl</i>	1	GC
<i>diphenoxylate/atropine</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
<i>famotidine tablet</i>	1	GC
<i>gavilyte-c</i>	1	GC
<i>gavilyte-g</i>	1	GC
<i>gavilyte-n</i>	1	GC
<i>generlac</i>	1	GC
GOLYTELY	2	
HALFLYTELY	2	
<i>lactulose</i>	1	GC
<i>lansoprazole</i>	1	QL (60 per 30 days) GC
<i>loperamide hcl rx</i>	1	GC
<i>metoclopramide hcl</i>	1	GC
<i>misoprostol</i>	1	GC
MOTOFEN	2	
MOVIPREP	3	
NEXIUM	2	QL (60 per 30 days)
NULYTELY	2	
<i>omeprazole</i>	1	QL (60 per 30 days) GC
<i>pantoprazole sodium</i>	1	QL (60 per 30 days) GC
<i>polyethylene glycol 3350</i>	1	GC
<i>ranitidine hcl</i>	1	GC
<i>sucralfate</i>	1	GC
<i>trilyte</i>	1	GC
<i>ursodiol capsule</i>	1	GC
Genitourinary Agents – Bladder/BPH Medications		
<i>alfuzosin hcl er</i>	1	QL (30 per 30 days) GC
AVODART	2	QL (30 per 30 days)
DETROL	2	QL (60 per 30 days)

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2012 Abridged Formulary

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DETROL LA	2	QL (30 per 30 days)
<i>doxazosin mesylate</i>	1	GC
ENABLEX	3	QL (30 per 30 days)
<i>finasteride</i>	1	QL (30 per 30 days) GC
FOSRENOL	2	
GELNIQUE	2	QL (30 per 30 days)
JALYN	2	QL (30 per 30 days)
<i>oxybutynin chloride</i>	1	GC
<i>oxybutynin chloride er 5mg</i>	1	QL (30 per 30 days) GC
<i>oxybutynin chloride er 10mg, 15mg</i>	1	QL (60 per 30 days) GC
PHOSLO	2	
RAPAFLO	2	QL (30 per 30 days) ST
REVELA	2	
<i>tamsulosin hcl</i>	1	QL (60 per 30 days) GC
<i>terazosin hcl</i>	1	GC
TOVIAZ	2	QL (30 per 30 days)
VESICARE	3	QL (30 per 30 days)
Hormonal Agents – Adrenal Regulating Medications		
<i>dexamethasone tablet</i>	1	GC
<i>fludrocortisone acetate</i>	1	GC
LYSODREN	2	
<i>methylprednisolone tablet 4mg</i>	1	GC
<i>methylprednisolone tablet 8mg, 16mg, 32mg</i>	1	B vs D GC
<i>prednisone tablet</i>	1	B vs D GC

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents – Androgens/Estrogens/Antiandrogens/Others		
ALORA	2	QL (8 per 28 days)
ANDRODERM	2	
ANDROGEL	2	
<i>bicalutamide</i>	1	GC
ENJUVIA	2	
ESTRACE CREAM	3	
<i>estradiol</i>	1	GC
EVISTA	2	QL (30 per 30 days)
<i>medroxyprogesterone acetate</i>	1	GC
MEGACE ES	2	
<i>megestrol acetate</i>	1	GC
OXANDRIN	4	
PREMARIN CREAM	2	
PREMARIN TABLET	3	QL (30 per 30 days)
TESTIM	2	
<i>testosterone cypionate</i>	1	PA GC
VAGIFEM	3	
VIVELLE-DOT	2	QL (8 per 28 days)
Hormonal Agents – Parathyroid Suppressant Medication		
SENSIPAR 30MG	2	QL (60 per 30 days)
SENSIPAR 60MG	4	QL (60 per 30 days)
SENSIPAR 90MG	4	QL (120 per 30 days)
Hormonal Agents – Pituitary Medications		
HUMATROPE	4	PA
SAIZEN	4	PA
SOMATULINE DEPOT	4	
TRELSTAR	2	PA

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents – Thyroid Medications		
ARMOUR THYROID	2	
<i>levothyroxine sodium</i>	1	GC
LEVOXYL	2	
<i>methimazole</i>	1	GC
<i>propylthiouracil</i>	1	GC
SYNTHROID	3	
UNITHROID	2	
Immunological Agents – Immunology Medications/Vaccines		
ADACEL	2	
AVONEX	4	PA
<i>azathioprine</i>	1	B vs D GC
BETASERON	4	PA
COPAXONE	4	PA
DECAVAC	2	
ENBREL	4	PA
HUMIRA	4	PA
<i>leflunomide</i>	1	GC
<i>methotrexate</i>	1	B vs D GC
MYFORTIC	2	B vs D
PEG-INTRON	4	PA
REBIF	4	PA
SANDIMMUNE	2	B vs D
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	1	GC
ZOSTAVAX	2	
Inflammatory Bowel Disease Agents – Ulcerative Colitis/Proctitis		
APRISO	3	
<i>balsalazide disodium</i>	1	GC

Drug Name	Drug Tier	Requirements/ Limits
CANASA	2	
DIPENTUM	2	
LIALDA	2	
PENTASA	2	
<i>sulfasalazine</i>	1	GC
Metabolic Bone Disease Agents – Osteoporosis/Others		
ACTONEL 5MG, 30MG	3	QL (30 per 30 days) ST
ACTONEL 35MG	3	QL (4 per 28 days) ST
ACTONEL 150MG	3	QL (1 per 30 days) ST
<i>alendronate sodium tablet 35mg, 70mg</i>	1	QL (4 per 28 days) GC
BONIVA TABLET	2	QL (1 per 30 days)
<i>calcitriol</i>	1	B vs D GC
FORTEO	4	
FORTICAL	1	GC
ZEMPLAR	2	B vs D
Ophthalmic Agents – Eye Conditions		
<i>acetazolamide</i>	1	GC
ALPHAGAN P	2	
AZASITE	2	
<i>azelastine hcl</i>	1	GC
AZOPT	2	
BETIMOL	2	
BETOPTIC-S	2	
<i>brimonidine tartrate</i>	1	GC
COMBIGAN	2	
<i>diclofenac sodium</i>	1	GC
<i>dorzolamide hcl</i>	1	GC
<i>dorzolamide hcl/timolol maleate</i>	1	GC

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2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
DUREZOL	3	
<i>erythromycin ointment</i>	1	GC
<i>fluorometholone</i>	1	GC
<i>gentamicin sulfate</i>	1	GC
IQUIX	2	
<i>ketorolac tromethamine</i>	1	GC
<i>latanoprost</i>	1	GC
<i>levobunolol hcl</i>	1	GC
LOTEMAX	3	
LUMIGAN	2	QL (2.5 per 30 days)
MOXEZA	2	
<i>neomycin/polymyxin/ dexamethasone</i>	1	GC
NEVANAC	2	
<i>ofloxacin</i>	1	GC
PATADAY	2	
PATANOL	2	
<i>prednisolone acetate</i>	1	GC
RESTASIS	2	
<i>timolol maleate</i>	1	GC
TOBRADEX OINTMENT	3	
TOBRADEX ST	3	
<i>tobramycin sulfate</i>	1	GC
<i>tobramycin sulfate/ dexamethasone</i>	1	GC
TRAVATAN Z	2	QL (2.5 per 30 days)
<i>trimethoprim sulfate/ polymyxin b sulfate</i>	1	GC
VIGAMOX	2	
Otic Agents – Ear Conditions		
CIPRO HC	2	
CIPRODEX	2	

Drug Name	Drug Tier	Requirements/ Limits
<i>cortomycin</i>	1	GC
<i>hydrocortisone/acetic acid</i>	1	GC
<i>neomycin/polymyxin/ hydrocortisone</i>	1	GC
<i>ofloxacin</i>	1	GC
Respiratory Tract Agents – Allergies/Asthma/ COPD		
<i>acetylcysteine</i>	1	B vs D GC
ADVAIR DISKUS/HFA	2	
<i>albuterol sulfate inhalation solution</i>	1	B vs D GC
ALVESCO	3	
ASMANEX	2	
ASTEPRO	2	
ATROVENT HFA	3	ST
<i>azelastine hcl</i>	1	GC
BROVANA	3	B vs D
<i>budesonide</i>	1	B vs D GC
<i>cyproheptadine hcl</i>	1	GC
EPIPEN	2	QL (2 per 1 day)
FLOVENT DISKUS/HFA	2	
<i>flunisolide</i>	1	GC
<i>fluticasone propionate</i>	1	GC
FORADIL	2	
<i>hydroxyzine hcl</i>	1	GC
<i>hydroxyzine pamoate</i>	1	GC
<i>ipratropium bromide/ albuterol sulfate</i>	1	B vs D GC
<i>ipratropium bromide inhalation solution</i>	1	B vs D GC
<i>ipratropium bromide nasal solution</i>	1	GC

GC: Gap coverage. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

HI: This prescription drug may be covered under our medical benefit. For more information, call Customer Service at 1-800-627-7534, seven days a week, (hours apply Monday – Friday February 15 – October 14). TTY/TTD users should all 1-800-987-8816.

2012 Abridged Formulary

Drug Name	Drug Tier	Requirements/ Limits
LETAIRIS	4	
MAXAIR	3	QL (14 per 30 days)
NASACORT AQ	3	ST
NASONEX	3	ST
OMNARIS	3	
PERFOROMIST	3	B vs D
PROAIR HFA	2	
QVAR	2	
SEREVENT DISKUS	2	
SINGULAIR	2	
SPIRIVA	2	
SYMBICORT	2	
<i>theochron</i>	1	GC
<i>theophylline er</i>	1	GC
TRACLEER	4	RA
VENTOLIN HFA	2	
VERAMYST	2	
XOPENEX INHALATION SOLUTION	3	B vs D
XOPENEX HFA	3	
ZYFLO CR	2	
Sedatives/Hypnotics – Sleep Aids		
LUNESTA	3	QL (30 per 30 days)
<i>zaleplon</i>	1	QL (30 per 30 days) GC
<i>zolpidem tartrate</i>	1	QL (30 per 30 days) GC

Drug Name	Drug Tier	Requirements/ Limits
Skeletal Muscle Relaxants – Muscle Spasms		
<i>carisoprodol 350mg</i>	1	GC
<i>cyclobenzaprine hcl</i>	1	GC
<i>metaxalone</i>	1	ST GC
<i>methocarbamol</i>	1	GC
Therapeutic Nutrients/Minerals/Electrolytes – Minerals/Electrolytes		
K-TABS	1	GC
<i>klor-con & klor-con m</i>	1	GC
<i>potassium chloride er</i>	1	GC
<i>potassium citrate er</i>	1	GC

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2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
ABILIFY DISCMELT 10MG	10	<i>amphetamine/dextroamphetamine</i>		AZILECT	10
ABILIFY DISCMELT 15MG	10	<i>tablet</i>	14	<i>azithromycin tablet 250mg</i>	7
ABILIFY TABLET 2MG, 5MG, 10MG, 15MG	10	AMTURNIDE	12	<i>azithromycin tablet 500mg, 600mg</i>	7
ABILIFY TABLET 20MG, 30MG	10	<i>anastrozole</i>	10	AZOPT	17
<i>acarbose</i>	11	ANDRODERM	16	<i>baclofen</i>	11
<i>acetaminophen/codeine</i>	6	ANDROGEL	16	<i>balsalazide disodium</i>	17
<i>acetazolamide</i>	17	APIDRA	11	<i>benazepril hcl</i>	12
<i>acetylcysteine</i>	18	APOKYN	10	BENICAR/BENICAR HCT	12
ACIPHEX	15	APRISO	17	<i>benztropine mesylate</i>	10
ACTONEL 5MG, 30MG	17	ARANESP 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML, 60MCG/ML	12	<i>betamethasone dipropionate</i>	14
ACTONEL 35MG	17	ARANESP 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML	12	<i>betamethasone valerate</i>	14
ACTONEL 150MG	17	ARICEPT TABLET 23MG	7	BETASERON	17
ACTOPLUS MET	11	ARIXTRA 2.5MG/0.5ML	12	BETIMOL	17
ACTOS	11	ARIXTRA 5MG/0.4ML	12	BETOPTIC-S	17
<i>acyclovir capsule, tablet</i>	11	ARIXTRA 7.5MG/0.6ML	12	<i>bicalutamide</i>	16
ADACEL	17	ARIXTRA 10MG/0.8ML	12	BONIVA TABLET	17
ADVAIR DISKUS/HFA	18	ARMOUR THYROID	17	<i>brimonidine tartrate</i>	17
<i>afeditab cr</i>	12	ASMANEX	18	BROVANA	18
AGGRENOX	12	ASTEPRO	18	<i>budeprion sr</i>	8
<i>albuterol sulfate inhalation</i> <i>solution</i>	18	<i>atenolol</i>	12	<i>budeprion xl</i>	8
ALCOHOL PREP PADS	11	ATROVENT HFA	18	<i>budesonide</i>	18
<i>alendronate sodium tablet 35mg,</i> <i>70mg</i>	17	<i>augmented betamethasone</i> <i>dipropionate</i>	14	<i>bumetanide</i>	12
<i>alfuzosin hcl er</i>	15	AVANDIA 2MG, 4MG	11	<i>buproban</i>	8
<i>allopurinol</i>	9	AVANDIA 8MG	11	<i>bupropion hcl</i>	8
ALORA	16	AVELOX TABLET	7	<i>bupropion hcl sr</i>	8
ALPHAGAN P	17	AVODART	15	<i>buspirone hcl</i>	11
ALVESCO	18	AVONEX	17	BYETTA	11
<i>amantadine hcl</i>	10	AZASITE	17	BYSTOLIC TABLET 2.5MG, 5MG	12
<i>amiodarone hcl</i>	12	<i>azathioprine</i>	17	BYSTOLIC TABLET 10MG	12
AMITIZA	15	<i>azelastine hcl</i>	17	BYSTOLIC TABLET 20MG	12
<i>amitriptyline hcl</i>	8	<i>azelastine hcl</i>	18	<i>calcitriol</i>	17
<i>amlodipine besylate</i>	12			CANASA	17
<i>amlodipine besylate/benazepril</i> <i>hydrochloride</i>	12			CAPITAL/CODEINE	6
<i>amoxicillin</i>	7			<i>captopril</i>	12
<i>amoxicillin/potassium clavulanate</i>	7			CARAC	14

2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
<i>carbidopa/levodopa sr</i>	10	CUTIVATE LOTION	14	<i>econazole nitrate</i>	8
<i>carisoprodol 350mg</i>	19	<i>cyclobenzaprine hcl</i>	19	EFFIENT 5MG	12
<i>cartia xt</i>	12	CYMBALTA	8	EFFIENT 10MG	12
<i>carvedilol</i>	12	<i>cyproheptadine hcl</i>	18	EFUDEX	14
<i>cefdinir</i>	7	CYSTAGON	15	EMBEDA	6
<i>cefuroxime axetil</i>	7	DECAVAC	17	EMEND 40MG	8
CELEBREX	9	<i>desonide</i>	14	EMEND 80MG	8
<i>cephalexin</i>	7	DETROL	15	EMEND 125MG	8
CHANTIX 0.5MG, 1MG	8	DETROL LA	16	EMEND TRIFOLD PACK	8
CHANTIX STARTING MONTH PAK	8	<i>dexamethasone tablet</i>	16	ENABLEX	16
<i>chlorhexidine gluconate</i>	14	DEXILANT	15	<i>enalapril maleate</i>	13
<i>chlorthalidone</i>	12	<i>diclofenac potassium</i>	9	<i>enalapril maleate/ hydrochlorothiazide</i>	13
<i>cilostazol</i>	12	<i>diclofenac sodium</i>	9	ENBREL	17
<i>cimetidine</i>	15	<i>diclofenac sodium</i>	17	<i>endocet</i>	6
CIPRODEX	18	<i>dicyclomine hcl</i>	15	ENJUVA	16
<i>ciprofloxacin hcl</i>	7	DIFFERIN	14	<i>enoxaparin sodium 30mg/0.3ml</i>	12
CIPRO HC	18	<i>diflunisal</i>	9	<i>enoxaparin sodium 40mg/0.4ml</i>	12
<i>citalopram hydrobromide solution</i>	8	<i>digoxin</i>	12	<i>enoxaparin sodium 60mg/0.6ml</i>	12
<i>citalopram hydrobromide tablet 10mg, 40mg</i>	8	<i>dihydroergotamine mesylate</i>	9	<i>enoxaparin sodium 80mg/0.8ml</i>	12
<i>citalopram hydrobromide tablet 20mg</i>	8	<i>dilt-cd</i>	13	<i>enoxaparin sodium 100mg/ml, 150mg/ml</i>	12
<i>clarithromycin</i>	7	<i>diltiazem cd</i>	13	<i>enoxaparin sodium 120mg/0.8ml</i>	12
<i>clindamycin hcl</i>	7	<i>diltiazem hcl er</i>	13	EPIPEN	18
<i>clobetasol propionate</i>	14	<i>dilt-xr</i>	13	EPIVIR	11
CLODERM	14	<i>diltzac</i>	13	EPIVIR HBV	11
<i>clonidine hcl tablet</i>	12	DIOVAN/DIOVAN HCT	13	EQUETRO	11
<i>clotrimazole/betamethasone dipropionate</i>	8	DIPENTUM	17	<i>erythromycin base</i>	7
<i>clotrimazole troche</i>	8	<i>diphenoxylate/atropine</i>	15	<i>erythromycin ointment</i>	18
COLCRYS	9	<i>divalproex sodium</i>	7	ESTRACE CREAM	16
COMBIGAN	17	<i>divalproex sodium er</i>	11	<i>estradiol</i>	16
COPAXONE	17	<i>donepezil hcl</i>	7	<i>ethambutol hcl</i>	10
COREG CR	12	<i>dorzolamide hcl</i>	17	<i>etodolac</i>	9
<i>cortomycin</i>	18	<i>dorzolamide hcl/timolol maleate</i>	17	EVISTA	16
CREON	15	DOVONEX CREAM	14	EXELDERM	9
CRESTOR	12	<i>doxazosin mesylate</i>	16	EXELON PATCH	7
CRIXIVAN	11	<i>doxepin hcl</i>	8	EXFORGE/EXFORGE HCT	13
		<i>doxycycline hyclate</i>	7	FACTIVE	7
		DUETACT	11		
		DUREZOL	18		

2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
<i>famciclovir</i>	11	<i>glipizide/metformin hcl</i>	11	<i>itraconazole</i>	9
<i>famotidine tablet</i>	15	GLUCAGEN HYPOKIT	11	JALYN	16
FANAPT	10	<i>glyburide</i>	11	<i>jantoven</i>	12
<i>felodipine er</i>	13	<i>glyburide/metformin hcl</i>	11	JANUMET	11
FEMARA	10	GOLYTELY	15	JANUVIA	11
<i>fenofibrate micronized</i>	13	GRIFULVIN V	9	KADIAN	6
<i>fenofibrate tablet 54mg</i>	13	<i>guanidine hcl</i>	9	<i>ketoconazole</i>	9
<i>fenofibrate tablet 160mg</i>	13	HALFLYTELY	15	<i>ketorolac tromethamine</i>	18
<i>fentanyl patch</i>	6	HUMALOG	11	<i>ketorolac tromethamine tablet</i>	9
<i>finasteride</i>	16	HUMATROPE	16	<i>klor-con & klor-con m</i>	19
<i>flecainide acetate</i>	13	HUMIRA	17	KOMBIGLYZE XR 500MG/5MG, 1000MG/5MG	11
FLECTOR	9	<i>hydralazine hcl</i>	13	KOMBIGLYZE XR 1000MG/2.5MG	11
FLOVENT DISKUS/HFA	18	<i>hydrochlorothiazide</i>	13	K-TABS	19
<i>fluconazole tablet</i>	9	<i>hydrocodone/acetaminophen</i>	6	<i>labetalol hcl</i>	13
<i>fludrocortisone acetate</i>	16	<i>hydrocodone/ibuprofen</i>	6	<i>lactulose</i>	15
<i>flunisolide</i>	18	<i>hydrocortisone/acetic acid</i>	18	LAMICTAL TABLET, ODT & XR	7
<i>fluocinonide</i>	14	<i>hydrocortisone cream, lotion, ointment</i>	15	<i>lamotrigine</i>	7
<i>fluorometholone</i>	18	<i>hydrocortisone valerate</i>	15	LANOXIN	13
<i>fluorouracil cream</i>	15	<i>hydromorphone hcl</i>	6	<i>lansoprazole</i>	15
<i>fluoxetine hcl</i>	8	<i>hydroxychloroquine sulfate</i>	10	LANTUS	11
<i>fluticasone propionate</i>	18	<i>hydroxyzine hcl</i>	18	<i>latanoprost</i>	18
FORADIL	18	<i>hydroxyzine pamoate</i>	18	LATUDA	10
FORTEO	17	<i>ibuprofen</i>	9	<i>leflunomide</i>	17
FORTICAL	17	<i>imiquimod</i>	15	LESCOL 20MG	13
FOSRENOL	16	<i>indapamide</i>	13	LESCOL 40MG	13
<i>furosemide</i>	13	<i>indomethacin</i>	9	LESCOL XL 80MG	13
<i>gabapentin capsule, tablet</i>	7	INSULIN SYRINGES & NEEDLES	11	LETAIRIS	19
<i>gavilyte-c</i>	15	<i>ipratropium bromide/albuterol sulfate</i>	18	LEVEMIR	11
<i>gavilyte-g</i>	15	<i>ipratropium bromide inhalation solution</i>	18	<i>levetiracetam</i>	7
<i>gavilyte-n</i>	15	<i>ipratropium bromide nasal solution</i>	18	<i>levobunolol hcl</i>	18
GELNIQUE	16	IQUIX	18	<i>levofloxacin tablet</i>	7
<i>gemfibrozil</i>	13	<i>isoniazid tablet</i>	10	<i>levothyroxine sodium</i>	17
<i>generlac</i>	15	<i>isosorbide dinitrate</i>	13	LEVOXYL	17
<i>gentamicin sulfate</i>	18	<i>isosorbide dinitrate er</i>	13	LEXAPRO TABLET	8
GEODON CAPSULE	10	<i>isosorbide dinitrate er</i>	13	LEXAPRO TABLET	11
<i>glimepiride</i>	11	<i>isosorbide mononitrate er</i>	13	LIALDA	17
<i>glipizide</i>	11				
<i>glipizide er</i>	11				

2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
<i>lidocaine hcl jelly</i>	7	<i>methotrexate</i>	17	NASONEX.....	19
<i>lidocaine hcl viscous</i>	7	<i>methylphenidate hcl</i>	14	<i>neomycin/polymyxin/ dexamethasone</i>	18
<i>lidocaine/prilocaine</i>	7	<i>methylphenidate hcl sr</i>	14	<i>neomycin/polymyxin/ hydrocortisone</i>	18
LIDODERM.....	7	<i>methylprednisolone tablet 4mg</i>	16	<i>neomycin sulfate</i>	7
LIPITOR.....	13	<i>methylprednisolone tablet 8mg, 16mg, 32mg</i>	16	NEVANAC.....	18
<i>lisinopril</i>	13	<i>metoclopramide hcl</i>	15	NEXIUM.....	15
<i>lisinopril/hydrochlorothiazide</i>	13	<i>metolazone</i>	13	NIASPAN 500MG.....	13
<i>lithium carbonate</i>	11	<i>metoprolol succinate er 25mg, 50mg, 100mg</i>	13	NIASPAN 750MG, 1000MG.....	13
LODOSYN.....	10	<i>metoprolol succinate er 200mg</i>	13	<i>nifediac cc</i>	13
<i>loperamide hcl rx</i>	15	<i>metoprolol tartrate tablet</i>	13	<i>nifedical xl</i>	13
<i>losartan potassium</i>	13	METROGEL.....	15	<i>nifedipine er</i>	13
<i>losartan potassium/ hydrochlorothiazide</i>	13	<i>metronidazole</i>	7	<i>nitrofurantoin macrocrystalline</i>	7
LOTEMAX.....	18	MICARDIS/MICARDIS HCT.....	13	<i>nitrofurantoin monohydrate</i>	7
<i>lovastatin 10mg, 20mg</i>	13	MIGRANAL.....	9	<i>nitroglycerin patch</i>	13
<i>lovastatin 40mg</i>	13	MIRAPEX ER.....	10	NITROLINGUAL PUMPSPRAY.....	13
LOVAZA.....	13	<i>mirtazapine</i>	8	NITROSTAT.....	13
LUMIGAN.....	18	<i>misoprostol</i>	15	<i>nortriptyline hcl</i>	8
LUNESTA.....	19	<i>mometasone furoate</i>	15	NORVIR.....	11
LYRICA.....	7	<i>morphine sulfate er 60mg, 100mg, 200mg</i>	6	NOVOLIN.....	11
LYSODREN.....	16	<i>morphine sulfate er tablet 15mg, 30mg</i>	6	NOVOLOG.....	11
MARPLAN.....	8	<i>morphine sulfate tablet</i>	6	NULYTELY.....	15
MAXAIR.....	19	MOTOFEN.....	15	<i>nystatin</i>	9
MAXALT & MAXALT-MLT 5MG.....	9	MOVIPREP.....	15	<i>nystatin/triamcinolone</i>	9
MAXALT & MAXALT-MLT 10MG.....	9	MOXEZA.....	18	<i>nystop</i>	9
<i>mebendazole</i>	10	MULTAQ.....	13	<i>ofloxacin</i>	18
<i>medroxyprogesterone acetate</i>	16	<i>mupirocin</i>	15	<i>ofloxacin</i>	18
<i>mefloquine hcl</i>	10	MYFORTIC.....	17	<i>omeprazole</i>	15
MEGACE ES.....	16	<i>nabumetone</i>	9	OMNARIS.....	19
<i>megestrol acetate</i>	16	<i>nadolol</i>	13	<i>ondansetron hcl tablet & odt 4mg</i>	8
<i>meloxicam</i>	9	NAMENDA SOLUTION.....	7	<i>ondansetron hcl tablet & odt 8mg</i>	8
MESTINON TIMESPAN.....	9	NAMENDA TABLET.....	7	ONGLYZA.....	11
<i>metaxalone</i>	19	<i>naproxen</i>	9	ONSOLIS.....	6
<i>metformin hcl</i>	11	<i>naratriptan hcl 1mg</i>	9	OPANA ER 5MG, 10MG, 20MG, 30MG.....	6
<i>metformin hcl er</i>	11	<i>naratriptan hcl 2.5mg</i>	9	OPANA ER 40MG.....	6
<i>methadone hcl tablet</i>	6	NASACORT AQ.....	19		
<i>methimazole</i>	17				
<i>methocarbamol</i>	19				

2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
OXANDRIN.....	16	PREMARIN CREAM.....	16	SANCUSO.....	8
<i>oxcarbazepine</i>	7	PREMARIN TABLET.....	16	SANDIMMUNE.....	17
OXISTAT.....	9	<i>primidone</i>	7	SANTYL.....	15
OXSORALEN ULTRA.....	15	PRISTIQ.....	8	SAPHRIS.....	10
<i>oxybutynin chloride</i>	16	PROAIR HFA.....	19	SAVELLA.....	8
<i>oxybutynin chloride er 5mg</i>	16	<i>prochlorperazine maleate</i>	8	SELZENTRY.....	11
<i>oxybutynin chloride er 10mg, 15mg</i>	16	PROCRIT 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML.....	12	SENSIPAR 30MG.....	16
<i>oxycodone hcl</i>	6	PROCRIT 10000UNIT/ML.....	12	SENSIPAR 60MG.....	16
<i>oxycodone hcl/acetaminophen</i>	6	PROCRIT 20000UNIT/ML, 40000UNIT/ML.....	12	SENSIPAR 90MG.....	16
OXYCONTIN 10MG, 15MG, 20MG, 30MG, 40MG, 60MG.....	6	<i>proctosol hc</i>	15	SEREVENT DISKUS.....	19
OXYCONTIN 80MG.....	7	<i>promethazine hcl</i>	8	SEROQUEL 25MG, 50MG, 100MG, 200MG.....	10
PANDEL.....	15	<i>propranolol hcl</i>	14	SEROQUEL 300MG, 400MG.....	10
<i>pantoprazole sodium</i>	15	<i>propranolol hcl er</i>	14	SEROQUEL XR 50MG, 300MG, 400MG.....	10
<i>paroxetine hcl tablet</i>	8	<i>propylthiouracil</i>	17	SEROQUEL XR 150MG, 200MG.....	10
PATADAY.....	18	<i>pyridostigmine bromide</i>	9	<i>sertraline hcl 25mg, 50mg</i>	8
PATANOL.....	18	<i>quinapril hcl</i>	14	<i>sertraline hcl 100mg</i>	8
PEG-INTRON.....	17	QVAR.....	19	<i>silver sulfadiazine</i>	15
<i>penicillin v potassium</i>	7	<i>ramipril</i>	14	SIMCOR 500MG/20MG, 500MG/40MG, 1000MG/40MG.....	14
PENTASA.....	17	RANEXA.....	14	SIMCOR 750MG/20MG, 1000MG/20MG.....	14
<i>pentoxifylline er</i>	12	<i>ranitidine hcl</i>	15	<i>simvastatin 5mg, 10mg, 20mg</i>	14
PERFOROMIST.....	19	RAPAFLO.....	16	<i>simvastatin 40mg</i>	14
<i>phenadoz</i>	8	REBIF.....	17	<i>simvastatin 80mg</i>	14
PHENYTEK.....	7	RELPAK 20MG.....	9	SINGULAIR.....	19
<i>phenytoin sodium extended</i>	7	RELPAK 40MG.....	9	SOLARAZE.....	15
PHOSLO.....	16	REVELA.....	16	SOMATULINE DEPOT.....	16
<i>pilocarpine hcl</i>	14	REQUIP XL.....	10	<i>sotalol hcl</i>	14
<i>piroxicam</i>	9	RESCRIPTOR.....	11	SPIRIVA.....	19
PLAVIX 75MG.....	12	RESTASIS.....	18	<i>spironolactone</i>	14
<i>polycin b</i>	7	<i>rifampin capsule</i>	10	<i>spironolactone/ hydrochlorothiazide</i>	14
<i>polyethylene glycol 3350</i>	15	<i>risperidone tablet 0.25mg, 0.5mg, 1mg, 2mg, 3mg</i>	10	STALEVO.....	10
<i>potassium chloride er</i>	19	<i>risperidone tablet 4mg</i>	10	STRATTERA 10MG, 18MG, 25MG, 40MG.....	14
<i>potassium citrate er</i>	19	<i>ropinirole hcl</i>	10	STRATTERA 60MG, 80MG, 100MG.....	14
PRADAXA.....	12	<i>roxicet tablet</i>	7		
<i>pramipexole dihydrochloride</i>	10	SAIZEN.....	16		
<i>pravastatin sodium</i>	13	<i>salsalate</i>	9		
<i>prednisolone acetate</i>	18				
<i>prednisone tablet</i>	16				

2012 Abridged Formulary Index

Drug	Page	Drug	Page	Drug	Page
SUBOXONE	8	TRANSDERM-SCOP	8	VIVELLE-DOT	16
<i>sucralfate</i>	15	TRAVATAN Z	18	VYTORIN	14
<i>sulfamethoxazole/trimethoprim</i>	7	<i>trazodone hcl</i>	8	<i>warfarin sodium</i>	12
<i>sulfasalazine</i>	17	TRELSTAR	16	WELCHOL PACKET	14
<i>sulindac</i>	9	TREXIMET	9	WELCHOL TABLET	14
<i>sumatriptan succinate 25mg</i>	9	<i>triamcinolone acetonide</i>	15	XOPENEX HFA	19
<i>sumatriptan succinate 50mg</i>	9	<i>triamcinolone in orabase</i>	14	XOPENEX INHALATION SOLUTION	19
<i>sumatriptan succinate 100mg</i>	9	<i>triamterene/hydrochlorothiazide</i>	14	<i>zaleplon</i>	19
SYMBICORT	19	TRICOR 48MG	14	ZELAPAR	10
SYNTHROID	17	TRICOR 145MG	14	ZEMPLAR	17
TAMIFLU CAPSULE 75MG	11	<i>triderm</i>	15	ZENPEP	15
<i>tamoxifen citrate</i>	10	TRILIPIX 45MG	14	ZETIA	14
<i>tamsulosin hcl</i>	16	TRILIPIX 135MG	14	ZIAGEN	11
TASMAR	10	<i>trilyte</i>	15	<i>zolpidem tartrate</i>	19
<i>taztia xt</i>	14	<i>trimethoprim sulfate/polymyxin b sulfate</i>	18	ZOMIG SOLUTION	9
TEKAMLO	14	TRUVADA	11	ZOMIG & ZOMIG ZMT 2.5MG	9
TEKTURNA/TEKTURNA HCT	14	TWYNSTA	14	ZOMIG & ZOMIG ZMT 5MG	9
<i>terazosin hcl</i>	16	ULORIC	9	ZONALON	15
<i>terbinafine hcl tablet</i>	9	UNITHROID	17	ZOSTAVAX	17
TESTIM	16	<i>ursodiol capsule</i>	15	ZOVIRAX OINTMENT	11
<i>testosterone cypionate</i>	16	VAGIFEM	16	ZYCLARA	15
TETANUS/DIPHThERIA TOXOIDS- ADSORBED ADULT	17	<i>valacyclovir hcl</i>	11	ZYFLO CR	19
<i>tetracycline hcl</i>	7	<i>valproic acid</i>	7	ZYPREXA INJECTION	10
<i>theochron</i>	19	VALTURNA	14	ZYPREXA TABLET 2.5MG, 5MG, 7.5MG, 10MG	10
<i>theophylline er</i>	19	<i>venlafaxine hcl</i>	8	ZYPREXA TABLET 15MG, 20MG	10
<i>timolol maleate</i>	18	<i>venlafaxine hcl er capsule 37.5mg, 75mg</i>	8	ZYPREXA ZYDIS TABLET 5MG, 10MG	10
<i>tizanidine hcl</i>	11	<i>venlafaxine hcl er capsule 150mg</i>	8	ZYPREXA ZYDIS TABLET 15MG, 20MG	10
TOBRADEX OINTMENT	18	VENTOLIN HFA	19	ZYVOX	7
TOBRADEX ST	18	VERAMYST	19		
<i>tobramycin sulfate</i>	18	<i>verapamil hcl er</i>	14		
<i>tobramycin sulfate/ dexamethasone</i>	18	VESICARE	16		
<i>topiramate</i>	7	VICTOZA	11		
TOVIAZ	16	VIGAMOX	18		
TRACLEER	19	VIMOVO	9		
<i>tramadol hcl</i>	7	VIMPAT	7		
<i>tramadol hcl/acetaminophen</i>	7	VIRACEPT	11		

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