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POLICY & PROCEDURE	
POLICY TITLE: Formulary Transition	**DEPARTMENT/PROGRAM:** Pharmacy
ORIGINAL EFFECTIVE DATE: 11/09/2009	**REFERENCE NUMBER:** PHM002
ALL REVISION DATES: 04/12/2010, 08/12/2010	**ALL REVIEW DATES:** 06/18/2010

POLICY:
It is the policy of Care Wisconsin First, Inc. (CW) to comply with all CMS requirements regarding the Medicare Part D formulary transition supply by providing a transition process for its Partnership members to obtain non-formulary drugs in a retail or long-term care setting or via home infusion, safety-net, or Indian Tribal Unit pharmacies as applicable.

COMMENTS:

1) This policy and procedure addresses:
   a) Provision of a transition supply of medication for new members in a prescription drug plan at the beginning of a contract year; the transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year; the transition of individuals who switch from one plan to another after the beginning of a contract year; members residing in long-term care (LTC) facilities; and, in some cases, current members affected by formulary changes from one contract year to the next.
   b) Formal written notification to members when a transition supply is dispensed due to a drug being non-formulary or due to a formulary drug being subject to prior authorization, step therapy, or quantity limits. The notice informs the members of their rights and responsibilities regarding that medication.

2) This policy and procedure applies to non-formulary drugs, meaning both (1) drugs that are not on the formulary; and (2) drugs that are on the formulary but require prior authorization or step therapy under CW's utilization management rules. As described in the procedure, CW conducts medical review (referred to as "transition review" in the procedure) of non-formulary drug requests, and has a process for switching new Partnership members to therapeutically appropriate formulary alternatives following an affirmative medical necessity determination.

3) CW has systems capabilities that allow for the provision of a temporary supply of non-formulary drugs at the point-of-sale in order to accommodate the immediate needs of a member, as well as to allow CW and the member sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication or to allow for the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons. This process also applies to brand-new prescriptions for a non-formulary drug and ongoing prescriptions for a non-formulary drug if the distinction is unable to be made at the point-of-sale.

4) Until such time as alternative transactional coding is implemented in a new version of the HIPAA standard, Care Wisconsin will ensure that its Pharmacy Benefits Manager (PBM)

continues to either: (1) implement appropriate systems changes to achieve the goals of any additional new messaging approved by the industry through NCPDP to address clarifying information needed to adjudicate a Part D claim; or (2) implement alternative approaches that achieve the goals intended in the messaging guidance.

PROCEDURE:

1) **Transition Supply Process**
   a) Transition Supply at Point-of-Sale:
      i) Eligibility for transition supplies of medications is coded into the Pharmacy Benefit Manager's (PBM's) system upon member enrollment.
      ii) Enrollment transition supplies are automatically able to be filled at the point-of-sale with no further action by the pharmacy.
      iii) The member is notified of the transition supply status via the Transition Supply Notification Procedure (see below).
      iv) Should a member require a transition supply but the order receives an error at the pharmacy or should the member require a special LTC-related transition supply, the pharmacy is instructed by an electronic message to contact the Care Wisconsin Medication Room.
      v) If the error occurs at a time when the Medication Room or other CW staff are unavailable, the local pharmacy can override the non-formulary edits at the point-of-sale by obtaining an override code from CW's PBM, which maintains a 24 hour help desk, available via a toll free line.

   b) Transition Periods: Care Wisconsin provides the following transition periods for Partnership members:
      i) Members who enroll in CW at the beginning of the calendar year, mid-year from another plan, or in November or December of a calendar year are all eligible for a 90 day transition period, beginning on their date of enrollment and continuing for 90 days, regardless of the number of months or calendar years spanned by that period. During this transition period:
         (1) Community-dwelling members are eligible for one fill of up to a 30 days' supply or multiple fills totaling up to a 30 days' supply of the transition medication.
         (2) Long-term care residents are eligible to receive multiple fills of up to 31 days' supply each up to a total of a 93 days' supply of the transition medication as long as they are within the 90 day transition period.

   c) Additional Transition Supplies for Members in LTC Facilities:
      i) Additional transition supplies are also provided for members in long-term care facilities under certain circumstances. Specifically, residents of a long-term care facility may, at any time during the calendar year, receive up to a 31-day emergency supply of non-formulary drugs (unless the enrollee presents with a prescription written for less than 31 days) while an exception or prior authorization for that medication is requested.
      ii) Members who are being admitted to or discharged from a long-term care facility, will be eligible for "early fills" as needed to ensure appropriate and necessary access to their benefit during these level-of-care transitions.

   d) Transition Co-Payments: Co-payments will be the same for these transition medications as for formulary medications.

e) Transition Review Process:
   i) New Partnership Members receive a medication review by a Pharmacy Services Manager shortly after enrollment. This review assesses appropriateness of medications, drug-drug interactions, drug-disease interactions, and formulary concerns.
   ii) The Pharmacy Services Manager communicates all review findings, including formulary concerns, to the member's team.
   iii) For new members as well as existing members who experience negative formulary changes, the team generally handles formulary transition concerns prospectively, either by changing to a formulary compliant medication or by providing the appropriate Prior Authorization, before the member ever fills a non-formulary medication.
   iv) If additional time is required to gather information about a member's previous medical history and/or appropriateness of the medication, the Pharmacy Services Manager may provide fills in addition to the standard transition fill of the requested non-formulary medication on a case-by-case basis while such information is sought.

f) Annual Formulary Changes: At the end of a calendar year, the Pharmacy Services Managers notify the teams of significant changes to the formulary that will occur in the following calendar year. When necessary, teams are provided with lists of members affected by the change(s) and efforts to convert members to a medication that will remain on formulary or to provide appropriate prior authorizations are begun by the teams and the Pharmacy Services Managers before the end of the calendar year.

g) Transition Notices: If a non-formulary medication, or a medication that is subject to prior authorization, step therapy or quantity limits, is filled during the transition period, either before the team addresses the non-formulary medication or because the team was unaware that the member had a prescription for the non-formulary medication, a transition notice is sent to the member using the Transition Supply Notification Procedure (below). The Transition Notice is sent to the member via U.S. first class mail within three business days of adjudication of the transition fill. The Notice includes:
   i) An explanation of the temporary nature of the transition supply the member has received;
   ii) Instructions for working with CW and the member's prescriber to identify appropriate therapeutic alternatives that are on CW's formulary;
   iii) An explanation of the member's right to request a formulary exception; and
   iv) A description of the procedures for requesting a formulary exception.

h) Transitions and Member Exceptions:
   i) If a member requests an exception and CW has not processed the exception request or appeal by the end of the minimum transition period, CW will make arrangements on a case-by-case basis to extend the transition period during the exception or appeal process.
   ii) At the end of the plan year the Pharmacy Services Manager has the option of honoring exceptions granted during the current plan year. If the exception will not be honored in the new plan year, CW will provide a Transition Notice to the member.

i) Availability of Documents:

i) CW provides prior authorization and exceptions request forms, upon request, to members and prescribers via a variety of mechanisms, including mail, fax, email, and on the plan web site.
ii) This transition policy and procedure will be available to members via a link from Medicare Prescription Drug Plan Finder to our web site and will be included in pre- and post-enrollment marketing materials as directed by CMS. A copy of this transition policy and procedure will be provided to CMS upon request.

j) Role of the Pharmacy and Therapeutics (P&T) Committee:
i) CW's P&T Committee reviews and provides recommendations regarding the procedures for medical review of non-formulary drug requests.
ii) The P&T Committee involvement ensures that transition decisions appropriately address situations involving enrollees stabilized on drugs that are not on the formulary (or that are on the formulary but require prior authorization or step therapy) and which are known to have risks associated with any changes in the prescribed regimen.

k) Document Retention: This policy and procedure and all related documentation will be retained by CW in accordance with CW record retention policies, or for a minimum of 10 years per Part D requirements, whichever is longer.

2) Transition Supply Notification Procedure:

a) CW's PBM, PharmaStar, posts a daily list of members who received a transition drug supply due to the drug being non-formulary or subject to prior authorization, step therapy, or quantity limits to their secure FTP site.

b) The Partnership Sr. Administrative Assistant will access PharmaStar's secure FTP site once per day to download the transition report. The FTP site login is "cw" and the site is available at: https://ftps.group-health.com/thinclient/login.aspx

c) A separate template letter will be generated by the Partnership Sr. Administrative Assistant for each drug identified as being filled through the transition benefit. The template letters will use the Model Transition Letter in Attachment A*, including all language that is applicable to the identified drug with no edits.
i) If a transition medication is addressed by one of the template files, the appropriate template is filled out.
ii) If the identified medication does not appear on any of the template files, it is a non-formulary medication and the non-formulary template should be completed.
iii) A Pharmacy Services Manager may be contacted if the classification of any medication is unclear.

* The template language in Attachment A is approved by the Centers for Medicare and Medicaid Services (CMS). If any changes are made to the template letter, Regulatory Affairs must resubmit the letter to CMS for approval prior to use.

d) The date, member's name, medication name, name of the transition fill template used, and date of the medication fill will be recorded in a spreadsheet by the Partnership Sr. Administrative Assistant.

e) The template generated for each transition medication and an envelope for each member identified on the report will be printed by Sr. Administrative Assistant. The templates will be grouped by member, folded, placed in the appropriate envelope, and sealed.

f) A copy of each template will be forwarded to the appropriate team so the team is aware of the formulary issue and can address it by either converting the member to a formulary compliant medication or by providing the appropriate prior authorization.

APPROVED:

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ATTACHMENTS:
A-Model Transition Letter
B-2010 List of Formulary Restricted Medications (Prior Authorization, Step Therapy, or Quantity Limit restrictions)

WORD SEARCH: Transition, Formulary, Prior Authorization, Step Therapy, Generic

[Instructions: This model should be used to notify beneficiaries that they have received a transition supply of a drug because the drug is not on the plan's formulary, or it is subject to the following drug utilization management tools: prior authorization, step therapy, generic first fill, quantity limits (for safety or non-safety reasons). It can also be used when a member receives a transition fill across contract years.]

<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that <Care Wisconsin Health Plan, Inc> has provided you with a [*Insert one* <temporary> <limited>] supply, of the following prescription[s]: <list medication[s] here> .

This [These] drug[s] are either not included on our list of covered drugs (called our formulary) or included on the formulary, but subject to certain limits. As a [*Insert one* <new enrollee> <current enrollee who has remained with our plan this year>] <Care Wisconsin Health Plan, Inc> is required to provide at least a 30-day supply. [*Insert for members who reside in a LTC facility:* As a resident of a long term care facility, <Care Wisconsin Health Plan, Inc> is required to provide at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply.]

It is important that you understand that this is a [*Insert one* <temporary> *or* <limited>] supply of this drug. Before this supply ends, you should speak to <Care Wisconsin Health Plan, Inc> and/or your physician regarding whether you should change the drug[s] you are currently taking, or request an exception from <Care Wisconsin Health Plan, Inc> to continue coverage of this [these] drug[s].

If you need assistance in requesting an exception, or for more information about our transition policy, please call <Customer/Member> Service at <phone number>. TTY users should call <TTYnumber>. We are happy to take your calls from <hours of operations>. Instructions on how to apply for an exception or how to change your current prescription[s] is [are] discussed at the end of the letter.

The following is an explanation of why your drug[s] is [are] not covered or is [are] limited under <Care Wisconsin Health Plan, Inc>.

*[**Note**: Plans may include information about multiple transition supplies on the same notice.]*

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>

Reason for Notification: This drug is not covered on our formulary. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90>days in <Care Wisconsin Health Plan, Inc> unless you obtain a formulary exception from <Care Wisconsin Health Plan, Inc>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you obtain a formulary exception from <Care Wisconsin Health Plan, Inc>.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is not covered on our formulary. In addition, we could not provide the full amount that was prescribed because we limit the amount of this drug that we provide at one time. This is called quantity limits and we impose such limits for safety reasons. [*Insert for members who do not reside in a LTC facility:* We will allow you to refill your <*name of drug*> prescription until we have provided you with a <*must be at least 30*> day supply, but we will not pay for it after that unless you obtain a formulary exception from <Care Wisconsin Health Plan, Inc>.] [*Insert for members who reside in a LTC facility:* We will allow you to refill the limited supply of your <*name of drug*> prescription but will stop providing additional fills after your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you obtain a formulary exception from <Care Wisconsin Health Plan, Inc>.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is covered on our formulary. However, we could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit unless you obtain an exception from <Care Wisconsin Health Plan, Inc>. Please contact <Care Wisconsin Health Plan, Inc> to discuss the exception process. Our contact information is located below.

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug requires your doctor or other professional who prescribed this drug to ask us to satisfy certain requirements before you can fill this prescription at your pharmacy. This is called prior authorization. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc>, unless you obtain <Care Wisconsin Health Plan, Inc>'s prior authorization or you obtain an exception to the prior authorization from <Care Wisconsin Health Plan, Inc>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you obtain a prior authorization or you obtain an exception to the prior authorization from <Care Wisconsin Health Plan, Inc>.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>

Reason for Notification: This drug will be covered only if you first try certain other drugs, as part of what we call a step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Care Wisconsin Health Plan, Inc>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply > day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Care Wisconsin Health Plan, Inc>.]

Name of Drug: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug will be covered only if you first try a generic version of this drug. This drug will not be covered outside of the transition period because <Care Wisconsin Health Plan, Inc> would like you to try a generic of this drug before continuing to cover the brand drug. [*Insert for members who do not reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a <must be at least 30> day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Care Wisconsin Health Plan, Inc>.] [*Insert for members who reside in a LTC facility:* We have provided you with a <days supply on filled claim> day supply. The maximum days supply allowed is a < must be at least a 31 day supply (unless the prescription is written for less) with refills provided, if needed, up to a 93 day supply> day supply during your first <must be at least 90> days in <Care Wisconsin Health Plan, Inc> unless you try other drugs on our formulary first or you obtain an exception to the step therapy requirement from <Care Wisconsin Health Plan, Inc>.] We will cover this drug only while you seek to obtain an exception to the generic first fill requirement. Please contact <Care Wisconsin Health Plan, Inc> to discuss the exception process. Our contact information is located below.]

***Note**: The following notice provision is optional to address the situation when a drug is non-formulary and has quantity limits that are not safety-related (plan imposed). While the non-formulary language is mandatory, plans may choose to also include quantity limit language in order to provide as much information as possible to the member.*

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: We could not provide the full amount that was prescribed because of plan quantity limits. We will not provide more than what our quantity limits permit unless you obtain an exception from <Care Wisconsin Health Plan, Inc>. Please contact <Care Wisconsin Health Plan, Inc> to discuss the exception process. Our contact information is located below.]

***Note**: The following notice provision is for Emergency Fill and Level of Care Change transitions and is optional. However, we encourage plans notify beneficiaries of Emergency Fill and Level of Care Change Transitions.*

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug is not covered on our formulary. We will cover this drug for <days supply on filled claim –must be at least 31 days> while you seek to obtain a formulary exception from <Care Wisconsin Health Plan, Inc>. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made. Please contact <Care Wisconsin Health Plan, Inc> for more information regarding our exception process. Our contact information is located below.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug requires prior authorization. We will cover this drug for <days supply on filled claim –must be at least 31 days> while you seek to obtain an exception to the prior authorization from <Care Wisconsin Health Plan, Inc>. Please contact <Care Wisconsin Health Plan, Inc> to discuss the exemption process. Our contact information is located below.]

[**Name of Drug**: <*name of drug*>
Date Filled: <*date filled*>
Reason for Notification: This drug will be covered only if you first try certain other drugs as part of what we call our step therapy program. Step therapy is the practice of beginning drug therapy with what we consider to be a safe and effective, lower cost drug before progressing to other more costly drugs. We will cover this drug for <days supply on filled claim –must be at least 31 days> while you seek to obtain an exception to the step therapy requirement from <Care Wisconsin Health Plan, Inc>. Please contact <Care Wisconsin Health Plan, Inc> to discuss the exception process. Our contact information is located below.]

How do I change my prescription?

If your drug[s] is [are] not covered on our formulary, or is covered on our formulary but we have placed a prior authorization, step therapy, or quantity limit on it, you can ask us if we cover another drug used to treat your medical condition. If we cover another drug for your condition, we encourage you to ask your doctor if these drugs that we cover are an option for you. If your doctor tells you that none of the drugs we cover for treating your condition is medically appropriate, you have the right to request an exception from us. You also have the right to request an exception if your doctor tells you that a prior authorization, quantity limit, or other limit we have placed on a drug you are taking is not medically appropriate for treating your condition.

How do I request an exception?

The first step in requesting an exception is for you to ask your prescribing doctor to contact us. <Provide the necessary address, fax number, and phone number>.

Your doctor must submit a statement supporting your request. It may be helpful to take this notice with you to the doctor or submit it to his or her office. The doctor's statement must indicate that the requested drug is medically necessary for treating your condition because none

of the drugs we cover would be as effective as the requested drug or would have adverse effects for you. If the exception involves a prior authorization, quantity limit, or other limit we have placed on that drug, the doctor’s statement must indicate that the prior authorization, or limit, would not be appropriate given your condition or would have adverse effects for you.

Once the physician's statement is submitted, we must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request. Your request will be expedited if we determine, or your doctor informs us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

What if my request is denied?

If your request is denied, you have the right to appeal by asking for a review of the prior decision. You must request this appeal within 60 calendar days from the date of our first decision. <You must file a standard request in writing/we accept standard requests by telephone and in writing. We accept expedited requests by telephone and in writing. Provide the necessary address, fax number, and phone number>.
If you need assistance in requesting an exception or for more information about our transition policy, please call <Customer/Member> Service at <phone number>. TTY users should call <TTY number>. We are available from <hours of operations>.

Sincerely,

Care Wisconsin Health Plan, Inc.

B-2010 List of Formulary Restricted Medications (Prior Authorization, Step Therapy, or Quantity Limit restrictions)

2010 Prior Authorization drugs

Adalimumab (Humira)
Etanercept (Enbrel)
Alosetron (Lotronex)
Aprepitant (Emend)
Becaplermin (Regranex)
Cyclosporine (Restasis)
Dalteparin(Fragmin)
Exenatide (Byetta)
Darbepoetin (Aranesp)
Interferon Alpha 2B (Intron A, Rebetron)
Interferon beta-1A (Rebif)
Interferon beta-1B (Betaseron)
Lacosamide (Vimpat)
Lidocaine (Lidoderm)
Metformin Hydrochloride and Sitagliptin Phosphate (Janumet)
Micafungin sodium (Mycamine)
Modafinal (Provigil)
Montelukast sodium (Singulair Chew)
Montelukast sodium (Singulair)
Neupogen (Filgrastim)
Nicotine (Nicotrol NS)
Nicotine (Nicotrol)
Octreotide (Sandostatin)
Olanzapine (Zyprexa Zydis)
Ondansetron (Zofran)
Ondansetron Dispersible tablets (Zofran ODT)
Oxycodone (OxyContin)
Paliperidone (Invega)
Pramlintide Acetate (Symlin)
Pregabalin (Lyrica)
Ranolazine (Ranexa)
Riluzole (Rilutek)
Risperidone (Risperdal M-Tab)
Rufinamide (Banzel)
Selegiline (Emsam)
Sitagliptin Phosphate (Januvia)
Telithromycin (Ketek)
Teriparatide (Forteo)
Testosterone (Androderm)
Topriamate (Topamax sprinkle)
Vancomycin (Vancocin)
Zafirlukast (Accolate)
Vareniciline (Chantix)
Ezetimibe (Zetia)
Imiquimod (Aldara)
Desvenlafaxine (Pristiq)
Diclofenac (Solaraze)
Duloxetine (Cymbalta)

Eltrombopag olamine (Promacta)
Enoxaparin (Lovenox)
Epoetin (Epogen/Procrit)
Fentanyl (Duragesic)
Fondaparinux (Arixtra)
Glatiramer (Copaxone)
Infliximab (Remicade)

2010 Step Therapy drugs

ondansetron 24mg (Zofran)
Aprepitant (Emend)
granisetron (Granisol or Kytril)
Dolasetron (Anzemet)
Fexofenadine (Allegra)
Candesartan (Atacand)
Candesartan/Hydrochlorothiazide (Atacand HCT)
Losartan (Cozaar)
Losartan/ Hydrochlorothiazide (Hyzaar)
Valsartan (Diovan)
Valsartan/ Hydrochlorothiazide (Diovan HCT)
Famotidine (Pepsid)
Tiotropium Bromide (Spiriva)
risperidone orally disintegrating tablets (Risperdal M-tab)
risperidone injection (Risperdal Consta)
olanzapine (Zyprexa)
quetiapine (Seroquel)
ziprasidone (Geodon)
ariprazole (Abilify)
paliperidone (Invega)
Vancomycin Oral (Vanco)
Desvenlafaxine (Pristiq)
Fenofibrate (Lofibra, Tricor)
Ezetimibe (Zetia)
Ezetimibe/Simvastatin (Vytorin)
atorvastatin (Lipitor)
Almotriptan (Axert)
Sumatriptan (Imitrex)
Zolmatriptan (Zomig)
Zolmatriptan (Zomig ZMT)
gabapentin (Neurontin)
Celecoxib (Celebrex)
Oxycodone SR (Oxycontin)
fentanyl patches (Duragesic)
glipizide/metformin (Metaglip)
glyburide/metformin (Glucovance)
Pioglitazone (Actos)
Repaglinide (Prandin)
Sitagliptin Phosphate (Januvia)
Sitagliptin Phosphate/Metformin (Janumet)
acarbose (Precose)

exenatide (Byetta)
pramlintide (Symlin)
Pregabalin (Lyrica)
duloxetine (Cymbalta)
Pantoprazole (Protonix)
Lansoprazole (Prevacid)
Lidocaine patches (Lidoderm)
Tolterodine (Detrol)
Oxybutynin ER (Ditropan, Ditropan XL)
Tolterodine ER (Detrol LA)
Darifenaxin (Enablex)
Solifenacin (Vesicare)
Trospium (Sanctura, Sanctura XR)
Oxybutynin (Oxytrol)
Omalizumab (Xolair)

2010 Quantity Limit drugs

Aprepitant (Emend)
Dolasetron (Anzemet)
Ondansetron (Zofran)
Azelastine (Optivar)
Becaplermin (Regranex)
Bimatoprost (Lumigan)
fluticasone and salmeterol (Advair Diskus)
latanoprost (Xalatan)
Lidocaine patches (Lidoderm)
Nicotine inhalers (Nicotrol)
Nicotine nasal (Nicotrol NS)
loteprednol etabonate (Alrex)
loteprednol etabonate (Lotemax)
loteprednol etabonate and tobramycin (Zylet)
Olopatadine (Pataday)
Olopatadine (Patanol)
salmeterol(Servent Diskus)
travoprost (Travatan)
Almotriptan (Axert)
Sumatriptan (Imitrex)
Zolmatriptan (Zomig)
Zolmatriptan (Zomig ZMT)
Ketorolac (Acular)
Brimonidine (Alphagan)
Brimonidine (Alphagan - P)