

PREMIER PREFERRED DRUG LIST

Effective April 2011–September 2011

DRUG	PREFERRED ALTERNATIVES	
ABILIFY [^]	N risperidone	
ACCOLATE [^]	N SINGULAIR [^] #	
ACCU-CHEK TEST STRIPS [#]	N ONETOUCH TEST STRIPS [#]	
ACIPHEX	NCE DEXILANT [#] , omeprazole 20 mg [#]	
ACTONEL [^] #	N alendronate [#]	
ACTOPLUS MET [#]	P	
ACTOS [#]	P	
ACZONE	NCE benzoyl peroxide products*, topical tretinoin*, topical clindamycin*	
ADDERALL	N mixed salts amphetamines*	
ADDERALL XR	N mixed salts amphetamines ext-rel*	
ADVAIR [#]	P	
ALDARA	NC imiquimod*	
ALLEGRA	NC cetirizine [#] (OTC), fexofenadine [#] *, levocetirizine [#] *, loratadine [#] (OTC)	
FOLD ALLEGRA SUSPENSION	NCE cetirizine [#] (OTC), fexofenadine [#] *, levocetirizine [#] *, loratadine [#] (OTC)	FOLD
ALLEGRA-D 24 HOUR	NC fexofenadine-D 12-hour [#] *, fexofenadine-D 24-hour [#] *	
OT01 ALPHAGAN P	NC brimonidine	OT01
ALTACE	NC ramipril	
AMBIEN	NC zaleplon [#] , zolpidem [#] *	
AMBIEN CR	NC zolpidem ext-rel [#] *	
AMRIX	N cyclobenzaprine	
ANDRODERM	P	
ANDROGEL	P	
ARICEPT 23 MG	N donepezil	
ARICEPT/ARICEPT ODT	NC donepezil	
ARIMIDEX	NC anastrozole	
ARIXTRA	N heparin (if not contraindicated), LOVENOX	
ARMOUR THYROID	N levothyroxine	
ARTHROTEC	N diclofenac and misoprostol	
ASACOL	P	
ASMANEX [#]	P	
ASTELIN	NC azelastine [#]	
ASTEPRO [#]	N azelastine [#]	
ATACAND [^] #	N AVAPRO [^] #, DIOVAN [^] #, lisinopril, losartan, quinapril	
ATACAND HCT [^] #	N AVALIDE [^] #, DIOVAN HCT [^] #, lisinopril/HCTZ, losartan/HCTZ, quinapril/HCTZ	
ATRIPLA	N	
AVALIDE [^] #	P	
AVANDAMET [#]	N	
AVANDIA [#]	N	
FOLD AVAPRO [^] #	P	FOLD
AVELOX [#]	N ciprofloxacin, LEVAQUIN [#] , ofloxacin	
AVINZA [#]	N morphine sulfate [#] , oxycodone/acetaminophen [#]	
AVODART	N finasteride	
OT01 AXERT [#]	N MAXALT [#] , naratriptan [#] , RELPAX [#] , sumatriptan [#]	OT01
AZELEX CREAM 20%	NCE benzoyl peroxide products*, topical tretinoin*, topical clindamycin*	
AZOR	N amlodipine and losartan	
BACTROBAN	NC mupirocin	
BENICAR [^] #	N AVAPRO [^] #, DIOVAN [^] #, lisinopril, losartan, quinapril	
BENICAR HCT [^] #	N AVALIDE [^] #, DIOVAN HCT [^] #, lisinopril/HCTZ, losartan/HCTZ, quinapril/HCTZ	
BENZACLIN	NC benzoyl peroxide/clindamycin*	
BONIVA [^] #	N alendronate [#]	
BYETTA [#]	P	
BYSTOLIC	N atenolol, timolol	
CADUET [#]	N simvastatin [#] and amlodipine	
CARDIZEM CD	NC diltiazem ext-rel	
CELEBREX [^] #	N diclofenac, ibuprofen, meloxicam [#] , nabumetone	
CELEXA	NC citalopram	

– Quantity Limits for some plans; * = tier 2 generic

P = Preferred drug; N = Non-Preferred drug

[^] May require Prior Authorization for some plans

NC = Not Covered - Drugs not covered are not eligible for an exception process.

NCE = Not Covered, eligible for medical criteria exception

This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.

OTC – Over the Counter; may not be covered by your prescription drug benefit

UPPERCASE = BRAND; lowercase = generic

DRUG	PREFERRED ALTERNATIVES	
CHANTIX	P	
CIPRODEX	P	
CLARINEX 5 MG	NCE	cetirizine (OTC), fexofenadine*, levocetirizine*, loratadine (OTC)
CLARINEX SYRUP	NCE	cetirizine (OTC), fexofenadine*, levocetirizine*, loratadine (OTC)
CLARINEX-D	NCE	fexofenadine-D 12-hour*
CLIMARA PRO	P	
CLOBEX	NC	clobetasol
COMBIGAN	N	
COMBIVENT#	P	
CONCERTA	P	
CONTOUR TEST STRIPS#	N	ONETOUCH TEST STRIPS#
COREG CR	N	carvedilol
COUMADIN	NC	warfarin
COZAAR	NC	losartan
CRESTOR#	P	
CYMBALTA^#	N	venlafaxine ext-rel*
CYOMEL	N	lithyronine
DAYTRANA	N	CONCERTA, FOCALIN SR, mixed salts amphetamines ext-rel*
DENAVIR	P	
DEPAKOTE^/DEPAKOTE ER^	N	divalproex sodium/divalproex sodium ext-rel
DERMA-SMOOTHIE/FS	N	fluocinolone
DETROL LA	P	
DEXILANT#	P	
DIFFERIN	NC	adapalene, tretinoin
DILANTIN	N	phenytoin
DIOVAN^#	P	
DIOVAN HCT^#	P	
DORYX	NC	doxycycline
DOVONEX CREAM#	P	
DOVONEX SCALP LOTION	NC	calcipotriene
DUAC CS	NC	benzoyl peroxide/clindamycin*
EFFEXOR XR	NC	venlafaxine ext-rel*
EFFIENT	N	
ELIDEL	P	
EMEND#	N	granisetron#, metoclopramide, ondansetron#
ENABLEX	N	DETROL, DETROL LA, oxybutynin ext-rel, trospium, VESICARE
ENTOCORT EC	P	
EPIDUO	NC	adapalene and benzoyl peroxide
EPIPEN/EPIPEN JR	P	
ERY-TAB	N	erythromycin
ESTRACE	NC	estradiol
ESTRING	P	
EVISTA#	P	
EVOCLIN	NC	clindamycin gel
EXFORGE^#	N	amlodipine and losartan
FACTIVE#	N	ciprofloxacin, LEVAQUIN#, ofloxacin
FEMARA	P	
FEMCON FE#	N	Balziva#, Zenchent#
FEMHRT	P	
FINACEA GEL	N	
FLECTOR	N^#	diclofenac
FLOMAX	NC	tamsulosin
FLONASE	NC	fluticasone#
FLOVENT#	P	
FOCALIN XR	P	
FORADIL#	P	
FOSAMAX PLUS D^#	N	alendronate#
FREESTYLE TEST STRIPS#	N	ONETOUCH TEST STRIPS#
FROVA#	N	MAXALT#, naratriptan#, RELPAX#, sumatriptan#
GEODON	P	
GLUMETZA	N	metformin ext-rel
HUMALOG	P	
HUMALOG MIX	P	
HUMULIN	P	
HYZAAR	NC	losartan/HCTZ
IMITREX	NC	sumatriptan#
INSULIN SYRINGES	P	

– Quantity Limits for some plans; * = tier 2 generic

P = Preferred drug; N = Non-Preferred drug

^ May require Prior Authorization for some plans

NC = Not Covered - Drugs not covered are not eligible for an exception process.

NCE = Not Covered, eligible for medical criteria exception

This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.

OTC – Over the Counter; may not be covered by your prescription drug benefit

UPPERCASE = BRAND; lowercase = generic

FOLD

FOLD

OTC

OTC

FOLD

FOLD

OTC

OTC

	DRUG	PREFERRED ALTERNATIVES	
	INTUNIV	N	guanfacine
	JANUMET#	N	
	JANUVIA#	N	
	KEPPRA^	N	levetiracetam
	KLONOPIN	NC	clonazepam
	LAMICTAL^	N	lamotrigine
	LANSOPRAZOLE	NCE	DEXILANT#, omeprazole 20 mg#
	LANTUS	P	
	LESCOL#/LESCOL XL#	N	CRESTOR#, LIPITOR#, lovastatin#, simvastatin#
	LEVAQUIN#	P	
	LEVEMIR	P	
	LEXAPRO^	N	citalopram, fluoxetine, paroxetine, sertraline
	LIALDA	P	
	LIDODERM^	N	hydrocodone/acetaminophen
	LIPITOR#	P	
	LOTEMAX	P	
	LOTREL	NC	amlodipine/benazepril
	LOVAZA	N	niacin
	LOVENOX	P	
	LUMIGAN	N	TRAVATAN Z, XALATAN
	LUNESTA	NCE	zolpidem#, zolpidem ext-rel**
	LYRICA^	N	gabapentin
FOLD	MALARONE	P	
	MAXALT#	P	
	METADATE CD	N	CONCERTA, methylphenidate ext-rel, mixed salts amphetamines ext-rel*
OTC	METROGEL#	N	
	MICARDIS^#	N	AVAPRO^#, DIOVAN^#, lisinopril, losartan, quinapril
	MICARDIS HCT^#	N	AVALIDE^#, DIOVAN HCT^#, lisinopril/HCTZ, losartan/HCTZ, quinapril/HCTZ
	NAFTIN	P	
	NAMENDA	P	
	NASACORT AQ#	N	flunisolide#, fluticasone#, NASONEX#
	NASONEX#	P	
	NEOSALUS	N	
	NEXIUM	NCE	DEXILANT#, omeprazole 20 mg#
	NIASPAN	P	
	NORVASC	NC	amlodipine
	NORVIR	P	
	NOVOLOG	N^	HUMALOG
	NOVOLOG MIX	N^	HUMALOG MIX
	NUVARING#	N	
	NUVIGIL^	P	
	OMEPRAZOLE CAP 10 MG	NCE	DEXILANT#, omeprazole 20 mg#
	OMEPRAZOLE CAP 40 MG	NCE	DEXILANT#, omeprazole 20 mg#
	OMEPRAZOLE/ SODIUM BICARBONATE	NCE	DEXILANT#, omeprazole 20 mg#
	OMNARIS#	N	flunisolide#, fluticasone#, NASONEX#
	ONETOUCH TEST STRIPS#	P	
	OPTICHAMBER#	P	
FOLD	ORACEA	NC	doxycycline
	ORTHO EVRA#	N	
	ORTHO TRI-CYCLEN	NC	Trinessa#, Tri-Previfem#, Tri-Sprintec#
OTC	ORTHO TRI-CYCLEN LO#	N	
	OXYCONTIN	N	
	PANTOPRAZOLE	NCE	DEXILANT#, omeprazole 20 mg#
	PATADAY#	N	
	PATANOL#	N	
	PENTASA	P	
	PERCOCET	NC	oxycodone/acetaminophen#
	PLAVIX#	P	
	PRANDIN	P	
	PREMARIN#	P	
	PREMPRO	P	
	PREVENT	NC	fluoride
	PREVPAC	NCE	
	PRISTIQ^#	N	venlafaxine ext-rel*
	PROAIR HFA#	P	
	PROTONIX	NC	DEXILANT#, omeprazole 20 mg#
	PROTONIX PAK	NCE	DEXILANT#, omeprazole 20 mg#
	PROTOPIC	P	

– Quantity Limits for some plans; * = tier 2 generic

P = Preferred drug; N = Non-Preferred drug

^ May require Prior Authorization for some plans

NC = Not Covered - Drugs not covered are not eligible for an exception process.

NCE = Not Covered, eligible for medical criteria exception

This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.

OTC – Over the Counter; may not be covered by your prescription drug benefit

UPPERCASE = BRAND; lowercase = generic

	DRUG	PREFERRED ALTERNATIVES	
	PROVENTIL HFA#	P	
	PROVIGIL ^	N	NUVIGIL ^
	PROZAC	NC	fluoxetine
	PULMICORT FLEXHALER#	P	
	PULMICORT RESPULES	NC	budesonide inhalation solution**
	QVAR#	P	
	RELPAx#	P	
	RESTASIS	NCE	artificial tears (OTC)
	RETIN-A	NC	tretinoin#
	RHINOCORT AQUA#	N	flunisolide#, fluticasone#, NASONEX#
	RITALIN LA	N	CONCERTA, methylphenidate ext-rel
	SAVELLA^#	N	
	SEASONIQUE# (3 copayments)	N	
	SEREVENT DISKUS#	P	
	SEROQUEL/SEROQUEL XR	P	
	SIMCOR	N	simvastatin# and niacin
	SINGULAIR^#	P	
	SKELAXIN	NC	metaxalone
	SOLODYN	NC	minocycline ext-rel 24-hour*
	SPIRIVA#	P	
	STRATTERA	P	
FOLD	SUBOXONE#	P	
	SULAR	NC	nisoldipine ext-rel
	SYMBICORT#	P	
OTC	SYNTHROID	N	levothyroxine
	TACLONEX	N	
	TAMIFLU#	N	amantadine, rimantadine
	TARKA	NC	trandolapril and verapamil ext-rel
	TAZORAC	N	tretinoin
	TEGRETOL-XR^	N	carbamazepine ext-rel
	TEKTURNA^#	N	benazepril, enalapril, lisinopril, quinapril, trandolapril
	TEKTURNA HCT^#	N	benazepril/HCTZ, enalapril/HCTZ, lisinopril/HCTZ, quinapril/HCTZ, trandolapril/HCTZ
	TOBRADEX SUSPENSION	NC	tobramycin/dexamethasone
	TOPAMAX^	N	topiramate
	TOPROL-XL	NC	metoprolol succinate ext-rel
	TOVIAZ	N	DETROL, DETROL LA, oxybutynin ext-rel, trospium, VESICARE
	TREXIMET	NC	sumatriptan# and naproxen
	TRICOR	NC	fenofibrate
	TRILEPTAL^	N	oxcarbazepine
	TRILIPIX	NC	fenofibrate
	TRUVADA	P	
	TUSSIONEX	N	generic antitussive/antihistamine combos
	UROXATRAL	N	doxazosin, tamsulosin, terazosin
	VALIUM	NC	diazepam
	VALTREX	NC	valacyclovir**
	VENTOLIN HFA#	N	PROAIR HFA#, PROVENTIL HFA#
	VERAMYST#	N	flunisolide#, fluticasone#, NASONEX#
FOLD	VESICARE	P	
	VICODIN	NC	hydrocodone/acetaminophen#
	VIGAMOX	P	
	VIVELLE-DOT	P	
OTC	VOLTAREN GEL#	N	
	VYTORIN#	N	simvastatin# and ZETIA#
	VYVANSE	N	CONCERTA, mixed salts amphetamines ext-rel*
	WELLBUTRIN SR	NC	bupropion ext-rel
	WELLBUTRIN XL	NC	bupropion ext-rel
	XALATAN#	P	
	XANAX	NC	alprazolam
	XOPENEX HFA#	N	PROAIR HFA#, PROVENTIL HFA#
	XYZAL SOLUTION	NC	levocetirizine*
	YASMIN	NC	Ocella#
	YAZ	NC	Gianvi#
	ZEGERID	NC	DEXILANT#, omeprazole 20 mg#
	ZEGERID PWD PAK	NCE	DEXILANT#, omeprazole 20 mg#
	ZETIA#	P	
	ZIANA	NC	clindamycin and tretinoin
	ZOLOFT	NC	sertraline
	ZOMIG#	N	MAXALT#, naratriptan#, RELPAX#, sumatriptan#
	ZYMAR	N	ciprofloxacin, ofloxacin, VIGAMOX

– Quantity Limits for some plans; * = tier 2 generic

P = Preferred drug; N = Non-Preferred drug

^ May require Prior Authorization for some plans

NC = Not Covered - Drugs not covered are not eligible for an exception process.

NCE = Not Covered, eligible for medical criteria exception

This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.

OTC – Over the Counter; may not be covered by your prescription drug benefit

UPPERCASE = BRAND; lowercase = generic

SPECIALTY DRUG LIST

The following is the **Specialty Drug List**, many of the drugs are oral tablets or self administered while some drugs (in **bold type**) are typically provided within a physician office setting with coverage under the medical benefit.

For members with a specialty benefit, coverage for drugs listed in bold type will not be provided under the medical benefit. Providers must obtain these products through a preferred specialty vendor. Medications noted with a ^ below may require prior authorization. Medications with a # may be subject to quantity limits. Medications with a † are preferred within their class. Please refer to www.bcsri.com for more detailed program benefit information.

DRUG CATEGORY	SPECIALTY MEDICATION / HIGHEST TIER	DRUG CATEGORY	SPECIALTY MEDICATION / HIGHEST TIER
ANTI-INFECTIVE			
FOLD OT0J	Antivirals, Hepatitis C	Hemophilia, Factor IX	Alphanine SD
			Infergen (interferon alfacon-1)
			Intron A (interferon alfa 2b)
			Pegasys (peginterferon alfa 2a)^
			PegIntron (peginterferon alfa 2b)^
FOLD	HIV, AIDS	Hemophilia, Factor VIIa	Novoseven
			PegIntron Redipen (peginterferon alfa 2b)^
DERMATOLOGY			
OT0J	Psoriasis	Hemophilia, Factor VIII	Advate
			Amevive (alefacept)^
			Humira (adalimumab)^#
			Remicade (infliximab)^
ENDOCRINE			
FOLD OT0J	Growth Hormone Products	Immune Globulins	Alphanate
			Genotropin (somatropin)^#
			Humatrope (somatropin)^#
			Increlex (mecasermin)^#
			Norditropin (somatropin)^#
			Norditropin Nordiflex (somatropin)^#
			Nutropin (somatropin)^#
			Nutropin AQ (somatropin)^#
			Omnitrope (somatropin)^#
			Saizen (somatropin)^#
			Serostim (somatropin)^#
			Tev-tropin (somatropin)^#
			Zorbtive (somatropin)^#
FOLD OT0J	Miscellaneous Endocrine Disorders	Thrombocytopenia	Neumega (oprelvekin)^
			H.P. Acthar qel (corticotrophin)^
			Sandostatin LAR Depot (octreotide acetate)
			Somatuline Depot (lanreotide acetate)
			Somavert (pegvisomant)
			Supprelin (histrelin acetate)
OT0J	Osteoporosis	WBC Deficiencies	Leukine (sargramostim)
			Boniva IV formulation only (ibandronate)^
			Forteo (teriparatide)^#
			Prolia (denosumab)^
GASTROENTEROLOGY			
FOLD	Crohns, UC	Immunomodulator	Cryopyrin-Associated Periodic Syndromes
			Cimzia (certolizumab)^#
			Humira (adalimumab)^#
			Remicade (infliximab)^
HEMATOLOGICAL			
FOLD	Anemia	Rheumatoid Arthritis	Actemra (tocilizumab)^
			Aranesp (darbepoetin alfa)^
			Cimzia (certolizumab)^#
FOLD	Fibrinogen Deficiency	Transplant Drugs	Mozobil (plerixafor)
			RiaSTAP (human fibrinogen concentrate)
FOLD	Hemophilia	INFERTILITY	Follitropins
			FEIBA
GASTROENTEROLOGY			
FOLD	Crohns, UC	GnRH Antagonists	Cetrotide (cetrorelix acetate)
			Ganirelix acetate

DRUG CATEGORY	SPECIALTY MEDICATION / HIGHEST TIER
HCG	chorionic gonadotropin (generic)
	Novarel (chorionic gonadotropins)
	Ovidrel (choriogonadotropin alfa)
	Pregnyl (chorionic gonadotropins)
	Profasi (chorionic gonadotropin)
LHRH	Lutrepulse (gonadorelin acetate)
Lutropin	Luveris (lutropin alfa)
Menotropins	Menopur (gonadotropins/ menotropins)
	Repronex (gonadotropins/ menotropins)
Urofollitropins	Bravelle (urofollitropin)
MISCELLANEOUS	
Anticonvulsants	Sabril (vigabatrin) [^]
Enzyme Replacements	Aldurazyme (laronidase)
	Aralast (alpha1 proteinase inhibitor)
	Carbaglu (carglumic acid)
	Ceredase (alglucerase)
	Cerezyme (imiglucerase)
	Cinryze (human C1 inhibitor)
	Elaprase (idursulfase)
	Fabrazyme (agalsidase beta)
	Kuvan (sapropterin)
	Lumizyme (alglucosidase alfa)[^]
	Myozyme (alglucosidase alfa)[^]
	Naglazyme (galsulfase)
	Prolastin (alpha1 proteinase inhibitor)
	Vpriv (velaglucerase)[^]
	Zavesca (miglustat) [^]
Zemaira (alpha1 proteinase inhibitor)	
Iron Overload	Exjade (deferasirox)
Macular Degeneration	Lucentis (ranibizumab)[^]
	Macugen (pegaptanib)[^]
NEUROMUSCULAR	
Huntington's	Xenazine (tetraabenazine) [^]
Multiple Sclerosis	Ampyra (dalfampridine) [^]
	Avonex (interferon beta 1a)
	Betaseron (interferon beta 1b)
	Copaxone (glatiramer)
	Extavia (interferon beta 1b)
	Rebif (interferon beta 1a)
Tysabri (natalizumab)[^]	
Muscle Disorder	Botox (botulinum toxin type A)[^]
	Myobloc (botulinum toxin type B)[^]
	Xeomin (botulinum toxin type A)[^]
ONCOLOGY/HEMATOLOGY	
Hematology	NPlate (romiplostim) [^]
	Promacta (eltrombopag olamine) [^]

DRUG CATEGORY	SPECIALTY MEDICATION / HIGHEST TIER
Oral Agents	Afinitor (everolimus) [^]
	Gleevec (imatinib) [^]
	Iressa (gefitinib)
	Nexavar (sorafenib) [^]
	Oforta (fludarabine) [^]
	Revlimid (lenalidomide) [^] [^]
	Sprycel (dasatinib) [^]
	Sutent (sunitinib) [^]
	Tarceva (erlotinib) [^]
	Targretin (bexarotene) [^]
	Tasigna (nilotinib) [^]
	Temodar (temozolomide) [^]
	Thalomid (thalidomide) [^]
	Tykerb (lapatinib) [^]
	Votrient (pazopanib) [^]
Xeloda (capecitabine) [^]	
Zolanza (vorinostat) [^]	
Injectable Agents	Eligard (leuprolide acetate)
	Firmagon (degarelix)
	Lupron Depot (leuprolide acetate)
	Plenaxis (abarelix)
	Trelstar Depot (triptorelin pamoate)
	Trelstar LA (triptorelin pamoate)
	Vantas (histrelin acetate)
Zoladex (goserelin acetate)	
PULMONARY	
Asthma	Xolair (omalizumab)[^]
Cystic Fibrosis	Cayston (aztreonam inhaled)
	Pulmozyme (dornase alfa inhaled)
	TOBI (tobramycin inhaled)
Pulmonary Hypertension	Adcirca (tadalafil)
	epoprostenol (generic)
	Flolan (epoprostenol)
	Letairis (ambrisentan)
	Remodulin (treprostnil)
	Revatio (sildenafil)
Tracleer (bosentan)	
	Tyvaso (treprostnil)
	Ventavis (iloprost inhaled)
RSV	Synagis (palivizumab)[^]

Preferred Specialty Vendors
VILLAGE FERTILITY PHARMACY Toll Free 1-877-334-1610
CAREMARK CONNECT Toll free 1-866-278-6634 website www.CAREMARK.com
Resource Information for Physicians/Providers
BLUE CROSS & BLUE SHIELD OF RHODE ISLAND Local (401) 459-1000 • Toll free 1-800-637-3718 website www.BCBSRI.com
PATIENT HEALTH EDUCATION PROGRAMS Local (401) 459-5625
PHYSICIAN AND PROVIDER SERVICE Local (401) 274-4848 Toll Free 1-800-230-9050

We reserve the right to make changes to this list. Please refer to our website @ www.bcsri.com for the most current information. Questions? Please call the Customer Service number on the back of your ID card.

5348-1-DL-PREM-0411

– Quantity Limits for some plans; * = tier 2 generic
P = Preferred drug; N = Non-Preferred drug
^ May require Prior Authorization for some plans
NC = Not Covered - Drugs not covered are not eligible for an exception process.
NCE = Not Covered, eligible for medical criteria exception
This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.

OTC – Over the Counter; may not be covered by your prescription drug benefit
UPPERCASE = BRAND; lowercase = generic

FOLD

OTC

FOLD

OTC

FOLD

OTC

FOLD

OTC