



Originally effective January 01, 2010

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About our formulary

The prescription drug formulary and Preferred Drug List has been approved by Health First Health Plans' Pharmacy & Therapeutics (P&T) Committee and is effective July 12, 2010. The formulary is a list of all eligible prescription drugs covered by HFHP.

Prescription drugs fit into one of three categories — generic, single-source brand name, and multi-source brand name drugs.

Generic drugs are prescription drugs that are identified by their chemical name. When the patent has expired on a brand name drug, the FDA permits new manufacturers to create an equivalent of the brand name drug and make it available to the public. Generally, more than one manufacturer will create generic versions, although often the same pharmaceutical firm that produces the brand name drug also makes the generic version. This prompts competitive pricing of the generic version and usually results in a less expensive drug.

Brand name drugs are the product names under which a drug is advertised and sold by the original manufacturer. Brand name drugs are divided into two groups:

1. Multi-source drugs are available from more than one manufacturer and have equivalent generic versions available.
2. Single-source drugs are only available from one manufacturer, are patent protected, and are generally more expensive.

HFHP's formulary includes all generic drugs, and most single-source brand name drugs. For multi-

source drugs, the generic version is covered with the lowest copayment, but the brand name version either requires the highest copayment or is excluded (not covered).

About our Drug List

While our formulary includes all the drugs we cover (hundreds of drug classes), our Preferred Drug List serves as a useful reference to show which drug classes include medications that may require a higher copayment ("non-preferred" drugs) or are not covered ("excluded" drugs). We encourage you to discuss your options with your physician.

Most "non-preferred" drugs have a similar version available at a lower cost. "Preferred" drugs are either single-source drugs, or the generic version of multi-source drugs, and are covered with the lowest copayment.

For your convenience, generic drugs are CAPITALIZED and listed in the "Preferred" category. Any single-source brand name drug will automatically become "Non-preferred" if a generic version becomes available. For the drug classes shown below, any single-source brand name drug not listed is not covered.

Please remember, this is not a complete list of all drugs covered under your benefit plan. For the most up-to-date listing, please contact HFHP Customer Service daily, 8 am to 8 pm, at (800) 716-7737, (321) 434-5665, or via TDD Relay Services during the same days/hours at (800) 955-8771.

Antibiotics	Preferred	Non-preferred	Excluded
First Generation Cephalosporins	CEPHALEXIN	Keftab	
Second-generation Cephalosporins	CEFACLOR CEFUROXIME Cefzil	Ceftin Lorabid	
Third-generation Cephalosporins	Omnicef	Cedax Spectacef Vantin	Suprax
Fluoroquinolones	CIPROFLOXACIN Factive Levaquin	Cipro Floxin Noroxin	Avelox
Gastrointestinal	Preferred	Non-preferred	Excluded
Proton pump inhibitors	Kapidex OMEPRAZOLE		Aciphex Nexium PANTOPRAZOLE Prevacid Protonix Zegerid
Heart and blood pressure medications	Preferred	Non-preferred	Excluded
Beta blocker	Bystolic Coreg CR		
Calcium channel blockers	Cardene SR Cardizem LA Covera-HS DILTIAZEM DILTIAZEM XR DynaCirc DynaCirc CR FELODIPINE Lotrel NICARDIPINE NIFEDEPINE NIFEDEPINE ER SULAR Tiazac (certain strengths) VERAPAMIL VERAPAMIL SR Verelan PM	Cardene Dilacor XR Isoptin SR Lexxel Plendil Norvasc Tarka Verelan	
ACE Inhibitors	BENAZEPRIL HCL BENAZEPRIL HCTZ CAPTOPRIL ENALAPRIL ENALAPRIL HCTZ LISINOPRIL LISINOPRIL HCT Mavik QUINAPRIL Univasc	Accupril Altace Lotensin Lotensin HCT Monopril	

ARBs	Benicar Benicar HCT Diovan Diovan/HCT Exforge	Atacand Atacand HCT Avapro Avalide Micardis Teveten	Cozaar Hyzaar
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Cholesterol medications	Preferred	Non-preferred	Excluded
Antihyperlipidemic	Crestor LOVASTATIN SIMVASTATIN Tricor Vytorin Zetia	Antara Lescol Lescol XL Lipitor Pravachol Welchol Zocor	Advicor Altoprev Triglide
Diabetic Drugs and Supplies	Preferred	Non-preferred	Excluded
Glucose Monitors and Test Strips	FreeStyle Freedom Lite Meter and Strips FreeStyle Lite Meter and Strips Precision Xtra Meter and Strips		All other manufacturers
Injectable Insulin	Novolin Lantus Levemir		Humulin (see exclusions)
Oral Diabetic Medication	ACARBOSE Actos Actoplus Met Avandamet Avandia Avandaryl Amaryl CHLORPROPAMIDE GLIPIZIDE GLIPIZIDE XL GLYBURIDE Janumet Januvia METFORMIN Onglyza Prandin Starlix	Glucorol XL Glucovance Precose	Glucophage XR Metaglip

Respiratory Agents	Preferred	Non-preferred	Excluded
Antihistamines		Allegra Allegra D Clarinet Zyrtec Zyrtec D	
Orally Inhaled Steroids	Beclovent Flovent Disk Flovent HFA Pulmicort Spiriva	AeroBid AeroBid-M Asmanex Azmacort Vanceril Vanceril DS	
Nasally Inhaled Steroids	FLUTICASON Rhinocort Rhinocort AQ Tri-Nasal Veramyst	Beconase Beconase AQ Flonase Nasacort Nasacort AQ Nasalide Nasarel Nasonex Vancenase Vancenase AQ	
Beta Agonists		Foradil	

Central Nervous System	Preferred	Non-preferred	Excluded
SSRIs/SNRI	CITALOPRAM Cymbalta Effexor XR FLUOXETINE Lexapro PAROXETINE	Celexa Paxil Prozac Zoloft	FLUOXETINE 40mg Prozac 90 mg Sarafem
NSAIDs (Non-Steroidal Anti-inflammatory Drugs)	DICLOFENAC DICLOFENAC XR DISALCID DIFLUNISAL ETODOLAC Flector patch IBUPROFEN INDOMETHACIN KETOPROFEN KETOROLAC MECLOMEN NAPROXYN PIROXICAM SALSALATE SULINDAC TOLECTIN	Arthrotec Mobic Naprelan	
Cox 2 Inhibitors		Celebrex	

Muscle Relaxants	METHOCARBAMOL CYCLOBENZAPRINE CARISOPRODOL	Skelaxin	
Analgesics	DILAUDID HYDROCODONE/ APAP MEPERIDINE Morphine Sulfate (MSIR) OXYCODONE/APAP OXYCODONE/ ASPIRIN PROPOXYPHENE NAPSYLATE/APAP ROXICET TYLENOL/CODEINE TRAMADOL	Avinza Duragesic OxyContin Ultracet Vicoprofen	
Oral contraceptives	Preferred	Non-preferred	Excluded
Biphasics	NELOVA	Ortho Novum 10/11	
Monophasics	Brevicon (certain strengths) GENORA LEVORA Loestrin (certain strengths) Lybrel NECON NELOVA Norethin Ovcon Yaz ZOVIA	Alesse Brevicon (certain strengths) Demulen Desogen Levlen Loestrin (certain strengths) Lo/Ovral Modicon Nordette Norinyl Nuvaring (this is not administered orally) Ortho-Cept Ortho Cyclen Ortho Novum Ovral Yasmin	
Progestin only	Ovrette	Nor-Q-D Micronor	
Tri-phasics	Estrostep Fe TRIVORA	Ortho Novum 7/7/7 Ortho Tri-Cyclen Ortho Tri-Cyclen LO Ortho Evra Tri-Levlen Tri-Norinyl	
Triptans	Preferred	Non-preferred	Excluded
	Maxalt Maxalt MLT SUMATRIPTAN TABS Treximet	Amerge Axert Frova Relpax Zomig	

Osteoporosis	Preferred	Non-preferred	Excluded
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	Boniva Calcitonin Evista Miacalcin	Actonel Fosamax Fosamax plus D	Fortical
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Health First Step Therapy Reference Table for the 5-Tier Commercial Drug List		
Step 2 Drugs	Step Therapy Criteria	Step 1 Drugs
AXERT (page 5)	Before using AXERT, you must first try the following Step 1 drug:	<i>sumatriptan</i>
AMERGE (page 5)	Before using AMERGE, you must first try the following Step 1 drug:	<i>sumatriptan</i>
FROVA (page 5)	Before using FROVA, you must first try the following Step 1 drug:	<i>sumatriptan</i>
LIPITOR (page 3)	Before using LIPITOR, you must first try at least 1 of the following <u>generic</u> Step 1 drugs and at least 1 of the following <u>brand</u> Step 1 drugs:	<i>pravastatin</i> <i>lovastatin</i> <i>simvastatin</i> CRESTOR VYTORIN
LYRICA (page 7)	Before using LYRICA, you must first try the following Step 1 drug:	<i>gabapentin</i>
MAXALT (page5)	Before using MAXALT, you must first try the following Step 1 drug:	<i>sumatriptan</i>
MAXALT MLT (page5)	Before using MAXALT MLT, you must first try the following Step 1 drug:	<i>sumatriptan</i>
RELPAK (page5)	Before using RELPAK, you must first try the following Step 1 drug:	<i>sumatriptan</i>
TREXIMET (page5)	Before using TREXIMET, you must first try the following Step 1 drug:	<i>sumatriptan</i>
ZOMIG (page5)	Before using ZOMIG, you must first try the following Step 1 drug:	<i>sumatriptan</i>

* Brand-name drugs are capitalized (e.g., LIPITOR) and generic drugs are listed in lower-case italics (e.g., *lovastatin*)

Excluded drugs

The following are NOT covered by HFHP:

- Compounded drugs
- Cosmetics or any drugs used for cosmetic purposes (such as Retin-A, Rogaine, Topical Minoxidil, and Vaniqa)
- Diabetic supplies, blood glucose monitors and test strips other than those manufactured by Abbott.
- Erectile dysfunction drugs (such as Viagra)
- Infertility drugs (such as Clomid) and abortive drugs such as Plan B and RU486
- Injectables (except insulin, Imitrex qty limit 12/34 days, and those requiring prior authorization)
- Multivitamins and nutritional supplements (except prescription pre-natal vitamins)
- Nicotine products
- Nonprescriptive supplies or substances
- Oral and topical antifungals for onychomycosis (such as Lamisil, Sporanox, and Penlac)
- Outpatient drugs for influenza (such as Relenza)
- Over-the-counter medications (such as Lotrimin, Zantac 75, Pepcid AC)
- Any drug for which a similar over-the-counter version is available. (At HFHP's discretion these may be moved to higher tiers instead of being excluded.)
- All new drugs approved by the FDA will be excluded from the preferred drug list/formulary unless HFHP's Pharmacy and Therapeutics Committee, in its sole discretion, decides to waive this exclusion for a particular drug.

- Sleeping agents (Zolpidem is covered for trial period qty. limit 1 tab per day)
- Support garments
- Syringes, needles, or other disposable supplies (except those used with insulin)

- Tikosyn (antiarrhythmic agent)
- Uloric
- Vancocin > 14 day supply
- Zyvox

Subject to change.

Step Therapy

In some cases, Health First requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover drug B unless you try Drug A first. If Drug A doesn't work for you, we will then cover Drug B.

Prior HFHP authorization and Quantity limits

The following drugs require proof of medical necessity from the physician requesting HFHP authorization:

- Anorexiant (such as Meridia and Xenical). In addition to proof of medical necessity, members must show proof of enrollment in an HFHP-authorized weight loss program.
- Afinitor
- Arixtra > 10 days of therapy
- Duragesic qty. limit 10/30 days
- Effient
- Fentanyl qty. limit 10/30 days
- Forteo
- Fragmin > 10 days of therapy
- Imitrex qty. limit 12/30 days
- Injectables (ie: Zofran, Kytril, growth hormone, Epogen, Anzemet, and Procrit)
- Lantus
- Lovenox >10 days of therapy
- Lyrica step therapy (see step therapy chart pg. 6)
- Lysteda qty. limit of 30/30
- Nuvigil qty. limit of 30/30
- Plevnar
- Provigil qty. limit of 30/30
- Pulmozyme
- Regranex
- Relistor
- Retin-A (for use other than cosmetic)
- Samsca
- Simponi
- Stadol
- Transdermal Scopolamine patches
- Treanda