UnitedHealthcare Services Company of the River Valley, Inc.

For drugs requiring preauthorization, please call the phone number on the back of your ID card. Items with a cost of $1,000 per prescription may require authorization.

DRUGS REQUIRING PREAUTHORIZATION*

Actimmune®	Cimzia®	Forteo™	Olux®-CP (e)	Sandostatin®/LAR®	Tysabri®
Actiq®	Clobex® Shampoo (e)	Gelnique™ (e)	Orencia®	Simponi™	Tyvaso™
Adcirca™	Compounded Meds (e)	Gleevec®	Pegasys®	Soma® 250 (e)	Vantas™
Adoxa® (e)	Copegus®/ribavirin	Humira®	PEG-Intron®	Somatuline®	Vectical™ (e)
Amevive™	Coreg CR™ (e)	Infergen®	Proscar®/finasteride	Somavert®	Venlafaxine ER (e)
Amitiza®	Detrol® LA (e)	Intron®	Protopic®	Sprycel™	Ventavis™
Amrix® (e)	Doryx® (e)	IVIG/Vivaglobin®	Provigil®	Stavzor™ (e)	Veramyst® (e)
Aplenzin™ (e)	Dysport™	Keppra XR™ (e)	Rebetol®/ribravirin	Suboxone®	Viadur™
Arcalyst™	Edluar™ (e)	Kineret®	Regranex®	Subutex®	Xolair®
Asacol® HD (e)	Elidel®	Kuvan®	Remicade®	Supprelin® LA	Xopenex® Nebs (e)
Augmentin XR® (e)	Enbrel®	Lamictal® ODT™ (e)	Remodulin®	Sutent®	Xyrem®
Avodart®	Epiduo™ (e)	Lamictal® XR™ (e)	Requip® XL (e)	Synagis™	Zavesca®
Benzaclin® Kit (e)	Epinephrine disposable syringe (e)	Letairis™	Restasis®	Tarceva®	Zelnorm®
Botox®/Myobloc®	Factor Products	Lyrica®	Revatio™	Tasigna®	Zipsor™ (e)
Caduet® (e)	Fentanyl lozenge	Momexin™ Combo Pkg (e)	Revlimid®	Testim® (e)	Zolinza™
Celebrex®	Fentora™	Neobenz® microspheres (e)	Rituxan® for RA	Tracleer™	
Cesamet®	Flector® (e)	Nexavar®	Ryzolt™ (e)	Treximet™ (e)	
Cetraxal® (e)	Floran®/epoprostenol	Nuvigil® (e)	Sancuso® (e)	Tykerb®	

DRUGS WITH PREVIOUS THERAPY PREREQUISITES*

These medications may require preauthorization in member who have not tried designated first in therapy or no previous claims history with UnitedHealthcare.

Kapidex® (e), Nexium® (e), Prevacid® (e),Prevacid® Solutab™ (e) (Two Tier 1 or Tier 2 Proton Pump Inhibitors)	Lunesta®, Rozerem™ Ambien®, Sonata® (zolpidem, zaleplon, Ambien CR™)	Allegra® ODT (e), Allegra® Suspension (e), Allegra-D® (e), Clarinex® (e), Clarinex-D® (e), Clarinex® Syrup (e), Clarinex® RediTabs® (e) (fexofenadine and Xyzal®)	Betaseron® (Rebif®)	Bravelle®, Follistim® AQ (Gonal-F®)
Celexa®, Cymbalta®, Effexor®/XR®, Lexapro®, Luvox®/CR, Paxil®, Paxil CR®, Pexeva®, Pristiq™, Prozac®, Prozac® Weekly™, Sarafem®, Wellbutrin®/ SR®/XL®, Zoloft® (Four week trial of generic antidepressant if no history of antidepressant use within the prior 6 months)				

(e) Medication may be excluded from coverage under some plans. Please consult prescription drug rider.

*Additional medications with over the counter therapeutic equivalents are excluded from coverage under some plans. Check benefit plan documents for coverage information or call the Customer Care number on your ID card for more information.

DRUGS WITH QUANTITY RESTRICTIONS

Please refer to the Prescription Drug List Reference Guides at www.uhcrivervalley.com for drugs with quantity restrictions and/or quantity limit designations.

PRESCRIPTION CATEGORY EXCLUSIONS*

Most plans – consult prescription drug rider

Anabolic Steroids	Growth Hormone/Growth Promoting Agents	Obesity Agents	Smoking Cessation
Cosmetic Agents	Infertility Agents	Sexual Dysfunction	Smoking Deterrents

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*Additional medications with over the counter therapeutic equivalents are excluded from coverage under some plans. Check benefit plan documents for coverage information or call the Customer Care number on your ID card for more information.