Rx prescribe generic first

Kern Family Health Care™

Drug Formulary

January 2020

The Kern Family Health Care Drug Formulary includes information boxes prior to some of the major therapeutic categories. Please use these tools to assist with your care of our members.

Kern Family Health Care™

G This symbol indicates some or all of the dosage forms are available generically. Prescribing generic brands of medication is key to keeping the escalating medication costs down to a minimum. Kern Health Systems PMPM medication cost is approaching $35.

65 This symbol indicates a drug identified by National Committee for Quality Assurance (NCQA) as a high risk medication for the elderly and should generally be avoided for this population. Please consider a formulary alternative.

✱ This symbol indicates the drug should be billed to Medicare Part B as primary and Kern Family Health Care as a secondary payer.

1 This symbol indicates a tier. It will designate the tier only in regards to cost share. It does not reflect any step-therapy status.

Preface

FORMULARY

The member identification number will be the CIN number. This is a number assigned by the state and is not the social security number.

Kern Family Health Care (KHS Medi-Cal)
BIN 600428
PCN 04970000
Pt. Number is CIN Number
Formulary OTC's Covered
Formulary Prenatal Vitamins Covered (OTC included)
Formulary Contraceptives Covered
No copayments
TAR's allowed for OTC and legend

PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee is composed of Physician and Pharmacist community providers as well as staff from Kern Health Systems. We have primary care providers, specialty physicians, and community based pharmacists (both chain and independent). Meetings are usually held quarterly. Issues you feel could improve our formularies or systems can be forwarded to the Director of Pharmacy at the plan offices, 9700 Stockdale Highway, Bakersfield, CA, 93311, phone 661-664-5101, fax 661-664-5191. Input from providers is welcomed. If you would like to serve on the Pharmacy & Therapeutics Committee please advise our Director of Pharmacy or Medical Director.

NON-FORMULARY REQUESTS

Requests for non-formulary medications or supplies may be submitted online (preferred), or state form 61-211. Please include the CIN number, medication failures, and non-formulary item requested as well as information on the patient. One drug per form please. Fax the information to Kern Health Systems at 661-664-5191. You may telephone Kern Health Systems about non-formulary requests but State Law does require information to be submitted (electronic or faxed).

SAMPLE MEDICATIONS

Providers are discouraged from providing samples; however, if samples are given to the member, the entire course of therapy must be covered by the samples in accordance with Policy 2.24, Pharmaceutical Guidelines. Medications provided as samples do not establish continuity precedent, and therefore, do not obligate coverage by KHS.

TRIAL PERIOD

Barring any medically adverse responses from the member, the trial period of a medication shall be determined per the recommended dosing titration guidelines presented to the FDA.

EMERGENCY DISPENSING

During weekends, holidays, and non-business hours a pharmacy may choose to dispense enough medication (72 hours supply maximum) as an emergency supply to the member until the next working day, at the dispensing pharmacist's discretion according to pharmacy policy and procedures. If the medication is not on the Plan Formulary, a request must be submitted to payment processing stating the emergency and medication dispensed. TAR approval is not needed for reimbursement before dispensing of 72 hour emergency supply of non-Formulary drugs.

BRAND NAME MEDICATIONS WHEN EQUIVALENT GENERIC BRAND IS AVAILABLE

If a medication is available as an AB rated generic, then the brand name version will become non-Formulary. If a generic brand becomes available during a patient's treatment, the patient will be expected to switch to the generic brand and must fail the generic brand prior to KHS granting authorization for the brand name. Providers with patients having untoward effects from a generic brand will be required to submit a completed FDA MedWatch form to KHS as part of the authorization for a request to allow a brand name version instead of a generic brand.

Biosimilars and drugs considered as Follow Ons will be treated in the same fashion as if they were a traditional generic of the innovator drug. Per FDA rules, they are not automatically substitutable, but from clinical perspectives they are viewed as a generic version.

PHARMACEUTICAL INDUSTRY SOLICITATION

If a representative would like something to be considered by the P&T committee they need to submit the request and supporting documents to KHS. KHS permits contact from the pharmaceutical industry only in written form.
All correspondence is to be directed to the KHS Pharmacy Department. Material may be submitted by fax, U.S. mail, or via e-mail. Unless specifically requested by KHS, face to face presentations, phone solicitations or any other means of communication are not allowed. KHS values the P&T committee members time and effort dedicated to the plan and its members. They should not be contacted for committee considerations and requests.

TIER STATUS

All medications listed in the KHS Formulary are Tier 1 and are covered if there is no restriction or the restriction(s) is/are met. Any medication authorized through the TAR process is also considered Tier 1 for coverage purposes. Please note that claims may reject at the pharmacy point of service for reasons not listed in the KHS Formulary, such as drug interactions and therapeutic duplications.

IV SOLUTIONS

Please see Formulary section for IV solution categories covered. KHS covers the stated infused agents in the categories listed. These are typically covered as part of a per diem case rate.

FORMULATIONS AND STRENGTHS

Medications listed in the KHS formulary are identified by the stated formulations and strengths. A drug may have only certain strengths or formulations covered. Non stated formulations would require a TAR.

Table of Contents

LEGEND MEDICATIONS

OVER THE COUNTER MEDICATIONS

Abbreviations

cr	continuous release	oint	ointment
conc	concentrate	ophth	ophthalmic
ec	enteric coated	sl	sublingual
inh	inhalation	soln	solution
liq	liquid	supp	suppository
mdi	metered dose inhaler	susp	suspension
NMT	not more than		

THIS PAGE LEFT BLANK INTENTIONALLY

GENERIC	BRAND	FORMS
Amyotrophic Lateral Sclerosis Agents		
1 G Riluzole	Rilutek®	50mg tablet
Restriction: Allowed for amyotrophic lateral sclerosis.		
Analgesics - Narcotics		
Medications in this category may be restricted in one or more ways. The restrictions are noted under the individual medications. Those patients who require additional quantities, fills or restricted medications will need to have their physician provide monitoring tools such as prescription drug monitoring programs (CURES), urine drug screens, and others as appropriate, along with physician's progress notes and treatment plan accompanying the request. This will help KHS staff determine how to properly encode the prior authorization. A good resource for guidelines may be found at C.A.R.E.S Alliance, caresalliance.org. The CDC has issued guidance as well. The recommendations entail evaluating the need of an opioid versus other pharmacologic and non-pharmacologic alternatives. Members should be started on as low a dose and as short a duration as clinically appropriate. KHS members who are opioid naive are allowed up to ***seven*** *days therapy. Regimens longer than that require prior authorization. Recently, focus on total daily dose based on morphine equivalents has been instituted by Medicare and Medicaid. The health plan limits to 120 mg MED for non-malignant pain. New opioid therapy regimens are limited to a* ***seven*** *day supply.* ***Concurrent use with benzodiazepines, sedatives, and/or muscle relaxants is not recommended.*** *Acetaminophen (APAP, Tylenol®) hepatotoxicity can result from frequent and/or high doses of those medications with an acetaminophen component. Maximum recommended daily dose of APAP for a patient who does not drink alcohol is 4000mg. Patients may also aggravate the problem by taking other OTC drugs with APAP or receiving prescriptions of other APAP combinations.* *It should be noted that the commonly prescribed Hydrocodone/APAP combinations are very limited on the KHS Formulary. KHS offers Oxycodone/APAP combinations such as Percocet® equivalents. Tramadol (Ultram®) although on the KHS formulary has many clinical limitations, including increasing risk of serotonin syndrome in addition to other centrally acting concerns. The FDA has recently added a new warning. Medications containing either codeine or tramadol are not to be prescribed to those under 18 years of age. Please consider morphine preparations before oxycodone or fentanyl formulations.*		
1 G Codeine sulfate		15mg, 30mg, 60mg tablet
Restriction: Limited to cancer patients or plan Pain Specialists. Authorization required for other diagnoses. Allowed for members > 18 years old.		

Continued on next page

GENERIC	BRAND	FORMS
Analgesics - Narcotics, continued • SEE PREVIOUS PAGE		
1 Codeine w/Acetaminophen	Tylenol w/Codeine®	15mg-300mg, 30mg-300mg tablet, 12mg-120mg/5ml soln
Restriction: NMT 60 tablets per month, NMT 3 dispensings per 90 day period. Allowed for members > 18 years old.		
1 Fentanyl	Duragesic®	12mcg, 25mcg, 50mcg, 75mcg, 100mcg patches
Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. Allow 10 patches per 30 days. Allowed for members failing morphine sulfate ER or unable to take solid dosage forms. 12 mcg patches are not recommended as starting doses.		
1 Hydrocodone/APAP	Norco®	5mg/325mg, 10mg/325mg tablet, 7.5-325/15ml liq
Restriction: 5/325 mg, NMT 60 tablets per month, NMT 3 dispensings per 90 days. 10/325mg -- Limited to cancer patients or plan Pain Specialist Physicians. NMT 120 tablets per month, NMT 3 dispensings per 90 days. Liquid is limited to members < 18 years old and maximum of 3 day supply.		
1 Hydromorphone	Dilaudid®	2mg, 4mg tablet, 3mg supp
Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. NMT 120 per month.		
1 Levorphanol	Levo-Dromoran®	2mg tablet
Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses.		
1 Morphine	MS-Contin®	10mg/5ml, 20mg/5ml oral soln, 20mg/ml conc, 15mg, 30mg tablet, 15mg, 30mg, 60mg cr tablet
Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. NMT 90 per month.		
1 Oxycodone	Oxy-Contin®	5mg, 10mg tablet, 10mg, 15mg, 20mg, 40mg cr tablet
Restriction: Restricted to use by KHS plan Oncologists or Pain Specialist Physicians. Member needs to fail morphine ER. NMT 90 per month of immediate release, 60 per month of time release formulations.		
1 Oxycodone w/Acetaminophen	Percocet®	5mg-325mg tablet
Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. NMT 120 per month.		
1 Tramadol	Ultram®	50mg tablet
Restriction: Not indicated for members with abuse potential. Contraindicated with alcohol, hypnotics, centrally acting analgesics, opioids, and psychotropic agents. Seizures and serotonin syndrome may occur with antidepressants, triptans, lithium, enzyme inducing medications, and some antibiotics. Allowed for members > 18 years old.		

GENERIC	BRAND	FORMS
Antiacne		
1 G Isotretinoin		20 mg, 40 mg capsule
Restriction: Prior authorization required. Allowed for Dermatologists.		
Anti-bacterial		
Inappropriate use of antibiotics is a concern nationwide. Resistance to antibiotics is growing nationally. Additionally, antibiotics are ineffective on viral infections. Uncomplicated bronchitis and viral infections do not warrant antibiotic use. Please reference www.AWARE.md or 916-779-6620 for more information on appropriate use of antibiotics. KHS has limits on days supply and number of fills per month on many antibiotics to help ensure appropriate use. A 10 day supply every 30 days is in place for the cephalosporins, macrolides, penicillins, and quinolone classes. Prior authorization justifying the necessity for longer or more frequent dosing will be needed for therapies exceeding those limits.		
Anti-bacterial - Cephalosporin		
1 G Cefdinir	Omnicef®	125mg/5ml susp, 250mg/5ml susp
Restriction: Restricted to members with OM < 8 years old failing 1st line ABX's or documented penicillin allergy. Documented ICD-10 code with provider's office required for online submission otherwise submit TAR with documentation.		
1 G Cefuroxime		250mg, 500mg tablet
Restriction: Prior authorization required.		
1 G Cephalexin	Keflex®	125mg/5ml, 250mg/5ml susp, 250mg, 500mg capsule
Anti-bacterial - Macrolide		
Zithromax® 250mg tablets have a maximum of 6 (5 days therapy) as the drug continues working for a number of additional days.		
Therapy / ***Days Supply*** / ***Cost***		
Erythromycin 500mg QID / *10* / *$678*		
Azithromycin® 500mg x1, 250mg QD / *5* / *$5*		
Clarithromycin® 500mg ii QD / *10* / *$8*		
1 G Azithromycin	Zithromax®	100mg/5ml, 200mg/5ml susp, 250mg, 600mg tablet, 1 gm powder pack
Restriction: 600mg Tablets – Restricted to members with MAC.		
1 G Clarithromycin	Biaxin®	125mg/5ml, 250mg/5ml susp, 250mg, 500mg tablet
Restriction: Susp Restricted to members < 8 years old w/OM who have recently failed first line antibiotics. 500mg tablets recommended for members who cannot tolerate or failed azithromycin.		
1 G Clindamycin	Cleocin®	75mg/5ml susp, 75mg, 150mg, 300mg capsule

Continued on next page

GENERIC	BRAND	FORMS
Anti-bacterial - Macrolide, continued • SEE PREVIOUS PAGE		
1 G Erythromycin Base	E-Mycin®	250mg, 333mg, 500mg ec tablet, 250mg ec particles capsule
Restriction: Prior authorization required.		
1 G Erythromycin Base	Ery-tab®	250mg, 333mg, 500mg ec tablet, 250mg ec particles capsule
Restriction: Prior authorization required.		
1 G Erythromycin Ethylsuccinate	EES®	200mg/5ml, 400 mg/5 ml, 400mg tablet
Restriction: Prior authorization required.		
1 G Erythromycin Stearate	Erythrocin®	250mg, 500mg tablet
Restriction: Prior authorization required.		
Anti-bacterial - Miscellaneous		
1 G Fosfomycin tromethamine	Monurol®	3 gm pckt
Restriction: Limit to ID or urologist for ESBL urinary infections.		
1 G Neomycin		125mg/5ml soln, 500mg tablet
1 65 G Nitrofurantoin	Macrobid®	100mg monohydrate macrocrystalline capsule
Restriction: Limit to 10 day supply unless prescribed by ID or urologist.		
1 65 G Nitrofurantoin	Furadantin®	25mg/5ml susp
Restriction: Limited to members <6 years old.		

Anti-bacterial - Penicillin

Augmentin® is restricted to children under 8 years of age. *It will be approved for animal and human bites and severe sinusitis with prior authorization.* ***Augmentin®*** *is available in generic brands and there will be some cost savings by using the generic brands. Formulary strengths will be allowed to clear as first line up to age 8. Pneumonia, otitis media, and sinusitis are dosed at 45mg/kg/day divided twice daily and skin and UTIs are dosed at 25mg/kg/day divided twice a day. Instead of dosing three times a day, the plan recommends using a twice daily dosing schedule of 200mg and 400mg and 600mg, per AAP guidelines. Please prescribe the twice a day regimen.*

		Costs
Amoxicillin 250mg/5ml	*150ml*	*$5*
Amoxicillin-clavulanate 250mg/5ml	*150ml*	*$89*
Amoxicillin-clavulanate 400mg/5ml	*200ml*	*$21*

Continued on next page

GENERIC	BRAND	FORMS
Anti-bacterial - Penicillin, continued • SEE PREVIOUS PAGE		
1 Amoxicillin	Amoxil®	50mg/ml drops, 125mg/5ml, 250mg/5ml, 200 mg/5ml, 400mg/5ml, 125mg, 250mg, 500mg capsule
1 Amoxicillin/Clavulanate	Augmentin®	200mg/5ml, 400mg/5ml, 600mg/5ml susp, 500mg, 875mg tablet
Restriction: Restricted to children < 8 years old with OM. First line treatment for animal bites. 10 days maximum therapy. Documented ICD-10 code with provider's office required for online submission otherwise submit TAR with documentation. Available first line for prescriptions written by ENT.		
1 Ampicillin	Principen®	100mg/ml, 125mg/5ml, 250mg/5ml susp, 250mg, 500mg capsule
1 Penicillin VK	Veetids®	125mg/5ml, 250mg/5ml oral soln, 125mg, 250mg, 500mg tablet
Anti-bacterial - Penicillinase Resistant Penicillin		
1 Dicloxacillin	Dynapen®	62.5mg/5ml susp, 125mg, 250mg, 500mg capsule
Anti-bacterial - Quinolone		
The medications in this category are limited to 10 days therapy. Patients who require therapy beyond that limit require prior authorization. ***Restricted in patients less than 18 years of age.*** *Levofloxacin (Levaquin®) probably has less resistance than ciprofloxacin (Cipro®) since Cipro® has been used in so many patients. A 28 day supply will be allowed of ciprofloxacin or levofloxacin for the management of prostatitis.*		
1 Ciprofloxacin	Cipro®	250mg, 500mg, 750mg tablet
Restriction: Urologists allowed 28 day supply.		
1 Levofloxacin	Levaquin®	250mg, 500mg, 750mg tablet
Restriction: Urologists allowed 28 day supply.		
Anti-bacterial - Sulfonilamide		
1 Sulfamethoxazole & Trimethoprim	Bactrim®/Septra®	400mg-80mg, 800mg-160mg tablet, 200mg-40mg/5ml susp
Anti-bacterial - Tetracycline		
1 Doxycycline hyclate	Vibramycin®	50mg, 100mg capsule, 100mg tablet
1 Minocycline	Minocin®	50mg, 75mg, 100mg capsule

GENERIC	BRAND	FORMS
Anti-infective		
1 G Linezolid	Zyvox®	600mg tablet
Restriction: Prior authorization required. Reserved for members with VRE.		
1 G Metronidazole	Flagyl®	250mg, 500mg tablet
1 G Tinidazole	Tindamax®	500 mg tablet
Restriction: Prior authorization required.		
1 G Vancomycin	Vancocin®, Firvanq®	25 mg/ml, 50 mg/ml soln, various vials
Restriction: Prior authorization required.		
Anti-infective - Antifungal		
Prior authorization will not be allowed for cosmetic purposes. Maximum therapy is 6 weeks for fingernails, 12 weeks for toenails. Sanford, et al, suggest that Terbinafine (Lamisil®) 250mg QD has one of the highest effectiveness rates (70-81%) of the FDA approved treatments. Sanford recommends ascertaining the ALT & AST levels prior to initiation of therapy since these drugs should not be used in chronic or active liver disease. KOH or positive culture required. Members with vaginal candidiasis, please use the fluconazole 200 mg tablet.		
1 G Clotrimazole	Mycelex®	10mg troche
1 G Fluconazole	Diflucan®	50mg, 100mg, 200mg tablet
Restriction: If needing the 150 mg dose, please use 200 mg.		
1 G Griseofulvin		125mg/5ml susp (microsize)
Restriction: Suspension is for children < 12 years old.		
1 Isavuconazounium sulfate	Cresemba®	186mg capsule
Restriction: Prior authorization required.		
1 G Itraconazole	Sporanox®	100mg capsule
Restriction: Trial and failure of fluconazole.		
1 G Nystatin	Mycostatin®	100,000 units/ml susp, 500,000 unit tablet
1 G Posaconazole	Noxafil®	40mg/ml susp, 100mg tablet
Restriction: Prior authorization required.		
1 G Terbinafine	Lamisil®	250mg tablet
Restriction: 12 week therapy maximum duration.		

Continued on next page

GENERIC	BRAND	FORMS
Anti-infective - Antifungal, continued • SEE PREVIOUS PAGE		
1 Voriconazole	Vfend®	50mg, 200mg tablet, 200mg/5 ml susp
Restriction: Prior authorization required.		
Anti-infective - Antihelmintic		
1 Albendazole	Albenza®	200 mg tablet
Restriction: Prior authorization required.		
1 Imervectin	Stromectol®	3 mg tablet
1 Pyrantel	Pin-X®	50mg/ml susp, 250mg chewable tablet
Anti-infective - Antimalarial		
1 Chloroquine		250mg tablet
1 Primaquine		26.3mg tablet
Anti-infective - Antiprotozoal		
1 Atovaquone	Mepron®	750mg/5ml susp
Restriction: Prior authorization required. Sulfa allergy and diagnosis of PCP.		
1 Benznidazole		12.5mg, 100mg tablet
Restriction: Prior authorization required.		
1 Paromomycin	Humatin®	250mg capsule
1 Pyrimethamine	Daraprim®	25mg tablet
Restriction: Prior authorization required.		
Anti-infective - Anti-tubercular		
1 Cycloserine	Seromycin®	250mg capsule
1 Ethambutal	Myambutal®	100mg, 400mg tablet
1 Isoniazid	INH®	50mg/5ml syrup, 50mg, 100mg, 300mg tablet
1 Pyrazinamide		500mg tablet
Restriction: Prior authorization required.		
1 Rifabutin	Mycobutin®	150mg capsule
Restriction: Restricted to prevention of MAC in patients with advanced HIV.		

Continued on next page

GENERIC	BRAND	FORMS
Anti-infective - Anti-tubercular, continued • SEE PREVIOUS PAGE		
1 Rifampin	Rimactane®	150mg, 300mg capsule
Anti-infective - Anti-viral		

Anti-viral agents for HIV *related cases, with the exception of Zidovudine and Didanosine, are covered by fee for service Medi-Cal. Bill EDS, not KHS, for these patients. The carved out anti-viral agents are listed in the Appendix.*

Anti-virals for Hepatitis, both B and C *are covered, but require prior authorization. Adherence to treatment is essential. These are generally restricted to specialists, and monitoring is required. Current guidelines for Hepatitis B suggest the use of tenofovir. Keep in mind that is billed to EDS. The state Medicaid program has outlined criteria that all Medicaid plans, including the managed care will follow for coverage of Hepatitis C medications. If a patient has Hepatitis C refer to Hepatitis C program as they case manage the KHS Hepatitis C patients. At minimum, the initial referral needs to include the viral load, genotype, lab results, liver function tests, CBC, Child-pugh assessment, Metavir score (or equivalent), biopsy results (if performed), and others as outlined by the DHCS criteria. A 4 week viral load is needed for determination if further treatment would be authorized. All medications require prior authorization. DHCS requires all current therapies to be considered based on current professional guidelines.*

Acyclovir is the only Formulary medication for Genital Herpes Therapy: *Sanford, et al, in Guide to Anti-microbial Therapy - suggests there is little difference between antiviral agents for genital herpes. Valacyclovir is the prodrug of acyclovir; isolates resistant to acyclovir although low, (<1% in immunocompromised patients) are also resistant to valacyclovir. KHS only allows acyclovir at this time. An example of costs for these drugs for recurrent treatment is as follows:*

Medication & Days Therapy	*Cost*
Acyclovir 400mg TID x 5 days	*$6*
Valtrex® 500mg BID x 3 days (non-formulary)	*$36*
Famvir® 125mg BID x 5 days (non-formulary)	*$47*

KHS requires failure of Acyclovir before the other agents would be allowed on prior authorization.

Topical Antiviral Therapy requires prior authorization: *Topical agents for antiviral therapy (Zovirax™, Abreva®) require prior authorization because of their limited effect. Usually topical products will only slightly decrease the duration of infection (3.4 vs. 4.1 days). Severe infections may benefit more from systemic therapy.*

1 Acyclovir	Zovirax®	200mg/5ml susp, 200mg capsule, 200mg, 400mg, 800mg tablet

Continued on next page

GENERIC	BRAND	FORMS
Anti-infective - Anti-viral, continued • SEE PREVIOUS PAGE		
1 Elbasvir/grazoprevir	Zepatier®	50-100 mg tablet
Restriction: Prior authorization required.		
1 G Entecavir	Baraclude®	0.5 mg, 1 mg tablet
Restriction: Prior authorization required.		
1 Ganciclovir	Cytovene®	250mg, 500mg capsule
Restriction: Prior authorization required.		
1 Interferon alpha	various	injection
Restriction: Prior authorization required.		
1 G Oseltamivir	Tamiflu®	30 mg, 45 mg, 75 mg capsule, 6 mg/ml susp
Restriction: One treatment per flu season.		
1 Ribavirin	various	tablet
Restriction: Prior authorization required.		
1 G Sofosbuvir/velpatasvir	Epclusa®	400mg-100mg tablet
Restriction: Prior authorization required.		
1 G Zidovudine	Retrovir®	50mg/5 ml syrup, 100mg capsule
Anti-infective - Leprosy		
1 Dapsone		25mg, 100mg tablet
Antineoplastic		
Kern Family Health Care covers all therapeutic categories of neoplastic agents. Many require authorization to ensure appropriate use in accordance with professional guidelines such as the National Comprehensive Cancer Network (NCCN) and FDA indications. Some sub-classes are covered through per diem or infusion arrangements and are not billed through the PBM. Many newer drugs are targeted therapies for very specific conditions. Proper documentation demonstrating the member is a candidate is required. Not every drug is listed in each category. The medications listed are representative only of the class/mechanism of action. Unless otherwise indicated, require prior authorization.		
1 * Alitretinoin	Panretin®	0.1% gel
Restriction: Prior authorization required.		
1 * Altretamine	Hexalen®	50mg capsule

Continued on next page

GENERIC	BRAND	FORMS
Antineoplastic, continued • SEE PREVIOUS PAGE		
1 ✱ G Anastrozole	Arimidex®	1mg tablet
1 ✱ Axicabtagene ciloleucel	Yescarta®	plastic bag
Restriction: Prior authorization required.		
1 ✱ G Bevacizumab	Avastin®	25 mg IV
Restriction: Prior authorization required.		
1 ✱ Bexarotene	Targretin®	75 mg capsule
Restriction: Prior authorization required.		
1 ✱ G Bicalutamide	Casodex®	50 mg tablet
1 ✱ G Chlorambucil	Leukeran®	2mg tablet
1 ✱ G Cyclophosphamide	Cytoxan®	25mg, 50mg capsule
Restriction: Prior authorization required.		
1 ✱ G Daunorubicin		5 mg, 20 mg IV
Restriction: Prior authorization required.		
1 ✱ Eribulin mesylate	Halaven®	1 mg/2 ml IV
Restriction: Prior authorization required.		
1 ✱ Estramustine	Emcyt®	140mg capsule
1 ✱ G Etoposide	Vepesid®	50mg capsule
1 ✱ Everolimus	Afinitor®	2.5 mg, 5 mg, 7.5 mg capsule
Restriction: Prior authorization required.		
1 ✱ G Fluorouracil	Adrucil®	500 mg/ml, 2.5 G/50 ml, 5G/100 ml, various
Restriction: Prior authorization required.		
1 ✱ G Flutamide	Eulexin®	125mg capsule
1 ✱ Gemtuzumab ozogamicin	Mylotarg®	4.5 mg IV
Restriction: Prior authorization required.		
1 ✱ G Hydroxyurea	Hyrea®	500mg capsule

Continued on next page

GENERIC	BRAND	FORMS
Antineoplastic, continued • SEE PREVIOUS PAGE		
1 ✱ G Imatinib mesylate	Gleevec®	100mg, 400mg tablet
Restriction: Prior authorization required.		
1 ✱ Ipilimumab	Yervoy®	50mg/10 ml, 200 mg/40 ml IV
Restriction: Prior authorization required.		
1 ✱ Irinotecan	Camptosar®	100 mg/ 5 ml, 40 mg/2 ml, 300 mg/15 ml IV
Restriction: Prior authorization required.		
1 ✱ Ixabepilone	Ixempra®	15 mg, 45 mg IV
Restriction: Prior authorization required.		
1 ✱ Lenalidomide	Revlimid®	2.5 mg, 5 mg, 10 mg, 15 mg, 20 mg, 25 mg capsule
Restriction: Prior authorization required.		
1 ✱ G Letrozole	Femara®	2.5mg tablet
1 ✱ Leuprolide	Lupron®	3.75-5 mg, 11.25-5 mg, 22.5 mg syringe
Restriction: Prior authorization required.		
1 ✱ Lomustine	Gleostine®	10mg, 40mg, 100mg capsule
1 ✱ G Megestrol	Megace®	40mg/ml susp, 20mg, 40mg tablet
1 ✱ Melphalan	Alkeran®	2mg tablet
1 ✱ G Mercaptopurine	Purinethol®	50mg tablet
1 ✱ G Methotrexate		2.5mg tablet, 25mg/ml vial
1 ✱ Mitotane	Lysodren®	500mg tablet
1 ✱ Nivolumab	Opdivo®	40mg/4 ml, 100mg/10 ml IV
Restriction: Prior authorization required.		
1 ✱ Paclitaxel		6 mg/ml vial
Restriction: Prior authorization required.		
1 ✱ Pazopanib	Votrient®	200mg tablet
Restriction: Prior authorization required.		

Continued on next page

GENERIC	BRAND	FORMS
Antineoplastic, continued • SEE PREVIOUS PAGE		
1 * Porfimer sodium	Photofrin®	75 mg IV
Restriction: Prior authorization required.		
1 * Procarbazine	Matulane®	50mg capsule
1 * Ramucirumab	Cyramza®	100 mg/10 ml, 500 mg/50 ml IV
Restriction: Prior authorization required.		
1 * Rituximab- ABBS	Truxima®	10mg IV
Restriction: Prior authorization required.		
1 * G Tamoxifen	Nolvadex®	10mg, 20mg tablet
1 * G Temozolomide	Temodar®	5mg, 20mg, 100mg, 140mg, 180mg, 250mg capsule
Restriction: Prior authorization required.		
1 * Thalidomide	Thalomid®	50 mg, 100 mg, 150 mg, 200 mg capsule
Restriction: Prior authorization required.		
1 * G Thioguanine		40mg tablet
1 * Trastuzumab-ANNS	Kanjinti®	150 mg, 440 mg IV
Restriction: Prior authorization required.		
1 * Triptorelin	Trelstar®	3.75 mg, 11.25 mg, 22.5 mg IV
Restriction: Prior authorization required.		
1 * G Vincristine		1 mg/1 ml, 2 mg/ 2 ml IV
Restriction: Prior authorization required.		
1 * Vismodegib	Erivedge®	150 mg capsule
Restriction: Prior authorization required.		
1 * Vorinostat	Zolinza®	100 mg capsule
Restriction: Prior authorization required.		
1 * Ziv-Aflibercept	Zaltrap®	100 mg/ 4 ml, 200 mg/8 ml IV
Restriction: Prior authorization required.		

GENERIC	BRAND	FORMS
Anti-Parkinsonism		
1 Carbidopa & Levodopa	Sinemet®	10mg-100mg, 25mg-100mg, 25mg-250mg tablet, 25mg-100mg, 50mg-200mg cr tablet
1 Entacapone	Comtan®	200 mg tablet
Restriction: Required trial and failure of carbidopa/levodopa alone. Works only in combination with levodopa.		
1 Levodopa		250mg, 500mg capsule
1 Pramipexole	Mirapex®	0.125mg, 0.25mg, 0.5mg, 1mg, 1.5mg tablet
Restriction: Restricted to Parkinsons only. Requires failure of levadopamine therapy.		
1 Ropinirole	Requip®	0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg, 5mg tablet
Restriction: Restricted to Parkinsons only. Requires failure of levadopamine therapy.		
Antirheumatiod and Disease Modifiers		
1 Apremilast	Otezla®	30mg tablet
Restriction: Prior authorization required.		
1 Auranofin	Ridaura®	3mg capsule
Restriction: Prior authorization required.		
1 * Azathioprine	Imuran®	50mg tablet
1 Hydroxychloroquine	Plaquenil®	200mg tablet
1 Leflunomide	Arava®	10mg, 20mg tablet
Restriction: Plan rheumatologists only.		
1 Methotrexate		2.5mg tablet, 25mg/ml vial
1 Sulfasalazine	Azulfidine®	250mg/5ml susp, 500mg tablet & ec tablet
Antiuricosuric		
1 Allopurinol	Zyloprim®	100mg, 300mg tablet
1 Colchicine & Probenecid	ColBenemid®	0.5mg-500mg tablet
1 Probenecid	Benemid®	500mg tablet
Autonomic - Anticholinergic		
1 65 Dicyclomine	Bentyl®	10mg/5ml syrup, 10mg, 20mg capsule, 20mg tablet

Continued on next page

GENERIC	BRAND	FORMS
Autonomic - Anticholinergic, continued • SEE PREVIOUS PAGE		
1 G Glycopyrrolate	Robinul®	1mg, 2mg tablet
1 G Hyoscyamine	Levsin®	0.125mg/ml drops
Autonomic - Cholinergic		
1 G Bethanechol	Urecholine®	5mg, 10mg, 25mg, 50mg tablet
1 Neostigmine	Prostigmin®	15mg tablet
1 G Pyridostigmine	Mestinon®	60mg tablet
Benign Prostate Hypertrophy		
1 G Finasteride	Proscar®	5 mg tablet
Restriction: Plan urologists only.		
1 G Tamsulosin	Flomax®	0.4mg capsule
Restriction: Trial and failure of formulary alpha blockers.		
Biologics & Biosimilars		
1 G Adalimumab	Humira®	40mg/0.8ml
Restriction: Prior authorization required.		
1 G Etanercept	Enbrel®	25 mg, 50 mg
Restriction: Prior authorization required.		
1 G Glatiramer acetate	Glatopa®	20mg/ml, 40mg/ml syringe
Restriction: Prior authorization required.		
1 Infliximab-ABDA	Renflexis®	100mg vial
Restriction: Prior authorization required.		
1 Interferon beta	Extavia®	injection
Restriction: Prior authorization required.		
1 Secukinumab	Cosentyx®	150 mg, 300 mg injection
Restriction: Prior authorization required.		
Cardiovascular - Alphablocker		
1 G Clonidine	Catapres®	0.1mg, 0.2mg,0.3mg tablet

Continued on next page

GENERIC	BRAND	FORMS
Cardiovascular - Alphablocker, continued • SEE PREVIOUS PAGE		
1 Doxazosin	Cardura®	1mg, 2mg, 4mg, 8mg tablet
1 Guanfacine	Tenex®	1mg, 2mg tablet
1 Methyldopa	Aldomet®	125mg, 250mg, 500mg tablet
1 Prazosin	Minipress®	1mg, 2mg, 5mg capsules
1 Terazocin	Hytrin®	1mg, 2mg, 5mg, 10mg tablet or capsule
Cardiovascular - Angiotensin Converting Enzyme Inhibtors		
1 Benazepril	Lotensin®	5mg, 10mg, 20mg, 40mg tablet
1 Enalapril	Vasotec®	5mg, 10mg, 20mg tablet
1 Lisinopril	Zestril®	10mg, 20mg, 30 mg, 40mg tablet
1 Quinapril	Accupril®	10mg, 20mg, 40mg tablet
1 Ramipril	Altace®	1.25mg, 2.5mg, 5mg, 10mg capsule
Cardiovascular - Angiotensin Converting Enzyme Inhibtors Combination		
1 Benazepril - HCTZ		5mg-6.25mg, 10mg-12.5mg, 20mg-12.5mg, 20mg-25mg tablet
1 Lisinopril - HCTZ		10mg-12.5mg, 20mg-12.5mg, 20mg-25mg tablet
Cardiovascular - Angiotensin II Receptor Blocker		
1 Irbesartan	Avapro®	150mg, 300 mg tablet
1 Losartan	Cozaar®	50 mg, 100 mg tablet
1 Valsartan	Diovan®	80mg, 160mg, 320mg tablet
Cardiovascular - Angiotensin II Receptor Blocker Thiazide Combination		
1 Irbesartan-hctz	Avalide®	150-12.5mg, 300-25mg tablet
1 Losartan-hctz	Hyzaar®	50-12.5mg, 100-12.5mg, 100-50mg tablet
1 Valsartan-hctz	DiovanHCT®	160-12.5mg, 160-25mg, 320-12.5mg, 320-25mg tablet

GENERIC	BRAND	FORMS
Cardiovascular - Antiarrhythmic		
1 Amiodarone		200mg tablet
1 Digoxin	Lanoxin®	0.05mg/ml elixir, 0.125mg, 0.25mg tablet
1 Disopyramide	Norpace®	100mg, 150mg capsule, 100mg, 150 cr capsule
Restriction: Restricted to plan cardiologists only, others require prior authorization.		
1 Flecainide	Tambocor®	50mg, 100mg, 150 mg tablet
Restriction: Restricted to plan cardiologists only, others require prior authorization.		
1 Mexiletine	Mexitil®	150mg, 200mg, 250mg capsule
1 Propafenone	Rythmol®	150mg, 225mg, 300mg tablet
Restriction: plan cardiologists only, others require prior authorization.		
1 Sotalol	Betapace®	80mg, 120mg, 160mg, 240mg tablet
Cardiovascular - Antilipid (HMG - CoA Reductase Inhibitors)		
KHS currently has the "Statin" drugs listed below on the Formulary. ***Half tablet dosing is required on statins.***		
1 Atorvastatin	Lipitor®	20mg, 40mg, 80mg tablet
1 Pravastatin	Pravachol®	20mg, 40mg tablet
1 Rosuvastatin	Crestor®	10mg, 20mg, 40mg tablet
1 Simvastatin	Zocor®	10mg, 20mg, 40mg, 80mg tablet
Cardiovascular - Antilipid - Fibrates		
1 Fenofibrate		54mg, 145mg, 160mg tablet
Restriction: Trial and failure of gemfibrozil. Ok first line if on statin therapy.		
1 Gemfibrozil	Lopid®	600mg tablet
Cardiovascular - Antilipid - Lipotropics		
1 Ezetimibe	Zetia®	10mg tablet
Restriction: Prior authorization required. Should be adjunct to statin therapy.		
Cardiovascular - Antilipid - Other Medications		
1 Cholestyramine	Questran®	Powder (bulk can only)

Continued on next page

GENERIC	BRAND	FORMS
Cardiovascular - Antilipid - Other Medications, continued • SEE PREVIOUS PAGE		
1 Colestipol	Colestid®	1g tablet
Cardiovascular - Betablocker		
1 Acebutolol	Sectral®	200mg, 400mg capsule
1 Atenolol	Tenormin®	25mg, 50mg, 100mg tablet
1 Carvedilol	Coreg®	3.125mg, 6.25mg, 12.5mg tablet
1 Labetolol	Trandate®	100mg, 200mg, 300mg tablet
1 Metoprolol tartrate	Lopressor®	50mg, 100mg tablet
1 Propranolol	Inderal®	20mg/5ml, 40mg/5ml oral soln, 10mg, 20mg, 40mg, 60mg, 80mg tablet
Cardiovascular - Betablocker Thiazide Combination		
1 Bisoprolol - HCTZ		2.5-6.25 mg, 5-6.25 mg, 10-6.25 mg tablet
Cardiovascular - Calcium Channel Blocker		
1 Amlodipine	Norvasc®	2.5mg, 5mg, 10mg tablet
1 Diltiazem	Cardizem®	30mg, 60mg, 90mg, 120mg tablet, 120mg/24hr, 180mg/24hr, 240mg/24hr, 300mg/24hr, 360mg/24hr cr capsule
1 65 Nifedipine	Adalat CC®	30mg, 60mg, 90mg cr tablet
1 Verapamil	Calan®, Calan SR®	40mg, 80mg, 120mg tablet, 120mg cr tablet, 180mg cr tablet, 240mg cr tablet
Cardiovascular - Diuretic		
1 Chlorthalidone		15mg, 25mg tablet
1 Furosemide	Lasix®	8mg/ml, 10mg/ml soln, 20mg, 40mg, 80mg tablet
1 Hydrochlorothiazide	Esidrix®	25mg tablet
1 Indapamide	Lozol®	1.25mg, 2.5mg tablet
1 Metolazone	Zaroxolyn®	2.5mg, 5mg, 10mg tablet

Restriction: Restricted to members on furosemide therapy.

Continued on next page

GENERIC	BRAND	FORMS
Cardiovascular - Diuretic, continued • SEE PREVIOUS PAGE		
1 Spironolactone	Aldactone®	25mg, 50mg, 100mg tablet
1 Triamterene	Dyrenium®	50mg, 100mg capsule
1 Triamterene & Hydrochlorothiazide	Dyazide®, Maxide®	37.5mg-25mg capsule, 75mg-50mg tablet
Cardiovascular - Electrolyte Depleter		
1 Calcium Acetate	PhosLo®	667mg capsule
Restriction: For renal patients only.		
1 Lanthunum Carbonate	Fosrenol®	500mg, 750mg, 1000mg tablet
Restriction: Max 3000mg/day.		
1 Patiromer	Veltassa®	8.4 g, 16.8g, 25.2 gm powder
Restriction: Prior authorization required.		
1 Potassium Chloride		8mEq,10mEq, 20mEq cr tablet, 10%, 20% liquid
1 Sevelamer Carbonate	Renvela®	800mg tablet
Restriction: Maximum of 12 tablets daily if prescribed by a nephrologist. Higher doses require prior authorization, support with lab values.		
1 Sodium Polystyrene Sulfonate	Kayexalate®	25% susp only
Cardiovascular - Pulmonary Arterial Hypertension Endothelin Receptor Antagonist		
1 Ambrisentan	Letairis®	5 mg, 10 mg tablet
Restriction: Prior authorization required.		
1 Bosentan	Tracleer®	62.5 mg, 125 mg tablet
Restriction: Prior authorization required.		
Cardiovascular - Pulmonary Arterial Hypertension Phosphodiesterase 5 Inhibitor		
1 Sildenafil	Revatio®	20mg tablet
Restriction: Prior authorization required.		
Cardiovascular - Pulmonary Arterial Hypertension Prostacyclin type		
1 Epoprostenol	Flolan®	0.5 mg, 1.5 mg vial
Restriction: Prior authorization required.		

GENERIC	BRAND	FORMS
Cardiovascular - Vasodilator		
1 Hydralazine	Apresoline®	10mg, 25mg, 50mg, 100mg tablet
1 Isosorbide Dinitrate	Isordil®	5mg, 10mg, 20mg, 30mg tablet, 2.5mg, 5mg sl tablet, 5mg, 10mg chewable tablet
1 Isosorbide Mononitrate	Imdur®	60mg, 120mg tablet
1 Minoxidil	Loniten®	2.5mg, 10mg tablet
1 Nitroglycerin	Nitrostat®	0.3mg, 0.4mg, 0.6mg sl tablet
1 Nitroglycerin		0.1 mg/hr, 0.2 mg/hr, 0.3 mg/hr, 0.4 mg/hr, 0.6 mg/hr, 0.8 mg/hr patch
Central Nervous System - Anticonvulsant		
1 Carbamazepine	Tegretol®	100mg chewable tablet, 200mg tablet, 100mg/5ml susp
1 Clonazepam	Klonopin®	0.5mg, 1mg, 2mg tablet
1 Divalproex	Depakote®, Depakote ER®	125mg ec capule, 125mg, 250mg, 500mg ec tablet, 500mg cr tablet, 250mg/5ml soln
1 Ethosuximide	Zarontin®	250mg/5ml syrup, 250mg capsule
1 Gabapentin	Neurontin®	100mg, 300mg, 400mg capsule, 600mg, 800mg tablet
1 Lamotrigine	Lamictal®	5mg, 25mg chewable tablet, 100mg,150mg, 200mg tablet
1 Levetiracetam	Keppra®	500mg, 750mg, 1000mg tablet, 500mg XR, 750mg XR tablet
1 Oxcarbazepine	Trileptal®	300mg, 600mg tablet
1 Phenobarbital		20mg/5ml elixir, 15mg, 30mg, 60mg, 100mg tablet
1 Phenytoin	Dilantin®, Phenytek®	50mg chewable tablet, 30mg, 100mg capsule, 30mg/5ml, 125mg/5ml susp
1 Pregabalin	Lyrica®	25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg capsule
1 Primidone	Mysoline®	250mg/5ml susp, 50mg, 250mg tablet

Continued on next page

GENERIC	BRAND	FORMS
Central Nervous System - Anticonvulsant, continued • SEE PREVIOUS PAGE		
1 G Tiagabine	Gabitril®	2mg, 4mg, 12mg, 16mg tablet
Restriction: Restricted to plan Neurologists.		
1 G Topiramate	Topamax®	15mg, 25mg sprinkle capsule, 25mg, 50 mg, 100mg, 200mg tablet
Restriction: Capsules allowed for children < 10 years old.		
1 G Zonisamide	Zonegran®	25mg, 50mg, 100mg capsule
Central Nervous System - Antidepressant - Antipsychotic		
1 G Perphenazine & Amitriptyline	Triavil®	2-10mg, 2-25mg, 4-10mg, 4-25mg tablet
Restriction: Prior authorization required.		
Central Nervous System - Antidepressant - Norepinephrine Antagonist and Serotonin Antagonist Antidepressants		
1 G Mirtazapine	Remeron®	15mg, 30mg, 45mg tablet
Central Nervous System - Antidepressant - Norepinephrine-Dopamine Reuptake Inhibitors (NDRI)		
1 G Bupropion	Wellbutrin®	100 mg, 150 mg, 200 mg cr tablet, 150 mg, 300 mg xl tablet
Restriction: Restricted to Depression formulation designation.		
1 G Trazodone	Desyrel®	50mg, 100mg, 150mg tablet
Central Nervous System - Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRI)		
Fluoxetine is the least expensive of the SSRIs. KHS recommends the generic Fluoxetine as the economic SSRI of choice. *Only the 20mg capsules will be covered since they are so inexpensive compared to the 40mg. DHCS has age restrictions on use in pediatrics. Please consult FDA on specific guidelines.* ***KHS formulary requires half tablet dosing for all tablets in this class except for citalopram. All generic formulations must be tried and considered before branded, non-formulary medications will be considered.*** ***Tablet splitters are covered for KHS patients.***		
1 G Citalopram	Celexa®	10mg, 20mg, 40mg tablet
Restriction: Allowed > 12 years old.		
1 G Escitalopram	Lexapro®	5mg, 10mg, 20mg tablet
Restriction: Citalopram trial and failure required. Allowed > 12 years old.		

Continued on next page

GENERIC	BRAND	FORMS
Central Nervous System - Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRI), continued • SEE PREVIOUS PAGE		
1 G Fluoxetine	Prozac®	10mg, 20mg capsule, 20mg/5ml soln
Restriction: Restricted to 10mg NMT 1 daily, 20mg NMT 4 daily. Allowed > 7 years old.		
1 G Fluvoxamine	Luvox®	50mg, 75mg, 100mg tablet, 100mg, 150mg er capsule
Restriction: 100mg and 150 mg ER capsule PA required. Allowed > 8 years old.		
1 G Paroxetine	Paxil®	20mg, 30mg, 40mg tablets, 10mg/5ml susp
Restriction: Allowed > 18 years old. Suspension requires prior authorization.		
1 G Sertraline	Zoloft®	50mg, 100mg tablet
Restriction: Allowed > 6 years old.		
Central Nervous System - Antidepressant - Tricyclics (TCA)		
1 G Amitriptyline		10mg, 25mg, 50mg, 75mg, 100mg, 150mg tablet
1 G Clomipramine	Anafranil®	25mg, 50mg, 75mg capsule
Restriction: Prior authorization required.		
1 G Desipramine	Norpramin®	10mg, 25mg, 50mg, 75mg, 100mg, 150mg tablet
1 G Imipramine	Tofranil®	10mg, 25mg, 50mg tablet, 75mg, 100mg, 150mg capsule (pamoate)
1 G Nortriptyline	Pamelor®	10mg, 25mg, 50mg, 75mg capsule, 10mg/5ml soln
Central Nervous System - Antidepressant-Serotonin - Norepinephrine Reuptake Inhibitors (SNRI)		
1 G Duloxetine	Cymbalta®	20mg, 30mg, 60mg capsule
1 G Venlafaxine	Effexor®, Effexor XR®	25mg, 37.5mg, 50mg, 75mg, 100mg tablet, 37.5mg, 75mg, 150mg cr capsule
Central Nervous System - Antipsychotic		
For Kern Family Health Care (KHS Medi-Cal) most of the straight antipsychotic agents are carved out to Medi-Cal. Please see Appendix.		
Central Nervous System - Anxiolytic		
*The **Benzodiazepine anxiolytic medications are restricted** to prevent patients becoming habituated or addicted to them. Doses for physicians who are not mental health specialists are also restricted. Diazepam and lorazepam are restricted to an initial 90 days supply and have the following daily maximums. The SSRI's are recommended for long term antianxiety therapy.*		

Continued on next page

GENERIC	BRAND	FORMS
Central Nervous System - Anxiolytic, continued • SEE PREVIOUS PAGE		
Caution should be used when combining with opioids.		
Medication / ***Daily Maximum Dose***		
Diazepam / *10mg*		
Lorazepam / *2mg*		
1 G Buspirone	Buspar®	5mg, 10mg, 15mg tablet
1 G Clonazepam	Klonopin®	0.5mg, 1mg, 2mg tablet
1 65 G Diazepam	Valium®	2mg, 5mg, 10mg tablet
Restriction: Restricted to 90 days therapy and 10mg maximum daily dose.		
1 G Lorazepam	Ativan®	0.5mg, 1mg, 2mg tablet
Restriction: Restricted to 90 days therapy and 2mg maximum daily dose.		
Central Nervous System - Migraine		
1 G Butalbital, Caffeine, & Acetaminophen	Fioricet®	50mg-40mg-325mg tablet
Restriction: 50 tablets maximum per month.		
1 G Butalbital, Caffeine, & Aspirin	Fiorinal®	50mg-40mg-325mg capsule/tablet
Restriction: 50 capsules maximum per month.		
1 Ergotamine & Caffeine	Cafergot®	1mg-100mg tablet, 2mg-100mg supp
Restriction: 20 doses per month.		
1 Ergotamine Tartarate		2mg sl tablet
Central Nervous System - Migraine-Triptan		
*The **Triptan** medications are the largest expense category of the anti-migraine drugs. The Triptan medications are maximally restricted to 9 tablets per 30 day period and 3 dispensings in a 365 day period. Patients whose demand exceeds the 3 fills are recommended to be considered for prophylactic medications and for a Neurology referral.*		
Medication / ***Cost/9 tablets***		
Sumatriptan (Imitrex®) 50-100mg / *$9*		
Naratriptan (Amerge®) 2.5mg / *$25*		
Rizatriptan (Maxalt®) 5mg / *$19*		
Zolmitriptan (Zomig®) 5mg / *$57*		
1 G Naratriptan	Amerge®	1mg, 2.5mg tablet
Restriction: 9 tablets in 30 days with a maximum of 3 fills in a 12 month period.		

Continued on next page

GENERIC	BRAND	FORMS
Central Nervous System - Migraine-Triptan, continued • SEE PREVIOUS PAGE		
1 Rizatriptan	Maxalt®	5mg, 10mg tablet
Restriction: 12 tablets in 40 days with a maximum of 2 fills in a 12 month period.		
1 Sumatriptan	Imitrex®	50mg, 100mg tablet only
Restriction: Restricted to 9 tablets in 30 days with a maximum of 3 fills in a 12 month period.		
Central Nervous System - Sedative		
Many references on insomnia recommend against prescribing sedative medication on a nightly basis. KHS will promote this utilization. These medications will be restricted to the treatment of insomnia and 15 per 30 days. For those patients experiencing morning drowsiness from the regular strengths of the Formulary medications low dose Temazepam (Restoril® 7.5mg) is offered. The FDA has issued recommendations for lower doses for women. ***Caution should be used in combination with opioids.***		
1 Temazepam	Restoril®	15mg, 30mg capsule
Restriction: Allow 15 capsules in 30 days.		
1 Zolpidem	Ambien®	5mg, 10mg tablet
Restriction: Allow 15 tablets in 30 days. 5mg daily maximum allowed for women.		
Central Nervous System - Stimulant		
Restricted to members between the ages of 4 and 16 years old with ADD/ADHD. ER formulations limited to once daily dosing in accordance to FDA dosing guidelines.		
1 Amphetamine Combination	Adderall®, Adderall XR®	5mg, 7.5mg, 10mg, 20mg, 30mg tablet, 5mg, 10mg, 15mg, 20mg, 25mg, 30mg cr tablet
1 Atomoxetine	Strattera®	10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, 100 mg capsule
Restriction: Psychiatrist only.		
1 Dexmethylphenidate	Focalin®, Focalin XR®	5mg, 10mg tablet, 5mg, 10mg, 15mg, 20mg, 30mg capsule
1 Dextro-amphetamine	Dexedrine®	5mg, 10mg tablet, 10mg, 15mg, cr capsule
1 Lisdexamfetamine	Vyvanse®	20mg, 30mg, 40mg, 50mg, 60mg, 70mg capsule
Restriction: Must fail generic amphetamines first.		
1 Methylphenidate	Ritalin®	5mg, 10mg, 20mg tablet, 20mg cr tablet

GENERIC	BRAND	FORMS
Cholinesterase Inhibitors		
1 G Donepezil	Aricept®	5mg, 10mg tablet
Restriction: Prior authorization required. MMSE		
Drug Dependency Therapy		
1 G Nicotine	Nicorette®, Nicotrol®, Nicoderm CQ®	2mg, 4mg gum, 2mg, 4 mg lozenge, 10mg cartridge, 10mg/ml spray, 7mg, 14 mg, 21 mg patches
1 G Varenicline	Chantix®	0.5mg, 1mg tablet

Enterals

Enterals are covered by KHS following the Medi-Cal guidelines for coverage and exclusion. Only products listed on the Fee-For-Service product list are covered. The products are grouped by the following product categories:

- *Elemental and Semi-Elemental*
- *Metabolic*
- *Specialized*
- *Specialty Infant*
- *Standard*

KHS members must meet the medical criteria for the product category specific to the product requested.

Enteral nutrition products may be covered upon authorization when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food (California Code of Regulations [CCR], Title 22, Section 51313.3).

Enteral nutrition products covered are subject to the Medi-Cal List of Enteral Nutrition Products and utilization controls (Welfare and Institutions Code [W&I Code], Sections 14132.86, 14105.8 and 14105.395).

Enteral nutrition products provided to inpatients receiving inpatient hospital services are included in the hospital's reimbursement made under the CCR, Title 22, Section 51536. These products are not separately reimbursable. Enteral nutrition products provided to inpatients receiving Nursing Intermediate Care Facilities Facility Level A services or Nursing Facility Level B services are not separately reimbursable.

Enteral nutrition products provided to patients in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) or Intermediate Care Facility for the Developmentally Disabled/Nursing ICF/DD-N) are reimbursed as part of the facility's daily rate and are not

Continued on next page

GENERIC	BRAND	FORMS
Enterals, continued • SEE PREVIOUS PAGE		
separately reimbursable (CCR, Title 22, Sections 51510.1, 51510.2 and 51510.3). *The following nutrition products are not covered by Medi-Cal:* • *Regular food, including solid, semi-solid, blenderized and pureed foods* • *Common household items* • *Regular infant formula as defined in the Federal Food, Drug and Cosmetic Act (FD&C Act)* • *Shakes, cereals, thickened products, puddings, bars, gels and other non-liquid products* • *Thickeners* • *Products for assistance with weight loss* • *Vitamin and/or mineral supplements, except for pregnancy and birth up to 5 years of age (Refer to the appropriate contract drugs list section in this manual for more information).* • *Enteral nutrition products used orally as a convenient alternative to preparing and/or consuming regular solid or pureed foods*		
Gastrointestinal - Antidiarrheal		
1 65 G Diphenoxylate & Atropine	Lomotil®	2.5mg/5ml liq, 2.5mg tablet
1 G Paregoric		2mg/5ml liq
Gastrointestinal - Antiemetic		
1 Aprepitant	Emend®	40mg, 80mg, 125mg, 125-80mg, 150mg vial
Restriction: Restricted to highly emetic chemotherapy such as 'platinum' therapy. Allow up to 3 days per treatment.		
1 Dronabinol	Marinol®	2.5mg, 5mg, 10mg capsule
Restriction: Restricted to use by KHS plan Oncologist.		
1 * G Granisetron	Kytril®	1mg tablet
Restriction: Prior authorization required.		
1 * G Ondansetron	Zofran®	4mg, 8mg tablet, ODT
Restriction: Allow up to 3 days of therapy per oncology treatment.		
1 * G Prochlorperazine	Compazine®	5mg, 10mg tablet, 15mg cr capsule, 2.5mg, 5mg, 10mg supp, 5mg/5ml syrup
1 * 65 G Promethazine	Phenergan®	6.25mg/5ml, 25mg/5ml syrup, 12.5mg, 25mg, 50mg tablet or supp
Restriction: Restricted to members > 2 years old.		

GENERIC	BRAND	FORMS
Gastrointestinal - Digestant		
1 Amylase, Lipase, & Protease	Creon®, Zenpep®	varying strengths -capsule, tablet, chewable tablet, ec tablet
Restriction: Prior authorization required.		
1 G Ursodiol	Actigall®	300mg capsule, 250 mg, 500 mg tablet
Restriction: Prior authorization required.		
Gastrointestinal - H2 Antagonist		
If the patient is on a PPI there is usually no advantage of also prescribing an H2 Antagonist. Some patients experiencing break through symptoms at night with a morning PPI may benefit from a night dose of an H2 Antagonist. If the drugs are given at the same time it may lessen the effectiveness of the PPI. Note that the OTC H2 Antagonists require a package size of 30 or more.		
1 G Famotidine	Pepcid®	10mg, 20mg, 40mg tablet
1 G Ranitidine	Zantac®	150mg tablet, 15mg/ml syrup
Gastrointestinal - Helicobacter Pylori Treatment		
Preferred Therapy according to the American College of Gastroenterology, 2017, is quadruple therapy. ***Quadruple Therapy*** *PO for 10-14 days: bismuth subsalicylate 262mg QID + metronidazole 500mg TID-QID + doxycycline 100mg BID + PPI* ***Concomitant Quadruple Therapy*** *PO for 10-14 days: clarithromycin 500 mg BID +amoxicillin 1 g BID + metronidazole 500 mg BID + PPI* ***Triple therapy*** *PO x 7-14 days: clarithromycin 500 mg bid + amoxicillin 1 g bid (or metronidazole 500 mg bid) + a PPI** **PPI's omeprazole 20 mg bid, pantoprazole 20mg bid*		
Gastrointestinal - Laxative		
1 G Lactulose	Cephulac®	10mg/15ml syrup
1 G PEG	Miralax®	powder
1 G PEG-Electrolyte	Go-Lytely®	powder for soln
Gastrointestinal - Miscellaneous		
1 G Balsalazide	Colazal®	750mg capsule
1 G Hemorrhoidal Suppository w/Hydrocortisone	Anusol-HC®	supp
Restriction: Max 2/day, and 7 days every 30 days.		

Continued on next page

GENERIC	BRAND	FORMS
Gastrointestinal - Miscellaneous, continued • SEE PREVIOUS PAGE		
1 G Hydrocortisone enema	Cortenema®	100mg/60ml susp
1 G Mesalamine	Asacol®, Delzicol®, Lialda®	800mg er tablet, 400mg tablet, 1.2 g DR tablet
Restriction: Try and fail balsalazide therapy before considering mesalamine.		
1 G Metoclopramide	Reglan®	5mg/5ml syrup, 5mg, 10mg tablet
1 G Misoprostol	Cytotec®	100mg, 200mg tablet
1 65 Propantheline	Pro-Banthine®	15mg tablet
Restriction: plan gastroenterologists only.		
1 G Sucralfate	Carafate®	1gm tablet
Restriction: Restricted to members with duodenal ulcer, NMT 90 days therapy.		
1 G Sulfasalazine	Azulfidine®	500mg tablet & ec tablet
Gastrointestinal - Proton Pump Inhibitor		

Proton Pump Inhibitors (PPIs) are one of the highest expense medication categories for most health plans. The Plan PPIs of choice are omeprazole and pantoprazole. Other PPIs will only be allowed with a fair trial of up to BID dosing of the preferred PPIs. Prescription strength PPIs will be allowed in order of escalating cost. It is important to guide patients with life style changes to eliminate possible causes of GERD. Long term use of PPIs in management of GERD should be used with caution. KHS offers triple therapy for the treatment of Heliobacter Pylori (H. Pylori). See H. pylori section. While bedtime dosing of an H2 antagonist for break through reflux may be tried, usually taking a PPI and H2 antagonist together is not clinically justified and may actually make the PPI less effective.

Cost of PPI per patient month to KHS

Medication	***Drug Cost for 30***
Omeprazole	*$4*
Pantoprazole	*$5*
Lansoprazole	*$19*
Rabeprazole	*$19*

Non-Formulary Prescription PPIs	***Monthly Additional Cost***	***Annual Additional Cost***
Dexilent®	*$271*	*$3252*

1 G Esomeprazole	Nexium 24HR (OTC)®	20mg capsule
Restriction: Must fail omeprazole and pantoprazole therapy.		

Continued on next page

GENERIC	BRAND	FORMS
Gastrointestinal - Proton Pump Inhibitor, continued • SEE PREVIOUS PAGE		
1 Lansoprazole	Prevacid®	30mg capsule
Restriction: Must fail omeprazole and pantoprazole therapy.		
1 Omeprazole	Prilosec®	20mg, 40 mg capsule
1 Pantoprazole	Protonix®	20mg, 40mg tablet
1 Rabeprazole	Aciphex®	20mg tablet
Restriction: Must fail omeprazole and pantoprazole therapy.		
Hematology - Anticoagulant		
1 Apixaban	Eliquis®	2.5mg, 5mg tablet, Starter pack
1 Enoxaparin	Lovenox®	30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/1m, 120mg/1ml, 150mg/1ml injection
Restriction: Restricted to a 14 day supply. Authorization is required for additional amounts.		
1 Heparin		1000 units/ml, 5000 units/ml, 10,000 units/ml (bovine), 1000 units/ml, 5000 units/ml, 10,000 units/ml, 20,000 units/ml, 40,000 units/ml, 100 units/ml lock flush (porcine)
Restriction: Lock flush billed as Medical claim.		
1 Rivaroxaban	Xarelto®	10mg, 15mg, 20mg tablet, Starter pack
1 Warfarin	Coumadin®	1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg,10mg tablet
Hematology - Antiplatelet		
1 Anagrelide	Agrylin®	1mg capsule
Restriction: Prior authorization required.		
1 Clopidogrel	Plavix®	75mg tablet
1 65 Dipyridamole	Persantine®	25mg, 50mg, 75mg tablet
1 Prasugrel	Effient®	5mg, 10mg tablet
Restriction: Prior authorization required. Available first line if written by cardiologist. Up to 12 month therapy allowed.		
1 Ticagrelor	Brilinta®	60mg, 90mg tablet
Restriction: Prior authorization required. Available first line if written by cardiologist. Up to 12 month therapy allowed.		

GENERIC	BRAND	FORMS
Hematology - Coagulant		
1 G Phytonadione	Mephyton®	5mg tablet
Hematology - Hematopoietic		
1 * Darbepoetin	Aranesp®	25mcg/ml, 40mcg/ml, 60mcg/ml, 100mcg/ml and 200mcg/ml.
1 * Epoetin, Alpha	Retacrit®	2000 units/ml, 3000 units/ml, 4000 units/ml, 10,000 units/ml, 20,000 units/ml, 40,000 units/ml injection
Restriction: Restricted to patients with anemia from Zidovudine therapy or CRF. Epogen allowed for 20,000 unit/ml.		
Hematology - Miscellaneous		
1 G Cilostazol		50mg, 100mg tablet
Restriction: Restricted to members > 65 years old with intermittant claudication or diabetic of any age with intermittant claudication.		
1 G Pentoxifylline	Trental®	400mg tablet
Restriction: Restricted to members > 65 years old with intermittant claudication or diabetic of any age with intermittant claudication.		
Hormone - Androgen		
1 Testosterone	Depo-Testosterone®	100mg/ml, 200mg/ml vial
Restriction: Prior authorization required.		
Hormone - Anti-Androgen		
1 Danazol	Danocrine®	50mg, 100mg, 200mg capsule
Restriction: Prior authorization required.		
Hormone - Antidiabetic - Amylin Analog		
1 Pramalintide	Symlin®	Pen injector
Restriction: Prior authorization required.		
Hormone - Antidiabetic - Dipeptidyl Peptidase-4		
1 G Alogliptin	Nesina®	6.25mg, 12.5mg, 25mg tablet
Restriction: Restricted to members on metformin or cannot take or failed metformin. Please consider when initiating DPP-4 therapy.		
1 Linagliptin	Tradjenta®	5mg tablet
Restriction: Restricted to members on metformin or cannot take or failed metformin. PA required. Consider DPP-4 therapy with Alogliptin unless CHF contraindications exist.		

GENERIC	BRAND	FORMS
Hormone - Antidiabetic - Dipeptidyl Peptidase-4 - Metformin		
1 G Alogliptin/metformin	Kazano®	12.5-500mg, 12.5-1000mg tablet
Restriction: Restricted to members on metformin.		
Hormone - Antidiabetic - Dipeptidyl Peptidase-4 - Thiazolidinedione		
1 G Alogliptin/pioglitazone	Oseni®	12.5-15mg, 12.5-30mg, 12.5-45mg, 25-15mg, 25-30mg, 25-45mg tablet
Restriction: Restricted to members on metformin or cannot take or failed metformin.		
Hormone - Antidiabetic Alpha-glucodiase Inhibitor		
1 G Acarbose	Precose®	25mg, 50mg, 100 mg tablet
Restriction: Restricted to endocrinologists.		
Hormone - Antidiabetic Biguanide		
***Metformin** is a valuable medication for the treatment of diabetes. A specific advantage of Metformin is that it can help minimize weight gain. Patients who try generic Metformin and have nausea may be considered for Glucophage XR®.*		
1 G Metformin	Glucophage®, Glucophage XR®	500mg, 850mg, 1000mg tablet, 500mg cr tablet
Hormone - Antidiabetic GLP-1 Agonists		
1 Dulaglutide	Trulicity®	0.75mg/0.5, 1.5mg/0.5 injection
Restriction: Restricted to members adherent to > 90 of SGLT-2 therapy. Plan endocrinologists exempt.		
1 Exenatide	Bydureon®	2mg vial, pen, Bcise
Restriction: Restricted to members adherent to > 90 days of SGLT-2 therapy. Plan endocrinologist exempt.		
1 Liraglutide	Victoza®	0.6mg/0.1 injection
Restriction: Restricted to members seen by endocrinologists on SGLT-2 therapy of any duration. Has FDA indication for use in managing concurrent cardiovascular disease.		
1 Lixisenatide	Adlyxin®	20 mcg injection, starter
Restriction: Restricted to members adherent to > 90 of SGLT-2 therapy. Plan endocrinologists exempt.		
1 Semaglutide	Ozempic® Rybelsus®	3 mg, 7 mg, 14 mg tablet, 1 mg injection
Restriction: Restricted to members seen by endocrinologists on SGLT-2 therapy of any duration.		
Hormone - Antidiabetic GLP-1 Agonists glargine combination		
1 Insulin glargine/lixisenatide	Soliqua®	100-33/ml injection
Restriction: Restricted to members currently on insulin glargine or GLP-1.		

GENERIC	BRAND	FORMS
Hormone - Antidiabetic Insulin		
1 ✱ G Insulin aspart	Novolog®	100 units/ml, 70-30 mix
1 ✱ Insulin degludec	Tresiba®	100 units/ml, 200 units/ml
Restriction: Restricted to endocrinologists.		
1 ✱ Insulin detemir	Levemir®	100 units/ml
Restriction: Restricted to adverse reactions to glargine or for use in pregnant women.		
1 ✱ Insulin glargine	Basaglar®, Toujeo®	100 units/ml, 300 units/ml
Restriction: Toujeo therapy reserved for endocrinologist for members failing maximum dosed Basaglar.		
1 ✱ Insulin glulisine	Apidra®	100 units/ml
1 ✱ G Insulin lispro	Admelog®, Humalog®	100 units/ml, 50-50mix, 75-25 mix
Restriction: Admelog allowed for single ingredient formulation. Humalog for mixed formulations.		
1 ✱ Insulin, Human	Humulin® Novolin®	100 units/ml Regular, Lente, NPH, 50-50, 70-30 mix, 500 unit/ml Regular
Restriction: U-500 restricted to endocrinology.		
Hormone - Antidiabetic Meglitinide		
1 G Nateglinide	Starlix®	60mg, 120mg tablet
Restriction: Restricted to plan endocrinologists.		
Hormone - Antidiabetic Other Agents		
1 G Glucagon		1mg kit
Restriction: Limit 2 per dispensing, 2 dispensings per 12 months.		
Hormone - Antidiabetic SGLT-2 Inhibitors		
1 Empagliflozin	Jardiance®	10mg, 25mg tablet
Restriction: Restricted to members adherent to > 90 days of metformin therapy. PA required. Has FDA indication for use in managing concurrent cardiovascular disease. Consider Steglatro for initiating SGLT-2 therapy unless contraindicated.		
1 Ertugliflozin	Steglatro®	5mg, 15 mg tablet
Restriction: Restricted to members adherent to > 90 days of metformin therapy. Preferred SGLT-2. Please consider when initiating SGLT-2 therapy.		

GENERIC	BRAND	FORMS
Hormone - Antidiabetic SGLT-2 Inhibitors Combination		
1 Empagliflozin/metformin	Synjardy®	5mg-500mg, 5mg-1000mg, 12.5mg-500mg, 12.5mg-1000mg tablet
Restriction: Restricted to members adherent to > 90 days of metformin therapy. Has FDA indication for use in managing concurrent cardiovascular disease. Segluromet is preferred. Please consider Segluromet when starting SGLT-2/metformin therapy.		
1 Ertugliflozin/metformin	Segluromet®	2.5-500mg, 7.5-500mg, 2.5-1000mg, 7.5-1000mg tablet
Restriction: Restricted to members adherent to > 90 days of metformin therapy. Preferred SGLT-2/metformin combination.		
Hormone - Antidiabetic Sulfonylureas		
1 G Glimepiride	Amaryl®	1mg, 2mg, 4mg tablet
1 G Glipizide	Glucotrol®	5mg, 10mg tablet
1 G Glyburide	Diabeta®	1.25mg, 2.5mg, 5mg tablet
Hormone - Antidiabetic Thiazolidinedione		
*These agents are reserved for patients who fail or cannot take Metformin. KHS **recommends using Metformin prior to "Glitazone" therapy for diabetic patients since it helps patients minimize weight gain.** Prior authorization will be considered for patients who cannot tolerate Metformin or should not take Metformin (renal patients and those over 80 years old).*		
1 G Pioglitazone	Actos®	15mg, 30mg, 45mg tablet
Restriction: Restricted to members on metformin or cannot take or have failed metformin.		
Hormone - Anti-thyroid		
1 G Propylthiouracil		50mg tablet
Hormone - Endocrine		
1 Bromocriptine	Parlodel®	2.5mg tablet, 5mg capsule
Restriction: Restricted to patients with amenorhhea, galactorrhea, or acromegaly.		
1 * G Cabergoline		0.5 mg tablet
Restriction: Restricted to plan endocrinologists.		
1 G Cinacalcet	Sensipar®	30mg, 60mg, 90mg, tablet
Restriction: Prior authorization required.		
1 G Desmopressin	DDAVP®	0.1mg, 0.2mg tablet
Restriction: Prior authorization required. Not covered for enuresis.		

GENERIC	BRAND	FORMS
Hormone - Estrogen		
1 G Estradiol	Estrace®	0.5mg, 1mg, 2mg tablet
1 65 Estrogens, Conjugated	Premarin®	0.3mg, 0.45mg, 0.625mg, 0.9mg, 1.25mg, 2.5mg tablet
Hormone - Estrogen - Androgen		
1 65 G Esterified Estrogens & Methyltestosterone	Estratest®	6.25mg-1.2mg, 1.25mg-2.5mg tablet
Hormone - Estrogen - Progestin		
1 65 Estrogen, Conjugated & Medroxyprogesterone	Prempro®	0.625mg-5mg, 0.3mg-1.5 mg, 0.45mg-1.5 mg tablet
1 65 Estrogen, Conjugated & Medroxyprogesterone	Premphase®	0.625mg Estrogen (14) & 0.625mg-5mg Estrogen-Medroxyprogesterone (14) tablet
Hormone - Glucocorticoid		
1 G Dexamethasone	Decadron®	0.5mg, 0.75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg tablet
1 G Flurocortisone	Florinef®	0.1mg tablet
1 G Hydrocortisone		5mg,10mg, 20mg tablet, 25mg supp, 100mg/60ml enema
1 * G Methylprednisolone	Medrol®	4mg tablet in dosepack
1 * G Prednisolone	Prelone®	5mg/5ml, 6.7mg/5ml, 15mg/5ml soln, 5mg tablet
1 * G Prednisone		1mg/1ml oral soln or syrup, 5mg/ml conc, 1mg,2.5mg, 5mg, 10mg, 20mg, 25mg, 50mg tablet 5mg, 10mg dose pack
Hormone - Oxytoxic		
1 Methylergonovine	Methergine®	0.2mg tablet
Hormone - Progestin		
1 Elagolix	Orilissa®	150 mg, 200 mg tablet

Restriction: Prior authorization required.

Continued on next page

GENERIC	BRAND	FORMS
Hormone - Progestin, continued • SEE PREVIOUS PAGE		
1 G Hydroxyprogesterone Caproate	Makena®	250mg/ml
Restriction: Prior authorization required--FDA indication only for singleton pregnancies. Not FDA indicated for incompetent cervix.		
1 Leuprolide/norethindrone	Lupaneta®	3.75-5 mg, 11.25-5 mg syringe-tab
Restriction: Prior authorization required.		
1 G Medroxyprogesterone	Provera®, Depo-Provera®	2.5mg,10mg tablet, 150mg/ml depo injection
Restriction: Depo-Provera® allowed for maximum of 24 months.		
1 Progesterone miconized	Crinone®	4%, 8% vaginal gel
Restriction: Restricted to plan OB/GYN.		
Hormone - Thyroid		
1 G Levothyroxine	Levoxyl®	0.025mg, 0.05mg, 0.075mg, 0.088mg, 0.1mg, 0.112mg, 0.125mg, 0.137mg, 0.15mg, 0.175mg, 0.2mg, 0.3mg tablet
1 G Liothyronine	Cytomel®	5mcg, 25mcg, 50mcg tablet
Restriction: Prior authorization required.		
1 G Methimazole	Tapazole®	5mg, 10mg tablet
1 65 G Thyroid--dessicated	Armour®	15mg, 30mg, 60mg, 90mg, 120mg, 180mg, 240mg, 300mg tablet
Restriction: Plan endocrinologists. Prior authorization required.		
Immunosuppressant		
1 * G Azathioprine	Imuran®	50mg tablet
1 * G Cyclosporine, Microemulsion	Neoral®	25mg, 100mg capsule
1 * Everolimus	Zortress®	0.25mg, 0.5mg, 0.75mg tablet
Restriction: Prior authorization required.		
1 * G Tacrolimus	Prograf®	0.5mg, 1mg, 5 mg capsule
Restriction: Prior authorization required.		

GENERIC	BRAND	FORMS
Intravenous Solutions		
The following intravenous solutions are available to plan members. These solutions are covered under per diem arrangements and typically not billed through the PBM. Authorization is required to coordinate with the infusion services and centers.		
1 G Antibacterial/Antifungal Agents		various
Restriction: Prior authorization required. Bill per diem.		
1 G Electrolyte Maintenance		various
Restriction: Prior authorization required. Bill per diem.		
1 G IV solutions: Dextrose-water, Dextrose-saline, Dextrose and Lactated Ringer's		various
Restriction: Prior authorization required. Bill per diem.		
1 G Intravenous lipids		various
Restriction: Prior authorization required. Bill per diem.		
1 G Parenteral Amino Acid Solutions and Combinations		various
Restriction: Prior authorization required. Bill per diem.		
1 G Potassium Replacement		various
Restriction: Prior authorization required. Bill per diem.		
1 G Protein Replacement		various
Restriction: Prior authorization required. Bill per diem.		
1 G Sodium and Saline Preparations		various
Restriction: Prior authorization required. Bill per diem.		
Muscle Relaxant		
Methocarbamol (Robaxin®) and Diazepam (Valium®) can be habituating and should be given with caution to patients with abuse potential. Diazepam is restricted to patients with cerebral palsy or severe spinal column injury. Diazepam is limited to 90 days' supply and 10mg daily maximum dose without prior authorization. Limited to FDA maximum daily dosing guidelines. ***Caution in use with combination with opioids.*** *FDA and other professional societies provide guidance statements of the usefulness of muscle relaxants for short periods of time, typically 2-3*		

Continued on next page

GENERIC	BRAND	FORMS
Muscle Relaxant, continued • SEE PREVIOUS PAGE		
weeks. Beyond that the effectiveness seems to diminish. The plan will allow up to 90 days of antispasmodics. Medications treating spasticity will not have this limitation.		
1 G Baclofen		10mg, 20mg tablet
1 65 G Cyclobenzaprine		10mg tablet
Restriction: Restricted to 90 days therapy.		
1 65 G Diazepam	Valium®	2mg, 5mg, 10mg tablet
Restriction: Restricted to 90 days therapy and 10mg maximum daily dose.		
1 65 G Methocarbamol	Robaxin®	500mg, 750mg tablet
Restriction: Restricted to 90 days therapy.		
1 G Tizanidine	Zanaflex®	2 mg, 4 mg tablet
NSAID - Acetic Acids		
1 G Diclofenac Na	Voltaren®	50mg, 75mg ec tablet
Restriction: Restricted to members with RA.		
1 G Indomethacin	Indocin®	25mg, 50mg capsule
1 G Sulindac	Clinoril®	150mg, 200mg tablet
Restriction: Restricted to members with RA.		
NSAID - COX-2 Agents		
Celecoxib (Celebrex®) is allowed without prior authorization for patients over the age of 65 or who are currently taking Warfarin (Coumadin®). Other indications require prior authorization. Only one daily is allowed - Celebrex® 100mg or 200mg. KHS requires that patients start at the lowest dose possible. Patients who fail a reasonable trial of two other Formulary NSAIDs will be considered for a COX-2 agent.		
Effectiveness: COX-2 medications are not more effective than other NSAIDs. NSAIDs cannot provide an unlimited amount of pain relief. While NSAIDs do provide pain relief and have anti-inflammatory ability, they do not alter the course of arthritis or prevent joint destruction.		
Safety: COX-2 medications are not risk free. Data does seem to reflect a lower incidence of GI toxicity but that may be diminished by concurrent aspirin therapy.		
Vioxx® had been allowed by the FDA to add to their product insert a statement of safety for GI problems. Celebrex® was denied a similar request. Adding another NSAID such as aspirin to COX-2 therapy will probably increase risk. (CLASS Study)		

Continued on next page

GENERIC	BRAND	FORMS
NSAID - COX-2 Agents, continued • SEE PREVIOUS PAGE		
COX-2 agents have renal liability as other NSAIDs. This risk may be less, but there is some potential for renal problems. These drugs can cause sodium and fluid retention like other NSAIDs. Cardiovascular safety with COX-2 drugs is being questioned.		
1 Celecoxib	Celebrex®	100mg, 200mg capsule
Restriction: Restricted to members > 65 years old or members on warfarin. Limited to one dose daily. Members not at risk are required to fail two other Formulary NSAIDs first. Other members and doses require prior authorization.		
NSAID - Other		
1 Nabumetone	Relafen®	500mg, 750mg tablet
NSAID - Oxicam		
1 Meloxicam	Mobic®	7.5mg, 15mg tablet
NSAID - Propionic Acids		
1 Ibuprofen	Motrin®	100mg/5ml susp, 400mg, 600mg, 800mg tablet
Restriction: FDA does not recommend in children < 6 months.		
1 Ketoprofen	Orudis®	25mg, 50mg, 75mg capsule
Restriction: Restricted to members with RA.		
1 Naproxen	Naprosyn®	125mg/5ml susp, 250mg, 375mg, 500mg tablet
NSAID - Salicylate		
1 Salsalate	Disalcid®	500mg capsule, tablet or cr tablet, 750mg tablet
Ophthalmic - Anesthetic		
1 Proparacaine		0.5% ophth soln
Restriction: Prior authorization required.		
Ophthalmic - Anti-fungal		
1 Natamycin	Natacyn®	5% ophth susp
Ophthalmic - Antihistamine		
1 Azelastine ophth soln	Optivar®	0.05% ophth soln
Restriction: Trial and failure of Zaditor required.		
1 Olopatadine	Patanol®	0.1% ophth soln
Restriction: Restricted to plan ophthalmologists only.		

GENERIC	BRAND	FORMS
Ophthalmic - Anti-infective		
1 G Bacitracin		ophth oint
1 G Bacitracin & Polymyxin	Polysporin®	ophth oint
1 Besifloxacin	Besivance®	0.6% ophth susp
Restriction: Patients must have recently failed first line ophth antibiotics. Allow 1st line for ophthalmologists.		
1 G Ciprofloxacin	Ciloxan®	0.3% ophth soln
1 G Erythromycin	Ilotycin®	0.5% ophth oint
1 G Gentamicin	Garamycin®	0.3% ophth oint & soln
1 G Neomycin, Bacitracin & Polymyxin	Neo-Polycin®	3.5mg-400 units (or 500 units)-10000 units ophth oint
1 G Neomycin,Polymyxin & Gramicidin	Neosporin®	ophth soln
1 G Ofloxacin	Ocuflox®	0.3% ophth soln
1 G Polymyxin & Trimethaprim	Polytrim®	ophth soln
1 G Sodium Sulfacetamide	Sulamyd®	10% ophth soln & oint
1 G Tobramycin	Tobrex®	0.3% ophth soln
Ophthalmic - Anti-infective - Glucocorticoid		
1 G Neomycin, Polymyxin & Dexamethasone	Maxitrol®	ophth susp, ophth oint
1 G Neomycin,Polymyxin & Prednisolone	Poly-Pred®	ophth susp
1 G Tobramyin & Dexamethasone	Tobradex®	0.3%-0.1% ophth susp
Restriction: Consider second line to neomycin/steroid preparations.		
Ophthalmic - Anti-viral		
1 Ganciclovir	Zirgan®	0.15% gel
Restriction: Restricted to plan ophthalmologists only.		
1 G Trifluridine	Viroptic®	1% ophth soln

GENERIC	BRAND	FORMS
Ophthalmic - Glaucoma		
1 Acetazolamide	Diamox®	125mg, 250mg tablet, 500mg cr capsule
1 Betaxolol	Betopic®	0.25%, 0.5% ophth soln or susp
1 Bimatoprost	Lumigan®	0.01%, 0.03% ophth soln
Restriction: Limited to 2.5ml size only. 1 bottle per dispensing.		
1 Brimonidine	Alphagan® Alphagan P®	0.2% ophth soln
1 Brimonidine tartrate/timolol	Combigan®	0.2%-0.5% ophth drops
1 Brinzolamide	Azopt®	1% ophth susp
Restriction: Prior authorization required.		
1 Dorzolamide	Trusopt®	2% ophth soln
1 Dorzolamide/timolol	Cosopt®	2%-0.5% ophth drops
1 Latanoprost	Xalatan®	0.005% ophth soln
1 Levobunolol	Betagan®	0.25% ophth soln
1 Methazolamide	Neptazane®	25mg, 50 mg tablet
1 Metipranolol	Optipranolol®	0.3% ophth soln
1 Pilocarpine	Isopto-Carpine®	1%, 2%, 4% ophth soln
1 Scopolamine	Isopto-Hyosine®	0.25% ophth soln
1 Timolol	Timoptic®	0.25%, 0.5% ophth soln
Ophthalmic - Glucocorticoid		
1 Difluprednate	Durezol®	0.05% ophth susp
Restriction: Restricted to plan ophthalmologists only.		
1 Fluorometholone	FML®	0.1%, 0.25% ophth susp
1 Loteprednol	Lotemax®	0.5% ophth susp
Restriction: Prior authorization required.		
1 Prednisolone	Pred Mild®, Pred Forte®	0.12%, 1% ophth susp

GENERIC	BRAND	FORMS
Ophthalmic - Miscellaneous		
1 Cromolyn	Crolom®	4% ophth drops
1 Cyclosporine	Restasis®	0.05% ophth emulsion
Restriction: Prior authorization required.		
1 Sodium Chloride	Muro® (128)	2% ophth soln, 5% ophth oint or soln
Ophthalmic - Mydriatic		
1 Atropine	Isopto-Atropine®	1% ophth soln
1 Cyclopentolate	Cyclogyl®	0.5%, 1%, 2% ophth soln
1 Homatropine	Isopto-Homatropine®	2%, 5% ophth soln
Ophthalmic - NSAID		
1 Diclofenac	Voltaren®	0.1% ophth drops
1 Ketorolac	Acular®, Acular LS	0.4%, 0.5% ophth soln
Restriction: Restricted to plan ophthalmologist only.		
1 Nepafanac	Nevanac®	0.1% ophth susp
Restriction: Restricted to plan ophthalmologist only.		
Oral Contraceptive		
1 Desogestrel & Ethinyl Estradiol	Desogen®	0.15mg-30mcg tablet
1 Drospirenone & Ethinyl Estradiol	Yasmin®, Yaz®	0.03-3mg, 0.02-3mg tablet
Restriction: Prior authorization required.		
1 Ethynodiol & Ethinyl Estradiol	Demulen®	1mg-35mcg tablet
1 Levonorgestrel & Ethinyl Estradiol	Levlen®	0.15mg-30mcg tablet
1 Levonorgestrel & Ethinyl Estradiol	Alesse®	0.1mg-20mcg tablet
1 Norethindrone & Ethinyl Estradiol	Ortho-Novum 1/35®, Demulen 1/50®	35mcg-1mg, 50mcg-1mg tablet

Continued on next page

GENERIC	BRAND	FORMS
Oral Contraceptive, continued • SEE PREVIOUS PAGE		
1 Norethindrone & Mestranol	Ortho-Novum 1/50®	1mg-50mcg tablet
1 Norethindrone Acetate & Ethinyl Estradiol	Loestrin 1/20®, 1/20 Fe®, Lo Loestrin Fe®	1mg-20mcg, 1mg-20mcg, 1mg-10mcg w/iron tablet
Restriction: Lo Loestrin prior authorization required.		
1 Norethindrone Acetate & Ethinyl Estradiol	Norlestrin 1/50®, 1/50 Fe®	1mg-50mcg tablet, 1mg-50mcg w/iron tablet
1 Norethindrone Acetate & Ethinyl Estradiol	Loestrin 1.5/30®, 1.5/30 Fe®	1.5mg-30mcg tablet, 1.5mg-30mcg w/iron tablet
1 Norgestimate & Ethinyl Estradiol	Ortho-Cyclen®	0.25mg-35mcg tablet
1 Norgestrel & Ethinyl Estradiol	Lo-Ovral®	0.3mg-30mcg tablet
1 Norgestrel & Ethinyl Estradiol	Ovral®	0.5mg-50mcg tablet
Oral Contraceptive - Biphasic		
1 Desogestrel & Ethinyl Estradiol	Mircette®	0.15mg/20mcg (21), 10mcg (7) tablet
1 Norethindrone & Ethinyl Estradiol	Ortho-Novum 10/11®	0.5mg-35mcg (10), 1mg-35mcg (11) tablet
1 Norethindrone & Ethinyl Estradiol	Ortho-Novum 7/14®	0.5mg-35mcg (7), 1mg-35mcg(14) tablet
Oral Contraceptive - Progestin Only		
1 Levonorgestrel	Plan B One Step®	1.5mg tablet
Restriction: Maximum of 2 fills in 30 days.		
1 Norethindrone	Micronor®	0.35mg tablet
Oral Contraceptive - Triphasic		
1 Levonorgestrel & Ethinyl Estradiol	Triphasil®	0.05mg-30mcg, 0.075mg-40mcg, 0.125mg-30mcg tablet
1 Norethindrone & Ethinyl Estradiol	Ortho-Novum 7/7/7®	0.5mg-35mcg(7), 0.75mg-35mcg(7), 1mg-35mcg(7) tablet

Continued on next page

GENERIC	BRAND	FORMS
Oral Contraceptive - Triphasic, continued • SEE PREVIOUS PAGE		
1 Norethindrone & Ethinyl Estradiol	Estrostep®	1mg-20mcg(5), 1mg-30mcg(7), 1mg-35mcg(9) tablet
1 G Norgestimate & Ethinyl Estradiol	Ortho-Tricyclen®	0.18mg-35mcg/0.215mg-35mcmg/0.25mg-35mcg tablet
1 G Norgestimate & Ethinyl Estradiol	Ortho-Tricyclen Lo®	0.18mg-25mcg/0.215mg-25mcmg/0.25mg-25mcg tablet
Osteoporosis		
1 G Alendronate	Fosamax®	35mg, 70mg weekly tablet only
Restriction: Restricted to members > 61 years old or having T-score < – 2.5.		
1 G Calcitonin-salmon	Miacalcin®	200unit/spray
Restriction: Allowed for osteoporosis failing bisphosphonates.		
1 G Risdronate	Actonel®	35 mg tablet
Restriction: Prior authorization required.		
Otic		
1 Ciprofloxacin- Dexamethasone	Ciprodex®	0.3%-0.4% otic susp
Restriction: Restricted to plan ENT providers. If the patient recently failed Cortisporin® or Floxin® Otic, consideration will be given to a prior authorization request.		
1 G Hydrocortisone & acetic acid	Acetasol HC®	otic soln
1 G Neomycin, Polymyxin & Hydrocortisone	Cortisporin®	otic susp
1 G Ofloxacin	Floxin® Otic	0.3% otic soln
Restriction: Restricted to 5 mls per dispensing.		
Rescue Agents		
1 G Epinephrine		0.15mg/0.3, 0.3mg/0.3 auto injection
1 G Leucovorin		5mg, 25mg tablet
1 Succimer	Chemet®	100mg capsule
Respiratory - Antihistamine		
1st generation antihistamines are considered to be more effective than the later generations.		

Continued on next page

GENERIC	BRAND	FORMS
Respiratory - Antihistamine, continued • SEE PREVIOUS PAGE		
National guidelines suggest better outcomes with treatment with nasal steroids as opposed to antihistamines. ***The FDA recommends not to use antihistamines and cough preparations in individuals less than 2 years of age.*** ***Allergic Rhinitis adult patients are recommended to be treated with Nasal Steroids.***		
1 65 G Hydroxyzine	Atarax®	10mg/5ml syrup, 10mg, 25mg, 50mg tablet, 25mg, 50mg capsule
Respiratory - Antihistamine - Antitussive		
1 65 G Promethazine & Codeine	Phenergan w/Codeine®	6.25mg-10mg/5ml syrup
Restriction: Only for patients > 18 years old. Plan allows maximum 240 mls per 30 days, 3 fills per 12 months.		
1 G Promethazine & Dextromethorphan	Phenergan DM®	6.25mg-15mg/5ml syrup
Restriction: Only for patients > 2 years old.		
Respiratory - Antihistamine - Antitussive - Decongestant		
1 65 G Phenylephrine, Promethazine & Codeine	Phenergan-VC Codeine®	5mg-6.25mg-10mg/5ml syrup
Restriction: Only for patients >18 years old. Plan allows maximum 240 mls per 30 days, 3 fills per 12 months.		
1 G Pseudoephedrine, Chlorpheniramine & Dextromethorphan	Cardec-DM®	15mg-12.5mg-4mg syrup
Restriction: Only for patients < 6 years old.		
Respiratory - Antihistamine - Decongestant		
1 G Promethazine & Phenylephrine	Phenergan-VC®	6.25mg-5mg/5ml syrup
Restriction: Only for patients > 2 years old.		
Respiratory - Antiserotonin		
1 65 G Cyproheptadine	Periactin®	2mg/5ml syrup, 4mg tablet
Respiratory - Antitussive		
1 G Benzonatate	Tessalon®	100mg perles
Restriction: Prior authorization required.		

Continued on next page

GENERIC	BRAND	FORMS
Respiratory - Antitussive, continued • SEE PREVIOUS PAGE		
1 Saturated soln of potassium iodide	SSKI®	1g/ml soln
Restriction: Prior authorization required.		
Respiratory - Antitussive - Expectorant		
1 65 Codeine & Guaifenesin	Robitussin AC®	10mg-100mg/5ml soln or syrup
Restriction: Only for patients > 18 years old. Plan allows maximum 240 mls per 30 days, 3 fills per 12 months.		
1 65 Codeine, Guaifenesin, Pseudoephedrine	Robitussin DAC®	10mg-100mg-30mg/5ml syrup
Restriction: Only for patients > 18 years old. Plan allows maximum 240 mls per 30 days, 3 fills per 12 months.		
Respiratory - Asthma		
There are National Guidelines for treating Asthma. KHS has a Pocket Guide for Asthma Management and Prevention available. Some of the tables in that text are in the Formulary. Asthma is a chronic inflammatory disease. It is important to remember this inflammatory process and that the inhaled steroids are recommended to be the second step in treatment. Please review the step tables of Asthma Treatment at the end of this Formulary. Spacers (Aerochambers®), with or without masks, and peak flow meters are available by prescription. Preference for referrals for low or non-sedating antihistamines will be given to asthma patients.		
Respiratory - Asthma - Step 1 -Short Acting Bronchodilator		
1 * Albuterol		0.083% & 0.5% inh soln, 2mg/5ml syrup
Restriction: Individual nebulized vial limited to 360 mls per month, the concentrated nebulized solution limited to 60 mls.		
1 Albuterol HFA	Ventolin HFA®, ProAir®	90mcg/dose MDI
Restriction: NMT 2 inhalers in 30 days or greater than 3 consecutive months without an inhaled steroid.		
1 Terbutaline	Brethine®	2.5mg, 5mg tablet
Respiratory - Asthma - Step 2 -Glucocorticoid		
1 Beclomethasone	Qvar Redihaler®	40mcg/dose, 80mcg/dose MDI
1 * Budesonide	Pulmicort®	90mcg/dose, 180mcg/dose breath activated device, 0.25mg/2ml, 0.5mg/2ml inh susp
Restriction: 0.25mg nebulizer susp is restricted to once daily dosing. Doses of 0.25 BID are required to fail 0.5mg once daily. Allowed in members < 5 years old.		
1 Flunisolide	Aerospan®	80mcg/dose MDI

Continued on next page

GENERIC	BRAND	FORMS
Respiratory - Asthma - Step 2 -Glucocorticoid, continued • SEE PREVIOUS PAGE		
1 Fluticasone	Flovent HFA®	44mcg, 110mcg, 220mcg/dose MDI, 50 mcg, 100mcg, 250mcg/dose breath activated device
1 Fluticasone furoate	Arnuity Ellipta®	50 mcg, 100 mcg, 200 mcg breath activated device
Preferred fluticasone inhalation product.		
1 Fluticasone propionate	Armonair Respiclick®	55 mcg, 113 mcg, 232 mcg breath activated device
Respiratory - Asthma - Step 3 - Antileukotriene - (Step 2 Alternative)		
Restricted to members with asthma--requires member to be on a beta-agonist mdi. Inhaled steroids should be considered for second line (Step 2) treatment before antileukotriene. ***Allowed for children < 5 years old as Step 2. Not authorized for allergic rhinitis by plan. Prior authorization not required by ENT.***		
1 G Montelukast	Singulair®	4mg, 5mg chewable tablet, 10mg tablet
1 G Zafirlukast	Accolate®	10mg, 20mg tablet
Respiratory - Asthma - Steps 3 & 4 - ICS/Long Acting Bronchodilator		
1 G Fluticasone/salmeterol	Advair®, Wixela Inhub® , AirDuo®	100/50mcg, 250/50mcg, 500/50mcg breath activated device, 45/21mcg, 115/21mcg, 230/21mcg HFA; 55-14 mcg, 113-14 mcg, 232-14 mcg inhalation
Restriction: Restricted to patients failing a 30-day trial of inhaled steroids alone (see National Asthma Guidelines). Consider generic AirDuo® for asthma management; Wixela Inhub for COPD.		
1 Fluticasone/vilanterol	Breo Ellipta®	100-25mcg, 200-25mcg breath activated device
Restriction: Restricted to patients failing a 30-day trial of inhaled steroids alone (see National Asthma Guidelines). Consider generic AirDuo first, Wixela Inhub for COPD.		
1 Mometasone/formoterol	Dulera®	100/5 mcg, 200/5 mcg MDI
Restriction: Restricted to patients failing a 30-day trial of inhaled steroids alone (see National Asthma Guidelines). Consider generic AirDuo first, Wixela Inhub for COPD.		
Respiratory - Asthma Device		
1 * Monitoring Device	Peak Flow Meter	
Restriction: $35 max per unit.		
1 * Spacer Device		With or without mask
Restriction: Spacers with a mask are available to members under < 6 years old. Please make sure of the fit for the spacers with masks. $35 max per unit without mask. $50 max per unit with mask.		

GENERIC	BRAND	FORMS
Respiratory - COPD - Anticholinergic bronchodilator		
1 * G Ipratropium	Atrovent HFA®	18mcg/dose MDI, 0.02% inhalation soln
Respiratory - COPD - Anticholinergic Bronchodilator Combination		
1 65 G Ipratropium - Albuterol	Ipratropium- albuterol	0.5-3mg/3ml inhalation soln
1 * G Ipratropium- albuterol Respimat	Combivent Respimat®	18mcg-90mcg/spray MDI
Respiratory - COPD - Anticholinergic Bronchodilator Long Acting		
1 Tiotropium bromide	Spiriva® Spiriva Respimat®	18 mcg inhalation capsule, 1.25mcg, 2.5 mcg Respimat
1 Umeclidinium	Incruse Ellipta®	62.5mcg inhalation tablet
Respiratory - COPD - Anticholinergic Bronchodilator Long Acting Combination		
1 Tiotropium bromide - Olodaterol	Stiolto Respimat®	2.5-2.5 mcg breath activated device
1 Umeclidinium - Vilanterol	Anoro Ellipta®	62.5-25 mcg MDI
Respiratory - COPD - Long Acting Anticholinergic - Long Acting Bronchodilator - ICS Combination		
1 Fluticasone - Umeclindium - Vilanterol	Trelegy Ellipta®	100-62.5-25 mcg breath activated device
Restriction: Long acting cholinergic/bronchodilator or ICS/bronchodilator required first.		
Respiratory - Mast Cell Stabilizer		
1 * G Cromolyn	Intal®	20mg/2ml inhalation soln
Respiratory - Mucolytic		
1 * G Acetylcysteine	Mucomyst®	10%, 20% soln
Respiratory - Nasal Antihistamine		
1 G Azelastine	Astelin®	137 mcg/spray
Restriction: Trial and failure of nasal steroids required.		
Respiratory - Nasal Glucocorticoids		
*Nasal Steroids are recommended for the initial treatment of allergic rhinitis. For patients over 12 years of age it is required they fail a 30 day trial of nasal steroids before a prior authorization of non-sedating antihistamines will be approved. Plan requires **generic nasal steroids** to be used first. Nasonex will be allowed for individuals between the ages of 2-4 as first line.*		

Continued on next page

GENERIC	BRAND	FORMS
Respiratory - Nasal Glucocorticoids, continued • SEE PREVIOUS PAGE		
1 G Flunisolide		25 mcg/spray
1 G Fluticasone	Flonase®	50 mcg/spray
1 G Mometasone	Nasonex®	50mcg/spray
Restriction: Allowed as first line for members age 2-4 years old.		
Respiratory - Xanthine		
1 G Theophylline	Theodur, Uniphyl®	80mg/15ml, 100mg, 200mg, 300mg, 400mg cr capsule, 100mg, 200mg, 300mg, 400mg, 450mg cr tablet
Topical - Acne		
1 G Tretinoin	Retin-A®	0.025%, 0.05%, 0.1% cream
Restriction: Restricted to plan dermatologists. 20g maximum. Secondary to trial and failure of Differin 0.1% gel OTC.		
Topical - Anesthetic		
1 G Viscous lidocaine	Xylocaine®	2% gel
Restriction: Restricted to 100ml every 30 days.		
Topical - Antifungal		
1 G Econazole	Spectazole®	1% cream
Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).		
1 G Ketoconazole	Nizoral®	2% cream
1 Ketoconazole	Nizoral AD®	1% OTC, 2% shampoo
1 G Nystatin	Mycostatin®	100,000 units/gm cream & oint, powder
1 Oxiconazole	Oxistat®	1% cream
Restriction: Prior authorization required.		
1 G Terbinafine	Lamisil®	1% cream
Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).		
Topical - Anti-infective		
1 G Clindamycin	Cleocin-T®	1% soln, gel
1 G Erythromycin		2% soln

Continued on next page

GENERIC	BRAND	FORMS
Topical - Anti-infective, continued • SEE PREVIOUS PAGE		
1 Mupirocin	Bactroban®	2% oint
Efficacy of decolonization in preventing re-infection or transmission in the outpatient setting is not documented, and NOT routinely recommended. Consultation with an infectious disease specialist is recommended before eradication of colonization is initiated. Plan allows 1 tube per dispensing per infectious episode.		
1 Selenium	Selsun®	2.5% shampoo
1 Silver Sulfadiazine	Silvadene®	1% cream
Topical - Antineoplastic		
1 Fluorouracil	Efudex®	1%, 5% cream, 2%, 5% soln
Topical - Antiviral		
1 Imiquimod	Aldara®	5% cream
Restriction: 12 packets per 30 days. Preferred for genital warts.		
1 Podofilox	Condylox®	0.5% soln
Restriction: Consider second line to imiquimod.		
Topical - Contraceptive		
1 Diaphragm		
1 Etonogestrel/ethinyl estradiol	Nuvaring®	0.12-0.15 mg vaginal ring
1 Norelgestromin- ethinyl estradiol	Xulane®	150mcg/20mcg/day patch
Restriction: Plan does not cover replacement patches. Limited to 3 patches/28 days or 6 patches/56 days.		
Topical - Enzymes		
1 Hyaluronidase		various
Restriction: Used for skin test, dehydration, dispersion/absorption enhancement of injected drugs.		
Topical - Estrogens		
1 Estradiol	Climara®, Vivelle®	Biweekly- 0.025mg, 0.0375mg, 0.075mg, 0.1mg patch Weekly- 0.025mg, 0.05mg, 0.06mg, 0.075mg, 0.1mg patch
Topical - Glucocorticoid a Low Potency		
1 Betamethasone	Valisone®	0.05% cream, oint, lotion, 0.1% cream, 0.1% oint, 0.05%, 0.1% lotion

Continued on next page

GENERIC	BRAND	FORMS
Topical - Glucocorticoid a Low Potency, continued • SEE PREVIOUS PAGE		
1 Fluocinolone	Synalar®	0.01%, 0.025% cream, 0.01% soln
1 Flurandrenolide	Cordran®	0.05% cream, oint, lotion
1 Hydrocortisone		0.5%, 1% cream, 2.5% cream, oint & lotion are also available OTC
1 Triamcinolone	Kenalog®	0.025% cream, oint, lotion
Topical - Glucocorticoid b Medium Potency		
1 Mometasone	Elocon®	0.1% cream, oint, lotion
Restriction: Prior authorization required.		
1 Triamcinolone	Kenalog®	0.1% cream, oint, lotion
Topical - Glucocorticoid c High Potency		
1 Betamethasone dipropionate	Diprosone®	0.05% cream, oint
1 Clobetasol	Temovate®	0.05% cream, oint, soln, lotion
Restriction: Prior authorization required.		
1 Fluocinonide	Lidex®	0.05% cream, oint, soln, gel
1 Triamcinolone	Kenalog®	0.5% cream, oint
Topical - Miscellaneous		
1 Acetic Acid		0.25% soln
1 Anthralin	Drithocreme HP®	1% cream
1 Calcipotriene	Dovonex®	0.005% cream
Restriction: Member needs to fail topical steroids (triamcinolone, betamethasone). 120g maximum.		
1 * Sodium Chloride		0.9% soln
Topical - Scabicide		
1 Crotamiton	Eurax®	10% cream and lotion
Restriction: Prior authorization required.		
1 Permethrin	Elimite®	5% cream
Restriction: Prior authorization required.		

GENERIC	BRAND	FORMS
Urinary Tract		
1 Oxybutynin	Ditropan®	5mg tablet
1 Pentosan	Elmiron®	100mg capsule
1 Phenazopyridine	Pyridium®	100mg, 200mg tablet
Restriction: Maximum therapy allowed is three days.		
Vaccines - Immune Globulin		
Vaccines play an important part in enhancing one's health. The plan allows the following vaccines without authorization. As many of these are covered under the Vaccines For Children program, the ingredient cost is carved out from the plan. They should be billed to the VFC program. Extensive documentation is required for reporting to the California Immunization Registry (CAIR), member consent, and provider notification. This documentation is required to be available. The vaccines below are billed to KHS for members over the age of 19 unless otherwise noted. In addition to age limits, limits exist on number per lifetime, and limits per injection. Vaccines needed for employment or travel are not covered benefits.		
1 * Hepatitis A	Havrix®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.		
1 * Hepatitis A & B	Twinrix®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime.		
1 * Hepatitis B	Engerix-B®, Heplisav-B®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime, 2 for Heplisav-B.		
1 * Influenza	Fluzone®, Fluvirin®, Fluvarix®, others	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 1 per flu season.		
1 * Measles, Mumps, Rubella	M-M-R II®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.		
1 * Menigitits	Menveo®, Menomune®, Bexsero®, Trumenba®, others	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).		

Continued on next page

GENERIC	BRAND	FORMS
Vaccines - Immune Globulin, continued • SEE PREVIOUS PAGE		
1 * Papillomavirus	Gardasil®, Cervarix®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime. Maximum age 26 years.		
1 * Pneumococcal	Prevnar 13®, Prevnar 23®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).		
1 * Rabies	Hyperrab®, Imogam rabies®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).		
1 * TDAP	Boostrix®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).		
1 * Tetanus	Adacel®, Tenivac®, others	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).		
1 * Varicella	Varivax®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.		
1 * Varicella-zoster	Shingrix®	50 mcg
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). >50 years. Limit 2 per lifetime.		
1 * Zoster	Zostavax®	various
Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 1 per lifetime. >50 years.		
Vaginal - Anti-infective		
1 Butoconazole	Gynazole-1®	2% vaginal cream
Restriction: Restricted to patients who have failed first line agents (Clotrimazole, Miconazole).		
1 G Clindamycin	Cleocin®	2% vaginal cream
1 G Metronidazole	Metrogel®	0.75% Vaginal Gel
1 G Nystatin	Mycostatin®	100,000 units vaginal tablet
1 Sulfanilamide	Sultrin®	15% vaginal cream, 1.05 gm vaginal supp

Continued on next page

GENERIC	BRAND	FORMS
Vaginal - Anti-infective, continued • SEE PREVIOUS PAGE		
1 G Terconazole	Terazol®	0.4%, 0.8% vaginal cream, 80mg vaginal supp
Restriction: Restricted to patients who have failed first line agents (Clotrimazole, Miconazole).		
1 G Tioconazole	Vagistat 1®	6.5% vaginal oint
Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).		
Vaginal - Estrogens		
1 G Estradiol	Estrace®	0.01% cream
1 Estrogens, Conjugated	Premarin Vaginal Cream®	0.625mg/gm cream
Vitamins - Dietary Supplements		
1 G Calcitriol	Rocaltrol®	0.25mcg, 0.5mcg capsule
1 G Cyanocobalamin		1000mcg injection
Restriction: Restricted to documented deficiency. Consider sublingual supplementation.		
1 G Ergocalciferol	Drisdol®	50,000 IU capsule
1 G Folic acid		1mg tablet
Restriction: Pregnant women and those on MTX therapy.		
1 Levocarnitine	Carnitor®	10% soln, 330mg tablet
Restriction: Prior authorization required.		
1 G Pediatric Vitamins w/Fluoride	Poly-Vi-Flor®, Tri-Vi-Flor®	0.25mg/ml, 0.5mg/ml drops, 0.25mg, 0.5mg, 1mg chewable tablet
Restriction: Restricted to members < 5 years old.		
1 G Pediatric Vitamins w/Fluoride & Iron	Poly-Vi-Flor w/Iron®, Tri-Vi-Flor w/Iron®	0.25mg-10mg/ml drops
Restriction: Restricted to members < 5 years old.		
1 G Prenatal Vitamins w/Minerals, Iron & Folic Acid		capsule or tablet
Restriction: Pregnant females only.		
1 G Sodium Fluoride	Luride®	0.55mg(0.25mgF), 1.1mg(0.5mgF), 2.2mg(1mgF) chewable tablet, 0.125mg/drop, 0.275mg/drop, 0.55mg/drop, 1.1mg/ml drops

GENERIC	BRAND	FORMS
Analgesics - Non-narcotic/OTC		
Acetaminophen (APAP, Tylenol®) hepatotoxicity can result from frequent and/or high doses of those medications with an acetaminophen component. Maximum recommended daily dose of APAP for a patient who does not drink alcohol is 4000mg. Patients may also aggravate the problem by taking other OTC drugs with APAP or receiving prescriptions of other APAP combinations (Norco®, Tylenol #3).		
1 G Acetaminophen	Tylenol®	325mg, 500mg, 650mg tablet, 100mg/ml, 160mg/5ml soln
1 G Aspirin	ASA	81mg, 325mg, 650mg tablet & ec tablet, 325mg buffered tablet
1 G Ibuprofen	Motrin®	100mg/5ml susp, 200mg tablet
Restriction: FDA does not recommend in children < 6 months.		
Cardiovascular - Antilipid/OTC		
1 G Niacin		100mg, 250mg, 500mg tablet, 125mg cr capsule, 125mg, 250mg cr tablet
Cardiovascular - Electrolyte/OTC		
1 G Oral electrolyte Soln	Pedialyte®	Soln
Restriction: Limited to 3000 ml per dispensing.		
Contraceptive/OTC		
1 Condoms-Male		
Restriction: Limited to 12 per 30 days.		
1 Nonoxynol-9	Emko®	8%,12.5% foam, 2% gel
Device - Supplies/OTC		
1 Blood pressure monitor		
Restriction: One per member per 5 years. $50 maximum per unit.		
1 Braces		various (knee, ankle, wrist)
Restriction: One per affected area per member per 12 months. $50 maximum per unit.		
1 Crutches		various
Restriction: One pair per member per 12 months		

Continued on next page

GENERIC	BRAND	FORMS
Device - Supplies/OTC, continued • SEE PREVIOUS PAGE		
1 Nebulizer		various
Restriction: One per member per 3 years. $65 maximum per unit.		
1 Tablet Splitter		
1 Thermometer		
1 Vaporizer		
Gastrointestinal - Antacid/OTC		
1 G Aluminum & Magnesium Hydroxides	Maalox®	200mg-200mg/5ml susp
1 G Aluminum & Magnesium Hydroxides w/Simethicone	Mylanta®	200mg-200mg-25mg chewable tablet, 400mg-400mg-40mg/ 5ml susp
1 Aluminum Hydroxide & Mag. Trisilicate	Gaviscon®	80mg-14.2mg chewable tablet
1 Aluminum Hydroxide, Mag. Carbonate	Gaviscon®	160mg-105mg chewable tablet, 31.7mg-119.3mg/5ml susp
1 G Calcium		500mg tablet
1 G Calcium Carbonate (20 mEq Ca++/Gm) Calcium Carbonate w/Vitamin D	Tums® Os-Cal D®	650mg tablet, 1250mg tablet or capsule, 500mg tablet
1 G Calcium Gluconate (4.5mEq Ca++/Gm)		500mg, 650mg, 1 gm tablet
1 G Calcium acetate (12.5mEq Ca++/Gm)		667mg tablet
1 G Calcium lactate (6.5mEq Ca++/Gm)		325mg, 650mg tablet
1 G Magaldrate	Riopan®	540mg/5ml susp
Gastrointestinal - Antidiarrhea/OTC		
1 G Loperamide	Imodium®	2mg capsule, tablet, 1mg/5ml liquid

GENERIC	BRAND	FORMS
Gastrointestinal - Antiemetic/OTC		
1 65 G Doxylamine Succinate		25mg tablet
Restriction: Restricted to plan OB/GYN only.		
1 G Meclizine	Antivert®	25mg chewable tablet
Gastrointestinal - H2 Antagonist/OTC		
1 G Famotidine	Pepcid AC®	10mg tablet
Restriction: Minimum of 30/package.		
Gastrointestinal - Laxative /OTC		
1 G Bisacodyl	Dulcolax®	5mg tablet, 10mg supp
Restriction: Tablet for colon diagnostic testing only.		
1 G Docusate	Colace®	100mg, 250mg capsule, 10 mg/5 ml syrup for members < 6 years old NMT 240 ml/ rx, 20 mg/5 ml, 50 mg/5 ml liq
1 G Magnesium citrate		solution
Restriction: For colon diagnostic testing only.		
1 G Mineral oil	Fleets®	enema
Restriction: For colon diagnostic testing only.		
Gastrointestinal - Protectant/OTC		
1 G Bismuth Subsalicylate	Pepto-Bismal®	262mg tablet or chewable tablet, 525mg/15ml 527mg/30ml susp
Hematinic/OTC		
1 G Ferrous Gluconate	various	240mg, 324mg tablet
1 G Ferrous Sulfate	Fer-in-Sol®	75mg/ml soln, 300mg/5ml syrup, 324mg tablet, 325mg cr & ec tablet
Hormones - Antidiabetic/OTC		
1 * Insulin, human	Humulin®, Novolin®	100 units/ml
Ophthalmic - Antihistamine/OTC		
1 G Ketotifen	Zaditor®	0.025% ophth soln
Ophthalmic - Decongestant/OTC		
1 G Naphazoline	Albalon®	0.1% ophth soln

GENERIC	BRAND	FORMS
Ophthalmic - Decongestant - Antihistamine/OTC		
1 G Naphazoline & Pheniramine	Naphcon-A®	0.025%-0.3% ophth soln
Ostomy Items/OTC		
1 Ostomy supplies		various
Restriction: Pouches are allowed 30 per 30 days.		
Otic/ OTC		
1 G Carbamide Peroxide	Debrox®	6.5% soln
Respiratory - Antihistamine/OTC		
The FDA does not recommend antihistamines and other cough/cold products in individuals under the age of 2 years old. These products are restricted to members 2 years old and older. Unless a single antihistamine product, the following are allowed up to age 21 by DHCS.		
1 G Brompheniramine		2mg/5ml elixir
1 G Cetirizine	Zyrtec®	5 mg, 10 mg tablet, 1 mg/ml liq
Restriction: Limited to patients < 18 years old. Liquid allowed < 5 years old.		
1 G Chlorpheniramine	Chlortrimeton®	1mg/5ml liquid, 2mg/5ml syrup, 2mg, 4mg chewable tablet, 4mg tablet, 8mg, 12mg cr tablet, 6mg, 8mg, 12mg cr capsule
1 G Diphenhydramine	Benadryl®	12.5mg/5ml elixir or syrup, 25mg, 50mg capsule or tablet
1 G Loratadine	Claritin®	10mg quick dissolving tablet, 10mg tablet, 5mg/5ml syrup
Restriction: Liquid allowed < 5 years old.		
Respiratory - Antihistamine - Decongestant/OTC		
Restricted to members between the ages 4-21 years.		
1 G Brompheniramine & Phenylephrine	Dimetapp® new formualtion	1mg-2.5mg/5ml elixir
1 G Chlorpheniramine & Phenylephrine	Contac®	1mg-2.5mg/5ml, 2mg-5mg/5ml, 4mg-10mg/5ml, syrup, 2mg-5mg tablet, 4mg-20mg cr tablet
1 G Chlorpheniramine & Pseudoephedrine	Sudafed Plus®	2mg-30mg, 4mg-60mg tablet

GENERIC	BRAND	FORMS
Respiratory - Antihistamine - Decongestant - Antitussive/OTC		
Restricted to members between the ages 4-21 years.		
1 G Pseudoephedrine, Brompheniramine & Dextromethorphan	Dimetane DX®	30mg-2mg-10mg/5ml syrup
1 G Pseudoephedrine, Chlorpheniramine & Dextromethorphan	Pediacare®	15mg-1mg- 5mg/5ml, 15mg-1mg-7.5mg/5ml, 30mg-2mg-10mg/5ml liquid & syrup
Respiratory - Antitussive/OTC		
Restricted to members between the ages 4-21 years.		
1 G Dextromethorphan	Robitussin Pediatric®	7.5mg/5ml, 10mg/5ml syrup
Respiratory - Antitussive - Expectorant/OTC		
Restricted to members between the ages 4-21 years.		
1 G Dextromethorphan & Guaifenesin	Robitussin DM®	10mg-100mg/5ml, 15mg-200mg/5ml, 30mg-200mg/5ml liquid, 3.33mg-33.3mg/5ml, 6.67mg-66.7mg/5ml syrup
Respiratory - Decongestant/OTC		
Restricted to members between the ages 4-21 years.		
1 G Pseudoephedrine	Sudafed®	30mg, 60mg, 120mg tablet, 15mg/5ml, 30mg/5ml liquid
Respiratory - Expectorant/OTC		
Restricted to members between the ages 4-21 years.		
1 G Guaifenesin	Robitussin®	100mg/5ml, 200mg/5ml syrup
Respiratory - Miscellaneous/OTC		
1 * G Sodium Chloride		0.9% nebulizer soln
Respiratory - Nasal Glucocorticoids/OTC		
1 G Triamcinolone	Nasacort Allergy 24 HR OTC®	55 mcg mdi
Supplies - Diabetic/OTC		
1 Alcohol		70%, 91% topical soln

Continued on next page

GENERIC	BRAND	FORMS
Supplies - Diabetic/OTC, continued • SEE PREVIOUS PAGE		
1 * Blood Glucose Strips	TRUE Metrix®	strip
Restriction: Restricted to True Metrix ® or Fora®. True Metrix® meters are billed with a special code from Trividia and are preferred. Fora® meters are ordered directly from the manufacturer. Please write prescriptions for strips, lancets, etc. The members should then have the pharmacy fill the meter and strips together so as to ensure the correct products are given. Plan allows up to #100/30 days for Type I, #100/90 days for Type II, and #150/30 days for gestational diabetics.		
1 * Lancets		
1 * Syringes, Syringes w/Needles, Pen Needles	TRUEplus®	
Restriction: Requires insulin to clear. Coinsides with insulin vial, pen. Limit up to 200 per 40 days.		
1 * G Urine Test Strips	Keto-Diastix®, Ketostix®	strip
Topical - Acne/OTC		
1 Adapalene	Differin®	0.1% gel
Restriction: Max 45 g per dispensing per 30 days.		
1 G Benzoyl Peroxide	Benzagel®	5%, 10% gel
Topical - Antibiotic/OTC		
1 G Bacitracin		ointment
1 G Neomycin, Bacitracin & Polymyxin	Neosporin®	ointment
Topical - Antifungal/OTC		
1 G Clotrimazole	Lotrimin®	1% cream, oint, soln
Restriction: Solution allowed by ENT.		
1 G Miconazole	Micatin®	2% cream
1 G Tolnaftate	Tinactin®	1% cream and soln
Topical - Anti-Infective/OTC		
1 G Calamine		plain, phenolated lotion
Topical - Astringent/OTC		
1 Aluminum Acetate	Domeboro's Soln®	Powder

GENERIC	BRAND	FORMS
Topical - Glucocorticoid/OTC		
1 G Hydrocortisone		0.5%,1% cream, oint, lotion
Topical - Scabicide/OTC		
1 G Permethrin	Nix®	1% cream rinse
1 G Pyrethrins-Piperonyl	Rid®	4%-0.33% liquid
Vaginal - Anti-infective/OTC		
1 Butoconazole	Gynazole 1®	2% vaginal cream
1 G Clotrimazole	Gyne-lotrimin®	1% vaginal cream
1 G Miconazole	Monistat®	2% vaginal cream, vaginal kit, 100mg vaginal supp
Vitamins/OTC		
1 G Pediatric Vitamins	Tri-Vi-Sol®	ADC plain and w/iron drops
Restriction: Restricted to patients < 5 years old.		
1 G Prenatal Vitamins w/Minerals, Iron & Folic Acid		0.1mg, 1mg Folic Acid capsule, 0.4mg, 0.8mg, 1mg Folic Acid tablet
Restriction: Pregnant female members only.		
1 G Prenatal Vitamins w/Minerals, Iron & Folic Acid, w/DHA		0.1mg, 1mg Folic Acid capsule, 0.4mg, 0.8mg, 1mg Folic Acid tablet
Restriction: Pregnant female members only.		
1 G Pyridoxine (Vitamin B-6)		25mg, 50mg, 100mg tablet
1 G Vitamin E		400 international units, 1000 international unit capsule

THIS PAGE LEFT BLANK INTENTIONALLY

Appendix

These medications are carved out by Medi-Cal as stated in the Medi-Cal bulletin. The prescriptions for any of the carved out medications are transmitted to Medi-Cal. **If the claim for the listed drugs is rejected by EDS for a Kern Family Health Care patient with a message stating to bill the primary insurance it is likely the patient has insurance in addition to Kern Health Systems. Some prescriptions may require a TAR from Medi-Cal.**

Psychotherapeutic Agents

Amantadine
Aripipazole ..... Abilify®
Asenapine ..... Saphris®
Benztropine ..... Cogentin®
Biperidin ..... Akineton®
Brexpiprazole ..... Rexulti®
Cariprazine ..... Vraylar®
Chlorpromazine ..... Thorazine®
Clozapine ..... Clozaril®
Fluphenazine ..... Prolixin®
Haloperidol ..... Haldol®
Iloperidone ..... Fanapt®
Isocarboxazid ..... Marplan®
Lithium
Loxapine ..... Loxitane®
Lurasidone ..... Latuda®
Molindone ..... Moban®
Olanzapine ..... Zyprexa®
Olanzapine & fluoxetine ..... Symbyax®
Paliperidone ..... Invega®
Perphenazine ..... Trilafon®
Phenelzine ..... Nardil®
Pimozide ..... Orap®
Promazine ..... Sparine®
Quetiapine ..... Seroquel®
Risperidone ..... Risperdal®
Selegiline ..... Emsam®
Thioridazine ..... Mellaril®
Thiothixene ..... Navane®
Tranylcypromine ..... Parnate®
Trifluoperazine ..... Stelazine®
Trifluopromazine ..... Vesprin®
Trihexyphenidyl ..... Artane®
Ziprasidone ..... Geodon®

Alcohol, Heroin Detoxification and Dependency Treatement Drugs

Acamposate ..... Campral®
Buprenorphrine ..... Subutex®, Butrans®
Buprenorphrine/naloxone ..... Suboxone®
Disulfiram ..... Antabuse®
Naloxone ..... Narcan®
Naltrexone ..... Revia®

Antiviral Agents

Abacavir ..... Ziagen®
Abacavir, dolutegravir & lamivudine ..... Trimeq®
Abacavir, lamivudine..... Epzicom®
Abacavir, lamivudine & zidovudine..... Trizivir®
Amprenavir ..... Agenerase®
Atazanivir ..... Reyataz®
Atazanivir & cobicistat ..... Evotaz®
Bictegravir, emtricitabine, tenofovir, alafenamide..... Biktarvy®
Cobicistat..... Tybost®
Darunavir..... Prezista®
Darunavir & cobicistat..... Prezcobix®
Darunavir, cobicistat, emtricitabine, tenofovir, alafenamide ..... Symtuza®
Delavirdine..... Rescriptor®
Dolutegravir ..... Tivicay®
Dolutegravir, rilpivirine ..... Juluca®
Doravine..... Pifeltro®
Doravine, lamivudine, tenofovir..... Delstrigo®
Efavirenz ..... Sustiva®
Efavirenz, emtricitabine & tenofovir ..... Atripla®
Efavirenz, lamivudine, tenofovir ..... Symfi®
Elvitegravir..... Vitekta®
Elvitegravir, cobicistat, emitricitabine & tenofovir..... Stribild®, Genvoya®
Emicitabine ..... Emitriva®
Emicitabine, rilpivirine & tenofivir ..... Complera®, Odefsey®
Emtricitabine, tenofovir ..... Descovy®
Enfuvirtide..... Fuzeon®
Etravirine ..... Itelence®
Fosamprenavir..... Levixa®
Ibalizumab-uiyk ..... Trogarzo®
Indinavir ..... Crixivan®
Lamivudine ..... Epivir HBR®, Epivir®
Lamivudine & zidovudine ..... Combivir®
Lopinavir & ritonavir ..... Kaletra®
Maraviroc..... Selzentry®
Nelfinavir ..... Viracept®
Nevirapine..... Viramune®
Raltegravir ..... Isentress®
Rilpivirine..... Edurant®
Ritonavir ..... Norvir®
Saquinavir..... Invirase®
Stavudine ..... Zerit®
Tenofivir ..... Viread®
Tenofivir & emtricitabine ..... Truvada®
Tipranavir..... Aptivus®

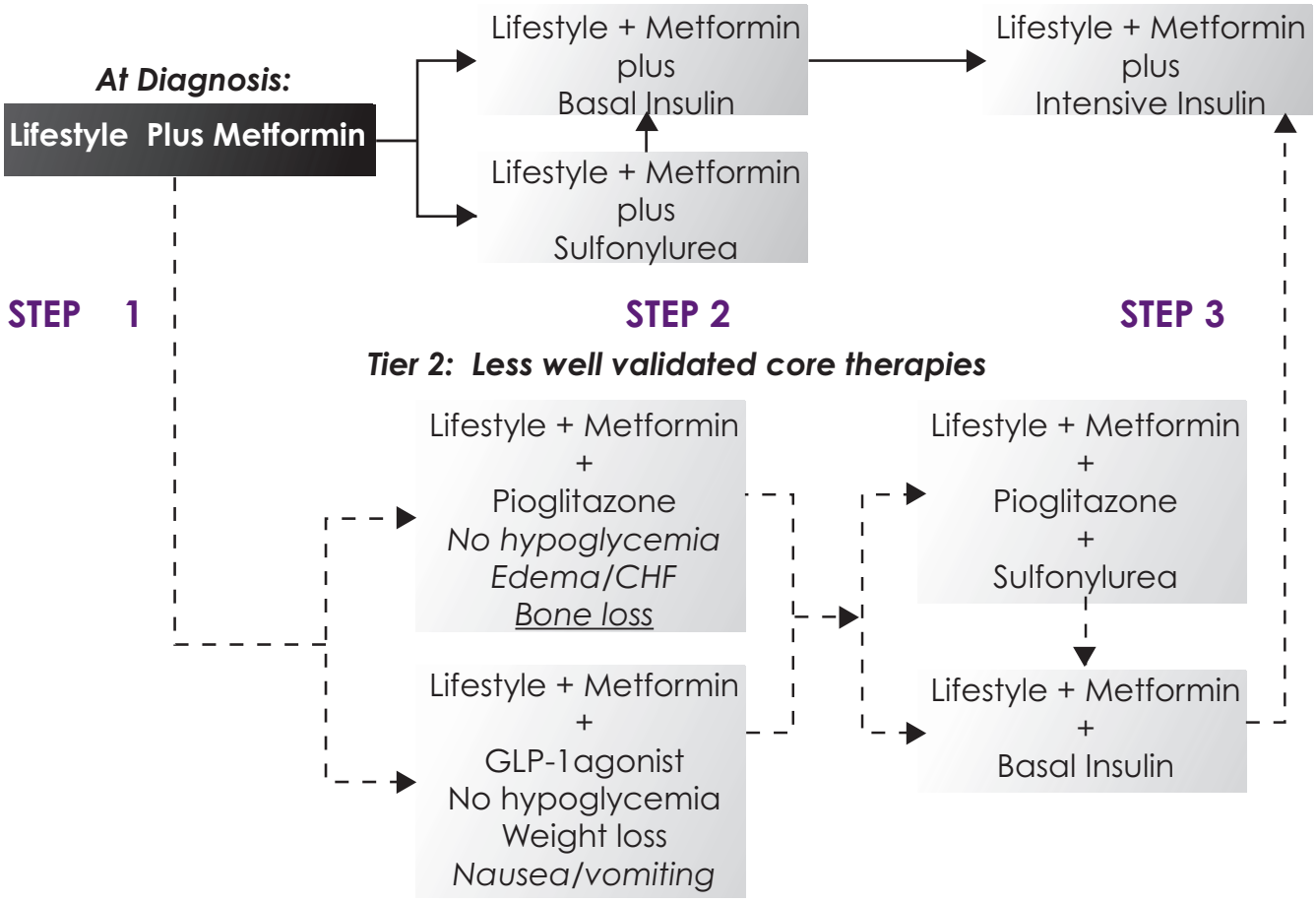
Blood Factors

Please refer to FFS Medi-Cal for full listing.

Management of Type 2 Diabetes Treatment

Algorithm for the metabolic management of Type 2 diabetes

Tier 1: Well validated core therapies



Type 2 Diabetes is treated in a step wise manner from the time of diagnosis:

Always included in the treatment is Lifestyle Intervention and Exercise. These components are always complementary to medication therapies and include medical nutrition therapy, weight loss and regular daily exercise. The most convincing long term data that weight loss effectively lowers glycemia have been generated in the follow up of type 2 diabetic patients who have had bariactric surgery. In this setting, with a mean sustained weight loss of > 20 kg, diabetes is virtually eliminated.

Management of Type 2 Diabetes Treatment, continued...

Intervention	A1C response (%)	Advantages	Disadvantages
TIER 1: Well validated core Rx			
• **Step 1**: Initial Therapy Lifestyle to decrease weight & increase activity	1.0-2.0	Broad benefits	Insufficient for most in 1 year
• Metformin	1.0-2.0	Weight neutral	GI side effects; contraindicated renal insufficiency

Titration of Metformin

1. Begin with low dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mgm once per day.
2. After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner)
3. If gastrointestinal side effects appear as doses advanced, decrease to previous lower dose and try to advance the dose at a later time.
4. The maximum effective dose can be up to 1,000 mg twice per day but is often 850 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.
5. Based on cost considerations, generic metformin is the first choice of therapy. A longer acting formulation is available in some countries and can be given once per day.

The major action of metformin is to decrease hepatic glucose output and lower fasting glycemia.

• **Step 2**: additional therapy if A1C is 7 or greater after 2-3 months of step one:			
Insulin (basal insulin-Lantus) Humalog, Apidra, Novolog	1.5-3.5	No dose limit; Rapidly effective Improved lipid profile.	1-4 injections daily, wt.+, Monitoring; Hypoglycemia hypoglycemia, Wt. gain expensive med
Sulfonylurea	1.0-2.0	Rapidly effective	
TIER 2: less well validated. Oral therapy without insulin			
TZDs	0.5-1.4	Improved lipid profile (actos) Potential decrease in MI (actos)	Fluid retention CHF, Wt. +, bone fxs; Potential MI increase (avandia)
GLP-1 Agonist (exenatide) (Byetta)	0.5-1.0	Wt. -	2 injections daily frequent GI side effects Long term safety??? Expensive
Other therapy (all expensive)			
DPP-4 inhibitor (Januvia)	0.5-0.8	Wt. neutral	Long term safety?
Pramlintide (Amylin)	0.5-1.0	Wt. -	3 injections daily, Long term safety? Frequent GI side effects

Management of Type 2 Diabetes Treatment, continued...

Step 2: Addition of a second medication. If lifestyle intervention and the maximal tolerated dose of metformin fail to achieve or sustain the glycemic goals, another medication should be added within 2-3 months of the initiation of therapy or at any time the target A1C level is not achieved. Another medication may also be necessary if metformin is contraindicated or not tolerated. The consensus regarding the second medication was to choose either insulin or a sulfonylurea. The A1C level will determine in part which agent is selected next, with consideration given to the more effective glycemia-lowering agent, insulin, for patients with an A1C level >8.5% or with symptoms secondary to ehyperglycemia. Insulin may be initiated with a basal (intermediate to long acting) insulin. However, many newly diagnosed type 2 diabetic patients will usually respond to oral medications, even if symptoms of ehyperglycemia are present.

Step 3: Further adjustments. If lifestyle, metformin, and sulfonylurea or basal insulin do not result in achievement of target glycemia, the next step should be to start, or intensify, insulin therapy. Intensification of insulin therapy usually consists of additional injections that might include a short- or rapid-acting insulin given before selected meals to reduce postprandial glucose excursions. When insulin injections are started, insulin secretagogues (sulfonylureas or glinides) should be discontinued, or tapered and then discontinued, since they are not considered to be synergistic. Although addition of a third agent can be considered, especially if the A1C level is close to target (A1C <8.0%), this approach is usually not preferred, as it is no more effective in lowering glycemia, and is more costly, than initiation or intensifying insulin.

Special considerations/patients. In the setting of severely uncontrolled diabetes with catabolism, defined as fasting plasma glucose levels > 13.9mmol/l (250 mg/dl), random glucose levels consistently above 16.7 mmol/l (300 mg/dl), A1C above 10%, or the presence of ketonuria, or as symptomatic diabetes with polyuria, polydipsia and weight loss, insulin therapy in combination with lifestyle intervention is the treatment of choice. Some patients with these characteristics will have unrecognized type 1 diabetes; others will have type 2 diabetes with severe insulin deficiency. Insulin can be titrated rapidly and is associated with the greatest likelihood of returning glucose levels rapidly to target levels. After symptoms are relieved and glucose levels decreased, oral agents can often be added and it may be possible to withdraw insulin, if preferred.

Insulin Therapy

Start with bedtime intermediate-acting insulin
Or bedtime or morning long-acting insulin (can Initiate with 10 units or 0.2 units per kg)

Check fasting glucose (fingerstick) usually daily and increase
dose, typically by 2 units every 3 days until fasting levels are
consistently in target range (3.9-7.2 mmol/l [70-130 mg/dl]). Can increase dose in larger increments, e.g., by 4 units every 3 days, if fasting glucose is >10 mmol/l (180mg/dl)

If hypoglycemia occurs, or if fasting glucose level < 3.9mmol/l [70mg/dl], Reduce bedtime dose by 4 units or 10% - whichever is greater.

If A1C is <7%, continue regimen and check A1C every 3 months.

If A1C >7% after 2-3 months

If fasting bg is in target range (3.9 -7.2 mmol/l [70-130mg/dl], check bg before lunch, dinner, and bed. Depending on bg results, add second injection as below. Can usually begin with around 4 units and adjust by 2 units every 3 days until bg is in range

- Pre lunch bg out of range- Add rapid-acting insulin at breakfast
- Pre-dinner bg out of range-Add NPH insulin at breakfast or rapid-acting at lunch
- Pre-bed bg out of range- Add rapid-acting insulin at dinner

A1C >7% after 3 months

Recheck pre-meal bg levels and if out of range, may need to add another injection. If A1C continues to be out of range, check 2 h postprandial levels and adjust preprandial rapid acting insulin.

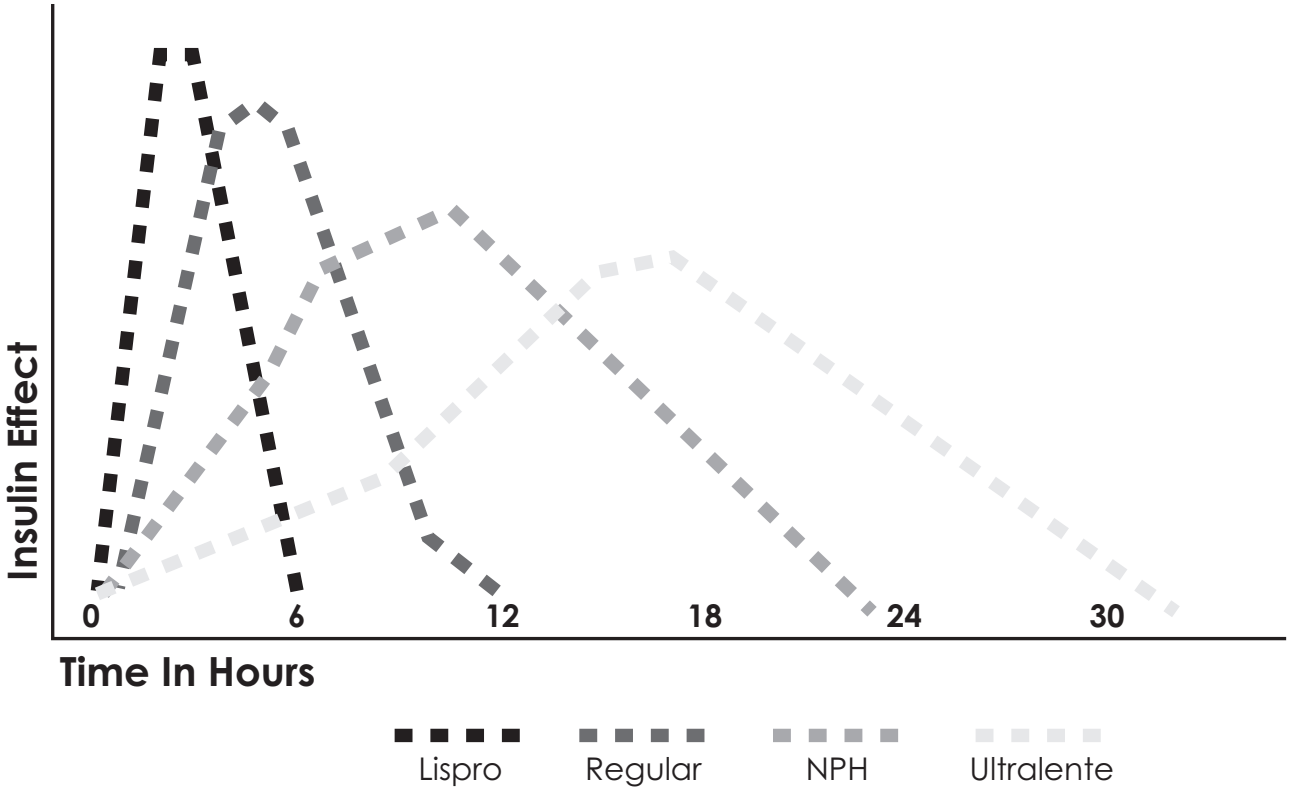
Management of Type 2 Diabetes Treatment, continued...

Insulin Types and Action Times

There are five main types of insulin. They each work at different speeds. Most people who take insulin use two types of insulin and take at least two shots a day.

Type of Insulin/ Name	Letter on Bottle	Starts Working*	Works Hardest*	Stops Working*
Quick acting, Humalog Insulin	lispro H	5-15 minutes	45-90 minutes	3-4 hours
Short acting, Regular Insulin	R	30 minutes	2-5 hours	5-8 hours
Intermediate acting, NPH	N	1-3 hours	6-12 hours	16-24 hours
Long acting, Ultralente Insulin	U	4-6 hours	8-20 hours	24-28 hours
NPH and Regular Insulin mixtures (2 Insulins combined)	70/30 or 50/50	30 minutes	7-12 hours	16-24 hours

*Action times of insulins are based on average responses. How insulin works in an individual body may vary. Work with your doctor and diabetes educator to understand how insulin works in each individual case.



Provided by Kern Health Systems

TREATMENT FOR INFANTS AND YOUNG CHILDREN
(5 years or younger)

Preferred treatments are in bold print.
*Patient education is essential at every step

	Long-Term Preventive	Quick-Relief
STEP 4 **Severe Persistent**	Daily medication: • **Inhaled corticosteroid** - MDI with spacer and face mask >1 mg daily or - Nebulized budesonide >1 mg bid - If needed, add oral steroids-lowest possible dose on an alternate-day, early morning schedule.	• Inhaled short-acting bronchodilator: inhaled Beta2-agonist or ipratropium bromide, or Beta2-agonist tablets or syrup as needed for symptoms, not to exceed 3-4 times in one day.
STEP 3 **Moderate Persistent**	Daily medication: • **Inhaled corticosteroid** - MDI with spacer and face mask 400-800 mcg daily or - Nebulized budesonide <=1 mg bid	• Inhaled short-acting bronchodilator: inhaled Beta2-agonist or ipratropium bromide, or Beta2-agonist tablets or syrup as needed for symptoms, not to exceed 3-4 times in one day.
STEP 2 **Mild Persistent**	Daily medication: • Either **inhaled corticosteroid**, (200-400 mcg) or cromoglycate (use MDI with a spacer and face mask or use a nebulizer)	• Inhaled short-acting bronchodilator: **inhaled Beta2-agonist** or ipratropium bromide, or Beta2-agonist tablets or syrup as needed for symptoms, not to exceed 3-4 times in one day.
STEP 1 **Intermittent**	• None needed.	• Inhaled short-acting bronchodilator: inhaled Beta2-agonist or ipratropium bromide, as needed for symptoms, but not more than three times a week • Intensity of treatment will depend on severity of attack (see figures on management of asthma attacks).

Stepdown
Review treatment every 3 to 6 months. If control is sustained for at least 3 months, a gradual stepwise reduction in treatment may be possible.

Stepup
If control is not achieved, consider stepup. But first: review patient medication technique, compliance, and environmental control (avoidance of allergens or other trigger factors).

TREATMENT: ADULTS & CHILDREN OVER 5 YEARS OLD

Preferred treatments are in bold print.
*** Patient education is essential at every step**

	Long-Term Preventive	Quick-Relief
STEP 4 **Severe Persistent**	Daily medications: • **Inhaled corticosteroid**, 800-2,000 mcg or more, and • Long-acting bronchodilator: either **long-acting inhaled Beta$_2$-agonist**, and/or sustained-release theophylline, and/or long-acting Beta$_2$-agonist tablets or syrup, and • Corticosteroid tablets or syrup long term.	• Short-acting bronchodilator: **inhaled Beta$_2$-agonist** as needed for symptoms.
STEP 3 **Moderate Persistent**	Daily medications: • **Inhaled corticosteroid**, ≥500 mcg AND, if needed • Long-acting bronchodilator: either **long-acting inhaled Beta$_2$-agonist**, sustained-release theophylline, or long-acting Beta$_2$-agonist tablets or syrup. (Long-acting Beta$_2$-agonist may provide more effective symptom control when added to low-medium dose steroid compared to increasing the steroid dose). • Consider adding anti-leukotriene, especially for aspirin-sensitive patients and for preventing exercise-induced bronchospasm.	• Short-acting bronchodilator: **inhaled Beta$_2$-agonist** as needed for symptoms, not to exceed 3-4 times in one day.
STEP 2 **Mild Persistent**	Daily medication: • Either **Inhaled corticosteroid**, 200-500 mcg, cromoglycate, nedocromil, or sustained-release theophylline. Antileukotrienes may be considered, but their position in therapy has not been fully established.	• Short-acting bronchodilator: **inhaled Beta$_2$-agonist** as needed for symptoms, not to exceed 3-4 times in one day.
STEP 1 **Intermittent**	• None needed.	• Short-acting bronchodilator: **inhaled Beta$_2$-agonist** as needed for symptoms, but less than once a week • Intensity of treatment will depend on severity of attack (see figures on management of asthma attacks) • Inhaled Beta$_2$-agonist or cromoglycate before exercise or exposure to allergen.

Stepdown
Review treatment every 3 to 6 months. If control is sustained for at least 3 months, a gradual stepwise reduction in treatment may be possible.

Stepup
If control is not achieved, consider stepup. But first: review patient medication technique, compliance, and environmental control (avoidance of allergens or other trigger factors).

*Dosage note: Steroid doses are for Beclomethasone Dipropionate (on the WHO list of "Essential Drugs"). Other preparations have equal effect, but adjust the dose because inhaled steroids are not equivalent on a microgram or per puff basis.

INDEX–GENERIC and BRAND

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z

Notes

Notes

Kern Family Health Care™

Kern Family Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Kern Family Health Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-391-2000 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-391-2000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-391-2000 (TTY: 711)。

Drug Formulary

Kern Family Health Care™

9700 Stockdale Highway
Bakersfield, California 93311-3617
1-800-391-2000
kernfamilyhealthcare.com

January 2020