

Commercial 4 Tier/PIC Preferred Drug Listing
 Alphabetical Listing by Tier - 2012

TIER 1 Preferred Generic Drugs Covered at a First Tier Copayment (some medications may be excluded as determined by benefit)

ACCU-CHEK STRIPS (QL)	CLARITHROMYCIN (QL)	METHADONE SOLN. (QL)	TERBINAFIN
ADAPALENE 0.1% CRM, GEL (AG)	CODEINE (QL)	METHYLPHENIDATE (QL)	TESTOSTERONE
ACETAMINOPHEN/CODEINE (QL)	DEXTROAMPHETAMINE (QL)	METHYLPHENIDATE ER (QL)	CYPIONATE (PA)
ACETAMINOPHEN/PENTAZOCINE (QL)	DONEPEZIL 5MG, 10MG (QL)	METHYLPHENIDATE SR (QL)	TESTOSTERONE ENANTHATE (PA)
AMPHETAMINE/DEXTROAMPHETAMINE (QL)	ENOXAPARIN (QL)	MORPHINE SULFATE (QL)	
AMPHETAMINE/DEXTROAMPHETAMINE SR (QL)	ESCITALOPRAM (ST) (QL)	MORPHINE SULFATE SR (QL)	TRAMADOL (QL)
ASPIRIN/CODEINE (QL)	FENTANYL PATCH (QL)	OLANZAPINE (QL)	
ATORVASTATIN (QL)	FLUCONAZOLE SUSP (QL)	OMEPRAZOLE (QL)	TRAMADOL/APAP (QL)
ATORVASTATIN/AMLODIPINE (QL)	FLUOXETINE 60MG (QL)	OMEPRAZOLE/SODIUM BICARBONATE CAP (QL)	TRAMADOL ER (QL)
BUDESONIDE NEB (AG)	GRANISETRON TAB (ST) (QL)	ONDANSETRON (QL)	TRETINOIN TOPICAL (AG)
	HYDROCODONE/ACETAMINOPHEN (QL)	ONDANSETRON ODT (QL)	VENLAFAXINE ER CAP (ST) (QL)
BUPROPION SR (QL)			VENLAFAXINE ER TAB (ST) (QL)
BUPROPION XL (QL)	HYDROCODONE/IBUPROFEN (QL)	OXYCODONE (QL)	ZEGERID PDR PKT 20-1680MG, 40-1680MG (ST) (QL)
	HYDROMORPHONE TAB (QL)	OXYCODONE/ACETAMINOPHEN (QL)	
BUTALBITAL/ASPIRIN/CODEINE (QL)	KETOROLAC TAB (QL)	OXYCODONE/ASPIRIN (QL)	ZIPRASIDONE (QL)
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE (QL)	LANSOPRAZOLE (QL)	PANTOPRAZOLE (QL)	ZOLPIDEM (QL)
CARISOPRODOL/ASPIRIN/CODEINE (QL)	MEBENDAZOLE (QL)	PAROXYTINE ER (ST)	
CICLOPIROX 8% NAIL LACQUER (QL)	MEPERIDINE (QL)	PILOCARPINE TAB (QL)	
CITALOPRAM (QL)	METHADONE 5MG TAB (QL)	SUMATRIPTAN (QL)	

TIER 2 Preferred Brand Drugs Covered at a Second Tier Copayment (some medications may be excluded as determined by benefit)

ABILIFY	CELLCEPT	ERYTHROMYCIN TABS	
ACIPHEX (ST) (QL)	CHEMSTRIP UGK	ESTRACE VAGINAL CREAM	LUMIGAN
ACTIVELLA	CIPRO SUSP	ESTRADERM	MATULANE (PA) (SP)
ACTONEL	CIPRODEX OTIC	ESTRATEST	MAXALT (QL)
ACTONEL w/ CALCIUM	CLEOCIN PEDIATRIC GRANULES	ESTRATEST HS	MAXALT MLT (QL)
ACTOPLUS MET (ST)	COLCRYS	EURAX	MEGACE ES (PA)
ACTOS (ST)	COMBIPATCH (ST)	EVISTA	MENEST
	COMBIVENT	FANSIDAR	MENOSTAR
		FEMHRT LOW DOSE	MEPHYTON
ADVICOR (ST)	COMTAN	FINACEA	MEPRON
ALKERAN	CREON	FK506	MESNEX
ALLEGRA SUSPENSIN (AG)	CRESTOR	FLOVENT DISKUS	METADATE CD (QL)
ALOMIDE	CRIVAN	FLOVENT HFA	METHERGINE TAB
ALORA	CUPRIMINE	FLUMIST	MICALCIN IM, SC
AMOXIL SUSP 50MG/ML	CYTOXAN	FML OINT.	MIGRANAL (QL)
ANDROGEL (PA) (QL)	DALIRESP (PA) (QL)	FML FORTE, FML LIQUIFILM	MOBAN
APTIVUS	DAPSONE	FORADIL	MYFORTIC
ARMOUR THYROID	DENAVIR	FORTESTA (PA) (QL)	MYLERAN (PA) (SP)
ASACOL (ST)	DETROL	FUZEON	NAMENDA
ASMANEX (30,60,120 MDI)	DETROL LA	GENGRAF	NATURE-THROID
ATELVIA	DIASTAT (ST)		NECON 10/11
ATRIPLA	DILANTIN 30MG CAPS	GLUCAGON	NEORAL
ATROVENT HFA	DILANTIN INFATABS	HECTOROL	NEURONTIN SOLN
AVALIDE	DILATRATE SR CAP	HYCAMTIN	NIASPAN
AVANDAMET (ST)	DIOVAN	INTELENCE 100mg	NORVIR
	DIOVAN HCT	INVIRASE	NOVOLIN
	DIVIGEL	ISOPTO CARBACHOL	NOVOLOG
AZELEX	DUAC	ISOPTO HOMATROPINE	NOVOLOG MIX 70/30
AZOPT	DUETACT (ST)	ISOPTO HYOSCINE	NUVARING

This listing is not all inclusive nor does it imply a guarantee of coverage, but it represents an abbreviation of the drug listing. Substitution of generic products is mandatory when a generic is available. If brand name is desired, member pays the difference in cost between the brand and the generic drug. PRIOR AUTHORIZATION MAY BE REQUIRED.

TIER

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Continued

BENICAR	DULERA (ST) (QL)	JANUMET (ST) (QL)	PANCREAZE
BENICAR HCT	DUTOPROL	JANUMET XR (ST) (QL)	PATADAY
BENZAFLIN	DYRENIUM	JANUVIA (ST) (QL)	PATANOL
BENZAMYCINPAK	EDECIN	KALETRA	PEAKFLOW METER
BETOPTIC-S	EMTRIVA	LANTUS	
BLEPHAMIDE	EPIPEN	LEUKERAN (PA) (SP)	PHISOHEX
BLEPHAMIDE S.O.P.	EPIVIR SOLN	LEVEMIR	PHOSPHOLINE IODIDE
BUPHENYL	EPIVIR HBV		PLAVIX
BYETTA (ST) (QL)	EPZICOM	LEXIVA	PREFEST
CANASA SUPP	ERGOTRATE	LOESTRIN 24 FE	PREMARIN
CARAFATE SUSP	ERY-TAB	LOTEMAS SUSP (ST)	PREMARIN VAGINAL CRM
			VICTOZA (ST) (QL)
PREMPHASE	RESCRIPTOR	TAZORAC	VIDEX
PREMPRO	REYATAZ	TEGRETOL	VIRACEPT
PREZISTA	RIDAURA	TEGRETOL XR	VIRAMUNE (QL)
PRIMAQUINE	SANDIMMUNE	TOPAMAX (QL)	VIREAD
PROAIR HFA	SELZENTRY	TOPAMAX SPRINKLE (QL)	VIVELLE-DOT (QL)
	SEREVENT DISKUS	TRAVATAN Z	VYTORIN
PULMICORT RESPULES (AG)	SEROQUEL	TREXALL	WELCHOL
PULMICORT FLEXHALER	SIMCOR (ST)	TRIZIVIR	ZETIA
QVAR	SINGULAIR (ST) (QL)	TRUVADA	ZIAGEN
	SPIRIVA	UROCID-K	ZOSTAVAX (AG)
RELPAK (QL)	SUPRAX	VAGIFEM	ZOVIRAX, TOPICAL
RENAGEL	SUSTIVA	VENTOLIN HFA	
REVELA	SYMBICORT (ST) (QL)	VESICARE	

TIER 3 Non-Preferred Drugs Covered at a Third Tier Copayment (some medications may be excluded as determined by benefit)

ABILIFY DISCMELT (PA)	COMBIGAN	KOMBIGLYZE (PA) (QL)	RESTASIS
ACCUHIST DM DROP PED	*COSOPT	LESCOL	RHINOCORT AQUA (ST)
*ACEON	CYMBALTA (PA) (QL)	LESCOL XL	RISPERDAL M-TAB (PA)
ACZONE (PA)	DALLERGY CHW	LEVATOL	ROZEREM (PA) (QL)
		LIDODERM PATCHES (PA) (QL)	
*ADIPEX-P (PA)	DALLERGY-JR SUS		SAFYRAL
ADVAIR (ST) (QL)	*DECLOMYCIN	*LoSEASONIQUE	*SANCTURA (ST)
AGGRENOX	DECONEX CAP 10-390MG	LOVENOX 300mg/3ml (QL)	SEASONIQUE
ALAMAST	DELTUSS DMX LIQ	LUNESTA (PA) (QL)	SENSIPAR (PA)
ALBENZA	DIAMOX SEQUELS		SILDEC SYP
ALOCRIAL	DIBENZYLIN	LYRICA (PA) (QL)	STALEVO
ALREX (ST)	*DURICEF	MATULANE (PA) (SP)	
*AMBIEN CR (PA) (QL)	DYNACIRIC CR	MAXAIR	STRATTERA (ST)
*AMERGE (QL)	ED CHLORPED SUS D	MUCINEX DM	SUBOXONE (PA) (QL)
AMITIZA (ST) (QL)	EFFIENT (PA)	MULTAQ (PA) (QL)	*SUBUTEX (PA) (QL)
ANDRODERM (PA) (QL)	ELIDEL (PA) (QL)	NASONEX (ST)	SUPRESS-PE DROP
ANDROXY (PA)	EMCYT (PA) (SP)		SYMLIN (PA)
ANZEMET TAB (PA) (QL)	EMEND CAPS (PA) (QL)	NATAZIA	TABLOID (PA) (SP)
APOKYN (PA) (SP)	EMSAM TRANSDERMAL (PA) (QL)	NICOTROL INHALER (QL)	TAMIFLU (QL)
*AROMASIN	ENABLEX (ST)	NICOTROL NASAL (QL)	TASMAR
ARTHROTEC	*ENTOCORT EC	NOROXIN	TESTIM (PA) (QL)
ATACAND	ESTRASORB		TIKOSYN
ATACAND HCT	ESTRING	ONGLYZA (PA) (QL)	TRANSDERM SCOP
AVALIDE	ESTROGEL	*OPANA ER (ST) (QL)	ULORIC (PA) (QL)
AVANDIA (ST)	*ETOPOSIDE CAPS (SP)	ORAP	*UROXATRAL
AVAPRO	EVAMIST	ORTHO-EVRA	VANCOCIN PULVULES (PA)
AVINZA (ST) (QL)	*EXELON CAP., SOL.	OVCON -50	VEXOL
AVODART (ST)	FACTIVE	OXYFAST	VFEND SUSP (PA) (QL)
AXERT (QL)	*FELBATOL	OXYTROL (ST)	*VFEND TABS (PA) (QL)
BECONASE AQ (ST)	*FEMARA	PENTASA (ST)	VIIBRYD (PA) (QL)
BEYAZ	FEMRING	PRANDIMET (ST)	VIGAMOX
BILTRICIDE	FERESTON (PA) (SP)	PRANDIN	
BRONTEX TAB	FOSAMAX PLUS D	PREPIDIL	VIRAMUNE XR (QL)
BYSTOLIC	FROVA (QL)	*PREVACID SOLUTAB (PA)	VOLTAREN GEL (ST) (QL)
*CAFCIT	GABITRIL	PRIFTIN	VYVANSE (QL)
CAMPRAL (PA) (QL)	GENEXA LA CAP 30-400MG	PROTOPIC (PA) (QL)	
CARDENE SR	GILPHEX TR TAB 10-388MG	PROVIGIL (PA) (QL)	XENICAL (PA)
CEENU (PA) (SP)		QV-ALLERGY SYP	
CEFPODOXIME	GRIS-PEG		*YAZ
CELEBREX (QL)	HALFLYTELY	RANEXA (ST)	ZOMIG (QL)
CENESTIN	HELIDAC	RAPAMUNE	ZOMIG ZMT (QL)
CHANTIX (QL)	HUMALOG INSULINS	REGRANEX	ZYMAR
CIPRO HC OTIC	HUMULIN INSULINS	RELENZA (QL)	*ZYPREXA ZYDIS (PA) (QL)
		RESPERAL-DM DROP 12-1-5MG	
COGNEX	*KADIAN (ST) (QL)		

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Tier 4 Non-Preferred Drugs Covered at a Fourth Tier Copayment (some medications may be excluded as determined by benefit)

ACTIMMUNE (SP)		NEUPOGEN (PA)	SUTENT (PA) (SP)
AFINITOR (PA) (SP)		NEXAVAR (PA) (SP)	SYLATRON (PA) (SP)
AMPYRA (PA) (SP) (QL)	GAMUNEX-C (PA)	NORDITROPIN (PA) (SP)	TARCEVA (PA) (SP)
		NORDITROPIN NORDIFLEX (PA) (SP)	TARGRETIN (PA) (SP)
ARANESP (PA)	GLEEVEC (PA) (SP)	NORDITROPIN FLEXPRO (PA) (SP)	TASIGNA (PA) (SP)
*ARIXTRA (PA)	HEXALEN (PA) (SP)	OFORTA (PA) (SP)	TEMODAR (PA) (SP)
		ORENCIA SUBCUTANEOUS (PA) (SP)	TEV-TROPIN (PA) (SP)
AVONEX (SP)	HIZENTRA (PA)		THALOMID (PA)
CAPRELSA (PA)	HUMIRA (PA) (SP)	PEGASYS (PA) (SP)	TOBI
CINRYZE (PA)	HYCANTIN (PA) (SP)	PEG-INTRON (PA) (SP)	TYKERB (PA) (SP)
		PROCRIT (PA)	VALCYTE (PA) (QL)
COMPLERA (SP)	INCIVEK (PA) (SP) (QL)	PULMOZYME	VICTRELIS (PA) (SP) (QL)
COPAXONE (SP)	INCRELEX (PA) (SP)	*REBETOL (PA) (SP)	VIVAGLOBIN (PA)
*CYTOVENE	INFERGEN (PA) (SP)		VOTRIENT (PA) (SP)
*DDAVP INJECTION (PA)	INLYTA (PA) (SP)	REBIF (PA) (SP)	XALKORI (PA) (SP)
	INTRON-A (PA) (SP)	REVATIO (PA) (QL)	XIFAXAN (PA) (QL)
DIFICID (PA) (QL)	IRESSA (PA)		XELODA (PA) (SP)
EDURANT (SP)	JAKAFI (PA) (SP)	REVLIMID (PA) (SP)	XYREM
ENBREL (PA) (SP)	LOTRONEX	RILUTEK	ZELBORAF (PA) (SP)
EPOGEN (PA)	LYSODREN	*SANDOSTATIN	ZOLINZA (PA) (SP)
ERIVEDGE (PA) (QL) (SP)	NEULASTA (PA)	SPRYCEL (PA) (SP)	ZYTIGA (PA) (SP)
EXTAVIA (PA) (SP)	NEUMEGA (PA) (SP)		ZYVOX (PA)
FORTEO (PA) (SP)			

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DISCLAIMER

Please be sure a Prescription Drug benefit is part of your specific coverage before consulting this list. If you do not know which list is correct, please contact the Presbyterian Customer Service Center at (505) 923-5678 or toll-free at 1-800-356-2219, Monday through Friday from 7:00 a.m. to 6:00 p.m. TTY users may call 1-877-298-7407.

Coverage for some drugs may be limited to specific dosage forms and/or strengths. Your benefit design determines what is covered for you and what your copayment will be. Additional limitations or exclusions may apply for members of Presbyterian Individual Plans. Please refer to your benefit materials for your specific coverage information. The medications listed on this Formulary/Preferred Drug Listing (PDL) are subject to change pursuant to the Formulary/PDL management activities of Presbyterian Health Plan. This list is not all-inclusive nor does it imply a guarantee of coverage. In addition, coverage for some drugs listed may be limited to specific dosage forms and/or strengths. Substitution of a generic product for a brand-name drug is mandatory when a generic equivalent is available. If a member requests the brand-name drug in this situation, a prior authorization may be required and the member must pay the difference in cost between the generic and branded versions. Non-formulary medications are not considered for coverage unless trial and failure of formulary alternatives are documented.

EXPLANATION OF INDICATORS

You will see these indicators next to some drug names:

- 1. Prior Authorization (PA)** -- a drug that requires prior approval before the Plan will cover it, and when the patient meets the established criteria. The doctor must submit a Pharmacy Prior Authorization Form. The doctor can submit the request by fax, phone, or regular mail.
- 2. Step Edit (ST)** -- a drug that requires a prescription history of specific drugs in the pharmacy claims or data system, and these specific drugs must be taken during a given time frame. After the specific drugs have been taken within the given time frame, online coverage of the newly-prescribed drug occurs at the pharmacy. Step Edits make it easier to access drugs that would normally require a Prior Authorization.
- 3. Medical Exception** -- a drug that is not on the Plan's formulary. Non-formulary drugs require an Exception to the formulary due to allergy, adverse reactions, or no response to all formulary drugs.
- 4. Quantity Limit (QL)** -- a coverage limit on the medication quantity covered for a defined days' supply (usually 30 or 90 days) based on safety, efficacy and/or dose optimization issues.
- 5. Age Limitation (AG)** -- a coverage limit based on minimum or maximum age of the member imposed as a result of safety, efficacy or dosage form considerations.
- 6. Specialty (SP)** -- Tier 4 medications obtained through the pharmacy benefit. Tier 4 medications are defined as high cost (greater than \$600 per 30 day supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty pharmaceuticals are self-administered, meaning they are administered by the patient or to the patient by a family member or caregiver. Non-formulary medications, when approved by prior authorization, may be subject to specialty pharmacy requirements.
- 7. Medical Drugs (MED)** -- Medications obtained through the medical benefit. Medical drugs are defined as medications administered in the office or facility that require a health care professional to administer. These medications include, but are not limited to, injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be provided by a specialty pharmacy vendor. Some Medical Drugs may require Benefit Certification before they can be obtained. Office administered applies to all outpatient settings including, but are not limited to, physician's offices, emergency rooms, urgent care facilities and outpatient surgery facilities. For a complete list of Medical Drugs and to determine which require Benefit Certification please see the Presbyterian Pharmacy web site at: <http://www.phs.org/PHS/programs/pharmacy/formulary/index.htm>

* = Generic preferred/ Generic equivalent available.