



Preferred Drug List

**2008 Abridged Formulary
(Partial List of Covered Drugs)**

We want you to know[®]

 **Aetna[®] Medicare**

**Note to existing members:
This formulary has changed since last year.
Please review this document to make sure that
it still contains the drugs you take.**

This document includes the Aetna Medicare plan's partial formulary as of September 2007. For a complete, updated formulary, please visit our website at **www.aetnamedicare.com** or call the toll-free number on the back of your Aetna Medicare member ID card, Monday through Sunday, 8 am to 8 pm. TTY/TDD users should call 1-800-628-3323.

What is the Aetna Medicare formulary?

A formulary is a list of covered drugs selected by Aetna Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Aetna Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Aetna Medicare network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Aetna Medicare. For a complete listing of all prescription drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com or call 1-800-213-4599, Monday through Friday, 8 am to 6 pm. TTY/TDD users should call 1-800-628-3323.

Can the formulary change?

Generally, if you are taking a drug on our 2008 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2008 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or improve the safety of your drugs.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of September 2007. To get updated information about the drugs covered by Aetna Medicare, please visit our website at www.aetnamedicare.com or call Aetna Medicare at 1-800-213-4599, Monday through Friday, 8 am to 6 pm. TTY/TDD users should call 1-800-628-3323.

How do I use the formulary?

There are two ways to find your drug within the formulary:

■ Medical Condition

The formulary begins on page 7. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Heart, Blood Pressure and Cholesterol Drugs.” If you know what your drug is used for, look for the category name in the list that begins on page 7. Then look under the category name for your drug.

■ Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the index that begins on page 23. The index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the index. Look in the index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the index and find the name of your drug in the first or second column.

What are generic drugs?

Aetna Medicare covers both brand-name drugs and generic drugs. A generic drug has the same active-ingredient as the brand name drug. Generic drugs usually cost less than brand name drugs and are approved by the Food and Drug Administration (FDA).

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Aetna Medicare requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from Aetna Medicare before you fill your prescriptions. If you don't get approval, Aetna Medicare may not cover the drug.
- **Quantity Limits:** For certain drugs, Aetna Medicare limits the amount of the drug that Aetna Medicare will cover. For example, Aetna Medicare provides 1 tablet per day, or up to 31 tablets per one-month supply per prescription for Ambien. This may be in addition to a standard one-month or three month supply.
- **Step Therapy:** In some cases, Aetna Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Aetna Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Aetna Medicare will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7.

You can ask Aetna Medicare to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Aetna Medicare formulary?" on page 4 for information about how to request an exception.

What if my drug is not on the formulary?

If your drug is not included in this formulary, you should first contact Aetna Medicare and ask if your drug is covered. This document includes only a partial list of covered drugs, so Aetna Medicare may cover your drug. You can contact Aetna Medicare at 1-800-213-4599, Monday through Friday, 8 am to 6 pm. TTY/TDD users should call 1-800-628-3323.

If you learn that Aetna Medicare does not cover your drug, you have two options:

- You can ask Aetna Medicare for a list of similar drugs that are covered by Aetna Medicare. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Aetna Medicare.
- You can ask Aetna Medicare to make an exception and cover your drug. See below for information about how to request an exception.

NOTE: Due to a change in Medicare, most Medicare drug plans will no longer cover erectile dysfunction (ED) drugs like Viagra, Cilais, Levitra, and Caverject. For more information, you can contact Aetna Medicare at 1-800-213-4599, Monday through Friday, 8 am to 6 pm. TTY/TDD users should call 1-800-628-3323.

How do I request an exception to the Aetna Medicare formulary?

You can ask Aetna Medicare to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Aetna Medicare limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the high-cost/unique drug tier.

Generally, Aetna Medicare will only approve your request for an exception if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Aetna Transition of Care Policy

Aetna understands the importance of maintaining a consistent drug regimen, the challenges associated with changing coverage and the uncertainty changing coverage can have on drug coverage. All Medicare prescription drug plans include a transition provision for medications that are not on our Aetna Medicare preferred drug list or are included in our precertification or step therapy programs.

To diminish the impact changing coverage can have upon you, Aetna has established a liberal transition benefit that provides you with up to one courtesy fill (maximum of a 31-day supply) for each prescription you may already be taking and that is not on our preferred drug list, or that requires precertification or step therapy. The courtesy fill can be used anytime during your first 90 days in the plan. If you reside in a long-term care facility, we will extend the courtesy fill up to two additional fills as long as they occur during your first 90 days in the plan. You will share in the cost of the drug in the same manner as if the drug were on our preferred drug list.

Following your courtesy fill, you will receive a letter from Aetna instructing you of the action(s) you must take prior to filling that prescription again, in order to not interrupt your drug regimen. Of course, you always have the option to switch prescriptions to a drug on our preferred drug list in advance of filling your prescription, which will serve to reduce your drug costs and limit any future interruptions. You may also be eligible to receive courtesy fill(s) at other times during the year, such as changes in setting of care, emergencies, etc.

The important thing to keep in mind is Aetna's commitment to working with you and your physician to assure you have the safest and most effective drug necessary to treat your health care needs.

For more information

For more detailed information about your Aetna Medicare prescription drug coverage, please review your Aetna Medicare Evidence of Coverage (EOC) and other plan materials.

If you have questions about Aetna Medicare, please call Aetna Medicare at 1-800-213-4599, Monday through Friday, 8 am to 6 pm. (TTY/TDD users should call 1-800-628-3323.) Or, visit www.aetnamedicare.com.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. (TTY/TDD users should call 1-877-486-2048.) Or, visit www.medicare.gov.

Aetna Medicare's Formulary

The formulary that begins on the next page provides coverage information about some of the drugs covered by Aetna Medicare. If you have trouble finding your drug in the list, turn to the index that begins on page 23. Remember: This is only a partial list of drugs covered by Aetna Medicare. If your prescription is not in this partial formulary, please visit our website at www.aetnamedicare.com or call Aetna Medicare at 1-800-213-4599, Monday through Friday, 8 am to 6 pm (TTY/TDD users should call 1-800-628-3323) for additional help.

The first two columns of the chart list the drug name. Brand-name drugs are capitalized (e.g., ALLEGRA) and generic drugs are listed in lower-case italics (e.g., *fexofenadine*).

The information in the Requirements/Limits column tells you if Aetna Medicare has any special requirements for coverage of your drug. The following abbreviations are used:

QL = Quantity limits

PR = Precertification

ST = Step Therapy

Drug Tier Copay Levels

Aetna's 2008 abridged formulary is a condensed representative listing of brand name drugs highlighted from the thousands of Medicare-approved drugs. Aetna Medicare's 2008 formulary is an open formulary, meaning we cover every drug identified by Medicare as a Part D drug. An open formulary provides you with the greatest flexibility, but your copay will differ depending upon whether the drug is a generic or brand name drug. All generic drugs are covered at the lowest copay available for a plan.

If a brand name drug has a generic equivalent, its name is listed to the right of the brand name. This is to assist you in determining if less expensive alternatives to drugs you may currently be taking are available. The drug name in **bold** print is the preferred medication and will always carry the lowest cost-share.

If a brand name drug has a generic equivalent, the generic drug will be covered at the tier 1 level, and the non-preferred brand name drug (non-bolded) will be covered at tier 3.

The copay tiers for covered prescription medications are listed below. Copay amounts and coinsurance percentages for each tier vary by Aetna Medicare plan. Consult the Summary of Benefits for your applicable copays and coinsurance amounts.

Copay Tier

Tier 1 (*Lowest Copay Amount*)

Tier 2

Tier 3

Tier 4

Type of Drug

Generic medications

Preferred brand name medications

Non-preferred brand name medications

Specialty medications

KEY:	UPPERCASE = Brand name medications Lower case italics = Generic medications	1, 2, 3, 4 = Copay tier level	QL = Quantity limits ST = Step therapy PR = Precertification
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Preferred Drug List

Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
ALCOHOL, SMOKING DETERRENTS AND ANTIDOTES			
ACETADOTE		3	
CAMPRAL		3	
KAYEXALATE	<i>sodium polystyrene sulfonate</i>	1	
NARCAN	<i>naloxone</i>	1	
NICOTROL INHALER		3	(PR)
REVIA	<i>naltrexone</i>	1	
ANALGESICS – PAIN DRUGS			
DARVOCET-N	<i>propoxyphene napsylate and acetaminophen</i>	1	(PR)
DURAGESIC	<i>fentanyl patch</i>	1	(QL)
EQUAGESIC		3	(PR)
KADIAN		2	
LORTAB	<i>acetaminophen and hydrocodone bitartrate</i>	1	
OPANA ER		2	
OXYCONTIN		2	(QL)
PERCOCET	<i>acetaminophen and oxycodone</i>	1	
PRIALT		4	
ROXICET	<i>acetaminophen and oxycodone</i>	1	
TYLENOL/CODEINE	<i>acetaminophen and codeine</i>	1	
ULTRAM	<i>tramadol</i>	1	
ANESTHETIC DRUGS			
EMLA		3	
LIDODERM		2	
XYLOCAINE	<i>lidocaine</i>	1	
ANTI-ANXIETY DRUGS			
BUSPAR	<i>buspirone</i>	1	
EQUANIL	<i>meprobamate</i>	1	(PR)
LEXAPRO		3	(QL) (ST)
PAXIL	<i>paroxetine</i>	1	(QL)

KEY:

UPPERCASE = Brand name medications
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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
SINEQUAN	<i>doxepin</i>	1	
ZOLOFT	<i>sertraline</i>	1	(QL)
ANTIBACTERIAL DRUGS – ANTIBIOTICS			
AMIKIN	<i>amikacin sulfate</i>	1	
AMOXIL	<i>amoxicillin</i>	1	
AUGMENTIN	<i>amoxicillin and clavulanic acid</i>	1	
AVELOX		2	(PR)
BACTRIM DS	<i>sulfamethoxazole and trimethoprim</i>	1	
CIPRO	<i>ciprofloxacin</i>	1	(PR)
CLEOCIN	<i>clindamycin</i>	1	
DURICEF	<i>cefadroxil hemihydrate</i>	1	
E-MYCN	<i>erythromycin ec</i>	1	
FLAGYL	<i>metronidazole</i>	1	
FLOXIN	<i>ofloxacin</i>	1	(PR)
	<i>gentamicin</i>	1	
INVANZ		3	
KEFLEX	<i>cephalexin</i>	1	
LEVAQUIN		3	(PR)
MINOCIN	<i>minocycline</i>	1	(PR)
PRIMAXIN I.M.		3	
	<i>sulfadiazine</i>	1	
VIBRATAB	<i>doxycycline</i>	1	(PR)
ZITHROMAX	<i>azithromycin</i>	1	
ANTICONVULSANTS – SEIZURE CONTROL DRUGS			
DILANTIN	<i>phenytoin</i>	1	
FELBATOL		3	
GABITRIL		3	(ST)
KEPPRA		2	
LAMICTAL		2	
NEURONTIN	<i>gabapentin</i>	1	(QL)
TEGRETOL-XR		3	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
ZARONTIN	<i>ethosuximide</i>	1	
ZONEGRAN	<i>zonisamide</i>	1	
ANTIDEMENTIA DRUGS			
ARICEPT		2	
	<i>ergoloid mesylates</i>	1	
EXELON		2	
NAMENDA		2	
ANTIDEPRESSANT DRUGS			
ASENDIN	<i>amoxapine</i>	1	
CELEXA	<i>citalopram</i>	1	(QL)
CYMBALTA		2	(QL) (ST)
EFFEXOR	<i>venlafaxine</i>	1	(QL)
EFFEXOR XR		2	(QL) (ST)
ELAVIL	<i>amitriptyline</i>	1	
LUDIOMIL	<i>maprotiline</i>	1	(QL)
NARDIL		2	
PARNATE	<i>tranylcypromine sulfate</i>	1	
PROZAC	<i>fluoxetine</i>	1	(QL)
REMERON	<i>mirtazapine</i>	1	(QL)
	<i>trazodone</i>	1	
WELLBUTRIN XL 300	<i>bupropion sr</i>	1	(QL)
ANTIEMETICS – NAUSEA/VOMITING DRUGS			
ANTIVERT	<i>meclizine</i>	1	
EMEND		2	(QL) (PR)
REGLAN	<i>metoclopramide</i>	1	
ZOFRAN	<i>ondansetron</i>	1	(QL) (PR)
ANTIFUNGAL DRUGS			
DIFLUCAN	<i>fluconazole</i>	1	(PR)
SPORANOX	<i>itraconazole</i>	1	(PR)
ANTIGOUT AGENTS – GOUT DRUGS			
BENEMID	<i>probenecid</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
COLBENEMID	<i>colchicine</i>	1	
ZYLOPRIM	<i>allopurinol</i>	1	
ANTI-INFLAMMATORY DRUGS			
CELEBREX		3	(QL) (PR)
MOTRIN	<i>ibuprofen</i>	1	
NAPROSYN	<i>naproxen</i>	1	
VOLTAREN	<i>diclofenac sodium</i>	1	
ANTIMIGRAINE AGENTS – MIGRAINE DRUGS			
AMERGE		2	(QL)
DEPAKOTE ER		2	
IMITREX		2	(QL)
MAXALT		2	(QL)
RELPAX		2	(QL)
TOPAMAX		3	
ZOMIG		3	(QL)
ANTIMYASTHENIC AGENTS – MYESTHENIA GRAVIS DRUGS			
	<i>guanidine hydrochloride</i>	1	
MESTINON TIMESPAN		3	
ANTIMYCOBACTERIALS – TUBERCULOSIS DRUGS			
	<i>dapsone</i>	1	
MYAMBUTOL	<i>ethambutol</i>	1	
MYCOBUTIN		3	
RIFADIN	<i>rifampin</i>	1	
RIFAMATE	<i>isoniazid and rifampin</i>	1	
ANTINEOPLASTICS – ANTI-CANCER DRUGS			
ADRIAMYCIN	<i>doxorubicin</i>	1	
ARIMIDEX		3	
AROMASIN		3	
CYTOXAN	<i>cyclophosphamide</i>	1	(PR)
EMCYT		2	
ERBITUX		4	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
GLEEVEC		4	
HERCEPTIN		4	
LEUKERAN		2	
NOVLADEX	<i>tamoxifen citrate</i>	1	
PANRETIN		3	
REVLIMID		4	
SUTENT		4	
TARGRETIN CAPSULES		2	
TAXOL	<i>paclitaxel</i>	1	
THALOMID		4	
VESANOID	<i>tretinoin</i>	1	
ANTIPARASITICS – DRUGS FOR THE TREATMENT OF PARASITES			
ELIMATE	<i>permethrin</i>	1	
KWELL	<i>lindane</i>	1	
LARIAM	<i>mefloquine</i>	1	
MEPRON		3	
MINTEZOL		3	
VERMOX	<i>mebendazole</i>	1	
ANTI-PARKINSON AGENTS – PARKINSON'S DRUGS			
AZILECT		2	
COMTAN		2	
MIRAPEX		2	
REQUIP		2	
SINEMET	<i>carbidopa and levodopa</i>	1	
STALEVO		2	
ANTIPSYCHOTIC/BIPOLAR DRUGS			
ABILIFY		3	(QL) (ST)
DEPAKOTE		2	
HALDOL	<i>haloperidol</i>	1	
LITHOBID	<i>lithium carbonate er</i>	1	
PROLIXIN	<i>fluphenazine</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
RISPERDAL		2	(QL)
RISPERDAL M		2	(QL)
SEROQUEL		2	(QL)
SEROQUEL XR		2	(QL)
ZYPREXA		2	(QL)
ZYPREXA ZYDIS		2	(QL)
ANTISPASTICITY AGENTS AND SKELETAL MUSCLE RELAXERS			
	<i>baclofen</i>	1	
FLEXERIL	<i>cyclobenzaprine</i>	1	(PR)
NORFLEX	<i>orphenadrine citrate</i>	1	(PR)
ZANAFLEX	<i>tizanidine</i>	1	
BLOOD GLUCOSE REGULATORS – DIABETES DRUGS			
ACTOPLUS MET		2	
ACTOS		2	
AMARYL	<i>glimepiride</i>	1	
APIDRA		2	
AVANDAMET		2	
AVANDARYL		2	
AVANDIA		2	
B-D INSULIN SYRINGES		2	
BYETTA		2	(QL)
DIABETA	<i>glyburide</i>	1	
DUETACT		2	
GLUCAGON EMERGENCY KIT		2	
GLUCOPHAGE	<i>metformin</i>	1	
GLUCOTROL	<i>glipizide</i>	1	
GLUCOTROL XL	<i>glipizide er</i>	1	
GLUCOVANCE	<i>glyburide and metformin</i>	1	
HUMALOG		2	
HUMULIN		2	
JANUMET		2	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
JANUVIA		2	
LANTUS		3	
LEVEMIR		2	
NOVOLIN		2	
NOVOLOG		2	
PRANDIN		2	
PROGLYCEM		2	
STARLIX		2	
SYMLIN		2	
BLOOD PRODUCTS			
AGGRENOX		2	
COUMADIN	<i>warfarin sodium</i>	1	
CYKLOKAPRON		4	
LEUKINE		4	
LOVENOX		4	
NEUPOGEN		4	
PERSANTINE	<i>dipyridamole</i>	1	(PR)
PLAVIX		3	
PLETAL	<i>cilostazol</i>	1	
CARDIOVASCULAR AGENTS – HEART, BLOOD PRESSURE AND CHOLESTEROL DRUGS			
ACCUPRIL	<i>quinapril</i>	1	(QL)
ALDACTAZIDE	<i>spironolactone and hydrochlorothiazide</i>	1	
ALDACTONE	<i>spironolactone</i>	1	
ALDOMET	<i>methyldopa</i>	1	
ALTACE		2	(QL)
BLOCADREN	<i>timolol maleate</i>	1	
CALAN	<i>verapamil</i>	1	(QL)
CALAN SR	<i>verapamil cr</i>	1	(QL)
CAPOTEN	<i>captopril</i>	1	(QL)
CARDIZEM CD	<i>diltiazem cd</i>	1	(QL)
CARDIZEM LA		2	(QL)

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
CATAPRES	<i>clonidine</i>	1	
CORDARONE	<i>amiodarone</i>	1	
COREG		2	
COREG CR		2	
COZAAR		2	(QL)
CRESTOR		2	(QL)
DEMADEX	<i>torsemide</i>	1	
DIBENZYLINE		3	
DIOVAN		2	
DIOVAN HCT		2	(QL)
HYDRODIURIL	<i>hydrochlorothiazide</i>	1	
HYZAAR		2	(QL)
IMDUR	<i>isosorbide mononitrate er</i>	1	
INDERAL	<i>propranolol</i>	1	
LANOXIN	<i>digoxin</i>	1	
LASIX	<i>furosemide</i>	1	
LIPITOR		2	(QL)
LOPID	<i>gemfibrozil</i>	1	
LOPRESSOR	<i>metoprolol tartrate</i>	1	
LOTENSIN	<i>benazepril</i>	1	(QL)
LOTREL		2	
MAXZIDE	<i>triamterene and hydrochlorothiazide</i>	1	
MEVACOR	<i>lovastatin</i>	1	(QL)
NIASPAN		2	
NITROSTAT SL	<i>nitroglycerin sl</i>	1	
NORVASC	<i>amlodipine</i>	1	(QL)
PLENDIL	<i>felodipine er</i>	1	
PRAVACHOL	<i>pravastatin</i>	1	(QL)
PROCARDIA	<i>nifedipine</i>	1	(PR)
RANEXA		2	(QL) (ST)
	<i>reserpine</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
SECTRAL	<i>acebutolol</i>	1	
TENORMIN	<i>atenolol</i>	1	
TIKOSYN		2	
TOPROL XL		2	
TRICOR		2	
TRIGLIDE	<i>fenofibrate</i>	1	
VASOTEC	<i>enalapril maleate</i>	1	(QL)
VYTORIN		2	(QL)
ZEBETA	<i>bisoprolol fumarate</i>	1	
ZESTORETIC	<i>lisinopril and hydrochlorothiazide</i>	1	
ZESTRIL	<i>lisinopril</i>	1	(QL)
ZETIA		2	(QL)
ZOCOR	<i>simvastatin</i>	1	(QL)
CENTRAL NERVOUS SYSTEM DRUGS – ATTENTION DEFICIT DISORDER/NARCOLEPSY DRUGS			
ADDERALL	<i>amphetamine aspartate and amphetamine sulfate</i>	1	(QL) (PR)
DEXEDRINE	<i>dextroamphetamine sulfate cr</i>	1	(QL) (PR)
PROVIGIL		2	(QL) (PR)
RILUTEK		2	(PR)
RITALIN	<i>methylphenidate</i>	1	(QL) (PR)
STRATTERA		2	(QL) (ST)
DENTAL AND DRUGS FOR THE MOUTH			
EVOXAC		3	
PERIDEX	<i>chlorhexidine gluconate</i>	1	
DERMATOLOGICAL AGENTS – DRUGS FOR SKIN CONDITIONS			
ALDARA		2	
CARMOL 40	<i>urea carbamide</i>	1	
CLARAVIS	<i>isotretinoin</i>	1	(PR)
CONDYLOX	<i>podofilox</i>	1	
DRITHOCREME	<i>anthralin</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
LAC-HYDRIN	<i>ammonium lactate</i>	1	
OXSORALEN ULTRA		2	
PODOCON		1	
REGRANEX		3	
SANTYL		2	
SELSUN	<i>selenium sulfide lotion</i>	1	
TAZORAC		2	
ENZYMES			
CYSTADANE		2	
CYSTAGON		2	
PANCRELIPASE		2	
ULTRASE		2	
VIOKASE		2	
GASTROINTESTINAL AGENTS – ULCER AND STOMACH DRUGS			
ACTIGALL	<i>ursodiol</i>	1	
BENTYL	<i>dicyclomine</i>	1	(PR)
CARAFATE	<i>sucralfate</i>	1	
KRISTALOSE	<i>lactulose</i>	1	
LOTRONEX		2	(PR)
NEXIUM		2	(QL) (PR)
PEPCID	<i>famotidine</i>	1	
PREVACID		2	(QL) (PR)
PREVACID SOLUTAB		2	(QL) (PR)
PRILOSEC	<i>omeprazole</i>	1	(QL) (PR)
PROTONIX		2	(QL) (PR)
ROBINUL	<i>glycopyrrolate</i>	1	
ZANTAC	<i>ranitidine</i>	1	
GASTROINTESTINAL AGENTS – BOWEL DISEASE DRUGS			
AMITIZA		3	
ANUSOL-HC		3	
ASACOL		3	(QL)

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
	<i>atropine sulfate</i>	1	(PR)
AZULFIDINE	<i>sulfasalazine</i>	1	(QL)
CANASA		2	(QL)
COLAZAL		2	(QL)
COLOCORT	<i>hydrocortisone enema</i>	1	
CYTOTEC	<i>misoprostol</i>	1	
DECADRON	<i>dexamethasone tablets</i>	1	
DELTASONE	<i>prednisone</i>	1	
	<i>polyethylene glycol</i>	1	
GENITOURINARY AGENTS – URINARY AND PROSTATE DRUGS			
CARDURA	<i>doxazosin mesylate</i>	1	
DETROL		2	
DETROL LA		2	
DITROPAN	<i>oxybutynin chloride</i>	1	
ELMIRON		2	
FLOMAX		2	(PR)
FOSRENOL		2	
OXYTROL		2	
PHOSLO		2	
PYRIDIUM	<i>phenazopyridine</i>	1	
RENAGEL		2	
UROXATRAL		2	(PR)
VESICARE		2	
HORMONAL AGENTS – ADRENAL REGULATING DRUGS			
ARISTOCORT A	<i>triamcinolone acetonide</i>	1	
FLORINEF	<i>fludrocortisone acetate</i>	1	
LYSODREN		2	(PR)
HORMONAL AGENTS – ESTROGEN AND STEROID REPLACEMENT DRUGS, OTHERS			
ANDRODERM		2	
ANDROGEL		2	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
AVODART		2	(PR)
CASODEX		3	
CLIMARA	<i>estradiol patch</i>	1	(QL)
	<i>danazol</i>	1	
DECA-DURABOL	<i>nandrolone decanoate</i>	1	(PR)
DEPO-PROVERA	<i>medroxyprogesterone acetate injection</i>	1	
EVISTA		2	
NOR-QD	<i>norethindrone acetate</i>	1	
OGEN	<i>estropipate</i>	1	(PR)
OXANDRIN	<i>oxandralone</i>	1	(PR)
PREMARIN		3	(PR)
PREMPHASE		3	(PR)
PREMPRO		3	(PR)
PROSCAR	<i>finasteride</i>	1	(PR)
HORMONAL AGENTS – PITUITARY DRUGS			
DDAVP	<i>desmopressin acetate</i>	1	
DOSTINEX	<i>cabergoline</i>	1	
LUPRON	<i>leuprolide acetate</i>	1	(PR)
NORDITROPIN		4	(PR)
PARLODEL	<i>bromocriptine mesylate</i>	1	
PLENAXIS		4	(PR)
SAIZEN		4	(PR)
SANDOSTATIN	<i>octreotide acetate</i>	1	
TEV-TROPIN		4	(PR)
ZOLADEX		4	(PR)
HORMONAL AGENTS – THYROID DRUGS			
CYTOMEL		3	
	<i>propylthiouracil</i>	1	
SYNTHROID	<i>levothyroxine</i>	1	
TAPAZOLE	<i>methimazole</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
IMMUNOLOGIC AGENTS – IMMUNOLOGY DRUGS AND VACCINES			
AVONEX		4	
BETASERON		4	
CELLCEPT		2	(PR)
COPAXONE		4	
ENBREL		4	
GAMASTAN S/D	<i>immune globulin</i>	1	(PR)
HAVRIX		2	(PR)
HUMIRA		4	
M-M-R II W/DILUENT 1 DOSE		2	
NEORAL		3	(PR)
PEGASYS		4	(PR)
PEG-INTRON		4	(PR)
REBIF		4	
SANDIMMUNE		3	(PR)
THYMOGLOBULIN		3	(PR)
ZOSTAVAX		2	(PR)
METABOLIC BONE DISEASE AGENTS – OSTEOPOROSIS (BONE LOSS) DRUGS			
ACTONEL		2	
ACTONEL WITH CALCIUM		2	(QL)
FORTEO		2	
FOSAMAX		2	
FOSAMAX PLUS D		2	(QL)
HECTOROL		2	
ZEMPLAR		2	
OPHTHALMIC AND OTIC AGENTS – EYE AND EAR DRUGS			
ACULAR		2	
ACULAR LS		2	
AK-CON		1	
ALPHAGAN P		2	
ALREX		2	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
AZOPT		2	
BETOPTIC-S		3	
CORTISPORIN HC	<i>hydrocortisone and neomycin sulfate and polymyxin</i>	1	
COSOPT		2	
CROLOM	<i>cromolyn sodium ophl</i>	1	
DERMOTIC		2	
DIAMOX		3	
FML LIQUIFLM	<i>fluorometholone</i>	1	
ISO-ATROPINE	<i>atropine sulfata ophl</i>	1	
LOTEMAX		2	
LUMIGAN		2	
NEVANAC		2	
OPTIVAR		2	
PATADAY		2	
PATANOL		2	
RESTASIS		2	
TIMOPTIC	<i>timolol maleate ophl</i>	1	
TRAVATAN		2	
TRAVATAN Z		2	
VIGAMOX		3	
VOLTAREN OPHL		2	
XALATAN		2	
ZYMAR		3	
PARATHYROID SUPPRESSANT DRUGS			
SENSIPAR		2	
RESPIRATORY TRACT AGENTS – ALLERGY/ASTHMA/COPD DRUGS			
ACCOLATE		3	(QL)
ADVAIR DISKUS		2	
ALLEGRA	<i>fexofenadine</i>	1	(QL) (PR)
	<i>aminophylline</i>	1	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
ASMANEX		2	
ATROVENT	<i>ipratropium bromide inhalant</i>	1	(PR)
AZMACORT		2	
COMBIVENT		3	
FLOVENT HFA		2	
FORADIL AEROLIZER		2	(ST)
INTAL INHALER		2	
MAXAIR AUTOHALER		2	
MUCOMYST	<i>acetylcysteine</i>	1	(PR)
PHENERGAN	<i>promethazine</i>	1	(PR)
PROAIR HFA		2	
PROVENTIL HFA		2	
PULMICORT INH		3	
REVATIO		4	(PR)
RHINOCORT AQUA		3	
SINGULAIR		2	(QL)
SPIRIVA HANDIHALER		2	
SYMBICORT		2	
THEOCAP	<i>theophylline er</i>	1	
TILADE		2	
TRACLEER		4	
ZEMAIRA		3	
ZYRTEC		3	(QL) (PR)
SEDATIVES/HYPNOTICS – SLEEP AIDS			
AMBIEN		3	(QL) (ST)
AMBIEN CR		2	(QL) (ST)
SONATA		3	(QL) (ST)
THERAPEUTIC SUPPLEMENTS			
	<i>calcitriol</i>	1	
INTRALIPID		3	

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Covered Brand Drug	Covered Generic Drug	Copay Tier	Requirements/Limits
K-DUR	<i>potassium chloride cr</i>	1	
	<i>leucovorin</i>	1	
VIRAL INFECTION DRUGS			
AGENERASE		3	
COMBIVIR		3	
COPEGUS	<i>ribavirin</i>	1	(PR)
CYTOVENE	<i>ganciclovir</i>	1	
DENAVIR		3	
EPIVIR HBV		2	
EPZICOM		3	
FAMVIR		2	
FLUMADINE	<i>rimantadine</i>	1	
FOSCAVIR	<i>foscarnet sodium</i>	1	(PR)
FUZEON		4	
HEPSERA		3	
LEXIVA		3	
RETROVIR	<i>zidovudine</i>	1	
REYATAZ		2	
SUSTIVA		3	
SYMMETREL	<i>amantadine</i>	1	
TRIZIVIR		3	
VALCYTE		3	
VALTREX		2	
VIDEX		3	
VIDEX EC	<i>didanosine</i>	1	
VIRAMUNE		3	
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ZIAGEN		3	

Aetna Medicare Preferred Drug List

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nifedipine	14	PERIDEX	15
nitroglycerin sl	14	permethrin	11
NITROSTAT SL	14	PERSANTINE	13
NORDITROPIN	18	phenazopyridine	17
norethindrone acetate	18	PHENERGAN	21
NORFLEX	12	phenytoin	8
NOR-QD	18	PHOSLO	17
NORVASC	14	PLAVIX	13
NOVLADEX	11	PLENAXIS	18
NOVOLIN	13	PLENDIL	14
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OGEN	18	polyethylene glycol	17
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PYRIDIUM	17	SEROQUEL	12
quinapril	13	SEROQUEL XR	12
RANEXA	14	sertraline	8
ranitidine	16	simvastatin	15
REBIF	19	SINEMET	11
REGLAN	9	SINEQUAN	8
REGRANEX	16	SINGULAIR	21
RELPAK	10	sodium polystyrene sulfonate	7
REMERON	9	SONATA	21
RENAGEL	17	SPIRIVA HANDIHALER	21
REQUIP	11	spironolactone	13
reserpine	14	spironolactone and hydrochlorothiazide	13
RESTASIS	20	SPORANOX	9
RETROVIR	22	STALEVO	11
REVATIO	21	STARLIX	13
REVIA	7	STRATTERA	15
REVLIMID	11	sucralfate	16
REYATAZ	22	sulfadiazine	8
RHINOCORT AQUA	21	sulfamethoxazole and trimethoprim	8
ribavirin	22	sulfasalazine	17

SUSTIVA	22	TRIZIVIR	22
SUTENT	11	TYLENOL/CODEINE	7
SYMBICORT	21	ULTRAM	7
SYMLIN	13	ULTRASE	16
SYMMETREL	22	urea carbamide	15
SYNTHROID	18	UROXATRAL	17
tamoxifen citrate	11	ursodiol	16
TAPAZOLE	18	VALCYTE	22
TARGRETIN CAPSULES	11	VALTREX	22
TAXOL	11	VASOTEC	15
TAZORAC	16	venlafaxine	9
TEGRETOL-XR	8	verapamil	13
TENORMIN	15	verapamil cr	13
TEV-TROPIN	18	VERMOX	11
THALOMID	11	VESANOID	11
THEOCAP	21	VESICARE	17
theophylline er	21	VIBRATAB	8
THYMOGLOBULIN	19	VIDEX	22
TIKOSYN	15	VIDEX EC	22
TILADE	21	VIGAMOX	20
timolol maleate	13	VIKASE	16
timolol maleate ophthl	20	VIRAMUNE	22
TIMOPTIC	20	VOLTAREN	10
tizanidine	12	VOLTAREN OPHTHL	20
TOPAMAX	10	VYTORIN	15
TOPROL XL	15	warfarin sodium	13
torse mide	14	WELLBUTRIN XL 300	9
TRACLEER	21	XALATAN	20
tramadol	7	XYLOCAINE	7
tranylcypromine sulfate	9	ZANAFLEX	12
TRAVATAN	20	ZANTAC	16
TRAVATAN Z	20	ZARONTIN	9
trazodone	9	ZEBETA	15
tretinoin	11	ZEMAIRA	21
triamcinolone acetonide	17	ZEMPLAR	19
triamterene and hydrochlorothiazide	14	ZERIT	22
TRICOR	15	ZESTORETIC	15
TRIGLIDE	15	ZESTRIL	15

ZETIA	15
ZIAGEN	22
zidovudine	22
ZITHROMAX	8
ZOCOR	15
ZOFRAN	9
ZOLADEX	18
ZOLOFT	8
ZOMIG	10
ZONEGRAN	9
zonisamide	9
ZOSTAVAX	19
ZYLOPRIM	10
ZYMAR	20
ZYPREXA	12
ZYPREXA ZYDIS	12
ZYRTEC	21

NOTES

Benefits coverage is provided by Aetna Health Inc., Aetna Health of California Inc., Aetna Health of Illinois Inc. and/or Aetna Life Insurance Company, which are Medicare Advantage organizations with a Medicare contract and benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

This material is for informational purposes only. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.

Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.

Pharmacy clinical programs such as precertification, step therapy, and quantity limits may apply to your prescription drug coverage. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Discount programs provide access to discounted prices and are not insured benefits.

Translation of this material into another language may be available. For assistance, please call our plan specialists at 1-800-213-4599 (TTY/TDD 1-800-628-3323), Monday through Friday, 8 am to 6 pm.

Puede estar disponible la traducción de este material en otro idioma. Por favor, para ayuda llame a los especialistas de nuestro plan al 1-800-213-4599 (TTY/TDD 1-800-628-3323), Lunes – Viernes, 8 am a 6 pm.

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