

Quantity Limits (QL)

Quantity limits identify the maximum quantity of medication that can be dispensed over a specific period of time at the applicable copayment, coinsurance, or deductible. Typically, quantity limits are in place to encourage appropriate drug utilization and contain medication cost. This list includes most of the common drugs with quantity level limits. Some quantity limits based on the product's labeling, or adopted clinical guidelines may not be included on this list. **Some items on this list may not apply to every Medica drug plan benefit.** See your plan documents for complete information. 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.

Preferred Drug Quantity Limits

<p>ABILIFY 2, 5, 10, 15 mg - 1 tab/day ABILIFY 20, 30 mg – 2 tabs/day alendronate 5mg & 10mg – 30 tabs/month alendronate 35mg & 70mg – 4 tabs/28 days ASACOL HD – 6 tablets per day 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 CAVERJECT – 6 injections/month CHANTIX – 6 fills per calendar year DETROL – 60 tablets/month DETROL LA – 30 tablets/month DIASTAT – 1 kit/copay dronabinol - 2 units/day ELIDEL – 100 grams/month ELLA – 1 tablet/fill EMEND 80mg – 4 capsules/month EMEND 125mg – 2 capsules/month EMEND TRIFOLD – 2 trifolds/month EPIPEN/EPIPEN JR – 4 pens/copay ESTRADERM – 8 patches/28 days famciclovir 125mg/500mg – 21 tablets/month famciclovir 250mg – 60 tablets/month fentanyl (Duragesic) – 10 patches/30 days fentanyl (Actiq, Fentora) – 120 units/month FORTEO – 1 pen/month FOSAMAX PLUS D – 4 tablets/28 days</p>	<p>GEODON 80mg – 3 caps/day GEODON all other strengths – 2 caps/day granisetron – 2 tablets/copay granisetron oral solution – 30ml/copay ketorolac – 20 tablets/month lansoprazole – 60 tablets/month leflunomide (Arava) – 30 tablets/month LETAIRIS – 1 unit/day loratadine OTC– 30 tablets/month loratadine-D OTC– 30 tablets/month LYSTEDA – 30 tablets/28 days MAXALT/MLT – 18 tablets/month MIGRANAL – 4 units/ month MUSE – 6 suppositories/month naratriptan – 18 tablets/month nicotine gum – 3 fills per year nicotine lozenges – 3 fills per 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 olanzapine/rapid dissolve 2.5, 5mg – 1 tab/day olanzapine/rapid dissolve 7.5,15, 20mg – 2 tabs/day olanzapine/rapid dissolve 10mg – 4 tabs/day omeprazole 10mg– 60 units/month omeprazole 20mg OTC – 120 units/month oxybutynin XL 5mg,10mg – 30 tabs/month oxybutynin XL 15mg – 60 tablets/month OXYCONTIN – 120/month pantoprazole – 60 tablets/month PREVACID NAPRAPAC – 84 capsules/month PREVPAC – 14 dose packs/copay</p>	<p>PROAIR HFA- 2 units/month PROLIA – 1 injector/6 months 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 risperidone 4 mg – 4 tabs/day risperidone (all other strengths) – 3 tabs/day SABRIL – 6 packets/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 80mg & 100mg — 1 capsule/day STRATTERA all other strengths— 2 caps/day sumatriptan injection – 6 injections/month sumatriptan tablets – 18 tablets/month sumatriptan nasal spray 12 units/month TAMFLU 75mg – 10 units/fill terbinafine – 120 therapy days/year TYKERB – 150 units/30 days valacyclovir - 90 tablets/month VIMOVO – 60 tablets/month VIMPAT – 2 units/day VIVELLE-DOT – 8 patches/28 days XOLAIR – 6 vials/30 days ZIRGAN – 1 tube/fill zolpidem ext release - 30 tablets/month</p>
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Non-Preferred Drug Quantity Limits

***Note: Non-preferred drugs may not be covered by your plan, or may be covered at a lesser benefit. Please see your plan documents for complete information.**

ACIPHEX – 60 tablets/month	FANAPT – 60 tablets/month	NEXIUM – 60 capsules/month
ADVAIR DISKUS– 2 units/month	FROVA – 18 capsules/month	ONSOLIS – 4 units/month
ALLEGRA-D 12 HR – 60 tablets/month	INTUNIV – 30 tablets/month	PERFOROMIST – 60 vials/moth
ALLEGRA-D 24 HR – 30 tablets/month	LAMICTAL XR – 1 kit/month	PROVIGIL 100mg - 60 tablets/month
AMITIZA – 60 tablets/month	LEVITRA – 6 tablets/month	PROVIGIL 200mg – 30 tablets/month
CAMBIA – 18 packets/month	LIDODERM – 120 patches/month	SANCUSO – 1 patch/copay
CESAMET – 4 units/day	LUNESTA – 30 tablets/month	TREXIMET – 18 units/month
CIALIS – 6 tablets/month	LYRICA – 90 tablets/month	VENTOLIN HFA – 2 units/month
DAYTRANA – 30 patches/month	MENOSTAR patch - 4 patches/28 days	VIAGRA – 6 tablets/month
ESTROGEL – 2 bottles/month		XIFAXAN – 9 tablets/fill
		ZOMIG – 12 tablets/month