

# Your Pharmacy Program

*Effective January 1, 2009*



MASSACHUSETTS

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# Introduction

Blue Cross Blue Shield of Massachusetts remains committed to providing affordable, quality prescription coverage that meets our members' needs. We've developed our prescription medication coverage guidelines to help you get the most value from your pharmacy program.

These guidelines include:

- *Prior Authorization*
- *Step Therapy*
- *Quality Care Dosing*
- *Non-Covered Medications*
- *New Medication Approval Process*

Medications affected by these guidelines are listed throughout this brochure.\*

For additional information on your Pharmacy Program or prescription medications, please feel free to visit the **Pharmacy Program** section at [www.bluecrossma.com](http://www.bluecrossma.com). You can also call Member Service at the toll-free number on the front of your ID card.

\* Please note: The guidelines and the list of affected medications are subject to change from time to time.

## Prior Authorization

Your doctor is required to obtain prior authorization before prescribing specific medications. This is generally required in cases where the patient must meet certain medical-necessity criteria in order to receive coverage.

For the most up-to-date list of medications that require prior authorization, please visit our website [www.bluecrossma.com](http://www.bluecrossma.com), click on **Pharmacy Program**, and proceed to **Medications That Require Prior Authorization**.

Another part of our prior authorization program is step therapy. Please refer to pages 4–5 for a listing of medications that require step therapy.

### Prior Authorization List

*This list of medications that require prior authorization is up-to-date as of January 1, 2009, and may change from time to time.*

** Aldurazyme <sup>®</sup>	Enbrel <sup>®</sup> (QCD)	Prograf <sup>®</sup>
** Amevive <sup>®</sup>	** enteral formula	** Prolastin <sup>®</sup>
amphetamines	Epogen <sup>®</sup> (QCD)	Protopic <sup>®</sup>
Aranesp <sup>®</sup> (QCD)	** Fabrazyme <sup>®</sup>	Provigil <sup>®</sup>
azathioprine	** factor VIII, VIIIa & IX	Rapamune <sup>®</sup>
* Boniva <sup>®</sup> syringe	Forteo <sup>®</sup> (QCD)	Raptiva <sup>™</sup>
botulinum toxin	growth hormone	** Reclast <sup>®</sup>
Cellcept <sup>®</sup>	Humira <sup>®</sup> (QCD)	Remicade <sup>®</sup>
** Ceredase <sup>®</sup>	interferons ( <i>alpha</i> , <i>gamma</i> )	** Respiratory SyncytialVirus IG/Synagis <sup>®</sup>
** Cerezyme <sup>®</sup>	itraconazole (QCD)	Revatio <sup>®</sup>
ciclopirox nail lacquer (QCD)	** IV Immunoglobulin	Rituxan <sup>®</sup>
Cimzia <sup>®</sup>	Kineret <sup>®</sup>	Simulect <sup>®</sup>
* CNL 8 <sup>®</sup> nail kit (QCD)	Lamisil <sup>®</sup> (QCD)	Somatuline <sup>®</sup>
cyclosporine	Lyrica <sup>®</sup>	Somavert <sup>®</sup>
Cytoxan <sup>®</sup>	Orencia <sup>™</sup>	* Sporanox <sup>®</sup> (QCD)
Desoxy <sup>®</sup>	Penlac <sup>®</sup> (QCD)	Strattera <sup>®</sup> (QCD)
dextroamphetamines (e.g. Dexedrine <sup>®</sup> )	** Preservative-Free Morphine	terbinafine (QCD)
Elidel <sup>®</sup>	Procrit <sup>®</sup> (QCD)	

\* (Non-covered Medication) prior authorization required for members with approved formulary exceptions

\*\* Covered under medical benefit only  
(QCD) Quality Care Dosing limits apply

topical retinoic  
acid derivatives  
(e.g., Retin A<sup>®</sup>)

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\*\*TPN (*total parenteral  
nutrition*)

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\*\*Tysabri<sup>®</sup>

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VePesid<sup>®</sup>

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Zenapax<sup>®</sup>

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\*\*Zometa<sup>®</sup>

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\* (Non-covered Medication) prior authorization required for members with approved formulary exceptions

\*\* Covered under medical benefit only

(QCD) Quality Care Dosing limits apply

# Step Therapy

Step therapy is a key part of our prior authorization program that allows us to help your doctor provide you with an appropriate and affordable drug treatment. Before coverage is allowed for certain costly “second-step” medications, it is required that you first try an effective, but less expensive, “first-step” medication.

## Step Therapy List

*This list is up-to-date as of January 1, 2009, and is subject to change at any time. You can find the most up-to-date information about a specific prescription medication on our website at [www.bluecrossma.com](http://www.bluecrossma.com).*

### Antidepressant Drugs

Celexa <sup>®</sup> (QCD)
Cymbalta <sup>®</sup>
Effexor <sup>®</sup> (QCD)
Effexor XR <sup>®</sup> (QCD)
Lexapro <sup>™</sup> (QCD)
* Luvox <sup>®</sup> (QCD)
Paxil <sup>®</sup> (QCD)
* Paxil CR <sup>™</sup> (QCD)
* Pexeva <sup>™</sup> (QCD)
* Pristiq <sup>®</sup> (QCD)
Prozac <sup>®</sup> (QCD)
* Prozac <sup>®</sup> Weekly <sup>™</sup> (QCD)
* Sarafem <sup>®</sup> (QCD)
Wellbutrin SR <sup>®</sup> (100 mg, 150 mg) (QCD)
* Wellbutrin SR <sup>®</sup> (200 mg) (QCD)
* Wellbutrin XL <sup>®</sup> (QCD)
Zoloft <sup>®</sup> (QCD)

### Asthma Management

* Accolate <sup>®</sup>
Advair <sup>®</sup> Discus <sup>®</sup> (QCD)
Advair <sup>®</sup> HFA (QCD)
Singular <sup>®</sup>
Symbicort <sup>®</sup> (QCD)
* Zyflo <sup>®</sup>
* Zyflo CR <sup>™</sup>

### Cardiovascular Drugs

eplerenone
Inspra <sup>™</sup>

### Cholesterol Treatment

Advicor <sup>™</sup>
* Altoprev <sup>™</sup>
Crestor <sup>®</sup> (QCD)
* Lescol <sup>®</sup> (QCD)
* Lescol XL <sup>®</sup> (QCD)
Lipitor <sup>®</sup> (QCD)
* Mevacor <sup>®</sup> (QCD)
Pravachol <sup>®</sup> (QCD)
* Simcor <sup>®</sup> (QCD)
Vytorin <sup>™</sup> (QCD)

Zetia<sup>™</sup> (QCD)

Zocor<sup>®</sup> (QCD)

### Diabetes Management

Exubera <sup>®</sup>
Janumet <sup>™</sup>
Januvia <sup>™</sup>

### Gastrointestinal Drugs (Proton Pump Inhibitors)

* AcipHex <sup>®</sup> (QCD)
* Nexium <sup>™</sup> (QCD)
pantoprazole (QCD)
Prevacid <sup>®</sup> (QCD)
* Prilosec <sup>®</sup> (QCD)
Protonix <sup>®</sup> (QCD)
* Zegerid <sup>®</sup> (QCD)

\* (Non-covered Medication) step therapy required for members with approved formulary exceptions (QCD) Quality Care Dosing limits apply

## Heart/Blood Modifiers/ Circulation

\*Atacand®

\*Atacand HCT®

Avalide®

Avapro®

Azor®

Benicar®

Benicar HCT™

\*Cozaar®

Diovan®

Diovan HCT®

Exforge®

\*Hyzaar®

\*Micardis®

\*Micardis HCT®

\*Teveten®

\*Teveten HCT®

## Insomnia Treatment

Ambien™ (QCD)

\*Ambien CR™ (QCD)

Lunesta™ (QCD)

\*Rozerem™ (QCD)

Sonata® (QCD)

## Oncology (Oral) Agents

Sprycel®

Sutent®

Tasigna®

## Osteoporosis

### Treatment (Oral)

Actonel® (QCD)

\*Boniva® (QCD)

Fosamax® (QCD)

## Pain Relievers (Cox II Inhibitors)

Celebrex® (QCD)

## Prostate Treatment

Avodart®

Proscar®

\* (Non-covered Medication) step therapy required for members with approved formulary exceptions (QCD) Quality Care Dosing limits apply

## Quality Care Dosing

Quality Care Dosing efforts help to monitor the quantity and dose of medication a patient receives based on Food and Drug Administration (FDA) recommendations, as well as manufacturer and clinical information. *Changes to your medication will be done with your doctor's approval.*

When you fill a prescription for one of the following medications, your prescription is checked electronically in two ways:

- **Dose Consolidation**—Checks to see whether you're taking two or more pills a day that can be replaced with one pill providing the same daily dosage.
- **Recommended Monthly Dosing Level**—Checks to see that your monthly dosage is consistent with the manufacturer's and FDA's monthly dosing recommendations and clinical information.

For the most up-to-date list of medications subject to Quality Care Dosing, along with associated dosing limits, please visit our website at [www.bluecrossma.com](http://www.bluecrossma.com), click on **Pharmacy Program**, and proceed to the **Quality Care Dosing** section.

*Please note: Your doctor may request an exception from the guidelines for medications that are subject to Quality Care Dosing (when medically necessary).*

### Quality Care Dosing List

*This list of medications that are in our Quality Care Dosing program is up-to-date as of January 1, 2009, and may change from time to time.*

* AcipHex <sup>®</sup> (ST)	* Aerobid <sup>®</sup> -M	* Ambien <sup>™</sup> CR (ST)
Actonel <sup>®</sup> (ST)	* Alamast <sup>®</sup>	Amerge <sup>™</sup>
ACTOplus met <sup>™</sup>	albuterol/HFA inhaler	amlodipine
Actos <sup>®</sup>	alendronate	* Anzemet <sup>®</sup>
Acular <sup>®</sup> /PF/LS	* Alocril <sup>®</sup>	Aranesp <sup>®</sup> (PA)
Adderall XR <sup>®</sup>	Alomide <sup>®</sup>	Arava <sup>®</sup>
Advair <sup>®</sup> Discus <sup>®</sup> (ST)	* Alora <sup>®</sup>	Arixtra <sup>®</sup>
Advair <sup>®</sup> HFA (ST)	* Alrex <sup>™</sup>	* Asmanex <sup>®</sup> Twisthaler <sup>®</sup>
Advicor <sup>®</sup> (ST)	Alupent <sup>®</sup> inhaler	Astelina <sup>®</sup>
* Aerobid <sup>®</sup>	Ambien <sup>™</sup> (ST)	Atrovent <sup>®</sup> (nasal spray)

*\* (Non-covered Medication) Quality Care Dosing limits apply for members with approved formulary exceptions (PA) prior authorization required (ST) step therapy required*

Atrovent <sup>®</sup> HFA	Crolom <sup>®</sup>	granisetron
Avandamet <sup>™</sup>	cromolyn	Humira <sup>®</sup> (PA)
Avandia <sup>®</sup>	Diflucan <sup>®</sup> (150 mg only)	* Hytrin <sup>®</sup>
Avonex <sup>®</sup>	Dostinex <sup>®</sup>	Imitrex <sup>®</sup>
* Axert <sup>®</sup>	doxazosin	Imitrex <sup>®</sup> Syringe
* Azmacort <sup>®</sup>	Effexor <sup>®</sup> XR (ST)	Infergen <sup>®</sup> (PA)
* Beconase <sup>®</sup>	* Elestat <sup>™</sup>	Intal <sup>®</sup>
* Beconase <sup>®</sup> AQ	Emadine <sup>®</sup>	ipratropium NS <sup>®</sup>
Betaseron <sup>®</sup>	Emend <sup>®</sup>	itraconazole (PA)
* Boniva <sup>®</sup> (ST)	Enbrel <sup>®</sup> (PA)	* Kytril <sup>™</sup>
Budeprion <sup>™</sup> SR	Epogen <sup>®</sup> (PA)	Lamisil <sup>®</sup> (PA)
Budeprion <sup>™</sup> XL	Estraderm <sup>®</sup>	leflunomide
bupropion SR	estradiol patch	* Lescol <sup>®</sup> (ST)
bupropion XL	* Estrasorb <sup>®</sup>	* Lescol <sup>®</sup> XL (ST)
butorphanol NS	* Estrogel <sup>®</sup>	Lexapro <sup>™</sup> (ST)
cabergoline	* Evamist <sup>®</sup>	Lipitor <sup>®</sup> (ST)
* Caduet <sup>®</sup> (ST)	famciclovir	* Livostin <sup>®</sup>
* Cardura <sup>®</sup>	* Famvir <sup>®</sup>	Lotronex <sup>®</sup>
* Cardura XL <sup>®</sup>	Flonase <sup>®</sup>	lovastatin
Catapres TTS <sup>®</sup>	Flovent <sup>®</sup> /HFA	Lovenox <sup>®</sup>
Celebrex <sup>™</sup> (ST)	fluconazole (150 mg only)	Lunesta <sup>™</sup> (ST)
Celexa <sup>®</sup> (ST)	flunisolide	** Luvox CR <sup>®</sup>
* Cesamet <sup>™</sup>	fluoxetine	* Maxair <sup>®</sup>
ciclopirox nail lacquer (PA)	fluticasone	* Maxair <sup>®</sup> Autohaler <sup>®</sup>
citalopram	fluvoxamine	* Maxalt <sup>®</sup>
Climara <sup>®</sup>	Foradil <sup>®</sup>	* Maxalt-MLT <sup>®</sup>
Climara <sup>®</sup> Pro	Forteo <sup>®</sup> (PA)	meloxicam
* CNL 8 <sup>®</sup> nail kit (PA)	Fosamax <sup>®</sup> (ST)	* Menostar <sup>®</sup>
Combivent <sup>®</sup>	Fragmin <sup>®</sup>	* Mevacor <sup>®</sup> (ST)
Concerta <sup>®</sup>	* Frova <sup>™</sup>	Migranal <sup>®</sup>
Copaxone <sup>®</sup>	Glucose testing strips (all)	mirtazapine
Crestor <sup>®</sup> (ST)		* Mobic <sup>®</sup> (ST)
		* Nasacort <sup>®</sup>

\* (Non-covered Medication) Quality Care Dosing limits apply for members with approved formulary exceptions

\*\* (New to market drug – non-covered while under review) Quantity limits apply to members with approved formulary exceptions

(PA) prior authorization required

(ST) step therapy required

*Nasacort <sup>®</sup> AQ	Protonix <sup>®</sup> (ST)	Valtrex <sup>®</sup>
*Nasarel <sup>®</sup>	*Proventil <sup>®</sup> HFA	*Ventolin <sup>®</sup>
*Nasonex <sup>®</sup>	*Proventil <sup>®</sup> Inhaler	*Ventolin <sup>®</sup> HFA
NebuPent <sup>™</sup>	Prozac <sup>®</sup> (ST)	*Veramyst <sup>®</sup>
Neulasta <sup>®</sup>	*Prozac <sup>®</sup> Weekly (ST)	Vigamox <sup>™</sup>
Neupogen <sup>®</sup>	Pulmicort <sup>®</sup> Flexhaler <sup>™</sup>	Vivelle <sup>®</sup>
*Nexium <sup>™</sup> (ST)	Pulmicort <sup>®</sup> Respules <sup>™</sup>	Vivelle <sup>®</sup> DOT
Norvasc <sup>®</sup>	Pulmicort <sup>®</sup>	Vytorin <sup>™</sup> (ST)
omeprazole	Turbuhaler <sup>®</sup>	*Vyvanse <sup>®</sup>
*Omniaris <sup>™</sup>	Quaaliquin <sup>®</sup>	Wellbutrin SR <sup>®</sup> (100 mg, 150 mg) (ST)
ondansetron	QVAR <sup>™</sup>	*Wellbutrin SR <sup>®</sup> (200 mg) (ST)
*Optivar <sup>™</sup>	Rebif <sup>®</sup>	*Wellbutrin XL <sup>™</sup> (ST)
pantoprazole (ST)	Relpax <sup>®</sup>	*Xopenex <sup>®</sup> HFA
paroxetine	*Remeron <sup>®</sup>	zaleplon
paroxetine CR	Restasis <sup>®</sup>	*Zegerid <sup>®</sup> (ST)
*Pataday <sup>™</sup>	*Rhinocort Aqua <sup>®</sup>	Zelnorm <sup>®</sup>
**Patanase <sup>®</sup>	*Rozerem <sup>™</sup> (ST)	Zetia <sup>™</sup> (ST)
Patanol <sup>®</sup>	*Sarafem <sup>®</sup> (ST)	Zocor <sup>®</sup> (ST)
Paxil <sup>™</sup> (ST)	Selferma <sup>®</sup>	Zofran <sup>®</sup>
*Paxil <sup>™</sup> CR (ST)	Serevent Diskus <sup>®</sup>	Zolof <sup>®</sup> (ST)
Pegasy <sup>®</sup> (PA)	sertraline	zolpidem
PEG-Intron <sup>®</sup> (PA)	*Simcor <sup>®</sup> (ST)	Zomig <sup>®</sup>
Penlac <sup>®</sup> (PA)	simvastatin	Zymar <sup>®</sup>
*Pexeva <sup>™</sup> (ST)	Sonata <sup>®</sup> (ST)	
Pravachol <sup>®</sup> (ST)	Spiriva <sup>®</sup>	
pravastatin	*Sporanox <sup>®</sup> (PA)	
*Pravigard <sup>™</sup> PAC	Strattera <sup>®</sup> (PA)	
Prevacid <sup>®</sup> (ST)	Symbicort <sup>®</sup> (ST)	
Prevpac <sup>®</sup>	Symbyax <sup>™</sup>	
*Prilosec <sup>™</sup> (ST)	terazosin	
*Pristiq <sup>®</sup> (ST)	terbinafine (PA)	
ProAir <sup>™</sup> HFA	Tilade <sup>®</sup>	
Procrit <sup>®</sup> (PA)	**Treximet <sup>®</sup>	

\* (Non-covered Medication) Quality Care Dosing limits apply for members with approved formulary exceptions

\*\* (New to market drug – non-covered while under review) Quantity limits apply to members with approved formulary exceptions

(PA) prior authorization required

(ST) step therapy required

## Non-Covered Medications

Your Pharmacy Program provides coverage for over 4,000 prescription medications. Most medications on our non-covered list have equally safe, effective, covered alternatives for treating the same medical conditions. Check with your doctor about appropriate alternatives if you currently take any of these medications.

For the most up-to-date list of medications that are not covered and their covered alternatives, please visit our website [www.bluecrossma.com](http://www.bluecrossma.com), click on **Pharmacy Program**, and proceed to the **Medications That Are Not Covered** section.

*Please note: Your doctor may request coverage for a non-covered medication if no covered alternative is appropriate for treating your condition.*

### Non-Covered Medication List

*This list of non-covered medications is up-to-date as of January 1, 2009, and may change from time to time.*

Abilify <sup>®</sup> DiscMelt <sup>™</sup>	Alocril <sup>®</sup> (QCD)	Ascensia <sup>™</sup> diabetic testing supplies (QCD)
Accolate <sup>®</sup> (ST)	Alodox <sup>®</sup>	Asmanex <sup>®</sup>
AccuNeb <sup>®</sup>	Alora <sup>®</sup> (QCD)	Twisthaler <sup>®</sup> (QCD)
Accupril <sup>®</sup>	Alrex <sup>™</sup> (QCD)	Assure <sup>®</sup> Pro diabetic testing supplies (QCD)
Accuretic <sup>®</sup>	Altanax <sup>®</sup>	Atacand <sup>™</sup> (ST)
Accutane <sup>®</sup>	Altace <sup>™</sup>	Atacand HCT <sup>™</sup> (ST)
Aceon <sup>®</sup>	Altoprev <sup>™</sup> (ST)	Ativan <sup>®</sup>
AcipHex <sup>®</sup> (QCD) (ST)	Ambien CR <sup>®</sup> (QCD) (ST)	Atopiclair <sup>™</sup>
Activella <sup>®</sup>	Amitiza <sup>®</sup>	Atralin <sup>®</sup>
Adalat <sup>®</sup> CC	Amrix <sup>®</sup>	Atropen <sup>®</sup>
Adoxa CK <sup>®</sup>	AndroGel <sup>®</sup>	Augmentin XR <sup>™</sup>
Adoxa TT <sup>®</sup>	Angeliq <sup>®</sup>	Avinza <sup>™</sup>
Aerobid <sup>®</sup> (QCD)	Antara <sup>™</sup>	Avita <sup>®</sup>
Aerobid <sup>®</sup> -M (QCD)	Anzemet <sup>®</sup> (QCD)	Axert <sup>®</sup> (QCD)
Airet <sup>®</sup>	Apidra <sup>®</sup>	Axid <sup>®</sup>
Alamast <sup>®</sup> (QCD)		

*(PA) prior authorization required for members with approved formulary exceptions  
(QCD) Quality Care Dosing limits apply for members with approved formulary exceptions  
(ST) step therapy required for members with approved formulary exceptions*

Azasite <sup>®</sup>	Daytrana <sup>™</sup>	Fertinex <sup>®</sup>
Azmacort <sup>™</sup> (QCD)	Demulen <sup>®</sup>	Fexmid <sup>®</sup>
B-D <sup>™</sup> diabetic testing supplies (QCD)	Depo-Sub Q Provera 104 <sup>™</sup>	Fioricet <sup>®</sup>
Beconase <sup>®</sup> AQ (QCD)	DermOtic <sup>®</sup>	Flagyl <sup>®</sup>
Bionect <sup>®</sup>	Desogen <sup>®</sup>	Flagyl <sup>®</sup> ER
Boniva <sup>®</sup> (QCD) (ST)	Dilacor XR <sup>®</sup>	Flector <sup>®</sup>
Brevicon <sup>®</sup>	Dipentum <sup>®</sup>	Focalin <sup>™</sup>
Brovana <sup>®</sup>	Dispermox <sup>™</sup>	Focalin <sup>™</sup> XR
Bystolic <sup>®</sup>	Divigel <sup>®</sup>	Follistim <sup>®</sup> /AQ
Caduet <sup>®</sup> (QCD)	Doryx <sup>®</sup>	Fortamet <sup>®</sup>
Capoten <sup>®</sup>	Dynabac <sup>®</sup>	Freestyle <sup>®</sup> diabetic supplies (QCD)
Cardene <sup>®</sup>	Dynacin <sup>®</sup>	Fresh Kote <sup>™</sup>
Cardene <sup>®</sup> SR	Dynacirc <sup>®</sup>	Frova <sup>™</sup> (QCD)
Cardizem <sup>®</sup> CD	Dynacirc <sup>®</sup> CR	Glucometer <sup>®</sup> diabetic supplies (QCD)
Cardizem <sup>®</sup> LA	Dytan <sup>™</sup>	Glumetza <sup>™</sup>
Cardura XL <sup>®</sup> (QCD)	Elestat <sup>™</sup> (QCD)	Halotin <sup>®</sup>
Cataflam <sup>®</sup>	Elestrin <sup>®</sup>	Hylira <sup>®</sup>
Ceclor <sup>®</sup>	Eletone <sup>®</sup>	Hytrin <sup>®</sup> (QCD)
Ceclor <sup>®</sup> CD	Emsam <sup>®</sup>	Hyzaar <sup>®</sup> (ST)
Cedax <sup>®</sup>	Enablex <sup>®</sup>	IB-Stat <sup>®</sup>
Cenestin <sup>™</sup>	Enjuvia <sup>®</sup>	InnoPran XL <sup>™</sup>
Centany <sup>®</sup>	Equetro <sup>™</sup>	Invega <sup>™</sup>
Cesamet <sup>™</sup> (QCD)	Ertaczo <sup>™</sup>	Iquix <sup>®</sup>
Chibroxin <sup>™</sup>	Estrasorb <sup>®</sup> (QCD)	Istalol <sup>™</sup>
Cipro-XR <sup>®</sup>	Estrojel <sup>®</sup> (QCD)	Kadian <sup>®</sup>
Cleervue-M <sup>™</sup>	Evamist <sup>®</sup> (QCD)	Klonopin <sup>™</sup>
CNL 8 <sup>®</sup> nail kit (QCD) (PA)	ExacTech <sup>®</sup> diabetic testing supplies (QCD)	Kytril <sup>™</sup> (QCD)
Combigan <sup>®</sup>	Extina <sup>®</sup>	Lescol <sup>®</sup> (QCD)
Combunox <sup>®</sup>	Factive <sup>®</sup>	Lescol XL <sup>®</sup> (QCD)
Coreg CR <sup>™</sup>	Famvir <sup>®</sup> (QCD)	Levaquin <sup>®</sup>
Cozaar <sup>®</sup> (ST)	FazaClo <sup>®</sup>	Levlen <sup>®</sup>
Darvocet <sup>®</sup> N-100	Femtrace <sup>®</sup>	Lexxel <sup>™</sup>
Daypro <sup>™</sup>	Fentora <sup>®</sup>	

(PA) prior authorization required for members with approved formulary exceptions  
(QCD) Quality Care Dosing limits apply for members with approved formulary exceptions  
(ST) step therapy required for members with approved formulary exceptions

Lipofen <sup>®</sup>	Nasarel <sup>™</sup> (QCD)	Precision <sup>®</sup> diabetic supplies (QCD)
Livostin <sup>®</sup> (QCD)	Nasonex <sup>®</sup> (QCD)	Prestige <sup>®</sup> diabetic testing supplies (QCD)
Lodine <sup>®</sup>	Neupro <sup>®</sup>	Prevacid <sup>®</sup> NapraPAC <sup>™</sup>
Lodine <sup>®</sup> XL	Nevanac <sup>™</sup>	Prilosec <sup>®</sup> (QCD) (ST)
Lofibra <sup>™</sup>	Nexavir <sup>®</sup>	Prinivil <sup>®</sup>
Lopressor <sup>®</sup>	Nexium <sup>®</sup> (QCD) (ST)	Prinzide <sup>®</sup>
Lorabid <sup>™</sup>	Niravam <sup>®</sup>	Pristiq <sup>®</sup> (QCD) (ST)
Lotensin <sup>®</sup>	Norinyl <sup>®</sup>	ProQuin <sup>®</sup> XR
Lotensin <sup>®</sup> HCT	Noroxin <sup>®</sup>	Proventil <sup>®</sup> HFA (QCD)
Lovaza <sup>™</sup>	Nor-Q-D <sup>®</sup>	Proventil <sup>®</sup> Inhaler (QCD)
Lytensopril <sup>®</sup>	Novacort <sup>™</sup>	Proventil <sup>®</sup> /Repetab
Mavik <sup>®</sup>	Omnaris <sup>™</sup> (QCD)	Prozac <sup>®</sup> Weekly <sup>™</sup> (QCD) (ST)
Maxair <sup>®</sup> Autohaler <sup>®</sup> (QCD)	Omnicef <sup>®</sup>	Quixin <sup>™</sup>
Maxalt <sup>®</sup> /Maxalt-MLT <sup>®</sup> (QCD)	Opana <sup>®</sup> /ER	Raniclor <sup>™</sup>
Maxaquin <sup>®</sup>	Optivar <sup>™</sup> (QCD)	Raxar <sup>®</sup>
Maxipime <sup>®</sup>	Oracea <sup>®</sup>	Relafen <sup>™</sup>
Megace <sup>®</sup> ES	Oramorph SR <sup>™</sup>	Remeron <sup>®</sup> (QCD)
Menostar <sup>®</sup> (QCD)	Orapred <sup>®</sup> ODT	Rescula <sup>®</sup>
Metaglip <sup>™</sup>	Ortho-Prefest <sup>®</sup>	Restoril <sup>®</sup>
Mevacor <sup>®</sup> (QCD) (ST)	Ovcon <sup>®</sup>	Retin-A Micro <sup>®</sup>
Micardis <sup>®</sup> (ST)	Oxytrol <sup>®</sup>	Rhinocort Aqua <sup>®</sup> (QCD)
Micardis <sup>®</sup> HCT (ST)	Pamine FQ <sup>®</sup>	Risperdal <sup>®</sup> M-Tab
Minocin <sup>®</sup>	Panixine Disper Dose <sup>™</sup>	Ritalin LA <sup>®</sup>
Minocin <sup>®</sup> Combo Pack	Paptase <sup>®</sup>	Rozerem <sup>™</sup> (QCD) (ST)
Mobic <sup>®</sup> (QCD)	Pataday <sup>™</sup> (QCD)	Rynatan <sup>®</sup>
Monodox <sup>®</sup>	Paxil CR <sup>™</sup> (QCD) (ST)	Sanctura <sup>™</sup>
Monopril <sup>®</sup>	PCE <sup>®</sup>	Sanctura XR <sup>™</sup>
Monopril <sup>®</sup> HCT	PCE <sup>®</sup> Dispertab <sup>®</sup>	Sarafem <sup>®</sup> (QCD) (ST)
Naprelan <sup>®</sup>	Penetrex <sup>™</sup>	Seasonique <sup>®</sup>
Naprosyn <sup>®</sup>	Pepcid <sup>®</sup>	Simcor <sup>®</sup> (QCD) (ST)
Naprosyn <sup>®</sup> EC	Percocet <sup>®</sup>	Skelid <sup>®</sup>
Nasacort <sup>®</sup> (QCD)	Pergonal <sup>®</sup>	
Nasacort <sup>®</sup> AQ (QCD)	Pexeva <sup>™</sup> (QCD) (ST)	
	Pravigard <sup>™</sup> PAC (QCD)	

(PA) prior authorization required for members with approved formulary exceptions  
(QCD) Quality Care Dosing limits apply for members with approved formulary exceptions  
(ST) step therapy required for members with approved formulary exceptions

Sof-Tact <sup>®</sup> diabetic supplies (QCD)	Ventolin <sup>®</sup> HFA (QCD)	Zyflo CR <sup>™</sup> (ST)
Solodyn <sup>®</sup>	Veramyst <sup>®</sup> (QCD)	Zyprexa <sup>®</sup> IM
Soltamox <sup>™</sup>	Veregen <sup>®</sup>	Zytopic <sup>®</sup>
Spectracef <sup>®</sup>	Vesicare <sup>®</sup>	
Sporanox <sup>®</sup> (QCD) (PA)	Vicodin <sup>®</sup>	
Striant <sup>®</sup>	Vicodin <sup>®</sup> ES	
Sular <sup>®</sup>	Voltaren <sup>®</sup>	
Tagamet <sup>®</sup>	Voltaren <sup>®</sup> XR	
Tekturna <sup>®</sup>	Vusion <sup>™</sup>	
Tekturna <sup>®</sup> HCT	Vyvanse <sup>®</sup> (QCD)	
Tequin <sup>™</sup>	Welchol <sup>®</sup>	
Tersi <sup>®</sup>	Wellbutrin SR <sup>®</sup> (200 mg) (QCD) (ST)	
Teveten <sup>®</sup> (ST)	Wellbutrin XL <sup>®</sup> (QCD) (ST)	
Teveten <sup>®</sup> HCT (ST)	Xanax <sup>®</sup>	
Tiamate <sup>®</sup>	Xanax <sup>®</sup> XR	
Tiazac <sup>®</sup>	X-Clair <sup>™</sup>	
Tindamax <sup>™</sup>	Xenaderm <sup>®</sup>	
Tretin-X <sup>®</sup> (PA)	Xibrom <sup>®</sup>	
Tri-Levlen <sup>®</sup>	Xifaxan <sup>®</sup>	
Trinalin <sup>®</sup>	Xolegel <sup>™</sup>	
Tri-Norinyl <sup>®</sup>	Xopenex <sup>®</sup> HFA (QCD)	
Tritec <sup>®</sup>	Xopenex <sup>®</sup> nebulas	
TrueTrack <sup>®</sup> diabetic supplies (QCD)	Xyralid <sup>®</sup>	
Ultracet <sup>™</sup>	Zanaflex <sup>™</sup>	
Ultram <sup>®</sup> /ER	Zantac <sup>®</sup>	
Valium <sup>®</sup>	Zebeta <sup>®</sup>	
Vanos <sup>®</sup>	Zegerid <sup>®</sup> (QCD) (ST)	
Vantin <sup>®</sup>	Zelapar <sup>®</sup>	
Vaseretic <sup>®</sup>	Zestril <sup>®</sup>	
Vasotec <sup>®</sup>	Ziana <sup>™</sup>	
Vectrin <sup>®</sup>	Zinotic <sup>®</sup>	
Ventolin <sup>®</sup> (QCD)	Zmax <sup>®</sup>	
	Zyflo <sup>®</sup> (ST)	

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## New Medication Approval Process

Our Pharmacy and Therapeutics (P&T) Committee, which is made up of pharmacists and physicians of various specialties, reviews the effectiveness and overall value of new medications approved by the FDA on an ongoing basis. The Committee provides expertise and advice to help Blue Cross Blue Shield of Massachusetts give its members prescription drug options that meet their medical needs and achieve desired treatment goals.

While under review, new medications will not be covered by your plan. As with other medications that are not covered, your doctor may request coverage for any medication under review when medically necessary.



## MASSACHUSETTS

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