



# Employer Based Plans Quick Reference Drug List

Last updated: February 1, 2012

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/drugformulary](http://deancare.com/drugformulary) or upon request by calling (800) 279-1301. Drugs will be dispensed generically when acceptable generic equivalents are available.

<b>ANTI-INFECTIVES</b>	DIOVAN (TS)	2	hydrocodone/	1
<b>ANTI-FUNGALS</b>	DIOVAN HCTZ	2	acetaminophen	
clotrimazole troche	EXFORGE (TS)	2	oxycodone/acetaminophen	1
fluconazole	EXFORGE HCT	2	morphine sulfate ER	1
nystatin tab/susp	AVALIDE	3	tramadol	1
terbinafine	AVAPRO	3	OXYCONTIN	2
itraconazole (PA)	<b>BETA BLOCKERS</b>		<b>ANTI-ANXIETY AGENTS &amp; SEDATIVES</b>	
ketoconazole	atenolol (GS)	1	alprazolam	1
<b>ANTI-VIRALS</b>	bisoprolol/hctz (GS)	1	buspirone	1
acyclovir	carvedilol	1	lorazepam	1
amantadine caps	labetalol	1	temazepam	1
TAMIFLU	metoprolol (GS)	1	zolpidem	1
RELENZA DISKHALER	metoprolol er	1	<b>ANTI-CONVULSANTS</b>	
valacyclovir	metoprolol/hctz	1	carbamazepine	1
<b>CEPHALOSPORINS</b>	nadolol	1	clonazepam	1
cefadroxil	propranolol/er	1	divalproex	1
cefuroxime	BYSTOLIC	2	gabapentin	1
cephalexin	<b>CALCIUM CHANNEL BLOCKERS</b>		phenobarbital	1
cefdinir	amlodipine	1	phenytoin sodium ER	1
cefprozil	amlodipine/benazepril	1	valproic acid	1
<b>IV DRUGS</b>	nifedipine ER	1	CARBATROL	2
All HIV drugs are covered at level 2	verapamil SR (GS)	1	DILANTIN 30 mg	2
<b>MACROLIDES</b>	diltiazem ER	1	lamotrigine	2
azithromycin 250mg	(all generic forms)	2	TEGRETOL, XR	2
azithromycin suspension	<b>CHOLESTEROL LOWERING AGENTS</b>		topiramate	2
clarithromycin	cholestyramine (light)	1	<b>ANTI-DEPRESSANTS</b>	
erythromycin	gemfibrozil	1	amitriptyline	1
<b>PENICILLINS</b>	LIPITOR (TS)	1	citalopram	1
amoxicillin	LOFIBRA	1	EFFEXOR XR	1
amoxicillin/clavulanate	lovastatin	1	fluoxetine (GS)	1
penicillin vk	pravastatin	1	mirtazapine	1
Quinolones	simvastatin (GS)	1	nortriptyline	1
ciprofloxacin	CRESTOR (TS)	2	paroxetine	1
amoxicillin/clav ER	LOVAZA	2	sertraline (GS)	1
AVELOX	NIASPAN	2	trazodone	1
LEVAQUIN	SIMCOR	2	bupropion SR,XL	2
<b>MISCELLANEOUS</b>	TRILIPIX	2	budeprion SR,XL	2
<b>ANTI-INFECTIVES</b>	ZETIA	2	CYMBALTA	2
clindamycin 150 mg	Atorvastatin tab	3/NC	LEXAPRO (TS)	2
smz-tmp ds	VYTORIN	3/NC	VENLAFAXINE SR	2
erythromycin/	<b>DIURETICS</b>		<b>ANTI-PARKINSON AGENTS</b>	
nitrofurantoin macro crystals	hydrochlorothiazide	1	carbidopa/levodopa	1
(MACROBID equiv)	indapamide	1	pramipexole	1
sulfisoxazole susp	furosemide	1	pergolide	1
metronidazole	hydrochlorothiazide	1	ropinirole	1
<b>CARDIOVASCULAR</b>	spironolactone	1	selegiline	1
<b>ACE INHIBITORS</b>	triamterene/hctz (GS)	1	AZILECT	2
benazepril/hctz	acetazolamide cap	1	STALEVO	2
captopril/hctz	<b>OTHER CADRIOVASCULAR AGENTS</b>		<b>ANTI-PSYCHOTIC AGENTS</b>	
enalapril (GS)	clonidine oral	1	haloperidol	1
enalapril/hctz	doxazosin (GS)	1	risperidone	1
lisinopril (GS)	terazosin (GS)	1	clozapine	2
lisinopril/hctz	clonidine patch	2	GEODON	2
<b>ANGIOTENSIN RECEPTOR BLOCKERS</b>	EFFIENT (PA)	2	olanzapine tab	2
losartan/hct	MULTAQ (RS)	2	SEROQUEL (TS)	2
	<b>CNS AGENTS</b>		SEROQUEL XR	2
	<b>CNS AGENTS</b>		SYMBYAX	2
	<b>ANALGESICS</b>		ABILIFY (PA)	2
	acetaminophen/codeine	1	ZYPREXA (TS)	3
	fentanyl patch	1	<b>MIGRAINE AGENTS</b>	

## 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 needs to be met for product to be covered

(QL) Quantity limits

(ST) Step Therapy applies

(INJ) Self-injectable medication

(RS) Restricted to a specialist

(-) Zero copay

(SP) Must obtain through Dean Specialty Pharmacy

(TS) Tablet Splitting Program

(NC) Not covered under any tier

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