



CCHP
Health Plan

What if your drug is not on the Formulary?

If your prescription is not listed on the formulary, you should first contact the Member Services Center at 1-415-834-2118 to ensure that it is not covered. If the Member Services Center confirms that we do not cover your drug, you have three options:

- 1) You can ask your doctor if you can switch to another drug covered by us.
- 2) You can ask us to make an authorization to cover your drug.
- 3) You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an authorization. If the authorization request is not approved, the Plan is not obligated to reimburse you. If the authorization request is not approved, you may appeal the Plan's denial.

You can obtain non-formulary prescription drugs (those not listed on our drug formulary for your condition) if authorized by the Plan and a CCHP physician determines that they are medically necessary. If you disagree with your physician's determination that a non-formulary prescription drug is not medically necessary, you may file a grievance as described in the "Grievances and Appeals Process" section of your Evidence of Coverage booklet.

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar. It will then display a search box for you to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
8-MOP CAP	-	2	DERMATOLOGICALS
abacavir tab (ZIAGEN equiv)	-	1	ANTIVIRALS
abacavir/ lamivudine/ zidovudine tab (TRIZIVIR equiv)	-	1	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	4	ANTIVIRALS
ABILIFY DISCMELT	PA	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY SOLN	PA	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
acamprosate calcium DR tab (CAMPRAL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	1	ANTIDIABETICS
ACCOLATE TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ACCU-CHEK AVIVA CONNECT METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK NANO SMARTVIEW METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
ACCUNEB NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ACCUPRIL TAB	-	3	ANTIHYPERTENSIVES
ACCURETIC TAB	-	3	ANTIHYPERTENSIVES
acebutolol cap (SECTRAL equiv)	-	1	BETA BLOCKERS
ACEON TAB	-	3	ANTIHYPERTENSIVES
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	3	ANALGESICS - OPIOID
acetaminophen/codeine soln	-	1	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1	ANALGESICS - OPIOID
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1	DIURETICS
acetazolamide tab	-	1	DIURETICS
ACETAZOLAMIDE TAB 125MG	-	1	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	1	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	1	COUGH/COLD/ALLERGY
ACIDIC VAGINAL JELLY	-	2	VAGINAL PRODUCTS
acitretin cap (SORIATANE equiv)	-	1	DERMATOLOGICALS
ACLOVATE CREAM (QL= 60gm/fill)	QL	3	DERMATOLOGICALS
ACLOVATE OINT (QL= 60gm/fill)	QL	3	DERMATOLOGICALS
ACTEMRA IV INJ	M	M	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ (QL= 2 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ACTIGALL CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ACTIQ LOZENGE (QL= 120 units/30 days)	PA-QL	3	ANALGESICS - OPIOID
ACTIVEVILLA TAB	-	3	ESTROGENS
ACTONEL TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ACTOPLUS MET TAB	-	3	ANTIDIABETICS
ACTOS TAB	-	3	ANTIDIABETICS
ACULAR (LS) OPHTH SOLN	-	3	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir oint (ZOVIRAX OINT equiv) (Step Therapy requires trial of one of the following oral medications: acyclovir, famciclovir, valacyclovir)	ST	4	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	1	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	1	ANTIVIRALS
ADAGEN INJ	M	M	BIOLOGICALS MISC
ADALAT CC TAB	-	3	CALCIUM CHANNEL BLOCKERS
adapalene cream (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
adapalene gel 0.1% (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
ADAPALENE LOTION (Acne Only – members age 35 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
ADCIRCA TAB	MSP-PA	4	CARDIOVASCULAR AGENTS - MISC.
ADDERALL TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
ADDERALL XR CAP	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
adefovir dipivoxil tab (HEPSERA equiv)	MSP-PA	4	ANTIVIRALS
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
ADIPEX-P CAP	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
ADIPEX-P TAB	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
ADOXA TAB	-	3	TETRACYCLINES
ADVAIR DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AEROCHAMBER	OTC	2	MEDICAL DEVICES AND SUPPLIES
AEROCHAMBER SUPPLIES	-	2	MEDICAL DEVICES AND SUPPLIES
AFINITOR DISPERZ (QL= 1 tab/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ	VAC	\$0	VACCINES
AFLURIA/FLUZONE INJ	VAC	\$0	VACCINES
AGGRENOL/ASPIRIN-DIPYRIDAMOLE CAP	-	2	HEMATOLOGICAL AGENTS - MISC.
AGRYLIN CAP	-	3	HEMATOLOGICAL AGENTS - MISC.
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
ALAMAST OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALBENZA TAB	-	2	ANTHELMINTICS
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
albuterol sulfate syrup	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALCAINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
alclometasone cream (ACLOVATE equiv) (QL= 60gm/fill)	QL	1	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv) (QL= 60gm/fill)	QL	1	DERMATOLOGICALS
ALCOHOL SWABS	OTC	1	MEDICAL DEVICES AND SUPPLIES
ALDACTAZIDE TAB	-	3	DIURETICS
ALDACTONE TAB	-	3	DIURETICS
ALDARA CREAM	-	3	DERMATOLOGICALS
ALDURAZYME INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alendronate tab (FOSAMAX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALFERON-N INJ	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alfuzosin SR tab (UROXATRAL equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP	-	2	ANTI-INFECTIVE AGENTS - MISC.
ALINIA TAB	-	2	ANTI-INFECTIVE AGENTS - MISC.
ALKERAN TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
allopurinol tab (ZYLOPRIM equiv)	-	1	GOUT AGENTS
ALOCRILOPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALOMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALPHAGAN P OPHTH SOLN (QL= 10ml/30 days)	QL	2	OPHTHALMIC AGENTS
ALPHAGAN P OPHTH SOLN 0.1% (QL= 10ml/30 days)	QL	2	OPHTHALMIC AGENTS
alprazolam ER tab (XANAX XR equiv)	-	1	ANTI-ANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	1	ANTI-ANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	1	ANTI-ANXIETY AGENTS
ALREX OPHTH SUSP/ LOTEMAX OPHTH SUSP	-	2	OPHTHALMIC AGENTS
ALTACE CAP	-	3	ANTI-HYPERTENSIVES
aluminum chloride soln (DRYSOL equiv)	-	1	DERMATOLOGICALS
amantadine cap (SYMMETREL equiv)	-	1	ANTI-PARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	1	ANTI-PARKINSON AGENTS
AMARYL TAB	-	3	ANTI-DIABETICS
AMBIEN TAB 10MG (Male QL= 1 tab/day; Female QL= 0.5 tab/day)	QL	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
AMBIEN TAB 5MG (QL= 1 tab/day)	QL	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
AMERGE TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
AMICAR SYRUP	-	3	HEMOSTATICS
AMICAR TAB	-	3	HEMOSTATICS
amiloride tab (MIDAMOR equiv)	-	1	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1	DIURETICS
aminocaproic acid syrup (AMICAR equiv)	-	1	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	1	HEMOSTATICS
AMINOCAPROIC ACID TAB	-	3	HEMOSTATICS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
aminophylline tab	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
amiodarone tab (CORDARONE equiv)	-	1	ANTIARRHYTHMICS
AMITIZA CAP	PA	2	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	1	ANTIDEPRESSANTS
amlodipine tab (NORVASC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
amlodipine/ valsartan tab (EXFORGE equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/atorvastatin tab (CADUET equiv)	-	1	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	1	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1	ANTIHYPERTENSIVES
AMMONIUM CHLORIDE INJ	M	M	MINERALS & ELECTROLYTES
ammonium lactate cream (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1	DERMATOLOGICALS
AMOXAPINE TAB	-	1	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin chew tab (AMOXIL equiv)	-	1	PENICILLINS
AMOXICILLIN CHEW TAB 250MG	-	1	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	1	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	1	PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1	PENICILLINS
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	1	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1	PENICILLINS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
ampicillin cap (PRINCIPEN equiv)	-	1	PENICILLINS
ampicillin susp (PRINCIPEN equiv)	-	1	PENICILLINS
AMPYRA TAB (QL= 2 tabs/day)	MSP-PA-QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ANAFRANIL CAP	-	3	ANTIDEPRESSANTS
anagrelide cap (AGRYLIN equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM-E KIT	-	3	ANORECTAL AGENTS
ANAPROX TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ANASPAZ ODT	-	3	ULCER DRUGS
anastrozole tab (ARIMIDEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANCOBON CAP	-	3	ANTIFUNGALS
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL 1% 25MG (QL= 1 packet/day)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL 1% 50MG (QL= 2 packets/day)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 1.25GM (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 2.5GM (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1.62% (QL= 2 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
ANDROID/TESTRED CAP	-	3	ANDROGENS-ANABOLIC
ANDROXY TAB	-	2	ANDROGENS-ANABOLIC
ANTABUSE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ANTARA CAP	-	3	ANTIHYPERLIPIDEMICS
ANTIVERT TAB	-	1	ANTIEMETICS
ANUSOL-HC CREAM	-	3	ANORECTAL AGENTS
APHTHASOL PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
APOKYN INJ (Only available through Walgreens 888-347-3416)	LD	4	ANTIPARKINSON AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	1	OPHTHALMIC AGENTS
apri tab (DESOGEN equiv)	-	\$0	CONTRACEPTIVES
APRISO CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
APTIVUS CAP	-	4	ANTIVIRALS
APTIVUS SOLN	-	4	ANTIVIRALS
ARALAST/PROLASTIN/ZEMAIRA INJ	M	M	RESPIRATORY AGENTS - MISC.
ARALEN TAB	-	3	ANTIMALARIALS
aranelle tab (TRI-NORINYL equiv)	-	\$0	CONTRACEPTIVES
ARANESP INJ (Step Therapy requires trial of EPOGEN or PROCREDIT)	MSP-ST	4	HEMATOPOIETIC AGENTS
ARAVA TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ARICEPT ODT (QL= 1 tab/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARICEPT TAB (QL= 2 tabs/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARICEPT TAB 23MG (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARIMIDEX TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
aripiprazole ODT (ABILIFY equiv)	PA	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	PA	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ARIXTRA INJ	PA	3	ANTICOAGULANTS
ARNUITY ELLIPTA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AROMASIN TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ARTHROTEC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
ASACOL HD/MESALAMINE TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
ASMANEX HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	1	ANALGESICS - OPIOID
ASTELIN/ASTEPRO NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
ATACAND HCT TAB	-	3	ANTIHYPERTENSIVES
atenolol tab (TENORMIN equiv)	-	1	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1	ANTIHYPERTENSIVES
ATIVAN TAB	-	3	ANTIANKXIETY AGENTS
atorvastatin tab (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	1	ANTIMALARIALS
ATRIPLA TAB	-	2	ANTIVIRALS
atropine ophth oint	-	1	OPHTHALMIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ATROVENT NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
AUBAGIO TAB (QL= 1 tab/day)	MSP-PA-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUGMENTIN ES-600 SUSP	-	3	PENICILLINS
AUGMENTIN TAB	-	3	PENICILLINS
AUGMENTIN XR TAB	-	3	PENICILLINS
AURYXIA TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
AVALIDE TAB	-	3	ANTIHYPERTENSIVES
AVANDAMET TAB	-	2	ANTIDIABETICS
AVANDARYL TAB	-	2	ANTIDIABETICS
AVANDIA TAB	-	2	ANTIDIABETICS
AVAPRO TAB	-	3	ANTIHYPERTENSIVES
AVAR GEL	-	2	DERMATOLOGICALS
AVC VAGINAL CREAM	-	2	VAGINAL PRODUCTS
AVELOX TAB	-	3	FLUOROQUINOLONES
aviane tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
AVODART CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
AVONEX INJ	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AXID CAP	-	3	ULCER DRUGS
AXID SOLN	-	3	ULCER DRUGS
AXIRON SOLN	-	3	ANDROGENS-ANABOLIC
AYGESTIN TAB	-	3	PROGESTINS
AZASITE SOLN (QL= 2.5ml/fill)	QL	2	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	1	ASSORTED CLASSES
azelastine nasal spray (ASTELIN/ASTEPRO equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	1	OPHTHALMIC AGENTS
AZILECT TAB	-	2	ANTIPARKINSON AGENTS
azithromycin susp (ZITHROMAX equiv)	-	1	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	1	MACROLIDES
AZOPT OPHTH SUSP	-	2	OPHTHALMIC AGENTS
AZULFIDINE EN-TABS	-	3	GASTROINTESTINAL AGENTS - MISC.
AZULFIDINE TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
BACITRACIN OPHTH OINT	-	2	OPHTHALMIC AGENTS
bacitracin/ neomycin/ polymyxin b ophth oint (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/ polymyxin b ophth oint (POLYSPORIN equiv)	-	1	OPHTHALMIC AGENTS
bacitracin/ polymyxin/ neomycin/ hydrocortisone ophth oint (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
baclofen tab	-	1	MUSCULOSKELETAL THERAPY AGENTS
BACTRIM DS TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
BACTROBAN CREAM	-	3	DERMATOLOGICALS
BACTROBAN OINT	-	3	DERMATOLOGICALS
balsalazide cap (COLAZAL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
BANZEL SUSP	-	2	ANTICONVULSANTS
BANZEL TAB	-	2	ANTICONVULSANTS
BARACLUDE SOLN	MSP-PA	4	ANTIVIRALS
B-D INSULIN SYRINGE	OTC	2	MEDICAL DEVICES AND SUPPLIES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
B-D PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
BELLADONNA ALKALOID/OPIUM SUPP	-	2	ULCER DRUGS
BELVIQ TAB (QL= 2 tabs/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
BELVIQ XR TAB (QL= 1 tab/day)	PA-QL	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
benazepril tab (LOTENSIN equiv)	-	1	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1	ANTIHYPERTENSIVES
BENTYL CAP	-	3	ULCER DRUGS
BENTYL SYRUP	-	3	ULCER DRUGS
BENTYL TAB	-	3	ULCER DRUGS
BENZACLIN GEL	-	3	DERMATOLOGICALS
BENZAMYCIN GEL	-	3	DERMATOLOGICALS
benzonatate cap (TESSALON equiv)	-	1	COUGH/COLD/ALLERGY
BENZONATATE CAP	-	3	COUGH/COLD/ALLERGY
benztropine tab	-	1	ANTIPARKINSON AGENTS
BETAGAN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1	DERMATOLOGICALS
betamethasone augmented gel (DIPROLENE GEL equiv)	-	1	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv) (QL= 45gm/fill)	QL	1	DERMATOLOGICALS
betamethasone dipropionate lotion (QL= 60gm/fill)	QL	1	DERMATOLOGICALS
betamethasone dipropionate oint (DIPROSONE OINT equiv) (QL= 45gm/fill)	QL	1	DERMATOLOGICALS
betamethasone valerate cream (QL= 45gm/fill)	QL	1	DERMATOLOGICALS
betamethasone valerate lotion (QL= 60gm/fill)	QL	1	DERMATOLOGICALS
betamethasone valerate oint (QL= 45gm/fill)	QL	1	DERMATOLOGICALS
BETAPACE AF TAB	-	3	BETA BLOCKERS
BETAPACE TAB	-	3	BETA BLOCKERS
betaxolol ophth soln (BETOPTIC-S equiv)	-	1	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	1	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	1	URINARY ANTISPASMODICS
BETHKIS NEB SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4	AMINOGLYCOSIDES
BETIMOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	2	OPHTHALMIC AGENTS
bexarotene cap (TARGRETIN equiv)	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BEYAZ TAB	-	\$0	CONTRACEPTIVES
BIAXIN SUSP	-	3	MACROLIDES
BIAXIN XL TAB	-	3	MACROLIDES
bicalutamide tab (CASODEX equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bisoprolol tab (ZEBETA equiv)	-	1	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1	ANTIHYPERTENSIVES
BLEPH-10 OPHTH SOLN	-	3	OPHTHALMIC AGENTS
BLEPHAMIDE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
BONIVA TAB 150MG (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
BOSULIF TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRAVELLE INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
BREO ELLIPTA INHALER	-	2	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
BRETHINE TAB	-	3	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln (ALPHAGAN P equiv) (QL= 10ml/30 days)	QL	1	OPHTHALMIC AGENTS
bromfenac ophth soln (BROMDAY equiv)	-	1	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	1	ANTIPARKINSON AGENTS
budesonide inh susp (PULMICORT equiv)	-	1	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
budesonide SR cap (ENTOCORT EC equiv)	-	1	CORTICOSTEROIDS
bumetanide tab (BUMEX equiv)	-	1	DIURETICS
BUPHENYL TAB	PA-SP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	1	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv)	-	1	ANTIDEPRESSANTS
BUSPAR TAB	-	3	ANTI-ANXIETY AGENTS
buspirone tab (BUSPAR equiv)	-	1	ANTI-ANXIETY AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	1	ANALGESICS - OPIOID
BUTRANS PATCH	-	3	ANALGESICS - OPIOID
BYDUREON INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
BYSTOLIC TAB	-	2	BETA BLOCKERS
cabergoline tab (DOSTINEX equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAFCIT SOLN	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
CALAN SR TAB	-	3	CALCIUM CHANNEL BLOCKERS
CALAN TAB	-	3	CALCIUM CHANNEL BLOCKERS
calcipotriene cream (DOVONEX CREAM equiv)	-	1	DERMATOLOGICALS
calcipotriene oint	-	1	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	1	DERMATOLOGICALS
calcipotriene/ betamethasone oint (TACLONEX equiv)	-	1	DERMATOLOGICALS
calcitonin nasal spray (MIACALCIN equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol inj (CALCIJEX equiv)	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol soln (ROCALTROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
calcium acetate tab (ELIPHOS equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	1	MEDICAL DEVICES AND SUPPLIES
CAMPRAL TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
CANASA SUPP	-	2	GASTROINTESTINAL AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	1	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	1	ANTIHYPERTENSIVES
capecitabine tab (XELODA equiv)	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPOTEN TAB	-	3	ANTIHYPERTENSIVES
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
captopril tab (CAPOTEN equiv)	-	1	ANTIHYPERTENSIVES
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	1	ANTIHYPERTENSIVES
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	1	ANTIHYPERTENSIVES
CARAC CREAM	-	2	DERMATOLOGICALS
CARAFATE SUSP	-	1	ULCER DRUGS
CARAFATE TAB	-	3	ULCER DRUGS
carbamazepine chew tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	1	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	1	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	1	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	1	ANTICONVULSANTS
CARBATROL CAP	-	3	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	1	ANTIPARKINSON AGENTS
CARBIDOPA/ LEVODOPA/ ENTACAPONE TAB (STALEVO equiv)	-	2	ANTIPARKINSON AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	1	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	1	ANTIPARKINSON AGENTS
carbinoxamine soln (PALGIC equiv)	-	1	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	1	ANTIHISTAMINES
CARDIZEM CD CAP	-	3	CALCIUM CHANNEL BLOCKERS
CARDIZEM LA TAB	-	3	CALCIUM CHANNEL BLOCKERS
CARDIZEM TAB	-	3	CALCIUM CHANNEL BLOCKERS
CARDURA TAB	-	3	ANTIHYPERTENSIVES
carisoprodol tab (SOMA equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CARMOL-HC CREAM	-	3	DERMATOLOGICALS
CARNITOR TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
carteolol ophth soln (OCUPRESS equiv)	-	1	OPHTHALMIC AGENTS
carvedilol tab (COREG equiv)	-	1	BETA BLOCKERS
CASODEX TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CATAFLAM TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
CATAPRES TAB	-	3	ANTIHYPERTENSIVES
CATAPRES-TTS PATCH	-	3	ANTIHYPERTENSIVES
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	4	ANTI-INFECTIVE AGENTS - MISC.
CEENU CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cefaclor cap (CECLOR equiv)	-	1	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	1	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	1	CEPHALOSPORINS
CEFAZOLIN INJ	M	M	CEPHALOSPORINS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
cefdinir cap (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	1	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	1	CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	1	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	1	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	1	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	1	CEPHALOSPORINS
CEFTIN TAB	-	3	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	1	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	1	CEPHALOSPORINS
CELEBREX CAP (QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS)	QL-ST	3	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS)	QL-ST	1	ANALGESICS - ANTI-INFLAMMATORY
CELEXA SOLN	-	3	ANTIDEPRESSANTS
CELEXA TAB	-	3	ANTIDEPRESSANTS
CELONTIN CAP	-	2	ANTICONVULSANTS
cephalexin cap (KEFLEX equiv)	-	1	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	1	CEPHALOSPORINS
CEPHALEXIN TAB	-	1	CEPHALOSPORINS
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
cesia tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
CETROTIDE INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
cevimeline cap (EVOXAC equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	2	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	1	ANTIANKXIETY AGENTS
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlorhexidine gluconate soln (PERIDEX equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	1	ANTIMALARIALS
chlorothiazide tab (DIURIL equiv)	-	1	DIURETICS
CHLOROTHIAZIDE TAB 250MG	-	1	DIURETICS
chlorpheniramine ER cap	-	1	ANTI-HISTAMINES
chlorpromazine tab (THORAZINE equiv)	-	1	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
CHLORPROPAMIDE TAB	-	1	ANTI-DIABETICS
chlorpropamide tab (DIABINESE equiv)	-	1	ANTI-DIABETICS
CHLORTHALIDONE TAB	-	1	DIURETICS
chlorzoxazone tab (PARAFON FORTE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4	GASTROINTESTINAL AGENTS - MISC.
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	1	ANTIHYPERLIPIDEMICS
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1	ANALGESICS - NONNARCOTIC
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1	ANALGESICS - NONNARCOTIC
CHROMAGEN FA TAB	-	3	HEMATOPOIETIC AGENTS
CIALIS TAB 2.5MG, 5MG (PAH Only: Additional criteria required)	PA	4	CARDIOVASCULAR AGENTS - MISC.
ciclopirox cream (LOPROX CREAM equiv)	-	1	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ciclopirox gel (LOPROX GEL equiv)	-	1	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	1	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	1	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
cimetidine soln (TAGAMET equiv)	-	1	ULCER DRUGS
cimetidine tab (TAGAMET equiv)	-	1	ULCER DRUGS
CIMZIA INJ	MSP-PA	4	GASTROINTESTINAL AGENTS - MISC.
CIMZIA STARTER INJ KIT	MSP-PA	4	GASTROINTESTINAL AGENTS - MISC.
CIPRO SUSP	-	3	FLUOROQUINOLONES
CIPRO TAB	-	3	FLUOROQUINOLONES
CIPRO XR TAB	-	3	FLUOROQUINOLONES
CIPRODEX OTIC SUSP	-	2	OTIC AGENTS
CIPROFLOXACIN 100MG TAB	-	3	FLUOROQUINOLONES
ciprofloxacin ER tab (CIPRO XR equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin ophth soln (CILOXAN equiv)	-	1	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	2	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	1	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	1	FLUOROQUINOLONES
citalopram soln (CELEXA equiv)	-	1	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	1	ANTIDEPRESSANTS
CLARIFOAM EF FOAM	-	3	DERMATOLOGICALS
clarithromycin ER tab (BIAXIN XL equiv)	-	1	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	1	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	1	MACROLIDES
CLEOCIN CAP	-	3	ANTI-INFECTIVE AGENTS - MISC.
CLEOCIN SOLN	-	3	ANTI-INFECTIVE AGENTS - MISC.
CLEOCIN VAGINAL CREAM	-	3	VAGINAL PRODUCTS
CLEOCIN-T GEL	-	3	DERMATOLOGICALS
CLEOCIN-T LOTION	-	3	DERMATOLOGICALS
CLEOCIN-T PAD	-	3	DERMATOLOGICALS
CLEOCIN-T SOLN	-	3	DERMATOLOGICALS
CLIMARA PATCH	-	3	ESTROGENS
clindamycin cap (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
clindamycin gel (CLEOCIN GEL equiv)	-	1	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	1	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	1	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	-	1	VAGINAL PRODUCTS
clindamycin/ benzoyl peroxide gel (DUAC GEL equiv)	-	1	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1	DERMATOLOGICALS
CLINISTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
CLINORIL TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
clobetasol foam (OLUX equiv)	PA	1	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv) (QL= 30gm/fill)	PA-QL	1	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	PA	1	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv) (QL= 30gm/fill)	PA-QL	1	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
COPAXONE INJ 20MG/ML	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
COPAXONE INJ 40MG/ML	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CORDARONE TAB	-	3	ANTIARRHYTHMICS
COREG TAB	-	3	BETA BLOCKERS
CORGARD TAB	-	3	BETA BLOCKERS
CORLANOR TAB	PA	3	CARDIOVASCULAR AGENTS - MISC.
CORTANE-B AQUEOUS OTIC SOLN	-	3	OTIC AGENTS
CORTEF TAB	-	1	CORTICOSTEROIDS
CORTENEMA	-	3	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	2	CORTICOSTEROIDS
CORTISPORIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
CORTISPORIN OTIC SOLN	-	3	OTIC AGENTS
COSENTYX INJ (QL= 2 inj/28 days)	MSP-PA-QL	4	DERMATOLOGICALS
COSOPT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
COSOPT PF OPHTH SOLN	-	2	OPHTHALMIC AGENTS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COUMADIN TAB	-	3	ANTICOAGULANTS
COZAAR TAB	-	3	ANTIHYPERTENSIVES
CREON CAP	-	2	DIGESTIVE AIDS
CRESTOR TAB (QL= 1 tab/day)	QL	3	ANTIHYPERTENSIVES
CRESTOR TAB 20MG (QL= 1.5 tabs/day)	QL	3	ANTIHYPERTENSIVES
CRINONE GEL	PA	2	VAGINAL PRODUCTS
CRIXIVAN CAP	-	4	ANTIVIRALS
CROLOM OPHTH SOLN	-	3	OPHTHALMIC AGENTS
cromolyn conc (GASTROCROM equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
cromolyn neb soln (INTAL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
CROMOLYN NEB SOLN	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
cromolyn ophth soln (CROLOM equiv)	-	1	OPHTHALMIC AGENTS
cryselle tab (OGESTREL equiv)	-	\$0	CONTRACEPTIVES
CUTIVATE CREAM	-	3	DERMATOLOGICALS
CUTIVATE OINT	-	3	DERMATOLOGICALS
cyanocobalamin inj	-	1	HEMATOPOIETIC AGENTS
CYCLESSA TAB	-	3	CONTRACEPTIVES
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
CYCLOGYL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
CYCLOMYDRIL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1	OPHTHALMIC AGENTS
CYCLOPHOSPHAMIDE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclosporine cap (SANDIMMUNE equiv)	-	4	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	4	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	4	ASSORTED CLASSES
CYMBALTA CAP (QL= 2 caps/day)	QL	3	ANTIDEPRESSANTS
cyproheptadine syrup	-	1	ANTI-HISTAMINES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ciproheptadine tab	-	1	ANTIHISTAMINES
CYSTAGON CAP (Only available through Pharmicare 800-238-7828)	LD-PA	4	GENITOURINARY AGENTS - MISCELLANEOUS
CYTOMEL TAB	-	3	THYROID AGENTS
CYTOTEC TAB	-	3	ULCER DRUGS
CYTRA-3 SYRUP	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
D.H.E. INJ	-	3	MIGRAINE PRODUCTS
DAKLINZA TAB (QL= 1 tab/day)	MSP-PA-QL	4	ANTIVIRALS
danazol cap (DANOCRINE equiv)	-	1	ANDROGENS-ANABOLIC
DANTRIUM CAP	-	3	MUSCULOSKELETAL THERAPY AGENTS
dantrolene cap (DANTRIUM equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
dapsone tab	-	1	ANTI-INFECTIVE AGENTS - MISC.
DARAPRIM TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTIMALARIALS
DAYPRO TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
DDAVP INJ	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP NASAL SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP NASAL SPRAY	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DECLOMYCIN TAB	-	3	TETRACYCLINES
DELZICOL CAP	-	2	GASTROINTESTINAL AGENTS - MISC.
DEMADEX TAB	-	3	DIURETICS
demeclocycline tab (DECLOMYCIN equiv)	-	1	TETRACYCLINES
DEMEROL TAB	-	3	ANALGESICS - OPIOID
DENAVIR CREAM	-	2	DERMATOLOGICALS
DEPAKENE CAP	-	3	ANTICONVULSANTS
DEPAKENE SYRUP	-	3	ANTICONVULSANTS
DEPAKOTE ER TAB	-	3	ANTICONVULSANTS
DEPAKOTE SPRINKLE CAP	-	3	ANTICONVULSANTS
DEPAKOTE TAB	-	3	ANTICONVULSANTS
DEPEN TITRATAB	-	2	ASSORTED CLASSES
DEPO-PROVERA INJ	QL	3	CONTRACEPTIVES
DEPO-PROVERA INJ (QL = 1 inj/90 day)	QL	3	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
DEPO-TESTOSTERONE INJ	-	3	ANDROGENS-ANABOLIC
DERMA-SMOOTH/FS OIL	-	3	DERMATOLOGICALS
DERMATOP CREAM	-	3	DERMATOLOGICALS
DERMATOP OINT	-	3	DERMATOLOGICALS
DERMOTIC OIL	-	3	OTIC AGENTS
DESCOVY TAB	PA	2	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	1	ANTIDEPRESSANTS
desmopressin acetate inj (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate nasal spray (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin nasal soln (DDAVP equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESOGEN TAB	-	3	CONTRACEPTIVES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
desoximetasone cream 0.25% (TOPICORT CREAM 0.25% equiv) (QL=60gm/fill)	QL	1	DERMATOLOGICALS
DESOXYN TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
DETROL LA CAP	-	3	URINARY ANTISPASMODICS
DETROL TAB	-	3	URINARY ANTISPASMODICS
DEXAMETHASONE CONC	-	1	CORTICOSTEROIDS
dexamethasone elixir	-	1	CORTICOSTEROIDS
dexamethasone ophth soln	-	1	OPHTHALMIC AGENTS
dexamethasone soln	-	1	CORTICOSTEROIDS
DEXAMETHASONE TAB	-	1	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	1	CORTICOSTEROIDS
DEXEDRINE CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
dexmethylphenidate tab (FOCALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
DIALYVITE TAB	-	1	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	1	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	1	MULTIVITAMINS
DIAMOX SEQUEL CAP	-	3	DIURETICS
DIAPHRAGM	-	\$0	MEDICAL DEVICES AND SUPPLIES
DIATZ ZN TAB	-	3	MULTIVITAMINS
diazepam conc (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
DIAZEPAM SOLN	-	1	ANTI-ANXIETY AGENTS
diazepam tab (VALIUM equiv)	-	1	ANTI-ANXIETY AGENTS
DIBENZYLIN CAP	-	3	ANTI-HYPERTENSIVES
diclofenac gel (SOLARAZE equiv)	PA	1	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1	DERMATOLOGICALS
diclofenac potassium tab (CATAFLAM equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1	OPHTHALMIC AGENTS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
dicloxacillin cap (DYNAPEN equiv)	-	1	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	1	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	1	ULCER DRUGS
didanosine DR cap (VIDEX EC equiv)	-	1	ANTIVIRALS
DIFFERIN CREAM	PA	3	DERMATOLOGICALS
DIFFERIN GEL 0.1%	PA	3	DERMATOLOGICALS
DIFFERIN GEL 0.3% (Acne Only – members age 35 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
DIFFERIN LOTION	PA	3	DERMATOLOGICALS
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap)	QL-ST	2	MACROLIDES
diflorasone oint	-	1	DERMATOLOGICALS
DIFLUCAN SUSP	-	3	ANTIFUNGALS
DIFLUCAN TAB	-	3	ANTIFUNGALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
diflunisal tab (DOLOBID equiv)	-	1	ANALGESICS - NONNARCOTIC
digoxin soln (LANOXIN equiv)	-	1	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	1	CARDIOTONICS
dihydroergotamine mesylate inj (D.H.E. equiv)	-	1	MIGRAINE PRODUCTS
DILACOR XR CAP	-	3	CALCIUM CHANNEL BLOCKERS
DILANTIN CAP 100MG	-	3	ANTICONVULSANTS
DILANTIN CAP 30MG	-	2	ANTICONVULSANTS
DILANTIN INFATABS	-	3	ANTICONVULSANTS
DILANTIN SUSP	-	3	ANTICONVULSANTS
DILAUDID TAB	-	3	ANALGESICS - OPIOID
diltiazem ER cap (CARDIZEM CD equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
DIOVAN HCT TAB	-	3	ANTIHYPERTENSIVES
DIOVAN TAB	-	3	ANTIHYPERTENSIVES
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	OTC	1	ANTIHISTAMINES
diphenhydramine inj (BENADRYL equiv)	-	1	ANTIHISTAMINES
diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1	ANTIDIARRHEALS
DIPROLENE AF CREAM	-	3	DERMATOLOGICALS
DIPROLENE LOTION	-	3	DERMATOLOGICALS
DIPROLENE OINT	-	3	DERMATOLOGICALS
dipyridamole tab (PERSANTINE equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	1	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	1	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DITROPAN XL TAB	-	3	URINARY ANTISPASMODICS
DIURIL SUSP	-	2	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	1	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	1	ANTICONVULSANTS
dofetilide cap (TIKOSYN equiv)	-	1	ANTIARRHYTHMICS
DOLOPHINE TAB	-	3	ANALGESICS - OPIOID
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DORYX TAB	-	3	TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	1	OPHTHALMIC AGENTS
dorzolamide/ timolol ophth soln (COSOPT equiv)	-	1	OPHTHALMIC AGENTS
DOVONEX CREAM	-	3	DERMATOLOGICALS
DOVONEX SOLN	-	3	DERMATOLOGICALS
doxazosin tab (CARDURA equiv)	-	1	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS
DOXEPIN CAP 75MG	-	1	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	1	ANTIDEPRESSANTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
doxercalciferol cap (HECTOROL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	1	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	1	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	1	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	1	TETRACYCLINES
DRISDOL CAP	-	3	VITAMINS
dronabinol cap (MARINOL equiv)	-	1	ANTIEMETICS
DROXIA CAP	-	2	HEMATOPOIETIC AGENTS
DRYSOL SOLN	-	1	DERMATOLOGICALS
DUAC GEL	-	3	DERMATOLOGICALS
DUAVEE TAB	-	2	ESTROGENS
DUETACT TAB	-	3	ANTIDIABETICS
DULERA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine EC cap (CYMBALTA equiv) (QL= 2 caps/day)	QL	1	ANTIDEPRESSANTS
DUONEB NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DURAGESIC PATCH (QL= 10 patches/30 days)	QL	3	ANALGESICS - OPIOID
DUREZOL OPHTH EMULSION (QL= 5ml/fill)	QL	2	OPHTHALMIC AGENTS
dutasteride cap (AVODART equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
dutasteride/tamsulosin cap (JALYN equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
DUTOPROL TAB	-	2	ANTIHYPERTENSIVES
DYAZIDE CAP	-	3	DIURETICS
DYNACIN TAB	-	3	TETRACYCLINES
DYRENIUM CAP	-	2	DIURETICS
econazole cream (SPECTAZOLE equiv)	-	1	DERMATOLOGICALS
EDECRIN TAB	-	3	DIURETICS
EDURANT TAB	-	4	ANTIVIRALS
EFFEXOR TAB	-	3	ANTIDEPRESSANTS
EFFEXOR XR CAP	-	3	ANTIDEPRESSANTS
EFFIENT TAB	-	2	HEMATOLOGICAL AGENTS - MISC.
EFUDEX CREAM	-	3	DERMATOLOGICALS
EFUDEX SOLN	-	3	DERMATOLOGICALS
ELDEPYRL CAP	-	3	ANTIPARKINSON AGENTS
ELESTAT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ELIDEL CREAM	-	2	DERMATOLOGICALS
ELIMITE CREAM	-	3	DERMATOLOGICALS
ELIPHOS TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
ELIQUIS TAB	-	2	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
ELOCON CREAM	-	3	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ELOCON OINT	-	3	DERMATOLOGICALS
ELOCON SOLN	-	3	DERMATOLOGICALS
EMCYT CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMEND CAP (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
EMEND PAK (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
EMLA CREAM	-	3	DERMATOLOGICALS
EMTRIVA CAP	-	4	ANTIVIRALS
EMTRIVA SOLN	-	4	ANTIVIRALS
enalapril tab (VASOTEC equiv)	-	1	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1	ANTIHYPERTENSIVES
ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
ENDOMETRIN INSERT	PA	2	VAGINAL PRODUCTS
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	1	ANTICOAGULANTS
enpresse tab (TRI-LEVELEN equiv)	-	\$0	CONTRACEPTIVES
entacapone tab (COMTAN equiv)	-	1	ANTIPARKINSON AGENTS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	PA-QL	4	ANTIVIRALS
ENTOCORT EC CAP	-	3	CORTICOSTEROIDS
ENTRESTO TAB	PA	2	CARDIOVASCULAR AGENTS - MISC.
EPANED SOLN	PA	3	ANTIHYPERTENSIVES
EPIDUO (FORTE) GEL (Acne Only – members age 35 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
EPIFOAM AEROSOL	-	2	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	1	OPHTHALMIC AGENTS
EPIPEN INJ (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIPEN-JR INJ (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIVIR HBV SOLN	PA	4	ANTIVIRALS
eplerenone tab (INSPRA equiv)	-	1	ANTIHYPERTENSIVES
EPOGEN INJ	MSP-PA	4	HEMATOPOIETIC AGENTS
EPZICOM TAB	-	4	ANTIVIRALS
EQUETRO CAP	-	2	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ergoloid mesylates tab (HYDERGINE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOLOID MESYLATES TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOMAR SL TAB	-	3	MIGRAINE PRODUCTS
ERIVEDGE CAP	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERYPED SUSP	-	2	MACROLIDES
ERYPED SUSP 200MG/5ML	-	3	MACROLIDES
ERY-TAB	-	1	MACROLIDES
ERYTHROMYCIN CAP	-	1	MACROLIDES
erythromycin DR cap (ERYC equiv)	-	1	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1	MACROLIDES
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	1	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2	MACROLIDES
erythromycin gel	-	1	DERMATOLOGICALS
erythromycin ophth oint	-	1	OPHTHALMIC AGENTS
erythromycin pad	-	1	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
erythromycin soln	-	1	DERMATOLOGICALS
erythromycin stearate tab	-	1	MACROLIDES
ERYTHROMYCIN TAB (all forms except PCE)	-	3	MACROLIDES
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	1	DERMATOLOGICALS
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
escitalopram soln (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	1	ANTIDEPRESSANTS
estazolam tab (PROSOM equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ESTRACE TAB	-	3	ESTROGENS
ESTRACE VAGINAL CREAM	-	2	VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv)	-	1	ESTROGENS
estradiol patch (VIVELLE-DOT equiv)	-	1	ESTROGENS
estradiol tab (ESTRACE equiv)	-	1	ESTROGENS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1	ESTROGENS
ESTRING (3 copays per Rx)	-	2	VAGINAL PRODUCTS
ESTROPIPATE TAB	-	1	ESTROGENS
estropipate tab (OGEN equiv)	-	1	ESTROGENS
ESTROSTEP FE TAB	-	3	CONTRACEPTIVES
ethacrynic tab (EDECRIN equiv)	-	1	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	1	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	1	ANTICONVULSANTS
etidronate disodium tab 200mg (DIDRONEL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
ETIDRONATE DISODIUM TAB 400MG	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
etodolac cap (LODINE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
etoposide cap (VEPESID equiv)	MSP	4	ANTINEOPLASTICS
EURAX CREAM	-	2	DERMATOLOGICALS
EVISTA TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
EVOTAZ TAB	-	4	ANTIVIRALS
EVOXAC CAP	-	3	MOUTH/THROAT/DENTAL AGENTS
EXELON CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXELON PATCH	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXELON SOLN	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
exemestane tab (AROMASIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXFORGE HCT TAB	-	3	ANTIHYPERTENSIVES
EXFORGE TAB	-	3	ANTIHYPERTENSIVES
EXJADE TAB	MSP	4	ANTIDOTES
EXTAVIA INJ (Step Therapy requires trial of 2: AVONEX, COPAXONE, or PLEGRIDY)	MSP-ST	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FABRAZYME INJ	M	M	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	4	FLUOROQUINOLONES
famciclovir tab (FAMVIR equiv)	-	1	ANTIVIRALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
famotidine susp (PEPCID equiv)	-	1	ULCER DRUGS
famotidine tab (PEPCID equiv)	-	1	ULCER DRUGS
FAMVIR TAB	-	3	ANTIVIRALS
FARESTON TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FARXIGA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
FARYDAK CAP (QL= 6 caps/21 days; Required through Chinese Hospital Pharmacy 415-677-2430 or Diplomat Pharmacy 877-651-4943)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FAZACLO ODT 25MG, 100MG	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
felbamate susp (FELBATOL equiv)	-	1	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	1	ANTICONVULSANTS
FELBATOL SUSP	-	3	ANTICONVULSANTS
FELBATOL TAB	-	2	ANTICONVULSANTS
FELDENE CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
felodipine ER tab (PLENDIL equiv)	-	1	CALCIUM CHANNEL BLOCKERS
FEMALE CONDOMS	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FEMARA TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FEMCON FE CHEW TAB	-	3	CONTRACEPTIVES
FEMHRT TAB	-	3	ESTROGENS
fenofibrate cap (ANTARA equiv)	-	1	ANTIHYPERTENSIVES
fenofibrate tab (TRICOR equiv)	-	1	ANTIHYPERTENSIVES
FENOGLIDE/TRICOR TAB	-	3	ANTIHYPERTENSIVES
fenoprofen calcium tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	1	ANALGESICS - OPIOID
fentanyl patch (DURAGESIC equiv) (QL= 10 patches/30 days)	QL	1	ANALGESICS - OPIOID
FENTORA TAB (QL= 120 tabs/30 days)	PA-QL	2	ANALGESICS - OPIOID
ferrex 150 forte cap	-	1	HEMATOPOIETIC AGENTS
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4	ANTIDOTES
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4	ANTIDOTES
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FETZIMA CAP (QL= 1 cap/day)	PA-QL	3	ANTIDEPRESSANTS
FETZIMA TITRATION PACK (QL= 1 cap/day)	PA-QL	3	ANTIDEPRESSANTS
FEXMID TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
FINACEA FOAM	-	2	DERMATOLOGICALS
FINACEA GEL	-	2	DERMATOLOGICALS
FINACEA PLUS KIT	-	2	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
FLAGYL CAP	-	3	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
flecainide tab (TAMBOCOR equiv)	-	1	ANTIARRHYTHMICS
FLEXERIL TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
FLOMAX CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
FLOVENT DISKUS INHALER	-	1	ASTHMA AND BRONCHODILATOR AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
FLOVENT HFA INHALER	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ	VAC	\$0	VACCINES
FLUBLOK INJ	VAC	\$0	VACCINES
FLUCELVAX INJ	VAC	\$0	VACCINES
FLUCELVAX QUAD INJ	VAC	\$0	VACCINES
fluconazole susp (DIFLUCAN equiv)	-	1	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	1	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	1	ANTIFUNGALS
fludarabine inj	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fludrocortisone tab (FLORINEF equiv)	-	1	CORTICOSTEROIDS
FLUMADINE TAB	-	3	ANTIVIRALS
flunisolide nasal spray (NASAREL equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	1	DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1	DERMATOLOGICALS
fluocinolone acetonide oint	-	1	DERMATOLOGICALS
fluocinolone acetonide soln	-	1	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	1	OTIC AGENTS
fluocinonide cream (LIDEX equiv)	-	1	DERMATOLOGICALS
fluocinonide emollient cream (QL= 30gm/fill)	QL	1	DERMATOLOGICALS
fluocinonide gel	-	1	DERMATOLOGICALS
fluocinonide oint	-	1	DERMATOLOGICALS
fluocinonide soln	-	1	DERMATOLOGICALS
FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
FLUOR-A-DAY CHEW TAB	-	1	MINERALS & ELECTROLYTES
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1	OPHTHALMIC AGENTS
FLUROPLEX CREAM	-	2	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	1	DERMATOLOGICALS
fluorouracil soln (EFUDEX SOLN equiv)	-	1	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine soln (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	1	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FLURAZEPAM CAP	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
flurbiprofen ophth soln (OCUFEN equiv)	-	1	OPHTHALMIC AGENTS
flurbiprofen tab (ANSAID equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	1	DERMATOLOGICALS
fluvastatin cap (LESCOL equiv)	-	1	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	PA	1	ANTIHYPERLIPIDEMICS
FLUVIRIN INJ	VAC	\$0	VACCINES
FLUVIRIN PF INJ	VAC	\$0	VACCINES
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine)	ST	1	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	1	ANTIDEPRESSANTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
FLUZONE HIGH DOSE PF INJ	VAC	\$0	VACCINES
FLUZONE INTRADERMAL	VAC	\$0	VACCINES
FLUZONE QUADRIVALENT INJ	VAC	\$0	VACCINES
FLUZONE/FLUARIX QUAD INJ	VAC	\$0	VACCINES
FLUZONE/FLULAVAL QUAD INJ	VAC	\$0	VACCINES
FML LIQUIFLIM OPHTH SUSP	-	3	OPHTHALMIC AGENTS
FOCALIN TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
FOLBEE PLUS CZ TAB	-	1	MULTIVITAMINS
folbee tab	-	1	HEMATOPOIETIC AGENTS
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
FOLLISTIM AQ INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
fondaparinux inj (ARIXTRA equiv)	PA	1	ANTICOAGULANTS
FORADIL AEROLIZER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTAMET TAB (Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv))	ST	3	ANTIDIABETICS
FORTEO INJ	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORTICAL NASAL SPRAY	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX TAB	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosinopril tab (MONOPRIL equiv)	-	1	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1	ANTIHYPERTENSIVES
FOSRENOL CHEW TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
FOSRENOL POWDER PACK	-	2	GASTROINTESTINAL AGENTS - MISC.
FREESTYLE FREEDOM LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULIN SYRINGE	OTC	2	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
FURADANTIN SUSP	-	2	URINARY ANTI-INFECTIVES
FUROSEMIDE SOLN	-	1	DIURETICS
furosemide soln (LASIX equiv)	-	1	DIURETICS
furosemide tab (LASIX equiv)	-	1	DIURETICS
FUZEON INJ	SP	4	ANTIVIRALS
gabapentin cap (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv)	-	1	ANTICONVULSANTS
gabapentin tab (NEURONTIN equiv)	-	1	ANTICONVULSANTS
GABITRIL TAB	-	3	ANTICONVULSANTS
GABITRIL TAB 12MG, 16MG	-	2	ANTICONVULSANTS
galantamine ER cap (RAZADYNE ER equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
GALZIN CAP	-	2	MINERALS & ELECTROLYTES
GANCICLOVIR CAP	-	2	ANTIVIRALS
GANIRELIX AC INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
GASTROCROM CONC	-	2	GASTROINTESTINAL AGENTS - MISC.
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	1	OPHTHALMIC AGENTS
gemfibrozil tab (LOPID equiv)	-	1	ANTIHYPERTENSIVES
gentamicin ophth oint (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	1	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	1	DERMATOLOGICALS
gentamicin sulfate oint	-	1	DERMATOLOGICALS
GENVOYA TAB	-	4	ANTIVIRALS
GEODON CAP	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
GILENYA CAP (QL= 1 cap/day)	MSP-PA-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GLEEVEC TAB ()	MSP-PA-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GLEOSTINE/LOMUSTINE CAP	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	1	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	1	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	1	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	1	ANTIDIABETICS
GLUCAGEN HYPOKIT INJ	-	2	ANTIDIABETICS
GLUCAGEN INJ	-	2	DIAGNOSTIC PRODUCTS
GLUCAGON INJ KIT	-	2	ANTIDIABETICS
GLUCOPHAGE TAB	-	3	ANTIDIABETICS
GLUCOPHAGE XR TAB	-	3	ANTIDIABETICS
GLUCOTROL TAB	-	3	ANTIDIABETICS
GLUCOTROL XL TAB	-	3	ANTIDIABETICS
GLUCOVANCE TAB	-	3	ANTIDIABETICS
glyburide micronized tab (GLYNASE equiv)	-	1	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	1	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	1	ANTIDIABETICS
glycopyrrolate tab (ROBINUL equiv)	-	1	ULCER DRUGS
GLYNASE TAB	-	3	ANTIDIABETICS
GONAL-F RFF INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
GORDON'S UREA OINT 40%	-	2	DERMATOLOGICALS
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	1	ANTIEMETICS
GRIFULVIN V TAB	-	3	ANTIFUNGALS
griseofulvin micro tab (GRIFULVIN V equiv)	-	1	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	1	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	1	ANTIFUNGALS
GRIS-PEG TAB	-	3	ANTIFUNGALS
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1	COUGH/COLD/ALLERGY
guanfacine ER tab (INTUNIV equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
guanfacine IR tab (TENEX equiv)	-	1	ANTIHYPERTENSIVES
GUANIDINE TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
HALCION TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
halobetasol propionate cream (ULTRAVATE equiv) (QL= 50gm/fill)	PA-QL	1	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv) (QL= 50gm/fill)	PA-QL	1	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HARVONI TAB (QL= 1 tab/day)	MSP-PA-QL	4	ANTIVIRALS
HECTOROL CAP	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
HEXALEN CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HIPREX TAB	-	3	URINARY ANTI-INFECTIVES
HIZENTRA INJ	PA-SP	3	PASSIVE IMMUNIZING AGENTS
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1	OPHTHALMIC AGENTS
HUMIRA INJ (QL= 2 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX PEN INJ	OTC	2	ANTIDIABETICS
HUMULIN N PEN INJ	OTC	2	ANTIDIABETICS
HUMULIN R INJ U-500	-	2	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ	-	2	ANTIDIABETICS
HUMULIN VIAL	-	3	ANTIDIABETICS
HYCANTIN CAP	MSP-PA	4	ANTINEOPLASTICS
HYCET SOLN	-	3	ANALGESICS - OPIOID
HYCODAN SYRUP	-	3	COUGH/COLD/ALLERGY
hydralazine tab (APRESOLINE equiv)	-	1	ANTIHYPERTENSIVES
HYDREA CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydrochlorothiazide cap (MICROZIDE equiv)	-	1	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1	DIURETICS
hydrocodone/acetaminophen cap (LORCET equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET/LORTAB equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	1	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	1	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1	ANALGESICS - OPIOID
hydrocortisone cream (PROCTOCORT equiv)	-	1	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	1	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	1	DERMATOLOGICALS
hydrocortisone oint	-	1	DERMATOLOGICALS
hydrocortisone tab (CORTEF equiv)	-	1	CORTICOSTEROIDS
HYDROMORPHONE SUPP	-	1	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	1	ANALGESICS - OPIOID
hydroxychloroquine tab (PLAQUENIL equiv)	-	1	ANTIMALARIALS
hydroxyurea cap (HYDREA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyzine pamoate cap (VISTARIL equiv)	-	1	ANTI-ANXIETY AGENTS
HYDROXYZINE PAMOATE CAP 100MG	-	1	ANTI-ANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	1	ANTI-ANXIETY AGENTS
hyoscyamine sulfate CR tab (LEVIBID equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1	ULCER DRUGS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	1	ULCER DRUGS
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	1	ULCER DRUGS
HYPER-SAL NEB SOLN	-	3	COUGH/COLD/ALLERGY
HYSINGLA ER TAB (QL= 1 tab/day)	QL	2	ANALGESICS - OPIOID
HYTONE LOTION	-	3	DERMATOLOGICALS
HYTRIN CAP	-	3	ANTIHYPERTENSIVES
HYZAAR TAB	-	3	ANTIHYPERTENSIVES
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ibuprofen susp (Rx ONLY) (ADVIL/MOTRIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	1	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab (Rx covered Only)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ILEVRO OPHTH SUSP (QL= 3ml/fill)	QL	2	OPHTHALMIC AGENTS
IMBRUVICA CAP (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMDUR TAB	-	3	ANTIANGINAL AGENTS
imipramine pamoate cap (TOFRANIL PM equiv)	-	1	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	1	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	1	DERMATOLOGICALS
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMITREX TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMITREX VIAL INJ (QL= 5 inj/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
IMURAN TAB	-	3	ASSORTED CLASSES
INCIVEK TAB	MSP-PA-SF	4	ANTIVIRALS
INCRELEX INJ	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	1	DIURETICS
INDERAL LA CAP	-	3	BETA BLOCKERS
INDOCIN SUPP	-	2	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
INFERGEN INJ	MSP	4	ANTIVIRALS
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INNOPRAN XL CAP	-	1	BETA BLOCKERS
INSPIRA TAB	-	3	ANTIHYPERTENSIVES
INSULIN SYRINGE	OTC	2	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	4	ANTIVIRALS
INTRON-A INJ	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INVIRASE CAP	-	4	ANTIVIRALS
INVIRASE TAB	-	4	ANTIVIRALS
IOPIDINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
IOPIDINE OPHTH SOLN 1%	-	2	OPHTHALMIC AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
ipratropium neb soln (ATROVENT equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	1	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1	ANTIHYPERTENSIVES
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	1	HEMATOPOIETIC AGENTS
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ISENTRESS CHEW TAB	-	2	ANTIVIRALS
ISENTRESS POWDER PACK	-	2	ANTIVIRALS
ISENTRESS TAB	-	2	ANTIVIRALS
ISONIAZID SYRUP	-	1	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	1	ANTIMYCOBACTERIAL AGENTS
ISOPTO ATROPINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISOPTO CARPINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2	OPHTHALMIC AGENTS
ISOPTO HOMATROPINE OPHTH SOLN 5%	-	2	OPHTHALMIC AGENTS
ISOPTO HYOSCINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ISORDIL TITRADOSE TAB	-	3	ANTIANGINAL AGENTS
ISOSORBIDE DINITRATE ER TAB	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate SL tab	-	1	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	1	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	1	ANTIANGINAL AGENTS
isotretinoin cap (AC CUTANE equiv)	-	1	DERMATOLOGICALS
isradipine cap (DYNACIRC equiv)	-	1	CALCIUM CHANNEL BLOCKERS
itraconazole cap (SPORANOX equiv)	PA	1	ANTIFUNGALS
ivermectin tab (STROMECTOL equiv)	-	1	ANTHELMINTICS
JADENU TAB	MSP	4	ANTIDOTES
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JALYN CAP	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
JANUMET TAB	-	2	ANTIDIABETICS
JANUMET XR TAB	-	2	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
JENTADUETO TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	1	ESTROGENS
jolessa tab/ amethia tab (SEASONALE/SEASONIQUE equiv) (3 copays per Rx)	-	\$0	CONTRACEPTIVES
junel FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
KADIAN CAP	-	3	ANALGESICS - OPIOID
KALETRA SOLN	-	4	ANTIVIRALS
KALETRA TAB	-	4	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
KALYDECO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
KAYEXALATE POWDER	-	3	ASSORTED CLASSES
KAZANO/ALOGLIPTIN-METFORMIN TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2	ANTIDIABETICS
KEFLEX CAP	-	3	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KEPPRA SOLN	-	3	ANTICONVULSANTS
KEPPRA TAB	-	3	ANTICONVULSANTS
KEPPRA XR TAB	-	3	ANTICONVULSANTS
KERLONE TAB	-	3	BETA BLOCKERS
ketoconazole cream (NIZORAL CREAM equiv)	-	1	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	1	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	1	DIAGNOSTIC PRODUCTS
ketoprofen cap (ORUDIS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln (ACULAR (LS) equiv)	-	1	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1	ANALGESICS - ANTI-INFLAMMATORY
KETOSTIX	OTC	1	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (QL= 10ml/30 days)	OTC-QL	\$0	OPHTHALMIC AGENTS
KINERET INJ (Only available through Rx Crossroads: 1-866-547-0644)	LD-PA	4	ANALGESICS - ANTI-INFLAMMATORY
KITABIS PAK NEB SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4	AMINOGLYCOSIDES
KLARON LOTION	-	3	DERMATOLOGICALS
KLONOPIN TAB	-	3	ANTICONVULSANTS
KLOR-CON M15 TAB	-	2	MINERALS & ELECTROLYTES
KLOR-CON POWDER PACKET	-	3	MINERALS & ELECTROLYTES
KLOR-CON TAB	-	3	MINERALS & ELECTROLYTES
KOMBIGLYZE XR TAB	-	2	ANTIDIABETICS
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	4	ANTIDIABETICS
K-PHOS NEUTRAL TAB	-	3	MINERALS & ELECTROLYTES
K-PHOS TAB	-	2	MINERALS & ELECTROLYTES
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
labetalol tab (NORMODYNE equiv)	-	1	BETA BLOCKERS
LAC-HYDRIN CREAM	-	3	DERMATOLOGICALS
LAC-HYDRIN LOTION	-	3	DERMATOLOGICALS
LACRISERT OPTH INSERT	-	2	OPHTHALMIC AGENTS
lactulose soln	-	1	GASTROINTESTINAL AGENTS - MISC.
LAMICTAL CHEW TAB	-	3	ANTICONVULSANTS
LAMICTAL CHEW TAB 2MG	-	2	ANTICONVULSANTS
LAMICTAL ODT	-	3	ANTICONVULSANTS
LAMICTAL TAB	-	3	ANTICONVULSANTS
LAMICTAL XR TAB	-	3	ANTICONVULSANTS
LAMISIL TAB	-	3	ANTIFUNGALS
lamivudine soln (EPIVIR equiv)	PA	1	ANTIVIRALS
lamivudine tab (EPIVIR equiv)	PA	1	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	PA	1	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	1	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	1	ANTICONVULSANTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
lamotrigine ODT (LAMICTAL equiv)	-	1	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	1	ANTICONVULSANTS
LANCET DEVICE	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCET KIT	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	1	MEDICAL DEVICES AND SUPPLIES
LANOXIN TAB	-	3	CARDIOTONICS
lansoprazole cap (PREVACID equiv) (Rx Only)	-	1	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1	ULCER DRUGS
LANTUS INJ	-	2	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	2	ANTIDIABETICS
LARIAM TAB	-	3	ANTIMALARIALS
LASIX TAB	-	3	DIURETICS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1	OPHTHALMIC AGENTS
leflunomide tab (ARAVA equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LESCOL CAP	-	3	ANTIHYPERTENSIVES
LESCOL XL TAB	PA	3	ANTIHYPERTENSIVES
LETAIRIS TAB (QL= 1 tab/day)	PA-QL-SP	4	CARDIOVASCULAR AGENTS - MISC.
letrozole tab (FEMARA equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKERAN TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	MSP	4	HEMATOPOIETIC AGENTS
leuprolide inj (LUPRON equiv)	INF	50%	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
levalbuterol neb soln (XOPENEX equiv)	-	1	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
LEVAQUIN SOLN	-	3	FLUOROQUINOLONES
LEVAQUIN TAB	-	3	FLUOROQUINOLONES
LEVBID TAB	-	3	ULCER DRUGS
LEVEMIR FLEXPEN/FLEXTOUCH INJ	-	2	ANTIDIABETICS
LEVEMIR INJ	-	2	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	1	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	1	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	1	ANTICONVULSANTS
levobunolol ophth soln (BETAGAN equiv)	-	1	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
levofloxacin ophth soln (QUIXIN equiv)	-	1	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	1	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
LEVONORGESTREL TAB 0.75MG	-	\$0	CONTRACEPTIVES
LEVORPHANOL TAB	-	2	ANALGESICS - OPIOID
LEVSIN SOLN	-	3	ULCER DRUGS
LEVSIN TAB	-	3	ULCER DRUGS
LEVSIN/SL TAB	-	3	ULCER DRUGS
LEVSINEX CAP	-	3	ULCER DRUGS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
LEXAPRO SOLN	-	3	ANTIDEPRESSANTS
LEXAPRO TAB	-	3	ANTIDEPRESSANTS
LEXIVA SUSP	-	4	ANTIVIRALS
LEXIVA TAB	-	4	ANTIVIRALS
LIALDA TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
LIBRIUM CAP	-	3	ANTIANKXIETY AGENTS
lidocaine cream 3% (LIDAMANTLE equiv)	-	1	DERMATOLOGICALS
lidocaine cream 5% (QL= 50gm/30 days)	OTC-QL	\$0	ANORECTAL AGENTS
lidocaine gel (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine oint (QL= 50gm/30 days; Step Therapy requires trial of lidocaine cream 5%)	QL-ST	1	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	2	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch (LIDODERM equiv) (QL= 1 patch/day)	PA-QL	1	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	1	DERMATOLOGICALS
lidocaine viscous soln	-	1	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	1	DERMATOLOGICALS
LIDODERM PATCH (QL= 1 patch/day)	PA-QL	3	DERMATOLOGICALS
LIMBITROL TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
lindane lotion	-	1	DERMATOLOGICALS
LINDANE LOTION	-	3	DERMATOLOGICALS
lindane shampoo	-	1	DERMATOLOGICALS
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP (QL= 1 cap/day)	PA-QL	2	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	1	THYROID AGENTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1	ANTIHYPERTENSIVES
lithium carbonate cap (ESKALITH ER equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate tab	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium citrate soln	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOBID TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LO LOESTRIN TAB	-	\$0	CONTRACEPTIVES
LODOSYN TAB	-	3	ANTIPARKINSON AGENTS
LOESTRIN FE TAB	-	3	CONTRACEPTIVES
LOESTRIN TAB	-	3	CONTRACEPTIVES
LOMOTIL LIQUID	-	3	ANTIDIARRHEALS
LOMOTIL TAB	-	3	ANTIDIARRHEALS
LONSURF TAB	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LOPID TAB	-	3	ANTIHYPERTENSIVES
LOPRESSOR HCT TAB	-	3	ANTIHYPERTENSIVES
LOPRESSOR TAB	-	3	BETA BLOCKERS
LOPROX CREAM	-	3	DERMATOLOGICALS
LOPROX GEL	-	3	DERMATOLOGICALS
LOPROX SHAMPOO	-	3	DERMATOLOGICALS
lorazepam conc (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	1	ANTIANKXIETY AGENTS
LORTAB	-	3	ANALGESICS - OPIOID
losartan tab (COZAAR equiv)	-	1	ANTIHYPERTENSIVES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1	ANTIHYPERTENSIVES
LOTEMAX OPHTH GEL	-	2	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	2	OPHTHALMIC AGENTS
LOTENSIN HCT TAB	-	3	ANTIHYPERTENSIVES
LOTENSIN TAB	-	3	ANTIHYPERTENSIVES
LOTREL CAP	-	3	ANTIHYPERTENSIVES
LOTRISONE CREAM	-	3	DERMATOLOGICALS
LOTRISONE LOTION	-	3	DERMATOLOGICALS
lovastatin tab (MEVACOR equiv)	-	1	ANTIHYPERTENSIVES
LOVAZA CAP	-	3	ANTIHYPERTENSIVES
loxapine cap (LOXITANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LOXITANE CAP	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LTA 360 KIT	-	3	MOUTH/THROAT/DENTAL AGENTS
LUMIGAN OPHTH SOLN (QL= 5ml/30 days)	QL	2	OPHTHALMIC AGENTS
LUPRON DEPOT INJ	INF	50%	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUPRON DEPOT PED INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
LURIDE SOLN (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
LURIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
LUVERIS INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUVOX CR CAP (Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine)	ST	3	ANTIDEPRESSANTS
LYNPARZA CAP (Only available through Biologics 800-850-4306)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	-	2	ANTICONVULSANTS
LYRICA SOLN	-	2	ANTICONVULSANTS
LYSODREN TAB	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYSTEDA TAB	-	2	HEMOSTATICS
MACROBID CAP	-	3	URINARY ANTI-INFECTIVES
MACRODANTIN CAP	-	3	URINARY ANTI-INFECTIVES
magnesium sulfate inj	M	M	MINERALS & ELECTROLYTES
MALARONE TAB	-	2	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	1	DERMATOLOGICALS
maldemar tab (SCOPACE equiv)	-	1	ANTIEMETICS
MAPROTILINE TAB	-	1	ANTIDEPRESSANTS
MARINOL CAP	-	3	ANTIEMETICS
MARPLAN TAB	-	2	ANTIDEPRESSANTS
MATULANE CAP	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MAVIK TAB	-	3	ANTIHYPERTENSIVES
MAXALT MLT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3	MIGRAINE PRODUCTS
MAXALT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3	MIGRAINE PRODUCTS
MAXIDEX OPHTH SOLN	-	2	OPHTHALMIC AGENTS
MAXITROL OPHTH OINT	-	3	OPHTHALMIC AGENTS
MAXITROL OPHTH SUSP	-	3	OPHTHALMIC AGENTS
MAXZIDE TAB	-	3	DIURETICS
mebendazole chew tab (VERMOX equiv)	-	1	ANTHELMINTICS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
meclizine tab (ANTIVERT equiv) (Rx Only)	-	1	ANTIEMETICS
MECLOFENAMATE CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
MEDROL DOSE PACK	-	3	CORTICOSTEROIDS
MEDROL TAB	-	1	CORTICOSTEROIDS
MEDROL TAB	-	3	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	1	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
mefloquine tab (LARIAM equiv)	-	1	ANTIMALARIALS
MEGACE SUSP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol susp (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam tab (MOBIC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
melphalan inj (ALKERAN equiv)	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
memantine sol (NAMENDA equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab (NAMENDA equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
meperidine tab (DEMEROL equiv)	-	1	ANALGESICS - OPIOID
MEPHYTON TAB	-	2	VITAMINS
meprobamate tab (MILTOWN equiv)	-	1	ANTI-ANXIETY AGENTS
MEPRON SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
mercaptopurine tab (PURINETHOL equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mesalamine enema (ROWASA equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESTINON TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
MESTINON TIMESPAN TAB	-	3	ANTIMYASTHENIC/CHOLINERGIC AGENTS
METADATE CD CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
METAGLIP TAB	-	3	ANTIDIABETICS
METAPROTERENOL SYRUP	-	1	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
metaxalone tab (SKELAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
METAXALONE TAB 400MG	-	3	MUSCULOSKELETAL THERAPY AGENTS
metformin ER osmotic tab (FORTAMET equiv) (Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv))	ST	1	ANTIDIABETICS
metformin ER (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	1	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	1	ANTIDIABETICS
METHADONE SOLN	-	1	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv)	-	1	ANALGESICS - OPIOID
METHADOSE CONC	-	3	ANALGESICS - OPIOID
methadose tab	-	1	ANALGESICS - OPIOID
methamphetamine tab (DESOXYN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	1	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	1	URINARY ANTI-INFECTIVES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
methenamine mandelate tab	-	1	URINARY ANTI-INFECTIVES
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	2	OXYTOCICS
methimazole tab (TAPAZOLE equiv)	-	1	THYROID AGENTS
METHITEST TAB	-	3	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
METHOTREXATE INJ	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methoxsalen cap (OXSORALEN ULTRA equiv)	-	1	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	1	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	1	DIURETICS
methyl dopa tab (ALDOMET equiv)	-	1	ANTIHYPERTENSIVES
methyl dopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	1	OXYTOCICS
METHYLIN SOLN	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylphenidate CD cap (METADATE CD equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
METHYLPHENIDATE ER TAB	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylphenidate ER tab 10mg, 20mg	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylphenidate tab (RITALIN equiv)	-	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	1	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	1	CORTICOSTEROIDS
methyltestosterone cap (ANDROID/TESTRED equiv)	-	1	ANDROGENS-ANABOLIC
METIPRANOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
metoclopramide soln (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	1	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	1	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	1	BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1	ANTIHYPERTENSIVES
METROCREAM	-	3	DERMATOLOGICALS
METROGEL 1% (Step Therapy requires trial of FINACEA)	ST	3	DERMATOLOGICALS
METROGEL VAGINAL GEL	-	3	VAGINAL PRODUCTS
METROLOTION	-	3	DERMATOLOGICALS
metronidazole cap (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	1	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	1	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	1	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	1	VAGINAL PRODUCTS
MEVACOR TAB	-	3	ANTIHYPERLIPIDEMICS
mexiletine cap (MEXITIL equiv)	-	1	ANTIARRHYTHMICS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
MIACALCIN INJ	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIACALCIN NASAL SPRAY	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
MICRO-K CAP	-	3	MINERALS & ELECTROLYTES
MICROZIDE CAP	-	3	DIURETICS
MIDAMOR TAB	-	3	DIURETICS
midodrine tab (PROAMATINE equiv)	-	1	VASOPRESSORS
MIGERGOT SUPP	-	2	MIGRAINE PRODUCTS
MINIPRESS CAP	-	3	ANTIHYPERTENSIVES
MINOCIN CAP	-	3	TETRACYCLINES
minocycline cap (MINOCIN equiv)	-	1	TETRACYCLINES
minocycline tab (DYNACIN equiv)	-	1	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	1	ANTIHYPERTENSIVES
MIRAPEX TAB	-	3	ANTIPARKINSON AGENTS
MIRCETTE TAB	-	3	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	1	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	1	ANTIDEPRESSANTS
misoprostol tab (CYTOTEC equiv)	-	1	ULCER DRUGS
MITIGARE CAP	-	2	GOUT AGENTS
MOBIC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
moexipril tab (UNIVASC equiv)	-	1	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1	ANTIHYPERTENSIVES
mometasone cream (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone oint (ELOCON equiv)	-	1	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	1	DERMATOLOGICALS
MONODOX CAP	-	3	TETRACYCLINES
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
MONOPRIL HCT TAB	-	3	ANTIHYPERTENSIVES
MONOPRIL TAB	-	3	ANTIHYPERTENSIVES
montelukast chew tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
morphine sulfate ER cap (KADIAN equiv)	-	1	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv)	-	1	ANALGESICS - OPIOID
morphine sulfate soln	-	1	ANALGESICS - OPIOID
morphine sulfate supp	-	1	ANALGESICS - OPIOID
morphine sulfate tab	-	1	ANALGESICS - OPIOID
MOTRIN SUSP	-	3	ANALGESICS - ANTI-INFLAMMATORY
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2	LAXATIVES
MOXEZA OPHTH SOLN	-	2	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	1	FLUOROQUINOLONES
MS CONTIN TAB	-	3	ANALGESICS - OPIOID
MULTAQ TAB	-	2	ANTIARRHYTHMICS
multigen folic tab (CHROMAGEN FA equiv)	-	1	HEMATOPOIETIC AGENTS
multigen plus tab (CHROMAGEN FORTE equiv)	-	1	HEMATOPOIETIC AGENTS
multigen tab (CHROMAGEN equiv)	-	1	HEMATOPOIETIC AGENTS
multivitamin tab	-	1	HEMATOPOIETIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
MULTIVITAMIN TAB	-	3	HEMATOPOIETIC AGENTS
multivitamin w/ minerals tab (STROVITE equiv)	-	1	MULTIVITAMINS
mupirocin cream (BACTROBAN equiv)	-	1	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	1	DERMATOLOGICALS
MYAMBUTOL TAB	-	3	ANTIMYCOBACTERIAL AGENTS
MYCELEX TROCHES	-	3	MOUTH/THROAT/DENTAL AGENTS
MYCOBUTIN CAP	-	3	ANTIMYCOBACTERIAL AGENTS
mycophenolate DR tab (MYFORTIC equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	4	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	4	ASSORTED CLASSES
MYDFRIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
MYDRIACYL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
MYLERAN TAB	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYSOLINE TAB	-	3	ANTICONVULSANTS
nabumetone tab (RELAFEN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	1	BETA BLOCKERS
NAFTIFINE CREAM 1%	-	3	DERMATOLOGICALS
naftifine cream 2% (NAFTIN equiv)	-	1	DERMATOLOGICALS
NAFTIN CREAM	-	3	DERMATOLOGICALS
NAFTIN GEL	-	3	DERMATOLOGICALS
nalbuphine inj	M	M	ANALGESICS - OPIOID
naloxone inj	-	1	ANTIDOTES
naltrexone tab (REVIA equiv)	-	1	ANTIDOTES
NAMENDA SOL	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA XR CAP	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
naphazoline ophth soln	-	1	OPHTHALMIC AGENTS
NAPROSYN EC TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN SUSP	-	3	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
naproxen EC tab (NAPROSYN EC equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naproxen susp (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
NARDIL TAB	-	2	ANTIDEPRESSANTS
NASONEX NASAL SPRAY (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
nateglinide tab (STARLIX equiv)	-	1	ANTIDIABETICS
NATPARA INJ (QL= 1 inj/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
NATURE THROID/ARMOUR THYROID TAB	-	1	THYROID AGENTS
NAVANE CAP	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
NEBUPENT NEB SOLN	-	2	ANTI-INFECTIVE AGENTS - MISC.
NEBUSAL NEB SOLN	-	2	COUGH/COLD/ALLERGY
necon tab (ORTHO-NOVUM equiv)	-	\$0	CONTRACEPTIVES
necon tab 1/50 (NORYNIL equiv)	-	\$0	CONTRACEPTIVES
NEFAZODONE TAB	-	1	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	1	ANTIDEPRESSANTS
neomycin tab	-	1	AMINOGLYCOSIDES
neomycin/ polymyxin b/ gramicidin ophth soln (NEOSPORIN equiv)	-	1	OPHTHALMIC AGENTS
neomycin/ polymyxin/ dexamethasone ophth oint (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/ polymyxin/ dexamethasone ophth soln (MAXITROL equiv)	-	1	OPHTHALMIC AGENTS
neomycin/ polymyxin/ hydrocortisone ophth soln (CORTISPORIN equiv)	-	1	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1	OTIC AGENTS
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1	OTIC AGENTS
NEOSPORIN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
NEPHROCAP	-	3	MULTIVITAMINS
NEPHRON FA TAB	-	2	HEMATOPOIETIC AGENTS
NEPHRO-VITE TAB	-	3	MULTIVITAMINS
NEPTAZANE TAB	-	3	DIURETICS
NESINA/ALOGLIPTIN TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2	ANTIDIABETICS
NEULASTA INJ	MSP	4	HEMATOPOIETIC AGENTS
NEUMEGA INJ	MSP	4	HEMATOPOIETIC AGENTS
NEURONTIN CAP	-	3	ANTICONVULSANTS
NEURONTIN SOLN	-	3	ANTICONVULSANTS
NEURONTIN TAB	-	3	ANTICONVULSANTS
NEVANAC OPHTH SUSP	-	2	OPHTHALMIC AGENTS
nevirapine ER tab (VIRAMUNE XR equiv)	-	1	ANTIVIRALS
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	1	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	1	ANTIVIRALS
NEXAVAR TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NIACOR TAB	-	1	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	1	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NICODERM PATCH (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	1	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	1	CALCIUM CHANNEL BLOCKERS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
nilutamide tab (NILANDRON equiv) (Required through Chinese Hospital Pharmacy 415-677-2430 or Diplomat Pharmacy 877-651-4943)	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NIMOTOP CAP	-	3	CALCIUM CHANNEL BLOCKERS
NINLARO CAP	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NIRAVAM ODT	-	3	ANTIANGIETY AGENTS
nisoldipine ER tab (SULAR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 25.5MG	-	1	CALCIUM CHANNEL BLOCKERS
NITRO-DUR PATCH	-	3	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1	URINARY ANTI-INFECTIVES
nitrofurantoin susp (FURADANTIN equiv)	-	1	URINARY ANTI-INFECTIVES
nitroglycerin patch (NITRO-DUR equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	1	ANTIANGINAL AGENTS
nitroglycerin SR cap	-	1	ANTIANGINAL AGENTS
NITROSTAT SL TAB	-	3	ANTIANGINAL AGENTS
nizatidine cap (AXID equiv)	-	1	ULCER DRUGS
nizatidine soln (AXID equiv)	-	1	ULCER DRUGS
NIZORAL SHAMPOO	-	3	DERMATOLOGICALS
NORDITROPIN INJ	MSP-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	1	PROGESTINS
NORPACE CAP	-	3	ANTIARRHYTHMICS
NORPACE CR CAP	-	2	ANTIARRHYTHMICS
NORPRAMIN TAB	-	3	ANTIDEPRESSANTS
NOR-QD TAB	-	3	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	\$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	1	ANTIDEPRESSANTS
NORTRIPTYLINE SOLN	-	1	ANTIDEPRESSANTS
NORVASC TAB	-	3	CALCIUM CHANNEL BLOCKERS
NORVIR CAP	-	2	ANTIVIRALS
NORVIR SOLN	-	2	ANTIVIRALS
NORVIR TAB	-	2	ANTIVIRALS
NOVOFINE PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
NOVOLIN INJ	OTC	1	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG INJ	-	2	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	2	ANTIDIABETICS
NOVOLOG MIX INJ	-	2	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	2	ANTIDIABETICS
NOVOTWIST PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
NOXAFIL SUSP	-	2	ANTIFUNGALS
np thyroid tab (NATURE THROID/ARMOUR THYROID equiv)	-	1	THYROID AGENTS
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	2	ANALGESICS - OPIOID
NUDEXTA CAP (QL= 2 caps/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NUVARING	-	\$0	CONTRACEPTIVES
nystatin cream (MYCOSTATIN CREAM equiv)	-	1	DERMATOLOGICALS
nystatin oint	-	1	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
nystatin powder	-	1	ANTIFUNGALS
nystatin susp	-	1	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	1	ANTIFUNGALS
nystatin topical powder	-	1	DERMATOLOGICALS
NYSTATIN VAGINAL TAB	-	1	VAGINAL PRODUCTS
nystatin/triamcinolone cream	-	1	DERMATOLOGICALS
nystatin/triamcinolone oint	-	1	DERMATOLOGICALS
octreotide inj (SANDOSTATIN equiv)	MSP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCUFEN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
OCUFLOX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ODEFSEY TAB	-	4	ANTIVIRALS
ODOMZO CAP (QL= 1 cap/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	1	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	1	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	1	FLUOROQUINOLONES
olanzapine ODT (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine/ fluoxetine cap (SYMBYAX equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
olopatadine nasal spray (PATANASE equiv)	-	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
OLUX FOAM	PA	3	DERMATOLOGICALS
omedia otic soln (AMERICAINE equiv)	-	1	OTIC AGENTS
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	1	ULCER DRUGS
OMNICEF SUSP	-	3	CEPHALOSPORINS
ondansetron ODT (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	1	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	1	ANTIEMETICS
ONFI TAB	PA	2	ANTICONVULSANTS
ONGLYZA TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
opium tincture	-	1	ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
OPTIVAR OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ORACIT SOLN	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
ORAP TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ORAPRED ODT	-	2	CORTICOSTEROIDS
ORAPRED ODT	-	3	CORTICOSTEROIDS
ORAPRED SOLN	-	3	CORTICOSTEROIDS
ORFADIN CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4	RESPIRATORY AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
orphenadrine/ aspirin/ caffeine tab (NORGESIC FORTE equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ORTHO TRI-CYCLEN (LO) TAB	-	3	CONTRACEPTIVES
ORTHO-CYCLEN TAB	-	3	CONTRACEPTIVES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ORTHO-EVRA PATCH	-	3	CONTRACEPTIVES
OSENI/ALOGLIPTIN-PIOGLITAZONE TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2	ANTIDIABETICS
OSMOPREP TAB	-	3	LAXATIVES
OVACE PLUS SHAMPOO	-	3	DERMATOLOGICALS
OVACE WASH	-	3	DERMATOLOGICALS
OVCON 35 TAB	-	3	CONTRACEPTIVES
OVIDE LOTION (QL= 2 bottles/fill)	QL	3	DERMATOLOGICALS
OVIDREL INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
OXANDRIN TAB	-	3	ANDROGENS-ANABOLIC
oxandrolone tab (OXANDRIN equiv)	-	1	ANDROGENS-ANABOLIC
oxaprozin tab (DAYPRO equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	1	ANTI-ANXIETY AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	1	ANTICONVULSANTS
oxiconazole nitrate cream (OXISTAT equiv)	-	1	DERMATOLOGICALS
OXISTAT CREAM	-	3	DERMATOLOGICALS
OXISTAT LOTION	-	3	DERMATOLOGICALS
OXSORALEN ULTRA CAP	-	3	DERMATOLOGICALS
oxybutynin ER tab (DITROPAN XL equiv)	-	1	URINARY ANTISPASMODICS
oxybutynin syrup	-	1	URINARY ANTISPASMODICS
oxybutynin tab (DITROPAN equiv)	-	1	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	1	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv)	-	1	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	1	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1	ANALGESICS - OPIOID
oxycodone/aspirin tab (PERCODAN equiv)	-	1	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1	ANALGESICS - OPIOID
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2	ANALGESICS - OPIOID
OXYIR CAP	-	2	ANALGESICS - OPIOID
PALGIC SOLN	-	3	ANTIHISTAMINES
PALGIC TAB	-	3	ANTIHISTAMINES
PAMELOR CAP	-	3	ANTIDEPRESSANTS
PAMINE TAB	-	3	ULCER DRUGS
PANCREAZE CAP	-	2	DIGESTIVE AIDS
pantoprazole EC tab (PROTONIX equiv)	-	1	ULCER DRUGS
PARAFON FORTE TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
PARCOPA ODT	-	3	ANTIPARKINSON AGENTS
paricalcitol cap (ZEMPLAR equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
PARLODEL CAP	-	3	ANTIPARKINSON AGENTS
PARLODEL TAB	-	3	ANTIPARKINSON AGENTS
PARNATE TAB	-	3	ANTIDEPRESSANTS
paromomycin cap (HUMATIN equiv)	-	1	AMINOGLYCOSIDES
paroxetine ER tab (PAXIL CR equiv)	-	1	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	1	ANTIDEPRESSANTS
PATADAY OPHTH SOLN (QL= 2.5ml/30 days; Step Therapy requires trial of ketotifen ophth soln)	QL-ST	2	OPHTHALMIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
PATANASE NASAL SPRAY	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
PAXIL CR TAB	-	3	ANTIDEPRESSANTS
PAXIL TAB	-	3	ANTIDEPRESSANTS
PEAK FLOW METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
pediatric multiple vitamins/fluoride chew tab	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	1	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	1	MULTIVITAMINS
PEDIAZOLE SUSP	-	3	ANTI-INFECTIVE AGENTS - MISC.
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
PEGANONE TAB	-	2	ANTICONVULSANTS
PEGASYS INJ	MSP-PA	4	ANTIVIRALS
PEGASYS INJ KIT	MSP-PA	4	ANTIVIRALS
PEG-INTRON INJ	MSP-PA	4	ANTIVIRALS
PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
penicillin vk soln (VEETIDS equiv)	-	1	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	1	PENICILLINS
pentazocine/acetaminophen tab (TALACEN equiv)	-	1	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv)	-	1	ANALGESICS - OPIOID
pentoxifylline ER tab (TRENTAL equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
PEPCID SUSP	-	2	ULCER DRUGS
PEPCID TAB	-	3	ULCER DRUGS
PERCOCET TAB	-	3	ANALGESICS - OPIOID
PERCODAN TAB	-	3	ANALGESICS - OPIOID
PERIDEX SOLN	-	3	MOUTH/THROAT/DENTAL AGENTS
perindopril tab (ACEON equiv)	-	1	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	1	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PERSANTINE TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
phenazopyridine tab (PYRIDIUM equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
phenelzine tab (NARDIL equiv)	-	1	ANTIDEPRESSANTS
phenobarbital elixir	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
PHENOBARBITAL TAB	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	-	1	ANTIHYPERTENSIVES
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	1	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
phenylephrine ophth soln (MYDFRIN equiv)	-	1	OPHTHALMIC AGENTS
phenylephrine/chlorpheniramine DM tab (ZOTEX equiv)	-	1	COUGH/COLD/ALLERGY
phenytoin cap (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	1	ANTICONVULSANTS
phenytoin susp (DILANTIN equiv)	-	1	ANTICONVULSANTS
PHOSLO CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
PHOSLYRA SOLN	-	2	GASTROINTESTINAL AGENTS - MISC.
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1	MINERALS & ELECTROLYTES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
PHOSPHOLINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
pimozide tab	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	1	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	1	ANTIDIABETICS
pioglitazone/glimepiride tab (DUETACT equiv)	-	1	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	1	ANTIDIABETICS
piroxicam cap (FELDENE equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
PLAQUENIL TAB	-	3	ANTIMALARIALS
PLAVIX TAB 75MG	-	3	HEMATOLOGICAL AGENTS - MISC.
PLEGRIDY INJ	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLENDIL TAB	-	3	CALCIUM CHANNEL BLOCKERS
PLETAL TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
PLEXION LOTION	-	3	DERMATOLOGICALS
PLEXION SCT CREAM	-	3	DERMATOLOGICALS
PODOCON SOLN	-	2	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	1	DERMATOLOGICALS
POLY HIST DM LIQUID	-	3	COUGH/COLD/ALLERGY
POLYCITRA CRYSTAL PACK	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
POLYCITRA-LC SOLN	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
POLYETHYLENE GLYCOL 8000 GRANULES	-	2	PHARMACEUTICAL ADJUVANTS
polymyxin b/ trimethoprim ophth soln (POLYTRIM equiv)	-	1	OPHTHALMIC AGENTS
POLYTRIM OPHTH SOLN	-	3	OPHTHALMIC AGENTS
PONSTEL CAP	-	3	ANALGESICS - ANTI-INFLAMMATORY
POTABA POWDER PACKET	-	2	VITAMINS
POTABA TAB	-	2	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	1	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE ER TAB	-	1	MINERALS & ELECTROLYTES
potassium chloride ER tab (KLOR-CON equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	1	MINERALS & ELECTROLYTES
potassium chloride soln	-	1	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROCIT-K TAB equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
POTIGA TAB (QL= 3 tabs/day)	QL	2	ANTICONSULSANTS
POTIGA TAB 50MG (QL= 9 tabs/day)	QL	2	ANTICONSULSANTS
PRADAXA CAP (QL= 2 caps/day)	QL	2	ANTICOAGULANTS
pramipexole ER tab (MIRAPEX ER equiv)	-	1	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	1	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1%	-	2	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
PRAMOSONE OINT	-	2	DERMATOLOGICALS
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1	ANORECTAL AGENTS
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	1	OTIC AGENTS
PRANDIN TAB	-	3	ANTIDIABETICS
PRASCION RA CREAM	-	2	DERMATOLOGICALS
PRAVACHOL TAB	-	3	ANTIHYPERTENSIVES
pravastatin tab (PRAVACHOL equiv)	-	1	ANTIHYPERTENSIVES
prazosin cap (MINIPRESS equiv)	-	1	ANTIHYPERTENSIVES
PRECISION INSULIN SYRINGE	OTC	2	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
PRECOSE TAB	-	3	ANTIDIABETICS
PRED FORTE OPHTH SUSP	-	3	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
PRED-G OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednicarbate cream (DERMATOP equiv)	-	1	DERMATOLOGICALS
prednicarbate oint (DERMATOP equiv)	-	1	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	1	CORTICOSTEROIDS
prednisolone ophth soln (PRED FORTE equiv)	-	1	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednisolone soln (PEDIAPRED equiv)	-	1	CORTICOSTEROIDS
prednisolone syrup (PRELONE equiv)	-	1	CORTICOSTEROIDS
PREDNISON PAK	-	2	CORTICOSTEROIDS
PREDNISON SOLN	-	1	CORTICOSTEROIDS
PREDNISON TAB	-	1	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	1	CORTICOSTEROIDS
pregnyl inj (PROFASI equiv)	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
PRELONE SYRUP	-	3	CORTICOSTEROIDS
PREMARIN TAB	-	2	ESTROGENS
PREMARIN VAGINAL CREAM	-	2	VAGINAL PRODUCTS
PREMPHASE/PREMPRO TAB	-	2	ESTROGENS
PRENATAL VITAMINS (NON-PREFERRED)	-	3	MULTIVITAMINS
PRENATAL VITAMINS (PRENATAL PLUS/ PREPLUS/PRENAPLUS)	-	1	VITAMINS
PREVACID SOLUTAB	-	2	ULCER DRUGS
PREVIDENT CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT GEL	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT PASTE	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT RINSE	-	2	MOUTH/THROAT/DENTAL AGENTS
PREVPAC KIT	-	3	ULCER DRUGS
PREZCOBIX TAB	-	4	ANTIVIRALS
PREZISTA SUSP	-	4	ANTIVIRALS
PREZISTA TAB	-	4	ANTIVIRALS
PRIFTIN TAB	-	2	ANTIMYCOBACTERIAL AGENTS
PRIMAQUINE TAB	-	2	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	1	ANTICONVULSANTS
PRINIVIL TAB/ ZESTRIL TAB	-	3	ANTIHYPERTENSIVES
PROAMATINE TAB	-	3	VASOPRESSORS
probenecid tab (BENEMID equiv)	-	1	GOUT AGENTS
PROCARDIA CAP	-	3	CALCIUM CHANNEL BLOCKERS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
PROCENTRA SOLN	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
prochlorperazine supp (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROCRIT INJ	MSP-PA	4	HEMATOPOIETIC AGENTS
PROCTOCORT CREAM	-	3	DERMATOLOGICALS
PROCTOFOAM HC FOAM	-	2	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	1	ANORECTAL AGENTS
progesterone cap (PROMETRIUM equiv)	-	1	PROGESTINS
progesterone oil inj	INF	50%	PROGESTINS
PROLENSA OPHTH SOLN (QL= 3ml/fill)	QL	2	OPHTHALMIC AGENTS
PROLEUKIN INJ	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PROMACTA TAB	MSP-PA	4	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	1	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	1	ANTIHISTAMINES
promethazine syrup	-	1	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	1	ANTIHISTAMINES
promethazine VC syrup (PHENERGAN VC equiv)	-	1	COUGH/COLD/ALLERGY
promethazine VC w/codeine syrup (PHENERGAN VC W/CODIENE equiv)	-	1	COUGH/COLD/ALLERGY
promethazine w/codeine syrup (PHENERGAN W/CODIENE equiv)	-	1	COUGH/COLD/ALLERGY
PROMETRIUM CAP	-	3	PROGESTINS
propafenone ER cap (RYTHMOL SR equiv)	-	1	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	1	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	2	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	1	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	1	BETA BLOCKERS
PROPRANOLOL SOLN	-	1	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	1	BETA BLOCKERS
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1	ANTIHYPERTENSIVES
propylthiouracil tab	-	1	THYROID AGENTS
PROSCAR TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
PROSOM TAB	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
PROSTIGMIN TAB	-	2	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PROTOPIC OINT	-	3	DERMATOLOGICALS
protriptyline tab (VIVACTIL equiv)	-	1	ANTIDEPRESSANTS
PROVERA TAB	-	3	PROGESTINS
PROVIGIL TAB (QL= 2 tabs/day)	PA-QL	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS
PROZAC CAP	-	3	ANTIDEPRESSANTS
PROZAC SOLN	-	3	ANTIDEPRESSANTS
PROZAC TAB	-	3	ANTIDEPRESSANTS
pseudoephedrine/brompheniramine/codeine liquid (CPB WC equiv)	OTC	1	COUGH/COLD/ALLERGY
PULMICORT INH SUSP	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	MSP	4	RESPIRATORY AGENTS - MISC.
PURINETHOL TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pyrazinamide tab	-	1	ANTIMYCOBACTERIAL AGENTS
PYRIDIUM TAB	-	3	GENITOURINARY AGENTS - MISCELLANEOUS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
pyridostigmine CR tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	1	ANTIMYASTHENIC/CHOLINERGIC AGENTS
QUESTRAN LITE POWDER	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN LITE POWDER PACK	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN POWDER	-	3	ANTIHYPERLIPIDEMICS
QUESTRAN POWDER PACK	-	3	ANTIHYPERLIPIDEMICS
quetiapine tab (SEROQUEL equiv)	-	1	ANTI PSYCHOTICS/ANTIMANIC AGENTS
QUFLORA PEDIATRIC CHEW TAB	-	3	MULTIVITAMINS
QUFLORA PEDIATRIC DROP	-	3	MULTIVITAMINS
quinapril tab (ACCUPRIL equiv)	-	1	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	1	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB	-	1	ANTIARRHYTHMICS
rabeprazole EC tab (ACIPHEX equiv)	-	1	ULCER DRUGS
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramipril cap (ALTACE equiv)	-	1	ANTIHYPERTENSIVES
RANEXA TAB	-	2	ANTIANGINAL AGENTS
ranitidine cap (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine syrup (ZANTAC equiv)	-	1	ULCER DRUGS
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1	ULCER DRUGS
RAPAMUNE SOLN	-	4	ASSORTED CLASSES
RAZADYNE ER CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RAZADYNE SOLN	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RAZADYNE TAB	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBETOL SOLN	MSP	4	ANTIVIRALS
REGLAN TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
REGRANEX GEL (QL= 30gm/fill)	QL	2	DERMATOLOGICALS
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2	ANTIVIRALS
RELISTOR INJ	MSP-PA	4	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	MSP-PA	4	GASTROINTESTINAL AGENTS - MISC.
REMERON SOLUTAB	-	3	ANTIDEPRESSANTS
REMERON TAB	-	3	ANTIDEPRESSANTS
renaphro cap (NEPHROCAP equiv)	-	1	MULTIVITAMINS
RENVELA PACKET	-	2	GASTROINTESTINAL AGENTS - MISC.
RENVELA TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
repaglinide tab (PRANDIN equiv)	-	1	ANTIDIABETICS
REPRONEX INJ	INF	50%	ENDOCRINE AND METABOLIC AGENTS - MISC.
REQUIP TAB	-	3	ANTIPARKINSON AGENTS
REQUIP XL TAB	-	3	ANTIPARKINSON AGENTS
RESCRIPTOR TAB	-	4	ANTIVIRALS
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2	OPHTHALMIC AGENTS
RESTORIL CAP 15MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
RESTORIL CAP 22.5MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
RESTORIL CAP 30MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
RESTORIL CAP 7.5MG	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
RETIN-A CREAM	PA	3	DERMATOLOGICALS
RETIN-A GEL	PA	3	DERMATOLOGICALS
RETIN-A MICRO GEL 0.04%, 0.1% (Acne Only – members age 35 or older require Prior Authorization)	PA	2	DERMATOLOGICALS
REVIA TAB	-	3	ANTIDOTES
REVLIMID CAP (QL= 1 cap/day; Not available through Chinese Hospital Pharmacy-use Diplomat)	MSP-PA-QL	3	ASSORTED CLASSES
REYATAZ CAP	-	4	ANTIVIRALS
REYATAZ POWDER PACK	-	4	ANTIVIRALS
ribavirin cap (REBETOL equiv)	MSP	1	ANTIVIRALS
ribavirin tab (COPEGUS equiv)	MSP	1	ANTIVIRALS
RIDAURA CAP	-	2	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RIFADIN CAP	-	3	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	2	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	1	ANTIMYCOBACTERIAL AGENTS
RILUTEK TAB	-	3	NEUROMUSCULAR AGENTS
riluzole tab (RILUTEK equiv)	-	1	NEUROMUSCULAR AGENTS
rimantadine tab (FLUMADINE equiv)	-	1	ANTIVIRALS
risedronate tab (ACTONEL equiv)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERDAL M ODT	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RISPERDAL SOLN	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RISPERDAL TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
RITALIN LA CAP	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
RITALIN SR TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
RITALIN TAB	-	3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
RITUXAN INJ	M	M	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rivastigmine cap (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1	MIGRAINE PRODUCTS
ROBAXIN TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ROBINUL TAB	-	3	ULCER DRUGS
ROCALtrol CAP	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ROCALtrol SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ropinirole ER tab (REQUIP XL equiv)	-	1	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	1	ANTIPARKINSON AGENTS
ROSULA EMULSION	-	3	DERMATOLOGICALS
ROSULA GEL	-	3	DERMATOLOGICALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ROSULA PAD	-	3	DERMATOLOGICALS
rosuvastatin tab (CRESTOR equiv) (QL= 1 tab/day)	QL	1	ANTIHYPERLIPIDEMICS
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1	ANTIHYPERLIPIDEMICS
ROXICET SOLN	-	3	ANALGESICS - OPIOID
ROXICODONE TAB	-	3	ANALGESICS - OPIOID
ROZEREM TAB (QL= 1 tab/day)	PA-QL	2	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
RYDEX	OTC	3	COUGH/COLD/ALLERGY
RYTARY CAP (Step Therapy requires trial of carbidopa/levodopa ER)	ST	3	ANTIPARKINSON AGENTS
RYTHMOL SR CAP	-	3	ANTIARRHYTHMICS
RYTHMOL TAB	-	3	ANTIARRHYTHMICS
SABRIL POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTICONVULSANTS
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	4	ANTICONVULSANTS
SALAGEN TAB	-	3	MOUTH/THROAT/DENTAL AGENTS
SALEX SHAMPOO	-	3	DERMATOLOGICALS
salicylic acid shampoo (SALEX equiv)	-	1	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	1	ANALGESICS - NONNARCOTIC
SANCTURA TAB	-	3	URINARY ANTISPASMODICS
SANCTURA XR CAP	-	3	URINARY ANTISPASMODICS
SANDIMMUNE SOLN 100MG/ML	-	4	ASSORTED CLASSES
SANTYL OINT	-	2	DERMATOLOGICALS
SAVELLA PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SEASONIQUE TAB	-	3	CONTRACEPTIVES
seb-prev cream (OVACE CREAM equiv)	-	1	DERMATOLOGICALS
SECONAL CAP	-	2	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
SECTRAL CAP	-	3	BETA BLOCKERS
selegiline cap (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	1	ANTIPARKINSON AGENTS
selenium sulfide lotion	-	1	DERMATOLOGICALS
SELZENTRY TAB	-	4	ANTIVIRALS
SENSIPAR TAB	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEREVENT DISKUS INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SEROQUEL TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SEROQUEL XR TAB	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
sertraline conc (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	1	ANTIDEPRESSANTS
SEVELAMER CARBONATE TAB	-	2	GASTROINTESTINAL AGENTS - MISC.
SHOHL'S SOLN	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
sildenafil tab (REVATIO equiv)	PA	1	CARDIOVASCULAR AGENTS - MISC.
SILVADENE CREAM	-	3	DERMATOLOGICALS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	2	OPHTHALMIC AGENTS
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1	ANTIHYPERLIPIDEMICS
SINEMET CR TAB	-	3	ANTIPARKINSON AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
SINEMET TAB	-	3	ANTIPARKINSON AGENTS
SINGULAIR CHEW TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR GRANULE PACK	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sirolimus tab (RAPAMUNE equiv)	-	4	ASSORTED CLASSES
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2	ANTI-INFECTIVE AGENTS - MISC.
SKELAXIN TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM/SEPTRA equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
sodium chloride 0.9% irr soln	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium chloride inj	M	M	MINERALS & ELECTROLYTES
sodium chloride neb soln (HYPER-SAL equiv)	-	1	COUGH/COLD/ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
sodium phenylbutyrate powder (BUPHENYL equiv)	PA-SP	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	1	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	1	ASSORTED CLASSES
sodium sulfacetamide lotion (KLARON equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/ urea pad (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	1	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	1	DERMATOLOGICALS
SOLARAZE GEL	PA	3	DERMATOLOGICALS
SOLARCAINE EXTRA GEL	-	3	DERMATOLOGICALS
SOMA TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
SONATA CAP	-	3	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
SORIATANE CAP	-	3	DERMATOLOGICALS
SORIATANE CK KIT	-	2	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	1	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	1	BETA BLOCKERS
SOVALDI TAB (QL= 1 tab/day)	MSP-PA-QL	4	ANTIVIRALS
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2	DERMATOLOGICALS
SPIRIVA HANDIHALER (For use with Handihaler device)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (Step Therapy requires trial of inhaled corticosteroid)	ST	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	1	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1	DIURETICS
SPORANOX CAP	PA	3	ANTIFUNGALS
SPRYCEL TAB	MSP-PA-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SSKI SOLN	-	2	MINERALS & ELECTROLYTES
STARLIX TAB	-	3	ANTIDIABETICS
stavudine cap (ZERIT equiv)	-	1	ANTIVIRALS
stavudine soln (ZERIT equiv)	-	1	ANTIVIRALS
STIMATE NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
STIOLTO INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRATTERA CAP (Step Therapy requires trial of 2 formulary stimulants)	ST	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIBILD TAB ()	-	2	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	PA-QL	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STROMECTOL TAB	-	3	ANTHELMINTICS
STROVITE TAB	-	3	MULTIVITAMINS
SUBOXONE SL FILM	-	2	ANALGESICS - OPIOID
SUBOXONE SL TAB	-	3	ANALGESICS - OPIOID
sucralfate tab (CARAFATE equiv)	-	1	ULCER DRUGS
SULAR TAB	-	3	CALCIUM CHANNEL BLOCKERS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1	OPHTHALMIC AGENTS
sulfacetamide sodium/ prednisolone ophth soln (VASOCIDIN equiv)	-	1	OPHTHALMIC AGENTS
SULFADIAZINE TAB	-	1	SULFONAMIDES
SULFAMYLON CREAM	-	2	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan nasal spray (SUMATRIPTAN/IMITREX equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
SUMAXIN PAD	-	3	DERMATOLOGICALS
SUMAXIN TS SUSP	-	3	DERMATOLOGICALS
SUMAXIN WASH	-	3	DERMATOLOGICALS
SUPRAX SUSP	-	3	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	3	CEPHALOSPORINS
SUPRAX TAB	-	3	CEPHALOSPORINS
SURMONTIL CAP	-	3	ANTIDEPRESSANTS
SUSTIVA CAP	-	4	ANTIVIRALS
SUSTIVA TAB	-	4	ANTIVIRALS
SUTENT CAP	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUTTAR SF SYRUP	-	3	COUGH/COLD/ALLERGY
SYMBYAX CAP	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SYNAREL NASAL SOLN	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNJARDY TAB (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
SYNTHROID TAB	-	1	THYROID AGENTS
TABLOID TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX OINT	-	3	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	4	ASSORTED CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	1	DERMATOLOGICALS
TAFINLAR CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAGAMET TAB	-	3	ULCER DRUGS
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAMBOCOR TAB	-	3	ANTIARRHYTHMICS
TAMIFLU CAP (QL= 10 caps/fill)	QL	2	ANTIVIRALS
TAMIFLU CAP 30MG (QL= 20 caps/fill)	QL	2	ANTIVIRALS
TAMIFLU SUSP 6MG/ML (QL= 250ml/fill)	QL	2	ANTIVIRALS
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
TAPAZOLE TAB	-	3	THYROID AGENTS
TARCEVA TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	SP	4	DERMATOLOGICALS
TARKA TAB	-	3	ANTIHYPERTENSIVES
TASIGNA CAP	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TECFIDERA CAP	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	MSP	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEGRETOL CHEW TAB	-	3	ANTICONVULSANTS
TEGRETOL SUSP	-	3	ANTICONVULSANTS
TEGRETOL TAB	-	3	ANTICONVULSANTS
TEGRETOL XR TAB	-	3	ANTICONVULSANTS
telmisartan/amlodipine tab (TWINSTA equiv)	-	1	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
temazepam cap 22.5mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
TEMOVATE CREAM (QL= 30gm/fill)	PA-QL	3	DERMATOLOGICALS
TEMOVATE GEL	PA	3	DERMATOLOGICALS
TEMOVATE OINT (QL= 30gm/fill)	PA-QL	3	DERMATOLOGICALS
TEMOVATE SOLN	PA	3	DERMATOLOGICALS
TEMOVATE-E CREAM	PA	3	DERMATOLOGICALS
temozolomide cap (TEMODAR equiv)	MSP	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TENEX TAB	-	3	ANTIHYPERTENSIVES
TENORETIC TAB	-	3	ANTIHYPERTENSIVES
TENORMIN TAB	-	3	BETA BLOCKERS
TERAZOL CREAM	-	3	VAGINAL PRODUCTS
TERAZOL SUPP	-	3	VAGINAL PRODUCTS
terazosin cap (HYTRIN equiv)	-	1	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	1	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	1	VAGINAL PRODUCTS
TESSALON CAP	-	3	COUGH/COLD/ALLERGY
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2	ANDROGENS-ANABOLIC
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2	ANDROGENS-ANABOLIC
tetrabenazine tab (XENAZINE equiv)	MSP-PA	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	1	TETRACYCLINES
TETRACYCLINE CAP	-	3	TETRACYCLINES
TEVETEN TAB	-	3	ANTIHYPERTENSIVES
THALOMID CAP	MSP-PA	4	ASSORTED CLASSES
theophylline CR tab (QUIBRON-T equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
thioridazine tab (MELLARIL equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
THYROLAR TAB	-	2	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	1	ANTICONVULSANTS
TIAZAC CAP	-	3	CALCIUM CHANNEL BLOCKERS
TICLOPIDINE TAB	-	1	HEMATOLOGICAL AGENTS - MISC.
ticlopidine tab (TICLID equiv)	-	1	HEMATOLOGICAL AGENTS - MISC.
TIGAN CAP	-	3	ANTIEMETICS
TIKOSYN CAP	-	3	ANTIARRHYTHMICS
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1	OPHTHALMIC AGENTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln (TIMOPTIC equiv)	-	1	OPHTHALMIC AGENTS
timolol maleate tab (BLOCADREN equiv)	-	1	BETA BLOCKERS
TIMOPTIC OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TIMOPTIC-XE OPHTH GEL	-	3	OPHTHALMIC AGENTS
TINDAMAX TAB	-	3	ANTI-INFECTIVE AGENTS - MISC.
tinidazole tab (TINDAMAX equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
TIVICAY TAB (QL= 2 tabs/day)	QL	2	ANTIVIRALS
tizanidine cap (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	1	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	2	OPHTHALMIC AGENTS
TOBRADEX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX equiv)	-	1	OPHTHALMIC AGENTS
tobramycin/ dexamethasone ophth soln (TOBRADEX equiv)	-	1	OPHTHALMIC AGENTS
TOBREX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	\$0	VAGINAL PRODUCTS
TOFRANIL PM CAP	-	3	ANTIDEPRESSANTS
TOFRANIL TAB	-	3	ANTIDEPRESSANTS
tolazamide tab (TOLINASE equiv)	-	1	ANTIDIABETICS
TOLBUTAMIDE TAB	-	1	ANTIDIABETICS
TOLMETIN CAP	-	1	ANALGESICS - ANTI-INFLAMMATORY
tolmetin cap (TOLECTIN DS equiv)	-	1	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
tolterodine SR cap (DETROL LA equiv)	-	1	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	1	URINARY ANTISPASMODICS
TOPAMAX SPRINKLE CAP	-	3	ANTICONVULSANTS
TOPAMAX TAB	-	3	ANTICONVULSANTS
TOPICORT CREAM 0.25% (QL= 60gm/fill)	QL	3	DERMATOLOGICALS
TOPICORT/DESOXIMETASONE CREAM 0.05% (QL= 60gm/fill)	QL	2	DERMATOLOGICALS
topiramate sprinkle cap (TOPAMAX equiv)	-	1	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	1	ANTICONVULSANTS
TOPROL XL TAB	-	3	BETA BLOCKERS
toremide tab (DEMADEX equiv)	-	1	DIURETICS
TOUJEO SOLOSTAR INJ	-	2	ANTIDIABETICS
TOVIAZ TAB	-	2	URINARY ANTISPASMODICS
TRACLEER TAB (QL= 2 tabs/day)	PA-QL-SP	4	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2	ANTIDIABETICS
tramadol ER tab (ULTRAM ER equiv)	-	1	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	1	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	1	ANALGESICS - OPIOID
TRANDATE TAB	-	3	BETA BLOCKERS
trandolapril tab (MAVIK equiv)	-	1	ANTIHYPERTENSIVES
trandolapril/verapamil ER tab (TARKA equiv)	-	1	ANTIHYPERTENSIVES
tranexamic acid inj (CYKLOKAPRON equiv)	M	M	HEMOSTATICS
tranexamic acid tab (LYSTEDA equiv)	-	1	HEMOSTATICS
TRANSDERM-SCOP PATCH	-	3	ANTIEMETICS
TRANXENE-T TAB	-	3	ANTI-ANXIETY AGENTS
tranylcypromine tab (PARNATE equiv)	-	1	ANTIDEPRESSANTS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
TRAVATAN Z OPHTH SOLN (QL= 5ml/30 days)	QL	2	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	1	ANTIDEPRESSANTS
TRECTOR TAB	-	3	ANTIMYCOBACTERIAL AGENTS
TRELSTAR INJ	INF	50%	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRENTAL TAB	-	3	HEMATOLOGICAL AGENTS - MISC.
TRESIBA INJ	-	2	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	MSP	4	ANTINEOPLASTICS
tretinoin cream (Acne Only – members age 35 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1	DERMATOLOGICALS
TREXALL TAB	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
triamcinolone cream	-	1	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1	MOUTH/THROAT/DENTAL AGENTS
triamcinolone lotion	-	1	DERMATOLOGICALS
triamcinolone nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	QL	1	NASAL AGENTS - SYSTEMIC AND TOPICAL
triamcinolone oint	-	1	DERMATOLOGICALS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1	DIURETICS
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1	DIURETICS
TRIAZOLAM TAB	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
triazolam tab (HALCION equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
tricitrates soln (POLYCITRA-LC equiv)	-	1	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	1	HEMATOPOIETIC AGENTS
trifluoperazine tab (STELAZINE equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
trifluridine ophth soln (VIROPTIC equiv)	-	1	OPHTHALMIC AGENTS
trihexyphenidyl elixir (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	1	ANTIPARKINSON AGENTS
tri-legest tab (ESTROSTEP FE equiv)	-	\$0	CONTRACEPTIVES
TRILEPTAL SUSP	-	2	ANTICONSULSANTS
TRILEPTAL TAB	-	3	ANTICONSULSANTS
TRILIPIX CAP	-	1	ANTIHYPERLIPIDEMICS
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	1	ANTIEMETICS
trimethoprim tab (PROLOPRIM equiv)	-	1	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	1	ANTIDEPRESSANTS
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRI-NORINYL TAB	-	3	CONTRACEPTIVES
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	3	ANTIDEPRESSANTS
TRIUMEQ TAB	-	4	ANTIVIRALS
tropicamide ophth soln (MYDRIACYL equiv)	-	1	OPHTHALMIC AGENTS
tropium chloride SR cap (SANCTURA XR equiv)	-	1	URINARY ANTISPASMODICS
tropium tab (SANCTURA equiv)	-	1	URINARY ANTISPASMODICS
TRULICITY INJ (QL= 4 inj/28 days)	QL	2	ANTIDIABETICS
TRUSOPT OPHTH SOLN	-	3	OPHTHALMIC AGENTS
TRUVADA TAB	PA	2	ANTIVIRALS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
tussigon tab (HYCODAN equiv)	-	1	COUGH/COLD/ALLERGY
TUSSIONEX SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	3	COUGH/COLD/ALLERGY
TWYNSTA TAB	-	3	ANTIHYPERTENSIVES
TYKERB TAB	MSP-PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYLENOL/CODEINE TAB	-	3	ANALGESICS - OPIOID
TYSABRI INJ	M	M	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TYVASO INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	4	CARDIOVASCULAR AGENTS - MISC.
TYZEKA TAB	MSP-PA	4	ANTIVIRALS
TYZINE NASAL SOLN	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
UCERIS RECTAL FOAM	PA	3	ANORECTAL AGENTS
U-CORT CREAM	-	2	DERMATOLOGICALS
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST	2	GOUT AGENTS
ULTRACET TAB	-	3	ANALGESICS - OPIOID
ULTRAM ER TAB	-	3	ANALGESICS - OPIOID
ULTRAM TAB	-	3	ANALGESICS - OPIOID
ULTRAVATE CREAM (QL= 50gm/fill)	PA-QL	3	DERMATOLOGICALS
ULTRAVATE LOTION (QL= 60ml/fill)	PA-QL	3	DERMATOLOGICALS
ULTRAVATE OINT (QL= 50gm/fill)	PA-QL	3	DERMATOLOGICALS
UNIPHYL TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UNIRETIC TAB	-	3	ANTIHYPERTENSIVES
UNIVASC TAB	-	3	ANTIHYPERTENSIVES
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4	CARDIOVASCULAR AGENTS - MISC.
URECHOLINE TAB	-	3	URINARY ANTISPASMODICS
UROXATRAL TAB	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
URSO FORTE TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
ursodiol cap (ACTIGALL equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	1	GASTROINTESTINAL AGENTS - MISC.
valacyclovir tab (VALTREX equiv)	-	1	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	4	DERMATOLOGICALS
VALCYTE SOLN	-	3	ANTIVIRALS
VALCYTE TAB	-	3	ANTIVIRALS
valganciclovir soln (VALCYTE equiv)	-	1	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	1	ANTIVIRALS
VALIUM TAB	-	3	ANTIANSXIETY AGENTS
valproic acid cap (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	1	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	1	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1	ANTIHYPERTENSIVES
VALTREX TAB	-	3	ANTIVIRALS
VANCOGIN CAP (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	3	ANTI-INFECTIVE AGENTS - MISC.
vancomycin cap (VANCOGIN equiv) (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	1	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN KIT	-	1	ANTI-INFECTIVE AGENTS - MISC.
VANOS CREAM	-	3	DERMATOLOGICALS
VANTIN TAB	-	3	CEPHALOSPORINS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2	ANTIEMETICS
VASERETIC TAB	-	3	ANTIHYPERTENSIVES
VASOTEC TAB	-	3	ANTIHYPERTENSIVES
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0	VAGINAL PRODUCTS
VECTICAL OINT	-	2	DERMATOLOGICALS
venlafaxine ER cap (EFFEXOR XR equiv)	-	1	ANTIDEPRESSANTS
venlafaxine ER tab	-	1	ANTIDEPRESSANTS
VENLAFAXINE ER TAB	-	2	ANTIDEPRESSANTS
VENLAFAXINE ER TAB 225MG	-	1	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	1	ANTIDEPRESSANTS
VENTAVIS INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	4	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VERAMYST NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
verapamil SR cap (VERELAN PM equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR/ISOPTIN SR equiv)	-	1	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	1	CALCIUM CHANNEL BLOCKERS
VERELAN CAP	-	3	CALCIUM CHANNEL BLOCKERS
VERELAN PM CAP	-	3	CALCIUM CHANNEL BLOCKERS
VESICARE TAB	-	2	URINARY ANTISPASMODICS
VEXOL OPHTH SUSP	-	2	OPHTHALMIC AGENTS
VFEND SUSP (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
VFEND TAB (Restricted to Infectious Disease Specialist)	RS	3	ANTIFUNGALS
V-GO INJ KIT (QL= 1 kit/day)	QL	2	MEDICAL DEVICES AND SUPPLIES
VIAGRA TAB (QL= 6 tabs/30 days)	QL	2	CARDIOVASCULAR AGENTS - MISC.
VIBRAMYCIN CAP	-	3	TETRACYCLINES
VIBRAMYCIN SUSP	-	3	TETRACYCLINES
VICOPROFEN TAB	-	3	ANALGESICS - OPIOID
VICTOZA INJ (QL= 9ml/30 days)	QL	2	ANTIDIABETICS
VICTRELIS CAP	MSP-PA-SF	4	ANTIVIRALS
VIDEX SOLN	-	4	ANTIVIRALS
VIGAMOX OPHTH SOLN (QL= 3ml/fill)	QL	2	OPHTHALMIC AGENTS
VIMPAT SOLN	-	2	ANTICONVULSANTS
VIMPAT TAB (QL= 2 tabs/day)	QL	2	ANTICONVULSANTS
VIRACEPT POWDER	-	4	ANTIVIRALS
VIRACEPT TAB	-	4	ANTIVIRALS
VIRAMUNE SUSP	-	1	ANTIVIRALS
VIREAD TAB	PA	4	ANTIVIRALS
VIROPTIC OPHTH SOLN	-	3	OPHTHALMIC AGENTS
VISICOL TAB	-	3	LAXATIVES
VISTARIL CAP	-	3	ANTIANSIETY AGENTS
vitamin D cap (Rx covered Only)	-	1	VITAMINS
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0	VITAMINS
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0	VITAMINS
VITEKTA TAB	-	3	ANTIVIRALS
VIVACTIL TAB	-	3	ANTIDEPRESSANTS
VIVELLE-DOT PATCH	-	3	ESTROGENS
VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2	VACCINES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
VOLTAREN GEL (QL= 5 tubes/fill)	QL	3	DERMATOLOGICALS
VOLTAREN OPTH SOLN	-	3	OPHTHALMIC AGENTS
VOLTAREN TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
VOLTAREN XR TAB	-	3	ANALGESICS - ANTI-INFLAMMATORY
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTIFUNGALS
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1	ANTIFUNGALS
VOSOL HC OTIC SOLN	-	3	OTIC AGENTS
VOSOL OTIC SOLN	-	3	OTIC AGENTS
VOSPIRE ER TAB	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VOTRIENT TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VYVANSE CAP	-	2	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
warfarin tab (COUMADIN equiv)	-	1	ANTICOAGULANTS
WELCHOL PAK	-	2	ANTIHYPERLIPIDEMICS
WELCHOL TAB	-	2	ANTIHYPERLIPIDEMICS
WELLBUTRIN SR TAB	-	3	ANTIDEPRESSANTS
WELLBUTRIN TAB	-	3	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	3	ANTIDEPRESSANTS
wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
XALATAN OPTH SOLN (QL= 2.5ml/30 days)	QL	3	OPHTHALMIC AGENTS
XALKORI CAP	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XANAX TAB	-	3	ANTIANKXIETY AGENTS
XANAX XR TAB	-	3	ANTIANKXIETY AGENTS
XARELTO STARTER PACK	-	2	ANTICOAGULANTS
XARELTO TAB	-	2	ANTICOAGULANTS
XELJANZ TAB (QL= 2 tabs/day)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB (QL= 1 tab/day)	MSP-PA-QL	4	ANALGESICS - ANTI-INFLAMMATORY
XIGDUO XR TAB (QL= 1 tab/day)	QL	2	ANTIDIABETICS
XIGDUO XR TAB 5-1000MG (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
XOPENEX NEB SOLN	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XTANDI CAP (QL= 4 caps/day)	MSP-PA-QL-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XULANE PATCH	-	\$0	CONTRACEPTIVES
XYLOCAINE SOLN	-	3	DERMATOLOGICALS
XYREM SOLN (Only available through Xyrem Central Pharmacy 866-997-3688)	LD	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
YASMIN TAB	-	\$0	CONTRACEPTIVES
YAZ TAB	-	\$0	CONTRACEPTIVES
ZADITOR OPTH SOLN (QL= 10ml/30 days)	OTC-QL	\$0	OPHTHALMIC AGENTS
zafirlukast tab (ACCOLATE equiv)	-	1	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv)	-	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZANAFLEX TAB	-	3	MUSCULOSKELETAL THERAPY AGENTS
ZANTAC CAP	-	3	ULCER DRUGS
ZANTAC SYRUP	-	3	ULCER DRUGS
ZANTAC TAB	-	3	ULCER DRUGS
ZARONTIN CAP	-	3	ANTICONVULSANTS
ZARONTIN SOLN	-	3	ANTICONVULSANTS
ZAROXOLYN TAB	-	3	DIURETICS

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ZARXIO INJ	MSP	4	HEMATOPOIETIC AGENTS
ZAVESCA CAP (Only available through Accredo 888-773-7376)	LD-PA	4	HEMATOPOIETIC AGENTS
ZEBETA TAB	-	3	BETA BLOCKERS
ZELBORAF TAB	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEMPLAR CAP	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZEPATIER TAB (QL= 1 tab/day)	MSP-PA-QL	4	ANTIVIRALS
ZESTORETIC TAB	-	3	ANTIHYPERTENSIVES
ZETIA TAB (QL= 1 tab/day)	QL	2	ANTIHYPERLIPIDEMICS
ZIAC TAB	-	3	ANTIHYPERTENSIVES
zidovudine cap (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	1	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	1	ANTIVIRALS
zinc sulfate cap	-	1	MINERALS & ELECTROLYTES
ziprasidone cap (GEODON equiv)	-	1	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIRGAN OPHTH GEL	-	2	OPHTHALMIC AGENTS
ZITHROMAX SUSP	-	3	MACROLIDES
ZITHROMAX TAB	-	3	MACROLIDES
ZOCOR TAB	-	3	ANTIHYPERLIPIDEMICS
ZOFRAN ODT	-	3	ANTIEMETICS
ZOFRAN SOLN	-	3	ANTIEMETICS
ZOFRAN TAB	-	3	ANTIEMETICS
ZOLINZA CAP	MSP-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1	MIGRAINE PRODUCTS
ZOLOFT CONC	-	3	ANTIDEPRESSANTS
ZOLOFT TAB	-	3	ANTIDEPRESSANTS
zolpidem tab 10mg (AMBIEN equiv) (Male QL= 1 tab/day; Female QL= 0.5 tab/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
zolpidem tab 5mg (AMBIEN equiv) (QL= 1 tab/day)	QL	1	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOMIG TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
ZOMIG ZMT (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
ZONEGRAN CAP	-	3	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	1	ANTICONVULSANTS
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	3	HEMATOLOGICAL AGENTS - MISC.
ZORTRESS TAB	PA	4	ASSORTED CLASSES
ZOVIRAX CAP	-	3	ANTIVIRALS
ZOVIRAX SUSP	-	3	ANTIVIRALS
ZOVIRAX TAB	-	3	ANTIVIRALS
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2	OPHTHALMIC AGENTS
ZYLOPRIM TAB	-	3	GOUT AGENTS
ZYMAXID OPHTH SOLN (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3	OPHTHALMIC AGENTS
ZYPREXA TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZYPREXA ZYDIS TAB	-	3	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZYTIGA TAB	MSP-PA-SF	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Alphabetical Index
Last Updated 12/1/2016

Drug Name	Special Code	Tier	Category
ZYVOX SUSP (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.
ZYVOX TAB (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
ADDERALL XR CAP	-	1
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	1
dextroamphetamine ER cap (DEXEDRINE equiv)	-	1
dextroamphetamine soln (PROCENTRA equiv)	-	1
dextroamphetamine tab (DEXEDRINE equiv)	-	1
methamphetamine tab (DESOXYN equiv)	-	1
VYVANSE CAP	-	2
ADDERALL TAB	-	3
DESOXYN TAB	-	3
DEXEDRINE CAP	-	3
PROCENTRA SOLN	-	3
ANALEPTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	1
CAFCIT SOLN	-	2
ANOREXIANTS NON-AMPHETAMINE		
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	1
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	1
ADIPEX-P CAP	PA-QL	3
ADIPEX-P TAB	PA-QL	3
ANTI-OBESITY AGENTS		
BELVIQ TAB (QL= 2 tabs/day)	PA-QL	2
BELVIQ XR TAB (QL= 1 tab/day)	PA-QL	2
CONTRAVE TAB (QL= 4 tabs/day)	PA-QL	2
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
guanfacine ER tab (INTUNIV equiv)	-	1
STRATTERA CAP (Step Therapy requires trial of 2 formulary stimulants)	ST	2
STIMULANTS - MISC.		
dexamethylphenidate tab (FOCALIN equiv)	-	1
methylphenidate CD cap (METADATE CD equiv)	-	1
methylphenidate ER cap (RITALIN LA equiv)	-	1
methylphenidate ER tab 10mg, 20mg	-	1
methylphenidate soln (METHYLIN equiv)	-	1
methylphenidate tab (RITALIN equiv)	-	1
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	1
CONCERTA TAB	-	2
METHYLIN SOLN	-	2
METHYLPHENIDATE ER TAB	-	2
FOCALIN TAB	-	3
METADATE CD CAP	-	3
PROVIGIL TAB (QL= 2 tabs/day)	PA-QL	3
RITALIN LA CAP	-	3
RITALIN SR TAB	-	3
RITALIN TAB	-	3

AMINOGLYCOSIDES

AMINOGLYCOSIDES

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
AMINOGLYCOSIDES Cont.		
neomycin tab	-	1
paromomycin cap (HUMATIN equiv)	-	1
BETHKIS NEB SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4
KITABIS PAK NEB SOLN (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4
TOBI PODHALER (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	4
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
XELJANZ TAB (QL= 2 tabs/day)	MSP-PA-QL	4
XELJANZ XR TAB (QL= 1 tab/day)	MSP-PA-QL	4
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
HUMIRA INJ (QL= 2 inj/28 days)	MSP-PA-QL	4
HUMIRA PEN INJ (QL= 2 inj/28 days)	MSP-PA-QL	4
GOLD COMPOUNDS		
RIDAURA CAP	-	2
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (Only available through Rx Crossroads: 1-866-547-0644)	LD-PA	4
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA SC INJ (QL= 2 inj/28 days)	MSP-PA-QL	4
ACTEMRA IV INJ	M	M
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS)	QL-ST	1
diclofenac potassium tab (CATAFLAM equiv)	-	1
diclofenac sodium EC tab (VOLTAREN equiv)	-	1
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	1
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	1
etodolac cap (LODINE equiv)	-	1
etodolac ER tab (LODINE XL equiv)	-	1
etodolac tab	-	1
fenoprofen calcium tab	-	1
flurbiprofen tab (ANSAID equiv)	-	1
ibuprofen susp (Rx ONLY) (ADVIL/MOTRIN equiv)	-	1
ibuprofen tab	-	1
ibuprofen tab (Rx covered Only)	-	1
indomethacin cap (INDOCIN equiv)	-	1
indomethacin CR cap (INDOCIN SR equiv)	-	1
ketoprofen cap (ORUDIS equiv)	-	1
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	1
MECLOFENAMATE CAP	-	1
mefenamic acid cap (PONSTEL equiv)	-	1
meloxicam tab (MOBIC equiv)	-	1
nabumetone tab (RELAFEN equiv)	-	1
naproxen EC tab (NAPROSYN EC equiv)	-	1
naproxen sodium tab (ANAPROX equiv)	-	1
naproxen susp (NAPROSYN equiv)	-	1
naproxen tab (NAPROSYN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
oxaprozin tab (DAYPRO equiv)	-	1
piroxicam cap (FELDENE equiv)	-	1
sulindac tab (CLINORIL equiv)	-	1
TOLMETIN CAP	-	1
tolmetin cap (TOLECTIN DS equiv)	-	1
INDOCIN SUPP	-	2
INDOCIN SUSP	-	2
NAPROXEN SUSP	-	2
ANAPROX TAB	-	3
ARTHROTEC TAB	-	3
CATAFLAM TAB	-	3
CELEBREX CAP (QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS)	QL-ST	3
CLINORIL TAB	-	3
DAYPRO TAB	-	3
FELDENE CAP	-	3
MOBIC TAB	-	3
MOTRIN SUSP	-	3
NAPROSYN EC TAB	-	3
NAPROSYN SUSP	-	3
NAPROSYN TAB	-	3
PONSTEL CAP	-	3
TOLMETIN TAB	-	3
VOLTAREN TAB	-	3
VOLTAREN XR TAB	-	3

PYRIMIDINE SYNTHESIS INHIBITORS

leflunomide tab (ARAVA equiv)	-	1
ARAVA TAB	-	3

SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS

ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	4
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	4
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	4

ANALGESICS - NONNARCOTIC

SALICYLATES

ASPIRIN CHEW TAB 75MG (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	1
choline magnesium trisalicylate tab (TRILISATE equiv)	-	1
diflunisal tab (DOLOBID equiv)	-	1
salsalate tab (DISALCID equiv)	-	1

ANALGESICS - OPIOID

OPIOID AGONISTS

codeine sulfate tab	-	1
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
fentanyl patch (DURAGESIC equiv) (QL= 10 patches/30 days)	QL	1
HYDROMORPHONE SUPP	-	1
hydromorphone tab (DILAUDID equiv)	-	1
meperidine tab (DEMEROL equiv)	-	1
METHADONE SOLN	-	1
methadone tab (DOLOPHINE equiv)	-	1
methadose tab	-	1
morphine sulfate ER cap (KADIAN equiv)	-	1
morphine sulfate ER tab (MS CONTIN equiv)	-	1
morphine sulfate soln	-	1
morphine sulfate supp	-	1
morphine sulfate tab	-	1
oxycodone cap (OXYIR equiv)	-	1
oxycodone conc (ROXICODONE equiv)	-	1
oxycodone soln (ROXICODONE equiv)	-	1
oxycodone tab (ROXICODONE equiv)	-	1
tramadol ER tab (ULTRAM ER equiv)	-	1
tramadol tab (ULTRAM equiv)	-	1
FENTORA TAB (QL= 120 tabs/30 days)	PA-QL	2
HYSINGLA ER TAB (QL= 1 tab/day)	QL	2
LEVORPHANOL TAB	-	2
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	2
OXYCONTIN CR TAB (QL= 120 tabs/30 days)	QL	2
OXYIR CAP	-	2
ACTIQ LOZENGE (QL= 120 units/30 days)	PA-QL	3
DEMEROL TAB	-	3
DILAUDID TAB	-	3
DOLOPHINE TAB	-	3
DURAGESIC PATCH (QL= 10 patches/30 days)	QL	3
KADIAN CAP	-	3
METHADOSE CONC	-	3
MS CONTIN TAB	-	3
ROXICODONE TAB	-	3
ULTRAM ER TAB	-	3
ULTRAM TAB	-	3
OPIOID COMBINATIONS		
acetaminophen/codeine soln	-	1
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	1
aspirin/codeine tab	-	1
hydrocodone/acetaminophen cap (LORCET equiv)	-	1
hydrocodone/acetaminophen soln (HYCET/LORTAB equiv)	-	1
hydrocodone/acetaminophen tab (LORTAB equiv)	-	1
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	1
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	1
oxycodone/acetaminophen cap (TYLOX equiv)	-	1
OXYCODONE/ACETAMINOPHEN SOLN	-	1
oxycodone/acetaminophen tab (PERCOCET equiv)	-	1
oxycodone/aspirin tab (PERCODAN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	1
pentazocine/acetaminophen tab (TALACEN equiv)	-	1
tramadol/acetaminophen tab (ULTRACET equiv)	-	1
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	3
HYCET SOLN	-	3
LORTAB	-	3
PERCOCET TAB	-	3
PERCODAN TAB	-	3
ROXICET SOLN	-	3
TYLENOL/CODEINE TAB	-	3
ULTRACET TAB	-	3
VICOPROFEN TAB	-	3
OPIOID PARTIAL AGONISTS		
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	1
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	1
pentazocine/naloxone tab (TALWIN NX equiv)	-	1
SUBOXONE SL FILM	-	2
BUTRANS PATCH	-	3
SUBOXONE SL TAB	-	3
nalbuphine inj	M	M
ANDROGENS-ANABOLIC		
ANABOLIC STEROIDS		
oxandrolone tab (OXANDRIN equiv)	-	1
OXANDRIN TAB	-	3
ANDROGENS		
danazol cap (DANOCRINE equiv)	-	1
methyltestosterone cap (ANDROID/TESTRED equiv)	-	1
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	1
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	1
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	1
testosterone gel 1% pump (ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	1
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	2
ANDROGEL 1.62% 1.25GM (QL= 1 packet/day)	PA-QL	2
ANDROGEL 1.62% 2.5GM (QL= 2 packets/day)	PA-QL	2
ANDROGEL PUMP 1.62% (QL= 2 bottles/30 days)	PA-QL	2
ANDROXY TAB	-	2
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	2
TESTOSTERONE GEL 1% 50MG (QL= 2 packets/day)	PA-QL	2
TESTOSTERONE GEL PUMP (QL= 4 bottles/30 days)	PA-QL	2
ANDROGEL 1% 25MG (QL= 1 packet/day)	PA-QL	3
ANDROGEL 1% 50MG (QL= 2 packets/day)	PA-QL	3
ANDROGEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3
ANDROID/TESTRED CAP	-	3
AXIRON SOLN	-	3
DEPO-TESTOSTERONE INJ	-	3
METHITEST TAB	-	3
ANORECTAL AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANORECTAL AGENTS Cont.		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	1
CORTENEMA	-	3
UCERIS RECTAL FOAM	PA	3
RECTAL COMBINATIONS		
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	1
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	1
PROCTOFOAM HC FOAM	-	2
ANALPRAM-E KIT	-	3
RECTAL LOCAL ANESTHETICS		
lidocaine cream 5% (QL= 50gm/30 days)	OTC-QL	\$0
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	1
ANUSOL-HC CREAM	-	3
ANTHELMINTICS		
ANTHELMINTICS		
ivermectin tab (STROMECTOL equiv)	-	1
mebendazole chew tab (VERMOX equiv)	-	1
ALBENZA TAB	-	2
STROMECTOL TAB	-	3
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
RANEXA TAB	-	2
NITRATES		
ISOSORBIDE DINITRATE ER TAB	-	1
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	1
isosorbide dinitrate SL tab	-	1
isosorbide dinitrate tab (ISORDIL equiv)	-	1
isosorbide mononitrate ER tab (IMDUR equiv)	-	1
isosorbide mononitrate tab (MONOKET equiv)	-	1
nitroglycerin patch (NITRO-DUR equiv)	-	1
nitroglycerin SL tab (NITROSTAT equiv)	-	1
nitroglycerin SR cap	-	1
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	2
IMDUR TAB	-	3
ISORDIL TITRADOSE TAB	-	3
NITRO-DUR PATCH	-	3
NITROSTAT SL TAB	-	3
ANTIANSIETY AGENTS		
ANTIANSIETY AGENTS - MISC.		
buspirone tab (BUSPAR equiv)	-	1
hydroxyzine pamoate cap (VISTARIL equiv)	-	1
HYDROXYZINE PAMOATE CAP 100MG	-	1
hydroxyzine syrup (ATARAX equiv)	-	1
hydroxyzine tab (ATARAX equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIANGIENSIY AGENTS Cont.		
meprobamate tab (MILTOWN equiv)	-	1
BUSPAR TAB	-	3
VISTARIL CAP	-	3
BENZODIAZEPINES		
alprazolam ER tab (XANAX XR equiv)	-	1
alprazolam ODT (NIRAVAM equiv)	-	1
alprazolam tab (XANAX equiv)	-	1
chlordiazepoxide cap (LIBRIUM equiv)	-	1
clorazepate tab (TRANXENE-T equiv)	-	1
diazepam conc (VALIUM equiv)	-	1
DIAZEPAM SOLN	-	1
diazepam tab (VALIUM equiv)	-	1
lorazepam conc (ATIVAN equiv)	-	1
lorazepam tab (ATIVAN equiv)	-	1
oxazepam cap (SERAX equiv)	-	1
ATIVAN TAB	-	3
LIBRIUM CAP	-	3
NIRAVAM ODT	-	3
TRANXENE-T TAB	-	3
VALIUM TAB	-	3
XANAX TAB	-	3
XANAX XR TAB	-	3

ANTIARRHYTHMICS

ANTIARRHYTHMICS TYPE I-A

disopyramide cap (NORPACE equiv)	-	1
disopyramide ER cap (NORPACE CR equiv)	-	1
quinidine gluconate CR tab	-	1
QUINIDINE SULFATE TAB	-	1
NORPACE CR CAP	-	2
NORPACE CAP	-	3

ANTIARRHYTHMICS TYPE I-B

mexiletine cap (MEXITIL equiv)	-	1
--------------------------------	---	---

ANTIARRHYTHMICS TYPE I-C

flecainide tab (TAMBOCOR equiv)	-	1
propafenone ER cap (RYTHMOL SR equiv)	-	1
propafenone tab (RYTHMOL equiv)	-	1
RYTHMOL SR CAP	-	3
RYTHMOL TAB	-	3
TAMBOCOR TAB	-	3

ANTIARRHYTHMICS TYPE III

amiodarone tab (CORDARONE equiv)	-	1
dofetilide cap (TIKOSYN equiv)	-	1
MULTAQ TAB	-	2
CORDARONE TAB	-	3
TIKOSYN CAP	-	3

ANTIASTHMATIC AND BRONCHODILATOR AGENTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	1
CROMOLYN NEB SOLN	-	2
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	1
ATROVENT HFA INHALER	-	2
INCRUSE ELLIPTA INHALER	-	2
SPIRIVA HANDIHALER (For use with Handihaler device)	-	2
SPIRIVA RESPIMAT INHALER	-	2
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (Step Therapy requires trial of inhaled corticosteroid)	ST	2
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	1
montelukast granule pack (SINGULAIR equiv)	-	1
montelukast tab (SINGULAIR equiv)	-	1
zafirlukast tab (ACCOLATE equiv)	-	1
ACCOLATE TAB	-	3
SINGULAIR CHEW TAB	-	3
SINGULAIR GRANULE PACK	-	3
SINGULAIR TAB	-	3
STEROID INHALANTS		
ARNUITY ELLIPTA INHALER	-	1
ASMANEX HFA INHALER	-	1
ASMANEX INHALER	-	1
budesonide inh susp (PULMICORT equiv)	-	1
FLOVENT DISKUS INHALER	-	1
FLOVENT HFA INHALER	-	1
PULMICORT INH SUSP	-	3
SYMPATHOMIMETICS		
albuterol neb soln 0.083% (PROVENTIL equiv)	-	1
albuterol neb soln 0.5% (VENTOLIN equiv)	-	1
albuterol neb soln 0.63mg (ACCUNEB equiv)	-	1
albuterol neb soln 1.25mg (ACCUNEB equiv)	-	1
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	1
albuterol sulfate syrup	-	1
albuterol sulfate tab	-	1
albuterol/ipratropium neb soln (DUONEB equiv)	-	1
levalbuterol neb soln (XOPENEX equiv)	-	1
METAPROTERENOL SYRUP	-	1
terbutaline sulfate tab (BRETHINE equiv)	-	1
ADVAIR DISKUS INHALER	-	2
ADVAIR HFA INHALER	-	2
BREO ELLIPTA INHALER	-	2
COMBIVENT INHALER	-	2
COMBIVENT RESPIMAT INHALER	-	2
DULERA INHALER	-	2
FORADIL AEROLIZER	-	2
SEREVENT DISKUS INHALER	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
STIOLTO INHALER	-	2
VENTOLIN HFA INHALER	-	2
ACCUNEB NEB SOLN	-	3
BRETHINE TAB	-	3
DUONEB NEB SOLN	-	3
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	PA-QL	3
VOSPIRE ER TAB	-	3
XOPENEX NEB SOLN	-	3
XANTHINES		
aminophylline tab	-	1
theophylline CR tab (QUIBRON-T equiv)	-	1
theophylline ER tab (UNIPHYL equiv)	-	1
theophylline soln	-	1
ELIXOPHYLLIN ELIXIR	-	2
UNIPHYL TAB	-	3
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	1
COUMADIN TAB	-	3
DIRECT FACTOR XA INHIBITORS		
ELIQUIS TAB	-	2
XARELTO STARTER PACK	-	2
XARELTO TAB	-	2
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	1
fondaparinux inj (ARIXTRA equiv)	PA	1
ARIXTRA INJ	PA	3
THROMBIN INHIBITORS		
PRADAXA CAP (QL= 2 caps/day)	QL	2
ANTICONVULSANTS		
ANTICONVULSANTS - BENZODIAZEPINES		
clonazepam ODT (KLONOPIN equiv)	-	1
clonazepam tab (KLONOPIN equiv)	-	1
ONFI TAB	PA	2
KLONOPIN TAB	-	3
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	1
carbamazepine ER cap (CARBATROL equiv)	-	1
carbamazepine ER tab (TEGRETOL XR equiv)	-	1
carbamazepine susp (TEGRETOL equiv)	-	1
carbamazepine tab (TEGRETOL equiv)	-	1
gabapentin cap (NEURONTIN equiv)	-	1
gabapentin soln (NEURONTIN equiv)	-	1
gabapentin tab (NEURONTIN equiv)	-	1
lamotrigine chew tab (LAMICTAL equiv)	-	1
lamotrigine ER tab (LAMICTAL XR equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
lamotrigine ODT (LAMICTAL equiv)	-	1
lamotrigine tab (LAMICTAL equiv)	-	1
levetiracetam ER tab (KEPPRA XR equiv)	-	1
levetiracetam soln (KEPPRA equiv)	-	1
levetiracetam tab (KEPPRA equiv)	-	1
oxcarbazepine susp (TRILEPTAL equiv)	-	1
oxcarbazepine tab (TRILEPTAL equiv)	-	1
primidone tab (MYSOLINE equiv)	-	1
topiramate sprinkle cap (TOPAMAX equiv)	-	1
topiramate tab (TOPAMAX equiv)	-	1
zonisamide cap (ZONEGRAN equiv)	-	1
BANZEL SUSP	-	2
BANZEL TAB	-	2
LAMICTAL CHEW TAB 2MG	-	2
LYRICA CAP	-	2
LYRICA SOLN	-	2
POTIGA TAB (QL= 3 tabs/day)	QL	2
POTIGA TAB 50MG (QL= 9 tabs/day)	QL	2
TRILEPTAL SUSP	-	2
VIMPAT SOLN	-	2
VIMPAT TAB (QL= 2 tabs/day)	QL	2
CARBATROL CAP	-	3
KEPPRA SOLN	-	3
KEPPRA TAB	-	3
KEPPRA XR TAB	-	3
LAMICTAL CHEW TAB	-	3
LAMICTAL ODT	-	3
LAMICTAL TAB	-	3
LAMICTAL XR TAB	-	3
MYSOLINE TAB	-	3
NEURONTIN CAP	-	3
NEURONTIN SOLN	-	3
NEURONTIN TAB	-	3
TEGRETOL CHEW TAB	-	3
TEGRETOL SUSP	-	3
TEGRETOL TAB	-	3
TEGRETOL XR TAB	-	3
TOPAMAX SPRINKLE CAP	-	3
TOPAMAX TAB	-	3
TRILEPTAL TAB	-	3
ZONEGRAN CAP	-	3
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	1
felbamate tab (FELBATOL equiv)	-	1
FELBATOL TAB	-	2
FELBATOL SUSP	-	3
GABA MODULATORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
tiagabine tab (GABITRIL equiv)	-	1
GABITRIL TAB 12MG, 16MG	-	2
GABITRIL TAB	-	3
SABRIL POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	4
SABRIL TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
HYDANTOINS		
phenytoin cap (DILANTIN equiv)	-	1
phenytoin chew tab (DILANTIN equiv)	-	1
phenytoin susp (DILANTIN equiv)	-	1
DILANTIN CAP 30MG	-	2
PEGANONE TAB	-	2
DILANTIN CAP 100MG	-	3
DILANTIN INFATABS	-	3
DILANTIN SUSP	-	3
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	1
ethosuximide soln (ZARONTIN equiv)	-	1
CELONTIN CAP	-	2
ZARONTIN CAP	-	3
ZARONTIN SOLN	-	3
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	1
divalproex sodium DR tab (DEPAKOTE equiv)	-	1
divalproex sprinkle cap (DEPAKOTE equiv)	-	1
valproic acid cap (DEPAKENE equiv)	-	1
valproic acid syrup (DEPAKENE equiv)	-	1
DEPAKENE CAP	-	3
DEPAKENE SYRUP	-	3
DEPAKOTE ER TAB	-	3
DEPAKOTE SPRINKLE CAP	-	3
DEPAKOTE TAB	-	3
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	1
mirtazapine tab (REMERON equiv)	-	1
REMERON SOLUTAB	-	3
REMERON TAB	-	3
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	1
bupropion tab (WELLBUTRIN equiv)	-	1
bupropion XL tab (WELLBUTRIN XL equiv)	-	1
MAPROTILINE TAB	-	1
WELLBUTRIN SR TAB	-	3
WELLBUTRIN TAB	-	3
WELLBUTRIN XL TAB	-	3
MONOAMINE OXIDASE INHIBITORS (MAOIS)		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
phenelzine tab (NARDIL equiv)	-	1
tranylcypromine tab (PARNATE equiv)	-	1
MARPLAN TAB	-	2
NARDIL TAB	-	2
PARNATE TAB	-	3
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	1
citalopram tab (CELEXA equiv)	-	1
escitalopram soln (LEXAPRO equiv)	-	1
escitalopram tab (LEXAPRO equiv)	-	1
fluoxetine cap (PROZAC equiv)	-	1
fluoxetine soln (PROZAC equiv)	-	1
fluoxetine tab (PROZAC equiv)	-	1
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine)	ST	1
fluvoxamine tab (LUVOX equiv)	-	1
paroxetine ER tab (PAXIL CR equiv)	-	1
paroxetine tab (PAXIL equiv)	-	1
sertraline conc (ZOLOFT equiv)	-	1
sertraline tab (ZOLOFT equiv)	-	1
CELEXA SOLN	-	3
CELEXA TAB	-	3
LEXAPRO SOLN	-	3
LEXAPRO TAB	-	3
LUVOX CR CAP (Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine)	ST	3
PAXIL CR TAB	-	3
PAXIL TAB	-	3
PROZAC CAP	-	3
PROZAC SOLN	-	3
PROZAC TAB	-	3
ZOLOFT CONC	-	3
ZOLOFT TAB	-	3
SEROTONIN MODULATORS		
NEFAZODONE TAB	-	1
nefazodone tab 50mg, 250mg	-	1
trazodone tab (DESYREL equiv)	-	1
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	3
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
duloxetine EC cap (CYMBALTA equiv) (QL= 2 caps/day)	QL	1
venlafaxine ER cap (EFFEXOR XR equiv)	-	1
venlafaxine ER tab	-	1
VENLAFAXINE ER TAB 225MG	-	1
venlafaxine tab (EFFEXOR equiv)	-	1
VENLAFAXINE ER TAB	-	2
CYMBALTA CAP (QL= 2 caps/day)	QL	3
EFFEXOR TAB	-	3
EFFEXOR XR CAP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
FETZIMA CAP (QL= 1 cap/day)	PA-QL	3
FETZIMA TITRATION PACK (QL= 1 cap/day)	PA-QL	3
TRICYCLIC AGENTS		
amitriptyline tab (ELAVIL equiv)	-	1
AMOXAPINE TAB	-	1
clomipramine cap (ANAFRANIL equiv)	-	1
desipramine tab (NORPRAMIN equiv)	-	1
doxepin cap (SINEQUAN equiv)	-	1
DOXEPIN CAP 75MG	-	1
doxepin conc (SINEQUAN equiv)	-	1
imipramine pamoate cap (TOFRANIL PM equiv)	-	1
imipramine tab (TOFRANIL equiv)	-	1
nortriptyline cap (PAMELOR equiv)	-	1
NORTRIPTYLINE SOLN	-	1
protriptyline tab (VIVACTIL equiv)	-	1
trimipramine cap (SURMONTIL equiv)	-	1
ANAFRANIL CAP	-	3
NORPRAMIN TAB	-	3
PAMELOR CAP	-	3
SURMONTIL CAP	-	3
TOFRANIL PM CAP	-	3
TOFRANIL TAB	-	3
VIVACTIL TAB	-	3
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab (PRECOSE equiv)	-	1
PRECOSE TAB	-	3
ANTIDIABETIC COMBINATIONS		
glipizide/metformin tab (METAGLIP equiv)	-	1
glyburide/metformin tab (GLUCOVANCE equiv)	-	1
pioglitazone/glimepiride tab (DUETACT equiv)	-	1
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	1
AVANDAMET TAB	-	2
AVANDARYL TAB	-	2
JANUMET TAB	-	2
JANUMET XR TAB	-	2
JENTADUETO TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2
KAZANO/ALOGLIPTIN-METFORMIN TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2
KOMBIGLYZE XR TAB	-	2
OSENI/ALOGLIPTIN-PIOGLITAZONE TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2
SYNJARDY TAB (QL= 2 tabs/day)	QL	2
XIGDUO XR TAB (QL= 1 tab/day)	QL	2
XIGDUO XR TAB 5-1000MG (QL= 2 tabs/day)	QL	2
ACTOPLUS MET TAB	-	3
DUETACT TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
GLUCOVANCE TAB	-	3
METAGLIP TAB	-	3
BIGUANIDES		
metformin ER osmotic tab (FORTAMET equiv) (Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv))	ST	1
metformin ER tab (GLUCOPHAGE XR equiv)	-	1
metformin tab (GLUCOPHAGE equiv)	-	1
FORTAMET TAB (Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv))	ST	3
GLUCOPHAGE TAB	-	3
GLUCOPHAGE XR TAB	-	3
DIABETIC OTHER		
GLUCAGEN HYPOKIT INJ	-	2
GLUCAGON INJ KIT	-	2
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	4
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB (QL= 1 tab/day)	QL	2
NESINA/ALOGLIPTIN TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2
ONGLYZA TAB (QL= 1 tab/day)	QL	2
TRADJENTA TAB (Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR)	ST	2
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON INJ (QL= 4 inj/28 days)	QL	2
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	2
TRULICITY INJ (QL= 4 inj/28 days)	QL	2
VICTOZA INJ (QL= 9ml/30 days)	QL	2
INSULIN		
NOVOLIN INJ	OTC	1
HUMULIN MIX PEN INJ	OTC	2
HUMULIN N PEN INJ	OTC	2
HUMULIN R INJ U-500	-	2
HUMULIN R U-500 KWIKPEN INJ	-	2
LANTUS INJ	-	2
LANTUS SOLOSTAR INJ	-	2
LEVEMIR FLEXPEN/FLEXTOUCH INJ	-	2
LEVEMIR INJ	-	2
NOVOLOG FLEXPEN INJ	-	2
NOVOLOG INJ	-	2
NOVOLOG MIX FLEXPEN INJ	-	2
NOVOLOG MIX INJ	-	2
NOVOLOG PENFILL INJ	-	2
TOUJEO SOLOSTAR INJ	-	2
TRESIBA INJ	-	2
HUMULIN VIAL	-	3
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	1
AVANDIA TAB	-	2
ACTOS TAB	-	3
MEGLITINIDE ANALOGUES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
----------	--------------	------

ANTIDIABETICS Cont.

nateglinide tab (STARLIX equiv)	-	1
repaglinide tab (PRANDIN equiv)	-	1
PRANDIN TAB	-	3
STARLIX TAB	-	3

SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS

FARXIGA TAB (QL= 1 tab/day)	QL	2
JARDIANCE TAB (QL= 1 tab/day)	QL	2

SULFONYLUREAS

CHLORPROPAMIDE TAB	-	1
chlorpropamide tab (DIABINESE equiv)	-	1
glimepiride tab (AMARYL equiv)	-	1
glipizide ER tab (GLUCOTROL XL equiv)	-	1
glipizide tab (GLUCOTROL equiv)	-	1
glyburide micronized tab (GLYNASE equiv)	-	1
glyburide tab (MICRONASE equiv)	-	1
tolazamide tab (TOLINASE equiv)	-	1
TOLBUTAMIDE TAB	-	1
AMARYL TAB	-	3
GLUCOTROL TAB	-	3
GLUCOTROL XL TAB	-	3
GLYNASE TAB	-	3

ANTIDIARRHEALS

ANTIPERISTALTIC AGENTS

diphenoxylate/atropine liquid (LOMOTIL equiv)	-	1
diphenoxylate/atropine tab (LOMOTIL equiv)	-	1
opium tincture	-	1
LOMOTIL LIQUID	-	3
LOMOTIL TAB	-	3

ANTIDOTES

ANTIDOTES - CHELATING AGENTS

CHEMET CAP	-	2
EXJADE TAB	MSP	4
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	4
JADENU TAB	MSP	4

OPIOID ANTAGONISTS

naloxone inj	-	1
naltrexone tab (REVIA equiv)	-	1
REVIA TAB	-	3

ANTIDOTES AND SPECIFIC ANTAGONISTS

OPIOID ANTAGONISTS

NALOXONE INJ	-	1
--------------	---	---

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS

granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	1
--	----	---

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
ondansetron ODT (ZOFTRAN equiv)	-	1
ondansetron soln (ZOFTRAN equiv)	-	1
ondansetron tab (ZOFTRAN equiv)	-	1
ZOFTRAN ODT	-	3
ZOFTRAN SOLN	-	3
ZOFTRAN TAB	-	3
ANTIEMETICS - ANTICHOLINERGIC		
ANTIVERT TAB	-	1
maldemar tab (SCOPACE equiv)	-	1
meclizine tab (ANTIVERT equiv) (Rx Only)	-	1
trimethobenzamide cap (TIGAN equiv)	-	1
TIGAN CAP	-	3
TRANSDERM-SCOP PATCH	-	3
ANTIEMETICS - MISCELLANEOUS		
dronabinol cap (MARINOL equiv)	-	1
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
MARINOL CAP	-	3
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
EMEND CAP (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
EMEND PAK (QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	2
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	2
ANTIFUNGALS		
ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	1
griseofulvin micro tab (GRIFULVIN V equiv)	-	1
griseofulvin susp (GRIFULVIN equiv)	-	1
griseofulvin tab (GRIS-PEG equiv)	-	1
nystatin powder	-	1
nystatin tab	-	1
terbinafine tab (LAMISIL equiv)	-	1
ANCOBON CAP	-	3
GRIFULVIN V TAB	-	3
GRIS-PEG TAB	-	3
LAMISIL TAB	-	3
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	1
fluconazole tab (DIFLUCAN equiv)	-	1
itraconazole cap (SPORANOX equiv)	PA	1
ketoconazole tab (NIZORAL equiv)	-	1
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	1
NOXAFIL SUSP	-	2
DIFLUCAN SUSP	-	3
DIFLUCAN TAB	-	3
SPORANOX CAP	PA	3
VFEND SUSP (Restricted to Infectious Disease Specialist)	RS	3
VFEND TAB (Restricted to Infectious Disease Specialist)	RS	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Mandatory Specialty Pharmacy Program	OTC	Limited Distribution	PA	Medical Benefit
QL	Quantity Limit	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Smoking Cessation	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Vaccine Program		Available through Specialty Pharmacy Program		Step Therapy

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
chlorpheniramine ER cap	-	1
ANTIHISTAMINES - ETHANOLAMINES		
carbinoxamine soln (PALGIC equiv)	-	1
carbinoxamine tab (PALGIC equiv)	-	1
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	OTC	1
diphenhydramine inj (BENADRYL equiv)	-	1
PALGIC SOLN	-	3
PALGIC TAB	-	3
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine supp (PHENERGAN equiv)	-	1
promethazine syrup	-	1
promethazine tab (PHENERGAN equiv)	-	1
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	1
cyproheptadine tab	-	1
ANTIHYPERSLIPIDEMICS		
ANTIHYPERSLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	1
LOVAZA CAP	-	3
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	1
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	1
cholestyramine powder (QUESTRAN equiv)	-	1
cholestyramine powder pack (QUESTRAN equiv)	-	1
colestipol granule (COLESTID equiv)	-	1
colestipol powder packet (COLESTID equiv)	-	1
colestipol tab (COLESTID equiv)	-	1
WELCHOL PAK	-	2
WELCHOL TAB	-	2
COLESTID GRANULE	-	3
COLESTID POWDER PACK	-	3
COLESTID TAB	-	3
QUESTRAN LITE POWDER	-	3
QUESTRAN LITE POWDER PACK	-	3
QUESTRAN POWDER	-	3
QUESTRAN POWDER PACK	-	3
FIBRIC ACID DERIVATIVES		
fenofibrate cap (ANTARA equiv)	-	1
fenofibrate tab (TRICOR equiv)	-	1
gemfibrozil tab (LOPID equiv)	-	1
TRILIPIX CAP	-	1
ANTARA CAP	-	3
FENOGLIDE/TRICOR TAB	-	3
LOPID TAB	-	3
HMG COA REDUCTASE INHIBITORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTHYPERLIPIDEMICS Cont.		
atorvastatin tab (LIPITOR equiv)	-	1
fluvastatin cap (LESCOL equiv)	-	1
fluvastatin ER tab (LESCOL XL equiv)	PA	1
lovastatin tab (MEVACOR equiv)	-	1
pravastatin tab (PRAVACHOL equiv)	-	1
rosuvastatin tab (CRESTOR equiv) (QL= 1 tab/day)	QL	1
rosuvastatin tab 20mg (CRESTOR equiv) (QL= 1.5 tabs/day)	QL	1
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1
CRESTOR TAB (QL= 1 tab/day)	QL	3
CRESTOR TAB 20MG (QL= 1.5 tabs/day)	QL	3
LESCOL CAP	-	3
LESCOL XL TAB	PA	3
MEVACOR TAB	-	3
PRAVACHOL TAB	-	3
ZOCOR TAB	-	3

INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS

ZETIA TAB (QL= 1 tab/day)	QL	2
---------------------------	----	---

NICOTINIC ACID DERIVATIVES

NIACOR TAB	-	1
NIASPAN ER TAB	-	1

ANTIHYPERTENSIVES

ACE INHIBITORS

benazepril tab (LOTENSIN equiv)	-	1
captopril tab (CAPOTEN equiv)	-	1
enalapril tab (VASOTEC equiv)	-	1
fosinopril tab (MONOPRIL equiv)	-	1
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	1
moexipril tab (UNIVASC equiv)	-	1
perindopril tab (ACEON equiv)	-	1
quinapril tab (ACCUPRIL equiv)	-	1
ramipril cap (ALTACE equiv)	-	1
trandolapril tab (MAVIK equiv)	-	1
ACCUPRIL TAB	-	3
ACEON TAB	-	3
ALTACE CAP	-	3
CAPOTEN TAB	-	3
EPANED SOLN	PA	3
LOTENSIN TAB	-	3
MAVIK TAB	-	3
MONOPRIL TAB	-	3
PRINIVIL TAB/ ZESTRIL TAB	-	3
UNIVASC TAB	-	3
VASOTEC TAB	-	3

AGENTS FOR PHEOCHROMOCYTOMA

phenoxybenzamine cap (DIBENZYLINE equiv)	-	1
DIBENZYLINE CAP	-	3

ANGIOTENSIN II RECEPTOR ANTAGONISTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
candesartan tab (ATACAND equiv)	-	1
irbesartan tab (AVAPRO equiv)	-	1
losartan tab (COZAAR equiv)	-	1
valsartan tab (DIOVAN equiv)	-	1
AVAPRO TAB	-	3
COZAAR TAB	-	3
DIOVAN TAB	-	3
TEVETEN TAB	-	3
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine patch (CATAPRES-TTS equiv)	-	1
clonidine tab (CATAPRES equiv)	-	1
doxazosin tab (CARDURA equiv)	-	1
guanfacine IR tab (TENEX equiv)	-	1
methyldopa tab (ALDOMET equiv)	-	1
prazosin cap (MINIPRESS equiv)	-	1
terazosin cap (HYTRIN equiv)	-	1
CARDURA TAB	-	3
CATAPRES TAB	-	3
CATAPRES-TTS PATCH	-	3
HYTRIN CAP	-	3
MINIPRESS CAP	-	3
TENEX TAB	-	3
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/ valsartan tab (EXFORGE equiv)	-	1
amlodipine/benazepril cap (LOTREL equiv)	-	1
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	1
atenolol/chlorthalidone tab (TENORETIC equiv)	-	1
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	1
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	1
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	1
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	1
captopril/hydrochlorothiazide tab (CAPOZIDE equiv)	-	1
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	1
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	1
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	1
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	1
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	1
methyldopa/hydrochlorothiazide tab (ALDORIL equiv)	-	1
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	1
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	1
propranolol/hydrochlorothiazide tab (INDERIDE equiv)	-	1
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	1
telmisartan/amlodipine tab (TWYNSTA equiv)	-	1
trandolapril/verapamil ER tab (TARKA equiv)	-	1
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	1
DUTOPROL TAB	-	2
ACCURETIC TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
ATACAND HCT TAB	-	3
AVALIDE TAB	-	3
DIOVAN HCT TAB	-	3
EXFORGE HCT TAB	-	3
EXFORGE TAB	-	3
HYZAAR TAB	-	3
LOPRESSOR HCT TAB	-	3
LOTENSIN HCT TAB	-	3
LOTREL CAP	-	3
MONOPRIL HCT TAB	-	3
TARKA TAB	-	3
TENORETIC TAB	-	3
TWYNSTA TAB	-	3
UNIRETIC TAB	-	3
VASERETIC TAB	-	3
ZESTORETIC TAB	-	3
ZIAC TAB	-	3
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	1
INSPRA TAB	-	3
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	1
minoxidil tab (LONITEN equiv)	-	1
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole cap (FLAGYL equiv)	-	1
metronidazole tab (FLAGYL equiv)	-	1
tinidazole tab (TINDAMAX equiv)	-	1
trimethoprim tab (PROLOPRIM equiv)	-	1
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	1
VANCOMYCIN SOLN KIT	-	1
NEBUPENT NEB SOLN	-	2
FLAGYL CAP	-	3
FLAGYL TAB	-	3
TINDAMAX TAB	-	3
VANCOCIN CAP (QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln)	QL-ST	3
CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-RS	4
ANTI-INFECTIVE MISC. - COMBINATIONS		
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	1
smz/tmp (DS) tab (BACTRIM DS equiv)	-	1
smz/tmp susp (BACTRIM/SEPTRA equiv)	-	1
BACTRIM DS TAB	-	3
PEDIAZOLE SUSP	-	3
ANTIPROTOZOAL AGENTS		
atovaquone susp (MEPRON equiv)	-	1
ALINIA SUSP	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
ALINIA TAB	-	2
MEPRON SUSP	-	3
LEPROSTATICS		
dapsone tab	-	1
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	1
clindamycin soln (CLEOCIN equiv)	-	1
CLEOCIN CAP	-	3
CLEOCIN SOLN	-	3
OXAZOLIDINONES		
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	1
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	2
ZYVOX SUSP (Restricted to Infectious Disease Specialist)	RS	3
ZYVOX TAB (Restricted to Infectious Disease Specialist)	RS	3
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	1
MALARONE TAB	-	2
ANTIMALARIALS		
chloroquine tab (ARALEN equiv)	-	1
hydroxychloroquine tab (PLAQUENIL equiv)	-	1
mefloquine tab (LARIAM equiv)	-	1
PRIMAQUINE TAB	-	2
ARALEN TAB	-	3
LARIAM TAB	-	3
PLAQUENIL TAB	-	3
DARAPRIM TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine CR tab (MESTINON equiv)	-	1
pyridostigmine tab (MESTINON equiv)	-	1
PROSTIGMIN TAB	-	2
GUANIDINE TAB	-	3
MESTINON TAB	-	3
MESTINON TIMESPAN TAB	-	3
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFAMATE CAP	-	2
ANTIMYCOBACTERIAL AGENTS		
ethambutol tab (MYAMBUTOL equiv)	-	1
ISONIAZID SYRUP	-	1
isoniazid tab	-	1
pyrazinamide tab	-	1
rifabutin cap (MYCOBUTIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
rifampin cap (RIFADIN equiv)	-	1
PRIFTIN TAB	-	2
MYAMBUTOL TAB	-	3
MYCOBUTIN CAP	-	3
RIFADIN CAP	-	3
TRECTOR TAB	-	3
ANTINEOPLASTICS		
ANTINEOPLASTICS MISC.		
tretinoin cap (VESANOID equiv)	MSP	4
MITOTIC INHIBITORS		
etoposide cap (VEPESID equiv)	MSP	4
TOPOISOMERASE I INHIBITORS		
HYCANTIN CAP	MSP-PA	4
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
cyclophosphamide tab (CYTOXAN equiv)	-	1
GLEOSTINE/LOMUSTINE CAP	-	1
ALKERAN TAB	-	2
CYCLOPHOSPHAMIDE CAP	-	2
HEXALEN CAP	-	2
LEUKERAN TAB	-	2
CEENU CAP	-	3
AFINITOR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4
MYLERAN TAB	MSP	4
temozolomide cap (TEMODAR equiv)	MSP	4
melphalan inj (ALKERAN equiv)	M	M
ANTIMETABOLITES		
mercaptopurine tab (PURINETHOL equiv)	-	1
methotrexate inj	-	1
methotrexate tab (Trexall equiv)	-	1
METHOTREXATE INJ	-	2
TABLOID TAB	-	2
TREXALL TAB	-	2
PURINETHOL TAB	-	3
capecitabine tab (XELODA equiv)	MSP	4
fludarabine inj	M	M
ANTINEOPLASTIC - ANTIBODIES		
RITUXAN INJ	M	M
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP	MSP-PA-SF	4
ODOMZO CAP (QL= 1 cap/day)	MSP-PA-QL-SF	4
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
anastrozole tab (ARIMIDEX equiv)	-	1
bicalutamide tab (CASODEX equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
exemestane tab (AROMASIN equiv)	-	1
flutamide cap (EULEXIN equiv)	-	1
letrozole tab (FEMARA equiv)	-	1
megestrol susp (MEGACE equiv)	-	1
megestrol tab (MEGACE equiv)	-	1
EMCYT CAP	-	2
FARESTON TAB	-	2
ARIMIDEX TAB	-	3
AROMASIN TAB	-	3
CASODEX TAB	-	3
FEMARA TAB	-	3
MEGACE SUSP	-	3
ZYTIGA TAB	MSP-PA-SF	3
LYSODREN TAB	MSP	4
nilutamide tab (NILANDRON equiv) (Required through Chinese Hospital Pharmacy 415-677-2430 or Diplomat Pharmacy 877-651-4943)	MSP	4
XTANDI CAP (QL= 4 caps/day)	MSP-PA-QL-SF	4
leuprolide inj (LUPRON equiv)	INF	50%
LUPRON DEPOT INJ	INF	50%
TRELSTAR INJ	INF	50%
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB	MSP-PA	4
ANTINEOPLASTIC ENZYME INHIBITORS		
GLEEVEC TAB ()	MSP-PA-SF	3
SPRYCEL TAB	MSP-PA-SF	3
AFINITOR DISPERZ (QL= 1 tab/day)	MSP-PA-QL-SF	4
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL-SF	4
BOSULIF TAB	MSP-PA-SF	4
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	4
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	4
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	4
FARYDAK CAP (QL= 6 caps/21 days; Required through Chinese Hospital Pharmacy 415-677-2430 or Diplomat Pharmacy 877-651-4943)	MSP-PA-QL	4
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	4
ICLUSIG TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	4
IMBRUVICA CAP (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	4
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	4
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	4
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
LYNPARZA CAP (Only available through Biologics 800-850-4306)	LD-PA-SF	4
MEKINIST TAB	MSP-PA	4
NEXAVAR TAB	MSP-PA-SF	4
NINLARO CAP	MSP-PA	4
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4
SUTENT CAP	MSP-PA-SF	4
TAFINLAR CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	4
TARCEVA TAB	MSP-PA-SF	4
TASIGNA CAP	MSP-PA-SF	4
TYKERB TAB	MSP-PA	4
VOTRIENT TAB	MSP-PA-SF	4
XALKORI CAP	MSP-PA-SF	4
ZELBORAF TAB	MSP-PA-SF	4
ZOLINZA CAP	MSP-PA-SF	4
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-SF	4
ANTINEOPLASTICS MISC.		
hydroxyurea cap (HYDREA equiv)	-	1
MATULANE CAP	-	2
PROLEUKIN INJ	-	2
HYDREA CAP	-	3
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD	4
ALFERON-N INJ	MSP	4
bexarotene cap (TARGRETIN equiv)	MSP-PA-SF	4
INTRON-A INJ	MSP	4
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	1
MESNEX TAB	MSP	4
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	1
LODOSYN TAB	-	3
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	1
trihexyphenidyl elixir (ARTANE equiv)	-	1
trihexyphenidyl tab (ARTANE equiv)	-	1
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	1
COMTAN TAB	-	3
ANTIPARKINSON DOPAMINERGICS		
amantadine cap (SYMMETREL equiv)	-	1
amantadine syrup (SYMMETREL equiv)	-	1
bromocriptine cap (PARLODEL equiv)	-	1
bromocriptine tab (PARLODEL equiv)	-	1
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	1
carbidopa/levodopa ODT (PARCOPA equiv)	-	1
carbidopa/levodopa tab (SINEMET equiv)	-	1
pramipexole ER tab (MIRAPEX ER equiv)	-	1
pramipexole tab (MIRAPEX equiv)	-	1
ropinirole ER tab (REQUIP XL equiv)	-	1
ropinirole tab (REQUIP equiv)	-	1
CARBIDOPA/ LEVODOPA/ ENTACAPONE TAB (STALEVO equiv)	-	2
MIRAPEX TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
PARCOPA ODT	-	3
PARLODEL CAP	-	3
PARLODEL TAB	-	3
REQUIP TAB	-	3
REQUIP XL TAB	-	3
RYTARY CAP (Step Therapy requires trial of carbidopa/levodopa ER)	ST	3
SINEMET CR TAB	-	3
SINEMET TAB	-	3
APOKYN INJ (Only available through Walgreens 888-347-3416)	LD	4
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	1
selegiline tab (ELDEPRYL equiv)	-	1
AZILECT TAB	-	2
ELDEPYRL CAP	-	3
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	1
lithium carbonate ER tab (LITHOBID equiv)	-	1
lithium carbonate tab	-	1
lithium citrate soln	-	1
LITHOBID TAB	-	3
ANTIPSYCHOTICS - MISC.		
ziprasidone cap (GEODON equiv)	-	1
EQUETRO CAP	-	2
GEODON CAP	-	3
BENZISOXAZOLES		
risperidone ODT (RISPERDAL M equiv)	-	1
risperidone soln (RISPERDAL equiv)	-	1
risperidone tab (RISPERDAL equiv)	-	1
RISPERDAL M ODT	-	3
RISPERDAL SOLN	-	3
RISPERDAL TAB	-	3
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	1
haloperidol tab (HALDOL equiv)	-	1
DIBENZAPINES		
clozapine ODT 25mg, 100mg (CLOZAPINE/FAZACLO equiv)	-	1
clozapine tab (CLOZARIL equiv)	-	1
loxapine cap (LOXITANE equiv)	-	1
olanzapine ODT (ZYPREXA equiv)	-	1
olanzapine tab (ZYPREXA equiv)	-	1
quetiapine tab (SEROQUEL equiv)	-	1
SEROQUEL XR TAB	-	1
CLOZAPINE ODT/FAZACLO ODT	-	2
CLOZARIL TAB	-	3
FAZACLO ODT 25MG, 100MG	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
LOXITANE CAP	-	3
SEROQUEL TAB	-	3
ZYPREXA TAB	-	3
ZYPREXA ZYDIS TAB	-	3
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	1
fluphenazine tab (PROLIXIN equiv)	-	1
perphenazine tab (TRILAFON equiv)	-	1
prochlorperazine supp (COMPAZINE equiv)	-	1
prochlorperazine tab (COMPAZINE equiv)	-	1
thioridazine tab (MELLARIL equiv)	-	1
trifluoperazine tab (STELAZINE equiv)	-	1
QUINOLINONE DERIVATIVES		
aripiprazole ODT (ABILIFY equiv)	PA	1
aripiprazole soln (ABILIFY equiv)	PA	1
aripiprazole tab (ABILIFY equiv)	-	1
ABILIFY DISCMELT	PA	3
ABILIFY SOLN	PA	3
ABILIFY TAB	-	3
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	1
NAVANE CAP	-	3

ANTIVIRALS

ANTIRETROVIRALS

abacavir tab (ZIAGEN equiv)	-	1
abacavir/ lamivudine/ zidovudine tab (TRIZIVIR equiv)	-	1
didanosine DR cap (VIDEX EC equiv)	-	1
lamivudine soln (EPIVIR equiv)	PA	1
lamivudine tab (EPIVIR equiv)	PA	1
lamivudine/zidovudine tab (COMBIVIR equiv)	-	1
nevirapine ER tab (VIRAMUNE XR equiv)	-	1
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	1
nevirapine tab (VIRAMUNE equiv)	-	1
stavudine cap (ZERIT equiv)	-	1
stavudine soln (ZERIT equiv)	-	1
VIRAMUNE SUSP	-	1
zidovudine cap (RETROVIR equiv)	-	1
zidovudine syrup (RETROVIR equiv)	-	1
zidovudine tab (RETROVIR equiv)	-	1
ATRIPLA TAB	-	2
DESCOVY TAB	PA	2
ISENTRESS CHEW TAB	-	2
ISENTRESS POWDER PACK	-	2
ISENTRESS TAB	-	2
NORVIR CAP	-	2
NORVIR SOLN	-	2
NORVIR TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
STRIBILD TAB ()	-	2
TIVICAY TAB (QL= 2 tabs/day)	QL	2
TRUVADA TAB	PA	2
VITEKTA TAB	-	3
abacavir/lamivudine tab (EPZICOM equiv)	-	4
APTIVUS CAP	-	4
APTIVUS SOLN	-	4
COMPLERA TAB	-	4
CRIXIVAN CAP	-	4
EDURANT TAB	-	4
EMTRIVA CAP	-	4
EMTRIVA SOLN	-	4
EPZICOM TAB	-	4
EVOTAZ TAB	-	4
FUZEON INJ	SP	4
GENVOYA TAB	-	4
INTELENCE TAB	-	4
INVIRASE CAP	-	4
INVIRASE TAB	-	4
KALETRA SOLN	-	4
KALETRA TAB	-	4
LEXIVA SUSP	-	4
LEXIVA TAB	-	4
ODEFSEY TAB	-	4
PREZCOBIX TAB	-	4
PREZISTA SUSP	-	4
PREZISTA TAB	-	4
RESCRIPTOR TAB	-	4
REYATAZ CAP	-	4
REYATAZ POWDER PACK	-	4
SELZENTRY TAB	-	4
SUSTIVA CAP	-	4
SUSTIVA TAB	-	4
TRIUMEQ TAB	-	4
VIDEX SOLN	-	4
VIRACEPT POWDER	-	4
VIRACEPT TAB	-	4
VIREAD TAB	PA	4
CMV AGENTS		
valganciclovir soln (VALCYTE equiv)	-	1
valganciclovir tab (VALCYTE equiv)	-	1
GANCICLOVIR CAP	-	2
VALCYTE SOLN	-	3
VALCYTE TAB	-	3
HEPATITIS AGENTS		
lamivudine tab 100mg (EPIVIR HBV equiv)	PA	1
ribavirin cap (REBETOL equiv)	MSP	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ribavirin tab (COPEGUS equiv)	MSP	1
adefovir dipivoxil tab (HEPSERA equiv)	MSP-PA	4
BARACLUDE SOLN	MSP-PA	4
DAKLINZA TAB (QL= 1 tab/day)	MSP-PA-QL	4
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	PA-QL	4
EPIVIR HBV SOLN	PA	4
HARVONI TAB (QL= 1 tab/day)	MSP-PA-QL	4
INCIVEK TAB	MSP-PA-SF	4
INFERGEN INJ	MSP	4
PEGASYS INJ	MSP-PA	4
PEGASYS INJ KIT	MSP-PA	4
PEG-INTRON INJ	MSP-PA	4
REBETOL SOLN	MSP	4
SOVALDI TAB (QL= 1 tab/day)	MSP-PA-QL	4
TYZEKA TAB	MSP-PA	4
VICTRELIS CAP	MSP-PA-SF	4
ZEPATIER TAB (QL= 1 tab/day)	MSP-PA-QL	4
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	1
acyclovir susp (ZOVIRAX equiv)	-	1
acyclovir tab (ZOVIRAX equiv)	-	1
famciclovir tab (FAMVIR equiv)	-	1
valacyclovir tab (VALTREX equiv)	-	1
FAMVIR TAB	-	3
VALTREX TAB	-	3
ZOVIRAX CAP	-	3
ZOVIRAX SUSP	-	3
ZOVIRAX TAB	-	3
INFLUENZA AGENTS		
rimantadine tab (FLUMADINE equiv)	-	1
RELENZA DISKHALER (QL= 1 inhaler/fill)	QL	2
TAMIFLU CAP (QL= 10 caps/fill)	QL	2
TAMIFLU CAP 30MG (QL= 20 caps/fill)	QL	2
TAMIFLU SUSP 6MG/ML (QL= 250ml/fill)	QL	2
FLUMADINE TAB	-	3
ASSORTED CLASSES		
CHELATING AGENTS		
DEPEN TITRATAB	-	2
IMMUNOMODULATORS		
REVLIMID CAP (QL= 1 cap/day; Not available through Chinese Hospital Pharmacy-use Diplomat)	MSP-PA-QL	3
THALOMID CAP	MSP-PA	4
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	1
IMURAN TAB	-	3
cyclosporine cap (SANDIMMUNE equiv)	-	4
cyclosporine modified cap (NEORAL equiv)	-	4
cyclosporine modified soln (NEORAL equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
mycophenolate DR tab (MYFORTIC equiv)	-	4
mycophenolate mofetil cap (CELLCEPT equiv)	-	4
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	4
mycophenolate mofetil tab (CELLCEPT equiv)	-	4
RAPAMUNE SOLN	-	4
SANDIMMUNE SOLN 100MG/ML	-	4
sirolimus tab (RAPAMUNE equiv)	-	4
tacrolimus cap (PROGRAF equiv)	-	4
ZORTRESS TAB	PA	4
POTASSIUM REMOVING RESINS		
sodium polystyrene powder (KAYEXALATE equiv)	-	1
sodium polystyrene susp (SPS equiv)	-	1
KAYEXALATE POWDER	-	3
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	1
labetalol tab (NORMODYNE equiv)	-	1
COREG TAB	-	3
TRANDATE TAB	-	3
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	1
atenolol tab (TENORMIN equiv)	-	1
betaxolol tab (KERLONE equiv)	-	1
bisoprolol tab (ZEBETA equiv)	-	1
metoprolol ER tab (TOPROL XL equiv)	-	1
metoprolol tab (LOPRESSOR equiv)	-	1
BYSTOLIC TAB	-	2
KERLONE TAB	-	3
LOPRESSOR TAB	-	3
SECTRAL CAP	-	3
TENORMIN TAB	-	3
TOPROL XL TAB	-	3
ZEBETA TAB	-	3
BETA BLOCKERS NON-SELECTIVE		
INNOPRAN XL CAP	-	1
nadolol tab (CORGARD equiv)	-	1
pindolol tab (VISKEN equiv)	-	1
propranolol ER cap (INDERAL LA equiv)	-	1
PROPRANOLOL SOLN	-	1
propranolol tab (INDERAL equiv)	-	1
sotalol AF tab (BETAPACE AF equiv)	-	1
sotalol tab (BETAPACE equiv)	-	1
timolol maleate tab (BLOCADREN equiv)	-	1
BETAPACE AF TAB	-	3
BETAPACE TAB	-	3
CORGARD TAB	-	3
INDERAL LA CAP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	LD	generic =small letters Limited Distribution	M	BRANDS =CAPITAL LETTERS Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
----------	--------------	------

BIOLOGICALS MISC

BIOLOGICALS MISC

ADAGEN INJ	M	M
------------	---	---

CALCIUM CHANNEL BLOCKERS

CALCIUM CHANNEL BLOCKERS

amlodipine tab (NORVASC equiv)	-	1
diltiazem ER cap (CARDIZEM CD equiv)	-	1
diltiazem ER cap (CARDIZEM SR equiv)	-	1
diltiazem ER cap (DILACOR XR equiv)	-	1
diltiazem ER cap (TIAZAC equiv)	-	1
diltiazem ER tab (CARDIZEM LA equiv)	-	1
diltiazem tab (CARDIZEM equiv)	-	1
felodipine ER tab (PLENDIL equiv)	-	1
isradipine cap (DYNACIRC equiv)	-	1
nicardipine cap (CARDENE equiv)	-	1
nifedipine cap (PROCARDIA equiv)	-	1
nifedipine ER tab (ADALAT CC equiv)	-	1
nimodipine cap (NIMOTOP equiv)	-	1
nisoldipine ER tab (SULAR equiv)	-	1
NISOLDIPINE ER TAB 25.5MG	-	1
verapamil SR cap (VERELAN PM equiv)	-	1
verapamil SR cap (VERELAN SR equiv)	-	1
verapamil SR tab (CALAN SR/ISOPTIN SR equiv)	-	1
verapamil tab (CALAN equiv)	-	1
ADALAT CC TAB	-	3
CALAN SR TAB	-	3
CALAN TAB	-	3
CARDIZEM CD CAP	-	3
CARDIZEM LA TAB	-	3
CARDIZEM TAB	-	3
DILACOR XR CAP	-	3
NIMOTOP CAP	-	3
NORVASC TAB	-	3
PLENDIL TAB	-	3
PROCARDIA CAP	-	3
SULAR TAB	-	3
TIAZAC CAP	-	3
VERELAN CAP	-	3
VERELAN PM CAP	-	3

CARDIOTONICS

CARDIAC GLYCOSIDES

digoxin soln (LANOXIN equiv)	-	1
digoxin tab (LANOXIN equiv)	-	1
LANOXIN TAB	-	3

CARDIOVASCULAR AGENTS - MISC.

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

amlodipine/atorvastatin tab (CADUET equiv)	-	1
--	---	---

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
ENTRESTO TAB	PA	2
IMPOTENCE AGENTS		
VIAGRA TAB (QL= 6 tabs/30 days)	QL	2
CIALIS TAB 2.5MG, 5MG (PAH Only: Additional criteria required)	PA	4
PROSTAGLANDIN VASODILATORS		
TYVASO INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	4
VENTAVIS INH SOLN (Only available through Accredo 888-773-7376)	LD-PA	4
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
LETAIRIS TAB (QL= 1 tab/day)	PA-QL-SP	4
OPSUMIT TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
TRACLEER TAB (QL= 2 tabs/day)	PA-QL-SP	4
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab (REVATIO equiv)	PA	1
ADCIRCA TAB	MSP-PA	4
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
SINUS NODE INHIBITORS		
CORLANOR TAB	PA	3
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	1
cefadroxil susp (DURICEF equiv)	-	1
cefadroxil tab (DURICEF equiv)	-	1
cephalexin cap (KEFLEX equiv)	-	1
cephalexin susp (KEFLEX equiv)	-	1
CEPHALEXIN TAB	-	1
KEFLEX CAP	-	3
CEFAZOLIN INJ	M	M
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap (CECLOR equiv)	-	1
cefprozil susp (CEFZIL equiv)	-	1
cefprozil tab (CEFZIL equiv)	-	1
cefuroxime susp (CEFTIN equiv)	-	1
cefuroxime tab (CEFTIN equiv)	-	1
CEFTIN TAB	-	3
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	1
cefdinir susp (OMNICEF equiv)	-	1
cefixime susp (SUPRAX equiv)	-	1
cefpodoxime proxetil susp (VANTIN equiv)	-	1
cefpodoxime proxetil tab (VANTIN equiv)	-	1
OMNICEF SUSP	-	3
SUPRAX SUSP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
SUPRAX SUSP 500MG/5ML	-	3
SUPRAX TAB	-	3
VANTIN TAB	-	3

CONTRACEPTIVES

COMBINATION CONTRACEPTIVES - ORAL

apri tab (DESOGEN equiv)	-	\$0
aranelle tab (TRI-NORINYL equiv)	-	\$0
aviane tab (ALESSE equiv)	-	\$0
BEYAZ TAB	-	\$0
cesia tab (CYCLESSA equiv)	-	\$0
cryselle tab (OGESTREL equiv)	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
jolessa tab/ amethia tab (SEASONALE/SEASONIQUE equiv) (3 copays per Rx)	-	\$0
junel FE tab (LOESTRIN FE equiv)	-	\$0
junel tab (LOESTRIN equiv)	-	\$0
kariva tab (MIRCETTE equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
LO LOESTRIN TAB	-	\$0
mononessa tab (ORTHO-CYCLEN equiv)	-	\$0
necon tab (ORTHO-NOVUM equiv)	-	\$0
necon tab 1/50 (NORYNIL equiv)	-	\$0
nortrel tab (OVCON 35 equiv)	-	\$0
tri-legest tab (ESTROSTEP FE equiv)	-	\$0
tri-nessa (LO) tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0
wymzya FE tab (FEMCON FE equiv)	-	\$0
YASMIN TAB	-	\$0
YAZ TAB	-	\$0
CYCLESSA TAB	-	3
DESOGEN TAB	-	3
ESTROSTEP FE TAB	-	3
FEMCON FE CHEW TAB	-	3
LOESTRIN FE TAB	-	3
LOESTRIN TAB	-	3
MIRCETTE TAB	-	3
ORTHO TRI-CYCLEN (LO) TAB	-	3
ORTHO-CYCLEN TAB	-	3
OVCON 35 TAB	-	3
SEASONIQUE TAB	-	3
TRI-NORINYL TAB	-	3

COMBINATION CONTRACEPTIVES - TRANSDERMAL

XULANE PATCH	-	\$0
ORTHO-EVRA PATCH	-	3

COMBINATION CONTRACEPTIVES - VAGINAL

NUVARING	-	\$0
----------	---	-----

EMERGENCY CONTRACEPTIVES

ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
LEVONORGESTREL TAB 0.75MG	-	\$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	\$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	\$0
DEPO-PROVERA INJ	QL	3
DEPO-PROVERA INJ (QL = 1 inj/90 day)	QL	3
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	\$0
NOR-QD TAB	-	3
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
budesonide SR cap (ENTOCORT EC equiv)	-	1
CORTEF TAB	-	1
DEXAMETHASONE CONC	-	1
dexamethasone elixir	-	1
dexamethasone soln	-	1
DEXAMETHASONE TAB	-	1
dexamethasone tab (DECADRON equiv)	-	1
hydrocortisone tab (CORTEF equiv)	-	1
MEDROL TAB	-	1
methylprednisolone dose pack (MEDROL equiv)	-	1
methylprednisolone tab (MEDROL equiv)	-	1
prednisolone ODT (ORAPRED equiv)	-	1
prednisolone soln (PEDIAPRED equiv)	-	1
prednisolone syrup (PRELONE equiv)	-	1
PREDNISONE SOLN	-	1
PREDNISONE TAB	-	1
prednisone tab (DELTASONE equiv)	-	1
CORTISONE ACETATE TAB	-	2
ORAPRED ODT	-	2
PREDNISONE PAK	-	2
ENTOCORT EC CAP	-	3
MEDROL DOSE PACK	-	3
MEDROL TAB	-	3
ORAPRED ODT	-	3
ORAPRED SOLN	-	3
PRELONE SYRUP	-	3
MINERALOCORTICIDS		
fludrocortisone tab (FLORINEF equiv)	-	1
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap (TESSALON equiv)	-	1
hydrocodone/homatropine syrup (HYCODAN equiv)	-	1
tussigon tab (HYCODAN equiv)	-	1
BENZONATATE CAP	-	3
HYCODAN SYRUP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
TESSALON CAP	-	3
COUGH/COLD/ALLERGY COMBINATIONS		
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	1
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	1
phenylephrine/chlorpheniramine DM tab (ZOTEX equiv)	-	1
promethazine DM syrup	-	1
promethazine VC syrup (PHENERGAN VC equiv)	-	1
promethazine VC w/codeine syrup (PHENERGAN VC W/CODIENE equiv)	-	1
promethazine w/codeine syrup (PHENERGAN W/CODIENE equiv)	-	1
pseudoephedrine/brompheniramine/codeine liquid (CPB WC equiv)	OTC	1
POLY HIST DM LIQUID	-	3
RYDEX	OTC	3
SUTTAR SF SYRUP	-	3
TUSSIONEX SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	3
MISC. RESPIRATORY INHALANTS		
sodium chloride neb soln (HYPER-SAL equiv)	-	1
NEBUSAL NEB SOLN	-	2
HYPER-SAL NEB SOLN	-	3
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	1
DERMATOLOGICALS		
ACNE PRODUCTS		
adapalene cream (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1
adapalene gel 0.1% (DIFFERIN equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1
clindamycin gel (CLEOCIN GEL equiv)	-	1
clindamycin lotion (CLEOCIN- T equiv)	-	1
clindamycin pad (CLEOCIN-T equiv)	-	1
clindamycin topical soln (CLEOCIN-T equiv)	-	1
clindamycin/ benzoyl peroxide gel (DUAC GEL equiv)	-	1
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	1
DIFFERIN GEL 0.3% (Acne Only – members age 35 or older require Prior Authorization)	PA	1
erythromycin gel	-	1
erythromycin pad	-	1
erythromycin soln	-	1
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	1
isotretinoin cap (AC CUTANE equiv)	-	1
sodium sulfacetamide lotion (KLARON equiv)	-	1
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	1
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	1
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	1
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	1
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	1
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	1
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	1
sodium sulfacetamide/sulfur susp (SUMAXIN equiv)	-	1
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	LD	generic =small letters Limited Distribution	M	BRANDS =CAPITAL LETTERS Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
tretinoin cream (Acne Only – members age 35 or older require Prior Authorization)	PA	1
tretinoin gel (RETIN-A GEL equiv) (Acne Only – members age 35 or older require Prior Authorization)	PA	1
ADAPALENE LOTION (Acne Only – members age 35 or older require Prior Authorization)	PA	2
AVAR GEL	-	2
EPIDUO (FORTE) GEL (Acne Only – members age 35 or older require Prior Authorization)	PA	2
PRASCION RA CREAM	-	2
RETIN-A MICRO GEL 0.04%, 0.1% (Acne Only – members age 35 or older require Prior Authorization)	PA	2
BENZACLIN GEL	-	3
BENZAMYCIN GEL	-	3
CLARIFOAM EF FOAM	-	3
CLEOCIN-T GEL	-	3
CLEOCIN-T LOTION	-	3
CLEOCIN-T PAD	-	3
CLEOCIN-T SOLN	-	3
DIFFERIN CREAM	PA	3
DIFFERIN GEL 0.1%	PA	3
DIFFERIN LOTION	PA	3
DUAC GEL	-	3
KLARON LOTION	-	3
PLEXION LOTION	-	3
PLEXION SCT CREAM	-	3
RETIN-A CREAM	PA	3
RETIN-A GEL	PA	3
ROSULA EMULSION	-	3
ROSULA GEL	-	3
SUMAXIN PAD	-	3
SUMAXIN TS SUSP	-	3
SUMAXIN WASH	-	3
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream	-	1
gentamicin sulfate oint	-	1
mupirocin cream (BACTROBAN equiv)	-	1
mupirocin oint (BACTROBAN OINT equiv)	-	1
BACTROBAN CREAM	-	3
BACTROBAN OINT	-	3
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	1
ciclopirox gel (LOPROX GEL equiv)	-	1
ciclopirox nail soln (PENLAC equiv)	-	1
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	1
ciclopirox topical susp (LOPROX SUSP equiv)	-	1
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	1
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	1
econazole cream (SPECTAZOLE equiv)	-	1
ketoconazole cream (NIZORAL CREAM equiv)	-	1
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	1
naftifine cream 2% (NAFTIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Mandatory Specialty Pharmacy Program	OTC	Limited Distribution	PA	Medical Benefit
QL	Quantity Limit	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Smoking Cessation	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Vaccine Program		Available through Specialty Pharmacy Program		Step Therapy

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
nystatin cream (MYCOSTATIN CREAM equiv)	-	1
nystatin oint	-	1
nystatin topical powder	-	1
nystatin/triamcinolone cream	-	1
nystatin/triamcinolone oint	-	1
oxiconazole nitrate cream (OXISTAT equiv)	-	1
LOPROX CREAM	-	3
LOPROX GEL	-	3
LOPROX SHAMPOO	-	3
LOTRISONE CREAM	-	3
LOTRISONE LOTION	-	3
NAFTIFINE CREAM 1%	-	3
NAFTIN CREAM	-	3
NAFTIN GEL	-	3
NIZORAL SHAMPOO	-	3
OXISTAT CREAM	-	3
OXISTAT LOTION	-	3
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	1
VOLTAREN GEL (QL= 5 tubes/fill)	QL	3
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
diclofenac gel (SOLARAZE equiv)	PA	1
fluorouracil cream (EFUDEX CREAM equiv)	-	1
fluorouracil soln (EFUDEX SOLN equiv)	-	1
CARAC CREAM	-	2
FLUOROPLEX CREAM	-	2
EFUDEX CREAM	-	3
EFUDEX SOLN	-	3
SOLARAZE GEL	PA	3
TARGRETIN GEL	SP	4
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 888-773-7376)	LD-PA-QL	4
ANTIPSORIATICS		
acitretin cap (SORIATANE equiv)	-	1
calcipotriene cream (DOVONEX CREAM equiv)	-	1
calcipotriene oint	-	1
calcipotriene soln (DOVONEX SOLN equiv)	-	1
methoxsalen cap (OXSORALEN ULTRA equiv)	-	1
8-MOP CAP	-	2
SORIATANE CK KIT	-	2
VECTICAL OINT	-	2
DOVONEX CREAM	-	3
DOVONEX SOLN	-	3
OXSORALEN ULTRA CAP	-	3
SORIATANE CAP	-	3
COSENTYX INJ (QL= 2 inj/28 days)	MSP-PA-QL	4
ANTISEBORRHEIC PRODUCTS		
seb-prev cream (OVACE CREAM equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
selenium sulfide lotion	-	1
sodium sulfacetamide shampoo (OVACE equiv)	-	1
sodium sulfacetamide wash (OVACE WASH equiv)	-	1
sodium sulfacetamide/ urea pad (ROSULA equiv)	-	1
OVACE PLUS SHAMPOO	-	3
OVACE WASH	-	3
ROSULA PAD	-	3
ANTIVIRALS - TOPICAL		
DENA VIR CREAM	-	2
acyclovir oint (ZOVIRAX OINT equiv) (Step Therapy requires trial of one of the following oral medications: acyclovir, famciclovir, valacyclovir)	ST	4
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	1
SULFAMYLON CREAM	-	2
SILVADENE CREAM	-	3
CORTICOSTEROIDS - TOPICAL		
alclometasone cream (ACLOVATE equiv) (QL= 60gm/fill)	QL	1
alclometasone oint (ACLOVATE OINT equiv) (QL= 60gm/fill)	QL	1
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	1
betamethasone augmented gel (DIPROLENE GEL equiv)	-	1
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	1
betamethasone augmented oint (DIPROLENE OINT equiv)	-	1
betamethasone dipropionate cream (DIPROSONE CREAM equiv) (QL= 45gm/fill)	QL	1
betamethasone dipropionate lotion (QL= 60gm/fill)	QL	1
betamethasone dipropionate oint (DIPROSONE OINT equiv) (QL= 45gm/fill)	QL	1
betamethasone valerate cream (QL= 45gm/fill)	QL	1
betamethasone valerate lotion (QL= 60gm/fill)	QL	1
betamethasone valerate oint (QL= 45gm/fill)	QL	1
calcipotriene/ betamethasone oint (TACLONEX equiv)	-	1
clobetasol foam (OLUX equiv)	PA	1
clobetasol lotion (CLOBEX equiv)	PA	1
clobetasol propionate cream (TEMOVATE equiv) (QL= 30gm/fill)	PA-QL	1
clobetasol propionate emollient cream (TEMOVATE E equiv)	PA	1
clobetasol propionate gel (TEMOVATE GEL equiv)	PA	1
clobetasol propionate oint (TEMOVATE equiv) (QL= 30gm/fill)	PA-QL	1
clobetasol propionate soln (TEMOVATE equiv)	PA	1
clobetasol shampoo (CLOBEX equiv)	PA	1
desoximetasone cream 0.25% (TOPICORT CREAM 0.25% equiv) (QL= 60gm/fill)	QL	1
diflorasone oint	-	1
fluocinolone acetonide cream	-	1
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	1
fluocinolone acetonide oint	-	1
fluocinolone acetonide soln	-	1
fluocinonide cream (LIDEX equiv)	-	1
fluocinonide emollient cream (QL= 30gm/fill)	QL	1
fluocinonide gel	-	1
fluocinonide oint	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
fluocinonide soln	-	1
fluticasone propionate cream (CUTIVATE equiv)	-	1
fluticasone propionate oint (CUTIVATE equiv)	-	1
halobetasol propionate cream (ULTRAVATE equiv) (QL= 50gm/fill)	PA-QL	1
halobetasol propionate oint (ULTRAVATE equiv) (QL= 50gm/fill)	PA-QL	1
hydrocortisone cream (PROCTOCORT equiv)	-	1
hydrocortisone lotion (HYTONE equiv)	-	1
hydrocortisone oint	-	1
mometasone cream (ELOCON equiv)	-	1
mometasone oint (ELOCON equiv)	-	1
mometasone soln (ELOCON equiv)	-	1
prednicarbate cream (DERMATOP equiv)	-	1
prednicarbate oint (DERMATOP equiv)	-	1
triamcinolone cream	-	1
triamcinolone lotion	-	1
triamcinolone oint	-	1
EPIFOAM AEROSOL	-	2
PRAMOSONE CREAM 1%	-	2
PRAMOSONE OINT	-	2
TOPICORT/DESOXIMETASONE CREAM 0.05% (QL= 60gm/fill)	QL	2
U-CORT CREAM	-	2
ACLOVATE CREAM (QL= 60gm/fill)	QL	3
ACLOVATE OINT (QL= 60gm/fill)	QL	3
CARMOL-HC CREAM	-	3
CLOBEX LOTION	PA	3
CLOBEX SHAMPOO	PA	3
CUTIVATE CREAM	-	3
CUTIVATE OINT	-	3
DERMA-SMOOTH/FS OIL	-	3
DERMATOP CREAM	-	3
DERMATOP OINT	-	3
DIPROLENE AF CREAM	-	3
DIPROLENE LOTION	-	3
DIPROLENE OINT	-	3
ELOCON CREAM	-	3
ELOCON OINT	-	3
ELOCON SOLN	-	3
HYTONE LOTION	-	3
OLUX FOAM	PA	3
PROCTOCORT CREAM	-	3
TACLONEX OINT	-	3
TEMOVATE CREAM (QL= 30gm/fill)	PA-QL	3
TEMOVATE GEL	PA	3
TEMOVATE OINT (QL= 30gm/fill)	PA-QL	3
TEMOVATE SOLN	PA	3
TEMOVATE-E CREAM	PA	3
TOPICORT CREAM 0.25% (QL= 60gm/fill)	QL	3
ULTRAVATE CREAM (QL= 50gm/fill)	PA-QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ULTRAVATE LOTION (QL= 60ml/fill)	PA-QL	3
ULTRAVATE OINT (QL= 50gm/fill)	PA-QL	3
VANOS CREAM	-	3
EMOLLIENT/KERATOLYTIC AGENTS		
GORDON'S UREA OINT 40%	-	2
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	-	1
ammonium lactate lotion (LAC-HYDRIN equiv)	-	1
LAC-HYDRIN CREAM	-	3
LAC-HYDRIN LOTION	-	3
ENZYMES - TOPICAL		
SANTYL OINT	-	2
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	1
ALDARA CREAM	-	3
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
tacrolimus oint (PROTOPIC OINT equiv)	-	1
ELIDEL CREAM	-	2
PROTOPIC OINT	-	3
KERATOLYTIC/ANTIMITOTIC AGENTS		
podofilox soln (CONDYLOX equiv)	-	1
salicylic acid shampoo (SALEX equiv)	-	1
PODOCON SOLN	-	2
CONDYLOX SOLN	-	3
SALEX SHAMPOO	-	3
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	1
lidocaine gel (XYLOCAINE equiv)	-	1
lidocaine oint (QL= 50gm/30 days; Step Therapy requires trial of lidocaine cream 5%)	QL-ST	1
lidocaine patch (LIDODERM equiv) (QL= 1 patch/day)	PA-QL	1
lidocaine soln (XYLOCAINE equiv)	-	1
lidocaine/prilocaine cream (EMLA equiv)	-	1
EMLA CREAM	-	3
LIDODERM PATCH (QL= 1 patch/day)	PA-QL	3
SOLARCAINE EXTRA GEL	-	3
XYLOCAINE SOLN	-	3
MISC. TOPICAL		
aluminum chloride soln (DRYSOL equiv)	-	1
DRYSOL SOLN	-	1
ROSACEA AGENTS		
metronidazole cream (METROCREAM equiv)	-	1
metronidazole gel (METROGEL equiv)	-	1
metronidazole lotion (METROLOTION equiv)	-	1
FINACEA FOAM	-	2
FINACEA GEL	-	2
FINACEA PLUS KIT	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
METROCREAM	-	3
METROGEL 1% (Step Therapy requires trial of FINACEA)	ST	3
METROLOTION	-	3
SCABICIDES & PEDICULICIDES		
lindane lotion	-	1
lindane shampoo	-	1
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	1
permethrin cream (ELIMITE CREAM equiv)	-	1
EURAX CREAM	-	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	2
ELIMITE CREAM	-	3
LINDANE LOTION	-	3
OVIDE LOTION (QL= 2 bottles/fill)	QL	3
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	2
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	2
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	2
DIAGNOSTIC TESTS		
CLINISTIX TEST STRIP	OTC	1
KETO-DIASTIX TEST STRIP	OTC	1
KETOSTIX	OTC	1
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC	2
ACCU-CHEK SMARTVIEW TEST STRIP	OTC	2
ACCU-CHEK TEST STRIP	OTC	2
FREESTYLE INSULINX TEST STRIP	OTC	2
FREESTYLE TEST STRIP	OTC	2
PRECISION XTRA TEST STRIP	OTC	2
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	2
PANCREAZE CAP	-	2
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	1
acetazolamide tab	-	1
ACETAZOLAMIDE TAB 125MG	-	1
methazolamide tab (NEPTAZANE equiv)	-	1
DIAMOX SEQUEL CAP	-	3
NEPTAZANE TAB	-	3
DIURETIC COMBINATIONS		
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	1
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
DIURETICS Cont.		
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	1
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	1
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	2
ALDACTAZIDE TAB	-	3
DYAZIDE CAP	-	3
MAXZIDE TAB	-	3
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	1
ethacrynic tab (EDECIN equiv)	-	1
FUROSEMIDE SOLN	-	1
furosemide soln (LASIX equiv)	-	1
furosemide tab (LASIX equiv)	-	1
toremide tab (DEMADEX equiv)	-	1
DEMADEX TAB	-	3
EDECIN TAB	-	3
LASIX TAB	-	3
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	1
spironolactone tab (ALDACTONE equiv)	-	1
DYRENIUM CAP	-	2
ALDACTONE TAB	-	3
MIDAMOR TAB	-	3
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorothiazide tab (DIURIL equiv)	-	1
CHLOROTHIAZIDE TAB 250MG	-	1
chlorthalidone tab	-	1
hydrochlorothiazide cap (MICROZIDE equiv)	-	1
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	1
indapamide tab (LOZOL equiv)	-	1
METHYCLOTHIAZIDE TAB	-	1
metolazone tab (ZAROXOLYN equiv)	-	1
DIURIL SUSP	-	2
MICROZIDE CAP	-	3
ZAROXOLYN TAB	-	3
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	1
ETIDRONATE DISODIUM TAB 400MG	-	1
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	1
risedronate tab (ACTONEL equiv)	-	1
ALENDRONATE TAB 40MG	-	2
FORTICAL NASAL SPRAY	-	2
ACTONEL TAB	-	3
BONIVA TAB 150MG (QL= 1 tab/30 days; Step Therapy requires trial of alendronate)	QL-ST	3
NATPARA INJ (QL= 1 inj/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	4
CALCIUM REGULATORS - MISC.		
calcitonin nasal spray (MIACALCIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
etidronate disodium tab 200mg (DIDRONEL equiv)	-	1
FOSAMAX TAB	-	3
MIACALCIN NASAL SPRAY	-	3
FORTEO INJ	MSP	4
MIACALCIN INJ	MSP	4
FERTILITY REGULATORS		
BRAVELLE INJ	INF	50%
CLOMID TAB	INF	50%
CLOMIPHENE CITRATE POWDER	INF	50%
clomiphene citrate tab (CLOMID equiv)	INF	50%
FOLLISTIM AQ INJ	INF	50%
GONAL-F RFF INJ	INF	50%
LUVERIS INJ	INF	50%
OVIDREL INJ	INF	50%
pregnyl inj (PROFASI equiv)	INF	50%
REPRONEX INJ	INF	50%
GNRH/LHRH ANTAGONISTS		
CETROTIDE INJ	INF	50%
GANIRELIX AC INJ	INF	50%
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	4
GROWTH HORMONES		
NORDITROPIN INJ	MSP-PA	4
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
EVISTA TAB	-	3
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ	MSP	4
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	-	2
LUPRON DEPOT PED INJ	INF	50%
LUPRON DEPOT-PED INJ	INF	50%
METABOLIC MODIFIERS		
calcitriol cap (ROCALTRONL equiv)	-	1
calcitriol soln (ROCALTRONL equiv)	-	1
doxercalciferol cap (HECTOROL equiv)	-	1
levocarnitine soln (CARNITOR equiv)	-	1
levocarnitine tab (CARNITOR equiv)	-	1
paricalcitol cap (ZEMPLAR equiv)	-	1
SENSIPAR TAB	-	2
CARNITOR TAB	-	3
HECTOROL CAP	-	3
ROCALTRONL CAP	-	3
ROCALTRONL SOLN	-	3
ZEMPLAR CAP	-	3
BUPHENYL TAB	PA-SP	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
calcitriol inj (CALCIJEX equiv)	MSP	4
KUVAN TAB (Only available through Walgreens 888-347-3416)	LD-PA	4
ORFADIN CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4
sodium phenylbutyrate powder (BUPHENYL equiv)	PA-SP	4
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	4
ALDURAZYME INJ	M	M
FABRAZYME INJ	M	M
POSTERIOR PITUITARY HORMONES		
desmopressin acetate inj (DDAVP equiv)	-	1
desmopressin acetate nasal spray (DDAVP equiv)	-	1
desmopressin acetate tab (DDAVP equiv)	-	1
desmopressin nasal soln (DDAVP equiv)	-	1
STIMATE NASAL SOLN	-	2
DDAVP INJ	-	3
DDAVP NASAL SOLN	-	3
DDAVP NASAL SPRAY	-	3
DDAVP TAB	-	3
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	1
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	MSP	4
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 888-773-7376)	LD-PA-QL	4
ESTROGENS		
ESTROGEN COMBINATIONS		
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	1
jinteli tab (FEMHRT equiv)	-	1
DUAVEE TAB	-	2
PREMPHASE/PREMPRO TAB	-	2
ACTIVEVELLA TAB	-	3
COMBIPATCH	-	3
FEMHRT TAB	-	3
ESTROGENS		
estradiol patch (CLIMARA equiv)	-	1
estradiol patch (VIVELLE-DOT equiv)	-	1
estradiol tab (ESTRACE equiv)	-	1
ESTROPIPATE TAB	-	1
estropipate tab (OGEN equiv)	-	1
PREMARIN TAB	-	2
CLIMARA PATCH	-	3
ESTRACE TAB	-	3
VIVELLE-DOT PATCH	-	3
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin ER tab (CIPRO XR equiv)	-	1
ciprofloxacin susp (CIPRO equiv)	-	1
ciprofloxacin tab (CIPRO equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
levofloxacin soln (LEVAQUIN equiv)	-	1
levofloxacin tab (LEVAQUIN equiv)	-	1
moxifloxacin tab (AVELOX equiv)	-	1
ofloxacin tab (FLOXIN equiv)	-	1
AVELOX TAB	-	3
CIPRO SUSP	-	3
CIPRO TAB	-	3
CIPRO XR TAB	-	3
CIPROFLOXACIN 100MG TAB	-	3
LEVAQUIN SOLN	-	3
LEVAQUIN TAB	-	3
FACTIVE TAB	-	4
GASTROINTESTINAL AGENTS - MISC.		
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	4
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	1
ursodiol tab (URSO (FORTE) equiv)	-	1
ACTIGALL CAP	-	3
URSO FORTE TAB	-	3
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	1
GASTROCROM CONC	-	2
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
AMITIZA CAP	PA	2
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	1
metoclopramide tab (REGLAN equiv)	-	1
REGLAN TAB	-	3
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	1
mesalamine enema (ROWASA equiv)	-	1
sulfasalazine EC tab (AZULFIDINE equiv)	-	1
sulfasalazine tab (AZULFIDINE equiv)	-	1
APRISO CAP	-	2
ASACOL HD/MESALAMINE TAB	-	2
CANASA SUPP	-	2
DELZICOL CAP	-	2
LIALDA TAB	-	2
AZULFIDINE EN-TABS	-	3
AZULFIDINE TAB	-	3
COLAZAL CAP	-	3
CIMZIA INJ	MSP-PA	4
CIMZIA STARTER INJ KIT	MSP-PA	4
INTESTINAL ACIDIFIERS		
lactulose soln	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
LINZESS CAP (QL= 1 cap/day)	PA-QL	2
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
RELISTOR INJ	MSP-PA	4
RELISTOR INJ KIT	MSP-PA	4
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	1
calcium acetate tab (ELIPHOS equiv)	-	1
FOSRENOL CHEW TAB	-	2
FOSRENOL POWDER PACK	-	2
PHOSLYRA SOLN	-	2
RENVELA PACKET	-	2
RENVELA TAB	-	2
SEVELAMER CARBONATE TAB	-	2
AURYXIA TAB	-	3
ELIPHOS TAB	-	3
PHOSLO CAP	-	3
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA-3 SYRUP	-	1
ORACIT SOLN	-	1
potassium citrate CR tab (UROKIT-K TAB equiv)	-	1
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	1
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	1
sodium citrate/citric acid soln (BICITRA equiv)	-	1
tricitrates soln (POLYCITRA-LC equiv)	-	1
SHOHL'S SOLN	-	2
POLYCITRA CRYSTAL PACK	-	3
POLYCITRA-LC SOLN	-	3
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through Pharmicare 800-238-7828)	LD-PA	4
GENITOURINARY IRRIGANTS		
sodium chloride 0.9% irr soln	-	1
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	2
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	1
dutasteride cap (AVODART equiv)	-	1
dutasteride/tamsulosin cap (JALYN equiv)	-	1
finasteride tab (PROSCAR equiv)	-	1
tamsulosin cap (FLOMAX equiv)	-	1
UROXATRAL TAB	-	2
AVODART CAP	-	3
FLOMAX CAP	-	3
JALYN CAP	-	3
PROSCAR TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIUM equiv)	-	1
PYRIDIUM TAB	-	3
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	1
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	1
MITIGARE CAP	-	2
ULORIC TAB (Step Therapy requires trial of allopurinol)	ST	2
ZYLOPRIM TAB	-	3
URICOSURICS		
probenecid tab (BENEMID equiv)	-	1
HEMATOLOGICAL AGENTS - MISC.		
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	1
TRENTAL TAB	-	3
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	1
cilostazol tab (PLETAL equiv)	-	1
clopidogrel tab 75mg (PLAVIX equiv)	-	1
dipyridamole tab (PERSANTINE equiv)	-	1
TICLOPIDINE TAB	-	1
ticlopidine tab (TICLID equiv)	-	1
AGGRENOX/ASPIRIN-DIPYRIDAMOLE CAP	-	2
EFFIENT TAB	-	2
AGRYLIN CAP	-	3
BRILINTA TAB	-	3
PERSANTINE TAB	-	3
PLAVIX TAB 75MG	-	3
PLETAL TAB	-	3
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	3
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
ZAVESCA CAP (Only available through Accredo 888-773-7376)	LD-PA	4
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	2
COBALAMINS		
cyanocobalamin inj	-	1
FOLIC ACID/FOLATES		
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0
HEMATOPOIETIC GROWTH FACTORS		
ARANESP INJ (Step Therapy requires trial of EPOGEN or PROCRIT)	MSP-ST	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
EPOGEN INJ	MSP-PA	4
LEUKINE INJ	MSP	4
NEULASTA INJ	MSP	4
NEUMEGA INJ	MSP	4
PROCRIT INJ	MSP-PA	4
PROMACTA TAB	MSP-PA	4
ZARXIO INJ	MSP	4
HEMATOPOIETIC MIXTURES		
ferrex 150 forte cap	-	1
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	1
folbee tab	-	1
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	1
multigen folic tab (CHROMAGEN FA equiv)	-	1
multigen plus tab (CHROMAGEN FORTE equiv)	-	1
multigen tab (CHROMAGEN equiv)	-	1
multivitamin tab	-	1
tricon cap (TRINSICON equiv)	-	1
NEPHRON FA TAB	-	2
CHROMAGEN FA TAB	-	3
MULTIVITAMIN TAB	-	3
IRON		
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE SYRUP (Covered for members 1 year or younger)	OTC	\$0
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid syrup (AMICAR equiv)	-	1
aminocaproic acid tab (AMICAR equiv)	-	1
tranexamic acid tab (LYSTEDA equiv)	-	1
LYSTEDA TAB	-	2
AMICAR SYRUP	-	3
AMICAR TAB	-	3
AMINOCAPROIC ACID TAB	-	3
tranexamic acid inj (CYKLOKAPRON equiv)	M	M
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	1
phenobarbital tab	-	1
SECONAL CAP	-	2
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	1
FLURAZEPAM CAP	-	1
temazepam cap 15mg (RESTORIL equiv)	-	1
temazepam cap 22.5mg (RESTORIL equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
temazepam cap 30mg (RESTORIL equiv)	-	1
temazepam cap 7.5mg (RESTORIL equiv)	-	1
TRIAZOLAM TAB	-	1
triazolam tab (HALCION equiv)	-	1
zaleplon cap (SONATA equiv)	-	1
zolpidem tab 10mg (AMBIEN equiv) (Male QL= 1 tab/day; Female QL= 0.5 tab/day)	QL	1
zolpidem tab 5mg (AMBIEN equiv) (QL= 1 tab/day)	QL	1
AMBIEN TAB 10MG (Male QL= 1 tab/day; Female QL= 0.5 tab/day)	QL	3
AMBIEN TAB 5MG (QL= 1 tab/day)	QL	3
HALCION TAB	-	3
PROSOM TAB	-	3
RESTORIL CAP 15MG	-	3
RESTORIL CAP 22.5MG	-	3
RESTORIL CAP 30MG	-	3
RESTORIL CAP 7.5MG	-	3
SONATA CAP	-	3
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ROZEREM TAB (QL= 1 tab/day)	PA-QL	2
LAXATIVES		
LAXATIVE COMBINATIONS		
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
MOVIPREP SOLN (QL= 1 bottle/fill)	QL	2
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	1
SALINE LAXATIVES		
OSMOPREP TAB	-	3
VISICOL TAB	-	3
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	1
azithromycin tab (ZITHROMAX equiv)	-	1
ZITHROMAX SUSP	-	3
ZITHROMAX TAB	-	3
CLARITHROMYCIN		
clarithromycin ER tab (BIAXIN XL equiv)	-	1
clarithromycin susp (BIAXIN equiv)	-	1
clarithromycin tab (BIAXIN equiv)	-	1
BIAXIN SUSP	-	3
BIAXIN XL TAB	-	3
ERYTHROMYCINS		
ERY-TAB	-	1
ERYTHROMYCIN CAP	-	1
erythromycin DR cap (ERYC equiv)	-	1
erythromycin ethylsuccinate susp (ERYPED equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
MACROLIDES Cont.		
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	1
erythromycin stearate tab	-	1
ERYPED SUSP	-	2
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	2
ERYPED SUSP 200MG/5ML	-	3
ERYTHROMYCIN TAB (all forms except PCE)	-	3
FIDAXOMICIN		
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap)	QL-ST	2
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS	OTC	\$0
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA CONNECT METER	OTC	\$0
ACCU-CHEK AVIVA PLUS METER	OTC	\$0
ACCU-CHEK NANO METER	OTC	\$0
ACCU-CHEK NANO SMARTVIEW METER	OTC	\$0
FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE INSULINX METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
CALIBRATION LIQUID	OTC	1
LANCET DEVICE	OTC	1
LANCET KIT	OTC	1
LANCETS	OTC	1
V-GO INJ KIT (QL= 1 kit/day)	QL	2
MISC. DEVICES		
ALCOHOL SWABS	OTC	1
PARENTERAL THERAPY SUPPLIES		
B-D INSULIN SYRINGE	OTC	2
B-D PEN NEEDLE	OTC	2
FREESTYLE INSULIN SYRINGE	OTC	2
INSULIN SYRINGE	OTC	2
NOVOFINE PEN NEEDLE	OTC	2
NOVOTWIST PEN NEEDLE	OTC	2
PEN NEEDLE	OTC	2
PRECISION INSULIN SYRINGE	OTC	2
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	1
AEROCHAMBER	OTC	2
AEROCHAMBER SUPPLIES	-	2
MIGRAINE PRODUCTS		
MIGRAINE COMBINATIONS		
MIGERGOT SUPP	-	2
MIGRAINE PRODUCTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
dihydroergotamine mesylate inj (D.H.E. equiv)	-	1
D.H.E. INJ	-	3
ERGOMAR SL TAB	-	3
SEROTONIN AGONISTS		
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	1
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	1
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	1
sumatriptan nasal spray (SUMATRIPTAN/IMITREX equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	1
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days)	QL	1
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	1
AMERGE TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3
IMITREX TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
IMITREX VIAL INJ (QL= 5 inj/fill, 2 fills/30 days)	QL	3
MAXALT MLT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3
MAXALT TAB (QL= 12 tabs/fill, 3 fills/60 days)	QL	3
ZOMIG TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
ZOMIG ZMT (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
MINERALS & ELECTROLYTES		
CHLORIDE		
AMMONIUM CHLORIDE INJ	M	M
FLUORIDE		
FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
LURIDE SOLN (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0
LURIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at non-preferred brand copay)	-	\$0
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
FLUOR-A-DAY CHEW TAB	-	1
IODINE PRODUCTS		
SSKI SOLN	-	2
MAGNESIUM		
magnesium sulfate inj	M	M
PHOSPHATE		
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	1
K-PHOS TAB	-	2
K-PHOS NEUTRAL TAB	-	3
POTASSIUM		
potassium bicarbonate effer tab (K-LYTE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	LD	generic =small letters Limited Distribution	M	BRANDS =CAPITAL LETTERS Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
potassium chloride effer tab (K-LYTE/CL equiv)	-	1
potassium chloride ER cap (MICRO-K equiv)	-	1
POTASSIUM CHLORIDE ER TAB	-	1
potassium chloride ER tab (KLOR-CON equiv)	-	1
potassium chloride micro tab (K-DUR equiv)	-	1
potassium chloride powder packet (KLOR-CON equiv)	-	1
potassium chloride soln	-	1
KLOR-CON M15 TAB	-	2
KLOR-CON POWDER PACKET	-	3
KLOR-CON TAB	-	3
MICRO-K CAP	-	3
SODIUM		
sodium chloride inj	M	M
ZINC		
zinc sulfate cap	-	1
GALZIN CAP	-	2
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
lidocaine viscous soln	-	1
LIDOCAINE ORAL SOLN 4%	-	2
LTA 360 KIT	-	3
ANTIALLERGY AGENTS - MOUTH/THROAT		
APHTHASOL PASTE	-	2
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	1
nystatin susp	-	1
MYCELEX TROCHES	-	3
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	1
PERIDEX SOLN	-	3
DENTAL PRODUCTS		
PREVIDENT CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride gel (PREVIDENT equiv)	-	1
sodium fluoride paste (PREVIDENT equiv)	-	1
sodium fluoride rinse (PREVIDENT equiv)	-	1
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	1
PREVIDENT GEL	-	2
PREVIDENT PASTE	-	2
PREVIDENT RINSE	-	2
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	1
THROAT PRODUCTS - MISC.		
cevimeline cap (EVOXAC equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
pilocarpine tab (SALAGEN equiv)	-	1
EVOXAC CAP	-	3
SALAGEN TAB	-	3
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	1
dialyvite tab (NEPHRO-VITE equiv)	-	1
DIALYVITE/ZINC TAB	-	1
FOLBEE PLUS CZ TAB	-	1
renaphro cap (NEPHROCAP equiv)	-	1
DIATZ ZN TAB	-	3
NEPHROCAP	-	3
NEPHRO-VITE TAB	-	3
MULTIPLE VITAMINS W/ MINERALS		
multivitamin w/ minerals tab (STROVITE equiv)	-	1
STROVITE TAB	-	3
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	1
PED MV W/ FLUORIDE		
pediatric multiple vitamins/fluoride chew tab	-	1
pediatric multiple vitamins/fluoride soln	-	1
QUFLORA PEDIATRIC CHEW TAB	-	3
QUFLORA PEDIATRIC DROP	-	3
PRENATAL VITAMINS		
PRENATAL VITAMINS (NON-PREFERRED)	-	3
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab	-	1
carisoprodol tab (SOMA equiv)	-	1
chlorzoxazone tab (PARAFON FORTE equiv)	-	1
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	1
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	1
metaxalone tab (SKELAXIN equiv)	-	1
methocarbamol tab (ROBAXIN equiv)	-	1
orphenadrine citrate ER tab (NORFLEX equiv)	-	1
tizanidine cap (ZANAFLEX equiv)	-	1
tizanidine tab (ZANAFLEX equiv)	-	1
FEXMID TAB	-	3
FLEXERIL TAB	-	3
METAXALONE TAB 400MG	-	3
PARAFON FORTE TAB	-	3
ROBAXIN TAB	-	3
SKELAXIN TAB	-	3
SOMA TAB	-	3
ZANAFLEX TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	1
DANTRIUM CAP	-	3
MUSCLE RELAXANT COMBINATIONS		
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	1
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	1
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	1
ORPHENADRINE/ASPIRIN/CAFFEINE TAB	-	3
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL ANTIALLERGY		
azelastine nasal spray (ASTELIN/ASTEPRO equiv)	-	1
olopatadine nasal spray (PATANASE equiv)	-	1
ASTELIN/ASTEPRO NASAL SPRAY	-	3
PATANASE NASAL SPRAY	-	3
NASAL ANTICHOLINERGICS		
ipratropium nasal spray (ATROVENT equiv)	-	1
ATROVENT NASAL SPRAY	-	3
NASAL STEROIDS		
flunisolide nasal spray (NASAREL equiv) (QL= 2 bottles/fill)	QL	1
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	1
NASONEX NASAL SPRAY (QL= 2 bottles/fill)	QL	1
triamcinolone nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	QL	1
VERAMYST NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX)	QL-ST	3
SYMPATHOMIMETIC DECONGESTANTS		
TYZINE NASAL SOLN	-	3
NEUROMUSCULAR AGENTS		
ALS AGENTS		
riluzole tab (RILUTEK equiv)	-	1
RILUTEK TAB	-	3
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	2
BETA-BLOCKERS - OPHTHALMIC		
betaxolol ophth soln (BETOPTIC-S equiv)	-	1
carteolol ophth soln (OCUPRESS equiv)	-	1
dorzolamide/ timolol ophth soln (COSOPT equiv)	-	1
levobunolol ophth soln (BETAGAN equiv)	-	1
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	1
timolol maleate ophth soln (TIMOPTIC equiv)	-	1
BETIMOL OPHTH SOLN	-	2
BETOPTIC-S OPHTH SOLN	-	2
COMBIGAN OPHTH SOLN	-	2
COSOPT PF OPHTH SOLN	-	2
METIPRANOLOL OPHTH SOLN	-	2
BETAGAN OPHTH SOLN	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered Infertility	LD	generic =small letters Limited Distribution	M	BRANDS =CAPITAL LETTERS Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RS	Restricted to Specialist	SF	Limited to two 15 day fills per month for first 3 months
SMKG	Smoking Cessation	SP	Available through Specialty Pharmacy Program	ST	Step Therapy
VAC	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
COSOPT OPHTH SOLN	-	3
TIMOPTIC OPHTH SOLN	-	3
TIMOPTIC-XE OPHTH GEL	-	3
CYCLOPLEGIC MYDRIATICS		
atropine ophth oint	-	1
atropine ophth soln (ISOPTO ATROPINE equiv)	-	1
cyclopentolate ophth soln (CYCLOGYL equiv)	-	1
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	1
tropicamide ophth soln (MYDRIACYL equiv)	-	1
CYCLOMYDRIL OPHTH SOLN	-	2
ISOPTO HOMATROPINE OPHTH SOLN 2%	-	2
ISOPTO HOMATROPINE OPHTH SOLN 5%	-	2
ISOPTO HYOSCINE OPHTH SOLN	-	2
CYCLOGYL OPHTH SOLN	-	3
ISOPTO ATROPINE OPHTH SOLN	-	3
MYDRIACYL OPHTH SOLN	-	3
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	1
ISOPTO CARBACHOL OPHTH SOLN	-	2
PHOSPHOLINE OPHTH SOLN	-	2
ISOPTO CARPINE OPHTH SOLN	-	3
OPHTHALMIC ADRENERGIC AGENTS		
apraclonidine ophth soln (IOPIDINE equiv)	-	1
brimonidine ophth soln (ALPHAGAN P equiv) (QL= 10ml/30 days)	QL	1
ALPHAGAN P OPHTH SOLN (QL= 10ml/30 days)	QL	2
ALPHAGAN P OPHTH SOLN 0.1% (QL= 10ml/30 days)	QL	2
IOPIDINE OPHTH SOLN 1%	-	2
SIMBRINZA OPHTH SUSP	-	2
IOPIDINE OPHTH SOLN	-	3
OPHTHALMIC ANTI-INFECTIVES		
bacitracin/ neomycin/ polymyxin b ophth oint (NEOSPORIN equiv)	-	1
bacitracin/ polymyxin b ophth oint (POLYSPORIN equiv)	-	1
ciprofloxacin ophth soln (CILOXAN equiv)	-	1
erythromycin ophth oint	-	1
gatifloxacin ophth soln (ZYMAXID equiv) (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	1
gentamicin ophth oint (GARAMYCIN equiv)	-	1
gentamicin ophth soln (GARAMYCIN equiv)	-	1
levofloxacin ophth soln (QUIXIN equiv)	-	1
neomycin/ polymyxin b/ gramicidin ophth soln (NEOSPORIN equiv)	-	1
ofloxacin ophth soln (OCUFLOX equiv)	-	1
polymyxin b/ trimethoprim ophth soln (POLYTRIM equiv)	-	1
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	1
tobramycin ophth soln (TOBREX equiv)	-	1
trifluridine ophth soln (VIROPTIC equiv)	-	1
AZASITE SOLN (QL= 2.5ml/fill)	QL	2
BACITRACIN OPHTH OINT	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
MOXEZA OPHTH SOLN	-	2
VIGAMOX OPHTH SOLN (QL= 3ml/fill)	QL	2
ZIRGAN OPHTH GEL	-	2
BLEPH-10 OPHTH SOLN	-	3
CILOXAN OPHTH SOLN	-	3
NEOSPORIN OPHTH SOLN	-	3
OCUFLOX OPHTH SOLN	-	3
POLYTRIM OPHTH SOLN	-	3
TOBREX OPHTH SOLN	-	3
VIROPTIC OPHTH SOLN	-	3
ZYMAXID OPHTH SOLN (Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA)	ST	3
OPHTHALMIC DECONGESTANTS		
naphazoline ophth soln	-	1
phenylephrine ophth soln (MYDFRIN equiv)	-	1
MYDFRIN OPHTH SOLN	-	3
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS OPHTH EMULSION (Restricted to Ophthalmology or Optometry Specialist)	RS	2
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	1
ALCAINE OPHTH SOLN	-	3
OPHTHALMIC STEROIDS		
bacitracin/ polymyxin/ neomycin/ hydrocortisone ophth oint (CORTISPORIN equiv)	-	1
dexamethasone ophth soln	-	1
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	1
neomycin/ polymyxin/ dexamethasone ophth oint (MAXITROL equiv)	-	1
neomycin/ polymyxin/ dexamethasone ophth soln (MAXITROL equiv)	-	1
neomycin/ polymyxin/ hydrocortisone ophth soln (CORTISPORIN equiv)	-	1
prednisolone ophth soln (PRED FORTE equiv)	-	1
sulfacetamide sodium/ prednisolone ophth soln (VASOCIDIN equiv)	-	1
tobramycin/ dexamethasone ophth soln (TOBRADEX equiv)	-	1
ALREX OPHTH SUSP/ LOTEMAX OPHTH SUSP	-	2
BLEPHAMIDE OPHTH SOLN	-	2
DUREZOL OPHTH EMULSION (QL= 5ml/fill)	QL	2
LOTEMAX OPHTH GEL	-	2
LOTEMAX OPHTH OINT	-	2
MAXIDEX OPHTH SOLN	-	2
PRED MILD OPHTH SOLN	-	2
PRED-G OPHTH SOLN	-	2
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2
TOBRADEX OPHTH OINT	-	2
VEXOL OPHTH SUSP	-	2
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	2
CORTISPORIN OPHTH SOLN	-	3
FML LIQUIFLIM OPHTH SUSP	-	3
MAXITROL OPHTH OINT	-	3
MAXITROL OPHTH SUSP	-	3
PRED FORTE OPHTH SUSP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Mandatory Specialty Pharmacy Program	OTC	Limited Distribution	PA	Medical Benefit
QL	Quantity Limit	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Smoking Cessation	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Vaccine Program		Available through Specialty Pharmacy Program		Step Therapy

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
TOBRADEX OPHTH SOLN	-	3
OPHTHALMICS - MISC.		
ketotifen ophth soln (ZADITOR equiv) (QL= 10ml/30 days)	OTC-QL	\$0
ZADITOR OPHTH SOLN (QL= 10ml/30 days)	OTC-QL	\$0
azelastine ophth soln (OPTIVAR equiv)	-	1
bromfenac ophth soln (BROMDAY equiv)	-	1
cromolyn ophth soln (CROLOM equiv)	-	1
diclofenac sodium ophth soln (VOLTAREN equiv)	-	1
dorzolamide ophth soln (TRUSOPT equiv)	-	1
epinastine ophth soln (ELESTAT equiv)	-	1
flurbiprofen ophth soln (OCUFEN equiv)	-	1
ketorolac ophth soln (ACULAR (LS) equiv)	-	1
ALAMAST OPHTH SOLN	-	2
ALOCRILOPHTH SOLN	-	2
ALOMIDOPHTH SOLN	-	2
AZOPT OPHTH SUSP	-	2
ILEVRO OPHTH SUSP (QL= 3ml/fill)	QL	2
NEVANAC OPHTH SUSP	-	2
PATADAY OPHTH SOLN (QL= 2.5ml/30 days; Step Therapy requires trial of ketotifen ophth soln)	QL-ST	2
PROLENSA OPHTH SOLN (QL= 3ml/fill)	QL	2
ACULAR (LS) OPHTH SOLN	-	3
CROLOM OPHTH SOLN	-	3
ELESTAT OPHTH SOLN	-	3
OCUFEN OPHTH SOLN	-	3
OPTIVAR OPHTH SOLN	-	3
TRUSOPT OPHTH SOLN	-	3
VOLTAREN OPHTH SOLN	-	3
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	1
LUMIGAN OPHTH SOLN (QL= 5ml/30 days)	QL	2
TRAVATAN Z OPHTH SOLN (QL= 5ml/30 days)	QL	2
XALATAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	3
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	1
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	1
VOSOL OTIC SOLN	-	3
OTIC ANALGESICS		
omedia otic soln (AMERICAINE equiv)	-	1
OTIC ANTI-INFECTIVES		
ofloxacin otic soln (FLOXIN equiv)	-	1
CIPROFLOXACIN OTIC SOLN	-	2
OTIC COMBINATIONS		
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	1
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	1
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
CIPRODEX OTIC SUSP	-	2
COLY-MYCIN S OTIC SUSP	-	2
CORTANE-B AQUEOUS OTIC SOLN	-	3
CORTISPORIN OTIC SOLN	-	3
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	1
fluocinolone otic oil (DERMOTIC equiv)	-	1
DERMOTIC OIL	-	3
VOSOL HC OTIC SOLN	-	3
OXYTOCICS		
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	1
METHERGINE TAB (QL= 28 tabs/fill, 1 fill/365 days)	QL	2
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
HIZENTRA INJ	PA-SP	3
PENICILLINS		
AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	1
amoxicillin chew tab (AMOXIL equiv)	-	1
AMOXICILLIN CHEW TAB 250MG	-	1
amoxicillin susp (TRIMOX equiv)	-	1
amoxicillin tab (AMOXIL equiv)	-	1
ampicillin cap (PRINCIPEN equiv)	-	1
ampicillin susp (PRINCIPEN equiv)	-	1
NATURAL PENICILLINS		
penicillin vk soln (VEETIDS equiv)	-	1
penicillin vk tab (VEETIDS equiv)	-	1
PENICILLIN COMBINATIONS		
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	1
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	1
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	1
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	1
AUGMENTIN ES-600 SUSP	-	3
AUGMENTIN TAB	-	3
AUGMENTIN XR TAB	-	3
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	1
PHARMACEUTICAL ADJUVANTS		
SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	2
PROGESTINS		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	1
norethindrone tab (AYGESTIN equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
PROGESTINS Cont.		
progesterone cap (PROMETRIUM equiv)	-	1
AYGESTIN TAB	-	3
PROMETRIUM CAP	-	3
PROVERA TAB	-	3
progesterone oil inj	INF	50%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium DR tab (CAMPRAL equiv)	-	1
disulfiram tab (ANTABUSE equiv)	-	1
ANTABUSE TAB	-	2
CAMPRAL TAB	-	3
ANTI-CATAPLECTIC AGENTS		
XYREM SOLN (Only available through Xyrem Central Pharmacy 866-997-3688)	LD	4
ANTIDEMENTIA AGENTS		
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	1
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	1
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	1
galantamine ER cap (RAZADYNE ER equiv)	-	1
GALANTAMINE SOLN	-	1
galantamine tab (RAZADYNE equiv)	-	1
memantine sol (NAMENDA equiv)	-	1
memantine tab (NAMENDA equiv)	-	1
rivastigmine cap (EXELON equiv)	-	1
rivastigmine patch (EXELON equiv)	-	1
EXELON SOLN	-	2
NAMENDA XR CAP	-	2
NAMZARIC CAP (Step Therapy requires trial of donepezil and memantine)	ST	2
NAMZARIC STARTER PACK (Step Therapy requires trial of donepezil and memantine)	ST	2
ARICEPT ODT (QL= 1 tab/day)	QL	3
ARICEPT TAB (QL= 2 tabs/day)	QL	3
ARICEPT TAB 23MG (QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg)	QL-ST	3
EXELON CAP	-	3
EXELON PATCH	-	3
NAMENDA SOL	-	3
NAMENDA TAB	-	3
RAZADYNE ER CAP	-	3
RAZADYNE SOLN	-	3
RAZADYNE TAB	-	3
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide/amitriptyline tab (LIMBITROL equiv)	-	1
olanzapine/ fluoxetine cap (SYMBYAX equiv)	-	1
PERPHENAZINE/ AMITRIPTYLINE TAB	-	1
LIMBITROL TAB	-	3
SYMBYAX CAP	-	3
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	2
SAVELLA TAB (QL= 2 tabs/day)	QL	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Mandatory Specialty Pharmacy Program	OTC	Limited Distribution	PA	Medical Benefit
QL	Quantity Limit	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Smoking Cessation	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Vaccine Program		Available through Specialty Pharmacy Program		Step Therapy

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
MOVEMENT DISORDER DRUG THERAPY		
tetrabenazine tab (XENAZINE equiv)	MSP-PA	4
MULTIPLE SCLEROSIS AGENTS		
AMPYRA TAB (QL= 2 tabs/day)	MSP-PA-QL	3
AUBAGIO TAB (QL= 1 tab/day)	MSP-PA-QL	4
AVONEX INJ	MSP	4
COPAXONE INJ 20MG/ML	MSP	4
COPAXONE INJ 40MG/ML	MSP	4
EXTAVIA INJ (Step Therapy requires trial of 2: AVONEX, COPAXONE, or PLEGRIDY)	MSP-ST	4
GILENYA CAP (QL= 1 cap/day)	MSP-PA-QL	4
PLEGRIDY INJ	MSP	4
PLEGRIDY PEN INJ	MSP	4
TECFIDERA CAP	MSP	4
TECFIDERA STARTER PACK	MSP	4
TYSABRI INJ	M	M
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUDEXTA CAP (QL= 2 caps/day)	QL	2
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ergoloid mesylates tab (HYDERGINE equiv)	-	1
pimozide tab	-	1
ERGOLOID MESYLATES TAB	-	3
ORAP TAB	-	3
SMOKING DETERRENENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
NICODERM PATCH (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTINE KIT (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	\$0
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	\$0
RESPIRATORY AGENTS - MISC.		
ALPHA-PROTEINASE INHIBITOR (HUMAN)		
ARALAST/PROLASTIN/ZEMAIRA INJ	M	M
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK (QL= 2 packets/day)	MSP-PA-QL-SF	4
KALYDECO TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	4
ORKAMBI TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	4
PULMOZYME INH SOLN	MSP	4
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP (QL= 9 caps/day)	MSP-PA-QL-SF	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
OFEV CAP (QL= 2 caps/day)	MSP-PA-QL-SF	4
SULFONAMIDES		
SULFONAMIDES		
SULFADIAZINE TAB	-	1
TETRACYCLINES		
TETRACYCLINES		
demeclocycline tab (DECLOMYCIN equiv)	-	1
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	1
doxycycline hyclate DR tab (DORYX equiv)	-	1
doxycycline hyclate tab (VIBRATAB equiv)	-	1
doxycycline monohydrate cap 100mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 50mg (MONODOX equiv)	-	1
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	1
doxycycline monohydrate tab (ADOXA equiv)	-	1
doxycycline susp (VIBRAMYCIN equiv)	-	1
minocycline cap (MINOCIN equiv)	-	1
minocycline tab (DYNACIN equiv)	-	1
tetracycline cap	-	1
ADOXA TAB	-	3
DECLOMYCIN TAB	-	3
DORYX TAB	-	3
DYNACIN TAB	-	3
MINOCIN CAP	-	3
MONODOX CAP	-	3
TETRACYCLINE CAP	-	3
VIBRAMYCIN CAP	-	3
VIBRAMYCIN SUSP	-	3
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	1
propylthiouracil tab	-	1
TAPAZOLE TAB	-	3
THYROID HORMONES		
liothyronine tab (CYTOMEL equiv)	-	1
NATURE THROID/ARMOUR THYROID TAB	-	1
np thyroid tab (NATURE THROID/ARMOUR THYROID equiv)	-	1
SYNTHROID TAB	-	1
THYROLAR TAB	-	2
CYTOMEL TAB	-	3
ULCER DRUGS		
ANTISPASMODICS		
dicyclomine cap (BENTYL equiv)	-	1
dicyclomine soln (BENTYL equiv)	-	1
dicyclomine tab (BENTYL equiv)	-	1
glycopyrrolate tab (ROBINUL equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
hyoscyamine sulfate CR tab (LEVBID equiv)	-	1
hyoscyamine sulfate elixir (LEVSIN equiv)	-	1
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	1
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	1
hyoscyamine sulfate soln (LEVSIN equiv)	-	1
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	1
hyoscyamine tab (LEVSIN equiv)	-	1
methscopolamine tab (PAMINE equiv)	-	1
BELLADONNA ALKALOID/OPIUM SUPP	-	2
PROPANTHELINE TAB	-	2
ANASPAZ ODT	-	3
BENTYL CAP	-	3
BENTYL SYRUP	-	3
BENTYL TAB	-	3
LEVBID TAB	-	3
LEVSIN SOLN	-	3
LEVSIN TAB	-	3
LEVSIN/SL TAB	-	3
LEVSINEX CAP	-	3
PAMINE TAB	-	3
ROBINUL TAB	-	3
H-2 ANTAGONISTS		
cimetidine soln (TAGAMET equiv)	-	1
cimetidine tab (TAGAMET equiv)	-	1
famotidine susp (PEPCID equiv)	-	1
famotidine tab (PEPCID equiv)	-	1
nizatidine cap (AXID equiv)	-	1
nizatidine soln (AXID equiv)	-	1
ranitidine cap (ZANTAC equiv)	-	1
ranitidine syrup (ZANTAC equiv)	-	1
ranitidine tab (Rx Only) (ZANTAC equiv)	-	1
PEPCID SUSP	-	2
AXID CAP	-	3
AXID SOLN	-	3
PEPCID TAB	-	3
TAGAMET TAB	-	3
ZANTAC CAP	-	3
ZANTAC SYRUP	-	3
ZANTAC TAB	-	3
MISC. ANTI-ULCER		
CARAFATE SUSP	-	1
sucralfate tab (CARAFATE equiv)	-	1
CARAFATE TAB	-	3
PROTON PUMP INHIBITORS		
lansoprazole cap (PREVACID equiv) (Rx Only)	-	1
omeprazole DR cap (PRILOSEC equiv)	-	1
pantoprazole EC tab (PROTONIX equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
-----------------	---------------------	-------------

ULCER DRUGS Cont.

rabeprazole EC tab (ACIPHEX equiv)	-	1
PREVACID SOLUTAB	-	2

ULCER DRUGS - PROSTAGLANDINS

misoprostol tab (CYTOTEC equiv)	-	1
CYTOTEC TAB	-	3

ULCER THERAPY COMBINATIONS

lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	1
PREVPAC KIT	-	3

URINARY ANTI-INFECTIVES

URINARY ANTI-INFECTIVES

methenamine hippurate tab (HIPREX equiv)	-	1
methenamine mandelate tab	-	1
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	1
nitrofurantoin monohydrate cap (MACROBID equiv)	-	1
nitrofurantoin susp (FURADANTIN equiv)	-	1
FURADANTIN SUSP	-	2
HIPREX TAB	-	3
MACROBID CAP	-	3
MACRODANTIN CAP	-	3

URINARY ANTISPASMODICS

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)

oxybutynin ER tab (DITROPAN XL equiv)	-	1
oxybutynin syrup	-	1
oxybutynin tab (DITROPAN equiv)	-	1
tolterodine tab (DETROL equiv)	-	1
tropium chloride SR cap (SANCTURA XR equiv)	-	1
tropium tab (SANCTURA equiv)	-	1
TOVIAZ TAB	-	2
VESICARE TAB	-	2
DETROL TAB	-	3
DITROPAN XL TAB	-	3
SANCTURA TAB	-	3
SANCTURA XR CAP	-	3

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)

tolterodine SR cap (DETROL LA equiv)	-	1
DETROL LA CAP	-	3

URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS

bethanechol tab (URECHOLINE equiv)	-	1
URECHOLINE TAB	-	3

VACCINES

BACTERIAL VACCINES

VIVOTIF CAP (QL= 4 caps/fill)	QL-VAC	2
-------------------------------	--------	---

VIRAL VACCINES

AFLURIA INJ	VAC	\$0
AFLURIA/FLUZONE INJ	VAC	\$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
VACCINES Cont.		
FLUAD INJ	VAC	\$0
FLUBLOK INJ	VAC	\$0
FLUCELVAX INJ	VAC	\$0
FLUCELVAX QUAD INJ	VAC	\$0
FLUVIRIN INJ	VAC	\$0
FLUVIRIN PF INJ	VAC	\$0
FLUZONE HIGH DOSE PF INJ	VAC	\$0
FLUZONE INTRADERMAL	VAC	\$0
FLUZONE QUADRIVALENT INJ	VAC	\$0
FLUZONE/FLUARIX QUAD INJ	VAC	\$0
FLUZONE/FLULAVAL QUAD INJ	VAC	\$0
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
ACIDIC VAGINAL JELLY	-	2
SPERMICIDES		
CONCEPTROL GEL	OTC	\$0
CONTRACEPTIVE FILM	OTC	\$0
CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
CONTRACEPTIVE SUPP	OTC	\$0
TODAY SPONGE	OTC	\$0
vcf vaginal gel (CONCEPTROL equiv)	OTC	\$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv)	-	1
metronidazole vaginal gel (METROGEL equiv)	-	1
NYSTATIN VAGINAL TAB	-	1
terconazole cream (TERAZOL equiv)	-	1
terconazole supp (TERAZOL equiv)	-	1
AVC VAGINAL CREAM	-	2
CLEOCIN VAGINAL CREAM	-	3
METROGEL VAGINAL GEL	-	3
TERAZOL CREAM	-	3
TERAZOL SUPP	-	3
VAGINAL ESTROGENS		
ESTRACE VAGINAL CREAM	-	2
ESTRING (3 copays per Rx)	-	2
PREMARIN VAGINAL CREAM	-	2
VAGINAL PROGESTINS		
CRINONE GEL	PA	2
ENDOMETRIN INSERT	PA	2
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
EPIPEN INJ (QL= 2 inj/fill)	QL	2
EPIPEN-JR INJ (QL= 2 inj/fill)	QL	2
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Mandatory Specialty Pharmacy Program	OTC	Limited Distribution	PA	Medical Benefit
QL	Quantity Limit	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Smoking Cessation	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Vaccine Program		Available through Specialty Pharmacy Program		Step Therapy

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Chinese Community Health Plan 4-Tier Formulary (Commercial)
Category/Class**

Last Updated* 12/1/2016

DrugName	Special Code	Tier
VASOPRESSORS Cont.		
PROAMATINE TAB	-	3
VITAMINS		
MISC. NUTRITIONAL FACTORS		
PRENATAL VITAMINS (PRENATAL PLUS/ PREPLUS/PRENAPLUS)	-	1
PRENATAL VITAMINS (NON-PREFERRED)	-	3
OIL SOLUBLE VITAMINS		
vitamin D cap 1000unit (Covered for members 65 years or older)	OTC	\$0
vitamin D cap 400unit (Covered for members 65 years or older)	OTC	\$0
VITAMIN D TAB 400UNIT (Covered for members 65 years or older)	OTC	\$0
vitamin D cap (Rx covered Only)	-	1
MEPHYTON TAB	-	2
DRISDOL CAP	-	3
WATER SOLUBLE VITAMINS		
POTABA POWDER PACKET	-	2
POTABA TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

INF	NC =Not Covered	LD	generic =small letters	M	BRANDS =CAPITAL LETTERS
MSP	Infertility	OTC	Limited Distribution	PA	Medical Benefit
QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter	SF	Prior Authorization
SMKG	Quantity Limit	SP	Restricted to Specialist	ST	Limited to two 15 day fills per month for first 3 months
VAC	Smoking Cessation		Available through Specialty Pharmacy Program		Step Therapy
	Vaccine Program				

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Prior Authorization Drug List
Last Updated* 12/1/2016

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ABILIFY DISCMELT	3
ABILIFY SOLN	3
ACTEMRA SC INJ	4
ACTIQ LOZENGE	3
adapalene cream	1
adapalene gel 0.1%	1
ADAPALENE LOTION	2
ADCIRCA TAB	4
adefovir dipivoxil tab	4
ADEMPAS TAB	4
ADIPEX-P CAP	3
ADIPEX-P TAB	3
AFINITOR DISPERZ	4
AFINITOR TAB	4
ALECENSA CAP	4
AMITIZA CAP	2
AMPYRA TAB	3
ANDRODERM PATCH	2
ANDROGEL 1% 25MG	3
ANDROGEL 1% 50MG	3
ANDROGEL 1.62% 1.25GM	2
ANDROGEL 1.62% 2.5GM	2
ANDROGEL PUMP 1%	3
ANDROGEL PUMP 1.62%	2
aripiprazole ODT	1
aripiprazole soln	1
ARIXTRA INJ	3
AUBAGIO TAB	4
BARACLUDE SOLN	4
BELVIQ TAB	2
BELVIQ XR TAB	2
bexarotene cap	4
BOSULIF TAB	4
BUPHENYL TAB	4
CABOMETYX TAB	4
CAPRELSA TAB	4
CHOLBAM CAP	4
CIALIS TAB 2.5MG, 5MG	4
CIMZIA INJ	4
CIMZIA STARTER INJ KIT	4
clobetasol foam	1
clobetasol lotion	1
clobetasol propionate cream	1
clobetasol propionate emollient cream	1
clobetasol propionate gel	1

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) cont.
Prior Authorization Drug List
Last Updated* 12/1/2016

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
clobetasol propionate oint	1
clobetasol propionate soln	1
clobetasol shampoo	1
CLOBEX LOTION	3
CLOBEX SHAMPOO	3
CONTRACE TAB	2
CORLANOR TAB	3
COSENTYX INJ	4
COTELLIC TAB	4
CRINONE GEL	2
CYSTAGON CAP	4
DAKLINZA TAB	4
DARAPRIM TAB	4
DESCOVY TAB	2
diclofenac gel	1
DIFFERIN CREAM	3
DIFFERIN GEL 0.1%	3
DIFFERIN GEL 0.3%	1
DIFFERIN LOTION	3
ENBREL INJ 25MG	4
ENBREL INJ 50MG	4
ENBREL SURECLICK INJ 50MG	4
ENDOMETRIN INSERT	2
entecavir tab	4
ENTRESTO TAB	2
EPANED SOLN	3
EPIDUO (FORTE) GEL	2
EPIVIR HBV SOLN	4
EPOGEN INJ	4
ERIVEDGE CAP	4
ESBRIET CAP	4
FARYDAK CAP	4
fentanyl citrate lollipop	1
FENTORA TAB	2
FERRIPROX SOLN	4
FERRIPROX TAB	4
FETZIMA CAP	3
FETZIMA TITRATION PACK	3
fluvastatin ER tab	1
fondaparinux inj	1
GILENYA CAP	4
GILOTRIF TAB	4
GLEEVEC TAB	3
halobetasol propionate cream	1
halobetasol propionate oint	1

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) cont.
Prior Authorization Drug List
Last Updated* 12/1/2016

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
HARVONI TAB	4
HIZENTRA INJ	3
HUMIRA INJ	4
HUMIRA PEN INJ	4
HYCAMTIN CAP	4
IBRANCE CAP	4
ICLUSIG TAB	4
IMBRUVICA CAP	4
INCIVEK TAB	4
INLYTA TAB	4
IRESSA TAB	4
itraconazole cap	1
JAKAFI TAB	4
KALYDECO PAK	4
KALYDECO TAB	4
KINERET INJ	4
KORLYM TAB	4
KUVAN TAB	4
lamivudine soln	1
lamivudine tab	1
lamivudine tab 100mg	1
LENVIMA CAP	4
LESCOL XL TAB	3
LETAIRIS TAB	4
lidocaine patch	1
LIDODERM PATCH	3
LINZESS CAP	2
LONSURF TAB	4
LYNPARZA CAP	4
MEKINIST TAB	4
modafinil tab	1
NATPARA INJ	4
NEXAVAR TAB	4
NINLARO CAP	4
NORDITROPIN INJ	4
ODOMZO CAP	4
OFEV CAP	4
OLUX FOAM	3
ONFI TAB	2
OPSUMIT TAB	4
ORFADIN CAP	4
ORKAMBI TAB	4
PEGASYS INJ	4
PEGASYS INJ KIT	4
PEG-INTRON INJ	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) cont.
Prior Authorization Drug List
Last Updated* 12/1/2016

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
phentermine cap	1
phentermine tab	1
PROCRIT INJ	4
PROMACTA TAB	4
PROVIGIL TAB	3
RELISTOR INJ	4
RELISTOR INJ KIT	4
RETIN-A CREAM	3
RETIN-A GEL	3
RETIN-A MICRO GEL 0.04%, 0.1%	2
REVLIMID CAP	3
ROZEREM TAB	2
SABRIL POWDER PACK	4
SABRIL TAB	4
SIGNIFOR INJ	4
sildenafil tab	1
sodium phenylbutyrate powder	4
SOLARAZE GEL	3
SOMAVERT INJ	4
SOVALDI TAB	4
SPORANOX CAP	3
SPRYCEL TAB	3
STIVARGA TAB	4
STRENSIQ INJ	4
STRIVERDI RESPIMAT INHALER	3
SUTENT CAP	4
TAFINLAR CAP	4
TAGRISSO TAB	4
TARCEVA TAB	4
TASIGNA CAP	4
TEMOVATE CREAM	3
TEMOVATE GEL	3
TEMOVATE OINT	3
TEMOVATE SOLN	3
TEMOVATE-E CREAM	3
TESTOSTERONE GEL 1% 25MG	2
TESTOSTERONE GEL 1% 50MG	2
testosterone gel 1% pump	1
TESTOSTERONE GEL PUMP	2
tetrabenazine tab	4
THALOMID CAP	4
TRACLEER TAB	4
tretinoin cream	1
tretinoin gel	1
TRINTELLIX TAB	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) cont.
Prior Authorization Drug List
Last Updated* 12/1/2016

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
TRUVADA TAB	2
TYKERB TAB	4
TYVASO INH SOLN	4
TYZEKA TAB	4
UCERIS RECTAL FOAM	3
ULTRAVATE CREAM	3
ULTRAVATE LOTION	3
ULTRAVATE OINT	3
UPTRAVI TAB	4
VALCHLOR GEL	4
VENTAVIS INH SOLN	4
VICTRELIS CAP	4
VIREAD TAB	4
VOTRIENT TAB	4
XALKORI CAP	4
XELJANZ TAB	4
XELJANZ XR TAB	4
XTANDI CAP	4
ZAVESCA CAP	4
ZELBORAF TAB	4
ZEPATIER TAB	4
ZOLINZA CAP	4
ZORTRESS TAB	4
ZYDELIG TAB	4
ZYTIGA TAB	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Last Updated* 12/1/2016
Over-the-Counter (OTC)

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK AVIVA CONNECT METER ACCU-CHEK NANO SMARTVIEW METER ALCOHOL SWABS aspirin ec tab 81mg B-D PEN NEEDLE CONTRACEPTIVE FILM diphenhydramine cap 50mg	ACCU-CHEK AVIVA PLUS METER ACCU-CHEK SMARTVIEW TEST STRIP ASPIRIN CHEW TAB 75MG aspirin tab 325mg CALIBRATION LIQUID CONTRACEPTIVE FOAM FEMALE CONDOMS	ACCU-CHEK AVIVA PLUS TEST STRIP ACCU-CHEK TEST STRIP aspirin chew tab 81mg aspirin tab 81mg CLINISTIX TEST STRIP CONTRACEPTIVE GEL ferrous sulfate elixir	ACCU-CHEK NANO METER AEROCHAMBER aspirin ec tab 325mg B-D INSULIN SYRINGE CONCEPTROL GEL CONTRACEPTIVE SUPP FERROUS SULFATE LIQUID folic acid tab 800mcg
ferrous sulfate soln	FERROUS SULFATE SYRUP	folic acid tab 400mcg	folic acid tab 800mcg
FREESTYLE FREEDOM LITE METER FREESTYLE LITE METER	FREESTYLE INSULIN SYRINGE FREESTYLE LITE TEST STRIP	FREESTYLE INSULINX METER FREESTYLE TEST STRIP	FREESTYLE INSULINX TEST STRIP guaifenesin/codeine syrup
HUMULIN MIX PEN INJ KETO-DIASTIX TEST STRIP	HUMULIN N PEN INJ KETOSTIX	INSULIN SYRINGE ketotifen ophth soln	IRON SUSP LANCET DEVICE
LANCET KIT NICODERM PATCH NICOTINE KIT NOVOLIN INJ PRECISION INSULIN SYRINGE RYDEX vitamin D cap 400unit	LANCETS NICORETTE GUM nicotine lozenge NOVOTWIST PEN NEEDLE PRECISION XTRA METER TODAY SPONGE VITAMIN D TAB 400UNIT	levonorgestrel tab NICORETTE LOZENGE nicotine patch PEAK FLOW METER PRECISION XTRA TEST STRIP vcf vaginal gel ZADITOR OPHTH SOLN	lidocaine cream 5% nicotine gum NOVOFINE PEN NEEDLE PEN NEEDLE pseudoephedrine/brompheni ramine/codeine liquid vitamin D cap 1000unit

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Last Updated* 12/1/2016
Mandatory Specialty Pharmacy (MSP)

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

ACTEMRA SC INJ	ACTIMMUNE INJ	ADCIRCA TAB	adefovir dipivoxil tab
ADEMPAS TAB	AFINITOR DISPERZ	AFINITOR TAB	ALECENSA CAP
ALFERON-N INJ	AMPYRA TAB	APOKYN INJ	ARANESP INJ
AUBAGIO TAB	AVONEX INJ	BARACLUDGE SOLN	BETHKIS NEB SOLN
bexarotene cap	BOSULIF TAB	CABOMETYX TAB	calcitriol inj
capecitabine tab	CAPRELSA TAB	CAYSTON INH SOLN	CHOLBAM CAP
CIMZIA INJ	CIMZIA STARTER INJ KIT	COPAXONE INJ 20MG/ML	COPAXONE INJ 40MG/ML
COSENTYX INJ	COTELLIC TAB	CYSTAGON CAP	DAKLINZA TAB
DARAPRIM TAB	ENBREL INJ 25MG	ENBREL INJ 50MG	ENBREL SURECLICK INJ 50MG
EPOGEN INJ	ERIVEDGE CAP	ESBRIET CAP	etoposide cap
EXJADE TAB	EXTAVIA INJ	FARYDAK CAP	FERRIPROX SOLN
FERRIPROX TAB	FORTEO INJ	GILENYA CAP	GILOTRIF TAB
GLEEVEC TAB	HARVONI TAB	HUMIRA INJ	HUMIRA PEN INJ
HYCAMTIN CAP	IBRANCE CAP	ICLUSIG TAB	IMBRUVICA CAP
INCIVEK TAB	INCRELEX INJ	INFERGEN INJ	INLYTA TAB
INTRON-A INJ	IRESSA TAB	JADENU TAB	JAKAFI TAB
KALYDECO PAK	KALYDECO TAB	KINERET INJ	KITABIS PAK NEB SOLN
KORLYM TAB	KUVAN TAB	LENVIMA CAP	LEUKINE INJ
LONSURF TAB	LYNPARZA CAP	LYSODREN TAB	MEKINIST TAB
MESNEX TAB	MIACALCIN INJ	MYLERAN TAB	NATPARA INJ
NEULASTA INJ	NEUMEGA INJ	NEXAVAR TAB	nilutamide tab
NINLARO CAP	NORDITROPIN INJ	octreotide inj	ODOMZO CAP
OFEV CAP	OPSUMIT TAB	ORFADIN CAP	ORKAMBI TAB
PEGASYS INJ	PEGASYS INJ KIT	PEG-INTRON INJ	PLEGRIDY INJ
PLEGRIDY PEN INJ	PROCRIT INJ	PROMACTA TAB	PULMOZYME INH SOLN
REBETOL SOLN	RELISTOR INJ	RELISTOR INJ KIT	REVLIMID CAP
ribavirin cap	ribavirin tab	SABRIL POWDER PACK	SABRIL TAB
SIGNIFOR INJ	SOMAVERT INJ	SOVALDI TAB	SPRYCEL TAB
STIVARGA TAB	STRENSIQ INJ	SUTENT CAP	TAFINLAR CAP
TAGRISSO TAB	TARCEVA TAB	TASIGNA CAP	TECFIDERA CAP
TECFIDERA STARTER PACK	temozolomide cap	tetrabenazine tab	THALOMID CAP
TOBI PODHALER	tobramycin neb soln	tretinoin cap	TYKERB TAB
TYVASO INH SOLN	TYZEKA TAB	UPTRAVI TAB	VALCHLOR GEL
VENTAVIS INH SOLN	VICTRELIS CAP	VOTRIENT TAB	XALKORI CAP
XELJANZ TAB	XELJANZ XR TAB	XTANDI CAP	XYREM SOLN
ZARXIO INJ	ZAVESCA CAP	ZELBORAF TAB	ZEPATIER TAB
ZOLINZA CAP	ZYDELIG TAB	ZYTIGA TAB	

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Last Updated* 12/1/2016
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
acyclovir oint	Step Therapy requires trial of one of the following oral medications: acyclovir, famciclovir, valacyclovir
ARANESP INJ	Step Therapy requires trial of EPOGEN or PROCRIT
ARICEPT TAB 23MG	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
BONIVA TAB 150MG	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
CELEBREX CAP	QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS
celecoxib cap	QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
EXTAVIA INJ	Step Therapy requires trial of 2: AVONEX, COPAXONE, or PLEGRIDY
fluvoxamine ER cap	Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine
FORTAMET TAB	Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv)
gatifloxacin ophth soln	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA
ibandronate tab 150mg	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
JENTADUETO TAB	Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR
KAZANO/ALOGLIPTIN-METFORMIN TAB	Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR
lidocaine oint	QL= 50gm/30 days; Step Therapy requires trial of lidocaine cream 5%
LUVOX CR CAP	Step Therapy requires trial of sertraline, fluoxetine, citalopram, paroxetine or fluvoxamine
metformin ER osmotic tab	Step Therapy requires trial of metformin ER (GLUCOPHAGE XR equiv)
METROGEL 1%	Step Therapy requires trial of FINACEA
NAMZARIC CAP	Step Therapy requires trial of donepezil and memantine
NAMZARIC STARTER PACK	Step Therapy requires trial of donepezil and memantine
NESINA/ALOGLIPTIN TAB	Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR
OSENI/ALOGLIPTIN-PIOGLITAZONE TAB	Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR
PATADAY OPHTH SOLN	QL= 2.5ml/30 days; Step Therapy requires trial of ketotifen ophth soln
RYTARY CAP	Step Therapy requires trial of carbidopa/levodopa ER
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	Step Therapy requires trial of inhaled corticosteroid
STRATTERA CAP	Step Therapy requires trial of 2 formulary stimulants
TRADJENTA TAB	Step Therapy requires trial of JANUVIA, ONGLYZA, JANUMET, JANUMET XR, or KOMBIGLYZE XR
ULORIC TAB	Step Therapy requires trial of allopurinol
VANCOCIN CAP	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.

Last Updated* 12/1/2016

Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
VERAMYST NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
ZYMAXID OPHTH SOLN	Step Therapy requires trial of ciprofloxacin, levofloxacin, ofloxacin or VIGAMOX/MOXEZA

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Smoking Cessation Agents
Last Updated* 12/1/2016

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	\$0
CHANTIX PAK(Limited to 180 days/plan year)	\$0
CHANTIX TAB(Limited to 180 days/plan year)	\$0
NICODERM PATCH(Limited to 180 days/plan year)	\$0
NICORETTE GUM(Limited to 180 days/plan year)	\$0
NICORETTE LOZENGE(Limited to 180 days/plan year)	\$0
nicotine gum(Limited to 180 days/plan year)	\$0
NICOTINE KIT(Limited to 180 days/plan year)	\$0
nicotine lozenge(Limited to 180 days/plan year)	\$0
nicotine patch(Limited to 180 days/plan year)	\$0
NICOTROL INHALER(Limited to 180 days/plan year)	\$0
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	\$0
ZYBAN TAB(Limited to 180 days/plan year)	\$0

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Infertility Drug List
Last Updated* 12/1/2016

Drug Name	Tier # for Drug Copay
BRAVELLE INJ	50%
CETROTIDE INJ	50%
CLOMID TAB	50%
CLOMIPHENE CITRATE POWDER	50%
clomiphene citrate tab	50%
FOLLISTIM AQ INJ	50%
GANIRELIX AC INJ	50%
GONAL-F RFF INJ	50%
leuprolide inj	50%
LUPRON DEPOT INJ	50%
LUPRON DEPOT PED INJ	50%
LUPRON DEPOT-PED INJ	50%
LUVERIS INJ	50%
OVIDREL INJ	50%
pregnyl inj	50%
progesterone oil inj	50%
REPRONEX INJ	50%
TRELSTAR INJ	50%

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial)
Last Updated* 12/1/2016
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ACLOVATE CREAM	QL= 60gm/fill
ACLOVATE OINT	QL= 60gm/fill
ACTEMRA SC INJ	QL= 2 inj/28 days
ACTIQ LOZENGE	QL= 120 units/30 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 888-773-7376
ADIPEX-P CAP	
ADIPEX-P TAB	
AFINITOR DISPERZ	QL= 1 tab/day
AFINITOR TAB	QL= 1 tab/day
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
alclometasone cream	QL= 60gm/fill
alclometasone oint	QL= 60gm/fill
ALECENSA CAP	QL= 8 caps/day
ALPHAGAN P OPHTH SOLN	QL= 10ml/30 days
ALPHAGAN P OPHTH SOLN 0.1%	QL= 10ml/30 days
AMBIEN TAB 10MG	Male QL= 1 tab/day; Female QL= 0.5 tab/day
AMBIEN TAB 5MG	QL= 1 tab/day
AMERGE TAB	QL= 9 tabs/fill, 2 fills/30 days
AMPYRA TAB	QL= 2 tabs/day
ANDRODERM PATCH	QL= 1 patch/day
ANDROGEL 1% 25MG	QL= 1 packet/day
ANDROGEL 1% 50MG	QL= 2 packets/day
ANDROGEL 1.62% 1.25GM	QL= 1 packet/day
ANDROGEL 1.62% 2.5GM	QL= 2 packets/day
ANDROGEL PUMP 1%	QL= 4 bottles/30 days
ANDROGEL PUMP 1.62%	QL= 2 bottles/30 days
ARICEPT ODT	QL= 1 tab/day
ARICEPT TAB	QL= 2 tabs/day
ARICEPT TAB 23MG	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
AUBAGIO TAB	QL= 1 tab/day
AZASITE SOLN	QL= 2.5ml/fill
BELVIQ TAB	QL= 2 tabs/day
BELVIQ XR TAB	QL= 1 tab/day
betamethasone dipropionate cream	QL= 45gm/fill
betamethasone dipropionate lotion	QL= 60gm/fill
betamethasone dipropionate oint	QL= 45gm/fill
betamethasone valerate cream	QL= 45gm/fill
betamethasone valerate lotion	QL= 60gm/fill
betamethasone valerate oint	QL= 45gm/fill
BONIVA TAB 150MG	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
brimonidine ophth soln	QL= 10ml/30 days
bupropion SR tab	Limited to 180 days/plan year
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Last Updated* 12/1/2016
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
CABOMETYX TAB	QL= 1 tab/day
CELEBREX CAP	QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS
celecoxib cap	QL= 2 caps/day; Step Therapy requires trial of 2 generic NSAIDS
CHANTIX PAK	Limited to 180 days/plan year
CHANTIX TAB	Limited to 180 days/plan year
clobetasol propionate cream	QL= 30gm/fill
clobetasol propionate oint	QL= 30gm/fill
CONTRAVE TAB	QL= 4 tabs/day
COSENTYX INJ	QL= 2 inj/28 days
COTELLIC TAB	QL= 3 tabs/day
CRESTOR TAB	QL= 1 tab/day
CRESTOR TAB 20MG	QL= 1.5 tabs/day
CYMBALTA CAP	QL= 2 caps/day
DAKLINZA TAB	QL= 1 tab/day
DEPO-PROVERA INJ	QL = 1 inj/90 day
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
desoximetasone cream 0.25%	QL= 60gm/fill
diclofenac gel 1%	QL= 5 tubes/fill
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin cap
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day; Step Therapy requires trial of donepezil 10mg
duloxetine EC cap	QL= 2 caps/day
DURAGESIC PATCH	QL= 10 patches/30 days
DUREZOL OPHTH EMULSION	QL= 5ml/fill
EMEND CAP	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
EMEND PAK	QL= 3 caps/fill; Restricted to Oncology or Hematology Specialist
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
enoxaparin inj	QL= 17 days supply
entecavir tab	QL= 1 tab/day
EPIPEN INJ	QL= 2 inj/fill
EPIPEN-JR INJ	QL= 2 inj/fill
ESBRIET CAP	QL= 9 caps/day
FARXIGA TAB	QL= 1 tab/day
FARYDAK CAP	QL= 6 caps/21 days; Required through Chinese Hospital Pharmacy 415-677-2430 or Diplomat Pharmacy 877-651-4943
fentanyl citrate lollipop	QL= 120 lozenges/30 days
fentanyl patch	QL= 10 patches/30 days
FENTORA TAB	QL= 120 tabs/30 days
FETZIMA CAP	QL= 1 cap/day
FETZIMA TITRATION PACK	QL= 1 cap/day
flunisolide nasal spray	QL= 2 bottles/fill
fluocinonide emollient cream	QL= 30gm/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Last Updated* 12/1/2016
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
fluticasone nasal spray	QL= 2 bottles/fill
GILENYA CAP	QL= 1 cap/day
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 888-773-7376
granisetron tab	QL= 9 tabs/fill
guaifenesin/codeine syrup	QL= 240ml/fill
halobetasol propionate cream	QL= 50gm/fill
halobetasol propionate oint	QL= 50gm/fill
HARVONI TAB	QL= 1 tab/day
HUMIRA INJ	QL= 2 inj/28 days
HUMIRA PEN INJ	QL= 2 inj/28 days
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
HYSINGLA ER TAB	QL= 1 tab/day
ibandronate tab 150mg	QL= 1 tab/30 days; Step Therapy requires trial of alendronate
IBRANCE CAP	QL= 21 caps/28 days
ILEVRO OPHTH SUSP	QL= 3ml/fill
IMBRUVICA CAP	QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMITREX INJ	QL= 4 inj/fill, 2 fills/30 days
IMITREX TAB	QL= 9 tabs/fill, 2 fills/30 days
IMITREX VIAL INJ	QL= 5 inj/fill, 2 fills/30 days
INLYTA TAB	QL= 8 tabs/day
JAKAFI TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
KALYDECO PAK	QL= 2 packets/day
KALYDECO TAB	QL= 2 tabs/day
ketorolac tab	QL= 20 tabs/5 days
ketotifen ophth soln	QL= 10ml/30 days
latanoprost ophth soln	QL= 2.5ml/30 days
LENVIMA CAP	QL= 3 caps/day; Only available through Accredo 888-773-7376
LETAIRIS TAB	QL= 1 tab/day
lidocaine cream 5%	QL= 50gm/30 days
lidocaine oint	QL= 50gm/30 days; Step Therapy requires trial of lidocaine cream 5%
lidocaine patch	QL= 1 patch/day
LIDODERM PATCH	QL= 1 patch/day
LINZESS CAP	QL= 1 cap/day
LUMIGAN OPHTH SOLN	QL= 5ml/30 days
malathion lotion	QL= 2 bottles/fill
MAXALT MLT TAB	QL= 12 tabs/fill, 3 fills/60 days
MAXALT TAB	QL= 12 tabs/fill, 3 fills/60 days
medroxyprogesterone inj	QL= 1 inj/90 days
METHERGINE TAB	QL= 28 tabs/fill, 1 fill/365 days
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
modafinil tab	QL= 2 tabs/day
MOVIPREP SOLN	QL= 1 bottle/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Last Updated* 12/1/2016
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NASONEX NASAL SPRAY	QL= 2 bottles/fill
NATPARA INJ	QL= 1 inj/day; Only available through Walgreens 888-347-3416
NICODERM PATCH	Limited to 180 days/plan year
NICORETTE GUM	Limited to 180 days/plan year
NICORETTE LOZENGE	Limited to 180 days/plan year
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	Limited to 180 days/plan year
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
NUCYNTA ER TAB	QL= 2 tabs/day
NUDEXTA CAP	QL= 2 caps/day
ODOMZO CAP	QL= 1 cap/day
OFEV CAP	QL= 2 caps/day
ONGLYZA TAB	QL= 1 tab/day
OPSUMIT TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
ORKAMBI TAB	QL= 4 tabs/day
OVIDE LOTION	QL= 2 bottles/fill
OXYCONTIN CR TAB	QL= 120 tabs/30 days
PATADAY OPHTH SOLN	QL= 2.5ml/30 days; Step Therapy requires trial of ketotifen ophth soln
peg 3350/electrolytes soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
phentermine cap	QL= 1 cap/day
phentermine tab	QL= 1 tab/day
POTIGA TAB	QL= 3 tabs/day
POTIGA TAB 50MG	QL= 9 tabs/day
PRADAXA CAP	QL= 2 caps/day
PROLENSA OPHTH SOLN	QL= 3ml/fill
PROVIGIL TAB	QL= 2 tabs/day
REGRANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/fill
REVLIMID CAP	QL= 1 cap/day; Not available through Chinese Hospital Pharmacy-use Diplomat
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
rosuvastatin tab	QL= 1 tab/day
rosuvastatin tab 20mg	QL= 1.5 tabs/day
ROZEREM TAB	QL= 1 tab/day
SAVELLA TAB	QL= 2 tabs/day
SIGNIFOR INJ	QL= 2 vials/day; Only available through Accredo 888-773-7376
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SOVALDI TAB	QL= 1 tab/day
SPINOSAD SUSP	QL= 1 bottle/fill
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Last Updated* 12/1/2016
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
sumatriptan inj	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SYNJARDY TAB	QL= 2 tabs/day
TAFINLAR CAP	QL= 2 caps/day
TAGRISSO TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
TAMIFLU CAP	QL= 10 caps/fill
TAMIFLU CAP 30MG	QL= 20 caps/fill
TAMIFLU SUSP 6MG/ML	QL= 250ml/fill
TEMOVATE CREAM	QL= 30gm/fill
TEMOVATE OINT	QL= 30gm/fill
TESTOSTERONE GEL 1% 25MG	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
TESTOSTERONE GEL PUMP	QL= 4 bottles/30 days
TIVICAY TAB	QL= 2 tabs/day
TOPICORT CREAM 0.25%	QL= 60gm/fill
TOPICORT/DESOXIMETASONE CREAM 0.05%	QL= 60gm/fill
TRACLEER TAB	QL= 2 tabs/day
TRAVATAN Z OPHTH SOLN	QL= 5ml/30 days
triamcinolone nasal spray	QL= 2 bottles/fill
trilyte soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
TRINTELLIX TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 inj/28 days
TUSSIONEX SUSP	QL= 120ml/fill; 2 fills/30 days
ULTRAVATE CREAM	QL= 50gm/fill
ULTRAVATE LOTION	QL= 60ml/fill
ULTRAVATE OINT	QL= 50gm/fill
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 888-773-7376
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 888-773-7376
VANCOGIN CAP	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
vancomycin cap	QL= 56 caps/fill; Step Therapy requires trial of vancomycin soln
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VERAMYST NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or NASONEX
V-GO INJ KIT	QL= 1 kit/day
VIAGRA TAB	QL= 6 tabs/30 days
VICTOZA INJ	QL= 9ml/30 days
VIGAMOX OPHTH SOLN	QL= 3ml/fill
VIMPAT TAB	QL= 2 tabs/day
VIVOTIF CAP	QL= 4 caps/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Chinese Community Health Plan 4-Tier Formulary (Commercial) Cont.
Last Updated* 12/1/2016
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
VOLTAREN GEL	QL= 5 tubes/fill
XALATAN OPHTH SOLN	QL= 2.5ml/30 days
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
XIGDUO XR TAB	QL= 1 tab/day
XIGDUO XR TAB 5-1000MG	QL= 2 tabs/day
XTANDI CAP	QL= 4 caps/day
ZADITOR OPHTH SOLN	QL= 10ml/30 days
ZEPATIER TAB	QL= 1 tab/day
ZETIA TAB	QL= 1 tab/day
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem tab 10mg	Male QL= 1 tab/day; Female QL= 0.5 tab/day
zolpidem tab 5mg	QL= 1 tab/day
ZOMIG TAB	QL= 9 tabs/fill, 2 fills/30 days
ZOMIG ZMT	QL= 9 tabs/fill, 2 fills/30 days
ZYBAN TAB	Limited to 180 days/plan year
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.