

2016



Formulary
List of covered Drugs

Health Partners Medicare Special



Health Partners Plans

Health Partners Medicare Special (HMO SNP) 2016 Formulary (List of Covered Drugs)

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

Formulary ID 16343, Version 9

This formulary was updated on 7/1/2016. For more recent information or other questions, please contact Health Partners Medicare at 1-866-901-8000 or, for TTY users, 711, 24 hours a day, seven days a week, or visit www.HPPMedicare.com.

This information is available for free in other languages. Please contact our Member Relations number at 1-866-901-8000 for additional information. (TTY users should call 711). Hours are 24 hours a day, seven days a week. Member Relations also has free language interpreter services available for non-English speakers.

Esta información se puede obtener en otros idiomas gratuitamente. Comuníquese con nuestro Departamento de Servicios para los Miembros al 1-866-901-8000 para obtener información adicional (los usuarios de TTY deben llamar 711). Disponible las 24 horas al día, los siete días a la semana. El Departamento de Servicios para los Miembros también tiene servicios gratuitos de interpretación de idiomas para las personas que no hablan inglés.

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.

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Health Partners Medicare. When it refers to “plan” or “our plan,” it means Health Partners Medicare Special.

This document includes a list of the drugs (formulary) for our plan which is current as of 7/1/2016. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2017, and from time to time during the year.

What is the Health Partners Medicare Special Formulary?

A formulary is a list of covered drugs selected by Health Partners Medicare Special 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. Health Partners Medicare Special will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Health Partners Medicare Special network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2016 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2016 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, 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 7/1/2016. To get updated information about the drugs covered by Health Partners Medicare Special, please contact us. Our contact information appears on the front and back cover pages.

Our print formulary will be updated, either by reprinting or through the use of correction sheets, in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. 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 Drugs.” If you know what your drug is used for, look for the category name in the list that begins on page number 109. 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 115. 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?

Health Partners Medicare Special covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

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:** Health Partners Medicare Special requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Health Partners Medicare Special before you fill your prescriptions. If you don't get approval, Health Partners Medicare Special may not cover the drug.
- **Quantity Limits:** For certain drugs, Health Partners Medicare Special limits the amount of the drug that Health Partners Medicare Special will cover. For example, Health Partners Medicare Special provides 12 tablets per day per prescription for Endocet tablets, 5-325 mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Health Partners Medicare Special 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, Health Partners Medicare Special may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Health Partners Medicare Special 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 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.HPPMedicare.com. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Health Partners Medicare Special to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Health Partners Medicare Special Formulary?” on this page 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 (list of covered drugs), you should first contact Member Relations and ask if your drug is covered.

If you learn that Health Partners Medicare Special does not cover your drug, you have two options:

- You can ask us for a list of similar drugs that are covered by Health Partners Medicare Special. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Health Partners Medicare Special.
- You can ask Health Partners Medicare Special 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 Health Partners Medicare Special Formulary?

You can ask Health Partners Medicare Special 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 a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health Partners Medicare Special 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 a greater amount.

Generally, Health Partners Medicare Special will only approve your request for an exception if the alternative drugs included on the plan's formulary 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 or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber'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 a supporting statement from your doctor or other prescriber.

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 allow you to refill your prescription until we have provided you with a 98-day transition supply, consistent with dispensing increment, (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.

If you are a **current member** and have a change in treatment setting due to a change in the level of care you require you can ask us to make a formulary exception.

Examples of level of care changes might include:

- Discharge from a hospital to home;
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan;
- Changing from Hospice Status and reverting back to standard Medicare Part A and B coverage;
- Ending a long-term care stay and returning to the community;
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens.

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered, are known to have risks.

For more information

For more detailed information about your Health Partners Medicare Special prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Health Partners Medicare Special, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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 users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

Health Partners Medicare Special's Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Special. If you have trouble finding your drug in the list, turn to the Index that begins on page 115.

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

The information in the Requirements/Limits column tells you if Health Partners Medicare Special has any special requirements for coverage of your drug.

Drugs marked LA: This prescription may be available only at certain pharmacies. For more information call us anytime at 1-866-901-8000. TTY users should call 711.

LEGEND

TIER	NAME	
1	Covered	

SYMBOL	NAME	DESCRIPTION
QL	Quantity Limit	There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame.
PA	Prior Authorization	You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
ST	Step Therapy	In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
LA	Limited Access	This prescription drug is limited to certain pharmacies.
FDA	FDA Quantity Limit	There is an FDA limit on the amount of this drug that is covered per prescription, or within a specific time frame.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Analgesics		
<i>acetaminophen with codeine 300mg-15mg tablet</i>	1-Covered	QL (13 PER 1 DAYS)
<i>acetaminophen with codeine 300mg-30mg tablet</i>	1-Covered	QL (12 PER 1 DAYS)
<i>acetaminophen with codeine 300mg-60mg tablet</i>	1-Covered	QL (6 PER 1 DAYS)
<i>acetaminophen with codeine phosphate (120-12mg/5, 300mg/12.5)</i>	1-Covered	
<i>butalbit/acetamin/caff/codeine 50-325-30 capsule</i>	1-Covered	PA
<i>butalbital/acetaminophen 50mg-325mg tablet</i>	1-Covered	PA
<i>butalbital/acetaminophen/caffeine (capsule, tablet)</i>	1-Covered	PA
<i>butalbital/aspirin/caffeine 50-325-40 capsule</i>	1-Covered	PA
ENDOCET (7.5-325 MG TABLET, 10-325 MG TABLET)	1-Covered	
ENDOCET 5-325 TABLET	1-Covered	QL (12 PER 1 DAYS)
<i>hydrocodone bitartrate/acetaminophen (2.5-108/5, 5-217mg/10, 7.5-325/15)</i>	1-Covered	
<i>hydrocodone/acetaminophen 10mg-325mg tablet</i>	1-Covered	QL (6 PER 1 DAYS)
<i>hydrocodone/acetaminophen 5 mg-325mg tablet</i>	1-Covered	QL (12 PER 1 DAYS)
<i>hydrocodone/acetaminophen 7.5-325mg tablet</i>	1-Covered	QL (8 PER 1 DAYS)
<i>hydrocodone/ibuprofen 7.5-200 mg tablet</i>	1-Covered	QL (5 PER 1 DAYS)
<i>oxycodone hcl/acetaminophen (2.5-325mg tablet, 5 mg-325mg tablet)</i>	1-Covered	QL (12 PER 1 DAYS)
<i>oxycodone hcl/acetaminophen (7.5-325mg tablet, 10mg-325mg tablet)</i>	1-Covered	
<i>oxycodone hcl/aspirin 4.8355-325 tablet</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pentazocine hcl/naloxone hcl 50mg-0.5mg tablet</i>	1-Covered	QL (12 PER 1 DAYS)
ROXICET 5-325 TABLET	1-Covered	
<i>tramadol hcl/acetaminophen 37.5-325mg tablet</i>	1-Covered	QL (8 PER 1 DAYS)

Nonsteroidal Anti-inflammatory Drugs

<i>celecoxib (50 mg capsule, 100 mg capsule, 200 mg capsule, 400 mg capsule)</i>	1-Covered	
<i>diclofenac potassium 50 mg tablet</i>	1-Covered	
<i>diclofenac sodium (1.5 % drops, 25 mg tablet dr, 50 mg tablet dr, 75 mg tablet dr, 100 mg tab er 24h)</i>	1-Covered	
<i>diclofenac sodium/misoprostol (50 tab ir dr, 75 tab ir dr)</i>	1-Covered	
<i>diflunisal 500 mg tablet</i>	1-Covered	
<i>etodolac (200 mg capsule, 300 mg capsule, 400 mg tablet, 500 mg tablet)</i>	1-Covered	
<i>fenoprofen calcium 600 mg tablet</i>	1-Covered	
<i>flurbiprofen (50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>ibuprofen (400 mg tablet, 600 mg tablet, 800 mg tablet)</i>	1-Covered	
<i>ibuprofen/oxycodone hcl 400mg-5mg tablet</i>	1-Covered	
<i>indomethacin (25 mg capsule, 50 mg capsule, 75 mg capsule er)</i>	1-Covered	PA
<i>ketoprofen (50 mg capsule, 75 mg capsule)</i>	1-Covered	
<i>ketoprofen 200 mg cap24h pel</i>	1-Covered	QL (1 PER 1 DAYS)
<i>meclofenamate sodium (50 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>meloxicam 15 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>meloxicam 7.5 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>meloxicam 7.5 mg/5ml oral susp</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nabumetone (500 mg tablet, 750 mg tablet)</i>	1-Covered	
<i>naproxen (125 mg/5ml oral susp, 250 mg tablet, 375 mg tablet, 375 mg tablet dr, 500 mg tablet dr, 500 mg tablet)</i>	1-Covered	
<i>naproxen sodium (275 mg tablet, 375 mg tbmp 24hr, 500 mg tbmp 24hr, 550 mg tablet)</i>	1-Covered	
<i>oxaprozin 600 mg tablet</i>	1-Covered	
<i>piroxicam (10 mg capsule, 20 mg capsule)</i>	1-Covered	
<i>sulindac (150 mg tablet, 200 mg tablet)</i>	1-Covered	
<i>tolmetin sodium (400 mg capsule, 600 mg tablet)</i>	1-Covered	
Opioid Analgesics, Long-acting		
<i>DURAMORPH (5 ML, 10 ML)</i>	1-Covered	
<i>fentanyl (12 mcg/hr, 25 mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100 mcg/hr)</i>	1-Covered	QL (10 PER 23 DAYS)
<i>fentanyl citrate (200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)</i>	1-Covered	PA
<i>methadone hcl (5 mg/5 ml solution, 5 mg tablet, 10 mg/5 ml solution, 10 mg tablet)</i>	1-Covered	
<i>morphine sulfate (10 mg/5 ml solution, 15 mg tablet, 20 mg/5 ml solution, 30 mg tablet, 60 mg tablet er, 100 mg/5ml solution)</i>	1-Covered	
<i>morphine sulfate (15 mg tablet er, 30 mg tablet er, 100 mg tablet er, 200 mg tablet er)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>oxycodone hcl (10 mg tab er, 15 mg tab er, 20 mg tab er, 30 mg tab er, 40 mg tab er, 60 mg tab er, 80 mg tab er)</i>	1-Covered	PA

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OXYCONTIN (10 MG TABLET, 15 MG TABLET, 20 MG TABLET, 30 MG TABLET, 40 MG TABLET, 60 MG TABLET, 80 MG TABLET)	1-Covered	PA, QL (2 PER 1 DAYS)
<i>oxymorphone hcl (5 mg tab er, 7.5 mg tab er, 10 mg tab er, 15 mg tab er, 20 mg tab er, 30 mg tab er, 40 mg tab er)</i>	1-Covered	
<i>tramadol hcl (100 mg tbmp 24hr, 100 mg cpbp 25-75, 100 mg tab er 24h, 200 mg tbmp 24hr, 200 mg tab er 24h, 200 mg cpbp 25-75, 300 mg tab er 24h, 300 mg cpbp 17-83, 300 mg tbmp 24hr)</i>	1-Covered	

Opioid Analgesics, Short-acting

<i>butorphanol tartrate 10 mg/ml spray</i>	1-Covered	
<i>codeine/butalbital/asa/caffeine 30-50-325 capsule</i>	1-Covered	
<i>hydrocodone/acetaminophen 2.5-325mg tablet</i>	1-Covered	
<i>hydrocodone/ibuprofen (5mg-200mg tablet, 10mg-200mg tablet)</i>	1-Covered	
<i>hydromorphone hcl (2 mg tablet, 4 mg tablet, 8 mg tablet)</i>	1-Covered	
<i>morphine sulfate (2 mg/ml cartridge, 2 mg/ml syringe, 4 mg/ml syringe, 4 mg/ml cartridge, 8 mg/ml syringe, 8 mg/ml cartridge, 10 mg/ml syringe, 10 mg/ml cartridge)</i>	1-Covered	
<i>oxycodone hcl (5 mg/5 ml solution, 5 mg capsule, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg/ml oral conc, 20 mg tablet, 30 mg tablet)</i>	1-Covered	
<i>oxymorphone hcl (5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>tramadol hcl 50 mg tablet</i>	1-Covered	

Anesthetics

Local Anesthetics

<i>lidocaine 5 % adh. patch</i>	1-Covered	PA
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lidocaine 5 % oint. (g)</i>	1-Covered	
<i>lidocaine hcl (2 % solution, 2 % jel/pf app, 2 % jel (ml), 4 % solution, 5 mg/ml vial, 10 mg/ml vial, 20 mg/ml vial, 40 mg/ml solution)</i>	1-Covered	
<i>lidocaine hcl/pf (5 mg/ml vial, 10 mg/ml ampul, 20 mg/ml vial)</i>	1-Covered	
<i>lidocaine/prilocaine (2.5 cream (g), 2.5 kit)</i>	1-Covered	

Anti-Addiction/ Substance Abuse Treatment Agents

Alcohol Deterrents/ Anti-craving

<i>acamprosate calcium 333 mg tablet dr</i>	1-Covered	
<i>disulfiram (250 mg tablet, 500 mg tablet)</i>	1-Covered	
<i>naltrexone hcl 50 mg tablet</i>	1-Covered	
VIVITROL (380 MG VIAL + DILUENT, 380 MG VIAL)	1-Covered	

Opioid Dependence Treatments

<i>buprenorphine hcl (0.3 mg/ml vial, 0.3 mg/ml syringe)</i>	1-Covered	
<i>buprenorphine hcl (2 mg tab, 8 mg tab)</i>	1-Covered	PA
REVIA 50 MG TABLET	1-Covered	
SUBOXONE (2 MG-0.5 MG, 4 MG-1 MG, 8 MG-2 MG, 12 MG-3 MG)	1-Covered	PA

Opioid Reversal Agents

EVZIO 0.4 MG AUTO-INJECTOR	1-Covered	
<i>naloxone hcl 1 mg/ml syringe</i>	1-Covered	
NARCAN 4 MG NASAL SPRAY	1-Covered	

Smoking Cessation Agents

CHANTIX (0.5 MG TABLET, 1 MG CONT MONTH BOX, 1 MG TABLET, STARTING MONTH BOX)	1-Covered	
NICOTROL CARTRIDGE INHALER	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NICOTROL NS 10 MG/ML SPRAY	1-Covered	
Anti-inflammatory Agents		
Glucocorticoids		
<i>triamcinolone acetonide (10 mg/ml vial, 40 mg/ml vial)</i>	1-Covered	
Nonsteroidal Anti-inflammatory Drugs		
<i>ibuprofen 100 mg/5ml oral susp</i>	1-Covered	
<i>mefenamic acid 250 mg capsule</i>	1-Covered	
Antibacterials		
Aminoglycosides		
<i>amikacin sulfate (500 mg/2ml vial, 1000mg/4ml vial)</i>	1-Covered	
<i>gentamicin sulfate (0.1 % oint. (g), 0.1 % cream (g), 0.3 % oint. (g), 0.3 % drops, 40 mg/ml vial)</i>	1-Covered	
<i>gentamicin sulfate in sodium chloride, iso-osmotic (gentamic60 mg/50ml, gentamic70 mg/50ml, gentamic80 mg/50ml, gentamic80mg/100ml, gentamic90mg/100ml, gentamic100mg/0.1l, gentamic120mg/0.1l)</i>	1-Covered	
<i>gentamicin sulfate/pf (20 mg/2 ml vial, 60 mg/6 ml vial port, 80 mg/8 ml vial port, 100mg/10ml vial port)</i>	1-Covered	
<i>neomycin sulfate 500 mg tablet</i>	1-Covered	
<i>neomycin sulfate/polymyxin b sulfate (ampul, vial)</i>	1-Covered	
<i>paromomycin sulfate 250 mg capsule</i>	1-Covered	
<i>streptomycin sulfate 1 g vial</i>	1-Covered	
TOBI PODHALER 28 MG INHALE CAP	1-Covered	
TOBRADEX EYE OINTMENT	1-Covered	
<i>tobramycin 0.3 % drops</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tobramycin in 0.225% nacl 300 mg/5ml ampul-neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>tobramycin sulfate (1.2 g vial, 10 mg/ml vial, 40 mg/ml vial)</i>	1-Covered	
<i>tobramycin/sodium chloride 80mg/100ml piggyback</i>	1-Covered	
<i>colistin (colistimethate na) 150 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
SYNERCID 500 MG VIAL	1-Covered	

Antibacterials, Other

<i>acetic acid 2 % solution</i>	1-Covered	
<i>alcohol antiseptic pads med. pad</i>	1-Covered	
<i>bacitracin (500 unit/g oint. (g), 50000 unit vial)</i>	1-Covered	
BACTROBAN NASAL 2% OINTMENT	1-Covered	
<i>chloramphenicol sod succ 1 g vial</i>	1-Covered	
<i>clindamycin hcl (75 mg capsule, 150 mg capsule, 300 mg capsule)</i>	1-Covered	
<i>clindamycin palmitate hcl 75 mg/5 ml soln recon</i>	1-Covered	
<i>clindamycin phosphate (1 % lotion, 1 % med. swab, 1 % gel (gram), 1 % solution, 2 % cream/appl, 150 mg/ml vial, 300 mg/2ml vial port, 600 mg/4ml vial port, 900mg/6ml vial port)</i>	1-Covered	
<i>clindamycin phosphate/dextrose 5 % in water (300mg/50ml, 600mg/50ml, 900mg/50ml)</i>	1-Covered	
CUBICIN 500 MG VIAL	1-Covered	ST
<i>linezolid (100 mg/5ml susp recon, 600mg/300 iv soln, 600 mg tablet)</i>	1-Covered	PA
<i>methenamine hippurate 1 g tablet</i>	1-Covered	
<i>metronidazole (0.75 % gel (gram), 0.75 % cream (g), 0.75 % gel w/appl, 0.75 % lotion, 1 % gel w/pump, 1 % gel (gram), 250 mg tablet, 375 mg capsule, 500 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>metronidazole/sodium chloride 500mg/0.1l piggyback</i>	1-Covered	
<i>mupirocin 2 % oint. (g)</i>	1-Covered	
<i>mupirocin calcium 2 % cream (g)</i>	1-Covered	
<i>nitrofurantoin 25 mg/5 ml oral susp</i>	1-Covered	
<i>nitrofurantoin macrocrystal (25 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>nitrofurantoin macrocrystal 50 mg capsule</i>	1-Covered	QL (112 PER 30 DAYS)
<i>nitrofurantoin monohyd/m-cryst 100 mg capsule</i>	1-Covered	
<i>polymyxin b sulfate 500k unit vial</i>	1-Covered	
<i>trimethoprim 100 mg tablet</i>	1-Covered	
TYGACIL 50 MG VIAL	1-Covered	
<i>vancomycin hcl (1 g vial, 1 g vial port, 5 g vial, 10 g vial, 500 mg vial, 500 mg vial port, 750 mg vial)</i>	1-Covered	
<i>vancomycin hcl 125 mg capsule</i>	1-Covered	QL (4 PER 1 DAYS)
<i>vancomycin hcl 250 mg capsule</i>	1-Covered	QL (8 PER 1 DAYS)
ZYVOX (100 MG/5 ML SUSPENSION, 200 MG/100 ML IV SOLN)	1-Covered	PA

Beta-lactam, Cephalosporins

CEDAX 90 MG/5 ML SUSPENSION	1-Covered	
<i>cefaclor (250 mg capsule, 500 mg tablet 12h, 500 mg capsule)</i>	1-Covered	
<i>cefadroxil (1 g tablet, 250 mg/5ml susp recon, 500 mg capsule, 500 mg/5ml susp recon)</i>	1-Covered	
<i>cefazolin sodium (1 g vial, 1 g vial port, 10 g vial, 20 g vial, 100 g bulkbaginj, 300g bulkbaginj, 500 mg vial)</i>	1-Covered	
<i>cefazolin sodium/dextrose, iso-osmotic (1 ml froz.piggy, 1 ml piggyback)</i>	1-Covered	
<i>cefdinir (125 mg/5ml susp recon, 250 mg/5ml susp recon, 300 mg capsule)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>cefepime hcl 1 g vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cefepime hcl 2 g vial</i>	1-Covered	
<i>cefepime hcl/dextrose 5 % in water (1 ml, 2 ml)</i>	1-Covered	
<i>cefixime (100, 200)</i>	1-Covered	
<i>cefotetan disodium (1 vial, 2 vial, 10 vial)</i>	1-Covered	
<i>cefoxitin sodium (1 vial, 2 vial, 10 vial)</i>	1-Covered	
<i>cefoxitin sodium/dextrose, iso-osmotic (1 ml, 2 ml)</i>	1-Covered	
<i>cefpodoxime proxetil (50 mg/5 ml susp recon, 100 mg tablet, 100 mg/5ml susp recon, 200 mg tablet)</i>	1-Covered	
<i>cefprozil (125 mg/5ml susp recon, 250 mg tablet, 250 mg/5ml susp recon, 500 mg tablet)</i>	1-Covered	
<i>ceftazidime (1 vial, 2 vial, 6 vial)</i>	1-Covered	
<i>ceftazidime in dextrose 5% and water (1 ml, 2 ml)</i>	1-Covered	
<i>ceftriaxone sodium (1 g vial, 1 g vial port, 2 g vial port, 2 g vial, 10 g vial, 100 g bulkbaginj, 250 mg vial, 500 mg vial)</i>	1-Covered	
<i>cefuroxime axetil (250 mg tablet, 500 mg tablet)</i>	1-Covered	
<i>cefuroxime sodium (1.5 g vial, 7.5g vial, 7.5 g vial, 75 g bulkbaginj, 750 mg vial)</i>	1-Covered	
<i>cephalexin (125 mg/5ml susp recon, 250 mg capsule, 250 mg/5ml susp recon, 500 mg capsule)</i>	1-Covered	
SPECTRACEF 400 MG DOSE PACK TB	1-Covered	
SUPRAX 400 MG CAPSULE	1-Covered	
TEFLARO (400 MG VIAL, 600 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
Beta-lactam, Other		
AZACTAM-ISO-OSMOTIC DEXTROSE (1 ML, 2 ML)	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>aztreonam (1 vial, 2 vial)</i>	1-Covered	
<i>imipenem/cilastatin sodium (250 mg vial, 500 mg vial)</i>	1-Covered	
INVANZ 1 GM VIAL	1-Covered	
<i>meropenem (1 g vial, 500 mg vial)</i>	1-Covered	

Beta-lactam, Penicillins

<i>amoxicillin (125 mg tab chew, 125 mg/5ml susp recon, 200 mg/5ml susp recon, 250 mg capsule, 250 mg tab chew, 250 mg/5ml susp recon, 400 mg/5ml susp recon, 500 mg tablet, 500 mg capsule, 875 mg tablet)</i>	1-Covered	
<i>amoxicillin/potassium clavulanate (200-28.5mg tab chew, 200-28.5/5 susp recon, 250-62.5/5 susp recon, 250-125 mg tablet, 400-57mg tab chew, 400-57mg/5 susp recon, 500-125 mg tablet, 600-42.9/5 susp recon, 875-125 mg tablet, 1000-62.5 tab er 12h)</i>	1-Covered	
<i>ampicillin sodium (1 g vial, 1 g vial port, 2 g vial, 10 g vial, 125 mg vial, 250 mg vial, 500 mg vial)</i>	1-Covered	
<i>ampicillin sodium/sulbactam sodium (1.5 vial port, 1.5 vial, 3 vial, 3 vial port, 15 vial)</i>	1-Covered	
<i>ampicillin trihydrate (125 mg/5ml susp recon, 250 mg capsule, 250 mg/5ml susp recon, 500 mg capsule)</i>	1-Covered	
BICILLIN L-A (600,000 UNIT/ML, 1,200,000 UNITS, 2,400,000 UNITS)	1-Covered	
<i>dicloxacillin sodium (250 mg capsule, 500 mg capsule)</i>	1-Covered	
<i>nafcillin in dextrose, iso-osmotic (1 g/50 ml, 2 g/100 ml)</i>	1-Covered	
<i>nafcillin sodium (1 vial, 2 vial, 10 vial)</i>	1-Covered	
<i>oxacillin sodium (1 vial, 2 vial port, 2 vial, 10 vial)</i>	1-Covered	
<i>oxacillin sodium/dextrose, iso-osmotic (1 ml, 2 ml)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>penicillin g potassium (5mm vial, 20mm vial)</i>	1-Covered	
<i>penicillin g potassium/dextrose-water (2mm/50ml froz.piy, 3mm/50ml froz.piy)</i>	1-Covered	
<i>penicillin g procaine 1.2mm/2 ml syringe</i>	1-Covered	
<i>penicillin g sodium 5mm unit vial</i>	1-Covered	
<i>penicillin v potassium (125 mg/5ml soln recon, 250 mg tablet, 250 mg/5ml soln recon, 500 mg tablet)</i>	1-Covered	
<i>piperacillin sodium/tazobactam sodium (2.25 vial, 3.375 vial, 3.375 vial port, 4.5 vial, 4.5 vial port, 40.5 vial)</i>	1-Covered	
Macrolides		
<i>azithromycin (1 g packet, 250 mg tablet, 500 mg vial port, 500 mg vial)</i>	1-Covered	
<i>azithromycin (100, 200)</i>	1-Covered	QL (25 PER 1 DAYS)
<i>azithromycin 500 mg tablet</i>	1-Covered	QL (10 PER 23 DAYS)
<i>azithromycin 600 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>clarithromycin (125 mg/5ml susp recon, 250 mg/5ml susp recon, 500 mg tab er 24h)</i>	1-Covered	
<i>clarithromycin (250 mg tablet, 500 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
ERY-TAB (EC 250 MG TABLET, EC 333 MG TABLET, EC 500 MG TABLET)	1-Covered	
ERYTHROCIN LACTOBIONATE (500 MG VIAL, 500 MG ADDVNT VL)	1-Covered	
<i>erythromycin base (5 mg/g oint. (g), 250 mg tablet, 250 mg capsule dr, 500 mg tablet)</i>	1-Covered	
<i>erythromycin base/ethyl alcohol (2 % solution, 2 % gel (gram))</i>	1-Covered	
<i>erythromycin ethylsuccinate 400 mg tablet</i>	1-Covered	
ZMAX 2 G/60 ML ORAL SUSPENSION	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Quinolones		
<i>ciprofloxacin (250, 500)</i>	1-Covered	
<i>ciprofloxacin hcl (0.2 % droperette, 0.3 % drops, 100 mg tablet, 250 mg tablet, 500 mg tablet, 750 mg tablet)</i>	1-Covered	
<i>ciprofloxacin lactate (200mg/20ml vial, 400mg/40ml vial)</i>	1-Covered	
<i>ciprofloxacin lactate/dextrose 5 % in water (200mg/0.1l, 400mg/0.2l)</i>	1-Covered	
<i>ciprofloxacin/ciprofloxacin hcl (500 mg, 1000 mg)</i>	1-Covered	
<i>gatifloxacin 0.5 % drops</i>	1-Covered	
<i>levofloxacin (0.5 % drops, 25 mg/ml vial, 250mg/10ml solution, 500mg/20ml solution)</i>	1-Covered	
<i>levofloxacin (250 mg tablet, 500 mg tablet, 750 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>levofloxacin/dextrose 5 % in water (250mg/50ml, 500mg/0.1l, 750mg/.15l)</i>	1-Covered	
<i>moxifloxacin hcl 400 mg tablet</i>	1-Covered	
<i>moxifloxacin/sod.ace,sul/water 400mg/.25l piggyback</i>	1-Covered	
<i>ofloxacin (0.3 % drops, 400 mg tablet)</i>	1-Covered	
Sulfonamides		
SILVADENE 1% CREAM	1-Covered	
<i>silver sulfadiazine 1 % cream (g)</i>	1-Covered	
SSD 1% CREAM	1-Covered	
<i>sulfacetamide sodium (10 % drops, 10 % suspension)</i>	1-Covered	
<i>sulfadiazine 500 mg tablet</i>	1-Covered	
<i>sulfamethoxazole/trimethoprim (80-16mg/ml vial, 200-40mg/5 oral susp, 400mg-80mg tablet, 800-160/20 oral susp, 800-160 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Tetracyclines		
<i>demeclocycline hcl (150 mg tablet, 300 mg tablet)</i>	1-Covered	
<i>doxycycline hyclate (20 mg tablet, 50 mg capsule, 75 mg tablet dr, 100 mg capsule, 100 mg tablet, 100 mg tablet dr, 150 mg tablet dr)</i>	1-Covered	
<i>doxycycline hyclate 100 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>doxycycline monohydrate (25 mg/5 ml susp recon, 50 mg capsule, 50 mg tablet, 75 mg capsule, 75 mg tablet, 100 mg tablet, 100 mg capsule, 150 mg tablet)</i>	1-Covered	
<i>minocycline hcl (50 mg capsule, 75 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>tetracycline hcl (250 mg capsule, 500 mg capsule)</i>	1-Covered	
Anticonvulsants		
Anticonvulsants, Other		
<i>diazepam (2.5 mg, 5-7.5-10mg, 12.5-15-20)</i>	1-Covered	
<i>levetiracetam (100 mg/ml solution, 250 mg tablet, 500 mg/5ml solution, 500 mg tab er 24h, 500 mg tablet, 500 mg/5ml vial, 750 mg tablet, 750 mg tab er 24h, 1000 mg tablet)</i>	1-Covered	
<i>levetiracetam in sodium chloride, iso-osmotic (500mg/0.1l, 1000mg/100, 1500mg/100)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
POTIGA (50 MG TABLET, 200 MG TABLET, 300 MG TABLET, 400 MG TABLET)	1-Covered	ST
ROWEEPRA 500 MG TABLET	1-Covered	
Calcium Channel Modifying Agents		
CELONTIN 300 MG KAPSEAL	1-Covered	ST
<i>ethosuximide (250 mg/5ml solution, 250 mg capsule)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LYRICA (20 MG/ML ORAL SOLUTION, 25 MG CAPSULE, 50 MG CAPSULE, 75 MG CAPSULE, 100 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE, 225 MG CAPSULE, 300 MG CAPSULE)	1-Covered	
<i>zonisamide (25 mg capsule, 50 mg capsule, 100 mg capsule)</i>	1-Covered	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>clonazepam (0.125 mg tab rapdis, 0.25 mg tab rapdis, 0.5 mg tablet, 0.5 mg tab rapdis, 1 mg tab rapdis, 1 mg tablet, 2 mg tab rapdis, 2 mg tablet)</i>	1-Covered	
<i>clorazepate dipotassium (3.75 mg tablet, 7.5 mg tablet, 15 mg tablet)</i>	1-Covered	
<i>diazepam (2 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>diazepam 5 mg/5 ml solution</i>	1-Covered	QL (40 PER 1 DAYS)
<i>diazepam 5 mg/ml oral conc</i>	1-Covered	QL (8 PER 1 DAYS)
<i>divalproex sodium (125 mg tablet dr, 125 mg cap sprink, 250 mg tab er 24h, 250 mg tablet dr, 500 mg tablet dr, 500 mg tab er 24h)</i>	1-Covered	
<i>gabapentin (100 mg capsule, 250 mg/5ml solution, 300 mg/6ml solution, 300 mg capsule, 400 mg capsule)</i>	1-Covered	
<i>gabapentin 600 mg tablet</i>	1-Covered	QL (6 PER 1 DAYS)
<i>gabapentin 800 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
GABITRIL 12 MG TABLET	1-Covered	ST, QL (4 PER 1 DAYS)
GABITRIL 16 MG TABLET	1-Covered	ST, QL (3 PER 1 DAYS)
GRALISE (30-DAY STARTER PACK, ER 300 MG TABLET, ER 600 MG TABLET)	1-Covered	ST
HORIZANT ER 300 MG TABLET	1-Covered	
<i>lorazepam (0.5 mg tablet, 1 mg tablet)</i>	1-Covered	QL (6 PER 1 DAYS)
<i>lorazepam 2 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
LORAZEPAM INTENSOL 2 MG/ML	1-Covered	QL (5 PER 1 DAYS)
ONFI (10 MG TABLET, 20 MG TABLET)	1-Covered	ST

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ONFI 2.5 MG/ML SUSPENSION	1-Covered	
<i>phenobarbital (15 mg tablet, 16.2 mg tablet, 20 mg/5 ml elixir, 30 mg tablet, 32.4 mg tablet, 60 mg tablet, 64.8 mg tablet, 97.2mg tablet, 100 mg tablet)</i>	1-Covered	
<i>primidone (50 mg tablet, 250 mg tablet)</i>	1-Covered	
SABRIL (500 MG TABLET, 500 MG POWDER PACKET)	1-Covered	ST, LA
<i>tiagabine hcl 2 mg tablet</i>	1-Covered	QL (14 PER 1 DAYS)
<i>tiagabine hcl 4 mg tablet</i>	1-Covered	
<i>valproic acid (as sodium salt) (valproate sodium) (250 mg/5ml solution, 500 mg/5ml vial, 500mg/10ml solution)</i>	1-Covered	
<i>valproic acid 250 mg capsule</i>	1-Covered	

Glutamate Reducing Agents

<i>felbamate (400 mg tablet, 600 mg tablet, 600 mg/5ml oral susp)</i>	1-Covered	
FYCOMPA (2 MG TABLET, 4 MG TABLET, 6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET)	1-Covered	
LAMICTAL TAB START KIT (BLUE)	1-Covered	
LAMICTAL TAB START KIT (GREEN)	1-Covered	
LAMICTAL TB START KIT (ORANGE)	1-Covered	
LAMICTAL XR START KIT (BLUE)	1-Covered	
LAMICTAL XR START KIT (GREEN)	1-Covered	
LAMICTAL XR START KIT (ORANGE)	1-Covered	
<i>lamotrigine (5 mg tb chw dsp, 25 mg tablet, 25 mg tab er 24, 25 mg tab rapdis, 25 mg tb chw dsp, 50 mg tab rapdis, 50 mg tab er 24, 100 mg tab er 24, 100 mg tab rapdis, 100 mg tablet, 150 mg tablet, 200 mg tablet, 200 mg tab er 24, 200 mg tab rapdis, 250 mg tab er 24, 300 mg tab er 24)</i>	1-Covered	
QUDEXY XR (25 MG CAPSULE, 50 MG CAPSULE, 100 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg cap spr 24, 50 mg cap spr 24, 100 mg cap spr 24, 150 mg cap spr 24, 200 mg cap spr 24)</i>	1-Covered	
<i>topiramate (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	QL (6 PER 1 DAYS)
<i>topiramate 200 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
TROKENDI XR (25 MG CAPSULE, 50 MG CAPSULE, 100 MG CAPSULE, 200 MG CAPSULE)	1-Covered	ST

Sodium Channel Agents

APTIOM (200 MG TABLET, 400 MG TABLET, 600 MG TABLET, 800 MG TABLET)	1-Covered	
BANZEL (40 MG/ML SUSPENSION, 200 MG TABLET, 400 MG TABLET)	1-Covered	ST
<i>carbamazepine (100 mg tab er 12h, 100 mg/5ml oral susp, 100 mg tab chew, 200 mg tablet, 200 mg tab er 12h, 400 mg tab er 12h)</i>	1-Covered	
CARBATROL (ER 100 MG CAPSULE, ER 200 MG CAPSULE, ER 300 MG CAPSULE)	1-Covered	ST
CEREBYX (100 MG PE/2 ML VIAL, 500 MG PE/10 ML VIAL)	1-Covered	
DILANTIN 30 MG CAPSULE	1-Covered	ST
EPITOL 200 MG TABLET	1-Covered	ST
EQUETRO (100 MG CAPSULE, 200 MG CAPSULE, 300 MG CAPSULE)	1-Covered	ST
<i>fosphenytoin sodium (100mg pe/2 vial, 500 pe/10 vial)</i>	1-Covered	
<i>oxcarbazepine (150 mg tablet, 300 mg tablet, 300 mg/5ml oral susp, 600 mg tablet)</i>	1-Covered	
OXTELLAR XR (150 MG TABLET, 300 MG TABLET, 600 MG TABLET)	1-Covered	ST
PEGANONE 250 MG TABLET	1-Covered	ST

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>phenytoin sodium (50 mg/ml vial, 50 mg/ml ampul)</i>	1-Covered	
<i>phenytoin sodium extended (100 mg capsule, 200 mg capsule, 300 mg capsule)</i>	1-Covered	
TEGRETOL XR 100 MG TABLET	1-Covered	ST
VIMPAT (10 MG/ML SOLUTION, 50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG/20 ML VIAL, 200 MG TABLET)	1-Covered	

Antidementia Agents

Antidementia Agents, Other

<i>ergoloid mesylates 1 mg tablet</i>	1-Covered	PA
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Cholinesterase Inhibitors

<i>donepezil hcl (5 mg tab rapdis, 5 mg tablet, 10 mg tablet, 10 mg tab rapdis)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>donepezil hcl 23 mg tablet</i>	1-Covered	
EXELON (4.6, 9.5, 13.3)	1-Covered	QL (1 PER 1 DAYS)
<i>galantamine hbr (4 mg tablet, 4 mg/ml solution, 8 mg cap24h pel, 8 mg tablet, 12 mg tablet, 16 mg cap24h pel, 24 mg cap24h pel)</i>	1-Covered	
<i>rivastigmine (4.6mg/24hr, 9.5mg/24hr, 13.3mg/24h)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>rivastigmine tartrate (1.5 mg capsule, 3 mg capsule, 4.5 mg capsule, 6 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)

N-methyl-D-aspartate (NMDA) Receptor Antagonist

<i>memantine hcl (5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>memantine hcl 2 mg/ml solution</i>	1-Covered	QL (5 PER 1 DAYS)
<i>memantine hcl 5 mg-10 mg tab ds pk</i>	1-Covered	
NAMENDA (5-10 MG TITRATION PK, 5 MG TABLET, 10 MG TABLET)	1-Covered	
NAMENDA 2 MG/ML SOLUTION	1-Covered	QL (10 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NAMENDA XR (7 MG CAPSULE, 14 MG CAPSULE, 21 MG CAPSULE, 28 MG CAPSULE, TITRATION PACK)	1-Covered	
Antidepressants		
<i>amitriptyline hcl/chlordiazepoxide (12.5mg-5mg tablet, 25 mg-10mg tablet)</i>	1-Covered	
<i>fluoxetine hcl 60 mg tablet</i>	1-Covered	
<i>olanzapine/fluoxetine hcl (3 mg-25 mg capsule, 6mg-50mg capsule, 6mg-25mg capsule, 12mg-25mg capsule, 12mg-50mg capsule)</i>	1-Covered	
<i>perphenazine/amitriptyline hcl (2 mg-10 mg tablet, 2 mg-25 mg tablet, 4 mg-25 mg tablet, 4mg-10mg tablet, 4 mg-50 mg tablet)</i>	1-Covered	
Antidepressants, Other		
APLENZIN (ER 174 MG TABLET, ER 348 MG TABLET, ER 522 MG TABLET)	1-Covered	
BUPROBAN 150 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
<i>bupropion hcl (100 mg tablet er, 150 mg tablet er, 200 mg tablet er)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>bupropion hcl (75 mg tablet, 100 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>bupropion hcl 150 mg tab er 24h</i>	1-Covered	QL (3 PER 1 DAYS)
<i>bupropion hcl 300 mg tab er 24h</i>	1-Covered	QL (1 PER 1 DAYS)
FORFIVO XL 450 MG TABLET	1-Covered	
<i>maprotiline hcl (25 mg tablet, 50 mg tablet, 75 mg tablet)</i>	1-Covered	
<i>mirtazapine (15 mg tablet, 15 mg tab rapidis)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>mirtazapine (30 mg tablet, 30 mg tab rapidis)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>mirtazapine (7.5 mg tablet, 45 mg tablet, 45 mg tab rapidis)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>nefazodone hcl (50 mg tablet, 100 mg tablet, 250 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nefazodone hcl 150 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>nefazodone hcl 200 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
SEROQUEL XR (150 MG TABLET, 200 MG TABLET)	1-Covered	QL (1 PER 1 DAYS)
SEROQUEL XR (50 MG TABLET, 300 MG TABLET, 400 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
<i>trazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 300 mg tablet)</i>	1-Covered	
VIIBRYD 10-20-40 MG STARTER PK	1-Covered	
Monoamine Oxidase Inhibitors		
EMSAM (6, 9, 12)	1-Covered	
MARPLAN 10 MG TABLET	1-Covered	
<i>phenelzine sulfate 15 mg tablet</i>	1-Covered	
<i>tranylcypromine sulfate 10 mg tablet</i>	1-Covered	
SSRIs/ SNRIs		
BRINTELLIX (5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1-Covered	
BRISDELLE 7.5 MG CAPSULE	1-Covered	
<i>citalopram hydrobromide (20 mg tablet, 40 mg tablet)</i>	1-Covered	QL (1.5 PER 1 DAYS)
<i>citalopram hydrobromide 10 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>citalopram hydrobromide 10 mg/5 ml solution</i>	1-Covered	
<i>desvenlafaxine (50 mg tab er 24h, 50 mg tab er 24, 100 mg tab er 24h, 100 mg tab er 24)</i>	1-Covered	
<i>escitalopram oxalate 10 mg tablet</i>	1-Covered	QL (1.5 PER 1 DAYS)
<i>escitalopram oxalate 20 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>escitalopram oxalate 5 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>escitalopram oxalate 5 mg/5 ml solution</i>	1-Covered	QL (20 PER 1 DAYS)
FETZIMA (20-40 MG TITRATION PAK, ER 20 MG CAPSULE, ER 40 MG CAPSULE, ER 80 MG CAPSULE, ER 120 MG CAPSULE)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>fluoxetine hcl (10 mg tablet, 10 mg capsule)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>fluoxetine hcl (20 mg tablet, 20 mg capsule)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>fluoxetine hcl (20 mg/5 ml solution, 90 mg capsule dr)</i>	1-Covered	
<i>fluoxetine hcl 40 mg capsule</i>	1-Covered	QL (2 PER 1 DAYS)
<i>fluvoxamine maleate (100 mg cap er, 150 mg cap er)</i>	1-Covered	
<i>fluvoxamine maleate (50 mg tablet, 100 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>fluvoxamine maleate 25 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
KHEDEZLA (ER 50 MG TABLET, ER 100 MG TABLET)	1-Covered	
<i>paroxetine hcl (10 mg tablet, 12.5 mg tab er 24h, 20 mg tablet, 25 mg tab er 24h, 30 mg tablet, 37.5 mg tab er 24h, 40 mg tablet)</i>	1-Covered	
PAXIL 10 MG/5 ML SUSPENSION	1-Covered	
PEXEVA (10 MG TABLET, 20 MG TABLET, 30 MG TABLET, 40 MG TABLET)	1-Covered	
PRISTIQ ER (ER 25 MG TABLET, ER 50 MG TABLET, ER 100 MG TABLET)	1-Covered	
<i>sertraline hcl (25 mg tablet, 50 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>sertraline hcl 100 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>sertraline hcl 20 mg/ml oral conc</i>	1-Covered	QL (10 PER 1 DAYS)
<i>venlafaxine hcl (150 mg cap er 24h, 150 mg tab er 24)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>venlafaxine hcl (25 mg tablet, 37.5 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>venlafaxine hcl (37.5 mg cap er 24h, 37.5 mg tab er 24, 75 mg tab er 24, 75 mg cap er 24h)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>venlafaxine hcl 225 mg tab er 24</i>	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIIBRYD (10-20 MG STARTER PACK, 10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1-Covered	
Tricyclics		
<i>amitriptyline hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet, 150 mg tablet)</i>	1-Covered	
<i>amoxapine (25 mg tablet, 50 mg tablet, 100 mg tablet, 150 mg tablet)</i>	1-Covered	
<i>clomipramine hcl (25 mg capsule, 50 mg capsule, 75 mg capsule)</i>	1-Covered	
<i>desipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet, 150 mg tablet)</i>	1-Covered	
<i>doxepin hcl (5 % cream (g), 10 mg/ml oral conc, 10 mg capsule, 25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule)</i>	1-Covered	
<i>imipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet)</i>	1-Covered	
<i>imipramine pamoate (75 mg capsule, 100 mg capsule, 125 mg capsule, 150 mg capsule)</i>	1-Covered	
<i>nortriptyline hcl (10 mg/5 ml solution, 10 mg capsule, 25 mg capsule, 50 mg capsule, 75 mg capsule)</i>	1-Covered	
<i>protriptyline hcl (5 mg tablet, 10 mg tablet)</i>	1-Covered	
PRUDOXIN 5% CREAM	1-Covered	
SILENOR (3 MG TABLET, 6 MG TABLET)	1-Covered	
SURMONTIL (25 MG CAPSULE, 50 MG CAPSULE, 100 MG CAPSULE)	1-Covered	
<i>trimipramine maleate (25 mg capsule, 50 mg capsule)</i>	1-Covered	QL (6 PER 1 DAYS)
<i>trimipramine maleate 100 mg capsule</i>	1-Covered	QL (3 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antiemetics		
Antiemetics, Other		
<i>chlorpromazine hcl (10 mg tablet, 25 mg tablet, 25 mg/ml ampul, 50 mg tablet, 100 mg tablet, 200 mg tablet)</i>	1-Covered	
<i>diphenhydramine hcl 50 mg/ml vial</i>	1-Covered	
<i>hydroxyzine hcl (10 mg tablet, 10 mg/5 ml solution, 25 mg/ml vial, 25 mg tablet, 50 mg/ml vial, 50 mg/25ml solution, 50 mg tablet)</i>	1-Covered	
<i>hydroxyzine pamoate (25 mg capsule, 50 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>meclizine hcl (12.5 mg tablet, 25 mg tablet)</i>	1-Covered	
<i>metoclopramide hcl (5 mg tab rapdis, 5 mg tablet, 5 mg/ml vial, 5 mg/5 ml solution, 10 mg tablet, 10 mg tab rapdis)</i>	1-Covered	
<i>perphenazine (2 mg tablet, 4 mg tablet, 8 mg tablet, 16 mg tablet)</i>	1-Covered	
<i>prochlorperazine 25 mg supp.rect</i>	1-Covered	
<i>prochlorperazine edisylate (5 mg/ml vial, 10 mg/2 ml vial)</i>	1-Covered	
<i>prochlorperazine maleate (5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>promethazine hcl (12.5 mg supp.rect, 25 mg/ml vial, 25 mg/ml ampul, 25 mg supp.rect, 25 mg/ml syringe, 50 mg/ml ampul, 50 mg supp.rect, 50 mg/ml vial)</i>	1-Covered	
<i>promethazine hcl (6.25mg/5ml syrup, 12.5 mg tablet, 25 mg tablet, 50 mg tablet)</i>	1-Covered	PA
<i>trimethobenzamide hcl 300 mg capsule</i>	1-Covered	
Emetogenic Therapy Adjuncts		
<i>dronabinol (2.5 mg capsule, 5 mg capsule, 10 mg capsule)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EMEND (40 MG CAPSULE, 80 MG CAPSULE, 125 MG CAPSULE, 150 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMEND TRIPACK	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (3 PER 14 DAYS)
<i>granisetron hcl (1 mg/ml(1) vial, 1 mg/ml vial)</i>	1-Covered	
<i>granisetron hcl 1 mg tablet</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>granisetron hcl/pf (1 mg/ml(1) vial, 100 mcg/ml vial)</i>	1-Covered	
<i>ondansetron (4 mg tab rapdis, 8 mg tab rapdis)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl (4 mg/5 ml solution, 24 mg tablet)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl 4 mg tablet</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (6 PER 1 DAYS)
<i>ondansetron hcl 8 mg tablet</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (3 PER 1 DAYS)
<i>ondansetron hcl/pf (4 ml ampul, 4 ml vial)</i>	1-Covered	

Antifungals

ABELCET 100 MG/20 ML VIAL	1-Covered	
AMBISOME 50 MG VIAL	1-Covered	
<i>amphotericin b 50 mg vial</i>	1-Covered	
CANCIDAS (50 MG VIAL, 70 MG VIAL)	1-Covered	
<i>ciclopirox (0.77 % gel (gram), 1 % shampoo, 8 % solution)</i>	1-Covered	
<i>ciclopirox olamine (0.77 % cream (g), 0.77 % suspension)</i>	1-Covered	
<i>clotrimazole (1 % cream (g), 1 % solution, 10 mg troche)</i>	1-Covered	
<i>econazole nitrate 1 % cream (g)</i>	1-Covered	
<i>fluconazole (10 mg/ml susp recon, 40 mg/ml susp recon, 50 mg tablet, 100 mg tablet, 200 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>fluconazole 150 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>fluconazole in dextrose, iso-os 400mg/0.2l piggyback</i>	1-Covered	
<i>fluconazole in sodium chloride, iso-osmotic (pggybk btl, piggyback)</i>	1-Covered	
<i>flucytosine (250 mg capsule, 500 mg capsule)</i>	1-Covered	
<i>griseofulvin ultramicrosize (125 mg tablet, 250 mg tablet)</i>	1-Covered	
<i>griseofulvin, microsize (125 mg/5ml oral susp, 500 mg tablet)</i>	1-Covered	
GYNAZOLE 1 2% CREAM	1-Covered	
<i>itraconazole 100 mg capsule</i>	1-Covered	
<i>ketoconazole (2 % cream (g), 2 % shampoo, 200 mg tablet)</i>	1-Covered	
<i>naftifine hcl (1 %, 2 %)</i>	1-Covered	
NOXAFIL (40 MG/ML SUSPENSION, DR 100 MG TABLET)	1-Covered	
NYAMYC 100,000 UNITS/GM POWDER	1-Covered	
<i>nystatin (50mm unit powder(ea), 150mm unit powder(ea), 500mm unit powder(ea), 500k unit tablet, 100000/ml oral susp, 100000/g powder, 100000/g cream (g), 100000/g oint. (g))</i>	1-Covered	
NYSTOP 100,000 UNITS/GM POWDER	1-Covered	
ONMEL 200 MG TABLET	1-Covered	
<i>oxiconazole nitrate 1 % cream (g)</i>	1-Covered	
SPORANOX 10 MG/ML SOLUTION	1-Covered	
<i>terbinafine hcl 250 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>terconazole (0.4 % cream/appl, 0.8 % cream/appl, 80 mg supp.vag)</i>	1-Covered	
VFEND 40 MG/ML SUSPENSION	1-Covered	
<i>voriconazole (50 mg tablet, 200 mg tablet, 200 mg vial, 200 mg/5ml susp recon)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZOLINZA 100 MG CAPSULE	1-Covered	
Antigout Agents		
<i>allopurinol (100 mg tablet, 300 mg tablet)</i>	1-Covered	
<i>colchicine (0.6 mg capsule, 0.6 mg tablet)</i>	1-Covered	
<i>probenecid 500 mg tablet</i>	1-Covered	
Antimigraine Agents		
<i>methylergonovine maleate 0.2 mg tablet</i>	1-Covered	
TREXIMET 85-500 MG TABLET	1-Covered	
Ergot Alkaloids		
<i>dihydroergotamine mesylate (1 mg/ml ampul, 1 mg/ml vial)</i>	1-Covered	
ERGOMAR 2 MG TABLET SL	1-Covered	
MIGRANAL NASAL SPRAY	1-Covered	
Prophylactic		
BOTOX (100 VIAL, 200 VIAL)	1-Covered	PA
<i>timolol maleate (5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
Serotonin (5-HT) 1b/1d Receptor Agonists		
<i>almotriptan malate (6.25 mg tablet, 12.5 mg tablet)</i>	1-Covered	
<i>frovatriptan succinate 2.5 mg tablet</i>	1-Covered	
<i>naratriptan hcl (1 mg tablet, 2.5 mg tablet)</i>	1-Covered	QL (9 PER 23 DAYS)
<i>rizatriptan benzoate (5 mg tablet, 5 mg tab rapdis, 10 mg tablet, 10 mg tab rapdis)</i>	1-Covered	
<i>sumatriptan (5 mg, 20 mg)</i>	1-Covered	
<i>sumatriptan succinate (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	QL (9 PER 23 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sumatriptan succinate (4 pen injctr, 4 cartridge, 6 pen injctr, 6 syringe, 6 cartridge, 6 vial)</i>	1-Covered	
<i>zolmitriptan (2.5 mg tab rapdis, 2.5 mg tablet, 5 mg tab rapdis, 5 mg tablet)</i>	1-Covered	

Antimyasthenic Agents

Parasympathomimetics

<i>guanidine hcl 125 mg tablet</i>	1-Covered	
MESTINON (60 MG/5 ML SYRUP, 180 MG TIMESPAN)	1-Covered	
<i>pyridostigmine bromide (60 mg tablet, 180 mg tablet er)</i>	1-Covered	

Antimycobacterials

Antimycobacterials, Other

<i>dapsone (25 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>rifabutin 150 mg capsule</i>	1-Covered	

Antituberculars

CAPASTAT SULFATE 1 GM VIAL	1-Covered	
<i>ethambutol hcl (100 mg tablet, 400 mg tablet)</i>	1-Covered	
<i>isoniazid (50 mg/5 ml solution, 100 mg/ml vial, 100 mg tablet, 300 mg tablet)</i>	1-Covered	
PASER GRANULES 4 GM PACKET	1-Covered	
PRIFTIN 150 MG TABLET	1-Covered	
<i>pyrazinamide 500 mg tablet</i>	1-Covered	
<i>rifampin (150 mg capsule, 300 mg capsule, 600 mg vial)</i>	1-Covered	
RIFATER TABLET	1-Covered	
SIRTURO 100 MG TABLET	1-Covered	
TRECTOR 250 MG TABLET	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antineoplastics		
Alkylating Agents		
BUSULFEX 60 MG/10 ML VIAL	1-Covered	
<i>cyclophosphamide (25 mg capsule, 50 mg capsule)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAUNOXOME 50 MG (2 MG/ML) VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE (5 MG CAPSULE, 10 MG CAPSULE, 40 MG CAPSULE, 100 MG CAPSULE)	1-Covered	
HEXALEN 50 MG CAPSULE	1-Covered	
LEUKERAN 2 MG TABLET	1-Covered	
<i>lomustine (10 mg capsule, 40 mg capsule, 100 mg capsule)</i>	1-Covered	
MATULANE 50 MG CAPSULE	1-Covered	
<i>melphalan hcl 50 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
TREANDA (45 MG/0.5 ML VIAL, 180 MG/2 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
VALCHLOR 0.016% GEL	1-Covered	
Antiandrogens		
<i>bicalutamide 50 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>flutamide 125 mg capsule</i>	1-Covered	
NILANDRON 150 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
XTANDI 40 MG CAPSULE	1-Covered	
ZYTIGA 250 MG TABLET	1-Covered	
Antiangiogenic Agents		
POMALYST (1 MG CAPSULE, 2 MG CAPSULE, 3 MG CAPSULE, 4 MG CAPSULE)	1-Covered	
REVLIMID (5 MG CAPSULE, 10 MG CAPSULE, 15 MG CAPSULE, 25 MG CAPSULE)	1-Covered	
THALOMID (50 MG CAPSULE, 100 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE)	1-Covered	PA - FOR NEW STARTS ONLY

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antiestrogens/Modifiers		
EMCYT 140 MG CAPSULE	1-Covered	
FARESTON 60 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
SOLTAMOX 10 MG/5 ML SOLN	1-Covered	
<i>tamoxifen citrate (10 mg tablet, 20 mg tablet)</i>	1-Covered	
Antimetabolites		
<i>cytarabine/pf (20 mg/ml vial, 100 mg/5ml vial)</i>	1-Covered	
DROXIA (200 MG CAPSULE, 300 MG CAPSULE, 400 MG CAPSULE)	1-Covered	
<i>gemcitabine hcl (1 g vial, 1 g/26.3ml vial, 2 g vial, 2 g/52.6ml vial, 200 mg vial, 200mg/5.26 vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>hydroxyurea 500 mg capsule</i>	1-Covered	
LONSURF (15 MG-6.14 MG TABLET, 20 MG-8.19 MG TABLET)	1-Covered	
PURINETHOL 50 MG TABLET	1-Covered	
PURIXAN 20 MG/ML ORAL SUSP	1-Covered	
TABLOID 40 MG TABLET	1-Covered	
ALIMTA (100 MG VIAL, 500 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ARRANON 250 MG VIAL	1-Covered	
AVASTIN (100 MG/4 ML VIAL, 400 MG/16 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>azacitidine 100 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
BELEODAQ 500 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
BICNU 100 MG VIAL	1-Covered	
<i>bleomycin sulfate (15 vial, 30 vial)</i>	1-Covered	
<i>carboplatin (10 mg/ml vial, 150 mg vial)</i>	1-Covered	
<i>cisplatin 1 mg/ml vial</i>	1-Covered	
<i>cladribine 10 mg/10ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLOLAR 20 MG/20 ML VIAL	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
COSMEGEN 0.5 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine 20 mg/ml vial</i>	1-Covered	
<i>cytarabine/pf (1 g vial, 2 g/20 ml vial)</i>	1-Covered	
<i>dacarbazine (100 mg vial, 200 mg vial)</i>	1-Covered	
DACOGEN 50 MG VIAL	1-Covered	
<i>daunorubicin hcl (5 mg/ml vial, 20 mg vial)</i>	1-Covered	
<i>decitabine 50 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>dexrazoxane hcl (250 mg vial, 500 mg vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
DOCEFREZ 20 MG VIAL	1-Covered	
<i>docetaxel (20 mg/2 ml vial, 20mg/ml(1) vial, 80 mg/8 ml vial, 80 mg/4 ml vial, 140 mg/7ml vial, 160mg/16ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>docetaxel 160 mg/8ml vial</i>	1-Covered	
DOXIL 2 MG/ML VIAL	1-Covered	
<i>doxorubicin hcl (2 mg/ml vial, 10 mg vial, 10 mg/5 ml vial, 20 mg/10ml vial, 50 mg vial, 50 mg/25ml vial)</i>	1-Covered	
ELITEK (1.5 MG VIAL, 7.5 MG VIAL)	1-Covered	
<i>epirubicin hcl (50 mg vial, 50 mg/25ml vial, 200 mg vial, 200mg/0.1l vial)</i>	1-Covered	
ERBITUX (100 MG/50 ML VIAL, 200 MG/100 ML VIAL)	1-Covered	
ERWINAZE 10,000 UNITS VIAL	1-Covered	
FASLODEX 250 MG/5 ML SYRINGE	1-Covered	
FOLOTYN (20 MG/ML VIAL, 40 MG/2 ML VIAL)	1-Covered	
HALAVEN 1 MG/2 ML VIAL	1-Covered	
HERCEPTIN 440 MG VIAL	1-Covered	
<i>idarubicin hcl 1 mg/ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ifosfamide (1 g/20 ml vial, 1 g vial, 3g/60ml vial, 3 g vial)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>irinotecan hcl (40 mg/2 ml vial, 100 mg/5ml vial, 500mg/25ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISTODAX 10 MG VIAL	1-Covered	
IXEMPRA (15 MG, 45 MG)	1-Covered	
JEVTANA 60 MG/1.5 ML KIT	1-Covered	
KADCYLA (100 MG VIAL, 160 MG VIAL)	1-Covered	
<i>mesna 100 mg/ml vial</i>	1-Covered	
MESNEX (1 GRAM/10 ML VIAL, 400 MG TABLET)	1-Covered	
<i>mitomycin (5 mg vial, 20 mg vial, 40 mg vial)</i>	1-Covered	
MUSTARGEN 10 MG VIAL	1-Covered	
NIPENT 10 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>oxaliplatin (50 mg vial, 50 mg/10ml vial, 100 mg vial, 100mg/20ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>paclitaxel 6 mg/ml vial</i>	1-Covered	
PERJETA 420 MG/14 ML VIAL	1-Covered	
PROLEUKIN 22 MILLION UNIT VIAL	1-Covered	
TREANDA (25 MG VIAL, 100 MG VIAL)	1-Covered	
TRISENOX 10 MG/10 ML AMPULE	1-Covered	
VECTIBIX (100 MG/5 ML VIAL, 400 MG/20 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
VELCADE 3.5 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
VIDAZA 100 MG VIAL	1-Covered	
<i>vinblastine sulfate (1 mg/ml vial, 10 mg vial)</i>	1-Covered	
VINCASAR PFS (1 MG/ML VIAL, 2 MG/2 ML VIAL)	1-Covered	
<i>vincristine sulfate (1 mg/ml vial, 2 mg/2 ml vial)</i>	1-Covered	
<i>vinorelbine tartrate (10 mg/ml vial, 50 mg/5 ml vial)</i>	1-Covered	
ZINECARD (250 MG VIAL, 500 MG VIAL)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antineoplastics, Other		
ABRAXANE 100 MG VIAL	1-Covered	
<i>amifostine crystalline 500 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
CYRAMZA (100 MG/10 ML VIAL, 500 MG/50 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>docetaxel 200mg/20ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
FARYDAK (10 MG CAPSULE, 15 MG CAPSULE, 20 MG CAPSULE)	1-Covered	
<i>fludarabine phosphate (50 mg vial, 50 mg/2 ml vial)</i>	1-Covered	
FUSILEV I.V. 50 MG VIAL	1-Covered	
<i>leucovorin calcium (5 mg tablet, 10 mg/ml vial, 10 mg tablet, 15 mg tablet, 25 mg tablet, 50 mg vial, 100 mg vial, 200 mg vial, 350 mg vial, 500mg/50ml vial, 500 mg vial)</i>	1-Covered	
<i>levoleucovorin calcium 10 mg/ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
LYNPARZA 50 MG CAPSULE	1-Covered	
<i>mitoxantrone hcl 2 mg/ml vial</i>	1-Covered	
ONCASPAR 750 UNIT/ML VIAL	1-Covered	
REVLIMID (2.5 MG CAPSULE, 20 MG CAPSULE)	1-Covered	
SYNRIBO 3.5 MG/ML VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>thiotepa 15 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
YERVOY (50 MG/10 ML VIAL, 200 MG/40 ML VIAL)	1-Covered	
ZALTRAP (100 MG/4 ML VIAL, 200 MG/8 ML VIAL)	1-Covered	
Aromatase Inhibitors, 3rd Generation		
<i>anastrozole 1 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>exemestane 25 mg tablet</i>	1-Covered	
<i>letrozole 2.5 mg tablet</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Enzyme Inhibitors		
ETOPOPHOS 100 MG VIAL	1-Covered	
<i>etoposide 20 mg/ml vial</i>	1-Covered	
<i>topotecan hcl (4 mg/4 ml vial, 4 mg vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZYDELIG (100 MG TABLET, 150 MG TABLET)	1-Covered	
Molecular Target Inhibitors		
AFINITOR (5 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1-Covered	
ALECENSA 150 MG CAPSULE	1-Covered	
BOSULIF (100 MG TABLET, 500 MG TABLET)	1-Covered	
CAPRELSA (100 MG TABLET, 300 MG TABLET)	1-Covered	
COMETRIQ (60 MG PACK, 100 MG PK, 140 MG PK)	1-Covered	
COTELLIC 20 MG TABLET	1-Covered	LA
ERIVEDGE 150 MG CAPSULE	1-Covered	
GILOTRIF (20 MG TABLET, 30 MG TABLET, 40 MG TABLET)	1-Covered	
GLEEVEC (100 MG TABLET, 400 MG TABLET)	1-Covered	
IBRANCE (75 MG CAPSULE, 100 MG CAPSULE, 125 MG CAPSULE)	1-Covered	
ICLUSIG (15 MG TABLET, 45 MG TABLET)	1-Covered	
<i>imatinib mesylate (100 mg tablet, 400 mg tablet)</i>	1-Covered	
IMBRUVICA 140 MG CAPSULE	1-Covered	
INLYTA (1 MG TABLET, 5 MG TABLET)	1-Covered	
IRESSA 250 MG TABLET	1-Covered	
JAKAFI (5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET, 25 MG TABLET)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LENVIMA (10 MG, 14 MG, 20 MG, 24 MG)	1-Covered	
MEKINIST (0.5 MG TABLET, 2 MG TABLET)	1-Covered	
NEXAVAR 200 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
NINLARO (2.3 MG CAPSULE, 3 MG CAPSULE, 4 MG CAPSULE)	1-Covered	
ODOMZO 200 MG CAPSULE	1-Covered	LA
SPRYCEL (20 MG TABLET, 50 MG TABLET, 70 MG TABLET, 80 MG TABLET, 100 MG TABLET, 140 MG TABLET)	1-Covered	
STIVARGA 40 MG TABLET	1-Covered	
SUTENT (25 MG CAPSULE, 50 MG CAPSULE)	1-Covered	QL (1 PER 1 DAYS)
SUTENT 12.5 MG CAPSULE	1-Covered	QL (3 PER 1 DAYS)
SUTENT 37.5 MG CAPSULE	1-Covered	
TAFINLAR (50 MG CAPSULE, 75 MG CAPSULE)	1-Covered	
TAGRISSO (40 MG TABLET, 80 MG TABLET)	1-Covered	LA
TARCEVA (25 MG TABLET, 100 MG TABLET, 150 MG TABLET)	1-Covered	
TASIGNA (150 MG CAPSULE, 200 MG CAPSULE)	1-Covered	
TYKERB 250 MG TABLET	1-Covered	
VENCLEXTA (10 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1-Covered	
VENCLEXTA STARTING PACK	1-Covered	
VOTRIENT 200 MG TABLET	1-Covered	
XALKORI (200 MG CAPSULE, 250 MG CAPSULE)	1-Covered	
ZELBORAF 240 MG TABLET	1-Covered	
ZYKADIA 150 MG CAPSULE	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Monoclonal Antibodies		
DARZALEX (100 MG/5 ML VIAL, 400 MG/20 ML VIAL)	1-Covered	LA
EMPLICITI (300 MG VIAL, 400 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
KEYTRUDA (50 MG VIAL, 100 MG/4 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
OPDIVO (40 MG/4 ML VIAL, 100 MG/10 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
RITUXAN 10 MG/ML VIAL	1-Covered	
SYLVANT (100 MG VIAL, 400 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
Retinoids		
ATRALIN 0.05% GEL	1-Covered	
<i>bexarotene 75 mg capsule</i>	1-Covered	
PANRETIN 0.1% GEL	1-Covered	
TARGRETIN (1% GEL, 75 MG SOFTGEL, 75 MG CAPSULE)	1-Covered	
TRETIN-X 0.05% COMBO PACK	1-Covered	
<i>tretinoin (0.01 % gel (gram), 0.025 % gel (gram), 0.025 % cream (g), 0.05 % cream (g), 0.05 % gel (gram), 0.1 % cream (g), 10 mg capsule)</i>	1-Covered	
Antiparasitics		
Anthelmintics		
ALBENZA 200 MG TABLET	1-Covered	
BILTRICIDE 600 MG TABLET	1-Covered	
STROMEKTOL 3 MG TABLET	1-Covered	
Antiprotozoals		
ALINIA (100 MG/5 ML SUSPENSION, 500 MG TABLET)	1-Covered	
<i>atovaquone 750 mg/5ml oral susp</i>	1-Covered	
<i>atovaquone/proguanil hcl (62.5-25 mg tablet, 250-100 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>chloroquine phosphate (250 mg tablet, 500 mg tablet)</i>	1-Covered	
COARTEM TABLETS	1-Covered	
DARAPRIM 25 MG TABLET	1-Covered	
<i>hydroxychloroquine sulfate 200 mg tablet</i>	1-Covered	
<i>mefloquine hcl 250 mg tablet</i>	1-Covered	
NEBUPENT 300 MG INHAL POWDER	1-Covered	PA - TO CONFIRM PART D COVERAGE
PENTAM 300 VIAL	1-Covered	
<i>primaquine phosphate 26.3 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>quinine sulfate 324 mg capsule</i>	1-Covered	
Pediculicides/ Scabicides		
<i>lindane (1 % lotion, 1 % shampoo)</i>	1-Covered	
<i>malathion 0.5 % lotion</i>	1-Covered	
<i>permethrin 5 % cream (g)</i>	1-Covered	
ULESFIA 5% LOTION	1-Covered	
Antiparkinson Agents		
Anticholinergics		
<i>benztropine mesylate (0.5 mg tablet, 1 mg tablet, 2 mg tablet)</i>	1-Covered	PA
<i>benztropine mesylate (2 ml vial, 2 ml ampul)</i>	1-Covered	
<i>trihexyphenidyl hcl (2 mg/5 ml elixir, 2 mg tablet, 5 mg tablet)</i>	1-Covered	PA
Antiparkinson Agents, Other		
<i>amantadine hcl (50 mg/5 ml solution, 100 mg tablet, 100 mg capsule)</i>	1-Covered	
<i>carbidopa/levodopa/entacapone (12.5-50 mg tablet, 18.75-75mg tablet, 25-100-200 tablet, 31.25-125 tablet, 37.5-150mg tablet, 50-200-200 tablet)</i>	1-Covered	
<i>entacapone 200 mg tablet</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tolcapone 100 mg tablet</i>	1-Covered	
Dopamine Agonists		
APOKYN 30 MG/3 ML CARTRIDGE	1-Covered	
<i>bromocriptine mesylate (2.5 mg tablet, 5 mg capsule)</i>	1-Covered	
MIRAPEX ER (ER 0.375 MG TABLET, ER 2.25 MG TABLET, ER 3 MG TABLET, ER 3.75 MG TABLET, ER 4.5 MG TABLET)	1-Covered	
NEUPRO (1 HR, 2 HR, 3 HR, 4 HR, 6 HR, 8 HR)	1-Covered	
<i>pramipexole di-hcl (0.125 mg tablet, 0.25 mg tablet, 0.5 mg tablet, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>pramipexole di-hcl (0.375 mg tab er, 0.75 mg tab er, 1.5 mg tab er, 2.25 mg tab er, 3 mg tab er, 4.5 mg tab er)</i>	1-Covered	
<i>ropinirole hcl (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tab er 24h, 2 mg tablet, 3 mg tablet, 4 mg tablet, 4 mg tab er 24h, 5 mg tablet, 6 mg tab er 24h, 8 mg tab er 24h, 12 mg tab er 24h)</i>	1-Covered	
Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors		
<i>carbidopa 25 mg tablet</i>	1-Covered	
<i>carbidopa/levodopa (10mg-100mg tab rapdis, 10mg-100mg tablet, 25mg-250mg tab rapdis, 25mg-250mg tablet, 25mg-100mg tab rapdis, 25mg-100mg tablet er, 25mg-100mg tablet, 50mg-200mg tablet er)</i>	1-Covered	
Monoamine Oxidase B (MAO-B) Inhibitors		
AZILECT (0.5 MG TABLET, 1 MG TABLET)	1-Covered	
<i>selegiline hcl (5 mg tablet, 5 mg capsule)</i>	1-Covered	
ZELAPAR 1.25 MG ODT TABLET	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antipsychotics		
1st Generation/ Typical		
<i>fluphenazine decanoate 25 mg/ml vial</i>	1-Covered	
<i>fluphenazine hcl (1 mg tablet, 2.5 mg/5ml elixir, 2.5 mg tablet, 2.5 mg/ml vial, 5 mg tablet, 5 mg/ml oral conc, 10 mg tablet)</i>	1-Covered	
<i>haloperidol (0.5 mg tablet, 1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>haloperidol decanoate (50 mg/ml vial, 50 mg/ml ampul, 100 mg/ml ampul, 100 mg/ml vial)</i>	1-Covered	
<i>haloperidol lactate (2 mg/ml oral conc, 5 mg/ml vial, 5 mg/ml ampul)</i>	1-Covered	
<i>loxapine succinate (10 mg capsule, 25 mg capsule, 50 mg capsule)</i>	1-Covered	
<i>loxapine succinate 5 mg capsule</i>	1-Covered	QL (12 PER 1 DAYS)
<i>molindone hcl (5 mg tablet, 10 mg tablet, 25 mg tablet)</i>	1-Covered	
ORAP (1 MG TABLET, 2 MG TABLET)	1-Covered	
<i>pimozide (1 mg tablet, 2 mg tablet)</i>	1-Covered	QL (5 PER 1 DAYS)
<i>thioridazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>thiothixene (1 mg capsule, 2 mg capsule, 5 mg capsule, 10 mg capsule)</i>	1-Covered	
<i>trifluoperazine hcl (1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	
2nd Generation/ Atypical		
ABILIFY (1 MG/ML SOLUTION, 9.7 MG/1.3 ML VIAL)	1-Covered	
ABILIFY DISCMELT (10 MG TABLET, 15 MG TABLET)	1-Covered	
ABILIFY MAINTENA (ER 300 MG SYR, ER 300 MG VL, ER 400 MG VL, ER 400 MG SYR)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>aripiprazole (2 mg tablet, 5 mg tablet, 10 mg tablet, 10 mg tab rapdis, 15 mg tablet, 15 mg tab rapdis, 20 mg tablet, 30 mg tablet)</i>	1-Covered	
FANAPT (1 MG TABLET, 2 MG TABLET, 4 MG TABLET, 6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET, TITRATION PACK)	1-Covered	
GEODON 20 MG/ML VIAL	1-Covered	
INVEGA (ER 1.5 MG TABLET, ER 3 MG TABLET, ER 6 MG TABLET, ER 9 MG TABLET)	1-Covered	
INVEGA SUSTENNA (39 MG/0.25 ML, 78 MG/0.5 ML, 117 MG/0.75 ML, 156 MG/ML SYRG, 234 MG/1.5 ML)	1-Covered	QL (1 PER 28 DAYS)
INVEGA TRINZA (273 MG/0.875 ML, 410 MG/1.315 ML, 546 MG/1.75 ML, 819 MG/2.625 ML)	1-Covered	QL (1 PER 84 DAYS)
LATUDA (20 MG TABLET, 40 MG TABLET, 60 MG TABLET, 80 MG TABLET, 120 MG TABLET)	1-Covered	
<i>olanzapine (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>olanzapine (5 mg tab rapdis, 10 mg tab rapdis, 10 mg vial, 15 mg tab rapdis, 20 mg tab rapdis)</i>	1-Covered	
<i>paliperidone (1.5 mg tab er 24, 3 mg tab er 24)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>paliperidone (6 mg tab er 24, 9 mg tab er 24)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>quetiapine fumarate (300 mg tablet, 400 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>quetiapine fumarate (50 mg tablet, 100 mg tablet, 200 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>quetiapine fumarate 25 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
REXULTI (0.25 MG TABLET, 0.5 MG TABLET, 1 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
REXULTI (2 MG TABLET, 3 MG TABLET, 4 MG TABLET)	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RISPERDAL CONSTA (12.5 MG, 25 MG, 37.5 MG, 50 MG)	1-Covered	
<i>risperidone (0.25 mg tablet, 0.25 mg tab rapdis, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 2 mg tab rapdis, 3 mg tablet, 4 mg tab rapdis, 4 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>risperidone 0.5 mg tab rapdis</i>	1-Covered	QL (4 PER 1 DAYS)
<i>risperidone 1 mg tab rapdis</i>	1-Covered	QL (1 PER 1 DAYS)
<i>risperidone 1 mg/ml solution</i>	1-Covered	
<i>risperidone 3 mg tab rapdis</i>	1-Covered	QL (3 PER 1 DAYS)
SAPHRIS (2.5 MG TAB SL BLK CHRY, 5 MG TAB SL BLK CHERRY, 5 MG TABLET SUBLINGUAL, 10 MG TAB SUBLINGUAL, 10 MG TAB SL BLK CHERY)	1-Covered	
VRAYLAR (1.5 MG CAPSULE, 3 MG CAPSULE, 4.5 MG CAPSULE, 6 MG CAPSULE)	1-Covered	
<i>ziprasidone hcl (20 mg capsule, 40 mg capsule, 60 mg capsule, 80 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
ZYPREXA RELPREVV (210 MG VIAL, 210 MG VL KIT, 300 MG VL KIT, 300 MG VIAL, 405 MG VL KIT, 405 MG VIAL)	1-Covered	
Treatment-Resistant		
<i>clozapine (12.5 mg tab rapdis, 25 mg tab rapdis, 100 mg tab rapdis, 150 mg tab rapdis, 200 mg tab rapdis)</i>	1-Covered	
<i>clozapine 100 mg tablet</i>	1-Covered	QL (9 PER 1 DAYS)
<i>clozapine 200 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>clozapine 25 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>clozapine 50 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
FAZACLO (12.5 MG ODT, 25 MG ODT, 100 MG ODT, 150 MG ODT, 200 MG ODT)	1-Covered	
VERSACLOZ 50 MG/ML SUSPENSION	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Antispasticity Agents		
<i>baclofen (10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>dantrolene sodium (25 mg capsule, 50 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>tizanidine hcl (2 mg tablet, 4 mg tablet)</i>	1-Covered	
Antivirals		
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
GENVOYA TABLET	1-Covered	
ISENTRESS 100 MG POWDER PACKET	1-Covered	
ISENTRESS 100 MG TABLET CHEW	1-Covered	QL (8 PER 1 DAYS)
ISENTRESS 25 MG TABLET CHEW	1-Covered	QL (6 PER 1 DAYS)
ISENTRESS 400 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
STRIBILD TABLET	1-Covered	
TIVICAY 50 MG TABLET	1-Covered	
VITEKTA (85 MG TABLET, 150 MG TABLET)	1-Covered	
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA TABLET	1-Covered	QL (1 PER 1 DAYS)
EDURANT 25 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
INTELENCE 100 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
INTELENCE 200 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
INTELENCE 25 MG TABLET	1-Covered	
<i>nevirapine (100 mg tab er, 400 mg tab er)</i>	1-Covered	
<i>nevirapine 200 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>nevirapine 50 mg/5 ml oral susp</i>	1-Covered	QL (40 PER 1 DAYS)
RESCRIPTOR 100 MG TABLET	1-Covered	QL (12 PER 1 DAYS)
RESCRIPTOR 200 MG TABLET	1-Covered	QL (6 PER 1 DAYS)
SUSTIVA 200 MG CAPSULE	1-Covered	QL (3 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SUSTIVA 50 MG CAPSULE	1-Covered	QL (8 PER 1 DAYS)
SUSTIVA 600 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
VIRAMUNE XR 100 MG TABLET	1-Covered	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
<i>abacavir sulfate 300 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>abacavir/lamivudine/zidovudine 150-300mg tablet</i>	1-Covered	
ATRIPLA TABLET	1-Covered	QL (1 PER 1 DAYS)
COMBIVIR TABLET	1-Covered	QL (2 PER 1 DAYS)
DESCOVY 200-25 MG TABLET	1-Covered	
<i>didanosine (125 mg capsule dr, 200 mg capsule dr)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>didanosine (250 mg capsule dr, 400 mg capsule dr)</i>	1-Covered	QL (1 PER 1 DAYS)
EMTRIVA 10 MG/ML SOLUTION	1-Covered	QL (24 PER 1 DAYS)
EMTRIVA 200 MG CAPSULE	1-Covered	QL (1 PER 1 DAYS)
EPZICOM TABLET	1-Covered	QL (1 PER 1 DAYS)
<i>lamivudine/zidovudine 150-300mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
RETROVIR 200 MG/20 ML VIAL	1-Covered	
<i>stavudine (15 mg capsule, 20 mg capsule)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>stavudine (30 mg capsule, 40 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>stavudine 1 mg/ml soln recon</i>	1-Covered	QL (80 PER 1 DAYS)
TRIZIVIR TABLET	1-Covered	QL (2 PER 1 DAYS)
TRUVADA 200 MG-300 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
VIDEX (2 GM SOLN, 4 GM SOLN)	1-Covered	QL (40 PER 1 DAYS)
ZIAGEN 20 MG/ML SOLUTION	1-Covered	QL (30 PER 1 DAYS)
<i>zidovudine 10 mg/ml syrup</i>	1-Covered	QL (60 PER 1 DAYS)
<i>zidovudine 100 mg capsule</i>	1-Covered	QL (6 PER 1 DAYS)
<i>zidovudine 300 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Anti-HIV Agents, Other		
FUZEON (90 MG VIAL, CONVENIENCE KIT)	1-Covered	
SELZENTRY (150 MG TABLET, 300 MG TABLET)	1-Covered	QL (4 PER 1 DAYS)
TRIUMEQ TABLET	1-Covered	
TYBOST 150 MG TABLET	1-Covered	
Anti-HIV Agents, Protease Inhibitors		
APTIVUS 100 MG/ML SOLUTION	1-Covered	QL (10 PER 1 DAYS)
APTIVUS 250 MG CAPSULE	1-Covered	QL (4 PER 1 DAYS)
CRIXIVAN (200 MG CAPSULE, 400 MG CAPSULE)	1-Covered	
EVOTAZ 300 MG-150 MG TABLET	1-Covered	
INVIRASE 200 MG CAPSULE	1-Covered	QL (10 PER 1 DAYS)
INVIRASE 500 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
KALETRA 100-25 MG TABLET	1-Covered	QL (10 PER 1 DAYS)
KALETRA 200-50 MG TABLET	1-Covered	QL (5 PER 1 DAYS)
KALETRA 400-100/5 ML ORAL SOLU	1-Covered	QL (14 PER 1 DAYS)
LEXIVA 50 MG/ML SUSPENSION	1-Covered	QL (56 PER 1 DAYS)
LEXIVA 700 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
NORVIR (100 MG TABLET, 100 MG SOFTGEL CAP)	1-Covered	QL (12 PER 1 DAYS)
NORVIR 80 MG/ML SOLUTION	1-Covered	QL (16 PER 1 DAYS)
PREZCOBIX 800 MG-150 MG TABLET	1-Covered	
PREZISTA 100 MG/ML SUSPENSION	1-Covered	
PREZISTA 150 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
PREZISTA 600 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
PREZISTA 75 MG TABLET	1-Covered	QL (8 PER 1 DAYS)
PREZISTA 800 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
REYATAZ (150 MG CAPSULE, 200 MG CAPSULE)	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REYATAZ 300 MG CAPSULE	1-Covered	QL (1 PER 1 DAYS)
REYATAZ 50 MG POWDER PACKET	1-Covered	
VIRACEPT 250 MG TABLET	1-Covered	QL (9 PER 1 DAYS)
VIRACEPT 625 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
Anti-cytomegalovirus (CMV) Agents		
<i>cidofovir 75 mg/ml vial</i>	1-Covered	
<i>foscarnet sodium 24 mg/ml infus. btl</i>	1-Covered	
<i>ganciclovir sodium 500 mg vial</i>	1-Covered	
VALCYTE 50 MG/ML SOLUTION	1-Covered	
<i>valganciclovir hcl 450 mg tablet</i>	1-Covered	
ZIRGAN 0.15% OPHTHALMIC GEL	1-Covered	
Anti-hepatitis B (HBV) Agents		
<i>adefovir dipivoxil 10 mg tablet</i>	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	QL (20 PER 1 DAYS)
<i>entecavir (0.5 mg tablet, 1 mg tablet)</i>	1-Covered	
EPIVIR 10 MG/ML ORAL SOLN	1-Covered	QL (30 PER 1 DAYS)
EPIVIR HBV 25 MG/5 ML SOLN	1-Covered	
INTRON A (10 MILLION UNITS VIL, 18 MILLION UNIT/3 ML, 25 MILLION UNIT/2.5ML)	1-Covered	
<i>lamivudine (10 mg/ml solution, 100 mg tablet)</i>	1-Covered	
<i>lamivudine 150 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>lamivudine 300 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
TYZEKA 600 MG TABLET	1-Covered	
VIRAZOLE 6 GM VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
VIREAD (150 MG TABLET, 200 MG TABLET, 250 MG TABLET, POWDER)	1-Covered	
VIREAD 300 MG TABLET	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Anti-hepatitis C (HCV) Agents		
HARVONI 90-400 MG TABLET	1-Covered	PA
INTRON A (18 MILLION VIL, 50 MILLION VIL)	1-Covered	
OLYSIO 150 MG CAPSULE	1-Covered	PA
PEGINTRON (50 MCG, 80 MCG, 120 MCG, 150 MCG)	1-Covered	PA, QL (4 PER 28 DAYS)
PEGINTRON REDIPEN (50 MCG, 50 MCG 4PK, 80 MCG, 80 MCG 4PK, 120 MCG 4PK, 120 MCG, 150 MCG, 150 MCG 4PK)	1-Covered	PA, QL (4 PER 28 DAYS)
REBETOL 40 MG/ML SOLUTION	1-Covered	PA
<i>ribavirin (200 mg capsule, 200 mg tablet)</i>	1-Covered	PA, QL (7 PER 1 DAYS)
SOVALDI 400 MG TABLET	1-Covered	PA
SYLATRON (200 MCG, 300 MCG, 600 MCG)	1-Covered	
SYLATRON 4-PACK (200 MCG, 300 MCG)	1-Covered	
VIEKIRA PAK	1-Covered	PA
Anti-influenza Agents		
RAPIVAB 200 MG/20 ML VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
RELENZA 5 MG DISKHALER	1-Covered	
<i>rimantadine hcl 100 mg tablet</i>	1-Covered	
TAMIFLU (6 MG/ML SUSPENSION, 30 MG CAPSULE, 45 MG CAPSULE, 75 MG CAPSULE)	1-Covered	
Antiherpetic Agents		
<i>acyclovir (5 % oint. (g), 200 mg capsule, 200 mg/5ml oral susp, 400 mg tablet, 800 mg tablet)</i>	1-Covered	
<i>acyclovir sodium (50 mg/ml vial, 500 mg vial, 1000 mg vial)</i>	1-Covered	
<i>famciclovir (125 mg tablet, 250 mg tablet, 500 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>trifluridine 1 % drops</i>	1-Covered	
<i>valacyclovir hcl (500 mg tablet, 1000 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
ZOVIRAX 5% CREAM	1-Covered	

Anxiolytics

Anxiolytics, Other

<i>bupirone hcl (5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 30 mg tablet)</i>	1-Covered	
<i>oxazepam (10 mg capsule, 15 mg capsule, 30 mg capsule)</i>	1-Covered	
<i>triazolam 0.125 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>triazolam 0.25 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)

Benzodiazepines

<i>alprazolam (0.25 mg tab rapdis, 0.25 mg tablet, 0.5 mg tab rapdis, 0.5 mg tab er 24h, 0.5 mg tablet, 1 mg tablet, 1 mg tab rapdis, 1 mg tab er 24h, 2 mg tab rapdis, 2 mg tablet, 2 mg tab er 24h, 3 mg tab er 24h)</i>	1-Covered	
ALPRAZOLAM 1 MG/ML ORAL CONC	1-Covered	
<i>chlordiazepoxide hcl 10 mg capsule</i>	1-Covered	QL (10 PER 1 DAYS)
<i>chlordiazepoxide hcl 25 mg capsule</i>	1-Covered	QL (12 PER 1 DAYS)
<i>chlordiazepoxide hcl 5 mg capsule</i>	1-Covered	QL (8 PER 1 DAYS)

Bipolar Agents

Mood Stabilizers

<i>carbamazepine (100 mg, 200 mg, 300 mg)</i>	1-Covered	
<i>lithium carbonate (150 mg capsule, 300 mg tablet er, 300 mg tablet, 300 mg capsule, 450 mg tablet er, 600 mg capsule)</i>	1-Covered	
<i>lithium citrate 8 meq/5 ml solution</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Blood Glucose Regulators		
Antidiabetic Agents		
<i>acarbose (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
BYDUREON 2 MG PEN INJECT	1-Covered	
BYDUREON 2 MG VIAL	1-Covered	
BYETTA (5 MCG, 10 MCG)	1-Covered	
<i>chlorpropamide 100 mg tablet</i>	1-Covered	PA, QL (7 PER 1 DAYS)
<i>chlorpropamide 250 mg tablet</i>	1-Covered	PA, QL (3 PER 1 DAYS)
CYCLOSET 0.8 MG TABLET	1-Covered	
<i>glimepiride (1 mg tablet, 2 mg tablet, 4 mg tablet)</i>	1-Covered	
<i>glipizide (5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>glipizide 10 mg tab er 24</i>	1-Covered	QL (2 PER 1 DAYS)
<i>glipizide 2.5 mg tab er 24</i>	1-Covered	
<i>glipizide 5 mg tab er 24</i>	1-Covered	QL (3 PER 1 DAYS)
<i>glyburide (1.25 mg tablet, 2.5 mg tablet, 5 mg tablet)</i>	1-Covered	PA, QL (4 PER 1 DAYS)
<i>glyburide, micronized (1.5 mg tablet, 3 mg tablet, 6 mg tablet)</i>	1-Covered	PA, QL (2 PER 1 DAYS)
GLYSET (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1-Covered	
INVOKAMET (50-1,000 MG TABLET, 50-500 MG TABLET, 150-500 MG TABLET, 150-1,000 MG TABLET)	1-Covered	
INVOKANA (100 MG TABLET, 300 MG TABLET)	1-Covered	
JANUVIA (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1-Covered	
JARDIANCE (10 MG TABLET, 25 MG TABLET)	1-Covered	
JENTADUETO (2.5 MG-850 MG TAB, 2.5 MG-1000 MG TAB, 2.5 MG-500 MG TAB)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>metformin hcl (500 mg tab er 24h, 500 mg tab er 24, 500 mg tab er 24h)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>metformin hcl 1000 mg tab er 24</i>	1-Covered	
<i>metformin hcl 1000 mg tablet</i>	1-Covered	QL (2.5 PER 1 DAYS)
<i>metformin hcl 500 mg tablet</i>	1-Covered	QL (5 PER 1 DAYS)
<i>metformin hcl 750 mg tab er 24h</i>	1-Covered	QL (2 PER 1 DAYS)
<i>metformin hcl 850 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>nateglinide 120 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>nateglinide 60 mg tablet</i>	1-Covered	QL (6 PER 1 DAYS)
<i>pioglitazone hcl (15 mg tablet, 30 mg tablet, 45 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>repaglinide (0.5 mg tablet, 1 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>repaglinide 2 mg tablet</i>	1-Covered	QL (8 PER 1 DAYS)
<i>repaglinide/metformin hcl (1mg-500mg tablet, 2 mg-500mg tablet)</i>	1-Covered	QL (5 PER 1 DAYS)
SYMLINPEN 120 PEN INJECTOR	1-Covered	
SYMLINPEN 60 PEN INJECTOR	1-Covered	
SYNJARDY (5-1,000 MG TABLET, 12.5-500 MG TABLET, 12.5-1,000 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
SYNJARDY 5-500 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
<i>tolazamide 250 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>tolazamide 500 mg tablet</i>	1-Covered	QL (2 PER 30 DAYS)
<i>tolbutamide 500 mg tablet</i>	1-Covered	QL (6 PER 1 DAYS)
TRADJENTA 5 MG TABLET	1-Covered	
VICTOZA 2-PAK 18 MG/3 ML PEN	1-Covered	
VICTOZA 3-PAK 18 MG/3 ML PEN	1-Covered	
WELCHOL (3.75G PACKET, 625 MG TABLET)	1-Covered	
<i>glipizide/metformin hcl (2.5-250 mg tablet, 2.5-500 mg tablet, 5 mg-500mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>glyburide/metformin hcl (1.25-250mg tablet, 2.5-500 mg tablet, 5 mg-500mg tablet)</i>	1-Covered	PA, QL (4 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
JANUMET (50-1,000 MG TABLET, 50-500 MG TABLET)	1-Covered	
JANUMET XR (50-500 MG TABLET, 50-1,000 MG TABLET, 100-1,000 MG TABLET)	1-Covered	
<i>pioglitazone hcl/glimepiride (30 mg-4 mg tablet, 30 mg-2 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>pioglitazone hcl/metformin hcl (15mg-500mg tablet, 15mg-850mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
Glycemic Agents		
GLUCAGEN (1 MG HYPOKIT, DIAGNOSTIC 1 MG VIAL, 1 MG HYPOKIT 2-PACK)	1-Covered	
GLUCAGON 1 MG EMERGENCY KIT	1-Covered	
PROGLYCEM 50 MG/ML ORAL SUSP	1-Covered	
Insulins		
AFREZZA (4 S CARTRIDGE INH, 30-4 + 60-8, 60-4 + 30-8, 60-8 + 30-12)	1-Covered	
APIDRA 100 UNITS/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
APIDRA SOLOSTAR 100 UNITS/ML	1-Covered	QL (45 PER 23 DAYS)
<i>gauze bandage (2" 2", 3" 3", 4" 4")</i>	1-Covered	
HUMALOG 100 UNITS/ML CARTRIDGE	1-Covered	QL (45 PER 23 DAYS)
HUMALOG 100 UNITS/ML KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMALOG 100 UNITS/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
HUMALOG 200 UNITS/ML KWIKPEN	1-Covered	
HUMALOG MIX 50-50 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMALOG MIX 50-50 VIAL	1-Covered	QL (40 PER 23 DAYS)
HUMALOG MIX 75-25 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMALOG MIX 75-25 VIAL	1-Covered	QL (40 PER 23 DAYS)
HUMULIN 70-30 (RELION VIAL, VIAL)	1-Covered	QL (40 PER 23 DAYS)
HUMULIN 70/30 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMULIN N (N 100 UNITS/ML VIAL, RELION N 100 UNIT/ML)	1-Covered	QL (40 PER 23 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMULIN N 100 UNITS/ML KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMULIN R (R 100 UNITS/ML VIAL, RELION R 100 UNIT/ML)	1-Covered	QL (40 PER 23 DAYS)
HUMULIN R 500 UNITS/ML VIAL	1-Covered	
<i>insulin syringe-needle,safety,disposal unit,0.5 ml (0.5ml,29 g x1/2", 0.5ml,30gx 5/16")</i>	1-Covered	
LANTUS 100 UNITS/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
LANTUS SOLOSTAR 100 UNITS/ML	1-Covered	QL (45 PER 23 DAYS)
LEVEMIR 100 UNITS/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
LEVEMIR FLEXPEN 100 UNITS/ML	1-Covered	QL (45 PER 23 DAYS)
LEVEMIR FLEXTOUCH 100 UNITS/ML	1-Covered	QL (45 PER 23 DAYS)
<i>needles, insulin disposable, safety (29gx 5/16", , 29gx3/16", , 29 g x1/2", , 30 gx 1/3")</i>	1-Covered	
NOVOLIN 70-30 (100 UNIT/ML VIAL, RELION VIAL)	1-Covered	QL (40 PER 23 DAYS)
NOVOLIN N (N 100 UNITS/ML VIAL, RELION N 100 UNIT/ML)	1-Covered	QL (40 PER 23 DAYS)
NOVOLIN R (R 100 UNITS/ML VIAL, RELION R 100 UNIT/ML)	1-Covered	QL (40 PER 23 DAYS)
NOVOLOG 100 UNIT/ML CARTRIDGE	1-Covered	QL (45 PER 23 DAYS)
NOVOLOG 100 UNIT/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
NOVOLOG 100 UNITS/ML FLEXPEN	1-Covered	QL (45 PER 23 DAYS)
NOVOLOG MIX 70-30 FLEXPEN SYRN	1-Covered	QL (45 PER 23 DAYS)
NOVOLOG MIX 70-30 VIAL	1-Covered	QL (40 PER 23 DAYS)
<i>pen needle, diabetic (, 29 g x1/2", , 29 gauge, , 29gx 5/16", , 30 gx 1/3", , 30gx 5/16", , 31 g x1/4", , 31 gx3/16", , 31 gx5/16", , 31 g x1/3", , 32 gx5/16", , 32 gx3/16", , 32 gx 1/4", , 32 gx 1/6", , 32gx 5/32", , 32 gx 1/5", , 33 gx5/32", , 33 gx5/16", , 33 g x1/4", , 33 gx3/16")</i>	1-Covered	
<i>pen needle,dual safety,diabetc 30 gx3/16" dis needle</i>	1-Covered	
<i>syr,ndl 0.3 ml,ins,safe,d.unit 30gx 5/16" disp syrin</i>	1-Covered	

You can find information on what the symbols and abbreviations
on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>syring w-ndl,disp,insul,0.3 ml/container,empty (29 g x1/2", 30gx 5/16")</i>	1-Covered	
<i>syring w-ndl,disp,insul,0.5 ml/container,empty (29 g x1/2", 30gx 5/16")</i>	1-Covered	
<i>syringe with needle, insulin, safety, 0.3 ml (ge,needle,insuln,sf,0.3ml 30gx 5/16", ge,needle,insuln,sf,0.3ml 29 g x1/2")</i>	1-Covered	
<i>syringe with needle, insulin, safety, 0.5 ml (29 g x1/2", 30gx 5/16")</i>	1-Covered	
<i>syringe with needle, insulin, safety, 1 ml (29 g x1/2", 30gx 5/16", 30gx1/2", 31 gx5/16")</i>	1-Covered	
<i>syringe with needle, insulin,1 ml and sharps container (29 g x1/2", 30gx 5/16")</i>	1-Covered	
<i>syringe with needle,disposable,insulin (ge .,, ge ., 29 g x1/2")</i>	1-Covered	
<i>syringe with needle,disposable,insulin 1 ml (ge, ge 25gx1", ge 25gx5/8", ge 26gx1/2", ge 27gx5/8", ge 27gx1/2", ge 28gx1/2", ge 28 gauge, ge 29gx7/16", ge 29 g x1/2", ge 29 gauge, ge 30gx 5/16", ge 30gx3/8", ge 30gx1/2", ge 30 gauge, ge 31gx15/64", ge 31 gx5/16", ge 31gx3/8", ge 31 g x1/4")</i>	1-Covered	
<i>syringe with needle,insulin 0.3 ml (half unit mark) (0.3 ml 30gx 5/16", 0.3 ml 31 g x1/4", 0.3 ml 31 gx5/16", 0.3 ml 31gx15/64", 0.3 ml 29 g x1/2")</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>syringe with needle,insulin,0.3 ml (g-needl,,insul,0.3 ml 31 gx5/16", g-needl,,insul,0.3 ml 30gx3/8", g-needl,,insul,0.3 ml 29 g x1/2", g-needl,,insul,0.3 ml 31gx15/64", g-needl,,insul,0.3 ml 30gx 5/16", g-needl,,insul,0.3 ml 30gx1/2", g-needl,,insul,0.3 ml 28gx1/2", g-needl,,insul,0.3 ml 31gx3/8", g-needl,,insul,0.3 ml 30 gauge, g-needl,,insul,0.3 ml 28 gauge, g-needl,,insul,0.3 ml 29 gauge, g-needl,,insul,0.3 ml 31 g x1/4")</i>	1-Covered	
<i>syringe with needle,insulin,0.5 ml (ml 27gx1/2", ml 28 gauge, ml 28gx1/2", ml 29 gauge, ml 29 g x1/2", ml 30gx1/2", ml 30gx3/8", ml 30gx 5/16", ml 30 gauge, ml 31 gx5/16", ml 31gx15/64", ml 31gx3/8", ml 31 g x1/4")</i>	1-Covered	
<i>syringe,needle,insulin,safety,disposal unit, 1 ml (1 29 g x1/2", 1 28gx1/2")</i>	1-Covered	
TOUJEO SOLOSTAR 300 UNITS/ML	1-Covered	

Blood Products/ Modifiers/ Volume Expanders

Anticoagulants

COUMADIN (1 MG TABLET, 2 MG TABLET, 2.5 MG TABLET, 3 MG TABLET, 4 MG TABLET, 5 MG TABLET, 6 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1-Covered	
ELIQUIS (2.5 MG TABLET, 5 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
<i>enoxaparin sodium (30mg/0.3ml syringe, 40mg/0.4ml syringe, 60mg/0.6ml syringe, 80mg/0.8ml syringe, 100 mg/ml syringe, 120mg/.8ml syringe, 150 mg/ml syringe, 300mg/3ml vial)</i>	1-Covered	
<i>fondaparinux sodium (2.5 mg/0.5, 5mg/0.4ml, 7.5mg/0.6, 10mg/0.8ml)</i>	1-Covered	
<i>heparin sodium,porcine (1000/ml vial, 5000/ml vial, 5000/ml(1) cartridge, 10000/ml vial, 20000/ml vial)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>heparin sodium, porcine/dextrose 5 % in water (20k/500ml soln, 12500/250 soln, 25000/250 soln, 25000/500 soln)</i>	1-Covered	
JANTOVEN (1 MG TABLET, 2 MG TABLET, 2.5 MG TABLET, 3 MG TABLET, 4 MG TABLET, 5 MG TABLET, 6 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1-Covered	
PRADAXA (75 MG CAPSULE, 110 MG CAPSULE, 150 MG CAPSULE)	1-Covered	
<i>warfarin sodium (1 mg tablet, 2 mg tablet, 2.5 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet, 6 mg tablet, 7.5 mg tablet, 10 mg tablet)</i>	1-Covered	
XARELTO (10 MG TABLET, 15 MG TABLET, 20 MG TABLET, STARTER PACK)	1-Covered	

Blood Formation Modifiers

<i>anagrelide hcl (0.5 mg capsule, 1 mg capsule)</i>	1-Covered	
LEUKINE 250 MCG VIAL	1-Covered	
MOZOBIL (20 MG/ML VIAL, 24 MG/1.2 ML VIAL)	1-Covered	
NEULASTA 6 MG/0.6 ML SYRINGE	1-Covered	PA
NEULASTA ONPRO 6 MG/0.6 ML KIT	1-Covered	
NEUMEGA 5 MG VIAL	1-Covered	
NEUPOGEN (300 MCG/ML VIAL, 300 MCG/0.5 ML SYR, 480 MCG/1.6 ML VIAL, 480 MCG/0.8 ML SYR)	1-Covered	PA
PROCRIT (2,000 VIAL, 3,000 VIAL, 4,000 VIAL, 10,000 VIAL, 20,000 VIAL, 40,000 VIAL)	1-Covered	PA
PROMACTA (12.5 MG TABLET, 25 MG TABLET, 50 MG TABLET, 75 MG TABLET)	1-Covered	PA, LA
ZARXIO (300 MCG/0.5 ML, 480 MCG/0.8 ML)	1-Covered	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Coagulants		
<i>tranexamic acid (650 mg tablet, 1000 mg/10 vial, 1000 mg/10 ampul)</i>	1-Covered	
Platelet Modifying Agents		
AGGRENEX 25 MG-200 MG CAPSULE	1-Covered	QL (3 PER 1 DAYS)
<i>aspirin/dipyridamole 25mg-200mg cpm 12hr</i>	1-Covered	QL (3 PER 1 DAYS)
BRILINTA (60 MG TABLET, 90 MG TABLET)	1-Covered	
<i>cilostazol (50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>clopidogrel bisulfate 300 mg tablet</i>	1-Covered	
<i>clopidogrel bisulfate 75 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>dipyridamole (25 mg tablet, 50 mg tablet, 75 mg tablet)</i>	1-Covered	PA
EFFIENT (5 MG TABLET, 10 MG TABLET)	1-Covered	
<i>ticlopidine hcl 250 mg tablet</i>	1-Covered	PA, QL (2 PER 1 DAYS)
ZONTIVITY 2.08 MG TABLET	1-Covered	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
<i>clonidine (0.1mg/24hr, 0.2mg/24hr, 0.3mg/24hr)</i>	1-Covered	QL (4 PER 22 DAYS)
<i>clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)</i>	1-Covered	
<i>guanfacine hcl (1 mg tablet, 2 mg tablet)</i>	1-Covered	PA
<i>methyldopa (250 mg tablet, 500 mg tablet)</i>	1-Covered	PA
<i>methyldopate hcl 250 mg/5ml vial</i>	1-Covered	
<i>midodrine hcl (2.5 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	
NORTHERA (100 MG CAPSULE, 200 MG CAPSULE, 300 MG CAPSULE)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Alpha-adrenergic Blocking Agents		
<i>doxazosin mesylate (1 mg tablet, 2 mg tablet, 4 mg tablet, 8 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>phenoxybenzamine hcl 10 mg capsule</i>	1-Covered	
<i>prazosin hcl (1 mg capsule, 2 mg capsule, 5 mg capsule)</i>	1-Covered	
<i>terazosin hcl (1 mg capsule, 2 mg capsule, 5 mg capsule, 10 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
Angiotensin II Receptor Antagonists		
<i>candesartan cilexetil (4 mg tablet, 8 mg tablet, 16 mg tablet, 32 mg tablet)</i>	1-Covered	
<i>irbesartan (75 mg tablet, 150 mg tablet, 300 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>losartan potassium (25 mg tablet, 50 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>losartan potassium 100 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>telmisartan (20 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	
<i>valsartan (40 mg tablet, 80 mg tablet, 160 mg tablet, 320 mg tablet)</i>	1-Covered	
Angiotensin-converting Enzyme (ACE) Inhibitors		
<i>benazepril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>captopril (12.5 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>enalapril maleate (2.5 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>fosinopril sodium (10 mg tablet, 20 mg tablet, 40 mg tablet)</i>	1-Covered	
<i>lisinopril (2.5 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>lisinopril (20 mg tablet, 30 mg tablet, 40 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>moexipril hcl (7.5 mg tablet, 15 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>perindopril erbumine (2 mg tablet, 4 mg tablet, 8 mg tablet)</i>	1-Covered	
<i>quinapril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>ramipril (1.25 mg capsule, 2.5 mg capsule, 5 mg capsule, 10 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>trandolapril (1 mg tablet, 2 mg tablet, 4 mg tablet)</i>	1-Covered	

Antiarrhythmics

<i>amiodarone hcl (50 mg/ml vial, 50 mg/ml ampul, 100 mg tablet, 200 mg tablet, 400 mg tablet)</i>	1-Covered	
<i>disopyramide phosphate (100 mg capsule, 150 mg capsule)</i>	1-Covered	PA
<i>flecainide acetate (50 mg tablet, 100 mg tablet, 150 mg tablet)</i>	1-Covered	
<i>mexiletine hcl (150 mg capsule, 200 mg capsule, 250 mg capsule)</i>	1-Covered	
MULTAQ 400 MG TABLET	1-Covered	
PACERONE 100 MG TABLET	1-Covered	
<i>procainamide hcl (100 mg/ml vial, 500 mg/ml vial)</i>	1-Covered	
<i>propafenone hcl (150 mg tablet, 225 mg cap er 12h, 225 mg tablet, 300 mg tablet, 325 mg cap er 12h, 425 mg cap er 12h)</i>	1-Covered	
<i>quinidine gluconate (80 mg/ml vial, 324 mg tablet er)</i>	1-Covered	
<i>quinidine sulfate (200 mg tablet, 300 mg tablet er, 300 mg tablet)</i>	1-Covered	
<i>sotalol hcl (80 mg tablet, 120 mg tablet, 160 mg tablet, 240 mg tablet)</i>	1-Covered	
TIKOSYN (125 MCG CAPSULE, 250 MCG CAPSULE, 500 MCG CAPSULE)	1-Covered	

Beta-adrenergic Blocking Agents

<i>acebutolol hcl (200 mg capsule, 400 mg capsule)</i>	1-Covered	
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>atenolol (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>betaxolol hcl (10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>bisoprolol fumarate (5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>carvedilol (3.125 mg tablet, 6.25 mg tablet, 12.5 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>carvedilol 25 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
COREG CR (10 MG CAPSULE, 20 MG CAPSULE, 40 MG CAPSULE, 80 MG CAPSULE)	1-Covered	
<i>labetalol hcl (5 mg/ml vial, 100 mg tablet, 200 mg tablet, 300 mg tablet)</i>	1-Covered	
<i>metoprolol succinate (25 mg tab er, 50 mg tab er, 100 mg tab er)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>metoprolol succinate 200 mg tab er 24h</i>	1-Covered	QL (2 PER 1 DAYS)
<i>metoprolol tartrate (5 mg/5 ml syringe, 5 mg/5 ml ampul, 5 mg/5 ml vial, 25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>nadolol (20 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	
<i>pindolol (5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>propranolol hcl (1 mg/ml vial, 10 mg tablet, 20 mg/5 ml solution, 20 mg tablet, 40 mg tablet, 40mg/5ml solution, 60 mg cap sa 24h, 60 mg tablet, 80 mg tablet, 80 mg cap sa 24h, 120 mg cap sa 24h, 160 mg cap sa 24h)</i>	1-Covered	

Calcium Channel Blocking Agents

AFEDITAB CR (30 MG TABLET, 60 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
<i>amlodipine besylate (2.5 mg tablet, 5 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>amlodipine besylate 10 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARTIA XT (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE, 300 MG CAPSULE)	1-Covered	
DILT-CD (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE)	1-Covered	
DILT-XR (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE)	1-Covered	
<i>diltiazem hcl (120 mg cap er deg, 120 mg capsule er, 120 mg cap er 24h, 300 mg capsule er, 300 mg cap er 24h)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>diltiazem hcl (180 mg cap er 24h, 180 mg capsule er, 180 mg cap er deg, 240 mg capsule er, 240 mg cap er deg, 240 mg cap er 24h, 360 mg capsule er, 360 mg cap er 24h)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>diltiazem hcl (5 mg/ml vial, 30 mg tablet, 60 mg tablet, 60 mg cap er 12h, 90 mg cap er 12h, 90 mg tablet, 100 mg vial port, 120 mg cap er 12h, 120 mg tablet, 420 mg capsule er)</i>	1-Covered	
<i>felodipine (2.5 mg tab er, 5 mg tab er, 10 mg tab er)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>isradipine (2.5 mg capsule, 5 mg capsule)</i>	1-Covered	
MATZIM LA (180 MG TABLET, 240 MG TABLET, 300 MG TABLET, 360 MG TABLET, 420 MG TABLET)	1-Covered	
<i>nicardipine hcl (20 mg capsule, 30 mg capsule)</i>	1-Covered	
NIFEDICAL XL (30 MG TABLET, 60 MG TABLET)	1-Covered	
<i>nifedipine (10 mg capsule, 20 mg capsule)</i>	1-Covered	PA
<i>nifedipine (30 mg tab er 24, 30 mg tablet er, 60 mg tablet er, 60 mg tab er 24, 90 mg tab er 24, 90 mg tablet er)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>nimodipine 30 mg capsule</i>	1-Covered	
<i>nisoldipine (20 mg tab er, 30 mg tab er, 40 mg tab er)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nisoldipine (8.5mg tab er, 17 mg tab er, 25.5 mg tab er, 34 mg tab er)</i>	1-Covered	QL (1 PER 1 DAYS)
TAZTIA XT (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE, 300 MG CAPSULE, 360 MG CAPSULE)	1-Covered	
<i>verapamil hcl (120 mg, 180 mg, 240 mg)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>verapamil hcl (2.5 mg/ml ampul, 2.5 mg/ml vial, 40 mg tablet, 80 mg tablet, 100 mg cap24h pct, 120 mg tablet, 120 mg tablet er, 180 mg tablet er, 200 mg cap24h pct, 240 mg tablet er, 300 mg cap24h pct, 360 mg cap24h pel)</i>	1-Covered	
<i>amiloride/hydrochlorothiazide 5 mg-50 mg tablet</i>	1-Covered	
<i>amlodipine besylate/benazepril hcl (2.5mg-10mg capsule, 5 mg-40 mg capsule, 5 mg-10 mg capsule, 5 mg-20 mg capsule, 10 mg-40mg capsule, 10 mg-20mg capsule)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>amlodipine besylate/valsartan (5mg-320mg tablet, 5 mg-160mg tablet, 10mg-160mg tablet, 10mg-320mg tablet)</i>	1-Covered	
<i>amlodipine besylate/valsartan/hydrochlorothiazide (5-160-25mg tablet, 5-160-12.5 tablet, 10mg-160mg tablet, 10-320-25 tablet, 10-160-25 tablet)</i>	1-Covered	
<i>atenolol/chlorthalidone (50 mg-25mg tablet, 100mg-25mg tablet)</i>	1-Covered	
<i>benazepril hcl/hydrochlorothiazide (5-6.25mg tablet, 10-12.5mg tablet, 20-12.5 mg tablet, 20 mg-25mg tablet)</i>	1-Covered	
<i>bisoprolol fumarate/hydrochlorothiazide (2.5-6.25mg tablet, 5-6.25mg tablet, 10-6.25mg tablet)</i>	1-Covered	
<i>candesartan cilexetil/hydrochlorothiazide (16-12.5mg tablet, 32-12.5mg tablet, 32mg-25mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>captopril/hydrochlorothiazide (25 mg-25mg tablet, 25 mg-15mg tablet, 50 mg-15mg tablet, 50 mg-25mg tablet)</i>	1-Covered	
CLOPRES (0.1-15 TABLET, 0.2-15 TABLET, 0.3-15 TABLET)	1-Covered	
DEMSEER 250 MG CAPSULE	1-Covered	
DUTOPROL (25-12.5 MG TABLET, 50-12.5 MG TABLET, 100-12.5 MG TABLET)	1-Covered	
<i>enalapril maleate/hydrochlorothiazide (5mg-12.5mg tablet, 10 mg-25mg tablet)</i>	1-Covered	
<i>fosinopril sodium/hydrochlorothiazide (10-12.5mg tablet, 20-12.5 mg tablet)</i>	1-Covered	
<i>irbesartan/hydrochlorothiazide (150-12.5mg tablet, 300-12.5mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>lisinopril/hydrochlorothiazide (10-12.5mg tablet, 20-12.5 mg tablet, 20 mg-25mg tablet)</i>	1-Covered	
<i>losartan potassium/hydrochlorothiazide (100-12.5mg tablet, 100mg-25mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>losartan/hydrochlorothiazide 50-12.5 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>methyldopa/hydrochlorothiazide (250mg-25mg tablet, 250mg-15mg tablet)</i>	1-Covered	PA
<i>metoprolol tartrate/hydrochlorothiazide (50 mg-25mg tablet, 100mg-50mg tablet, 100mg-25mg tablet)</i>	1-Covered	
<i>propranolol hcl/hydrochlorothiazide (40 tablet, 80 tablet)</i>	1-Covered	
<i>quinapril hcl/hydrochlorothiazide (10-12.5mg tablet, 20 mg-25mg tablet, 20-12.5 mg tablet)</i>	1-Covered	
<i>reserpine 0.1 mg tablet</i>	1-Covered	PA, QL (1 PER 1 DAYS)
<i>reserpine 0.25 mg tablet</i>	1-Covered	PA
<i>spironolact/hydrochlorothiazid 25 mg-25mg tablet</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>triamterene/hydrochlorothiazide (37.5-25 mg capsule, 37.5-25 mg tablet, 50 mg-25mg capsule, 75 mg-50mg tablet)</i>	1-Covered	
<i>valsartan/hydrochlorothiazide (80-12.5mg tablet, 160-12.5mg tablet, 160-25mg tablet, 320mg-25mg tablet, 320-12.5mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)

Cardiovascular Agents, Other

<i>amlodipine besylate/atorvastatin calcium (2.5mg-20mg tablet, 2.5mg-40mg tablet, 2.5mg-10mg tablet, 5 mg-20 mg tablet, 5 mg-80 mg tablet, 5 mg-40 mg tablet, 5 mg-10 mg tablet, 10 mg-80mg tablet, 10 mg-20mg tablet, 10 mg-40mg tablet, 10 mg-10mg tablet)</i>	1-Covered	
CORLANOR (5 MG TABLET, 7.5 MG TABLET)	1-Covered	
DIGITEK (125 MCG TABLET, 250 MCG TABLET)	1-Covered	
DIGOX (125 MCG TABLET, 250 MCG TABLET)	1-Covered	
<i>digoxin (50 mcg/ml solution, 125 mcg tablet, 250 mcg/ml ampul, 250 mcg tablet, 250 mcg/ml syringe)</i>	1-Covered	
LANOXIN (62.5 MCG TABLET, 125 MCG TABLET, 187.5 MCG TABLET, 250 MCG TABLET)	1-Covered	
<i>moexipril hcl/hydrochlorothiazide (7.5-12.5mg tablet, 15-25mg tablet, 15-12.5mg tablet)</i>	1-Covered	
<i>pentoxifylline 400 mg tablet er</i>	1-Covered	
RANEXA (ER 500 MG TABLET, ER 1,000 MG TABLET)	1-Covered	
<i>telmisartan/amlodipine besylate (40 mg-10mg tablet, 40 mg-5 mg tablet, 80 mg-10mg tablet, 80 mg-5 mg tablet)</i>	1-Covered	
<i>telmisartan/hydrochlorothiazide (40-12.5 mg tablet, 80-12.5mg tablet, 80 mg-25mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>trandolapril/verapamil hcl (1-240mg tab, 2-240mg tab, 2 mg-180mg tab, 4-240mg tab)</i>	1-Covered	
Diuretics, Carbonic Anhydrase Inhibitors		
<i>acetazolamide (125 mg tablet, 250 mg tablet, 500 mg capsule er)</i>	1-Covered	
<i>acetazolamide sodium 500 mg vial</i>	1-Covered	
KEVEYIS 50 MG TABLET	1-Covered	
<i>methazolamide (25 mg tablet, 50 mg tablet)</i>	1-Covered	
Diuretics, Loop		
<i>bumetanide (0.25 mg/ml vial, 0.5 mg tablet, 1 mg tablet, 2 mg tablet)</i>	1-Covered	
EDECIN 25 MG TABLET	1-Covered	
<i>ethacrynate sodium 50 mg vial</i>	1-Covered	
<i>furosemide (10 mg/ml syringe, 10 mg/ml solution, 10 mg/ml vial, 20 mg tablet, 40 mg tablet, 40mg/5ml solution, 80 mg tablet)</i>	1-Covered	
<i>toremide (5 mg tablet, 10 mg tablet, 20 mg tablet, 100 mg tablet)</i>	1-Covered	
Diuretics, Potassium-sparing		
<i>amiloride hcl 5 mg tablet</i>	1-Covered	
DYRENIUM (50 MG CAPSULE, 100 MG CAPSULE)	1-Covered	
<i>eplerenone (25 mg tablet, 50 mg tablet)</i>	1-Covered	
<i>spironolactone (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
Diuretics, Thiazide		
<i>chlorothiazide (250 mg tablet, 500 mg tablet)</i>	1-Covered	
<i>chlorothiazide sodium 500 mg vial</i>	1-Covered	
<i>chlorthalidone (25 mg tablet, 50 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURIL 250 MG/5 ML ORAL SUSP	1-Covered	
<i>hydrochlorothiazide (12.5 mg capsule, 12.5 mg tablet, 25 mg tablet, 50 mg tablet)</i>	1-Covered	
<i>indapamide (1.25 mg tablet, 2.5 mg tablet)</i>	1-Covered	
<i>methyclothiazide 5 mg tablet</i>	1-Covered	
<i>metolazone (2.5 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	

Dyslipidemics, Fibric Acid Derivatives

<i>fenofibrate (50 mg capsule, 150 mg capsule)</i>	1-Covered	
<i>fenofibrate (54 mg tablet, 120 mg tablet, 160 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>fenofibrate 40 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>fenofibrate nanocrystallized (48 mg tablet, 145mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>fenofibrate, micronized (67 mg capsule, 134mg capsule, 200 mg capsule)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>fenofibric acid (choline) (45 mg capsule dr, 135 mg capsule dr)</i>	1-Covered	
<i>fenofibric acid 105 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>fenofibric acid 35 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>gemfibrozil 600 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)

Dyslipidemics, HMG CoA Reductase Inhibitors

<i>atorvastatin calcium (10 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>atorvastatin calcium 20 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
CRESTOR (5 MG TABLET, 10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1-Covered	
<i>lovastatin (10 mg tablet, 20 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>lovastatin 40 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>pravastatin sodium (10 mg tablet, 20 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>simvastatin (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
Dyslipidemics, Other		
<i>cholestyramine/aspartame (4 powd pack, 4 powder)</i>	1-Covered	
<i>colestipol hcl (1 tablet, 5 packet, 5 ranules)</i>	1-Covered	
JUXTAPID (5 MG CAPSULE, 10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE, 60 MG CAPSULE)	1-Covered	PA
KYNAMRO 200 MG/ML SYRINGE	1-Covered	PA
<i>niacin (500 mg tab er, 750 mg tab er, 1000 mg tab er)</i>	1-Covered	
NIACOR 500 MG TABLET	1-Covered	
<i>omega-3 acid ethyl esters 1 g capsule</i>	1-Covered	
PRALUENT PEN (75 MG/ML, 150 MG/ML)	1-Covered	PA
PRALUENT SYRINGE (75 MG/ML, 150 MG/ML)	1-Covered	PA
REPATHA 140 MG/ML SURECLICK	1-Covered	PA
REPATHA 140 MG/ML SYRINGE	1-Covered	PA
ZETIA 10 MG TABLET	1-Covered	
Vasodilators, Direct-acting Arterial		
<i>hydralazine hcl (10 mg tablet, 20 mg/ml vial, 25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	
<i>minoxidil (2.5 mg tablet, 10 mg tablet)</i>	1-Covered	
Vasodilators, Direct-acting Arterial/ Venous		
<i>isosorbide dinitrate (5 mg tablet, 10 mg tablet, 20 mg tablet, 30 mg tablet, 40 mg tablet er)</i>	1-Covered	
<i>isosorbide mononitrate (10 mg tablet, 20 mg tablet, 30 mg tab er 24h, 60 mg tab er 24h, 120 mg tab er 24h)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NITRO-BID 2% OINTMENT	1-Covered	
NITRO-DUR (0.3, 0.8)	1-Covered	
<i>nitroglycerin (0.1mg/hr patch td24, 0.2mg/hr patch td24, 0.4mg/hr patch td24, 0.6mg/hr patch td24, 50 mg/10ml vial, 400mcg/spr spray)</i>	1-Covered	
NITROSTAT (0.3 MG TABLET, 0.4 MG TABLET, 0.6 MG TABLET)	1-Covered	

Central Nervous System Agents

Attention Deficit Hyperactivity Disorder Agents, Amphetamines

<i>dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (10 mg tablet, 12.5 mg tablet, 15 mg tablet, 20 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (5 mg cap er, 10 mg cap er, 15 mg cap er, 20 mg cap er, 25 mg cap er, 30 mg cap er)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (5 mg tablet, 7.5 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>dextroamphetamine sulfate (5 mg/5 ml solution, 5 mg tablet, 5 mg capsule er, 10 mg tablet, 10 mg capsule er, 15 mg capsule er)</i>	1-Covered	
<i>dextroamphetamine/amphetamine 30 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
VYVANSE (10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE, 50 MG CAPSULE, 60 MG CAPSULE, 70 MG CAPSULE)	1-Covered	
ZENZEDI (2.5 MG TABLET, 7.5 MG TABLET, 15 MG TABLET, 20 MG TABLET, 30 MG TABLET)	1-Covered	

Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines

<i>clonidine hcl 0.1 mg tab er 12h</i>	1-Covered	
<i>dexmethylphenidate hcl (2.5 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dexmethylphenidate hcl 20 mg cpbp 50-50</i>	1-Covered	
<i>guanfacine hcl (1 mg tab er, 2 mg tab er, 3 mg tab er, 4 mg tab er)</i>	1-Covered	
<i>methylphenidate hcl (18 mg tab er 24, 27 mg tab er 24, 54 mg tab er 24)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>methylphenidate hcl (2.5 mg tab chew, 5 mg/5 ml solution, 5 mg tab chew, 10 mg/5 ml solution, 10 mg tab chew, 20 mg tablet er)</i>	1-Covered	
<i>methylphenidate hcl (5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>methylphenidate hcl 36 mg tab er 24</i>	1-Covered	QL (2 PER 1 DAYS)
STRATTERA (10 MG CAPSULE, 25 MG CAPSULE, 40 MG CAPSULE)	1-Covered	QL (2 PER 1 DAYS)
STRATTERA (60 MG CAPSULE, 80 MG CAPSULE, 100 MG CAPSULE)	1-Covered	QL (1 PER 1 DAYS)
STRATTERA 18 MG CAPSULE	1-Covered	QL (4 PER 1 DAYS)

Central Nervous System, Other

NUEDEXTA 20-10 MG CAPSULE	1-Covered	
<i>riluzole 50 mg tablet</i>	1-Covered	
<i>tetrabenazine (12.5 mg tablet, 25 mg tablet)</i>	1-Covered	
VECAMYL 2.5 MG TABLET	1-Covered	LA
XENAZINE (12.5 MG TABLET, 25 MG TABLET)	1-Covered	

Fibromyalgia Agents

<i>duloxetine hcl (20 mg capsule dr, 30 mg capsule dr, 40 mg capsule dr, 60 mg capsule dr)</i>	1-Covered	
SAVELLA (12.5 MG TABLET, 25 MG TABLET, 50 MG TABLET, 100 MG TABLET, TITRATION PACK)	1-Covered	

Multiple Sclerosis Agents

AMPYRA ER 10 MG TABLET	1-Covered	FDA (2 / 1 DAYS)
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AUBAGIO (7 MG TABLET, 14 MG TABLET)	1-Covered	PA
AVONEX (30 MCG KT, 30 MCG)	1-Covered	
AVONEX ADMIN PACK 30 MCG VL	1-Covered	
AVONEX PEN (30 ML, 30 ML KIT)	1-Covered	
BETASERON (0.3 MG VIAL, 0.3 MG KIT)	1-Covered	
COPAXONE (20 MG/ML, 40 MG/ML)	1-Covered	
GILENYA 0.5 MG CAPSULE	1-Covered	
GLATOPA 20 MG/ML SYRINGE	1-Covered	
PLEGRIDY PEN (125 MCG/0.5 ML, INJ STARTER PACK)	1-Covered	
TECFIDERA (DR 120 MG CAPSULE, DR 240 MG CAPSULE, STARTER PACK)	1-Covered	PA
TYSABRI 300 MG/15 ML VIAL	1-Covered	

Dental and Oral Agents

<i>cevimeline hcl 30 mg capsule</i>	1-Covered	
<i>chlorhexidine gluconate 0.12 % mouthwash</i>	1-Covered	
PERIOGARD 0.12% ORAL RINSE	1-Covered	
<i>pilocarpine hcl (5 mg tablet, 7.5 mg tablet)</i>	1-Covered	
<i>triamcinolone acetonide 0.1 % paste (g)</i>	1-Covered	

Dermatological Agents

8-MOP 10 MG CAPSULE	1-Covered	
<i>acitretin (10 mg capsule, 17.5 mg capsule, 25 mg capsule)</i>	1-Covered	
<i>adapalene (0.1 % gel (gram), 0.1 % cream (g), 0.3 % gel (gram), 0.3 % gel w/pump)</i>	1-Covered	
ADRUCIL (5 GRAM/100 ML VIAL, 500 MG/10 ML VIAL, 2,500 MG/50 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ammonium lactate (12 % lotion, 12 % cream (g))</i>	1-Covered	
AMNESTEEM (10 MG CAPSULE, 20 MG CAPSULE, 40 MG CAPSULE)	1-Covered	
<i>betamethasone dipropionate 0.05 % lotion</i>	1-Covered	
<i>calcipotriene (0.005 % cream (g), 0.005 % oint. (g), 0.005 % solution)</i>	1-Covered	
<i>calcipotriene/betamethasone 0.005-.064 oint. (g)</i>	1-Covered	
<i>calcitriol 3 mcg/g oint. (g)</i>	1-Covered	
CLARAVIS (10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE)	1-Covered	
<i>clindamycin phosphate/benzoyl peroxide (1 %-5 % gel (gram), 1 %-5 % gel w/pump, 1.2(1)%-5% gel (gram))</i>	1-Covered	
<i>clotrimazole/betamethasone dipropionate (1 % lotion, 1 % cream (g))</i>	1-Covered	
<i>diclofenac sodium 1 % gel (gram)</i>	1-Covered	
ELIDEL 1% CREAM	1-Covered	
<i>erythromycin/benzoyl peroxide 3 %-5 % gel (gram)</i>	1-Covered	
<i>fluorouracil (0.5 % cream (g), 1 g/20 ml vial, 2 % solution, 2.5 g/50ml vial, 5 % solution, 5 g/100 ml vial, 5 % cream (g), 500mg/10ml vial)</i>	1-Covered	
<i>fluticasone propionate (0.005 % oint. (g), 0.05 % lotion, 0.05 % cream (g))</i>	1-Covered	
<i>imiquimod 5 % cream pack</i>	1-Covered	
<i>nystatin/triamcinolone acetonide (cream, oint.)</i>	1-Covered	
<i>podofilox 0.5 % solution</i>	1-Covered	
SANTYL OINTMENT	1-Covered	
<i>selenium sulfide 2.5 % lotion</i>	1-Covered	
<i>tacrolimus (0.03 %, 0.1 %)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TAZORAC (0.05% CREAM, 0.05% GEL, 0.1% GEL, 0.1% CREAM)	1-Covered	
TOLAK 4% CREAM	1-Covered	
<i>tretinoin microspheres (0.04 % gel w/pump, 0.04 % gel (gram), 0.1 % gel (gram), 0.1 % gel w/pump)</i>	1-Covered	
<i>urea 40 % cream (g)</i>	1-Covered	
VOLTAREN 1% GEL	1-Covered	
X-VIATE (CREAM, GEL, LOTION)	1-Covered	
ZONALON 5% CREAM	1-Covered	

Enzyme Replacement/ Modifiers

ADAGEN 250 UNITS/ML VIAL	1-Covered	
ALDURAZYME 2.9 MG/5 ML VIAL	1-Covered	LA
CEREZYME 400 UNITS VIAL	1-Covered	LA
CREON (DR 3,000 CAPSULE, DR 6,000 CAPSULE, DR 12,000 CAPSULE, DR 24,000 CAPSULE, DR 36,000 CAPSULE)	1-Covered	
CYSTADANE POWDER	1-Covered	
CYSTAGON (50 MG CAPSULE, 150 MG CAPSULE)	1-Covered	
FABRAZYME (5 MG VIAL, 35 MG VIAL)	1-Covered	
KANUMA 20 MG/10 ML VIAL	1-Covered	
KUVAN (100 MG TABLET, 100 MG POWDER PACKET, 500 MG POWDER PACKET)	1-Covered	
NAGLAZYME 5 MG/5 ML VIAL	1-Covered	
ORFADIN (2 MG CAPSULE, 5 MG CAPSULE, 10 MG CAPSULE)	1-Covered	
PANCREAZE (DR 4,200 CAP, DR 10,500 CAP, DR 16,800 CAP, DR 21,000 CAP)	1-Covered	
RAVICTI 1.1 GRAM/ML LIQUID	1-Covered	
STRENSIQ (18 MG/0.45 ML VIAL, 28 MG/0.7 ML VIAL, 40 MG/ML VIAL, 80 MG/0.8 ML VIAL)	1-Covered	LA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VPRIV 400 UNITS VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZAVESCA 100 MG CAPSULE	1-Covered	

Gastrointestinal Agents

Antispasmodics, Gastrointestinal

<i>atropine sulfate (0.05mg/ml syringe, 0.1 mg/ml disp syrin, 0.1 mg/ml syringe)</i>	1-Covered
<i>dicyclomine hcl (10 mg capsule, 10 mg/5 ml solution, 20 mg tablet)</i>	1-Covered
<i>glycopyrrolate (0.2 mg/ml vial, 1 mg tablet, 2 mg tablet)</i>	1-Covered
<i>methscopolamine bromide (2.5 mg tablet, 5 mg tablet)</i>	1-Covered
<i>propantheline bromide 15 mg tablet</i>	1-Covered
TRANSDERM-SCOP 1.5 MG/3 DAY	1-Covered
<i>lansoprazole/amoxicilin/clarith 30-500-500 combo. pkg</i>	1-Covered
UCERIS 9 MG ER TABLET	1-Covered

Gastrointestinal Agents, Other

<i>diphenoxylate hcl/atropine sulfate (2.5-.025mg tablet, 2.5-.025/5 liquid)</i>	1-Covered
GATTEX (5 MG ONE-VIAL, 5 MG 30-VIAL)	1-Covered
GAVILYTE-H AND BISACODYL KIT	1-Covered
<i>loperamide hcl 2 mg capsule</i>	1-Covered
RELISTOR (12 ML KIT, 12 ML VIAL)	1-Covered
<i>ursodiol (250 mg tablet, 300 mg capsule, 500 mg tablet)</i>	1-Covered

Histamine2 (H2) Receptor Antagonists

<i>cimetidine (200 mg tablet, 300 mg tablet, 400 mg tablet, 800 mg tablet)</i>	1-Covered
<i>cimetidine hcl 300 mg/5ml solution</i>	1-Covered
<i>famotidine (20 mg tablet, 40mg/5ml oral susp, 40 mg tablet)</i>	1-Covered

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>famotidine in nacl,iso-osm/pf 20 mg/50ml piggyback</i>	1-Covered	
<i>famotidine/pf 20 mg/2 ml vial</i>	1-Covered	
<i>ranitidine hcl (15 mg/ml syrup, 25 mg/ml vial, 50 mg/2 ml vial, 150 mg capsule, 150 mg tablet, 300 mg tablet, 300 mg capsule)</i>	1-Covered	
Irritable Bowel Syndrome Agents		
<i>alosetron hcl (0.5 mg tablet, 1 mg tablet)</i>	1-Covered	
<i>budesonide 3 mg capdr - er</i>	1-Covered	
DELZICOL DR 400 MG CAPSULE	1-Covered	
LINZESS (145 MCG CAPSULE, 290 MCG CAPSULE)	1-Covered	QL (1 PER 1 DAYS)
LOTRONEX (0.5 MG TABLET, 1 MG TABLET)	1-Covered	
VIBERZI (75 MG TABLET, 100 MG TABLET)	1-Covered	
Laxatives		
COLYTE WITH FLAVOR PACKETS	1-Covered	
COLYTE WITH FLAVOR PACKS	1-Covered	
CONSTULOSE 10 GM/15 ML SOLN	1-Covered	
ENULOSE 10 GM/15 ML SOLUTION	1-Covered	
GAVILYTE-C SOLUTION	1-Covered	
GAVILYTE-G SOLUTION	1-Covered	
GAVILYTE-N SOLUTION	1-Covered	
GENERLAC 10 GM/15 ML SOLUTION	1-Covered	
GOLYTELY (PACKET, SOLUTION)	1-Covered	
KRISTALOSE (10 GM, 20 GM)	1-Covered	
<i>lactulose (10 g/15 ml, 20 g/30 ml)</i>	1-Covered	
MOVIPREP POWDER PACKET	1-Covered	
NULYTELY WITH FLAVOR PACKS SOL	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>polyethylene glycol 3350 (3350 17g powd pack, 3350 17g/dose powder)</i>	1-Covered	
<i>sodium chloride/nahco3/kcl/peg 420g soln recon</i>	1-Covered	
TRILYTE WITH FLAVOR PACKETS	1-Covered	

Protectants

CARAFATE 1 GM/10 ML SUSP	1-Covered	
<i>misoprostol (100 mcg tablet, 200 mcg tablet)</i>	1-Covered	
<i>sucralfate 1 g tablet</i>	1-Covered	

Proton Pump Inhibitors

<i>esomeprazole magnesium (20 mg capsule dr, 40 mg capsule dr)</i>	1-Covered	
<i>lansoprazole (15 mg capsule dr, 30 mg capsule dr)</i>	1-Covered	
NEXIUM I.V. 40 MG VIAL	1-Covered	
<i>omeprazole (20 mg capsule dr, 40 mg capsule dr)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>omeprazole 10 mg capsule dr</i>	1-Covered	QL (1 PER 1 DAYS)
<i>omeprazole/sodium bicarbonate (20mg-1.1g capsule, 40mg-1.1g capsule)</i>	1-Covered	
<i>pantoprazole sodium (20 mg tablet dr, 40 mg tablet dr)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>pantoprazole sodium 40 mg vial</i>	1-Covered	
<i>rabeprazole sodium 20 mg tablet dr</i>	1-Covered	

Genitourinary Agents

Antispasmodics, Urinary

<i>darifenacin hydrobromide (7.5 mg tab er, 15 mg tab er)</i>	1-Covered	
<i>flavoxate hcl 100 mg tablet</i>	1-Covered	
MYRBETRIQ (ER 25 MG TABLET, ER 50 MG TABLET)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>oxybutynin chloride (10 mg tab er 24, 15 mg tab er 24)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>oxybutynin chloride 5 mg tab er 24</i>	1-Covered	QL (1 PER 1 DAYS)
<i>oxybutynin chloride 5 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>oxybutynin chloride 5 mg/5 ml syrup</i>	1-Covered	QL (20 PER 1 DAYS)
<i>tolterodine tartrate (1 mg tablet, 2 mg tablet)</i>	1-Covered	
<i>tolterodine tartrate (2 mg cap er, 4 mg cap er)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>tropium chloride (20 mg tablet, 60 mg cap er 24h)</i>	1-Covered	
VESICARE (5 MG TABLET, 10 MG TABLET)	1-Covered	
Benign Prostatic Hypertrophy Agents		
<i>alfuzosin hcl 10 mg tab er 24h</i>	1-Covered	
<i>dutasteride 0.5 mg capsule</i>	1-Covered	QL (1 PER 1 DAYS)
<i>dutasteride/tamsulosin hcl 0.5-0.4 mg cpmp 24hr</i>	1-Covered	QL (1 PER 1 DAYS)
<i>finasteride 5 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
JALYN 0.5-0.4 MG CAPSULE	1-Covered	
<i>tamsulosin hcl 0.4 mg cap er 24h</i>	1-Covered	
Genitourinary Agents, Other		
<i>bethanechol chloride (5 mg tablet, 10 mg tablet, 25 mg tablet, 50 mg tablet)</i>	1-Covered	
DEPEN 250 MG TITRATAB	1-Covered	
ELMIRON 100 MG CAPSULE	1-Covered	
<i>potassium citrate (5 tablet er, 10 tablet er, 15 tablet er)</i>	1-Covered	
UROCIT-K ER 15 MEQ TABLET	1-Covered	
Phosphate Binders		
<i>calcium acetate 667 mg capsule</i>	1-Covered	
ELIPHOS 667 MG TABLET	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FOSRENOL (500 MG TABLET CHEW, 750 MG TABLET CHEW, 750 MG POWDER PACKET, 1,000 MG POWDER PACK, 1,000 MG TABLET CHEW)	1-Covered	
RENAGEL (400 MG TABLET, 800 MG TABLET)	1-Covered	
REVELA 800 MG TABLET	1-Covered	QL (17 PER 1 DAYS)

Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)

A-HYDROCORT 100 MG VIAL	1-Covered	
<i>alclometasone dipropionate (0.05 % oint., 0.05 % cream)</i>	1-Covered	
<i>amcinonide (0.1 % cream (g), 0.1 % lotion, 0.1 % oint. (g))</i>	1-Covered	
<i>betamethasone dipropionate (0.05 % gel (gram), 0.05 % cream (g), 0.05 % oint. (g))</i>	1-Covered	
<i>betamethasone dipropionate/propylene glycol (0.05 % cream (g), 0.05 % oint. (g), 0.05 % lotion)</i>	1-Covered	
<i>betamethasone valerate (0.1 % cream (g), 0.1 % lotion, 0.1 % oint. (g), 0.12 % foam)</i>	1-Covered	
CAPEX SHAMPOO	1-Covered	
<i>clobetasol propionate (0.05 % solution, 0.05 % lotion, 0.05 % shampoo, 0.05 % spray, 0.05 % foam, 0.05 % oint. (g), 0.05 % gel (gram))</i>	1-Covered	
<i>clobetasol propionate/emoll 0.05 % cream (g)</i>	1-Covered	
<i>cortisone acetate 25 mg tablet</i>	1-Covered	
<i>desonide (0.05 % lotion, 0.05 % cream (g), 0.05 % oint. (g))</i>	1-Covered	
DESOWEN 0.05% LOTION	1-Covered	
<i>desoximetasone (0.05 % cream (g), 0.05 % gel (gram), 0.05 % oint. (g), 0.25 % oint. (g), 0.25 % cream (g))</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dexamethasone (0.5 mg tablet, 0.5 mg/5ml elixir, 0.5 mg/5ml solution, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet, 2 mg tablet, 4 mg tablet, 6 mg tablet)</i>	1-Covered	
DEXAMETHASONE INTENSOL 1MG/1ML	1-Covered	
<i>dexamethasone sod phosphate (4 mg/ml vial, 4 mg/ml syringe, 10 mg/ml vial)</i>	1-Covered	
<i>dexamethasone sodium phosp/pf 10 mg/ml vial</i>	1-Covered	
<i>diflorasone diacetate (0.05 % oint., 0.05 % cream)</i>	1-Covered	
<i>fludrocortisone acetate 0.1 mg tablet</i>	1-Covered	
<i>fluocinolone acetonide (0.01 % cream (g), 0.01 % oil, 0.01 % solution, 0.025 % oint. (g), 0.025 % cream (g))</i>	1-Covered	
<i>fluocinolone acetonide oil 0.01 % drops</i>	1-Covered	
<i>fluocinonide (0.05 % gel (gram), 0.05 % solution, 0.05 % oint. (g))</i>	1-Covered	
<i>fluocinonide/emollient base 0.05 % cream (g)</i>	1-Covered	
<i>halobetasol propionate (0.05 % oint., 0.05 % cream)</i>	1-Covered	
HP ACTHAR GEL 80 UNIT/ML VIAL	1-Covered	
<i>hydrocortisone (1 % oint. (g), 1 % cream (g), 2.5 % lotion, 2.5 % cream (g), 2.5 % oint. (g), 5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>hydrocortisone butyrate (0.1 % oint. (g), 0.1 % solution, 0.1 % cream (g))</i>	1-Covered	
<i>hydrocortisone valerate (0.2 % cream, 0.2 % oint.)</i>	1-Covered	
KORLYM 300 MG TABLET	1-Covered	
<i>methylprednisolone (4 mg tablet, 4 mg tab ds pk, 8 mg tablet, 16 mg tablet, 32 mg tablet)</i>	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>methylprednisolone acetate (40 mg/ml vial, 80 mg/ml vial)</i>	1-Covered	
<i>methylprednisolone sodium succinate (40 mg vial, 125 mg vial, 1000 mg vial)</i>	1-Covered	
MILLIPRED 5 MG TABLET	1-Covered	
<i>mometasone furoate (0.1 % cream (g), 0.1 % oint. (g), 0.1 % solution)</i>	1-Covered	
<i>prednisolone 15 mg/5 ml solution</i>	1-Covered	
<i>prednisolone sod phosphate (5 mg/5 ml solution, 10 mg tab rapdis, 15 mg tab rapdis, 15 mg/5 ml solution, 25 mg/5 ml solution, 30 mg tab rapdis)</i>	1-Covered	
<i>prednisone (1 mg tablet, 2.5 mg tablet, 5 mg tablet, 5 mg/5 ml solution, 5 mg tab ds pk, 10 mg tablet, 10 mg tab ds pk, 20 mg tablet, 50 mg tablet)</i>	1-Covered	
PREDNISONE 5 MG/ML SOLUTION	1-Covered	
SOLU-CORTEF (100 MG VIAL, 250 MG VIAL, 500 MG VIAL, 1,000 MG VIAL)	1-Covered	
SOLU-MEDROL (125 MG VIAL, 500 MG VIAL, 1,000 MG VIAL, 2,000 MG VIAL)	1-Covered	
<i>triamcinolone acetonide (0.025 % cream (g), 0.025 % oint. (g), 0.025 % lotion, 0.1 % lotion, 0.1 % oint. (g), 0.1 % cream (g), 0.147mg/g aerosol, 0.5 % oint. (g), 0.5 % cream (g))</i>	1-Covered	

Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)

<i>chorionic gonadotropin, human 10000 unit vial</i>	1-Covered	
<i>desmopressin acetate (0.1 mg tablet, 0.2 mg tablet, 4mcg/ml ampul, 4mcg/ml vial)</i>	1-Covered	
<i>desmopressin acetate (0.1 mg/ml solution, 10/spray spray/pump)</i>	1-Covered	QL (15 PER 23 DAYS)
INCRELEX 40 MG/4 ML VIAL	1-Covered	
MYALEPT 11.3 MG (5 MG/ML) VIAL	1-Covered	PA
NORDITROPIN FLEXPRO (5 MG/1.5, 10 MG/1.5, 15 MG/1.5, 30 MG/3 ML)	1-Covered	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NORDITROPIN NORDIFLEX 30 MG/3	1-Covered	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)		
CYTOTEC 100 MCG TABLET	1-Covered	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
Anabolic Steroids		
ANADROL-50 TABLET	1-Covered	
<i>oxandrolone 10 mg tablet</i>	1-Covered	PA, QL (2 PER 1 DAYS)
<i>oxandrolone 2.5 mg tablet</i>	1-Covered	PA, QL (8 PER 1 DAYS)
Androgens		
ANDROGEL (1.62%(1.25G) GEL PCKT, 1.62% GEL PUMP, 1.62%(2.5G) GEL PCKT)	1-Covered	QL (150 PER 23 DAYS)
ANDROGEL 1%(5G) GEL PACKET	1-Covered	
<i>danazol (50 mg capsule, 100 mg capsule, 200 mg capsule)</i>	1-Covered	
<i>methyltestosterone 10 mg capsule</i>	1-Covered	
<i>testosterone (1.25 g(1%) gel md pmp, 25mg(1%) gel packet, 50 mg (1%) gel (gram), 50 mg (1%) gel packet)</i>	1-Covered	
<i>testosterone enanthate 200 mg/ml vial</i>	1-Covered	
TESTRED 10 MG CAPSULE	1-Covered	
Estrogens		
<i>estradiol (.025mg/24h patch tdwk, .025mg/24h patch tds, .0375mg/24 patch tdwk, .0375mg/24 patch tds, 0.05mg/24h patch tds, 0.05mg/24h patch tdwk, 0.06mg/24h patch tdwk, .075mg/24h patch tdwk, .075mg/24h patch tds, 0.1mg/24hr patch tdwk, 0.1mg/24hr patch tds, 0.5 mg tablet, 1 mg tablet, 2 mg tablet)</i>	1-Covered	PA
<i>estropipate (0.75 mg tablet, 1.5 mg tablet, 3 mg tablet)</i>	1-Covered	PA
MENEST (0.3 MG TABLET, 0.625 MG TABLET, 1.25 MG TABLET, 2.5 MG TABLET)	1-Covered	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PREMARIN (0.3 MG TABLET, 0.45 MG TABLET, 0.625 MG TABLET, 0.9 MG TABLET)	1-Covered	PA, QL (1 PER 1 DAYS)
PREMARIN (25 MG VIAL, VAGINAL CREAM-APPL)	1-Covered	
PREMARIN 1.25 MG TABLET	1-Covered	PA, QL (6 PER 1 DAYS)
VAGIFEM 10 MCG VAGINAL TAB	1-Covered	
APRI 28 DAY TABLET	1-Covered	
ARANELLE 28 TABLET	1-Covered	
AVIANE-28 TABLET	1-Covered	
BALZIVA 28 TABLET	1-Covered	
CRYSSELLE-28 TABLET	1-Covered	
CYCLAFEM (1-35-28 TABLET, 7-7-7-28 TABLET)	1-Covered	
ENPRESSE-28 TABLET	1-Covered	
<i>ethinyl estradiol/drospirenone 0.03mg-3mg tablet</i>	1-Covered	
FEMCON FE (MCON CHEWABLE TABLET, MCON TABLET)	1-Covered	
GILDESS FE 1-20 TABLET	1-Covered	
JUNEL (1 MG-20 MCG TABLET, 1.5 MG-30 MCG TABLET)	1-Covered	
JUNEL FE (1 MG-20 MCG TABLET, 1.5 MG-30 MCG TABLET)	1-Covered	
KARIVA 28 DAY TABLET	1-Covered	
KELNOR 1-35 28 TABLET	1-Covered	
LESSINA-28 TABLET	1-Covered	
LEVORA-28 TABLET	1-Covered	
LOW-OGESTREL-28 TABLET	1-Covered	
LUTERA-28 TABLET	1-Covered	
MICROGESTIN (21 1.5-30 TAB, 21 1-20 TABLET)	1-Covered	
MICROGESTIN FE (1-20 TABLET, 1.5-30 TAB)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MONONESSA 28 TABLET	1-Covered	
NECON (0.5-35-28 TABLET, 1-35-28 TABLET, 7-7-7-28 TABLET, 10-11-28 TABLET)	1-Covered	
NORTREL (0.5-35 TABLET, 1-35 TABLET, 7-7-7-28 TABLET)	1-Covered	
NUVARING VAGINAL RING	1-Covered	QL (1 PER 28 DAYS)
OGESTREL TABLET	1-Covered	
PORTIA-28 TABLET	1-Covered	
PREMPHASE 0.625-5 MG TABLET	1-Covered	PA
PREMPRO (0.3 MG-1.5 MG TABLET, 0.45-1.5 MG TABLET, 0.625-5 MG TABLET, 0.625-2.5 MG TABLET)	1-Covered	PA, QL (1 PER 1 DAYS)
PREVIFEM TABLET	1-Covered	
RECLIPSEN 28 DAY TABLET	1-Covered	
SPRINTEC 28 DAY TABLET	1-Covered	
SRONYX 0.10-0.02 MG TABLET	1-Covered	
TRI-LEGEST FE-28 DAY TABLET	1-Covered	
TRI-LINYAH TABLET	1-Covered	
TRI-PREVIFEM TABLET	1-Covered	
TRI-SPRINTEC TABLET	1-Covered	
TRINESSA TABLET	1-Covered	
TRIVORA-28 TABLET	1-Covered	
VELIVET 28 DAY TABLET	1-Covered	
XULANE PATCH	1-Covered	
YASMIN 28 TABLET	1-Covered	
ZENCHENT 0.4 MG-35 MCG TABLET	1-Covered	
ZOVIA 1-35E TABLET	1-Covered	
ZOVIA 1-50E TABLET	1-Covered	
Progestins		
DEPO-PROVERA 400 MG/ML VIAL	1-Covered	
DEPO-SUBQ PROVERA 104 SYRINGE	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
JOLIVETTE TABLET	1-Covered	
<i>medroxyprogesterone acetate (150 mg/ml vial, 150 mg/ml syringe)</i>	1-Covered	QL (1 PER 68 DAYS)
<i>medroxyprogesterone acetate (2.5 mg tablet, 5 mg tablet, 10 mg tablet)</i>	1-Covered	
MEGACE ES 625 MG/5 ML SUSP	1-Covered	PA
<i>megestrol acetate (20 mg tablet, 40 mg tablet)</i>	1-Covered	
<i>megestrol acetate (400mg/10ml, 625mg/5ml)</i>	1-Covered	PA
<i>norethindrone 0.35 mg tablet</i>	1-Covered	
<i>norethindrone acetate 5 mg tablet</i>	1-Covered	
<i>progesterone, micronized (100 mg capsule, 200 mg capsule)</i>	1-Covered	

Selective Estrogen Receptor Modifying Agents

<i>raloxifene hcl 60 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
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Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)

<i>levothyroxine sodium (25 mcg tablet, 50 mcg tablet, 75 mcg tablet, 88 mcg tablet, 100 mcg tablet, 112 mcg tablet, 125 mcg tablet, 137 mcg tablet, 150 mcg tablet, 175mcg tablet, 200 mcg tablet, 300 mcg tablet)</i>	1-Covered	
<i>liothyronine sodium (5 mcg tablet, 25 mcg tablet, 50 mcg tablet)</i>	1-Covered	
SYNTHROID (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET, 300 MCG TABLET)	1-Covered	
THYROLAR-1 STRENGTH TABLET	1-Covered	
THYROLAR-1/2 STRENGTH TAB	1-Covered	
THYROLAR-1/4 STRENGTH TAB	1-Covered	
THYROLAR-2 STRENGTH TABLET	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
THYROLAR-3 STRENGTH TABLET	1-Covered	
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN 500 MG TABLET	1-Covered	
Hormonal Agents, Suppressant (Parathyroid)		
SENSIPAR (30 MG TABLET, 60 MG TABLET, 90 MG TABLET)	1-Covered	
Hormonal Agents, Suppressant (Pituitary)		
<i>cabergoline 0.5 mg tablet</i>	1-Covered	
ELIGARD (7.5 MG B, 7.5 MG KIT, 22.5 MG B, 22.5 MG KIT, 30 MG B, 30 MG KIT, 45 MG B, 45 MG KIT)	1-Covered	PA
<i>leuprolide acetate 1 mg/0.2ml kit</i>	1-Covered	PA
<i>leuprolide acetate 1 mg/0.2ml vial</i>	1-Covered	
LUPRON DEPOT (3.75 MG, 7.5 MG, 11.25 MG 3MO, 45 MG 6MO)	1-Covered	PA
LUPRON DEPOT 22.5 MG 3MO KIT	1-Covered	PA, QL (1 PER 90 DAYS)
LUPRON DEPOT-4 MONTH KIT	1-Covered	PA, QL (1 PER 120 DAYS)
LUPRON DEPOT-PED (7.5 MG KIT, 11.25 MG 3MO, 11.25 MG KIT, 15 MG KIT)	1-Covered	PA
LUPRON DEPOT-PED 30 MG 3MO KIT	1-Covered	PA, QL (1 PER 120 DAYS)
<i>octreotide acetate (50 mcg/ml vial, 50 mcg/ml ampul, 100 mcg/ml ampul, 100 mcg/ml vial, 200 mcg/ml vial, 500 mcg/ml ampul, 500 mcg/ml vial, 1000mcg/ml vial)</i>	1-Covered	
SANDOSTATIN LAR (10 MG, 20 MG, 30 MG)	1-Covered	
SANDOSTATIN LAR DEPOT (10 MG VL, 10 MG KT, 20 MG VL, 20 MG KT, 30 MG KT, 30 MG VL)	1-Covered	
SIGNIFOR (0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML)	1-Covered	
SIGNIFOR LAR (20 MG VIAL, 20 MG KIT, 40 MG KIT, 40 MG VIAL, 60 MG VIAL, 60 MG KIT)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SOMATULINE DEPOT (60 MG/0.2 ML, 90 MG/0.3 ML, 120 MG/0.5 ML)	1-Covered	
SOMAVERT (10 MG VIAL, 15 MG VIAL, 20 MG VIAL)	1-Covered	
SYNAREL 2 MG/ML NASAL SPRAY	1-Covered	

Hormonal Agents, Suppressant (Thyroid)

Antithyroid Agents

<i>methimazole (5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>propylthiouracil 50 mg tablet</i>	1-Covered	

Immunological Agents

Angioedema (HAE) Agents

CINRYZE 500 UNIT VIAL	1-Covered	LA
FIRAZYR 30 MG/3 ML SYRINGE	1-Covered	

Immune Suppressants

AFINITOR 2.5 MG TABLET	1-Covered	
AFINITOR DISPERZ (2 MG TABLET, 3 MG TABLET, 5 MG TABLET)	1-Covered	
ASTAGRAF XL (0.5 MG CAPSULE, 1 MG CAPSULE, 5 MG CAPSULE)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ATGAM 50 MG/ML AMPUL	1-Covered	
AZASAN (75 MG TABLET, 100 MG TABLET)	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>azathioprine 50 mg tablet</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>azathioprine sodium 100 mg vial</i>	1-Covered	
BENLYSTA (120 MG VIAL, 400 MG VIAL)	1-Covered	
<i>cyclosporine (25 mg capsule, 100 mg capsule, 250 mg/5ml vial, 250 mg/5ml ampul)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine, modified (25 mg capsule, 50 mg capsule, 100 mg/ml solution, 100 mg capsule)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENBREL (25 MG/0.5 ML SYRINGE, 50 MG/ML SYRINGE, 50 MG/ML SURECLICK SYR)	1-Covered	PA
ENBREL 25 MG KIT	1-Covered	PA, QL (8 PER 28 DAYS)
ENVARUSUS XR (0.75 MG TABLET, 1 MG TABLET, 4 MG TABLET)	1-Covered	PA - TO CONFIRM PART D COVERAGE
HUMIRA (10 MG/0.2 ML, 40 MG/0.8 ML)	1-Covered	PA
HUMIRA 20 MG/0.4 ML SYRINGE	1-Covered	PA, QL (2 PER 28 DAYS)
HUMIRA 40 MG/0.8 ML PEN	1-Covered	PA
HUMIRA PEDIATRIC CROHN'S START	1-Covered	PA
HUMIRA PEN CROHN'S-UC-HS START	1-Covered	PA
HUMIRA PEN PSORIASIS START PK	1-Covered	PA
KINERET 100 MG/0.67 ML SYRINGE	1-Covered	
<i>mercaptopurine 50 mg tablet</i>	1-Covered	
<i>methotrexate sodium (2.5 mg tablet, 25 mg/ml vial)</i>	1-Covered	
<i>methotrexate sodium/pf (1 g vial, 25 mg/ml vial)</i>	1-Covered	
<i>mycophenolate mofetil (200 mg/ml susp recon, 250 mg capsule, 500 mg tablet)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate sodium (180 mg tablet dr, 360 mg tablet dr)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
NULOJIX 250 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
ORENCIA (125 MG/ML SYRINGE, 250 MG VIAL)	1-Covered	PA
OTREXUP (7.5 ML AUTO-INJ, 10 ML AUTO-INJ, 15 ML AUTO-INJ, 17.5 ML AUTOINJ, 20 ML AUTO-INJ, 22.5 ML AUTOINJ, 25 ML AUTO-INJ)	1-Covered	
PROGRAF 5 MG/ML AMPULE	1-Covered	PA - TO CONFIRM PART D COVERAGE
RAPAMUNE 1 MG/ML ORAL SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RASUVO (7.5 MG/0.15 ML, 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 27.5 MG/0.55 ML, 30 MG/0.6 ML)	1-Covered	
REMICADE 100 MG VIAL	1-Covered	
RHEUMATREX 2.5 MG TABLET	1-Covered	
SANDIMMUNE 100 MG/ML SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
SIMULECT (10 MG VIAL, 20 MG VIAL)	1-Covered	
<i>sirolimus (0.5 mg tablet, 1 mg tablet, 2 mg tablet)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>tacrolimus (0.5 mg capsule, 1 mg capsule, 5 mg capsule)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
TORISEL 25 MG KIT	1-Covered	
TREXALL (5 MG TABLET, 7.5 MG TABLET, 10 MG TABLET, 15 MG TABLET)	1-Covered	
ZORTRESS (0.25 MG TABLET, 0.5 MG TABLET, 0.75 MG TABLET)	1-Covered	PA - TO CONFIRM PART D COVERAGE

Immunizing Agents, Passive

CARIMUNE NF NANOFILTERED (3 GM VIAL, 6 GM VIAL, 12 GM VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMASTAN S-D VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAGARD LIQUID 10% VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAGARD S-D (2.5 GM VL W/ST, 5 G (IGA<1) SOLN, 5 GM VL W/SET, 10 G (IGA<1) SOL, 10 GM VL W/ST)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAPLEX 5% VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMUNEX-C (1 GRAM/10 ML VIAL, 2.5 GRAM/25 ML VIAL, 5 GRAM/50 ML VIAL, 10 GRAM/100 ML VIAL, 20 GRAM/200 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMUNEX-C 40 GRAM/400 ML VIAL	1-Covered	
HYPERRAB S-D 150 UNITS/ML VIAL	1-Covered	
PRIVIGEN 10% VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
THYMOGLOBULIN 25 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VARIZIG 125 UNIT/1.2 ML VIAL	1-Covered	
ARAVA (10 MG TABLET, 20 MG TABLET)	1-Covered	
SYNAGIS (50 MG/0.5 ML VIAL, 100 MG/1 ML VIAL)	1-Covered	PA, LA

Immunomodulators

ACTEMRA (80 MG/4 ML VIAL, 200 MG/10 ML VIAL, 400 MG/20 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ACTIMMUNE 100 MCG/0.5 ML VIAL	1-Covered	LA
ARCALYST 220 MG INJECTION	1-Covered	LA
ILARIS 180 MG VIAL	1-Covered	
<i>leflunomide 10 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>leflunomide 20 mg tablet</i>	1-Covered	QL (5 PER 1 DAYS)
RIDAURA 3 MG CAPSULE	1-Covered	

Vaccines

ACTHIB (VIAL, WITH DILUENT)	1-Covered	
ADACEL TDAP SYRINGE	1-Covered	QL (1 PER 1 OVER TIME)
ADACEL TDAP VIAL	1-Covered	
<i>bcg vaccine, live/pf 50 mg vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
BEXSERO PREFILLED SYRINGE	1-Covered	
BOOSTRIX TDAP (SYRINGE, VIAL)	1-Covered	
CERVARIX VACCINE SYRINGE	1-Covered	
COMVAX VACCINE VIAL	1-Covered	
DAPTACEL DTAP VACCINE	1-Covered	
ENGERIX-B ADULT (20 MCG/ML SYRN, 20 MCG/ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ENGERIX-B PEDIATRIC-ADOLESCENT (10 ML PED VL, PEDI 10 SYRN)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL (SYRINGE, VIAL)	1-Covered	
GARDASIL 9 (9 VIAL, 9 SYRINGE)	1-Covered	
HAVRIX (720 UNITS/0.5 ML VIAL, 720 UNIT/0.5 ML SYRINGE, 1,440 UNITS/ML VIAL)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMOVAX RABIES VACCINE (VACCINE VIAL, VACCINE+DILUENT)	1-Covered	
INFANRIX DTAP VIAL	1-Covered	
IPOLE (SINGLE DOSE SYRINGE, VIAL)	1-Covered	
IXIARO 6 MCG/0.5 ML SYRINGE	1-Covered	
M-M-R II VACCINE (VIAL, WITH DILUENT)	1-Covered	
MENACTRA VIAL	1-Covered	
MENHIBRIX VACCINE VIAL	1-Covered	
MENOMUNE-A-C-Y-W-135 VIAL	1-Covered	
MENVEO A-C-Y-W-135-DIP VIAL KT	1-Covered	
PEDVAXHIB VACCINE VIAL	1-Covered	
PENTACEL ACTHIB COMPONENT VIAL	1-Covered	
PROQUAD VIAL	1-Covered	
QUADRACEL DTAP-IPV VIAL	1-Covered	
RABAVERT RABIES VACCINE VIAL	1-Covered	
RECOMBIVAX HB (5 MCG/0.5 ML SYR, 5 MCG/0.5 ML VL, 10 MCG/ML VIAL, 10 MCG/ML SYR, 40 MCG/ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ROTARIX VACCINE SUSPENSION	1-Covered	
ROTATEQ VACCINE	1-Covered	
TENIVAC SYRINGE	1-Covered	
<i>tetanus, diphtheria tox, adult 2-2 lf/0.5 vial</i>	1-Covered	
<i>tetanus, diphtheria tox d ped/pf 5-25/0.5ml vial</i>	1-Covered	
TRUMENBA 120 MCG/0.5 ML VACCIN	1-Covered	
TWINRIX VACCINE VIAL	1-Covered	
TYPHIM VI (25 ML SYRNG, 25 ML AL)	1-Covered	
VAQTA (25 UNITS/0.5 ML, 50 UNITS/ML)	1-Covered	
VARIVAX VACCINE (VIAL, WITH DILUENT)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
YF-VAX (1 VIAL, 5 VIAL)	1-Covered	
ZOSTAVAX VIAL	1-Covered	

Inflammatory Bowel Disease Agents

Aminosalicylates

APRISO ER 0.375 GRAM CAPSULE	1-Covered	
<i>balsalazide disodium 750 mg capsule</i>	1-Covered	
DIPENTUM 250 MG CAPSULE	1-Covered	
<i>mesalamine w/cleansing wipes 4 g/60 ml enema kit</i>	1-Covered	
PENTASA (250 MG CAPSULE, 500 MG CAPSULE)	1-Covered	QL (8 PER 1 DAYS)

Glucocorticoids

COLOCORT 100 MG ENEMA	1-Covered	
<i>hydrocortisone (1 % cream (g), 2.5 % cream/appl, 100mg/60ml enema)</i>	1-Covered	
PROCTOSOL-HC 2.5% CREAM	1-Covered	
PROCTOZONE-HC 2.5% CREAM	1-Covered	
SOLU-MEDROL (40 MG VIAL, 125 MG VIAL)	1-Covered	

Sulfonamides

<i>sulfasalazine 500 mg tablet</i>	1-Covered	QL (8 PER 1 DAYS)
<i>sulfasalazine 500 mg tablet dr</i>	1-Covered	

Metabolic Bone Disease Agents

<i>alendronate sodium (35 mg tablet, 70 mg tablet)</i>	1-Covered	QL (1 PER 7 DAYS)
<i>alendronate sodium (5 mg tablet, 10 mg tablet, 40 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>alendronate sodium 70 mg/75ml solution</i>	1-Covered	
AELVIA DR 35 MG TABLET	1-Covered	
BINOSTO 70 MG TABLET EFF	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>calcitonin, salmon, synthetic 200/spray spray/pump</i>	1-Covered	
<i>calcitriol (0.25 mcg capsule, 0.5 mcg capsule, 1 mcg/ml solution, 1 mcg/ml ampul)</i>	1-Covered	
<i>doxercalciferol (0.5 mcg capsule, 1 mcg capsule, 2.5 mcg capsule, 4mcg/2ml ampul, 4mcg/2ml vial)</i>	1-Covered	
<i>etidronate disodium (200 mg tablet, 400 mg tablet)</i>	1-Covered	
FORTEO 600 MCG/2.4 ML PEN INJ	1-Covered	
<i>ibandronate sodium (3 mg/3 ml syringe, 150 mg tablet)</i>	1-Covered	
<i>ibandronate sodium 3 mg/3 ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
MIACALCIN (200 UNIT/ML VIAL, 400 UNIT/2 ML VIAL)	1-Covered	
NATPARA (25 MCG, 50 MCG, 75 MCG, 100 MCG)	1-Covered	
<i>pamidronate disodium (30 mg vial, 30mg/10ml vial, 60 mg/10ml vial, 90 mg vial, 90 mg/10ml vial)</i>	1-Covered	
PROLIA 60 MG/ML SYRINGE	1-Covered	
<i>risedronate sodium (5 mg tablet, 30 mg tablet, 35 mg tablet dr, 35 mg tablet, 150 mg tablet)</i>	1-Covered	
XGEVA 120 MG/1.7 ML VIAL	1-Covered	
<i>zoledronic acid in mannitol & water for injection (5 infus. btl, 5 piggyback)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

Ophthalmic Agents

<i>bacitracin/polymyxin b sulfate 500-10k/g oint. (g)</i>	1-Covered
BLEPHAMIDE EYE DROPS	1-Covered
BLEPHAMIDE EYE OINTMENT	1-Covered
<i>neomycin su/baci zn/poly/hc 3.5-10k-1 oint. (g)</i>	1-Covered
<i>neomycin su/bacitra/polymyxin 3.5mg-400 oint. (g)</i>	1-Covered

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>neomycin/polymyxin b sulf/hc 3.5-10k-10 drops susp</i>	1-Covered	
<i>neomycin/polymyxin b sulfate/dexamethasone (0.1 % drops susp, 3.5-10k-.1 oint. (g))</i>	1-Covered	
<i>neomycin/polymyxn b/gramicidin 1.75mg-10k drops</i>	1-Covered	
POLYCIN EYE OINTMENT	1-Covered	
<i>polymyxin b sulf/trimethoprim 10000-1/ml drops</i>	1-Covered	
<i>prednisolone acetate 1 % drops susp</i>	1-Covered	
<i>sulfacetamide sodium 10 % oint. (g)</i>	1-Covered	
<i>sulfacetamide/prednisolone sp 10 %-0.23% drops</i>	1-Covered	
<i>tobramycin/dexamethasone 0.3 %-0.1% drops susp</i>	1-Covered	
Ophthalmic Agents, Other		
<i>atropine sulfate 1 % drops</i>	1-Covered	
<i>cyclopentolate hcl (1 % drops, 2 % drops)</i>	1-Covered	
<i>naphazoline hcl 0.1 % drops</i>	1-Covered	
<i>proparacaine hcl 0.5 % drops</i>	1-Covered	
RESTASIS 0.05% EYE EMULSION	1-Covered	QL (2 PER 1 DAYS)
<i>tropicamide (0.5 % drops, 1 % drops)</i>	1-Covered	
Ophthalmic Anti-allergy Agents		
ALOCRIL 2% EYE DROPS	1-Covered	
ALOMIDE 0.1% EYE DROPS	1-Covered	
<i>azelastine hcl 0.05 % drops</i>	1-Covered	
<i>cromolyn sodium 4 % drops</i>	1-Covered	
<i>epinastine hcl 0.05 % drops</i>	1-Covered	
<i>olopatadine hcl 0.1 % drops</i>	1-Covered	QL (5 PER 22 DAYS)

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Ophthalmic Anti-inflammatories		
ALREX 0.2% EYE DROPS	1-Covered	
<i>bromfenac sodium 0.09% drops</i>	1-Covered	
<i>dexamethasone sod phosphate 0.1 % drops</i>	1-Covered	
<i>diclofenac sodium 0.1 % drops</i>	1-Covered	
DUREZOL 0.05% EYE DROPS	1-Covered	
FLAREX 0.1% EYE DROPS	1-Covered	
<i>fluorometholone 0.1 % drops susp</i>	1-Covered	
<i>flurbiprofen sodium 0.03 % drops</i>	1-Covered	
FML FORTE 0.25% EYE DROPS	1-Covered	
FML LIQUIFILM 0.1% EYE DROP	1-Covered	
FML S.O.P. 0.1% OINTMENT	1-Covered	
ILEVRO 0.3% OPHTH DROPS	1-Covered	
<i>ketorolac tromethamine 0.4 % drops</i>	1-Covered	
<i>ketorolac tromethamine 0.5 % drops</i>	1-Covered	QL (5 PER 18 DAYS)
PRED MILD 0.12% EYE DROPS	1-Covered	
<i>prednisolone sod phosphate 1 % drops</i>	1-Covered	
PROLENSA 0.07% EYE DROPS	1-Covered	
VEXOL 1% EYE DROPS	1-Covered	
Ophthalmic Antiglaucoma Agents		
ALPHAGAN P 0.1% DROPS	1-Covered	
<i>apraclonidine hcl 0.5 % drops</i>	1-Covered	
AZOPT 1% EYE DROPS	1-Covered	
<i>betaxolol hcl 0.5 % drops</i>	1-Covered	
<i>bimatoprost 0.03 % drops</i>	1-Covered	
<i>brimonidine tartrate (0.15 % drops, 0.2 % drops)</i>	1-Covered	
<i>carteolol hcl 1 % drops</i>	1-Covered	
<i>dorzolamide hcl 2 % drops</i>	1-Covered	QL (10 PER 18 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dorzolamide hcl/timolol maleat 22.3-6.8/1 drops</i>	1-Covered	QL (10 PER 18 DAYS)
<i>levobunolol hcl 0.5 % drops</i>	1-Covered	
<i>metipranolol 0.3 % drops</i>	1-Covered	
<i>pilocarpine hcl (1 % drops, 2 % drops, 4 % drops)</i>	1-Covered	
SIMBRINZA 1%-0.2% EYE DROPS	1-Covered	
<i>timolol maleate (0.25 % drops, 0.25 % sol-gel, 0.5 % sol-gel, 0.5 % drops)</i>	1-Covered	
<i>travoprost (benzalkonium) 0.004 % drops</i>	1-Covered	

Ophthalmic Prostaglandin and Prostaglandin Analogs

<i>latanoprost 0.005 % drops</i>	1-Covered	QL (2.5 PER 18 DAYS)
LUMIGAN 0.01% EYE DROPS	1-Covered	
TRAVATAN Z 0.004% EYE DROP	1-Covered	QL (5 PER 18 DAYS)

Otic Agents

<i>acetic acid/hydrocortisone 2 %-1 % drops</i>	1-Covered	
CIPRODEX OTIC SUSPENSION	1-Covered	
CORTISPORIN-TC EAR SUSPENSION	1-Covered	
<i>neomycin sulfate/polymyxin b sulfate/hydrocortisone (drops susp, solution)</i>	1-Covered	

Respiratory Tract/ Pulmonary Agents

Anti-inflammatories, Inhaled Corticosteroids

AEROSPAN 80 MCG INHALER	1-Covered	
<i>budesonide 0.25mg/2ml ampul-neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)
<i>budesonide 0.5 mg/2ml ampul-neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (4 PER 1 DAYS)
<i>budesonide 1 mg/2 ml ampul-neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (2 PER 1 DAYS)

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>budesonide 32mcg spray/pump</i>	1-Covered	
FLOVENT DISKUS (50 MCG, 100 MCG, 250 MCG)	1-Covered	QL (80 PER 20 DAYS)
FLOVENT HFA (44 MCG, 110 MCG, 220 MCG)	1-Covered	
<i>fluticasone propionate 50 mcg spray susp</i>	1-Covered	QL (16 PER 20 DAYS)
<i>mometasone furoate 50 mcg spray/pump</i>	1-Covered	
NASONEX 50 MCG NASAL SPRAY	1-Covered	
PULMICORT 1 MG/2 ML RESPULE	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (2 PER 1 DAYS)
PULMICORT FLEXHALER (90 MCG, 180 MCG)	1-Covered	
QVAR (40 MCG, 80 MCG)	1-Covered	
<i>triamcinolone acetonide 55 mcg spray</i>	1-Covered	

Antihistamines

<i>azelastine hcl (137 mcg, 205.5mcg)</i>	1-Covered	
<i>carbinoxamine maleate (4 mg tablet, 4 mg/5 ml liquid)</i>	1-Covered	PA
<i>clemastine fumarate (0.67mg/5ml syrup, 2.68 mg tablet)</i>	1-Covered	PA
<i>cyproheptadine hcl (2 mg/5 ml syrup, 4 mg/10 ml syrup, 4 mg tablet)</i>	1-Covered	PA
<i>desloratadine (2.5 mg tab rapdis, 5 mg tablet, 5 mg tab rapdis)</i>	1-Covered	
<i>levocetirizine dihydrochloride (2.5 mg/5ml solution, 5 mg tablet)</i>	1-Covered	
<i>olopatadine hcl 0.6 % spray/pump</i>	1-Covered	

Antileukotrienes

<i>montelukast sodium (4 mg gran pack, 4 mg tab chew, 5 mg tab chew, 10 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>zafirlukast 10 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>zafirlukast 20 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Bronchodilators, Anticholinergic		
ATROVENT HFA INHALER	1-Covered	
<i>ipratropium bromide (21 mcg, 42 mcg)</i>	1-Covered	
<i>ipratropium bromide 0.2 mg/ml solution</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (15 PER 1 DAYS)
PROAIR RESPICLICK INHAL POWDER	1-Covered	
SPIRIVA 18 MCG CP-HANDIHALER	1-Covered	
SPIRIVA RESPIMAT (1.25 MCG, 2.5 MCG)	1-Covered	
TUDORZA PRESSAIR 400 MCG INH	1-Covered	
Bronchodilators, Sympathomimetic		
ADRENALIN 1 MG/ML VIAL	1-Covered	
ADRENALIN CL 1 MG/ML VIAL	1-Covered	
<i>albuterol sulfate (0.63mg/3ml vial-neb, 1.25mg/3ml vial-neb, 2.5 mg/3ml vial-neb, 2.5 mg/0.5 vial-neb, 5 mg/ml solution)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>albuterol sulfate (2 mg/5 ml syrup, 2 mg tablet, 4 mg tab er 12h, 4 mg tablet, 8 mg tab er 12h)</i>	1-Covered	
AUVI-Q (0.15 MG, 0.3 MG)	1-Covered	
DULERA 100 MCG/5 MCG INHALER	1-Covered	QL (13.3 PER 30 DAYS)
DULERA 200 MCG/5 MCG INHALER	1-Covered	QL (13 PER 30 DAYS)
<i>epinephrine (0.15/0.15, 0.3mg/0.3)</i>	1-Covered	
EPIPEN 2-PAK 0.3 MG AUTO-INJCT	1-Covered	
EPIPEN JR 2-PAK 0.15 MG INJCTR	1-Covered	
<i>levalbuterol hcl (0.31mg/3ml, 0.63mg/3ml, 1.25mg/0.5, 1.25mg/3ml)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>metaproterenol sulfate (10 mg tablet, 10 mg/5 ml syrup, 20 mg tablet)</i>	1-Covered	
PROAIR HFA 90 MCG INHALER	1-Covered	
PROVENTIL HFA 90 MCG INHALER	1-Covered	
SEREVENT DISKUS 50 MCG	1-Covered	QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
STRIVERDI RESPIMAT INHAL SPRAY	1-Covered	
<i>terbutaline sulfate (2.5 mg tablet, 5 mg tablet)</i>	1-Covered	
VENTOLIN HFA 90 MCG INHALER	1-Covered	QL (36 PER 30 DAYS)
XOPENEX HFA 45 MCG INHALER	1-Covered	
Cystic Fibrosis Agents		
CAYSTON 75 MG INHAL SOLUTION	1-Covered	
KALYDECO (50 MG GRANULES PACKET, 75 MG GRANULES PACKET, 150 MG TABLET)	1-Covered	PA
Mast Cell Stabilizers		
<i>cromolyn sodium 20 mg/2 ml ampul- neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)
<i>cromolyn sodium 20 mg/ml oral conc</i>	1-Covered	
Phosphodiesterase Inhibitors, Airways Disease		
<i>aminophylline (250mg/10ml vial, 250mg/10ml ampul, 500mg/20ml vial, 500mg/20ml ampul)</i>	1-Covered	
DALIRESP 500 MCG TABLET	1-Covered	
ELIXOPHYLLIN 80 MG/15 ML ELIX	1-Covered	
<i>theophylline anhydrous (80 mg/15ml elixir, 80 mg/15ml solution, 100 mg tab er 12h, 200 mg tab er 12h, 300 mg tab er 12h, 400 mg tablet er, 450 mg tab er 12h, 600 mg tablet er)</i>	1-Covered	
Pulmonary Antihypertensives		
ADCIRCA 20 MG TABLET	1-Covered	PA
ADEMPAS (0.5 MG TABLET, 1 MG TABLET, 1.5 MG TABLET, 2 MG TABLET, 2.5 MG TABLET)	1-Covered	
LETAIRIS (5 MG TABLET, 10 MG TABLET)	1-Covered	PA, LA
OPSUMIT 10 MG TABLET	1-Covered	
REMODULIN (1 MG/ML VIAL, 2.5 MG/ML VIAL, 5 MG/ML VIAL, 10 MG/ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REVATIO 10 MG/ML ORAL SUSP	1-Covered	PA
<i>sildenafil citrate (10 mg/12.5 vial, 20 mg tablet)</i>	1-Covered	PA
TRACLEER (62.5 MG TABLET, 125 MG TABLET)	1-Covered	PA, LA
Respiratory Tract Agents, Other		
<i>acetylcysteine (100 mg/ml vial, 200 mg/ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
ANORO ELLIPTA 62.5-25 MCG INH	1-Covered	
ARALAST NP (500 MG VIAL, 1,000 MG VIAL)	1-Covered	
BREO ELLIPTA 200-25 MCG INH	1-Covered	
ESBRIET 267 MG CAPSULE	1-Covered	PA
GLASSIA 1 GM/50 ML VIAL	1-Covered	
GRASTEK 2,800 BAU SL TABLET	1-Covered	
LUMIZYME 50 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, LA
OFEV (100 MG CAPSULE, 150 MG CAPSULE)	1-Covered	
ORALAIR (300 IR STARTER PACK, 300 IR SUBLINGUAL TAB, 300 IR ADULT SAMPLE KT)	1-Covered	
PROLASTIN C 1,000 MG VIAL	1-Covered	
RAGWITEK SUBLINGUAL TABLET	1-Covered	
STIOLTO RESPIMAT INHAL SPRAY	1-Covered	
TYZINE PEDIATRIC 0.05% DROP	1-Covered	
ZEMAIRA 1,000 MG VIAL	1-Covered	
ADVAIR DISKUS (100-50, 250-50, 500-50)	1-Covered	
ADVAIR HFA (45-21 MCG, 115-21 MCG, 230-21 MCG)	1-Covered	
COMBIVENT RESPIMAT INHAL SPRAY	1-Covered	QL (4 PER 23 DAYS)
<i>ipratropium/albuterol sulfate 0.5-3mg/3 ampul-neb</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>phenylephrine hcl/prometh hcl 5-6.25mg/5 syrup</i>	1-Covered	PA
PULMOZYME 1 MG/ML AMPUL	1-Covered	PA - TO CONFIRM PART D COVERAGE
SYMBICORT (80-4.5 MCG, 160-4.5 MCG)	1-Covered	
XOLAIR 150 MG VIAL	1-Covered	PA, LA

Skeletal Muscle Relaxants

<i>carisoprodol (250 mg tablet, 350 mg tablet)</i>	1-Covered	PA, QL (4 PER 1 DAYS)
<i>chlorzoxazone 500 mg tablet</i>	1-Covered	PA
<i>cyclobenzaprine hcl 10 mg tablet</i>	1-Covered	PA, QL (3 PER 1 DAYS)
<i>cyclobenzaprine hcl 5 mg tablet</i>	1-Covered	PA, QL (6 PER 1 DAYS)
<i>metaxalone 800 mg tablet</i>	1-Covered	PA
<i>methocarbamol (500 mg tablet, 750 mg tablet)</i>	1-Covered	PA
<i>orphenadrine citrate 100 mg tablet er</i>	1-Covered	PA

Sleep Disorder Agents

GABA Receptor Modulators

<i>eszopiclone (1 mg tablet, 2 mg tablet, 3 mg tablet)</i>	1-Covered	PA
<i>temazepam (15 mg capsule, 30 mg capsule)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>zaleplon (5 mg capsule, 10 mg capsule)</i>	1-Covered	PA
<i>zolpidem tartrate 10 mg tablet</i>	1-Covered	PA, QL (1 PER 1 DAYS)
<i>zolpidem tartrate 5 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)

Sleep Disorders, Other

HETLIOZ 20 MG CAPSULE	1-Covered	
NUVIGIL (50 MG TABLET, 150 MG TABLET, 200 MG TABLET, 250 MG TABLET)	1-Covered	PA
ROZEREM 8 MG TABLET	1-Covered	
XYREM 500 MG/ML ORAL SOLUTION	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>zolpidem tartrate (1.75 mg tab, 3.5 mg tab)</i>	1-Covered	
<i>zolpidem tartrate (6.25 mg tab, 12.5 mg tab)</i>	1-Covered	PA

Therapeutic Nutrients/ Minerals/ Electrolytes

Electrolyte/ Mineral Modifiers

CHEMET 100 MG CAPSULE	1-Covered
EXJADE (125 MG TABLET, 250 MG TABLET, 500 MG TABLET)	1-Covered
FERRIPROX (100 MG/ML SOLUTION, 500 MG TABLET)	1-Covered
KIONEX (15 GM/60 ML SUSPENSION, POWDER)	1-Covered
<i>sodium polystyrene sulfonate (15 g/60 ml oral susp, 30g/120ml enema, 50g/200ml enema, powder)</i>	1-Covered
SYPRINE 250 MG CAPSULE	1-Covered
VELTASSA (8.4 GM, 16.8 GM, 25.2 GM)	1-Covered

Electrolyte/ Mineral Replacement

<i>0.9 % sodium chloride (0.9 % 0.9 % iv soln, 0.9 % pggybk prt, 0.9 % 0.9 % vial, 0.9 % pgy vl prt)</i>	1-Covered
CARBAGLU 200 MG DISPER TABLET	1-Covered
DENTA 5000 PLUS CREAM	1-Covered
FLUOR-A-DAY (0.25 MG TAB, 0.5 MG TAB, 1 MG TABLET)	1-Covered
FLUORITAB (0.5 MG TABLET, 1 MG TABLET)	1-Covered
K-TAB ER (ER 8 TABLET, ER 10 TABLET, ER 20 TABLET)	1-Covered
KLOR-CON 10 MEQ TABLET	1-Covered
KLOR-CON 8 MEQ TABLET	1-Covered
KLOR-CON M10 TABLET	1-Covered
KLOR-CON M15 TABLET	1-Covered

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
KLOR-CON M20 TABLET	1-Covered	
KLOR-CON SPRINKLE (ER 8 CAP, ER 10 CP)	1-Covered	
LUDENT FLUORIDE (0.25 MG TB CHW, 0.5 MG TB CHEW, 1 MG TAB CHEW)	1-Covered	
<i>magnesium sulfate 4 meq/ml syringe</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>magnesium sulfate 4 meq/ml vial</i>	1-Covered	
NORMOSOL-R PH 7.4 IV SOLUTION	1-Covered	
PLASMA-LYTE 148 IV SOLUTION	1-Covered	
PLASMA-LYTE A PH 7.4 SOLN.	1-Covered	
<i>potassium chloride (2 vial, 2 iv soln)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>potassium chloride (8 meq capsule er, 8 meq tablet er, 10 meq tab er prt, 10 meq capsule er, 10meq/50ml piggyback, 10 meq tablet er, 10meq/0.1l piggyback, 20meq/50ml piggyback, 20 meq packet, 20meq/15ml liquid, 20meq/0.1l piggyback, 20 meq tablet er, 20 meq tab er prt, 40meq/0.1l piggyback, 40meq/15ml liquid)</i>	1-Covered	
<i>potassium chloride in 0.9 % sodium chloride (20 soln, 40 soln)</i>	1-Covered	
<i>potassium chloride-0.45% nacl 20 meq/l iv soln</i>	1-Covered	
PREVIDENT 1.1% GEL	1-Covered	
PREVIDENT 5000 SENSITIVE PASTE	1-Covered	
SF 1.1% GEL	1-Covered	
<i>sodium chloride 0.45 % (0.45 % pgybk prt, 0.45 % 0.45 % iv soln)</i>	1-Covered	
<i>sodium chloride 2.5 meq/ml vial</i>	1-Covered	
<i>sodium chloride 3 % 3 % iv soln</i>	1-Covered	
<i>sodium chloride 5 % 5 % iv soln</i>	1-Covered	
<i>sodium chloride irrig solution 0.9 % irrig soln</i>	1-Covered	
<i>sodium fluoride (0.25(0.55) tab, 0.5(1.1)mg tab, 1mg(2.2mg) tab)</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ACTIVE OB SOFTGEL	1-Covered	
AMINOSYN 8.5%-ELECTROLYTES SOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN II (7%, 8.5%, 10%, 15%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN II 8.5%-ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
ATABEX EC CAPLET	1-Covered	
BAL-CARE DHA COMBO PACK	1-Covered	
BAL-CARE DHA ESSENTIAL PACK	1-Covered	
C-NATE DHA SOFTGEL	1-Covered	
CADEAU DHA SOFTGEL	1-Covered	
CALCIUM-PNV 28-1-250 MG SFTGL	1-Covered	
CAVAN-EC SOD DHA VITAMINS	1-Covered	
CITRANATAL 90 DHA COMBO PACK	1-Covered	
CITRANATAL ASSURE COMBO PACK	1-Covered	
CITRANATAL B-CALM COMBO PACK	1-Covered	
CITRANATAL DHA PACK	1-Covered	
CITRANATAL HARMONY CAPSULE	1-Covered	
CITRANATAL RX TABLET	1-Covered	
CLINIMIX (2.75%-5%, 4.25%-5%, 4.25%-25%, 4.25%-20%, 4.25%-10%, 5%-20%, 5%-25%, 5%-15%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E (4.25%-5%, 5%-20%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
COMPLETE NATAL DHA	1-Covered	
COMPLETENATE TABLET CHEW	1-Covered	
CONCEPT DHA CAPSULE	1-Covered	
CONCEPT OB CAPSULE	1-Covered	
<i>dextrose 10 % and 0.2 % nacl 10 %-0.2 % dehp fr bg</i>	1-Covered	
<i>dextrose 10 % and 0.45 % nacl 10%- 0.45% iv soln</i>	1-Covered	
<i>dextrose 10 % in water (10 % 10 % iv soln, 10 % 10 % dehp fr bg)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>dextrose 2.5 % and 0.45 % nacl 2.5%- 0.45% iv soln</i>	1-Covered	

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on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dextrose 5 % and 0.3 % nacl 5 %-0.3 % iv soln</i>	1-Covered	
<i>dextrose 5 % and 0.9 % nacl 5 %-0.9 % iv soln</i>	1-Covered	
<i>dextrose 5 % in water (5 % 5 % iv soln, 5 % pgy vl prt, 5 % 5 % vial, 5 % pggybk prt)</i>	1-Covered	
<i>dextrose 5 %-0.2 % nacl 5 %-0.2 % iv soln</i>	1-Covered	
<i>dextrose 5 %-0.45 % nacl 5 %-0.45 % iv soln</i>	1-Covered	
<i>dextrose 5%-lactated ringers 5 % iv soln</i>	1-Covered	
DOTHELLE DHA SOFTGEL	1-Covered	
DUET DHA 400 COMBO PACK	1-Covered	
DUET DHA 430 MG COMBO PACK	1-Covered	
DUET DHA BALANCED (25 MG IRON)	1-Covered	
DUET DHA EC (400 EC, 430 EC)	1-Covered	
ELITE OB DHA SOFTGEL	1-Covered	
ELITE-OB 400 CAPSULE	1-Covered	
ENBRACE HR SOFTGEL	1-Covered	
EXTRA-VIRT PLUS DHA SOFTGEL	1-Covered	
FOCALGIN 90 DHA COMBO PACK	1-Covered	
FOCALGIN CA COMBO PACK	1-Covered	
FOCALGIN-B TABLET	1-Covered	
FOLBECAL TABLET	1-Covered	
FOLET DHA COMBO PACK	1-Covered	
FOLET ONE SOFTGEL	1-Covered	
FOLIVANE-OB CAPSULE	1-Covered	
FOLIVANE-PRX DHA NF CAPSULE	1-Covered	
<i>fomepizole 1 g/ml vial</i>	1-Covered	
GESTICARE DHA COMBO PACK	1-Covered	
HEMENATAL OB + DHA COMBO PACK	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HEMENATAL OB TABLET	1-Covered	
INATAL ADVANCE TABLET	1-Covered	
INATAL ULTRA TABLET	1-Covered	
INFANATE BALANCE SOFTGEL	1-Covered	
INFANATE PLUS SOFTGEL	1-Covered	
INTRALIPID (20%, 30%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
KOSHER PRENATAL PLUS IRON TAB	1-Covered	
M-VIT CAPLET	1-Covered	
MACNATAL CN DHA SOFTGEL	1-Covered	
MARNATAL-F CAPSULE	1-Covered	
MAXINATE TABLET	1-Covered	
MYNATAL (CAPSULE, ULTRACAPLET)	1-Covered	
MYNATAL ADVANCE TABLET	1-Covered	
MYNATAL PLUS CAPTAB	1-Covered	
MYNATAL-Z CAPTAB	1-Covered	
MYNATE 90 PLUS CAPLET SA	1-Covered	
NATACHEW TABLET	1-Covered	
NATALVIRT 90 DHA COMBO PACK	1-Covered	
NATALVIRT CA COMBO PACK	1-Covered	
NATALVIT TABLET	1-Covered	
NATELLE ONE CAPSULE	1-Covered	
NEEVODHA CAPSULE	1-Covered	
NESTABS ABC PRENATAL COMBO PK	1-Covered	
NESTABS DHA COMBO PACK	1-Covered	
NESTABS TABLET	1-Covered	
NEWGEN TABLET	1-Covered	
NEXA PLUS SOFTGEL	1-Covered	
NIVA-PLUS TABLET	1-Covered	
NORMOSOL-M AND DEXTROSE 5%	1-Covered	
NORMOSOL-R-DEXTROSE 5% IV SOLN	1-Covered	

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on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
O-CAL FA TABLET	1-Covered	
O-CAL PRENATAL TABLET	1-Covered	
OB COMPLETE (CAPLET, CHEWABLE TABLET)	1-Covered	
OB COMPLETE 400 CAPSULE	1-Covered	
OB COMPLETE GOLD SOFTGEL	1-Covered	
OB COMPLETE ONE SOFTGEL	1-Covered	
OB COMPLETE PETITE SOFTGEL	1-Covered	
OB COMPLETE PREMIER TABLET	1-Covered	
OB COMPLETE WITH DHA SOFTGEL	1-Covered	
OBSTETRIX DHA COMBO PAK	1-Covered	
OBSTETRIX EC CAPLET	1-Covered	
OBTREX DHA PRENATAL VITAMIN	1-Covered	
OBTREX PRENATAL CAPLET	1-Covered	
PAIRE OB PLUS DHA COMBO PACK	1-Covered	
PLASMA-LYTE 56-DEXTROSE 5%	1-Covered	
PNV 29-1 TABLET	1-Covered	
<i>pnv no.115/iron fumarate/fa 29 mg-1 mg tab chew</i>	1-Covered	
PNV OB+DHA COMBO PACK	1-Covered	
<i>pnv w-o ca no5/fe fumarate/fa 106.5-1mg capsule</i>	1-Covered	
<i>pnv with ca#74/iron/folic acid 27 mg-1 mg tablet</i>	1-Covered	
<i>pnv with ca,no.72/iron,carb/fa 29 mg-1 mg tablet</i>	1-Covered	
<i>pnv with ca,no.72/iron/fa 27 mg-1 mg tablet</i>	1-Covered	
<i>pnv#79/iron/fa/lmfolate ca/dha 27-1.13 mg capsule</i>	1-Covered	
PNV-DHA + DOCUSATE SOFTGEL	1-Covered	
PNV-OMEGA SOFTGEL	1-Covered	
PNV-SELECT TABLET	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PNV-TOTAL SOFTGEL	1-Covered	
PNV-VP-U CAPSULE	1-Covered	
<i>prv115/iron fumarate/fa/dss 29-1-25 mg tablet</i>	1-Covered	
<i>potassium chloride in 5 % dextrose in water (20 soln, 40 soln)</i>	1-Covered	
<i>potassium chloride in dextrose 5 % and 0.9 % sodium chloride (20 soln, 40 soln)</i>	1-Covered	
<i>potassium chloride in dextrose 5 %-0.45 % sodium chloride (10 soln, 20 soln, 30 soln, 40 soln)</i>	1-Covered	
<i>potassium chloride in Ir-d5 20 meq/l iv soln</i>	1-Covered	
<i>potassium chloride/d5-0.2%nacl 20 meq/l iv soln</i>	1-Covered	
<i>potassium chloride/d5-0.3%nacl 20 meq/l iv soln</i>	1-Covered	
PR NATAL 400 COMBO PACK	1-Covered	
PR NATAL 400 EC COMBO PACK	1-Covered	
PR NATAL 430 COMBO PACK	1-Covered	
PR NATAL 430 EC COMBO PACK	1-Covered	
PREFERA OB TABLET	1-Covered	
PREFERA-OB ONE SOFTGEL	1-Covered	
PREFERA-OB PLUS DHA COMBO PACK	1-Covered	
PREFOL-DHA CAPSULE	1-Covered	
PRENA1 CHEW TABLET	1-Covered	
PRENA1 PEARL SOFTGEL	1-Covered	
PRENA1 PLUS COMBO PACK	1-Covered	
PRENA1 SOFTGEL	1-Covered	
PRENA1 TRUE COMBO PACK	1-Covered	
PRENAISSANCE 90 DHA COMBO PACK	1-Covered	
PRENAISSANCE BALANCE SOFTGEL	1-Covered	
PRENAISSANCE CAPSULE	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRENAISSANCE DHA COMBO PACK	1-Covered	
PRENAISSANCE NEXT TABLET	1-Covered	
PRENAISSANCE NEXT-B TABLET	1-Covered	
PRENAISSANCE PLUS SOFTGEL	1-Covered	
PRENAISSANCE PROMISE COMBO PCK	1-Covered	
PRENAPLUS TABLET	1-Covered	
PRENATA CHEWABLE TABLET	1-Covered	
PRENATABS FA TABLET	1-Covered	
PRENATABS RX TABLET	1-Covered	
<i>prenatal vit #60/iron fum/fa 27 mg-1 mg tablet</i>	1-Covered	
<i>prenatal vit 15/iron cb/fa/dss 90-1-50 mg tablet</i>	1-Covered	
PRENATE AM TABLET	1-Covered	
PRENATE CHEWABLE TABLET	1-Covered	
PRENATE DHA SOFTGEL	1-Covered	
PRENATE ELITE TABLET	1-Covered	
PRENATE ENHANCE SOFTGEL	1-Covered	
PRENATE ESSENTIAL SOFTGEL	1-Covered	
PRENATE MINI SOFTGEL	1-Covered	
PRENATE PIXIE SOFTGEL	1-Covered	
PRENATE RESTORE SOFTGEL	1-Covered	
PRENATE STAR TABLET	1-Covered	
PREPLUS CA-FE 27 MG-FA 1 MG TB	1-Covered	
PREQUE 10 TABLET	1-Covered	
PRETAB 29 MG-1 MG TABLET	1-Covered	
PROVIDA DHA CAPSULE	1-Covered	
PROVIDA OB CAPSULE	1-Covered	
PUREFE OB PLUS CAPSULE	1-Covered	
PUREFE PLUS CAPSULE	1-Covered	
R-NATAL OB SOFTGEL	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RELNATE DHA PRENATAL SOFTGEL	1-Covered	
<i>ringers solution (irrigsoln, ivsoln)</i>	1-Covered	
<i>ringers solution, lactated (irrigsoln, ivsoln)</i>	1-Covered	
RULAVITE DHA SOFTGEL	1-Covered	
SE-NATAL 19 (19 CHEWABLE TABLET, 19 TABLET)	1-Covered	
SE-TAN DHA CAPSULE	1-Covered	
SELECT-OB + DHA PACK	1-Covered	
SELECT-OB CHEWABLE CAPLET	1-Covered	
<i>sodium lactate 5 meq/ml vial</i>	1-Covered	
TARON-BC TABLET	1-Covered	
TARON-C DHA CAPSULE	1-Covered	
TARON-PREX PRENATAL DHA CAP	1-Covered	
THRIVITE 19 TABLET	1-Covered	
TL FOLATE TABLET	1-Covered	
TL-CARE DHA SOFTGEL	1-Covered	
TL-SELECT CAPSULE	1-Covered	
TL-SELECT DHA SOFTGEL	1-Covered	
TPN ELECTROLYTES VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL 10% SOLN VIAFLEX	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRI-TABS DHA COMBO PACK	1-Covered	
TRIADVANCE TABLET	1-Covered	
TRICARE PRENATAL COMPLEAT PACK	1-Covered	
TRICARE PRENATAL DHA ONE SFTGL	1-Covered	
TRICARE PRENATAL TABLET	1-Covered	
TRICARE PRENATAL WITH DHA PACK	1-Covered	
TRINATAL GT TABLET	1-Covered	
TRINATAL RX 1 TABLET	1-Covered	
TRINATE TABLET	1-Covered	
TRISTART DHA SOFTGEL	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRIVEEN-DUO DHA COMBO PACK	1-Covered	
TRIVEEN-ONE CAPSULE	1-Covered	
TRIVEEN-PRX RNF CAPSULE	1-Covered	
TROPHAMINE (6%, 10%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRUST NATAL DHA	1-Covered	
ULTIMATECARE ONE CAPSULE	1-Covered	
ULTIMATECARE ONE NF CAPSULE	1-Covered	
VEMAVITE-PRX 2 CAPSULE	1-Covered	
VENA-BAL DHA COMBO PACK	1-Covered	
VENATAL-FA TABLET	1-Covered	
VINACAL PRENATAL TABLET	1-Covered	
VINATE CARE CHEWABLE TABLET	1-Covered	
VINATE DHA GELCAP	1-Covered	
VINATE DHA RF GELCAP	1-Covered	
VINATE GT TABLET	1-Covered	
VINATE II TABLET	1-Covered	
VINATE ONE TABLET	1-Covered	
VINATE PN CARE TABLET	1-Covered	
VINATE ULTRA TABLET	1-Covered	
VINATE-M TABLET	1-Covered	
VIRT NATE TABLET	1-Covered	
VIRT-ADVANCE TABLET	1-Covered	
VIRT-BAL DHA COMBO PACK	1-Covered	
VIRT-BAL DHA PLUS COMBO PACK	1-Covered	
VIRT-C DHA SOFTGEL	1-Covered	
VIRT-CARE ONE CAPSULE	1-Covered	
VIRT-NATE DHA SOFTGEL	1-Covered	
VIRT-NATE TABLET	1-Covered	
VIRT-PN DHA SOFTGEL	1-Covered	
VIRT-PN PLUS SOFTGEL	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIRT-PN TABLET	1-Covered	
VIRT-SELECT CAPSULE	1-Covered	
VIRT-VITE GT TABLET	1-Covered	
VIRTPREX CAPSULE	1-Covered	
VITAFOL FE+ DOCUSATE COMBO PCK	1-Covered	
VITAFOL GUMMIES	1-Covered	
VITAFOL NANO TABLET	1-Covered	
VITAFOL ULTRA SOFTGEL	1-Covered	
VITAFOL-OB CAPLET	1-Covered	
VITAFOL-OB+DHA COMBO PACK	1-Covered	
VITAFOL-ONE CAPSULE	1-Covered	
VITAMEDMD ONE RX SOFTGEL	1-Covered	
VITAMEDMD PLUS RX COMBO PACK	1-Covered	
VITAMEDMD REDICHEW RX TAB CHEW	1-Covered	
VITAPEARL SOFTGEL	1-Covered	
VITATRUE COMBO PACK	1-Covered	
VIVA DHA PRENATAL SOFTGEL	1-Covered	
VOL-NATE TABLET	1-Covered	
VOL-PLUS TABLET	1-Covered	
VOL-TAB RX TABLET	1-Covered	
VP CH ULTRA SOFTGEL	1-Covered	
VP-CH PLUS SOFTGEL	1-Covered	
VP-CH-PNV PRENATAL SOFTGEL	1-Covered	
VP-ERA OB PLUS TABLET	1-Covered	
VP-GGR-B6 TABLET	1-Covered	
VP-HEME OB + DHA COMBO PACK	1-Covered	
VP-HEME OB TABLET	1-Covered	
VP-HEME ONE SOFTGEL	1-Covered	
VP-PNV-DHA (CAPSULE, SOFTGEL)	1-Covered	
<i>water for irrigation,sterile irrig soln</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZATEAN-CH CAPSULE	1-Covered	
ZATEAN-PN DHA CAPSULE	1-Covered	
ZATEAN-PN PLUS SOFTGEL	1-Covered	
ZATEAN-PN TABLET	1-Covered	
ZINGIBER TABLET	1-Covered	

Uncategorized

Unclassified

DELZICOL DR 400 MG CAPSULE	1-Covered	
<i>dicyclomine hcl 10 mg/ml vial</i>	1-Covered	
HUMULIN R 500 UNITS/ML KWIKPEN	1-Covered	
ODEFSEY TABLET	1-Covered	
<i>pen needle, diabetic (, 29 g x1/2" , , 31 gx3/16" , , 31 gx5/16" , , 32gx 5/32")</i>	1-Covered	
SPRITAM (250 MG TABLET, 500 MG TABLET, 750 MG TABLET, 1,000 MG TABLET)	1-Covered	
VRAYLAR 1.5 MG-3 MG PACK	1-Covered	

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dicyclomine hcl	70,108	duloxetine hcl	66
didanosine	42	DURAMORPH	4
diflorasone diacetate	75	DUREZOL	90
diflunisal	3	dutasteride	73
DIGITEK	61	dutasteride/tamsulosin hcl	73
DIGOX	61	DUTOPROL	60
digoxin	61	DYRENIUM	62
dihydroergotamine mesylate	26	E	
DILANTIN	17	econazole nitrate	24
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diltiazem hcl	58	EFFIENT	54
DIPENTUM	87	ELIDEL	68
diphenhydramine hcl	23	ELIGARD	81
diphenoxylate hcl/atropine sulfate	70	ELIPHOS	73
dipyridamole	54	ELIQUIS	52
disopyramide phosphate	56	ELITE OB DHA	100

ELITE-OB 400	100	erythromycin base/benzoyl peroxide	68
ELITEK	30	erythromycin base/ethyl alcohol	12
ELIXOPHYLLIN	94	erythromycin ethylsuccinate	12
ELMIRON	73	ESBRIET	95
EMCYT	29	escitalopram oxalate	20
EMEND	24	esomeprazole magnesium	72
EMPLICITI	35	estradiol	77
EMSAM	20	estropipate	77
EMTRIVA	42	eszopiclone	96
enalapril maleate	55	ethacrynate sodium	62
enalapril maleate/hydrochlorothiazide	60	ethambutol hcl	27
ENBRACE HR	100	ethinyl estradiol/drospirenone	78
ENBREL	83	ethosuximide	14
ENDOCET	2	etidronate disodium	88
ENGERIX-B ADULT	85	etodolac	3
ENGERIX-B PEDIATRIC-ADOLESCENT	85	ETOPOPHOS	33
enoxaparin sodium	52	etoposide	33
ENPRESSE	78	EVOTAZ	43
entacapone	36	EVZIO	6
entecavir	44	EXELON	18
ENULOSE	71	exemestane	32
ENVARUSUS XR	83	EXJADE	97
epinastine hcl	89	EXTRA-VIRT PLUS DHA	100
epinephrine	93		
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epirubicin hcl	30	famciclovir	45
EPITOL	17	famotidine	70
EPIVIR	44	famotidine in sodium chloride, iso-	
EPIVIR HBV	44	osmotic/pf	71
eplerenone	62	famotidine/pf	71
EPZICOM	42	FANAPT	39
EQUETRO	17	FARESTON	29
ERBITUX	30	FARYDAK	32
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ERGOMAR	26	FAZACLO	40
ERIVEDGE	33	felbamate	16
ERWINAZE	30	felodipine	58
ERY-TAB	12	FEMCON FE	78
ERYTHROCIN LACTOBIONATE	12	fenofibrate	63
erythromycin base	12	fenofibrate nanocrystallized	63

fenofibrate, micronized	63	FOCALGIN CA	100
fenofibric acid	63	FOCALGIN-B	100
fenofibric acid (choline)	63	FOLBECAL	100
fenopropfen calcium	3	FOLET DHA	100
fentanyl	4	FOLET ONE	100
fentanyl citrate	4	FOLIVANE-OB	100
FERRIPROX	97	FOLIVANE-PRX DHA NF	100
FETZIMA	20	FOLOTYN	30
finasteride	73	fomepizole	100
FIRAZYR	82	fondaparinux sodium	52
FLAREX	90	FORFIVO XL	19
flavoxate hcl	72	FORTEO	88
flecainide acetate	56	foscarnet sodium	44
FLOVENT DISKUS	92	fosinopril sodium	55
FLOVENT HFA	92	fosinopril sodium/hydrochlorothiazide	60
fluconazole	24,25	fosphenytoin sodium	17
fluconazole in dextrose, iso-osmotic	25	FOSRENOL	74
fluconazole in sodium chloride, iso-osmotic	25	frovatriptan succinate	26
flucytosine	25	furosemide	62
fludarabine phosphate	32	FUSILEV	32
fludrocortisone acetate	75	FUZEON	43
fluocinolone acetonide	75	FYCOMPA	16
fluocinolone acetonide oil	75		
fluocinonide	75	G	
fluocinonide/emollient base	75	gabapentin	15
FLUOR-A-DAY	97	GABITRIL	15
FLUORITAB	97	galantamine hbr	18
fluorometholone	90	GAMASTAN S-D	84
fluorouracil	68	GAMMAGARD LIQUID	84
fluoxetine hcl	19,21	GAMMAGARD S-D	84
fluphenazine decanoate	38	GAMMAPLEX	84
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flurbiprofen	3	ganciclovir sodium	44
flurbiprofen sodium	90	GARDASIL	85
flutamide	28	GARDASIL 9	85
fluticasone propionate	68,92	gatifloxacin	13
fluvoxamine maleate	21	GATTEX	70
FML	90	gauze bandage	49
FML FORTE	90	GAVILYTE-C	71
FML S.O.P.	90	GAVILYTE-G	71
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GEODON.....	39	HEMENATAL OB + DHA.....	100
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		hydrocodone/ibuprofen.....	2,5
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		ipratropium bromide/albuterol sulfate	95
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