Rx prescribe generic first

Kern Family Health Care™

This may be found online at
https://www.kernfamilyhealthcare.com/members/medication-search/

Member handbook may be found online at
https://www.kernfamilyhealthcare.com/members/member-resources/member-handbook/

Drug Formulary

The formulary is updated regularly and is subject to change.
All previous versions of the formulary are no longer in effect.

June 2021

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™

This symbol indicates some or all of the dosage forms are available generically. Prescribing generic brands of medication (and biosimilar and Follow Ons) is key to keeping the escalating medication costs down to a minimum.

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.

Table of Contents

Based on American Hospital Formulary Services (AHFS) Pharmacologic-Therapeutic Classification

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		

Preface

FORMULARY

Members wishing to obtain a formulary or having general questions please call 1-800-391-2000 or visit kernfamilyhealthcare.com.

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

DEFINITIONS

"Brand name drug" is a drug that is marketed under a proprietary, trademark protected name. The brand name drug shall be listed in all CAPITAL letters.

"Enrollee" is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this this formulary template shall also include subscriber as defined in this section below.

"Exception request" is a request for coverage of a prescription drug. If an enrollee, his or her designee or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

"Exigent circumstances" are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

"Formulary" is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

"Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized*** lowercase letters.

"Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

"Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

"Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

"Prescription drug" is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

"Prior Authorization" is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

"Step therapy" is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

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, 2900 Buck Owens Blvd, Bakersfield, CA, 93308, 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 or those needing a prior authorization must be submitted online by the provider or its designee. Please include the CIN number, medication failures, and non-formulary item requested as well as information on the patient. One drug per form please. You may telephone Kern Health Systems about non-formulary requests but State Law does require information to be submitted in writing.

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 to 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 as defined by Title 22 Section 51056 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. In a few instances, a brand may be the preferred drug even though a generic version exists. These are extremely rare and will be clearly identified to the effect.

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, US 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

As a Medicaid plan, there are no tiers. All medications listed in the KHS Formulary are covered if there is no restriction or the restriction(s) is/are met. Any medication authorized through the Prior Authorization process for coverage purposes will be handled like a Formulary drug. Please note that claims may reject at the pharmacy point of service for reasons not listed in the KHS Formulary, such as refill too soon, 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 under the medical benefit 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.

LOCATING A DRUG

A drug may be located in the formulary in a couple of ways. One may search the therapeutic category in the table of contents. Another is to look in the alphabetical index. Both brand and generic names are listed in the index. When locating the drug in the body of the Formulary, identifiers will indicate if a generic is available, the strengths and forms covered, and any restrictions that apply. Further clarity may be communicated in dialogue boxes associated to the categories they apply.

UTILIZATION MANAGEMENT

The health plan uses a variety of methods to provide medically necessary drugs while being cost effective. These methods are called utilization management. Some of these methods include edits that will limit a coverage of a drug due to: prior authorizations, step therapy, quantity limits, refill too soon, therapeutic duplication, drug interaction, age limits, provider limits.

MEDICAL VS PRESCRIPTION BENEFIT

Medications are covered by the either the pharmacy benefit or medical benefit or in some cases both, such as vaccines. Most drugs listed here are considered to be a pharmacy benefit unless otherwise indicated.

FORMULARY CHANGES

The Formulary may be changed throughout the year. The latest version will display the month and year it applies. Earlier versioins should be discarded.

FORMULARY LISTING VS IT BEING PRESCRIBED

Even if a drug is on the Formulary, that does not guarantee the provider will prescribe it. There are some limitations that may apply to the listed drugs, such as the reason your doctor prescribed it, your age, or other medical conditions you may have.

PHARMACIES

Prescriptions may only be filled at pharmacies contracted with Kern Family Health Care. The Provider Directory will help you find a pharmacy. These are mainly in Kern County. If traveling within the state of California, a prescription may be filled at CVS, Rite Aid, Savon-Alberton's-Vons, or Walgreens. Outside the state, or if one of the mentioned pharmacies are not available, the pharmacy will need to contact Kern Family Health Care for prior authorization.

MEDICATIONS	RESTRICTIONS
'Central Nervous System - Antipsychotic - Drugs for the nervous system	
For Kern Family Health Care (KHS Medi-Cal) most of the straight antipsychotic agents are carved out to Medi-Cal. Please see Appendix.	
Amyotrophic Lateral Sclerosis Agents	
G RILUTEK® ***(riluzole)*** 50mg tablet	Restriction: Allowed for amyotrophic lateral sclerosis.
Analgesics - Narcotics - Drugs for pain	
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.*	
G ***codeine sulfate*** 15 mg, 30 mg, 60 mg tablet	Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. Allowed for members > 18 years old.

Continued on next page

MEDICATIONS	RESTRICTIONS
Analgesics - Narcotics - Drugs for pain, continued • SEE PREVIOUS PAGE	
G DILAUDID® ***(hydromorphone)*** 2mg, 4mg tablet, 3mg supp	Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. NMT 120 per month.
G DURAGESIC® ***(fentanyl)*** 12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg 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.
G LEVO-DROMORAN® ***(levorphanol)*** 2 mg tablet	Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses.
G MS-CONTIN® ***(morphine)*** 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.
G NORCO® ***(hydrocodone/apap)*** 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.
G OXY-CONTIN® ***(oxycodone)*** 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.
G PERCOCET® ***(oxycodone w/acetaminophen)*** 5mg-325mg tablet	Restriction: Limited to cancer patients or plan Pain Specialist Physicians. Authorization required for other diagnoses. NMT 120 per month.
G TYLENOL W/CODEINE® ***(codeine w/acetaminophen)*** 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.
G ULTRAM® ***(tramadol)*** 50 mg 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.

MEDICATIONS	RESTRICTIONS
Antiacne	
G ***isotretinoin*** 20 mg, 40 mg capsule	Restriction: Prior authorization required. Allowed for Dermatologists.
Anti-bacterial - Cephalosporin - Drugs for infection	
G ***cefuroxime*** 250mg, 500mg tablet	Restriction: Prior authorization required.
G KEFLEX® ***(cephalexin)*** 125mg/5ml, 250mg/5ml susp, 250mg, 500mg capsule	
G OMNICEF® ***(cefdinir)*** 125 mg/5 ml susp, 250 mg/5 ml susp	Restriction: Restricted to members with Otits Media < 8 years old failing 1st line antibiotics or documented penicillin allergy. Documented ICD-10 code with provider's office required for online submission otherwise submit TAR with documentation.
Anti-bacterial - Drugs for infection	
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 - Macrolide - Drugs for infection	
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*	
G BIAXIN® ***(clarithromycin)*** 125 mg/5 ml, 250 mg/5 ml susp, 250 mg, 500 mg tablet	Restriction: Susp restricted to members < 8 years old w/Otitis Media who have recently failed first line antibiotics. 500mg tablets recommended for members who cannot tolerate or failed azithromycin.
G CLEOCIN® ***(clindamycin)*** 75mg/5ml susp, 75mg, 150mg, 300mg capsule	
G E-MYCIN® ***(erythromycin base)*** 250mg, 333mg, 500mg ec tablet, 250mg ec particles capsule	Restriction: Prior authorization required.

Continued on next page

MEDICATIONS	RESTRICTIONS
Anti-bacterial - Macrolide - Drugs for infection, continued • SEE PREVIOUS PAGE	
G EES® ***(erythromycin ethylsuccinate)*** 200mg/5ml, 400 mg/5 ml, 400mg tablet	Restriction: Prior authorization required.
G ERY-TAB® ***(erythromycin base)*** 250mg, 333mg, 500mg ec tablet, 250mg ec particles capsule	Restriction: Prior authorization required.
G ERYTHROCIN® ***(erythromycin stearate)*** 250mg, 500mg tablet	Restriction: Prior authorization required.
G ZITHROMAX® ***(azithromycin)*** 100mg/5ml, 200mg/5ml susp, 250mg, 600mg tablet, 1 gm powder pack	Restriction: 600mg Tablets – Restricted to members with MAC.
Anti-bacterial - Miscellaneous - Drugs for infection	
65 G FURADANTIN® ***(nitrofurantoin)*** 25mg/5ml susp	Restriction: Limited to members <6 years old.
65 G MACROBID® ***(nitrofurantoin)*** 100mg monohydrate macrocrystalline capsule	Restriction: Limit to 10 day supply unless prescribed by ID or urologist.
G MONUROL® ***(fosfomycin tromethamine)*** 3 gm pckt	Restriction: Limit to ID or urologist for ESBL urinary infections.
G ***neomycin*** 125mg/5ml soln, 500mg tablet	
Anti-bacterial - Penicillin - Drugs for infection	
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.*	
Amoxicillin 250mg/5ml — 150ml — Costs $5 *Amoxicillin-clavulanate 250mg/5ml — 150ml — $89* *Amoxicillin-clavulanate 400mg/5ml — 200ml — $21*	
G AMOXIL® ***(amoxicillin)*** 50 mg/ml drops, 125 mg/5 ml, 250 mg/5 ml, 200 mg/5 ml, 400 mg/5 ml susp, 125mg, 250mg, 500mg capsule	

Continued on next page

MEDICATIONS	RESTRICTIONS
Anti-bacterial - Penicillin - Drugs for infection, continued • SEE PREVIOUS PAGE	
AUGMENTIN® ***(amoxicillin/clavulanate)*** 200 mg/5 ml, 400 mg/5 ml, 600 mg/5 ml susp, 500 mg, 875 mg tablet	Restriction: Restricted to children < 8 years old with Otitis Media. 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.
PRINCIPEN® ***(ampicillin)*** 100mg/ml, 125mg/5ml, 250mg/5ml susp, 250mg, 500mg capsule	
VEETIDS® ***(penicillin vk)*** 125mg/5ml, 250mg/5ml oral soln, 125mg, 250mg, 500mg tablet	
Anti-bacterial - Penicillinase Resistant Penicillin - Drugs for infection	
DYNAPEN® ***(dicloxacillin)*** 62.5mg/5ml susp, 125mg, 250mg, 500mg capsule	
Anti-bacterial - Quinolone - Drugs for infection	
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.*	
CIPRO® ***(ciprofloxacin)*** 250mg, 500mg, 750mg tablet	Restriction: Urologists allowed 28 day supply.
LEVAQUIN® ***(levofloxacin)*** 250mg, 500mg, 750mg tablet	Restriction: Urologists allowed 28 day supply.
Anti-bacterial - Sulfonilamide - Drugs for infection	
BACTRIM®/SEPTRA® ***(sulfamethoxazole & trimethoprim)*** 400mg-80mg, 800mg-160mg tablet, 200mg-40mg/5ml susp	
Anti-bacterial - Tetracycline - Drugs for infection	
MINOCIN® ***(minocycline)*** 50mg, 75mg, 100mg capsule	
VIBRAMYCIN® ***(doxycycline hyclate)*** 50mg, 100mg capsule, 100mg tablet	

MEDICATIONS	RESTRICTIONS
Anti-infective - Antifungal - Drugs for infection	
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.	
G DIFLUCAN® ***(fluconazole)*** 50mg, 100mg, 200mg tablet	Restriction: If needing the 150 mg dose, please use 200 mg.
G ***griseofulvin*** 125mg/5ml susp (microsize)	Restriction: Suspension is for children < 12 years old.
G LAMISIL® ***(terbinafine)*** 250mg tablet	Restriction: 12 week therapy maximum duration.
G MYCELEX® ***(clotrimazole)*** 10mg troche	
G MYCOSTATIN® ***(nystatin)*** 100,000 units/ml susp, 500,000 unit tablet	
G SPORANOX® ***(itraconazole)*** 100mg capsule	Restriction: Trial and failure of fluconazole.
G VFEND® ***(voriconazole)*** 50mg, 200mg tablet, 200mg/5 ml susp	Restriction: Prior authorization required.
Anti-infective - Antihelmintic - Drugs for infection	
ALBENZA® ***(albendazole)*** 200 mg tablet	Restriction: Prior authorization required.
PIN-X® ***(pyrantel)*** 50mg/ml susp, 250mg chewable tablet	
G STROMECTOL® ***(ivermectin)*** 3 mg tablet	
Anti-infective - Antimalarial - Drugs for infection	
G ***chloroquine*** 250 mg tablet	Restriction: Prior authorization required.
G ***primaquine*** 26.3 mg tablet	
Anti-infective - Antiprotozoal - Drugs for infection	
G ***benznidazole*** 12.5mg, 100mg tablet	Restriction: Prior authorization required.
G DARAPRIM® ***(pyrimethamine)*** 25 mg tablet	Restriction: Prior authorization required.
G HUMATIN® ***(paromomycin)*** 250mg capsule	
G MEPRON® ***(atovaquone)*** 750mg/5ml susp	Restriction: Prior authorization required. Sulfa allergy and diagnosis of PCP.

MEDICATIONS	RESTRICTIONS
Anti-infective - Anti-tubercular - Drugs for infection	
INH® ***(isoniazid)*** 50mg/5ml syrup, 50mg, 100mg, 300mg tablet	
MYAMBUTAL® ***(ethambutal)*** 100mg, 400mg tablet	
MYCOBUTIN® ***(rifabutin)*** 150mg capsule	Restriction: Restricted to prevention of MAC in patients with advanced HIV.
pyrazinamide 500 mg tablet	Restriction: Prior authorization required.
RIMACTANE® ***(rifampin)*** 150mg, 300mg capsule	
SEROMYCIN® ***(cycloserine)*** 250mg capsule	

Anti-infective - Anti-viral - Drugs for infection

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*

Continued on next page

MEDICATIONS	RESTRICTIONS
Anti-infective - Anti-viral - Drugs for infection, continued • SEE PREVIOUS PAGE	
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.*	
G BARACLUDE® ***(entecavir)*** 0.5 mg, 1 mg tablet	Restriction: Prior authorization required.
CYTOVENE® ***(ganciclovir)*** 250 mg, 500 mg capsule	Restriction: Prior authorization required.
G EPCLUSA® ***(sofosbuvir/velpatasvir)*** 400mg-100mg tablet	Restriction: Prior authorization required.
G RETROVIR® ***(zidovudine)*** 50mg/5 ml syrup, 100mg capsule	
G TAMIFLU® ***(oseltamivir)*** 30 mg, 45 mg, 75 mg capsule, 6 mg/ml susp	Restriction: Members that are clinically eligible are strongly encouraged to receive the flu vaccine. Exceeding 2 fills within one flu season will require confirmation of infection.
VARIOUS ***(interferon alpha)*** injection	Restriction: Prior authorization required.
VARIOUS ***(ribavirin)*** tablet	Restriction: Prior authorization required.
ZEPATIER® ***(elbasvir/grazoprevir)*** 50-100 mg tablet	Restriction: Prior authorization required.
G ZOVIRAX® ***(acyclovir)*** 200mg/5ml susp, 200mg capsule, 200mg, 400mg, 800mg tablet	
Anti-infective - Drugs for infection	
G FIRVANQ, ® VANCOCIN® ***(vancomycin)*** 25 mg/ml, 50 mg/ml soln, various vials	Restriction: Prior authorization required. Use Firvanq® for oral administrations.
G FLAGYL® ***(metronidazole)*** 250mg, 500mg tablet	
G TINDAMAX® ***(tinidazole)*** 500 mg tablet	Restriction: Prior authorization required.
G ZYVOX® ***(linezolid)*** 600mg tablet	Restriction: Prior authorization required. Reserved for members with VRE.
Anti-infective - Leprosy - Drugs for infection	
G ***dapsone*** 25 mg, 100 mg tablet	

MEDICATIONS	RESTRICTIONS
Antineoplastic - Drugs for Cancer	
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.	
* G ADRUCIL® ***(fluorouracil)*** 500 mg/ml, 2.5 G/50 ml, 5G/100 ml, various	Restriction: Prior authorization required.
* AFINITOR® ***(everolimus)*** 2.5 mg, 5 mg, 7.5 mg capsule	Restriction: Prior authorization required.
* ALKERAN® ***(melphalan)*** 2mg tablet	
* G ARIMIDEX® ***(anastrozole)*** 1mg tablet	
* CAMPTOSAR® ***(irinotecan)*** 100 mg/ 5 ml, 40 mg/2 ml, 300 mg/15 ml IV	Restriction: Prior authorization required.
* G CASODEX® ***(bicalutamide)*** 50 mg tablet	
* CYRAMZA® ***(ramucirumab)*** 100 mg/10 ml, 500 mg/50 ml IV	Restriction: Prior authorization required.
* G CYTOXAN® ***(cyclophosphamide)*** 25 mg, 50 mg capsule	Restriction: Prior authorization required.
* G ***daunorubicin*** 5 mg, 20 mg IV	Restriction: Prior authorization required.
* EMCYT® ***(estramustine)*** 140mg capsule	
* ERIVEDGE® ***(vismodegib)*** 150 mg capsule	Restriction: Prior authorization required.
* G EULEXIN® ***(flutamide)*** 125mg capsule	
* G FEMARA® ***(letrozole)*** 2.5mg tablet	
* G GLEEVEC® ***(imatinib mesylate)*** 100 mg, 400 mg tablet	Restriction: Prior authorization required.
* GLEOSTINE® ***(lomustine)*** 10mg, 40mg, 100mg capsule	

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MEDICATIONS	RESTRICTIONS
Antineoplastic - Drugs for Cancer, continued • SEE PREVIOUS PAGE	
* HALAVEN® ***(eribulin mesylate)*** 1 mg/2 ml IV	Restriction: Prior authorization required.
* HEXALEN® ***(altretamine)*** 50mg capsule	
* G HYREA® ***(hydroxyurea)*** 500mg capsule	
* IXEMPRA® ***(ixabepilone)*** 15 mg, 45 mg IV	Restriction: Prior authorization required.
* G LEUKERAN® ***(chlorambucil)*** 2mg tablet	
* LUPRON® ***(leuprolide)*** 3.75-5 mg, 11.25-5 mg, 22.5 mg syringe	Restriction: Prior authorization required.
* LYSODREN® ***(mitotane)*** 500mg tablet	
* MATULANE® ***(procarbazine)*** 50mg capsule	
* G MEGACE® ***(megestrol)*** 40mg/ml susp, 20mg, 40mg tablet	
* G ***methotrexate*** 2.5mg tablet, 25mg/ml vial	
* MYLOTARG® ***(gemtuzumab ozogamicin)*** 4.5 mg IV	Restriction: Prior authorization required.
* G NOLVADEX® ***(tamoxifen)*** 10mg, 20mg tablet	
* OPDIVO® ***(nivolumab)*** 40mg/4 ml, 100mg/10 ml IV	Restriction: Prior authorization required.
* G ***paclitaxel*** 6 mg/ml vial	Restriction: Prior authorization required.
* PANRETIN® ***(alitretinoin)*** 0.1% gel	Restriction: Prior authorization required.
* PHOTOFRIN® ***(porfimer sodium)*** 75 mg IV	Restriction: Prior authorization required.
* G PURINETHOL® ***(mercaptopurine)*** 50mg tablet	
* REVLIMID® ***(lenalidomide)*** 2.5 mg, 5 mg, 10 mg, 15 mg, 20 mg, 25 mg capsule	Restriction: Prior authorization required.
* G RUXIENCE® ***(rituximab- pvvr)*** 10mg IV	Restriction: Prior authorization required.
* TARGRETIN® ***(bexarotene)*** 75 mg capsule	Restriction: Prior authorization required.

Continued on next page

MEDICATIONS	RESTRICTIONS
Antineoplastic - Drugs for Cancer, continued • SEE PREVIOUS PAGE	
✱ G TEMODAR® ***(temozolomide)*** 5mg, 20mg, 100mg, 140mg, 180mg, 250mg capsule	Restriction: Prior authorization required.
✱ THALOMID® ***(thalidomide)*** 50 mg, 100 mg, 150 mg, 200 mg capsule	Restriction: Prior authorization required.
✱ G ***thioguanine*** 40mg tablet	
✱ G TRAZIMERA® ***(trastuzumab-qyyp)*** 150 mg, 440 mg IV	Restriction: Prior authorization required.
✱ TRELSTAR® ***(triptorelin)*** 3.75 mg, 11.25 mg, 22.5 mg IV	Restriction: Prior authorization required.
✱ G VEPESID® ***(etoposide)*** 50mg capsule	
✱ G ***vincristine*** 1 mg/1 ml, 2 mg/ 2 ml IV	Restriction: Prior authorization required.
✱ VOTRIENT® ***(pazopanib)*** 200 mg tablet	Restriction: Prior authorization required.
✱ YERVOY® ***(ipilimumab)*** 50mg/10 ml, 200 mg/40 ml IV	Restriction: Prior authorization required.
✱ YESCARTA® ***(axicabtagene ciloleucel)*** plastic bag	Restriction: Prior authorization required.
✱ ZALTRAP® ***(ziv-aflibercept)*** 100 mg/ 4 ml, 200 mg/8 ml IV	Restriction: Prior authorization required.
✱ G ZIRABEV® ***(bevacizumab-bvzr)*** 25 mg IV	Restriction: Prior authorization required.
✱ ZOLINZA® ***(vorinostat)*** 100 mg capsule	Restriction: Prior authorization required.
Anti-Parkinsonism	
G COMTAN® ***(entacapone)*** 200 mg tablet	Restriction: Required trial and failure of carbidopa/levodopa alone. Works only in combination with levodopa.
G ***levodopa*** 250mg, 500mg capsule	
G MIRAPEX® ***(pramipexole)*** 0.125mg, 0.25mg, 0.5mg, 1mg, 1.5mg tablet	Restriction: Restricted to Parkinsons only. Requires failure of levadopamine therapy.
G REQUIP® ***(ropinirole)*** 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg, 5mg tablet	Restriction: Restricted to Parkinsons only. Requires failure of levadopamine therapy.

Continued on next page

MEDICATIONS	RESTRICTIONS
Anti-Parkinsonism, continued • SEE PREVIOUS PAGE	
SINEMET® ***(carbidopa & levodopa)*** 10mg-100mg, 25mg-100mg, 25mg-250mg tablet, 25mg-100mg, 50mg-200mg cr tablet	
Antirheumatiod and Disease Modifiers - Drugs for the immune system	
ARAVA® ***(leflunomide)*** 10mg, 20mg tablet	Restriction: Plan rheumatologists only.
AZULFIDINE® ***(sulfasalazine)*** 250mg/5ml susp, 500mg tablet & ec tablet	
* IMURAN® ***(azathioprine)*** 50mg tablet	
methotrexate 2.5mg tablet, 25mg/ml vial	
OTEZLA® ***(apremilast)*** 30 mg tablet	Restriction: Prior authorization required.
PLAQUENIL® ***(hydroxychloroquine)*** 200 mg tablet	Restriction: Prior authorization required.
RIDAURA® ***(auranofin)*** 3 mg capsule	Restriction: Prior authorization required.
Antiuricosuric - Drugs for gout	
BENEMID® ***(probenecid)*** 500mg tablet	
COLBENEMID® ***(colchicine & probenecid)*** 0.5mg-500mg tablet	
ZYLOPRIM® ***(allopurinol)*** 100mg, 300mg tablet	
Autonomic - Anticholinergic - Drugs to reduce GI motility	
65 BENTYL® ***(dicyclomine)*** 10mg/5ml syrup, 10mg, 20mg capsule, 20mg tablet	
LEVSIN® ***(hyoscyamine)*** 0.125mg/ml drops	
ROBINUL® ***(glycopyrrolate)*** 1mg, 2mg tablet	
Autonomic - Cholinergic - Drugs to improve GI motility	
MESTINON® ***(pyridostigmine)*** 60 mg tablet	
PROSTIGMIN® ***(neostigmine)*** 15 mg tablet	
URECHOLINE® ***(bethanechol)*** 5mg, 10mg, 25mg, 50mg tablet	

MEDICATIONS	RESTRICTIONS
Benign Prostate Hypertrophy - Drugs for the prostate	
FLOMAX® ***(tamsulosin)*** 0.4mg capsule	Restriction: Trial and failure of formulary alpha blockers.
PROSCAR® ***(finasteride)*** 5 mg tablet	Restriction: Plan urologists only.
Biologics & Biosimilars	
AVSOLA® ***(infliximab-axxq)*** 100 mg vial	Restriction: Prior authorization required.
COSENTYX® ***(secukinumab)*** 150 mg, 300 mg injection	Restriction: Prior authorization required.
ENBREL® ***(etanercept)*** 25 mg, 50 mg	Restriction: Prior authorization required.
EXTAVIA® ***(interferon beta -1b)*** 0.3 mg injection	Restriction: Prior authorization required. Trial and failure of Glatopa.
GLATOPA® ***(glatiramer acetate)*** 20 mg/ml, 40 mg/ml syringe	Restriction: Prior authorization required. Allowed for Neurologist and failure of steroid therapy.
HUMIRA® ***(adalimumab)*** 40mg/0.8ml	Restriction: Prior authorization required.
Cardiovascular - Alphablocker - Drugs for the heart	
ALDOMET® ***(methyldopa)*** 125mg, 250mg, 500mg tablet	
CARDURA® ***(doxazosin)*** 1mg, 2mg, 4mg, 8mg tablet	
CATAPRES® ***(clonidine)*** 0.1mg, 0.2mg,0.3mg tablet	
HYTRIN® ***(terazocin)*** 1mg, 2mg, 5mg, 10mg tablet or capsule	
MINIPRESS® ***(prazosin)*** 1mg, 2mg, 5mg capsules	
TENEX® ***(guanfacine)*** 1mg, 2mg tablet; 3mg ER tablet	
Cardiovascular - Angiotensin Converting Enzyme Inhibtors - Drugs for the heart	
ACCUPRIL® ***(quinapril)*** 10mg, 20mg, 40mg tablet	
ALTACE® ***(ramipril)*** 1.25mg, 2.5mg, 5mg, 10mg capsule	
LOTENSIN® ***(benazepril)*** 5mg, 10mg, 20mg, 40mg tablet	

Continued on next page

MEDICATIONS	RESTRICTIONS
Cardiovascular - Angiotensin Converting Enzyme Inhibtors - Drugs for the heart, continued • SEE PREVIOUS PAGE	
VASOTEC® ***(enalapril)*** 5mg, 10mg, 20mg tablet	
ZESTRIL® ***(lisinopril)*** 10mg, 20mg, 30 mg, 40mg tablet	
Cardiovascular - Angiotensin Converting Enzyme Inhibtors Combination - Drugs for the heart	
benazepril - hctz 5mg-6.25mg, 10mg-12.5mg, 20mg-12.5mg, 20mg-25mg tablet	
lisinopril - hctz 10mg-12.5mg, 20mg-12.5mg, 20mg-25mg tablet	
Cardiovascular - Angiotensin II Receptor Blocker - Drugs for the heart	
AVAPRO® ***(irbesartan)*** 150mg, 300 mg tablet	
COZAAR® ***(losartan)*** 50 mg, 100 mg tablet	
DIOVAN® ***(valsartan)*** 80mg, 160mg, 320mg tablet	
Cardiovascular - Angiotensin II Receptor Blocker Thiazide Combination - Drugs for the heart	
AVALIDE® ***(irbesartan-hctz)*** 150-12.5mg, 300-25mg tablet	
DIOVANHCT® ***(valsartan-hctz)*** 160-12.5mg, 160-25mg, 320-12.5mg, 320-25mg tablet	
HYZAAR® ***(losartan-hctz)*** 50-12.5mg, 100-12.5mg, 100-50mg tablet	
Cardiovascular - Antiarrhythmic - Drugs for the heart	
amiodarone 200mg tablet	
BETAPACE® ***(sotalol)*** 80mg, 120mg, 160mg, 240mg tablet	
LANOXIN® ***(digoxin)*** 0.05mg/ml elixir, 0.125mg, 0.25mg tablet	
MEXITIL® ***(mexiletine)*** 150mg, 200mg, 250mg capsule	

Continued on next page

MEDICATIONS	RESTRICTIONS
Cardiovascular - Antiarrhythmic - Drugs for the heart, continued • SEE PREVIOUS PAGE	
G NORPACE® ***(disopyramide)*** 100mg, 150mg capsule, 100mg, 150 cr capsule	Restriction: Restricted to plan cardiologists only, others require prior authorization.
G RYTHMOL® ***(propafenone)*** 150mg, 225mg, 300mg tablet	Restriction: plan cardiologists only, others require prior authorization.
G TAMBOCOR® ***(flecainide)*** 50mg, 100mg, 150 mg tablet	Restriction: Restricted to plan cardiologists only, others require prior authorization.
Cardiovascular - Antilipid (HMG - CoA Reductase Inhibitors) - Drugs for the heart	
KHS currently has the "Statin" drugs listed below on the Formulary. ***Half tablet dosing is required on statins.***	
G CRESTOR® ***(rosuvastatin)*** 10mg, 20mg, 40mg tablet	
G LIPITOR® ***(atorvastatin)*** 20mg, 40mg, 80mg tablet	
G PRAVACHOL® ***(pravastatin)*** 20mg, 40mg tablet	
G ZOCOR® ***(simvastatin)*** 10mg, 20mg, 40mg, 80mg tablet	
Cardiovascular - Antilipid - Fibrates - Drugs for the heart	
G ***fenofibrate*** 54mg, 145mg, 160mg tablet	Restriction: Trial and failure of gemfibrozil. Ok first line if on statin therapy.
G LOPID® ***(gemfibrozil)*** 600mg tablet	
Cardiovascular - Antilipid - Lipotropics - Drugs for the heart	
G ZETIA® ***(ezetimibe)*** 10mg tablet	Restriction: Prior authorization required. Should be adjunct to statin therapy.
Cardiovascular - Antilipid - Other Medications - Drugs for the heart	
G COLESTID® ***(colestipol)*** 1g tablet	
G QUESTRAN® ***(cholestyramine)*** Powder (bulk can only)	
Cardiovascular - Betablocker - Drugs for the heart	
G COREG® ***(carvedilol)*** 3.125mg, 6.25mg, 12.5mg tablet	
G INDERAL® ***(propranolol)*** 20mg/5ml, 40mg/5ml oral soln, 10mg, 20mg, 40mg, 60mg, 80mg tablet	

Continued on next page

MEDICATIONS	RESTRICTIONS
Cardiovascular - Betablocker - Drugs for the heart, continued • SEE PREVIOUS PAGE	
G LOPRESSOR® ***(metoprolol tartrate)*** 50mg, 100mg tablet	
G SECTRAL® ***(acebutolol)*** 200mg, 400mg capsule	
G TENORMIN® ***(atenolol)*** 25mg, 50mg, 100mg tablet	
G TRANDATE® ***(labetolol)*** 100mg, 200mg, 300mg tablet	
Cardiovascular - Betablocker Thiazide Combination - Drugs for the heart	
G ***bisoprolol - hctz*** 2.5-6.25 mg, 5-6.25 mg, 10-6.25 mg tablet	
Cardiovascular - Calcium Channel Blocker - Drugs for the heart	
65 G ADALAT CC® ***(nifedipine)*** 30mg, 60mg, 90mg cr tablet	
G CALAN®, CALAN SR® ***(verapamil)*** 40mg, 80mg, 120mg tablet, 120mg cr tablet, 180mg cr tablet, 240mg cr tablet	
G CARDIZEM® ***(diltiazem)*** 30mg, 60mg, 90mg, 120mg tablet, 120mg/24hr, 180mg/24hr, 240mg/24hr, 300mg/24hr, 360mg/24hr cr capsule	
G NORVASC® ***(amlodipine)*** 2.5mg, 5mg, 10mg tablet	
Cardiovascular - Diuretic - Drugs for the heart	
G ALDACTONE® ***(spironolactone)*** 25mg, 50mg, 100mg tablet	
G ***chlorthalidone*** 15mg, 25mg tablet	
G DYAZIDE®, MAXIDE® ***(triamterene & hydrochlorothiazide)*** 37.5mg-25mg capsule, 75mg-50mg tablet	
G DYRENIUM® ***(triamterene)*** 50mg, 100mg capsule	
G ESIDRIX® ***(hydrochlorothiazide)*** 25mg tablet	

Continued on next page

MEDICATIONS	RESTRICTIONS
Cardiovascular - Diuretic - Drugs for the heart, continued • SEE PREVIOUS PAGE	
LASIX® ***(furosemide)*** 8mg/ml, 10mg/ml soln, 20mg, 40mg, 80mg tablet	
LOZOL® ***(indapamide)*** 1.25mg, 2.5mg tablet	
ZAROXOLYN® ***(metolazone)*** 2.5 mg, 5 mg, 10 mg tablet	Restriction: Restricted to members on furosemide therapy.
Cardiovascular - Electrolyte Depleter - Drugs for the heart	
FOSRENOL® ***(lanthunum carbonate)*** 500mg, 750mg, 1000mg chewable tablet	Restriction: Max 3000mg/day.
KAYEXALATE® ***(sodium polystyrene sulfonate)*** 25% susp only	
PHOSLO® ***(calcium acetate)*** 667mg capsule	Restriction: For renal patients only.
potassium chloride 8mEq,10mEq, 20mEq cr tablet, 10%, 20% liquid	
RENVELA® ***(sevelamer carbonate)*** 800mg tablet	Restriction: Maximum of 12 tablets daily if prescribed by a nephrologist. Higher doses require prior authorization, support with lab values.
VELTASSA® ***(patiromer)*** 8.4 g, 16.8g, 25.2 gm powder	Restriction: Prior authorization required.
Cardiovascular - Pulmonary Arterial Hypertension Endothelin Receptor Antagonist - Drugs for the heart	
LETAIRIS® ***(ambrisentan)*** 5 mg, 10 mg tablet	Restriction: Prior authorization required.
TRACLEER® ***(bosentan)*** 62.5 mg, 125 mg tablet	Restriction: Prior authorization required.
Cardiovascular - Pulmonary Arterial Hypertension Phosphodiesterase 5 Inhibitor - Drugs for the heart	
REVATIO® ***(sildenafil)*** 20mg tablet	Restriction: Prior authorization required.
Cardiovascular - Pulmonary Arterial Hypertension Prostacyclin type - Drugs for the heart	
FLOLAN® ***(epoprostenol)*** 0.5 mg, 1.5 mg vial	Restriction: Prior authorization required.
Cardiovascular - Vasodilator - Drugs for the heart	
APRESOLINE® ***(hydralazine)*** 10mg, 25mg, 50mg, 100mg tablet	

Continued on next page

MEDICATIONS	RESTRICTIONS
Cardiovascular - Vasodilator - Drugs for the heart, continued • SEE PREVIOUS PAGE	
G IMDUR® ***(isosorbide mononitrate)*** 60mg, 120mg tablet	
G ISORDIL® ***(isosorbide dinitrate)*** 5mg, 10mg, 20mg, 30mg tablet, 2.5mg, 5mg sl tablet, 5mg, 10mg chewable tablet	
G LONITEN® ***(minoxidil)*** 2.5mg, 10mg tablet	
G ***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	
G NITROSTAT® ***(nitroglycerin)*** 0.3mg, 0.4mg, 0.6mg sl tablet	
Central Nervous System - Anticonvulsant - Drugs for the nervous system	
G DEPAKOTE®, DEPAKOTE ER® ***(divalproex)*** 125mg ec capule, 125mg, 250mg, 500mg ec tablet, 500mg cr tablet, 250mg/5ml soln	
G DILANTIN®, PHENYTEK® ***(phenytoin)*** 50mg chewable tablet, 30mg, 100mg capsule, 30mg/5ml, 125mg/5ml susp	
G GABITRIL® ***(tiagabine)*** 2mg, 4mg, 12mg, 16mg tablet	Restriction: Restricted to plan Neurologists.
G KEPPRA® ***(levetiracetam)*** 500mg, 750mg, 1000mg tablet, 500mg XR, 750mg XR tablet	
G KLONOPIN® ***(clonazepam)*** 0.5mg, 1mg, 2mg tablet	
G LAMICTAL® ***(lamotrigine)*** 5mg, 25mg chewable tablet, 100mg,150mg, 200mg tablet	
G LYRICA® ***(pregabalin)*** 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg capsule	
G MYSOLINE® ***(primidone)*** 250mg/5ml susp, 50mg, 250mg tablet	
G NEURONTIN® ***(gabapentin)*** 100mg, 300mg, 400mg capsule, 600mg, 800mg tablet	

Continued on next page

MEDICATIONS	RESTRICTIONS
Central Nervous System - Anticonvulsant - Drugs for the nervous system, continued • SEE PREVIOUS PAGE	
G ***phenobarbital*** 20mg/5ml elixir, 15mg, 30mg, 60mg, 100mg tablet	
G TEGRETOL® ***(carbamazepine)*** 100mg chewable tablet, 200mg tablet, 100mg/5ml susp	
G TOPAMAX® ***(topiramate)*** 15mg, 25mg sprinkle capsule, 25mg, 50 mg, 100mg, 200mg tablet	Restriction: Capsules allowed for children < 10 years old.
G TRILEPTAL® ***(oxcarbazepine)*** 300mg, 600mg tablet	
G ZARONTIN® ***(ethosuximide)*** 250mg/5ml syrup, 250mg capsule	
G ZONEGRAN® ***(zonisamide)*** 25mg, 50mg, 100mg capsule	
Central Nervous System - Antidepressant - Antipsychotic - Drugs for the nervous system	
G TRIAVIL® ***(perphenazine & amitriptyline)*** 2-10mg, 2-25mg, 4-10mg, 4-25mg tablet	Restriction: Prior authorization required.
Central Nervous System - Antidepressant - Norepinephrine Antagonist and Serotonin Antagonist Antidepressants - Drugs for the nervous system	
G REMERON® ***(mirtazapine)*** 15mg, 30mg, 45mg tablet	
Central Nervous System - Antidepressant - Norepinephrine-Dopamine Reuptake Inhibitors (NDRI) - Drugs for the nervous system	
G DESYREL® ***(trazodone)*** 50mg, 100mg, 150mg tablet	
G WELLBUTRIN® ***(bupropion)*** 100 mg, 150 mg, 200 mg cr tablet, 150 mg, 300 mg xl tablet	Restriction: Restricted to Depression formulation designation.
Central Nervous System - Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRI) - Drugs for the nervous system	
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***	

Continued on next page

MEDICATIONS	RESTRICTIONS
Central Nervous System - Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRI) - Drugs for the nervous system, continued • SEE PREVIOUS PAGE	
will be considered. ***Tablet splitters are covered for KHS patients.***	
G CELEXA® ***(citalopram)*** 10mg, 20mg, 40mg tablet	Restriction: Allowed > 12 years old.
G LEXAPRO® ***(escitalopram)*** 5mg, 10mg, 20mg tablet	Restriction: Citalopram trial and failure required. Allowed > 12 years old.
G LUVOX® ***(fluvoxamine)*** 50mg, 75mg, 100mg tablet, 100mg, 150mg er capsule	Restriction: 100mg and 150 mg ER capsule PA required. Allowed > 8 years old.
G PAXIL® ***(paroxetine)*** 20mg, 30mg, 40mg tablets	Restriction: Allowed > 18 years old.
G PROZAC® ***(fluoxetine)*** 10mg, 20mg capsule, 20mg/5ml soln	Restriction: Restricted to 10mg NMT 1 daily, 20mg NMT 4 daily. Allowed > 7 years old.
G ZOLOFT® ***(sertraline)*** 50mg, 100mg tablet	Restriction: Allowed > 6 years old.
Central Nervous System - Antidepressant - Tricyclics (TCA) - Drugs for the nervous system	
G ***amitriptyline*** 10mg, 25mg, 50mg, 75mg, 100mg, 150mg tablet	
G ANAFRANIL® ***(clomipramine)*** 25mg, 50mg, 75mg capsule	Restriction: Prior authorization required.
G NORPRAMIN® ***(desipramine)*** 10mg, 25mg, 50mg, 75mg, 100mg, 150mg tablet	
G PAMELOR® ***(nortriptyline)*** 10mg, 25mg, 50mg, 75mg capsule, 10mg/5ml soln	
G TOFRANIL® ***(imipramine)*** 10mg, 25mg, 50mg tablet, 75mg, 100mg, 150mg capsule (pamoate)	
Central Nervous System - Antidepressant-Serotonin - Norepinephrine Reuptake Inhibitors (SNRI) - Drugs for the nervous system	
G CYMBALTA® ***(duloxetine)*** 20mg, 30mg, 60mg capsule	
G EFFEXOR®, EFFEXOR XR® ***(venlafaxine)*** 25mg, 37.5mg, 50mg, 75mg, 100mg tablet, 37.5mg, 75mg, 150mg cr capsule	

MEDICATIONS	RESTRICTIONS
Central Nervous System - Anxiolytic - Drugs for the nervous system	
*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.* ***Caution should be used when combining with opioids.***	
Medication — ***Daily Maximum Dose***: *Diazepam* — *10mg*; *Lorazepam* — *2mg*	
G ATIVAN® ***(lorazepam)*** 0.5mg, 1mg, 2mg tablet	Restriction: Restricted to 90 days therapy and 2mg maximum daily dose.
G BUSPAR® ***(buspirone)*** 5mg, 10mg, 15mg tablet	
G KLONOPIN® ***(clonazepam)*** 0.5mg, 1mg, 2mg tablet	
65 G VALIUM® ***(diazepam)*** 2mg, 5mg, 10mg tablet	Restriction: Restricted to 90 days therapy and 10mg maximum daily dose.
Central Nervous System - Migraine - Drugs for the nervous system	
AIMOVIG® ***(erenumab - aooe)*** 70 mg/ml, 140 mg/ml injection	Restriction: PA required.
CAFERGOT® ***(ergotamine & caffeine)*** 1mg-100mg tablet, 2mg-100mg supp	Restriction: 20 doses per month.
G ***ergotamine tartarate*** 2 mg sl tablet	
G FIORICET® ***(butalbital, caffeine, & acetaminophen)*** 50mg-40mg-325mg tablet	Restriction: 50 tablets maximum per month.
G FIORINAL® ***(butalbital, caffeine, & aspirin)*** 50mg-40mg-325mg capsule/tablet	Restriction: 50 capsules maximum per month.
Central Nervous System - Migraine-Triptan - Drugs for the nervous system	
*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.*	

Continued on next page

MEDICATIONS	RESTRICTIONS
Central Nervous System - Migraine-Triptan - Drugs for the nervous system, continued • SEE PREVIOUS PAGE	
Medication / ***Cost/9 tablets***	
Sumatriptan (Imitrex®) 50-100mg / *$9*	
Naratriptan (Amerge®) 2.5mg / *$25*	
Rizatriptan (Maxalt®) 5mg / *$19*	
Zolmitriptan (Zomig®) 5mg / *$57*	
G AMERGE® ***(naratriptan)*** 1mg, 2.5mg tablet	Restriction: 9 tablets in 30 days with a maximum of 3 fills in a 12 month period.
G IMITREX® ***(sumatriptan)*** 50mg, 100mg tablet only	Restriction: Restricted to 9 tablets in 30 days with a maximum of 3 fills in a 12 month period.
G MAXALT® ***(rizatriptan)*** 5mg, 10mg tablet	Restriction: 12 tablets in 40 days with a maximum of 2 fills in a 12 month period.
Central Nervous System - Sedative - Drugs for the nervous system	
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.***	
G AMBIEN® ***(zolpidem)*** 5mg, 10mg tablet	Restriction: Allow 15 tablets in 30 days. 5mg daily maximum allowed for women.
G RESTORIL® ***(temazepam)*** 15mg, 30mg capsule	Restriction: Allow 15 capsules in 30 days.
Central Nervous System - Stimulant - Drugs for the nervous system	
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.	
G ADDERALL®, ADDERALL XR® ***(amphetamine combination)*** 5mg, 7.5mg, 10mg, 20mg, 30mg tablet, 5mg, 10mg, 15mg, 20mg, 25mg, 30mg cr tablet	
G DEXEDRINE® ***(dextro-amphetamine)*** 5mg, 10mg tablet, 10mg, 15mg, cr capsule	
G FOCALIN®, FOCALIN XR® ***(dexmethylphenidate)*** 5mg, 10mg tablet, 5mg, 10mg, 15mg, 20mg, 30mg capsule	

Continued on next page

MEDICATIONS	RESTRICTIONS
Central Nervous System - Stimulant - Drugs for the nervous system, continued • SEE PREVIOUS PAGE	
G RITALIN® ***(methylphenidate)*** 5mg, 10mg, 20mg tablet, 20mg cr tablet	
G STRATTERA® ***(atomoxetine)*** 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, 100 mg capsule	Restriction: Psychiatrist only.
VYVANSE® ***(lisdexamfetamine)*** 20mg, 30mg, 40mg, 50mg, 60mg, 70mg capsule	Restriction: Must fail generic amphetamines first.
Cholinesterase Inhibitors - Drugs for memory loss	
G ARICEPT® ***(donepezil)*** 5mg, 10mg tablet	Restriction: Prior authorization required. MMSE
Drug Dependency Therapy	
G CHANTIX® ***(varenicline)*** 0.5mg, 1mg tablet	
G NICORETTE®, NICOTROL®, NICODERM CQ® ***(nicotine)*** 2mg, 4mg gum, 2mg, 4 mg lozenge, 10mg cartridge, 10mg/ml spray, 7mg, 14 mg, 21 mg patches	

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).

Continued on next page

MEDICATIONS	RESTRICTIONS
Enterals, continued • SEE PREVIOUS PAGE	
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 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 - Drugs for the stomach	
65 G LOMOTIL® ***(diphenoxylate & atropine)*** 2.5mg/5ml liq, 2.5mg tablet	
G ***paregoric*** 2mg/5ml liq	
Gastrointestinal - Antiemetic - Drugs for the stomach	
✱ G COMPAZINE® ***(prochlorperazine)*** 5mg, 10mg tablet, 15mg cr capsule, 2.5mg, 5mg, 10mg supp, 5mg/5ml syrup	
EMEND® ***(aprepitant)*** 40mg, 80mg, 125mg, 125-80mg, 150mg vial	Restriction: Restricted to highly emetic chemotherapy such as 'platinum' therapy. Allow up to 3 days per treatment.

Continued on next page

MEDICATIONS	RESTRICTIONS
Gastrointestinal - Antiemetic - Drugs for the stomach, continued • SEE PREVIOUS PAGE	
✱ G KYTRIL® ***(granisetron)*** 1 mg tablet	Restriction: Prior authorization required.
G MARINOL® ***(dronabinol)*** 2.5 mg, 5 mg, 10 mg capsule	Restriction: Restricted to use by KHS plan Oncologist.
✱ 65 G PHENERGAN® ***(promethazine)*** 6.25mg/5ml, 25mg/5ml syrup, 12.5mg, 25mg, 50mg tablet or supp	Restriction: Restricted to members > 2 years old.
✱ G ZOFRAN® ***(ondansetron)*** 4mg, 8mg tablet, ODT	Restriction: Allow up to 3 days of therapy per oncology treatment.
Gastrointestinal - Digestant - Drugs for the stomach	
G ACTIGALL® ***(ursodiol)*** 250 mg, 500 mg tablet	Restriction: Prior authorization required.
CREON®, ZENPEP® ***(amylase, lipase, & protease)*** varying strengths -capsule, tablet, chewable tablet, ec tablet	Restriction: Prior authorization required.
Gastrointestinal - H2 Antagonist - Drugs for the stomach	
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.	
G PEPCID® ***(famotidine)*** 10mg, 20mg, 40mg tablet	
Gastrointestinal - Helicobacter Pylori Treatment - Drugs for the stomach	
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 - Drugs for the stomach	
G CEPHULAC® ***(lactulose)*** 10mg/15ml syrup	
G GO-LYTELY® ***(peg-electrolyte)*** powder for soln	
G MIRALAX® ***(peg)*** powder	

MEDICATIONS	RESTRICTIONS
Gastrointestinal - Miscellaneous - Drugs for the stomach	
G ANUSOL-HC® ***(hemorrhoidal suppository w/hydrocortisone)*** supp	Restriction: Max 2/day, and 7 days every 30 days.
G ASACOL®, DELZICOL®, LIALDA® ***(mesalamine)*** 800mg er tablet, 400mg tablet, 1.2 g DR tablet	Restriction: Try and fail balsalazide therapy before considering mesalamine.
G AZULFIDINE® ***(sulfasalazine)*** 500mg tablet & ec tablet	
G CARAFATE® ***(sucralfate)*** 1gm tablet	Restriction: Restricted to members with duodenal ulcer, NMT 90 days therapy.
G COLAZAL® ***(balsalazide)*** 750mg capsule	
G CORTENEMA® ***(hydrocortisone enema)*** 100mg/60ml susp	
G CYTOTEC® ***(misoprostol)*** 100mg, 200mg tablet	
65 PRO-BANTHINE® ***(propantheline)*** 15mg tablet	Restriction: plan gastroenterologists only.
G REGLAN® ***(metoclopramide)*** 5mg/5ml syrup, 5mg, 10mg tablet	

Gastrointestinal - Proton Pump Inhibitor - Drugs for the stomach

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*

Continued on next page

MEDICATIONS	RESTRICTIONS
Gastrointestinal - Proton Pump Inhibitor - Drugs for the stomach, continued • SEE PREVIOUS PAGE	
Non-Formulary Prescription PPIs *Dexilent®*	***Monthly Additional Cost*** *$271* ***Annual Additional Cost*** *$3252*
♥ ACIPHEX® ***(rabeprazole)*** 20mg tablet	Restriction: Must fail omeprazole and pantoprazole therapy.
♥ NEXIUM 24HR (OTC)® ***(esomeprazole)*** 20mg capsule	Restriction: Must fail omeprazole and pantoprazole therapy.
♥ PREVACID® ***(lansoprazole)*** 30mg capsule	Restriction: Must fail omeprazole and pantoprazole therapy.
♥ PRILOSEC® ***(omeprazole)*** 20mg, 40 mg capsule	
♥ PROTONIX® ***(pantoprazole)*** 20mg, 40mg tablet	
Hematology - Anticoagulant - Drugs for the blood	
♥ COUMADIN® ***(warfarin)*** 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg,10mg tablet	
ELIQUIS® ***(apixaban)*** 2.5mg, 5mg tablet, Starter pack	
♥ ***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.
♥ LOVENOX® ***(enoxaparin)*** 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.
XARELTO® ***(rivaroxaban)*** 10mg, 15mg, 20mg tablet, Starter pack	
Hematology - Antiplatelet - Drugs for the blood	
AGRYLIN® ***(anagrelide)*** 1mg capsule	Restriction: Prior authorization required.
BRILINTA® ***(ticagrelor)*** 60mg, 90mg tablet	Restriction: Prior authorization required. Available first line if written by cardiologist. Up to 12 month therapy allowed.
♥ EFFIENT® ***(prasugrel)*** 5mg, 10mg tablet	Restriction: Prior authorization required. Available first line if written by cardiologist. Up to 12 month therapy allowed.
65 ♥ PERSANTINE® ***(dipyridamole)*** 25mg, 50mg, 75mg tablet	
♥ PLAVIX® ***(clopidogrel)*** 75mg tablet	

♥ Generic Available 65 Should be avoided in the elderly ✱ Bill to Medicare Part B

MEDICATIONS	RESTRICTIONS
Hematology - Coagulant - Drugs for the blood	
MEPHYTON® ***(phytonadione)*** 5mg tablet	
Hematology - Hematopoietic - Drugs for the blood	
✱ ARANESP® ***(darbepoetin)*** 25mcg/ml, 40mcg/ml, 60mcg/ml, 100mcg/ml and 200mcg/ml.	
✱ NIVESTYM® ***(filfrastim - aafi)*** 300 mcg/0.5/ml, 480 mcg/0.8 ml syringe, vial	Restriction: Prior authorization required. Quantity and lab values required.
✱ RETACRIT® ***(epoetin, alpha)*** 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.
Hematology - Miscellaneous - Drugs for the blood	
cilostazol 50mg, 100mg tablet	Restriction: Restricted to members > 65 years old with intermittant claudication or diabetic of any age with intermittant claudication.
TRENTAL® ***(pentoxifylline)*** 400mg tablet	Restriction: Restricted to members > 65 years old with intermittant claudication or diabetic of any age with intermittant claudication.
Hormone - Androgen - Drugs for hormones	
DANOCRINE® ***(danazol)*** 50 mg, 100 mg, 200 mg capsule	Restriction: Prior authorization required.
DEPO-TESTOSTERONE® ***(testosterone)*** 100mg/ml, 200mg/ml vial	Restriction: Prior authorization required.
Hormone - Antidiabetic - Amylin Analog - Drugs for diabetes	
SYMLIN® ***(pramalintide)*** Pen injector	Restriction: Prior authorization required.
Hormone - Antidiabetic - Dipeptidyl Peptidase-4 - Drugs for diabetes	
NESINA® ***(alogliptin)*** 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.
TRADJENTA® ***(linagliptin)*** 5mg tablet	Restriction: Restricted to members adherent on metformin or cannot take or failed metformin. PA required. DPP-4 therapy is expected to use Alogliptin unless CHF contraindications exist demonstrated by supporting documentation.

MEDICATIONS	RESTRICTIONS
Hormone - Antidiabetic - Dipeptidyl Peptidase-4 - Metformin - Drugs for diabetes	
G KAZANO® ***(alogliptin/metformin)*** 12.5-500mg, 12.5-1000mg tablet	Restriction: Restricted to members on metformin.
Hormone - Antidiabetic - Dipeptidyl Peptidase-4 - Thiazolidinedione - Drugs for diabetes	
G OSENI® ***(alogliptin/pioglitazone)*** 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 - Drugs for diabetes	
G PRECOSE® ***(acarbose)*** 25mg, 50mg, 100 mg tablet	Restriction: Restricted to endocrinologists.
Hormone - Antidiabetic Biguanide - Drugs for diabetes	
__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®.	
G GLUCOPHAGE®, GLUCOPHAGE XR® ***(metformin)*** 500mg, 850mg, 1000mg tablet, 500mg cr tablet	
Hormone - Antidiabetic GLP-1 Agonists - Drugs for diabetes	
ADLYXIN® ***(lixisenatide)*** 20 mcg pen, starter	Restriction: Restricted to members adherent to > 90 of SGLT-2 therapy or members seen by endocrinologists with history of SGLT-2 therapy.
BYDUREON® ***(exenatide)*** 2 mg vial, pen, Bcise	Restriction: Restricted to members adherent to > 90 of SGLT-2 therapy or members seen by endocrinologists with history of SGLT-2 therapy. Grandfathered only. New GLP-1 therapy consider Adlyxin or Trulicity if cardiac (heart) disease.
OZEMPIC® RYBELSUS® ***(semaglutide)*** 3 mg, 7 mg, 14 mg tablet, 1 mg pen, starter	Restriction: Restricted to members seen by endocrinologists on SGLT-2 therapy of any duration.
TRULICITY® ***(dulaglutide)*** 0.75 mg/0.5, 1.5 mg/0.5, 3 mg/0.5 ml, 4.5 mg/0.5 ml pen	Restriction: Restricted to members adherent to > 90 of SGLT-2 therapy or members seen by endocrinologists with history of SGLT-2 therapy. Preferred for those with cardiovascular (heart) disease.
VICTOZA® ***(liraglutide)*** 18 mg/1 ml pen	Restriction: Restricted to members seen by endocrinologists on SGLT-2 therapy of any duration also demonstrating concurrent atherosclerotic cardiovascular (heart) disease with supporting clinical documentation.

MEDICATIONS	RESTRICTIONS
Hormone - Antidiabetic GLP-1 Agonists glargine combination - Drugs for diabetes	
SOLIQUA® ***(insulin glargine/lixisenatide)*** 100-33/ml pen	Restriction: Restricted to members currently on insulin glargine or GLP-1.
Hormone - Antidiabetic Insulin - Drugs for diabetes	
✱ G ADMELOG®, HUMALOG® ***(insulin lispro)*** 100 units/ml, 50-50 mix, 75-25 mix	Restriction: Admelog allowed for single ingredient formulation.
✱ APIDRA® ***(insulin glulisine)*** 100 units/ml	
✱ HUMULIN® NOVOLIN® ***(insulin, human)*** 100 units/ml Regular, Lente, NPH, 50-50, 70-30 mix, 500 unit/ml Regular	Restriction: U-500 restricted to endocrinology.
✱ LEVEMIR® ***(insulin detemir)*** 100 units/ml	Restriction: Restricted to adverse reactions to glargine or for use in pregnant women.
✱ G NOVOLOG® ***(insulin aspart)*** 100 units/ml, 70-30 mix	
✱ SEMGLEE®, TOUJEO® ***(insulin glargine)*** 100 units/ml, 300 units/ml	Restriction: Toujeo therapy reserved for endocrinologist for members failing maximum dosed Semglee.
✱ TRESIBA® ***(insulin degludec)*** 100 units/ml, 200 units/ml	Restriction: Restricted to endocrinologists.
Hormone - Antidiabetic Meglitinide - Drugs for diabetes	
G STARLIX® ***(nateglinide)*** 60mg, 120mg tablet	Restriction: Restricted to plan endocrinologists.
Hormone - Antidiabetic Other Agents - Drugs for diabetes	
G ***glucagon*** 1mg kit	Restriction: Limit 2 per dispensing, 2 dispensings per 12 months.
Hormone - Antidiabetic SGLT-2 Inhibitors - Drugs for diabetes	
FARXIGA® ***(dapagliflozin)*** 5 mg, 10 mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. PA required. Steglatro is expected for initiating SGLT-2 therapy unless demonstrating concurrent atherosclerotic cardiovascular disease with supporting clinical documentation.

Continued on next page

MEDICATIONS	RESTRICTIONS
Hormone - Antidiabetic SGLT-2 Inhibitors - Drugs for diabetes, continued • SEE PREVIOUS PAGE	
JARDIANCE® ***(empagliflozin)*** 10 mg, 25 mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. PA required. Steglatro is expected for initiating SGLT-2 therapy unless demonstrating concurrent atherosclerotic cardiovascular disease with supporting clinical documentation.
STEGLATRO® ***(ertugliflozin)*** 5 mg, 15 mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. Preferred SGLT-2. Please consider when initiating SGLT-2 therapy.
Hormone - Antidiabetic SGLT-2 Inhibitors Combination - Drugs for diabetes	
SEGLUROMET® ***(ertugliflozin/metformin)*** 2.5-500 mg, 7.5-500 mg, 2.5-1000 mg, 7.5-1000 mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. Preferred SGLT-2/metformin combination.
SYNJARDY® ***(empagliflozin/metformin)*** 5mg-500mg, 5mg-1000mg, 12.5mg-500mg, 12.5mg-1000mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. PA required. Segluromet is expected for initiating SGLT-2 therapy unless demonstrating concurrent atherosclerotic cardiovascular disease with supporting clinical documentation.
XIGDUO XR® ***(dapagliflozin/metformin)*** 5-500 mg, 5-1000 mg, 10-500 mg, 10-1000 mg tablet	Restriction: Restricted to members adherent to > 90 days of metformin therapy. PA required. Segluromet is expected for initiating SGLT-2 therapy unless demonstrating concurrent atherosclerotic cardiovascular disease with supporting clinical documentation.
Hormone - Antidiabetic Sulfonylureas - Drugs for diabetes	
G AMARYL® ***(glimepiride)*** 1mg, 2mg, 4mg tablet	
G DIABETA® ***(glyburide)*** 1.25mg, 2.5mg, 5mg tablet	
G GLUCOTROL® ***(glipizide)*** 5mg, 10mg tablet	
Hormone - Antidiabetic Thiazolidinedione - Drugs for diabetes	
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).*	
G ACTOS® ***(pioglitazone)*** 15mg, 30mg, 45mg tablet	Restriction: Restricted to members on metformin or cannot take or have failed metformin.

MEDICATIONS	RESTRICTIONS
Hormone - Anti-thyroid	
G ***propylthiouracil*** 50mg tablet	
Hormone - Endocrine - Drugs for hormones	
✱ G ***cabergoline*** 0.5 mg tablet	Restriction: Restricted to plan endocrinologists.
G DDAVP® ***(desmopressin)*** 0.1mg, 0.2mg tablet	Restriction: Prior authorization required. Not covered for enuresis.
G PARLODEL® ***(bromocriptine)*** 2.5 mg tablet, 5 mg capsule	Restriction: Restricted to patients with amenorhhea, galactorrhea, or acromegaly.
G SENSIPAR® ***(cinacalcet)*** 30 mg, 60 mg, 90 mg, tablet	Restriction: Prior authorization required.
Hormone - Estrogen - Androgen - Drugs for hormones	
65 G ESTRATEST® ***(esterified estrogens & methyltestosterone)*** 6.25mg-1.2mg, 1.25mg-2.5mg tablet	
Hormone - Estrogen - Drugs for hormones	
G ESTRACE® ***(estradiol)*** 0.5mg, 1mg, 2mg tablet	
65 PREMARIN® ***(estrogens, conjugated)*** 0.3mg, 0.45mg, 0.625mg, 0.9mg, 1.25mg, 2.5mg tablet	
Hormone - Estrogen - Progestin - Drugs for hormones	
65 PREMPHASE® ***(estrogen, conjugated & medroxyprogesterone)*** 0.625mg Estrogen (14) & 0.625mg-5mg Estrogen-Medroxyprogesterone (14) tablet	
65 PREMPRO® ***(estrogen, conjugated & medroxyprogesterone)*** 0.625mg-5mg, 0.3mg-1.5 mg, 0.45mg-1.5 mg tablet	
Hormone - Glucocorticoid - Drugs for hormones	
G DECADRON® ***(dexamethasone)*** 0.5mg, 0.75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg tablet	
G FLORINEF® ***(flurocortisone)*** 0.1mg tablet	
G ***hydrocortisone*** 5mg,10mg, 20mg tablet, 25mg supp, 100mg/60ml enema	

Continued on next page

MEDICATIONS	RESTRICTIONS
Hormone - Glucocorticoid - Drugs for hormones, continued • SEE PREVIOUS PAGE	
✱ G MEDROL® ***(methylprednisolone)*** 4mg tablet in dosepack	
✱ G ***prednisone*** 1mg/1ml oral soln or syrup, 5mg/ml conc, 1mg,2.5mg, 5mg, 10mg, 20mg, 25mg, 50mg tablet 5mg, 10mg dose pack	
✱ G PRELONE® ***(prednisolone)*** 5mg/5ml, 6.7mg/5ml, 15mg/5ml soln, 5mg tablet	
Hormone - Oxytoxic - Drugs for hormones	
METHERGINE® ***(methylergonovine)*** 0.2mg tablet	
Hormone - Progestin - Drugs for hormones	
CRINONE® ***(progesterone miconized)*** 4%, 8% vaginal gel	Restriction: Restricted to plan OB/GYN.
LUPANETA® ***(leuprolide/norethindrone)*** 3.75-5 mg, 11.25-5 mg syringe-tab	Restriction: Prior authorization required.
G MAKENA® ***(hydroxyprogesterone caproate)*** 250mg/ml	Restriction: Prior authorization required--FDA indication only for singleton pregnancies. Not FDA indicated for incompetent cervix.
ORILISSA® ***(elagolix)*** 150 mg, 200 mg tablet	Restriction: Prior authorization required.
G PROVERA®, DEPO-PROVERA® ***(medroxyprogesterone)*** 2.5mg,10mg tablet, 150mg/ml depo injection	Restriction: Depo-Provera® allowed for maximum of 24 months.
Hormone - Thyroid	
65 G ARMOUR® ***(thyroid--dessicated)*** 15mg, 30mg, 60mg, 90mg, 120mg, 180mg, 240mg, 300mg tablet	Restriction: Plan endocrinologists. Prior authorization required.
G CYTOMEL® ***(liothyronine)*** 5 mcg, 25 mcg, 50 mcg tablet	Restriction: Prior authorization required.
G LEVOXYL® ***(levothyroxine)*** 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	
G TAPAZOLE® ***(methimazole)*** 5mg, 10mg tablet	

MEDICATIONS	RESTRICTIONS
Immunosuppressant -Drugs for the immune system	
* G IMURAN® ***(azathioprine)*** 50mg tablet	
* G ***mycophenolate*** 500 mg tablet	Restriction: Prior authorization required.
* G NEORAL® ***(cyclosporine, microemulsion)*** 25mg, 100mg capsule	
* G PROGRAF® ***(tacrolimus)*** 0.5mg, 1mg, 5 mg capsule	Restriction: Prior authorization required.
* ZORTRESS® ***(everolimus)*** 0.25mg, 0.5mg, 0.75mg tablet	Restriction: Prior authorization required.
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.	
G ***antibacterial/antifungal agents*** various	Restriction: Prior authorization required. Bill per diem.
G ***electrolyte maintenance*** various	Restriction: Prior authorization required. Bill per diem.
G ***intravenous lipids*** various	Restriction: Prior authorization required. Bill per diem.
G ***iv solutions: dextrose-water, dextrose-saline, dextrose and lactated ringer's*** various	Restriction: Prior authorization required. Bill per diem.
G ***parenteral amino acid solutions and combinations*** various	Restriction: Prior authorization required. Bill per diem.
G ***potassium replacement*** various	Restriction: Prior authorization required. Bill per diem.
G ***protein replacement*** various	Restriction: Prior authorization required. Bill per diem.
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

MEDICATIONS	RESTRICTIONS
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.	
G ***baclofen*** 10mg, 20mg tablet	
65 G ***cyclobenzaprine*** 10mg tablet	Restriction: Restricted to 90 days therapy.
65 G ROBAXIN® ***(methocarbamol)*** 500mg, 750mg tablet	Restriction: Restricted to 90 days therapy.
65 G VALIUM® ***(diazepam)*** 2mg, 5mg, 10mg tablet	Restriction: Restricted to 90 days therapy and 10mg maximum daily dose.
G ZANAFLEX® ***(tizanidine)*** 2 mg, 4 mg tablet	
NSAID - Acetic Acids - Drugs for pain	
G CLINORIL® ***(sulindac)*** 150mg, 200mg tablet	Restriction: Restricted to members with RA.
G INDOCIN® ***(indomethacin)*** 25mg, 50mg capsule	
G VOLTAREN® ***(diclofenac na)*** 50mg, 75mg ec tablet	Restriction: Restricted to members with RA.
NSAID - COX-2 Agents - Drugs for pain	
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)* ***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.***	

Continued on next page

MEDICATIONS	RESTRICTIONS
NSAID - COX-2 Agents - Drugs for pain, continued • SEE PREVIOUS PAGE	
CELEBREX® ***(celecoxib)*** 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 - Drugs for pain	
RELAFEN® ***(nabumetone)*** 500mg, 750mg tablet	
NSAID - Oxicam - Drugs for pain	
MOBIC® ***(meloxicam)*** 7.5mg, 15mg tablet	
NSAID - Propionic Acids - Drugs for pain	
MOTRIN® ***(ibuprofen)*** 100mg/5ml susp, 400mg, 600mg, 800mg tablet	Restriction: FDA does not recommend in children < 6 months.
NAPROSYN® ***(naproxen)*** 125mg/5ml susp, 250mg, 375mg, 500mg tablet	
ORUDIS® ***(ketoprofen)*** 25mg, 50mg, 75mg capsule	Restriction: Restricted to members with RA.
NSAID - Salicylate - Drugs for pain	
DISALCID® ***(salsalate)*** 500mg capsule, tablet or cr tablet, 750mg tablet	
Ophthalmic - Anesthetic - Drugs for the eyes	
proparacaine 0.5% ophth soln	Restriction: Prior authorization required.
Ophthalmic - Anti-fungal - Drugs for the eyes	
NATACYN® ***(natamycin)*** 5% ophth susp	
Ophthalmic - Antihistamine - Drugs for the eyes	
OPTIVAR® ***(azelastine ophth soln)*** 0.05% ophth soln	Restriction: Trial and failure of Zaditor required.
PATANOL® ***(olopatadine)*** 0.1% ophth soln	Restriction: Restricted to plan ophthalmologists only.
Ophthalmic - Anti-infective - Drugs for the eyes	
bacitracin ophth oint	
BESIVANCE® ***(besifloxacin)*** 0.6% ophth susp	Restriction: Patients must have recently failed first line ophth antibiotics. Allow 1st line for ophthalmologists.

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MEDICATIONS	RESTRICTIONS
Ophthalmic - Anti-infective - Drugs for the eyes, continued • SEE PREVIOUS PAGE	
G CILOXAN® ***(ciprofloxacin)*** 0.3% ophth soln	
G GARAMYCIN® ***(gentamicin)*** 0.3% ophth oint & soln	
G ILOTYCIN® ***(erythromycin)*** 0.5% ophth oint	
G NEO-POLYCIN® ***(neomycin, bacitracin & polymyxin)*** 3.5mg-400 units (or 500 units)-10000 units ophth oint	
G NEOSPORIN® ***(neomycin,polymyxin & gramicidin)*** ophth soln	Restriction: Prior authorization required.
G OCUFLOX® ***(ofloxacin)*** 0.3% ophth soln	
G POLYSPORIN® ***(bacitracin & polymyxin)*** ophth oint	
G POLYTRIM® ***(polymyxin & trimethaprim)*** ophth soln	
G SULAMYD® ***(sodium sulfacetamide)*** 10% ophth soln & oint	
G TOBREX® ***(tobramycin)*** 0.3% ophth soln	
Ophthalmic - Anti-infective - Glucocorticoid - Drugs for the eyes	
G MAXITROL® ***(neomycin, polymyxin & dexamethasone)*** ophth susp, ophth oint	
G POLY-PRED® ***(neomycin,polymyxin & prednisolone)*** ophth susp	
G TOBRADEX® ***(tobramyin & dexamethasone)*** 0.3%-0.1% ophth susp	Restriction: Consider second line to neomycin/steroid preparations.
Ophthalmic - Anti-viral - Drugs for the eyes	
G VIROPTIC® ***(trifluridine)*** 1% ophth soln	
ZIRGAN® ***(ganciclovir)*** 0.15% gel	Restriction: Restricted to plan ophthalmologists only.
Ophthalmic - Glaucoma - Drugs for the eyes	
G ALPHAGAN® ALPHAGAN P® ***(brimonidine)*** 0.2% ophth soln	
AZOPT® ***(brinzolamide)*** 1% ophth susp	Restriction: Prior authorization required.

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MEDICATIONS	RESTRICTIONS
Ophthalmic - Glaucoma - Drugs for the eyes, continued • SEE PREVIOUS PAGE	
G BETAGAN® ***(levobunolol)*** 0.25% ophth soln	
G BETOPIC® ***(betaxolol)*** 0.25%, 0.5% ophth soln or susp	
G COMBIGAN® ***(brimonidine tartrate/timolol)*** 0.2%-0.5% ophth drops	
G COSOPT® ***(dorzolamide/timolol)*** 2%-0.5% ophth drops	
G DIAMOX® ***(acetazolamide)*** 125mg, 250mg tablet, 500mg cr capsule	
G ISOPTO-CARPINE® ***(pilocarpine)*** 1%, 2%, 4% ophth soln	
ISOPTO-HYOSINE® ***(scopolamine)*** 0.25% ophth soln	
G LUMIGAN® ***(bimatoprost)*** 0.01%, 0.03% ophth soln	Restriction: Limited to 2.5ml size only. 1 bottle per dispensing.
G NEPTAZANE® ***(methazolamide)*** 25mg, 50 mg tablet	
G OPTIPRANOLOL® ***(metipranolol)*** 0.3% ophth soln	
G TIMOPTIC® ***(timolol)*** 0.25%, 0.5% ophth soln	
G TRUSOPT® ***(dorzolamide)*** 2% ophth soln	
G XALATAN® ***(latanoprost)*** 0.005% ophth soln	
Ophthalmic - Glucocorticoid - Drugs for the eyes	
DUREZOL® ***(difluprednate)*** 0.05% ophth susp	Restriction: Restricted to plan ophthalmologists only.
G FML® ***(fluorometholone)*** 0.1%, 0.25% ophth susp	
LOTEMAX® ***(loteprednol)*** 0.5% ophth susp	Restriction: Prior authorization required.
G PRED MILD®, PRED FORTE® ***(prednisolone)*** 0.12%, 1% ophth susp	
Ophthalmic - Miscellaneous - Drugs for the eyes	
G CROLOM® ***(cromolyn)*** 4% ophth drops	
G MURO® (128) ***(sodium chloride)*** 2% ophth soln, 5% ophth oint or soln	

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MEDICATIONS	RESTRICTIONS
Ophthalmic - Miscellaneous - Drugs for the eyes, continued • SEE PREVIOUS PAGE	
G RESTASIS® ***(cyclosporine)*** 0.05% ophth emulsion	Restriction: Prior authorization required.
Ophthalmic - Mydriatic - Drugs for the eyes	
G CYCLOGYL® ***(cyclopentolate)*** 0.5%, 1%, 2% ophth soln	
G ISOPTO-ATROPINE® ***(atropine)*** 1% ophth soln	
ISOPTO-HOMATROPINE® ***(homatropine)*** 2%, 5% ophth soln	
Ophthalmic - NSAID - Drugs for the eyes	
G ACULAR®, ACULAR LS ***(ketorolac)*** 0.4%, 0.5% ophth soln	Restriction: Restricted to plan ophthalmologist only.
NEVANAC® ***(nepafanac)*** 0.1% ophth susp	Restriction: Restricted to plan ophthalmologist only.
G VOLTAREN® ***(diclofenac)*** 0.1% ophth drops	
Oral Contraceptive - Biphasic - Drugs for women	
G MIRCETTE® ***(desogestrel & ethinyl estradiol)*** 0.15mg/20mcg (21), 10mcg (7) tablet	
G ORTHO-NOVUM 10/11® ***(norethindrone & ethinyl estradiol)*** 0.5mg-35mcg (10), 1mg-35mcg (11) tablet	
G ORTHO-NOVUM 7/14® ***(norethindrone & ethinyl estradiol)*** 0.5mg-35mcg (7), 1mg-35mcg(14) tablet	
Oral Contraceptive - Drugs for women	
G ALESSE® ***(levonorgestrel & ethinyl estradiol)*** 0.1mg-20mcg tablet	
G DEMULEN® ***(ethynodiol & ethinyl estradiol)*** 1mg-35mcg tablet	
G DESOGEN® ***(desogestrel & ethinyl estradiol)*** 0.15mg-30mcg tablet	
G LEVLEN® ***(levonorgestrel & ethinyl estradiol)*** 0.15mg-30mcg tablet	
G LO-OVRAL® ***(norgestrel & ethinyl estradiol)*** 0.3mg-30mcg tablet	

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MEDICATIONS	RESTRICTIONS
Oral Contraceptive - Drugs for women, continued • SEE PREVIOUS PAGE	
G LOESTRIN 1.5/30®, 1.5/30 FE® ***(norethindrone acetate & ethinyl estradiol)*** 1.5mg-30mcg tablet, 1.5mg-30mcg w/iron tablet	
G LOESTRIN 1/20®, 1/20 FE®, LO LOESTRIN FE® ***(norethindrone acetate & ethinyl estradiol)*** 1mg-20mcg, 1mg-20mcg, 1mg-10mcg w/iron tablet	Restriction: Lo Loestrin prior authorization required.
G NORLESTRIN 1/50®, 1/50 FE® ***(norethindrone acetate & ethinyl estradiol)*** 1mg-50mcg tablet, 1mg-50mcg w/iron tablet	
G ORTHO-CYCLEN® ***(norgestimate & ethinyl estradiol)*** 0.25mg-35mcg tablet	
G ORTHO-NOVUM 1/35®, DEMULEN 1/50® ***(norethindrone & ethinyl estradiol)*** 35mcg-1mg, 50mcg-1mg tablet	
G ORTHO-NOVUM 1/50® ***(norethindrone & mestranol)*** 1mg-50mcg tablet	
G OVRAL® ***(norgestrel & ethinyl estradiol)*** 0.5mg-50mcg tablet	
G YASMIN®, YAZ® ***(drospirenone & ethinyl estradiol)*** 0.03-3mg, 0.02-3mg tablet	Restriction: Prior authorization required.
Oral Contraceptive - Progestin Only - Drugs for women	
G MICRONOR® ***(norethindrone)*** 0.35mg tablet	
PLAN B ONE STEP® ***(levonorgestrel)*** 1.5 mg tablet	Restriction: Maximum of 2 fills in 30 days.
Oral Contraceptive - Triphasic - Drugs for women	
ESTROSTEP® ***(norethindrone & ethinyl estradiol)*** 1mg-20mcg(5), 1mg-30mcg(7), 1mg-35mcg(9) tablet	
G ORTHO-NOVUM 7/7/7® ***(norethindrone & ethinyl estradiol)*** 0.5mg-35mcg(7), 0.75mg-35mcg(7), 1mg-35mcg(7) tablet	

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MEDICATIONS	RESTRICTIONS
Oral Contraceptive - Triphasic - Drugs for women, continued • SEE PREVIOUS PAGE	
G ORTHO-TRICYCLEN LO® ***(norgestimate & ethinyl estradiol)*** 0.18mg-25mcg/0.215mg-25mcmg/0.25mg-25mcg tablet	
G ORTHO-TRICYCLEN® ***(norgestimate & ethinyl estradiol)*** 0.18mg-35mcg/0.215mg-35mcmg/0.25mg-35mcg tablet	
G TRIPHASIL® ***(levonorgestrel & ethinyl estradiol)*** 0.05mg-30mcg, 0.075mg-40mcg, 0.125mg-30mcg tablet	
Osteoporosis Drugs for bone loss	
G ACTONEL® ***(risedronate)*** 35 mg tablet	Restriction: Prior authorization required.
G FOSAMAX® ***(alendronate)*** 35mg, 70mg weekly tablet only	Restriction: Restricted to members > 61 years old or having T-score < – 2.5.
G MIACALCIN® ***(calcitonin-salmon)*** 200unit/spray	Restriction: Allowed for osteoporosis failing bisphosphonates.
Otic - Drugs for the ears	
G ACETASOL HC® ***(hydrocortisone & acetic acid)*** otic soln	
CIPRODEX® ***(ciprofloxacin- dexamethasone)*** 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.
G CORTISPORIN® ***(neomycin, polymyxin & hydrocortisone)*** otic susp	
G FLOXIN® OTIC ***(ofloxacin)*** 0.3% otic soln	Restriction: Restricted to 5 mls per dispensing.
Otic/ OTC - Drugs for the ears	
G DEBROX® ***(carbamide peroxide)*** 6.5% soln	
Rescue Agents - Antidotes	
CHEMET® ***(succimer)*** 100mg capsule	
G ***epinephrine*** 0.15mg/0.3, 0.3mg/0.3 auto injection	
G ***leucovorin*** 5mg, 25mg tablet	

MEDICATIONS	RESTRICTIONS
Respiratory - Antihistamine - Antitussive - Decongestant - Drugs for the lungs	
G CARDEC-DM® ***(pseudoephedrine, chlorpheniramine & dextromethorphan)*** 15mg-12.5mg-4mg syrup	Restriction: Only for patients < 6 years old.
65 G PHENERGAN-VC CODEINE® ***(phenylephrine, promethazine & 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.
Respiratory - Antihistamine - Antitussive - Drugs for the lungs	
G PHENERGAN DM® ***(promethazine & dextromethorphan)*** 6.25mg-15mg/5ml syrup	Restriction: Only for patients > 2 years old.
65 G PHENERGAN W/CODEINE® ***(promethazine & 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.
Respiratory - Antihistamine - Decongestant - Drugs for the lungs	
G PHENERGAN-VC® ***(promethazine & phenylephrine)*** 6.25mg-5mg/5ml syrup	Restriction: Only for patients > 2 years old.
Respiratory - Antihistamine - Drugs for the lungs	
1st generation antihistamines are considered to be more effective than the later generations. 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.***	
65 G ATARAX® ***(hydroxyzine)*** 10mg/5ml syrup, 10mg, 25mg, 50mg tablet, 25mg, 50mg capsule	
Respiratory - Antiserotonin - Drugs for the lungs	
65 G PERIACTIN® ***(cyproheptadine)*** 2mg/5ml syrup, 4mg tablet	
Respiratory - Antitussive - Drugs for the lungs	
G SSKI® ***(saturated soln of potassium iodide)*** 1g/ml soln	Restriction: Prior authorization required.
G TESSALON® ***(benzonatate)*** 100mg perles	Restriction: Prior authorization required.

MEDICATIONS	RESTRICTIONS
Respiratory - Antitussive - Expectorant - Drugs for the lungs	
65 G ROBITUSSIN AC® ***(codeine & guaifenesin)*** 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.
65 G ROBITUSSIN DAC® ***(codeine, guaifenesin, pseudoephedrine)*** 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 - Drugs for the lungs	
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 - Drugs for the lungs	
✱ G ***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.
BRETHINE® ***(terbutaline)*** 2.5mg, 5mg tablet	
G VENTOLIN HFA®, PROAIR HFA®, PROVENTIL HFA® ***(albuterol hfa)*** 90 mcg/dose MDI	Restriction: NMT 2 inhalers in 30 days or greater than 3 consecutive months without an inhaled steroid.
Respiratory - Asthma - Step 2 -Glucocorticoid - Drugs for the lungs	
AEROSPAN® ***(flunisolide)*** 80mcg/dose MDI	
ARMONAIR RESPICLICK® ***(fluticasone propionate)*** 55 mcg, 113 mcg, 232 mcg breath activated device	
ARNUITY ELLIPTA® ***(fluticasone furoate)*** 50 mcg, 100 mcg, 200 mcg breath activated device	Preferred fluticasone inhalation product.
FLOVENT HFA® ***(fluticasone)*** 44mcg, 110mcg, 220mcg/dose MDI, 50 mcg, 100mcg, 250mcg/dose breath activated device	
✱ G PULMICORT® ***(budesonide)*** 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.
QVAR REDIHALER® ***(beclomethasone)*** 40mcg/dose, 80mcg/dose MDI	

MEDICATIONS	RESTRICTIONS
Respiratory - Asthma - Step 3 - Antileukotriene - (Step 2 Alternative) - Drugs for the lungs	
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.***	
G SINGULAIR® ***(montelukast)*** 4 mg, 5 mg chewable tablet, 10 mg tablet	
Respiratory - Asthma - Steps 3 & 4 - ICS/Long Acting Bronchodilator - Drugs for the lungs	
G ADVAIR®, Wixela Inhub®, AIRDUO® ***(fluticasone/salmeterol)*** 100/50 mcg, 250/50 mcg, 500/50 mcg breath activated device, 45/21 mcg, 115/21 mcg, 230/21 mcg 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. HFA, prior authorization required.
G SYMBICORT® ***(budesonide/formoterol)*** 80/4.5 mcg, 160/4.5 mcg inhaler	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.
Respiratory - Asthma Device	
* PEAK FLOW METER ***(monitoring device)***	Restriction: $35 max per unit.
* ***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.
Respiratory - COPD - Anticholinergic bronchodilator - Drugs for the lungs	
* G ATROVENT HFA® ***(ipratropium)*** 18mcg/dose MDI, 0.02% inhalation soln	
Respiratory - COPD - Anticholinergic Bronchodilator Combination - Drugs for the lungs	
* G COMBIVENT RESPIMAT® ***(ipratropium- albuterol respimat)*** 18mcg-90mcg/spray MDI	
65 G ***ipratropium - albuterol*** 0.5-3mg/3ml inhalation soln	

MEDICATIONS	RESTRICTIONS
Respiratory - COPD - Anticholinergic Bronchodilator Long Acting - Drugs for the lungs	
INCRUSE ELLIPTA® ***(umeclidinium)*** 62.5mcg inhalation tablet	
SPIRIVA RESPIMAT® ***(tiotropium bromide)*** 1.25mcg, 2.5 mcg Respimat	
Respiratory - COPD - Anticholinergic Bronchodilator Long Acting Combination - Drugs for the lungs	
ANORO ELLIPTA® ***(umeclidinium - vilanterol)*** 62.5-25 mcg MDI	
STIOLTO RESPIMAT® ***(tiotropium bromide - olodaterol)*** 2.5-2.5 mcg breath activated device	
Respiratory - COPD - Long Acting Anticholinergic - Long Acting Bronchodilator - ICS Combination - Drugs for the lungs	
TRELEGY ELLIPTA® ***(fluticasone - umeclindium - vilanterol)*** 100-62.5-25 mcg breath activated device	Restriction: Long acting cholinergic/bronchodilator or ICS/bronchodilator required first.
Respiratory - Mast Cell Stabilizer - Drugs for the lungs	
✱ G INTAL® ***(cromolyn)*** 20mg/2ml inhalation soln	
Respiratory - Mucolytic - Drugs for the lungs	
✱ G MUCOMYST® ***(acetylcysteine)*** 10%, 20% soln	
Respiratory - Nasal Antihistamine - Drugs for the lungs	
G ASTELIN® ***(azelastine)*** 137 mcg/spray	Restriction: Trial and failure of nasal steroids required.
Respiratory - Nasal Glucocorticoids - Drugs for the lungs	
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.*	
G FLONASE® ***(fluticasone)*** 50 mcg/spray	
G ***flunisolide*** 25 mcg/spray	
G NASONEX® ***(mometasone)*** 50mcg/spray	Restriction: Allowed as first line for members age 2-4 years old.

MEDICATIONS	RESTRICTIONS
Respiratory - Xanthine - Drugs for the lungs	
G THEODUR, UNIPHYL® ***(theophylline)*** 80mg/15ml, 100mg, 200mg, 300mg, 400mg cr capsule, 100mg, 200mg, 300mg, 400mg, 450mg cr tablet	
Topical - Acne	
G RETIN-A® ***(tretinoin)*** 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 - Drugs for pain	
G XYLOCAINE® ***(viscous lidocaine)*** 2% gel	Restriction: Restricted to 100ml every 30 days.
Topical - Antifungal - Drugs for infection	
G LAMISIL® ***(terbinafine)*** 1% cream	Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).
G MYCOSTATIN® ***(nystatin)*** 100,000 units/gm cream & oint, powder	
NIZORAL AD® ***(ketoconazole)*** 1% OTC, 2% shampoo	
G NIZORAL® ***(ketoconazole)*** 2% cream	
OXISTAT® ***(oxiconazole)*** 1% cream	Restriction: Prior authorization required.
G SPECTAZOLE® ***(econazole)*** 1% cream	Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).
Topical - Anti-infective - Drugs for infection	
G BACTROBAN® ***(mupirocin)*** 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.
G CLEOCIN-T® ***(clindamycin)*** 1% soln, gel	
G ***erythromycin*** 2% soln	
G SELSUN® ***(selenium)*** 2.5% shampoo	
G SILVADENE® ***(silver sulfadiazine)*** 1% cream	

MEDICATIONS	RESTRICTIONS
Topical - Antineoplastic - Drugs for cancer	
EFUDEX® ***(fluorouracil)*** 1%, 5% cream, 2%, 5% soln	
Topical - Antiviral - Drugs for infection	
G ALDARA® ***(imiquimod)*** 5% cream	Restriction: 12 packets per 30 days. Preferred for genital warts.
G CONDYLOX® ***(podofilox)*** 0.5% soln	Restriction: Consider second line to imiquimod.
Topical - Contraceptive - Drugs for women	
diaphragm	
G NUVARING® ***(etonogestrel/ethinyl estradiol)*** 0.12-0.15 mg vaginal ring	
XULANE® ***(norelgestromin- ethinyl estradiol)*** 150mcg/20mcg/day patch	Restriction: Plan does not cover replacement patches. Limited to 3 patches/28 days or 6 patches/56 days.
Topical - Enzymes	
hyaluronidase various	Restriction: Used for skin test, dehydration, dispersion/absorption enhancement of injected drugs.
Topical - Estrogens- Drugs for women	
G CLIMARA®, VIVELLE® ***(estradiol)*** 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 - Drugs for the skin	
G CORDRAN® ***(flurandrenolide)*** 0.05% cream, oint, lotion	
G ***hydrocortisone*** 0.5%, 1% cream, 2.5% cream, oint & lotion are also available OTC	
G KENALOG® ***(triamcinolone)*** 0.025% cream, oint, lotion	
G SYNALAR® ***(fluocinolone)*** 0.01%, 0.025% cream, 0.01% soln	
G VALISONE® ***(betamethasone)*** 0.05% cream, oint, lotion, 0.1% cream, 0.1% oint, 0.05%, 0.1% lotion	

MEDICATIONS	RESTRICTIONS
Topical - Glucocorticoid b Medium Potency - Drugs for the skin	
G ELOCON® ***(mometasone)*** 0.1% cream, oint, lotion	Restriction: Prior authorization required.
G KENALOG® ***(triamcinolone)*** 0.1% cream, oint, lotion	
Topical - Glucocorticoid c High Potency - Drugs for the skin	
G DIPROSONE® ***(betamethasone dipropionate)*** 0.05% cream, oint	
G KENALOG® ***(triamcinolone)*** 0.5% cream, oint	
G LIDEX® ***(fluocinonide)*** 0.05% cream, oint, soln, gel	
G TEMOVATE® ***(clobetasol)*** 0.05% cream, oint, soln, lotion	Restriction: Prior authorization required.
Topical - Miscellaneous - Drugs for the skin	
G ***acetic acid*** 0.25% soln	
G DOVONEX® ***(calcipotriene)*** 0.005% cream	Restriction: Member needs to fail topical steroids (triamcinolone, betamethasone). 120g maximum.
G DRITHOCREME HP® ***(anthralin)*** 1% cream	
✱ G ***sodium chloride*** 0.9% soln	
Topical - Scabicide - Drugs for infection	
G ELIMITE® ***(permethrin)*** 5% cream	Restriction: Prior authorization required.
EURAX® ***(crotamiton)*** 10% cream and lotion	Restriction: Prior authorization required.
Urinary Tract - Drugs for bladder	
G DITROPAN® ***(oxybutynin)*** 5mg tablet	
G ELMIRON® ***(pentosan)*** 100mg capsule	
G ***potassium citrate- citric acid*** 1100-334/5 ml	Restriction: Plan nephrologists allowed, otherwise prior authorization required.
G PYRIDIUM® ***(phenazopyridine)*** 100 mg, 200 mg 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	

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MEDICATIONS	RESTRICTIONS
Vaccines - Immune Globulin, continued • SEE PREVIOUS PAGE	
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.	
✱ ADACEL®, TENIVAC®, OTHERS ***(tetanus)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).
✱ BOOSTRIX® ***(tdap)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).
✱ ENGERIX-B®, HEPLISAV-B® ***(hepatitis b)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime, 2 for Heplisav-B.
✱ FLUZONE®, FLUVIRIN®, FLUVARIX®, OTHERS ***(influenza)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 1 per flu season.
✱ GARDASIL® ***(papillomavirus)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime. Maximum age 45 years.
✱ HAVRIX® ***(hepatitis a)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.
✱ HYPERRAB®, IMOGAM RABIES® ***(rabies)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).
✱ M-M-R II® ***(measles, mumps, rubella)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.
✱ MENVEO®, MENOMUNE®, BEXSERO®, TRUMENBA®, OTHERS ***(menigitits)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).
✱ PREVNAR 13®, PREVNAR 23® ***(pneumococcal)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others).
✱ SHINGRIX® ***(varicella-zoster)*** 50 mcg	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). >50 years. Limit 2 per lifetime.

Continued on next page

MEDICATIONS	RESTRICTIONS
Vaccines - Immune Globulin, continued • SEE PREVIOUS PAGE	
✱ TWINRIX® ***(hepatitis a & b)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 3 per lifetime.
✱ VARIVAX® ***(varicella)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 2 per lifetime.
✱ ZOSTAVAX® ***(zoster)*** various	Restriction: Coordinate with other payers (ex Vaccines for Children, Medicare, CCS, others). Limit 1 per lifetime. >50 years.
Vaginal - Anti-infective - Drugs for women	
G CLEOCIN® ***(clindamycin)*** 2% vaginal cream	
GYNAZOLE-1® ***(butoconazole)*** 2% vaginal cream	Restriction: Restricted to patients who have failed first line agents (Clotrimazole, Miconazole).
G METROGEL® ***(metronidazole)*** 0.75% Vaginal Gel	
G MYCOSTATIN® ***(nystatin)*** 100,000 units vaginal tablet	
SULTRIN® ***(sulfanilamide)*** 15% vaginal cream, 1.05 gm vaginal supp	
G TERAZOL® ***(terconazole)*** 0.4%, 0.8% vaginal cream, 80mg vaginal supp	Restriction: Restricted to patients who have failed first line agents (Clotrimazole, Miconazole).
G VAGISTAT 1® ***(tioconazole)*** 6.5% vaginal oint	Restriction: Restricted to members who have recently failed first line agents (Clotrimazole, Miconazole).
Vaginal - Estrogens - Drugs for women	
G ESTRACE® ***(estradiol)*** 0.01% cream	
PREMARIN VAGINAL CREAM® ***(estrogens, conjugated)*** 0.625mg/gm cream	Restriction: Prior authorization required.
Vitamins - Dietary Supplements	
CARNITOR® ***(levocarnitine)*** 10% soln, 330mg tablet	Restriction: Prior authorization required.
G ***cyanocobalamin*** 1000mcg injection	Restriction: Restricted to documented deficiency. Consider sublingual supplementation.
G DRISDOL® ***(ergocalciferol)*** 50,000 IU capsule	
G ***folic acid*** 1mg tablet	Restriction: Pregnant women and those on MTX therapy.

Continued on next page

MEDICATIONS	RESTRICTIONS
Vitamins - Dietary Supplements, continued • SEE PREVIOUS PAGE	
G LURIDE® ***(sodium fluoride)*** 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	
G POLY-VI-FLOR W/IRON®, TRI-VI-FLOR W/IRON® ***(pediatric vitamins w/fluoride & iron)*** 0.25mg-10mg/ml drops	Restriction: Restricted to members < 5 years old.
G POLY-VI-FLOR®, TRI-VI-FLOR® ***(pediatric vitamins w/fluoride)*** 0.25mg/ml, 0.5mg/ml drops, 0.25mg, 0.5mg, 1mg chewable tablet	Restriction: Restricted to members < 5 years old.
G ***prenatal vitamins w/minerals, iron & folic acid*** capsule or tablet	Restriction: Pregnant females only.
G ROCALTROL® ***(calcitriol)*** 0.25mcg, 0.5mcg capsule	

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MEDICATIONS	RESTRICTIONS
Analgesics - Non-narcotic/OTC - Drugs for pain	
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).	
G ***aspirin*** 81mg, 325mg, 650mg tablet & ec tablet, 325mg buffered tablet	
G MOTRIN® ***(ibuprofen)*** 100mg/5ml susp, 200mg tablet	Restriction: FDA does not recommend in children < 6 months.
G TYLENOL® ***(acetaminophen)*** 325mg, 500mg, 650mg tablet, 100mg/ml, 160mg/5ml soln	
Cardiovascular - Antilipid/OTC - Drugs for the heart	
G ***niacin*** 100mg, 250mg, 500mg tablet, 125mg cr capsule, 125mg, 250mg cr tablet	
Cardiovascular - Electrolyte/OTC	
G PEDIALYTE® ***(oral electrolyte soln)*** Soln	Restriction: Limited to 3000 ml per dispensing.
Contraceptive/OTC	
condoms-male	Restriction: Limited to 12 per 30 days.
EMKO® ***(nonoxynol-9)*** 8%,12.5% foam, 2% gel	
Device - Supplies/OTC	
blood pressure monitor	Restriction: One per member per 5 years. $50 maximum per unit.
braces various (knee, ankle, wrist)	Restriction: One per affected area per member per 12 months. $50 maximum per unit.
crutches various	Restriction: One pair per member per 12 months
nebulizer various	Restriction: One per member per 3 years. $65 maximum per unit.
tablet splitter	
thermometer	Restriction: One per member per 12 months. Maximum $15 per unit.
vaporizer	

MEDICATIONS	RESTRICTIONS
Gastrointestinal - Antacid/OTC - Drugs for the stomach	
G ***calcium*** 500mg tablet	
G ***calcium acetate (12.5meq ca++/gm)*** 667mg tablet	
G ***calcium gluconate (4.5meq ca++/gm)*** 500mg, 650mg, 1 gm tablet	
G ***calcium lactate (6.5meq ca++/gm)*** 325mg, 650mg tablet	
GAVISCON® ***(aluminum hydroxide & mag. trisilicate)*** 80mg-14.2mg chewable tablet	
GAVISCON® ***(aluminum hydroxide, mag. carbonate)*** 160mg-105mg chewable tablet, 31.7mg-119.3mg/5ml susp	
G MAALOX® ***(aluminum & magnesium hydroxides)*** 200mg-200mg/5ml susp	
G MYLANTA® ***(aluminum & magnesium hydroxides w/simethicone)*** 200mg-200mg-25mg chewable tablet, 400mg-400mg-40mg/ 5ml susp	
G RIOPAN® ***(magaldrate)*** 540mg/5ml susp	
G TUMS® OS-CAL D® ***(calcium carbonate (20 meq ca++/gm) calcium carbonate w/vitamin d)*** 650mg tablet, 1250mg tablet or capsule, 500mg tablet	
Gastrointestinal - Antidiarrhea/OTC - Drugs for the stomach	
G IMODIUM® ***(loperamide)*** 2mg capsule, tablet, 1mg/5ml liquid	
Gastrointestinal - Antiemetic/OTC - Drugs for the stomach	
G ANTIVERT® ***(meclizine)*** 25mg chewable tablet	
65 G ***doxylamine succinate*** 25mg tablet	Restriction: Restricted to plan OB/GYN only.
Gastrointestinal - H2 Antagonist/OTC - Drugs for the stomach	
G PEPCID AC® ***(famotidine)*** 10mg tablet	Restriction: Minimum of 30/package.

MEDICATIONS	RESTRICTIONS
Gastrointestinal - Laxative /OTC - Drugs for the stomach	
G COLACE® ***(docusate)*** 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	
G DULCOLAX® ***(bisacodyl)*** 5mg tablet, 10mg supp	Restriction: Tablet for colon diagnostic testing only.
G FLEETS® ***(mineral oil)*** enema	Restriction: For colon diagnostic testing only.
G ***magnesium citrate*** solution	Restriction: For colon diagnostic testing only.
Gastrointestinal - Protectant/OTC - Drugs for the stomach	
G PEPTO-BISMAL® ***(bismuth subsalicylate)*** 262mg tablet or chewable tablet, 525mg/15ml 527mg/30ml susp	
Hematinic/OTC - Drugs for the blood	
G FER-IN-SOL® ***(ferrous sulfate)*** 75mg/ml soln, 300mg/5ml syrup, 324mg tablet, 325mg cr & ec tablet	
G VARIOUS ***(ferrous gluconate)*** 240mg, 324mg tablet	
Hormones - Antidiabetic/OTC - Drugs for diabetes	
* HUMULIN®, NOVOLIN® ***(insulin, human)*** 100 units/ml	
Ophthalmic - Antihistamine/OTC - Drugs for the eyes	
G ZADITOR® ***(ketotifen)*** 0.025% ophth soln	
Ophthalmic - Decongestant - Antihistamine/OTC Drugs for the eyes	
G NAPHCON-A® ***(naphazoline & pheniramine)*** 0.025%-0.3% ophth soln	
Ophthalmic - Decongestant/OTC - Drugs for the eyes	
G ALBALON® ***(naphazoline)*** 0.1% ophth soln	
Ostomy Items/OTC	
ostomy supplies various	Restriction: Pouches are allowed 30 per 30 days.
Respiratory - Antihistamine - Decongestant - Antitussive/OTC - Drugs for the lungs	
Restricted to members over 4 years.	

Continued on next page

MEDICATIONS	RESTRICTIONS
Respiratory - Antihistamine - Decongestant - Antitussive/OTC - Drugs for the lungs, continued • SEE PREVIOUS PAGE	
G DIMETANE DX® ***(pseudoephedrine, brompheniramine & dextromethorphan)*** 30mg-2mg-10mg/5ml syrup	
G PEDIACARE® ***(pseudoephedrine, chlorpheniramine & dextromethorphan)*** 15mg-1mg- 5mg/5ml, 15mg-1mg-7.5mg/5ml, 30mg-2mg-10mg/5ml liquid & syrup	
Respiratory - Antihistamine - Decongestant/OTC - Drugs for the lungs	
Restricted to members over 4 years.	
G CONTAC® ***(chlorpheniramine & phenylephrine)*** 1mg-2.5mg/5ml, 2mg-5mg/5ml, 4mg-10mg/5ml, syrup, 2mg-5mg tablet, 4mg-20mg cr tablet	
G DIMETAPP® NEW FORMUALTION ***(brompheniramine & phenylephrine)*** 1mg-2.5mg/5ml elixir	
G SUDAFED PLUS® ***(chlorpheniramine & pseudoephedrine)*** 2mg-30mg, 4mg-60mg tablet	
Respiratory - Antihistamine/OTC - Drugs for the lungs	
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.	
G BENADRYL® ***(diphenhydramine)*** 12.5mg/5ml elixir or syrup, 25mg, 50mg capsule or tablet	
G ***brompheniramine*** 2mg/5ml elixir	
G CHLORTRIMETON® ***(chlorpheniramine)*** 1mg/5ml liquid, 2mg/5ml syrup, 2mg, 4mg chewable tablet, 4mg tablet, 8mg, 12mg cr tablet, 6mg, 8mg, 12mg cr capsule	
G CLARITIN® ***(loratadine)*** 10mg quick dissolving tablet, 10mg tablet, 5mg/5ml syrup	Restriction: Liquid allowed < 5 years old.
G ZYRTEC® ***(cetirizine)*** 5 mg, 10 mg tablet, 1 mg/ml liq	Restriction: Limited to patients < 18 years old. Liquid allowed < 5 years old.

MEDICATIONS	RESTRICTIONS
Respiratory - Antitussive/OTC - Drugs for the lungs	
Restricted to members over 4 years.	
ROBITUSSIN PEDIATRIC® ***(dextromethorphan)*** 7.5mg/5ml, 10mg/5ml syrup	
Respiratory - Antitussive - Expectorant/OTC - Drugs for the lungs	
Restricted to members over 4 years.	
ROBITUSSIN DM® ***(dextromethorphan & guaifenesin)*** 10mg-100mg/5ml, 15mg-200mg/5ml, 30mg-200mg/ 5ml liquid, 3.33mg-33.3mg/5ml, 6.67mg-66.7mg/5ml syrup	
Respiratory - Decongestant/OTC - Drugs for the lungs	
Restricted to members over 4 years.	
SUDAFED® ***(pseudoephedrine)*** 30mg, 60mg, 120mg tablet, 15mg/5ml, 30mg/5ml liquid	
Respiratory - Expectorant/OTC - Drugs for the lungs	
Restricted to members over 4 years.	
ROBITUSSIN® ***(guaifenesin)*** 100mg/5ml, 200mg/5ml syrup	
Respiratory - Miscellaneous/OTC - Drugs for the lungs	
* ***sodium chloride*** 0.9% nebulizer soln	
Respiratory - Nasal Glucocorticoids/OTC - Drugs for the lungs	
NASACORT ALLERGY 24 HR OTC® ***(triamcinolone)*** 55 mcg mdi	
Supplies - /OTC	
Antiseptic solutions and hand wipes. One package allowed per 30 days.	
alcohol 70%, 91% topical soln	
CA-REZZ® ***(triclosan)*** cream, washes	
ethyl alchohol solutions, creams, gels, foam, washes, wipes	
HIBICLENS® ***(chlorhexidine gluconate)*** 4% liquid	

MEDICATIONS	RESTRICTIONS
Supplies - Diabetic/OTC	
✱ G KETO-DIASTIX®, KETOSTIX® ***(urine test strips)*** strip	
✱ ***lancets***	
✱ TRUE METRIX® ***(blood glucose strips)*** 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.
✱ TRUEPLUS® ***(syringes, syringes w/needles, pen needles)***	Restriction: Requires insulin to clear. Coinsides with insulin vial, pen. Limit up to 200 per 40 days.
Topical - Acne/OTC -Drugs for the skin	
G BENZAGEL® ***(benzoyl peroxide)*** 5%, 10% gel	
DIFFERIN® ***(adapalene)*** 0.1% gel	Restriction: Max 45 g per dispensing per 30 days.
Topical - Analgesics - Non-narcotic/OTC - Drugs for pain	
G ASPERCREME LIDOCAINE® ***(lidocaine)*** 4% patches	Restriction: 30 patches /month
G ICY HOT PATCHES® ***(lidocaine/ menthol)*** 4%/ 1% patches	Restriction: 30 patches/month
G VOLTAREN ARTHRITIS PAIN® ***(diclofenac na)*** 1% gel	Restriction: Maximum 350 gm per month
Topical - Antibiotic/OTC -Drugs for the skin	
G ***bacitracin*** ointment	
G NEOSPORIN® ***(neomycin, bacitracin & polymyxin)*** ointment	
Topical - Antifungal/OTC -Drugs for the skin	
G LOTRIMIN® ***(clotrimazole)*** 1% cream, oint, soln	Restriction: Solution allowed prescribed by ENT.
G MICATIN® ***(miconazole)*** 2% cream	

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MEDICATIONS	RESTRICTIONS
Topical - Antifungal/OTC -Drugs for the skin, continued • SEE PREVIOUS PAGE	
G TINACTIN® ***(tolnaftate)*** 1% cream and soln	
Topical - Anti-Infective/OTC -Drugs for the skin	
G ***calamine*** plain, phenolated lotion	
Topical - Astringent/OTC -Drugs for the skin	
DOMEBORO'S SOLN® ***(aluminum acetate)*** Powder	
Topical - Glucocorticoid/OTC -Drugs for the skin	
G ***hydrocortisone*** 0.5%,1% cream, oint, lotion	
Topical - Scabicide/OTC	
G NIX® ***(permethrin)*** 1% cream rinse	
G RID® ***(pyrethrins-piperonyl)*** 4%-0.33% liquid	
Vaginal - Anti-infective/OTC - Drugs for women	
GYNAZOLE 1® ***(butoconazole)*** 2% vaginal cream	
G GYNE-LOTRIMIN® ***(clotrimazole)*** 1% vaginal cream	
G MONISTAT® ***(miconazole)*** 2% vaginal cream, vaginal kit, 100mg vaginal supp	
Vitamins/OTC	
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.
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.
G ***pyridoxine (vitamin b-6)*** 25mg, 50mg, 100mg tablet	
G TRI-VI-SOL® ***(pediatric vitamins)*** ADC plain and w/iron drops	Restriction: Restricted to patients < 5 years old.
G ***vitamin e*** 400 international units, 1000 international unit capsule	

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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®

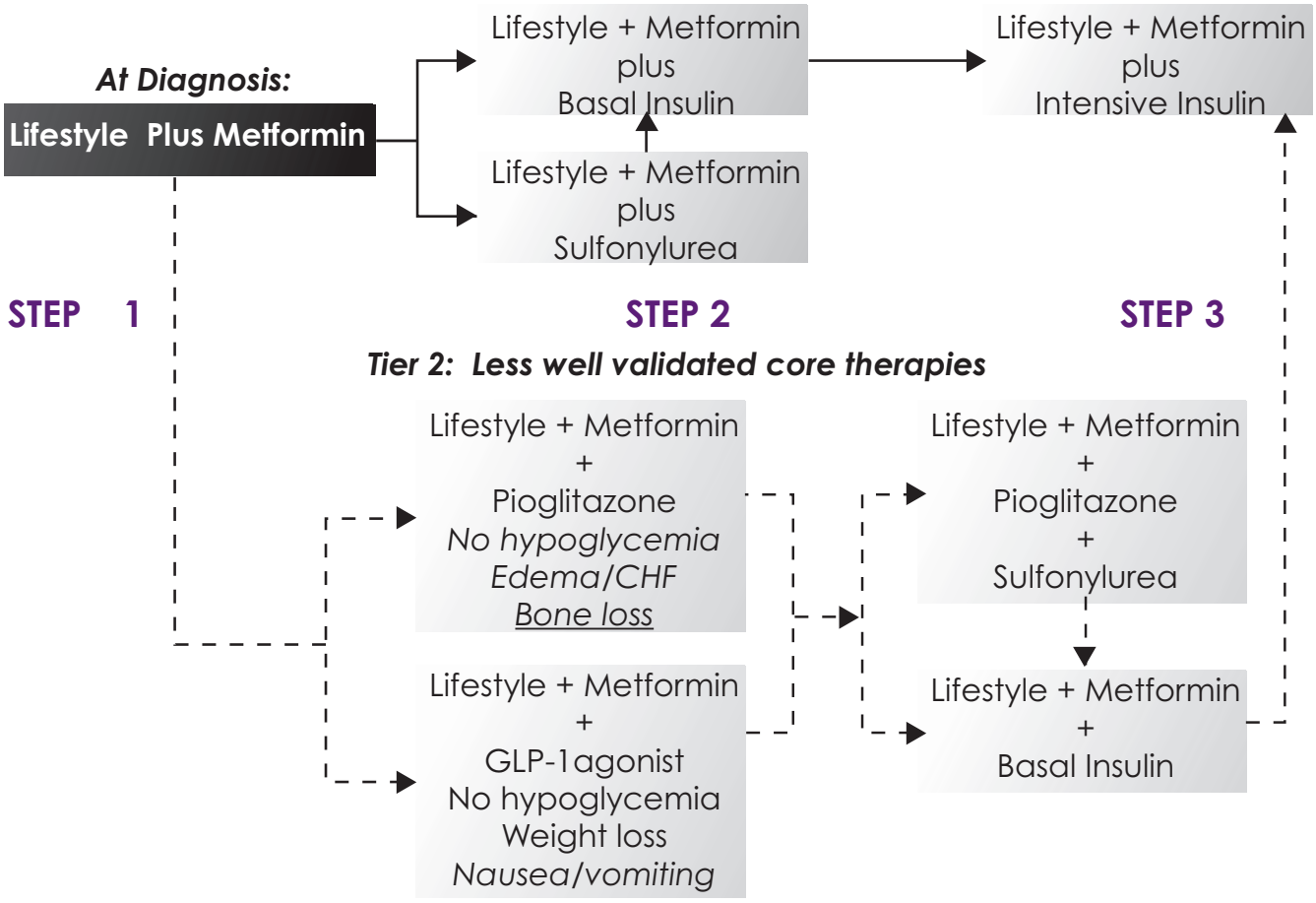
Blood Factors

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.

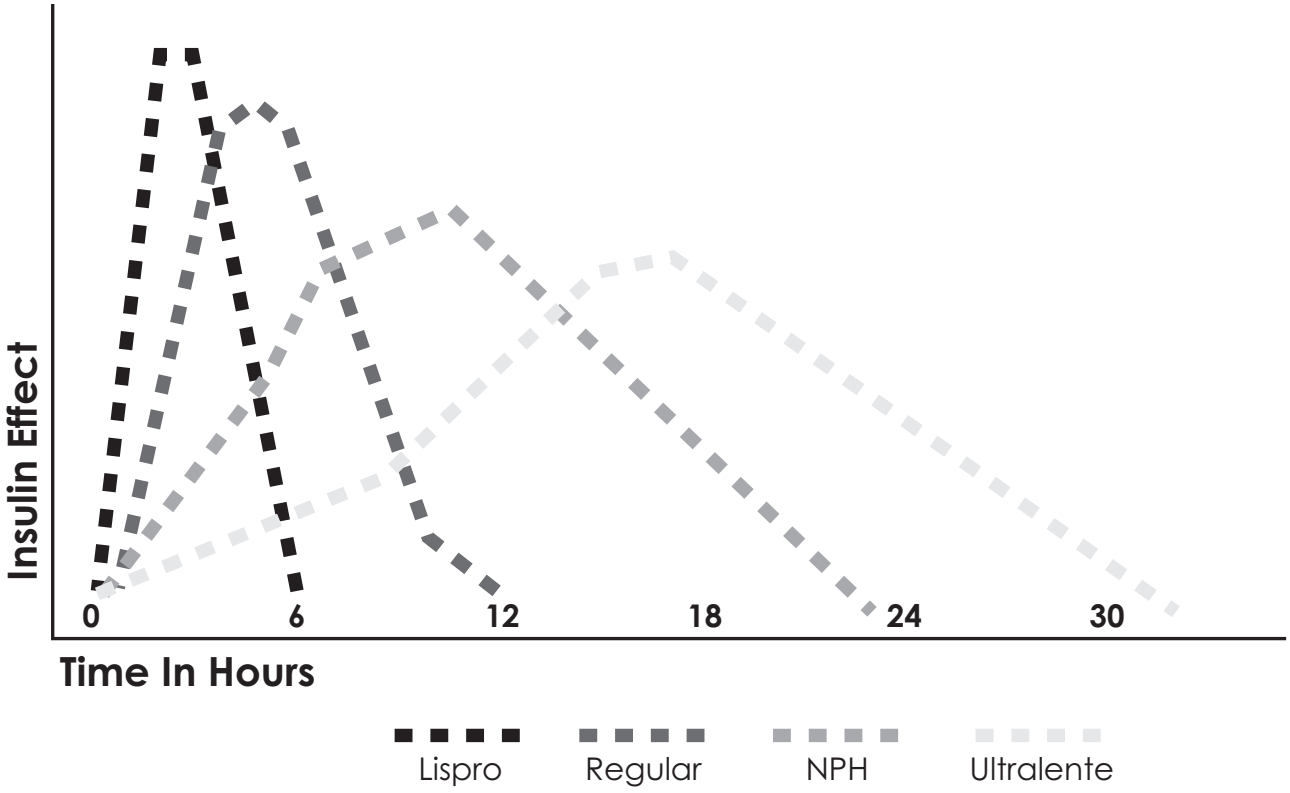
Management of Type 2 Diabetes Treatment, continued...

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

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z

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Drug Formulary

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