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Welcome to your guide to the Maryland Physicians Care (MPC) drug coverage for prescription medications. This booklet will provide you with information on the medications that are covered under the MPC formulary.

The formulary was developed by the MPC Pharmacy and Therapeutics Committee (P&T Committee) that is comprised of physicians from various medical specialties. The P&T Committee reviews new and existing medications to ensure the formulary remains responsive to the needs of our members and providers, as well as monitoring the safety, effectiveness and cost associated with all drug categories.

The formulary is the cornerstone of drug therapy quality assurance and cost containment efforts. The review process has been successfully used by hospitals and managed care organizations to provide a comprehensive and cost-effective formulary. As you use the formulary, we invite your suggestions to improve the format or content.

## **Formulary Medications**

The formulary is a listing of medications marketed at the time of printing and intended for use by the health plan physicians and pharmacy providers. Unless exceptions are noted, all forms (tablet, capsule, liquid, topical) and strengths of a drug product are included in the formulary and will be covered by MPC.

The formulary applies only to prescription medications dispensed to outpatients by participating pharmacies. The formulary does not apply to in-patient medications or to medications obtained from and/or administered by a physician.

## **HIV Medications**

HIV medications are carved out for MPC and are payable as fee-for-service through Maryland Medical Assistance.

## **Mental Health Medications**

Certain mental health medications are carved out for MPC and are payable as fee-for-service through Maryland Medical Assistance. Please refer to the following website for a list of medications that are carved out and those that must be covered by MPC:

[http://www.mdmahealthchoicerox.com/healthchoice\\_docs/mmmh\\_form.pdf](http://www.mdmahealthchoicerox.com/healthchoice_docs/mmmh_form.pdf)

## **Over-the-Counter, Non-prescription Medications Policy**

Some over-the-counter (OTC) products are covered according to the MPC OTC list.

## **Generic Drug Policy**

Specific drugs, which have generic equivalents are covered at a generic reimbursement level and should be prescribed and dispensed in the generic form. Providers are reminded of the following:

1. When generic substitution conflicts with state regulations or restrictions, the pharmacist must gain approval from the prescribing physician to use the generic equivalent.
2. If a physician indicates "Dispense As Written" (DAW) and completes a MedWatch form to document any adverse effects caused by previous experience with the generic alternative, MPC will pay for the brand name drug.

## **Unapproved Use of Medications**

The member's benefit handbook states medications will be eligible for coverage only if they are FDA approved medications used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA-approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion.

Experimental and investigational drugs, and drugs used for cosmetic purposes are not eligible for coverage.

Drugs, which have Drug Efficiency Studies Implementation (DESI) status, are not covered by MPC.

## **Prescriptions for Non-Formulary Medications**

The MPC P&T Committee has attempted to include medications from all therapeutic needs. If a patient requires medication that is not listed on the formulary, the physician may request an exception to allow payment for the medication. It is anticipated that such exceptions will be rare and physicians should be able to find a medication on the formulary for most therapeutic needs. However, if a health care provider wishes that a member receive a medication not covered, he/she must submit a letter explaining the necessity, past therapeutic failures, and patient identification (name, address, and member id number). The P&T Committee will monitor prescriptions written in a non-



conformance with the formulary and contact physicians who prescribe non-formulary products to request compliance.

### **Specialty Medications**

All specialty drugs available through CuraScript™ require prior authorization. The CuraScript specialty medication form can be downloaded from the MPC website at: <http://www.marylandphysicianscare.com/pdf/SpecialtyMedAuthForm.pdf>. Specialty medications available through CuraScript can also be downloaded from the MPC website at:

<http://www.marylandphysicianscare.com/pdf/SpecialtyInjectableMedicationDrug.pdf>

### **Prior Authorization (PA)**

Certain medications on the MPC formulary require pre-authorization. Drugs that require Prior Authorization are identified on the formulary with <sup>PA</sup> after the drug name. In order for a member to receive coverage for a medication requiring Prior Authorization a provider must:

- Fax the Pharmacy Prior Authorization Request Form to: the Maryland Physicians Care Pharmacy Prior Authorization Department at: 1-800-854-7614. The Pharmacy Prior Authorization Request form can be downloaded from the MPC website at [www.MarylandPhysiciansCare.com](http://www.MarylandPhysiciansCare.com).
- If you need to have a Prior Authorization form sent to you, you can contact the Maryland Physicians Care at (800) 953-8854, option 2.

### **Quantity Limits (QL)**

Certain prescription drugs may be prescribed only in limited quantities. Drugs that have quantity limits are identified on the formulary with <sup>QL</sup> after the drug name or you can download a list of drugs having quantity limits from the MPC website. In order to receive an override for the indicated quantity limit, you will be required to complete a Prior Authorization form and fax to the MPC Pharmacy Prior Authorization at (800) 854-7614. Prior Authorization forms can be downloaded from the MPC website.

### **Step Therapy (ST)**

The ST program requires certain first-line drugs: generic drugs or other formulary drugs to be prescribed prior to approval of specific second-line drugs. The ST requirements document can be downloaded from the MPC website at:

<http://www.marylandphysicianscare.com/approveddrug.aspx>.



If there is a new or existing medication that you would like to have added to the formulary, you will need to complete the Drug Formulary Change Request Form and send to MPC for presentation to the P&T Committee. Forms are located in the MPC Provider Manual or you can call Provider Services at (800) 953-8854, option 5 to request a form. You will be notified in writing of the decision taken at the P&T Committee. The MPC P&T Committee meets on a quarterly basis.

## DRUG FORMULARY

<b>CHAPTER 1: ANESTHETICS</b>
<b>1.2 TOPICAL ANESTHETICS</b>
Lidocaine HCL Viscous
Lidocaine-HC 3-1% Cream
Lidoderm
<b>CHAPTER 2: ANTIINFECTIVES</b>
<b>2.1.1 CEPHALOSPORINS</b>
Cefaclor
Cefaclor ER
Ceftriaxone <sup>QL</sup>
Cefuroxime tablets, suspension
Cefuroxime Sodium <sup>PA</sup>
Cephalexin
Cefdinir
Suprax <sup>QL</sup>
<b>2.1.3 CLINDAMYCINS</b>
Clindamycin HCL
<b>2.1.4 ERYTHROMYCINS</b>
Erythrocin Stearate
Erythromycin Ethylsuccinate
<b>2.1.4.1 OTHER MACROLIDES</b>
Azithromycin <sup>QL</sup>
Clarithromycin, ER <sup>QL</sup>
<b>2.1.5 PENICILLINS</b>
Amox TR/Potassium Clavulanate <sup>QL</sup>
Amoxicillin
Penicillin V Potassium
Amox TR-K CLV 600
<b>2.1.6 SULFONAMIDES</b>
Erythromycin w/Sulfisoxazole
Sulfamethoxazole /Trimethoprim
<b>2.1.7 TETRACYCLINES</b>

Doxycycline Hyclate
Minocycline
Tetracycline
<b>2.1.8 URINARY ANTINFECTIVES</b>
Nitrofurantoin Macrocrystal
Trimethoprim
Macrobid
<b>2.1.9 QUINOLONES</b>
Levaquin
Ciprofloxacin
<b>2.2 TOPICAL ANTIBACTERIAL DRUGS</b>
Chlorhexidine Gluconate
Silver Sulfadiazine
Bactroban cream
Mupirocin ointment
<b>2.3 ORAL ANTIFUNGAL DRUGS</b>
Clotrimazole
Fluconazole
Grifulvin V
Gris-PEG
Ketoconazole
Sporanox <sup>PA</sup>
Nystatin
Terbinafine
<b>2.4.2 OTHER TOPICAL ANTIFUNGALS</b>
Econazole Nitrate
Ketoconazole shampoo
Nystatin
OTC Clotrimazole
OTC Miconazole
<b>2.4.3 TOPICAL ANTIFUNGAL- CORTICOSTEROID COMBINATIONS</b>
Nystatin w/Triamcinolone
Clotrimazole/Betamethasone
<b>2.5.2 OTHER ANTIVIRAL DRUGS</b>
Acyclovir <sup>QL</sup>

Amantadine
Famvir <sup>QL</sup>
Relenza <sup>QL</sup>
Ribavirin <sup>PA,QL</sup>
Tamiflu <sup>QL</sup>
Tyzeka <sup>PA</sup>
<b>2.7.1 AMEBICIDES</b>
Paromomycin Sulfate
<b>2.7.2. ANTITUBERCULOSIS DRUGS</b>
Ethambutol
Isoniazid
Rifampin
Isonarif Capsule
Pyrazinamide
<b>2.7.3 PLASMODICIDES</b>
Hydroxychloroquine Sulfate
Mefloquine
<b>2.7.5 TRICHOMONOCIDES</b>
Metronidazole
<b>2.8.1 PARENTERAL ANTIFUNGALS</b>
Sporanox <sup>PA</sup>
<b>CHAPTER 3: ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS</b>
<b>3.0 ANTINEOPLASTIC/IMMUNOSUPPRESSANT DRUGS</b>
Arimidex
Azathioprine
Bicalutamide
Cellcept [inj] <sup>PA</sup>
Cyclosporine
Degarelix <sup>PA</sup>
Eligard <sup>PA</sup>
Flutamide
Mesnex
Methotrexate
Mycophenolate 250 mg capsule; 500 mg tablet

Myforitic
Nexavar <sup>PA</sup>
Revlimid <sup>PA</sup>
Sandostatin <sup>PA</sup>
Somatuline <sup>PA</sup>
Tabloid
Tacrolimus
Tamoxifen Citrate
Tykerb <sup>PA</sup>
<b>CHAPTER 4: CARDIOVASCULAR MEDICATIONS</b>
<b>4.1 CARDIAC GLYCOSIDES</b>
Digitek
Digoxin
Lanoxin
<b>4.2 CALCIUM ANTAGONISTS</b>
Amlodipine <sup>QL</sup>
Cartia XT
Diltiazem
Diltiazem ER
Diltiazem XR
Felodipine
Isradipine
Nicardipine
Nifedipine
Nifedipine ER <sup>QL</sup>
Verapamil, ER
<b>4.3.1 LOOP DIURETICS</b>
Bumetanide
Furosemide
Torsemide
<b>4.3.2 THIAZIDE AND RELATED DRUGS</b>
Hydrochlorothiazide
Indapamide
Zaroxolyn

<b>4.3.3 POTASSIUM SPARING DIURETICS</b>
Amiloride HCL w/HCTZ
Spirolactone
Spirolactone w/HCTZ
Triamterene w/HCTZ
<b>4.4 BETA-ADRENERGIC ANTAGONIST DRUGS</b>
Atenolol
Metoprolol Succinate (generic for Toprol XL) <sup>QL</sup>
Metoprolol Tartrate
Propranolol
Propranolol Extended-Release
Carvedilol
Toprol XL <sup>QL</sup>
<b>4.5.1 VASODILATOR ANTIHYPERTENSIVES</b>
Doxazosin Mesylate <sup>QL</sup>
Hydralazine
Prazosin
Terazosin <sup>QL</sup>
<b>4.5.2 CENTRALLY ACTING ANTIHYPERTENSIVES</b>
Clonidine
Methyldopa
Catapres-TTS <sup>QL</sup>
Guanfacine (Tenex)
<b>4.5.4.1 ANGIOTENSIN CONVERTING ENZYME INHIBITORS</b>
Captopril
Enalapril Maleate
Fosinopril
Lisinopril
Moexipril
<b>4.5.4.2 ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>
Benicar <sup>ST,QL</sup>
Diovan <sup>ST,QL</sup>
<b>4.5.6 OTHER ANTIHYPERTENSIVES</b>
Benicar HCT <sup>ST,QL</sup>
Captopril/Hydrochlorothiazide

Diovan HCT <sup>ST,QL</sup>
Enalapril Maleate/HCTZ
Atenolol/Chlorthalidone
Bisopropol fumarate/HCTZ
Lisinopril/HCTZ
<b>4.6.1 NITRATES</b>
Isosorbide Mononitrate
Nitroglycerin patches, ointment, sublingual
<b>4.7.1.1 CLASS 1A ANTIARRHYTHMICS</b>
Quinidine Gluconate
<b>4.7.1.2 CLASS 1B ANTIARRHYTHMICS</b>
Mexiletine hcl
<b>4.7.1.3 CLASS 1C ANTIARRHYTHMICS</b>
Flecainide Acetate
Propafenone
<b>4.7.3 AMIODARONES</b>
Amiodarone
Pacerone
<b>4.7.5 OTHER ANTIARRHYTHMICS</b>
Sotalol
<b>4.8.1 HYPOLIPOPROTEINEMICS</b>
Cholestyramine
Gemfibrozil <sup>QL</sup>
Fenofibrate
Colestipol
OTC Niacin
Trilipix
<b>4.8.2 HMG-COA REDUCTASE INHIBITORS</b>
Lovastatin <sup>QL</sup>
Pravastatin <sup>QL</sup>
Simvastatin <sup>QL</sup>
Vytorin <sup>QL</sup>
<b>4.9 OTHER CARDIOVASCULAR DRUGS</b>
Pentoxifylline

<b>CHAPTER 5: AUTONOMIC AND CNS MEDICATIONS</b>
<b>5.1.1 ANALGESICS</b>
Tramadol <sup>QL</sup> , Tramadol/APAP <sup>QL</sup>
Diflunisal
OTC Enteric Coated Aspirin
<b>5.1.1.1 CLASS II NARCOTICS</b>
Fentanyl Patches <sup>QL</sup>
Meperidine <sup>QL</sup>
Oxycodone w/Acetaminophen <sup>QL</sup> (5/325 mg, 7.5/325 mg, 10/325 mg, 5/500 mg, 7.5/500 mg, 10/650 mg)
MS Contin
MSIR
Oramorph
OxyIR <sup>QL</sup>
Oxycontin <sup>QL,PA</sup>
Roxicet 5-325/5 ml solution
<b>5.1.1.2 CLASS III NARCOTICS</b>
Acetaminophen w/Codeine <sup>QL</sup>
Hydrocodone w/Acetaminophen <sup>QL</sup>
Norco <sup>QL</sup>
Suboxone (Buprenorphine & Naloxone)
<b>5.1.1.3 CLASS IV NARCOTICS</b>
Propoxyphene HCLw/APAP <sup>QL</sup>
Propoxyphene Napsylate w/APAP <sup>QL</sup>
<b>5.1.2 DRUGS TO PREVENT AND TREAT HEADACHES</b>
Butalbital Compound
Butalbital/APAP/Caffeine
Migranal <sup>QL</sup>
Relpax <sup>QL</sup>
sumatriptan <sup>QL</sup>
Zomig <sup>QL</sup>
Zomig ZMT <sup>QL</sup>
<b>5.4.3 HYDANTOINS</b>
Phenytoin
Phenytoin Sodium, Extended-Release

Dilantin Infatabs, Extended-Release (30 mg only)
Phenytek
<b>5.4.5 SUCCINIMIDES</b>
Ethosuximide
<b>5.4.6 ANTICONVULSANT BARBITURATES</b>
Phenobarbital
Primidone (Mysoline))
<b>5.6 ANTIVERTIGO AND ANTIEMETIC DRUGS</b>
Granisetron <sup>PA,QL</sup>
Meclizine
Ondansetron, ODT <sup>PA, QL</sup>
Prochlorperazine
Prochlorperazine Maleate
Trimethobenzamide
<b>5.7.2 OTHER ANTIPARKINSON DRUGS</b>
Bromocriptine Mesylate
Carbidopa/Levodopa, extended-release
Selegiline
ropinirole <sup>QL</sup>
<b>5.9.2 OTHER CNS/AUTONOMIC DRUGS</b>
Naltrexone
<b>5.9.2.1 ALCOHOL ANTAGONIST</b>
Antabuse
Campral <sup>PA</sup>
<b>5.9.3 ANTIDEMENTIA DRUGS</b>
Exelon
galantamine, ER <sup>QL</sup>
<b>5.9.5 SMOKING CESSATION DRUGS</b>
buproban <sup>QL</sup>
Chantix <sup>QL</sup>
OTC Nicotine patches <sup>QL</sup>
<b>CHAPTER 6: DERMATOLOGICAL MEDICATIONS</b>
<b>6.1 TOPICAL CORTICOSTEROID DRUGS</b>
Amcinonide

Betamethasone Dipropionate
Clobetasol Propionate
Desoximetasone
Diflorasone Diacetate
Fluocinolone
Hydrocortisone (includes OTC dosage forms)
Pramoxine HC
Triamcinolone Acetonide
Topicort Cream
<b>6.2 ANTIPRURITIC DRUGS</b>
Hydroxyzine HCL
Hydroxyzine Pamoate
<b>6.3 ANTIACNE DRUGS</b>
Amnesteem
Claravis
Tretinoin <sup>PA required age&gt;21 years,QL</sup>
Benzoyl Peroxide/Erythromycin
Finacea
Metronidazole Cream
Metrogel
Metro lotion
Mometasone furoate cream
Clindamycin Phosphate (1% solution, gel, topical pledget, lotion, foam)
Erythromycin Base
Metronidazole 0.75%
Sodium Sulfacetamide/Sulfur <sup>QL</sup>
Sotret
<b>6.7 KERATOLYTIC DRUGS</b>
Condylox
<b>6.8 ANTIPSORIASIS AND ANTIECZEMA DRUGS</b>
Selenium Sulfide
Dovonex topical cream
Calcipotriene topical solution
Klaron
Vectical Ointment

<b>6.9.2 TOPICAL DERMATOLOGICAL DRUGS</b>
Carac
Elidel <sup>PA, QL</sup>
OTC Ammonium Lactate Cream, Lotion (Generic for Lac-Hydrin)
<b>6.9.3 SCABICIDES</b>
Malathion 0.5% lotion (Generic for Ovide Lotion)
Permethrin OTC lotion, Permethrin cream
<b>CHAPTER 7: EAR-NOSE-THROAT MEDICATIONS</b>
<b>7.1 DRUGS AFFECTING THE EAR</b>
A/B Otic
Cerumenex
Ciprodex
Cipro HC
<b>7.2 DRUG AFFECTING THE NOSE</b>
Ipratropium Bromide <sup>QL</sup>
Fluticasone <sup>QL</sup>
Flunisolide <sup>QL</sup>
Nasacort AQ <sup>ST, QL</sup>
Nasonex <sup>ST, QL</sup>
<b>7.3 DRUGS AFFECTING THE THROAT AND MOUTH</b>
Chlorhexidene Gluconate
<b>CHAPTER 8: ENDOCRINE MEDICATIONS</b>
<b>8.1.1 INSULIN (VIALS ONLY)</b>
Humalog
Humalog Mix 75/25
Humulin 50/50
Humulin 70/30
Humulin N
Humulin R
Lantus
Levemir
Novolin 70/30
Novolin N
Novolin R

Novolog, Novolog 70/30
<b>8.1.2 ORAL HYPOGLYCEMIC DRUGS</b>
Acarbose
Glipizide
Glyburide
Metformin
Metformin ER
Glimepiride
Glipizide ER
Glyburide/Metformin
Nateglinide
Prandin
Prandimet
<b>8.1.3 INSULIN SENSITIZERS</b>
Actos <sup>QL</sup>
Actoplus Met <sup>QL</sup>
Avandamet <sup>QL</sup>
Avandaryl <sup>QL</sup>
Avandia <sup>QL</sup>
Duetact <sup>QL</sup>
<b>8.2.0 GLUCOSE ELEVATING DRUGS</b>
Glucagon
OTC glucose chewable tablets
<b>8.3.1 GLUCOCORTICOID DRUGS</b>
Dexamethasone
Hydrocortisone
Methylprednisolone
Prednisone
Prednisolone
<b>8.3.2 MINERALOCORTICOID DRUGS</b>
Fludrocortisone Acetate
<b>8.4.1 THYROID SUPPLEMENTS</b>
Cytomel
Levothyroxine Sodium
Unithroid

Levothroid
Levoxyl
Armour thyroid
<b>8.4.2 ANTITHYROID DRUGS</b>
Propylthiouracil
<b>8.6 OTHER ENDOCRINE DRUGS</b>
alendronate <sup>QL</sup>
calcitonin nasal spray
desmopressin
fortical nasal spray
Miacalcin Injection
Increlex <sup>PA</sup>
Etidronate
<b>CHAPTER 9: GASTROINTESTINAL MEDICATIONS</b>
<b>9.2. ANTIDIARRHEAL DRUGS</b>
Diphenoxylate w/Atropine
OTC Loperamide
<b>9.3 ANTISPASMODICS/DRUGS AFFECTING GI MOTILITY</b>
Dicyclomine
Hyoscyamine Sulfate
Metoclopramide
Nulev
<b>9.4 ANTIULCER DRUGS</b>
Cimetidine
Famotidine
Nizatidine
Ranitidine
<b>9.4.1 OTHER ANTIULCER DRUGS</b>
Sucralfate
Misoprostol
<b>9.4.2 PROTON PUMP INHIBITORS</b>
OTC omeprazole, OTC Prilosec, omeprazole <sup>ST,QL</sup>
pantoprazole <sup>PA,QL</sup>
<b>9.4.3 HELICOBACTER PYLORI DRUGS</b>

Prevpac <sup>QL</sup>
<b>9.6 OTHER GI DRUGS</b>
Sulfasalazine
Asacol, Asacol HD
Analpram-HC
Canasa
Cotazym
Creon (Lipase 6,000 unit)
Creon (Lipase 12,000 unit)
Creon (Lipase 24,000 unit)
Golytely
Mesalamine
Nulytely
OTC Miralax <sup>QL</sup>
Pancrease
OTC Simethicone Drops <sup>PA&gt;2 years</sup>
ultracaps MT 20
Ultrase
Ultrase MT 12, 18
URSO, URSO Forte
<b>CHAPTER 10: IMMUNOLOGICALS AND VACCINES</b>
<b>10.0 IMMUNOLOGICALS AND VACCINES</b>
BayRho-D
Flumist <sup>PA &lt;2 and &gt;49</sup>
Gamimune N
Zostavax
<b>10.2.1 MYELOID STIMULANTS</b>
Leukine <sup>PA</sup>
Neulasta <sup>PA</sup>
Neupogen <sup>PA</sup>
<b>10.2.2 ERYTHROID STIMULANTS</b>
Epogen <sup>PA</sup>
Procrit <sup>PA</sup>
<b>10.2.3 INTERFERONS</b>

Avonex Administration Pack <sup>PA</sup>
Betaseron <sup>PA, QL</sup>
Intron A <sup>PA</sup>
Pegasys <sup>PA</sup>
Peg-Intron <sup>PA</sup>
Rebif <sup>PA, QL</sup>
Roferon-A <sup>PA</sup>
<b>10.2.4 GROWTH HORMONES AND RELATED DRUGS</b>
Norditropin <sup>PA</sup>
Nutropin <sup>PA</sup>
Nutropin AQ <sup>PA</sup>
<b>10.2.5 INTERLEUKINS</b>
Neumega <sup>PA, QL</sup>
<b>10.2.7 IMMUNOGLOBULIN ANTIBODIES</b>
Soliris <sup>PA</sup>
<b>10.3.0 HEMATOPOIETIC AGENTS</b>
Mozobil <sup>PA</sup>
<b>CHAPTER 11: MUSCULOSKELETAL MEDICATIONS</b>
<b>11.1.1 SALICYLATES AND RELATED DRUGS</b>
Salsalate
Diflunisal
<b>11.1.2 NON-STEROIDAL ANTIINFLAMMATORY AGENTS</b>
Diclofenac Sodium
Etodolac
Ibuprofen
Indomethacin
Ketoprofen
Meloxicam
Nabumetone
Naproxen
Oxaprozin
Celebrex <sup>QL, ST</sup>
<b>11.2 DRUGS TO PREVENT AND TREAT GOUT</b>
Allopurinol

Colchicine
Probenecid
Uloric <sup>PA</sup>
<b>11.3.1 DIRECT MUSCLE RELAXANTS</b>
Baclofen
<b>11.3.2 CNS MUSCLE RELAXANTS</b>
Carisoprodol <sup>QL</sup>
Cyclobenzaprine
Methocarbamol
<b>CHAPTER 12: NUTRITION, BLOOD MODIFIERS, ELECTROLYTES</b>
<b>12.0 THERAPEUTIC VITAMINS &amp; MINERAL &amp; RELATED PRODUCTS</b>
calcium acetate
Calcitriol
Folic Acid
Multivitamin with fluoride
OTC Ergocalciferol, Calciferol Drops (Vitamin D)
OTC Ferrous gluconate
OTC Ferrous sulfate (oral preparations)
<b>12.1 POTASSIUM SUPPLEMENTS</b>
Klor-Con
Potassium Chloride
Potassium Citrate ER
K-Dur
K-Phos
<b>12.2 ORAL ANTICOAGULANTS, VITAMIN K</b>
Warfarin Sodium (Coumadin)
<b>12.2.1 HEPARIN AND HEPARIN ANTAGONISTS</b>
Arixtra <sup>PA</sup>
Fragmin <sup>PA,QL</sup>
Heparin (heparin lock flush solution not covered)
Lovenox <sup>PA,QL</sup>
<b>12.3 ANTIPLATELET DRUGS</b>
Ticlopidine
Plavix

<b>12.5 HEMOSTATICS</b>
Aminocaproic Acid
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Lutera
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Nortrel
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Ogestrel
Ortho Evra <sup>QL</sup>
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Previfem
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Solia
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Proventil HFA <sup>QL</sup>
Serevent Diskus <sup>QL</sup>
Ventolin HFA <sup>QL</sup>

<b>15.1.2 METHYL XANTHINE DRUGS</b>
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<b>15.1.3 OTHER DRUGS FOR ASTHMA</b>
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Advair Diskus <sup>QL</sup> , Advair HFA <sup>QL</sup>
Ana-Kit
Atrovent <sup>QL</sup>
Combivent <sup>QL</sup>
Epipen
Epipen Jr.
Flovent HFA <sup>QL</sup>
Flovent Rotadisk <sup>QL</sup>
Intal <sup>QL</sup>
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Pulmicort <sup>QL</sup>
Spiriva <sup>ST,QL</sup>
Symbicort
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Singulair <sup>QL,ST</sup> (for allergic rhinitis only) Please note: No ST required for members with use of an asthma medication within the past 6 months; ST required for allergic rhinitis
<b>15.2.1 ANTIHISTAMINES</b>
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OTC Cetirizine solution <sup>QL</sup>
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Deconamine
diphenhydramine
OTC Loratadine, OTC loratadine-D
Cyproheptadine
Promethazine
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Cphen, Cphen DM drops, syrup
Guaifenesin w/Codeine
Guaifenex PSE
OTC guaifenesin
OTC Mucinex D ER, Mucinex DM ER
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Breeze2 Glucometer and Test Strips
Contour Glucometer and Test Strips
Contour TS Glucometer and Test Strips

Elite, Elite XL Glucometer and Test Strips
Microlet Lancets and Lancing Device
Accu-Chek Advantage Glucometer
Accu-Chek Active Glucometer
Accu-Chek Aviva Glucometer
Accu-Chek Compact Glucometer
Accu-Chek Complete Glucometer
Accu-Chek Active Test Strips
Accu-Chek Advantage Test Strips
Accu-Chek Comfort Test Strips
Accu-Chek Aviva Test Strips
Accu-Chek Compact Test Strips
Accu-Chek Multiclix Lancet Device
Accu-Chek Multiclix Lancets
Accu-Chek Softclix Lancet Device
Accu-Chek Softclix Lancets

Certain prescription drugs may be prescribed only in limited quantities. Some drugs on the list may require prior authorization (PA) and are identified by PA next to the drug name. In order to receive an override for the indicated quantity limit or prior authorization, you are required to complete a Prior Authorization form and fax to Maryland Physicians Care (MPC) Pharmacy Authorization at (800) 854-7614. Prior Authorization forms can be downloaded from the MPC website at [www.marylandphysicianscare.com](http://www.marylandphysicianscare.com). This list is subject to change and will be periodically updated.

<b>FORMULARY DRUGS</b>	<b>QUANTITY LIMIT</b>
Accolate	60/month
acetaminophen combination products	Combined quantity limit cannot exceed 4 g acetaminophen
Actoplus Met	90/month
Actos	30/month
Acyclovir	60/month
Advair Diskus	100/50, 250/50, 500/50 28 blisters/month or 60 blisters/month
Advair HFA	2 inhalers/30 days
albuterol inhaler	Inhalers: 3/month Nebulized: 5 boxes (25x3ml vials)/month
albuterol solution	5 x 25-3ml 0.083% /month; 3 x 20 ml 0.5%/month
alendronate	5 mg, 10 mg, 40 mg =30/month 35 mg and 70 mg weekly=4 tabs/month
amlodipine	30/month
Amoxicillin/Clavulanate Potassium tablets or suspension	2 Rxs/60 days
Atrovent Inhaler	3/month
Atrovent Nasal	.03%, 31.1 gm – 2/month; .06%, 16.6 gm – 1/month
Avandamet	60 tabs/month
Avandaryl	60 tabs/month
Avandia	2mg, 4mg – 60/month; 8mg – 30/month
azithromycin	250mg, zpack, suspension – 2 Rxs/60 days 600mg – 8/month
Benicar <sup>ST</sup>	30/month
Benicar HCT <sup>ST</sup>	30/month
Betaseron <sup>PA</sup>	15 syringes/month
buproban	90 day supply/year
carisoprodol	240/month

Catapres TTS	5/month
ceftriaxone	2 grams/Rx
Celebrex <sup>ST</sup>	100 mg, 200mg – 60/month
cetirizine otc solution	150 ml/month
cetirizine otc tablets	30 tablets/month
Chantix	90 day supply/year
	200 mg and 500 mg – combined 28/30 days 500 mg extended-release – 14/30 days
clarithromycin	
Combivent	14.7 gm – 3/month
Diabetic Test Strips	204/month (combined QLL)
Diovan <sup>ST</sup>	60/month
Diovan HCT <sup>ST</sup>	30/month
	1mg, 2mg, 4mg – 30/month; 8mg – 60/month
doxazosin Mesylate	
Duetact	30/month
Elidel <sup>I</sup> (PA required age>12 years)	30gm/month
	125 mg, 500mg – 21/month 250 mg – 60/month
Famvir	
fentanyl patches	15/month
	44 mcg, 110 mcg – 2 month; 220 mcg – 3/month
Flovent	
	50 mcg – 1x60/month 100 mcg – 1x60/month 250 mcg x 60 – 4/month
Flovent Rotodisk	
Flunisolide nasal spray	2 bottles/month
fluticasone nasal spray	2 bottles/month
Fragmin <sup>PA</sup>	10 syringes/year
galantamine	60/month
galantamine ER	30/month
gemfibrozil	60/month
granisetron tablets	2 tabs/Rx
	Inj-2 kits or 4 vials/month Nasal – 2x6/month tab Tablets– 9 tabs/month
Imitrex	
Intal Inhaler	2/month
ipratropium bromide nasal spray	2/month
lovastatin	30/month
Lovenox <sup>PA</sup>	20 syringes/year
Meperidine	56/month
Migranal	4/month
Nasacort AQ <sup>ST</sup>	2 bottles/month

Nasonex <sup>ST</sup>	2/month
Neumega <sup>PA</sup>	21/month
nifedipine ER	30/month
Norco	Combined quantity limit cannot exceed 4 g acetaminophen
NuvaRing	1 ring/month
ondansetron, ODT <sup>PA</sup>	12 tablets/month
Ortho Evra	3 patches/month
OTC Miralax	510g/month
OTC Nicotine Patches	90 day supply/year
OTC omeprazole/OTC Prilosec/omeprazole <sup>ST</sup>	120/month
oxycodone (Oxy IR)	240/month
Oxycontin <sup>PA</sup>	90/month
oxycodone w/Acetaminophen	Combined quantity limit cannot exceed 4 g acetaminophen
pantoprazole <sup>PA</sup>	30/month
pravastatin	30/month
PrevPac	1 per 90 days
ProAir HFA	2 inhalers/month
propoxyphene HCL w/APAP	Combined quantity limit cannot exceed 4 g acetaminophen
propoxyphene napsylate w/APAP	Combined quantity limit cannot exceed 4 g acetaminophen
Proventil HFA	2 inhalers/month
Pulmicort	Flexhaler: 1 every 30 days Respules: 60 x 2ml/month
Rebif <sup>PA</sup>	15 syringes/month
Relenza	3 packs/6 months
Relpax	6/month
ropinirole	90/month
ribavirin <sup>PA</sup>	2 packs/month
Serevent Diskus	1 pack/month
simvastatin	30/month
Singulair <sup>ST</sup> (for allergic rhinitis only)	30/month
Sodium Sulfacetamide/Sulfur	2 pkgs/month
Spiriva <sup>ST</sup>	5 caps – 1 pack/month 90 caps – 1pack/month
Suprax	1 tab/Rx
Tamiflu	1 pack/6 months 1 powder for oral suspension/6 month
terazosin	1mg, 2mg, 5mg – 30/month; 10mg – 60/month

Tilade	3/month
Toprol XL	60/month
tramadol	240/month
tretinoin	20gm/30 days
Ventolin HFA	2 inhalers/month
Vytorin	30/month
	2.5mg or ZMT – 1 pack/month
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