

# INTER VALLEY HEALTH PLAN

## Desert Preferred Choice (HMO)

### FORMULARIO COMPLETO DE 2010

(Lista de medicamentos cubiertos)

**POR FAVOR LEA:** Este documento contiene información sobre los medicamentos que cubrimos en este plan.

**NOTA PARA NUESTROS MIEMBROS:**  
Este formulario ha cambiado desde el año pasado. Por favor, revise este documento para asegurarse de que todavía contiene los medicamentos que usted toma.



**Inter Valley Health Plan**

Para la salud. No para ganar.

**Desert Preferred Choice (HMO)**

**MedicareRx**  
Prescription Drug Coverage



# ÍNDICE

|  |            |
|--|------------|
| ¿Qué es el formulario de Inter Valley Health Plan? . . . . .   | página 2   |
| ¿Puede cambiar el formulario? . . . . .  | página 2   |
| ¿Cómo utilizo el formulario? . . . . .   | página 3   |
| ¿Qué son los medicamentos genéricos? . . . . .   | página 3   |
| ¿Hay alguna restricción en mi cobertura? . . . . .   | página 3   |
| ¿Qué son los medicamentos de venta sin receta? . . . . .   | página 4   |
| ¿Qué ocurre si mi medicamento no está en el formulario? . . . . .  | página 4   |
| ¿Cómo pido una excepción al formulario de Inter Valley Health Plan? .  | página 5   |
| ¿Qué debo hacer antes de hablar con mi médico respecto a cambiar<br>de medicamentos o solicitar una excepción? . . . . . | página 5   |
| Para obtener más información. . . . .  | página 7   |
| Inter Valley Health Plan   |            |
| Copagos de Desert Preferred Choice (HMO). . . . .  | página 8   |
| Formulario (Lista de medicamentos cubiertos). . . . .  | página 10  |
| Medicamentos que requieren autorización previa . . . . .   | página 108 |
| Medicamentos con límites en la cantidad. . . . .   | página 109 |
| Medicamentos que requieren tratamientos en pasos . . . . .   | página 113 |
| Índice de medicamentos . . . . .   | página 114 |

## ¿Qué es el formulario de Inter Valley Health Plan?

Un formulario es una lista de medicamentos cubiertos que Inter Valley Health Plan seleccionó en consulta con un equipo de proveedores de atención de la salud, el cual representa los tratamientos farmacológicos que son considerados una parte necesaria de un programa de tratamiento de calidad. Inter Valley Health Plan generalmente cubrirá los medicamentos que se listan en nuestro formulario, siempre que estos sean médicamente necesarios, que se expandan en farmacias de la red de Inter Valley Health Plan y que se sigan otras reglas del plan. Para obtener más información sobre cómo obtener sus medicamentos con receta, consulte su Evidencia de Cobertura.

## ¿Puede cambiar el formulario?

En general, si usted toma un medicamento que figura en nuestro formulario de 2010, el cual estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura de ese medicamento durante el año de cobertura 2010, excepto si aparece un medicamento genérico nuevo y menos costoso o si se da a conocer información adversa sobre la seguridad o eficacia del medicamento. Otros tipos de cambios al formulario, como retirar un medicamento de esta lista, no afectarán a los miembros que actualmente toman el medicamento. Para aquellos miembros que toman ese medicamento éste continuará estando disponible con el mismo costo compartido por lo que resta del año de cobertura. Creemos que es importante que tenga acceso continuo durante el resto del año de cobertura a los medicamentos del formulario que estaban disponibles cuando eligió nuestro plan, excepto en los casos en que puede ahorrar más dinero o en que debemos asegurarnos de mantener su seguridad.

Si retiramos medicamentos de nuestro



formulario; añadimos requisitos de autorización previa, límites en las cantidades o restricciones del tratamiento en pasos en un medicamento; o transferimos un medicamento a un nivel de costo compartido mayor, debemos notificar el cambio a los miembros afectados por lo menos 60 días antes de que el cambio entre en efecto, o en el momento en que el miembro solicita una reposición del medicamento, momento en que el miembro recibirá un suministro del medicamento para 60 días. Si la Administración de Alimentos y Medicamentos (FDA) considera que un medicamento de nuestro formulario no es seguro, o el fabricante del medicamento lo retira del mercado, retiraremos el medicamento de nuestro formulario inmediatamente y notificaremos a los miembros que lo toman. El formulario que se incluye está vigente desde octubre de 2009. Para obtener información actualizada sobre los medicamentos cubiertos por Inter Valley Health Plan, visite nuestro sitio Web en [www.ivhp.com/ivhp/partd.asp](http://www.ivhp.com/ivhp/partd.asp). o llame a los Servicios para Miembros al 800-546-5677, las 24 horas del día, los siete días de la semana. Los usuarios de TTY/TDD deberán llamar al 800-505-7150. Inter Valley Health Plan proporciona actualizaciones del formulario en nuestro

boletín trimestral InterView, o en nuestro sitio Web en [www.ivhp.com/ivhp.partd.asp](http://www.ivhp.com/ivhp.partd.asp).

## ¿Cómo utilizo el formulario?

Hay dos maneras para encontrar su medicamento en el formulario:

### Por afección médica

El formulario comienza en la página 10. Los medicamentos de este formulario están agrupados en categorías, dependiendo del tipo de afecciones médicas que tratan. Por ejemplo, los medicamentos que se utilizan para tratar una afección cardíaca se listan bajo la categoría "Medicamentos cardiovasculares". Si usted sabe para qué se utiliza su medicamento, busque la categoría en la lista que comienza en la página 10. Luego busque el medicamento en esa categoría.

### Listado por orden alfabético

Si no está seguro en qué categoría debe buscar, busque su medicamento en el Índice que comienza en la página 114. El Índice contiene una lista en orden alfabético de todos los medicamentos que están incluidos en este documento. Tanto los medicamentos de marca como los genéricos están enumerados en el Índice. Busque su medicamento en el Índice. Al lado del medicamento verá el número de página en donde puede encontrar información sobre la cobertura. Vaya a la página indicada en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

## ¿Qué son los medicamentos genéricos?

Inter Valley Health Plan cubre medicamentos de marca y medicamentos genéricos. Un medicamento genérico está aprobado por la FDA (Administración de Alimentos y Medicamentos) por tener el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos cuestan menos que los de marca.

## ¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos adicionales o límites en la cobertura. Estos requisitos y límites pueden incluir:

**Autorización previa:** Inter Valley Health Plan requiere que usted o su médico obtengan autorización previa para ciertos medicamentos. Esto significa que usted necesitará obtener la aprobación de Inter Valley Health Plan antes de obtener sus medicamentos con receta. Si no obtiene la autorización, Inter Valley Health Plan podría no cubrir el medicamento.

**Límites en la cantidad:** Para ciertos medicamentos, Inter Valley Health Plan limita la cantidad de medicamento que el plan cubre. Por ejemplo, para el medicamento Lipitor Inter Valley Health Plan proporciona 31 comprimidos por receta. Esto podría ser además del suministro común para un mes o para tres meses.



**Tratamiento en pasos:** En algunos casos, Inter Valley Health Plan requiere que usted primero pruebe un medicamento para tratar su afección antes de que el plan cubra otro medicamento para esa afección. Por ejemplo, si tanto el medicamento A como el medicamento B tratan su afección, Inter Valley Health Plan podría no cubrir el medicamento B a menos que usted primero pruebe el medicamento A. Si el medicamento A no le da resultado, Inter Valley Health Plan cubrirá el medicamento B.

En el formulario que comienza en la página 10 puede ver si su medicamento tiene requisitos adicionales o límites. También puede obtener más información sobre las restricciones que se aplican a ciertos medicamentos cubiertos específicos en nuestro sitio Web

[www.ivhp.com/ivhp./partd.asp](http://www.ivhp.com/ivhp./partd.asp).

Usted puede pedirle a Inter Valley Health Plan que haga una excepción a estas restricciones o límites. Para obtener información sobre cómo solicitar una excepción, consulte la sección "¿Cómo solicito una excepción al formulario de Inter Valley Health Plan?"

## ¿Qué son los medicamentos de venta sin receta?

Los medicamentos de venta sin receta son medicamentos que no requieren receta y por lo general no están cubiertos por un Plan de Medicamentos Recetados de Medicare. Inter Valley Health Plan (HMO) paga ciertos medicamentos de venta sin receta. Estos son:

- Prilosec de venta sin receta
- Omeprazole de venta sin receta

Inter Valley Health Plan proporcionará estos medicamentos de venta sin receta sin ningún costo para usted. El costo para Inter Valley Health Plan de estos medicamentos de venta sin receta no contará para sus costos totales de medicamentos.



## ¿Qué ocurre si mi medicamento no está en el formulario?

Si su medicamento no está incluido en este formulario, primero deberá comunicarse con los Servicios de Farmacia y confirmar que su medicamento no está cubierto. Si le dicen que Inter Valley Health Plan no cubre su medicamento, tiene dos opciones:

- Puede pedir a los Servicios de Farmacia una lista de los medicamentos similares que están cubiertos por Inter Valley Health Plan. Cuando reciba la lista, muéstrasela a su médico y pídale que le recete un medicamento similar que esté cubierto por Inter Valley Health Plan.
- Puede pedir a Inter Valley Health Plan que haga una excepción y cubra su medicamento. A continuación encontrará información sobre cómo solicitar una excepción.

## ¿Cómo pido una excepción al formulario de Inter Valley Health Plan?

Puede pedir a Inter Valley Health Plan que haga una excepción a nuestras reglas de cobertura. Hay varios tipos de excepciones que nos puede pedir.

- Puede pedirnos que cubramos su medicamento incluso si no está en nuestro formulario.
- Puede pedirnos que renunciemos a las restricciones o límites en la cobertura para su medicamento. Por ejemplo, para ciertos medicamentos Inter Valley Health Plan limita la cantidad de medicamento que cubrirá. Si su medicamento tiene un límite en la cantidad, puede pedirnos que renunciemos al límite y cubramos una cantidad mayor.
- Puede pedirnos que le proporcionemos un nivel de cobertura más alto para su medicamento. Si su medicamento está en nuestro nivel de medicamentos genéricos o de marca no preferidos, puede pedirnos que cubramos su medicamento al nivel de gasto compartido que se aplica a los medicamentos del nivel de medicamentos genéricos o de marca preferidos. Esto reducirá el importe que usted tendrá que pagar por su medicamento. Note que si aceptamos cubrir un medicamento que no está en nuestro formulario, usted no puede pedirnos que le otorguemos un nivel de cobertura más alto

para el medicamento. Además, no puede pedirnos que le proporcionemos un nivel más alto de cobertura para los medicamentos que están en el nivel de Medicamentos Especializados.

Generalmente, Inter Valley Health Plan sólo aprobará el pedido de una excepción si los medicamentos alternativos que están incluidos en el formulario del plan, el medicamento del nivel más bajo o las restricciones adicionales de uso no serían tan eficaces para tratar su afección o le causarían efectos médicos adversos.

Póngase en contacto con nosotros para pedirnos una decisión de cobertura inicial para una excepción al formulario, al nivel del medicamento o a una restricción del uso. **Cuando solicite una excepción al formulario, al nivel del medicamento o a una restricción del uso, deberá presentar una declaración de su médico que le respalde.** En general debemos tomar nuestra decisión en un plazo de 72 horas a partir de que obtenemos la declaración de respaldo de su médico. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría verse gravemente afectada por esperar hasta 72 horas para obtener la decisión. Si aceptamos acelerar la decisión, debemos informarle nuestra decisión a más tardar en 24 horas, después que recibimos la declaración de respaldo de su médico.

## ¿Qué debo hacer antes de hablar con mi médico respecto a cambiar de medicamentos o solicitar una excepción?

Como miembro de nuestro plan, ya sea nuevo o no, usted podría estar tomando medicamentos que no son parte de nuestro formulario. También podría estar tomando un medicamento que es parte de nuestro formulario pero tener una capacidad limitada para obtenerlo. Por ejemplo, usted podría necesitar que le demos una autorización previa



antes de poder obtener su medicamento. Deberá hablar con su médico para decidir si necesita cambiar de medicamento a otro apropiado que cubrimos o si debe solicitar una excepción al formulario para que cubramos el medicamento que toma. Mientras habla con su médico para determinar el curso de acción adecuado para usted, es posible que cubramos su medicamento en ciertos casos durante los primeros 90 días que es miembro de nuestro plan.

Para cada uno de los medicamentos que toma que no está en nuestro formulario, o si su capacidad para obtener sus medicamentos está limitada, cubriremos un suministro provisorio para 31 días cuando vaya a una farmacia de la red (a menos que tenga una receta para una cantidad menor de días). Después de su primer suministro para 31 días, no pagaremos esos medicamentos, incluso si ha sido miembro del plan durante menos de 90 días.

Si reside en un centro de atención de larga duración, cubriremos un suministro provisorio de transición para 31 días (a menos que tenga una receta para una cantidad menor de días). Cubriremos más de una reposición de estos medicamentos para los primeros 90 días en que es miembro de nuestro plan. Si necesita un medicamento que no está en nuestro formulario, o si su capacidad para obtener su medicamento está limitada, pero ya han pasado los primeros 90 días de su afiliación a nuestro plan, cubriremos un suministro de emergencia de ese medicamento para 31 días (a menos que tenga una receta para una cantidad menor de días), mientras pide una excepción al formulario.

Hay excepciones para los beneficiarios que han tenido un cambio en el nivel de la atención que reciben, lo cual los obliga a cambiar de establecimiento o centro de tratamiento. A continuación damos algunos ejemplos de situaciones en las que los beneficiarios serían elegibles para una única excepción temporaria a

un suministro de medicamentos cuando están fuera de la fecha de vigencia de tres meses en el programa de la Parte D:

- ▶ Si un beneficiario fue dado de alta del hospital y le dieron una lista de medicamentos para después del alta en base al formulario del hospital.
- ▶ Beneficiarios que terminan una estancia de la Parte A de Medicare en un centro especializado de enfermería (en donde los pagos incluyen todos los cargos de farmacia) y que necesitan volver a su formulario del plan de la Parte D.
- ▶ Beneficiarios que renuncian al estado de Cuidado Paliativo para regresar a los beneficios regulares de las Partes A y B de Medicare.
- ▶ Beneficiarios que son dados de alta de Hospitales para Enfermedades Psiquiátricas Crónicas con regímenes de medicación muy individualizados.

Todas estas situaciones garantizarían un único suministro temporario de medicamentos, independientemente de si el beneficiario está en sus primeros noventa (90) días de inscripción en el programa.



## Para obtener más información

Para obtener información más detallada sobre la cobertura de medicamentos recetados de Inter Valley Health Plan, consulte su Evidencia de Cobertura (EOC) y los otros materiales del plan.

Si tiene preguntas sobre Inter Valley Health Plan, llame a los Servicios para Miembros al **800-251-8191, de 7:30 a.m. a 8:00 p.m., los siete días de la semana. Los usuarios TTY/TDD deberán llamar al 800-505-7150. También puede visitar [www.ivhp.com/ivhp/partd.asp](http://www.ivhp.com/ivhp/partd.asp).**

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame a Medicare al **800-MEDICARE (800-633-4227), las 24 horas del día, los siete días de la semana. Los usuarios TTY/TDD deberán llamar al 877-877-486-2048. También puede visitar [www.medicare.gov](http://www.medicare.gov).**

## Copagos de Desert Preferred Choice (HMO) de Inter Valley Health Plan

**LÍMITE DE COBERTURA INICIAL** \$2,700; los costos anuales totales en medicamentos en el límite de cobertura inicial pagados por usted y Desert Preferred Choice de Inter Valley Health Plan

| Nivel de medicamento                                | Copago/coseguro en farmacia (suministro para 31 días) | Copago/coseguro en farmacia (suministro para 90 días) | Costo compartido para atención de larga duración de la red (suministro para 31 días) | Copago/coseguro para pedido por correo (suministro para 90 días) | Copago/coseguro fuera de la red (suministro para 31 días) |
|---|---|---|--|--|---|
| <b>NIVEL 1</b> Medicamentos genéricos preferidos    | Copago de \$0   | Copago de \$0 <sup>††</sup>                           | Copago de \$0  | Copago de \$0 <sup>††</sup>                                      | Copago de \$0 <sup>†</sup>                                |
| <b>NIVEL 2</b> Medicamentos genéricos no preferidos | Copago de \$3   | Copago de \$9 <sup>††</sup>                           | Copago de \$3  | Copago de \$9 <sup>††</sup>                                      | Copago de \$3 <sup>†</sup>                                |
| <b>NIVEL 3</b> Medicamentos de marca preferidos     | Copago de \$25  | Copago de \$75 <sup>††</sup>                          | Copago de \$25   | Copago de \$75 <sup>††</sup>                                     | Copago de \$25 <sup>†</sup>                               |
| <b>NIVEL 4</b> Medicamentos de marca no preferidos  | Copago de \$40  | Copago de \$120 <sup>††</sup>                         | Copago de \$40   | Copago de \$120 <sup>††</sup>                                    | Copago de \$40 <sup>†</sup>                               |
| <b>NIVEL 5</b> Medicamentos inyectables             | 10% Coseguro  | 10% <sup>††</sup> Coseguro                            | 10% Coseguro   | 10% <sup>††</sup> Coseguro                                       | 10% <sup>†</sup> Coseguro                                 |
| <b>NIVEL 6</b> Medicamentos de especialidad         | 25% Coseguro  | 25% Coseguro  | 25% Coseguro   | 25% Coseguro   | 25% <sup>†</sup> Coseguro                                 |

### INTERRUPCIÓN EN LA COBERTURA

|   |                    |                             |                    |                             |                            |
|---|--------------------|-----------------------------|--------------------|-----------------------------|----------------------------|
| <b>NIVEL 1</b> Medicamentos genéricos preferidos    | Copago de \$0      | Copago de \$0 <sup>††</sup> | Copago de \$0      | Copago de \$0 <sup>††</sup> | Copago de \$0 <sup>†</sup> |
| <b>NIVEL 2</b> Medicamentos genéricos no preferidos | Copago de \$3      | Copago de \$9 <sup>††</sup> | Copago de \$3      | Copago de \$9 <sup>††</sup> | Copago de \$3 <sup>†</sup> |
| <b>NIVEL 3</b> Medicamentos de marca preferidos     | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100%         |
| <b>NIVEL 4</b> Medicamentos de marca no preferidos  | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100%         |
| <b>NIVEL 5</b> Medicamentos inyectables             | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100% | Usted paga el 100%          | Usted paga el 100%         |
| <b>NIVEL 6</b> Medicamentos de especialidad         | 25% Coseguro       | 25% Coseguro                | 25% Coseguro       | 25% Coseguro                | 25% <sup>†</sup> Coseguro  |

**COBERTURA CATASTRÓFICA** Después de que los costos de sus desembolsos anuales en medicamentos alcanzan los \$4,550, usted paga un copago de \$2.50 por medicamento genérico (incluidos los medicamentos de marca tratados como genéricos), y \$6.30 para todos los otros medicamentos, o 5% de coseguro, lo que sea mayor.

<sup>†</sup>La cobertura de medicamentos con receta dentro de la red está limitada al área de servicio de Inter Valley Health Plan. Usted puede pagar más que el copago si obtiene sus medicamentos en una farmacia fuera de la red.

<sup>††</sup>No todos los medicamentos están disponibles para un suministro para más días. Para obtener más información, comuníquese con el Plan.

## Formulario de Inter Valley Health Plan

El formulario que comienza en la página 10 ofrece información de cobertura sobre algunos de los medicamentos que cubre Inter Valley Health Plan. Si tiene dificultad para encontrar su medicamento en la lista, vaya al Índice que comienza en la página 114.

La primera columna de la tabla lista el nombre del medicamento. Los medicamentos de marca están escritos en mayúsculas (p.ej., LIPITOR) y los medicamentos genéricos en minúsculas y cursiva (p.ej., *simvastatin*).

La información en la columna de Requisitos/Límites le dice si Inter Valley Health Plan tiene algún requisito especial para cubrir el medicamento. Lo siguiente explica las abreviaciones que se utilizan en el formulario: **PA** – Autorización Previa; **QL** – Límites en la Cantidad; **ST** – Tratamiento en Pasos; **Elix** – Elixir; **SUSP** – Suspensión; **OINT** – Ungüento; **Inj** – Inyección; **TD** – Transdérmico; **Rec** – Rectal; **Top** – Tópico; **NS** – Nasal; **Vag** – Vaginal; **Inh** – Inhalación; **OP** – Oftálmico; **OT** – Ótico.

Los medicamentos marcados con “\*\*\*” no están normalmente cubiertos en un Plan de Medicamentos Recetados de Medicare. La cantidad que usted paga cuando presenta una receta para este medicamento no cuenta para sus costos totales de medicamentos (es decir, la cantidad que usted paga no le ayuda a calificar para cobertura catastrófica). Además, si está recibiendo ayuda adicional para pagar sus medicamentos con receta, no obtendrá ayuda adicional para pagar este medicamento.

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

## Analgésicos

**Medicamentos antiinflamatorios no esteroideos**

|                               |                             |        |  |
|-------------------------------|-----------------------------|--------|--|
| CELEBREX                      | CELECOXIB                   | Tier 3 | ST; QL - 60 capsules per 30 days                                       |
| <i>diclofenac potassium</i>   | <i>cataflam</i>             | Tier 2 |  |
| <i>diclofenac sodium</i>      | <i>voltaren</i>             | Tier 2 |  |
| <i>diclofenac sodium ec</i>   | <i>voltaren</i>             | Tier 2 |  |
| <i>diclofenac sodium xr</i>   | <i>voltaren-xr</i>          | Tier 2 |  |
| <i>diflunisal</i>             | <i>dolobid</i>              | Tier 2 |  |
| <i>etodolac</i>               | <i>lodine</i>               | Tier 2 |  |
| <i>etodolac er</i>            | <i>lodine xl</i>            | Tier 2 |  |
| <i>fenoprofen calcium</i>     | <i>fenoprofen calcium</i>   | Tier 2 |  |
| <i>flurbiprofen</i>           | <i>ansaid</i>               | Tier 2 |  |
| <i>ibuprofen</i>              | <i>motrin</i>               | Tier 1 |  |
| <i>indomethacin</i>           | <i>indocin</i>              | Tier 1 |  |
| <i>indomethacin er</i>        | <i>indocin sr</i>           | Tier 1 |  |
| <i>ketoprofen er</i>          | <i>orudis</i>               | Tier 1 |  |
| <i>ketorolac tromethamine</i> | <i>toradol</i>              | Tier 2 | QL - 20 tablets per 30 days  |
| <i>meclofenamate sodium</i>   | <i>meclofenamate sodium</i> | Tier 2 |  |
| <i>meloxicam</i>              | <i>mobic</i>                | Tier 2 | QL - 30 tablets per 30 days, 180ml per 30 days on 7.5mg/5ml suspension |
| <i>nabumetone</i>             | <i>nabumetone</i>           | Tier 2 |  |
| <i>naproxen</i>               | <i>naprosyn</i>             | Tier 1 |  |
| <i>naproxen sodium</i>        | <i>anaprox</i>              | Tier 1 |  |
| <i>oxaprozin</i>              | <i>daypro</i>               | Tier 2 |  |
| <i>piroxicam</i>              | <i>feldene</i>              | Tier 2 |  |
| <i>sulindac</i>               | <i>clinoril</i>             | Tier 2 |  |
| <i>tolmetin sodium</i>        | <i>tolmetin sodium</i>      | Tier 2 |  |
| TREXIMET                      | NAPROXEN/SUMATRIPTAN        | Tier 3 |  |

**Analgésicos opioides**

|                              |  |        |                                  |
|------------------------------|--|--------|----------------------------------|
| <i>acetaminophen/codeine</i> | <i>tylenol/codeine</i>                   | Tier 1 | QL - 400 tablets per 30 days     |
| <i>ascomp/codeine</i>        | <i>fiorinal/codeine #3</i>               | Tier 2 |                                  |
| AVINZA                       | MORPHINE SULFATE                         | Tier 4 | ST; QL - 30 capsules per 30 days |
| BALACET 325                  | ACETAMINOPHEN AND PROPOXYPHENE NAPSYLATE | Tier 2 |                                  |

## Formulario

| Nombre de medicamento cubierto              | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|---|-----------------------------------|------------------|---|
| <i>buprenorphine hcl</i>                    | <i>buprenex</i>                   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>butalbital/apap/caffeine/codeine</i>     | <i>fioricet/codeine</i>           | Tier 2           |   |
| <i>butorphanol tartrate</i>                 | <i>stadol</i>                     | Tier 2           | This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.; QL - 10ml per 30 days   |
| <i>co-gesic</i>                             | <i>vicodin</i>                    | Tier 2           | QL - 240 tablets per 30 days  |
| DARVON-N                                    | PROPOXYPHENE NAPSYLATE            | Tier 4           |   |
| <i>endocet</i>                              | <i>percocet</i>                   | Tier 2           | QL - 360 tablets per 30 days  |
| <i>endodan</i>                              | <i>aspirin/oxycodone</i>          | Tier 2           |   |
| <i>fentanyl</i>                             | <i>duragesic</i>                  | Tier 2           | QL - 30 patches per 30 days; Transdermal Dosage Formulation   |
| <i>hydrocodone bitartrate/acetaminophen</i> | <i>maxidone</i>                   | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>hydrocodone/acetaminophen</i>            | <i>lorcet</i>                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>hydrocodone/acetaminophen</i>            | <i>lortab</i>                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>hydrocodone/acetaminophen</i>            | <i>norco</i>                      | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |

## Formulario

| Nombre de medicamento cubierto                                 | Nombre de medicamento alternativo                                       | Desert Preferred           | Requisitos / Limites  |
|--|---|----------------------------|---|
| <i>hydrocodone/acetaminophen</i>                               | <i>vicodin</i>  | Tier 2                     | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>hydrocodone/libuprofen</i>                                  | <i>vicoprofen</i>   | Tier 1                     | QL - 480 tablets per 30 days  |
| <i>hydromorphone hcl</i><br>KADIAN                             | <i>dilaudid</i><br>MORPHINE SULFATE                                     | Tier 2<br>Tier 3           | QL - 60 capsules per 30 days; ST  |
| <i>levorphanol tartrate</i><br><i>margesic-h</i>               | <i>levo-dromoran</i><br><i>acetaminophen and hydrocodone bitartrate</i> | Tier 2<br>Tier 2           | QL - 240 capsules per 30 days   |
| <i>meperidine hcl</i><br><i>methadone hcl</i><br>METHADONE HCL | <i>demerol</i><br><i>dolophine hcl</i><br>METHADONE HYDROCHLORIDE       | Tier 1<br>Tier 2<br>Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>methadose</i><br><i>morphine sulfate</i>                    | <i>dolophine</i><br><i>morphine sulfate</i>                             | Tier 2<br>Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>morphine sulfate er</i>                                     | <i>ms contin</i>  | Tier 1                     |   |

## Formulario

| Nombre de medicamento cubierto      | Nombre de medicamento alternativo                   | Desert Preferred | Requisitos / Limites  |
|-------------------------------------|---|------------------|---|
| <i>nalbuphine hcl</i>               | <i>nalbuphine hydrochloride</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>oxycodone hcl</i>                | <i>oxycontin</i>                                    | Tier 2           |   |
| <i>oxycodone-apap</i>               | <i>percocet</i>                                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>oxycodone/acetaminophen</i>      | <i>percocet</i>                                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>oxycodone/acetaminophen</i>      | <i>tylox</i>  | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>oxycodone/apap</i>               | <i>percocet</i>                                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>oxycodone/aspirin</i>            | <i>percodan</i>                                     | Tier 2           | QL - 360 tablets per 30 days  |
| OXYCONTIN                           | OXYCODONE HYDROCHLORIDE                             | Tier 3           | ST; QL - 120 tablets per 30 days  |
| <i>pentazocine/acetaminophen</i>    | <i>talacen</i>                                      | Tier 2           | QL - 180 tablets per 30 days  |
| <i>pentazocine/naloxone hcl</i>     | <i>talwin nx</i>                                    | Tier 2           |   |
| <i>propoxyphene hcl</i>             | <i>darvon</i>                                       | Tier 2           |   |
| <i>propoxyphene-n/acetaminophen</i> | <i>darvocet</i>                                     | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>propoxyphene/acetaminophen</i>   | <i>acetaminophen and propoxyphene hydrochloride</i> | Tier 2           | QL - Not to exceed 4,000mg of acetaminophen/day   |
| <i>roxicet</i>                      | <i>acetaminophen and oxycodone hydrochloride</i>    | Tier 2           | QL - 360 per 30 days on 325mg, 240 per 30 days on 500mg   |
| <i>roxicet</i>                      | <i>percocet</i>                                     | Tier 2           | QL - 360 per 30 days on 325mg, 240 per 30 days on 500mg   |

## Formulario

| Nombre de medicamento cubierto              | Nombre de medicamento alternativo                                | Desert Preferred | Requisitos / Limites         |
|---|--|------------------|------------------------------|
| <i>stagesic</i>                             | <i>acetaminophen and hydrocodone bitartrate</i>                  | Tier 2           | QL - 240 capules per 30 days |
| SUBOXONE                                    | BUPRENORPHINE HYDROCHLORIDE AND NALOXONE HYDROCHLORIDE DIHYDRATE | Tier 4           |                              |
| SUBUTEX                                     | BUPRENORPHINE HYDROCHLORIDE                                      | Tier 4           |                              |
| <i>tramadol hcl</i>                         | <i>ultram</i>  | Tier 1           | QL - 240 tablets per 30 days |
| <i>tramadol hydrochloride/acetaminophen</i> | <i>ultracet</i>  | Tier 1           | QL - 240 tablets per 30 days |
| <i>trezix</i>                               | <i>panlor dc</i>   | Tier 1           |                              |
| <i>vanacet</i>                              | <i>vicodin</i>   | Tier 2           | QL - 240 tablets per 30 days |
| <i>zerlor</i>                               | <i>panlor ss</i>   | Tier 1           |                              |
| ZYDONE                                      | ACETAMINOPHEN AND HYDROCODONE BITARTRATE                         | Tier 4           |                              |

## Anestésicos

## Anestésicos locales

|                             |                        |        |   |
|-----------------------------|------------------------|--------|---|
| <i>lidocaine hcl</i>        | <i>xylocaine</i>       | Tier 2 | Topical Dosage Formulation                                    |
| <i>lidocaine hcl jelly</i>  | <i>xylocaine jelly</i> | Tier 2 | Topical Dosage Formulation                                    |
| <i>lidocaine/prilocaine</i> | <i>emla</i>            | Tier 2 | QL - 30 grams per prescription;<br>Topical Dosage Formulation |

## Antiinflamatorios

## Glucocorticoides

|                    |                    |        |   |
|--------------------|--------------------|--------|---|
| <i>a-methapred</i> | <i>solu-medrol</i> | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
|--------------------|--------------------|--------|---|

## Formulario

| Nombre de medicamento cubierto            | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|---|-----------------------------------|------------------|---|
| CELESTONE                                 | BETAMETHASONE                     | Tier 4           |   |
| <i>cortisone acetate</i>                  | <i>cortisone acetate</i>          | Tier 1           |   |
| <i>dexamethasone</i>                      | <i>dexamethasone</i>              | Tier 1           |   |
| <i>hydrocortisone</i>                     | <i>cortef</i>                     | Tier 1           |   |
| <i>methylprednisolone</i>                 | <i>medrol</i>                     | Tier 1           |   |
| <i>methylprednisolone</i>                 | <i>medrol dosepak</i>             | Tier 1           |   |
| <i>methylprednisolone acetate</i>         | <i>depo-medrol</i>                | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>methylprednisolone sodiumsuccinate</i> | <i>solu-medrol</i>                | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>prednisolone sodium phosphate</i>      | <i>orapred</i>                    | Tier 2           |   |
| <i>prednisolone sodium phosphate</i>      | <i>pediapred</i>                  | Tier 2           |   |

**Medicamentos antiinflamatorios no esteroideos**

|                   |                                   |        |                              |
|-------------------|-----------------------------------|--------|------------------------------|
| ARTHROTEC         | DICLOFENAC SODIUM AND MISOPROSTOL | Tier 4 | ST                           |
| PREVACID NAPRAPAC | LANSOPRAZOLE AND NAPROXEN         | Tier 4 | QL - 30 capsules per 30 days |

**Antibacterianos****Aminoglucósidos**

|                 |                           |        |  |
|-----------------|---------------------------|--------|--|
| <i>ak-tob</i>   | <i>tobrex</i>             | Tier 2 |  |
| <i>genoptic</i> | <i>gentamicin sulfate</i> | Tier 1 |  |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>gentak</i>                  | <i>gentamicin sulfate</i>         | Tier 1           |   |
| <i>gentamicin sulfate</i>      | <i>gentamicin sulfate</i>         | Tier 2           | Topical Dosage Formulation  |
| <i>gentasol</i>                | <i>gentamicin sulfate</i>         | Tier 1           |   |
| <i>kanamycin sulfate</i>       | <i>kanamycin sulfate</i>          | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| NEO-FRADIN                     | NEOMYCIN SULFATE                  | Tier 4           |   |
| <i>neomycin sulfate</i>        | <i>neomycin sulfate</i>           | Tier 2           |   |
| <i>paromomycin sulfate</i>     | <i>paromomycin sulfate</i>        | Tier 1           |   |
| <i>tobramycin sulfate</i>      | <i>tobramycin sulfate</i>         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>tobramycin sulfate</i>      | <i>tobrex</i>                     | Tier 2           |   |
| <i>tobrasol</i>                | <i>tobrex</i>                     | Tier 2           |   |

**Antibacterianos, Otros**

|                    |  |        |  |
|--------------------|--|--------|--|
| <i>ak-poly-bac</i> | <i>bacitracin zinc and polymyxin b sulfate</i> | Tier 2 |  |
|--------------------|--|--------|--|

## Formulario

| Nombre de medicamento cubierto           | Nombre de medicamento alternativo                                   | Desert Preferred | Requisitos / Limites  |
|--|---|------------------|---|
| <i>baciim</i>                            | <i>bacitracin</i>   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>bacitracin</i>                        | <i>bacitracin</i>   | Tier 2           |   |
| <i>bacitracin/neomycin/polymyxin</i>     | <i>bacitracin zinc and neomycin sulfate and polymyxin b sulfate</i> | Tier 2           |   |
| <i>bacitracin/polymyxin b</i>            | <i>bacitracin zinc and polymyxin b sulfate</i>                      | Tier 2           |   |
| CLEOCIN                                  | CLINDAMYCIN PHOSPHATE   | Tier 4           | Vaginal Dosage Formulation  |
| <i>clindamycin hcl</i>                   | <i>cleocin</i>  | Tier 1           |   |
| <i>clindamycin phosphate</i>             | <i>cleocin</i>  | Tier 2           | Vaginal Dosage Formulation  |
| <i>clindamycin phosphate</i>             | <i>cleocin-t</i>  | Tier 2           | Topical Dosage Formulation  |
| <i>clindamycin phosphate</i>             | <i>clindagel</i>  | Tier 2           | Topical Dosage Formulation  |
| <i>clindamycin phosphate add-vantage</i> | <i>clindamycin phosphate</i>  | Tier 5           |   |
| <i>colistimethate sodium</i>             | <i>coly-mycin-m</i>   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto                  | Nombre de medicamento alternativo              | Desert Preferred | Requisitos / Limites  |
|---|--|------------------|---|
| CUBICIN   | DAPTOMYCIN                                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>erythromycin/sulfisoxazole</i>               | <i>erythromycin</i>                            | Tier 1           |   |
| FURADANTIN                                      | NITROFURANTOIN                                 | Tier 4           |   |
| HIPREX  | METHENAMINE HIPPURATE                          | Tier 4           |   |
| <i>methenamine hippurate</i>                    | <i>hiprex</i>                                  | Tier 2           |   |
| METROGEL  | METRONIDAZOLE                                  | Tier 4           | PA; Topical Dosage Formulation  |
| <i>metronidazole</i>                            | <i>flagyl</i>                                  | Tier 1           |   |
| <i>metronidazole</i>                            | <i>metrocream</i>                              | Tier 2           | Topical Dosage Formulation  |
| <i>metronidazole</i>                            | <i>metrolotion</i>                             | Tier 2           | Topical Dosage Formulation  |
| <i>metronidazole vaginal</i>                    | <i>metrogel</i>                                | Tier 2           | Vaginal Dosage Formulation  |
| MONUROL   | FOSFOMYCIN TROMETHAMINE (TROMETAMOL)           | Tier 4           |   |
| <i>mupirocin</i>                                | <i>bactroban</i>                               | Tier 2           | Topical Dosage Formulation  |
| <i>neomycin/polymyxin/gramicidin</i>            | <i>neosporin</i>                               | Tier 2           |   |
| <i>nitrofurantoin macrocrystalline</i>          | <i>macrodantin</i>                             | Tier 1           |   |
| <i>nitrofurantoin monohydrate</i>               | <i>macrobid</i>                                | Tier 1           |   |
| NORITATE  | METRONIDAZOLE                                  | Tier 4           | Topical Dosage Formulation  |
| <i>polycin b</i>                                | <i>bacitracin zinc and polymyxin b sulfite</i> | Tier 2           |   |
| <i>trimethoprim</i>                             | <i>trimethoprim</i>                            | Tier 2           |   |
| <i>trimethoprim sulfite/polymyxin b sulfite</i> | <i>polytrim</i>                                | Tier 2           |   |
| TYGACIL   | TIGECYCLINE                                    | Tier 5           | PA; Injectable dosage Formulation   |
| UREX  | METHENAMINE HIPPURATE                          | Tier 4           |   |
| VANCOGIN HCL                                    | VANCOMYCIN HYDROCHLORIDE                       | Tier 6           | PA  |
| <i>vancomycin hcl</i>                           | <i>vancomycin hydrochloride</i>                | Tier 5           | PA; Injectable dosage Formulation   |

## Formulario

| Nombre de medicamento cubierto      | Nombre de medicamento alternativo                 | Desert Preferred | Requisitos / Limites              |
|-------------------------------------|---|------------------|-----------------------------------|
| VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE | DEXTROSE (ANHYDROUS) AND VANCOMYCIN HYDROCHLORIDE | Tier 5           | PA; Injectable dosage Formulation |
| <i>vandazole</i>                    | <i>metronidazole</i>                              | Tier 1           |                                   |
| ZYVOX                               | LINEZOLID   | Tier 6           | PA; QL - 56 tablets per 28 days   |

**Betalactámicos, Cefalosporinas**

|                              |                               |        |   |
|------------------------------|-------------------------------|--------|---|
| <i>cefaclor</i>              | <i>ceclor</i>                 | Tier 1 |   |
| <i>cefadroxil</i>            | <i>cefadroxil monohydrate</i> | Tier 1 |   |
| CEFAZOLIN SODIUM             | CEFAZOLIN SODIUM              | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>cefdinir</i>              | <i>omnicef</i>                | Tier 2 |   |
| <i>cefoxitin sodium</i>      | <i>mefoxin</i>                | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>cefepodoxime proxetil</i> | <i>vantin</i>                 | Tier 1 |   |
| <i>cefprozil</i>             | <i>cefzil</i>                 | Tier 2 |   |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>ceftriaxone sodium</i>      | <i>rocephin</i>                   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>cefuroxime axetil</i>       | <i>ceftin</i>                     | Tier 1           |   |
| <i>cephalexin</i>              | <i>keflex</i>                     | Tier 1           |   |
| MAXIPIME                       | CEFEPIME HYDROCHLORIDE            | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| SPECTRACEF                     | CEFDITOREN PIVOXIL                | Tier 4           |   |
| SUPRAX                         | CEFIXIME                          | Tier 4           |   |

**Betalactámicos, Otros**

|         |                  |        |                                   |
|---------|------------------|--------|-----------------------------------|
| AZACTAM | AZTREONAM        | Tier 5 | PA; Injectable dosage Formulation |
| INVANZ  | ERTAPENEM SODIUM | Tier 5 | PA; Injectable dosage Formulation |
| MERREM  | MEROPENEM        | Tier 5 |                                   |

**Betalactámicos, Penicilinas**

|  |                    |        |  |
|--|--------------------|--------|--|
| <i>amoxicillin</i>                       | <i>amoxil</i>      | Tier 1 |  |
| <i>amoxicillin/clavulanate potassium</i> | <i>augmentin</i>   | Tier 1 |  |
| <i>amoxicillin/potassium clavulanate</i> | <i>augmentin</i>   | Tier 1 |  |
| <i>amoxil</i>                            | <i>amoxicillin</i> | Tier 1 |  |
| <i>ampicillin</i>                        | <i>omnipen</i>     | Tier 1 |  |
| <i>ampicillin</i>                        | <i>principen</i>   | Tier 1 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>ampicillin sodium</i>       | <i>principen</i>                  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>ampicillin-sulbactam</i>    | <i>unasyn</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dicloxacillin sodium</i>    | <i>diclox</i>                     | Tier 1           |   |
| <i>nafcillin sodium</i>        | <i>nafcillin sodium</i>           | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo         | Desert Preferred | Requisitos / Limites  |
|--------------------------------|---|------------------|---|
| PENICILLIN                     | PENICILLIN                                | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| PIPERACILLIN SODIUM            | PIPERACILLIN SODIUM                       | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>trimox</i>                  | <i>amoxicillin</i>                        | Tier 1           |   |
| <i>veetids</i>                 | <i>penicillin v potassium</i>             | Tier 1           |   |
| ZOSYN                          | PIPERACILLIN SODIUM AND TAZOBACTAM SODIUM | Tier 5           | PA; Injectable dosage Formulation   |

**Macrólidos**

|                          |                     |        |                                  |
|--------------------------|---------------------|--------|----------------------------------|
| <i>azithromycin</i>      | <i>zithromax</i>    | Tier 2 | QL - 6 tablets per prescription  |
| <i>clarithromycin</i>    | <i>biaxin</i>       | Tier 2 | QL - 28 tablets per prescription |
| <i>clarithromycin er</i> | <i>biaxin xl</i>    | Tier 1 | QL - 28 tablets per prescription |
| <i>ery</i>               | <i>erythromycin</i> | Tier 2 | Topical Dosage Formulation       |
| <i>ery-tab</i>           | <i>erythromycin</i> | Tier 1 |                                  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| ERYTHROCIN LACTOBIONATE        | ERYTHROMYCIN LACTOBIONATE         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>erythrocin stearate</i>     | <i>erythromycin</i>               | Tier 1           |   |
| <i>erythromycin</i>            | <i>erythromycin</i>               | Tier 2           | Topical Dosage Formulation  |
| ZMAX                           | AZITHROMYCIN DIHYDRATE            | Tier 3           |   |

**Quinolonas**

|                          |  |        |   |
|--------------------------|--|--------|---|
| AVELOX                   | MOXIFLOXACIN HYDROCHLORIDE                     | Tier 4 | QL - 14 tablets per prescription  |
| AVELOX                   | MOXIFLOXACIN HYDROCHLORIDE AND SODIUM CHLORIDE | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AVELOX ABC PACK          | MOXIFLOXACIN HYDROCHLORIDE                     | Tier 4 | QL - 14 tablets per prescription  |
| CILOXAN                  | CIPROFLOXACIN HCL                              | Tier 4 |   |
| <i>ciprofloxacin er</i>  | <i>ciprofloxacin and ciprofloxacin hcl</i>     | Tier 1 |   |
| <i>ciprofloxacin hcl</i> | <i>ciloxan</i>                                 | Tier 2 |   |
| <i>ciprofloxacin hcl</i> | <i>cipro</i>                                   | Tier 1 |   |
| FACTIVE                  | GEMIFLOXACIN MESYLATE                          | Tier 4 | QL - 7 tablets per prescription   |
| LEVAQUIN                 | LEVOFLOXACIN HEMIHYDRATE                       | Tier 4 | QL - 14 tablets per prescription  |
| NOROXIN                  | NORFLOXACIN                                    | Tier 4 |   |
| <i>ofloxacin</i>         | <i>floxacin</i>                                | Tier 2 |   |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| <i>ofloxacin</i>               | <i>ocuflox</i>                    | Tier 2           |                      |
| QUIXIN                         | LEVOFLOXACIN HEMIHYDRATE          | Tier 4           |                      |
| VIGAMOX                        | MOXIFLOXACIN HYDROCHLORIDE        | Tier 4           |                      |
| ZYMAR                          | GATIFLOXACIN SESQUIHYDRATE        | Tier 4           |                      |

**Sulfonamidas**

|   |  |        |   |
|---|--|--------|---|
| GANTRISIN PEDIATRIC                     | SULFISOXAZOLE ACETYL                     | Tier 4 |   |
| <i>ocusulf-10</i>                       | <i>bleph-10</i>                          | Tier 1 |   |
| <i>silver sulfadiazine</i>              | <i>silvadene</i>                         | Tier 1 | Topical Dosage Formulation  |
| <i>sodium sulfacetamide</i>             | <i>klaron</i>                            | Tier 2 | Topical Dosage Formulation  |
| <i>ssd</i>                              | <i>silvadene</i>                         | Tier 1 | Topical Dosage Formulation  |
| <i>sulfadiazine</i>                     | <i>sulfadiazine</i>                      | Tier 2 |   |
| <i>sulfamethoxazole/trimethoprim</i>    | <i>sulfamethoxazole and trimethoprim</i> | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>sulfamethoxazole/trimethoprim ds</i> | <i>sepra ds</i>                          | Tier 1 |   |
| SULFAMYLON                              | MAFENIDE ACETATE                         | Tier 4 | Topical Dosage Formulation  |
| <i>sulfatrim</i>                        | <i>sulfamethoxazole and trimethoprim</i> | Tier 1 |   |
| <i>thermazene</i>                       | <i>silvadene</i>                         | Tier 1 | Topical Dosage Formulation  |

**Tetraciclinas**

|                                |                            |        |  |
|--------------------------------|----------------------------|--------|--|
| <i>demeclocycline hcl</i>      | <i>declomycin</i>          | Tier 2 |  |
| <i>doxycycline hyclate</i>     | <i>doryx</i>               | Tier 5 |  |
| <i>doxycycline hyclate</i>     | <i>doxycycline hyclate</i> | Tier 1 |  |
| <i>doxycycline hyclate</i>     | <i>periostat</i>           | Tier 1 |  |
| <i>doxycycline hyclate</i>     | <i>vibramycin</i>          | Tier 1 |  |
| <i>doxycycline hyclate</i>     | <i>vibratab</i>            | Tier 1 |  |
| <i>doxycycline monohydrate</i> | <i>adoxa</i>               | Tier 1 |  |
| <i>minocycline hcl</i>         | <i>minocin</i>             | Tier 2 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| <i>tetracycline hcl</i>        | <i>sumycin</i>                    | Tier 1           |                      |

## Antiespasmódicos

**Antiespasmódicos, Otros**

|                      |               |        |  |
|----------------------|---------------|--------|--|
| BANZEL               | RUFINAMIDE    | Tier 4 |  |
| KEPPRA               | LEVETIRACETAM | Tier 3 |  |
| KEPPRA XR            | LEVETIRACETAM | Tier 4 |  |
| <i>levetiracetam</i> | <i>keppra</i> | Tier 2 |  |
| VIMPAT               | LACOSAMIDE    | Tier 4 |  |

**Modificadores de los canales de calcio**

|                     |                 |        |  |
|---------------------|-----------------|--------|--|
| CELONTIN            | METHSUXIMIDE    | Tier 4 |  |
| <i>ethosuximide</i> | <i>zarontin</i> | Tier 2 |  |
| LYRICA              | PREGABALIN      | Tier 3 |  |
| <i>zonisamide</i>   | <i>zonegran</i> | Tier 2 |  |

**Aumentadores del ácido gama-aminobutírico**

|                          |                         |        |   |
|--------------------------|-------------------------|--------|---|
| DEPACON                  | VALPROATE SODIUM        | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| DEPAKOTE SPRINKLES       | DIVALPROEX SODIUM       | Tier 3 |   |
| <i>divalproex sodium</i> | <i>depakote</i>         | Tier 2 |   |
| <i>gabapentin</i>        | <i>neurontin</i>        | Tier 2 | QL - 360 capsules per 30 days on 100mg and 300mg; 270 capsules per 30 days on 400mg   |
| GABITRIL                 | TIAGABINE HYDROCHLORIDE | Tier 4 |   |
| NEURONTIN                | GABAPENTIN              | Tier 4 |   |
| <i>primidone</i>         | <i>mysoline</i>         | Tier 2 |   |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites   |
|--------------------------------|-----------------------------------|------------------|--|
| SABRIL                         | VIGABATRIN                        | Tier 6           | PA for new starts; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. |
| STAVZOR                        | VALPROATE                         | Tier 4           |  |
| <i>valproate sodium</i>        | <i>depacon</i>                    | Tier 5           | Injectable dosage Formulation  |
| <i>valproic acid</i>           | <i>depakene</i>                   | Tier 2           |  |

**Reductores de glutamato**

|                    |                 |        |  |
|--------------------|-----------------|--------|--|
| FELBATOL           | FELBAMATE       | Tier 4 |  |
| <i>lamotrigine</i> | <i>lamactil</i> | Tier 2 |  |
| TOPAMAX            | TOPIRAMATE      | Tier 3 |  |

**Inhibidores de canales de sodio**

|                      |                     |        |   |
|----------------------|---------------------|--------|---|
| <i>carbamazepine</i> | <i>tegretol</i>     | Tier 1 |   |
| CARBATROL            | CARBAMAZEPINE       | Tier 4 |   |
| CEREBYX              | FOSPHENYTOIN SODIUM | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| DILANTIN             | PHENYTOIN SODIUM    | Tier 3 |   |
| <i>epitol</i>        | <i>tegretol</i>     | Tier 1 |   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>fosphenytoin sodium</i>     | <i>cerebyx</i>                    | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>oxcarbazepine</i>           | <i>trileptal</i>                  | Tier 1           |   |
| PEGANONE                       | ETHOTOIN                          | Tier 4           |   |
| PHENYTEK                       | PHENYTOIN SODIUM                  | Tier 4           |   |
| <i>phenytoin</i>               | <i>dilantin</i>                   | Tier 1           |   |
| <i>phenytoin sodium</i>        | <i>phenytoin sodium</i>           | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| TEGRETOL-XR                    | CARBAMAZEPINE                     | Tier 4           |   |
| TRILEPTAL                      | OXCARBAZEPINE                     | Tier 4           |   |

**Agentes para la demencia****Agentes para la demencia, Otros**

|                           |              |        |  |
|---------------------------|--------------|--------|--|
| <i>ergoloid mesylates</i> | <i>ergot</i> | Tier 2 |  |
|---------------------------|--------------|--------|--|

**Cholinesterase Inhibitors**

|             |                         |        |                               |
|-------------|-------------------------|--------|-------------------------------|
| ARICEPT     | DONEPEZIL HYDROCHLORIDE | Tier 3 | QL - 30 tablets per 30 days   |
| ARICEPT ODT | DONEPEZIL HYDROCHLORIDE | Tier 3 | QL - 30 tablets per 30 days   |
| COGNEX      | TACRINE HYDROCHLORIDE   | Tier 4 | QL - 120 capsules per 30 days |

**Formulario**

| Nombre de medicamento cubierto  | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites                            |
|---------------------------------|-----------------------------------|------------------|---|
| EXELON                          | RIVASTIGMINE TARTRATE             | Tier 3           | QL - 60 capsules per 30 days; 180ml per 30 days |
| <i>galantamine hydrobromide</i> | <i>razadyne</i>                   | Tier 2           |   |
| RAZADYNE                        | GALANTAMINE HYDROBROMIDE          | Tier 4           | Oral solution; QL - 180ml per 30 days           |

**Modificadores de la ruta de glutamato**

|         |                         |        |  |
|---------|-------------------------|--------|--|
| NAMENDA | MEMANTINE HYDROCHLORIDE | Tier 3 | QL - 60 tablets per 30 days; 360ml per 30 days |
|---------|-------------------------|--------|--|

**Antidepresivos****Antidepresivos, Otros**

|                                       |   |        |                             |
|---------------------------------------|---|--------|-----------------------------|
| <i>amoxapine</i>                      | <i>amoxapine</i>                                    | Tier 2 |                             |
| <i>budeprion sr</i>                   | <i>wellbutrin sr</i>                                | Tier 2 |                             |
| <i>budeprion xl</i>                   | <i>wellbutrin xl</i>                                | Tier 2 | QL - 30 tablets per 30 days |
| <i>bupropion hcl sr</i>               | <i>wellbutrin sr</i>                                | Tier 2 |                             |
| <i>chlordiazepoxide/amitriptyline</i> | <i>limbitrol</i>                                    | Tier 2 |                             |
| <i>maprotiline hcl</i>                | <i>maprotiline hydrochloride</i>                    | Tier 2 |                             |
| <i>mirtazapine</i>                    | <i>mirtazapine</i>                                  | Tier 2 | QL - 30 tablets per 30 days |
| <i>mirtazapine</i>                    | <i>remeron</i>                                      | Tier 2 | QL - 30 tablets per 30 days |
| <i>mirtazapine</i>                    | <i>remeron soltab</i>                               | Tier 2 | QL - 30 tablets per 30 days |
| <i>nefazodone hcl</i>                 | <i>serzone</i>                                      | Tier 2 |                             |
| <i>perphenazine/amitriptyline</i>     | <i>amitriptyline hydrochloride and perphenazine</i> | Tier 2 |                             |
| <i>trazodone hcl</i>                  | <i>desryl</i>                                       | Tier 1 |                             |

**Inhibidores de monoamina oxidasa**

|                                |                    |        |  |
|--------------------------------|--------------------|--------|--|
| EMSAM                          | SELEGILINE         | Tier 4 | PA for new starts; QL - 30 patches per 30 days; Transdermal Dosage Formulation |
| MARPLAN                        | ISOCARBOXAZID      | Tier 4 |  |
| NARDIL                         | PHENELZINE SULFATE | Tier 3 |  |
| <i>tranylcypromine sulfate</i> | <i>parnate</i>     | Tier 2 |  |

## Formulario

| Nombre de medicamento cubierto  | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites   |
|---|-----------------------------------|------------------|--|
| <b><i>Inhibidores de la recaptación de serotonina/norepinefrina</i></b> |                                   |                  |  |
| CELEXA  | CITALOPRAM HYDROBROMIDE           | Tier 4           | Oral solution  |
| <i>citalopram hydrobromide</i>  | <i>celexa</i>                     | Tier 1           |  |
| CYMBALTA  | DULOXETINE HYDROCHLORIDE          | Tier 3           | QL - 60 capsules per 30 days on 20mg; 30 capsules per 30 days on 30mg and 60mg                             |
| EFFEXOR XR  | VENLAFAXINE HCL                   | Tier 4           | QL - 180 capsules per 30 days on 37.5mg; 90 capsules per 30 days on 75mg; 60 capsules per 30 days on 150mg |
| <i>fluoxetine hcl</i>   | <i>prozac</i>                     | Tier 1           |  |
| <i>fluoxetine hcl</i>   | <i>rapiflux</i>                   | Tier 1           |  |
| <i>fluvoxamine maleate</i>  | <i>luvox</i>                      | Tier 2           | QL - 45 tablets per 30 days on 25mg; 60 tablets per 30 days on 50mg; 90 tablets per 30 days on 100mg       |
| LEXAPRO   | ESCITALOPRAM OXALATE              | Tier 4           | QL - 30 tablets per 30 days, 620ml per 30 days on 5mg/5ml solution;  |
| LUVOX CR  | FLUVOXAMINE MALEATE               | Tier 4           | QL - 60 capsules per 30 days   |
| <i>paroxetine hcl</i>   | <i>paxil</i>                      | Tier 2           | QL - 30 tablets per 30 days, 946ml per 30 days on 10mg/5ml suspension                                      |
| PRISTIQ   | DESVENLAFAXINE                    | Tier 4           | QL - 30 tablets per 30 days  |
| <i>sertraline hcl</i>   | <i>zoloft</i>                     | Tier 2           | QL - 30 per 30 days on 25mg and 50mg,  |
| 60  |                                   |                  | per 30 days on 100mg 300ml per 30 days on 20mg/ml solution   |
| <i>venlafaxine hcl</i>  | <i>effexor</i>                    | Tier 2           | QL - 150 tablets per 30 days   |
| VENLAFAXINE HCL ER  | VENLAFAXINE                       | Tier 3           |  |

***Tricíclicos***

|                          |                  |        |  |
|--------------------------|------------------|--------|--|
| <i>amitriptyline hcl</i> | <i>elavil</i>    | Tier 1 |  |
| <i>clomipramine hcl</i>  | <i>anafranil</i> | Tier 2 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| <i>desipramine hcl</i>         | <i>norpramin</i>                  | Tier 2           |                      |
| <i>doxepin hcl</i>             | <i>sinequan</i>                   | Tier 1           |                      |
| <i>imipramine hcl</i>          | <i>tofranil</i>                   | Tier 2           |                      |
| <i>nortriptyline hcl</i>       | <i>pamelor</i>                    | Tier 1           |                      |
| <i>protriptyline hcl</i>       | <i>vivactil</i>                   | Tier 2           |                      |
| SURMONTIL                      | TRIMIPRAMINE MALEATE              | Tier 4           |                      |
| TOFRANIL-PM                    | IMIPRAMINE PAMOATE                | Tier 4           |                      |
| <i>trimipramine maleate</i>    | <i>surmontil</i>                  | Tier 2           |                      |

## Antídotos, disuasivos, agentes toxicológicos

## Antídotos

|           |                               |        |   |
|-----------|-------------------------------|--------|---|
| ACETADOTE | ACETYLCYSTEINE                | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| ANTIZOL   | FOMEPIZOLE (4 METHYLPYRAZOLE) | Tier 6 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto      | Nombre de medicamento alternativo   | Desert Preferred | Requisitos / Limites  |
|-------------------------------------|-------------------------------------|------------------|---|
| DEPEN TITRATABS                     | PENICILLAMINE                       | Tier 4           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| EXJADE                              | DEFERASIROX                         | Tier 6           | PA  |
| <i>sodium polystyrene sulfonate</i> | <i>sodium polystyrene sulfonate</i> | Tier 2           |   |
| SYPRINE                             | TRIENTINE HCL                       | Tier 4           |   |

**Disuasivos**

|                         |                      |        |                                 |
|-------------------------|----------------------|--------|---------------------------------|
| <i>bupropion hcl sr</i> | <i>zyban</i>         | Tier 2 |                                 |
| CAMPRAL                 | ACAMPROSATE CALCIUM  | Tier 4 |                                 |
| CHANTIX                 | VARENICLINE TARTRATE | Tier 4 | PA; QL - 60 tablets per 30 days |
| NICOTROL NS             | NICOTINE             | Tier 4 | QL - 4 inhalers per 30 days     |

**Agentes toxicológicos**

|                       |                               |        |   |
|-----------------------|-------------------------------|--------|---|
| <i>depade</i>         | <i>revia</i>                  | Tier 2 |   |
| LEUCOVORIN CALCIUM    | LEUCOVORIN CALCIUM            | Tier 4 | PA for new starts   |
| MESNEX                | MESNA                         | Tier 6 |   |
| <i>naloxone hcl</i>   | <i>naloxone hydrochloride</i> | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>naltrexone hcl</i> | <i>revia</i>                  | Tier 2 |   |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

## Antieméticos

*Antieméticos*

|                            |                                      |        |  |
|----------------------------|--------------------------------------|--------|--|
| ALOXI                      | PALONOSETRON HYDROCHLORIDE           | Tier 5 | PA; Injectable dosage Formulation; QL - 5mls per month   |
| ANZEMET                    | DOLASETRON MESYLATE                  | Tier 4 | PA - QL - 10 tablets per prescription  |
| <i>chlorpromazine hcl</i>  | <i>chlorpromazine hydrochloride</i>  | Tier 1 |  |
| <i>diphenhydramine hcl</i> | <i>benadryl</i>                      | Tier 1 |  |
| <i>diphenhydramine hcl</i> | <i>diphenhydramine hydrochloride</i> | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination.                            |
| <i>dronabinol</i>          | <i>marinol</i>                       | Tier 2 |  |
| EMEND                      | APREPITANT                           | Tier 3 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. - Limit 5 per prescription |
| <i>granisetron hcl</i>     | <i>kytril</i>                        | Tier 1 | PA for new starts; QL 10 per prescription  |
| <i>granisol</i>            | <i>kytril</i>                        | Tier 1 | PA for new starts  |
| <i>hydroxyzine pamoate</i> | <i>vistaril</i>                      | Tier 1 |  |
| <i>meclizine hcl</i>       | <i>antivert</i>                      | Tier 1 |  |
| <i>metoclopramide hcl</i>  | <i>reglan</i>                        | Tier 1 |  |

## Formulario

| Nombre de medicamento cubierto    | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites   |
|-----------------------------------|-----------------------------------|------------------|--|
| <i>ondansetron hcl</i>            | <i>zofran</i>                     | Tier 2           | PA for new starts; QL - 10 tablets per prescription; 50ml oral solution per prescription |
| <i>ondansetron odt</i>            | <i>zofran odt</i>                 | Tier 2           | PA for new starts; QL - 10 tablets per prescription; 50ml oral solution per prescription |
| <i>perphenazine</i>               | <i>trilafon</i>                   | Tier 1           |  |
| <i>phenadoz</i>                   | <i>promethazine hydrochloride</i> | Tier 1           |  |
| <i>prochlorperazine edisylate</i> | <i>prochlorperazine edisylate</i> | Tier 5           |  |
| <i>prochlorperazine maleate</i>   | <i>prochlorperazine maleate</i>   | Tier 2           |  |
| <i>promethazine hcl</i>           | <i>phenergan</i>                  | Tier 1           |  |
| TRANSDERM-SCOP                    | SCOPOLAMINE                       | Tier 4           | Transdermal Dosage Formulation; QL 24 per 30 days  |
| <i>trimethobenzamide hcl</i>      | <i>tigan</i>                      | Tier 2           |  |

## Antimicóticos

## Antimicóticos

|                                |                            |        |   |
|--------------------------------|----------------------------|--------|---|
| ABELCET                        | AMPHOTERICIN B             | Tier 6 | PA; Injectable dosage Formulation   |
| <i>amphotericin b</i>          | <i>amphotericin b</i>      | Tier 5 | PA; Injectable dosage Formulation   |
| ANCOBON                        | FLUCYTOSINE                | Tier 4 |   |
| CANCIDAS                       | CASPOFUNGIN ACETATE        | Tier 6 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>ciclopirox</i>              | <i>loprox</i>              | Tier 2 | Topical Dosage Formulation  |
| <i>ciclopirox nail lacquer</i> | <i>penlac nail lacquer</i> | Tier 1 |   |
| <i>ciclopirox olamine</i>      | <i>loprox</i>              | Tier 2 | Topical Dosage Formulation  |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo           | Desert Preferred | Requisitos / Limites                                  |
|--------------------------------|---|------------------|---|
| <i>clotrimazole</i>            | <i>clotrimazole</i>                         | Tier 2           | Topical Dosage Formulation                            |
| <i>clotrimazole</i>            | <i>mycelex</i>                              | Tier 1           |   |
| <i>econazole nitrate</i>       | <i>econazole nitrate</i>                    | Tier 2           | Topical Dosage Formulation                            |
| ERAXIS                         | ANIDULAFUNGIN                               | Tier 5           | PA; Injectable dosage Formulation                     |
| EXELDERM                       | SULCONAZOLE NITRATE                         | Tier 4           | Topical Dosage Formulation                            |
| <i>fluconazole</i>             | <i>diflucan</i>                             | Tier 1           |   |
| <i>griseofulvin microsize</i>  | <i>gris-peg</i>                             | Tier 4           |   |
| <i>itraconazole</i>            | <i>sporanox pulsepak</i>                    | Tier 2           |   |
| <i>ketoconazole</i>            | <i>nizoral</i>                              | Tier 2           | Topical Dosage Formulation                            |
| <i>kuric</i>                   | <i>ketoconazole</i>                         | Tier 2           | Topical Dosage Formulation                            |
| LAMISIL                        | TERBINAFINE HYDROCHLORIDE                   | Tier 3           | QL - 30 grams per 30 days; Topical Dosage Formulation |
| LOPROX                         | CICLOPIROX                                  | Tier 4           | Topical Dosage Formulation                            |
| LOPROX SHAMPOO                 | CICLOPIROX                                  | Tier 4           | Topical Dosage Formulation                            |
| <i>miconazole 3</i>            | <i>miconazole nitrate</i>                   | Tier 2           | Vaginal Dosage Formulation                            |
| NAFTIN                         | NAFTIFINE HYDROCHLORIDE                     | Tier 4           | Topical Dosage Formulation                            |
| NATACYN                        | NATAMYCIN                                   | Tier 3           |   |
| <i>nystatin</i>                | <i>mycostatin</i>                           | Tier 1           | Topical Dosage Formulation                            |
| <i>nystatin</i>                | <i>nystatin</i>                             | Tier 1           |   |
| <i>nystatin/triamcinolone</i>  | <i>nystatin and triamcinolone acetonide</i> | Tier 1           | Topical Dosage Formulation                            |
| <i>nystop</i>                  | <i>mycostatin</i>                           | Tier 1           | Topical Dosage Formulation                            |
| OXISTAT                        | OXICONAZOLE NITRATE                         | Tier 4           | Topical Dosage Formulation                            |
| <i>pedi-dri</i>                | <i>mycostatin</i>                           | Tier 1           | Topical Dosage Formulation                            |
| <i>terbinafine hcl</i>         | <i>lamisil</i>                              | Tier 2           |   |
| <i>terconazole</i>             | <i>terazol</i>                              | Tier 1           |   |
| VFEND                          | VORICONAZOLE                                | Tier 6           | PA  |
| VFEND IV                       | VORICONAZOLE                                | Tier 6           | PA; Injectable dosage Formulation                     |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| <i>zazole</i>                  | <i>terconazole</i>                | Tier 1           |                      |

## Agentes antigota

## Agentes antigota

|                              |                                  |        |  |
|------------------------------|----------------------------------|--------|--|
| <i>allopurinol</i>           | <i>zyloprim</i>                  | Tier 1 |  |
| COLCRYS                      | COLCHICINE                       | Tier 4 |  |
| <i>probenecid</i>            | <i>probenecid</i>                | Tier 2 |  |
| <i>probenecid/colchicine</i> | <i>colchicine and probenecid</i> | Tier 2 |  |

## Agentes antihaemorróicos

## Abortivos

|                                     |   |        |   |
|-------------------------------------|---|--------|---|
| AMERGE                              | NARATRIPTAN HYDROCHLORIDE               | Tier 4 | QL - 9 tablets per 30 days                              |
| AXERT                               | ALMOTRIPTAN MALATE                      | Tier 4 | QL - 12 tablets per 30 days                             |
| <i>dihydroergotamine mesylate</i>   | <i>d.h.e. 45</i>                        | Tier 5 |   |
| ERGOMAR                             | ERGOTAMINE TARTRATE                     | Tier 4 | QL - 20 tablets per 28 days                             |
| <i>ergotamine tartrate/caffeine</i> | <i>caffeine and ergotamine tartrate</i> | Tier 2 |   |
| FROVA                               | FROVATRIPTAN SUCCINATE MONOHYDRATE      | Tier 4 | QL - 12 tablets per 30 days                             |
| MAXALT                              | RIZATRIPTAN BENZOATE                    | Tier 4 | QL - 12 tablets per 30 days                             |
| MAXALT-MLT                          | RIZATRIPTAN BENZOATE                    | Tier 4 | QL - 12 tablets per 30 days                             |
| <i>migergot</i>                     | <i>caffeine and ergotamine tartrate</i> | Tier 1 |   |
| MIGRANAL                            | DIHYDROERGOTAMINE MESYLATE              | Tier 4 | QL - 16 ml per 30 days                                  |
| RELPAX                              | ELETRIPTAN HYDROBROMIDE                 | Tier 3 | QL - 6 tablets per 30 days                              |
| <i>sumatriptan succinate</i>        | <i>imitrex</i>                          | Tier 2 |   |
| ZOMIG                               | ZOLMITRIPTAN                            | Tier 3 | QL - 6 tablets per 30 days; 6ml nasal spray per 30 days |
| ZOMIG ZMT                           | ZOLMITRIPTAN                            | Tier 3 | QL - 6 tablets per 30 days                              |

## Profilácticos

|                          |                        |        |  |
|--------------------------|------------------------|--------|--|
| DEPAKOTE ER              | DIVALPROEX SODIUM      | Tier 3 |  |
| <i>divalproex sodium</i> | <i>depakote</i>        | Tier 2 |  |
| <i>timolol maleate</i>   | <i>timolol maleate</i> | Tier 2 |  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes contra la debilidad muscular*****Parasimpaticomiméticos***

|                               |                         |        |  |
|-------------------------------|-------------------------|--------|--|
| GUANIDINE HCL                 | GUANIDINE HYDROCHLORIDE | Tier 3 |  |
| MESTINON                      | PYRIDOSTIGMINE BROMIDE  | Tier 4 |  |
| MYTELASE                      | AMBENONIUM CHLORIDE     | Tier 4 |  |
| <i>pyridostigmine bromide</i> | <i>mestinon</i>         | Tier 2 |  |

**Antimicrobacterianos*****Antimicrobacterianos, Otros***

|           |           |        |  |
|-----------|-----------|--------|--|
| DAPSONE   | DAPSONE   | Tier 3 |  |
| MYCOBUTIN | RIFABUTIN | Tier 4 |  |

***Antituberculosos***

|                       |   |        |   |
|-----------------------|---|--------|---|
| CAPASTAT SULFATE      | CAPREOMYCIN SULFATE                     | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>ethambutol hcl</i> | <i>myambutol</i>                        | Tier 2 |   |
| <i>isonarif</i>       | <i>rifamate</i>                         | Tier 1 |   |
| <i>isoniazid</i>      | <i>isoniazid</i>                        | Tier 1 |   |
| PASER                 | AMINOSALICYLIC ACID (4-ASA)             | Tier 4 |   |
| PRIFTIN               | RIFAPENTINE                             | Tier 4 |   |
| <i>pyrazinamide</i>   | <i>pyrazinamide</i>                     | Tier 1 |   |
| RIFAMATE              | ISONIAZID AND RIFAMPIN                  | Tier 4 |   |
| <i>rifampin</i>       | <i>rifadin</i>                          | Tier 2 |   |
| RIFATER               | ISONIAZID AND PYRAZINAMIDE AND RIFAMPIN | Tier 4 |   |
| SEROMYCIN             | CYCLOSERINE                             | Tier 4 |   |
| TRECTOR               | ETHIONAMIDE                             | Tier 4 |   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Antineoplásicos****Agentes alquilantes**

|          |                               |        |  |
|----------|-------------------------------|--------|--|
| CEENU    | LOMUSTINE                     | Tier 4 | PA for new starts                                |
| EMCYT    | ESTRAMUSTINE PHOSPHATE SODIUM | Tier 5 | PA for new starts                                |
| HEXALEN  | ALTRETAMINE                   | Tier 6 | PA for new starts                                |
| LEUKERAN | CHLORAMBUCIL                  | Tier 3 | PA for new starts                                |
| MATULANE | PROCARBAZINE HYDROCHLORIDE    | Tier 4 |  |
| ZANOSAR  | STREPTOZOCIN                  | Tier 5 | PA for new starts; Injectable dosage Formulation |

**Agentes antiangiogénicos**

|          |              |        |  |
|----------|--------------|--------|--|
| REVLIMID | LENALIDOMIDE | Tier 6 | PA for new starts; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. |
| THALOMID | THALIDOMIDE  | Tier 6 | PA for new starts  |

**Antiestrogénicos/Modificadores**

|                          |                 |        |  |
|--------------------------|-----------------|--------|--|
| FARESTON                 | TOREMIFENE      | Tier 4 |  |
| <i>tamoxifen citrate</i> | <i>nolvadex</i> | Tier 1 |  |

**Antimetabolitos**

|                       |                   |        |                   |
|-----------------------|-------------------|--------|-------------------|
| DROXIA                | HYDROXYUREA       | Tier 4 |                   |
| <i>hydroxyurea</i>    | <i>hydrea</i>     | Tier 2 |                   |
| <i>mercaptopurine</i> | <i>purinethol</i> | Tier 2 |                   |
| TABLOID               | THIOGUANINE       | Tier 4 | PA for new starts |

**Antineoplásicos, Otros**

|          |            |        |  |
|----------|------------|--------|--|
| AFINITOR | EVEROLIMUS | Tier 6 | QL - 60 tablets per 30 days                      |
| ARRANON  | NELARABINE | Tier 6 | PA for new starts; Injectable dosage Formulation |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>bleomycin sulfate</i>       | <i>bleomycin sulfate</i>          | Tier 5           | PA for new starts; Injectable dosage Formulation  |
| <i>cyclophosphamide</i>        | <i>cytoxan</i>                    | Tier 2           | PA for new starts   |
| ELITEK                         | RASBURICASE                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| <i>mitoxantrone hcl</i>        | <i>novantrone</i>                 | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| ONTAK                          | DENILEUKIN DIFTITOX               | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| PROLEUKIN                      | ALDESLEUKIN                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| TRISENOX                       | ARSENIC TRIOXIDE                  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| TYKERB                         | LAPATINIB DITOSYLATE              | Tier 6           | PA for new starts   |
| VELCADE                        | BORTEZOMIB                        | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| VIDAZA                         | AZACITIDINE                       | Tier 6           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| ZOLINZA                        | VORINOSTAT                        | Tier 6           |   |

**Formulario**

| Nombre de medicamento cubierto                               | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--|-----------------------------------|------------------|---|
| <b><i>Tercera generación de inhibidores de aromatasa</i></b> |                                   |                  |   |
| ARIMIDEX   | ANASTROZOLE                       | Tier 3           | QL - 30 tablets per 30 days   |
| AROMASIN   | EXEMESTANE                        | Tier 3           |   |
| FEMARA   | LETROZOLE                         | Tier 4           |   |
| <b><i>Inhibidores moleculares</i></b>                        |                                   |                  |   |
| GLEEVEC  | IMATINIB MESYLATE                 | Tier 6           | PA for new starts - QL - 90 tablets per 30 days on 100mg, 60 tablets per 30 days on 400mg |
| IRESSA   | GEFITINIB                         | Tier 6           | PA for new starts; QL - 30 tablets per 30 days  |
| NEXAVAR  | SORAFENIB TOSYLATE                | Tier 6           | PA for new starts; QL 120 per 30 days   |
| SPRYCEL  | DASATINIB                         | Tier 6           | PA for new starts   |
| SUTENT   | SUNITINIB MALATE                  | Tier 6           | PA for new starts   |
| TARCEVA  | ERLOTINIB                         | Tier 6           | PA for new starts   |
| TASIGNA  | NILOTINIB                         | Tier 6           |   |
| <b><i>Anticuerpos monoclonales</i></b>                       |                                   |                  |   |
| AVASTIN  | BEVACIZUMAB                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| CAMPATH  | ALEMTUZUMAB                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| HERCEPTIN  | TRASTUZUMAB                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| MYLOTARG   | GEMTUZUMAB OZOGAMICIN             | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| RITUXAN  | RITUXIMAB                         | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| <b><i>Retinoides</i></b>                                     |                                   |                  |   |
| PANRETIN   | ALITRETINOIN                      | Tier 6           | Topical Dosage Formulation  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| TARGRETIN                      | BEXAROTENE                        | Tier 6           | PA for new starts;<br>QL - 60 grams per prescription;<br>Topical Dosage Formulation |
| <i>tretinoin</i>               | <i>vesanoid</i>                   | Tier 2           | PA for new starts   |

**Antiparasitarios****Antihelmínticos**

|                    |                    |        |  |
|--------------------|--------------------|--------|--|
| BILTRICIDE         | PRAZIQUANTEL       | Tier 4 |  |
| <i>mebendazole</i> | <i>mebendazole</i> | Tier 2 |  |
| STROMEKTOL         | IVERMECTIN         | Tier 4 |  |

**Antiprotozoicos**

|                                   |  |        |                                   |
|-----------------------------------|--|--------|-----------------------------------|
| ALINIA                            | NITAZOXANIDE                           | Tier 4 |                                   |
| <i>chloroquine phosphate</i>      | <i>aralen</i>                          | Tier 2 |                                   |
| DARAPRIM                          | PYRIMETHAMINE                          | Tier 4 |                                   |
| FANSIDAR                          | PYRIMETHAMINE AND SULFADOXINE          | Tier 4 |                                   |
| <i>hydroxychloroquine sulfate</i> | <i>plaquenil</i>                       | Tier 1 |                                   |
| MALARONE                          | ATOVAQUONE AND PROGUANIL HYDROCHLORIDE | Tier 4 |                                   |
| <i>mefloquine hcl</i>             | <i>lariam</i>                          | Tier 2 |                                   |
| MEPRON                            | ATOVAQUONE                             | Tier 3 | PA                                |
| NEUTREXIN                         | TRIMETREXATE GLUCURONATE               | Tier 6 | PA; Injectable dosage Formulation |
| PRIMAQUINE PHOSPHATE              | PRIMAQUINE PHOSPHATE                   | Tier 4 |                                   |
| TINDAMAX                          | TINIDAZOLE                             | Tier 3 |                                   |

**Pediculicidas/Escabicidas**

|                   |                |        |                            |
|-------------------|----------------|--------|----------------------------|
| <i>acticin</i>    | <i>elimite</i> | Tier 2 | Topical Dosage Formulation |
| <i>lindane</i>    | <i>lindane</i> | Tier 2 | Topical Dosage Formulation |
| OVIDE             | MALATHION      | Tier 4 | Topical Dosage Formulation |
| <i>permethrin</i> | <i>elimite</i> | Tier 2 | Topical Dosage Formulation |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

## Antiparkinsonianos

*Antiparkinsonianos*

|                               |   |        |                                   |
|-------------------------------|---|--------|-----------------------------------|
| <i>amantadine hcl</i>         | <i>amantadine hydrochloride</i>                   | Tier 1 |                                   |
| APOKYN                        | APOMORPHINE HYDROCHLORIDE                         | Tier 6 | PA; Injectable dosage Formulation |
| <i>atamet</i>                 | <i>sinemet</i>                                    | Tier 1 |                                   |
| AZILECT                       | RASAGILINE MESYLATE                               | Tier 4 |                                   |
| <i>benztropine mesylate</i>   | <i>cogentin</i>                                   | Tier 2 |                                   |
| <i>bromocriptine mesylate</i> | <i>parlodel</i>                                   | Tier 2 |                                   |
| <i>carbidopallevodopa</i>     | <i>sinemet</i>                                    | Tier 1 |                                   |
| <i>carbidopallevodopa cr</i>  | <i>sinemet cr</i>                                 | Tier 1 |                                   |
| <i>carbidopallevodopa odt</i> | <i>sinemet</i>                                    | Tier 2 |                                   |
| <i>carbidopallevodopa sr</i>  | <i>sinemet cr</i>                                 | Tier 1 |                                   |
| COMTAN                        | ENTACAPONE  | Tier 3 | QL - 240 tablets per 30 days      |
| LODOSYN                       | CARBIDOPA MONOHYDRATE                             | Tier 4 |                                   |
| MIRAPEX                       | PRAMIPEXOLE DIHYDROCHLORIDE MONOHYDRATE           | Tier 3 | QL - 90 tablets per 30 days       |
| REQUIP XL                     | ROPINIROLE  | Tier 3 |                                   |
| <i>ropinirole hcl</i>         | <i>requip xl</i>                                  | Tier 2 |                                   |
| <i>selegiline hcl</i>         | <i>eldepryl</i>                                   | Tier 2 |                                   |
| STALEVO                       | CARBIDOPA MONOHYDRATE AND ENTACAPONE AND LEVODOPA | Tier 3 |                                   |
| TASMAR                        | TOLCAPONE   | Tier 4 | QL - 90 tablets per 30 days       |
| <i>trihexyphenidyl hcl</i>    | <i>trihexyphenidyl hydrochloride</i>              | Tier 2 |                                   |

## Antipsicóticos

*Atípicos*

|                  |                           |        |  |
|------------------|---------------------------|--------|--|
| ABILIFY          | ARIPIRAZOLE               | Tier 4 | QL - 30 tablets per 30 days; 900ml per month of solution |
| ABILIFY DISCMELT | ARIPIRAZOLE               | Tier 4 | QL - 60 tablets per 30 days                              |
| <i>clozapine</i> | <i>clozaril</i>           | Tier 1 | QL - 120 tablets per 30 days                             |
| FAZACLO          | CLOZAPINE                 | Tier 4 | QL - 270 tablets per 30 days                             |
| GEODON           | ZIPRASIDONE HYDROCHLORIDE | Tier 3 | QL - 60 capsules per 30 days                             |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| GEODON                         | ZIPRASIDONE MESYLATE              | Tier 5           | Injectable dosage Formulation   |
| INVEGA                         | PALIPERIDONE                      | Tier 4           | QL - 30 tablets per 30 days on 3mg and 9mg, 60 tablets per 30 days on 6mg   |
| RISPERDAL                      | RISPERIDONE                       | Tier 4           | QL - 60 tablets per 30 days, 480ml per 30 days on 1mg/ml solution   |
| RISPERDAL CONSTA               | RISPERIDONE                       | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| RISPERDAL M-TAB                | RISPERIDONE                       | Tier 4           | QL - 60 tablets per 30 days; 120 tablets per 30 days on 4mg   |
| <i>risperidone</i>             | <i>risperal</i>                   | Tier 2           |   |
| SAPHRIS                        | ASENAPINE                         | Tier 4           | QL - 60 tablets per 30 days   |
| SEROQUEL                       | QUETIAPINE FUMARATE               | Tier 3           | QL - 60 per 30 days on 400mg, 90 per 30 days on 200mg and 300mg, 120 per 30 days on 25mg and 50mg and 100mg   |
| SEROQUEL XR                    | QUETIAPINE                        | Tier 3           | QL - 30 tablets per 30 days on 200mg; 60 tablets per 30 days on 300mg and 400mg   |
| SYMBYAX                        | FLUOXETINE HCL AND OLANZAPINE     | Tier 3           | QL - 30 capsules per 30 days  |
| ZYPREXA                        | OLANZAPINE                        | Tier 3           | QL - 30 tablets per 30 days   |
| ZYPREXA ZYDIS                  | OLANZAPINE                        | Tier 3           | QL - 30 tablets per 30 days   |

## Convencionales

|               |                         |        |  |
|---------------|-------------------------|--------|--|
| <i>compro</i> | <i>prochlorperazine</i> | Tier 2 |  |
|---------------|-------------------------|--------|--|

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo    | Desert Preferred | Requisitos / Limites  |
|--------------------------------|--------------------------------------|------------------|---|
| <i>fluphenazine decanoate</i>  | <i>fluphenazine decanoate</i>        | Tier 5           |   |
| <i>fluphenazine hcl</i>        | <i>fluphenazine hydrochloride</i>    | Tier 2           |   |
| <i>haloperidol</i>             | <i>haldol</i>                        | Tier 2           |   |
| <i>haloperidol decanoate</i>   | <i>haldol decanoate</i>              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>haloperidol lactate</i>     | <i>haldol</i>                        | Tier 5           |   |
| <i>loxapine succinate</i>      | <i>loxitane</i>                      | Tier 2           |   |
| MOBAN                          | MOLINDONE HYDROCHLORIDE              | Tier 4           |   |
| NAVANE                         | THIOTHIXENE                          | Tier 4           |   |
| ORAP                           | PIMOZIDE                             | Tier 4           |   |
| <i>prochlorperazine</i>        | <i>compazine</i>                     | Tier 2           |   |
| <i>thioridazine hcl</i>        | <i>thioridazine hydrochloride</i>    | Tier 2           |   |
| <i>thiothixene</i>             | <i>navane</i>                        | Tier 2           |   |
| <i>trifluoperazine hcl</i>     | <i>trifluoperazine hydrochloride</i> | Tier 2           |   |

## Agentes antiespasticidad

## Agentes antiespasticidad

|                          |                 |        |  |
|--------------------------|-----------------|--------|--|
| <i>baclofen</i>          | <i>baclofen</i> | Tier 1 |  |
| <i>dantrolene sodium</i> | <i>dantrium</i> | Tier 2 |  |
| <i>tizanidine hcl</i>    | <i>zanaflex</i> | Tier 1 |  |

## Antivirales

## Agentes contra el citomegalovirus (CMV)

|                    |                              |        |  |
|--------------------|------------------------------|--------|--|
| CYTOVENE           | GANCICLOVIR SODIUM           | Tier 5 |  |
| FOSCAVIR           | FOSCARNET SODIUM             | Tier 6 |  |
| <i>ganciclovir</i> | <i>ganciclovir</i>           | Tier 2 |  |
| VALCYTE            | VALGANCICLOVIR HYDROCHLORIDE | Tier 6 |  |
| VISTIDE            | CIDOFOVIR DIHYDRATE          | Tier 6 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes contra el VIH, inhibidores no nucleósidos de la transcriptasa reversa**

|            |                      |        |  |
|------------|----------------------|--------|--|
| INTELENCE  | ETRAVIRINE           | Tier 4 |  |
| RESCRIPTOR | DELAVIRDINE MESYLATE | Tier 4 |  |
| SUSTIVA    | EFAVIRENZ            | Tier 3 |  |
| VIRAMUNE   | NEVIRAPINE           | Tier 3 |  |

**Agentes contra el VIH, inhibidores nucleósidos y nucleótidos de la transcriptasa reversa**

|                      |   |        |                               |
|----------------------|---|--------|-------------------------------|
| ATRIPLA              | EFAVIRENZ AND EMTRICITABINE AND TENOFOVIR DISOPROXIL FUMARATE | Tier 4 |                               |
| COMBIVIR             | LAMIVUDINE AND ZIDOVUDINE                                     | Tier 3 |                               |
| <i>didanosine</i>    | <i>videx</i>  | Tier 2 |                               |
| <i>didanosine</i>    | <i>videx ec</i>   | Tier 2 |                               |
| EMTRIVA              | EMTRICITABINE   | Tier 4 |                               |
| EPIVIR               | LAMIVUDINE  | Tier 3 |                               |
| EPIVIR HBV           | LAMIVUDINE  | Tier 3 |                               |
| EPZICOM              | ABACAVIR SULFATE AND LAMIVUDINE                               | Tier 3 |                               |
| RETROVIR IV INFUSION | ZIDOVUDINE  | Tier 5 | Injectable dosage Formulation |
| <i>stavudine</i>     | <i>zerit</i>  | Tier 2 |                               |
| TRIZIVIR             | ABACAVIR SULFATE AND LAMIVUDINE AND ZIDOVUDINE                | Tier 3 |                               |
| TRUVADA              | EMTRICITABINE AND TENOFOVIR DISOPROXIL FUMARATE               | Tier 3 |                               |
| VIDEX EC             | DIDANOSINE  | Tier 4 |                               |
| VIDEXPEDIATRIC       | DIDANOSINE  | Tier 4 |                               |
| VIREAD               | TENOFOVIR DISOPROXIL FUMARATE                                 | Tier 4 |                               |
| ZERIT                | STAVUDINE   | Tier 4 |                               |
| ZIAGEN               | ABACAVIR SULFATE  | Tier 3 |                               |
| <i>zidovudine</i>    | <i>retrovir</i>   | Tier 2 |                               |

**Agentes contra el VIH, Otros**

|           |                       |        |  |
|-----------|-----------------------|--------|--|
| FUZEON    | ENFUVIRTIDE           | Tier 6 |  |
| ISENTRESS | RALTEGRAVIR POTASSIUM | Tier 6 |  |
| SELZENTRY | MARAVIROC             | Tier 6 |  |

**Agentes contra el VIH, inhibidores de proteasas**

|         |            |        |                                    |
|---------|------------|--------|------------------------------------|
| APTIVUS | TIPRANAVIR | Tier 4 | QL - 300ml per 30 days on solution |
|---------|------------|--------|------------------------------------|

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| CRIXIVAN                       | INDINAVIR SULFATE                 | Tier 4           |                      |
| INVIRASE                       | SAQUINAVIR MESYLATE               | Tier 4           |                      |
| KALETRA                        | LOPINAVIR AND RITONAVIR           | Tier 3           |                      |
| LEXIVA                         | FOSAMPRENAVIR CALCIUM             | Tier 4           |                      |
| NORVIR                         | RITONAVIR                         | Tier 4           |                      |
| PREZISTA                       | DARUNAVIR                         | Tier 4           |                      |
| REYATAZ                        | ATAZANAVIR SULFATE                | Tier 3           |                      |
| VIRACEPT                       | NELFINAVIR MESYLATE               | Tier 4           |                      |

**Antigripales**

|                        |                       |        |  |
|------------------------|-----------------------|--------|--|
| RELENZA DISKHALER      | ZANAMIVIR             | Tier 3 |  |
| <i>rimantadine hcl</i> | <i>flumadine</i>      | Tier 1 |  |
| TAMIFLU                | OSELTAMIVIR PHOSPHATE | Tier 3 |  |

**Agentes contra la hepatitis**

|                   |                       |        |  |
|-------------------|-----------------------|--------|--|
| BARACLUDE         | ENTECAVIR MONOHYDRATE | Tier 5 | Oral solution; PA; QL - 600ml per 30 days        |
| HEPSERA           | ADEFOVIR DIPIVOXIL    | Tier 6 | PA for new starts; Injectable dosage Formulation |
| <i>ribasphere</i> | <i>copegus</i>        | Tier 2 |  |
| <i>ribasphere</i> | <i>rebetol</i>        | Tier 2 |  |
| <i>ribavirin</i>  | <i>rebetol</i>        | Tier 2 |  |
| TYZEKA            | TELBIVUDINE           | Tier 4 | PA for new starts                                |

**Antiherpéticos**

|                     |                  |        |  |
|---------------------|------------------|--------|--|
| <i>acyclovir</i>    | <i>zovirax</i>   | Tier 1 |  |
| DENAVIR             | PENCICLOVIR      | Tier 4 | QL - 1.5 grams per 28 days; Topical Dosage Formulation   |
| <i>famciclovir</i>  | <i>famvir</i>    | Tier 1 |  |
| <i>trifluridine</i> | <i>viroptic</i>  | Tier 2 |  |
| VALTREX             | VALACYCLOVIR HCL | Tier 3 |  |
| ZOVIRAX             | ACYCLOVIR        | Tier 4 | QL - 10 grams per 30 days on cream, 30 grams per 30 days on ointment; Topical Dosage Formulation |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Ansiolíticos****Ansiolíticos, Otros**

|                     |                    |        |  |
|---------------------|--------------------|--------|--|
| <i>bupirone hcl</i> | <i>buspar</i>      | Tier 1 |  |
| <i>meprobamate</i>  | <i>meprobamate</i> | Tier 2 |  |

**Agentes para trastorno bipolar****Agentes para trastorno bipolar**

|                             |                          |        |  |
|-----------------------------|--------------------------|--------|--|
| EQUETRO                     | CARBAMAZEPINE            | Tier 4 |  |
| <i>lithium carbonate</i>    | <i>lithium carbonate</i> | Tier 1 |  |
| <i>lithium carbonate er</i> | <i>lithobid</i>          | Tier 1 |  |
| <i>lithium citrate</i>      | <i>lithium citrate</i>   | Tier 1 |  |

**Reguladores de glucosa en la sangre****Agentes contra la diabetes**

|                                |   |        |   |
|--------------------------------|---|--------|---|
| <i>acarbose</i>                | <i>precose</i>  | Tier 2 |   |
| ACTOPLUS MET                   | METFORMIN HYDROCHLORIDE AND<br>PIOGLITAZONE HYDROCHLORIDE | Tier 3 | QL - 90 tablets per<br>30 days                              |
| ACTOS                          | PIOGLITAZONE HYDROCHLORIDE                                | Tier 4 | QL - 30 tablets per<br>30 days                              |
| AVANDAMET                      | METFORMIN HYDROCHLORIDE AND<br>ROSIGLITAZONE MALEATE      | Tier 3 | QL - 60 tablets per<br>30 days                              |
| AVANDARYL                      | GLIMEPIRIDE AND<br>ROSIGLITAZONE MALEATE                  | Tier 3 | QL - 60 tablets per<br>30 days                              |
| AVANDIA                        | ROSIGLITAZONE MALEATE                                     | Tier 3 | QL - 60 tablets per<br>30 days                              |
| BYETTA                         | EXENATIDE   | Tier 5 | QL - 1 kit per 30<br>days; Injectable<br>dosage Formulation |
| <i>chlorpropamide</i>          | <i>diabinese</i>  | Tier 1 |   |
| <i>glimepiride</i>             | <i>amaryl</i>   | Tier 2 |   |
| <i>glipizide</i>               | <i>glucotrol</i>  | Tier 1 |   |
| <i>glipizide er</i>            | <i>glucotrol xl</i>                                       | Tier 1 |   |
| <i>glipizide xl</i>            | <i>glucotrol xl</i>                                       | Tier 1 |   |
| <i>glipizide/metformin hcl</i> | <i>metaglip</i>   | Tier 2 |   |
| <i>glyburide</i>               | <i>diabeta</i>  | Tier 1 |   |
| <i>glyburide</i>               | <i>micronase</i>  | Tier 1 |   |
| <i>glyburide micronized</i>    | <i>glynase</i>  | Tier 1 |   |
| <i>glyburide/metformin hcl</i> | <i>glucovance</i>   | Tier 2 |   |
| <i>glycron</i>                 | <i>glynase</i>  | Tier 1 |   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                 | Desert Preferred | Requisitos / Limites                                 |
|--------------------------------|---|------------------|--|
| GLYSET                         | MIGLITOL  | Tier 4           |  |
| JANUMET                        | METFORMIN HYDROCHLORIDE AND SITAGLIPTIN PHOSPHATE | Tier 4           | ST   |
| JANUVIA                        | SITAGLIPTIN PHOSPHATE                             | Tier 4           | ST; QL - 30 tablets per 30 days                      |
| <i>metformin hcl</i>           | <i>glucophage</i>                                 | Tier 1           |  |
| <i>metformin hcl er</i>        | <i>glucophage xr</i>                              | Tier 1           |  |
| PRANDIMET                      | METFORMIN/REPAGLINIDE                             | Tier 4           |  |
| PRANDIN                        | REPAGLINIDE                                       | Tier 4           | QL - 240 tablets per 30 days                         |
| STARLIX                        | NATEGLINIDE                                       | Tier 4           | QL - 90 tablets per 30 days                          |
| SYMLIN                         | PRAMLINTIDE ACETATE                               | Tier 5           | QL - 20ml per 30 days; Injectable dosage Formulation |
| <i>tolazamide</i>              | <i>tolinase</i>                                   | Tier 2           |  |
| <i>tolbutamide</i>             | <i>tolbutamide</i>                                | Tier 2           |  |

***Reguladores de glucosa en la sangre***

|                    |                             |        |  |
|--------------------|-----------------------------|--------|--|
| ALCOHOL PREPS      | ISOPROPYL ALCOHOL PAD       | Tier 3 |  |
| BD INSULIN SYRINGE | INSULIN SAFETY SYRINGE      | Tier 3 |  |
| GAUZE PADS         | GAUZE PADS AND DRESSING 2X2 | Tier 3 |  |

***Agentes glucémicos***

|                        |                                   |        |  |
|------------------------|-----------------------------------|--------|--|
| GLUCAGEN HYPOKIT       | GLUCAGON HYDROCHLORIDE (RDNA)     | Tier 5 |  |
| GLUCAGON EMERGENCY KIT | GLUCAGON RDNA (HUMAN RECOMBINANT) | Tier 5 |  |
| PROGLYCEM              | DIAZOXIDE                         | Tier 3 |  |

***Insulins***

|                   |   |        |  |
|-------------------|---|--------|--|
| APIDRA            | INSULIN GLULISINE                                 | Tier 3 | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMALOG           | INSULIN LISPRO                                    | Tier 3 | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMALOG MIX 50/50 | INSULIN LISPRO AND INSULIN LISPRO PROTAMINE (NPL) | Tier 3 | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMALOG MIX 75/25 | INSULIN LISPRO AND INSULIN LISPRO PROTAMINE (NPL) | Tier 3 | QL - 30ml per 30 days; Injectable dosage Formulation |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                          | Desert Preferred | Requisitos / Limites                                 |
|--------------------------------|--|------------------|--|
| HUMULIN 50/50                  | INSULIN HUMAN (REGULAR) AND INSULIN HUMAN, ISOPHANE (NPH)  | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMULIN 70/30                  | INSULIN HUMAN (REGULAR) AND INSULIN HUMAN, ISOPHANE (NPH)  | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMULIN N                      | INSULIN HUMAN, ISOPHANE (NPH)                              | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| HUMULIN R                      | INSULIN HUMAN (REGULAR)                                    | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| LANTUS                         | INSULIN GLARGINE   | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| LEVEMIR                        | INSULIN DETEMIR  | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| NOVOLIN 70/30                  | INSULIN HUMAN (REGULAR) AND INSULIN HUMAN, ISOPHANE (NPH)  | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| NOVOLIN N                      | INSULIN HUMAN, ISOPHANE (NPH)                              | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| NOVOLIN R                      | INSULIN HUMAN (REGULAR)                                    | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| NOVOLOG                        | INSULIN ASPART (HUMAN ANALOG)                              | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| NOVOLOG MIX 70/30              | INSULIN ASPART (HUMAN ANALOG) AND INSULIN ASPART PROTAMINE | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| RELION 70/30                   | INSULIN HUMAN (REGULAR) AND INSULIN HUMAN, ISOPHANE (NPH)  | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| RELION N                       | INSULIN HUMAN, ISOPHANE (NPH)                              | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |
| RELION R                       | INSULIN HUMAN (REGULAR)                                    | Tier 3           | QL - 30ml per 30 days; Injectable dosage Formulation |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

### Productos de la sangre/Modificadores/Expansores de volumen

#### *Anticoagulantes*

|                        |                          |        |   |
|------------------------|--------------------------|--------|---|
| ARIXTRA                | FONDAPARINUX SODIUM      | Tier 5 | 2.5/0.5; PA; Injectable dosage Formulation; QL  |
| COUMADIN               | WARFARIN SODIUM          | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| FRAGMIN                | DALTEPARIN SODIUM        | Tier 5 | PA; Injectable dosage Formulation   |
| HEPARIN SODIUM         | HEPARIN SODIUM (PORCINE) | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| INNOHEP                | TINZAPARIN SODIUM        | Tier 5 | PA; Injectable dosage Formulation   |
| <i>jantoven</i>        | <i>coumadin</i>          | Tier 1 |   |
| LOVENOX                | ENOXAPARIN SODIUM        | Tier 5 | 30/0.3, 40/0.4; PA; Injectable dosage Formulation; QL - 28 syringes per 30 days   |
| <i>warfarin sodium</i> | <i>coumadin</i>          | Tier 1 |   |

#### *Productos de formación de células sanguíneas*

|                      |                  |        |  |
|----------------------|------------------|--------|--|
| ARANESP ALBUMIN FREE | DARBEPOETIN ALFA | Tier 5 | 25mcg and 40mcg; PA; Injectable dosage Formulation; QL |
|----------------------|------------------|--------|--|

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites   |
|--------------------------------|-----------------------------------|------------------|--|
| EPOGEN                         | EPOETIN ALFA                      | Tier 5           | 2000, 3000, 4000 unit strengths only; QL - 12 per 28 days; PA; Injectable dosage Formulation |
| METHERGINE                     | METHYLERGONOVINE MALEATE          | Tier 4           |  |
| NEULASTA                       | PEGFILGRASTIM                     | Tier 6           | PA; Injectable dosage Formulation  |
| NEUMEGA                        | OPRELVEKIN                        | Tier 6           | PA; Injectable dosage Formulation  |
| NEUPOGEN                       | FILGRASTIM                        | Tier 6           | PA; Injectable dosage Formulation  |
| PROCRIT                        | EPOETIN ALFA                      | Tier 5           | 2000, 3000, 4000 unit strengths; PA; Injectable dosage Formulation; QL - 12 per 28 days      |

### Coagulantes

|             |                 |        |  |
|-------------|-----------------|--------|--|
| CYKLOKAPRON | TRANEXAMIC ACID | Tier 5 |  |
|-------------|-----------------|--------|--|

### Inhibidores de la agregación plaquetaria

|                                 |                          |        |                             |
|---------------------------------|--------------------------|--------|-----------------------------|
| AGGRENOX                        | ASPIRIN AND DIPYRIDAMOLE | Tier 4 |                             |
| <i>anagrelide hydrochloride</i> | <i>agrylin</i>           | Tier 2 |                             |
| <i>cilostazol</i>               | <i>pletal</i>            | Tier 2 |                             |
| <i>dipyridamole</i>             | <i>persantine</i>        | Tier 1 |                             |
| <i>pentoxifylline er</i>        | <i>trental</i>           | Tier 1 |                             |
| PLAVIX                          | CLOPIDOGREL BISULFATE    | Tier 3 | QL - 30 tablets per 30 days |
| <i>ticlopidine hcl</i>          | <i>ticlid</i>            | Tier 2 |                             |

## Agentes cardiovasculares

### Agonistas alfa-adrenérgicos

|  |  |        |  |
|--|--|--------|--|
| CATAPRES                               | CLONIDINE HYDROCHLORIDE                    | Tier 4 | Transdermal Dosage Formulation; QL 4 patches per 30 days |
| <i>clonidine hcl</i>                   | <i>catapres</i>                            | Tier 1 |  |
| <i>guanabenz acetate</i>               | <i>guanabenz acetate</i>                   | Tier 2 |  |
| <i>guanfacine hcl</i>                  | <i>tenex</i>                               | Tier 2 |  |
| <i>methyl dopa</i>                     | <i>methyl dopa</i>                         | Tier 1 |  |
| <i>methyl dopa/hydrochlorothiazide</i> | <i>hydrochlorothiazide and methyl dopa</i> | Tier 1 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>methyldopate hcl</i>        | <i>methyldopate hydrochloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>midodrine hcl</i>           | <i>proamatine</i>                 | Tier 2           |   |

**Bloqueadores alfa-adrenérgicos**

|                           |                  |        |  |
|---------------------------|------------------|--------|--|
| <i>doxazosin mesylate</i> | <i>cardura</i>   | Tier 1 |  |
| <i>prazosin hcl</i>       | <i>minipress</i> | Tier 1 |  |
| <i>reserpine</i>          | <i>reserpine</i> | Tier 1 |  |
| <i>terazosin hcl</i>      | <i>hytrin</i>    | Tier 1 |  |

**Antiarrítmicos**

|                               |                                 |        |  |
|-------------------------------|---------------------------------|--------|--|
| <i>acebutolol hcl</i>         | <i>sectral</i>                  | Tier 2 |  |
| <i>amiodarone hcl</i>         | <i>cordarone</i>                | Tier 2 |  |
| <i>amiodarone hcl</i>         | <i>pacerone</i>                 | Tier 2 |  |
| <i>cartia xt</i>              | <i>cardizem cd</i>              | Tier 2 |  |
| <i>dilt-cd</i>                | <i>cardizem cd</i>              | Tier 2 |  |
| <i>dilt-xr</i>                | <i>dilacor xr</i>               | Tier 2 |  |
| <i>diltiazem cd</i>           | <i>cardizem cd</i>              | Tier 2 |  |
| <i>diltiazem hcl</i>          | <i>cardizem</i>                 | Tier 2 |  |
| <i>diltiazem hcl</i>          | <i>tiazac</i>                   | Tier 2 |  |
| <i>diltiazem hcl er</i>       | <i>cardizem</i>                 | Tier 2 |  |
| <i>diltiazem hcl er</i>       | <i>diltiazem hydrochloride</i>  | Tier 2 |  |
| <i>diltiazem hcl er</i>       | <i>tiazac</i>                   | Tier 2 |  |
| <i>disopyramide phosphate</i> | <i>norpace</i>                  | Tier 1 |  |
| <i>flecainide acetate</i>     | <i>tambocor</i>                 | Tier 2 |  |
| <i>mexiletine hcl</i>         | <i>mexiletine hydrochloride</i> | Tier 2 |  |
| PACERONE                      | CORDARONE                       | Tier 4 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| PROCAINAMIDE HCL               | PROCAINAMIDE HYDROCHLORIDE        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>propafenone hcl</i>         | <i>rythmol</i>                    | Tier 2           |   |
| <i>propranolol hcl</i>         | <i>propranolol hydrochloride</i>  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>propranolol hcl er</i>      | <i>inderal la</i>                 | Tier 1           |   |
| <i>quinidine gluconate cr</i>  | <i>quinidine gluconate</i>        | Tier 1           |   |
| <i>quinidine sulfate</i>       | <i>quinidine sulfate</i>          | Tier 1           |   |
| <i>quinidine sulfate er</i>    | <i>quinidine sulfate</i>          | Tier 1           |   |
| <i>sorine</i>                  | <i>betapace</i>                   | Tier 2           |   |
| <i>sotalol hcl</i>             | <i>betapace</i>                   | Tier 2           |   |
| <i>taztia xt</i>               | <i>tiazac</i>                     | Tier 2           |   |
| TIKOSYN                        | DOFETILIDE                        | Tier 4           |   |
| <i>verapamil hcl</i>           | <i>calan</i>                      | Tier 2           |   |
| <i>verapamil hcl er</i>        | <i>calan sr</i>                   | Tier 2           |   |
| <i>verapamil hcl er</i>        | <i>isoptin sr</i>                 | Tier 2           |   |
| <i>verapamil hcl er</i>        | <i>verelan</i>                    | Tier 2           |   |

**Bloqueadores beta-adrenérgicos**

|                                |                  |        |  |
|--------------------------------|------------------|--------|--|
| <i>atenolol</i>                | <i>tenormin</i>  | Tier 1 |  |
| <i>atenolol/chlorthalidone</i> | <i>tenoretic</i> | Tier 1 |  |
| <i>betaxolol hcl</i>           | <i>kerlone</i>   | Tier 2 |  |
| <i>bisoprolol fumarate</i>     | <i>zebeta</i>    | Tier 1 |  |

**Formulario**

| Nombre de medicamento cubierto                 | Nombre de medicamento alternativo                        | Desert Preferred | Requisitos / Limites  |
|--|--|------------------|---|
| <i>bisoprolol fumarate/hydrochlorothiazide</i> | <i>ziac</i>  | Tier 1           |   |
| CARTROL  | CARTEOLOL HCL  | Tier 4           |   |
| <i>carvedilol</i>                              | <i>coreg</i>   | Tier 1           |   |
| COREG CR                                       | CARVEDILOL PHOSPHATE                                     | Tier 3           | QL - 30 tablets per 30 days   |
| EXFORGE  | AMLODIPINE BESYLATE AND VALSARTAN                        | Tier 3           | QL - 30 tablets per 30 days   |
| EXFORGE HCT                                    | AMLODIPINE HYDROCHLOROTHIAZIDE VALSARTAN                 | Tier 3           | QL - 30 tablets per 30 days   |
| <i>labetalol hcl</i>                           | <i>trandate</i>  | Tier 2           |   |
| LEVATOL  | PENBUTOLOL SULFATE                                       | Tier 2           |   |
| <i>metoprolol succinate er</i>                 | <i>toprol xl</i>   | Tier 2           | QL - 30 tablets per 30 days on 25mg, 50mg, and 100mg; 60 tablets per 30 days on 200mg |
| <i>metoprolol tartrate</i>                     | <i>lopressor</i>   | Tier 1           |   |
| <i>metoprolol/hydrochlorothiazide</i>          | <i>lopressor hct</i>                                     | Tier 2           |   |
| <i>nadolol</i>                                 | <i>corgard</i>   | Tier 2           |   |
| <i>nadolol</i>                                 | <i>nadolol</i>   | Tier 2           |   |
| <i>nadolol/bendroflumethiazide</i>             | <i>corzide</i>   | Tier 1           |   |
| <i>pindolol</i>                                | <i>pindolol</i>  | Tier 2           |   |
| <i>propranolol/hydrochlorothiazide</i>         | <i>hydrochlorothiazide and propranolol hydrochloride</i> | Tier 1           |   |

**Bloqueadores de canales de calcio**

|   |                     |        |                              |
|---|---------------------|--------|------------------------------|
| <i>afeditab cr</i>                                  | <i>adalat cc</i>    | Tier 2 |                              |
| <i>amlodipine besylate</i>                          | <i>norvasc</i>      | Tier 2 | QL - 30 tablets per 30 days  |
| <i>amlodipine besylate/benazepril hydrochloride</i> | <i>lotrel</i>       | Tier 2 | QL - 30 capsules per 30 days |
| <i>felodipine er</i>                                | <i>plendil</i>      | Tier 2 |                              |
| <i>isradipine</i>                                   | <i>isradipine</i>   | Tier 1 |                              |
| <i>nicardipine hcl</i>                              | <i>cardene</i>      | Tier 2 |                              |
| <i>nifediac cc</i>                                  | <i>adalat cc</i>    | Tier 2 |                              |
| <i>nifedical xl</i>                                 | <i>procardia xl</i> | Tier 2 |                              |
| <i>nifedipine</i>                                   | <i>procardia</i>    | Tier 2 |                              |
| <i>nifedipine er</i>                                | <i>procardia xl</i> | Tier 2 |                              |
| <i>nimodipine</i>                                   | <i>nimotop</i>      | Tier 1 |                              |
| <i>nisoldipine</i>                                  | <i>sular</i>        | Tier 2 |                              |

## Formulario

| Nombre de medicamento cubierto            | Nombre de medicamento alternativo                                  | Desert Preferred | Requisitos / Limites         |
|---|--|------------------|------------------------------|
| <b>Agentes cardiovasculares, Otros</b>    |  |                  |                              |
| <i>digoxin</i>                            | <i>lanoxin</i>   | Tier 1           |                              |
| LANOXIN                                   | DIGOXIN  | Tier 3           |                              |
| RANEXA                                    | RANOLAZINE   | Tier 3           | QL - 120 tablets per 30 days |
| <b>Diuréticos</b>                         |  |                  |                              |
| <i>amiloride hcl</i>                      | <i>midamor</i>   | Tier 2           |                              |
| <i>amiloride/hydrochlorothiazide</i>      | <i>amiloride hydrochloride (anhydrous) and hydrochlorothiazide</i> | Tier 2           |                              |
| <i>bumetanide</i>                         | <i>bumex</i>   | Tier 2           |                              |
| <i>chlorothiazide</i>                     | <i>chlorothiazide</i>  | Tier 2           |                              |
| <i>chlorthalidone</i>                     | <i>chlorthalidone</i>  | Tier 2           |                              |
| <i>eplerenone</i>                         | <i>inspra</i>  | Tier 2           |                              |
| <i>furosemide</i>                         | <i>lasix</i>   | Tier 1           |                              |
| <i>hydrochlorothiazide</i>                | <i>microzide</i>   | Tier 1           |                              |
| <i>indapamide</i>                         | <i>indapamide</i>  | Tier 2           |                              |
| <i>methazolamide</i>                      | <i>methazolamide</i>   | Tier 2           |                              |
| <i>methyclothiazide</i>                   | <i>methyclothiazide</i>  | Tier 2           |                              |
| <i>metolazone</i>                         | <i>zaroxolyn</i>   | Tier 2           |                              |
| <i>spironolactone</i>                     | <i>aldactone</i>   | Tier 1           |                              |
| <i>spironolactone/hydrochlorothiazide</i> | <i>aldactazide</i>   | Tier 2           |                              |
| <i>toremide</i>                           | <i>demadex</i>   | Tier 2           |                              |
| <i>triamterene/hydrochlorothiazide</i>    | <i>dyazide</i>   | Tier 1           |                              |
| <i>triamterene/hydrochlorothiazide</i>    | <i>maxzide</i>   | Tier 1           |                              |
| <b>Dislipidémicos</b>                     |  |                  |                              |
| ADVICOR                                   | LOVASTATIN AND NIACIN  | Tier 4           | QL - 30 tablets per 30 days  |
| CADUET                                    | AMLODIPINE BESYLATE AND ATORVASTATIN CALCIUM                       | Tier 3           | QL - 30 tablets per 30 days  |
| <i>cholestyramine</i>                     | <i>questran</i>  | Tier 2           |                              |
| <i>cholestyramine light</i>               | <i>questran light</i>  | Tier 2           |                              |
| <i>colestipol hcl</i>                     | <i>colestid</i>  | Tier 1           |                              |
| CRESTOR                                   | ROSUVASTATIN CALCIUM   | Tier 3           | QL - 30 tablets per 30 days  |
| <i>fenofibrate</i>                        | <i>lofibra</i>   | Tier 2           |                              |
| <i>fenofibrate micronized</i>             | <i>lofibra</i>   | Tier 2           |                              |
| <i>gemfibrozil</i>                        | <i>lopid</i>   | Tier 1           |                              |
| LESCOL                                    | FLUVASTATIN SODIUM   | Tier 4           | QL - 60 capsules per 30 days |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| LESCOL XL                      | FLUVASTATIN SODIUM                | Tier 4           | QL - 30 tablets per 30 days   |
| LIPITOR                        | ATORVASTATIN CALCIUM              | Tier 3           | QL - 30 tablets per 30 days   |
| <i>lovastatin</i>              | <i>mevacor</i>                    | Tier 2           | QL - 30 tablets per 30 days on 10mg and 20mg; 60 tablets per 30 days on 40mg        |
| LOVAZA                         | OMEGA-3 ACID ETHYL ESTERS         | Tier 3           | QL - 120 capsules per 30 days   |
| <i>niacor</i>                  | <i>niacin</i>                     | Tier 1           |   |
| NIASPAN                        | NIACIN                            | Tier 3           | QL - 60 tablets per 30 days   |
| <i>pravastatin sodium</i>      | <i>pravachol</i>                  | Tier 2           | QL - 30 tablets per 30 days on 10mg, 20mg, and 80mg; 60 tablets per 30 days on 40mg |
| <i>prevalite</i>               | <i>cholestyramine</i>             | Tier 2           |   |
| SIMCOR                         | NIACIN AND SIMVASTATIN            | Tier 3           | QL - 60 tablets per 30 days   |
| <i>simvastatin</i>             | <i>zocor</i>                      | Tier 1           | QL - 30 tablets per 30 days   |
| TRICOR                         | FENOFIBRATE                       | Tier 3           | QL - 30 tablets per 30 days   |
| TRILIPIX                       | FENOFIBRIC ACID                   | Tier 3           |   |
| VYTORIN                        | EZETIMIBE AND SIMVASTATIN         | Tier 4           | QL - 30 tablets per 30 days   |
| WELCHOL                        | COLESEVELAM HYDROCHLORIDE         | Tier 4           |   |
| ZETIA                          | EZETIMIBE                         | Tier 4           | QL - 30 tablets per 30 days   |

***Inhibidores del sistema renina-angiotensina-aldosterona***

|   |   |        |                                 |
|---|---|--------|---------------------------------|
| ATACAND                                   | CANDESARTAN CILEXETIL                         | Tier 3 | QL - 30 tablets per 30 days     |
| ATACAND HCT                               | CANDESARTAN CILEXETIL AND HYDROCHLOROTHIAZIDE | Tier 3 | QL - 30 tablets per 30 days     |
| AVALIDE                                   | HYDROCHLOROTHIAZIDE AND IRBESARTAN            | Tier 4 | ST; QL - 30 tablets per 30 days |
| AVAPRO                                    | IRBESARTAN                                    | Tier 4 | ST; QL - 30 tablets per 30 days |
| <i>benazepril hcl</i>                     | <i>lotensin</i>                               | Tier 1 |                                 |
| <i>benazepril hcl/hydrochlorothiazide</i> | <i>lotensin hct</i>                           | Tier 1 |                                 |
| BENICAR                                   | OLMESARTAN MEDOXOMIL                          | Tier 4 | ST; QL - 30 tablets per 30 days |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

## Formulario

| Nombre de medicamento cubierto               | Nombre de medicamento alternativo            | Desert Preferred | Requisitos / Limites            |
|--|--|------------------|---------------------------------|
| BENICAR HCT                                  | HYDROCHLOROTHIAZIDE AND OLMESARTAN MEDOXOMIL | Tier 4           | ST; QL - 30 tablets per 30 days |
| <i>captopril</i>                             | <i>capoten</i>                               | Tier 1           |                                 |
| <i>captopril/hydrochlorothiazide</i>         | <i>capozide</i>                              | Tier 1           |                                 |
| COZAAR                                       | LOSARTAN POTASSIUM                           | Tier 4           | ST; QL - 30 tablets per 30 days |
| DIOVAN                                       | VALSARTAN                                    | Tier 3           | ST; QL - 30 tablets per 30 days |
| DIOVAN HCT                                   | HYDROCHLOROTHIAZIDE AND VALSARTAN            | Tier 3           | ST; QL - 30 tablets per 30 days |
| <i>enalapril maleate</i>                     | <i>vasotec</i>                               | Tier 1           |                                 |
| <i>enalapril maleate/hydrochlorothiazide</i> | <i>vaseretic</i>                             | Tier 1           |                                 |
| <i>fosinopril sodium</i>                     | <i>monopril</i>                              | Tier 2           |                                 |
| <i>fosinopril sodium/hydrochlorothiazide</i> | <i>monopril hct</i>                          | Tier 2           |                                 |
| HYZAAR                                       | HYDROCHLOROTHIAZIDE AND LOSARTAN POTASSIUM   | Tier 4           | ST; QL - 30 tablets per 30 days |
| <i>lisinopril</i>                            | <i>prinivil</i>                              | Tier 1           |                                 |
| <i>lisinopril</i>                            | <i>zestril</i>                               | Tier 1           |                                 |
| <i>lisinopril/hydrochlorothiazide</i>        | <i>prinzide</i>                              | Tier 1           |                                 |
| <i>lisinopril/hydrochlorothiazide</i>        | <i>zestoretic</i>                            | Tier 1           |                                 |
| MICARDIS                                     | TELMISARTAN                                  | Tier 4           | ST; QL - 30 tablets per 30 days |
| MICARDIS HCT                                 | HYDROCHLOROTHIAZIDE AND TELMISARTAN          | Tier 4           | ST; QL - 30 tablets per 30 days |
| <i>moexipril hcl</i>                         | <i>univasc</i>                               | Tier 1           |                                 |
| <i>moexipril/hydrochlorothiazide</i>         | <i>uniretic</i>                              | Tier 2           |                                 |
| <i>quinapril hcl</i>                         | <i>accupril</i>                              | Tier 2           |                                 |
| <i>quinapril/hydrochlorothiazide</i>         | <i>accuretic</i>                             | Tier 2           |                                 |
| <i>quinaretic</i>                            | <i>accuretic</i>                             | Tier 2           |                                 |
| <i>ramipril</i>                              | <i>altace</i>                                | Tier 2           |                                 |
| TARKA  | TRANDOLAPRIL AND VERAPAMIL HYDROCHLORIDE     | Tier 3           | QL - 30 tablets per 30 days     |
| TEKTURNA                                     | ALISKIREN FUMARATE                           | Tier 3           | QL - 30 tablets per 30 days; ST |
| TEKTURNA HCT                                 | ALISKIREN FUMARATE AND HYDROCHLOROTHIAZIDE   | Tier 3           | ST; QL - 30 tablets per 30 days |
| <i>trandolapril</i>                          | <i>mavik</i>                                 | Tier 2           |                                 |

## Vasodilatadores

|                        |  |        |    |
|------------------------|--|--------|----|
| BIDIL                  | HYDRALAZINE HYDROCHLORIDE AND ISOSORBIDE DINITRATE | Tier 4 | PA |
| <i>hydralazine hcl</i> | <i>hydralazine hydrochloride</i>                   | Tier 1 |    |
| <i>isochron</i>        | <i>isosorbide dinitrate</i>                        | Tier 1 |    |

**Formulario**

| Nombre de medicamento cubierto   | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|----------------------------------|-----------------------------------|------------------|---|
| <i>isosorbide dinitrate</i>      | <i>isordil titradose</i>          | Tier 1           |   |
| <i>isosorbide dinitrate er</i>   | <i>isosorbide dinitrate</i>       | Tier 1           |   |
| <i>isosorbide mononitrate</i>    | <i>ismo</i>                       | Tier 1           |   |
| <i>isosorbide mononitrate</i>    | <i>monoket</i>                    | Tier 1           |   |
| <i>isosorbide mononitrate er</i> | <i>imdur</i>                      | Tier 1           |   |
| <i>isosorbide mononitrate er</i> | <i>ismo</i>                       | Tier 1           |   |
| <i>minitran</i>                  | <i>nitroglycerin</i>              | Tier 1           | Transdermal Dosage Formulation  |
| <i>minoxidil</i>                 | <i>minoxidil</i>                  | Tier 2           |   |
| NITRO-DUR                        | NITROGLYCERIN                     | Tier 4           | Transdermal Dosage Formulation  |
| <i>nitroglycerin</i>             | <i>nitro-dur</i>                  | Tier 1           | Transdermal Dosage Formulation  |
| <i>nitroglycerin</i>             | <i>nitroglycerin</i>              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>nitroglycerin transdermal</i> | <i>nitro-dur</i>                  | Tier 1           | Transdermal Dosage Formulation  |
| NITROLINGUAL PUMPSPRAY           | NITROGLYCERIN                     | Tier 4           |   |

**Agentes del sistema nervioso central****Anfetaminas, TDAH**

|                                    |                                  |        |  |
|------------------------------------|----------------------------------|--------|--|
| ADDERALL XR                        | AMPHETAMINE                      | Tier 4 | QL - 30 capsules per 30 days on 5mg, 10mg, and 15mg; 60 capsules per 30 days on 20mg, 25mg, and 30mg |
| <i>amphetamine salt combo</i>      | <i>adderall</i>                  | Tier 2 | QL - 90 tablets per 30 days  |
| <i>dextroamphetamine sulfate</i>   | <i>dextroamphetamine sulfate</i> | Tier 2 | QL - 180 tablets per 30 days   |
| <i>dextroamphetamine sulfateer</i> | <i>dextrostat</i>                | Tier 2 | QL - 120 capsules per 30 days  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <b>No anfetaminas, TDAH</b>    |                                   |                  |   |
| CONCERTA                       | METHYLPHENIDATE                   | Tier 4           | QL - 60 tablets per 30 days on 36mg; 30 tablets per 30 days on 18mg, 27mg, and 54mg |
| <i>dexmethylphenidate hcl</i>  | <i>focalin</i>                    | Tier 2           | QL - 90 tablets per 30 days   |
| METADATE CD                    | METHYLPHENIDATE HYDROCHLORIDE     | Tier 4           | QL - 180 capsules per 30 days   |
| <i>metadate er</i>             | <i>ritalin sr</i>                 | Tier 1           | QL - 90 capsules per 30 days  |
| <i>methylin</i>                | <i>ritalin</i>                    | Tier 1           | QL - 90 tablets per 30 days   |
| <i>methylin er</i>             | <i>metadate er</i>                | Tier 1           | QL - 90 tablets per 30 days   |
| <i>methylin er</i>             | <i>ritalin sr</i>                 | Tier 1           | QL - 90 tablets per 30 days   |
| <i>methylphenidate hcl</i>     | <i>ritalin</i>                    | Tier 1           | QL - 90 tablets per 30 days   |
| <i>methylphenidate hcl er</i>  | <i>ritalin sr</i>                 | Tier 1           | QL - 90 tablets per 30 days   |
| RITALIN LA                     | METHYLPHENIDATE HYDROCHLORIDE     | Tier 4           | QL - 60 capsules per 30 days  |
| STRATTERA                      | ATOMOXETINE HYDROCHLORIDE         | Tier 3           | QL - 60 capsules per 30 days  |

**No anfetaminas, Otros**

|          |                |        |   |
|----------|----------------|--------|---|
| PROVIGIL | MODAFINIL      | Tier 3 | QL - 60 tablets per 30 days   |
| RILUTEK  | RILUZOLE       | Tier 4 | PA  |
| XYREM    | SODIUM OXYBATE | Tier 4 | PA; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes dentales y bucales****Agentes dentales y bucales**

|   |                                |        |  |
|---|--------------------------------|--------|--|
| APHTHASOL                                 | AMLEXANOX                      | Tier 4 |  |
| <i>chlorhexidine gluconate oral rinse</i> | <i>peridex oral rinse</i>      | Tier 2 |  |
| <i>periogard</i>                          | <i>peridex oral rinse</i>      | Tier 2 |  |
| <i>pilocarpine hcl</i>                    | <i>salagen</i>                 | Tier 2 |  |
| <i>pilocarpine hydrochloride</i>          | <i>salagen</i>                 | Tier 2 |  |
| <i>triamcinolone in orabase</i>           | <i>triamcinolone acetonide</i> | Tier 2 |  |

**Agentes dermatológicos****Agentes dermatológicos**

|  |                                |        |   |
|--|--------------------------------|--------|---|
| 8-MOP  | METHOXSALEN                    | Tier 3 | PA  |
| ALDARA   | IMIQUIMOD                      | Tier 4 | PA for new starts;<br>Topical Dosage<br>Formulation                     |
| <i>ammonium lactate</i>                        | <i>lac-hydrin</i>              | Tier 2 | Topical Dosage<br>Formulation   |
| <i>avita</i>                                   | <i>retin-a</i>                 | Tier 2 | Topical Dosage<br>Formulation   |
| <i>clotrimazole/betamethasone dipropionate</i> | <i>lotrisone</i>               | Tier 2 | Topical Dosage<br>Formulation   |
| <i>colocort</i>                                | <i>cortenema</i>               | Tier 2 |   |
| CORTIFOAM                                      | HYDROCORTISONE ACETATE         | Tier 4 |   |
| DIFFERIN                                       | ADAPALENE                      | Tier 4 | Topical Dosage<br>Formulation; PA                                       |
| DOVONEX  | CALCIPOTRIENE                  | Tier 4 | Topical Dosage<br>Formulation   |
| ELIDEL   | PIMECROLIMUS                   | Tier 3 | PA; QL - 30 grams<br>per prescription;<br>Topical Dosage<br>Formulation |
| <i>erythromycin/benzoyl peroxide</i>           | <i>benzamycin</i>              | Tier 1 |   |
| <i>fluorouracil</i>                            | <i>efudex</i>                  | Tier 2 | Topical Dosage<br>Formulation   |
| <i>hydrocortisone</i>                          | <i>cortenema</i>               | Tier 2 |   |
| <i>laclotion</i>                               | <i>lac-hydrin</i>              | Tier 2 | Topical Dosage<br>Formulation   |
| <i>lidocaine</i>                               | <i>lidocaine hydrochloride</i> | Tier 2 | Topical Dosage<br>Formulation   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| LIDODERM                       | LIDOCAINE                         | Tier 4           | QL - 90 patches per 30 days; Transdermal Dosage Formulation                   |
| ORACEA                         | DOXYCYCLINE                       | Tier 4           |   |
| OXSORALEN ULTRA                | METHOXSALEN                       | Tier 4           | PA for new starts   |
| <i>podofilox</i>               | <i>condylox</i>                   | Tier 2           | Topical Dosage Formulation  |
| <i>proctocream-hc</i>          | <i>anusol-hc</i>                  | Tier 2           |   |
| <i>proctosol hc</i>            | <i>anusol-hc</i>                  | Tier 2           |   |
| <i>proctozone-hc</i>           | <i>anusol-hc</i>                  | Tier 2           |   |
| PROTOPIC                       | TACROLIMUS                        | Tier 4           | PA for new starts; QL - 30 grams per prescription; Topical Dosage Formulation |
| REGRANEX                       | BECAPLERMIN                       | Tier 4           | PA; QL - 15 grams per prescription; Topical Dosage Formulation                |
| RETIN-A MICRO                  | TRETINOIN                         | Tier 4           | Topical Dosage Formulation  |
| SANTYL                         | COLLAGENASE                       | Tier 4           | QL - 30 grams per prescription; Topical Dosage Formulation                    |
| <i>selenium sulfide</i>        | <i>selsun shampoo</i>             | Tier 2           | Topical Dosage Formulation  |
| SOLARAZE                       | DICLOFENAC SODIUM                 | Tier 4           | PA; QL - 50 grams per prescription; Topical Dosage Formulation                |
| TAZORAC                        | TAZAROTENE                        | Tier 4           | Topical Dosage Formulation  |
| <i>tretinoin</i>               | <i>retin-a</i>                    | Tier 2           | Topical Dosage Formulation  |
| <i>u-cort</i>                  | <i>carmol-hc</i>                  | Tier 1           | Topical Dosage Formulation  |

**Reemplazos/Modificadores enzimáticos*****Reemplazos/Modificadores enzimáticos***

|            |                   |        |                                   |
|------------|-------------------|--------|-----------------------------------|
| ADAGEN     | PEGADEMASE BOVINE | Tier 6 | PA; Injectable dosage Formulation |
| ALDURAZYME | LARONIDASE        | Tier 6 | PA; Injectable dosage Formulation |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                            | Desert Preferred | Requisitos / Limites              |
|--------------------------------|--|------------------|-----------------------------------|
| BUPHENYL                       | SODIUM PHENYL BUTYRATE                                       | Tier 4           |                                   |
| CEREDASE                       | ALGLUCERASE  | Tier 6           | PA; Injectable dosage Formulation |
| CEREZYME                       | IMIGLUCERASE   | Tier 6           | PA; Injectable dosage Formulation |
| CYSTADANE                      | BETAINE (TRIMETHYLGLYCINE)                                   | Tier 4           |                                   |
| CYSTAGON                       | CYSTEAMINE BITARTRATE  | Tier 4           |                                   |
| ELAPRASE                       | IDURSULFASE  | Tier 6           | PA; Injectable dosage Formulation |
| FABRAZYME                      | AGALSIDASE BETA  | Tier 6           | PA; Injectable dosage Formulation |
| <i>levocarnitine</i>           | <i>carnitor</i>  | Tier 2           |                                   |
| LIPRAM                         | AMYLASE (DIASTASE) AND LIPASE (AS PANCRELIPASE) AND PROTEASE | Tier 4           |                                   |
| MYOZYME                        | ALGLUCOSIDASE ALFA   | Tier 6           | PA; Injectable dosage Formulation |
| NAGLAZYME                      | GALSULFASE   | Tier 6           | PA; Injectable dosage Formulation |
| ORFADIN                        | NITISINONE   | Tier 6           | PA                                |
| PANCREASE MT                   | AMYLASE (DIASTASE) AND LIPASE (AS PANCRELIPASE) AND PROTEASE | Tier 3           |                                   |
| PANCRELIPASE                   | AMYLASES /ENDOPEPTIDASES LIPASE                              | Tier 3           |                                   |
| PANCRON                        | AMYLASE (DIASTASE) AND LIPASE (AS PANCRELIPASE) AND PROTEASE | Tier 4           |                                   |
| SUCRAID                        | SACROSIDASE  | Tier 4           |                                   |
| ULTRASE                        | AMYLASE (DIASTASE) AND LIPASE (AS PANCRELIPASE) AND PROTEASE | Tier 4           |                                   |
| VIKASE                         | AMYLASE (DIASTASE) AND LIPASE (AS PANCRELIPASE) AND PROTEASE | Tier 3           |                                   |
| ZAVESCA                        | MIGLUSTAT  | Tier 4           |                                   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes gastrointestinales*****Antiespasmódicos, gastrointestinal***

|                                |                         |        |   |
|--------------------------------|-------------------------|--------|---|
| <i>atropine sulfate</i>        | <i>atropine sulfate</i> | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| CANTIL                         | MEPENZOLATE BROMIDE     | Tier 4 |   |
| <i>dicyclomine hcl</i>         | <i>bentyl</i>           | Tier 1 |   |
| <i>glycopyrrolate</i>          | <i>robinul</i>          | Tier 2 |   |
| <i>methscopolamine bromide</i> | <i>pamine</i>           | Tier 2 |   |

***Antiespasmódicos, gastrointestinal, Otros***

|                               |  |        |  |
|-------------------------------|--|--------|--|
| <i>colyte</i>                 | <i>colyte-flavor packs</i>   | Tier 2 |  |
| <i>constulose</i>             | <i>lactulose</i>   | Tier 2 |  |
| <i>diphenoxylate/atropine</i> | <i>lomotil</i>   | Tier 1 |  |
| <i>enulose</i>                | <i>lactulose</i>   | Tier 2 |  |
| GASTROCROM                    | CROMOLYN SODIUM  | Tier 4 |  |
| HELIDAC                       | BISMUTH SUBSALICYLATE AND METRONIDAZOLE AND TETRACYCLINE HYDROCHLORIDE | Tier 4 |  |
| <i>lactulose</i>              | <i>lactulose</i>   | Tier 2 |  |
| <i>lonox</i>                  | <i>lomotil</i>   | Tier 1 |  |
| MOTOFEN                       | ATROPINE SULFATE AND DIFENOXIN HYDROCHLORIDE                           | Tier 4 |  |
| NULYTELY                      | POLYETHYLENE GLYCOL AND POTASSIUM CHLORIDE AND SODIUM                  | Tier 3 |  |
| <i>peg 3350/electrolytes</i>  | <i>colyte-flavor packs</i>   | Tier 2 |  |
| <i>trilyte</i>                | <i>nulytely</i>  | Tier 2 |  |
| URSO 250                      | URSODIOL   | Tier 4 |  |
| URSO FORTE                    | URSODEOXYCHOLATE   | Tier 4 |  |
| <i>ursodiol</i>               | <i>actigall</i>  | Tier 2 |  |

**Formulario**

| Nombre de medicamento cubierto                                     | Nombre de medicamento alternativo              | Desert Preferred | Requisitos / Limites  |
|--|--|------------------|---|
| <b><i>Bloqueadores de histamina2 (H2)</i></b>                      |  |                  |   |
| <i>cimetidine</i>  | <i>tagament</i>                                | Tier 2           |   |
| <i>famotidine</i>  | <i>pepcid</i>                                  | Tier 1           |   |
| <i>nizatidine</i>  | <i>axid</i>                                    | Tier 2           |   |
| <i>ranitidine hcl</i>  | <i>zantac</i>                                  | Tier 1           |   |
| <b><i>Agentes para el síndrome de irritabilidad intestinal</i></b> |  |                  |   |
| LOTRONEX   | ALOSETRON                                      | Tier 3           | QL - 60 tablets per 30 days   |
| <b><i>Protectores</i></b>  |  |                  |   |
| <i>misoprostol</i>   | <i>cytotec</i>                                 | Tier 2           |   |
| <i>sucralfate</i>  | <i>carafate</i>                                | Tier 1           |   |
| <b><i>Inhibidores de la bomba de protones</i></b>                  |  |                  |   |
| ACIPHEX  | RABEPRAZOLE SODIUM                             | Tier 4           | ST; QL - 30 tablets per 30 days   |
| NEXIUM   | ESOMEPRAZOLE MAGNESIUM TRIHYDRATE              | Tier 3           | ST; QL - 30 capsules per 30 days  |
| NEXIUM I.V.  | ESOMEPRAZOLE SODIUM                            | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>omeprazole</i>  | <i>prilosec</i>                                | Tier 2           | QL - 60 capsules per 30 days  |
| PREVACID   | LANSOPRAZOLE                                   | Tier 4           | ST; QL - 30 capsules per 30 days  |
| PREVPAC  | AMLODIPINE<br>HYDROCHLOROTHIAZIDE<br>VALSARTAN | Tier 4           | QL - 1 pack per year  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes genitourinarios****Antiespasmódicos, urinarios**

|                               |                          |        |   |
|-------------------------------|--------------------------|--------|---|
| <i>bethanechol chloride</i>   | <i>urecholine</i>        | Tier 2 |   |
| DETROL                        | TOLTERODINE TARTRATE     | Tier 3 | QL - 60 tablets per 30 days   |
| DETROL LA                     | TOLTERODINE TARTRATE     | Tier 3 | QL - 30 capsules per 30 days  |
| ENABLEX                       | DARIFENACIN HYDROBROMIDE | Tier 3 | QL - 30 tablets per 30 days   |
| <i>flavoxate hcl</i>          | <i>urispas</i>           | Tier 1 |   |
| <i>oxybutynin chloride</i>    | <i>ditropan</i>          | Tier 1 |   |
| <i>oxybutynin chloride er</i> | <i>ditropan xl</i>       | Tier 2 | QL - 180 tablets per 30 days on 5mg; 90 tablets per 30 days on 10mg; 60 tablets per 30 days on 15mg |
| OXYTROL                       | OXYBUTYNIN               | Tier 4 | Transdermal Dosage Formulation  |
| SANCTURA                      | TROSPIUM CHLORIDE        | Tier 4 | QL - 60 tablets per 30 days   |
| SANCTURA XR                   | TROSPIUM CHLORIDE        | Tier 4 | QL - 30 capsules per 30 days  |
| TOVIAZ                        | FESOTERODINE FUMARATE    | Tier 3 |   |
| VESICARE                      | SOLIFENACIN SUCCINATE    | Tier 3 | QL - 30 tablets per 30 days   |

**Agentes para la hipertrofia prostática benigna**

|                    |                          |        |                              |
|--------------------|--------------------------|--------|------------------------------|
| AVODART            | DUTASTERIDE              | Tier 3 | QL - 30 capsules per 30 days |
| <i>finasteride</i> | <i>proscar</i>           | Tier 2 | QL - 30 tablets per 30 days  |
| FLOMAX             | TAMSULOSIN HYDROCHLORIDE | Tier 3 | QL - 60 capsules per 30 days |
| UROXATRAL          | ALFUZOSIN HYDROCHLORIDE  | Tier 4 | QL - 30 tablets per 30 days  |

**Agentes genitourinarios, Otros**

|                             |                        |        |  |
|-----------------------------|------------------------|--------|--|
| <i>sodium chloride 0.9%</i> | <i>sodium chloride</i> | Tier 2 |  |
| THIOLA                      | TIOPRONIN              | Tier 3 |  |

**Agentes que unen fosfato**

|                        |               |        |  |
|------------------------|---------------|--------|--|
| <i>calcium acetate</i> | <i>phoslo</i> | Tier 2 |  |
|------------------------|---------------|--------|--|

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| FOSRENOL                       | LANTHANUM CARBONATE               | Tier 4           |                      |
| RENVELA                        | SEVELAMER CARBONATE               | Tier 4           |                      |

**Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Suprarrenales)****Glucocorticoides/Mineralocorticoides**

|   |   |        |                            |
|---|---|--------|----------------------------|
| <i>ala-cort</i>                             | <i>hydrocortisone</i>                       | Tier 2 | Topical Dosage Formulation |
| <i>ala-cort</i>                             | <i>proctocort</i>                           | Tier 2 | Topical Dosage Formulation |
| <i>alclometasone dipropionate</i>           | <i>aclovate</i>                             | Tier 1 | Topical Dosage Formulation |
| <i>amcinonide</i>                           | <i>cyclocort</i>                            | Tier 2 | Topical Dosage Formulation |
| <i>augmented betamethasone dipropionate</i> | <i>diprolene</i>                            | Tier 2 | Topical Dosage Formulation |
| <i>beta-val</i>                             | <i>betamethasone valerate</i>               | Tier 1 | Topical Dosage Formulation |
| <i>betamethasone dipropionate</i>           | <i>augmented betamethasone dipropionate</i> | Tier 2 | Topical Dosage Formulation |
| <i>betamethasone dipropionate</i>           | <i>betamethasone dipropionate</i>           | Tier 2 | Topical Dosage Formulation |
| <i>betamethasone valerate</i>               | <i>betamethasone valerate</i>               | Tier 1 | Topical Dosage Formulation |
| CAPEX                                       | FLUOCINOLONE ACETONIDE                      | Tier 4 | Topical Dosage Formulation |
| <i>lobetasol propionate</i>                 | <i>temovate</i>                             | Tier 1 | Topical Dosage Formulation |
| <i>lobetasol propionate e</i>               | <i>temovate e</i>                           | Tier 1 | Topical Dosage Formulation |
| <i>cormax</i>                               | <i>temovate</i>                             | Tier 1 | Topical Dosage Formulation |
| <i>del-beta</i>                             | <i>betamethasone dipropionate</i>           | Tier 1 | Topical Dosage Formulation |
| DERMA-SMOOTH/FS BODY OIL                    | FLUOCINOLONE ACETONIDE                      | Tier 4 | Topical Dosage Formulation |
| <i>desonide</i>                             | <i>desowen</i>                              | Tier 2 | Topical Dosage Formulation |
| <i>desoximetasone</i>                       | <i>topicort</i>                             | Tier 2 | Topical Dosage Formulation |
| <i>desoximetasone</i>                       | <i>topicort lp</i>                          | Tier 2 | Topical Dosage Formulation |
| <i>diflorasone diacetate</i>                | <i>diflorasone diacetate</i>                | Tier 2 | Topical Dosage Formulation |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

**Formulario**

| Nombre de medicamento cubierto               | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites       |
|--|-----------------------------------|------------------|----------------------------|
| <i>fludrocortisone acetate</i>               | <i>fludrocortisone acetate</i>    | Tier 1           |                            |
| <i>fluocinolone acetonide</i>                | <i>fluocinolone acetonide</i>     | Tier 1           | Topical Dosage Formulation |
| <i>fluocinonide</i>                          | <i>fluocinonide</i>               | Tier 1           | Topical Dosage Formulation |
| <i>fluocinonide emollient base</i>           | <i>fluocinonide</i>               | Tier 1           | Topical Dosage Formulation |
| <i>fluticasone propionate</i>                | <i>cutivate</i>                   | Tier 2           | Topical Dosage Formulation |
| <i>halobetasol propionate</i>                | <i>ultravate</i>                  | Tier 1           | Topical Dosage Formulation |
| HALOG  | HALCINONIDE                       | Tier 4           | Topical Dosage Formulation |
| <i>hydrocortisone</i>                        | <i>hydrocort</i>                  | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone</i>                        | <i>hydrocortisone</i>             | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone</i>                        | <i>hytone</i>                     | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone</i>                        | <i>proctocort</i>                 | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone butyrate</i>               | <i>locoid</i>                     | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone in absorbbase</i>          | <i>hydrocortisone</i>             | Tier 2           | Topical Dosage Formulation |
| <i>hydrocortisone valerate</i>               | <i>westcort</i>                   | Tier 2           | Topical Dosage Formulation |
| <i>isovate</i>                               | <i>temovate</i>                   | Tier 1           | Topical Dosage Formulation |
| <i>lokara</i>                                | <i>desowen</i>                    | Tier 2           | Topical Dosage Formulation |
| <i>mometasone furoate</i>                    | <i>elocon</i>                     | Tier 2           | Topical Dosage Formulation |
| OLUX-E                                       | CLOBETASOL PROPIONATE             | Tier 4           | Topical Dosage Formulation |
| <i>prednicarbate</i>                         | <i>dermatop</i>                   | Tier 2           | Topical Dosage Formulation |
| <i>procto-pak</i>                            | <i>proctocort</i>                 | Tier 2           | Topical Dosage Formulation |
| <i>triamcinolone acetonide</i>               | <i>kenalog</i>                    | Tier 2           | Topical Dosage Formulation |
| <i>triamcinolone acetonide</i>               | <i>triamcinolone acetonide</i>    | Tier 2           | Topical Dosage Formulation |
| <i>triamcinolone acetonide in absorbbase</i> | <i>triamcinolone acetonide</i>    | Tier 2           | Topical Dosage Formulation |

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites       |
|--------------------------------|-----------------------------------|------------------|----------------------------|
| <i>triderm</i>                 | <i>kenalog</i>                    | Tier 2           | Topical Dosage Formulation |
| <i>triderm</i>                 | <i>triamcinolone acetonide</i>    | Tier 2           | Topical Dosage Formulation |

**Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Pituitarias)****Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Pituitarias)**

|                             |                      |        |                                   |
|-----------------------------|----------------------|--------|-----------------------------------|
| <i>desmopressin acetate</i> | <i>ddavp</i>         | Tier 2 |                                   |
| GENOTROPIN                  | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |
| GENOTROPIN MINIQUICK        | SOMATROPIN           | Tier 5 | PA; Injectable dosage Formulation |
| HUMATROPE                   | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |
| NORDITROPIN NORDIFLEX PEN   | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |
| NUTROPIN                    | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |
| NUTROPIN AQ                 | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |
| SAIZEN                      | SOMATROPIN (SERONO)  | Tier 6 | PA; Injectable dosage Formulation |
| SEROSTIM                    | SOMATROPIN (SERONO)  | Tier 6 | PA; Injectable dosage Formulation |
| STIMATE                     | DESMOPRESSIN ACETATE | Tier 4 |                                   |
| ZORBTIVE                    | SOMATROPIN           | Tier 6 | PA; Injectable dosage Formulation |

**Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Hormonas sexuales/Modificadores)****Esteroides anabólicos**

|                    |                 |        |  |
|--------------------|-----------------|--------|--|
| ANADROL-50         | OXYMETHOLONE    | Tier 4 |  |
| <i>oxandrolone</i> | <i>oxandrin</i> | Tier 2 |  |

**Andrógenos**

|                |                    |        |   |
|----------------|--------------------|--------|---|
| ANDRODERM      | TESTOSTERONE       | Tier 4 | Transdermal Dosage Formulation; QL 30 patches per 30 days |
| ANDROGEL       | TESTOSTERONE       | Tier 4 | QL - 150 grams per 30 days; Topical Dosage Formulation    |
| ANDROID        | METHYLTESTOSTERONE | Tier 4 |   |
| <i>danazol</i> | <i>danazol</i>     | Tier 2 |   |

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| STRIANT                        | TESTOSTERONE                      | Tier 4           | PA  |
| TESTIM                         | TESTOSTERONE                      | Tier 4           | Topical Dosage Formulation  |
| <i>testosterone enanthate</i>  | <i>testosterone enanthate</i>     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| TESTRED                        | METHYLTESTOSTERONE                | Tier 4           |   |

**Estrógenos**

|  |   |        |  |
|--|---|--------|--|
| ACTIVELLA                              | ESTRADIOL AND NORETHINDRONE ACETATE         | Tier 3 |  |
| ALORA                                  | ESTRADIOL                                   | Tier 3 | Transdermal Dosage Formulation                 |
| <i>apri</i>                            | <i>desogen</i>                              | Tier 1 |  |
| <i>aranelle</i>                        | <i>tri-norinyl 28</i>                       | Tier 2 |  |
| <i>aviane</i>                          | <i>levlite-28</i>                           | Tier 1 |  |
| <i>balziva</i>                         | <i>ovcon-35</i>                             | Tier 1 |  |
| CENESTIN                               | ESTROGENS, CONJUGATED SYNTHETIC A           | Tier 3 |  |
| <i>cesia</i>                           | <i>cyclessa</i>                             | Tier 2 |  |
| <i>cryselle-28</i>                     | <i>lo/ovral-28</i>                          | Tier 2 |  |
| <i>enpresse-28</i>                     | <i>ethinyl estradiol and levonorgestrel</i> | Tier 2 |  |
| ESTRACE                                | ESTRADIOL                                   | Tier 4 | Vaginal Dosage Formulation                     |
| ESTRADERM                              | ESTRADIOL                                   | Tier 4 | Transdermal Dosage Formulation                 |
| <i>estradiol</i>                       | <i>climara</i>                              | Tier 1 | Transdermal Dosage Formulation                 |
| <i>estradiol</i>                       | <i>estrace</i>                              | Tier 1 |  |
| <i>estradiol/norethindrone acetate</i> | <i>activella</i>                            | Tier 2 |  |
| ESTRASORB                              | ESTRADIOL HEMIHYDRATE                       | Tier 4 |  |
| ESTRING                                | ESTRADIOL                                   | Tier 4 | Vaginal Dosage Formulation; QL - 1 per 90 days |
| <i>estropipate</i>                     | <i>ogen</i>                                 | Tier 1 |  |

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                     | Desert Preferred | Requisitos / Limites           |
|--------------------------------|---|------------------|--------------------------------|
| FEMHRT 1/5                     | ETHINYL ESTRADIOL AND NORETHINDRONE ACETATE           | Tier 4           |                                |
| FEMHRT LOW DOSE                | ETHINYL ESTRADIOL AND NORETHINDRONE ACETATE           | Tier 4           |                                |
| <i>gynodiol</i>                | <i>estrace</i>  | Tier 1           |                                |
| <i>junel</i>                   | <i>loestrin</i>                                       | Tier 2           |                                |
| <i>kariva</i>                  | <i>desogestrel and ethinyl estradiol</i>              | Tier 2           |                                |
| <i>kelnor 1/35</i>             | <i>ethinyl estradiol and ethynodiol diacetate</i>     | Tier 2           |                                |
| <i>leena</i>                   | <i>tri-norinyl 28</i>                                 | Tier 2           |                                |
| <i>lessina-28</i>              | <i>levlite-28</i>                                     | Tier 2           |                                |
| <i>levora 0.15/30-28</i>       | <i>nordette-28</i>                                    | Tier 2           |                                |
| <i>low-ogestrel</i>            | <i>lolovral-28</i>                                    | Tier 2           |                                |
| <i>lutera</i>                  | <i>levlite-28</i>                                     | Tier 1           |                                |
| MENEST                         | ESTROGENS, ESTERIFIED                                 | Tier 3           |                                |
| <i>microgestin</i>             | <i>loestrin</i>                                       | Tier 2           |                                |
| <i>mononessa</i>               | <i>ortho-cyclen-28</i>                                | Tier 2           |                                |
| <i>necon 0.5/35-28</i>         | <i>brevicon-28</i>                                    | Tier 2           |                                |
| <i>necon 1/35-28</i>           | <i>norinyl 1+35</i>                                   | Tier 2           |                                |
| <i>necon 1/50-28</i>           | <i>ortho-novum 1/50-28</i>                            | Tier 2           |                                |
| <i>necon 10/11-28</i>          | <i>ethinyl estradiol and norethindrone</i>            | Tier 2           |                                |
| <i>necon 7/7/7</i>             | <i>ortho-novum 7/7/7-28</i>                           | Tier 1           |                                |
| <i>nortrel 0.5/35 (28)</i>     | <i>brevicon-28</i>                                    | Tier 2           |                                |
| <i>nortrel 1/35 (21)</i>       | <i>norinyl 1+35</i>                                   | Tier 2           |                                |
| <i>nortrel 1/35 (28)</i>       | <i>norinyl 1+35</i>                                   | Tier 2           |                                |
| <i>nortrel 7/7/7</i>           | <i>ortho-novum 7/7/7-28</i>                           | Tier 1           |                                |
| NUVARING                       | ETHINYL ESTRADIOL AND ETONOGESTREL                    | Tier 4           | Vaginal Dosage Formulation     |
| <i>ocella</i>                  | <i>drospirenone/ethinyl estradiol</i>                 | Tier 2           |                                |
| <i>ogestrel</i>                | <i>ethinyl estradiol and norgestrel</i>               | Tier 2           |                                |
| ORTHO EVRA                     | ETHINYL ESTRADIOL AND NORELGESTROMIN                  | Tier 4           | Transdermal Dosage Formulation |
| <i>ortho-est</i>               | <i>ogen</i>   | Tier 1           |                                |
| <i>portia-28</i>               | <i>nordette-28</i>                                    | Tier 2           |                                |
| PREFEST                        | ESTRADIOL AND NORGESTIMATE                            | Tier 3           |                                |
| PREMARIN                       | ESTROGENS, CONJUGATED                                 | Tier 3           |                                |
| PREMARIN W/APPLICATOR          | ESTROGENS, CONJUGATED                                 | Tier 3           | Vaginal Dosage Formulation     |
| PREMPHASE                      | ESTROGENS, CONJUGATED AND MEDROXYPROGESTERONE ACETATE | Tier 3           |                                |
| PREMPRO                        | ESTROGENS, CONJUGATED AND MEDROXYPROGESTERONE ACETATE | Tier 3           |                                |
| <i>previfem</i>                | <i>ortho-cyclen-28</i>                                | Tier 2           |                                |

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                 | Desert Preferred | Requisitos / Limites           |
|--------------------------------|---|------------------|--------------------------------|
| <i>quasense</i>                | <i>seasonale</i>                                  | Tier 1           |                                |
| <i>reclipsen</i>               | <i>desogen</i>                                    | Tier 1           |                                |
| <i>solia</i>                   | <i>desogen</i>                                    | Tier 1           |                                |
| <i>sprintec 28</i>             | <i>ortho-cyclen-28</i>                            | Tier 2           |                                |
| <i>sronyx</i>                  | <i>levlite-28</i>                                 | Tier 1           |                                |
| <i>tri-legest fe</i>           | <i>estrostep fe</i>                               | Tier 1           |                                |
| <i>tri-previfem</i>            | <i>ethinyl estradiol and norgestimate</i>         | Tier 2           |                                |
| <i>tri-sprintec</i>            | <i>ethinyl estradiol and norgestimate</i>         | Tier 1           |                                |
| <i>trinessa</i>                | <i>ethinyl estradiol and norgestimate</i>         | Tier 1           |                                |
| <i>trivora-28</i>              | <i>ethinyl estradiol and levonorgestrel</i>       | Tier 2           |                                |
| VAGIFEM                        | ESTRADIOL   | Tier 4           | Vaginal Dosage Formulation     |
| <i>velivet</i>                 | <i>cyclessa</i>                                   | Tier 2           |                                |
| VIVELLE-DOT                    | ESTRADIOL   | Tier 4           | Transdermal Dosage Formulation |
| <i>zovia 1/35e</i>             | <i>ethinyl estradiol and ethynodiol diacetate</i> | Tier 2           |                                |
| <i>zovia 1/50e</i>             | <i>ethinyl estradiol and ethynodiol diacetate</i> | Tier 2           |                                |

**Progestinas**

|                                    |                                   |        |                               |
|------------------------------------|-----------------------------------|--------|-------------------------------|
| <i>camila</i>                      | <i>nor-qd</i>                     | Tier 2 |                               |
| CRINONE                            | PROGESTERONE                      | Tier 4 | Vaginal Dosage Formulation    |
| <i>errin</i>                       | <i>nor-qd</i>                     | Tier 2 |                               |
| <i>jolivette</i>                   | <i>nor-qd</i>                     | Tier 2 |                               |
| <i>medroxyprogesterone acetate</i> | <i>depo-provera contraceptive</i> | Tier 5 | Injectable dosage Formulation |
| <i>medroxyprogesterone acetate</i> | <i>provera</i>                    | Tier 1 |                               |
| MEGACE ES                          | MEGESTROL ACETATE                 | Tier 4 | PA for new starts             |
| <i>megestrol acetate</i>           | <i>megace oral</i>                | Tier 2 | PA for new starts             |
| <i>nora-be</i>                     | <i>nor-qd</i>                     | Tier 2 |                               |
| <i>norethindrone acetate</i>       | <i>aygestin</i>                   | Tier 2 |                               |
| PLAN B                             | LEVONORGESTREL                    | Tier 4 |                               |
| PROCHIEVE                          | PROGESTERONE                      | Tier 4 | Vaginal Dosage Formulation    |
| PROMETRIUM                         | PROGESTERONE                      | Tier 4 |                               |

**Agentes modificantes de receptores selectivos de estrógeno**

|        |            |        |                             |
|--------|------------|--------|-----------------------------|
| EVISTA | RALOXIFENE | Tier 3 | QL - 30 tablets per 30 days |
|--------|------------|--------|-----------------------------|

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Tiroides)****Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Tiroides)**

|                             |                      |        |  |
|-----------------------------|----------------------|--------|--|
| CYTOMEL                     | LIOTHYRONINE SODIUM  | Tier 4 |  |
| <i>levothroid</i>           | <i>levoxyl</i>       | Tier 1 |  |
| <i>levothroid</i>           | <i>synthroid</i>     | Tier 1 |  |
| <i>levothyroxine sodium</i> | <i>levoxyl</i>       | Tier 1 |  |
| <i>levothyroxine sodium</i> | <i>synthroid</i>     | Tier 1 |  |
| SYNTHROID                   | LEVOTHYROXINE SODIUM | Tier 3 |  |
| THYROLAR                    | LIOTRIX              | Tier 3 |  |
| <i>unithroid</i>            | <i>levoxyl</i>       | Tier 1 |  |
| <i>unithroid</i>            | <i>synthroid</i>     | Tier 1 |  |

**Agentes hormonales/ Supresores (Suprarrenales)****Agentes hormonales/ Supresores (Suprarrenales)**

|          |          |        |  |
|----------|----------|--------|--|
| LYSODREN | MITOTANE | Tier 3 |  |
|----------|----------|--------|--|

**Agentes hormonales/ Supresores (Paratiroides)****Agentes hormonales/ Supresores (Paratiroides)**

|          |                          |        |  |
|----------|--------------------------|--------|--|
| SENSIPAR | CINACALCET HYDROCHLORIDE | Tier 3 |  |
|----------|--------------------------|--------|--|

**Agentes hormonales/ Supresores (Pituitarias)****Agentes hormonales/ Supresores (Pituitarias)**

|                           |                           |        |  |
|---------------------------|---------------------------|--------|--|
| <i>cabergoline</i>        | <i>cabergoline</i>        | Tier 2 |  |
| <i>leuprolide acetate</i> | <i>leuprolide acetate</i> | Tier 5 | PA for new starts; Injectable dosage Formulation |
| <i>octreotide acetate</i> | <i>sandostatin</i>        | Tier 5 | 50mcg/ml; PA; Injectable dosage Formulation      |
| SANDOSTATIN LAR DEPOT     | OCTREOTIDE ACETATE        | Tier 6 | PA; Injectable dosage Formulation                |
| SOMAVERT                  | PEGVISOMANT               | Tier 6 | PA; Injectable dosage Formulation                |
| SYNAREL                   | NAFARELIN ACETATE         | Tier 6 | PA   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes hormonales/ Estimulantes/ Reemplazo/ Modificadores (Hormonas sexuales/Modificadores)****Antiandrógenos**

|                  |                  |        |                             |
|------------------|------------------|--------|-----------------------------|
| CASODEX          | BICALUTAMIDE     | Tier 3 | QL - 30 tablets per 30 days |
| <i>flutamide</i> | <i>flutamide</i> | Tier 1 |                             |
| NILANDRON        | NILUTAMIDE       | Tier 4 |                             |

**Agentes hormonales/ Supresores (Tiroides)****Agentes antitiroideos**

|                         |                         |        |  |
|-------------------------|-------------------------|--------|--|
| <i>methimazole</i>      | <i>tapazole</i>         | Tier 2 |  |
| <i>propylthiouracil</i> | <i>propylthiouracil</i> | Tier 2 |  |

**Agentes inmunológicos****Inmunosupresores**

|                              |                                     |        |   |
|------------------------------|-------------------------------------|--------|---|
| AZASAN                       | AZATHIOPRINE                        | Tier 4 |   |
| <i>azathioprine</i>          | <i>imuran</i>                       | Tier 2 |   |
| CELLCEPT                     | MYCOPHENOLATE MOFETIL               | Tier 4 | PA for new starts   |
| CELLCEPT INTRAVENOUS         | MYCOPHENOLATE MOFETIL HYDROCHLORIDE | Tier 5 | PA for new starts; Injectable dosage Formulation  |
| <i>cyclosporine</i>          | <i>sandimmune</i>                   | Tier 2 | PA for new starts   |
| CYCLOSPORINE MODIFIED        | CYCLOSPORINE                        | Tier 1 | PA for new starts   |
| <i>cyclosporine modified</i> | <i>neoral</i>                       | Tier 2 | Oral solution; PA for new starts  |
| ENBREL                       | ETANERCEPT                          | Tier 6 | PA - Quantity Limitation - 16ml per 30 days on 25mg; 8ml per 30 days on 50mg; Injectable dosage Formulation |
| ENBREL SURECLICK             | ETANERCEPT                          | Tier 6 | PA - Quantity Limitation - 16ml per 30 days on 25mg; 8ml per 30 days on 50mg; Injectable dosage Formulation |
| <i>gengraf</i>               | <i>neoral</i>                       | Tier 2 | PA for new starts   |
| HUMIRA                       | ADALIMUMAB                          | Tier 6 | PA - QL - 2 injections per 28 days; Injectable dosage Formulation   |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| <i>methotrexate</i>            | <i>methotrexate</i>               | Tier 2           |   |
| <i>methotrexate sodium</i>     | <i>methotrexate sodium</i>        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| MYFORTIC                       | MYCOPHENOLATE SODIUM              | Tier 4           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| NEORAL                         | CYCLOSPORINE                      | Tier 3           | PA for new starts   |
| ORENCIA                        | ABATACEPT                         | Tier 6           | PA; Injectable dosage Formulation   |
| ORTHOCLONE OKT3                | MUROMONAB CD3                     | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| PROGRAF                        | TACROLIMUS                        | Tier 6           | PA for new starts   |
| RAPAMUNE                       | SIROLIMUS                         | Tier 4           | PA for new starts   |
| REMICADE                       | INFLIXIMAB                        | Tier 6           | PA; Injectable dosage Formulation   |
| SANDIMMUNE                     | CYCLOSPORINE                      | Tier 4           | Oral solution; PA for new starts  |
| SIMULECT                       | BASILIXIMAB                       | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| TREXALL                        | METHOTREXATE SODIUM               | Tier 4           |   |
| ZENAPAX                        | DACLIZUMAB                        | Tier 6           | PA for new starts; Injectable dosage Formulation  |

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**Formulario**

| Nombre de medicamento cubierto      | Nombre de medicamento alternativo                | Desert Preferred | Requisitos / Limites              |
|-------------------------------------|--|------------------|-----------------------------------|
| <b>Agentes inmunizantes pasivos</b> |  |                  |                                   |
| <i>carimune nanofiltered</i>        | <i>globulin, immune</i>                          | Tier 6           | PA; Injectable dosage Formulation |
| <i>flebogamma</i>                   | <i>globulin, immune</i>                          | Tier 6           | PA; Injectable dosage Formulation |
| <i>gamastan s/d</i>                 | <i>globulin, immune</i>                          | Tier 5           | PA; Injectable dosage Formulation |
| <i>gammagard liquid</i>             | <i>gamunex</i>                                   | Tier 6           | PA; Injectable dosage Formulation |
| <i>octagam</i>                      | <i>globulin, immune iv (octapharm)</i>           | Tier 6           | PA; Injectable dosage Formulation |
| <i>polygam s/d</i>                  | <i>globulin, immune iv (baxter/lam red cros)</i> | Tier 6           | PA; Injectable dosage Formulation |
| VIVAGLOBIN                          | GLOBULIN, IMMUNE SC (ZLB BEHRING)                | Tier 6           | PA; Injectable dosage Formulation |

**Inmunomoduladores**

|                    |                       |        |   |
|--------------------|-----------------------|--------|---|
| ACTIMMUNE          | INTERFERON GAMMA-1B   | Tier 6 | PA for new starts; Injectable dosage Formulation                |
| ALFERON N          | INTERFERON ALFA-N3    | Tier 6 | PA for new starts; Injectable dosage Formulation                |
| AVONEX             | INTERFERON BETA-1A    | Tier 6 | PA; QL - 1 kit per 28 days; Injectable dosage Formulation       |
| BETASERON          | INTERFERON BETA       | Tier 6 | PA; Injectable dosage Formulation                               |
| COPAXONE           | GLATIRAMER            | Tier 6 | PA - QL - 1 kit per 30 days; Injectable dosage Formulation      |
| INFERGEN           | INTERFERON ALFACON-1  | Tier 6 | PA; Injectable dosage Formulation                               |
| INTRON-A           | INTERFERON ALFA-2B    | Tier 5 | 10MU, 3MU Pen; PA for new starts; Injectable dosage Formulation |
| KINERET            | ANAKINRA              | Tier 6 | PA; Injectable dosage Formulation                               |
| <i>leflunomide</i> | <i>arava</i>          | Tier 2 |   |
| PEG-INTRON         | PEGINTERFERON ALFA-2B | Tier 6 | PA; Injectable dosage Formulation; QL - 4 syringes per 28 days  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| PEG-INTRON REDIPEN             | PEGINTERFERON ALFA-2B             | Tier 6           | PA; Injectable dosage Formulation; QL - 4 syringes per 28 days  |
| PEGASYS                        | PEGINTERFERON ALFA-2A             | Tier 6           | PA; Injectable dosage Formulation; QL - 1 kit per 28 days   |
| REBIF                          | INTERFERON BETA-1A                | Tier 6           | PA - QL - 12ml per 30 days; Injectable dosage Formulation   |
| REBIF TITRATION PACK           | INTERFERON BETA-1A                | Tier 6           | PA - QL - 6ml per 30 days; Injectable dosage Formulation  |
| RIDAURA                        | AURANOFIN                         | Tier 4           |   |
| TYSABRI                        | NATALIZUMAB                       | Tier 6           | PA; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. |

**Vacunas**

|                                    |  |        |  |
|------------------------------------|--|--------|--|
| ACTHIB                             | HAEMOPHILUS B POLYSACCHARIDE CONJ VACC   | Tier 5 |  |
| ADACEL                             | ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID                     | Tier 5 |  |
| ATTENUVAX                          | MEASLES VIRUS VACCINE LIVE   | Tier 5 |  |
| BOOSTRIX                           | ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID                     | Tier 5 |  |
| COMVAX                             | HAEMOPHILUS B POLYSACCHARIDE CONJ VACC AND HEPATITIS B VIRUS VACCINE RECOMBINANT | Tier 5 |  |
| DAPTACEL                           | ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID                     | Tier 5 |  |
| <i>decavac</i>                     | <i>diphtheria toxoid and tetanus toxoid</i>                                      | Tier 5 |  |
| DIPHTHERIA/TETANUS TOXOIDPEDIATRIC | DIPHTHERIA TOXOID AND TETANUS TOXOID   | Tier 5 |  |

## Formulario

| Nombre de medicamento cubierto            | Nombre de medicamento alternativo   | Desert Preferred | Requisitos / Limites              |
|---|---|------------------|-----------------------------------|
| ENGERIX-B                                 | HEPATITIS B VIRUS VACCINE RECOMBINANT   | Tier 5           |                                   |
| GARDASIL                                  | QUADRIVALENT HPV (6,11,16,18) RECOMB VAC  | Tier 5           | PA; Injectable dosage Formulation |
| HAVRIX                                    | HEPATITIS A VIRUS VACCINE INACTIVATED   | Tier 5           |                                   |
| IMOVAX RABIES (H.D.C.V.)                  | RABIES VACCINE HUMAN DIPLOID CELL   | Tier 5           |                                   |
| INFANRIX                                  | ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID                    | Tier 5           |                                   |
| IPOV INACTIVATED IPV                      | POLIOVIRUS VACCINE INACTIVATED  | Tier 5           |                                   |
| JE-VAX                                    | JAPANESE ENCEPHALITIS VIRUS VACCINE   | Tier 5           |                                   |
| M-M-R II W/DILUENT 10 DOSE                | MEASLES VIRUS VACCINE LIVE  | Tier 5           |                                   |
| MENACTRA                                  | MENINGOCOCCAL POLYSACCHARIDE VAC A-C-Y-W  | Tier 5           |                                   |
| MENOMUNE-A/C/Y/W-135                      | MENINGOCOCCAL POLYSACCHARIDE VAC A-C-Y-W  | Tier 5           |                                   |
| MERUVAX II W/DILUENT 10 DOSE              | RUBELLA VIRUS VACCINE LIVE  | Tier 5           |                                   |
| PEDIARIX                                  | ACELLULAR PERTUSSIS VACCINE   | Tier 5           |                                   |
| <i>pedvax hib</i>                         | <i>haemophilus b polysaccharide conj vacc</i>                                   | Tier 5           |                                   |
| PROQUAD                                   | MEASLES VIRUS VACCINE LIVE  | Tier 5           |                                   |
| RABAVERT                                  | RABIES VIRUS VACCINE FLURY LEP STRAIN   | Tier 5           |                                   |
| RECOMBIVAX HB                             | HEPATITIS B VIRUS VACCINE RECOMBINANT   | Tier 5           |                                   |
| ROTATEQ                                   | ROTAVIRUS VACCINE LIVE PENTAVALENT  | Tier 4           |                                   |
| TETANUS TOXOID ADSORBED                   | TETANUS TOXOID ADSORBED   | Tier 3           |                                   |
| TETANUS/DIPHTHERIA TOXOIDS ADSORBED ADULT | DIPHTHERIA TOXOID AND TETANUS TOXOID  | Tier 5           |                                   |
| TRIHIBIT                                  | ACELLULAR PERTUSSIS VACCINE   | Tier 5           |                                   |
| TRIPEDIA                                  | ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID                    | Tier 5           |                                   |
| TWINRIX                                   | HEPATITIS A VIRUS VACCINE INACTIVATED AND HEPATITIS B VIRUS VACCINE RECOMBINANT | Tier 5           |                                   |
| TYPHIM VI                                 | TYPHOID VI POLYSACCHARIDE VACCINE   | Tier 5           |                                   |
| VAQTA                                     | HEPATITIS A VIRUS VACCINE INACTIVATED   | Tier 5           |                                   |
| VARIVAX                                   | VARICELLA VIRUS VACCINE LIVE  | Tier 5           |                                   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites              |
|--------------------------------|-----------------------------------|------------------|-----------------------------------|
| VIVOTIF BERNA                  | TYPHOID VACCINE                   | Tier 4           |                                   |
| YF-VAX                         | YELLOW FEVER VACCINE              | Tier 5           | Injectable dosage Formulation     |
| ZOSTAVAX                       | ZOSTER                            | Tier 5           | PA; Injectable dosage Formulation |

**Agentes para la enfermedad inflamatoria intestinal****Glucocorticoides**

|                            |                   |        |  |
|----------------------------|-------------------|--------|--|
| ENTOCORT EC                | BUDESONIDE        | Tier 3 |  |
| <i>prednisone</i>          | <i>prednisone</i> | Tier 1 |  |
| <i>prednisone intensol</i> | <i>prednisone</i> | Tier 1 |  |

**Salicilatos**

|                             |                    |        |  |
|-----------------------------|--------------------|--------|--|
| ASACOL                      | MESALAMINE (5-ASA) | Tier 3 |  |
| <i>balsalazide disodium</i> | <i>colazal</i>     | Tier 1 |  |
| CANASA                      | MESALAMINE (5-ASA) | Tier 4 |  |
| DIPENTUM                    | OLSALAZINE         | Tier 4 |  |
| <i>mesalamine</i>           | <i>rowasa</i>      | Tier 2 |  |
| PENTASA                     | MESALAMINE (5-ASA) | Tier 4 |  |

**Sulfonamidas**

|                      |                           |        |  |
|----------------------|---------------------------|--------|--|
| <i>sulfasalazine</i> | <i>azulfidine</i>         | Tier 1 |  |
| <i>sulfazine</i>     | <i>azulfidine</i>         | Tier 1 |  |
| <i>sulfazine ec</i>  | <i>azulfidine en-tabs</i> | Tier 1 |  |

**Agentes para la enfermedad metabólica ósea****Agentes para la enfermedad metabólica ósea**

|                           |  |        |  |
|---------------------------|--|--------|--|
| ACTONEL                   | RISEDRONATE SODIUM                       | Tier 3 | 150mg tablet   |
| ACTONEL WITH CALCIUM      | CALCIUM CARBONATE AND RISEDRONATE SODIUM | Tier 4 | QL - 28 tablets per 30 days  |
| <i>alendronate sodium</i> | <i>fosamax</i>                           | Tier 1 | QL - 5 tablets per 30 days on 35mg and 70mg; 120 tablets per 30 days on 10mg; 240 tablets per 30 days on 5mg; 30 tablets per 30 days on 40mg |
| BONIVA                    | IBANDRONATE SODIUM                       | Tier 4 | QL - 30 per 30 days on 2.5mg; 1 per 30 days on 150mg; ST   |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| CALCITRIOL                     | CALCITRIOL                        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>calcitriol</i>              | <i>rocaltrol</i>                  | Tier 2           |   |
| DIDRONEL                       | ETIDRONATE DISODIUM               | Tier 4           |   |
| <i>etidronate disodium</i>     | <i>didronel</i>                   | Tier 1           |   |
| FORTEO                         | TERIPARATIDE                      | Tier 6           | PA; Injectable dosage Formulation   |
| FORTICAL                       | CALCITONIN, SALMON (RDNA)         | Tier 4           |   |
| HECTOROL                       | DOXERCALCIFEROL                   | Tier 4           |   |
| MIACALCIN                      | CALCITONIN,SALMON                 | Tier 3           |   |
| PAMIDRONATE DISODIUM           | PAMIDRONATE DISODIUM              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| SKELID                         | TILUDRONATE DISODIUM              | Tier 4           |   |
| ZEMPLAR                        | PARICALCITOL                      | Tier 3           | PA  |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|--------------------------------|-----------------------------------|------------------|---|
| ZOMETA                         | ZOLEDRONIC ACID MONOHYDRATE       | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Agentes oftálmicos****Agentes oftálmicos, Otros**

|   |   |        |    |
|---|---|--------|----|
| <i>ak-con</i>   | <i>albalon</i>  | Tier 1 |    |
| <i>bac/poly/neomy/hc</i>                                  | <i>bac/poly/neomy/hc</i>  | Tier 2 |    |
| BLEPHAMIDE  | PREDNISOLONE ACETATE AND SULFACETAMIDE SODIUM                     | Tier 4 |    |
| BLEPHAMIDE S.O.P.   | PREDNISOLONE ACETATE AND SULFACETAMIDE SODIUM                     | Tier 4 |    |
| <i>dexasporin</i>   | <i>maxitrol</i>   | Tier 2 |    |
| LACRISERT   | HYDROXYPROPYL CELLULOSE   | Tier 3 |    |
| <i>naphazoline hcl</i>                                    | <i>albalon</i>  | Tier 1 |    |
| <i>neomycin/polymyxin/dexamethasone</i>                   | <i>maxitrol</i>   | Tier 2 |    |
| <i>neomycin/polymyxin/hydrocortisone</i>                  | <i>cortisporin</i>  | Tier 1 |    |
| <i>parcaine</i>   | <i>alcaine</i>  | Tier 2 |    |
| <i>poly-dex</i>   | <i>maxitrol</i>   | Tier 2 |    |
| POLY-PRED   | NEOMYCIN SULFATE AND POLYMYXIN B SULFATE AND PREDNISOLONE ACETATE | Tier 4 |    |
| PRED-G  | GENTAMICIN SULFATE PREDNISOLONE                                   | Tier 4 |    |
| PRED-G S.O.P.   | GENTAMICIN SULFATE AND PREDNISOLONE ACETATE                       | Tier 4 |    |
| <i>proparacaine hcl</i>                                   | <i>alcaine</i>  | Tier 2 |    |
| RESTASIS  | CYCLOSPORINE  | Tier 4 | PA |
| <i>sulfacetamide sodium/prednisolone sodium phosphate</i> | <i>prednisolone sodium phosphate and sulfacetamide sodium</i>     | Tier 2 |    |
| TOBRADEX  | DEXAMETHASONE AND TOBRAMYCIN SULFATE                              | Tier 4 |    |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Límites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Agentes oftálmicos antialérgicos**

|                        |                                      |        |  |
|------------------------|--------------------------------------|--------|--|
| ALAMAST                | PEMIROLAST POTASSIUM                 | Tier 4 |  |
| ALOCIL                 | NEDOCROMIL SODIUM                    | Tier 4 |  |
| ALOMIDE                | LODOXAMIDE TROMETHAMINE (TROMETAMOL) | Tier 4 |  |
| <i>cromolyn sodium</i> | <i>crolom</i>                        | Tier 2 |  |
| OPTIVAR                | AZELASTINE HYDROCHLORIDE             | Tier 3 |  |
| PATANOL                | OLOPATADINE HYDROCHLORIDE            | Tier 4 |  |

**Ophthalmic Anti-inflammatories**

|                                       |                                       |        |  |
|---------------------------------------|---------------------------------------|--------|--|
| ACULAR                                | KETOROLAC TROMETHAMINE                | Tier 4 |  |
| ACULAR LS                             | KETOROLAC TROMETHAMINE                | Tier 4 |  |
| ALREX                                 | LOTEPREDNOL ETABONATE                 | Tier 4 |  |
| <i>dexamethasone sodium phosphate</i> | <i>dexamethasone sodium phosphate</i> | Tier 1 |  |
| <i>diclofenac sodium</i>              | <i>voltaren</i>                       | Tier 1 |  |
| FLAREX                                | FLUOROMETHOLONE ACETATE               | Tier 4 |  |
| <i>fluor-op</i>                       | <i>fml liquifilm</i>                  | Tier 1 |  |
| <i>fluorometholone</i>                | <i>fml liquifilm</i>                  | Tier 1 |  |
| <i>flurbiprofen sodium</i>            | <i>ocufen</i>                         | Tier 2 |  |
| FML                                   | FLUOROMETHOLONE                       | Tier 4 |  |
| FML FORTE                             | FLUOROMETHOLONE                       | Tier 4 |  |
| LOTEMAX                               | LOTEPREDNOL ETABONATE                 | Tier 4 |  |
| MAXIDEX                               | DEXAMETHASONE                         | Tier 4 |  |
| NEVANAC                               | NEPAFENAC                             | Tier 4 |  |
| PRED MILD                             | PREDNISOLONE ACETATE                  | Tier 4 |  |
| <i>prednisolone acetate</i>           | <i>econopred plus</i>                 | Tier 2 |  |
| <i>prednisolone sodium phosphate</i>  | <i>prednisolone sodium phosphate</i>  | Tier 2 |  |
| VEXOL                                 | RIMEXOLONE                            | Tier 4 |  |

**Agentes oftálmicos antiglaucoma**

|                             |                                |        |  |
|-----------------------------|--------------------------------|--------|--|
| <i>acetazolamide</i>        | <i>diamox</i>                  | Tier 2 |  |
| ALPHAGAN P                  | BRIMONIDINE TARTRATE           | Tier 4 |  |
| AZOPT                       | BRINZOLAMIDE                   | Tier 4 |  |
| <i>betaxolol hcl</i>        | <i>betaxolol hydrochloride</i> | Tier 2 |  |
| BETIMOL                     | TIMOLOL                        | Tier 4 |  |
| BETOPTIC-S                  | BETAXOLOL                      | Tier 4 |  |
| <i>brimonidine tartrate</i> | <i>brimonidine tartrate</i>    | Tier 2 |  |
| <i>carteolol hcl</i>        | <i>carteolol hcl</i>           | Tier 2 |  |
| <i>dipivefrin hcl</i>       | <i>propine</i>                 | Tier 2 |  |
| IOPIDINE                    | APRACLONIDINE HYDROCHLORIDE    | Tier 4 |  |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
| <i>levobunolol hcl</i>         | <i>betagan</i>                    | Tier 2           |                      |
| <i>metipranolol</i>            | <i>optipranolol</i>               | Tier 1           |                      |
| <i>mydral</i>                  | <i>mydracyl</i>                   | Tier 2           |                      |
| <i>mydral</i>                  | <i>tropicamide</i>                | Tier 2           |                      |
| PHOSPHOLINE IODIDE             | ECHOTHIOPHATE IODIDE              | Tier 4           |                      |
| PILOPINE HS                    | PILOCARPINE HYDROCHLORIDE         | Tier 4           |                      |
| <i>timolol maleate</i>         | <i>timoptic ocudose</i>           | Tier 1           |                      |
| <i>tropicacyl</i>              | <i>mydracyl</i>                   | Tier 2           |                      |
| <i>tropicamide</i>             | <i>mydracyl</i>                   | Tier 2           |                      |

### **Prostaglandina oftálmica y análogos de prostamida**

|            |             |        |                      |
|------------|-------------|--------|----------------------|
| LUMIGAN    | BIMATOPROST | Tier 4 | QL - 3ml per 30 days |
| TRAVATAN Z | TRAVOPROST  | Tier 4 | QL - 5ml per 30 days |
| XALATAN    | LATANOPROST | Tier 3 | QL - 5ml per 30 days |

## Agentes óticos

### **Agentes óticos**

|  |   |        |  |
|--|---|--------|--|
| <i>acetic acid</i>                       | <i>acetazol</i>                             | Tier 2 |  |
| <i>acetic acid/hydrocortisone</i>        | <i>acetazol</i>                             | Tier 2 |  |
| <i>borofair</i>                          | <i>acetic acid and aluminum acetate</i>     | Tier 1 |  |
| CIPRO HC                                 | CIPROFLOXACIN HCL AND HYDROCORTISONE        | Tier 3 |  |
| CIPRODEX                                 | CIPROFLOXACIN HCL AND DEXAMETHASONE         | Tier 4 |  |
| COLY-MYCIN S                             | COLISTIN/HYDROCORTISONE NEOMYCIN/THONZONIUM | Tier 4 |  |
| <i>cortomycin</i>                        | <i>cortisporin</i>                          | Tier 1 |  |
| <i>cortomycin</i>                        | <i>pediotic</i>                             | Tier 1 |  |
| DERMOTIC                                 | FLUOCINOLONE ACETONIDE                      | Tier 3 |  |
| <i>neomycin/polymyxin/hc</i>             | <i>cortisporin</i>                          | Tier 1 |  |
| <i>neomycin/polymyxin/hydrocortisone</i> | <i>pediotic</i>                             | Tier 1 |  |

## Agentes del tracto respiratorio

### **Corticosteroides inhalables antiinflamatorios**

|                           |                    |        |                             |
|---------------------------|--------------------|--------|-----------------------------|
| AEROBID-M                 | FLUNISOLIDE        | Tier 4 | QL - 3 inhalers per 30 days |
| ASMANEX 120 METERED DOSES | MOMETASONE FUROATE | Tier 4 | QL - 2 inhalers per 30 days |
| ASMANEX 14 METERED DOSES  | MOMETASONE FUROATE | Tier 4 | QL - 4 inhalers per 30 days |

\*\* Estos medicamentos **NO** cuentan para su gasto total de desembolso y, si recibe ayuda adicional para pagar sus medicamentos, **NO** recibirá esta ayuda adicional para pagar estos medicamentos en particular.

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites        |
|--------------------------------|-----------------------------------|------------------|-----------------------------|
| ASMANEX 30 METERED DOSES       | MOMETASONE FUROATE                | Tier 4           | QL - 2 inhalers per 30 days |
| ASMANEX 60 METERED DOSES       | MOMETASONE FUROATE                | Tier 4           | QL - 2 inhalers per 30 days |
| AZMACORT                       | TRIAMCINOLONE                     | Tier 4           | QL - 2 inhalers per 30 days |
| BECONASE AQ                    | BECLOMETHASONE DIPROPIONATE       | Tier 4           | QL - 1 inhaler per 30 days  |
| FLOVENT DISKUS                 | FLUTICASONE/SALMETEROL            | Tier 3           |                             |
| FLOVENT HFA                    | FLUTICASONE PROPIONATE            | Tier 3           | QL - 2 inhalers per 30 days |
| <i>flunisolide</i>             | <i>flunisolide</i>                | Tier 1           | QL - 1 inhaler per 30 days  |
| <i>fluticasone propionate</i>  | <i>flonase</i>                    | Tier 2           | QL - 1 inhaler per 30 days  |
| NASACORT AQ                    | TRIAMCINOLONE ACETONIDE           | Tier 4           | QL - 2 inhalers per 30 days |
| NASONEX                        | MOMETASONE FUROATE MONOHYDRATE    | Tier 4           | QL - 1 inhaler per 30 days  |
| PULMICORT FLEXHALER            | BUDESONIDE                        | Tier 3           | QL - 2 inhalers per 30 days |
| QVAR                           | BECLOMETHASONE DIPROPIONATE       | Tier 4           | QL - 3 inhalers per 30 days |
| RHINOCORT AQUA                 | BUDESONIDE                        | Tier 3           | QL - 2 inhalers per 30 days |
| VERAMYST                       | FLUTICASONE FUROATE               | Tier 3           |                             |

**Antihistamínicos**

|                                    |                                     |        |   |
|------------------------------------|-------------------------------------|--------|---|
| ASTELIN                            | AZELASTINE HYDROCHLORIDE            | Tier 4 | QL - 1 inhaler per 30 days  |
| <i>cetirizine hcl</i>              | <i>zyrtec</i>                       | Tier 2 |   |
| <i>clemastine fumarate</i>         | <i>clemastine fumarate</i>          | Tier 1 |   |
| <i>cyproheptadine hcl</i>          | <i>cyproheptadine hydrochloride</i> | Tier 1 |   |
| <i>dexchlorpheniramine maleate</i> | <i>dexchlorpheniramine maleate</i>  | Tier 1 |   |
| <i>fexofenadine hcl</i>            | <i>allegra</i>                      | Tier 2 | QL - 60 tablets per 30 days on 30mg and 60mg; 30 tablets per 30 days on 180mg |
| <i>hydroxyzine hcl</i>             | <i>hydroxyzine hydrochloride</i>    | Tier 1 |   |
| <i>palgic</i>                      | <i>carbinoxamine maleate</i>        | Tier 2 |   |

**Antileucotrienos**

|          |             |        |                             |
|----------|-------------|--------|-----------------------------|
| ACCOLATE | ZAFIRLUKAST | Tier 3 | QL - 60 tablets per 30 days |
|----------|-------------|--------|-----------------------------|

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites         |
|--------------------------------|-----------------------------------|------------------|------------------------------|
| SINGULAIR                      | MONTELUKAST SODIUM                | Tier 4           | QL - 30 tablets per 30 days  |
| ZYFLO CR                       | ZILEUTON                          | Tier 4           | QL - 120 tablets per 30 days |

**Broncodilatadores, anticolinérgicos**

|                            |                                |        |                               |
|----------------------------|--------------------------------|--------|-------------------------------|
| ATROVENT HFA               | IPRATROPIUM BROMIDE            | Tier 4 | QL - 2 inhalers per 30 days   |
| <i>ipratropium bromide</i> | <i>atrovent</i>                | Tier 2 | QL - 30ml per 30 days         |
| SPIRIVA HANDIHALER         | TIOTROPIUM BROMIDE MONOHYDRATE | Tier 3 | QL - 1 handihaler per 30 days |

**Broncodilatadores, inhibidores de fosfodiesterasa (Xantinas)**

|                        |                      |        |  |
|------------------------|----------------------|--------|--|
| <i>aminophylline</i>   | <i>aminophylline</i> | Tier 2 |  |
| <i>theochron</i>       | <i>theophylline</i>  | Tier 1 |  |
| <i>theophylline cr</i> | <i>theophylline</i>  | Tier 1 |  |
| <i>theophylline er</i> | <i>uniphyl</i>       | Tier 1 |  |

**Broncodilatadores, simpaticomiméticos**

|                             |   |        |   |
|-----------------------------|---|--------|---|
| ADVAIR DISKUS               | FLUTICASONE PROPIONATE AND SALMETEROL XINAFOATE | Tier 3 | QL - 1 inhaler per 30 days  |
| ADVAIR HFA                  | FLUTICASONE PROPIONATE AND SALMETEROL XINAFOATE | Tier 3 | QL - 1 inhaler per 30 days  |
| <i>albuterol sulfate</i>    | <i>albuterol sulfate</i>                        | Tier 1 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>albuterol sulfate</i>    | <i>ventolin</i>                                 | Tier 1 |   |
| <i>albuterol sulfate er</i> | <i>albuterol sulfate</i>                        | Tier 1 |   |
| COMBIVENT                   | ALBUTEROL SULFATE AND IPRATROPIUM BROMIDE       | Tier 3 | QL - 2 inhalers per 30 days   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo            | Desert Preferred | Requisitos / Limites  |
|--------------------------------|--|------------------|---|
| <i>epinephrine hcl</i>         | <i>epinephrine hydrochloride</i>             | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| EPIPEN                         | EPINEPHRINE HYDROCHLORIDE                    | Tier 5           |   |
| FORADIL AEROLIZER              | FORMOTEROL FUMARATE                          | Tier 4           | QL - 1 inhaler per 30 days  |
| <i>metaproterenol sulfata</i>  | <i>metaproterenol sulfata</i>                | Tier 2           |   |
| PROAIR HFA                     | ALBUTEROL SULFATE                            | Tier 4           | QL - 2 inhalers per 30 days   |
| PROVENTIL HFA                  | ALBUTEROL SULFATE                            | Tier 4           | QL - 2 inhalers per 30 days   |
| SEREVENT DISKUS                | SALMETEROL XINAFOATE                         | Tier 3           | QL - 1 inhaler per 30 days  |
| SYMBICORT                      | BUDESONIDE AND FORMOTEROL FUMARATE DIHYDRATE | Tier 3           |   |
| <i>terbutaline sulfata</i>     | <i>brethine</i>                              | Tier 1           |   |
| TWINJECT                       | EPINEPHRINE                                  | Tier 5           |   |
| VENTOLIN HFA                   | ALBUTEROL SULFATE                            | Tier 3           | QL - 2 inhalers per 30 days   |
| <i>vospire er</i>              | <i>albuterol sulfata</i>                     | Tier 1           |   |
| XOPENEX HFA                    | LEVALBUTEROL TARTRATE                        | Tier 4           | QL - 2 inhalers per 30 days   |

***Antihipertensivos pulmonares***

|          |                      |        |   |
|----------|----------------------|--------|---|
| REVATIO  | SILDENAFIL CITRATE   | Tier 6 | PA  |
| TRACLEER | BOSENTAN MONOHYDRATE | Tier 6 | PA; This prescription may be available only at certain pharmacies. For more information call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. |

## Formulario

| Nombre de medicamento cubierto                | Nombre de medicamento alternativo                                 | Desert Preferred | Requisitos / Limites  |
|---|---|------------------|---|
| <b>Agentes del tracto respiratorio, Otros</b> |   |                  |   |
| ARALAST                                       | PROTEINASE INHIBITOR (HUMAN)                                      | Tier 6           | PA for new starts; Injectable dosage Formulation  |
| CLARINEX-D 12 HOUR                            | DES Loratadine and Pseudoephedrine Sulfate                        | Tier 4           | QL - 60 tablets per 30 days   |
| CLARINEX-D 24 HOUR                            | DES Loratadine and Pseudoephedrine Sulfate                        | Tier 4           | QL - 30 tablets per 30 days   |
| PROLASTIN                                     | PROTEINASE INHIBITOR (HUMAN)                                      | Tier 6           |   |
| <i>promethazine vc</i>                        | <i>phenylephrine hydrochloride and promethazine hydrochloride</i> | Tier 2           |   |
| TYZINE  | Tetrahydrozoline Hydrochloride                                    | Tier 3           |   |
| TYZINE PEDIATRIC NASAL DROPS                  | Tetrahydrozoline Hydrochloride                                    | Tier 3           |   |
| VENTAVIS                                      | Iloprost  | Tier 6           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| XOLAIR  | OMALIZUMAB  | Tier 6           | PA; Injectable dosage Formulation   |
| ZEMAIRA                                       | PROTEINASE INHIBITOR (HUMAN)                                      | Tier 6           | PA; Injectable dosage Formulation   |

## Sedantes/Hipnóticos

*Sedantes/Hipnóticos*

|                          |                   |        |                                 |
|--------------------------|-------------------|--------|---------------------------------|
| AMBIEN CR                | Zolpidem Tartrate | Tier 4 | ST; QL - 30 tablets per 30 days |
| ROZEREM                  | Ramelteon         | Tier 4 | ST; QL - 30 tablets per 30 days |
| <i>zaleplon</i>          | <i>sonata</i>     | Tier 2 |                                 |
| <i>zolpidem tartrate</i> | <i>ambien</i>     | Tier 2 | QL - 30 tablets per 30 days     |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

## Relajantes musculoesqueletales

*Relajantes musculoesqueletales*

|                                     |  |        |   |
|-------------------------------------|--|--------|---|
| <i>carisoprodol</i>                 | <i>soma</i>  | Tier 1 |   |
| <i>carisoprodol/aspirin</i>         | <i>soma compound</i>                                 | Tier 1 |   |
| <i>carisoprodol/aspirin/codeine</i> | <i>soma compound</i>                                 | Tier 1 |   |
| <i>chlorzoxazone</i>                | <i>parafon forte dsc</i>                             | Tier 2 |   |
| <i>cyclobenzaprine hcl</i>          | <i>flexeril</i>                                      | Tier 1 |   |
| <i>methocarbamol</i>                | <i>robaxin</i>                                       | Tier 2 |   |
| MYOBLOC                             | CLOSTRIDIUM BOTULINUM TOXIN TYPE B                   | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>orphenadrine citrate</i>         | <i>norflex</i>                                       | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>orphenadrine citrate er</i>      | <i>orphenadrine citrate</i>                          | Tier 2 |   |
| <i>orphenadrine compound ds</i>     | <i>aspirin and caffeine and orphenadrine citrate</i> | Tier 1 |   |
| <i>orphenadrine/asal/caffeine</i>   | <i>aspirin and caffeine and orphenadrine citrate</i> | Tier 2 |   |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites |
|--------------------------------|-----------------------------------|------------------|----------------------|
|--------------------------------|-----------------------------------|------------------|----------------------|

**Nutrientes terapéuticos/Minerales/Electrolitos*****Electrolitos/Minerales***

|          |   |        |   |
|----------|---|--------|---|
| AMINOSYN | ACETATE ALANINE ARGININE<br>ASPARTIC GLUTAMIC ACID                  | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN | ACETATE AND ALANINE AND<br>ARGININE AND CHLORIDE ION<br>AND GLYCINE | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN | ACETATE AND ALANINE AND<br>ARGININE AND GLYCINE AND<br>HISTIDINE    | Tier 5 | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto    | Nombre de medicamento alternativo                                    | Desert Preferred | Requisitos / Limites  |
|-----------------------------------|--|------------------|---|
| AMINOSYN 7%/ELECTROLYTES          | ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND GLYCINE        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>aminosyn 8.5%/electrolytes</i> | <i>acetate and alanine and arginine and chloride ion and glycine</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II                       | ACETATE ALANINE ARGININE ASPARTIC GLUTAMIC ACID                      | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo   | Desert Preferred | Requisitos / Limites  |
|--------------------------------|---|------------------|---|
| AMINOSYN II 3.5/DEXTROSE25%    | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CALCIUM              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II 3.5%/DEXTROSE25%   | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND DEXTROSE (ANHYDROUS) | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II 4.25/DEXTROSE10%   | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CHLORIDE ION         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo   | Desert Preferred | Requisitos / Limites  |
|--------------------------------|---|------------------|---|
| AMINOSYN II 4.25/DEXTROSE20%   | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND DEXTROSE (ANHYDROUS) | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II 4.25/DEXTROSE25%   | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CALCIUM              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II 4.25/DEXTROSE25%   | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND DEXTROSE (ANHYDROUS) | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto       | Nombre de medicamento alternativo   | Desert Preferred | Requisitos / Limites  |
|--------------------------------------|---|------------------|---|
| AMINOSYN II 5/DEXTROSE 25            | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND DEXTROSE (ANHYDROUS) | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>aminosyn ii 8.5%/electrolytes</i> | <i>acetate and alanine and arginine and aspartic acid and chloride ion</i>  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN II M 3.5%/DEXTROSE 5%       | ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CHLORIDE ION         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                             | Desert Preferred | Requisitos / Limites  |
|--------------------------------|---|------------------|---|
| AMINOSYN M                     | ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND GLYCINE | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN-HBC                   | ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND GLYCINE | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>aminosyn-hf</i>             | <i>hepatasol</i>  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo  | Desert Preferred | Requisitos / Limites   |
|--------------------------------|--|------------------|--|
| AMINOSYN-PF                    | ACETATE ALANINE ARGININE<br>ASPARTIC GLUTAMIC ACID                         | Tier 5           | Injectable<br>Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| AMINOSYN-PF 7%                 | ACETATE AND ALANINE AND<br>ARGININE AND ASPARTIC ACID<br>AND GLUTAMIC ACID | Tier 5           | Injectable<br>Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| DEXTROSE 10%/NACL 0.45%        | DEXTROSE (ANHYDROUS) AND<br>SODIUM CHLORIDE                                | Tier 5           | Injectable<br>Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto             | Nombre de medicamento alternativo               | Desert Preferred | Requisitos / Limites  |
|--|---|------------------|---|
| <i>dextrose 5%/electrolyte #48 viaflex</i> | <i>dextrose</i>                                 | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 10%/nacl 0.2%</i>              | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 10%flex container</i>          | <i>dextrose (anhydrous)</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto             | Nombre de medicamento alternativo               | Desert Preferred | Requisitos / Limites  |
|--|---|------------------|---|
| <i>dextrose 2.5%/sodium chloride 0.45%</i> | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 5%</i>                         | <i>dextrose (anhydrous)</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 5%/Inacl 0.2%</i>              | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto  | Nombre de medicamento alternativo               | Desert Preferred | Requisitos / Limites  |
|---------------------------------|---|------------------|---|
| <i>dextrose 5%/Inacl 0.225%</i> | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 5%/Inacl 0.33%</i>  | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>dextrose 5%/Inacl 0.45%</i>  | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto        | Nombre de medicamento alternativo               | Desert Preferred | Requisitos / Limites  |
|---------------------------------------|---|------------------|---|
| <i>dextrose 5%/nacl 0.9%</i>          | <i>dextrose (anhydrous) and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| DEXTROSE 5%/POTASSIUM CHLORIDE 0.075% | DEXTROSE (ANHYDROUS) AND POTASSIUM CHLORIDE     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>ed k+10</i>                        | <i>k-tabs</i>                                   | Tier 1           |   |
| <i>freamine iii</i>                   | <i>aminosyn</i>                                 | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto   | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|----------------------------------|--|------------------|---|
| FREAMINE III 3%                  | ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND CYSTEINE         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>intralipid</i>                | <i>glycerin and phospholipids and soybean oil</i>                      | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>kaon-cl-10</i>                | <i>k-tabs</i>  | Tier 1           |   |
| <i>kcl 0.075%/d5w/nacl 0.45%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|--------------------------------|--|------------------|---|
| KCL 0.15%/D10W/NACL 0.2%       | DEXTROSE (ANHYDROUS) AND POTASSIUM CHLORIDE AND SODIUM CHLORIDE        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| KCL 0.15%/D5W/LR               | KCL 0.15%/D5W/LR   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>kcl 0.15%/d5w/nacl 0.2%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto   | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|----------------------------------|--|------------------|---|
| <i>kcl 0.15%/d5w/nacl 0.225%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>kcl 0.224%/d5w/nacl 0.2%</i>  | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| KCL 0.3%/D5W/LR IV LAC RING      | KCL 0.3%/D5W/LR IV LAC RING  | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|--------------------------------|--|------------------|---|
| <i>kcl 0.3%/d5w/nacl 0.2%</i>  | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>kcl 0.3%/d5w/nacl 0.45%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| KCL 0.3%/D5W/NACL 0.9%         | DEXTROSE (ANHYDROUS) AND POTASSIUM CHLORIDE AND SODIUM CHLORIDE        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>klor-con 10</i>             | <i>k-tabs</i>  | Tier 1           |   |
| <i>klor-con 8</i>              | <i>potassium chloride</i>  | Tier 1           |   |
| <i>klor-con m20</i>            | <i>potassium chloride</i>  | Tier 1           |   |

**Formulario**

| Nombre de medicamento cubierto  | Nombre de medicamento alternativo | Desert Preferred | Requisitos / Limites  |
|---------------------------------|-----------------------------------|------------------|---|
| <i>lactated ringers viaflex</i> | <i>lactated ringer's</i>          | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| MAGNESIUM SULFATE               | MAGNESIUM SULFATE, HEPTAHYDRATE   | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride</i>       | <i>potassium chloride</i>         | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto                   | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|--|--|------------------|---|
| <i>potassium chloride 0.075%/d5w/nacl 0.225%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride 0.15%/d5w</i>              | <i>dextrose (anhydrous) and potassium chloride</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| POTASSIUM CHLORIDE 0.15%/NACL 0.45% VIAFLEX      | POTASSIUM CHLORIDE AND SODIUM CHLORIDE                                 | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto                         | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|--|--|------------------|---|
| <i>potassium chloride 0.15% d5w/nacl 0.33%</i>         | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride 0.15% d5w/nacl 0.45% viaflex</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride 0.15% nacl 0.9%</i>              | <i>potassium chloride 0.15%/nacl 0.9%</i>                              | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto                   | Nombre de medicamento alternativo                                      | Desert Preferred | Requisitos / Limites  |
|--|--|------------------|---|
| <i>potassium chloride 0.22% d5w / nacl 0.45%</i> | <i>dextrose (anhydrous) and potassium chloride and sodium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride 0.224% / d5w</i>           | <i>dextrose (anhydrous) and potassium chloride</i>                     | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| POTASSIUM CHLORIDE 0.224% D5W / NACL 0.33%       | DEXTROSE (ANHYDROUS) AND POTASSIUM CHLORIDE AND SODIUM CHLORIDE        | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

## Formulario

| Nombre de medicamento cubierto            | Nombre de medicamento alternativo                  | Desert Preferred | Requisitos / Limites  |
|---|--|------------------|---|
| <i>potassium chloride 0.3%/d5w</i>        | <i>dextrose (anhydrous) and potassium chloride</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>potassium chloride cr</i>              | <i>k-tabs</i>                                      | Tier 1           |   |
| <i>potassium chloride er</i>              | <i>klor-con</i>                                    | Tier 1           |   |
| <i>potassium citrate extended-release</i> | <i>urocit-k 10</i>                                 | Tier 2           |   |
| <i>potassium citrate extended-release</i> | <i>urocit-k 5</i>                                  | Tier 2           |   |
| <i>sodium bicarbonate</i>                 | <i>sodium bicarbonate</i>                          | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| <i>sodium chloride</i>                    | <i>sodium chloride</i>                             | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

**Formulario**

| Nombre de medicamento cubierto | Nombre de medicamento alternativo  | Desert Preferred | Requisitos / Limites  |
|--------------------------------|--|------------------|---|
| <i>tpn electrolytes ftv</i>    | <i>acetate and calcium (+2) and chloride ion and magnesium (+2) and potassium (+1)</i> | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| TRAVASOL                       | ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND GLYCINE                          | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |
| TROPHAMINE                     | ACETIC ACID AND ALANINE AND ARGININE AND ASPARTIC ACID AND CYSTEINE                    | Tier 5           | Injectable Formulation - This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of drug to make the determination. |

***Vitaminas***

|                        |  |        |  |
|------------------------|--|--------|--|
| PRENATABS OBN          | ASCORBIC ACID/BIOTIN/CALCIUM CARBONATE/CUPRIC OXIDE FERROUS FUMARATE | Tier 1 |  |
| <i>sodium fluoride</i> | <i>fluoride preparation</i>  | Tier 1 |  |

## Medicamentos que requieren autorización previa

|                       |                           |                            |
|-----------------------|---------------------------|----------------------------|
| ABELCET               | INVANZ                    | VANCOMYCIN HCL ISO-OSMOTIC |
| ACTIMMUNE             | IRESSA                    | DEXTROSE                   |
| ADAGEN                | KINERET                   | VELCADE                    |
| ALDARA                | leucovorin calcium        | VFEND IV                   |
| ALDURAZYME            | leuprolide acetate        | VIVAGLOBIN                 |
| ALFERON N             | LOVENOX                   | XOLAIR                     |
| ALOXI                 | METROGEL                  | XYREM                      |
| amphotericin b        | mitoxantrone hcl          | ZANOSAR                    |
| ANZEMET               | MYLOTARG                  | ZEMAIRA                    |
| APOKYN                | MYOZYME                   | ZEMPLAR                    |
| ARALAST               | NAGLAZYME                 | ZENAPAX                    |
| ARANESP ALBUMIN FREE  | NEULASTA                  | ZORBIVE                    |
| ARIXTRA               | NEUMEGA                   | ZOSTAVAX                   |
| ARRANON               | NEUPOGEN                  | ZOSYN                      |
| AVASTIN               | NEUTREXIN                 | ZYVOX                      |
| AVONEX                | NEXAVAR                   |                            |
| AZACTAM               | NORDITROPIN NORDIFLEX PEN |                            |
| BARACLUDE             | NUTROPIN                  |                            |
| BETASERON             | NUTROPIN AQ               |                            |
| bleomycin sulfate     | octagam                   |                            |
| CAMPATH               | octreotide acetate        |                            |
| carimune nanofiltered | ondansetron hcl           |                            |
| CELLCEPT INTRAVENOUS  | ondansetron odt           |                            |
| CEREDASE              | ONTAK                     |                            |
| CEREZYME              | ORENCIA                   |                            |
| CHANTIX               | ORTHOCLONE OKT3           |                            |
| cyclosporine          | PEG-INTRON                |                            |
| ELAPRASE              | PEG-INTRON REDIPEN        |                            |
| ELIDEL                | PEGASYS                   |                            |
| ELITEK                | polygam s/d               |                            |
| EMSAM                 | PROCRIT                   |                            |
| EPOGEN                | PROLEUKIN                 |                            |
| ERAXIS                | PROTOPIC                  |                            |
| FABRAZYME             | REGRANEX                  |                            |
| flebogamma            | REMICADE                  |                            |
| FORTEO                | REVLIMID                  |                            |
| FRAGMIN               | RITUXAN                   |                            |
| gamastan s/d          | SABRIL                    |                            |
| gammagard liquid      | SAIZEN                    |                            |
| GARDASIL              | SANDOSTATIN LAR DEPOT     |                            |
| GENOTROPIN            | SEROSTIM                  |                            |
| GENOTROPIN MINIQUICK  | SIMULECT                  |                            |
| granisetron hcl       | SOLARAZE                  |                            |
| HEPSERA               | SOMAVERT                  |                            |
| HERCEPTIN             | TARGRETIN                 |                            |
| HUMATROPE             | TRACLEER                  |                            |
| INFERGEN              | TYGACIL                   |                            |
| INNOHEP               | TYSABRI                   |                            |
| INTRON-A              | vancomycin hcl            |                            |

## Medicamentos con límites en la cantidad

| Medicamento cubierto                            | Límite en la cantidad  | Medicamento cubierto      | Límite en la cantidad                              |
|---|--|---------------------------|--|
| ABILIFY   | 30 tablets per 30 days;<br>900ml per month of solution   | ARIXTRA                   |  |
| ABILIFY DISCMELT                                | 60 tablets per 30 days   | ASMANEX 120 METERED DOSES | 2 inhalers per 30 days                             |
| ACCOLATE  | 60 tablets per 30 days   | ASMANEX 14 METERED DOSES  | 4 inhalers per 30 days                             |
| acetaminophen/codeine                           | 400 tablets per 30 days  | ASMANEX 30 METERED DOSES  | 2 inhalers per 30 days                             |
| ACIPHEX   | 30 tablets per 30 days   | ASMANEX 60 METERED DOSES  | 2 inhalers per 30 days                             |
| ACTONEL   | 30 per 30 days on 5mg;5<br>per 30 days on 35mg,<br>and 30mg; 2 per 28 days<br>on 75mg  | ASTELIN                   | 1 inhaler per 30 days                              |
| ACTONEL WITH CALCIUM                            | 28 tablets per 30 days   | ATACAND                   | 30 tablets per 30 days                             |
| ACTOPLUS MET                                    | 90 tablets per 30 days   | ATACAND HCT               | 30 tablets per 30 days                             |
| ACTOS   | 30 tablets per 30 days   | ATROVENT HFA              | 2 inhalers per 30 days                             |
| ADDERALL XR                                     | 30 capsules per 30 days on<br>5mg, 10mg, and 15mg;<br>60 capsules per 30 days<br>on 20mg, 25mg, and<br>30mg  | AVALIDE                   | 30 tablets per 30 days                             |
| ADVAIR DISKUS                                   | 1 inhaler per 30 days  | AVANDAMET                 | 60 tablets per 30 days                             |
| ADVAIR HFA                                      | 1 inhaler per 30 days  | AVANDARYL                 | 60 tablets per 30 days                             |
| ADVICOR   | 30 tablets per 30 days   | AVANDIA                   | 60 tablets per 30 days                             |
| AEROBID-M                                       | 3 inhalers per 30 days   | AVAPRO                    | 30 tablets per 30 days                             |
| AFINITOR  | 60 tablets per 30 days   | AVELOX                    | 14 tablets per prescription                        |
| alendronate sodium                              | 5 tablets per 30 days on<br>35mg and 70mg; 120<br>tablets per 30 days on<br>10mg; 240 tablets per 30<br>days on 5mg; 30 tablets<br>per 30 days on 40mg | AVELOX ABC PACK           | 14 tablets per prescription                        |
| ALOXI   | 5mls per month   | AVINZA                    | 30 capsules per 30 days                            |
| AMBIEN CR                                       | 30 tablets per 30 days   | AVODART                   | 30 capsules per 30 days                            |
| AMERGE  | 9 tablets per 30 days  | AVONEX                    | 1 kit per 28 days                                  |
| amlodipine besylate                             | 30 tablets per 30 days   | AXERT                     | 12 tablets per 30 days                             |
| amlodipine besylate/benazepril<br>hydrochloride | 30 capsules per 30 days  | azithromycin              | 6 tablets per prescription                         |
| amphetamine salt combo                          | 90 tablets per 30 days   | AZMACORT                  | 2 inhalers per 30 days                             |
| ANDRODERM                                       | 30 patches per 30 days   | BARACLUDE                 | 600ml per 30 days                                  |
| ANDROGEL  | 150 grams per 30 days  | BARACLUDE                 | 30 tablets per 30 days                             |
| ANZEMET   | 10 tablets per prescription  | BECONASE AQ               | 1 inhaler per 30 days                              |
| APIDRA  | 30ml per 30 days   | BENICAR                   | 30 tablets per 30 days                             |
| APTIVUS   | 300ml per 30 days on<br>solution   | BENICAR HCT               | 30 tablets per 30 days                             |
| ARANESP ALBUMIN FREE                            |  | BONIVA                    | 30 per 30 days on 2.5mg; 1<br>per 30 days on 150mg |
| ARICEPT   | 30 tablets per 30 days   | BONIVA                    | 1 per 30 days                                      |
| ARICEPT ODT                                     | 30 tablets per 30 days   | budeprion xl              | 30 tablets per 30 days                             |
| ARIMIDEX  | 30 tablets per 30 days   | butorphanol tartrate      | 10ml per 30 days                                   |
| ARIXTRA   | QL   | BYETTA                    | 1 kit per 30 days                                  |
|   |  | CADUET                    | 30 tablets per 30 days                             |
|   |  | CASODEX                   | 30 tablets per 30 days                             |
|   |  | CATAPRES                  | 4 patches per 30 days                              |
|   |  | CELEBREX                  | 60 capsules per 30 days                            |
|   |  | CHANTIX                   | 60 tablets per 30 days                             |
|   |  | CLARINEX-D 12 HOUR        | 60 tablets per 30 days                             |
|   |  | CLARINEX-D 24 HOUR        | 30 tablets per 30 days                             |
|   |  | clarithromycin            | 28 tablets per prescription                        |
|   |  | clarithromycin er         | 28 tablets per prescription                        |
|   |  | clozapine                 | 120 tablets per 30 days                            |
|   |  | co-gesic                  | 240 tablets per 30 days                            |
|   |  | COGNEX                    | 120 capsules per 30 days                           |
|   |  | COMBIVENT                 | 2 inhalers per 30 days                             |
|   |  | COMTAN                    | 240 tablets per 30 days                            |

## Medicamentos con límites en la cantidad

| Medicamento cubierto        | Límite en la cantidad   | Medicamento cubierto                 | Límite en la cantidad   |
|-----------------------------|---|--------------------------------------|---|
| CONCERTA                    | 60 tablets per 30 days on 36mg; 30 tablets per 30 days on 18mg, 27mg, and 54mg                        | fluvoxamine maleate                  | 45 tablets per 30 days on 25mg; 60 tablets per 30 days on 50mg; 90 tablets per 30 days on 100mg |
| COPAXONE                    | 1 kit per 30 days   | FORADIL AEROLIZER                    | 1 inhaler per 30 days   |
| COREG CR                    | 30 tablets per 30 days  | FROVA                                | 12 tablets per 30 days  |
| COZAAR                      | 30 tablets per 30 days  | gabapentin                           | 360 capsules per 30 days on 100mg and 300mg; 270 capsules per 30 days on 400mg                  |
| CRESTOR                     | 30 tablets per 30 days  | GEODON                               | 60 capsules per 30 days   |
| CYMBALTA                    | 60 capsules per 30 days on 20mg; 30 capsules per 30 days on 30mg and 60mg                             | GLEEVEC                              | 90 tablets per 30 days on 100mg, 60 tablets per 30 days on 400mg                                |
| DENAVIR                     | 1.5 grams per 28 days   | granisetron hcl                      | QL 10 per prescription  |
| DETROL                      | 60 tablets per 30 days  | HUMALOG                              | 30ml per 30 days  |
| DETROL LA                   | 30 capsules per 30 days   | HUMALOG MIX 50/50                    | 30ml per 30 days  |
| dexamethylphenidate hcl     | 90 tablets per 30 days  | HUMALOG MIX 75/25                    | 30ml per 30 days  |
| dextroamphetamine sulfate   | 180 tablets per 30 days   | HUMIRA                               | 2 injections per 28 days  |
| dextroamphetamine sulfateer | 120 capsules per 30 days  | HUMULIN 50/50                        | 30ml per 30 days  |
| DIOVAN                      | 30 tablets per 30 days  | HUMULIN 70/30                        | 30ml per 30 days  |
| DIOVAN HCT                  | 30 tablets per 30 days  | HUMULIN N                            | 30ml per 30 days  |
| EFFEXOR XR                  | 180 capsules per 30 days on 37.5mg; 90 capsules per 30 days on 75mg; 60 capsules per 30 days on 150mg | HUMULIN R                            | 30ml per 30 days  |
| ELIDEL                      | 30 grams per prescription   | hydrocodone bitartrate/acetaminophen | Not to exceed 4,000mg of acetaminophen/day  |
| EMSAM                       | 30 patches per 30 days  | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| ENABLEX                     | 30 tablets per 30 days  | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| endocet                     | 360 tablets per 30 days   | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| EPOGEN                      | 12 per 28 days; PA  | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| ERGOMAR                     | 20 tablets per 28 days  | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| ESTRING                     | 1 per 90 days   | hydrocodone/acetaminophen            | Not to exceed 4,000mg of acetaminophen/day  |
| EVISTA                      | 30 tablets per 30 days  | hydrocodone/ibuprofen                | 480 tablets per 30 days   |
| EXELON                      | 60 capsules per 30 days; 180ml per 30 days  | HYZAAR                               | 30 tablets per 30 days  |
| EXFORGE                     | 30 tablets per 30 days  | INVEGA                               | 30 tablets per 30 days on 3mg and 9mg, 60 tablets per 30 days on 6mg                            |
| EXFORGE HCT                 | 30 tablets per 30 days  | ipratropium bromide                  | 30ml per 30 days  |
| FACTIVE                     | 7 tablets per prescription  | IRESSA                               | 30 tablets per 30 days  |
| FAZACLO                     | 270 tablets per 30 days   | JANUVIA                              | 30 tablets per 30 days  |
| fentanyl                    | 30 patches per 30 days  | KADIAN                               | 60 capsules per 30 days   |
| fexofenadine hcl            | 60 tablets per 30 days on 30mg and 60mg; 30 tablets per 30 days on 180mg                              | ketorolac tromethamine               | 20 tablets per 30 days  |
| finasteride                 | 30 tablets per 30 days  | LAMISIL                              | 30 grams per 30 days  |
| FLOMAX                      | 60 capsules per 30 days   | LANTUS                               | 30ml per 30 days  |
| FLOVENT HFA                 | 2 inhalers per 30 days  | LESCOL                               | 60 capsules per 30 days   |
| flunisolide                 | 1 inhaler per 30 days   | LESCOL XL                            | 30 tablets per 30 days  |
| fluticasone propionate      | 1 inhaler per 30 days   | LEVAQUIN                             | 14 tablets per prescription   |

## Medicamentos con límites en la cantidad

| Medicamento cubierto    | Límite en la cantidad   | Medicamento cubierto             | Límite en la cantidad   |
|-------------------------|---|----------------------------------|---|
| LEVEMIR                 | 30ml per 30 days  | NICOTROL NS                      | 4 inhalers per 30 days  |
| LEXAPRO                 | 30 tablets per 30 days,<br>620ml per 30 days on<br>5mg/5ml solution                       | NOVOLIN 70/30                    | 30ml per 30 days  |
| lidocaine/prilocaine    | 30 grams per prescription   | NOVOLIN N                        | 30ml per 30 days  |
| LIDODERM                | 90 patches per 30 days  | NOVOLIN R                        | 30ml per 30 days  |
| LIPITOR                 | 30 tablets per 30 days  | NOVOLOG                          | 30ml per 30 days  |
| LOTRONEX                | 60 tablets per 30 days  | NOVOLOG MIX 70/30                | 30ml per 30 days  |
| lovastatin              | 30 tablets per 30 days on<br>10mg and 20mg; 60<br>tablets per 30 days on<br>40mg          | omeprazole                       | 60 capsules per 30 days   |
| LOVAZA                  | 120 capsules per 30 days  | ondansetron hcl                  | 10 tablets per prescription;<br>50ml oral solution per<br>prescription                                  |
| LOVENOX                 | 28 syringes per 30 days   | ondansetron odt                  | 10 tablets per prescription;<br>50ml oral solution per<br>prescription                                  |
| LOVENOX                 | 28 syringes per 30 days   | oxybutynin chloride er           | 180 tablets per 30 days on<br>5mg; 90 tablets per 30<br>days on 10mg; 60 tablets<br>per 30 days on 15mg |
| LUMIGAN                 | 3ml per 30 days   | oxycodone-apap                   | Not to exceed 4,000mg of<br>acetaminophen/day   |
| LUVOX CR                | 60 capsules per 30 days   | oxycodone/acetaminophen          | Not to exceed 4,000mg of<br>acetaminophen/day   |
| margesic-h              | 240 capsules per 30 days  | oxycodone/acetaminophen          | Not to exceed 4,000mg of<br>acetaminophen/day   |
| MAXALT                  | 12 tablets per 30 days  | oxycodone/apap                   | Not to exceed 4,000mg of<br>acetaminophen/day   |
| MAXALT-MLT              | 12 tablets per 30 days  | oxycodone/aspirin                | 360 tablets per 30 days   |
| meloxicam               | 30 tablets per 30 days,<br>180ml per 30 days on<br>7.5mg/5ml suspension                   | OXYCONTIN                        | 120 tablets per 30 days   |
| METADATE CD             | 180 capsules per 30 days  | paroxetine hcl                   | 30 tablets per 30 days,<br>946ml per 30 days on<br>10mg/5ml suspension                                  |
| metadate er             | 90 capsules per 30 days   | PEG-INTRON                       | 4 syringes per 28 days  |
| methylin                | 90 tablets per 30 days  | PEG-INTRON REDIPEN               | 4 syringes per 28 days  |
| methylin er             | 90 tablets per 30 days  | PEGASYS                          | 1 kit per 28 days   |
| methylin er             | 90 tablets per 30 days  | pentazocine/acetaminophen        | 180 tablets per 30 days   |
| methylphenidate hcl     | 90 tablets per 30 days  | PLAVIX                           | 30 tablets per 30 days  |
| methylphenidate hcl er  | 90 tablets per 30 days  | PRANDIN                          | 240 tablets per 30 days   |
| metoprolol succinate er | 30 tablets per 30 days on<br>25mg, 50mg, and 100mg;<br>60 tablets per 30 days on<br>200mg | pravastatin sodium               | 30 tablets per 30 days on<br>10mg, 20mg, and 80mg;<br>60 tablets per 30 days on<br>40mg                 |
| MICARDIS                | 30 tablets per 30 days  | PREVACID                         | 30 capsules per 30 days   |
| MICARDIS HCT            | 30 tablets per 30 days  | PREVACID NAPRAPAC                | 30 capsules per 30 days   |
| MIGRANAL                | 16 ml per 30 days   | PREVPAC                          | 1 pack per year   |
| MIRAPEX                 | 90 tablets per 30 days  | PRISTIQ                          | 30 tablets per 30 days  |
| mirtazapine             | 30 tablets per 30 days  | PROAIR HFA                       | 2 inhalers per 30 days  |
| mirtazapine             | 30 tablets per 30 days  | PROCRIT                          | 12 per 28 days  |
| mirtazapine             | 30 tablets per 30 days  | propoxyphene-<br>n/acetaminophen | Not to exceed 4,000mg of<br>acetaminophen/day   |
| NAMENDA                 | 60 tablets per 30 days;<br>360ml per 30 days  |                                  |   |
| NASACORT AQ             | 2 inhalers per 30 days  |                                  |   |
| NASONEX                 | 1 inhaler per 30 days   |                                  |   |
| NEXAVAR                 | QL 120 per 30 days  |                                  |   |
| NEXIUM                  | 30 capsules per 30 days   |                                  |   |
| NIASPAN                 | 60 tablets per 30 days  |                                  |   |

## Medicamentos con límites en la cantidad

| Medicamento cubierto       | Límite en la cantidad  | Medicamento cubierto                 | Límite en la cantidad   |
|----------------------------|--|--------------------------------------|---|
| propoxyphene/acetaminophen | Not to exceed 4,000mg of acetaminophen/day   | SIMCOR                               | 60 tablets per 30 days  |
| PROTOPIC                   | 30 grams per prescription  | simvastatin                          | 30 tablets per 30 days  |
| PROVENTIL HFA              | 2 inhalers per 30 days   | SINGULAIR                            | 30 tablets per 30 days  |
| PROVIGIL                   | 60 tablets per 30 days   | SOLARAZE                             | 50 grams per prescription                                       |
| PULMICORT FLEXHALER        | 2 inhalers per 30 days   | SPIRIVA HANDIHALER                   | 1 handihaler per 30 days  |
| QVAR                       | 3 inhalers per 30 days   | stagesic                             | 240 capules per 30 days   |
| RANEXA                     | 120 tablets per 30 days  | STARLIX                              | 90 tablets per 30 days  |
| RAZADYNE                   | 180ml per 30 days  | STRATTERA                            | 60 capsules per 30 days   |
| REBIF                      | 12ml per 30 days   | SYMBYAX                              | 30 capsules per 30 days   |
| REBIF TITRATION PACK       | 6ml per 30 days  | SYMLIN                               | 20ml per 30 days  |
| REGRANEX                   | 15 grams per prescription  | TARGRETIN                            | 60 grams per prescription                                       |
| RELION 70/30               | 30ml per 30 days   | TARKA                                | 30 tablets per 30 days  |
| RELION N                   | 30ml per 30 days   | TASMAR                               | 90 tablets per 30 days  |
| RELION R                   | 30ml per 30 days   | TEKTURNA                             | 30 tablets per 30 days  |
| RELPAK                     | 6 tablets per 30 days  | TEKTURNA HCT                         | 30 tablets per 30 days  |
| RHINOCORT AQUA             | 2 inhalers per 30 days   | tramadol hcl                         | 240 tablets per 30 days   |
| RISPERDAL                  | 60 tablets per 30 days, 480ml per 30 days on 1mg/ml solution   | tramadol hydrochloride/acetaminophen | 240 tablets per 30 days   |
| RISPERDAL M-TAB            | 60 tablets per 30 days; 120 tablets per 30 days on 4mg   | TRANSDERM-SCOP                       | QL 24 per 30 days   |
| RITALIN LA                 | 60 capsules per 30 days  | TRAVATAN Z                           | 5ml per 30 days   |
| roxicet                    | 360 per 30 days on 325mg, 240 per 30 days on 500mg   | TRICOR                               | 30 tablets per 30 days  |
| roxicet                    | 360 per 30 days on 325mg, 240 per 30 days on 500mg   | UROXATRAL                            | 30 tablets per 30 days  |
| ROZEREM                    | 30 tablets per 30 days   | vanacet                              | 240 tablets per 30 days   |
| SANCTURA                   | 60 tablets per 30 days   | venlafaxine hcl                      | 150 tablets per 30 days   |
| SANCTURA XR                | 30 capsules per 30 days  | venlafaxine hcl                      | 90 tablets per 30 days; 150 tablets per 30 days on 75mg         |
| SANTYL                     | 30 grams per prescription  | VENTOLIN HFA                         | 2 inhalers per 30 days  |
| SEREVENT DISKUS            | 1 inhaler per 30 days  | VESICARE                             | 30 tablets per 30 days  |
| SEROQUEL                   | 60 per 30 days on 400mg, 90 per 30 days on 200mg and 300mg, 120 per 30 days on 25mg and 50mg and 100mg | VIMPAT                               | 1200ml per 30 days  |
| SEROQUEL XR                | 30 tablets per 30 days on 200mg; 60 tablets per 30 days on 300mg and 400mg                             | VYTORIN                              | 30 tablets per 30 days  |
| sertraline hcl             | 30 per 30 days on 25mg and 50mg, 60 per 30 days on 100mg 300ml per 30 days on 20mg/ml solution         | XALATAN                              | 5ml per 30 days   |
|                            |  | XOPENEX HFA                          | 2 inhalers per 30 days  |
|                            |  | ZETIA                                | 30 tablets per 30 days  |
|                            |  | zolpidem tartrate                    | 30 tablets per 30 days  |
|                            |  | ZOMIG                                | 6 tablets per 30 days; 6ml nasal spray per 30 days              |
|                            |  | ZOMIG ZMT                            | 6 tablets per 30 days   |
|                            |  | ZOVIRAX                              | 10 grams per 30 days on cream, 30 grams per 30 days on ointment |
|                            |  | ZYFLO CR                             | 120 tablets per 30 days   |
|                            |  | ZYPREXA                              | 30 tablets per 30 days  |
|                            |  | ZYPREXA ZYDIS                        | 30 tablets per 30 days  |
|                            |  | ZYVOX                                | 56 tablets per 28 days  |

## Medicamentos que requieren tratamiento en pasos

ACIPHEX  
AMBIEN CR  
AVALIDE  
AVAPRO  
AVINZA  
BENICAR  
BENICAR HCT  
BONIVA  
CELEBREX  
COZAAR  
DIOVAN  
DIOVAN HCT  
HYZAAR  
JANUVIA  
MICARDIS  
MICARDIS HCT  
NEXIUM  
OXYCONTIN  
PREVACID  
ROZEREM  
TEKTURNA HCT

# Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (**en negritas**) y nombres de medicamentos alternativos

|   |     |
|---|-----|
| <b>A</b>  |     |
| <b>a-methapred</b> .....  | 14  |
| ABACAVIR SULFATE .....  | 44  |
| ABACAVIR SULFATE AND LAMIVUDINE .....   | 44  |
| ABACAVIR SULFATE AND LAMIVUDINE AND ZIDOVUDINE .....                                  | 44  |
| ABATACEPT .....   | 73  |
| <b>ABELCET</b> .....  | 33  |
| <b>ABILIFY</b> .....  | 41  |
| <b>ABILIFY DISCMELT</b> .....   | 41  |
| ACAMPROSATE CALCIUM .....   | 31  |
| <b>acarbose</b> .....   | 46  |
| <b>ACCOLATE</b> .....   | 82  |
| accupril .....  | 56  |
| accuretic .....   | 56  |
| <b>acebutolol hcl</b> .....   | 51  |
| ACELLULAR PERTUSSIS AND DIPHTHERIA TOXOID AND TETANUS TOXOID .....                    | 75  |
| ACELLULAR PERTUSSIS VACCINE .....   | 76  |
| <b>ACETADOTE</b> .....  | 30  |
| acetaminophen and hydrocodone bitartrate .....  | 12  |
| acetaminophen and oxycodone hydrochloride .....                                       | 13  |
| acetaminophen and propoxyphene hydrochloride .....                                    | 13  |
| ACETAMINOPHEN AND PROPOXYPHENE NAPSYLATE .....  | 10  |
| <b>acetaminophen/codeine</b> .....  | 10  |
| acetazolamide .....   | 80  |
| ACETATE ALANINE ARGININE ASPARTIC GLUTAMIC ACID .....                                 | 87  |
| ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CALCIUM .....                  | 89  |
| ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND CHLORIDE ION .....             | 89  |
| ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND DEXTROSE (ANHYDROUS) .....     | 89  |
| ACETATE AND ALANINE AND ARGININE AND ASPARTIC ACID AND GLUTAMIC ACID .....            | 93  |
| ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND CYSTEINE .....                  | 98  |
| ACETATE AND ALANINE AND ARGININE AND CHLORIDE ION AND GLYCINE .....                   | 87  |
| ACETATE AND ALANINE AND ARGININE AND GLYCINE AND HISTIDINE .....                      | 87  |
| acetate and calcium (+2) and chloride ion and magnesium (+2) and potassium (+1) ..... | 107 |
| <b>acetazolamide</b> .....  | 80  |
| <b>acetic acid</b> .....  | 81  |
| ACETIC ACID AND ALANINE AND ARGININE AND ASPARTIC ACID AND CYSTEINE .....             | 107 |
| acetic acid and aluminum acetate .....  | 81  |
| <b>acetic acid/hydrocortisone</b> .....   | 81  |
| ACETYLCYSTEINE .....  | 30  |
| <b>ACIPHEX</b> .....  | 63  |
| aclovate .....  | 65  |
| <b>ACTHIB</b> .....   | 75  |
| acticin .....   | 40  |
| actigall .....  | 62  |
| <b>ACTIMMUNE</b> .....  | 74  |
| activella .....   | 68  |
| <b>ACTONEL</b> .....  | 77  |
| <b>ACTONEL WITH CALCIUM</b> .....   | 77  |
| <b>ACTOPLUS MET</b> .....   | 46  |
| <b>ACTOS</b> .....  | 46  |
| <b>ACULAR</b> .....   | 80  |
| <b>ACULAR LS</b> .....  | 80  |
| ACYCLOVIR .....   | 45  |
| <b>ADACEL</b> .....   | 75  |
| <b>ADAGEN</b> .....   | 60  |
| adalat cc .....   | 53  |
| ADALIMUMAB .....  | 72  |
| ADAPALENE .....   | 59  |
| adderall .....  | 57  |
| <b>ADDERALL XR</b> .....  | 57  |
| ADEFOVIR DIPIVOXIL .....  | 45  |
| adoxa .....   | 24  |
| <b>ADVAIR DISKUS</b> .....  | 83  |
| <b>ADVAIR HFA</b> .....   | 83  |
| <b>ADVICOR</b> .....  | 54  |
| <b>AEROBID-M</b> .....  | 81  |
| <b>afeditab cr</b> .....  | 53  |
| <b>AFINITOR</b> .....   | 37  |
| AGALSIDASE BETA .....   | 61  |
| <b>AGGRENOX</b> .....   | 50  |
| agrylin .....   | 50  |
| <b>ak-con</b> .....   | 79  |
| <b>ak-poly-bac</b> .....  | 16  |
| <b>ak-tob</b> .....   | 15  |
| <b>ala-cort</b> .....   | 65  |
| <b>ALAMAST</b> .....  | 80  |
| albalon .....   | 79  |
| albuterol sulfate .....   | 83  |
| ALBUTEROL SULFATE AND IPRATROPIUM BROMIDE .....                                       | 83  |
| <b>albuterol sulfate er</b> .....   | 83  |
| alcaine .....   | 79  |
| <b>alclometasone dipropionate</b> .....   | 65  |
| <b>ALCOHOL PREPS</b> .....  | 47  |
| aldactazide .....   | 54  |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en negritas) y nombres de medicamentos alternativos

|  |    |   |    |
|--|----|---|----|
| aldactone  | 54 | aminosyn ii 8.5%/electrolytes                                   | 91 |
| <b>ALDARA</b>  | 59 | <b>AMINOSYN II M 3.5%/DEXTROSE 5%</b>                           | 91 |
| ALDESLEUKIN  | 38 | <b>AMINOSYN M</b>   | 92 |
| <b>ALDURAZYME</b>  | 60 | <b>AMINOSYN-HBC</b>   | 92 |
| ALEMTUZUMAB  | 39 | aminosyn-hf   | 92 |
| alendronate sodium   | 77 | <b>AMINOSYN-PF</b>  | 93 |
| <b>ALFERON N</b>   | 74 | <b>AMINOSYN-PF 7%</b>   | 93 |
| ALFUZOSIN HYDROCHLORIDE  | 64 | amiodarone hcl  | 51 |
| ALGLUCERASE  | 61 | amitriptyline hcl   | 29 |
| ALGLUCOSIDASE ALFA   | 61 | amitriptyline hydrochloride and<br>perphenazine                 | 28 |
| <b>ALINIA</b>  | 40 | AMLEXANOX   | 59 |
| ALISKIREN FUMARATE   | 56 | <b>amlodipine besylate</b>                                      | 53 |
| ALISKIREN FUMARATE AND<br>HYDROCHLOROTHIAZIDE                  | 56 | AMLODIPINE BESYLATE AND ATORVASTATIN<br>CALCIUM                 | 54 |
| ALITRETINOIN   | 39 | AMLODIPINE BESYLATE AND VALSARTAN                               | 53 |
| allegra  | 82 | <b>amlodipine besylate/benazepril</b>                           | 53 |
| <b>allopurinol</b>   | 35 | <b>hydrochloride</b>  | 53 |
| ALMOTRIPTAN MALATE   | 35 | AMLODIPINE/ HYDROCHLOROTHIAZIDE/<br>VALSARTAN                   | 53 |
| <b>ALOCRII</b>   | 80 | <b>ammonium lactate</b>   | 59 |
| <b>ALOMIDE</b>   | 80 | amoxapine   | 28 |
| <b>ALORA</b>   | 68 | amoxicillin   | 20 |
| ALOSETRON  | 63 | <b>amoxicillin/clavulanate potassium</b>                        | 20 |
| <b>ALOXI</b>   | 32 | <b>amoxicillin/potassium clavulanate</b>                        | 20 |
| <b>ALPHAGAN P</b>  | 80 | amoxil  | 20 |
| <b>ALREX</b>   | 80 | AMPHETAMINE   | 57 |
| altace   | 56 | <b>amphetamine salt combo</b>                                   | 57 |
| ALTRETAMINE  | 37 | AMPHOTERICIN B  | 33 |
| <b>amantadine hcl</b>  | 41 | <b>ampicillin</b>   | 20 |
| amantadine hydrochloride                                       | 41 | <b>ampicillin sodium</b>  | 21 |
| amaryl   | 46 | <b>ampicillin-sulbactam</b>                                     | 21 |
| AMBENONIUM CHLORIDE  | 36 | AMYLASE (DIASTASE) AND LIPASE (AS<br>PANCRELIPASE) AND PROTEASE | 61 |
| ambien   | 85 | AMYLASES /ENDOPEPTIDASES/LIPASE                                 | 61 |
| <b>AMBIEN CR</b>   | 85 | <b>ANADROL-50</b>   | 67 |
| <b>amcinonide</b>  | 65 | anafranil   | 29 |
| <b>AMERGE</b>  | 35 | <b>anagrelide hydrochloride</b>                                 | 50 |
| <b>amiloride hcl</b>   | 54 | ANAKINRA  | 74 |
| amiloride hydrochloride (anhydrous)<br>and hydrochlorothiazide | 54 | anaprox   | 10 |
| <b>amiloride/hydrochlorothiazide</b>                           | 54 | ANASTROZOLE   | 39 |
| aminophylline  | 83 | <b>ANCOBON</b>  | 33 |
| AMINOSALICYLIC ACID (4-ASA)                                    | 36 | <b>ANDRODERM</b>  | 67 |
| <b>AMINOSYN</b>  | 87 | <b>ANDROGEL</b>   | 67 |
| <b>AMINOSYN 7%/ELECTROLYTES</b>                                | 88 | <b>ANDROID</b>  | 67 |
| aminosyn 8.5%/electrolytes                                     | 88 | ANIDULAFUNGIN   | 34 |
| <b>AMINOSYN II</b>   | 88 | ansaid  | 10 |
| <b>AMINOSYN II 3.5/DEXTROSE25%</b>                             | 89 | antivert  | 32 |
| <b>AMINOSYN II 3.5%/DEXTROSE25%</b>                            | 89 | <b>ANTIZOL</b>  | 30 |
| <b>AMINOSYN II 4.25/DEXTROSE10%</b>                            | 89 | anusol-hc   | 60 |
| <b>AMINOSYN II 4.25/DEXTROSE20%</b>                            | 90 | <b>ANZEMET</b>  | 32 |
| <b>AMINOSYN II 4.25/DEXTROSE25%</b>                            | 90 |   |    |
| <b>AMINOSYN II 5/DEXTROSE 25</b>                               | 91 |   |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|   |     |  |    |
|---|-----|--|----|
| <b>APHTHASOL</b> .....                        | 59  | atrovent .....                             | 83 |
| <b>APIDRA</b> .....                           | 47  | <b>ATROVENT HFA</b> .....                  | 83 |
| <b>APOKYN</b> .....                           | 41  | <b>ATTENUVAX</b> .....                     | 75 |
| A POMORPHINE HYDROCHLORIDE .....              | 41  | augmented betamethasone dipropionate ..... | 65 |
| APRACLONIDINE HYDROCHLORIDE .....             | 80  | augmentin .....                            | 20 |
| APREPITANT .....                              | 32  | AURANOFIN .....                            | 75 |
| apri .....                                    | 68  | <b>AVALIDE</b> .....                       | 55 |
| <b>APTIVUS</b> .....                          | 44  | <b>AVANDAMET</b> .....                     | 46 |
| <b>ARALAST</b> .....                          | 85  | <b>AVANDARYL</b> .....                     | 46 |
| aralen .....                                  | 40  | <b>AVANDIA</b> .....                       | 46 |
| aranelle .....                                | 68  | <b>AVAPRO</b> .....                        | 55 |
| <b>ARANESP ALBUMIN FREE</b> .....             | 49  | <b>AVASTIN</b> .....                       | 39 |
| arava .....                                   | 74  | <b>AVELOX</b> .....                        | 23 |
| <b>ARICEPT</b> .....                          | 27  | <b>AVELOX ABC PACK</b> .....               | 23 |
| <b>ARICEPT ODT</b> .....                      | 27  | aviane .....                               | 68 |
| <b>ARIMIDEX</b> .....                         | 39  | <b>AVINZA</b> .....                        | 10 |
| ARIPRAZOLE .....                              | 41  | avita .....                                | 59 |
| <b>ARIXTRA</b> .....                          | 49  | <b>AVODART</b> .....                       | 64 |
| <b>AROMASIN</b> .....                         | 39  | <b>AVONEX</b> .....                        | 74 |
| <b>ARRANON</b> .....                          | 37  | <b>AXERT</b> .....                         | 35 |
| ARSENIC TRIOXIDE .....                        | 38  | axid .....                                 | 63 |
| <b>ARTHROTEC</b> .....                        | 15  | aygestin .....                             | 70 |
| <b>ASACOL</b> .....                           | 77  | AZACITIDINE .....                          | 38 |
| ascomp/codeine .....                          | 10  | <b>AZACTAM</b> .....                       | 20 |
| ASCORBIC ACID/BIOTIN/CALCIUM .....            | 107 | <b>AZASAN</b> .....                        | 72 |
| CARBONATE/CUPRIC OXIDE/FERROUS FUMARATE ..... |     | AZATHIOPRINE .....                         | 72 |
| ASENAPINE .....                               | 42  | AZELASTINE HYDROCHLORIDE .....             | 80 |
| <b>ASMANEX 120 METERED DOSES</b> .....        | 81  | <b>AZILECT</b> .....                       | 41 |
| <b>ASMANEX 14 METERED DOSES</b> .....         | 81  | azithromycin .....                         | 22 |
| <b>ASMANEX 30 METERED DOSES</b> .....         | 82  | AZITHROMYCIN DIHYDRATE .....               | 23 |
| <b>ASMANEX 60 METERED DOSES</b> .....         | 82  | <b>AZMACORT</b> .....                      | 82 |
| aspirin and caffeine and .....                | 86  | <b>AZOPT</b> .....                         | 80 |
| orphenadrine citrate .....                    |     | AZTREONAM .....                            | 20 |
| ASPIRIN AND DIPYRIDAMOLE .....                | 50  | azulfidine .....                           | 77 |
| aspirin/oxycodone .....                       | 11  | azulfidine en-tabs .....                   | 77 |
| <b>ASTELIN</b> .....                          | 82  |  |    |
| <b>ATACAND</b> .....                          | 55  | <b>B</b>                                   |    |
| <b>ATACAND HCT</b> .....                      | 55  | bac/poly/neomy/hc .....                    | 79 |
| atamet .....                                  | 41  | <b>baciim</b> .....                        | 17 |
| ATAZANAVIR SULFATE .....                      | 45  | bacitracin .....                           | 17 |
| <b>atenolol</b> .....                         | 52  | bacitracin zinc and neomycin sulfate ..... | 17 |
| <b>atenolol/chlorthalidone</b> .....          | 52  | and polymyxin b sulfate .....              |    |
| ATOMOXETINE HYDROCHLORIDE .....               | 58  | bacitracin zinc and polymyxin b .....      | 16 |
| ATORVASTATIN CALCIUM .....                    | 55  | sulfate .....                              |    |
| ATOVAQUONE .....                              | 40  | <b>bacitracin/neomycin/polymyxin</b> ..... | 17 |
| ATOVAQUONE AND PROGUANIL .....                | 40  | <b>bacitracin/polymyxin b</b> .....        | 17 |
| HYDROCHLORIDE .....                           |     | baclofen .....                             | 43 |
| <b>ATRIPLA</b> .....                          | 44  | bactroban .....                            | 18 |
| atropine sulfate .....                        | 62  | <b>BALACET 325</b> .....                   | 10 |
| ATROPINE SULFATE AND DIFENOXIN .....          | 62  | <b>balsalazide disodium</b> .....          | 77 |
| HYDROCHLORIDE .....                           |     | balziva .....                              | 68 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|   |    |   |    |
|---|----|---|----|
| <b>BANZEL</b> .....                             | 25 | BOSENTAN MONOHYDRATE .....                    | 84 |
| <b>BARACLUDE</b> .....                          | 45 | brethine .....                                | 84 |
| BASILIXIMAB .....                               | 73 | brevicon-28 .....                             | 69 |
| <b>BD INSULIN SYRINGE</b> .....                 | 47 | BRIMONIDINE TARTRATE .....                    | 80 |
| BECAPLERMIN .....                               | 60 | BRINZOLAMIDE .....                            | 80 |
| BECLOMETHASONE DIPROPIONATE .....               | 82 | <b>bromocriptine mesylate</b> .....           | 41 |
| <b>BECONASE AQ</b> .....                        | 82 | <b>budeprion sr</b> .....                     | 28 |
| benadryl .....                                  | 32 | <b>budeprion xl</b> .....                     | 28 |
| <b>benazepril hcl</b> .....                     | 55 | BUDESONIDE .....                              | 77 |
| <b>benazepril hcl/hydrochlorothiazide</b> ..... | 55 | BUDESONIDE AND FORMOTEROL FUMARATE ..         | 84 |
| <b>BENICAR</b> .....                            | 55 | DIHYDRATE .....                               |    |
| <b>BENICAR HCT</b> .....                        | 56 | <b>bumetanide</b> .....                       | 54 |
| bentyl .....                                    | 62 | bumex .....                                   | 54 |
| benzamycin .....                                | 59 | <b>BUPHENYL</b> .....                         | 61 |
| <b>benztropine mesylate</b> .....               | 41 | buprenex .....                                | 11 |
| <b>beta-val</b> .....                           | 65 | <b>buprenorphine hcl</b> .....                | 11 |
| betagan .....                                   | 81 | BUPRENORPHINE HYDROCHLORIDE .....             | 14 |
| BETAINE (TRIMETHYLGLYCINE) .....                | 61 | BUPRENORPHINE HYDROCHLORIDE AND .....         | 14 |
| BETAMETHASONE .....                             | 15 | NALOXONE HYDROCHLORIDE DIHYDRATE .....        |    |
| betamethasone dipropionate .....                | 65 | <b>bupropion hcl sr</b> .....                 | 28 |
| betamethasone valerate .....                    | 65 | buspar .....                                  | 46 |
| betapace .....                                  | 52 | <b>buspiron hcl</b> .....                     | 46 |
| <b>BETASERON</b> .....                          | 74 | <b>butalbital/apap/caffeine/codeine</b> ..... | 11 |
| BETAXOLOL .....                                 | 80 | <b>butorphanol tartrate</b> .....             | 11 |
| <b>betaxolol hcl</b> .....                      | 52 | <b>BYETTA</b> .....                           | 46 |
| betaxolol hydrochloride .....                   | 80 |   |    |
| <b>bethanechol chloride</b> .....               | 64 | <b>C</b>                                      |    |
| <b>BETIMOL</b> .....                            | 80 | cabergoline .....                             | 71 |
| <b>BETOPTIC-S</b> .....                         | 80 | <b>CADUET</b> .....                           | 54 |
| BEVACIZUMAB .....                               | 39 | caffeine and ergotamine tartrate .....        | 35 |
| BEXAROTENE .....                                | 40 | calan .....                                   | 52 |
| biaxin .....                                    | 22 | calan sr .....                                | 52 |
| biaxin xl .....                                 | 22 | CALCIPOTRIENE .....                           | 59 |
| BICALUTAMIDE .....                              | 72 | CALCITONIN, SALMON (RDNA) .....               | 78 |
| <b>BIDIL</b> .....                              | 56 | CALCITONIN,SALMON .....                       | 78 |
| <b>BILTRICIDE</b> .....                         | 40 | CALCITRIOL .....                              | 78 |
| BIMATOPROST .....                               | 81 | <b>calcium acetate</b> .....                  | 64 |
| BISMUTH SUBSALICYLATE AND .....                 | 62 | CALCIUM CARBONATE AND RISEDRONATE .....       | 77 |
| METRONIDAZOLE AND TETRACYCLINE HY-              |    | SODIUM .....                                  |    |
| DROCHLORIDE .....                               |    | <b>camila</b> .....                           | 70 |
| <b>bisoprolol fumarate</b> .....                | 52 | <b>CAMPATH</b> .....                          | 39 |
| <b>bisoprolol</b> .....                         | 53 | <b>CAMPRAL</b> .....                          | 31 |
| <b>fumarate/hydrochlorothiazide</b> .....       |    | <b>CANASA</b> .....                           | 77 |
| bleomycin sulfate .....                         | 38 | <b>CANCIDAS</b> .....                         | 33 |
| bleph-10 .....                                  | 24 | CANDESARTAN CILEXETIL .....                   | 55 |
| <b>BLEPHAMIDE</b> .....                         | 79 | CANDESARTAN CILEXETIL AND .....               | 55 |
| <b>BLEPHAMIDE S.O.P.</b> .....                  | 79 | HYDROCHLOROTHIAZIDE .....                     |    |
| <b>BONIVA</b> .....                             | 77 | <b>CANTIL</b> .....                           | 62 |
| <b>BOOSTRIX</b> .....                           | 75 | <b>CAPASTAT SULFATE</b> .....                 | 36 |
| <b>borofair</b> .....                           | 81 | <b>CAPEX</b> .....                            | 65 |
| BORTEZOMIB .....                                | 38 | capoten .....                                 | 56 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                      |    |  |    |
|--------------------------------------|----|--|----|
| capozide                             | 56 | <b>CELEBREX</b>                          | 10 |
| CAPREOMYCIN SULFATE                  | 36 | CELECOXIB                                | 10 |
| <b>captopril</b>                     | 56 | <b>CELESTONE</b>                         | 15 |
| <b>captopril/hydrochlorothiazide</b> | 56 | celexa                                   | 29 |
| carafate                             | 63 | <b>CELLCEPT</b>                          | 72 |
| CARBAMAZEPINE                        | 26 | <b>CELLCEPT INTRAVENOUS</b>              | 72 |
| <b>CARBATROL</b>                     | 26 | <b>CELONTIN</b>                          | 25 |
| CARBIDOPA MONOHYDRATE                | 41 | <b>CENESTIN</b>                          | 68 |
| CARBIDOPA MONOHYDRATE AND ENTACAPONE | 41 | cephalexin                               | 20 |
| AND LEVODOPA                         |    | <b>CEREBYX</b>                           | 26 |
| <b>carbidopa/levodopa</b>            | 41 | <b>CEREDASE</b>                          | 61 |
| <b>carbidopa/levodopa cr</b>         | 41 | <b>CEREZYME</b>                          | 61 |
| <b>carbidopa/levodopa odt</b>        | 41 | cesia                                    | 68 |
| <b>carbidopa/levodopa sr</b>         | 41 | cetirizine hcl                           | 82 |
| carbinoxamine maleate                | 82 | <b>CHANTIX</b>                           | 31 |
| cardene                              | 53 | CHLORAMBUCIL                             | 37 |
| cardizem                             | 51 | <b>chlordiazepoxide/amitriptyline</b>    | 28 |
| cardizem cd                          | 51 | <b>chlorhexidine gluconateoral rinse</b> | 59 |
| cardura                              | 51 | <b>chloroquine phosphate</b>             | 40 |
| <b>carimune nanofiltered</b>         | 74 | chlorothiazide                           | 54 |
| <b>carisoprodol</b>                  | 86 | <b>chlorpromazine hcl</b>                | 32 |
| <b>carisoprodol/aspirin</b>          | 86 | chlorpromazine hydrochloride             | 32 |
| <b>carisoprodol/aspirin/codeine</b>  | 86 | <b>chlorpropamide</b>                    | 46 |
| carmol-hc                            | 60 | chlorthalidone                           | 54 |
| carnitor                             | 61 | <b>chlorzoxazone</b>                     | 86 |
| CARTEOLOL HCL                        | 53 | <b>cholestyramine</b>                    | 54 |
| <b>cartia xt</b>                     | 51 | <b>cholestyramine light</b>              | 54 |
| <b>CARTROL</b>                       | 53 | <b>ciclopirox</b>                        | 33 |
| <b>carvedilol</b>                    | 53 | <b>ciclopirox nail lacquer</b>           | 33 |
| CARVEDILOL PHOSPHATE                 | 53 | <b>ciclopirox olamine</b>                | 33 |
| <b>CASODEX</b>                       | 72 | CIDOFOVIR DIHYDRATE                      | 43 |
| CASPOFUNGIN ACETATE                  | 33 | <b>cilostazol</b>                        | 50 |
| cataflam                             | 10 | ciloxan                                  | 23 |
| catapres                             | 50 | <b>cimetidine</b>                        | 63 |
| ceclor                               | 19 | CINACALCET HYDROCHLORIDE                 | 71 |
| <b>CEENU</b>                         | 37 | cipro                                    | 23 |
| <b>cefaclor</b>                      | 19 | <b>CIPRO HC</b>                          | 81 |
| <b>cefadroxil</b>                    | 19 | <b>CIPRODEX</b>                          | 81 |
| cefadroxil monohydrate               | 19 | ciprofloxacin and ciprofloxacin hcl      | 23 |
| CEFAZOLIN SODIUM                     | 19 | <b>ciprofloxacin er</b>                  | 23 |
| <b>cefdinir</b>                      | 19 | CIPROFLOXACIN HCL                        | 23 |
| CEFDITOREN PIVOXIL                   | 20 | CIPROFLOXACIN HCL AND DEXAMETHASONE      | 81 |
| CEFEPIME HYDROCHLORIDE               | 20 | CIPROFLOXACIN HCL AND HYDROCORTISONE     | 81 |
| CEFIXIME                             | 20 | CITALOPRAM HYDROBROMIDE                  | 29 |
| <b>cefoxitin sodium</b>              | 19 | <b>CLARINEX-D 12 HOUR</b>                | 85 |
| <b>cefpodoxime proxetil</b>          | 19 | <b>CLARINEX-D 24 HOUR</b>                | 85 |
| <b>cefprozil</b>                     | 19 | <b>clarithromycin</b>                    | 22 |
| ceftin                               | 20 | <b>clarithromycin er</b>                 | 22 |
| <b>ceftriaxone sodium</b>            | 20 | clemastine fumarate                      | 82 |
| <b>cefuroxime axetil</b>             | 20 | cleocin                                  | 17 |
| cefzil                               | 19 | cleocin-t                                | 17 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|  |    |                              |    |
|--|----|------------------------------|----|
| climara                                  | 68 | corgard                      | 53 |
| clindagel                                | 17 | <b>cormax</b>                | 65 |
| <b>clindamycin hcl</b>                   | 17 | cortef                       | 15 |
| CLINDAMYCIN PHOSPHATE                    | 17 | cortenema                    | 59 |
| <b>clindamycin phosphateadd-vantage</b>  | 17 | <b>CORTIFOAM</b>             | 59 |
| clinoril                                 | 10 | cortisone acetate            | 15 |
| <b>clobetasol propionate</b>             | 65 | cortisporin                  | 79 |
| <b>clobetasol propionate e</b>           | 65 | <b>cortomycin</b>            | 81 |
| <b>clomipramine hcl</b>                  | 29 | corzide                      | 53 |
| <b>clonidine hcl</b>                     | 50 | coumadin                     | 49 |
| CLONIDINE HYDROCHLORIDE                  | 50 | <b>COZAAR</b>                | 56 |
| CLOPIDOGREL BISULFATE                    | 50 | <b>CRESTOR</b>               | 54 |
| CLOSTRIDIUM BOTULINUM TOXIN TYPE B       | 86 | <b>CRINONE</b>               | 70 |
| clotrimazole                             | 34 | <b>CRIXIVAN</b>              | 45 |
| <b>clotrimazole/betamethasone</b>        | 59 | crolo                        | 80 |
| <b>dipropionate</b>                      |    | CROMOLYN SODIUM              | 62 |
| CLOZAPINE                                | 41 | <b>cryselle-28</b>           | 68 |
| clozaril                                 | 41 | <b>CUBICIN</b>               | 18 |
| <b>co-gesic</b>                          | 11 | cutivate                     | 66 |
| cogentin                                 | 41 | cyclessa                     | 68 |
| <b>COGNEX</b>                            | 27 | <b>cyclobenzaprine hcl</b>   | 86 |
| colazal                                  | 77 | cyclocort                    | 65 |
| COLCHICINE                               | 35 | <b>cyclophosphamide</b>      | 38 |
| colchicine and probenecid                | 35 | CYCLOSERINE                  | 36 |
| <b>COLCRYS</b>                           | 35 | CYCLOSPORINE                 | 72 |
| COLESEVELAM HYDROCHLORIDE                | 55 | <b>CYCLOSPORINE MODIFIED</b> | 72 |
| colestid                                 | 54 | <b>CYKLOKAPRON</b>           | 50 |
| <b>colestipol hcl</b>                    | 54 | <b>CYMBALTA</b>              | 29 |
| <b>colistimethate sodium</b>             | 17 | <b>cyproheptadine hcl</b>    | 82 |
| COLISTIN/HYDROCORTISONE/NEOMYCIN/THONZON |    | cyproheptadine hydrochloride | 82 |
| IUM                                      | 81 | <b>CYSTADANE</b>             | 61 |
| COLLAGENASE                              | 60 | <b>CYSTAGON</b>              | 61 |
| <b>colocort</b>                          | 59 | CYSTEAMINE BITARTRATE        | 61 |
| <b>COLY-MYCIN S</b>                      | 81 | <b>CYTOMEL</b>               | 71 |
| coly-mycin-m                             | 17 | cytotec                      | 63 |
| <b>colyte</b>                            | 62 | <b>CYTOVENE</b>              | 43 |
| colyte-flavor packs                      | 62 | cytoxan                      | 38 |
| <b>COMBIVENT</b>                         | 83 |                              |    |
| <b>COMBIVIR</b>                          | 44 | <b>D</b>                     |    |
| compazine                                | 43 | d.h.e. 45                    | 35 |
| <b>compro</b>                            | 42 | DACLIZUMAB                   | 73 |
| <b>COMTAN</b>                            | 41 | DALTEPARIN SODIUM            | 49 |
| <b>COMVAX</b>                            | 75 | danazol                      | 67 |
| <b>CONCERTA</b>                          | 58 | dantrium                     | 43 |
| condylox                                 | 60 | <b>dantrolene sodium</b>     | 43 |
| <b>constulose</b>                        | 62 | DAPSONE                      | 36 |
| <b>COPAXONE</b>                          | 74 | <b>DAPTACEL</b>              | 75 |
| copegus                                  | 45 | DAPTOMYCIN                   | 18 |
| cordarone                                | 51 | <b>DARAPRIM</b>              | 40 |
| coreg                                    | 53 | DARBEPOETIN ALFA             | 49 |
| <b>COREG CR</b>                          | 53 | DARIFENACIN HYDROBROMIDE     | 64 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|  |    |   |    |
|--|----|---|----|
| DARUNAVIR                                  | 45 | <b>DEXTROSE 10%/NACL 0.45%</b>                                  | 93 |
| darvocet                                   | 13 | <b>dextrose 5%/electrolyte #48 viaflex</b>                      | 94 |
| darvon                                     | 13 | dextrose (anhydrous)  | 94 |
| <b>DARVON-N</b>                            | 11 | <b>DEXTROSE (ANHYDROUS) AND POTASSIUM CHLORIDE</b>              | 97 |
| DASATINIB                                  | 39 | dextrose (anhydrous) and potassium chloride and sodium chloride | 98 |
| daypro                                     | 10 | <b>DEXTROSE (ANHYDROUS) AND SODIUM CHLORIDE</b>                 | 93 |
| ddavp                                      | 67 | <b>DEXTROSE (ANHYDROUS) AND VANCOMYCIN HYDROCHLORIDE</b>        | 19 |
| <b>decavac</b>                             | 75 | <b>dextrose 10%/nacl 0.2%</b>                                   | 94 |
| declomycin                                 | 24 | <b>dextrose 10%flex container</b>                               | 94 |
| DEFERASIROX                                | 31 | <b>dextrose 2.5%/sodium chloride 0.45%</b>                      | 95 |
| <b>del-beta</b>                            | 65 | <b>dextrose 5%</b>  | 95 |
| DELAVIRDINE MESYLATE                       | 44 | <b>dextrose 5%/nacl 0.2%</b>                                    | 95 |
| demadex                                    | 54 | <b>dextrose 5%/nacl 0.225%</b>                                  | 96 |
| <b>demeclocycline hcl</b>                  | 24 | <b>dextrose 5%/nacl 0.33%</b>                                   | 96 |
| demerol                                    | 12 | <b>dextrose 5%/nacl 0.45%</b>                                   | 96 |
| <b>DENAVIR</b>                             | 45 | <b>dextrose 5%/nacl 0.9%</b>                                    | 97 |
| DENILEUKIN DIFTITOX                        | 38 | <b>DEXTROSE 5%/POTASSIUM CHLORIDE 0.075%</b>                    | 97 |
| <b>DEPACON</b>                             | 25 | dextrostat  | 57 |
| <b>depade</b>                              | 31 | diabeta   | 46 |
| depakene                                   | 26 | diabinese   | 46 |
| depakote                                   | 25 | diamox  | 80 |
| <b>DEPAKOTE ER</b>                         | 35 | DIAZOXIDE   | 47 |
| <b>DEPAKOTE SPRINKLES</b>                  | 25 | <b>diclofenac potassium</b>                                     | 10 |
| <b>DEPEN TITRATABS</b>                     | 31 | <b>diclofenac sodium</b>  | 10 |
| depo-medrol                                | 15 | DICLOFENAC SODIUM AND MISOPROSTOL                               | 15 |
| depo-provera contraceptive                 | 70 | <b>diclofenac sodium ec</b>                                     | 10 |
| <b>DERMA-SMOOTH/FS BODY OIL</b>            | 65 | <b>diclofenac sodium xr</b>                                     | 10 |
| dermatop                                   | 66 | diclox  | 21 |
| <b>DERMOTIC</b>                            | 81 | <b>dicloxacillin sodium</b>                                     | 21 |
| <b>desipramine hcl</b>                     | 30 | <b>dicyclomine hcl</b>  | 62 |
| DES LorATADINE AND PSEUDOEPHEDRINE SULFATE | 85 | DIDANOSINE  | 44 |
| DESMOPRESSIN ACETATE                       | 67 | didronel  | 78 |
| desogen                                    | 68 | <b>DIFFERIN</b>   | 59 |
| desogestrel and ethinyl estradiol          | 69 | diflorasone diacetate   | 65 |
| <b>desonide</b>                            | 65 | diflucan  | 34 |
| desowen                                    | 65 | <b>diflunisal</b>   | 10 |
| <b>desoximetasone</b>                      | 65 | DIGOXIN   | 54 |
| desryl                                     | 28 | DIHYDROERGOTAMINE MESYLATE                                      | 35 |
| DESVENLAFAXINE                             | 29 | dilacor xr  | 51 |
| <b>DETROL</b>                              | 64 | <b>DILANTIN</b>   | 26 |
| <b>DETROL LA</b>                           | 64 | dilaudid  | 12 |
| dexamethasone                              | 15 | <b>dilt-cd</b>  | 51 |
| DEXAMETHASONE AND TOBRAMYCIN SULFATE       | 79 | <b>dilt-xr</b>  | 51 |
| dexamethasone sodium phosphate             | 80 | <b>diltiazem cd</b>   | 51 |
| <b>dexasporin</b>                          | 79 | <b>diltiazem hcl</b>  | 51 |
| dexchlorpheniramine maleate                | 82 | <b>diltiazem hcl er</b>   | 51 |
| <b>dexmethylphenidate hcl</b>              | 58 |   |    |
| dextroamphetamine sulfate                  | 57 |   |    |
| <b>dextroamphetamine sulfateer</b>         | 57 |   |    |
| dextrose                                   | 94 |   |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|   |    |                              |    |
|---|----|------------------------------|----|
| diltiazem hydrochloride                   | 51 | elavil                       | 29 |
| <b>DIOVAN</b>                             | 56 | eldepryl                     | 41 |
| <b>DIOVAN HCT</b>                         | 56 | ELETRIPTAN HYDROBROMIDE      | 35 |
| <b>DIPENTUM</b>                           | 77 | <b>ELIDEL</b>                | 59 |
| <b>diphenhydramine hcl</b>                | 32 | elimite                      | 40 |
| diphenhydramine hydrochloride             | 32 | <b>ELITEK</b>                | 38 |
| <b>diphenoxylate/atropine</b>             | 62 | elocon                       | 66 |
| diphtheria toxoid and tetanus toxoid      | 75 | <b>EMCYT</b>                 | 37 |
| <b>DIPHThERIA/TETANUS TOXOIDPEDIATRIC</b> | 75 | <b>EMEND</b>                 | 32 |
| <b>dipivefrin hcl</b>                     | 80 | emla                         | 14 |
| diprolene                                 | 65 | <b>EMSAM</b>                 | 28 |
| <b>dipyridamole</b>                       | 50 | EMTRICITABINE                | 44 |
| <b>disopyramide phosphate</b>             | 51 | EMTRICITABINE AND TENOFOVIR  | 44 |
| ditropan                                  | 64 | DISOPROXIL FUMARATE          |    |
| ditropan xl                               | 64 | <b>EMTRIVA</b>               | 44 |
| DIVALPROEX SODIUM                         | 25 | <b>ENABLEX</b>               | 64 |
| DOFETILIDE                                | 52 | enalapril maleate            | 56 |
| DOLASETRON MESYLATE                       | 32 | enalapril                    | 56 |
| dolobid                                   | 10 | maleate/hydrochlorothiazide  |    |
| dolophine                                 | 12 | <b>ENBREL</b>                | 72 |
| dolophine hcl                             | 12 | <b>ENBREL SURECLICK</b>      | 72 |
| DONEPEZIL HYDROCHLORIDE                   | 27 | endocet                      | 11 |
| doryx                                     | 24 | endodan                      | 11 |
| <b>DOVONEX</b>                            | 59 | ENFUVIRTIDE                  | 44 |
| <b>doxazosin mesylate</b>                 | 51 | <b>ENGERIX-B</b>             | 76 |
| <b>doxepin hcl</b>                        | 30 | ENOXAPARIN SODIUM            | 49 |
| DOXERCALCIFEROL                           | 78 | <b>enpresse-28</b>           | 68 |
| DOXYCYCLINE                               | 60 | ENTACAPONE                   | 41 |
| doxycycline hyclate                       | 24 | ENTECAVIR MONOHYDRATE        | 45 |
| <b>doxycycline monohydrate</b>            | 24 | <b>ENTOCORT EC</b>           | 77 |
| <b>dronabinol</b>                         | 32 | enulose                      | 62 |
| drospirenone/ethinyl estradiol            | 69 | EPINEPHRINE                  | 84 |
| <b>DROXIA</b>                             | 37 | <b>epinephrine hcl</b>       | 84 |
| DULOXETINE HYDROCHLORIDE                  | 29 | epinephrine hydrochloride    | 84 |
| duragesic                                 | 11 | <b>EPIPEN</b>                | 84 |
| DUTASTERIDE                               | 64 | epitol                       | 26 |
| dyazide                                   | 54 | <b>EPIVIR</b>                | 44 |
| <b>E</b>                                  |    | <b>EPIVIR HBV</b>            | 44 |
| ECHOTHIOPHATE IODIDE                      | 81 | eplerenone                   | 54 |
| econazole nitrate                         | 34 | EPOETIN ALFA                 | 50 |
| econopred plus                            | 80 | <b>EPOGEN</b>                | 50 |
| <b>ed k+10</b>                            | 97 | <b>EPZICOM</b>               | 44 |
| EFAVIRENZ                                 | 44 | <b>EQUETRO</b>               | 46 |
| EFAVIRENZ AND EMTRICITABINE AND           | 44 | <b>ERAXIS</b>                | 34 |
| TENOFOVIR DISOPROXIL FUMARATE             |    | ergoloid mesylates           | 27 |
| effexor                                   | 29 | <b>ERGOMAR</b>               | 35 |
| <b>EFFEXOR XR</b>                         | 29 | ergot                        | 27 |
| efudex                                    | 59 | ERGOTAMINE TARTRATE          | 35 |
| <b>8-MOP</b>                              | 59 | ergotamine tartrate/caffeine | 35 |
| <b>ELAPRASE</b>                           | 61 | ERLOTINIB                    | 39 |
|   |    | errin                        | 70 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|  |    |                               |    |
|--|----|-------------------------------|----|
| ERTAPENEM SODIUM                       | 20 | <b>EXELON</b>                 | 28 |
| <b>ery</b>                             | 22 | EXEMESTANE                    | 39 |
| <b>ery-tab</b>                         | 22 | EXENATIDE                     | 46 |
| <b>ERYTHROCIN LACTOBIONATE</b>         | 23 | <b>EXFORGE</b>                | 53 |
| <b>erythrocin stearate</b>             | 23 | <b>EXFORGE HCT</b>            | 53 |
| erythromycin                           | 18 | <b>EXJADE</b>                 | 31 |
| ERYTHROMYCIN LACTOBIONATE              | 23 | EZETIMIBE                     | 55 |
| <b>erythromycin/benzoyl peroxide</b>   | 59 | EZETIMIBE AND SIMVASTATIN     | 55 |
| <b>erythromycin/sulfisoxazole</b>      | 18 |                               |    |
| ESCITALOPRAM OXALATE                   | 29 | <b>F</b>                      |    |
| ESOMEPRAZOLE MAGNESIUM TRIHYDRATE      | 63 | <b>FABRAZYME</b>              | 61 |
| ESOMEPRAZOLE SODIUM                    | 63 | <b>FACTIVE</b>                | 23 |
| estrace                                | 68 | <b>famciclovir</b>            | 45 |
| <b>ESTRADERM</b>                       | 68 | <b>famotidine</b>             | 63 |
| ESTRADIOL                              | 68 | famvir                        | 45 |
| ESTRADIOL AND NORETHINDRONE ACETATE    | 68 | <b>FANSIDAR</b>               | 40 |
| ESTRADIOL AND NORGESTIMATE             | 69 | <b>FARESTON</b>               | 37 |
| ESTRADIOL HEMIHYDRATE                  | 68 | <b>FAZACLO</b>                | 41 |
| <b>estradiol/norethindrone acetate</b> | 68 | FELBAMATE                     | 26 |
| ESTRAMUSTINE PHOSPHATE SODIUM          | 37 | <b>FELBATOL</b>               | 26 |
| <b>ESTRASORB</b>                       | 68 | feldene                       | 10 |
| <b>ESTRING</b>                         | 68 | <b>felodipine er</b>          | 53 |
| ESTROGENS, CONJUGATED                  | 69 | <b>FEMARA</b>                 | 39 |
| ESTROGENS, CONJUGATED AND              | 69 | <b>FEMHRT 1/5</b>             | 69 |
| MEDROXYPROGESTERONE ACETATE            |    | <b>FEMHRT LOW DOSE</b>        | 69 |
| ESTROGENS, CONJUGATED SYNTHETIC A      | 68 | <b>fenofibrate</b>            | 54 |
| ESTROGENS, ESTERIFIED                  | 69 | <b>fenofibrate micronized</b> | 54 |
| <b>estropipate</b>                     | 68 | FENOFIBRIC ACID               | 55 |
| estrostep fe                           | 70 | fenoprofen calcium            | 10 |
| ETANERCEPT                             | 72 | <b>fentanyl</b>               | 11 |
| <b>ethambutol hcl</b>                  | 36 | FESOTERODINE FUMARATE         | 64 |
| ethinyl estradiol and ethynodiol       | 69 | <b>fexofenadine hcl</b>       | 82 |
| diacetate                              |    | FILGRASTIM                    | 50 |
| ETHINYL ESTRADIOL AND ETONOGESTREL     | 69 | <b>finasteride</b>            | 64 |
| ethinyl estradiol and levonorgestrel   | 68 | fioricet/codeine              | 11 |
| ETHINYL ESTRADIOL AND NORELGESTROMIN   | 69 | fiorinal/codeine #3           | 10 |
| ethinyl estradiol and norethindrone    | 69 | flagyl                        | 18 |
| ETHINYL ESTRADIOL AND NORETHINDRONE    | 69 | <b>FLAREX</b>                 | 80 |
| ACETATE                                |    | <b>flavoxate hcl</b>          | 64 |
| ethinyl estradiol and norgestimate     | 70 | <b>flebogamma</b>             | 74 |
| ethinyl estradiol and norgestrel       | 69 | <b>flecainide acetate</b>     | 51 |
| ETHIONAMIDE                            | 36 | flexeril                      | 86 |
| <b>ethosuximide</b>                    | 25 | <b>FLOMAX</b>                 | 64 |
| ETHOTOIN                               | 27 | flonase                       | 82 |
| ETIDRONATE DISODIUM                    | 78 | <b>FLOVENT DISKUS</b>         | 82 |
| <b>etodolac</b>                        | 10 | <b>FLOVENT HFA</b>            | 82 |
| <b>etodolac er</b>                     | 10 | floxacin                      | 23 |
| ETRAVIRINE                             | 44 | <b>fluconazole</b>            | 34 |
| EVEROLIMUS                             | 37 | FLUCYTOSINE                   | 33 |
| <b>EVISTA</b>                          | 70 | fludrocortisone acetate       | 66 |
| <b>EXELDERM</b>                        | 34 | flumadine                     | 45 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                      |     |                                     |    |
|--------------------------------------|-----|-------------------------------------|----|
| FLUNISOLIDE                          | 81  | <b>FUZEON</b>                       | 44 |
| FLUCINOLONE ACETONIDE                | 65  | <b>G</b>                            |    |
| fluocinonide                         | 66  | <b>GABAPENTIN</b>                   | 25 |
| <b>fluocinonide emollient base</b>   | 66  | <b>GABITRIL</b>                     | 25 |
| <b>fluor-op</b>                      | 80  | GALANTAMINE HYDROBROMIDE            | 28 |
| fluoride prepartion                  | 107 | GALSULFASE                          | 61 |
| FLUROMETHOLONE                       | 80  | <b>gamastan s/d</b>                 | 74 |
| FLUROMETHOLONE ACETATE               | 80  | <b>gammagard liquid</b>             | 74 |
| <b>fluorouracil</b>                  | 59  | gamunex                             | 74 |
| <b>fluoxetine hcl</b>                | 29  | ganciclovir                         | 43 |
| FLUOXETINE HCL AND OLANZAPINE        | 42  | GANCICLOVIR SODIUM                  | 43 |
| fluphenazine decanoate               | 43  | <b>GANTRISIN PEDIATRIC</b>          | 24 |
| <b>fluphenazine hcl</b>              | 43  | <b>GARDASIL</b>                     | 76 |
| fluphenazine hydrochloride           | 43  | <b>GASTROCROM</b>                   | 62 |
| <b>flurbiprofen</b>                  | 10  | GATIFLOXACIN SESQUIHYDRATE          | 24 |
| <b>flurbiprofen sodium</b>           | 80  | <b>GAUZE PADS</b>                   | 47 |
| flutamide                            | 72  | GAUZE PADS AND DRESSING - 2X2       | 47 |
| FLUTICASONE FUROATE                  | 82  | GEFITINIB                           | 39 |
| <b>fluticasone propionate</b>        | 66  | <b>gemfibrozil</b>                  | 54 |
| FLUTICASONE PROPIONATE AND           | 83  | GEMIFLOXACIN MESYLATE               | 23 |
| SALMETEROL XINAFOATE                 |     | GEMTUZUMAB OZOGAMICIN               | 39 |
| FLUTICASONE/SALMETEROL               | 82  | <b>gengraf</b>                      | 72 |
| FLUVASTATIN SODIUM                   | 54  | <b>genoptic</b>                     | 15 |
| FLUVOXAMINE MALEATE                  | 29  | <b>GENOTROPIN</b>                   | 67 |
| <b>FML</b>                           | 80  | <b>GENOTROPIN MINIQUICK</b>         | 67 |
| <b>FML FORTE</b>                     | 80  | <b>gentak</b>                       | 16 |
| fml liquifilm                        | 80  | gentamicin sulfate                  | 15 |
| focalin                              | 58  | GENTAMICIN SULFATE AND PREDNISOLONE | 79 |
| FOMEPIZOLE (4-METHYLPYRAZOLE)        | 30  | ACETATE                             |    |
| FONDAPARINUX SODIUM                  | 49  | GENTAMICIN SULFATE/PREDNISOLONE     | 79 |
| <b>FORADIL AEROLIZER</b>             | 84  | <b>gentasol</b>                     | 16 |
| FORMOTEROL FUMARATE                  | 84  | <b>GEODON</b>                       | 41 |
| <b>FORTEO</b>                        | 78  | GLATIRAMER                          | 74 |
| <b>FORTICAL</b>                      | 78  | <b>GLEEVEC</b>                      | 39 |
| fosamax                              | 77  | <b>glimepiride</b>                  | 46 |
| FOSAMPRENAVIR CALCIUM                | 45  | GLIMEPIRIDE AND ROSIGLITAZONE       | 46 |
| FOSCARNET SODIUM                     | 43  | MALEATE                             |    |
| <b>FOSCAVIR</b>                      | 43  | <b>glipizide</b>                    | 46 |
| FOSFOMYCIN TROMETHAMINE (TROMETAMOL) | 18  | <b>glipizide er</b>                 | 46 |
| <b>fosinopril sodium</b>             | 56  | <b>glipizide xl</b>                 | 46 |
| <b>fosinopril</b>                    | 56  | <b>glipizide/metformin hcl</b>      | 46 |
| sodium/hydrochlorothiazide           |     | globulin, immune                    | 74 |
| FOSPHENYTOIN SODIUM                  | 26  | globulin, immune iv (baxter/am red  | 74 |
| <b>FOSRENOL</b>                      | 65  | cros)                               |    |
| <b>FRAGMIN</b>                       | 49  | globulin, immune iv (octapharm)     | 74 |
| <b>freamine iii</b>                  | 97  | GLOBULIN, IMMUNE SC (ZLB BEHRING)   | 74 |
| <b>FREAMINE III 3%</b>               | 98  | <b>GLUCAGEN HYPOKIT</b>             | 47 |
| <b>FROVA</b>                         | 35  | <b>GLUCAGON EMERGENCY KIT</b>       | 47 |
| FROVATRIPTAN SUCCINATE MONOHYDRATE   | 35  | GLUCAGON HYDROCHLORIDE (RDNA)       | 47 |
| <b>FURADANTIN</b>                    | 18  | GLUCAGON RDNA (HUMAN RECOMBINANT)   | 47 |
| <b>furosemide</b>                    | 54  |                                     |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en negritas) y nombres de medicamentos alternativos

|  |    |   |    |
|--|----|---|----|
| glucophage                                       | 47 | <b>HEPSERA</b>                              | 45 |
| glucophage xr                                    | 47 | <b>HERCEPTIN</b>                            | 39 |
| glucotrol  | 46 | <b>HEXALEN</b>                              | 37 |
| glucotrol xl                                     | 46 | hiprex                                      | 18 |
| glucovance                                       | 46 | <b>HUMALOG</b>                              | 47 |
| <b>glyburide</b>                                 | 46 | <b>HUMALOG MIX 50/50</b>                    | 47 |
| <b>glyburide micronized</b>                      | 46 | <b>HUMALOG MIX 75/25</b>                    | 47 |
| <b>glyburide/metformin hcl</b>                   | 46 | <b>HUMATROPE</b>                            | 67 |
| glycerin and phospholipids and<br>soybean oil    | 98 | <b>HUMIRA</b>                               | 72 |
| <b>glycopyrrolate</b>                            | 62 | <b>HUMULIN 50/50</b>                        | 48 |
| <b>glycron</b>                                   | 46 | <b>HUMULIN 70/30</b>                        | 48 |
| glynase  | 46 | <b>HUMULIN N</b>                            | 48 |
| <b>GLYSET</b>                                    | 47 | <b>HUMULIN R</b>                            | 48 |
| <b>granisetron hcl</b>                           | 32 | <b>hydralazine hcl</b>                      | 56 |
| <b>granisol</b>                                  | 32 | hydralazine hydrochloride                   | 56 |
| gris-peg   | 34 | <b>HYDRALAZINE HYDROCHLORIDE AND</b>        | 56 |
| <b>griseofulvin microsize</b>                    | 34 | <b>ISOSORBIDE DINITRATE</b>                 |    |
| guanabenz acetate                                | 50 | hydra                                       | 37 |
| <b>guanfacine hcl</b>                            | 50 | <b>hydrochlorothiazide</b>                  | 54 |
| <b>GUANIDINE HCL</b>                             | 36 | <b>HYDROCHLOROTHIAZIDE AND IRBESARTAN</b>   | 55 |
| <b>GUANIDINE HYDROCHLORIDE</b>                   | 36 | <b>HYDROCHLOROTHIAZIDE AND LOSARTAN</b>     | 56 |
| <b>gynodiol</b>                                  | 69 | <b>POTASSIUM</b>                            |    |
|  |    | hydrochlorothiazide and methyldopa          | 50 |
|  |    | <b>HYDROCHLOROTHIAZIDE AND OLMESARTAN</b>   | 56 |
|  |    | <b>MEDOXOMIL</b>                            |    |
| <b>H</b>   |    | hydrochlorothiazide and propranolol         | 53 |
| <b>HAEMOPHILUS B POLYSACCHARIDE CONJ</b>         | 75 | hydrochloride                               |    |
| <b>VACC</b>                                      |    | <b>HYDROCHLOROTHIAZIDE AND TELMISARTAN</b>  | 56 |
| <b>HAEMOPHILUS B POLYSACCHARIDE CONJ</b>         | 75 | <b>HYDROCHLOROTHIAZIDE AND VALSARTAN</b>    | 56 |
| <b>VACC AND HEPATITIS B VIRUS VACCINE RECOM-</b> |    | <b>hydrocodone bitartrate/acetaminophen</b> | 11 |
| <b>BINANT</b>                                    |    | <b>hydrocodone/acetaminophen</b>            | 11 |
| <b>HALCINONIDE</b>                               | 66 | <b>hydrocodone/ibuprofen</b>                | 12 |
| haldol   | 43 | hydrocort                                   | 66 |
| haldol decanoate                                 | 43 | <b>hydrocortisone</b>                       | 15 |
| <b>halobetasol propionate</b>                    | 66 | <b>HYDROCORTISONE ACETATE</b>               | 59 |
| <b>HALOG</b>                                     | 66 | <b>hydrocortisone butyrate</b>              | 66 |
| haloperidol                                      | 43 | <b>hydrocortisone in absorbase</b>          | 66 |
| haloperidol decanoate                            | 43 | <b>hydrocortisone valerate</b>              | 66 |
| haloperidol lactate                              | 43 | <b>hydromorphone hcl</b>                    | 12 |
| <b>HAVRIX</b>                                    | 76 | <b>hydroxychloroquine sulfate</b>           | 40 |
| <b>HECTOROL</b>                                  | 78 | <b>HYDROXYPROPYL CELLULOSE</b>              | 79 |
| <b>HELIDAC</b>                                   | 62 | <b>HYDROXYUREA</b>                          | 37 |
| <b>HEPARIN SODIUM</b>                            | 49 | <b>hydroxyzine hcl</b>                      | 82 |
| <b>HEPARIN SODIUM (PORCINE)</b>                  | 49 | hydroxyzine hydrochloride                   | 82 |
| hepatasol  | 92 | <b>hydroxyzine pamoate</b>                  | 32 |
| <b>HEPATITIS A VIRUS VACCINE</b>                 | 76 | hytone                                      | 66 |
| <b>INACTIVATED</b>                               |    | hytrin                                      | 51 |
| <b>HEPATITIS A VIRUS VACCINE</b>                 | 76 | <b>HYZAAR</b>                               | 56 |
| <b>INACTIVATED AND HEPATITIS B VIRUS VACCINE</b> |    |   |    |
| <b>RECOMBINANT</b>                               |    |   |    |
| <b>HEPATITIS B VIRUS VACCINE</b>                 | 76 |   |    |
| <b>RECOMBINANT</b>                               |    |   |    |
|  |    | <b>I</b>                                    |    |
|  |    | <b>IBANDRONATE SODIUM</b>                   | 77 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                       |    |  |     |
|---------------------------------------|----|--|-----|
| <b>ibuprofen</b> .....                | 10 | <b>IPOL INACTIVATED IPV</b> .....      | 76  |
| IDURSULFASE .....                     | 61 | IPRATROPIUM BROMIDE .....              | 83  |
| ILOPROST .....                        | 85 | IRBESARTAN .....                       | 55  |
| IMATINIB MESYLATE .....               | 39 | <b>IRESSA</b> .....                    | 39  |
| imdur .....                           | 57 | <b>ISENTRESS</b> .....                 | 44  |
| IMIGLUCERASE .....                    | 61 | ismo .....                             | 57  |
| <b>imipramine hcl</b> .....           | 30 | ISOCARBOXAZID .....                    | 28  |
| IMIPRAMINE PAMOATE .....              | 30 | <b>isochron</b> .....                  | 56  |
| IMIQUIMOD .....                       | 59 | <b>isonarif</b> .....                  | 36  |
| imitrex .....                         | 35 | isoniazid .....                        | 36  |
| <b>IMOVAX RABIES (H.D.C.V.)</b> ..... | 76 | ISONIAZID AND PYRAZINAMIDE AND         | 36  |
| imuran .....                          | 72 | RIFAMPIN .....                         | 36  |
| indapamide .....                      | 54 | ISONIAZID AND RIFAMPIN .....           | 36  |
| inderal la .....                      | 52 | ISOPROPYL ALCOHOL PAD .....            | 47  |
| INDINAVIR SULFATE .....               | 45 | isoptin sr .....                       | 52  |
| indocin .....                         | 10 | isordil titradose .....                | 57  |
| indocin sr .....                      | 10 | isosorbide dinitrate .....             | 56  |
| <b>indomethacin</b> .....             | 10 | <b>isosorbide dinitrate er</b> .....   | 57  |
| <b>indomethacin er</b> .....          | 10 | <b>isosorbide mononitrate</b> .....    | 57  |
| <b>INFANRIX</b> .....                 | 76 | <b>isosorbide mononitrate er</b> ..... | 57  |
| <b>INFERGEN</b> .....                 | 74 | <b>isovate</b> .....                   | 66  |
| INFLIXIMAB .....                      | 73 | isradipine .....                       | 53  |
| <b>INNOHEP</b> .....                  | 49 | <b>itraconazole</b> .....              | 34  |
| inspra .....                          | 54 | IVERMECTIN .....                       | 40  |
| INSULIN ASPART (HUMAN ANALOG) .....   | 48 |  |     |
| INSULIN ASPART (HUMAN ANALOG) AND     | 48 | <b>J</b>                               |     |
| INSULIN ASPART PROTAMINE              |    | <b>jantoven</b> .....                  | 49  |
| INSULIN DETEMIR .....                 | 48 | <b>JANUMET</b> .....                   | 47  |
| INSULIN GLARGINE .....                | 48 | <b>JANUVIA</b> .....                   | 47  |
| INSULIN GLULISINE .....               | 47 | JAPANESE ENCEPHALITIS VIRUS VACCINE    | 76  |
| INSULIN HUMAN (REGULAR) .....         | 48 | <b>JE-VAX</b> .....                    | 76  |
| INSULIN HUMAN (REGULAR) AND INSULIN   | 48 | <b>jolivette</b> .....                 | 70  |
| HUMAN, ISOPHANE (NPH)                 |    | <b>junel</b> .....                     | 69  |
| INSULIN HUMAN, ISOPHANE (NPH) .....   | 48 |  |     |
| INSULIN LISPRO .....                  | 47 | <b>K</b>                               |     |
| INSULIN LISPRO AND INSULIN LISPRO     | 47 | k-tabs .....                           | 97  |
| PROTAMINE (NPL)                       |    | <b>KADIAN</b> .....                    | 12  |
| INSULIN SAFETY SYRINGE .....          | 47 | <b>KALETRA</b> .....                   | 45  |
| <b>INTELENCE</b> .....                | 44 | kanamycin sulfate .....                | 16  |
| INTERFERON ALFA-2B .....              | 74 | <b>kaon-cl-10</b> .....                | 98  |
| INTERFERON ALFA-N3 .....              | 74 | <b>kariva</b> .....                    | 69  |
| INTERFERON ALFACON-1 .....            | 74 | <b>kcl 0.075%/d5w/nacl 0.45%</b> ..... | 98  |
| INTERFERON BETA .....                 | 74 | <b>KCL 0.15%/D10W/NAACL 0.2%</b> ..... | 99  |
| INTERFERON BETA-1A .....              | 74 | KCL 0.15%/D5W/LR .....                 | 99  |
| INTERFERON GAMMA-1B .....             | 74 | <b>kcl 0.15%/d5w/nacl 0.2%</b> .....   | 99  |
| <b>intralipid</b> .....               | 98 | <b>kcl 0.15%/d5w/nacl 0.225%</b> ..... | 100 |
| <b>INTRON-A</b> .....                 | 74 | <b>kcl 0.224%/d5w/nacl 0.2%</b> .....  | 100 |
| <b>INVANZ</b> .....                   | 20 | KCL 0.3%/D5W/LR IV LAC RING .....      | 100 |
| <b>INVEGA</b> .....                   | 42 | <b>kcl 0.3%/d5w/nacl 0.2%</b> .....    | 101 |
| <b>INVIRASE</b> .....                 | 45 | <b>kcl 0.3%/d5w/nacl 0.45%</b> .....   | 101 |
| <b>IOPIDINE</b> .....                 | 80 | <b>KCL 0.3%/D5W/NAACL 0.9%</b> .....   | 101 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                 |     |                                       |    |
|---------------------------------|-----|---------------------------------------|----|
| keflex                          | 20  | leuprolide acetate                    | 71 |
| <b>kelnor 1/35</b>              | 69  | LEVALBUTEROL TARTRATE                 | 84 |
| kenalog                         | 66  | <b>LEVAQUIN</b>                       | 23 |
| keppra                          | 25  | LEVATOL                               | 53 |
| <b>KEPPRA XR</b>                | 25  | <b>LEVEMIR</b>                        | 48 |
| kerlone                         | 52  | LEVETIRACETAM                         | 25 |
| ketoconazole                    | 34  | levlite-28                            | 68 |
| <b>ketoprofen er</b>            | 10  | levo-dromoran                         | 12 |
| <b>ketorolac tromethamine</b>   | 10  | <b>levobunolol hcl</b>                | 81 |
| <b>KINERET</b>                  | 74  | <b>levocarnitine</b>                  | 61 |
| klaron                          | 24  | LEVOFLOXACIN HEMIHYDRATE              | 23 |
| klor-con                        | 106 | LEVONORGESTREL                        | 70 |
| <b>klor-con 10</b>              | 101 | <b>levora 0.15/30-28</b>              | 69 |
| <b>klor-con 8</b>               | 101 | <b>levorphanol tartrate</b>           | 12 |
| <b>klor-con m20</b>             | 101 | <b>levothroid</b>                     | 71 |
| kuric                           | 34  | LEVOTHYROXINE SODIUM                  | 71 |
| kytril                          | 32  | levoxyl                               | 71 |
| <b>L</b>                        |     | <b>LEXAPRO</b>                        | 29 |
| <b>labetalol hcl</b>            | 53  | <b>LEXIVA</b>                         | 45 |
| lac-hydrin                      | 59  | <b>lidocaine</b>                      | 59 |
| <b>laclotion</b>                | 59  | <b>lidocaine hcl</b>                  | 14 |
| LACOSAMIDE                      | 25  | <b>lidocaine hcl jelly</b>            | 14 |
| <b>LACRISERT</b>                | 79  | lidocaine hydrochloride               | 59 |
| lactated ringer's               | 102 | <b>lidocaine/prilocaine</b>           | 14 |
| <b>lactated ringers viaflex</b> | 102 | <b>LIDODERM</b>                       | 60 |
| lactulose                       | 62  | limbitrol                             | 28 |
| lamactil                        | 26  | lindane                               | 40 |
| lamisil                         | 34  | LINEZOLID                             | 19 |
| LAMIVUDINE                      | 44  | LIOTHYRONINE SODIUM                   | 71 |
| LAMIVUDINE AND ZIDOVUDINE       | 44  | LIOTRIX                               | 71 |
| <b>lamotrigine</b>              | 26  | <b>LIPITOR</b>                        | 55 |
| lanoxin                         | 54  | <b>LIPRAM</b>                         | 61 |
| LANSOPRAZOLE                    | 63  | <b>lisinopril</b>                     | 56 |
| LANSOPRAZOLE AND NAPROXEN       | 15  | <b>lisinopril/hydrochlorothiazide</b> | 56 |
| LANTHANUM CARBONATE             | 65  | lithium carbonate                     | 46 |
| <b>LANTUS</b>                   | 48  | <b>lithium carbonate er</b>           | 46 |
| LAPATINIB DITOSYLATE            | 38  | lithium citrate                       | 46 |
| lariam                          | 40  | lithobid                              | 46 |
| LARONIDASE                      | 60  | lo/ovral-28                           | 68 |
| lasix                           | 54  | locoid                                | 66 |
| LATANOPROST                     | 81  | iodine                                | 10 |
| <b>leena</b>                    | 69  | iodine xl                             | 10 |
| <b>leflunomide</b>              | 74  | <b>LODOSYN</b>                        | 41 |
| LENALIDOMIDE                    | 37  | LODOXAMIDE TROMETHAMINE (TROMETAMOL)  | 80 |
| <b>LESCOL</b>                   | 54  | loestrin                              | 69 |
| <b>LESCOL XL</b>                | 55  | lofibra                               | 54 |
| <b>lessina-28</b>               | 69  | <b>lokara</b>                         | 66 |
| LETROZOLE                       | 39  | lomotil                               | 62 |
| LEUCOVORIN CALCIUM              | 31  | LOMUSTINE                             | 37 |
| <b>LEUKERAN</b>                 | 37  | <b>lonox</b>                          | 62 |
|                                 |     | lopid                                 | 54 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                   |     |                                     |    |
|-----------------------------------|-----|-------------------------------------|----|
| LOPINAVIR AND RITONAVIR           | 45  | maxitrol                            | 79 |
| lopressor                         | 53  | maxzide                             | 54 |
| lopressor hct                     | 53  | MEASLES VIRUS VACCINE LIVE          | 75 |
| loprox                            | 33  | mebendazole                         | 40 |
| <b>LOPROX SHAMPOO</b>             | 34  | <b>meclizine hcl</b>                | 32 |
| lorcet                            | 11  | meclofenamate sodium                | 10 |
| lortab                            | 11  | medrol                              | 15 |
| LOSARTAN POTASSIUM                | 56  | medrol dosepak                      | 15 |
| <b>LOTEMAX</b>                    | 80  | <b>medroxyprogesterone acetate</b>  | 70 |
| lotensin                          | 55  | <b>mefloquine hcl</b>               | 40 |
| lotensin hct                      | 55  | mefoxin                             | 19 |
| LOTEPREDNOL ETABONATE             | 80  | <b>MEGACE ES</b>                    | 70 |
| lotrel                            | 53  | megace oral                         | 70 |
| lotrisone                         | 59  | MEGESTROL ACETATE                   | 70 |
| <b>LOTRONEX</b>                   | 63  | <b>meloxicam</b>                    | 10 |
| lovastatin                        | 55  | MEMANTINE HYDROCHLORIDE             | 28 |
| LOVASTATIN AND NIACIN             | 54  | <b>MENACTRA</b>                     | 76 |
| <b>LOVAZA</b>                     | 55  | <b>MENEST</b>                       | 69 |
| <b>LOVENOX</b>                    | 49  | MENINGOCOCCAL POLYSACCHARIDE VAC    | 76 |
| low-ogestrel                      | 69  | A-C-Y-W                             |    |
| loxapine succinate                | 43  | <b>MENOMUNE-A/C/Y/W-135</b>         | 76 |
| loxitane                          | 43  | MEPENZOLATE BROMIDE                 | 62 |
| <b>LUMIGAN</b>                    | 81  | <b>meperidine hcl</b>               | 12 |
| lutera                            | 69  | meprobamate                         | 46 |
| luvox                             | 29  | <b>MEPRON</b>                       | 40 |
| <b>LUVOX CR</b>                   | 29  | <b>mercaptapurine</b>               | 37 |
| <b>LYRICA</b>                     | 25  | MEROPENEM                           | 20 |
| <b>LYSODREN</b>                   | 71  | <b>MERREM</b>                       | 20 |
|                                   |     | <b>MERUVAX II W/DILUENT 10 DOSE</b> | 76 |
| <b>M</b>                          |     | <b>mesalamine</b>                   | 77 |
| <b>M-M-R II W/DILUENT 10 DOSE</b> | 76  | MESALAMINE (5-ASA)                  | 77 |
| macrobid                          | 18  | MESNA                               | 31 |
| macrodantin                       | 18  | <b>MESNEX</b>                       | 31 |
| MAFENIDE ACETATE                  | 24  | mestinon                            | 36 |
| <b>MAGNESIUM SULFATE</b>          | 102 | <b>METADATE CD</b>                  | 58 |
| MAGNESIUM SULFATE, HEPTAHYDRATE   | 102 | metadate er                         | 58 |
| <b>MALARONE</b>                   | 40  | metaglip                            | 46 |
| MALATHION                         | 40  | metaproterenol sulfate              | 84 |
| <b>maprotiline hcl</b>            | 28  | <b>metformin hcl</b>                | 47 |
| maprotiline hydrochloride         | 28  | <b>metformin hcl er</b>             | 47 |
| MARAVIROC                         | 44  | METFORMIN HYDROCHLORIDE AND         | 46 |
| <b>margesic-h</b>                 | 12  | PIOGLITAZONE HYDROCHLORIDE          |    |
| marinol                           | 32  | METFORMIN HYDROCHLORIDE AND         | 46 |
| <b>MARPLAN</b>                    | 28  | ROSIGLITAZONE MALEATE               |    |
| <b>MATULANE</b>                   | 37  | METFORMIN HYDROCHLORIDE AND         | 47 |
| mavik                             | 56  | SITAGLIPTIN PHOSPHATE               |    |
| <b>MAXALT</b>                     | 35  | METFORMIN/REPAGLINIDE               | 47 |
| <b>MAXALT-MLT</b>                 | 35  | <b>methadone hcl</b>                | 12 |
| <b>MAXIDEX</b>                    | 80  | METHADONE HYDROCHLORIDE             | 12 |
| maxidone                          | 11  | <b>methadose</b>                    | 12 |
| <b>MAXIPIME</b>                   | 20  | methazolamide                       | 54 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (**en negritas**) y nombres de medicamentos alternativos

|   |    |   |    |
|---|----|---|----|
| METHENAMINE HIPPURATE                     | 18 | MIGLUSTAT   | 61 |
| <b>METHERGINE</b>                         | 50 | <b>MIGRANAL</b>                                   | 35 |
| <b>methimazole</b>                        | 72 | minipress   | 51 |
| <b>methocarbamol</b>                      | 86 | <b>minitran</b>                                   | 57 |
| methotrexate                              | 73 | minocin   | 24 |
| methotrexate sodium                       | 73 | <b>minocycline hcl</b>                            | 24 |
| METHOXSALEN                               | 59 | minoxidil   | 57 |
| <b>methscopolamine bromide</b>            | 62 | <b>MIRAPEX</b>                                    | 41 |
| METHSUXIMIDE                              | 25 | mirtazapine                                       | 28 |
| methylclothiazide                         | 54 | <b>misoprostol</b>                                | 63 |
| methyl dopa                               | 50 | MITOTANE  | 71 |
| <b>methyl dopa/hydrochlorothiazide</b>    | 50 | <b>mitoxantrone hcl</b>                           | 38 |
| <b>methyl dopate hcl</b>                  | 51 | <b>MOBAN</b>                                      | 43 |
| methyl dopate hydrochloride               | 51 | mobic   | 10 |
| METHYLERGONOVINE MALEATE                  | 50 | MODAFINIL   | 58 |
| <b>methylin</b>                           | 58 | <b>moexipril hcl</b>                              | 56 |
| <b>methylin er</b>                        | 58 | <b>moexipril/hydrochlorothiazide</b>              | 56 |
| METHYLPHENIDATE                           | 58 | MOLINDONE HYDROCHLORIDE                           | 43 |
| <b>methylphenidate hcl</b>                | 58 | <b>mometasone furoate</b>                         | 66 |
| <b>methylphenidate hcl er</b>             | 58 | MOMETASONE FUROATE MONOHYDRATE                    | 82 |
| METHYLPHENIDATE HYDROCHLORIDE             | 58 | monoket   | 57 |
| <b>methylprednisolone</b>                 | 15 | <b>mononessa</b>                                  | 69 |
| <b>methylprednisolone acetate</b>         | 15 | monopril  | 56 |
| <b>methylprednisolone sodiumsuccinate</b> | 15 | monopril hct                                      | 56 |
| METHYLTESTOSTERONE                        | 67 | MONTELUKAST SODIUM                                | 83 |
| <b>metipranolol</b>                       | 81 | <b>MONUROL</b>                                    | 18 |
| <b>metoclopramide hcl</b>                 | 32 | MORPHINE SULFATE                                  | 10 |
| <b>metolazone</b>                         | 54 | <b>morphine sulfate er</b>                        | 12 |
| <b>metoprolol succinate er</b>            | 53 | <b>MOTOFEN</b>                                    | 62 |
| <b>metoprolol tartrate</b>                | 53 | motrin  | 10 |
| <b>metoprolol/hydrochlorothiazide</b>     | 53 | MOXIFLOXACIN HYDROCHLORIDE                        | 23 |
| metrocream                                | 18 | MOXIFLOXACIN HYDROCHLORIDE AND<br>SODIUM CHLORIDE | 23 |
| metrogel                                  | 18 | ms contin   | 12 |
| metrolotion                               | 18 | <b>mupirocin</b>                                  | 18 |
| METRONIDAZOLE                             | 18 | MUROMONAB CD3                                     | 73 |
| <b>metronidazole vaginal</b>              | 18 | myambutol   | 36 |
| mevacor                                   | 55 | mycelex   | 34 |
| <b>mexiletine hcl</b>                     | 51 | <b>MYCOBUTIN</b>                                  | 36 |
| mexiletine hydrochloride                  | 51 | MYCOPHENOLATE MOFETIL                             | 72 |
| <b>MIACALCIN</b>                          | 78 | MYCOPHENOLATE MOFETIL HYDROCHLORIDE               | 72 |
| <b>MICARDIS</b>                           | 56 | MYCOPHENOLATE SODIUM                              | 73 |
| <b>MICARDIS HCT</b>                       | 56 | mycostatin  | 34 |
| <b>miconazole 3</b>                       | 34 | <b>mydral</b>                                     | 81 |
| miconazole nitrate                        | 34 | mydriacyl   | 81 |
| <b>microgestin</b>                        | 69 | <b>MYFORTIC</b>                                   | 73 |
| micronase                                 | 46 | <b>MYLOTARG</b>                                   | 39 |
| microzide                                 | 54 | <b>MYOBLOC</b>                                    | 86 |
| midamor                                   | 54 | <b>MYOZYME</b>                                    | 61 |
| <b>midodrine hcl</b>                      | 51 | mysoline  | 25 |
| <b>migergot</b>                           | 35 | <b>MYTELASE</b>                                   | 36 |
| MIGLITOL                                  | 47 |   |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|  |    |
|--|----|
| <b>N</b>                                 |    |
| nabumetone                               | 10 |
| nadolol                                  | 53 |
| <b>nadolol/bendroflumethiazide</b>       | 53 |
| NAFARELIN ACETATE                        | 71 |
| nafcillin sodium                         | 21 |
| NAFTIFINE HYDROCHLORIDE                  | 34 |
| <b>NAFTIN</b>                            | 34 |
| <b>NAGLAZYME</b>                         | 61 |
| <b>nalbuphine hcl</b>                    | 13 |
| nalbuphine hydrochloride                 | 13 |
| <b>naloxone hcl</b>                      | 31 |
| naloxone hydrochloride                   | 31 |
| <b>naltrexone hcl</b>                    | 31 |
| <b>NAMENDA</b>                           | 28 |
| <b>naphazoline hcl</b>                   | 79 |
| naprosyn                                 | 10 |
| <b>naproxen</b>                          | 10 |
| <b>naproxen sodium</b>                   | 10 |
| NAPROXEN/SUMATRIPTAN                     | 10 |
| NARATRIPTAN HYDROCHLORIDE                | 35 |
| <b>NARDIL</b>                            | 28 |
| <b>NASACORT AQ</b>                       | 82 |
| <b>NASONEX</b>                           | 82 |
| <b>NATACYN</b>                           | 34 |
| NATALIZUMAB                              | 75 |
| NATAMYCIN                                | 34 |
| NATEGLINIDE                              | 47 |
| navane                                   | 43 |
| <b>necon 0.5/35-28</b>                   | 69 |
| <b>necon 1/35-28</b>                     | 69 |
| <b>necon 1/50-28</b>                     | 69 |
| <b>necon 10/11-28</b>                    | 69 |
| <b>necon 7/7/7</b>                       | 69 |
| NEDOCROMIL SODIUM                        | 80 |
| <b>nefazodone hcl</b>                    | 28 |
| NELARABINE                               | 37 |
| NELFINAVIR MESYLATE                      | 45 |
| <b>NEO-FRADIN</b>                        | 16 |
| NEOMYCIN SULFATE                         | 16 |
| NEOMYCIN SULFATE AND POLYMYXIN B         | 79 |
| SULFATE AND PREDNISOLONE ACETATE         |    |
| <b>neomycin/polymyxin/dexamethasone</b>  | 79 |
| <b>neomycin/polymyxin/gramicidin</b>     | 18 |
| <b>neomycin/polymyxin/hc</b>             | 81 |
| <b>neomycin/polymyxin/hydrocortisone</b> | 79 |
| neoral                                   | 72 |
| neosporin                                | 18 |
| NEPAFENAC                                | 80 |
| <b>NEULASTA</b>                          | 50 |
| <b>NEUMEGA</b>                           | 50 |
| <b>NEUPOGEN</b>                          | 50 |
| neurontin                                | 25 |
| <b>NEUTREXIN</b>                         | 40 |
| <b>NEVANAC</b>                           | 80 |
| NEVIRAPINE                               | 44 |
| <b>NEXAVAR</b>                           | 39 |
| <b>NEXIUM</b>                            | 63 |
| <b>NEXIUM I.V.</b>                       | 63 |
| niacin                                   | 55 |
| NIACIN AND SIMVASTATIN                   | 55 |
| <b>niacor</b>                            | 55 |
| <b>NIASPAN</b>                           | 55 |
| <b>nicardipine hcl</b>                   | 53 |
| NICOTINE                                 | 31 |
| <b>NICOTROL NS</b>                       | 31 |
| <b>nifediac cc</b>                       | 53 |
| <b>nifedical xl</b>                      | 53 |
| <b>nifedipine</b>                        | 53 |
| <b>nifedipine er</b>                     | 53 |
| <b>NILANDRON</b>                         | 72 |
| NILOTINIB                                | 39 |
| NILUTAMIDE                               | 72 |
| <b>nimodipine</b>                        | 53 |
| nimotop                                  | 53 |
| <b>nisoldipine</b>                       | 53 |
| NITAZOXANIDE                             | 40 |
| NITISINONE                               | 61 |
| nitro-dur                                | 57 |
| NITROFURANTOIN                           | 18 |
| <b>nitrofurantoin macrocrystalline</b>   | 18 |
| <b>nitrofurantoin monohydrate</b>        | 18 |
| nitroglycerin                            | 57 |
| <b>nitroglycerin transdermal</b>         | 57 |
| <b>NITROLINGUAL PUMPSPRAY</b>            | 57 |
| <b>nizatidine</b>                        | 63 |
| nizoral                                  | 34 |
| nolvadex                                 | 37 |
| nor-qd                                   | 70 |
| <b>nora-be</b>                           | 70 |
| norco                                    | 11 |
| nordette-28                              | 69 |
| <b>NORDITROPIN NORDIFLEX PEN</b>         | 67 |
| <b>norethindrone acetate</b>             | 70 |
| norflex                                  | 86 |
| NORFLOXACIN                              | 23 |
| norinyl 1+35                             | 69 |
| <b>NORITATE</b>                          | 18 |
| <b>NOROXIN</b>                           | 23 |
| norpace                                  | 51 |
| norpramin                                | 30 |
| <b>nortrel 0.5/35 (28)</b>               | 69 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                      |    |                                  |    |
|--------------------------------------|----|----------------------------------|----|
| nortrel 1/35 (21)                    | 69 | <b>ORFADIN</b>                   | 61 |
| nortrel 1/35 (28)                    | 69 | orphenadrine citrate             | 86 |
| nortrel 7/7/7                        | 69 | <b>orphenadrine citrate er</b>   | 86 |
| nortriptyline hcl                    | 30 | <b>orphenadrine compound ds</b>  | 86 |
| norvasc                              | 53 | <b>orphenadrine/asa/caffeine</b> | 86 |
| <b>NORVIR</b>                        | 45 | <b>ORTHO EVRA</b>                | 69 |
| novantrone                           | 38 | ortho-cyclen-28                  | 69 |
| <b>NOVOLIN 70/30</b>                 | 48 | <b>ortho-est</b>                 | 69 |
| <b>NOVOLIN N</b>                     | 48 | ortho-novum 1/50-28              | 69 |
| <b>NOVOLIN R</b>                     | 48 | ortho-novum 7/7/7-28             | 69 |
| <b>NOVOLOG</b>                       | 48 | <b>ORTHOCLONE OKT3</b>           | 73 |
| <b>NOVOLOG MIX 70/30</b>             | 48 | orudis                           | 10 |
| nulytely                             | 62 | <b>OSELTAMIVIR PHOSPHATE</b>     | 45 |
| <b>NUTROPIN</b>                      | 67 | ovcon-35                         | 68 |
| <b>NUTROPIN AQ</b>                   | 67 | <b>OVIDE</b>                     | 40 |
| <b>NUVARING</b>                      | 69 | oxandrin                         | 67 |
| nystatin                             | 34 | <b>oxandrolone</b>               | 67 |
| nystatin and triamcinolone acetonide | 34 | <b>oxaprozin</b>                 | 10 |
| <b>nystatin/triamcinolone</b>        | 34 | <b>OXCARBAZEPINE</b>             | 27 |
| <b>nystop</b>                        | 34 | <b>OXICONAZOLE NITRATE</b>       | 34 |
| <b>O</b>                             |    | <b>OXISTAT</b>                   | 34 |
| <b>ocella</b>                        | 69 | <b>OXSORALEN ULTRA</b>           | 60 |
| <b>octagam</b>                       | 74 | OXYBUTYNIN                       | 64 |
| OCTREOTIDE ACETATE                   | 71 | <b>oxybutynin chloride</b>       | 64 |
| ocufen                               | 80 | <b>oxybutynin chloride er</b>    | 64 |
| ocuflox                              | 24 | <b>oxycodone hcl</b>             | 13 |
| <b>ocusulf-10</b>                    | 24 | <b>OXYCODONE HYDROCHLORIDE</b>   | 13 |
| <b>ofloxacin</b>                     | 23 | <b>oxycodone-apap</b>            | 13 |
| ogen                                 | 68 | <b>oxycodone/acetaminophen</b>   | 13 |
| <b>ogestrel</b>                      | 69 | <b>oxycodone/apap</b>            | 13 |
| OLANZAPINE                           | 42 | <b>oxycodone/aspirin</b>         | 13 |
| OLMESARTAN MEDOXOMIL                 | 55 | oxycontin                        | 13 |
| OLOPATADINE HYDROCHLORIDE            | 80 | <b>OXYMETHOLONE</b>              | 67 |
| OLSALAZINE                           | 77 | <b>OXYTROL</b>                   | 64 |
| <b>OLUX-E</b>                        | 66 | <b>P</b>                         |    |
| OMALIZUMAB                           | 85 | pacerone                         | 51 |
| OMEGA-3 ACID ETHYL ESTERS            | 55 | <b>palgic</b>                    | 82 |
| <b>omeprazole</b>                    | 63 | PALIPERIDONE                     | 42 |
| omnicef                              | 19 | PALONOSETRON HYDROCHLORIDE       | 32 |
| omnipen                              | 20 | pamelor                          | 30 |
| <b>ondansetron hcl</b>               | 33 | PAMIDRONATE DISODIUM             | 78 |
| <b>ondansetron odt</b>               | 33 | pamine                           | 62 |
| <b>ONTAK</b>                         | 38 | <b>PANCREASE MT</b>              | 61 |
| OPRELVEKIN                           | 50 | <b>PANCRELIPASE</b>              | 61 |
| optipranolol                         | 81 | <b>PANCRON</b>                   | 61 |
| <b>OPTIVAR</b>                       | 80 | panlor dc                        | 14 |
| <b>ORACEA</b>                        | 60 | panlor ss                        | 14 |
| <b>ORAP</b>                          | 43 | <b>PANRETIN</b>                  | 39 |
| orapred                              | 15 | parafon forte dsc                | 86 |
| <b>ORENCIA</b>                       | 73 | <b>parcaine</b>                  | 79 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                   |    |  |     |
|-----------------------------------|----|--|-----|
| PARICALCITOL                      | 78 | PHENYTOIN SODIUM                           | 26  |
| parlodel                          | 41 | phoslo                                     | 64  |
| parnate                           | 28 | <b>PHOSPHOLINE IODIDE</b>                  | 81  |
| paromomycin sulfate               | 16 | <b>pilocarpine hcl</b>                     | 59  |
| <b>paroxetine hcl</b>             | 29 | <b>pilocarpine hydrochloride</b>           | 59  |
| <b>PASER</b>                      | 36 | <b>PILOPINE HS</b>                         | 81  |
| <b>PATANOL</b>                    | 80 | PIMECROLIMUS                               | 59  |
| paxil                             | 29 | PIMOZIDE                                   | 43  |
| <b>pedi-dri</b>                   | 34 | pindolol                                   | 53  |
| pediapred                         | 15 | PIOGLITAZONE HYDROCHLORIDE                 | 46  |
| <b>PEDIARIX</b>                   | 76 | PIPERACILLIN SODIUM                        | 22  |
| pediotic                          | 81 | PIPERACILLIN SODIUM AND TAZOBACTAM         | 22  |
| <b>pedvax hib</b>                 | 76 | SODIUM                                     |     |
| <b>peg 3350/electrolytes</b>      | 62 | <b>piroxicam</b>                           | 10  |
| <b>PEG-INTRON</b>                 | 74 | <b>PLAN B</b>                              | 70  |
| <b>PEG-INTRON REDIPEN</b>         | 75 | plaquenil                                  | 40  |
| PEGADEMASE BOVINE                 | 60 | <b>PLAVIX</b>                              | 50  |
| <b>PEGANONE</b>                   | 27 | plendil                                    | 53  |
| <b>PEGASYS</b>                    | 75 | pletal                                     | 50  |
| PEGFILGRASTIM                     | 50 | <b>podofilox</b>                           | 60  |
| PEGINTERFERON ALFA-2A             | 75 | POLIOVIRUS VACCINE INACTIVATED             | 76  |
| PEGINTERFERON ALFA-2B             | 74 | <b>poly-dex</b>                            | 79  |
| PEGVISOMANT                       | 71 | <b>POLY-PRED</b>                           | 79  |
| PEMIROLAST POTASSIUM              | 80 | <b>polycin b</b>                           | 18  |
| PENBUTOLOL SULFATE                | 53 | POLYETHYLENE GLYCOL AND POTASSIUM          | 62  |
| PENCICLOVIR                       | 45 | CHLORIDE AND SODIUM                        |     |
| PENICILLAMINE                     | 31 | <b>polygam s/d</b>                         | 74  |
| PENICILLIN                        | 22 | polytrim                                   | 18  |
| penicillin v potassium            | 22 | <b>portia-28</b>                           | 69  |
| penlac nail lacquer               | 33 | potassium chloride                         | 101 |
| <b>PENTASA</b>                    | 77 | <b>potassium chloride 0.075%/d5w/nacl</b>  | 103 |
| <b>pentazocine/acetaminophen</b>  | 13 | 0.225%                                     |     |
| <b>pentazocine/naloxone hcl</b>   | 13 | <b>potassium chloride 0.15%/d5w</b>        | 103 |
| <b>pentoxifylline er</b>          | 50 | <b>POTASSIUM CHLORIDE 0.15%/NACL 0.45%</b> | 103 |
| pepcid                            | 63 | VIAFLEX                                    |     |
| percocet                          | 11 | potassium chloride 0.15%/nacl 0.9%         | 104 |
| percodan                          | 13 | <b>potassium chloride 0.15%d5w/nacl</b>    | 104 |
| peridex oral rinse                | 59 | 0.33%                                      |     |
| <b>periogard</b>                  | 59 | <b>potassium chloride 0.15%d5w/nacl</b>    | 104 |
| periostat                         | 24 | 0.45% viaflex                              |     |
| <b>permethrin</b>                 | 40 | <b>potassium chloride 0.15%nacl 0.9%</b>   | 104 |
| <b>perphenazine</b>               | 33 | <b>potassium chloride 0.22%d5w/nacl</b>    | 105 |
| <b>perphenazine/amitriptyline</b> | 28 | 0.45%                                      |     |
| persantine                        | 50 | <b>potassium chloride 0.224%/d5w</b>       | 105 |
| <b>phenadoz</b>                   | 33 | <b>POTASSIUM CHLORIDE 0.224%D5W/NACL</b>   | 105 |
| PHENELZINE SULFATE                | 28 | 0.33%                                      |     |
| phenergan                         | 33 | <b>potassium chloride 0.3%/d5w</b>         | 106 |
| phenylephrine hydrochloride and   | 85 | POTASSIUM CHLORIDE AND SODIUM              | 103 |
| promethazine hydrochloride        |    | CHLORIDE                                   |     |
| <b>PHENYTEK</b>                   | 27 | <b>potassium chloride cr</b>               | 106 |
| <b>phenytoin</b>                  | 27 | <b>potassium chloride er</b>               | 106 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en negritas) y nombres de medicamentos alternativos

|   |     |  |    |
|---|-----|--|----|
| <b>potassium citrate extended-release</b> . . . . . | 106 | procardia . . . . .                              | 53 |
| <b>PRAMIPEXOLE DIHYDROCHLORIDE</b> . . . . .        | 41  | procardia xl . . . . .                           | 53 |
| MONOHYDRATE   |     | <b>PROCHIEVE</b> . . . . .                       | 70 |
| <b>PRAMLINTIDE ACETATE</b> . . . . .                | 47  | prochlorperazine . . . . .                       | 42 |
| <b>PRANDIMET</b> . . . . .                          | 47  | prochlorperazine edisylate . . . . .             | 33 |
| <b>PRANDIN</b> . . . . .                            | 47  | prochlorperazine maleate . . . . .               | 33 |
| pravachol . . . . .                                 | 55  | <b>PROCRIT</b> . . . . .                         | 50 |
| <b>pravastatin sodium</b> . . . . .                 | 55  | <b>procto-pak</b> . . . . .                      | 66 |
| <b>PRAZIQUANTEL</b> . . . . .                       | 40  | proctocort . . . . .                             | 65 |
| <b>prazosin hcl</b> . . . . .                       | 51  | <b>proctocream-hc</b> . . . . .                  | 60 |
| precose . . . . .                                   | 46  | <b>proctosol hc</b> . . . . .                    | 60 |
| <b>PRED MILD</b> . . . . .                          | 80  | <b>proctozone-hc</b> . . . . .                   | 60 |
| <b>PRED-G</b> . . . . .                             | 79  | PROGESTERONE . . . . .                           | 70 |
| <b>PRED-G S.O.P.</b> . . . . .                      | 79  | <b>PROGLYCEM</b> . . . . .                       | 47 |
| <b>prednicarbate</b> . . . . .                      | 66  | <b>PROGRAF</b> . . . . .                         | 73 |
| PREDNISOLONE ACETATE . . . . .                      | 80  | <b>PROLASTIN</b> . . . . .                       | 85 |
| PREDNISOLONE ACETATE AND . . . . .                  | 79  | <b>PROLEUKIN</b> . . . . .                       | 38 |
| SULFACETAMIDE SODIUM                                |     | <b>promethazine hcl</b> . . . . .                | 33 |
| <b>prednisolone sodium phosphate</b> . . . . .      | 15  | promethazine hydrochloride . . . . .             | 33 |
| prednisolone sodium phosphate and . . . . .         | 79  | <b>promethazine vc</b> . . . . .                 | 85 |
| sulfacetamide sodium                                |     | <b>PROMETRIUM</b> . . . . .                      | 70 |
| prednisone . . . . .                                | 77  | <b>propafenone hcl</b> . . . . .                 | 52 |
| <b>prednisone intensol</b> . . . . .                | 77  | <b>proparacaine hcl</b> . . . . .                | 79 |
| <b>PREFEST</b> . . . . .                            | 69  | propine . . . . .                                | 80 |
| PREGABALIN . . . . .                                | 25  | <b>propoxyphene hcl</b> . . . . .                | 13 |
| <b>PREMARIN</b> . . . . .                           | 69  | PROPOXYPHENE NAPSYLATE . . . . .                 | 11 |
| <b>PREMARIN W/APPLICATOR</b> . . . . .              | 69  | <b>propoxyphene-n/acetaminophen</b> . . . . .    | 13 |
| <b>PREMPHASE</b> . . . . .                          | 69  | <b>propoxyphene/acetaminophen</b> . . . . .      | 13 |
| <b>PREMPRO</b> . . . . .                            | 69  | <b>propranolol hcl</b> . . . . .                 | 52 |
| <b>PRENATABS OBN</b> . . . . .                      | 107 | <b>propranolol hcl er</b> . . . . .              | 52 |
| <b>PREVACID</b> . . . . .                           | 63  | propranolol hydrochloride . . . . .              | 52 |
| <b>PREVACID NAPRAPAC</b> . . . . .                  | 15  | <b>propranolol/hydrochlorothiazide</b> . . . . . | 53 |
| prevalite . . . . .                                 | 55  | propylthiouracil . . . . .                       | 72 |
| previfem . . . . .                                  | 69  | <b>PROQUAD</b> . . . . .                         | 76 |
| <b>PREVPAC</b> . . . . .                            | 63  | proscar . . . . .                                | 64 |
| <b>PREZISTA</b> . . . . .                           | 45  | PROTEINASE INHIBITOR (HUMAN) . . . . .           | 85 |
| <b>PRIFTIN</b> . . . . .                            | 36  | <b>PROTOPIC</b> . . . . .                        | 60 |
| prilosec . . . . .                                  | 63  | <b>protriptyline hcl</b> . . . . .               | 30 |
| PRIMAQUINE PHOSPHATE . . . . .                      | 40  | <b>PROVENTIL HFA</b> . . . . .                   | 84 |
| <b>primidone</b> . . . . .                          | 25  | provera . . . . .                                | 70 |
| principen . . . . .                                 | 20  | <b>PROVIGIL</b> . . . . .                        | 58 |
| prinivil . . . . .                                  | 56  | prozac . . . . .                                 | 29 |
| prinzide . . . . .                                  | 56  | <b>PULMICORT FLEXHALER</b> . . . . .             | 82 |
| <b>PRISTIQ</b> . . . . .                            | 29  | purinethol . . . . .                             | 37 |
| <b>PROAIR HFA</b> . . . . .                         | 84  | pyrazinamide . . . . .                           | 36 |
| proamatine . . . . .                                | 51  | PYRIDOSTIGMINE BROMIDE . . . . .                 | 36 |
| probenecid . . . . .                                | 35  | PYRIMETHAMINE . . . . .                          | 40 |
| <b>probenecid/colchicine</b> . . . . .              | 35  | PYRIMETHAMINE AND SULFADOXINE . . . . .          | 40 |
| <b>PROCAINAMIDE HCL</b> . . . . .                   | 52  |  |    |
| PROCAINAMIDE HYDROCHLORIDE . . . . .                | 52  |  |    |
| PROCARBAZINE HYDROCHLORIDE . . . . .                | 37  |  |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|   |    |   |
|---|----|---|
| <b>Q</b>  |    |   |
| QUADRIVALENT HPV (6,11,16,18) RECOMB VAC        | 76 | <b>REVELA</b> . . . . .65               |
| <b>quasense</b> . . . . .                       | 70 | REPAGLINIDE . . . . .47                 |
| questran . . . . .                              | 54 | requip xl . . . . .41                   |
| questran light . . . . .                        | 54 | <b>RESCRIPTOR</b> . . . . .44           |
| QUETIAPINE . . . . .                            | 42 | reserpine . . . . .51                   |
| QUETIAPINE FUMARATE . . . . .                   | 42 | <b>RESTASIS</b> . . . . .79             |
| <b>quinapril hcl</b> . . . . .                  | 56 | retin-a . . . . .59                     |
| <b>quinapril/hydrochlorothiazide</b> . . . . .  | 56 | <b>RETIN-A MICRO</b> . . . . .60        |
| <b>quinaretic</b> . . . . .                     | 56 | retrovir . . . . .44                    |
| quinidine gluconate . . . . .                   | 52 | <b>RETROVIR IV INFUSION</b> . . . . .44 |
| <b>quinidine gluconate cr</b> . . . . .         | 52 | <b>REVATIO</b> . . . . .84              |
| quinidine sulfate . . . . .                     | 52 | revia . . . . .31                       |
| <b>quinidine sulfate er</b> . . . . .           | 52 | <b>REVLIMID</b> . . . . .37             |
| <b>QUIXIN</b> . . . . .                         | 24 | <b>REYATAZ</b> . . . . .45              |
| <b>QVAR</b> . . . . .                           | 82 | <b>RHINOCORT AQUA</b> . . . . .82       |
| <b>R</b>  |    | <b>ribasphere</b> . . . . .45           |
| <b>RABAVERT</b> . . . . .                       | 76 | <b>ribavirin</b> . . . . .45            |
| RABEPRAZOLE SODIUM . . . . .                    | 63 | <b>RIDAURA</b> . . . . .75              |
| RABIES VACCINE HUMAN DIPLOID CELL . . . . .     | 76 | RIFABUTIN . . . . .36                   |
| RABIES VIRUS VACCINE FLURY-LEP STRAIN . . . . . | 76 | rifadin . . . . .36                     |
| RALOXIFENE . . . . .                            | 70 | rifamate . . . . .36                    |
| RALTEGRAVIR POTASSIUM . . . . .                 | 44 | <b>rifampin</b> . . . . .36             |
| RAMELTEON . . . . .                             | 85 | RIFAPENTINE . . . . .36                 |
| <b>ramipril</b> . . . . .                       | 56 | <b>RIFATER</b> . . . . .36              |
| <b>RANEXA</b> . . . . .                         | 54 | <b>RILUTEK</b> . . . . .58              |
| <b>ranitidine hcl</b> . . . . .                 | 63 | RILUZOLE . . . . .58                    |
| RANOLAZINE . . . . .                            | 54 | <b>rimantadine hcl</b> . . . . .45      |
| <b>RAPAMUNE</b> . . . . .                       | 73 | RIMEXOLONE . . . . .80                  |
| rapiflux . . . . .                              | 29 | RISEDRONATE SODIUM . . . . .77          |
| RASAGILINE MESYLATE . . . . .                   | 41 | risperal . . . . .42                    |
| RASBURICASE . . . . .                           | 38 | <b>RISPERDAL</b> . . . . .42            |
| razadyne . . . . .                              | 28 | <b>RISPERDAL CONSTA</b> . . . . .42     |
| rebetol . . . . .                               | 45 | <b>RISPERDAL M-TAB</b> . . . . .42      |
| <b>REBIF</b> . . . . .                          | 75 | RISPERIDONE . . . . .42                 |
| <b>REBIF TITRATION PACK</b> . . . . .           | 75 | ritalin . . . . .58                     |
| reclipsen . . . . .                             | 70 | <b>RITALIN LA</b> . . . . .58           |
| <b>RECOMBIVAX HB</b> . . . . .                  | 76 | ritalin sr . . . . .58                  |
| reglan . . . . .                                | 32 | RITONAVIR . . . . .45                   |
| <b>REGRANEX</b> . . . . .                       | 60 | <b>RITUXAN</b> . . . . .39              |
| <b>RELENZA DISKHALER</b> . . . . .              | 45 | RITUXIMAB . . . . .39                   |
| <b>RELION 70/30</b> . . . . .                   | 48 | RIVASTIGMINE TARTRATE . . . . .28       |
| <b>RELION N</b> . . . . .                       | 48 | RIZATRIPTAN BENZOATE . . . . .35        |
| <b>RELION R</b> . . . . .                       | 48 | robaxin . . . . .86                     |
| <b>RELPAK</b> . . . . .                         | 35 | robinul . . . . .62                     |
| remeron . . . . .                               | 28 | rocaltrol . . . . .78                   |
| remeron soltab . . . . .                        | 28 | rocephin . . . . .20                    |
| <b>REMICADE</b> . . . . .                       | 73 | ROPINIROLE . . . . .41                  |
|   |    | <b>ropinirole hcl</b> . . . . .41       |
|   |    | ROSIGLITAZONE MALEATE . . . . .46       |
|   |    | ROSUVASTATIN CALCIUM . . . . .54        |
|   |    | <b>ROTATEQ</b> . . . . .76              |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|                                    |    |   |     |
|------------------------------------|----|---|-----|
| ROTAVIRUS VACCINE LIVE PENTAVALENT | 76 | SITAGLIPTIN PHOSPHATE                     | 47  |
| rowasa                             | 77 | <b>SKELID</b>                             | 78  |
| <b>roxicet</b>                     | 13 | sodium bicarbonate                        | 106 |
| <b>ROZEREM</b>                     | 85 | sodium chloride                           | 64  |
| RUBELLA VIRUS VACCINE LIVE         | 76 | <b>sodium chloride 0.9%</b>               | 64  |
| RUFINAMIDE                         | 25 | <b>sodium fluoride</b>                    | 107 |
| rythmol                            | 52 | SODIUM OXYBATE                            | 58  |
| <b>S</b>                           |    | SODIUM PHENYLBUTYRATE                     | 61  |
| <b>SABRIL</b>                      | 26 | sodium polystyrene sulfonate              | 31  |
| SACROSIDASE                        | 61 | <b>sodium sulfacetamide</b>               | 24  |
| <b>SAIZEN</b>                      | 67 | <b>SOLARAZE</b>                           | 60  |
| salagen                            | 59 | <b>solia</b>                              | 70  |
| SALMETEROL XINAFOATE               | 84 | SOLIFENACIN SUCCINATE                     | 64  |
| <b>SANCTURA</b>                    | 64 | solu-medrol                               | 14  |
| <b>SANCTURA XR</b>                 | 64 | soma                                      | 86  |
| sandimmune                         | 72 | soma compound                             | 86  |
| sandostatin                        | 71 | SOMATROPIN                                | 67  |
| <b>SANDOSTATIN LAR DEPOT</b>       | 71 | SOMATROPIN (SERONO)                       | 67  |
| <b>SANTYL</b>                      | 60 | <b>SOMAVERT</b>                           | 71  |
| <b>SAPHRIS</b>                     | 42 | sonata                                    | 85  |
| SAQUINAVIR MESYLATE                | 45 | SORAFENIB TOSYLATE                        | 39  |
| SCOPOLAMINE                        | 33 | <b>sorine</b>                             | 52  |
| seasonale                          | 70 | <b>sotalol hcl</b>                        | 52  |
| sectral                            | 51 | <b>SPECTRACEF</b>                         | 20  |
| SELEGILINE                         | 28 | <b>SPIRIVA HANDIHALER</b>                 | 83  |
| selegiline hcl                     | 41 | spironolactone                            | 54  |
| selenium sulfide                   | 60 | <b>spironolactone/hydrochlorothiazide</b> | 54  |
| selsun shampoo                     | 60 | sporanox pulsepak                         | 34  |
| <b>SELZENTRY</b>                   | 44 | <b>sprintec 28</b>                        | 70  |
| <b>SENSIPAR</b>                    | 71 | <b>SPRYCEL</b>                            | 39  |
| septra ds                          | 24 | <b>sronyx</b>                             | 70  |
| <b>SEREVENT DISKUS</b>             | 84 | <b>ssd</b>                                | 24  |
| SEROMYCIN                          | 36 | stadol                                    | 11  |
| SEROQUEL                           | 42 | <b>stagesic</b>                           | 14  |
| SEROQUEL XR                        | 42 | <b>STALEVO</b>                            | 41  |
| SEROSTIM                           | 67 | <b>STARLIX</b>                            | 47  |
| sertraline hcl                     | 29 | STAVUDINE                                 | 44  |
| serzone                            | 28 | <b>STAVZOR</b>                            | 26  |
| SEVELAMER CARBONATE                | 65 | <b>STIMATE</b>                            | 67  |
| SILDENAFIL CITRATE                 | 84 | <b>STRATTERA</b>                          | 58  |
| silvadene                          | 24 | STREPTOZOCIN                              | 37  |
| <b>silver sulfadiazine</b>         | 24 | <b>STRIANT</b>                            | 68  |
| <b>SIMCOR</b>                      | 55 | <b>STROMECTOL</b>                         | 40  |
| <b>SIMULECT</b>                    | 73 | <b>SUBOXONE</b>                           | 14  |
| simvastatin                        | 55 | <b>SUBUTEX</b>                            | 14  |
| sinemet                            | 41 | <b>SUCRAID</b>                            | 61  |
| sinemet cr                         | 41 | sucralfate                                | 63  |
| sinequan                           | 30 | sular                                     | 53  |
| <b>SINGULAIR</b>                   | 83 | SULCONAZOLE NITRATE                       | 34  |
| SIROLIMUS                          | 73 | <b>sulfacetamide sodium/prednisolone</b>  | 79  |
|                                    |    | <b>sodium phosphate</b>                   |     |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en **negritas**) y nombres de medicamentos alternativos

|   |    |  |    |
|---|----|--|----|
| sulfadiazine                            | 24 | temovate                                   | 65 |
| sulfamethoxazole and trimethoprim       | 24 | temovate e                                 | 65 |
| <b>sulfamethoxazole/trimethoprim</b>    | 24 | tenex                                      | 50 |
| <b>sulfamethoxazole/trimethoprim ds</b> | 24 | TENOFOVIR DISOPROXIL FUMARATE              | 44 |
| <b>SULFAMYLON</b>                       | 24 | tenoretic                                  | 52 |
| sulfasalazine                           | 77 | tenormin                                   | 52 |
| <b>sulfatrim</b>                        | 24 | terazol                                    | 34 |
| sulfazine                               | 77 | <b>terazosin hcl</b>                       | 51 |
| sulfazine ec                            | 77 | <b>terbinafine hcl</b>                     | 34 |
| SULFISOXAZOLE ACETYL                    | 24 | TERBINAFINE HYDROCHLORIDE                  | 34 |
| sulindac                                | 10 | <b>terbutaline sulfate</b>                 | 84 |
| sumatriptan succinate                   | 35 | <b>terconazole</b>                         | 34 |
| sumycin                                 | 25 | TERIPARATIDE                               | 78 |
| SUNITINIB MALATE                        | 39 | <b>TESTIM</b>                              | 68 |
| <b>SUPRAX</b>                           | 20 | TESTOSTERONE                               | 67 |
| surmontil                               | 30 | testosterone enanthate                     | 68 |
| <b>SUSTIVA</b>                          | 44 | <b>TESTRED</b>                             | 68 |
| <b>SUTENT</b>                           | 39 | TETANUS TOXOID ADSORBED                    | 76 |
| <b>SYMBICORT</b>                        | 84 | <b>TETANUS/DIPHTHERIA TOXOIDS-ADSORBED</b> | 76 |
| <b>SYMBYAX</b>                          | 42 | <b>ADULT</b>                               |    |
| <b>SYMLIN</b>                           | 47 | tetracycline hcl                           | 25 |
| <b>SYNAREL</b>                          | 71 | TETRAHYDROZOLINE HYDROCHLORIDE             | 85 |
| synthroid                               | 71 | THALIDOMIDE                                | 37 |
| <b>SYPRINE</b>                          | 31 | <b>THALOMID</b>                            | 37 |
| <b>T</b>                                |    | <b>theochron</b>                           | 83 |
| <b>TABLOID</b>                          | 37 | theophylline                               | 83 |
| TACRINE HYDROCHLORIDE                   | 27 | <b>theophylline cr</b>                     | 83 |
| TACROLIMUS                              | 60 | <b>theophylline er</b>                     | 83 |
| tagament                                | 63 | <b>thermazene</b>                          | 24 |
| talacen                                 | 13 | THIOGUANINE                                | 37 |
| talwin nx                               | 13 | <b>THIOLA</b>                              | 64 |
| tambocor                                | 51 | <b>thioridazine hcl</b>                    | 43 |
| <b>TAMIFLU</b>                          | 45 | thioridazine hydrochloride                 | 43 |
| <b>tamoxifen citrate</b>                | 37 | THIOTHIXENE                                | 43 |
| TAMSULOSIN HYDROCHLORIDE                | 64 | <b>THYROLAR</b>                            | 71 |
| tapazole                                | 72 | TIAGABINE HYDROCHLORIDE                    | 25 |
| <b>TARCEVA</b>                          | 39 | tiazac                                     | 51 |
| <b>TARGRETIN</b>                        | 40 | ticlid                                     | 50 |
| <b>TARKA</b>                            | 56 | <b>ticlopidine hcl</b>                     | 50 |
| <b>TASIGNA</b>                          | 39 | tigan                                      | 33 |
| <b>TASMAR</b>                           | 41 | TIGECYCLINE                                | 18 |
| TAZAROTENE                              | 60 | <b>TIKOSYN</b>                             | 52 |
| <b>TAZORAC</b>                          | 60 | TILUDRONATE DISODIUM                       | 78 |
| <b>taztia xt</b>                        | 52 | TIMOLOL                                    | 80 |
| tegretol                                | 26 | timolol maleate                            | 35 |
| <b>TEGRETOL-XR</b>                      | 27 | timoptic ocudose                           | 81 |
| <b>TEKTRNA</b>                          | 56 | <b>TINDAMAX</b>                            | 40 |
| <b>TEKTRNA HCT</b>                      | 56 | TINIDAZOLE                                 | 40 |
| TELBIVUDINE                             | 45 | TINZAPARIN SODIUM                          | 49 |
| TELMISARTAN                             | 56 | TIOPRONIN                                  | 64 |
|   |    | TIOTROPIUM BROMIDE MONOHYDRATE             | 83 |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en negritas) y nombres de medicamentos alternativos

|   |     |   |     |
|---|-----|---|-----|
| TIPRANAVIR                                  | 44  | triamcinolone acetonide in absorbase            | 66  |
| <b>tizanidine hcl</b>                       | 43  | <b>triamcinolone in orabase</b>                 | 59  |
| <b>TOBRADEX</b>                             | 79  | <b>triamterene/hydrochlorothiazide</b>          | 54  |
| tobramycin sulfate                          | 16  | <b>TRICOR</b>                                   | 55  |
| <b>tobrasol</b>                             | 16  | <b>triderm</b>                                  | 67  |
| tobrex                                      | 15  | TRIENTINE HCL                                   | 31  |
| tofranil                                    | 30  | <b>trifluoperazine hcl</b>                      | 43  |
| <b>TOFRANIL-PM</b>                          | 30  | trifluoperazine hydrochloride                   | 43  |
| <b>tolazamide</b>                           | 47  | <b>trifluridine</b>                             | 45  |
| tolbutamide                                 | 47  | <b>trihexyphenidyl hcl</b>                      | 41  |
| TOLCAPONE                                   | 41  | trihexyphenidyl hydrochloride                   | 41  |
| tolinase                                    | 47  | <b>TRIHIBIT</b>                                 | 76  |
| tolmetin sodium                             | 10  | trilafon  | 33  |
| TOLTERODINE TARTRATE                        | 64  | trileptal                                       | 27  |
| <b>TOPAMAX</b>                              | 26  | <b>TRILIPIX</b>                                 | 55  |
| topicort                                    | 65  | <b>trilyte</b>                                  | 62  |
| topicort lp                                 | 65  | <b>trimethobenzamide hcl</b>                    | 33  |
| TOPIRAMATE                                  | 26  | trimethoprim                                    | 18  |
| toprol xl                                   | 53  | <b>trimethoprim sulfate/polymyxin b sulfate</b> | 18  |
| toradol                                     | 10  | TRIMETREXATE GLUCURONATE                        | 40  |
| TOREMIFENE                                  | 37  | TRIMIPRAMINE MALEATE                            | 30  |
| <b>torseamide</b>                           | 54  | <b>trimox</b>                                   | 22  |
| <b>TOVIAZ</b>                               | 64  | <b>trinessa</b>                                 | 70  |
| <b>tpn electrolytes ftv</b>                 | 107 | <b>TRIPEDIA</b>                                 | 76  |
| <b>TRACLEER</b>                             | 84  | <b>TRISENOX</b>                                 | 38  |
| tramadol hcl                                | 14  | <b>trivora-28</b>                               | 70  |
| <b>tramadol hydrochloride/acetaminophen</b> | 14  | <b>TRIZIVIR</b>                                 | 44  |
| trandate                                    | 53  | <b>TROPHAMINE</b>                               | 107 |
| <b>trandolapril</b>                         | 56  | <b>tropicacyl</b>                               | 81  |
| TRANDOLAPRIL AND VERAPAMIL HYDROCHLORIDE    | 56  | tropicamide                                     | 81  |
| TRANEXAMIC ACID                             | 50  | TROSPIMUM CHLORIDE                              | 64  |
| <b>TRANSDERM-SCOP</b>                       | 33  | <b>TRUVADA</b>                                  | 44  |
| <b>tranylcypromine sulfate</b>              | 28  | <b>TWINJECT</b>                                 | 84  |
| TRASTUZUMAB                                 | 39  | <b>TWINRIX</b>                                  | 76  |
| <b>TRAVASOL</b>                             | 107 | <b>TYGACIL</b>                                  | 18  |
| <b>TRAVATAN Z</b>                           | 81  | <b>TYKERB</b>                                   | 38  |
| TRAVOPROST                                  | 81  | tylenol/codeine                                 | 10  |
| <b>trazodone hcl</b>                        | 28  | tylox   | 13  |
| <b>TRECTOR</b>                              | 36  | <b>TYPHIM VI</b>                                | 76  |
| trental                                     | 50  | TYPHOID VACCINE                                 | 77  |
| <b>tretinoin</b>                            | 40  | TYPHOID VI POLYSACCHARIDE VACCINE               | 76  |
| <b>TREXALL</b>                              | 73  | <b>TYSABRI</b>                                  | 75  |
| <b>TREXIMET</b>                             | 10  | <b>TYZEKA</b>                                   | 45  |
| <b>trezix</b>                               | 14  | <b>TYZINE</b>                                   | 85  |
| <b>tri-legest fe</b>                        | 70  | <b>TYZINE PEDIATRIC NASAL DROPS</b>             | 85  |
| tri-norinyl 28                              | 68  |   |     |
| <b>tri-previfem</b>                         | 70  | <b>U</b>  |     |
| <b>tri-sprintec</b>                         | 70  | <b>u-cort</b>                                   | 60  |
| TRIAMCINOLONE                               | 82  | ultracet  | 14  |
| triamcinolone acetonide                     | 59  | ultram  | 14  |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (en negritas) y nombres de medicamentos alternativos

|  |     |                                   |    |
|--|-----|-----------------------------------|----|
| <b>ULTRASE</b> . . . . .                             | 61  | <b>verapamil hcl</b> . . . . .    | 52 |
| ultravate . . . . .                                  | 66  | <b>verapamil hcl er</b> . . . . . | 52 |
| unasyn . . . . .                                     | 21  | verelan . . . . .                 | 52 |
| uniphyl . . . . .                                    | 83  | vesanoid . . . . .                | 40 |
| uniretic . . . . .                                   | 56  | <b>VESICARE</b> . . . . .         | 64 |
| <b>unithroid</b> . . . . .                           | 71  | <b>VEXOL</b> . . . . .            | 80 |
| univasc . . . . .                                    | 56  | <b>VFEND</b> . . . . .            | 34 |
| urecholine . . . . .                                 | 64  | <b>VFEND IV</b> . . . . .         | 34 |
| <b>UREX</b> . . . . .                                | 18  | vibramycin . . . . .              | 24 |
| urispas . . . . .                                    | 64  | vibratab . . . . .                | 24 |
| urocit-k 10 . . . . .                                | 106 | vicodin . . . . .                 | 11 |
| urocit-k 5 . . . . .                                 | 106 | vicoprofen . . . . .              | 12 |
| <b>UROXATRAL</b> . . . . .                           | 64  | <b>VIDAZA</b> . . . . .           | 38 |
| <b>URSO 250</b> . . . . .                            | 62  | videx . . . . .                   | 44 |
| <b>URSO FORTE</b> . . . . .                          | 62  | videx ec . . . . .                | 44 |
| URSODEOXYCHOLATE . . . . .                           | 62  | <b>VIDEXPEDIATRIC</b> . . . . .   | 44 |
| URSODIOL . . . . .                                   | 62  | VIGABATRIN . . . . .              | 26 |
| <b>V</b>   |     | <b>VIGAMOX</b> . . . . .          | 24 |
| <b>VAGIFEM</b> . . . . .                             | 70  | <b>VIMPAT</b> . . . . .           | 25 |
| VALACYCLOVIR HCL . . . . .                           | 45  | <b>VIOKASE</b> . . . . .          | 61 |
| <b>VALCYTE</b> . . . . .                             | 43  | <b>VIRACEPT</b> . . . . .         | 45 |
| VALGANCICLOVIR HYDROCHLORIDE . . . . .               | 43  | <b>VIRAMUNE</b> . . . . .         | 44 |
| VALPROATE . . . . .                                  | 26  | <b>VIREAD</b> . . . . .           | 44 |
| VALPROATE SODIUM . . . . .                           | 25  | viroptic . . . . .                | 45 |
| <b>valproic acid</b> . . . . .                       | 26  | vistaril . . . . .                | 32 |
| VALSARTAN . . . . .                                  | 56  | <b>VISTIDE</b> . . . . .          | 43 |
| <b>VALTRES</b> . . . . .                             | 45  | vivactil . . . . .                | 30 |
| vanacet . . . . .                                    | 14  | <b>VIVAGLOBIN</b> . . . . .       | 74 |
| <b>VANOCIN HCL</b> . . . . .                         | 18  | <b>VIVELLE-DOT</b> . . . . .      | 70 |
| vancomycin hcl . . . . .                             | 18  | <b>VIVOTIF BERNA</b> . . . . .    | 77 |
| <b>VANCOMYCIN HCL ISO-OSMOTIC DEXTROSE</b> . . . . . | 19  | voltaren . . . . .                | 10 |
| VANCOMYCIN HYDROCHLORIDE . . . . .                   | 18  | voltaren-xr . . . . .             | 10 |
| <b>vandazole</b> . . . . .                           | 19  | VORICONAZOLE . . . . .            | 34 |
| vantin . . . . .                                     | 19  | VORINOSTAT . . . . .              | 38 |
| <b>VAQTA</b> . . . . .                               | 76  | <b>vospire er</b> . . . . .       | 84 |
| VARENICLINE TARTRATE . . . . .                       | 31  | <b>VYTORIN</b> . . . . .          | 55 |
| VARICELLA VIRUS VACCINE LIVE . . . . .               | 76  | <b>W</b>                          |    |
| <b>VARIVAX</b> . . . . .                             | 76  | WARFARIN SODIUM . . . . .         | 49 |
| vaseretic . . . . .                                  | 56  | <b>WELCHOL</b> . . . . .          | 55 |
| vasotec . . . . .                                    | 56  | wellbutrin sr . . . . .           | 28 |
| <b>veetids</b> . . . . .                             | 22  | wellbutrin xl . . . . .           | 28 |
| <b>VELCADE</b> . . . . .                             | 38  | westcort . . . . .                | 66 |
| <b>velivet</b> . . . . .                             | 70  | <b>X</b>                          |    |
| VENLAFAXINE . . . . .                                | 29  | <b>XALATAN</b> . . . . .          | 81 |
| VENLAFAXINE HCL . . . . .                            | 29  | <b>XOLAIR</b> . . . . .           | 85 |
| <b>VENLAFAXINE HCL ER</b> . . . . .                  | 29  | <b>XOPENEX HFA</b> . . . . .      | 84 |
| <b>VENTAVIS</b> . . . . .                            | 85  | xylocaine . . . . .               | 14 |
| ventolin . . . . .                                   | 83  | xylocaine jelly . . . . .         | 14 |
| <b>VENTOLIN HFA</b> . . . . .                        | 84  | <b>XYREM</b> . . . . .            | 58 |
| <b>VERAMYST</b> . . . . .                            | 82  |                                   |    |

## Índice de medicamentos

El índice de medicamentos incluye medicamentos cubiertos (**en negritas**) y nombres de medicamentos alternativos

|  |    |                                |    |
|--|----|--------------------------------|----|
| <b>Y</b>                                     |    | zovirax . . . . .              | 45 |
| YELLOW FEVER VACCINE . . . . .               | 77 | zyban . . . . .                | 31 |
| <b>YF-VAX</b> . . . . .                      | 77 | <b>ZYDONE</b> . . . . .        | 14 |
| <b>Z</b>                                     |    | <b>ZYFLO CR</b> . . . . .      | 83 |
| ZAFIRLUKAST . . . . .                        | 82 | zyloprim . . . . .             | 35 |
| <b>zaleplon</b> . . . . .                    | 85 | <b>ZYMAR</b> . . . . .         | 24 |
| zanaflex . . . . .                           | 43 | <b>ZYPREXA</b> . . . . .       | 42 |
| ZANAMIVIR . . . . .                          | 45 | <b>ZYPREXA ZYDIS</b> . . . . . | 42 |
| <b>ZANOSAR</b> . . . . .                     | 37 | zyrtec . . . . .               | 82 |
| zantac . . . . .                             | 63 | <b>ZYVOX</b> . . . . .         | 19 |
| zarontin . . . . .                           | 25 |                                |    |
| zaroxolyn . . . . .                          | 54 |                                |    |
| <b>ZAVESCA</b> . . . . .                     | 61 |                                |    |
| <b>zazole</b> . . . . .                      | 35 |                                |    |
| zebeta . . . . .                             | 52 |                                |    |
| <b>ZEMAIRA</b> . . . . .                     | 85 |                                |    |
| <b>ZEMPLAR</b> . . . . .                     | 78 |                                |    |
| <b>ZENAPAX</b> . . . . .                     | 73 |                                |    |
| zerit . . . . .                              | 44 |                                |    |
| <b>zerlor</b> . . . . .                      | 14 |                                |    |
| zestoretic . . . . .                         | 56 |                                |    |
| zestril . . . . .                            | 56 |                                |    |
| <b>ZETIA</b> . . . . .                       | 55 |                                |    |
| ziac . . . . .                               | 53 |                                |    |
| <b>ZIAGEN</b> . . . . .                      | 44 |                                |    |
| ZIDOVUDINE . . . . .                         | 44 |                                |    |
| ZILEUTON . . . . .                           | 83 |                                |    |
| ZIPRASIDONE HYDROCHLORIDE . . . . .          | 41 |                                |    |
| ZIPRASIDONE MESYLATE . . . . .               | 42 |                                |    |
| zithromax . . . . .                          | 22 |                                |    |
| <b>ZMAX</b> . . . . .                        | 23 |                                |    |
| zocor . . . . .                              | 55 |                                |    |
| zofran . . . . .                             | 33 |                                |    |
| zofran odt . . . . .                         | 33 |                                |    |
| <b>ZOLEDRONIC ACID MONOHYDRATE</b> . . . . . | 79 |                                |    |
| <b>ZOLINZA</b> . . . . .                     | 38 |                                |    |
| ZOLMITRIPTAN . . . . .                       | 35 |                                |    |
| zoloft . . . . .                             | 29 |                                |    |
| ZOLPIDEM TARTRATE . . . . .                  | 85 |                                |    |
| <b>ZOMETA</b> . . . . .                      | 79 |                                |    |
| <b>ZOMIG</b> . . . . .                       | 35 |                                |    |
| <b>ZOMIG ZMT</b> . . . . .                   | 35 |                                |    |
| zonegran . . . . .                           | 25 |                                |    |
| <b>zonisamide</b> . . . . .                  | 25 |                                |    |
| <b>ZORBTIVE</b> . . . . .                    | 67 |                                |    |
| <b>ZOSTAVAX</b> . . . . .                    | 77 |                                |    |
| ZOSTER . . . . .                             | 77 |                                |    |
| <b>ZOSYN</b> . . . . .                       | 22 |                                |    |
| zovia 1/35e . . . . .                        | 70 |                                |    |
| zovia 1/50e . . . . .                        | 70 |                                |    |



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