P&T Committee Meeting Minutes
Medicaid Business
January 19, 2016

Present:	**Absent:**
Bret Yarczower, MD, MBA – Chair Kristen Bender, Pharm.D. – via phone Beverly Blaisure, MD – via phone Holly Bones, Pharm.D. – via phone Kimberly Clark, Pharm.D. Kristi Clarke, Pharm. D. – via phone Jamie Dodson, RPh Michael Evans, Pharm.D., B.S. – via phone Tricia Heitzman, Pharm.D. Michelle Holt-Macey, Pharm.D. – via phone Steven Kheloussi, Pharm.D. Phillip Krebs, R.EEG T. – via phone Lisa Mazonkey, RPh Perry Meadows, MD Mariette Njei, Pharm.D., Pharmacy Resident Kristen Scheib, Pharm. D. – via phone Todd Sponenberg, Pharm.D., RPh Kevin Szczecina, RPh Elaine Tino, CRNP – via phone William Seavey, Pharm.D. – via phone Keith Boell, DO Thomas Morland, MD Richard Silbert, MD – via phone Lori Zaleski, RPh – via phone	John Bulger, MD, Chief Medical Officer Dean Christian, MD John Flaherty, Pharm.D. Jonas Pearson, MS, RPh James Schuster, MD Steve Tracy, Pharm.D. Michael Spishock RPh

Call To Order:
Bret Yarczower called the meeting to order at 1:04 p.m., Tuesday, January 19, 2016.

Review and Approval of Minutes:
Bret Yarczower for a motion or approval to accept the November 17, 2015 minutes as written. Jamie Dodson accepted the motion and Dr. Perry Meadows seconded the motion. None were opposed.

DRUG REVIEWS:

Genvoya **Steven Kheloussi**
(elvitegravir, cobicistat, emtricitabine and tenofovir alafenamide)

Steven Kheloussi provided a review of Genvoya to the committee for consideration as a pharmacy benefit. Each Genvoya tablet contains 150 mg of elvitegravir, 150 mg of cobicistat, 200 mg of

emtricitabine, and 10 mg of tenofovir alafenamide (TAF) (equivalent to 11.2 mg of tenofovir alafenamide fumarate) and is a complete regimen for the treatment of HIV-1 infection in adults and pediatric patients 12 years of age and older who have no antiretroviral treatment history or to replace the current antiretroviral regimen in those who are virologically-suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen for at least 6 months with no history of treatment failure and no known substitutions associated with resistance to the individual components of Genvoya.

Formulary alternatives: Atripla, Complera, Stribild, Triumq

Proposed Clinical Recommendations: Genvoya will be a pharmacy benefit and should be added to the GHP Family formulary.

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Todd Sponenberg made a motion to accept the recommendation as written. Kim Clark seconded the motion. None were opposed.

Proposed Financial Recommendations: Genvoya will be a pharmacy benefit and should be added to the GHP Family formulary.

Financial Discussion: none

Financial Outcome: Dr. Perry Meadows made a motion to accept the recommendation as proposed. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Genvoya will be added to the GHP Family formulary as a pharmacy benefit.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Imlygic (talimogene laherparepvec) **Kimberly Clark**

Kimberly Clark provided a review of Imlygic to the committee for consideration as a medical benefit. Imlygic is a genetically modified oncolytic viral therapy indicated for the local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery.

Limitations of use: Imlygic has not been shown to improve overall survival

Formulary alternatives: Medical Benefit: BCG, IFN, IL-2

Proposed Clinical Recommendations: Imlygic will be a medical benefit and should not be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Must be prescribed by an oncologist or dermatologist **AND**
- Medical record documentation of the patient being ≥18 years of age **AND**
- Medical record documentation of a diagnosis of unresectable cutaneous, subcutaneous, and nodal melanoma lesions **AND**
- Medical record documentation of melanoma recurrence after initial surgery

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Contraindications, Warnings and Precautions, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed. Tricia Heitzman pointed out that the diagnosis should be "…and/or nodal melanoma lesions".

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendation as amended. Steven Kheloussi seconded the motion. None were opposed.

Proposed Financial Recommendations: Imlygic will be a medical benefit and should not be added to the GHP Family formulary.

Financial Discussion: none

Financial Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Lisa Mazonkey seconded the motion. None were opposed.

Approved Recommendations: Imlygic will not be added to the GHP Family formulary and will be considered a medical benefit. The following criteria will apply to prior authorization request:

- Must be prescribed by an oncologist or dermatologist AND
- Medical record documentation of the patient being ≥18 years of age AND
- Medical record documentation of a diagnosis of unresectable cutaneous, subcutaneous, and/or nodal melanoma lesions AND
- Medical record documentation of melanoma recurrence after initial surgery

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued

disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Cotellic (cobimetinib) **Steven Kheloussi**

Steven Kheloussi provided a review of Cotellic to the committee for consideration as a pharmacy benefit. Cotellic is indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib.

Limitations of use: Cotellic is not indicated for treatment of patients with wild-type BRAF melanoma.

Formulary alternatives: Mekinist, Tafinlar, Zelboraf

Proposed Clinical Recommendations: Cotellic will be a pharmacy benefit and should be added to the GHP Family formulary with the following prior authorization criteria:

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of unresectable or metastatic melanoma **AND**
- Medical record documentation of BRAF V600E or V600K mutation as detected by an FDA-approved test **AND**
- Medical record documentation of concomitant use with Zelboraf (vemurafenib) **AND**
- Medical record documentation of use as a first line therapy **OR** medical record documentation of no prior therapeutic failure with a BRAF inhibitor therapy (Zelboraf (vemurafenib) or Tafinlar (dabrafenib)) or MEK inhibitor (Mekinist (trametinib))

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Todd Sponenberg seconded the motion. None were opposed.

Proposed Financial Recommendations: Cotelic will be pharmacy benefit and should be added to the GHP Family formulary. The following quantity limit and authorization duration should apply: **QL** – 90 tablets/30 days; **AUTHORIZATION DURATION**: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require

medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Financial Discussion: none

Financial Outcome: Lisa Mazonkey made a motion to accept the recommendation as proposed. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Cotellic will be added to the GHP Family formulary. The following criteria will apply to prior authorization request:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of unresectable or metastatic melanoma AND
- Medical record documentation of BRAF V600E or V600K mutation as detected by an FDA-approved test AND
- Medical record documentation of concomitant use with Zelboraf (vemurafenib) AND
- Medical record documentation of use as a first line therapy OR medical record documentation of no prior therapeutic failure with a BRAF inhibitor therapy (Zelboraf (vemurafenib) or Tafinlar (dabrafenib)) or MEK inhibitor (Mekinist (trametinib))

QL – 90 tablets/30 days; AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Yondelis **Kimberly Clark**
(trabectedin)

Kimberly Clark provided a review of Yondelis to the committee for consideration as a medical benefit. Yondelis is an alkylating drug indicated for the treatment of patients with unresectable or metastatic liposarcoma or leiomyosarcoma who received a prior anthracycline-containing regimen.

Proposed Clinical Recommendations: Yondelis will be a medical benefit and should not be added to the GHP Family formulary. The following criteria should apply to prior authorization requests:

- Must be prescribed by an oncologist **AND**
- Medical record documentation of the patient being ≥18 years of age **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic liposarcoma or leiomyosarcoma **AND**
- Medical record documentation of prior therapy with an anthracycline-containing regimen

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Contraindications, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Lisa Mazonkey seconded the motion. None were opposed.

Proposed Financial Recommendations: Yondelis will be a medical benefit and should not be added to the GHP Family formulary.

Financial Discussion: none

Financial Outcome: Dr. Meadows made a motion to accept the recommendation as proposed. Lisa Mazonkey seconded the motion. None were opposed.

Approved Recommendations: Yondelis will not be added to the GHP Family formulary and will be considered a medical benefit. The following criteria will apply to prior authorization request.

- Must be prescribed by an oncologist **AND**
- Medical record documentation of the patient being ≥18 years of age **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic liposarcoma or leiomyosarcoma **AND**
- Medical record documentation of prior therapy with an anthracycline-containing regimen

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Keveyis (dichlorphenamide) **Steven Kheloussi**

Steven Kheloussi provided a review of Keveyis to the committee for consideration as a pharmacy benefit. Keveyis is indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.

Proposed Clinical Recommendations: Keveyis will be a pharmacy benefit and should not be added to the GHP Family formulary. The following criteria should apply to prior authorization requests:

- Medical record documentation of a diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants AND
- Documentation that the patient is ≥ 18 years of age AND
- Medical record documentation that the patient's condition was diagnosed by a neurologist with neuromuscular expertise.

QL: 4 tablets per day

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Contraindications, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed. Specialist feedback came from two medical advisors for the Periodic Paralysis Association (PPA), Dr. Rabi Tawil, Professor of Neurology and Co-Director of Neuromuscular Disease clinic at University of Rochester School of Medicine, and Dr. Jacob Levitt, MD, President, Board Member, and Medical Advisor to the PPA. Additional feedback came from Dr. Michael Segal, a pediatric neurologist also with the Periodic Paralysis Association

Clinical Outcome: Dr. Meadows made a motion to accept the recommendation as proposed. Kevin Szczecina seconded the motion. None were opposed.

Proposed Financial Recommendations: Keveyis will be a pharmacy benefit and should not be added to the GHP Family formulary. The following additional criteria should apply:

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to acetazolamide.

Authorization duration: Initial authorization will be for 2 months. Reauthorization will require documentation that the patient has had a reduction in the number of paralytic attacks. Subsequent authorizations will be for 6 months each requiring documentation that the patient is stable and has had a reduction in the number of paralytic paralysis attacks as compared to baseline.

Financial Discussion: It was recommended that failure of spironolactone and acetazolamide be considered for hypokalemic period paralysis based on the specialist feedback received.

Financial Outcome: Jamie Dodson made a motion to accept the recommendation as amended. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Keveyis will not be added to the GHP Family formulary. The following criteria will apply to prior authorization request.

- Medical record documentation of a diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants AND
- Documentation that the patient is > 18 years of age AND
- Medical record documentation that the patient's condition was diagnosed by a neurologist with neuromuscular expertise AND
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to acetazolamide AND
- **For hypokalemic periodic paralysis only**: Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to spironolactone.

QL: 4 tablets per day

Authorization duration: Initial authorization will be for 2 months. Reauthorization will require documentation that the patient has had a reduction in the number of paralytic attacks. Subsequent authorizations will be for 6 months each requiring documentation that the patient is stable and has had a reduction in the number of paralytic paralysis attacks as compared to baseline.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Onivyde **Kimberly Clark**
(irinotecan liposome injection)

Kimberly Clark provided a review of Onivyde to the committee for consideration as a medical benefit. Onivyde is a topoisomerase inhibitor indicated, in combination with fluorouracil and leucovorin, for the treatment of patients with metastatic adenocarcinoma of the pancreas after disease progression following gemcitabine-based therapy.

Limitation of Use: Onivyde is not indicated as a single agent for the treatment of patients with metastatic adenocarcinoma of the pancreas.

Formulary alternative: Tarceva

Proposed Clinical Recommendations: It is recommended that Onivyde be considered a medical benefit for GHP Family members. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Must be prescribed by an oncologist AND
- Medical record documentation of the patient being ≥18 years of age AND
- Medical record documentation of a diagnosis of metastatic adenocarcinoma of the pancreas AND
- Medical record documentation that Onivyde is being prescribed in combination with fluorouracil and leucovorin AND
- Medical record documentation of disease progression following gemcitabine-based therapy

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Black Box Warnings, Contraindications, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, Patent Life, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Dr. Meadows seconded the motion. None were opposed.

Proposed Financial Recommendations: Onivyde will be a medical benefit and should not be added to the GHP Family formulary.

Financial Discussion: none

Financial Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Todd Sponenberg seconded the motion. None were opposed.

Approved Recommendations: Onivyde will not be added to the GHP Family formulary and will be considered a medical benefit. The following criteria will apply to prior authorization request:

- Must be prescribed by an oncologist AND
- Medical record documentation of the patient being ≥18 years of age AND
- Medical record documentation of a diagnosis of metastatic adenocarcinoma of the pancreas AND
- Medical record documentation that Onivyde is being prescribed in combination with fluorouracil and leucovorin AND
- Medical record documentation of disease progression following gemcitabine-based therapy

Authorization duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Ninlaro (ixazomib) **Steven Kheloussi**

Steven Kheloussi provided a review of Ninlaro to the committee for consideration as a pharmacy benefit. Ninlaro is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.

Formulary alternative: Farydak, Pomalyst, Revlimid

Proposed Clinical Recommendations: It is recommended that Ninlaro be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of multiple myeloma AND
- Medical record documentation that Ninlaro will be used in combination with Revlimid and dexamethasone AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior therapy.

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Jamie Dodson made a motion to accept the recommendation as proposed. Kevin Szczecina seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Ninlaro be added to the GHP Family formulary. The following should apply to requests for prior authorization:
QL – 3 capsules/28 days; Approve authorizations by GPID. AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Financial Discussion: none

Financial Outcome: Kim Clark made a motion to accept the recommendation as proposed. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Ninlaro will be added to the GHP Family formulary and will require prior authorization. The following criteria will apply to prior authorization request:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of multiple myeloma AND
- Medical record documentation that Ninlaro will be used in combination with Revlimid and dexamethasone AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior therapy

QL – 3 capsules/28 days; Approve authorizations by GPID. AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Darzalex **Steven Kheloussi**
(daratumumab)

Steven Kheloussi provided a review of Darzalex to the committee for consideration as a medical benefit. Darzalex is indicated for the treatment of patients with multiple myeloma who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent.

Formulary alternative: Farydak, Pomalyst, Revlimid

Proposed Clinical Recommendations: It is recommended that Darzalex be considered a medical benefit and not be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of multiple myeloma AND
- One of the following:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least three prior lines of therapy including a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*) OR
    - Medical record documentation that the patient is double-refractory to a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*)

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Warnings and Precautions, Adverse Events, Special Population Precautions, Unique Therapeutic Features, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Lisa Mazonkey made a motion to accept the recommendation as proposed. Todd Sponenberg seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Darzalex be considered a medical benefit for GHP family. The following should apply to requests for prior authorization:
AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the

reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Financial Discussion: none

Financial Outcome: Tricia Heitzman made a motion to accept the recommendation as proposed. Lisa Mazonkey seconded the motion. None were opposed.

Approved Recommendations: Darzalex will be considered a medical benefit and not be added to the GHP Family formulary. The following criteria will apply to prior authorization request:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of multiple myeloma AND
- One of the following:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least three prior lines of therapy including a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*) OR
    - Medical record documentation that the patient is double-refractory to a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*)

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Empliciti (elotuzumab) **Steven Kheloussi**

Steven Kheloussi provided a review of Empliciti to the committee for consideration as a medical benefit. Empliciti is indicated in combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received one to three prior therapies.

Formulary alternative: Farydak, Pomalyst, Revlimid

Proposed Clinical Recommendations: It is recommended that Empliciti be considered a medical benefit and not be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of multiple myeloma **AND**
- Medical record documentation of use in combination with lenalidomide (Revlimid) and dexamethasone **AND**

- Medical record documentation that the patient has previously been treated with at least one prior therapy for multiple myeloma

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Warnings and Precautions, Adverse Events, Special Population Precautions, Unique Therapeutic Features, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Mariette Njei made a motion to accept the recommendation as proposed. Tricia Heitzman seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Empliciti be considered a medical benefit for GHP family. The following should apply to requests for prior authorization:
AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Financial Discussion: none

Financial Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Tricia Heitzman seconded the motion. None were opposed.

Approved Recommendations: Empliciti will be considered a medical benefit and will not be added to the GHP Family formulary. The following criteria will apply to prior authorization request:

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of multiple myeloma AND
- Medical record documentation of use in combination with lenalidomide (Revlimid) and dexamethasone AND
- Medical record documentation that the patient has previously been treated with at least one prior therapy for multiple myeloma

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Synjardy (empagliflozin/metformin) **Kimberly Clark**

Kimberly Clark provided a review of Synjardy to the committee for consideration as a pharmacy benefit.

Synjardy is a combination of empagliflozin and metformin HCl indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus whoare not adequately controlled on a regimen containing empagliflozin or metformin, or in patients already being treated with both empagliflozin and metformin.

Limitations include patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

Formulary alternative: Jardiance, Invokana

Proposed Clinical Recommendations: It is recommended that Synjardy be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following step criteria apply:
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to metformin

**Quantity Limit: 2 tablets per day

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Black Box Warnings, Contraindications, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Patent Life Assessment, and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Dr. Meadows made a motion to accept the recommendation as proposed. Jamie Dodson seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Synjardy be added to the GHP Family formulary.

Financial Discussion: none

Financial Outcome: Lisa Mazonkey made a motion to accept the recommendation as proposed. Dr. Meadows seconded the motion. None were opposed.

Approved Recommendations: Synjardy will be added to the GHP Family formulary with the following step criteria:
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to metformin

**Quantity Limit: 2 tablets per day

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Tagrisso (osimertinib) **Steven Kheloussi**

Steven Kheloussi provided a review of Tagrisso to the committee for consideration as a pharmacy benefit. Tagrisso is indicated for the treatment of patients with metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC), as detected by an FDA-approved test, who have progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy.

Formulary alternative: Gilotrif, Iressa, Tarceva

Proposed Clinical Recommendations: It is recommended that Tagrisso be added to the GHP Family formulary. In order to ensure appropriate utilization, it is recommended that the following prior authorization criteria apply:

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of metastatic EGFR T790M-mutation positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test **AND**
    - Medical record documentation of failure on or intolerance to prior tyrosine kinase inhibitor therapy with Iressa (gefitinib), Gilotrif (afatinib), or Tarceva (erlotinib)

Clinical Discussion: FDA Approved Indications, Dosing, Pharmacology/MOA, Evidence of Efficacy, Evidence of Safety, Warnings and Precautions, Adverse Events, Drug Interactions, Special Population Precautions, Unique Therapeutic Features and Recommendations of National Agencies and Organizations were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendation as proposed. Dr. Meadows seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Tagrisso be added to the GHP Family formulary. The following should apply to requests for prior authorization:
QL – 30 tablets/30 days; Approve authorizations by GPID. **AUTHORIZATION DURATION:** Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Financial Discussion: none

Financial Outcome: Lisa Mazonkey made a motion to accept the recommendation as proposed. Dr. Meadows seconded the motion. None were opposed.

Approved Recommendations: Tagrisso will be added to the GHP Family formulary with the following prior authorization criteria:

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of metastatic EGFR T790M-mutation positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test **AND**
- Medical record documentation of failure on or intolerance to prior tyrosine kinase inhibitor therapy with Iressa (gefitinib), Gilotrif (afatinib), or Tarceva (erlotinib)

QL – 30 tablets/30 days; Approve authorizations by GPID. **AUTHORIZATION DURATION:** Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

FAST FACTS:

Procysbi **Kimberly Clark**
(cysteamine bitartrate)

Updated age restriction:

- Procysbi is a cysteine-depleting agent indicated for the treatment of nephropathic cystinosis in adult and pediatric patients 2 years of age and older.
- Previously indicated in patients 6 years of age and older

Recommendation: There are no tiering changes recommended at this time. Procysbi should remain non-formulary and the following criteria should apply to prior authorization requests:

- Medical record of a diagnosis of nephropathic cystinosis AND
- Medical record documentation of age greater than or equal to 2 years AND
- Prescription is written by a nephrologist AND
- There is medical record documentation of therapeutic failure on, intolerance to, or contraindication to Cystagon

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Opdivo **Steven Kheloussi**
(nivolumab)

New Indication: Opdivo is now indicated for the treatment of advanced renal cell carcinoma (RCC) in patients who have received prior anti-angiogenic therapy

Recommendation: The following additional criteria should apply:

- Medical record documentation of use as a single agent for relapse or for surgically unresectable advanced or metastatic renal cell carcinoma with predominant clear-cell histology **AND**
- Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Oxycontin **Kimberly Clark**
(oxycodone hydrochloride)

New Age Restriction:

- Oxycontin is an opioid agonist indicated for pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in opioid-tolerant pediatric patients 11 years of age and older who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent.

- Previously only indicated for use in adults.

Recommendation: There are no tiering changes recommended at this time. The following criteria should be added to the existing Oxycontin policy to include the expanded indications:

- Member age 11 to 17 years for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate

Quantity Limit: 10 mg, 15 mg, 20 mg, 30 mg, 40 mg = 3 tabs/day, 60 mg, 80 mg = 4 tabs/day

Discussion: There were numerous concerns raised about the new age restriction

Outcome: A decision was made to table a decision until a later time

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Yervoy **Steven Kheloussi**
(ipilimumab)

New Indication:

- Yervoy is now indicated for the adjuvant treatment of patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy.

Recommendation: The following criteria should be added to the existing Yervoy policy to include the expanded indications:

- Medical record documentation of use as a single agent for adjuvant therapy:

- For Stage IIIA with metastases > 1 mm, or Stage IIIB or Stage IIIC cutaneous melanoma with nodal metastases following a complete lymph node dissection or resection **OR**
- Following complete lymph node dissection and/or complete resection of nodal recurrence

Discussion: Tricia Heitzman had questions about existing criteria.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Brilinta **Kimberly Clark**
(ticagrelor)

New Indication:

- Brilinta is now approved to reduce the rate of cardiovascular death, myocardial infarction, and stroke in patients with a history of myocardial infarction

Recommendation: There are no tiering changes recommended at this time. It is recommended that the use in patients with a history of MI be added to the existing policy. The following criteria should be applied to requests for Brilinta:

- Medical record documentation of a diagnosis of ACS (unstable angina, non-ST elevation myocardial infarction (MI), or ST elevation MI) OR
- Medical record documentation of a history of myocardial infarction within the previous 3 years

Discussion: No questions or comments.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Humira **Steven Kheloussi**
(adalimumab)

New Indication:

- Humira is now indicated for the treatment of moderate to severe hidradenitis suppurativa (HS).

Recommendation: It is recommended that the following criteria be added to the Humira policies for GHP Family:

- Prescription written by a dermatologist **AND**

- Medical record documentation of a diagnosis of moderate to severe hidradenitis suppurativa (HS), defined as Stage II or III on the Hurley staging system* **AND**
- Medical record documentation of at least 3 abscesses or inflammatory nodules **AND**
- Medical record documentation of concomitant use of oral or systemic antibiotics **AND**
- Medical record documentation that the member has received counseling on weight management (if overweight) and smoking cessation (if the member is an active smoker)

*Hurley staging system:
- Stage I: A single lesion without sinus tract formation.
- Stage II: More than one lesion or area, but with limited tunneling.
- Stage III: multiple lesions, with more extensive sinus tracts and scarring.

QL: One-week auth for QL of 6 syringes per 28 days; Remainder of the 6 month auth duration, QL of 4 syringes per 28 days

Authorization duration: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of hidradenitis suppurativa on six (6) months of adalimumab therapy is required.

After the initial six (6) month approval, subsequent approvals for coverage will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of hidradenitis suppurativa while on adalimumab therapy.

Discussion: No questions or comments.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Delzicol **Kimberly Clark**
(mesalamine)

New Indication:
- Delzicol is an aminosalicylate indicated for the treatment of mildly to moderately active ulcerative colitis in patients 5 years of age and older.

- Previously indicated in patients 12 years of age and older.

Recommendation: No changes are recommended based on the expanded age.

Discussion: No questions or comments.

Outcome: Lisa Mazonkey made a motion to accept the recommendations as written. Todd Sponenberg seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

CLASS REVIEW

Atypical Antipsychotic Class Review **Steven Kheloussi**

Steven Kheloussi presented a review of the Long Acting Atypical Antipsychotic class to include the following products:

	Generic Name	Benefit	Manufacturer	How Supplied	FDA Approval Date
Abilify Maintena	aripiprazole monohydrate	Medical, requiring PA*	Otsuka America	300 mg and 400 mg Pre-filled Dual Chamber Syringe OR Single-use vials of active ingredient and 5 mL vial of diluent	2/28/2013
Aristada	aripiprazole lauroxil	Medical (review pending)	Alkermes	441 mg, 662 mg, 882 mg Single-use pre-filled syringe	10/5/2015
Invega Sustenna	paliperidone palmitate	Medical, requiring PA*	Janssen	39 mg, 78 mg, 117 mg, 156 mg, and 234 mg Prefilled syringe kits	7/31/2009
Invega Trinza	paliperidone palmitate	Medical, requiring PA*	Janssen	273 mg, 410 mg, 546 mg, and 819 mg Prefilled syringe kits	5/18/2015
Risperdal Consta	risperidone microspheres	Medical, requiring PA*	Janssen	12.5 mg, 25 mg, 37.5 mg, and 50 mg Vial containing the risperidone microspheres and a pre-filled syringe containing 2 mL of diluent	10/29/2003
Zyprexa Relprevv	olanzapine pamoate	Medical, requiring PA*	Eli Lilly	210 mg, 300 mg, and 405 mg Vial containing active ingredient and a 3 mL vial containing diluent	12/11/2009

FDA Approved Indications

Indications

	Schizophrenia	Schizoaffective disorders as monotherapy and as an adjunct to mood stabilizers or antidepressants	Bipolar I Disorder as monotherapy or as adjunctive therapy to lithium or valproate
Abilify Maintena	✓		
Aristada	✓		
Invega Sustenna	✓	✓	
Invega Trinza	✓*		
Risperdal Consta	✓		✓
Zyprexa Relprevv	✓		

Recommendations based on clinical review: It is recommended that the prior authorization criteria be updated to the following:

- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of a history of poor adherence to oral medications and documentation that education to improve adherence has been attempted **AND**
- Medical record documentation of use for an FDA approved indication.
    - Abilify Maintena – Schizophrenia
    - Aristada – Schizophrenia
    - Invega Sustenna – Schizophrenia or Schizoaffective disorders as monotherapy and as an adjunct to mood stabilizers or antidepressants
    - Invega Trinza – Schizophrenia
    - Risperdal Consta – Schizophrenia or Bipolar I Disorder as monotherapy or as adjunctive therapy to lithium or valproate
    - Zyprexa Relprevv – Schizophrenia
- In addition: The following criteria should apply to Invega Trinza:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months.

Discussion: FDA Approved Indications, Clinical Evidence of Safety and Efficacy, Black Box Warnings, Contraindications, Adverse Reactions, Drug Interactions, Special Population Precautions, Dosing Schedule, Specialist Input and Patent Life were discussed. Class review and specialist input agree that agents with a longer duration of action would have the advantage of preventing decompensation in members.

Outcome: Jamie Dodson made a motion to accept the recommendations as written. Lisa Mazonkey seconded the motion. None were opposed.

Recommendations based on financial review: The following quantity limits should apply:

- Abilify Maintena – One syringe or vial per 28 days – Currently 1 syringe per 30 days and no QL on vial.
- Aristada – One syringe per 28 days – new QL
- Invega Sustenna – One syringe per 28 days – no changes needed to current QL
- Invega Trinza – One syringe per 84 days (3 months) – no changes needed to current QL
- Risperdal Consta – Two vials per 28 days – no changes needed to current QL
- Zyprexa Relprevv – Two vials per 28 days – new QL

Discussion: No questions or comments

Outcome: Lisa Mazonkey made a motion to accept the recommendations as written. Kim Clark seconded the motion. None were opposed

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Erythropoietin Stimulating Agents (ESA) Class Review **Mariette Njei**

Mariette Njei presented a review of the Erythromycin Stimulating Agents to include the following products:

Brand	Generic name	How supplied				Manufacturer	FDA approval date[5]
Epogen	Epoetin Alfa	Single-dose vial: 2000, 3000, 4000, and 10,000 Units/1 mL		Multidose vial containing benzyl alcohol: 20,000 Units/2 mL and 20,000 Units/1 mL		Amgen	1989
Procrit	Epoetin Alfa	Single-dose, Preservative-free Vial: Each 1 mL of solution contains 2000, 3000, 4000 or 10,000	Single-dose, Preservative-free Vial: 1 mL (40,000 Units/mL)	Multidose, Preserved Vial: 2 mL (20,000 Units, 10,000 Units/mL)	Multidose, Preserved Vial: 1 mL (20,000 Units/mL	Amgen	2008
Aranesp	Darbepoetin Alfa	Single-dose vials: 25, 40, 60, 100, 200, 300, and 500 mcg/1 mL, and 150 mcg/0.75 mL		Single-dose prefilled syringes: 10 mcg/0.4mL, 25 mcg/0.42mL, 40 mcg/0.4mL, 60 mcg/0.3 mL, 100 mcg/0.5 mL, 150 mcg/0.3 mL, 200 mcg/0.4 mL, 300 mcg/0.6 mL, and 500 mcg/1 mL		Amgen	2001

Mircera	Methoxy Polyethylene glycol-Epoetin Beta		Single use prefilled syringes: 50, 75, 100, 150, 200, or 250 mcg in 0.3 mL	Hoffmann-La Roche Inc	2007

FDA Approved Indications:

	Epogen	Procrit	Aranesp	Mircera
Anemia due to chronic renal failure	✓	✓	✓	✓
Treatment of Anemia in Zidovudine-treated HIV-infected Patients	✓	✓		
Treatment of Anemia in Cancer Patients on Chemotherapy	✓	✓	✓	
Reduction of Allogeneic Blood Transfusion in Patients undergoing elective, non-cardiac, nonvascular Surgery	✓	✓		

Non FDA Approved Indications:

	Epogen	Procrit	Aranesp	Mircera
Anemia - Hepatitis C, In patients being treated with a combination of ribavirin and interferon alfa or ribavirin and peginterferon alfa	✓	✓		
Anemia - Myelodysplastic syndrome	✓	✓	✓	
Anemia - Multiple myeloma	✓	✓		
Anemia - Rheumatoid arthritis	✓	✓		
Anemia - Congestive heart failure	✓	✓		
Anemia due to radiation	✓	✓		
Anemia during the puerperium	✓	✓		
Anemia – Myelofibrosis	✓	✓		
Anemia of prematurity	✓	✓		
Beta Thalassemia	✓	✓		
Blood unit collection for autotransfusion	✓	✓		

Recommendations based on clinical review: It is recommended that the following updates be made:

Epogen, Procrit, Aranesp:

1. Treatment of anemia secondary to myelosuppressive chemotherapy in non-myeloid malignancies when all of the following criteria are met:
    - Hgb less than or equal to 10 g/dL for new starts and less than 12 g/dL for continuation of therapy.

Note: Non-Myeloid Malignancies include all types of carcinoma, sarcoma, melanoma, multiple myeloma, lymphoma and lymphocytic leukemia.

2. Treatment of symptomatic anemia of chronic renal insufficiency, chronic renal failure, including end stage renal disease either requiring or not requiring dialysis when all of the following criteria are met:

    - Hgb less than or equal to 10 g/dL for new starts and less than 12 g/dL for continuation of therapy.

3. For all other indications:

    - Hgb less than or equal to 12 g/dL for new starts and for continuation of therapy

Mircera:

Mircera will be a medical or a pharmacy benefit for GHP Family. It is recommended that Mircera be added to the GHP family formulary. Mircera should require a prior authorization on both the pharmacy and medical benefits with the following criteria:

- Medical record documentation of CKD with or without dialysis and
- Hgb less than or equal to 10 g/dL for new starts and less than 12 g/dL for continuation of therapy and
- Ferritin greater than or equal to 100 ng/mL or transferrin saturation level greater than or equal to 20%, or a history of chelation therapy for iron

Approval for Epogen, Procrit, Aranesp or Mircera therapy will be given for an initial duration of six months. Subsequent authorizations will be considered based on the stated criteria.

Discussion: FDA Approved Indications, Dosing Schedule, Clinical Evidence of Safety and Efficacy, Black Box Warnings, Contraindications, Warnings and Precautions, Adverse Reactions, Special Population Precautions and Patent Life were discussed. Numerous questions were raised about the various indications and hemoglobin levels.

Outcome: It was decided to table a decision until a later time.

Recommendations based on financial review:

Epogen, Procrit and Aranesp: No changes recommended to current formulary status

Mircera: Will be medical or pharmacy benefit for GHP Family. It is recommended that Mircera be added to the brand tier on the GHP Family formulary

Discussion: No questions or comments

Outcome: It was decided to table a decision until a later time.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

POLICY UPDATES:

Hepatitis C Policy Updates **Kristi Clarke**

Recommendation: The following changes are recommended to existing Hepatitis C policies for GHP Family:

Sovaldi, Olysio, Daklinza, Technivie, Viekira Pak, Harvoni, Hepatitis C Direct Acting Antivirals: Add: Medical record documentation of a hepatocellular carcinoma screening in those with cirrhosis (METAVIR score F4)

Sovaldi, Olysio, Daklinza, Technivie, Viekira Pak, Harvoni, Hepatitis C Direct Acting Antivirals: Remove "in writing" from: Medical record documentation that the member in writing commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment

Harvoni: Remove: Medical record documentation for not using Viekira Pak if clinically appropriate

Discussion: No questions or comments.

Outcome: Steven Kheloussi made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Testosterone Replacement **Kevin Szczecina**

Recommendation: Prior authorization criteria for reviewing requests for testosterone replacement for GHP Family should be changed to:

- Medical record documentation of a diagnosis of primary hypogonadism (congenital or acquired) **OR** hypogonadotropic hypogonadism (congenital or acquired) **AND**
- Medical record documentation of two morning serum testosterone levels < 300 µg/dL drawn on separate days

AND for a non-preferred Testosterone product:

- Medical record documentation of a therapeutic failure on, intolerance to or contraindication to Androderm

Exclusions:

- Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women.
- Testosterone replacement will not be covered for the treatment of sexual dysfunction.

Striant Quantity Limit: 2 tablets per day

Discussion: no questions or comments

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Non-preferred Inhaled Corticosteroids **Kevin Szczecina**

Recommendation: The following criteria should apply to requests for Qvar, Pulmicort Flexhaler, Alvesco, Aerospan, and Asmanex for GHP Family members:

For members age 12 and older:

- Medical record documentation of a therapeutic failure on, intolerance to or contraindication to Arnuity Ellipta

For members under age 12:

- Medical record documentation of a therapeutic failure on, intolerance to or contraindication to Flovent

Discussion: no questions or comments

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Promacta **Kevin Szczecina**

Recommendation: The following criterion should remain in place for requests for Promacta for GHP Family members:

- Medical record documentation of a therapeutic failure on, or contraindication to the following: corticosteroids, immunoglobulins or splenectomy **AND** Rituxan(requires prior authorization)

Discussion: no questions or comments

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Gleevec **Kevin Szczecina**

Recommendation: Gleevec was approved for the treatment of newly diagnosed Ph+ ALL in children (in combination with chemotherapy). It is recommended the indication be added to the Gleevec Policy for GHP Family.

Discussion: no questions or comments

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

GHP Family Formulary Update **Kevin Szczecina**

Recommendation: It is recommended the following medications be added to the GHP Family formulary with no restrictions:

FML S.O.P. (fluorometholone ophthalmic ointment)
NuvaRing (etonogestrel/ethinyl estradiol vaginal ring)
Xulane (norelgestromin/ethinyl estradiol transdermal system

Discussion: No questions or comments.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Steven Kheloussi Seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

GHP Family Quantity Limits Exception **Kristen Scheib**

Recommendation: Given the recent addition of quantity limits to many products on the GHP Family formulary, it was requested that a policy for quantity limit exceptions be developed for consistency among reviewers. Proposed criteria are as follows:

- Medical record documentation that requested dose cannot be achieved by using a formulary alternative (i.e.- use of one 10mg tablet in place of two 5mg tablets) **AND**
- Medical record documentation that prescribed dosage does not exceed those approved by the Food and Drug Administration (FDA) or accepted standards of care **AND**
- If request is for dose that exceeds FDA approved labeling, medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing that exceeds FDA approved labeling **AND**
- Medical record documentation that current formulary quantity limit has been ineffective in management of member's condition

Authorization Duration: If approved, quantity limit exceptions will be for a duration of one (1) year.

Discussion: no questions or comments

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Jamie Dodson seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

GHP Family Formulary **Kevin Szczecina**

Recommendation: The Pennsylvania Department of Human Services requires that the GHP Family Formulary be approved annually by each MCO's P&T Committee. It is recommended the formulary be approved by the Committee

Discussion: No questions or comments.

Outcome: Steven Kheloussi made a motion to accept the recommendations as written. Tricia Heitzman seconded the motion. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

GHP Family 2016 Pharmacy Formulary:

Drug Name		Drug Tier	Requirements/Limits
Analgesics			
Analgesics, Miscellaneous			
acetaminophen with codeine solution	(Acetaminophen with Codeine)	1	QL: 166.67 in 1 days
acetaminophen with codeine tablet: 300mg-30mg	(Tylenol-Codeine No.3)	1	QL: 12 in 1 days
acetaminophen with codeine tablet: 300mg-15mg	(Tylenol-Codeine No.3)	1	QL: 13 in 1 days
acetaminophen with codeine tablet: 300mg-60mg	(Tylenol-Codeine No.3)	1	QL: 6 in 1 days
butalb/acetaminophen/caffeine capsule: 50-300-40, 50-325-40; solution, tablet	(Fioricet)	1	
butalbit/acetamin/caff/codeine capsule: 50-300-30	(Fioricet with Codeine)	1	
butalbital/acetaminophen tablet: 50mg-325mg	(Tencon)	1	
butalbital/acetaminophen tablet: 50mg-325mg	(Tencon)	1	QL: 6 in 1 days
butalbital/aspirin/caffeine	(Fiorinal)	1	
codeine sulfate solution	(Codeine Sulfate)	1	
codeine sulfate tablet	(Codeine Sulfate)	1	QL: 6 in 1 days
fentanyl citrate	(Actiq)	1	PA, QL: 120 in 30 days

fentanyl patch td72: 12mcg/hr, 25mcg/hr, 50mcg/hr	(Duragesic)	1	QL: 10 in 30 days
fentanyl patch td72: 75mcg/hr, 100mcg/hr	(Duragesic)	1	QL: 20 in 30 days
hydrocodone/acetaminophen solution: 2.5-167/5, 5-163/7.5	(Lortab)	1	
hydrocodone/acetaminophen solution: 10-300/15	(Lortab)	1	QL: 67.5 in 1 days
hydrocodone/acetaminophen solution: 7.5-325/15	(Lortab)	1	QL: 90 in 1 days
hydrocodone/acetaminophen tablet: 5mg-325mg, 7.5-325mg, 10mg-325mg	(Norco)	1	QL: 12 in 1 days
hydrocodone/acetaminophen tablet: 5mg-300mg, 7.5-300mg, 10mg-300mg	(Norco)	1	QL: 13 in 1 days
hydrocodone/ibuprofen	(Ibudone)	1	QL: 5 in 1 days
hydromorphone hcl tablet: 2mg, 4mg	(Dilaudid)	1	QL: 6 in 1 days
hydromorphone hcl tablet: 8mg	(Dilaudid)	1	QL: 8 in 1 days
ibuprofen/oxycodone hcl	(Ibuprofen/Oxycodone HCl)	1	QL: 4 in 1 days
levorphanol tartrate	(Levorphanol Tartrate)	1	QL: 6 in 1 days
meperidine hcl solution, tablet	(Demerol)	1	
methadone hcl oral conc, tablet	(Dolophine HCl)	1	QL: 12 in 1 days
methadone hcl tablet sol	(Methadone HCl)	1	QL: 3 in 1 days

methadone hcl solution	(Methadone HCl)	1	QL: 60 in 1 days
morphine sulfate cap er pel: 30mg, 50mg, 100mg; tablet er: 15mg, 30mg, 100mg	(Morphine Sulfate ER)	1	QL: 3 in 1 days
morphine sulfate cap er pel: 10mg, 20mg, 60mg, 80mg; tablet er: 60mg, 200mg	(Morphine Sulfate ER)	1	QL: 4 in 1 days
morphine sulfate supp.rect	(Morphine Sulfate)	1	
morphine sulfate solution: 20mg/5ml	(Morphine Sulfate)	1	QL: 45 in 1 days
morphine sulfate solution: 100mg/5ml	(Morphine Sulfate)	1	QL: 9 in 1 days
morphine sulfate solution: 10mg/5ml	(Morphine Sulfate)	1	QL: 90 in 1 days
MORPHINE SULFATE		1	QL: 6 in 1 days
oxycodone hcl solution	(Oxycodone HCl)	1	QL: 43.33 in 1 days
oxycodone hcl capsule, oral conc, tablet	(Roxicodone)	1	QL: 6 in 1 days
oxycodone hcl/acetaminophen solution	(Oxycodone HCl/ Acetaminophen)	1	QL: 61 in 1 days
oxycodone hcl/acetaminophen tablet: 2.5-325mg, 5mg-325mg, 7.5-325mg, 10mg-325mg	(Oxycodone-Acetaminophen)	1	QL: 12 in 1 days
oxycodone hcl/aspirin	(Percodan)	1	QL: 12 in 1 days
oxycodone hcl/oxycodon ter/asa	(Oxycodone HCl/Oxycodon Ter/Asa)	1	QL: 12 in 1 days
oxymorphone hcl tablet	(Opana)	1	QL: 6 in 1 days

tramadol hcl tab er 24h: 200mg, 300mg	(Ultram ER)	1	QL: 30 in 30 days
tramadol hcl tab er 24h: 100mg	(Ultram ER)	1	QL: 90 in 30 days
tramadol hcl tablet	(Ultram)	1	QL: 240 in 30 days
tramadol hcl/acetaminophen	(Ultracet)	1	QL: 240 in 30 days
acetaminophen capsule: 500mg; elixir: 160mg/5ml; solution, supp.rect: 120mg, 650mg; tab chew: 80mg; tablet: 500mg	(Acetaminophen)	OTC	
acetaminophen/phenyltolx tablet: 325mg-30mg	(Acetaminophen/Phenyltolx)	OTC	
Nonsteroidal Anti-Inflammatory Agents			
celecoxib	(Celebrex)	1	ST, QL: 60 in 30 days
choline sal/mag salicylate	(Choline Sal/Mag Salicylate)	1	
COMFORT PAC-IBUPROFEN		1	
COMFORT PAC-MELOXICAM		1	
COMFORT PAC-NAPROXEN		1	
diclofenac potassium	(Cataflam)	1	
diclofenac sodium tab er 24h, tablet dr	(Diclofenac Sodium)	1	
diflunisal	(Diflunisal)	1	
etodolac	(Etodolac)	1	
fenoprofen calcium	(Fenoprofen Calcium)	1	
flurbiprofen	(Flurbiprofen)	1	

ibuprofen oral susp: 100mg/5ml; tablet: 400mg, 600mg, 800mg	(Ibuprofen)	1	
indomethacin	(Indomethacin)	1	
ketoprofen capsule	(Ketoprofen)	1	
ketorolac tromethamine tablet	(Ketorolac Tromethamine)	1	QL: 20 per fill
magnesium salicylate	(Magnesium Salicylate)	1	
meclofenamate sodium	(Meclofenamate Sodium)	1	
mefenamic acid	(Ponstel)	1	
meloxicam	(Mobic)	1	
methyl salicylate	(Methyl Salicylate)	1	
nabumetone	(Nabumetone)	1	
naproxen sodium tablet: 275mg, 550mg	(Anaprox Ds)	1	
naproxen	(Naprosyn)	1	
oxaprozin	(Daypro)	1	
piroxicam	(Feldene)	1	
salsalate	(Salsalate)	1	
sulindac	(Sulindac)	1	
tolmetin sodium	(Tolmetin Sodium)	1	
CELEBREX		2	ST, QL: 60 in 30 days
VOLTAREN		2	PA
aspirin supp.rect, tab chew: 81mg; tablet, tablet dr: 81mg, 325mg	(Ecotrin)	OTC	

ibuprofen drops susp: 50mg/1.25; oral susp: 100mg/ 5ml; tab chew: 100mg; tablet: 200mg	(Motrin Ib)	OTC	
naproxen sodium tablet: 220mg	(Naproxen Sodium)	OTC	
Anesthetics			
Local Anesthetics			
benzocaine drops	(Benzocaine)	1	
lidocaine hcl jel (ml), jel/pf app: 2%; solution	(Lidocaine HCl)	1	
lidocaine oint. (g)	(Lidocaine)	1	
lidocaine adh. patch	(Lidoderm)	1	PA, QL: 90 in 30 days
lidocaine/prilocaine	(EMLA)	1	
RELADOR PAK		1	
LIDODERM		2	PA, QL: 90 in 30 days
benzocaine gel (gram): 20%	(Hurricaine)	OTC	
Anti-Addiction/Substance Abuse Treatment Agents			
Anti-Addiction/Substance Abuse Treatment Agents			
acamprosate calcium	(Campral)	1	
buprenorphine hcl	(Subutex)	1	PA
buprenorphine hcl/naloxone hcl	(Suboxone)	1	PA
bupropion hcl	(Zyban)	1	
disulfiram	(Antabuse)	1	
naloxone hcl syringe	(Naloxone HCl)	1	
naltrexone hcl	(Naltrexone HCl)	1	

SUBOXONE		2	PA
nicotine polacrilex	(Nicorette)	OTC	
nicotine patch td24: 7mg/24hr, 14mg/24hr, 21mg/24hr	(Nicoderm Cq)	OTC	
Antianxiety Agents			
Benzodiazepines			
alprazolam tab er 24h: 2mg, 3mg; tab rapdis: 2mg; tablet: 2mg	(Xanax)	1	QL: 2 in 1 days
alprazolam tab er 24h: 0.5mg, 1mg; tab rapdis: 0.25mg, 0.5mg, 1mg; tablet: 0.25mg, 0.5mg, 1mg	(Xanax)	1	QL: 4 in 1 days
chlordiazepoxide hcl	(Chlordiazepoxide HCl)	1	QL: 4 in 1 days
clonazepam tab rapdis: 2mg; tablet: 2mg	(Klonopin)	1	QL: 10 in 1 days
clonazepam tab rapdis: 0.125mg, 0.25mg, 0.5mg, 1mg; tablet: 0.5mg, 1mg	(Klonopin)	1	QL: 20 in 1 days
diazepam kit	(Diastat Acudial)	1	QL: 5 in 30 days
diazepam solution	(Diazepam)	1	QL: 40 in 1 days
diazepam oral conc	(Diazepam)	1	QL: 8 in 1 days
diazepam tablet	(Valium)	1	QL: 4 in 1 days
flurazepam hcl capsule: 30mg	(Flurazepam HCl)	1	QL: 1 in 1 days
flurazepam hcl capsule: 15mg	(Flurazepam HCl)	1	QL: 2 in 1 days
lorazepam tablet: 0.5mg, 1mg	(Ativan)	1	QL: 10 in 1 days

lorazepam oral conc, tablet: 2mg	(Ativan)	1	QL: 5 in 1 days
oxazepam	(Oxazepam)	1	QL: 4 in 1 days
temazepam	(Restoril)	1	QL: 1 in 1 days
triazolam tablet: 0.25mg	(Halcion)	1	QL: 2 in 1 days
triazolam tablet: 0.125mg	(Halcion)	1	QL: 4 in 1 days
Antibacterials			
Aminoglycosides			
neomycin sulfate	(Neomycin Sulfate)	1	
tobramycin in 0.225% nacl	(Tobi)	1	PA
tobramycin/nebulizer	(Tobramycin/Nebulizer)	1	PA
TOBI		2	PA (Specialty Drug)
Antibacterials, Miscellaneous			
clindamycin hcl	(Cleocin HCl)	1	
clindamycin palmitate hcl	(Cleocin Palmitate)	1	
linezolid tablet	(Zyvox)	1	PA
methenamine hippurate	(Hiprex)	1	
methenamine mandelate	(Methenamine Mandelate)	1	
nitrofurantoin macrocrystal	(Macrodantin)	1	
nitrofurantoin monohyd/m-cryst	(Macrobid)	1	
nitrofurantoin	(Furadantin)	1	
trimethoprim	(Trimethoprim)	1	
vancomycin hcl capsule, vial: 1g	(Vancomycin HCl)	1	
vancomycin hcl/d5w froz.piggy	(Vancomycin HCl/D5W)	1	
SIVEXTRO tablet		2	PA

XIFAXAN tablet: 550mg		2	PA, QL: 60 in 30 days
XIFAXAN tablet: 200mg		2	PA
ZYVOX susp recon, tablet		2	PA
Cephalosporins			
cefaclor	(Cefaclor)	1	
cefadroxil	(Cefadroxil)	1	
cefdinir	(Cefdinir)	1	
cefpodoxime proxetil	(Cefpodoxime Proxetil)	1	
cefuroxime axetil	(Ceftin)	1	
CEFUROXIME AXETIL		1	
cephalexin capsule: 250mg, 500mg; susp recon, tablet	(Keflex)	1	
Macrolides			
azithromycin packet, susp recon, tablet	(Zithromax)	1	
clarithromycin susp recon, tablet	(Biaxin)	1	
ery e-succ/sulfisoxazole	(Ery E-Succ/Sulfisoxazole)	1	
erythromycin base	(Erythromycin Base)	1	
erythromycin ethylsuccinate tablet	(Erythromycin Ethylsuccinate)	1	
erythromycin stearate	(Erythromycin Stearate)	1	
ERYPED 200		2	
ERYPED 400		2	
Penicillins			

amoxicillin capsule, susp recon, tab chew, tablet	(Amoxicillin)	1	
amoxicillin/potassium clav	(Augmentin)	1	
ampicillin trihydrate	(Ampicillin Trihydrate)	1	
dicloxacillin sodium	(Dicloxacillin Sodium)	1	
penicillin v potassium	(Penicillin V Potassium)	1	
Quinolones			
ciprofloxacin hcl	(Cipro)	1	
ciprofloxacin	(Cipro)	1	
levofloxacin solution, tablet	(Levaquin)	1	
ofloxacin	(Ofloxacin)	1	
Sulfonamides			
sulfamethoxazole/trimethoprim oral susp, tablet	(Bactrim DS)	1	
sulfasalazine	(Azulfidine)	1	
Tetracyclines			
doxycycline hyclate capsule, tablet: 20mg, 100mg	(Vibramycin)	1	
doxycycline monohydrate capsule: 50mg, 100mg; susp recon, tablet	(Avidoxy)	1	
minocycline hcl capsule, tablet	(Minocin)	1	
tetracycline hcl	(Tetracycline HCl)	1	
TETRACYCLINE HCL		1	
Anticancer Agents			

Anticancer Agents			
anastrozole	(Arimidex)	1	
bexarotene	(Targretin)	1	PA
bicalutamide	(Casodex)	1	
capecitabine	(Xeloda)	1	
cyclophosphamide tablet	(Cyclophosphamide)	1	
CYCLOPHOSPHAMIDE		1	
etoposide capsule	(Etoposide)	1	
exemestane	(Aromasin)	1	
flutamide	(Flutamide)	1	
hydroxyurea	(Hydrea)	1	
letrozole	(Femara)	1	Age must be >= 44 (PA Required for < 44)
lomustine	(Ceenu)	1	
megestrol acetate oral susp: 400mg/10ml; tablet	(Megace Es)	1	
mercaptopurine	(Purinethol)	1	
methotrexate sodium	(Methotrexate Sodium)	1	
tamoxifen citrate	(Tamoxifen Citrate)	1	
temozolomide	(Temodar)	1	
tretinoin	(Tretinoin)	1	
AFINITOR		2	PA
ALKERAN tablet		2	
BOSULIF		2	PA

CAPRELSA	2	PA
CAPRELSA	2	PA (Specialty Drug)
carboplatin (Carboplatin)	2	
COMETRIQ	2	PA
EMCYT	2	
ERIVEDGE	2	PA, QL: 30 in 30 days (Specialty Drug)
FARYDAK	2	PA, QL: 6 in 21 days
GILOTRIF	2	PA, QL: 30 in 30 days
GLEEVEC	2	PA
GLEOSTINE capsule: 5mg	2	
HEXALEN	2	
HYCAMTIN capsule	2	(Specialty Drug)
IBRANCE	2	PA, QL: 21 in 28 days
ICLUSIG	2	PA
IMBRUVICA	2	PA, QL: 4 in 1 days
INLYTA	2	PA (Specialty Drug)
JAKAFI	2	PA, QL: 60 in 30 days (Specialty Drug)
LENVIMA	2	PA, QL: 3 in 1 days
LEUKERAN	2	
LYNPARZA	2	PA, QL: 16 in 28 days
LYSODREN	2	
MATULANE	2	(Specialty Drug)

MEKINIST tablet: 2mg	2	PA, QL: 30 in 30 days (Specialty Drug)
MEKINIST tablet: 0.5mg	2	PA, QL: 90 in 30 days (Specialty Drug)
MYLERAN	2	
NEXAVAR	2	PA, QL: 120 in 30 days (Specialty Drug)
NILANDRON	2	
POMALYST	2	PA (Specialty Drug)
REVLIMID	2	PA, QL: 30 in 30 days (Specialty Drug)
SPRYCEL	2	PA
STIVARGA	2	PA, QL: 120 in 30 days
SUTENT	2	PA
TAFINLAR	2	PA, QL: 120 in 30 days
TARCEVA tablet: 100mg, 150mg	2	PA NSO, QL: 1 in 1 days
TARCEVA tablet: 25mg	2	PA NSO, QL: 3 in 1 days
TARGRETIN capsule	2	PA
TASIGNA	2	PA
TEMODAR capsule	2	
TYKERB	2	PA (Specialty Drug)
VANDETANIB	2	PA
VOTRIENT	2	PA, QL: 120 in 30 days

XALKORI		2	PA, QL: 60 in 30 days (Specialty Drug)
XELODA		2	
ZELBORAF		2	PA, QL: 240 in 30 days (Specialty Drug)
ZOLINZA		2	PA
ZYKADIA		2	PA, QL: 5 in 1 days
ZYTIGA		2	PA, QL: 120 in 30 days (Specialty Drug)
Anticholinergic Agents			
Antimuscarinics/Antispasmodics			
propantheline bromide	(Propantheline Bromide)	1	
Anticonvulsants			
Anticonvulsants			
carbamazepine	(Tegretol)	1	
divalproex sodium	(Depakote ER)	1	
ethosuximide solution	(Zarontin)	1	
felbamate	(Felbatol)	1	
gabapentin	(Neurontin)	1	
lamotrigine tab ds pk, tablet, tb chw dsp	(Lamictal)	1	
levetiracetam solution, tab er 24h, tablet	(Keppra)	1	
oxcarbazepine	(Trileptal)	1	

phenobarbital	(Phenobarbital)	1	
phenytoin sodium extended	(Dilantin)	1	
phenytoin	(Dilantin)	1	
primidone	(Mysoline)	1	
tiagabine hcl	(Gabitril)	1	
topiramate cap sprink, tablet	(Topamax)	1	
valproic acid (as sodium salt) solution	(Depakene)	1	
valproic acid	(Depakene)	1	
zonisamide	(Zonegran)	1	
BANZEL		2	PA
DILANTIN capsule: 30mg		2	
GABITRIL tablet: 12mg, 16mg		2	
LYRICA capsule: 225mg, 300mg		2	PA, QL: 60 in 30 days
LYRICA capsule: 25mg, 50mg, 75mg, 100mg, 150mg, 200mg		2	PA, QL: 90 in 30 days
Antidementia Agents			
Antidementia Agents			
donepezil hcl tab rapdis, tablet: 5mg, 10mg	(Aricept)	1	Age must be >= 18 (PA Required for < 18)
memantine hcl tablet	(Namenda)	1	Age must be >= 18
memantine hcl solution	(Namenda)	1	
rivastigmine tartrate	(Exelon)	1	Age must be >= 18 (PA Required for < 18)

NAMENDA solution, tablet		2	Age must be >= 18 (PA Required for < 18)
Antidepressants			
Antidepressants			
amitrip hcl/chlordiazepoxide	(Amitrip HCl/ Chlordiazepoxide)	1	
amitriptyline hcl	(Amitriptyline HCl)	1	
amoxapine	(Amoxapine)	1	
bupropion hcl	(Wellbutrin XL)	1	
citalopram hydrobromide tablet: 40mg	(Celexa)	1	QL: 1 in 1 days
citalopram hydrobromide tablet: 10mg, 20mg	(Celexa)	1	QL: 1.5 in 1 days
citalopram hydrobromide solution	(Citalopram Hydrobromide)	1	QL: 20 in 1 days
clomipramine hcl	(Anafranil)	1	
desipramine hcl	(Norpramin)	1	
doxepin hcl	(Doxepin HCl)	1	
duloxetine hcl capsule dr: 40mg	(Cymbalta)	1	
duloxetine hcl capsule dr: 30mg	(Cymbalta)	1	QL: 1 in 1 days
duloxetine hcl capsule dr: 20mg, 60mg	(Cymbalta)	1	QL: 2 in 1 days
escitalopram oxalate tablet	(Lexapro)	1	QL: 1 in 1 days
escitalopram oxalate solution	(Lexapro)	1	QL: 20 in 1 days
fluoxetine hcl solution	(Fluoxetine HCl)	1	QL: 20 in 1 days

fluoxetine hcl capsule: 10mg; tablet: 10mg	(Fluoxetine HCl)	1	QL: 3 in 1 days
fluoxetine hcl capsule: 40mg	(Prozac)	1	QL: 2 in 1 days
fluoxetine hcl capsule: 20mg; tablet: 20mg	(Prozac)	1	QL: 4 in 1 days
FLUOXETINE HCL		1	QL: 1 in 1 days
fluvoxamine maleate tablet: 25mg	(Fluvoxamine Maleate)	1	QL: 1 in 1 days
fluvoxamine maleate tablet: 50mg	(Fluvoxamine Maleate)	1	QL: 1.5 in 1 days
fluvoxamine maleate tablet: 100mg	(Fluvoxamine Maleate)	1	QL: 3 in 1 days
imipramine hcl	(Tofranil)	1	
imipramine pamoate	(Tofranil-Pm)	1	
mirtazapine	(Remeron)	1	
nefazodone hcl	(Nefazodone HCl)	1	
nortriptyline hcl	(Pamelor)	1	
paroxetine hcl oral susp	(Paroxetine HCl)	1	QL: 30 in 1 days
paroxetine hcl tab er 24h: 12.5mg; tablet: 10mg, 20mg, 40mg	(Paxil)	1	QL: 1 in 1 days
paroxetine hcl tab er 24h: 25mg, 37.5mg; tablet: 30mg	(Paxil)	1	QL: 2 in 1 days
perphenazine/amitriptyline hcl	(Perphenazine/Amitriptyline HCl)	1	
sertraline hcl tablet: 25mg, 50mg	(Zoloft)	1	QL: 1.5 in 1 days
sertraline hcl oral conc	(Zoloft)	1	QL: 10 in 1 days
sertraline hcl tablet: 100mg	(Zoloft)	1	QL: 2 in 1 days
trazodone hcl	(Trazodone HCl)	1	

venlafaxine hcl cap er 24h: 150mg	(Effexor XR)	1	
venlafaxine hcl cap er 24h: 37.5mg	(Effexor XR)	1	QL: 1 in 1 days
venlafaxine hcl cap er 24h: 75mg; tablet	(Effexor XR)	1	QL: 3 in 1 days
CYMBALTA capsule dr: 30mg		2	QL: 1 in 1 days
CYMBALTA capsule dr: 20mg, 60mg		2	QL: 2 in 1 days
Antidiabetic Agents			
Antidiabetic Agents, Miscellaneous			
acarbose	(Precose)	1	
metformin hcl	(Glucophage)	1	
nateglinide	(Starlix)	1	
pioglitazone hcl	(Actos)	1	
repaglinide	(Prandin)	1	
INVOKAMET		2	ST, QL: 2 in 1 days
INVOKANA		2	ST, QL: 1 in 1 days
JANUMET XR		2	
JANUMET		2	
JANUVIA		2	ST
JARDIANCE		2	ST, QL: 1 in 1 days
TANZEUM		2	ST
VICTOZA 3-PAK		2	ST
Insulins			
LANTUS SOLOSTAR		2	

LANTUS		2	
LEVEMIR FLEXTOUCH		2	
LEVEMIR		2	
NOVOLIN 70-30 cartridge		2	
NOVOLIN 70-30 vial		2	
NOVOLIN N cartridge		2	
NOVOLIN N vial		2	
NOVOLIN R		2	
NOVOLOG FLEXPEN		2	
NOVOLOG MIX 70-30 FLEXPEN		2	
NOVOLOG MIX 70-30		2	
NOVOLOG		2	
TOUJEO SOLOSTAR		2	Age must be >= 18, PA
Sulfonylureas			
glimepiride	(Amaryl)	1	
glipizide	(Glucotrol)	1	
glipizide/metformin hcl	(Metaglip)	1	
glyburide	(Glyburide)	1	
glyburide,micronized	(Glynase)	1	
glyburide/metformin hcl	(Glucovance)	1	
Antifungals			
Antifungals			
clotrimazole cream (g): 1%; solution: 1%; troche	(Clotrimazole)	1	

clotrimazole/betamethasone dip	(Lotrisone)	1	
econazole nitrate	(Econazole Nitrate)	1	
fluconazole	(Diflucan)	1	
griseofulvin ultramicrosize	(Gris-Peg)	1	
griseofulvin, microsize	(Griseofulvin, Microsize)	1	
itraconazole	(Sporanox)	1	PA
ketoconazole cream (g), foam: 2%; shampoo, tablet	(Ketoconazole)	1	
miconazole nitrate supp.vag: 200mg	(Monistat 3)	1	
MICONAZOLE NITRATE powder: n/a		1	
nystatin cream (g), oint. (g), oral susp, powder: 100000/g; tablet	(Nystatin)	1	
nystatin/triamcin	(Nystatin/Triamcin)	1	
NYSTATIN		1	
terbinafine hcl tablet	(Lamisil)	1	
voriconazole susp recon, tablet	(Vfend)	1	PA
GRIFULVIN V		2	
clotrimazole cream/appl: 1%, 2%; solution: 1%; tablet	(Gyne-Lotrimin-7)	OTC	
miconazole nitrate aero powd: 2%; cmb pf crm: 200mg-2%; cream (g): 2%; kit: 200mg-2%; powder: 2%	(Lotrimin AF)	OTC	

MICONAZOLE NITRATE aero powd		OTC	
miconazole/skin cleanser no.17	(Miconazole/Skin Cleanser No.17)	OTC	
terbinafine hcl cream (g)	(Lamisil At)	OTC	
tolnaftate aero powd: 1%; powder: 1%; solution	(Tinactin)	OTC	
undecylenic acid solution: 25%	(Undecylenic Acid)	OTC	
Antihistamines			
Antihistamines			
cyproheptadine hcl	(Cyproheptadine HCl)	1	
diphenhydramine hcl capsule: 50mg	(Benadryl)	1	
fexofenadine hcl tablet: 30mg, 60mg, 180mg	(Allegra)	1	
levocetirizine dihydrochloride	(Xyzal)	1	
promethazine hcl	(Promethazine HCl)	1	
cetirizine hcl solution: 1mg/ml; tab chew	(Zyrtec)	OTC	
chlorpheniramine maleate syrup: 2mg/5ml; tablet er	(Chlor-Trimeton)	OTC	
clemastine fumarate tablet: 1.34mg	(Tavist)	OTC	
diphenhydramine hcl capsule: 25mg; liquid: 12.5mg/ 5ml; tablet: 25mg	(Benadryl)	OTC	
fexofenadine hcl tablet: 60mg	(Fexofenadine HCl)	OTC	

loratadine tab rapdis	(Claritin)	OTC	
loratadine/pseudoephedrine tab er 12h: 5mg-120mg	(Claritin-D 12 hour)	OTC	
Anti-infectives (Skin and Mucous Membrane)			
Anti-infectives (Skin and Mucous Membrane)			
clindamycin phosphate	(Cleocin)	1	
metronidazole	(Metrogel-Vaginal)	1	
terconazole cream/appl: 0.4%, 0.8%; supp.vag	(Terazol 7)	1	
ABREVA		OTC	
Antimigraine Agents			
Antimigraine Agents			
naratriptan hcl	(Amerge)	1	QL: 16 in 28 days (QL applies to all oral Antimigraine agents combined)
rizatriptan benzoate	(Maxalt)	1	QL: 16 in 28 days (QL applies to all oral Antimigraine agents combined)
sumatriptan succinate cartridge, pen injctr, tablet, vial	(Imitrex)	1	QL: 16 in 28 days (QL applies to all oral Antimigraine agents combined)

sumatriptan succinate cartridge, pen injctr, tablet, vial	(Imitrex)	1	QL: 16 in 28 days
sumatriptan succinate syringe	(Sumatriptan Succinate)	1	
sumatriptan	(Imitrex)	1	QL: 16 in 28 days (QL applies to all oral Antimigraine agents combined)
zolmitriptan	(Zomig)	1	QL: 16 in 28 days (QL applies to all oral Antimigraine agents combined)
Antimycobacterials			
Antimycobacterials			
dapsone	(Dapsone)	1	
ethambutol hcl	(Myambutol)	1	
isoniazid solution, tablet	(Isoniazid)	1	
pyrazinamide	(Pyrazinamide)	1	
rifampin capsule	(Rifadin)	1	
Antinausea Agents			
Antinausea Agents			
meclizine hcl tablet: 12.5mg, 25mg	(Meclizine HCl)	1	
ondansetron hcl solution, tablet: 4mg, 8mg	(Zofran)	1	
ondansetron	(Zofran Odt)	1	

prochlorperazine maleate	(Prochlorperazine Maleate)	1	
prochlorperazine	(Prochlorperazine)	1	
promethazine hcl supp.rect, tablet	(Promethazine HCl)	1	
trimethobenzamide hcl capsule	(Tigan)	1	
AKYNZEO		2	PA, QL: 2 in 28 days
EMEND capsule: 40mg		2	PA, QL: 1 in 30 days
EMEND capsule: 125mg		2	PA, QL: 2 in 30 days
EMEND capsule: 80mg		2	PA, QL: 4 in 30 days
EMEND cap ds pk		2	PA, QL: 6 in 30 days, QL: 2 in 30 days
meclizine hcl tablet: 12.5mg	(Meclizine HCl)	OTC	
Antiparasite Agents			
Antiparasite Agents			
atovaquone	(Mepron)	1	
atovaquone/proguanil hcl	(Malarone)	1	
chloroquine phosphate	(Chloroquine Phosphate)	1	
hydroxychloroquine sulfate	(Plaquenil)	1	
mebendazole	(Mebendazole)	1	
mefloquine hcl	(Mefloquine HCl)	1	
metronidazole	(Flagyl)	1	
METRONIDAZOLE		1	
paromomycin sulfate	(Paromomycin Sulfate)	1	
tinidazole	(Tindamax)	1	
ALBENZA		2	QL: 4 per fill

BILTRICIDE		2	
MEPRON		2	
Antiparkinsonian Agents			
Antiparkinsonian Agents			
amantadine hcl	(Amantadine HCl)	1	
benztropine mesylate tablet	(Benztropine Mesylate)	1	
bromocriptine mesylate	(Bromocriptine Mesylate)	1	
cabergoline	(Cabergoline)	1	
carbidopa/levodopa	(Sinemet 25-100)	1	
carbidopa/levodopa/entacapone	(Stalevo 200)	1	
pramipexole di-hcl tablet	(Mirapex)	1	
ropinirole hcl tablet	(Requip)	1	
selegiline hcl	(Eldepryl)	1	
trihexyphenidyl hcl	(Trihexyphenidyl HCl)	1	
Antipsychotic Agents			
Antipsychotic Agents			
aripiprazole tablet	(Abilify)	1	PA, QL: 30 in 30 days
aripiprazole solution	(Abilify)	1	PA, QL: 900 in 30 days
chlorpromazine hcl tablet	(Chlorpromazine HCl)	1	
clozapine tablet: 25mg, 50mg	(Clozaril)	1	QL: 3 in 1 days
clozapine tablet: 200mg	(Clozaril)	1	QL: 4 in 1 days
clozapine tablet: 100mg	(Clozaril)	1	QL: 9 in 1 days
fluphenazine decanoate	(Fluphenazine Decanoate)	1	

fluphenazine hcl elixir, oral conc, tablet	(Fluphenazine HCl)	1	
haloperidol decanoate	(Haloperidol Decanoate)	1	
haloperidol lactate oral conc	(Haloperidol Lactate)	1	
haloperidol	(Haloperidol)	1	
loxapine succinate	(Loxapine Succinate)	1	
olanzapine tablet	(Zyprexa)	1	QL: 1 in 1 days
perphenazine	(Perphenazine)	1	
pimozide	(Orap)	1	
quetiapine fumarate tablet: 300mg, 400mg	(Seroquel)	1	QL: 2 in 1 days
quetiapine fumarate tablet: 50mg, 100mg	(Seroquel)	1	QL: 3 in 1 days
quetiapine fumarate tablet: 200mg	(Seroquel)	1	QL: 4 in 1 days
quetiapine fumarate tablet: 25mg	(Seroquel)	1	QL: 6 in 1 days
risperidone tablet	(Risperdal)	1	QL: 2 in 1 days
risperidone solution	(Risperdal)	1	QL: 8 in 1 days
thioridazine hcl tablet	(Thioridazine HCl)	1	
thiothixene	(Thiothixene)	1	
trifluoperazine hcl	(Trifluoperazine HCl)	1	
ziprasidone hcl	(Geodon)	1	QL: 60 in 30 days
ABILIFY tablet		2	PA, QL: 30 in 30 days
ORAP		2	
Antivirals (Systemic)			

Antiretrovirals			
abacavir sulfate	(Ziagen)	1	
abacavir/lamivudine/zidovudine	(Trizivir)	1	
didanosine	(Videx EC)	1	
lamivudine solution, tablet: 150mg, 300mg	(Epivir Hbv)	1	
lamivudine/zidovudine	(Combivir)	1	
nevirapine	(Viramune)	1	
stavudine	(Zerit)	1	
zidovudine	(Zidovudine)	1	
APTIVUS capsule		2	
APTIVUS solution		2	
ATRIPLA		2	
COMPLERA		2	
CRIXIVAN		2	
EDURANT		2	QL: 34 in 34 days
EMTRIVA		2	
EPIVIR solution		2	
EPZICOM		2	
EVOTAZ		2	
FUZEON		2	(Specialty Drug)
INTELENCE		2	
INVIRASE		2	
ISENTRESS		2	

KALETRA	2	
LEXIVA	2	
NORVIR	2	
PREZCOBIX	2	
PREZISTA	2	
RESCRIPTOR	2	
REYATAZ	2	
SELZENTRY	2	
STRIBILD	2	
SUSTIVA	2	
TIVICAY	2	
TRIUMEQ	2	
TRIZIVIR	2	
TRUVADA	2	
VIDEX	2	
VIRACEPT tablet	2	
VIRAMUNE XR	2	
VIREAD tablet	2	
VITEKTA	2	QL: 1 in 1 days
ZIAGEN solution	2	
Antivirals, Miscellaneous		
rimantadine hcl (Rimantadine HCl)	1	
RELENZA	2	QL: 20 in 365 days
TAMIFLU capsule	2	QL: 10 in 180 days

TAMIFLU susp recon: 12mg/ml		2	QL: 100 in 180 days
TAMIFLU susp recon: 6mg/ml		2	QL: 120 in 180 days
Hcv Antivirals			
SOVALDI		2	PA, QL: 28 in 28 days
VIEKIRA PAK		2	PA, QL: 112 in 28 days
Interferons			
INTRON A		2	(Specialty Drug)
PEGASYS PROCLICK		2	(Specialty Drug)
PEGASYS PROCLICK		2	
PEGASYS		2	(Specialty Drug)
PEGINTRON REDIPEN		2	(Specialty Drug)
PEGINTRON REDIPEN		2	
PEGINTRON		2	(Specialty Drug)
SYLATRON		2	PA, QL: 4 in 28 days (Specialty Drug)
Nucleosides and Nucleotides			
acyclovir	(Zovirax)	1	(Oral Formulations)
acyclovir	(Zovirax)	1	
entecavir	(Baraclude)	1	
famciclovir	(Famvir)	1	
ganciclovir	(Ganciclovir)	1	
ribavirin capsule: 200mg; tablet: 200mg	(Rebetol)	1	
valacyclovir hcl	(Valtrex)	1	

BARACLUDE		2	
Blood Products/Modifiers/Volume Expanders			
Anticoagulants			
enoxaparin sodium syringe: 40mg/0.4ml	(Lovenox)	1	QL: 11.2 in 14 days (Specialty Drug)
enoxaparin sodium syringe: 60mg/0.6ml	(Lovenox)	1	QL: 16.8 in 14 days
enoxaparin sodium syringe: 80mg/0.8ml, 120mg/.8ml	(Lovenox)	1	QL: 22.4 in 14 days (Specialty Drug)
enoxaparin sodium syringe: 100mg/ml, 150mg/ml; vial	(Lovenox)	1	QL: 28 in 14 days (Specialty Drug)
enoxaparin sodium syringe: 30mg/0.3ml	(Lovenox)	1	QL: 8.4 in 14 days (Specialty Drug)
fondaparinux sodium syringe: 10mg/0.8ml	(Arixtra)	1	QL: 11.2 in 14 days
fondaparinux sodium syringe: 5mg/0.4ml	(Arixtra)	1	QL: 5.6 in 14 days
fondaparinux sodium syringe: 2.5mg/0.5	(Arixtra)	1	QL: 7 in 14 days
fondaparinux sodium syringe: 7.5mg/0.6	(Arixtra)	1	QL: 8.4 in 14 days
heparin sodium,porcine vial: 5000/ml, 10000/ml, 20000/ml	(Heparin Sodium,Porcine)	1	
heparin sodium,porcine/pf vial: 1000/ml, 5000/0.5ml	(Heparin Sodium,Porcine/ PF)	1	

warfarin sodium	(Jantoven)	1	
ELIQUIS		2	
PRADAXA		2	PA
XARELTO		2	
Blood Formation Modifiers			
ARANESP		2	PA
ARANESP		2	PA (Specialty Drug)
EPOGEN		2	PA (Specialty Drug)
LEUKINE		2	PA
NEULASTA		2	PA
NEULASTA		2	PA (Specialty Drug)
NEUMEGA		2	PA
NEUPOGEN		2	PA
NEUPOGEN		2	PA (Specialty Drug)
PROCRIT		2	PA (Specialty Drug)
Hematologic Agents, Miscellaneous			
aminocaproic acid solution, tablet	(Aminocaproic Acid)	1	
anagrelide hcl	(Agrylin)	1	
ADVATE UH		2	PA (Specialty Drug)
ADVATE		2	PA (Specialty Drug)
ALPHANATE		2	PA (Specialty Drug)
ELOCTATE		2	PA
FEIBA NF		2	PA (Specialty Drug)
HELIXATE FS		2	PA (Specialty Drug)

HEMOFIL M		2	PA (Specialty Drug)
HUMATE-P		2	PA
KOATE-DVI		2	PA
KOATE-DVI		2	PA (Specialty Drug)
KOGENATE FS		2	PA (Specialty Drug)
MONOCLATE-P		2	PA (Specialty Drug)
NOVOEIGHT		2	PA
OBIZUR		2	PA
RECOMBINATE		2	PA (Specialty Drug)
WILATE		2	PA (Specialty Drug)
XYNTHA SOLOFUSE		2	PA (Specialty Drug)
XYNTHA		2	PA (Specialty Drug)
Platelet-Aggregation Inhibitors			
aspirin/dipyridamole	(Aggrenox)	1	
cilostazol	(Pletal)	1	
clopidogrel bisulfate tablet: 75mg	(Plavix)	1	QL: 30 in 30 days
dipyridamole	(Persantine)	1	
pentoxifylline	(Pentoxifylline)	1	
ticlopidine hcl	(Ticlopidine HCl)	1	
AGGRENOX		2	
EFFIENT		2	PA
Caloric Agents			
Caloric Agents			
dextrose	(Dextrose)	2	

Cardiovascular Agents			
Alpha-Adrenergic Agents			
clonidine hcl	(Catapres)	1	
doxazosin mesylate	(Cardura)	1	
guanabenz acetate	(Guanabenz Acetate)	1	
guanfacine hcl	(Tenex)	1	
methyldopa	(Methyldopa)	1	
methyldopa/hydrochlorothiazide	(Methyldopa/ Hydrochlorothiazide)	1	
midodrine hcl	(Midodrine HCl)	1	
prazosin hcl	(Minipress)	1	
phenylephrine hcl/acetaminophn capsule	(Phenylephrine HCl/ Acetaminophn)	OTC	
Angiotensin II Receptor Antagonists			
candesartan cilexetil	(Atacand)	1	
candesartan/hydrochlorothiazid	(Atacand HCT)	1	
eprosartan mesylate	(Teveten)	1	
irbesartan	(Avapro)	1	
irbesartan/hydrochlorothiazide	(Avalide)	1	
losartan potassium	(Cozaar)	1	
losartan/hydrochlorothiazide	(Hyzaar)	1	
valsartan/hydrochlorothiazide	(Diovan HCT)	1	
Angiotensin-Converting Enzyme Inhibitors			
benazepril hcl	(Lotensin)	1	

benazepril/hydrochlorothiazide	(Lotensin HCT)	1	
captopril	(Captopril)	1	
captopril/hydrochlorothiazide	(Captopril/ Hydrochlorothiazide)	1	
enalapril maleate	(Vasotec)	1	
enalapril/hydrochlorothiazide	(Vaseretic)	1	
fosinopril sodium	(Fosinopril Sodium)	1	
fosinopril/hydrochlorothiazide	(Fosinopril/ Hydrochlorothiazide)	1	
lisinopril	(Zestril)	1	
lisinopril/hydrochlorothiazide	(Zestoretic)	1	
quinapril hcl	(Accupril)	1	
quinapril/hydrochlorothiazide	(Accuretic)	1	
ramipril	(Altace)	1	
trandolapril	(Mavik)	1	
Antiarrhythmic Agents			
amiodarone hcl tablet	(Cordarone)	1	
disopyramide phosphate	(Norpace)	1	
flecainide acetate	(Tambocor)	1	
mexiletine hcl	(Mexiletine HCl)	1	
propafenone hcl tablet	(Rythmol)	1	
quinidine sulfate tablet	(Quinidine Sulfate)	1	
Beta-Adrenergic Blocking Agents			
acebutolol hcl	(Sectral)	1	
atenolol	(Tenormin)	1	

atenolol/chlorthalidone	(Tenoretic 50)	1	
betaxolol hcl	(Kerlone)	1	
bisoprolol fumarate	(Zebeta)	1	
bisoprolol fumarate/hctz	(Ziac)	1	
carvedilol	(Coreg)	1	
labetalol hcl tablet	(Trandate)	1	
metoprolol succinate	(Toprol XL)	1	
metoprolol tartrate tablet	(Lopressor)	1	
metoprolol/hydrochlorothiazide	(Lopressor HCT)	1	
nadolol	(Corgard)	1	
pindolol	(Pindolol)	1	
propranolol hcl cap sa 24h, solution, tablet	(Propranolol HCl)	1	
propranolol/hydrochlorothiazid	(Propranolol/ Hydrochlorothiazid)	1	
sotalol hcl	(Betapace AF)	1	
timolol maleate	(Timolol Maleate)	1	
Calcium-Channel Blocking Agents			
diltiazem hcl various dosage and/or strengths are available	(Cardizem CD)	1	
verapamil hcl cap24h pct, cap24h pel, tablet, tablet er	(Calan SR)	1	
Cardiovascular Agents, Miscellaneous			
AUVI-Q		1	QL: 2 per fill

digoxin tablet	(Lanoxin)	1	
DIGOXIN		1	
epinephrine auto injct	(Adrenaclick)	1	
hydralazine hcl tablet	(Hydralazine HCl)	1	
EPIPEN 2-PAK		2	QL: 2 in 30 days
EPIPEN JR 2-PAK		2	QL: 2 in 30 days
EPIPEN JR		2	QL: 2 in 30 days
Dihydropyridines			
amlodipine besylate	(Norvasc)	1	
amlodipine besylate/benazepril	(Lotrel)	1	
felodipine	(Felodipine)	1	
isradipine	(Isradipine)	1	
nifedipine	(Procardia XL)	1	
nimodipine	(Nimodipine)	1	
nisoldipine	(Sular)	1	
Diuretics			
amiloride hcl	(Midamor)	1	
amiloride/hydrochlorothiazide	(Amiloride/ Hydrochlorothiazide)	1	
bumetanide tablet	(Bumetanide)	1	
chlorothiazide	(Chlorothiazide)	1	
chlorthalidone	(Chlorthalidone)	1	
furosemide solution, tablet	(Lasix)	1	
hydrochlorothiazide	(Microzide)	1	

indapamide	(Indapamide)	1	
metolazone	(Zaroxolyn)	1	
torsemide tablet	(Demadex)	1	
triamterene/hydrochlorothiazid	(Maxzide-25 Mg)	1	
DIURIL		2	Age must be <= 2
Dyslipidemics			
atorvastatin calcium	(Lipitor)	1	
cholestyramine (with sugar)	(Questran)	1	
cholestyramine/aspartame	(Questran Light)	1	
colestipol hcl	(Colestid)	1	
fenofibrate nanocrystallized	(Tricor)	1	
fenofibrate tablet: 40mg, 54mg, 160mg	(Fenoglide)	1	
fenofibrate,micronized capsule: 67mg, 134mg, 200mg	(Antara)	1	
fenofibric acid (choline)	(Trilipix)	1	
fenofibric acid	(Fibricor)	1	
gemfibrozil	(Lopid)	1	
lovastatin	(Mevacor)	1	
niacin tab er 24h	(Niaspan)	1	
pravastatin sodium	(Pravachol)	1	
simvastatin	(Zocor)	1	
KYNAMRO		2	PA, QL: 4 in 28 days (Specialty Drug)

ZETIA		2	
niacin (inositol niacinate) capsule: 400(500mg)	(No Flush Niacin)	OTC	
NIACIN FLUSH FREE		OTC	
niacin capsule er: 125mg, 250mg, 500mg; tablet: 50mg, 100mg, 500mg; tablet er: 1000mg	(Niacin)	OTC	
niacinamide	(Niacinamide)	OTC	
omega-3 fatty acids/fish oil	(Fish Oil Omega-3)	OTC	
Renin-Angiotensin-Aldosterone System Inhibitors			
eplerenone	(Inspra)	1	
spironolact/hydrochlorothiazid	(Aldactazide)	1	
spironolactone	(Aldactone)	1	
Vasodilators			
isosorbide dinitrate	(Isordil Titradose)	1	
isosorbide mononitrate	(Imdur)	1	
minoxidil	(Minoxidil)	1	
nitroglycerin capsule er, patch td24	(Nitro-Dur)	1	
NITROSTAT		2	
Central Nervous System Agents			
Central Nervous System Agents			
caffeine citrated solution	(Cafcit)	1	Age must be <= 2

dexmethylphenidate hcl tablet	(Focalin)	1	Age must be <= 21, QL: 60 in 30 days (PA Required for > 21)
dextroamphetamine sulfate capsule er: 5mg	(Dexedrine)	1	Age must be <= 21, QL: 30 in 30 days (PA Required for > 21)
dextroamphetamine sulfate capsule er: 10mg, 15mg; tablet: 5mg, 10mg	(Dextroamphetamine Sulfate)	1	Age must be <= 21, QL: 120 in 30 days (PA Required for > 21)
dextroamphetamine/amphetamine cap er 24h: 5mg, 10mg, 15mg, 25mg	(Adderall XR)	1	Age must be <= 21, QL: 30 in 30 days (PA Required for > 21)
dextroamphetamine/amphetamine cap er 24h: 20mg, 30mg; tablet: 15mg, 30mg	(Adderall XR)	1	Age must be <= 21, QL: 60 in 30 days (PA Required for > 21)
dextroamphetamine/amphetamine tablet: 20mg	(Adderall)	1	Age must be <= 21, QL: 3 in 1 days
dextroamphetamine/amphetamine cap er 24h: 20mg, 30mg; tablet: 15mg, 30mg	(Adderall)	1	Age must be <= 21, QL: 60 in 30 days
dextroamphetamine/amphetamine tablet: 5mg, 7.5mg, 10mg, 12.5mg, 20mg	(Adderall)	1	Age must be <= 21, QL: 90 in 30 days (PA Required for > 21)
lithium carbonate	(Lithium Carbonate)	1	
lithium citrate	(Lithium Citrate)	1	

methylphenidate hcl cpbp 30-70: 20mg, 40mg, 50mg, 60mg; tab er 24: 18mg, 27mg, 54mg; tablet er: 10mg	(Concerta)	1	Age must be <= 21, QL: 30 in 30 days (PA Required for > 21)
methylphenidate hcl cpbp 50-50, tab er 24: 36mg	(Concerta)	1	Age must be <= 21, QL: 60 in 30 days (PA Required for > 21)
methylphenidate hcl cpbp 30-70: 10mg	(Metadate Cd)	1	Age must be <= 21, QL: 120 in 30 days (PA Required for > 21)
methylphenidate hcl solution	(Methylin)	1	Age must be <= 21, QL: 450 in 30 days (PA Required for > 21)
methylphenidate hcl tablet, tablet er: 20mg	(Ritalin)	1	Age must be <= 21, QL: 90 in 30 days (PA Required for > 21)
AMPYRA		2	PA, QL: 60 in 30 days (Specialty Drug)
STRATTERA capsule: 10mg, 40mg, 60mg, 80mg, 100mg		2	Age must be <= 21, ST, QL: 30 in 30 days (PA Required for > 21)
STRATTERA capsule: 18mg		2	Age must be <= 21, ST, QL: 60 in 30 days (PA Required for > 21)

STRATTERA capsule: 25mg		2	Age must be <= 21, ST, QL: 90 in 30 days (PA Required for > 21)
Contraceptives			
Contraceptives			
AMETHYST		1	
desog-e.estradiol/e.estradiol	(Mircette)	1	
desogestrel-ethinyl estradiol	(Velivet)	1	
ethinyl estradiol/drospirenone	(Yaz)	1	
ethynodiol d-ethinyl estradiol	(Ethynodiol D-Ethinyl Estradiol)	1	
levonorgestrel tablet: 0.75mg, 1.5mg	(Plan B One-Step)	1	
levonorgestrel-ethin estradiol tablet	(Amethyst)	1	
l-norgest/e.estradion-e.estrad tbdspk 3mo: 100-20(84), 150-30(84)	(Seasonique)	1	
noreth-ethinyl estradiol/iron	(Generess Fe)	1	
norethindrone ac-eth estradiol	(Loestrin)	1	
norethindrone	(Ortho Micronor)	1	
norethindrone-e.estradiol-iron	(Loestrin 24 Fe)	1	
norethindrone-ethinyl estrad	(Ortho-Novum)	1	
norethindrone-mestranol	(Norinyl 1+50)	1	
norgestimate-ethinyl estradiol	(Ortho Tri-Cyclen)	1	

norgestrel-ethinyl estradiol	(Norgestrel-Ethinyl Estradiol)	1	
CAYA CONTOURED		2	
FEMCAP		2	
ORTHO ALL-FLEX each		2	
ORTHO ALL-FLEX kit		2	
WIDE SEAL DIAPHRAGM		2	
AIMSCO		OTC	
CONCEPTROL		OTC	
CONDOMS		OTC	QL: 48 in 30 days
DUREX AVANTI BARE		OTC	QL: 48 in 30 days
FANTASY		OTC	QL: 48 in 30 days
FC CONDOM, FEMALE		OTC	QL: 48 in 30 days
FC2 FEMALE CONDOM		OTC	
GYNOL II		OTC	
KIMONO MAXX		OTC	QL: 48 in 30 days
KIMONO MICROTHIN AQUA LUBE		OTC	QL: 48 in 30 days
KIMONO MICROTHIN each: n/a		OTC	QL: 48 in 30 days
KIMONO MICROTHIN each: n/a		OTC	QL: 48 in 30 days
KIMONO TEXTURED		OTC	QL: 48 in 30 days
KIMONO		OTC	QL: 48 in 30 days
levonorgestrel tablet: 1.5mg	(Levonorgestrel)	OTC	
nonoxynol 9	(Nonoxynol 9)	OTC	

REALITY		OTC	QL: 48 in 30 days
TODAY CONTRACEPTIVE SPONGE		OTC	
TRUSTEX CONDOM		OTC	QL: 48 in 30 days
TRUSTEX LATEX CONDOM		OTC	QL: 48 in 30 days
TRUSTEX		OTC	QL: 48 in 30 days
TRUSTEX-RIA each: n/a		OTC	QL: 48 in 30 days
TRUSTEX-RIA each: n/a		OTC	QL: 48 in 30 days
VCF		OTC	
Cough And Cold Products			
Cough And Cold Products			
benzonatate capsule: 100mg, 200mg	(Zonatuss)	1	Age must be <= 20
bromphenira/pseudoephed/codein liquid: 1.3-10-6.3	(Bromphenira/Pseudoephed/ Codein)	1	Age must be <= 20
brompheniram/phenylephrine/dm liquid: 2-5-10mg/5, 4-10-20/5	(Ala-Hist Dm)	1	Age must be <= 20
guaifenesin/codeine phosphate liquid: 100-10mg/5, 100-6.3/5, 225-7.5/5	(M-Clear Wc)	1	Age must be <= 20
guaifenesin/dm/pseudoephedrine tablet: 400-20-60	(Poly-Vent Dm)	1	Age must be <= 20
hydrocodone bit/homatrop me-br	(Hydrocodone Bit/Homatrop Me-Br)	1	Age must be <= 20

hydrocodone/chlorphen p-stirex	(Hydrocodone/Chlorphen P-Stirex)	1	Age must be <= 20
promethazine hcl/codeine	(Promethazine HCl/Codeine)	1	Age must be <= 20
dextromethorphan hbr syrup: 5mg/5ml	(Dextromethorphan Hbr)	OTC	Age must be <= 20
dm/p-ephed/acetaminoph/doxylam capsule: 15-30-325	(Dm/P-Ephed/Acetaminoph/ Doxylam)	OTC	Age must be <= 20
guaifenesin liquid: 100mg/5ml	(Robitussin Mucus-Chest Congest)	OTC	Age must be <= 20
pseudoephedrine hcl liquid: 30mg/5ml	(Pseudoephedrine HCl)	OTC	
Dental And Oral Agents			
Dental And Oral Agents			
chlorhexidine gluconate	(Peridex)	1	
pilocarpine hcl	(Salagen)	1	
sodium fluoride cream (g), gel (gram), solution: 0.2%	(Prevident 5000 Plus)	1	
stannous fluoride soln(gram)	(Stannous Fluoride)	1	
triamcinolone acetonide	(Triamcinolone Acetonide)	1	
Dermatological Agents			
Dermatological Agents, Other			
ammonium lactate cream (g): 12%; lotion: 12%	(Lac-Hydrin)	1	
benzoyl peroxide and skin cleansr5	(Benzoyl Peroxide and Skin Cleansr5)	1	

benzoyl peroxide microspheres	(Benzoyl Peroxide Microspheres)	1	
benzoyl peroxide various dosage and/or strengths are available	(Benzoyl Peroxide)	1	
BP WASH cleanser: 2.5%, 10%		1	
calcipotriene	(Dovonex)	1	
fluorouracil	(Carac)	1	
imiquimod	(Aldara)	1	
isotretinoin	(Isotretinoin)	1	PA
lactic acid	(Lactic Acid)	1	
lidocaine hcl cream (g)	(Lidocaine HCl)	1	
lidocaine/hydrocortisone ac	(Lidocaine/Hydrocortisone Ac)	1	
podofilox	(Condylox)	1	
pramoxine hcl foam	(Proctofoam)	1	
salicylic acid cream (g), lotion: 6%; shampoo: 6%	(Salacyn)	1	
salicylic acid/ceramide cmb #1	(Salex)	1	
sulfacetamide sodium cleanser: 10%	(Sulfacetamide Sodium)	1	
sulfacetamide sodium/sulfur various dosage and/or strengths are available	(Sumadan)	1	
urea cream (g), foam: 35%; gel (ml), gel/pf app, lotion, sol/pf app	(Aluvea)	1	

SANTYL		2	
ACNE MEDICATION		OTC	
ALUMINUM ACETATE powd pack		OTC	
benzoyl peroxide lotion: 10%	(Benzoyl Peroxide)	OTC	
cod liver oil/zinc oxide oint. (g): 40%	(Cod Liver Oil/Zinc Oxide)	OTC	
DR. SMITH'S RASH-SKIN		OTC	
KENDALL SOOTHING		OTC	
zinc oxide oint. (g): 20%; paste (g)	(Boudreauxs)	OTC	
zinc oxide/petrolatum,white cream (g), oint. (g): n/a	(Zinc Oxide/ Petrolatum,White)	OTC	
Dermatological Antibacterials			
clindamycin phos/benzoyl perox	(Duac)	1	
clindamycin phosphate foam, gel (gram), lotion, med. swab, solution: 1%	(Cleocin T)	1	
EMGEL		1	
erythromycin base/ethanol	(Emgel)	1	
erythromycin/benzoyl peroxide	(Benzamycin)	1	
gentamicin sulfate	(Gentamicin Sulfate)	1	
metronidazole cream (g): 0.75%; gel (gram), lotion	(Metrogel)	1	
mupirocin calcium	(Bactroban)	1	

mupirocin	(Bactroban)	1	
selenium sulfide	(Selenium Sulfide)	1	
silver sulfadiazine	(Silvadene)	1	
sulfacetamide sodium	(Klaron)	1	
bacitracin zinc	(Bacitracin Zinc)	OTC	
bacitracin/polymyxin b sulfate packet	(Bacitracin/Polymyxin B Sulfate)	OTC	
neomycn/baci zn/pmyx bs/pramox oint. (g): 3.5-10k-10	(Neomycn/Baci Zn/Pmyx Bs/Pramox)	OTC	
Dermatological Anti-Inflammatory Agents			
amcinonide	(Amcinonide)	1	
betamethasone dipropionate	(Betamethasone Dipropionate)	1	
betamethasone valerate cream (g), lotion, oint. (g)	(Betamethasone Valerate)	1	
betamethasone/propylene glyc	(Diprolene AF)	1	
clobetasol propionate cream (g), foam, gel (gram), lotion, oint. (g), shampoo, solution	(Temovate)	1	
desonide cream (g), lotion: 0.05%; oint. (g): 0.05%	(Desowen)	1	
desoximetasone	(Topicort)	1	
diflorasone diacetate	(Apexicon)	1	
fluocinolone acetonide	(Synalar)	1	
fluocinolone/shower cap	(Derma-Smoothe-Fs)	1	

fluocinonide cream (g): 0.05%; gel (gram), oint. (g), solution	(Vanos)	1	
fluticasone propionate	(Cutivate)	1	
hydrocort/pramoxn/skn clnsr#16	(Hydrocort/Pramoxn/Skn Clnsr#16)	1	
hydrocortisone butyrate	(Locoid)	1	
hydrocortisone valerate	(Hydrocortisone Valerate)	1	
hydrocortisone cream (g): 1%, 2.5%; cream/appl, enema, lotion: 2.5%; oint. (g): 1%, 2.5%	(Anusol-HC)	1	
hydrocortisone/iodoquinol	(Hydrocortisone/Iodoquinol)	1	
hydrocortisone/pramoxine cream (g)	(Hydrocortisone/Pramoxine)	1	
lidocaine/hydrocortisone ac	(Lidocaine/Hydrocortisone Ac)	1	
mometasone furoate	(Elocon)	1	
tacrolimus	(Protopic)	1	PA
triamcinolone acetonide cream (g): 0.025%, 0.1%, 0.5%; lotion, oint. (g)	(Triamcinolone Acetonide)	1	
ELIDEL		2	PA
PROCTOFOAM-HC		2	
PROTOPIC		2	PA
hydrocortisone oint. (g): 0.5%	(Hydrocortisone)	OTC	
Dermatological Retinoids			

adapalene cream (g), gel (gram): 0.1%	(Differin)	1	
tretinoin microspheres	(Retin-A Micro)	1	Age must be <= 30
tretinoin	(Retin-A)	1	Age must be <= 30
tretinoin	(Retin-A)	1	Age must be <= 30 (PA Required for > 30)
tretinoin/emollient base	(Tretinoin/Emollient Base)	1	Age must be <= 30 (PA Required for > 30)
Scabicides and Pediculicides			
lindane	(Lindane)	1	
malathion	(Ovide)	1	
permethrin cream (g)	(Elimite)	1	
permethrin spray: 0.5%	(Permethrin)	OTC	
pip butox/pyrethrins/permeth kit: 4-.33-.5%	(Pip Butox/Pyrethrins/ Permeth)	OTC	
piperonyl butoxide/pyrethrins spray	(Piperonyl Butoxide/ Pyrethrins)	OTC	
Devices			
Devices			
1ST CHOICE LANCETS		2	
1ST TIER UNILET COMFORTOUCH		2	
ACCU-CHEK FASTCLIX		2	

ACCU-CHEK SAFE-T-PRO PLUS	2	
ACCU-CHEK SAFE-T-PRO	2	
ACCU-CHEK SOFTCLIX	2	
ACCU-CHEK	2	
ACTI-LANCE	2	
ADVANCED TRAVEL LANCETS	2	
ADVOCATE LANCET	2	
ADVOCATE LANCETS	2	
ALTERNATE SITE LANCETS	2	
ASSURE HAEMOLANCE PLUS each: 18gauge, 21gauge, 25gauge, 28gauge	2	
ASSURE LANCE PLUS	2	
ASSURE LANCE	2	
AURORA SUPER THIN LANCETS	2	
BD MICROTAINER LANCETS	2	
BD ULTRA-FINE II	2	
BD ULTRA-FINE	2	
BULLSEYE MINI SAFETY LANCETS	2	
CAREONE	2	
CARESENS	2	

CLEVER CHEK LANCETS	2	
COAGUCHEK	2	
COLOR LANCETS	2	
COMFORT EZ	2	
COMFORT LANCETS	2	
DROPLET LANCETS	2	
EASY COMFORT	2	
EASY TOUCH LANCETS	2	
EASY TOUCH	2	
EASY TWIST AND CAP LANCETS	2	
ECLIPSE LUER-LOK SYRINGE	2	
EMBRACE	2	
E-Z JECT LANCETS	2	
EZ SMART LANCETS	2	
E-ZJECT LANCETS	2	
FIFTY50 SAFETY SEAL LANCETS	2	
FINE 30 UNIVERSAL LANCETS	2	
FINGERSTIX	2	
FORACARE LANCETS	2	
FREESTYLE LANCETS	2	
FREESTYLE UNISTIK 2	2	
GLUCOCOM LANCETS	2	

GLUCOCOM	2	
GLUCOSOURCE	2	
GMATE	2	
HAEMOLANCE PLUS	2	
HAEMOLANCE, RETRACTABLE	2	
HAEMOLANCE	2	
HEALTHY ACCENTS UNILET LANCET	2	
INCONTROL SUPER THIN LANCETS	2	
INCONTROL ULTRA THIN LANCETS	2	
INJECT EASE LANCETS	2	
INVACARE LANCETS	2	
KINNEY BRAND LANCETS	2	
LANCETS THIN	2	
LANCETS ULTRA THIN	2	
LANCETS	2	
LANCING DEVICE	2	
LITE TOUCH	2	
MEDI-LANCE	2	
MEDISENSE THIN LANCETS	2	
MEDLANCE PLUS	2	
MICRO THIN LANCETS	2	

MICROLET	2	
MICROTAINER LANCETS	2	
MONOJECT INSULIN SYRINGE	2	
MONOLET LANCETS	2	
MONOLET THIN LANCETS	2	
MYGLUCOHEALTH LANCETS	2	
NOVA SAFETY LANCETS	2	
NOVA SUREFLEX	2	
ON CALL LANCET	2	
ON CALL PLUS LANCET	2	
ONE TOUCH DELICA each	2	
ONE TOUCH DELICA kit	2	QL: 1 in 730 days
ONE TOUCH GLUCOSE CONTROL SOLN	2	
ONE TOUCH VERIO each: n/a	2	
ONE TOUCH VERIO each: n/a	2	
ONE TOUCH VERIO strip	2	QL: 200 in 30 days
ONETOUCH DELICA each	2	
ONETOUCH DELICA kit	2	QL: 1 in 730 days
ONETOUCH FINEPOINT LANCETS	2	
ONETOUCH LANCETS	2	
ONETOUCH SURESOFT	2	QL: 1 in 730 days

ONETOUCH ULTRA CONTROL SOLN		2	
ONETOUCH ULTRA SMART		2	QL: 1 in 730 days
ONETOUCH ULTRA SYSTEM		2	QL: 1 in 730 days
ONETOUCH ULTRA TEST STRIPS		2	QL: 200 in 30 days
ONETOUCH ULTRA2		2	QL: 1 in 730 days
ONETOUCH ULTRALINK		2	QL: 1 in 730 days
ONETOUCH ULTRAMINI		2	QL: 1 in 730 days
ONETOUCH VERIO IQ		2	
ONETOUCH VERIO SYNC		2	QL: 1 in 730 days
ONETOUCH VERIO each: n/a		2	
ONETOUCH VERIO each: n/a		2	
ONETOUCH VERIO each: n/a		2	
ONETOUCH VERIO strip		2	QL: 200 in 30 days
ON-THE-GO		2	
OPTICHAMBER DIAMOND		2	
OPTICHAMBER each		2	
OPTICHAMBER spacer		2	
pen needle, diabetic	(Pen Needle, Diabetic)	2	
pen needle, diabetic, safety	(Pen Needle, Diabetic, Safety)	2	
PENLET PLUS BLOOD SAMPLER		2	

PRESSURE ACTIVATED LANCETS	2	
PRODIGY LANCETS	2	
PRODIGY TWIST TOP LANCET	2	
PUSH BUTTON SAFETY LANCETS	2	
RELIAMED SAFETY SEAL LANCETS	2	
RELIAMED	2	
RELION THIN	2	
RENEW ADVANCED MICRO-LANCETS	2	
RIGHTEST GL300 LANCETS	2	
SAFETY LANCETS	2	
SAFETY SEAL LANCETS	2	
SAFETY-LET	2	
SINGLE-LET	2	
SMART SENSE LANCETS	2	
SMART SENSE	2	
SMARTDIABETES VANTAGE	2	
SMARTEST LANCET	2	
SOFT TOUCH	2	
SOLUS V2 LANCETS	2	
SOLUS V2	2	

STERILANCE TL		2	
SUPER THIN LANCETS		2	
SURE COMFORT LANCETS		2	
SURE-LANCE		2	
SURESTEP PRO kit		2	
SURESTEP PRO strip		2	QL: 200 in 30 days
SURE-TOUCH		2	
syring w-ndl,disp,insul,0.3 ml	(Syring W-Ndl,Disp,Insul,0.3 Ml)	2	
syring w-ndl,disp,insul,0.5 ml	(Syring W-Ndl,Disp,Insul,0.5 Ml)	2	
syringe and needle,insulin,1 ml	(Syringe and Needle,Insulin,1 Ml)	2	
TECHLITE BLOOD LANCET		2	
TECHLITE LANCETS		2	
TELCARE		2	
THIN LANCETS		2	
TOPCARE UNIVERSAL1 THIN LANCET		2	
TRUEPLUS LANCETS		2	
ULTICARE disp syrin		2	
ULTICARE each		2	
ULTILET BASIC		2	
ULTILET CLASSIC		2	
ULTILET LANCETS		2	

ULTILET SAFETY	2	
ULTRA THIN II	2	
ULTRA THIN LANCETS	2	
ULTRA THIN PLUS LANCETS	2	
ULTRA THIN PLUS	2	
ULTRALANCE	2	
ULTRA-THIN II LANCETS	2	
ULTRA-THIN II	2	
ULTRATLC LANCETS	2	
UNILET COMFORTOUCH	2	
UNILET EXCELITE II	2	
UNILET EXCELITE	2	
UNILET GP LANCET	2	
UNILET LANCET	2	
UNILET LANCETS	2	
UNISTIK 3 EXTRA	2	
UNISTIK 3	2	
UNISTIK CZT	2	
UNISTIK SAFETY	2	
UNIVERSAL 1	2	
Enzyme Replacement/Modifiers		
Enzyme Replacement/Modifiers		
lipase/protease/amylase (Zenpep)	1	
CIMZIA syringekit	2	PA (Specialty Drug)

CREON		2	
CYSTAGON		2	(Specialty Drug)
KUVAN		2	PA
KUVAN		2	PA (Specialty Drug)
PULMOZYME		2	PA, QL: 75 in 30 days
ZAVESCA		2	PA (Specialty Drug)
ZENPEP		2	
Eye, Ear, Nose, Throat Agents			
Eye, Ear, Nose, Throat Agents, Miscellaneous			
atropine sulfate	(Isopto Atropine)	1	
azelastine hcl spray/pump: 137mcg	(Astepro)	1	QL: 1.2 in 1 days
azelastine hcl drops	(Optivar)	1	
carteolol hcl	(Carteolol HCl)	1	
cromolyn sodium	(Cromolyn Sodium)	1	
cyclopentolate hcl drops: 1%	(Cyclogyl)	1	
epinastine hcl	(Elestat)	1	
homatropine hbr	(Isopto Homatropine)	1	
ipratropium bromide spray: 21mcg	(Atrovent)	1	QL: 1.1 in 1 days
ipratropium bromide spray: 42mcg	(Atrovent)	1	QL: 1.5 in 1 days
naphazoline hcl	(Naphazoline HCl)	1	
phenylephrine hcl drops: 2.5%, 10%	(Mydfrin)	1	
oxymetazoline hcl spray: 0.05%	(Afrin)	OTC	
phenol	(Phenol)	OTC	

phenylephrine hcl spray: 1%	(Neo-Synephrine)	OTC	
polyethylene glycol/polyvinyl	(Polyethylene Glycol/ Polyvinyl)	OTC	
polyvinyl alcohol drops: 1.4%	(Polyvinyl Alcohol)	OTC	
sodium chloride drops: 5%; oint. (g): 5%; spray: 0.65%	(Sodium Chloride)	OTC	
Eye, Ear, Nose, Throat Anti-Infectives Agents			
acetic acid	(Acetic Acid)	1	
acetic acid/hydrocortisone	(Vosol HC)	1	
antipyrine/benzocaine	(Antipyrine/Benzocaine)	1	
bacitracin	(Bacitracin)	1	
bacitracin/polymyxin b sulfate	(Bacitracin/Polymyxin B Sulfate)	1	
ciprofloxacin hcl	(Ciloxan)	1	
erythromycin base oint. (g): 5mg/g	(Erythromycin Base)	1	
gentamicin sulfate	(Garamycin)	1	
levofloxacin	(Levofloxacin)	1	
neo/polymyx b sulf/dexameth	(Maxitrol)	1	
neomycin su/baci zn/poly/hc	(Neomycin Su/Baci Zn/Poly/ HC)	1	
neomycin su/bacitra/polymyxin oint. (g): 3.5mg-400	(Triple Antibiotic)	1	
neomycin/polymyxin b sulf/hc	(Cortisporin)	1	
neomycin/polymyxn b/gramicidin	(Neosporin)	1	
ofloxacin	(Ocuflox)	1	

polymyxin b sulf/trimethoprim	(Polytrim)	1	
sulfacetamide sodium	(Sulfacetamide Sodium)	1	
sulfacetamide/prednisolone sp	(Sulfacetamide/Prednisolone Sp)	1	
tobramycin	(Tobrex)	1	
tobramycin/dexamethasone	(Tobradex)	1	
trifluridine	(Viroptic)	1	
Eye, Ear, Nose, Throat Anti-Inflammatory Agents			
dexamethasone sod phosphate	(Dexasol)	1	
diclofenac sodium	(Diclofenac Sodium)	1	
flunisolide spray: 29mcg	(Flunisolide)	1	
flunisolide spray: 25mcg	(Flunisolide)	1	QL: 1 in 1 days
fluocinolone acetonide oil	(Dermotic)	1	
fluorometholone	(FML)	1	
fluticasone propionate	(Flonase)	1	QL: 0.54 in 1 days
ketorolac tromethamine	(Acular LS)	1	
prednisolone acetate	(Pred Forte)	1	
prednisolone sod phosphate	(Prednisolone Sod Phosphate)	1	
triamcinolone acetonide	(Nasacort Aq)	1	QL: 0.57 in 1 days
Gastrointestinal Agents			
Antiflatulents			
simethicone capsule: 125mg, 180mg	(Gas-X)	OTC	
Antiulcer Agents And Acid Suppressants			

cimetidine hcl solution	(Cimetidine HCl)	1	
cimetidine tablet: 200mg, 300mg, 400mg, 800mg	(Cimetidine)	1	
famotidine oral susp, tablet: 20mg, 40mg	(Pepcid)	1	
lansoprazole	(Prevacid)	1	
misoprostol	(Cytotec)	1	
nizatidine	(Axid)	1	
omeprazole capsule dr	(Prilosec)	1	
pantoprazole sodium tablet dr	(Protonix)	1	
rabeprazole sodium	(Aciphex)	1	
ranitidine hcl capsule, syrup, tablet: 150mg, 300mg	(Zantac)	1	
sucralfate	(Carafate)	1	
NEXIUM susp dr pkt		2	
PREVACID tab rap dr		2	QL: 30 in 30 days
PROTONIX granpkt dr		2	
cimetidine tablet: 200mg	(Tagamet Hb)	OTC	
omeprazole tablet dr	(Omeprazole)	OTC	
ranitidine hcl tablet: 75mg	(Zantac 75)	OTC	
Gastrointestinal Agents, Other			
cromolyn sodium	(Gastrocrom)	1	
dicyclomine hcl capsule, solution, tablet	(Bentyl)	1	

diphenoxylate hcl/atropine	(Lomotil)	1	
glycopyrrolate tablet	(Robinul)	1	
hyoscyamine sulfate drops, elixir, tab rapdis, tab subl, tablet	(Levsin-Sl)	1	
lactulose solution: 10g/15ml	(Lactulose)	1	
loperamide hcl capsule: 2mg	(Loperamide HCl)	1	
metoclopramide hcl solution, tablet	(Reglan)	1	
sodium bicarbonate tablet: 325mg	(Sodium Bicarbonate)	1	
ursodiol	(Actigall)	1	
CHOLBAM		2	PA
aluminum hydroxide	(Aluminum Hydroxide)	OTC	
bismuth subsalicylate oral susp: 262mg/15ml, 525mg/ 15ml; tab chew: 262mg; tablet: 262mg	(Pepto-Bismol)	OTC	
calcium carbonate tab chew: 200(500)mg, 300mg(750), 400(1000), 500(1250), 600mg	(Tums)	OTC	
loperamide hcl liquid: 1mg/5ml; tablet: 2mg	(Imodium A-D)	OTC	
mag carb/al hydrox/alginic ac oral susp: 358-95/15	(Gaviscon)	OTC	
mag hydrox/al hydrox/simeth oral susp: 200-200-20	(Rulox)	OTC	
magnesium carbonate/al hydrox tab chew: 105-160mg	(Magnesium Carbonate/Al Hydrox)	OTC	

magnesium oxide tablet: 400mg	(Magox 400)	OTC	
mg trisilicate/alh/nahco3/aa	(Gaviscon)	OTC	
Laxatives			
bisac/nacl/nahco3/kcl/peg 3350	(Halflytely-Bisacodyl)	1	
peg 3350/na sulf,bicarb,cl/kcl	(Golytely)	1	
polyethylene glycol 3350 powd pack: 17g	(Polyethylene Glycol 3350)	1	
sodium chloride/nahco3/kcl/peg	(Nulytely with Flavor Packs)	1	
bisacodyl supp.rect: 10mg; tablet	(Dulcolax)	OTC	
calcium polycarbophil tablet: 625mg	(Fibercon)	OTC	
docusate sodium syrup: 60mg/15ml	(Docusate Sodium)	OTC	
magnesium citrate solution: n/a	(Magnesium Citrate)	OTC	
magnesium hydroxide oral susp: 400mg/5ml	(Phillips' Milk Of Magnesia)	OTC	
methylcellulose (with sugar) powder: 2g/19g	(Methylcellulose (With Sugar))	OTC	
methylcellulose tablet	(Citrucel)	OTC	
MILK OF MAGNESIA		OTC	
psyllium husk capsule: 0.52g	(Metamucil)	OTC	
psyllium seed (with dextrose) powder: n/a	(Psyllium Seed (With Dextrose))	OTC	
sennosides/docusate sodium tablet: 8.6mg-50mg	(Sennosides/Docusate Sodium)	OTC	

Phosphate Binders			
calcium acetate	(Phoslo)	1	
sodium polystyrene sulfonate	(Sodium Polystyrene Sulfonate)	1	
FOSRENOL tab chew		2	
RENAGEL		2	
RENVELA		2	PA
Genitourinary Agents			
Antispasmodics, Urinary			
flavoxate hcl	(Flavoxate HCl)	1	
oxybutynin chloride	(Oxybutynin Chloride)	1	
tolterodine tartrate tablet	(Detrol)	1	
trospium chloride tablet	(Sanctura)	1	
Genitourinary Agents, Miscellaneous			
alfuzosin hcl	(Uroxatral)	1	
phenazopyridine hcl	(Phenazopyridine HCl)	1	
tamsulosin hcl	(Flomax)	1	
terazosin hcl	(Terazosin HCl)	1	
Hormonal Agents, Stimulant/Replacement/Modifying			
Androgens			
danazol	(Danazol)	1	
fluoxymesterone	(Fluoxymesterone)	1	
oxandrolone	(Oxandrin)	1	
testosterone cypionate	(Depo-Testosterone)	1	

testosterone enanthate	(Delatestryl)	1	
ANDRODERM		2	PA
Estrogens and Antiestrogens			
estradiol tablet	(Estrace)	1	
estradiol/norethindrone acet	(Activella)	1	
estropipate	(Estropipate)	1	
raloxifene hcl	(Evista)	1	
EVISTA		2	
PREMARIN cream/appl, tablet		2	
PREMPHASE		2	
PREMPRO		2	
Glucocorticoids/Mineralocorticoids			
cortisone acetate	(Cortisone Acetate)	1	
dexamethasone acetate	(Dexamethasone Acetate)	1	
dexamethasone sod phosphate	(Dexamethasone Sod Phosphate)	1	
dexamethasone	(Dexamethasone)	1	
fludrocortisone acetate	(Fludrocortisone Acetate)	1	
hydrocortisone	(Cortef)	1	
methylprednisolone	(Medrol)	1	
prednisolone sod phosphate solution: 5mg/5ml	(Orapred)	1	
prednisolone solution: 15mg/5ml	(Prednisolone)	1	
prednisone	(Prednisone)	1	

Pituitary			
desmopressin acetate tablet	(DDAVP)	1	
desmopressin acetate solution, spray/pump	(DDAVP)	1	QL: 0.3 in 1 days
GENOTROPIN		2	PA (Specialty Drug)
NORDITROPIN FLEXPRO		2	PA
NORDITROPIN FLEXPRO		2	PA (Specialty Drug)
SOMATULINE DEPOT		2	PA, QL: 1 in 28 days
Progestins			
HYDROXYPROGESTERONE CAPROATE		1	
medroxyprogesterone acetate syringe	(Depo-Provera)	1	QL: 1 in 84 days
medroxyprogesterone acetate tablet, vial	(Provera)	1	
norethindrone acetate	(Aygestin)	1	
progesterone	(Progesterone)	1	
progesterone,micronized	(Prometrium)	1	
Thyroid and Antithyroid Agents			
levothyroxine sodium tablet	(Synthroid)	1	
liothyronine sodium tablet	(Cytomel)	1	
methimazole tablet: 5mg, 10mg	(Tapazole)	1	
potassium iodide	(Potassium Iodide)	1	
potassium iodide/iodine	(Potassium Iodide/Iodine)	1	

propylthiouracil	(Propylthiouracil)	1	
ARMOUR THYROID		2	
Immunological Agents			
Immunological Agents			
azathioprine	(Imuran)	1	
cyclosporine capsule, solution	(Sandimmune)	1	
cyclosporine, modified	(Neoral)	1	
leflunomide	(Arava)	1	
mycophenolate mofetil capsule, tablet	(Cellcept)	1	
sirolimus	(Rapamune)	1	
tacrolimus	(Prograf)	1	
ENBREL pen injctr, syringe		2	PA, QL: 4 in 14 days (Specialty Drug)
ENBREL pen injctr, syringe		2	PA, QL: 4 in 14 days
ENBREL vial		2	PA, QL: 8 in 14 days (Specialty Drug)
HUMIRA PEN CROHN'S-UC-HS		2	PA, QL: 6 in 28 days (Specialty Drug - Starter Kit for Crohn's/ Ulcerative Colitis)
HUMIRA PEN		2	PA, QL: 4 in 28 days (Specialty Drug)

HUMIRA syringekit: 10mg/0.2ml, 20mg/0.4ml		2	PA, QL: 2 in 28 days (Specialty Drug)
HUMIRA syringekit: 10mg/0.2ml, 20mg/0.4ml		2	PA, QL: 2 in 28 days
HUMIRA syringekit: 40mg/0.8ml		2	PA, QL: 4 in 28 days
KINERET		2	PA
ORENCIA syringe		2	PA, QL: 4 in 28 days
RAPAMUNE		2	PA
RIDAURA		2	
ZORTRESS		2	PA
Vaccines			
VIVOTIF BERNA		2	QL: 4 per fill
Inflammatory Bowel Disease Agents			
Inflammatory Bowel Disease Agents			
balsalazide disodium	(Colazal)	1	
budesonide	(Entocort EC)	1	
mesalamine	(Sfrowasa)	1	
ASACOL HD		2	
DELZICOL		2	
Metabolic Bone Disease Agents			
Metabolic Bone Disease Agents			
alendronate sodium	(Fosamax)	1	
calcitonin,salmon,synthetic	(Miacalcin)	1	QL: 0.13 in 1 days
calcitriol capsule, solution	(Rocaltrol)	1	

ibandronate sodium tablet	(Boniva)	1	
FORTEO		2	PA, QL: 3 in 28 days (Specialty Drug)
Miscellaneous Therapeutic Agents			
Miscellaneous Therapeutic Agents			
allopurinol	(Zyloprim)	1	
bethanechol chloride	(Urecholine)	1	
buspirone hcl	(Buspirone HCl)	1	
colchicine/probenecid	(Colchicine/Probenecid)	1	
finasteride tablet: 5mg	(Propecia)	1	
hydroxyzine hcl solution, tablet	(Hydroxyzine HCl)	1	
hydroxyzine pamoate	(Vistaril)	1	
leucovorin calcium tablet	(Leucovorin Calcium)	1	
levocarnitine (with sugar)	(Carnitor)	1	
levocarnitine tablet	(Carnitor)	1	
methylergonovine maleate tablet	(Methergine)	1	
ORA PLUS		1	
ORA SWEET		1	
ORA-BLEND SF		1	
ORA-BLEND		1	
ORA-SWEET-SF		1	
probenecid	(Probenecid)	1	
pyridostigmine bromide tablet	(Mestinon)	1	
water for injection,sterile	(Water For Injection,Sterile)	1	

AVONEX ADMINISTRATION PACK		2	PA (Specialty Drug)
AVONEX PEN		2	PA
AVONEX		2	PA (Specialty Drug)
BETASERON		2	
COPAXONE syringe: 40mg/ml		2	QL: 12 in 28 days (Specialty Drug)
COPAXONE syringe: 20mg/ml		2	QL: 30 in 30 days (Specialty Drug)
GILENYA		2	(Specialty Drug)
GLUCAGEN		2	QL: 2 in 30 days
GLUCAGON EMERGENCY KIT		2	QL: 2 in 30 days
REBIF REBIDOSE		2	PA (Specialty Drug)
REBIF		2	PA (Specialty Drug)
STELARA syringe		2	PA
SYNAREL		2	PA, QL: 0.89 in 1 days
TECFIDERA		2	(Specialty Drug)
melatonin tablet: 3mg	(Melatonin)	OTC	
MELATONIN tablet		OTC	
Ophthalmic Agents			
Antiglaucoma Agents			
acetazolamide	(Acetazolamide)	1	
betaxolol hcl	(Betaxolol HCl)	1	
brimonidine tartrate	(Alphagan P)	1	

dorzolamide hcl	(Trusopt)	1	
dorzolamide hcl/timolol maleat	(Cosopt)	1	
latanoprost	(Xalatan)	1	
levobunolol hcl	(Betagan)	1	
methazolamide	(Neptazane)	1	
pilocarpine hcl	(Isopto Carpine)	1	
timolol maleate	(Timolol Maleate)	1	
travoprost (benzalkonium)	(Travoprost (Benzalkonium))	1	
PILOPINE HS		2	
SIMBRINZA		2	
Replacement Preparations			
Replacement Preparations			
KLOR-CON 8		1	
KLOR-CON		1	
phosphorus #1 tablet: 250mg	(K-Phos Neutral)	1	
potassium chloride capsule er, liquid, packet, tab er prt, tablet er	(Potassium Chloride)	1	
potassium citrate tablet er: 5meq, 10meq	(Urocit-K)	1	
K-PHOS ORIGINAL		2	
calcium carb/vit d3/minerals tablet: 600mg-400	(Caltrate 600 + D Plus)	OTC	
calcium carbonate oral susp	(Os-Cal)	OTC	

calcium carbonate/vitamin d3 tab chew, tablet: 500mg-200, 600mg-400	(Os-Cal with D)	OTC	
calcium citrate/vitamin d3 tablet: 250mg-200, 315mg-200, 315mg-250	(Citracal + D)	OTC	
Respiratory Tract Agents			
Anti-Inflammatories, Inhaled Corticosteroids			
budesonide ampul-neb: 0.5mg/2ml	(Pulmicort)	1	QL: 120 in 30 days
budesonide ampul-neb: 0.25mg/2ml	(Pulmicort)	1	QL: 240 in 30 days
budesonide ampul-neb: 1mg/2ml	(Pulmicort)	1	QL: 60 in 30 days
ADVAIR DISKUS		2	PA, QL: 2 in 1 days
ADVAIR HFA		2	PA, QL: 0.4 in 1 days
ARNUITY ELLIPTA		2	
ASMANEX HFA hfa aer ad: 200mcg		2	QL: 0.44 in 1 days
ASMANEX HFA hfa aer ad: 100mcg		2	QL: 0.87 in 1 days
ASMANEX aer pow ba: 110mcg(30), 220mcg(30), 220mcg(60), 220mcg120		2	QL: 0.04 in 1 days
ASMANEX aer pow ba: 110mcg(7), 220mcg(14)		2	QL: 0.14 in 1 days
BREO ELLIPTA		2	
DULERA		2	

FLOVENT DISKUS		2	(PA Requried for > 11)
FLOVENT HFA		2	(PA Requried for > 11)
Antileukotrienes			
montelukast sodium	(Singulair)	1	
Bronchodilators			
albuterol sulfate vial-neb	(Accuneb)	1	QL: 18 in 1 days
albuterol sulfate syrup, tab er 12h, tablet	(Albuterol Sulfate)	1	
albuterol sulfate solution	(Albuterol Sulfate)	1	QL: 6 in 1 days
ipratropium bromide	(Ipratropium Bromide)	1	QL: 15 in 1 days
ipratropium/albuterol sulfate	(Duoneb)	1	QL: 18 in 1 days
terbutaline sulfate tablet	(Terbutaline Sulfate)	1	
theophylline anhydrous elixir, tab er 12h: 100mg, 200mg, 300mg, 450mg; tablet er	(Theophylline Anhydrous)	1	
VENTOLIN HFA hfa aer ad: 90mcg		1	QL: 36 in 30 days
ANORO ELLIPTA		2	
ATROVENT HFA		2	QL: 0.86 in 1 days
COMBIVENT RESPIMAT		2	
COMBIVENT		2	
SEREVENT DISKUS blst w/dev: 50mcg		2	
SPIRIVA RESPIMAT		2	QL: 4 in 30 days

SPIRIVA		2	QL: 30 in 30 days
XOPENEX HFA		2	PA, QL: 1 in 1 days
Respiratory Tract Agents, Other			
acetylcysteine	(Acetadote)	1	
cromolyn sodium	(Cromolyn Sodium)	1	QL: 8 in 1 days
sodium chloride for inhalation	(Sodium Chloride For Inhalation)	1	
DALIRESP		2	PA, QL: 30 in 30 days
KALYDECO tablet		2	PA, QL: 2 in 1 days, QL: 68 in 34 days (Specialty Drug)
KALYDECO gran pack		2	PA, QL: 2 in 1 days
Skeletal Muscle Relaxants			
Skeletal Muscle Relaxants			
baclofen	(Baclofen)	1	
carisoprodol	(Soma)	1	
chlorzoxazone	(Parafon Forte DSC)	1	
COMFORT PAC-CYCLOBENZAPRINE		1	
COMFORT PAC-TIZANIDINE		1	
cyclobenzaprine hcl tablet: 5mg, 10mg	(Fexmid)	1	
dantrolene sodium capsule	(Dantrium)	1	
methocarbamol tablet	(Robaxin-750)	1	
tizanidine hcl	(Zanaflex)	1	

Sleep Disorder Agents			
Sleep Disorder Agents			
modafinil	(Provigil)	1	PA, QL: 30 in 30 days
zaleplon	(Sonata)	1	
zolpidem tartrate tablet	(Ambien)	1	
Urine And Feces Contents			
Ketones			
KETOSTIX REAGENT		2	
Vasodilating Agents			
Vasodilating Agents			
sildenafil citrate tablet	(Revatio)	1	PA, QL: 90 in 30 days
ADCIRCA		2	PA, QL: 60 in 30 days
LETAIRIS		2	PA, QL: 30 in 30 days (Specialty Drug)
TRACLEER		2	PA, QL: 60 in 30 days (Specialty Drug)
Vitamins and Minerals			
Vitamins and Minerals			
b complex and c no.20/folic acid capsule: 1mg	(Nephrocaps)	1	
cyanocobalamin (vitamin b-12) vial	(Vitamin B-12)	1	
cyanocobalamin/fa/pyridoxine tablet: 0.5-2.2-25	(Folgard Rx)	1	

ergocalciferol (vitamin d2) capsule	(Drisdol)	1	
folic acid tablet: 1mg	(Folic Acid)	1	
methyl-b12/l-mefolate/b6 phos tablet: 2-3-35mg	(Metanx)	1	
mv,min #10/fa/d3/alip acid/lut	(Mv,Min #10/Fa/D3/Alip Acid/Lut)	1	
NEPHROCAPS capsule: 1mg		1	
pedi multivit #22/vit d3/vit k	(Pedi Multivit #22/Vit D3/ Vit K)	1	
pedi multivit #65/vit d3/vit k	(Pedi Multivit #65/Vit D3/ Vit K)	1	
pnv with ca,no.72/iron/fa	(Pnv with Ca,No.72/Iron/Fa)	1	
pnv#71/iron/folic acid/dha	(Pnv#71/Iron/Folic Acid/ Dha)	1	
pnv#79/iron/fa/lmfolate ca/dha	(Neevo Dha)	1	
sodium fluoride	(Sodium Fluoride)	1	
MEPHYTON		2	
ascorbic acid tablet: 100mg, 250mg	(Vitamin C, Vitamin C with Rose Hips)	OTC	
b complex and c no.20/folic acid capsule: 1mg	(B Complex and C No.20/ Folic Acid)	OTC	
beta-carotene(a) w-c and e/min tablet: n/a	(Beta-Carotene(A) W-C and E/Min)	OTC	
cholecalciferol (vitamin d3) capsule: 10000unit; tablet: 400unit	(Vitamin D3)	OTC	

cyanocobalamin (vitamin b-12) tablet: 100mcg, 500mcg	(Vitamin B-12)	OTC	
fa/mv,ca,iron,min/lycopene/lut tablet: 0.4-162-18	(A Thru Z)	OTC	
ferrous fumarate tablet: 324(106)mg	(Ferrets)	OTC	
ferrous gluconate tablet: 240(27)mg, 325(36)mg	(Fergon)	OTC	
ferrous sulfate tablet: 134mg, 325(65)mg; tablet er: 47.5iron, 140(45)mg	(Fer-in-sol, Slow Fe, Feosol)	OTC	
ferrous sulfate, dried	(Ferrous Sulfate, Dried)	OTC	
folic acid tablet: 0.4mg, 0.8mg, 1mg	(Folic Acid)	OTC	
folic acid/multivit-min/lutein tablet: 0.4mg-250	(Essential Woman 50+)	OTC	
folic acid/mv,fe,other min tablet: 0.4mg-18mg	(Centrum Complete, Centrum Ultra Women's)	OTC	
iron aspgly and ps cmplx/c/sucac	(Iron Aspgly and Ps Cmplx/ C/Sucac)	OTC	
iron polysaccharide complex capsule: 150mg	(Pic 200)	OTC	
multivitamin w/iron, minerals tablet: n/a	(Complete Senior)	OTC	
multivitamin w-minerals/lutein tablet: n/a	(Centrum, Centrum Silver, Vision Plus Lutein)	OTC	

multivitamin/iron/folic acid tablet: 18mg-0.4mg	(One Daily Plus Iron)	OTC	
multivitamins with iron tab chew: n/a	(Multivitamins with Iron)	OTC	
multivit-min/fa/lycopene/lut tablet: .4-300-250	(Centrum Silver)	OTC	
multivits w-fe,other min/lut tablet: n/a	(Centrum Silver)	OTC	
multivits,ca,minerals/iron/fa tablet: 500-18-0.4	(Multivits,Ca,Minerals/Iron/Fa)	OTC	
mv,ca,iron,min/fa/phytosterol tablet: 3-200-400	(Century Cardio)	OTC	
niacinamide tablet	(Niacinamide)	OTC	
pnv95/ferrous fumarate/fa tablet: 28mg-0.8mg	(Prenatal)	OTC	
POLY-VI-SOL WITH IRON		OTC	
PRENATAL 19		OTC	
prenatal vit/iron fumarate/fa tablet: 27mg-0.8mg, 28mg-0.8mg	(Classic Prenatal)	OTC	
pyridoxine hcl tablet: 100mg	(Vitamin B6)	OTC	
riboflavin tablet: 25mg, 50mg	(Vitamin B2)	OTC	
thiamine hcl tablet: 50mg	(Vitamin B1)	OTC	
vitamin e capsule: 200unit	(Vitamin E)	OTC	

Meeting adjourned at 4:37 pm.

Future Scheduled Meetings

March 15, 2016 at 1:00 HCNFL3 Conference room

All of these meetings are scheduled to be held at Geisinger Health Plan, Hughes Center North and South Buildings; 108 Woodbine Lane; Danville, PA 17821.