

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 12

This formulary was updated on 10/1/2016. 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 10/1/2016. 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 10/1/2016. 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 98. 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 104. 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 104.

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-cod #2 tablet</i>	1-Covered	QL (13 PER 1 DAYS)
<i>acetaminophen-cod #3 tablet</i>	1-Covered	QL (12 PER 1 DAYS)
<i>acetaminophen-cod #4 tablet</i>	1-Covered	QL (6 PER 1 DAYS)
<i>acetaminophen-codeine (acetamin- codein 300-30 mg/12.5, acetaminop- codeine 120-12 mg/5)</i>	1-Covered	
<i>butalb-caff-acetaminoph-codein</i>	1-Covered	PA
<i>butalbital-acetaminophen</i>	1-Covered	PA
<i>butalbital-acetaminophen-caffe (butalb-acetamin-caff 50-325-40, butalbit-acetaminophen-caff cp)</i>	1-Covered	PA
<i>butalbital-aspirin-caffeine</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>hydrocodon-acetaminoph 7.5-325</i>	1-Covered	QL (8 PER 1 DAYS)
<i>hydrocodon-acetaminophen 5-325</i>	1-Covered	QL (12 PER 1 DAYS)
<i>hydrocodon-acetaminophn 10-325</i>	1-Covered	QL (6 PER 1 DAYS)
<i>hydrocodone-acetaminophen (hydrocodon-acetamin 7.5-325/15, hydrocodone-acetamin 2.5-108/5, hydrocodone-acetamin 5-217/10)</i>	1-Covered	
<i>hydrocodone-ibuprofen 7.5-200</i>	1-Covered	QL (5 PER 1 DAYS)
<i>oxycodone hcl-aspirin</i>	1-Covered	
<i>oxycodone-acetaminophen (oxycodon- acetaminophen 2.5-325, oxycodone- acetaminophen 5-325)</i>	1-Covered	QL (12 PER 1 DAYS)
<i>oxycodone-acetaminophen (oxycodon- acetaminophen 7.5-325, oxycodone- acetaminophen 10-325)</i>	1-Covered	
<i>pentazocine-naloxone hcl</i>	1-Covered	QL (12 PER 1 DAYS)
ROXICET 5-325 TABLET	1-Covered	
<i>tramadol hcl-acetaminophen</i>	1-Covered	QL (8 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
Nonsteroidal Anti-inflammatory Drugs		
<i>celecoxib</i>	1-Covered	
<i>diclofenac potassium</i>	1-Covered	
<i>diclofenac sodium (1.5% topical soln, sod dr 25 mg tab, sod dr 50 mg tab, sod dr 75 mg tab, sod ec 25 mg tab, sod ec 50 mg tab, sod ec 75 mg tab)</i>	1-Covered	
<i>diclofenac sodium er</i>	1-Covered	
<i>diclofenac sodium-misoprostol</i>	1-Covered	
<i>diflunisal</i>	1-Covered	
<i>etodolac</i>	1-Covered	
<i>fenoprofen 600 mg tablet</i>	1-Covered	
<i>flurbiprofen</i>	1-Covered	
<i>ibuprofen (400 mg tablet, 600 mg tablet, 800 mg tablet)</i>	1-Covered	
<i>indomethacin (25 mg capsule, 50 mg capsule, er 75 mg capsule)</i>	1-Covered	PA
<i>ketoprofen (50 mg capsule, 75 mg capsule)</i>	1-Covered	
<i>ketoprofen er 200 mg capsule</i>	1-Covered	QL (1 PER 1 DAYS)
<i>meclofenamate sodium</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/5 ml susp</i>	1-Covered	
<i>nabumetone</i>	1-Covered	
<i>naproxen (125 mg/5 ml suspen, 250 mg tablet, dr 375 mg tablet, 375 mg tablet, ec 375 mg tablet, 500 mg kit, 500 mg tablet, dr 500 mg tablet, ec 500 mg tablet)</i>	1-Covered	
<i>naproxen sodium (275 mg tab, 550 mg tab)</i>	1-Covered	
<i>naproxen sodium cr</i>	1-Covered	
<i>naproxen sodium 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>oxaprozin</i>	1-Covered	
<i>oxycodone hcl-ibuprofen</i>	1-Covered	
<i>piroxicam</i>	1-Covered	
<i>sulindac</i>	1-Covered	
<i>tolmetin sodium (400 mg cap, 600 mg tab)</i>	1-Covered	

Opioid Analgesics, Long-acting

DURAMORPH	1-Covered	
<i>fentanyl (12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, 100 mcg/hr)</i>	1-Covered	QL (10 PER 23 DAYS)
<i>fentanyl citrate (cit 1,200 mcg, cit 1,600 mcg, citrate 200 mcg, citrate 400 mcg, citrate 600 mcg, citrate 800 mcg)</i>	1-Covered	PA
<i>methadone hcl (hcl 5 mg tablet, 5 mg/5 ml solution, 10 mg/5 ml solution, hcl 10 mg tablet)</i>	1-Covered	
<i>morphine sulf er 60 mg tablet</i>	1-Covered	
<i>morphine sulfate (sulf 10 mg/5 ml soln, sulf 20 mg/5 ml soln, sulf 100 mg/5 ml soln, sulfate ir 15 mg tab, sulfate ir 30 mg tab)</i>	1-Covered	
<i>morphine sulfate er (er 15 mg tablet, er 30 mg tablet, er 100 mg tablet, er 200 mg tablet)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>oxycodone hcl er</i>	1-Covered	PA
OXYCONTIN	1-Covered	PA, QL (2 PER 1 DAYS)
<i>oxymorphone hcl er</i>	1-Covered	
<i>tramadol hcl er</i>	1-Covered	

Opioid Analgesics, Short-acting

<i>asa-butalb-caffeine-codeine</i>	1-Covered	
<i>butalbital compound-codeine</i>	1-Covered	
<i>butorphanol 10 mg/ml spray</i>	1-Covered	
<i>hydrocodon-acetaminoph 2.5-325</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>hydrocodone-ibuprofen (5-200 mg, 10-200)</i>	1-Covered	
<i>hydromorphone hcl (2 mg tablet, 4 mg tablet, 8 mg tablet)</i>	1-Covered	
<i>morphine sulfate (2 mg/ml carpject, 2 mg/ml syringe, 2 mg/ml isecure syr, 4 mg/ml carpject, 4 mg/ml isecure syr, 8 mg/ml syringe, 8 mg/ml isecure syr, 10 mg/ml isecure syr, 10 mg/ml carpject)</i>	1-Covered	
<i>oxycodone hcl (5 mg/5 ml soln, 5 mg capsule, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet, 100 mg/5 ml soln)</i>	1-Covered	
<i>oxymorphone hcl</i>	1-Covered	
<i>tramadol hcl</i>	1-Covered	

Anesthetics

Local Anesthetics

<i>lidocaine 5% ointment</i>	1-Covered	
<i>lidocaine 5% patch</i>	1-Covered	PA
<i>lidocaine hcl (0.5% vial, 1% 20 mg/2 ml, 1% ampul, 1% vial, 1% 50 mg/5 ml, 2% vial, 2% jelly, 4% solution)</i>	1-Covered	
<i>lidocaine hcl viscous</i>	1-Covered	
<i>lidocaine-prilocaine</i>	1-Covered	

Anti-Addiction/ Substance Abuse Treatment Agents

Alcohol Deterrents/ Anti-craving

<i>acamprosate calcium</i>	1-Covered	
<i>disulfiram</i>	1-Covered	
<i>naltrexone 50 mg tablet</i>	1-Covered	
VIVITROL	1-Covered	

Opioid Dependence Treatments

<i>buprenorphine hcl (0.3 mg/ml syrn, 0.3 mg/ml vial)</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>buprenorphine hcl (2 mg tablet, 8 mg tablet)</i>	1-Covered	PA
REVIA	1-Covered	
SUBOXONE	1-Covered	PA
Opioid Reversal Agents		
EVZIO	1-Covered	
<i>naloxone hcl (0.4 mg/ml vial, 2 mg/2 ml syringe, 4 mg/10 ml vial)</i>	1-Covered	
NARCAN	1-Covered	
Smoking Cessation Agents		
CHANTIX	1-Covered	
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
Anti-inflammatory Agents		
Glucocorticoids		
<i>triamcinolone acetonide (40mg/ml, 50mg/5ml)</i>	1-Covered	
Nonsteroidal Anti-inflammatory Drugs		
<i>ibuprofen 100 mg/5 ml susp</i>	1-Covered	
<i>mefenamic acid</i>	1-Covered	
Antibacterials		
Aminoglycosides		
<i>amikacin sulfate (1 gram/4 ml vial, 500 mg/2 ml vial)</i>	1-Covered	
<i>gentamicin sulfate (0.1% ointment, 0.1% cream, 0.3% eye ointment, 0.3% eye drops, 3 mg/ml eye drops, 3 mg/gm eye oint, 10 mg/ml vial, ped 20 mg/2 ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 800 mg/20 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>gentamicin sulfate in ns (70 mg/ns 50 ml pb, isoton 80 mg/100 ml, 80 mg/ns 50 ml pb, 90 mg/ns 100 ml pb, iso 120 mg/100 ml, isoton 60 mg/50 ml, 60 mg/ns 50 ml pb, isoton 80 mg/50 ml, 80 mg/ns 100 ml pb, 100 mg/ns 100 ml, iso 100 mg/100 ml)</i>	1-Covered	
<i>neomycin sulfate</i>	1-Covered	
<i>neomycin-polymyxin b</i>	1-Covered	
<i>paromomycin sulfate</i>	1-Covered	
<i>streptomycin sulfate</i>	1-Covered	
TOBI PODHALER	1-Covered	
TOBRADEX EYE OINTMENT	1-Covered	
<i>tobramycin 0.3% eye drops</i>	1-Covered	
<i>tobramycin 300 mg/5 ml ampule</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>tobramycin 80 mg/100 ml ns</i>	1-Covered	
<i>tobramycin sulfate (1.2 gm vial, 1.2 gram/30 ml vial, 10 mg/ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 1,200 mg/30 ml vial)</i>	1-Covered	
<i>colistimethate</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
SYNERCID	1-Covered	

Antibacterials, Other

<i>acetic acid 2% ear solution</i>	1-Covered	
<i>bacitracin (500 unit/gm ophth, 50,000 units vial)</i>	1-Covered	
BACTROBAN NASAL	1-Covered	
<i>chloramphenicol sod succinate</i>	1-Covered	
<i>clindamycin hcl</i>	1-Covered	
<i>clindamycin palmitate hcl</i>	1-Covered	
<i>clindamycin pediatric</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clindamycin phosphate (ph 1% solution, ph 1% gel, 2% vaginal cream, ph 9 g/60 ml vial, phosp 1% lotion, 150 mg/ml addvan, 300 mg/2 ml addvan, ph 300 mg/2 ml vl, 600 mg/4 ml addvan, ph 600 mg/4 ml vl, ph 900 mg/6 ml vl, phos 1% pledget, 900 mg/6 ml addvan)</i>	1-Covered	
<i>clindamycin phosphate-d5w</i>	1-Covered	
CUBICIN	1-Covered	ST
<i>isopropyl alcohol 0.7 ml/ml medicated pad</i>	1-Covered	
<i>linezolid (100 mg/5 ml susp, 600 mg tablet, 600 mg/300 ml iv sol)</i>	1-Covered	PA
<i>methenamine hippurate</i>	1-Covered	
<i>metronidazole (0.75% cream, topical 0.75% gl, 0.75% lotion, topical 1% gel, vaginal 0.75% gl, 250 mg tablet, 375 mg capsule, 500 mg/100 ml, 500 mg tablet)</i>	1-Covered	
<i>mupirocin</i>	1-Covered	
<i>nitrofurantoin (25 mg/5 ml susp, mcr 25 mg cap, mcr 100 mg cap)</i>	1-Covered	
<i>nitrofurantoin mcr 50 mg cap</i>	1-Covered	QL (112 PER 30 DAYS)
<i>nitrofurantoin mono-macro</i>	1-Covered	
<i>polymyxin b sulfate</i>	1-Covered	
<i>trimethoprim</i>	1-Covered	
TYGACIL	1-Covered	
<i>vancomycin hcl (1 gm vial, 1 gm addvan vial, hcl 5 gm vial, hcl 10 gm vial, 500 mg a-v vial, 500 mg vial, hcl 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

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
Beta-lactam, Cephalosporins		
CEDAX 90 MG/5 ML SUSPENSION	1-Covered	
<i>cefaclor (250 mg capsule, 500 mg capsule)</i>	1-Covered	
<i>cefaclor er</i>	1-Covered	
<i>cefadroxil (1 gm tablet, 250 mg/5 ml susp, 500 mg/5 ml susp, 500 mg capsule)</i>	1-Covered	
<i>cefazolin 1 g/50 ml-dextrose</i>	1-Covered	
<i>cefazolin sodium</i>	1-Covered	
<i>cefdinir (125 mg/5 ml susp, 250 mg/5 ml susp, 300 mg capsule)</i>	1-Covered	
<i>cefepime hcl 1 gm vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cefepime hcl 2 gram vial</i>	1-Covered	
<i>cefepime-dextrose</i>	1-Covered	
<i>cefixime</i>	1-Covered	
<i>cefotetan</i>	1-Covered	
<i>cefoxitin</i>	1-Covered	
<i>cefoxitin sodium</i>	1-Covered	
<i>cefpodoxime proxetil (50 mg/5 ml susp, 100 mg tablet, 100 mg/5 ml susp, 200 mg tablet)</i>	1-Covered	
<i>cefprozil (125 mg/5 ml susp, 250 mg/5 ml susp, 250 mg tablet, 500 mg tablet)</i>	1-Covered	
<i>ceftazidime</i>	1-Covered	
<i>ceftriaxone (1 gm vial, 2 gm add vial, 2 gm vial, 10 gm vial, 100 gram bulk bag, 250 mg vial, 500 mg vial)</i>	1-Covered	
<i>cefuroxime (250 mg tab, 500 mg tab)</i>	1-Covered	
<i>cefuroxime sodium (1.5 gm vial, 7.5 gm vial, 75 gm bulk bag, 750 mg vial)</i>	1-Covered	
<i>cephalexin (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 500 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
SPECTRACEF 400 MG DOSE PACK TB	1-Covered	
SUPRAX 400 MG CAPSULE	1-Covered	
TEFLARO	1-Covered	PA - TO CONFIRM PART D COVERAGE
Beta-lactam, Other		
AZACTAM-ISO-OSMOTIC DEXTROSE	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>aztreonam</i>	1-Covered	
<i>imipenem-cilastatin sodium</i>	1-Covered	
INVANZ 1 GM VIAL	1-Covered	
<i>meropenem</i>	1-Covered	
Beta-lactam, Penicillins		
<i>amoxicillin (125 mg tab chew, 125 mg/5 ml susp, 200 mg/5 ml susp, 250 mg capsule, 250 mg tab chew, 250 mg/5 ml susp, 400 mg/5 ml susp, 500 mg tablet, 500 mg capsule, 875 mg tablet)</i>	1-Covered	
<i>amoxicillin-clavulanate pot er</i>	1-Covered	
<i>amoxicillin-clavulanate potass (200-28.5 mg tab chew, 200-28.5 mg/5 ml sus, 250-62.5 mg/5 ml sus, 250-125 mg tablet, 400-57 mg/5 ml susp, 400-57 mg tab chew, 500-125 mg tablet, 600-42.9 mg/5 ml sus, 875-125 mg tablet)</i>	1-Covered	
<i>ampicillin sodium (1 gm a-v vial, 1 gm vial, 2 gm vial, 10 gm vial, 125 mg vial, 250 mg vial, 500 mg vial)</i>	1-Covered	
<i>ampicillin trihydrate (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 500 mg capsule)</i>	1-Covered	
<i>ampicillin-sulbactam (ampicillin-sulb 3 gm add vial, ampicillin-sulbactam 1.5 gm vl, ampicillin-sulbactam 3 gm vial, ampicillin-sulbactam 15 gm vl)</i>	1-Covered	
BICILLIN L-A	1-Covered	
<i>dicloxacillin sodium</i>	1-Covered	
<i>nafcillin</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>nafcillin sodium (1 gm vial, 2 gm vial, 10 gm bulk vial, 10 gm vial)</i>	1-Covered	
<i>oxacillin</i>	1-Covered	
<i>oxacillin sodium (1 gm vial, 2 gm advantage vl, 2 gm vial, 10 gm vial)</i>	1-Covered	
<i>pen g 1.2 million unit/2 ml</i>	1-Covered	
<i>penicillin g potassium</i>	1-Covered	
<i>penicillin g sodium</i>	1-Covered	
<i>penicillin gk-iso-osm dextrose (2 million unit/50 ml, 3 million unit/50 ml)</i>	1-Covered	
<i>penicillin v potassium (125 mg/5 ml soln, 250 mg tablet, 250 mg/5 ml soln, 500 mg tablet)</i>	1-Covered	
<i>piperacillin-tazobactam (2.25 gm vl, 3.375 gm vl, 4.5 gm vial, 40.5 gram)</i>	1-Covered	

Macrolides

<i>azithromycin (1 gm pwd packet, 250 mg tablet, i.v. 500 mg vial)</i>	1-Covered	
<i>azithromycin (100 mg/5 ml, 200 mg/5 ml)</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/5 ml, 250 mg/5 ml)</i>	1-Covered	
<i>clarithromycin (250 mg tablet, 500 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>clarithromycin er</i>	1-Covered	
ERY-TAB	1-Covered	
ERYTHROCIN LACTOBIONATE (500 MG VIAL, 500 MG ADDVNT VL)	1-Covered	
<i>erythromycin (0.5% eye ointment, 2% gel, 2% solution, ec 250 mg cap, 250 mg filmtab, 500 mg filmtab)</i>	1-Covered	
<i>erythromycin ethylsuccinate</i>	1-Covered	
ZMAX	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</i>	1-Covered	
<i>ciprofloxacin er</i>	1-Covered	
<i>ciprofloxacin hcl (0.2% otic soln, 0.3% eye drop, hcl 100 mg tab, hcl 250 mg tab, hcl 500 mg tab, hcl 750 mg tab)</i>	1-Covered	
<i>ciprofloxacin-d5w</i>	1-Covered	
<i>gatifloxacin</i>	1-Covered	
<i>levofloxacin (0.5% eye drops, 25 mg/ml solution, 250 mg/10 ml soln, 500 mg/20 ml vial, 500 mg/20 ml soln, 750 mg/30 ml vial)</i>	1-Covered	
<i>levofloxacin (250 mg tablet, 500 mg tablet, 750 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>levofloxacin-d5w</i>	1-Covered	
<i>moxifloxacin</i>	1-Covered	
<i>moxifloxacin hcl</i>	1-Covered	
<i>ofloxacin (0.3% eye drops, 0.3% ear drops, 400 mg tablet)</i>	1-Covered	
Sulfonamides		
SILVADENE	1-Covered	
<i>silver sulfadiazine</i>	1-Covered	
<i>sodium sulfacetamide 10% lot</i>	1-Covered	
SSD	1-Covered	
<i>sulfacetamide sodium (eye drops, sod top susp, sodium lotn)</i>	1-Covered	
<i>sulfadiazine</i>	1-Covered	
<i>sulfamethoxazole-trimethoprim (ds tablet, inj vial, ss tablet, susp)</i>	1-Covered	
Tetracyclines		
<i>demeclocycline hcl</i>	1-Covered	
<i>doxycycline hyc 100 mg vial</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>doxycycline hyclate (hyc dr 50 mg tab, hyc dr 75 mg tab, hyc dr 100 mg tab, hyc dr 150 mg tab, hyc dr 200 mg tab, hyclate 20 mg tab, hyclate 50 mg cap, hyclate 100 mg tab, hyclate 100 mg cap)</i>	1-Covered	
<i>doxycycline monohydrate (25 mg/5 ml susp, mono 50 mg cap, mono 50 mg tablet, mono 75 mg tablet, mono 75 mg capsule, mono 100 mg tablet, mono 100 mg cap, mono 150 mg tablet)</i>	1-Covered	
<i>minocycline hcl (50 mg capsule, 75 mg capsule, 100 mg capsule)</i>	1-Covered	
<i>tetracycline hcl</i>	1-Covered	

Anticonvulsants

Anticonvulsants, Other

BRIVIACT (10 MG/ML ORAL SOLN, 10 MG TABLET, 25 MG TABLET, 50 MG TABLET, 50 MG/5 ML VIAL, 75 MG TABLET, 100 MG TABLET)	1-Covered	
<i>diazepam (2.5 mg gel sys, 10 mg gel syst, 20 mg gel syst)</i>	1-Covered	
FYCOMPA 0.5 MG/ML ORAL SUSP	1-Covered	
<i>levetiracetam (100 mg/ml soln, 250 mg tablet, 500 mg/5 ml vial, 500 mg tablet, 500 mg/5 ml soln, 750 mg tablet, 1,000 mg tablet)</i>	1-Covered	
<i>levetiracetam er</i>	1-Covered	
<i>levetiracetam-nacl</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
POTIGA	1-Covered	ST
ROWEEPRA	1-Covered	

Calcium Channel Modifying Agents

CELONTIN	1-Covered	ST
<i>ethosuximide (250 mg/5 ml soln, 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</i>	1-Covered	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>clonazepam</i>	1-Covered	
<i>clorazepate dipotassium</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, 5 mg/5 ml oral soln)</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</i>	1-Covered	
<i>divalproex sodium er</i>	1-Covered	
<i>gabapentin (100 mg capsule, 250 mg/5 ml soln, 300 mg/6 ml soln, 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	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	1-Covered	QL (5 PER 1 DAYS)
ONFI (10 MG TABLET, 20 MG TABLET)	1-Covered	ST
ONFI 2.5 MG/ML SUSPENSION	1-Covered	
<i>phenobarbital (15 mg tablet, 16.2 mg tablet, 20 mg/5 ml soln, 20 mg/5 ml elix, 30 mg tablet, 32.4 mg tablet, 60 mg tablet, 64.8 mg tablet, 97.2 mg tablet, 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>primidone</i>	1-Covered	
SABRIL	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>valproate sodium</i>	1-Covered	
<i>valproic acid (250 mg capsule, 250 mg/5 ml soln, 500 mg/10 ml sol)</i>	1-Covered	
Glutamate Reducing Agents		
<i>felbamate (400 mg tablet, 600 mg tablet, 600 mg/5 ml 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 (BLUE)	1-Covered	
LAMICTAL (GREEN)	1-Covered	
LAMICTAL (ORANGE)	1-Covered	
LAMICTAL XR (BLUE)	1-Covered	
LAMICTAL XR (GREEN)	1-Covered	
LAMICTAL XR (ORANGE)	1-Covered	
<i>lamotrigine (5 mg disper tablet, 25 mg disper tab, 25 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)</i>	1-Covered	
<i>lamotrigine er</i>	1-Covered	
<i>lamotrigine odt</i>	1-Covered	
QUDEXY XR	1-Covered	
<i>topiramate (15 mg cap, 25 mg cap)</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)
<i>topiramate er</i>	1-Covered	
TROKENDI XR	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
Sodium Channel Agents		
APTIOM	1-Covered	
BANZEL (40 MG/ML SUSPENSION, 200 MG TABLET, 400 MG TABLET)	1-Covered	ST
<i>carbamazepine (100 mg tab chew, 100 mg/5 ml susp, 200 mg tablet)</i>	1-Covered	
<i>carbamazepine er (er 100 mg tablet, er 200 mg tablet, er 400 mg tablet)</i>	1-Covered	
CARBATROL	1-Covered	ST
CEREBYX	1-Covered	
DILANTIN 30 MG CAPSULE	1-Covered	ST
EPITOL	1-Covered	ST
EQUETRO	1-Covered	ST
<i>fosphenytoin sodium</i>	1-Covered	
<i>oxcarbazepine (150 mg tablet, 300 mg/5 ml susp, 300 mg tablet, 600 mg tablet)</i>	1-Covered	
OXTELLAR XR	1-Covered	ST
PEGANONE	1-Covered	ST
<i>phenytoin (50 mg infatab, 50 mg tablet chew, 100 mg/4 ml susp, 125 mg/5 ml susp)</i>	1-Covered	
<i>phenytoin sodium (50 mg/ml vial, 50 mg/ml ampul, 100 mg/2 ml vial, 250 mg/5 ml vial)</i>	1-Covered	
<i>phenytoin sodium extended</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	

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
Antidementia Agents		
Antidementia Agents, Other		
<i>ergoloid mesylates</i>	1-Covered	PA
Cholinesterase Inhibitors		
<i>donepezil hcl (5 mg tablet, 10 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>donepezil hcl 23 mg tablet</i>	1-Covered	
<i>donepezil hcl odt</i>	1-Covered	QL (2 PER 1 DAYS)
EXELON (4.6 MG/24HR, 9.5 MG/24HR, 13.3 MG/24HR)	1-Covered	QL (1 PER 1 DAYS)
<i>galantamine hbr</i>	1-Covered	
<i>galantamine hydrobromide</i>	1-Covered	
<i>rivastigmine (1.5 mg capsule, 3 mg capsule, 4.5 mg capsule, 6 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>rivastigmine (4.6 mg/24hr patch, 9.5 mg/24hr patch, 13.3 mg/24hr ptch)</i>	1-Covered	QL (1 PER 1 DAYS)
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
<i>memantine 5-10 mg titration pk</i>	1-Covered	
<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)
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)
NAMENDA XR	1-Covered	
Antidepressants		
<i>chlordiazepoxide-amitriptyline</i>	1-Covered	
<i>fluoxetine hcl 60 mg tablet</i>	1-Covered	
<i>olanzapine-fluoxetine hcl</i>	1-Covered	
<i>perphenazine-amitriptyline</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
Antidepressants, Other		
APLENZIN	1-Covered	
BUPROBAN	1-Covered	QL (2 PER 1 DAYS)
<i>bupropion hcl</i>	1-Covered	QL (4 PER 1 DAYS)
<i>bupropion hcl sr</i>	1-Covered	QL (2 PER 1 DAYS)
<i>bupropion hcl xl 150 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>bupropion hcl xl 300 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
FORFIVO XL	1-Covered	
<i>maprotiline hcl</i>	1-Covered	
<i>mirtazapine (15 mg tablet, 15 mg odt)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>mirtazapine (30 mg tablet, 30 mg odt)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>mirtazapine (7.5 mg tablet, 45 mg tablet, 45 mg odt)</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)
<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</i>	1-Covered	
VIIBRYD 10-20-40 MG STARTER PK	1-Covered	
Monoamine Oxidase Inhibitors		
EMSAM	1-Covered	
MARPLAN	1-Covered	
<i>phenelzine sulfate</i>	1-Covered	
<i>tranylcypromine sulfate</i>	1-Covered	
SSRIs/ SNRIs		
BRINTELLIX	1-Covered	
BRISDELLE	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>citalopram hbr (20 mg tablet, 40 mg tablet)</i>	1-Covered	QL (1.5 PER 1 DAYS)
<i>citalopram hbr 10 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>citalopram hbr 10 mg/5 ml soln</i>	1-Covered	
<i>desvenlafaxine er (er 50 mg tab, er 50 mg tablet, er 100 mg tab)</i>	1-Covered	
<i>escitalopram 10 mg tablet</i>	1-Covered	QL (1.5 PER 1 DAYS)
<i>escitalopram 20 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>escitalopram 5 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>escitalopram oxalate 5 mg/5 ml</i>	1-Covered	QL (20 PER 1 DAYS)
FETZIMA	1-Covered	
<i>fluoxetine 20 mg/5 ml solution</i>	1-Covered	
<i>fluoxetine dr</i>	1-Covered	
<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 40 mg capsule</i>	1-Covered	QL (2 PER 1 DAYS)
<i>fluvoxamine maleate (50 mg tab, 100 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>fluvoxamine maleate 25 mg tab</i>	1-Covered	QL (1 PER 1 DAYS)
<i>fluvoxamine maleate er</i>	1-Covered	
KHEDEZLA	1-Covered	
<i>paroxetine cr</i>	1-Covered	
<i>paroxetine er</i>	1-Covered	
<i>paroxetine hcl</i>	1-Covered	
PAXIL 10 MG/5 ML SUSPENSION	1-Covered	
PEXEVA	1-Covered	
PRISTIQ ER	1-Covered	
<i>sertraline 20 mg/ml oral conc</i>	1-Covered	QL (10 PER 1 DAYS)
<i>sertraline hcl (25 mg tablet, 50 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>sertraline hcl 100 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
TRINTELLIX	1-Covered	
<i>venlafaxine hcl</i>	1-Covered	
<i>venlafaxine hcl er (er 150 mg cap, er 150 mg tab)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>venlafaxine hcl er (er 37.5 mg cap, er 37.5 mg tab, er 75 mg cap, er 75 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>venlafaxine hcl er 225 mg tab</i>	1-Covered	QL (1 PER 1 DAYS)
VIIIBRYD (10 MG TABLET, 10-20 MG STARTER PACK, 20 MG TABLET, 40 MG TABLET)	1-Covered	
Tricyclics		
<i>amitriptyline hcl</i>	1-Covered	
<i>amoxapine</i>	1-Covered	
<i>clomipramine hcl</i>	1-Covered	
<i>desipramine hcl</i>	1-Covered	
<i>doxepin hcl (5% cream, 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</i>	1-Covered	
<i>imipramine pamoate</i>	1-Covered	
<i>nortriptyline hcl (10 mg/5 ml sol, hcl 10 mg cap, hcl 25 mg cap, hcl 50 mg cap, hcl 75 mg cap)</i>	1-Covered	
<i>protriptyline hcl</i>	1-Covered	
PRUDOXIN	1-Covered	
SILENOR	1-Covered	
SURMONTIL	1-Covered	
<i>trimipramine maleate (25 mg cap, 50 mg cap)</i>	1-Covered	QL (6 PER 1 DAYS)
<i>trimipramine maleate 100 mg cp</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 amp, 50 mg tablet, 100 mg tablet, 200 mg tablet)</i>	1-Covered	
<i>diphenhydramine 50 mg/ml vial</i>	1-Covered	
<i>hydroxyzine hcl (hcl 10 mg tablet, 10 mg/5 ml syrup, 10 mg/5 ml soln, 25 mg/ml vial, hcl 25 mg tablet, 50 mg/ml vial, 50 mg/25 ml syrup, hcl 50 mg tablet, 100 mg/2 ml vial, 500 mg/10 ml vial)</i>	1-Covered	
<i>hydroxyzine pamoate</i>	1-Covered	
<i>meclizine hcl (12.5 mg tablet, 25 mg tablet)</i>	1-Covered	
<i>metoclopramide hcl (5 mg tablet, 5 mg/5 ml syrup, 5 mg/5 ml soln, 10 mg/2 ml vial, 10 mg tablet)</i>	1-Covered	
<i>metoclopramide hcl odt</i>	1-Covered	
<i>perphenazine</i>	1-Covered	
<i>prochlorperazine</i>	1-Covered	
<i>prochlorperazine edisylate</i>	1-Covered	
<i>prochlorperazine maleate</i>	1-Covered	
<i>promethazine hcl (12.5 mg suppos, 25 mg/ml syringe, 25 mg/ml vial, 25 mg suppository, 25 mg/ml ampul, 50 mg/ml vial, 50 mg suppository, 50 mg/ml ampul)</i>	1-Covered	
<i>promethazine hcl (6.25 mg/5 ml syr, 12.5 mg tablet, 25 mg tablet, 50 mg tablet)</i>	1-Covered	PA
<i>trimethobenzamide 300 mg cap</i>	1-Covered	
Emetogenic Therapy Adjuncts		
<i>dronabinol</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMEND (40 MG CAPSULE, 80 MG CAPSULE, 125 MG POWDER PACKET, 125 MG CAPSULE, 150 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
EMEND TRIPACK	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (3 PER 14 DAYS)
<i>granisetron hcl</i>	1-Covered	
<i>ondansetron hcl (4 mg/5 ml solution, hcl 24 mg tablet)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl (hcl 4 mg/2 ml vial, 4 mg/2 ml ampule)</i>	1-Covered	
<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 odt</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

Antifungals

ABELCET	1-Covered	
AMBISOME	1-Covered	
<i>amphotericin b</i>	1-Covered	
CANCIDAS	1-Covered	
<i>ciclopirox (0.77% gel, 0.77% cream, 0.77% topical susp, 1% shampoo, 8% solution)</i>	1-Covered	
<i>clotrimazole (1% solution, 1% cream, 10 mg troche)</i>	1-Covered	
<i>econazole nitrate</i>	1-Covered	
<i>fluconazole (10 mg/ml susp, 40 mg/ml susp, 50 mg tablet, 100 mg tablet, 200 mg tablet)</i>	1-Covered	
<i>fluconazole 150 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>fluconazole-dext 400 mg/200 ml</i>	1-Covered	
<i>fluconazole-nacl 200 mg/100 ml</i>	1-Covered	
<i>fluconazole-ns 200 mg/100 ml</i>	1-Covered	
<i>flucytosine</i>	1-Covered	
<i>griseofulvin (125 mg/5 ml susp, micro 500 mg tab)</i>	1-Covered	
<i>griseofulvin ultramicrosize</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GYNAZOLE 1	1-Covered	
<i>itraconazole</i>	1-Covered	
<i>ketoconazole (2% shampoo, 2% cream, 200 mg tablet)</i>	1-Covered	
<i>naftifine hcl</i>	1-Covered	
NOXAFIL (40 MG/ML SUSPENSION, DR 100 MG TABLET)	1-Covered	
NYAMYC	1-Covered	
<i>nystatin (100,000 unit/gm cream, 100,000 units/gm oint, 100,000 unit/ml susp, 100,000 unit/gm powd, 500,000 unit oral tab, 500,000 unit/5 ml sus, 50,000,000 units pwd, 150,000,000 units pwd, 500,000,000 units pwd)</i>	1-Covered	
NYSTOP	1-Covered	
ONMEL	1-Covered	
<i>oxiconazole nitrate</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, 0.8% cream, 80 mg suppository)</i>	1-Covered	
VFEND 40 MG/ML SUSPENSION	1-Covered	
<i>voriconazole (40 mg/ml susp, 50 mg tablet, 200 mg tablet, 200 mg vial)</i>	1-Covered	
ZOLINZA	1-Covered	

Antigout Agents

<i>allopurinol</i>	1-Covered	
<i>colchicine (0.6 mg capsule, 0.6 mg tablet)</i>	1-Covered	
<i>probenecid</i>	1-Covered	

Antimigraine Agents

<i>methylergonovine 0.2 mg tablet</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
TREXIMET	1-Covered	
Ergot Alkaloids		
<i>dihydroergotamine mesylate (1 mg/ml vial, 1 mg/ml amp)</i>	1-Covered	
ERGOMAR	1-Covered	
MIGRANAL	1-Covered	
Prophylactic		
BOTOX	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</i>	1-Covered	
<i>frovatriptan succinate</i>	1-Covered	
<i>naratriptan</i>	1-Covered	QL (9 PER 23 DAYS)
<i>naratriptan hcl</i>	1-Covered	QL (9 PER 23 DAYS)
<i>rizatriptan</i>	1-Covered	
<i>sumatriptan</i>	1-Covered	
<i>sumatriptan succinate (25 mg tablet, 50 mg tablet, 100 mg tablet)</i>	1-Covered	QL (9 PER 23 DAYS)
<i>sumatriptan succinate (4 mg/0.5 ml cart, 4 mg/0.5 ml inject, 6 mg/0.5 ml vial, 6 mg/0.5 ml refill, 6 mg/0.5 ml inject, 6 mg/0.5 ml syringe)</i>	1-Covered	
<i>zolmitriptan</i>	1-Covered	
<i>zolmitriptan odt</i>	1-Covered	
Anticholinergic Agents		
Parasympathomimetics		
<i>guanidine hcl</i>	1-Covered	
MESTINON (60 MG/5 ML SYRUP, 180 MG TIMESPAN)	1-Covered	
<i>pyridostigmine bromide</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>pyridostigmine bromide er</i>	1-Covered	
Antimycobacterials		
Antimycobacterials, Other		
<i>dapsone</i>	1-Covered	
<i>rifabutin</i>	1-Covered	
Antituberculars		
CAPASTAT SULFATE	1-Covered	
<i>ethambutol hcl</i>	1-Covered	
<i>isoniazid (50 mg/5 ml solution, 100 mg/ml vial, 100 mg tablet, 300 mg tablet)</i>	1-Covered	
PASER	1-Covered	
PRIFTIN	1-Covered	
<i>pyrazinamide</i>	1-Covered	
<i>rifampin</i>	1-Covered	
RIFATER	1-Covered	
SIRTURO	1-Covered	
TRECTOR	1-Covered	
Antineoplastics		
Alkylating Agents		
BUSULFEX	1-Covered	
<i>cyclophosphamide (25 mg capsule, 50 mg capsule)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAUNOXOME	1-Covered	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE	1-Covered	
HEXALEN	1-Covered	
LEUKERAN	1-Covered	
<i>lomustine</i>	1-Covered	
MATULANE	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>melphalan hcl</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	1-Covered	
Antiandrogens		
<i>bicalutamide</i>	1-Covered	QL (1 PER 1 DAYS)
<i>flutamide</i>	1-Covered	
NILANDRON	1-Covered	QL (2 PER 1 DAYS)
<i>nilutamide</i>	1-Covered	
XTANDI	1-Covered	
ZYTIGA	1-Covered	
Antiangiogenic Agents		
POMALYST	1-Covered	
REVLIMID (5 MG CAPSULE, 10 MG CAPSULE, 15 MG CAPSULE, 25 MG CAPSULE)	1-Covered	
THALOMID	1-Covered	PA - FOR NEW STARTS ONLY
Antiestrogens/Modifiers		
EMCYT	1-Covered	
FARESTON	1-Covered	QL (4 PER 1 DAYS)
SOLTAMOX	1-Covered	
<i>tamoxifen citrate</i>	1-Covered	
Antimetabolites		
<i>cytarabine (20 mg/ml vial, 100 mg/5 ml vial)</i>	1-Covered	
DROXIA	1-Covered	
<i>gemcitabine hcl (hcl 1 gram vial, 1 gram/26.3 ml vl, 2 gram/52.6 ml vl, hcl 2 gram vial, hcl 200 mg vial, 200 mg/5.26 ml vl)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>hydroxyurea</i>	1-Covered	
LONSURF	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
PURINETHOL	1-Covered	
PURIXAN	1-Covered	
TABLOID	1-Covered	
ALIMTA	1-Covered	PA - TO CONFIRM PART D COVERAGE
ARRANON	1-Covered	
AVASTIN	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>azacitidine</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
BELEODAQ	1-Covered	PA - TO CONFIRM PART D COVERAGE
BICNU	1-Covered	
<i>bleomycin sulfate</i>	1-Covered	
<i>carboplatin (50 mg/5 ml vial, 150 mg/15 ml vial, 150 mg vial, 450 mg/45 ml vial, 600 mg/60 ml vial)</i>	1-Covered	
<i>cisplatin</i>	1-Covered	
<i>cladribine</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLOLAR	1-Covered	
COSMEGEN	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine 2 g/20 ml vial</i>	1-Covered	
<i>dacarbazine</i>	1-Covered	
DACOGEN	1-Covered	
<i>daunorubicin hcl (20 mg/4 ml vial, 20 mg vial)</i>	1-Covered	
<i>decitabine</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>dexrazoxane</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
DOCEFREZ 20 MG VIAL	1-Covered	
<i>docetaxel (20 mg/2 ml vial, 20 mg/ml vial, 80 mg/4 ml vial, 80 mg/8 ml vial, 140 mg/7 ml vial, 160 mg/16 ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>docetaxel 160 mg/8 ml vial</i>	1-Covered	
DOXIL	1-Covered	
<i>doxorubicin hcl (10 mg vial, 10 mg/5 ml vial, 20 mg/10 ml vial, 50 mg vial, 50 mg/25 ml vial, 150 mg/75 ml vial, 200 mg/100 ml vial)</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>doxorubicin hcl liposome</i>	1-Covered	
ELITEK	1-Covered	
<i>epirubicin hcl (hcl 50 mg vial, 50 mg/25 ml vial, hcl 200 mg vial, 200 mg/100 ml vial)</i>	1-Covered	
ERBITUX	1-Covered	
ERWINAZE	1-Covered	
FASLODEX	1-Covered	
FOLOTYN	1-Covered	
HALAVEN	1-Covered	
HERCEPTIN	1-Covered	
<i>idarubicin hcl</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ifosfamide (1 gm/20 ml vial, 1 gm vial, 3 gm vial, 3 gm/ 60 ml vial)</i>	1-Covered	
<i>irinotecan hcl</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISTODAX	1-Covered	
IXEMPRA	1-Covered	
JEVTANA	1-Covered	
KADCYLA	1-Covered	
<i>mesna</i>	1-Covered	
MESNEX (1 GRAM/10 ML VIAL, 400 MG TABLET)	1-Covered	
<i>mitomycin</i>	1-Covered	
MUSTARGEN	1-Covered	
NIPENT	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>oxaliplatin (50 mg vial, 50 mg/10 ml vial, 100 mg vial, 100 mg/20 ml vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>paclitaxel</i>	1-Covered	
PERJETA	1-Covered	
PROLEUKIN	1-Covered	
TREANDA (25 MG VIAL, 100 MG VIAL)	1-Covered	
TRISENOX	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VECTIBIX	1-Covered	PA - TO CONFIRM PART D COVERAGE
VELCADE	1-Covered	PA - TO CONFIRM PART D COVERAGE
VIDAZA	1-Covered	
<i>vinblastine sulfate</i>	1-Covered	
VINCASAR PFS	1-Covered	
<i>vincristine sulfate</i>	1-Covered	
<i>vinorelbine tartrate</i>	1-Covered	
ZINECARD	1-Covered	

Antineoplastics, Other

ABRAXANE	1-Covered	
<i>amifostine</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>calcium folinate</i>	1-Covered	
CYRAMZA	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>docetaxel 200 mg/20 ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
FARYDAK	1-Covered	
<i>fludarabine phosphate (50 mg vial, 50 mg/2 ml vial)</i>	1-Covered	
FUSILEV	1-Covered	
<i>leucovorin calcium (cal 500 mg/50 ml vl, calcium 5 mg tab, calcium 10 mg tab, calcium 15 mg tab, calcium 25 mg tab, calcium 50 mg vial, calcium 100 mg vial, calcium 200 mg vial, calcium 350 mg vial, calcium 500 mg vl)</i>	1-Covered	
<i>levoleucovorin 175 mg/17.5 ml</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>levoleucovorin 250 mg/25 ml vl</i>	1-Covered	
LYNPARZA	1-Covered	
<i>mitoxantrone hcl</i>	1-Covered	
ONCASPAR	1-Covered	
REVLIMID (2.5 MG CAPSULE, 20 MG CAPSULE)	1-Covered	
SYNRIBO	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
<i>thiotepa</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
YERVOY	1-Covered	
ZALTRAP	1-Covered	
Aromatase Inhibitors, 3rd Generation		
<i>anastrozole</i>	1-Covered	QL (1 PER 1 DAYS)
<i>exemestane</i>	1-Covered	
<i>letrozole</i>	1-Covered	
Enzyme Inhibitors		
ETOPOPHOS	1-Covered	
<i>etoposide (100 mg/5 ml vial, 500 mg/25 ml vial, 1,000 mg/50 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	1-Covered	
Molecular Target Inhibitors		
AFINITOR (5 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1-Covered	
ALECENSA	1-Covered	
BOSULIF	1-Covered	
CABOMETYX	1-Covered	
CAPRELSA	1-Covered	
COMETRIQ	1-Covered	
COTELLIC	1-Covered	LA
ERIVEDGE	1-Covered	
GILOTRIF	1-Covered	
GLEEVEC	1-Covered	
IBRANCE	1-Covered	
ICLUSIG	1-Covered	
<i>imatinib mesylate</i>	1-Covered	
IMBRUVICA	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INLYTA	1-Covered	
IRESSA	1-Covered	
JAKAFI	1-Covered	
LENVIMA	1-Covered	
MEKINIST	1-Covered	
NEXAVAR	1-Covered	QL (4 PER 1 DAYS)
NINLARO	1-Covered	
ODOMZO	1-Covered	LA
SPRYCEL	1-Covered	
STIVARGA	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	1-Covered	
TAGRISSO	1-Covered	LA
TARCEVA	1-Covered	
TASIGNA	1-Covered	
TYKERB	1-Covered	
VENCLEXTA	1-Covered	
VENCLEXTA STARTING PACK	1-Covered	
VOTRIENT	1-Covered	
XALKORI	1-Covered	
ZELBORAF	1-Covered	
ZYKADIA	1-Covered	

Monoclonal Antibodies

DARZALEX	1-Covered	LA
EMPLICITI	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

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPDIVO	1-Covered	PA - TO CONFIRM PART D COVERAGE
RITUXAN	1-Covered	
SYLVANT	1-Covered	PA - TO CONFIRM PART D COVERAGE
TECENTRIQ	1-Covered	
Retinoids		
ATRALIN	1-Covered	
<i>bexarotene</i>	1-Covered	
PANRETIN	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, 0.025% gel, 0.025% cream, 0.05% gel, 0.05% cream, 0.1% cream, 10 mg capsule)</i>	1-Covered	
Antiparasitics		
Anthelmintics		
ALBENZA	1-Covered	
BILTRICIDE	1-Covered	
STROMEKTOL	1-Covered	
Antiprotozoals		
ALINIA (100 MG/5 ML SUSPENSION, 500 MG TABLET)	1-Covered	
<i>atovaquone</i>	1-Covered	
<i>atovaquone-proguanil hcl</i>	1-Covered	
<i>chloroquine phosphate</i>	1-Covered	
COARTEM	1-Covered	
DARAPRIM	1-Covered	
<i>hydroxychloroquine sulfate</i>	1-Covered	
<i>mefloquine hcl</i>	1-Covered	
NEBUPENT	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
PENTAM 300	1-Covered	
<i>primaquine</i>	1-Covered	QL (2 PER 1 DAYS)
<i>quinine sulfate</i>	1-Covered	
Pediculicides/ Scabicides		
<i>lindane</i>	1-Covered	
<i>malathion</i>	1-Covered	
<i>permethrin 5% cream</i>	1-Covered	
ULESFIA	1-Covered	
Antiparkinson Agents		
Anticholinergics		
<i>benztropine mesylate (0.5 mg tab, 1 mg tablet, 2 mg tablet)</i>	1-Covered	PA
<i>benztropine mesylate (2 mg/2 ml vial, 2 mg/2 ml ampule)</i>	1-Covered	
<i>trihexyphenidyl hcl (2 mg tablet, 2 mg/5 ml elx, 5 mg tablet)</i>	1-Covered	PA
Antiparkinson Agents, Other		
<i>amantadine (50 mg/5 ml solution, 100 mg tablet, 100 mg/10 ml soln, 100 mg capsule)</i>	1-Covered	
<i>carbidopa-levodopa-entacapone</i>	1-Covered	
<i>entacapone</i>	1-Covered	
NUPLAZID	1-Covered	
<i>tolcapone</i>	1-Covered	
Dopamine Agonists		
APOKYN	1-Covered	
<i>bromocriptine mesylate</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-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pramipexole dihydrochloride</i>	1-Covered	QL (3 PER 1 DAYS)
<i>pramipexole er</i>	1-Covered	
<i>ropinirole er</i>	1-Covered	
<i>ropinirole hcl</i>	1-Covered	

Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors

<i>carbidopa</i>	1-Covered	
<i>carbidopa-levodopa</i>	1-Covered	
<i>carbidopa-levodopa er</i>	1-Covered	

Monoamine Oxidase B (MAO-B) Inhibitors

AZILECT	1-Covered	
<i>selegiline hcl</i>	1-Covered	
ZELAPAR	1-Covered	

Antipsychotics

1st Generation/ Typical

<i>fluphenazine decanoate</i>	1-Covered	
<i>fluphenazine hcl (1 mg tablet, 2.5 mg/ml vial, 2.5 mg tablet, 2.5 mg/5 ml elix, 5 mg/ml conc, 5 mg tablet, 10 mg tablet)</i>	1-Covered	
<i>haloperidol (0.5 mg tablet, 1 mg tablet, 2 mg tablet, 5 mg/ml ampul, 5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>haloperidol decanoate</i>	1-Covered	
<i>haloperidol decanoate 100</i>	1-Covered	
<i>haloperidol lactate</i>	1-Covered	
<i>loxapine (10 mg capsule, 25 mg capsule, 50 mg capsule)</i>	1-Covered	
<i>loxapine 5 mg capsule</i>	1-Covered	QL (12 PER 1 DAYS)
<i>molindone hcl</i>	1-Covered	
ORAP	1-Covered	
<i>pimozide</i>	1-Covered	QL (5 PER 1 DAYS)

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>thioridazine hcl</i>	1-Covered	
<i>thiothixene</i>	1-Covered	
<i>trifluoperazine hcl</i>	1-Covered	
2nd Generation/ Atypical		
ABILIFY (1 MG/ML SOLUTION, 9.7 MG/1.3 ML VIAL)	1-Covered	
ABILIFY DISCMELT	1-Covered	
ABILIFY MAINTENA	1-Covered	
<i>aripiprazole (2 mg tablet, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet)</i>	1-Covered	
<i>aripiprazole odt</i>	1-Covered	
ARISTADA	1-Covered	
FANAPT	1-Covered	
GEODON 20 MG/ML VIAL	1-Covered	
INVEGA	1-Covered	
INVEGA SUSTENNA	1-Covered	QL (1 PER 28 DAYS)
INVEGA TRINZA	1-Covered	QL (1 PER 84 DAYS)
LATUDA	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 10 mg vial</i>	1-Covered	
<i>olanzapine odt</i>	1-Covered	
<i>paliperidone er (er 1.5 mg tablet, er 3 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>paliperidone er (er 6 mg tablet, er 9 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>quetiapine fumarate (300 mg tab, 400 mg tab)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>quetiapine fumarate (50 mg tab, 100 mg tab, 200 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>quetiapine fumarate 25 mg tab</i>	1-Covered	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
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)
RISPERDAL CONSTA	1-Covered	
<i>risperidone (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet, 4 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>risperidone 0.5 mg odt</i>	1-Covered	QL (4 PER 1 DAYS)
<i>risperidone 1 mg odt</i>	1-Covered	QL (1 PER 1 DAYS)
<i>risperidone 1 mg/ml solution</i>	1-Covered	
<i>risperidone 3 mg odt</i>	1-Covered	QL (3 PER 1 DAYS)
<i>risperidone odt (0.25 mg odt, 2 mg odt, 4 mg odt)</i>	1-Covered	QL (2 PER 1 DAYS)
SAPHRIS	1-Covered	
VRAYLAR (1.5 MG CAPSULE, 3 MG CAPSULE, 4.5 MG CAPSULE, 6 MG CAPSULE)	1-Covered	
<i>ziprasidone hcl</i>	1-Covered	QL (2 PER 1 DAYS)
ZYPREXA RELPREVV	1-Covered	

Treatment-Resistant

<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)
<i>clozapine odt</i>	1-Covered	
FAZACLO	1-Covered	
VERSACLOZ	1-Covered	

Antispasticity Agents

<i>baclofen</i>	1-Covered	
<i>dantrolene sodium</i>	1-Covered	
<i>tizanidine hcl (2 mg tablet, 4 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
Antivirals		
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
GENVOYA	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	1-Covered	
TIVICAY	1-Covered	
VITEKTA	1-Covered	
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA	1-Covered	QL (1 PER 1 DAYS)
EDURANT	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 200 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>nevirapine 50 mg/5 ml susp</i>	1-Covered	QL (40 PER 1 DAYS)
<i>nevirapine er</i>	1-Covered	
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)
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</i>	1-Covered	QL (2 PER 1 DAYS)
<i>abacavir-lamivudine-zidovudine</i>	1-Covered	
ATRIPLA	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
COMBIVIR	1-Covered	QL (2 PER 1 DAYS)
DESCOVY	1-Covered	
<i>didanosine (dr 125 mg capsule, dr 200 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>didanosine (dr 250 mg capsule, dr 400 mg capsule)</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	1-Covered	QL (1 PER 1 DAYS)
<i>lamivudine-zidovudine</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 solution</i>	1-Covered	QL (80 PER 1 DAYS)
TRIZIVIR	1-Covered	QL (2 PER 1 DAYS)
TRUVADA (100 MG-150 MG TABLET, 133 MG-200 MG TABLET, 167 MG-250 MG TABLET)	1-Covered	
TRUVADA 200 MG-300 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
VIDEX	1-Covered	QL (40 PER 1 DAYS)
ZIAGEN 20 MG/ML SOLUTION	1-Covered	QL (30 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)
<i>zidovudine 50 mg/5 ml syrup</i>	1-Covered	QL (60 PER 1 DAYS)

Anti-HIV Agents, Other

FUZEON	1-Covered	
SELZENTRY	1-Covered	QL (4 PER 1 DAYS)
TRIUMEQ	1-Covered	
TYBOST	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
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	1-Covered	
EVOTAZ	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	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)
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</i>	1-Covered	
<i>foscarnet sodium</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>ganciclovir sodium</i>	1-Covered	
VALCYTE 50 MG/ML SOLUTION	1-Covered	
<i>valganciclovir 450 mg tablet</i>	1-Covered	
ZIRGAN	1-Covered	

Anti-hepatitis B (HBV) Agents

<i>adefovir dipivoxil</i>	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	QL (20 PER 1 DAYS)
<i>entecavir</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 oral soln, 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)
<i>lamivudine hbv</i>	1-Covered	
TYZEKA	1-Covered	
VIRAZOLE	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)

Anti-hepatitis C (HCV) Agents

HARVONI	1-Covered	PA
INTRON A (18 MILLION VIL, 50 MILLION VIL)	1-Covered	
OLYSIO	1-Covered	PA
PEGINTRON	1-Covered	PA, QL (4 PER 28 DAYS)
PEGINTRON REDIPEN	1-Covered	PA, QL (4 PER 28 DAYS)
REBETOL 40 MG/ML SOLUTION	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
<i>ribavirin</i>	1-Covered	PA, QL (7 PER 1 DAYS)
SOVALDI	1-Covered	PA
SYLATRON	1-Covered	
SYLATRON 4-PACK	1-Covered	
VIEKIRA PAK	1-Covered	PA

Anti-influenza Agents

RAPIVAB	1-Covered	PA - TO CONFIRM PART D COVERAGE
RELENZA	1-Covered	
<i>rimantadine hcl</i>	1-Covered	
TAMIFLU (6 MG/ML SUSPENSION, 30 MG CAPSULE, 45 MG CAPSULE, 75 MG CAPSULE)	1-Covered	

Antiherpetic Agents

<i>acyclovir (5% ointment, 200 mg capsule, 200 mg/5 ml susp, 400 mg tablet, 800 mg tablet)</i>	1-Covered	
<i>acyclovir sodium (sodium 1 gm vial, sodium 500 mg vial, 500 mg/10 ml vial, 1,000 mg/20 ml vial)</i>	1-Covered	
<i>famciclovir</i>	1-Covered	QL (3 PER 1 DAYS)
<i>trifluridine</i>	1-Covered	
<i>valacyclovir</i>	1-Covered	QL (4 PER 1 DAYS)
ZOVIRAX 5% CREAM	1-Covered	

Anxiolytics

Anxiolytics, Other

<i>buspirone hcl</i>	1-Covered	
<i>oxazepam</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</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>alprazolam er</i>	1-Covered	
ALPRAZOLAM INTENSOL	1-Covered	
<i>alprazolam odt</i>	1-Covered	
<i>alprazolam xr</i>	1-Covered	
<i>chlordiazepoxide 10 mg capsule</i>	1-Covered	QL (10 PER 1 DAYS)
<i>chlordiazepoxide 25 mg capsule</i>	1-Covered	QL (12 PER 1 DAYS)
<i>chlordiazepoxide 5 mg capsule</i>	1-Covered	QL (8 PER 1 DAYS)

Bipolar Agents

Mood Stabilizers

<i>carbamazepine er (er 100 mg cap, er 200 mg cap, er 300 mg cap)</i>	1-Covered	
<i>lithium</i>	1-Covered	
<i>lithium carbonate</i>	1-Covered	
<i>lithium carbonate er</i>	1-Covered	

Blood Glucose Regulators

Antidiabetic Agents

<i>acarbose</i>	1-Covered	QL (3 PER 1 DAYS)
BYDUREON	1-Covered	
BYDUREON PEN	1-Covered	
BYETTA	1-Covered	
<i>chlorpropamide 100 mg tablet</i>	1-Covered	QL (7 PER 1 DAYS)
<i>chlorpropamide 250 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
CYCLOSET	1-Covered	
<i>glimepiride</i>	1-Covered	
<i>glipizide</i>	1-Covered	QL (4 PER 1 DAYS)
<i>glipizide er 10 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>glipizide er 2.5 mg tablet</i>	1-Covered	
<i>glipizide er 5 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>glipizide xl 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>glipizide xl 2.5 mg tablet</i>	1-Covered	
<i>glipizide xl 5 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>glyburide</i>	1-Covered	QL (4 PER 1 DAYS)
<i>glyburide micronized</i>	1-Covered	QL (2 PER 1 DAYS)
GLYSET	1-Covered	
INVOKAMET	1-Covered	
INVOKANA	1-Covered	
JANUVIA	1-Covered	
JARDIANCE	1-Covered	
JENTADUETO	1-Covered	
JENTADUETO XR	1-Covered	
<i>metformin er 1,000 mg osm-tab</i>	1-Covered	
<i>metformin hcl 1,000 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 850 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>metformin hcl er (er 500 mg osm-tb, er 500 mg tablet)</i>	1-Covered	QL (4 PER 1 DAYS)
<i>metformin hcl er 750 mg tablet</i>	1-Covered	QL (2 PER 1 DAYS)
<i>miglitol</i>	1-Covered	
<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</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</i>	1-Covered	QL (5 PER 1 DAYS)
SYMLINPEN 120	1-Covered	
SYMLINPEN 60	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)

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>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</i>	1-Covered	QL (6 PER 1 DAYS)
TRADJENTA	1-Covered	
VICTOZA 2-PAK	1-Covered	
VICTOZA 3-PAK	1-Covered	
WELCHOL	1-Covered	
<i>glipizide-metformin</i>	1-Covered	QL (4 PER 1 DAYS)
<i>glyburide-metformin hcl</i>	1-Covered	QL (4 PER 1 DAYS)
JANUMET	1-Covered	
JANUMET XR	1-Covered	
<i>pioglitazone-glimepiride</i>	1-Covered	QL (1 PER 1 DAYS)
<i>pioglitazone-metformin</i>	1-Covered	QL (3 PER 1 DAYS)
Glycemic Agents		
GLUCAGEN	1-Covered	
GLUCAGON EMERGENCY KIT	1-Covered	
PROGLYCEM	1-Covered	
Insulins		
<i>1st tier unifine pentips</i>	1-Covered	
<i>1st tier unifine pentips plus (pntip 8mm 31g, pntp 31gx3/16, pntp 32gx5/32)</i>	1-Covered	
<i>advocate pen needles</i>	1-Covered	
AFREZZA (4 CARTRIDGE, 30-4 / 60-8, 60-4 / 30-8, 60-8 / 30-12)	1-Covered	
APIDRA	1-Covered	QL (40 PER 23 DAYS)
APIDRA SOLOSTAR	1-Covered	QL (45 PER 23 DAYS)
<i>bd ultra-fine pen needle</i>	1-Covered	
<i>carefine pen needle (6mm 31g, 8mm 30g, 12.7mm 29g)</i>	1-Covered	
<i>clickfine</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>comfort ez (4mm 32g, 4mm 33g, 5mm 31g, 5mm 33g, 5mm 32g, 6mm 32g, 6mm 31g, 6mm 33g, 8mm 31g, 8mm 32g, 8mm 33g)</i>	1-Covered	
<i>curity guaze pads</i>	1-Covered	
<i>easy comfort pen needles</i>	1-Covered	
<i>easy touch pen needle</i>	1-Covered	
<i>gauze pads & dressings - pads 2 x 2</i>	1-Covered	
<i>healthy accents unifine pentip (4mm 32g, 5mm 31g, 6mm 31g, 8mm 31g)</i>	1-Covered	
HUMALOG 100 UNITS/ML CARTRIDGE	1-Covered	QL (45 PER 23 DAYS)
HUMALOG 100 UNITS/ML VIAL	1-Covered	QL (40 PER 23 DAYS)
HUMALOG KWIKPEN U-100	1-Covered	QL (45 PER 23 DAYS)
HUMALOG KWIKPEN U-200	1-Covered	
HUMALOG MIX 50-50	1-Covered	QL (40 PER 23 DAYS)
HUMALOG MIX 50-50 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMALOG MIX 75-25	1-Covered	QL (40 PER 23 DAYS)
HUMALOG MIX 75-25 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMULIN 70-30	1-Covered	QL (40 PER 23 DAYS)
HUMULIN 70/30 KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMULIN N	1-Covered	QL (40 PER 23 DAYS)
HUMULIN N KWIKPEN	1-Covered	QL (45 PER 23 DAYS)
HUMULIN R	1-Covered	QL (40 PER 23 DAYS)
HUMULIN R U-500	1-Covered	
<i>incontrol pen needle</i>	1-Covered	
<i>insulin pen needle (comfort point ndl 29gx1/2", comfort point ndl 31gx1/3", comfort point ndl 31gx1/4", insulin needle)</i>	1-Covered	
<i>insulin syringe (disp) u-100 0.3 ml</i>	1-Covered	
<i>insulin syringe (disp) u-100 1 ml</i>	1-Covered	
<i>insulin syringe (disp) u-100 1/2 ml</i>	1-Covered	
<i>insupen</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
LANTUS	1-Covered	QL (40 PER 23 DAYS)
LANTUS SOLOSTAR	1-Covered	QL (45 PER 23 DAYS)
LEVEMIR	1-Covered	QL (40 PER 23 DAYS)
LEVEMIR FLEXPEN	1-Covered	QL (45 PER 23 DAYS)
LEVEMIR FLEXTOUCH	1-Covered	QL (45 PER 23 DAYS)
<i>lite touch (29g, 31gx1/4", 31g)</i>	1-Covered	
<i>mini ultra-thin ii</i>	1-Covered	
<i>needles, insulin disp., safety</i>	1-Covered	
<i>novofine</i>	1-Covered	
<i>novofine 32</i>	1-Covered	
<i>novofine plus</i>	1-Covered	
NOVOLIN 70-30	1-Covered	QL (40 PER 23 DAYS)
NOVOLIN N	1-Covered	QL (40 PER 23 DAYS)
NOVOLIN R	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 FLEXPEN	1-Covered	QL (45 PER 23 DAYS)
NOVOLOG MIX 70-30	1-Covered	QL (40 PER 23 DAYS)
NOVOLOG MIX 70-30 FLEXPEN	1-Covered	QL (45 PER 23 DAYS)
<i>novotwist</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>pen needle (eql pen 8mm 31g x 5/16" needle, eql pen needle 6mm 31g, fifty50 pen 31g x 5/16" needle, fifty50 pen 31g x 3/16" needle, gnp clickfine pen ndl 31gx5/16, gnp clickfine pen ndl 31gx1/4", kroger pen needles 29g, kroger pen needles 31g x 5/16", leader pen needle 6mm 31g, live better pen needle 6mm 31g, live better pen needles 8mm, live better pen needles 12mm, ms pen needle 6mm 31g, pen needle 6mm 31g, pen needle 30g x 5/16", pen needle 31g x 5/16", pen needle 31g x 3/16", pen needles 8mm 31g, pen needles 12mm 29g, pub pen 8mm 31g needles, pub pen 12mm 29g needles, pub pen needle 6mm 31g, pv pen needle 6mm 31g, pv pen needles 6mm 31g, ra pen needle 31gx3/16", ra pen needle 31gx5/16", relion mini pen 31g x 1/4" ndl, relion pen 29g needle, relion pen 31g needle, relion pen needle 29gx1/2", relion pen needle 31gx5/16", today's hlt pn needle 12mm 29g, today's hlth pn needle 6mm 31g, today's hlth pn needle 8mm 31g)</i>	1-Covered	
<i>pen needles</i>	1-Covered	
<i>ra sterile pads</i>	1-Covered	
<i>reli on 31g x 1/4" needles</i>	1-Covered	
<i>relion pen needles</i>	1-Covered	
<i>sure comfort (ndl 29gx1/2", 30g needle, 31g needle, ndl 31gx3/16", ndl 31gx5/16", ndl 32gx5/32")</i>	1-Covered	
<i>sure-fine pen needles</i>	1-Covered	
<i>topcare clickfine</i>	1-Covered	
TOUJEO SOLOSTAR	1-Covered	
<i>ulticare pen needle (ndl 12.7 mm 29g, needles 4mm 32g, needles 6mm 31g, needles 6 mm 31 g, needles 8 mm 31 g, needles 8mm 31g, needles 12mm 29g)</i>	1-Covered	
<i>ultilet pen needle</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>ultra-thin ii (29gx1/2", 31gx5/16)</i>	1-Covered	
<i>unifine pentips (careone pentip 4mm 32g, careone pentip 5mm 31g, careone pentip 6mm 31g, careone pentip 8mm 31g, careone pntp 12mm 29g, dr pentips 6mm ndl, dr pentips 8mm ndl, dr pentips 12mm ndl, pc pentips 6mm needle, pc pentips 8mm needle, pc pentips 12mm needle, pc pentips 31gx3/16", pentip 0.5cc needle, pentip needles, pentips 6mm needle, pentips 6mm 31g, pentips 8mm needles, pentips 8mm needle, pentips 8mm 31g, pentips 12mm needle, pentips 12mm 29g, pentips 31gx3/16", pentips 32gx5/32", pentips needles 29g, pv pentips 31gx3/16", pv pentips 32gx5/32", qc pentips 4mm 32g, qc pentips 32gx5/32", shopko pentips 4mm 32g, shopko pentips 5mm 31g, shopko pentips 8mm 31g, shopko pntips 12mm 29g)</i>	1-Covered	
<i>unifine pentips plus (careone pentp 29gx1/2", careone pentp 31gx1/4", careone pntp 31gx3/16", careone pntp 31gx5/16", careone pntp 32gx5/32", pentips plus 29gx1/2", pentips plus 31gx5/16", pentips plus 31gx1/4", pentips plus 31gx3/16", pentips plus 32gx5/32", pub pntp plus 31gx3/16, wm pentip plus 4mm 32g, wm pentip plus 5mm 31g, wm pentip plus 6mm 31g, wm pentip plus 8mm 31g)</i>	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	1-Covered	QL (2 PER 1 DAYS)
ELIQUIS 5 MG TABLET	1-Covered	QL (74 PER 30 DAYS)
<i>enoxaparin sodium</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>fondaparinux sodium</i>	1-Covered	
<i>heparin sodium (sod 1,000 unit/ml vial, sod 5,000 unit/ml vial, sod 5,000 unit/ml syr, sod 10,000 unit/ml vl, 10,000 unit/10 ml vial, sod 20,000 unit/ml vl, 30,000 unit/30 ml vial, 40,000 units/4 ml vial, 50,000 units/5 ml vial, 50,000 unit/10 ml vial, 50,000 units/10 ml vl)</i>	1-Covered	
<i>heparin sodium-d5w</i>	1-Covered	
JANTOVEN	1-Covered	
PRADAXA	1-Covered	
<i>warfarin sodium</i>	1-Covered	
XARELTO	1-Covered	
Blood Formation Modifiers		
<i>anagrelide hcl</i>	1-Covered	
LEUKINE 250 MCG VIAL	1-Covered	
MOZOBIL	1-Covered	
NEULASTA	1-Covered	PA
NEUMEGA	1-Covered	
NEUPOGEN	1-Covered	PA
PROCRIT	1-Covered	PA
PROMACTA	1-Covered	PA, LA
ZARXIO	1-Covered	PA
Coagulants		
<i>tranexamic acid</i>	1-Covered	
Platelet Modifying Agents		
AGGRENOX	1-Covered	QL (3 PER 1 DAYS)
<i>aspirin-dipyridamole er</i>	1-Covered	QL (3 PER 1 DAYS)
BRILINTA	1-Covered	
<i>cilostazol</i>	1-Covered	
<i>clopidogrel 300 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>clopidogrel 75 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>dipyridamole</i>	1-Covered	PA
EFFIENT	1-Covered	
<i>ticlopidine hcl</i>	1-Covered	PA, QL (2 PER 1 DAYS)
ZONTIVITY	1-Covered	

Cardiovascular Agents

Alpha-adrenergic Agonists

<i>clonidine</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</i>	1-Covered	PA
<i>methyldopa</i>	1-Covered	PA
<i>methyldopate hcl</i>	1-Covered	
<i>midodrine hcl</i>	1-Covered	
NORTHERA	1-Covered	

Alpha-adrenergic Blocking Agents

<i>doxazosin mesylate</i>	1-Covered	QL (2 PER 1 DAYS)
<i>phenoxybenzamine hcl</i>	1-Covered	
<i>prazosin hcl</i>	1-Covered	
<i>terazosin hcl</i>	1-Covered	QL (2 PER 1 DAYS)

Angiotensin II Receptor Antagonists

<i>candesartan cilexetil</i>	1-Covered	
<i>irbesartan</i>	1-Covered	QL (1 PER 1 DAYS)
<i>losartan potassium (25 mg tab, 50 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>losartan potassium 100 mg tab</i>	1-Covered	QL (1 PER 1 DAYS)
<i>telmisartan</i>	1-Covered	
<i>valsartan</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
Angiotensin-converting Enzyme (ACE) Inhibitors		
<i>benazepril hcl</i>	1-Covered	QL (2 PER 1 DAYS)
<i>captopril</i>	1-Covered	
<i>enalapril maleate</i>	1-Covered	
<i>fosinopril sodium</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</i>	1-Covered	
<i>perindopril erbumine</i>	1-Covered	
<i>quinapril hcl</i>	1-Covered	QL (2 PER 1 DAYS)
<i>ramipril</i>	1-Covered	QL (2 PER 1 DAYS)
<i>trandolapril</i>	1-Covered	
Antiarrhythmics		
<i>amiodarone hcl (hcl 100 mg tablet, 150 mg/3 ml amp, 150 mg/3 ml vial, hcl 200 mg tablet, hcl 400 mg tablet, 450 mg/9 ml vial, 900 mg/18 ml vial)</i>	1-Covered	
<i>disopyramide phosphate</i>	1-Covered	PA
<i>dofetilide</i>	1-Covered	
<i>flecainide acetate</i>	1-Covered	
<i>mexiletine hcl</i>	1-Covered	
MULTAQ	1-Covered	
PACERONE 100 MG TABLET	1-Covered	
<i>procainamide hcl</i>	1-Covered	
<i>propafenone hcl</i>	1-Covered	
<i>propafenone hcl er</i>	1-Covered	
<i>quinidine gluconate (80 mg/ml vial, er 324 mg tab)</i>	1-Covered	
<i>quinidine sulfate</i>	1-Covered	
<i>sotalol</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>sotalol af</i>	1-Covered	
TIKOSYN	1-Covered	
Beta-adrenergic Blocking Agents		
<i>acebutolol hcl</i>	1-Covered	
<i>atenolol</i>	1-Covered	
<i>betaxolol hcl (10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>bisoprolol fumarate</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	1-Covered	
<i>labetalol hcl (100 mg tablet, 100 mg/20 ml vl, 200 mg/40 ml vl, 200 mg tablet, 300 mg tablet)</i>	1-Covered	
<i>metoprolol succ er 200 mg tab</i>	1-Covered	QL (2 PER 1 DAYS)
<i>metoprolol succinate (er 25 mg tab, er 50 mg tab, er 100 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>metoprolol tartrate (1 mg/ml carpject, tart 5 mg/5 ml amp, tart 5 mg/5 ml vial, tartrate 25 mg tab, tartrate 50 mg tab, tartrate 100 mg tab)</i>	1-Covered	
<i>nadolol</i>	1-Covered	
<i>pindolol</i>	1-Covered	
<i>propranolol hcl (1 mg/ml vial, 10 mg tablet, 20 mg/5 ml soln, 20 mg tablet, 40 mg tablet, 40 mg/5 ml soln, 60 mg tablet, 80 mg tablet)</i>	1-Covered	
<i>propranolol hcl er</i>	1-Covered	
Calcium Channel Blocking Agents		
AFEDITAB CR	1-Covered	QL (2 PER 1 DAYS)
<i>amlodipine besylate (2.5 mg tab, 5 mg tab)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>amlodipine besylate 10 mg tab</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	1-Covered	
DILT-CD (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE)	1-Covered	
DILT-XR	1-Covered	
<i>diltiazem 12hr er</i>	1-Covered	
<i>diltiazem 24hr cd (120 mg cap, 300 mg cap)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>diltiazem 24hr cd (180 mg cap, 240 mg cap, 360 mg cap)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>diltiazem 24hr er (er 120 mg cap, er 300 mg cap)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>diltiazem 24hr er (er 180 mg cap, er 240 mg cap, er 360 mg cap)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>diltiazem er (er 120 mg capsule, hcl er 120 mg cap, hcl er 300 mg cap)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>diltiazem er (er 180 mg capsule, er 240 mg capsule, hcl er 180 mg cap, hcl er 240 mg cap, hcl er 360 mg cap)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>diltiazem hcl (25 mg/5 ml vial, 30 mg tablet, 50 mg/10 ml vial, 60 mg tablet, 90 mg tablet, hcl 100 mg vial, 120 mg tablet, 125 mg/25 ml vial)</i>	1-Covered	
<i>diltiazem hcl er 420 mg cap</i>	1-Covered	
<i>felodipine er</i>	1-Covered	QL (1 PER 1 DAYS)
<i>isradipine</i>	1-Covered	
MATZIM LA	1-Covered	
<i>nicardipine hcl (20 mg capsule, 30 mg capsule)</i>	1-Covered	
NIFEDICAL XL	1-Covered	
<i>nifedipine</i>	1-Covered	PA
<i>nifedipine er (er 30 mg tablet, er 60 mg tablet, er 90 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>nimodipine</i>	1-Covered	
<i>nisoldipine (er 20 mg tablet, er 30 mg tablet, er 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>nisoldipine (er 8.5 mg tablet, er 17 mg tablet, er 25.5 mg tablet, er 34 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
TAZTIA XT	1-Covered	
<i>verapamil er (er 120 mg capsule, er 180 mg capsule, er 240 mg capsule)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>verapamil er (er 120 mg tablet, er 180 mg tablet, er 240 mg tablet)</i>	1-Covered	
<i>verapamil er pm</i>	1-Covered	
<i>verapamil hcl (2.5 mg/ml vial, 2.5 mg/ml ampul, 40 mg tablet, 80 mg tablet, 120 mg tablet, 360 mg cap pellet)</i>	1-Covered	
<i>verapamil sr</i>	1-Covered	QL (2 PER 1 DAYS)
<i>amiloride-hydrochlorothiazide</i>	1-Covered	
<i>amlodipine besylate-benazepril</i>	1-Covered	QL (1 PER 1 DAYS)
<i>amlodipine-valsartan</i>	1-Covered	
<i>amlodipine-valsartan-hctz</i>	1-Covered	
<i>atenolol-chlorthalidone</i>	1-Covered	
<i>benazepril-hydrochlorothiazide</i>	1-Covered	
<i>bisoprolol-hydrochlorothiazide</i>	1-Covered	
<i>candesartan-hydrochlorothiazid</i>	1-Covered	
<i>captopril-hydrochlorothiazide</i>	1-Covered	
CLOPRES	1-Covered	
DEMSER	1-Covered	
DUTOPROL	1-Covered	
<i>enalapril-hydrochlorothiazide</i>	1-Covered	
<i>fosinopril-hydrochlorothiazide</i>	1-Covered	
<i>irbesartan-hydrochlorothiazide</i>	1-Covered	QL (1 PER 1 DAYS)
<i>lisinopril-hydrochlorothiazide</i>	1-Covered	
<i>losartan-hctz 50-12.5 mg tab</i>	1-Covered	QL (2 PER 1 DAYS)
<i>losartan-hydrochlorothiazide (100-12.5 mg tab, 100-25 mg tab)</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>methyldopa-hydrochlorothiazide</i>	1-Covered	PA
<i>metoprolol-hydrochlorothiazide</i>	1-Covered	
<i>propranolol-hydrochlorothiazid</i>	1-Covered	
<i>quinapril-hydrochlorothiazide</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>spironolactone-hctz</i>	1-Covered	
<i>triamterene-hydrochlorothiazid</i>	1-Covered	
<i>valsartan-hydrochlorothiazide</i>	1-Covered	QL (1 PER 1 DAYS)

Cardiovascular Agents, Other

<i>amlodipine-atorvastatin</i>	1-Covered	
CORLANOR	1-Covered	
DIGITEK	1-Covered	
DIGOX	1-Covered	
<i>digoxin (0.05 mg/ml solution, 0.25 mg/ml syringe, 0.25 mg tablet, 125 mcg tablet, 250 mcg tablet, 500 mcg/2 ml ampule)</i>	1-Covered	
<i>digoxin 0.125 mg tablet</i>	1-Covered	PA
LANOXIN (62.5 MCG TABLET, 125 MCG TABLET, 187.5 MCG TABLET, 250 MCG TABLET)	1-Covered	
<i>moexipril-hydrochlorothiazide</i>	1-Covered	
<i>pentoxifylline</i>	1-Covered	
RANEXA	1-Covered	
<i>telmisartan-amlodipine</i>	1-Covered	
<i>telmisartan-hydrochlorothiazid</i>	1-Covered	
<i>trandolapril-verapamil er</i>	1-Covered	

Diuretics, Carbonic Anhydrase Inhibitors

<i>acetazolamide</i>	1-Covered	
<i>acetazolamide sodium</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
KEVEYIS	1-Covered	
<i>methazolamide</i>	1-Covered	
Diuretics, Loop		
<i>bumetanide (0.25 mg/ml vial, 0.5 mg tablet, 1 mg/4 ml vial, 1 mg tablet, 2 mg tablet, 2.5 mg/10 ml vial)</i>	1-Covered	
EDECIN	1-Covered	
<i>ethacrynate sodium</i>	1-Covered	
<i>furosemide (10 mg/ml syringe, 10 mg/ml solution, 20 mg tablet, 20 mg/2 ml vial, 40 mg/4 ml vial, 40 mg/5 ml soln, 40 mg tablet, 80 mg tablet, 100 mg/10 ml vial)</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</i>	1-Covered	
DYRENIUM	1-Covered	
<i>eplerenone</i>	1-Covered	
<i>spironolactone</i>	1-Covered	
Diuretics, Thiazide		
<i>chlorothiazide</i>	1-Covered	
<i>chlorothiazide sodium</i>	1-Covered	
<i>chlorthalidone</i>	1-Covered	
DIURIL	1-Covered	
<i>hydrochlorothiazide</i>	1-Covered	
<i>indapamide</i>	1-Covered	
<i>methyclothiazide</i>	1-Covered	
<i>metolazone</i>	1-Covered	
Dyslipidemics, Fibric Acid Derivatives		
<i>fenofibrate (48 mg tablet, 54 mg tablet, 67 mg capsule, 120 mg tablet, 134 mg capsule, 145 mg tablet, 160 mg tablet, 200 mg capsule)</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>fenofibrate (50 mg capsule, 150 mg capsule)</i>	1-Covered	
<i>fenofibrate 40 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>fenofibric acid (dr 45 mg cap, dr 135 mg cap)</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</i>	1-Covered	QL (2 PER 1 DAYS)

Dyslipidemics, HMG CoA Reductase Inhibitors

<i>atorvastatin 20 mg tablet</i>	1-Covered	QL (3 PER 1 DAYS)
<i>atorvastatin calcium (10 mg tablet, 40 mg tablet, 80 mg tablet)</i>	1-Covered	QL (1 PER 1 DAYS)
CRESTOR	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</i>	1-Covered	QL (1 PER 1 DAYS)
<i>rosuvastatin calcium</i>	1-Covered	
<i>simvastatin</i>	1-Covered	QL (1 PER 1 DAYS)

Dyslipidemics, Other

<i>cholestyramine light (packet, powder)</i>	1-Covered	
<i>colestipol hcl (hcl 1 gm tablet, hcl granules, hcl granules packet, micronized 1 gm tab)</i>	1-Covered	
JUXTAPID	1-Covered	PA
KYNAMRO	1-Covered	PA
<i>niacin er</i>	1-Covered	
NIACOR	1-Covered	
<i>omega-3 acid ethyl esters</i>	1-Covered	
PRALUENT PEN	1-Covered	PA
PRALUENT SYRINGE	1-Covered	PA
REPATHA PUSHTRONEX	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
REPATHA SURECLICK	1-Covered	PA
REPATHA SYRINGE	1-Covered	PA
ZETIA	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</i>	1-Covered	

Vasodilators, Direct-acting Arterial/ Venous

<i>isosorbide dinitrate (5 mg tablet, 10 mg tablet, 20 mg tablet, 30 mg tablet, er 40 mg tablet)</i>	1-Covered	
<i>isosorbide mononitrate</i>	1-Covered	
<i>isosorbide mononitrate er</i>	1-Covered	
NITRO-BID	1-Covered	
NITRO-DUR (0.3 MG/HR, 0.8 MG/HR)	1-Covered	
<i>nitroglycerin (lingual 0.4 mg, 5 mg/ml vial, 400 mcg spray)</i>	1-Covered	
<i>nitroglycerin patch</i>	1-Covered	
NITROSTAT	1-Covered	

Central Nervous System Agents

Attention Deficit Hyperactivity Disorder Agents, Amphetamines

<i>dextroamp-amphetamin 30 mg tab</i>	1-Covered	QL (2 PER 1 DAYS)
<i>dextroamphetamine sulfate (5 mg tab, 5 mg/5 ml, 10 mg tab)</i>	1-Covered	
<i>dextroamphetamine sulfate er</i>	1-Covered	
<i>dextroamphetamine-amphet er</i>	1-Covered	QL (1 PER 1 DAYS)
<i>dextroamphetamine-amphetamine (dextroamp-amphetam 12.5 mg tab, dextroamp-amphetamin 10 mg tab, dextroamp-amphetamin 15 mg tab, dextroamp-amphetamin 20 mg tab)</i>	1-Covered	QL (3 PER 1 DAYS)
<i>dextroamphetamine-amphetamine (dextroamp-amphetam 7.5 mg tab, dextroamp-amphetamine 5 mg tab)</i>	1-Covered	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
VYVANSE	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 er</i>	1-Covered	
<i>dexmethylphenidate er 20 mg cp</i>	1-Covered	
<i>dexmethylphenidate hcl</i>	1-Covered	QL (2 PER 1 DAYS)
<i>guanfacine hcl er</i>	1-Covered	
<i>methylphenidate er (er 18 mg tab, er 27 mg tab, er 54 mg tab)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>methylphenidate er 20 mg tab</i>	1-Covered	
<i>methylphenidate er 36 mg tab</i>	1-Covered	QL (2 PER 1 DAYS)
<i>methylphenidate hcl (2.5 mg chew tb, 5 mg/5 ml soln, 5 mg chew tab, 10 mg/5 ml sol, 10 mg chew tab)</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 sr</i>	1-Covered	
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	1-Covered	
<i>riluzole</i>	1-Covered	
<i>tetrabenazine</i>	1-Covered	
VECAMYL	1-Covered	LA
XENAZINE	1-Covered	
Fibromyalgia Agents		
<i>duloxetine hcl</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
SAVELLA	1-Covered	
Multiple Sclerosis Agents		
AMPYRA	1-Covered	FDA (2 / 1 DAYS)
AUBAGIO	1-Covered	PA
AVONEX (30 MCG VIAL KIT, PREFILLED SYR 30 MCG, PREFILLED SYR 30 MCG KT)	1-Covered	
AVONEX PEN (30 MCG/0.5 ML, 30 MCG/0.5 ML KIT)	1-Covered	
BETASERON	1-Covered	
COPAXONE	1-Covered	
GILENYA	1-Covered	
GLATOPA	1-Covered	
PLEGRIDY PEN	1-Covered	
TECFIDERA	1-Covered	PA
TYSABRI	1-Covered	
Dental and Oral Agents		
<i>cevimeline hcl</i>	1-Covered	
<i>chlorhexidine 0.12% rinse</i>	1-Covered	
PERIOGARD	1-Covered	
<i>pilocarpine hcl (5 mg tablet, 7.5 mg tablet)</i>	1-Covered	
<i>triamcinolone 0.1% paste</i>	1-Covered	
Dermatological Agents		
8-MOP	1-Covered	
<i>acitretin</i>	1-Covered	
<i>adapalene</i>	1-Covered	
ADRUCIL	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ammonium lactate</i>	1-Covered	
AMNESTEEM	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>betamethasone dp 0.05% lot</i>	1-Covered	
<i>calcipotriene (cream, ointment, solution)</i>	1-Covered	
<i>calcipotriene-betamethasone dp</i>	1-Covered	
<i>calcitriol 3 mcg/g ointment</i>	1-Covered	
CLARAVIS	1-Covered	
<i>clindamycin phos-benzoyl perox</i>	1-Covered	
<i>clindamycin-benzoyl peroxide</i>	1-Covered	
<i>clotrimazole-betamethasone (crm, lot)</i>	1-Covered	
<i>diclofenac sodium 1% gel</i>	1-Covered	
ELIDEL	1-Covered	
<i>erythromycin-benzoyl peroxide</i>	1-Covered	
<i>fluorouracil (0.5% cream, 2% topical soln, 2.5 gm/50 ml btl, 2.5 gm/50 ml vial, 5% top solution, 5% cream, 5 gm/100 ml vial, 500 mg/10 ml vial, 1,000 mg/20 ml vl, 2,500 mg/50 ml vl, 5,000 mg/100 ml)</i>	1-Covered	
<i>fluticasone propionate (0.005% oint, 0.05% cream, 0.05% lotion)</i>	1-Covered	
<i>imiquimod 5% cream packet</i>	1-Covered	
<i>nystatin-triamcinolone</i>	1-Covered	
<i>podofilox</i>	1-Covered	
SANTYL	1-Covered	
<i>selenium sulfide 2.5% lotion</i>	1-Covered	
<i>tacrolimus (0.03%, 0.1%)</i>	1-Covered	
TAZORAC	1-Covered	
TOLAK	1-Covered	
<i>tretinoin microsphere</i>	1-Covered	
<i>urea 40% cream</i>	1-Covered	
VOLTAREN	1-Covered	
X-VIATE (CREAM, GEL, LOTION)	1-Covered	
ZONALON	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
Enzyme Replacement/ Modifiers		
ADAGEN	1-Covered	
ALDURAZYME	1-Covered	LA
BUPHENYL 500 MG TABLET	1-Covered	
CEREZYME	1-Covered	LA
CREON	1-Covered	
CYSTADANE	1-Covered	
CYSTAGON	1-Covered	
FABRAZYME	1-Covered	
KANUMA	1-Covered	
KUVAN	1-Covered	
NAGLAZYME	1-Covered	
ORFADIN (2 MG CAPSULE, 4 MG/ML SUSPENSION, 5 MG CAPSULE, 10 MG CAPSULE)	1-Covered	
PANCREAZE	1-Covered	
RAVICTI	1-Covered	
STRENSIQ	1-Covered	LA
VPRIV	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZAVESCA	1-Covered	

Gastrointestinal Agents

Antispasmodics, Gastrointestinal

<i>atropine sulfate (0.05 mg/ml syringe, 0.1 mg/ml abboject, 0.1 mg/ml syringe)</i>	1-Covered
<i>dicyclomine hcl (10 mg capsule, 10 mg/5 ml soln, 20 mg tablet)</i>	1-Covered
<i>glycopyrrolate (0.2 mg/ml vial, 0.4 mg/2 ml vl, 1 mg/5 ml vial, 1 mg tablet, 2 mg tablet, 4 mg/20 ml vial)</i>	1-Covered
<i>methscopolamine bromide</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>propantheline bromide</i>	1-Covered	
TRANSDERM-SCOP	1-Covered	
<i>lansoprazol-amoxicil-clarithro</i>	1-Covered	
UCERIS 9 MG ER TABLET	1-Covered	
Gastrointestinal Agents, Other		
<i>diphenoxylate-atropine (diphenoxylat-atrop 2.5-0.025/5, diphenoxylate-atrop 2.5-0.025)</i>	1-Covered	
FULYZAQ	1-Covered	
GATTEX	1-Covered	
GAVILYTE-H AND BISACODYL	1-Covered	
<i>loperamide 2 mg capsule</i>	1-Covered	
RELISTOR (12 MG/0.6 ML KIT, 12 MG/0.6 ML VIAL)	1-Covered	
<i>ursodiol</i>	1-Covered	
Histamine2 (H2) Receptor Antagonists		
<i>cimetidine (200 mg tablet, 300 mg tablet, 300 mg/5 ml soln, 400 mg tablet, 800 mg tablet)</i>	1-Covered	
<i>famotidine (20 mg tablet, 20 mg piggyback, 20 mg/2 ml vial, 40 mg/5 ml susp, 40 mg tablet)</i>	1-Covered	
<i>ranitidine hcl (15 mg/ml syrup, hcl 25 mg/ml vial, hcl 50 mg/2 ml vial, 150 mg/10 ml syrup, hcl 150 mg/6 ml vl, 150 mg tablet, 150 mg capsule, 300 mg capsule, 300 mg tablet, 1,000 mg/40 ml vial)</i>	1-Covered	
Irritable Bowel Syndrome Agents		
<i>alosetron hcl</i>	1-Covered	
<i>budesonide ec</i>	1-Covered	
DELZICOL	1-Covered	
LINZESS	1-Covered	QL (1 PER 1 DAYS)
LOTRONEX	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
VIBERZI	1-Covered	
Laxatives		
COLYTE WITH FLAVOR PACKETS	1-Covered	
COLYTE WITH FLAVOR PACKS	1-Covered	
CONSTULOSE	1-Covered	
ENULOSE	1-Covered	
GAVILYTE-C	1-Covered	
GAVILYTE-G	1-Covered	
GAVILYTE-N	1-Covered	
GENERLAC	1-Covered	
GOLYTELY (PACKET, SOLUTION)	1-Covered	
KRISTALOSE	1-Covered	
<i>lactulose</i>	1-Covered	
MOVIPREP	1-Covered	
NULYTELY WITH FLAVOR PACKS	1-Covered	
<i>peg 3350-electrolyte</i>	1-Covered	
<i>peg-3350 and electrolytes</i>	1-Covered	
<i>peg-3350 with flavor packs</i>	1-Covered	
<i>polyethylene glycol 3350</i>	1-Covered	
TRILYTE WITH FLAVOR PACKETS	1-Covered	
Protectants		
CARAFATE 1 GM/10 ML SUSP	1-Covered	
<i>misoprostol</i>	1-Covered	
<i>sucrafate</i>	1-Covered	
Proton Pump Inhibitors		
<i>esomeprazole magnesium</i>	1-Covered	
<i>lansoprazole (dr 15 mg capsule, dr 30 mg capsule)</i>	1-Covered	
NEXIUM I.V. 40 MG VIAL	1-Covered	
<i>omeprazole (dr 20 mg capsule, dr 40 mg capsule)</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>omeprazole dr 10 mg capsule</i>	1-Covered	QL (1 PER 1 DAYS)
<i>omeprazole-sodium bicarbonate (20-1,680 pkt, 20-1,100 cap, 40-1,100 cap, 40-1,680 pkt)</i>	1-Covered	
<i>pantoprazole sodium (dr 20 mg tab, dr 40 mg tab)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>pantoprazole sodium 40 mg vial</i>	1-Covered	
<i>rabeprazole sodium</i>	1-Covered	

Genitourinary Agents

Antispasmodics, Urinary

<i>darifenacin er</i>	1-Covered	
<i>flavoxate hcl</i>	1-Covered	
MYRBETRIQ	1-Covered	
<i>oxybutynin 5 mg tablet</i>	1-Covered	QL (4 PER 1 DAYS)
<i>oxybutynin 5 mg/5 ml syrup</i>	1-Covered	QL (20 PER 1 DAYS)
<i>oxybutynin chloride er (er 10 mg tablet, er 15 mg tablet)</i>	1-Covered	QL (2 PER 1 DAYS)
<i>oxybutynin cl er 5 mg tablet</i>	1-Covered	QL (1 PER 1 DAYS)
<i>tolterodine tartrate</i>	1-Covered	
<i>tolterodine tartrate er</i>	1-Covered	QL (1 PER 1 DAYS)
<i>trospium chloride</i>	1-Covered	
<i>trospium chloride er</i>	1-Covered	
VESICARE	1-Covered	

Benign Prostatic Hypertrophy Agents

<i>alfuzosin hcl er</i>	1-Covered	
<i>dutasteride</i>	1-Covered	QL (1 PER 1 DAYS)
<i>dutasteride-tamsulosin</i>	1-Covered	QL (1 PER 1 DAYS)
<i>finasteride</i>	1-Covered	QL (1 PER 1 DAYS)
JALYN	1-Covered	
<i>tamsulosin hcl</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
Genitourinary Agents, Other		
<i>bethanechol chloride</i>	1-Covered	
DEPEN	1-Covered	
ELMIRON	1-Covered	
<i>potassium citrate er</i>	1-Covered	
UROCIT-K ER 15 MEQ TABLET	1-Covered	
Phosphate Binders		
<i>calcium acetate (667 mg capsule, 667 mg gelcap)</i>	1-Covered	
ELIPHOS	1-Covered	
FOSRENOL	1-Covered	
RENAGEL	1-Covered	
REVELA 800 MG TABLET	1-Covered	QL (17 PER 1 DAYS)
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
A-HYDROCORT	1-Covered	
<i>alclometasone dipropionate</i>	1-Covered	
<i>amcinonide (cream, lotion, ointment)</i>	1-Covered	
<i>betamethasone dipropionate (aug crm, aug gel, aug lot, aug oin, crm, oint)</i>	1-Covered	
<i>betamethasone valerate (va 0.1% cream, va 0.1% lotion, valer 0.1% ointm, valer 0.12% foam)</i>	1-Covered	
CAPEX SHAMPOO	1-Covered	
<i>clobetasol emollient 0.05% crm</i>	1-Covered	
<i>clobetasol propionate (gel, ointment, prop foam, prop spray, shampoo, solution, topical lotn)</i>	1-Covered	
<i>cortisone acetate</i>	1-Covered	
<i>desonide (cream, lotion, ointment)</i>	1-Covered	
DESOWEN 0.05% LOTION	1-Covered	
<i>desoximetasone</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/5 ml elx, 0.5 mg/5 ml liq, 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	1-Covered	
<i>dexamethasone sodium phosphate</i>	1-Covered	
<i>diflorasone diacetate</i>	1-Covered	
<i>fludrocortisone acetate</i>	1-Covered	
<i>fluocinolone acetonide (0.01% solution, 0.01% cream, 0.01% body oil, 0.025% cream, 0.025% ointment)</i>	1-Covered	
<i>fluocinolone acetonide oil</i>	1-Covered	
<i>fluocinonide (cream, gel, ointment, solution)</i>	1-Covered	
<i>fluocinonide emollient</i>	1-Covered	
<i>fluocinonide-e</i>	1-Covered	
H.P. ACTHAR	1-Covered	
<i>halobetasol propionate</i>	1-Covered	
<i>hydrocortisone (1% ointment, 1% cream, 2.5% cream, 2.5% ointment, 2.5% lotion, 5 mg tablet, 10 mg tablet, 20 mg tablet)</i>	1-Covered	
<i>hydrocortisone butyrate (buty cream, butyr oint, soln)</i>	1-Covered	
<i>hydrocortisone valerate</i>	1-Covered	
KORLYM	1-Covered	
<i>methylprednisolone</i>	1-Covered	
<i>methylprednisolone acetate</i>	1-Covered	
<i>methylprednisolone sod succ</i>	1-Covered	
MILLIPRED 5 MG TABLET	1-Covered	
<i>mometasone furoate (cream, oint, soln)</i>	1-Covered	
<i>prednisolone 15 mg/5 ml soln</i>	1-Covered	
<i>prednisolone sodium phos odt</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>prednisolone sodium phosphate (5 mg/5 ml soln, sod ph 25 mg/5 ml)</i>	1-Covered	
<i>prednisone (1 mg tablet, 2.5 mg tablet, 5 mg tab dose pack, 5 mg tablet, 5 mg/5 ml solution, 10 mg tab dose pack, 10 mg tablet, 20 mg tablet, 50 mg tablet)</i>	1-Covered	
PREDNISON INTENSOL	1-Covered	
SOLU-CORTEF	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% lotion, 0.025% oint, 0.025% cream, 0.1% ointment, 0.1% cream, 0.1% lotion, 0.147 mg/g spray, 0.5% ointment, 0.5% cream)</i>	1-Covered	

Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)

<i>chorionic gonad 10,000 unit vl</i>	1-Covered	
<i>desmopressin acetate (0.01% spray, 0.01% solution, 0.1 mg/ml sol)</i>	1-Covered	QL (15 PER 23 DAYS)
<i>desmopressin acetate (ac 4 mcg/ml vial, ac 4 mcg/ml ampul, acetate 0.1 mg tb, acetate 0.2 mg tb, 40 mcg/10 ml vial)</i>	1-Covered	
INCRELEX	1-Covered	
MYALEPT	1-Covered	PA
NORDITROPIN FLEXPRO	1-Covered	PA
NORDITROPIN NORDIFLEX	1-Covered	PA

Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)

CYTOTEC 100 MCG TABLET	1-Covered	
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Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)

Anabolic Steroids

ANADROL-50	1-Covered	
<i>oxandrolone 10 mg tablet</i>	1-Covered	PA, 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>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</i>	1-Covered	
<i>methyltestosterone</i>	1-Covered	
<i>testosterone (12.5 mg/1.25 gram, 25 mg/2.5 gm pkt, 50 mg/5 gram gel, 50 mg/5 gram pkt)</i>	1-Covered	
<i>testosterone enanthate (testosteron 1,000 mg/5 ml, testosterone 200 mg/ml)</i>	1-Covered	
TESTRED	1-Covered	
Estrogens		
<i>estradiol</i>	1-Covered	PA
<i>estropipate</i>	1-Covered	PA
MENEST	1-Covered	PA
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	1-Covered	
APRI	1-Covered	
ARANELLE	1-Covered	
AVIANE	1-Covered	
BALZIVA	1-Covered	
CRYSELLE	1-Covered	
CYCLAFEM	1-Covered	
<i>drospirenone-ee 3-0.03 mg tab</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
ENPRESSE	1-Covered	
FEMCON FE	1-Covered	
GILDESS FE 1-20 TABLET	1-Covered	
JUNEL	1-Covered	
JUNEL FE	1-Covered	
KARIVA	1-Covered	
KELNOR 1-35	1-Covered	
LESSINA	1-Covered	
LEVORA-28	1-Covered	
LOW-OGESTREL	1-Covered	
LUTERA	1-Covered	
MICROGESTIN	1-Covered	
MICROGESTIN FE	1-Covered	
MONONESSA	1-Covered	
NECON (0.5-35-28 TABLET, 1-35-28 TABLET, 7-7-7-28 TABLET, 10-11-28 TABLET)	1-Covered	
<i>norg-ee 0.18-0.215-0.25/0.035</i>	1-Covered	
NORTREL	1-Covered	
NUVARING	1-Covered	QL (1 PER 28 DAYS)
OGESTREL	1-Covered	
PORTIA	1-Covered	
PREMPHASE	1-Covered	PA
PREMPRO	1-Covered	PA, QL (1 PER 1 DAYS)
PREVIFEM	1-Covered	
RECLIPSEN	1-Covered	
SPRINTEC	1-Covered	
SRONYX	1-Covered	
TRI-LEGEST FE	1-Covered	
TRI-LINYAH	1-Covered	
TRI-PREVIFEM	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
TRI-SPRINTEC	1-Covered	
TRINESSA	1-Covered	
TRIVORA-28	1-Covered	
VELIVET	1-Covered	
XULANE	1-Covered	
YASMIN 28	1-Covered	
ZENCHENT	1-Covered	
ZOVIA 1-35E	1-Covered	
ZOVIA 1-50E	1-Covered	

Progestins

DEPO-PROVERA 400 MG/ML VIAL	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
JOLIVETTE	1-Covered	
<i>medroxyprogesterone 150 mg/ml</i>	1-Covered	QL (1 PER 68 DAYS)
<i>medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	1-Covered	
MEGACE ES	1-Covered	PA
<i>megestrol acetate (20 mg tablet, 40 mg tablet)</i>	1-Covered	
<i>megestrol acetate (acet 40 mg/ml susp, acet 400 mg/10 ml, 625 mg/5 ml susp)</i>	1-Covered	PA
<i>norethindrone</i>	1-Covered	
<i>norethindrone acetate</i>	1-Covered	
<i>progesterone (100 mg capsule, 200 mg capsule)</i>	1-Covered	

Selective Estrogen Receptor Modifying Agents

<i>raloxifene hcl</i>	1-Covered	QL (1 PER 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
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, 175 mcg tablet, 200 mcg tablet, 300 mcg tablet)</i>	1-Covered	
<i>liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)</i>	1-Covered	
SYNTHROID	1-Covered	
THYROLAR-1	1-Covered	
THYROLAR-1/2	1-Covered	
THYROLAR-1/4	1-Covered	
THYROLAR-2	1-Covered	
THYROLAR-3	1-Covered	
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	1-Covered	
Hormonal Agents, Suppressant (Parathyroid)		
SENSIPAR	1-Covered	
Hormonal Agents, Suppressant (Pituitary)		
<i>cabergoline</i>	1-Covered	
ELIGARD	1-Covered	PA
<i>leuprolide 1 mg/0.2 ml vial</i>	1-Covered	
<i>leuprolide 2wk 1 mg/0.2 ml kit</i>	1-Covered	PA
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

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
LUPRON DEPOT-PED 30 MG 3MO KIT	1-Covered	PA, QL (1 PER 120 DAYS)
<i>octreotide acetate (acet 0.05 mg/ml vl, acet 50 mcg/ml amp, acet 50 mcg/ml vial, acet 100 mcg/ml vl, acet 100 mcg/ml amp, acet 200 mcg/ml vl, acet 500 mcg/ml vl, acet 500 mcg/ml amp, 1,000 mcg/5 ml vial, 1,000 mcg/ml vial, 5,000 mcg/5 ml vial)</i>	1-Covered	
SANDOSTATIN LAR	1-Covered	
SANDOSTATIN LAR DEPOT	1-Covered	
SIGNIFOR	1-Covered	
SIGNIFOR LAR	1-Covered	
SOMATULINE DEPOT	1-Covered	
SOMAVERT (10 MG VIAL, 15 MG VIAL, 20 MG VIAL)	1-Covered	
SYNAREL	1-Covered	

Hormonal Agents, Suppressant (Thyroid)

Antithyroid Agents

<i>methimazole</i>	1-Covered	
<i>propylthiouracil</i>	1-Covered	

Immunological Agents

Angioedema (HAE) Agents

CINRYZE	1-Covered	LA
FIRAZYR	1-Covered	

Immune Suppressants

AFINITOR 2.5 MG TABLET	1-Covered	
AFINITOR DISPERZ	1-Covered	
ASTAGRAF XL	1-Covered	PA - TO CONFIRM PART D COVERAGE
ATGAM	1-Covered	
AZASAN	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>azathioprine</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>azathioprine sodium</i>	1-Covered	
BENLYSTA	1-Covered	
<i>cyclosporine (25 mg capsule, 50 mg/ml vial, 50 mg/ml ampul, 100 mg capsule, 100 mg/ml soln)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine modified</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
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)
ENVARSUS XR	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 PEDIATRIC CROHN'S	1-Covered	PA
HUMIRA PEN	1-Covered	PA
HUMIRA PEN CROHN-UC-HS STARTER	1-Covered	PA
HUMIRA PEN PSORIASIS-UVEITIS	1-Covered	PA
KINERET	1-Covered	
<i>mercaptopurine</i>	1-Covered	
<i>methotrexate (1 gm vial, 2.5 mg tablet, 50 mg/2 ml vial, 100 mg/4 ml vial, 250 mg/10 ml vial)</i>	1-Covered	
<i>methotrexate sodium</i>	1-Covered	
<i>mycophenolate mofetil (200 mg/ml susp, 250 mg capsule, 500 mg tablet)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolic acid</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
NULOJIX	1-Covered	PA - TO CONFIRM PART D COVERAGE
ORENCIA (125 MG/ML SYRINGE, 250 MG VIAL)	1-Covered	PA
ORENCIA CLICKJECT	1-Covered	PA
OTREXUP	1-Covered	
PROGRAF 5 MG/ML AMPULE	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
RAPAMUNE 1 MG/ML ORAL SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
RASUVO	1-Covered	
REMICADE	1-Covered	
RHEUMATREX	1-Covered	
SANDIMMUNE 100 MG/ML SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
SIMULECT	1-Covered	
<i>sirolimus</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	1-Covered	
TREXALL	1-Covered	
ZORTRESS	1-Covered	PA - TO CONFIRM PART D COVERAGE

Immunizing Agents, Passive

CARIMUNE NF NANOFILTERED	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMASTAN S-D	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAGARD LIQUID	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAGARD S-D	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAPLEX	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	1-Covered	
PRIVIGEN	1-Covered	PA - TO CONFIRM PART D COVERAGE
THYMOGLOBULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE
VARIZIG 125 UNIT/1.2 ML VIAL	1-Covered	
ARAVA	1-Covered	
SYNAGIS	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
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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ACTIMMUNE	1-Covered	LA
ARCALYST	1-Covered	LA
ILARIS	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	1-Covered	

Vaccines

ACTHIB	1-Covered	
ADACEL TDAP SYRINGE	1-Covered	QL (1 PER 1 OVER TIME)
ADACEL TDAP VIAL	1-Covered	
<i>bcg vaccine (tice strain)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
BEXSERO	1-Covered	
BOOSTRIX TDAP	1-Covered	
CERVARIX	1-Covered	
COMVAX	1-Covered	
DAPTACEL DTAP	1-Covered	
<i>diphtheria-tetanus toxoids-ped</i>	1-Covered	
ENGERIX-B ADULT	1-Covered	PA - TO CONFIRM PART D COVERAGE
ENGERIX-B PEDIATRIC-ADOLESCENT	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL	1-Covered	
GARDASIL 9	1-Covered	
HAVRIX (720 UNITS/0.5 ML VIAL, 720 UNIT/0.5 ML SYRINGE, 1,440 UNITS/ML VIAL)	1-Covered	
HIBERIX	1-Covered	
IMOVAX RABIES VACCINE	1-Covered	
INFANRIX DTAP VIAL	1-Covered	
IPOL	1-Covered	
IXIARO	1-Covered	
M-M-R II VACCINE	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MENACTRA	1-Covered	
MENHIBRIX	1-Covered	
MENOMUNE-A-C-Y-W-135	1-Covered	
MENVEO A-C-Y-W-135-DIP	1-Covered	
PEDVAXHIB	1-Covered	
PENTACEL ACTHIB COMPONENT	1-Covered	
PROQUAD	1-Covered	
QUADRACEL DTAP-IPV	1-Covered	
RABAVERT	1-Covered	
RECOMBIVAX HB	1-Covered	PA - TO CONFIRM PART D COVERAGE
ROTARIX	1-Covered	
ROTATEQ	1-Covered	
TENIVAC SYRINGE	1-Covered	
<i>tetanus diphtheria toxoids</i>	1-Covered	
TRUMENBA	1-Covered	
TWINRIX VACCINE VIAL	1-Covered	
TYPHIM VI	1-Covered	
VAQTA (25 UNITS/0.5 ML, 50 UNITS/ML)	1-Covered	
VARIVAX VACCINE	1-Covered	
YF-VAX	1-Covered	
ZOSTAVAX	1-Covered	

Inflammatory Bowel Disease Agents

Aminosalicylates

APRISO	1-Covered	
<i>balsalazide disodium</i>	1-Covered	
DIPENTUM	1-Covered	
<i>mesalamine 4 gm/60 ml kit</i>	1-Covered	
PENTASA	1-Covered	QL (8 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
Glucocorticoids		
COLOCORT	1-Covered	
<i>hydrocortisone 100 mg/60 ml</i>	1-Covered	
PROCTO-MED HC	1-Covered	
PROCTOSOL-HC	1-Covered	
PROCTOZONE-HC	1-Covered	
SOLU-MEDROL 40 MG VIAL	1-Covered	
UCERIS 2 MG RECTAL FOAM	1-Covered	
Sulfonamides		
<i>sulfasalazine</i>	1-Covered	QL (8 PER 1 DAYS)
<i>sulfasalazine dr</i>	1-Covered	
Metabolic Bone Disease Agents		
<i>alendronate sod 70 mg/75 ml</i>	1-Covered	
<i>alendronate sodium (35 mg tab, 70 mg tab)</i>	1-Covered	QL (1 PER 7 DAYS)
<i>alendronate sodium (5 mg tablet, 10 mg tab, 40 mg tab)</i>	1-Covered	QL (1 PER 1 DAYS)
ATELVIA	1-Covered	
BINOSTO	1-Covered	
<i>calcitonin-salmon</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 cap, 1 mcg capsule, 2.5 mcg cap, 4 mcg/2 ml vl, 4 mcg/2 ml amp)</i>	1-Covered	
<i>etidronate disodium</i>	1-Covered	
FORTEO	1-Covered	
<i>ibandronate 3 mg/3 ml vial</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>ibandronate sodium (3 mg/3 ml syringe, sodium 150 mg tab)</i>	1-Covered	
MIACALCIN (200 UNIT/ML VIAL, 400 UNIT/2 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
NATPARA	1-Covered	
<i>pamidronate disodium (disod 30 mg vial, 30 mg/10 ml vial, 60 mg/10 ml vial, 90 mg/10 ml vial, disod 90 mg vial)</i>	1-Covered	
PROLIA	1-Covered	
<i>risedronate sodium</i>	1-Covered	
<i>risedronate sodium dr</i>	1-Covered	
XGEVA	1-Covered	
<i>zoledronic acid 5 mg/100 ml</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE

Ophthalmic Agents

<i>bacitracin-polymyxin eye oint</i>	1-Covered	
BLEPHAMIDE	1-Covered	
BLEPHAMIDE S.O.P.	1-Covered	
<i>neomycin-bacitracin-poly-hc</i>	1-Covered	
<i>neomycin-bacitracin-polymyxin</i>	1-Covered	
<i>neomycin-poly-hc eye drops</i>	1-Covered	
<i>neomycin-polymyxin-dexameth (neomyc-polym-dexamet ointm, neomyc-polym-dexameth drop)</i>	1-Covered	
<i>neomycin-polymyxin-gramicidin</i>	1-Covered	
POLYCIN	1-Covered	
<i>polymyxin b sul-trimethoprim</i>	1-Covered	
<i>prednisolone acetate</i>	1-Covered	
<i>sulfacetamide 10% eye ointment</i>	1-Covered	
<i>sulfacetamide-prednisolone</i>	1-Covered	
<i>tobramycin-dexamethasone</i>	1-Covered	

Ophthalmic Agents, Other

<i>atropine 1% eye drops</i>	1-Covered	
<i>cyclopentolate hcl (1% eye drops, hcl 2% 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>naphazoline hcl</i>	1-Covered	
<i>proparacaine hcl</i>	1-Covered	
RESTASIS	1-Covered	QL (2 PER 1 DAYS)
<i>tropicamide</i>	1-Covered	
Ophthalmic Anti-allergy Agents		
ALOCRIL	1-Covered	
ALOMIDE	1-Covered	
<i>azelastine hcl 0.05% drops</i>	1-Covered	
<i>cromolyn 4% eye drops</i>	1-Covered	
<i>epinastine hcl</i>	1-Covered	
<i>olopatadine hcl 0.1% eye drops</i>	1-Covered	QL (5 PER 22 DAYS)
Ophthalmic Anti-inflammatories		
ALREX	1-Covered	
<i>bromfenac sodium 0.09% eye drp</i>	1-Covered	
<i>diclofenac 0.1% eye drops</i>	1-Covered	
DUREZOL	1-Covered	
FLAREX	1-Covered	
<i>fluorometholone</i>	1-Covered	
<i>flurbiprofen sodium</i>	1-Covered	
FML	1-Covered	
FML FORTE	1-Covered	
FML S.O.P.	1-Covered	
ILEVRO	1-Covered	
<i>ketorolac 0.4% ophth solution</i>	1-Covered	
<i>ketorolac 0.5% ophth solution</i>	1-Covered	QL (5 PER 18 DAYS)
PRED MILD	1-Covered	
<i>prednisolone sod 1% eye drop</i>	1-Covered	
PROLENSA	1-Covered	
VEXOL	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Ophthalmic Antiglaucoma Agents		
ALPHAGAN P 0.1% DROPS	1-Covered	
<i>apraclonidine hcl</i>	1-Covered	
AZOPT	1-Covered	
<i>betaxolol hcl 0.5% eye drop</i>	1-Covered	
<i>bimatoprost</i>	1-Covered	
<i>brimonidine tartrate</i>	1-Covered	
<i>carteolol hcl</i>	1-Covered	
<i>dorzolamide hcl</i>	1-Covered	QL (10 PER 18 DAYS)
<i>dorzolamide-timolol</i>	1-Covered	QL (10 PER 18 DAYS)
<i>levobunolol 0.5% eye drops</i>	1-Covered	
<i>metipranolol</i>	1-Covered	
<i>pilocarpine hcl (1% drops, 2% drops, 4% drops)</i>	1-Covered	
SIMBRINZA	1-Covered	
<i>timolol maleate (0.25% gfs gel-solution, 0.25% gel-solution, 0.25% eye drops, 0.5% eye drops, 0.5% gfs gel-solution, 0.5% gel-solution)</i>	1-Covered	
<i>travoprost</i>	1-Covered	
Ophthalmic Prostaglandin and Prostanoid Analogs		
<i>latanoprost</i>	1-Covered	QL (2.5 PER 18 DAYS)
LUMIGAN	1-Covered	
TRAVATAN Z	1-Covered	QL (5 PER 18 DAYS)
Otic Agents		
CIPRODEX	1-Covered	
CORTISPORIN-TC	1-Covered	
<i>hydrocortisone-acetic acid</i>	1-Covered	
<i>neomycin-polymyxin-hc ear susp</i>	1-Covered	
<i>neomycin-polymyxin-hydrocort</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
Respiratory Tract/ Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
AEROSPAN	1-Covered	
<i>budesonide 0.25 mg/2 ml susp</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)
<i>budesonide 0.5 mg/2 ml susp</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (4 PER 1 DAYS)
<i>budesonide 1 mg/2 ml inh susp</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (2 PER 1 DAYS)
<i>budesonide 32 mcg nasal spray</i>	1-Covered	
FLOVENT DISKUS	1-Covered	QL (80 PER 20 DAYS)
FLOVENT HFA	1-Covered	
<i>fluticasone prop 50 mcg spray</i>	1-Covered	QL (16 PER 20 DAYS)
<i>mometasone furoate 50 mcg spry</i>	1-Covered	
NASONEX	1-Covered	
PULMICORT 1 MG/2 ML RESPULE	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (2 PER 1 DAYS)
PULMICORT FLEXHALER	1-Covered	
QVAR	1-Covered	
<i>triamcinolone 55 mcg nasal spr</i>	1-Covered	
Antihistamines		
<i>azelastine hcl (0.1% (137 mcg) spry, 0.15% nasal spray)</i>	1-Covered	
<i>carbinoxamine maleate (4 mg/5 ml liquid, maleate 4 mg tab)</i>	1-Covered	PA
<i>clemastine fumarate (0.5 mg/5 ml syrup, fum 2.68 mg tab)</i>	1-Covered	PA
<i>cyproheptadine hcl (2 mg/5 ml syrup, 4 mg tablet, 4 mg/10 ml syrpr)</i>	1-Covered	PA
<i>desloratadine</i>	1-Covered	
<i>levocetirizine dihydrochloride (2.5 mg/5 ml sol, 5 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>olopatadine 665 mcg nasal spray</i>	1-Covered	
Antileukotrienes		
<i>montelukast sodium</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)
Bronchodilators, Anticholinergic		
ATROVENT HFA	1-Covered	
<i>ipratropium br 0.02% soln</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (15 PER 1 DAYS)
<i>ipratropium bromide (0.03%, 0.06%)</i>	1-Covered	
PROAIR RESPICLICK	1-Covered	
SPIRIVA	1-Covered	
SPIRIVA RESPIMAT	1-Covered	
TUDORZA PRESSAIR	1-Covered	
Bronchodilators, Sympathomimetic		
ADRENALIN	1-Covered	
<i>albuterol sulfate (sul 0.63 mg/3 ml sol, sul 1.25 mg/3 ml sol, sul 2.5 mg/3 ml soln, 2.5 mg/0.5 ml sol, 5 mg/ml solution)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>albuterol sulfate (sulf 2 mg/5 ml syrup, sulfate 2 mg tab, sulfate 4 mg tab, sulfate er 4 mg tab, sulfate er 8 mg tab)</i>	1-Covered	
AUVI-Q	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 mg auto-inject, 0.3 mg auto-inject)</i>	1-Covered	
EPIPEN 2-PAK	1-Covered	
EPIPEN JR 2-PAK	1-Covered	
<i>levalbuterol concentrate</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>levalbuterol hcl</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>metaproterenol sulfate (10 mg tablet, 10 mg/5 ml syr, 20 mg tablet)</i>	1-Covered	
PROAIR HFA	1-Covered	
PROVENTIL HFA	1-Covered	
SEREVENT DISKUS	1-Covered	QL (2 PER 1 DAYS)
STRIVERDI RESPIMAT	1-Covered	
<i>terbutaline sulfate (2.5 mg tab, 5 mg tab)</i>	1-Covered	
VENTOLIN HFA	1-Covered	QL (36 PER 30 DAYS)
XOPENEX HFA	1-Covered	
Cystic Fibrosis Agents		
CAYSTON	1-Covered	
KALYDECO	1-Covered	PA
Mast Cell Stabilizers		
<i>cromolyn 100 mg/5 ml oral conc</i>	1-Covered	
<i>cromolyn 20 mg/2 ml neb soln</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)
Phosphodiesterase Inhibitors, Airways Disease		
<i>aminophylline (250 mg/10 ml, 500 mg/20 ml)</i>	1-Covered	
DALIRESP	1-Covered	
ELIXOPHYLLIN	1-Covered	
<i>theophylline (80 mg/15 ml soln, er 400 mg tablet, er 600 mg tablet)</i>	1-Covered	
<i>theophylline anhydrous (er 100 mg tablet, er 200 mg tablet, er 300 mg tab, er 450 mg tab)</i>	1-Covered	
Pulmonary Antihypertensives		
ADCIRCA	1-Covered	PA
ADEMPAS	1-Covered	
LETAIRIS	1-Covered	PA, 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
OPSUMIT	1-Covered	
REMODULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE
REVATIO 10 MG/ML ORAL SUSP	1-Covered	PA
<i>sildenafil</i>	1-Covered	PA
<i>sildenafil citrate</i>	1-Covered	PA
TRACLEER	1-Covered	PA, LA

Respiratory Tract Agents, Other

<i>acetylcysteine (10% vial, 20% vial)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
ANORO ELLIPTA	1-Covered	
ARALAST NP	1-Covered	
BREO ELLIPTA 200-25 MCG INH	1-Covered	
ESBRIET	1-Covered	PA
GLASSIA	1-Covered	
GRASTEK	1-Covered	
LUMIZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE, LA
OFEV	1-Covered	
ORALAIR (300 IR STARTER PACK, 300 IR SUBLINGUAL TAB, 300 IR ADULT SAMPLE KT)	1-Covered	
PROLASTIN C	1-Covered	
RAGWITEK	1-Covered	
STIOLTO RESPIMAT	1-Covered	
TYZINE PEDIATRIC 0.05% DROP	1-Covered	
ZEMAIRA	1-Covered	
ADVAIR DISKUS	1-Covered	
ADVAIR HFA	1-Covered	
COMBIVENT RESPIMAT	1-Covered	QL (4 PER 23 DAYS)
<i>ipratropium-albuterol</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>promethazine vc</i>	1-Covered	PA
<i>promethazine-phenylephrine</i>	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
PULMOZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE
SYMBICORT	1-Covered	
XOLAIR	1-Covered	PA, LA

Skeletal Muscle Relaxants

<i>carisoprodol</i>	1-Covered	PA, QL (4 PER 1 DAYS)
<i>chlorzoxazone</i>	1-Covered	PA
<i>cyclobenzaprine 10 mg tablet</i>	1-Covered	PA, QL (3 PER 1 DAYS)
<i>cyclobenzaprine 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 er 100 mg tablet</i>	1-Covered	PA

Sleep Disorder Agents

GABA Receptor Modulators

<i>eszopiclone</i>	1-Covered	PA
<i>temazepam (15 mg capsule, 30 mg capsule)</i>	1-Covered	QL (1 PER 1 DAYS)
<i>zaleplon</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

<i>armodafinil</i>	1-Covered	PA
HETLIOZ	1-Covered	
NUVIGIL	1-Covered	PA
ROZEREM	1-Covered	
XYREM	1-Covered	
<i>zolpidem tartrate (1.75 mg tab, 3.5 mg tablet)</i>	1-Covered	
<i>zolpidem tartrate er</i>	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
Therapeutic Nutrients/ Minerals/ Electrolytes		
Electrolyte/ Mineral Modifiers		
CHEMET	1-Covered	
EXJADE	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 (sod polystyren sulf 15 g/60 ml, sodium polystyrene sulf powder, sps 15 gm/60 ml suspension, sps 30 gm/120 ml enema, sps 50 gm/200 ml enema)</i>	1-Covered	
SYPRINE	1-Covered	
VELTASSA	1-Covered	
Electrolyte/ Mineral Replacement		
CARBAGLU	1-Covered	
DENTA 5000 PLUS	1-Covered	
FLUOR-A-DAY (0.25 MG TAB, 0.5 MG TAB, 1 MG TABLET)	1-Covered	
<i>fluoride</i>	1-Covered	
FLUORITAB (0.5 MG TABLET, 1 MG TABLET)	1-Covered	
K-TAB ER	1-Covered	
KLOR-CON 10	1-Covered	
KLOR-CON 8	1-Covered	
KLOR-CON M10	1-Covered	
KLOR-CON M15	1-Covered	
KLOR-CON M20	1-Covered	
KLOR-CON SPRINKLE	1-Covered	
LUDENT FLUORIDE	1-Covered	
<i>magnesium sulfate 50% syringe</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>magnesium sulfate 50% vial</i>	1-Covered	
NORMOSOL-R PH 7.4	1-Covered	
PLASMA-LYTE 148	1-Covered	
PLASMA-LYTE A PH 7.4	1-Covered	
<i>potassium chl-normal saline</i>	1-Covered	
<i>potassium chloride (2 meq/ml vial, 2 meq/ml iv sol, 10 meq/5 ml conc, 20 meq/10 ml conc, 30 meq/15 ml conc, 40 meq/20 ml conc)</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>potassium chloride (er 8 meq capsule, er 8 meq tablet, er 10 meq tablet, 10 meq/50 ml sol, 10% (40 meq/30 ml, 10 meq/100 ml sol, er 10 meq capsule, 10% (20 meq/15 ml, 20 meq packet, 20 meq/50 ml sol, 20% (40 meq/15 ml, er 20 meq tablet, 20 meq/100 ml sol, 40 meq/100 ml sol)</i>	1-Covered	
<i>potassium chloride-nacl</i>	1-Covered	
PREVIDENT 1.1% GEL	1-Covered	
PREVIDENT 5000 SENSITIVE	1-Covered	
SF	1-Covered	
<i>sodium chloride (saline 0.45% soln-excel con, saline 0.9% soln-excel cont, sodium chloride 0.45% soln, sodium chloride 0.45% solution, sodium chloride 0.9% 250 ml, sodium chloride 0.9% 50 ml, sodium chloride 0.9% vial, sodium chloride 0.9% solution, sodium chloride 0.9% irrig., sodium chloride 0.9% soln, sodium chloride 0.9% 500 ml, sodium chloride 0.9% 1,000 ml, sodium chloride 0.9% 100 ml, sodium chloride 3% iv soln, sodium chloride 5% iv soln, sodium chloride 50 meq/20 ml, sodium chloride 100 meq/40 ml)</i>	1-Covered	
<i>sodium fluoride (0.5 mg(1.1 mg), 1 mg (2.2 mg))</i>	1-Covered	
ACTIVE OB	1-Covered	
AMINOSYN 8.5%-ELECTROLYTES SOL	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
AMINOSYN II	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN II WITH ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
ATABEX EC	1-Covered	
BAL-CARE DHA	1-Covered	
BAL-CARE DHA ESSENTIAL	1-Covered	
C-NATE DHA	1-Covered	
CADEAU DHA	1-Covered	
CALCIUM PNV	1-Covered	
CITRANATAL 90 DHA	1-Covered	
CITRANATAL ASSURE	1-Covered	
CITRANATAL B-CALM	1-Covered	
CITRANATAL DHA	1-Covered	
CITRANATAL HARMONY	1-Covered	
CITRANATAL RX	1-Covered	
CLINIMIX	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	1-Covered	
CONCEPT DHA	1-Covered	
CONCEPT OB	1-Covered	
<i>dextrose 10%-0.2% nacl</i>	1-Covered	
<i>dextrose 10%-0.45% nacl</i>	1-Covered	
<i>dextrose 10%-water iv solution</i>	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>dextrose 2.5%-0.45% nacl</i>	1-Covered	
<i>dextrose 5%-0.2% nacl</i>	1-Covered	
<i>dextrose 5%-0.2% nacl-kcl</i>	1-Covered	
<i>dextrose 5%-0.225% nacl</i>	1-Covered	
<i>dextrose 5%-0.225% nacl-kcl</i>	1-Covered	
<i>dextrose 5%-0.3% nacl</i>	1-Covered	
<i>dextrose 5%-0.3% nacl-kcl</i>	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dextrose 5%-0.33% nacl</i>	1-Covered	
<i>dextrose 5%-0.33% nacl-kcl</i>	1-Covered	
<i>dextrose 5%-0.45% nacl</i>	1-Covered	
<i>dextrose 5%-0.45% nacl-kcl</i>	1-Covered	
<i>dextrose 5%-0.9% nacl</i>	1-Covered	
<i>dextrose 5%-1/2ns-kcl</i>	1-Covered	
<i>dextrose 5%-ns-kcl</i>	1-Covered	
<i>dextrose 5%-potassium chloride (20, 40)</i>	1-Covered	
<i>dextrose in lactated ringers</i>	1-Covered	
<i>dextrose in water (iv soln, vial)</i>	1-Covered	
DOTHELLE DHA	1-Covered	
DUET DHA	1-Covered	
DUET DHA 400	1-Covered	
DUET DHA BALANCED	1-Covered	
DUET DHA EC	1-Covered	
ELITE OB DHA	1-Covered	
ELITE-OB 400	1-Covered	
ENBRACE HR	1-Covered	
EXTRA-VIRT PLUS DHA	1-Covered	
FOCALGIN 90 DHA	1-Covered	
FOCALGIN CA	1-Covered	
FOCALGIN-B	1-Covered	
FOLBECAL	1-Covered	
FOLET DHA	1-Covered	
FOLET ONE	1-Covered	
FOLIVANE-OB	1-Covered	
FOLIVANE-PRX DHA NF	1-Covered	
<i>fomepizole</i>	1-Covered	
GESTICARE DHA	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HEMENATAL OB	1-Covered	
HEMENATAL OB + DHA	1-Covered	
INATAL ADVANCE	1-Covered	
INATAL ULTRA	1-Covered	
INFANATE BALANCE	1-Covered	
INFANATE PLUS	1-Covered	
INTRALIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
<i>kcl 20 meq in d5w-lact ringer</i>	1-Covered	
KOSHER PRENATAL PLUS IRON	1-Covered	
<i>lactated ringers</i>	1-Covered	
<i>levomefolate dha</i>	1-Covered	
M-VIT	1-Covered	
MACNATAL CN DHA	1-Covered	
MARNATAL-F	1-Covered	
MAXINATE	1-Covered	
MYNATAL	1-Covered	
MYNATAL ADVANCE	1-Covered	
MYNATAL PLUS	1-Covered	
MYNATAL-Z	1-Covered	
MYNATE 90 PLUS	1-Covered	
NATACHEW	1-Covered	
NATALVIRT 90 DHA	1-Covered	
NATALVIRT CA	1-Covered	
NATALVIT	1-Covered	
NATELLE ONE	1-Covered	
NEEVODHA	1-Covered	
NESTABS	1-Covered	
NESTABS ABC	1-Covered	
NESTABS DHA	1-Covered	
NEWGEN	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
NEXA PLUS	1-Covered	
NIVA-PLUS	1-Covered	
NORMOSOL-M AND DEXTROSE	1-Covered	
NORMOSOL-R AND DEXTROSE	1-Covered	
O-CAL FA	1-Covered	
O-CAL PRENATAL	1-Covered	
OB COMPLETE	1-Covered	
OB COMPLETE GOLD	1-Covered	
OB COMPLETE ONE	1-Covered	
OB COMPLETE PETITE	1-Covered	
OB COMPLETE PREMIER	1-Covered	
OB COMPLETE WITH DHA	1-Covered	
OBSTETRIX DHA	1-Covered	
OBSTETRIX EC	1-Covered	
OBSTETRIX ONE	1-Covered	
OBTREX	1-Covered	
OBTREX DHA	1-Covered	
PAIRE OB PLUS DHA	1-Covered	
PLASMA-LYTE 56 IN DEXTROSE	1-Covered	
PNV 29-1	1-Covered	
<i>pnv folic acid + iron</i>	1-Covered	
PNV OB+DHA	1-Covered	
PNV-DHA + DOCUSATE	1-Covered	
<i>pnv-ferrous fumarate-docu-fa</i>	1-Covered	
PNV-OMEGA	1-Covered	
PNV-SELECT	1-Covered	
PNV-TOTAL	1-Covered	
PNV-VP-U	1-Covered	
PR NATAL 400	1-Covered	
PR NATAL 400 EC	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
PR NATAL 430	1-Covered	
PR NATAL 430 EC	1-Covered	
PREFERA OB	1-Covered	
PREFERA-OB ONE	1-Covered	
PREFERA-OB PLUS DHA	1-Covered	
PREFOL-DHA	1-Covered	
PRENA1 CHEW	1-Covered	
PRENA1 PEARL	1-Covered	
PRENA1 TRUE	1-Covered	
PRENAISSANCE	1-Covered	
PRENAISSANCE 90 DHA	1-Covered	
PRENAISSANCE BALANCE	1-Covered	
PRENAISSANCE DHA	1-Covered	
PRENAISSANCE NEXT	1-Covered	
PRENAISSANCE NEXT-B	1-Covered	
PRENAISSANCE PLUS	1-Covered	
PRENAISSANCE PROMISE	1-Covered	
PRENAPLUS	1-Covered	
PRENATA	1-Covered	
PRENATABS FA	1-Covered	
PRENATABS RX	1-Covered	
<i>prenatal 19</i>	1-Covered	
<i>prenatal ad</i>	1-Covered	
<i>prenatal low iron</i>	1-Covered	
<i>prenatal plus</i>	1-Covered	
<i>prenatal vitamin plus low iron</i>	1-Covered	
<i>prenatal-u</i>	1-Covered	
PRENATE AM	1-Covered	
PRENATE CHEWABLE	1-Covered	
PRENATE DHA	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
PRENATE ELITE	1-Covered	
PRENATE ENHANCE	1-Covered	
PRENATE ESSENTIAL	1-Covered	
PRENATE MINI	1-Covered	
PRENATE PIXIE	1-Covered	
PRENATE RESTORE	1-Covered	
PRENATE STAR	1-Covered	
PREPLUS	1-Covered	
PREQUE 10	1-Covered	
PRETAB	1-Covered	
PROVIDA DHA	1-Covered	
PROVIDA OB	1-Covered	
PUREFE OB PLUS	1-Covered	
PUREFE PLUS	1-Covered	
R-NATAL OB	1-Covered	
RELNATE DHA	1-Covered	
<i>ringers injection</i>	1-Covered	
<i>ringers irrigation</i>	1-Covered	
RULAVITE DHA	1-Covered	
SE-NATAL 19	1-Covered	
SE-TAN DHA	1-Covered	
SELECT-OB	1-Covered	
SELECT-OB + DHA	1-Covered	
<i>sodium lactate</i>	1-Covered	
<i>sterile water for irrigation</i>	1-Covered	
TARON-BC	1-Covered	
TARON-C DHA	1-Covered	
TARON-PREX PRENATAL	1-Covered	
THRIVITE 19	1-Covered	
TL FOLATE	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
TL-CARE DHA	1-Covered	
TL-SELECT	1-Covered	
TPN ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRI-TABS DHA	1-Covered	
TRIADVANCE	1-Covered	
TRICARE	1-Covered	
TRICARE PRENATAL DHA ONE	1-Covered	
TRINATAL GT	1-Covered	
TRINATAL RX 1	1-Covered	
TRINATE	1-Covered	
TRISTART DHA	1-Covered	
TRIVEEN-DUO DHA	1-Covered	
TRIVEEN-ONE	1-Covered	
TRIVEEN-PRX RNF	1-Covered	
TROPHAMINE	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRUST NATAL DHA	1-Covered	
ULTIMATECARE ONE	1-Covered	
ULTIMATECARE ONE NF	1-Covered	
VEMAVITE-PRX 2	1-Covered	
VENA-BAL DHA	1-Covered	
VENATAL-FA	1-Covered	
VINACAL	1-Covered	
VINATE CARE	1-Covered	
VINATE DHA	1-Covered	
VINATE DHA RF	1-Covered	
VINATE GT	1-Covered	
VINATE II	1-Covered	
VINATE ONE	1-Covered	
VINATE PN CARE	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
VINATE ULTRA	1-Covered	
VINATE-M	1-Covered	
VIRT NATE	1-Covered	
VIRT-ADVANCE	1-Covered	
VIRT-BAL DHA	1-Covered	
VIRT-BAL DHA PLUS	1-Covered	
VIRT-C DHA	1-Covered	
VIRT-CARE ONE	1-Covered	
VIRT-NATE	1-Covered	
VIRT-NATE DHA	1-Covered	
VIRT-PN	1-Covered	
VIRT-PN DHA	1-Covered	
VIRT-PN PLUS	1-Covered	
VIRT-SELECT	1-Covered	
VIRT-VITE GT	1-Covered	
VIRTPREX	1-Covered	
VITAFOL FE+	1-Covered	
VITAFOL GUMMIES	1-Covered	
VITAFOL NANO	1-Covered	
VITAFOL ULTRA	1-Covered	
VITAFOL-OB	1-Covered	
VITAFOL-OB+DHA	1-Covered	
VITAFOL-ONE	1-Covered	
VITAMEDMD ONE RX	1-Covered	
VITAMEDMD PLUS RX	1-Covered	
VITAMEDMD REDICHEW RX	1-Covered	
VITAPEARL	1-Covered	
VITATRUE	1-Covered	
VIVA DHA	1-Covered	
VOL-NATE	1-Covered	

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Health Partners Medicare Special Formulary (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VOL-PLUS	1-Covered	
VOL-TAB RX	1-Covered	
VP CH ULTRA	1-Covered	
VP-CH PLUS	1-Covered	
VP-CH-PNV	1-Covered	
VP-ERA OB PLUS	1-Covered	
VP-GGR-B6	1-Covered	
VP-HEME OB	1-Covered	
VP-HEME OB + DHA	1-Covered	
VP-HEME ONE	1-Covered	
VP-PNV-DHA	1-Covered	
ZATEAN-CH	1-Covered	
ZATEAN-PN	1-Covered	
ZATEAN-PN DHA	1-Covered	
ZATEAN-PN PLUS	1-Covered	
ZINGIBER	1-Covered	

Uncategorized

Unclassified

<i>dicyclomine 20 mg/2 ml vial</i>	1-Covered	
HUMULIN R U-500 KWIKPEN	1-Covered	
ODEFSEY	1-Covered	
SPRITAM	1-Covered	
VRAYLAR 1.5 MG-3 MG PACK	1-Covered	

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

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