

Sparrow Health System Employee Benefit Rider (current through November 3, 2009) Updated 10-6-09 sk

Quantity Limit List

Category	Medication *	Quantity Limit
Analgesics	Stadol Nasal Spray	5mL (2 bottles) / month
	Ultram tablets	240 tablets / month
Anti-Emetic Products	Anzemet 50mg & 100mg tabs	12 tablets / copay - 2 fills per month
	Emend 40mg (non-preferred)	5 capsules month
	Emend 80mg	2 caps per month
	Emend 125mg	1 cap per month
	Kytril 1 mg tablets	2 tablets / copay - 2 fills per month
	Zofran 4mg & 8mg tablets	30 tablets / copay - 2 fills per month
	Zofran ODT all strength tablets	30 tablets / copay - 2 fills per month
	Zofran 4mg/5ml oral solutions	150 mL (3 bottles) / copay - 2 fills per month
Antineoplastic Agents	Zolinza	120 capsules per month
Beta agonist inhalant and nebulizing agents	All products (e.g. albuterol, metaproterenol)	2 inhalers or bottles of solution / month
	Duoneb	360 ml / month (120 vials)
	Levalbuterol	288 ml / month (96 vials)
Central Nervous System (CNS) Stimulants (effective 8-1-04)	Adderall XR 5mg, 10mg, 15mg (preferred)	34 capsules per month
	Adderall XR 20mg, 25mg, 30mg (preferred)	68 capsules per month
	Concerta all strengths except 36mg (preferred)	34 tablets per month
	Concerta 36mg strength ONLY (preferred)	68 tablets per month
	Metadate CD all strengths (non-preferred)	34 tablets per month
	Provigil all strengths (non-preferred)	68 capsules per month (prior notification required)
	Ritalin LA 20mg & 40mg (non-preferred)	34 capsules per month
	Ritalin LA 30 mg (non-peferred)	68 capsules / month
	Strattera 10mg, 18mg, 25mg, 40mg (Preferred)	68 capsules / month
	Strattera 60mg, 80mg, 100mg (Preferred)	34 capsules / month
	Vyvanse (all strengths) (non-preferred)	34 capsules / month
	COX-2 Sparing Agents	Celebrex 50mg, 100mg & 200mg tabs (non-preferred)
Mobic 7.5mg & 15mg tabs (non-preferred)		68 tablets / month
Erectile Dysfunction Agents	Cialis (all strengths)	5 tablets / month
	Levitra (all strengths)	5 tablets / month
	Viagra (all strengths)	5 tablets / month
Estrogen patches	Generic products	90 day supply for 1 copay
HMG-CoA Reductase Inhibitors	Caduet (all strengths) (non-preferred)	34 tablets / month
	Crestor (all strengths) (non-preferred)	34 tablets / month
Insulin	All products	3 vials or 2 boxes of pens / copay
Narcotic Analgesics (added per P& T action 1-6-04)	Actiq (all strengths)	90 Oralets / month
	Avinza (all strengths)	68 capsules / month
	Duragesic patches (all strengths)	11 patches per strength per month
	Fentora	84 tablets
	Kadian (all strengths)	136 capsules / month
	MS Contin (all strengths)	204 tablets / month
	Oramorph (all strengths)	204 tablets / month
	Oxycontin (EXCEPT 10MG and 20MG)	136 tablets / month
	Oxycontin 10mg and 20mg strengths	180 tablets / month
Nasal steroid inhalers	All products (e.g. beclomethasone, flunisolide)	1 inhaler / month
Non-Sedating Antihistamines	Allegra 30mg, 60mg, and Allegra D (Non-preferred)	68 tablets per month
	Allegra 180mg and Allegra D - 24 hr (non-preferred)	34 tablets per month
	Clarinet 5mg & Clarinet D 24 hr (non-preferred)	34 tablets per month
	Clarinet D 12 hour	68 tablets per month
	fexofenadine 30mg, 60mg (preferred)	68 tablets per month
	fexofenadine 180mg (preferred)	34 tablets per month
	Xyzal 5mg (non-preferred)	34 tablets per month
NSAIDS	Toradol 10mg tablets	20 tablets / month

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Category	Medication	Quantity Limit
Oral Contraceptives	All products	3 month supply / 3 copays
Oral Steroid Inhalers	All products	2 inhalers / month
Proton Pump Inhibitors	Aciphex 20mg tablets (non-preferred)	34 tablets / month
	Nexium 20mg & 40mg caps (preferred)	34 tablets / month
	Omeprazole all strengths	136 tablets / month
	Prevacid 15mg & 30mg caps (non-preferred)	34 capsules / month
	Prilosec 10mg, 20mg, 40mg caps (non-preferred)	34 capsules / month
	Protonix 20mg & 40mg (preferred)	34 capsules / month
Sedative / Hypnotic Agents (effective 2-1-06)	Ambien all strengths (preferred)	34 capsules / month
	Ambien CR all strengths (non-preferred)	34 capsules / month
	Lunesta all strengths (preferred)	34 capsules / month
	Rozerem all strengths (non-preferred)	34 capsules / month
	Sonata all strengths (preferred)	34 capsules / month
Selective Serotonin Receptor Agonist	Amerge 1mg & 2.5mg tabs	9 tablets / Rx; 18 tablets / month
	Axert 6.26mg & 12.5mg tabs	6 tablets / Rx; 12 tablets / month
	Frova tabs (all strengths)	9 tablets / Rx; 18 tablets / month
	Imitrex Syringe	1 Kit (2 syringes) / Rx; 2 fills per month
	Imitrex 25mg, 50mg, and 100mg tabs	9 tablets (each strength) / Rx; 18 tablets month
	Imitrex Nasal Spray 5mg & 20mg	6 spray bottles (1 box) / month
	Imitrex Vials	5 vials (1 pack) per Rx; 10 vials/ per month
	Maxalt 5mg & 10mg tablets & disintegrating tabs	12 tablets / Rx; 24 tablets / month
	Relpax 20mg & 40mg tablets	6 tablets per fill / 12 tablets per month
	Zomig 2.5mg tablets	6 tablets / 12 month
	Zomig Nasal Spray	1 box of 6 UD sprays per month
	Zomig 5mg tablets & Zomig ZMT 5mg	3 tablets / month
Selective Serotonin Reuptake inhibitor Medication Class (Added to the list per P&T action on October 17, 2002)	Citalopram 20mg (preferred)	102 tablets / month generic only
	Citalopram 40mg tablets (preferred)	45 tablets / month
	fluoxetine 10mg (preferred)	34 tablets / month
	fluoxetine 20mg (preferred)	90 capsules / month
	fluoxetine 40mg (non-preferred)	68 tablets / month
	Lexapro 5mg & 20mg tablets (non-preferred)	34 tablets / month
	Lexapro 10mg (non-preferred)	45 tablets / month
	Luvox and fluvoxamine 25mg tab (non-preferred)	34 tablets / month
	Luvox and fluvoxamine 50mg tab (non-preferred)	68 tablets / month
	Luvox and fluvoxamine 100mg tab (non-preferred)	102 tablets / month
	Luvox CR 100mg & 150mg	34 tablets / month
	Paxil 10mg tablets (non-preferred)	34 tablets / month
	Paxil 20mg, 30mg, & 40mg tablets (non-preferred)	68 tablets / month
	Paroxetine 20mg, 30mg, & 40mg tablets (preferred)	68 tablets / month
	Paxil CR 12.5mg, 25mg, & 37.5mg (non-preferred)	68 tablets / month
	Prozac 10mg tab/cap (non-preferred)	34 tablets / month
	Prozac 20mg caps (non-preferred)	90 capsules / month
	Prozac 40mg caps (non-preferred)	34 capsules / month
Prozac 90mg caps (non-preferred)	4 capsules / month	
Symbyax all strengths (non-preferred)	34 capsules / month	
Smoking Cessation Products	Chantix (non-preferred)	24 weeks of therapy maximum lifetime

* Generic products are subject to quantity limits

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Preferred Drug List			
Category		Preferred (Tier 1 or 2)	Non Preferred (Tier 3)
SSRI's	fluoxetine 10mg & 20mg	X	
	citalopram	X	
	sertraline	X	
	paroxetine	X	
	Celexa		X
	Lexapro		X
	Luvox		X
	Paxil		X
	Paxil CR		X
	Prozac		X
	Sarafem		X
Symbyax		X	
Central Nervous System (CNS) Stimulants	methylphenidate	X	
	methylphenidate SR	X	
	amphetamine salts and Adderall XR	X	
	Strattera	X	
	Concerta (effective 6-1-05)	X	
	Daytrana		X
	Focalin		X
	Metadate CD		X
	Nuvigil (not covered)		
	Provigil (requires prior notification)		X
	Ritalin LA		X
Vyvanse		X	
Congestive Heart Failure Agents	Agents except BiDil	X	
	BiDil		X
Diabetic Agents	glimepiride	X	
	Avandia	X	
	Avandaryl		X
	Exubera (Prior notification approval required)		X
	Glumetza		X
	Prandimet (ind. Products are preferred)		X
	Insulin	X	
	Symlin	X (ONLY if prescribed by an endocrinologist. Excluded for all other prescribers)	
Byetta		X	
HMG-CoA Reductase Agents (Including combination products)	Pravachol	X	
	lovastatin	X	
	Lipitor 40mg & 80mg	X	
	Vytorin	X	
	Zetia	X	
	Zocor(simvastatin) (effective 5-1-05)	X	
	Advicor		X
	Caduet		X
	Crestor		X
	Lescol		X
	Lipitor 10mg & 20mg (step edit - simvastatin)		X
	Mevacor		X
	Pravigard PAC		X
Simcor		X	

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Preferred Drug List			
Category		Preferred (Tier 1 or 2)	Non Preferred (Tier 3)
Inhaled Nasal Steroids Step edit requires use of generic product prior to using a brand name agent.	Fluticasone propionate	X	
	Flunisolide	X	
	Beconase AQ (Step edit - use of generic product)	X	
	Flonase (Step edit - use of generic product)	X	
	Nasacort AQ (Step edit - use of generic product)	X	
	Nasonex (Step edit - use of generic product)	X	
	Rhinocort Aqua (Step edit - use of generic product)	X	
	Omnanis (Step edit - use of generic product)		X
	Veramyst (Step edit - use of generic product)		X
NSAID Agents	Acetic Acid Agents (indomethacin capsule, sulindac, diclofenac delayed release tablet, tolmetin)	X	
	Fenemates (meclofenamate)	X	
	Oxicams (piroxicam)	X	
	Propionic Acid Agents (flurbiprofen, ibuprofen, naprosyn sodium tablet, fenoprofen, ketoprofen)	X	
	Pyranocarboxylic Acid (etodolac tablet)	X	
	Misc (nabumetone)	X	
	Celebrex		X
	Mobic		X
	The following require Prior Notification Approval: naprosyn sodium sustained action tablet, indomethacin sustained action capsule, etodolac sustained release 24 hr tablet, and diclofenac sustained release 24 hour tablet.	X (requires prior notification approval)	
Non-Sedating Antihistamine (note the step edit for nasal steroid inhalers {fluticasone or flunisolide} is use of one generic nasal steroid inhaler before using a brand name product)	fexofenadine	X	
	Allegra		X
	Allegra ODT		X
	Allegra D		X
	Allegra Suspension		X
	Clarinet		X
	Clarinet D 12 hour and 24 hour		X
	Xyzal		X
Leukotriene Receptor Antagonist (step edit for class =use of nasal steroid inhaler OR other asthma medication within previous 12 months)	Advair (available at tier 1 copay)	X	
	Singulair (no step edit if member 5 yrs or younger)	X	
	Zyflo	X	
	Zyflo CR		X
Proton Pump Inhibitors	Omeprazole all strengths	X	
	OTC omeprazole / OTC Prilosec	X	
	Protonix (Tier 1)	X	
	Nexium (caps tier 1, susp tier 2)	X	
	Prevacid / NapraPAC		X
	Aciphex - step edit for 2 preferred agents		X
	Prevacid		X
	Prilosec		blocked - use omeprazole 20mg caps
Kapidex	Not a covered benefit. Use other PPI agents.		
Antiviral Agents	Acyclovir	X	
	Famvir- Step Edit - acyclovir first line therapy		X
	Valtrex - Step Edit - acyclovir first line therapy		X
Hepatitis B Agents	Epivir	X	
	Baraclude		X (Tier 2 if patient had a 60 trial of Epivir within the previous 90 days)

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Preferred Drug List			
Category		Preferred (Tier 1 or 2)	Non Preferred (Tier 3)
Sedative Hypnotics - Non Barbiturate	Flurazepam	X	
	Temazepam	X	
	Triazolam	X	
	Sonata	X	
	Ambien	X	
	Ambien CR		X
	Lunesta		X
	Rozerem		X
Combination Products	ibuprofen and oxycodone individually	X	
	metformin and glipizide	X	
	pravastatin and aspirin	X	
	Combunox (ibuprofen/oxycodone)		X
	Exforge (amlodipine / valsartan)		X
	Metaglip (metformin and glipizide)		X
	Pravigard PAC (pravastatin and aspirin)		X
Antispasmodic Agents	Ditropan & Ditropan XL	X	
	Detrol & Detrol LA	X	
	Enablex	X	
	Sanctura & Sanctura XR		X
	Toviaz		X
Bisphosphonates - (Bone resorption suppression agents)	Actonel	X	
	Fosamax	X	
	Boniva		X
Neuropathic Pain Agents (effective 9-15-05)	Neurontin	X	
	Lyrica		X (Tier 2 if patient has had a 60 day trial of Neurontin (gabapentin) in the last 90 days)
Pulmonary Arterial Hypertension (PAH) Agents (effective 9-15-05)	Calcium Channel Blockers	X	
	Revatio and Cialis	X <small>(ONLY if prescribed by a cardiologist or pulmonologist - prior authorization approval required for all other prescribers.</small>	

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Category		Preferred (Tier 1 or 2)	Non Preferred (Tier 3)
Misc Agents	Altabax		X
	Alvesco HFA Inhaler / Alvesco Inhaler (step edit - trial of all formulary inhaled steroid asthma products)		X
	Apriso		X
	Azilect		X
	Azor		X
	Brovana		X
	Calafol RX		X
	Centany		X
	Chantix		X
	Citranatal Products		X
	Clarifoam EF		X
	Cleeravue -M		X
	Coartem		X
	Combigan		X
	Coreg CR		X
	Effexor XR (venlafaxine ER is covered on tier 2)		X
	Epidou		X
	Equetro		X
	Fexmid		X
	Keppra XR		X
	Lamictal XR		X
	Lavoclen-4 and Lavoclen-8		X
	Lovaza		X
	Metrogel Combo Package		X
	Moviprep		X
	Omnaris		X
	Onglyza		
	Otosporin		X
	Ostiva		X
	Otosporin		X
	Oxandrin		X
	Patanase Nasal Spray		X
	Pristiq		X
	Pyrex and Pyrex PD		X
	Rapaflo		X
	Renvela		X
	Requip XL		X
	Rosac		X
	Savella (step edit)		X
	Seradex		X
	Seroquel XR		X
	Servira		X
	Somatuline Depot		X
	Sprycel		X
	Stavzor		X
Symbicort		X	
Tacolnex Scalp		X	
Tasigna		X	
Trilpix		X	
Ultram ER		X	
Veramyst		X	
Ziana		X	
Zymine XR and DXR		X	
Brand Name Products available at the Generic Tier 1 (\$7.00) Copay Rate	Accolate		
	Advair		
	Alphagan P 5mL bottle ONLY (Quantity limit of 2 bottles / copay)		
	Aricept		
	Atacand		
	EpiPen and EpiPen Jr (Quantity limit of 2 pens / copay)		
	Nexium (caps tier 1, susp tier 2)		
	Novolin R, N and 70/30 Vials ONLY		
	Prevacid		
	Protonix		

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Excluded Products

Accuhist products
Ala-Hist products
Alcortin A
Aldex products
Allfen products
Allerx products
Alodex products
Alodox
Aloquin
Ambifed Products
Amrix
Analpram E
Aplenzin
Aquoral
Avidoxy DK
Bifillin G
Biomed
Brovex Products
Bystolic
Cardiotek Products
Centratex
Cleanse and Treat
Clindareach
CNL 8 topical
Codclear DH
Cotab products
Coraz
Dallergy products
Desowen
Dexall
Dexodryl
Dailyvite 5000
Differin products for members > 29 yrs of age. Tier 3 for all others
Digex NF
Doryx
Duac CS
Duet DHA Stuartnatal
Duovit DHA
Dytan CD
Endal CD
Endometrin
Entereg
Entex
Epiceram
Evamist
Extendryl products
Ferralet 90
Flector Patch
Folbee Plus
Fosteum
HC Guai
Hyaltopic
Ibudone
IC400; IC 800
J-Coff DHC
J-Max Products
J-Tan D HC
Kapidex
Kerol Products
LidoCort KIT
Limbrel
Manuvit SP
Maxichlor PSE DM
Maxifed products / Maxiflu products / Maxiphen products
Medent-DMI
Mi-Omega NF

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Minocin Kits
Momexin
Monodox
Moxatag
Nalfrx
Nasofed
Nasohist products
Natelle Plus
Neo HC
Neutrahist Products
Niravam
Notuss-forte
Nucynta
Nuvigil
Nutridox
Nutrestore
Obagi - C
Optinate
Oraxyl
Papfyll
Peranex HC
PhenFlu products
Physician Therapeutics products
Polytussin DHC
Pramine FQ
Prefera-OB
Prenate products
Prenatal vitamins with DHA supplements
Probarimin QT
Protect Cardio / Protect CMB2/Ceramide
Pryflex
Pylera
Quinzyme
Radigel
Re Dualvit products
Relcof DN PE
Renatabs with Iron
Reocyte Plus
Respi-tann products
Rezyst IM
Rhinahist
Rinnovi
Rosula products
Rowasa KITS
Ryzolt (tramadol preferred; Ultram ER tier 3)
Salex
Salvax Duo
Samsca
Scalacort DK
Solaraze Gel
Solotuss
Strovite Advance + D
Sudates-G
Sympak products
Tandem DHA
Tear Again
Tersi Foam
Treximet
Trital SR
Tussicaps
Ultravate PAC
Uloric
Umecta
Vanacof products
Vanoxide HC Kit
Viravan products

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Vitamax
Vitaphil
Viva DHA
Xolegel DUO and Corepak
Xyralid products
Zamicet
Zenieve
Z-Care
Zinotic
Zinx
Zotex-D
Z Tuss 2
Zypram
Zytopic

Benefit Exclusions
 Cosmetic Agents - Medications used for cosmetic purposes are not covered. (e.g. Propecia)
 Vitamins - OTC Vitamins are not covered - Prescription vitamins may be covered
 Weight Loss Products - Products for weight loss are not covered (e.g. Meridia and Xenical)

Fertility Medications are a 40% copay for all members

SPHN covers the following Over-the-Counter Medications (\$5.00 Copay for a 28-34 days supply, depending on package size)
 Nicotine Patches, Lozenges, and Gum (quantity limit of 2 boxes per fill)
 OTC Prilosec and OTC omeprazole
 loratadine tablets and liquid

Prior Notification Medications

Medication	Information
Afinitor	Submit request to MedImpact. If approved, covered on Tier 3
Arcalyst	Submit request to MedImpact. If approved, covered on Tier 3
Aplenzin	Submit request to MedImpact. If approved, covered on Tier 3
Brovana	Submit request to MedImpact. If approved, covered on Tier 3
Emend 40mg	Submit request to MedImpact. If approved, covered on Tier 3
Emsam	Submit request to MedImpact. If approved, covered under Tier 3. Oral seligiline is preferred
Enbrel	Submit request to MedImpact. If approved, covered on Tier 2
Exjade	Submit request to Plan. If approved, covered under Tier 3. Specialty Pharmacy item.
Exubera	Submit request to MedImpact. If approved, covered on Tier 3.
Famvir	Submit request to MedImpact. If approved, covered on Tier 3.
Fentora	Submit request to MedImpact. If approved, covered under Tier 3.
Humira	Submit request to MedImpact. If approved, covered on Tier 2
Kuvan	Submit request to MedImpact. If approved covered on Tier 3. Need diagnosis verification
NPlate	Submit request to Plan. If approved, covered under Tier 2. Specialty Pharmacy item.
Opana	Submit request to MedImpact, include documentation showing superiority over other opioids. If approved, covered under Tier 3.
Prilosec	Submit request to MedImpact. If approved, covered on Tier 3
Promacta	Submit request to Plan. If approved, covered under Tier 2. Specialty Pharmacy item.
Provigil	Submit request to MedImpact. If approved, covered on Tier 3
Ranexa	Submit request to MedImpact. If approved, covered on Tier 3
Relistor	Submit request to MedImpact. If approved, covered on Tier 3
Sancuso	Submit request to MedImpact. If approved, covered on Tier 3
Suboxone	Submit request to MedImpact.
Valtrex	Submit request to MedImpact. If approved, covered on Tier 3
Xenazine	Submit request to MedImpact. If approved, covered on Tier 2
Zegerid	Submit request to MedImpact. If approved, covered on Tier 3
indomethacin sustained action capsule	indomethacin capsule preferred. Submit request to MedImpact. If approved, covered under Tier 1
etodolac sustained release 24 hour tablet	etodolac tablet preferred. Submit request to MedImpact. If approved, covered under Tier 1
naprosyn sodium sustained action tablet	naprosyn sodium tablet preferred. Submit request to MedImpact. If approved, covered under Tier 1
diclofenac sustained release 24 hour tablet	diclofenac delayed release tablet preferred. Submit request to MedImpact. If approved, covered under Tier 1

Medication Extended Supply List

Please Note:

Generic dispensed when available. Brand name in most cases only listed for name recognition.

*Asterisked agents do not currently have a generic available.

I. 100 Units or 34 days supply, whichever is greater

Antidiabetic Agents

Chlorpropamide (eg. Diabinese)
 Glipizide (Glucotrol)
 Glyburide (Micronase/Diabeta)
 Metformin (Glucophage)

Antihypertensives

Atenolol (eg. Tenormin)
 Diltiazem (Dilacor XR only)
 Hydrochlorothiazide /
 Triamterene (eg. Dyazide/Maxzide)
 Nifedipine (Adalate CC only)
 Nitroglycerine (eg. Nitrobid/Nitrostat)
 Propranolol (eg. Inderal)
 Verapamil (Verapamil SR only)

Anti-inflammatory agents

Ibuprofen (eg. Motrin)
 Naproxen (eg. Naprosyn)
 Naproxen Sodium (eg. Anaprox)

Anti-Lipid Agents

Atorvastatin (Lipitor)*
 Fluvastatine (Lescol)*
 Gemfibrozil (Lopid)
 Lovastatin (Mevacor)
 Pravastatin (Pravachol)
 Simvastatin (Zocor)

Bronchodilators

Theophylline (eg. Theodur/Slo-bid)

Cardiac Agents

Digoxin
 Procainamide HCl (Procan/Pronestyl)
 Quinidine

Diuretics

Bumetanide (Bumex)
 Chlorthalidone (eg. Hygroton)
 Chlorothiazide (eg. Diuril)
 Furosemide (eg. Lasix)
 Hydrochlorothiazide (eg. Hydrodiuril)

Estrogen and Hormone Therapy

Esterified Estrogens (eg. Estratab, Estrace, Ortho-est)
 Conjugated Estrogens Maximum 3 packs
 (eg. Premarin*, Premaphase*, Prempro*)
 Medroxyprogesterone (Provera)

H₂ Blockers

Cimetidine
 Ranitidine

Hyperuricemia/Gout agents

Allopurinol (eg. Zyloprim)

Potassium Chloride

(eg. Kay Ciel/Slow K/K Dur/ Micro K/Klotrix)

II. 200 Units or 34 day supply, whichever is greater

Isoniazid (eg. INH)
 Levothyroxine (eg. Levothroid/Synthroid)
 Para-Aminosalicylic acid (eg. PAS)

Phenytoin (eg. Dilantin)
 Primidone (eg. Mysoline)
 Propylthiouricil (eg. PTU)
 Thyroid (eg. Armour Thyroid)