

Prescription Drug Benefit Description

Prescription Drug Program For State of Kansas Employees Health Plan

This booklet describes the Prescription Drug benefits available through the State of Kansas ("the State") program (the Plan). The prescription drug program is underwritten by the State of Kansas and administered by Caremark. The State of Kansas reserves the right to change or terminate the program at any time or to change the company that administers the program.

The Caremark Pharmacy and Therapeutics Committee administers the Preferred Drug List and assists the State in determining the appropriate tiers of coverage. Caremark is not the insurer of this Plan and does not assume any financial risk or obligation with respect to claims.

Contact Information

For answers to any questions regarding Your prescription claims payment, contact:

Caremark

P.O. Box 52136

Phoenix, AZ 85072-2136

1-800-294-6324

<http://www2.caremark.com/kse/>

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Section 1 Definitions

Allowed Charge – The maximum amount the Plan determines is payable for a covered expense. For this Plan, the Allowed Charge will be the contracted reimbursement rate including any applicable sales tax. When this Plan is secondary to other insurance coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Plan.

Brand Name – Typically, this means a drug manufactured and marketed under a trademark, or name by a specific drug manufacturer. For the purposes of pricing, drug classification (e.g., brand vs. generic) will be established by a nationally recognized drug pricing and classification source.

Compound Medication – A medicine mixed for a specific patient and not available commercially. To be eligible for reimbursement, a Compound Medication must contain at least one Legend Drug that has been assigned a national drug code (NDC) number, requiring a Physician's Order to dispense, and eligible for coverage under this Plan.

Coinsurance – A sharing mechanism of the cost of health care and is expressed as a percentage of the Allowed Charge that will be paid by You and the balance paid by the Plan.

Copayment – A specified amount that You are required to pay for each quantity or supply of prescription medicine that is purchased.

Copayment/Coinsurance Maximum – The maximum combined total for a Member on the Coinsurance and Copayments for Generic, Preferred and Special Case Medications. The Coinsurance for a Non Preferred Drug does not accumulate toward the Copayment/Coinsurance Maximum.

Drug Override – A feature that allows Members who meet specific criteria outlined in the Plan to receive Non Preferred Drugs at the Preferred Drug Coinsurance level.

Experimental, Investigational, Educational or Unproven Services – Medical, surgical, diagnostic, psychiatric, substance abuse, other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by the Plan (at the time it makes a determination regarding coverage) to be: **(1)** not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or **(2)** subject to review and approval by any Institutional Review Board for the proposed use; or **(3)** the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or **(4)** not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or **(5)** for the primary purpose of providing training in the activities of daily living, instruction in scholastic skills such as reading or writing, or preparation for an occupation or treatment for learning disabilities.

Generic – Typically, this means a medicine chemically equivalent to a Brand Name drug on which the patent has expired. For purposes of pricing, drug classification (e.g., Brand vs. Generic) will be established by a nationally-recognized drug pricing and classification source.

Legend Drug – Medications or vitamins that by law require a physician's prescription in order to purchase them.

Lifestyle Medications – Medicines with primary indications for use of: infertility; erectile dysfunction; medications used primarily for cosmetic purposes; dental preparations (e.g., toothpaste, mouthwash, etc.); prescription medicine where an equivalent product is available without a prescription; Drug Efficacy Study Implementation (DESI-5) medications (older medicines which still require a prescription, and which the FDA has approved only on the basis of safety, not safety and effectiveness); and ostomy supplies.

Maximum Allowable Cost List ("MAC List") – A list of specific multi-source Brand Name and Generic drug products that the maximum allowable costs have been established on the amount reimbursed to pharmacies.

Maximum Allowable Quantity List ("MAQ List") – Some medicines are limited in the amount allowed per fill. Limiting factors are FDA approval indications for the MAQ list as well as manufacture package size and standard units of therapy. The list is subject to periodic review and modification.

Medically Necessary – Prescription Drug Products that are determined by the Plan to be medically appropriate and: **(1)** dispensed pursuant to a Prescription Order or Refill; **(2)** necessary to meet the basic health needs of the Member; **(3)** consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, health care coverage organizations, or governmental agencies; and **(4)** commonly and customarily recognized as appropriate for treatment of the illness, injury, sickness or mental illness. The fact that a provider prescribed a Prescription Drug Product or the fact that it may be the only treatment for a particular illness, injury, sickness or mental illness does not mean that it is Medically Necessary. The fact that a medicine may be medically necessary or appropriate does not mean that is a covered service.

Member – An individual eligible for benefits under the Plan as determined by the Plan Sponsor.

Non Preferred Drug – Any drug not listed on the Preferred Drug List or the Special Case Medication List of the Plan are considered Non Preferred.

Participating Pharmacy – A pharmacy that has entered into an agreement to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates.

Pharmacy – A licensed provider authorized to prepare and dispense drugs and medicines. A Pharmacy must have a National Association of Boards of Pharmacy identification number ("NABP number").

Plan – The benefits defined herein and administered on behalf of the State of Kansas by Caremark.

Plan Sponsor – The State of Kansas

Preferred Drug List – A list that identifies those Prescription Drug Products that are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modification. The Preferred Drug List is available at: <http://www2.caremark.com/kse/>.

Preferred Drug – A drug listed on the Preferred Drug List.

Prescription Drug Product – A medicine, product or device registered with and approved by the Food and Drug Administration (“FDA”) and dispensed under federal or state law only pursuant to a Prescription Order or Refill. For the purpose of coverage under the Plan, this definition includes insulin and diabetic supplies, such as insulin syringes with needles; alcohol swabs; blood testing strips-glucose; urine testing strips-glucose; ketone testing strips and tablets; and lancets and lancet devices.

Prescription Order or Refill – The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization – The process of obtaining pre-approval of coverage for certain Prescription Drug Products, prior to their dispensing, and using guidelines approved by the Plan Sponsor. The Plan retains the final discretionary authority regarding coverage.

Self-Injectable Drug – Injectable medicine that are intended to be self-administered by the Member and/or a family member. Coverage is limited to those medicines that have been designated by the Plan. This list is subject to periodic review and modification.

Self Management – The tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions.

Special Case Medication – A group of high cost medications used for the treatment of catastrophic conditions. The list is subject to periodic review and modification.

Standard Unit of Therapy – A manufacturer’s pre-packaged quantity or an amount sufficient for one course of treatment at normal dosages.

Tobacco Control – A program that encourages members to discontinue using tobacco products and reduces the risk of disease, disability and death related to tobacco use.

You or Your – Refers to the Member.

Section 2 Benefit Provisions

Coverage for Outpatient Prescription Drug Products:

The Plan provides coverage for Prescription Drug Products, if all of these conditions are met:

- (1) It is Medically Necessary
- (2) It is obtained through a Participating Retail, Mail service/online pharmacy or a Non Participating Retail Pharmacy
- (3) You are an eligible Member in the Plan
- (4) The Prescription Drug Product is covered under the Plan and it is dispensed according to Plan guidelines

Standard Prescription Drug Benefits

Coverage Level	Prescription Drug Product	Member Responsibility
Tier 1	Generic Drugs	20% Coinsurance
Tier 2	Preferred Drugs	35% Coinsurance
Tier 3	Special Case Medications	\$75 Copayment per unit
Coinsurance/Copayment Maximum	Tiers 1, Tier 2 and Tier 3 Only	\$2580 per person per year
Tier 4	Non Preferred and Compound Medications	60% Coinsurance
Tier 5	Lifestyle Medications	100% Coinsurance

Benefits are provided for each eligible Prescription Drug Product filled, subject to payment of any applicable Coinsurance or Copayment. The Provider and the patient, not the Plan or the employer, determine the course of treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be. If You use a Participating Pharmacy, the Member’s payment shall not exceed the Allowed Charge provided that You present Your identification card to the pharmacy as required. When a Non Participating Pharmacy is used, You will be responsible for the difference between the pharmacy’s billed charge and Allowed Charge in addition to applicable Coinsurance or Copayment. Benefits for services received from a Retail Non Participating Pharmacy will be paid to the primary insured. You can not assign benefits under this program to any other person or entity.

Generic Prescription Drug Products:

Your Coinsurance is 20 percent of the Allowed Charge.

Preferred Brand Name Prescription Drug Products:

For eligible Preferred Brand Name Drugs, Your Coinsurance is 35 percent of the Allowed Charge. The Preferred Drug List is subject to periodic review and modification.

Non Preferred Brand Name Drug Products:

For eligible Non Preferred Brand Name Drug Products not included on the Preferred Drug List, Your Coinsurance is 60 percent of the Allowed Charge.

Special Case Medications:

The Copayment is \$75 per standard unit of therapy not to exceed a thirty (30) day supply of Prescription Drug Product. For quantities less than a thirty (30) day supply, Your responsibility is 25 percent Coinsurance of the Allowed Charge not to exceed \$75.

Lifestyle Medications:

You will be responsible for 100 percent of the Allowed Charge.

Compound Medications:

The Coinsurance will be 60 percent of the Allowed Charge of the Compounded Medication.

Chronic Care Benefit:

Prescription Drugs for:	Prescription Drug Product	Member Responsibility (Per 30 Day Supply)
Diabetes	Generic Drug	10% to a maximum of \$10
	Preferred Brand Drug	20% to a maximum of \$20
Asthma	Generic Drug	10% to a maximum of \$10
	Preferred Brand Drug	20% to a maximum of \$20

Chronic Care Benefit:

The chronic care benefit is designed to support self management of asthma and diabetes. Regularly taking Your medicine along with monitoring peak flows and blood sugar levels are critical to the self management of asthma and diabetes. To promote adherence to medication therapy, the coinsurance has been reduced on prescription drug products primarily used for the treatment of asthma and diabetes as indicated above. The Plan retains the final discretionary authority on what constitutes an asthma or diabetic prescription drug product. This list is subject to periodic review and modification.

Copayment/Coinsurance Maximum:

The total Copayment/Coinsurance Maximum per year for Generic, Preferred or Special Case Medication is \$2,580 per person. Non Preferred Drugs, even those being purchased with a Drug Override, do not accumulate toward the Copayment/Coinsurance Maximum. Purchases of Generic, Preferred and Special Medications in excess of the Member's Copayment/Coinsurance Maximum will be reimbursed at 100 percent of the Allowable Charge for the remainder of the calendar year.

Self-Injectable Medications:

Coverage for Self-Injectable drugs under this Plan is limited to those medicines that have been designated by the Plan Sponsor. A list of designated medications is available on the Web at <http://www2.caremark.com/kse/> or <http://www.khpa.ks.gov/subject/benlink.htm> (click the word Caremark.) This list is subject to periodic review and modification. The Self-Injectable treatment must be medically necessary and appropriate for the condition being treated. Some Self-Injectable medications are available through the Caremark® Specialty Pharmacy Services.

Caremark® Specialty Pharmacy Services:

The Caremark Specialty Pharmacy Services is a program that focuses on patients who use certain high cost injectable medicines. Eligible Members will be contacted directly by Caremark. This program offers Members a convenient source for these high cost injectable drugs, lower potential drug-to-drug interactions, and improved therapy compliance. Members who elect to participate in the Caremark Specialty Pharmacy program will have access to pharmacists or nurses 24 hours a day, seven days a week. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve You, Your physician, nurse, case manager, and clinical pharmacist in a coordinated and monitored course of treatment. Participation in the Caremark Specialty Pharmacy program is optional.

Tobacco Control Wellness Program:

Prescription Drugs for:	Prescription Drug Product	Member Responsibility (Per 30 Day Supply)
Tobacco Control (Enrollment in Program Required)	Generic Drug	10% to a maximum of \$10
	Brand Name Drug	20% to a maximum of \$20

Tobacco Control Wellness Program:

Enrollment in an approved tobacco control program is required for coverage of prescription medicines. The Plan will pay up to a maximum of \$300 per member per year toward the cost of tobacco control prescription drug products while you are enrolled in an approved tobacco control program. Information on approved programs is available on the State of Kansas Web site at: <http://www.khpa.ks.gov/healthquest/default.htm>. The Plan retains the final discretionary authority on what constitutes tobacco control prescription drug products. This list is subject to periodic review and modification.

Weight Management Wellness Program:

Prescription Drugs for:	Prescription Drug Product	Member Responsibility
Weight Control (Enrollment in Program Required)	Generic Drug	20% Coinsurance
	Preferred Brand Name Drug	35% Coinsurance
	Non Preferred Brand Name Drug	60% Coinsurance

Weight Management Wellness Program:

Enrollment in an approved weight management program is required for coverage of weight control prescription medicines. The Plan will pay as indicated above toward the cost of weight control prescription drug products while you are enrolled in an approved weight management program. Information on approved programs is available on the State of Kansas Web site at: <http://www.khpa.ks.gov/healthquest/default.htm>. The Plan retains the final discretionary authority on what constitutes weight management or weight control prescription drug products. This list is subject to periodic review and modification.

Initial Prescription Drug Product Purchase:

Covered Prescription Drug Products are subject to the initial fill limit of thirty (30) consecutive day supply or one standard unit of therapy, whichever is less.

A standard unit of therapy is up to a thirty (30) consecutive day supply of a Prescription Drug Product unless adjusted based on the drug manufactured packaging size or “standard units of therapy guidelines.” Some products may be subject to additional supply limits adopted by the Plan.

Refill Guidelines:

Refills for up to a sixty (60) day supply may be obtained at one time for most medications. The refill prescriptions must be filled within one hundred and twenty (120) days of the prior fill and must be for the same strength of Prescription Drug Product. If not filled within one hundred and twenty (120) days of the prior fill or if the drug strength changes, only a thirty (30) day supply will be allowed. Refills may be obtained on the following schedule:

Supply of Prescription Product	Percentage Consumed	Refill Available After
5 Day Supply	40%	2 Days
10 Day Supply	60%	6 Days
21 Day Supply	70%	15 Days
30 Day Supply	75%	22 Days
60 Day Supply	75%	45 Days

Advance Purchases:

Advance Purchase of Prescription Drug Products are available for active employees only who will be departing the United States for an extended period of time. Copayment and Coinsurance will be the applicable Participating Pharmacy payments required for each thirty (30) day supply or standard unit of therapy received. Active employees may contact their Human Resource office to obtain the Advance Purchase Certificate. The completed form must be signed by both You and an agency employee with the authority to expend agency funds, and submitted to the Health Benefits Administration office **15 days in advance** of the anticipated departure date. Up to a one (1) year supply of medications may be obtained if the request is approved.

- When adequate time is not available to submit an Advance Purchase Request or purchases are made outside of the country the cardholder may submit the pharmacy receipts for reimbursement upon return from the extended absence. In order to be considered for reimbursement, the patient must have continuous coverage for the entire period of absence.

For Prescription drugs purchased in the United States by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to: Health Benefits Administration, 900 SW Jackson, Rm. 900-N, Topeka, KS 66605.

Prescription Drug Products purchased and used while outside the United States must include documentation of the purchase to include the original receipt that contains the patient's name, the name of the product, day supply and quantity purchased and price paid. An English translation and currency exchange rate for the date of service is required from You in order to process the claim. Only prescription drug that is eligible for payment under this Plan may be claimed for reimbursement. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to: Health Benefits Administration, 900 SW Jackson, Rm. 900-N, Topeka, KS 66605.

Mail Service Pharmacy:

Caremark offers a mail service that may save You money on Your prescription drug services. The Caremark Mail Pharmacy is a convenient and cost effective way to obtain Your medicine through the mail to any location in the United States. The maximum supply available is a sixty (60) day supply. All supply limits and plan requirements apply to mail service pharmacy purchases.

To order by mail, send the Mail Service Profile Order Form available at <http://www2.caremark.com/kse/> or <http://www.khpa.ks.gov/subject/benlink.htm> (click the word Caremark) or by calling toll-free 1-800-294-6324, and attach the original prescription from Your physician along with Your payment or credit card number to the address listed on the form.

If You have a new prescription and wish to start mail service right away, Caremark will call Your physician directly and enroll You in the FastStart® program. Simply call FastStart toll free at 1-866-772-9503. You must have Your prescription information as well as Your physician's telephone and FAX numbers for the representative. Caremark will call Your physician directly for Your prescription information and enroll You for mail service as soon as Your physician provides the necessary information.

You can expect your medicine to arrive approximately 10 to 14 calendar days after Caremark receives your order. The mail service pharmacy is required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than plan maximums per fill, the mail service pharmacy will fill the exact quantity prescribed.

For Refills:

The prescription label lists the date when You can request a refill and shows how many refills You have left. Refill prescriptions on the Internet by visiting <http://www.caremark.com>. Have Your prescription number, date of birth and credit card information ready. You can also order refills by phone or through the mail. To use the automated phone service, call the toll-free number on the prescription label and have the prescription number, ZIP code and credit card information ready, or mail the refill slip and payment to Caremark in the envelope that was included with Your previous shipment.

Paper Claims:

Members will need to file a paper claim for the following situations:

- Anytime Prescription Drug Products are purchased from a Non Participating Pharmacy.

- If You do not present Your ID card at a Participating Pharmacy and are charged the retail cost of the Prescription, You will be responsible for filing a paper claim for reimbursement. (The Caremark Help Desk, toll-free 1-800-364-6331 can assist in transmitting a claim online if the Member does not have their ID card available.)
- If a Prescription Drug Product requires prior authorization and it has not been obtained, the Member may pay the full purchase price for the Product and submit a claim along with documentation for consideration of coverage under the Plan. Payment is not guaranteed by the Plan.

Prescription drugs purchased by the Member in excess of the supply limits of the plan may be covered once the time period covered by the excess supply has elapsed so long as the excess supply purchased does not overlap any other purchases for the same product. Claims must be filed within one (1) year and ninety (90) days of the date of purchase to: Health Benefits Administration, 900 SW Jackson, Rm. 900-N, Topeka, KS 66605.

In any of these situations, You must pay full retail price at the pharmacy. A claim form should then be completed and sent (along with the original receipt and any additional information) to: Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136. Reimbursement to the Member for the cost of the prescription is limited to the Allowed Charge a Participating Pharmacy would have been paid, less applicable Coinsurance or Copayments. Claim forms can be found on the internet at <http://www2.caremark.com/kse>.

Time Limit for Filing Claims:

You are responsible for making sure the Participating Pharmacy knows You have prescription drug coverage and submits a claim for You. Most claims under this program are submitted electronically at the time of purchase. For those claims that are not, electronic claims may be submitted or adjusted within thirty (30) days of purchase. If You use a Non Participating Provider, You must submit the notice yourself. Notice of Your claim must be given to the Plan within ninety (90) days after You receive services. If it is not reasonably possible for You to submit a claim within ninety (90) days after You receive services, You or someone authorized by You must submit the claim as soon as reasonably possible. No claim will be paid if not received by the Company within one (1) year and ninety (90) days after You receive services.

Section 3 Coordination of Benefits

Coordination of Benefits with Medicare as Primary:

When Medicare is primary, the Plan will pay the balance of the Medicare Allowed Charge in full.

Coordination of Benefits with Commercial Insurance:

Only prescription drug products covered under this Plan are eligible for payment. The Allowed Charge will be the amount allowed but not covered by the other plan. Payments are subject to this Plan's applicable Coinsurance, Copayments and Plan provisions and limitations.

Order of Benefit Determination:

The plan that covers You as an active employee is primary to the plan that covers You as a dependent or retired employee unless otherwise required by Medicare.

Determination of primary/secondary coverage for dependent children will be based upon the “birthday rule” unless otherwise required by court order or by law. The primary plan is the plan of the parent whose birthday is earlier (month and day) in the year.

If the parents are not married or separated (whether or not they were married) or are divorced, and the court decree does not allocate responsibility for health care or expenses, the order of benefit determination will be as follows:

- a) The plan of the custodial parent
- b) The plan of the spouse of the custodial parent
- c) The plan of the noncustodial parent
- d) The plan of the spouse of the noncustodial parent

Section 4 Prior Authorization

Certain Prescription Drug Products require Prior Authorization to be covered by the Plan. Prior Authorization is usually initiated by Your physician or pharmacist on Your behalf; however, it remains Your responsibility. If these Prescription Drug Products are not authorized before being dispensed, You will be responsible for paying the full retail charge. In this case, You will need to submit a paper claim with supporting documentation to allow for consideration under the Plan. The Plan retains the final discretionary authority regarding coverage by the Plan.

The following list of medicines require Prior Authorization to be covered. The list is subject to periodic review and modifications:

ADHD/Narcolepsy

Adderall®
Adderall® XR
Desoxyn®
Dexedrine®
Dextrostat®
Vyvanse

Arthritis Agents

Arava®
Enbrel®
Humira
Kineret®
Orencia®
Remicade®

Asthma

Xolair®

Diabetic

Byetta™
Symlin®

Growth Hormones

Genotropin®
Geref®
Humatrope®
Norditropin®
Nutropin®
Nutropin AQ®
Nutropin Depot®
Omnitrope™
Saizen®
Serostim®
Somavert™
Tev-tropin®
Zorbtive®

Migraine

Amerge®
Axert®
Frova™
Imitrex® Nasal Spray
Imitrex® Tablet
Imitrex®
Injection
Maxalt®
Maxalt® MLT
Relpax®
Zomig®
Zomig® Nasal Spray
Zomig® ZMT

MS Drugs

Avonex®
Betaseron®
Copaxone®
Novantrone®
Rebif®

Pain

Stadol® Nasal Spray

Psoriasis

Raptiva™

Tretinoin Products

Avita™
Retin-A®
Retin-A® Micro
Tretin-X™
Ziana™

Section 5 Drug Override

If You are taking a Non Preferred Drug and can show that You tried at least **two (2)** different Preferred Drugs in the same therapeutic class, Your physician may call the Caremark Prior Authorization Department toll-free at 1-800-294-5979 (for physician use only) to request a drug override. Approvals will be granted in the following situations:

1) The patient has used at least two (2) Preferred Drugs

and

a) The Preferred Drugs were ineffective for the patient

b) The patient could not tolerate the Preferred Drugs

or

2) The patient meets other pre-established clinical criteria approved by the Plan Sponsor.

If the request is approved, an override will be entered to allow the Non Preferred Drug to be paid for at the Preferred Drug Coinsurance. Non Preferred Drugs which have been approved for an override based on the above criteria will count toward the Coinsurance/Copayment maximum.

Section 6 Fraudulent, Inappropriate Use or Misrepresentation

You and Your dependent(s) coverage may be terminated and other appropriate action taken as determined by the Plan Sponsor, if You or Your dependents participate in any act that constitutes fraud, gross misbehavior, misrepresentation or omission of pertinent facts in applying for or seeking benefits under the Plan. This shall also include other improper action as determined by the Plan Sponsor. This includes but is not limited to:

- a. Misrepresent or omission of material facts to obtain coverage or allowing unauthorized persons use of Your State of Kansas Drug Plan ID card to obtain services, supplies or medicine that are not prescribed or ordered for You or a covered family member or for which You are not otherwise entitled to receive. In this instance, Coverage for You and/or any covered

dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

- b. Permitting the unauthorized use of Your State of Kansas Drug Plan ID card to obtain medication, services or supplies for someone not covered under Your State of Kansas Prescription Drug membership. In this instance, Coverage of the member and/or dependent(s) may be terminated by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.
- c. Using another State of Kansas member's Prescription Drug Plan ID card to obtain medicine, services or supplies for Your or some other third party not specifically covered under that membership may result in the termination of your coverage and that of your dependents by the Plan Sponsor and any other action determined appropriate by the Plan Sponsor.

Section 7 Exclusions

The plan does not cover the following:

1. Prescription Drug Products in amounts exceeding the supply limit referenced in Section 2.
2. Drugs which are prescribed, dispensed or intended for use while You are an inpatient in a hospital or other facility.
3. Experimental, Investigational, Educational or Unproven Services, technologies which include medical, surgical, diagnostic, psychiatric, substance abuse, other health care, supplies, treatments, procedures, drug therapies, or devices.
4. Prescription Drug Products furnished to a Member by any local, state or federal government entity; except as otherwise provided by law, any Prescription Drug Product to the extent payment or benefits are provided or available from any local, state or federal government entity (e.g., Medicare) regardless of whether payment or benefits are received.
5. Prescription Drug Products for any condition, illness, injury, sickness or mental illness arising out of or in the course of employment for which compensation benefits are available under any Worker's Compensation Law or other similar laws, regardless of whether the Member makes a claim for, or receives such compensation or benefits.
6. Compounded drugs not containing at least one (1) ingredient with a valid National Drug Code (NDC) number and requiring a Physician's Order to dispense. In addition, the Compounded Medication must have FDA approval.
7. Drugs available over-the-counter or for which the active ingredients do not require a Prescription by federal or state law.
8. Injectable drugs administered by a Health Professional in an inpatient or outpatient setting.
9. Durable or disposable medical equipment or supplies, other than the specified diabetic and ostomy supplies.
10. Replacement Prescription Drug Products resulting from lost, stolen or spilled Prescription Orders or Refills.

- 11.** Legend general vitamins except Legend prenatal vitamins, Legend vitamins with fluoride, and Legend single entity vitamins.
- 12.** Prescription Drug Products that are not medically necessary.
- 13.** Charges to administer or inject any drug.
- 14.** Prescription Drug Products that are administered or entirely used up at the time and place ordered, such as in a clinic or physician's office.
- 15.** Prescription Drug Products for which there is normally no charge in professional practice.
- 16.** Contraceptive devices, therapeutic devices, artificial appliances, or similar devices, regardless of intended use.
- 17.** Prescription Drug Products purchased from an institutional pharmacy for use while the Member is an inpatient in that institution.
- 18.** Charges for the delivery of any drugs.
- 19.** Prescription Drug Products obtained for use in connection with the treatment of drug addiction.
- 20.** Prescription Drug Products approved for experimental use only.
- 21.** The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice.
- 22.** Benefits are not available to the extent a Prescription Drug Product has been covered under another contract, certificate or rider issued by the Plan Sponsor.
- 23.** Coverage for allergy antigens under any circumstances.
- 24.** Enteral nutritional supplements which do not qualify as a Prescription Drug Product as defined herein.
- 25.** Drugs imported for use in the United States from foreign countries.

Section 8 Preferred Drug List



Kansas State Group Health Insurance Program Member Preferred Drug List

2008

The drug representation on the Preferred Drug List is subject to continuing review by the Caremark National Pharmacy and Therapeutics Committee solely as it relates to safety and efficacy.

If you have questions or need additional information, contact **Kansas State Employees Prescription Drug Program** toll-free at: **1-800-294-6324** or access the Web site at: <http://khpa.ks.gov>

To locate covered prescriptions on-line, you may access the most current drug list on the State of Kansas Web site at:
<http://khpa.ks.gov>

What is a Preferred Drug List?

A Preferred Drug List is a list of safe and cost effective drugs, chosen by a committee of physicians and pharmacists. Drug lists have been used in hospitals for many years to help ensure quality drug use. The Kansas State Employees Preferred Drug List will be continually revised to reflect the changing drug market.

Should I ask my physician to switch my current medications to a medication that is on the Preferred Drug List?

Many of your medications will already be on the Preferred Drug List. However, if you have a medication that is not, ask your physician to choose a similar Preferred Drug List product for you to use.

Should I use generics?

There are many medications on the market that do not come in generic form. For those drugs that do, your pharmacist should suggest safe and effective generic alternatives.

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2008

ANALGESICS

NSAIDs
diclofenac sodium delayed-rel
diflunisal
etodolac
ibuprofen
indomethacin
indomethacin ext-rel
meloxicam
nabumetone
naproxen
naproxen sodium
oxaprozin
salsalate
sulindac

COX-2 INHIBITORS
celecoxib (CELEBREX)

GOUT
allopurinol
colchicine
probenecid

NARCOTIC ANALGESICS
codeine/acetaminophen
hydrocodone/acetaminophen

NARCOTIC ANALGESICS, CII
fentanyl transdermal
hydromorphone
morphine
morphine ext-rel
morphine supp
oxycodone
oxycodone ext-rel
oxycodone/acetaminophen 5/325
oxycodone soln
morphine ext-rel (AVINZA)

NON-NARCOTIC ANALGESICS
butalbital/acetaminophen/cafeine
butalbital/aspirin/cafeine
tramadol

ANTI-INFECTIVES

ANTIBACTERIALS
Cephalosporins
First Generation
cefadroxil
cephalexin

Second Generation

cefaclor
cefprozil
cefuroxime axetil

Third Generation

cefdinir

Erythromycins/Macrolides

azithromycin
clarithromycin
erythromycin delayed-rel
erythromycin ethylsuccinate
erythromycin stearate
erythromycin/sulfisoxazole
clarithromycin ext-rel (BIAXIN XL)

Fluoroquinolones

ciprofloxacin ext-rel
ciprofloxacin tabs
ciprofloxacin susp (CIPRO susp)
levofloxacin (LEVAQUIN)
moxifloxacin (AVELOX)

Penicillins

amoxicillin
amoxicillin/clavulanate
ampicillin
dicloxacillin
penicillin VK

Sulfonamides

acetyl sulfisoxazole susp (GANTRISIN)

Tetracyclines

doxycycline hyclate
minocycline
tetracycline

ANTIFUNGALS

clotrimazole troches
fluconazole
itraconazole
ketoconazole
nystatin
terbinafine tabs
griseofulvin ultramicrosize (GRIS-PEG)
voriconazole (VFEND)

ANTIMALARIALS

chloroquine
mefloquine
atovaquone/proguanil (MALARONE)

Boldface type indicates generic availability.

Your Kansas State Employees Preferred Drug List As Of January 2008

ANTIRETROVIRAL AGENTS

Antiretroviral Combinations

abacavir/lamivudine (EPZICOM)
abacavir/lamivudine/zidovudine (TRIZIVIR)
efavirenz/emtricitabine/tenofovir (ATRIPLA)
emtricitabine/tenofovir (TRUVADA)
lamivudine/zidovudine (COMBIVIR)

Non-nucleoside Reverse

Transcriptase Inhibitors

delavirdine (RESCRIPTOR)
efavirenz (SUSTIVA)
nevirapine (VIRAMUNE)

Nucleoside Reverse

Transcriptase Inhibitors

didanosine delayed-rel
zidovudine

abacavir (ZIAGEN)
didanosine (VIDEX)
emtricitabine (EMTRIVA)
lamivudine (EPIVIR)
stavudine (ZERIT)

Nucleotide Reverse

Transcriptase Inhibitors

tenofovir (VIREAD)

Protease Inhibitors

amprenavir (AGENERASE)
atazanavir (REYATAZ)
darunavir (PREZISTA)
fosamprenavir (LEXIVA)
indinavir (CRIXIVAN)
lopinavir/ritonavir (KALETRA)
nelfinavir (VIRACEPT)
ritonavir (NORVIR)
saquinavir mesylate (INVIRASE)
tipranavir (APTIVUS)

ANTITUBERCULAR AGENTS

ethambutol

isoniazid

pyrazinamide

rifampin

ANTIVIRALS

Cytomegalovirus Agents

ganciclovir

valganciclovir (VALCYTE)

Hepatitis Agents

ribavirin

adefovir dipivoxil (HEPSERA)
entecavir (BARACLUDE)
lamivudine (EPIVIR-HBV)
ribavirin oral soln (REBETOL)
telbivudine (TYZKA)

Herpes Agents

acyclovir

famciclovir

valacyclovir (VALTREX)

Influenza Agents

amantadine

rimantadine

oseltamivir (TAMIFLU)

MISCELLANEOUS

clindamycin

mebendazole

metronidazole

nitrofurantoin ext-rel

nitrofurantoin macrocrystals

sulfamethoxazole/trimethoprim

trimethoprim

dapsone

nitrofurantoin susp (FURADANTIN)

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

cyclophosphamide

busulfan (MYLERAN)

chlorambucil (LEUKERAN)

lomustine (CEENU)

melphalan (ALKERAN)

temozolomide (TEMODAR)

ANTIMETABOLITES

mercaptopurine

capecitabine (XELODA)

methotrexate (TREXALL)

thioguanine

HORMONAL ANTINEOPLASTIC AGENTS

Antiandrogens

flutamide

bicalutamide (CASODEX)

Antiestrogens

tamoxifen

fulvestrant (FASLODEX)

toremifene (FARESTON)

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Aromatase Inhibitors

anastrozole (ARIMIDEX)
exemestane (AROMASIN)
letrozole (FEMARA)

Luteinizing Hormone-releasing Hormone (LHRH) Agonists

leuprolide acetate
goserelin acetate (ZOLADEX)
triptorelin pamoate (TRELSTAR)

Progestins

megestrol acetate

KINASE INHIBITORS

dasatinib (SPRYCEL)
erlotinib (TARCEVA)
imatinib mesylate (GLEEVEC)
lapatinib (TYKERB)
sorafenib (NEXAVAR)
sunitinib (SUTENT)

MISCELLANEOUS

etoposide
hydroxyurea
tretinoin caps
altretamine (HEXALEN)
bexarotene caps (TARGRETIN caps)
mitotane (LYSODREN)
procarbazine (MATULANE)
vorinostat (ZOLINZA)

CARDIOVASCULAR

ACE INHIBITORS

benazepril
captopril
enalapril
fosinopril
lisinopril
quinapril
trandolapril
ramipril (ALTACE)

ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/benazepril
trandolapril/verapamil ext-rel (TARKA)

ACE INHIBITOR/DIURETIC COMBINATIONS

benazepril/hydrochlorothiazide
captopril/hydrochlorothiazide
enalapril/hydrochlorothiazide
fosinopril/hydrochlorothiazide
lisinopril/hydrochlorothiazide
quinapril/hydrochlorothiazide

ADRENOLYTICS, CENTRAL

clonidine
guanfacine

ALDOSTERONE RECEPTOR ANTAGONISTS

spironolactone

ALPHA BLOCKERS

doxazosin
terazosin

ANGIOTENSIN II RECEPTOR ANTAGONIST/ CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/valsartan (EXFORGE)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ DIURETIC COMBINATIONS

candesartan (ATACAND)[†]
candesartan/hydrochlorothiazide
(ATACAND HCT)
irbesartan (AVAPRO)
irbesartan/hydrochlorothiazide (AVALIDE)
losartan (COZAAR)
losartan/hydrochlorothiazide (HYZAAR)
[†] Atacand should be reserved for participants
who meet CHARM (Candesartan in Heart
Failure - Assessment of Reduction in Mortality
and Morbidity) trial criteria.

ANTIARRHYTHMICS

amiodarone
disopyramide
disopyramide ext-rel
flecainide
mexiletine
propafenone
sotalol
dofetilide (TIKOSYN)

ANTILIPEMICS

Antilipemic Combinations
ezetimibe/simvastatin (VYTORIN)

Bile Acid Resins

cholestyramine (cans cost preferred)
colestipol
colesevelam (WELCHOL)

Cholesterol Absorption Inhibitors

ezetimibe (ZETIA)

Fibrates

fenofibrate
gemfibrozil
fenofibrate (TRICOR)

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HMG-CoA Reductase Inhibitors

lovastatin
pravastatin
simvastatin
 atorvastatin (LIPITOR)

Niacins/Combinations

niacin ext-rel (NIASPAN)
 niacin ext-rel/lovastatin (ADVICOR)

BETA-BLOCKERS

atenolol
bisoprolol
carvedilol
labetalol
metoprolol
metoprolol ext-rel
nadolol
pindolol
propranolol
propranolol ext-rel
 carvedilol phosphate ext-rel (COREG CR)

BETA-BLOCKER/DIURETIC COMBINATIONS

atenolol/chlorthalidone
bisoprolol/hydrochlorothiazide
metoprolol/hydrochlorothiazide

CALCIUM CHANNEL BLOCKERS

Dihydropyridines
amlodipine
felodipine ext-rel
nifedipine ext-rel

Nondihydropyridines

diltiazem
diltiazem ext-rel
verapamil
verapamil ext-rel

CALCIUM CHANNEL BLOCKER/

ANTIPEMIC COMBINATIONS
 amlodipine/atorvastatin (CADUET)

DIGITALIS GLYCOSIDES

digoxin
digoxin ped elixir

DIURETICS

amiloride
amiloride/hydrochlorothiazide
bumetanide
chlorthalidone
furosemide
hydrochlorothiazide
indapamide
metolazone
spironolactone/hydrochlorothiazide
torsemide
triamterene/hydrochlorothiazide

NITRATES

Oral

isosorbide dinitrate ext-rel tabs
isosorbide dinitrate oral
isosorbide mononitrate
isosorbide mononitrate ext-rel

Sublingual

nitroglycerin sublingual

Transdermal

nitroglycerin transdermal

NITRATE/VASODILATOR COMBINATIONS

isosorbide dinitrate/hydralazine (BIDIL)

PULMONARY ARTERIAL HYPERTENSION

Endothelin Receptor Antagonists

ambrisentan (LETAIRIS)
 bosentan (TRACLEER)

Phosphodiesterase Inhibitors

sildenafil (REVATIO)

Prostaglandin Vasodilators

epoprostenol sodium (FLOLAN)
 iloprost (VENTAVIS)
 treprostinil (REMODULIN)

MISCELLANEOUS

hydralazine
methyldopa
midodrine
 ranolazine ext-rel (RANEXA)

CENTRAL NERVOUS SYSTEM

ANTI-ANXIETY

Benzodiazepines

alprazolam
clonazepam tabs
diazepam
lorazepam
oxazepam

Boldface type indicates generic availability.

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Miscellaneous

buspirone
clomipramine
fluvoxamine

ANTICONVULSANTS

carbamazepine
ethosuximide
gabapentin
oxcarbazepine
phenobarbital
phenytoin sodium extended
primidone
valproic acid
zonisamide
diazepam rectal gel (DIASTAT)
divalproex sodium delayed-rel (DEPAKOTE)
divalproex sodium ext-rel (DEPAKOTE ER)
lamotrigine (LAMICTAL)
levetiracetam (KEPPRA)
phenytoin (DILANTIN INFATABS)
pregabalin (LYRICA)
topiramate (TOPAMAX)

ANTIDEMENTIA

donepezil (ARICEPT)
galantamine (RAZADYNE)
galantamine ext-rel (RAZADYNE ER)
memantine (NAMENDA)
rivastigmine (EXELON)

ANTIDEPRESSANTS

Monoamine Oxidase Inhibitors (MAOIs)

tranylcypromine
phenelzine (NARDIL)

Selective Serotonin Reuptake Inhibitors (SSRIs)

citalopram
fluoxetine
paroxetine HCl
sertraline

escitalopram (LEXAPRO)
paroxetine HCl ext-rel (PAXIL CR)

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)*

* Indicates the proposed mechanism of action,
based on the American Psychiatric Association
Summary of Treatment Recommendations.

venlafaxine

duloxetine (CYMBALTA)
venlafaxine ext-rel (EFFEXOR XR)

Tricyclic Antidepressants (TCAs)

amitriptyline
desipramine
doxepin
imipramine HCl
nortriptyline

Miscellaneous Agents

bupropion
bupropion ext-rel
mirtazapine
trazodone

ANTIPARKINSONIAN AGENTS

amantadine
benztropine
bromocriptine
carbidopa/levodopa
carbidopa/levodopa ext-rel
selegiline
trihexyphenidyl
carbidopa/levodopa/entacapone (STALEVO)
entacapone (COMTAN)
pramipexole (MIRAPEX)
rasagiline mesylate (AZILECT)
ropinirole (REQUIP)
rotigotine transdermal (NEUPRO)

ANTIPSYCHOTICS

Atypicals

clozapine
aripiprazole (ABILIFY)
aripiprazole inj (ABILIFY injection)
olanzapine (ZYPREXA)
paliperidone ext-rel (INVEGA)
quetiapine (SEROQUEL)
quetiapine ext-rel (SEROQUEL XR)
risperidone (RISPERDAL)
ziprasidone (GEODON)

Miscellaneous

chlorpromazine
fluphenazine
haloperidol
perphenazine
thioridazine
thiothixene
trifluoperazine

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ATTENTION DEFICIT HYPERACTIVITY DISORDER

dexmethylphenidate
dextroamphetamine
dextroamphetamine ext-rel
methylphenidate
methylphenidate ext-rel
 amphetamine/dextroamphetamine
 mixed salts ext-rel (ADDERALL XR)
 dexmethylphenidate ext-rel (FOCALIN XR)
 methylphenidate ext-rel (CONCERTA)
 methylphenidate ext-rel (METADATE CD)
 methylphenidate ext-rel (RITALIN LA)

HYPNOTICS

Benzodiazepines

temazepam
triazolam

Nonbenzodiazepines

zolpidem
 eszopiclone (LUNESTA)

MIGRAINE

Ergotamine Derivatives

dihydroergotamine inj
ergotamine/caffeine

Selective Serotonin Agonists

rizatriptan (MAXALT)
 sumatriptan (IMITREX)
 zolmitriptan (ZOMIG)

MOOD STABILIZERS

lithium carbonate
lithium carbonate ext-rel

MULTIPLE SCLEROSIS AGENTS

glatiramer (COPAXONE)
 interferon beta-1a (REBIF)

MUSCULOSKELETAL THERAPY AGENTS

baclofen
carisoprodol
chlorzoxazone
cyclobenzaprine
dantrolene
methocarbamol
orphenadrine/aspirin/caffeine
tizanidine

MYASTHENIA GRAVIS

pyridostigmine

NARCOLEPSY/CATAPLEXY

modafinil (PROVIGIL)
 sodium oxybate (XYREM)

PSYCHOTHERAPEUTIC-MISCELLANEOUS

Narcotic Antagonists
naltrexone

ENDOCRINE AND METABOLIC

ANDROGENS

testosterone gel (ANDROGEL)

ANTIDIABETICS

Alpha-glucosidase Inhibitors

acarbose (PRECOSE)

Amylin Analogs

pramlintide (SYMLIN)

Biguanides

metformin
metformin ext-rel

Biguanide/Sulfonylurea Combinations

glipizide/metformin
glyburide/metformin

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

sitagliptin phosphate (JANUVIA)

Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/

Biguanide Combinations
 sitagliptin/metformin (JANUMET)

Incretin Mimetic Agents

exenatide (BYETTA)

Insulins

insulin aspart (NOVOLOG)
 insulin aspart protamine 70%/insulin aspart 30% (NOVOLOG MIX 70/30)
 insulin detemir (LEVEMIR)
 insulin glargine (LANTUS)
 insulin glulisine (APIDRA)
 insulin human (HUMULIN R)
 insulin human (NOVOLIN R)
 insulin isophane human (NOVOLIN N)
 insulin isophane human (HUMULIN N)
 insulin isophane human 50%/regular 50% (HUMULIN 50/50)
 insulin isophane human 70%/regular 30% (NOVOLIN 70/30)
 insulin isophane human 70%/regular 30% (HUMULIN 70/30)
 insulin lispro (HUMALOG)
 insulin lispro protamine/insulin lispro (HUMALOG MIX)

Insulin Sensitizers

pioglitazone (ACTOS)
 rosiglitazone (AVANDIA)

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Insulin Sensitizer/

Biguanide Combinations

pioglitazone/metformin (ACTOPLUS MET)
rosiglitazone/metformin (AVANDAMET)

Insulin Sensitizer/

Sulfonylurea Combinations

pioglitazone/glimepiride (DUETACT)
rosiglitazone/glimepiride (AVANDARYL)

Meglitinides

repaglinide (PRANDIN)

Sulfonylureas

glimepiride

glipizide

glipizide ext-rel

glyburide

glyburide, micronized

Supplies

Accu-Chek kits and test strips
OneTouch kits and test strips
lancets
BD insulin syringes and needles

BISPHOSPHONATES

alendronate (FOSAMAX)
alendronate/vitamin D3 (FOSAMAX PLUS D)
risedronate (ACTONEL)
risedronate + calcium carbonate
(ACTONEL WITH CALCIUM)

CONTRACEPTIVES

EE = ethinyl estradiol

ME = mestranol

Monophasic

20 mcg Estrogen

levonorgestrel/EE 0.1/20

norethindrone acetate/EE/iron 1/20

norethindrone acetate/EE 1/20

drospirenone/EE 3/20 (YAZ)

30 mcg Estrogen

desogestrel/EE 0.15/30

levonorgestrel/EE 0.15/30

levonorgestrel/EE 0.15/30 - Levora

norethindrone acetate/EE/iron 1.5/30

norethindrone acetate/EE 1.5/30

norgestrel/EE 0.3/30 - Low-Ogestrel

drospirenone/EE 3/30 (YASMIN)

30 mcg Estrogen, Extended Cycle

levonorgestrel/EE 0.15/30

35 mcg Estrogen

ethynodiol diacetate/EE 1/35

ethynodiol diacetate/EE 1/35 - Zovia 1/35

norethindrone/EE 0.5/35

norethindrone/EE 1/35

norgestimate/EE 0.25/35

50 mcg Estrogen

ethynodiol diacetate/EE 1/50

ethynodiol diacetate/EE 1/50 - Zovia 1/50

norethindrone/ME 1/50

Biphasic

desogestrel/EE

Triphasic

desogestrel/EE

levonorgestrel/EE

levonorgestrel/EE - Trivora

norethindrone/EE

norgestimate/EE

norgestimate/EE (ORTHO TRI-CYCLEN LO)

Progestin Only

norethindrone

Emergency Contraception

levonorgestrel (PLAN B)

Injectables

medroxyprogesterone acetate 150 mg/mL

Transdermal

norelgestromin/EE (ORTHO EVRA)

Vaginal

etonogestrel/EE ring (NUVARING)

ENDOMETRIOSIS

danazol

ESTROGENS

Oral

estradiol

estropipate

estrogens, conjugated, synthetic A (CENESTIN)

estrogens, conjugated, synthetic B (ENJUVIA)

estrogens, conjugated (PREMARIN)

Transdermal

estradiol

estradiol (ESTRADERM)

estradiol (VIVELLE/VIVELLE-DOT)

Vaginal

estradiol vaginal crm (ESTRACE)

estradiol vaginal ring (FEMRING)

estrogens, conjugated crm (PREMARIN crm)

Boldface type indicates generic availability.

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ESTROGEN/PROGESTINS

Oral

estrogens, conjugated/medroxyprogesterone
(PREMPHASE)

estrogens, conjugated/medroxyprogesterone
(PREMPRO)

Transdermal

estradiol/levonorgestrel (CLIMARA PRO)

GLUCOCORTICOIDS

dexamethasone

fludrocortisone

hydrocortisone

methylprednisolone

prednisolone sodium phosphate

prednisolone syrup

prednisone

GLUCOSE ELEVATING AGENTS

glucagon, human recombinant (GLUCAGON)

HUMAN GROWTH HORMONES

somatropin (NORDITROPIN)

somatropin (GENOTROPIN)

somatropin (HUMATROPE)

somatropin (SAIZEN)

somatropin (NUTROPIN/NUTROPIN AQ)

HYPERPARATHYROID TREATMENT, VITAMIN D

ANALOGS

doxercalciferol (HECTOROL)

paricalcitol (ZEMPLAR)

PARATHYROID HORMONES

teriparatide (FORTEO)

PHOSPHATE BINDER AGENTS

calcium acetate (PHOSLO)

sevelamer (RENAGEL)

PROGESTINS

medroxyprogesterone acetate

norethindrone acetate

progesterone, micronized (PROMETRIUM)

SELECTIVE ESTROGEN RECEPTOR MODULATORS

raloxifene (EVISTA)

THYROID AGENTS

Antithyroid Agents

methimazole

propylthiouracil

Thyroid Supplements

levothyroxine (SYNTHROID)

levothyroxine (LEVOXYL)

levothyroxine

VASOPRESSINS

desmopressin spray, tabs

MISCELLANEOUS

cabergoline

levocarnitine

GASTROINTESTINAL

ANTIDIARRHEALS

diphenoxylate/atropine

loperamide

ANTIEMETICS

meclizine

metoclopramide

ondansetron

prochlorperazine

promethazine

trimethobenzamide caps

dronabinol (MARINOL)

scopolamine (TRANSDERM SCOP)

ANTISPASMODICS

chlordiazepoxide/clidinium

dicyclomine

hyoscyamine sulfate

hyoscyamine sulfate ext-rel

CHOLELITHOLYTICS

ursodiol

ursodiol (URSO)

H₂-RECEPTOR ANTAGONISTS

cimetidine

famotidine

ranitidine

INFLAMMATORY BOWEL DISEASE

Oral Agents

sulfasalazine

sulfasalazine delayed-rel

budesonide (ENTOCORT EC)

mesalamine delayed-rel tabs (ASACOL)

Rectal Agents

hydrocortisone enema

mesalamine rectal susp

hydrocortisone acetate foam (CORTIFOAM)

mesalamine supp (CANASA)

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LAXATIVES

lactulose
peg 3350/electrolytes
**peg 3350/sodium bicarbonate/
sodium chloride/potassium chloride**
polyethylene glycol 3350
lactulose (KRISTALOSE)
peg 3350/sodium bicarbonate/sodium chloride/
potassium chloride + bisacodyl (HALFLYTELY)
sodium phosphates (VISICOL)

PANCREATIC ENZYMES

pancrelipase (VIOKASE)
pancrelipase delayed-rel (CREON)
pancrelipase delayed-rel (ULTRASE)
pancrelipase delayed-rel (ULTRASE MT)

PROSTAGLANDINS

misoprostol

PROTON PUMP INHIBITORS

omeprazole delayed-rel
esomeprazole delayed-rel (NEXIUM)
lansoprazole delayed-rel (PREVACID)

SALIVA STIMULANTS

pilocarpine

STEROIDS, RECTAL

hydrocortisone rectal crm

MISCELLANEOUS

sucalfate

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

finasteride
dutasteride (AVODART)
tamsulosin (FLOMAX)

URINARY ANTISPASMODICS

oxybutynin
oxybutynin ext-rel
darifenacin ext-rel (ENABLEX)
oxybutynin transdermal (OXYTROL)
solifenacin succinate (VESICARE)
tolterodine (DETROL)
tolterodine ext-rel (DETROL LA)

VAGINAL ANTI-INFECTIVES

clindamycin crm
metronidazole
terconazole

MISCELLANEOUS

bethanechol
phenazopyridine
potassium citrate
pentosan polysulfate sodium (ELMIRON)

HEMATOLOGIC

ANTICOAGULANTS

warfarin
warfarin (COUMADIN)

HEMATOPOIETIC GROWTH FACTORS

darbepoetin alfa (ARANESP)
epoetin alfa (PROCRIT)
filgrastim (NEUPOGEN)
pegfilgrastim (NEULASTA)

PLATELET AGGREGATION INHIBITORS

dipyridamole
clopidogrel (PLAVIX)

PLATELET SYNTHESIS INHIBITORS

anagrelide

MISCELLANEOUS

cilostazol

IMMUNOLOGIC AGENTS

DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)

hydroxychloroquine
leflunomide
methotrexate
adalimumab (HUMIRA)
auranofin (RIDAURA)
etanercept (ENBREL)
methotrexate (RHEUMATREX)
penicillamine (CUPRIMINE)

IMMUNOMODULATORS

Interferons
interferon alfa-2a (ROFERON-A)
interferon alfa-2b (INTRON A)
interferon alfacon-1 (INFERGEN)
peginterferon alfa-2a (PEGASYS)
peginterferon alfa-2b (PEG-INTRON)

IMMUNOSUPPRESSANTS

Antimetabolites
azathioprine
azathioprine (AZASAN)
mycophenolate mofetil (CELLCEPT)

Boldface type indicates generic availability.

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Calcineurin Inhibitors

cyclosporine

cyclosporine, modified

tacrolimus (PROGRAF)

Rapamycin Derivatives

sirolimus (RAPAMUNE)

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

Potassium

potassium chloride ext-rel

potassium chloride liquid

VITAMINS AND MINERALS

Folic Acid Agents

folic acid

folic acid/vitamin B6/vitamin B12

Prenatal Vitamins

prenatal vitamins w/folic acid (DUET)

prenatal vitamins w/folic acid

(PRECARE CHEWABLES)

prenatal vitamins w/folic acid

(PRECARE CONCEIVE)

prenatal vitamins w/folic acid

(PRECARE PRENATAL)

prenatal vitamins w/folic acid

(PRIMACARE)

prenatal vitamins w/folic acid

(PRIMACARE ONE)

Miscellaneous

calcitriol (1,25-D3)

cyanocobalamin inj

ergocalciferol (D2)

fluoride drops

fluoride tabs

multivitamins/fluoride/iron drops, tabs

multivitamins/fluoride drops, tabs

vitamin ADC/fluoride/iron drops

vitamin ADC/fluoride drops

RESPIRATORY

ANAPHYLAXIS TREATMENT AGENTS

epinephrine (EPIPEN JR.)

epinephrine (EPIPEN)

ANTICHOLINERGICS

ipratropium soln

tiotropium (SPIRIVA)

ANTICHOLINERGIC/

BETA AGONIST COMBINATIONS

ipratropium/albuterol soln

ipratropium/albuterol (COMBIVENT)

Boldface type indicates generic availability.

ANTIHISTAMINES, LOW SEDATING

cetirizine (ZYRTEC)

ANTIHISTAMINES, NONSEDATING

fexofenadine

ANTIHISTAMINES, SEDATING

clemastine 2.68 mg

cyproheptadine

hydroxyzine HCl

ANTIHISTAMINE/DECONGESTANT COMBINATIONS

brompheniramine/pseudoephedrine ext-rel

12 mg/120 mg

brompheniramine/pseudoephedrine ext-rel

6 mg/60 mg

brompheniramine/pseudoephedrine

4 mg/45 mg per 5 mL

chlorpheniramine/pseudoephedrine ext-rel

8 mg/120 mg

cetirizine/pseudoephedrine ext-rel

(ZYRTEC-D 12 Hour)

fexofenadine/pseudoephedrine ext-rel

(ALLEGRA-D)

ANTITUSSIVES

benzonatate

ANTITUSSIVE COMBINATIONS

Narcotic

codeine/chlorpheniramine/

pseudoephedrine

codeine/guaifenesin

codeine/guaifenesin/pseudoephedrine

codeine/promethazine

codeine/promethazine/phenylephrine

Non-narcotic

dextromethorphan/brompheniramine/

pseudoephedrine

dextromethorphan/promethazine

BETA AGONISTS

Inhalants

Short Acting

albuterol

albuterol soln

albuterol sulfate, CFC-free aerosol

(PROVENTIL HFA)

albuterol sulfate, CFC-free aerosol

(PROAIR HFA)

levalbuterol (XOPENEX)

levalbuterol tartrate, CFC-free aerosol

(XOPENEX HFA)

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Long Acting

formoterol inhalation caps (FORADIL)
salmeterol xinafoate (SEREVENT)

Oral Agents

albuterol
albuterol ext-rel
terbutaline

LEUKOTRIENE RECEPTOR ANTAGONISTS

montelukast (SINGULAIR)

MAST CELL STABILIZERS

cromolyn soln
cromolyn inhaler (INTAL)

NASAL ANTIHISTAMINES

azelastine spray (ASTELIN)

NASAL STEROIDS

flunisolide spray
fluticasone spray
budesonide spray (RHINOCORT AQUA)
mometasone spray (NASONEX)
triamcinolone acetonide spray
(NASACORT AQ)

STEROID/BETA AGONIST COMBINATIONS

budesonide/formoterol (SYMBICORT)
fluticasone/salmeterol (ADVAIR)
fluticasone/salmeterol, CFC-free aerosol
(ADVAIR HFA)

STEROID INHALANTS

budesonide (PULMICORT)
fluticasone, CFC-free aerosol (FLOVENT HFA)
mometasone (ASMANEX)

XANTHINES

theophylline ext-rel tabs

MISCELLANEOUS

ipratropium spray

TOPICAL

DERMATOLOGY

Acne

Oral

isotretinoin

Topical

benzoyl peroxide
clindamycin gel, lotion, soln
erythromycin/benzoyl peroxide
erythromycin gel 2%
erythromycin soln
sulfacetamide/sulfur crm, gel, lotion, pads
sulfacetamide lotion 10%
tretinoin
adapalene (DIFFERIN)
clindamycin/benzoyl peroxide (BENZACLIN)
clindamycin/benzoyl peroxide (DUAC)
tretinoin gel microsphere (RETIN-A MICRO)

Actinic Keratosis

fluorouracil (CARAC)

Antibiotics

gentamicin
mupirocin
silver sulfadiazine

Antifungals

ciclopirox
clotrimazole
econazole
ketoconazole
nystatin

Antipsoriatics

calcipotriene (DOVONEX)
tazarotene (TAZORAC)

Antiseborrheics

ketoconazole shampoo 2%
selenium sulfide shampoo 2.5%

Corticosteroids

Low Potency

alclometasone crm, oint 0.05%
desonide crm, lotion, oint 0.05%
fluocinolone acetonide soln 0.01%
hydrocortisone crm 2.5%
hydrocortisone lotion 1%

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Medium Potency

betamethasone valerate crm, lotion,
oint 0.1%
desoximetasone crm 0.05%
fluocinolone acetonide crm, oint 0.025%
fluticasone propionate crm 0.05%,
oint 0.005%
hydrocortisone butyrate crm, oint,
soln 0.01%
hydrocortisone valerate crm, oint 0.2%
mometasone crm, lotion, oint 0.1%
triamcinolone acetonide crm,
lotion 0.025%
triamcinolone acetonide crm, lotion,
oint 0.1%

High Potency

betamethasone dipropionate
augmented crm, lotion 0.05%
betamethasone dipropionate crm,
lotion, oint 0.05%
desoximetasone crm, oint 0.25%,
gel 0.05%
diflorasone diacetate crm 0.05%
diflorasone diacetate emollient crm 0.05%
fluocinonide crm, gel, oint, soln 0.05%
triamcinolone acetonide crm 0.5%

Very High Potency

betamethasone dipropionate augmented
gel, oint 0.05%
clobetasol propionate crm, gel, lotion,
oint 0.05%
diflorasone diacetate oint 0.05%
halobetasol propionate crm, oint 0.05%

Emollients

ammonium lactate 12%

Immunomodulators

pimecrolimus (ELIDEL)
tacrolimus (PROTOPIC)

Local Anesthetics

lidocaine/prilocaine

Rosacea

metronidazole crm, gel, lotion 0.75%
sulfacetamide/sulfur
azelaic acid gel (FINACEA)
doxycycline monohydrate (ORACEA)

Scabicides and Pediculicides

permethrin 5%
malathion (OVIDE)

Miscellaneous Skin and Mucous Membrane

podofilox

MOUTH/THROAT/DENTAL AGENTS

Anesthetics - Topical Oral

lidocaine viscous

Steroids - Mouth/Throat

triamcinolone paste

OPHTHALMIC

Antiallergics

cromolyn sodium
ketotifen
azelastine (OPTIVAR)

Anti-infectives

bacitracin
ciprofloxacin
erythromycin
gentamicin
neomycin/polymyxin B/gramicidin
ofloxacin
polymyxin B/bacitracin
polymyxin B/trimethoprim
sulfacetamide 10%
tobramycin
gatifloxacin (ZYMAR)
levofloxacin (QUIXIN)
moxifloxacin (VIGAMOX)

Anti-infective/Anti-inflammatory

Combinations

neomycin/polymyxin B/bacitracin/
hydrocortisone oint
neomycin/polymyxin B/dexamethasone
neomycin/polymyxin B/hydrocortisone susp
sulfacetamide/prednisolone phosphate
10%/0.25%

sulfacetamide/prednisolone acetate
oint 10%/0.2% (BLEPHAMIDE SOP)
tobramycin/dexamethasone (TOBRADEX)
tobramycin/loteprednol (ZYLET)

Anti-inflammatories

Nonsteroidal

ketorolac (ACULAR)

Steroidal

dexamethasone sodium phosphate
fluorometholone
prednisolone acetate 1%
prednisolone phosphate 1%
loteprednol 0.5% (LOTEMAX)
prednisolone acetate 0.12% (PRED MILD)

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Antivirals

trifluridine

Beta-blockers

Nonselective

levobunolol

metipranolol

timolol maleate

timolol maleate gel

timolol hemihydrate (BETIMOL)

Selective

betaxolol (BETOPTIC S)

Carbonic Anhydrase Inhibitors

Oral

acetazolamide

methazolamide

Topical

dorzolamide (TRUSOPT)

Parasympathomimetics

pilocarpine

Prostaglandins

bimatoprost (LUMIGAN)

latanoprost (XALATAN)

travoprost (TRAVATAN)

Sympathomimetics

brimonidine 0.2%

brimonidine 0.1%, 0.15% (ALPHAGAN P)

OTIC

Anti-infectives

acetic acid

acetic acid/aluminum acetate

ofloxacin otic

Anti-infective/Anti-inflammatory

Combinations

acetic acid/hydrocortisone

neomycin/polymyxin B/hydrocortisone

ciprofloxacin/dexamethasone (CIPRODEX)

Miscellaneous

benzocaine/antipyrine

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