

Quantity Limits (QL)

A quantity limit is the maximum amount of a drug that will be covered by your plan over a certain period of time. Typically, quantity limits are in place to encourage appropriate drug use and contain drug costs. Quantity limits are based on the product's labeling, or adopted clinical guidelines. Select drugs are subject to quantity limits. This list is subject to change and is not all-inclusive.

- Brand name drugs are listed in CAPITAL letters and generic drugs are listed in lower case letters.

Formulary Quantity Limits

<p>ABILIFY 2, 5, 10, 15 mg - 1 tab/day ABILIFY 20, 30 mg – 2 tabs/day ADVAIR DISKUS – 2 units/month albuterol inhaler – 2 units/month alendronate 5mg & 10mg – 30 tabs/month alendronate 35mg & 70mg – 4 tabs/28 days BETASERON – 15 vials/month bupropion ER (Zyban) –6 fills per year butorphanol nasal spray – 2 units/copay BROVANA – 60 vials/month BYETTA – 1 pen/month clonidine patches – 4 patches/28 days CHANTIX – 6 fills per calendar year DETROL – 60 tablets/month DETROL LA – 30 tablets/month DIASTAT – 1 kit/copay ELIDEL – 100 grams/month EMEND 80mg – 4 capsules/month EMEND 125mg – 2 capsules/month EMEND TRIFOLD – 2 trifolds/month EPIPEN/EPIPEN JR – 4 pens/copay estradiol (Climara) – 8 patches/28 days famciclovir 125mg/500mg – 21 tablets/mo famciclovir 250mg – 60 tablets/month fentanyl (Duragesic) – 10 patches/30 days fentanyl (Actiq, Fentora) – 120 units/mo FORTEO – 1 pen/month FOSAMAX PLUS D – 4 tablets/28 days GEODON 80mg – 3 caps/day</p>	<p>GEODON all other strengths – 2 caps/day granisetron – 2 tablets/copay granisetron oral solution – 30ml/copay ketorolac – 20 tablets/month leflunomide (Arava) – 30 tablets/month LETAIRIS – 1 unit/day Loratadine OTC – 30 tablets/month loratadine-D OTC – 30 tablets/month MAXALT/MLT – 18 tablets/month nicotine gum – 3 fills per year nicotine lozenges – 3 fills/year nicotine patches – 30/fill, max 12 weeks/yr NICOTROL inhaler – 16 per day, 6 fills/year NICOTROL nasal– 4 ml/day, 3 fills/year omeprazole 10mg– 60 units/month omeprazole 20mg – 120 units/month omeprazole OTC – 120 units/month oxybutynin XL 5mg,10mg – 30 tabs/mo oxybutynin XL 15mg – 60 tablets/month OXYCONTIN – 120/mo PREVACID – 60 tablets/month PREVPAC – 14 dose packs/copay PROAIR HFA – 2 units/month PROTOPIC – 100 grams/copay REGRANEX – 15 grams/copay RELENZA – 20 blister packs/fill RESTASIS – 64 vials/month risperidone 2mg – 2 tabs/day risperidone 3mg – 5 tabs/day</p>	<p>risperidone 4 mg – 4 tabs/day risperidone (all other strengths) – 3 tabs/day SEROQUEL 200mg – 2 tabs/day SEROQUEL all other strengths – 3 tabs/day SEROQUEL XR 150mg, 200mg – 1 tab/day SEROQUEL XR 50mg – 2 tabs/day SEROQUEL XR 300, 400 mg – 3 tabs/day STRATTERA — 60 capsules/month sumatriptan injection – 6 injections/month sumatriptan nasal spray – 12 units/months sumatriptan tablets – 18 tablets/month SUPRAX - 1 tablet per prescription TAMIFLU – 10 units/fill terbinafine – 120 therapy days/year TOPAMAX 15, 25mg – 4 tabs/day TOPAMAX 50, 200 mg – 2 tabs/day TOPAMAX 100mg – 6 tabs/day TYKERB – 150 units/30 days VENTOLIN HFA – 2 units/month VIMPAT – 2 units/day VIVELLE-DOT – 8 patches/28 days XOLAIR – 6 vials/30 days zolpidem 5mg – 60 tablets/month zolpidem 10mg – 30 tablets/month ZYPREXA/ZYDIS 2.5, 5mg – 1 tab/day ZYPREXA/ZYDIS 7.5,15, 20mg – 2 tabs/day ZYPREXA/ZYDIS 10mg – 4 tabs/day</p>
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Non-Formulary Quantity Limits

Note: Non-Formulary drugs typically are not covered by your plan. However, your provider can request a formulary exception. If your condition meets certain criteria, you will receive authorization for coverage of the non-formulary drug.

<p>ACIPHEX – 60 tablets/month ALLEGRA-D 12 HR – 60 tablets/month ALLEGRA-D 24 HR – 30 tablets/month AMBIEN CR - 30 tablets/month AMERGE – 18 tablets/month AMITIZA – 60 tablets/month DAYTRANA – 30 patches/month ESTRADERM – 8 patches/28 days FROVA – 18 capsules/month</p>	<p>IMITREX injection – 6 injections/month IMITREX tablets – 18 tablets/month IMITREX nasal spray – 12 units/month LAMICTAL XR – 1 kit/month LIDODERM – 120 patches/month LUNESTA – 30 tablets/month LYRICA – 90 tablets/month MENOSTAR patch - 4 patches/28 days MIGRANAL – 4 units/ month NEXIUM – 60 capsules/month pantoprazole – 60 tablets/month</p>	<p>PERFOROMIST – 60 vials/moth PREVACID NAPRAPAC – 84 capsules/mo PRILOSEC OTC – 120 units/month PROTONIX – 60 tablets/month PROVIGIL 100mg - 60 tablets/month PROVIGIL 200mg – 30 tablets/month TREXIMET – 18 units/month VALTREX – 90 tablets/month VIAGRA – 8 tablets/month ZOMIG – 12 tablets/month</p>
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Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac Medica: 952-992-2260.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم 1-800-373-8335 :Medica

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните Medica: 952-992-2294.

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Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-800-373-8335.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 952-992-2297.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែឥតមាន ថ្លៃដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ Medica: 1-800-373-8335 ។

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi Medica: 952-992-2295.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 952-992-2296.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu Medica: 1-800-373-8335.

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Attention. If you want free help translating this information, call 1-800-373-8335.

This information is available in other forms to people with disabilities by calling 952-992-2322 (voice), or 1-800-373-8335 (toll free), or 952-992-2357, or 1-800-234-8819 (TTY), or 711, or through the Minnesota Relay at 1-877-627-3848 (speech to speech relay service)