

First+Plus
(HMO) and (PPO)
2010 Formulary
(List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE
DRUGS WE COVER IN THIS PLAN**

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

This document includes First+Plus' partial formulary as of January 1, 2010.

For a complete, updated formulary, please visit our Web site at www.firstpluspr.com or call 1-888-767-7717, Monday through Friday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242.

Last Updated October 2010

What is the First+Plus' Formulary?

A formulary is a list of covered drugs selected by First+Plus in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. First+Plus will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a First+Plus network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by First+Plus. For a complete listing of all prescription drugs covered by First+Plus, please visit our Web site at www.firstpluspr.com or call 1-888-767-7717, Monday through Friday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242.

Can the Formulary change?

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2010. To get updated information about the drugs covered by First+Plus, please visit our Web site at www.firstpluspr.com or call Member Service at 1-888-767-7717, Monday through Friday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242.

If changes occur throughout the year, these will be mailed in a separate notification to all members. In addition, any updates will be posted on our web site www.firstpluspr.com throughout the calendar year 2010.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 8. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "cardiovascular". If you know what your drug is used for, look for the category name in the list that begins on page number 8, then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 17. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

First+Plus covers both brand-name drugs and generic drugs. A generic drug has the same active-ingredient as the brand name drug. Generic drugs usually cost less than brand name drugs and are approved by the Food and Drug Administration (FDA).

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** First+Plus requires you to get prior authorization for certain drugs. This means that you will need to get approval from First+Plus before you fill your prescriptions. If you don't get approval, First+Plus may not cover the drug.
- **Quantity Limits:** For certain drugs, First+Plus limits the amount of the drug that First+Plus will cover. For example, First+Plus provides 25 tablets per prescription for zolpidem. This may be in addition to a standard one month or three month supply.

- **Step Therapy:** In some cases, First+Plus requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, First+Plus may not cover drug B unless you try Drug A first. If Drug A does not work for you, First+Plus will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 8. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site at www.firstpluspr.com

You can ask First+Plus to make an exception to these restrictions or limits. See the section, “How do I request an exception to the First+Plus formulary?” below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so First+Plus may cover your drug. You can contact Member Services at 1-888-767-7717, Monday through Friday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242.

If you learn that First+Plus does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by First+Plus. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by First+Plus.
- You can ask First+Plus to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the First+Plus Formulary?

You can ask First+Plus of to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, First+Plus limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our specialty drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the generic tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, First+Plus will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30 day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30 day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited,

but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For more information

For more detailed information about your First+Plus prescription drug coverage, please review your First+Plus Evidence of Coverage and other plan materials.

If you have questions about First+Plus, please call Member Services at 1-888-767-7717, Monday through Sunday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242. Or visit www.firstpluspr.com.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

First+PlusFormulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by First+Plus. If you have trouble finding your drug in the list, turn to the Index that begins on page 17. Remember: This is only a partial list of drugs covered by First+Plus. If your prescription is not in this partial formulary, please visit our Web site at www.firstpluspr.com or call Member Services at 1-888-767-7717, Monday through Sunday 8:00am – 8:00 pm. TTY/TDD users should call 1-877-672-4242.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ACTONEL and generic drugs are listed in lower-case italics (e.g., *alendronate*).

The second column indicates the tier level.

Tier 1 – Generics

Tier 2 – Brand Preferred

Tier 3 – Brand Non- Preferred

Tier 4 – Specialized Drugs

The information in notes column tells you if First+Plus has any special requirements for coverage of your drug.

PA – Indicates Prior Authorization is required

QL – Indicates Quantity Limits

ST – Indicates Step Therapy is required

Mail Order medications will be covered at a 90-day supply at a copayment which equals 2 times that of the retail copayments.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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Analgesics		
<i>acetaminophen/caffeine/dihydrocodeine</i>	1	
<i>acetaminophen/codeine elixir</i>	1	
<i>acetaminophen/codeine tablet</i>	1	
AVINZA	3	
<i>butorphanol tartrate</i>	1	
DEMEROL INJECTION	3	
ENDOCET	1	
<i>fentanyl citrate</i>	SP	
<i>fentanyl patch</i>	1	
<i>hydrocodone/acetaminophen</i>	1	
<i>hydromorphone tablet</i>	1	
<i>hydromorphone 10mg/ml injection</i>	1	
KADIAN	2	
<i>meperidine</i>	1	
<i>methadone</i>	1	
<i>morphine</i>	1	
<i>oxycodone</i>	1	
<i>oxycodone/acetaminophen</i>	1	
OXYCONTIN	2	
<i>propoxyphene-n/acetaminophen</i>	1	
ROXICET 5/325 ORAL SOLUTION, TABLET	3	
SUBOXONE	3	
<i>tramadol</i>	1	
<i>tramadol/acetaminophen</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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Anesthetics		
<i>lidocaine</i>	1	
LIDODERM	2	

Antibacterials		
ALTABAX	3	
<i>amoxicillin</i>	1	
AMOXIL 250MG/5ML SUSPENSION	3	
<i>amoxil 500mg capsule</i>	1	
<i>ampicillin oral</i>	1	
AUGMENTIN XR	3	
AVELOX	3	
AVELOX INJECTION	3	
<i>azithromycin</i>	1	
<i>bacitracin ophthalmic ointment</i>	1	
<i>cefaclor capsule, suspension</i>	1	
<i>cefadroxil</i>	1	
<i>cefdinir</i>	1	
<i>cefprozil</i>	1	
<i>ceftazidime</i>	1	
<i>cefuroxime axetil</i>	1	
<i>cefuroxime sodium</i>	1	
<i>cephalexin</i>	1	
CIPRO HC	3	
CIPRODEX	2	
<i>ciprofloxacin ophthalmic solution, tablet</i>	1	
<i>ciprofloxacin 400mg/40ml injection</i>	1	
<i>ciprofloxacin in D5W</i>	1	

PA=Prior Authorization

QL=Quantity Limits

ST=Step Therapy

PA**=Part B vs Part D Determination Prior Authorization Only

*=Requirements/Limits Apply to New Starts Only

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clarithromycin</i>	1	
<i>clarithromycin ER</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ofloxacin</i>	1	
<i>penicillin v potassium</i>	1	
<i>polymyxin b sulfate/trimethoprim</i>	1	

<i>clindamycin hydrochloride</i>	1	
<i>clindamycin phosphate</i>	1	
<i>dicloxacillin</i>	1	
DORYX	3	
<i>doxycycline</i>	1	
E.E.S. 400 TABLET	1	
ERY-TAB	3	
ERYTHROCIN TABLET	1	
<i>erythromycin (base) filmtablet</i>	1	
<i>erythromycin 250mg DR capsule, ointment</i>	1	
<i>erythromycin/sulfisoxazole</i>	1	
FORTAZ 500MG, 2GM/50ML INJECTION	3	
GENTAK	1	
<i>gentamicin sulfate</i>	1	
KETEK	3	
LEVAQUIN	2	
<i>metronidazole</i>	1	
<i>metronidazole vaginal</i>	1	
<i>minocycline</i>	1	
<i>neomycin tablet</i>	1	
<i>neomycin/polymyxin b/dexamethasone</i>	1	
<i>neomycin/polymyxin/hydrocortisone</i>	1	
<i>neomycin/polymyxin b/gramicid</i>	1	
<i>nitrofurantoin</i>	1	

<i>silver sulfadiazine</i>	1	
SPECTRACEF	3	
<i>sulfacetamide sodium ointment, solution</i>	1	
<i>sulfamethoxazole/trimethoprim</i>	1	
<i>tetracycline</i>	1	
SULFATRIM	1	
TOBRADEX	2	
<i>tobramycin</i>	1	
<i>trimethoprim 100mg tablet</i>	1	
VANCOCIN CAPSULE	2	
VANCOCIN 1G/200ML SOLUTION	3	
<i>vancomycin</i>	1	
VANDAZOLE	1	
XIFAXAN	3	
ZYVOX 2MG/ML INJECTION	SP	
ZYVOX 100MG/5ML SUSPENSION	SP	PA, QL
ZYVOX 600MG TABLET	SP	PA, QL

Anticonvulsants		
<i>carbamazepine</i>	1	
CARBATROL	2	
DEPAKOTE	2	
DEPAKOTE ER	2	
DEPAKOTE SPRINKLE	2	
DILANTIN	2	
<i>divalproex</i>	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>epitol</i>	1	
<i>gabapentin 600mg, 800mg tablet</i>	1	
GABITRIL	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antidepressants		
<i>amitriptyline</i>	1	
BUDEPRION SR	1	

KEPPRA	2	
LAMICTAL	2	
LAMICTAL ODT	2	
<i>lamotrigine</i>	1	
<i>levetiracetam</i>	1	
LYRICA	3	
NEURONTIN SOLUTION	3	
<i>oxcarbazepine</i>	1	
PHENYTEK	2	
<i>phenytoin 100mg ER capsule</i>	1	
<i>phenytoin 125mg/5ml suspension</i>	1	
<i>primidone</i>	1	
STAVZOR	2	
TEGRETOL	2	
TEGRETOL XR	2	
TRILEPTAL	2	
<i>valproic acid</i>	1	
<i>zonisamide</i>	1	

BUDEPRION XL	1	
<i>bupropion</i>	1	
<i>bupropion SR</i>	1	
<i>citalopram</i>	1	
<i>clomipramine</i>	1	
CYMBALTA	2	
<i>desipramine</i>	1	
<i>doxepin</i>	1	
EFFEXOR XR	3	
<i>fluoxetine</i>	1	
<i>fluvoxamine</i>	1	
<i>imipramine</i>	1	
LEXAPRO	2	
LUVOX CR	3	
<i>mirtazapine</i>	1	
<i>nefazodone</i>	1	
<i>nortriptyline</i>	1	
<i>paroxetine</i>	1	
<i>paroxetine ER 12.5mg, 25mg tablet</i>	1	
PRISTIQ	3	
PROZAC WEEKLY	3	
<i>sertraline</i>	1	
SYMBYAX	2	
<i>tranylcypromine</i>	1	
<i>trazodone</i>	1	
<i>venlafaxine</i>	1	
VENLAFAXINE ER	3	

Antidementia Agents		
ARICEPT TABLET	2	
ARICEPT ODT	2	
COGNEX	3	
EXELON	2	
<i>galantamine</i>	1	
<i>galantamine ER</i>	1	
NAMENDA SOLUTION, TABLET	2	
RAZADYNE ORAL SOLUTION	2	

Antidotes, Deterrents, and Toxicologic Agents		
<i>amifostine</i>	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CAMPRAL	2	
CHANTIX TABLET, STARTING MONTH PAK	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GRIFULVIN V 500MG TABLET	3	
GRIS-PEG	3	
<i>itraconazole</i>	1	PA

<i>naloxone</i>	1	
<i>naltrexone</i>	1	

Antiemetics		
<i>dronabinol</i>	1	
<i>meclizine</i>	1	
<i>metoclopramide</i>	1	
<i>ondansetron 2mg/ml injection</i>	1	
<i>ondansetron 4mg/5ml solution</i>	1	PA**
<i>ondansetron ODT</i>	1	PA**
<i>ondansetron tablet</i>	1	PA**
<i>prochlorperazine</i>	1	
<i>promethazine injection, suppository, tablet</i>	1	
PROMETHEGAN	1	
TRANSDERM-SCOP	3	
<i>trimethobenzamide 100mg/ml injection</i>	1	
<i>trimethobenzamide 300mg capsule</i>	1	

Antifungals		
<i>ciclopirox gel, nail lacquer</i>	1	
<i>ciclopirox olamine cream, suspension</i>	1	
<i>clotrimazole/betamethasone</i>	1	
<i>fluconazole suspension, tablet</i>	1	

<i>ketoconazole</i>	1	
LAMISIL 1% SPRAY	2	
<i>miconazole 3</i>	1	
<i>nystatin</i>	1	
<i>nystatin/triamcinolone</i>	1	
NYSTOP	1	
OXISTAT	3	
<i>terbinafine tablet</i>	1	PA
<i>terconazole suppository</i>	1	
<i>terconazole 0.4%, 0.8% cream</i>	1	
ZAZOLE	1	

Antigout Agents		
<i>allopurinol tablet</i>	1	
<i>colchicine 0.6mg tablet</i>	1	
<i>probenecid</i>	1	

Anti-Inflammatory Agents		
ARTHROTEC	3	
CELEBREX	3	
<i>diclofenac potassium</i>	1	
<i>diclofenac sodium</i>	1	
<i>diflunisal 500mg tablet</i>	1	
<i>etodolac</i>	1	
<i>flurbiprofen</i>	1	
<i>ibuprofen</i>	1	
<i>indomethacin capsule</i>	1	
<i>ketoprofen 50mg, 75mg tablet</i>	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ketorolac</i>	1	QL
<i>meloxicam</i>	1	
<i>nabumetone</i>	1	
<i>naproxen</i>	1	
<i>oxaprozin</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FEMARA	2	
GLEEVEC TABLET	2	
<i>hydroxyurea capsule</i>	1	
<i>mercaptopurine</i>	1	
<i>methotrexate</i>	1	
<i>tamoxifen</i>	1	
TARCEVA	2	

<i>piroxicam</i>	1	
PONSTEL	3	
<i>sulindac</i>	1	

Antimigraine Agents		
AMERGE	3	PA
AXERT	3	PA
FROVA	3	PA
MAXALT	2	PA
MAXALT MLT	2	PA
RELPAX	2	PA
<i>sumatriptan injection, tablet</i>	1	PA
TREXIMET	3	PA
ZOMIG	3	PA
ZOMIG ZMT	3	PA

Antimyasthenic Agents		
MESTINON SYRUP	3	
<i>pyridostigmine</i>	1	

Antimycobacterials		
<i>dapsone</i>	1	
<i>ethambutol</i>	1	
<i>isoniazid</i>	1	
<i>rifampin</i>	1	

Antineoplastics		
ARIMIDEX	2	
AROMASIN	2	

Antiparasitics		
<i>hydroxychloroquine</i>	1	
MALARONE	2	
<i>mebendazole</i>	1	
<i>permethrin cream</i>	1	
STROMEKTOL	2	

Antiparkinson Agents		
<i>amantadine capsule, tablet</i>	1	
AZILECT	2	
<i>benztropine</i>	1	
<i>bromocriptine</i>	1	
<i>carbidopa/levodopa</i>	1	
<i>carbidopa/levodopa ER</i>	1	
<i>carbidopa/levodopa ODT</i>	1	
COMTAN	2	
MIRAPEX	2	
PARCOPA	3	
REQUIP XL	3	
<i>ropinirole</i>	1	
<i>selegiline</i>	1	
STALEVO	2	
<i>trihexyphenidyl elixir, tablet</i>	1	

Antipsychotics		
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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ABILIFY TABLET	2	
ABILIFY 1MG/ML SOLUTION	2	
<i>chlorpromazine</i>	1	
<i>clozapine</i>	1	
FAZACLO	3	
<i>fluphenazine</i>	1	
GEODON	2	
<i>haloperidol</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HEPSERA	2	
KALETRA	2	
NORVIR	2	
REYATAZ	2	
<i>ribavirin</i>	1	
SUSTIVA	2	
SYNAGIS	2	
TAMIFLU	2	QL
TRIZIVIR	2	

<i>haloperidol decanoate</i>	1	
<i>loxapine</i>	1	
<i>perphenazine tablet</i>	1	
<i>risperidone solution, tablet</i>	1	
SEROQUEL	2	
SEROQUEL XR	2	
<i>thioridazine tablet</i>	1	
<i>thiothixene capsule</i>	1	
<i>trifluoperazine</i>	1	
ZYPREXA	2	

TRUVADA	2	
VALCYTE	SP	
VALTREX	2	
VIRACEPT	2	
VIRAMUNE	2	
VIREAD	2	
ZIAGEN	2	
ZOVIRAX CREAM, OINTMENT	3	

Antispasticity		
<i>baclofen</i>	1	
<i>dantrolene</i>	1	
<i>tizanidine</i>	1	

Anxiolytics		
<i>bupirone</i>	1	
<i>meprobamate</i>	1	

Antivirals		
<i>acyclovir capsule, suspension, tablet</i>	1	
ATRIPLA	2	
COMBIVIR	2	
EPIVIR	2	
EPZICOM	2	
<i>famciclovir</i>	1	
FUZEON	2	
<i>ganciclovir</i>	1	

Bipolar Agents		
<i>lithium carbonate</i>	1	
LITHOBID	2	

Blood Glucose Regulators		
<i>acarbose</i>	1	
ACTOPLUS MET	2	
ACTOS	2	
APIDRA	2	
AVANDAMET	2	
AVANDARYL	2	
AVANDIA	2	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BD INSULIN SAFETY SYRINGES	2	
BD INSULIN SYRINGES (DISP)	2	
BD PEN NEEDLE	2	
BD SINGLE USE ALCOHOL SWABS	1	
BYETTA 10MCG DOSE PEN INJECTION	2	
<i>glimepiride</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LANTUS 100 UNIT/ML VIAL	2	
LANTUS SOLOSTAR	2	
LEVEMIR	2	
LEVEMIR FLEXPEN	2	
<i>metformin</i>	1	
<i>metformin ER</i>	1	
NOVOLIN 70/30	2	
NOVOLIN N	2	
NOVOLIN N INNOLET	2	
NOVOLIN R	2	
NOVOLOG	2	

<i>glipizide</i>	1	
<i>glipizide ER 2.5mg tablet</i>	1	
<i>glipizide XL 5mg, 10mg tablet</i>	1	
<i>glipizide/metformin</i>	1	
GLUCAGON EMERGENCY KIT	2	
<i>glyburide</i>	1	
<i>glyburide micronized 1.5mg, 3mg, 6mg tablet</i>	1	
<i>glyburide/metformin</i>	1	
GLYSET	3	
HUMALOG 100 UNITS/ML PEN, VIAL	2	
HUMALOG MIX 50/50 PEN, VIAL	2	
HUMALOG MIX 75/25 PEN, VIAL	2	
HUMULIN 70/30	2	
HUMULIN N	2	
HUMULIN R	2	
JANUMET	2	
JANUVIA	2	

NOVOLOG MIX 70/30	2	
PRANDIMET	3	
PRANDIN	3	
STARLIX	2	
SYMLIN	2	

Blood Products/Modifiers/Volume Expanders		
AGGRENOX	2	
ARANESP ALBUMIN FREE	2	PA**
<i>cilostazol</i>	1	
COUMADIN	2	
<i>dipyridamole tablet</i>	1	
EPOGEN	3	PA**
HEPARIN 2,000 UNIT/ML INJECTION	3	
HEPARIN 2,500 UNIT/ML INJECTION	3	
<i>heparin sodium</i>	1	
JANTOVEN	1	
LOVENOX	2	
<i>pentoxifylline</i>	1	
PLAVIX	2	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROCRIT	2	PA**
<i>ticlopidine</i>	1	
<i>warfarin</i>	1	

Cardiovascular Agents		
<i>acebutolol</i>	1	
ACEON	3	
AFEDITAB CR	1	
<i>amiloride</i>	1	
<i>amiodarone</i>	1	
<i>amlodipine</i>	1	
<i>amlodipine/benazepril</i>	1	
ATACAND	3	
ATACAND HCT	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>chlorthalidone</i> 25mg, 50mg tablet	1	
<i>cholestyramine</i>	1	
<i>cholestyramine light</i>	1	
<i>clonidine</i>	1	
COREG CR	3	
COZAAR	3	
CRESTOR	3	
<i>digoxin</i>	1	
DILT-CD	1	
DILT-XR 180MG, 240MG CAPSULE	1	
<i>diltiazem</i>	1	
<i>diltiazem ER</i>	1	
DIOVAN TABLET	2	

<i>atenolol</i>	1	
AVALIDE	3	
AVAPRO	3	
AZOR	3	
<i>benazepril</i>	1	
<i>benazepril/HCTZ</i>	1	
BENICAR	3	
BENICAR HCT	3	
<i>betaxolol</i>	1	
BIDIL	2	
<i>bisoprolol</i>	1	
<i>bumetanide</i>	1	
CADUET	3	
<i>captopril</i>	1	
<i>captopril/HCTZ</i>	1	
CARDIZEM CD 360MG CAPSULE	3	
CARDIZEM LA	3	
CARTIA XT	1	
<i>carvedilol</i>	1	
CATAPRES-TTS	3	

DIOVAN HCT	2	
<i>disopyramide phosphate</i>	1	
<i>doxazosin</i>	1	
DYNACIRC 10MG CR TABLET	3	
<i>enalapril</i>	1	
<i>enalapril/HCTZ</i>	1	
EPIPEN 2-PAK	2	
EPIPEN JR 2-PAK	2	
<i>eplerenone</i>	1	
EXFORGE	2	
<i>felodipine ER</i>	1	
<i>fenofibrate</i>	1	
<i>flecainide</i>	1	
<i>fosinopril</i>	1	
<i>fosinopril/HCTZ</i>	1	
<i>furosemide</i>	1	
<i>gemfibrozil</i>	1	
<i>guanfacine</i>	1	
<i>hydralazine</i>	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>hydrochlorothiazide</i>	1	
HYZAAR	3	
<i>indapamide</i>	1	
<i>isosorbide dinitrate</i>	1	
<i>isosorbide mononitrate</i>	1	
<i>labetalol</i>	1	
LANOXIN	2	
LIPITOR	2	
<i>lisinopril</i>	1	
<i>lisinopril/HCTZ</i>	1	
LOTREL 5/40MG, 10/40MG CAPSULE	2	
<i>lovastatin</i>	1	
LOVAZA	3	
<i>methyclothiazide 5mg tablet</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nitroglycerin patch</i>	1	
NITROSTAT	3	
PACERONE	3	
<i>pindolol</i>	1	
<i>pravastatin</i>	1	
<i>prazosin</i>	1	
<i>propafenone</i>	1	
<i>propranolol</i>	1	
<i>quinapril</i>	1	
<i>quinaretic</i>	1	
<i>quinidine sulfate</i>	1	
<i>quinidine sulfate ER</i>	1	
<i>ramipril</i>	1	
RANEXA	2	
RYTHMOL SR	3	
<i>simvastatin</i>	1	

<i>methyldopa</i>	1	
<i>methyldopa/HCTZ</i>	1	
<i>metolazone</i>	1	
<i>metoprolol</i>	1	
<i>metoprolol ER</i>	1	
MICARDIS	2	
MICARDIS HCT	2	
<i>minoxidil tablet</i>	1	
<i>moexipril</i>	1	
MULTAQ	3	
<i>nadolol</i>	1	
NIASPAN	2	
NIFEDIAC CC	1	
NIFEDICAL XL	1	
<i>nifedipine</i>	1	
<i>nifedipine ER</i>	1	
NITRO-DUR 0.3MG/HR PATCH	3	
<i>nitroglycerin injection</i>	1	

<i>sotalol</i>	1	
<i>spironolactone</i>	1	
<i>spironolactone/HCTZ</i>	1	
TARKA	2	
TAZTIA XT	1	
<i>terazosin capsule</i>	1	
TEVETEN	3	
TEVETEN HCT	3	
TIKOSYN	3	
<i>torseamide</i>	1	
<i>trandolapril</i>	1	
<i>triamterene/HCTZ</i>	1	
TRICOR 48MG, 145MG TABLET	3	
TRILIPIX	2	
<i>verapamil</i>	1	
VYTORIN	3	
WELCHOL	3	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZETIA	2	

Central Nervous System Agents		
<i>amphetamine salt combo</i>	1	
CONCERTA	3	
<i>dexmethylphenidate</i>	1	
<i>dextroamphetamine tablet</i>	1	
<i>dextroamphetamine capsule CR</i>	1	
FOCALIN 5MG, 10MG TABLET	3	
METADATE CD 10MG, 20MG, 30MG TABLET	3	
METHYLIN CHEWABLE TABLET, SOLUTION	3	

METHYLIN TABLET	1	
METHYLIN ER	1	
<i>methylphenidate</i>	1	
PROVIGIL	2	
RITALIN LA	3	
STRATTERA	2	

Dental and Oral Agents		
<i>chlorhexidine</i>	1	
<i>clotrimazole</i>	1	
EVOXAC	2	
<i>pilocarpine tablet</i>	1	
<i>triamcinolone paste</i>	1	

Dermatological Agents		
<i>ammonium lactate</i>	1	
AZELEX	3	
BACTROBAN NASAL	3	
<i>calcipotriene</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARAC	3	
CLINDESSE	3	
<i>clotrimazole</i>	1	
DENAVIR	3	
DOVONEX CREAM	2	
<i>erythromycin 2% gel</i>	1	
FINACEA	3	
FLECTOR	3	
METROGEL 1% TOPICAL GEL	3	
<i>mupirocin</i>	1	
NAFTIN	3	
NORITATE	3	
REGRANEX	2	
SANTYL	3	
<i>sodium sulfacetamide lotion</i>	1	
TAZORAC	2	

<i>tretinoin capsule, cream, gel</i>	1	
<i>triamcinolone acetonide</i>	1	
ZONALON	3	

Enzyme Replacements/Modifiers		
ARALAST 500MG INJECTION	3	
CREON DR	2	
LIPRAM 4500	1	
ULTRASE MT	2	

Gastrointestinal Agents		
<i>atropine 0.05mg/ml, 0.1mg/ml injection</i>	1	
<i>cimetidine 300mg/5ml solution</i>	1	
<i>cimetidine tablet</i>	1	
<i>dicyclomine</i>	1	

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<i>diphenoxylate/atropine</i>	1	
ENULOSE	1	
<i>famotidine 10mg/ml injection</i>	1	
<i>famotidine 20mg, 40mg tablet</i>	1	
<i>famotidine premixed</i>	1	
<i>glycopyrrolate</i>	1	
GOLYTELY	3	
KRISTALOSE	3	
<i>lactulose</i>	1	
LONOX	1	
<i>loperamide capsule</i>	1	
<i>misoprostol</i>	1	
MOVIPREP	3	
NEXIUM CAPSULE, SUSPENSION	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AVODART	3	
<i>bethanechol</i>	1	
DETROL	2	
DETROL LA	2	
ELMIRON	3	
ENABLEX	3	
<i>finasteride</i>	1	
FLOMAX	2	
FOSRENOL	3	
<i>oxybutynin syrup, tablet</i>	1	
<i>oxybutynin ER</i>	1	
OXYTROL	3	
PHOSLO CAPSULE	2	
<i>potassium citrate ER</i>	1	
REVELA	2	
SANCTURA	3	
UROXATRAL	3	
VESICARE	2	

<i>nizatidine</i>	1	
<i>omeprazole capsule</i>	1	
PEG 3350 AND ELECTROLYTES	1	
PREVACID CAPSULE	3	
PREVACID NAPRAPAC 500	3	
PREVACID SOLUTAB	3	
PREVPAC	3	
PROTONIX INJECTION	3	
PYLERA	2	
<i>ranitidine</i>	1	
<i>sucralfate</i>	1	
<i>ursodiol</i>	1	

Genitourinary Agents

Hormonal Agents, Stimulant/Replacement/ Modifying (Adrenal)		
<i>augmented betamethasone dipropionate</i>	1	
<i>betamethasone dipropionate (augmented) gel</i>	1	
<i>betamethasone valerate</i>	1	
BETA-VAL	1	
CAPEX	3	
CELESTONE SYRUP	3	
<i>clobetasol</i>	1	
CLOBEX	3	
CORDRAN LOTION	3	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CORTEF 10MG TABLET	3	
<i>cortisone tablet</i>	1	
<i>desonide</i>	1	
<i>desoximetasone</i>	1	
<i>dexamethasone</i>	1	
<i>diflorasone cream</i>	1	
ENTOCORT EC	3	
<i>fludrocortisone</i>	1	
<i>fluocinolone acetonide</i>	1	
<i>fluticasone cream, ointment</i>	1	
<i>hydrocortisone</i>	1	
<i>hydrocortisone butyrate</i>	1	
<i>hydrocortisone valerate</i>	1	
KENALOG SPRAY	3	
<i>methylprednisolone</i>	1	
<i>mometasone</i>	1	
<i>prednisolone</i>	1	
<i>prednisone</i>	1	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANDROGEL 1%(5G) GEL PACKET	2	
APRI	1	
ARANELLE	1	
AVIANE	1	
BALZIVA	1	
CAMILA	1	
CENESTIN	2	
COMBIPATCH	2	
CRYSSELLE	1	
ENPRESSE	1	
ERRIN	1	
ESTRACE CREAM	3	
ESTRADERM	2	
<i>estradiol</i>	1	
<i>estradiol valerate</i>	1	
<i>estradiol/norethindrone</i>	1	
ESTRING	3	
<i>estropipate</i>	1	
EVISTA	2	

PROCTOSOL HC CREAM	1	
PROCTOZONE-HC	1	
U-CORT	1	

Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
<i>desmopressin</i>	1	
HUMATROPE CARTRIDGE KIT	SP	

Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
ACTIVELLA	3	
ALORA	2	
ANDRODERM	2	

FEMHRT	3	
FEMRING	3	
JOLIVETTE	1	
JUNEL FE	1	
KARIVA	1	
LESSINA-28	1	
LEVORA	1	
LOW-OGESTREL	1	
LUTERA	1	
<i>medroxyprogesterone</i>	1	
MEGACE ES	2	
<i>megestrol</i>	1	
<i>menest</i>	1	
MICROGESTIN	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MICROGESTIN FE	1	
NECON 0.5/35 (28)	1	
NECON 1/35 (28)	1	
NECON 1/50 (28)	1	
NECON 7/7/7	1	
NORA-BE	1	
<i>norethindrone</i>	1	
NORTREL 0.5/35 (28)	1	
NORTREL 1/35	1	
NORTREL 7/7/7	1	
OCELLA	1	
OGESTREL	1	
ORTHO EVRA	3	
ORTHO TRI-CYCLEN LO	3	
PORTIA (28)	1	
PREFEST	3	
PREMARIN	2	
PREMPHASE	2	
PREMPRO	2	
PROMETRIUM	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIVELLE-DOT	2	
ZOVIA 1/35E (28)	1	

Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)

CYTOMEL	2	
LEVOTHROID	2	
<i>levothyroxine tablet</i>	1	
LEVOXYL	2	
<i>liothyronine tablet</i>	1	
SYNTHROID	2	
UNITHROID	2	

Hormonal Agents, Suppressant (Parathyroid)

SENSIPAR	2	
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Hormonal Agents, Suppressant (Pituitary)

<i>cabergoline</i>	1	
<i>leuprolide 2wk 1mg/0.2ml kit</i>	1	PA*
LUPRON DEPOT	2	PA*

QUASENSE	1	
RECLIPSEN	1	
SPRINTEC 28	1	
SRONYX	1	
TESTIM	3	
<i>testosterone cypionate 100mg/ml injection</i>	1	
TRI-LEGEST FE	1	
TRI-LO-SPRINTEC	1	
TRINESSA	1	
TRI-SPRINTEC	1	
TRIVORA-28	1	
VAGIFEM	2	
VELIVET	1	

Hormonal Agents, Suppressant (Sex Hormones/Modifiers)

<i>flutamide</i>	1	
NILANDRON	2	

Hormonal Agents, Suppressant (Thyroid)

<i>methimazole</i>	1	
<i>propylthiouracil</i>	1	

Immunological Agents

ALDARA	2	
ARCALYST	SP	
AVONEX	SP	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>azathioprine tablet</i>	1	
BETASERON INJECTION KIT	SP	
CELLCEPT CAPSULE, SUSPENSION, TABLET	2	PA**
CIMZIA	SP	PA
COPAXONE	SP	
<i>cyclosporine capsule</i>	1	PA**
<i>cyclosporine 50mg/ml injection</i>	1	PA**
ELIDEL	2	
ENBREL	SP	PA
HUMIRA 40MG/0.8ML SYRINGE	SP	PA
HUMIRA CROHN'S STARTER PACK	SP	PA
<i>leflunomide</i>	1	
<i>mycophenolate 250mg capsule</i>	1	PA**
<i>mycophenolate 500mg tablet</i>	1	PA**

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>balsalazide</i>	1	
CANASA 1000MG SUPPOSITORY	2	
<i>HC pramoxine</i>	1	
PENTASA	2	
<i>sulfasalazine</i>	1	

Metabolic Bone Disease Agents		
ACTONEL	3	
ACTONEL WITH CALCIUM	3	
<i>alendronate</i>	1	
BONIVA TABLET	2	
BONIVA KIT	2	
<i>calcitriol</i>	1	
FORTEO 600MCG/2.4ML PEN INJECTION	3	PA
FORTICAL	2	
FOSAMAX PLUS D	2	
HECTOROL	2	
MIACALCIN 200 UNIT/ML INJECTION	2	
ZEMPLAR	3	

NEORAL	2	PA**
PEGASYS 180MCG/0.5ML	2	
PROGRAF CAPSULE	2	PA**
PROGRAF INJECTION	3	PA**
PROTOPIC	3	
RAPAMUNE	2	PA**
REBIF	SP	

Inflammatory Bowel Disease Agents		
ASACOL	2	

Ophthalmic Agents		
<i>acetazolamide capsule, tablet</i>	1	
ACULAR	2	
ACULAR LS	2	
ALPHAGAN P	2	
ALREX	2	
AZOPT	2	
<i>bacitracin/polymyxin b</i>	1	
BETIMOL	3	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BETOPTIC S	2	
BLEPHAMIDE	3	
BLEPHAMIDE S.O.P.	3	
<i>brimonidine</i>	1	
<i>cromolyn ophthalmic solution</i>	1	
ELESTAT	2	
<i>fluorometholone</i>	1	
FML S.O.P.	3	
LOTEMAX	2	
LUMIGAN	2	
NEVANAC	2	
OPTIVAR	2	
PATADAY	2	
PATANOL	2	
<i>prednisolone acetate</i>	1	
<i>prednisolone sodium phosphate</i>	1	
RESTASIS	2	
<i>timolol eye drops</i>	1	
TRAVATAN Z	2	
<i>trifluridine</i>	1	
VIGAMOX	2	
XALATAN	3	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ADVAIR DISKUS	2	
ADVAIR HFA	2	
AEROBID	3	
<i>albuterol solution</i>	1	
<i>albuterol syrup, tablet</i>	1	
<i>albuterol ER</i>	1	
ALLEGRA SUSPENSION	3	
ALLEGRA-D 12-HOUR	3	
ALLEGRA-D 24-HOUR	3	
ASMANEX	2	
ASTELIN	2	
ATROVENT HFA	3	
AZMACORT INHALER	3	
BECONASE AQ	3	
<i>cetirizine syrup</i>	1	
CLARINEX	3	
CLARINEX REDITABS	3	
CLARINEX-D	3	
COMBIVENT	2	
<i>cromolyn nebulizer solution</i>	1	
<i>cyproheptadine</i>	1	

ZYLET	2	
ZYMAR	2	

Otic Agents		
ACETASOL HC	1	
<i>acetic acid otic</i>	1	

Respiratory Tract Agents		
ACCOLATE	3	ST*
<i>acetylcysteine</i>	1	

<i>dexchlorpheniramine syrup</i>	1	
<i>diphenhydramine</i>	1	
<i>fexofenadine</i>	1	
FLOVENT HFA, DISKUS	2	
<i>flunisolide</i>	1	
<i>fluticasone nasal spray</i>	1	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FORADIL AEROLIZER	2	
<i>hydroxyzine tablet</i>	1	
<i>hydroxyzine pamoate capsule</i>	1	
<i>hydroxyzine 10mg/5ml syrup</i>	1	
<i>ipratropium bromide nasal spray</i>	1	
MAXAIR AUTOHALER	3	
NASACORT AQ	2	
NASONEX	2	
PERFOROMIST	3	
PROAIR HFA	2	
<i>promethazine syrup</i>	1	
PULMICORT RESPULE, FLEXHALER	2	
PROVENTIL HFA	2	
QVAR	2	
RHINOCORT AQUA	3	
SEREVENT DISKUS	2	
SINGULAIR	2	ST*
SPIRIVA HANDIHALER	2	
SYMBICORT	2	
<i>terbutaline</i>	1	
THEO-24	2	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XOPENEX HFA	2	
XYZAL	3	
ZYFLO CR	3	ST*

Sedatives/Hypnotics

AMBIEN CR	3	QL
LUNESTA	3	QL
ROZEREM	3	QL
<i>zaleplon</i>	1	QL
<i>zolpidem</i>	1	QL

Skeletal Muscle Relaxants

<i>carisoprodol</i>	1	
<i>chlorzoxazone</i>	1	
<i>cyclobenzaprine</i>	1	
<i>methocarbamol</i>	1	
<i>orphenadrine ER</i>	1	
SKELAXIN 800MG TABLET	3	

Therapeutic Nutrients/Minerals/Electrolytes

KAON-CL 10	1	
KLOR-CON	1	
KLOR-CON M15, M20	1	
<i>potassium chloride</i>	1	

<i>theophylline anhydrous</i>	1	
<i>theophylline ER</i>	1	
TRACLEER	2	
UNIPHYL 600MG TABLET	2	
VENTOLIN HFA	3	
VERAMYST	2	

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TRI-LEGEST FE	19
TRILEPTAL	9
TRILIPIX.....	15
TRI-LO-SPRINTEC	19
<i>trimethobenzamide</i> <i>100mg/ml injection</i>	10
<i>trimethobenzamide</i> <i>300mg capsule</i>	10
<i>trimethoprim 100mg tablet</i>	8
TRINESSA	19
TRI-SPRINTEC.....	19
TRIVORA-28	19
TRIZIVIR	12
TRUVADA.....	12

U

U-CORT.....	18
ULTRASE MT.....	16
UNIPHYL 600MG TABLET	22
UNITHROID	19
UROXATRAL.....	17
<i>ursodiol</i>	17

V

VAGIFEM	19
VALCYTE.....	12
<i>valproic acid</i>	9
VALTREX.....	12
VANCOCIN 1G/200ML SOLUTION.....	8
VANCOCIN CAPSULE.....	8
<i>vancomycin</i>	8
VANDAZOLE.....	8
VELIVET.....	19
<i>venlafaxine</i>	9
VENLAFAXINE ER	9
VENTOLIN HFA	22
VERAMYST.....	22
<i>verapamil</i>	15
VESICARE.....	17
VIGAMOX	20
VIRACEPT.....	12
VIRAMUNE.....	12
VIREAD	12
VIVELLE-DOT	19
VYTORIN.....	15

W

<i>warfarin</i>	13
WELCHOL.....	15

X

XALATAN	20
XIFAXAN.....	8
XOPENEX HFA.....	22
XYZAL.....	22

Z

<i>zaleplon</i>	22
ZAZOLE.....	10
ZEMPLAR.....	20

ZETIA.....	15	ZOVIA 1/35E (28).....	19	ZYVOX	
ZIAGEN.....	12	ZOVIRAX CREAM,		2MG/ML INJECTION.....	8
<i>zolpidem</i>	22	OINTMENT.....	12	ZYVOX 100MG/5ML	
ZOMIG	11	ZYFLO CR	22	SUSPENSION	8
ZOMIG ZMT	11	ZYLET	21	ZYVOX 600MG TABLET.....	8
ZONALON	16	ZYMAR	21		
<i>zonisamide</i>	9	ZYPREXA	12		