Blue Shield
Drug Formulary
Member Booklet 2006
Dear Blue Shield member,

Here is your 2006 Blue Shield Drug Formulary. Please review this booklet for important information regarding your drug coverage and prior authorization requirements.

The Blue Shield Drug Formulary is a comprehensive list of preferred generic and brand-name drugs.

The formulary is developed and maintained by the Pharmacy and Therapeutics (P&T) Committee. It contains medications that have been reviewed for safety and efficacy, and have Food and Drug Administration (FDA) approval. The Blue Shield P&T Committee includes physicians and clinical pharmacists in community practice. The committee reviews and updates the formulary at least quarterly to assist physicians in prescribing medically appropriate and cost-effective medications.

The formulary is current as of the date listed on the back cover. For the most current information you can access the formulary on our Web site at mylifepath.com by clicking on “Pharmacy,” then selecting the “Drug Database & Formulary.” For additional information about your prescription drug benefit, please consult your Blue Shield Summary of Benefits and your Evidence of Coverage (EOC) or Certificate of Insurance (COI)/Policy. You can also call Member Services at the number listed on the front of your Blue Shield member identification card.

Note: The Blue Shield Drug Formulary applies to outpatient prescription drug benefits available through plans underwritten by Blue Shield of California and Blue Shield of California Life & Health Insurance Company (individually and/or collectively referred to as Blue Shield throughout this document).
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Introduction to the Drug Formulary

What is a drug formulary?
Formularies, currently used by many health plans, are lists of preferred medications recommended to prescribing physicians. Frequently, several drugs may work equally well for a medical condition. Blue Shield’s P&T Committee uses medical literature to verify that the formulary drugs chosen are clinically effective and safe. Through the use of a drug formulary, we can maximize treatment quality while keeping your prescription drug costs lower. (For the latest updates, please check the Drug Database & Formulary in the Pharmacy section of mylifepath.com.)

The Blue Shield Drug Formulary is a comprehensive list of generic and brand-name drugs preferred by your Blue Shield health plan. The fact that a drug is listed in the formulary does not guarantee that it will be prescribed by your physician.

What is a generic drug?
A generic drug has three characteristics:

• It must contain the same active ingredient as the brand-name drug.
• The Food and Drug Administration (FDA) must consider it to be therapeutically equivalent to the brand-name drug.
• It must cost less than the brand-name equivalent.

The Blue Shield Drug Formulary includes all generic drugs (unless otherwise excluded), even if they are not listed. However, some generic drugs are in classes that are excluded from coverage, such as a drug used for cosmetic purposes. Please refer to your Blue Shield Summary of Benefits and your Evidence of Coverage (EOC) or Certificate of Insurance (COI) for benefit exclusions.

Also note that some generic drugs are available from only a few manufacturers, and may be considered “brand-name” drugs. Examples are:

• A generic drug first becomes available and the cost is not less than the brand-name drug
• Or manufacturers may discontinue making a generic drug, leaving only a single manufacturer, which is also known as a single source “brand” drug.

Using generic drugs instead of brand-name drugs is one of the easier ways to reduce your prescription costs. Most Blue Shield health plans include a lower copayment for generic drugs, compared with brand-name drugs.
What is a brand-name drug?
A brand-name drug is patented and sold under the original manufacturer's brand-name. Many brand-name drugs with no generic equivalent are included in the Blue Shield Drug Formulary.

If a brand-name drug is followed by “(generic only)” in this formulary, it means that Blue Shield will cover only the generic version of the brand-name drug. For most plans, if you select a brand-name drug when a generic equivalent is available, you pay the difference between Blue Shield’s cost for the brand-name drug and its equivalent generic drug, in addition to your generic copayment. This does not apply to covered brand-name drugs that do not have generic equivalents.

Why do some drugs require prior authorization?
Blue Shield requires prior authorization for specific drugs identified by the Pharmacy and Therapeutics (P&T) Committee, based on the following criteria:

- Non-formulary drugs, if your plan does not have coverage for them (Check your Evidence of Coverage or Certificate of Insurance/Policy).
- Drugs with a significant potential for misuse, overuse or safety concerns.
- Drugs that are limited to a maximum quantity or duration of therapy based upon FDA-approved indications.
- Drugs that are not the recommended first-choice treatment, based on national clinical guidelines or Blue Shield P&T Committee findings.
- Drugs that have a cost-effective covered alternative.

Drugs requiring prior authorization for medical necessity are listed in the formulary with either a “◆” or there is note of a quantity limit or maximum dose.

Are injectable drugs covered?
Most of our health plans now cover home self-administered injectables under the outpatient prescription drug benefit. To see if this applies to you, please check your Evidence of Coverage or Certificate of Insurance/Policy, or call Member Services at the phone number listed on your Blue Shield ID card.

A home self-administered injectable is a medication that is injected subcutaneously (under the skin), by you or your family member on a regular basis, usually daily or weekly. Examples include drugs such as Enbrel for rheumatoid arthritis or Betaseron for multiple sclerosis.

These injectables usually require prior authorization review. Please have your physician call Blue Shield Pharmacy Services at (800) 535-9481 to request prior authorization if
your health plan covers these drugs under the outpatient prescription drug benefit. You can see a list of these drugs at the end of this booklet.

**Using the Blue Shield Drug Formulary**

To ensure that the drug your physician prescribes is covered, and to minimize your out-of-pocket expenses, we recommend that physicians consult their copy of the Blue Shield Drug Formulary when writing prescriptions. We also ask that you review this formulary to verify that the medications your doctor has prescribed are listed. **It may be helpful to bring your Blue Shield Drug Formulary when you visit your doctor so that you and your doctor can make decisions about alternative medications, if necessary.**

Always check the Drug Database & Formulary in the Pharmacy section of mylifepath.com for the most current information about which drugs are on the formulary.

If your doctor prescribes a brand-name drug that is not listed in the formulary, consider asking your doctor whether a formulary drug may be just as effective.

**Copayments and coverage**

- Members with a benefit only for formulary drugs: Drugs that are not in the Blue Shield Drug Formulary are excluded from coverage. Non-formulary drugs may be approved for coverage if the formulary treatments have proven ineffective and your physician obtains prior authorization from Blue Shield Pharmacy Services.

- Members with a benefit for non-formulary drugs at a higher copayment are covered for drugs not listed on the formulary. For non-formulary drugs, the higher copayment always applies. Selected non-formulary drugs may require prior authorization. If a non-formulary drug requiring prior authorization is approved, the member is responsible for the non-formulary copayment. For a list of these drugs, please refer to the tables at the end of this booklet.

(If you are not certain about which of the above coverage applies to you, please check your Evidence of Coverage or Certificate of Insurance/Policy under Outpatient Prescription Drug Coverage.)

- For all members, formulary medications listed with a "◆" may require your physician to obtain prior authorization for medical necessity from Blue Shield Pharmacy Services.

**How to read the formulary**

For your convenience, we’ve listed the covered medications in three different ways. In the first section, medications are listed in alphabetical order. In the second section,
drugs are listed by therapeutic class, so you can check the class of drugs appropriate for your condition. The back of this booklet lists:

1. Formulary alternatives for commonly prescribed non-formulary drugs
2. Non-formulary drugs requiring prior authorization
3. Non-formulary drugs with quantity limits
4. Home self-administered injectable drugs

Remember, all generic drugs are considered formulary drugs whether or not they are listed, unless they are in a class excluded from your benefits.

Here are some other things to note when consulting this formulary:

- Generic drugs begin with lowercase letters.
- Brand-name drugs begin with capital letters.
- Drugs listed with a “◆” may require prior authorization from Blue Shield.
- All FDA-approved oral antineoplastic (cancer) and immunosuppressant drugs are formulary drugs, even if they are not listed. Some may require prior authorization.

This list is subject to change on a quarterly basis. When medications are added to or removed from the formulary, we notify members and physicians of the changes through newsletters and mylifepath.com.
List of Formulary Drugs

This section lists formulary drugs alphabetically. Brand-name drugs begin with capital letters while generic drugs begin with lower case letters.

Accu-Chek test strips (not covered for all plans)
Accu-Chek Advantage test strips (not covered for all plans)
Accupril (generic only)
Accuretic (generic only)
Accutane (not covered through mail service) (generic only)
acetaminophen/butalbital/caffeine
acetaminophen/codeine
acetaminophen/hydrocodone
acetaminophen/oxycodone
Acetasol (generic only)
Acetasol HC (generic only)
acetazolamide
acetic acid
acetic acid/aluminum acetate
acetic acid/HCl
Aciphex
Aclovate (generic only)
Actigall (generic only)
Actiq
Activella
Actonel 30 mg only (For Paget’s Disease, up to 60 days of treatment covered) (not covered through mail service)
Actoplus met (Prior authorization required if no prior diabetic drug therapy)
Actos (Prior authorization required, if no prior diabetic drug therapy)
Acular
acyclovir capsule (ointment not covered)
Adalat CC (generic only)
Adderall (generic only)
Adderall XR (quantity limit of 1 per day)
Advair Diskus Inhaler (quantity limit of 1 inhaler per 30 days)
Advicor
Agenerase
Agylin
Alamast
Albalon (generic only)
albuterol aerosol (quantity limit of 2 inhalers per 30 days)
albuterol solution for inhalation (quantity limits may apply)
albuterol syrup
albuterol tablet
alclolemetason
Aldactazide (generic only)
Aldactone (generic only)
Aldara
Aldomet (generic only)
Alesse (generic only)
allopurinol
Alomide
Alphagan
alprazolam
Ambien
Amerge (Prior Authorization for over 9 tablets per month) (not covered through mail service)
Amicar
amiodarone
amitriptyline (considered inappropriate for use in the elderly)***

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
amoxapine (single source manufacturer, brand copay may apply)
amoxicillin
amoxicillin/clavulanate 500/125 and 875/125
Amoxil (generic only)
ampicillin
Anafranil (generic only)
Androderm Patches
Androxy
Ansaid (generic only)
Antabuse (generic only)
anthralien cream
antipyrine/benzocaine
Antivert (generic only)
Anturane (generic only)
Anusol HC Suppositories (generic only)
Ansomet (Prior Authorization for more than one tablet per prescription) (not covered through mail service)
Apexitus (generic only)
Apsetus (Prior Authorization required if no prior therapy with a Protease Inhibitor)
Aralen (generic only)
Arava (generic only)
Aricept
Aristocort (generic only)
Armour Thyroid (generic only)
asa/butalbital/caffeine
asa/codeine
asa/oxycodone
Asacol
Astelin Nasal Spray (quantity limit of 1 bottle per 30 days)
Atarax (generic only)
atenolol
atenolol/chlorthalidone
Ativan (generic only)
atropine (eye drops)
Atrovent Inhaler (nasal spray non-formulary) (limit of 2 inhalers per 30 days)
Atrovent Nasal (generic only)
Augmentin (some strengths are generic only, quantity limit of 28 per prescription)
Auralgan (generic only)
AVC
Avalide (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
Avapro (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
Avelox (Prior Authorization for greater than #10 per prescription)
Aventyl (generic only)
aviane
Avita (Prior Authorization if over age 40)
Axit (generic only)
Aygestin (generic only)
azathioprine
Azmacort (quantity limit of 2 inhalers per 30 days)
Azopt
Azulfidine (generic only)
bacitracin ophthalmic ointment (single source manufacturer, considered brand)
baclofen
Bactrim (generic only)
Bactrim DS (generic only)
Bactroban (generic only)
Baraclude (if approved, quantity limit of 1 tablet/day)
Bellamine (generic only)
Bellaspa (generic only)
belladonna alkaloid/phenobarbital/ergotamine
benazepril (quantity limit of 1 per day; 40 mg limited to 2 per day)
benazepril w/HCTZ (quantity limit of 1 per day)
Benicar (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Benicar HCT◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)

Bentyl (generic only)
benzonatate
Benzamycin Gel (generic only)
benztropine
Betagan (generic only)
betamethasone dipropionate
betamethasone valerate
Betapace (generic only)
Betapace AF (generic only)
betaxolol
bethanechol
Betoptic (generic only)
Betoptic-S

Biaxin (generic only)◆ (Prior Authorization for >42 tablets per prescription)
Biaxin XL◆ (Prior Authorization for >42 tablets per prescription)

Bidhist (generic only)
bisoprolol
bisoprolol with hydrochlorothiazide
Bleph-10 (generic only)
Blephamide
Blocadren (generic only)
Brethine (generic only)
Brevicon 0.5/35 (generic only)
bromocriptine mesylate
brompheniramine
bumetanide

Bumex (generic only)
bupropion (maximum dose of 400 mg/day)
bupropion sustained release 100 mg
Buspar (generic only)
Buspirone
butorphanol NS◆ (generic only) (Prior Authorization for over 2 canisters per prescription and/or over 4 canisters per 30 days) (not covered through mail service)

Cafergot tablet (generic only, maximum of 10/week)
Cafergot suppository (maximum of 10/week)
Calan (generic only)
Calan SR (generic only)
Calciferol (generic only)
calcitriol
camila
Capoten (generic only)
captopril
Carac
Carafate (generic only)
carbachol
carbamazepine
Carbtrol
carbipoda/levodopa
carbinoxamine
Cardizem (generic only)
Cardizem SR (generic only)
Cardura (generic only)
carisoprodol (considered inappropriate for use in the elderly)***
carteolol ophthalmic
Catapres (generic only)
Catapres TTS
Ceclor (generic only)
Ceclor CD◆ (generic only) (Prior Authorization for >14 tablets per prescription)
Cefaclor
cefpodoxime tablet
Ceftin (generic only)
Celexa (generic only)
Cellcept
Centany (generic only)
cephalexin (caps and suspension only)
Cephulac (generic only)
Cerumenex
cesia

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
Chemet
chloridiazepoxide (considered inappropriate for use in the elderly)***
chloroquine phosphate
chlorpromazine
chlorpropamide (considered inappropriate for use in the elderly)***
chlorthalidone
chlorzoxazone
cholestyramine
choline magnesium salicylate
cilostazol
Ciloxan Ophthalmic (generic only)
cimetidine (OTC forms not covered)
ciprofloxacin oral and ophthalmic
Cipro tablets (generic only)
Cipro XR (quantity limit of 3 tablets of 500 mg or 14 tablets of 1000 mg per prescription)
citalopram
clarithromycin (Prior Authorization for > 42 tablets per prescription)
clemastine (2.68 mg, syrup only)
Cleocin (generic only)
Cleocin T (generic only)
Cleocin Vaginal (generic only)
Climara Patches (quantity limit of 4/month) (0.05 mg and 0.1 mg are generic only)
clindamycin
clindamycin topical
clindamycin vaginal
Clinoril (generic only)
clobetasol
clomipramine
clonazepam
clonidine
clorazepate
clotrimazole troches
clozapine
Clozaril (generic only)

codeine/promethazine
codeine/promethazine/phenylephrine
codeine/pseudoephedrine/chlorpheniramine
Cogentin (generic only)
Colazal
colchicine
Colchicine (generic only)
Colestid (packets not covered)
Colyte (generic only)
CombiPatch (quantity limit of 8/month)
Combivir
Compazine (generic only)
Comtan (covered if taking levodopa/carbidopa)
Concerta (quantity limit of 1 per day)
Condylox
Cordarone (generic only)
Coreg
Corgard (generic only)
Cormax
Cortef (generic only)
Cortifoam
cortisone acetate
Cortisporin (topical non-formulary) (generic only)
Cosopt
Counadin (generic available)
Crinone Gel (generic only)
Crixivan
Crolo
cromovyn inhalation solution
cryselle
Cuprimine
Cyclessa (generic only)
cyclobenzaprine (considered inappropriate for use in the elderly)***
Cylert (generic only)
cyroheptadine
Cytadren
Cytomel

Medications listed with a • require your physician to obtain prior authorization for medical necessity
Cytotec (generic only)
Cytovene (generic only)

Danazol
Dapsone
Daraprim
Darvocet N (generic only) (considered inappropriate for use in the elderly)**
Daypro (generic only)
DDAVP Nasal Spray, tablets
Decadron (generic only)
Deltasone (generic only)
Demadex (generic only)
Demulen
Depakene (generic only)
Depakote
desipramine
Desogen (generic copay applies)
desonide 0.05%
Desowen (generic only)
Desyrel (generic only)
dexamethasone
dexamethasone/neomycin
dexchlorpheniramine sustained action
Dexedrine (generic only) (extended release limited to 1/day)
dextroamphetamine (extended release limited to 1/day)
DHT
Diabeta (generic only)
Diabinese (generic only) (considered inappropriate for use in the elderly)**
Diamox (generic only) (Sequel not covered)
diazepam (considered inappropriate for use in the elderly)**
diclofenac extended release
dicloxacillin
dicyclomine
Didronel
Differin (Prior Authorization required if age > 40)
diflorasone cream, ointment
diflorasone emollient cream
Diflucan (generic only)
diflunisal
digitek (generic for Lanoxin)
digoxin (Lanoxin covered)
Dilacor XR (generic only)
Dilantin (generic available)
Dilaudid (generic only)
diltiazem
diltiazem, sustained release
Diovan (if no prior drug therapy with an ACE inhibitor) (quantity limit of 1 per day)
Diovan HCT (if no prior drug therapy with an ACE inhibitor) (quantity limit of 1 per day)
Dipentum
diphenoxylate/atropine
dipivefrin
Diprolene lotion
Diprolene ointment (generic only)
Diprolene AF (generic only)
Diprosone, Aerosol (generic only)
dipyridamole (considered inappropriate for use in the elderly)**
Disalcid (generic only)
disopyramide
disulfiram
 Ditropan (generic only)
Dolobid (generic only)
Dolophine (generic only)
Domeboro Otic (generic only)
Dovonex
doxazosin

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doxepin
doxycline
DuoNeb (quantity limit of 6 boxes/month)
Duragesic Patches (generic only) (quantity limit of 20 patches per 30 days)
Dyazide (generic only)
Dynapen (generic only)

E.E.S
E-Mycin (generic only)
Effexor XR
Efudex
Elavil (generic only) (considered inappropriate for use in the elderly)**
eldepryl (generic only)
Elidel◆ (if approved, quantity limit of 1 tube/month)
Elimite
Elmiron
Elocon (generic only)
Emtriva
Enablex◆ (prior therapy with oxybutynin required)
enalapril
enalapril with HCTZ
EpiPen, Jr. (quantity limit of 2 per prescription)
Epivir
Epivir-HBV
Epzicom
ergocalciferol
Ergomar SL (maximum dose of 5/week)
ergotamine/caffeine (maximum dose of 10/week)
errin
Ery-Tab (generic only)
EryDerm (generic only)

Erythrocin (generic only)
eythromycin base
eythromycin/benzoyl peroxide gel
eythromycin delayed release caps
eythromycin ethylsuccinate
eythromycin ethylsuccinate/sulfasoxazole
eythromycin ophthalmic
eythromycin solution
eythromycin stearate
Eskalith (generic only)
Eskalith CR (generic only)
estazolam
esterified estrogens
Estrace cream
Estrace tablet (generic only)
estriol tablet
Estratest
Estratest HS
Estring
estropipate
estrogens, conjugated (Premarin covered)
ethambutol
ethosuximide
ethynodiol/ethinyl estradiol oral contraceptive
etodolac
etodolac sustained release
Eurax
Evista (not covered for males)
Evoxac

famotidine (OTC forms not covered)
Fansidar
Fast Take test strips (not covered for all plans)
Feldene (generic only)
felodipine
fenoprofen

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
fentanyl patches (quantity limit of 20 patches per 30 days)
Fioricet (generic only) (maximum dose of 6/day)
Fiorinal (generic only) (maximum dose of 6/day)
Flagyl (generic only)
flavoxate
Flexeril (generic only) (considered inappropriate for use in the elderly)***
Flomax◆ (prior therapy with doxazosin or terazosin required)
Flonase (quantity limit of 1 bottle per 30 days)
Florinef
Florone 0.05% (generic only)
Flovent (quantity limit of 2 inhalers per 30 days)
Flexin oral (generic only)
Flexin otic
fluconazole
fluconolone cream, ointment, solution
flucononide 0.5%
fluorometholone
fluorouracil
fluoxetine
FML (generic only)
FML Forte
folic acid
Foradil (quantity limit of 1 inhaler per 30 days)
Fortovase
Fosamax (35 and 70 mg limited to 1 per week)
Fosamax D
fosinopril (quantity limit of 1 per day, 40 mg limited to 2 per day)
fosinopril with hydrochlorothiazide
Fulvicin P-G (generic only)
furosemide
Furoxone Liquid

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
Hycodan (generic only)  
hydradrine  
hydrochlorothiazide  
hydrocodone/homatropine  
hydrocortisone 2.5%  
hydrocortisone 1%/iodoquinol  
hydrocortisone enema  
hydrocortisone suppository  
hydrocortisone valerate  
Hydrodiuril (generic only)  
ydromorphone  
ydroxycaproquine  
ydroxyxazine (single source manufacturer, brand copay may apply)  
Hygrotan (generic only)  
hyoscyamine sulfate  
Hytone (generic only)  
Hytrin (generic only)  
ibuprofen (OTC forms not covered)  
Ilotycin (generic only)  
Imdur (generic only, ISMO non-formulary)  
imipramine  
Imitrex Nasal Spray◆ (Prior Authorization for over 6 doses per month) (not covered through mail service)  
Imitrex tablets◆ (Prior Authorization for over 9 tablets per month) (not covered through mail service)  
Imuran (generic only)  
Inderal (generic only)  
Inderal LA  
Indocin (generic only) (considered inappropriate for use in the elderly)***  
Indocin SR (generic only) (considered inappropriate for use in the elderly)***  
indomethacin (considered inappropriate for use in the elderly)***  
Indocin SR (generic only) (considered inappropriate for use in the elderly)***  
indomethacin sustained release (considered inappropriate for use in the elderly)***  
Inflamase, Forte (generic only)  
Intal aerosol (quantity limit of 3 inhalers per 30 days)  
Intal inhalation solution (generic only) (quantity limit of 240 mls per 30 days)  
Invirase  
ipratropium nasal  
isotethene/dichloralphenazine/apap (maximum dose of 5/day)  
isoniazid  
Isop-Atropine (generic only)  
Isop Carbachol  
isordil (generic only)  
isosorbid dinitrate  
isosorbid dinitrate sustained release  
isosorbid mononitrate  
isotretinoin  
itraconzaole◆  
junel  
K-Dur (generic only)  
K-Lor (generic only)  
K-Lyte, K-Lyte/Cl (generic only)  
K-Tab (generic only)  
Kalextra  
Kaochlor (generic only)  
Kaon Solution (generic only)  
Keflex (generic only)  
Kenalog (generic only)  
Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
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<th>Notes</th>
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<td>Kronofed-A, Jr. (generic only)</td>
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<td>Kytril (Prior Authorization for over 2 tablets per prescription) (not covered through mail service)</td>
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<td>labetalol</td>
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<td>lactulose</td>
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<td>lamivudine (3TC)</td>
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<td>Lanoxin (generic available)</td>
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<td>Lantus vial</td>
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<td>Levitra (not covered in all plans) (if approved for coverage – limit of 6 tablets per 30 days) (not covered through mail service)</td>
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<td>levonorgestrel/ethinyl estradiol 0.1/20, 0.1/30</td>
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<td>levothyroxine</td>
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<tr>
<td>levoxyl</td>
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<tr>
<td>Levsin (generic only)</td>
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<tr>
<td>Levsinex (generic only)</td>
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<tr>
<td>Lexiva</td>
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<tr>
<td>Librium (generic only) (considered inappropriate for use in the elderly) ***</td>
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<tr>
<td>Lidex (generic only)</td>
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<tr>
<td>Lidex E (generic only)</td>
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<tr>
<td>lidocaine-prilocaine 2.5-2% cream</td>
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<tr>
<td>lidocaine spray, viscous</td>
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<td>lindane</td>
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<tr>
<td>Lioresal (generic only)</td>
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<tr>
<td>lisinopril (quantity limit of 1 per day)</td>
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<tr>
<td>lisinopril/hydrochlorothiazide (quantity limit of 1 per day)</td>
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<tr>
<td>lithium carbonate</td>
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<td>lithium citrate</td>
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<tr>
<td>Lo/Ovral (generic only)</td>
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<td>Loestrin 1/20, 1.5/30</td>
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<td>Lopid (generic only)</td>
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<td>Lopressor (generic only)</td>
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<td>lorazepam</td>
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<td>Lotensin (limit of 1 per day; 40 mg limited to 2 per day) (generic only)</td>
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<td>Lotensin HCT (limit of 1 per day) (generic only)</td>
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<td>Lotrisone (cream covered in generic only)</td>
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<td>Loxitane (generic only)</td>
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<td>Ludiomil (generic only)</td>
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<td>Lumigan (quantity limit-one 2.5 ml bottle per prescription per month)</td>
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<tr>
<td>lutera</td>
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<tr>
<td>Luvox (generic only)</td>
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<td>Macrobid</td>
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<tr>
<td>Medication</td>
<td>Accessibility</td>
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<td>Malarone</td>
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<td>maprotiline</td>
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<tr>
<td>Maxair (quantity limit of 1 inhaler per 30 days)</td>
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<tr>
<td>Maxalt (Prior Authorization for over 9 tablets per month) (not covered through mail service)</td>
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<tr>
<td>Maxidex (generic only)</td>
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<td>Maxzide 25 (generic only)</td>
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<tr>
<td>Menest</td>
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<td>Mephyton</td>
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<tr>
<td>mesalamine enema</td>
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<td>Mestinon</td>
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<tr>
<td>metaproterenol aerosol (quantity limits may apply)</td>
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<tr>
<td>metaproterenol inhalation solution (quantity limits may apply)</td>
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<td>metformin extended release 500 mg</td>
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<td>methenamine mandelate</td>
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<td>methenamine/phenylsalicylate/atropine/ hyoscyamine/benzoic acid/methylene blue</td>
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<td>Methergine</td>
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<tr>
<td>methimazole</td>
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<tr>
<td>methocarbamol (considered inappropriate for use in the elderly)***</td>
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<tr>
<td>methotrexate</td>
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<td>metipranolol</td>
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<td>Metrogel</td>
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<td>Metrogel Vaginal</td>
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<tr>
<td>Mevacor (generic only)</td>
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<td>Mexitil (generic only)</td>
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<td>Miacalcin NS (generic only)</td>
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<td>microgestin</td>
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<tr>
<td>Micro-K (generic only)</td>
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<tr>
<td>Micronase (generic only)</td>
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<tr>
<td>Midrin (generic only, maximum dose of 5 per day)</td>
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<tr>
<td>Migranal Nasal Spray (Prior Authorization for more than 1 box per 30 days) (not covered through mail service)</td>
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<tr>
<td>Minipress (generic only)</td>
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<tr>
<td>Minocin (generic only)</td>
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<td>minocycline</td>
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<tr>
<td>minoxidil (oral only)</td>
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<tr>
<td>Mintex CT, PD (generic only)</td>
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<tr>
<td>Miralax (generic only)</td>
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<tr>
<td>Mirapex</td>
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<td>Mircette (generic copay applies)</td>
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<tr>
<td>mirtazapine</td>
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<tr>
<td>mirtazapine rapidly dissolving tablet</td>
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<tr>
<td>misoprostol</td>
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<tr>
<td>moexipril</td>
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<td>mometasone</td>
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<tr>
<td>mononessa</td>
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</tbody>
</table>

Medications listed with a • require your physician to obtain prior authorization for medical necessity
Monopril (generic only, quantity limit of 1 per day; 40 mg limited to 2 per day)
Monopril HCT
morphine sulfate tablet, solution
morphine sulfate sustained action
Motrin (generic only) (OTC forms not covered)
MS Contin (generic only)
MSIR (generic only)
multivitamins w/fluoride drops
multivitamins w/fluoride & iron drops
multivitamins, prenatal
mupirocin topical
Muse Suppository◆ (Prior Authorization required and then limited to 6 per 30 days)
(not covered through mail service) (not covered for all plans)
Myambutol (generic only)
Mycelex Troche
Mycobutin
Mycolog II (generic only)
Mycostatin (generic only)
Mysoline (generic only)
nabumetone
nadolol
Nalfon (generic only)
Namenda
naphazoline
Naprosyn (generic only)
naproxen
Nardil
Nasarel (quantity limit of 1 inhaler per 30 days)
Nasonex (quantity limit of 1 inhaler per 30 days)
Navane (generic only)
necon
nefazodone
Neo-Decadron (generic only)
Neomycin oral (generic only)
neomycin sulfate oral
neomycin/bacitracin/polymyxin/HC
neomycin/bacitracin/polymyxin ophth. ointment
neomycin/polymyxin/dexamethasone
neomycin polymyxin/hydrocortisone otic
Neosporin Ophthalmic (generic only)
neosporin/polymyxin/HC (ear drops only)
Neo-synephrine (generic only)
Neurontin (generic only)
Niaspan
nifedipine
nifedipine XL
Nitro-Bid
Nitro-Dur
nitrofurantoin
nitroglycerin sublingual
nitroglycerin sustained release
nitroglycerin transdermal patch (Nitrodur covered)
Nitrostat
nizatidine (OTC forms not covered)
Nizoral (cream, shampoo, oral, generic only)
Nordette (generic only)
norethindrone/ethinyl estradiol oral contraceptives
norethindrone/mestranol oral contraceptives
Norflex (generic only) (considered inappropriate for use in the elderly)***
norgestrel/ethinyl estradiol oral contraceptives
norgestimate/ethinyl estradiol oral contraceptives
norinyl 1 + 35
norinyl 1 + 50
Norpace (generic only)
Norpace CR (generic only)
Norpramin (generic only)
nortrel
nortriptyline
Norvir
Nuvaring

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
nystatin
nystatin/triamcinolone

O

Ocufen (generic only)
Ocuflox (generic only)
Ocupress (generic only)
ofloxacin (eye drop & tablet)
Ogen tablets (generic only)
ogestrel
omepazole
Omnicef
One Touch test strips (not covered by all plans)
One Touch Ultra test strips (not covered by all plans)
opium tincture
Optipranolol (generic only)
Orap
Oretic (generic only)
Orinase
orphenadrine (considered inappropriate for use in the elderly)***
Ovcon
Ovide
Ovral (generic only)
Ovrette
oxaprozin
oxazepam
Oxsoralen Ultra capsule (lotion non-formulary)
oxbutynin
Oxycontin◆ (Prior Authorization required if >400 mg or >12 tablets per day or 80 mg and 160 mg strengths)
Oxytrol◆ (prior therapy with oxybutynin required)

O

Palgic liquid (generic only)
Pamelor (generic only)
pancrelipase
Pancrease (generic only)
Parafon Forte DSC (generic only)
Parcopa◆
paregoric
Parlodel (generic only)
Parnate
paromomycin
paroxetine
Patanol (quantity limit of one bottle per 30 days)
Paxil (generic only)
Paxil CR
Pediazole (generic only)
pemoline
Pen-Vee K (generic only)
penicillin VK
Pentasa (generic only)
pentazocine/naloxone (considered inappropriate for use in the elderly)***
pentoxifylline
Pepcid (generic only) (OTC forms not covered)
Percocet (generic only)
Percodan (generic only)
pergolide
Periactin (generic only)
Permax (generic only)
perphenazine
Persantine (generic only) (considered inappropriate for use in the elderly)***
phenazopyridine
Phenergan (generic only)
Phenergan/Codeine (generic only)
Phenergan VC/Codeine (generic only)
phenobarbital

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
phenylephrine (eye drops)
phenytoin (Dilantin covered)
Phoslo
Pilocar (generic only)
pilocarpine HCl
piroxicam
Plan B (limit of 2 tablets per 30 days)
Plaquenil (generic only)
Plavix
Plendil (generic only)
Pletal (generic only)
Polaramine
Polycitra-K
Polycitra-LC
polyethylene glycol
Poly-Pred
Poly-Vi-Flor (generic only)
polymyxin/bacitracin eye ointment
polymyxin B/HC
polymyxin/neomycin/gramicidin
polymyxin/trimethoprim eye drop
Polysporin eye ointment (generic only)
Polytrim (generic only)
potassium chloride effervescent
potassium chloride liquid
potassium chloride, powdered
potassium chloride, sustained release
potassium gluconate liquid
Pravachol (quantity limit of 1 per day)
prazosin
Precose
PredForte (generic only)
PredMild (generic only)
prednisolone acetate
prednisolone sodium phosphate
prednisone
Presone Syrup
Premarin
Premarin Vaginal Cream
Premphase
Prempro
previfem
Priftin
Primaquine
primidone
Prinivil (generic only, quantity limit of 1 per day; 40 mg limited to 2 per day)
ProAmatine
probenecid
procainamide
procainamide SR
Procanbid (generic only)
Procardia, XL (generic only)
prochlorperazine
Proctocream HC
Proctofoam HC
Prolin (generic only)
Proloprim (generic only)
promethazine
Promestrien
Propranolol
propoxyphene HCL/apap (considered inappropriate for use in the elderly)***
propoxyphene napsylate/apap (considered inappropriate for use in the elderly)***
propranolol
propranolol LA
propylthiouracil
Proscar
Prosom (generic only)
Protonix
Proventil (generic only, quantity limits may apply)
Proventil HFA (quantity limit of 2 inhalers per 30 days)
Provera (generic only)
Provigil* (if approved, quantity limit of 2 tablets/day)

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Prozac (generic only)
pseudoephedrine/chlorpheniramine
Psorcon 0.05% (generic only)
Psorcon E cream (generic only)
Psoriatec (generic only)
Pulmicort ◆ (Prior Authorization over 1 inhaler per 45 days)
pyrazinamide
Pyridium (generic only)

Questran (generic only)
Questran Light (generic only)
Quinaglute Duratab (generic only)
quinapril
quinapril w/HCTZ
Quinidex (generic only)
quindine gluconate
quinidine sulfate
quinidine sulfate SR
QVAR (quantity limit of 2 inhalers per 30 days)

ranitidine tablets (OTC forms not covered)
Razadyne
Rebetol◆ (generic only)
Reglan (generic only)
Regranex◆
Relafen (generic only)
Remeron (generic only)
Remeron SolTabs (generic only)
Renagel◆
Requip
Rescriptor
Restasis◆
Restoril (generic only)
Retin-A◆ (Prior Authorization if over age 40) (generic only)
Retin-A Micro◆ (Prior Authorization if over age 40)
Retrovir
Reyataz
Rheumatrex (generic only)
ribavirin◆
Ridaura
Rifadin (generic only)
rifampin
Rilutek
Risperdal
Ritalin (generic only)
Ritalin SR (generic only, quantity limit of 1 per day)
RMS suppository
Robaxin (generic only) (considered inappropriate for use in the elderly)***
Robinul (generic only)
Rocaltrol (generic only)
Rosanil cleanser (generic only)
Rowasa (generic only)
Roxanol (generic only)
Rythmol

Salagen (generic only)
salsalate
selegiline
selenium sulfide 2.5%
Sensipar◆
Septra (generic only)
Septra DS (generic only)
Serax (generic only)
Serevent (quantity limit of 1 inhaler per 30 days)
Silvadene (generic only)
silver sulfadiazine
Sinemet (generic only)
Sinemet CR
Sinequan (generic only)

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Singulair◆ (Prior Authorization required if prescription is for allergic rhinitis)
Slow K (generic only)
Soma (generic only) (considered inappropriate for use in the elderly)***
Soriatane
sotalol
Spectazole cream
Spiriva
sprintec
spironolactone
spironolactone/HCTZ
Sporanox◆ (generic only)
Stadol NS◆ (generic only) (Prior Authorization for over 2 canisters per prescription and/or over 4 canisters per 30 days) (not covered through mail service)
Stalevo
Stelazine (generic only)
Stuartnatal Plus 3 (generic only)
sucralfate
Sulamyd (generic only)
Sular
sulfacetamide/sulfur cleanser
sulfacetamide/sulfur lotion
sulfacetamide/prednisolone
sulfasalazine
sulfinpyrazone
sulfisoxazole
sulindac
Sumycin (generic only)
Surestep test strips (not covered by all plans)
Surestep Pro test strips (not covered by all plans)
Sustiva
Symmetrel (generic only)
Synalar cream, solution (generic only)
Synarel Nasal Spray
Synthroid (generic available)

T-Stat (generic only)
Tagamet (generic only)
Talwin NX (generic only) (considered inappropriate for use in the elderly)***
Tambocor (generic only)
Tapazole (generic only)
Tasmar◆
Tegretol (generic available)
Tegretol XR
temazepam
Temovate (generic only)
Tenoretic (generic only)
Tenormin (generic only)
Terazol
terazosin
terbutaline, oral
tetracycline
theophylline
theophylline liquid
theophylline rapid release
theophylline timed release
thioridazine
thiothixene
Thorazine (generic only)
thyroid, dessicated
Thyrolar
Tiazac (generic only)
Ticlid (generic only)
ticlopidine
Tigan (generic only) (considered inappropriate for use in the elderly)***
timolol
Timoptic (generic only)
Timoptic XE (generic only)
tizanidine tablet

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TOBI◆ (if prior authorization is approved, quantity limit of 1 box/month)
tobramycin ophthalmic
Tobrex (generic only)
Tofranil (generic only)
tolazamide
tolbutamide (single source manufacturer, brand copay may apply)
Tolestin DS (generic only)
Tolinase (generic only)
tolmetin
Tonocard
Topamax
Toprol XL
torsemide
tramadol
tramadol/acetaminophen
Tranxene (generic only) (SD not covered)
Travatan (quantity limit – one 2.5 ml bottle/prescription per month)
trazodone
Trental (generic only)
tretinoin◆ (Prior Authorization if over age 40)
Tricor
Tri-Levlen (generic only)
Tri-Norinyl (generic only)
Tri-Vi-Flor (generic only)
Tri-Vi-Flor with Iron (generic only)
triamcinolone (cream, ointment)
triamterene/HCTZ
triamterene/HCTZ 25
triazolam
Tridesilon (generic only)
trifluoperazine
trifluridine
trihexyphenidyl
Trilafon (generic only)
Trileptal
Trilisate (generic only)
trimethobenzamide (considered inappropriate for use in the elderly)***
trimethoprim
trimethoprim sulfa
trinessa
Triphasil (generic only)
triprevifem
trisprintec
trivora
Trizivir
Truvada
Tylenol/Codeine (generic only)
Ultracet (generic only)
Ultram (generic only)
Uniphyl
Urecholine (generic only)
Urex (generic only)
Urised (generic only)
Urispas (generic only)
Urocr-K
Urso
ursodiol
Vagifem vaginal tablets
Valcyte
Valium (generic only) (considered inappropriate for use in the elderly)***
valproic acid
Valtrex
Vantin tabs (generic only)
Vaseretic (generic only)
Vasocidin (generic only)
Vasotec (generic only)

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
velivet
verapamil
verapamil long acting
Vibramycin (generic only)
Vicodin (generic only)
Vicodin ES (generic only)
Videx
Vigamox
Viracept
Viramune
Viread
Viroptic (generic only)
Vistaril (generic only)
vitamins ADC with fluoride and iron drops
vitamins ADC with fluoride drops
Vivactil
Vivelle, Dot Patches (generic only) (quantity limit of 8/month)
Voltaren (generic only)
Vosol (generic only)
Vosol HC (generic only)
Vytone (generic only)
Vytorin

warfarin (generic for Coumadin)
Wellbutrin (generic only, maximum dose of 400 mg/day)
Wellbutrin SR (maximum dose of 400 mg/day) (100 mg generic only)
Westcort (generic only)
Wygesic (generic only)

Xanax (generic only)
Xylocaine spray, viscous (generic only)

Y
Yasmin
Yodoxin

Z
Zanaflex tablet (generic only)
Zantac (generic only) (OTC not covered)
Zarontin (generic only)
Zaroxolyn (generic only)
Zavesca◆
Zebeta (generic only)
Zerit
Zestoretic (generic only)
Zestril (generic only)
Ziac (generic only)
Ziagen
Zithromax◆ (Prior Authorization if >6 tablets/capsules of the 250 mg or 3 of the 500 mg tabs or 8 of the 600 mg tablets per prescription) (not covered through mail service)
Zocor
Zofran◆ (Prior Authorization for >9 tablets of 4 or 8 mg or 1 of the 24 mg tablets per prescription) (not covered through mail service)
Zonegran
Zovia
Zovirax capsules (generic only)
Zyloprim (generic only)
Zyprexa
Zyvox◆

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**Formulary Drugs by Therapeutic Class**

This section lists formulary medications by their therapeutic class. Find the condition for which you are being treated, then look up the medications included in the Blue Shield Drug Formulary.

<table>
<thead>
<tr>
<th>Cancer Treatment &amp; Immunosuppressants</th>
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<tbody>
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Formulary Drugs by Therapeutic Class

Cancer Treatment & Immunosuppressants
All oral medications in this category are included in the formulary. Some may require prior authorization.

Dermatologicals: Acne
A/T/S (generic only)
Accutane◆ (not covered through mail service) (generic only)
Avita◆ (Prior Authorization required for patients over age 40)
Benzamycin Gel (generic only)
Cleocin T (generic only)
clindamycin solution
Differin◆ (Prior Authorization required if age >40)
EryDerm (generic only)
erthyromycin/benzoyl peroxide gel
erythromycin solution
isotretinoin
Retin-A◆ (generic only) (Prior Authorization required for patients over age 40)
Retin-A Micro◆ (Prior Authorization required for patients over age 40)
Rosanil cleanser (generic only)
sulfacetamide/sulfur cleanser
sulfacetamide/sulfur lotion
T-STAT (generic only)

Dermatologicals: Anesthetics
Emla (generic only)
lidocaine-prilocaine 2.5-2% cream
lidocaine spray
lidocaine viscous
Xylocaine spray (generic only)
Xylocaine viscous (generic only)

Dermatologicals: Antibacterials
Bactroban (generic only)
Centany (generic only)
Garamycin ointment (generic only)
gentamicin ointment
MetroGel
mupirocin topical
Silvadene (generic only)
silver sulfadiazine

Dermatologicals: Antifungals
ketoconazole cream, shampoo, oral
Lotrisone
Mycolog II (generic only)
Mycostatin (generic only)
Nizoral cream, shampoo (generic only)
Nizoral (oral) (generic only)
nystatin
nystatin/triamcinolone
Spectazole cream

Dermatologicals: Psoriasis & Seborrhea
anthralin cream
Dovonex
Oxsoralen Ultra capsule◆ (Lotion non-formulary)
Psoriatec (generic only)
selenium sulfide 2.5%
Soriatane

Dermatologicals: Scabies/Lice
Elimite
Eurax
lindane
Ovide

Dermatologicals: Steroids
Aclovate (generic only)
alclometasone
betamethasone dipropionate 0.05%
betamethasone dipropionate 0.1% aerosol

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
betamethasone valerate 0.1% cream, ointment, lotion

clobetasol 0.05% cream, lotion, ointment
Cormax (generic only)
desonide 0.05% cream, ointment, lotion
DesOwen (generic only)
diflorasone cream, ointment
diflorasone emollient cream
Diprolene lotion
Diprolene gel, ointment (generic only)
Diprolene AF (generic only)
Diprosone, Aerosol (generic only)
Elocon (generic only)
Florone 0.05% (generic only)
fluocinolone
fluocinonide 0.05% cream, gel, ointment, solution
hydrocortisone 1%/iodoquinol
hydrocortisone 2.5% cream, ointment, lotion
hydrocortisone valerate
Hytone (generic only)
Kenalog (generic only)
Lidex (generic only)
Lidex E (generic only)
Maxivate (generic only)
mometasone
Psorcon (generic only)
Psorcon E cream (generic only)
Synalar cream, solution (generic only)
Temovate (generic only)
triamcinolone acetonide 0.01% cream
triamcinolone acetonide 0.025% cream, ointment, lotion
triamcinolone acetonide 0.1% ointment, lotion
triamcinolone acetonide 0.5% cream, ointment
Tridesilon (generic only)
Vytone (generic only)
Westcort (generic only)

Dermatologicals: Miscellaneous
Aldara
Carac
Condylox Solution, Gel
Efudex
Elidel◆ (if approved, quantity limit of 1 tube/month)
Regranex Gel◆

Ear, Nose and Throat: Ear
Acetasol (generic only)
Acetasol HC (generic only)
acetic acid
acetic acid/aluminum acetate
acetic acid/hydrocortisone
antipyrine/benzocaine
Auralgan (generic only)
Cerumenex
Cortisporin (generic only, topical non-formulary)
Floxin otic
neosporin/polymixin B/hydrocortisone (topical non-formulary)
Domeboro Otic (generic only)
polymixin B/hydrocortisone
Vosol (generic only)
Vosol HC (generic only)

Ear, Nose and Throat: Nasal Steroids
Flonase (quantity limit of 1 bottle per 30 days)
Nasarel (quantity limit of 1 bottle per 30 days)
Nasonex (quantity limit of 1 bottle per 30 days)

Ear, Nose and Throat: Miscellaneous
Astelin Nasal Spray (quantity limit of 1 bottle per 30 days)
Atrovent Nasal (generic only)
Evoxac
ipratropium nasal
pilocarpine tablet
Salagen (generic only)

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Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
Endocrine: Diabetes
Actoplus met◆ (Prior authorization required if no prior diabetic drug therapy)
Actos◆ (Prior authorization required, if no prior diabetic drug therapy)
chlorpropamide (considered inappropriate for use in the elderly)***
Diabeta (generic only)
Diabinese (generic only)
glipizide
glipizide extended release
Glucophage (generic only)
Glucophage XR (generic only)
Glucotrol (generic only)
Glucotrol XL (generic only)
glyburide
Glynase PresTab (generic only)
Humalog vial
Humalog Mix 75/25 vial
Humulin Insulin vial
Lantus vial
metformin
metformin extended release
Micronase (generic only)
Orinase (generic only)
Precose
tolazamide
tolbutamide (single source manufacturer, brand copay may apply)
Tolinase (generic only)

Glucose Testing Strips
(not covered for all plans)
Accu-Chek test strips
Accu-Chek Advantage test strips
Accu-Chek Instant test strips
Fast Take test strips
One Touch test strips
One Touch Ultra test strips
Surestep test strips
Surestep Pro test strips

Endocrine: Male Hormones
Androderm patches
Androxy

Endocrine: Osteoporosis
Didronel
Evista (not covered for males)
Fosamax (35 and 70 mg limited to 1 per week)
Fosamax D
Miacalcin Nasal Spray◆

Endocrine: Steroids
Cortef (generic only)
cortisone acetate
Decadron (generic only)
Deltasone (generic only)
dexamethasone
Florinef
hydrocortisone
Medrol (generic only)
methylprednisolone
prednisone
Prelone syrup (generic only)

Endocrine: Thyroid
Armour Thyroid (generic only)
Cytomel
levothyroxine
levoxyl
methimazole
propylthiouracil
Synthroid (generic available)
Tapazole (generic only)
thyroid, dessicated
Thyrolar

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Endocrine: Miscellaneous
Actonel 30 mg only◆ (For Paget’s disease, will cover up to 60 days of treatment) (not covered through mail service)
calcitriol
Cytadren
Danazol
DDAVP Nasal Spray, tablets
Rocaltrol (generic only)
Sensipar◆
Synarel Nasal Spray

Eye: Antiallergy
Alamast
Alomide
Crolom
Patanol (quantity limit one bottle per 30 days)

Eye: Anti-Infective & Antiviral
bacitracin ophthalmic ointment (single source manufacturer, considered brand)
Bleph-10 (generic only)
Ciloxan ophthalmic (generic only)
ciprofloxacin ophthalmic
erthromycin ophthalmic
Garamycin ointment (generic only)
gentamicin
Ilotycin (generic only)
neomycin/bacitracin/polymyxin ophthalmic ointment
Neosporin ophthalmic (generic only)
Ocuflox (generic only)
ofloxacin eye drop
polymyxin/bacitracin
polymyxin/neomycin/ gramicidin eye drop
polymyxin/trimethoprim eye drop
Polysporin (generic only)
Polytrim (generic only)
Sulamyd (generic only)
sulfacetamide
tobramycin ophthalmic
Tobrex (generic only)
tripluridine
Vigamox
Viroptic (generic only)

Eye: Anti-Inflammatory
Acular
flurbiprofen
Ocufen (generic only)

Eye: Decongestants
Albalon (generic only)
atropine
Isopto-Atropine (generic only)
naphazoline
Neo-synephrine (generic only)
phenylephrine

Eye: Glaucoma
acetazolamide
Alphagan
Azopt
Betagan (generic only)
betaxolol
Betoptic (generic only)
Betoptic-S
carteolol
Cosopt
Diamox (generic only) (Sequels not covered)
dipivefrin
Isopto Carbachol
levobunolol
Lumigan (quantity limit one 2.5 ml bottle per prescription per month)
methazolamide
metipranolol
Ocupress (generic only)
Optipranolol (generic only)

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Blue Shield Drug Formulary

Pilocar (generic only)
pilocarpine
Propine (generic only)
timolol
Timoptic (generic only)
Timoptic XE (generic only)
Travatan (quantity limit, one 2.5 ml bottle per prescription per month)
Trusopt

Eye: Other
Restasis◆

Eye: Steroids
Decadron (generic only)
dexamethasone
fluorometholone
FML (generic only)
FML Forte
Inflamase Forte (generic only)
Maxidex (generic only)
Pred Forte (generic only)
Pred Mild (generic only)
prednisolone acetate
prednisolone sodium phosphate

Eye: Steroid-Antibiotic Combinations
Blephamide (generic only)
Cortisporin (topical non-formulary) (generic only)
dexamethasone/neomycin
Maxitrol (generic only)
Neo-Decadron (generic only)
neomycin/bacitracin/polymyxin/HC
neomycin/polymyxin/dexamethasone
Poly-Pred
sulfacetamide/prednisolone
Tobradex
Vasocidin (generic only)

Gynecology: Contraceptives
Alesse (generic only)
aviane
Brevicon 0.5/35 (generic only)
camila
cesia
cryselle
Cyclessa
Demulen (generic only)
Desogen (generic copay applies)
errin
junel
leena
lessina
levlen
levlite
levonorgestrel/ethinyl estradiol 0.1/20, 0.1/30
levora
Lo/Ovral (generic only)
Loestrin 1/20, 1.5/30
Loestrin FE 1/20, 1.5/30
low-oestrel
lutera
microgestin
Mircette (generic copay applies)
mononessa
necon
Nordette (generic only)
norethindrone/ethinyl estradiol 0.5/35, 1/35
norethindrone/mestranol 1/50
norgestimate/ethinyl estradiol
norgestrel/ethinyl estradiol
norinyl 1+35
norinyl 1+50
nortrel
Nuvaring
ogestrel
Ovcon
Ovral
Ovrette

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Previafm
sprintec
Tri-Levlen (generic only)
Tri-Norinyl
triessa
Triphasil (generic only)
triprevifem
trisprintec
trivora
velivet
Yasmin
zovia

Gynecology: Estrogen & Progesterone Replacement
Activella
Aygestin (generic only)
Climara patches (quantity limit of 4/month)(0.05mg and 0.1mg generic only)
CombiPatch (quantity limit of 8/month)
Crinone gel
 Estrace cream
Estrace tabs (generic only)
estradiol tabs
Estratest
Estratest HS
Estring
estropipate
medroxyprogesterone
Menest
Ogen tablets (generic only)
Premarin
Premarin vaginal cream
Premphase
Prempro
Protemrium
Provera (generic only)
Vagifem vaginal tablets
VivelleDot Patches (generic only) (quantity limit of 8/month)

Gynecology: Vaginal Antifungals
Mycostatin (generic only)
nystatin
Terazol

Gynecology: Vaginal Anti-Infectives
AVC
Cleocin Vaginal (generic only)
clindamycin vaginal
MetroGel Vaginal

Gynecology: Miscellaneous
Methergine
Plan B (limit of 2 tabs per 30 days)

Heart: Blood Clotting
Agyrlin
Amicar
cilostazol
Coumadin (generic available)
dipyridamole (considered inappropriate for use in the elderly)***
Mephyton
pentoxifylline
Persantine (generic only) (considered inappropriate for use in the elderly)***
Plavix
Pletal (generic only)
Ticlid (generic only)
ticlopidine
Trental (generic only)
warfarin (generic for Coumadin)

Heart: Blood Pressure
Accupril (generic only)
Accuretic (generic only)
Adalat CC (generic only)
Aldomet (generic only)
Apresoline (generic only)
atenolol

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atenolol/chlorthalidone
Avalide◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
Avapro◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
benazepril (quantity limit of 1 per day; 40 mg limited to 2 per day)
benazepril w/HCTZ (quantity limit of 1 per day)
Benicar◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
Benicar HCT◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)

bisoprolol
bisoprolol w/HCTZ
Blocadren (generic only)
Calan (generic only)
Calan SR (generic only)
Capoten (generic only)
captopril
Cardizem (generic only)
Cardizem SR (generic only)
Cardura (generic only)
Catapres (generic only)
Catapres-TTS
clonidine
Coreg
Corgard (generic only)
Dilacor XR (generic only)
diltiazem
diltiazem sustained release
Diovan◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
Diovan HCT◆ (if no prior drug therapy with an ACE inhibitor, quantity limit of 1 per day)
doxazosin
enalapril
enalapril w/HCTZ
felodipine
fosinopril (quantity limit of 1 per day, 40 mg limited to 2 per day)
hydralazine
Hytrin (generic only)
Inderal (generic only)
Inderal LA
labetalol
lisinopril (quantity limit of 1 per day)
lisinopril w/HCTZ (quantity limit of 1 per day)
Loniten (generic only)
Lopressor (generic only)
Lotensin (quantity limit of 1 per day; 40 mg limited to 2 per day) (generic only)
Lotensin HCT (generic only)
methyldopa
metoprolol
Minipress (generic only)
minoxidil (oral only)
Monopril (generic only, quantity limit of 1 per day; 40 mg limited to 2 per day)
Monopril HCT
nadolol
nifedipine
nifedipine XL
Plendil (generic only)
prazosin
Prinivil (generic only, quantity limit of 1 per day; 40 mg limited to 2 per day)
Procardia, XL (generic only)
propranolol
propranolol LA
quinapril
quinapril w/HCTZ
Sular
Tenoretic (generic only)
Tenormin (generic only)
terazosin
Tiazac (generic only)
timolol
Toprol XL
Vaserectic (generic only)

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Vasotec (generic only)
verapamil
verapamil long-acting
Zebeta (generic only)
Zestoretic (generic only)
Zestril (generic only)
Ziac (generic only)

Heart: Cholesterol/Triglyceride Lowering

Advicor
cholestyramine
Colestid (packets not covered)
gemfibrozil
Lopid (generic only)
lovastatin (quantity limit of 1 per day)
Mevacor (generic only, quantity limit of 1 per day)
Niaspan
Pravachol (quantity limit of 1 per day)
Questran (generic only, packets not covered)
Questran Light (generic only, packets not covered)
Tricor
Vytorin
Zocor

Heart: Heart Failure, Angina & Irregular Beats

amiodarone
Betapace (generic only)
Betapace AF (generic only)
betaxolol oral
Cordarone (generic only)
digitek (generic for Lanoxin)
digoxin (Lanoxin covered)
disopyramide
Imdur (generic only, ISMO non-formulary)
Isordil (generic only)
isosorbide dinitrate
isosorbide mononitrate
Lanoxin (generic available)
mexilitine
Mexitil (generic only)
NitroBid
NitroDur
nitroglycerin, sustained release
Nitrostat
Norpace, CR (generic only)
procainamide
procainamide SR
Procanbid (generic only)
Pronestyl
Quinaglute Duratab (generic only)
Quinidex (generic only)
quinidine gluconate
quinidine sulfate
quinidine sulfate sustained release
Rythmol
sotalol
Tambocor (generic only)
Tonocard

Heart: Potassium Supplements (tablets, powders, and solutions)

effervescent potassium
Kaochlor (generic only)
Kaon solution (generic only)
K-Dur (generic only)
K-Lor (generic only)
K-Lyte (generic only)
K-Lyte/Cl (generic only)
K-Tab (generic only)
Micro-K (generic only)
potassium chloride, sustained release
potassium gluconate liquid
powdered potassium
Slow K (generic only)

Heart: “Water” Pills (Diuretics)

Aldactazide (generic only)
Aldactone (generic only)

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Bumetanide
Bumex (generic only)
chlorthalidone
Demadex (generic only)
Dyazide (generic only)
flavoxate
furosemide
hydrochlorothiazide
Hydrodiuril (generic only)
Hygroton (generic only)
Lasix (generic only)
Maxzide (generic only)
Maxzide 25 (generic only)
metholazine
Oretic (generic only)
spironolactone
spironolactone/HCTZ
torsemide
triamterene/HCTZ
triamterene/HCTZ 25
Zaroxolyn (generic only)

Heart: Miscellaneous
ProAmatine

Infections: Antibacterial and Antiviral
acyclovir (ointment not covered)
amoxicillin
amoxicillin/clavulanate 500/125 and 875/125
Amoxil (generic only)
ampicillin
Augmentin (some strengths are generic only, quantity limit of 28 per prescription)
Avelox◆ (Prior Authorization for greater than #10 per prescription)
Azulfidine (generic only)
Bactrim (generic only)
Baraclude◆ (if approved, quantity limit of 1/day)
Biaxin◆ (generic only) (Prior Authorization required if quantity exceeds 42 tablets per prescription)
Biaxin XL◆ (Prior Authorization required if quantity exceeds 42 tablets per prescription)
Cefaclor (generic only)
Cefadroxil (generic only)
Cefalexin (caps & susp. only)
ciprofloxacin oral
Cipro tablets (generic only)
Cipro XR (quantity limit of 3 tablets of 500 mg or 14 tablets of 1000 mg per prescription)
clarithromycin◆ (Prior Authorization required if quantity exceeds 42 tablets per prescription)
Cleocin (generic only)
clindamycin
cytoxan (generic only)
Dapsone
dicloxacillin
doxycycline
Dynapen (generic only)
E.E.S.
E-Mycin (generic only)
Epivir HBV
Ery-Tab (generic only)
Erythromycin (generic only)
erthromycin base film & enteric coated
erthromycin base, delayed release cap
erthromycin ethylsuccinate
erthromycin ethylsuccinate/sulfisoxazole
erthromycin stearate
Flagyl (generic only)
Floxin oral (generic only)
ganciclovir
Gantrisin (generic only)

Medications listed with a◆ require your physician to obtain prior authorization for medical necessity
Hepsera◆ (if approved, quantity limit of 1/day)
Keflex (generic only, caps & susp only)
Macrobid
Macrobid (generic only)
metronidazole
Minocin (generic only)
minocycline
Neomycin oral (generic only)
neomycin sulfate oral
nitrofurantoin
ofloxacin oral
Omnicef
Pediazole (generic only)
penicillin VK
Pen-Vee K (generic only)
Proloprim (generic only)
Rebetol◆ (generic only)
ribavirin◆
Septra, DS (generic only)
sulfasalazine
sulfisoxazole
Sumycin (generic only)
tetracycline
trimethoprim
trimethoprim sulfa
Valcyte
Valtrex
Vantin tabs (generic only)
Vibramycin (generic only)
Zithromax◆ (Prior Authorization required for >6 of the 250 mg tablets/capsules or 3 of the 500 mg tabs or 8 of the 600 mg tablets per prescription) (not covered through mail service)
Zovirax oral (generic only, ointment not covered)
Zyvox◆

Infections: Antifungal
clotrimazole troche

Diflucan◆ (generic only)
fluconazole
Fulvicin P-G (generic only)
Grifulvin-V (generic only)
griseofulvin microsize
griseofulvin ultramicrosize
itraconazole◆
ketoconazole
Lamisil◆
Mycelex Troche (generic only)
Mycostatin (generic only)
Nizoral oral (generic only)
Nystatin
Sporanox◆ (generic only)

Infections: HIV/AIDS
Agenerase
Aptivus (Prior Authorization required if no prior therapy with a Protease Inhibitor)
Combivir
Crixivan
Emtriva
Epivir
Epzicom
Fortovase
Hivid
Invirase
Kaletra
Lexiva
Norvir
Repositor
Retrovir
Reyataz
Sustiva
Trizivir
Truvada
Videx

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Viracept
Viramune
Viread
Zerit
Ziagen

**Infections: Parasites**
Aralen *(generic only)*
chloroquine phosphate
Daraprim
Fansidar
Flagyl *(generic only)*
Furoxone *(liquid only)*
Humatin *(generic only)*
hydroxychloroquine
Lariam *(generic only)* (quantity limit of 4 per prescription) (not covered through mail service)
Malarone◆
Mebendazole
Mepron◆
metronidazole
promomycin
Plaquenil *(generic only)*
Primaquine
Yodoxin

**Infections: Tuberculosis**
etambutol
isoniazid
Myambutol *(generic only)*
Mycobutin
Priftin
Pyrazinamide
Rifadin *(generic only)*
rifampin

**Mental Health: Anxiety**
alprazolam
Ativan *(generic only)*

chlordiazepoxide *(considered inappropriate for use in the elderly)***
clorazepate
diazepam *(considered inappropriate for use in the elderly)***
Librium *(generic only)* (considered inappropriate for use in the elderly)***
lorazepam
oxazepam
Serax *(generic only)*
Tranxene *(generic only)*
Valium *(generic only)* (considered inappropriate for use in the elderly)***
Xanax *(generic only)*

**Mental Health: Depression**
amitriptyline *(considered inappropriate for use in the elderly)***
amoxapine *(single source manufacturer, brand copay may apply)*
Anafranil *(generic only)*
Aventyl *(generic only)*
bupropion *(maximum dose of 400 mg/day)*
bupropion sustained release 100 mg
Buspar *(generic only)*
buspirone
citalopram
Celexa *(generic only)*
clomipramine
desipramine
Desyrel *(generic only)*
doxepin
Effexor XR
Elavil *(generic only)* (considered inappropriate for use in the elderly)***
fluoxetine
imipramine
Ludiomil *(generic only)*
maprotiline
mirtazapine

*Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity*
mirtazapine rapidly dissolving tablet
Nardil
nefazodone
Norpramin (generic only)
nortriptyline
Pamelor (generic only)
Parnate
paroxetine
Paxil (generic only)
Paxil CR
Prozac (generic only)
Remeron (generic only)
Remeron SolTabs (generic only)
Sinequan (generic only)
Tofranil (generic only)
trazodone
Vivactil
Wellbutrin (generic only, maximum of 400 mg/day)
Wellbutrin SR (maximum of 400 mg/day)
(100 mg generic only)

Mental Health: Psychosis
chlorpromazine
clozapine
Clozaril (generic only)
fluphenazine
haloperidol (0.5 and 1 mg considered brand, single manufacturer only)
lozapine
Loxotane (generic only)
Mellaril (generic only)
Navane (generic only)
Orap
perphenazine
Prolixin (generic only)
Risperdal
Stelazine (generic only)
thioridazine
thiothixene

Thorazine (generic only)
trifluoperazine
Trilafon (generic only)
Zyprexa

Mental Health: Sleep
Ambien
estazolam
Halcion (generic only)
oxazepam
Prosom (generic only)
Restoril (generic only)
Serax (generic only)
temazepam
triazolam

Mental Health: Miscellaneous
Adderall (generic only)
Adderall XR (quantity limit of 1 per day)
Aricept
Concerta (quantity limit of 1 per day)
Dexedrine (generic only, extended release limited to 1/day)
dextroamphetamine (extended release limited to 1/day)
Eskalith, CR (generic only)
fluvoxamine
lithium carbonate
lithium citrate
Luvox (generic only)
methylphenidate, SR (SR quantity limit of 1 per day)
Rilutek
Ritalin, SR (generic only, SR quantity limit of 1 per day)

Miscellaneous
Antabuse (generic only)
Chemet
disulfiram

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
Epipen, Jr. (quantity limit of 2 per prescription)
Glucagon kit
Renagel◆
Zavesca◆

Muscle Relaxants
baclofen
carisoprodol (considered inappropriate for use in the elderly)***
chlorzoxazone
cyclobenzaprine (considered inappropriate for use in the elderly)***
Flexeril (generic only) (considered inappropriate for use in the elderly)***
Lioresal (generic only)
methocarbamol (considered inappropriate for use in the elderly)***
Norflex (generic only) (considered inappropriate for use in the elderly)***
orphenadrine (considered inappropriate for use in the elderly)***
Parafon Forte DSC (generic only)
Robaxin (generic only) (considered inappropriate for use in the elderly)***
Soma (generic only) (considered inappropriate for use in the elderly)***
tizanidine tablet
Zanaflex tablet (generic only)

Muscle Stimulants
Mestinon

Neurology: Parkinson’s Disease
amantadine
benztropine
bromocriptine mesylate
carbidopa-levodopa
Cogentin (generic only)
Comtan◆ (covered if taking levodopa/carbidopa)

Eldepryl (generic only)
Mirapex
Parcopa◆
Parlodel (generic only)
pergolide
Requip
selegiline
Sinemet (generic only)
Sinemet CR
Stalevo
Symmetrel (generic only)
Tasmar◆
trihexyphenidyl

Neurology: Seizures
carbamazepine
Carbatrol
clonazepam
Depakene (generic only)
Depakote
Dilantin (generic available)
ethosuximide
gabapentin
Gabitril
Keppra
Klonopin (generic only)
Lamictal
Mysoline (generic only)
Neurontin (generic only)
phenobarbital
phenytoin
primidone
Tegretol (generic available)
Tegretol XR
Topamax
Trileptal
valproic acid
Zarontin (generic only)
Zonegran

Medications listed with a◆ require your physician to obtain prior authorization for medical necessity
Neurology: Miscellaneous

Aricept
Namenda
Provigil◆ (if approved, quantity limit of 2 tablets/day)
Razadyne
Rilutek

Pain Management: Arthritis and Inflammation

Ansaid (generic only)
Arava (generic only)
azathioprine
choline magnesium salicylate
Clinoril (generic only)
Cuprimine
Daypro (generic only)
diclofenac
diclofenac extended release
diflunisal
Disalcid (generic only)
Dolobid (generic only)
etodolac
etodolac sustained release
Feldene (generic only)
fenoprofen
flurbiprofen
hydroxychloroquine
ibuprofen (OTC forms not covered)
Imuran (generic only)
Indocin (generic only) (considered inappropriate for use in the elderly)***
Indocin SR (generic only) (considered inappropriate for use in the elderly)***
indomethacin (considered inappropriate for use in the elderly)***
indomethacin sustained release (considered inappropriate for use in the elderly)***
ketoprofen
leflunomide
Lodine, XL (generic only)
methotrexate
Methotrexate (generic only)
Motrin (generic only) (OTC forms not covered)
nabumetone
Nalfon (generic only)
Naprosyn (generic only)
naproxen
oxaprozin
piroxicam
Plaquenil (generic only)
Relafen (generic only)
Rheumatrex (generic only)
Ridaura
salsalate
sulindac
tolmetin (generic only)
Trilisate (generic only)
Voltaren (generic only)

Pain Management: Gout

allopurinol
Anturane (generic only)
colchicine
Colchicine (generic only)
Indocin (generic only) (considered inappropriate for use in the elderly)***
Indocin SR (generic only) (considered inappropriate for use in the elderly)***
indomethacin (considered inappropriate for use in the elderly)***
indomethacin SR (considered inappropriate for use in the elderly)***
probenecid
sulfinpyrazone
Zyloprim (generic only)

Pain Management: Migraine Headaches

acetaminophen/butalbital/caffeine
Amerge (Prior Authorization required over 9 tablets per month) (not covered through mail service)

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38 • Blue Shield Drug Formulary
aspirin/butalbital/caffeine
Cafergot tablet  (generic only) (maximum of 10/week)
Cafergot suppository  (maximum of 10/week)
Ergomar SL  (maximum dose of 5/week)
ergotamine/caffeine  (maximum dose of 10/week)
Fioricet  (generic only) (maximum dose of 6/day)
Fiorinal  (generic only) (maximum dose of 6/day)
Imitrex Nasal Spray◆ (Prior Authorization required for more than 6 inhaler units per month) (not covered through mail service)
Imitrex Tab◆ (Prior Authorization required for over 9 tablets per month) (not covered through mail service)
Isometheptene/dichloralphenazone/acetaminophen  (maximum dose of 5/day)
Maxalt◆ (Prior Authorization required over 9 tablets per month) (not covered through mail service)
Midrin  (generic only, maximum dose of 5/day)
Migranal NS◆ (Prior Authorization required over 1 kit of 6 sprays per 30 days) (not covered through mail service)

Pain Management:
Narcotics/Non-narcotics
acetaminophen/codeine
acetaminophen/hydrocodone
acetaminophen/oxycodone
Actiq◆
aspirin/codeine
aspirin/oxycodone
butorphanol NS◆ (generic only) (Prior Authorization for over 2 canisters per prescription and/or over 4 canisters per 30 days) (not covered through mail service)
Darvocet N  (generic only) (considered inappropriate for use in the elderly)***
Dilaudid  (generic only)

Dolophine  (generic only)
Duragesic Patches  (generic only) (quantity limit of 20 patches per 30 days)
Empirin/Codeine  (generic only)
fentanyl patches  (quantity limit of 20 patches per 30 days)
ydromorphone
methadone
morphine sulfate solution, tablets
morphine sulfate suppository
morphine sulfate sustained action
MS Contin  (generic only)
MSIR  (generic only)
OxyContin◆ (Prior Authorization required if >400 mg or >12 tablets per day or 80 mg and 160 mg strengths)
pentazocine/naloxone  (considered inappropriate for use in the elderly)***
Percocet  (generic only)
Percodan  (generic only)
propoxyphene HCl/acetaminophen  (considered inappropriate for use in the elderly)***
propoxyphene napsylate/acetaminophen  (considered inappropriate for use in the elderly)***
RMS suppository  (generic only)
Roxanol  (generic only)
Stadol NS◆ (generic only) (Prior Authorization required for over 2 units per prescription, not to exceed 4 units per 30 days) (not covered through mail service)
Talwin NX  (generic only) (considered inappropriate for use in the elderly)***
tramadol
tramadol/acetaminophen
Tylenol/Codeine  (generic only)
Ultracet  (generic only)
Ultram  (generic only)
Vicodin, ES  (generic only)
Wygesic  (generic only)

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
<table>
<thead>
<tr>
<th>Respiratory: Antihistamine &amp; Antiallergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atarax (generic only)</td>
</tr>
<tr>
<td>Bidhist (generic only)</td>
</tr>
<tr>
<td>clemastine (2.68 mg, syrup only)</td>
</tr>
<tr>
<td>cyproheptadine</td>
</tr>
<tr>
<td>dexchlorpheniramine sustained action</td>
</tr>
<tr>
<td>hydroxyzine (single source manufacturer, brand copays may apply)</td>
</tr>
<tr>
<td>Lohist (generic only)</td>
</tr>
<tr>
<td>Mintex CT, PD (generic only)</td>
</tr>
<tr>
<td>Palgic liquid (generic only)</td>
</tr>
<tr>
<td>Periactin (generic only)</td>
</tr>
<tr>
<td>Polaramine (generic only)</td>
</tr>
<tr>
<td>Vistaril (generic only)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory: Antihistamine/Decongestants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kronofed-A-Jr. (generic only)</td>
</tr>
<tr>
<td>pseudoephedrine/chlorpheniramine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory: Cough &amp; Cold</th>
</tr>
</thead>
<tbody>
<tr>
<td>benzonatate</td>
</tr>
<tr>
<td>codeine/promethazine</td>
</tr>
<tr>
<td>codeine/promethazine/phenylephrine</td>
</tr>
<tr>
<td>codeine/pseudoephedrine/chlorpheniramine</td>
</tr>
<tr>
<td>guaifenesin/codeine</td>
</tr>
<tr>
<td>guaifenesin/pseudoephedrine/codeine</td>
</tr>
<tr>
<td>Hycodan (generic only)</td>
</tr>
<tr>
<td>hydrocodone/homatropine</td>
</tr>
<tr>
<td>Phenergan/Codeine (generic only)</td>
</tr>
<tr>
<td>Phenergan VC/Codeine (generic only)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory: Inhalants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair Diskus (quantity limit of 1 inhaler per 30 days)</td>
</tr>
<tr>
<td>albuterol aerosol (quantity limit of 2 inhalers per 30 days)</td>
</tr>
<tr>
<td>albuterol solution for inhalation (quantity limits may apply)</td>
</tr>
</tbody>
</table>

| Alupent aerosol                                                           |
| Atrovent (Oral inhaler only, quantity limit of 2 inhalers per 30 days)   |
| Atrovent inhalation solution (generic only) (quantity limits may apply)  |
| Azmacort (quantity limit of 2 inhalers per 30 days)                      |
| cromolyn inhalation solution                                             |
| DuoNeb (quantity limit of 6 boxes/month)                                 |
| Foradil (quantity limit of 1 inhaler per 30 days)                        |
| Flovent (quantity limit of 2 inhalers per 30 days)                       |
| Intal aerosol (quantity limit of 3 inhalers per 30 days)                 |
| Intal inhalation solution (generic only) (quantity limit of 2 boxes per month) |
| Isoetharine                                                              |
| Maxair (quantity limit of 1 inhaler per 30 days)                         |
| Metaprel (generic only)                                                  |
| metaproterenol aerosol (quantity limits may apply)                       |
| metaproterenol solution for inhalation (quantity limits may apply)        |
| Proventil (generic only, quantity limits may apply)                      |
| Proventil HFA (quantity limit of 2 inhalers per 30 days)                  |
| Pulmicort Turbuhaler (Prior Authorization required for more than 1 inhaler per 45 days) |
| QVAR (quantity limit of 2 inhalers per 30 days)                          |
| Serevent (quantity limit of 1 inhaler per 30 days)                       |
| Spiriva                                                                   |
| TOBI inhalation solution (if prior authorization is approved, quantity limit of 1 box/month) |

<table>
<thead>
<tr>
<th>Respiratory: Oral Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>albuterol tablets, syrup</td>
</tr>
<tr>
<td>Brethine (generic only)</td>
</tr>
<tr>
<td>Metaprel syrup (generic only)</td>
</tr>
<tr>
<td>metaproterenol tablets, syrup</td>
</tr>
<tr>
<td>Proventil tablets, syrup</td>
</tr>
</tbody>
</table>

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.***
terbutaline, oral
theophylline
Uniphyl

**Stomach & Intestinal: Diarrhea**
diphenoxylate/atropine
Lomotil *(generic only)*
paregoric

**Stomach & Intestinal: Intestinal Spasms**
Bellamine *(generic only)*
Bellaspas *(generic only)*
belladonna alkaloid/phenobarbital/ergotamine
Bentyl *(generic only)*
dicyclomine
glycopyrrolate
hyoscymamine sulfate
Levsin *(generic only)*
Levsinex *(generic only)*
Propantheline
Robinul *(generic only)*

**Stomach & Intestinal: Nausea**
Anzemet ◆ *(Prior Authorization required for over 1 tablet per prescription) (not covered through mail service)*
Compazine *(generic only)*
Kytril ◆ *(Prior Authorization required for over 2 tablets per prescription) (not covered through mail service)*
metoclopramide
Phenergan *(generic only)*
prochlorperazine
promethazine
Reglan *(generic only)*
Tigan *(generic only) (considered inappropriate for use in the elderly)***
trimethobenzamide *(considered inappropriate for use in the elderly)***

Zofran ◆ *(Prior Authorization required for > 9 tablets of 4 or 8 mg or 1 of the 24 mg tablets per prescription) (not covered through mail service)*

**Stomach & Intestinal: Ulcer & Reflux**
Aciphex
Aclid *(generic only)*
Carafate *(generic only)*
cimetidine *(OTC forms not covered)*
Cytotec *(generic only)*
famotidine *(OTC forms not covered)*
misoprostol
nizatidine *(OTC forms not covered)*
omeprazole
Pepcid *(generic only, OTC forms not covered)*
Protonix
ranitidine *(OTC forms not covered)*
sucralfate
Tagamet *(generic only, OTC forms not covered)*
Zantac *(generic only, OTC forms not covered)*

**Stomach & Intestinal: Miscellaneous**
Actigall *(generic only)*
Anusol HC suppository *(generic only)*
Asacol
Azulfidine *(generic only)*
Cephulac *(generic only)*
Colazal
CoLyte *(generic only)*
Cortifoam
Dipentum
hydrocortisone enema
hydrocortisone suppository
lactulose
mesalamine enema
metoclopramide
Miralax *(generic only)*
pancrealipase
Pancrease *(generic only)*

Medications listed with a ◆ require your physician to obtain prior authorization for medical necessity
Pentasa (generic only)  
polyethylene glycol 3350  
Proctocream HC  
Proctofoam HC  
Reglan (generic only)  
Rowasa (generic only)  
sulfasalazine  
Urso  
ursodiol

**Urinary**
Bentyl (generic only)  
bethanechol  
Cardura (generic only)  
dicyclomine  
Ditropan (generic only)  
doxazosin  
Elmiron  
Enablex (prior therapy with oxybutynin required)  
flavoxate  
Flomax (prior therapy with doxazosin or terazosin required)  
Hiprex (generic only)  
yoscyamine sulfate  
Hytrin (generic only)  
Levsin (generic only)  
Levsinex (generic only)  
Levitra (not covered in all plans) (if approved for coverage – limit of 6 tablets per 30 days) (not covered through mail service)  
Mandelamine (generic only)  
methenamine hippurate  
methenamine mandelate  
methenamine/phenylsalicylate/atropine/hyoscyamine/benzoic acid/methylene blue  
Muse Suppository (Prior Authorization required and then limited to 6 per 30 days) (not covered through mail service) (not covered for all plans)  
oxbyutynin

Oxytrol (prior therapy with oxybutynin required)  
phenazopyridine  
Polycitra K  
Polycitra LC  
Probanthine (generic only)  
propantheline  
Proscar  
Pyridium (generic only)  
terazosin  
Urecholine (generic only)  
Urex (generic only)  
Urised (generic only)  
Urispas (generic only)  
Urocid K

**Vitamins**
Calciferol (generic only)  
calcitriol  
DHT  
ergocalciferol  
folic acid  
Leucovorin (generic only)  
Mephyton  
multivitamins with fluoride drops  
multivitamins with fluoride & iron drops  
multivitamins, prenatal  
Phoslo  
Poly-Vi-Flor (generic only)  
Poly-Vi-Flor with Iron (generic only)  
Rocaltrol (generic only)  
Stuartnatal Plus 3 (generic only)  
Tri-Vi-Flor (generic only)  
Tri-Vi-Flor with Iron (generic only)  
vitamins ADC with fluoride drops  
vitamins ADC with fluoride and iron drops

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.***
## Non-Formulary Drugs Requiring Prior Authorization

Note: If your plan has coverage for non-formulary drugs, the following drugs require prior authorization.

<table>
<thead>
<tr>
<th>Non-Formulary Drug</th>
<th>Requirement Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alinia</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Allegra, Allegra-D*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Atacand HCT</td>
<td>if no prior therapy with an ACE inhibitor, quantity limit of 1 per day</td>
</tr>
<tr>
<td>Avandamet*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Avandia*</td>
<td>If no prior diabetic drug therapy</td>
</tr>
<tr>
<td>Avodart*</td>
<td>medical necessity prior authorization, quantity limit of 1 per day</td>
</tr>
<tr>
<td>Byetta</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Celebrex*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Cialis*</td>
<td>medical necessity prior authorization, quantity limit of 6 per month</td>
</tr>
<tr>
<td>Clarinex*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Cozaar*</td>
<td>if no prior therapy with an ACE inhibitor, quantity limit of 1 per day</td>
</tr>
<tr>
<td>Crestor</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Detrol, Detrol LA*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Ditropan XL*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Hyzaar*</td>
<td>if no prior therapy with an ACE inhibitor, quantity limit of 1 per day</td>
</tr>
<tr>
<td>Klonopin Wafer</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Lipitor*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Lotronex</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Micardis HCT</td>
<td>if no prior therapy with an ACE inhibitor, quantity limit of 1 per day</td>
</tr>
<tr>
<td>Nexium*</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Omacor</td>
<td>medical necessity prior authorization</td>
</tr>
<tr>
<td>Orfadin</td>
<td>medical necessity prior authorization</td>
</tr>
</tbody>
</table>

*See Formulary Alternatives for Non-Formulary drugs on page 47
Non-Formulary Drugs
Requiring Prior Authorization, *continued*

<table>
<thead>
<tr>
<th>Non-Formulary Drug</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penlac*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Pexeva</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Prevacid*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Protopic*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td></td>
<td>Limit of 1 tube per month</td>
</tr>
<tr>
<td>Risperdal M-Tab</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Sanctura</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Sporanox*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Symlin</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Tazorac*</td>
<td>Prior authorization required if over age 40</td>
</tr>
<tr>
<td>Teveten, Teveten HCT</td>
<td>If no prior therapy with an ACE inhibitor,</td>
</tr>
<tr>
<td></td>
<td>Quantity limit of 1 per day</td>
</tr>
<tr>
<td>Thalomid</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Vesicare</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Vfend</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Viagra*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td></td>
<td>Quantity limit of 6 per month</td>
</tr>
<tr>
<td>Xyrem</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td></td>
<td>Quantity limit of 540 mls per 30 days</td>
</tr>
<tr>
<td>Zelnorm*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td></td>
<td>Quantity limit of 2 per day</td>
</tr>
<tr>
<td>Zetia*</td>
<td>Medical necessity prior authorization</td>
</tr>
<tr>
<td>Zyrtec, Zyrtec-D*</td>
<td>Medical necessity prior authorization</td>
</tr>
</tbody>
</table>

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.***
Non-Formulary Drugs with Quantity Limits

If you have coverage for non-formulary drugs, or if you have obtained a prior authorization for a non-formulary drug, the following quantity limits apply.

<table>
<thead>
<tr>
<th>Non-Formulary Drug</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuneb</td>
<td>5 boxes of 25 doses/box per month</td>
</tr>
<tr>
<td>Actonel weekly dose</td>
<td>4 tablets per month</td>
</tr>
<tr>
<td>Aerobid</td>
<td>3 inhalers per month</td>
</tr>
<tr>
<td>Alora</td>
<td>8 patches per month</td>
</tr>
<tr>
<td>Androgel pump</td>
<td>2 pumps per month</td>
</tr>
<tr>
<td>Atacand</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Avodart</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Beconase, AQ</td>
<td>1 inhaler per month</td>
</tr>
<tr>
<td>Boniva</td>
<td>1 tablet (150 mg) per month or 1 tablet (2.5 mg) per day</td>
</tr>
<tr>
<td>Caduet</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Cialis</td>
<td>6 tablets per 30 days</td>
</tr>
<tr>
<td>Combivent</td>
<td>2 inhalers per month</td>
</tr>
<tr>
<td>Combunox</td>
<td>28 tablets per prescription</td>
</tr>
<tr>
<td>Cozaar</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Crestor</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>3 tablets (20 mg) per day or 2 tablets (30 mg) per day or 1 tablet (60 mg) per day</td>
</tr>
<tr>
<td>Diastat</td>
<td>1 twin pack per prescription</td>
</tr>
<tr>
<td>Dostinex</td>
<td>16 tablets per month</td>
</tr>
<tr>
<td>Elestat</td>
<td>1 bottle per month</td>
</tr>
<tr>
<td>Emend</td>
<td>3 capsules per prescription</td>
</tr>
<tr>
<td>Ertaczo</td>
<td>1 tube per month</td>
</tr>
<tr>
<td>Estraderm</td>
<td>16 patches per month</td>
</tr>
<tr>
<td>Estrasorb</td>
<td>1 box (56 patches) per month</td>
</tr>
<tr>
<td>Estrogel</td>
<td>1 bottle per 60 days</td>
</tr>
<tr>
<td>Factive</td>
<td>5 or 7 tablets per prescription depending on package size</td>
</tr>
<tr>
<td>Femring</td>
<td>1 ring every 90 days</td>
</tr>
</tbody>
</table>
Non-Formulary Drugs with Quantity Limits (continued)

<table>
<thead>
<tr>
<th>Non-Formulary Drug</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finacea</td>
<td>One 50gm tube every 30 days</td>
</tr>
<tr>
<td>Frova</td>
<td>9 tablets per month</td>
</tr>
<tr>
<td>Hyzaar◆</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Inspra</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Ketek</td>
<td>20 tablets per prescription</td>
</tr>
<tr>
<td>Lescol, Lescol XL</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Lexapro</td>
<td>1.5 tablet per day of the 10 mg or 2 tablets per day of the 20 mg</td>
</tr>
<tr>
<td>Lidoderm</td>
<td>90 patches per month</td>
</tr>
<tr>
<td>Lipitor◆</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Micardis◆, Micardis HCT◆</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Nasacort AQ</td>
<td>1 inhaler per month</td>
</tr>
<tr>
<td>Ortho-Evra</td>
<td>3 patches per prescription</td>
</tr>
<tr>
<td>Protopic◆</td>
<td>1 tube per prescription</td>
</tr>
<tr>
<td>Provigil◆</td>
<td>3 tablets (100 mg) per day or 2 tablets (200 mg) per day</td>
</tr>
<tr>
<td>Relpax</td>
<td>6 tablets per month</td>
</tr>
<tr>
<td>Rhinocort Aqua</td>
<td>2 inhalers per month</td>
</tr>
<tr>
<td>Sanctura</td>
<td>2 tablets per day</td>
</tr>
<tr>
<td>Sonata</td>
<td>20 mg per day</td>
</tr>
<tr>
<td>Strattera</td>
<td>4 tablets (10 mg, 18 mg, or 25 mg) per day or 2 tablets (40 mg) per day or 1 tablet (60 mg) per day</td>
</tr>
<tr>
<td>Teveten◆, Teveten HCT◆</td>
<td>1 tablet per day</td>
</tr>
<tr>
<td>Tilade</td>
<td>3 inhalers per month</td>
</tr>
<tr>
<td>Tindamax</td>
<td>40 tablets (250 mg) per prescription or 20 tablets (500 mg) per prescription</td>
</tr>
<tr>
<td>Viagra◆</td>
<td>6 tablets per 30 days</td>
</tr>
<tr>
<td>Visicol</td>
<td>40 tablets per prescription</td>
</tr>
<tr>
<td>Vivelle</td>
<td>16 patches per month</td>
</tr>
<tr>
<td>Xifaxan</td>
<td>9 tablets per prescription</td>
</tr>
<tr>
<td>Xopenex</td>
<td>4 boxes (24 doses/box) per month</td>
</tr>
<tr>
<td>Xyrem◆</td>
<td>540 mls per 30 days</td>
</tr>
<tr>
<td>Zomig</td>
<td>6 tablets or sprays per month</td>
</tr>
</tbody>
</table>
Formulary Alternatives for Commonly Prescribed Non-Formulary Drugs

For your convenience we have listed some of the most common brand name drugs not included on our formulary, along with their covered alternatives.

<table>
<thead>
<tr>
<th>Non-Formulary Drugs</th>
<th>Formulary Alternative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>Risperdal, Zyprexa</td>
</tr>
<tr>
<td>Allegra, Allegra-D</td>
<td>Nasonex, Flonase</td>
</tr>
<tr>
<td>Avandamet♦</td>
<td>Actos♦ with metformin</td>
</tr>
<tr>
<td>Avandia♦</td>
<td>Actos♦ (if no prior diabetic drug therapy), glipizide, glyburide, metformin</td>
</tr>
<tr>
<td>Avodart♦</td>
<td>Proscar</td>
</tr>
<tr>
<td>Celebrex♦</td>
<td>choline magnesium trisalicylate, etodolac, salsalate, nabumetone (generic for Relafen)</td>
</tr>
<tr>
<td>Celexa</td>
<td>citalopram (generic for Celexa)</td>
</tr>
<tr>
<td>Cialis♦</td>
<td>Levitra♦ (prior authorization required, not covered for all plans)</td>
</tr>
<tr>
<td>Clarinex♦</td>
<td>Nasonex, Flonase</td>
</tr>
<tr>
<td>Cozaar♦</td>
<td>Avapro♦, Benicar♦, Diovan♦ (if no prior drug therapy with an ACE inhibitor)</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>For Depression: citalopram, Effexor XR, fluoxetine, paroxetine, Paxil CR; For diabetic neuropathy: amitriptyline, doxepin, nortriptyline, desipramine, imipramine, gabapentin,</td>
</tr>
<tr>
<td>Detrol, Detrol LA♦</td>
<td>Oxybutynin, Enablex♦, Oxytrol♦ (if no prior drug therapy with oxybutynin)</td>
</tr>
<tr>
<td>Ditropan XL♦</td>
<td>oxybutynin, Enablex♦, Oxytrol♦ (if no prior drug therapy with oxybutynin)</td>
</tr>
<tr>
<td>Hyzaar♦</td>
<td>Avalide♦, Benicar HCT♦, Diovan HCT♦ (if no prior drug therapy with an ACE inhibitor)</td>
</tr>
<tr>
<td>Lexapro</td>
<td>bupropion, fluoxetine, paroxetine (generic for Paxil), Paxil CR, Effexor XR</td>
</tr>
<tr>
<td>Lipitor♦</td>
<td>lovastatin (generic for Mevacor), Pravachol, Zocor, Vytorin</td>
</tr>
</tbody>
</table>

Medications listed with a ♦ require your physician to obtain prior authorization for medical necessity
# Formulary Alternatives for Commonly Prescribed Non-Formulary Drugs (continued)

<table>
<thead>
<tr>
<th>Non-Formulary Drugs</th>
<th>Formulary Alternative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nexium◆</td>
<td>omeprazole <em>(generic for Prilosec)</em>, Aciphex, Protonix <em>(also consider Prilosec OTC)</em></td>
</tr>
<tr>
<td>Norvasc</td>
<td>felodipine, nifedipine SR, Sular</td>
</tr>
<tr>
<td>Penlac◆</td>
<td>Lamisil◆</td>
</tr>
<tr>
<td>Prevacid◆</td>
<td>omeprazole <em>(generic for Prilosec)</em>, Aciphex, Protonix <em>(also consider Prilosec OTC)</em></td>
</tr>
<tr>
<td>Protopic◆</td>
<td>Elidel◆</td>
</tr>
<tr>
<td>Seroquel</td>
<td>Risperdal, Zyprexa</td>
</tr>
<tr>
<td>Sporanox◆</td>
<td>Fluconazole <em>(generic for Diflucan)</em></td>
</tr>
<tr>
<td>Strattera</td>
<td>Adderall XR, Concerta, dextroamphetamine, methylphenidate</td>
</tr>
<tr>
<td>Tazorac◆</td>
<td>For Acne vulgaris: Benzamycin, tretinoin◆, Retin-A Micro◆ For psoriasis: topical corticosteroids, anthralin cream, Dovonex</td>
</tr>
<tr>
<td>Viagra◆</td>
<td>Levitra◆ <em>(not covered for all plans)</em></td>
</tr>
<tr>
<td>Zelnorm◆</td>
<td>fiber supplements, laxatives <em>(OTCs are not a covered benefit)</em>, polyethylene glycol 3350</td>
</tr>
<tr>
<td>Zetia◆</td>
<td>lovastatin <em>(generic for Mevacor)</em>, Pravachol, Zocor, Vytorin</td>
</tr>
<tr>
<td>Zoloft</td>
<td>fluoxetine <em>(generic for Prozac)</em>, paroxetine <em>(generic for Paxil)</em></td>
</tr>
<tr>
<td>Zyrtec, Zyrtec-D◆</td>
<td>Nasonex, Flonase</td>
</tr>
</tbody>
</table>

***The U.S. General Accounting Office advises that these drugs may not be appropriate for people over age 65. Blue Shield of California suggests that you discuss with your physician whether these drugs are appropriate for you.
Home Self-Administered Injectables:

Not covered in the Outpatient Prescription Drug benefit for all groups. Please check your Evidence of Coverage or Certificate of Insurance/Policy handbook.

A home self-administered injectable is a medication that is injected subcutaneously (under the skin) on a regular basis, usually daily or weekly.

If home self-administered injectables are covered in the Outpatient Prescription Drug benefit for you, please have your doctor contact Pharmacy Services at (800) 535-9481 to request a prior authorization.

** Actimmune**
- Alferon N
- Aranesp
- Arixtra
- Avonex
- Betaseron
- Caverject
- Copaxone
- Delatestryl
- Edex
- Enbrel (Preferred Brand)
- Epogen (Procrit is the Preferred Brand)
- Forteo
- Fragmin
- Fuzeon
- Genotropin (Nutropin, Saizen, Serostim are the Preferred Brands)
- Heparin
- Humatrope (Nutropin, Saizen, Serostim are the Preferred Brands)
- Humira (Enbrel is the Preferred Brand)
- Imitrex Injectable (quantity limit of 4 kits per month at 2 kits per fill with out prior authorization)
- Interferon
- Innohep
- Intron A
- Kineret
- Leukine**
- Lovenox (Up to a 14 day supply covered without prior authorization)
- Methotrexate
- Miacalcin
- Neulasta
- Neumega
- Neupogen**
- Norditropin (Nutropin, Saizen, Serostim are the Preferred Brands)
- Nutropin (Preferred Brand) (not Depo)
- Nutropin AQ
- Pegasys
- Peg-Intron
- Procrit (Preferred Brand)
- Proleukin**
- Raptiva
- Rebetron
- Rebif
- Roferon A
- Saizen (Preferred Brand)
- Sandostatin (not Depo)
- Serostim (Preferred Brand)
- Somavert
- Testosterone Propionate

** If the injectable drug is infused, coverage is provided under your medical benefits.