



QUICK REFERENCE DRUG LIST

November 2009

This formulary is not inclusive nor does it guarantee coverage. It is an abbreviated list of Pharmacy and Therapeutics Committee approved drugs that may be prescribed for Dean Health Plan members. This document is subject to change. The most updated version of this document as well as a complete formulary listing is available at deancare.com or upon request by calling (800) 279-1301. Drugs will be dispensed generically when acceptable generic equivalents are available.

ANTI-INFECTIVES		
Anti-Fungals		
clotrimazole troche	1	
ketoconazole	1	
fluconazole	1	
griseofulvin	1	
itraconazole (PA)	1	
nystatin tab/susp	1	
terbinafine	1	
GRIFULVIN	2	
Anti-Virals		
acyclovir	1	
amantadine caps	1	
ribavirin (SP)	1	
rimantadine	1	
VALTREX	2	
HEPSERA	2	
TAMIFLU (QL)	2	
RELENZA DISKHALER (QL)2 (QL=20 units/fill)	2	
FAMVIR	3/NC	
Cephalosporins		
cefadroxil	1	
cefadroxil susp	1	
cefdinir	1	
cefprozil	1	
cefuroxime	1	
cephalexin	1	
cephradine	1	
OMNICEF	3/NC	
cefaclor	3/NC	
CEFTIN SUSP	3/NC	
SPECTRACEF	3/NC	
SUPRAX	3/NC	
HIV Drugs		
All HIV drugs are covered at level 2.		
Macrolides		
azithromycin	1	
clarithromycin	1	
ery-tab	1	
erythromycin (all forms except PCE)	1	
DYNABAC	3/NC	
PCE	3/NC	
Penicillins		
amoxicillin	1	
amoxicillin/clavulanate	1	
dicloxacillin	1	
penicillin vk	1	
AUGMENTIN XR	2	
Quinolones		
ciprofloxacin	1	
ciprofloxacin er	1	
ofloxacin	1	
AVELOX	2	
LEVAQUIN	2	
CIPRO CYSTITIS	3/NC	
MAXAQUIN	3/NC	
NOROXIN	3/NC	
TEQUIN	3/NC	
Miscellaneous		
Anti-infectives		
clindamycin 150 mg	1	
erythromycin/ sulfisoxazole susp	1	
metronidazole	1	
monohydrate/macro- crystals (MACROBID equiv)	1	
nitrofurantoin	1	
rifampin	1	
smz-tmp ds	1	
ACTIMMUNE (INJ/SP)	2	
DAPSONE	2	
VANCOCIN	2	
FLAGYL ER	3/NC	
clindamycin 300 mg	NC	
ANTINEOPLASTICS/ IMMUNOSUPPRESSANTS		
azathioprine	1	
cyclosporine	1	
etoposide	1	
tamoxifen	1	
ARIMIDEX (SP)	2	
LEUKERAN	2	
XELODA (SP)	2	
CELLCEPT	3/NC	
CARDIOVASCULAR		
ACE Inhibitors		
benazepril/hctz	1	
captopril/hctz	1	
enalapril (GS)	1	
enalapril/hctz	1	
fosinopril	1	
lisinopril (GS)	1	
lisinopril/hctz	1	
trandolapril	1	
ramipril	1	
moexipril/ hctz	3/NC	
UNIVASC	3/NC	
Angiotensin Receptor Blockers		
ATACAND/HCT (TS)	2	
AVAPRO (TS)	2	
AVALIDE (TS)	2	
DIOVAN (TS)	2	
DIOVAN HCTZ	2	
EXFORGE (TS)	2	
EXFORGE HCT	2	
BENICAR	3/NC	
BENICAR HCT	3/NC	
COZAAR	3/NC	
HYZAAR	3/NC	
MICARDIS/HCT	3/NC	
TEVETEN	3/NC	
Beta Blockers		
acebutolol	1	
atenolol (GS)	1	
betaxolol	1	
bisoprolol/hctz (GS)	1	
carvedilol	1	
INNOPRAN XL	1	
labetalol	1	
metoprolol (GS)	1	
metoprolol er	1	
metoprolol/hctz	1	
nadolol	1	
propranolol	1	
propranolol/er	1	
COREG	3	
BYSTOLIC	2	
LEVATOL	2	
COREG CR	3/NC	
TOPROL XL	3/NC	
Calcium Channel Blockers		
amlodipine	1	
amlodipine/benazepril	1	
diltiazem (all generic forms)	1	
nicardipine	1	
nifedipine ER	1	
verapamil SR (GS)	1	
CARDIZEM LA	2	
NORVASC	3/NC	
CARDIZEM CD	3/NC	
COVERA-HS	3/NC	
PLENDIL	3/NC	
verapamil ER	3/NC	
Cholesterol Lowering Agents		
cholestyramine (light)	1	
colestipol powder (COLESTID POWDER equiv)	1	
gemfibrozil	1	
LOFIBRA	1	
lovastatin	1	
NIASPAN	1	
pravastatin	1	
simvastatin (GS)	1	
ADVICOR	2	
CRESTOR (TS)	2	
(TS/QL = 30 tabs/Rx)		
LESCOL (XL) (PA)	2	
LIPITOR (PA)	2	
3/NC if PA not obtained		
LOVAZA	2	
SIMCOR	2	
TRILIPIX	2	
VYTORIN	2	
(QL = 30 tabs/Rx)		
ZETIA (QL)	2	
(QL=1 tab/day)		
WELCHOL	2	
ALTOPREV	3/NC	
TRICOR	3/NC	
ZOCOR	3/NC	
Diuretics		
amiloride/hctz	1	
furosemide	1	
hydrochlorothiazide	1	
indapamide	1	
metolazone	1	
spironolactone	1	
triamterene/hctz (GS)	1	
acetazolamide cap	1	
DIAMOX SEQUELS	2	
Other Cardiovascular Agents		
clonidine patch	1	
doxazosin (GS)	1	
Reading the Drug List		
Generic medications are listed in all lower case letters; brand name medications are listed in all upper case letters. Each drug product is associated with a coverage level, shown to the right of each drug product.		
Tier	Description to member	Relative cost
1	Formulary, Lower cost products	\$
2	Formulary, High cost products	\$\$
3/NC	Covered products under the Three-Tier Pharmacy Benefit/ Not-covered (NC) products under the Two-Tier Pharmacy Benefit	\$\$\$\$
NC	Excluded products	
Cases where drug products are followed by parentheses indicate that the entry relates to a certain dosage form, e.g. ESTRACE (vaginal cream), or more than one form of the drug, e.g. ZOMIG (ZMT). Quantity limits provided are for prescriptions filled at retail pharmacies; please consult complete version of formulary for mail order quantity limits.		
All newly approved drugs on the market will initially NOT be covered, pending further review by the P & T Committee. Brand drugs having therapeutically equivalent generic products available will be covered at a Level 3 unless otherwise noted.		
Tablet Splitting Program (TS)		
Member will be assessed one-half of the normal copayment or coinsurance if a qualifying product (denoted with TS) is split to obtain the required dose. Please note that ABILIFY, lamictal, and DIOVAN are also part of this program even though they are not listed in this document.		
Generic Sampling Program (GS)		
Member will pay \$0 for first fill on selected generic products (denoted with GS).		

(GS)=Generic Sampling Program (PA)=Prior Authorization required; criteria (QL)=Quantity limits (ST)=Step Therapy applies
(INJ)=Self-injectable medication needs to be met for product to be covered (RS)=Restricted to a specialist (SP)=Must obtain through Dean
(TS)=Tablet Splitting Program NC =Not covered under any tier — = Zero copay Specialty Pharmacy

