2023 MEDICARE FORMULARY

LIST OF COVERED DRUGS

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

MetroPlus Health

MetroPlus Health Plan, Inc.
For more recent information or other questions, please contact MetroPlus Health Plan Member Services, at 866.986.0356 or, for TTY users, 711, 24 hours a day, 7 days a week, or visit metroplusmedicare.org .

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MetroPlus Health Plan

2023 Formulary

(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

00024161, Version Number 5

This formulary was updated on 07/27/2023. For more recent information or other questions, please contact MetroPlus Health Plan Member Services at 866.986.0356 or, for TTY users, 711, 24 hours a day, 7 days a week, or visit **metroplusmedicare.org**.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means MetroPlus Health Plan. When it refers to "plan" or "our plan," it means MetroPlus Advantage Plan (HMO-DSNP), MetroPlus UltraCare (HMO-DSNP), and MetroPlus Platinum Plan (HMO).

This document includes a list of the drugs (formulary) for our plan which is current as of August 1. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

What is the MetroPlus Health Plan Formulary?

A formulary is a list of covered drugs selected by MetroPlus Health Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. MetroPlus Health Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a MetroPlus Health Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but MetroPlus Health Plan may add or remove drugs on the Drug List during the year, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the MetroPlus Health Plan Formulary?"

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the MetroPlus Health Plan Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of August 1. To get updated information about the drugs covered by MetroPlus Health Plan, please contact us. Our contact information appears on the front and back cover pages. We will send you a letter in the event of mid-year non-maintenance formulary changes which tells you where to find the updated formulary on our website.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 22. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular". If you know what your drug is used for, look for the category name in the list that begins on page 22. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 77. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

MetroPlus Health Plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** MetroPlus Health Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from MetroPlus Health Plan before you fill your prescriptions. If you don't get approval, MetroPlus Health Plan may not cover the drug.

- **Quantity Limits:** For certain drugs, MetroPlus Health Plan limits the amount of the drug that MetroPlus Health Plan will cover. For example, MetroPlus Health Plan provides 120 pills per prescription for Colcrys. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, MetroPlus Health Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, MetroPlus Health Plan may not cover Drug B unless

you try Drug A first. If Drug A does not work for you, MetroPlus Health Plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 22. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask MetroPlus Health Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the MetroPlus Health Plan formulary?" below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that MetroPlus Health Plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by MetroPlus Health Plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by MetroPlus Health Plan.

- You can ask MetroPlus Health Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the MetroPlus Health Plan Formulary?

You can ask MetroPlus Health Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, MetroPlus Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, MetroPlus Health Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If your level of care changes after the first 90 days that you are a member, we may provide you with an emergency supply of up to 31-day (unless your prescription is for less). Oral brand solid medications are limited to a 14-day supply with exception as required by CMS guidance.

For more information

For more detailed information about your MetroPlus Health Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about MetroPlus Health Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

MetroPlus Health Plan Formulary

The formulary below provides coverage information about the drugs covered by MetroPlus Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 77.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., DURAMORPH) and generic drugs are listed in lower-case italics (e.g., *endocet*).

The information in the Requirements/Limits column tells you if MetroPlus Health Plan has any special requirements for coverage of your drug.

- **PA**: MetroPlus requires your physician to get prior authorization for certain drugs. This means you will need to get approval from MetroPlus before you fill your prescriptions. If you don't get approval, MetroPlus may not cover the drug.
- **QL**: For certain drugs, MetroPlus limits the amount of the drug that MetroPlus will cover. For example, MetroPlus provides one unit per day per prescription for pantoprazole. This may be in addition to a standard one month or three month supply.
- **ST**: In some cases, MetroPlus requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, MetroPlus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, MetroPlus will then cover Drug B.
- **LA**: Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Provider/Pharmacy Directory or call Member Services at 1-866-693-4615, 24 hours a day, 7 days a week. TTY users should call 1-800-881-2812.
- **B/D**: This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **NM**: This drug is not available via mail order and not available for a long-term supply.

MetroPlus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

MetroPlus Health Plan
Formulario para 2023
(Lista de medicamentos cubiertos)

POR FAVOR, LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

00024161, Version Number 5

Este formulario fue actualizado el 07/27/2023. Para obtener información más reciente u otras preguntas, por favor póngase en contacto con Servicios al Miembro de MetroPlus Health Plan a través del 1-866-986-0356 o para usuarios de TTY, 711, durante las 24 horas del día, los 7 días de la semana, ovisite www.metroplusmedicare.org.

Mensaje importante sobre lo que paga por las vacunas: nuestro plan cubre la mayoría de las vacunas de la Parte D sin costo para usted, incluso si no ha pagado su deducible. Llame a Servicios al Miembro para obtener más información.

Mensaje importante sobre lo que paga por la insulina: no pagará más de $35 por un suministro para un mes de cada producto de insulina cubierto por nuestro plan, independientemente del nivel de costos compartidos en el que se encuentre, incluso si usted no ha pagado su deducible.

Nota dirigida a los miembros activos: Este formulario ha cambiado desde el año pasado. Por favor, revise este documento para asegurarse de que todavía contiene los medicamentos que usted toma.

Cuando en esta lista de medicamentos (formulario) dice “nosotros” o “nuestro”, hace referencia a MetroPlus Health Plan. Cuando dice “plan” o “nuestro plan”, significa MetroPlus Advantage Plan (HMO-DSNP), MetroPlus Ultracare (HMO-DSNP) y MetroPlus Platinum Plan (HMO).

Este documento incluye una lista de medicamentos (formulario) de nuestro plan actualizada al agosto 1. Para conocer un formulario actualizado, por favor póngase en contacto con nosotros. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Por lo general, debe acudir a las farmacias de la red para utilizar su beneficio de los medicamentos recetados. Los beneficios, el formulario, la red de farmacias y/o los copagos/coaseguros pueden cambiar el 1 de enero del 2024 y de vez en cuando durante el año.

¿Qué es el Formulario de MetroPlus Health Plan?

Un formulario es una lista de medicamentos cubiertos seleccionados por MetroPlus Health Plan después de consultar a un equipo de proveedores de atención médica, el cual representa las terapias a base de medicamentos de venta con receta que se creen necesarias para llevar a cabo un programa de tratamiento de calidad. MetroPlus Health Plan por lo general cubre los medicamentos listados en nuestro formulario siempre y cuando el medicamento sea necesario en términos médicos, los medicamentos de venta con receta se despachen en una farmacia de la red del plan, y se sigan otras reglas del plan. Para más información sobre cómo obtener los medicamentos de venta con receta, por favor revise su Evidencia de cobertura.

¿Puede cambiar el Formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos ocurren el 1 de enero, pero MetroPlus Health Plan puede agregar o eliminar medicamentos en la Lista de Medicamentos durante el año o agregar nuevas restricciones. Debemos seguir las normas de Medicare al hacer estos cambios.

Cambios que pueden afectarlo este año: En los siguientes casos, usted se verá afectado por cambios en la cobertura durante el año:

- **Medicamentos genéricos nuevos.** Podemos eliminar de inmediato un medicamento de marca en nuestra Lista de Medicamentos si lo reemplazamos con un nuevo medicamento genérico y con las mismas restricciones o menos. Además, al agregar el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de Medicamentos, pero agregar nuevas restricciones. Si actualmente está tomando ese medicamento de marca, es posible que no le informemos con anticipación antes de hacer ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos realizado.
    - Si realizamos dicho cambio, usted o quien prescribe pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al Formulario de MetroPlus Health Plan?"

- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento de nuestro formulario no es seguro o si el fabricante del medicamento lo saca del mercado, quitaremos de inmediato el medicamento de nuestro formulario y les avisaremos a los miembros que toman el medicamento.

- **Otros cambios.** Es posible que hagamos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que actualmente está incluido en el formulario o agregar nuevas restricciones al medicamento de marca. O podemos hacer cambios basados en nuevas pautas clínicas. Si quitamos medicamentos de nuestro formulario, agregamos autorización previa, límites de cantidades y/o restricciones en terapias escalonadas de un medicamento, debemos notificar a los miembros afectados sobre el cambio con al menos 30 días de antelación antes de que el cambio se haga efectivo, o cuando el miembro solicite los medicamentos de venta con receta, momento en el que el miembro recibirá un suministro de 30 días del medicamento.
    - Si realizamos estos otros cambios, usted o quien prescribe pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al Formulario de MetroPlus Health Plan?"

Cambios que no lo afectarán si actualmente está tomando el medicamento. Por lo general, si usted está tomando un medicamento que está dentro de nuestro formulario del 2023 que estaba cubierto al comienzo del año, no suspenderemos ni reduciremos la cobertura del medicamento durante el año de cobertura 2023, excepto como se describió anteriormente. Esto significa que estos medicamentos permanecerán disponibles con el mismo costo compartido y sin nuevas restricciones para aquellos

miembros que los toman por el resto del año de cobertura. Este año no recibirá un aviso directo sobre cambios que no lo afecten. Sin embargo, los cambios lo afectarían a partir del 1 de enero del año próximo y es importante que consulte la Lista de Medicamentos del nuevo año de beneficios para ver si hay algún cambio en los medicamentos.

El formulario adjunto está actualizado al agosto 1. Para obtener información actualizada sobre los medicamentos cubiertos por MetroPlus Health Plan, por favor póngase en contacto con nosotros. Nuestra información de contacto aparece en las portadas delanteras y traseras. Le enviaremos una carta en caso de cambios en el formulario a mitad de año que no sean de mantenimiento, que le indicará dónde encontrar el formulario actualizado en nuestro sitio web.

¿Cómo utilizo el formulario?

Hay dos maneras de encontrar su medicamento dentro del formulario:

Enfermedad

El formulario comienza en la página 22 Los medicamentos en este formulario están agrupados en categorías dependiendo del tipo de enfermedades para las que se utilizan. Por ejemplo, los medicamentos utilizados para tratar una enfermedad cardíaca están listados bajo la categoría "Cardiovascular". Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 22. Luego busque su medicamento bajo el nombre de la categoría.

Lista en orden alfabético

Si no sabe en qué categoría buscar, debería buscar su medicamento en el Índice que comienza en la página 77. El Índice contiene una lista en orden alfabético de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los genéricos están listados en este Índice. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento, verá el número de la página donde puede encontrar la información sobre la cobertura. Vaya a la página listada en el Índice y encontrará el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

MetroPlus Health Plan cubre tanto medicamentos de marca como medicamentos genéricos. Un medicamento genérico es aquel que contiene los mismos ingredientes activos que el medicamento de marca según la aprobación de la FDA (Administración de Alimentos y Medicamentos). Por lo general, los medicamentos genéricos son más baratos que los de marca.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos podrían tener requerimientos adicionales o límites de cobertura. Estos requerimientos o límites podrían incluir:

- **Autorización previa:** MetroPlus Health Plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que usted necesitará una aprobación por parte de MetroPlus Health Plan antes de obtener su medicamento de venta con receta. Si no obtiene esta aprobación, MetroPlus Health Plan podría no cubrir el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, MetroPlus Health Plan limita la cantidad del medicamento que cubrirá MetroPlus Health Plan. Por ejemplo, MetroPlus Health Plan proporciona 120 píldoras por receta de Colcrys. Esto podría ser en adición a un suministro estándar para uno o tres meses.

- **Terapia escalonada:** En algunos casos, MetroPlus Health Plan exige que usted primero pruebe algunos medicamentos para tratar su enfermedad antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B sirven para el tratamiento de su enfermedad, MetroPlus Health Plan puede no cubrir el medicamento B, a menos que pruebe el medicamento A primero. Si el medicamento A no le sirve, entonces MetroPlus Health Plan cubrirá el medicamento B.

Puede averiguar si su medicamento tiene requisitos adicionales o límites buscando en el formulario que comienza en la página 22. También puede obtener más información sobre las restricciones que aplican a ciertos medicamentos cubiertos visitando nuestra página web. Hemos publicado documentos en línea que explican nuestras restricciones en cuanto a las autorizaciones previas y la terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Puede pedirle a MetroPlus Health Plan que haga una excepción en cuanto a estas restricciones o límites o pedirle una lista de otros medicamentos similares que puedan servir para tratar su enfermedad. Vea la sección "¿Cómo solicito una excepción al Formulario de MetroPlus Health Plan?" a continuación para obtener información sobre cómo solicitar una excepción.

¿Qué ocurre si mi medicamento no se encuentra en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe ponerse en contacto con Servicios al Miembro y preguntar si su medicamento está cubierto.

Si se entera de que MetroPlus Health Plan no cubre su medicamento, tiene dos opciones:

- Puede pedirle a Servicios al Miembro una lista de medicamentos similares que estén cubiertos por MetroPlus Health Plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por MetroPlus Health Plan.

- Puede pedirle a MetroPlus Health Plan que haga una excepción y cubra su medicamento. Revise más abajo para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al Formulario de MetroPlus Health Plan?

Puede solicitarle a MetroPlus Health Plan que haga una excepción en cuanto a nuestras reglas para la cobertura. Existen varios tipos de excepciones que nos puede pedir que hagamos.

- Puede pedirnos que cubramos un medicamento aún si este no está en nuestro formulario. De aprobarse, este medicamento será cubierto a un nivel predeterminado de costo compartido y no podrá pedirnos que proporcionemos el medicamento a un nivel de costo compartido más bajo.
- Puede solicitarnos que no apliquemos las restricciones de cobertura o límites sobre su medicamento. Por ejemplo, para ciertos medicamentos, MetroPlus Health Plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que no apliquemos el límite y cubramos una cantidad mayor.

Generalmente, MetroPlus Health Plan solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de costo compartido más bajo o las restricciones de uso adicionales no serán efectivos para tratar su enfermedad y/o le causarán un efecto médico adverso.

Debe ponerse en contacto con nosotros con el fin de solicitarnos una decisión de cobertura inicial para una excepción en el formulario o en las restricciones de uso. **Cuando solicita una excepción en el formulario o en las restricciones de uso, debe enviar una declaración por parte de su médico que apoye su solicitud.** Por lo general, debemos tomar nuestra decisión dentro de las primeras 72 horas de haber recibido la declaración de apoyo de su médico. Puede solicitar una excepción expedita (rápida) si usted o su médico creen que su salud puede verse gravemente afectada si debe esperar 72 horas por una decisión. Si se le concede esta solicitud expedita, debemos darle a conocer una decisión a más tardar dentro de las 24 horas después de haber recibido la declaración de apoyo por parte de su médico u otra persona que haya emitido la receta.

¿Qué debo hacer antes de poder hablar con mi médico sobre cambiar mis medicamentos o solicitar una excepción?

Como miembro nuevo o regular de nuestro plan, podría estar tomando medicamentos que no están dentro de nuestro formulario. O podría estar tomando un medicamento que está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, podría necesitar una autorización previa de nuestra parte antes de que pueda obtener su medicamento de venta con receta. Es recomendable que hable con su médico para decidir si debería cambiar a un medicamento apropiado que cubramos o solicitar una excepción en el formulario para que cubramos el medicamento que usted toma. Mientras habla con su médico para determinar qué debe hacer, podríamos cubrir su medicamento en algunos casos durante los primeros 90 días en los que usted es miembro de nuestro plan.

Por cada uno de sus medicamentos que no estén en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal de 30 días. Si su receta está hecha por menos días, permitiremos surtidos para proporcionarle hasta un máximo de 30 días de suministro del medicamento. Después de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si usted ha sido miembro del plan por menos de 90 días.

Si usted es un residente de un centro de cuidados de largo plazo y necesita un medicamento que no está en nuestro formulario o si su capacidad de obtener los medicamentos es limitada, pero ya pasó los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia por 31 días para este medicamento mientras tramita una excepción al formulario.

Si su nivel de atención cambia después de los primeros 90 días de ser miembro, podemos proporcionarle un suministro de emergencia de hasta 31 días (a menos que su receta sea por menos). Los medicamentos sólidos de marca por vía oral están limitados a un suministro de 14 días, con excepción de lo requerido por la guía de CMS.

Para más información

Para más información sobre la cobertura de medicamentos recetados de MetroPlus Health Plan, por favor revise su Evidencia de cobertura y otros materiales sobre el plan.

Si tiene preguntas sobre MetroPlus Health Plan, por favor póngase en contacto con nosotros. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, por favor llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas al día, los 7 días a la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O bien visite www.metroplusmedicare.org.

Formulario de MetroPlus Health Plan

El formulario a continuación proporciona información sobre la cobertura de medicamentos por parte de MetroPlus Health Plan. Si tiene dificultades para encontrar su medicamento en la lista, pase al Índice que comienza en la página 77.

La primera columna del cuadro lista el nombre del medicamento. Los medicamentos de marca están en mayúscula (por ejemplo, DURAMORPH) y los medicamentos genéricos están en minúscula y cursiva (por ejemplo, *endocet*).

La información en la columna de Requerimientos/Límites le dice si MetroPlus Health Plan tiene algún requerimiento especial para la cobertura de su medicamento.

- **PA (siglas en inglés de "aprobación previa"):** MetroPlus requiere que su médico obtenga una autorización previa para ciertos medicamentos. Esto significa que usted necesitará una aprobación antes de obtener su medicamento de venta con receta. Si no obtiene esta aprobación, puede que no cubramos el medicamento.
- **QL (siglas en inglés de "límites a la cantidad")** Para ciertos medicamentos, MetroPlus limita la cantidad del medicamento que cubriremos. Por ejemplo, MetroPlus proporciona una unidad por día por receta de pantoprazole. Esto podría ser en adición a un suministro estándar para uno o tres meses.
- **ST (siglas en inglés de "terapia escalonada"):** En algunos casos, MetroPlus exige que usted primero pruebe algunos medicamentos para tratar su enfermedad antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B sirven para el tratamiento de su enfermedad, MetroPlus podría no cubrir el medicamento B, a menos que pruebe el medicamento A primero. Si el medicamento A no le sirve, entonces MetroPlus cubrirá el medicamento B.

- **LA (siglas en inglés de "disponibilidad limitada")**: Acceso limitado Estos medicamentos de venta con receta pueden estar disponibles solo en algunas farmacias. Para obtener más información, consulte su Directorio de proveedores y farmacias o llame a Servicios al Miembro al 1-866-693-4615, las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-800-881-2812.
- **B/D**: Este medicamento recetado debe ser autorizado previamente por vía administrativa como Parte B o D. El medicamento podría estar cubierto bajo la Parte B o D de Medicare según las circunstancias. Podría ser necesario enviar información donde se describa el uso y tipo de medicamento para llevar a cabo la determinación.
- **NM (siglas en inglés de "no disponible por correo")**: Este medicamento no está disponible mediante el pedido por correo y no está disponible para un suministro a largo plazo.

MetroPlus Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, país de origen, edad, discapacidad o sexo.

MetroPlus Health

Plan 2023 處方一覽表

（承保藥品清單）

請閱讀：本文件包含有關我們在此計劃中承保藥物的資訊

00024161, Version Number 5
本處方一覽表更新於 07/27/23。想要瞭解更多新資訊或其他問題，請聯絡 MetroPlus Health Plan會員服務部 1-866-986-0356，聽力障礙電傳使用者請致電 711，每週 7 天，每天 24 小時開放，或瀏覽 www.metroplusmedicare.org。

關於您需支付的疫苗費用的重要資訊——本計劃免費承保大部分D部分疫苗，即使您未支付自負額。請致電會員服務部了解詳情。

關於您需支付的胰島素費用的重要資訊——無論屬於哪個費用分攤層級，對於本計劃所承保的一個月用量的每種胰島素產品，您支付的金額將不超過35 ，即使您未支付自負額。

現有會員注意：此處方一覽表自去年以來發生了變更。請閱覽此文件，確保處方一覽表仍然包含您服用的藥品。
本藥品清單（處方一覽表）中的「我們」或「我們的」指代 MetroPlus Health Plan。本文件中的「計劃」或「我們的計劃」指代 MetroPlus Advantage Plan (HMO-DSNP)，MetroPlus UltraCare (HMO-DSNP)和 MetroPlus Platinum Plan (HMO)。

本文件包含一份用於我們計劃的藥品清單（處方一覽表），**最後更新日期為 8 月 1 日 。**如需獲得最新處方一覽表，請聯絡我們。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。
一般情況下，您必須使用網絡內藥房來使用您的處方藥福利。福利、處方一覽表、藥房網絡和/或自付費用/共同保險費可能會在 2024年 1 月 1 日發生變更，並在當年中不時發生變更。

何謂MetroPlus Health Plan處方一覽表?

處方一覽表是 MetroPlus Health Plan 在諮詢醫療保健提供者團隊後選擇的承保藥品清單，這個清單上列出了有效的治療計劃所必須的處方療法。MetroPlus Health Plan 一般會承保處方一覽表內列出的藥品，只要這些藥品屬於醫療必需藥品，且處方由 MetroPlus Health Plan 網絡內的藥房開出，也符合其他的計劃規則。如想獲得關於如何開處方藥的更多資訊，請查閱您的承保福利說明。

處方一覽表（藥品清單）會發生變更嗎？

大部分藥物承保變更發生在 1 月 1 日，但在一年當中 MetroPlus Health Plan 可能會新增或移除藥品清單中的藥品，或增加新的限制。在進行這些變更時，我們須遵循 Medicare 的規定。

當年可影響您的變更：在以下案例中，您將因目前年度的承保變更受到影響：

- **新普通藥品。**如果我們用一種新的、具有相同或更少限制的普通藥品替代某種品牌藥品，我們可立即將該品牌藥品從我們的藥品清單上移除。此外，在添加新普通藥品時，我們可能會決定將品牌藥品保留在我們的藥品清單中，但會添加新的限制。如果您目前正在服用該品牌藥品，我們可能不會在進行變更之前提前告知您，但我們之後會向您提供有關我們所做出的具體變更的資訊。
    - 如果我們做出這樣的變更，您或您的處方醫生可以要求我們例外對待並繼續為您承保品牌藥品。我們為您提供的通知還將包含您如何請求例外對待的資訊，您還可以在下面標題為「如何向 MetroPlus Health Plan 處方一覽表請求特例處理？」部分中找到相關資訊。

- **退市的藥物。**如果食品與藥物管理局裁定我們處方一覽表上的一種藥品不安全或此藥品的製造商將藥品撤出市場，我們會立即將此藥品從我們的處方一覽表上移除並通知服用此藥品的會員。

- **其他變動。**我們可能會進行影響目前服用藥物的會員的其他變動。例如， 我們可能會新增一種非新上市的普通藥品來替代處方一覽表上已有的品牌藥品，或對品牌藥品增加新的限制。或者，我們可以根據新的臨床指導原則進行變更。如果我們將藥品從處方一覽表中移除，增加了一種藥品的事先核准、數量限制以及/或者逐步治療限制，我們必須在變更生效前至少 30 天內通知受影響的會員這一變更情況，或在會員要求續開藥品時進行通知，在這種情況下，此會員將獲得 30 天的藥品供應量。
    - 如果我們做出此類變更，您或您的處方醫生可以要求我們例外對待並繼續為您承保品牌藥品。我們為您提供的通知還將包含您如何請求例外對待的資訊，您還可以在下面標題為「如何向 MetroPlus Health Plan 處方一覽表請求特例處理？」部分中找到相關資訊。

如果您目前正在服用該藥物，則您將不會受到影響的變化。一般情況下，如果您正在服用我們的 2023 年處方一覽表上的藥品，且此藥品年初屬於承保藥品，我們不會在 2023 年保險年期間中斷或減少藥品承保。這意味著正在服用該藥品的會員能夠在該保險年的剩餘時間以相同的分攤費用取得該藥品，且無需受到新的限制。您當年不會受到任何對您不產生影響的變化的直接通知。但是，自下一年的 1 月 1 日開始，這些變更的影響就會生效，因此請務必查看新福利年度藥品清單上的藥品是否有任何變化。

隨信附上的處方一覽表最後更新日期為 8 月 1 日。如想獲得 MetroPlus Health Plan 藥品保險的最新資訊，請聯絡我們。我們的聯絡資料在封面和封底。如果年中並未出現處方一覽表維護變更，我們將向您郵寄一封信，告知您在我們網站的什麼位置尋找最新處方一覽表。

如何使用處方一覽表？

有兩個方法可以在處方一覽表中尋找您的藥品：

醫療狀況

處方一覽表從第22頁開始。此處方一覽表中的藥品根據它們用於治療的醫療狀況類型劃分為不同種類。例如，用於治療心臟狀況的藥品被列於「心血管」種類之下。如果您知道自己藥品的作用，則可從22開始的清單中查詢類別名稱。然後在這一種類下方查詢您的藥品。

字母排列

如果您不確定應該在哪個種類下方查詢，您應該在從第77頁開始的索引中尋找您的藥品。索引提供了一份清單，將本文件包含的所有藥品按照字母順序進行排列。品牌藥品和普通藥品都列於此索引之中。查詢索引，找到您的藥品。在您的藥品旁邊，您將看到承保資訊所在頁面的頁碼。翻至索引中所列頁面，並在清單第一欄找到您的藥品名稱。

什麼是普通藥物？

MetroPlus Health Plan 承保品牌藥品和普通藥品。普通藥品是透過 FDA 審核的與品牌藥品具有相同活性成分的藥品。一般情況下，普通藥品的費用比品牌藥品低。

我的受保範圍是否有約束或限制?

部分承保藥品可能有額外承保要求或限制。這些要求和限制可能包括：

- **事前核准：**MetroPlus Health Plan 要求您或您的醫生為某些藥品獲得事前核准。這意味著您領取處方藥之前需要獲得 MetroPlus Health Plan 的核准。若您未獲得核准，MetroPlus Health Plan 可能不承保此藥品。

- **數量限制：**對於某些藥品，MetroPlus Health Plan 的承保藥量有限。例如，MetroPlus Health Plan 將秋水仙鹼(Colcrys)的單次處方量限制為 120 片。這可能是對標準一個月或三個月供應量的補充。

- **分步治療：**在某些情況下，MetroPlus Health Plan 會要求您在其承保治療您所患病症的藥物前先試用某些藥物。例如，如果藥品 A 和藥品 B 都可治療您的疾病情況，MetroPlus Health Plan 可能會要求您先試用藥品 A，否則就不承保藥品 B。如果藥品 A 對您無效，MetroPlus Health Plan 將承保藥品 B。

如想瞭解您的藥品是否有其他額外要求或限制，您可從第22頁開始檢視處方一覽表。您也可以瀏覽我們的網站，瞭解有關特定承保藥品所受約束的詳細資訊。我們已在網上發佈文件，解釋我們的事先核准和逐步治療限制。您也可以要求我們向您傳送一份副本。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。

您可以要求 MetroPlus Health Plan 對這些約束和限製作出特例處理，或對也許能夠治療您的健康狀況的其他類似藥品清單作出特例處理。參見下方的「如何向 MetroPlus Health Plan 處方一覽表請求特例處理？」部分，瞭解請求特例處理的方法。

如果我的藥品未納入此處方一覽表該怎麼辦？

如果您的藥品未納入此處方一覽表（承保藥品清單），您首先應該聯絡會員服務部，詢問您的藥品是否在承保範圍內。

如果您瞭解到 MetroPlus Health Plan 不承保您的藥品，您有兩個選項：

- 您可以向會員服務部要求一份 MetroPlus Health Plan 承保的類似藥品清單。 當您收到這份清單之後，將這份清單給您的醫生檢視並要求醫生開一種與 MetroPlus Health Plan 的承保藥品類似的藥品。

- 您可以向 MetroPlus Health Plan 請求特例處理並要求承保您的藥品。參見下方資訊，瞭解如何請求特例處理。

如何向 **MetroPlus Health Plan** 處方一覽表請求特例處理？

您可以向 MetroPlus Health Plan 請求對我們的承保規則進行特例處理。您可以向我們請求進行幾類特例處理。

- 即使一種藥品不在我們的處方一覽表之上，您也可以向我們請求承保此藥品。如果請求被核准，此藥品將以事先決定的費用分攤水準被承保，而您無法要求我們提供更低的費用分攤水準。

- 您可以向我們請求撤銷對您的藥品承保約束或限制。例如，對於某些藥品，MetroPlus Health Plan 限制我們承保的藥量。如果您的藥品有藥量限制，您可以向我們請求撤銷此限制並承保更大藥量。

一般情況下，只有當計劃處方一覽表上包含的替代藥品、分攤費用更低的藥品或額外使用約束對您的治療效果不佳以及/或者可能對您產生副作用，MetroPlus Health Plan 才會核准您的特例請求。

您應該聯絡我們，要求獲得一份有關處方一覽表或使用限制特例的初始保險決定。**當您請求一份處方一覽表或使用約束特例時，您應該提交一份您的開藥醫生或醫師出具的支持您請求的聲明。**一般情況下，我們必須在收到您的開藥醫生出具的支援性聲明後的 72 小時內作出決定。如果您或您的醫生認為等待 72 小時才能裁定可能會對您的健康造成嚴重傷害，您可以請求加急（快速）特例。如果您的加急請求得到許可，我們必須在收到您的醫生或其他開藥醫生出具的支援性聲明的 24 小時之內告知您我們的決定。

在我能夠和我的醫生討論變更我的藥品或請求特例之前我應該做什麼？

作為我們的計劃的新會員或持續會員，您可能正在服用不在我們的處方一覽表上的藥品。或者，您可能正在服用我們處方一覽表上的藥品，但您獲得該藥品的能力受限。例如，在開處方藥之前，您可能需要得到我們的事前核准。您應該向您的醫生諮詢，確認您是否應該更換為我們承保的合適藥品，或請求處方一覽表特例處理，要求我們承保您服用的藥品。在您向您的醫生諮詢並決定正確的處理措施之時，我們可能會在特定情況下在您成為我們的計劃會員的最初 90 天內承保您的藥品。

對於您所服用的不在我們處方一覽表上的每一種藥品或如果您獲得您的藥品的能力有限，我們將暫時承保 30 天的供應藥量。如果您所開的處方藥用量天數較少，我們將允許再次配藥，以便提供最多 30 天供應的藥品。結束您最初 30 天的供應藥量之後，我們不會為這些藥品支付費用，即使您成為本計劃會員的時間不超過 90 天亦如此。

如果您是一家長期護理機構的住院病患且您需要的藥品並不在我們的處方一覽表上或者如果您獲得藥品的能力有限，而您加入我們計劃成為會員已經超過 90 天，在您尋求處方一覽表例外處理期間，我們將承保 31 天的急救用藥用量。

如果您在成為會員的頭 90 天后護理等級發生變化，我們可以為您提供長達 31 天的緊急藥品供應（除非您的處方用量少於該期限）。品牌口服固體製劑藥量控制在 14 天用量，例外情況依照 CMS 指導要求。

更多資訊

為獲得關於您的 MetroPlus Health Plan 處方藥品承保的詳細資訊，請閱覽您的《承保福利說明》和其他計劃材料。

如果您對 MetroPlus Health Plan 有疑問，請聯絡我們。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。

如果您對 Medicare 處方藥品承保有一般性問題，請致電 Medicare，電話是 1-800-MEDICARE (1-800-633-4227)，每週 7 天、每天 24 小時開通。聽力障礙電傳使用者應致電 1-877-486-2048。或者瀏覽 http://www.medicare.gov。

MetroPlus Health Plan 處方一覽表

下方的處方一覽表向您提供 MetroPlus Health Plan 承保的藥物資訊。如果您在藥物清單上找藥物有困難，請翻至位於第 77 頁上的索引部分。

圖表第一列是藥品名稱。品牌藥品名稱大寫（如：DURAMORPH），普通藥品為斜體小寫（如：*endocet*）。

要求/限制欄中的資訊告知您 MetroPlus Health Plan 對您的藥品承保是否有任何特殊要求。

- **PA**：MetroPlus 要求您的醫生為某些藥品獲得事前核准。這意味著您領取處方藥之前需要獲得 MetroPlus 的核准。若您未獲得核准，MetroPlus 可能不承保此藥品。
- **QL**：對於某些藥品，MetroPlus 限制承保的藥量。例如，MetroPlus 每天為每一處方的泮托拉唑(pantoprazole)提供一個單位的藥量。這可能是對標準一個月或三個月供應量的補充。
- **ST**：在某些情況下，MetroPlus 會要求您在其承保治療您所患病症的藥物前先試用其他藥物。例如，如果藥品 A 和藥品 B 都可治療您的疾病情況，MetroPlus 可能會要求您先試用藥品 A，否則就不承保藥品 B。如果藥物 A 對您無效，MetroPlus 將承保藥物 B。
- **LA**：獲得管道有限。該處方可能只允許在一些藥房配藥。欲瞭解更多訊息，請諮詢您的醫療服務提供者/參閱《藥房名錄》或致電會員服務部：1-866-693-4615，工作時間為每週 7 天，每天 24 小時。聽力障礙電傳使用者應致電 1-800-881-2812。
- **B/D**：此處方藥品在核准要求之前有一個 B 部分與 D 部分的行政問題。視不同情況而定，此藥品可能根據 Medicare B 部分或 D 部分進行承保。可能需要提交資訊，說明此藥品的用途和治療情況，以便作出決定。
- **NM**：此藥品不能郵購，也不提供長期用量配藥。

MetroPlus Health Plan 遵守適用的聯邦民權法律，沒有種族、膚色、民族血統、年齡、殘障或性別方面的歧視。

METRO_PLUS_CY23_1T_SNP eff 08/01/2023

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
allopurinol TABS 100mg, 300mg	1	
colchicine TABS .6mg	1	QL (120 tabs / 30 days)
colchicine w/ probenecid tab 0.5-500 mg	1	
MITIGARE CAPS .6mg	1	QL (60 caps / 30 days)
probenecid TABS 500mg	1	
NSAIDS		
celecoxib CAPS 50mg, 100mg, 200mg	1	QL (60 caps / 30 days)
celecoxib CAPS 400mg	1	QL (30 caps / 30 days)
diclofenac potassium TABS 50mg	1	QL (120 tabs / 30 days)
diclofenac sodium TB24 100mg; TBEC 25mg, 50mg, 75mg	1	
diflunisal TABS 500mg	1	
ec-naproxen TBEC 375mg	1	QL (120 tabs / 30 days)
ec-naproxen TBEC 500mg	1	QL (90 tabs / 30 days)
etodolac CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	1	
flurbiprofen TABS 100mg	1	
ibu TABS 400mg, 600mg, 800mg	1	
ibuprofen SUSP 100mg/5ml; TABS 400mg, 600mg, 800mg	1	
meloxicam TABS 7.5mg, 15mg	1	
nabumetone TABS 500mg, 750mg	1	
naproxen TABS 250mg, 375mg, 500mg	1	
naproxen TBEC 375mg	1	QL (120 tabs / 30 days)
naproxen TBEC 500mg	1	QL (90 tabs / 30 days)
naproxen sodium TABS 275mg, 550mg	1	
piroxicam CAPS 10mg, 20mg	1	
sulindac TABS 150mg, 200mg	1	
OPIOID ANALGESICS, LONG-ACTING		
fentanyl PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr	1	QL (10 patches / 30 days), PA
hydrocodone bitartrate T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	1	QL (30 tabs / 30 days), PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	1	QL (30 tabs / 30 days), PA
methadone hcl SOLN 5mg/5ml, 10mg/5ml	1	QL (450 mL / 30 days), PA
methadone hcl TABS 5mg, 10mg	1	QL (90 tabs / 30 days), PA
methadone hydrochloride i CONC 10mg/ml	1	QL (90 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate TBCR 15mg, 30mg, 60mg, 100mg, 200mg	1	QL (90 tabs / 30 days), PA
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen w/ codeine soln 120-12 mg/5ml	1	QL (2700 mL / 30 days)
acetaminophen w/ codeine tab 300-15 mg	1	QL (400 tabs / 30 days)
acetaminophen w/ codeine tab 300-30 mg	1	QL (360 tabs / 30 days)
acetaminophen w/ codeine tab 300-60 mg	1	QL (180 tabs / 30 days)
butorphanol tartrate SOLN 1mg/ml, 2mg/ml	1	
endocet tab 2.5-325mg	1	QL (360 tabs / 30 days)
endocet tab 5-325mg	1	QL (360 tabs / 30 days)
endocet tab 7.5-325mg	1	QL (240 tabs / 30 days)
endocet tab 10-325mg	1	QL (180 tabs / 30 days)
fentanyl citrate LPOP 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	1	QL (120 lozenges / 30 days), PA
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	QL (2700 mL / 30 days)
hydrocodone-acetaminophen tab 5-325 mg	1	QL (240 tabs / 30 days)
hydrocodone-acetaminophen tab 7.5-325 mg	1	QL (180 tabs / 30 days)
hydrocodone-acetaminophen tab 10-325 mg	1	QL (180 tabs / 30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	1	QL (150 tabs / 30 days)
hydromorphone hcl LIQD 1mg/ml	1	QL (600 mL / 30 days)
hydromorphone hcl TABS 2mg, 4mg, 8mg	1	QL (180 tabs / 30 days)
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	1	B/D
morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml	1	B/D
morphine sulfate SOLN 10mg/5ml, 20mg/5ml	1	QL (900 mL / 30 days)
morphine sulfate SOLN 20mg/ml	1	QL (180 mL / 30 days)
morphine sulfate TABS 15mg, 30mg	1	QL (180 tabs / 30 days)
MORPHINE SULFATE/SODIUM C SOLN 1mg/ml	1	B/D
nalbuphine hcl SOLN 10mg/ml, 20mg/ml	1	
oxycodone hcl CAPS 5mg	1	QL (180 caps / 30 days)
oxycodone hcl CONC 100mg/5ml	1	QL (180 mL / 30 days)
oxycodone hcl SOLN 5mg/5ml	1	QL (900 mL / 30 days)
oxycodone hcl TABS 5mg, 10mg, 15mg, 20mg, 30mg	1	QL (180 tabs / 30 days)
oxycodone w/ acetaminophen tab 2.5-325 mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen tab 5-325 mg	1	QL (360 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
oxycodone w/ acetaminophen tab 7.5-325 mg	1	QL (240 tabs / 30 days)
oxycodone w/ acetaminophen tab 10-325 mg	1	QL (180 tabs / 30 days)
tramadol hcl TABS 50mg	1	QL (240 tabs / 30 days)
tramadol-acetaminophen tab 37.5-325 mg	1	QL (240 tabs / 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) SOLN .5%, 1%, 1.5%, 2%	1	B/D
ANTI-INFECTIVES		
ANTI-INFECTIVES - MISCELLANEOUS		
albendazole TABS 200mg	1	
amikacin sulfate SOLN 1gm/4ml, 500mg/2ml	1	
atovaquone SUSP 750mg/5ml	1	
aztreonam SOLR 1gm, 2gm	1	
CAYSTON SOLR 75mg	1	NM, LA, PA
clindamycin hcl CAPS 75mg, 150mg, 300mg	1	
clindamycin palmitate hydrochloride SOLR 75mg/5ml	1	
clindamycin phosphate SOLN 300mg/2ml, 600mg/4ml, 900mg/6ml, 9000mg/60ml	1	
clindamycin phosphate in d5w iv soln 300 mg/50ml	1	
clindamycin phosphate in d5w iv soln 600 mg/50ml	1	
clindamycin phosphate in d5w iv soln 900 mg/50ml	1	
CLINDMYC/NAC INJ 300/50ML	1	
CLINDMYC/NAC INJ 600/50ML	1	
CLINDMYC/NAC INJ 900/50ML	1	
colistimethate sodium SOLR 150mg	1	
dapsone TABS 25mg, 100mg	1	
DAPTOMYCIN SOLR 350mg	1	
daptomycin SOLR 350mg, 500mg	1	
EMVERM CHEW 100mg	1	QL (12 tabs / year)
ertapenem sodium SOLR 1gm	1	
gentamicin in saline inj 0.8 mg/ml	1	
gentamicin in saline inj 1 mg/ml	1	
gentamicin in saline inj 1.2 mg/ml	1	
gentamicin in saline inj 1.6 mg/ml	1	
gentamicin in saline inj 2 mg/ml	1	
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	1	

Drug Name	Drug Tier	Requirements/Limits
imipenem-cilastatin intravenous for soln 250 mg	1	
imipenem-cilastatin intravenous for soln 500 mg	1	
ivermectin TABS 3mg	1	QL (12 tabs / 90 days), PA
linezolid SOLN 600mg/300ml	1	
linezolid SUSR 100mg/5ml	1	QL (1800 mL / 30 days)
linezolid TABS 600mg	1	QL (60 tabs / 30 days)
linezolid in sodium chloride iv soln 600 mg/300ml-0.9%	1	
meropenem SOLR 1gm, 500mg	1	
methenamine hippurate TABS 1gm	1	
metronidazole SOLN 500mg/100ml; TABS 250mg, 500mg	1	
neomycin sulfate TABS 500mg	1	
nitazoxanide TABS 500mg	1	QL (6 tabs / 30 days)
nitrofurantoin macrocrystal CAPS 50mg, 100mg	1	
nitrofurantoin monohyd macro CAPS 100mg	1	
paromomycin sulfate CAPS 250mg	1	
pentamidine isethionate inh SOLR 300mg	1	B/D
pentamidine isethionate inj SOLR 300mg	1	
praziquantel TABS 600mg	1	
SIVEXTRO SOLR 200mg; TABS 200mg	1	
streptomycin sulfate SOLR 1gm	1	
sulfadiazine TABS 500mg	1	
sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml	1	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
SYNERCID INJ 500MG	1	
tobramycin NEBU 300mg/5ml	1	NM, PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	1	
trimethoprim TABS 100mg	1	
vancomycin hcl CAPS 125mg	1	QL (80 caps / 180 days)
vancomycin hcl CAPS 250mg	1	QL (160 caps / 180 days)
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	1	
VANCOMYCIN INJ 1 GM	1	

Drug Name	Drug Tier	Requirements/Limits
VANCOMYCIN INJ 500MG	1	
VANCOMYCIN INJ 750MG	1	
ANTIFUNGALS		
ABELCET SUSP 5mg/ml	1	B/D
amphotericin b SOLR 50mg	1	B/D
amphotericin b liposome SUSR 50mg	1	B/D
caspofungin acetate SOLR 50mg, 70mg	1	
fluconazole SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 150mg, 200mg	1	
fluconazole in nacl 0.9% inj 200 mg/100ml	1	
fluconazole in nacl 0.9% inj 400 mg/200ml	1	
flucytosine CAPS 250mg, 500mg	1	PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	1	
griseofulvin ultramicrosize TABS 125mg, 250mg	1	
itraconazole CAPS 100mg	1	PA
ketoconazole TABS 200mg	1	PA
micafungin sodium SOLR 50mg, 100mg	1	
NOXAFIL SUSP 40mg/ml	1	QL (630 mL / 30 days), PA
nystatin TABS 500000unit	1	
posaconazole SUSP 40mg/ml	1	QL (630 mL / 30 days), PA
posaconazole TBEC 100mg	1	QL (93 tabs / 30 days), PA
terbinafine hcl TABS 250mg	1	QL (90 tabs / year)
voriconazole SOLR 200mg; SUSR 40mg/ml	1	PA
voriconazole TABS 50mg	1	QL (480 tabs / 30 days), PA
voriconazole TABS 200mg	1	QL (120 tabs / 30 days), PA
ANTIMALARIALS		
atovaquone-proguanil hcl tab 62.5-25 mg	1	
atovaquone-proguanil hcl tab 250-100 mg	1	
chloroquine phosphate TABS 250mg, 500mg	1	
COARTEM TAB 20-120MG	1	
mefloquine hcl TABS 250mg	1	
primaquine phosphate TABS 26.3mg	1	
PRIMAQUINE PHOSPHATE TABS 26.3mg	1	
quinine sulfate CAPS 324mg	1	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate SOLN 20mg/ml; TABS 300mg	1	
APTIVUS CAPS 250mg	1	

Drug Name	Drug Tier	Requirements/Limits
atazanavir sulfate CAPS 150mg, 200mg, 300mg	1	
darunavir TABS 600mg	1	QL (60 tabs / 30 days)
darunavir TABS 800mg	1	QL (30 tabs / 30 days)
EDURANT TABS 25mg	1	
efavirenz CAPS 50mg, 200mg; TABS 600mg	1	
emtricitabine CAPS 200mg	1	
EMTRIVA SOLN 10mg/ml	1	
etravirine TABS 100mg, 200mg	1	
fosamprenavir calcium TABS 700mg	1	
FUZEON SOLR 90mg	1	
INTELENCE TABS 25mg	1	
ISENTRESS CHEW 25mg, 100mg; PACK 100mg; TABS 400mg	1	
ISENTRESS HD TABS 600mg	1	
lamivudine SOLN 10mg/ml; TABS 150mg, 300mg	1	
LEXIVA SUSP 50mg/ml	1	
maraviroc TABS 150mg, 300mg	1	
nevirapine SUSP 50mg/5ml; TABS 200mg; TB24 100mg, 400mg	1	
NORVIR PACK 100mg	1	
PIFELTRO TABS 100mg	1	
PREZISTA SUSP 100mg/ml	1	QL (400 mL / 30 days)
PREZISTA TABS 75mg	1	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	1	QL (240 tabs / 30 days)
PREZISTA TABS 600mg	1	QL (60 tabs / 30 days)
PREZISTA TABS 800mg	1	QL (30 tabs / 30 days)
REYATAZ PACK 50mg	1	
ritonavir TABS 100mg	1	
RUKOBIA TB12 600mg	1	
SELZENTRY SOLN 20mg/ml; TABS 25mg, 75mg	1	
stavudine CAPS 15mg, 20mg, 30mg, 40mg	1	
SUNLENCA TBPK 300mg	1	LA
tenofovir disoproxil fumarate TABS 300mg	1	
TIVICAY TABS 10mg, 25mg, 50mg	1	
TIVICAY PD TBSO 5mg	1	
TROGARZO SOLN 200mg/1.33ml	1	LA
TYBOST TABS 150mg	1	
VIRACEPT TABS 250mg, 625mg	1	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	1	
zidovudine CAPS 100mg; SYRP 50mg/5ml; TABS 300mg	1	

Drug Name	Drug Tier	Requirements/Limits
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine tab 600-300 mg	1	
BIKTARVY TAB 30-120-15 MG	1	
BIKTARVY TAB 50-200-25 MG	1	
CIMDUO TAB 300-300	1	
COMPLERA TAB	1	
DELSTRIGO TAB	1	
DESCOVY TAB 120-15MG	1	QL (30 tabs / 30 days)
DESCOVY TAB 200/25MG	1	QL (30 tabs / 30 days)
DOVATO TAB 50-300MG	1	
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	1	
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	1	
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	1	
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	1	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	1	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	1	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	1	QL (30 tabs / 30 days)
EVOTAZ TAB 300-150	1	
GENVOYA TAB	1	
JULUCA TAB 50-25MG	1	
lamivudine-zidovudine tab 150-300 mg	1	
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	1	
lopinavir-ritonavir tab 100-25 mg	1	
lopinavir-ritonavir tab 200-50 mg	1	
ODEFSEY TAB	1	
PREZCOBIX TAB 800-150	1	
STRIBILD TAB	1	
SYMTUZA TAB	1	
TRIUMEQ PD TAB	1	
TRIUMEQ TAB	1	
TRIZIVIR TAB	1	
ANTITUBERCULAR AGENTS		
cycloserine CAPS 250mg	1	
ethambutol hcl TABS 100mg, 400mg	1	
isoniazid SYRP 50mg/5ml; TABS 100mg, 300mg	1	
PRIFTIN TABS 150mg	1	
pyrazinamide TABS 500mg	1	

Drug Name	Drug Tier	Requirements/Limits
rifabutin CAPS 150mg	1	
rifampin CAPS 150mg, 300mg; SOLR 600mg	1	
SIRTURO TABS 20mg, 100mg	1	NM, LA, PA
TRECATOR TABS 250mg	1	
ANTIVIRALS		
acyclovir CAPS 200mg; SUSP 200mg/5ml; TABS 400mg, 800mg	1	
acyclovir sodium SOLN 50mg/ml	1	B/D
adefovir dipivoxil TABS 10mg	1	
BARACLUDE SOLN .05mg/ml	1	
entecavir TABS .5mg, 1mg	1	
EPCLUSA PAK 150-37.5	1	NM, PA
EPCLUSA PAK 200-50MG	1	NM, PA
EPCLUSA TAB 200-50MG	1	NM, PA
EPCLUSA TAB 400-100	1	NM, PA
EPIVIR HBV SOLN 5mg/ml	1	
famciclovir TABS 125mg, 250mg, 500mg	1	
ganciclovir sodium SOLR 500mg	1	B/D
HARVONI PAK 33.75-150MG	1	NM, PA
HARVONI PAK 45-200MG	1	NM, PA
HARVONI TAB 45-200MG	1	NM, PA
HARVONI TAB 90-400MG	1	NM, PA
lamivudine (hbv) TABS 100mg	1	
MAVYRET PAK 50-20MG	1	NM, PA
MAVYRET TAB 100-40MG	1	NM, PA
oseltamivir phosphate CAPS 30mg	1	QL (168 caps / year)
oseltamivir phosphate CAPS 45mg, 75mg	1	QL (84 caps / year)
oseltamivir phosphate SUSR 6mg/ml	1	QL (1080 mL / year)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	1	NM, PA
PREVYMIS TABS 240mg, 480mg	1	QL (28 tabs / 28 days), PA
RELENZA DISKHALER AEPB 5mg/blister	1	QL (6 inhalers / year)
ribavirin (hepatitis c) CAPS 200mg; TABS 200mg	1	NM
rimantadine hydrochloride TABS 100mg	1	
valacyclovir hcl TABS 1gm, 500mg	1	
valganciclovir hcl SOLR 50mg/ml; TABS 450mg	1	
VEMLIDY TABS 25mg	1	
VOSEVI TAB	1	NM, PA
XOFLUZA TBPK 40mg, 80mg	1	QL (1 tab / 180 days)
CEPHALOSPORINS		
cefaclor CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml, 375mg/5ml	1	

Drug Name	Drug Tier	Requirements/Limits
CEFACLOR ER TB12 500mg	1	
cefadroxil CAPS 500mg; SUSR 250mg/5ml, 500mg/5ml	1	
CEFAZOLIN SOLR 2gm, 3gm	1	
CEFAZOLIN INJ 1GM/50ML	1	
cefazolin sodium SOLR 1gm, 2gm, 10gm, 500mg	1	
CEFAZOLIN SOLN 2GM/100ML-4%	1	
cefdinir CAPS 300mg; SUSR 125mg/5ml, 250mg/5ml	1	
cefepime hcl SOLR 1gm, 2gm	1	
cefixime CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	1	
cefoxitin sodium SOLR 1gm, 2gm, 10gm	1	
cefpodoxime proxetil SUSR 50mg/5ml, 100mg/5ml; TABS 100mg, 200mg	1	
cefprozil SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
ceftazidime SOLR 1gm, 2gm, 6gm	1	
CEFTAZIDIME/ SOL D5W 1GM	1	
CEFTAZIDIME/ SOL D5W 2GM	1	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
cefuroxime axetil TABS 250mg, 500mg	1	
cefuroxime sodium SOLR 1.5gm, 750mg	1	
cephalexin CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml	1	
tazicef SOLR 1gm, 2gm, 6gm	1	
TEFLARO SOLR 400mg, 600mg	1	
ERYTHROMYCINS/MACROLIDES		
azithromycin PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml; TABS 250mg, 500mg, 600mg	1	
clarithromycin SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg; TB24 500mg	1	
DIFICID SUSR 40mg/ml; TABS 200mg	1	
e.e.s. 400 TABS 400mg	1	
ery-tab TBEC 250mg, 333mg, 500mg	1	
ERYTHROCIN LACTOBIONATE SOLR 500mg	1	
erythrocin stearate TABS 250mg	1	
erythromycin base CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	1	
erythromycin ethylsuccinate TABS 400mg	1	
erythromycin lactobionate SOLR 500mg	1	

Drug Name	Drug Tier	Requirements/Limits
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	1	
ciprofloxacin 200 mg/100ml in d5w	1	
ciprofloxacin 400 mg/200ml in d5w	1	
ciprofloxacin hcl TABS 100mg, 250mg, 500mg, 750mg	1	
levofloxacin SOLN 25mg/ml; TABS 250mg, 500mg, 750mg	1	
levofloxacin in d5w iv soln 250 mg/50ml	1	
levofloxacin in d5w iv soln 500 mg/100ml	1	
levofloxacin in d5w iv soln 750 mg/150ml	1	
moxifloxacin hcl TABS 400mg	1	
PENICILLINS		
amoxicillin CAPS 250mg, 500mg; CHEW 125mg, 250mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	
amoxicillin & k clavulanate chew tab 200-28.5 mg	1	
amoxicillin & k clavulanate chew tab 400-57 mg	1	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	1	
amoxicillin & k clavulanate tab 250-125 mg	1	
amoxicillin & k clavulanate tab 500-125 mg	1	
amoxicillin & k clavulanate tab 875-125 mg	1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	1	
ampicillin CAPS 500mg	1	
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm	1	
ampicillin & sulbactam sodium for inj 3 (2-1) gm	1	
ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm	1	
ampicillin & sulbactam sodium for iv soln 3 (2-1) gm	1	
ampicillin & sulbactam sodium for iv soln 15 (10-5) gm	1	
ampicillin sodium SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	1	

Drug Name	Drug Tier	Requirements/Limits
BICILLIN L-A SUSY 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml	1	
dicloxacillin sodium CAPS 250mg, 500mg	1	
nafcillin sodium SOLR 1gm, 2gm, 10gm	1	
oxacillin sodium SOLR 1gm, 2gm, 10gm	1	
PEN GK/DEXTR INJ 40000/ML	1	
PEN GK/DEXTR INJ 60000/ML	1	
penicillin g potassium SOLR 5000000unit, 20000000unit	1	
PENICILLIN G PROCAINE SUSP 600000unit/ml	1	
penicillin g sodium SOLR 5000000unit	1	
penicillin v potassium SOLR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
pfizerpen SOLR 5000000unit, 20000000unit	1	
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	1	
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	1	
piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)	1	
piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)	1	
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	1	
TETRACYCLINES		
doxy 100 SOLR 100mg	1	
doxycycline (monohydrate) CAPS 50mg, 100mg; TABS 50mg, 75mg, 100mg	1	
doxycycline hyclate CAPS 50mg, 100mg; SOLR 100mg; TABS 20mg, 100mg	1	
minocycline hcl CAPS 50mg, 75mg, 100mg	1	
NUZYRA SOLR 100mg; TABS 150mg	1	NM, LA
tetracycline hcl CAPS 250mg, 500mg	1	PA
tigecycline SOLR 50mg	1	
TIGECYCLINE SOLR 50mg	1	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml	1	B/D, NM, LA
carboplatin SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	1	B/D
cisplatin SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	1	B/D
cyclophosphamide CAPS 25mg, 50mg; SOLR 1gm, 2gm, 500mg	1	B/D

Drug Name	Drug Tier	Requirements/Limits
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml; TABS 25mg, 50mg	1	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	1	B/D
GLEOSTINE CAPS 10mg, 40mg, 100mg	1	NM
LEUKERAN TABS 2mg	1	
oxaliplatin SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg, 100mg	1	B/D
paraplatin SOLN 1000mg/100ml	1	B/D
ANTIBIOTICS		
doxorubicin hcl SOLN 2mg/ml	1	B/D
doxorubicin hcl liposomal INJ 2mg/ml	1	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	1	B/D
ANTIMETABOLITES		
azacitidine SUSR 100mg	1	B/D, NM
cytarabine SOLN 20mg/ml	1	B/D
fluorouracil SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	1	B/D
gemcitabine hcl SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	1	B/D
INQOVI TAB 35-100MG	1	NM, LA, PA
LONSURF TAB 15-6.14	1	NM, LA, PA
LONSURF TAB 20-8.19	1	NM, LA, PA
mercaptopurine TABS 50mg	1	
methotrexate sodium SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	1	B/D
ONUREG TABS 200mg, 300mg	1	NM, LA, PA
pemetrexed disodium SOLR 100mg, 500mg, 750mg, 1000mg	1	B/D
PURIXAN SUSP 2000mg/100ml	1	NM
TABLOID TABS 40mg	1	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate TABS 250mg, 500mg	1	NM, PA
anastrozole TABS 1mg	1	
bicalutamide TABS 50mg	1	
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	1	NM, PA
EMCYT CAPS 140mg	1	
ERLEADA TABS 60mg, 240mg	1	NM, LA, PA
EULEXIN CAPS 125mg	1	
exemestane TABS 25mg	1	
fulvestrant SOSY 250mg/5ml	1	B/D
letrozole TABS 2.5mg	1	
leuprolide acetate KIT 1mg/0.2ml	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT (1-MONTH) KIT 3.75mg	1	NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	1	NM, PA
LYSODREN TABS 500mg	1	NM
megestrol acetate TABS 20mg, 40mg	1	
nilutamide TABS 150mg	1	
NUBEQA TABS 300mg	1	NM, LA, PA
ORGOVYX TABS 120mg	1	NM, LA, PA
ORSERDU TABS 86mg, 345mg	1	NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	1	
tamoxifen citrate TABS 10mg, 20mg	1	
toremifene citrate TABS 60mg	1	
XTANDI CAPS 40mg; TABS 40mg, 80mg	1	NM, LA, PA
IMMUNOMODULATORS		
lenalidomide CAPS 2.5mg, 5mg, 10mg, 15mg	1	QL (28 caps / 28 days), NM, LA, PA
lenalidomide CAPS 20mg, 25mg	1	QL (21 caps / 28 days), NM, LA, PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg	1	QL (21 caps / 28 days), NM, LA, PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	1	QL (28 caps / 28 days), NM, LA, PA
REVLIMID CAPS 20mg, 25mg	1	QL (21 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg, 100mg	1	QL (28 caps / 28 days), NM, LA, PA
THALOMID CAPS 150mg, 200mg	1	QL (56 caps / 28 days), NM, LA, PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml	1	NM, LA, PA
bexarotene CAPS 75mg	1	NM, PA
hydroxyurea CAPS 500mg	1	
irinotecan hcl SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	1	B/D
KISQALI 200 PAK FEMARA	1	QL (49 tabs / 28 days), NM, PA
KISQALI 400 PAK FEMARA	1	QL (70 tabs / 28 days), NM, PA
KISQALI 600 PAK FEMARA	1	QL (91 tabs / 28 days), NM, PA
MATULANE CAPS 50mg	1	NM, LA
SYNRIBO SOLR 3.5mg	1	NM, PA
tretinoin (chemotherapy) CAPS 10mg	1	
WELIREG TABS 40mg	1	NM, LA, PA
MITOTIC INHIBITORS		
docetaxel CONC 20mg/ml, 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D

Drug Name	Drug Tier	Requirements/Limits
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
etoposide SOLN 100mg/5ml, 500mg/25ml	1	B/D
paclitaxel CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	1	B/D
paclitaxel protein-bound particles for iv susp 100 mg	1	B/D, NM
toposar SOLN 1gm/50ml, 100mg/5ml	1	B/D
vincristine sulfate SOLN 1mg/ml	1	B/D
vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml	1	B/D
MOLECULAR TARGET AGENTS		
ALECENSA CAPS 150mg	1	NM, LA, PA
ALUNBRIG TABS 30mg, 90mg, 180mg	1	NM, LA, PA
ALUNBRIG PAK	1	NM, LA, PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg	1	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA TABS 3mg, 4mg, 5mg	1	NM, LA, PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	1	NM, PA
bortezomib SOLR 3.5mg	1	NM, PA
BOSULIF TABS 100mg, 400mg, 500mg	1	NM, PA
BRAFTOVI CAPS 75mg	1	NM, LA, PA
BRUKINSA CAPS 80mg	1	NM, LA, PA
CABOMETYX TABS 20mg, 40mg, 60mg	1	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE CAPS 100mg	1	QL (60 caps / 30 days), NM, LA, PA
CALQUENCE TABS 100mg	1	QL (60 tabs / 30 days), NM, LA, PA
CAPRELSA TABS 100mg, 300mg	1	NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	1	NM, LA, PA
COMETRIQ KIT 100MG	1	NM, LA, PA
COMETRIQ KIT 140MG	1	NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	1	NM, LA, PA
COTELLIC TABS 20mg	1	NM, LA, PA
DAURISMO TABS 25mg, 100mg	1	NM, LA, PA
ERIVEDGE CAPS 150mg	1	NM, LA, PA
erlotinib hcl TABS 25mg	1	QL (90 tabs / 30 days), NM, PA
erlotinib hcl TABS 100mg, 150mg	1	QL (30 tabs / 30 days), NM, PA
everolimus TABS 2.5mg, 5mg, 7.5mg, 10mg	1	QL (30 tabs / 30 days), NM, PA
everolimus TBSO 2mg	1	QL (150 tabs / 30 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
everolimus TBSO 3mg	1	QL (90 tabs / 30 days), NM, PA
everolimus TBSO 5mg	1	QL (60 tabs / 30 days), NM, PA
EXKIVITY CAPS 40mg	1	NM, LA, PA
FOTIVDA CAPS .89mg, 1.34mg	1	QL (21 caps / 28 days), NM, LA, PA
GAVRETO CAPS 100mg	1	NM, LA, PA
gefitinib TABS 250mg	1	NM, PA
GILOTRIF TABS 20mg, 30mg, 40mg	1	NM, LA, PA
HERCEP HYLEC SOL 60-10000	1	NM, LA, PA
HERCEPTIN SOLR 150mg	1	NM, LA, PA
HERZUMA SOLR 150mg, 420mg	1	NM, LA, PA
IBRANCE CAPS 75mg, 100mg, 125mg	1	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS 75mg, 100mg, 125mg	1	QL (21 tabs / 28 days), NM, LA, PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg	1	QL (30 tabs / 30 days), NM, LA, PA
IDHIFA TABS 50mg, 100mg	1	QL (30 tabs / 30 days), NM, LA, PA
imatinib mesylate TABS 100mg	1	QL (90 tabs / 30 days), NM, PA
imatinib mesylate TABS 400mg	1	QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAPS 70mg	1	QL (30 caps / 30 days), NM, LA, PA
IMBRUVICA CAPS 140mg	1	QL (120 caps / 30 days), NM, LA, PA
IMBRUVICA SUSP 70mg/ml	1	QL (216 mL / 27 days), NM, LA, PA
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg	1	QL (30 tabs / 30 days), NM, LA, PA
INLYTA TABS 1mg	1	QL (180 tabs / 30 days), NM, LA, PA
INLYTA TABS 5mg	1	QL (120 tabs / 30 days), NM, LA, PA
INREBIC CAPS 100mg	1	NM, LA, PA
IRESSA TABS 250mg	1	NM, LA, PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg	1	QL (60 tabs / 30 days), NM, LA, PA
JAYPIRCA TABS 50mg	1	QL (30 tabs / 30 days), NM, LA, PA
JAYPIRCA TABS 100mg	1	QL (60 tabs / 30 days), NM, LA, PA
KADCYLA SOLR 100mg, 160mg	1	B/D, NM, LA
KANJINTI SOLR 150mg, 420mg	1	NM, LA, PA
KEYTRUDA SOLN 100mg/4ml	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
KISQALI 200 DOSE TBPK 200mg	1	QL (21 tabs / 28 days), NM, PA
KISQALI 400 DOSE TBPK 200mg	1	QL (42 tabs / 28 days), NM, PA
KISQALI 600 DOSE TBPK 200mg	1	QL (63 tabs / 28 days), NM, PA
KRAZATI TABS 200mg	1	NM, LA, PA
lapatinib ditosylate TABS 250mg	1	NM, PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg	1	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg	1	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 12MG DAILY DOSE CPPK 4mg	1	QL (90 caps / 30 days), NM, LA, PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 14 MG	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 18 MG	1	QL (90 caps / 30 days), NM, LA, PA
LENVIMA CAP 24 MG	1	QL (90 caps / 30 days), NM, LA, PA
LORBRENA TABS 25mg, 100mg	1	NM, LA, PA
LUMAKRAS TABS 120mg, 320mg	1	NM, LA, PA
LYNPARZA TABS 100mg, 150mg	1	QL (120 tabs / 30 days), NM, LA, PA
LYTGOBI TBPK 4mg	1	NM, LA, PA
MEKINIST SOLR .05mg/ml; TABS .5mg, 2mg	1	NM, LA, PA
MEKTOVI TABS 15mg	1	NM, LA, PA
MONJUVI SOLR 200mg	1	NM, LA, PA
MVASI SOLN 100mg/4ml, 400mg/16ml	1	NM, LA, PA
NERLYNX TABS 40mg	1	NM, LA, PA
NEXAVAR TABS 200mg	1	QL (120 tabs / 30 days), NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	1	QL (3 caps / 28 days), NM, PA
ODOMZO CAPS 200mg	1	NM, LA, PA
OGIVRI SOLR 150mg	1	NM, LA, PA
OGIVRI INJ 420MG	1	NM, LA, PA
ONTRUZANT SOLR 150mg, 420mg	1	NM, LA, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	1	NM, LA, PA
PHESGO SOL	1	NM, LA, PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	1	NM, PA
PIQRAY 250MG TAB DOSE	1	NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
QINLOCK TABS 50mg	1	NM, LA, PA
RETEVMO CAPS 40mg, 80mg	1	NM, LA, PA
REZLIDHIA CAPS 150mg	1	NM, LA, PA
ROZLYTREK CAPS 100mg, 200mg	1	NM, LA, PA
RUBRACA TABS 200mg, 250mg, 300mg	1	QL (120 tabs / 30 days), NM, LA, PA
RYDAPT CAPS 25mg	1	NM, PA
SCEMBLIX TABS 20mg	1	QL (60 tabs / 30 days), NM, PA
SCEMBLIX TABS 40mg	1	QL (300 tabs / 30 days), NM, PA
sorafenib tosylate TABS 200mg	1	QL (120 tabs / 30 days), NM, PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	1	NM, PA
STIVARGA TABS 40mg	1	NM, LA, PA
sunitinib malate CAPS 12.5mg, 25mg, 37.5mg, 50mg	1	QL (30 caps / 30 days), NM, PA
TABRECTA TABS 150mg, 200mg	1	NM, PA
TAFINLAR CAPS 50mg, 75mg; TBSO 10mg	1	NM, LA, PA
TAGRISSO TABS 40mg, 80mg	1	QL (30 tabs / 30 days), NM, LA, PA
TALZENNA CAPS .5mg, .75mg, 1mg	1	QL (30 caps / 30 days), NM, LA, PA
TALZENNA CAPS .25mg	1	QL (90 caps / 30 days), NM, LA, PA
TASIGNA CAPS 50mg, 150mg, 200mg	1	NM, PA
TAZVERIK TABS 200mg	1	NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	1	NM, LA, PA
TEPMETKO TABS 225mg	1	NM, LA, PA
TIBSOVO TABS 250mg	1	NM, LA, PA
TRAZIMERA SOLR 150mg, 420mg	1	NM, PA
TRUSELTIQ 50MG DAILY DOSE CPPK 25mg	1	LA, PA
TRUSELTIQ 75MG DAILY DOSE CPPK 25mg	1	LA, PA
TRUSELTIQ 100MG DAILY DOSE CPPK 100mg	1	LA, PA
TRUSELTIQ 125MG DAILY DOSE	1	LA, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	1	NM, PA
TUKYSA TABS 50mg, 150mg	1	NM, LA, PA
TURALIO CAPS 125mg, 200mg	1	NM, LA, PA
VENCLEXTA TABS 10mg, 50mg	1	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	1	QL (180 tabs / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA TAB START PK	1	QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	1	QL (56 tabs / 28 days), NM, LA, PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	1	NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	1	NM, LA, PA
VONJO CAPS 100mg	1	QL (120 caps / 30 days), NM, LA, PA
VOTRIENT TABS 200mg	1	NM, LA, PA
XALKORI CAPS 200mg, 250mg	1	NM, LA, PA
XOSPATA TABS 40mg	1	NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg	1	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg	1	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg	1	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	1	QL (24 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg	1	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	1	QL (32 tabs / 28 days), NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg	1	QL (8 tabs / 28 days), NM, LA, PA
ZEJULA CAPS 100mg	1	QL (90 caps / 30 days), NM, LA, PA
ZELBORAF TABS 240mg	1	NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	1	NM, LA, PA
ZOLINZA CAPS 100mg	1	NM, PA
ZYDELIG TABS 100mg, 150mg	1	NM, LA, PA
ZYKADIA TABS 150mg	1	NM, LA, PA
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	1	B/D
leucovorin calcium TABS 5mg, 10mg, 15mg, 25mg	1	
MESNEX TABS 400mg	1	
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 5-10 mg	1	QL (30 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
amlodipine besylate-benazepril hcl cap 5-20 mg	1	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 5-40 mg	1	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 10-20 mg	1	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 10-40 mg	1	QL (30 caps / 30 days)
benazepril & hydrochlorothiazide tab 5-6.25mg	1	
benazepril & hydrochlorothiazide tab 10-12.5 mg	1	
benazepril & hydrochlorothiazide tab 20-12.5 mg	1	
benazepril & hydrochlorothiazide tab 20-25 mg	1	
captopril & hydrochlorothiazide tab 25-15 mg	1	
captopril & hydrochlorothiazide tab 25-25 mg	1	
captopril & hydrochlorothiazide tab 50-15 mg	1	
captopril & hydrochlorothiazide tab 50-25 mg	1	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	1	
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	
lisinopril & hydrochlorothiazide tab 20-25 mg	1	
quinapril-hydrochlorothiazide tab 10-12.5 mg	1	
quinapril-hydrochlorothiazide tab 20-12.5 mg	1	
quinapril-hydrochlorothiazide tab 20-25 mg	1	
ACE INHIBITORS		
benazepril hcl TABS 5mg, 10mg, 20mg, 40mg	1	
captopril TABS 12.5mg, 25mg, 50mg, 100mg	1	

Drug Name	Drug Tier	Requirements/Limits
enalapril maleate TABS 2.5mg, 5mg, 10mg, 20mg	1	
fosinopril sodium TABS 10mg, 20mg, 40mg	1	
lisinopril TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	
moexipril hcl TABS 7.5mg, 15mg	1	
perindopril erbumine TABS 2mg, 4mg, 8mg	1	
quinapril hcl TABS 5mg, 10mg, 20mg, 40mg	1	
ramipril CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	
trandolapril TABS 1mg, 2mg, 4mg	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone TABS 25mg, 50mg	1	
KERENDIA TABS 10mg, 20mg	1	QL (30 tabs / 30 days)
spironolactone TABS 25mg, 50mg, 100mg	1	
ALPHA BLOCKERS		
doxazosin mesylate TABS 1mg, 2mg, 4mg, 8mg	1	
prazosin hcl CAPS 1mg, 2mg, 5mg	1	
terazosin hcl CAPS 1mg, 2mg, 5mg, 10mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 5-160 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 5-320 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 10-160 mg	1	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 10-320 mg	1	QL (30 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	1	QL (60 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	1	QL (30 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	1	QL (30 tabs / 30 days)
ENTRESTO TAB 24-26MG	1	
ENTRESTO TAB 49-51MG	1	

Drug Name	Drug Tier	Requirements/Limits
ENTRESTO TAB 97-103MG	1	
irbesartan-hydrochlorothiazide tab 150-12.5 mg	1	QL (60 tabs / 30 days)
irbesartan-hydrochlorothiazide tab 300-12.5 mg	1	QL (30 tabs / 30 days)
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	1	QL (30 tabs / 30 days)
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	1	QL (30 tabs / 30 days)
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	1	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	1	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	1	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	1	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	1	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	1	QL (30 tabs / 30 days)
telmisartan-amlodipine tab 40-5 mg	1	QL (30 tabs / 30 days)
telmisartan-amlodipine tab 40-10 mg	1	QL (30 tabs / 30 days)
telmisartan-amlodipine tab 80-5 mg	1	QL (30 tabs / 30 days)
telmisartan-amlodipine tab 80-10 mg	1	QL (30 tabs / 30 days)
telmisartan-hydrochlorothiazide tab 40-12.5 mg	1	QL (30 tabs / 30 days)
telmisartan-hydrochlorothiazide tab 80-12.5 mg	1	QL (60 tabs / 30 days)
telmisartan-hydrochlorothiazide tab 80-25 mg	1	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 80-12.5 mg	1	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 160-12.5 mg	1	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 160-25 mg	1	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 320-12.5 mg	1	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 320-25 mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil TABS 4mg, 8mg, 16mg	1	QL (60 tabs / 30 days)
candesartan cilexetil TABS 32mg	1	QL (30 tabs / 30 days)
irbesartan TABS 75mg, 150mg, 300mg	1	QL (30 tabs / 30 days)
losartan potassium TABS 25mg, 50mg, 100mg	1	
olmesartan medoxomil TABS 5mg	1	QL (60 tabs / 30 days)
olmesartan medoxomil TABS 20mg, 40mg	1	QL (30 tabs / 30 days)
telmisartan TABS 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
valsartan TABS 40mg, 80mg, 160mg	1	QL (60 tabs / 30 days)
valsartan TABS 320mg	1	QL (30 tabs / 30 days)
ANTIARRHYTHMICS		
amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 200mg, 400mg	1	
disopyramide phosphate CAPS 100mg, 150mg	1	
dofetilide CAPS 125mcg, 250mcg, 500mcg	1	
flecainide acetate TABS 50mg, 100mg, 150mg	1	
MULTAQ TABS 400mg	1	
NORPACE CR CP12 100mg, 150mg	1	
pacerone TABS 100mg, 200mg, 400mg	1	
propafenone hcl CP12 225mg, 325mg, 425mg; TABS 150mg, 225mg, 300mg	1	
quinidine sulfate TABS 200mg, 300mg	1	
sorine TABS 80mg, 120mg, 160mg, 240mg	1	
sotalol hcl TABS 80mg, 120mg, 160mg, 240mg	1	
sotalol hcl (afib/afl) TABS 80mg, 120mg, 160mg	1	
ANTILIPEMICS, FIBRATES		
fenofibrate TABS 48mg, 54mg, 145mg, 160mg	1	
fenofibrate micronized CAPS 67mg, 134mg, 200mg	1	
gemfibrozil TABS 600mg	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
atorvastatin calcium TABS 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
lovastatin TABS 10mg, 20mg, 40mg	1	QL (60 tabs / 30 days)
pravastatin sodium TABS 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
rosuvastatin calcium TABS 5mg, 10mg, 20mg, 40mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
simvastatin TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
cholestyramine PACK 4gm; POWD 4gm/dose	1	
cholestyramine light PACK 4gm; POWD 4gm/dose	1	
colesevelam hcl PACK 3.75gm; TABS 625mg	1	
colestipol hcl GRAN 5gm; PACK 5gm; TABS 1gm	1	
ezetimibe TABS 10mg	1	
ezetimibe-simvastatin tab 10-10 mg	1	QL (30 tabs / 30 days)
ezetimibe-simvastatin tab 10-20 mg	1	QL (30 tabs / 30 days)
ezetimibe-simvastatin tab 10-40 mg	1	QL (30 tabs / 30 days)
ezetimibe-simvastatin tab 10-80 mg	1	QL (30 tabs / 30 days)
niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg	1	QL (60 tabs / 30 days)
PRALUENT SOAJ 75mg/ml, 150mg/ml	1	NM, PA
prevalite PACK 4gm; POWD 4gm/dose	1	
VASCEPA CAPS .5gm, 1gm	1	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone tab 50-25 mg	1	
atenolol & chlorthalidone tab 100-25 mg	1	
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	
metoprolol & hydrochlorothiazide tab 50-25 mg	1	
metoprolol & hydrochlorothiazide tab 100-25 mg	1	
metoprolol & hydrochlorothiazide tab 100-50 mg	1	
BETA-BLOCKERS		
acebutolol hcl CAPS 200mg, 400mg	1	
atenolol TABS 25mg, 50mg, 100mg	1	
betaxolol hcl TABS 10mg, 20mg	1	
bisoprolol fumarate TABS 5mg, 10mg	1	
carvedilol TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	
labetalol hcl TABS 100mg, 200mg, 300mg	1	
metoprolol succinate TB24 25mg, 50mg, 100mg, 200mg	1	

Drug Name	Drug Tier	Requirements/Limits
metoprolol tartrate SOLN 5mg/5ml; TABS 25mg, 50mg, 100mg	1	
nadolol TABS 20mg, 40mg, 80mg	1	
nebivolol hcl TABS 2.5mg, 5mg, 10mg	1	QL (30 tabs / 30 days)
nebivolol hcl TABS 20mg	1	QL (60 tabs / 30 days)
pindolol TABS 5mg, 10mg	1	
propranolol hcl CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml; TABS 10mg, 20mg, 40mg, 60mg, 80mg	1	
timolol maleate TABS 5mg, 10mg, 20mg	1	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate TABS 2.5mg, 5mg, 10mg	1	
cartia xt CP24 120mg, 180mg, 240mg, 300mg	1	
dilt-xr CP24 120mg, 180mg, 240mg	1	
diltiazem hcl CP12 60mg, 90mg, 120mg; SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml; TABS 30mg, 60mg, 90mg, 120mg	1	
diltiazem hcl coated beads CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
diltiazem hcl extended release beads CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
felodipine TB24 2.5mg, 5mg, 10mg	1	
isradipine CAPS 2.5mg, 5mg	1	
nicardipine hcl CAPS 20mg, 30mg	1	
nifedipine TB24 30mg, 60mg, 90mg	1	
nimodipine CAPS 30mg	1	
NYMALIZE SOLN 6mg/ml	1	
taztia xt CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
tiadylt er CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
verapamil hcl CP24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; SOLN 2.5mg/ml; TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	1	
DIURETICS		
acetazolamide CP12 500mg; TABS 125mg, 250mg	1	
amiloride & hydrochlorothiazide tab 5-50 mg	1	
amiloride hcl TABS 5mg	1	
bumetanide SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	1	

Drug Name	Drug Tier	Requirements/Limits
chlorthalidone TABS 25mg, 50mg	1	
furosemide SOLN 10mg/ml, 40mg/5ml; TABS 20mg, 40mg, 80mg	1	
furosemide inj SOLN 10mg/ml	1	
hydrochlorothiazide CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	
indapamide TABS 1.25mg, 2.5mg	1	
methazolamide TABS 25mg, 50mg	1	
metolazone TABS 2.5mg, 5mg, 10mg	1	
spironolactone & hydrochlorothiazide tab 25-25 mg	1	
torsemide TABS 5mg, 10mg, 20mg, 100mg	1	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 75-50 mg	1	
MISCELLANEOUS		
ADRENALIN SOLN 1mg/ml	1	
aliskiren fumarate TABS 150mg, 300mg	1	
clonidine PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	1	
clonidine hcl TABS .1mg, .2mg, .3mg	1	
CORLANOR SOLN 5mg/5ml; TABS 5mg, 7.5mg	1	
digoxin SOLN .05mg/ml, .25mg/ml	1	
digoxin TABS 125mcg, 250mcg	1	QL (30 tabs / 30 days)
droxidopa CAPS 100mg	1	QL (90 caps / 30 days), NM, PA
droxidopa CAPS 200mg, 300mg	1	QL (180 caps / 30 days), NM, PA
epinephrine (anaphylaxis) SOLN 1mg/ml	1	
guanfacine hcl TABS 1mg, 2mg	1	PA; PA if 70 years and older
hydralazine hcl SOLN 20mg/ml; TABS 10mg, 25mg, 50mg, 100mg	1	
metyrosine CAPS 250mg	1	PA
midodrine hcl TABS 2.5mg, 5mg, 10mg	1	
minoxidil TABS 2.5mg, 10mg	1	
ranolazine TB12 500mg, 1000mg	1	
VERQUVO TABS 2.5mg, 5mg, 10mg	1	
NITRATES		
isosorbide dinitrate TABS 5mg, 10mg, 20mg, 30mg	1	

Drug Name	Drug Tier	Requirements/Limits
isosorbide mononitrate TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	1	
NITRO-BID OINT 2%	1	
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SOLN .4mg/spray; SUBL .3mg, .4mg, .6mg	1	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	1	QL (90 tabs / 30 days), NM, LA, PA
ambrisentan TABS 5mg, 10mg	1	QL (30 tabs / 30 days), NM, LA, PA
bosentan TABS 62.5mg, 125mg	1	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	1	QL (30 tabs / 30 days), NM, LA, PA
sildenafil citrate (pulmonary hypertension) TABS 20mg	1	QL (360 tabs / 30 days), NM, PA
treprostinil SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	1	NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	1	NM, LA, PA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
alprazolam TABS .25mg, .5mg, 1mg, 2mg	1	QL (150 tabs / 30 days)
buspirone hcl TABS 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
fluvoxamine maleate TABS 25mg, 50mg, 100mg	1	
lorazepam CONC 2mg/ml	1	QL (150 mL / 30 days)
lorazepam SOLN 2mg/ml, 4mg/ml	1	
lorazepam TABS .5mg, 1mg, 2mg	1	QL (150 tabs / 30 days)
lorazepam intensol CONC 2mg/ml	1	QL (150 mL / 30 days)
ANTICONVULSANTS		
APTIOM TABS 200mg, 400mg	1	QL (30 tabs / 30 days)
APTIOM TABS 600mg, 800mg	1	QL (60 tabs / 30 days)
BRIVIACT SOLN 10mg/ml	1	QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	1	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	1	QL (60 tabs / 30 days), PA
carbamazepine CHEW 100mg; CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TABS 200mg; TB12 100mg, 200mg, 400mg	1	
CELONTIN CAPS 300mg	1	
clobazam SUSP 2.5mg/ml	1	QL (480 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
clobazam TABS 10mg, 20mg	1	QL (60 tabs / 30 days), PA
clonazepam TABS 2mg; TBDP 2mg	1	QL (300 tabs / 30 days)
clonazepam TABS .5mg, 1mg; TBDP .125mg, .25mg, .5mg, 1mg	1	QL (90 tabs / 30 days)
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg	1	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIACOMIT CAPS 250mg	1	QL (360 caps / 30 days), NM, LA, PA
DIACOMIT CAPS 500mg	1	QL (180 caps / 30 days), NM, LA, PA
DIACOMIT PACK 250mg	1	QL (360 packets / 30 days), NM, LA, PA
DIACOMIT PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
diazepam CONC 5mg/ml	1	QL (240 mL / 30 days), PA; PA if 65 years and older
diazepam SOLN 5mg/5ml	1	QL (1200 mL / 30 days), PA; PA if 65 years and older
diazepam TABS 2mg, 5mg, 10mg	1	QL (120 tabs / 30 days), PA; PA if 65 years and older
diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	1	
diazepam inj SOLN 5mg/ml	1	
DILANTIN CAPS 30mg, 100mg	1	
DILANTIN INFATABS CHEW 50mg	1	
DILANTIN-125 SUSP 125mg/5ml	1	
divalproex sodium CSDR 125mg; TB24 250mg, 500mg; TBEC 125mg, 250mg, 500mg	1	
EPIDIOLEX SOLN 100mg/ml	1	QL (600 mL / 30 days), NM, LA, PA
epitol TABS 200mg	1	
EPRONTIA SOLN 25mg/ml	1	QL (480 mL / 30 days), PA
ethosuximide CAPS 250mg; SOLN 250mg/5ml	1	
felbamate SUSP 600mg/5ml; TABS 400mg, 600mg	1	
FINTEPLA SOLN 2.2mg/ml	1	QL (360 mL / 30 days), NM, LA, PA
FYCOMPA SUSP .5mg/ml	1	QL (720 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TABS 2mg	1	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg	1	QL (30 tabs / 30 days), PA
gabapentin CAPS 100mg, 300mg, 400mg	1	QL (180 caps / 30 days)
gabapentin SOLN 250mg/5ml, 300mg/6ml	1	QL (2160 mL / 30 days)
gabapentin TABS 600mg	1	QL (180 tabs / 30 days)
gabapentin TABS 800mg	1	QL (120 tabs / 30 days)
lacosamide SOLN 200mg/20ml	1	
lacosamide TABS 50mg	1	QL (120 tabs / 30 days)
lacosamide TABS 100mg, 150mg, 200mg	1	QL (60 tabs / 30 days)
lacosamide oral SOLN 10mg/ml	1	QL (1200 mL / 30 days)
lamotrigine CHEW 5mg, 25mg; TABS 25mg, 100mg, 150mg, 200mg; TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	1	
levetiracetam SOLN 100mg/ml, 500mg/5ml; TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	1	
levetiracetam in sodium chloride iv soln 500 mg/100ml	1	
levetiracetam in sodium chloride iv soln 1000 mg/100ml	1	
levetiracetam in sodium chloride iv soln 1500 mg/100ml	1	
methsuximide CAPS 300mg	1	
NAYZILAM SOLN 5mg/0.1ml	1	
oxcarbazepine SUSP 300mg/5ml; TABS 150mg, 300mg, 600mg	1	
phenobarbital ELIX 20mg/5ml; TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	1	PA; PA if 70 years and older
phenobarbital sodium SOLN 65mg/ml, 130mg/ml	1	PA; PA if 70 years and older
PHENYTEK CAPS 200mg, 300mg	1	
phenytoin CHEW 50mg; SUSP 125mg/5ml	1	
phenytoin sodium SOLN 50mg/ml	1	
phenytoin sodium extended CAPS 100mg, 200mg, 300mg	1	
pregabalin CAPS 25mg, 50mg, 75mg, 100mg, 150mg	1	QL (120 caps / 30 days), PA
pregabalin CAPS 200mg	1	QL (90 caps / 30 days), PA
pregabalin CAPS 225mg, 300mg	1	QL (60 caps / 30 days), PA
pregabalin SOLN 20mg/ml	1	QL (900 mL / 30 days), PA
primidone TABS 50mg, 125mg, 250mg	1	

Drug Name	Drug Tier	Requirements/Limits
roweepra TABS 500mg	1	
rufinamide SUSP 40mg/ml	1	QL (2400 mL / 30 days), PA
rufinamide TABS 200mg	1	QL (480 tabs / 30 days), PA
rufinamide TABS 400mg	1	QL (240 tabs / 30 days), PA
SPRITAM TB3D 250mg	1	QL (360 tabs / 30 days)
SPRITAM TB3D 500mg	1	QL (180 tabs / 30 days)
SPRITAM TB3D 750mg	1	QL (120 tabs / 30 days)
SPRITAM TB3D 1000mg	1	QL (90 tabs / 30 days)
subvenite TABS 25mg, 100mg, 150mg, 200mg	1	
SYMPAZAN FILM 5mg, 10mg, 20mg	1	QL (60 films / 30 days), PA
tiagabine hcl TABS 2mg, 4mg, 12mg, 16mg	1	
topiramate CPSP 15mg, 25mg; TABS 25mg, 50mg, 100mg, 200mg	1	
valproate sodium SOLN 100mg/ml, 250mg/5ml	1	
valproic acid CAPS 250mg	1	
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml	1	
VALTOCO 10 MG DOSE LIQD 10mg/0.1ml	1	
VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml	1	
VALTOCO 20 MG DOSE LQPK 10mg/0.1ml	1	
vigabatrin PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
vigabatrin TABS 500mg	1	QL (180 tabs / 30 days), NM, LA, PA
vigadrone PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
VIMPAT SOLN 10mg/ml	1	QL (1200 mL / 30 days)
XCOPRI TABS 50mg, 100mg	1	QL (30 tabs / 30 days)
XCOPRI TABS 150mg, 200mg	1	QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	1	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	1	QL (28 tabs / 28 days)
XCOPRI PAK 100-150	1	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	1	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	1	QL (28 tabs / 28 days)
ZONISADE SUSP 100mg/5ml	1	QL (900 mL / 30 days), PA
zonisamide CAPS 25mg, 50mg, 100mg	1	
ZTALMY SUSP 50mg/ml	1	QL (1100 mL / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg; TBDP 5mg	1	QL (30 tabs / 30 days)
donepezil hydrochloride TABS 10mg; TBDP 10mg	1	
galantamine hydrobromide CP24 8mg, 16mg, 24mg	1	QL (30 caps / 30 days)
galantamine hydrobromide SOLN 4mg/ml	1	
galantamine hydrobromide TABS 4mg, 8mg, 12mg	1	QL (60 tabs / 30 days)
memantine hcl CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml; TABS 5mg, 10mg	1	PA; PA if < 30 yrs
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	1	PA; PA if < 30 yrs
NAMZARIC CAP 7-10MG	1	
NAMZARIC CAP 14-10MG	1	
NAMZARIC CAP 21-10MG	1	
NAMZARIC CAP 28-10MG	1	
NAMZARIC CAP PACK	1	
rivastigmine PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	1	QL (30 patches / 30 days)
rivastigmine tartrate CAPS 1.5mg, 3mg, 4.5mg, 6mg	1	QL (60 caps / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	1	
amoxapine TABS 25mg, 50mg, 100mg, 150mg	1	
AUVELITY TAB 45-105MG	1	QL (60 tabs / 30 days), PA
bupropion hcl TABS 75mg, 100mg; TB12 100mg, 150mg, 200mg; TB24 150mg, 300mg	1	
citalopram hydrobromide SOLN 10mg/5ml; TABS 10mg, 20mg, 40mg	1	
clomipramine hcl CAPS 25mg, 50mg, 75mg	1	PA
desipramine hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	1	
desvenlafaxine succinate TB24 25mg, 50mg, 100mg	1	QL (30 tabs / 30 days), PA
doxepin hcl CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	1	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	1	QL (60 caps / 30 days), PA
duloxetine hcl CPEP 20mg, 30mg, 60mg	1	QL (60 caps / 30 days)
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	1	QL (30 patches / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
escitalopram oxalate SOLN 5mg/5ml; TABS 5mg, 10mg, 20mg	1	
FETZIMA CP24 20mg, 40mg	1	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	1	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	1	PA
fluoxetine hcl CAPS 10mg, 20mg, 40mg; SOLN 20mg/5ml	1	
imipramine hcl TABS 10mg, 25mg, 50mg	1	
MARPLAN TABS 10mg	1	QL (180 tabs / 30 days)
mirtazapine TABS 7.5mg, 15mg, 30mg, 45mg; TBDP 15mg, 30mg, 45mg	1	
nefazodone hcl TABS 50mg, 100mg, 150mg, 200mg, 250mg	1	
nortriptyline hcl CAPS 10mg, 25mg, 50mg, 75mg; SOLN 10mg/5ml	1	
paroxetine hcl SUSP 10mg/5ml	1	QL (900 mL / 30 days), PA
paroxetine hcl TABS 10mg, 20mg, 30mg, 40mg	1	
phenelzine sulfate TABS 15mg	1	
protriptyline hcl TABS 5mg, 10mg	1	
sertraline hcl CONC 20mg/ml; TABS 25mg, 50mg, 100mg	1	
tranylcypromine sulfate TABS 10mg	1	
trazodone hcl TABS 50mg, 100mg, 150mg	1	
trimipramine maleate CAPS 25mg, 50mg	1	QL (120 caps / 30 days)
trimipramine maleate CAPS 100mg	1	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg, 10mg, 20mg	1	QL (30 tabs / 30 days)
venlafaxine hcl CP24 37.5mg, 75mg, 150mg; TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	1	
VIIBRYD KIT STARTER	1	
vilazodone hcl TABS 10mg, 20mg, 40mg	1	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
amantadine hcl CAPS 100mg	1	QL (120 caps / 30 days)
amantadine hcl SOLN 50mg/5ml; TABS 100mg	1	
benztropine mesylate SOLN 1mg/ml	1	
benztropine mesylate TABS .5mg, 1mg, 2mg	1	PA; PA if 70 years and older
bromocriptine mesylate CAPS 5mg; TABS 2.5mg	1	
carb/levo orally disintegrating tab 10-100mg	1	
carb/levo orally disintegrating tab 25-100mg	1	

Drug Name	Drug Tier	Requirements/Limits
carb/levo orally disintegrating tab 25-250mg	1	
carbidopa & levodopa tab 10-100 mg	1	
carbidopa & levodopa tab 25-100 mg	1	
carbidopa & levodopa tab 25-250 mg	1	
carbidopa & levodopa tab er 25-100 mg	1	
carbidopa & levodopa tab er 50-200 mg	1	
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	
entacapone TABS 200mg	1	
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	1	
pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg	1	
rasagiline mesylate TABS .5mg, 1mg	1	QL (30 tabs / 30 days)
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	1	
selegiline hcl CAPS 5mg; TABS 5mg	1	
trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg	1	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA PRSY 300mg, 400mg	1	QL (1 syringe / 28 days)
ABILIFY MAINTENA SRER 300mg, 400mg	1	QL (1 injection / 28 days)
aripiprazole SOLN 1mg/ml	1	QL (900 mL / 30 days)
aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg	1	QL (30 tabs / 30 days)
aripiprazole TBDP 10mg, 15mg	1	QL (60 tabs / 30 days)
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	1	QL (1 syringe / 28 days)
ARISTADA PRSY 1064mg/3.9ml	1	QL (1 syringe / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	1	
asenapine maleate SUBL 2.5mg, 5mg, 10mg	1	QL (60 tabs / 30 days)
CAPLYTA CAPS 10.5mg, 21mg, 42mg	1	QL (30 caps / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
chlorpromazine hcl CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	1	
clozapine TABS 25mg, 50mg	1	
clozapine TABS 100mg	1	QL (270 tabs / 30 days)
clozapine TABS 200mg	1	QL (120 tabs / 30 days)
clozapine TBDP 12.5mg, 25mg	1	PA
clozapine TBDP 100mg	1	QL (270 tabs / 30 days), PA
clozapine TBDP 150mg	1	QL (180 tabs / 30 days), PA
clozapine TBDP 200mg	1	QL (120 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	1	QL (60 tabs / 30 days), PA
FANAPT PAK	1	PA
fluphenazine decanoate SOLN 25mg/ml	1	
fluphenazine hcl CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	1	
haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	1	
haloperidol decanoate SOLN 50mg/ml, 100mg/ml	1	
haloperidol lactate CONC 2mg/ml; SOLN 5mg/ml	1	
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml	1	QL (1 injection / 180 days)
INVEGA SUSTENNA SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	1	QL (1 syringe / 28 days)
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml	1	QL (1 syringe / 90 days)
LATUDA TABS 20mg, 40mg, 60mg, 120mg	1	QL (30 tabs / 30 days)
LATUDA TABS 80mg	1	QL (60 tabs / 30 days)
loxapine succinate CAPS 5mg, 10mg, 25mg, 50mg	1	
lurasidone hcl TABS 20mg, 40mg, 60mg, 120mg	1	QL (30 tabs / 30 days)
lurasidone hcl TABS 80mg	1	QL (60 tabs / 30 days)
molindone hcl TABS 5mg, 10mg, 25mg	1	
NUPLAZID CAPS 34mg	1	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	1	QL (30 tabs / 30 days), NM, LA, PA
olanzapine SOLR 10mg	1	QL (3 vials / 1 day)

Drug Name	Drug Tier	Requirements/Limits
olanzapine TABS 2.5mg, 5mg, 10mg; TBDP 10mg	1	QL (60 tabs / 30 days)
olanzapine TABS 7.5mg, 15mg, 20mg; TBDP 5mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
paliperidone TB24 1.5mg, 3mg, 9mg	1	QL (30 tabs / 30 days)
paliperidone TB24 6mg	1	QL (60 tabs / 30 days)
perphenazine TABS 2mg, 4mg, 8mg, 16mg	1	
PERSERIS PRSY 90mg, 120mg	1	QL (1 syringe / 30 days)
pimozide TABS 1mg, 2mg	1	
quetiapine fumarate TABS 25mg, 50mg, 100mg, 150mg, 200mg, 300mg, 400mg	1	
quetiapine fumarate TB24 50mg, 300mg, 400mg	1	QL (60 tabs / 30 days), PA
quetiapine fumarate TB24 150mg, 200mg	1	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	1	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	1	QL (60 tabs / 30 days)
RISPERDAL CONSTA SRER 12.5mg, 25mg, 37.5mg, 50mg	1	QL (2 injections / 28 days)
risperidone SOLN 1mg/ml	1	QL (240 mL / 30 days)
risperidone TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	1	
risperidone TBDP 1mg, 2mg, 3mg	1	QL (60 tabs / 30 days)
risperidone TBDP 4mg	1	QL (120 tabs / 30 days)
risperidone TBDP .25mg, .5mg	1	QL (90 tabs / 30 days)
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	1	QL (30 patches / 30 days)
thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	1	
thiothixene CAPS 1mg, 2mg, 5mg, 10mg	1	
trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	1	
VERSACLOZ SUSP 50mg/ml	1	QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	1	QL (60 caps / 30 days)
VRAYLAR CAPS 3mg, 4.5mg, 6mg	1	QL (30 caps / 30 days)
VRAYLAR CAP 1.5-3MG	1	
ziprasidone hcl CAPS 20mg, 40mg, 60mg, 80mg	1	QL (60 caps / 30 days)
ziprasidone mesylate SOLR 20mg	1	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg, 300mg	1	QL (2 vials / 28 days), NM, PA
ZYPREXA RELPREVV SUSR 405mg	1	QL (1 vial / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine cap er 24hr 5 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 10 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 15 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 20 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine tab 5 mg	1	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 10 mg	1	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 15 mg	1	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 20 mg	1	QL (90 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 30 mg	1	QL (60 tabs / 30 days), PA
atomoxetine hcl CAPS 10mg, 18mg, 25mg	1	QL (120 caps / 30 days)
atomoxetine hcl CAPS 40mg	1	QL (60 caps / 30 days)
atomoxetine hcl CAPS 60mg, 80mg, 100mg	1	QL (30 caps / 30 days)
dexmethylphenidate hcl TABS 2.5mg, 5mg	1	QL (120 tabs / 30 days), PA
dexmethylphenidate hcl TABS 10mg	1	QL (60 tabs / 30 days), PA
guanfacine hcl (adhd) TB24 1mg, 2mg, 4mg	1	QL (30 tabs / 30 days), PA; PA if 70 years and older
guanfacine hcl (adhd) TB24 3mg	1	QL (60 tabs / 30 days), PA; PA if 70 years and older
metadate er TBCR 20mg	1	QL (90 tabs / 30 days), PA
methylphenidate hcl SOLN 5mg/5ml	1	QL (1800 mL / 30 days), PA
methylphenidate hcl SOLN 10mg/5ml	1	QL (900 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl TABS 5mg, 10mg	1	QL (180 tabs / 30 days), PA
methylphenidate hcl TABS 20mg; TBCR 10mg, 20mg	1	QL (90 tabs / 30 days), PA
HYPNOTICS		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
DAYVIGO TABS 5mg, 10mg	1	QL (30 tabs / 30 days)
doxepin hcl (sleep) TABS 3mg, 6mg	1	QL (30 tabs / 30 days)
eszopiclone TABS 1mg, 2mg, 3mg	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
tasimelteon CAPS 20mg	1	QL (30 caps / 30 days), NM, PA
temazepam CAPS 7.5mg, 30mg	1	QL (30 caps / 30 days), PA; PA if 65 years and older
temazepam CAPS 15mg	1	QL (60 caps / 30 days), PA; PA if 65 years and older
zaleplon CAPS 5mg	1	QL (30 caps / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
zaleplon CAPS 10mg	1	QL (60 caps / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
zolpidem tartrate TABS 5mg, 10mg	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
AIMOVIG SOAJ 70mg/ml, 140mg/ml	1	QL (1 pen / 30 days), NM, PA
dihydroergotamine mesylate SOLN 1mg/ml	1	
dihydroergotamine mesylate SOLN 4mg/ml	1	QL (8 mL / 30 days), PA
ergotamine w/ caffeine tab 1-100 mg	1	QL (40 tabs / 28 days), PA
naratriptan hcl TABS 1mg, 2.5mg	1	QL (12 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
NURTEC TBDP 75mg	1	QL (16 tabs / 30 days), PA
rizatriptan benzoate TABS 5mg, 10mg; TBDP 5mg, 10mg	1	QL (18 tabs / 30 days)
sumatriptan SOLN 5mg/act	1	QL (24 units / 30 days)
sumatriptan SOLN 20mg/act	1	QL (12 units / 30 days)
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml	1	QL (18 injections / 30 days)
sumatriptan succinate SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml	1	QL (12 injections / 30 days)
sumatriptan succinate TABS 25mg, 50mg, 100mg	1	QL (12 tabs / 30 days)
zolmitriptan TABS 2.5mg, 5mg; TBDP 2.5mg, 5mg	1	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO TABS 6mg	1	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO TABS 9mg, 12mg	1	QL (120 tabs / 30 days), NM, LA, PA
AUSTEDO XR TB24 6mg	1	QL (90 tabs / 30 days), NM, PA
AUSTEDO XR TB24 12mg	1	QL (120 tabs / 30 days), NM, PA
AUSTEDO XR TB24 24mg	1	QL (60 tabs / 30 days), NM, PA
INGREZZA CAPS 40mg, 60mg, 80mg	1	QL (30 caps / 30 days), NM, LA, PA
INGREZZA CAP 40-80MG	1	QL (28 caps / 28 days), NM, LA, PA
lithium carbonate CAPS 150mg, 300mg, 600mg; TABS 300mg; TBCR 300mg, 450mg	1	
NUEDEXTA CAP 20-10MG	1	QL (60 caps / 30 days), PA
pyridostigmine bromide TABS 60mg	1	
riluzole TABS 50mg	1	
tetrabenazine TABS 12.5mg	1	QL (90 tabs / 30 days), NM, PA
tetrabenazine TABS 25mg	1	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BAFIERTAM CPDR 95mg	1	QL (120 caps / 30 days), NM, LA, PA
BETASERON KIT .3mg	1	QL (14 syringes / 28 days), NM, PA
dalfampridine TB12 10mg	1	NM, PA
fingolimod hcl CAPS .5mg	1	QL (28 caps / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
glatiramer acetate SOSY 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
glatiramer acetate SOSY 40mg/ml	1	QL (12 syringes / 28 days), NM, PA
glatopa SOSY 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
glatopa SOSY 40mg/ml	1	QL (12 syringes / 28 days), NM, PA
KESIMPTA SOAJ 20mg/0.4ml	1	QL (16 pens / year), NM, LA, PA
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS 10mg, 20mg	1	
carisoprodol TABS 350mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
cyclobenzaprine hcl TABS 5mg, 10mg	1	PA; PA if 70 years and older
dantrolene sodium CAPS 25mg, 50mg, 100mg	1	
methocarbamol TABS 500mg, 750mg	1	PA; PA if 70 years and older
tizanidine hcl TABS 2mg, 4mg	1	
vanadom TABS 350mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
NARCOLEPSY/CATAPLEXY		
armodafinil TABS 50mg	1	QL (60 tabs / 30 days), PA
armodafinil TABS 150mg, 200mg, 250mg	1	QL (30 tabs / 30 days), PA
SODIUM OXYBATE SOLN 500mg/ml	1	QL (540 mL / 30 days), NM, LA, PA
XYREM SOLN 500mg/ml	1	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium TBEC 333mg	1	
buprenorphine hcl SUBL 2mg, 8mg	1	QL (90 tabs / 30 days), PA
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	QL (60 films / 30 days)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	QL (90 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	QL (90 tabs / 30 days)
bupropion hcl (smoking deterrent) TB12 150mg	1	
disulfiram TABS 250mg, 500mg	1	
naloxone hcl LIQD 4mg/0.1ml; SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	1	
naltrexone hcl TABS 50mg	1	
NICOTROL INHALER INHA 10mg	1	
NICOTROL NS SOLN 10mg/ml	1	
varenicline tartrate TABS .5mg, 1mg	1	QL (56 tabs / 28 days), PA
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	1	PA
VIVITROL SUSR 380mg	1	NM
ENDOCRINE AND METABOLIC		
ANDROGENS		
depo-testosterone SOLN 100mg/ml, 200mg/ml	1	PA
oxandrolone TABS 2.5mg	1	QL (120 tabs / 30 days), PA
oxandrolone TABS 10mg	1	QL (60 tabs / 30 days), PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm	1	QL (300 gm / 30 days), PA
testosterone GEL 1.62%	1	QL (150 gm / 30 days), PA
testosterone cypionate SOLN 100mg/ml, 200mg/ml	1	PA
testosterone enanthate SOLN 200mg/ml	1	PA
ANTIDIABETICS		
acarbose TABS 25mg, 50mg, 100mg	1	
BYDUREON BCISE AUIJ 2mg/0.85ml	1	QL (4 pens / 28 days)
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml	1	QL (1 pen / 30 days)
FARXIGA TABS 5mg, 10mg	1	QL (30 tabs / 30 days)
glimepiride TABS 1mg, 2mg	1	QL (90 tabs / 30 days)
glimepiride TABS 4mg	1	QL (60 tabs / 30 days)
glipizide TABS 5mg	1	QL (240 tabs / 30 days)
glipizide TABS 10mg	1	QL (120 tabs / 30 days)
glipizide TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide TB24 10mg	1	QL (60 tabs / 30 days)
glipizide xl TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide xl TB24 10mg	1	QL (60 tabs / 30 days)
glipizide-metformin hcl tab 2.5-250 mg	1	QL (240 tabs / 30 days)
glipizide-metformin hcl tab 2.5-500 mg	1	QL (120 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
glipizide-metformin hcl tab 5-500 mg	1	QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	1	QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	1	QL (30 tabs / 30 days)
JANUMET TAB 50-500MG	1	QL (60 tabs / 30 days)
JANUMET TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	1	QL (30 tabs / 30 days)
JANUVIA TABS 25mg, 50mg, 100mg	1	QL (30 tabs / 30 days)
JARDIANCE TABS 10mg	1	QL (60 tabs / 30 days)
JARDIANCE TABS 25mg	1	QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	1	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	1	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	1	QL (30 tabs / 30 days)
metformin hcl TABS 500mg	1	QL (150 tabs / 30 days)
metformin hcl TABS 850mg	1	QL (90 tabs / 30 days)
metformin hcl TABS 1000mg	1	QL (75 tabs / 30 days)
metformin hcl TB24 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin hcl TB24 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
nateglinide TABS 60mg, 120mg	1	QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml, 2mg/3ml	1	QL (1 pen / 28 days)
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml	1	QL (1 pen / 28 days)
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML	1	QL (1 pen / 28 days)
pioglitazone hcl TABS 15mg, 30mg, 45mg	1	QL (30 tabs / 30 days)
repaglinide TABS 2mg	1	QL (240 tabs / 30 days)
repaglinide TABS .5mg, 1mg	1	QL (120 tabs / 30 days)
RYBELSUS TABS 3mg, 7mg, 14mg	1	QL (30 tabs / 30 days)
SYNJARDY TAB 5-500MG	1	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000	1	QL (30 tabs / 30 days)
TRADJENTA TABS 5mg	1	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000MG	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000MG	1	QL (30 tabs / 30 days)
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml	1	QL (4 pens / 28 days)
VICTOZA SOPN 18mg/3ml	1	QL (3 pens / 30 days)
XIGDUO XR TAB 2.5-1000	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000	1	QL (30 tabs / 30 days)
ANTIDIABETICS, INSULINS		
BASAGLAR KWIKPEN SOPN 100unit/ml	1	
BD ALCOHOL SWABS	1	
FIASP FLEX INJ TOUCH	1	
FIASP INJ 100/ML	1	
FIASP PENFIL INJ U-100	1	
GAUZE PADS 2" X 2"	1	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	1	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	1	
INSULIN PEN NEEDLES: BD/NOVO	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGES: BD	1	
LANTUS SOLN 100unit/ml	1	
LANTUS SOLOSTAR SOPN 100unit/ml	1	
LEVEMIR SOLN 100unit/ml	1	
LEVEMIR FLEXPEN SOPN 100unit/ml	1	
LEVEMIR FLEXTOUCH SOPN 100unit/ml	1	
NOVOLIN INJ 70/30	1	(brand RELION not covered)
NOVOLIN INJ 70/30 FP	1	(brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	1	(brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	1	(brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	1	(brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	1	(brand RELION not covered)
NOVOLOG SOLN 100unit/ml	1	(brand RELION not covered)
NOVOLOG FLEXPEN SOPN 100unit/ml	1	(brand RELION not covered)

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG MIX INJ 70/30	1	(brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	1	(brand RELION not covered)
NOVOLOG PENFILL SOCT 100unit/ml	1	(brand RELION not covered)
OMNIPOD 5 G6 KIT INTRO	1	QL (1 kit / year), PA
OMNIPOD 5 G6 MIS PODS	1	QL (15 pods / 30 days), PA
OMNIPOD DASH KIT INTRO	1	QL (1 kit / year), PA
OMNIPOD DASH MIS PODS	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 10UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 15UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 20UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 25UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 30UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 35UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 40UNT/DY	1	QL (15 pods / 30 days), PA
OMNIPOD MIS CLASSIC	1	QL (15 pods / 30 days), PA
OMNIPOD PDM KIT CLASSIC	1	QL (1 kit / year), PA
SOLIQUA INJ 100/33	1	QL (5 pens / 25 days)
TOUJEO MAX SOLOSTAR SOPN 300unit/ml	1	
TOUJEO SOLOSTAR SOPN 300unit/ml	1	
TRESIBA SOLN 100unit/ml	1	
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	1	
V-GO 20 KIT	1	QL (1 kit / 30 days), PA
V-GO 30 KIT	1	QL (1 kit / 30 days), PA
V-GO 40 KIT	1	QL (1 kit / 30 days), PA
XULTOPHY INJ 100/3.6	1	QL (5 pens / 30 days)
CALCIUM REGULATORS		
alendronate sodium SOLN 70mg/75ml; TABS 10mg, 35mg, 70mg	1	
calcitonin (salmon) spray SOLN 200unit/act	1	B/D
FORTEO SOPN 600mcg/2.4ml	1	NM, PA
ibandronate sodium TABS 150mg	1	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	1	LA, PA

Drug Name	Drug Tier	Requirements/Limits
PAMIDRONATE DISODIUM SOLN 6mg/ml	1	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml	1	B/D
PROLIA SOSY 60mg/ml	1	QL (1 syringe / 180 days), NM
risedronate sodium TABS 5mg, 35mg, 150mg; TBEC 35mg	1	
TERIPARATIDE SOPN 620mcg/2.48ml	1	NM, PA
XGEVA SOLN 120mg/1.7ml	1	NM, PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml, 5mg/100ml	1	B/D, NM
CHELATING AGENTS		
CHEMET CAPS 100mg	1	
deferasirox PACK 90mg, 180mg, 360mg; TABS 90mg, 180mg, 360mg	1	NM, PA
LOKELMA PACK 5gm, 10gm	1	
penicillamine TABS 250mg	1	NM
sodium polystyrene sulfonate powder	1	
sps SUSP 15gm/60ml	1	
trientine hcl CAPS 250mg	1	NM, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	1	
CONTRACEPTIVES		
afirmelle	1	
altavera	1	
alyacen 1/35	1	
alyacen 7/7/7	1	
amethia	1	
apri	1	
aranelle	1	
ashlyna	1	
aubra eq	1	
aurovela 1/20	1	
aurovela 24 fe	1	
aurovela fe 1.5/30	1	
aurovela fe 1/20	1	
aviane	1	
ayuna	1	
azurette	1	
balziva	1	
blisovi 24 fe	1	
blisovi fe 1.5/30	1	
briellyn	1	
camila TABS .35mg	1	
camrese	1	
camrese lo	1	
chateal	1	

Drug Name	Drug Tier	Requirements/Limits
cryselle-28	1	
cyred eq	1	
dasetta 1/35	1	
dasetta 7/7/7	1	
daysee	1	
deblitane TABS .35mg	1	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	1	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	1	
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	1	
drospirenone-ethinyl estradiol tab 3-0.02 mg	1	
drospirenone-ethinyl estradiol tab 3-0.03 mg	1	
elinest	1	
eluryng	1	
emoquette	1	
enpresse-28	1	
enskyce	1	
errin TABS .35mg	1	
estarylla	1	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	1	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	1	
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	1	
falmina	1	
femynor	1	
finzala	1	
hailey 1.5/30	1	
hailey 24 fe	1	
heather TABS .35mg	1	
iclevia	1	
incassia TABS .35mg	1	
introvale	1	
isibloom	1	
jasmiel	1	
jolessa	1	
juleber	1	
junel 1.5/30	1	
junel 1/20	1	
junel fe 1.5/30	1	
junel fe 1/20	1	
junel fe 24	1	

Drug Name	Drug Tier	Requirements/Limits
kaitlib fe	1	
kariva	1	
kelnor 1/35	1	
kelnor 1/50	1	
kurvelo	1	
larin 1.5/30	1	
larin 1/20	1	
larin 24 fe	1	
larin fe 1.5/30	1	
larin fe 1/20	1	
layolis fe	1	
leena	1	
lessina	1	
levonest	1	
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg	1	
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	1	
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	1	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	1	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	1	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	1	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	1	
levora 0.15/30-28	1	
lillow	1	
loestrin 1.5/30-21	1	
loestrin 1/20-21	1	
loestrin fe 1.5/30	1	
loestrin fe 1/20	1	
loryna	1	
low-ogestrel	1	
lutera	1	
lyleq TABS .35mg	1	
lyza TABS .35mg	1	
marlissa	1	
medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml	1	
microgestin 1.5/30	1	
microgestin 1/20	1	
microgestin 24 fe	1	
microgestin fe 1.5/30	1	

Drug Name	Drug Tier	Requirements/Limits
microgestin fe 1/20	1	
mili	1	
mono-linyah	1	
necon 0.5/35-28	1	
nikki	1	
nora-be TABS .35mg	1	
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg	1	
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg	1	
norethindrone (contraceptive) TABS .35mg	1	
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	1	
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	1	
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	1	
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	1	
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	1	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	1	
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	1	
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	1	
norlyroc TABS .35mg	1	
nortrel 0.5/35 (28)	1	
nortrel 1/35 (21)	1	
nortrel 1/35 (28)	1	
nortrel 7/7/7	1	
nylia 1/35	1	
nylia 7/7/7	1	
nymyo	1	
ocella	1	
philith	1	
pimtrea	1	
pirmella 1/35	1	
portia-28	1	
reclipsen	1	
rivelsa	1	
setlakin	1	
sharobel TABS .35mg	1	
simliya	1	
simpesse	1	

Drug Name	Drug Tier	Requirements/Limits
sprintec 28	1	
sronyx	1	
syeda	1	
tarina 24 fe	1	
tarina fe 1/20 eq	1	
tilia fe	1	
tri-estarylla	1	
tri-legest fe	1	
tri-linyah	1	
tri-lo-estarylla	1	
tri-lo-marzia	1	
tri-lo-mili	1	
tri-lo-sprintec	1	
tri-mili	1	
tri-nymyo	1	
tri-sprintec	1	
tri-vylibra	1	
tri-vylibra lo	1	
trivora-28	1	
tydemy	1	
velivet	1	
vestura	1	
vienva	1	
viorele	1	
vyfemla	1	
vylibra	1	
wera	1	
wymzya fe	1	
xulane	1	
zafemy	1	
zovia 1/35	1	
zumandimine	1	
ENDOMETRIOSIS		
danazol CAPS 50mg, 100mg, 200mg	1	
SYNAREL SOLN 2mg/ml	1	
ESTROGENS		
amabelz	1	
DELESTROGEN OIL 10mg/ml	1	
dotti PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
estradiol PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr; TABS .5mg, 1mg, 2mg	1	

Drug Name	Drug Tier	Requirements/Limits
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	
estradiol & norethindrone acetate tab 1-0.5 mg	1	
estradiol vaginal CREA .1mg/gm; TABS 10mcg	1	
estradiol valerate OIL 10mg/ml, 20mg/ml, 40mg/ml	1	
fyavolv tab 0.5mg-2.5mcg	1	
fyavolv tab 1mg-5mcg	1	
jinteli	1	
lyllana PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
mimvey	1	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	1	
yuvafem TABS 10mcg	1	
GLUCOCORTICOIDS		
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	1	
DEXAMETHASONE INTENSOL CONC 1mg/ml	1	
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	1	
fludrocortisone acetate TABS .1mg	1	
hydrocortisone TABS 5mg, 10mg, 20mg	1	
methylprednisolone TABS 4mg, 8mg, 16mg, 32mg	1	B/D
methylprednisolone TBPK 4mg	1	
methylprednisolone acetate SUSP 40mg/ml, 80mg/ml	1	B/D
methylprednisolone sod succ SOLR 40mg, 125mg, 1000mg	1	B/D
prednisolone SOLN 15mg/5ml	1	B/D
prednisolone sodium phosphate SOLN 5mg/5ml, 15mg/5ml, 25mg/5ml	1	B/D
prednisone SOLN 5mg/5ml; TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	1	B/D
prednisone TBPK 5mg, 10mg	1	
PREDNISONE INTENSOL CONC 5mg/ml	1	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	1	
GLUCOSE ELEVATING AGENTS		
diazoxide SUSP 50mg/ml	1	

Drug Name	Drug Tier	Requirements/Limits
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	1	
GVOKE KIT SOLN 1mg/0.2ml	1	
GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml	1	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	1	NM, LA, PA
betaine powder for oral solution	1	NM, LA
cabergoline TABS .5mg	1	
carglumic acid TBSO 200mg	1	NM, LA, PA
CERDELGA CAPS 84mg	1	NM, LA, PA
CEREZYME SOLR 400unit	1	NM, LA, PA
cinacalcet hcl TABS 30mg, 60mg	1	B/D, QL (60 tabs / 30 days), NM
cinacalcet hcl TABS 90mg	1	B/D, QL (120 tabs / 30 days), NM
CYSTAGON CAPS 50mg, 150mg	1	NM, LA, PA
desmopressin acetate SOLN 4mcg/ml; TABS .1mg, .2mg	1	
desmopressin acetate spray SOLN .01%	1	
desmopressin acetate spray refrigerated SOLN .01%	1	
FABRAZYME SOLR 5mg, 35mg	1	NM, LA, PA
GENOTROPIN CART 5mg, 12mg	1	NM, PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	1	NM, PA
INCRELEX SOLN 40mg/4ml	1	NM, LA, PA
javygtor PACK 100mg, 500mg; TABS 100mg	1	NM, LA, PA
KORLYM TABS 300mg	1	NM, LA, PA
levocarnitine (metabolic modifiers) SOLN 1gm/10ml; TABS 330mg	1	B/D
LUMIZYME SOLR 50mg	1	NM, LA, PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	1	NM, PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	1	NM, PA
LUPRON DEPOT-PED (6-MONTH KIT 45mg	1	NM, PA
miglustat CAPS 100mg	1	QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	1	NM, LA, PA
nitisinone CAPS 2mg, 5mg, 10mg	1	NM, PA
octreotide acetate SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; SOSY 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM, PA
raloxifene hcl TABS 60mg	1	

Drug Name	Drug Tier	Requirements/Limits
sapropterin dihydrochloride PACK 100mg, 500mg; TABS 100mg	1	NM, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	1	NM, LA, PA
sodium phenylbutyrate POWD 3gm/tsp; TABS 500mg	1	NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	1	NM, LA, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	1	NM, LA, PA
PHOSPHATE BINDER AGENTS		
calcium acetate (phosphate binder) CAPS 667mg	1	QL (360 caps / 30 days)
calcium acetate (phosphate binder) TABS 667mg	1	QL (360 tabs / 30 days)
sevelamer carbonate PACK 2.4gm	1	QL (180 packets / 30 days)
sevelamer carbonate PACK .8gm	1	QL (540 packets / 30 days)
sevelamer carbonate TABS 800mg	1	QL (540 tabs / 30 days)
VELPHORO CHEW 500mg	1	QL (180 tabs / 30 days)
PROGESTINS		
medroxyprogesterone acetate TABS 2.5mg, 5mg, 10mg	1	
megestrol acetate SUSP 40mg/ml	1	
megestrol acetate (appetite) SUSP 625mg/5ml	1	PA
norethindrone acetate TABS 5mg	1	
THYROID AGENTS		
euthyrox TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
levothyroxine sodium TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
levoxyl TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
liothyronine sodium TABS 5mcg, 25mcg, 50mcg	1	
methimazole TABS 5mg, 10mg	1	
propylthiouracil TABS 50mg	1	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	

Drug Name	Drug Tier	Requirements/Limits
unithroid TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
VITAMIN D ANALOGS		
calcitriol CAPS .25mcg, .5mcg	1	B/D
calcitriol (oral) SOLN 1mcg/ml	1	B/D
paricalcitol CAPS 1mcg, 2mcg, 4mcg	1	B/D
RAYALDEE CPCR 30mcg	1	
GASTROINTESTINAL		
ANTIEMETICS		
aprepitant CAPS 40mg, 80mg, 125mg	1	B/D
aprepitant capsule therapy pack 80 & 125 mg	1	B/D
compro SUPP 25mg	1	
dronabinol CAPS 2.5mg, 5mg, 10mg	1	B/D, QL (60 caps / 30 days)
granisetron hcl SOLN 1mg/ml, 4mg/4ml	1	
granisetron hcl TABS 1mg	1	B/D
meclizine hcl TABS 12.5mg, 25mg	1	
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml; TABS 5mg, 10mg	1	
ondansetron TBDP 4mg, 8mg	1	B/D
ondansetron hcl SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	1	
ondansetron hcl SOLN 4mg/5ml; TABS 4mg, 8mg	1	B/D
prochlorperazine SUPP 25mg	1	
prochlorperazine edisylate SOLN 10mg/2ml	1	
prochlorperazine maleate TABS 5mg, 10mg	1	
promethazine hcl SOLN 25mg/ml, 50mg/ml; SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	1	PA; PA if 70 years and older
scopolamine PT72 1mg/3days	1	QL (10 patches / 30 days), PA; PA if 70 years and older
ANTISPASMODICS		
dicyclomine hcl CAPS 10mg; SOLN 10mg/5ml; TABS 20mg	1	
glycopyrrolate TABS 1mg, 2mg	1	
H2-RECEPTOR ANTAGONISTS		
famotidine SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	1	
famotidine SUSR 40mg/5ml	1	QL (300 mL / 30 days)
famotidine TABS 20mg	1	QL (120 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
famotidine TABS 40mg	1	QL (60 tabs / 30 days)
famotidine in nacl 0.9% iv soln 20 mg/50ml	1	
nizatidine CAPS 150mg, 300mg	1	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium CAPS 750mg	1	
budesonide CPEP 3mg	1	QL (90 caps / 30 days), PA
budesonide TB24 9mg	1	QL (30 tabs / 30 days), PA
hydrocortisone (intrarectal) ENEM 100mg/60ml	1	
mesalamine CP24 .375gm	1	QL (120 caps / 30 days)
mesalamine CPDR 400mg	1	QL (180 caps / 30 days)
mesalamine ENEM 4gm; SUPP 1000mg	1	
mesalamine TBEC 1.2gm	1	QL (120 tabs / 30 days)
mesalamine w/ cleanser KIT 4gm	1	
sulfasalazine TABS 500mg; TBEC 500mg	1	
LAXATIVES		
constulose SOLN 10gm/15ml	1	
enulose SOLN 10gm/15ml	1	
gavilyte-c	1	
gavilyte-g	1	
generlac SOLN 10gm/15ml	1	
GOLYTELY SOL	1	
lactulose SOLN 10gm/15ml	1	
lactulose (encephalopathy) SOLN 10gm/15ml	1	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
PLENVU SOL	1	
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	1	
SUPREP BOWEL SOL PREP KIT	1	
MISCELLANEOUS		
alosetron hcl TABS .5mg, 1mg	1	QL (60 tabs / 30 days), PA
cromolyn sodium (mastocytosis) CONC 100mg/5ml	1	
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1	
GATTEX KIT 5mg	1	NM, LA, PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	1	QL (30 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
loperamide hcl CAPS 2mg	1	
misoprostol TABS 100mcg, 200mcg	1	
MOVANTIK TABS 12.5mg, 25mg	1	QL (30 tabs / 30 days)
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	1	PA
sucralfate TABS 1gm	1	
ursodiol CAPS 300mg; TABS 250mg, 500mg	1	
XERMELO TABS 250mg	1	QL (90 tabs / 30 days), NM, LA, PA
XIFAXAN TABS 550mg	1	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	1	
CREON CAP 6000UNIT	1	
CREON CAP 12000UNT	1	
CREON CAP 24000UNT	1	
CREON CAP 36000UNT	1	
ZENPEP CAP 3000UNIT	1	
ZENPEP CAP 5000UNIT	1	
ZENPEP CAP 10000UNT	1	
ZENPEP CAP 15000UNT	1	
ZENPEP CAP 20000UNT	1	
ZENPEP CAP 25000UNT	1	
ZENPEP CAP 40000UNT	1	
PROTON PUMP INHIBITORS		
esomeprazole magnesium CPDR 20mg, 40mg	1	QL (30 caps / 30 days), ST
lansoprazole CPDR 15mg, 30mg	1	QL (60 caps / 30 days)
omeprazole CPDR 10mg, 20mg, 40mg	1	
pantoprazole sodium SOLR 40mg; TBEC 20mg, 40mg	1	
rabeprazole sodium TBEC 20mg	1	QL (30 tabs / 30 days)
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl TB24 10mg	1	QL (30 tabs / 30 days)
dutasteride CAPS .5mg	1	QL (30 caps / 30 days)
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1	QL (30 caps / 30 days)
finasteride TABS 5mg	1	
tamsulosin hcl CAPS .4mg	1	
MISCELLANEOUS		
acetic acid SOLN .25%	1	
bethanechol chloride TABS 5mg, 10mg, 25mg, 50mg	1	
potassium citrate (alkalinizer) TBCR 15meq, 540mg, 1080mg	1	
URINARY ANTISPASMODICS		
fesoterodine fumarate TB24 4mg, 8mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
GEMTESA TABS 75mg	1	QL (30 tabs / 30 days)
MYRBETRIQ SRER 8mg/ml	1	QL (300 mL / 28 days)
MYRBETRIQ TB24 25mg, 50mg	1	QL (30 tabs / 30 days)
oxybutynin chloride SYRP 5mg/5ml; TABS 5mg	1	
oxybutynin chloride TB24 5mg	1	QL (30 tabs / 30 days)
oxybutynin chloride TB24 10mg, 15mg	1	QL (60 tabs / 30 days)
solifenacin succinate TABS 5mg, 10mg	1	QL (30 tabs / 30 days)
tolterodine tartrate CP24 2mg, 4mg	1	QL (30 caps / 30 days), ST
tolterodine tartrate TABS 1mg, 2mg	1	QL (60 tabs / 30 days)
trospium chloride TABS 20mg	1	QL (60 tabs / 30 days)
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal CREA 2%	1	
metronidazole vaginal GEL .75%	1	
terconazole vaginal CREA .4%, .8%; SUPP 80mg	1	
HEMATOLOGIC		
ANTICOAGULANTS		
dabigatran etexilate mesylate CAPS 75mg, 150mg	1	QL (60 caps / 30 days)
ELIQUIS TABS 2.5mg	1	QL (60 tabs / 30 days)
ELIQUIS TABS 5mg	1	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK TBPK 5mg	1	QL (74 tabs / 30 days)
enoxaparin sodium SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	1	
fondaparinux sodium SOLN 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	1	
HEP SOD/D5W INJ 20000UNT	1	
HEP SOD/D5W INJ 25000UNT	1	
HEP SOD/NACL INJ 12500UNT	1	
HEP SOD/NACL INJ 25000UNT	1	
heparin sodium (porcine) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	1	B/D
HEPARIN/NACL INJ 25000UNT	1	
jantoven TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
PRADAXA CAPS 75mg, 150mg	1	QL (60 caps / 30 days)
PRADAXA CAPS 110mg	1	QL (120 caps / 30 days)
warfarin sodium TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
XARELTO SUSR 1mg/ml	1	QL (620 mL / 30 days)
XARELTO TABS 2.5mg	1	QL (60 tabs / 30 days)
XARELTO TABS 10mg, 15mg, 20mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
XARELTO STAR TAB 15/20MG	1	QL (51 tabs / 30 days)
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml	1	NM, PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	1	NM, PA
ZIEXTENZO SOSY 6mg/0.6ml	1	NM, PA
MISCELLANEOUS		
anagrelide hcl CAPS .5mg, 1mg	1	
BERINERT KIT 500unit	1	QL (24 boxes / 30 days), NM, LA, PA
cilostazol TABS 50mg, 100mg	1	
DOPTELET TABS 20mg	1	NM, LA, PA
DROXIA CAPS 200mg, 300mg, 400mg	1	
ENDARI PACK 5gm	1	NM, LA, PA
HAEGARDA SOLR 2000unit	1	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	1	QL (20 vials / 30 days), NM, LA, PA
icatibant acetate SOSY 30mg/3ml	1	QL (9 syringes / 30 days), NM, PA
pentoxifylline TBCR 400mg	1	
PROMACTA PACK 12.5mg	1	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	1	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	1	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	1	QL (60 tabs / 30 days), NM, LA, PA
sajazir SOSY 30mg/3ml	1	QL (9 syringes / 30 days), NM, LA, PA
tranexamic acid SOLN 1000mg/10ml; TABS 650mg	1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	1	
BRILINTA TABS 60mg, 90mg	1	
clopidogrel bisulfate TABS 75mg	1	
dipyridamole TABS 25mg, 50mg, 75mg	1	PA; PA if 70 years and older
prasugrel hcl TABS 5mg, 10mg	1	

Drug Name	Drug Tier	Requirements/Limits
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	1	NM, PA
ENBREL SOLN 25mg/0.5ml; SOLR 25mg	1	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	1	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	1	QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	1	QL (8 cartridges / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	1	QL (8 pens / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml	1	QL (2 syringes / 28 days), NM, PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	1	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIA INJ CROHNS	1	NM, PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	1	NM, PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml	1	QL (6 pens / 28 days), NM, PA
HUMIRA PEN PNKT 80mg/0.8ml	1	QL (4 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	1	NM, PA
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	1	NM, PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml	1	NM, PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	1	NM, PA
INFLIXIMAB SOLR 100mg	1	NM, LA, PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml	1	QL (2 pens / 28 days), NM, PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml	1	QL (2 syringes / 28 days), NM, PA
OTEZLA TABS 30mg	1	QL (60 tabs / 30 days), NM, PA
OTEZLA TAB 10/20/30	1	QL (110 tabs / year), NM, PA
REMICADE SOLR 100mg	1	NM, LA, PA
RENFLEXIS SOLR 100mg	1	NM, LA, PA
RINVOQ TB24 15mg, 30mg	1	QL (30 tabs / 30 days), NM, PA
RINVOQ TB24 45mg	1	QL (112 tabs / year), NM, PA

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml	1	QL (1 cartridge / 56 days), NM, PA
SKYRIZI SOLN 600mg/10ml	1	QL (6 vials / year), NM, PA
SKYRIZI SOSY 150mg/ml	1	QL (6 syringes / 365 days), NM, PA
SKYRIZI PEN SOAJ 150mg/ml	1	QL (6 pens / 365 days), NM, PA
STELARA SOLN 45mg/0.5ml	1	QL (1 vial / 28 days), NM, LA, PA
STELARA SOLN 130mg/26ml	1	NM, LA, PA
STELARA SOSY 45mg/0.5ml, 90mg/ml	1	QL (1 syringe / 28 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	1	QL (3 syringes / 28 days), NM, LA, PA
XELJANZ SOLN 1mg/ml	1	QL (480 mL / 24 days), NM, PA
XELJANZ TABS 5mg, 10mg	1	QL (60 tabs / 30 days), NM, PA
XELJANZ XR TB24 11mg, 22mg	1	QL (30 tabs / 30 days), NM, PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
hydroxychloroquine sulfate TABS 200mg	1	
leflunomide TABS 10mg, 20mg	1	QL (30 tabs / 30 days)
methotrexate sodium TABS 2.5mg	1	
XATMEP SOLN 2.5mg/ml	1	B/D
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml, 10%	1	NM, LA, PA
FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM, PA
GAMASTAN INJ	1	B/D, NM, LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	1	NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	1	NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM, LA, PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	1	NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	1	NM, LA, PA
ARCALYST SOLR 220mg	1	NM, LA, PA
INTRON A SOLR 10000000unit, 18000000unit, 50000000unit	1	B/D, NM, LA
IMMUNOSUPPRESSANTS		
azathioprine TABS 50mg	1	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	1	QL (8 syringes / 28 days), NM, LA, PA
BENLYSTA SOLR 120mg, 400mg	1	NM, LA, PA
cyclosporine CAPS 25mg, 100mg; SOLN 50mg/ml	1	B/D
cyclosporine modified (for microemulsion) CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	1	B/D
everolimus (immunosuppressant) TABS .25mg, .5mg, .75mg, 1mg	1	B/D
gengraf CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D
mycophenolate mofetil CAPS 250mg; SUSR 200mg/ml; TABS 500mg	1	B/D
mycophenolate sodium TBEC 180mg, 360mg	1	B/D
NULOJIX SOLR 250mg	1	B/D
PROGRAF PACK .2mg, 1mg	1	B/D
REZUROCK TABS 200mg	1	NM, LA, PA
SANDIMMUNE SOLN 100mg/ml	1	B/D
sirolimus SOLN 1mg/ml; TABS .5mg, 1mg, 2mg	1	B/D
tacrolimus CAPS .5mg, 1mg, 5mg	1	B/D
VACCINES		
ACTHIB INJ	1	
ADACEL INJ	1	
BCG VACCINE SOLR 50mg	1	
BEXSERO INJ	1	
BOOSTRIX INJ	1	
DAPTACEL INJ	1	
DENGVAXIA SUS	1	

Drug Name	Drug Tier	Requirements/Limits
DIP/TET PED INJ 25-5LFU	1	B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	B/D
GARDASIL 9 INJ	1	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	
HEPLISAV-B SOSY 20mcg/0.5ml	1	B/D
HIBERIX SOLR 10mcg	1	
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	B/D
INFANRIX INJ	1	
IPOL INJ INACTIVE	1	
IXIARO INJ	1	
KINRIX INJ	1	
M-M-R II INJ	1	
MENACTRA INJ	1	
MENQUADFI INJ	1	
MENVEO INJ	1	
MENVEO SOL	1	
PEDIARIX INJ 0.5ML	1	
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	
PENTACEL INJ	1	
PREHEVBRIO SUSP 10mcg/ml	1	B/D
PRIORIX INJ	1	
PROQUAD INJ	1	
QUADRACEL INJ	1	
QUADRACEL INJ 0.5ML	1	
RABAVERT INJ	1	B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	1	B/D
ROTARIX SUS	1	
ROTATEQ SOL	1	
SHINGRIX SUSR 50mcg/0.5ml	1	QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	1	B/D
TENIVAC INJ 5-2LF	1	B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	1	
TRUMENBA INJ	1	
TWINRIX INJ	1	
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	1	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	1	
VARIVAX INJ 1350pfu/0.5ml	1	
YF-VAX INJ	1	

Drug Name	Drug Tier	Requirements/Limits
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES/MINERALS, INJECTABLE		
D2.5W/NACL INJ 0.45%	1	
D5W/LYTES INJ #48	1	
D10W/NACL INJ 0.2%	1	
dextrose 2.5% w/ sodium chloride 0.45%	1	
dextrose 5% in lactated ringers	1	
dextrose 5% w/ sodium chloride 0.2%	1	
dextrose 5% w/ sodium chloride 0.3%	1	
dextrose 5% w/ sodium chloride 0.9%	1	
dextrose 5% w/ sodium chloride 0.45%	1	
dextrose 5% w/ sodium chloride 0.225%	1	
dextrose 10% w/ sodium chloride 0.45%	1	
ISOLYTE-P INJ /D5W	1	
ISOLYTE-S INJ	1	
ISOLYTE-S INJ PH 7.4	1	
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	1	
kcl 20 meq/l (0.15%) in nacl 0.9% inj	1	
kcl 20 meq/l (0.15%) in nacl 0.45% inj	1	
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	1	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj	1	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	1	
kcl 40 meq/l (0.3%) in nacl 0.9% inj	1	
KCL/D5W/NACL INJ 0.3/0.9%	1	
lactated ringer's solution	1	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	1	
magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	1	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	1	
MG SO4/D5W INJ 10MG/ML	1	
PLASMA-LYTE INJ -148	1	
PLASMA-LYTE INJ -A	1	
POT CHL 20MEQ/L IN NACL 0.9% INJ	1	

Drug Name	Drug Tier	Requirements/Limits
POT CHL 20MEQ/L IN NACL 0.45% INJ	1	
POT CHL 40MEQ/L IN NACL 0.9% INJ	1	
potassium chloride SOLN 2meq/ml, 10meq/100ml, 20meq/100ml, 40meq/100ml	1	
POTASSIUM CHLORIDE SOLN 10meq/50ml, 20meq/50ml	1	
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	1	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	1	
TPN ELECTROL INJ	1	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
klor-con PACK 20meq	1	
klor-con 8 TBCR 8meq	1	
klor-con 10 TBCR 10meq	1	
klor-con m10 TBCR 10meq	1	
klor-con m15 TBCR 15meq	1	
klor-con m20 TBCR 20meq	1	
M-NATAL PLUS TAB	1	
potassium chloride CPCR 8meq, 10meq; PACK 20meq; SOLN 10%, 20%; TBCR 8meq, 10meq, 20meq	1	
potassium chloride microencapsulated crystals er TBCR 10meq, 15meq, 20meq	1	
PRENATAL TAB 27-1MG	1	
PRENATAL TAB PLUS	1	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	1	
TRICARE TAB PRENATAL	1	
IV NUTRITION		
CLINIMIX INJ 4.25/D5W	1	B/D
CLINIMIX INJ 4.25/D10	1	B/D
CLINIMIX INJ 5%/D15W	1	B/D
CLINIMIX INJ 5%/D20W	1	B/D
CLINIMIX INJ 6/5	1	B/D
CLINIMIX INJ 8/10	1	B/D
CLINIMIX INJ 8/14	1	B/D
clinisol sf 15%	1	B/D
CLINOLIPID EMU 20%	1	B/D
dextrose SOLN 5%, 10%	1	
dextrose SOLN 50%, 70%	1	B/D
FREAMINE III INJ 10%	1	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	1	B/D
NUTRILIPID EMUL 20gm/100ml	1	B/D
plenamine	1	B/D

Drug Name	Drug Tier	Requirements/Limits
PREMASOL SOL 10%	1	B/D
PROSOL INJ 20%	1	B/D
TRAVASOL INJ 10%	1	B/D
TROPHAMINE INJ 10%	1	B/D
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1	
neo-polycin hc ophth oint 1%	1	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	1	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	1	
neomycin-polymyxin-hc ophth susp	1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1%	1	
TOBRADEX ST SUS 0.3-0.05	1	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
ZYLET SUS 0.5-0.3%	1	
ANTI-INFECTIVES		
bacitracin (ophthalmic) OINT 500unit/gm	1	
bacitracin-polymyxin b ophth oint	1	
BESIVANCE SUSP .6%	1	
CILOXAN OINT .3%	1	
ciprofloxacin hcl (ophth) SOLN .3%	1	
erythromycin (ophth) OINT 5mg/gm	1	
gatifloxacin (ophth) SOLN .5%	1	
gentak OINT .3%	1	
gentamicin sulfate (ophth) SOLN .3%	1	
moxifloxacin hcl (ophth) SOLN .5%	1	
NATACYN SUSP 5%	1	
neo-polycin 5(3.5)mg-400unt-10000unt op oin	1	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	1	
ofloxacin (ophth) SOLN .3%	1	
polycin ophth oint	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
sulfacetamide sodium (ophth) OINT 10%; SOLN 10%	1	
tobramycin (ophth) SOLN .3%	1	
trifluridine SOLN 1%	1	

Drug Name	Drug Tier	Requirements/Limits
ZIRGAN GEL .15%	1	
ANTI-INFLAMMATORIES		
ALREX SUSP .2%	1	
BROMSITE SOLN .075%	1	
dexamethasone sodium phosphate (ophth) SOLN .1%	1	
diclofenac sodium (ophth) SOLN .1%	1	
difluprednate EMUL .05%	1	
EYSUVIS SUSP .25%	1	
FLAREX SUSP .1%	1	
fluorometholone (ophth) SUSP .1%	1	
flurbiprofen sodium SOLN .03%	1	
ILEVRO SUSP .3%	1	
ketorolac tromethamine (ophth) SOLN .4%, .5%	1	
LOTEMAX OINT .5%	1	
prednisolone acetate (ophth) SUSP 1%	1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	1	
PROLENSA SOLN .07%	1	
ANTIALLERGICS		
azelastine hcl (ophth) SOLN .05%	1	
cromolyn sodium (ophth) SOLN 4%	1	
olopatadine hcl SOLN .1%	1	
ZERVIATE SOLN .24%	1	
ANTIGLAUCOMA		
ALPHAGAN P SOLN .1%	1	
betaxolol hcl (ophth) SOLN .5%	1	
BETOPTIC-S SUSP .25%	1	
brimonidine tartrate SOLN .15%, .2%	1	
brinzolamide SUSP 1%	1	
carteolol hcl (ophth) SOLN 1%	1	
COMBIGAN SOL 0.2/0.5%	1	
dorzolamide hcl SOLN 2%	1	
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml	1	
latanoprost SOLN .005%	1	
levobunolol hcl SOLN .5%	1	
LUMIGAN SOLN .01%	1	
pilocarpine hcl SOLN 1%, 2%, 4%	1	
RHOPRESSA SOLN .02%	1	
ROCKLATAN DRO	1	
SIMBRINZA SUS 1-0.2%	1	
timolol maleate (ophth) SOLG .25%, .5%; SOLN .25%, .5%	1	
VYZULTA SOLN .024%	1	

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	1	
atropine sulfate (ophthalmic) SOLN 1%	1	
CYSTADROPS SOLN .37%	1	NM, LA, PA
CYSTARAN SOLN .44%	1	NM, LA, PA
ISOPTO ATROPINE SOLN 1%	1	
proparacaine hcl SOLN .5%	1	
RESTASIS EMUL .05%	1	
RESTASIS MULTIDOSE EMUL .05%	1	
TYRVAYA SOLN .03mg/act	1	
XIIDRA SOLN 5%	1	
OTIC		
OTIC AGENTS		
acetic acid (otic) SOLN 2%	1	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
flac OIL .01%	1	
fluocinolone acetonide (otic) OIL .01%	1	
neomycin-polymyxin-hc otic soln 1%	1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1	
ofloxacin (otic) SOLN .3%	1	
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPT AER 62.5-25	1	QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	1	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE	1	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	1	QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	1	QL (2 inhalers / 30 days)
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	1	QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	1	QL (60 blisters / 30 days)
ANTICHOLINERGICS		
ATROVENT HFA AERS 17mcg/act	1	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	1	QL (30 blisters / 30 days)
ipratropium bromide SOLN .02%	1	B/D
ipratropium bromide (nasal) SOLN .03%, .06%	1	

Drug Name	Drug Tier	Requirements/Limits
ANTIHISTAMINES		
azelastine hcl SOLN .1%, .15%	1	
cetirizine hcl SOLN 1mg/ml	1	
cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg	1	PA; PA if 70 years and older
diphenhydramine hcl SOLN 50mg/ml	1	
hydroxyzine hcl SOLN 25mg/ml, 50mg/ml; SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg	1	PA; PA if 70 years and older
hydroxyzine pamoate CAPS 25mg, 50mg	1	PA; PA if 70 years and older
levocetirizine dihydrochloride SOLN 2.5mg/5ml; TABS 5mg	1	
BETA AGONISTS		
albuterol sulfate AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Proair HFA)
albuterol sulfate AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Proventil HFA)
albuterol sulfate AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
albuterol sulfate NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	1	B/D
albuterol sulfate SYRP 2mg/5ml; TABS 2mg, 4mg	1	
levalbuterol hcl NEBU .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	1	B/D
levalbuterol tartrate AERO 45mcg/act	1	QL (2 inhalers / 30 days), ST
SEREVENT DISKUS AEPB 50mcg/dose	1	QL (60 inhalations / 30 days)
terbutaline sulfate TABS 2.5mg, 5mg	1	
VENTOLIN HFA AERS 108mcg/act	1	QL (2 inhalers / 30 days)
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	1	QL (6 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
montelukast sodium CHEW 4mg, 5mg; PACK 4mg; TABS 10mg	1	
zafirlukast TABS 10mg, 20mg	1	
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	1	B/D
ARALAST NP SOLR 500mg, 1000mg	1	NM, LA, PA
cromolyn sodium NEBU 20mg/2ml	1	B/D

Drug Name	Drug Tier	Requirements/Limits
epinephrine (anaphylaxis) SOAJ .15mg/0.3ml, .3mg/0.3ml	1	(generic of EpiPen)
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml	1	(generic of Adrenaclick)
FASENRA SOSY 30mg/ml	1	NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	1	NM, LA, PA
KALYDECO PACK 13.4mg, 25mg, 50mg, 75mg	1	QL (56 packs / 28 days), NM, LA, PA
KALYDECO TABS 150mg	1	QL (60 tabs / 30 days), NM, LA, PA
OFEV CAPS 100mg, 150mg	1	QL (60 caps / 30 days), NM, LA, PA
ORKAMBI GRA 75-94MG	1	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 100-125	1	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 150-188	1	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI TAB 100-125	1	QL (112 tabs / 28 days), NM, LA, PA
ORKAMBI TAB 200-125	1	QL (112 tabs / 28 days), NM, LA, PA
pirfenidone CAPS 267mg	1	QL (270 caps / 30 days), NM, PA
pirfenidone TABS 267mg	1	QL (270 tabs / 30 days), NM, PA
pirfenidone TABS 534mg, 801mg	1	QL (90 tabs / 30 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	1	NM, LA, PA
PULMOZYME SOLN 2.5mg/2.5ml	1	NM, PA
roflumilast TABS 250mcg, 500mcg	1	
SYMDEKO TAB 50-75MG	1	QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	1	QL (56 tabs / 28 days), NM, LA, PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	1	
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	1	
theophylline ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 300mg, 450mg; TB24 400mg, 600mg	1	
TRIKAFTA PAK 59.5MG	1	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA PAK 75MG	1	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA TAB 50-25-37.5MG & 75MG	1	QL (84 tabs / 28 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
TRIKAFTA TAB 100-50-75MG & 150MG	1	QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	1	NM, LA, PA
ZEMAIRA SOLR 1000mg	1	NM, LA, PA
NASAL STEROIDS		
flunisolide (nasal) SOLN .025%	1	QL (3 bottles / 30 days)
fluticasone propionate (nasal) SUSP 50mcg/act	1	QL (1 bottle / 30 days)
XHANCE EXHU 93mcg/act	1	QL (32 mL / 30 days), PA
STEROID INHALANTS		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	1	QL (30 inhalations / 30 days)
budesonide (inhalation) SUSP .25mg/2ml, .5mg/2ml	1	B/D
FLOVENT DISKUS AEPB 50mcg/blist	1	QL (180 inhalations / 30 days)
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist	1	QL (240 inhalations / 30 days)
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act	1	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 90mcg/act	1	QL (3 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 180mcg/act	1	QL (2 inhalers / 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKU AER 100/50	1	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 250/50	1	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 500/50	1	QL (60 inhalations / 30 days)
ADVAIR HFA AER 45/21	1	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	1	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	1	QL (1 inhaler / 30 days)
BREO ELLIPTA INH 100-25	1	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	1	QL (60 blisters / 30 days)
SYMBICORT AER 80-4.5	1	QL (3 inhalers / 30 days)
SYMBICORT AER 160-4.5	1	QL (3 inhalers / 30 days)
TOPICAL		
DERMATOLOGY, ACNE		
accutane CAPS 10mg, 20mg, 30mg, 40mg	1	PA

Drug Name	Drug Tier	Requirements/Limits
amnesteem CAPS 10mg, 20mg, 40mg	1	PA
avita CREA .025%	1	QL (45 gm / 30 days), PA
benzoyl peroxide-erythromycin gel 5-3%	1	QL (46.6 gm / 30 days)
claravis CAPS 10mg, 20mg, 30mg, 40mg	1	PA
clindamycin phosphate (topical) GEL 1%	1	QL (75 gm / 30 days)
clindamycin phosphate (topical) LOTN 1%; SOLN 1%	1	QL (60 mL / 30 days)
ery PADS 2%	1	QL (60 pledgets / 30 days)
erythromycin (acne aid) SOLN 2%	1	QL (60 mL / 30 days)
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	1	PA
sulfacetamide sodium (acne) LOTN 10%	1	QL (118 mL / 30 days)
tretinoin CREA .025%, .05%, .1%; GEL .01%, .025%	1	QL (45 gm / 30 days), PA
zenatane CAPS 10mg, 20mg, 30mg, 40mg	1	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) CREA .1%; OINT .1%	1	QL (30 gm / 30 days)
mupirocin OINT 2%	1	QL (220 gm / 30 days)
silver sulfadiazine CREA 1%	1	
ssd CREA 1%	1	
SULFAMYLON CREA 85mg/gm	1	QL (453.6 gm / 30 days)
DERMATOLOGY, ANTIFUNGALS		
ciclopirox olamine CREA .77%	1	QL (90 gm / 30 days)
ciclopirox olamine SUSP .77%	1	QL (60 mL / 30 days)
clotrimazole (topical) CREA 1%	1	QL (45 gm / 30 days)
clotrimazole (topical) SOLN 1%	1	QL (30 mL / 30 days)
clotrimazole w/ betamethasone cream 1-0.05%	1	QL (45 gm / 30 days)
ketoconazole (topical) CREA 2%	1	QL (60 gm / 30 days)
nyamyc POWD 100000unit/gm	1	QL (60 gm / 30 days)
nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm	1	QL (30 gm / 30 days)
nystatin (topical) POWD 100000unit/gm	1	QL (60 gm / 30 days)
nystop POWD 100000unit/gm	1	QL (60 gm / 30 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin CAPS 10mg, 17.5mg, 25mg	1	PA
calcipotriene OINT .005%	1	QL (120 gm / 30 days), PA
calcipotriene SOLN .005%	1	QL (120 mL / 30 days), PA
calcitrene OINT .005%	1	QL (120 gm / 30 days), PA
tazarotene CREA .1%	1	QL (60 gm / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
TAZORAC CREA .05%	1	QL (60 gm / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) SHAM 2%	1	QL (120 mL / 30 days)
selenium sulfide LOTN 2.5%	1	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort CREA 1%, 2.5%	1	
alclometasone dipropionate CREA .05%; OINT .05%	1	QL (60 gm / 30 days)
betamethasone dipropionate (topical) CREA .05%; OINT .05%	1	QL (120 gm / 30 days)
betamethasone dipropionate (topical) LOTN .05%	1	QL (120 mL / 30 days)
betamethasone dipropionate augmented CREA .05%; GEL .05%; OINT .05%	1	QL (120 gm / 30 days)
betamethasone dipropionate augmented LOTN .05%	1	QL (120 mL / 30 days)
betamethasone valerate CREA .1%; OINT .1%	1	QL (120 gm / 30 days)
betamethasone valerate LOTN .1%	1	QL (120 mL / 30 days)
clobetasol propionate CREA .05%; GEL .05%; OINT .05%	1	QL (60 gm / 30 days)
clobetasol propionate SOLN .05%	1	QL (50 mL / 30 days)
clobetasol propionate e CREA .05%	1	QL (60 gm / 30 days)
ENSTILAR AER	1	QL (120 gm / 30 days), PA
fluocinolone acetonide CREA .01%	1	QL (60 gm / 30 days)
fluocinolone acetonide CREA .025%; OINT .025%	1	QL (120 gm / 30 days)
fluocinolone acetonide OIL .01%	1	QL (118.28 mL / 30 days)
fluocinolone acetonide SOLN .01%	1	QL (90 mL / 30 days)
fluocinonide CREA .05%	1	QL (120 gm / 30 days)
fluocinonide GEL .05%; OINT .05%	1	QL (60 gm / 30 days)
fluocinonide SOLN .05%	1	QL (60 mL / 30 days)
fluocinonide emulsified base CREA .05%	1	QL (120 gm / 30 days)
fluticasone propionate CREA .05%; OINT .005%	1	
halobetasol propionate CREA .05%; OINT .05%	1	QL (50 gm / 30 days)
hydrocortisone (topical) CREA 1%, 2.5%; LOTN 2.5%; OINT 2.5%	1	
mometasone furoate CREA .1%; OINT .1%; SOLN .1%	1	
triamcinolone acetonide (topical) CREA .1%	1	QL (454 gm / 30 days)

Drug Name	Drug Tier	Requirements/Limits
triamcinolone acetonide (topical) CREA .025%, .5%; LOTN .025%, .1%; OINT .025%, .1%, .5%	1	
DERMATOLOGY, LOCAL ANESTHETICS		
glydo PRSY 2%	1	QL (60 mL / 30 days), PA
lidocaine OINT 5%	1	QL (50 gm / 30 days), PA
lidocaine PTCH 5%	1	QL (3 patches / 1 day), PA
lidocaine hcl SOLN 4%	1	QL (50 mL / 30 days), PA
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30 gm / 30 days), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
bexarotene (topical) GEL 1%	1	QL (60 gm / 30 days), NM, PA
diclofenac sodium (topical) GEL 1%	1	QL (1000 gm / 30 days)
doxepin hcl (antipruritic) CREA 5%	1	QL (45 gm / 30 days), PA
EUCRISA OINT 2%	1	PA
fluorouracil (topical) CREA 5%	1	QL (40 gm / 30 days)
fluorouracil (topical) SOLN 2%, 5%	1	QL (10 mL / 30 days)
hydrocortisone (rectal) CREA 2.5%	1	
imiquimod CREA 5%	1	QL (24 packets / 30 days)
lactic acid (ammonium lactate) CREA 12%; LOTN 12%	1	
metronidazole (topical) CREA .75%; GEL .75%	1	QL (45 gm / 30 days)
metronidazole (topical) LOTN .75%	1	QL (59 mL / 30 days)
PANRETIN GEL .1%	1	QL (60 gm / 30 days), PA
podofilox SOLN .5%	1	QL (7 mL / 28 days)
procto-med hc CREA 2.5%	1	
procto-pak CREA 1%	1	
proctosol hc CREA 2.5%	1	
proctozone-hc CREA 2.5%	1	
RECTIV OINT .4%	1	QL (30 gm / 30 days)
tacrolimus (topical) OINT .03%, .1%	1	QL (100 gm / 30 days)
VALCHLOR GEL .016%	1	QL (60 gm / 30 days), NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
malathion LOTN .5%	1	QL (59 mL / 30 days)
permethrin CREA 5%	1	QL (60 gm / 30 days)

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01%	1	QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	1	QL (180 gm / 30 days)
sodium chloride (gu irrigant) SOLN .9%	1	
water for irrigation, sterile irrigation soln	1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl CAPS 30mg	1	
chlorhexidine gluconate (mouth-throat) SOLN .12%	1	
clotrimazole TROC 10mg	1	QL (150 lozenges / 30 days)
lidocaine hcl (mouth-throat) SOLN 2%	1	
nystatin (mouth-throat) SUSP 100000unit/ml	1	
periogard SOLN .12%	1	
pilocarpine hcl (oral) TABS 5mg, 7.5mg	1	
triamcinolone acetonide (mouth) PSTE .1%	1	

Index

A

abacavir sulfate 11
abacavir sulfate-lamivudine tab 600-300 mg 13
ABELCET 11
ABILIFY MAINTENA 38
abiraterone acetate 18
acamprosate calcium 44
acarbose 45
accutane 73
acebutolol hcl 29
acetaminophen w/ codeine soln 120-12 mg/5ml 8
acetaminophen w/ codeine tab 300-15 mg 8
acetaminophen w/ codeine tab 300-30 mg 8
acetaminophen w/ codeine tab 300-60 mg 8
acetazolamide 30
acetic acid 59
acetic acid (otic) 70
acetylcysteine 71
acitretin 74
ACTHIB INJ 64
ACTIMMUNE 64
acyclovir 14
acyclovir sodium 14
ADACEL INJ 64
adefovir dipivoxil 14
ADEMPAS 32
ADRENALIN 31
ADVAIR DISKU AER 100/50 73
ADVAIR DISKU AER 250/50 73
ADVAIR DISKU AER 500/50 73
ADVAIR HFA AER 115/21 73
ADVAIR HFA AER 230/21 73
ADVAIR HFA AER 45/21 73
afirmelle 49
AIMOVIG 42
ala-cort 75
albendazole 9
albuterol sulfate 71
alclometasone dipropionate 75
ALDURAZYME 55
ALECENSA 20
alendronate sodium 48
alfuzosin hcl 59
aliskiren fumarate 31
allopurinol 7
alosetron hcl 58
ALPHAGAN P 69
alprazolam 32
ALREX 69
altavera 49
ALUNBRIG 20
ALUNBRIG PAK 20
alyacen 1/35 49
alyacen 7/7/7 49
amabelz 53
amantadine hcl 37
ambrisentan 32
amethia 49
amikacin sulfate 9
amiloride & hydrochlorothiazide tab 5-50 mg 30
amiloride hcl 30
amiodarone hcl 28
amitriptyline hcl 36
amlodipine besylate 30
amlodipine besylate-benazepril hcl cap 10-20 mg 25
amlodipine besylate-benazepril hcl cap 10-40 mg 25
amlodipine besylate-benazepril hcl cap 2.5-10 mg 24
amlodipine besylate-benazepril hcl cap 5-10 mg 24
amlodipine besylate-benazepril hcl cap 5-20 mg 25
amlodipine besylate-benazepril hcl cap 5-40 mg 25
amlodipine besylate-olmesartan medoxomil tab 10-20 mg 26
amlodipine besylate-olmesartan medoxomil tab 10-40 mg 26
amlodipine besylate-olmesartan medoxomil tab 5-20 mg 26
amlodipine besylate-olmesartan medoxomil tab 5-40 mg 26
amlodipine besylate-valsartan tab 10-160 mg 26

amlodipine besylate-valsartan tab 10-320 mg 26
amlodipine besylate-valsartan tab 5-160 mg 26
amlodipine besylate-valsartan tab 5-320 mg 26
amnesteem 74
amoxapine 36
amoxicillin 16
amoxicillin & k clavulanate chew tab 200-28.5 mg 16
amoxicillin & k clavulanate chew tab 400-57 mg 16
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml 16
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml 16
amoxicillin & k clavulanate for susp 400-57 mg/5ml 16
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml 16
amoxicillin & k clavulanate tab 250-125 mg 16
amoxicillin & k clavulanate tab 500-125 mg 16
amoxicillin & k clavulanate tab 875-125 mg 16
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg 16
amphetamine-dextroamphetamine cap er 24hr 10 mg 41
amphetamine-dextroamphetamine cap er 24hr 15 mg 41
amphetamine-dextroamphetamine cap er 24hr 20 mg 41
amphetamine-dextroamphetamine cap er 24hr 25 mg 41
amphetamine-dextroamphetamine cap er 24hr 30 mg 41
amphetamine-dextroamphetamine cap er 24hr 5 mg 41
amphetamine-dextroamphetamine tab 10 mg 41
amphetamine-dextroamphetamine tab 12.5 mg 41
amphetamine-dextroamphetamine tab 15 mg 41
amphetamine-dextroamphetamine tab 20 mg 41
amphetamine-dextroamphetamine tab 30 mg 41
amphetamine-dextroamphetamine tab 5 mg 41
amphetamine-dextroamphetamine tab 7.5 mg 41
amphotericin b 11
amphotericin b liposome 11
ampicillin 16
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm 16
ampicillin & sulbactam sodium for inj 3 (2-1) gm 16
ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm 16
ampicillin & sulbactam sodium for iv soln 15 (10-5) gm 16
ampicillin & sulbactam sodium for iv soln 3 (2-1) gm 16
ampicillin sodium 16
anagrelide hcl 61
anastrozole 18
ANORO ELLIPT AER 62.5-25 70
aprepitant 57
aprepitant capsule therapy pack 80 & 125 mg 57
apri 49
APTIOM 32
APTIVUS 11
ARALAST NP 71
aranelle 49
ARCALYST 64
aripiprazole 38
ARISTADA 38
ARISTADA INITIO 38
armodafinil 44
ARNUITY ELLIPTA 73
asenapine maleate 38
ashlyna 49
aspirin-dipyridamole cap er 12hr 25-200 mg 61
atazanavir sulfate 12
atenolol 29
atenolol & chlorthalidone tab 100-25 mg 29

atenolol & chlorthalidone tab 50-25 mg 29
atomoxetine hcl 41
atorvastatin calcium 28
atovaquone 9
atovaquone-proguanil hcl tab 250-100 mg 11
atovaquone-proguanil hcl tab 62.5-25 mg 11
ATROPINE SULFATE 70
atropine sulfate (ophthalmic) 70
ATROVENT HFA 70
aubra eq 49
aurovela 1/20 49
aurovela 24 fe 49
aurovela fe 1/20 49
aurovela fe 1.5/30 49
AUSTEDO 43
AUSTEDO XR 43
AUVELITY TAB 45-105MG 36
aviane 49
avita 74
ayuna 49
AYVAKIT 20
azacitidine 18
azathioprine 64
azelastine hcl 71
azelastine hcl (ophth) 69
azithromycin 15
aztreonam 9
azurette 49
B
bacitracin (ophthalmic) 68
bacitracin-polymyxin b ophth oint 68
bacitracin-polymyxin-neomycin-hc ophth oint 1% 68
baclofen 44
BAFIERTAM 43
balsalazide disodium 58
BALVERSA 20
balziva 49
BARACLUDE 14
BASAGLAR KWIKPEN 47
BCG VACCINE 64
BD ALCOHOL SWABS 47
BELSOMRA 42
benazepril & hydrochlorothiazide tab 10-12.5 mg 25
benazepril & hydrochlorothiazide tab 20-12.5 mg 25
benazepril & hydrochlorothiazide tab 20-25 mg 25
benazepril & hydrochlorothiazide tab 5-6.25mg 25
benazepril hcl 25
BENDEKA 17
BENLYSTA 64
benzoyl peroxide-erythromycin gel 5-3% 74
benztropine mesylate 37
BERINERT 61
BESIVANCE 68
BESREMI 19
betaine powder for oral solution 55
betamethasone dipropionate (topical) 75
betamethasone dipropionate augmented 75
betamethasone valerate 75
BETASERON 43
betaxolol hcl 29
betaxolol hcl (ophth) 69
bethanechol chloride 59
BETOPTIC-S 69
BEVESPI AER 9-4.8MCG 70
bexarotene 19
bexarotene (topical) 76
BEXSERO INJ 64
bicalutamide 18
BICILLIN L-A 17
BIKTARVY TAB 30-120-15 MG 13
BIKTARVY TAB 50-200-25 MG 13
bisoprolol & hydrochlorothiazide tab 10-6.25 mg 29
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg 29
bisoprolol & hydrochlorothiazide tab 5-6.25 mg 29
bisoprolol fumarate 29
BIVIGAM 63
blisovi 24 fe 49
blisovi fe 1.5/30 49
BOOSTRIX INJ 64

bortezomib.....20
BORTEZOMIB 20
bosentan 32
BOSULIF.....20
BRAFTOVI.....20
BREO ELLIPTA INH 100-25 73
BREO ELLIPTA INH 200-25 73
BREZTRI AERO AER SPHERE.....70
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK) 70
briellyn 49
BRILINTA.....61
brimonidine tartrate 69
brinzolamide 69
BRIVIACT.....32
bromocriptine mesylate 37
BROMSITE 69
BRUKINSA 20
budesonide 58
budesonide (inhalation) 73
bumetanide.....30
buprenorphine hcl 44
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) 44
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) 44
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) 44
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) 44
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv) 44
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv) 45
bupropion hcl 36
bupropion hcl (smoking deterrent) ...45
buspirone hcl.....32
butorphanol tartrate.....8
BYDUREON BCISE 45
BYETTA.....45
C
cabergoline 55
CABOMETYX 20
calcipotriene.....74
calcitonin (salmon) spray 48
calcitrene.....74
calcitriol.....57
calcitriol (oral) 57
calcium acetate (phosphate binder) ..56
CALQUENCE 20
camila 49
camrese 49
camrese lo 49
candesartan cilexetil.....28
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg 26
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg 26
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg .26
CAPLYTA.....38
CAPRELSA.....20
captopril 25
captopril & hydrochlorothiazide tab 25-15 mg.....25
captopril & hydrochlorothiazide tab 25-25 mg.....25
captopril & hydrochlorothiazide tab 50-15 mg.....25
captopril & hydrochlorothiazide tab 50-25 mg.....25
carb/levo orally disintegrating tab 10-100mg.....37
carb/levo orally disintegrating tab 25-100mg.....37
carb/levo orally disintegrating tab 25-250mg.....38
carbamazepine 32
*carbidopa & levodopa tab 10-100 mg*38
*carbidopa & levodopa tab 25-100 mg*38
*carbidopa & levodopa tab 25-250 mg*38
carbidopa & levodopa tab er 25-100 mg 38
carbidopa & levodopa tab er 50-200 mg 38
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg.....38
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg 38
carbidopa-levodopa-entacapone tabs 25-100-200 mg.....38

carbidopa-levodopa-entacapone tabs 31.25-125-200 mg 38
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg 38
carbidopa-levodopa-entacapone tabs 50-200-200 mg 38
carboplatin 17
carglumic acid 55
carisoprodol 44
carteolol hcl (ophth) 69
cartia xt 30
carvedilol 29
caspofungin acetate 11
CAYSTON 9
cefaclor 14
CEFACLOR ER 15
cefadroxil 15
CEFAZOLIN 15
CEFAZOLIN INJ 1GM/50ML 15
cefazolin sodium 15
CEFAZOLIN SOLN 2GM/100ML-4% 15
cefdinir 15
cefepime hcl 15
cefixime 15
cefoxitin sodium 15
cefpodoxime proxetil 15
cefprozil 15
ceftazidime 15
CEFTAZIDIME/ SOL D5W 1GM 15
CEFTAZIDIME/ SOL D5W 2GM 15
ceftriaxone sodium 15
cefuroxime axetil 15
cefuroxime sodium 15
celecoxib 7
CELONTIN 32
cephalexin 15
CERDELGA 55
CEREZYME 55
cetirizine hcl 71
cevimeline hcl 77
chateal 49
CHEMET 49
chlorhexidine gluconate (mouth-throat) 77
chloroquine phosphate 11
chlorpromazine hcl 39
chlorthalidone 31
cholestyramine 29
cholestyramine light 29
ciclopirox olamine 74
cilostazol 61
CILOXAN 68
CIMDUO TAB 300-300 13
cinacalcet hcl 55
CIPRO 16
ciprofloxacin 200 mg/100ml in d5w ..16
ciprofloxacin 400 mg/200ml in d5w ..16
ciprofloxacin-dexamethasone otic susp 0.3-0.1% 70
ciprofloxacin hcl 16
ciprofloxacin hcl (ophth) 68
cisplatin 17
citalopram hydrobromide 36
claravis 74
clarithromycin 15
clindamycin hcl 9
clindamycin palmitate hydrochloride ...9
clindamycin phosphate 9
clindamycin phosphate (topical) 74
clindamycin phosphate in d5w iv soln 300 mg/50ml 9
clindamycin phosphate in d5w iv soln 600 mg/50ml 9
clindamycin phosphate in d5w iv soln 900 mg/50ml 9
clindamycin phosphate vaginal 60
CLINDMYC/NAC INJ 300/50ML 9
CLINDMYC/NAC INJ 600/50ML 9
CLINDMYC/NAC INJ 900/50ML 9
CLINIMIX INJ 4.25/D10 67
CLINIMIX INJ 4.25/D5W 67
CLINIMIX INJ 5%/D15W 67
CLINIMIX INJ 5%/D20W 67
CLINIMIX INJ 6/5 67
CLINIMIX INJ 8/10 67
CLINIMIX INJ 8/14 67
clinisol sf 15% 67
CLINOLIPID EMU 20% 67
clobazam 32, 33
clobetasol propionate 75
clobetasol propionate e 75
clomipramine hcl 36
clonazepam 33
clonidine 31

clonidine hcl 31
clopidogrel bisulfate 61
clorazepate dipotassium 33
clotrimazole 77
clotrimazole (topical) 74
clotrimazole w/ betamethasone cream 1-0.05% 74
clozapine 39
COARTEM TAB 20-120MG 11
colchicine 7
colchicine w/ probenecid tab 0.5-500 mg 7
colesevelam hcl 29
colestipol hcl 29
colistimethate sodium 9
COMBIGAN SOL 0.2/0.5% 69
COMBIVENT AER 20-100 70
COMETRIQ (60MG DOSE) 20
COMETRIQ KIT 100MG 20
COMETRIQ KIT 140MG 20
COMPLERA TAB 13
compro 57
constulose 58
COPIKTRA 20
CORLANOR 31
COTELLIC 20
CREON CAP 12000UNT 59
CREON CAP 24000UNT 59
CREON CAP 3000UNIT 59
CREON CAP 36000UNT 59
CREON CAP 6000UNIT 59
cromolyn sodium 71
cromolyn sodium (mastocytosis) 58
cromolyn sodium (ophth) 69
cryselle-28 50
cyclobenzaprine hcl 44
cyclophosphamide 17
CYCLOPHOSPHAMIDE 18
CYCLOPHOSPHAMIDE MONOHYDR 18
cycloserine 13
cyclosporine 64
cyclosporine modified (for microemulsion) 64
cyproheptadine hcl 71
cyred eq 50
CYSTADROPS 70
CYSTAGON 55
CYSTARAN 70
cytarabine 18

D

D10W/NACL INJ 0.2% 66
D2.5W/NACL INJ 0.45% 66
D5W/LYTES INJ #48 66
dabigatran etexilate mesylate 60
dalfampridine 43
danazol 53
dantrolene sodium 44
dapsone 9
DAPTACEL INJ 64
daptomycin 9
DAPTOMYCIN 9
darunavir 12
dasetta 1/35 50
dasetta 7/7/7 50
DAURISMO 20
daysee 50
DAYVIGO 42
deblitane 50
deferasirox 49
DELESTROGEN 53
DELSTRIGO TAB 13
DENGVAXIA SUS 64
depo-testosterone 45
DESCOVY TAB 120-15MG 13
DESCOVY TAB 200/25MG 13
desipramine hcl 36
desmopressin acetate 55
desmopressin acetate spray 55
desmopressin acetate spray refrigerated 55
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5) 50
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg 50
desvenlafaxine succinate 36
dexamethasone 54
DEXAMETHASONE INTENSOL 54
dexamethasone sodium phosphate 54
dexamethasone sodium phosphate (ophth) 69
dexmethylphenidate hcl 41
dextrose 67
dextrose 10% w/ sodium chloride 0.45% 66

dextrose 2.5% w/ sodium chloride 0.45% 66
dextrose 5% in lactated ringers 66
dextrose 5% w/ sodium chloride 0.2% 66
dextrose 5% w/ sodium chloride 0.225% 66
dextrose 5% w/ sodium chloride 0.3% 66
dextrose 5% w/ sodium chloride 0.45% 66
dextrose 5% w/ sodium chloride 0.9% 66
DIACOMIT 33
diazepam 33
diazepam (anticonvulsant) 33
diazepam inj 33
diazoxide 54
diclofenac potassium 7
diclofenac sodium 7
diclofenac sodium (ophth) 69
diclofenac sodium (topical) 76
dicloxacillin sodium 17
dicyclomine hcl 57
DIFICID 15
diflunisal 7
difluprednate 69
digoxin 31
dihydroergotamine mesylate 42
DILANTIN 33
DILANTIN-125 33
DILANTIN INFATABS 33
diltiazem hcl 30
diltiazem hcl coated beads 30
diltiazem hcl extended release beads 30
dilt-xr 30
DIP/TET PED INJ 25-5LFU 65
diphenhydramine hcl 71
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml 58
diphenoxylate w/ atropine tab 2.5-0.025 mg 58
dipyridamole 61
disopyramide phosphate 28
disulfiram 45
divalproex sodium 33
docetaxel 19
DOCETAXEL 20
dofetilide 28
donepezil hydrochloride 36
DOPTELET 61
dorzolamide hcl 69
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml 69
dotti 53
DOVATO TAB 50-300MG 13
doxazosin mesylate 26
doxepin hcl 36
doxepin hcl (antipruritic) 76
doxepin hcl (sleep) 42
doxorubicin hcl 18
doxorubicin hcl liposomal 18
doxy 100 17
doxycycline (monohydrate) 17
doxycycline hyclate 17
DRIZALMA SPRINKLE 36
dronabinol 57
drospirenone-ethinyl estradiol tab 3-0.02 mg 50
drospirenone-ethinyl estradiol tab 3-0.03 mg 50
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg 50
DROXIA 61
droxidopa 31
duloxetine hcl 36
DUPIXENT 62
dutasteride 59
dutasteride-tamsulosin hcl cap 0.5-0.4 mg 59

E

e.e.s. 400 15
ec-naproxen 7
EDURANT 12
efavirenz 12
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg 13
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg 13
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg 13
ELIGARD 18
elinest 50
ELIQUIS 60

ELIQUIS STARTER PACK 60
ELLENCE.....18
eluryng.....50
EMCYT.....18
emoquette 50
EMSAM 36
emtricitabine 12
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg 13
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg 13
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg 13
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg 13
EMTRIVA.....12
EMVERM 9
enalapril maleate 26
enalapril maleate & hydrochlorothiazide tab 10-25 mg 25
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg 25
ENBREL 62
ENBREL MINI.....62
ENBREL SURECLICK 62
ENDARI 61
endocet tab 10-325mg 8
endocet tab 2.5-325mg 8
endocet tab 5-325mg 8
endocet tab 7.5-325mg 8
ENGERIX-B 65
enoxaparin sodium.....60
enpresse-28 50
enskyce 50
ENSTILAR AER.....75
entacapone 38
entecavir 14
ENTRESTO TAB 24-26MG 26
ENTRESTO TAB 49-51MG 26
ENTRESTO TAB 97-103MG 27
enulose.....58
EPCLUSA PAK 150-37.5 14
EPCLUSA PAK 200-50MG.....14
EPCLUSA TAB 200-50MG.....14
EPCLUSA TAB 400-100 14
EPIDIOLEX 33
epinephrine (anaphylaxis).....31, 72
epitol.....33
EPIVIR HBV 14
eplerenone 26
EPRONTIA 33
ergotamine w/ caffeine tab 1-100 mg 42
ERIVEDGE.....20
ERLEADA 18
erlotinib hcl 20
errin.....50
ertapenem sodium 9
ery.....74
ery-tab 15
ERYTHROCIN LACTOBIONATE 15
erythrocin stearate.....15
erythromycin (acne aid).....74
erythromycin (ophth) 68
erythromycin base 15
erythromycin ethylsuccinate 15
erythromycin lactobionate 15
escitalopram oxalate 37
esomeprazole magnesium 59
estarylla 50
estradiol 53
estradiol & norethindrone acetate tab 0.5-0.1 mg.....54
estradiol & norethindrone acetate tab 1-0.5 mg.....54
estradiol vaginal 54
estradiol valerate 54
eszopiclone 42
ethambutol hcl 13
ethosuximide.....33
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg 50
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg 50
etodolac 7
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr 50
etoposide.....20
etravirine 12
EUCRISA.....76
EULEXIN 18
euthyrox.....56
everolimus.....20, 21
everolimus (immunosuppressant).....64

EVOTAZ TAB 300-150 13
exemestane 18
EXKIVITY 21
EYSUVIS 69
ezetimibe 29
ezetimibe-simvastatin tab 10-10 mg 29
ezetimibe-simvastatin tab 10-20 mg 29
ezetimibe-simvastatin tab 10-40 mg 29
ezetimibe-simvastatin tab 10-80 mg 29
F
FABRAZYME 55
falmina 50
famciclovir 14
famotidine 57, 58
famotidine in nacl 0.9% iv soln 20 mg/50ml 58
FANAPT 39
FANAPT PAK 39
FARXIGA 45
FASENRA 72
FASENRA PEN 72
felbamate 33
felodipine 30
femynor 50
fenofibrate 28
fenofibrate micronized 28
fentanyl 7
fentanyl citrate 8
fesoterodine fumarate 59
FETZIMA 37
FETZIMA CAP TITRATIO 37
FIASP FLEX INJ TOUCH 47
FIASP INJ 100/ML 47
FIASP PENFIL INJ U-100 47
finasteride 59
fingolimod hcl 43
FINTEPLA 33
finzala 50
flac 70
FLAREX 69
FLEBOGAMMA DIF 63
flecainide acetate 28
FLOVENT DISKUS 73
FLOVENT HFA 73
fluconazole 11
fluconazole in nacl 0.9% inj 200 mg/100ml 11
fluconazole in nacl 0.9% inj 400 mg/200ml 11
flucytosine 11
fludrocortisone acetate 54
flunisolide (nasal) 73
fluocinolone acetonide 75
fluocinolone acetonide (otic) 70
fluocinonide 75
fluocinonide emulsified base 75
fluorometholone (ophth) 69
fluorouracil 18
fluorouracil (topical) 76
fluoxetine hcl 37
fluphenazine decanoate 39
fluphenazine hcl 39
flurbiprofen 7
flurbiprofen sodium 69
fluticasone propionate 75
fluticasone propionate (nasal) 73
fluvoxamine maleate 32
fondaparinux sodium 60
FORTEO 48
fosamprenavir calcium 12
fosinopril sodium 26
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg 25
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg 25
FOTIVDA 21
FREAMINE III INJ 10% 67
fulvestrant 18
furosemide 31
furosemide inj 31
FUZEON 12
fyavolv tab 0.5mg-2.5mcg 54
fyavolv tab 1mg-5mcg 54
FYCOMPA 33, 34
G
gabapentin 34
galantamine hydrobromide 36
GAMASTAN INJ 63
GAMMAGARD LIQUID 63
GAMMAGARD S/D IGA LESS TH 63
GAMMAKED 63
GAMMAPLEX 63
GAMUNEX-C 63
ganciclovir sodium 14

GARDASIL 9 INJ 65
gatifloxacin (ophth) 68
GATTEX 58
GAUZE PADS 2 47
gavilyte-c 58
gavilyte-g 58
GAVRETO 21
gefitinib 21
gemcitabine hcl 18
gemfibrozil 28
GEMTESA 60
generlac 58
gengraf 64
GENOTROPIN 55
GENOTROPIN MINIQUICK 55
gentak 68
gentamicin in saline inj 0.8 mg/ml 9
gentamicin in saline inj 1.2 mg/ml 9
gentamicin in saline inj 1.6 mg/ml 9
gentamicin in saline inj 1 mg/ml 9
gentamicin in saline inj 2 mg/ml 9
gentamicin sulfate 9
gentamicin sulfate (ophth) 68
gentamicin sulfate (topical) 74
GENVOYA TAB 13
GILOTRIF 21
glatiramer acetate 44
glatopa 44
GLEOSTINE 18
glimepiride 45
glipizide 45
glipizide-metformin hcl tab 2.5-250 mg 45
glipizide-metformin hcl tab 2.5-500 mg 45
glipizide-metformin hcl tab 5-500 mg 46
glipizide xl 45
glycopyrrolate 57
glydo 76
GLYXAMBI TAB 10-5 MG 46
GLYXAMBI TAB 25-5 MG 46
GOLYTELY SOL 58
granisetron hcl 57
griseofulvin microsize 11
griseofulvin ultramicrosize 11
guanfacine hcl 31
guanfacine hcl (adhd) 41
GVOKE HYPOPEN 2-PACK 55
GVOKE KIT 55
GVOKE PFS 55
H
HAEGARDA 61
hailey 1.5/30 50
hailey 24 fe 50
halobetasol propionate 75
haloperidol 39
haloperidol decanoate 39
haloperidol lactate 39
HARVONI PAK 33.75-150MG 14
HARVONI PAK 45-200MG 14
HARVONI TAB 45-200MG 14
HARVONI TAB 90-400MG 14
HAVRIX 65
heather 50
HEPARIN/NACL INJ 25000UNT 60
heparin sodium (porcine) 60
HEPLISAV-B 65
HEP SOD/D5W INJ 20000UNT 60
HEP SOD/D5W INJ 25000UNT 60
HEP SOD/NACL INJ 12500UNT 60
HEP SOD/NACL INJ 25000UNT 60
HERCEP HYLEC SOL 60-10000 21
HERCEPTIN 21
HERZUMA 21
HIBERIX 65
HUMIRA 62
HUMIRA PEDIA INJ CROHNS 62
HUMIRA PEDIATRIC CROHNS D 62
HUMIRA PEN 62
HUMIRA PEN-CD/UC/HS START 62
HUMIRA PEN KIT PS/UV 62
HUMIRA PEN-PEDIATRIC UC S 62
HUMIRA PEN-PS/UV STARTER 62
HUMULIN R U-500 (CONCENTR 47
HUMULIN R U-500 KWIKPEN 47
hydralazine hcl 31
hydrochlorothiazide 31
hydrocodone-acetaminophen soln 7.5-325 mg/15ml 8
hydrocodone-acetaminophen tab 10-325 mg 8
hydrocodone-acetaminophen tab 5-325 mg 8

hydrocodone-acetaminophen tab 7.5-325 mg 8
hydrocodone bitartrate 7
hydrocodone-ibuprofen tab 7.5-200 mg 8
hydrocortisone 54
hydrocortisone (intrarectal) 58
hydrocortisone (rectal) 76
hydrocortisone (topical) 75
hydromorphone hcl 8
hydroxychloroquine sulfate 63
hydroxyurea 19
hydroxyzine hcl 71
hydroxyzine pamoate 71
HYSINGLA ER 7
I
ibandronate sodium 48
IBRANCE 21
ibu 7
ibuprofen 7
icatibant acetate 61
iclevia 50
ICLUSIG 21
IDHIFA 21
ILEVRO 69
imatinib mesylate 21
IMBRUVICA 21
imipenem-cilastatin intravenous for soln 250 mg 10
imipenem-cilastatin intravenous for soln 500 mg 10
imipramine hcl 37
imiquimod 76
IMOVAX RABIES (H.D.C.V.) 65
incassia 50
INCRELEX 55
INCRUSE ELLIPTA 70
indapamide 31
INFANRIX INJ 65
INFLIXIMAB 62
INGREZZA 43
INGREZZA CAP 40-80MG 43
INLYTA 21
INQOVI TAB 35-100MG 18
INREBIC 21
INSULIN PEN NEEDLES: BD/NOVO 47
INSULIN SAFETY NEEDLES 47
INSULIN SYRINGES: BD 47
INTELENCE 12
INTRALIPID 67
INTRON A 64
introvale 50
INVEGA HAFYERA 39
INVEGA SUSTENNA 39
INVEGA TRINZA 39
IPOL INJ INACTIVE 65
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml 70
ipratropium bromide 70
ipratropium bromide (nasal) 70
irbesartan 28
irbesartan-hydrochlorothiazide tab 150-12.5 mg 27
irbesartan-hydrochlorothiazide tab 300-12.5 mg 27
IRESSA 21
irinotecan hcl 19
ISENTRESS 12
ISENTRESS HD 12
isibloom 50
ISOLYTE-P INJ /D5W 66
ISOLYTE-S INJ 66
ISOLYTE-S INJ PH 7.4 66
isoniazid 13
ISOPTO ATROPINE 70
isosorbide dinitrate 31
isosorbide mononitrate 32
isotretinoin 74
isradipine 30
itraconazole 11
ivermectin 10
IXIARO INJ 65
J
JAKAFI 21
jantoven 60
JANUMET TAB 50-1000 46
JANUMET TAB 50-500MG 46
JANUMET XR TAB 100-1000 46
JANUMET XR TAB 50-1000 46
JANUMET XR TAB 50-500MG 46
JANUVIA 46
JARDIANCE 46
jasmiel 50
javygtor 55

JAYPIRCA.....21
JENTADUETO TAB 2.5-1000.....46
JENTADUETO TAB 2.5-500.....46
JENTADUETO TAB 2.5-850.....46
JENTADUETO TAB XR 2.5-1000MG...46
JENTADUETO TAB XR 5-1000MG.....46
jinteli.....54
jolessa.....50
juleber.....50
JULUCA TAB 50-25MG.....13
junel 1/20.....50
junel 1.5/30.....50
junel fe 1/20.....50
junel fe 1.5/30.....50
junel fe 24.....50
K
KADCYLA.....21
kaitlib fe.....51
KALYDECO.....72
KANJINTI.....21
kariva.....51
KCL/D5W/NACL INJ 0.3/0.9%.....66
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj.....66
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj.....66
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj.....66
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj.....66
kcl 20 meq/l (0.15%) in nacl 0.45% inj.....66
kcl 20 meq/l (0.15%) in nacl 0.9% inj.....66
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj.....66
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj.....66
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj.....66
*kcl 40 meq/l (0.3%) in nacl 0.9% inj*66
kelnor 1/35.....51
kelnor 1/50.....51
KERENDIA.....26
KESIMPTA.....44
ketoconazole.....11
ketoconazole (topical).....74, 75
ketorolac tromethamine (ophth).....69
KEVZARA.....62
KEYTRUDA.....21
KINRIX INJ.....65
KISQALI 200 DOSE.....22
KISQALI 200 PAK FEMARA.....19
KISQALI 400 DOSE.....22
KISQALI 400 PAK FEMARA.....19
KISQALI 600 DOSE.....22
KISQALI 600 PAK FEMARA.....19
klor-con.....67
klor-con 10.....67
klor-con 8.....67
klor-con m10.....67
klor-con m15.....67
klor-con m20.....67
KORLYM.....55
KRAZATI.....22
kurvelo.....51
L
labetalol hcl.....29
lacosamide.....34
lacosamide oral.....34
lactated ringer's solution.....66
lactic acid (ammonium lactate).....76
lactulose.....58
lactulose (encephalopathy).....58
lamivudine.....12
lamivudine (hbv).....14
lamivudine-zidovudine tab 150-300 mg.....13
lamotrigine.....34
lansoprazole.....59
LANTUS.....47
LANTUS SOLOSTAR.....47
lapatinib ditosylate.....22
larin 1/20.....51
larin 1.5/30.....51
larin 24 fe.....51
larin fe 1/20.....51
larin fe 1.5/30.....51
latanoprost.....69
LATUDA.....39
layolis fe.....51
leena.....51
leflunomide.....63
lenalidomide.....19

LENVIMA 10 MG DAILY DOSE 22
LENVIMA 12MG DAILY DOSE 22
LENVIMA 20 MG DAILY DOSE 22
LENVIMA 4 MG DAILY DOSE 22
LENVIMA 8 MG DAILY DOSE 22
LENVIMA CAP 14 MG 22
LENVIMA CAP 18 MG 22
LENVIMA CAP 24 MG 22
lessina 51
letrozole 18
leucovorin calcium 24
LEUKERAN 18
leuprolide acetate 18
levalbuterol hcl 71
levalbuterol tartrate 71
LEVEMIR 47
LEVEMIR FLEXPEN 47
LEVEMIR FLEXTOUCH 47
levetiracetam 34
levetiracetam in sodium chloride iv soln 1000 mg/100ml 34
levetiracetam in sodium chloride iv soln 1500 mg/100ml 34
levetiracetam in sodium chloride iv soln 500 mg/100ml 34
levobunolol hcl 69
levocarnitine (metabolic modifiers) ...55
levocetirizine dihydrochloride 71
levofloxacin 16
levofloxacin in d5w iv soln 250 mg/50ml 16
levofloxacin in d5w iv soln 500 mg/100ml 16
levofloxacin in d5w iv soln 750 mg/150ml 16
levonest 51
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg 51
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg 51
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg 51
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg 51
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg 51
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7) 51
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7) 51
levora 0.15/30-28 51
levothyroxine sodium 56
levoxyl 56
LEXIVA 12
lidocaine 76
lidocaine hcl 76
lidocaine hcl (local anesth.) 9
lidocaine hcl (mouth-throat) 77
lidocaine-prilocaine cream 2.5-2.5% .76
lillow 51
linezolid 10
linezolid in sodium chloride iv soln 600 mg/300ml-0.9% 10
LINZESS 58
liothyronine sodium 56
lisinopril 26
lisinopril & hydrochlorothiazide tab 10-12.5 mg 25
lisinopril & hydrochlorothiazide tab 20-12.5 mg 25
lisinopril & hydrochlorothiazide tab 20-25 mg 25
lithium carbonate 43
loestrin 1/20-21 51
loestrin 1.5/30-21 51
loestrin fe 1/20 51
loestrin fe 1.5/30 51
LOKELMA 49
LONSURF TAB 15-6.14 18
LONSURF TAB 20-8.19 18
loperamide hcl 59
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml) 13
lopinavir-ritonavir tab 100-25 mg 13
lopinavir-ritonavir tab 200-50 mg 13
lorazepam 32
lorazepam intensol 32
LORBRENA 22
loryna 51
losartan potassium 28
losartan potassium & hydrochlorothiazide tab 100-12.5 mg 27

*losartan potassium & hydrochlorothiazide tab 100-25 mg*27
losartan potassium & hydrochlorothiazide tab 50-12.5 mg 27
LOTEMAX 69
lovastatin 28
low-ogestrel 51
loxapine succinate 39
LUMAKRAS 22
LUMIGAN 69
LUMIZYME 55
LUPRON DEPOT (1-MONTH) 19
LUPRON DEPOT (3-MONTH) 19
LUPRON DEPOT-PED (1-MONTH 55
LUPRON DEPOT-PED (3-MONTH 55
LUPRON DEPOT-PED (6-MONTH 55
lurasidone hcl 39
lutera 51
lyleq 51
lyllana 54
LYNPARZA 22
LYSODREN 19
LYTGOBI 22
lyza 51
M
magnesium sulfate 66
MAGNESIUM SULFATE 66
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml 66
malathion 76
maraviroc 12
marlissa 51
MARPLAN 37
MATULANE 19
MAVYRET PAK 50-20MG 14
MAVYRET TAB 100-40MG 14
meclizine hcl 57
medroxyprogesterone acetate 56
medroxyprogesterone acetate (contraceptive) 51
mefloquine hcl 11
megestrol acetate 19, 56
megestrol acetate (appetite) 56
MEKINIST 22
MEKTOVI 22
meloxicam 7
memantine hcl 36
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack 36
MENACTRA INJ 65
MENQUADFI INJ 65
MENVEO INJ 65
MENVEO SOL 65
mercaptopurine 18
meropenem 10
mesalamine 58
mesalamine w/ cleanser 58
MESNEX 24
metadate er 41
metformin hcl 46
methadone hcl 7
methadone hydrochloride i 7
methazolamide 31
methenamine hippurate 10
methimazole 56
methocarbamol 44
methotrexate sodium 18, 63
methsuximide 34
methylphenidate hcl 41, 42
methylprednisolone 54
methylprednisolone acetate 54
methylprednisolone sod succ 54
metoclopramide hcl 57
metolazone 31
metoprolol & hydrochlorothiazide tab 100-25 mg 29
metoprolol & hydrochlorothiazide tab 100-50 mg 29
metoprolol & hydrochlorothiazide tab 50-25 mg 29
metoprolol succinate 29
metoprolol tartrate 30
metronidazole 10
metronidazole (topical) 76
metronidazole vaginal 60
metyrosine 31
MG SO4/D5W INJ 10MG/ML 66
micafungin sodium 11
microgestin 1/20 51
microgestin 1.5/30 51
microgestin 24 fe 51
microgestin fe 1/20 52
microgestin fe 1.5/30 51

midodrine hcl 31
miglustat 55
mili 52
mimvey 54
minocycline hcl 17
minoxidil 31
mirtazapine 37
misoprostol 59
MITIGARE 7
M-M-R II INJ 65
M-NATAL PLUS TAB 67
moexipril hcl 26
molindone hcl 39
mometasone furoate 75
MONJUVI 22
mono-linyah 52
montelukast sodium 71
morphine sulfate 8
MORPHINE SULFATE 8
MORPHINE SULFATE/SODIUM C 8
MOVANTIK 59
moxifloxacin hcl 16
moxifloxacin hcl (ophth) 68
MULTAQ 28
mupirocin 74
MVASI 22
mycophenolate mofetil 64
mycophenolate sodium 64
MYRBETRIQ 60

N

nabumetone 7
nadolol 30
nafcillin sodium 17
NAGLAZYME 55
nalbuphine hcl 8
naloxone hcl 45
naltrexone hcl 45
NAMZARIC CAP 14-10MG 36
NAMZARIC CAP 21-10MG 36
NAMZARIC CAP 28-10MG 36
NAMZARIC CAP 7-10MG 36
NAMZARIC CAP PACK 36
naproxen 7
naproxen sodium 7
naratriptan hcl 42
NATACYN 68
nateglinide 46
NATPARA 48
NAYZILAM 34
nebivolol hcl 30
necon 0.5/35-28 52
nefazodone hcl 37
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin 68
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml ..68
neomycin-polymyxin-dexamethasone ophth oint 0.1% 68
neomycin-polymyxin-dexamethasone ophth susp 0.1% 68
neomycin-polymyxin-hc ophth susp ..68
neomycin-polymyxin-hc otic soln 1% 70
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1% 70
neomycin sulfate 10
neo-polycin 5(3.5)mg-400unt-10000unt op oin 68
neo-polycin hc ophth oint 1% 68
NERLYNX 22
NEUPRO 38
nevirapine 12
NEXAVAR 22
niacin (antihyperlipidemic) 29
nicardipine hcl 30
NICOTROL INHALER 45
NICOTROL NS 45
nifedipine 30
nikki 52
nilutamide 19
nimodipine 30
NINLARO 22
nitazoxanide 10
nitisinone 55
NITRO-BID 32
nitrofurantoin macrocrystal 10
nitrofurantoin monohyd macro 10
nitroglycerin 32
nizatidine 58
nora-be 52
norethindrone (contraceptive) 52
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg 52
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg 52

norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg 52
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg.....52
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg 52
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24) 52
norethindrone acetate.....56
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg.....54
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg 54
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg 52
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg 52
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg 52
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg 52
norlyroc.....52
NORPACE CR.....28
nortrel 0.5/35 (28).....52
nortrel 1/35 (21) 52
nortrel 1/35 (28) 52
nortrel 7/7/7 52
nortriptyline hcl 37
NORVIR.....12
NOVOLIN INJ 70/30 47
NOVOLIN INJ 70/30 FP 47
NOVOLIN N 47
NOVOLIN N FLEXPEN 47
NOVOLIN R 47
NOVOLIN R FLEXPEN 47
NOVOLOG 47
NOVOLOG FLEXPEN.....47
NOVOLOG MIX INJ 70/30 48
NOVOLOG MIX INJ FLEXPEN 48
NOVOLOG PENFILL.....48
NOXAFIL.....11
NUBEQA 19
NUEDEXTA CAP 20-10MG.....43
NULOJIX 64
NUPLAZID.....39
NURTEC.....43
NUTRILIPID.....67
NUZYRA.....17
nyamyc 74
nylia 1/35 52
nylia 7/7/7 52
NYMALIZE.....30
nymyo.....52
nystatin 11
nystatin (mouth-throat) 77
nystatin (topical) 74
nystop.....74
O
ocella 52
OCTAGAM 64
octreotide acetate 55
ODEFSEY TAB.....13
ODOMZO 22
OFEV.....72
ofloxacin (ophth) 68
ofloxacin (otic) 70
OGIVRI.....22
OGIVRI INJ 420MG.....22
olanzapine 39, 40
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg 27
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg 27
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg 27
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg 27
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg 27
olmesartan medoxomil.....28
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg 27
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg 27
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg .27
olopatadine hcl 69

omeprazole 59
OMNIPOD 5 G6 KIT INTRO 48
OMNIPOD 5 G6 MIS PODS.....48
OMNIPOD DASH KIT INTRO.....48
OMNIPOD DASH MIS PODS 48
OMNIPOD GO KIT 10UNT/DY 48
OMNIPOD GO KIT 15UNT/DY 48
OMNIPOD GO KIT 20UNT/DY 48
OMNIPOD GO KIT 25UNT/DY 48
OMNIPOD GO KIT 30UNT/DY 48
OMNIPOD GO KIT 35UNT/DY 48
OMNIPOD GO KIT 40UNT/DY 48
OMNIPOD MIS CLASSIC.....48
OMNIPOD PDM KIT CLASSIC.....48
ondansetron 57
ondansetron hcl 57
ONTRUZANT.....22
ONUREG 18
OPSUMIT 32
ORGOVYX 19
ORKAMBI GRA 100-125 72
ORKAMBI GRA 150-188 72
ORKAMBI GRA 75-94MG 72
ORKAMBI TAB 100-125.....72
ORKAMBI TAB 200-125.....72
ORSERDU 19
oseltamivir phosphate.....14
OTEZLA 62
OTEZLA TAB 10/20/30.....62
oxacillin sodium 17
oxaliplatin 18
oxandrolone 45
oxcarbazepine 34
oxybutynin chloride 60
oxycodone hcl 8
oxycodone w/ acetaminophen tab 10-325 mg.....9
oxycodone w/ acetaminophen tab 2.5-325 mg.....8
oxycodone w/ acetaminophen tab 5-325 mg.....8
oxycodone w/ acetaminophen tab 7.5-325 mg.....9
OZEMPIC (0.25 OR 0.5MG/DOSE) 46
OZEMPIC (1MG/DOSE) 46
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML 46

P

pacerone 28
paclitaxel 20
paclitaxel protein-bound particles for iv susp 100 mg 20
paliperidone 40
pamidronate disodium 49
PAMIDRONATE DISODIUM.....49
PANRETIN 76
pantoprazole sodium 59
PANZYGA.....64
paraplatin 18
paricalcitol 57
paromomycin sulfate 10
paroxetine hcl.....37
PEDIARIX INJ 0.5ML.....65
PEDVAX HIB.....65
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm 58
peg 3350-kcl-sod bicarb-nacl for soln 420 gm.....58
PEGASYS 14
PEMAZYRE 22
pemetrexed disodium 18
PEN GK/DEXTR INJ 40000/ML.....17
PEN GK/DEXTR INJ 60000/ML.....17
penicillamine 49
penicillin g potassium 17
PENICILLIN G PROCAINE.....17
penicillin g sodium 17
penicillin v potassium 17
PENTACEL INJ 65
pentamidine isethionate inh.....10
pentamidine isethionate inj 10
pentoxifylline.....61
perindopril erbumine 26
periogard 77
permethrin.....76
perphenazine.....40
PERSERIS 40
pfizerpen 17
phenelzine sulfate 37
phenobarbital 34
phenobarbital sodium 34
PHENYTEK.....34
phenytoin 34
phenytoin sodium 34

phenytoin sodium extended.....34
PHESGO SOL.....22
philith.....52
PIFELTRO.....12
pilocarpine hcl.....69
pilocarpine hcl (oral).....77
pimozide.....40
pimtrea.....52
pindolol.....30
pioglitazone hcl.....46
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm).....17
piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm).....17
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm).....17
piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm).....17
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm).....17
PIQRAY 200MG DAILY DOSE.....22
PIQRAY 250MG TAB DOSE.....22
PIQRAY 300MG DAILY DOSE.....22
pirfenidone.....72
pirmella 1/35.....52
piroxicam.....7
PLASMA-LYTE INJ -148.....66
PLASMA-LYTE INJ -A.....66
plenamine.....67
PLENVU SOL.....58
podofilox.....76
polycin ophth oint.....68
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%.....68
POMALYST.....19
portia-28.....52
posaconazole.....11
potassium chloride.....67
POTASSIUM CHLORIDE.....67
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj.....67
potassium chloride microencapsulated crystals er.....67
potassium citrate (alkalinizer).....59
POT CHL 20MEQ/L IN NACL 0.45% INJ.....67
POT CHL 20MEQ/L IN NACL 0.9% INJ.....66
POT CHL 40MEQ/L IN NACL 0.9% INJ.....67
PRADAXA.....60
PRALUENT.....29
pramipexole dihydrochloride.....38
prasugrel hcl.....61
pravastatin sodium.....28
praziquantel.....10
prazosin hcl.....26
prednisolone.....54
prednisolone acetate (ophth).....69
PREDNISOLONE SODIUM PHOSP.....69
prednisolone sodium phosphate.....54
prednisone.....54
PREDNISONE INTENSOL.....54
pregabalin.....34
PREHEVBRIO.....65
PREMASOL SOL 10%.....68
PRENATAL TAB 27-1MG.....67
PRENATAL TAB PLUS.....67
prevalite.....29
PREVYMIS.....14
PREZCOBIX TAB 800-150.....13
PREZISTA.....12
PRIFTIN.....13
primaquine phosphate.....11
PRIMAQUINE PHOSPHATE.....11
primidone.....34
PRIORIX INJ.....65
PRIVIGEN.....64
probenecid.....7
prochlorperazine.....57
prochlorperazine edisylate.....57
prochlorperazine maleate.....57
PROCRIT.....61
procto-med hc.....76
procto-pak.....76
proctosol hc.....76
proctozone-hc.....76
PROGRAF.....64
PROLASTIN-C.....72
PROLENSA.....69
PROLIA.....49
PROMACTA.....61
promethazine hcl.....57

propafenone hcl 28
proparacaine hcl 70
propranolol hcl 30
propylthiouracil 56
PROQUAD INJ 65
PROSOL INJ 20% 68
protriptyline hcl 37
PULMICORT FLEXHALER 73
PULMOZYME 72
PURIXAN 18
pyrazinamide 13
pyridostigmine bromide 43
Q
QINLOCK 23
QUADRACEL INJ 65
QUADRACEL INJ 0.5ML 65
quetiapine fumarate 40
quinapril hcl 26
quinapril-hydrochlorothiazide tab 10-12.5 mg 25
quinapril-hydrochlorothiazide tab 20-12.5 mg 25
quinapril-hydrochlorothiazide tab 20-25 mg 25
quinidine sulfate 28
quinine sulfate 11
R
RABAVERT INJ 65
rabeprazole sodium 59
raloxifene hcl 55
ramipril 26
ranolazine 31
rasagiline mesylate 38
RAYALDEE 57
reclipsen 52
RECOMBIVAX HB 65
RECTIV 76
REGRANEX 77
RELENZA DISKHALER 14
RELISTOR 59
REMICADE 62
RENFLEXIS 62
repaglinide 46
RESTASIS 70
RESTASIS MULTIDOSE 70
RETEVMO 23
REVLIMID 19
REXULTI 40
REYATAZ 12
REZLIDHIA 23
REZUROCK 64
RHOPRESSA 69
ribavirin (hepatitis c) 14
rifabutin 14
rifampin 14
riluzole 43
rimantadine hydrochloride 14
RINVOQ 62
risedronate sodium 49
RISPERDAL CONSTA 40
risperidone 40
ritonavir 12
rivastigmine 36
rivastigmine tartrate 36
rivelsa 52
rizatriptan benzoate 43
ROCKLATAN DRO 69
roflumilast 72
ropinirole hydrochloride 38
rosuvastatin calcium 28
ROTARIX SUS 65
ROTATEQ SOL 65
roweepra 35
ROZLYTREK 23
RUBRACA 23
rufinamide 35
RUKOBIA 12
RYBELSUS 46
RYDAPT 23
S
sajazir 61
SANDIMMUNE 64
SANTYL 77
sapropterin dihydrochloride 56
SCEMBLIX 23
scopolamine 57
SECUADO 40
selegiline hcl 38
selenium sulfide 75
SELZENTRY 12
SEREVENT DISKUS 71
sertraline hcl 37
setlakin 52
sevelamer carbonate 56

sharobel 52
SHINGRIX.....65
SIGNIFOR.....56
sildenafil citrate (pulmonary hypertension) 32
silver sulfadiazine.....74
SIMBRINZA SUS 1-0.2%.....69
simliya 52
simpesse 52
simvastatin 29
sirolimus.....64
SIRTURO 14
SIVEXTRO.....10
SKYRIZI.....63
SKYRIZI PEN 63
sodium chloride 67
sodium chloride (gu irrigant) 77
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln.....67
SODIUM OXYBATE.....44
sodium phenylbutyrate 56
sodium polystyrene sulfonate powder 49
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml.....58
solifenacin succinate.....60
SOLIQUA INJ 100/33 48
SOLTAMOX.....19
SOLU-CORTEF 54
SOMATULINE DEPOT 56
SOMAVERT.....56
sorafenib tosylate 23
sorine.....28
sotalol hcl 28
sotalol hcl (afib/afl) 28
spironolactone 26
spironolactone & hydrochlorothiazide tab 25-25 mg 31
sprintec 28.....53
SPRITAM.....35
SPRYCEL.....23
sps.....49
sronyx.....53
ssd.....74
stavudine.....12
STELARA.....63
STIVARGA.....23
streptomycin sulfate.....10
STRIBILD TAB 13
subvenite.....35
sucralfate.....59
sulfacetamide sodium (acne) 74
sulfacetamide sodium (ophth).....68
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)% 68
sulfadiazine.....10
sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml.....10
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml.....10
sulfamethoxazole-trimethoprim tab 400-80 mg 10
sulfamethoxazole-trimethoprim tab 800-160 mg 10
SULFAMYLON 74
sulfasalazine.....58
sulindac.....7
sumatriptan 43
sumatriptan succinate.....43
sunitinib malate 23
SUNLENCA 12
SUPREP BOWEL SOL PREP KIT 58
syeda 53
SYMBICORT AER 160-4.5 73
SYMBICORT AER 80-4.5.....73
SYMDEKO TAB 100-150 72
SYMDEKO TAB 50-75MG 72
SYMJEPI 72
SYMPAZAN.....35
SYMTUZA TAB 13
SYNAREL 53
SYNERCID INJ 500MG.....10
SYNJARDY TAB 12.5-1000MG 46
SYNJARDY TAB 12.5-500.....46
SYNJARDY TAB 5-1000MG.....46
SYNJARDY TAB 5-500MG.....46
SYNJARDY XR TAB 10-1000.....46
SYNJARDY XR TAB 12.5-1000MG.....46
SYNJARDY XR TAB 25-1000.....46
SYNJARDY XR TAB 5-1000MG 46
SYNRIBO 19
SYNTHROID 56

T

TABLOID.....18

TABRECTA.....23
tacrolimus.....64
tacrolimus (topical) 76
TAFINLAR 23
TAGRISSO 23
TALTZ 63
TALZENNA 23
tamoxifen citrate.....19
tamsulosin hcl 59
tarina 24 fe 53
tarina fe 1/20 eq.....53
TASIGNA 23
tasimelteon 42
tazarotene 74
tazicef 15
TAZORAC.....75
taztia xt.....30
TAZVERIK 23
TDVAX INJ 2-2 LF 65
TECENTRIQ 23
TEFLARO.....15
telmisartan 28
telmisartan-amlodipine tab 40-10 mg 27
telmisartan-amlodipine tab 40-5 mg .27
telmisartan-amlodipine tab 80-10 mg 27
telmisartan-amlodipine tab 80-5 mg .27
telmisartan-hydrochlorothiazide tab 40-12.5 mg.....27
telmisartan-hydrochlorothiazide tab 80-12.5 mg.....27
telmisartan-hydrochlorothiazide tab 80-25 mg.....27
temazepam 42
TENIVAC INJ 5-2LF.....65
tenofovir disoproxil fumarate 12
TEPMETKO 23
terazosin hcl.....26
terbinafine hcl 11
terbutaline sulfate.....71
terconazole vaginal 60
TERIPARATIDE.....49
testosterone.....45
testosterone cypionate.....45
testosterone enanthate.....45
tetrabenazine 43
tetracycline hcl 17
THALOMID 19
THEO-24.....72
theophylline 72
thioridazine hcl 40
thiothixene.....40
tiadylt er.....30
tiagabine hcl.....35
TIBSOVO 23
TICOVAC.....65
tigecycline.....17
TIGECYCLINE 17
tilia fe.....53
timolol maleate.....30
timolol maleate (ophth) 69
TIVICAY.....12
TIVICAY PD 12
tizanidine hcl 44
TOBRADEX OIN 0.3-0.1% 68
TOBRADEX ST SUS 0.3-0.05.....68
tobramycin.....10
tobramycin (ophth) 68
tobramycin-dexamethasone ophth susp 0.3-0.1% 68
tobramycin sulfate 10
tolterodine tartrate.....60
topiramate 35
toposar.....20
toremifene citrate 19
torsemide 31
TOUJEO MAX SOLOSTAR 48
TOUJEO SOLOSTAR 48
TPN ELECTROL INJ 67
TRADJENTA.....46
tramadol-acetaminophen tab 37.5-325 mg.....9
tramadol hcl.....9
trandolapril 26
tranexamic acid 61
tranylcypromine sulfate 37
TRAVASOL INJ 10% 68
TRAZIMERA.....23
trazodone hcl 37
TRECATOR 14
TRELEGY AER ELLIPTA 100-62.5-25 MCG 70

TRELEGY AER ELLIPTA 200-62.5-25 MCG 70
treprostinil 32
TRESIBA 48
TRESIBA FLEXTOUCH 48
tretinoin 74
tretinoin (chemotherapy) 19
triamcinolone acetonide (mouth) 77
triamcinolone acetonide (topical) 75, 76
triamterene & hydrochlorothiazide cap 37.5-25 mg 31
triamterene & hydrochlorothiazide tab 37.5-25 mg 31
triamterene & hydrochlorothiazide tab 75-50 mg 31
TRICARE TAB PRENATAL 67
trientine hcl 49
tri-estarylla 53
trifluoperazine hcl 40
trifluridine 68
trihexyphenidyl hcl 38
TRIJARDY XR TAB ER 24HR 10-5-1000MG 46
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG 47
TRIJARDY XR TAB ER 24HR 25-5-1000MG 47
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG 46
TRIKAFTA PAK 59.5MG 72
TRIKAFTA PAK 75MG 72
TRIKAFTA TAB 100-50-75MG & 150MG 73
TRIKAFTA TAB 50-25-37.5MG & 75MG 72
tri-legest fe 53
tri-linyah 53
tri-lo-estarylla 53
tri-lo-marzia 53
tri-lo-mili 53
tri-lo-sprintec 53
trimethoprim 10
tri-mili 53
trimipramine maleate 37
TRINTELLIX 37
tri-nymyo 53
tri-sprintec 53
TRIUMEQ PD TAB 13
TRIUMEQ TAB 13
trivora-28 53
tri-vylibra 53
tri-vylibra lo 53
TRIZIVIR TAB 13
TROGARZO 12
TROPHAMINE INJ 10% 68
trospium chloride 60
TRULICITY 47
TRUMENBA INJ 65
TRUSELTIQ 100MG DAILY DOSE 23
TRUSELTIQ 125MG DAILY DOSE 23
TRUSELTIQ 50MG DAILY DOSE 23
TRUSELTIQ 75MG DAILY DOSE 23
TRUXIMA 23
TUKYSA 23
TURALIO 23
TWINRIX INJ 65
TYBOST 12
tydemy 53
TYPHIM VI 65
TYRVAYA 70

U

unithroid 57
ursodiol 59

V

valacyclovir hcl 14
VALCHLOR 76
valganciclovir hcl 14
valproate sodium 35
valproic acid 35
valsartan 28
valsartan-hydrochlorothiazide tab 160-12.5 mg 27
valsartan-hydrochlorothiazide tab 160-25 mg 27
valsartan-hydrochlorothiazide tab 320-12.5 mg 27
valsartan-hydrochlorothiazide tab 320-25 mg 27
valsartan-hydrochlorothiazide tab 80-12.5 mg 27
VALTOCO 10 MG DOSE 35
VALTOCO 15 MG DOSE 35
VALTOCO 20 MG DOSE 35
VALTOCO 5 MG DOSE 35

vanadom 44
vancomycin hcl 10
VANCOMYCIN INJ 1 GM.....10
VANCOMYCIN INJ 500MG 11
VANCOMYCIN INJ 750MG 11
VAQTA.....65
varenicline tartrate.....45
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack 45
VARIVAX.....65
VASCEPA 29
velivet 53
VELPHORO 56
VELTASSA.....49
VEMLIDY.....14
VENCLEXTA.....23
VENCLEXTA TAB START PK.....24
venlafaxine hcl 37
VENTAVIS 32
VENTOLIN HFA 71
VENTOLIN HFA (INSTITUTIONAL PACK) 71
verapamil hcl.....30
VERQUVO 31
VERSACLOZ 40
VERZENIO.....24
vestura 53
V-GO 20 KIT.....48
V-GO 30 KIT.....48
V-GO 40 KIT.....48
VICTOZA.....47
vienva 53
vigabatrin 35
vigadrone 35
VIIBRYD KIT STARTER 37
vilazodone hcl.....37
VIMPAT.....35
vincristine sulfate.....20
vinorelbine tartrate 20
viorele 53
VIRACEPT 12
VIREAD 12
VITRAKVI.....24
VIVITROL.....45
VIZIMPRO 24
VONJO.....24
voriconazole 11
VOSEVI TAB 14
VOTRIENT 24
VRAYLAR 40
VRAYLAR CAP 1.5-3MG 40
vyfemla 53
vylibra 53
VYZULTA.....69
W
warfarin sodium 60
water for irrigation, sterile irrigation soln 77
WELIREG 19
wera 53
wymzya fe 53
X
XALKORI.....24
XARELTO 60
XARELTO STAR TAB 15/20MG 61
XATMEP 63
XCOPRI 35
XCOPRI PAK 100-150 35
XCOPRI PAK 12.5-25 35
XCOPRI PAK 150-200MG (MAINTENANCE) 35
XCOPRI PAK 150-200MG (TITRATION) 35
XCOPRI PAK 50-100MG.....35
XELJANZ 63
XELJANZ XR 63
XERMELO 59
XGEVA.....49
XHANCE.....73
XIFAXAN 59
XIGDUO XR TAB 10-1000 47
XIGDUO XR TAB 10-500MG 47
XIGDUO XR TAB 2.5-1000 47
XIGDUO XR TAB 5-1000MG 47
XIGDUO XR TAB 5-500MG.....47
XIIDRA 70
XOFLUZA 14
XOLAIR.....73
XOSPATA 24
XPOVIO 100 MG ONCE WEEKLY 24
XPOVIO 40 MG ONCE WEEKLY 24
XPOVIO 40 MG TWICE WEEKLY.....24
XPOVIO 60 MG ONCE WEEKLY 24
XPOVIO 60 MG TWICE WEEKLY.....24

XPOVIO 80 MG ONCE WEEKLY 24
XPOVIO 80 MG TWICE WEEKLY.....24
XTANDI 19
xulane 53
XULTOPHY INJ 100/3.6 48
XYREM.....44
Y
YF-VAX INJ.....65
yuvafem 54
Z
zafemy 53
zafirlukast 71
zaleplon 42
ZARXIO 61
ZEJULA.....24
ZELBORAF.....24
ZEMAIRA 73
zenatane.....74
ZENPEP CAP 10000UNT 59
ZENPEP CAP 15000UNT 59
ZENPEP CAP 20000UNT 59
ZENPEP CAP 25000UNT 59
ZENPEP CAP 3000UNIT 59
ZENPEP CAP 40000UNT 59
ZENPEP CAP 5000UNIT 59
ZERVIATE 69
zidovudine 12
ZIEXTENZO 61
ziprasidone hcl.....40
ziprasidone mesylate 40
ZIRABEV.....24
ZIRGAN 69
zoledronic acid.....49
ZOLINZA.....24
zolmitriptan.....43
zolpidem tartrate 42
ZONISADE 35
zonisamide.....35
zovia 1/35.....53
ZTALMY 35
zumandimine.....53
ZYDELIG.....24
ZYKADIA.....24
ZYLET SUS 0.5-0.3%.....68
ZYPREXA RELPREVV 40

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