

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

Reading the Drug List

Generic drugs are listed in all lower case letters. Brand name drugs are listed in all upper case letters. Each drug product is assigned a coverage tier, shown to the right of each drug product.

Relative Cost to Member

Tier 1	Formulary generics and some lower cost brand products	\$
Tier 2	Formulary, brand products	\$\$
Tier 3	Non-preferred formulary products	\$\$\$

Cases where drug products are followed by parentheses indicate that the entry relates to a certain dosage form, e.g. ESTRACE (vaginal cream) or more than one form of the drug, e.g. ZOMIG (ZMT). Quantity limits are for prescriptions filled at retail pharmacies. Please consult the complete version of the formulary for mail order quantity limits.

All newly approved drugs on the market will initially NOT be covered, pending further review by the Navitus P&T Committee.

A complete version of the Navitus Formulary, as well as information on prior authorization and clinical programs, are available at www.navitus.com

ADHD/ ANTI-NARCOLEPSY/ ANTI-OBESITY/ ANOREXIANTS		ANALGESICS - ANTI-INFLAMMATORY	
dexamethylphenidate ER cap	1	celecoxib cap	1 QL
dexamethylphenidate tab	1	diclofenac sodium EC tab	1
methylphenidate ER cap	1	diclofenac sodium XR tab	1
methylphenidate tab	1 QL	diclofenac/ misoprostol DR tab	1
VYVANSE CAP	3 QL	ibuprofen tab	1
ADDERALL XR CAP	NC	ketorolac tab	1 QL
AMINOGLYCOSIDES		meloxicam tab	1
		meloxicam tab 7.5mg	1 QL
		TOBI PODHALER	3 MSP, RS

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

nabumetone tab	1		ASMANEX HFA INHALER	2	QL
piroxicam cap	1		ASMANEX INHALER	2	QL
sulindac tab	1		BREO ELLIPTA INHALER	2	
ANALGESICS - OPIOID			COMBIVENT INHALER	2	QL
acetaminophen/ codeine tab	1	QL	COMBIVENT RESPIMAT INHALER	2	QL
fentanyl patch	1	QL	DULERA INHALER	2	QL
hydrocodone/ acetaminophen tab	1		FLOVENT DISKUS INHALER	2	QL
morphine sulfate ER tab	1		FLOVENT HFA INHALER	2	QL
oxycodone/ acetaminophen tab	1		INCRUSE ELLIPTA INHALER	2	
tramadol tab	1	QL	SEREVENT DISKUS INHALER	2	QL
MORPHINE SULFATE ER BEAD CAP	3		ANORO ELLIPTA INHALER	3	
OXYCODONE ER TAB,	NC		PULMICORT FLEXHALER	NC	
OXYCONTIN CR TAB			QVAR INHALER	NC	
OXYCONTIN CR TAB	NC		TUDORZA PRESSAIR INHALER	NC	
ANTIANGIOTENSIVES			ANTICOAGULANTS		
alprazolam tab	1		warfarin tab	1	
bupirone tab	1		PRADAXA CAP	2	
hydroxyzine tab	1		ANTICONVULSANTS		
lorazepam tab	1		carbamazepine ER tab	1	
ANTIARRHYTHMICS			carbamazepine tab	1	
MULTAQ TAB	2	QL	clonazepam tab	1	
ANTIASTHMATIC AND BRONCHODILATOR AGENTS			divalproex sodium DR tab	1	
albuterol/ ipratropium neb soln	1		gabapentin cap	1	QL
ARNUIITY ELLIPTA INHALER	1		gabapentin cap 400mg	1	QL
budesonide inh susp	1		gabapentin tab 600mg	1	QL
ipratropium neb soln	1		gabapentin tab 800mg	1	QL
montelukast chew tab	1	QL	lamotrigine ER tab	1	QL
montelukast tab	1	QL	lamotrigine tab	1	QL
ADVAIR HFA INHALER	2	QL	levetiracetam tab	1	
			phenytoin cap	1	
			topiramate tab	1	
			ANTIDEPRESSANTS		

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request.

Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only.

Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

amitriptyline tab	1		BYDUREON PEN INJ	2	QL
bupropion ER tab	1	QL	FARXIGA TAB	2	QL
bupropion XL tab	1	QL	HUMULIN MIX PEN INJ	2	OTC
citalopram soln	1		JANUMET TAB	2	QL
citalopram tab	1	QL	JANUMET XR TAB	2	QL
citalopram tab 40mg	1	QL	JANUVIA TAB	2	QL, ¢
duloxetine EC cap	1		JENTADUETO TAB	2	QL
escitalopram soln	1	QL	LANTUS INJ	2	
escitalopram tab	1	QL	LANTUS SOLOSTAR INJ	2	
fluoxetine cap	1		LEVEMIR FLEXTOUCH INJ	2	
fluoxetine tab	1		LEVEMIR INJ	2	
mirtazapine tab	1	QL	NOVOLIN 70/ 30 INJ	2	OTC
NEFAZODONE TAB	1		NOVOLIN N INJ	2	OTC
nefazodone tab 50mg, 250mg	1		NOVOLIN R INJ	2	OTC
nortriptyline cap	1		TOUJEO MAX SOLOSTAR INJ	2	
paroxetine ER tab	1	QL	TOUJEO SOLOSTAR INJ	2	
paroxetine tab	1	QL	TRADJENTA TAB	2	QL
sertraline conc	1	QL	TRESIBA FLEXTOUCH INJ	2	
sertraline tab	1		VICTOZA INJ	2	QL
trazodone tab	1		ADMELOG INJ, INSULIN LISPRO	3	
venlafaxine ER cap	1	QL	INJ		
venlafaxine tab	1	QL	ADMELOG SOLOSTAR INJ,	3	
venlafaxine ER tab	NC		INSULIN LISPRO KWIKPEN INJ		
ANTIDIABETICS					
glipizide ER tab	1		(JUNIOR)		
glipizide tab	1		AVANDARYL TAB	3	QL, ST
glyburide tab	1		HUMALOG MIX INJ	3	
metformin tab	1		HUMALOG MIX KWIKPEN INJ,	3	
nateglinide tab	1	QL	INSULIN LISPRO PROTAMINE		
ACTOPLUS MET XR TAB	2	ST	INJ		
AVANDAMET TAB	2	QL	HUMALOG PEN INJ	3	
AVANDIA TAB	2	QL	HUMULIN MIX INJ	3	OTC
AVANDIA TAB 8MG	2	QL	HUMULIN N INJ	3	OTC
			HUMULIN N PEN INJ	3	OTC

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

HUMULIN R INJ	3	OTC	benazepril tab	1
BASAGLAR INJ	NC		benazepril/ hydrochlorothiazide tab	1
KOMBIGLYZE XR TAB	NC		bisoprolol/ hydrochlorothiazide tab	1
ONGLYZA TAB	NC		candesartan tab	1
pioglitazone/ metformin tab	NC		captopril tab	1
ANTIFUNGALS				
fluconazole susp	1		doxazosin tab	1
fluconazole tab	1		enalapril tab	1
griseofulvin micro tab	1		enalapril/ hydrochlorothiazide tab	1
griseofulvin susp	1		irbesartan tab	1 QL
itraconazole cap	1	PA	irbesartan/ hydrochlorothiazide tab	1 QL
ketoconazole tab	1		lisinopril tab	1
nystatin tab	1		lisinopril/ hydrochlorothiazide tab	1
terbinafine tab	1		losartan tab	1 QL
voriconazole tab	1	RS	losartan/ hydrochlorothiazide tab	1 QL
ANTI-HISTAMINES				
cetirizine tab	1	OTC, QL	metoprolol/ hydrochlorothiazide tab	1
desloratadine tab	1		perindopril tab	1 QL
fexofenadine tab	1	OTC	phenoxybenzamine cap	1
levocetirizine soln	1		telmisartan/ hydrochlorothiazide tab	1 QL
loratadine tab	1	OTC	terazosin cap	1
ANTIHYPERLIPIDEMICS				
cholestyramine powder	1		valsartan tab	1 QL
fenofibric acid DR cap	1	QL	VALTURNA TAB	3 QL
fluvastatin cap 20mg	1	QL	candesartan/ hydrochlorothiazide tab	NC
fluvastatin cap 40mg	1	QL	ANTI-INFECTIVE AGENTS - MISC.	
gemfibrozil tab	1		clindamycin cap	1
TRILIPIX CAP	1	QL	erythromycin/ sulfisoxazole susp	1
ALTOPREV TAB	3		metronidazole tab	1
ANTIHYPERTENSIVES				
amlodipine/ benazepril cap	1	QL	nitrofurantoin monohydrate cap	1
amlodipine/ valsartan tab	1		smz/ tmp (DS) tab	1

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

metronidazole cap	NC				
ANTIMALARIALS				ANTIPSYCHOTICS/ ANTIMANIC AGENTS	
hydroxychloroquine tab	1			aripiprazole tab	1
ANTIMYCOBACTERIAL AGENTS				clozapine tab	1
rifampin cap	1			lithium carbonate cap	1
ANTINEOPLASTICS				lithium carbonate tab	1
methotrexate tab	1			olanzapine ODT	1 QL
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES				olanzapine tab	1 QL
tamoxifen tab	\$0			paliperidone ER tab	1 PA
bexarotene cap	1	LMSP, PA, SF		quetiapine tab	1 QL
letrozole tab	1			quetiapine tab 300mg	1 QL
AFINITOR DISPERZ	3	LMSP, PA, QL, SF		risperidone ODT	1 QL
AFINITOR TAB 10MG	3	LMSP, PA, QL, SF		risperidone odt 2mg	1 QL
BOSULIF TAB	3	MSP, PA, QL, SF		risperidone tab	1 QL
ERIVEDGE CAP	3	MSP, PA, SF		ziprasidone cap	1 QL
ANTIPARKINSON AGENTS				ANTIVIRALS	
amantadine cap	1			acyclovir cap	1
carbidopa/ levodopa tab	1			acyclovir susp	1
pramipexole ER tab	1	QL		entecavir tab	1 QL
pramipexole tab	1	QL		nevirapine tab	1
ropinirole ER tab	1			valacyclovir tab	1
ropinirole tab	1	QL		zidovudine cap	1
selegiline cap	1			FUZEON INJ	3 LMSP
				PEG-INTRON INJ	3 LMSP
				PEGASYS INJ	3 LMSP
				RELENZA DISKHALER	3 QL
				ASSORTED CLASSES	
				azathioprine tab	1
				cyclosporine cap	1
				mycophenolate mofetil tab	1
				BETA BLOCKERS	
				atenolol tab	1

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

carvedilol tab	1	QL	cefprozil susp	1	
carvedilol tab 25mg	1	QL	cefprozil tab	1	
labetalol tab	1		cefuroxime susp	1	
metoprolol ER tab	1	QL	cephalexin cap	1	
metoprolol tab	1		CONTRACEPTIVES		
propranolol tab	1		amethyst tab	1	
LEVATOL TAB	2		norethindrone tab	1	
INDERAL XL CAP, INNOPRAN XL CAP	3		isibloom tab, enskyce tab, apri tab	2	
CALCIUM CHANNEL BLOCKERS			tri-sprintec tab	2	
amlodipine tab	1	QL	YAZ TAB	2	
diltiazem ER cap	1		CORTICOSTEROIDS		
diltiazem ER tab	1		prednisolone soln	1	
diltiazem tab	1		COUGH/ COLD/ ALLERGY		
felodipine ER tab	1		cetirizine/ pseudoephedrine 12-hour tab	1	OTC, QL
nifedipine cap	1		guaifenesin/ codeine syrup	1	OTC, QL
nifedipine ER tab	1		loratadine/ pseudoephedrine 12-hour tab	1	OTC
nisoldipine ER tab	1		loratadine/ pseudoephedrine 24-hour tab	1	OTC
verapamil SR tab	1		DERMATOLOGICALS		
COVERA-HS TAB	3		adapalene cream	1	PA
CARDIOVASCULAR AGENTS - MISC.			adapalene gel	1	PA
CAVERJECT INJ	3	QL	amnesteem cap, claravis cap,	1	
MUSE SUPP	3	QL	isotretinoin cap, myorisan cap,		
STENDRA TAB	3	QL	zenatane cap		
CEPHALOSPORINS			calcipotriene cream	1	
cefaclor cap	1		clindamycin gel	1	
cefadroxil cap	1		clindamycin/ benzoyl peroxide gel	1	
cefdinir cap	1		clotrimazole/ betamethasone cream	1	
cefdinir susp	1				
cefepodoxime proxetil tab	1				

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

erythromycin gel	1		triamterene/ hydrochlorothiazide	1	
imiquimod cream	1		tab		
ketoconazole cream	1		THALITONE TAB		NC
lidocaine patch	1	QL	ENDOCRINE AND METABOLIC AGENTS - MISC.		
lidocaine/ prilocaine cream	1		raloxifene tab		\$0
metronidazole cream	1		alendronate tab	1	QL
metronidazole gel	1		alendronate tab 10mg	1	QL
mupirocin oint	1		alendronate tab 5mg	1	QL
pimecrolimus cream	1	QL, ST	ibandronate tab 150mg	1	QL
tacrolimus oint	1	ST	risedronate tab 150mg	1	
tretinoin cream	1	PA	FORTICAL NASAL SPRAY	2	
tretinoin gel	1	PA	FOSAMAX+D TAB	2	QL
ELIDEL CREAM	2	QL, ST	FORTEO INJ	3	LMSP
TAZORAC CREAM 0.05%	3		ESTROGENS		
AZELEX CREAM	NC		estradiol patch	1	QL
mupirocin cream	NC		estradiol tab	1	
nystatin/ triamcinolone oint	NC		estradiol/ norethindrone tab	1	
DIAGNOSTIC PRODUCTS			CLIMARA PRO PATCH	2	QL
ACCU-CHECK TEST STRIP	15%	OTC	PREMARIN TAB	2	
FREESTYLE LITE TEST STRIP	15%	OTC	PREMPHASE TAB, PREMPRO	2	
FREESTYLE TEST STRIP	15%	OTC	TAB		
PRECISION XTRA TEST STRIP	15%	OTC	ALORA PATCH	3	QL
TEST STRIP (all other test strips)	NC	OTC	MENOSTAR PATCH	3	QL
DIURETICS			FLUOROQUINOLONES		
acetazolamide ER cap	1		ciprofloxacin tab	1	
amiloride/ hydrochlorothiazide tab	1		levofloxacin tab	1	QL
furosemide tab	1		moxifloxacin tab	1	
hydrochlorothiazide tab	1		ofloxacin tab	1	
spironolactone tab	1				
triamterene/ hydrochlorothiazide cap	1				

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

GENITOURINARY AGENTS - MISCELLANEOUS			PRECISION XTRA METER	\$0	OTC
finasteride tab	1		CALIBRATION LIQUID	15 ⁹	OTC
tamsulosin cap	1	QL	B-D INSULIN SYRINGE	2	OTC
GOUT AGENTS			B-D PEN NEEDLE	2	OTC
allopurinol tab	1		FREESTYLE INSULIN SYRINGE	2	OTC
HEMATOLOGICAL AGENTS - MISC.			NOVOFINE PEN NEEDLE	2	OTC
clopidogrel tab 75mg	1	QL	NOVOTWIST PEN NEEDLE	2	OTC
HYPNOTICS/ SEDATIVES/ SLEEP DISORDER AGENTS			NOVOTWIST/ NOVOFINE PEN NEEDLE	2	OTC
phenobarbital tab	1		PRECISION INSULIN SYRINGE	2	OTC
temazepam cap 15mg	1		MIGRAINE PRODUCTS		
temazepam cap 30mg	1		almotriptan tab	1	QL
zaleplon cap	1		naratriptan tab	1	QL
zolpidem ER tab	1	QL, ST	rizatriptan ODT	1	QL
ramelteon tab	NC		rizatriptan tab	1	QL
ROZEREM TAB	NC		sumatriptan inj	1	QL
MACROLIDES			SUMATRIPTAN INJ 6MG/ 0.5ML	1	QL
azithromycin susp	1		sumatriptan tab	1	QL
azithromycin tab	1		sumatriptan vial inj	1	QL
clarithromycin tab	1	QL	zolmitriptan 2.5mg tab	1	QL
DIFICID TAB	2	QL, ST	zolmitriptan 5mg tab	1	QL
MEDICAL DEVICES AND SUPPLIES			zolmitriptan ODT tab 2.5mg	1	QL
ACCU-CHEK AVIVA PLUS METER	\$0	OTC	zolmitriptan ODT tab 5mg	1	QL
FREESTYLE FREEDOM LITE METER	\$0	OTC	TREXIMET TAB	2	QL
FREESTYLE LITE METER	\$0	OTC	acetaminophen/ isometheptene/ dichloral cap	NC	
			SUMAVEL DOSEPRO INJ	NC	
			MOUTH/ THROAT/ DENTAL AGENTS		
			clotrimazole troches	1	
			nystatin susp	1	
			MULTIVITAMINS		

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	2		LUMIGAN OPHTH SOLN	2	QL
NASAL AGENTS - SYSTEMIC AND TOPICAL			NATACYN OPHTH SOLN	2	
budesonide nasal spray	1	OTC, QL	PROLENSA OPHTH SOLN	2	
fluticasone nasal spray	1	QL	RESTASIS OPHTH EMULSION	2	RS
FLONASE SENSIMIST NASAL SPRAY	2	OTC	TOBRADEX OPHTH OINT	2	
BECONASE AQ NASAL SPRAY	NC		ALREX OPHTH SUSP	3	
RHINOCORT AQUA NASAL SPRAY	NC		OTIC AGENTS		
OPHTHALMIC AGENTS			acetic acid otic soln	1	
azelastine ophth soln	1		neomycin/ polymixin/ hydrocortisone otic susp	1	
bacitracin/ polymyxin b ophth oint	1		ofloxacin otic soln	1	
ciprofloxacin ophth soln	1		CIPRODEX OTIC SUSP	3	
dorzolamide/ timolol (pf) ophth soln	1		PENICILLINS		
gentamicin ophth soln	1		amoxicillin cap	1	
ketorolac ophth soln	1		amoxicillin/ clavulanate ER tab	1	
latanoprost ophth soln	1	QL	amoxicillin/ clavulanate tab	1	
ofloxacin ophth soln	1		penicillin vk tab	1	
pilocarpine ophth soln	1		PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
timolol maleate ophth soln	1		bupropion SR tab	\$0	QL, SMKG
tobramycin ophth soln	1		CHANTIX PAK	\$0	QL, SMKG
tobramycin/ dexamethasone ophth soln	1	QL	CHANTIX TAB	\$0	QL, SMKG
ACUVAIL OPHTH SOLN	2		nicotine gum	\$0	OTC, QL, SMKG
ALPHAGAN P OPHTH SOLN 0.1%	2		nicotine lozenge	\$0	OTC, QL, SMKG
BETIMOL OPHTH SOLN	2		nicotine patch	\$0	OTC, QL, SMKG
			NICOTROL INHALER	\$0	QL, SMKG
			NICOTROL NASAL SPRAY	\$0	QL, SMKG
			donepezil ODT	1	QL

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		

Quick Reference Formulary - Community First Health Plans Formulary

This document is subject to change. The most updated version of this document, as well as a complete formulary listing, are available at www.navitus.com or upon request. Drugs will be filled as generics when acceptable generic equivalents are available. This document is copyrighted by Navitus Health Solutions® and may be reprinted for personal use only. Reproduction of this document for any other reason is expressly prohibited, unless prior written consent is obtained from Navitus.

donepezil tab	1	QL	PREMARIN VAGINAL CREAM	2
galantamine ER cap	1			
galantamine tab	1	¢		
memantine tab	1			
rivastigmine cap	1			
NAMENDA XR TITRATION PACK 3				

TETRACYCLINES

doxycycline hyclate cap	1			
minocycline cap	1			

THYROID AGENTS

liothyronine tab	1			
methimazole tab	1			
SYNTHROID TAB	1			
THYROLAR TAB	2			

ULCER DRUGS

cimetidine tab	1	OTC		
famotidine susp	1			
famotidine tab	1	OTC		
misoprostol tab	1			
pantoprazole EC tab	1	QL		
rabeprazole EC tab	1			
PREVACID OTC CAP	3	OTC		
DEXILANT CAP		NC		

URINARY ANTISPASMODICS

oxybutynin ER tab	1	QL		
oxybutynin ER tab 5mg	1	QL		
oxybutynin tab	1			
tolterodine SR cap	1	QL		
tolterodine tab	1	QL		
TOVIAZ TAB		NC		

VAGINAL PRODUCTS

NC	Not Covered	generic =small letters	BRANDS =CAPITAL LETTERS
EXC	Plan Exclusion	INF	Infertility
LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
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
¢	RxCENTS		