

The following is a **partial** list of Restat's most commonly used generic drugs.

ANTIDEPRESSANTS

citalopram
fluvoxamine
fluoxetine
paroxetine
sertraline
venlafaxine

NSAIDs**(ANTI-INFLAMMATORY)**

ibuprofen
indomethacin
naproxen
piroxicam
fenoprofen
ketoprofen
etodolac

**ANTIHYPERTENSIVES
(HIGH BLOOD
PRESSURE)**

benazepril
captopril
enalapril
fosinopril
lisinopril
quinapril
ramipril
moexipril
trandolapril
benazepril/HCTZ
captopril/HCTZ
enalapril/HCTZ
lisinopril/HCTZ
quinapril/HCTZ
fosinopril/HCTZ
moexipril/HCTZ
quinaretic
amlodipine/benazepril

sulindac
diclofenac
nabumetone
oxaprozin
meloxicam
tolmetin sodium
meclofenamate sodium

HYPNOTICS**(SLEEP AGENTS)**

zolpidem
zaleplon

INTRANASAL STEROIDS**(ALLERGY)**

fluticasone
flunisolide spray

**NON-SEDATING ANTIHIS-
TAMINES (ALLERGY)**

levocetirizine

**ANTI-VIRALS
(ANTI-HERPES)**

acyclovir
famciclovir
valacyclovir

**PROTON PUMP INHIBITOR
(GI/ULCER)**

omeprazole
lansoprazole
pantoprazole

**BISPHOSPHONATES
(OSTEOPOROSIS)**

alendronate

STATINS**(HIGH CHOLESTEROL)**

lovastatin
pravastatin
simvastatin

If your prescription is for a generic medication, you will pay the lowest copay.

For specific coverage on your plan or copay amounts, please refer to your prescription information on your ID card.

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Preferred Product Formulary

Member Guidelines

Restat administers your prescription benefit plan. Our goal is to provide the highest quality pharmaceutical care, at lower costs.

The most effective way to control costs are through the use of generic drugs and a drug formulary.

When a generic is not available, there may be more than one brand name drug that may be appropriate for you. The brand name medications listed are considered preferred and were selected based on their ability to meet patient needs at a lower cost.

If a generic medication is not available, ask your physician to prescribe a preferred brand.

The list may not include all preferred items.

Always ask for a Generic when available to minimize your out of pocket cost.

- Generics have the lowest copay.
- Preferred brands have the middle copay.
- Non-Preferred Brands have the highest copay.
- Medications highlighted in **orange** will be removed 10/31/11.
- Single source oncology, transplant, and HIV brands are preferred.
- **Effective Date 8/1/11—10/31/11**

View the most current Preferred Product Listing at www.restat.com

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A

ACCU-CHEK STRIPS/
LANCETS
ACTONEL (CR)
ACTOPLUS MET
ACTOS
ACUVAIL
ADVAIR DISKUS (CR)
ADVAIR HFA (CR)
ALPHAGAN-P (0.1%)
ALREX
ALTABAX
ANDRODERM (CR)
ANDROGEL (CR)
ANTARA
APIDRA
ARANESP (CR)
ARICEPT 23 MG (CR)
ASACOL
ASACOL HD
ASTEPRO
ASMANEX
ATRALIN GEL
AVELOX/AVELOX-ABC
AVINZA
AVODART (CR)
AZILECT
AZOR (CR)

B

BARACLUDE
B-D SYRINGES/NEEDLES
BENICAR (CR)
BENICAR HCT (CR)
BETIMOL
BETOPTIC-S
BYETTA (CR)
BYSTOLIC

C

CADUET (CR)
CAMPRAL
CANASA
CARAC
CELEBREX (CR)
CETROTIDE
CHANTIX
CIALIS (CR)
CIPRODEX
CLIMARA PRO
COLCRYS
COMBIVENT
COMTAN
CONCERTA

CONDYLOX GEL ONLY
COPAXONE (CR)
COREG CR
CORTEF
CORTIFOAM
CREON
CRESTOR (CR)
CUPRIMINE
CYMBALTA (CR)

D

DALIRESP
DAPSONE
DETROL
DETROL LA
DIASTAT
DIFFERIN Lot/0.3%, Gel
DIOVAN (CR)
DIOVAN HCT (CR)
DOVONEX CREAM/OINT
DUETACT
DYNACIRC CR

E

EFFIENT
ELMIRON
ENABLEX (CR)
ENBREL (CR)
ENJUVIA
ENTOCORT EC
EPIDUO GEL
EPINEPHRINE INJECTION
EPIPEN / EPIPEN JR.
ESTRADERM
EVISTA
EVOXAC
EXELON (PATCH/SOL)
EXFORGE
EXFORGE HCT

F

FEMARA
FEMRING
FLECTOR PATCH
FLOVENT
FLOVENT ROTADISK
FOCALIN XR
FORADIL
FORTEO (CR)
FOSRENOL

G

GENOTROPIN (CR)

GEODON
GLUCAGON
GRIS-PEG

H

HALFLYTELY
HECTOROL
HEPSERA
HUMALOG
HUMIRA (CR)
HUMULIN

I

INTAL INHALERS
INTRON A (CR)
INVEGA

J

JANUMET
JANUVIA

K

KADIAN
KOMBIGLYZE XR
KRISTALOSE

L

LAMICTAL CHEW, IR, ODT, XR
LANTUS
LEVAQUIN
LEVEMIR
LEXAPRO (CR)
LIDODERM
LIPITOR (CR)
LIPOFEN
LO SEASONIQUE
LOTEMAX
LOVAZA
LUMIGAN (CR)
LUXIQ
LYRICA

M

MALARONE
MAXALT (CR)
METADATE CD
MICARDIS (CR)
MICARDIS HCT (CR)
MOVIPREP
MULTAQ

N

NAMENDA

NARDIL
NASACORT AQ (CR)
NASONEX (CR)
NEULASTA (CR)
NEUPOGEN (CR)
NEUPRO
NEXA SELECT
NEXIUM (CR)
NIASPAN
NORDITROPIN (CR)
NOVOLIN
NOVOLOG
NUTROPIN AQ (CR)
NUTROPIN (CR)
NUVARING

O

ONE TOUCH TEST STRIPS
ONGLYZA
OPANA ER
ORTHO EVRA
ORTHO TRI-CYCLEN LO
OSMOPREP
OXYCONTIN
OXYTROL (CR)

P

PEG-INTRON (CR)
PEGASYS (CR)
PENTASA
PLAVIX
PRANDIN
PRED MILD
PREFERA OB
PREFERA OB ONE
PREFERA OB + DHA
PREMARIN
PREMARIN CREAM
PREMPHASE
PREMPRO
PRENEXA
PRIMABELLA
PRO-AIR HFA
PROCRIT (CR)
PROMETRIUM
PROTOPIC (CR)
PROVENTIL HFA
PULMICORT FLEXHALER
PULMICORT RESPULES

Q

QVAR

R

RANEXA
REBETRON (CR)
REBIF (CR)
RENAGEL
RETIN-A MICRO
REVATIO (CR)
RIDAURA

S

SAIZEN (CR)
SANCTURA XR (CR)
SAVELLA
SEASONIQUE
SEREVENT DISKUS
SEROQUEL
SEROQUEL XR
SIMCOR
SINGULAIR (CR)
SPIRIVA
SOLARAZE
SPIRIVA
STALEVO
STRATTERA
SUBOXONE
SYMBICORT (CR)
SYMLIN (CR)

T

TAZORAC
TEKTURNA
TEKTURNA HCT
TOBRADEX ST
TRAVATAN Z (CR)
TREXIMET (CR)
TRICOR
TRILIPIX
TYZEKA

U

ULTRASE
ULTRASE MT
URSO

V

VALCYTE
VALTURNA
VENTOLIN HFA
VERAMYST (CR)
VESICARE (CR)
VICTOZA (CR)
VIGAMOX
VIMOVO
VIMPAT
VIOKASE
VIVELLE-DOT

W

WELCHOL

X

XALATAN
XIBROM
XYREM

Z

ZEMPLAR
ZETIA
ZOMIG TABS/NASAL
SPRAY/ZMT TABS (CR)
ZYLET
ZYMAR
ZYPREXA
ZYPREXA ZYDIS

Some of the medications and categories on this list may NOT be covered by your plan. Their presence on this list does NOT guarantee coverage.

(CR) - These drugs may include a Restat clinical review.