

Commercial 4 Tier/PIC Preferred Drug Listing
Alphabetical Listing by Tier - 2012
TIER 1 Preferred Generic Drugs Covered at a First Tier Copayment (some medications may be excluded as determined by benefit)

ACCU-CHEK STRIPS (QL)	DEXTROAMPHETAMINE (QL)	METHYLPHENIDATE ER (QL)	TERBINAFINE
ADAPALENE 0.1% CRM, GEL (AG)	DONEPEZIL 5MG, 10MG (QL)	METHYLPHENIDATE SR (QL)	TESTOSTERONE
AMPHETAMINE/DEXTROAMP HETAMINE (QL)	ENOXAPARIN (QL)	OLANZAPINE (QL)	CYPIONATE (PE)
AMPHETAMINE/DEXTROAMP HETAMINE SR (QL)	FENTANYL PATCH (QL)	OMEPRAZOLE (QL)	TESTOSTERONE ENANTHATE (PE)
		OMEPRAZOLE/SODIUM BICARBONATE CAP (QL)	TRAMADOL (QL)
BUDESONIDE NEB (AG)	FLUCONAZOLE SUSP (QL)	ONDANSETRON (QL)	TRAMADOL/APAP (QL)
BUPROPION SR (QL)	GRANISETRON TAB (ST) (QL)	ONDANSETRON ODT (QL)	TRAMADOL ER (QL)
		PANTOPRAZOLE (QL)	TRETINOIN TOPICAL (AG)
BUPROPION XL (QL)	KETOROLAC TAB (QL)	PAROXETINE ER (ST)	VENLAFAXINE ER CAP (ST) (QL)
CICLOPIROX 8% NAIL LACQUER (QL)	LANSOPRAZOLE (QL)	PILOCARPINE TAB (QL)	VENLAFAXINE ER TAB (ST) (QL)
		SUMATRIPTAN (QL)	ZEGERID PDR PKT 20-1680MG, 40-1680MG (ST) (QL)
CITALOPRAM (QL)	MEBENDAZOLE (QL)		ZOLPIDEM (QL)
CLARITHROMYCIN (QL)	METHYLPHENIDATE (QL)		

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

ABILIFY	CELLCEPT	ERYTHROMYCIN TABS	LUMIGAN
ACIPHEX (ST) (QL)	CHEMSTRIP UGK	ESTRACE VAGINAL CREAM	MATULANE (PE) (SP)
ACTIVELLA	CIPRO SUSP	ESTRADERM	MAXALT (QL)
ACTONEL	CIPRODEX OTIC	ESTRATEST	MAXALT MLT (QL)
ACTONEL w/ CALCIUM	CLEOCIN PEDIATRIC GRANULES	ESTRATEST HS	MEGACE ES (PE)
ACTOPLUS MET (ST)	COLCRYS	EURAX	MENEST
ACTOS (ST)	COMBIPATCH (ST)	EVISTA	MENOSTAR
	COMBIVENT	FANSIDAR	MEPHYTON
ADVICOR (ST)	COMBIVIR	FEMHRT LOW DOSE	MEPRON
ALKERAN	COMTAN	FINACEA	MESNEX
ALLEGRA SUSPENSIN (AG)	CREON	FK506	METADATE CD (QL)
ALOMIDE	CRESTOR	FLOVENT DISKUS	METHERGINE TAB
ALORA	CRIXIVAN	FLOVENT HFA	MIACALCIN IM, SC
AMOXIL SUSP 50MG/ML	CUPRIMINE	FLUMIST	MIGRANAL (QL)
ANDROGEL (PE) (QL)	CYTOXAN	FML OINT.	MOBAN
	DAPSONE		
APTIVUS	DENAVIR	FML FORTE, FML LIQUIFILM	MYFORTIC
ARMOUR THYROID	DETROL	FORADIL	MYLERAN (PE) (SP)
ASACOL (ST)	DETROL LA	FORTESTA (PE) (QL)	NAMENDA
ASMANEX (30,60,120 MDI)	DIASTAT (ST)	FUZEON	NATURE-THROID
ATELVIA		GENGRAF	NECON 10/11
ATRIPLA	DILANTIN 30MG CAPS	GEODON	NEORAL
ATROVENT HFA	DILANTIN INFATABS	GLUCAGON	NEURONTIN SOLN
AVALIDE	DILATRATE SR CAP	HECTOROL	NIASPAN
AVANDAMET (ST)	DIOVAN	HYCAMTIN	NORVIR
	DIOVAN HCT	INTELENCE 100mg	NOVOLIN
	DIPENTUM (ST)	INVIRASE	NOVOLOG
AZELEX	DIVIGEL	ISOPTO CARBACHOL	NOVOLOG MIX 70/30
AZOPT	DUAC	ISOPTO HOMATROPINE	NUVARING
BENICAR	DUETACT (ST)	ISOPTO HYOSCINE	PANCREAZE
BENICAR HCT	DULERA (ST) (QL)	JANUMET (ST) (QL)	PATADAY
BENZACLIN	DYRENIUM	JANUVIA (ST) (QL)	PATANOL
BENZAMYCINPAK	EDECRIN	KALETRA	PEAKFLOW METER
BETOPTIC-S	EMTRIVA	LANTUS	PENTASA (ST)
BLEPHAMIDE	EPIPEN	LEUKERAN (PE) (SP)	PHISOHEX
BLEPHAMIDE S.O.P.	EPIVIR	LEVEMIR	PHOSPHOLINE IODIDE
BUPHENYL	EPIVIR HBV	LEXAPRO (ST) (QL)	PLAVIX
BYETTA (ST) (QL)	EPZICOM	LEXIVA	PREFEST
CANASA SUPP	ERGOTRATE	LOESTRIN 24 FE	PREMARIN
CARAFATE SUSP	ERY-TAB	LOTEMAX SUSP (ST)	PREMARIN VAGINAL CRM

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TIER

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PREMPHASE	RESCRIPTOR	TAZORAC	VICTOZA (ST) (QL)
PREMPRO	REYATAZ	TEGRETOL	VIDEX
PREZISTA	RIDAURA	TEGRETOL XR	VIRACEPT
PRIMAQUINE	SANDIMMUNE	TOPAMAX (QL)	VIRAMUNE (QL)
PROAIR HFA	SELZENTRY	TOPAMAX SPRINKLE (QL)	VIREAD
PROMETRIUM	SEREVENT DISKUS	TRAVATAN Z	VIVELLE-DOT
PULMICORT RESPULES (AG)	SEROQUEL	TREXALL	VYTORIN
PULMICORT FLEXHALER	SIMCOR (ST)	TRIZIVIR	WELCHOL
QVAR	SINGULAIR (ST) (QL)	TRUVADA	ZETIA
	SPIRIVA	UROCIT-K	ZIAGEN
RELPAK (QL)	SUPRAX	VAGIFEM	ZOSTAVAX (AG)
RENAGEL	SUSTIVA	VENTOLIN HFA	ZOVIRAX, TOPICAL
RENVELA	SYMBICORT (ST) (QL)	VESICARE	

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

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

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

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

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DISCLAIMER

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

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

EXPLANATION OF INDICATORS

You will see these indicators next to some drug names:

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

<http://www.phs.org/PHS/programs/pharmacy/formulary/index.htm>

* = Generic preferred/ Generic equivalent available.