



**Group Health  
Clear Care Part D Formulary**

**2009 Abridged Formulary  
(List of Covered Drugs)**

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE  
COVER IN THIS PLAN**

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

This document includes Group Health's partial formulary as of September 1<sup>st</sup>, 2009. For a complete, updated formulary, please visit our Web site at [www.ghc.org](http://www.ghc.org) or call 1-888-901-4600, Monday- Friday, 8 a.m. to 8 p.m. From Nov.15, 2008 – Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/Relay users should call 1-800-833-6388

## **What is the Group Health Clear Care Part D Formulary?**

A formulary is a list of covered drugs selected by Group Health in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Group Health will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Group Health network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a **partial formulary** and includes only some of the drugs covered by Group Health. For a complete listing of all prescription drugs covered by Group Health, please visit our Web site at [www.ghc.org](http://www.ghc.org) or call 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov.15, 2008 through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388.

## **Can the Formulary change?**

Generally, if you are taking a drug on our 2009 Group Health Clear Care formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2009 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits on a drug or move a drug to a higher cost-sharing tier we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of January 1, 2009. To get updated information about the drugs covered by Group Health please visit our Web site at [www.ghc.org](http://www.ghc.org) or call Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov .15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388.

## **How do I use the Formulary?**

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on page number 6. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiac Drugs. If you know what your drug is used for, look for the category name in the list that begins page number 6. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page number 19. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

Group Health covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

## Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Group Health requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Group Health before you fill your prescriptions. If you don't get approval, Group Health may not cover the drug.
- **Quantity Limits:** For certain drugs, Group Health limits the amount of the drug that Group Health will cover. For example, Group Health provides 12 doses per prescription for MAXALT. This may be in addition to a standard one month or three month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page number 6.

You can ask Group Health to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Group Health formulary?" on page number 3 for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Service and ask if your drug is covered. This document includes only a **partial list** of covered drugs, so Group Health may cover your drug. You can contact Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov. 15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388.

The 2009 Group Health Clear Care Formulary includes all Medicare Part D allowable prescription drugs. Group Health does not cover any drugs that Medicare does not cover. Medicare Part D (and therefore Group Health) does not cover the following types of drugs:

- Benzodiazepines—mood drugs such as Valium
- Barbiturates such as Phenobarbital
- Cosmetic or hair-growth products.
- Drugs for weight loss or weight gain.
- Drugs for symptomatic relief of cough and cold
- Prescription vitamins and minerals

- Erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, and Caverject

If you learn that Group Health does not cover your drug, you have two options:

- You can ask Customer Services for a list of similar drugs that are covered by Group Health. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Group Health.
- You can ask Group Health to make an exception and cover your drug. See below for information about how to request an exception.

## **How do I request an exception to the 2009 Group Health Clear Care Formulary?**

You can ask Group Health to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Group Health limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Generic or Non-Preferred Brand-name drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Generic or Preferred Brand-name drug tier instead. This would lower the amount you must pay for your drug.

Generally, Group Health will only approve your request for an exception if the Preferred Generic or Preferred Brand-name drug is included on the plan's formulary, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a tiering or utilization restriction exception. **When you are requesting a tiering or utilization restriction exception you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

## **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary or covered at the Non-Preferred Generic or Non-Preferred Brand-name Coverage level. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Group Health assures that members in transition have access to covered medications without an interruption in therapy.

## For more information

For more detailed information about your Group Health prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Group Health, please call Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov. 15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388. Or visit [www.ghc.org](http://www.ghc.org).

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit [www.medicare.gov](http://www.medicare.gov).

## Group Health 2009 Clear Care Part D Formulary

The abridged formulary below provides coverage information about some of the drugs covered by Group Health. Remember: This is only a **partial list** of drugs covered by Group Health. If your prescription is not in this **partial formulary**, please visit our web site at [www.ghc.org](http://www.ghc.org) or call Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov. 15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., MAXALT) and generic drugs are listed in lower-case italics (e.g., *rizatriptan benzoate*).

The second column of the chart lists the drug tier or coverage level. Group Health covers all Medicare Part D allowable prescription drugs at three levels of coverage: Preferred Generic (Tier 1), Preferred Brand (Tier 2), and Non-Preferred Generic or Non-Preferred Brand-name drugs (Tier 3). To determine the coverage level you will need to determine the tier level (1, 2, or 3) of your drug. Once you have found your drug, look in the “Tier” column to determine whether your drug is Tier 1 (Preferred Generic), Tier 2 (Preferred Brand-name), or Tier 3 (Non-Preferred Generic or Non-Preferred Brand-name). Once you have determined the type of drug, you can refer to your 2009 Summary of Benefits or Evidence of Coverage for information on the level of coverage.

### Initial Coverage Level\*

Tier	Coverage Level	Clear Care Essential	Clear Care Optimal	Clear Care Sound
1	Preferred Generic	15% coinsurance	\$9 copayment	\$10 copayment

2	Preferred Brand	30% coinsurance	\$15 copayment	\$10 copayment
3	Non-Preferred Generic or Brand	50% coinsurance	50% coinsurance	50% coinsurance

\*Coverage level shown does not reflect deductibles, gap coverage, or catastrophic benefit coverage. Please refer to your 2009 Summary of Benefits or Evidence of Coverage for details.

The information in the Notes column tells you if Group Health has any special requirements for coverage of your drug. The following abbreviations are used:

- **PA = Prior Authorization:** Group Health requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Group Health before you fill your prescriptions. If you don't get approval, Group Health may not cover the drug.
- **QL = Quantity Limits:** For certain drugs, Group Health limits the amount of the drug that Group Health will cover. For example, Group Health provides 12 doses per prescription for MAXALT. This may be in addition to a standard one month or three month supply.
- **ML = Maintenance List:** For certain drugs you take on a regular basis, for a chronic or long term medical condition, you may order up to a 90-day supply of the drugs through mail-order prescription drug services or retail pharmacies who have agreed to accept the mail-order cost-sharing amount for an extended supply of maintenance medications.
- **LA = Limited Availability:** This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov. 15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY/TDD users should call TTY WA Relay: 711 or 1-800-833-6388.
- **HI = Home Infusion:** For certain drugs, Group Health may be covered under your medical benefit. For more information, call Customer Service at 1-888-901-4600, Monday – Friday, 8 a.m. to 8 p.m. From Nov. 15, 2008, through Mar. 1, 2009, we will be available every day of the week from 8 a.m. to 8 p.m. TTY WA Relay: 711 or 1-800-833-6388.

Drug Name	Drug Tier	Notes
<b>ADRENALS</b>		
<b>ADRENALS</b>		
ASMANEX 120 METERED DOSES	2	ML
ASMANEX 60 METERED DOSES	2	ML
<i>dexamethasone</i>	1	ML
FLOVENT HFA	2	ML
<i>fludrocortisone acetate</i>	1	ML
<i>methylprednisolone</i>	1	ML
<i>prednisolone</i>	1	ML
<i>prednisone</i>	1	ML
QVAR	2	ML
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>doxazosin mesylate</i>	1	ML
<i>terazosin hcl</i>	1	ML
<b>ANALGESICS AND ANTIPYRETICS</b>		
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS</b>		
CELEBREX	3	ML
<i>diclofenac sodium</i>	1	ML
<i>etodolac er</i>	1	ML
<i>ibuprofen</i>	1	ML
<i>indomethacin</i>	1	ML
<i>nabumetone</i>	1	ML
<i>naproxen</i>	1	ML
<i>sulindac</i>	1	ML
<i>tolmetin sodium</i>	1	ML
<b>OPIATE AGONISTS</b>		
<i>acetaminophen/codeine</i>	1	ML
<i>fentanyl</i>	1	
<i>hydrocodone /acetaminophen</i>	1	ML
<i>hydromorphone hcl</i>	1	ML
<i>morphine sulfate</i>	1	ML
<i>oxycodone /acetaminophen</i>	1	ML
<i>oxycodone hcl</i>	1	ML
OXYCONTIN	2	ML
<b>ANDROGENS</b>		
<b>ANDROGENS</b>		
ANDRODERM	2	ML
<i>testosterone cypionate</i>	1	ML
<i>testosterone enanthate</i>	1	
<b>ANTI-INFECTIVES (EENT)</b>		
<b>ANTIBACTERIALS (EENT)</b>		
<i>doxycycline hyclate</i>	1	ML
<b>ANTI-INFECTIVES (SKIN AND MUCOUS MEMBRANE)</b>		
<b>ANTIBACTERIALS (SKIN AND MUCOUS MEMBRANE)</b>		
<i>mupirocin</i>	1	ML
<b>ANTIFUNGALS (SKIN AND MUCOUS MEMBRANE)</b>		
<i>econazole nitrate</i>	1	ML
<i>ketoconazole</i>	1	ML

Drug Name	Drug Tier	Notes
<i>nystatin</i>	1	ML
<b>LOCAL ANTI-INFECTIVES, MISCELLANEOUS</b>		
<i>metronidazole</i>	1	ML
<i>selenium sulfide</i>	1	ML
<i>silver sulfadiazine</i>	1	ML
<i>sodium sulfacetamide</i>	1	ML
<b>ANTI-INFLAMMATORY AGENTS (EENT)</b>		
<b>CORTICOSTEROIDS (EENT)</b>		
<i>flunisolide</i>	1	ML
<i>fluticasone propionate</i>	1	ML
NASONEX	3	ML
<b>ANTI-INFLAMMATORY AGENTS (GI DRUGS)</b>		
<b>ANTI-INFLAMMATORY AGENTS (GI DRUGS)</b>		
ASACOL	2	ML
<b>ANTI-INFLAMMATORY AGENTS (RESPIRATORY)</b>		
<b>LEUKOTRIENE MODIFIERS</b>		
ACCOLATE	3	ML
SINGULAIR	2	ML
<b>ANTI-INFLAMMATORY AGENTS (SKIN AND MUCOUS)</b>		
<b>ANTI-INFLAMMATORY AGENTS (SKIN AND MUCOUS)</b>		
<i>clobetasol propionate</i>	1	ML
<i>desonide</i>	1	ML
<i>fluocinolone acetonide</i>	1	ML
<i>fluocinonide</i>	1	ML
<i>triamcinolone acetonide</i>	1	ML
<b>ANTIALLERGIC AGENTS</b>		
<b>ANTIALLERGIC AGENTS</b>		
ALOMIDE	2	ML
ASTELIN	2	ML
OPTIVAR	2	ML
PATANOL	2	ML
<b>ANTIBACTERIALS</b>		
<b>ANTIBACTERIALS, MISCELLANEOUS</b>		
<i>clindamycin hcl</i>	1	ML
VANCOCIN HCL	2	
<b>CEPHALOSPORINS</b>		
<i>cefuroxime axetil</i>	1	ML
<i>cephalexin</i>	1	ML
<b>MACROLIDES</b>		
<i>azithromycin tablet</i>	1	
<i>clarithromycin</i>	1	ML
ERYTHROMYCIN BASE TABLET 250MG	2	ML
<b>PENICILLINS</b>		
<i>amoxicillin</i>	1	ML
<i>amoxicillin/potassium clavulanate</i>	1	ML
<i>penicillin v potassium</i>	1	ML
<b>QUINOLONES</b>		
AVELOX TABLET	2	ML
<i>ciprofloxacin hcl tablet 100mg, 500mg</i>	1	ML
LEVAQUIN TABLET	2	

Drug Name	Drug Tier	Notes
<b>SULFONAMIDES (SYSTEMIC)</b>		
<i>sulfamethoxazole /trimethoprim</i>	1	ML
<i>sulfasalazine</i>	1	ML
<b>TETRACYCLINES</b>		
<i>doxycycline hyclate capsule, tablet</i>	1	ML
<i>minocycline hcl</i>	1	ML
<i>tetracycline hcl</i>	1	ML
<b>ANTICHOLINERGIC AGENTS</b>		
<b>ANTIMUSCARINICS/ANTISPASMODICS</b>		
ATROVENT HFA	2	ML
<i>propantheline bromide</i>	1	ML
SPIRIVA HANDIHALER	2	ML
<b>ANTICONVULSANTS</b>		
<b>ANTICONVULSANTS, MISCELLANEOUS</b>		
<i>carbamazepine</i>	1	ML
CARBATROL	2	ML
DEPAKOTE	3	ML
<i>gabapentin</i>	1	ML
KEPPRA	2	ML
<i>lamotrigine</i>	1	ML
TEGRETOL-XR	2	ML
TOPAMAX	2	ML
<i>valproic acid</i>	1	ML
<b>HYDANTOINS</b>		
CEREBYX	2	HI; ML
<i>phenytoin sodium extended</i>	1	ML
<b>SUCCINIMIDES</b>		
CELONTIN	2	ML
<i>ethosuximide</i>	1	ML
<b>ANTIDIABETIC AGENTS</b>		
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose</i>	1	ML
GLYSET	3	ML
<b>AMYLINOMIMETICS</b>		
SYMLIN	2	
<b>BIGUANIDES</b>		
<i>metformin hcl</i>	1	ML
<b>DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS</b>		
JANUVIA	2	ML
<b>INSULINS</b>		
APIDRA	3	ML
HUMALOG	3	ML
HUMULIN N	3	ML
HUMULIN R	3	ML
LANTUS	2	ML
LEVEMIR	3	ML
NOVOLIN 70/30	2	ML
NOVOLIN N	2	ML
NOVOLIN R	2	ML
NOVOLOG	2	ML

Drug Name	Drug Tier	Notes
<b>MEGLITINIDES</b>		
PRANDIN	2	ML
STARLIX	3	ML
<b>SULFONYLUREAS</b>		
<i>glipizide</i>	1	ML
<i>glyburide</i>	1	ML
<b>THIAZOLIDINEDIONES</b>		
ACTOS	3	ML
AVANDIA	3	ML
<b>ANTIEMETICS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
ANZEMET	3	PA
<i>ondansetron hcl</i>	1	PA
<b>ANTIEMETICS, MISCELLANEOUS</b>		
MARINOL	3	
TRANSDERM-SCOP	2	ML
<b>ANTIHISTAMINES (GI DRUGS)</b>		
<i>meclizine hcl</i>	1	
<i>prochlorperazine</i>	1	ML
<b>ANTIFUNGAL (SYSTEMIC)</b>		
<b>AZOLES</b>		
<i>fluconazole</i>	1	ML
<i>itraconazole</i>	1	
<b>ANTIGLAUCOMA AGENTS</b>		
<b>ALPHA-ADRENERGIC AGONISTS (EENT)</b>		
<i>brimonidine tartrate</i>	1	ML
<b>BETA-ADRENERGIC BLOCKING AGENTS (EENT)</b>		
<i>betaxolol hcl</i>	1	ML
<i>levobunolol hcl</i>	1	ML
<i>metipranolol</i>	1	ML
<i>timolol maleate</i>	1	ML
<b>CARBONIC ANHYDRASE INHIBITORS (EENT)</b>		
<i>acetazolamide</i>	1	ML
AZOPT	2	ML
<i>methazolamide</i>	1	ML
TRUSOPT	3	ML
<b>PROSTAGLANDIN ANALOGS</b>		
TRAVATAN	2	ML
TRAVATAN Z	2	ML
XALATAN	2	ML
<b>ANTILIPEMIC AGENTS</b>		
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
VYTORIN	2	ML
ZETIA	2	ML
<b>HMG-COA REDUCTASE INHIBITORS</b>		
CADUET	3	ML
LIPITOR TABLET 80MG	2	ML
LIPITOR TABLET 10MG, 20MG, 40MG	3	ML
<i>lovastatin</i>	1	ML
<i>pravastatin sodium</i>	1	ML

Drug Name	Drug Tier	Notes
<i>simvastatin</i>	1	ML
<b>ANTIMIGRAINE AGENTS</b>		
<b>SELECTIVE SEROTONIN AGONISTS</b>		
AMERGE	2	QL; ML
IMITREX	3	QL; ML
MAXALT-MLT	2	QL; ML
<b>ANTINEOPLASTIC AGENTS</b>		
<b>ANTINEOPLASTIC AGENTS</b>		
ARIMIDEX	2	ML
CASODEX	2	
<i>cyclophosphamide</i>	1	ML
EMCYT	2	
<i>etoposide</i>	1	PA HI
FEMARA	2	ML
<i>flutamide</i>	1	ML
GLEEVEC	2	
<i>hydroxyurea</i>	1	ML
<i>leuprolide acetate</i>	1	ML
<i>megestrol acetate</i>	1	ML
<i>mercaptopurine</i>	1	ML
<i>methotrexate</i>	1	ML
NEXAVAR	2	
SPRYCEL	2	
SUTENT	2	
<i>tamoxifen citrate</i>	1	ML
TARCEVA	2	
<b>ANTIPARKINSONIAN AGENTS</b>		
<b>ADAMANTANES (CNS)</b>		
<i>amantadine hcl</i>	1	ML
<b>ANTICHOLINERGIC AGENTS (CNS)</b>		
<i>benztropine mesylate</i>	1	ML
<i>trihexyphenidyl hcl</i>	1	ML
<b>CATECHOL-O-METHYLTRANSFERASE(COMT)INHIB.</b>		
COMTAN	2	ML
<b>DOPAMINE PRECURSORS</b>		
<i>carbidopa/levodopa</i>	1	ML
STALEVO 100	2	ML
STALEVO 150	2	ML
STALEVO 200	2	ML
STALEVO 50	2	ML
<b>DOPAMINE RECEPTOR AGONISTS</b>		
<i>cabergoline</i>	1	
MIRAPEX	2	ML
<i>ropinirole hcl</i>	1	ML
<b>MONOAMINE OXIDASE B INHIBITORS</b>		
AZILECT	2	ML
<i>selegiline hcl</i>	1	ML
<b>ANTIPROTOZOALS</b>		
<b>ANTIPROTOZOALS, MISCELLANEOUS</b>		
<i>metro iv</i>	1	HI

Drug Name	Drug Tier	Notes
<i>metronidazole</i>	1	ML
<b>ANTIPRURITICS AND LOCAL ANESTHETICS</b>		
<b>ANTIPRURITICS AND LOCAL ANESTHETICS</b>		
<i>lidocaine/prilocaine</i>	1	ML
LIDODERM	2	ML
<b>ANTITHROMBOTIC AGENTS</b>		
<b>ANTICOAGULANTS</b>		
LOVENOX	2	
<i>warfarin sodium</i>	1	ML
<b>PLATELET-AGGREGATION INHIBITORS</b>		
PLAVIX	2	ML
PLETAL	3	ML
<b>ANTIULCER AGENTS AND ACID SUPPRESSANTS</b>		
<b>HISTAMINE H2-ANTAGONISTS</b>		
<i>cimetidine</i>	1	ML
<i>ranitidine hcl</i>	1	ML
<b>PROSTAGLANDINS</b>		
<i>misoprostol</i>	1	ML
<b>PROTECTANTS</b>		
<i>sucralfate</i>	1	ML
<b>PROTON-PUMP INHIBITORS</b>		
NEXIUM	3	ML
<i>omeprazole</i>	1	ML
<i>pantoprazole sodium</i>	1	ML
<b>ANTIVIRALS (SYSTEMIC)</b>		
<b>ANTIRETROVIRALS</b>		
ATRIPLA	2	
COMBIVIR	2	
CRIXIVAN	2	
<i>didanosine</i>	1	
EMTRIVA	2	
EPIVIR	2	
EPZICOM	2	
INVIRASE	2	
KALETRA	2	
LEXIVA	2	
NORVIR	2	
PREZISTA	2	
RESCRIPTOR	2	
SUSTIVA	2	
TRUVADA	2	
VIRACEPT	2	
VIRAMUNE	2	
VIREAD	2	
ZERIT	2	
ZIAGEN	2	
<i>zidovudine</i>	1	
<b>INTERFERONS</b>		
INTRON-A	2	
PEGASYS	2	

Drug Name	Drug Tier	Notes
<b>NEURAMINIDASE INHIBITORS</b>		
RELENZA DISKHALER	3	
TAMIFLU	2	QL
<b>NUCLEOSIDES AND NUCLEOTIDES</b>		
<i>acyclovir</i>	1	ML
BARACLUDE	2	
FAMVIR	3	
<i>ganciclovir</i>	1	
HEPSERA	2	
<i>ribavirin</i>	1	
VALCYTE	2	
VALTREX	3	
<b>ANXIOLYTICS, SEDATIVES AND HYPNOTICS</b>		
<b>ANXIOLYTICS, SEDATIVES AND HYPNOTICS, MISC.</b>		
<i>bupirone hcl</i>	1	ML
LUNESTA	3	ML
ROZEREM	3	ML
<i>zaleplon</i>	3	ML
<i>zolpidem tartrate</i>	1	ML
<b>AUTONOMIC DRUGS, MISCELLANEOUS</b>		
<b>AUTONOMIC DRUGS, MISCELLANEOUS</b>		
CHANTIX	2	ML
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>atenolol</i>	1	ML
<i>carvedilol</i>	1	ML
<i>labetalol hcl</i>	1	ML
<i>metoprolol tartrate</i>	1	ML
<i>nadolol</i>	1	ML
<i>pindolol</i>	1	ML
<i>propranolol hcl</i>	1	ML
<i>sotalol hcl</i>	1	ML
<i>timolol maleate</i>	1	ML
<b>CALCIUM-CHANNEL BLOCKING AGENTS</b>		
<b>CALCIUM-CHANNEL BLOCKING AGENTS, MISC.</b>		
<i>diltiazem hcl</i>	1	ML
<i>verapamil hcl</i>	1	ML
<b>DIHYDROPYRIDINES</b>		
<i>amlodipine besylate</i>	1	ML
<i>felodipine er</i>	1	ML
<i>nifedipine</i>	1	ML
<b>CARDIAC DRUGS</b>		
<b>ANTIARRHYTHMIC AGENTS</b>		
<i>amiodarone hcl</i>	1	ML
<i>disopyramide phosphate</i>	1	ML
<i>flecainide acetate</i>	1	ML
<i>mexiletine hcl</i>	1	ML
<i>propafenone hcl</i>	1	ML
<i>quinidine gluconate cr</i>	1	ML
<i>quinidine sulfate er</i>	1	ML

Drug Name	Drug Tier	Notes
<b>CARDIAC DRUGS, MISCELLANEOUS</b>		
RANEXA	2	ML
<b>CARDIOTONIC AGENTS</b>		
DIGOXIN	2	ML
<b>CENTRAL NERVOUS SYSTEM AGENTS, MISC.</b>		
<b>CENTRAL NERVOUS SYSTEM AGENTS, MISC.</b>		
NAMENDA	2	ML
RILUTEK	2	
STRATTERA	2	ML
<b>DIURETICS</b>		
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	1	ML
EDECIN	2	ML
<i>furosemide</i>	1	ML
<b>POTASSIUM-SPARING DIURETICS</b>		
DYRENIUM	2	ML
<i>triamterene /hydrochlorothiazide</i>	1	ML
<b>THIAZIDE DIURETICS</b>		
<i>chlorothiazide</i>	1	ML
<i>hydrochlorothiazide</i>	1	ML
<b>THIAZIDE-LIKE DIURETICS</b>		
<i>chlorthalidone</i>	1	ML
<i>metolazone</i>	1	ML
<b>EENT DRUGS, MISCELLANEOUS</b>		
<b>EENT DRUGS, MISCELLANEOUS</b>		
<i>carteolol hcl</i>	1	ML
LUMIGAN	2	ML
<b>ESTROGENS AND ANTIESTROGENS</b>		
<b>ESTROGEN AGONIST-ANTAGONISTS</b>		
EVISTA	2	ML
<b>ESTROGENS</b>		
ESTRACE	2	ML
<i>estradiol</i>	1	ML
ESTRING	2	ML
<i>estropipate</i>	1	ML
PREMARIN	2	ML
<b>GENITOURINARY SMOOTH MUSCLE RELAXANTS</b>		
<b>GENITOURINARY SMOOTH MUSCLE RELAXANTS</b>		
DETROL LA	2	ML
<i>oxybutynin chloride</i>	1	ML
OXYTROL	2	ML
VESICARE	3	ML
<b>HEMATOPOIETIC AGENTS</b>		
<b>HEMATOPOIETIC AGENTS</b>		
ARANESP ALBUMIN FREE	3	PA
EPOGEN	2	PA
LEUKINE	2	
NEULASTA	3	
NEUPOGEN	2	
PROCRIT	2	PA

Drug Name	Drug Tier	Notes
<b>HYPOTENSIVE AGENTS</b>		
<b>CENTRAL ALPHA-AGONISTS</b>		
CATAPRES-TTS-1	2	ML
CATAPRES-TTS-2	2	ML
CATAPRES-TTS-3	2	ML
<i>clonidine hcl</i>	1	ML
<i>methyldopa</i>	1	ML
<b>DIRECT VASODILATORS</b>		
<i>hydralazine hcl</i>	1	ML
<i>minoxidil</i>	1	ML
PROGLYCEM	2	
<b>ION-REMOVING AGENTS</b>		
<b>PHOSPHATE-REMOVING AGENTS</b>		
FOSRENOL	3	
PHOSLO	2	ML
RENAGEL	2	
<b>POTASSIUM-REMOVING AGENTS</b>		
<i>sodium polystyrene sulfonate</i>	1	ML
<b>LOCAL ANESTHETICS (EENT)</b>		
<b>LOCAL ANESTHETICS (EENT)</b>		
<i>lidocaine hcl</i>	1	
<b>MISCELLANEOUS THERAPEUTIC AGENTS</b>		
<b>MISCELLANEOUS THERAPEUTIC AGENTS</b>		
ACTONEL	2	ML
<i>alendronate sodium</i>	1	ML
<i>allopurinol</i>	1	ML
AVODART	3	ML
AVONEX	2	QL
<i>azathioprine</i>	1	PA; ML
BETASERON	2	QL
BONIVA	3	ML
CELLCEPT	2	PA
COPAXONE	2	QL
<i>cyclosporine injection</i>	1	PA
<i>cyclosporine capsule</i>	1	PA; ML
ENBREL	2	
<i>finasteride</i>	1	ML
FLOMAX	3	ML
FOSAMAX	3	ML
FOSAMAX PLUS D	3	ML
HUMIRA	2	
<i>leflunomide</i>	1	
<i>leucovorin calcium tablet 15mg, 25mg, 5mg</i>	1	ML
MYFORTIC	2	PA
ORENCIA	2	
PROGRAF	2	PA
RAPAMUNE	2	PA
REBIF	2	QL
REMICADE	2	PA HI
REVLIMID	2	LA

Drug Name	Drug Tier	Notes
SENSIPAR	2	
THALOMID	2	
TYSABRI	3	LA HI
ZOMETA	2	HI
<b>PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS)</b>		
<b>PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS)</b>		
ARICEPT	2	ML
ARICEPT ODT	3	ML
<i>bethanechol chloride</i>	1	ML
EXELON	3	ML
RAZADYNE	3	ML
<b>PARATHYROID</b>		
<b>PARATHYROID</b>		
FORTEO	3	
FORTICAL	2	ML
<b>PROGESTINS</b>		
<b>PROGESTINS</b>		
<i>medroxyprogesterone acetate</i>	1	ML
<i>norethindrone acetate</i>	1	ML
PROMETRIUM	3	ML
<b>PROKINETIC AGENTS</b>		
<b>PROKINETIC AGENTS</b>		
<i>metoclopramide hcl</i>	1	ML
<b>PSYCHOTHERAPEUTIC AGENTS</b>		
<b>ANTIDEPRESSANTS</b>		
<i>bupropion hcl</i>	1	ML
<i>citalopram hydrobromide</i>	1	ML
CYMBALTA	2	ML
<i>desipramine hcl</i>	1	ML
EFFEXOR XR	2	ML
<i>fluoxetine hcl</i>	1	ML
LEXAPRO	3	ML
<i>mirtazapine</i>	1	ML
<i>nortriptyline hcl</i>	1	ML
<i>paroxetine hcl</i>	1	ML
<i>sertraline hcl</i>	1	ML
<i>sertraline hydrochloride</i>	1	ML
<i>trazodone hcl</i>	1	ML
<i>venlafaxine hcl</i>	1	ML
<b>ANTIPSYCHOTIC AGENTS</b>		
ABILIFY	2	
ABILIFY DISCMELT	3	
<i>clozapine</i>	1	
GEODON	2	ML
<i>haloperidol</i>	1	ML
<i>risperidone</i>	1	ML
SEROQUEL	2	ML
SEROQUEL XR	3	ML
ZYPREXA	2	ML
ZYPREXA ZYDIS	3	ML

Drug Name	Drug Tier	Notes
<b>RENIN-ANGIOTENSIN-ALDOSTERONE SYS. INHIB</b>		
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
AVAPRO	3	ML
BENICAR	3	ML
COZAAR	2	ML
DIOVAN	3	ML
HYZAAR	3	ML
MICARDIS	3	ML
<b>ANGIOTENSIN-CONVERTING ENZYME INHIBITORS</b>		
<i>benazepril hcl</i>	1	ML
<i>captopril</i>	1	ML
<i>enalapril maleate</i>	1	ML
<i>lisinopril</i>	1	ML
<i>lisinopril /hydrochlorothiazide</i>	1	ML
<i>quinapril hcl</i>	1	ML
<b>MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS</b>		
INSPRA	2	ML
<i>spironolactone</i>	1	ML
<i>spironolactone /hydrochlorothiazide</i>	1	ML
<b>REPLACEMENT PREPARATIONS</b>		
<b>REPLACEMENT PREPARATIONS</b>		
MICRO-K	3	ML
<i>potassium chloride er</i>	1	ML
<b>SECOND GENERATION ANTIHISTAMINES</b>		
<b>SECOND GENERATION ANTIHISTAMINES</b>		
<i>fexofenadine hcl</i>	1	ML
<b>SKELETAL MUSCLE RELAXANTS</b>		
<b>CENTRALLY ACTING SKELETAL MUSCLE RELAXNT</b>		
<i>cyclobenzaprine hcl</i>	1	ML
<i>methocarbamol</i>	1	ML
<i>tizanidine hcl</i>	1	ML
<b>GABA-DERIVATIVE SKELETAL MUSCLE RELAXANT</b>		
<i>baclofen</i>	1	ML
<b>SYMPATHOMIMETIC (ADRENERGIC) AGENTS</b>		
<b>ALPHA- AND BETA-ADRENERGIC AGONISTS</b>		
<i>epinephrine hcl</i>	1	
EIPEN 2-PAK	2	ML
EIPEN-JR 2-PAK	2	ML
TWINJECT	2	ML
<b>ALPHA-ADRENERGIC AGONISTS</b>		
<i>midodrine hcl</i>	1	ML
<b>BETA-ADRENERGIC AGONISTS</b>		
ADVAIR HFA	3	ML
ALUPENT	2	QL; ML
COMBIVENT	2	ML
PROAIR HFA	2	QL; ML
PROVENTIL HFA	3	QL; ML
SEREVENT DISKUS	2	ML
<b>THYROID AND ANTITHYROID AGENTS</b>		
<b>ANTITHYROID AGENTS</b>		

Drug Name	Drug Tier	Notes
<i>methimazole</i>	1	ML
<i>propylthiouracil</i>	1	ML
<b>THYROID AGENTS</b>		
CYTOMEL	2	ML
LEVOTHROID	2	ML
<i>levothyroxine sodium</i>	1	ML
<b>VASODILATING AGENTS</b>		
<b>NITRATES AND NITRITES</b>		
<i>isosorbide dinitrate</i>	1	ML
<i>isosorbide mononitrate</i>	1	ML
<i>nitroglycerin transdermal</i>	1	ML
NITROSTAT	2	ML
<b>VITAMIN D</b>		
<b>VITAMIN D</b>		
<i>calcitriol</i>	1	ML
HECTOROL	2	ML
ZEMPLAR	3	ML

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SENSIPAR	15
SEREVENT DISKUS	15
SEROQUEL	15
SEROQUEL XR	15
<i>sertraline hcl</i>	15
<i>sertraline hydrochloride</i>	15
<i>silver sulfadiazine</i>	11
<i>simvastatin</i>	15
SINGULAIR	12
<i>sodium polystyrene sulfonate</i>	15
<i>sodium sulfacetamide</i>	11
<i>sotalol hcl</i>	15
SPIRIVA HANDIHALER	13
<i>spironolactone</i>	15
<i>spironolactone /hydrochlorothiazide</i>	15
SPRYCEL	15
STALEVO 100	15
STALEVO 150	15
STALEVO 200	15
STALEVO 50	15
STARLIX	14
STRATTERA	15
<i>sucralfate</i>	15
<i>sulfamethoxazole /trimethoprim</i>	13
<i>sulfasalazine</i>	13
<i>sulindac</i>	10
SUSTIVA	15
SUTENT	15

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SYMLIN	14
TAMIFLU	15
<i>tamoxifen citrate</i>	15
TARCEVA	15
TEGRETOL-XR	13
<i>terazosin hcl</i>	10
<i>testosterone cypionate</i>	11
<i>testosterone enanthate</i>	11
<i>tetracycline hcl</i>	13
THALOMID	15
<i>timolol maleate</i>	15
<i>timolol maleate</i>	15
<i>tizanidine hcl</i>	15
<i>tolmetin sodium</i>	10
TOPAMAX	13
TRANSDERM-SCOP	15
TRAVATAN	15
TRAVATAN Z	15
<i>trazodone hcl</i>	15
<i>triamcinolone acetonide</i>	12
<i>triamterene /hydrochlorothiazide</i>	15
<i>trihexyphenidyl hcl</i>	15
TRUSOPT	15
TRUVADA	15
TWINJECT	15
TYSABRI	15
VALCYTE	15
<i>valproic acid</i>	13
VALTREX	15
VANCOCIN HCL	12
<i>venlafaxine hcl</i>	15
<i>verapamil hcl</i>	15
VESICARE	15
VIRACEPT	15
VIRAMUNE	15
VIREAD	15
VYTORIN	15
<i>warfarin sodium</i>	15
XALATAN	15
<i>zaleplon</i>	15
ZEMPLAR	15
ZERIT	15
ZETIA	15
ZIAGEN	15
<i>zidovudine</i>	15
<i>zolpidem tartrate</i>	15
ZOMETA	15
ZYPREXA	15
ZYPREXA ZYDIS	15