

**Additional Preferred Drug List Changes
Effective 7.1.10**

Preferred	Non-Preferred
Antidepressant Agents – Selective Serotonin Reuptake Inhibitors (SSRIs)	
CITALOPRAM GENERIC	PAROXETINE ER*
FLUOXETINE GENERIC	PAXIL
LEXAPRO	PAXIL CR*
PAROXETINE IR GENERIC	
SERTRALINE GENERIC	
Antispasmodic Agents – Urinary Tract	
ENABLEX	DETROL*
OXYBUTYNIN GENERIC	DETROL LA*
SANCTURA	DITROPAN XL*
VESICARE	OXYBUTYNIN ER GENERIC*
	SANCTURA XR*
	TOVIAZ*
Benign Prostatic Hyperplasia (BPH) Agents	
FINASTERIDE GENERIC	AVODART*
TAMSULOSIN GENERIC	FLOMAX
	PROSCAR
	RAPAFLO*
	UROXATRAL*
CNS Stimulant Agents	
AMPHETAMINE SALT COMBINATION IR GENERIC [±]	ADDERALL XR* ⁺
	AMPHETAMINE SALT COMBINATION SR GENERIC*
Gastrointestinal Agents – Proton Pump Inhibitors (PPIs)	
DEXILANT* (formerly Kapidex)	ACIPHEX*
OMEPRAZOLE GENERIC*	NEXIUM*
	PANTOPRAZOLE GENERIC*
	PREVACID*
	PRILOSEC*
	PROTONIX*
Ophthalmic Beta Blocker Agents	
COMBIGAN 5mL	BETIMOL*
BETOPTIC-S	COMBIGAN 10mL* [^]
LEVOBUNOLOL GENERIC	
TIMOLOL MALEATE GENERIC	
Tumor Necrosis Factor (TNF) Blocker Agents	
ENBREL*	CIMZIA*
HUMIRA*	REMICADE*
	SIMPONI*
Topical Local Anesthetic Agents	
LIDOCAINE TOPICAL	LIDODERM*

*Requires prior authorization [±]Requires prior authorization if ≥21 years old

⁺Requires prior authorization for patients newly started; current users will be allowed to continue therapy

[^]For patients that need a 5mL bottle, use Combigan 5mL; for those patients that need a 10mL bottle, use timolol maleate generic 0.5% and brimonidine generic 0.2%