

SELF-ADMINISTERED INJECTABLE FORMULARY 2009

(for commercial and Medicaid plans only)

Formulary

Actimmune	Fragmin [†]	Methotrexate*
Apokyn	Fuzeon	Neupogen
Arcalyst	Heparin*	Norditropin*
Avonex	Humira	Pegasys
Copaxone	Intron-A	Procrit
Enbrel	Leukine	Sandostatin (LAR under medical)
Forteo	Lovenox [‡]	

Non Formulary

Formulary Alternatives

Aranesp.....	Procrit
Arixtra [†]	Fragmin [†] , Lovenox [‡]
Betaseron.....	Avonex, Copaxone
Caverject.....	Erectile Dysfunction Medications on 3rd tier
D.H.E. 45*.....	Migranal, Imitrex, Maxalt
Edex.....	Erectile Dysfunction Medications on 3rd tier
Epogen.....	Procrit
Increlex	
Infergen.....	Pegasys
Innohep [†]	Fragmin [†] , Lovenox [‡]
Iplex	
Kineret.....	Enbrel, Humira
Miacalcin Injection*.....	Miacalcin Nasal Spray
Neulasta.....	Neupogen
Peg-Intron.....	Pegasys
Raptiva.....	Enbrel, Humira
Rebif.....	Avonex, Copaxone
Serostim.....	No alternative available
Somavert.....	Sandostatin
Vivaglobin.....	(refer to medical benefit for IVIG)
Zorbtive.....	No alternative available

All self administered injectables require prior authorization

* indicates generic is on the Formulary

† initial therapy of 5 doses will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.

‡ initial therapy of 10 doses will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.

* Some plans cover only one growth hormone product -- Norditropin. Under these plans, Nutropin, Nutropin AQ, Humatrope, Genotropin, Saizen, Tev-Tropin and comparable agents are not covered. Please contact Member Services with questions if your doctor prescribes a growth hormone agent that is not covered.

For some benefit plans, self-administered injectables may be included under a member's medical benefit, not the pharmacy benefit plan. Please refer to your health plan documents regarding coverage of and any limitations or exclusions that may apply to your self-administered injectable benefit.