

Specialty Medication Listing

Your pharmacy benefit program may include coverage for certain products that are referred to as Specialty Medications. Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders, and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan). Most Specialty medications are injectables, however some may be oral or transdermal. Specialty Medications may be medication that you administer to yourself or have a healthcare provider administer for you. The following is a list of medications that are considered Specialty Medications. *As new medications that have similar indications enter the market these products may be added to the program without notice.* (This list is subject to change - please consult customer service for an updated list.) These medications may require prior authorization before being dispensed.

HEMATOPOIETIC GROWTH FACTORS	COAGULATION THERAPY (continued)	MISCELLANEOUS THERAPIES (continued)	ORAL CHEMOTHERAPY AGENTS (continued)
ARANESP EPOGEN NEULASTA NEUMEGA NEUPOGEN PROCRIT	NORMIFLO NOVOSEVEN PANHEMATIN THROMBATE VASCEZE XYNTHA	BUMINATE CAYSTON* CIMZIA CYANOCOBALAMIN* FABRAZYME FASLODEX FUZEON FV VIT B-12* HYDROBEXAN INCRELEX	SUTENT TARCEVA TARGRETIN TEMODAR THALOMID TYKERB VESONOID XELODA ZOLINZA
MULTIPLE SCLEROSIS & NEUROLOGICAL DISORDERS	CHRONIC GRANULATOMOUS DISEASE	IPLEX MITOXANTRONE HCL NAGLIZYME OCTREOTIDE PLASMANATE PLASMATEIN PRIMABALT PULMOZYME RAPTIVA REMODULIN* RETROVIR IV INFUSION* REVLIID RITUXAN SANDOSTATIN SASH KIT FOR FLUSHING VAS SHOVITE SIMPONI SOLIRIS* SOMATULINE SOMAVERT* SYNAGIS* TIA-DOCE S TOBI TORISEL TRELSTAR TRELSTAR LA VANTAS XOLAIR*	ORAL HEPATITIS AGENTS
AMPYRA* AVONEX BETASERON COPAXONE GILENYA* NOVANTRONE REBIF TYSABRI*	ACTIMMUNE INTERFERONS INTRON-A INFERGEN PEG-INTRON PEGASYS REBETRON ROFERON-A	INTERFERONS ENBREL HUMIRA KINERET METHOTREXATE* ORENCIA* REMICADE*	BARACLUDE COPEGUS EPIVIR HBV HESPERA REBETOL RIBAVIRIN TYZEKA
COAGULATION THERAPY	RHEUMATOID ARTHRITIS	OSTEOPOROSIS	GROWTH HORMONES
ADVATE ALPHANATE ALPHANINE AMICAR ARIXTRA* AUTOPLEX T BEBULIN VH BENEFIX CYKLOKAPRON DDAVP FEIBA VH FRAGMIN* HELIXATE HEMOFIL M HUMATE-P HYATE:C INNOHEP KOATE KOGENATE KONYNE LOVENOX* MONARC-M MONOCLATE-P MONONINE PROFILNINE PROPLEX T RECOMBINATE REFACTO FACTOR VIII	AREIDIA CALCITONIN* FORTEO MIACALCIN PAMIDRONATE* RECLAST HORMONAL THERAPIES ELIGARD LUPRON DEPOT SUPPRELIN SUPPRELIN LA SYNAREL VIADUR ZOLADEX	AREIDIA CALCITONIN* FORTEO MIACALCIN PAMIDRONATE* RECLAST HORMONAL THERAPIES ELIGARD LUPRON DEPOT SUPPRELIN SUPPRELIN LA SYNAREL VIADUR ZOLADEX	GENOTROPIN GEREF HUMATROPE LEUPROLIDE ACETATE NORDITROPIN NUTROPIN OMNITROPE PROTROPIN SAIZEN SEROSTIM* TEV-TROPIN ZORBTIVE
	MISCELLANEOUS THERAPIES	ORAL CHEMOTHERAPY AGENTS	MISCELLANEOUS ORAL THERAPIES
	ALBUMIN HUMAN ALFERON N AMEVIVE APOKYN* ARCALYST*	CEENU GLEEVEC IRESSA* NEXAVAR REVLIMID SPRYCEL	EXJADE* KUVAN LETAIRIS* ORFADIN* REVATIO SENSIPAR TASIGNA TRACLEER* VALCYTE*

Medications listed with an asterisk () are included in the specialty program copayment, however are not limited to Fairview Specialty Pharmacy providers. These medications may also be obtained by your local retail pharmacy. For the most up to date information on additional medications or to check your medication to see if it is included in the specialty program, please contact customer service at 1-800-546-5677. Revised 4/1/11