

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Abilify	2mg	60 tablets	180 tablets
Abilify	10mg	30 tablets	90 tablets
Abilify	15mg	30 tablets	90 tablets
Abilify	20mg	30 tablets	90 tablets
Abilify	30mg	30 tablets	90 tablets
Abilify	5mg	30 tablets	90 tablets
Abilify	1mg/ml	750 ml	2250 ml
Accolate	10mg	60 tablets	180 tablets
Accolate	20mg	60 tablets	180 tablets
Accucheck	Test Drum	306 strips	918 strips
Accuneb	0.63mg/3ml	375 ml: Covered 13 years and under	1125 ml : Covered 13 years and under
Accuneb	1.25mg/3ml	375 ml:Covered 13 years and under	1125 ml : Covered 13 years and under
Acetone Urine Test Strips	Check-Stix, Relion, Ketostix, Ketocare, Chemstrips	100 strips	300 strips
Actiq (7) (9)	200mcg	30 lollipops per copay	30 lollipops per copay
Actiq (7) (9)	400mcg	30 lollipops per copay	30 lollipops per copay
Actiq (7) (9)	600mcg	30 lollipops per copay	30 lollipops per copay
Actiq (7) (9)	800mcg	30 lollipops per copay	30 lollipops per copay
Actiq (7) (9)	1200mcg	30 lollipops per copay	30 lollipops per copay
Actiq (7) (9)	1600mcg	30 lollipops per copay	30 lollipops per copay
Activella	1-0.5mg	28 tablets	84 tablets
Actonel	30mg	30 tablets	90 tablets
Actonel	5mg	30 tablets	90 tablets
Actonel	35mg	4 tablets	12 tablets
Actonel	75mg	2 tablets	6 tablets
Actonel	150mg	1 tablet	3 tablets
Actonel with Calcium (4)	35mg	1 blister pack (#28)	3 blister packs (#84)
Actoplus Met	15-500mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Actoplus Met	15-850mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Actos	15mg	30 tablets	90 tablets
Actos	30mg	30 tablets	90 tablets
Actos	45mg	30 tablets	90 tablets
Adderall XR	10mg	30 capsules	90 capsules
Adderall XR	15mg	30 capsules	90 capsules
Adderall XR	20mg	30 capsules	90 capsules

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Adderall XR	25mg	30 capsules	90 capsules
Adderall XR	30mg	30 capsules	90 capsules
Adderall XR	5mg	30 capsules	90 capsules
Adoxa	100mg	90 tablets	270 tablets
Adoxa	50mg	120 tablets	360 tablets
Adoxa	75mg	120 tablets	360 tablets
Adoxa	150mg	60 tablets	180 tablets
Advair Diskus	50-100mcg	60 blisters	180 blisters
Advair Diskus	50-250mcg	60 blisters	180 blisters
Advair Diskus	50-500mcg	60 blisters	180 blisters
Advair HFA	45-21mcg	1-12gm inhaler: Covered 3 years and older	3-12gm inhalers: Covered 3 years and older
Advair HFA	115-21mcg	1-12gm inhaler: Covered 3 years and older	3-12gm inhalers: Covered 3 years and older
Advair HFA	230-21mcg	1-12gm inhaler: Covered 3 years and older	3-12gm inhalers: Covered 3 years and older
Advicor	1000-20mg	60 tablets	180 tablets
Advicor	1000-40mg	60 tablets	180 tablets
Advicor	500-20mg	60 tablets	180 tablets
Advicor	750-20mg	60 tablets	180 tablets
Aerochambers		2 per year: Level 1	2 per year: Level 1
Alamast Ophthalmic	0.10%	10 ml	30 ml
Albumin Urine Test Strips	Micro-Bumin, Albustix, Chemstrips	100 strips	300 strips
Allegra Susp	30mg	300ml:Covered 12 years & younger	900ml:Covered 12 years & younger
Allegra tab	180mg	30 tablets	90 tablets
Allegra tab	30mg	60 tablets	180 tablets
Allegra tab	60mg	60 tablets	180 tablets
Allegra-D 12 hour	60-120mg	60 tablets	180 tablets
Allegra-D 24 hour	180-240mg	30 tablets:Covered 12 years and older	90 tablets:Covered 12 years and older
Altanax Ointment	1%	1 tube per copay (any size): Max 2	1 tube per copay (any size) Max 6
Altace	1.25mg	30 tablets	90 tablets
Altace	2.5mg	30 tablets	90 tablets
Altace	5mg	30 tablets	90 tablets
Altace	10mg	30 tablets	90 tablets
Alvesco	80mcg	6.1grams (1 inhaler)	18.3 grams (3 inhalers)

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Alvesco	160mcg	12.2 grams (2 inhalers)	36.6 grams (6 inhalers)
Amaryl	1mg	90 tablets	270 tablets
Amaryl	2mg	90 tablets	270 tablets
Amaryl	4mg	60 tablets	180 tablets
Ambien CR	6.25mg	30 tablets	90 tablets
Ambien CR	12.5mg	30 tablets	90 tablets
Amerge (7)	1mg	9 tablets per copay	9 tablets per copay
Amerge (7)	2.5mg	9 tablets per copay	9 tablets per copay
Amitiza	24mcg	60 capsules:Covered 16 years and older	180 capsules:Covered 16 years and older
Amitiza (4)	8mcg	60 capsules: Covered 18 years and older	180 capsules: Covered 18 years and older
Ampyra	10mg	60 tablets: Covered 18 years and older	180 tablets: Covered 18 years and older
Amrix	15mg	30 capsules: Covered 18 years and older	90 capsules: Covered 18 years and older
Amrix	30mg	30 capsules: Covered 18 years and older	90 capsules: Covered 18 years and older
Anamantle HC Forte Kit	3-1%	1 kit:Covered 16 years and older	3 kits:Covered 16 years and older
Anaspaz	0.125mg	360 tablets	1080 tablets
Andoderm (3)	5mg		
Androderm (3)	2.5mg		
Androgel (3)	25mg		
Androgel (3)	50mg		
Androgel Pump (3)	1%	300gm	900gm
Angeliq (4)	0.5-1mg	28 tablets: Covered 18 years and older	84 tablets: Covered 18 years and older
Antara	43mg	30 capsules	90 capsules
Antara	130mg	30 capsules	90 capsules
Aphthasol PST	5%	5 grams per copay:Covered 18 years and older	5 grams per copay:Covered 18 years and older
Aplenzin	174mg	30 tablets:Covered 18 years and older	90 tablets: Covered 18 years and older
Aplenzin	348mg	30 tablets:Covered 18 years and older	90 tablets: Covered 18 years and older
Aplenzin	522mg	30 tablets:Covered 18 years and older	90 tablets: Covered 18 years and older
Apriso	0.375gm	120 capsules	360 capsules
Arava	100mg	30 tablets	90 tablets
Arava	10mg	30 tablets	90 tablets
Arava	20mg	30 tablets	90 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Aricept	10mg	30 tablets	90 tablets
Aricept	5mg	30 tablets	90 tablets
Arimidex	1mg	30 tablets	90 tablets
Aromasin	25mg	30 tablets	90 tablets
Asmanex Twisthaler	220mcg/inhaler	Covered age 4 and older	Covered age 4 and older
Astelin NS	137mcg	30ml	90ml
Astepro	137mcg	30ml	90ml
Atacand	16mg	30 tablets	90 tablets
Atacand	32mg	30 tablets	90 tablets
Atacand	4mg	30 tablets	90 tablets
Atacand	8mg	30 tablets	90 tablets
Atacand HCT	16/12.5mg	30 tablets	90 tablets
Atacand HCT	32/12.5mg	30 tablets	90 tablets
Atripla	600-200-300mg	30 tablets: Covered age 18 and older	90 tablets: Covered age 18 and older
Atrovent HFA	17mcg/act	25.8gm (2 inhalers)	77.4gm (6 inhalers)
Avalide	150/12.5mg	30 tablets	90 tablets
Avalide	300/12.5mg	30 tablets	90 tablets
Avalide	300/25mg	30 tablets	90 tablets
Avandamet	2-500mg	120 tablets	360 tablets
Avandamet	4-500mg	60 tablets	180 tablets
Avandamet	2-1000mg	60 tablets	180 tablets
Avandamet	4-1000mg	60 tablets	180 tablets
Avandaryl	4-1mg	60 tablets: Covered age 18 and older	180 tablets: Covered age 18 and older
Avandaryl	4-2mg	60 tablets: Covered age 18 and older	180 tablets: Covered age 18 and older
Avandaryl	4-4mg	60 tablets: Covered age 18 and older	180 tablets: Covered age 18 and older
Avandaryl	8-2mg	30 tablets: Covered age 18 and older	90 tablets: Covered age 18 and older
Avandaryl	8-4mg	30 tablets: Covered age 18 and older	90 tablets: Covered age 18 and older
Avandia	2mg	60 tablets	180 tablets
Avandia	4mg	60 tablets	180 tablets
Avandia	8mg	30 tablets	90 tablets
Avapro	150mg	45 tablets	135 tablets
Avapro	300mg	30 tablets	90 tablets
Avapro	75mg	45 tablets	135 tablets
Avodart (3)	0.5mg	30 capsules	90 capsules
Axert (7)	12.5mg	9 capsules per copay	9 capsules per copay
Axert (7)	6.25mg	9 capsules per copay	9 capsule per copay

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Axid	150mg	60 capsules	180 capsules
Axid	300mg	30 capsules	90 capsules
Azmacort	75mcg	40 gm (2 inhalers)	120 gm (6 inhalers)
Azopt	1%	10ml	30ml
Azor	5/20mg	30 tablets	90 tablets
Azor	5/40mg	30 tablets	90 tablets
Azor	10/20mg	30 tablets	90 tablets
Azor	10/40mg	30 tablets	90 tablets
Baraclude	0.5mg	30 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Baraclude	1.0mg	30 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Baraclude	0.05mg/ml oral solution	600 ml: Covered 16 years and older	1800 ml: Covered 16 years and older
Benicar	20mg	45 tablets	135 tablets
Benicar	40mg	30 tablets	90 tablets
Benicar	5mg	90 tablets	270 tablets
Benicar HCT	20 -12.5mg	45 tablets	135 tablets
Benicar HCT	40 – 12.5 mg	30 tablets	90 tablets
Benicar HCT	40 – 25mg	30 tablets	90 tablets
Benziq	5.25% gel	50gm: Covered 12 years and older	150gm: Covered 12 years and older
Benziq LS	2.75% gel	50gm: Covered 12 years and older	150gm: Covered 12 years and older
Benziq Wash	5.25% Liquid	175gm: Covered 12 years and older	525gm: Covered 12 years and older
Biaxin	500mg	90 tablets	270 tablets
Biaxin XL	500mg	60 tablets	180 tablets
Bidil	20-37.5 MG	180 tablets Covered 16 years and older	540 tablets Covered 16 years and older
Boniva (4)	2.5mg	30 tablets	90 tablets
Boniva (4)	150mg	1 tablet	3 tablets
Brevoxyl Acne Wash Kit	4 %	1 kit	3 kits
Brevoxyl Acne Wash Kit	8 %	1 kit	3 kits
Brovana	15mcg/2ml	120 units: Covered 18 years and older	360 units: Covered 18 years and older
Buspar	10mg	180 tablets	540 tablets
Buspar	15mg	120 tablets	360 tablets
Buspar	30mg	90 tablets	270 tablets
Buspar	5mg	360 tablets	1080 tablets
Byetta	5mcg	1.2ml (60 doses) Covered 18 years and older	3.6ml (180 doses) Covered 18 years and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Byetta	10mcg	2.4ml (60 doses) Covered 18 years and older	7.2 (180 doses) Covered 18 years and older
Bystolic	2.5mg	30 tablets: Covered 18 years and older	90 tablets: Covered 18 years and older
Bystolic	5mg	90 tablets: Covered 18 years and older	270 tablets: Covered 18 years and older
Bystolic	10mg	60 tablets: Covered 18 years and older	180 tablets: Covered 18 years and older
Bystolic	20mg	60 tablets: Covered 18 years and older	180 tablets: Covered 18 years and older
Caduet	2.5/10mg	90 tablets	270 tablets
Caduet	2.5/20mg	90 tablets	270 tablets
Caduet	2.5/40mg	30 tablets	90 tablets
Caduet	5/10mg	30 tablets	90 tablets
Caduet	5/20mg	30 tablets	90 tablets
Caduet	5/40mg	30 tablets	90 tablets
Caduet	5/80mg	30 tablets	90 tablets
Caduet	10/10mg	30 tablets	90 tablets
Caduet	10/20mg	30 tablets	90 tablets
Caduet	10/40mg	30 tablets	90 tablets
Caduet	10/80mg	30 tablets	90 tablets
Calomist	25mcg	1-18 ml bottle: Covered 18 years and older	3-18 ml bottles: Covered 18 years and older
Campral	333mg	180 tablets	540 tablets
Canasa	1000mg	30 suppositories	90 suppositories
Carac Cream	0.50%	30 gm	90 gm
Cardizem LA	120mg	30 tablets	90 tablets
Cardizem LA	180mg	30 tablets	90 tablets
Cardizem LA	240mg	60 tablets	180 tablets
Cardizem LA	300mg	30 tablets	90 tablets
Cardizem LA	360mg	30 tablets	90 tablets
Cardizem LA	420mg	30 tablets	90 tablets
Casodex	50mg	90 tablets	270 tablets
Caverject (1)(3) (7)(8)	20mcg	6 vials per 30 days	18 vials per 90 days
Caverject (1)(3) (7)(8)	40mcg	6 vials per 30 days	18 vials per 90 days
Caverject Kit (1)(3)(7)(8)	10mcg	one per year	one per year
Caverject Kit (1)(3) (7)(8)	20mcg	one per year	one per year
Caverject Kit (1)(3) (7) (8)	40mcg	one per year	one per year

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Celexa	10mg	45 tablets	135 tablets
Celexa	20mg	45 tablets	135 tablets
Celexa	40mg	60 tablets	180 tablets
Cenestin	0.625 mg	30 tablets: Covered 18 and older	90 tablets: Covered 18 and older
Cenestin	0.9 mg	30 tablets: Covered 18 and older	90 tablets: Covered 18 and older
Cenestin	1.25 mg	30 tablets: Covered 18 and older	90 tablets: Covered 18 and older
Cenestin	0.3mg/hr	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Cenestin	0.45mg	30 tablets: Covered 18 and older	90 tablets: Covered 18 and older
Cesamet	1mg	180 tablets: Covered 18 and older	540 tablets: Covered 18 and older
Chantix (7) (8)	0.5mg	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Chantix (7) (8)	1mg	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Chantix Pack (7) (8)	0.5mg & 1mg	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Cialis (1) (7) (8) (3)	2.5mg	8 tabs per 30 days: Covered 18 and older	24 tabs per 90 days: Covered 18 and older
Cialis (1) (7) (8) (3)	5mg	8 tabs per 30 days: Covered 18 and older	24 tabs per 90 days: Covered 18 and older
Cialis (1) (7) (8) (3)	10mg	8 tabs per 30 days: Covered 18 and older	24 tabs per 90 days: Covered 18 and older
Cialis(1) (7) (8) (3)	20mg	8 tabs per 30 days: Covered 18 and older	24 tabs per 90 days: Covered 18 and older
Cipro	100mg	60 tablets	180 tablets
Cipro	250mg	60 tablets	180 tablets
Cipro	500mg	60 tablets	180 tablets
Cipro	750mg	60 tablets	180 tablets
Cipro XR	500mg	30 tablets	90 tablets
Cipro XR	1000mg	30 tablets	90 tablets
Ciprodex Susp.	0.3-0.1%	7.5ml	22.5ml
Clarifoam EF	10-5%	1-60 gm can per copay: Max 2	1-60gm can per copay: Max 6
Clarinex	2.5mg	30 redivitabs	90 redivitabs
Clarinex	5mg	30 tablets	90 tablets
Clarinex D 12 hour	2.5-120mg	60 tablets	180 tablets
Clarinex D 24 hour	5-240mg	30 tablets	90 tablets
Clarinex Reditabs	5mg	30 tablets	90 tablets
Clarinex Syrup	0.5mg/ml	300ml	900ml
Cleocin Cream	2%	40gms per 7 days	40gms per 7 days
Cleocin Suppos	100mg	3 suppositories	3 suppositories
Climara Patch	0.0375 mg	4 patches	12 patches
Climara Patch	0.025 mg	4 patches	12 patches
Climara Patch	0.05 mg	4 patches	12 patches
Climara Patch	0.06 mg	4 patches	12 patches
Climara Patch	0.075 mg	4 patches	12 patches

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Climara Patch	0.1mg	4 patches	12 patches
Climara Pro Patch	0.045-0.015 mg	4 patches	12 patches
Clindamax Cream	2%	40gms per 7 days	40gms per 7 days
Clindamycin Cream	2%	40gms per 7 days	40gms per 7 days
Clobex Spray	0.05%	Covered 18 years and older	Covered 18 years and older
Combigan	0.2/0.5% 5ml	1-5ml bottle	3-5 ml bottles
Combigan	0.20/0.5% 10ml	Not covered	1-10ml bottle
Combunox	5mg/400mg	28 tablets per 7 days	28 tablets per 7 days
Concerta	18mg	30 tablets	90 tablets
Concerta	27mg	30 tablets	90 tablets
Concerta	36mg	60 tablets	180 tablets
Concerta	54mg	30 tablets	90 tablets
Compounds (5) (8)			Not covered
Crestor	5mg	30 tablets	90 tablets
Crestor	10mg	30 tablets	90 tablets
Crestor	20mg	30 tablets	90 tablets
Crestor	40mg	30 tablets	90 tablets
Cymbalta	20mg	60 capsules	180 capsules
Cymbalta	30mg	90 capsules	270 capsules
Cymbalta	60mg	60 capsules	180 capsules
Darvocet A500	100-500mg	240 tablets	720 tablets
Daytrana patch	15mg/9hr	1 tray of 30 or 3 trays of 10: Covered 6 years and older	3 trays of 30 or 9 trays of 10: Covered 6 years and older
Daytrana patch	10mg/9hr	1 tray of 30 or 3 trays of 10: Covered 6 years and older	3 trays of 30 or 9 trays of 10: Covered 6 years and older
Daytrana patch	20mg/9hr	1 tray of 30 or 3 trays of 10: Covered 6 years and older	3 trays of 30 or 9 trays of 10: Covered 6 years and older
Daytrana patch	30mg/9hr	1 tray of 30 or 3 trays of 10: Covered 6 years and older	3 trays of 30 or 9 trays of 10: Covered 6 years and older
DDAVP spray	0.01%	15 ml	45 ml
DDAVP tab	0.1mg	90 tablets	270 tablets
DDAVP tab	0.2mg	120 tablets	360 tablets
Depo-Provera	104 mg inj.	1 injection per 90 days: 3 copays	1 injection
Depo-Provera	150mg Inj.	1 injection per 90 days: 3 copays	1 injection
Dermotic Oil	.01%	2 -20ml bottles	6-20ml bottles
Desmopressin	0.01%	15 ml	45 ml

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Desyrel	300mg	30 tablets	90 tablets
Dexilant (formerly Kapidex)	30mg	30 caps: Not covered under 18 years of age	90 capsules: Not covered under 18 years of age
Dexilant (formerly Kapidex)	60mg	30 capsules: Not covered under 18 years of age	90 capsules: Not covered under 18 years of age
Diabetic Test Strips	Glucose blood test strips	300 strips	900 strips
Diaphragm (4)		1 per copay	1 per copay
Diovan HCT	160/12.5mg	60 tablets	180 tablets
Diovan HCT	160/25mg	60 tablets	180 tablets
Diovan HCT	320/12.5mg	30 tablets	90 tablets
Diovan HCT	320/25mg	30 tablets	90 tablets
Diovan HCT	80/12.5mg	60 tablets	180 tablets
Diovan Tab	160mg	60 tablets	180 tablets
Diovan Tab	320mg	30 tablets	90 tablets
Diovan Tab	80mg	60 tablets	180 tablets
Diovan Tab	40mg	60 tablets	180 tablets
Dipentium	250mg	120 capsules	360 capsules
Divigel (4)	0.25 mg	30 packets: Covered 18 years and older	90 packets: Covered 18 years and older
Divigel (4)	0.5 mg	30 packets: Covered 18 years and older	90 packets: Covered 18 years and older
Divigel (4)	1.0 mg	30 packets: Covered 18 years and older	90 packets: Covered 18 years and older
Dolgic Plus	50-750-40mg	150 tablets	450 tablets
Doryx	150mg	60 tablets or capsules	180 tablets or capsules
Doryx	100mg	60 tablets or capsules	180 tablets or capsules
Doryx	75mg	60 tablets or capsules	180 tablets or capsules
Duetact	30-2mg	30 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Duetact	30-4mg	30 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Durabac Forte		40 tablets: Covered 12 years and older	120 tablets: Covered 12 years and older
Durahist D	3.5-45-1mg	60 tablets: Covered 6 years and older	180 tablets: Covered 6 years and older
Dytan	25mg	60 tablets	180 tablets
Dytan	25mg/5ml	360 ml	1080 ml
Edex Kit (1) (7) (8)	10mcg	one per year	one per year
Edex Kit (1) (7) (8)	20mcg	one per year	one per year
Edex Kit (1) (7) (8)	40mcg	one per year	one per year
Effient	5mg	35 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Effient	10mg	35 tablets: Covered 16 years and older	90 tablets: Covered 16 years and older
Elidel cream	1%	Not covered under 2 years of age	Not covered under 2 years of age

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Emsam	6mg	30 patches:Covered 16 years and older	90 patches:Covered 16 years and older
Emsam	9mg	30 patches:Covered 16 years and older	90 patches:Covered 16 years and older
Emsam	12mg	30 patches:Covered 16 years and older	90 patches:Covered 16 years and older
Emtriva	200mg	30 capsules	90 capsules
Emtriva	10mg/ml	720ml	2160ml
Enablex	7.5mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Enablex	15mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Enjuvia (4)	0.3mg	Covered 18 years and older	Covered 18 years and older
Enjuvia (4)	0.45mg	Covered 18 years and older	Covered 18 years and older
Enjuvia (4)	0.625mg	Covered 18 years and older	Covered 18 years and older
Enjuvia (4)	0.9mg	30 tablets: Covered 18 years and older	90 tablets: Covered 18 years and older
Enjuvia (4)	1.25mg	Covered 18 years and older	Covered 18 years and older
Entocort EC	3mg/24hr	90 capsules	270 capsules
Equetro	100mg	90 capsules	270 capsules
Equetro	200mg	240 capsules	720 capsules
Equetro	300mg	150 capsules	450 capsules
Ergomar	2mg	20 tablets	60 tablets
Estring	2mg	1 vaginal ring per 90 days	1 vaginal ring per 90 days
Evista	60mg	30 tablets	90 tablets
Evoclin	50gm/can	50 gm:Covered 12 years and older	150 gm: Covered 12 years and older
Evoclin (6)	100gm/can		100 gm: Covered 12 years and older
Evoxac	30mg	90 capsules	270 capsules
Exelon	1.5mg	60 capsules	180 capsules
Exelon	3mg	60 capsules	180 capsules
Exelon	4.5mg	60 capsules	180 capsules
Exelon	4.6mg/24 hr	30 patches: Covered 18 years and older	90 patches: Covered 18 years and older
Exelon	6mg	60 capsules	180 capsules
Exelon	9.5mg/24hr	30 patches:Covered 18 years and older	90 patches: Covered 18 years and older
Exforge	5-160mg	30 tablets	90 tablets
Exforge	5-320mg	30 tablets	90 tablets
Exforge	10-160mg	30 tablets	90 tablets
Exforge	10-320mg	30 tablets	90 tablets
Exforge HCT	5-160mg-12.5mg	30 tablets	90 tablets
Exforge HCT	5-160-25mg	30 tablets	90 tablets
Exforge HCT	10-160-12.5mg	30 tablets	90 tablets
Exforge HCT	10-160-25mg	30 tablets	90 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Exforge HCT	10-320-25mg	30 tablets	90 tablets
Exjade	500mg	120 tablets:Covered 2 years and older	360 tablets:Covered 2 years and older
Exubera		Covered 6 years and older	Covered 6 years and older
Fareston	60mg	30 tablets	90 tablets
Femara	2.5mg	30 tablets	90 tablets
Femhrt Low Dose (4)	0.5mg-2.5mcg	1-28 blisterpack or #30: Not covered under age 18	3-28 blisterpacks or #90: Not covered under age 18
Femring	2 mg	1 vaginal ring per 90 days	1 vaginal ring per 90 days
Femtrace (4)	0.45mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Femtrace (4)	0.9mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Femtrace (4)	1.8	30 tablets:Covered 18 years and older	90 tablets: Covered 18 years and older
Fenofibric Acid	35mg	60 tablets	180 tablets
Fenofibric Acid	105mg	30 tablets	90 tablets
Fentora (9)	100mcg		
Fentora (9)	200mcg		
Fentora (9)	300mcg		
Fentora (9)	400mcg		
Fentora (9)	600mcg		
Fentora (9)	800mcg		
Fexofenadine	30mg	60 tablets	180 tablets
Fexofenadine	60mg	60 tablets	180 tablets
Fexofenadine	180mg	30 tablets	90 tablets
Fibricor	35mg	60 tablets	180 tablets
Fibricor	105mg	30 tablets	90 tablets
Flector patch	1.3%	60 patches: Covered 18 years and older	180 patches: Covered 18 years and older
Flomax (3)			
Floxin	200mg	60 tablets	180 tablets
Floxin	300mg	60 tablets	180 tablets
Floxin	400mg	60 tablets	180 tablets
Floxin Otic Singles	0.30%	20 containers	60 containers
Focalin	10mg	60 tablets	180 tablets
Focalin	2.5mg	90 tablets	270 tablets
Focalin	5mg	90 tablets	270 tablets
Focalin XR	5mg	90 capsules: Covered 6 years and older	270 capsules:Covered 6 years and older
Focalin XR	10mg	30 capsules:Covered 6 years and older	90 capsules: Covered 6 years and older
Focalin XR	15mg	30 capsules:Covered 6 years and older	90 capsules: Covered 6 years and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Focalin XR	20mg	30 capsules: Covered 6 years and older	90 capsules: Covered 6 years and older
Foradil	12mcg	60 capsules	180 capsules
Fortamet	500mg	150 tablets	450 tablets
Fortamet	1000mg	75 tablets	225 tablets
Fortical Nasal Spray	200 units/ml	3.7ml bottle	3-3.7ml bottles
Fosamax	10mg	30 tablets	90 tablets
Fosamax	35mg	4 tablets	12 tablets
Fosamax	40mg	30 tablets	90 tablets
Fosamax	5mg	30 tablets	90 tablets
Fosamax	70mg	4 tablets	12 tablets
Fosamax D	70-2800mg	4 tablets	12 tablets
Fosamax D	70-5600mg	4 tablets: Covered 18 years and older	12 tablets: Covered 18 years and older
Fosamax Solution	70mg	300 ml per 28 days	900 ml per 84 days
Fosrenol	250mg	90 tablets: Covered 16 years and older	270 tablets: Covered 16 years and older
Fosrenol	500mg	90 tablets: Covered 16 years and older	270 tablets: Covered 16 years and older
Fosrenol	750mg	90 tablets: Covered 16 years and older	270 tablets: Covered 16 years and older
Fosrenol	1000mg	90 tablets: Covered 16 years and older	270 tablets: Covered 16 years and older
Frova (7)	2.5mg	9 tablets per copay	9 tablets per copay
Geodon	20mg	300 capsules	900 capsules
Geodon	40mg	60 capsules	180 capsules
Geodon	60mg	60 capsules	180 capsules
Geodon	80mg	60 capsules	180 capsules
Gleevec	100mg	180 tablets	540 tablets
Gleevec	400mg	60 tablets	180 tablets
Glucophage XR	500mg	150 tablets	450 tablets
Glucophage XR	750mg	90 tablets	270 tablets
Glucovance	1.25-250mg	90 tablets	270 tablets
Glucovance	2.5-500mg	120 tablets	360 tablets
Glucovance	5-500mg	120 tablets	360 tablets
Glumetza	500mg	120 tablets: Covered 18 and older	360 tablets: Covered 18 and older
Glumetza	1000mg	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Gynazole-1	2%	6 prefilled syringes	18 prefilled syringes

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) **Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.**
- 2) **For Future Use**
- 3) **Males only**
- 4) **Females only**
- 5) **Retail only**
- 6) **Mail Order only**
- 7) **Quantity may vary by benefit plan**
- 8) **Coverage may vary by benefit plan**
- 9) **Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.**

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Helidac		1 box	1 box
Hexafed	4-60mg	60 tablets	180 tablets
Hylira gel	0.2%	1-340 gm bottle per copay	1-340 gm bottle per copay
Imitrex vial (7)	6mg/0.5ml	9 single dose vials per copay	9 single dose vials per copay
Imitrex Kit (7)	6mg/0.5ml	4 kits (8) injections per copay	4 kits (8) injections per copay
Imitrex Kit (7)	4mg/0.5ml	4 kits (8) injections per copay	4 kits (8) injections per copay
Imitrex NS (7)	5mg	9 inhalers per copay	9 inhalers per copay
Imitrex NS (7)	20mg	9 inhalers per copay	9 inhalers per copay
Imitrex Tablet (7)	100mg	9 tablets per copay	9 tablets per copay
Imitrex Tablet (7)	25mg	9 tablets per copay	9 tablets per copay
Imitrex Tablet (7)	50mg	9 tablets per copay	9 tablets per copay
Innopran XL	80mg	30 capsules	90 capsules
Innopran XL	120mg	30 capsules	90 capsules
Inspirease Bags		3 per year	3 per year
Inspra	25mg	30 tablets	90 tablets
Inspra	50mg	60 tablets	180 tablets
Insulin vials	All	6 vials	18 vials
Invega	1.5mg	60 tablets:Not covered under age 18	180 tablets:Not covered under age 18
Invega	3mg	30 tablets:Not covered under age 18	90 tablets:Not covered under age 18
Invega	6mg	60 tablets:Not covered under age 18	180 tablets:Not covered under age 18
Invega	9mg	30 tablets:Not covered under age 18	90 tablets:Not covered under age 18
Iquix	1.5%	10 ml	30 ml
Isoniazid	100mg	60 tablets	180 tablets
Isoniazid	300mg	30 tablets	90 tablets
Janumet	50-500mg	60 tablets: Not covered under 18 years of age	180 tablets:Not covered under 18 years of age
Janumet	50-1000mg	60 tablets: Not covered under 18 years of age	180 tablets:Not covered under 18 years of age
Januvia	25mg	30 tablets: Not covered under 18 years of age	90 tablets: Not covered under 18 years of age
Januvia	50mg	30 tablets: Not covered under 18 years of age	90 tablets: Not covered under 18 years of age

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Januvia	100mg	30 tablets: Not covered under 18 years of age	90 tablets: Not covered under 18 years of age
Keppra XR	500mg	180 tablets: Not covered under 16 years of age	540 tablets: Not covered under 16 years of age
Kerafoam	30%	60 grams	180 grams
Kerlone	10mg	45 tablets	135 tablets
Kerlone	20mg	30 tablets	90 tablets
Kerol suspension	50%	1-284gm tube per copay: Max 2 tubes	1-284gm tube per copay: Max 6 tubes
Ketone Blood Test Strips	PTS Panels or Precision Xtra	100 strips	300 strips
Ketone Urine Test Strips	Keto-Diastix, Chemstrip	100 strips	300 strips
Ketoprofen ER 24hr	200mg	30 capsules	90 capsules
Klonopin Wafers	0.125mg	450 tablets	1350 tablets
Klonopin Wafers	0.25mg	450 tablets	1350 tablets
Klonopin Wafers	0.5mg	180 tablets	540 tablets
Klonopin Wafers	1mg	90 tablets	270 tablets
Klonopin Wafers	2mg	60 tablets	180 tablets
Kuvan	100mg	120 tablets per copay. Covered 4 years and older	360 tablets per copay. Covered 4 years and older
Lamisil	125mg	60 granule packets	180 granule packets
Lamisil	187.5mg	30 granule packets	90 granule packets
Lamisil	250mg	30 tablets	90 tablets
Lariam (1)	250mg	5 tablets per 30 days	15 tablets per 90 days
Lavoclen Acne Wash Kit	4 %	1 kit	3 kits
Lavoclen Acne Wash Kit	8 %	1 kit	3 kits
Lescol	20mg	90 tablets	270 tablets
Lescol	40mg	30 capsules	90 capsules
Lescol XL	80mg	30 tablets	90 tablets
Letairis	5 mg	30 tablets: Covered 18 years and older	90 tablets: Covered 18 years and older
Letairis	10 mg	30 tablets: Covered 18 years and older	90 tablets: Covered 18 years and older
Levaquin	250mg	90 tablets	270 tablets
Levaquin	500mg	30 tablets	90 tablets
Levaquin	750mg	30 tablets	90 tablets
Levitra (1) (7) (8) (3)	5mg	8 per 30 days	24 per 90 days

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Levitra (1) (7) (8) (3)	2.5mg	8 per 30 days	24 per 90 days
Levitra (1) (7) (8) (3)	10mg	8 per 30 days	24 per 90 days
Levitra (1) (7) (8) (3)	20mg	8 per 30 days	24 per 90 days
Levothyroxine Injection	200mg	30 vials	90 vials
Levothyroxine Injection	500mg	30 vials	90 vials
Lexapro (7)	10mg	45 tablets	135 tablets
Lexapro (7)	20mg	30 tablets	90 tablets
Lexapro (7)	5mg	30 tablets	90 tablets
Lialda	1.2gm	120 tablets: Covered 18 and older	360 tablets: Covered 18 and older
Lifescan One Touch Meter	Any Style	Not a benefit through the retail pharmacy. Please contact Lifescan's toll-free number 1-888-887-6299 or 1-888-233-3282 code 257BCA001. 1 per Lifetime	Not a benefit through the mail order pharmacy. Please contact Lifescan's toll-free number 1-888-887-6299 or 1-888-233-3282 code 257BCA001. 1 per Lifetime
Lipitor	10mg	45 tablets	135 tablets
Lipitor	20mg	45 tablets	135 tablets
Lipitor	40mg	45 tablets	135 tablets
Lipitor	80mg	45 tablets	135 tablets
Locoid Lotion	0.1%	1-59ml bottle per copay	1-59ml bottle per copay
Lodine	200mg	180 capsules	540 capsules
Lodine	300mg	120 capsules	360 capsules
Lodine	400mg	90 tablets	270 tablets
Lodine	500mg	60 tablets	180 tablets
Lodine XL	400mg	90 tablets	270 tablets
Lodine XL	500mg	60 tablets	180 tablets
Lodine XL	600mg	60 tablets	180 tablets
Lofibra	54mg	30 tablets:Covered 12 years and older	90 tablets: Covered 12 years and older
Lofibra	160mg	30 tablets:Covered 12 years and older	90 tablets:Covered 12 years and older
Loseasonique (4)	0.1-0.02mg	91 tablets per 91 days	91 tablets per 91 days
Lotronex	1mg	60 tablets	180 tablets
Lovaza	1 gram	120 capsules:Covered 18 and older	360 capsules:Covered 18 and older
Lumigan	0.03%	5ml	15ml
Lunesta	1mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Lunesta	2 mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Lunesta	3mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Luvox CR	100mg	60 capsules	180 capsules

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Luvox CR	150mg	60 capsules	180 capsules
Lybrel (4)	90-20 mcg	28 tablets:Covered 12 years and older	84 tablets:Covered 12 years and older
Lyrica (7)	25mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	50mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	75mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	100mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	150mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	200mg	90 tablets:Covered 16 years and older	270 tablets: Covered 16 years and older
Lyrica (7)	225mg	60 tablets:Covered 16 years and older	180 tablets: Covered 16 years and older
Lyrica (7)	300mg	60 tablets:Covered 16 years and older	180 tablets:Covered 16 years and older
Maxalt (7)	10mg	9 tablets per copay	9 tablets per copay
Maxalt (7)	5mg	9 tablets per copay	9 tablets per copay
Maxalt MLT (7)	10mg	9 tablets per copay	9 tablets per copay
Maxalt MLT (7)	5mg	9 tablets per copay	9 tablets per copay
Megace ES	625mg/5ml	150 ml	450 ml
Menostar (4)	14mcg	4 patches	12 patches
Meridia (7) (8)	5mg	Not covered under 16 years of age	Not covered under 16 years of age
Meridia (7) (8)	10mg	Not covered under 16 years of age	Not covered under 16 years of age
Meridia (7) (8)	15mg	Not covered under 16 years of age	Not covered under 16 years of age
Metadate CD	10mg	30 capsules	90 capsules
Metadate CD	20mg	30 capsules	90 capsules
Metadate CD	30mg	30 capsules	90 capsules
Metadate CD	40mg	30 capsules	90 capsules
Metadate CD	50mg	30 capsules	90 capsules
Metadate CD	60mg	30 capsules	90 capsules
Metaglip	2.5-250mg	60 tablets	180 tablets
Metaglip	2.5-500mg	120 tablets	360 tablets
Metaglip	5.0-500mg	120 tablets	360 tablets
Metrogel (7)	1% topical	1-45gram tube or 1-60 gram tube Covered 16 years and older	4-45 gram tubes or 3-60 gram tubes Covered 16 years and older
Metrogel Vaginal Gel	0.75%	70gm	70gm
Mevacor	40mg	60 tablets	180 tablets
Miacalcin Nasal Spray	200 units/ml	1 bottle (4ml)	3 bottles (12ml)

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) **Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.**
- 2) **For Future Use**
- 3) **Males only**
- 4) **Females only**
- 5) **Retail only**
- 6) **Mail Order only**
- 7) **Quantity may vary by benefit plan**
- 8) **Coverage may vary by benefit plan**
- 9) **Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.**

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Micardis HCT	80-25mg	30 tablets	90 tablets
Migranal	4mg/ml	8 ampules per Copay: Max 16 ampules	8 ampules per Copay: Max 48 ampules
Mirapex ER	.375mg	30 tablets	90 tablets
Mirapex ER	.75mg	30 tablets	90 tablets
Mirapex ER	1.5mg	30 tablets	90 tablets
Mirapex ER	3.0mg	30 tablets	90 tablets
Mirapex ER	4.5mg	30 tablets	90 tablets
Mobic	15mg	30 tablets	90 tablets
Mobic	7.5mg	30 tablets	90 tablets
Mobic	7.5mg/5ml	300ml	900 ml
Multaq	400mg	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Multiple Urine Test Strips	Multistix, Uristix, Bili-labstix, Labstix, Hema-combist, Combistix, Keto-diastix, Chemstrip	100 strips	300 strips
Muse (1) (7) (8)	1000mcg	6 per 30 days supply	18 per 90 days
Muse (1) (7) (8)	125mcg	6 per 30 days supply	18 per 90 days
Muse (1) (7) (8)	250mcg	6 per 30 days supply	18 per 90 days
Muse (1) (7) (8)	500mcg	6 per 30 days supply	18 per 90 days
Myfortic	180mg	180 tablets	540 tablets
Myfortic	360mg	120 tablets	360 tablets
Namenda	5mg	90 tablets	270 tablets
Namenda	10mg	60 tablets	180 tablets
Namenda	10mg/5ml	1-360ml bottle: Covered 12 and older	3-360ml bottles: Covered 12 and older
Naprelan	375mg	30 per copay: Covered 18 and older	30 per copay: Covered 18 and older
Naprelan	500mg	30 per copay: Covered 18 and older	30 per copay: Covered 18 and older
Naprelan	750mg	30 per copay: Covered 18 and older	30 per copay: Covered 18 and older
Nasacort AQ	55mcg	1 bottle	3 bottles
Nascobal	500mcg/1ml	2.3ml per 60 days: 2 copays	2.3ml
Neobenz Micro Cream	3.5%	1-45gm tube: Covered 12 and older	3- 45gm tubes: Covered 12 and older
Neobenz Micro Cream	5.5%	1-45gm tube: Covered 12 and older	3- 45gm tubes: Covered 12 and older
Neobenz Micro Cream	8.5%	1-45gm tube: Covered 12 and older	3- 45gm tubes: Covered 12 and older
Nevanac	0.1%	1-3ml bottle: Covered 10 and older	1-3ml bottle: Covered 10 and older
Nexavar	200mg	120 tablets: Covered 16 years and older	Not Covered at Mailorder

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Nexium	20mg	60 capsules	180 capsules
Nexium	40mg	60 capsules	180 capsules
Nexium Granules	10mg	60 packets	180 packets
Nexium Granules	20mg	60 packets	180 packets
Nexium Granules	40mg	60 packets	180 packets
Niaspan	500mg	90 tablets	270 tablets
Niaspan	750mg	60 tablets	180 tablets
Niaspan	1000mg	60 tablets	180 tablets
Nicotrol NS (7) (8)	10mg/ml (0.5mg/spray)	12 -10ml bottles: Covered 18 years and older	36 -10ml bottles: Covered 18 years and older
Nimotop	30mg	252 capsules	756 capsules
Niravam	0.25mg	90 tablets:Covered 18 years and older	270 tablets: Covered 18 years and older
Niravam	0.50mg	90 tablets Covered 18 years and older	270 tablets: Covered 18 years and older
Niravam	1mg	90 tablets:Covered 18 years and older	270 tablets: Covered 18 years and older
Niravam	2mg	150 tablets: Covered 18 years & older	450 tablets:Covered 18 years & older
Nisoldipine	20mg	30 tablets	90 tablets
Nisoldipine	30mg	60 tablets	180 tablets
Nisoldipine	40mg	30 tablets	90 tablets
Nitro-Dur	0.1mg/hr	30 patches	90 patches
Nitro-Dur	0.2mg/hr	30 patches	90 patches
Nitro-Dur	0.3mg/hr	30 patches	90 patches
Nitro-Dur	0.4mg/hr	30 patches	90 patches
Nitro-Dur	0.6mg/hr	30 patches	90 patches
Nitro-Dur	0.8mg/hr	30 patches	90 patches
Nitromist	400 mcg/spray	1 bottle per copay	1 bottle per copay
Noroxin	400mg	60 tablets	180 tablets
Northyx	15mg	90 tablets	270 tablets
Northyx	20mg	90 tablets	270 tablets
Novolin Innolet	Novolin 70/30	3 cartons	9 cartons
Novolin Innolet	Novolin N	3 cartons	9 cartons
Noxafil	40mg/ml	4-105ml bottles:Covered 13 years and older	12-105ml bottles: Covered 13 years and older
NuCort lotion	2%	60 ml	180 ml
Nuox Gel	6-3%	1-43 gram tube	3-43 gram tubes
NuvaRing	0.120-0.15mg	1 ring	3 rings

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) **Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.**
- 2) **For Future Use**
- 3) **Males only**
- 4) **Females only**
- 5) **Retail only**
- 6) **Mail Order only**
- 7) **Quantity may vary by benefit plan**
- 8) **Coverage may vary by benefit plan**
- 9) **Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.**

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Nuvigil (9)	50mg		
Nuvigil (9)	150mg		
Nuvigil (9)	250mg		
NuZon (7)	2% gel	1-43 gram tube	3-43 gram tubes
Olux E	0.05% Aerosol	100 gram per copay: Max 300 gram: Covered 12 years and older	100 gram per copay: Max 900 gram: Covered 12 years and older
Omnaris	50mcg	1 bottle: Covered 12 and older	3 bottles: Covered 12 and older
Onglyza	2.5mg	30 tablets: Covered 16 and older	90 tablets: Covered 16 and older
Onglyza	5mg	30 tablets: Covered 16 and older	90 tablets: Covered 16 and older
Onsolis (7) (9)	200mcg	120 doses; Covered 18 and older	Not covered at mailorder
Onsolis (7) (9)	400mcg	120 doses; Covered 18 and older	Not covered at mailorder
Onsolis (7) (9)	600mcg	120 doses; Covered 18 and older	Not covered at mailorder
Onsolis (7) (9)	800mcg	120 doses; Covered 18 and older	Not covered at mailorder
Onsolis (7) (9)	1200mcg	120 doses; Covered 18 and older	Not covered at mailorder
Omnihist II LA	8-25mg/2.5mg	60 tablets	180 tablets
Optivar 3ml (5)	0.05%	1 bottle	Not covered
Optivar 6ml	0.05%	1 bottle	2 bottles
Oracea	40mg	30 capsules: Covered 9 and older	90 capsules: Covered 9 and older
Oral Contraceptives	28's	28 tablets per 30 days	112 tablets per 90 days
Oral Contraceptives	21's	21 tablets per 30 days	84 tablets per 90 days
Oravig	50mg	14 tablets per copay: Covered 16 and older	14 tablets per copay: Covered 16 and older
Orbivan	50-300-40 mg	30 capsules per copay: Covered 12 and older	30 capsules per copay: Covered 12 and older
Ortho Evra	150-20mcg/24hr	3 patches	9 patches
Ovide Lotion	0.50%	59mls	59mls
Oxytrol TD	Patch	8 patches	24 patches
Pamine	2.5mg	360 tablets	1080 tablets
Patanase Nasal spray	0.6%	1-30.5gm bottle: Covered 6 years and older	3-30.5gm bottles: Covered 6 years and older
Patanol	0.10%	3 bottles	8 bottles
Paxil	10mg	45 tablets	135 tablets
Paxil	20mg	30 tablets	90 tablets
Paxil	30mg	60 tablets	180 tablets
Paxil	40mg	45 tablets	135 tablets
Paxil CR	12.5mg	30 tablets	90 tablets
Paxil CR	25mg	60 tablets	180 tablets
Paxil CR	37.5mg	60 tablets	180 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Peranex HC Kit	2-2%	1 box of 24 per copay: Max 2 boxes: Not covered under 18 years of age	1 box of 24 per copay: Max 4 boxes: Not covered under 18 years of age
Peranex HC Pad	3-1%	60 pads per copay. Covered 18 years and older	60 pads per copay. Covered 18 years and older
Perforomist	20mcg/2ml	1 carton: Not covered under 18 years of age	3 cartons: Not covered under 18 years of age
Periostat	20mg	60 tablets	180 tablets
Phenytek	200mg	60 capsules	180 capsules
Phenytek	300mg	60 capsules	180 capsulless
Plan B One Step(4) (5)	1.5mg	1 tablet per copay: Covered age 17 and under with Prescription (OTC if >17)	Not Covered
Plavix	75mg	30 tablets	90 tablets
Plavix	300mg	1 tablet per copay	1 tablet per copay
Pletal	100mg	60 tablets	180 tablets
Pletal	50mg	60 tablets	180 tablets
Pravachol	10mg	30 tablets	90 tablets
Pravachol	20mg	30 tablets	90 tablets
Pravachol	40mg	60 tablets	180 tablets
Pravachol	80mg	30 tablets	90 tablets
Premphase	0.625mg-6	30 tablets	90 tablets
Prempro	0.3/1.5mg	30 tablets	90 tablets
Prempro	0.625mg-5	60 tablets	180 tablets
Prempro	0.625mg-2.5	60 tablets	180 tablets
Prempro Low Dose	.45-1.5mg	30 tablets	90 tablets
Prevacid	15mg	60 capsules	180 capsules
Prevacid Naprapac	375mg Kit	4 kits	12 kits
Prevacid Naprapac	500mg Kit	4 kits	12 kits
Prevacid Solutab	15mg	30 tablets	90 tablets
Prevpac		1 box	1 box
Prezista	75mg	180 tablets	540 tablets
Prezista	300mg	120 tablets	360 tablets
Prezista	400mg	60 tablets	180 tablets
Pristiq	50mg	30 tablets	90 tablets
Pristiq	100mg	30 tablets	90 tablets
Proscar (3)	5mg/24hr	30 tablets	90 tablets
Prosed DS	81.6mg	56 capsules per copay: Covered age 12 and older	56 capsules per copay: Covered age 12 and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Protonix	20mg	90 tablets	270 tablets
Protonix	40mg	180 tablets	540 tablets
Protonix Pak	40mg	180 packets	540 packets
Protopic	0.10%	60gm: Covered age 2 and older	180gm: Covered age 2 and older
Protopic	0.03%	60gm : Covered age 2 and older	180gm : Covered age 2 and older
Provigil	100mg	Covered age 16 and older	Covered age 16 and older
Provigil	200mg	Covered age 16 and older	Covered age 16 and older
Prozac	90mg	5 capsules	15 capsules
Pulmicort Flexhaler	90mcg	2 inhalers	6 inhalers
Pulmicort Flexhaler	180mcg	2 inhalers	6 inhalers
Pulmicort Susp	0.25mg/2ml	240mls	720mls
Pulmicort Susp	0.5mg/2ml	120mls	360mls
Pulmicort Susp	1mg/2ml	60mls	180mls
Pulmozyme sol	1mg/ml	180ml	540ml
Quixin Ophthalmic	0.50%	5ml	15ml
Qvar	40mcg	5 inhalers	15 inhalers
Qvar	80mcg	3 inhalers	9 inhalers
Ranexa	500mg	60 tablets:Covered 16 yrs and older	180 tablets: Covered 16 yrs and older
Ranexa	1000mg	60 tablets:Covered 16 yrs and older	180 tablets:Covered 16 yrs and older
Rapaflo (3)	4mg		
Rapaflo (3)	8mg		
Razadyne ER	8mg	30 capsules:Covered 18 yrs and older	90 capsules:Covered 18 yrs and older
Razadyne ER	16mg	30 capsules:Covered 18 yrs and older	90 capsules: Covered 18 yrs and older
Razadyne ER	24mg	30 capsules:Covered 18 yrs and older	90 capsules:Covered 18 yrs and older
Rebetol Solution	40mg/ml	9 bottles	27 bottles
Rectagel HC	2.8-0.55%	100gm per copay: Covered 16 and older	300gm per copay: Covered 16 and older
Relenza	5mg	20 blisters	20 blisters
Relpax (7)	20mg	9 tablets per copay	9 tablets per copay
Relpax (7)	40mg	9 tablets per copay	9 tablets per copay
Remeron	15mg	30 tablets	90 tablets
Remeron	30mg	90 tablets	270 tablets
Remeron	45mg	60 tablets	180 tablets
Remeron Sol Tabs	15mg	30 tablets	90 tablets
Remeron Sol Tabs	30mg	90 tablets	270 tablets
Remeron Sol Tabs	45mg	60 tablets	180 tablets
Reminyl	12mg	60 tablets	180 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) **Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.**
- 2) **For Future Use**
- 3) **Males only**
- 4) **Females only**
- 5) **Retail only**
- 6) **Mail Order only**
- 7) **Quantity may vary by benefit plan**
- 8) **Coverage may vary by benefit plan**
- 9) **Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.**

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Reminyl	4mg	90 tablets	270 tablets
Reminyl	8mg	60 tablets	180 tablets
Renagel	403mg	1050 capsules	3150 capsules
Renagel	400mg	1050 tablets	3150 tablets
Renagel	800mg	600 tablets	1800 tablets
Renvela	0.8gm	450 packets	1350 packets
Renvela	2.4gm	150 packets	450 packets
Renvela	800mg	450 tablets	1350 tablets
Requip Starter Kit	0.25mg-0.5mg-1mg	1 kit	1 kit
Requip XL	2mg	240 tablets	720 tablets
Requip XL	4mg	120 tablets	540 tablets
Requip XL	8 mg	90 tablets	270 tablets
Restasis	0.05%	60 vials	180 vials
Restoril	7.5mg	45 capsules	135 capsules
Restoril	22.5mg	30 capsules	90 capsules
Retin-A Micro	20gm	1 tube	1 tube
Retin-A Micro	45gm	1 tube per copay	1 tube per copay
Retin-A Micro	50gm	1 bottle per copay	1 bottle per copay
Revlimid	5mg	30 capsules	Not covered
Revlimid	10mg	30 capsules	Not covered
Revlimid	15mg	30 capsules	Not covered
Revlimid	25mg	30 capsules	Not covered
Reyataz	100mg	30 capsules	90 capsules
Reyataz	150mg	60 capsules	180 capsules
Reyataz	200mg	60 capsules	180 capsules
Reyataz	300mg	30 capsules	90 capsules
Rhinocort Sus Aqua	32mcg/5ml	18gm (2 bottles)	54gm (4 bottles)
Ribapak	400mg	60 tablets	180 tablets
Ribapak	600mg	60 tablets	180 tablets
Ribasphere	400mg	60 tablets	180 tablets
Ribasphere	600mg	60 tablets	180 tablets
Ribavirin	400mg	60 tablets	180 tablets
Ribavirin	600mg	60 tablets	180 tablets
Ritalin LA	10mg	30 capsules	90 capsules

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Rozerem	8mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Ryzolt	100mg	30 tablets:Covered 16 years and older	90 tablets:Covered 16 years and older
Ryzolt	200mg	30 tablets:Covered 16 years and older	90 tablets:Covered 16 years and older
Ryzolt	300mg	30 tablets:Covered 16 years and older	90 tablets: Covered 16 years and older
Sanctura XR	60mg	30 capsules:Covered 18 years and older	90 capsules: Covered 18 years and older
Sarafem (4)	10mg	30 tablets or capsules	90 tablets or capsules
Sarafem (4)	15mg	30 tablets or capsules	90 tablets or capsules
Sarafem (4)	20mg	30 tablets or capsules	90 tablets or capsules
Savella	Titration Pak	1 Pak: Covered 16 and older	1 Pak: Covered 16 and older
Savella	12.5mg	60 tablets: Covered 16 and older	180 tablets: Covered 16 and older
Savella	25mg	60 tablets: Covered 16 and older	180 tablets: Covered 16 and older
Savella	50mg	60 tablets: Covered 16 and older	180 tablets: Covered 16 and older
Savella	100mg	60 tablets: Covered 16 and older	180 tablets: Covered 16 and older
Seasonale	0.15-0.03mg	91 tablets per 91 days	91 tablets per 91 days
Seasonique	0.1-0.02MG	91 tablets per 91 days	91 tablets per 91 days
Semprex-D	8-60mg	120 capsules	360 capsules
Sensipar	30mg	150 tablets	450 tablets
Sensipar	60mg	150 tablets	450 tablets
Sensipar	90mg	120 tablets	360 tablets
Serevent Disk	50mcg	60 blisters	180 blisters
Seroquel	50mg	90 tablets	270 tablets
Seroquel	400mg	60 tablets	180 tablets
Seroquel XR	50mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Seroquel XR	150mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Seroquel XR	200mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Seroquel XR	300mg	60 tablets:Covered 18 years and older	180 tablets:Covered 18 years and older
Seroquel XR	400mg	60 tablets:Covered 18 years and older	180 tablets:Covered 18 years and older
Singulair	10mg	30 tablets	90 tablets
Singulair	5mg	60 tablets	180 tablets
Singulair chew	4mg	30 tablets	90 tablets
Singulair Granules	4mg	30 packs	90 packs
Skelaxin	800mg	120 tablets	360 tablets
Solaraze	3%	1-100gm tube	1-100gm tube
Solodyn (9)	45mg	30 tablets: Covered 12 yrs and older	90 tablets: Covered 12 yrs and older
Solodyn (9)	65mg	30 tablets: Covered 12 yrs and older	90 tablets: Covered 12 yrs and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Solodyn (9)	90mg	30 tablets: Covered 12 yrs and older	90 tablets: Covered 12 yrs and older
Solodyn (9)	115mg	30 tablets: Covered 12 yrs and older	90 tablets: Covered 12 yrs and older
Solodyn (9)	135mg	30 tablets: Covered 12 yrs and older	90 tablets: Covered 12 yrs and older
Soltamox	10mg/5ml	4-150ml bottles	12-150ml bottles
Sonata	10mg	60 capsules	180 capsules
Sonata	5mg	90 capsules	270 capsules
Soriatane CK	10mg	One kit per copay	One kit per copay
Spiriva Handihaler	18mcg	30 capsules	90 capsules
Sprycel	20mg	60 tablets	180 tablets
Sprycel	50mg	60 tablets	180 tablets
Sprycel	70mg	60 tablets	180 tablets
Stalevo 100	37.5-150-200mg	240 tablets	720 tablets
Stalevo 150	25-100-200mg	240 tablets	720 tablets
Stalevo 50	12.5-50-200mg	240 tablets	720 tablets
Starlix	120mg	90 tablets	270 tablets
Starlix	60mg	90 tablets	270 tablets
Strattera	10mg	300 capsules	900 capsules
Strattera	18mg	150 capsules	450 capsules
Strattera	25mg	120 capsules	360 capsules
Strattera	40mg	60 capsules	180 capsules
Strattera	60mg	60 capsules	180 capsules
Strattera	80mg	30 capsules	90 capsules
Strattera	100mg	30 capsules	90 capsules
Subutex	2mg	240 tablets	720 tablets
Striant (3)	30mg	60 packets: Covered 18 yrs and older	180 packets: Covered 18 yrs and older
Subutex	8mg	60 tablets	180 tablets
Sular	8.5mg	30 tablets	90 tablets
Sular	17mg	30 tablets	90 tablets
Sular	25.5mg	30 tablets	90 tablets
Sular	34mg	30 tablets	90 tablets
Sumatriptan syringe (7)	4mg/0.5ml	8 injections per copay	8 injections per copay
Sumatriptan syringe (7)	6mg/0.5ml	8 injections per copay	8 injections per copay
Sumatriptan vial (7)	4mg/0.5ml	9 single dose vials per copay	9 single dose vials per copay
Sumavel Dosepro	6mg/0.5ml	9 pre-filled single dose units per copay	9 pre-filled single dose units per copay
Sumaxin	10-4%	60 pads (1box): Covered 12 and older	180 pads (3 boxes): Covered 12 and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Sutent	12.5mg	28 capsules	56 capsules
Sutent	25mg	28 capsules	56 capsules
Sutent	50mg	28 capsules	56 capsules
Symbyax	3/25mg	30 capsules	90 capsules
Symbyax	6/25mg	90 capsules	270 capsules
Symbyax	6/50mg	30 capsules	90 capsules
Symbyax	12/25mg	30 capsules	90 capsules
Symbyax	12/50mg	30 capsules	90 capsules
Symlin	0.6mg/ml	4 vials: Covered 18 years and older	11 vials: Covered 18 years and older
Symlinpen 120	1000mcg/ml	4 pens: Covered 18 years and older	12 pens: Covered 18 years and older
Symlinpen 60	1000mcg/ml	4 pens: Covered 18 years and older	12 pens: Covered 18 years and older
Synera Topical Patch	70-70mg	1 box:Covered 3 years and older	3 boxes:Covered 3 years and older
Taclonex ointment	0.005-0.064%	6 tubes: Covered 16 years and older	20 tubes: Covered 16 years and older
Taclonex Scalp	Topical Suspension	1-60 gram bottle per copay: Covered 18 years and older	3-60 gram bottles per copay: Covered 18 years and older
Tamiflu	12mg/ml	3 bottles (75ml) per copay	3 bottles (75ml) per copay
Tamiflu	30mg	10 capsules per copay	10 capsules per copay
Tamiflu	45mg	10 capsules per copay	10 capsules per copay
Tamiflu	75mg	10 capsules per copay	10 capsules per copay
Targretin 1% Gel	60gm	120 gm	360 gm
Tekturna	150mg	30 tablets:Covered 18 years and older	60 tablets:Covered 18 years and older
Tekturna	300mg	30 tablets:Covered 18 years and older	60 tablets:Covered 18 years and older
Tekturna HCT	150-12.5mg	30 tablets	90 tablets
Tekturna HCT	150-25mg	30 tablets	90 tablets
Tekturna HCT	300-12.5mg	30 tablets	90 tablets
Tekturna HCT	300-25mg	30 tablets	90 tablets
Testim (3)	1%		
Teveten	400mg	60 tablets	180 tablets
Teveten	600mg	30 tablets	90 tablets
Tikosyn	125mg	60 capsules	180 capsules
Tikosyn	250mg	60 capsules	180 capsules
Time-Hist QD	6-120-2.5mg	30 tablets:Covered 18 years and older	90 tablets: Covered 18 years and older
Tiskoyn	500mg	60 capsules	180 capsules
Tofranil-PM	150mg	60 capsules	180 capsules
Tofranil-PM	75mg	90 capsules	270 capsules

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Tofranil-PM	100mg	60 capsules	180 capsules
Tofranil-PM	125mg	60 capsules	180 capsules
Toviaz	4mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Toviaz	8mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Tracleer	125mg	60 tablets	180 tablets
Tracleer	62.5mg	60 tablets	180 tablets
Transderm-Scop	1.5mg/72hr	10 patches	30 patches
Travatan	0.004%	5ml	10ml
Travatan Z	0.004%	2.5ml:Covered 18 years and older	5ml:Covered 18 years and older
Tretin-X Cream Kit	.1%	2 Kits	6 Kits
Tretin-X Cream Kit	.05%	2 Kits	6 Kits
Tretin-X Cream Kit	.025%	2 Kits	6 Kits
Tretin-X Gel Kit	.01%	2 Kits	6 Kits
Tretin-X Gel Kit	.025%	2 Kits	6 Kits
Treximet (7)	85-500 mg	9 per copay	9 per copay
Tricor	145mg	30 tablets	90 tablets
Tricor	48mg	60 tablets	180 tablets
Triglide	50mg	60 tablets:Covered 18 years and older	180 tablets:Covered 18 years and older
Triglide	160mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Trilipix	45mg	30 capsules:Covered 18 years and older	90 capsules: Covered 18 years and older
Trilipix	135mg	30 capsules:Covered 18 years and older	90 capsules: Covered 18 years and older
Trizivir	300-150-300	60 tablets	180 tablets
Truvada	200-300mg	30 tablets	90 tablets
Tykerb	250mg	150 tablets	450 tablets
Tyzeka	600mg	30 tablets:Covered 16 years and older	90 tablets:Covered 16 years and older
Uloric	40mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Uloric	80mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Ultracet	37.5/325mg	240 tablets	720 tablets
Ultralytic 2	20%	100gm Foam	300gm Foam
Ultralytic 2	20%	113gm Cream	113gm Cream
Ultram	50mg	240 tablets	720 tablets
Ultram ER	100mg	30 tablets:Covered 18 and older	90 tablets: Covered 18 and older
Ultram ER	200mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Ultram ER	300mg	30 tablets:Covered 18 years and older	90 tablets:Covered 18 years and older
Uroxatral	10mg	30 tablets	90 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) **Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.**
- 2) **For Future Use**
- 3) **Males only**
- 4) **Females only**
- 5) **Retail only**
- 6) **Mail Order only**
- 7) **Quantity may vary by benefit plan**
- 8) **Coverage may vary by benefit plan**
- 9) **Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.**

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Vagifem	25mcg	30 tablets	90 tablets
Valcyte	450mg	120 tablets	360 tablets
Vectical Ointment	3 mcg/gm	1-100gm tube	3-100 gram tubes
Veramyst	27.5mcg	10gm (1 bottle)	30gm (3 bottles)
Veregen Ointment	15%	1 tube per copay	3 tubes per copay
Vesicare	10mg	30 tablets:Covered 18 yrs and older	90 tablets:Covered 18 yrs and older
Vesicare	5mg	30 tablets:Covered 18 yrs and older	90 tablets: Covered 18 yrs and older
Vfend	200mg	90 tablets	270 tablets
Viagra (1) (7) (8) (3)	100mg	8 per 30 days	24 per 90 days
Viagra (1) (7) (8) (3)	25mg	8 per 30 days	24 per 90 days
Viagra (1) (7) (8) (3)	50mg	8 per 30 days	24 per 90 days
Victoza	18MG/3ml	1 package of 3: Covered 18 yrs and older	3 packages of 3: Covered 18 yrs and older
Victoza	18 MG/3ml	1 package of 2: Covered 18 yrs and older	3 packages of 2: Covered 18 yrs and older
Viread	300mg	30 tablets	90 tablets
Visicol	1.5gm	40 tablets	120 tablets
Viva DHA (4)	28-1-200 MG		
Vivelle Dot	0.025mg	2 patches per week	2 patches per week
Vivelle Dot	0.0375mg	2 patches per week	2 patches per week
Vivelle Dot	0.05mg	2 patches per week	2 patches per week
Vivelle Dot	0.075mg	2 patches per week	2 patches per week
Vivelle Dot	0.1mg	2 patches per week	2 patches per week
Voltaren gel	1%	1-100 gm tube per copay	1-100 gm tube per copay
Vopac	30/650mg	180 tablets	540 tablets
Vospire ER	4mg	180 tablets	540 tablets
Vospire ER	8mg	120 tablets	360 tablets
Vusion Ointment	0.25-15-81.35%	1 tube per copay up to 3	1 tube per copay up to 3
Vytorin	10/10mg	30 tablets	90 tablets
Vytorin	10/20mg	30 tablets	90 tablets
Vytorin	10/40mg	30 tablets	90 tablets
Vytorin	10/80mg	30 tablets	90 tablets
Vyvanse	20mg	30 capsules	90 capsules
Vyvanse	30mg	60 capsules:Covered 6 years and older	180 capsules: Covered 6 years and older
Vyvanse	40mg	30 capsules	90 capsules
Vyvanse	50mg	30 capsules: Covered 6 years and older	90 capsules: Covered 6 years and older

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Vyvanse	60mg	30 capsules	90 capsules
Vyvanse	70mg	30 capsules: Covered 6 years and older	90 capsules: Covered 6 years and older
Welchol	625mg	210 tablets	630 tablets
Welchol	3.75gm	30 packets	90 packets
Wellbutrin SR	200mg	60 tablets	180 tablets
Wellbutrin XL	150mg	90 tablets	270 tablets
Wellbutrin XL	300mg	45 tablets	135 tablets
Xenical (7) (8)	120mg	Covered 12 years and older	Covered 12 years and older
Xibrom	0.09%	5ml: Covered 18 years and older	15ml: Covered 18 years and older
Xifaxan	200mg	9 tablets per copay max 90: Covered 12 years and older	9 tablets per copay max 270: Covered 12 years and older
Xifaxan	550mg	60 tablets: Covered 18 years and older	180 tablets: Covered 18 years and older
Xolegel Gel	2%	1-15gm tube per copay: Covered 12 years and older	3-15gm tubes per copay : Covered 12 years and older
Xopenex HFA	45 mcg	One inhaler per copay	Three inhalers per copay
Xyrem	500mg/ml	540ml: Covered between age 18 & 65	1620ml: Covered between age 18 & 65
Xyzal	5mg	30 tablets	90 tablets
Xyzal	2.5mg/5ml	150 ml	450ml
Zanaflex	2mg	540 tablets or capsules	1620 tablets or capsules
Zanaflex	4mg	270 tablets or capsules	810 tablets
Zanaflex	6mg	180 capsules	540 capsules
Zegerid	20-1680mg	30 packets: Covered 18 years and older	90 packets: Covered 18 years and older
Zegerid	40-1680mg	30 packets: Covered 18 years and older	90 packets: Covered 18 years and older
Zegerid	20-1100mg	30 capsules: Covered 18 years and older	90 capsules: Covered 18 years and older
Zegerid	40-1100mg	30 capsules: Covered 18 years and older	90 capsules: Covered 18 years and older
Zelapar	1.25mg	60 tablets	180 tablets
Zemplar	1mcg	30 capsules: Covered 18 yrs and older	90 capsules: Covered 18 yrs and older
Zemplar	2mcg	30 capsules: Covered 18 yrs and older	90 capsules: Covered 18 yrs and older
Zemplar	4mcg	12 capsules: Covered 18 yrs and older	36 capsules: Covered 18 yrs and older
Zetia	10mg	30 tablets	90 tablets
Zingo	0.5mg	1 per copay	1 per copay
Zmax	2gm susp	75ml: Covered 16 years and older	75ml: Covered 16 years and older
Zocor	10mg	30 tablets	90 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Zocor	20mg	30 tablets	90 tablets
Zocor	40mg	60 tablets	180 tablets
Zocor	5mg	30 tablets	90 tablets
Zocor	80mg	30 tablets	90 tablets
Zolinza	100mg	80 capsules: Covered 16 yrs and older	240 capsules: Covered 16 yrs and older
Zoloft	100mg	60 tablets	180 tablets
Zoloft	25mg	45 tablets	135 tablets
Zoloft	50mg	45 tablets	135 tablets
Zomig (7)	5gm nasal spray	9 bottles per copay	9 bottles per copay
Zomig (7)	2.5mg	9 tablets per copay	9 tablets per copay
Zomig (7)	5mg	9 tablets per copay	9 tablets per copay
Zomig ZMT (7)	2.5mg	9 tablets per copay	9 tablets per copay
Zomig ZMT (7)	5mg	9 tablets per copay	9 tablets per copay
Zonegran	100mg	180 capsules	540 capsules
Zyban (7) (8)	150mg SR	60 tablets: Covered 18 and older	180 tablets: Covered 18 and older
Zyflo CR	600mg	120 tablets: Not covered under 12 years of age	360 tablets: Not covered under 12 years of age
Zylet	0.5-0.3%	20mls	20 mls
Zymar	0.30%	10ml	30ml
Zyprexa	2.5mg	30 tablets	90 tablets
Zyprexa	5mg	30 tablets	90 tablets
Zyprexa	7.5mg	30 tablets	90 tablets
Zyprexa	10mg	30 tablets	90 tablets
Zyprexa	15mg	30 tablets	90 tablets
Zyprexa	20mg	30 tablets	90 tablets
Zyprexa Zydis	5gm	30 tablets	90 tablets
Zyprexa Zydis	10mg	30 tablets	90 tablets
Zyprexa Zydis	15mg	30 tablets	90 tablets
Zyprexa Zydis	20mg	30 tablets	90 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.

Prescription Limitations and Precertification Requirements for Retail and Mail Order Prescriptions

Revised 7/2/10

- 1) *Quantity listed is the maximum amount in a 30 day period (retail) and a 90 day period (mail order). Mail order prescriptions are allowed to process 1 week earlier to allow for shipping.*
- 2) *For Future Use*
- 3) *Males only*
- 4) *Females only*
- 5) *Retail only*
- 6) *Mail Order only*
- 7) *Quantity may vary by benefit plan*
- 8) *Coverage may vary by benefit plan*
- 9) *Precertification required. Contact (602) 864-4273 or (800) 232-2345 ext. 4273 for precertification information.*

Brand Medication Name	Medication Strength	Retail Pharmacy Maximum Quantity Per Co-pay	Mail Order Maximum Quantity Per Copay
Zyvox	600mg	60 tablets	180 tablets

Refills are covered when ¾ of the medication is used as prescribed, unless otherwise noted. Limitations are numbered and their definitions are noted at the top of the page (other limitations apply, please refer to your benefit plan booklet). Limitations for generic versions of the brand names listed also apply. Medications are also limited to a maximum 30 day supply through your retail benefit or a 90 day supply through your mail order benefit. If the information on this document differs from your benefit plan, the terms of your benefit plan will apply.