2023

Formulary/Formulario

LiveWell (HMO)

(List of Covered Drugs)/(Lista de medicamentos cubiertos)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN
LEA: ESTE DOCUMENTO TIENE INFORMACIÓN SOBRELOS MEDICAMENTOS CUBIERTOS EN ESTE PLAN

The Way to Age Well in New York

HPMS Approved Formulary File Submission ID: 23571, Version Number: 06, Effective Date: 01/01/2023.
This formulary was updated on 10/04/2022. For more recent information or other questions, please contact Elixir, AgeWell New York's Pharmacy Benefit Manager, at **1-844-782-7670** or TTY/TDD users **1-800-662-1220**, 24 hours a day, 7 days a week 24 hours a day, or visit **www.agewellnewyork.com**.

Important Message About What You Pay for Insulin – You won't pay more than $35.00 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it is on, even if you haven't paid your deductible.

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.

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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 AgeWell New York. When it refers to "plan" or "our plan," it means LiveWell (HMO).

This document includes list of the drugs (formulary) for our plan which is current as of 01/01/2023 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, 2023, and from time to time during the year.

What is the LiveWell (HMO) Formulary?

A formulary is a list of covered drugs selected by our 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. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a 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 we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, 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 that will appear on the same or lower cost sharing tier and 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 immediately move it to a different cost-sharing tier or 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 find information in the section below titled "How do I request an exception to the LiveWell (HMO) 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 new generic drug to replace a brand name drug currently on the formulary; or

add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, 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 LiveWell (HMO)'s 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 01/01/2023 To get updated information about the drugs covered by our plan please contact us. Our contact information appears on the front and back cover pages. In the event that the plan makes a mid-year non-maintenance formulary change, we will mail you updated information at least 60 days prior to the date the change becomes effective.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. 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 agents. If you know what your drug is used for, look for the category name in the list that begins on page 2. 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 89. 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?

Our 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:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 12 tablets per prescription for Sumatriptan Succinate 100 mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we 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 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted documents online 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 us 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 LiveWell (HMO) formulary?" on page iv 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 our 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 our 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 us.

- You can ask us 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 LiveWell (HMO) Formulary?

You can ask us 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 cover a formulary drug at lower cost-sharing level, unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our 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, our 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, tier or utilization restriction exception. **When you request a formulary, tier 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.

Existing Member with Level of Care Changes

If you are outside your transition period and experience a level of care change in which you are changing from one treatment setting to another (example: Long-Term Care to hospital, hospital to home, home to Long-Term Care), upon admission or discharge from a treatment setting or Long-Term Care, we will allow you access to a 30/31 day refill (30 days in the retail setting and 31 days in the Long-Term Care setting) for formulary medications and an emergency 30/31 day refill (30 days in the retail setting and 31 days in the Long-Term Care setting) for non-formulary medications (including Part D drugs that are on our formulary but require prior authorization or step therapy).

To the extent that you are outside your 90-day transition period and are in an outpatient setting, we will still provide an emergency 30-day supply of non-formulary medications (including Part D drugs that are on our formulary that would otherwise require prior authorization or step therapy under our utilization management rules), on a case-by-case basis, while an exception request is being processed.

To the extent that you are outside your 90-day transition period and are in a Long-Term Care setting, we will still provide an emergency 31-day supply of Part D covered non-formulary medications (including Part D covered drugs that are on our formulary that would otherwise require prior authorization or step therapy under our utilization management rules), while an exception request is being processed.
This policy does not apply for short-term leaves of absences (i.e. holidays or vacations) from Long-Term Care or hospital facilities.

For more information

For more detailed information about your LiveWell (HMO) prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about our 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/TDD users should call **1-877-486-2048**. Or visit http://www.medicare.gov.

LiveWell (HMO) Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 89.

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

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

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Symbol	Name	Description
QL	Quantity Limit	There is a limit on the amount of this drug that is covered per prescription or within a specific time frame.
PA	Prior Authorization	You (or your physician) are required to obtain a prior authorization before you fill your prescription for this drug. Without a prior authorization, we may not cover this drug.
ST	Step Therapy	In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
GC	Gap Coverage	We provide additional coverage of this prescription drug in the coverage gap.
MO	Mail Order	This prescription may also be available via mail.
LA	Limited Access	This prescription drug is limited to certain pharmacies.
HRM	Health Risk Medications	The Centers for Medicare and Medicaid Services (CMS) has identified the drug listed as posing a higher risk to patients, especially to seniors (PA required for ages 65 or over).
BD	Part B vs. Part D	This prescription drug may be covered under Medicare Part B or Part D depending on the circumstances.

Tier	Name	
1	Preferred Generic Drugs	This is the lowest cost-sharing tier.
2	Generic Drugs	
3	Preferred Brand Name Drugs	
4	Non-preferred drugs	
5	Specialty Drugs	This is the highest cost-sharing tier.

Nota para los miembros actuales: este Formulario ha cambiado con respecto al año pasado. Por favor, revise este documento para asegurarse de que aún contiene los medicamentos que usted toma.

Cuando esta Lista de medicamentos (Formulario) menciona "nosotros", "nos" o "nuestro", hace referencia a AgeWell New York. Cuando dice "plan" o "nuestro plan", hace referencia a LiveWell (HMO).

Este documento incluye una lista de los medicamentos (Formulario) de nuestro plan, la cual está en vigencia desde el 01/01/2023. Comuníquese con nosotros para obtener un formulario actualizado. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Generalmente, debe usar a las farmacias de la red para usar el beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos/el coseguro pueden cambiar el 1 de enero de 2023 y periódicamente durante el año.

¿Qué es el Formulario de LiveWell (HMO)?

Un Formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan con la colaboración de un equipo de proveedores de atención médica, que representa los tratamientos recetados que se consideran una parte necesaria de un programa de tratamiento de calidad. Normalmente, nuestro plan cubrirá los medicamentos incluidos en el formulario, siempre que el medicamento sea médicamente necesario, el medicamento recetado se obtenga en una farmacia de la red de nuestro plan y se cumpla con otras normas del plan. Para obtener más información sobre cómo obtener sus medicamentos recetados, consulte la *Evidencia de cobertura*.

¿Puede cambiar el Formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de los medicamentos ocurre el 1 de enero, pero se podrían agregar o quitar medicamentos de la Lista de medicamentos durante el año, moverlos a diferentes niveles de costo compartido o podríamos agregar nuevas restricciones. Debemos seguir las normas de Medicare al hacer estos cambios.

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

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o en un nivel de costo compartido más bajo y con las mismas o menos restricciones. Además, cuando agreguemos el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de Medicamentos, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente está tomando ese medicamento de marca, quizás no le informemos con anticipación antes de que realicemos el cambio, pero más adelante le proporcionaremos información sobre los cambios específicos que hemos realizado.
    - Si realizamos un cambio, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. En el aviso que le proporcionamos también se incluirá información sobre cómo solicitar una excepción, y usted también puede encontrar información en la sección a continuación titulada "¿Cómo puedo solicitar que se haga una excepción al Formulario de LiveWell (HMO)?".

- **Medicamentos retirados del mercado.** Si la Administración de Drogas y Alimentos considera que un medicamento de nuestro Formulario es inseguro o el fabricante del medicamento lo retira del mercado, eliminaremos de inmediato dicho medicamento de nuestro Formulario y les notificaremos a los miembros que toman el medicamento en cuestión.

- **Otros cambios.** Podemos hacer otros cambios que afectan a los miembros que actualmente toman un medicamento. Por ejemplo, podríamos agregar un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que actualmente se encuentra en el Formulario; o agregar nuevas restricciones al medicamento de marca o moverlo a un nivel de costo compartido diferente o a ambos. O podemos hacer cambios en función de las nuevas pautas clínicas. Si retiramos medicamentos de nuestro Formulario, o agregamos autorizaciones previas, restricciones de límite de cantidad o de tratamiento escalonado sobre un medicamento o pasamos un medicamento a un nivel de costo compartido más alto, debemos notificarles a los miembros afectados por el cambio al menos 30 días antes de que entre en vigencia dicho cambio, o cuando el miembro solicite un resurtido del medicamento, momento en el cual el miembro recibirá un suministro del medicamento para 30 días.
    - Si realizamos estos otros cambios, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. En el aviso que le proporcionamos también se incluirá información sobre cómo solicitar una excepción, y usted también puede encontrar información en la sección a continuación titulada "¿Cómo puedo solicitar que se haga una excepción al Formulario de LiveWell (HMO)?".

Cambios que no lo afectarán si actualmente toma el medicamento. Generalmente, si usted toma un medicamento de nuestro Formulario para 2023 que estaba cubierto al comienzo del año, nosotros no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura de 2023, excepto como se describe anteriormente. Esto significa que, por el resto del año de cobertura, estos medicamentos continuarán disponibles al mismo costo compartido y sin nuevas restricciones para aquellos miembros que estén tomándolos. No recibirá un aviso directo este año sobre cambios que no lo afectan. Sin embargo, dichos cambios lo afectarían a partir del 1 de enero del año siguiente, y es importante que verifique la Lista de medicamentos del nuevo año de beneficios por cualquier cambio en los medicamentos.

El Formulario adjunto entra en vigencia el 01/01/2023. Para recibir información actualizada sobre los medicamentos cubiertos por nuestro plan comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de la portada y la portada posterior. En el caso de que el plan realice a mitad de año un cambio en el formulario no relacionado con su mantenimiento, le enviaremos por correo su información actualizada al menos 60 días antes de que entre en vigencia dicho cambio.

¿Cómo utilizo el Formulario?

Hay dos formas para encontrar su medicamento dentro del Formulario:

<u>Condición médica</u>

El Formulario comienza en la pagina 1. Los medicamentos de este Formulario están agrupados en categorías según el tipo de afección médica para cuyo tratamiento se los emplea. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran dentro de la categoría "agentes

cardiovasculares." Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que empieza en la pagina 2. Luego, busque su medicamento debajo del nombre de la categoría.

Listado alfabético

Si no está seguro de qué categoría consultar, debe buscar su medicamento en el Índice que comienza en la pagina 89. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. En el Índice, están tanto los medicamentos de marca como los genéricos. Busque en el Índice y encuentre su medicamento. Junto a su medicamento, verá el número de página donde puede encontrar información acerca de la cobertura. Vaya a la página que figura en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre tanto los medicamentos de marca como los genéricos. Un medicamento genérico está aprobado por la Administración de Drogas y Alimentos (FDA), dado que se considera que tiene el mismo ingrediente activo que el medicamento de marca. Normalmente, los medicamentos genéricos cuestan menos que los de marca.

¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales de cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** nuestro plan exige que usted o su médico obtenga una autorización previa para determinados medicamentos. Esto significa que necesitará contar con la aprobación de nuestro plan antes de obtener sus medicamentos recetados. Si no obtiene autorización, es posible que nuestro plan no cubra el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubrirá nuestro plan. Por ejemplo, nuestro plan proporciona 12 pastillas por receta para 100 mg de Sumatriptan Succinate. Esto puede ser complementario a un suministro estándar para un mes o tres meses.

- **Tratamiento escalonado:** En algunos casos, nuestro plan requiere que usted primero pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B ambos tratan su afección médica, es posible que nuestro plan no cubra el medicamento B, a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, nuestro plan cubrirá el medicamento B.

Para averiguar si su medicamento tiene requisitos o límites adicionales, consulte el Formulario que empieza en la pagina 1. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos en nuestro sitio web. Hemos publicado documentos en nuestra página web para explicar nuestra restricción de autorización previa y de tratamiento escalonado. También puede

solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Puede pedirle a nuestro plan que haga una excepción a estas restricciones o límites, o puede solicitarle una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección "¿Cómo puedo solicitar que se haga una excepción al Formulario de nuestro plan?" en la página x para obtener información acerca de cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en el Formulario?

Si el medicamento que usted toma no está incluido en este Formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicios para los miembros y preguntar si su medicamento está cubierto.

Si resulta que nuestro plan no cubre el medicamento que toma, tiene dos alternativas:

- Puede pedir a Servicios para los miembros una lista de medicamentos similares que estén cubiertos por nuestro plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.

- Puede solicitar que nuestro plan haga una excepción y cubra su medicamento. Consulte a continuación para obtener información sobre cómo solicitar una excepción.

¿Cómo puedo solicitar que se haga una excepción al Formulario de LiveWell (HMO)?

Puede solicitarle a nuestro plan que haga una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que cubramos un medicamento, incluso si no está en nuestro Formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y usted no podrá pedirnos que le brindemos el medicamento a un nivel de costo compartido menor.

- Puede pedirnos que cubramos un medicamento del Formulario a un nivel de costo compartido menor, a menos que el medicamento esté en el nivel de especialidad. Si se aprueba, esto reduciría el monto que debe pagar por su medicamento.

- Puede pedirnos que no apliquemos restricciones o límites de cobertura para su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que hagamos una excepción al límite y cubramos una cantidad mayor.

Por lo general, nuestro plan solo aprobará su pedido de excepción si los medicamentos alternativos incluidos en el Formulario del plan, el medicamento es de menor costo compartido, o las restricciones de uso adicionales no fueran tan efectivos para tratar su afección o pudieran causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión inicial de cobertura para una excepción al Formulario, nivel, o a la restricción de uso. **Cuando solicita una excepción al Formulario, nivel, o a la**

restricción de uso, debe presentar una declaración de su médico o de la persona autorizada a dar recetas que respalde su solicitud. Por lo general, debemos tomar una decisión dentro de las 72 horas a partir de la fecha de haber recibido la declaración que respalda su solicitud por parte de la persona autorizada a dar recetas. Puede solicitar una excepción acelerada (rápida) si usted o su médico consideran que esperar 72 horas para la toma de la decisión podría perjudicar gravemente su salud. Si se le concede el trámite rápido de la excepción, debemos comunicarle nuestra decisión a más tardar dentro de las 24 horas después de haber recibido la declaración de respaldo de su médico o de otra persona autorizada a dar recetas.

¿Qué debo hacer antes de hablar con mi médico sobre el cambio de los medicamentos que tomo o la solicitud de una excepción?

Como miembro nuevo o permanente de nuestro plan, es posible que esté tomando medicamentos que no están incluidos en el Formulario. También es posible que esté tomando un medicamento incluido en el Formulario, pero su capacidad de conseguirlo sea limitada. Por ejemplo, puede necesitar nuestra autorización previa antes de poder obtener su medicamento con receta. Debe consultar con su médico para decidir si debe cambiar su medicamento por uno apropiado que nosotros cubramos o solicitar una excepción al formulario para que le cubramos el medicamento que toma. Mientras evalúa con su médico el procedimiento adecuado para seguir en su caso, podemos cubrir su medicamento, en ciertos casos, durante los primeros 90 días en que usted sea miembro de nuestro plan.

Para cada uno de los medicamentos que no estén incluidos en el Formulario, o si su capacidad para conseguir los medicamentos es limitada, cubriremos un suministro temporal para 30 días. Si su receta está indicada para menos días, permitiremos que realice resurtidos por un máximo de hasta 30 días del medicamento. Después del primer suministro para 30 días, no seguiremos pagando estos medicamentos, incluso si ha sido miembro del plan durante menos de 90 días.

Si es residente de un centro de atención a largo plazo y necesita un medicamento que no está en el Formulario o si su capacidad para conseguir los medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia del medicamento para 31 días mientras solicita la excepción al formulario.

Miembro actual de un plan con cambios en el nivel de atención

Si se encuentra fuera de su período de transición y experimenta cambios en el nivel de atención en el que pasaron de un entorno de tratamiento a otro (por ejemplo: de un centro de atención a largo plazo (Long-Term Care, LTC) a un hospital, de un hospital a su casa, de su casa a un centro de LTC, al momento en que se lo admita o se le dé el alta en el entorno de tratamiento o centro de LTC, les permitiremos acceder a un resurtido para 30/31 días (30 días en el entorno minorista, y 31 días en el entorno de LTC) de medicamentos del formulario y a un resurtido de emergencia para 30/31 días (30 días en el entorno minorista, y 31 días en el entorno de LTC) de medicamentos que no se encuentran en el formulario (como medicamentos de la Parte D que se encuentren en el formulario del patrocinador del plan pero que requieren autorización previa o tratamiento escalonado).

Esta política no se aplica a licencias a corto plazo (como feriados y vacaciones) del centro de atención a largo plazo (LTC) o centro hospitalario.

En la medida en que usted se encuentre fuera del período de transición de 90 días, y que se encuentre en un

entorno para pacientes externos, le ofreceremos un suministro de emergencia para 30 días de medicamentos que no están en el formulario (como medicamentos de la Parte D que se encuentren en nuestro formulario y que de otro modo requerirían autorización previa o tratamiento escalonado en virtud de nuestras normas de manejo de la utilización de medicamentos), revisando caso por caso mientras se aguarda que se procese la solicitud de excepción.

En la medida en que usted se encuentre fuera del período de transición de 90 días, y que se encuentre en un entorno de LTC, le ofreceremos un suministro de emergencia para 31 días de medicamentos cubiertos por la Parte D que no están en el formulario (como medicamentos cubiertos por la Parte D que se encuentren en nuestro formulario y que de otro modo requerirían autorización previa o tratamiento escalonado en virtud de nuestras normas de manejo de la utilización de medicamentos) mientras se aguarda que se procese la solicitud de excepción.

Para obtener más información

Para obtener información más detallada sobre la cobertura para medicamentos con receta de nuestro plan, consulte la Evidencia de cobertura y otra documentación del plan.

Si tiene alguna pregunta sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Si tiene preguntas generales sobre su cobertura para medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (**1-800-633-4227**), las 24 horas, los 7 días de la semana. Los usuarios de TTY/TDD deben llamar al **1-877-486-2048**. O visite http://www.medicare.gov.

Formulario de nuestro plan

El Formulario que comienza en la siguiente página proporciona información acerca de la cobertura de los medicamentos cubiertos por nuestro plan. Si tiene alguna dificultad para encontrar el medicamento que toma en la lista, consulte el Índice que comienza en la pagina 89.

La primera columna de la tabla menciona el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (por ejemplo, SYNTHROID) y los medicamentos genéricos están en letra minúscula y cursiva (por ejemplo, *levothyroxine*).

La información incluida en la columna de Requisitos/límites indica si nuestro plan tiene algún requisito especial para la cobertura del medicamento.

LEYENDA

Símbolo	Nombre	Descripción
QL	Límite de cantidad	Existe un límite con respecto a la cantidad que es de este medicamento se cubre mediante una receta o en un plazo específico.
PA	Autorización previa	Usted (o su médico) debe obtener una autorización previa antes de surtir la receta de este medicamento. Sin autorización previa, es posible que no cubramos este medicamento.
ST	Tratamiento escalonado	En algunos casos, es posible que deba probar otros medicamentos para tratar su afección médica, antes de que podamos cubrir otro medicamento para dicha afección.
GC	Período sin cobertura	Proporcionamos cobertura adicional para este medicamento con receta durante el período sin cobertura.
MO	Pedidos por correo	Esta receta también podría estar disponible por correo.
LA	Acceso limitado	Este medicamento con receta está limitado a ciertas farmacias.
HRM	Medicamento de alto riesgo	Los Centros de Servicios de Medicare y Medicaid (*Centers for Medicare and Medicaid Services*, CMS) han identificado el medicamento detallado como un medicamento con riesgo elevado para los pacientes, especialmente para personas mayores (se requiere autorización previa para pacientes de 65 años o más)
BD	Parte B vs. Parte D	Este medicamento con receta puede estar cubierto por la Parte B o la Parte D de Medicare, según las circunstancias.

Nivel	Nombre	
1	Medicamentos genéricos preferidos	Este es el nivel de distribución de costos más bajo.
2	Medicamentos genéricos	
3	Medicamentos de marca preferidos	
4	Medicamentos no preferidos	
5	Medicamentos especializados	Este es el nivel de distribución de costos más alto.

LEGEND

1: Tier 1 - Preferred Generics Drugs (This is the lowest cost-sharing tier.)

2: Tier 2 - Generic Drugs

3: Tier 3 - Preferred Brand Name Drugs

4: Tier 4 - Non-Preferred Drugs

5: Tier 5 - Specialty Drugs (This is the highest cost-sharing tier.)

BD: Part B vs Part D - This prescription drug may be covered under Medicare Part B or D depending upon the circumstances.

GC: Gap Coverage. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

LA: Limited Access - This prescription drug is limited to certain pharmacies.

MO: Mail Order - This prescription may also be available via mail.

PA: Prior Authorization - You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.

QL: Quantity Limit - There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame.

ST: Step Therapy - In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

AgeWell 5 Tier (List of Covered Drugs)

Drug Name	Tier	Requirements/Limits
ANALGESICS		
ANALGESICS		
butalbital-apap-caffeine oral tablet 50-325-40 mg	2	QL (180 EA per 30 days)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	4	QL (180 EA per 30 days)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	2	QL (180 EA per 30 days)
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	2	MO
diclofenac potassium oral tablet 50 mg	2	MO
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	MO; GC
diclofenac sodium external gel 1 %	2	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	MO; GC
diflunisal oral tablet 500 mg	2	MO
etodolac oral capsule 200 mg, 300 mg	2	MO
etodolac oral tablet 400 mg, 500 mg	2	MO
flurbiprofen oral tablet 100 mg	1	MO; GC
IBU ORAL TABLET 600 MG, 800 MG	1	MO; GC
ibuprofen oral suspension 100 mg/5ml	1	GC
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	MO; GC
indomethacin er oral capsule extended release 75 mg	2	MO
indomethacin oral capsule 25 mg, 50 mg	1	MO; GC
ketorolac tromethamine oral tablet 10 mg	1	GC
meloxicam oral tablet 15 mg, 7.5 mg	1	MO; GC
nabumetone oral tablet 500 mg, 750 mg	1	MO; GC
naproxen oral suspension 125 mg/5ml	2	MO
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	MO; GC
naproxen oral tablet delayed release 375 mg, 500 mg	2	MO
naproxen sodium oral tablet 275 mg, 550 mg	2	MO

Drug Name	Tier	Requirements/Limits
oxaprozin oral tablet 600 mg	2	MO
piroxicam oral capsule 10 mg, 20 mg	2	MO
sulindac oral tablet 150 mg, 200 mg	1	MO; GC
OPIOID ANALGESICS, LONG-ACTING		
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr	4	PA; QL (10 EA per 30 days)
methadone hcl oral tablet 10 mg, 5 mg	2	QL (240 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	2	QL (90 EA per 30 days)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg	4	
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine #3 oral tablet 300-30 mg	2	QL (360 EA per 30 days)
acetaminophen-codeine oral solution 120-12 mg/5ml	2	QL (5000 ML per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-60 mg	2	QL (360 EA per 30 days)
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	2	QL (180 EA per 30 days)
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 600 mcg, 800 mcg	5	PA; QL (120 EA per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg, 400 mcg	4	PA; QL (120 EA per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	2	QL (5500 ML per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	2	QL (360 EA per 30 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	2	QL (150 EA per 30 days)
hydromorphone hcl oral liquid 1 mg/ml	4	QL (1920 ML per 30 days)
hydromorphone hcl oral tablet 2 mg, 4 mg	2	QL (360 EA per 30 days)
hydromorphone hcl oral tablet 8 mg	2	QL (240 EA per 30 days)
morphine sulfate (concentrate) oral solution 20 mg/ml	2	QL (600 ML per 30 days)
morphine sulfate oral solution 10 mg/5ml	2	QL (1800 ML per 30 days)
morphine sulfate oral solution 20 mg/5ml	2	QL (1500 ML per 30 days)
morphine sulfate oral tablet 15 mg, 30 mg	2	QL (180 EA per 30 days)

Drug Name	Tier	Requirements/Limits
oxycodone hcl oral concentrate 100 mg/5ml	4	QL (180 ML per 30 days)
oxycodone hcl oral solution 5 mg/5ml	4	QL (1080 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	2	QL (180 EA per 30 days)
oxycodone-acetaminophen oral solution 5-325 mg/5ml	2	QL (1080 ML per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	2	QL (360 EA per 30 days)
tramadol hcl oral tablet 100 mg	1	GC; QL (120 EA per 30 days)
tramadol hcl oral tablet 50 mg	1	GC; QL (240 EA per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	2	QL (240 EA per 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine external patch 5 %	4	PA; QL (90 EA per 30 days)
lidocaine hcl external solution 4 %	2	QL (50 ML per 30 days)
lidocaine viscous hcl mouth/throat solution 2 %	4	
lidocaine-prilocaine external cream 2.5-2.5 %	2	QL (30 GM per 30 days)
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium oral tablet delayed release 333 mg	2	MO
disulfiram oral tablet 250 mg	2	MO
naltrexone hcl oral tablet 50 mg	2	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5	
OPIOID DEPENDENCE		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	2	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	2	
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG	4	
OPIOID REVERSAL AGENTS		
KLOXXADO NASAL LIQUID 8 MG/0.1ML	3	
naloxone hcl injection solution 0.4 mg/ml	2	

Drug Name	Tier	Requirements/Limits
naloxone hcl injection solution cartridge 0.4 mg/ml	2	
naloxone hcl injection solution prefilled syringe 2 mg/2ml	2	
naloxone hcl nasal liquid 4 mg/0.1ml	2	
NARCAN NASAL LIQUID 4 MG/0.1ML	3	
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML	3	
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	1	GC
NICOTROL INHALATION INHALER 10 MG	4	
varenicline tartrate oral 0.5 mg x 11 & 1 mg x 42	3	
varenicline tartrate oral tablet 0.5 mg, 1 mg	3	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate injection solution 500 mg/2ml	4	BD
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML	4	PA
gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%	2	
gentamicin sulfate external cream 0.1 %	2	
gentamicin sulfate external ointment 0.1 %	2	
gentamicin sulfate injection solution 40 mg/ml	2	
neomycin sulfate oral tablet 500 mg	2	
paromomycin sulfate oral capsule 250 mg	4	
tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml	4	BD
ZEMDRI INTRAVENOUS SOLUTION 500 MG/10ML	5	
ANTIBACTERIALS, OTHER		
aztreonam injection solution reconstituted 1 gm	2	
aztreonam injection solution reconstituted 2 gm	4	BD
clindamycin hcl oral capsule 150 mg, 75 mg	1	GC
clindamycin hcl oral capsule 300 mg	2	

Drug Name	Tier	Requirements/Limits
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	4	
clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml, 900 mg/50ml	4	
clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml	4	BD
clindamycin phosphate vaginal cream 2 %	2	
colistimethate sodium (cba) injection solution reconstituted 150 mg	4	BD
daptomycin intravenous solution reconstituted 350 mg	4	
daptomycin intravenous solution reconstituted 500 mg	5	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML	4	
linezolid intravenous solution 600 mg/300ml	4	PA
linezolid oral tablet 600 mg	4	PA
methenamine hippurate oral tablet 1 gm	2	
metronidazole external cream 0.75 %	2	
metronidazole external gel 0.75 %, 1 %	2	
metronidazole external lotion 0.75 %	2	
metronidazole intravenous solution 500 mg/100ml	2	BD
metronidazole oral tablet 250 mg, 500 mg	2	
metronidazole vaginal gel 0.75 %	3	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	2	
nitrofurantoin monohyd macro oral capsule 100 mg	2	
tigecycline intravenous solution reconstituted 50 mg	5	BD
tinidazole oral tablet 250 mg, 500 mg	2	
trimethoprim oral tablet 100 mg	1	GC
vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 500 mg, 750 mg	4	
vancomycin hcl oral capsule 125 mg, 250 mg	4	
vancomycin hcl oral solution reconstituted 250 mg/5ml	4	
XIFAXAN ORAL TABLET 200 MG	4	

Drug Name	Tier	Requirements/Limits
XIFAXAN ORAL TABLET 550 MG	4	MO
BETA-LACTAM, CEPHALOSPORINS		
cefaclor er oral tablet extended release 12 hour 500 mg	4	
cefaclor oral capsule 250 mg, 500 mg	2	
cefaclor oral suspension reconstituted 125 mg/5ml, 250 mg/5ml, 375 mg/5ml	4	
cefadroxil oral capsule 500 mg	1	GC
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	2	
cefadroxil oral tablet 1 gm	2	
cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 500 mg	4	
cefdinir oral capsule 300 mg	2	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefepime hcl injection solution reconstituted 1 gm, 2 gm	4	
cefixime oral capsule 400 mg	4	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	4	
cefotetan disodium injection solution reconstituted 1 gm, 2 gm	4	BD
cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm	4	BD
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	4	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	4	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefprozil oral tablet 250 mg, 500 mg	2	
ceftazidime injection solution reconstituted 1 gm, 6 gm	4	
ceftazidime intravenous solution reconstituted 2 gm	4	
ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg	4	

Drug Name	Tier	Requirements/Limits
ceftriaxone sodium intravenous solution reconstituted 10 gm	4	
cefuroxime axetil oral tablet 250 mg, 500 mg	2	
cefuroxime sodium injection solution reconstituted 750 mg	4	BD
cefuroxime sodium intravenous solution reconstituted 1.5 gm	4	BD
cephalexin oral capsule 250 mg, 500 mg	1	GC
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cephalexin oral tablet 250 mg, 500 mg	2	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5	BD
BETA-LACTAM, PENICILLINS		
amoxicillin oral capsule 250 mg, 500 mg	1	GC
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	GC
amoxicillin oral tablet 500 mg, 875 mg	1	GC
amoxicillin oral tablet chewable 125 mg, 250 mg	1	GC
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	4	
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	2	
amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	2	
ampicillin oral capsule 500 mg	1	GC
ampicillin sodium injection solution reconstituted 1 gm, 125 mg	4	BD
ampicillin sodium intravenous solution reconstituted 10 gm	4	BD
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm	4	
ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm	4	
BICILLIN L-A INTRAMUSCULAR SUSPENSION 2400000 UNIT/4ML	4	

Drug Name	Tier	Requirements/Limits
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 600000 UNIT/ML	4	
dicloxacillin sodium oral capsule 250 mg, 500 mg	2	
nafcillin sodium injection solution reconstituted 1 gm, 2 gm	4	BD
nafcillin sodium intravenous solution reconstituted 10 gm	4	BD
oxacillin sodium in dextrose intravenous solution 1 gm/50ml, 2 gm/50ml	4	BD
oxacillin sodium injection solution reconstituted 1 gm, 2 gm	4	BD
oxacillin sodium intravenous solution reconstituted 10 gm	4	BD
penicillin g pot in dextrose intravenous solution 40000 unit/ml, 60000 unit/ml	4	
penicillin g potassium injection solution reconstituted 20000000 unit	4	BD
penicillin g procaine intramuscular suspension 600000 unit/ml	4	
penicillin g sodium injection solution reconstituted 5000000 unit	4	BD
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	2	
penicillin v potassium oral tablet 250 mg, 500 mg	1	GC
piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm	4	
CARBAPENEMS		
ertapenem sodium injection solution reconstituted 1 gm	4	
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	4	
meropenem intravenous solution reconstituted 1 gm, 500 mg	4	
MACROLIDES		
azithromycin intravenous solution reconstituted 500 mg	2	BD
azithromycin oral packet 1 gm	2	

Drug Name	Tier	Requirements/Limits
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	2	
azithromycin oral tablet 250 mg, 250 mg (6 pack)	1	GC
azithromycin oral tablet 500 mg, 500 mg (3 pack), 600 mg	2	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	2	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5	PA; QL (136 ML per 10 days)
DIFICID ORAL TABLET 200 MG	5	PA; QL (20 EA per 10 days)
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	BD
erythromycin base oral capsule delayed release particles 250 mg	4	
erythromycin base oral tablet 250 mg, 500 mg	4	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml	4	
erythromycin ethylsuccinate oral tablet 400 mg	4	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	4	
QUINOLONES		
ciprofloxacin hcl ophthalmic solution 0.3 %	1	GC
ciprofloxacin hcl oral tablet 100 mg, 750 mg	2	
ciprofloxacin hcl oral tablet 250 mg, 500 mg	1	GC
ciprofloxacin in d5w intravenous solution 200 mg/100ml	4	BD
levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml	4	
levofloxacin intravenous solution 25 mg/ml	4	
levofloxacin oral solution 25 mg/ml	4	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	2	
moxifloxacin hcl in nacl intravenous solution 400 mg/250ml	4	BD
moxifloxacin hcl oral tablet 400 mg	4	

Drug Name	Tier	Requirements/Limits
ofloxacin oral tablet 300 mg, 400 mg	2	
SULFONAMIDES		
sulfacetamide sodium (acne) external lotion 10 %	2	
sulfadiazine oral tablet 500 mg	2	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	2	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	GC
TETRACYCLINES		
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	4	BD
doxycycline hyclate oral capsule 100 mg, 50 mg	2	
doxycycline hyclate oral tablet 100 mg, 20 mg	2	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	GC
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	2	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	2	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	2	
tetracycline hcl oral capsule 250 mg, 500 mg	2	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT ORAL SOLUTION 10 MG/ML	4	MO; QL (600 ML per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	4	MO; QL (60 EA per 30 days)
DIACOMIT ORAL CAPSULE 250 MG, 500 MG	4	PA; MO
DIACOMIT ORAL PACKET 250 MG, 500 MG	4	PA; MO
EPIDIOLEX ORAL SOLUTION 100 MG/ML	4	PA; MO
felbamate oral suspension 600 mg/5ml	5	MO
felbamate oral tablet 400 mg, 600 mg	4	MO
FINTEPLA ORAL SOLUTION 2.2 MG/ML	4	PA; MO
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	4	ST; MO; QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG	5	ST; MO; QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG, 8 MG	4	ST; MO; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	4	MO
lamotrigine oral kit 25 & 50 & 100 mg	2	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	MO; GC
lamotrigine oral tablet chewable 25 mg, 5 mg	2	MO
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	4	MO
lamotrigine starter kit-blue oral kit 35 x 25 mg	2	
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	2	
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	2	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	2	MO
levetiracetam oral solution 100 mg/ml	2	MO
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	MO; GC
phenobarbital oral elixir 20 mg/5ml	2	MO; QL (1500 ML per 30 days)
phenobarbital oral tablet 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	2	MO; QL (90 EA per 30 days)
phenobarbital oral tablet 15 mg, 60 mg	2	MO; QL (120 EA per 30 days)
phenobarbital oral tablet 30 mg	2	MO; QL (300 EA per 30 days)
primidone oral tablet 250 mg, 50 mg	1	MO; GC
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG	4	ST; MO; QL (90 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG, 750 MG	4	ST; MO; QL (120 EA per 30 days)
valproic acid oral capsule 250 mg	2	MO
valproic acid oral solution 250 mg/5ml	2	MO
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	4	MO; QL (56 EA per 28 days)
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	4	MO; QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	MO; QL (60 EA per 30 days)

Drug Name	Tier	Requirements/Limits
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG	4	QL (28 EA per 28 days)
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN ORAL CAPSULE 300 MG	4	ST; MO
ethosuximide oral capsule 250 mg	2	MO
ethosuximide oral solution 250 mg/5ml	2	MO
zonisamide oral capsule 100 mg, 25 mg, 50 mg	2	MO
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam oral suspension 2.5 mg/ml	4	MO; QL (480 ML per 30 days)
clobazam oral tablet 10 mg, 20 mg	4	MO; QL (60 EA per 30 days)
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	4	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	MO; GC; QL (270 EA per 30 days)
gabapentin oral solution 250 mg/5ml	2	MO
gabapentin oral tablet 600 mg, 800 mg	1	MO; GC; QL (180 EA per 30 days)
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	ST; MO; QL (60 EA per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	ST; MO; QL (60 EA per 30 days)
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	4	MO
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	4	ST
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	4	ST
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	4	ST
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	4	ST
vigabatrin oral packet 500 mg	5	PA; MO; QL (180 EA per 30 days)
vigabatrin oral tablet 500 mg	5	PA; MO; QL (180 EA per 30 days)
SODIUM CHANNEL AGENTS		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	5	ST; MO; QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG	5	ST; MO; QL (60 EA per 30 days)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	2	MO

Drug Name	Tier	Requirements/Limits
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	2	MO
carbamazepine oral suspension 100 mg/5ml	2	MO
carbamazepine oral tablet 200 mg	2	MO
carbamazepine oral tablet chewable 100 mg	1	MO; GC
DILANTIN ORAL CAPSULE 30 MG	4	ST; MO
EPITOL ORAL TABLET 200 MG	2	MO
lacosamide oral solution 10 mg/ml	4	MO; QL (1395 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	4	MO; QL (60 EA per 30 days)
oxcarbazepine oral suspension 300 mg/5ml	4	MO
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	MO; GC
phenytoin oral suspension 125 mg/5ml	1	MO; GC
phenytoin oral tablet chewable 50 mg	1	MO; GC
phenytoin sodium extended oral capsule 100 mg, 200 mg	1	MO; GC
phenytoin sodium extended oral capsule 300 mg	2	MO
rufinamide oral suspension 40 mg/ml	5	MO; QL (2760 ML per 30 days)
rufinamide oral tablet 200 mg	4	MO; QL (480 EA per 30 days)
rufinamide oral tablet 400 mg	5	MO; QL (240 EA per 30 days)
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	3	MO; QL (30 EA per 30 days)
memantine hcl oral solution 2 mg/ml	2	MO; QL (360 ML per 30 days)
memantine hcl oral tablet 10 mg, 5 mg	2	MO; QL (60 EA per 30 days)
memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg	2	QL (49 EA per 28 days)
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG	3	PA
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	3	PA; MO
CHOLINESTERASE INHIBITORS		
donepezil hcl oral tablet 10 mg	1	MO; GC; QL (60 EA per 30 days)
donepezil hcl oral tablet 23 mg	2	MO; QL (30 EA per 30 days)
donepezil hcl oral tablet 5 mg	1	MO; GC; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
donepezil hcl oral tablet dispersible 10 mg	1	MO; GC; QL (60 EA per 30 days)
donepezil hcl oral tablet dispersible 5 mg	1	MO; GC; QL (30 EA per 30 days)
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	2	MO; QL (30 EA per 30 days)
galantamine hydrobromide oral solution 4 mg/ml	2	MO; QL (200 ML per 30 days)
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	2	MO; QL (60 EA per 30 days)
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	2	MO; QL (60 EA per 30 days)
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	2	MO; QL (30 EA per 30 days)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg	1	MO; GC; QL (120 EA per 30 days)
bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg	1	MO; GC; QL (90 EA per 30 days)
bupropion hcl er (sr) oral tablet extended release 12 hour 200 mg	1	MO; GC; QL (60 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg	2	MO; QL (60 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg	2	MO; QL (90 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg	3	MO; QL (30 EA per 30 days)
bupropion hcl oral tablet 100 mg	1	MO; GC; QL (180 EA per 30 days)
bupropion hcl oral tablet 75 mg	1	MO; GC; QL (120 EA per 30 days)
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	1	MO; GC; QL (30 EA per 30 days)
mirtazapine oral tablet 7.5 mg	1	MO; GC; QL (45 EA per 30 days)
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	2	MO; QL (30 EA per 30 days)
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg	4	MO; QL (30 EA per 30 days)
olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg	4	MO; QL (90 EA per 30 days)
MONOAMINE OXIDASE INHIBITORS		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5	ST; MO; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
MARPLAN ORAL TABLET 10 MG	4	ST; MO; QL (180 EA per 30 days)
phenelzine sulfate oral tablet 15 mg	2	MO
tranylcypromine sulfate oral tablet 10 mg	4	MO
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
citalopram hydrobromide oral capsule 30 mg	1	MO; GC; QL (30 EA per 30 days)
citalopram hydrobromide oral solution 10 mg/5ml	2	MO; QL (600 ML per 30 days)
citalopram hydrobromide oral tablet 10 mg, 40 mg	1	MO; GC; QL (30 EA per 30 days)
citalopram hydrobromide oral tablet 20 mg	1	MO; GC; QL (60 EA per 30 days)
desvenlafaxine er oral tablet extended release 24 hour 100 mg, 50 mg	4	MO; QL (30 EA per 30 days)
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	4	MO; QL (30 EA per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	3	MO; QL (60 EA per 30 days)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 40 mg, 60 mg	2	MO; QL (60 EA per 30 days)
escitalopram oxalate oral solution 5 mg/5ml	2	MO; QL (600 ML per 30 days)
escitalopram oxalate oral tablet 10 mg	1	MO; GC; QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg	1	MO; GC; QL (60 EA per 30 days)
escitalopram oxalate oral tablet 5 mg	1	MO; GC; QL (30 EA per 30 days)
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	3	MO; QL (30 EA per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	3	QL (28 EA per 28 days)
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	MO; GC; QL (60 EA per 30 days)
fluoxetine hcl oral solution 20 mg/5ml	2	MO; QL (600 ML per 30 days)
fluoxetine hcl oral tablet 10 mg	2	MO; QL (60 EA per 30 days)
fluoxetine hcl oral tablet 20 mg	2	MO; QL (120 EA per 30 days)
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	2	MO; QL (90 EA per 30 days)
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	4	MO
paroxetine hcl oral suspension 10 mg/5ml	4	MO; QL (900 ML per 30 days)
paroxetine hcl oral tablet 10 mg, 20 mg	1	MO; GC; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
paroxetine hcl oral tablet 30 mg, 40 mg	1	MO; GC; QL (60 EA per 30 days)
sertraline hcl oral capsule 150 mg, 200 mg	2	MO; QL (30 EA per 30 days)
sertraline hcl oral concentrate 20 mg/ml	1	MO; GC; QL (300 ML per 30 days)
sertraline hcl oral tablet 100 mg	1	MO; GC; QL (60 EA per 30 days)
sertraline hcl oral tablet 25 mg, 50 mg	1	MO; GC; QL (90 EA per 30 days)
trazodone hcl oral tablet 100 mg, 150 mg, 50 mg	1	MO; GC
trazodone hcl oral tablet 300 mg	2	MO
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	ST; MO; QL (30 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	MO; GC; QL (60 EA per 30 days)
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg, 75 mg	2	MO; QL (30 EA per 30 days)
venlafaxine hcl er oral tablet extended release 24 hour 225 mg	4	MO; QL (30 EA per 30 days)
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	MO; GC; QL (90 EA per 30 days)
VIIBRYD STARTER PACK ORAL KIT 10 & 20 MG	3	QL (30 EA per 30 days)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	3	MO; QL (30 EA per 30 days)
TRICYCLICS		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	MO
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	2	MO
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	4	MO
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	MO
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	MO
doxepin hcl oral concentrate 10 mg/ml	2	MO
imipramine hcl oral tablet 10 mg, 25 mg	1	MO; GC
imipramine hcl oral tablet 50 mg	2	MO
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	MO; GC
nortriptyline hcl oral solution 10 mg/5ml	2	MO

Drug Name	Tier	Requirements/Limits
protriptyline hcl oral tablet 10 mg, 5 mg	4	MO
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	4	MO
ANTIEMETICS		
ANTIEMETICS, OTHER		
meclizine hcl oral tablet 12.5 mg, 25 mg	1	GC
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	BD; MO; GC
prochlorperazine rectal suppository 25 mg	4	
promethazine hcl oral syrup 6.25 mg/5ml	2	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	GC
promethazine hcl rectal suppository 12.5 mg, 25 mg	2	
scopolamine transdermal patch 72 hour 1 mg/3days	4	
EMETOGENIC THERAPY ADJUNCTS		
aprepitant oral capsule 125 mg, 40 mg, 80 mg	4	BD; QL (30 EA per 30 days)
aprepitant oral capsule 80 & 125 mg	4	BD; QL (12 EA per 30 days)
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	4	PA; QL (60 EA per 30 days)
granisetron hcl oral tablet 1 mg	4	BD; QL (60 EA per 30 days)
ondansetron hcl oral solution 4 mg/5ml	2	BD
ondansetron hcl oral tablet 4 mg, 8 mg	1	BD; GC
ondansetron oral tablet dispersible 4 mg, 8 mg	2	BD
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG	3	BD
ANTIFUNGALS		
ANTIFUNGALS		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	BD
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG	5	BD
amphotericin b intravenous solution reconstituted 50 mg	4	BD
caspofungin acetate intravenous solution reconstituted 50 mg	5	

Drug Name	Tier	Requirements/Limits
caspofungin acetate intravenous solution reconstituted 70 mg	4	
ciclopirox olamine external cream 0.77 %	2	
ciclopirox olamine external suspension 0.77 %	2	
clotrimazole external cream 1 %	1	GC
clotrimazole external solution 1 %	2	
clotrimazole mouth/throat troche 10 mg	2	
econazole nitrate external cream 1 %	2	
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	BD
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	4	BD
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%	2	BD
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	
flucytosine oral capsule 250 mg, 500 mg	5	
griseofulvin microsize oral suspension 125 mg/5ml	2	
griseofulvin microsize oral tablet 500 mg	2	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	2	
itraconazole oral capsule 100 mg	4	PA
itraconazole oral solution 10 mg/ml	4	PA
JUBLIA EXTERNAL SOLUTION 10 %	4	
ketoconazole external cream 2 %	2	
ketoconazole external shampoo 2 %	1	GC
ketoconazole oral tablet 200 mg	1	GC
NOXAFIL ORAL SUSPENSION 40 MG/ML	5	PA; MO
NYAMYC EXTERNAL POWDER 100000 UNIT/GM	3	
nystatin external cream 100000 unit/gm	1	GC
nystatin external ointment 100000 unit/gm	1	GC
nystatin external powder 100000 unit/gm	2	
nystatin mouth/throat suspension 100000 unit/ml	2	

Drug Name	Tier	Requirements/Limits
nystatin oral tablet 500000 unit	2	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	3	
posaconazole oral tablet delayed release 100 mg	4	PA; MO
terbinafine hcl oral tablet 250 mg	2	
terconazole vaginal cream 0.4 %, 0.8 %	2	
terconazole vaginal suppository 80 mg	2	
voriconazole intravenous solution reconstituted 200 mg	5	PA
voriconazole oral suspension reconstituted 40 mg/ml	5	PA
voriconazole oral tablet 200 mg, 50 mg	4	PA
ANTIGOUT AGENTS		
ANTIGOUT AGENTS		
allopurinol oral tablet 100 mg, 300 mg	1	MO; GC
colchicine oral capsule 0.6 mg	3	
colchicine oral tablet 0.6 mg	3	
colchicine-probenecid oral tablet 0.5-500 mg	3	MO
febuxostat oral tablet 40 mg, 80 mg	3	PA; MO
probenecid oral tablet 500 mg	2	MO
ANTIMIGRAINE AGENTS		
ERGOT ALKALOIDS		
dihydroergotamine mesylate nasal solution 4 mg/ml	5	
ergotamine-caffeine oral tablet 1-100 mg	2	QL (40 EA per 28 days)
PROPHYLACTIC		
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	3	PA; MO
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	3	PA; MO
EPRONTIA ORAL SOLUTION 25 MG/ML	3	MO
propranolol hcl er oral capsule extended release 24 hour 80 mg	2	MO
propranolol hcl oral tablet 80 mg	2	MO
topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	4	MO

Drug Name	Tier	Requirements/Limits
topiramate oral capsule sprinkle 15 mg, 25 mg	2	MO
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	MO; GC
UBRELVY ORAL TABLET 100 MG, 50 MG	4	PA; QL (16 EA per 30 days)
SEROTONIN (5-HT) RECEPTOR AGONIST		
naratriptan hcl oral tablet 1 mg, 2.5 mg	2	QL (9 EA per 30 days)
rizatriptan benzoate oral tablet 10 mg, 5 mg	2	QL (12 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	2	QL (12 EA per 30 days)
sumatriptan nasal solution 20 mg/act	4	QL (12 EA per 30 days)
sumatriptan nasal solution 5 mg/act	4	QL (18 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	GC; QL (9 EA per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	2	QL (4 ML per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	2	QL (4 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	2	QL (4 ML per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	2	QL (6 EA per 30 days)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	2	QL (6 EA per 30 days)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
pyridostigmine bromide oral solution 60 mg/5ml	2	
pyridostigmine bromide oral tablet 30 mg, 60 mg	2	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone oral tablet 100 mg, 25 mg	2	MO
PRIFTIN ORAL TABLET 150 MG	4	
rifabutin oral capsule 150 mg	4	
ANTITUBERCULARS		
ethambutol hcl oral tablet 100 mg, 400 mg	2	
isoniazid oral syrup 50 mg/5ml	1	MO; GC
isoniazid oral tablet 100 mg, 300 mg	1	MO; GC
PASER ORAL PACKET 4 GM	4	

Drug Name	Tier	Requirements/Limits
pyrazinamide oral tablet 500 mg	2	
rifampin intravenous solution reconstituted 600 mg	4	
rifampin oral capsule 150 mg, 300 mg	2	
SIRTURO ORAL TABLET 100 MG, 20 MG	5	PA
TRECATOR ORAL TABLET 250 MG	4	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
cyclophosphamide oral capsule 25 mg, 50 mg	4	BD
cyclophosphamide oral tablet 25 mg, 50 mg	2	BD
LEUKERAN ORAL TABLET 2 MG	4	
MATULANE ORAL CAPSULE 50 MG	5	PA
VALCHLOR EXTERNAL GEL 0.016 %	5	PA; QL (60 GM per 14 days)
ANTIANDROGENS		
abiraterone acetate oral tablet 250 mg, 500 mg	5	PA; QL (120 EA per 30 days)
bicalutamide oral tablet 50 mg	1	GC
ERLEADA ORAL TABLET 60 MG	5	PA; QL (120 EA per 30 days)
LYSODREN ORAL TABLET 500 MG	5	
nilutamide oral tablet 150 mg	5	QL (60 EA per 30 days)
NUBEQA ORAL TABLET 300 MG	5	PA; QL (120 EA per 30 days)
XTANDI ORAL CAPSULE 40 MG	5	PA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA; QL (120 EA per 30 days)
XTANDI ORAL TABLET 80 MG	5	PA; QL (90 EA per 30 days)
YONSA ORAL TABLET 125 MG	5	PA; QL (120 EA per 30 days)
ANTIANGIOGENIC AGENTS		
lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg	5	PA; QL (28 EA per 28 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA; QL (21 EA per 28 days)
REVLIMID ORAL CAPSULE 2.5 MG, 20 MG	5	PA; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 100 MG, 200 MG, 50 MG	5	PA; MO; QL (30 EA per 30 days)
THALOMID ORAL CAPSULE 150 MG	5	PA; MO; QL (60 EA per 30 days)
ANTIESTROGENS/MODIFIERS		
EMCYT ORAL CAPSULE 140 MG	3	

Drug Name	Tier	Requirements/Limits
SOLTAMOX ORAL SOLUTION 10 MG/5ML	4	PA; MO
tamoxifen citrate oral tablet 10 mg, 20 mg	1	MO; GC
toremifene citrate oral tablet 60 mg	5	PA; MO
ANTIMETABOLITES		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	4	MO
hydroxyurea oral capsule 500 mg	1	GC
INQOVI ORAL TABLET 35-100 MG	5	PA
mercaptopurine oral tablet 50 mg	2	
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA
PURIXAN ORAL SUSPENSION 2000 MG/100ML	4	
TABLOID ORAL TABLET 40 MG	4	PA
ANTINEOPLASTICS, OTHER		
IDHIFA ORAL TABLET 100 MG	5	PA; QL (30 EA per 30 days)
IDHIFA ORAL TABLET 50 MG	5	PA; QL (60 EA per 30 days)
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	2	
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA
LUMAKRAS ORAL TABLET 120 MG	5	PA; QL (240 EA per 30 days)
LYNPARZA ORAL TABLET 100 MG	5	PA; QL (180 EA per 30 days)
LYNPARZA ORAL TABLET 150 MG	5	PA; QL (120 EA per 30 days)
MESNEX ORAL TABLET 400 MG	5	
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA
ORGOVYX ORAL TABLET 120 MG	5	PA; QL (60 EA per 30 days)
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG	5	PA
WELIREG ORAL TABLET 40 MG	5	PA; QL (90 EA per 30 days)

Drug Name	Tier	Requirements/Limits
XATMEP ORAL SOLUTION 2.5 MG/ML	4	BD
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA
ZOLINZA ORAL CAPSULE 100 MG	5	PA; QL (120 EA per 30 days)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole oral tablet 1 mg	1	MO; GC
exemestane oral tablet 25 mg	4	MO
letrozole oral tablet 2.5 mg	1	MO; GC
MOLECULAR TARGET INHIBITORS		
ALECENSA ORAL CAPSULE 150 MG	5	PA
ALUNBRIG ORAL TABLET 180 MG	5	PA; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; QL (180 EA per 30 days)
ALUNBRIG ORAL TABLET 90 MG	5	PA; QL (60 EA per 30 days)
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA; QL (30 EA per 30 days)
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5	PA; QL (30 EA per 30 days)
BALVERSA ORAL TABLET 3 MG	5	PA; QL (90 EA per 30 days)
BALVERSA ORAL TABLET 4 MG	5	PA; QL (60 EA per 30 days)
BALVERSA ORAL TABLET 5 MG	5	PA; QL (30 EA per 30 days)
BOSULIF ORAL TABLET 100 MG	5	PA; QL (120 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA; QL (30 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; QL (180 EA per 30 days)
BRUKINSA ORAL CAPSULE 80 MG	5	PA; QL (120 EA per 30 days)

Drug Name	Tier	Requirements/Limits
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA
CALQUENCE ORAL CAPSULE 100 MG	5	PA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; QL (30 EA per 30 days)
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA; QL (56 EA per 28 days)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA; QL (112 EA per 28 days)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA; QL (84 EA per 28 days)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA; QL (60 EA per 30 days)
COTELLIC ORAL TABLET 20 MG	5	PA; QL (63 EA per 28 days)
DAURISMO ORAL TABLET 100 MG, 25 MG	5	PA
ERIVEDGE ORAL CAPSULE 150 MG	5	PA
erlotinib hcl oral tablet 100 mg, 150 mg	5	PA; QL (30 EA per 30 days)
erlotinib hcl oral tablet 25 mg	5	PA; QL (90 EA per 30 days)
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	5	PA; QL (30 EA per 30 days)
everolimus oral tablet soluble 2 mg, 3 mg	5	PA; QL (30 EA per 30 days)
everolimus oral tablet soluble 5 mg	5	PA; QL (60 EA per 30 days)
EXKIVITY ORAL CAPSULE 40 MG	5	PA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5	PA; QL (21 EA per 28 days)
GAVRETO ORAL CAPSULE 100 MG	5	PA; QL (120 EA per 30 days)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; QL (30 EA per 30 days)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA
ICLUSIG ORAL TABLET 10 MG, 30 MG, 45 MG	5	PA; QL (30 EA per 30 days)
ICLUSIG ORAL TABLET 15 MG	5	PA; QL (60 EA per 30 days)
imatinib mesylate oral tablet 100 mg	5	PA; QL (90 EA per 30 days)
imatinib mesylate oral tablet 400 mg	5	PA; QL (60 EA per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; QL (28 EA per 28 days)

Drug Name	Tier	Requirements/Limits
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	5	PA; QL (28 EA per 28 days)
INLYTA ORAL TABLET 1 MG	5	PA; QL (180 EA per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA; QL (60 EA per 30 days)
INREBIC ORAL CAPSULE 100 MG	5	PA; QL (120 EA per 30 days)
IRESSA ORAL TABLET 250 MG	5	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA; QL (60 EA per 30 days)
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KOSELUGO ORAL CAPSULE 10 MG	5	PA; QL (240 EA per 30 days)
KOSELUGO ORAL CAPSULE 25 MG	5	PA; QL (120 EA per 30 days)
lapatinib ditosylate oral tablet 250 mg	5	PA; QL (180 EA per 30 days)
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA
LORBRENA ORAL TABLET 100 MG	5	PA; QL (30 EA per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA; QL (120 EA per 30 days)
MEKINIST ORAL TABLET 0.5 MG	5	PA; QL (120 EA per 30 days)

Drug Name	Tier	Requirements/Limits
MEKINIST ORAL TABLET 2 MG	5	PA; QL (30 EA per 30 days)
MEKTOVI ORAL TABLET 15 MG	5	PA; QL (180 EA per 30 days)
NERLYNX ORAL TABLET 40 MG	5	PA; QL (180 EA per 30 days)
ODOMZO ORAL CAPSULE 200 MG	5	PA
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA; QL (14 EA per 21 days)
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA
QINLOCK ORAL TABLET 50 MG	5	PA; QL (90 EA per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5	PA; QL (120 EA per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PA; QL (180 EA per 30 days)
ROZLYTREK ORAL CAPSULE 100 MG	5	PA; QL (150 EA per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA; QL (90 EA per 30 days)
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA
RYDAPT ORAL CAPSULE 25 MG	5	PA; QL (240 EA per 30 days)
SCEMBLIX ORAL TABLET 20 MG, 40 MG	5	PA
sorafenib tosylate oral tablet 200 mg	5	PA; QL (120 EA per 30 days)
SPRYCEL ORAL TABLET 100 MG, 50 MG, 70 MG, 80 MG	5	PA; QL (60 EA per 30 days)
SPRYCEL ORAL TABLET 140 MG	5	PA; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG	5	PA; QL (90 EA per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA; QL (84 EA per 28 days)
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	PA; QL (28 EA per 28 days)
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA; QL (120 EA per 30 days)
TAFINLAR ORAL CAPSULE 50 MG	5	PA; QL (180 EA per 30 days)
TAFINLAR ORAL CAPSULE 75 MG	5	PA; QL (120 EA per 30 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA
TALZENNA ORAL CAPSULE 0.25 MG	5	PA; QL (120 EA per 30 days)
TALZENNA ORAL CAPSULE 0.5 MG	5	PA; QL (60 EA per 30 days)
TALZENNA ORAL CAPSULE 0.75 MG, 1 MG	5	PA; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	5	PA; QL (120 EA per 30 days)
TAZVERIK ORAL TABLET 200 MG	5	PA; QL (240 EA per 30 days)
TEPMETKO ORAL TABLET 225 MG	5	PA; QL (60 EA per 30 days)
TIBSOVO ORAL TABLET 250 MG	5	PA; QL (60 EA per 30 days)
TRUSELTIQ (100MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 MG	5	PA; QL (21 EA per 28 days)
TRUSELTIQ (125MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 & 25 MG	5	PA; QL (42 EA per 28 days)
TRUSELTIQ (50MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5	PA; QL (42 EA per 28 days)
TRUSELTIQ (75MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5	PA; QL (63 EA per 28 days)
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA; QL (120 EA per 30 days)
TURALIO ORAL CAPSULE 200 MG	5	PA; QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 10 MG, 50 MG	4	PA
VENCLEXTA ORAL TABLET 100 MG	5	PA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	3	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA
VITRAKVI ORAL CAPSULE 100 MG	5	PA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA; QL (180 EA per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA; QL (310 ML per 30 days)
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA; QL (30 EA per 30 days)
VONJO ORAL CAPSULE 100 MG	5	PA
VOTRIENT ORAL TABLET 200 MG	5	PA; QL (120 EA per 30 days)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA; QL (120 EA per 30 days)
XOSPATA ORAL TABLET 40 MG	5	PA; QL (90 EA per 30 days)
ZEJULA ORAL CAPSULE 100 MG	5	PA; QL (90 EA per 30 days)
ZELBORAF ORAL TABLET 240 MG	5	PA; QL (240 EA per 30 days)
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA; QL (60 EA per 30 days)
ZYKADIA ORAL TABLET 150 MG	5	PA; QL (150 EA per 30 days)
RETINOIDS		
bexarotene external gel 1 %	5	PA

Drug Name	Tier	Requirements/Limits
bexarotene oral capsule 75 mg	5	PA; QL (300 EA per 30 days)
tretinoin oral capsule 10 mg	5	
ANTIPARASITICS		
ANTHELMINTICS		
albendazole oral tablet 200 mg	4	
EMVERM ORAL TABLET CHEWABLE 100 MG	5	
ivermectin oral tablet 3 mg	2	PA
ANTIPROTOZOALS		
atovaquone oral suspension 750 mg/5ml	5	
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	2	
benznidazole oral tablet 100 mg, 12.5 mg	2	
chloroquine phosphate oral tablet 250 mg, 500 mg	2	MO
COARTEM ORAL TABLET 20-120 MG	4	
hydroxychloroquine sulfate oral tablet 100 mg, 200 mg, 300 mg, 400 mg	2	MO
LAMPIT ORAL TABLET 120 MG, 30 MG	4	
mefloquine hcl oral tablet 250 mg	2	MO
nitazoxanide oral tablet 500 mg	4	QL (40 EA per 30 days)
pentamidine isethionate inhalation solution reconstituted 300 mg	4	BD
pentamidine isethionate injection solution reconstituted 300 mg	4	BD
primaquine phosphate oral tablet 26.3 (15 base) mg	4	
quinine sulfate oral capsule 324 mg	2	PA
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	MO; GC
trihexyphenidyl hcl oral solution 0.4 mg/ml	1	MO; GC
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	MO; GC
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl oral capsule 100 mg	2	MO

Drug Name	Tier	Requirements/Limits
amantadine hcl oral solution 50 mg/5ml	2	MO
amantadine hcl oral tablet 100 mg	2	MO
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	2	MO
entacapone oral tablet 200 mg	2	MO
DOPAMINE AGONISTS		
bromocriptine mesylate oral capsule 5 mg	2	MO
bromocriptine mesylate oral tablet 2.5 mg	2	MO
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; QL (150 EA per 30 days)
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR	4	MO
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	MO; GC
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	MO; GC
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa oral tablet 25 mg	2	MO
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	2	MO
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	2	MO
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	2	MO
INBRIJA INHALATION CAPSULE 42 MG	5	MO
RYTARY ORAL CAPSULE EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG	4	ST; MO
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate oral tablet 0.5 mg, 1 mg	4	MO
selegiline hcl oral capsule 5 mg	2	MO
selegiline hcl oral tablet 5 mg	2	MO
ANTIPSYCHOTICS		

Drug Name	Tier	Requirements/Limits
1ST GENERATION/TYPICAL		
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	4	MO
chlorpromazine hcl oral tablet 10 mg, 25 mg	4	BD; MO
chlorpromazine hcl oral tablet 100 mg, 200 mg, 50 mg	4	MO
fluphenazine decanoate injection solution 25 mg/ml	4	
fluphenazine hcl injection solution 2.5 mg/ml	4	
fluphenazine hcl oral concentrate 5 mg/ml	2	MO
fluphenazine hcl oral elixir 2.5 mg/5ml	2	MO
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	2	MO
haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml(1ml)	2	
haloperidol lactate injection solution 5 mg/ml	4	
haloperidol lactate oral concentrate 2 mg/ml	1	MO; GC
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	MO; GC
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	2	MO
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	2	MO
perphenazine oral tablet 16 mg, 2 mg	2	MO
perphenazine oral tablet 4 mg, 8 mg	2	BD; MO
pimozide oral tablet 1 mg, 2 mg	2	MO
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	MO
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	2	MO
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	1	MO; GC
2ND GENERATION/ATYPICAL		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	5	MO
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	5	MO
aripiprazole oral solution 1 mg/ml	4	MO; QL (750 ML per 30 days)

Drug Name	Tier	Requirements/Limits
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	4	MO; QL (30 EA per 30 days)
aripiprazole oral tablet dispersible 10 mg	5	MO; QL (90 EA per 30 days)
aripiprazole oral tablet dispersible 15 mg	5	MO; QL (60 EA per 30 days)
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	4	MO; QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 42 MG	5	MO
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	4	ST; QL (60 EA per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	5	ST; QL (60 EA per 30 days)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	4	ST; QL (60 EA per 30 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML	5	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 78 MG/0.5ML	5	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML	5	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG	5	ST; MO
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	ST; MO; QL (30 EA per 30 days)
NUPLAZID ORAL CAPSULE 34 MG	5	PA; MO
NUPLAZID ORAL TABLET 10 MG	5	PA; MO
olanzapine intramuscular solution reconstituted 10 mg	4	QL (60 EA per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 5 mg, 7.5 mg	1	MO; GC; QL (30 EA per 30 days)
olanzapine oral tablet 20 mg	1	MO; GC; QL (60 EA per 30 days)
olanzapine oral tablet dispersible 10 mg, 5 mg	4	MO; QL (60 EA per 30 days)
olanzapine oral tablet dispersible 15 mg, 20 mg	4	MO; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	4	MO; QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 6 mg	4	MO; QL (60 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 150 mg	4	MO; QL (90 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 200 mg, 300 mg, 400 mg	4	MO; QL (60 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 50 mg	4	MO; QL (120 EA per 30 days)
quetiapine fumarate oral tablet 100 mg, 25 mg, 300 mg, 400 mg, 50 mg	1	MO; GC; QL (60 EA per 30 days)
quetiapine fumarate oral tablet 200 mg	1	MO; GC; QL (30 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	MO
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG	4	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG	5	
risperidone oral solution 1 mg/ml	2	MO; QL (480 ML per 30 days)
risperidone oral tablet 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	MO; GC; QL (60 EA per 30 days)
risperidone oral tablet 0.5 mg	1	MO; GC; QL (120 EA per 30 days)
risperidone oral tablet dispersible 0.25 mg, 1 mg, 2 mg	2	MO; QL (60 EA per 30 days)
risperidone oral tablet dispersible 0.5 mg	2	MO; QL (120 EA per 30 days)
risperidone oral tablet dispersible 3 mg	4	MO; QL (60 EA per 30 days)
risperidone oral tablet dispersible 4 mg	4	MO; QL (120 EA per 30 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	5	ST; MO; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG	5	ST; MO; QL (60 EA per 30 days)
VRAYLAR ORAL CAPSULE 3 MG, 4.5 MG, 6 MG	5	ST; MO; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	4	ST; QL (7 EA per 28 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	MO; QL (60 EA per 30 days)

Drug Name	Tier	Requirements/Limits
ziprasidone mesylate intramuscular solution reconstituted 20 mg	4	QL (6 EA per 3 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	4	ST
TREATMENT-RESISTANT		
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	QL (120 EA per 30 days)
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 25 mg	4	QL (120 EA per 30 days)
clozapine oral tablet dispersible 200 mg	5	QL (120 EA per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	ST; QL (540 ML per 30 days)
ANTISPASTICITY AGENTS		
ANTISPASTICITY AGENTS		
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	GC
tizanidine hcl oral tablet 2 mg, 4 mg	2	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
LIVTENCITY ORAL TABLET 200 MG	5	PA; MO
PREVYMIS ORAL TABLET 240 MG, 480 MG	5	PA; MO; QL (28 EA per 28 days)
valganciclovir hcl oral solution reconstituted 50 mg/ml	4	MO
valganciclovir hcl oral tablet 450 mg	3	MO
ZIRGAN OPHTHALMIC GEL 0.15 %	4	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil oral tablet 10 mg	5	PA; MO; QL (30 EA per 30 days)
BARACLUDE ORAL SOLUTION 0.05 MG/ML	5	PA; MO; QL (600 ML per 30 days)
entecavir oral tablet 0.5 mg, 1 mg	4	PA; MO; QL (30 EA per 30 days)
EPIVIR HBV ORAL SOLUTION 5 MG/ML	3	MO
lamivudine oral tablet 100 mg	2	MO; QL (90 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	5	PA; MO; QL (30 EA per 30 days)
ANTI-HEPATITIS C (HCV) AGENTS		
MAVYRET ORAL PACKET 50-20 MG	5	PA
MAVYRET ORAL TABLET 100-40 MG	5	PA
ribavirin oral capsule 200 mg	4	
ribavirin oral tablet 200 mg	2	

Drug Name	Tier	Requirements/Limits
sofosbuvir-velpatasvir oral tablet 400-100 mg	5	PA
VOSEVI ORAL TABLET 400-100-100 MG	5	PA
ANTIHERPETIC AGENTS		
acyclovir oral capsule 200 mg	1	GC
acyclovir oral suspension 200 mg/5ml	2	
acyclovir oral tablet 400 mg, 800 mg	1	GC
acyclovir sodium intravenous solution 50 mg/ml	2	BD
famciclovir oral tablet 125 mg, 250 mg, 500 mg	2	
trifluridine ophthalmic solution 1 %	2	
valacyclovir hcl oral tablet 1 gm, 500 mg	2	
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	MO; QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5	MO; QL (30 EA per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG	5	MO; QL (30 EA per 30 days)
ISENTRESS HD ORAL TABLET 600 MG	5	MO; QL (60 EA per 30 days)
ISENTRESS ORAL PACKET 100 MG	4	MO; QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	5	MO; QL (60 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG	4	MO; QL (180 EA per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	5	MO; QL (30 EA per 30 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	MO; QL (30 EA per 30 days)
TIVICAY ORAL TABLET 10 MG	4	MO; QL (60 EA per 30 days)
TIVICAY ORAL TABLET 25 MG, 50 MG	5	MO; QL (60 EA per 30 days)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	4	MO; QL (360 EA per 30 days)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA ORAL TABLET 200-25-300 MG	5	MO; QL (30 EA per 30 days)
EDURANT ORAL TABLET 25 MG	5	MO; QL (30 EA per 30 days)
efavirenz oral capsule 200 mg	4	MO; QL (120 EA per 30 days)
efavirenz oral capsule 50 mg	4	MO; QL (360 EA per 30 days)
efavirenz oral tablet 600 mg	4	MO; QL (30 EA per 30 days)
etravirine oral tablet 100 mg	5	MO; QL (120 EA per 30 days)

Drug Name	Tier	Requirements/Limits
etravirine oral tablet 200 mg	5	MO; QL (60 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	4	MO; QL (120 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 100 mg	4	MO; QL (120 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 400 mg	4	MO; QL (30 EA per 30 days)
nevirapine oral suspension 50 mg/5ml	4	MO; QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	2	MO; QL (60 EA per 30 days)
PIFELTRO ORAL TABLET 100 MG	5	MO; QL (30 EA per 30 days)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate oral solution 20 mg/ml	4	MO; QL (960 ML per 30 days)
abacavir sulfate oral tablet 300 mg	4	MO; QL (60 EA per 30 days)
abacavir sulfate-lamivudine oral tablet 600-300 mg	4	MO; QL (30 EA per 30 days)
CIMDUO ORAL TABLET 300-300 MG	5	MO; QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	5	MO; QL (30 EA per 30 days)
DESCOVY ORAL TABLET 200-25 MG	5	MO; QL (30 EA per 30 days)
efavirenz-emtricitab-tenofovir oral tablet 600-200-300 mg	5	MO; QL (30 EA per 30 days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	5	MO; QL (30 EA per 30 days)
emtricitabine oral capsule 200 mg	4	MO; QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	5	MO; QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	MO; QL (680 ML per 28 days)
JULUCA ORAL TABLET 50-25 MG	5	MO; QL (30 EA per 30 days)
lamivudine oral solution 10 mg/ml	4	MO; QL (900 ML per 30 days)
lamivudine oral tablet 150 mg	3	MO; QL (60 EA per 30 days)
lamivudine oral tablet 300 mg	3	MO; QL (30 EA per 30 days)
lamivudine-zidovudine oral tablet 150-300 mg	4	MO; QL (60 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	5	MO; QL (30 EA per 30 days)
tenofovir disoproxil fumarate oral tablet 300 mg	4	MO; QL (30 EA per 30 days)
TRIZIVIR ORAL TABLET 300-150-300 MG	5	MO; QL (60 EA per 30 days)
VIREAD ORAL POWDER 40 MG/GM	5	MO; QL (240 GM per 30 days)

Drug Name	Tier	Requirements/Limits
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	MO; QL (30 EA per 30 days)
zidovudine oral capsule 100 mg	2	MO; QL (180 EA per 30 days)
zidovudine oral syrup 50 mg/5ml	2	MO; QL (1680 ML per 28 days)
zidovudine oral tablet 300 mg	2	MO; QL (60 EA per 30 days)
ANTI-HIV AGENTS, OTHER		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	5	MO; QL (60 EA per 30 days)
maraviroc oral tablet 150 mg, 300 mg	5	MO; QL (120 EA per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	5	MO; QL (60 EA per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML	5	MO; QL (1800 ML per 30 days)
SELZENTRY ORAL TABLET 25 MG	3	MO; QL (120 EA per 30 days)
SELZENTRY ORAL TABLET 75 MG	5	MO; QL (60 EA per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG	5	MO; QL (30 EA per 30 days)
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	5	MO; QL (180 EA per 30 days)
TYBOST ORAL TABLET 150 MG	3	MO; QL (30 EA per 30 days)
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS ORAL CAPSULE 250 MG	5	MO; QL (120 EA per 30 days)
atazanavir sulfate oral capsule 150 mg, 200 mg	4	MO; QL (60 EA per 30 days)
atazanavir sulfate oral capsule 300 mg	4	MO; QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	5	MO; QL (30 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	5	MO; QL (120 EA per 30 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	4	MO; QL (1575 ML per 28 days)
lopinavir-ritonavir oral solution 400-100 mg/5ml	4	MO; QL (400 ML per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	4	MO; QL (300 EA per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	4	MO; QL (150 EA per 30 days)
NORVIR ORAL PACKET 100 MG	4	MO; QL (360 EA per 30 days)
NORVIR ORAL SOLUTION 80 MG/ML	4	MO; QL (480 ML per 30 days)
PREZCOBIX ORAL TABLET 800-150 MG	5	MO; QL (30 EA per 30 days)
PREZISTA ORAL SUSPENSION 100 MG/ML	5	MO; QL (360 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	4	MO; QL (240 EA per 30 days)
PREZISTA ORAL TABLET 600 MG	5	MO; QL (60 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	MO; QL (480 EA per 30 days)

Drug Name	Tier	Requirements/Limits
PREZISTA ORAL TABLET 800 MG	5	MO; QL (30 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	4	MO; QL (180 EA per 30 days)
ritonavir oral tablet 100 mg	3	MO; QL (360 EA per 30 days)
VIRACEPT ORAL TABLET 250 MG	5	MO; QL (300 EA per 30 days)
VIRACEPT ORAL TABLET 625 MG	5	MO; QL (120 EA per 30 days)
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	2	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	2	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/BLISTER	4	
rimantadine hcl oral tablet 100 mg	2	
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG	3	
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG	3	
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	GC
hydroxyzine hcl oral syrup 10 mg/5ml	4	
hydroxyzine hcl oral tablet 10 mg, 25 mg	1	GC
hydroxyzine hcl oral tablet 50 mg	2	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	2	
oxazepam oral capsule 10 mg, 15 mg, 30 mg	2	QL (120 EA per 30 days)
BENZODIAZEPINES		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	2	QL (300 ML per 30 days)
alprazolam oral tablet 0.25 mg, 0.5 mg	2	QL (120 EA per 30 days)
alprazolam oral tablet 1 mg	2	QL (240 EA per 30 days)
alprazolam oral tablet 2 mg	2	QL (150 EA per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	2	QL (120 EA per 30 days)

Drug Name	Tier	Requirements/Limits
clonazepam oral tablet 0.5 mg, 1 mg	1	GC; QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	1	GC; QL (300 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	2	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 2 mg	2	QL (300 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	2	QL (180 EA per 30 days)
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	2	QL (240 ML per 30 days)
diazepam oral solution 5 mg/5ml	2	QL (1200 ML per 30 days)
diazepam oral tablet 10 mg, 2 mg	1	GC; QL (120 EA per 30 days)
diazepam oral tablet 5 mg	1	GC; QL (240 EA per 30 days)
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	2	QL (240 ML per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	2	QL (150 EA per 30 days)
BIPOLAR AGENTS		
MOOD STABILIZERS		
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	MO
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	MO
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	MO; GC
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	MO; GC
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	MO; GC
lithium carbonate oral tablet 300 mg	1	MO; GC
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose oral tablet 100 mg, 25 mg, 50 mg	2	MO
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	MO; GC
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	MO; GC
glipizide oral tablet 10 mg, 5 mg	1	MO; GC
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	2	MO

Drug Name	Tier	Requirements/Limits
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	2	MO
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG	3	MO
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG	3	MO
INVOKANA ORAL TABLET 100 MG, 300 MG	3	MO
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	MO
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG	3	MO
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	MO
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	MO
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	1	MO; GC
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	MO; GC
miglitol oral tablet 100 mg, 25 mg, 50 mg	2	MO
nateglinide oral tablet 120 mg, 60 mg	2	MO
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	3	MO
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML	3	MO
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML	3	MO
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	MO; GC
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	2	MO
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	MO
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	2	MO
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	MO
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML	4	PA; MO

Drug Name	Tier	Requirements/Limits
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML	4	PA; MO
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	3	MO
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG	3	MO
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	MO
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	3	MO
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML	3	MO
GLYCEMIC AGENTS		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	3	
diazoxide oral suspension 50 mg/ml	5	MO
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG	3	
glucagon emergency injection kit 1 mg	3	
KORLYM ORAL TABLET 300 MG	5	PA; MO
INSULINS		
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	3	
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	3	
cvs gauze sterile pad 2"x2"	3	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM	3	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	MO
FIASP INJECTION SOLUTION 100 UNIT/ML	3	MO
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	MO
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	MO
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	MO

Drug Name	Tier	Requirements/Limits
LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	MO
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	MO
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	MO
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	MO
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	MO
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	MO
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	MO
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	MO
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	MO
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	3	MO
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	MO
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	MO
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	MO
preferred plus insulin syringe 28g x 1/2" 0.5 ml	3	
RELI-ON INSULIN SYRINGE 29G 0.3 ML	3	
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	MO
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	MO
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	MO
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	MO

Drug Name	Tier	Requirements/Limits
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	MO
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	3	MO
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml	4	QL (60 ML per 30 days)
enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml	4	QL (48 ML per 30 days)
enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml	4	QL (18 ML per 30 days)
enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml	4	QL (24 ML per 30 days)
enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml	4	QL (36 ML per 30 days)
fondaparinux sodium subcutaneous solution 10 mg/0.8ml	5	QL (24 ML per 30 days)
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	4	QL (15 ML per 30 days)
fondaparinux sodium subcutaneous solution 5 mg/0.4ml	5	QL (12 ML per 30 days)
fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml	5	QL (18 ML per 30 days)
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	2	BD
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	MO; GC
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	MO; GC
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	3	MO
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG	3	MO
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	
BLOOD PRODUCTS AND MODIFIERS, OTHER		

Drug Name	Tier	Requirements/Limits
anagrelide hcl oral capsule 0.5 mg, 1 mg	2	MO
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG	5	PA
PROMACTA ORAL PACKET 12.5 MG	5	PA; MO; QL (360 EA per 30 days)
PROMACTA ORAL PACKET 25 MG	5	PA; MO; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG	5	PA; MO; QL (60 EA per 30 days)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 20000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	4	PA; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 2000 UNIT/ML	4	PA; QL (23 ML per 30 days)
RETACRIT INJECTION SOLUTION 3000 UNIT/ML	4	PA; QL (16 ML per 30 days)
tranexamic acid oral tablet 650 mg	2	
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	2	MO
BRILINTA ORAL TABLET 60 MG, 90 MG	3	MO
CABLIVI INJECTION KIT 11 MG	5	PA
cilostazol oral tablet 100 mg, 50 mg	2	MO
clopidogrel bisulfate oral tablet 75 mg	2	MO
prasugrel hcl oral tablet 10 mg, 5 mg	4	MO
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	MO; GC
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	2	MO; QL (4 EA per 28 days)
droxidopa oral capsule 100 mg, 200 mg, 300 mg	5	PA; QL (180 EA per 30 days)
guanfacine hcl oral tablet 1 mg, 2 mg	1	MO; GC
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	2	
ALPHA-ADRENERGIC BLOCKING AGENTS		

Drug Name	Tier	Requirements/Limits
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	MO; GC
prazosin hcl oral capsule 1 mg, 2 mg	1	MO; GC
prazosin hcl oral capsule 5 mg	2	MO
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	MO; GC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg	2	MO; QL (60 EA per 30 days)
candesartan cilexetil oral tablet 32 mg	2	MO; QL (30 EA per 30 days)
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	MO; GC; QL (30 EA per 30 days)
losartan potassium oral tablet 100 mg, 25 mg	1	MO; GC; QL (30 EA per 30 days)
losartan potassium oral tablet 50 mg	1	MO; GC; QL (60 EA per 30 days)
olmesartan medoxomil oral tablet 20 mg, 40 mg	1	MO; GC; QL (30 EA per 30 days)
olmesartan medoxomil oral tablet 5 mg	1	MO; GC; QL (60 EA per 30 days)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	MO; GC; QL (30 EA per 30 days)
valsartan oral tablet 160 mg	2	MO; QL (60 EA per 30 days)
valsartan oral tablet 320 mg	2	MO; QL (30 EA per 30 days)
valsartan oral tablet 40 mg, 80 mg	2	MO; QL (90 EA per 30 days)
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	MO; GC
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	2	MO
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	MO; GC
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	MO; GC
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	MO; GC
moexipril hcl oral tablet 15 mg, 7.5 mg	2	MO
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	2	MO
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	MO; GC
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	MO; GC
trandolapril oral tablet 1 mg, 2 mg, 4 mg	2	MO
ANTIARRHYTHMICS		

Drug Name	Tier	Requirements/Limits
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	2	MO
disopyramide phosphate oral capsule 100 mg, 150 mg	2	MO
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	4	MO
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	MO; GC
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	2	MO
MULTAQ ORAL TABLET 400 MG	3	MO
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	2	MO
quinidine sulfate oral tablet 200 mg, 300 mg	1	MO; GC
sotalol hcl (af) oral tablet 120 mg, 160 mg	2	MO
sotalol hcl (af) oral tablet 80 mg	1	MO; GC
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	MO; GC
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl oral capsule 200 mg, 400 mg	1	MO; GC
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	MO; GC
betaxolol hcl oral tablet 10 mg, 20 mg	2	MO
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	MO; GC
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	MO; GC
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	2	MO
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	MO; GC
metoprolol succinate er oral tablet extended release 24 hour 200 mg	2	MO
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	MO; GC
nadolol oral tablet 20 mg, 40 mg, 80 mg	2	MO
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	4	MO
pindolol oral tablet 10 mg, 5 mg	2	MO
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg	2	MO

Drug Name	Tier	Requirements/Limits
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	2	MO
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg	1	MO; GC
propranolol hcl oral tablet 60 mg	2	MO
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	2	MO
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	MO; GC
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	MO; GC; QL (30 EA per 30 days)
isradipine oral capsule 2.5 mg, 5 mg	2	MO
KATERZIA ORAL SUSPENSION 1 MG/ML	4	MO
nicardipine hcl oral capsule 20 mg, 30 mg	2	MO
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg	1	MO; GC; QL (60 EA per 30 days)
nifedipine er oral tablet extended release 24 hour 90 mg	1	MO; GC; QL (30 EA per 30 days)
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg	1	MO; GC; QL (60 EA per 30 days)
nifedipine er osmotic release oral tablet extended release 24 hour 90 mg	1	MO; GC; QL (30 EA per 30 days)
nifedipine oral capsule 10 mg, 20 mg	2	MO
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES		
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG	2	MO; QL (60 EA per 30 days)
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG	2	MO; QL (30 EA per 30 days)
diltiazem hcl er beads oral capsule extended release 24 hour 360 mg, 420 mg	2	MO; QL (30 EA per 30 days)
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	MO; QL (60 EA per 30 days)
diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg	2	MO; QL (30 EA per 30 days)
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	2	MO
diltiazem hcl oral tablet 120 mg, 90 mg	2	MO
diltiazem hcl oral tablet 30 mg, 60 mg	1	MO; GC

Drug Name	Tier	Requirements/Limits
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	MO; QL (60 EA per 30 days)
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG	2	MO; QL (60 EA per 30 days)
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG	2	MO; QL (30 EA per 30 days)
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG	2	MO; QL (60 EA per 30 days)
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG, 420 MG	2	MO; QL (30 EA per 30 days)
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg	2	MO
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	2	MO
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	MO; GC
CARDIOVASCULAR AGENTS, OTHER		
aliskiren fumarate oral tablet 150 mg, 300 mg	3	MO; QL (30 EA per 30 days)
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	MO; GC
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	MO; GC
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	2	MO; QL (30 EA per 30 days)
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	2	MO; QL (30 EA per 30 days)
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	2	MO; QL (30 EA per 30 days)
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	MO; GC
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	2	MO
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	MO; GC
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	5	PA; MO; QL (30 EA per 30 days)
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	2	MO; QL (30 EA per 30 days)
CORLANOR ORAL TABLET 5 MG, 7.5 MG	4	PA; MO

Drug Name	Tier	Requirements/Limits
DIGITEK ORAL TABLET 125 MCG, 250 MCG	1	MO; GC; QL (30 EA per 30 days)
DIGOX ORAL TABLET 125 MCG, 250 MCG	1	MO; GC; QL (30 EA per 30 days)
digoxin oral solution 0.05 mg/ml	2	MO; QL (255 ML per 30 days)
digoxin oral tablet 125 mcg, 250 mcg	1	MO; GC; QL (30 EA per 30 days)
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	MO; GC
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	MO
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	2	MO
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	MO; GC; QL (30 EA per 30 days)
isosorb dinitrate-hydralazine oral tablet 20-37.5 mg	4	MO
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	MO; GC
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	MO; GC; QL (30 EA per 30 days)
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	2	MO
metyrosine oral capsule 250 mg	5	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	1	MO; GC; QL (30 EA per 30 days)
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	2	MO; QL (30 EA per 30 days)
pentoxifylline er oral tablet extended release 400 mg	1	MO; GC
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	MO
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	3	MO
spironolactone-hctz oral tablet 25-25 mg	1	MO; GC
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	2	MO; QL (30 EA per 30 days)
triamterene-hctz oral capsule 37.5-25 mg	1	MO; GC
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	MO; GC

Drug Name	Tier	Requirements/Limits
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	MO; GC; QL (30 EA per 30 days)
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	4	PA; MO
DIURETICS, LOOP		
bumetanide injection solution 0.25 mg/ml	2	
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	2	MO
furosemide injection solution 10 mg/ml, 10 mg/ml (4ml syringe)	2	BD
furosemide oral solution 10 mg/ml, 8 mg/ml	2	MO
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	MO; GC
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	MO; GC
DIURETICS, POTASSIUM-SPARING		
amiloride hcl oral tablet 5 mg	2	MO
eplerenone oral tablet 25 mg, 50 mg	2	MO
KERENDIA ORAL TABLET 10 MG, 20 MG	4	MO; QL (30 EA per 30 days)
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	MO; GC
DIURETICS, THIAZIDE		
chlorthalidone oral tablet 25 mg, 50 mg	2	MO
hydrochlorothiazide oral capsule 12.5 mg	1	MO; GC
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	MO; GC
indapamide oral tablet 1.25 mg, 2.5 mg	1	MO; GC
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	2	MO
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 67 mg	2	MO; QL (30 EA per 30 days)
fenofibrate micronized oral capsule 43 mg	2	MO; QL (60 EA per 30 days)
fenofibrate oral capsule 150 mg	2	MO; QL (30 EA per 30 days)
fenofibrate oral capsule 50 mg	2	MO; QL (60 EA per 30 days)
fenofibrate oral tablet 145 mg, 160 mg	2	MO; QL (30 EA per 30 days)
fenofibrate oral tablet 48 mg, 54 mg	2	MO; QL (60 EA per 30 days)
fenofibric acid oral capsule delayed release 135 mg, 45 mg	2	MO; QL (30 EA per 30 days)
gemfibrozil oral tablet 600 mg	1	MO; GC; QL (60 EA per 30 days)

Drug Name	Tier	Requirements/Limits
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	MO; GC; QL (30 EA per 30 days)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	3	MO; QL (30 EA per 30 days)
lovastatin oral tablet 10 mg	1	MO; GC; QL (45 EA per 30 days)
lovastatin oral tablet 20 mg	1	MO; GC; QL (30 EA per 30 days)
lovastatin oral tablet 40 mg	1	MO; GC; QL (60 EA per 30 days)
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	MO; GC; QL (30 EA per 30 days)
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	MO; GC; QL (30 EA per 30 days)
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	1	MO; GC; QL (30 EA per 30 days)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG	3	MO; QL (30 EA per 30 days)
DYSLIPIDEMICS, OTHER		
cholestyramine light oral packet 4 gm	2	MO
cholestyramine oral packet 4 gm	2	MO
colestipol hcl oral packet 5 gm	2	MO
colestipol hcl oral tablet 1 gm	2	MO
ezetimibe oral tablet 10 mg	1	MO; GC; QL (30 EA per 30 days)
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	5	PA; MO
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	2	MO
omega-3-acid ethyl esters oral capsule 1 gm	2	MO
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	3	PA; MO
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA; MO
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; MO
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM	3	MO
VASODILATORS, DIRECT-ACTING ARTERIAL/ VENOUS		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	MO; GC

Drug Name	Tier	Requirements/Limits
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	2	MO
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg	2	MO
isosorbide mononitrate er oral tablet extended release 24 hour 30 mg, 60 mg	1	MO; GC
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	MO; GC
minoxidil oral tablet 10 mg, 2.5 mg	1	MO; GC
NITRO-BID TRANSDERMAL OINTMENT 2 %	3	MO
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	2	MO
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	2	MO
nitroglycerin translingual solution 0.4 mg/spray	2	MO
RECTIV RECTAL OINTMENT 0.4 %	4	
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	2	MO; QL (90 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 30 mg	2	MO; QL (60 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	4	MO; QL (180 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	4	MO; QL (120 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	4	MO; QL (360 EA per 30 days)
dextroamphetamine sulfate oral solution 5 mg/5ml	4	MO; QL (1800 ML per 30 days)
dextroamphetamine sulfate oral tablet 10 mg	4	MO; QL (180 EA per 30 days)
dextroamphetamine sulfate oral tablet 15 mg	4	MO; QL (120 EA per 30 days)
dextroamphetamine sulfate oral tablet 20 mg	4	MO; QL (90 EA per 30 days)
dextroamphetamine sulfate oral tablet 30 mg	4	MO; QL (60 EA per 30 days)
dextroamphetamine sulfate oral tablet 5 mg	4	MO; QL (150 EA per 30 days)
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	4	MO; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
dexmethylphenidate hcl oral tablet 10 mg	1	MO; GC; QL (60 EA per 30 days)
dexmethylphenidate hcl oral tablet 2.5 mg	1	MO; GC; QL (240 EA per 30 days)
dexmethylphenidate hcl oral tablet 5 mg	1	MO; GC; QL (120 EA per 30 days)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	4	MO; QL (30 EA per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	2	MO; QL (90 EA per 30 days)
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	5	PA; MO; QL (120 EA per 30 days)
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML	5	PA; MO
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; MO
riluzole oral tablet 50 mg	4	PA; MO
tetrabenazine oral tablet 12.5 mg	5	PA; MO; QL (240 EA per 30 days)
tetrabenazine oral tablet 25 mg	5	PA; MO; QL (120 EA per 30 days)
FIBROMYALGIA AGENTS		
pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg	2	MO; QL (90 EA per 30 days)
pregabalin oral capsule 200 mg, 225 mg, 300 mg	2	MO; QL (60 EA per 30 days)
pregabalin oral capsule 75 mg	2	MO; QL (120 EA per 30 days)
pregabalin oral solution 20 mg/ml	2	MO; QL (900 ML per 30 days)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	3	MO; QL (60 EA per 30 days)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	3	QL (55 EA per 28 days)
MULTIPLE SCLEROSIS AGENTS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	5	PA; MO
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	5	PA; MO
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA; MO
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML	5	PA; MO
dalfampridine er oral tablet extended release 12 hour 10 mg	3	PA; MO; QL (60 EA per 30 days)

Drug Name	Tier	Requirements/Limits
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	5	PA; MO
dimethyl fumarate starter pack oral 120 & 240 mg	5	PA
GILENYA ORAL CAPSULE 0.5 MG	5	PA; MO
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML	5	PA; MO
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG	5	PA; MO
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 0.25 MG	4	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG	5	PA
DENTAL AND ORAL AGENTS		
DENTAL AND ORAL AGENTS		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	GC
PERIOGARD MOUTH/THROAT SOLUTION 0.12 %	1	GC
pilocarpine hcl oral tablet 5 mg, 7.5 mg	2	MO
triamcinolone acetonide mouth/throat paste 0.1 %	2	
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	3	
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	4	PA
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	4	
benzoyl peroxide-erythromycin external gel 5-3 %	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	
clindamycin phos-benzoyl perox external gel 1.2-5 %	2	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	4	
tazarotene external cream 0.1 %	2	PA
TAZORAC EXTERNAL CREAM 0.05 %	4	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 %	4	PA

Drug Name	Tier	Requirements/Limits
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	2	PA
tretinoin external gel 0.01 %, 0.025 %, 0.05 %	2	PA
DERMATITIS AND PRUITUS AGENTS		
alclometasone dipropionate external cream 0.05 %	2	
alclometasone dipropionate external ointment 0.05 %	2	
amcinonide external cream 0.1 %	4	
amcinonide external ointment 0.1 %	4	
ammonium lactate external cream 12 %	1	GC
ammonium lactate external lotion 12 %	1	GC
betamethasone dipropionate aug external cream 0.05 %	2	
betamethasone dipropionate aug external lotion 0.05 %	2	
betamethasone dipropionate aug external ointment 0.05 %	2	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	2	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	2	
betamethasone valerate external lotion 0.1 %	2	
betamethasone valerate external ointment 0.1 %	2	
clobetasol propionate e external cream 0.05 %	4	
clobetasol propionate external cream 0.05 %	4	
clobetasol propionate external gel 0.05 %	4	
clobetasol propionate external ointment 0.05 %	4	
clobetasol propionate external solution 0.05 %	2	
desonide external cream 0.05 %	4	
desonide external lotion 0.05 %	4	
desonide external ointment 0.05 %	2	
desoximetasone external cream 0.05 %, 0.25 %	4	
desoximetasone external gel 0.05 %	4	

Drug Name	Tier	Requirements/Limits
desoximetasone external ointment 0.25 %	4	
EUCRISA EXTERNAL OINTMENT 2 %	4	
fluocinolone acetonide external cream 0.01 %, 0.025 %	2	
fluocinolone acetonide external ointment 0.025 %	2	
fluocinolone acetonide external solution 0.01 %	4	
fluocinonide emulsified base external cream 0.05 %	2	
fluocinonide external gel 0.05 %	4	
fluocinonide external ointment 0.05 %	2	
fluocinonide external solution 0.05 %	2	
fluticasone propionate external cream 0.05 %	1	GC
fluticasone propionate external ointment 0.005 %	1	GC
halobetasol propionate external cream 0.05 %	4	
halobetasol propionate external ointment 0.05 %	2	
hydrocortisone (perianal) external cream 2.5 %	1	GC
hydrocortisone external cream 1 %	1	GC
hydrocortisone external lotion 2.5 %	1	GC
hydrocortisone external ointment 1 %	2	
hydrocortisone external ointment 2.5 %	1	GC
hydrocortisone valerate external cream 0.2 %	2	
hydrocortisone valerate external ointment 0.2 %	2	
mometasone furoate external cream 0.1 %	2	
mometasone furoate external ointment 0.1 %	2	
mometasone furoate external solution 0.1 %	2	
pimecrolimus external cream 1 %	4	
prednicarbate external ointment 0.1 %	4	
PROCTO-MED HC EXTERNAL CREAM 2.5 %	4	
PROCTO-PAK EXTERNAL CREAM 1 %	4	
PROCTOSOL HC EXTERNAL CREAM 2.5 %	4	
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	3	
selenium sulfide external lotion 2.5 %	1	GC
tacrolimus external ointment 0.03 %, 0.1 %	4	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	GC

Drug Name	Tier	Requirements/Limits
triamcinolone acetonide external lotion 0.025 %, 0.1 %	2	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	GC
DERMATOLOGICAL AGENTS, OTHER		
calcipotriene external solution 0.005 %	4	
clotrimazole-betamethasone external cream 1-0.05 %	2	
clotrimazole-betamethasone external lotion 1-0.05 %	2	
diclofenac sodium external gel 3 %	4	PA
fluorouracil external cream 5 %	3	
fluorouracil external solution 2 %, 5 %	2	
global alcohol prep ease pad 70 %	2	
hydrocortisone ace-pramoxine external cream 1-1 %	2	
imiquimod external cream 5 %	2	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
PANRETIN EXTERNAL GEL 0.1 %	5	PA
podofilox external solution 0.5 %	2	
REGRANEX EXTERNAL GEL 0.01 %	5	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	4	
silver sulfadiazine external cream 1 %	2	
SSD EXTERNAL CREAM 1 %	1	GC
PEDICULICIDES/SCABICIDES		
malathion external lotion 0.5 %	4	
permethrin external cream 5 %	2	
TOPICAL ANTI-INFECTIVES		
ciclopirox external gel 0.77 %	2	
ciclopirox external shampoo 1 %	2	
ciclopirox external solution 8 %	2	
clindamycin phosphate external gel 1 %	2	

Drug Name	Tier	Requirements/Limits
clindamycin phosphate external lotion 1 %	2	
clindamycin phosphate external solution 1 %	2	
ery external pad 2 %	3	
erythromycin external gel 2 %	2	
erythromycin external solution 2 %	2	
mupirocin calcium external cream 2 %	4	
mupirocin external ointment 2 %	1	GC
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/ MINERAL REPLACEMENT		
carglumic acid oral tablet soluble 200 mg	5	PA; MO
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION	4	BD
kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%	2	BD
kcl-lactated ringers-d5w intravenous solution 20 meq/l	2	BD
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	MO; GC
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	MO; GC
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	1	MO; GC
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	1	MO; GC
KLOR-CON ORAL PACKET 20 MEQ	2	MO
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	1	MO; GC
magnesium sulfate injection solution 50 %, 50 % (10ml syringe)	2	
PLASMA-LYTE 148 INTRAVENOUS SOLUTION	3	BD
PLASMA-LYTE A INTRAVENOUS SOLUTION	3	BD
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	MO; GC

Drug Name	Tier	Requirements/Limits
potassium chloride er oral capsule extended release 10 meq, 8 meq	2	MO
potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq	1	MO; GC
potassium chloride in dextrose intravenous solution 20-5 meq/l-%	2	BD
potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%	3	BD
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml	2	BD
potassium chloride oral packet 20 meq	2	MO
potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)	2	MO
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	2	
sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %	2	
sodium chloride irrigation solution 0.9 %	1	GC
sodium fluoride oral tablet 2.2 (1 f) mg	2	
ELECTROLYTE/MINERAL/METAL MODIFIERS		
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	5	PA; MO
deferasirox oral tablet 180 mg, 360 mg	5	PA; MO
deferasirox oral tablet 90 mg	4	PA; MO
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	5	PA; MO
deferiprone oral tablet 1000 mg, 500 mg	5	PA; MO
FERRIPROX ORAL SOLUTION 100 MG/ML	5	PA; MO
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG	5	PA; MO
LOKELMA ORAL PACKET 10 GM, 5 GM	4	MO
sodium polystyrene sulfonate oral powder	2	
SPS ORAL SUSPENSION 15 GM/60ML	3	
tolvaptan oral tablet 15 mg	5	PA; QL (120 EA per 30 days)
tolvaptan oral tablet 30 mg	5	PA; QL (60 EA per 30 days)
trientine hcl oral capsule 250 mg	5	PA

Drug Name	Tier	Requirements/Limits
ELECTROLYTES/MINERALS/METALS/VITAMINS		
CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %	3	BD
CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	3	BD
CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	3	BD
CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	3	BD
CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	3	BD
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	4	BD
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	4	BD
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	4	BD
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	4	BD
dextrose intravenous solution 10 %, 5 %	2	BD
dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %	3	BD
dextrose-nacl intravenous solution 5-0.2 %, 5-0.45 %, 5-0.9 %	3	
DOJOLVI ORAL LIQUID 100 %	5	PA; MO
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	BD
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	4	BD
levocarnitine oral solution 1 gm/10ml	2	MO
levocarnitine oral tablet 330 mg	2	MO
NUTRILIPID INTRAVENOUS EMULSION 20 %	4	BD
PREMASOL INTRAVENOUS SOLUTION 10 %	4	BD
prenatal oral tablet 27-1 mg	2	
PROCALAMINE INTRAVENOUS SOLUTION 3 %	4	BD
PROSOL INTRAVENOUS SOLUTION 20 %	4	BD

Drug Name	Tier	Requirements/Limits
TPN ELECTROLYTES INTRAVENOUS CONCENTRATE	2	BD
TRAVASOL INTRAVENOUS SOLUTION 10 %	4	BD
TROPHAMINE INTRAVENOUS SOLUTION 10 %	4	BD
PHOSPHATE BINDERS		
AURYXIA ORAL TABLET 1 GM 210 MG(FE)	4	PA; MO
calcium acetate (phos binder) oral capsule 667 mg	2	MO
calcium acetate oral tablet 667 mg	2	MO
sevelamer carbonate oral packet 0.8 gm	5	MO; QL (540 EA per 30 days)
sevelamer carbonate oral packet 2.4 gm	5	MO; QL (180 EA per 30 days)
sevelamer carbonate oral tablet 800 mg	4	MO; QL (540 EA per 30 days)
VELPHORO ORAL TABLET CHEWABLE 500 MG	4	MO
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
constulose oral solution 10 gm/15ml	1	MO; GC
enulose oral solution 10 gm/15ml	1	MO; GC
generlac oral solution 10 gm/15ml	1	MO; GC
lactulose oral solution 10 gm/15ml	1	MO; GC
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	MO; QL (30 EA per 30 days)
lubiprostone oral capsule 24 mcg, 8 mcg	3	MO; QL (60 EA per 30 days)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 EA per 30 days)
ANTI-DIARRHEAL AGENTS		
alosetron hcl oral tablet 0.5 mg, 1 mg	5	MO; QL (60 EA per 30 days)
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	4	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	2	
loperamide hcl oral capsule 2 mg	1	GC
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine hcl oral capsule 10 mg	1	GC
dicyclomine hcl oral solution 10 mg/5ml	2	
dicyclomine hcl oral tablet 20 mg	1	GC
glycopyrrolate oral tablet 1 mg, 2 mg	2	

Drug Name	Tier	Requirements/Limits
GASTROINTESTINAL AGENTS, OTHER		
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG	5	PA; MO
BYLVAY ORAL CAPSULE 1200 MCG, 400 MCG	5	PA; MO
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/160ML	4	
GATTEX SUBCUTANEOUS KIT 5 MG	5	PA; MO
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	1	GC
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	1	GC
LIVMARLI ORAL SOLUTION 9.5 MG/ML	5	PA; MO
metoclopramide hcl oral solution 5 mg/5ml	1	GC
metoclopramide hcl oral tablet 10 mg, 5 mg	1	MO; GC
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	2	
peg-3350/electrolytes oral solution reconstituted 236 gm	2	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML	4	
SUTAB ORAL TABLET 1479-225-188 MG	4	
ursodiol oral capsule 300 mg	2	MO
ursodiol oral tablet 250 mg, 500 mg	2	MO
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
famotidine oral suspension reconstituted 40 mg/5ml	2	MO
famotidine oral tablet 20 mg, 40 mg	1	MO; GC
nizatidine oral capsule 150 mg, 300 mg	2	MO
PROTECTANTS		
misoprostol oral tablet 100 mcg, 200 mcg	2	MO
sucralfate oral suspension 1 gm/10ml	4	MO
sucralfate oral tablet 1 gm	1	MO; GC
PROTON PUMP INHIBITORS		
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	3	MO

Drug Name	Tier	Requirements/Limits
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	2	MO
lansoprazole oral capsule delayed release 15 mg, 30 mg	2	MO
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	MO; GC
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	MO; GC
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
betaine oral powder	5	MO
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	3	MO
cromolyn sodium oral concentrate 100 mg/5ml	4	MO
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA; MO
ENDARI ORAL PACKET 5 GM	4	PA
GALAFOLD ORAL CAPSULE 123 MG	5	PA; MO
miglustat oral capsule 100 mg	5	PA; MO
nitisinone oral capsule 10 mg, 2 mg, 5 mg	5	PA; MO
ORFADIN ORAL CAPSULE 20 MG	5	PA; MO
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5	PA
RAVICTI ORAL LIQUID 1.1 GM/ML	5	PA; MO
sapropterin dihydrochloride oral packet 100 mg, 500 mg	5	PA; MO
sapropterin dihydrochloride oral tablet 100 mg	5	PA; MO
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML	5	PA; MO
VIJOICE ORAL TABLET THERAPY PACK 125 MG, 200 & 50 MG, 50 MG	5	PA; MO
VYNDAMAX ORAL CAPSULE 61 MG	5	PA; MO; QL (30 EA per 30 days)
XURIDEN ORAL PACKET 2 GM	5	PA; MO

Drug Name	Tier	Requirements/Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT	3	MO
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	4	MO
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	4	MO; QL (30 EA per 30 days)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	3	MO; QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	MO; QL (30 EA per 30 days)
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	2	MO; QL (60 EA per 30 days)
oxybutynin chloride oral syrup 5 mg/5ml	2	MO; QL (600 ML per 30 days)
oxybutynin chloride oral tablet 5 mg	1	MO; GC; QL (120 EA per 30 days)
solifenacin succinate oral tablet 10 mg, 5 mg	2	MO; QL (30 EA per 30 days)
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	2	MO; QL (30 EA per 30 days)
tolterodine tartrate oral tablet 1 mg, 2 mg	2	MO; QL (60 EA per 30 days)
trospium chloride er oral capsule extended release 24 hour 60 mg	2	MO; QL (30 EA per 30 days)
trospium chloride oral tablet 20 mg	2	MO; QL (60 EA per 30 days)
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	MO; GC; QL (30 EA per 30 days)
dutasteride oral capsule 0.5 mg	1	MO; GC; QL (30 EA per 30 days)
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	2	MO; QL (30 EA per 30 days)
finasteride oral tablet 5 mg	1	MO; GC; QL (30 EA per 30 days)
silodosin oral capsule 4 mg, 8 mg	4	MO; QL (30 EA per 30 days)
tamsulosin hcl oral capsule 0.4 mg	1	MO; GC; QL (60 EA per 30 days)
GENITOURINARY AGENTS, OTHER		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	2	

Drug Name	Tier	Requirements/Limits
ELMIRON ORAL CAPSULE 100 MG	4	
penicillamine oral tablet 250 mg	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
dexamethasone oral solution 0.5 mg/5ml	2	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	GC
fludrocortisone acetate oral tablet 0.1 mg	1	MO; GC
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	GC
ISTURISA ORAL TABLET 1 MG	5	PA; MO; QL (240 EA per 30 days)
ISTURISA ORAL TABLET 10 MG	5	PA; MO; QL (180 EA per 30 days)
ISTURISA ORAL TABLET 5 MG	5	PA; MO; QL (120 EA per 30 days)
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	BD
methylprednisolone oral tablet therapy pack 4 mg	2	
prednisolone oral solution 15 mg/5ml	2	BD
prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml	4	BD
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	2	BD
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	2	BD
prednisone oral solution 5 mg/5ml	2	BD
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	BD; GC
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	GC
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	2	MO
desmopressin acetate spray nasal solution 0.01 %	2	MO
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5	PA; MO

Drug Name	Tier	Requirements/Limits
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG	4	MO
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	5	PA; MO
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG	5	PA; MO
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
ANDROGENS		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR	3	MO
danazol oral capsule 100 mg, 50 mg	2	
danazol oral capsule 200 mg	4	
oxandrolone oral tablet 10 mg	4	PA
oxandrolone oral tablet 2.5 mg	3	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	2	MO
testosterone enanthate intramuscular solution 200 mg/ml	2	MO
testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	3	MO
testosterone transdermal solution 30 mg/act	3	MO
ESTROGENS		
DUAVEE ORAL TABLET 0.45-20 MG	3	MO
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	MO; GC
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	MO
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	MO
estradiol vaginal cream 0.1 mg/gm	4	MO
estradiol vaginal tablet 10 mcg	4	MO
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG	4	MO

Drug Name	Tier	Requirements/Limits
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG	4	MO
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	4	MO
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	MO
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	MO
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
alyacen 1/35 oral tablet 1-35 mg-mcg	1	MO; GC
APRI ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	MO
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
AVIANE ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
BALZIVA ORAL TABLET 0.4-35 MG-MCG	2	MO
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	MO; GC
briellyn oral tablet 0.4-35 mg-mcg	2	MO
CAZIANT ORAL TABLET 0.1/0.125/0.15 -0.025 MG	2	MO
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	2	MO
CYRED EQ ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	MO
desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg	1	MO; GC
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	2	MO
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	4	MO
EMOQUETTE ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG	1	MO; GC
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	1	MO; GC

Drug Name	Tier	Requirements/Limits
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	2	MO
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	4	MO
FALMINA ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
ICLEVIA ORAL TABLET 0.15-0.03 MG	2	MO
INTRAROSA VAGINAL INSERT 6.5 MG	3	PA; MO
INTROVALE ORAL TABLET 0.15-0.03 MG	2	MO
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
JASMIEL ORAL TABLET 3-0.02 MG	2	MO
JULEBER ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	MO
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	MO; GC
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	MO
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	1	MO; GC
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	1	MO; GC
KURVELO ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	MO
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	MO; GC
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
LARISSIA ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	MO
LESSINA ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	1	MO; GC
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	2	MO

Drug Name	Tier	Requirements/Limits
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg	1	MO; GC
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	1	MO; GC
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
LORYNA ORAL TABLET 3-0.02 MG	2	MO
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	2	MO
LUTERA ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
marlissa oral tablet 0.15-30 mg-mcg	1	MO; GC
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	MO
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	MO
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	MO; GC
MILI ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	MO
NIKKI ORAL TABLET 3-0.02 MG	2	MO
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg	1	MO; GC
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	2	MO
norethindrone-eth estradiol oral tablet 1-5 mg-mcg	2	MO
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	1	MO; GC
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	1	MO; GC
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	MO
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	1	MO; GC
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	1	MO; GC

Drug Name	Tier	Requirements/Limits
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	MO; GC
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	1	MO; GC
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	MO; GC
NYMYO ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
OCELLA ORAL TABLET 3-0.03 MG	2	MO
OSPHENA ORAL TABLET 60 MG	3	PA; MO
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	MO
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	1	MO; GC
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
PREMPHASE ORAL TABLET 0.625-5 MG	3	MO
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	MO
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	1	MO; GC
SETLAKIN ORAL TABLET 0.15-0.03 MG	2	MO
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
SRONYX ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
SYEDA ORAL TABLET 3-0.03 MG	2	MO
TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG	1	MO; GC
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	MO; GC
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	MO; GC
TRI-NYMYO ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	MO; GC
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	MO; GC
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	1	MO; GC
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	MO; GC
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	2	MO

Drug Name	Tier	Requirements/Limits
VESTURA ORAL TABLET 3-0.02 MG	2	MO
VIENVA ORAL TABLET 0.1-20 MG-MCG	1	MO; GC
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	2	MO
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	1	MO; GC
ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	1	MO; GC
PROGESTINS		
CAMILA ORAL TABLET 0.35 MG	1	MO; GC
DEBLITANE ORAL TABLET 0.35 MG	1	MO; GC
ERRIN ORAL TABLET 0.35 MG	1	MO; GC
INCASSIA ORAL TABLET 0.35 MG	1	MO; GC
LYLEQ ORAL TABLET 0.35 MG	1	MO; GC
LYZA ORAL TABLET 0.35 MG	1	MO; GC
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	2	
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	2	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	MO; GC
megestrol acetate oral suspension 40 mg/ml	2	
megestrol acetate oral suspension 625 mg/5ml	4	MO
megestrol acetate oral tablet 20 mg, 40 mg	1	GC
NORA-BE ORAL TABLET 0.35 MG	1	MO; GC
norethindrone acetate oral tablet 5 mg	2	MO
norethindrone oral tablet 0.35 mg	1	MO; GC
progesterone oral capsule 100 mg, 200 mg	2	MO
SHAROBEL ORAL TABLET 0.35 MG	1	MO; GC
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	MO; GC
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	MO; GC

Drug Name	Tier	Requirements/Limits
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO; GC
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	MO; GC
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	MO; GC
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	MO
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	MO
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
cabergoline oral tablet 0.5 mg	2	
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	4	PA
leuprolide acetate injection kit 1 mg/0.2ml	4	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	5	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	5	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	5	PA
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	5	PA
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml	2	PA; MO
octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml	5	PA; MO
octreotide acetate injection solution 200 mcg/ml	4	PA; MO
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	5	PA; MO; QL (60 ML per 30 days)

Drug Name	Tier	Requirements/Limits
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; MO; QL (60 EA per 30 days)
SYNAREL NASAL SOLUTION 2 MG/ML	5	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	5	PA
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	MO; GC
propylthiouracil oral tablet 50 mg	1	MO; GC
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
FIRAZYR SUBCUTANEOUS SOLUTION 30 MG/3ML	5	PA
icatibant acetate subcutaneous solution 30 mg/3ml	5	PA
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML	5	PA; MO
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; MO
IMMUNOGLOBULINS		
PANZYGA INTRAVENOUS SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5	BD
PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML	5	BD
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	5	PA; MO
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; MO
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; MO
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	5	PA; MO

Drug Name	Tier	Requirements/Limits
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML	5	PA; MO
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML, 200 MG/1.14ML, 300 MG/2ML	5	PA; MO
leflunomide oral tablet 10 mg, 20 mg	2	MO
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG	5	PA; MO
SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML	5	PA; MO
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; MO
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; MO
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; MO
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML	5	PA; MO
TAVNEOS ORAL CAPSULE 10 MG	5	PA; MO
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5	PA
IMMUNOSTIMULANTS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML	5	PA; MO
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	5	PA; MO
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT	5	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	5	PA
IMMUNOSUPPRESSANTS		
AZASAN ORAL TABLET 100 MG, 75 MG	3	BD; MO

Drug Name	Tier	Requirements/Limits
azathioprine oral tablet 100 mg, 75 mg	3	BD; MO
azathioprine oral tablet 50 mg	2	BD; MO
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA; MO
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA; MO
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	2	BD; MO
cyclosporine modified oral solution 100 mg/ml	2	BD; MO
cyclosporine oral capsule 100 mg, 25 mg	2	BD; MO
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; MO
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5	PA; MO
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML	5	PA; MO
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5	PA; MO
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; MO
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	5	PA; MO
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG	4	BD; MO
everolimus oral tablet 0.25 mg	4	BD; MO; QL (60 EA per 30 days)
everolimus oral tablet 0.5 mg	5	BD; MO; QL (120 EA per 30 days)
everolimus oral tablet 0.75 mg, 1 mg	5	BD; MO; QL (60 EA per 30 days)
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	BD; MO
GENGRAF ORAL SOLUTION 100 MG/ML	2	BD; MO
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML	5	PA; MO
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML	5	PA; MO
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML	5	PA; MO

Drug Name	Tier	Requirements/Limits
HUMIRA PEN-PEDIATRIC UC START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5	PA; MO
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; MO
HUMIRA PEN-PSOR/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; MO
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	5	PA; MO
LUPKYNIS ORAL CAPSULE 7.9 MG	5	PA; MO; QL (180 EA per 30 days)
methotrexate sodium (pf) injection solution 50 mg/2ml	1	BD; GC
methotrexate sodium injection solution 50 mg/2ml	1	BD; GC
methotrexate sodium oral tablet 2.5 mg	2	BD
mycophenolate mofetil oral capsule 250 mg	4	BD; MO
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	5	BD; MO
mycophenolate mofetil oral tablet 500 mg	2	BD; MO
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	2	BD; MO
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	BD; MO
REZUROCK ORAL TABLET 200 MG	5	PA; MO
sirolimus oral solution 1 mg/ml	5	BD; MO
sirolimus oral tablet 0.5 mg, 1 mg	4	BD; MO
sirolimus oral tablet 2 mg	5	BD; MO
tacrolimus oral capsule 0.5 mg	2	BD; MO
tacrolimus oral capsule 1 mg, 5 mg	4	BD; MO
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	4	BD
VACCINES		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	3	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	4	

Drug Name	Tier	Requirements/Limits
bcg vaccine injection solution reconstituted 50 mg	4	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5	3	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	3	
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	4	
diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml	4	BD
ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML	3	BD
GARDASIL 9 INTRAMUSCULAR SUSPENSION	3	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML	3	
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	3	
IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML	3	BD
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	4	
IPOL INJECTION INJECTABLE	3	
IXIARO INTRAMUSCULAR SUSPENSION	3	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	4	
MENACTRA INTRAMUSCULAR SOLUTION	3	
MENQUADFI INTRAMUSCULAR SOLUTION	3	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	3	
M-M-R II INJECTION SOLUTION RECONSTITUTED	3	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	4	
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	3	

Drug Name	Tier	Requirements/Limits
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	4	
prehevbrio intramuscular suspension 10 mcg/ml	3	BD
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	3	
QUADRACEL INTRAMUSCULAR SUSPENSION , (58 UNT/ML)	4	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	BD
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML	3	BD
ROTARIX ORAL SUSPENSION RECONSTITUTED	3	
ROTATEQ ORAL SOLUTION	3	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	3	
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML	3	BD
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU	3	BD
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 2.4 MCG/0.5ML	3	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	3	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	3	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	3	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	3	
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	3	
YF-VAX SUBCUTANEOUS INJECTABLE	3	
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		

Drug Name	Tier	Requirements/Limits
balsalazide disodium oral capsule 750 mg	2	
LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM	3	MO
mesalamine er oral capsule extended release 24 hour 0.375 gm	4	MO
mesalamine oral capsule delayed release 400 mg	4	MO
mesalamine oral tablet delayed release 800 mg	4	
mesalamine rectal enema 4 gm	4	
sulfasalazine oral tablet 500 mg	1	MO; GC
sulfasalazine oral tablet delayed release 500 mg	1	MO; GC
GLUCOCORTICOIDS		
budesonide er oral tablet extended release 24 hour 9 mg	4	
budesonide oral capsule delayed release particles 3 mg	4	
hydrocortisone rectal enema 100 mg/60ml	4	
METABOLIC BONE DISEASE AGENTS		
METABOLIC BONE DISEASE AGENTS		
alendronate sodium oral tablet 10 mg	1	MO; GC; QL (30 EA per 30 days)
alendronate sodium oral tablet 35 mg, 70 mg	1	MO; GC; QL (4 EA per 28 days)
calcitonin (salmon) nasal solution 200 unit/act	2	BD; MO; QL (4 ML per 28 days)
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	BD; MO; GC
calcitriol oral solution 1 mcg/ml	4	BD; MO
cinacalcet hcl oral tablet 30 mg	4	BD; MO; QL (60 EA per 30 days)
cinacalcet hcl oral tablet 60 mg	5	BD; MO; QL (60 EA per 30 days)
cinacalcet hcl oral tablet 90 mg	5	BD; MO; QL (120 EA per 30 days)
ibandronate sodium oral tablet 150 mg	1	MO; GC; QL (1 EA per 30 days)
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	5	PA; MO
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	4	BD; MO
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	4	QL (1 ML per 180 days)
raloxifene hcl oral tablet 60 mg	2	MO
risedronate sodium oral tablet 150 mg	2	MO; QL (1 EA per 28 days)
risedronate sodium oral tablet 30 mg	2	QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
risedronate sodium oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)	2	MO; QL (4 EA per 28 days)
risedronate sodium oral tablet 5 mg	2	MO; QL (30 EA per 30 days)
teriparatide (recombinant) subcutaneous solution pen-injector 620 mcg/2.48ml	5	PA; MO; QL (2.48 ML per 28 days)
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA; MO; QL (1.56 ML per 30 days)
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5	PA; QL (2 ML per 28 days)
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
atropine sulfate ophthalmic solution 1 %	2	MO
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	2	
cyclosporine ophthalmic emulsion 0.05 %	3	MO; QL (60 EA per 30 days)
CYSTADROPS OPHTHALMIC SOLUTION 0.37 %	5	PA; MO
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	5	PA; MO
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	2	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	1	GC
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	2	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	2	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	GC
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	2	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
OPHTHALMIC ANTI-ALLERGY AGENTS		
azelastine hcl ophthalmic solution 0.05 %	2	
cromolyn sodium ophthalmic solution 4 %	1	GC
olopatadine hcl ophthalmic solution 0.1 %, 0.2 %	3	
OPHTHALMIC ANTI-INFECTIVES		

Drug Name	Tier	Requirements/Limits
AZASITE OPHTHALMIC SOLUTION 1 %	4	
bacitracin ophthalmic ointment 500 unit/gm	2	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	2	
erythromycin ophthalmic ointment 5 mg/gm	1	GC
gatifloxacin ophthalmic solution 0.5 %	2	
GENTAK OPHTHALMIC OINTMENT 0.3 %	2	
gentamicin sulfate ophthalmic solution 0.3 %	1	GC
moxifloxacin hcl ophthalmic solution 0.5 %	2	
NATACYN OPHTHALMIC SUSPENSION 5 %	4	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	2	
ofloxacin ophthalmic solution 0.3 %	2	
sulfacetamide sodium ophthalmic solution 10 %	2	
tobramycin ophthalmic solution 0.3 %	1	GC
OPHTHALMIC ANTI-INFLAMMATORIES		
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	2	
BROMSITE OPHTHALMIC SOLUTION 0.075 %	4	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	2	
diclofenac sodium ophthalmic solution 0.1 %	2	
DUREZOL OPHTHALMIC EMULSION 0.05 %	3	
fluorometholone ophthalmic suspension 0.1 %	2	
flurbiprofen sodium ophthalmic solution 0.03 %	1	GC
ILEVRO OPHTHALMIC SUSPENSION 0.3 %	3	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	2	
loteprednol etabonate ophthalmic suspension 0.5 %	2	
prednisolone acetate ophthalmic suspension 1 %	2	
prednisolone sodium phosphate ophthalmic solution 1 %	2	
OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS		
betaxolol hcl ophthalmic solution 0.5 %	2	MO

Drug Name	Tier	Requirements/Limits
carteolol hcl ophthalmic solution 1 %	1	MO; GC
levobunolol hcl ophthalmic solution 0.5 %	1	MO; GC
timolol maleate (once-daily) ophthalmic solution 0.5 %	2	MO
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	2	MO
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	MO; GC
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
acetazolamide er oral capsule extended release 12 hour 500 mg	2	MO
acetazolamide oral tablet 125 mg, 250 mg	2	MO
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	3	MO
apraclonidine hcl ophthalmic solution 0.5 %	2	
AZOPT OPHTHALMIC SUSPENSION 1 %	3	MO
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	2	MO
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	3	MO
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 %	4	MO
dorzolamide hcl ophthalmic solution 2 %	1	MO; GC
dorzolamide hcl-timolol mal ophthalmic solution 22.3-6.8 mg/ml	2	MO
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	2	MO
methazolamide oral tablet 25 mg, 50 mg	4	MO
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	2	MO
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	4	MO
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	4	MO
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	4	MO
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
latanoprost ophthalmic solution 0.005 %	2	MO
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	MO

Drug Name	Tier	Requirements/Limits
travoprost (bak free) ophthalmic solution 0.004 %	3	MO
OTIC AGENTS		
OTIC AGENTS		
acetic acid otic solution 2 %	1	GC
ciprofloxacin hcl otic solution 0.2 %	4	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	3	
ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %	4	
fluocinolone acetonide otic oil 0.01 %	2	
neomycin-polymyxin-hc otic solution 1 %	2	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	2	
ofloxacin otic solution 0.3 %	4	
RESPIRATORY TRACT/ PULMONARY AGENTS		
ANTIHISTAMINES		
azelastine hcl nasal solution 0.1 %, 0.15 %	2	QL (30 ML per 25 days)
cetirizine hcl oral solution 1 mg/ml	1	GC
cyproheptadine hcl oral syrup 2 mg/5ml	4	
cyproheptadine hcl oral tablet 4 mg	4	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	2	
levocetirizine dihydrochloride oral tablet 5 mg	1	GC
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	MO; QL (30 EA per 30 days)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/INH	3	MO; QL (2 EA per 30 days)
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/INH, 220 MCG/INH	3	MO; QL (2 EA per 30 days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/INH	3	MO; QL (2 EA per 30 days)

Drug Name	Tier	Requirements/Limits
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	MO; QL (26 GM per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	4	BD; MO
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 250 MCG/BLIST, 50 MCG/BLIST	3	MO; QL (60 EA per 30 days)
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT	3	MO; QL (24 GM per 30 days)
FLOVENT HFA INHALATION AEROSOL 44 MCG/ACT	3	MO; QL (21.2 GM per 30 days)
flunisolide nasal solution 25 mcg/act (0.025%)	2	QL (50 ML per 30 days)
fluticasone propionate nasal suspension 50 mcg/act	1	GC; QL (16 GM per 30 days)
mometasone furoate nasal suspension 50 mcg/act	2	QL (34 GM per 30 days)
ANTILEUKOTRIENES		
montelukast sodium oral packet 4 mg	2	MO; QL (30 EA per 30 days)
montelukast sodium oral tablet 10 mg	1	MO; GC; QL (30 EA per 30 days)
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	MO; GC; QL (30 EA per 30 days)
zafirlukast oral tablet 10 mg, 20 mg	2	MO; QL (60 EA per 30 days)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	4	MO; QL (26 GM per 30 days)
ipratropium bromide inhalation solution 0.02 %	2	BD; MO
ipratropium bromide nasal solution 0.03 %	2	MO; QL (60 ML per 30 days)
ipratropium bromide nasal solution 0.06 %	2	MO; QL (30 ML per 30 days)
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	3	MO; QL (30 EA per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	3	MO; QL (4 GM per 30 days)
BRONCHODILATORS, SYMPATHOMIMETIC		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	2	MO; QL (17 GM per 30 days)
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act (nda020503)	2	MO; QL (13.4 GM per 30 days)
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act (nda020983)	2	MO; QL (36 GM per 30 days)

Drug Name	Tier	Requirements/Limits
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml	2	BD; MO
albuterol sulfate oral syrup 2 mg/5ml	2	MO
albuterol sulfate oral tablet 2 mg, 4 mg	2	MO
epinephrine injection solution 0.3 mg/0.3ml	2	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	2	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE	3	MO; QL (60 EA per 30 days)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	4	MO
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	MO; QL (36 GM per 30 days)
CYSTIC FIBROSIS AGENTS		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	5	PA; MO
KALYDECO ORAL TABLET 150 MG	5	PA; MO
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG	5	PA; MO
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; MO
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	BD; MO
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5	PA; MO
TOBI PODHALER INHALATION CAPSULE 28 MG	5	PA; MO
tobramycin inhalation nebulization solution 300 mg/5ml	5	BD; MO
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5	PA; MO
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
DALIRESP ORAL TABLET 250 MCG, 500 MCG	3	MO; QL (30 EA per 30 days)
theophylline er oral tablet extended release 12 hour 300 mg, 450 mg	2	MO

Drug Name	Tier	Requirements/Limits
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	2	MO
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA; MO; QL (90 EA per 30 days)
ambrisentan oral tablet 10 mg, 5 mg	5	PA; MO; QL (30 EA per 30 days)
bosentan oral tablet 125 mg, 62.5 mg	5	PA; MO; QL (60 EA per 30 days)
OPSUMIT ORAL TABLET 10 MG	5	PA; MO; QL (90 EA per 30 days)
sildenafil citrate oral tablet 20 mg	2	PA; MO; QL (90 EA per 30 days)
PULMONARY FIBROSIS AGENTS		
ESBRIET ORAL CAPSULE 267 MG	5	PA; MO
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA; MO
pirfenidone oral tablet 267 mg, 801 mg	5	PA; MO
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine inhalation solution 10 %, 20 %	2	BD
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	3	MO; QL (60 EA per 30 days)
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	MO; QL (12 GM per 30 days)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH	3	MO; QL (60 EA per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH, 200-25 MCG/INH	3	MO; QL (60 EA per 30 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	3	MO; QL (10.7 GM per 30 days)
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	3	MO; QL (10.2 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	4	MO; QL (4 GM per 20 days)
cromolyn sodium inhalation nebulization solution 20 mg/2ml	2	BD; MO
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	MO; QL (60 EA per 30 days)

Drug Name	Tier	Requirements/Limits
fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act	3	MO; QL (1 EA per 30 days)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	BD; MO
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	5	PA; MO
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA; MO
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	5	PA; MO
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH, 200-62.5-25 MCG/INH	3	MO; QL (60 EA per 30 days)
SKELETAL MUSCLE RELAXANTS		
SKELETAL MUSCLE RELAXANTS		
chlorzoxazone oral tablet 250 mg, 375 mg, 500 mg, 750 mg	2	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	2	
cyclobenzaprine hcl oral tablet 7.5 mg	4	
methocarbamol oral tablet 500 mg, 750 mg	2	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	
SLEEP DISORDER AGENTS		
SLEEP PROMOTING AGENTS		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	4	QL (30 EA per 30 days)
temazepam oral capsule 15 mg, 30 mg	3	QL (30 EA per 30 days)
temazepam oral capsule 22.5 mg	4	QL (30 EA per 30 days)
temazepam oral capsule 7.5 mg	4	QL (120 EA per 30 days)
zaleplon oral capsule 10 mg, 5 mg	2	QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg, 5 mg	2	QL (30 EA per 30 days)
WAKEFULNESS PROMOTING AGENTS		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	3	PA; MO; QL (30 EA per 30 days)
modafinil oral tablet 100 mg, 200 mg	4	PA; MO; QL (60 EA per 30 days)
SUNOSI ORAL TABLET 150 MG, 75 MG	4	PA; MO; QL (30 EA per 30 days)

Drug Name	Tier	Requirements/Limits
XYREM ORAL SOLUTION 500 MG/ML	5	PA; QL (540 ML per 30 days)
XYWAV ORAL SOLUTION 500 MG/ML	5	PA; QL (540 ML per 30 days)

Alphabetical Listing

A

abacavir sulfate....36
abacavir sulfate-lamivudine .36
ABELCET....18
ABILIFY MAINTENA....31
abiraterone acetate....22
acamprosate calcium 4
acarbose....39
ACCUTANE....54
acebutolol hcl 46
acetaminophen-codeine....3
acetaminophen-codeine #3....3
acetazolamide....82
acetazolamide er....82
acetic acid....83
acetylcysteine 86
acitretin....54
ACTHIB....76
ACTIMMUNE 74
acyclovir....35
acyclovir sodium 35
ADACEL....76
adefovir dipivoxil 34
ADEMPAS....86
ADVAIR DISKUS....86
ADVAIR HFA 86
albendazole....29
albuterol sulfate....85
albuterol sulfate hfa....84
alclometasone dipropionate..55
ALECENSA....24
alendronate sodium 79
alfuzosin hcl er 64
aliskiren fumarate....48
allopurinol 20
alosetron hcl 61
ALPHAGAN P....82
alprazolam....38
ALPRAZOLAM INTENSOL 38
ALTAVERA 67
ALUNBRIG 24
alyacen 1/35....67
amantadine hcl....29, 30
AMBISOME 18
ambrisentan 86
amcinonide 55
amikacin sulfate....5
amiloride hcl....50
amiloride-hydrochlorothiazide 48
amiodarone hcl 46
amitriptyline hcl 17
amlodipine besy-benazepril hcl 48
amlodipine besylate....47
amlodipine besylate-valsartan 48
amlodipine-atorvastatin 48
amlodipine-olmesartan 48
ammonium lactate 55
AMNESTEEM 54
amoxapine 17
amoxicillin....8
amoxicillin-pot clavulanate 8
amoxicillin-pot clavulanate er 8
amphetamine-dextroamphetamine 52
amphotericin b....18
ampicillin....8
ampicillin sodium....8
ampicillin-sulbactam sodium .8
anagrelide hcl 44
anastrozole....24
ANDRODERM 66
ANORO ELLIPTA....86
apraclonidine hcl 82
aprepitant....18
APRI....67
APTIOM....13
APTIVUS 37
ARANELLE....67
ARCALYST....73
ARIKAYCE 5
aripiprazole....31, 32
armodafinil 87
ARNUITY ELLIPTA....83
asenapine maleate....32
ASMANEX (120 METERED DOSES)....83
ASMANEX (30 METERED DOSES)....83
ASMANEX (60 METERED DOSES)....83
ASMANEX HFA 84
aspirin-dipyridamole er 44
ASSURE ID INSULIN SAFETY SYR 41
atazanavir sulfate....37
atenolol 46
atenolol-chlorthalidone....48
atomoxetine hcl 52
atorvastatin calcium....51
atovaquone....29
atovaquone-proguanil hcl 29
atropine sulfate 80
ATROVENT HFA....84
AUBRA EQ....67
AURYXIA....61
AUSTEDO 53
AVIANE....67
AVONEX PEN....53
AVONEX PREFILLED 53
AYVAKIT....24
AZASAN....74
AZASITE 81
azathioprine 75
azelastine hcl 80, 83
azithromycin....9, 10
AZOPT 82
aztreonam 5

B

bacitracin 81
bacitracin-polymyxin b....81
bacitra-neomycin-polymyxin-hc 80
baclofen 34
balsalazide disodium 79
BALVERSA 24
BALZIVA....67
BAQSIMI ONE PACK 41
BARACLUDE....34
bcg vaccine 77
BELSOMRA 87
benazepril hcl....45
benazepril-hydrochlorothiazide 48
BENLYSTA 75
benznidazole....29
benzoyl peroxide-erythromycin 54
benztropine mesylate....29
BESREMI....74
betaine....63

betamethasone dipropionate.55
betamethasone dipropionate aug.....55
betamethasone valerate.....55
BETASERON.....53
betaxolol hcl.....46, 81
bethanechol chloride.....64
bexarotene.....28, 29
BEXSERO.....77
bicalutamide.....22
BICILLIN L-A.....8, 9
BIKTARVY.....35
bisoprolol fumarate.....46
bisoprolol-hydrochlorothiazide.....48
BLISOVI FE 1.5/30.....67
BOOSTRIX.....77
bosentan.....86
BOSULIF.....24
BRAFTOVI.....24
BREO ELLIPTA.....86
BREZTRI AEROSPHERE..86
briellyn.....67
BRILINTA.....44
brimonidine tartrate.....82
brimonidine tartrate-timolol.82
BRIVIACT.....11
bromfenac sodium (once-daily).....81
bromocriptine mesylate.....30
BROMSITE.....81
BRUKINSA.....24
budesonide.....79, 84
budesonide er.....79
budesonide-formoterol fumarate.....86
bumetanide.....50
buprenorphine hcl.....4
buprenorphine hcl-naloxone hcl.....4
bupropion hcl.....15
bupropion hcl er (smoking det).....5
bupropion hcl er (sr).....15
bupropion hcl er (xl).....15
buspirone hcl.....38
butalbital-apap-caffeine.....2
butalbital-asa-caff-codeine.....2
butalbital-aspirin-caffeine.....2
BYLVAY.....62
BYLVAY (PELLETS).....62

C

cabergoline.....72
CABLIVI.....44
CABOMETYX.....25
calcipotriene.....57
calcitonin (salmon).....79
calcitriol.....79
calcium acetate.....61
calcium acetate (phos binder).....61
CALQUENCE.....25
CAMILA.....71
CAMZYOS.....48
candesartan cilexetil.....45
candesartan cilexetil-hctz.....48
CAPLYTA.....32
CAPRELSA.....25
captopril.....45
carbamazepine.....14
carbamazepine er.....13, 14
carbidopa.....30
carbidopa-levodopa.....30
carbidopa-levodopa er.....30
carbidopa-levodopa-entacapone.....30
carglumic acid.....58
carteolol hcl.....82
CARTIA XT.....47
carvedilol.....46
caspofungin acetate.....18, 19
CAYSTON.....85
CAZIANT.....67
cefaclor.....7
cefaclor er.....7
cefadroxil.....7
cefazolin sodium.....7
cefdinir.....7
cefepime hcl.....7
cefixime.....7
cefotetan disodium.....7
cefoxitin sodium.....7
cefpodoxime proxetil.....7
cefprozil.....7
ceftazidime.....7
ceftriaxone sodium.....7, 8
cefuroxime axetil.....8
cefuroxime sodium.....8
celecoxib.....2
CELONTIN.....13
cephalexin.....8
cetirizine hcl.....83
chlordiazepoxide hcl.....38
chlorhexidine gluconate.....54
chloroquine phosphate.....29
chlorpromazine hcl.....31
chlorthalidone.....50
chlorzoxazone.....87
cholestyramine.....51
cholestyramine light.....51
ciclopirox.....57
ciclopirox olamine.....19
cilostazol.....44
CIMDUO.....36
cinacalcet hcl.....79
ciprofloxacin hcl.....10, 83
ciprofloxacin in d5w.....10
ciprofloxacin-dexamethasone.....83
ciprofloxacin-fluocinolone pf.....83
citalopram hydrobromide.....16
CLARAVIS.....54
clarithromycin.....10
clarithromycin er.....10
CLENPIQ.....62
clindamycin hcl.....5
clindamycin palmitate hcl.....6
clindamycin phos-benzoyl perox.....54
clindamycin phosphate....6, 57, 58
clindamycin phosphate in d5w.....6
CLINIMIX E/DEXTROSE (2.75/5).....60
CLINIMIX E/DEXTROSE (4.25/10).....60
CLINIMIX E/DEXTROSE (4.25/5).....60
CLINIMIX E/DEXTROSE (5/15).....60
CLINIMIX E/DEXTROSE (5/20).....60
CLINIMIX/DEXTROSE (4.25/10).....60
CLINIMIX/DEXTROSE (4.25/5).....60
CLINIMIX/DEXTROSE (5/15).....60
CLINIMIX/DEXTROSE (5/20).....60
clobazam.....13

clobetasol propionate.....55
clobetasol propionate e.....55
clomipramine hcl.....17
clonazepam.....39
clonidine.....44
clonidine hcl.....44
clopidogrel bisulfate.....44
clorazepate dipotassium 39
clotrimazole.....19
clotrimazole-betamethasone.57
clozapine.....34
COARTEM 29
codeine sulfate.....3
colchicine 20
colchicine-probenecid 20
colestipol hcl 51
colistimethate sodium (cba) ...6
COMBIGAN 82
COMBIVENT RESPIMAT .86
COMETRIQ (100 MG DAILY DOSE) 25
COMETRIQ (140 MG DAILY DOSE) 25
COMETRIQ (60 MG DAILY DOSE) 25
COMFORT ASSIST INSULIN SYRINGE 41
COMPLERA 35
constulose.....61
COPAXONE 53
COPIKTRA.....25
CORLANOR.....48
COSENTYX.....73
COSENTYX (300 MG DOSE) 73
COSENTYX SENSOREADY (300 MG).....73
COTELLIC.....25
CREON 63
cromolyn sodium.....63, 80, 86
CRYSELLE-28 67
cvs gauze sterile 41
cyclobenzaprine hcl.....87
cyclophosphamide.....22
cyclosporine 75, 80
cyclosporine modified.....75
cyproheptadine hcl 83
CYRED EQ.....67
CYSTADROPS.....80
CYSTAGON.....63
CYSTARAN 80

D

dalfampridine er 53
DALIRESP.....85
danazol.....66
dapsone.....21
DAPTACEL 77
daptomycin 6
darifenacin hydrobromide er 64
DAURISMO.....25
DEBLITANE.....71
deferasirox 59
deferasirox granules 59
deferiprone.....59
DELSTRIGO.....36
DESCOVY 36
desipramine hcl.....17
desmopressin acetate 65
desmopressin acetate spray ..65
desogestrel-ethinyl estradiol.67
desonide.....55
desoximetasone 55, 56
desvenlafaxine er.....16
desvenlafaxine succinate er ..16
dexamethasone 65
dexamethasone sodium phosphate.....81
dexlansoprazole 62
dexmethylphenidate hcl.....53
dextroamphetamine sulfate...52
dextroamphetamine sulfate er 52
dextrose 60
dextrose-nacl 60
DIACOMIT 11
diazepam.....13, 39
DIAZEPAM INTENSOL.....39
diazoxide 41
diclofenac potassium 2
diclofenac sodium.....2, 57, 81
diclofenac sodium er 2
dicloxacillin sodium 9
dicyclomine hcl 61
DIFICID 10
diflunisal.....2
DIGITEK.....49
DIGOX 49
digoxin.....49
dihydroergotamine mesylate 20
DILANTIN.....14
diltiazem hcl 47
diltiazem hcl er.....47
diltiazem hcl er beads 47
diltiazem hcl er coated beads47
dilt-xr 48
dimethyl fumarate.....54
dimethyl fumarate starter pack 54
diphenoxylate-atropine 61
diphtheria-tetanus toxoids dt 77
disopyramide phosphate 46
disulfiram.....4
divalproex sodium 39
divalproex sodium er 39
dofetilide.....46
DOJOLVI 60
donepezil hcl.....14, 15
dorzolamide hcl 82
dorzolamide hcl-timolol mal 82
dorzolamide hcl-timolol mal pf 82
DOVATO 35
doxazosin mesylate.....45
doxepin hcl 17
DOXY 100.....11
doxycycline hyclate.....11
doxycycline monohydrate 11
DRIZALMA SPRINKLE.....16
dronabinol.....18
drospirenone-ethinyl estradiol 67
DROXIA.....23
droxidopa.....44
DUAVEE.....66
duloxetine hcl 16
DUPIXENT 74
DUREZOL 81
dutasteride.....64
dutasteride-tamsulosin hcl 64

E

econazole nitrate.....19
EDURANT 35
efavirenz 35
efavirenz-emtricitab-tenofovir 36
efavirenz-lamivudine-tenofovir 36
ELIGARD.....72
ELIQUIS.....43
ELIQUIS DVT/PE STARTER PACK 43
ELMIRON.....65
ELURYNG.....67

EMCYT 22
EMGALITY 20
EMOQUETTE 67
EMSAM 15
emtricitabine 36
emtricitabine-tenofovir df 36
EMTRIVA 36
EMVERM 29
enalapril maleate 45
enalapril-hydrochlorothiazide 49
ENBREL 75
ENBREL MINI 75
ENBREL SURECLICK 75
ENDARI 63
ENGERIX-B 77
enoxaparin sodium 43
ENPRESSE-28 67
ENSKYCE 67
ENSPRYNG 75
entacapone 30
entecavir 34
ENTRESTO 49
enulose 61
ENVARSUS XR 75
EPIDIOLEX 11
epinephrine 85
EPITOL 14
EPIVIR HBV 34
eplerenone 50
EPRONTIA 20
ERAXIS 19
ergotamine-caffeine 20
ERIVEDGE 25
ERLEADA 22
erlotinib hcl 25
ERRIN 71
ertapenem sodium 9
ery 58
ERYTHROCIN LACTOBIONATE 10
erythromycin 10, 58, 81
erythromycin base 10
erythromycin ethylsuccinate 10
ESBRIET 86
escitalopram oxalate 16
esomeprazole magnesium 63
ESTARYLLA 68
estradiol 66
ethambutol hcl 21
ethosuximide 13
ethynodiol diac-eth estradiol 68
etodolac 2
etonogestrel-ethinyl estradiol 68
etravirine 35, 36
EUCRISA 56
EUTHYROX 71
everolimus 25, 75
EVOTAZ 37
EVRYSDI 53
EXEL COMFORT POINT PEN NEEDLE 41
exemestane 24
EXKIVITY 25
ezetimibe 51

F

FALMINA 68
famciclovir 35
famotidine 62
FANAPT 32
FANAPT TITRATION PACK 32
febuxostat 20
felbamate 11
felodipine er 47
FEMYNOR 68
fenofibrate 50
fenofibrate micronized 50
fenofibric acid 50
fentanyl 3
fentanyl citrate 3
FERRIPROX 59
FERRIPROX TWICE-A-DAY 59
fesoterodine fumarate er 64
FETZIMA 16
FETZIMA TITRATION 16
FIASP 41
FIASP FLEXTOUCH 41
FIASP PENFILL 41
finasteride 64
FINTEPLA 11
FIRAZYR 73
FIRVANQ 6
flecainide acetate 46
FLOVENT DISKUS 84
FLOVENT HFA 84
fluconazole 19
fluconazole in sodium chloride 19
flucytosine 19
fludrocortisone acetate 65
flunisolide 84
fluocinolone acetonide 56, 83
fluocinonide 56
fluocinonide emulsified base 56
fluorometholone 81
fluorouracil 57
fluoxetine hcl 16
fluphenazine decanoate 31
fluphenazine hcl 31
flurbiprofen 2
flurbiprofen sodium 81
fluticasone propionate 56, 84
fluticasone-salmeterol 86, 87
fluvoxamine maleate 16
fondaparinux sodium 43
fosamprenavir calcium 37
fosinopril sodium 45
fosinopril sodium-hctz 49
FOTIVDA 25
furosemide 50
FUZEON 37
FYCOMPA 11

G

gabapentin 13
GALAFOLD 63
galantamine hydrobromide ... 15
galantamine hydrobromide er 15
GARDASIL 9 77
gatifloxacin 81
GATTEX 62
GAVILYTE-C 62
GAVILYTE-G 62
GAVRETO 25
gemfibrozil 50
generlac 61
GENGRAF 75
GENTAK 81
gentamicin in saline 5
gentamicin sulfate 5, 81
GENVOYA 35
GILENYA 54
GILOTRIF 25
glimepiride 39
glipizide 39
glipizide er 39
glipizide-metformin hcl 39
global alcohol prep ease 57
GLUCAGEN HYPOKIT 41
glucagon emergency 41
glyburide-metformin 40

glycopyrrolate....61
granisetron hcl....18
griseofulvin microsize....19
griseofulvin ultramicrosize...19
guanfacine hcl....44
guanfacine hcl er....53
H
halobetasol propionate....56
haloperidol....31
haloperidol decanoate....31
haloperidol lactate....31
HAVRIX....77
heparin sodium (porcine)....43
HIBERIX....77
HUMIRA....76
HUMIRA PEDIATRIC CROHNS START....75
HUMIRA PEN....75
HUMIRA PEN-CD/UC/HS STARTER....75
HUMIRA PEN-PEDIATRIC UC START....76
HUMIRA PEN-PS/UV/ADOL HS START....76
HUMIRA PEN-PSOR/UVEIT STARTER....76
hydralazine hcl....51
hydrochlorothiazide....50
hydrocodone-acetaminophen....3
hydrocodone-ibuprofen....3
hydrocortisone....56, 65, 79
hydrocortisone (perianal)....56
hydrocortisone ace-pramoxine....57
hydrocortisone valerate....56
hydromorphone hcl....3
hydroxychloroquine sulfate..29
hydroxyurea....23
hydroxyzine hcl....38
hydroxyzine pamoate....38
I
ibandronate sodium....79
IBRANCE....25
IBU....2
ibuprofen....2
icatibant acetate....73
ICLEVIA....68
ICLUSIG....25
IDHIFA....23
ILEVRO....81
imatinib mesylate....25
IMBRUVICA....25, 26
imipenem-cilastatin....9
imipramine hcl....17
imiquimod....57
IMOVAX RABIES....77
IMVEXXY MAINTENANCE PACK....66
IMVEXXY STARTER PACK....67
INBRIJA....30
INCASSIA....71
INCRELEX....65
indapamide....50
indomethacin....2
indomethacin er....2
INFANRIX....77
INLYTA....26
INQOVI....23
INREBIC....26
INTELENCE....36
INTRALIPID....60
INTRAROSA....68
INTRON A....74
INTROVALE....68
INVEGA HAFYERA....32
INVEGA SUSTENNA....32
INVEGA TRINZA....32
INVOKAMET....40
INVOKAMET XR....40
INVOKANA....40
IPOL....77
ipratropium bromide....84
ipratropium-albuterol....87
irbesartan....45
irbesartan-hydrochlorothiazide....49
IRESSA....26
ISENTRESS....35
ISENTRESS HD....35
ISIBLOOM....68
ISOLYTE-P IN D5W....60
ISOLYTE-S PH 7.4....58
isoniazid....21
isosorb dinitrate-hydralazine 49
isosorbide dinitrate....52
isosorbide mononitrate....52
isosorbide mononitrate er....52
isotretinoin....54
isradipine....47
ISTURISA....65
itraconazole....19
ivermectin....29
IXIARO....77
J
JAKAFI....26
JANTOVEN....43
JANUMET....40
JANUMET XR....40
JANUVIA....40
JARDIANCE....40
JASMIEL....68
JUBLIA....19
JULEBER....68
JULUCA....36
JUNEL 1.5/30....68
JUNEL 1/20....68
JUNEL FE 1.5/30....68
JUNEL FE 1/20....68
JUXTAPID....51
K
KALYDECO....85
KARIVA....68
KATERZIA....47
kcl in dextrose-nacl....58
kcl-lactated ringers-d5w....58
KELNOR 1/35....68
KELNOR 1/50....68
KERENDIA....50
KESIMPTA....54
ketoconazole....19
ketorolac tromethamine....2, 81
KINRIX....77
KISQALI (200 MG DOSE)..26
KISQALI (400 MG DOSE)..26
KISQALI (600 MG DOSE)..26
KISQALI FEMARA (400 MG DOSE)....23
KISQALI FEMARA (600 MG DOSE)....23
KISQALI FEMARA(200 MG DOSE)....23
KLOR-CON....58
KLOR-CON 10....58
KLOR-CON M10....58
KLOR-CON M15....58
KLOR-CON M20....58
KLOXXADO....4
KORLYM....41
KOSELUGO....26
KURVELO....68
KYNMOBI....30

L
labetalol hcl 46
lacosamide 14
lactulose 61
lamivudine 34, 36
lamivudine-zidovudine 36
lamotrigine 12
lamotrigine er 12
lamotrigine starter kit-blue ... 12
lamotrigine starter kit-green . 12
lamotrigine starter kit-orange 12
LAMPIT 29
lansoprazole 63
LANTUS 41
LANTUS SOLOSTAR 41
lapatinib ditosylate 26
LARIN 1.5/30 68
LARIN 1/20 68
LARIN FE 1.5/30 68
LARIN FE 1/20 68
LARISSIA 68
latanoprost 82
LATUDA 32
LEENA 68
leflunomide 74
lenalidomide 22
LENVIMA (10 MG DAILY DOSE) 26
LENVIMA (12 MG DAILY DOSE) 26
LENVIMA (14 MG DAILY DOSE) 26
LENVIMA (18 MG DAILY DOSE) 26
LENVIMA (20 MG DAILY DOSE) 26
LENVIMA (24 MG DAILY DOSE) 26
LENVIMA (4 MG DAILY DOSE) 26
LENVIMA (8 MG DAILY DOSE) 26
LESSINA 68
letrozole 24
leucovorin calcium 23
LEUKERAN 22
LEUKINE 44
leuprolide acetate 72
LEVEMIR 42
LEVEMIR FLEXTOUCH ... 42
levetiracetam 12
levetiracetam er 12
levobunolol hcl 82
levocarnitine 60
levocetirizine dihydrochloride 83
levofloxacin 10
levofloxacin in d5w 10
LEVONEST 68
levonorgest-eth estrad 91-day 68
levonorgestrel-ethinyl estrad 69
levonorg-eth estrad triphasic 69
LEVORA 0.15/30 (28) 69
LEVO-T 71
levothyroxine sodium 72
LEVOXYL 72
LEXIVA 37
LIALDA 79
lidocaine 4
lidocaine hcl 4
lidocaine viscous hcl 4
lidocaine-prilocaine 4
linezolid 6
LINZESS 61
liothyronine sodium 72
lisinopril 45
lisinopril-hydrochlorothiazide 49
lithium carbonate 39
lithium carbonate er 39
LIVALO 51
LIVMARLI 62
LIVTENCITY 34
LOKELMA 59
LONSURF 23
loperamide hcl 61
lopinavir-ritonavir 37
lorazepam 39
LORAZEPAM INTENSOL . 39
LORBRENA 26
LORYNA 69
losartan potassium 45
losartan potassium-hctz 49
loteprednol etabonate 81
lovastatin 51
LOW-OGESTREL 69
loxapine succinate 31
lubiprostone 61
LUMAKRAS 23
LUMIGAN 82
LUPKYNIS 76
LUPRON DEPOT (1-MONTH) 72
LUPRON DEPOT (3-MONTH) 72
LUPRON DEPOT (4-MONTH) 72
LUPRON DEPOT (6-MONTH) 72
LUTERA 69
LYBALVI 32
LYLEQ 71
LYNPARZA 23
LYSODREN 22
LYZA 71
M
magnesium sulfate 58
malathion 57
maraviroc 37
marlissa 69
MARPLAN 16
MATULANE 22
MAVYRET 34
MAYZENT 54
MAYZENT STARTER PACK 54
meclizine hcl 18
medroxyprogesterone acetate 71
mefloquine hcl 29
megestrol acetate 71
MEKINIST 26, 27
MEKTOVI 27
meloxicam 2
memantine hcl 14
memantine hcl er 14
MENACTRA 77
MENEST 67
MENQUADFI 77
MENVEO 77
mercaptopurine 23
meropenem 9
mesalamine 79
mesalamine er 79
MESNEX 23
metformin hcl 40
metformin hcl er 40
methadone hcl 3
methazolamide 82
methenamine hippurate 6
methimazole 73

methocarbamol 87
methotrexate sodium 76
methotrexate sodium (pf) 76
methylphenidate hcl 53
methylprednisolone 65
metoclopramide hcl 62
metolazone 50
metoprolol succinate er 46
metoprolol tartrate 46
metoprolol-hydrochlorothiazide 49
metronidazole 6
metyrosine 49
mexiletine hcl 46
MICROGESTIN 1.5/30 69
MICROGESTIN 1/20 69
MICROGESTIN FE 1.5/30 69
MICROGESTIN FE 1/20 69
midodrine hcl 44
miglitol 40
miglustat 63
MILI 69
minocycline hcl 11
minoxidil 52
mirtazapine 15
misoprostol 62
M-M-R II 77
modafinil 87
moexipril hcl 45
molindone hcl 31
mometasone furoate 56, 84
montelukast sodium 84
morphine sulfate 3
morphine sulfate (concentrate) 3
morphine sulfate er 3
MOVANTIK 61
moxifloxacin hcl 10, 81
moxifloxacin hcl in nacl 10
MULTAQ 46
mupirocin 58
mupirocin calcium 58
mycophenolate mofetil 76
mycophenolate sodium 76
MYRBETRIQ 64

N

nabumetone 2
nadolol 46
nafcillin sodium 9
naloxone hcl 4, 5
naltrexone hcl 4
NAMZARIC 14
naproxen 2
naproxen sodium 2
naratriptan hcl 21
NARCAN 5
NATACYN 81
nateglinide 40
NATPARA 79
NAYZILAM 13
nebivolol hcl 46
NECON 0.5/35 (28) 69
nefazodone hcl 16
neomycin sulfate 5
neomycin-bacitracin zn-polymyx 81
neomycin-polymyxin-dexameth 80
neomycin-polymyxin-gramicidin 80
neomycin-polymyxin-hc 80, 83
NERLYNX 27
NEUPRO 30
nevirapine 36
nevirapine er 36
niacin er (antihyperlipidemic) 51
nicardipine hcl 47
NICOTROL 5
nifedipine 47
nifedipine er 47
nifedipine er osmotic release 47
NIKKI 69
nilutamide 22
NINLARO 23
nitazoxanide 29
nitisinone 63
NITRO-BID 52
nitrofurantoin macrocrystal 6
nitrofurantoin monohyd macro 6
nitroglycerin 52
nizatidine 62
NOCDURNA 66
NORA-BE 71
norethin ace-eth estrad-fe 69
norethindrone 71
norethindrone acetate 71
norethindrone acet-ethinyl est 69
norethindrone-eth estradiol 69
norgestimate-eth estradiol 69
norgestim-eth estrad triphasic 69
NORTREL 0.5/35 (28) 69
NORTREL 1/35 (21) 69
NORTREL 1/35 (28) 69
NORTREL 7/7/7 70
nortriptyline hcl 17
NORVIR 37
NOVOLIN 70/30 42
NOVOLIN 70/30 FLEXPEN 42
NOVOLIN N 42
NOVOLIN N FLEXPEN 42
NOVOLIN R 42
NOVOLIN R FLEXPEN 42
NOVOLOG 42
NOVOLOG FLEXPEN 42
NOVOLOG MIX 70/30 42
NOVOLOG MIX 70/30 FLEXPEN 42
NOVOLOG PENFILL 42
NOXAFIL 19
NUBEQA 22
NUCALA 87
NUEDEXTA 53
NUPLAZID 32
NUTRILIPID 60
NYAMYC 19
NYLIA 1/35 70
NYLIA 7/7/7 70
NYMYO 70
nystatin 19, 20
nystatin-triamcinolone 57
NYSTOP 20

O

OCELLA 70
octreotide acetate 72
ODEFSEY 36
ODOMZO 27
OFEV 86
ofloxacin 11, 81, 83
olanzapine 32
olanzapine-fluoxetine hcl 15
olmesartan medoxomil 45
olmesartan medoxomil-hctz 49
olmesartan-amlodipine-hctz 49
olopatadine hcl 80
omega-3-acid ethyl esters 51
omeprazole 63
OMNITROPE 66
ondansetron 18

ondansetron hcl 18
ONUREG 23
OPSUMIT 86
ORFADIN 63
ORGOVYX 23
ORKAMBI 85
orphenadrine citrate er 87
oseltamivir phosphate 38
OSPHENA 70
oxacillin sodium 9
oxacillin sodium in dextrose .. 9
oxandrolone 66
oxaprozin 3
oxazepam 38
oxcarbazepine 14
oxybutynin chloride 64
oxybutynin chloride er 64
oxycodone hcl 4
oxycodone hcl er 3
oxycodone-acetaminophen 4
OZEMPIC (0.25 OR 0.5 MG/DOSE) 40
OZEMPIC (1 MG/DOSE) 40
OZEMPIC (2 MG/DOSE) 40
P
paliperidone er 33
PANRETIN 57
pantoprazole sodium 63
PANZYGA 73
paricalcitol 79
paromomycin sulfate 5
paroxetine hcl 16, 17
PASER 21
PEDIARIX 77
PEDVAX HIB 77
peg 3350-kcl-na bicarb-nacl . 62
peg-3350/electrolytes 62
PEGASYS 74
PEMAZYRE 27
penicillamine 65
penicillin g pot in dextrose 9
penicillin g potassium 9
penicillin g procaine 9
penicillin g sodium 9
penicillin v potassium 9
PENTACEL 78
pentamidine isethionate 29
pentoxifylline er 49
perindopril erbumine 45
PERIOGARD 54
permethrin 57
perphenazine 31
phenelzine sulfate 16
phenobarbital 12
phenytoin 14
phenytoin sodium extended .. 14
PIFELTRO 36
pilocarpine hcl 54, 82
pimecrolimus 56
pimozide 31
PIMTREA 70
pindolol 46
pioglitazone hcl 40
pioglitazone hcl-glimepiride . 40
pioglitazone hcl-metformin hcl 40
piperacillin sod-tazobactam so 9
PIQRAY (200 MG DAILY DOSE) 27
PIQRAY (250 MG DAILY DOSE) 27
PIQRAY (300 MG DAILY DOSE) 27
pirfenidone 86
PIRMELLA 1/35 70
piroxicam 3
PLASMA-LYTE 148 58
PLASMA-LYTE A 58
podofilox 57
polymyxin b-trimethoprim ... 80
POMALYST 22
PORTIA-28 70
posaconazole 20
potassium chloride 59
potassium chloride crys er 58
potassium chloride er 59
potassium chloride in dextrose 59
potassium chloride in nacl 59
potassium citrate er 59
pramipexole dihydrochloride 30
prasugrel hcl 44
pravastatin sodium 51
prazosin hcl 45
prednicarbate 56
prednisolone 65
prednisolone acetate 81
prednisolone sodium phosphate 65, 81
prednisone 65
PREDNISONE INTENSOL . 65
preferred plus insulin syringe 42
pregabalin 53
prehevbrio 78
PREMARIN 67
PREMASOL 60
PREMPHASE 70
PREMPRO 70
prenatal 60
PREVYMIS 34
PREZCOBIX 37
PREZISTA 37, 38
PRIFTIN 21
primaquine phosphate 29
primidone 12
PRIVIGEN 73
probenecid 20
PROCALAMINE 60
prochlorperazine 18
prochlorperazine maleate 18
PROCTO-MED HC 56
PROCTO-PAK 56
PROCTOSOL HC 56
PROCTOZONE-HC 56
progesterone 71
PROGRAF 76
PROLASTIN-C 63
PROLIA 79
PROMACTA 44
promethazine hcl 18
propafenone hcl 46
propranolol hcl 20, 47
propranolol hcl er 20, 46
propylthiouracil 73
PROQUAD 78
PROSOL 60
protriptyline hcl 18
PULMOZYME 85
PURIXAN 23
pyrazinamide 22
pyridostigmine bromide 21
Q
QINLOCK 27
QUADRACEL 78
quetiapine fumarate 33
quetiapine fumarate er 33
quinapril hcl 45
quinapril-hydrochlorothiazide 49
quinidine sulfate 46
quinine sulfate 29

R
RABAVERT 78
raloxifene hcl 79
ramipril 45
ranolazine er 49
rasagiline mesylate 30
RAVICTI 63
RECLIPSEN 70
RECOMBIVAX HB 78
RECTIV 52
REGRANEX 57
RELENZA DISKHALER 38
RELI-ON INSULIN SYRINGE 42
repaglinide 40
REPATHA 51
REPATHA PUSHTRONEX SYSTEM 51
REPATHA SURECLICK 51
RETACRIT 44
RETEVMO 27
REVLIMID 22
REXULTI 33
REYATAZ 38
REZUROCK 76
RHOPRESSA 82
ribavirin 34
rifabutin 21
rifampin 22
riluzole 53
rimantadine hcl 38
RINVOQ 74
risedronate sodium 79, 80
RISPERDAL CONSTA 33
risperidone 33
ritonavir 38
rivastigmine 15
rivastigmine tartrate 15
rizatriptan benzoate 21
ROCKLATAN 82
ropinirole hcl 30
rosuvastatin calcium 51
ROTARIX 78
ROTATEQ 78
ROZLYTREK 27
RUBRACA 27
rufinamide 14
RUKOBIA 37
RYBELSUS 40
RYDAPT 27
RYTARY 30

S
SANTYL 57
sapropterin dihydrochloride 63
SAVELLA 53
SAVELLA TITRATION PACK 53
SCEMBLIX 27
scopolamine 18
SECUADO 33
selegiline hcl 30
selenium sulfide 56
SELZENTRY 37
SEREVENT DISKUS 85
sertraline hcl 17
SETLAKIN 70
sevelamer carbonate 61
SHAROBEL 71
SHINGRIX 78
SIGNIFOR 72
sildenafil citrate 86
silodosin 64
silver sulfadiazine 57
SIMBRINZA 82
simvastatin 51
sirolimus 76
SIRTURO 22
SKYRIZI 74
SKYRIZI (150 MG DOSE) 74
SKYRIZI PEN 74
sodium chloride 59
sodium fluoride 59
sodium polystyrene sulfonate 59
sofosbuvir-velpatasvir 35
solifenacin succinate 64
SOLIQUA 42
SOLTAMOX 23
SOMAVERT 73
sorafenib tosylate 27
sotalol hcl 46
sotalol hcl (af) 46
SPIRIVA HANDIHALER 84
SPIRIVA RESPIMAT 84
spironolactone 50
spironolactone-hctz 49
SPRINTEC 28 70
SPRITAM 12
SPRYCEL 27
SPS 59
SRONYX 70
SSD 57
STELARA 74
STIVARGA 27
STRIBILD 35
SUBOXONE 4
sucralfate 62
sulfacetamide sodium 81
sulfacetamide sodium (acne) 11
sulfacetamide-prednisolone 80
sulfadiazine 11
sulfamethoxazole-trimethoprim 11
sulfasalazine 79
sulindac 3
sumatriptan 21
sumatriptan succinate 21
sumatriptan succinate refill 21
sunitinib malate 27
SUNOSI 87
SUPREP BOWEL PREP KIT 62
SUTAB 62
SYEDA 70
SYMDEKO 85
SYMLINPEN 120 40
SYMLINPEN 60 41
SYMPAZAN 13
SYMTUZA 35
SYNAREL 73
SYNJARDY 41
SYNJARDY XR 41
SYNRIBO 23
SYNTHROID 72

T
TABLOID 23
TABRECTA 27
tacrolimus 56, 76
TAFINLAR 27
TAGRISSO 27
TAKHZYRO 73
TALZENNA 27
tamoxifen citrate 23
tamsulosin hcl 64
TARINA FE 1/20 EQ 70
TASIGNA 28
TAVNEOS 74
tazarotene 54
TAZORAC 54
TAZTIA XT 48
TAZVERIK 28
TDVAX 78
TEFLARO 8

TEGSEDI 63
telmisartan 45
telmisartan-hctz 49
temazepam 87
TENIVAC 78
tenofovir disoproxil fumarate 36
TEPMETKO 28
terazosin hcl 45
terbinafine hcl 20
terbutaline sulfate 85
terconazole 20
teriparatide (recombinant) 80
testosterone 66
testosterone cypionate 66
testosterone enanthate 66
tetrabenazine 53
tetracycline hcl 11
THALOMID 22
theophylline er 85, 86
thioridazine hcl 31
thiothixene 31
TIADYLT ER 48
tiagabine hcl 13
TIBSOVO 28
TICOVAC 78
tigecycline 6
timolol maleate 47, 82
timolol maleate (once-daily) 82
tinidazole 6
TIVICAY 35
TIVICAY PD 35
tizanidine hcl 34
TOBI PODHALER 85
tobramycin 81, 85
tobramycin sulfate 5
tobramycin-dexamethasone 80
tolterodine tartrate 64
tolterodine tartrate er 64
tolvaptan 59
topiramate 21
topiramate er 20
toremifene citrate 23
torsemide 50
TOUJEO MAX SOLOSTAR 42
TOUJEO SOLOSTAR 42
TPN ELECTROLYTES 61
tramadol hcl 4
tramadol-acetaminophen 4
trandolapril 45
tranexamic acid 44
tranylcypromine sulfate 16
TRAVASOL 61
travoprost (bak free) 83
trazodone hcl 17
TRECATOR 22
TRELEGY ELLIPTA 87
TRELSTAR MIXJECT 73
TRESIBA 43
TRESIBA FLEXTOUCH 42
tretinoin 29, 55
TREXALL 76
triamcinolone acetonide 54, 56, 57
triamterene-hctz 49
trientine hcl 59
TRI-ESTARYLLA 70
trifluoperazine hcl 31
trifluridine 35
trihexyphenidyl hcl 29
TRIKAFTA 85
trimethoprim 6
TRI-MILI 70
trimipramine maleate 18
TRINTELLIX 17
TRI-NYMYO 70
TRI-SPRINTEC 70
TRIUMEQ 37
TRIUMEQ PD 37
TRIVORA (28) 70
TRI-VYLIBRA 70
TRIZIVIR 36
TROPHAMINE 61
trospium chloride 64
trospium chloride er 64
TRULICITY 41
TRUMENBA 78
TRUSELTIQ (100MG DAILY DOSE) 28
TRUSELTIQ (125MG DAILY DOSE) 28
TRUSELTIQ (50MG DAILY DOSE) 28
TRUSELTIQ (75MG DAILY DOSE) 28
TUKYSA 28
TURALIO 28
TWINRIX 78
TYBOST 37
TYMLOS 80
TYPHIM VI 78

U

UBRELVY 21
UNITHROID 72
ursodiol 62

V

valacyclovir hcl 35
VALCHLOR 22
valganciclovir hcl 34
valproic acid 12
valsartan 45
valsartan-hydrochlorothiazide 50
VALTOCO 10 MG DOSE 13
VALTOCO 15 MG DOSE 13
VALTOCO 20 MG DOSE 13
VALTOCO 5 MG DOSE 13
vancomycin hcl 6
VAQTA 78
varenicline tartrate 5
VARIVAX 78
VARUBI (180 MG DOSE) 18
VASCEPA 51
VELIVET 70
VELPHORO 61
VEMLIDY 34
VENCLEXTA 28
VENCLEXTA STARTING PACK 28
venlafaxine hcl 17
venlafaxine hcl er 17
VENTOLIN HFA 85
verapamil hcl 48
verapamil hcl er 48
VERQUVO 50
VERSACLOZ 34
VERZENIO 28
VESTURA 71
VICTOZA 41
VIENVA 71
vigabatrin 13
VIIBRYD STARTER PACK 17
VIJOICE 63
vilazodone hcl 17
VIRACEPT 38
VIREAD 36, 37
VITRAKVI 28
VIVITROL 4
VIZIMPRO 28
VONJO 28
voriconazole 20

VOSEVI 35
VOTRIENT 28
VRAYLAR 33
VYFEMLA 71
VYLIBRA 71
VYNDAMAX 63
W
warfarin sodium 43
WELIREG 23
X
XALKORI 28
XARELTO 43
XARELTO STARTER PACK 43
XATMEP 24
XCOPRI 12, 13
XCOPRI (250 MG DAILY DOSE) 12
XCOPRI (350 MG DAILY DOSE) 12
XGEVA 80
XIFAXAN 6, 7
XOFLUZA (40 MG DOSE) 38
XOFLUZA (80 MG DOSE) 38
XOLAIR 74
XOSPATA 28
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 22
XULTOPHY 41
XURIDEN 63
XYREM 88
XYWAV 88
Y
YF-VAX 78
YONSA 22
Z
zafirlukast 84
zaleplon 87
ZARXIO 44
ZEJULA 28
ZELBORAF 28
ZEMDRI 5
ZENPEP 64
zidovudine 37
ZIEXTENZO 44
ZIMHI 5
ziprasidone hcl 33
ziprasidone mesylate 34
ZIRGAN 34
ZOLINZA 24
zolmitriptan 21
zolpidem tartrate 87
zonisamide 13
ZOVIA 1/35 (28) 71
ZYDELIG 28
ZYKADIA 28
ZYPITAMAG 51
ZYPREXA RELPREVV 34

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AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at **1-866-237-3210**. If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York	**1-866-237-3210**
Civil Rights Coordination Unit	TTY/TDD: **1-800-662-1220**
1991 Marcus Avenue Suite M107	Fax: **855-895-0778**
Lake Success, New York 11042-2057	Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, TTY/TDD: **1-800-537-7697**. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

AgeWell New York, LLC es un plan de una Organización para el mantenimiento de la salud (Health Maintenance Organization, HMO), que tiene contrato con Medicare. AgeWell New York, LLC tiene un contrato de la agencia estatal de Medicaid con el Departamento de Salud del Estado de Nueva York y un contrato con New York State Medicaid para AgeWell New York Advantage Plus (HMO D-SNP). No ofrecemos todos los planes disponibles en su área. Cualquier información que proporcionemos se limita a los planes que ofrecemos en su área. Comuníquese con Medicare.gov o llame al 1-800-MEDICARE para obtener información sobre todas sus opciones.La inscripción en AgeWell New York, LLC depende de la renovación del contrato. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. También hay disponibles servicios de asistencia gratuitos para otros idiomas llamando al número que se menciona arriba.

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AgeWell New York cumple todas las leyes federales sobre los derechos civiles aplicables y no discrimina por cuestiones de raza, color, nacionalidad, edad, discapacidad o sexo. AgeWell New York no excluye a las personas ni las trata de manera diferente por su raza, color, nacionalidad, edad, discapacidad o sexo. AgeWell New York proporciona ayuda y servicios gratuitos a las personas con discapacidades, a fin de que puedan comunicarse con nosotros eficazmente, como los siguientes:

- Intérpretes calificados de lenguaje de señas
- Información escrita en otros formatos (tamaño de letra grande, audio, formatos electrónicos accesibles y otros formatos)
- Servicios lingüísticos gratuitos para personas cuyo idioma nativo no sea el inglés, como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Servicios para Miembros de AgeWell New York al **1-866-237-3210.** Si considera que AgeWell New York no proporcionó estos servicios o lo discriminó de otra manera por cuestiones de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente dirección:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M107
Lake Success, New York 11042-2057

1-866-237-3210
TTY/TDD: **1-800-662-1220**
Fax: **855-895-0778**
Email: civilrightsunit@agewellnewyork.com

Puede presentar un reclamo personalmente o por correo postal, fax o correo electrónico. Si necesita ayuda para presentar un reclamo, la Unidad de Coordinación de Derechos Civiles se encuentra a su disposición. También puede presentar una queja relacionada con los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Sociales, en forma electrónica a través del portal de quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien por teléfono o correo postal a: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, TTY/TDD: **1-800-537-7697**. Los formularios de quejas se encuentran disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，**帮**助**您**解答**关**于健康或药物保险的任何疑问。如果**您**需要此翻译服务，请致电 **1-866-237-3210** (TTY/TDD: **1-800-662-1220**)。我们的中文工作人员很乐意**帮**助**您**。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 **1-866-237-3210** (TTY/TDD: **1-800-662-1220**)。我們講中文的人員將樂意為**您**提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-866-237-3210** (TTY/TDD: **1-800-662-1220**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-866-237-3210** (TTY/TDD: **1-800-662-1220**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Updated 08/30/2022

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-866-237-3210** (TTY/TDD: **1-800-662-1220**) سيقوم بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-866-237-3210** (TTY/TDD: **1-800-662-1220**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-866-237-3210** (TTY/TDD: **1-800-662-1220**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-866-237-3210** (TTY/TDD: **1-800-662-1220**)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

This formulary was updated on 10/04/2022. This formulary is effective 01/01/2023.

For more recent information or other questions, please contact Elixir, AgeWell New York's Pharmacy Benefit Manager, at **1-844-782-7670** or TTY/TDD users **1-800-662-1220**, 24 hours a day, 7 days a week 24 hours a day, or visit **www.agewellnewyork.com**.

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