



Non-injectable dosage forms of the drugs on this list, plus all drugs on the Specialty List, are limited to a thirty (30) day supply and must be filled by the PBM Plus Mail Service Pharmacy.

ANTIFUNGAL AGENTS

Vfend

ANTI-INFECTIVE AGENTS

Oracea
Mycobutin
Xifaxan

CNS AGENTS

Rilutek

ENDOCRINE & METABOLIC AGENTS

Samsca

HEMOTOLOGICAL AGENTS

Amicar
Aminocaproic
Vitamin K

HIV/AIDS

Aptivus
Atripla
Combivir
Crixivan
Didanosine

Emtriva
Epivir
Epzicom
Intelence
Invirase
Isentress
Kaletra
Lexiva
Norvir
Prezista
Rescriptor
Retrovir
Reyataz
Selzentry
Sustiva
Trizivir
Truvada
Videx
Viracept
Viramune
Viread
Zerit
Zidovudine
Ziagen

HORMONE THERAPY
Synarel Nasal Solution

IMMUNOSUPPRESSIVE AGENTS

Rapamune Tablets

ONCOLOGY

Alkeran
Aromasin
Casodex
Etoposide
Fluorouracil
Hexalen
Leucovorin
Lysodren
Matulane
Mesnex
Myleran
Nilandron
Panretin
Tabloid
Targretin
Vesanoid

RENAL & GENITOURINARY AGENTS

Cuprimine

Drugs on this list plus drugs included on the Specialty Drug List (refer to www.pbplus.com) are required to be filled at the PBM Plus Mail Service Pharmacy and are limited to a thirty (30) day supply.

The 30 day copayment will apply to the drugs on this list based on their status (generic, preferred brand, non-preferred brand). The specialty copayment will apply to drugs on the "Specialty Drug List".

Inclusion on this list does not indicate coverage. Coverage of any drug is determined by the pharmacy benefit provided by the plan sponsor.

This list is subject to change without notice.