

Commercial 4 Tier/PIC Preferred Drug Listing
Alpha Listing by Tier - 2009

TIER 1 Preferred Generic Drugs are covered at a first tier copay

MPG (09/20) ACCUCHEK STRIPS (QL)

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FLUOXETINE 10MG & 20MG
CAP

LEVOTHYROXINE (MYLAN
BRAND ONLY)
PRILOSEC OTC
WARFARIN (TEVA OR BARR
BRANDS ONLY)

TIER 2 Preferred Brand drugs are covered at a second tier copay (some medications may be excluded as determined by benefit)

ABILIFY	CANASA SUPP	FINACEA	MYCOBUTIN
ACCOLATE	CARBATROL	FLOMAX	MYLERAN
ACIPHEX (QL)		FLOVENT	
ACTIVELLA	CEENU	FLUMIST	NASACORT AQ (ST)
ACTONEL	CHEMSTRIP UGK	FML	NEURONTIN SOLN
ACTONEL w/ CALCIUM	CILOXAN	FML FORTE	NIASPAN
ACTOPLUS MET (ST)	CIPRO SUSP	FML S.O.P.	NICOTROL NASAL SPR (QL)
ACTOS	CIPRO HC SUSP	FORADIL	NORVIR
ADEKs	CIPRODEX OTIC	FOSAMAX D (QL)	NOVOLIN
ADVAIR DISKUS (ST)	CLEOCIN PEDIATRIC GRANULES	FURADANTIN	NOVOLIN INNOLET
ADVAIR HFA (ST)	COMBIPATCH (ST)	FUZEON	NOVOLOG
ADVICOR (ST)	COMBIVENT		NOVOLOG MIX 70/30
	COMBIVIR		NUVARING
ALKERAN	COMTAN	GEODON	
ALLANFILLENZYME LIQD	CONCERTA (QL)	GLUCAGON	ORTHO EVRA
ALOMIDE	CREON	HECTOROL	OVCON -50
	CRESTOR		
ALPHAGAN P	CRIXIVAN		
AMOXIL SUSP 50MG/ML		INVIRASE	PANCREASE
ANTABUSE	DETROL	ISOPTO CARBACHOL	PATANOL
APTIVUS	DETROL LA	ISOPTO HOMATROPINE	PEAKFLOW METER
ARICEPT (QL)	DIASTAT	ISOPTO HYOSCINE	PENTASA
ARIMIDEX	DIFFERIN (AG)		PHISOHEX
ARMOUR THYROID	DILANTIN 30MG CAPS	KALETRA	PHOSPHOLINE IODIDE
ASACOL	DILANTIN INFATABS		PLAVIX
ASMANEX (30,60,120 MDI)	DIOVAN		PREMARIN
ASTELIN	DIOVAN HCT	LANTUS	PREMARIN VAGINAL CRM
ASTEPRO NASAL SPRAY	DIPENTUM	LAMPRENE	PREMPHASE
ATRIPLA	DOVONEX SOLN	LEUKERAN	PREMPRO
ATROVENT HFA	DUETACT (ST)	LEVEMIR	PREZISTA
AUGMENTIN CHEW 250;62.5	DYRENIUM	LEXAPRO (ST)	PRIMAQUINE
AUGMENTIN SUS 125; 31.25MG		LEXIVA	PROAIR HFA
AUGMENTIN SUS 250;62.5/5ML	EDECIN	LIPITOR	PROMETRIUM
AVALIDE	EFFEXOR XR (ST)(QL)	LOTEMAX (PE)	PULMICORT RESPULES (AG)
AVANDAMET (ST)	ELESTAT	LUMIGAN	PULMICORT FLEXHALER
AVANDIA	EMTRIVA	LYSODREN	
AVAPRO	EPIPEN		QVAR
AVELOX	EPIVIR	MATULANE	
AVODART	EPIVIR HBV	MAXAIR	
AZELEX	EPZICOM	MAXALT (QL)	RELPAZ (QL)
AZOPT	ERGOTRATE	MAXALT MLT (QL)	RESCRIPTOR
	ESTRACE VAGINAL CREAM	MEGACE ES (PE)	REYATAZ
BECONASE AQ	ESTRATEST	MENEST	RHINOCORT AQ (ST)
BENICAR	ESTRATEST HS	MEPHYTON	RIDAURA
BENICAR HCT	ESTROSTEP FE	MEPRON	
BENZAACLIN	EURAX	METADATE CD (QL)	
BENZAMYCINPAK	EVISTA	METHERGINE	
BETOPTIC-S		METROGEL	
BLEPHAMIDE	FANSIDAR	MIGRANAL	
BLEPHAMIDE S.O.P.	FEMHRT	MIRAPEX	
BUPHENYL	FENOFIBRATE MICRONIZED	MOBAN	

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SEREVENT DISKUS	ULTRASE	WELCHOL
SEROQUEL		
SIMCOR (ST)	VAGIFEM	XALATAN
SINGULAR (ST)	VALCYTE	
SPIRIVA	VALTREX	YAZ
SUPRAX	VENLAFAXINE ER (ST) (QL)	
SUSTIVA	VENTOLIN HFA	ZEGERID (QL)
SYMBICORT (ST)	VIDEX	ZERIT
	VIOKASE	ZETIA
TABLOID	VIRACEPT	ZIAGEN
TAZORAC	VIRAMUNE	ZOVIRAX, TOPICAL
TOBRADEX OINTMENT	VIREAD	ZYPREXA
TRIZIVIR	VIVELLE DOT	
TRUVADA	VYTORIN (ST)	

TIER 3 Non-Preferred Brand drugs covered at a third tier copay

Not listed on Preferred Brand List (some medications may be excluded as determined by benefit)

ABILIFY DISCMELT (PE)	COGNEX	LOTREL 5/40, 10/40	SANCTURA (ST)
ACEON	COMBIGAN	LOVAZA (QL)	SEASONIQUE
ACULAR LS	CUPRIMINE	LUNESTA (PE) (QL)	SENSIPAR (PE)
ACULAR PF	CYMBALTA (PE) (QL)	LYBREL	SYMLIN (PE)
ACZONE (PE)		LYRICA (PE) (QL)	STARLIX
AEROBID	DIAMOX SEQUELS		STRATTERA (ST)
AGGRENOX	DIBENZYLINE	MERIDIA (PE)	SUBOXONE (PE)
ALAMAST	DORZOLAMIDE/TIMOLOL		SUBUTEX (PE)
ALBENZA	DRONABINOL	NAMENDA	
ALDARA	DYNACIRIC CR	NASONEX (AG)	TAMIFLU (QL)
ALOCRIL		NICOTROL INHALER (QL)	TASMAR
ALREX (PE)	ELIDEL (PE) (QL)	NOROXIN	TESTIM (PE) (QL)
AMBIEN CR (PE) (QL)	ENABLEX (ST)	NULYTELY	TIKOSYN
ANDRODERM (PE) (QL)	ENTOCORT EC		TOBI
ANDROGEL (PE) (QL)	ESTRING	OPANA ER (ST) (QL)	TRANSDERM SCOP
ANZEMET (QL)	EXELON	ORAP	TRAVATAN
AROMASIN		OXYTROL (ST)	
ARTHROTEC	FEMARA		ULORIC (PE) (QL)
ATACAND	FEMRING	PAROXETINE ER (ST)	UROXATRAL
ATACAND HCT		PHENTERMINE (PE)	
AVINZA (ST) (PE)	GABITRIL	PRANDIMET (ST)	VANCOCIN (PE)
AZMACORT	GOLYTLEY	PRANDIN	VANCOMYCIN (PE)
	GRIS-PEG	PREVACID	VESICARE (ST)
		PREVACID SOLUTAB	VEXOL
BENZACLIN	HALFLYTELY	PRIFTIN	VIGAMOX
BILTRICIDE	HELIDAC	PROCTOFOAM HC	VOLTAREN GEL (ST) (QL)
BYETTA (PE)	HUMALOG INSULINS	PROTOPIC (PE) (QL)	VYVANSE (QL)
BYSTOLIC	HUMULIN INSULINS	PROVIGIL (PE)	
			XELODA
CARDENE SR	JANUMET (PE)	RAMIPRIL	XENICAL (PE)
CATAPRES-TTS	JANUVIA (PE)	RANEXA (PE)	XIFAXAN (PE)
CEFPODOXIME		REGRANEX	XYREM (PE)
CELEBREX	KADIAN (ST) (QL)	RELENZA (QL)	
CENESTIN		RENAGEL	ZYMAR
CHANTIX (QL)	LESCOL	RENVELA	ZYPREXA ZYDIS (PE) (QL)
CICLOPIROX 8% NAIL			
LACQUER (PE)(QL)	LESCOL XL	RESTASIS (PE)	ZYVOX (PE)
CIPRO HC OTIC	LIDODERM PATCHES (PE) (QL)	RISPERDAL M-TAB (PE)	
	LoSEASONIQUE	ROZEREM (PE) (QL)	

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

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 1-800-356-2219 for assistance.

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 List (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.

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