Health CHOICE GENERATIONS



Health Choice Generations (HMO D-SNP)

2020 FORMULARY
(LIST OF COVERED DRUGS)
FORMULARIO DE 2020
(LISTA DE MEDICAMENTOS CUBIERTOS)

ARIZONA

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN / *FAVOR DE LEER: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN*

This formulary was updated on 12/1/2020. For more recent information or other questions, please contact Health Choice Generations Member Services at 1-800-656-8991 or, for TTY users, 711, 8 a.m. – 8 p.m., 7 days a week, or visit www.HealthChoiceGenAZ.com.

Este formulario se actualizó en 12/1/2020. Para obtener información más reciente o si tiene otras preguntas, comuníquese con nosotros, Health Choice Generations al Departamento de Servicios para Miembros, al 1-800-656-8991 o para usuarios del servicio TTY al 711, los 7 días de la semana de 8:00 a.m. a 8:00 p.m., hora local. O bien, visite www.HealthChoiceGenAZ.com.

The formulary may change at any time. You will receive notice when necessary.
El formulario puede modificarse en cualquier momento. Recibirá un aviso cuando sea necesario.
HPMS Approved Formulary File Submission ID 20541, Version Number 16

NOTICE OF NON-DISCRIMINATION

In Compliance with Section 1557 of the Affordable Care Act

Health Choice Generations (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Choice Generations does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Choice Generations:

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)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact:

Health Choice Generations
Address: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Phone: 1-800-656-8991
Fax: 480-760-4739
TTY: 711
Email: HCH.GrievanceForms@HealthChoiceAZ.com

If you believe that Health Choice Generations 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 by mail, fax, or email to:

Health Choice Generations
Address: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Phone: 1-800-656-8991
Fax: 480-760-4739
TTY: 711
Email: HCH.GrievanceForms@HealthChoiceAZ.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Grievance Manager/Civil Rights Coordinator 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This information is available in other formats, such as Braille, large print, and audio.

AVISO DE NO DISCRIMINACIÓN

En cumplimiento con la Sección 1557 de la Ley de Cuidado de Salud de Bajo Costo

Health Choice Generations (HMO D-SNP) cumple con las leyes de derechos civiles federales vigentes y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Health Choice Generations no excluye a las personas ni las trata de manera diferente por su raza, color, nacionalidad, edad, discapacidad o sexo.

Health Choice Generations:

Ofrece material de ayuda y servicios sin cargo a las personas que tienen discapacidades que les impiden comunicarse de manera eficaz con nosotros, como los siguientes:

- Intérpretes de lenguaje de señas calificados
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Brinda servicios de idiomas sin cargo a las personas cuya lengua materna no es el inglés, como los siguientes:

- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con nosotros:

Health Choice Generations
Dirección: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Teléfono: 1-800-656-8991
Fax: 480-760-4739
TTY: 711
Correo electrónico:
HCH.GrievanceForms@HealthChoiceAZ.com

Si considera que Health Choice Generations no ha logrado prestar estos servicios o ha discriminado de algún otro modo a una persona por su raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal por correo, fax o correo electrónico:

Health Choice Generations
Dirección: 410 N. 44th Street, Ste. 900
Phoenix, AZ 85008
Teléfono: 1-800-656-8991
Fax: 480-760-4739
TTY: 711
Correo electrónico:
HCH.GrievanceForms@HealthChoiceAZ.com

Puede presentar una queja formal personalmente o por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja formal, el administrador de quejas formales/coordinador de derechos civiles está a su disposición para ayudarlo.

También puede presentar una queja por violación a los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de forma electrónica a través de su Portal de quejas, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo o teléfono:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Los formularios de queja están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Esta información está disponible en otros formatos, como braille, letra grande y audio.

MULTI-LANGUAGE INTERPRETER SERVICES

as required by Section 1557 of the Affordable Care Act

Health CHOICE GENERATIONS

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-656-8991 (TTY: 711), 8AM – 8PM, 7 days a week.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia lingüística sin cargo. Llame al 1-800-656-8991 (TTY: 711).

請注意：若您使用繁體中文，您可以接受免費的語言協助服務。請致電 1-800-656-8991 (TTY: 711)。

Bilagáana bizaad doo bee yáníłti' dago dóó saad nááná ła' bee yáníłti'go, saad bee ata' hane', t'áá níik'eh, ná bee ahóót'i' . Kojį' hodíílnih 1-800-656-8991 (TTY: 711).

ATENÇÃO: Se você fala português brasileiro, oferecemos serviços gratuitos de assistência para idiomas. Ligue para 1-800-656-8991 (TTY: 711).

CHÚ Ý: Nếu quý vị nói [Tiếng Việt], chúng tôi sẽ cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi số 1-800-656-8991 (TTY: 711).

تنبيه: إذا كنت تتحدث العربية، فسوف تتوفر لديك خدمات المساعدة اللغوية، مجانًا. اتصل على 1-800-656-8991 (هاتف نصي: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-656-8991 (TTY: 711).

ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang, gratis, disponib pou ou. Rele 1-800-656-8991 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Fremdsprachenservice zur Verfügung. Rufen Sie 1-800 -656-8991 (TTY: 711) an.

ΠΡΟΣΟΧΗ: εάν μιλάτε Ελληνικά, μπορείτε να λάβετε δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό 1-800-656-8991 (TTY: 711).

સૂચના: જો તમે બોલતા હોવ, તો તમારા માટે મફત ભાષા સહાયતા સેવાઓ ઉપલબ્ધ છે. સંપર્ક 1-800-656-8991 (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। 1-800-656-8991 (TTY: 711) पर कॉल करें।

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiami il numero 1-800-656-8991 (TTY: 711).

MULTI-LANGUAGE INTERPRETER SERVICES

as required by Section 1557 of the Affordable Care Act

Health CHOICE GENERATIONS

注意：日本語を話される場合、無料で言語支援サービスをご利用いただけます。次の番号までお電話してください：1-800-656-8991 (TTY: 711)

주의: 한국어를 사용하는 경우, 언어 지원 서비스가 무료로 제공됩니다. 1-800-656-8991 (TTY: 711) 번으로 전화하십시오.

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើលោកអ្នកនិយាយភាសា ខ្មែរ យើងខ្ញុំមានសេវាកម្មជំនួយភាសាដល់លោកអ្នកដោយមិនគិតថ្លៃនោះទេ។ សូមហៅទូរសព្ទមកលេខ 1-800-656-8991 (TTY៖ 711)។

नेपाली – बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन् । ध्यान दिनुहोस्: तपाईं 1-800-656-8991 (TTY: 711) मा कल गर्नुहोस् ।

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی رایگان به شما ارائه می‌شود.با 1-800-656-8991 (TTY: 711). تماس بگیرید.

UWAGA: Jeżeli mówi Pan/Pani po polsku, oferujemy bezpłatne usługi pomocy językowej. Prosimy o kontakt pod numerem 1-800-656-8991 (telefon tekstowy (TTY: 711).

ВНИМАНИЕ! Если вы говорите на Русский, вам бесплатно доступны услуги языковой поддержки. Звоните 1-800-656-8991 (телетайп: 711).

PAŽNJA: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su Vam besplatno. Pozovite 1-800-656-8991 (TTY: 711).

ᠰᠡᠯᠪᠡᠭᠡ: ᠪᠢ ᠮᠣᠩᠭᠣᠯ ᠬᠡᠯᠡ ᠶᠠᠷᠢᠵᠤ ᠪᠠᠢᠨ᠎ᠠ ᠤᠤ (ᠬᠡᠯᠡᠬᠦ ᠵᠢᠨᠬᠡᠨᠡ) ᠲᠠᠨᠳ ᠲᠤᠰᠠᠯᠠᠮᠵᠢᠲᠠᠢ ᠬᠡᠯᠡ ᠪᠡᠯᠡᠭᠯᠡᠭᠡᠳ ᠪᠠᠢᠨ᠎ᠠ.1-800-656-8991 (TTY:711) ᠳᠤᠭᠠᠷ ᠵᠤᠷᠤᠭᠯᠠᠨ ᠬᠣᠯᠪᠣᠭᠤᠷᠠᠢ.

ATENSIYON: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, na walang singil, ay magagamit mo. Tumawag sa 1-800-656-8991 (TTY: 711).

โปรดทราบ: หากคุณพูดภาษา ไทย คุณจะสามารถใช้บริการความช่วยเหลือด้านภาษาได้โดยไม่มีค่าใช้จ่าย โทร 1-800-656-8991 (TTY: 711)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-656-8991 (TTY: 711).

Health Choice Generations (HMO D-SNP)

2020 Formulary

(List of Covered Drugs)

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

HPMS Approved Formulary File Submission ID 00020541, Version Number 16

This formulary was updated on 12/1/2020. For more recent information or other questions, please contact Health Choice Generations Member Services at 1-800-656-8991 or, for TTY users, 711, 7 days a week, 8:00 a.m. to 8:00 p.m., or visit www.HealthChoiceGenAZ.com.

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 Health Choice Generations (HMO D-SNP). When it refers to "plan" or "our plan," it means Health Choice Generations.

This document includes list of the drugs (formulary) for our plan which is current as of 12/1/2020. 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, 2020, and from time to time during the year.

Health Choice Generations (HMO D-SNP) is a Health Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Health Choice Generations (HMO D-SNP) depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.

H5587_Formulary1050_C

What is the Health Choice Generations Formulary?

A formulary is a list of covered drugs selected by Health Choice Generations 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. Health Choice Generations will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Health Choice Generations 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 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 also find information in the section below entitled "How do I request an exception to the Health Choice Generations Formulary?"

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

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier 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 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 31-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 Health Choice Generations Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 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.

The enclosed formulary is current as of December 1, 2020. To get updated information about the drugs covered by Health Choice Generations, please contact us. Our contact information appears on the front and back cover pages. Mid-year non-maintenance formulary changes will be posted to our website at www.HealthChoiceGenAZ.com.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. 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 7. 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 65. 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?

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

- **Quantity Limits:** For certain drugs, Health Choice Generations limits the amount of the drug that Health Choice Generations will cover. For example, Health Choice Generations provides 9 tablets per prescription for sumatriptan. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Health Choice Generations 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, Health Choice Generations may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Health Choice Generations 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 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Health Choice Generations 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 Health Choice Generations formulary?" on page v 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 Health Choice Generations does not cover your drug, you have two options:

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

- You can ask Health Choice Generations 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 Health Choice Generations Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health Choice Generations 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, Health Choice Generations will only approve your request for an exception if the alternative drugs included on the plan's formulary, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31 day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31 day supply of medication. After your first 31 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.

For current Health Choice Generations members moving from one treatment setting to another a transition fill of a Part D medication will be provided. Examples of these level of care changes include but are not limited to the following: beneficiary enters an LTC facility from a hospital, beneficiary is discharged

from a hospital to a home, beneficiary ends a skilled nursing facility Medicare Part A stay and reverts to the Part D plan formulary, beneficiary gives up hospice status and reverts to standard Medicare Part A and B benefits, beneficiary ends a LTC facility stay and returns to the community, and beneficiary is discharged from psychiatric hospitals with drug regimens that are highly individualized. Additionally for beneficiaries admitted to or discharged from an LTC facility, early refill edits are not used to limit appropriate and necessary access to their Part D benefit.

For more information

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

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

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

Health Choice Generations Formulary

The formulary below provides coverage information about the drugs covered by Health Choice Generations. If you have trouble finding your drug in the list, turn to the Index that begins on page 65.

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

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

List of Abbreviations

B/D: This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

EA: Each.

NM: Non-Mail Order Drug. This prescription drug is not available through a mail-order service.

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

QL: Quantity Limit. For certain drugs, Health Choice Generations limits the amount of the drug that Health Choice Generations will cover. For example, Health Choice Generations provides 30 tablets per prescription for zolpidem.

ST: Step Therapy. In some cases, Health Choice Generations 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, Health Choice Generations may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Health Choice Generations will then cover Drug B.

LA: This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-800-656-8991 or, for TTY users, 711, 7 days a week, 8:00 a.m. to 8:00 p.m.

Health Choice Generations (HMO D-SNP)

Formulario 2020

(Lista de medicamentos cubiertos)

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE ESTE PLAN CUBRE

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Este formulario fue actualizado el 12/1/2020. Para obtener la información más reciente o si tiene alguna otra pregunta, comuníquese con Servicios para Miembros de Health Choice Generations al 1-800-656-8991 o, para usuarios TTY, 711, los 7 días a la semana, de 8:00 a. m. a 8:00 p. m., o visite www.HealthChoiceGenAZ.com.

Nota para los miembros actuales: Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que aún contiene los medicamentos que toma.

Cuando esta lista de medicamentos (formulario) se refiere a “nosotros”, “nos” o “nuestro(s)”, hablamos de Health Choice Generations (HMO D-SNP). Cuando se refiere a “plan” o a “nuestro plan”, hablamos de Health Choice Generations.

Este documento incluye la lista de medicamentos (formulario) de nuestro plan, que fue actualizada el 12/1/2020. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y en la contraportada.

Por lo general, debe usar las farmacias de la red para obtener los beneficios para medicamentos de venta con receta médica. Los beneficios, el formulario, la red de farmacias o los copagos o coseguro pueden cambiar el 1 de enero de 2020 y de vez en cuando durante el año.

Health Choice Generations (HMO D-SNP) tiene contrato con Medicare y con el programa estatal de Medicaid. La inscripción en Health Choice Generations (HMO D-SNP) depende de la renovación del contrato.

Esta información está disponible en otros formatos, como braille, letra grande y audio.

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¿Qué es el formulario de Health Choice Generations?

Un formulario es una lista de medicamentos cubiertos seleccionados por Health Choice Generations en conjunto con un equipo de proveedores de atención de salud, que representan las terapias recetadas que se consideran una parte necesaria de un programa de tratamiento de calidad. Por lo general, Health Choice Generations cubrirá los medicamentos que aparecen en nuestro formulario, siempre y cuando el medicamento sea médicamente necesario, se compre en una farmacia de la red de Health Choice Generations y se sigan otras normas del plan. Para obtener más información sobre cómo surtir sus recetar médicas, revise su Evidencia de cobertura.

¿Puede cambiar el formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos ocurren el 1 de enero, pero "nosotros" podemos agregar o quitar medicamentos de la Lista de medicamentos durante el año, cambiarlos a diferentes niveles de costo compartido o agregar restricciones nuevas. Debemos seguir las reglas de Medicare al hacer estos cambios.

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

- **Nuevos medicamentos genéricos.** Es posible que eliminemos inmediatamente un medicamento de marca de nuestra lista de medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparece en el mismo nivel de costo compartido o en uno inferior y con las mismas restricciones o menos. Además, cuando se agrega un nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra lista de medicamentos, pero lo cambiaremos inmediatamente a un nivel distinto de costo compartido o agregaremos restricciones nuevas. Si actualmente toma dicho medicamento de marca, es posible que no le informemos con anticipación de dicho cambio, pero después le proporcionaremos información específica sobre los cambios precisos que hemos hecho.

    - Si hacemos dicho cambio, usted o el médico que receta pueden pedirnos que hagamos una excepción y sigamos con la cobertura del medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción y, además, puede encontrar información en la sección a continuación, que se titula “¿Cómo solicito una excepción al formulario de Health Choice Generations?”

- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento en nuestro formulario no es seguro o si el fabricante del medicamento retira el medicamento del mercado, eliminaremos inmediatamente dicho medicamento de nuestro formulario y les avisaremos a los miembros que toman dicho medicamento.

- **Otros cambios.** Es posible que hagamos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que no es nuevo en el mercado para reemplazar a uno de marca que aparece actualmente en el formulario o agregar nuevas restricciones al medicamento de marca o cambiarlo a un nivel distinto de costo compartido. O podemos hacer cambios según las nuevas pautas clínicas. Si eliminamos medicamentos de nuestro formulario o agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, debemos informar del cambio a los miembros afectados 30 días antes

de la entrada en vigencia del cambio o en el momento en que el miembro solicite una renovación del medicamento, en cuyo caso recibirá un suministro para 31 días del medicamento.

- Si hacemos estos cambios, usted o el médico que receta pueden pedirnos que hagamos una excepción y sigamos con la cobertura del medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción y, además, puede encontrar información en la sección a continuación, que se titula "¿Cómo solicito una excepción al formulario de Health Choice Generations?"

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si usted toma un medicamento que aparece en nuestro formulario 2020 que estuvo cubierto al principio del año, no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2020, excepto como se describió anteriormente. Esto significa que estos medicamentos permanecerán disponibles con el mismo costo compartido y sin nuevas restricciones para los miembros que toman los medicamentos durante el resto del año de cobertura.

El formulario adjunto entrará en vigencia en el 1 de diciembre de 2020. Comuníquese con nosotros para obtener información actualizada de los medicamentos cubiertos por Health Choice Generations. Nuestra información de contacto aparece en la portada y en la contraportada. Los cambios a mitad de año relacionados con los medicamentos que no son de mantenimiento se publicarán en nuestro sitio web, www.HealthChoiceGenAZ.com.

¿Cómo uso el formulario?

Hay dos formas de buscar un medicamento en el formulario:

Afección

El formulario comienza en la página 7. Los medicamentos en este formulario están agrupados en categorías según el tipo de afección que acostumbran tratar. Por ejemplo, los medicamentos que se usan para tratar una afección cardíaca aparecen en la categoría Agentes cardiovasculares. Si sabe para qué toma el medicamento, busque el nombre de la categoría en la lista que comienza en la página 7. Luego, busque el medicamento en el nombre de la categoría.

Lista en orden alfabético

Si no está seguro en qué categoría buscar, debería buscar el medicamento en el Índice que comienza en la página 65. El Índice proporciona una lista en orden alfabético de todos los medicamentos que se incluyen en este documento. En el Índice aparecen los medicamentos genéricos y los de marca. Busque en el Índice su medicamento. Al lado del nombre del medicamento, verá el número de página donde puede encontrar la información de cobertura. Vaya a la página que indica el Índice y busque el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Health Choice Generations cubre los medicamentos de marca y los medicamentos genéricos. Un medicamento genérico está aprobado por la Administración de Alimentos y Medicamentos (FDA, Food and Drug Administration) porque tiene los mismos ingredientes activos que el medicamento de marca. Por lo general, los medicamentos genéricos son menos costosos que los de marca.

¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos adicionales o límites en la cobertura. Estos requisitos y límites pueden ser, entre otros, los siguientes:

- **Autorización previa:** Health Choice Generations exige que usted (o el médico) obtengan autorización previa para ciertos medicamentos. Esto quiere decir que deberá obtener la aprobación de Health Choice Generations antes de surtir sus recetas médicas. Si no obtiene la aprobación, es posible que Health Choice Generations no cubra el medicamento.

- **Límites en la cantidad:** Para ciertos medicamentos, Health Choice Generations limita la cantidad de medicamento que cubrirá. Por ejemplo, Health Choice Generations proporciona 9 comprimidos por receta médica de sumatriptán. Esto puede ser adicional al suministro estándar para un mes o tres meses.

- **Terapia escalonada:** En algunos casos, Health Choice Generations exige que pruebe primero con ciertos medicamentos para tratar su afección antes de cubrir otro medicamento para dicha afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección, es posible que Health Choice Generations no cubra el medicamento B, a menos que primero pruebe el medicamento A. Si el medicamento A no es eficaz, entonces Health Choice Generations cubrirá el medicamento B.

Para saber si su medicamento tiene requisitos adicionales o límites, busque en el formulario que comienza en la página 7. Además, puede visitar nuestro sitio web para encontrar más información sobre las restricciones que se aplican a medicamentos cubiertos específicos. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y en la contraportada.

Puede pedir a Health Choice Generations que haga una excepción para estas restricciones o límites, o puede pedir una lista de otros medicamentos similares que pueden tratar su afección. Consulte la sección: "¿Cómo solicito una excepción al formulario de Health Choice Generations?" en la página xii para obtener información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no aparece en el formulario?

Si el medicamento no se incluye en este formulario (lista de medicamentos cubiertos), primero debería comunicarse con Servicios para Miembros y preguntar si el medicamento está cubierto.

Si le indicaron que Health Choice Generations no cubre su medicamento, tiene dos opciones:

- Puede pedir a Servicios para Miembros una lista de medicamentos similares que están cubiertos por Health Choice Generations. Cuando reciba la lista, muéstresela al médico y pídale que le recete un medicamento similar que esté cubierto por Health Choice Generations.

- Puede pedir a Health Choice Generations que haga una excepción y cubra su medicamento. Lea a continuación la información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario de Health Choice Generations?

Puede pedir a Health Choice Generations que haga una excepción a nuestras normas de cobertura. Hay distintos tipos de excepciones que puede solicitarnos.

- Puede pedirnos cubrir un medicamento incluso si no está en nuestro formulario. Si se aprueba, cubriremos el medicamento a un nivel de costo compartido de costo predeterminado y no podrá pedirnos que proporcionemos el medicamento a un nivel inferior de costo compartido.

- Puede pedirnos que renunciemos a las restricciones o límites de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, Health Choice Generations limita la cantidad de medicamento que cubriremos. Si el medicamento tiene un límite de cantidad, puede solicitarnos que renunciemos al límite y cubramos una cantidad mayor.

Por lo general, Health Choice Generations solo aprobará su solicitud de excepción si los medicamentos alternativos se incluyen en el formulario del plan o si las restricciones de uso adicionales no serían tan eficaces para el tratamiento de su afección o provocarían efectos secundarios adversos.

Debería comunicarse con nosotros para pedirnos tomar una decisión de cobertura inicial para una excepción al formulario o a la restricción de uso. **Cuando solicita una excepción al formulario o restricción de uso, debería presentar una declaración del médico que receta para respaldar su solicitud.** Por lo general, debemos tomar nuestra decisión dentro de 72 horas después de recibir la declaración de respaldo del médico que receta. Puede solicitar una excepción acelerada (rápida) si usted o el médico consideran que su salud podría estar en riesgo si espera hasta 72 horas por una decisión. Si se aprueba la solicitud para acelerar, debemos informarle de nuestra decisión a más tardar 24 horas después de recibir la declaración de respaldo del médico que receta u otro médico.

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

Como un afiliado nuevo o existente de nuestro plan, puede tomar medicamentos que no aparecen en el formulario. O es posible que tome un medicamento que aparece en nuestro formulario pero su capacidad de adquirirlo es limitada. Por ejemplo, es posible que necesite una autorización previa del plan antes de surtir su receta médica. Debería hablar con el médico para decidir si debe cambiar su medicamento por uno que cubramos o si debe solicitar una excepción al formulario para poder cubrir el medicamento que toma. Durante el tiempo que toma hablar con el médico para determinar el tratamiento adecuado para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días en que es afiliado del plan.

Para cada uno de los medicamentos que no aparecen en nuestro formulario o si su capacidad para obtenerlos es limitada, cubriremos un suministro temporal para 31 días. Si la receta es por menos días, autorizaremos renovaciones para proporcionarle un suministro para 31 días de medicamento, como máximo. Después del suministro para los primeros 31 días, no pagaremos estos medicamentos, incluso si ha sido afiliado 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 nuestro formulario o si su capacidad de obtenerlo es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia para 31 días de dicho medicamento mientras se resuelve la petición de excepción al formulario.

Para afiliados actuales de Health Choice Generations que cambian de un entorno de tratamiento a otro, se surtirá una receta de transición de un medicamento de la parte D. Ejemplos de cambios en este nivel de atención son, entre otros, los siguientes: un beneficiario ingresa a un centro de atención a largo plazo (LTC, long term care) desde un hospital, el beneficiario recibe el alta de un hospital a un hogar, el beneficiario finaliza una estancia en un centro de enfermería especializada de la parte A de Medicare y vuelve a la parte D del formulario del plan, el beneficiario renuncia al estado de cuidados paliativos y vuelve a los beneficios estándar de la parte A y B de Medicare, el beneficiario pone fin a una estancia en un centro de LTC y vuelve a la comunidad y el beneficiario recibe el alta de un hospital psiquiátrico con un régimen de medicamentos que es altamente personalizado. Además, para que los beneficiarios ingresen o reciban el alta de un centro LTC no se usan modificaciones de renovación antes de plazo para limitar el acceso adecuado y necesario a los beneficios de la parte D.

Para obtener más información

Para obtener información más detallada sobre la cobertura de medicamentos de venta con receta médica de Health Choice Generations, revise la Evidencia de cobertura y otro material del plan.

Si tiene preguntas sobre Health Choice Generations, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y en la contraportada.

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

Formulario de Health Choice Generations

El formulario que comienza en la página siguiente proporciona información de la cobertura de los medicamentos cubiertos por Health Choice Generations. Si tiene algún problema para buscar su medicamento en la lista, vaya al Índice en la página 65.

La primera columna de la tabla indica el nombre del medicamento. Los medicamentos de marca aparecen con mayúscula (por ejemplo, VESICARE) y los genéricos, con minúscula y en cursiva (por ejemplo, *glipizide*).

La información en la columna Requisitos o límites indica si Health Choice Generations tiene algún requisito especial de cobertura para el medicamento.

Lista de abreviaturas

B/D: Este medicamento de venta con receta médica tiene un requisito de autorización previa administrativa de la parte B versus la parte D. Este medicamento puede estar cubierto por la parte B o la parte D según las circunstancias. Es posible que sea necesario presentar información que describa el uso y el entorno donde se usará el medicamento para tomar una decisión.

EA: Cada uno.

NM: Medicamento sin pedido por correo. Este medicamento de venta con receta médica no está disponible mediante un servicio de pedido por correo.

PA: Autorización previa. Health Choice Generations exige que usted (o el médico) obtenga autorización previa para ciertos medicamentos. Esto quiere decir que deberá obtener la aprobación de Health Choice Generations antes de surtir sus recetas médicas. Si no obtiene la aprobación, es posible que Health Choice Generations no cubra el medicamento.

QL: Límite de cantidad. Para ciertos medicamentos, Health Choice Generations limita la cantidad de medicamento que cubrirá. Por ejemplo, Health Choice Generations proporciona 30 comprimidos por receta médica de zolpidem.

ST: Terapia escalonada. En algunos casos, Health Choice Generations exige que pruebe primero con ciertos medicamentos para tratar su afección antes de cubrir otro medicamento para dicha afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección, es posible que Health Choice Generations no cubra el medicamento B a menos que primero pruebe el medicamento A. Si el medicamento A no es eficaz, entonces Health Choice Generations cubrirá el medicamento B.

LA: Estos medicamentos recetados solo están disponibles para ciertas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame a Servicios para el Afiliado al 1-800-656-8991 o, para usuarios TTY, 711, los 7 días de la semana, de 8:00 a. m. a 8:00 p. m.

CY20_1T_SNP eff 12/01/2020

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
allopurinol tab	1	
colchicine w/ probenecid	1	
COLCRYS	1	QL (120 tabs / 30 days)
MITIGARE	1	QL (60 caps / 30 days)
probenecid	1	
NSAIDS		
celecoxib CAPS 50mg	1	QL (240 caps / 30 days)
celecoxib CAPS 100mg	1	QL (120 caps / 30 days)
celecoxib CAPS 200mg	1	QL (60 caps / 30 days)
celecoxib CAPS 400mg	1	QL (30 caps / 30 days)
diclofenac potassium	1	QL (120 tabs / 30 days)
diclofenac sodium TB24; TBEC	1	
diflunisal TABS	1	
ec-naproxen	1	
etodolac	1	
flurbiprofen TABS 100mg	1	
ibu tab 600mg	1	
ibu tab 800mg	1	
ibuprofen SUSP	1	
ibuprofen TABS 400mg, 600mg, 800mg	1	
meloxicam TABS	1	
nabumetone TABS	1	
naproxen TABS 250mg, 375mg, 500mg	1	
naproxen dr	1	
naproxen sodium TABS 275mg, 550mg	1	
piroxicam CAPS	1	
sulindac TABS	1	
OPIOID ANALGESICS		
acetaminophen w/ codeine 300-15mg	1	QL (400 tabs / 30 days)
acetaminophen w/ codeine 300-30mg	1	QL (360 tabs / 30 days)
acetaminophen w/ codeine 300-60mg	1	QL (180 tabs / 30 days)
acetaminophen w/ codeine soln	1	QL (2700 mL / 30 days)
butorphanol tartrate SOLN 1mg/ml, 2mg/ml	1	
nalbuphine hcl SOLN	1	
tramadol hcl tab 50 mg	1	QL (240 tabs / 30 days)
tramadol-acetaminophen	1	QL (240 tabs / 30 days)
OPIOID ANALGESICS, CII		
endocet 2.5-325mg	1	QL (360 tabs / 30 days)
endocet 5-325mg	1	QL (360 tabs / 30 days)
endocet 7.5-325mg	1	QL (240 tabs / 30 days)
endocet 10-325mg	1	QL (180 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
fentanyl citrate LPOP	1	QL (120 lozenges / 30 days), PA
fentanyl patch 12 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 25 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 50 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 75 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 100 mcg/hr	1	QL (10 patches / 30 days), PA
hydroco/apap tab 5-325mg	1	QL (240 tabs / 30 days)
hydroco/apap tab 7.5-325	1	QL (180 tabs / 30 days)
hydroco/apap tab 10-325mg	1	QL (180 tabs / 30 days)
hydrocodone-acetaminophen 7.5-325 mg/15ml	1	QL (2700 mL / 30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	1	QL (150 tabs / 30 days)
hydromorphone hcl LIQD	1	QL (600 mL / 30 days)
hydromorphone hcl SOLN 10mg/ml, 50mg/5ml, 500mg/50ml	1	B/D
hydromorphone hcl TABS	1	QL (180 tabs / 30 days)
HYSINGLA ER	1	QL (30 tabs / 30 days), PA
methadone hcl SOLN 5mg/5ml, 10mg/5ml	1	QL (450 mL / 30 days), PA
methadone hcl 5mg	1	QL (90 tabs / 30 days), PA
methadone hcl 10mg	1	QL (90 tabs / 30 days), PA
methadone hcl intensol	1	QL (90 mL / 30 days), PA
morphine ext-rel tab	1	QL (90 tabs / 30 days), PA
morphine sul inj 1mg/ml	1	B/D
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	1	B/D
morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml	1	B/D
morphine sulfate TABS	1	QL (180 tabs / 30 days)
morphine sulfate oral soln 10mg/5ml	1	QL (900 mL / 30 days)
morphine sulfate oral soln 20mg/5ml	1	QL (900 mL / 30 days)
morphine sulfate oral soln 100mg/5ml	1	QL (180 mL / 30 days)
NUCYNTA ER	1	QL (60 tabs / 30 days), PA
oxycodone hcl CAPS	1	QL (180 caps / 30 days)
oxycodone hcl CONC	1	QL (180 mL / 30 days)
oxycodone hcl SOLN	1	QL (900 mL / 30 days)

Drug Name	Drug Tier	Requirements/Limits
oxycodone hcl TABS	1	QL (180 tabs / 30 days)
oxycodone w/ acetaminophen 2.5-325mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 5-325mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 7.5-325mg	1	QL (240 tabs / 30 days)
oxycodone w/ acetaminophen 10-325mg	1	QL (180 tabs / 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.)	1	B/D
lidocaine inj 0.5%	1	B/D
lidocaine inj 1%	1	B/D
lidocaine inj 1.5% preservative free (pf)	1	B/D
ANTI-INFECTIVES		
ANTI-BACTERIALS - MISCELLANEOUS		
amikacin sulfate SOLN	1	
gentamicin in saline	1	
gentamicin sulfate SOLN	1	
neomycin sulfate TABS	1	
paromomycin sulfate CAPS	1	
streptomycin sulfate SOLR	1	
SULFADIAZINE TABS	1	
tobramycin NEBU 300mg/5ml	1	NM, PA
tobramycin inj 1.2 gm/30ml	1	
tobramycin inj 1.2gm	1	
tobramycin inj 10mg/ml	1	
tobramycin inj 80mg/2ml	1	
tobramycin sulfate SOLN	1	
ANTI-INFECTIVES - MISCELLANEOUS		
albendazole TABS	1	
ALINIA	1	
atovaquone SUSP	1	
aztreonam	1	
CAYSTON	1	NM, LA, PA
clindamycin cap 75mg	1	
clindamycin cap 300 mg	1	
clindamycin hcl cap 150 mg	1	
clindamycin phosphate in d5w	1	
CLINDAMYCIN PHOSPHATE IN NACL	1	
clindamycin phosphate inj	1	
clindamycin soln 75mg/5ml	1	
colistimethate sodium SOLR	1	
dapsone TABS	1	
daptomycin	1	
EMVERM	1	QL (12 tabs / 365 days)
ertapenem sodium	1	
imipenem-cilastatin	1	

Drug Name	Drug Tier	Requirements/Limits
ivermectin TABS	1	
linezolid in sodium chloride	1	
linezolid inj	1	
linezolid susp	1	
linezolid tab 600mg	1	
meropenem	1	
methenamine hippurate	1	
metronidazole TABS	1	
metronidazole in nacl	1	
nitrofurantoin macrocrystal 50mg, 100mg	1	
nitrofurantoin monohyd macro	1	
pentamidine isethionate inh	1	B/D
pentamidine isethionate inj	1	
praziquantel TABS	1	
SIVEXTRO	1	
sulfamethoxazole-trimethop ds	1	
sulfamethoxazole-trimethoprim inj	1	
sulfamethoxazole-trimethoprim susp	1	
sulfamethoxazole-trimethoprim tab 400-80mg	1	
SYNERCID	1	
tigecycline	1	
trimethoprim TABS	1	
vancomycin hcl CAPS 125mg	1	QL (120 caps / 30 days)
vancomycin hcl CAPS 250mg	1	QL (240 caps / 30 days)
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	1	
VANCOMYCIN IN NACL	1	
ANTIFUNGALS		
ABELCET	1	B/D
AMBISOME	1	B/D
amphotericin b SOLR	1	B/D
caspofungin acetate	1	
fluconazole SUSR; TABS	1	
fluconazole inj nacl 200	1	
fluconazole inj nacl 400	1	
flucytosine CAPS	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
itraconazole CAPS	1	PA
ketoconazole TABS	1	PA
micafungin sodium	1	
MYCAMINE	1	
NOXAFIL SUSP	1	QL (630 mL / 30 days)
nystatin TABS	1	
posaconazole	1	QL (93 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
terbinafine hcl TABS	1	QL (90 tabs / year)
voriconazole SOLR; SUSR	1	PA
voriconazole TABS	1	
ANTIMALARIALS		
atovaquone-proguanil hcl	1	
chloroquine phosphate TABS	1	
COARTEM	1	
mefloquine hcl	1	
primaquine phosphate 26.3mg	1	
PRIMAQUINE PHOSPHATE 26.3mg	1	
quinine sulfate CAPS	1	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate	1	NM
APTIVUS	1	NM
atazanavir sulfate	1	NM
CRIXIVAN	1	NM
didanosine	1	NM
EDURANT	1	NM
efavirenz	1	NM
emtricitabine	1	NM
EMTRIVA	1	NM
fosamprenavir tab 700 mg	1	NM
FUZEON	1	NM
INTELENCE	1	NM
INVIRASE	1	NM
ISENTRESS	1	NM
ISENTRESS HD	1	NM
lamivudine	1	NM
LEXIVA SUSP	1	NM
nevirapine susp 50 mg/5ml	1	NM
nevirapine tab 100mg er	1	NM
nevirapine tab 200mg	1	NM
nevirapine tab 400mg er	1	NM
NORVIR PACK	1	NM
NORVIR SOLN	1	NM
PIFELTRO	1	NM
PREZISTA SUSP	1	QL (400 mL / 30 days), NM
PREZISTA TABS 75mg	1	QL (480 tabs / 30 days), NM
PREZISTA TABS 150mg	1	QL (240 tabs / 30 days), NM
PREZISTA TABS 600mg	1	QL (60 tabs / 30 days), NM
PREZISTA TABS 800mg	1	QL (30 tabs / 30 days), NM

Drug Name	Drug Tier	Requirements/Limits
REYATAZ PACK	1	NM
ritonavir	1	NM
RUKOBIA	1	NM
SELZENTRY	1	NM
stavudine	1	NM
tenofovir disoproxil fumarate	1	NM
TIVICAY	1	NM
TIVICAY PD	1	NM
TROGARZO	1	NM, LA
TYBOST	1	NM
VIRACEPT	1	NM
VIREAD POWD	1	NM
VIREAD TABS 150mg, 200mg, 250mg	1	NM
zidovudine cap 100mg	1	NM
zidovudine syp 50mg/5ml	1	NM
zidovudine tab 300mg	1	NM
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine	1	NM
abacavir sulfate-lamivudine-zidovudine	1	NM
ATRIPLA	1	NM
BIKTARVY	1	NM
CIMDUO	1	NM
COMPLERA	1	NM
DELSTRIGO	1	NM
DESCOVY	1	NM
DOVATO	1	NM
efavirenz-emtricitabine-tenofovir disoproxil fumarate	1	NM
efavirenz-lamivudine-tenofovir disoproxil fumarate	1	NM
emtricitabine-tenofovir disoproxil fumarate	1	QL (30 tabs / 30 days), NM
EVOTAZ	1	NM
GENVOYA	1	NM
JULUCA	1	NM
KALETRA TAB 100-25MG	1	NM
KALETRA TAB 200-50MG	1	NM
lamivudine-zidovudine	1	NM
lopinavir-ritonavir	1	NM
ODEFSEY	1	NM
PREZCOBIX	1	NM
STRIBILD	1	NM
SYMFI	1	NM
SYMFI LO	1	NM
SYMTUZA	1	NM
TEMIXYS	1	NM

Drug Name	Drug Tier	Requirements/Limits
TRIUMEQ	1	NM
TRUVADA TAB 100-150	1	QL (30 tabs / 30 days), NM
TRUVADA TAB 133-200	1	QL (30 tabs / 30 days), NM
TRUVADA TAB 167-250	1	QL (30 tabs / 30 days), NM
TRUVADA TAB 200-300	1	QL (30 tabs / 30 days), NM
ANTITUBERCULAR AGENTS		
cycloserine CAPS	1	
ethambutol hcl TABS	1	
isoniazid TABS	1	
isoniazid syp 50mg/5ml	1	
PASER D/R	1	
PRIFTIN	1	
pyrazinamide TABS	1	
rifabutin	1	
rifampin CAPS; SOLR	1	
SIRTURO	1	LA, PA
TRECATOR	1	
ANTIVIRALS		
acyclovir CAPS; SUSP; TABS	1	
acyclovir sodium	1	B/D
adefovir dipivoxil	1	NM
BARACLUDE SOLN	1	NM
entecavir	1	NM
EPCLUSA	1	NM, PA
EPIVIR HBV SOLN	1	NM
famciclovir TABS	1	
ganciclovir sodium	1	B/D
HARVONI	1	NM, PA
lamivudine (hbv)	1	NM
MAVYRET	1	NM, PA
oseltamivir phosphate CAPS 30mg	1	QL (168 caps / year)
oseltamivir phosphate CAPS 45mg, 75mg	1	QL (84 caps / year)
oseltamivir phosphate SUSR	1	QL (1080 mL / year)
PEGASYS	1	NM, PA
PEGASYS PROCLICK	1	NM, PA
RELENZA DISKHALER	1	QL (6 inhalers / year)
ribavirin cap 200mg	1	NM
ribavirin tab 200mg	1	NM
rimantadine hydrochloride	1	
valacyclovir hcl TABS	1	
valganciclovir hcl	1	
VEMLIDY	1	NM

Drug Name	Drug Tier	Requirements/Limits
VOSEVI	1	NM, PA
CEPHALOSPORINS		
cefaclor	1	
CEFACLOR ER TAB 500MG	1	
cefadroxil	1	
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	1	
cefazolin inj	1	
cefazolin sodium SOLR 1gm	1	
CEFAZOLIN SODIUM 1 GM/50ML	1	
cefdinir	1	
cefepime for inj	1	
cefixime SUSR	1	
cefoxitin for inj	1	
cefpodoxime proxetil	1	
cefprozil	1	
ceftazidime SOLR	1	
CEFTAZIDIME/DEXTROSE	1	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
cefuroxime axetil	1	
cefuroxime sodium	1	
cephalexin CAPS 250mg, 500mg	1	
cephalexin SUSR	1	
tazicef SOLR	1	
TEFLARO	1	
ERYTHROMYCINS/MACROLIDES		
azithromycin PACK; SOLR; SUSR; TABS	1	
clarithromycin TABS	1	
clarithromycin er	1	
clarithromycin for susp	1	
DIFICID	1	
ery-tab	1	
ERYTHROCIN LACTOBIONATE	1	
erythrocin stearate	1	
erythromycin base	1	
erythromycin cap 250mg ec	1	
erythromycin ethylsuccinate TABS	1	
erythromycin tab ec	1	
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	1	
ciprofloxacin hcl tab	1	
ciprofloxacin in d5w	1	
levofloxacin TABS	1	
levofloxacin in d5w	1	
levofloxacin inj 25mg/ml	1	
levofloxacin oral soln 25 mg/ml	1	

Drug Name	Drug Tier	Requirements/Limits
moxifloxacin hcl TABS	1	
PENICILLINS		
amoxicillin	1	
amoxicillin & pot clavulanate 200-28.5 chw tabs	1	
amoxicillin & pot clavulanate 200/5ml susr	1	
amoxicillin & pot clavulanate 250-125 tabs	1	
amoxicillin & pot clavulanate 250/5ml susr	1	
amoxicillin & pot clavulanate 400-57 chw tabs	1	
amoxicillin & pot clavulanate 400/5ml susr	1	
amoxicillin & pot clavulanate 500-125 tabs	1	
amoxicillin & pot clavulanate 600/5ml susr	1	
amoxicillin & pot clavulanate 875-125 tabs	1	
amoxicillin & pot clavulanate er 12hr 1000-62.5 tabs	1	
ampicillin & sulbactam sodium	1	
ampicillin cap 500mg	1	
ampicillin inj	1	
ampicillin sodium	1	
BICILLIN L-A	1	
dicloxacillin sodium	1	
nafcillin sodium for inj	1	
NAFCILLIN SODIUM FOR INJ 10GM	1	
oxacillin sodium SOLR	1	
PENICILLIN G POT IN DEXTROSE 2MU	1	
PENICILLIN G POT IN DEXTROSE 3MU	1	
PENICILLIN G PROCAINE	1	
penicillin g sodium	1	
penicillin v potassium	1	
penicilln gk inj 5mu	1	
penicilln gk inj 20mu	1	
pfizerpen-g inj 5mu	1	
pfizerpen-g inj 20mu	1	
piper/tazoba inj 2-0.25gm	1	
piper/tazoba inj 3-0.375gm	1	
piper/tazoba inj 4-0.5gm	1	
piper/tazoba inj 12-1.5gm	1	
piper/tazoba inj 36-4.5gm	1	
TETRACYCLINES		
doxy 100	1	
doxycycline (monohydrate) CAPS 50mg, 100mg	1	
doxycycline (monohydrate) TABS 50mg, 75mg, 100mg	1	
doxycycline hyclate CAPS; SOLR	1	

Drug Name	Drug Tier	Requirements/Limits
doxycycline hyclate 20 mg	1	
doxycycline hyclate 100 mg	1	
minocycline hcl CAPS	1	
mondoxyne nl cap 100mg	1	
tetracycline hcl CAPS	1	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA	1	B/D, NM
cyclophosphamide CAPS; SOLR	1	B/D
CYCLOPHOSPHAMIDE SOLN	1	B/D
EMCYT	1	
GLEOSTINE	1	
LEUKERAN	1	
ANTHRACYCLINES		
adriamycin SOLN	1	B/D
doxorubicin hcl	1	B/D
doxorubicin hcl liposomal	1	B/D
epirubicin hcl	1	B/D
ANTIMETABOLITES		
ALIMTA	1	B/D
azacitidine	1	B/D, NM
cytarabine 20mg/ml	1	B/D
fluorouracil SOLN	1	B/D
gemcitabine inj soln	1	B/D
gemcitabine inj solr	1	B/D
mercaptopurine TABS	1	
methotrexate sodium inj soln	1	B/D
methotrexate sodium inj solr	1	B/D
ONUREG	1	NM, LA, PA
PURIXAN	1	NM
TABLOID	1	
ANTIMITOTIC, TAXOIDS		
ABRAXANE	1	B/D
docetaxel CONC 20mg/ml, 80mg/4ml, 160mg/8ml	1	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml, 200mg/10ml	1	B/D
docetaxel SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
DOCETAXEL SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
paclitaxel 30mg/5ml, 100mg/16.7ml, 150mg/25ml, 300mg/50ml	1	B/D
TAXOTERE	1	B/D
ANTIMITOTIC, VINCA ALKALOIDS		
vincristine sulfate	1	B/D

Drug Name	Drug Tier	Requirements/Limits
vinorelbine tartrate	1	B/D
BIOLOGIC RESPONSE MODIFIERS		
AVASTIN	1	NM, LA, PA
BORTEZOMIB	1	NM, PA
DAURISMO	1	NM, LA, PA
ERIVEDGE	1	NM, LA, PA
FARYDAK 10mg, 20mg	1	NM, LA, PA
HERCEPTIN	1	NM, PA
HERCEPTIN HYLECTA	1	NM, PA
HERZUMA	1	NM, PA
IBRANCE CAPS	1	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS	1	QL (21 tabs / 28 days), NM, LA, PA
IDHIFA	1	QL (30 tabs / 30 days), NM, LA, PA
KADCYLA	1	B/D, NM
KANJINTI	1	NM, PA
KEYTRUDA	1	NM, PA
KISQALI	1	NM, PA
KISQALI FEMARA 200 DOSE	1	NM, PA
KISQALI FEMARA 400 DOSE	1	NM, PA
KISQALI FEMARA 600 DOSE	1	NM, PA
LYNPARZA	1	NM, LA, PA
MVASI	1	NM, LA, PA
NINLARO	1	NM, PA
ODOMZO	1	NM, LA, PA
OGIVRI	1	NM, PA
ONTRUZANT	1	NM, PA
PHESGO	1	NM, LA, PA
RITUXAN	1	NM, LA, PA
RITUXAN HYCELA	1	NM, LA, PA
RUBRACA	1	NM, LA, PA
RUXIENCE	1	NM, PA
TALZENNA	1	NM, LA, PA
TECENTRIQ	1	NM, LA, PA
TIBSOVO	1	NM, LA, PA
TRAZIMERA	1	NM, PA
TRUXIMA	1	NM, PA
VELCADE	1	NM, PA
VENCLEXTA	1	NM, LA, PA
VENCLEXTA STARTING PACK	1	NM, LA, PA
VERZENIO	1	NM, LA, PA
ZEJULA	1	NM, LA, PA
ZIRABEV	1	NM, PA
ZOLINZA	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate	1	NM, PA
anastrozole TABS	1	
bicalutamide	1	
DEPO-PROVERA INJ 400/ML	1	B/D
ERLEADA	1	NM, LA, PA
exemestane	1	
flutamide	1	
fulvestrant	1	B/D
letrozole TABS	1	
leuprolide inj 1mg/0.2	1	NM, PA
LUPRON DEPOT (1-MONTH) 3.75mg	1	NM, PA
LUPRON DEPOT INJ 11.25MG (3-MONTH)	1	NM, PA
LYSODREN	1	
megestrol ac sus 40mg/ml	1	
megestrol ac tab 20mg	1	
megestrol ac tab 40mg	1	
megestrol sus 625mg/5ml	1	PA
nilutamide	1	
NUBEQA	1	NM, LA, PA
SOLTAMOX	1	
tamoxifen citrate TABS	1	
toremifene citrate	1	
TRELSTAR DEP INJ 3.75MG	1	NM, PA
TRELSTAR LA INJ 11.25MG	1	NM, PA
XTANDI	1	NM, LA, PA
ZYTIGA 500mg	1	NM, LA, PA
IMMUNOMODULATORS		
POMALYST 1mg, 2mg	1	QL (21 caps / 21 days), NM, LA, PA
POMALYST 3mg, 4mg	1	QL (21 caps / 28 days), NM, LA, PA
REVLIMID	1	QL (28 caps / 28 days), NM, LA, PA
THALOMID 50mg, 100mg	1	QL (28 caps / 28 days), NM, PA
THALOMID 150mg, 200mg	1	QL (56 caps / 28 days), NM, PA
KINASE INHIBITORS		
AFINITOR 10mg	1	QL (30 tabs / 30 days), NM, PA
AFINITOR DISPERZ 2mg	1	QL (150 tabs / 30 days), NM, PA
AFINITOR DISPERZ 3mg	1	QL (90 tabs / 30 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
AFINITOR DISPERZ 5mg	1	QL (60 tabs / 30 days), NM, PA
ALECENSA	1	NM, LA, PA
ALUNBRIG	1	NM, LA, PA
AYVAKIT	1	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA	1	NM, LA, PA
BOSULIF	1	NM, PA
BRAFTOVI	1	NM, LA, PA
BRUKINSA	1	NM, LA, PA
CABOMETYX	1	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE	1	NM, LA, PA
CAPRELSA	1	NM, LA, PA
COMETRIQ	1	NM, LA, PA
COPIKTRA	1	NM, LA, PA
COTELLIC	1	NM, LA, PA
erlotinib hcl 25mg	1	QL (90 tabs / 30 days), NM, PA
erlotinib hcl 100mg, 150mg	1	QL (30 tabs / 30 days), NM, PA
everolimus	1	QL (30 tabs / 30 days), NM, PA
GAVRETO	1	NM, LA, PA
GILOTRIF TAB 20MG	1	NM, LA, PA
GILOTRIF TAB 30MG	1	NM, LA, PA
GILOTRIF TAB 40MG	1	NM, LA, PA
ICLUSIG	1	NM, LA, PA
imatinib mesylate 100mg	1	QL (90 tabs / 30 days), NM, PA
imatinib mesylate 400mg	1	QL (60 tabs / 30 days), NM, PA
IMBRUVICA	1	NM, LA, PA
INLYTA 1mg	1	QL (180 tabs / 30 days), NM, LA, PA
INLYTA 5mg	1	QL (120 tabs / 30 days), NM, LA, PA
INREBIC	1	NM, LA, PA
IRESSA	1	NM, LA, PA
JAKAFI	1	QL (60 tabs / 30 days), NM, LA, PA
lapatinib ditosylate	1	NM, PA
LENVIMA 4 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 8 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 10 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 12MG DAILY DOSE	1	NM, LA, PA
LENVIMA 14 MG DAILY DOSE	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
LENVIMA 18 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 20 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 24 MG DAILY DOSE	1	NM, LA, PA
LORBRENA	1	NM, LA, PA
MEKINIST	1	NM, LA, PA
MEKTOVI	1	NM, LA, PA
NERLYNX	1	NM, LA, PA
NEXAVAR	1	NM, LA, PA
PEMAZYRE	1	NM, LA, PA
PIQRAY 200MG DAILY DOSE	1	NM, PA
PIQRAY 250MG DAILY DOSE	1	NM, PA
PIQRAY 300MG DAILY DOSE	1	NM, PA
QINLOCK	1	NM, LA, PA
RETEVMO	1	NM, LA, PA
ROZLYTREK	1	NM, LA, PA
RYDAPT	1	NM, PA
SPRYCEL	1	NM, PA
STIVARGA	1	NM, LA, PA
SUTENT	1	QL (30 caps / 30 days), NM, PA
TABRECTA	1	NM, PA
TAFINLAR	1	NM, LA, PA
TAGRISSO	1	QL (30 tabs / 30 days), NM, LA, PA
TASIGNA	1	NM, PA
TUKYSA	1	NM, LA, PA
TURALIO	1	NM, LA, PA
TYKERB	1	NM, LA, PA
VITRAKVI	1	NM, LA, PA
VIZIMPRO	1	NM, LA, PA
VOTRIENT	1	NM, LA, PA
XALKORI	1	NM, LA, PA
XOSPATA	1	NM, LA, PA
ZELBORAF	1	NM, LA, PA
ZYDELIG	1	NM, LA, PA
ZYKADIA	1	NM, LA, PA
MISCELLANEOUS		
bexarotene	1	NM, PA
hydroxyurea CAPS	1	
INQOVI	1	NM, LA, PA
LONSURF	1	NM, PA
MATULANE	1	LA
SYLATRON	1	NM, PA
SYNRIBO	1	NM, PA
TAZVERIK	1	NM, LA, PA
tretinoin (chemotherapy)	1	

Drug Name	Drug Tier	Requirements/Limits
XPOVIO 40 MG ONCE WEEKLY	1	NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY	1	NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY	1	NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY	1	NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY	1	NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY	1	NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY	1	NM, LA, PA
PLATINUM-BASED AGENTS		
carboplatin	1	B/D
cisplatin SOLN	1	B/D
oxaliplatin inj 50mg	1	B/D
oxaliplatin inj 50mg/10ml	1	B/D
oxaliplatin inj 100mg	1	B/D
oxaliplatin inj 100mg/20ml	1	B/D
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml	1	B/D
leucovorin calcium SOLR	1	B/D
leucovorin calcium TABS	1	
MESNEX TABS	1	
TOPOISOMERASE INHIBITORS		
etoposide SOLN	1	B/D
irinotecan hcl	1	B/D
toposar	1	B/D
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-20 mg	1	
amlodipine besylate-benazepril hcl cap 5-40 mg	1	
amlodipine besylate-benazepril hcl cap 10-20 mg	1	
amlodipine besylate-benazepril hcl cap 10-40 mg	1	
benazepril & hydrochlorothiazide	1	
captopril & hydrochlorothiazide	1	
enalapril maleate & hydrochlorothiazide	1	
fosinopril sodium & hydrochlorothiazide	1	
lisinopril & hydrochlorothiazide	1	
quinapril-hydrochlorothiazide	1	
ACE INHIBITORS		
benazepril hcl TABS	1	
captopril TABS	1	

Drug Name	Drug Tier	Requirements/Limits
enalapril maleate TABS	1	
fosinopril sodium	1	
lisinopril TABS	1	
moexipril hcl	1	
perindopril erbumine	1	
quinapril hcl	1	
ramipril	1	
trandolapril	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone	1	
spironolactone TABS	1	
ALPHA BLOCKERS		
doxazosin mesylate TABS	1	
prazosin hcl	1	
terazosin hcl	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-olmesartan medoxomil	1	
amlodipine besylate-valsartan tab	1	
amlodipine-valsartan-hydrochlorothiazide tab	1	
candesartan cilexetil-hydrochlorothiazide	1	
ENTRESTO	1	
irbesartan-hydrochlorothiazide	1	
losartan-hydrochlorothiazide	1	
olmesartan medoxomil-amlodipine-hydrochlorothiazide	1	
olmesartan medoxomil-hydrochlorothiazide	1	
telmisartan-amlodipine	1	
telmisartan-hydrochlorothiazide	1	
valsartan-hydrochlorothiazide	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1	
irbesartan	1	
losartan potassium TABS	1	
olmesartan medoxomil TABS	1	
telmisartan	1	
valsartan	1	
ANTIARRHYTHMICS		
amiodarone hcl soln	1	
amiodarone tab 100mg	1	
amiodarone tab 200mg	1	
amiodarone tab 400mg	1	
disopyramide phosphate	1	
dofetilide	1	NM
flecainide acetate	1	

Drug Name	Drug Tier	Requirements/Limits
MULTAQ	1	
NORPACE CR	1	
pacerone	1	
propafenone hcl	1	
propafenone hcl 12hr	1	
quinidine sulfate	1	
sorine	1	
sotalol hcl	1	
sotalol hcl (afib/afl)	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
atorvastatin calcium TABS	1	
lovastatin	1	
pravastatin sodium	1	
rosuvastatin calcium	1	QL (30 tabs / 30 days)
simvastatin TABS 5mg, 10mg, 20mg, 40mg	1	
simvastatin TABS 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
cholestyramine	1	
cholestyramine light pack	1	
cholestyramine light powd	1	
colesevelam hcl	1	
colestipol hcl gran	1	
colestipol hcl pack	1	
colestipol hcl tabs	1	
ezetimibe	1	
ezetimibe-simvastatin	1	
fenofibrate TABS 48mg, 54mg, 145mg, 160mg	1	
fenofibrate micronized 67mg, 134mg, 200mg	1	
gemfibrozil TABS	1	
JUXTAPID	1	NM, LA, PA
niacin (antihyperlipidemic)	1	
niacin er (antihyperlipidemic) 500mg	1	QL (60 tabs / 30 days)
niacin er (antihyperlipidemic) 750mg, 1000mg	1	
niacor	1	
PRALUENT	1	NM, PA
prevalite	1	
VASCEPA	1	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone	1	
bisoprolol & hydrochlorothiazide	1	
metoprolol & hydrochlorothiazide	1	
propranolol & hydrochlorothiazide	1	

Drug Name	Drug Tier	Requirements/Limits
BETA-BLOCKERS		
acebutolol hcl CAPS	1	
atenolol TABS	1	
betaxolol hcl	1	
bisoprolol fumarate	1	
BYSTOLIC 2.5mg, 5mg, 10mg	1	QL (30 tabs / 30 days)
BYSTOLIC 20mg	1	QL (60 tabs / 30 days)
carvedilol	1	
labetalol hcl TABS	1	
metoprolol succinate	1	
metoprolol tartrate SOCT	1	
metoprolol tartrate SOLN	1	
metoprolol tartrate TABS 25mg, 50mg, 100mg	1	
nadolol TABS	1	
pindolol	1	
propranolol cap er	1	
propranolol hcl TABS	1	
propranolol oral sol	1	
timolol maleate TABS	1	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate TABS	1	
cartia xt	1	
dilt-xr cap	1	
diltiazem cap 240mg cd	1	
diltiazem cap 360mg cd	1	
diltiazem cap er/12hr	1	
diltiazem hcl TABS	1	
diltiazem hcl coated beads CP24	1	
diltiazem hcl coated beads cap sr 24hr	1	
diltiazem hcl extended release beads cap sr	1	
diltiazem inj	1	
felodipine	1	
isradipine	1	
nicardipine hcl CAPS	1	
nifedipine TB24	1	
nifedipine er	1	
nimodipine CAPS	1	
NYMALIZE	1	
taztia xt	1	
tiadylt er	1	
verapamil cap er	1	
verapamil hcl SOLN; TABS; TBCR	1	
verapamil tab er	1	

Drug Name	Drug Tier	Requirements/Limits
DIGITALIS GLYCOSIDES		
digitek .25mg	1	PA; PA if 70 years and older
digitek .125mg	1	QL (30 tabs / 30 days)
digox 125mcg	1	QL (30 tabs / 30 days)
digox 250mcg	1	PA; PA if 70 years and older
digoxin TABS 125mcg	1	QL (30 tabs / 30 days)
digoxin TABS 250mcg	1	PA; PA if 70 years and older
digoxin inj	1	
digoxin sol 50mcg/ml	1	PA; PA if 70 years and older
DIURETICS		
acetazolamide CP12; TABS	1	
amiloride & hydrochlorothiazide	1	
amiloride hcl TABS	1	
bumetanide inj 0.25/ml	1	
bumetanide tab	1	
chlorothiazide TABS	1	
chlorthalidone	1	
furosemide SOLN; TABS	1	
furosemide inj	1	
hydrochlorothiazide CAPS; TABS	1	
indapamide	1	
methazolamide TABS	1	
metolazone	1	
spironolactone & hydrochlorothiazide	1	
torsemide tabs	1	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tabs	1	
MISCELLANEOUS		
aliskiren fumarate	1	
clonidine hcl TABS	1	
clonidine hcl ptwk	1	
CORLANOR	1	
DEMSER	1	PA
hydralazine hcl SOLN; TABS	1	
metyrosine	1	PA
midodrine hcl	1	
minoxidil TABS	1	
NORTHERA 100mg	1	QL (90 caps / 30 days), NM, LA, PA
NORTHERA 200mg, 300mg	1	QL (180 caps / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
ranolazine	1	
NITRATES		
isosorb mononitrate tab	1	
isosorbide dinitrate 5mg, 10mg, 20mg, 30mg	1	
isosorbide mononitrate er	1	
minitran	1	
NITRO-BID	1	
NITRO-DUR DIS 0.3MG/HR	1	
NITRO-DUR DIS 0.8MG/HR	1	
nitroglycerin SOLN .4mg/spray	1	
nitroglycerin SUBL	1	
nitroglycerin td patch	1	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS	1	QL (90 tabs / 30 days), NM, LA, PA
ambrisentan	1	QL (30 tabs / 30 days), NM, LA, PA
bosentan 62.5mg	1	QL (120 tabs / 30 days), NM, LA, PA
bosentan 125mg	1	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT	1	QL (30 tabs / 30 days), NM, LA, PA
sildenafil citrate tab 20 mg (pulmonary hypertension)	1	QL (90 tabs / 30 days), NM, PA
treprostinil	1	NM, LA, PA
VENTAVIS	1	NM, PA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
alprazolam tab 0.5mg	1	QL (150 tabs / 30 days)
alprazolam tab 0.25mg	1	QL (150 tabs / 30 days)
alprazolam tab 1mg	1	QL (150 tabs / 30 days)
alprazolam tab 2 mg	1	QL (150 tabs / 30 days)
buspirone hcl TABS	1	
fluvoxamine maleate TABS	1	
lorazepam SOLN	1	
lorazepam TABS	1	QL (150 tabs / 30 days)
lorazepam intensol	1	QL (150 mL / 30 days)
ANTICONVULSANTS		
APTIOM	1	QL (60 tabs / 30 days)
BANZEL SUS 40MG/ML	1	PA
BANZEL TAB 200MG	1	PA
BANZEL TAB 400MG	1	PA
BRIVIACT INJ 50MG/5ML	1	PA
BRIVIACT SOL 10MG/ML	1	PA

Drug Name	Drug Tier	Requirements/Limits
BRIVIACT TAB 10MG	1	PA
BRIVIACT TAB 25MG	1	PA
BRIVIACT TAB 50MG	1	PA
BRIVIACT TAB 75MG	1	PA
BRIVIACT TAB 100MG	1	PA
carbamazepine CHEW; CP12; SUSP; TABS; TB12	1	
CELONTIN	1	
clobazam	1	PA
clonazepam TABS 2mg	1	QL (300 tabs / 30 days)
clonazepam TABS .5mg, 1mg	1	QL (90 tabs / 30 days)
clonazepam TBDP 2mg	1	QL (300 tabs / 30 days)
clonazepam TBDP .125mg, .25mg, .5mg, 1mg	1	QL (90 tabs / 30 days)
clorazepate dipotassium	1	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIASTAT ACUDIAL	1	
DIASTAT PEDIATRIC	1	
diazepam TABS	1	QL (120 tabs / 30 days), PA; PA if 65 years and older
diazepam gel	1	
diazepam inj	1	
diazepam intensol	1	QL (240 mL / 30 days), PA; PA if 65 years and older
diazepam oral soln 1 mg/ml	1	QL (1200 mL / 30 days), PA; PA if 65 years and older
DILANTIN CAP 30MG	1	
DILANTIN CAP 100MG	1	
DILANTIN CHEW TAB 50MG	1	
DILANTIN-125 SUSP	1	
divalproex sodium CSDR; TB24; TBEC	1	
EPIDIOLEX	1	QL (600 mL / 30 days), NM, LA, PA
epitol	1	
ethosuximide CAPS; SOLN	1	
felbamate	1	
FINTEPLA	1	QL (360 mL / 30 days), NM, LA, PA
FYCOMPA SUSP	1	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg, 4mg, 6mg	1	QL (60 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TABS 8mg, 10mg, 12mg	1	QL (30 tabs / 30 days), PA
gabapentin CAPS 100mg	1	QL (1080 caps / 30 days)
gabapentin CAPS 300mg	1	QL (360 caps / 30 days)
gabapentin CAPS 400mg	1	QL (270 caps / 30 days)
gabapentin SOLN	1	QL (2160 mL / 30 days)
gabapentin TABS 600mg	1	QL (180 tabs / 30 days)
gabapentin TABS 800mg	1	QL (120 tabs / 30 days)
lamotrigine CHEW; TABS; TB24	1	
levetiracetam SOLN; TABS; TB24	1	
levetiracetam in sodium chloride	1	
levetiracetam oral soln 100 mg/ml	1	
NAYZILAM	1	
oxcarbazepine	1	
PEGANONE	1	
phenobarbital ELIX; TABS	1	PA; PA if 70 years and older
phenobarbital sodium SOLN	1	PA; PA if 70 years and older
PHENYTEK	1	
phenytoin CHEW; SUSP	1	
phenytoin sodium extended	1	
phenytoin sodium inj 50mg/ml	1	
pregabalin CAPS 25mg, 50mg, 75mg, 100mg, 150mg	1	QL (120 caps / 30 days), PA
pregabalin CAPS 200mg	1	QL (90 caps / 30 days), PA
pregabalin CAPS 225mg, 300mg	1	QL (60 caps / 30 days), PA
pregabalin SOLN	1	QL (900 mL / 30 days), PA
primidone TABS	1	
roweepra	1	
roweepra xr	1	
SPRITAM	1	
subvenite tab	1	
SYMPAZAN	1	PA
tiagabine hcl	1	
topiramate CPSP; TABS	1	
valproate sodium SOLN	1	
valproate sodium oral soln	1	
valproic acid CAPS	1	
VALTOCO	1	NM
vigabatrin powd pack 500mg	1	QL (180 packets / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
vigabatrin tab 500mg	1	QL (180 tabs / 30 days), NM, LA, PA
vigadrone	1	QL (180 packets / 30 days), NM, LA, PA
VIMPAT 50mg	1	QL (120 tabs / 30 days)
VIMPAT 100mg, 150mg, 200mg	1	QL (60 tabs / 30 days)
VIMPAT INJ 200MG/20ML	1	
VIMPAT SOL 10MG/ML	1	QL (1200 mL / 30 days)
XCOPRI MAINTENANCE PAK 150-200MG	1	QL (56 tabs / 28 days)
XCOPRI PAK 12.5-25MG	1	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	1	QL (28 tabs / 28 days)
XCOPRI PAK 50-200MG	1	QL (56 tabs / 28 days)
XCOPRI TABS 50mg	1	QL (90 tabs / 30 days)
XCOPRI TABS 100mg, 150mg, 200mg	1	QL (60 tabs / 30 days)
XCOPRI TITRATION PAK 150-200MG	1	QL (28 tabs / 28 days)
zonisamide CAPS	1	
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg	1	QL (30 tabs / 30 days)
donepezil hydrochloride TABS 10mg	1	
donepezil hydrochloride TBDP 5mg	1	QL (30 tabs / 30 days)
donepezil hydrochloride TBDP 10mg	1	
galantamine hydrobromide SOLN	1	
galantamine hydrobromide TABS	1	QL (60 tabs / 30 days)
galantamine hydrobromide er	1	QL (30 caps / 30 days)
memantine hcl cp24	1	PA; PA if < 30 yrs
memantine soln	1	PA; PA if < 30 yrs
memantine tabs	1	PA; PA if < 30 yrs
memantine titration pak	1	PA; PA if < 30 yrs
NAMZARIC	1	
rivastigmine tartrate 1.5mg, 3mg	1	QL (90 caps / 30 days)
rivastigmine tartrate 4.5mg, 6mg	1	QL (60 caps / 30 days)
rivastigmine td patch 24hr 4.6 mg/24hr	1	QL (30 patches / 30 days)
rivastigmine td patch 24hr 9.5 mg/24hr	1	QL (30 patches / 30 days)
rivastigmine td patch 24hr 13.3 mg/24hr	1	QL (30 patches / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS	1	
amoxapine	1	
bupropion hcl TABS	1	
bupropion hcl TB12	1	
bupropion hcl TB24 150mg, 300mg	1	
citalopram hydrobromide	1	
clomipramine hcl CAPS	1	PA
desipramine hcl TABS	1	

Drug Name	Drug Tier	Requirements/Limits
desvenlafaxine succinate	1	QL (30 tabs / 30 days), PA
doxepin hcl CAPS; CONC	1	
DRIZALMA SPRINKLE 20mg, 30mg, 60mg	1	QL (60 caps / 30 days), PA
DRIZALMA SPRINKLE 40mg	1	QL (90 caps / 30 days), PA
duloxetine hcl CPEP 20mg, 30mg, 60mg	1	QL (60 caps / 30 days)
EMSAM	1	QL (30 patches / 30 days), PA
escitalopram oxalate	1	
FETZIMA 20mg, 40mg	1	QL (60 caps / 30 days), PA
FETZIMA 80mg, 120mg	1	QL (30 caps / 30 days), PA
FETZIMA TITRATION PACK	1	PA
fluoxetine cap 10mg	1	
fluoxetine cap 20mg	1	
fluoxetine cap 40mg	1	
fluoxetine hcl SOLN	1	
imipramine hcl TABS	1	
maprotiline hcl	1	
MARPLAN TAB 10MG	1	QL (180 tabs / 30 days)
mirtazapine TABS; TBDP	1	
nefazodone hcl	1	
nortriptyline hcl CAPS; SOLN	1	
paroxetine hcl tabs	1	
PAXIL SUSP	1	QL (900 mL / 30 days)
phenelzine sulfate TABS	1	
protriptyline hcl	1	
sertraline hcl CONC; TABS	1	
tranylcypromine sulfate	1	
trazodone hcl TABS 50mg, 100mg, 150mg	1	
trimipramine maleate CAPS 25mg	1	QL (240 caps / 30 days)
trimipramine maleate CAPS 50mg	1	QL (120 caps / 30 days)
trimipramine maleate CAPS 100mg	1	QL (60 caps / 30 days)
TRINTELLIX 5mg	1	QL (120 tabs / 30 days)
TRINTELLIX 10mg	1	QL (60 tabs / 30 days)
TRINTELLIX 20mg	1	QL (30 tabs / 30 days)
venlafaxine hcl CP24; TABS	1	
VIIBRYD STARTER PACK	1	
VIIBRYD TAB	1	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
amantadine hcl CAPS	1	QL (120 caps / 30 days)
amantadine hcl SYRP; TABS	1	

Drug Name	Drug Tier	Requirements/Limits
APOKYN	1	QL (20 cartridges / 30 days), NM, LA, PA
benztropine mesylate inj	1	
benztropine mesylate tab 0.5mg	1	PA; PA if 70 years and older
benztropine mesylate tab 1mg	1	PA; PA if 70 years and older
benztropine mesylate tab 2mg	1	PA; PA if 70 years and older
bromocriptine mesylate CAPS; TABS	1	
carbidopa-levodopa	1	
carbidopa/levodopa/entacapone	1	
entacapone	1	
NEUPRO	1	
pramipexole tab 0.5mg	1	
pramipexole tab 0.25mg	1	
pramipexole tab 0.75mg	1	
pramipexole tab 0.125mg	1	
pramipexole tab 1.5mg	1	
pramipexole tab 1mg	1	
rasagiline mesylate TABS	1	
ropinirole tab 0.5mg	1	
ropinirole tab 0.25mg	1	
ropinirole tab 1mg	1	
ropinirole tab 2mg	1	
ropinirole tab 3mg	1	
ropinirole tab 4mg	1	
ropinirole tab 5mg	1	
selegiline hcl CAPS; TABS	1	
trihexyphenidyl hcl	1	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA	1	QL (1 injection / 28 days)
aripiprazole odt	1	QL (60 tabs / 30 days)
aripiprazole oral solution 1 mg/ml	1	QL (900 mL / 30 days)
aripiprazole tab	1	QL (30 tabs / 30 days)
ARISTADA 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	1	QL (1 injection / 28 days)
ARISTADA 1064mg/3.9ml	1	QL (1 injection / 56 days)
ARISTADA INITIO	1	
CAPLYTA	1	QL (30 caps / 30 days)
chlorpromazine hcl TABS	1	
chlorpromazine inj	1	
clozapine odt 12.5mg, 25mg	1	PA

Drug Name	Drug Tier	Requirements/Limits
clozapine odt 100mg	1	QL (270 tabs / 30 days), PA
clozapine odt 150mg	1	QL (180 tabs / 30 days), PA
clozapine odt 200mg	1	QL (135 tabs / 30 days), PA
clozapine tab 25mg	1	
clozapine tab 50mg	1	
clozapine tab 100mg	1	QL (270 tabs / 30 days)
clozapine tab 200mg	1	QL (135 tabs / 30 days)
FANAPT	1	QL (60 tabs / 30 days), PA
FANAPT TITRATION PACK	1	PA
fluphenazine decanoate SOLN	1	
fluphenazine hcl	1	
GEODON SOLR	1	QL (6 mL / 3 days)
haloperidol TABS	1	
haloperidol conc 2mg/ml	1	
haloperidol decanoate SOLN	1	
haloperidol lactate inj 5mg/ml	1	
INVEGA SUST INJ 39 MG/0.25 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 78 MG/0.5 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 117 MG/0.75 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 156MG/ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 234 MG/1.5 ML	1	QL (1 injection / 28 days)
INVEGA TRINZA	1	QL (1 injection / 90 days)
LATUDA 20mg, 40mg, 60mg, 120mg	1	QL (30 tabs / 30 days)
LATUDA 80mg	1	QL (60 tabs / 30 days)
loxapine succinate	1	
molindone hcl	1	
NUPLAZID CAPS	1	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10MG	1	QL (30 tabs / 30 days), NM, LA, PA
olanzapine SOLR	1	QL (3 vials / 1 day)
olanzapine TABS 2.5mg, 5mg, 10mg	1	QL (60 tabs / 30 days)
olanzapine TABS 7.5mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
olanzapine TBDP 5mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
olanzapine TBDP 10mg	1	QL (60 tabs / 30 days)
paliperidone 1.5mg, 3mg, 9mg	1	QL (30 tabs / 30 days)
paliperidone 6mg	1	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
perphenazine TABS	1	
PERSERIS	1	QL (1 injection / 30 days)
pimozide	1	
quetiapine fumarate TABS	1	
quetiapine fumarate TB24 50mg, 300mg, 400mg	1	QL (60 tabs / 30 days), PA
quetiapine fumarate TB24 150mg, 200mg	1	QL (30 tabs / 30 days), PA
REXULTI 3mg, 4mg	1	QL (30 tabs / 30 days)
REXULTI .25mg, .5mg, 1mg, 2mg	1	QL (60 tabs / 30 days)
RISPERDAL INJ 12.5MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 25MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 37.5MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 50MG	1	QL (2 injections / 28 days)
risperidone SOLN	1	QL (240 mL / 30 days)
risperidone TABS	1	
risperidone TBDP 1mg, 2mg, 3mg, 4mg	1	QL (60 tabs / 30 days)
risperidone TBDP .25mg, .5mg	1	QL (90 tabs / 30 days)
SAPHRIS	1	QL (60 tabs / 30 days)
SECUADO	1	QL (30 patches / 30 days)
thioridazine hcl TABS	1	
thiothixene	1	
trifluoperazine hcl	1	
VERSACLOZ	1	QL (600 mL / 30 days), PA
VRAYLAR 1.5mg	1	QL (60 caps / 30 days), PA
VRAYLAR 3mg, 4.5mg, 6mg	1	QL (30 caps / 30 days), PA
VRAYLAR THERAPY PACK	1	PA
ziprasidone hcl	1	QL (60 caps / 30 days)
ziprasidone mesylate	1	QL (6 injections / 3 days)
ZYPREXA RELPREVV 300mg	1	QL (2 vials / 28 days), PA
ZYPREXA RELPREVV 405mg	1	QL (1 vial / 28 days), PA
ZYPREXA RELPREVV INJ 210MG	1	QL (2 vials / 28 days), PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine cap sr 24hr 5 mg	1	QL (90 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
amphetamine-dextroamphetamine cap sr 24hr 10 mg	1	QL (90 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 15 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 20 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 25 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 30 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine tab 5 mg	1	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 10 mg	1	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 15 mg	1	QL (90 tabs / 30 days)
amphetamine-dextroamphetamine tab 20 mg	1	QL (90 tabs / 30 days)
amphetamine-dextroamphetamine tab 30 mg	1	QL (60 tabs / 30 days)
atomoxetine hcl 10mg, 18mg, 25mg	1	QL (120 caps / 30 days)
atomoxetine hcl 40mg	1	QL (60 caps / 30 days)
atomoxetine hcl 60mg, 80mg, 100mg	1	QL (30 caps / 30 days)
dexmethylphenidate hcl TABS 2.5mg, 5mg	1	QL (120 tabs / 30 days)
dexmethylphenidate hcl TABS 10mg	1	QL (60 tabs / 30 days)
guanfacine er (adhd)	1	PA; PA if 70 years and older
metadate er tab 20mg	1	QL (90 tabs / 30 days)
methylphenidate hcl TABS 5mg, 10mg	1	QL (180 tabs / 30 days)
methylphenidate hcl TABS 20mg	1	QL (90 tabs / 30 days)
methylphenidate hcl oral soln 5mg/5ml	1	QL (1800 mL / 30 days)
methylphenidate hcl oral soln 10mg/5ml	1	QL (900 mL / 30 days)
methylphenidate hcl tbcr 10 mg	1	QL (90 tabs / 30 days)
methylphenidate hcl tbcr 20mg	1	QL (90 tabs / 30 days)
HYPNOTICS		
BELSOMRA	1	QL (30 tabs / 30 days)
doxepin hcl (sleep)	1	QL (30 tabs / 30 days)
eszopiclone	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
HETLIOZ	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
temazepam 7.5mg	1	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
temazepam 15mg	1	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
zaleplon	1	QL (60 caps / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
zolpidem tartrate TABS	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
AIMOVIG	1	QL (1 pen / 30 days), NM, PA
dihydroergotamine mesylate inj 1 mg/ml	1	
dihydroergotamine mesylate nasal spr 4 mg/ml	1	QL (8 mL / 30 days), PA
eletriptan hydrobromide	1	QL (12 tabs / 30 days)
EMGALITY SOAJ	1	QL (2 pens / 30 days), NM, PA
EMGALITY SOSY 120mg/ml	1	QL (2 syringes / 30 days), NM, PA
ergotamine w/ caffeine TABS	1	
naratriptan hcl	1	QL (12 tabs / 30 days)
rizatriptan benzoate	1	QL (18 tabs / 30 days)
rizatriptan benzoate odt	1	QL (18 tabs / 30 days)
sumatriptan SOLN 5mg/act	1	QL (24 inhalers / 30 days)
sumatriptan SOLN 20mg/act	1	QL (12 inhalers / 30 days)
sumatriptan inj 4mg/0.5ml	1	QL (18 injections / 30 days)
sumatriptan inj 6mg/0.5ml	1	QL (12 injections / 30 days)
sumatriptan succinate TABS	1	QL (12 tabs / 30 days)
zolmitriptan TABS	1	QL (12 tabs / 30 days)
zolmitriptan odt	1	QL (12 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
AUSTEDO 6mg	1	QL (60 tabs / 30 days), NM, PA
AUSTEDO 9mg, 12mg	1	QL (120 tabs / 30 days), NM, PA
INGREZZA CAPS	1	QL (30 caps / 30 days), NM, PA
INGREZZA CPPK	1	QL (28 caps / 28 days), NM, PA
lithium carbonate CAPS; TABS	1	
lithium carbonate er	1	
LITHIUM SOLN 8MEQ/5ML	1	
LYRICA CR	1	QL (60 tabs / 30 days), PA
NUEDEXTA	1	QL (60 caps / 30 days), PA
pyridostigmine tab 60mg	1	
riluzole	1	
tetrabenazine 12.5mg	1	QL (240 tabs / 30 days), NM, PA
tetrabenazine 25mg	1	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BETASERON	1	QL (14 syringes / 28 days), NM, PA
dalfampridine TB12	1	NM, PA
GILENYA	1	QL (28 caps / 28 days), NM, PA
glatiramer acetate 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
glatiramer acetate 40mg/ml	1	QL (12 syringes / 28 days), NM, PA
glatopa 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
glatopa 40mg/ml	1	QL (12 syringes / 28 days), NM, PA
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS 10mg, 20mg	1	
carisoprodol TABS 350mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
cyclobenzaprine hcl TABS 5mg, 10mg	1	PA; PA if 70 years and older
dantrolene sodium CAPS	1	
methocarbamol TABS	1	PA; PA if 70 years and older
tizanidine hcl TABS	1	

Drug Name	Drug Tier	Requirements/Limits
vanadom	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
NARCOLEPSY/CATAPLEXY		
armodafinil 50mg	1	QL (90 tabs / 30 days), PA
armodafinil 150mg, 200mg, 250mg	1	QL (30 tabs / 30 days), PA
XYREM	1	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium	1	
buprenorphine hcl SUBL	1	QL (90 tabs / 30 days), PA
buprenorphine hcl-naloxone hcl dihydrate 2-0.5mg	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl dihydrate 4-1mg	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl dihydrate 8-2mg	1	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl dihydrate 12-3mg	1	QL (60 films / 30 days)
buprenorphine hcl-naloxone hcl sl	1	QL (90 tabs / 30 days)
bupropion hcl (smoking deterrent)	1	
CHANTIX	1	PA
CHANTIX CONTINUING MONTH	1	PA
CHANTIX STARTER PACK	1	PA
disulfiram TABS	1	
naloxone inj 0.4mg/ml	1	
naloxone inj 1mg/ml	1	
naltrexone hcl TABS	1	
NARCAN	1	
NICOTROL INHALER	1	
NICOTROL NS	1	
VIVITROL	1	NM
ENDOCRINE AND METABOLIC		
ANDROGENS		
ANADROL-50	1	PA
ANDRODERM	1	QL (30 patches / 30 days), PA
oxandrolone tab 2.5mg	1	PA
oxandrolone tab 10mg	1	PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm	1	QL (300 grams / 30 days), PA
testosterone cypionate SOLN	1	PA
testosterone enanthate SOLN	1	PA

Drug Name	Drug Tier	Requirements/Limits
ANTIDIABETICS, INJECTABLE		
BASAGLAR KWIKPEN	1	
BD ALCOHOL SWABS	1	
BD ULTRAFINE INSULIN SYRINGE	1	
BD ULTRAFINE/NANO PEN NEEDLES	1	
BYDUREON BCISE	1	QL (4 pens / 28 days)
BYDUREON PEN	1	QL (4 pens / 28 days)
BYETTA	1	QL (1 pen / 30 days)
FIASP	1	
FIASP FLEXTOUCH	1	
FIASP PENFILL	1	
GAUZE PADS 2" X 2"	1	
HUMULIN R INJ U-500	1	B/D
HUMULIN R U-500 KWIKPEN	1	
INSULIN PEN NEEDLE	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGE	1	
LEVEMIR	1	
LEVEMIR FLEXTOUCH	1	
NOVOLIN 70/30	1	(brand RELION not covered)
NOVOLIN 70/30 FLEXPEN	1	(brand RELION not covered)
NOVOLIN N	1	(brand RELION not covered)
NOVOLIN N FLEXPEN	1	(brand RELION not covered)
NOVOLIN R	1	(brand RELION not covered)
NOVOLIN R FLEXPEN	1	(brand RELION not covered)
NOVOLOG	1	
NOVOLOG 70/30 FLEXPEN	1	
NOVOLOG FLEXPEN	1	
NOVOLOG MIX 70/30	1	
NOVOLOG PENFILL	1	
OZEMPIC INJ 0.25 OR 0.5MG/DOSE	1	QL (1 pen / 28 days)
OZEMPIC INJ 1MG/DOSE	1	QL (2 pens / 28 days)
SOLIQUA 100/33	1	QL (10 pens / 30 days)
TRESIBA FLEXTOUCH	1	
TRESIBA INJ	1	
TRULICITY	1	QL (4 pens / 28 days)
VICTOZA	1	QL (3 pens / 30 days)
XULTOPHY 100/3.6	1	QL (5 pens / 30 days)
ANTIDIABETICS, ORAL		
acarbose TABS	1	

Drug Name	Drug Tier	Requirements/Limits
FARXIGA	1	QL (30 tabs / 30 days)
glimepiride 1mg, 2mg	1	QL (90 tabs / 30 days)
glimepiride 4mg	1	QL (60 tabs / 30 days)
glip/metform tab 2.5-250mg	1	QL (240 tabs / 30 days)
glip/metform tab 2.5-500mg	1	QL (120 tabs / 30 days)
glip/metform tab 5-500mg	1	QL (120 tabs / 30 days)
glipizide TABS 5mg	1	QL (240 tabs / 30 days)
glipizide TABS 10mg	1	QL (120 tabs / 30 days)
glipizide TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide TB24 10mg	1	QL (60 tabs / 30 days)
glipizide xl 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide xl 10mg	1	QL (60 tabs / 30 days)
glyburide TABS 1.25mg	1	QL (480 tabs / 30 days), PA; PA if 70 years and older
glyburide TABS 2.5mg	1	QL (240 tabs / 30 days), PA; PA if 70 years and older
glyburide TABS 5mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
glyburide micronized 1.5mg	1	QL (240 tabs / 30 days), PA; PA if 70 years and older
glyburide micronized 3mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
glyburide micronized 6mg	1	QL (60 tabs / 30 days), PA; PA if 70 years and older
glyburide-metformin tab 1.25-250 mg	1	QL (240 tabs / 30 days), PA; PA if 70 years and older
glyburide-metformin tab 2.5-500 mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
glyburide-metformin tab 5-500mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
GLYXAMBI	1	QL (30 tabs / 30 days)
JANUMET	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	1	QL (30 tabs / 30 days)
JANUVIA	1	QL (30 tabs / 30 days)
JARDIANCE 10mg	1	QL (60 tabs / 30 days)
JARDIANCE 25mg	1	QL (30 tabs / 30 days)
JENTADUETO	1	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO TAB XR 2.5-1000 MG	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	1	QL (30 tabs / 30 days)
metformin er 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin er 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin hcl TABS 500mg	1	QL (150 tabs / 30 days)
metformin hcl TABS 850mg	1	QL (90 tabs / 30 days)
metformin hcl TABS 1000mg	1	QL (75 tabs / 30 days)
nateglinide	1	QL (90 tabs / 30 days)
pioglitazone hcl	1	QL (30 tabs / 30 days)
repaglinide 2mg	1	QL (240 tabs / 30 days)
repaglinide .5mg, 1mg	1	QL (120 tabs / 30 days)
RYBELSUS	1	QL (30 tabs / 30 days)
SYNJARDY TAB 5-500MG	1	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500MG	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000MG	1	QL (30 tabs / 30 days)
TRADJENTA	1	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000 MG	1	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000 MG	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 2.5-1000MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	1	QL (30 tabs / 30 days)
BISPHOSPHONATES		
alendronate sodium soln 70mg/75ml	1	
alendronate sodium tab 5 mg	1	
alendronate sodium tab 10 mg	1	
alendronate sodium tab 35 mg	1	
alendronate sodium tab 40 mg	1	
alendronate sodium tab 70 mg	1	
ibandronate sodium tabs	1	B/D
PAMIDRONATE DISODIUM 6mg/ml	1	B/D
pamidronate disodium 30mg/10ml, 90mg/10ml	1	B/D

Drug Name	Drug Tier	Requirements/Limits
pamidronate inj 30mg	1	B/D
pamidronate inj 90mg	1	B/D
risedronate sodium TABS 5mg, 35mg, 150mg	1	
risedronate sodium TBEC	1	
zoledronic acid inj 4mg/100ml	1	B/D, NM
zoledronic acid inj 5mg/100ml	1	B/D, NM
zoledronic inj 4mg/5ml	1	B/D, NM
CHELATING AGENTS		
CHEMET	1	
clovique	1	PA
deferasirox granules	1	NM, PA
deferasirox tab	1	NM, PA
JADENU 180mg	1	NM, LA, PA
JADENU SPRINKLE	1	NM, LA, PA
kionex sus 15gm/60ml	1	
LOKELMA	1	
penicillamine TABS	1	
sodium polystyrene sulfonate powder	1	
sodium polystyrene sulfonate susp	1	
sps susp 15gm/60ml	1	
trientine hcl	1	PA
VELTASSA	1	PA
CONTRACEPTIVES		
altavera tab	1	
alyacen 1/35	1	
amethia	1	
amethia lo	1	
apri	1	
aranelle	1	
ashlyna	1	
aubra	1	
aviane	1	
balziva	1	
bekyree	1	
blisovi 24 fe	1	
blisovi fe 1.5/30	1	
briellyn	1	
camila	1	
camrese lo	1	
caziant pak	1	
cryselle-28	1	
cyclafem 1/35	1	
cyclafem 7/7/7	1	
cyred tab	1	
dasetta 1/35	1	

Drug Name	Drug Tier	Requirements/Limits
dasetta 7/7/7	1	
deblitane	1	
desogestrel-ethinyl estradiol (biphasic)	1	
drospirenone-ethinyl estradiol	1	
drospirenone-ethinyl estradiol-levomefolate calcium	1	
ELLA	1	
eluryng	1	
emoquette	1	
enpresse-28	1	
enskyce	1	
errin	1	
estarylla tab 0.25-35	1	
ethynodiol diacet & eth estrad	1	
ethynodiol tab 1-50	1	
etonogestrel-ethinyl estradiol	1	
falmina	1	
fayosim	1	
femynor	1	
gianvi tab 3-0.02mg	1	
hailey 24 fe	1	
heather	1	
incassia	1	
introvale	1	
isibloom	1	
jasmiel	1	
jolessa tab 0.15-0.03 mg	1	
jolivette	1	
juleber	1	
junel 1.5/30	1	
junel 1/20	1	
junel fe 1.5/30	1	
junel fe 1/20	1	
junel fe 24	1	
kaitlib fe	1	
kariva	1	
kelnor 1/35	1	
kelnor 1/50	1	
kurvelo	1	
larin 1.5/30	1	
larin 1/20	1	
larin fe 1.5/30	1	
larin fe 1/20	1	
larissia tab	1	
layolis fe	1	
leena tab	1	

Drug Name	Drug Tier	Requirements/Limits
lessina	1	
levonest	1	
levonor-eth est tab 0.15-0.02/0.025/0.03mg & eth est 0.01mg	1	
levonor/ethi tab	1	
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	1	
levonorg-eth est tab 0.15-0.03mg (84) & eth est tab 0.01mg(7)	1	
levonorgestrel & eth estradiol	1	
levonorgestrel-ethinyl estradiol 0.15-0.03mg (91-day)	1	
levora 0.15/30-28	1	
loryna	1	
low-ogestrel	1	
lutera	1	
lyza	1	
marlissa	1	
medroxyprogesterone acetate (contraceptive)	1	
melodetta 24 fe	1	
mibelas 24 fe	1	
microgestin 1.5/30	1	
microgestin 1/20	1	
microgestin fe 1.5/30	1	
microgestin fe 1/20	1	
mili	1	
mono-linyah tab 0.25-35	1	
necon 0.5/35-28	1	
nikki	1	
nora-be tab 0.35mg	1	
nore/eth/fer chw 0.4mg-35	1	
noreth/ethin chw fe	1	
norethin acet & estrad-fe	1	
norethindrone (contraceptive)	1	
norethindrone acet & eth estra	1	
norgest/ethi tab 0.25/35	1	
norgestimate-ethinyl estradiol (triphasic) 0.18-25/0.215-25/0.25-25 mg-mcg	1	
norgestimate-ethinyl estradiol (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg	1	
nortrel 0.5/35 (28)	1	
nortrel 1/35	1	
nortrel 7/7/7	1	
ocella tab 3-0.03mg	1	
orsythia	1	
philith	1	

Drug Name	Drug Tier	Requirements/Limits
pimtrea	1	
pirmella 1/35	1	
portia-28	1	
previfem	1	
reclipsen	1	
rivelsa	1	
setlakin tab	1	
sharobel	1	
sprintec 28	1	
sronyx	1	
syeda	1	
tarina 24 fe	1	
tarina fe 1/20	1	
tilia fe	1	
tri-estarylla	1	
tri-legest fe	1	
tri-linyah	1	
tri-lo marzia	1	
tri-lo-estarylla	1	
tri-lo-sprintec	1	
tri-mili	1	
tri-previfem	1	
tri-sprintec	1	
tri-vylibra	1	
tri-vylibra lo	1	
trivora-28	1	
tulana	1	
tydemy	1	
velivet	1	
vienva	1	
viorele	1	
vyfemla	1	
vylibra	1	
wymzya fe	1	
xulane dis 150-35	1	
zarah	1	
zovia 1/35e	1	
ENDOMETRIOSIS		
danazol CAPS	1	
SYNAREL	1	
ENZYME REPLACEMENTS		
ALDURAZYME	1	NM, LA, PA
CARBAGLU	1	NM, LA, PA
CERDELGA	1	NM, PA
CEREZYME	1	NM, LA, PA
CYSTADANE	1	NM, LA

Drug Name	Drug Tier	Requirements/Limits
CYSTAGON	1	NM, LA, PA
FABRAZYME	1	NM, LA, PA
KUVAN	1	NM, LA, PA
levocarnitine (metabolic modifiers)	1	B/D
LUMIZYME	1	NM, LA, PA
miglustat	1	NM, PA
NAGLAZYME	1	NM, LA, PA
nitisinone	1	NM, PA
NITYR	1	NM, LA, PA
ORFADIN	1	NM, LA, PA
sapropterin dihydrochloride	1	NM, PA
sodium phenylbutyrate	1	NM, PA
ESTROGENS		
DELESTROGEN 10mg/ml	1	
estradiol PTWK; TABS	1	
estradiol vaginal cream	1	
estradiol vaginal tab	1	
estradiol valerate inj	1	
fyavolv	1	
jinteli	1	
norethindrone acetate-ethinyl estradiol	1	
yuvafem vaginal tablet 10 mcg	1	
GLUCOCORTICOIDS		
cortisone acetate TABS	1	
dexamethasone ELIX; SOLN; TABS	1	
DEXAMETHASONE INTENSOL	1	
dexamethasone sodium phosphate	1	
fludrocortisone acetate TABS	1	
hydrocortisone TABS	1	
methylpr ss inj	1	B/D
methylpred pak 4mg	1	
methylpred tab 4mg	1	B/D
methylpred tab 8mg	1	B/D
methylpred tab 16mg	1	B/D
methylpred tab 32mg	1	B/D
methylprednisolone acetate	1	B/D
pred sod pho sol 5mg/5ml	1	B/D
prednisolone sodium phosphate SOLN 15mg/5ml	1	B/D
prednisolone sol 15mg/5ml	1	B/D
prednisolone sol 25mg/5ml	1	B/D
PREDNISONE CON 5MG/ML	1	B/D
prednisone pak 5mg	1	
prednisone pak 10mg	1	
prednisone sol 5mg/5ml	1	B/D
prednisone tab 1mg	1	B/D

Drug Name	Drug Tier	Requirements/Limits
prednisone tab 2.5mg	1	B/D
prednisone tab 5mg	1	B/D
prednisone tab 10mg	1	B/D
prednisone tab 20mg	1	B/D
prednisone tab 50mg	1	B/D
SOLU-CORTEF	1	
GLUCOSE ELEVATING AGENTS		
diazoxide SUSP	1	
GLUCAGEN HYPOKIT	1	
GLUCAGON EMERGENCY KIT	1	
GVOKE HYPOPEN 2-PACK	1	
GVOKE PFS	1	
PROGLYCEM SUS 50MG/ML	1	
MISCELLANEOUS		
cabergoline	1	
calcitonin (salmon)	1	B/D
cinacalcet hcl 30mg, 90mg	1	B/D, QL (120 tabs / 30 days), NM
cinacalcet hcl 60mg	1	B/D, QL (60 tabs / 30 days), NM
FORTEO	1	NM, PA
GENOTROPIN	1	NM, PA
GENOTROPIN MINIQUICK	1	NM, PA
INCRELEX	1	NM, LA, PA
KORLYM	1	NM, LA, PA
LUPRON DEP-PED INJ 7.5MG	1	NM, PA
LUPRON DEP-PED INJ 11.25MG (3-MONTH)	1	NM, PA
LUPRON DEPOT-PED (1-MONTH	1	NM, PA
LUPRON DEPOT-PED (3-MONTH	1	NM, PA
NATPARA	1	NM, PA
octreotide acetate	1	NM, PA
OSPHENA	1	PA
PROLIA	1	QL (1 injection / 180 days), NM
raloxifene tab 60mg	1	
SIGNIFOR	1	NM, LA, PA
SOMATULINE DEPOT	1	NM, PA
SOMAVERT	1	NM, LA, PA
TYMLOS	1	NM, PA
XGEVA	1	NM, PA
PHOSPHATE BINDER AGENTS		
AURYXIA	1	QL (360 tabs / 30 days), PA
calcium acetate (phosphate binder) CAPS	1	QL (360 caps / 30 days)
calcium acetate (phosphate binder) TABS	1	QL (360 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
sevelamer carbonate PACK 2.4gm	1	QL (180 packets / 30 days)
sevelamer carbonate PACK .8gm	1	QL (540 packets / 30 days)
sevelamer carbonate TABS	1	QL (540 tabs / 30 days)
PROGESTINS		
medroxyprogesterone acetate tab	1	
norethindrone acetate TABS	1	
THYROID AGENTS		
euthyrox	1	
levo-t	1	
levothyroxine sodium TABS	1	
levoxyl	1	
liothyronine sodium TABS	1	
methimazole TABS	1	
propylthiouracil TABS	1	
SYNTHROID	1	
unithroid	1	
VASOPRESSINS		
desmopressin acetate spray	1	
desmopressin acetate spray refrigerated	1	
desmopressin acetate tabs	1	
desmopressin inj 4mcg/ml	1	
STIMATE	1	NM
GASTROINTESTINAL		
ANTIEMETICS		
aprepitant	1	B/D
aprepitant pak 80mg & 125mg	1	B/D
compro supp	1	
dronabinol	1	B/D, QL (60 caps / 30 days)
EMEND SUSR	1	B/D
granisetron hcl SOLN	1	
granisetron hcl TABS	1	B/D
meclizine hcl TABS	1	
metoclopramide hcl SOLN; TABS	1	
metoclopramide hcl inj	1	
ondansetron hcl TABS	1	B/D
ondansetron hcl inj	1	
ondansetron hcl oral soln	1	B/D
ondansetron odt	1	B/D
prochlorperazine inj	1	
prochlorperazine maleate TABS	1	
prochlorperazine supp	1	
promethazine hcl SYRP; TABS	1	PA; PA if 70 years and older

Drug Name	Drug Tier	Requirements/Limits
promethazine hcl inj	1	PA; PA if 70 years and older
scopolamine	1	QL (10 patches / 30 days), PA; PA if 70 years and older
ANTISPASMODICS		
dicyclomine hcl cap 10mg	1	
dicyclomine hcl soln 10mg/5ml	1	
dicyclomine hcl tab 20mg	1	
glycopyrrolate tab 1mg	1	
glycopyrrolate tab 2mg	1	
H2-RECEPTOR ANTAGONISTS		
famotidine SUSR; TABS	1	
famotidine in nacl	1	
famotidine inj	1	
nizatidine CAPS	1	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium	1	
budesonide ec	1	
hydrocortisone (enema)	1	
mesalamine CPDR	1	
mesalamine ENEM	1	
mesalamine SUPP	1	
mesalamine TBEC 1.2gm	1	
mesalamine w/ cleanser	1	
sulfasalazine TABS	1	
sulfasalazine ec	1	
LAXATIVES		
constulose	1	
enulose	1	
gavilyte-c	1	
gavilyte-g	1	
gavilyte-n/flavor pack	1	
generlac	1	
GOLYTELY	1	
lactulose SOLN	1	
lactulose (encephalopathy)	1	
NULYTELY/FLAVOR PACKS	1	
peg 3350-kcl-sod bicarb-sod chloride-sod sulfate	1	
peg 3350-potassium chloride-sod bicarbonate-sod chloride	1	
PLENVU	1	
SUPREP BOWEL PREP KIT	1	
trilyte	1	

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
alosetron hcl	1	PA
AMITIZA CAP 8MCG	1	QL (180 caps / 30 days)
AMITIZA CAP 24MCG	1	QL (60 caps / 30 days)
cromolyn sodium (mastocytosis)	1	
diphenoxylate w/ atropine	1	
GATTEX	1	NM, LA, PA
LINZESS	1	QL (30 caps / 30 days)
loperamide hcl CAPS	1	
misoprostol TABS	1	
MOVANTIK 12.5mg	1	QL (60 tabs / 30 days)
MOVANTIK 25mg	1	QL (30 tabs / 30 days)
RELISTOR SOLN	1	PA
sucralfate TABS	1	
ursodiol CAPS; TABS	1	
XIFAXAN 550mg	1	PA
PANCREATIC ENZYMES		
CREON	1	
ZENPEP	1	
PROTON PUMP INHIBITORS		
DEXILANT	1	QL (30 caps / 30 days)
esomeprazole magnesium CPDR	1	QL (30 caps / 30 days), ST
lansoprazole CPDR	1	QL (30 caps / 30 days)
omeprazole cap 10mg	1	
omeprazole cap 20mg	1	
omeprazole cap 40mg	1	
pantoprazole sodium SOLR	1	
pantoprazole sodium tbec	1	
rabeprazole sodium	1	QL (30 tabs / 30 days)
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl	1	QL (30 tabs / 30 days)
dutasteride CAPS	1	QL (30 caps / 30 days)
dutasteride-tamsulosin hcl	1	QL (30 caps / 30 days)
finasteride TABS 5mg	1	
tamsulosin hcl	1	
MISCELLANEOUS		
bethanechol chloride TABS	1	
potassium citrate (alkalinizer) er tabs	1	
URINARY ANTISPASMODICS		
MYRBETRIQ	1	QL (30 tabs / 30 days)
oxybutynin chloride SYRP	1	
oxybutynin chloride TABS	1	
oxybutynin chloride TB24 5mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
oxybutynin chloride TB24 10mg, 15mg	1	QL (60 tabs / 30 days)
tolterodine tartrate CP24	1	QL (30 caps / 30 days), ST
tolterodine tartrate TABS	1	ST
TOVIAZ	1	QL (30 tabs / 30 days)
trospium chloride TABS	1	QL (60 tabs / 30 days)
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal	1	
metronidazole vaginal	1	
terconazole vaginal	1	
vandazole	1	
HEMATOLOGIC		
ANTICOAGULANTS		
ELIQUIS 2.5mg	1	QL (60 tabs / 30 days)
ELIQUIS 5mg	1	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK	1	QL (74 tabs / 30 days)
enoxaparin sodium	1	
fondaparinux sodium	1	
heparin sod (porcine) in d5w	1	
heparin sod inj 1000/ml	1	B/D
heparin sod inj 5000/ml	1	B/D
heparin sod inj 10000/ml	1	B/D
heparin sod inj 20000/ml	1	B/D
HEPARIN SODIUM/NACL 0.45%	1	
jantoven	1	
PRADAXA	1	QL (60 caps / 30 days)
warfarin sodium	1	
XARELTO 2.5mg	1	QL (60 tabs / 30 days)
XARELTO 10mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
XARELTO STARTER PACK	1	QL (51 tabs / 30 days)
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT	1	NM, PA
ZARXIO	1	NM, PA
MISCELLANEOUS		
anagrelide hcl	1	
BERINERT	1	QL (24 boxes / 30 days), NM, LA, PA
cilostazol	1	
DROXIA	1	
ENDARI	1	NM, LA, PA
HAEGARDA 2000unit	1	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA 3000unit	1	QL (20 vials / 30 days), NM, LA, PA
icatibant acetate	1	QL (9 syringes / 30 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
pentoxifylline TBCR	1	
PROMACTA PACK 12.5mg	1	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	1	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	1	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	1	QL (60 tabs / 30 days), NM, LA, PA
tranexamic acid SOLN; TABS	1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole	1	
BRILINTA	1	
clopidogrel tab 75mg	1	
prasugrel hcl	1	
IMMUNOLOGIC AGENTS		
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
ENBREL SOLN	1	QL (16 vials / 28 days), NM, PA
ENBREL SOLR	1	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	1	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	1	QL (8 syringes / 28 days), NM, PA
ENBREL MINI	1	QL (8 injections / 28 days), NM, PA
ENBREL SURECLICK	1	QL (8 injections / 28 days), NM, PA
HUMIRA 10mg/0.1ml, 20mg/0.2ml	1	QL (2 injections / 28 days), NM, PA
HUMIRA 40mg/0.4ml	1	QL (6 injections / 28 days), NM, PA
HUMIRA INJ 10MG/0.2ML	1	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 20MG/0.4ML	1	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 40MG/0.8ML	1	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIATRIC CROHNS DISEASE	1	NM, PA
HUMIRA PEN	1	QL (6 pens / 28 days), NM, PA
HUMIRA PEN CD/UC/HS STARTER	1	NM, PA
HUMIRA PEN INJ CD/UC/HS STARTER	1	NM, PA
HUMIRA PEN INJ PS/UV STARTER	1	NM, PA
HUMIRA PEN-PS/UV STARTER	1	NM, PA
hydroxychloroquine sulfate	1	

Drug Name	Drug Tier	Requirements/Limits
leflunomide TABS	1	QL (30 tabs / 30 days)
methotrexate sodium tabs	1	
REMICADE	1	NM, PA
RENFLEXIS	1	NM, LA, PA
RINVOQ	1	QL (30 tabs / 30 days), NM, PA
SKYRIZI	1	QL (7 kits / year), NM, PA
STELARA SOLN 45mg/0.5ml	1	QL (1 vial / 28 days), NM, LA, PA
STELARA SOSY	1	QL (1 syringe / 28 days), NM, PA
XATMEP	1	B/D
XELJANZ	1	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	1	QL (30 tabs / 30 days), NM, PA
IMMUNOGLOBULINS		
BIVIGAM	1	NM, PA
FLEBOGAMMA DIF 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM, PA
GAMASTAN	1	B/D, NM
GAMMAGARD LIQUID	1	NM, PA
GAMMAGARD S/D	1	NM, PA
GAMMAKED	1	NM, PA
GAMMAPLEX	1	NM, PA
GAMMAPLEX 10GM/100ML	1	NM, PA
GAMUNEX-C	1	NM, PA
OCTAGAM	1	NM, PA
PANZYGA	1	NM, PA
PRIVIGEN	1	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE	1	NM, LA, PA
ARCALYST	1	NM, PA
INTRON-A INJ 10MU	1	B/D, NM
INTRON-A INJ 18MU	1	B/D, NM
INTRON-A INJ 25MU	1	B/D, NM
INTRON-A INJ 50MU	1	B/D, NM
IMMUNOSUPPRESSANTS		
azathioprine TABS	1	B/D
BENLYSTA	1	NM, PA
cyclosporine CAPS; SOLN	1	B/D, NM
cyclosporine modified (for microemulsion)	1	B/D, NM
everolimus (immunosuppressant)	1	B/D, NM
gengraf	1	B/D, NM

Drug Name	Drug Tier	Requirements/Limits
mycophenolate mofetil CAPS; SUSR; TABS	1	B/D, NM
mycophenolate sodium tbec	1	B/D, NM
NULOJIX	1	B/D, NM
PROGRAF PACK	1	B/D, NM
SANDIMMUNE SOLN 100mg/ml	1	B/D, NM
sirolimus SOLN; TABS	1	B/D, NM
tacrolimus CAPS	1	B/D, NM
ZORTRESS TAB 0.5MG	1	B/D, NM
ZORTRESS TAB 0.25MG	1	B/D, NM
ZORTRESS TAB 0.75MG	1	B/D, NM
ZORTRESS TAB 1MG	1	B/D, NM
VACCINES		
ACTHIB	1	
ADACEL	1	
BCG VACCINE	1	
BEXSERO	1	
BOOSTRIX	1	
DAPTACEL	1	
DIPHTHERIA/TETANUS TOXOID	1	B/D
ENGERIX-B	1	B/D
GARDASIL 9	1	
HAVRIX	1	
HIBERIX	1	
IMOVAX RABIES (H.D.C.V.)	1	B/D
INFANRIX	1	
IPOL INACTIVATED IPV	1	
IXIARO	1	
KINRIX	1	
M-M-R II	1	
MENACTRA	1	
MENQUADFI	1	
MENVEO	1	
PEDIARIX	1	
PEDVAX HIB	1	
PENTACEL	1	
PROQUAD	1	
QUADRACEL	1	
RABAVERT	1	B/D
RECOMBIVAX HB	1	B/D
ROTARIX	1	
ROTATEQ	1	
SHINGRIX	1	QL (2 vials per lifetime)
TDVAX	1	B/D
TENIVAC	1	B/D
TRUMENBA	1	
TWINRIX INJ	1	

Drug Name	Drug Tier	Requirements/Limits
TYPHIM VI	1	
VAQTA	1	
VARIVAX	1	
YF-VAX	1	
ZOSTAVAX	1	QL (1 vial per lifetime)
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES		
klor-con 8	1	
klor-con 10	1	
klor-con m10	1	
klor-con m15	1	
klor-con m20	1	
klor-con pak 20meq	1	
klor-con spr cap 8meq	1	
klor-con spr cap 10meq	1	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	1	
magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	1	
MAGNESIUM SULFATE IN D5W	1	
magnesium sulfate in dextrose	1	
magnesium sulfate inj 50%	1	
potassium chloride CPCR	1	
potassium chloride PACK	1	
potassium chloride SOLN 10%, 20%	1	
potassium chloride TBCR	1	
potassium chloride microencapsulated crystals er	1	
sodium chloride SOLN 2.5meq/ml	1	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	1	
TPN ELECTROLYTES	1	B/D
IV NUTRITION		
AMINOSYN II INJ 10%	1	B/D
AMINOSYN-PF 7%	1	B/D
CLINIMIX 4.25%/DEXTROSE 5%	1	B/D
CLINIMIX 5%/DEXTROSE 15%	1	B/D
CLINIMIX 5%/DEXTROSE 20%	1	B/D
CLINIMIX INJ 4.25/D10	1	B/D
clinisol sf 15%	1	B/D
CLINOLIPID	1	B/D
FREAMINE HBC 6.9%	1	B/D
FREAMINE III	1	B/D
hepatamine	1	B/D

Drug Name	Drug Tier	Requirements/Limits
INTRALIPID 30%	1	B/D
INTRALIPID INJ 20%	1	B/D
NEPHRAMINE	1	B/D
NUTRILIPID INJ 20%	1	B/D
plenamine	1	B/D
PREMASOL 10%	1	B/D
PROCALAMINE	1	B/D
PROSOL	1	B/D
TRAVASOL	1	B/D
TROPHAMINE INJ 10%	1	B/D
IV REPLACEMENT SOLUTIONS		
dextrose 2.5%/nacl 0.45%	1	
dextrose 5%	1	
DEXTROSE 5% /ELECTROLYTE	1	
dextrose 5%/nacl 0.2%	1	
DEXTROSE 5%/NACL 0.3%	1	
dextrose 5%/nacl 0.9%	1	
dextrose 5%/nacl 0.45%	1	
dextrose 5%/potassium chl	1	
dextrose 10% flex contain	1	
DEXTROSE 10% W/ SODIUM CHLORIDE 0.2%	1	
dextrose 10%/nacl 0.45%	1	
dextrose 50%	1	
dextrose in lactated ringers	1	
dextrose inj 70%	1	
ISOLYTE P	1	
ISOLYTE S	1	
kcl0.15%/d5w/nacl0.2%	1	
KCL 0.3%/D5W/NACL 0.9%	1	
kcl 0.3%/d5w/nacl 0.45%	1	
kcl 0.15%/d5w/nacl 0.9%	1	
KCL 0.15%/D5W/NACL 0.225%	1	
kcl 0.075%/d5w/nacl 0.45%	1	
kcl/d5w/nacl inj 0.22%/0.45%	1	
kcl/d5w/nacl inj .15/.45%	1	
kcl/nacl inj 0.3-0.9	1	
kcl/nacl inj 0.15%-0.9%	1	
lactated ringer's	1	
NORMOSOL-M IN D5W	1	
PLASMA-LYTE A	1	
PLASMA-LYTE-148	1	
pot chloride inj 2meq/ml	1	
potassium chloride SOLN 2meq/ml	1	

Drug Name	Drug Tier	Requirements/Limits
POTASSIUM CHLORIDE SOLN .4meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 40meq/100ml	1	
potassium chloride in nacl	1	
sodium chloride SOLN 3%, 5%	1	
sodium chloride 0.45%	1	
sodium chloride inj 0.9%	1	
VITAMINS		
calcitriol CAPS	1	B/D
calcitriol inj	1	B/D
calcitriol oral soln 1 mcg/ml	1	B/D
M-NATAL PLUS	1	
paricalcitol CAPS	1	B/D
PNV FOLIC ACID + IRON MUL	1	
PRENATAL	1	
PRENATAL PLUS	1	
PRENATAL PLUS LOW IRON	1	
RAYALDEE	1	
TRICARE	1	
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-poly-neomycin-hc	1	
BLEPHAMIDE OINT	1	
neomycin-polymy-dexameth	1	
neomycin-polymyxin-hc (ophth)	1	
sulfacetamide sod-prednisolone	1	
TOBRADEX OINT	1	
TOBRADEX ST	1	
tobramycin-dexamethasone	1	
ZYLET	1	
ANTI-INFECTIVES		
AZASITE	1	
bacitracin (ophthalmic)	1	
bacitracin-polymyxin b (ophth)	1	
BESIVANCE	1	
CILOXAN OINT	1	
ciprofloxacin hcl (ophth)	1	
erythromycin (ophth)	1	
gatifloxacin (ophth)	1	
gentak	1	
gentamicin sulfate soln (ophth)	1	
MOXEZA	1	
moxifloxacin hcl (ophth)	1	
NATACYN	1	
neomycin-bacitracin zn-polymyxin	1	
neomycin-polymyxin-gramicidin	1	

Drug Name	Drug Tier	Requirements/Limits
ofloxacin (ophth)	1	
polymyxin b-trimethoprim	1	
sulfacetamide sodium (ophth)	1	
tobramycin (ophth)	1	
trifluridine	1	
ZIRGAN	1	
ANTI-INFLAMMATORIES		
ALREX	1	
bromfenac sodium (ophth)	1	
BROMSITE	1	
dexamethasone sodium phosphate (ophth)	1	
diclofenac sodium (ophth)	1	
DUREZOL	1	
FLAREX	1	
fluorometholone	1	
flurbiprofen sodium	1	
ILEVRO	1	
ketorolac tromethamine (ophth)	1	
LOTEMAX GEL; OINT	1	
loteprednol etabonate	1	
prednisolone acetate (ophth)	1	
PREDNISOLONE SODIUM PHOSPHATE (OPHTH)	1	
PROLENSA	1	
ANTIALLERGICS		
azelastine drop 0.05%	1	
BEPREVE	1	
cromolyn sodium (ophth)	1	
LASTACAFT	1	
olopatadine hcl 0.2%	1	
PAZEO	1	
ZERVIATE	1	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	1	
AZOPT	1	
betaxolol hcl (ophth)	1	
BETOPTIC-S	1	
brimonidine sol 0.2%	1	
brimonidine sol 0.15%	1	
carteolol hcl (ophth)	1	
COMBIGAN	1	
dorzolamide hcl	1	
dorzolamide hcl-timolol maleate	1	
latanoprost SOLN	1	
levobunolol hcl	1	
LUMIGAN	1	

Drug Name	Drug Tier	Requirements/Limits
PHOSPHOLINE IODIDE	1	
pilocarpine hcl SOLN	1	
RHOPRESSA	1	
SIMBRINZA	1	
timolol maleate (ophth) soln	1	
timolol maleate gel	1	
timolol maleate ophth soln 0.5% (once-daily)	1	
travoprost	1	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	1	
CYSTARAN	1	NM, LA, PA
proparacaine hcl SOLN	1	
RESTASIS	1	QL (60 single use vials / 30 days)
RESTASIS MULTIDOSE	1	QL (1 bottle / 30 days)
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPTA	1	QL (60 blisters / 30 days)
BEVESPI AEROSPHERE	1	QL (1 inhaler / 30 days)
BREZTRI AEROSPHERE	1	QL (1 inhaler / 30 days)
BREZTRI AEROSPHERE (INSTITUTIONAL PACK)	1	QL (4 inhalers / 28 days)
COMBIVENT RESPIMAT	1	QL (2 inhalers / 30 days)
ipratropium-albuterol nebu	1	B/D
TRELEGY ELLIPTA	1	QL (60 blisters / 30 days)
ANTICHOLINERGICS		
ATROVENT HFA	1	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA	1	QL (30 blisters / 30 days)
ipratropium bromide SOLN	1	B/D
ipratropium bromide (nasal)	1	
ANTIHISTAMINES		
azelastine spr 0.1%	1	
azelastine spr 0.15%	1	
cetirizine syrup	1	
cyproheptadine hcl SYRP; TABS	1	PA; PA if 70 years and older
diphenhydramine hcl inj 50mg/ml	1	
hydroxyzine hcl SYRP; TABS	1	PA; PA if 70 years and older

Drug Name	Drug Tier	Requirements/Limits
hydroxyzine hcl inj	1	PA; PA if 70 years and older
hydroxyzine pamoate CAPS 25mg, 50mg	1	PA; PA if 70 years and older
levocetirizine dihydrochloride	1	
BETA AGONISTS		
albuterol sulfate AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Proair HFA)
albuterol sulfate AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
albuterol sulfate NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	1	B/D
albuterol sulfate SYRP	1	
albuterol sulfate TABS	1	
albuterol sulfate TB12	1	
levalbuterol hcl NEBU	1	B/D
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml	1	B/D
levalbuterol tartrate hfa	1	QL (2 inhalers / 30 days)
SEREVENT DISKUS	1	QL (60 inhalations / 30 days)
terbutaline sulfate TABS	1	
VENTOLIN HFA	1	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
montelukast sodium CHEW; PACK; TABS	1	
zafirlukast	1	
MAST CELL STABILIZERS		
cromolyn sod neb 20mg/2ml	1	B/D
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	1	B/D
ARALAST NP	1	NM, LA, PA
DALIRESP	1	
epinephrine (anaphylaxis) .15mg/0.3ml, .3mg/0.3ml	1	(generic of EpiPen)
epinephrine (anaphylaxis) .15mg/0.15ml, .3mg/0.3ml	1	(generic of Adrenaclick)
ESBRIET	1	NM, PA
FASENRA	1	NM, LA, PA
FASENRA PEN	1	NM, LA, PA
KALYDECO	1	NM, PA
NUCALA	1	NM, LA, PA
OFEV	1	NM, PA
ORKAMBI	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
PROLASTIN-C	1	NM, LA, PA
PULMOZYME	1	NM, PA
SYMDEKO	1	NM, LA, PA
SYMJEPI	1	
THEO-24	1	
theophylline	1	
theophylline tab er 12hr 300 mg	1	
theophylline tab er 12hr 450 mg	1	
theophylline tab sr 24hr	1	
TRIKAFTA	1	NM, LA, PA
XOLAIR	1	NM, LA, PA
ZEMAIRA	1	NM, LA, PA
NASAL STEROIDS		
flunisolide (nasal)	1	QL (3 bottles / 30 days)
fluticasone propionate (nasal)	1	QL (1 bottle / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA	1	QL (30 inhalations / 30 days)
budesonide (inhalation) .25mg/2ml, .5mg/2ml	1	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	1	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	1	QL (240 inhalations / 30 days)
FLOVENT HFA	1	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER	1	QL (2 inhalers / 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKUS	1	QL (60 inhalations / 30 days)
ADVAIR HFA	1	QL (1 inhaler / 30 days)
BREO ELLIPTA	1	QL (60 blisters / 30 days)
SYMBICORT	1	QL (1 inhaler / 30 days)
TOPICAL		
DERMATOLOGY, ACNE		
amnesteem	1	PA
avita	1	QL (45 grams / 30 days), PA
benzoyl peroxide-erythromycin	1	
claravis	1	PA
clindamycin phosphate (topical) GEL	1	QL (75 grams / 30 days)
clindamycin phosphate (topical) LOTN	1	
clindamycin phosphate (topical) SOLN	1	QL (60 mL / 30 days)
ery pad 2%	1	

Drug Name	Drug Tier	Requirements/Limits
erythromycin (acne aid)	1	
isotretinoin CAPS	1	PA
myorisan	1	PA
sulfacetamide sodium (acne)	1	
tretinoin CREA	1	QL (45 grams / 30 days), PA
tretinoin GEL .01%, .025%	1	QL (45 grams / 30 days), PA
zenatane	1	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical)	1	
mupirocin OINT	1	QL (220 grams / 30 days)
silver sulfadiazine CREA	1	
ssd	1	
SULFAMYLON CREA	1	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox CREA	1	QL (90 grams / 30 days)
ciclopirox SUSP	1	QL (60 mL / 30 days)
clotrimazole (topical) CREA	1	
clotrimazole (topical) SOLN	1	QL (30 mL / 30 days)
clotrimazole w/ betamethasone CREA	1	
ketoconazole cream	1	QL (60 grams / 30 days)
nyamyc	1	QL (60 grams / 30 days)
nystatin (topical) CREA; OINT	1	
nystatin (topical) POWD	1	QL (60 grams / 30 days)
nystop	1	QL (60 grams / 30 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin	1	PA
calcipotriene CREA; OINT	1	QL (120 grams / 30 days), PA
calcipotriene SOLN	1	QL (120 mL / 30 days), PA
calcitrene	1	QL (120 grams / 30 days), PA
tazarotene CREA	1	QL (60 grams / 30 days), PA
TAZORAC CREA .05%	1	QL (60 grams / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole shampoo	1	
selenium sulfide LOTN	1	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort	1	
alclometasone dipropionate	1	
betamethasone dipropionate (topical)	1	

Drug Name	Drug Tier	Requirements/Limits
betamethasone dipropionate augmented	1	
betamethasone valerate CREA; LOTN; OINT	1	
ENSTILAR	1	QL (120 grams / 30 days), PA
fluocinolone acetonide CREA; OIL; OINT	1	
fluocinolone acetonide SOLN	1	QL (90 mL / 30 days)
fluocinolone acetonide oil body	1	
fluocinonide CREA .05%	1	QL (120 grams / 30 days)
fluocinonide GEL	1	QL (60 grams / 30 days)
fluocinonide OINT	1	QL (60 grams / 30 days)
fluocinonide SOLN	1	QL (60 mL / 30 days)
fluocinonide emulsified base	1	QL (120 grams / 30 days)
fluticasone propionate CREA; OINT	1	
halobetasol propionate CREA; OINT	1	QL (50 grams / 30 days)
hydrocortisone (topical) cream 1%	1	
hydrocortisone (topical) cream 2.5%	1	
hydrocortisone (topical) lotion 2.5%	1	
hydrocortisone (topical) oint 2.5%	1	
hydrocortisone butyrate cream 0.1%	1	QL (45 grams / 30 days)
hydrocortisone butyrate oint 0.1%	1	QL (45 grams / 30 days)
mometasone furoate CREA; OINT; SOLN	1	
TEXACORT SOLN 2.5%	1	
triamcinolone acetonide (topical) CREA .1%	1	QL (454 grams / 30 days)
triamcinolone acetonide (topical) CREA .025%, .5%	1	
triamcinolone acetonide (topical) LOTN	1	
triamcinolone acetonide (topical) OINT .025%, .1%, .5%	1	
triderm 0.5%	1	
DERMATOLOGY, LOCAL ANESTHETICS		
glydo	1	QL (30 mL / 30 days), PA
lidocaine PTCH 5%	1	QL (3 patches / 1 day), PA
lidocaine hcl GEL	1	QL (30 mL / 30 days), PA
lidocaine hcl SOLN 4%	1	QL (50 mL / 30 days), PA
lidocaine oint 5%	1	QL (50 grams / 30 days), PA
lidocaine-prilocaine	1	QL (30 grams / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ammonium lactate CREA; LOTN	1	
diclofenac sodium (topical) 1% gel	1	QL (1000 grams / 30 days), PA
fluorouracil (topical) crea 5%	1	QL (40 grams / 30 days)
fluorouracil (topical) soln	1	QL (10 mL / 30 days)
imiquimod CREA 5%	1	QL (24 packets / 30 days)
metronidazole (topical) CREA; LOTN	1	
metronidazole gel 0.75%	1	
PANRETIN	1	QL (60 grams / 30 days)
PICATO .05%	1	QL (2 tubes / 30 days)
PICATO .015%	1	QL (3 tubes / 30 days)
podofilox SOLN	1	
procto-med hc	1	
procto-pak	1	
proctosol hc cre 2.5%	1	
proctozone-hc	1	
RECTIV	1	QL (30 grams / 30 days)
rosadan cre 0.75%	1	
tacrolimus (topical)	1	QL (100 grams / 30 days)
TARGRETIN GEL	1	QL (60 grams / 30 days), NM, PA
VALCHLOR	1	QL (60 grams / 30 days), NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
malathion	1	
permethrin cre 5%	1	
DERMATOLOGY, WOUND CARE AGENTS		
acetic acid .25%	1	
REGRANEX	1	QL (30 grams / 30 days), PA
SANTYL	1	
sodium chlor sol 0.9% irr	1	
water for irrigation, sterile	1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl	1	
chlorhexidine gluconate (mouth-throat)	1	
clotrimazole TROC	1	
lidocaine hcl (mouth-throat)	1	
nystatin (mouth-throat)	1	
paroex sol 0.12%	1	
periogard	1	
pilocarpine hcl (oral)	1	
triamcinolone acetonide (mouth)	1	

Drug Name	Drug Tier	Requirements/Limits
OTIC		
acetic acid (otic)	1	
CIPRODEX	1	
ciprofloxacin-dexamethasone	1	
flac	1	
fluocinolone acetonide (otic)	1	
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