



Preferred Drug List

2/18/08



The *DataRx Management Preferred Drug List* is a guide within select therapeutic categories for clients and their plan participants. **Generics must always be considered the first line of prescribing.** Generics listed in therapeutic categories are for representation purposes only and not meant to be all-inclusive.

PLAN PARTICIPANT	HEALTHCARE PROVIDER
<p>Your benefit plan provides you with a prescription benefit program. Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from this list. Take this list along when you, or a covered family member, sees a doctor.</p> <p>Please note:</p> <ul style="list-style-type: none"> ■ Your specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. ■ Unless specifically indicated, drug list products will include all dosage forms. ■ Participants must always apply through available Medication Assistance Programs for all medications available through those programs. ■ <u>Prior-authorization by the Indigent Program is required for brand name medications not listed in this Formulary. Application to a Medication Assistance Program is also required before any consideration to approve a non-listed Brand Name Medication to be covered by this Program.</u> 	<p>Your patient is covered under a prescription benefit plan. As a way to help manage healthcare costs, generic utilization is the first line of prescribing. If you believe a brand name product is necessary, please submit your request to Rio Grande Valley Indigent Health Care Corporation for consideration of addition to the Formulary.</p> <p>Please note:</p> <ul style="list-style-type: none"> ■ Generics must be considered the first line of prescribing. ■ This drug list is not inclusive nor does it guarantee coverage, but represents a summary of prescription coverage. ■ Unless specifically indicated, drug list products will include all dosage forms. ■ Patients should always be referred to a Patient Assistance Program for Brand Name drugs prior to requesting authorization to cover. ■ <u>PRIOR AUTHORIZATION BY THE INDIGENT PROGRAM IS REQUIRED FOR BRAND NAME MEDICATIONS NOT LISTED IN THIS FORMULARY.</u>

ANTI-INFECTIVES

ANTIBACTERIALS
§ CEPHALOSPORINS
cefaclor
cephalexin

§ ERYTHROMYCINS / MACROLIDES
azithromycin
clarithromycin
erythromycins

§ FLUOROQUINOLONES
ciprofloxacin ext-rel
ciprofloxacin tablet

§ PENICILLINS
amoxicillin
amoxicillin-clavulanate
dicloxacillin
penicillin VK

§ TETRACYCLINES
doxycycline hyclate
minocycline
tetracycline

§ MISCELLANEOUS
metronidazole
sulfamethoxazole- trimethoprim

§ ANTIFUNGALS
fluconazole
itraconazole
terbinafine tablet

ANTIVIRALS
§ HERPES AGENTS
acyclovir

§ INFLUENZA AGENTS
amantadine
rimantadine

CARDIOVASCULAR

§ ACE INHIBITORS
fosinopril
lisinopril
quinapril

§ ACE INHIBITOR / DIURETIC COMBINATIONS
fosinopril-hydrochlorothiazide
lisinopril-hydrochlorothiazide
quinapril-hydrochlorothiazide

§ BILE ACID RESINS
cholestyramine

§ FIBRATES
fenofibrate

§ HMG-CoA REDUCTASE INHIBITORS
pravastatin
simvastatin

§ BETA-BLOCKERS
atenolol
metoprolol
metoprolol succinate ext-rel
nadolol
propranolol

§ CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem ext-rel
nifedipine ext-rel
verapamil ext-rel

§ DIGITALIS GLYCOSIDES
digoxin

§ DIURETICS

furosemide
hydrochlorothiazide
metolazone
spironolactone-hydrochlorothiazide
toremide
triamterene-hydrochlorothiazide

CENTRAL NERVOUS SYSTEM

ANTIDEPRESSANTS
§ MISCELLANEOUS AGENTS
bupropion
bupropion ext-rel
mirtazapine

§ SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)
citalopram
fluoxetine
paroxetine
sertraline

SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)³
venlafaxine

§ HYPNOTICS, NON-BENZODIAZEPINES
zolpidem



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ENDOCRINE AND METABOLIC	TOPICAL
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ANTIDIABETICS
§ BIGUANIDES
metformin
metformin ext-rel

INSULINS
NOVOLIN-N
NOVOLIN-R
NOVOLIN 70/30

§ NASAL STEROIDS
fluticasone

DERMATOLOGY
§ ACNE
erythromycin-benzoyl peroxide
tretinoin

OPHTHALMIC
§ BETA-BLOCKERS, NONSELECTIVE
timolol maleate solution

§ SYMPATHOMIMETICS
brimonidine 0.2%

FOR YOUR INFORMATION: Generics must always be considered the first line of prescribing. The Data Rx Drug List is not inclusive nor does it guarantee coverage, but represents a summary of prescription coverage. Specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. The plan participant's prescription benefit plan may have a different co-pay¹ for specific products on the list. Unless otherwise indicated, drug list products will include all dosage forms. This list represents brand products in CAPS and generic products in lower case italics. Generics listed in therapeutic categories are for representational purposes only and are not meant to be all-inclusive. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed.

- § Generics are available in this class and must be considered as the first line of prescribing.
- (1) Co-payment or co-pay means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
- (2) Atacand should be reserved for patients who meet CHARM (Candesartan in Heart Failure - Assessment of Reduction in Mortality and Morbidity) trial criteria.
- (3) Indicates the proposed mechanism of action, based on the American Psychiatric Association Summary of Treatment Recommendations.
- (4) Higher co-payments may apply depending on the plan participant's specific prescription benefit plan.
- (5) An Accu-Chek or OneTouch blood glucose meter will be provided at no charge by the manufacturer to those individuals currently using a meter other than Accu-Chek or OneTouch. For more information on how to obtain a blood glucose meter, call toll-free:1-800-588-4456.

The Data Rx Drug List contains prescription brand name medicines that are registered or trademarks of pharmaceutical manufacturers. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber.



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QUICK REFERENCE PREFERRED DRUG LIST

A

acyclovir
albuterol
amantadine
amlodipine
amoxicillin
amoxicillin-clavulanate
atenolol
azithromycin

B

brimonidine 0.2%
bupropion
bupropion ext-rel

C

cefaclor
cephalexin
cholestyramine
ciprofloxacin ext-rel
ciprofloxacin tablet
citalopram
clarithromycin

D

dicloxacillin
digoxin
diltiazem ext-rel
doxazosin
doxycycline hyclate

E

erythromycin-benzoyl peroxide
erythromycins
estradiol
estropipate
ethinyl estradiol-levonorgestrel

F

fenofibrate
fexofenadine
finasteride
fluconazole
fluoxetine
fluticasone
fosinopril
fosinopril-hydrochlorothiazide
furosemide

G

glimepiride
glipizide
glipizide ext-rel
glipizide-metformin
glyburide metformin

H

hydrochlorothiazide

I

ipratropium-albuterol
inhalation solution
itraconazole

L

levothyroxine
lisinopril
lisinopril-hydrochlorothiazide

M

medroxyprogesterone
metformin
metformin ext-rel
metolazone
metoprolol
metoprolol succinate ext-rel
metronidazole
minocycline
mirtazapine

N

nadolol
nifedipine ext-rel
NOVOLIN

O

omeprazole
oxybutynin
oxybutynin ext-rel

P

paroxetine
penicillin VK
pravastatin
propranolol

Q

quinapril
quinapril-hydrochlorothiazide

R

ranitidine
rimantadine

S

sertraline
simvastatin
spironolactone-
hydrochlorothiazide
sulfamethoxazole-trimethoprim

T

terazosin
terbinafine tablet
tetracycline
timolol maleate solution
torsemide
tretinoin
triamterene-hydrochlorothiazide

V

venlafaxine
verapamil ext-rel

W

warfarin

Z

zolpidem