2010 CareOregon Advantage Formulary Changes

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable

DATE POSTED	EFFECTIVE DATE	BRAND	GENERIC	STRENGTH	DOSAGE FORM	TYPE OF CHANGE	TIER; UTILIZATION RESTRICTIONS
2/15/10	1/1/10	ADCIRCA	TADALAFIL	20 MG	TABS	Added with PA.	Tier 2
2/15/10	1/1/10	AMOXICIL/CLAVULAN POTASSIUM	AMOXICILLIN AND CLAVULANIC ACID	250 MG/5ML,62.5 MG/5ML	SUSR	Added	Tier 1
2/15/10	1/1/10	CODEINE SULFATE	CODEINE SULFATE	15 MG, 30MG, 60MG	TABS	Added	Tier 2
2/15/10	1/1/10	COLCHICINE	COLCHICINE	0.6MG	TAB	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	1/1/10	COLCRYS	COLCHICINE	0.6 MG	TABS	Added	Tier 2
2/15/10	1/1/10	HECTOROL	DOXERCALCIFEROL	1 MCG	CAP	Added	Tier 2
2/15/10	1/1/10	HIBTITER	HAEMOPHILUS B OLIGOSACCHARIDE CONJUGATE	0	INJ	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	1/1/10	INTAL	CROMOLYN SODIUM	800MCG	INH	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	1/1/10	INVERSINE	MECAMYLAMINE	2.5MG	TAB	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	1/1/10	MULTAQ	DRONEDARONE HYDROCHLORIDE	400 MG	TABS	Added with PA.	Tier 2
2/15/10	1/1/10	ONGLYZA	SAXAGLIPTIN	2.5 MG, 5MG	TABS	Added with PA.	Tier 2
2/15/10	1/1/10	SABRIL	VIGABATRIN	500 MG / 50MG/ML	TABS/ SOLN	Added with PA and QL	Tier 2; PA Required for New Starts Only; QL= 60/30.
2/15/10	1/1/10	SAPHRIS	ASENAPINE	5MG, 10 MG	TABS	Added with QL and PA.	Tier 2; PA Required for New Starts Only; QL = 60/30.
2/15/10	1/1/10	STROMECTOL	IVERMECTIN	6MG	TAB	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	3/1/10	AMINESS	AMINO ACID INFUSION	0.052	IV SOLN	Removed from formulary. Medicare removed from Part D covered drug list.	NA
2/15/10	3/1/10	AMINOSYN II	ALANINE/ ARGININE / ASPARTATE / GLUCOSE / GLUTAMATE	3.5 % M IN 5 % DEXTROSE	IV SOLN	Added with PA.	Tier 2; PA Required for BvD.

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
2/15/10	3/1/10	ARZERRA	OFATUMUMAB	100MG/5ML	IV SOLN	Added to Part B drug list.	Covered under Medicare Part B.
2/15/10	3/1/10	BYETTA	EXENATIDE	5MCG	SYRINGE	Added with PA.	Tier 2; PA Required
2/15/10	3/1/10	DEXTROSE 5%-LACTATED RINGERS	DEXTROSE 5%-LACTATED RINGERS	0	IV SOLN	Added	Tier 1
2/15/10	3/1/10	DILTIAZEM	DILTIAZEM	420 MG	ER CAP	Added	Tier 1
2/15/10	3/1/10	DOXYCYCLINE HYCLATE	DOXYCYCLINE HYCLATE	100 MG	CAP	Added	Tier 1
2/15/10	3/1/10	ENBREL	ETANERCEPT	50 MG/ML	SOLN	Added with PA.	Tier 3; PA Required
2/15/10	3/1/10	EXTAVIA	INTERFERON BETA-1B	0.25 MG/ML	SOLN	Added	Tier 3
2/15/10	3/1/10	EXTAVIA	INTERFERON BETA-1B	0.25 MG/ML	SOLN	Added	Tier 3
2/15/10	3/1/10	GAVILYTE-C	POLYETHYLENE GLYCOL 3350 60 MG/ML / POTASSIUM CHLORIDE 0.01 MEQ/ML / SODIUM BICARBONATE 0.02 MEQ/ML / SODIUM CHLORIDE 0.025 MEQ/ML / SODIUM SULFATE 5.68 MG/ML	¾	SOLR	Added	Tier 1
2/15/10	3/1/10	GAVILYTE-N	POLYETHYLENE GLYCOL 3350 105 MG/ML / POTASSIUM CHLORIDE 0.005 MEQ/ML / SODIUM BICARBONATE 0.017 MEQ/ML / SODIUM CHLORIDE 0.048 MEQ/ML	¾	SOLR	Added	Tier 1
2/15/10	3/1/10	HUMIRA	ADALIMUMAB	20MG/0.4ML	PREFILLED SYRINGE	Added with PA.	Tier 3
2/15/10	3/1/10	HUMIRA	ADALIMUMAB	20MG/0.4ML	SYRINGE	Added with PA.	Tier 3; PA Required
2/15/10	3/1/10	INVEGA	PALIPERIDONE	1.5 MG	TB24	Added with PA.	Tier 2; PA Required for New Starts Only.
2/15/10	3/1/10	INVEGA SUSTENNA	PALIPERIDONE PALMITATE	39MG, 78MG, 117MG, 156MG, 234MG	IM SOLN	Added with PA.	Tier 2; PA Required for New Starts Only.
2/15/10	3/1/10	KETOROLAC	KETOROLAC	0.004	OPHTH SOLN	Added	Tier 1
2/15/10	3/1/10	LACTATED RINGERS	LACTATED RINGERS	0	IR SOLN	Added	Tier 1

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
2/15/10	3/1/10	LIPOSYN III	FAT EMULSION 10%	0.1	IV SOLN	Added with PA.	Tier 2; PA Required for BvD.
2/15/10	3/1/10	LIPOSYN III	FAT EMULSION 20%	0.2	IV SOLN	Added with PA.	Tier 1; PA Required for BvD.
2/15/10	3/1/10	LIPOSYN III	FAT EMULSION 30%	0.3	IV SOLN	Added with PA.	Tier 1; PA Required for BvD.
2/15/10	3/1/10	LIPSOYN II	FAT EMULSION 10%	0.1	IV SOLN	Added with PA.	Tier 2; PA Required for BvD.
2/15/10	3/1/10	LIPSOYN II	FAT EMULSION 20%	0.2	IV SOLN	Added with PA.	Tier 2; PA Required for BvD.
2/15/10	3/1/10	NAPROXEN	NAPROXEN	275MG, 550MG	TABS	Added	Tier 1
2/15/10	3/1/10	NUTROPIN	SOMATROPIN	5 MG/ML	SOLN	Added with PA.	Tier 3
2/15/10	3/1/10	NUTROPIN	SOMATROPIN	10 MG/ML	SOLN	Added with PA.	Tier 3
2/15/10	3/1/10	OMEPRAZOLE	OMEPRAZOLE	40MG	CAPS	Added	Tier 1
2/15/10	3/1/10	POLYETHYLENE GLYCOL 3350	POLYETHYLENE GLYCOL 3350	70.8 MG/ML	SOLR	Added	Tier 1
2/15/10	3/1/10	RENAGEL	SEVELAMER HYDROCHLORIDE	400 MG, 800MG	TABS	Added	Tier 2
2/15/10	3/1/10	SODIUM BICARBONATE	SODIUM BICARBONATE	0.084	IV SOLN	Added	Tier 1
2/15/10	3/1/10	SYMLIN	PRAMLINTIDE ACETATE	1 MG/ML	SOLN	Added with PA.	Tier 2; PA Required.
2/15/10	3/1/10	VOTRIENT	PAZOPANIB	200MG	TAB	Added with QL and PA.	Tier 2; PA Required for New Starts Only; QL = 120/30
2/15/10	3/1/10	ZENPEP 10	AMYLASES/ ENDOPEPTIDASES/ LIPASE	55000 UNT / 34000 UNT /10000 UNT	CAP	Added	Tier 2
2/15/10	3/1/10	ZENPEP 15	AMYLASES/ ENDOPEPTIDASES/ LIPASE	82000 UNT / 51000 UNT / 15000 UNT	CAP	Added	Tier 2
2/15/10	3/1/10	ZENPEP 20	AMYLASES/ ENDOPEPTIDASES/ LIPASE	109000 UNT / 68000 UNT /20000 UNT	CAP	Added	Tier 2
2/15/10	3/1/10	ZENPEP 5	AMYLASES/ ENDOPEPTIDASES/ LIPASE	27000 UNT / 17000 UNT /5000 UNT	CAP	Added	Tier 2

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
3/15/10	4/1/10	VIBATIV	TELAVANCIN	15MG/ML	SOLN	Added with PA.	Tier 2; PA Required for BvD.
3/15/10	4/1/10	MORPHINE SULFATE	MORPHINE SULFATE	20 MG/ML	SOLN	Added	Tier 1
3/15/10	4/1/10	AMINOSYN II 15%	AMINO ACID INFUSION WITH ELECTROLYTES		IV SOLN	Added with PA	Tier 2; PA Required for BvD.
3/15/10	4/1/10	AMINOSYN 8.5%	AMINO ACID INFUSION		IV SOLN	Added with PA	Tier 2; PA Required for BvD.
3/15/10	4/1/10	AMINOSYN II 10%	AMINO ACID INFUSION		IV SOLN	Added with PA	Tier 2; PA Required for BvD.
3/15/10	4/1/10	AMINOSYN II 8.5%	AMINO ACID INFUSION WITH ELECTROLYTES		IV SOLN	Added with PA	Tier 2; PA Required for BvD.
3/15/10	4/1/10	AMINOSYN-PF 10%	AMINO ACID INFUSION-PEDIATRIC FORMULA		IV SOLN	Added with PA	Tier 2; PA Required for BvD.
3/15/10	4/1/10	AMITIZA	LUBIPROSTONE	8MCG	CAP	Added with PA	Tier 2; PA Required.
3/15/10	4/1/10	CELEBREX	CELECOXIB	400 MG	CAP	Added with PA and QL	Tier 2; PA Required; QL #60 per 30d.
3/15/10	4/1/10	D5%-1/2NS-KCL 10 MEQ/L	D5%-1/2NS-KCL 10 MEQ/L		IV SOLN	Added	Tier 1
3/15/10	4/1/10	D5%-1/4NS-KCL 40 MEQ/L	D5%-1/4NS-KCL 40 MEQ/L		IV SOLN	Added	Tier 1
3/15/10	4/1/10	KCL 40 MEQ IN D5W-NACL 0.9%	KCL 40 MEQ IN D5W-NACL 0.9%		IV SOLN	Added	Tier 1
3/15/10	4/1/10	EMEND	APREPITANT	40MG	CAP	Added with PA	Tier 2; PA Required.
3/15/10	4/1/10	HEPARIN-D5W	HEPARIN-D5W	20,000 UNIT/500 ML	IV SOLN	Added	Tier 1
3/15/10	4/1/10	METHYLPREDNISOLONE	METHYLPREDNISOLONE	4MG	TAB	Added	Tier 1
3/15/10	4/1/10	OMNITROPE		5.8MG	VIAL	Added with PA	Tier 2; PA Required.
3/15/10	4/1/10	OXYCODONE-APAP	OXYCODONE-APAP	2.5-325 MG	TAB	Added	Tier 1
3/15/10	4/1/10	PROMETHAZINE	PROMETHAZINE	50 MG/ML	VIAL	Added	Tier 1
3/15/10	4/1/10	THALOMID	THALIDOMIDE	150 MG	CAP	Added	Tier 3
3/15/10	4/1/10	AMOCLAN	AMOXICILLIN & K CLAVULANATE FOR SUSP	200-28.5/5ML, 400-57/ML	SUSP	Added	Tier 1
3/15/10	4/1/10	DILT XR	DILTIAZEM HCL	240 MG	CAP	Added	Tier 1
3/15/10	4/1/10	KAON-CL	POTASSIUM CHLORIDE	10 MEQ	TABLET SA	Added	Tier 1
3/15/10	4/1/10	RENVELA	SEVELAMER CARBONATE	0.8 GM, 2.4GM	POWD PACKET	Added	Tier 2

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
3/15/10	4/1/10	DILTIAZEM HCL	DILTIAZEM HCL	100MG	VIAL	Added	Tier 1
2/15/10	5/1/10	ALKERAN	MELPHALAN	50MG	IV SOLN	New generic, melphalan, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	ELOXATIN	OXALIPLATIN	100MG/20ML	IV SOLN	New generic, oxaliplatin, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	IOPIDINE	APRACLONIDINE	0.5%	OPHTH SOLN	New generic, apraclonidine, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	PLAN B	LEVONORGESTREL	0.75MG	TAB	New generic, Next Choice/ Levonorgestrel, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	PREVACID	LANSOPRAZOLE	15MG, 30MG	CAP	New generic, lansoprazole, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	RAZADYNE	GALANTAMINE	4MG/ML	ORAL SOLN	New generic, galantamine, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	STARLIX	NATEGLINIDE	60MG, 120MG	TAB	New generic, nateglinide, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	SUBUTEX	BUPRENORPHINE	2MG, 8MG	SL TAB	New generic, buprenorphine, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	TRILEPTAL	OXCARBAZEPINE	300MG/5ML	ORAL SOLN	New generic, oxcarbazepine, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	VALTREX	VALACYCLOVIR	500MG, 1G	TAB	New generic, valacylcovir, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	5/1/10	ZOSYN	PIPERACILLIN-TAZOBACTAM	3.375 GM	IV SOLN	New generic, piperacillin-tazobactam, is available. Brand removed from formulary on 5/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	6/1/10	ACULAR	KETOROLAC	0.005	OPHTH SOLN	New generic, ketorolac, is available. Brand removed from formulary on 6/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
2/15/10	6/1/10	PROGRAF	TACROLIMUS	0.5MG, 1MG, 5MG	CAP	New generic, tacrolimus, is available. Brand removed from formulary on 6/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
2/15/10	6/1/10	RISPERDAL M-TAB	RISPERIDONE	1MG	TBDP	New generic, risperidone, is available. Brand removed from formulary on 6/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
3/15/10	7/1/10	MIRAPEX	PRAMIPEXOLE	0.125MG, 0.25MG, 0.5MG, 0.75MG, 1MG, 1.5MG	TAB	New generic, pramipexole, is available. Brand removed from formulary on 7/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
5/18/10	5/1/10	FANAPT	ILOPERIDONE	1MG/2MG/4MG	TITRAT. PACK	Added with PA	Tier 2. PA Required.
5/18/10	5/1/10	FANAPT	ILOPERIDONE	1MG, 2MG, 4MG, 6MH, 8MG, 10MG, 12 MG	TAB	Added with PA	Tier 2. PA Required.
5/18/10	5/1/10	SOMATULINE	LANREOTIDE	300MG/ML	SOLN	Added with PA	Tier 3. PA Required.
5/18/10	5/1/10	SUMATRIPTAN	SUMATRIPTAN SUCCINATE	12MG/ML	SOLN	Removed from formulary. Medicare removed from Part D covered drug list.	NA.
5/18/10	6/1/10	AMANTADINE HCL	AMANTADINE HCL	10MG/ML	SOLN	Added.	Tier 1.
5/18/10	6/1/10	COARTEM	ARTEMETHER/ LUMEFANTRINE	12MG/120MG	TAB	Added.	Tier 2.
5/18/10	6/1/10	GOLYTELY	PEG3350/KCL/SOD BICARB/SOD CL/ SOD SULF		PACKET	Added.	Tier 1.
5/18/10	8/1/10	PHENYTEK	PHENYTOIN SODIUM	200 MG	CAPS	New generic, phenytoin sodium, is available. Brand removed from formulary on 8/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
5/18/10	9/1/10	ALDARA	IMIQUIMOD	5% (50MG/ML)	CREAM	New generic, imiquimode, is available. Brand removed from formulary on 9/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
5/18/10	9/1/10	FLOMAX	TAMSULOSIN	0.4MG	CAPS	New generic, tamsulosin, is available. Brand removed from formulary on 9/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1.
6/3/10	3/1/10	NORVIR	RITONAVIR	100MG	TAB	Added.	Tier 2.
6/3/10	5/1/10	BRIMONIDINE TARTRATE	BRIMONIDINE TARTRATE	0.15%	OPHTH SOLN	Added.	Tier 1.
6/3/10	7/1/10	SORIATANE	ACITRETIN	17.5MG	CAP	Added.	Tier 2.

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
6/3/10	7/1/10	SORIATANE	ACITRETIN	22.5MG	CAP	Added.	Tier 2.
6/3/10	7/1/10	IXIARO	JAPANESE ENCEPHALITIS VIRUS VACCINE, INACTIVATED	0.012 MG/ML	SOLN	Added.	Tier 2.
6/3/10	7/1/10	VALCYTE	VALGANCICLOVIR	50MG/ML	SOLN	Added.	Tier 3.
6/3/10	10/1/10	HYZAAR	LOSARTAN /HCTZ	12.5/50MG, 12.5/100MG, 25/100MG	TAB	New generic, hydrochlorothiazide/ losartan, is available. Brand removed from formulary on 10/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1 and has a QL of 30 TABS per month.
6/3/10	10/1/10	COZAAR	LOSARTAN	25MG, 50MG, 100MG	TAB	New generic, losartan, is available. Brand removed from formulary on 10/1/10 and will no longer be covered.	Brand not covered, Generic is Tier 1 and has a QL of 30 TABS per month.
6/3/10	10/1/10	LIPRAM 4,500 LIPRAM-CR 5 LIPRAM-CR 20 LIPRAM-PN10 LIPRAM-PN16 LIPRAM-PN20 LIPRAM-UL12 LIPRAM-UL18 LIPRAM-UL 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
6/3/10	10/1/10	PANCRECARB MS-4 PANCRECARB MS-8 PANCRECARB MS-16	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
6/3/10	10/1/10	PANCREASE PANCREASE MT 4 PANCREASE MT 10 PANCREASE MT 16 PANCREASE MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
6/3/10	10/1/10	PANCRELIPASE PANCRELIPASE 8,000 PANCRELIPASE 16,000 PANCRELIPASE MT-16 PANCRELIPASE EC 4,500 PANCRELIPASE EC 10,000 PANCRELIPASE EC 16,000 PANCRELIPASE EC 20,000	AMYLASE/LIPASE/PROTEASE		TAB CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
6/3/10	10/1/10	PANCRON 10 PANCRON 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
6/3/10	10/1/10	ULTRASE ULTRASE MT 12 ULTRASE MT 18 ULTRASE MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
6/3/10	10/1/10	VIOKASE VIOKASE 8 VIOKASE 16	AMYLASE/LIPASE/PROTEASE		TAB PWDR	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	COTAZYM	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
7/6/10	10/1/10	CREON EC 5 CREON EC 10 CREON EC 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	DYGASE	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	ENZYCAP	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	KUTRASE	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	KU-ZYME KU-ZYME HP	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
7/6/10	10/1/10	LAPASE	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PALCAPS 10 PALCAPS 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PALIPASE PALIPASE MT 16 PALIPASE MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PALPEON DR 10 PALPEON DR 20 PALPEON MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PALTRASE V8	AMYLASE/LIPASE/PROTEASE		TAB	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
7/6/10	10/1/10	PANGESTYME PANGESTYME CN 10 PANGESTYME CN 20 PANGESTYME MT 16 PANGESTYME UL 12 PANGESTYME UL 18 PANGESTYME UL 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PANOCAPS PANOCAPS MT 16 PANOCAPS MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PANOKASE PANOKASE 16	AMYLASE/LIPASE/PROTEASE		TAB	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	PLARETASE 8,000	AMYLASE/LIPASE/PROTEASE		TAB	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	10/1/10	ULTRACAPS MT 20	AMYLASE/LIPASE/PROTEASE		CAP	Drug is not FDA-approved and will no longer be available as of the Date Posted. CareOregon Advantage will continue coverage until supply is exhausted. FDA-approved formulary alternatives are Creon and Zenpep. Members are encouraged to talk to their providers as soon as possible.	NA
7/6/10	7/1/10	ACTOPLUS MET	PIOGLITAZONE/METFORMIN	15 MG/1000 MG 30 MG/1000 MG	TAB	Added.	Tier 2 with ST to Actos.

Abbreviations: AGE = Age Restriction; PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; NA = Not Applicable							
DATE POSTED	**EFFECTIVE DATE**	**BRAND**	**GENERIC**	**STRENGTH**	**DOSAGE FORM**	**TYPE OF CHANGE**	**TIER; UTILIZATION RESTRICTIONS**
7/6/10	7/1/10	TYKERB	LAPATINIB DITOSYLATE	250 MG	TAB	Increased QL.	Tier 3. QL of 180 per 30 days. PA Required for new starts only.