

CMSP DRUG FORMULARY

Administered by MedImpact

October 2003

INTRODUCTION

Foreword

This document represents the efforts of the County Medical Services Program (CMSP) to provide physicians and pharmacists with a method to evaluate the various drug products available under CMSP. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the CMSP Drug Formulary is to enhance the ability of physicians and pharmacists participating in CMSP to provide optimal cost effective drug therapy for CMSP clients.

The development, maintenance, and improvement of the CMSP Drug Formulary is evolutionary and requires on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The CMSP Drug Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to CMSP.

CMSP uses the following criteria in the evaluation of product selection for the CMSP Drug Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Drug Formulary is a list of covered and preferred drug agents for CMSP members. All products are listed by their generic names, and most common proprietary (branded) name. The Drug Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by CMSP, shall be considered a Non-Formulary Drug.

All drugs are listed in each category in ascending order of cost. This is denoted by the relative dollar scale, described as follows:

\$	least expensive
\$\$	slightly more expensive
\$\$\$	more expensive
\$\$\$\$	significantly more expensive
\$\$\$\$\$	most expensive

The prices used to calculate the relative dollar scale are based on the monthly cost of therapy or cost of treatment course to allow for dosing interval differences between various products. The number of dollar signs is a relative indication of cost and does not represent the true cost of the drug. For example, two dollar signs do not mean that a product is twice as expensive as a product with one dollar sign. They are intended only to provide relative information regarding cost. Economics should not be the only factor involved with any therapeutic and clinical decision process. Price comparisons are reflective of pricing and contracts available through MedImpact and CMSP.

Coverage Limitations

The Drug Formulary does not provide information regarding the specific coverage and limitations an individual member may have. Members may have specific limitations, such as share of cost, or lack of coverage, which is not reflected in the Drug Formulary. This Drug Formulary contains only FDA approved outpatient drugs for eligible members, and does not apply to non-FDA approved drugs or medications used in in-patient settings. If a member has any specific questions regarding coverage, they should consult CMSP at (916) 649-2631 for Explanation of Benefits.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. *The brand names listed are for reference use only, and do not denote coverage, unless specifically noted.* Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by CMSPs pharmacy and therapeutics review process. CMSP approves such multisource drugs for addition to the MAC list based on the following criteria:

- A minimum of one "A" rated source of the product.
- A FDA Rating for generic equivalency.
- Review by CMSP for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:
 - ◊ Coumadin (EFF 6/20/03)
 - ◊ Dilantin
 - ◊ Lanoxin (EFF 6/20/03)
 - ◊ Premarin
 - ◊ Neoral Oral Solution
 - ◊ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products.

If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Preferred Branded Interchange

Certain multisource branded drug products may be excluded from coverage.

Experimental Drugs

The experimental nature or use of drug products will be determined by the CMSP using current medical literature. Any drug product or use of an existing product, which is determined to be experimental, will be excluded from coverage.

Over-The-Counter (OTC) Drugs

Over-the-counter drugs listed in the formulary document are a covered benefit if a prescription is written by a physician. Non-formulary over-the-counter drugs require approval through the medication request process.

Medication Request Process

Coverage for non-formulary agents may be applied for in advance by physicians. When a member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the non-formulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed **Medication Request Form (MRF)** to MedImpact at (858) 549-5348, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the Drug Formulary are not suited for the present patient care need, and the drug selected is required for patient safety.
- 4) The use of a Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

CMSP recognizes that not all medical needs can be met with this document and encourages inquires about alternative therapies.

Prior Authorization

Drug products that are listed as **Prior Authorization (PA) required** require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed **Medication Request Form (MRF)** to MedImpact at (858) 549-5348.
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by CMSP, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Prior authorization requests will be responded to within 24 hours (business day), upon receipt of a completed Medication Request Form (MRF). If approved, MedImpact will provide the physician with a prior authorization number, specific for the medical need.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per CMSP guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit, will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or members may request a formal appeal to CMSP at (916) 649-2631.

Formulary Process and Communication

The CMSP Drug Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. CMSP welcomes input on the formulary from physicians and pharmacists providing services to CMSP clients. Suggestions and comments should be submitted to the CMSP Governing Board at the following address:

CMSP Governing Board
ATTN: Pharmacy and Therapeutics Panel
1451 River Park Drive, Suite 222
Sacramento, CA 95815
(916) 649-2631

Recent Formulary Changes

Product Name	Formulary Change	Effective Date
OTC loratadine	PA restriction removed. Quantity limit added	9/29/03
Allegra	Removed from formulary	9/29/03
Vioxx	Added to formulary with PA restriction and quantity limits	9/29/03
Forteo	Added to formulary with PA restriction and quantity limits	9/29/03
Fuzeon	Added to formulary with PA restriction	9/29/03
Humira	Added to formulary with PA restriction	9/29/03
OTC Prilosec	Added to formulary with quantity limit	9/29/03
Protonix	Added PA restriction	9/29/03
Rebetol	Removed from formulary. Copegus preferred.	9/29/03
Nicotine Patches	Allow approval of only OTC patches. PA restriction not changed.	9/25/03
Axert	Concurrent use edit added. Quantity limit not changed.	9/1/03
Docusate sodium capsules	Quantity limits removed	9/1/03
Imitrex	PA restriction changed to concurrent use edit. Quantity limit not changed.	9/1/03
Prempro Low Dose	Added to formulary	8/1/03

TABLE OF CONTENTS

FOREWORD	1
HOW TO USE THE DRUG FORMULARY.....	1
COVERAGE LIMITATIONS	2
GENERIC SUBSTITUTION	2
PREFERRED BRANDED INTERCHANGE.....	2
EXPERIMENTAL DRUGS.....	2
OVER-THE-COUNTER (OTC) DRUGS.....	2
MEDICATION REQUEST PROCESS	2
PRIOR AUTHORIZATION.....	3
STEP CARE AGENTS	3
QUANTITY LIMITS	3
APPEALS PROCESS	3
FORMULARY PROCESS AND COMMUNICATION.....	3
RECENT FORMULARY CHANGES	4
CENTRAL NERVOUS SYSTEM AGENTS	9
ANALGESIC AND ANTI-INFLAMMATORY AGENTS.....	9
<i>Non-Steroidal Anti-Inflammatory Agents</i>	9
<i>Miscellaneous Arthritis Agents</i>	9
<i>Migraine Agents</i>	9
<i>Opiate Agonists</i>	10
<i>Opiate Antagonists</i>	10
<i>Miscellaneous Analgesics</i>	10
<i>Miscellaneous Central Nervous System Agents</i>	10
ANTICONVULSANT AGENTS	10
<i>Barbiturate Anticonvulsants</i>	10
<i>Benzodiazepine Anticonvulsants</i>	11
<i>Hydantoin Anticonvulsants</i>	11
<i>Miscellaneous Anticonvulsants</i>	11
ANTIPARKINSONIAN AGENTS	11
MUSCLE RELAXANT AGENTS	11
<i>Skeletal Muscle Relaxants</i>	11
PSYCHOTHERAPEUTIC AGENTS	11
<i>Tricyclic Antidepressant Agents</i>	11
<i>S.S.R.I. Agents</i>	12
<i>S.N.R.I. Agents</i>	12
<i>M.A.O. Inhibitor Agents</i>	12
<i>Miscellaneous Antidepressant Agents</i>	12
<i>Antimanic Agents</i>	12
<i>Benzodiazepines</i>	12
<i>Antipsychotic Agents</i>	12
<i>Miscellaneous Anxiolytics, Sedatives, and Hypnotics</i>	13
CARDIOVASCULAR/BLOOD AGENTS	13
ANTIARRHYTHMIC AGENTS	13
<i>Antidysrhythmic Drug Agents</i>	13
<i>Lidocaine Type Antidysrhythmic Drug Agents</i>	13
<i>Procainamide Antidysrhythmic Drug Agents</i>	13
ANTIHYPERTENSIVE AGENTS	13
<i>Alpha-Adrenergic Antagonist Antihypertensive Agents</i>	13
<i>Beta-Adrenergic Antagonist Agents</i>	13
<i>Combination Alpha-Beta Antagonist Agents</i>	14
<i>Angiotensin Converting Enzyme Inhibitor Agents</i>	14
<i>Angiotensin Receptor Blocker Agents</i>	14

<i>Calcium Channel Blocking Agents</i>	14
<i>Centrally Acting Antihypertensive Agents</i>	14
<i>Combination Antihypertensive Agents</i>	14
<i>Drugs for Pheochromocytoma</i>	14
<i>Potassium-Sparing Diuretics</i>	14
<i>Loop Diuretics</i>	14
<i>Thiazide and Related Diuretics</i>	15
<i>Vasodilator Antihypertensive Agents</i>	15
ANTILIPEMIC AGENTS.....	15
BLOOD AGENTS.....	15
<i>Coagulants and Anticoagulants</i>	15
HEMORHEOLOGIC AGENTS.....	15
CARDIAC GLYCOSIDE AGENTS.....	15
ANTIPLATELET AGENTS.....	15
VASODILATING AGENTS.....	15
GASTROINTESTINAL AGENTS.....	16
ANTIDIARRHEAL AGENTS.....	16
ANTIEMETIC AGENTS.....	16
ANTIMUSCARINIC/ANTISPASMODIC AGENTS.....	16
ANTIULCER/ANTIPEPTIC AGENTS.....	16
BOWEL EVACUANT AGENTS.....	16
DIGESTIVE ENZYMES.....	16
GALLSTONE SOLUBILIZING AGENTS.....	17
GASTROINTESTINAL STIMULANT AGENTS.....	17
H ₂ ANTAGONIST AGENTS.....	17
LAXATIVE AGENTS.....	17
MISCELLANEOUS GASTROINTESTINAL SUPPLIES.....	17
MISCELLANEOUS GASTROINTESTINAL AGENTS.....	17
ANTI-INFECTIVE AGENTS.....	17
AMEBICIDES.....	17
ANTHELMINTIC AGENTS.....	17
ANTIBIOTIC AGENTS.....	18
<i>Aminoglycosides</i>	18
<i>Cephalosporins</i>	18
<i>Macrolide Antibiotic Agents</i>	18
<i>Miscellaneous Antibiotic Agents</i>	18
<i>Penicillins</i>	18
<i>Quinolones</i>	18
<i>Sulfonamide Agents</i>	18
<i>Tetracyclines</i>	19
ANTIFUNGAL AGENTS.....	19
ANTIMALARIAL AGENTS.....	19
ANTITUBERCULOSIS AGENTS.....	19
ANTI-ULCER ERADICATION AGENTS.....	19
ANTIVIRAL AGENTS.....	19
LEPROSTATIC AGENTS.....	20
ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS.....	20
ANTINEOPLASTIC AGENTS.....	20
BLOOD COLONY STIMULATING FACTORS.....	21
MULTIPLE SCLEROSIS AGENTS.....	21
MISCELLANEOUS AGENTS.....	21
IMMUNOSUPPRESSANT AGENTS.....	21
RESPIRATORY/ENT AGENTS.....	22

ANTI-HISTAMINE AGENTS	22
<i>Single Entity Alkylamine Agents</i>	22
<i>Single Entity Ethanolamine Agents</i>	22
<i>Non-Sedating Single Entity Agents</i>	22
<i>Miscellaneous Antihistamine Agents</i>	22
ANTI-HISTAMINE/DECONGESTANT COMBINATION AGENTS	22
<i>Antihistamine/Decongestant Agents</i>	22
ANTITUSSIVE AGENTS.....	22
<i>Non-Narcotic Antitussive Agents</i>	22
<i>Narcotic Antitussive Agents</i>	22
<i>Decongestants</i>	23
ASTHMA AGENTS.....	23
<i>Inhaled Sympathomimetic (Adrenergic) Agents</i>	23
<i>Oral Sympathomimetic (Adrenergic) Agents</i>	23
<i>Inhaled Oral Corticosteroid Agents</i>	23
<i>Leukotriene Receptor Antagonists</i>	23
<i>Respiratory Smooth Muscle Relaxant Agents</i>	23
EXPECTORANT AGENTS	23
MUCOLYTIC AGENTS	23
EYE, EAR, NOSE AND THROAT (EENT) PREPARATIONS.....	24
<i>Ophthalmic Antibiotic Agents</i>	24
<i>Ophthalmic Anti-Inflammatory Agents, Corticosteroid</i>	24
<i>Ophthalmic Anti-Inflammatory Agents, NSAIDs</i>	24
<i>Ophthalmic Antiviral Agents</i>	24
<i>Ophthalmic Beta Blockers</i>	24
<i>Ophthalmic Miotic Agents</i>	24
<i>Ophthalmic Mydriatic Agents</i>	25
<i>Ophthalmic Sulfonamide Agents</i>	25
<i>Ophthalmic Antiallergic Agents</i>	25
<i>Miscellaneous Ophthalmic Agents</i>	25
<i>Otic Anti-Infective Agents</i>	25
<i>Miscellaneous Otic Agents</i>	25
INHALED/ORAL EENT AGENTS	25
<i>Inhaled Nasal Agents</i>	25
<i>Carbonic Anhydrase Inhibitor Agents</i>	25
<i>Local Anesthetic Agents</i>	25
MISCELLANEOUS EENT AGENTS.....	25
DIABETIC AND THYROID AGENTS	26
DIABETIC AGENTS	26
<i>Sulfonylureas</i>	26
<i>Non-Sulfonylureas</i>	26
<i>Miscellaneous Diabetic Agents</i>	26
INSULIN AGENTS	26
THYROID AGENTS	26
<i>Antithyroid Agents</i>	26
HORMONE AGENTS	27
ORAL ADRENAL CORTICOSTEROID AGENTS.....	27
ANDROGEN AGENTS	27
BISPHOSPHONATE AGENTS	27
PARATHYROID HORMONE.....	27
ESTROGEN AGENTS.....	27
<i>Estrogen Agonist-Antagonists</i>	27
<i>Miscellaneous Estrogen Agents</i>	27
ORAL CONTRACEPTIVE AGENTS	28
<i>Monophasic Oral Contraceptives</i>	28
<i>Biphasic Oral Contraceptives</i>	28

<i>Triphasic Oral Contraceptives</i>	28
<i>Progestin Only</i>	28
OXYTOCIC AGENTS.....	28
PITUITARY AGENTS.....	28
PROGESTIN AGENTS.....	28
GENITOURINARY AGENTS.....	28
URINARY ANTI-INFECTIVE AGENTS.....	28
URINARY ANTI-SPASMODIC AGENTS.....	29
GENITOURINARY SMOOTH MUSCLE RELAXANT AGENTS.....	29
PARASYMPATHOMIMETIC (CHOLINERGIC) AGENTS.....	29
TOPICAL/MUCOUS MEMBRANE AGENTS.....	29
KERATOLYTIC AGENTS.....	29
MISCELLANEOUS SKIN/MUCOUS MEMBRANE AGENTS.....	29
TOPICAL ANTIBIOTIC AGENTS.....	29
TOPICAL ANTIFUNGAL AGENTS.....	30
VAGINAL ANTIFUNGAL AGENTS.....	30
VAGINAL ANTI-INFECTIVE AGENTS.....	30
TOPICAL CONTRACEPTIVE AGENTS.....	30
TOPICAL ANTI-INFLAMMATORY AGENTS.....	30
TOPICAL ANTIPRURITIC AND LOCAL ANESTHETIC AGENTS.....	31
TOPICAL ANTIVIRAL AGENTS.....	31
TOPICAL MISCELLANEOUS ANTI-INFECTIVE AGENTS.....	31
SCABICIDE/PEDICULICIDE AGENTS.....	31
MISCELLANEOUS/UNCLASSIFIED AGENTS.....	31
ELECTROLYTE AGENTS.....	31
<i>Miscellaneous Agents</i>	31
<i>Potassium Agents</i>	32
HEAVY METAL ANTAGONIST AGENTS.....	32
VITAMIN AGENTS.....	32
<i>Vitamin B-Complex Agents</i>	32
<i>Vitamin D</i>	32
<i>Vitamin K Activity Agents</i>	32
<i>Iron Agents</i>	32
DIAGNOSTIC TESTING.....	32
<i>Blood Glucose Supplies</i>	32
ALCOHOL AND SMOKING DETERRENT AGENTS.....	33
GOUT AGENTS.....	33

CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

\$	Aspirin	ASPIRIN
\$	Aspirin EC	ECOTRIN
\$	Ibuprofen	MOTRIN (INCLUDES OTC)
\$	Indomethacin	INDOCIN INDOCIN SUPPOSITORIES NOT COVERED
\$\$	Choline Mag. Trisalicylate	TRILISATE
\$\$	Diclofenac Sodium	VOLTAREN
\$\$	Etodolac	LODINE
\$\$	Fenoprofen	NALFON
\$\$	Indomethacin, Sustained Release	INDOCIN SR
\$\$	Naproxen	NAPROSYN
\$\$	Naproxen Sodium	ANAPROX ANAPROX DS
\$\$	Piroxicam	FELDENE
\$\$	Salsalate	DISALCID
\$\$	Sulindac	CLINORIL

SECOND LINE AGENTS

SE	\$\$\$	Diclofenac/Misoprostol	ARTHROTEC, STEP THERAPY , RESTRICTED TO A TRIAL OF A FORMULARY NSAID IN THE PAST 90 DAYS
SE	\$\$\$	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
SE	\$\$\$	Ketoprofen	ORUVAIL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
SE	\$\$\$	Nabumetone	RELAFEN, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
PA, QL	\$\$\$\$	Rofecoxib	VIOXX, PA REQ, LIMITED TO 30 TABLETS/MONTH FOR 12.5 AND 25MG AND 5 TABLETS FOR 50MG (EFF 9/29/03)

Miscellaneous Arthritis Agents

PA	\$\$\$\$\$	Leflunomide	ARAVA, PA REQ
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Migraine Agents

\$\$	APAP/Dichloralphenazone/Isomethop	MIDRIN
\$\$	Butalbital/APAP/Caffeine	ESGIC ESGIC PLUS FIORICET
\$\$	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
\$\$\$\$	Ergotamine/Caffeine	CAFERGOT

QL	\$\$\$\$	Methysergide	SANSERT
QL	\$\$\$\$\$	Almotriptan	AXERT, LIMITED TO 6 TALBETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH. (EFF 9/1/03)
PA,QL	\$\$\$\$\$	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH
QL	\$\$\$\$\$	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH (EFF 9/1/03)

Opiate Agonists

QL	\$	Acetaminophen/Codeine (Capsules Not Covered)	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH (EFF 6/20/03)
QL	\$	Acetaminophen/Hydrocodone	VICODIN, LIMITED TO #240/MONTH (EFF 6/20/03)
QL			VICODIN ES, LIMITED TO #150/MONTH (EFF 6/20/03)
QL			LORCET, LIMITED TO #240/MONTH (EFF 6/20/03)
QL			LORCET PLUS, LIMITED TO #180/MONTH (EFF 6/20/03)
QL	\$	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH (EFF 6/20/03)
QL	\$	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH (EFF 6/20/03)
QL			TYLOX, LIMITED TO #240/MONTH (EFF 6/20/03)
QL	\$	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH (EFF 6/20/03)
QL	\$	Propoxyphene Napsylate/APAP	DARVOCET-N 100, LIMITED TO #180/MONTH (EFF 6/20/03)
QL	\$\$	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH (EFF 6/20/03)
QL	\$\$	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH (EFF 6/20/03)
QL	\$\$	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH (EFF 6/20/03)
QL	\$\$\$	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH (EFF 6/20/03)
QL	\$\$\$\$	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH (EFF 6/20/03)
PA, QL	\$\$\$\$	Oxycodone	OXYCONTIN, PA REQ LIMITED TO #120/MONTH (EFF 6/20/03)
PA, QL			OXYIR, PA REQ , LIMITED TO #240/MONTH (EFF 6/20/03)
PA, QL			OXYFAST, PA REQ , LIMITED TO #960ML/MONTH (EFF 6/20/03)

Opiate Antagonists

\$\$\$\$\$ Naltrexone REVIA

Miscellaneous Analgesics

	\$	Acetaminophen	TYLENOL
	\$\$	Tramadol	ULTRAM (EFF 6/20/03)
PA, QL	\$\$\$\$	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH

Miscellaneous Central Nervous System Agents

PA	\$\$\$\$	Donepezil	ARICEPT, PA REQ
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Anticonvulsant Agents

Barbiturate Anticonvulsants

	\$	Phenobarbital	PHENOBARBITAL
	\$\$	Mephobarbital	MEBARAL
	\$\$	Primidone	MYSOLINE

	Benzodiazepine Anticonvulsants	
QL	\$\$\$ Clonazepam	KLONOPIN, LIMITED TO #90/MONTH
	Hydantoin Anticonvulsants	
	\$ Phenytoin	DILANTIN
	Miscellaneous Anticonvulsants	
	\$\$ Carbamazepine	TEGRETOL
	\$\$ Trimethadione	TEGRETOL XR
	\$\$\$ Divalproex Sodium	TRIDIONE
PA	\$\$\$\$ Gabapentin	DEPAKOTE
	\$\$\$\$ Lamotrigine	NEURONTIN, PA REQ
	\$\$\$\$ Levetiracetam	LAMICTAL
	\$\$\$\$ Oxcarbazepine	KEPPRA
	\$\$\$\$ Topiramate	TRILEPTAL
	\$\$\$\$ Valproic Acid	TOPAMAX
	\$\$\$\$\$ Tiagabine	DEPAKENE
		GABITRIL

Antiparkinsonian Agents

\$	Trihexyphenidyl	ARTANE
\$\$	Amantadine	SYMMETREL
\$\$	Benzotropine Mesylate	COGENTIN
\$\$\$	Bromocriptine	PARLODEL
\$\$\$	Carbidopa/Levodopa	SINEMET
\$\$\$	Levodopa	LARODOPA
\$\$\$\$	Carbidopa/Levodopa CR	SINEMET CR
\$\$\$\$\$	Pramipexole	MIRAPEX
\$\$\$\$\$	Ropinirole	REQUIP

Muscle Relaxant Agents

	Skeletal Muscle Relaxants	
QL	\$ Carisoprodol	SOMA, LIMITED TO #120/MONTH
	\$ Methocarbamol	ROBAXIN
	\$\$ Baclofen	LIORESAL
	\$\$ Chlorzoxazone	PARAFON DSC
	\$\$ Metaxalone	SKELAXIN
	\$\$\$ Cyclobenzaprine	FLEXERIL
	\$\$\$ Orphenadrine/Aspirin/Caffeine	NORGESIC
	\$\$\$ Orphenadrine Citrate	NORGESIC FORTE
	\$\$\$\$ Dantrolene Sodium	NORFLEX
		DANTRium

Psychotherapeutic Agents

	Tricyclic Antidepressant Agents	
\$	Amitriptyline	ELAVIL
\$	Desipramine	NORPRAMIN
\$	Doxepin	SINEQUAN
\$	Imipramine	TOFRANIL
		TOFRANIL PM NOT COVERED
\$\$	Maprotiline	LUDIOMIL

\$\$ Protriptyline
\$\$\$ Nortriptyline

VIVACTIL
AVENTYL
PAMELOR

S.S.R.I. Agents

QL \$\$ Fluoxetine
ST, QL \$\$\$\$ Citalopram

PROZAC (10MG, 20MG CAPSULES ONLY) LIMITED TO #120/MONTH
CELEXA, **STEP THERAPY**, LIMITED TO #30/MONTH OR 300ML/MONTH, RESTRICTED TO USE AFTER A TRIAL OF PROZAC IN THE PAST 90 DAYS (EFF 6/20/03)

S.N.R.I. Agents

PA, QL \$\$\$\$ Venlafaxine
PA, QL

EFFEXOR, **PA REQ**, LIMITED TO #60/MONTH IF DOSE 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
EFFEXOR XR, **PA REQ**, LIMITED TO #30/MONTH IF DOSE 150MG/DAY, LIMITED TO #60 IF DOSE > 150MG/DAY

M.A.O. Inhibitor Agents

\$\$ Phenelzine
\$\$ Tranylcypromine

NARDIL
PARNATE

Miscellaneous Antidepressant Agents

\$ Trazodone
\$\$\$\$ Bupropion
\$\$\$\$ Bupropion SR
\$\$\$\$ Clomipramine
QL \$\$\$\$ Mirtazapine
QL \$\$\$\$ Nefazodone

DESYREL
WELLBUTRIN
WELLBUTRIN SR (100MG, 150MG TABLETS ONLY)
ANAFRANIL
REMERON, LIMITED TO #30/MONTH
REMERON SOLTABS, LIMITED TO #30/MONTH
SERZONE, LIMITED TO #60/MONTH

Antimanic Agents

\$\$ Lithium Carbonate

ESKALITH
LITHOBID

Benzodiazepines

QL \$ Chlordiazepoxide
QL \$ Diazepam
QL \$ Lorazepam
QL \$\$ Alprazolam
QL \$\$ Clorazepate
QL \$\$ Flurazepam
QL \$\$ Temazepam
QL \$\$ Triazolam

LIBRIUM, LIMITED TO #90/MONTH
VALIUM, LIMITED TO #90/MONTH
ATIVAN, LIMITED TO #90/MONTH
XANAX, LIMITED TO #90/MONTH
TRANXENE, LIMITED TO #90/MONTH
DALMANE, LIMITED TO #30/MONTH
RESTORIL, LIMITED TO #30/MONTH
HALCION, LIMITED TO #30/MONTH

Antipsychotic Agents

\$ Biperiden
\$ Chlorpromazine
\$ Chlorprothixene
\$ Haloperidol
\$ Trifluoperazine
\$\$ Mesoridazine
\$\$ Molindone
\$\$ Pimozide
\$\$ Procyclidine
\$\$ Thiothixene
\$\$\$ Fluphenazine
\$\$\$ Loxapine
\$\$\$ Perphenazine

AKINETON
THORAZINE
TARACTAN
HALDOL
STELAZINE
SERENTIL
MOBAN
ORAP
KEMADRIN
NAVANE
PROLIXIN
LOXITANE
TRILAFON

	\$\$\$	Thioridazine	MELLARIL
	\$\$\$\$	Clozapine	CLOZARIL
QL	\$\$\$\$	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL			ZYPREXA ZYDIS, LIMITED TO #60/MONTH
QL	\$\$\$\$	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH
QL	\$\$\$\$	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
QL	\$\$\$\$	Ziprasidone	GEODON, LIMITED TO #60/MONTH

Miscellaneous Anxiolytics, Sedatives, and Hypnotics

\$	Chloral Hydrate	NOCTEC
\$	Hydroxyzine	ATARAX
\$	Hydroxyzine Pamoate	VISTARIL
\$	Promethazine	PHENERGAN
\$\$\$	Buspirone	BUSPAR

CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

\$\$	Disopyramide	NORPACE
\$\$	Disopyramide CR	NORPACE CR
\$\$	Quinidine Gluconate	QUINAGLUTE
\$\$	Quinidine Sulfate	CIN-QUIN
\$\$	Quinidine Sulfate SR	QUINIDEX
\$\$\$	Quinidine Polygalacturonate	CARDIOQUIN

Lidocaine Type Antidysrhythmic Drug Agents

\$\$\$\$	Flecainide	TAMBOCOR
\$\$\$\$	Mexiletine	MEXITIL
\$\$\$\$	Moricizine	ETHMOZINE
\$\$\$\$	Propafenone	RYTHMOL
\$\$\$\$	Sotalol	BETAPACE
\$\$\$\$	Tocainide	TONOCARD
\$\$\$\$\$	Amiodarone	CORDARONE

Procainamide Antidysrhythmic Drug Agents

\$	Procainamide	PRONESTYL
\$\$	Procainamide SR	PROCAN SR
		PROCANBID

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

\$	Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

\$	Propranolol	INDERAL
\$\$	Atenolol	TENORMIN
\$\$	Metoprolol Succinate	TOPROL XL
\$\$	Metoprolol Tartrate	LOPRESSOR
\$\$	Nadolol	CORGARD
\$\$	Pindolol	VISKEN
\$\$	Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

\$\$	Labetalol	NORMODYNE
		TRANDATE
\$\$\$\$	Carvedilol	COREG

Angiotensin Converting Enzyme Inhibitor Agents

\$	Captopril	CAPOTEN
\$\$	Enalapril	VASOTEC
\$\$	Lisinopril	PRINIVIL
		ZESTRIL

Angiotensin Receptor Blocker Agents

SE, QL	\$\$\$	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS
SE, QL	\$\$\$\$	Valsartan	DIOVAN, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

\$	Diltiazem	CARDIZEM
\$	Verapamil	CALAN
\$\$	Diltiazem SR	CARDIZEM SR
\$\$	Verapamil LA Tablets	CALAN SR
\$\$\$	Felodipine	PLENDIL
\$\$\$	Nifedipine, Sustained Release	ADALAT CC
\$\$\$\$	Diltiazem CD	CARTIA XT

Centrally Acting Antihypertensive Agents

\$	Clonidine	CATAPRES
\$	Methyldopa	ALDOMET
\$\$\$	Guanfacine	TENEX

Combination Antihypertensive Agents

	\$\$	Atenolol/Chlorthalidone	TENORETIC
	\$\$	Captopril/HCTZ	CAPOZIDE
	\$\$	Enalapril/HCTZ	VASORETIC
	\$\$	Lisinopril/HCTZ	ZESTORETIC
			PRINZIDE
	\$\$\$	Bisoprolol/HCTZ	ZIAC
SE, QL	\$\$\$\$	Valsartan/HCTZ	DIOVAN HCT, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF AN ACE INHIBITOR IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

\$\$\$	Phenoxybenzamine	DIBENZYLINE
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Potassium-Sparing Diuretics

\$	Spirolactone	ALDACTONE
\$	Spirolactone/HCTZ	ALDACTAZIDE
\$\$	Triamterene	DYRENIUM
\$\$	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
		MAXZIDE 25
\$\$	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50

Loop Diuretics

\$	Furosemide	LASIX
\$\$	Bumetanide	BUMEX

Thiazide and Related Diuretics

\$	Chlorthalidone	HYGROTON
\$	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
\$\$	Indapamide	LOZOL
\$\$\$	Metolazone	ZAROXOLYN

Vasodilator Antihypertensive Agents

\$	Hydralazine	APRESOLINE
\$	Prazosin	MINIPRESS
\$\$	Minoxidil	LONITEN (EFF 6/20/03)
\$\$\$	Doxazosin Mesylate	CARDURA
\$\$\$	Terazosin	HYTRIN

Antilipemic Agents

	\$	Niacin	NIACIN
QL	\$\$	Fluvastatin	LESCOL, LIMITED TO #30/MONTH
QL			LESCOL XL, LIMITED TO #30/MONTH
	\$\$	Gemfibrozil	LOPID
QL	\$\$	Lovastatin	MEVACOR, LIMITED TO #30/MONTH
	\$\$\$	Niacin, Delayed Release	NIASPAN
QL	\$\$\$\$	Atorvastatin	LIPITOR, LIMITED TO #30/MONTH
	\$\$\$\$	Cholestyramine/Aspartame	QUESTRAN LIGHT
	\$\$\$\$	Cholestyramine/Sucrose	QUESTRAN

Blood Agents

Coagulants and Anticoagulants

	\$	Warfarin Sodium	COUMADIN
QL	\$\$\$\$	Enoxaparin	LOVENOX, LIMITED TO #20/FILL TIMES 3

Hemorheologic Agents

	\$\$	Pentoxifylline	TRENTAL
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Cardiac Glycoside Agents

	\$	Digoxin	LANOXIN
			LANOXICAPS NOT COVERED

Antiplatelet Agents

	\$	Dipyridamole	PERSANTINE
	\$\$\$\$	Clopidogrel	PLAVIX

Vasodilating Agents

	\$	Isosorbide Dinitrate (Chew Tablets Not Covered)	ISORDIL
	\$	Nitroglycerin Sublingual	NITROSTAT SL
	\$\$	Isosorbide Dinitrate SR	DILATRATE SR
	\$\$	Nitroglycerin Ointment	NITROL
SE	\$\$\$	Isosorbide Mononitrate	IMDUR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS

\$\$\$	Nitroglycerin Patches	NITRO-DUR
\$\$\$\$	Nitroglycerin Spray	NITROLINGUAL SPRAY

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

\$	Bismuth Subsalicylate	PEPTO BISMOL
\$	Diphenoxylate/Atropine	LOMOTIL
\$	Kaolin/Pectin	KAOPECTATE
\$\$	Attapulgit	PAREPECTOLIN
\$\$	Loperamide	IMODIUM

Antiemetic Agents

\$	Meclizine	ANTIVERT
\$	Metoclopramide	REGLAN
\$	Promethazine	PHENERGAN
\$\$	Prochlorperazine Maleate	COMPAZINE
		COMPAZINE SPANSULES NOT COVERED
\$\$\$	Trimethobenzamide	TIGAN
PA	\$\$\$\$\$ Ondansetron	ZOFRAN, PA REQ

Antimuscarinic/Antispasmodic Agents

\$	Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)	DONNATAL
\$	Dicyclomine	BENTYL
\$\$	Chlordiazepoxide/Clidinium	LIBRAX
\$\$\$	Hyoscyamine Sulfate	LEVBID
		LEVSIN
		LEVSIN SL

Antiulcer/Antipeptic Agents

\$	Antacid Mg OH/Al OH	MAALOX, TC
\$	Antacid Mg OH/Al OH/Simethicone	MYLANTA I, II
\$	Simethicone	MYLICON
QL	\$\$ Omeprazole Magnesium	PRILOSEC OTC, LIMITED TO #28/28 DAYS
	\$\$\$ Misoprostol	CYTOTEC
	\$\$\$ Sucralfate	CARAFATE
PA, QL	\$\$\$\$ Pantoprazole	PROTONIX, PA REQ, LIMITED TO #30/MONTH TIMES 3 MONTHS

Bowel Evacuant Agents

\$	Oral Colon Lavage Solution	COLYTELY
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Digestive Enzymes

\$\$\$	Amylase/Lipase/Protease/Pancreatin	CREON
\$\$\$\$	Amylase/Lipase/Protease	PANCREASE
		PANCREASE MT
		VIOKASE

Gallstone Solubilizing Agents

\$\$\$\$ Ursodiol ACTIGALL

Gastrointestinal Stimulant Agents

\$ Metoclopramide REGLAN

H₂ Antagonist Agents

\$\$ Cimetidine TAGAMET
\$\$ Ranitidine ZANTAC (TABLETS ONLY)

Laxative Agents

QL \$ Bisacodyl Suppositories DULCOLAX, LIMITED TO #30/MONTH
\$ Docusate Sodium Capsules COLACE , (EFF 9/1/03)
QL \$\$ Lactulose CEPHULAC, LIMITED TO 4L/MONTH
QL CHRONULAC, LIMITED TO 4L/MONTH

Miscellaneous Gastrointestinal Supplies

\$\$ Ostomy Supplies BILL EDS DIRECTLY FOR SUPPLIES

Miscellaneous Gastrointestinal Agents

\$\$\$ Mesalamine ASACOL
ROWASA
\$\$\$ Olsalazine DIPENTUM
\$\$\$ Sulfasalazine AZULFIDINE
PA \$\$\$\$ Budesonide ENTOCORT EC, PA REQ
PA \$\$\$\$ Tegaserod ZELNORM, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

\$ Metronidazole FLAGYL
\$\$ Iodoquinol (Diiodohydroxyquin) YODOXIN

Anthelmintic Agents

\$\$ Furazolidone FUROXONE
\$\$ Quinacrine ATABRINE
\$\$\$ Albendazole ALBENZA
\$\$\$ Mebendazole VERMOX
\$\$\$\$ Niclosamide NICLOCIDE
\$\$\$\$ Praziquantel BILTRICIDE
\$\$\$\$ Thiabendazole MINTEZOL

Antibiotic Agents

		Aminoglycosides	
	\$\$\$	Neomycin Sulfate	MYCIFRADIN
		Cephalosporins	
	\$	Cephalexin	KEFLEX
	\$\$\$	Cefaclor	CECLOR
	\$\$\$	Cefadroxil	DURICEF
SE, QL	\$\$\$	Cefdinir	OMNICEF, STEP THERAPY , LIMITED TO 10-DAY SUPPLY, RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED ANTIBIOTIC IN THE PAST 90 DAYS
QL	\$\$\$	Cefixime	SUPRAX, LIMITED TO #1 X 400MG/FILL
		Macrolide Antibiotic Agents	
	\$	Erythromycin Stearate	ERYTHROCIN
	\$\$	Erythromycin Base	ERY-TAB
			PCE
	\$\$	Erythromycin Ethylsuccinate	EES
	\$\$	Erythromycin/Sulfisoxazole	ERYPED SUSPENSION
SE, QL	\$\$\$	Azithromycin	PEDIAZOLE
			ZITHROMAX, STEP THERAPY , LIMITED TO 5-DAY SUPPLY, RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED ANTIBIOTIC IN THE PAST 90 DAYS OR CONCURRENT USE OF AN HIV MEDICATION
PA	\$\$\$	Clarithromycin	BIAXIN, PA REQ
		Miscellaneous Antibiotic Agents	
	\$	Metronidazole	FLAGYL
	\$\$\$	Clindamycin	CLEOCIN
		Penicillins	
	\$	Amoxicillin	AMOXIL
			TRIMOX
	\$	Ampicillin	PRINCIPEN
	\$	Penicillin VK (125mg Tablets Not Covered)	PEN VK
	\$\$	Dicloxacillin	DYNAPEN
SE, QL	\$\$\$	Amoxicillin/Potassium Clavulanate	AUGMENTIN, STEP THERAPY , LIMITED TO 10-DAY SUPPLY, RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED ANTIBIOTIC IN THE PAST 90 DAYS
		Quinolones	
SE, QL	\$\$\$\$	Levofloxacin	LEVAQUIN, STEP THERAPY , LIMITED TO 14-DAY SUPPLY, RESTRICTED TO USE AFTER A TRIAL OF AN UNRESTRICTED ANTIBIOTIC IN THE PAST 90 DAYS
		Sulfonamide Agents	
	\$	Sulfamethoxazole/Trimethoprim (SMZ/TMP)	BACTRIM
			SEPTRA
	\$	Trimethoprim	TRIMPEX
	\$\$	Erythromycin/Sulfisoxazole	PEDIAZOLE
	\$\$	Sulfasalazine	AZULFIDINE
			AZULFIDINE EN-TABS NOT COVERED
	\$\$	Sulfisoxazole	GANTRISIN
	\$\$\$	Sulfadiazine	SULFADIAZINE

Tetracyclines

\$	Tetracycline	ACHROMYCIN V SUMYCIN
\$\$	Doxycycline	VIBRAMYCIN VIBRA-TABS DORYX, PERIOSTAT NOT COVERED
\$\$	Minocycline	MINOCIN (EFF 6/20/03)

Antifungal Agents

\$	Nystatin (Oral Powder Not Covered)	MYCOSTATIN
\$\$	Clotrimazole	MYCELEX TROCHE
\$\$	Griseofulvin Ultramicrosized	GRIS-PEG FULVICIN P/G
\$\$\$\$	Ketoconazole	NIZORAL
PA	\$\$\$\$\$ Fluconazole	DIFLUCAN, PA REQ
QL		DIFLUCAN 150MG, LIMITED TO #2 TABLETS/MONTH

Antimalarial Agents

\$	Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
\$	Primaquine	PRIMAQUINE
\$	Quinine (260mg Not Covered)	QUININE
\$\$	Hydroxychloroquine	PLAQUENIL
\$\$	Iodoquinol	YODOXIN
\$\$	Pyrimethamine	DARAPRIM
\$\$	Quinacrine	ATABRINE
\$\$	Sulfadoxine/Pyrimethamine	FANSIDAR
\$\$\$\$	Atovaquone/Proguanil	MALARONE
\$\$\$\$\$	Mefloquine	LARIAM

Antituberculosis Agents

\$	Isoniazid	ISONIAZID
\$\$	Ethambutol	MYAMBUTOL
\$\$	Pyrazinamide	PYRAZINAMIDE
\$\$	Rifampin	RIFADIN
\$\$\$	Rifabutin	MYCOBUTIN

Anti-Ulcer Eradication Agents

QL	\$\$\$\$ Amoxicillin/Clarithromycin/Lansoprazole	PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL	\$\$\$\$ Tetracycline/Bismuth/Metronidazole	HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Antiviral Agents

\$	Amantadine	SYMMETREL
\$\$\$	Acyclovir Oral	ZOVIRAX ORAL
\$\$\$	Rimantadine	FLUMADINE
SE	\$\$\$\$ Famciclovir	FAMVIR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS
SE	\$\$\$\$ Valacyclovir	VALTREX, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS

	\$\$\$\$\$	Abacavir	ZIAGEN
	\$\$\$\$\$	Amprenavir	AGENERASE
	\$\$\$\$\$	Delavirdine	RESCRIPTOR
	\$\$\$\$\$	Didanosine (ddl)	VIDEX (EFF 6/20/03)
	\$\$\$\$\$	Efavirenz	SUSTIVA
	\$\$\$\$\$	Enfuvirtide	FUZEON (EFF 9/29/03)
	\$\$\$\$\$	Ganciclovir	CYTOVENE
	\$\$\$\$\$	Indinavir	CRIXIVAN
	\$\$\$\$\$	Lamivudine (3TC)	EPIVIR
	\$\$\$\$\$	Nelfinavir	VIRACEPT
	\$\$\$\$\$	Nevirapine	VIRAMUNE
PA	\$\$\$\$\$	Peginterferon Alfa 2a	PEGASYS, PA REQ
PA	\$\$\$\$\$	Peginterferon Alfa 2b	PEG-INTRON, PA REQ
PA	\$\$\$\$\$	Ribavirin	COPEGUS, PA REQ (EFF 6/20/03)
PA	\$\$\$\$\$	Ribavirin/Interferon Alfa 2b	REBETRON, PA REQ
	\$\$\$\$\$	Ritonavir	NORVIR
	\$\$\$\$\$	Ritonavir/Lopinavir	KALETRA (EFF 6/20/03)
	\$\$\$\$\$	Saquinavir	INVIRASE
	\$\$\$\$\$	Saquinavir Mesylate	FORTOVASE
	\$\$\$\$\$	Stavudine (d4T)	ZERIT
	\$\$\$\$\$	Tenofovir Disoproxil Fumarate	VIREAD (EFF 6/20/03)
	\$\$\$\$\$	Zalcitabine (ddC)	HIVID
	\$\$\$\$\$	Zidovudine (AZT)	RETROVIR
	\$\$\$\$\$	Zidovudine/Lamivudine	COMBIVIR
	\$\$\$\$\$	Zidovudine/Lamivudine/Abacavir	TRIZIVIR

Leprostatic Agents

\$	Clofazimine	LAMPRENE
\$	Dapsone	DAPSONE

ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

All oral, non-experimental antineoplastic agents are considered a formulary benefit/85.

Altretamine	HEXALEN
Anastrozole	ARIMIDEX
Bexarotene	TARGRETIN
Bicalutamide	CASODEX
Busulfan	MYLERAN
Capecitabine	XELODA
Chlorambucil	LEUKERAN
Cyclophosphamide	CYTOXAN
Estramustine	EMCYT
Etoposide	VEPESID

PA	Flutamide	EULEXIN
	Hydroxyurea	HYDREA
	Imatinib	GLEEVEC, PA REQ
	Letrozole	FEMARA
	Levamisole	ERGAMISOL
	Lomustine	CEENU
	Megestrol	MEGACE
	Melphalan	ALKERAN
	Mercaptopurine	PURINETHOL
	Methotrexate	RHEUMATREX
	Mitotane	LYSODREN
	Nilutamide	NILANDRON
	Procarbazine	MATULANE
	Tamoxifen Citrate	NOLVADEX
	Testolactone	TESLAC
	Thioguanine	THIOGUANINE
	Tretinoin	VESANOID

Blood Colony Stimulating Factors

PA	\$\$\$\$\$	Darbepoetin	ARANESP, PA REQ
PA	\$\$\$\$\$	Erythropoietin	EPOGEN, PA REQ
PA			PROCRIT, PA REQ
PA	\$\$\$\$\$	Filgrastim	NEUPOGEN, PA REQ
PA	\$\$\$\$\$	Oprelvekin	NEUMEGA, PA REQ
PA	\$\$\$\$\$	Pegfilgrastim	NEULASTA, PA REQ
PA	\$\$\$\$\$	Sargramostim	LEUKINE, PA REQ

Multiple Sclerosis Agents

PA	\$\$\$\$\$	Glatiramer	COPAXONE, PA REQ
PA	\$\$\$\$\$	Interferon Beta 1a	AVONEX, PA REQ
PA			REBIF, PA REQ
PA	\$\$\$\$\$	Interferon Beta 1b	BETASERON, PA REQ

Miscellaneous Agents

PA	\$\$\$\$\$	Adalimumab	HUMIRA, PA REQ (EFF 9/29/03)
PA	\$\$\$\$\$	Anakinra	KINERET, PA REQ
PA	\$\$\$\$\$	Etanercept	ENBREL, PA REQ
PA	\$\$\$\$\$	Interferon Alfa 2a	ROFERON A, PA REQ
PA	\$\$\$\$\$	Interferon Alfa 2b	INTRON A, PA REQ
PA	\$\$\$\$\$	Interferon Alfa N3	ALFERON N, PA REQ
PA	\$\$\$\$\$	Interferon Alfacon 1	INFERGEN, PA REQ
PA	\$\$\$\$\$	Interferon Gamma 1b	ACTIMMUNE, PA REQ
PA	\$\$\$\$\$	Leuprolide	LUPRON, PA REQ

Immunosuppressant Agents

\$\$	Leucovorin	WELLCOVORIN
\$\$\$	Azathioprine	IMURAN
\$\$\$\$	Cyclosporine	SANDIMMUNE
\$\$\$\$	Mycophenolate Mofetil	CELLCEPT (EFF 6/20/03)
\$\$\$\$	Sirolimus	RAPAMUNE (EFF 6/20/03)
\$\$\$\$	Tacrolimus (oral only)	PROGRAF (EFF 6/20/03)

RESPIRATORY/EENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

\$	Chlorpheniramine	CHLORTRIMETON
\$	Dexchlorpheniramine	POLARAMINE

Single Entity Ethanolamine Agents

\$	Cyproheptadine	PERIACTIN
\$	Diphenhydramine	BENADRYL

Non-Sedating Single Entity Agents

QL	\$\$	Loratadine	OTC LORATADINE ONLY, LIMITED TO #30 TABLETS/ MONTH (EFF 9/29/03)
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Miscellaneous Antihistamine Agents

\$	Hydroxyzine	ATARAX
\$	Hydroxyzine Pamoate	VISTARIL
\$\$	Promethazine	PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

\$\$	Bromphen/Pseudoephedrine	BROMFED
\$\$	Guaifenesin/Pseudoephedrine	GUAIFED-PD
\$\$	Pseudoephedrine/Chlorpheniramine	DECONAMINE SR
\$\$\$	Bromphen/Pseudoephedrine	BROMFED PD

Antitussive Agents

Non-Narcotic Antitussive Agents

\$	Benzonatate	TESSALON
\$	Dextromethorphan	TUSSIN PEDIATRIC
\$	Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

Narcotic Antitussive Agents

\$	Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
\$	Guaifenesin/Codeine	ROBITUSSIN A-C
\$	Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
\$	Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC ENDAL-HD
\$	Promethazine/Codeine	PHENERGAN/CODEINE
\$	Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE
\$	Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
\$	Tripolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE
\$\$\$	Guaifenesin/Codeine Phosphate	TUSSI-ORGANIDIN NR

Decongestants

\$ Pseudoephedrine SUDAFED

Asthma Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL \$\$ Albuterol PROVENTIL, LIMITED TO #2 INHALERS/MONTH
QL \$\$\$ Metaproterenol ALUPENT, LIMITED TO #2 INHALERS/MONTH
QL \$\$\$ Pirbuterol Acetate MAXAIR, LIMITED TO #2 INHALERS/MONTH
QL MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
QL \$\$\$\$ Albuterol/Ipratropium COMBIVENT, LIMITED TO #2 INHALERS/MONTH
QL \$\$\$\$ Formoterol FORADIL, LIMITED TO #60/MONTH
QL \$\$\$\$ Salmeterol/Fluticasone ADVAIR DISKUS, LIMITED TO #60/MONTH

Oral Sympathomimetic (Adrenergic) Agents

\$ Metaproterenol Oral ALUPENT
\$\$ Albuterol PROVENTIL
\$\$ Terbutaline Sulfate BRETHINE
BRICANYL
\$\$\$ Albuterol E.R. PROVENTIL REPETABS
VOLMAX

Inhaled Oral Corticosteroid Agents

QL \$\$ Beclomethasone Inhaler QVAR, LIMITED TO #2 INHALERS/MONTH
QL \$\$ Budesonide Inhaler PULMICORT, LIMITED TO #2 INHALERS/MONTH
QL \$\$ Triamcinolone Inhaler AZMACORT, LIMITED TO #3 INHALERS/MONTH
QL \$\$\$ Fluticasone FLOVENT INHALER, LIMITED TO 2 INHALERS/MONTH
QL FLOVENT DISKUS, LIMITED TO #62/MONTH

Leukotriene Receptor Antagonists

QL \$\$\$\$ Zafirlukast ACCOLATE, LIMITED TO #60/MONTH

Respiratory Smooth Muscle Relaxant Agents

\$ Aminophylline 150mg/5ml
\$ Aminophylline Suppositories
\$ Theophylline, 80mg/15cc (Alcohol Free) SLO-PHYLLIN 80
\$ Theophylline SLO-PHYLLIN
\$ Theophylline, Sustained Release THEO-DUR
SLO-BID
UNIPHYL

Expectorant Agents

\$ Guaifenesin ROBITUSSIN
\$ Guaifenesin/Dextromethorphan ROBITUSSIN DM
\$ Guaifenesin/Phenylephrine ENDAL
\$ Guaifenesin/Pseudoephedrine ZEPHREX LA
\$ Phenylephrine/Promethazine PHENERGAN VC
\$\$ Phenylephrine/Guaifenesin RESCON GC
\$\$ Potassium Iodide SSKI
\$\$\$ Guaifenesin/Pseudoephedrine GUAIFED

Mucolytic Agents

\$\$\$ Acetylcysteine MUCOMYST

Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

\$	Bacitracin	BACITRACIN
\$	Dexamethasone/Neomycin	NEO-DECADRON
\$	Dexamethasone/Polymyxin/Neomycin	MAXITROL
\$	Erythromycin Base	ILOTYCIN
\$	Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
\$\$	Chloramphenicol	CHLOROPTIC
\$\$	Gentamicin	GARAMYCIN
\$\$	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
\$\$	Tobramycin	TOBREX
\$\$\$	Neomycin/Polymyxin/Prednisone	POLY-PRED
\$\$\$	Polymixin B Sulfate/TMP	POLYTRIM
\$\$\$\$	Chloramphenicol	CHLOROMYCETIN OPHTHALMIC
\$\$\$\$	Gentamicin/Prednisolone	PRED-G
\$\$\$\$	Ofloxacin	OCUFLOX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

\$\$	Fluorometholone	EFLONE FML FML FORTE
\$\$	Prednisolone Acetate	PRED MILD OPHTHALMIC PRED FORTE
\$\$	Prednisolone Phosphate	INFLAMASE INFLAMASE FORTE
\$\$	Sulfacetamide/Fluorometholone	FML-S

Ophthalmic Anti-Inflammatory Agents, NSAIDs

\$\$\$	Diclofenac Sodium	VOLTAREN
\$\$\$	Flurbiprofen Sodium	OCUFEN
\$\$\$	Ketorolac Tromethamine	ACULAR

Ophthalmic Antiviral Agents

\$\$\$	Idoxuridine	HERPLEX
\$\$\$	Vidarabine Ophthalmic Ointment	VIRA A
\$\$\$\$	Trifluridine Ophthalmic Solution	VIROPTIC

Ophthalmic Beta Blockers

\$\$	Levobunolol	BETAGAN
\$\$	Timolol	BETIMOL TIMOPTIC TIMOPTIC-XE
\$\$\$	Betaxolol	BETOPTIC

Ophthalmic Miotic Agents

\$	Pilocarpine	PILOCAR OCUSERT NOT COVERED
\$\$	Echothiophate Iodide	PHOSPHOLINE IODIDE
\$\$	Epinephrine/Pilocarpine	P1E1 – ALL STRENGTHS
\$\$\$	Physostigmine Sulfate	ESERINE SULFATE
\$\$\$\$	Brimonidine	ALPHAGAN ALPHAGAN P
\$\$\$\$	Dorzolamide	TRUSOPT
\$\$\$\$	Dorzolamide/Timolol	COSOPT

Ophthalmic Mydriatic Agents

\$	Atropine Sulfate	ISOPTO ATROPINE
\$\$	Dipivefrin	PROPINE
\$\$	Epinephrine	EPIFRIN
\$\$\$	Tropicamide	MYDRIACYL

Ophthalmic Sulfonamide Agents

\$	Sulfacetamide	BLEPH-10 SODIUM SULAMYD
\$\$\$\$	Sulfacetamide 10%/Prednisolone 0.2%	BLEPHAMIDE
\$\$\$\$	Sulfacetamide 10%/Prednisolone 0.5%	METIMYD

Ophthalmic Antiallergic Agents

\$\$\$	Levocabastine	LIVOSTIN
\$\$\$	Lodoxamide	ALOMIDE
\$\$\$	Olopatadine	PATANOL

Miscellaneous Ophthalmic Agents

\$\$\$\$	Latanoprost	XALATAN
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Otic Anti-Infective Agents

\$\$	Acetic Acid	VOSOL
\$\$	Acetic Acid 2%	DOMBORO
\$\$	Acetic Acid 2%/Hydrocortisone 1%	VOSOL HC
\$\$	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN
\$\$\$\$	Ofloxacin	FLOXIN OTIC

Miscellaneous Otic Agents

\$	Carbamide Peroxide/Glycerin	DEBROX
\$\$	Benzocaine/Antipyrine	AURALGAN

Inhaled/Oral EENT Agents

Inhaled Nasal Agents

QL	\$\$	Budesonide	RHINOCORT AQ, LIMITED TO #2 DEVICES/MONTH
QL	\$\$	Triamcinolone Acetonide, Nasal	TRINASAL, LIMITED TO #2 DEVICES/MONTH
QL	\$\$\$	Ipratropium	ATROVENT, LIMITED TO #2 DEVICES/MONTH
QL	\$\$\$	Mometasone	NASONEX, LIMITED TO #2 DEVICES/MONTH
QL	\$\$\$	Triamcinolone Acetonide, Nasal	NASACORT, LIMITED TO #2 DEVICES/MONTH NASACORT AQ, LIMITED TO #2 DEVICES/MONTH

Carbonic Anhydrase Inhibitor Agents

\$\$	Acetazolamide	DIAMOX
\$\$\$	Acetazolamide SA	DIAMOX SEQUELS
\$\$\$	Methazolamide	NEPTAZANE

Local Anesthetic Agents

\$	Lidocaine, Viscous	VISCOUS XYLOCAINE
\$\$	Benzocaine/Antipyrine Otic	AURALGAN
\$\$\$	Triamcinolone 0.1% in Orabase	KENALOG IN ORABASE

Miscellaneous EENT Agents

\$	Sodium Chloride for Inhalation	GENERIC
\$\$	Carbachol	ISOPTO CARBACHOL
\$\$	Chlorhexidine Gluconate	PERIDEX
\$\$	Epinephrine Injection	EPIPEN

QL	\$\$	Optichamber	OPTICHAMBER, LIMITED TO #2/YEAR
	\$\$\$	Triethanolamine	CERUMENEX
	\$\$\$\$	Cromolyn Ophthalmic Solution	CROLOM
QL	\$\$\$\$	Cromolyn Sodium	INTAL INHALER, LIMITED TO #2 INHALERS/MONTH
QL	\$\$\$\$	Nedocromil Sodium	TILADE INHALER, LIMITED TO #2 INHALERS/MONTH

DIABETIC AND THYROID AGENTS

Diabetic Agents

Sulfonylureas

	\$	Chlorpropamide	DIABINESE
	\$	Tolazamide	TOLINASE
	\$	Tolbutamide	ORINASE
	\$\$	Acetohexamide	DYMELOR
	\$\$	Glipizide	GLUCOTROL
	\$\$	Glyburide	DIABETA
			MICRONASE
SE	\$\$\$	Glipizide L.A.	GLUCOTROL XL, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF GLIPIZIDE IN THE PAST 90 DAYS

Non-Sulfonylureas

	\$\$	Metformin	GLUCOPHAGE
	\$\$\$\$	Acarbose	PRECOSE
PA	\$\$\$\$\$	Pioglitazone	ACTOS, PA REQ

Miscellaneous Diabetic Agents

	\$\$\$	Glucagon	GLUCAGON
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Insulin Agents

	\$\$	Insulin	ALL NOVO INSULINS, VIALS ONLY
	\$\$\$	Human Insulin	ALL NOVO INSULINS, VIALS ONLY
	\$\$\$\$	Insulin Aspart	NOVOLOG, VIALS ONLY
	\$\$\$\$	Insulin Glargine	LANTUS

Thyroid Agents

	\$	Thyroid, Desiccated	ARMOUR THYROID
	\$\$	Levothyroxine	LEVOTHROID
			LEVOXYL
	\$\$	Liotrix	SYNTHROID
	\$\$\$	Liothyronine	THYROLAR
			CYTOMEL

Antithyroid Agents

	\$\$	Propylthiouracil	PROPYLTHIOURACIL
	\$\$\$	Calcitriol	ROCALTROL
	\$\$\$	Methimazole	TAPAZOLE

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

\$	Dexamethasone	DECADRON
\$	Hydrocortisone Oral	CORTEF
\$	Prednisone	DELTASONE
		ORASONE
\$\$	Cortisone Acetate	CORTONE
\$\$	Fludrocortisone Acetate	FLORINEF
\$\$	Methylprednisolone	MEDROL
		MEDROL DOSEPAK
\$\$	Prednisolone	PEDIAPRED
		PRELONE

Androgen Agents

\$\$	Fluoxymesterone	HALOTESTIN
\$\$	Methyltestosterone	ANDROID
		METANDREN
\$\$\$\$	Danazol	DANOCRINE

Bisphosphonate Agents

QL	\$\$\$	Risedronate	ACTONEL, 5MG, 30MG LIMITED TO #30/MONTH; 35MG LIMITED TO #4/MONTH
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Parathyroid Hormone

PA, QL	\$\$\$\$	Teriparatide	FORTEO, PA REQ , LIMITED TO 1 PEN/MONTH (EFF 9/29/03)
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Estrogen Agents

	\$	Diethylstilbestrol	DES
	\$\$	Conjugated Estrogens	PREMARIN
	\$\$	Conjugated Estrogens, Vaginal	PREMARIN VAGINAL CREAM
	\$\$	Estradiol	ESTRACE
SE	\$\$	Estradiol/Vaginal Ring	ESTRING, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS
	\$\$	Estrogen/Medroxyprogesterone	PREMPRO, PREMPRO LOW DOSE (EFF 8/1/03)
	\$\$\$	Esterified Estrogens/ Methyltestosterone	PREMPHASE
	\$\$\$\$	Estradiol Patches	ESTRATEST
			ESTRADERM
			VIVELLE
			VIVELLE DOT

Estrogen Agonist-Antagonists

\$\$\$\$\$	Raloxifene	EVISTA
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Miscellaneous Estrogen Agents

PA	\$\$\$\$	Calcitonin	MIACALCIN NS, PA REQ
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Oral Contraceptive Agents

Monophasic Oral Contraceptives

\$	Mestranol/Norethindrone	ORTHO-NOVUM 1/50
\$	Ethinyl Estradiol/Ethinodiol	DEMULEN 1/50, 1/35
\$	Ethinyl Estradiol/Norgestrel	OVRAL
		LO/OVRAL
\$	Ethinyl Estradiol/Norethindrone	ORTHO-NOVUM 1/35
		MODICON
		LOESTRIN FE
\$	Ethinyl Estradiol/Norgestimate	ORTHO CYCLEN
\$	Ethinyl Estradiol/Desogestrel	DESOGEN
\$	Ethinyl Estradiol/Levonorgestrel	NORDETTE
		ALESSE

Biphasic Oral Contraceptives

\$	Ethinyl Estradiol/Norethindrone	ORTHO-NOVUM 10/11
\$	Ethinyl Estradiol/Desogestrel	MIRCETTE

Triphasic Oral Contraceptives

\$	Ethinyl Estradiol/Norethindrone	ORTHO-NOVUM 777
\$	Ethinyl Estradiol/Levonorgestrel	TRIPHASIL

Progestin Only

\$\$	Norethindrone	NOR-QD
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Oxytocic Agents

\$\$	Ergonovine Maleate	ERGOTRATE
\$\$	Methylergonovine Maleate	METHERGINE

Pituitary Agents

\$\$\$\$	Desmopressin	DDAVP
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Progestin Agents

\$\$	Medroxyprogesterone	CYCRIN
		PROVERA
\$\$	Norethindrone Acetate	AYGESTIN
		NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

\$	Trimethoprim	TRIMPEX
\$\$	Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
\$\$\$	Nitrofurantoin (Tablets, Suspension Only)	FURADANTIN

Urinary Anti-Spasmodic Agents

\$	Phenazopyridine	PYRIDIUM
\$\$\$	Pentosan	ELMIRON

Genitourinary Smooth Muscle Relaxant Agents

	\$\$	Belladonna/Methylene Blue	URISED
	\$\$	Oxybutynin	DITROPAN
ST, QL	\$\$\$\$	Tolterodine	DITROPAN XL NOT COVERED DETROL, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS (EFF 6/20/03)
ST, QL			DETROL LA, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS (EFF 6/20/03)

Parasympathomimetic (Cholinergic) Agents

\$	Bethanechol	URECHOLINE
\$	Neostigmine	PROSTIGMIN
\$	Pyridostigmine	MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

\$	Anthralin	DRITHOCREME
\$\$\$	Podofilox	DRITHO-SCALP CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

	\$	Aluminum Acetate	BURROWS SOLUTION
	\$	Calamine	CALAMINE LOTION
	\$	Hydrocortisone 1% Rectal	PROCTOCORT
	\$\$	Aluminum Chloride Hexahydrate	DRYSOL
	\$\$	Calcipotriene	DOVONEX
	\$\$	Fluorouracil	EFUDEX
	\$\$	Masoprocol	ACTINEX
PA	\$\$\$	Isotretinoin	ACCUTANE, PA REQ
PA	\$\$\$\$	Becaplermin	REGGRANEX, PA REQ

Topical Antibiotic Agents

\$	Bacitracin	BACITRACIN
\$	Bacitracin/Polymixin/Neomycin	NEOSPORIN
\$	Erythromycin Topical	ERYGEL
		EMGEL
		T-STAT

\$\$	Clindamycin Solution	CLEOCIN T
\$\$	Gentamicin Sulfate	GARAMYCIN
\$\$\$	Erythromycin/Benzoyl Peroxide	BENZAMYCIN
\$\$\$	Silver Sulfadiazine	SILVADENE
\$\$\$\$	Mupirocin	BACTROBAN

Topical Antifungal Agents

\$	Nystatin	MYCOSTATIN
\$	Tolnaftate	TINACTIN
\$	Triamcinolone/Nystatin	MYCOLOG II
\$\$\$	Ciclopirox	LOPROX
\$\$\$	Clotrimazole/Betamethasone	LOTRISONE
\$\$\$	Clotrimazole	LOTRIMIN
\$\$\$	Ketoconazole	NIZORAL
\$\$\$	Miconazole Nitrate	MONISTAT-DERM
\$\$\$	Terbinafine	LAMISIL

Vaginal Antifungal Agents

\$	Clotrimazole Cream/Vaginal Tablets	MYCELEX
		MYCELEX G
\$	Nystatin	MYCOSTATIN
\$\$	Butoconazole	FEMSTAT
\$\$	Miconazole Cream/Vaginal Tablets	MONISTAT
		MONISTAT 3 (200MG TABLETS)
\$\$	Triple Sulfa Cream	SULTRIN
\$\$\$	Tioconazole	VAGISTAT-1

Vaginal Anti-Infective Agents

\$\$\$	Metronidazole	METROGEL-VAGINAL
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Topical Contraceptive Agents

\$	Nonoxynol 9 Foam	DELFIN (EFF 6/20/03)
\$	Nonoxynol 9 Gel	CONCEPTROL (EFF 6/20/03)
\$	Nonoxynol 9 Jelly	GYNOL (EFF 6/20/03)
\$	Nonoxynol 9 Suppositories	SEMICID (EFF 6/20/03)
\$	Octoxynol 9 Jelly	ORTHO-GYNOL (EFF 6/20/03)

Topical Anti-Inflammatory Agents

	LOW POTENCY	
\$	Fluocinolone 0.025%	SYNALAR
\$	Hydrocortisone	HYTONE
\$\$\$	Desonide	TRIDESILON
\$\$\$	Hydrocortisone Acetate	CORTIFOAM
\$\$\$	Hydrocortisone/Pramoxine	PROCTOCREAM-HC
\$\$\$\$	Hydrocortisone Enema	CORTENEMA

	MEDIUM POTENCY	
\$	Betamethasone Dipropionate	DIPROSONE MAXIVATE
\$	Betamethasone Valerate 0.01%	VALISONE REDUCED STRENGTH
\$	Betamethasone Valerate 0.1%	VALISONE
\$	Triamcinolone	ARISTOCORT ARISTOCORT A NOT COVERED KENALOG
\$\$\$	Desoximetasone Cream/Gel 0.05%	TOPICORT LP
\$\$\$	Flurandrenolide	CORDRAN
\$\$\$	Hydrocortisone Valerate	WESTCORT
\$\$\$	Mometasone Furoate Cream	ELOCON
	HIGH POTENCY	
\$\$	Desoximetasone 0.25%	TOPICORT
\$\$	Fluocinonide	LIDEX LIDEX E
\$\$	Fluocinolone Acetonide 0.2%	SYNALAR
\$\$\$	Betamethasone Dipropionate	DIPROLENE
	VERY HIGH POTENCY	
\$\$\$\$	Augmented Betamethasone Dipropionate	DIPROLENE AF
\$\$\$\$	Diflorasone Diacetate	FLORONE FLORONE-E PSORCON

Topical Antipruritic and Local Anesthetic Agents

	\$\$	Lidocaine (Viscous and Spray Only)	XYLOCAINE
	\$\$	Pramoxine/Hydrocortisone	PROCTOFOAM HC
	\$\$\$	Pramoxine	EPIFOAM
PA	\$\$\$\$	Pimecrolimus	ELIDEL, PA REQ

Topical Antiviral Agents

	\$\$\$\$	Acyclovir Topical	ZOVIRAX OINTMENT
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Topical Miscellaneous Anti-Infective Agents

	\$	Selenium Sulfide 2.5%	EXSEL SELSUN
	\$	Sulfacetamide Lotion	SEBIZON

Scabicide/Pediculicide Agents

	\$\$\$	Crotamiton	EURAX
	\$\$\$	Malathion	OVIDE
	\$\$\$	Permethrin	ELIMITE NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

	\$	Calcium Carbonate	TUMS
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\$\$	Calcium Acetate	PHOS LO
\$\$	Electrolyte Solution, Pediatric Oral	PEDIALYTE
Potassium Agents		
<i>Potassium Chloride 8mEq</i>		
\$\$	Potassium Chloride	MICRO-K
<i>Potassium Chloride 10mEq</i>		
\$\$	Potassium Chloride	KAON-CL 10
		K-DUR
		MICRO-K 10
<i>Potassium Chloride 20mEq</i>		
\$\$	Potassium Chloride	K-DUR
<i>Potassium Chloride Effervescent Tablets</i>		
\$	Potassium Chloride Tablets	K-LYTE
\$\$	Potassium Chloride Tablets	K-LYTE CL DS
<i>Potassium Chloride Powders</i>		
\$\$	Potassium Chloride Powder	K-LOR
<i>Potassium Chloride Liquids</i>		
\$	Potassium Chloride	KAON-CL
<i>Potassium-Removing Resins</i>		
\$\$\$\$	Sodium Polystyrene Sulfonate	KAYEXALATE

Heavy Metal Antagonist Agents

\$\$\$\$	Penicillamine	CUPRIMINE
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Vitamin Agents

Vitamin B-Complex Agents

\$	Cyanocobalamin	VITAMIN B ₁₂
\$	Folic Acid	FOLIC ACID
\$	Pyridoxine	VITAMIN B ₆
\$	Thiamine	VITAMIN B ₁
\$\$	Niacin	NIACIN

Vitamin D

\$\$\$	Calcitriol	ROCALTROL
\$\$\$	Ergocalciferol	DRISDOL

Vitamin K Activity Agents

\$\$	Phytonadione	MEPHYTON
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Iron Agents

\$	Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL
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Diagnostic Testing

Blood Glucose Supplies

\$	Alcohol Swabs	BILL EDS DIRECTLY FOR SUPPLIES
\$	Lancets	BILL EDS DIRECTLY FOR SUPPLIES
\$	Syringes	BILL EDS DIRECTLY FOR SUPPLIES
\$\$	Blood Glucose Testing Strips	BILL EDS DIRECTLY FOR SUPPLIES

Alcohol And Smoking Deterrent Agents

	\$\$	Disulfiram	ANTABUSE
PA	\$\$\$	Bupropion SR	ZYBAN, PA REQ
PA	\$\$\$	Nicotine	NICORETTE GUM, PA REQ
PA			NICOTINE PATCH, PA REQ (OTC PATCHES ONLY), (EFF 9/25/03)
PA			NICOTROL NASAL SPRAY, PA REQ

Gout Agents

	\$\$	Colchicine	COLCHICINE
	\$\$	Probenecid	BENEMID
	\$\$\$	Allopurinol	ZYLOPRIM
	\$\$\$	Colchicine/Probenecid	COL-BENEMID

INDEX

—A—

- Abacavir, 20
Acarbose, 26
ACCOLATE, 23
ACCUTANE, 29
Acetaminophen, 10
Acetaminophen/Codeine, 10
Acetaminophen/Hydrocodone, 10
Acetazolamide, 25
Acetazolamide SA, 25
Acetic Acid, 25
Acetic Acid 2%, 25
Acetic Acid 2%/Hydrocortisone 1%, 25
Acetohexamide, 26
Acetylcysteine, 23
ACHROMYCIN V, 19
ACTIFED/CODEINE, 22
ACTIGALL, 17
ACTIMMUNE, 21
ACTINEX, 29
ACTONEL, 27
ACTOS, 26
ACULAR, 24
Acyclovir Oral, 19
Acyclovir Topical, 31
ADALAT CC, 14
Adalimumab, 21
ADVAIR DISKUS, 23
AGENERASE, 20
AKINETON, 12
Albendazole, 17
ALBENZA, 17
Albuterol, 23
Albuterol E.R., 23
Albuterol/Ipratropium, 23
Alcohol And Smoking Deterrent Agents, 33
Alcohol Swabs, 32
ALDACTAZIDE, 14
ALDACTONE, 14
ALDOMET, 14
ALESSE, 28
ALFERON N, 21
ALKERAN, 21
Allopurinol, 33
Almotriptan, 10
ALOMIDE, 25
Alpha-Adrenergic Antagonist Antihypertensive Agents, 13
ALPHAGAN, 24
ALPHAGAN P, 24
Alprazolam, 12
Altretamine, 20
Aluminum Acetate, 29
Aluminum Chloride Hexahydrate, 29
ALUPENT, 23
Amantadine, 11, 19
Amebicides, 17
Aminoglycosides, 18
Aminophylline 150mg/5ml, 23
Aminophylline Suppositories, 23
Amiodarone, 13
Amitriptyline, 11
Amoxicillin, 18
Amoxicillin/Clarithromycin/Lansoprazole, 19
Amoxicillin/Potassium Clavulanate, 18
AMOXIL, 18
Ampicillin, 18
Amprenavir, 20
Amylase/Lipase/Protease, 16
Amylase/Lipase/Protease/Pancreatin, 16
ANAFRANIL, 12
Anakinra, 21
Analgesic and Anti-Inflammatory Agents, 9
ANAPROX, 9
ANAPROX DS, 9
Anastrozole, 20
Androgen Agents, 27
ANDROID, 27
Angiotensin Converting Enzyme Inhibitor Agents, 14
Angiotensin Receptor Blocker Agents, 14
ANTABUSE, 33
Antacid Mg OH/Al OH, 16
Antacid Mg OH/Al OH/Simethicone, 16
Anthralin, 29
Antiarrhythmic Agents, 13
Antibiotic Agents, 18
Anticonvulsant Agents, 10
Antidiarrheal Agents, 16
Antidysrhythmic Drug Agents, 13
Antiemetic Agents, 16
Antifungal Agents, 19
Antihelmintic Agents, 17
Antihistamine Agents, 22
Antihistamine/Decongestant Agents, 22
Antihistamine/Decongestant Combination Agents, 22
Antihypertensive Agents, 13
ANTI-INFECTIVE AGENTS, 17
Antilipemic Agents, 15
Antimalarial Agents, 19
Antimanic Agents, 12
Antimuscarinic/Antispasmodic Agents, 16
Antineoplastic Agents, 20
*ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD
COLONY STIMULATING FACTOR AND
IMMUNOSUPPRESSANT AGENTS, 20*
Antiparkinsonian Agents, 11
Antiplatelet Agents, 15
Antipsychotic Agents, 12
Antithyroid Agents, 26
Antituberculosis Agents, 19
Antitussive Agents, 22
Anti-Ulcer Eradication Agents, 19
Antiulcer/Antipeptic Agents, 16
ANTIVERT, 16
Antiviral Agents, 19
APAP/Dichloralphenazone/Isometheptene, 9
APRESOLINE, 15
ARANESP, 21
ARAVA, 9

ARICEPT, 10
ARIMIDEX, 20
ARISTOCORT, 31
ARISTOCORT A, 31
ARMOUR THYROID, 26
ARTANE, 11
ARTHROTEC, 9
ASACOL, 17
Aspirin, 9
Aspirin EC, 9
AsthmaAgents, 23
ATABRINE, 17, 19
ATARAX, 13, 22
Atenolol, 13
Atenolol/Chlorthalidone, 14
ATIVAN, 12
Atorvastatin, 15
Atovaquone/Proguanil, 19
Atropine Sulfate, 25
ATROVENT, 25
Attapulgit, 16
Augmented Betamethasone Dipropionate, 31
AUGMENTIN, 18
AURALGAN, 25
AVENTYL, 12
AVONEX, 21
AXERT, 10
AYGESTIN, 28
Azathioprine, 21
Azithromycin, 18
AZMACORT, 23
AZULFIDINE, 17, 18
AZULFIDINE EN-TABS, 18

—B—

BACITRACIN, 24, 29
Bacitracin, 24, 29
Bacitracin/Polymixin/Neomycin, 29
Baclofen, 11
BACTRIM, 18
BACTROBAN, 30
Barbiturate Anticonvulsants, 10
Becaplermin, 29
Beclomethasone Inhaler, 23
Beclomethasone, Nasal, 25
Belladonna/Methylene Blue, 29
Belladonna/Phenobarbital, 16
BENADRYL, 22
BENEMID, 33
BENICAR, 14
BENTYL, 16
BENZAMYCIN, 30
Benzocaine/Antipyrine, 25
Benzocaine/Antipyrine Otic, 25
Benzodiazepine Anticonvulsants, 11
Benzodiazepines, 12
Benzonatate, 22
Benztropine Mesylate, 11
Beta-Adrenergic Antagonist Agents, 13
BETAGAN, 24
Betamethasone Dipropionate, 31
Betamethasone Valerate 0.01%, 31
Betamethasone Valerate 0.1%, 31
BETAPACE, 13
BETASERON, 21

Betaxolol, 24
Bethanechol, 29
BETIMOL, 24
BETOPTIC, 24
Bexarotene, 20
BIAXIN, 18
Bicalutamide, 20
BILTRICIDE, 17
Biperiden, 12
Biphasic Oral Contraceptives, 28
Bisacodyl Suppositories, 17
Bismuth Subsalicylate, 16
Bisoprolol/HCTZ, 14
Bisphosphonate Agents, 27
BLEPH-10, 25
BLEPHAMIDE, 25
Blood Agents, 15
Blood Colony Stimulating Factors, 21
Blood Glucose Supplies, 32
Blood Glucose Testing Strips, 32
Bowel Evacuant Agents, 16
BRETHINE, 23
BRICANYL, 23
Brimonidine, 24
BROMFED, 22
BROMFED PD, 22
Bromocriptine, 11
Bromphen/Pseudoephedrine, 22
Budesonide, 17, 25
Budesonide Inhaler, 23
Bumetanide, 14
BUMEX, 14
Bupropion, 12
Bupropion SR, 12, 33
BURROWS SOLUTION, 29
BUSPAR, 13
Buspirone, 13
Busulfan, 20
Butalbital/APAP/Caffeine, 9
Butalbital/APAP/Caffeine/Codeine, 10
Butalbital/Aspirin/Caffeine, 9
Butalbital/Aspirin/Caffeine/Codeine, 10
Butoconazole, 30
Butorphanol NS, 10

—C—

CAFERGOT, 9
Calamine, 29
CALAMINE LOTION, 29
CALAN, 14
CALAN SR, 14
Calcipotriene, 29
Calcitonin, 27
Calcitriol, 26, 32
Calcium Acetate, 32
Calcium Carbonate, 31
Calcium Channel Blocking Agents, 14
Capecitabine, 20
CAPOTEN, 14
CAPOZIDE, 14
Captopril, 14
Captopril/HCTZ, 14
CARAFATE, 16
Carbachol, 25
Carbamazepine, 11

Carbamide Peroxide/Glycerin, 25
 Carbidopa/Levodopa, 11
 Carbidopa/Levodopa CR, 11
 Carbonic Anhydrase Inhibitor Agents, 25
 Cardiac Glycoside Agents, 15
 CARDIOQUIN, 13
 CARDIOVASCULAR/BLOOD AGENTS, 13
 CARDIZEM, 14
 CARDIZEM SR, 14
 CARDURA, 15
 Carisoprodol, 11
 CARTIA XT, 14
 Carvedilol, 14
 CASODEX, 20
 CATAPRES, 14
 CECLOR, 18
 CEENU, 21
 Cefaclor, 18
 Cefadroxil, 18
 Cefdinir, 18
 Cefixime, 18
 CELEXA, 12
 CELLCEPT, 21
 CENTRAL NERVOUS SYSTEM AGENTS, 9
 Centrally Acting Antihypertensive Agents, 14
 Cephalexin, 18
 Cephalosporins, 18
 CEPHULAC, 17
 CERUMENEX, 26
 Chloral Hydrate, 13
 Chlorambucil, 20
 Chloramphenicol, 24
 Chlordiazepoxide, 12
 Chlordiazepoxide/Clidinium, 16
 Chlorhexidine Gluconate, 25
 CHLOROMYCETIN OPHTHALMIC, 24
 CHLOROPTIC, 24
 CHLOROQUINE PHOSPHATE, 19
 Chloroquine Phosphate, 19
 Chlorpheniramine, 22
 Chlorpromazine, 12
 Chlorpropamide, 26
 Chlorprothixene, 12
 Chlorthalidone, 15
 CHLORTRIMETON, 22
 Chlorzoxazone, 11
 Cholestyramine/Aspartame, 15
 Cholestyramine/Sucrose, 15
 Choline Mag. Trisalicylate, 9
 CHRONULAC, 17
 Ciclopirox, 30
 Cimetidine, 17
 CIN-QUIN, 13
 Citalopram, 12
 Clarithromycin, 18
 CLEOCIN, 18
 CLEOCIN T, 30
 Clindamycin, 18
 Clindamycin Solution, 30
 CLINORIL, 9
 Clofazimine, 20
 Clomipramine, 12
 Clonazepam, 11
 Clonidine, 14
 Clopidogrel, 15
 Clorazepate, 12
 Clotrimazole, 19, 30

Clotrimazole Cream/Vaginal Tablets, 30
 Clotrimazole/Betamethasone, 30
 Clozapine, 13
 CLOZARIL, 13
 Coagulants and Anticoagulants, 15
 Codeine/Aspirin, 10
 Codeine/Chlorpheniramine/Pseudoephedrine, 22
 COGENTIN, 11
 COLACE, 17
 COL-BENEMID, 33
 COLCHICINE, 33
 Colchicine, 33
 Colchicine/Probenecid, 33
 COLYTELY, 16
 Combination Alpha-Beta Antagonist Agents, 14
 Combination Antihypertensive Agents, 14
 COMBIVENT, 23
 COMBIVIR, 20
 COMPAZINE, 16
 COMPAZINE SPANSULES, 16
 CONCEPTROL, 30
 CONDYLOX, 29
 Conjugated Estrogens, 27
 Conjugated Estrogens, Vaginal, 27
 COPAXONE, 21
 COPEGUS, 20
 CORDARONE, 13
 CORDRAN, 31
 COREG, 14
 CORGARD, 13
 CORTEF, 27
 CORTENEMA, 30
 CORTIFOAM, 30
 Cortisone Acetate, 27
 CORTISPORIN, 25
 CORTISPORIN OPHTHALMIC, 24
 CORTONE, 27
 COSOPT, 24
 COUMADIN, 15
 CREON, 16
 CRIXIVAN, 20
 CROLOM, 26
 Cromolyn Ophthalmic Solution, 26
 Cromolyn Sodium, 26
 Crotamiton, 31
 CUPRIMINE, 32
 Cyanocobalamin, 32
 Cyclobenzaprine, 11
 Cyclophosphamide, 20
 Cyclosporine, 21
 CYCRIN, 28
 Cyproheptadine, 22
 CYTOMEL, 26
 CYTOTEC, 16
 CYTOVENE, 20
 CYTOXAN, 20

—D—

DALMANE, 12
 Danazol, 27
 DANOCRINE, 27
 DANTRIUM, 11
 Dantrolene Sodium, 11
 DAPSONE, 20
 Dapsone, 20

DARAPRIM, 19
Darbepoetin, 21
DARVOCET-N 100, 10
DDAVP, 28
DEBROX, 25
DECADRON, 27
DECONAMINE SR, 22
Decongestants, 23
Delavirdine, 20
DELFEN, 30
DELTASONE, 27
DEMULEN 1/35, 28
DEMULEN 1/50, 28
DEPAKENE, 11
DEPAKOTE, 11
DES, 27
Desipramine, 11
Desmopressin, 28
DESOGEN, 28
Desonide, 30
Desoximetasone 0.25%, 31
Desoximetasone Cream/Gel 0.05%, 31
DESYREL, 12
DETROL, 29
DETROL LA, 29
Dexamethasone, 27
Dexamethasone/Neomycin, 24
Dexamethasone/Polymyxin/Neomycin, 24
Dexchlorpheniramine, 22
Dextromethorphan, 22
DIABETA, 26
Diabetic Agents, 26
DIABETIC AND THYROID AGENTS, 26
DIABINESE, 26
Diagnostic Testing, 32
DIAMOX, 25
DIAMOX SEQUELS, 25
Diazepam, 12
DIBENZYLIN, 14
Diclofenac Sodium, 9, 24
Diclofenac/Misoprostol, 9
Dicloxacillin, 18
Dicyclomine, 16
Didanosine (ddl), 20
Diethylstilbestrol, 27
Diflorasone Diacetate, 31
DIFLUCAN, 19
DIFLUCAN 150MG, 19
Digestive Enzymes, 16
Digoxin, 15
Dihydroergotamine, 10
DILANTIN, 11
DILATRATE SR, 15
DILAUDID, 10
Diltiazem, 14
Diltiazem CD, 14
Diltiazem SR, 14
DIOVAN, 14
DIOVAN HCT, 14
DIPENTUM, 17
Diphenhydramine, 22
Diphenoxylate/Atropine, 16
Dipivefrin, 25
DIPROLENE, 31
DIPROLENE AF, 31
DIPROSONE, 31
Dipyridamole, 15

DISALCID, 9
Disopyramide, 13
Disopyramide CR, 13
Disulfiram, 33
DITROPAN, 29
DITROPAN XL, 29
Divalproex Sodium, 11
Docusate Sodium Capsules, 17
DOMEBORO, 25
Donepezil, 10
DONNATAL, 16
DORYX, 19
Dorzolamide, 24
Dorzolamide/Timolol, 24
DOVONEX, 29
Doxazosin Mesylate, 15
Doxepin, 11
Doxycycline, 19
DRISDOL, 32
DRITHOCREME, 29
DRITHO-SCALP, 29
Drugs for Pheochromocytoma, 14
DRYSOL, 29
DULCOLAX, 17
DURICEF, 18
DYAZIDE, 14
DYMELOR, 26
DYNAPEN, 18
DYRENIUM, 14

—E—

Echothiophate Iodide, 24
ECOTRIN, 9
EES, 18
Efavirenz, 20
EFFEXOR, 12
EFFEXOR XR, 12
EFLONE, 24
EFUDEX, 29
ELAVIL, 11
Electrolyte Agents, 31
Electrolyte Solution, Pediatric Oral, 32
ELIDEL, 31
ELIMITE, 31
ELMIRON, 29
ELOCON, 31
EMCYT, 20
EMGEL, 29
EMPIRIN #2, #3, #4, 10
Enalapril, 14
Enalapril/HCTZ, 14
ENBREL, 21
ENDAL, 23
ENDAL-HD, 22
Enfuvirtide, 20
Enoxaparin, 15
ENTOCORT EC, 17
EPIFOAM, 31
EPIFRIN, 25
Epinephrine, 25
Epinephrine Injection, 25
Epinephrine/Pilocarpine, 24
EPIPEN, 25
EPIVIR, 20
EPOGEN, 21

ERGAMISOL, 21
Ergocalciferol, 32
Ergonovine Maleate, 28
Ergotamine/Caffeine, 9
ERGOTRATE, 28
ERYGEL, 29
ERYPED SUSPENSION, 18
ERY-TAB, 18
ERYTHROCIN, 18
Erythromycin Base, 18, 24
Erythromycin Ethylsuccinate, 18
Erythromycin Stearate, 18
Erythromycin Topical, 29
Erythromycin/Benzoyl Peroxide, 30
Erythromycin/Sulfisoxazole, 18
Erythropoietin, 21
ESERINE SULFATE, 24
ESGIC, 9
ESGIC PLUS, 9
ESKALITH, 12
Esterified Estrogens/Methyltestosterone, 27
ESTRACE, 27
ESTRADERM, 27
Estradiol, 27
Estradiol Patches, 27
Estradiol/Vaginal Ring, 27
Estramustine, 20
ESTRATEST, 27
ESTRING, 27
Estrogen Agents, 27
Estrogen Agonist-Antagonists, 27
Estrogen/Medroxyprogesterone, 27
Etanercept, 21
Ethambutol, 19
Ethinyl Estradiol/Desogestrel, 28
Ethinyl Estradiol/Ethinodiol, 28
Ethinyl Estradiol/Levonorgestrel, 28
Ethinyl Estradiol/Norethindrone, 28
Ethinyl Estradiol/Norgestimate, 28
Ethinyl Estradiol/Norgestrel, 28
ETHMOZINE, 13
Etodolac, 9
Etodolac Extended Release, 9
Etoposide, 20
EULEXIN, 21
EURAX, 31
EVISTA, 27
Expectorant Agents, 23
EXSEL, 31
Eye, Ear, Nose and Throat (EENT) Preparations, 24

—F—

Famciclovir, 19
FAMVIR, 19
FANSIDAR, 19
FELDENE, 9
Felodipine, 14
FEMARA, 21
FEMSTAT, 30
Fenoprofen, 9
FEOSOL, 32
Ferrous Sulfate, 32
Filgrastim, 21
FIORICET, 9
FIORICET/CODEINE, 10

FIORINAL, 9
FIORINAL/CODEINE, 10
FLAGYL, 17, 18
Flecainide, 13
FLEXERIL, 11
FLORINEF, 27
FLORONE, 31
FLORONE-E, 31
FLOVENT, 23
FLOVENT DISKUS, 23
FLOXIN OTIC, 25
Fluconazole, 19
Fludrocortisone Acetate, 27
FLUMADINE, 19
Fluocinolone, 31
Fluocinolone 0.025%, 30
Fluocinolone Acetonide 0.2%, 31
Fluorometholone, 24
Fluorouracil, 29
Fluoxetine, 12
Fluoxymesterone, 27
Fluphenazine, 12
Flurandrenolide, 31
Flurazepam, 12
Flurbiprofen Sodium, 24
Flutamide, 21
Fluticasone, 23
Fluvastatin, 15
FML, 24
FML FORTE, 24
FML-S, 24
FOLIC ACID, 32
Folic Acid, 32
FORADIL, 23
Formoterol, 23
FORTEO, 27
FORTOVASE, 20
FULVICIN P/G, 19
FURADANTIN, 28
Furazolidone, 17
Furosemide, 14
FUROXONE, 17
FUZEON, 20

—G—

Gabapentin, 11
GABITRIL, 11
Gallstone Solubilizing Agents, 17
Ganciclovir, 20
GANTRISIN, 18
GARAMYCIN, 24, 30
GASTROINTESTINAL AGENTS, 16
Gastrointestinal Stimulant Agents, 17
Gemfibrozil, 15
GENITOURINARY AGENTS, 28
Genitourinary Smooth Muscle Relaxant Agents, 29
Gentamicin, 24
Gentamicin Sulfate, 30
Gentamicin/Prednisolone, 24
GEODON, 13
Glatiramer, 21
GLEEVEC, 21
Glipizide, 26
Glipizide L.A., 26
Glucagon, 26

GLUCOPHAGE, 26
GLUCOTROL, 26
GLUCOTROL XL, 26
Glyburide, 26
Gout Agents, 33
Griseofulvin Ultramicrosize, 19
GRIS-PEG, 19
GUAIFED, 23
GUAIFED-PD, 22
Guaifenesin, 23
Guaifenesin/Codeine, 22
Guaifenesin/Codeine Phosphate, 22
Guaifenesin/Codeine/Pseudoephedrine, 22
Guaifenesin/Dextromethorphan, 23
Guaifenesin/Phenylephrine, 23
Guaifenesin/Pseudoephedrine, 22, 23
Guanfacine, 14
GYNOL, 30

—H—

H₂ Antagonist Agents, 17
HALCION, 12
HALDOL, 12
Haloperidol, 12
HALOTESTIN, 27
Heavy Metal Antagonist Agents, 32
HELIDAC, 19
Hemorheologic Agents, 15
HERPLEX, 24
HEXALEN, 20
HISTUSSIN HC, 22
HIVID, 20
HORMONE AGENTS, 27
Human Insulin, 26
HUMIRA, 21
Hydantoin Anticonvulsants, 11
Hydralazine, 15
HYDREA, 21
Hydrochlorothiazide (HCTZ), 15
Hydrocortisone, 30
Hydrocortisone 1% Rectal Cream, 29
Hydrocortisone Acetate, 30
Hydrocortisone Enema, 30
Hydrocortisone Oral, 27
Hydrocortisone Valerate, 31
Hydrocortisone/Neomycin/Polymyxin, 24, 25
Hydrocortisone/Pramoxine, 30
HYDRODIURIL, 15
Hydromorphone, 10
Hydroxychloroquine, 19
Hydroxyurea, 21
Hydroxyzine, 13, 22
Hydroxyzine Pamoate, 13, 22
HYGROTON, 15
Hyoscyamine Sulfate, 16
HYTONE, 30
HYTRIN, 15

—I—

Ibuprofen, 9
Idoxuridine, 24
ILOTYCIN, 24
Imatinib, 21
IMDUR, 15

Imipramine, 11
IMITREX, 10
Immunosuppressant Agents, 21
IMODIUM, 16
IMURAN, 21
Indapamide, 15
INDERAL, 13
INDERAL LA, 13
Indinavir, 20
INDOCIN, 9
INDOCIN SR, 9
INDOCIN SUPPOSITORIES, 9
Indomethacin, 9
Indomethacin, Sustained Release, 9
INFERGEN, 21
INFLAMASE, 24
INFLAMASE FORTE, 24
Inhaled Nasal Agents, 25
Inhaled Oral Corticosteroid Agents, 23
Inhaled Sympathomimetic (Adrenergic) Agents, 23
Inhaled/Oral EENT Agents, 25
Insulin, 26
Insulin Agents, 26
Insulin Aspart, 26
Insulin Glargine, 26
INTAL INHALER, 26
Interferon Alfa 2a, 21
Interferon Alfa 2b, 21
Interferon Alfa N3, 21
Interferon Alfacon 1, 21
Interferon Beta 1a, 21
Interferon Beta 1b, 21
Interferon Gamma 1b, 21
INTRON A, 21
INVIRASE, 20
Iodoquinol, 19
Iodoquinol (Diiiodohydroxyquin), 17
Ipratropium, 25
Iron Agents, 32
ISONIAZID, 19
Isoniazid, 19
ISOPTO ATROPINE, 25
ISOPTO CARBACHOL, 25
ISORDIL, 15
Isosorbide Dinitrate, 15
Isosorbide Dinitrate SR, 15
Isosorbide Mononitrate, 15
Isotretinoin, 29

—K—

KALETRA, 20
Kaolin/Pectin, 16
KAON-CL, 32
KAON-CL 10, 32
KAOPECTATE, 16
KAYEXALATE, 32
K-DUR, 32
K-DUR, 32
KEFLEX, 18
KEMADRIN, 12
KENALOG, 31
KENALOG IN ORABASE, 25
KEPPRA, 11
Keratolytic Agents, 29
Ketoconazole, 19, 30

Ketoprofen, 9
Ketorolac Tromethamine, 24
KINERET, 21
KLONOPIN, 11
K-LOR, 32
K-LYTE, 32
K-LYTE CL DS, 32

—L—

Labetalol, 14
Lactulose, 17
LAMICTAL, 11
LAMISIL, 30
Lamivudine (3TC), 20
Lamotrigine, 11
LAMPRENE, 20
Lancets, 32
LANOXICAPS, 15
LANOXIN, 15
LANTUS, 26
LARIAM, 19
LARODOPA, 11
LASIX, 14
Latanoprost, 25
Laxative Agents, 17
Leflunomide, 9
Leprostastic Agents, 20
LESCOL, 15
LESCOL XL, 15
Letrozole, 21
Leucovorin, 21
LEUKERAN, 20
LEUKINE, 21
Leukotriene Receptor Antagonists, 23
Leuprolide, 21
Levamisole, 21
LEVAQUIN, 18
LEVBID, 16
Levetiracetam, 11
Levobunolol, 24
Levocabastine, 25
Levodopa, 11
Levofloxacin, 18
LEVOTHROID, 26
Levothyroxine, 26
LEVOXYL, 26
LEVSIN, 16
LEVSIN SL, 16
LIBRAX, 16
LIBRIUM, 12
LIDEX, 31
LIDEX E, 31
Lidocaine, 31
Lidocaine Type Antidysrhythmic Drug Agents, 13
Lidocaine, Viscous, 25
LILLY INSULINS, 26
LIORESAL, 11
Liothyronine, 26
Liotrix, 26
LIPITOR, 15
Lisinopril, 14
Lisinopril/HCTZ, 14
Lithium Carbonate, 12
LITHOBID, 12
LIVOSTIN, 25

LO/OVRAL, 28
Local Anesthetic Agents, 25
LODINE, 9
LODINE XL, 9
Lodoxamide, 25
LOESTRIN FE, 28
LOMOTIL, 16
Lomustine, 21
LONITEN, 15
Loop Diuretics, 14
Loperamide, 16
LOPID, 15
LOPRESSOR, 13
LOPROX, 30
Loratadine, 22
Lorazepam, 12
LORCET, 10
LORCET PLUS, 10
LOTRIMIN, 30
LOTRISONE, 30
Lovastatin, 15
LOVENOX, 15
Loxapine, 12
LOXITANE, 12
LOZOL, 15
LUDIOMIL, 11
LUPRON, 21
LYSODREN, 21

—M—

M.A.O. Inhibitor Agents, 12
MAALOX, 16
MAALOX, TC, 16
Macrolide Antibiotic Agents, 18
MALARONE, 19
Malathion, 31
Maprotiline, 11
Masoprocol, 29
MATULANE, 21
MAXAIR, 23
MAXAIR AUTOHALER, 23
MAXITROL, 24
MAXIVATE, 31
MAXZIDE 25, 14
MAXZIDE 50, 14
MEBARAL, 10
Mebendazole, 17
Meclizine, 16
MEDROL, 27
MEDROL DOSEPAK, 27
Medroxyprogesterone, 28
Mefloquine, 19
MEGACE, 21
Megestrol, 21
MELLARIL, 13
Melfhalan, 21
Mephobarbital, 10
MEPHYTON, 32
Mercaptopurine, 21
Mesalamine, 17
Mesoridazine, 12
MESTINON, 29
Mestranol/Norethindrone, 28
METANDREN, 27
Metaproterenol, 23

Metaproterenol Oral, 23
 Metaxalone, 11
 Metformin, 26
 Meth/Me Blue/PA/Salol/ATP/Hyos, 28
 Methazolamide, 25
 METHERGINE, 28
 Methimazole, 26
 Methocarbamol, 11
 Methotrexate, 21
 Methyl dopa, 14
 Methylergonovine Maleate, 28
 Methylprednisolone, 27
 Methyltestosterone, 27
 Methysergide, 10
 METIMYD, 25
 Metoclopramide, 16, 17
 Metolazone, 15
 Metoprolol Succinate, 13
 Metoprolol Tartrate, 13
 METROGEL-VAGINAL, 30
 Metronidazole, 17, 18, 30
 MEVACOR, 15
 Mexiletine, 13
 MEXITIL, 13
 MIACALCIN NS, 27
 Miconazole, 30
 Miconazole Nitrate, 30
 MICRO-K, 32
 MICRO-K 10, 32
 MICRONASE, 26
 MIDRIN, 9
 Migraine Agents, 9
 MIGRANAL, 10
 MINIPRESS, 15
 MINOCIN, 19
 Minocycline, 19
 Minoxidil, 15
 MINTEZOL, 17
 MIRAPEX, 11
 MIRCETTE, 28
 Mirtazapine, 12
 Miscellaneous Agents, 21, 31
 Miscellaneous Analgesics, 10
 Miscellaneous Antibiotic Agents, 18
 Miscellaneous Anticonvulsants, 11
 Miscellaneous Antidepressant Agents, 12
 Miscellaneous Antihistamine Agents, 22
 Miscellaneous Anxiolytics, Sedatives, and Hypnotics, 13
 Miscellaneous Arthritis Agents, 9
 Miscellaneous Central Nervous System Agents, 10
 Miscellaneous Diabetic Agents, 26
 Miscellaneous EENT Agents, 25
 Miscellaneous Estrogen Agents, 27
 Miscellaneous Gastrointestinal Agents, 17
 Miscellaneous Gastrointestinal Supplies, 17
 Miscellaneous Ophthalmic Agents, 25
 Miscellaneous Otic Agents, 25
 Miscellaneous Skin/Mucous Membrane Agents, 29
 MISCELLANEOUS/UNCLASSIFIED AGENTS, 31
 Misoprostol, 16
 Mitotane, 21
 MOBAN, 12
 MODICON, 28
 Molindone, 12
 Mometasone, 25
 Mometasone Furoate Cream, 31
 MONISTAT, 30

MONISTAT 3 (200MG TABLETS), 30
 MONISTAT-DERM, 30
 Monophasic Oral Contraceptives, 28
 Moricizine, 13
 Morphine, 10
 Morphine SR, 10
 MOTRIN, 9
 MS CONTIN/ORAMORPH SR, 10
 MSIR, 10
 Mucolytic Agents, 23
 MUCOMYST, 23
 Multiple Sclerosis Agents, 21
 Mupirocin, 30
 Muscle Relaxant Agents, 11
 MYAMBUTOL, 19
 MYCELEX, 30
 MYCELEX G, 30
 MYCELEX TROCHE, 19
 MYCIFRADIN, 18
 MYCOBUTIN, 19
 MYCOLOG II, 30
 Mycophenolate Mofetil, 21
 MYCOSTATIN, 19, 30
 MYDRIACYL, 25
 MYLANTA I, 16
 MYLANTA II, 16
 MYLERAN, 20
 MYLICON, 16
 MYSOLINE, 10

—N—

Nabumetone, 9
 Nadolol, 13
 NALFON, 9
 Naltrexone, 10
 NAPROSYN, 9
 Naproxen, 9
 Naproxen Sodium, 9
 Narcotic Antitussive Agents, 22
 NARDIL, 12
 NASACORT, 25
 NASACORT AQ, 25
 NASONEX, 25
 NAVANE, 12
 Nedocromil Sodium, 26
 Nefazodone, 12
 Nelfinavir, 20
 NEO-DECADRON, 24
 Neomycin Sulfate, 18
 Neomycin/Gramicidin/Polymyxin, 24
 Neomycin/Polymyxin/Prednisone, 24
 NEOSPORIN, 29
 NEOSPORIN OPHTHALMIC, 24
 Neostigmine, 29
 NEPTAZANE, 25
 NEULASTA, 21
 NEUMEGA, 21
 NEUPOGEN, 21
 NEURONTIN, 11
 Nevirapine, 20
 Niacin, 15, 32
 Niacin, Delayed Release, 15
 NIASPAN, 15
 NICLOCIDE, 17
 Niclosamide, 17

NICORETTE GUM, 33
 Nicotine, 33
 NICOTINE PATCH, 33
 NICOTROL NASAL SPRAY, 33
 Nifedipine, Sustained Release, 14
 NILANDRON, 21
 Nilutamide, 21
 NITRO-DUR, 16
 Nitrofurantoin, 28
 Nitroglycerin Ointment, 15
 Nitroglycerin Patches, 16
 Nitroglycerin Spray, 16
 Nitroglycerin Sublingual, 15
 NITROL, 15
 NITROLINGUAL SPRAY, 16
 NITROSTAT SL, 15
 NIX, 31
 NIZORAL, 19, 30
 NOCTEC, 13
 NOLVADEX, 21
 Non-Narcotic Antitussive Agents, 22
 Nonoxynol 9 Foam, 30
 Nonoxynol 9 Gel, 30
 Nonoxynol 9 Jelly, 30
 Nonoxynol 9 Suppositories, 30
 Non-Sedating Single Entity Agents, 22
 Non-Steroidal Anti-Inflammatory Agents, 9
 Non-Sulfonylureas, 26
 NORDETTE, 28
 Norethindrone Acetate, 28
 NORFLEX, 11
 NORGESIC, 11
 NORGESIC FORTE, 11
 NORLUTATE, 28
 NORMODYNE, 14
 NORPACE, 13
 NORPACE CR, 13
 NORPRAMIN, 11
 NOR-QD, 28
 Nortriptyline, 12
 NORVIR, 20
 NOVAHISTINE DH, 22
 NOVAHISTINE EXPECTORANT, 22
 NOVOLOG, 26
 Nystatin, 19, 30

—O—

Octoxynol 9 Jelly, 30
 OCUFEN, 24
 OCUFLOX, 24
 OCUSERT, 24
 Ofloxacin, 24, 25
 Olanzapine, 13
 Olmesartan, 14
 Olopatadine, 25
 Olsalazine, 17
 Omeprazole Magnesium, 16
 OMNICEF, 18
 Ondansetron, 16
 Ophthalmic Antiallergic Agents, 25
 Ophthalmic Antibiotic Agents, 24
 Ophthalmic Anti-Inflammatory Agents, Corticosteroid, 24
 Ophthalmic Anti-Inflammatory Agents, NSAIDs, 24
 Ophthalmic Antiviral Agents, 24
 Ophthalmic Beta Blockers, 24

Ophthalmic Miotic Agents, 24
 Ophthalmic Mydriatic Agents, 25
 Ophthalmic Sulfonamide Agents, 25
 Opiate Agonists, 10
 Opiate Antagonists, 10
 Oprelvekin, 21
 OPTICHAMBER, 26
 Optichamber, 26
 Oral Adrenal Corticosteroid Agents, 27
 Oral Colon Lavage Solution, 16
 Oral Contraceptive Agents, 28
 Oral Sympathomimetic (Adrenergic) Agents, 23
 ORAP, 12
 ORASONE, 27
 ORINASE, 26
 Orphenadrine Citrate, 11
 Orphenadrine/Aspirin/Caffeine, 11
 ORTHO CYCLEN, 28
 ORTHO-GYNOL, 30
 ORTHO-NOVUM 1/35, 28
 ORTHO-NOVUM 1/50, 28
 ORTHO-NOVUM 10/11, 28
 ORTHO-NOVUM 777, 28
 ORUVAIL, 9
 Ostomy Supplies, 17
 OTC LORATADINE, 22
 Otic Anti-Infective Agents, 25
 OVIDE, 31
 OVRAL, 28
 Oxcarbazepine, 11
 Oxybutynin, 29
 Oxycodone, 10
 Oxycodone/Acetaminophen, 10
 Oxycodone/Aspirin, 10
 OXYCONTIN, 10
 OXYFAST, 10
 OXYIR, 10
 Oxytocic Agents, 28

—P—

P1E1, 24
 PAMELOR, 12
 PANCREASE, 16
 PANCREASE MT, 16
 Pantoprazole, 16
 PARAFON DSC, 11
 Parasympathomimetic (Cholinergic) Agents, 29
 Parathyroid Hormone, 27
 PAREPECTOLIN, 16
 PARLODEL, 11
 PARNATE, 12
 PATANOL, 25
 PCE, 18
 PEDIALYTE, 32
 PEDIAPRED, 27
 PEDIAZOLE, 18
 PEGASYS, 20
 Pegfilgrastim, 21
 Peginterferon Alfa 2a, 20
 Peginterferon Alfa 2b, 20
 PEG-INTRON, 20
 PEN VK, 18
 Penicillamine, 32
 Penicillin VK, 18
 Penicillins, 18

Pentosan, 29
 Pentoxifylline, 15
 PEPTO BISMOL, 16
 PERCOCET, 10
 PERCODAN, 10
 PERIACTIN, 22
 PERIDEX, 25
 PERIOSTAT, 19
 Permethrin, 31
 Perphenazine, 12
 PERSANTINE, 15
 Phenazopyridine, 29
 Phenelzine, 12
 PHENERGAN, 13, 16, 22
 PHENERGAN VC, 23
 PHENERGAN VC/CODEINE, 22
 PHENERGAN W/DEXTROMETHORPHAN, 22
 PHENERGAN/CODEINE, 22
 PHENOBARBITAL, 10
 Phenobarbital, 10
 Phenoxybenzamine, 14
 Phenylephrine/Guaifenesin, 23
 Phenylephrine/Hydrocodone/Chlorpheniramine, 22
 Phenylephrine/Promethazine, 23
 Phenytoin, 11
 PHOS LO, 32
 PHOSPHOLINE IODIDE, 24
 Physostigmine Sulfate, 24
 Phytanadione, 32
 PILOCAR, 24
 Pilocarpine, 24
 Pimecrolimus, 31
 Pimozide, 12
 Pindolol, 13
 Pioglitazone, 26
 Pirbuterol Acetate, 23
 Piroxicam, 9
 Pituitary Agents, 28
 PLAQUENIL, 19
 PLAVIX, 15
 PLENDIL, 14
 Podofilox, 29
 POLARAMINE, 22
 Polymixin B Sulfate/TMP, 24
 POLY-PRED, 24
 POLYTRIM, 24
 Potassium Agents, 32
 Potassium Chloride, 32
 Potassium Chloride Liquid, 32
 Potassium Chloride Powder, 32
 Potassium Chloride Tablets, 32
 Potassium Iodide, 23
 Potassium-Sparing Diuretics, 14
 Pramipexole, 11
 Pramoxine, 31
 Pramoxine/Hydrocortisone, 31
 Praziquantel, 17
 Prazosin, 15
 PRECOSE, 26
 PRED FORTE, 24
 PRED MILD OPHTHALMIC, 24
 PRED-G, 24
 Prednisolone, 27
 Prednisolone Acetate, 24
 Prednisolone Phosphate, 24
 Prednisone, 27
 PRELONE, 27
 PREMARIN, 27
 PREMARIN VAGINAL CREAM, 27
 PREMPHASE, 27
 PREMPRO, 27
 PREMPRO LOW DOSE, 27
 PREVPAC, 19
 PRILOSEC OTC, 16
 PRIMAQUINE, 19
 Primaquine, 19
 Primidone, 10
 PRINCIPEN, 18
 PRINIVIL, 14
 PRINZIDE, 14
 Probenecid, 33
 Procainamide, 13
 Procainamide Antidysrhythmic Drug Agents, 13
 Procainamide SR, 13
 PROCAN SR, 13
 PROCANBID, 13
 Procarbazine, 21
 Prochlorperazine Maleate, 16
 PROCROT, 21
 PROCTOCORT, 29
 PROCTOCREAM-HC, 30
 PROCTOFOAM HC, 31
 Procyclidine, 12
 Progestin Agents, 28
 Progestin Only, 28
 PROGRAF, 21
 PROLIXIN, 12
 Promethazine, 13, 16, 22
 Promethazine/Codeine, 22
 Promethazine/Dextromethorphan, 22
 Promethazine/Phenylephrine/Codeine, 22
 PRONESTYL, 13
 Propafenone, 13
 PROPINE, 25
 Propoxyphene Napsylate/APAP, 10
 Propranolol, 13
 Propranolol LA, 13
 PROPYLTHIOURACIL, 26
 Propylthiouracil, 26
 PROSTIGMIN, 29
 PROTONIX, 16
 Protriptyline, 12
 PROVENTIL, 23
 PROVENTIL REPETABS, 23
 PROVERA, 28
 PROZAC, 12
 Pseudoephedrine, 23
 Pseudoephedrine/Chlorpheniramine, 22
 PSORCON, 31
 Psychotherapeutic Agents, 11
 PULMICORT, 23
 PURINETHOL, 21
 PYRAZINAMIDE, 19
 Pyrazinamide, 19
 PYRIDIUM, 29
 Pyridostigmine, 29
 Pyridoxine, 32
 Pyrimethamine, 19

—Q—

QUESTRAN, 15

QUESTRAN LIGHT, 15
Quetiapine, 13
Quinacrine, 17, 19
QUINAGLUTE, 13
QUINIDEX, 13
Quinidine Gluconate, 13
Quinidine Polygalacturonate, 13
Quinidine Sulfate, 13
Quinidine Sulfate SR, 13
QUININE, 19
Quinine, 19
Quinolones, 18
QVAR, 23

—R—

Raloxifene, 27
Ranitidine, 17
RAPAMUNE, 21
REBETRON, 20
REBIF, 21
Recent Formulary Changes, 4
REGLAN, 16, 17
REGRANEX, 29
RELAFEN, 9
REMERON, 12
REMERON SOLTABS, 12
REQUIP, 11
RESCON GC, 23
RESCRIPTOR, 20
Reserpine, 13
Respiratory Smooth Muscle Relaxant Agents, 23
RESPIRATORY/EENT AGENTS, 22
RESTORIL, 12
RETROVIR, 20
REVIA, 10
RHEUMATREX, 21
RHINOCORT AQ, 25
Ribavirin, 20
Ribavirin/Interferon Alfa 2b, 20
Rifabutin, 19
RIFADIN, 19
Rifampin, 19
Rimantadine, 19
Risedronate, 27
RISPERDAL, 13
Risperidone, 13
Ritonavir, 20
Ritonavir/Lopinavir, 20
ROBAXIN, 11
ROBITUSSIN, 23
ROBITUSSIN A-C, 22
ROBITUSSIN DAC, 22
ROBITUSSIN DM, 23
ROCALTROL, 26, 32
Rofecoxib, 9
ROFERON A, 21
Ropinirole, 11
ROWASA, 17
RYTHMOL, 13

—S—

S.N.R.I. Agents, 12
S.S.R.I. Agents, 12
Salmeterol/Fluticasone, 23

Salsalate, 9
SANDIMMUNE, 21
SANSERT, 10
Saquinavir, 20
Saquinavir Mesylate, 20
Sargramostim, 21
Scabicide/Pediculicide Agents, 31
SEBIZON, 31
Selenium Sulfide 2.5%, 31
SELSUN, 31
SEMICID, 30
SEPTRA, 18
SERENTIL, 12
SEROQUEL, 13
SERPASIL, 13
SERZONE, 12
SILVADENE, 30
Silver Sulfadiazine, 30
Simethicone, 16
SINEMET, 11
SINEMET CR, 11
SINEQUAN, 11
Single Entity Alkylamine Agents, 22
Single Entity Ethanolamine Agents, 22
Sirolimus, 21
SKELAXIN, 11
Skeletal Muscle Relaxants, 11
SLO-BID, 23
SLO-PHYLLIN, 23
SLO-PHYLLIN 80, 23
Sodium Chloride for Inhalation, 25
Sodium Polystyrene Sulfonate, 32
SODIUM SULAMYD, 25
SOMA, 11
Sotalol, 13
Spironolactone, 14
Spironolactone/HCTZ, 14
SSKI, 23
STADOL NS, 10
Stavudine (d4T), 20
STELAZINE, 12
Sucralfate, 16
SUDAFED, 23
Sulfacetamide, 25
Sulfacetamide 10%/Prednisolone 0.2%, 25
Sulfacetamide 10%/Prednisolone 0.5%, 25
Sulfacetamide Lotion, 31
Sulfacetamide/Fluorometholone, 24
SULFADIAZINE, 18
Sulfadiazine, 18
Sulfadoxine/Pyrimethamine, 19
Sulfamethoxazole/Trimethoprim (SMZ/TMP), 18
Sulfasalazine, 17, 18
Sulfisoxazole, 18
Sulfonylureas, 26
Sulindac, 9
SULTRIN, 30
Sumatriptan, 10
SUMYCIN, 19
SUPRAX, 18
SUSTIVA, 20
SYMMETREL, 11, 19
SYNALAR, 30, 31
SYNTHROID, 26
Syringes, 32

—T—

Tacrolimus, 21
TAGAMET, 17
TAMBOCOR, 13
Tamoxifen Citrate, 21
TAPAZOLE, 26
TARACTAN, 12
TARGRETIN, 20
Tegaserod, 17
TEGRETOL, 11
TEGRETOL XR, 11
Temazepam, 12
TENEX, 14
Tenofovir Disoproxil Fumarate, 20
TENORETIC, 14
TENORMIN, 13
Terazosin, 15
Terbinafine, 30
Terbutaline Sulfate, 23
Teriparatide, 27
TERPIN HYDRATE/CODEINE, 22
Terpin Hydrate/Codeine, 22
TESLAC, 21
TESSALON, 22
Testolactone, 21
Tetracycline, 19
Tetracycline/Bismuth/Metronidazole, 19
Tetracyclines, 19
THEO-DUR, 23
Theophylline, 23
Theophylline, 80mg/15cc, 23
Theophylline, Sustained Release, 23
Thiabendazole, 17
Thiamine, 32
Thiazide and Related Diuretics, 15
THIOGUANINE, 21
Thioguanine, 21
Thioridazine, 13
Thiothixene, 12
THORAZINE, 12
Thyroid Agents, 26
Thyroid, Desiccated, 26
THYROLAR, 26
Tiagabine, 11
TIGAN, 16
TILADE INHALER, 26
Timolol, 24
TIMOPTIC, 24
TIMOPTIC-XE, 24
TINACTIN, 30
Tioconazole, 30
Tobramycin, 24
TOBEX, 24
Tocainide, 13
TOFRANIL, 11
TOFRANIL PM, 11
Tolazamide, 26
Tolbutamide, 26
TOLINASE, 26
Tolnaftate, 30
Tolterodine, 29
TONOCARD, 13
TOPAMAX, 11
Topical Antibiotic Agents, 29
Topical Antifungal Agents, 30

Topical Anti-Inflammatory Agents, 30
Topical Antipruritic and Local Anesthetic Agents, 31
Topical Antiviral Agents, 31
Topical Contraceptive Agents, 30
Topical Miscellaneous Anti-Infective Agents, 31
TOPICAL/MUCOUS MEMBRANE AGENTS, 29
TOPICORT, 31
TOPICORT LP, 31
Topiramate, 11
TOPROL XL, 13
Tramadol, 10
TRANDATE, 14
TRANXENE, 12
Tranlycypromine, 12
Trazodone, 12
TRENAL, 15
Tretinoin, 21
Triamcinolone, 31
Triamcinolone 0.1% in Orabase, 25
Triamcinolone Acetonide, Nasal, 25
Triamcinolone Inhaler, 23
Triamcinolone/Nystatin, 30
Triamterene, 14
Triamterene 37.5mg/HCTZ 25mg, 14
Triamterene 75mg/HCTZ 50mg, 14
Triazolam, 12
Tricyclic Antidepressant Agents, 11
TRIDESILON, 30
TRIDIONE, 11
Triethanolamine, 26
Trifluoperazine, 12
Trifluridine Ophthalmic Solution, 24
Trihexyphenidyl, 11
TRILAFON, 12
TRILEPTAL, 11
TRILISATE, 9
Trimethadione, 11
Trimethobenzamide, 16
Trimethoprim, 18, 28
TRIMOX, 18
TRIMPEX, 18, 28
TRINASAL, 25
Triphasic Oral Contraceptives, 28
TRIPHASIL, 28
Triple Sulfa Cream, 30
Triprolidine/Pseudoephedrine/Codeine, 22
TRIZIVIR, 20
Tropicamide, 25
TRUSOPT, 24
T-STAT, 29
TUMS, 31
TUSSIN PEDIATRIC, 22
TUSSI-ORGANIDIN NR, 22
TYLENOL, 10
TYLENOL/CODEINE, 10
TYLOX, 10

—U—

ULTRAM, 10
UNIPHYL, 23
URECHOLINE, 29
Urinary Anti-Infective Agents, 28
Urinary Anti-Spasmodic Agents, 29
URISED, 28, 29
Ursodiol, 17

—V—

Vaginal Antifungal Agents, 30
Vaginal Anti-Infective Agents, 30
VAGISTAT-1, 30
Valacyclovir, 19
VALISONE, 31
VALISONE REDUCED STRENGTH, 31
VALIUM, 12
Valproic Acid, 11
Valsartan, 14
Valsartan/HCTZ, 14
VALTREX, 19
Vasodilating Agents, 15
Vasodilator Antihypertensive Agents, 15
VASORETIC, 14
VASOTEC, 14
Venlafaxine, 12
VEPESID, 20
Verapamil, 14
Verapamil LA Tablets, 14
VERMOX, 17
VESANOID, 21
VIBRAMYCIN, 19
VIBRA-TABS, 19
VICODIN, 10
VICODIN ES, 10
Vidarabine Ophth Ointment, 24
VIDEX, 20
VIOKASE, 16
VIOXX, 9
VIRA A, 24
VIRACEPT, 20
VIRAMUNE, 20
VIREAD, 20
VIROPTIC, 24
VISCIOUS XYLOCAINE, 25
VISKEN, 13
VISTARIL, 13, 22
Vitamin Agents, 32
VITAMIN B₁, 32
VITAMIN B₁₂, 32
VITAMIN B₆, 32
Vitamin B-Complex Agents, 32
Vitamin D, 32
Vitamin K Activity Agents, 32
VIVACTIL, 12
VIVELLE, 27
VIVELLE DOT, 27
VOLMAX, 23

VOLTAREN, 9, 24
VOSOL, 25
VOSOL HC, 25

—W—

Warfarin Sodium, 15
WELLBUTRIN, 12
WELLBUTRIN SR, 12
WELLCOVORIN, 21
WESTCORT, 31

—X—

XALATAN, 25
XANAX, 12
XELODA, 20
XYLOCAINE, 31

—Y—

YODOXIN, 17, 19

—Z—

Zafirlukast, 23
Zalcitabine (ddC), 20
ZANTAC, 17
ZAROXOLYN, 15
ZELNORM, 17
ZEPHREX LA, 23
ZERIT, 20
ZESTORETIC, 14
ZESTRIL, 14
ZIAC, 14
ZIAGEN, 20
Zidovudine (AZT), 20
Zidovudine/Lamivudine, 20
Zidovudine/Lamivudine/Abacavir, 20
Ziprasidone, 13
ZITHROMAX, 18
ZOFRAN, 16
ZOVIRAX OINTMENT, 31
ZOVIRAX ORAL, 19
ZYBAN, 33
ZYLOPRIM, 33
ZYPREXA, 13
ZYPREXA ZYDIS, 13