

2025 Drug Formulary

Priority Health Choice, Inc.

Medicaid, Medicaid CSHCS, and Health Michigan Plan

This document contains information about the drugs covered under the pharmacy benefit of this plan. This list changes frequently. For the most current information, please refer to our Approved Drug List at priorityhealth.com/formulary/medicaid

COVERAGE LEVEL.

FORMULARY- Priority Health Medicaid or Healthy Michigan Plan pays for this drug. Please note you may need to meet the specific requirements listed under Restrictions.

NON-FORMULARY - Drug that your prescription plan will not pay for or that is not included on the approved drug list

CARVE-OUT - Pharmacy to submit claim to Fee For Service (FFS) Medicaid.

Restriction Descriptions

12 Months Allowed: The member may obtain up to a 12-month supply per dispensing

3 Months Allowed: The member may obtain up to a 3-month supply per dispensing

Age Limit: This product has an age limitation.

Brand Preferred: A specific brand is preferred.

CSHCS Covered: This drug is covered for Medicaid CSHCS members.

Dual Eligible Covered: This drug is covered for Medicaid Dual Eligible members.

EXCLD: Excluded Drug

MAINT: Maintenance Drug

OTC: Over-The-Counter

PA: The drug requires prior authorization. See Medicaid PA Criteria document for requirements.

PDL Non-Preferred: On the Preferred Drug List, this medication is non-preferred

PDL Preferred: On the Preferred Drug List, this medication is preferred

QL: This drug has a quantity limit

Step Therapy: The drug requires step therapy. Use searchable formulary tool to see step therapy requirements.

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

CURRENT AS OF 5/1/2025

Medications	Coverage Level	Restrictions
Alternative Therapy		
Alternative Therapy - Unclassified		
<i>creatine monohydrate powder (rx)</i>	Formulary	
<i>ubiquinol powder</i>	Formulary	
<i>ubiquinol powder (rx)</i>	Formulary	
Analgesic, Anti-Inflammatory Or Antipyretic		
Analgesic - Neurolysis Agents		
DEHYDRATED ALCOHOL	Non-Formulary	
Analgesic - Opioid Antagonists		
LOTREXONE	State Carve Out	
NALTREX	State Carve Out	
Analgesic Opioid Agonists		
<i>codeine sulfate 15 mg tablet</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days); Age Limit (Min 12 Years)
<i>codeine sulfate 30 mg tablet</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days); Age Limit (Min 12 Years)
<i>codeine sulfate 60 mg tablet</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days); Age Limit (Min 12 Years)
CONZIP 100 MG CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
CONZIP 200 MG CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
CONZIP 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
DEMEROL (PF) INJECTION SYRINGE	Non-Formulary	
DEMEROL INJECTION	Non-Formulary	
DILAUDID 2 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (180 tablets per 30 days)
DILAUDID 4 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (135 tablets per 30 days)
DILAUDID 5 MG/5 ML ORAL LIQUID	Formulary	PA; PDL Non-Preferred; QL (120 ML per 30 days)
DILAUDID 8 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (67 tablets per 30 days)

Medications	Coverage Level	Restrictions
DISKETTS 40 MG TABLET DISPR	Formulary	PA; PDL Non-Preferred
DURAMORPH (PF)	Non-Formulary	
<i>fentanyl 100 mcg/hr patch</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 100 mcg/hr patch outer</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 12 mcg/hr patch</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 12 mcg/hr patch outer</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 25 mcg/hr patch</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 25 mcg/hr patch outer</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 37.5 mcg/hr patch</i>	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
<i>fentanyl 37.5 mcg/hr patch outer</i>	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
<i>fentanyl 50 mcg/hr patch</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 50 mcg/hr patch outer</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 62.5 mcg/hr patch</i>	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
<i>fentanyl 62.5 mcg/hr patch outer</i>	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
<i>fentanyl 75 mcg/hr patch</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 75 mcg/hr patch outer</i>	Formulary	PDL Preferred; QL (10 patches per 1 claim)
<i>fentanyl 87.5 mcg/hr patch outer</i>	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
<i>fentanyl cit 400 mcg buccal tb outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>fentanyl cit 600 mcg buccal tb outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>fentanyl cit 800 mcg buccal tb outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>fentanyl cit oftc 1,200 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)

Medications	Coverage Level	Restrictions
<i>fentanyl cit otfc 1,600 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
<i>fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)</i>	Non-Formulary	
<i>fentanyl citrate otfc 200 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
<i>fentanyl citrate otfc 400 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
<i>fentanyl citrate otfc 600 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
<i>fentanyl citrate otfc 800 mcg outer</i>	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
FENTORA 100 MCG BUCCAL TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
FENTORA 200 MCG BUCCAL TABLET 4X7, OUTER	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
FENTORA 400 MCG BUCCAL TABLET 4X7, OUTER	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
FENTORA 600 MCG BUCCAL TABLET 4X7, OUTER	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
FENTORA 800 MCG BUCCAL TABLET 4X7, OUTER	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>hydrocodone er 10 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 120 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 15 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 20 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 30 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 30 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 40 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 50 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 60 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone er 80 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone (pf) injection solution</i>	Non-Formulary	
<i>hydromorphone 1 mg/ml solution</i>	Formulary	PDL Preferred; QL (120 ML per 30 days)

Medications	Coverage Level	Restrictions
<i>hydromorphone 2 mg tablet</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days)
<i>hydromorphone 2 mg tablet outer</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days)
<i>hydromorphone 2 mg tablet u-d</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days)
<i>hydromorphone 3 mg suppos</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone 4 mg tablet</i>	Formulary	PDL Preferred; QL (135 tablets per 30 days)
<i>hydromorphone 4 mg tablet outer</i>	Formulary	PDL Preferred; QL (135 tablets per 30 days)
<i>hydromorphone 4 mg tablet u-d</i>	Formulary	PDL Preferred; QL (135 tablets per 30 days)
<i>hydromorphone 5 mg/5 ml soln</i>	Formulary	PDL Preferred; QL (120 ML per 30 days)
<i>hydromorphone 5 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred; QL (120 ML per 30 days)
<i>hydromorphone 8 mg tablet</i>	Formulary	PDL Preferred; QL (67 tablets per 30 days)
<i>hydromorphone hcl er 12 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone hcl er 16 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone hcl er 32 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone hcl er 8 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>hydromorphone injection solution 2 mg/ml</i>	Non-Formulary	
<i>hydromorphone injection syringe 0.5 mg/0.5 ml, 1 mg/ml, 2 mg/ml, 4 mg/ml</i>	Non-Formulary	
HYSINGLA ER 100 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 120 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 20 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 30 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 40 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 60 MG TABLET	Formulary	PA; PDL Non-Preferred
HYSINGLA ER 80 MG TABLET	Formulary	PA; PDL Non-Preferred
INFUMORPH P/F	Non-Formulary	
<i>levorphanol 2 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>levorphanol 3 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>meperidine 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>meperidine 50 mg/5 ml solution</i>	Formulary	PA; PDL Non-Preferred; QL (240 ML per 30 days)
<i>methadone 10 mg/5 ml solution</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 10 mg/ml oral conc</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 10 mg/ml oral conc cherry</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 10 mg/ml oral conc d/f, unflavored</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 40 mg tablet dispr dispersable</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 40 mg tablet dispr disprsb</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 5 mg/5 ml solution</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 5 mg/5 ml solution cup inner</i>	Formulary	PA; PDL Non-Preferred
<i>methadone 5 mg/5 ml solution cup outer</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 10 mg tablet 10x10, outer</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 10 mg tablet inner</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 5 mg tablet 10x10, outer</i>	Formulary	PA; PDL Non-Preferred
<i>methadone hcl 5 mg tablet inner</i>	Formulary	PA; PDL Non-Preferred
METHADONE INTENSOL 10 MG/ML	Formulary	PA; PDL Non-Preferred
METHADOSE 10 MG/ML ORAL CONC CHERRY	Formulary	PA; PDL Non-Preferred
METHADOSE 10 MG/ML ORAL CONC D/F	Formulary	PA; PDL Non-Preferred
METHADOSE 40 MG TABLET DISPR DISPERSABLE	Formulary	PA; PDL Non-Preferred
MITIGO (PF)	Non-Formulary	
<i>morphine (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	Non-Formulary	
<i>morphine 10 mg/0.5 ml oral syringe inner</i>	Formulary	PDL Preferred; QL (4 ml per 1 day)
<i>morphine 10 mg/0.5 ml oral syringe outer</i>	Formulary	PDL Preferred; QL (4 ml per 1 day)
<i>morphine 20 mg/ml oral syringe outer</i>	Formulary	PDL Preferred; QL (4 ML per 1 day)
<i>morphine injection solution</i>	Non-Formulary	
<i>morphine injection syringe 2 mg/ml, 4 mg/ml</i>	Non-Formulary	
<i>morphine intravenous solution 10 mg/ml, 50 mg/ml</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>morphine intravenous syringe</i>	Non-Formulary	
<i>morphine sulf 10 mg suppos</i>	Formulary	PDL Preferred
<i>morphine sulf 10 mg/5 ml soln</i>	Formulary	PDL Preferred; QL (140 ML per 30 days)
<i>morphine sulf 10 mg/5 ml soln</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 10 mg/5 ml soln dosing cup</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 10 mg/5 ml solution cup inner</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 10 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 100 mg/5 ml conc</i>	Formulary	PDL Preferred; QL (120 ML per 30 days)
<i>morphine sulf 100 mg/5 ml conc added color</i>	Formulary	PDL Preferred; QL (120 ML per 30 days)
<i>morphine sulf 20 mg suppos</i>	Formulary	PDL Preferred
<i>morphine sulf 20 mg/5 ml soln</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 20 mg/5 ml soln dosing cup</i>	Formulary	PDL Preferred; QL (240 ML per 30 days)
<i>morphine sulf 30 mg suppos</i>	Formulary	PDL Preferred
<i>morphine sulf 5 mg suppos</i>	Formulary	PDL Preferred
<i>morphine sulf er 100 mg tablet</i>	Formulary	PDL Preferred
<i>morphine sulf er 100 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>morphine sulf er 100 mg tablet f/c</i>	Formulary	PDL Preferred
<i>morphine sulf er 100 mg tablet inner</i>	Formulary	PDL Preferred
<i>morphine sulf er 15 mg tablet</i>	Formulary	PDL Preferred
<i>morphine sulf er 15 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>morphine sulf er 15 mg tablet f/c</i>	Formulary	PDL Preferred
<i>morphine sulf er 15 mg tablet inner</i>	Formulary	PDL Preferred
<i>morphine sulf er 15 mg tablet outer</i>	Formulary	PDL Preferred
<i>morphine sulf er 200 mg tablet</i>	Formulary	PDL Preferred
<i>morphine sulf er 30 mg tablet</i>	Formulary	PDL Preferred
<i>morphine sulf er 30 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>morphine sulf er 30 mg tablet f/c</i>	Formulary	PDL Preferred
<i>morphine sulf er 30 mg tablet inner</i>	Formulary	PDL Preferred
<i>morphine sulf er 30 mg tablet outer</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>morphine sulf er 60 mg tablet</i>	Formulary	PDL Preferred
<i>morphine sulf er 60 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>morphine sulf er 60 mg tablet f/c</i>	Formulary	PDL Preferred
<i>morphine sulf er 60 mg tablet inner</i>	Formulary	PDL Preferred
<i>morphine sulfate er 10 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 100 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 120 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 20 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 30 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 45 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 50 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 60 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 75 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 80 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate er 90 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>morphine sulfate ir 15 mg tab</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days)
<i>morphine sulfate ir 15 mg tab outer</i>	Formulary	PDL Preferred; QL (180 tablets per 30 days)
<i>morphine sulfate ir 30 mg tab</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>morphine sulfate ir 30 mg tab outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>morphine sulfate ir 30 mg tab u-d 4x25, blister</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
MS CONTIN ER 100 MG TABLET	Formulary	PA; PDL Non-Preferred
MS CONTIN ER 15 MG TABLET	Formulary	PA; PDL Non-Preferred
MS CONTIN ER 200 MG TABLET	Formulary	PA; PDL Non-Preferred
MS CONTIN ER 30 MG TABLET	Formulary	PA; PDL Non-Preferred
MS CONTIN ER 60 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>oxycodone hcl (ir) 10 mg tab</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 10 mg tab outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 15 mg tab</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 15 mg tab inner</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)

Medications	Coverage Level	Restrictions
<i>oxycodone hcl (ir) 15 mg tab outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 15 mg tab u-d, 10x10, outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 20 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 30 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
<i>oxycodone hcl (ir) 30 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
<i>oxycodone hcl (ir) 30 mg tab u-d, 10x10, outer</i>	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
<i>oxycodone hcl (ir) 5 mg cap</i>	Formulary	PA; PDL Non-Preferred; QL (90 capsules per 30 days)
<i>oxycodone hcl (ir) 5 mg tablet</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 5 mg tablet 10x10, outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 5 mg tablet inner</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl (ir) 5 mg tablet u-d, 10x10, outer</i>	Formulary	PDL Preferred; QL (90 tablets per 30 days)
<i>oxycodone hcl 100 mg/5 ml conc</i>	Formulary	PA; PDL Non-Preferred; QL (90 ML per 30 days)
<i>oxycodone hcl 5 mg/5 ml soln</i>	Formulary	PDL Preferred; QL (8 ML per 1 day)
<i>oxycodone hcl 5 mg/5 ml soln w/calibrated cup</i>	Formulary	PDL Preferred; QL (8 ML per 1 day)
<i>oxycodone hcl 5 mg/5 ml solution cup inner</i>	Formulary	PDL Preferred; QL (8 ML per 1 day)
<i>oxycodone hcl 5 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred; QL (8 ML per 1 day)
<i>oxycodone hcl er 10 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 tablets per 1 day)
<i>oxycodone hcl er 20 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (3 tablets per 1 day)
<i>oxycodone hcl er 40 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (45 tablets per 30 days)

Medications	Coverage Level	Restrictions
<i>oxycodone hcl er 80 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (22 tablets per 30 days)
OXYCONTIN ER 10 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (6 tablets per 1 day)
OXYCONTIN ER 10 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (6 tablets per 1 day)
OXYCONTIN ER 15 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (4 tablets per 1 day)
OXYCONTIN ER 15 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (4 tablets per 1 day)
OXYCONTIN ER 20 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (3 tablets per 1 day)
OXYCONTIN ER 20 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (3 tablets per 1 day)
OXYCONTIN ER 30 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (2 tablets per 1 day)
OXYCONTIN ER 30 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (2 tablets per 1 day)
OXYCONTIN ER 40 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (45 tablets per 30 days)
OXYCONTIN ER 40 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (45 tablets per 30 days)
OXYCONTIN ER 60 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (1 tablet per 1 day)
OXYCONTIN ER 60 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (1 tablet per 1 day)
OXYCONTIN ER 80 MG TABLET 2X10, U-D	Formulary	PDL Preferred; QL (22 tablets per 30 days)
OXYCONTIN ER 80 MG TABLET REFORMULATED	Formulary	PDL Preferred; QL (22 tablets per 30 days)
<i>oxymorphone hcl 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (90 tablets per 30 days)
<i>oxymorphone hcl 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
<i>oxymorphone hcl er 10 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>oxymorphone hcl er 15 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>oxymorphone hcl er 20 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>oxymorphone hcl er 30 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>oxymorphone hcl er 40 mg tab</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>oxymorphone hcl er 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>oxymorphone hcl er 7.5 mg tab</i>	Formulary	PA; PDL Non-Preferred
ROXICODONE 15 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (90 tablets per 30 days)
ROXICODONE 30 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
ROXYBOND 10 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 day)
ROXYBOND 15 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 day)
ROXYBOND 30 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day)
ROXYBOND 5 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 day)
<i>tramadol er 100 mg tablet coated</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol er 200 mg tablet coated</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol er 300 mg tablet coated</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 100 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 25 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 25 mg/5 ml cup outer</i>	Formulary	PA; PDL Non-Preferred; QL (80 ML per 1 day); Age Limit (Min 12 Years)
<i>tramadol hcl 5 mg/ml solution</i>	Formulary	PA; PDL Non-Preferred; QL (80 ML per 1 day); Age Limit (Min 12 Years)
<i>tramadol hcl 50 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 50 mg tablet flc</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 50 mg tablet outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl 75 mg tablet</i>	Formulary	PDL Preferred
<i>tramadol hcl er 100 mg capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl er 100 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
<i>tramadol hcl er 100 mg tablet coated</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl er 200 mg capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl er 200 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl er 300 mg capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>tramadol hcl er 300 mg tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>Analgesic Opioid Codeine Combinations</i>		
<i>acetaminophen-cod #2 tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-cod #3 tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-cod #3 tablet 10x10, outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-cod #3 tablet inner</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-cod #4 tablet</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-codeine 120 mg-12 mg/5 ml solution</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-codeine 120-12 mg/5 ml cup outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>acetaminophen-codeine 300-30 mg/12.5 ml cup outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>asa-butalb-caff-cod #3 capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
ASCOMP WITH CODEINE CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>butalbital-acetaminophen-caffeine-codeine 50-300-40-30 mg cp</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>butalbital-acetaminophen-caffeine-codeine 50-325-40-30 mg cp</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
FIORICET-COD 50-300-40-30 CAP	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
<i>Analgesic Opioid Dihydrocodeine Combinations</i>		
<i>acetaminophen-caffeine-dihydrocodeine 320.5-30-16 mg capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
Analgesic Opioid Dihydrocodeine, Non-Salicylate Analgesic, Xanthine		
<i>acetaminophen-caffeine-dihydrocodeine 320.5-30-16 mg capsule</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
Analgesic Opioid Hydrocodone And Non-Salicylate Combinations		
<i>hydrocodone-acetaminophen 10 mg-325 mg/15 ml solution</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 2.5 mg-108 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 2.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5 mg-217 mg/10 ml solution cup outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg/15 ml solution</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg/15 ml solution cup outer</i>	Formulary	PDL Preferred
Analgesic Opioid Hydrocodone And Nsaid Combinations		
<i>hydrocodone-ibuprofen 10-200</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone-ibuprofen 5-200 mg</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone-ibuprofen 7.5-200</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>Analgesic Opioid Hydrocodone Combinations</i>		
<i>hydrocodone-acetaminophen 10 mg-325 mg/15 ml solution</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 10-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 2.5 mg-108 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 2.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5 mg-217 mg/10 ml solution cup outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-300 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg/15 ml solution</i>	Formulary	PDL Preferred
<i>hydrocodone-acetaminophen 7.5-325 mg/15 ml solution cup outer</i>	Formulary	PDL Preferred
<i>hydrocodone-ibuprofen 10-200</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone-ibuprofen 5-200 mg</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocodone-ibuprofen 7.5-200</i>	Formulary	PA; PDL Non-Preferred
<i>Analgesic Opioid Oxycodone And Non-Salicylate Combinations</i>		
ENDOCET 10-325 MG TABLET	Formulary	PDL Preferred
ENDOCET 2.5-325 MG TABLET	Formulary	PDL Preferred
ENDOCET 5-325 MG TABLET	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
ENDOCET 7.5-325 MG TABLET	Formulary	PDL Preferred
NALOCET 2.5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>oxycodone-acetaminophen 10-325 mg tab</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 2.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg/5 ml solution</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet outer</i>	Formulary	PDL Preferred
PERCOCET 10-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PERCOCET 2.5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PERCOCET 5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PERCOCET 7.5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PROLATE 10 MG-300 MG/5 ML SOLN	Formulary	PA; PDL Non-Preferred
PROLATE 10-300 MG TABLET	Formulary	PA; PDL Non-Preferred
PROLATE 5-300 MG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
PROLATE 7.5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
Analgesic Opioid Oxycodone Combinations		
ENDOCET 10-325 MG TABLET	Formulary	PDL Preferred
ENDOCET 2.5-325 MG TABLET	Formulary	PDL Preferred
ENDOCET 5-325 MG TABLET	Formulary	PDL Preferred
ENDOCET 7.5-325 MG TABLET	Formulary	PDL Preferred
NALOCET 2.5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>oxycodone-acetaminophen 10-325 mg tab</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tab outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 10-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 2.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tab outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 5-325 mg/5 ml solution</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet 10x10, outer</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet inner</i>	Formulary	PDL Preferred
<i>oxycodone-acetaminophen 7.5-325 mg tablet outer</i>	Formulary	PDL Preferred
PERCOCET 10-325 MG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
PERCOCET 2.5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PERCOCET 5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PERCOCET 7.5-325 MG TABLET	Formulary	PA; PDL Non-Preferred
PROLATE 10 MG-300 MG/5 ML SOLN	Formulary	PA; PDL Non-Preferred
PROLATE 10-300 MG TABLET	Formulary	PA; PDL Non-Preferred
PROLATE 5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
PROLATE 7.5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Analgesic Opioid Partial-Mixed Agonists</i>		
BELBUCA 150 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 150 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 300 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 300 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 450 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 450 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 600 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 600 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 75 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 75 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 750 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 750 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
BELBUCA 900 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)
BELBUCA 900 MCG FILM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 films per 30 days)
<i>buprenorphine 10 mcg/hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)

Medications	Coverage Level	Restrictions
<i>buprenorphine 10 mcg/hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 15 mcg/hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 15 mcg/hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 20 mcg/hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 20 mcg/hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 5 mcg/hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 5 mcg/hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 7.5 mcg/hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>buprenorphine 7.5 mcg/hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
<i>butorphanol 10 mg/ml spray</i>	Formulary	PA; PDL Non-Preferred; QL (15 ML per 30 days)
<i>butorphanol injection</i>	Non-Formulary	
BUTRANS 10 MCG/HR PATCH	Formulary	PDL Preferred; QL (6 patches per 28 days)
BUTRANS 15 MCG/HR PATCH	Formulary	PDL Preferred; QL (6 patches per 28 days)
BUTRANS 20 MCG/HR PATCH	Formulary	PDL Preferred; QL (6 patches per 28 days)
BUTRANS 5 MCG/HR PATCH	Formulary	PDL Preferred; QL (6 patches per 28 days)
BUTRANS 7.5 MCG/HR PATCH	Formulary	PDL Preferred; QL (6 patches per 28 days)
<i>nalbuphine</i>	Non-Formulary	
<i>pentazocine-naloxone tablet</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>Analgesic Opioid Tramadol And Non-Salicylate Combinations</i>		
<i>tramadol-acetaminophen 37.5-325 mg tab</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol-acetaminophen 37.5-325 mg tab f/c</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol-acetaminophen 37.5-325 mg tab outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>Analgesic Opioid Tramadol And Nsaid Combinations</i>		
SEGLENTIS 56 MG-44 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days); Age Limit (Min 12 Years)
<i>Analgesic Opioid Tramadol Combinations</i>		
<i>tramadol-acetaminophen 37.5-325 mg tab</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol-acetaminophen 37.5-325 mg tab f/c</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>tramadol-acetaminophen 37.5-325 mg tab outer</i>	Formulary	PDL Preferred; Age Limit (Min 12 Years)
<i>Analgesic Or Antipyretic Non-Opioid Combinations Other</i>		
TENSION HEADACHE	Non-Formulary	Dual Eligible Covered; OTC
<i>Analgesic Or Antipyretic Non-Opioid/Sedative Combinations</i>		
<i>butalb-acetaminophen-caff 50-325-40 tab</i>	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen 50-325 mg tab</i>	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen oral capsule</i>	Non-Formulary	
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	Non-Formulary	
<i>butalbital-acetaminophen-caff oral capsule</i>	Non-Formulary	
<i>butalbital-acetaminophen-caffeine 50-325-40 mg tablet</i>	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
<i>butalbital-acetaminophen-caffeine 50-325-40 mg tablet outer</i>	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)

Medications	Coverage Level	Restrictions
ESGIC 50-325-40 MG TABLET	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
FIORICET	Non-Formulary	
HISTAFLEX	Non-Formulary	OTC
MENSTRUAL RELIEF(PAMABR-PYRIL)	Non-Formulary	OTC
<i>Analgesic Or Antipyretic Non-Opioid</i>		
8 HOUR ACETAMINOPHEN ER 650 MG	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 120 mg suppos</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 120 mg suppos outer</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 160 mg/5 ml liq</i>	Formulary	OTC
<i>acetaminophen 160 mg/5 ml soln</i>	Formulary	OTC
<i>acetaminophen 160 mg/5 ml solution cup outer</i>	Formulary	OTC
<i>acetaminophen 160 mg/5 ml solution cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 160 mg/5 ml suspension cup inner</i>	Formulary	OTC
<i>acetaminophen 160 mg/5 ml suspension cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 325 mg gelcap</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 325 mg tablet</i>	Formulary	OTC
<i>acetaminophen 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 325 mg tablet u-d,10x10,asa-free</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg caplet</i>	Formulary	OTC
<i>acetaminophen 500 mg caplet</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg caplet caplet,ex-strength</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg gelcap</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg tablet asa-free,ex-str</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 500 mg tablet aspirin free,uld</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 650 mg suppos</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen 650 mg suppos outer</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen er 650 mg caplet</i>	Formulary	OTC
<i>acetaminophen er 650 mg caplet</i>	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
<i>acetaminophen er 650 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen er 650 mg tablet outer</i>	Formulary	Dual Eligible Covered; OTC
<i>acetaminophen oral solution 325 mg/10.15 ml, 650 mg/20.3 ml</i>	Non-Formulary	OTC
<i>acetaminophen oral suspension 325 mg/10.15 ml, 650 mg/20.3 ml</i>	Non-Formulary	OTC
<i>acetaminophen oral syringe</i>	Non-Formulary	OTC
<i>acetaminophen oral tablet, chewable 160 mg</i>	Non-Formulary	OTC
ARTHRITIS PAIN ER 650 MG CAPLT	Formulary	Dual Eligible Covered; OTC
ARTHRITIS PAIN ER 650 MG TAB OUTER	Formulary	Dual Eligible Covered; OTC
CHILD PAIN-FEVER 160 MG/5 ML	Formulary	OTC
CHILD PAIN-FEVER 160 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHILD PAIN-FEVER 160 MG/5 ML AS, IBU/F	Formulary	Dual Eligible Covered; OTC
CHILD PAIN-FEVER 160 MG/5 ML GLUTEN/F, CHERRY	Formulary	Dual Eligible Covered; OTC
CHILD PAIN-FEVER 160 MG/5 ML GLUTEN-F, GRAPE	Formulary	Dual Eligible Covered; OTC
CHILDREN'S ACETAMINOPHEN ORAL TABLET, CHEWABLE 160 MG	Non-Formulary	OTC
CHILDREN'S MAPAP 80 MG TAB CHW	Formulary	Dual Eligible Covered; OTC
CHILD'S PAIN RELIEVER SUSP CHILDREN'S	Formulary	Dual Eligible Covered; OTC
CHLD ACETAMINOPHEN 160 MG/5 ML	Formulary	OTC
CHLD ACETAMINOPHEN 160 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHLD ACETAMINOPHEN 160 MG/5 ML CUP	Formulary	OTC
CHLD ACETAMINOPHEN 160 MG/5 ML CUP INNER	Formulary	OTC
CHLD ACETAMINOPHEN 160 MG/5 ML CUP OUTER	Formulary	OTC
CHLD ACETAMINOPHEN 160 MG/5 ML CUP OUTER	Formulary	Dual Eligible Covered; OTC
CHLD ACETAMINOPHEN 160 MG/5 ML GLUTEN/F, GRAPE	Formulary	Dual Eligible Covered; OTC
CHLD ACETAMINOPHEN 160 MG/5 ML GLUTEN/F, CHERRY	Formulary	Dual Eligible Covered; OTC
ED-APAP 160 MG/5 ML LIQUID	Formulary	Dual Eligible Covered; OTC
FEVERALL 120 MG SUPPOSITORY CHILDRENS, OUTER	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
FEVERALL 120 MG SUPPOSITORY CHILDREN'S, OUTER	Formulary	Dual Eligible Covered; OTC
FEVERALL 325 MG SUPPOSITORY JUNIOR STR, OUTER	Formulary	Dual Eligible Covered; OTC
FEVERALL 650 MG SUPPOSITORY ADULT, OUTER	Formulary	Dual Eligible Covered; OTC
FEVERALL RECTAL SUPPOSITORY 80 MG	Non-Formulary	Dual Eligible Covered; OTC
FT 8 HOUR PAIN RLF ER 650 MG	Formulary	OTC
FT ARTHRITIS PAIN ER 650 MG TB	Formulary	OTC
FT CHILD PAIN-FEVER 160 MG/5 ML	Formulary	OTC
FT INFANT PAIN-FEVER 160 MG/5	Formulary	OTC
FT PAIN RELIEF 325 MG TABLET	Formulary	OTC
FT PAIN RELIEF 500 MG CAPLET	Formulary	OTC
FT PAIN RELIEF 500 MG GELCAP	Formulary	OTC
FT PAIN RELIEF 500 MG TABLET	Formulary	OTC
FT PAIN RELIEVER 500 MG CAPLET	Formulary	OTC
GNP 8 HOUR PAIN RELIEF 650 MG	Formulary	Dual Eligible Covered; OTC
GNP PAIN RELIEF 500 MG CAPLET	Formulary	Dual Eligible Covered; OTC
GNP PAIN RELIEF 500 MG CAPLET	Formulary	Dual Eligible Covered; OTC
GNP PAIN RELIEF 500 MG GELCAP	Formulary	Dual Eligible Covered; OTC
GS ARTHRITIS PAIN ER 650 MG	Formulary	Dual Eligible Covered; OTC
GS CHILD FEVER-PAIN 160 MG/5 ML	Formulary	Dual Eligible Covered; OTC
GS CHILD PAIN-FEVER 160 MG/5 ML	Formulary	Dual Eligible Covered; OTC
GS INFANT PAIN-FEVER 160 MG/5	Formulary	OTC
GS INFANT PAIN-FEVER 160 MG/5	Formulary	Dual Eligible Covered; OTC
GS PAIN RELIEF 325 MG TABLET	Formulary	Dual Eligible Covered; OTC
GS PAIN RELIEF 500 MG CAPLET	Formulary	OTC
GS PAIN RELIEF 500 MG CAPLET	Formulary	Dual Eligible Covered; OTC
GS PAIN RELIEF 500 MG TABLET	Formulary	Dual Eligible Covered; OTC
HM PAIN RELIEVER 325 MG TABLET REGULAR STRENGTH	Formulary	Dual Eligible Covered; OTC
INFANT PAIN-FEVER 160 MG/5 ML	Formulary	OTC
INFANT PAIN-FEVER 160 MG/5 ML	Formulary	Dual Eligible Covered; OTC
INFANT PAIN-FEVER 160 MG/5 ML W/SYRINGE, CHERRY	Formulary	Dual Eligible Covered; OTC
INFANT PAIN-FEVER 160 MG/5 ML W/SYRINGE, GRAPE	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
MAPAP (ACETAMINOPHEN) ORAL LIQUID	Non-Formulary	OTC
MAPAP 500 MG CAPSULE	Formulary	Dual Eligible Covered; OTC
M-PAP 160 MG/5 ML LIQUID	Formulary	OTC
M-PAP 160 MG/5 ML LIQUID	Formulary	Dual Eligible Covered; OTC
PAIN RELIEF 325 MG TABLET	Formulary	Dual Eligible Covered; OTC
PAIN RELIEF 500 MG CAPLET	Formulary	OTC
PAIN RELIEVER 325 MG TABLET REGULAR STRENGTH	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 325 MG TABLET	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 500 MG CAPLET	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 500 MG CAPLET CAPLET, EXTRA STR	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 500 MG CAPLET CAPLET, EXTRA STR	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 500 MG TABLET	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER 500 MG TABLET EXTRA STRENGTH	Formulary	Dual Eligible Covered; OTC
SM PAIN RELIEVER ER 650 MG	Formulary	OTC
<i>Anti-Inflammatory - Complement (C5) Receptor Inhibitors</i>		
TAVNEOS	State Carve Out	
<i>Anti-Inflammatory - Interleukin-1 Beta Blockers</i>		
ILARIS (PF)	State Carve Out	
<i>Anti-Inflammatory - Interleukin-1 Receptor Antagonist</i>		
ARCALYST	State Carve Out	
<i>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts, Non-Selective</i>		
ENBREL 25 MG/0.5 ML SYRINGE INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 25 MG/0.5 ML SYRINGE OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 25 MG/0.5 ML VIAL INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 25 MG/0.5 ML VIAL OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML MINI CARTRIDGE INNER, P/F, SUV	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
ENBREL 50 MG/ML MINI CARTRIDGE OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SURECLICK INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SURECLICK OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SYRINGE INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SYRINGE OUTER, P/F, SUV	Formulary	PDL Preferred
<i>Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts, Tnf-Alpha Sel</i>		
ABRILADA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML (2 PACK) 2 PEN/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN CROHN'S-UC-HS 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN PSORIASIS-UV 40 MG/0.8 ML (4 PACK)	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ailbox, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 10 mg/0.1 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, plf, suv</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 10 mg/0.2 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 20 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.8 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.8 ml</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 10 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.2 ML SYRING	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR INNER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG VIAL KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML SYRINGE KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML(X3)START KT	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 10 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HADLIMA 40 MG/0.8 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
HADLIMA PUSHTOUCH 40 MG/0.8 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA(CF) 40 MG/0.4 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA(CF) PUSHTOUCH 40 MG/0.4 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
HUMIRA 40 MG/0.8 ML SYRINGE P/F, SUV	Formulary	PDL Preferred
HUMIRA PEN 40 MG/0.8 ML P/F, SUV	Formulary	PDL Preferred
HUMIRA(CF) 10 MG/0.1 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) 20 MG/0.2 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) 40 MG/0.4 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) PEN 40 MG/0.4 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN 80 MG/0.8 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PS-UV-ADOL HS START 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PDL Preferred
HYRIMOZ	Non-Formulary	
HYRIMOZ PEN	Non-Formulary	
HYRIMOZ(CF) 10 MG/0.1 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) 20 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) 40 MG/0.4 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEDIATRIC CROHNS START 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
HYRIMOZ(CF) PEN 40 MG/0.4 ML P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN CROHNS- ULCERATIVE COLITIS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN PSORIASIS STARTER 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
IDACIO(CF) 40 MG/0.8 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN 40 MG/0.8 ML (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN CROHN'S-UC START 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN PLAQUE PSORIASIS STARTER 40 MG/0.8 ML (4PK)	Formulary	PA; PDL Non-Preferred
INFLECTRA	Non-Formulary	
RENFLEXIS	Non-Formulary	
SIMLANDI(CF) 20 MG/0.2 ML SYRINGE SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 80 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 80 MG/0.8 ML SYRINGE SUV,P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML PEN INJECTOR	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
SIMPONI 50 MG/0.5 ML PEN INJEC	Formulary	PA; PDL Non-Preferred
SIMPONI 50 MG/0.5 ML SYRINGE	Formulary	PA; PDL Non-Preferred
SIMPONI ARIA 50 MG/4 ML VIAL	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 20 MG/0.2 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR (2 PACK) 2 AI/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
YUFLYMA(CF) 80 MG/0.8 ML AUTOINJECTOR	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) AUTOINJECTOR CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
YUSIMRY(CF) 40 MG/0.8 ML PEN	Formulary	PA; PDL Non-Preferred
ZYMFENTRA 120 MG/ML PEN KIT (2 PACK) 2 PEN/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZYMFENTRA 120 MG/ML PEN KIT SUV, P/F	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZYMFENTRA 120 MG/ML SYRINGE KIT (2 PACK)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
<i>Dmard - Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents</i>		
ABRILADA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML (2 PACK) 2 PEN/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN CROHN'S-UC-HS 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN PSORIASIS-UV 40 MG/0.8 ML (4 PACK)	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ailbox, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 10 mg/0.1 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, plf, suv</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 10 mg/0.2 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 20 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.8 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.8 ml</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 10 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR INNER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG VIAL KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML SYRINGE KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML(X3)START KT	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 10 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ENBREL 25 MG/0.5 ML SYRINGE INNER, P/F, SUV	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
ENBREL 25 MG/0.5 ML SYRINGE OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 25 MG/0.5 ML VIAL INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 25 MG/0.5 ML VIAL OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML MINI CARTRIDGE INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML MINI CARTRIDGE OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SURECLICK INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SURECLICK OUTER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SYRINGE INNER, P/F, SUV	Formulary	PDL Preferred
ENBREL 50 MG/ML SYRINGE OUTER, P/F, SUV	Formulary	PDL Preferred
HADLIMA 40 MG/0.8 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA PUSHTOUCH 40 MG/0.8 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA(CF) 40 MG/0.4 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA(CF) PUSHTOUCH 40 MG/0.4 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
HUMIRA 40 MG/0.8 ML SYRINGE P/F, SUV	Formulary	PDL Preferred
HUMIRA PEN 40 MG/0.8 ML P/F, SUV	Formulary	PDL Preferred
HUMIRA(CF) 10 MG/0.1 ML SYRINGE	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
HUMIRA(CF) 20 MG/0.2 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) 40 MG/0.4 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) PEN 40 MG/0.4 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN 80 MG/0.8 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PS-UV-ADOL HS START 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PDL Preferred
HYRIMOZ	Non-Formulary	
HYRIMOZ PEN	Non-Formulary	
HYRIMOZ(CF) 10 MG/0.1 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) 20 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) 40 MG/0.4 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN 40 MG/0.4 ML P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN CROHNS-ULCERATIVE COLITIS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN PSORIASIS STARTER 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
IDACIO(CF) 40 MG/0.8 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN 40 MG/0.8 ML (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN CROHN'S-UC START 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN PLAQUE PSORIASIS STARTER 40 MG/0.8 ML (4PK)	Formulary	PA; PDL Non-Preferred
INFLECTRA	Non-Formulary	
RENFLEXIS	Non-Formulary	
SIMLANDI(CF) 20 MG/0.2 ML SYRINGE SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
SIMLANDI(CF) 80 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 80 MG/0.8 ML SYRINGE SUV,P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML PEN INJECTOR	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
SIMPONI 50 MG/0.5 ML PEN INJEC	Formulary	PA; PDL Non-Preferred
SIMPONI 50 MG/0.5 ML SYRINGE	Formulary	PA; PDL Non-Preferred
SIMPONI ARIA 50 MG/4 ML VIAL	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 20 MG/0.2 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR (2 PACK) 2 AI/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 80 MG/0.8 ML AUTOINJECTOR	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) AUTOINJECTOR CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
YUSIMRY(CF) 40 MG/0.8 ML PEN	Formulary	PA; PDL Non-Preferred
<i>Dmard - Antimalarials</i>		
<i>hydroxychloroquine 100 mg tab</i>	Formulary	
<i>hydroxychloroquine 200 mg tab</i>	Formulary	
<i>hydroxychloroquine 200 mg tab f/c</i>	Formulary	
<i>hydroxychloroquine 200 mg tab outer</i>	Formulary	
<i>hydroxychloroquine 200 mg tab u-d,10x10,outer</i>	Formulary	
<i>hydroxychloroquine 300 mg tab</i>	Formulary	
<i>hydroxychloroquine 400 mg tab</i>	Formulary	
SOVUNA	Non-Formulary	
<i>Dmard - Antimetabolites</i>		
JYLAMVO 2 MG/ML ORAL SOLUTION	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f, suv</i>	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f,sdv</i>	Formulary	
<i>methotrexate 2.5 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>methotrexate 2.5 mg tablet outer</i>	Formulary	
<i>methotrexate 2.5 mg tablet u-d, 10x10, blisters</i>	Formulary	
<i>methotrexate 2.5 mg tablet u-d, 2x10, outer</i>	Formulary	
<i>methotrexate 25 mg/ml vial p/f</i>	Formulary	
<i>methotrexate 250 mg/10 ml vial</i>	Formulary	
<i>methotrexate 250 mg/10 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial outer</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial outer, p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial p/f, suv</i>	Formulary	
OTREXUP (PF)	Non-Formulary	
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	Non-Formulary	
TREXALL 10 MG TABLET	Formulary	
TREXALL 15 MG TABLET	Formulary	
TREXALL 5 MG TABLET	Formulary	
TREXALL 7.5 MG TABLET	Formulary	
XATMEP 2.5 MG/ML ORAL SOLUTION	Formulary	
<i>Dmard - Antinflammatory, Select. Costimulation Modulator, T-Cell Inhib.</i>		
ORENCIA (WITH MALTOSE)	Non-Formulary	
ORENCIA 125 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
ORENCIA 50 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ORENCIA 87.5 MG/0.7 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ORENCIA CLICKJECT 125 MG/ML SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>Dmard - B Cell Targeted Agents</i>		
RUXIENCE	Non-Formulary	
<i>Dmard - Gold Compounds</i>		
RIDAURA	Non-Formulary	
<i>Dmard - Immunosuppressives</i>		
AZASAN 100 MG TABLET	Formulary	
AZASAN 75 MG TABLET	Formulary	
<i>azathioprine 100 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>azathioprine 50 mg tablet</i>	Formulary	
<i>azathioprine 50 mg tablet outer</i>	Formulary	
<i>azathioprine 75 mg tablet</i>	Formulary	
<i>azathioprine sodium</i>	Non-Formulary	
CELLCEPT 200 MG/ML ORAL SUSP	Formulary	
CELLCEPT 250 MG CAPSULE	Formulary	
CELLCEPT 500 MG TABLET F/C	Formulary	
<i>cyclophosphamide 25 mg capsule</i>	Formulary	
<i>cyclophosphamide 50 mg capsule</i>	Formulary	
<i>cyclophosphamide 50 mg tablet outer</i>	Formulary	
<i>cyclosporine 100 mg capsule</i>	Formulary	
<i>cyclosporine 100 mg capsule outer</i>	Formulary	
<i>cyclosporine 25 mg capsule</i>	Formulary	
<i>cyclosporine 25 mg capsule outer</i>	Formulary	
<i>cyclosporine modified 100 mg</i>	Formulary	
<i>cyclosporine modified 100 mg outer</i>	Formulary	
<i>cyclosporine modified 100 mg softgel,outer</i>	Formulary	
<i>cyclosporine modified 100 mg/ml</i>	Formulary	
<i>cyclosporine modified 25 mg</i>	Formulary	
<i>cyclosporine modified 25 mg outer</i>	Formulary	
<i>cyclosporine modified 25 mg outer, softgel</i>	Formulary	
<i>cyclosporine modified 50 mg</i>	Formulary	
<i>cyclosporine modified 50 mg outer</i>	Formulary	
GENGRAF 100 MG CAPSULE	Formulary	
GENGRAF 100 MG/ML SOLUTION	Formulary	
GENGRAF 25 MG CAPSULE	Formulary	
IMURAN 50 MG TABLET	Formulary	
<i>mycophenolate 200 mg/ml susp</i>	Formulary	
<i>mycophenolate 250 mg capsule</i>	Formulary	
<i>mycophenolate 250 mg capsule outer</i>	Formulary	
<i>mycophenolate 250 mg capsule u-d,10x10,outer</i>	Formulary	
<i>mycophenolate 500 mg tablet</i>	Formulary	
<i>mycophenolate 500 mg tablet f/c</i>	Formulary	
<i>mycophenolate 500 mg tablet outer</i>	Formulary	
<i>mycophenolate 500 mg tablet u-d,10x10,outer,f/c</i>	Formulary	

Medications	Coverage Level	Restrictions
NEORAL 100 MG GELATIN CAPSULE INNER, U-D	Formulary	
NEORAL 100 MG GELATIN CAPSULE OUTER, U-D	Formulary	
NEORAL 100 MG/ML SOLUTION	Formulary	
NEORAL 25 MG GELATIN CAPSULE INNER, U-D	Formulary	
NEORAL 25 MG GELATIN CAPSULE OUTER, U-D	Formulary	
SANDIMMUNE 100 MG CAPSULE U-D, SANDOPAK, OUTER	Formulary	
SANDIMMUNE 100 MG CAPSULE U-D, INNER	Formulary	
SANDIMMUNE 100 MG/ML SOLN	Formulary	
SANDIMMUNE 25 MG CAPSULE U-D, SANDOPAK, OUTER	Formulary	
SANDIMMUNE 25 MG CAPSULE U-D, INNER	Formulary	
<i>Dmard - Interleukin-1 Receptor Antagonist (Il-1Ra)</i>		
KINERET	State Carve Out	
<i>Dmard - Interleukin-6 (Il-6) Receptor Inhibitors, Monoclonal Antibody</i>		
ACTEMRA 162 MG/0.9 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred
ACTEMRA ACTPEN 162 MG/0.9 ML	Formulary	PA; PDL Non-Preferred
ACTEMRA INTRAVENOUS	Non-Formulary	
KEVZARA 150 MG/1.14 ML PEN INJ	Formulary	PA; PDL Non-Preferred
KEVZARA 150 MG/1.14 ML SYRINGE	Formulary	PA; PDL Non-Preferred
KEVZARA 200 MG/1.14 ML PEN INJ	Formulary	PA; PDL Non-Preferred
KEVZARA 200 MG/1.14 ML SYRINGE	Formulary	PA; PDL Non-Preferred
TYENNE 162 MG/0.9 ML AUTOINJCT	Formulary	PA; PDL Non-Preferred
TYENNE 162 MG/0.9 ML SYRINGE	Formulary	PA; PDL Non-Preferred
<i>Dmard - Janus Kinase (Jak) Inhibitors</i>		
OLUMIANT 1 MG TABLET	Formulary	PA; PDL Non-Preferred
OLUMIANT 2 MG TABLET	Formulary	PA; PDL Non-Preferred
OLUMIANT 4 MG TABLET	Formulary	PA; PDL Non-Preferred
RINVOQ ER 15 MG TABLET	Formulary	PA; PDL Non-Preferred
RINVOQ ER 30 MG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
RINVOQ ER 45 MG TABLET	Formulary	PA; PDL Non-Preferred
RINVOQ LQ 1 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred
XELJANZ 1 MG/ML SOLUTION OUTER	Formulary	PA; PDL Non-Preferred
XELJANZ 5 MG TABLET	Formulary	PA; PDL Non-Preferred
XELJANZ XR 11 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Dmard - Other</i>		
AZULFIDINE 500 MG TABLET	Formulary	PA; PDL Non-Preferred
AZULFIDINE ENTAB 500 MG	Formulary	PA; PDL Non-Preferred
CUPRIMINE	Non-Formulary	
DEPEN TITRATABS	Non-Formulary	
<i>minocycline 100 mg capsule</i>	Formulary	
<i>minocycline 100 mg capsule outer</i>	Formulary	
<i>minocycline 50 mg capsule</i>	Formulary	
<i>minocycline 75 mg capsule</i>	Formulary	
<i>minocycline oral tablet</i>	Non-Formulary	
<i>penicillamine</i>	Non-Formulary	
<i>sulfasalazine 500 mg tablet</i>	Formulary	PDL Preferred
<i>sulfasalazine dr 500 mg tab</i>	Formulary	PDL Preferred
<i>Dmard - Phosphodiesterase-4 (Pde4) Inhibitors</i>		
OTEZLA 10-20 MG STARTER 28 DAY	Formulary	PA; PDL Non-Preferred
OTEZLA 10-20-30 MG START 28 DAY	Formulary	PA; PDL Non-Preferred
OTEZLA 20 MG TABLET	Formulary	PA; PDL Non-Preferred
OTEZLA 30 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Dmard - Pyrimidine Synthesis Inhibitors</i>		
ARAVA	Non-Formulary	
<i>leflunomide 10 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>leflunomide 10 mg tablet outer</i>	Formulary	QL (1 tablet per 1 day)
<i>leflunomide 20 mg tablet</i>	Formulary	
<i>leflunomide 20 mg tablet outer</i>	Formulary	
<i>Immunomodulator - Rho Kinase Inhibitor</i>		
REZUROCK 200 MG TABLET	Formulary	
<i>Immunomodulator B-Lymphocyte Stimulator (Blys)-Specific Inhibitor Mcab</i>		
BENLYSTA SUBCUTANEOUS	Non-Formulary	

Medications	Coverage Level	Restrictions
Nsaid Analgesic And Histamine H2 Receptor Antagonist Combinations		
<i>ibuprofen-famotidin 800-26.6 mg</i>	Formulary	PA; PDL Non-Preferred
Nsaid Analgesic And Non-Salicylate Analgesic Combination		
<i>acetaminophen-ibuprofen 250-125 mg caplet</i>	Formulary	PA; PDL Non-Preferred; OTC
DUAL ACTION PAIN 250-125 MG	Formulary	PA; PDL Non-Preferred; OTC
FT DUAL ACTION PAIN 250-125 MG	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp acetaminophen-ibuprofen 250-125 mg tablet</i>	Formulary	PA; PDL Non-Preferred; OTC
GS DUAL ACTION PAIN 250-125 MG	Formulary	PA; PDL Non-Preferred; OTC
Nsaid Analgesic And Prostaglandin Analog Combinations		
ARTHROTEC 50 MG-200 MCG TAB F/C	Formulary	PA; PDL Non-Preferred
ARTHROTEC 75 MG-200 MCG TAB F/C	Formulary	PA; PDL Non-Preferred
<i>diclofenac-misoprostol dr 50-0.2 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac-misoprostol dr 75-0.2 mg tablet</i>	Formulary	PA; PDL Non-Preferred
Nsaid Analgesic And Proton Pump Inhibitor Combinations		
<i>naproxen-esomepraz dr 375-20 mg</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen-esomepraz dr 500-20 mg</i>	Formulary	PA; PDL Non-Preferred
VIMOVO DR 500-20 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
Nsaid Analgesic, Cyclooxygenase-2 (Cox-2) Selective Inhibitors		
CELEBREX 100 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day)
CELEBREX 100 MG CAPSULE OUTER	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day)
CELEBREX 100 MG CAPSULE U-D,BLISTER PK	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day)
CELEBREX 200 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day)
CELEBREX 400 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (1 capsule per 1 day)
CELEBREX 400 MG CAPSULE OUTER	Formulary	PA; PDL Non-Preferred; QL (1 capsule per 1 day)
CELEBREX 50 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day)
<i>celecoxib 100 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)

Medications	Coverage Level	Restrictions
<i>celecoxib 100 mg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>celecoxib 200 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>celecoxib 200 mg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>celecoxib 400 mg capsule</i>	Formulary	PDL Preferred; QL (1 capsule per 1 day)
<i>celecoxib 50 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>Nsaid Analgesics (Cox Non-Specific) - Anthranilic Acid Derivatives</i>		
<i>meclofenamate 100 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>meclofenamate 50 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>mefenamic acid 250 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>Nsaid Analgesics (Cox Non-Specific) - Other</i>		
<i>ketorolac 10 mg tablet</i>	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
<i>ketorolac 10 mg tablet f/c</i>	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
<i>ketorolac 10 mg tablet outer</i>	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	Non-Formulary	
<i>ketorolac injection syringe 30 mg/ml</i>	Non-Formulary	
<i>ketorolac intramuscular</i>	Non-Formulary	
<i>nabumetone 500 mg tablet</i>	Formulary	PDL Preferred
<i>nabumetone 500 mg tablet f/c</i>	Formulary	PDL Preferred
<i>nabumetone 500 mg tablet outer</i>	Formulary	PDL Preferred
<i>nabumetone 750 mg tablet</i>	Formulary	PDL Preferred
<i>nabumetone 750 mg tablet f/c</i>	Formulary	PDL Preferred
RELAFEN DS 1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>sulindac 150 mg tablet</i>	Formulary	PDL Preferred
<i>sulindac 200 mg tablet</i>	Formulary	PDL Preferred
TOLECTIN 600 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>tolmetin sodium 400 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>tolmetin sodium 600 mg tab</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>Nsaid Analgesics (Cox Non-Specific) - Oxicam Derivatives</i>		
FELDENE 10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>meloxicam 10 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>meloxicam 15 mg tablet</i>	Formulary	PDL Preferred
<i>meloxicam 15 mg tablet outer</i>	Formulary	PDL Preferred
<i>meloxicam 5 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>meloxicam 7.5 mg tablet</i>	Formulary	PDL Preferred
<i>meloxicam 7.5 mg tablet outer</i>	Formulary	PDL Preferred
<i>piroxicam 10 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>piroxicam 20 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>Nsaid Analgesics (Cox Non-Specific) - Phenylacetic Acid Derivatives</i>		
CAMBIA	Non-Formulary	
<i>diclofenac pot 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac pot 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac pot 50 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac potassium 25 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac potassium oral powder in packet</i>	Non-Formulary	
<i>diclofenac sod dr 25 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod dr 50 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod dr 75 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod dr 75 mg tab outer</i>	Formulary	PDL Preferred
<i>diclofenac sod ec 25 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod ec 50 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod ec 50 mg tab outer</i>	Formulary	PDL Preferred
<i>diclofenac sod ec 75 mg tab</i>	Formulary	PDL Preferred
<i>diclofenac sod er 100 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac sod er 100 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
LOFENA 25 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Nsaid Analgesics (Cox Non-Specific) - Propionic Acid Derivatives</i>		
ALL DAY PAIN RELIEF 220 MG TAB	Formulary	PDL Preferred; OTC
ALL DAY PAIN RELIEF 220 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALL DAY PAIN RLF 220 MG CAPLET	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
ALL DAY PAIN RLF 220 MG CAPLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALL DAY RELIEF 220 MG CAPLET	Formulary	PDL Preferred; OTC
ALL DAY RELIEF 220 MG CAPLET CAPLET, GLUTEN-FREE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALL DAY RELIEF 220 MG TABLET	Formulary	PDL Preferred; OTC
ALL DAY RELIEF 220 MG TABLET GLUTEN-FREE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML CUP OUTER	Formulary	PDL Preferred; OTC
CHILD IBUPROFEN 100 MG/5 ML SYRG	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML SYRG INNER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML SYRG OUTER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 200 MG/10 ML CUP OUTER	Formulary	PDL Preferred; OTC
CHILD IBUPROFEN 200 MG/10 ML CUP OUTER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; OTC
CHILDREN IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML BERRY FLAVOR	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP INNER, D/F	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP OUTER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP OUTER, D/F	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP U-D	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP U-D,100'S,HOSP USE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML CUP U-D,30'S,HOSP USE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML D/F	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML GLUTEN/F, BERRY	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
CHILDREN IBUPROFEN 100 MG/5 ML GLUTEN/F, GRAPE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML GLUTEN/F,BUBBLE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILDREN IBUPROFEN 100 MG/5 ML GRAPE	Formulary	PDL Preferred; Dual Eligible Covered; OTC
DAYPRO 600 MG CAPLET CAPLET, F/C	Formulary	PA; PDL Non-Preferred
<i>fenoprofen 400 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>fenoprofen 600 mg tablet</i>	Formulary	PA; PDL Non-Preferred
FENOPRON 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>flurbiprofen 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred
FT ALL DAY PAIN 220 MG CAPLET	Formulary	PDL Preferred; OTC
FT CHILD IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; OTC
<i>ft ibuprofen 200 mg caplet</i>	Formulary	PDL Preferred; OTC
<i>ft ibuprofen 200 mg mini sfgl</i>	Formulary	PDL Preferred; OTC
<i>ft ibuprofen 200 mg softgel</i>	Formulary	PDL Preferred; OTC
<i>ft ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; OTC
FT IBUPROFEN IB 100 MG CHEW TB	Formulary	PDL Preferred; OTC
FT INF IBUPROFEN 50 MG/1.25 ML	Formulary	PDL Preferred; OTC
<i>ft naproxen sodium 220 mg cap</i>	Formulary	PDL Preferred; OTC
FT PAIN RELIEF 200 MG TABLET	Formulary	PDL Preferred; OTC
<i>gnp ibuprofen 100 mg chew tab</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp ibuprofen 200 mg mini sfgl</i>	Formulary	PDL Preferred; OTC
<i>gnp ibuprofen 200 mg mini sfgl</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp ibuprofen 200 mg softgel</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp naproxen sod 220 mg caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp naproxen sod 220 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>gnp naproxen sod 220 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gs ibuprofen 100 mg chew tab</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
<i>gs ibuprofen 200 mg caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gs ibuprofen 200 mg liquid gel</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gs ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>gs ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS INF IBUPROFEN 50 MG/1.25 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gs naproxen sod 220 mg caplet</i>	Formulary	PDL Preferred; OTC
<i>gs naproxen sod 220 mg caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gs naproxen sod 220 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>gs naproxen sod 220 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
IBU 400 MG TABLET	Formulary	PDL Preferred
IBU 600 MG TABLET	Formulary	PDL Preferred
IBU 800 MG TABLET	Formulary	PDL Preferred
IBU-200 200 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 100 mg/5 ml susp (rx)</i>	Formulary	PDL Preferred; OTC
<i>ibuprofen 100 mg/5 ml susp (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 100 mg/5 ml susp cup outer (rx)</i>	Formulary	PDL Preferred; OTC
<i>ibuprofen 200 mg caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg caplet caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg caplet coated caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg capsule</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg softgel</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg tablet coated</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg tablet outer</i>	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>ibuprofen 200 mg/10 ml suspension cup 100's, u-d cups (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg/10 ml suspension cup 30's, u-d cups (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 200 mg/10 ml suspension cup outer (rx)</i>	Formulary	PDL Preferred; OTC
<i>ibuprofen 200 mg/10 ml suspension cup u-d (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ibuprofen 400 mg tablet</i>	Formulary	PDL Preferred
<i>ibuprofen 400 mg tablet f/c</i>	Formulary	PDL Preferred
<i>ibuprofen 400 mg tablet outer</i>	Formulary	PDL Preferred
<i>ibuprofen 600 mg tablet</i>	Formulary	PDL Preferred
<i>ibuprofen 600 mg tablet f/c</i>	Formulary	PDL Preferred
<i>ibuprofen 600 mg tablet outer</i>	Formulary	PDL Preferred
<i>ibuprofen 800 mg tablet</i>	Formulary	PDL Preferred
<i>ibuprofen 800 mg tablet f/c</i>	Formulary	PDL Preferred
<i>ibuprofen 800 mg tablet outer</i>	Formulary	PDL Preferred
IBUPROFEN JR STR 100 MG TB CHW	Formulary	PDL Preferred; Dual Eligible Covered; OTC
INFANT IBUPROFEN 50 MG/1.25 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
INFANT IBUPROFEN 50 MG/1.25 ML BERRY	Formulary	PDL Preferred; Dual Eligible Covered; OTC
INFANT IBUPROFEN 50 MG/1.25 ML D/F, NON-STAINING	Formulary	PDL Preferred; Dual Eligible Covered; OTC
INFANT IBUPROFEN 50 MG/1.25 ML GLUTEN/F, BERRY	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ketoprofen 50 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>ketoprofen 75 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>ketoprofen er 200 mg capsule</i>	Formulary	PA; PDL Non-Preferred
KIPROFEN 25 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NALFON 400 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NALFON 600 MG TABLET	Formulary	PA; PDL Non-Preferred
NAPRELAN CR 375 MG TABLET	Formulary	PA; PDL Non-Preferred
NAPRELAN CR 500 MG TABLET	Formulary	PA; PDL Non-Preferred
NAPRELAN CR 750 MG TABLET	Formulary	PA; PDL Non-Preferred
NAPROSYN 125 MG/5 ML SUSPEN	Formulary	PA; PDL Non-Preferred
<i>naproxen 125 mg/5 ml suspen</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>naproxen 250 mg tablet</i>	Formulary	PDL Preferred
<i>naproxen 250 mg tablet outer</i>	Formulary	PDL Preferred
<i>naproxen 375 mg tablet</i>	Formulary	PDL Preferred
<i>naproxen 375 mg tablet outer</i>	Formulary	PDL Preferred
<i>naproxen 500 mg tablet</i>	Formulary	PDL Preferred
<i>naproxen 500 mg tablet outer</i>	Formulary	PDL Preferred
<i>naproxen dr 375 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen dr 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod cr 375 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod cr 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod cr 500 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod cr 750 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod er 375 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod er 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sod er 750 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sodium 220 mg capsule</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>naproxen sodium 220 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>naproxen sodium 220 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>naproxen sodium 275 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sodium 275 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sodium 275 mg tab outer</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sodium 550 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>naproxen sodium 550 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
<i>oxaprozin 600 mg caplet caplet, f/c</i>	Formulary	PA; PDL Non-Preferred
<i>oxaprozin 600 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>oxaprozin 600 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
SM CHILD IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; OTC
<i>sm ibuprofen 200 mg caplet caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm ibuprofen 200 mg softgel</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm ibuprofen 200 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM IBUPROFEN IB 100 MG CHEW TB	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
SM INF IBUPROFEN 50 MG/1.25 ML D/F	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM INF IBUPROFEN 50 MG/1.25 ML W/DROPPER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm naproxen sod 220 mg caplet gluten free, caplet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
Nsaid Analgesics (Cyclooxygenase Inhibitors-Non-Selective)		
CAMBIA	Non-Formulary	
<i>diclofenac potassium oral powder in packet</i>	Non-Formulary	
Nsaid Analgesics, (Cox Non-Specific) - Indole Acetic Acid Derivatives		
<i>etodolac 200 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac 300 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac 400 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac 500 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 400 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 500 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 600 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>etodolac er 600 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>indomethacin 25 mg capsule</i>	Formulary	PDL Preferred
<i>indomethacin 25 mg capsule outer</i>	Formulary	PDL Preferred
<i>indomethacin 25 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>indomethacin 50 mg capsule</i>	Formulary	PDL Preferred
<i>indomethacin 50 mg capsule outer</i>	Formulary	PDL Preferred
<i>indomethacin er 75 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>indomethacin er 75 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred
Salicylate Analgesic And Sedative Combinations		
<i>butalbital-aspirin-caffeine 50-325-40 mg capsule</i>	Formulary	QL (6 capsules per 1 day); Age Limit (Max 64 Years)
<i>butalbital-aspirin-caffeine oral tablet</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
Salicylate Analgesics, Buffered		
<i>buffered aspirin 325 mg tb</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Min 40 Years)
TRI-BUFFERED ASPIRIN 325 MG TB BOXED	Formulary	Dual Eligible Covered; OTC; Age Limit (Min 40 Years)
Salicylate Analgesics		
<i>aspirin 300 mg suppository</i>	Formulary	Dual Eligible Covered; OTC
<i>aspirin 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 325 mg tablet micro-coated</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 81 mg chewable tablet</i>	Formulary	OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet gluten-free, orange</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet low dose</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet low dose, cherry</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin ec 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin ec 325 mg tablet safety-coated</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>aspirin ec 81 mg tablet low dose</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
ASPIRIN REGIMEN 81 MG EC TAB	Formulary	OTC; QL (3 tablets per 1 day)
<i>diflunisal 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>diflunisal 500 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
DISALCID	Non-Formulary	
DOLOBID 250 MG TABLET	Formulary	PA; PDL Non-Preferred
DOLOBID ORAL TABLET 375 MG	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>ft aspirin 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>ft aspirin 81 mg chewable tab</i>	Formulary	OTC; QL (2 tablets per 1 day)
<i>ft aspirin ec 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>ft aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>gnp aspirin 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>gnp aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>gnp aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>gs aspirin 81 mg chewable tab</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>hm aspirin 81 mg chewable tab adlt low dose,orange</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>hm aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>salsalate</i>	Non-Formulary	
<i>sm aspirin 81 mg chewable tab</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>sm aspirin ec 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>sm aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>sm aspirin ec 81 mg tablet adult low strength</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
Anesthetics		
General Anesthetic Adjuncts - Neuroleptic, Butyrophenone Derivative		
<i>droperidol injection solution</i>	State Carve Out	
General Anesthetic Adjuncts - Opioid		
<i>fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)</i>	Non-Formulary	
Local Anesthetic - Amides		
<i>bupivacaine (pf)</i>	Non-Formulary	
<i>bupivacaine hcl</i>	Non-Formulary	
<i>bupivacaine-dextrose-water(pf)</i>	Non-Formulary	
<i>lidocaine (pf) injection solution 10 mg/ml (1 %), 15 mg/ml (1.5 %), 20 mg/ml (2 %)</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>lidocaine hcl injection solution</i>	Non-Formulary	
<i>lidocaine hcl laryngotracheal</i>	Non-Formulary	
MARCAINE	Non-Formulary	
MARCAINE (PF)	Non-Formulary	
MARCAINE SPINAL (PF)	Non-Formulary	
NAROPIN (PF) INJECTION SOLUTION 10 MG/ML (1 %), 2 MG/ML (0.2 %), 7.5 MG/ML (0.75 %)	Non-Formulary	
POLOCAINE-MPF	Non-Formulary	
<i>ropivacaine (pf) injection solution 10 mg/ml (1 %), 2 mg/ml (0.2 %), 7.5 mg/ml (0.75 %)</i>	Non-Formulary	
SENSORCAINE	Non-Formulary	
SENSORCAINE-MPF	Non-Formulary	
SENSORCAINE-MPF SPINAL	Non-Formulary	
XYLOCAINE INJECTION SOLUTION 10 MG/ML (1 %), 20 MG/ML (2 %)	Non-Formulary	
XYLOCAINE-MPF INJECTION SOLUTION 10 MG/ML (1 %), 15 MG/ML (1.5 %), 20 MG/ML (2 %)	Non-Formulary	
Local Anesthetic - Esters		
<i>chloroprocaine (pf) injection solution 30 mg/ml (3 %)</i>	Non-Formulary	
NESACAINE	Non-Formulary	
NESACAINE-MPF	Non-Formulary	
<i>tetracaine hcl (pf) injection</i>	Non-Formulary	
Local Anesthetic - Sympathomimetic Combinations		
<i>bupivacaine-epinephrine</i>	Non-Formulary	
<i>bupivacaine-epinephrine (pf)</i>	Non-Formulary	
<i>lidocaine-epinephrine</i>	Non-Formulary	
<i>lidocaine-epinephrine (pf) injection solution 1.5 %-1:200,000, 2 %-1:200,000</i>	Non-Formulary	
MARCAINE-EPINEPHRINE (PF)	Non-Formulary	
MARCAINE-EPINEPHRINE INJECTION SOLUTION	Non-Formulary	
SENSORCAINE-EPINEPHRINE	Non-Formulary	
SENSORCAINE-MPF/EPINEPHRINE	Non-Formulary	
XYLOCAINE WITH EPINEPHRINE	Non-Formulary	
XYLOCAINE-MPF/EPINEPHRINE	Non-Formulary	

Medications	Coverage Level	Restrictions
Anorectal Preparations		
Anal Fissure Pain/Treatment Agents - Nitrates		
<i>nitroglycerin rectal</i>	Non-Formulary	
RECTIV	Non-Formulary	
Anorectal - Glucocorticoids		
ANUCORT-HC	Non-Formulary	
ANUSOL-HC RECTAL SUPPOSITORY	Non-Formulary	
<i>hydrocortisone 2.5% cream</i>	Formulary	
<i>hydrocortisone acetate rectal</i>	Non-Formulary	
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	Non-Formulary	
PROCTOCORT RECTAL	Non-Formulary	
PROCTO-MED HC 2.5% CREAM	Formulary	
PROCTOSOL-HC 2.5% CREAM	Formulary	
PROCTOZONE-HC 2.5% CREAM	Formulary	
Anorectal - Hemorrhoidal Rectal Glucocorticoid-Local Anesthetic Comb		
ANA-LEX KIT	Non-Formulary	
ANALPRAM-HC RECTAL	Non-Formulary	
<i>hydrocortisone-pramoxine rectal cream 1-1 %, 2.5-1 %</i>	Non-Formulary	
<i>lidocaine hcl-hydrocortison ac rectal cream</i>	Non-Formulary	
<i>lidocaine hcl-hydrocortison ac rectal kit</i>	Non-Formulary	
<i>lidocaine-hydrocortisone-aloe</i>	Non-Formulary	
PROCTOFOAM HC	Non-Formulary	
Antidotes And Other Reversal Agents		
Antidote - Acetaminophen Poisoning		
<i>acetylcysteine 10% vial (not for injection) inner</i>	Formulary	
<i>acetylcysteine 10% vial (not for injection) outer</i>	Formulary	
<i>acetylcysteine 10% vial (not for injection) p/f, outer</i>	Formulary	
<i>acetylcysteine 20% vial (not for injection) inner</i>	Formulary	
<i>acetylcysteine 20% vial (not for injection) outer</i>	Formulary	

Medications	Coverage Level	Restrictions
Antidote Others		
GALZIN	Non-Formulary	
Chelating Agents - Copper		
CUPRIMINE	Non-Formulary	
DEPEN TITRATABS	Non-Formulary	
<i>penicillamine</i>	Non-Formulary	
SYPRINE	Non-Formulary	
<i>trientine oral capsule 250 mg</i>	Non-Formulary	
Chelating Agents - Iron		
<i>deferasirox</i>	Non-Formulary	
<i>deferiprone</i>	Non-Formulary	
<i>deferoxamine</i>	Non-Formulary	
DESFERAL	Non-Formulary	
EXJADE	Non-Formulary	
FERRIPROX	Non-Formulary	
FERRIPROX (2 TIMES A DAY)	Non-Formulary	
JADENU	Non-Formulary	
JADENU SPRINKLE	Non-Formulary	
Chelating Agents - Lead Poisoning		
CHEMET 100 MG CAPSULE	Formulary	
Mu-Opioid Receptor Antagonists, Peripherally-Acting		
<i>alvimopan</i>	Non-Formulary	
ENTEREG	Non-Formulary	
MOVANTIK 12.5 MG TABLET	Formulary	PA; PDL Non-Preferred
MOVANTIK 25 MG TABLET	Formulary	PA; PDL Non-Preferred
RELISTOR 12 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred
RELISTOR 12 MG/0.6 ML VIAL	Formulary	PA; PDL Non-Preferred
RELISTOR 150 MG TABLET	Formulary	PA; PDL Non-Preferred
RELISTOR 8 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
SYMPROIC 0.2 MG TABLET	Formulary	PA; PDL Non-Preferred
Opioid Reversal Agents - Opioid Antagonists		
KLOXXADO 8 MG NASAL SPRAY	Formulary	QL (3 boxes per 90 days)
<i>naloxone 0.4 mg/ml carpject outer, plf, sub</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml syringe outer, sub, plf</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml vial outer</i>	Formulary	QL (6 ML per 90 days)

Medications	Coverage Level	Restrictions
<i>naloxone 0.4 mg/ml vial outer, sdv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml vial outer, suv, plf</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml vial sdv,outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml vial suv, outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 0.4 mg/ml vial suv,outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe outer, suv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe outer, suv, plf</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe plf, sdv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe plf, suv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe plf,sdv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 2 mg/2 ml syringe suv, plf, outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 4 mg/10 ml vial muv, outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 4 mg/10 ml vial muv,outer</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 4 mg/10 ml vial outer, muv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone 4 mg/10 ml vial outer,mdv</i>	Formulary	QL (6 ML per 90 days)
<i>naloxone hcl 4 mg nasal spray outer (otc)</i>	Formulary	OTC; QL (3 boxes per 90 days)
<i>naloxone hcl 4 mg nasal spray outer (rx)</i>	Formulary	OTC; QL (3 boxes per 90 days)
NARCAN 4 MG NASAL SPRAY (OTC)	Formulary	OTC; QL (3 boxes per 90 days)
NARCAN 4 MG NASAL SPRAY (RX)	Formulary	OTC; QL (3 boxes per 90 days)
OPVEE 2.7 MG NASAL SPRAY OUTER	Formulary	QL (3 boxes per 90 days)
REXTOVY 4 MG NASAL SPRAY	Formulary	QL (3 boxes per 90 days)
ZIMHI 5 MG/0.5 ML SYRINGE OUTER, SUV	Formulary	QL (3 ML per 90 days)
Anti-Infective Agents		
Amebicides		
<i>paromomycin 250 mg capsule</i>	Formulary	
Aminoglycoside Antibiotic		
<i>gentamicin injection</i>	Non-Formulary	
<i>neomycin 500 mg tablet</i>	Formulary	PDL Preferred
<i>streptomycin</i>	Non-Formulary	
<i>tobramycin 1,200 mg/30 ml vial mdv</i>	Formulary	
<i>tobramycin 1,200 mg/30 ml vial outer, muv</i>	Formulary	
<i>tobramycin 1.2 gram/30 ml vial mdv,outer</i>	Formulary	
<i>tobramycin 40 mg/ml vial mdv</i>	Formulary	
<i>tobramycin 80 mg/2 ml vial mdv,outer</i>	Formulary	
<i>tobramycin 80 mg/2 ml vial muv</i>	Formulary	
<i>tobramycin 80 mg/2 ml vial muv, outer</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>tobramycin 80 mg/2 ml vial outer,mdv</i>	Formulary	
<i>tobramycin sulfate injection recon soln</i>	Non-Formulary	
<i>tobramycin sulfate injection solution 10 mg/ml</i>	Non-Formulary	
Aminomethylcycline Antibiotics		
NUZYRA ORAL	Non-Formulary	
Aminopenicillin Antibiotic - Beta-Lactamase Inhibitor Combinations		
<i>amox-clav 200-28.5 mg tab chew</i>	Formulary	
<i>amox-clav 200-28.5 mg/5 ml sus</i>	Formulary	
<i>amox-clav 250-125 mg tablet</i>	Formulary	
<i>amox-clav 250-125 mg tablet f/c</i>	Formulary	
<i>amox-clav 250-125 mg tablet outer</i>	Formulary	
<i>amox-clav 250-62.5 mg/5 ml sus</i>	Formulary	
<i>amox-clav 400-57 mg tab chew</i>	Formulary	
<i>amox-clav 400-57 mg/5 ml susp</i>	Formulary	
<i>amox-clav 500-125 mg tablet</i>	Formulary	
<i>amox-clav 500-125 mg tablet f/c</i>	Formulary	
<i>amox-clav 500-125 mg tablet outer</i>	Formulary	
<i>amox-clav 600-42.9 mg/5 ml sus</i>	Formulary	
<i>amox-clav 875-125 mg tablet</i>	Formulary	
<i>amox-clav 875-125 mg tablet f/c</i>	Formulary	
<i>amox-clav 875-125 mg tablet outer</i>	Formulary	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	Non-Formulary	
<i>ampicillin-sulbactam injection</i>	Non-Formulary	
<i>ampicillin-sulbactam intravenous recon soln 1.5 gram</i>	Non-Formulary	
AUGMENTIN XR	Non-Formulary	
UNASYN INJECTION	Non-Formulary	
Aminopenicillin Antibiotic		
<i>amoxicillin 125 mg tab chew</i>	Formulary	3 Months Allowed
<i>amoxicillin 125 mg/5 ml susp</i>	Formulary	3 Months Allowed
<i>amoxicillin 200 mg/5 ml susp</i>	Formulary	3 Months Allowed
<i>amoxicillin 250 mg capsule</i>	Formulary	3 Months Allowed
<i>amoxicillin 250 mg tab chew</i>	Formulary	3 Months Allowed
<i>amoxicillin 250 mg/5 ml susp</i>	Formulary	3 Months Allowed

Medications	Coverage Level	Restrictions
<i>amoxicillin 400 mg/5 ml susp</i>	Formulary	3 Months Allowed
<i>amoxicillin 500 mg capsule</i>	Formulary	3 Months Allowed
<i>amoxicillin 500 mg tablet</i>	Formulary	3 Months Allowed
<i>amoxicillin 500 mg tablet f/c</i>	Formulary	3 Months Allowed
<i>amoxicillin 875 mg tablet</i>	Formulary	3 Months Allowed
<i>amoxicillin 875 mg tablet f/c</i>	Formulary	3 Months Allowed
<i>ampicillin 500 mg capsule</i>	Formulary	
<i>ampicillin sodium</i>	Non-Formulary	
Anthelmintic Agents - Benzimidazole Derivatives		
<i>albendazole</i>	Non-Formulary	
EMVERM	Non-Formulary	
Anthelmintic Agents - Macrocyclic Lactones		
<i>ivermectin 3 mg tablet</i>	Formulary	QL (10 tablets per 30 days)
<i>ivermectin oral tablet 6 mg</i>	Non-Formulary	
STROMEKTOL	Non-Formulary	
Anthelmintic Agents Other		
BILTRICIDE	Non-Formulary	
<i>praziquantel</i>	Non-Formulary	
Antibacterial Folate Antagonist - Other Combinations		
BACTRIM	Non-Formulary	
BACTRIM DS	Non-Formulary	
<i>sulfamethoxazole-tmp 800-160 mg/20 ml suspension cup outer</i>	Formulary	
<i>sulfamethoxazole-tmp ds tablet</i>	Formulary	
<i>sulfamethoxazole-tmp ds tablet outer</i>	Formulary	
<i>sulfamethoxazole-tmp ss tablet</i>	Formulary	
<i>sulfamethoxazole-tmp ss tablet outer</i>	Formulary	
<i>sulfamethoxazole-tmp susp</i>	Formulary	
<i>sulfamethoxazole-trimethoprim intravenous</i>	Non-Formulary	
SULFATRIM PEDIATRIC SUSPENSION	Formulary	
Antibacterial Folate Antagonist Others		
<i>trimethoprim 100 mg tablet</i>	Formulary	
Antibacterial Nitrofurans Derivatives		
FURADANTIN	Non-Formulary	

Medications	Coverage Level	Restrictions
MACROBID	Non-Formulary	
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	Non-Formulary	
<i>nitrofurantoin mcr 100 mg cap</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 100 mg cap outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 50 mg cap</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 50 mg cap outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg u-d,outer,10x10</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	Non-Formulary	
Antibacterial Other		
<i>fosfomycin tromethamine</i>	Non-Formulary	
Antifungal - Allylamines		
<i>terbinafine hcl 250 mg tablet</i>	Formulary	PDL Preferred; QL (84 tablets per 1 claim)
<i>terbinafine hcl 250 mg tablet</i>	Formulary	PDL Preferred; QL (84 tablets per 1 Fill)
Antifungal - Amphoteric Polyene Macrolides		
ABELCET	Non-Formulary	
AMBISOME	Non-Formulary	
<i>amphotericin b</i>	Non-Formulary	
<i>amphotericin b liposome</i>	Non-Formulary	
<i>nystatin 500,000 unit oral tab</i>	Formulary	PDL Preferred
<i>nystatin 500,000 unit oral tab oral</i>	Formulary	PDL Preferred
Antifungal - Fluorinated Pyrimidine-Type Agents		
ANCOBON 250 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ANCOBON 500 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>flucytosine 250 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>flucytosine 250 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>flucytosine 500 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>flucytosine 500 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred
Antifungal - Glucan Synthesis Inhibitor, Echinocandins		
CANCIDAS	Non-Formulary	
<i>caspofungin</i>	Non-Formulary	
ERAXIS(WATER DILUENT)	Non-Formulary	
<i>micafungin</i>	Non-Formulary	
<i>micafungin in 0.9 % sodium chl intravenous piggyback 150 mg/150 ml</i>	Non-Formulary	
MYCAMINE	Non-Formulary	
Antifungal - Glucan Synthesis Inhibitor, Triterpenoid		
BREXAFEMME 150 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 1 Fill)
Antifungal - Glucan Synthesis Inhibitors		
BREXAFEMME 150 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 1 Fill)
CANCIDAS	Non-Formulary	
<i>caspofungin</i>	Non-Formulary	
ERAXIS(WATER DILUENT)	Non-Formulary	
<i>micafungin</i>	Non-Formulary	
<i>micafungin in 0.9 % sodium chl intravenous piggyback 150 mg/150 ml</i>	Non-Formulary	
MYCAMINE	Non-Formulary	
Antifungal - Imidazoles		
<i>ketoconazole 200 mg tablet</i>	Formulary	PDL Preferred
ORAVIG 50 MG BUCCAL TABLET	Formulary	PA; PDL Non-Preferred
Antifungal - Tetrazoles		
VIVJOA 150 MG CAPSULE	Formulary	PA; PDL Non-Preferred
Antifungal - Triazoles		
CRESEMBA 186 MG CAPSULE OUTER	Formulary	PA; PDL Non-Preferred
CRESEMBA 74.5 MG CAPSULE OUTER	Formulary	PA; PDL Non-Preferred
CRESEMBA INTRAVENOUS	Non-Formulary	
DIFLUCAN 100 MG TABLET	Formulary	PA; PDL Non-Preferred
DIFLUCAN 100 MG TABLET U-D	Formulary	PA; PDL Non-Preferred
DIFLUCAN 200 MG TABLET	Formulary	PA; PDL Non-Preferred
DIFLUCAN 200 MG TABLET U-D	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
DIFLUCAN 40 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred
<i>fluconazole 10 mg/ml susp</i>	Formulary	PDL Preferred
<i>fluconazole 100 mg tablet</i>	Formulary	PDL Preferred
<i>fluconazole 100 mg tablet outer</i>	Formulary	PDL Preferred
<i>fluconazole 150 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
<i>fluconazole 150 mg tablet inner</i>	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
<i>fluconazole 150 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
<i>fluconazole 200 mg tablet</i>	Formulary	PDL Preferred
<i>fluconazole 200 mg tablet outer</i>	Formulary	PDL Preferred
<i>fluconazole 40 mg/ml susp</i>	Formulary	PDL Preferred
<i>fluconazole 50 mg tablet</i>	Formulary	PDL Preferred
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	Non-Formulary	
<i>itraconazole 10 mg/ml solution</i>	Formulary	PA; PDL Non-Preferred; QL (840 mL per 1 claim)
<i>itraconazole 100 mg capsule</i>	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
<i>itraconazole 100 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
<i>itraconazole 100 mg/10 ml cup outer</i>	Formulary	PA; PDL Non-Preferred; QL (840 ML per 1 claim)
NOXAFIL 300 MG POWDERMIX SUSP OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 17 Years)
NOXAFIL 40 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred
NOXAFIL DR 100 MG TABLET	Formulary	PA; PDL Non-Preferred
NOXAFIL INTRAVENOUS	Non-Formulary	
<i>posaconazole 200 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>posaconazole dr 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>posaconazole dr 100 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred
SPORANOX 10 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred; QL (840 mL per 1 claim)
SPORANOX 100 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
TOLSURA 65 MG CAPSULE	Formulary	PA; PDL Non-Preferred
VFEND 200 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
VFEND 40 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
VFEND 50 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
VFEND IV	Non-Formulary	
<i>voriconazole 200 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 200 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 200 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 40 mg/ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 50 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole 50 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred
<i>voriconazole intravenous</i>	Non-Formulary	
Antifungal Other		
<i>griseofulvin 125 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>griseofulvin micro 500 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>griseofulvin ultra 125 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>griseofulvin ultra 250 mg tab</i>	Formulary	PA; PDL Non-Preferred
Anti-Infective Immunologic Adjuvants - Interferons		
ACTIMMUNE	Non-Formulary	
Antileprotic - Immunomodulators		
THALOMID 100 MG CAPSULE	Formulary	
THALOMID 200 MG CAPSULE	Formulary	
THALOMID 50 MG CAPSULE	Formulary	
Antileprotic - Sulfone Agents		
<i>dapsone 100 mg tablet</i>	Formulary	
<i>dapsone 25 mg tablet</i>	Formulary	
Antimalarial Combinations		
<i>atovaquone-proguanil</i>	Non-Formulary	
COARTEM	Non-Formulary	
MALARONE	Non-Formulary	
MALARONE PEDIATRIC	Non-Formulary	
Antimalarials		
<i>chloroquine ph 250 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>chloroquine ph 250 mg tablet f/c</i>	Formulary	QL (1 tablet per 1 day)
<i>chloroquine ph 500 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>chloroquine ph 500 mg tablet f/c</i>	Formulary	QL (1 tablet per 1 day)
DARAPRIM	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>hydroxychloroquine 100 mg tab</i>	Formulary	
<i>hydroxychloroquine 200 mg tab</i>	Formulary	
<i>hydroxychloroquine 200 mg tab f/c</i>	Formulary	
<i>hydroxychloroquine 200 mg tab outer</i>	Formulary	
<i>hydroxychloroquine 200 mg tab u-d, 10x10, outer</i>	Formulary	
<i>hydroxychloroquine 300 mg tab</i>	Formulary	
<i>hydroxychloroquine 400 mg tab</i>	Formulary	
KRINTAFEL 150 MG TABLET	Formulary	QL (2 tablets per 1 year); Age Limit (Min 16 Years)
<i>mefloquine hcl 250 mg tablet</i>	Formulary	QL (5 tablets per 30 days)
<i>mefloquine hcl 250 mg tablet outer</i>	Formulary	QL (5 tablets per 30 days)
<i>primaquine 26.3 mg tablet</i>	Formulary	
<i>pyrimethamine 25 mg tablet</i>	Formulary	PA; QL (3 tablets per 1 day)
QUALAQUIN	Non-Formulary	
<i>quinine sulfate</i>	Non-Formulary	
SOVUNA	Non-Formulary	
Antiprotozoal Agents - Nitrofuran Derivatives		
LAMPIT	Non-Formulary	
Antiprotozoal Agents - Nitroimidazole Derivatives		
<i>benznidazole 100 mg tablet</i>	Formulary	PA
<i>benznidazole 12.5 mg tablet</i>	Formulary	PA
Antiprotozoal Agents - Other		
<i>atovaquone 750 mg/5 ml susp</i>	Formulary	
<i>atovaquone 750 mg/5 ml susp cup outer</i>	Formulary	
<i>atovaquone 750 mg/5 ml susp outer</i>	Formulary	
<i>atovaquone 750 mg/5 ml suspension cup outer</i>	Formulary	
MEPRON	Non-Formulary	
Antiprotozoal Agents (Antiparasitic) - 5-Nitrothiazolyl Derivatives		
<i>nitazoxanide 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (6 tablets per 30 days)
Antiprotozoal-Antibacterial 1St Generation 2-Methyl-5-Nitroimidazole		
FLAGYL 375 CAPSULE	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
LIKMEZ 500 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred; QL (400 ML per 10 days)
METRO I.V.	Non-Formulary	
<i>metronidazole 125 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>metronidazole 250 mg tablet</i>	Formulary	PDL Preferred
<i>metronidazole 250 mg tablet f/c</i>	Formulary	PDL Preferred
<i>metronidazole 250 mg tablet outer</i>	Formulary	PDL Preferred
<i>metronidazole 375 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>metronidazole 500 mg tablet</i>	Formulary	PDL Preferred
<i>metronidazole 500 mg tablet f/c</i>	Formulary	PDL Preferred
<i>metronidazole 500 mg tablet outer</i>	Formulary	PDL Preferred
<i>metronidazole in nacl (iso-os)</i>	Non-Formulary	
Antiprotozoal-Antibacterial 2Nd Generation 2-Methyl-5-Nitroimidazole		
SOLOSEC	Non-Formulary	
<i>tinidazole 250 mg tablet</i>	Formulary	PDL Preferred
<i>tinidazole 500 mg tablet</i>	Formulary	PDL Preferred
Antiretroviral - Anti-Cd4 Domain 2 Monoclonal Antibody		
TROGARZO	State Carve Out	
Antiretroviral - Capsid Inhibitors		
SUNLENCA	State Carve Out	
Antiretroviral - Ccr5 Co-Receptor Antagonist		
<i>maraviroc</i>	State Carve Out	
SELZENTRY	State Carve Out	
Antiretroviral - Cd4 Attachment Inhibitors		
RUKOBIA	State Carve Out	
Antiretroviral - Hiv-1 Fusion Inhibitors		
FUZEON SUBCUTANEOUS RECON SOLN	State Carve Out	
Antiretroviral - Hiv-1 Integrase Strand Transfer Inhibitors		
APRETUDE	State Carve Out	
<i>cabotegravir intramuscular suspension, extended release 600 mg/3 ml (200 mg/ml)</i>	State Carve Out	
ISENTRESS	State Carve Out	
ISENTRESS HD	State Carve Out	

Medications	Coverage Level	Restrictions
TIVICAY	State Carve Out	
TIVICAY PD	State Carve Out	
Antiretroviral - Integrase Inhibitor And Nnrti Combinations		
CABENUVA	State Carve Out	
JULUCA	State Carve Out	
Antiretroviral - Integrase Inhibitor And Nrti Combinations		
DOVATO	State Carve Out	
Antiretroviral - Non-Nucleoside Reverse Transcriptase Inhib (Nnrti)		
EDURANT	State Carve Out	
<i>efavirenz</i>	State Carve Out	
<i>etravirine</i>	State Carve Out	
INTELENCE	State Carve Out	
<i>nevirapine</i>	State Carve Out	
PIFELTRO	State Carve Out	
SUSTIVA	State Carve Out	
VIRAMUNE ORAL SUSPENSION	State Carve Out	
Antiretroviral - Nucleoside And Nucleotide Analog Rtis Combinations		
CIMDUO	State Carve Out	
DESCOVY	State Carve Out	
<i>emtricitabine-tenofovir (tdf)</i>	State Carve Out	
TEMIXYS	State Carve Out	
TRUVADA	State Carve Out	
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (Nrti)		
<i>abacavir</i>	State Carve Out	
<i>didanosine oral capsule, delayed release(drlec) 250 mg, 400 mg</i>	State Carve Out	
<i>emtricitabine</i>	State Carve Out	
EMTRIVA	State Carve Out	
EPIVIR	State Carve Out	
<i>lamivudine oral solution</i>	State Carve Out	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	State Carve Out	
RETROVIR INTRAVENOUS	State Carve Out	
RETROVIR ORAL CAPSULE	State Carve Out	

Medications	Coverage Level	Restrictions
RETROVIR ORAL SYRUP	State Carve Out	
<i>stavudine oral capsule 15 mg, 20 mg, 40 mg</i>	State Carve Out	
ZIAGEN	State Carve Out	
<i>zidovudine</i>	State Carve Out	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors		
<i>tenofovir disoproxil fumarate</i>	State Carve Out	
VIREAD	State Carve Out	
Antiretroviral Combinations - Protease Inhibitors		
EVOTAZ	State Carve Out	
KALETRA	State Carve Out	
<i>lopinavir-ritonavir</i>	State Carve Out	
PREZCOBIX	State Carve Out	
Antiretroviral- Nucleoside And Nucleotide Analogs, Protease Inhibitors		
SYMTUZA	State Carve Out	
Antiretroviral-Integrase Inhibitor, Nucleoside And Nucleotide Rti's Comb		
BIKTARVY	State Carve Out	
GENVOYA	State Carve Out	
STRIBILD	State Carve Out	
Antiretroviral-Nucleoside Analogs And Integrase Inhibitor Combinations		
TRIUMEQ	State Carve Out	
TRIUMEQ PD	State Carve Out	
Antiretroviral-Nucleoside Reverse Transcriptase Inhibitors (Nrti) Comb		
<i>abacavir-lamivudine</i>	State Carve Out	
<i>abacavir-lamivudine-zidovudine</i>	State Carve Out	
COMBIVIR	State Carve Out	
EPZICOM	State Carve Out	
<i>lamivudine-zidovudine</i>	State Carve Out	
TRIZIVIR	State Carve Out	
Antiretroviral-Nucleoside, Nucleotide Analogs And Non-Nucleoside Rti		
ATRIPLA	State Carve Out	

Medications	Coverage Level	Restrictions
COMPLERA	State Carve Out	
DELSTRIGO	State Carve Out	
<i>efavirenz-emtricitabin-tenofovir</i>	State Carve Out	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	State Carve Out	
ODEFSEY	State Carve Out	
SYMFI	State Carve Out	
SYMFI LO	State Carve Out	
Antitubercular - Aminobenzoic Acid Analogs		
PASER	Non-Formulary	
Antitubercular - D-Alanine Analogs		
<i>cycloserine 250 mg capsule outer</i>	Formulary	QL (4 capsules per 1 day)
Antitubercular - Diarylquinoline Antibiotics		
SIRTURO 100 MG TABLET	Formulary	PA
SIRTURO 20 MG TABLET	Formulary	PA
Antitubercular - Isonicotinic Acid Derivatives		
<i>isoniazid 100 mg tablet</i>	Formulary	
<i>isoniazid 300 mg tablet</i>	Formulary	
<i>isoniazid 300 mg tablet outer</i>	Formulary	
<i>isoniazid 300 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>isoniazid 50 mg/5 ml solution</i>	Formulary	Age Limit (Max 12 Years)
<i>isoniazid injection</i>	Non-Formulary	
Antitubercular - Niacinamide Derivatives		
<i>pyrazinamide 500 mg tablet</i>	Formulary	
<i>pyrazinamide 500 mg tablet outer</i>	Formulary	
Antitubercular - Nitroimidazole Derivatives		
<i>pretomanid 200 mg tablet</i>	Formulary	PA
Antitubercular - Rifamycin And Derivatives		
MYCOBUTIN	Non-Formulary	
PRIFTIN 150 MG TABLET OUTER	Formulary	QL (24 tablets per 28 days)
<i>rifabutin 150 mg capsule</i>	Formulary	
RIFADIN INTRAVENOUS	Non-Formulary	
<i>rifampin 150 mg capsule</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>rifampin 150 mg capsule outer</i>	Formulary	
<i>rifampin 300 mg capsule</i>	Formulary	
<i>rifampin 300 mg capsule outer</i>	Formulary	
<i>rifampin intravenous</i>	Non-Formulary	
Antitubercular Agents Other		
<i>ethambutol hcl 100 mg tablet</i>	Formulary	
<i>ethambutol hcl 400 mg tablet</i>	Formulary	
<i>ethambutol hcl 400 mg tablet flc</i>	Formulary	
<i>ethambutol hcl 400 mg tablet u-d, 10x10, outer</i>	Formulary	
TRECTOR 250 MG TABLET	Formulary	
Carbapenem Antibiotic Combinations		
<i>imipenem-cilastatin</i>	Non-Formulary	
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	Non-Formulary	
RECARBRIO	Non-Formulary	
Carbapenem Antibiotics (Thienamycins)		
<i>meropenem intravenous recon soln 1 gram, 500 mg</i>	Non-Formulary	
<i>meropenem-0.9% sodium chloride</i>	Non-Formulary	
Cephalosporin Antibiotics - 1St Generation		
<i>cefadroxil 1 gm tablet</i>	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
<i>cefadroxil 250 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefadroxil 500 mg capsule</i>	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
<i>cefadroxil 500 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml, 2 gram/100 ml, 2 gram/50 ml</i>	Non-Formulary	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	Non-Formulary	
<i>cefazolin intravenous recon soln 1 gram</i>	Non-Formulary	
<i>cephalexin 125 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cephalexin 250 mg capsule</i>	Formulary	PDL Preferred
<i>cephalexin 250 mg capsule outer</i>	Formulary	PDL Preferred
<i>cephalexin 250 mg tablet</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>cephalexin 250 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cephalexin 500 mg capsule</i>	Formulary	PDL Preferred
<i>cephalexin 500 mg capsule outer</i>	Formulary	PDL Preferred
<i>cephalexin 500 mg tablet</i>	Formulary	PDL Preferred
<i>cephalexin 750 mg capsule</i>	Formulary	PDL Preferred
Cephalosporin Antibiotics - 2Nd Generation		
<i>cefaclor 125 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>cefaclor 250 mg capsule</i>	Formulary	PA; PDL Non-Preferred; QL (42 capsules per 1 claim)
<i>cefaclor 375 mg/5 ml suspen</i>	Formulary	PA; PDL Non-Preferred
<i>cefaclor 500 mg capsule</i>	Formulary	PA; PDL Non-Preferred; QL (42 capsules per 1 claim)
<i>cefaclor er 500 mg tablet film coated</i>	Formulary	PA; PDL Non-Preferred; QL (42 tablets per 1 claim)
CEFOTAN	Non-Formulary	
<i>cefotetan</i>	Non-Formulary	
<i>cefoxitin</i>	Non-Formulary	
<i>cefoxitin in dextrose, iso-osm</i>	Non-Formulary	
<i>cefprozil 125 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefprozil 250 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>cefprozil 250 mg tablet f/c</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>cefprozil 250 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefprozil 500 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>cefuroxime axetil 250 mg tab</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>cefuroxime axetil 250 mg tab f/c</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>cefuroxime axetil 250 mg tab outer</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>cefuroxime axetil 500 mg tab</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>cefuroxime axetil 500 mg tab f/c</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>cefuroxime axetil 500 mg tab outer</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>cefuroxime sodium injection recon soln 750 mg</i>	Non-Formulary	
<i>cefuroxime sodium intravenous</i>	Non-Formulary	
Cephalosporin Antibiotics - 3Rd Generation		
<i>cefdinir 125 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefdinir 250 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>cefdinir 300 mg capsule</i>	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
<i>cefdinir 300 mg capsule outer</i>	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
<i>cefixime 100 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>cefixime 200 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>cefixime 400 mg capsule</i>	Formulary	PDL Preferred
<i>cefotaxime injection recon soln 1 gram</i>	Non-Formulary	
<i>cefpodoxime 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
<i>cefpodoxime 100 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>cefpodoxime 200 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
<i>cefpodoxime 50 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>ceftazidime injection recon soln 6 gram</i>	Non-Formulary	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	Non-Formulary	
<i>ceftriaxone intravenous</i>	Non-Formulary	
TAZICEF INJECTION RECON SOLN 6 GRAM	Non-Formulary	
TAZICEF INTRAVENOUS	Non-Formulary	
Cephalosporin Antibiotics - 4Th Generation		
<i>cefepime in dextrose 5 %</i>	Non-Formulary	
<i>cefepime in dextrose,iso-osm</i>	Non-Formulary	
<i>cefepime injection</i>	Non-Formulary	
Cmv Antiviral Agent - Inorganic Pyrophosphate Analogs		
<i>foscarnet</i>	Non-Formulary	
Cmv Antiviral Agent - Nucleoside Analogs		
CYTOVENE	Non-Formulary	
<i>ganciclovir sodium intravenous recon soln</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
VALCYTE	Non-Formulary	
<i>valganciclovir 450 mg tablet</i>	Formulary	QL (2 tablets per 1 day)
<i>valganciclovir 450 mg tablet f/c</i>	Formulary	QL (2 tablets per 1 day)
<i>valganciclovir 450 mg tablet f/c, outer</i>	Formulary	QL (2 tablets per 1 day)
<i>valganciclovir 450 mg tablet outer</i>	Formulary	QL (2 tablets per 1 day)
<i>valganciclovir oral recon soln</i>	Non-Formulary	
<i>Cmv Antiviral Agent - Nucleotide Analogs</i>		
<i>cidofovir</i>	Non-Formulary	
<i>Cmv Antiviral Agent - Protein Kinase Inhibitors</i>		
LIVTENCITY 200 MG TABLET	Formulary	
<i>Cmv Antiviral Agent - Terminase Complex Inhibitors</i>		
PREVYMIS 120 MG PELLETT PACKET OUTER	Formulary	
PREVYMIS 20 MG PELLETT PACKET OUTER	Formulary	
PREVYMIS 240 MG TABLET OUTER	Formulary	
PREVYMIS 480 MG TABLET OUTER	Formulary	
PREVYMIS INTRAVENOUS	Non-Formulary	
<i>Cyclic Lipopeptide Antibiotics</i>		
<i>daptomycin intravenous recon soln 350 mg</i>	Non-Formulary	
<i>Fluoroquinolone Antibiotics</i>		
AVELOX IN NAACL (ISO-OSMOTIC)	Non-Formulary	
BAXDELA 450 MG TABLET	Formulary	PA; PDL Non-Preferred
BAXDELA 450 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred
CIPRO 10% SUSPENSION	Formulary	PDL Preferred
CIPRO 250 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; QL (42 tablets per 1 claim)
CIPRO 5% SUSPENSION	Formulary	PDL Preferred
CIPRO 500 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin 250 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>ciprofloxacin 500 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>ciprofloxacin hcl 250 mg tab</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin hcl 250 mg tab f/c</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>ciprofloxacin hcl 500 mg tab</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin hcl 500 mg tab f/c</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin hcl 500 mg tab outer</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin hcl 750 mg tab</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin hcl 750 mg tab f/c</i>	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 400 mg/200 ml</i>	Non-Formulary	
<i>levofloxacin 25 mg/ml solution</i>	Formulary	PDL Preferred
<i>levofloxacin 250 mg tablet</i>	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
<i>levofloxacin 250 mg tablet f/c</i>	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
<i>levofloxacin 500 mg tablet</i>	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
<i>levofloxacin 500 mg tablet f/c</i>	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
<i>levofloxacin 750 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>levofloxacin 750 mg tablet f/c</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>levofloxacin intravenous</i>	Non-Formulary	
<i>moxifloxacin hcl 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
<i>moxifloxacin hcl 400 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
<i>moxifloxacin hcl 400 mg tablet f/c, outer</i>	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
<i>moxifloxacin hcl 400 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
<i>moxifloxacin-sod.chloride(iso)</i>	Non-Formulary	
<i>ofloxacin 300 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>ofloxacin 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred
Glycopeptide Antibiotics		
FIRVANQ 25 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred
FIRVANQ 50 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
VANCOGIN HCL 125 MG CAPSULE	Formulary	PA; PDL Non-Preferred
VANCOGIN HCL 250 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>vancomycin 1 gm vial inner, suv, p/f</i>	Formulary	
<i>vancomycin 1 gm vial outer</i>	Formulary	
<i>vancomycin 1 gm vial outer, p/f</i>	Formulary	
<i>vancomycin 1 gm vial outer, p/f, suv</i>	Formulary	
<i>vancomycin 1 gm vial outer, suv, p/f</i>	Formulary	
<i>vancomycin 1 gm vial p/f</i>	Formulary	
<i>vancomycin 1 gm vial p/f, muv, outer</i>	Formulary	
<i>vancomycin 1 gm vial p/f, outer</i>	Formulary	
<i>vancomycin 1 gm vial p/f, suv</i>	Formulary	
<i>vancomycin 1 gm vial p/f, suv, outer</i>	Formulary	
<i>vancomycin 1 gm vial p/f,outer</i>	Formulary	
<i>vancomycin 1 gm vial suv, outer</i>	Formulary	
<i>vancomycin 1 gm vial suv, p/f, outer</i>	Formulary	
<i>vancomycin 25 mg/ml oral soln</i>	Formulary	PDL Preferred
<i>vancomycin 250 mg/5 ml oral sol</i>	Formulary	PDL Preferred
<i>vancomycin 50 mg/ml oral soln</i>	Formulary	PDL Preferred
<i>vancomycin 50 mg/ml oral soln outer</i>	Formulary	PDL Preferred
<i>vancomycin 500 mg vial</i>	Formulary	
<i>vancomycin 500 mg vial outer</i>	Formulary	
<i>vancomycin 500 mg vial outer, p/f</i>	Formulary	
<i>vancomycin 500 mg vial outer, p/f, suv</i>	Formulary	
<i>vancomycin 500 mg vial outer, suv, p/f</i>	Formulary	
<i>vancomycin 500 mg vial outer,p/f</i>	Formulary	
<i>vancomycin 500 mg vial p/f</i>	Formulary	
<i>vancomycin 500 mg vial p/f, outer</i>	Formulary	
<i>vancomycin 500 mg vial p/f,outer</i>	Formulary	
<i>vancomycin 500 mg vial suv, p/f, outer</i>	Formulary	
<i>vancomycin 750 mg add-van vial outer, suv</i>	Formulary	
<i>vancomycin hcl 10 gm vial mdv</i>	Formulary	
<i>vancomycin hcl 10 gm vial muv</i>	Formulary	
<i>vancomycin hcl 10 gm vial muv, p/f</i>	Formulary	
<i>vancomycin hcl 10 gm vial p/f, mdv</i>	Formulary	
<i>vancomycin hcl 10 gm vial p/f, muv</i>	Formulary	
<i>vancomycin hcl 10 gm vial p/f,mdv</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>vancomycin hcl 125 mg capsule</i>	Formulary	PDL Preferred
<i>vancomycin hcl 125 mg capsule 2x10, outer</i>	Formulary	PDL Preferred
<i>vancomycin hcl 125 mg capsule 2x10, u-d</i>	Formulary	PDL Preferred
<i>vancomycin hcl 250 mg capsule</i>	Formulary	PDL Preferred
<i>vancomycin hcl 250 mg capsule 2x10, outer</i>	Formulary	PDL Preferred
<i>vancomycin hcl 250 mg capsule 2x10, u-d</i>	Formulary	PDL Preferred
<i>vancomycin hcl 5 gm vial mdv</i>	Formulary	
<i>vancomycin hcl 5 gm vial mov, plf</i>	Formulary	
<i>vancomycin hcl 5 gm vial plf, mdv</i>	Formulary	
<i>vancomycin hcl 5 gm vial plf, mov</i>	Formulary	
<i>vancomycin hcl 5 gm vial plf,mdv</i>	Formulary	
<i>vancomycin hcl 750 mg vial outer, suv, plf</i>	Formulary	
<i>vancomycin hcl 750 mg vial outer,suv</i>	Formulary	
<i>vancomycin hcl 750 mg vial plf, outer</i>	Formulary	
<i>vancomycin hcl 750 mg vial plf, suv, outer</i>	Formulary	
<i>vancomycin hcl 750 mg vial suv, outer</i>	Formulary	
<i>vancomycin in 0.9 % sodium chl intravenous piggyback</i>	Non-Formulary	
<i>vancomycin in dextrose 5 % intravenous piggyback 1 gram/200 ml, 500 mg/100 ml, 750 mg/150 ml</i>	Non-Formulary	
<i>vancomycin intravenous recon soln 1.5 gram, 1.75 gram, 2 gram</i>	Non-Formulary	
Hepatitis B Treatment- Nucleoside Analogs (Antiviral)		
BARACLUDE	Non-Formulary	
<i>entecavir 0.5 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>entecavir 0.5 mg tablet f/c</i>	Formulary	QL (1 tablet per 1 day)
<i>entecavir 0.5 mg tablet outer</i>	Formulary	QL (1 tablet per 1 day)
<i>entecavir 1 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>lamivudine hbv 100 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
Hepatitis B Treatment- Nucleotide Analogs (Antiviral)		
<i>adefovir dipivoxil 10 mg tab</i>	Formulary	QL (1 tablet per 1 day)
<i>tenofovir disoproxil fumarate</i>	State Carve Out	
VEMLIDY 25 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 6 Years)
VIREAD	State Carve Out	

Medications	Coverage Level	Restrictions
<i>Hepatitis C - Interferons</i>		
PEGASYS	State Carve Out	
<i>Hepatitis C - Ns5a Inhibitor And Ns3/4A Protease Inhibitor Combination</i>		
MAVYRET	State Carve Out	
TECHNIVIE	State Carve Out	
ZEPATIER	State Carve Out	
<i>Hepatitis C - Ns5a Replication Complex Inhibitors</i>		
DAKLINZA	State Carve Out	
<i>Hepatitis C - Ns5a, Ns3/4A Protease, Nucleo.Ns5b Polymerase Inhib Comb</i>		
VOSEVI	State Carve Out	
<i>Hepatitis C - Ns5b Polymerase And Ns5a Inhibitor Combinations</i>		
EPCLUSA	State Carve Out	
HARVONI	State Carve Out	
<i>ledipasvir-sofosbuvir</i>	State Carve Out	
<i>sofosbuvir-velpatasvir</i>	State Carve Out	
<i>Hepatitis C - Nucleos(T)Ide Analog Ns5b Polymerase Inhibitors</i>		
SOVALDI	State Carve Out	
<i>Hepatitis C - Nucleoside Analogs</i>		
<i>ribavirin oral capsule</i>	State Carve Out	
<i>ribavirin oral tablet 200 mg</i>	State Carve Out	
<i>Hepatitis C- Ns5a, Ns3/4A Protease And Non-Nucleo.Ns5b Poly Inh. Comb</i>		
VIEKIRA PAK	State Carve Out	
VIEKIRA XR	State Carve Out	
<i>Herpes Antiviral Agent - Purine Analogs</i>		
<i>acyclovir 200 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 200 mg capsule 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 200 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 200 mg/5 ml susp</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>acyclovir 400 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 400 mg tablet 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 400 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 800 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 800 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir sodium intravenous solution</i>	Non-Formulary	
<i>valacyclovir hcl 1 gram tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 1 gram tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 1 gram tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 1 gram tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 500 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 500 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valacyclovir hcl 500 mg tablet u-d, outer, 5x6, f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
VALTREX 1 GM CAPLET CAPLET, F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VALTREX 1 GM CAPLET F/C, CAPLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VALTREX 500 MG CAPLET CAPLET, F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VALTREX 500 MG CAPLET CAPLET, F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Herpes Antiviral Agent - Thymidine Analogs</i>		
<i>famciclovir 125 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>famciclovir 125 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>famciclovir 250 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>famciclovir 250 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>famciclovir 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>famciclovir 500 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Influenza Antiviral Agents - Neuraminidase Inhibitors</i>		
<i>oseltamivir 6 mg/ml suspension</i>	Formulary	PDL Preferred; QL (120 ML per 1 claim)
<i>oseltamivir 6 mg/ml suspension</i>	Formulary	PDL Preferred; QL (120 mL per 1 claim)
<i>oseltamivir phos 30 mg capsule</i>	Formulary	PDL Preferred; QL (14 capsules per 1 claim)
<i>oseltamivir phos 45 mg capsule</i>	Formulary	PDL Preferred; QL (14 capsules per 1 claim)
<i>oseltamivir phos 75 mg capsule</i>	Formulary	PDL Preferred; QL (14 capsules per 1 claim)
RELENZA 5 MG DISKHALER	Formulary	PDL Preferred; QL (20 EA per 1 claim)
TAMIFLU 30 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (14 capsules per 1 claim)
TAMIFLU 45 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (14 capsules per 1 claim)
TAMIFLU 6 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred; QL (120 ML per 1 claim)
TAMIFLU 75 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (14 capsules per 1 claim)
<i>Influenza Antiviral Agents - Pa Endonuclease Inhibitor</i>		
XOFLUZA 40 MG TABLET	Formulary	PDL Preferred
XOFLUZA 80 MG TABLET	Formulary	PDL Preferred
<i>Influenza-A Antiviral Agents</i>		
FLUMADINE 100 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
<i>rimantadine hcl 100 mg tablet</i>	Formulary	PDL Preferred
<i>Lincosamide Antibiotics</i>		
CLEOCIN HCL	Non-Formulary	
CLEOCIN INJECTION	Non-Formulary	

Medications	Coverage Level	Restrictions
CLEOCIN PEDIATRIC	Non-Formulary	
<i>clindamycin (pedi) 75 mg/5 ml</i>	Formulary	Age Limit (Max 12 Years)
CLINDAMYCIN (PEDI) 75 MG/5 ML	Formulary	Age Limit (Max 12 Years)
<i>clindamycin hcl 150 mg capsule</i>	Formulary	
<i>clindamycin hcl 150 mg capsule 10x10,u-d,outer</i>	Formulary	
<i>clindamycin hcl 150 mg capsule u-d,10x10</i>	Formulary	
<i>clindamycin hcl 300 mg capsule</i>	Formulary	
<i>clindamycin hcl 300 mg capsule 10x10,u-d,outer</i>	Formulary	
<i>clindamycin hcl 300 mg capsule outer</i>	Formulary	
<i>clindamycin hcl 75 mg capsule</i>	Formulary	
<i>clindamycin in 0.9 % sod chlor</i>	Non-Formulary	
<i>clindamycin in 5 % dextrose intravenous piggyback 300 mg/50 ml</i>	Non-Formulary	
<i>clindamycin phosphate injection</i>	Non-Formulary	
LINCOCIN	Non-Formulary	
<i>lincomycin</i>	Non-Formulary	
Macrolide Antibiotics		
<i>azithromycin 1 gm pwd packet outer</i>	Formulary	PDL Preferred; QL (2 packets per 1 claim)
<i>azithromycin 100 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>azithromycin 200 mg/5 ml susp</i>	Formulary	PDL Preferred
<i>azithromycin 250 mg tablet</i>	Formulary	PDL Preferred
<i>azithromycin 250 mg tablet f/c</i>	Formulary	PDL Preferred
<i>azithromycin 250 mg tablet inner</i>	Formulary	PDL Preferred
<i>azithromycin 250 mg tablet outer</i>	Formulary	PDL Preferred
<i>azithromycin 500 mg tablet</i>	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
<i>azithromycin 500 mg tablet 3's, f/c</i>	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
<i>azithromycin 500 mg tablet f/c</i>	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
<i>azithromycin 500 mg tablet inner</i>	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
<i>azithromycin 500 mg tablet outer</i>	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
<i>azithromycin 600 mg tablet</i>	Formulary	PDL Preferred; QL (12 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>azithromycin 600 mg tablet f/c</i>	Formulary	PDL Preferred; QL (12 tablets per 1 claim)
<i>azithromycin intravenous</i>	Non-Formulary	
<i>clarithromycin 125 mg/5 ml sus</i>	Formulary	PDL Preferred
<i>clarithromycin 250 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 250 mg tablet f/c</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 250 mg tablet outer</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 250 mg/5 ml sus</i>	Formulary	PDL Preferred
<i>clarithromycin 500 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 500 mg tablet f/c</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 500 mg tablet f/c, outer</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin 500 mg tablet outer</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>clarithromycin er 500 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>clarithromycin er 500 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
DIFICID 200 MG TABLET	Formulary	PDL Preferred
DIFICID 40 MG/ML SUSPENSION OUTER	Formulary	PDL Preferred; Age Limit (Max 17 Years)
E.E.S. 200 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred
E.E.S. 200 MG/5 ML SUSPENSION GRANULES	Formulary	PA; PDL Non-Preferred
E.E.S. 200 MG/5 ML SUSPENSION GRANULES, CHERRY	Formulary	PA; PDL Non-Preferred
E.E.S. 400 MG TABLET	Formulary	PA; PDL Non-Preferred
ERYPED 200 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred
ERYPED 400 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred
ERY-TAB DR 250 MG TABLET	Formulary	PA; PDL Non-Preferred
ERY-TAB DR 333 MG TABLET	Formulary	PA; PDL Non-Preferred
ERY-TAB DR 500 MG TABLET	Formulary	PA; PDL Non-Preferred
ERYTHROCIN 250 MG TABLET	Formulary	PDL Preferred
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	Non-Formulary	
<i>erythromycin 200 mg/5 ml susp</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>erythromycin 250 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin 400 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin dr 250 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin dr 250 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin dr 333 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin dr 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>erythromycin es 400 mg tab</i>	Formulary	PDL Preferred
<i>erythromycin lactobionate</i>	Non-Formulary	
ZITHROMAX 1 GM POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; QL (2 packets per 1 claim)
ZITHROMAX 100 MG/5 ML SUSP	Formulary	PA; PDL Non-Preferred
ZITHROMAX 200 MG/5 ML SUSP	Formulary	PA; PDL Non-Preferred
ZITHROMAX 250 MG TABLET	Formulary	PA; PDL Non-Preferred
ZITHROMAX 250 MG Z-PAK TABLET 3'S	Formulary	PA; PDL Non-Preferred
ZITHROMAX 500 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 claim)
ZITHROMAX INTRAVENOUS	Non-Formulary	
ZITHROMAX TRI-PAK 500 MG TAB F/C, TRI-PAK, 3X3	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 claim)
<i>Misc Anti-Infective Combinations</i>		
MB CAPS	Non-Formulary	
<i>methen-sod phos-meth blue-hyos</i>	Non-Formulary	
URELLE	Non-Formulary	
URIBEL	Non-Formulary	
URIBEL TABS	Non-Formulary	
URIMAR-T ORAL TABLET	Non-Formulary	
URO-458	Non-Formulary	
UROGESIC-BLUE	Non-Formulary	
URO-MP	Non-Formulary	
<i>Misc Anti-Infective</i>		
<i>methenamine hipp 1 gm tablet</i>	Formulary	
<i>methenamine hipp 1 gm tablet outer</i>	Formulary	
<i>methenamine mand 1 gm tablet</i>	Formulary	
<i>methenamine mand 500 mg tablet</i>	Formulary	
NEBUPENT	Non-Formulary	
PENTAM	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>pentamidine</i>	Non-Formulary	
Monobactam Antibiotics		
AZACTAM	Non-Formulary	
<i>aztreonam</i>	Non-Formulary	
Oxazolidinone Antibiotics		
<i>linezolid 100 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>linezolid 600 mg tablet</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>linezolid 600 mg tablet f/c</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
<i>linezolid 600 mg tablet outer</i>	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
SIVEXTRO 200 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
SIVEXTRO 200 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
ZYVOX 100 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred
ZYVOX 600 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
Penicillin Antibiotic - Natural		
BICILLIN L-A	Non-Formulary	
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	Non-Formulary	
<i>penicillin g potassium</i>	Non-Formulary	
<i>penicillin g sodium</i>	Non-Formulary	
<i>penicillin vk 125 mg/5 ml soln</i>	Formulary	3 Months Allowed
<i>penicillin vk 250 mg tablet</i>	Formulary	3 Months Allowed
<i>penicillin vk 250 mg tablet f/c</i>	Formulary	3 Months Allowed
<i>penicillin vk 250 mg/5 ml soln</i>	Formulary	3 Months Allowed
<i>penicillin vk 500 mg tablet</i>	Formulary	3 Months Allowed
<i>penicillin vk 500 mg tablet f/c</i>	Formulary	3 Months Allowed
PFIZERPEN-G	Non-Formulary	
Penicillin Antibiotic - Penicillinase-Resistant		
<i>dicloxacillin 250 mg capsule</i>	Formulary	
<i>dicloxacillin 500 mg capsule</i>	Formulary	
<i>nafcillin in dextrose iso-osm</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>nafcillin injection</i>	Non-Formulary	
<i>oxacillin</i>	Non-Formulary	
<i>oxacillin in dextrose(iso-osm)</i>	Non-Formulary	
Penicillin Antibiotic, Extended-Spectrum And Beta-Lactamase Inhib Comb		
<i>piperacillin-tazobactam</i>	Non-Formulary	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	Non-Formulary	
Penicillin Natural Antibiotic Combinations - Extended Release		
BICILLIN C-R	Non-Formulary	
Polymyxins And Derivatives - Single Agents		
<i>colistin (colistimethate na)</i>	Non-Formulary	
COLY-MYCIN M PARENTERAL	Non-Formulary	
<i>polymyxin b sulfate</i>	Non-Formulary	
Protease Inhibitors (Non-Peptidic) Antiretroviral		
APTIVUS	State Carve Out	
<i>darunavir</i>	State Carve Out	
<i>darunavir propylene glycolate</i>	State Carve Out	
PREZCOBIX	State Carve Out	
PREZISTA ORAL SUSPENSION	State Carve Out	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	State Carve Out	
Protease Inhibitors (Peptidic) Antiretroviral		
<i>atazanavir</i>	State Carve Out	
EVOTAZ	State Carve Out	
<i>fosamprenavir</i>	State Carve Out	
INVIRASE ORAL TABLET	State Carve Out	
LEXIVA	State Carve Out	
NORVIR ORAL POWDER IN PACKET	State Carve Out	
NORVIR ORAL SOLUTION	State Carve Out	
NORVIR ORAL TABLET	State Carve Out	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	State Carve Out	

Medications	Coverage Level	Restrictions
REYATAZ ORAL POWDER IN PACKET	State Carve Out	
<i>ritonavir</i>	State Carve Out	
VIRACEPT ORAL TABLET	State Carve Out	
<i>Rifamycins And Related Derivative Antibiotics</i>		
AEMCOLO DR 194 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 Fill); Age Limit (Min 18 Years)
MYCOBUTIN	Non-Formulary	
PRIFTIN 150 MG TABLET OUTER	Formulary	QL (24 tablets per 28 days)
<i>rifabutin 150 mg capsule</i>	Formulary	
RIFADIN INTRAVENOUS	Non-Formulary	
<i>rifampin 150 mg capsule</i>	Formulary	
<i>rifampin 150 mg capsule outer</i>	Formulary	
<i>rifampin 300 mg capsule</i>	Formulary	
<i>rifampin 300 mg capsule outer</i>	Formulary	
<i>rifampin intravenous</i>	Non-Formulary	
XIFAXAN 200 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim); Age Limit (Min 12 Years)
XIFAXAN 550 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
XIFAXAN 550 MG TABLET U-D, F/C	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
<i>Sars-Cov-2 Antiviral Agent - Main Protease (Mpro) Inhibitors</i>		
PAXLOVID 150-100 MG DOSE PACK (MODERATE RENAL DOSE) OUTER	Formulary	
PAXLOVID 300/150-100 MG DOSE PACK (SEVERE RENAL DOSE)	Formulary	
PAXLOVID 300-100 MG DOSE PACK OUTER	Formulary	
<i>Sulfonamide Antibiotic</i>		
<i>sulfadiazine</i>	Non-Formulary	
<i>Tetracycline Antibiotics</i>		
<i>demeclocycline</i>	Non-Formulary	
DORYX ORAL TABLET, DELAYED RELEASE (DR/EC) 200 MG, 80 MG	Non-Formulary	
DOXY-100	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>doxycycline 25 mg/5 ml susp</i>	Formulary	
<i>doxycycline hyclate 100 mg cap</i>	Formulary	
<i>doxycycline hyclate 100 mg cap outer</i>	Formulary	
<i>doxycycline hyclate 100 mg tab</i>	Formulary	
<i>doxycycline hyclate 100 mg tab coated, outer</i>	Formulary	
<i>doxycycline hyclate 100 mg tab f/c</i>	Formulary	
<i>doxycycline hyclate 100 mg tab outer</i>	Formulary	
<i>doxycycline hyclate 50 mg cap</i>	Formulary	
<i>doxycycline hyclate 50 mg cap outer</i>	Formulary	
<i>doxycycline hyclate intravenous</i>	Non-Formulary	
<i>doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg</i>	Non-Formulary	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec)</i>	Non-Formulary	
<i>doxycycline mono 100 mg cap</i>	Formulary	
<i>doxycycline mono 100 mg cap outer</i>	Formulary	
<i>doxycycline mono 100 mg tablet</i>	Formulary	
<i>doxycycline mono 100 mg tablet f/c</i>	Formulary	
<i>doxycycline mono 100 mg tablet outer</i>	Formulary	
<i>doxycycline mono 50 mg cap</i>	Formulary	
<i>doxycycline mono 50 mg cap outer</i>	Formulary	
<i>doxycycline mono 50 mg tablet</i>	Formulary	
<i>doxycycline monohydrate oral capsule 150 mg, 75 mg</i>	Non-Formulary	
<i>doxycycline monohydrate oral capsule, ir - delay rel, biphase</i>	Non-Formulary	
<i>doxycycline monohydrate oral tablet 150 mg, 75 mg</i>	Non-Formulary	
<i>minocycline 100 mg capsule</i>	Formulary	
<i>minocycline 100 mg capsule outer</i>	Formulary	
<i>minocycline 50 mg capsule</i>	Formulary	
<i>minocycline 75 mg capsule</i>	Formulary	
<i>minocycline oral tablet</i>	Non-Formulary	
<i>minocycline oral tablet extended release 24 hr</i>	Non-Formulary	
MORGIDOX 1X 50	Non-Formulary	
MORGIDOX 50 MG CAPSULE	Formulary	
NUZYRA ORAL	Non-Formulary	

Medications	Coverage Level	Restrictions
ORACEA	Non-Formulary	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 65 MG, 80 MG	Non-Formulary	
<i>tetracycline oral capsule</i>	Non-Formulary	
Antineoplastics		
<i>Antineoplastic-Epiderm.Growth Factor-Egfr (ErbB1),Her-2 (ErbB2)R.Inhib</i>		
EXKIVITY	State Carve Out	
<i>lapatinib</i>	State Carve Out	
TYKERB	State Carve Out	
<i>Antineoplastic - Cyp17 (17 Alpha-Hydroxylase/C17,20-Lyase) Inhibitor</i>		
<i>abiraterone acetate 250 mg tab</i>	Formulary	
<i>abiraterone acetate 250 mg tab outer</i>	Formulary	
<i>abiraterone acetate 500 mg tab</i>	Formulary	
ABIRTEGA 250 MG TABLET	Formulary	
YONSA 125 MG TABLET	Formulary	
ZYTIGA 250 MG TABLET	Formulary	
ZYTIGA 500 MG TABLET	Formulary	
<i>Antineoplastic - 1St Generation Egfr Tyrosine Kinase Inhibitor</i>		
<i>erlotinib</i>	State Carve Out	
<i>gefitinib</i>	State Carve Out	
IRESSA	State Carve Out	
TARCEVA	State Carve Out	
<i>Antineoplastic - 2Nd Generation Egfr Tyrosine Kinase Inhibitor</i>		
GILOTRIF	State Carve Out	
NERLYNX	State Carve Out	
VIZIMPRO	State Carve Out	
<i>Antineoplastic - 3Rd Generation Egfr Tyrosine Kinase Inhibitor</i>		
LAZCLUZE	State Carve Out	
TAGRISO	State Carve Out	
<i>Antineoplastic - Akt (Protein Kinase B (Pkb)) Inhibitor</i>		
TRUQAP	State Carve Out	

Medications	Coverage Level	Restrictions
Antineoplastic - Alkylating Agent - Methylhydrazines		
MATULANE 50 MG CAPSULE	Formulary	
Antineoplastic - Alkylating Agent - Nitrogen Mustards		
<i>cyclophosphamide 25 mg capsule</i>	Formulary	
<i>cyclophosphamide 50 mg capsule</i>	Formulary	
<i>cyclophosphamide 50 mg tablet outer</i>	Formulary	
Antineoplastic - Alkylating Agent - Triazines		
<i>temozolomide 100 mg capsule</i>	Formulary	
<i>temozolomide 100 mg capsule outer</i>	Formulary	
<i>temozolomide 140 mg capsule</i>	Formulary	
<i>temozolomide 140 mg capsule outer</i>	Formulary	
<i>temozolomide 180 mg capsule</i>	Formulary	
<i>temozolomide 180 mg capsule outer</i>	Formulary	
<i>temozolomide 20 mg capsule</i>	Formulary	
<i>temozolomide 20 mg capsule outer</i>	Formulary	
<i>temozolomide 250 mg capsule</i>	Formulary	
<i>temozolomide 250 mg capsule outer</i>	Formulary	
<i>temozolomide 5 mg capsule</i>	Formulary	
<i>temozolomide 5 mg capsule outer</i>	Formulary	
Antineoplastic - Anaplastic Lymphoma Kinase (Alk) Inhibitors		
ALECENSA	State Carve Out	
ALUNBRIG	State Carve Out	
LORBRENA	State Carve Out	
XALKORI	State Carve Out	
ZYKADIA	State Carve Out	
Antineoplastic - Antiadrenals		
LYSODREN 500 MG TABLET	Formulary	
Antineoplastic - Antiandrogens		
<i>abiraterone acetate 250 mg tab</i>	Formulary	
<i>abiraterone acetate 250 mg tab outer</i>	Formulary	
<i>abiraterone acetate 500 mg tab</i>	Formulary	
ABIRTEGA 250 MG TABLET	Formulary	
<i>bicalutamide 50 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>bicalutamide 50 mg tablet flc</i>	Formulary	
CASODEX 50 MG TABLET	Formulary	
ERLEADA 240 MG TABLET	Formulary	
ERLEADA 60 MG TABLET	Formulary	
<i>nilutamide 150 mg tablet</i>	Formulary	
NUBEQA 300 MG TABLET	Formulary	
XTANDI 40 MG CAPSULE	Formulary	
XTANDI 40 MG TABLET	Formulary	
XTANDI 80 MG TABLET	Formulary	
YONSA 125 MG TABLET	Formulary	
ZYTIGA 250 MG TABLET	Formulary	
ZYTIGA 500 MG TABLET	Formulary	
<i>Antineoplastic - Antimetabolite - Folic Acid Analogs</i>		
JYLAMVO 2 MG/ML ORAL SOLUTION	Formulary	
<i>methotrexate 1 gm vial p/f, lyophil, sdv</i>	Formulary	
<i>methotrexate 1 gm vial p/f, sdv</i>	Formulary	
<i>methotrexate 1 gm vial p/f, suv</i>	Formulary	
<i>methotrexate 1 gm vial suv, p/f</i>	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f, suv</i>	Formulary	
<i>methotrexate 1 gram/40 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 2.5 mg tablet</i>	Formulary	
<i>methotrexate 2.5 mg tablet outer</i>	Formulary	
<i>methotrexate 2.5 mg tablet u-d, 10x10, blisters</i>	Formulary	
<i>methotrexate 2.5 mg tablet u-d, 2x10, outer</i>	Formulary	
<i>methotrexate 25 mg/ml vial p/f</i>	Formulary	
<i>methotrexate 250 mg/10 ml vial</i>	Formulary	
<i>methotrexate 250 mg/10 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial outer</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial outer, p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial p/f, sdv</i>	Formulary	
<i>methotrexate 50 mg/2 ml vial p/f, suv</i>	Formulary	
TREXALL 10 MG TABLET	Formulary	
TREXALL 15 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
TREXALL 5 MG TABLET	Formulary	
TREXALL 7.5 MG TABLET	Formulary	
XATMEP 2.5 MG/ML ORAL SOLUTION	Formulary	
Antineoplastic - Antimetabolite - Purine Analogs		
<i>mercaptopurine 20 mg/ml suspen</i>	Formulary	
<i>mercaptopurine 50 mg tablet</i>	Formulary	
PURIXAN 20 MG/ML ORAL SUSP OUTER	Formulary	
TABLOID 40 MG TABLET	Formulary	
Antineoplastic - Antimetabolite - Pyrimidine Analogs		
<i>capecitabine 150 mg tablet</i>	Formulary	
<i>capecitabine 500 mg tablet</i>	Formulary	
<i>capecitabine 500 mg tablet f/c</i>	Formulary	
<i>capecitabine 500 mg tablet outer</i>	Formulary	
ONUREG 200 MG TABLET	Formulary	
ONUREG 300 MG TABLET	Formulary	
XELODA 150 MG TABLET	Formulary	
XELODA 500 MG TABLET	Formulary	
XELODA 500 MG TABLET F/C	Formulary	
Antineoplastic - Antimetabolite - Urea Derivatives		
HYDREA 500 MG CAPSULE	Formulary	3 Months Allowed
<i>hydroxyurea 500 mg capsule</i>	Formulary	3 Months Allowed
<i>hydroxyurea 500 mg capsule u-d,10x10,outer</i>	Formulary	3 Months Allowed
Antineoplastic - Antimetabolites - Pyrimidine Analog Combinations		
LONSURF 15 MG-6.14 MG TABLET	Formulary	
LONSURF 20 MG-8.19 MG TABLET	Formulary	
Antineoplastic - Aromatase Inhibitors		
<i>anastrozole 1 mg tablet</i>	Formulary	
<i>anastrozole 1 mg tablet coated</i>	Formulary	
<i>anastrozole 1 mg tablet f/c</i>	Formulary	
<i>anastrozole 1 mg tablet outer</i>	Formulary	
ARIMIDEX 1 MG TABLET	Formulary	
AROMASIN 25 MG TABLET	Formulary	
<i>exemestane 25 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>exemestane 25 mg tablet flc</i>	Formulary	
FEMARA 2.5 MG TABLET	Formulary	
<i>letrozole 2.5 mg tablet</i>	Formulary	
<i>letrozole 2.5 mg tablet flc</i>	Formulary	
<i>letrozole 2.5 mg tablet never launched</i>	Formulary	
<i>letrozole 2.5 mg tablet outer</i>	Formulary	
<i>Antineoplastic - B-Cell Lymphoma-2 (Bcl-2) Inhibitors</i>		
VENCLEXTA 10 MG TAB (10 MG X 2)	Formulary	
VENCLEXTA 10 MG TABLET	Formulary	
VENCLEXTA 100 MG TABLET	Formulary	
VENCLEXTA 50 MG TABLET	Formulary	
VENCLEXTA STARTING PACK	Formulary	
<i>Antineoplastic - Braf Kinase Inhibitors</i>		
BRAFTOVI 75 MG CAPSULE OUTER	Formulary	
OJEMDA 100 MG TAB (400 MG DOSE)	Formulary	
OJEMDA 100 MG TAB (500 MG DOSE)	Formulary	
OJEMDA 100 MG TAB (600 MG DOSE)	Formulary	
OJEMDA 25 MG/ML ORAL SUSP OUTER	Formulary	
TAFINLAR	State Carve Out	
ZELBORAF	State Carve Out	
<i>Antineoplastic - Bruton's Tyrosine Kinase (Btk) Inhibitor</i>		
BRUKINSA	State Carve Out	
CALQUENCE	State Carve Out	
CALQUENCE (ACALABRUTINIB MAL)	State Carve Out	
IMBRUVICA	State Carve Out	
JAYPIRCA	State Carve Out	
<i>Antineoplastic - Cd20 Specific Recombinant Monoclonal Antibody Agents</i>		
RUXIENCE	Non-Formulary	
<i>Antineoplastic - Cyclin-Dependent Kinase (Cdk) 4/6 Inhibitors</i>		
IBRANCE	State Carve Out	
KISQALI	State Carve Out	
VERZENIO	State Carve Out	

Medications	Coverage Level	Restrictions
<i>Antineoplastic - Epidermal Growth Factor Receptor-2 (Her2) Inhibitor</i>		
TUKYSA	State Carve Out	
<i>Antineoplastic - Epipodophyllotoxins</i>		
<i>etoposide 50 mg capsule outer</i>	Formulary	
<i>Antineoplastic - Exportin-1 (Xpo1) Inhibitors</i>		
XPOVIO 100 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 40 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 40 MG TWICE WEEKLY DOSE OUTER	Formulary	
XPOVIO 60 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 60 MG TWICE WEEKLY DOSE OUTER	Formulary	
XPOVIO 80 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 80 MG TWICE WEEKLY DOSE OUTER	Formulary	
<i>Antineoplastic - Ezh2 Histone Methyltransferase (Hmt) Inhibitor</i>		
TAZVERIK 200 MG TABLET	Formulary	
<i>Antineoplastic - Fibroblast Growth Factor Receptor (Fgfr) Kinase Inhib</i>		
BALVERSA	State Carve Out	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)	State Carve Out	
PEMAZYRE	State Carve Out	
TRUSELTIQ	State Carve Out	
<i>Antineoplastic - Fms-Like Tyrosine Kinase 3 (Flt3) Inhibitors</i>		
VANFLYTA	State Carve Out	
XOSPATA	State Carve Out	
<i>Antineoplastic - Gamma-Secretase Inhibitor (Gsi)</i>		
OGSIVEO	State Carve Out	

Medications	Coverage Level	Restrictions
<i>Antineoplastic - Hedgehog Pathway Inhibitor</i>		
DAURISMO 100 MG TABLET	Formulary	
DAURISMO 25 MG TABLET	Formulary	
ERIVEDGE 150 MG CAPSULE	Formulary	
ODOMZO 200 MG CAPSULE	Formulary	
<i>Antineoplastic - Histone Deacetylase (Hdac) Inhibitors</i>		
ZOLINZA 100 MG CAPSULE	Formulary	
<i>Antineoplastic - Hypoxia Inducible Factor (Hif) Inhibitors</i>		
WELIREG	State Carve Out	
<i>Antineoplastic - Interferons</i>		
BESREMI 500 MCG/ML SYRINGE	Formulary	
<i>Antineoplastic - Janus Kinase (Jak) Inhibitors</i>		
JAKAFI 10 MG TABLET	Formulary	
JAKAFI 15 MG TABLET	Formulary	
JAKAFI 20 MG TABLET	Formulary	
JAKAFI 25 MG TABLET	Formulary	
JAKAFI 5 MG TABLET	Formulary	
<i>Antineoplastic - Janus Kinase (Jak), Acvr1/Alk2 Inhibitors</i>		
OJJAARA	State Carve Out	
<i>Antineoplastic - Janus Kinase(Jak),Fms-Like Tyrosine Kinase(Flt) Inhib</i>		
INREBIC	State Carve Out	
VONJO	State Carve Out	
<i>Antineoplastic - Kinase Inhibitor And Aromatase Inhibitor Combination</i>		
KISQALI FEMARA 200 MG CO-PACK	Formulary	
KISQALI FEMARA 400 MG CO-PACK	Formulary	
KISQALI FEMARA 600 MG CO-PACK	Formulary	
<i>Antineoplastic - Kirsten Rat Sarcoma (Kras) Protein Inhibitor</i>		
KRAZATI 200 MG TABLET	Formulary	
LUMAKRAS 120 MG TABLET INNER	Formulary	
LUMAKRAS 120 MG TABLET OUTER	Formulary	

Medications	Coverage Level	Restrictions
LUMAKRAS 240 MG TABLET	Formulary	
LUMAKRAS 320 MG TABLET	Formulary	
Antineoplastic - Lhrh (Gnrh) Agonist Analog Pituitary Suppressants		
CAMCEVI 42 MG SYRINGE	Formulary	
ELIGARD 22.5 MG SYRINGE KIT OUTER, SUV	Formulary	
ELIGARD 22.5 MG SYRINGE KIT SUV	Formulary	
ELIGARD 30 MG SYRINGE KIT	Formulary	
ELIGARD 30 MG SYRINGE KIT OUTER,SUV	Formulary	
ELIGARD 45 MG SYRINGE KIT OUTER, SUV	Formulary	
ELIGARD 45 MG SYRINGE KIT SUV	Formulary	
ELIGARD 7.5 MG SYRINGE KIT OUTER,SUV	Formulary	
ELIGARD 7.5 MG SYRINGE KIT SUV	Formulary	
<i>leuprolide 2wk 14 mg/2.8 ml kt mdv</i>	Formulary	
<i>leuprolide 2wk 14 mg/2.8 ml kt muv</i>	Formulary	
<i>leuprolide 2wk 14 mg/2.8 ml kt outer, muv</i>	Formulary	
<i>leuprolide 2wk 14 mg/2.8 ml kt outer,mdv</i>	Formulary	
<i>leuprolide depot 22.5 mg vial outer, suv</i>	Formulary	
LUPRON DEPOT 22.5 MG 3MO KIT SUV, P/F	Formulary	
LUPRON DEPOT 45 MG 6MO KIT	Formulary	
LUPRON DEPOT 7.5 MG KIT SINGLE DOSE	Formulary	
LUPRON DEPOT-4 MONTH KIT SUV, P/F	Formulary	
TRELSTAR 11.25 MG VIAL INNER, SUV	Formulary	
TRELSTAR 11.25 MG VIAL OUTER, SUV	Formulary	
TRELSTAR 22.5 MG VIAL INNER,SUV	Formulary	
TRELSTAR 22.5 MG VIAL OUTER,SUV	Formulary	
TRELSTAR 3.75 MG VIAL INNER, SUV	Formulary	
TRELSTAR 3.75 MG VIAL OUTER, SUV	Formulary	
Antineoplastic - Lhrh (Gnrh) Antagonist Pituitary Suppressants		
ORGOVYX 120 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
Antineoplastic - Mast Cell Stabilizers		
<i>cromolyn 100 mg/5 ml oral conc</i>	Formulary	
<i>cromolyn 100 mg/5 ml oral conc outer</i>	Formulary	
GASTROCROM 100 MG/5 ML CONC OUTER	Formulary	
Antineoplastic - Mek1 And Mek2 Kinase Inhibitors		
COTELLIC	State Carve Out	
GOMEKLI	State Carve Out	
KOSELUGO	State Carve Out	
MEKINIST	State Carve Out	
MEKTOVI	State Carve Out	
Antineoplastic - Menin Inhibitors		
REVUFORJ	State Carve Out	
Antineoplastic - Mtor Kinase Inhibitors		
AFINITOR 10 MG TABLET INNER, U-D, 4X7	Formulary	
AFINITOR 10 MG TABLET OUTER, U-D,4X7	Formulary	
AFINITOR 2.5 MG TABLET INNER,U-D	Formulary	
AFINITOR 2.5 MG TABLET OUTER,4X7,U-D	Formulary	
AFINITOR 5 MG TABLET INNER, U-D, 4X7	Formulary	
AFINITOR 5 MG TABLET OUTER, U-D,4X7	Formulary	
AFINITOR 7.5 MG TABLET 4X7,OUTER,U-D	Formulary	
AFINITOR 7.5 MG TABLET INNER,U-D	Formulary	
AFINITOR DISPERZ 2 MG TABLET INNER	Formulary	
AFINITOR DISPERZ 2 MG TABLET OUTER	Formulary	
AFINITOR DISPERZ 3 MG TABLET INNER	Formulary	
AFINITOR DISPERZ 3 MG TABLET OUTER	Formulary	
AFINITOR DISPERZ 5 MG TABLET INNER	Formulary	
AFINITOR DISPERZ 5 MG TABLET OUTER	Formulary	
<i>everolimus 10 mg tablet</i>	Formulary	
<i>everolimus 10 mg tablet outer</i>	Formulary	
<i>everolimus 2 mg tab for susp outer</i>	Formulary	
<i>everolimus 2.5 mg tablet</i>	Formulary	
<i>everolimus 2.5 mg tablet outer</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>everolimus 3 mg tab for susp outer</i>	Formulary	
<i>everolimus 5 mg tab for susp outer</i>	Formulary	
<i>everolimus 5 mg tablet</i>	Formulary	
<i>everolimus 5 mg tablet outer</i>	Formulary	
<i>everolimus 7.5 mg tablet</i>	Formulary	
<i>everolimus 7.5 mg tablet outer</i>	Formulary	
TORPENZ 10 MG TABLET	Formulary	
TORPENZ 2.5 MG TABLET	Formulary	
TORPENZ 5 MG TABLET	Formulary	
TORPENZ 7.5 MG TABLET	Formulary	
<i>Antineoplastic - Multikinase Inhibitors</i>		
CABOMETYX	State Carve Out	
COMETRIQ	State Carve Out	
ICLUSIG	State Carve Out	
NEXAVAR	State Carve Out	
<i>sorafenib</i>	State Carve Out	
STIVARGA	State Carve Out	
UKONIQ	State Carve Out	
<i>Antineoplastic - Mutant Isocitrate Dehydrogenase 1 (Mdh1) Inhibitors</i>		
REZLIDHIA 150 MG CAPSULE	Formulary	
TIBSOVO 250 MG TABLET	Formulary	
<i>Antineoplastic - Mutant Isocitrate Dehydrogenase 2 (Mdh2) Inhibitors</i>		
IDHIFA 100 MG TABLET	Formulary	
IDHIFA 50 MG TABLET	Formulary	
<i>Antineoplastic - Ornithine Decarboxylase (Odc) Inhibitors</i>		
IWILFIN	State Carve Out	
<i>Antineoplastic - Pan-Class I Pi3k Inhibitors</i>		
ALIQOPA	State Carve Out	
<i>Antineoplastic - Parp Inhibitor And Antiandrogen Combinations</i>		
AKEEGA 100-500 MG TABLET	Formulary	
AKEEGA 50-500 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
Antineoplastic - Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors		
ALIQOPA	State Carve Out	
COPIKTRA	State Carve Out	
ZYDELIG	State Carve Out	
Antineoplastic - Pi3k-Alpha Inhibitors		
ITOVEBI	State Carve Out	
PIQRAY	State Carve Out	
Antineoplastic - Pi3k-Delta And Gamma Inhibitors		
COPIKTRA	State Carve Out	
Antineoplastic - Pi3k-Delta Inhibitors		
ZYDELIG	State Carve Out	
Antineoplastic - Poly (Adp-Ribose) Polymerase (Parp) Inhibitors		
LYNPARZA	State Carve Out	
RUBRACA	State Carve Out	
TALZENNA	State Carve Out	
ZEJULA	State Carve Out	
Antineoplastic - Progestins		
megestrol 20 mg tablet	Formulary	
megestrol 40 mg tablet	Formulary	
Antineoplastic - Proteasome Enzyme Inhibitors		
bortezomib injection	State Carve Out	
bortezomib intravenous recon soln	State Carve Out	
bortezomib intravenous solution 2.5 mg/ml	State Carve Out	
BORUZU	State Carve Out	
KYPROLIS	State Carve Out	
NINLARO	State Carve Out	
VELCADE	State Carve Out	
Antineoplastic - Protein-Tyrosine Kinase Inhibitors		
AUGTYRO	State Carve Out	
AYVAKIT	State Carve Out	
BOSULIF	State Carve Out	
BRUKINSA	State Carve Out	

Medications	Coverage Level	Restrictions
CALQUENCE	State Carve Out	
CALQUENCE (ACALABRUTINIB MAL)	State Carve Out	
CAPRELSA	State Carve Out	
DANZITEN	State Carve Out	
<i>dasatinib</i>	State Carve Out	
FOTIVDA	State Carve Out	
FRUZAQLA	State Carve Out	
GLEEVEC	State Carve Out	
<i>imatinib</i>	State Carve Out	
IMBRUVICA	State Carve Out	
IMKELDI	State Carve Out	
INLYTA	State Carve Out	
JAYPIRCA	State Carve Out	
LENVIMA	State Carve Out	
OFEV	Non-Formulary	
<i>pazopanib</i>	State Carve Out	
QINLOCK	State Carve Out	
ROMVIMZA	State Carve Out	
ROZLYTREK	State Carve Out	
RYDAPT	State Carve Out	
SCSEMBLIX	State Carve Out	
SPRYCEL	State Carve Out	
<i>sunitinib malate</i>	State Carve Out	
SUTENT	State Carve Out	
TABRECTA	State Carve Out	
TASIGNA	State Carve Out	
TEPMETKO	State Carve Out	
TURALIO	State Carve Out	
VOTRIENT	State Carve Out	
<i>Antineoplastic - Retinoids</i>		
<i>tretinoin 10 mg capsule</i>	Formulary	
<i>tretinoin 10 mg capsule 3x10, outer</i>	Formulary	
<i>Antineoplastic - Selective Estrogen Receptor Degradars (Serds)</i>		
ORSERDU 345 MG TABLET	Formulary	
ORSERDU 86 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
Antineoplastic - Selective Estrogen Receptor Modulators (Serms)		
FARESTON 60 MG TABLET	Formulary	
SOLTAMOX 20 MG/10 ML SOLN	Formulary	
<i>tamoxifen 10 mg tablet</i>	Formulary	
<i>tamoxifen 10 mg tablet 15.2mg tamoxifen cit</i>	Formulary	
<i>tamoxifen 20 mg tablet</i>	Formulary	
<i>tamoxifen 20 mg tablet 30.4mg tamoxifen cit</i>	Formulary	
<i>toremifene citrate 60 mg tab</i>	Formulary	
Antineoplastic - Selective Inhibitors Of Nuclear Export (Sine)		
XPOVIO 100 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 40 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 40 MG TWICE WEEKLY DOSE OUTER	Formulary	
XPOVIO 60 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 60 MG TWICE WEEKLY DOSE OUTER	Formulary	
XPOVIO 80 MG ONCE WEEKLY DOSE OUTER	Formulary	
XPOVIO 80 MG TWICE WEEKLY DOSE OUTER	Formulary	
Antineoplastic - Selective Ret Kinase Inhibitor		
GAVRETO	State Carve Out	
RETEVMO	State Carve Out	
Antineoplastic - Selective Retinoid X Receptor Agonists		
<i>bexarotene 75 mg capsule</i>	Formulary	
TARGRETIN 75 MG CAPSULE	Formulary	
Antineoplastic - Telomerase Inhibitors		
RYTELO	State Carve Out	
Antineoplastic - Thalidomide Analogs		
<i>lenalidomide 10 mg capsule</i>	Formulary	
<i>lenalidomide 15 mg capsule</i>	Formulary	
<i>lenalidomide 2.5 mg capsule</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>lenalidomide 20 mg capsule</i>	Formulary	
<i>lenalidomide 25 mg capsule</i>	Formulary	
<i>lenalidomide 5 mg capsule</i>	Formulary	
POMALYST 1 MG CAPSULE	Formulary	
POMALYST 2 MG CAPSULE	Formulary	
POMALYST 3 MG CAPSULE	Formulary	
POMALYST 4 MG CAPSULE	Formulary	
REVLIMID 10 MG CAPSULE	Formulary	
REVLIMID 15 MG CAPSULE	Formulary	
REVLIMID 2.5 MG CAPSULE	Formulary	
REVLIMID 20 MG CAPSULE	Formulary	
REVLIMID 25 MG CAPSULE	Formulary	
REVLIMID 5 MG CAPSULE	Formulary	
THALOMID 100 MG CAPSULE	Formulary	
THALOMID 200 MG CAPSULE	Formulary	
THALOMID 50 MG CAPSULE	Formulary	
<i>Antineoplastic - Topoisomerase I Inhibitors</i>		
HYCAMTIN 0.25 MG CAPSULE	Formulary	
HYCAMTIN 1 MG CAPSULE	Formulary	
<i>Antineoplastic - Tropomyosin Receptor Kinase (Trk) Inhibitor</i>		
VITRAKVI	State Carve Out	
<i>Antineoplastic-Anti-Programmed Cell Death Ligand-1 (Pd-L1) Mc Antib.</i>		
IMFINZI	Non-Formulary	
<i>Antineoplastic-Anti-Programmed Cell Death Receptor-1 (Pd-1) Mc Antib.</i>		
JEMPERLI	Non-Formulary	
OPDIVO INTRAVENOUS SOLUTION 240 MG/24 ML	Non-Formulary	
<i>Antineoplastic-Isocitrate Dehydrogenase-1 And -2 (Idh1 And Idh2) Inhib</i>		
VORANIGO 10 MG TABLET	Formulary	
VORANIGO 40 MG TABLET	Formulary	
<i>Antineoplastic-Pyrimidine Analog And Cytidine Deaminase Inhibitor Comb</i>		
INQOVI 35 MG-100 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
Bone Marrow Protective Agents Used In Conjunction With Chemotherapy		
COSELA	State Carve Out	
Immune-Mobilizing Monoclonal Tcr Against Cancer (Immtac)		
KIMMTRAK	Non-Formulary	
Methotrexate Rescue Agents - Folic Acid Antagonist Type		
leucovorin calcium 10 mg tab	Formulary	
leucovorin calcium 15 mg tab	Formulary	
leucovorin calcium 25 mg tab	Formulary	
leucovorin calcium 25 mg tab outer	Formulary	
leucovorin calcium 5 mg tab	Formulary	
leucovorin calcium 5 mg tab u-d,5x10,outer	Formulary	
Methotrexate Rescue Agents		
leucovorin calcium 10 mg tab	Formulary	
leucovorin calcium 15 mg tab	Formulary	
leucovorin calcium 25 mg tab	Formulary	
leucovorin calcium 25 mg tab outer	Formulary	
leucovorin calcium 5 mg tab	Formulary	
leucovorin calcium 5 mg tab u-d,5x10,outer	Formulary	
Urinary Tract Protective Agents Used In Conjunction With Chemotherapy		
mesna 400 mg tablet outer	Formulary	
MESNEX 400 MG TABLET	Formulary	
Antiseptics And Disinfectants		
Antiseptic - Alcohols		
alcohol 70% prep pads	Formulary	OTC
ALCOHOL 70% PREP PADS	Formulary	OTC
ALCOHOL 70% PREP PADS INNER	Formulary	OTC
ALCOHOL 70% PREP PADS OUTER	Formulary	OTC
ALCOHOL 70% PREP PADS STERILE	Formulary	OTC
ALCOHOL 70% PREP PADS TWO-PLY, LARGE	Formulary	OTC
ALCOHOL 70% PREP PADS TWO-PLY, MEDIUM	Formulary	OTC
alcohol 70% swabs	Formulary	OTC
alcohol 70% wipes	Formulary	OTC

Medications	Coverage Level	Restrictions
ALCOHOL PREP PADS	Formulary	OTC
<i>alcohol swab sterile, two ply</i>	Formulary	OTC
<i>alcohol swabs</i>	Formulary	OTC
BD SINGLE USE SWAB	Formulary	OTC
CARETOUCH ALCOHOL PREP PAD	Non-Formulary	OTC
CURITY ALCOHOL PREPS 2 PLY,MEDIUM	Formulary	OTC
CVS ALCOHOL 70% PREP PADS	Formulary	OTC
CVS ISOPROPYL ALCOHOL 70% WIPE	Formulary	OTC
DROPSAFE ALCOHOL PREP PADS	Non-Formulary	OTC
EASY COMFORT ALCOHOL PAD	Non-Formulary	OTC
EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED	Formulary	OTC
EASY TOUCH ALCOHOL 70% PADS MEDIUM 2-PLY	Formulary	OTC
FIFTY50 ALCOHOL PREP PADS	Formulary	OTC
<i>gnp alcohol swab sterile, two ply</i>	Formulary	OTC
HM ALCOHOL 70% PREP PADS	Formulary	OTC
INCONTROL ALCOHOL PADS	Non-Formulary	OTC
<i>pharm choice alcohol prep pads</i>	Formulary	OTC
PHARM CHOICE ALCOHOL PREP PADS	Formulary	OTC
PREP EASE ALCOHOL PADS	Formulary	OTC
PRO COMFORT ALCOHOL PADS	Non-Formulary	OTC
PURE COMFORT ALCOHOL PADS	Non-Formulary	OTC
<i>ra alcohol swabs health care, 70%</i>	Formulary	OTC
RA ISOPROPYL ALCOHOL 70% WIPES	Formulary	OTC
<i>relion alcohol 70% swabs</i>	Formulary	OTC
<i>saps alcohol 70% prep pads</i>	Formulary	OTC
SAPS ALCOHOL 70% PREP PADS	Formulary	OTC
SM ALCOHOL 70% PREP PADS	Formulary	OTC
SURE COMFORT ALCOHOL PREP PADS	Formulary	OTC
SURE-PREP ALCOHOL PREP PADS	Formulary	OTC
SWI ALCOHOL 70% PREP PADS	Formulary	OTC
TRUE COMFORT ALCOHOL PADS	Non-Formulary	OTC
TRUE COMFORT PRO ALCOHOL PADS	Non-Formulary	OTC
ULTILET ALCOHOL STERL SWAB	Formulary	OTC
WEBCOL ALCOHOL PREPS 20'S,LARGE	Formulary	OTC

Medications	Coverage Level	Restrictions
WEBCOL ALCOHOL PREPS 20'S,LARGE,2-PLY	Formulary	OTC
WEBCOL ALCOHOL PREPS 20'S,MEDIUM,2-PLY	Formulary	OTC
<i>Antiseptic - Iodine/Iodophores</i>		
LUGOLS TOPICAL	Non-Formulary	OTC
Biologicals		
<i>Allergenic Extracts - Grass Pollen</i>		
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	Non-Formulary	
<i>Antiviral Monoclonal Antibodies - Respiratory Syncytial Virus (Rsv)</i>		
BEYFORTUS 100 MG/ML SYRINGE SUV, P/F, INNER	Formulary	PA
BEYFORTUS 100 MG/ML SYRINGE SUV, P/F, OUTER	Formulary	PA
BEYFORTUS 50 MG/0.5 ML SYRINGE SUV, P/F, INNER	Formulary	PA
BEYFORTUS 50 MG/0.5 ML SYRINGE SUV, P/F, OUTER	Formulary	PA
SYNAGIS 100 MG/ML VIAL	Formulary	PA
SYNAGIS 50 MG/0.5 ML VIAL	Formulary	PA
<i>Hepatitis A And Hepatitis B Vaccine Combinations</i>		
TWINRIX (PF)	Formulary	QL (4 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Hepatitis A Vaccine - Single Agents</i>		
HAVRIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
VAQTA (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Hepatitis B Vaccines - Single Agents</i>		
ENGERIX-B (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
ENGERIX-B PEDIATRIC (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
HEPLISAV-B (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PREHEVBRIO (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)

Medications	Coverage Level	Restrictions
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 20 Years)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 5 MCG/0.5 ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years and Max 19 Years)
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 20 Years)
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years and Max 19 Years)
<i>Immune Globulin - Gamma Globulin (Igg), Human</i>		
CUTAQUIG	Non-Formulary	
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 %	Non-Formulary	
PANZYGA	Non-Formulary	
<i>Immune Globulin - Hepatitis B</i>		
NABI-HB INTRAMUSCULAR SOLUTION GREATR THAN 312 UNIT/ML	Non-Formulary	
<i>Immune Globulin - Rho(D)</i>		
HYPERRHO S/D	Non-Formulary	
RHOGAM ULTRA-FILTERED PLUS	Non-Formulary	
RHOPHYLAC	Non-Formulary	
WINRHO SDF	Non-Formulary	
<i>Live Vaccine And Live Virus Formulations</i>		
FLUMIST TRIVALENT 2024-2025	Formulary	Age Limit (Min 19 Years and Max 49 Years)
IXCHIQ (PF)	Formulary	Age Limit (Min 18 Years)
JYNNEOS (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
M-M-R II (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PRIORIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
VARIVAX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
VAXCHORA VACCINE	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 2 Years and Max 64 Years)

Medications	Coverage Level	Restrictions
VIVOTIF	Formulary	QL (4 capsules per 1 lifetime); Age Limit (Min 6 Years)
YF-VAX (PF)	Formulary	QL (1 dose per 1 lifetime)
<i>Peanut Desensitization Agents</i>		
PALFORZIA 1 MG (LEVEL 0)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 12 MG (LEVEL 3)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 120 MG (LEVEL 7)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 160 MG (LEVEL 8)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 20 MG (LEVEL 4)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 200 MG (LEVEL 9)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 240 MG (LEVEL 10)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 3 MG (LEVEL 1)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 300 MG (LEVEL 11)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 300 MG (MAINTENANCE)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 40 MG (LEVEL 5)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 6 MG (LEVEL 2)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA 80 MG (LEVEL 6)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA INITIAL (1-3 YRS)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
PALFORZIA INITIAL (4-17 YRS)	Formulary	PA; Age Limit (Min 1 Years and Max 17 Years)
<i>Toxoid Vaccine Combinations</i>		
ADACEL(TDAP ADOLESN/ADULT)(PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
BOOSTRIX TDAP	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
TDVAX	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)

Medications	Coverage Level	Restrictions
TENIVAC (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Bacterial - Gram Negative Bacilli (Non-Enteric)</i>		
ACTHIB (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
HIBERIX (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
PEDVAX HIB (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
TYPHIM VI	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 2 Years)
VIVOTIF	Formulary	QL (4 capsules per 1 lifetime); Age Limit (Min 6 Years)
<i>Vaccine Bacterial - Gram Negative Cocci</i>		
MENACTRA (PF) INTRAMUSCULAR SOLUTION	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years and Max 55 Years)
MENQUADFI (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
MENVEO A-C-Y-W-135-DIP (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years and Max 55 Years)
PENBRAYA (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Bacterial - Gram Positive Cocci</i>		
CAPVAXIVE	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
PNEUMOVAX-23	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
PREVNAR 13 (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
PREVNAR 20 (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
VAXNEUVANCE (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Bacterial - Meningococcal Group B Vaccines</i>		
BEXSERO	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)

Medications	Coverage Level	Restrictions
TRUMENBA	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Bacterial - Toxin-Producing Bacilli</i>		
VAXCHORA VACCINE	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 2 Years and Max 64 Years)
<i>Vaccine Viral - Chikungunya Virus (Chikv)</i>		
IXCHIQ (PF)	Formulary	Age Limit (Min 18 Years)
VIMKUNYA	Formulary	Age Limit (Min 12 Years)
<i>Vaccine Viral - Covid-19 (Sars-Cov-2)</i>		
COMIRNATY 2024-25 (12Y UP)(PF)	Formulary	QL (1 rx per 1 Year); Age Limit (Min 19 Years)
NOVAVAX COVID 2024-25(PF)(EUA)	Formulary	QL (1 rx per 1 Year); Age Limit (Min 19 Years)
SPIKEVAX 2024-2025(12Y UP)(PF)	Formulary	QL (1 rx per 1 Year); Age Limit (Min 19 Years)
<i>Vaccine Viral - Human Papillomavirus (Hpv) Vaccines</i>		
GARDASIL 9 (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Influenza A And B</i>		
AFLURIA TRIV 2024-2025	Formulary	Age Limit (Min 19 Years and Max 64 Years)
AFLURIA TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUAD TRIV 2024-25(65Y UP)(PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUARIX TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUBLOK TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUCELVAX TRIV 2024-2025	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUCELVAX TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLULAVAL TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUMIST TRIVALENT 2024-2025	Formulary	Age Limit (Min 19 Years and Max 49 Years)

Medications	Coverage Level	Restrictions
FLUZONE HIGH-DOSE TRIV 24-25	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUZONE TRIV 2024-2025	Formulary	Age Limit (Min 19 Years and Max 64 Years)
FLUZONE TRIV 2024-2025 (PF)	Formulary	Age Limit (Min 19 Years and Max 64 Years)
<i>Vaccine Viral - Japanese Encephalitis</i>		
IXIARO (PF)	Formulary	QL (2 doses per 1 lifetime)
<i>Vaccine Viral - Measles</i>		
M-M-R II (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PRIORIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Mpox</i>		
JYNNEOS (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Mumps And Related</i>		
M-M-R II (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PRIORIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Poliomyelitis</i>		
IPOL	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Respiratory Syncytial Virus (Rsv)</i>		
ABRYSVO (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 60 Years)
AREXVY (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 60 Years)
MRESVIA (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 60 Years)
<i>Vaccine Viral - Rubella</i>		
M-M-R II (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PRIORIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Smallpox</i>		
JYNNEOS (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)

Medications	Coverage Level	Restrictions
<i>Vaccine Viral - Varicella</i>		
SHINGRIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 18 Years)
VARIVAX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral - Yellow Fever</i>		
YF-VAX (PF)	Formulary	QL (1 dose per 1 lifetime)
<i>Vaccine Viral Combinations</i>		
M-M-R II (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
PRIORIX (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
<i>Vaccine Viral- Tick-Borne Encephalitis</i>		
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Max 15 Years)
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 16 Years)
Cardiovascular Therapy Agents		
<i>Ace Inhibitor And Calcium Channel Blocker Combinations</i>		
<i>amlodipine-benazepril 10-20 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-benazepril 10-40 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-benazepril 2.5-10</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-benazepril 5-10 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-benazepril 5-20 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-benazepril 5-40 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
LOTREL 10-20 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTREL 10-40 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTREL 5-10 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTREL 5-20 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>trandolapril-verapamil er 1-240 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>trandolapril-verapamil er 2-180 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>trandolapril-verapamil er 2-240 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>trandolapril-verapamil er 4-240 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Ace Inhibitor And Diuretic Combinations</i>		
ACCURETIC 10-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCURETIC 20-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCURETIC 20-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>benazepril-hydrochlorothiazide 10-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril-hydrochlorothiazide 20-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril-hydrochlorothiazide 20-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril-hydrochlorothiazide 5-6.25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>captopril-hydrochlorothiazide 25-15 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril-hydrochlorothiazide 25-25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril-hydrochlorothiazide 50-15 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril-hydrochlorothiazide 50-25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>enalapril-hydrochlorothiazide 10-25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril-hydrochlorothiazide 5-12.5 mg tab tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fosinopril-hydrochlorothiazide 10-12.5 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fosinopril-hydrochlorothiazide 20-12.5 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>lisinopril-hydrochlorothiazide 10-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>lisinopril-hydrochlorothiazide 20-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril-hydrochlorothiazide 20-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
LOTENSIN HCT 10-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTENSIN HCT 20-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTENSIN HCT 20-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril-hydrochlorothiazide 10-12.5 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril-hydrochlorothiazide 20-12.5 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril-hydrochlorothiazide 20-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASERETIC 10-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTORETIC 10-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTORETIC 20-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTORETIC 20-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Ace Inhibitors</i>		
ACCUPRIL 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCUPRIL 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCUPRIL 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCUPRIL 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ALTACE 1.25 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ALTACE 10 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ALTACE 2.5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ALTACE 5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>benazepril hcl 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 10 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 20 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 20 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>benazepril hcl 5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>captopril 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 12.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 12.5 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 12.5 mg tablet u-d, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 25 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 25 mg tablet u-d, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>captopril 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>enalapril 1 mg/ml oral soln</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>enalapril maleate 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 10 mg tab for repackaging only</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 2.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 2.5 mg tab for repackaging only</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 20 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enalapril maleate 5 mg tablet for repackaging only</i>	Formulary	PDL Preferred; 3 Months Allowed
EPANED 1 MG/ML ORAL SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fosinopril sodium 10 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fosinopril sodium 20 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fosinopril sodium 40 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>lisinopril 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 2.5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 20 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 30 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>lisinopril 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>lisinopril 5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
LOTENSIN 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTENSIN 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOTENSIN 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>moexipril hcl 15 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>moexipril hcl 7.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>perindopril erbumine 2 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>perindopril erbumine 4 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>perindopril erbumine 8 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QBRELIS 1 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 20 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 40 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>quinapril 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ramipril 1.25 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ramipril 10 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>ramipril 2.5 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ramipril 5 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>trandolapril 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>trandolapril 2 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>trandolapril 4 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASOTEC 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASOTEC 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASOTEC 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASOTEC 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZESTRIL 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Aldosterone Receptor Antagonists</i>		
ALDACTONE	Non-Formulary	
CAROSPIR	Non-Formulary	
<i>eplerenone</i>	Non-Formulary	
INSPRA	Non-Formulary	
KERENDIA 10 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
KERENDIA 20 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
<i>spironolactone 100 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>spironolactone 100 mg tablet f/c</i>	Formulary	
<i>spironolactone 100 mg tablet outer</i>	Formulary	
<i>spironolactone 25 mg tablet</i>	Formulary	
<i>spironolactone 25 mg tablet f/c</i>	Formulary	
<i>spironolactone 25 mg tablet f/c,u-d,10x10</i>	Formulary	
<i>spironolactone 25 mg tablet outer</i>	Formulary	
<i>spironolactone 25 mg tablet u-d,10x10,outer</i>	Formulary	
<i>spironolactone 50 mg tablet</i>	Formulary	
<i>spironolactone 50 mg tablet f/c</i>	Formulary	
<i>spironolactone 50 mg tablet f/c,u-d,10x10</i>	Formulary	
<i>spironolactone 50 mg tablet f/c,u-d,10x10,outer</i>	Formulary	
<i>spironolactone 50 mg tablet outer</i>	Formulary	
<i>spironolactone oral suspension</i>	Non-Formulary	
Alpha-Beta Blockers		
<i>carvedilol 12.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 12.5 mg tablet 12's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 12.5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 12.5 mg tablet f/c, u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 12.5 mg tablet f/c,outer,10x10,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 25 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 25 mg tablet f/c, u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 25 mg tablet f/c,outer,10x10,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 3.125 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 3.125 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 3.125 mg tablet f/c, u-d</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>carvedilol 6.25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 6.25 mg tablet 12's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 6.25 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 6.25 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol 6.25 mg tablet f/c, u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carvedilol er 10 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carvedilol er 20 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carvedilol er 40 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carvedilol er 80 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>labetalol hcl 100 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 100 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 100 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 200 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 200 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 200 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 300 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 300 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 300 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>labetalol hcl 400 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Angiotensin II Receptor Blocker (Arb)- Calcium Channel Blocker Comb.		
<i>amlodipine-olmesartan 10-20 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-olmesartan 10-40 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-olmesartan 5-20 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-olmesartan 5-40 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan 10-160 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan 10-320 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan 5-160 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan 5-320 mg</i>	Formulary	PDL Preferred; 3 Months Allowed
AZOR 10-20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AZOR 10-40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AZOR 5-20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AZOR 5-40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE 10-160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE 10-320 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE 5-160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE 5-320 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-amlodipine 40-10</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-amlodipine 40-5 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-amlodipine 80-10</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>telmisartan-amlodipine 80-5 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Angiotensin li Receptor Blocker (Arb)-Calcium Channel Blocker-Diuretic		
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan-hydrochlorothiazide 10-320-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
EXFORGE HCT 10-160-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE HCT 10-160-25 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE HCT 10-320-25 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE HCT 5-160-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EXFORGE HCT 5-160-25 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmsrtn-amldpn-hydrochlorothiazide 20-5-12.5</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmsrtn-amldpn-hydrochlorothiazide 40-10-12.5</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmsrtn-amldpn-hydrochlorothiazide 40-10-25 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmsrtn-amldpn-hydrochlorothiazide 40-5-12.5</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmsrtn-amldpn-hydrochlorothiazide 40-5-25 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIBENZOR 20-5-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIBENZOR 40-10-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIBENZOR 40-10-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
TRIBENZOR 40-5-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIBENZOR 40-5-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Angiotensin II Receptor Blocker (Arb)-Diuretic Combinations</i>		
ATACAND HCT 16-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ATACAND HCT 32-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ATACAND HCT 32-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AVALIDE 150-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AVALIDE 300-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR HCT 20-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR HCT 40-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR HCT 40-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan-hydrochlorothiazide 16-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan-hydrochlorothiazide 32-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan-hydrochlorothiazide 32-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN HCT 160-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN HCT 160-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN HCT 320-12.5 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN HCT 320-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN HCT 80-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EDARBYCLOR 40-12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
EDARBYCLOR 40-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
HYZAAR 100-12.5 TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
HYZAAR 100-25 TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
HYZAAR 50-12.5 TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan-hydrochlorothiazide 150-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan-hydrochlorothiazide 150-12.5 mg tb f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan-hydrochlorothiazide 300-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan-hydrochlorothiazide 300-12.5 mg tb f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 100-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 100-12.5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 100-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 100-25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 50-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan-hydrochlorothiazide 50-12.5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
MICARDIS HCT 40-12.5 MG TABLET 3X10 BLIST PACK,U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MICARDIS HCT 80-12.5 MG TABLET 3X10 BLIST PACK,U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MICARDIS HCT 80-25 MG TABLET 3X10 BLIST PACK,U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmesartan-hydrochlorothiazide 20-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>olmesartan-hydrochlorothiazide 40-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>olmesartan-hydrochlorothiazide 40-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>telmisartan-hydrochlorothiazide 40-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-hydrochlorothiazide 40-12.5 mg tb outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-hydrochlorothiazide 80-12.5 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-hydrochlorothiazide 80-12.5 mg tb outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-hydrochlorothiazide 80-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan-hydrochlorothiazide 80-25 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 160-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 160-12.5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 160-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 160-25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 320-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 320-12.5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 320-25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 320-25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 80-12.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan-hydrochlorothiazide 80-12.5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
Angiotensin II Receptor Blocker- Nepriylsin Inhibitor Comb. (Arni)		
ENTRESTO 24 MG-26 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
ENTRESTO 49 MG-51 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
ENTRESTO 97 MG-103 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
ENTRESTO SPRINKLE 15-16 MG PLT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
ENTRESTO SPRINKLE 6-6 MG PELLETT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
Angiotensin II Receptor Blockers (Arbs)		
ATACAND 16 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ATACAND 32 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ATACAND 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ATACAND 8 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AVAPRO 150 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AVAPRO 300 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AVAPRO 75 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BENICAR 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 16 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 16 mg tb outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 32 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 32 mg tb outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 4 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>candesartan cilexetil 8 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>candesartan cilexetil 8 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
COZAAR 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
COZAAR 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
COZAAR 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN 160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN 320 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DIOVAN 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EDARBI 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
EDARBI 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>eprosartan mesylate 600 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 150 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 150 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 150 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 300 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 300 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 300 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 75 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>irbesartan 75 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>irbesartan 75 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>losartan potassium 100 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 100 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 100 mg tab f/c,10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 100 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 25 mg tab f/c,10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 25 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 50 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 50 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 50 mg tab f/c,10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>losartan potassium 50 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
MICARDIS 20 MG TABLET U-D,3X10 CARDS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MICARDIS 40 MG TABLET 3X10 BLIST PACK,U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MICARDIS 80 MG TABLET 3X10 BLIST PACK,U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>olmesartan medoxomil 20 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>olmesartan medoxomil 40 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>olmesartan medoxomil 5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>telmisartan 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>telmisartan 20 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan 40 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan 80 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>telmisartan 80 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>valsartan 160 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 160 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 160 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 20 mg/5 ml solution</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>valsartan 320 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 320 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 320 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 4 mg/ml solution</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>valsartan 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 80 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>valsartan 80 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
Antianginal - Coronary Vasodilators (Nitrates)		
GONITRO	Non-Formulary	

Medications	Coverage Level	Restrictions
ISORDIL	Non-Formulary	
ISORDIL TITRADOSE ORAL TABLET 5 MG	Non-Formulary	
<i>isosorbide dinitrate 10 mg tab</i>	Formulary	
<i>isosorbide dinitrate 10 mg tab outer</i>	Formulary	
<i>isosorbide dinitrate 20 mg tab</i>	Formulary	
<i>isosorbide dinitrate 20 mg tab outer</i>	Formulary	
<i>isosorbide dinitrate 30 mg tab</i>	Formulary	
<i>isosorbide dinitrate 5 mg tab</i>	Formulary	
<i>isosorbide dinitrate 5 mg tab outer</i>	Formulary	
<i>isosorbide dinitrate oral tablet 40 mg</i>	Non-Formulary	
<i>isosorbide mononit 10 mg tab</i>	Formulary	
<i>isosorbide mononit 20 mg tab</i>	Formulary	
<i>isosorbide mononit er 120 mg</i>	Formulary	QL (2 tablets per 1 day)
<i>isosorbide mononit er 120 mg f/c</i>	Formulary	QL (2 tablets per 1 day)
<i>isosorbide mononit er 30 mg tb</i>	Formulary	QL (1 tablet per 1 day)
<i>isosorbide mononit er 30 mg tb f/c</i>	Formulary	QL (1 tablet per 1 day)
<i>isosorbide mononit er 30 mg tb outer</i>	Formulary	QL (1 tablet per 1 day)
<i>isosorbide mononit er 60 mg tb</i>	Formulary	QL (2 tablets per 1 day)
<i>isosorbide mononit er 60 mg tb f/c</i>	Formulary	QL (2 tablets per 1 day)
<i>isosorbide mononit er 60 mg tb outer</i>	Formulary	QL (2 tablets per 1 day)
NITRO-BID 2% OINTMENT 1 GM X 48 FOILPACS	Formulary	
NITRO-BID 2% OINTMENT W/ APPLICATOR	Formulary	
NITRO-DUR	Non-Formulary	
<i>nitroglycerin 0.1 mg/hr patch</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 0.1 mg/hr patch outer</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 0.2 mg/hr patch outer</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 0.3 mg tablet sl</i>	Formulary	
<i>nitroglycerin 0.4 mg tablet sl</i>	Formulary	
<i>nitroglycerin 0.4 mg tablet sl outer</i>	Formulary	
<i>nitroglycerin 0.4 mg/hr patch outer</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 0.6 mg tablet sl</i>	Formulary	
<i>nitroglycerin 0.6 mg/hr patch</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 0.6 mg/hr patch outer</i>	Formulary	QL (1 patch per 1 day)
<i>nitroglycerin 400 mcg spray</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>nitroglycerin 400 mcg spray 200-dose, pumpspray</i>	Formulary	
<i>nitroglycerin 400 mcg spray 60-dose, pumpspray</i>	Formulary	
NITROLINGUAL	Non-Formulary	
NITROSTAT	Non-Formulary	
<i>Antianginal And Anti-Ischemic Agents, Non-Hemodynamic</i>		
ASPRUZYO SPRINKLE ER 1,000 MG PK	Formulary	PA; QL (2 packets per 1 day); Age Limit (Min 18 Years)
ASPRUZYO SPRINKLE ER 500 MG PKT	Formulary	PA; QL (2 packets per 1 day); Age Limit (Min 18 Years)
<i>ranolazine er 1,000 mg tablet</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>ranolazine er 1,000 mg tablet outer</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>ranolazine er 500 mg tablet</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>ranolazine er 500 mg tablet outer</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>Antianginal And Anti-Ischemic Agents</i>		
VERQUVO 10 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VERQUVO 10 MG TABLET OUTER	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VERQUVO 2.5 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VERQUVO 2.5 MG TABLET OUTER	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VERQUVO 5 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VERQUVO 5 MG TABLET OUTER	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
<i>Antiarrhythmic - Class Ia</i>		
<i>disopyramide 100 mg capsule</i>	Formulary	Age Limit (Max 64 Years)
<i>disopyramide 150 mg capsule</i>	Formulary	Age Limit (Max 64 Years)
NORPACE	Non-Formulary	
NORPACE CR	Non-Formulary	
<i>quinidine gluconate oral</i>	Non-Formulary	
<i>quinidine sulfate 200 mg tab</i>	Formulary	
<i>quinidine sulfate 300 mg tab</i>	Formulary	
<i>Antiarrhythmic - Class Ib</i>		
<i>mexiletine 150 mg capsule</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>mexiletine 150 mg capsule outer</i>	Formulary	
<i>mexiletine 200 mg capsule</i>	Formulary	
<i>mexiletine 250 mg capsule</i>	Formulary	
<i>phenytoin sodium</i>	State Carve Out	
Antiarrhythmic - Class Ic		
<i>flecainide acetate 100 mg tab</i>	Formulary	
<i>flecainide acetate 100 mg tab outer</i>	Formulary	
<i>flecainide acetate 150 mg tab</i>	Formulary	
<i>flecainide acetate 50 mg tab</i>	Formulary	
<i>flecainide acetate 50 mg tab outer</i>	Formulary	
<i>propafenone hcl 150 mg tablet</i>	Formulary	
<i>propafenone hcl 150 mg tablet f/c</i>	Formulary	
<i>propafenone hcl 150 mg tablet outer</i>	Formulary	
<i>propafenone hcl 225 mg tab</i>	Formulary	
<i>propafenone hcl 225 mg tab f/c</i>	Formulary	
<i>propafenone hcl 300 mg tab</i>	Formulary	
<i>propafenone oral capsule, extended release 12 hr</i>	Non-Formulary	
Antiarrhythmic - Class Ii		
BETAPACE 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE 160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sotalol 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 120 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 160 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 240 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>sotalol 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 80 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 120 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 160 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 80 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTYLIZE 5 MG/ML ORAL SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antiarrhythmic - Class Iii</i>		
<i>amiodarone hcl 100 mg tablet</i>	Formulary	QL (1 tablet per 1 day)
<i>amiodarone hcl 100 mg tablet outer</i>	Formulary	QL (1 tablet per 1 day)
<i>amiodarone hcl 200 mg tablet</i>	Formulary	
<i>amiodarone hcl 200 mg tablet outer</i>	Formulary	
<i>amiodarone hcl 400 mg tablet</i>	Formulary	
<i>dofetilide 125 mcg capsule</i>	Formulary	
<i>dofetilide 250 mcg capsule</i>	Formulary	
<i>dofetilide 500 mcg capsule</i>	Formulary	
MULTAQ	Non-Formulary	
PACERONE 100 MG TABLET	Formulary	QL (1 tablet per 1 day)
PACERONE 100 MG TABLET U-D, 10X10, INNER	Formulary	QL (1 tablet per 1 day)
PACERONE 100 MG TABLET U-D,10X10, OUTER	Formulary	QL (1 tablet per 1 day)
PACERONE ORAL TABLET 200 MG, 400 MG	Non-Formulary	
TIKOSYN	Non-Formulary	
<i>Antiarrhythmic - Class Iv</i>		
<i>verapamil 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 120 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>verapamil 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 80 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
Antihyperlipidemic - Atp-Citrate Lyase (Acly) Inhibitor		
NEXLETOL 180 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
Antihyperlipidemic - Bile Acid Sequestrants		
CHOLESTYRAMINE LIGHT PACKET	Formulary	PDL Preferred; 3 Months Allowed
CHOLESTYRAMINE LIGHT PACKET OUTER	Formulary	PDL Preferred; 3 Months Allowed
CHOLESTYRAMINE LIGHT POWDER	Formulary	PDL Preferred; 3 Months Allowed
<i>cholestyramine packet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>cholestyramine packet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>cholestyramine powder</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>colesevelam 625 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>colesevelam 625 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>colesevelam hcl 3.75 g packet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
COLESTID 1 GM TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
COLESTID GRANULES	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>colestipol hcl 1 gm tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>colestipol hcl 1 gm tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>colestipol hcl 1 gm tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>colestipol hcl granules</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>colestipol hcl granules packet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PREVALITE PACKET	Formulary	PDL Preferred; 3 Months Allowed
PREVALITE PACKET INNER,SINGLE DOSE	Formulary	PDL Preferred; 3 Months Allowed
PREVALITE PACKET OUTER	Formulary	PDL Preferred; 3 Months Allowed
PREVALITE POWDER	Formulary	PDL Preferred; 3 Months Allowed
QUESTRAN LIGHT POWDER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QUESTRAN PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QUESTRAN POWDER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
WELCHOL 3.75G PACKET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
WELCHOL 625 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperlipidemic - Fibric Acid Derivatives</i>		
<i>fenofibrate 120 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 130 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 134 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 145 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 145 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 145 mg tablet f/c, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 145 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 150 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 160 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>fenofibrate 160 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 160 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 200 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 200 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 43 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 48 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 48 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 48 mg tablet f/c, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 48 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 50 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibrate 54 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 54 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 54 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 67 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>fenofibrate 90 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibric acid 105 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibric acid 35 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibric acid dr 135 mg cap</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fenofibric acid dr 45 mg cap</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
FENOGLIDE 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FENOGLIDE 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FIBRICOR 105 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>gemfibrozil 600 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>gemfibrozil 600 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>gemfibrozil 600 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
LIPOFEN 150 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LIPOFEN 50 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOPID 600 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRICOR 145 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRICOR 48 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRILIPIX DR 135 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRILIPIX DR 45 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperlipidemic - Hmg Coa Reductase Inhibitors (Statins)</i>		
ALTOPREV 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ALTOPREV 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ALTOPREV 60 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ATORVALIQ 20 MG/5 ML SUSP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (20 ML per 1 day)
<i>atorvastatin 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
<i>atorvastatin 10 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 10 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 10 mg tablet f/c,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet f/c, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet f/c,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 20 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 40 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 80 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 80 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 80 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>atorvastatin 80 mg tablet u-d, 5x6, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CRESTOR 10 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
CRESTOR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)
CRESTOR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)
CRESTOR 5 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)
EZALLOR SPRINKLE 10 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
EZALLOR SPRINKLE 20 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
EZALLOR SPRINKLE 40 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
EZALLOR SPRINKLE 5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
<i>fluvastatin er 80 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>fluvastatin sodium 20 mg cap</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
<i>fluvastatin sodium 40 mg cap</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
LESCOL XL 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 10 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 20 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
LIPITOR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 40 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIPITOR 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIVALO 1 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIVALO 2 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
LIVALO 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>lovastatin 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>lovastatin 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>lovastatin 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pitavastatin 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pitavastatin 2 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pitavastatin 4 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 10 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 10 mg tab u-d, 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 20 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
<i>pravastatin sodium 20 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 20 mg tab u-d, 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 20 mg tab u-d,outer,10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 40 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 40 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 40 mg tab u-d, 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 40 mg tab u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 80 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>pravastatin sodium 80 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 10 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 20 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 20 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 40 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 40 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>rosuvastatin calcium 5 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 10 mg tablet 10x10, u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 10 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
<i>simvastatin 10 mg tablet f/c,u-d,10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 20 mg tablet 10x10, u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 20 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 20 mg tablet f/c,u-d,10x30</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 40 mg tablet f/c, u-d, 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 5 mg tablet f/c, 10x10</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>simvastatin 80 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ZOCOR 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ZOCOR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ZOCOR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ZYPITAMAG 2 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
ZYPITAMAG 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
Antihyperlipidemic - Nicotinic Acid Derivatives		
<i>niacin 500 mg tablet (rx)</i>	Formulary	PDL Preferred; 3 Months Allowed; OTC
<i>niacin er 1,000 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>niacin er 1,000 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>niacin er 500 mg tablet (rx)</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>niacin er 500 mg tablet f/c (rx)</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>niacin er 500 mg tablet outer (rx)</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>niacin er 750 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperlipidemic - Omega-3 Fatty Acid Type		
<i>icosapent ethyl 0.5 gm capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>icosapent ethyl 1 gram capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>icosapent ethyl 1 gram capsule outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>icosapent ethyl 500 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>omega-3 ethyl esters 1 gm cap</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>omega-3 ethyl esters 1 gm cap outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperlipidemic - Pcsk9 Inhibitor, Monoclonal Antibody (Mab)		
PRALUENT 150 MG/ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
PRALUENT 75 MG/ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SURECLICK P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)

Medications	Coverage Level	Restrictions
REPATHA 140 MG/ML SURECLICK SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SYRINGE P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 420 MG/3.5 ML PUSHTRONX P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (7 ML per 28 days)
<i>Antihyperlipidemic - Pcsk9 Inhibitors</i>		
PRALUENT 150 MG/ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
PRALUENT 75 MG/ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SURECLICK P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SURECLICK SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SYRINGE P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 140 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
REPATHA 420 MG/3.5 ML PUSHTRONX P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (7 ML per 28 days)
<i>Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor</i>		
<i>ezetimibe 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ezetimibe 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
ZETIA 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperlipidemic- Atp-Citrate Lyase And Cholesterol Absorption Inhib</i>		
NEXLIZET 180-10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
<i>Antihyperlipidemic Hmg Coa Reduct Inhib And Calcium Channel Blocker</i>		
<i>amlodipine-atorvast 10-10 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
<i>amlodipine-atorvast 10-20 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 10-40 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 10-80 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 2.5-10 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 2.5-20 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 2.5-40 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 5-10 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 5-20 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 5-40 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>amlodipine-atorvast 5-80 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 10 MG-10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 10 MG-20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 10 MG-40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 10 MG-80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
CADUET 5 MG-10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 5 MG-20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 5 MG-40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
CADUET 5 MG-80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>Antihyperlipidemic-Hmg Coa Reduct Inhib And Cholesterol Absorp Inhibit</i>		
<i>ezetimibe-simvastatin 10-10 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>ezetimibe-simvastatin 10-20 mg</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>ezetimibe-simvastatin 10-40 mg</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>ezetimibe-simvastatin 10-80 mg</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
VYTORIN 10-10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
VYTORIN 10-20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
VYTORIN 10-40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
VYTORIN 10-80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>Antihyperlipidemic-Microsomal Triglyceride Transfer Protein (Mtp)Inhib</i>		
JUXTAPID	Non-Formulary	
<i>Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity</i>		
<i>acebutolol 200 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>acebutolol 200 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>acebutolol 400 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Beta Blockers Cardiac Selective		
<i>atenolol 100 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 100 mg tablet u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 25 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 25 mg tablet u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 50 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol 50 mg tablet u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>betaxolol 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>betaxolol 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>bisoprolol fumarate 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol fumarate 5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol fumarate 5 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol fumarate 5 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol fumarate oral tablet 2.5 mg</i>	Non-Formulary	
BYSTOLIC 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BYSTOLIC 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BYSTOLIC 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BYSTOLIC 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
KAPSPARGO SPRINKLE 100 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KAPSPARGO SPRINKLE 200 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KAPSPARGO SPRINKLE 25 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KAPSPARGO SPRINKLE 50 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOPRESSOR 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOPRESSOR 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metoprolol succ er 100 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 100 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 100 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 200 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 200 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 200 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 25 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 50 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 50 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol succ er 50 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 100 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 100 mg tab 10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>metoprolol tartrate 100 mg tab 12's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 100 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 100 mg tab u-d,robot ready,outr</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 25 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 25 mg tab u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 37.5 mg tb</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 50 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 50 mg tab 10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 50 mg tab 12's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 50 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 50 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol tartrate 75 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nebivolol 5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
TENORMIN 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TENORMIN 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TENORMIN 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TOPROL XL 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TOPROL XL 200 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TOPROL XL 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TOPROL XL 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity</i>		
<i>pindolol 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pindolol 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Beta Blockers Non-Cardiac Selective</i>		
BETAPACE 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE 160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 160 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BETAPACE AF 80 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
HEMANGEOL 4.28 MG/ML ORAL SOLN	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 1 Years)
INDERAL LA 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INDERAL LA 160 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
INDERAL LA 60 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INDERAL LA 80 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INDERAL XL 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INDERAL XL 80 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INNOPRAN XL 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INNOPRAN XL 80 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nadolol 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nadolol 20 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nadolol 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nadolol 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nadolol 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 20 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 20 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 20 mg/5 ml soln</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 20 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 40 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 40 mg/5 ml soln</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>propranolol 60 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 120 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 160 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 60 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 60 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 80 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>propranolol er 80 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 120 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 160 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 240 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>sotalol 80 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 120 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 160 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTALOL AF 80 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SOTYLIZE 5 MG/ML ORAL SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>timolol maleate 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>timolol maleate 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>timolol maleate 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Bradykinin B2 Receptor Antagonists</i>		
FIRAZYR	Non-Formulary	
<i>icatibant</i>	Non-Formulary	
SAJAZIR	Non-Formulary	
<i>Calcium Channel Blockers - Benzothiazepines</i>		
CARDIZEM 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM 60 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM CD 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM CD 180 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM CD 240 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM CD 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM CD 360 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 120 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 180 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 240 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 300 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 360 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDIZEM LA 420 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARTIA XT 120 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
CARTIA XT 180 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
CARTIA XT 240 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
CARTIA XT 300 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
DILT XR 120 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
DILT XR 180 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
DILT XR 240 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 120 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 120 mg cap u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 60 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 60 mg cap u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 90 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 12hr er 90 mg cap u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 120 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 120 mg cp outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 180 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 180 mg cp outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 240 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 240 mg cp outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 300 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 300 mg cp once a day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>diltiazem 24h er(cd) 300 mg cp outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(cd) 360 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 120 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 180 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 240 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 300 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 360 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(la) 420 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>diltiazem 24h er(xr) 120 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(xr) 180 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24h er(xr) 240 mg cp</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 120 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 120 mg cap once-a-day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 120 mg cap once-a-day-dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 180 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 180 mg cap once-a-day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 240 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 240 mg cap once-a-day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 300 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 300 mg cap once-a-day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>diltiazem 24hr er 360 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 360 mg cap once-a-day dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 360 mg cap once-a-day-dosage</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 24hr er 420 mg cap</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 30 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 30 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 60 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 60 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>diltiazem 90 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
MATZIM LA 180 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MATZIM LA 240 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MATZIM LA 300 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MATZIM LA 360 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
MATZIM LA 420 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TAZTIA XT 120 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
TAZTIA XT 180 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
TAZTIA XT 240 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
TAZTIA XT 300 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
TAZTIA XT 360 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed
TIADYLT ER 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
TIADYLt ER 180 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIADYLt ER 240 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIADYLt ER 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIADYLt ER 360 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIADYLt ER 420 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 180 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 240 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 360 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TIAZAC ER 420 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific</i>		
<i>nimodipine 30 mg capsule</i>	Formulary	QL (252 capsules per 365 days)
<i>nimodipine 30 mg capsule outer</i>	Formulary	QL (252 capsules per 365 days)
<i>nimodipine 30 mg capsule u-d, 25x4, outer</i>	Formulary	QL (252 capsules per 365 days)
<i>nimodipine 30 mg capsule u-d, 5x6</i>	Formulary	QL (252 capsules per 365 days)
NYMALIZE	Non-Formulary	
<i>Calcium Channel Blockers - Dihydropyridines</i>		
<i>amlodipine besylate 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine besylate 10 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>amlodipine besylate 2.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine besylate 5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amlodipine besylate 5 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>felodipine er 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>felodipine er 10 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>felodipine er 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>felodipine er 2.5 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>felodipine er 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>felodipine er 5 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>isradipine 2.5 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>isradipine 5 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KATERZIA 1 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 6 Years)
<i>levamlodipine 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levamlodipine maleate 5 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nicardipine 20 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nicardipine 30 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nifedipine 10 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine 10 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine 20 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 30 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>nifedipine er 30 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 30 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 60 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 60 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 60 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 90 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 90 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nifedipine er 90 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nisoldipine er 17 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 25.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 30 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 34 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>nisoldipine er 8.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NORLIQVA 1 MG/ML SOLUTION	Formulary	PA; PDL Preferred; 3 Months Allowed; Age Limit (Min 6 Years)
NORVASC 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NORVASC 10 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NORVASC 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NORVASC 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
NORVASC 5 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NORVASC 5 MG TABLET U-D	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROCARDIA XL 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROCARDIA XL 60 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROCARDIA XL 90 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SULAR ER 17 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SULAR ER 34 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SULAR ER 8.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Calcium Channel Blockers - Phenylalkylamines		
<i>verapamil 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 120 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 40 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 40 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 80 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil 80 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 120 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil er 120 mg capsule u-d, 10x10, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil er 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 120 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 180 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>verapamil er 180 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 180 mg tablet flc</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 240 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil er 240 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er 240 mg tablet flc</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>verapamil er pm 100 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil er pm 200 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil er pm 300 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil sr 120 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil sr 180 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil sr 240 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>verapamil sr 360 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 100 MG CAP PELLETT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 200 MG CAP PELLETT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 300 MG CAP PELLETT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Cardiac Inotropes - Phosphodiesterase Inhibitors</i>		
<i>milrinone</i>	Non-Formulary	
<i>milrinone in 5 % dextrose</i>	Non-Formulary	
<i>Cardiac Myosin Inhibitor</i>		
CAMZYOS 10 MG CAPSULE	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)
CAMZYOS 15 MG CAPSULE	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)
CAMZYOS 2.5 MG CAPSULE	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
CAMZYOS 5 MG CAPSULE	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)
Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb.		
<i>atenolol-chlorthalidone 100-25</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>atenolol-chlorthalidone 50-25</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 10-6.25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 10-6.25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 2.5-6.25 mg tb</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 2.5-6.25 mg tb f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 5-6.25 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>bisoprolol-hydrochlorothiazide 5-6.25 mg tab f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metoprolol-hydrochlorothiazide 100-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metoprolol-hydrochlorothiazide 100-50 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metoprolol-hydrochlorothiazide 50-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TENORETIC 100 TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TENORETIC 50 TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents		
AUVI-Q 0.1 MG AUTO-INJECTOR	Formulary	PA; PDL Non-Preferred; QL (4 auto-injectors per 1 claim)
AUVI-Q 0.1 MG AUTO-INJECTOR	Formulary	PA; PDL Non-Preferred; QL (4 pens per 1 claim)
AUVI-Q 0.15 MG AUTO-INJECTOR	Formulary	PA; PDL Non-Preferred; QL (4 pens per 1 claim)
AUVI-Q 0.3 MG AUTO-INJECTOR	Formulary	PA; PDL Non-Preferred; QL (4 pens per 1 claim)

Medications	Coverage Level	Restrictions
<i>epinephrine 0.15 mg auto-inject outer, suv</i>	Formulary	PDL Preferred; QL (4 pens per 1 claim)
<i>epinephrine 0.3 mg auto-inject outer, suv</i>	Formulary	PDL Preferred; QL (4 pens per 1 claim)
<i>epinephrine 0.3 mg auto-inject outer, suv,</i>	Formulary	PDL Preferred; QL (4 pens per 1 claim)
<i>epinephrine 0.3 mg auto-inject suv, outer</i>	Formulary	PDL Preferred; QL (4 pens per 1 claim)
EPIPEN 2-PAK 0.3 MG AUTO-INJECT OUTER,SUV	Formulary	PDL Preferred; QL (4 pens per 1 claim)
EPIPEN JR 2-PAK 0.15 MG INJCTR OUTER,SUV	Formulary	PDL Preferred; QL (4 pens per 1 claim)
NEFFY 1 MG/0.1 ML NASAL SPRAY	Formulary	PA; PDL Non-Preferred; QL (2 boxes per 1 claim)
NEFFY 2 MG/0.1 ML NASAL SPRAY	Formulary	PA; PDL Non-Preferred; QL (2 boxes per 1 claim)
<i>Cardiovascular Sympathomimetics</i>		
<i>dobutamine</i>	Non-Formulary	
<i>dobutamine in d5w intravenous parenteral solution 250 mg/250 ml (1 mg/ml), 500 mg/250 ml (2,000 mcg/ml)</i>	Non-Formulary	
<i>droxidopa</i>	Non-Formulary	
<i>midodrine hcl 10 mg tablet</i>	Formulary	
<i>midodrine hcl 10 mg tablet outer</i>	Formulary	
<i>midodrine hcl 2.5 mg tablet</i>	Formulary	
<i>midodrine hcl 2.5 mg tablet outer</i>	Formulary	
<i>midodrine hcl 5 mg tablet</i>	Formulary	
<i>midodrine hcl 5 mg tablet outer</i>	Formulary	
<i>midodrine hcl 5 mg tablet u-d, 10x10, inner</i>	Formulary	
<i>midodrine hcl 5 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>midodrine hcl 5 mg tablet u-d,10x10,outer</i>	Formulary	
NORTHERA	Non-Formulary	
<i>Central Alpha-2 Agonists-Thiazide Diuretic And Related Comb.</i>		
<i>methyldopa-hydrochlorothiazide 250-15 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>methyldopa-hydrochlorothiazide 250-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Central Alpha-2 Receptor Agonists		
<i>clonidine 0.1 mg/day patch</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine 0.1 mg/day patch outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine 0.2 mg/day patch</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine 0.2 mg/day patch outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine 0.3 mg/day patch</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine 0.3 mg/day patch outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
<i>clonidine hcl 0.1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl 0.1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl 0.2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl 0.2 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl 0.3 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl 0.3 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>clonidine hcl er 0.17 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>guanfacine 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>guanfacine 1 mg tablet inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>guanfacine 1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>guanfacine 2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>guanfacine 2 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>methyldopa 250 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>methyldopa 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
NEXICLON XR 0.17 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
<i>Digitalis Glycosides</i>		
<i>digoxin 0.125 mg tablet</i>	Formulary	
<i>digoxin 0.125 mg tablet outer</i>	Formulary	
<i>digoxin 0.25 mg tablet</i>	Formulary	
<i>digoxin 0.25 mg tablet outer</i>	Formulary	
<i>digoxin 125 mcg tablet</i>	Formulary	
<i>digoxin 125 mcg tablet outer</i>	Formulary	
<i>digoxin 250 mcg tablet</i>	Formulary	
<i>digoxin 250 mcg tablet outer</i>	Formulary	
<i>digoxin oral solution</i>	Non-Formulary	
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	Non-Formulary	
<i>Direct Acting Vasodilators</i>		
<i>hydralazine 10 mg tablet</i>	Formulary	
<i>hydralazine 10 mg tablet outer</i>	Formulary	
<i>hydralazine 10 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>hydralazine 10 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>hydralazine 100 mg tablet</i>	Formulary	
<i>hydralazine 100 mg tablet f/c</i>	Formulary	
<i>hydralazine 25 mg tablet</i>	Formulary	
<i>hydralazine 25 mg tablet f/c</i>	Formulary	
<i>hydralazine 25 mg tablet f/c, outer</i>	Formulary	
<i>hydralazine 25 mg tablet outer</i>	Formulary	
<i>hydralazine 25 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>hydralazine 50 mg tablet</i>	Formulary	
<i>hydralazine 50 mg tablet 10x10, u-d, f/c, outer</i>	Formulary	
<i>hydralazine 50 mg tablet f/c</i>	Formulary	
<i>hydralazine 50 mg tablet outer</i>	Formulary	
<i>hydralazine 50 mg tablet u-d, 10x10, outer</i>	Formulary	
<i>minoxidil 10 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>minoxidil 10 mg tablet outer</i>	Formulary	
<i>minoxidil 2.5 mg tablet</i>	Formulary	
<i>minoxidil 2.5 mg tablet outer</i>	Formulary	
Diuretic - Aldosterone Receptor Antagonist, Non-Selective		
ALDACTONE	Non-Formulary	
CAROSPIR	Non-Formulary	
<i>spironolactone 100 mg tablet</i>	Formulary	
<i>spironolactone 100 mg tablet flc</i>	Formulary	
<i>spironolactone 100 mg tablet outer</i>	Formulary	
<i>spironolactone 25 mg tablet</i>	Formulary	
<i>spironolactone 25 mg tablet flc</i>	Formulary	
<i>spironolactone 25 mg tablet flc,u-d,10x10</i>	Formulary	
<i>spironolactone 25 mg tablet outer</i>	Formulary	
<i>spironolactone 25 mg tablet u-d,10x10,outer</i>	Formulary	
<i>spironolactone 50 mg tablet</i>	Formulary	
<i>spironolactone 50 mg tablet flc</i>	Formulary	
<i>spironolactone 50 mg tablet flc,u-d,10x10</i>	Formulary	
<i>spironolactone 50 mg tablet flc,u-d,10x10,outer</i>	Formulary	
<i>spironolactone 50 mg tablet outer</i>	Formulary	
<i>spironolactone oral suspension</i>	Non-Formulary	
Diuretic - Aldosterone Receptor Antagonist, Selective		
<i>eplerenone</i>	Non-Formulary	
INSPRA	Non-Formulary	
Diuretic - Carbonic Anhydrase Inhibitors		
<i>acetazolamide 125 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>acetazolamide 250 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>acetazolamide 250 mg tablet outer</i>	Formulary	QL (4 tablets per 1 day)
<i>acetazolamide er 500 mg cap</i>	Formulary	QL (2 capsules per 1 day)
<i>acetazolamide er 500 mg cap outer</i>	Formulary	QL (2 capsules per 1 day)
<i>dichlorphenamide</i>	Non-Formulary	
<i>methazolamide</i>	Non-Formulary	
Diuretic - Loop		
<i>bumetanide 0.5 mg tablet</i>	Formulary	Step Therapy
<i>bumetanide 0.5 mg tablet outer</i>	Formulary	Step Therapy

Medications	Coverage Level	Restrictions
<i>bumetanide 1 mg tablet</i>	Formulary	Step Therapy
<i>bumetanide 1 mg tablet outer</i>	Formulary	Step Therapy
<i>bumetanide 2 mg tablet</i>	Formulary	Step Therapy
<i>bumetanide 2 mg tablet outer</i>	Formulary	Step Therapy
<i>bumetanide injection</i>	Non-Formulary	
EDECRIN	Non-Formulary	
<i>ethacrynic acid</i>	Non-Formulary	
<i>furosemide 10 mg/ml solution</i>	Formulary	
<i>furosemide 20 mg tablet</i>	Formulary	
<i>furosemide 40 mg tablet</i>	Formulary	
<i>furosemide 40 mg/5 ml soln</i>	Formulary	Age Limit (Max 12 Years)
<i>furosemide 40 mg/5 ml solution cup inner</i>	Formulary	Age Limit (Max 12 Years)
<i>furosemide 40 mg/5 ml solution cup outer</i>	Formulary	Age Limit (Max 12 Years)
<i>furosemide 80 mg tablet</i>	Formulary	
<i>furosemide injection solution</i>	Non-Formulary	
<i>furosemide oral solution 40 mg/4 ml</i>	Non-Formulary	
LASIX	Non-Formulary	
<i>torsemide 10 mg tablet</i>	Formulary	
<i>torsemide 10 mg tablet outer</i>	Formulary	
<i>torsemide 100 mg tablet</i>	Formulary	
<i>torsemide 100 mg tablet outer</i>	Formulary	
<i>torsemide 20 mg tablet</i>	Formulary	
<i>torsemide 20 mg tablet 10x10, u-d, outer</i>	Formulary	
<i>torsemide 20 mg tablet outer</i>	Formulary	
<i>torsemide 5 mg tablet</i>	Formulary	
<i>torsemide 5 mg tablet outer</i>	Formulary	
Diuretic - Potassium Sparing		
<i>amiloride hcl 5 mg tablet</i>	Formulary	
<i>triamterene</i>	Non-Formulary	
Diuretic - Potassium Sparing-Thiazide And Related Combinations		
<i>amiloride hcl-hydrochlorothiazide 5-50 mg tab</i>	Formulary	
<i>spironolactone-hydrochlorothiazide 25-25 tab</i>	Formulary	
<i>spironolactone-hydrochlorothiazide 25-25 tab outer</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>triamterene-hydrochlorothiazide 37.5-25 mg cp</i>	Formulary	
<i>triamterene-hydrochlorothiazide 37.5-25 mg tb</i>	Formulary	
<i>triamterene-hydrochlorothiazide 37.5-25 mg tb outer</i>	Formulary	
<i>triamterene-hydrochlorothiazide 75-50 mg tab</i>	Formulary	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists		
SAMSCA	Non-Formulary	
<i>tolvaptan</i>	Non-Formulary	
Diuretic - Thiazides And Related		
<i>chlorthalidone 25 mg tablet</i>	Formulary	
<i>chlorthalidone 25 mg tablet outer</i>	Formulary	
<i>chlorthalidone 25 mg tablet u-d, outer</i>	Formulary	
<i>chlorthalidone 50 mg tablet</i>	Formulary	
DIURIL 250 MG/5 ML ORAL SUSP	Formulary	Age Limit (Max 12 Years)
<i>hydrochlorothiazide 12.5 mg cp</i>	Formulary	
<i>hydrochlorothiazide 12.5 mg cp outer</i>	Formulary	
<i>hydrochlorothiazide 12.5 mg tb</i>	Formulary	
<i>hydrochlorothiazide 25 mg tab</i>	Formulary	
<i>hydrochlorothiazide 25 mg tab outer</i>	Formulary	
<i>hydrochlorothiazide 50 mg tab</i>	Formulary	
<i>indapamide 1.25 mg tablet</i>	Formulary	
<i>indapamide 1.25 mg tablet f/c</i>	Formulary	
<i>indapamide 2.5 mg tablet</i>	Formulary	
<i>indapamide 2.5 mg tablet f/c</i>	Formulary	
<i>metolazone 10 mg tablet</i>	Formulary	
<i>metolazone 2.5 mg tablet</i>	Formulary	
<i>metolazone 2.5 mg tablet outer</i>	Formulary	
<i>metolazone 2.5 mg tablet u-d,10x10,outer</i>	Formulary	
<i>metolazone 5 mg tablet</i>	Formulary	
<i>metolazone 5 mg tablet outer</i>	Formulary	
<i>metolazone 5 mg tablet u-d,10x10,outer</i>	Formulary	
THALITONE	Non-Formulary	

Medications	Coverage Level	Restrictions
Endothelin Receptor Antagonists		
TRYVIO 12.5 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Inhibitors		
CORLANOR 5 MG/5 ML ORAL SOLN INNER	Formulary	PA
CORLANOR 5 MG/5 ML ORAL SOLN OUTER	Formulary	PA
CORLANOR ORAL TABLET	Non-Formulary	
<i>ivabradine hcl 5 mg tablet</i>	Formulary	PA
<i>ivabradine hcl 7.5 mg tablet</i>	Formulary	PA
Muscarinic Receptor Antagonists (Anticholinergic)		
<i>atropine injection solution</i>	Non-Formulary	
<i>atropine injection syringe 0.1 mg/ml</i>	Non-Formulary	
<i>atropine intravenous syringe 0.25 mg/5 ml (0.05 mg/ml)</i>	Non-Formulary	
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb.		
<i>propranolol-hydrochlorothiazide 40-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>propranolol-hydrochlorothiazide 80-25 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Pah Agents - Selective Prostacyclin Receptor (Ip) Agonists		
UPTRAVI 1,000 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 1,200 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 1,400 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 1,600 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 200 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 200-800 TITRATION PACK	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 400 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
UPTRAVI 600 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI 800 MCG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
UPTRAVI INTRAVENOUS	Non-Formulary	
<i>Pah-Endothelin Receptor Antagonist-Selective Cgmp Pde5 Inhibitor Comb</i>		
OPSYNVI 10-20 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
OPSYNVI 10-20 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
OPSYNVI 10-40 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
OPSYNVI 10-40 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
<i>Patent Ductus Arteriosus (Pda) Treatment Agents , Nsaid-Type</i>		
<i>indomethacin sodium</i>	Non-Formulary	
<i>Peripheral Alpha-1 Receptor Blockers</i>		
CARDURA 1 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDURA 2 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDURA 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDURA 8 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDURA XL 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
CARDURA XL 8 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>doxazosin mesylate 1 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 1 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 2 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>doxazosin mesylate 2 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 4 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 4 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 8 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>doxazosin mesylate 8 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>phenoxybenzamine</i>	Non-Formulary	
<i>prazosin 1 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 1 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 1 mg capsule u-d, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 2 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 2 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 2 mg capsule u-d, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 5 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 5 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>prazosin 5 mg capsule u-d, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 1 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 1 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 10 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 10 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 2 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 2 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>terazosin 5 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>terazosin 5 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Pheochromocytoma, Agents To Treat</i>		
DEMSEER	Non-Formulary	
<i>metyrosine</i>	Non-Formulary	
<i>Plasma Kallikrein Inhibitor Agents, Recombinant Monoclonal Antibody</i>		
TAKHZYRO	State Carve Out	
<i>Plasma Kallikrein Inhibitor Agents, Recombinant Protein</i>		
KALBITOR	State Carve Out	
<i>Plasma Kallikrein Inhibitor Agents, Small Molecule</i>		
ORLADEYO	State Carve Out	
<i>Pulmonary Antihypertensive Agent - Activin Receptor Iia-Fc (Actriia)</i>		
WINREVAIR 45 MG ONE-VIAL KIT OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
WINREVAIR 45 MG TWO-VIAL KIT OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
WINREVAIR 60 MG ONE-VIAL KIT OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
WINREVAIR 60 MG TWO-VIAL KIT 2 VIAL/BOX,SUV,OUTER	Formulary	PA; PDL Non-Preferred
<i>Pulmonary Antihypertensive Agents - Prostacyclin-Type</i>		
ORENITRAM ER 0.125 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM ER 0.25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM ER 1 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM ER 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM ER 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM MONTH 1 TITRATION KT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ORENITRAM MONTH 2 TITRATION KT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ORENITRAM MONTH 3 TITRATION KT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REMODULIN	Non-Formulary	
<i>treprostinil sodium</i>	Non-Formulary	
TYVASO 1.74 MG/2.9 ML SOLUTION	Formulary	PA; PDL Preferred; 3 Months Allowed
TYVASO DPI 16 MCG CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 16 MCG CARTRIDGE OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 16-32 MCG TITR KIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 16-32-48 MCG TITRAT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 32 MCG CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 32 MCG CARTRIDGE OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 48 MCG CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 48 MCG CARTRIDGE OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 64 MCG CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO DPI 64 MCG CARTRIDGE OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TYVASO INHALATION REFILL KIT	Formulary	PA; PDL Preferred; 3 Months Allowed
TYVASO INHALATION STARTER KIT	Formulary	PA; PDL Preferred; 3 Months Allowed
TYVASO INSTITUTIONAL START KIT	Formulary	PA; PDL Preferred; 3 Months Allowed
VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F	Formulary	PA; PDL Preferred; 3 Months Allowed
VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F,30'S	Formulary	PA; PDL Preferred; 3 Months Allowed
VENTAVIS 20 MCG/1 ML SOLUTION 30'S,P/F,OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
VENTAVIS 20 MCG/1 ML SOLUTION SINGLE-USE,P/F,INNER	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator</i>		
ADEMPAS 0.5 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
ADEMPAS 1 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
ADEMPAS 1.5 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
ADEMPAS 2 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
ADEMPAS 2.5 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>Pulmonary Arterial Hypertension - Endothelin Receptor Antagonists</i>		
<i>ambrisentan 10 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>ambrisentan 5 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>bosentan 125 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
<i>bosentan 62.5 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
LETAIRIS 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LETAIRIS 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
OPSUMIT 10 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed
OPSUMIT 10 MG TABLET F/C,5X3	Formulary	PA; PDL Preferred; 3 Months Allowed
TRACLEER 125 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed
TRACLEER 125 MG TABLET F/C, U-D, 10X3	Formulary	PA; PDL Preferred; 3 Months Allowed
TRACLEER 32 MG TABLET FOR SUSP OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRACLEER 62.5 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
TRACLEER 62.5 MG TABLET F/C, U-D, 10X3	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>Pulmonary Arterial Hypertension - Selective Cgmp-Pde5 Inhibitors</i>		
ADCIRCA 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ALYQ 20 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed
LIQREV 10 MG/ML ORAL SUSP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVATIO 10 MG/ML ORAL SUSP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVATIO 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVATIO INTRAVENOUS	Non-Formulary	
<i>sildenafil (pulm.hypertension) intravenous</i>	Non-Formulary	
<i>sildenafil 10 mg/ml oral susp</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sildenafil 20 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sildenafil 20 mg tablet f/c</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sildenafil 20 mg tablet outer</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>tadalafil 20 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
TADLIQ 20 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
<i>Renin Inhibitor, Direct</i>		
<i>aliskiren 150 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>aliskiren 300 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TEKTURNA 150 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TEKTURNA 300 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Vasodilator Combinations</i>		
BIDIL	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>isosorbide-hydralazine</i>	Non-Formulary	
Central Nervous System Agents		
Agents To Treat Episodic Cluster Headaches		
EMGALITY 300 MG DOSE (100 MG/ML X 3 SYRINGES) P/F, SUV, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (3 ML per 30 days); Age Limit (Min 18 Years)
Antianxiety Agent - Antihistamine Type		
<i>hydroxyzine 10 mg/5 ml soln</i>	Formulary	
<i>hydroxyzine 10 mg/5 ml syrup</i>	Formulary	
<i>hydroxyzine hcl 10 mg tablet</i>	Formulary	
<i>hydroxyzine hcl 10 mg tablet coated</i>	Formulary	
<i>hydroxyzine hcl 10 mg tablet coated,u-d,10x10</i>	Formulary	
<i>hydroxyzine hcl 10 mg tablet f/c</i>	Formulary	
<i>hydroxyzine hcl 10 mg tablet outer</i>	Formulary	
<i>hydroxyzine hcl 25 mg tablet</i>	Formulary	
<i>hydroxyzine hcl 25 mg tablet coated</i>	Formulary	
<i>hydroxyzine hcl 25 mg tablet coated,u-d,10x10</i>	Formulary	
<i>hydroxyzine hcl 25 mg tablet f/c</i>	Formulary	
<i>hydroxyzine hcl 25 mg tablet outer</i>	Formulary	
<i>hydroxyzine hcl 50 mg tablet</i>	Formulary	
<i>hydroxyzine hcl 50 mg tablet coated</i>	Formulary	
<i>hydroxyzine hcl 50 mg tablet f/c</i>	Formulary	
<i>hydroxyzine hcl intramuscular</i>	Non-Formulary	
<i>hydroxyzine pam 100 mg cap</i>	Formulary	
<i>hydroxyzine pam 25 mg cap</i>	Formulary	
<i>hydroxyzine pam 25 mg cap outer</i>	Formulary	
<i>hydroxyzine pam 50 mg cap</i>	Formulary	
<i>hydroxyzine pam 50 mg cap outer</i>	Formulary	
VISTARIL ORAL CAPSULE 25 MG	Non-Formulary	
Antianxiety Agent - Benzodiazepines		
<i>alprazolam</i>	State Carve Out	
ALPRAZOLAM INTENSOL	State Carve Out	
ATIVAN ORAL	State Carve Out	
<i>chlordiazepoxide hcl</i>	State Carve Out	

Medications	Coverage Level	Restrictions
<i>clonazepam</i>	State Carve Out	
<i>clorazepate dipotassium</i>	State Carve Out	
<i>diazepam injection</i>	State Carve Out	
DIAZEPAM INTENSOL	State Carve Out	
<i>diazepam oral</i>	State Carve Out	
KLONOPIN	State Carve Out	
LORAZEPAM INTENSOL	State Carve Out	
<i>lorazepam oral</i>	State Carve Out	
LOREEV XR	State Carve Out	
<i>oxazepam</i>	State Carve Out	
TRANXENE T-TAB	State Carve Out	
VALIUM ORAL TABLET 10 MG	State Carve Out	
XANAX	State Carve Out	
XANAX XR	State Carve Out	
<i>Antianxiety Agent - Dicarbamate Type</i>		
<i>meprobamate</i>	State Carve Out	
<i>Antianxiety Agent - Non-Benzodiazepine</i>		
<i>buspirone</i>	State Carve Out	
<i>Anticonvulsant - Ampa-Type Glutamate Receptor Antagonists</i>		
FYCOMPA	State Carve Out	
<i>Anticonvulsant - Barbiturates And Derivatives</i>		
MYSOLINE	State Carve Out	
<i>phenobarbital</i>	State Carve Out	
<i>phenobarbital sodium injection solution</i>	State Carve Out	
<i>primidone</i>	State Carve Out	
SEZABY	State Carve Out	
<i>Anticonvulsant - Benzodiazepines</i>		
<i>clobazam oral suspension</i>	State Carve Out	
<i>clobazam oral tablet</i>	State Carve Out	
<i>clonazepam</i>	State Carve Out	
DIASTAT	State Carve Out	
DIASTAT ACUDIAL	State Carve Out	
<i>diazepam rectal</i>	State Carve Out	
KLONOPIN	State Carve Out	
LIBERVANT	State Carve Out	

Medications	Coverage Level	Restrictions
NAYZILAM	State Carve Out	
ONFI	State Carve Out	
SYMPAZAN	State Carve Out	
VALTOCO	State Carve Out	
Anticonvulsant - Cannabinoid Type		
EPIDIOLEX	State Carve Out	
Anticonvulsant - Carbamates		
<i>felbamate</i>	State Carve Out	
FELBATOL	State Carve Out	
Anticonvulsant - Carboxylic Acid Derivatives		
DEPAKOTE	State Carve Out	
DEPAKOTE ER	State Carve Out	
DEPAKOTE SPRINKLES	State Carve Out	
<i>divalproex</i>	State Carve Out	
<i>valproate sodium</i>	State Carve Out	
<i>valproic acid</i>	State Carve Out	
<i>valproic acid (as sodium salt)</i>	State Carve Out	
Anticonvulsant - Functionalized Amino Acid		
<i>lacosamide</i>	State Carve Out	
MOTPOLY XR	State Carve Out	
VIMPAT	State Carve Out	
Anticonvulsant - Gaba Analogs		
<i>gabapentin oral capsule</i>	State Carve Out	
<i>gabapentin oral solution</i>	State Carve Out	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	State Carve Out	
GABARONE	State Carve Out	
LYRICA	State Carve Out	
NEURONTIN	State Carve Out	
<i>pregabalin oral capsule</i>	State Carve Out	
<i>pregabalin oral solution</i>	State Carve Out	
Anticonvulsant - Gaba Re-Uptake Inhibitor, Nipecotic Acid Derivatives		
GABITRIL	State Carve Out	
<i>tiagabine</i>	State Carve Out	

Medications	Coverage Level	Restrictions
Anticonvulsant - Gaba Transaminase (Gaba-T) Inhibitor		
SABRIL	State Carve Out	
<i>vigabatrin</i>	State Carve Out	
VIGADRONE	State Carve Out	
VIGAFYDE	State Carve Out	
VIGPODER	State Carve Out	
Anticonvulsant - Hydantoins		
CEREBYX	State Carve Out	
DILANTIN	State Carve Out	
DILANTIN EXTENDED	State Carve Out	
DILANTIN INFATABS	State Carve Out	
DILANTIN-125	State Carve Out	
<i>fosphenytoin</i>	State Carve Out	
PHENYTEK	State Carve Out	
<i>phenytoin oral suspension</i>	State Carve Out	
<i>phenytoin oral tablet, chewable</i>	State Carve Out	
<i>phenytoin sodium</i>	State Carve Out	
<i>phenytoin sodium extended</i>	State Carve Out	
Anticonvulsant - Iminostilbene Derivatives		
APTIOM	State Carve Out	
<i>carbamazepine</i>	State Carve Out	
CARBATROL	State Carve Out	
EPITOL	State Carve Out	
EQUETRO	State Carve Out	
<i>oxcarbazepine</i>	State Carve Out	
OXTELLAR XR	State Carve Out	
TEGRETOL ORAL SUSPENSION	State Carve Out	
TEGRETOL ORAL TABLET	State Carve Out	
TEGRETOL XR	State Carve Out	
TRILEPTAL	State Carve Out	
Anticonvulsant - Monosaccharide Derivatives		
EPRONTIA	State Carve Out	
QUDEXY XR	State Carve Out	
TOPAMAX	State Carve Out	

Medications	Coverage Level	Restrictions
<i>topiramate</i>	State Carve Out	
TROKENDI XR	State Carve Out	
<i>Anticonvulsant - Neuroactive Steroid Gaba-A Receptor Modulator</i>		
ZTALMY	State Carve Out	
<i>Anticonvulsant - Phenyltriazine Derivatives</i>		
LAMICTAL ODT	State Carve Out	
LAMICTAL ODT STARTER (BLUE)	State Carve Out	
LAMICTAL ODT STARTER (GREEN)	State Carve Out	
LAMICTAL ODT STARTER (ORANGE)	State Carve Out	
LAMICTAL ORAL TABLET	State Carve Out	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	State Carve Out	
LAMICTAL STARTER (BLUE) KIT	State Carve Out	
LAMICTAL STARTER (GREEN) KIT	State Carve Out	
LAMICTAL STARTER (ORANGE) KIT	State Carve Out	
LAMICTAL XR	State Carve Out	
LAMICTAL XR STARTER (BLUE)	State Carve Out	
LAMICTAL XR STARTER (GREEN)	State Carve Out	
LAMICTAL XR STARTER (ORANGE)	State Carve Out	
<i>lamotrigine</i>	State Carve Out	
SUBVENITE	State Carve Out	
SUBVENITE STARTER (BLUE) KIT	State Carve Out	
SUBVENITE STARTER (GREEN) KIT	State Carve Out	
SUBVENITE STARTER (ORANGE) KIT	State Carve Out	
<i>Anticonvulsant - Pyrrolidine Derivatives</i>		
BRIVIACT	State Carve Out	
ELEPSIA XR	State Carve Out	
KEPPRA	State Carve Out	
KEPPRA XR	State Carve Out	
<i>levetiracetam in nacl (iso-os)</i>	State Carve Out	
<i>levetiracetam intravenous</i>	State Carve Out	
<i>levetiracetam oral solution</i>	State Carve Out	
<i>levetiracetam oral tablet</i>	State Carve Out	
<i>levetiracetam oral tablet extended release 24 hr</i>	State Carve Out	

Medications	Coverage Level	Restrictions
ROWEEPRA	State Carve Out	
ROWEEPRA XR	State Carve Out	
SPRITAM	State Carve Out	
<i>Anticonvulsant - Succinimides</i>		
CELONTIN ORAL CAPSULE 300 MG	State Carve Out	
<i>ethosuximide</i>	State Carve Out	
<i>methsuximide</i>	State Carve Out	
ZARONTIN	State Carve Out	
<i>Anticonvulsant - Sulfonamide Derivatives</i>		
ZONISADE	State Carve Out	
<i>zonisamide</i>	State Carve Out	
<i>Anticonvulsant - Triazole Derivatives</i>		
BANZEL	State Carve Out	
<i>rufinamide</i>	State Carve Out	
<i>Anticonvulsant Others</i>		
DIACOMIT	State Carve Out	
FINTEPLA	State Carve Out	
XCOPRI	State Carve Out	
XCOPRI MAINTENANCE PACK	State Carve Out	
XCOPRI TITRATION PACK	State Carve Out	
<i>Antidepressant - Alpha-2 Receptor Antagonists (Nassa)</i>		
<i>mirtazapine</i>	State Carve Out	
REMERON	State Carve Out	
REMERON SOLTAB	State Carve Out	
<i>Antidepressant - Mao Inhibitor Nonselective And Irreversible-Types A,B</i>		
EMSAM	State Carve Out	
MARPLAN	State Carve Out	
NARDIL	State Carve Out	
<i>phenelzine</i>	State Carve Out	
<i>tranylcypromine</i>	State Carve Out	
<i>Antidepressant - Ndma Receptor Antagonist And Ndri Combinations</i>		
AUVELITY	State Carve Out	

Medications	Coverage Level	Restrictions
Antidepressant - Neuroactive Steroid Gaba-A Receptor Modulator		
ZULRESSO	State Carve Out	
ZURZUVAE	State Carve Out	
Antidepressant - N-Methyl D-Aspartate (Nmda) Receptor Antagonist		
SPRAVATO NASAL SPRAY, NON- AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)	State Carve Out	
Antidepressant - Selective Serotonin Reuptake Inhibitors (Ssris)		
CELEXA	State Carve Out	
<i>citalopram</i>	State Carve Out	
<i>escitalopram oxalate</i>	State Carve Out	
<i>fluoxetine</i>	State Carve Out	
<i>fluvoxamine</i>	State Carve Out	
LEXAPRO	State Carve Out	
<i>paroxetine hcl</i>	State Carve Out	
PAXIL	State Carve Out	
PAXIL CR	State Carve Out	
PEXEVA	State Carve Out	
PROZAC ORAL CAPSULE	State Carve Out	
<i>sertraline</i>	State Carve Out	
ZOLOFT	State Carve Out	
Antidepressant - Serotonin-2 Antagonist- Reuptake Inhibitors (Saris)		
<i>nefazodone</i>	State Carve Out	
RALDESY	State Carve Out	
<i>trazodone</i>	State Carve Out	
Antidepressant - Serotonin- Norepinephrine Reuptake Inhibitors (Snris)		
CYMBALTA	State Carve Out	
<i>desvenlafaxine</i>	State Carve Out	
<i>desvenlafaxine succinate</i>	State Carve Out	
DRIZALMA SPRINKLE	State Carve Out	
<i>duloxetine</i>	State Carve Out	
DULOXICAININE	State Carve Out	

Medications	Coverage Level	Restrictions
EFFEXOR XR	State Carve Out	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	State Carve Out	
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	State Carve Out	
IRENKA	State Carve Out	
PRISTIQ	State Carve Out	
SAVELLA 100 MG TABLET	Formulary	PDL Preferred
SAVELLA 12.5 MG TABLET	Formulary	PDL Preferred
SAVELLA 25 MG TABLET	Formulary	PDL Preferred
SAVELLA 50 MG TABLET	Formulary	PDL Preferred
SAVELLA TITRATION PACK	Formulary	PDL Preferred
<i>venlafaxine</i>	State Carve Out	
<i>venlafaxine besylate</i>	State Carve Out	
Antidepressant - Ssri And 5Ht1a Partial Agonist		
VIIBRYD ORAL TABLET	State Carve Out	
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	State Carve Out	
<i>vilazodone</i>	State Carve Out	
Antidepressant - Ssri And Serotonin (5-Ht) Receptor Modulator		
TRINTELLIX	State Carve Out	
Antidepressant - Tricyclic And Antipsychotic, Phenothiazine Comb		
<i>perphenazine-amitriptyline</i>	State Carve Out	
Antidepressant - Tricyclic-Benzodiazepine Combinations		
<i>amitriptyline-chlordiazepoxide</i>	State Carve Out	
Antidepressant- Ssri And Atypical Antipsych,Dopamine,Serotonin Antagon		
<i>olanzapine-fluoxetine</i>	State Carve Out	
SYMBYAX	State Carve Out	
Antidepressant-Norepinephrine And Dopamine Reuptake Inhibitors (Ndris)		
APLENZIN	State Carve Out	
<i>bupropion hcl</i>	State Carve Out	
FORFIVO XL	State Carve Out	

Medications	Coverage Level	Restrictions
WELLBUTRIN	State Carve Out	
WELLBUTRIN SR	State Carve Out	
WELLBUTRIN XL	State Carve Out	
Antidepressant-Tricyclics And Related (Non-Select Reuptake Inhibitors)		
<i>amitriptyline</i>	State Carve Out	
<i>amoxapine</i>	State Carve Out	
ANAFRANIL	State Carve Out	
<i>clomipramine</i>	State Carve Out	
<i>desipramine</i>	State Carve Out	
<i>doxepin oral capsule</i>	State Carve Out	
<i>doxepin oral concentrate</i>	State Carve Out	
<i>imipramine hcl</i>	State Carve Out	
<i>imipramine pamoate</i>	State Carve Out	
<i>maprotiline</i>	State Carve Out	
NORPRAMIN ORAL TABLET 10 MG, 25 MG	State Carve Out	
<i>nortriptyline</i>	State Carve Out	
PAMELOR	State Carve Out	
<i>protriptyline</i>	State Carve Out	
<i>trimipramine</i>	State Carve Out	
Antiparkinson - Dopaminergic-Periph Comt-Dopa-Decarboxylase Inhib Comb		
<i>carbidopa-levodopa-entacapone 12.5-50-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levodopa-entacapone 18.75-75-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levodopa-entacapone 25-100-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levodopa-entacapone 31.25-125-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levodopa-entacapone 37.5-150-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levodopa-entacapone 50-200-200 mg tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson - Dopaminerg-Peripheral Dopa-Decarboxylase Inhibit Comb		
<i>carbidopa-levo 10-100 mg odt</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>carbidopa-levo 25-100 mg odt</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levo 25-250 mg odt</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>carbidopa-levo er 25-100 tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levo er 25-100 tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levo er 25-100 tab u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levo er 50-200 tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levo er 50-200 tab u-d, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levo er 50-200 tab u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 10-100 tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 25-100 tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 25-100 tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 25-250 tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 25-250 tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>carbidopa-levodopa 25-250 tab u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
CREXONT ER 35 MG-140 MG CAP	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
CREXONT ER 52.5 MG-210 MG CAP	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
CREXONT ER 70 MG-280 MG CAP	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
CREXONT ER 87.5 MG-350 MG CAP	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
DHIVY 25-100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DUOPA 4.63 MG-20 MG/ML SUSPENS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
RYTARY ER 23.75 MG-95 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RYTARY ER 36.25 MG-145 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RYTARY ER 48.75 MG-195 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RYTARY ER 61.25 MG-245 MG CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SINEMET 10-100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SINEMET 25-100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VYALEV 120 MG-2,400 MG/10 ML VL	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
<i>Antiparkinson Adjuvant - Adenosine Receptor Antagonist</i>		
NOURIANZ 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NOURIANZ 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antiparkinson Adjuvant - CentrallPeripheral Comt Inhibitors</i>		
TASMAR 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>tolcapone 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antiparkinson Adjuvant - Peripheral Comt Inhibitors</i>		
<i>entacapone 200 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>entacapone 200 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>entacapone 200 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
ONGENTYS 25 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ONGENTYS 50 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Antiparkinson Adjuvant - Peripheral Dopa-Decarboxylase Inhibitors		
<i>carbidopa 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LODOSYN 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson Therapy - Anticholinergic Agents		
<i>benztropine</i>	State Carve Out	
COGENTIN	State Carve Out	
<i>trihexyphenidyl</i>	State Carve Out	
Antiparkinson Therapy - Dopamine Precursors		
INBRIJA 42 MG INHALATION CAP	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson Therapy - Ergot Alkaloids And Derivatives		
<i>bromocriptine 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>bromocriptine 5 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(Mao-B)		
AZILECT 0.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
AZILECT 1 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
<i>rasagiline mesylate 0.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
<i>rasagiline mesylate 1 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
<i>selegiline hcl 5 mg capsule</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>selegiline hcl 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
XADAGO 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
XADAGO 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZELAPAR 1.25 MG ODT TABLET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antiparkinson Therapy - Non-Ergot Dopamine Agonist Agents</i>		
<i>amantadine 100 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amantadine 100 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amantadine 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>amantadine 100 mg tablet inner</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>amantadine 100 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>amantadine 100 mg/10 ml solution cup</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amantadine 100 mg/10 ml solution cup outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amantadine 50 mg/5 ml solution</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>amantadine 50 mg/5 ml solution dlf</i>	Formulary	PDL Preferred; 3 Months Allowed
APOKYN	Non-Formulary	
<i>apomorphine</i>	Non-Formulary	
GOCOVRI ER 137 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GOCOVRI ER 68.5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NEUPRO 1 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)
NEUPRO 2 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)
NEUPRO 3 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)

Medications	Coverage Level	Restrictions
NEUPRO 4 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)
NEUPRO 6 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)
NEUPRO 8 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (30 patches per 30 days)
OSMOLEX ER 129 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole 0.125 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 0.25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 0.25 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 0.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 0.5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 0.75 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole 1.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pramipexole er 0.375 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole er 0.75 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole er 1.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole er 2.25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole er 3 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pramipexole er 3.75 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>pramipexole er 4.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ropinirole hcl 0.25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 0.25 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 0.25 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 0.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 0.5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 0.5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 1 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 2 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 2 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 3 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 3 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 4 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 4 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl 5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ropinirole hcl er 12 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>ropinirole hcl er 2 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ropinirole hcl er 4 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ropinirole hcl er 6 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ropinirole hcl er 8 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles		
<i>asenapine maleate</i>	State Carve Out	
SAPHRIS	State Carve Out	
SECUADO	State Carve Out	
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisothiazolones		
GEODON	State Carve Out	
LATUDA	State Carve Out	
<i>lurasidone</i>	State Carve Out	
<i>ziprasidone hcl</i>	State Carve Out	
<i>ziprasidone mesylate</i>	State Carve Out	
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv		
ERZOFRI	State Carve Out	
FANAPT	State Carve Out	
INVEGA	State Carve Out	
INVEGA HAFYERA	State Carve Out	
INVEGA SUSTENNA	State Carve Out	
INVEGA TRINZA	State Carve Out	
<i>paliperidone</i>	State Carve Out	
PERSERIS	State Carve Out	
RISPERDAL CONSTA	State Carve Out	
RISPERDAL ORAL SOLUTION	State Carve Out	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	State Carve Out	
<i>risperidone microspheres</i>	State Carve Out	
<i>risperidone oral solution</i>	State Carve Out	
<i>risperidone oral tablet</i>	State Carve Out	
<i>risperidone oral tablet, disintegrating</i>	State Carve Out	

Medications	Coverage Level	Restrictions
RYKINDO	State Carve Out	
UZEDY	State Carve Out	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Butyrophenone Deriv		
CAPLYTA	State Carve Out	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzodiazepine Der		
<i>clozapine</i>	State Carve Out	
CLOZARIL	State Carve Out	
VERSACLOZ	State Carve Out	
Antipsychotic - Butyrophenone Derivatives		
HALDOL DECANOATE	State Carve Out	
<i>haloperidol</i>	State Carve Out	
<i>haloperidol decanoate</i>	State Carve Out	
<i>haloperidol lactate</i>	State Carve Out	
Antipsychotic - Dibenzoxazepine Derivatives		
<i>loxapine succinate</i>	State Carve Out	
Antipsychotic - Dihydroindolones		
<i>molindone</i>	State Carve Out	
Antipsychotic - Diphenylbutylpiperidine Derivatives		
<i>pimozide</i>	State Carve Out	
Antipsychotic - Muscarinic Agonist/Antagonist Combinations		
COBENFY	State Carve Out	
COBENFY STARTER PACK	State Carve Out	
Antipsychotic - Phenothiazines, Aliphatic		
<i>chlorpromazine</i>	State Carve Out	
Antipsychotic - Phenothiazines, Piperazine		
<i>fluphenazine hcl oral</i>	State Carve Out	
<i>perphenazine</i>	State Carve Out	
<i>prochlorperazine 10 mg tab</i>	Formulary	
<i>prochlorperazine 10 mg tab f/c</i>	Formulary	
<i>prochlorperazine 10 mg tab outer</i>	Formulary	
<i>prochlorperazine 5 mg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>prochlorperazine 5 mg tablet f/c</i>	Formulary	
<i>prochlorperazine 5 mg tablet outer</i>	Formulary	
<i>trifluoperazine</i>	State Carve Out	
Antipsychotic - Phenothiazines, Piperidine		
<i>thioridazine</i>	State Carve Out	
Antipsychotic - Thioxanthenes		
<i>thiothixene</i>	State Carve Out	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der		
<i>quetiapine</i>	State Carve Out	
SEROQUEL	State Carve Out	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	State Carve Out	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Thienobenzodiazepines		
LYBALVI	State Carve Out	
<i>olanzapine</i>	State Carve Out	
<i>olanzapine-fluoxetine</i>	State Carve Out	
SYMBYAX	State Carve Out	
ZYPREXA	State Carve Out	
ZYPREXA RELPREVV	State Carve Out	
ZYPREXA ZYDIS	State Carve Out	
Antipsychotic-Atyp Selective Serotonin 5-Ht2a Inverse Agonists (Ssia)		
NUPLAZID	State Carve Out	
Antipsychotic-Atypical,D2 Receptor Partial Agonist-5Ht Serotonin Mixed		
ABILIFY ASIMTUFII	State Carve Out	
ABILIFY MAINTENA	State Carve Out	
ABILIFY MYCITE MAINTENANCE KIT	State Carve Out	
ABILIFY MYCITE STARTER KIT	State Carve Out	
ABILIFY ORAL TABLET	State Carve Out	
<i>aripiprazole</i>	State Carve Out	
ARISTADA	State Carve Out	
ARISTADA INITIO	State Carve Out	
OPIPZA	State Carve Out	
REXULTI ORAL TABLET	State Carve Out	

Medications	Coverage Level	Restrictions
Antipsychotic-Atypical,D3/D2 Receptor Partial Agonist-Serotonin Mixed		
VRAYLAR	State Carve Out	
Antipsychotics,Atypical,Dopamine,Serotonin Antag And Opioid Antag Comb		
LYBALVI	State Carve Out	
Attention Deficit-Hyperact. Disorder (Adhd)- Alpha-2 Receptor Agonist		
<i>clonidine hcl oral tablet extended release 12 hr</i>	State Carve Out	
<i>guanfacine oral tablet extended release 24 hr</i>	State Carve Out	
INTUNIV ER	State Carve Out	
ONYDA XR	State Carve Out	
Attention Deficit-Hyperactivity (Adhd) Therapy, Stimulant-Type		
ADDERALL	State Carve Out	
ADDERALL XR	State Carve Out	
ADHANSIA XR	State Carve Out	
ADZENYS ER	State Carve Out	
ADZENYS XR-ODT	State Carve Out	
<i>amphetamine</i>	State Carve Out	
<i>amphetamine sulfate</i>	State Carve Out	
APTENSIO XR	State Carve Out	
AZSTARYS	State Carve Out	
CONCERTA	State Carve Out	
COTEMPLA XR-ODT	State Carve Out	
DAYTRANA	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
<i>dexmethylphenidate</i>	State Carve Out	
<i>dextroamphetamine sulfate oral capsule, extended release</i>	State Carve Out	
<i>dextroamphetamine sulfate oral tablet</i>	State Carve Out	
<i>dextroamphetamine-amphetamine</i>	State Carve Out	
DYANAVAL XR	State Carve Out	
EVEKEO	State Carve Out	
EVEKEO ODT	State Carve Out	
FOCALIN	State Carve Out	
FOCALIN XR	State Carve Out	

Medications	Coverage Level	Restrictions
JORNAY PM	State Carve Out	
<i>lisdexamfetamine</i>	State Carve Out	
METADATE CD	State Carve Out	
METHYLIN ORAL SOLUTION	State Carve Out	
<i>methylphenidate</i>	State Carve Out	
<i>methylphenidate hcl</i>	State Carve Out	
MYDAYIS	State Carve Out	
QUILLICHEW ER	State Carve Out	
QUILLIVANT XR	State Carve Out	
RELEXXII	State Carve Out	
RITALIN	State Carve Out	
RITALIN LA	State Carve Out	
VYVANSE	State Carve Out	
XELSTRYM	State Carve Out	
ZENZEDI	State Carve Out	
Attention Deficit-Hyperactivity Disorder (Adhd) Therapy, Nri-Type		
<i>atomoxetine</i>	State Carve Out	
QELBREE	State Carve Out	
STRATTERA	State Carve Out	
Benzodiazepines		
<i>alprazolam</i>	State Carve Out	
ALPRAZOLAM INTENSOL	State Carve Out	
<i>amitriptyline-chlordiazepoxide</i>	State Carve Out	
ATIVAN	State Carve Out	
<i>chlordiazepoxide hcl</i>	State Carve Out	
<i>chlordiazepoxide-clidinium</i>	Non-Formulary	
<i>clobazam oral suspension</i>	State Carve Out	
<i>clobazam oral tablet</i>	State Carve Out	
<i>clonazepam</i>	State Carve Out	
<i>clorazepate dipotassium</i>	State Carve Out	
DIASTAT	State Carve Out	
DIASTAT ACUDIAL	State Carve Out	
<i>diazepam</i>	State Carve Out	
DIAZEPAM INTENSOL	State Carve Out	
<i>estazolam</i>	State Carve Out	

Medications	Coverage Level	Restrictions
<i>flurazepam</i>	State Carve Out	
HALCION ORAL TABLET 0.25 MG	State Carve Out	
KLONOPIN	State Carve Out	
LIBERVANT	State Carve Out	
LIBRAX (WITH CLIDINIUM)	Non-Formulary	
<i>lorazepam</i>	State Carve Out	
LORAZEPAM INTENSOL	State Carve Out	
LOREEV XR	State Carve Out	
<i>midazolam oral</i>	State Carve Out	
NAYZILAM	State Carve Out	
ONFI	State Carve Out	
<i>oxazepam</i>	State Carve Out	
RESTORIL	State Carve Out	
SYMPAZAN	State Carve Out	
<i>temazepam</i>	State Carve Out	
TRANXENE T-TAB	State Carve Out	
<i>triazolam</i>	State Carve Out	
VALIUM ORAL TABLET 10 MG	State Carve Out	
VALTOCO	State Carve Out	
XANAX	State Carve Out	
XANAX XR	State Carve Out	
<i>Bipolar Therapy Agents - Anticonvulsant Type</i>		
<i>carbamazepine</i>	State Carve Out	
CARBATROL	State Carve Out	
DEPAKOTE	State Carve Out	
DEPAKOTE ER	State Carve Out	
DEPAKOTE SPRINKLES	State Carve Out	
<i>divalproex</i>	State Carve Out	
EPITOL	State Carve Out	
EQUETRO	State Carve Out	
LAMICTAL ODT	State Carve Out	
LAMICTAL ODT STARTER (BLUE)	State Carve Out	
LAMICTAL ODT STARTER (GREEN)	State Carve Out	
LAMICTAL ODT STARTER (ORANGE)	State Carve Out	
LAMICTAL STARTER (BLUE) KIT	State Carve Out	

Medications	Coverage Level	Restrictions
LAMICTAL STARTER (GREEN) KIT	State Carve Out	
LAMICTAL STARTER (ORANGE) KIT	State Carve Out	
<i>lamotrigine oral tablet disintegrating, dose pk</i>	State Carve Out	
<i>lamotrigine oral tablet, disintegrating</i>	State Carve Out	
<i>lamotrigine oral tablets, dose pack</i>	State Carve Out	
SUBVENITE STARTER (BLUE) KIT	State Carve Out	
SUBVENITE STARTER (GREEN) KIT	State Carve Out	
SUBVENITE STARTER (ORANGE) KIT	State Carve Out	
TEGRETOL ORAL SUSPENSION	State Carve Out	
TEGRETOL ORAL TABLET	State Carve Out	
TEGRETOL XR	State Carve Out	
<i>valproic acid</i>	State Carve Out	
<i>valproic acid (as sodium salt)</i>	State Carve Out	
<i>Bipolar Therapy Agents - Atypical Antipsychotics</i>		
ABILIFY MYCITE MAINTENANCE KIT	State Carve Out	
ABILIFY MYCITE STARTER KIT	State Carve Out	
ABILIFY ORAL TABLET	State Carve Out	
<i>aripiprazole</i>	State Carve Out	
<i>asenapine maleate</i>	State Carve Out	
GEODON	State Carve Out	
LYBALVI	State Carve Out	
<i>olanzapine</i>	State Carve Out	
<i>olanzapine-fluoxetine</i>	State Carve Out	
OPIPZA	State Carve Out	
<i>quetiapine</i>	State Carve Out	
RISPERDAL ORAL SOLUTION	State Carve Out	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	State Carve Out	
<i>risperidone oral solution</i>	State Carve Out	
<i>risperidone oral tablet</i>	State Carve Out	
<i>risperidone oral tablet, disintegrating</i>	State Carve Out	
SAPHRIS	State Carve Out	
SEROQUEL	State Carve Out	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	State Carve Out	
SYMBYAX	State Carve Out	

Medications	Coverage Level	Restrictions
VRAYLAR	State Carve Out	
<i>ziprasidone hcl</i>	State Carve Out	
<i>ziprasidone mesylate</i>	State Carve Out	
ZYPREXA	State Carve Out	
ZYPREXA ZYDIS	State Carve Out	
<i>Bipolar Therapy Agents - Lithium</i>		
<i>lithium carbonate</i>	State Carve Out	
<i>lithium citrate</i>	State Carve Out	
LITHOBID	State Carve Out	
<i>Cannabis And Cannabinoids</i>		
<i>dronabinol 10 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule outer</i>	Formulary	PA
<i>dronabinol 5 mg capsule</i>	Formulary	PA
<i>dronabinol 5 mg capsule outer</i>	Formulary	PA
MARINOL	Non-Formulary	
<i>Cns Stimulant - Amphetamine Combinations</i>		
ADDERALL	State Carve Out	
ADDERALL XR	State Carve Out	
ADZENYS ER	State Carve Out	
ADZENYS XR-ODT	State Carve Out	
<i>amphetamine</i>	State Carve Out	
<i>dextroamphetamine-amphetamine</i>	State Carve Out	
DYANAVAL XR	State Carve Out	
MYDAYIS	State Carve Out	
<i>Cns Stimulant - Amphetamines</i>		
<i>amphetamine sulfate</i>	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
<i>dextroamphetamine sulfate</i>	State Carve Out	
EVEKEO	State Carve Out	
EVEKEO ODT	State Carve Out	
PROCENTRA	State Carve Out	
XELSTRYM	State Carve Out	
ZENZEDI	State Carve Out	

Medications	Coverage Level	Restrictions
Cns Stimulant - Analeptics, Methylxanthine-Type		
CAFCIT	Non-Formulary	
<i>caffeine cit 60 mg/3 ml oral</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral 10's, sdv, p/f</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral inner</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral outer</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral p/f</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral p/f, sdv, outer</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine cit 60 mg/3 ml oral suv, outer</i>	Formulary	Age Limit (Max 1 Years)
<i>caffeine citrate intravenous</i>	Non-Formulary	
Diabetic Peripheral Neuropathy Agents		
LYRICA CR	State Carve Out	
<i>pregabalin oral tablet extended release 24 hr</i>	State Carve Out	
Fibromyalgia Agents - Gaba Analogs		
LYRICA	State Carve Out	
<i>pregabalin oral capsule</i>	State Carve Out	
<i>pregabalin oral solution</i>	State Carve Out	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (Snris)		
CYMBALTA	State Carve Out	
DRIZALMA SPRINKLE	State Carve Out	
<i>duloxetine</i>	State Carve Out	
DULOXICAININE	State Carve Out	
IRENKA	State Carve Out	
SAVELLA 100 MG TABLET	Formulary	PDL Preferred
SAVELLA 12.5 MG TABLET	Formulary	PDL Preferred
SAVELLA 25 MG TABLET	Formulary	PDL Preferred
SAVELLA 50 MG TABLET	Formulary	PDL Preferred
SAVELLA TITRATION PACK	Formulary	PDL Preferred
Hsdd Agents-Mixed Serotonin Agonist/Antagonists		
ADDYI	Benefit Exclusion	
Hypnotics - Melatonin - Single Agents		
MAXSLEEP JUNIOR 1 MG/ML LIQ	Non-Formulary	CSHCS Covered
<i>melatonin 1 mg/ml liquid</i>	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
Hypnotics - Melatonin M1/M2 Receptor Agonists		
HETLIOZ	State Carve Out	
HETLIOZ LQ	State Carve Out	
<i>ramelteon</i>	State Carve Out	
ROZEREM	State Carve Out	
<i>tasimelteon</i>	State Carve Out	
Migraine Therapy - Carboxylic Acid Derivatives		
DEPAKOTE ER	State Carve Out	
<i>divalproex oral tablet extended release 24 hr</i>	State Carve Out	
Migraine Therapy - Cgrp Ligand Blocker, Monoclonal Antibody		
AJOVY 225 MG/1.5 ML AUTOINJECT SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1.5 ML per 30 days); Age Limit (Min 18 Years)
AJOVY 225 MG/1.5 ML SYRINGE P/F, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1.5 ML per 30 days); Age Limit (Min 18 Years)
EMGALITY 120 MG/ML PEN P/F, SUV, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1 ML per 30 days); Age Limit (Min 18 Years)
EMGALITY 120 MG/ML SYRINGE P/F, SUV, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1 ML per 30 days); Age Limit (Min 18 Years)
Migraine Therapy - Cgrp Receptor Blockers (Gepants And Mab)		
AIMOVIG 140 MG/ML AUTOINJECTOR	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1 ML per 30 days); Age Limit (Min 18 Years)
AIMOVIG 70 MG/ML AUTOINJECTOR	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 30 days); Age Limit (Min 18 Years)
NURTEC ODT 75 MG TABLET	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (18 tablets per 30 days); Age Limit (Min 18 Years)
QULIPTA 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day); Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
QULIPTA 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
QULIPTA 60 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
UBRELVY 100 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (16 tablets per 30 days); Age Limit (Min 18 Years)
UBRELVY 50 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (16 tablets per 30 days); Age Limit (Min 18 Years)
ZAVZPRET 10 MG NASAL SPRAY OUTER	Formulary	PA; PDL Non-Preferred; QL (8 units per 30 days); Age Limit (Min 18 Years)
<i>Migraine Therapy - Ergot Alkaloids And Derivatives</i>		
<i>dihydroergotamine</i>	Non-Formulary	
MIGRANAL	Non-Formulary	
<i>Migraine Therapy - Ergot Combinations</i>		
MIGERGOT	Non-Formulary	
<i>Migraine Therapy - Nsaid Analgesics (Cyclooxygenase Inhibitor)</i>		
CAMBIA	Non-Formulary	
<i>diclofenac potassium oral powder in packet</i>	Non-Formulary	
ELYXYB 120 MG/4.8 ML SOLUTION	Formulary	PA; PDL Non-Preferred; QL (28 ML per 30 days); Age Limit (Min 18 Years)
<i>Migraine Therapy - Selective Serotonin Agonists 5-Ht(1)</i>		
<i>almotriptan malate 12.5 mg tab f/c, outer</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>almotriptan malate 12.5 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>almotriptan malate 12.5 mg tab outer, f/c</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>almotriptan malate 6.25 mg tab f/c, outer</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>almotriptan malate 6.25 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>almotriptan malate 6.25 mg tab outer, f/c</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>eletriptan hbr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>eletriptan hbr 20 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>eletriptan hbr 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>eletriptan hbr 40 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
FROVA 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
<i>frovatriptan succ 2.5 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
IMITREX 100 MG TABLET 100MG SUMATRIPTAN BS	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
IMITREX 25 MG TABLET 25MG SUMATRIPTAN BSE	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
IMITREX 4 MG/0.5 ML CARTRIDGES	Formulary	PA; PDL Non-Preferred; QL (4 mL per 1 claim)
IMITREX 4 MG/0.5 ML PEN INJECT	Formulary	PA; PDL Non-Preferred; QL (4 mL per 1 claim)
IMITREX 50 MG TABLET 50MG SUMATRIPTAN BSE	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
IMITREX 6 MG/0.5 ML CARTRIDGES 2 STAT DOSE SYR,SDV	Formulary	PA; PDL Non-Preferred; QL (4 mL per 1 claim)
IMITREX 6 MG/0.5 ML PEN INJECT 2 STAT DOSE SYR,SDV	Formulary	PA; PDL Non-Preferred; QL (4 mL per 1 claim)
MAXALT 10 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
MAXALT MLT 10 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (18 tablets per 1 claim)
<i>naratriptan hcl 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>naratriptan hcl 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
<i>naratriptan hcl 2.5 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)

Medications	Coverage Level	Restrictions
RELPAK 20 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
RELPAK 40 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>rizatriptan 10 mg odt</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg odt inner</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg odt outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg tablet</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg tablet 4x3, outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg tablet inner</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 10 mg tablet outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg odt</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg odt inner</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg odt outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg tablet</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg tablet 4x3, outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg tablet inner</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg tablet outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>rizatriptan 5 mg tablet u-d, outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan 20 mg nasal spray</i>	Formulary	PDL Preferred; QL (6 EA per 1 claim)
<i>sumatriptan 20 mg nasal spray</i>	Formulary	PDL Preferred; QL (6 units per 1 claim)
<i>sumatriptan 20 mg nasal spray</i>	Formulary	Brand Preferred; PDL Preferred; QL (6 units per 1 claim)

Medications	Coverage Level	Restrictions
<i>sumatriptan 20 mg nasal spray outer</i>	Formulary	PDL Preferred; QL (6 units per 1 claim)
<i>sumatriptan 4 mg/0.5 ml cart suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 4 mg/0.5 ml inject outer, suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 4 mg/0.5 ml inject suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 5 mg nasal spray</i>	Formulary	PDL Preferred; QL (6 units per 1 claim)
<i>sumatriptan 5 mg nasal spray outer</i>	Formulary	PDL Preferred; QL (6 units per 1 claim)
<i>sumatriptan 6 mg/0.5 ml autoinj outer, suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 6 mg/0.5 ml autoinj outer,suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 6 mg/0.5 ml autoinj sdv, outer</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 6 mg/0.5 ml autoinj suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 6 mg/0.5 ml cart suv</i>	Formulary	PDL Preferred; QL (4 mL per 1 claim)
<i>sumatriptan 6 mg/0.5 ml vial outer,sdv</i>	Formulary	PDL Preferred; QL (2 ML per 1 claim)
<i>sumatriptan 6 mg/0.5 ml vial sdv</i>	Formulary	PDL Preferred; QL (2 ML per 1 claim)
<i>sumatriptan 6 mg/0.5 ml vial suv, inner</i>	Formulary	PDL Preferred; QL (2 ML per 1 claim)
<i>sumatriptan 6 mg/0.5 ml vial suv, outer</i>	Formulary	PDL Preferred; QL (2 ML per 1 claim)
<i>sumatriptan succ 100 mg tablet</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 100 mg tablet f/c</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 100 mg tablet outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 100 mg tablet u-d</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 25 mg tablet</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>sumatriptan succ 25 mg tablet f/c</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 25 mg tablet outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 25 mg tablet u-d</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 50 mg tablet</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 50 mg tablet f/c</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 50 mg tablet outer</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
<i>sumatriptan succ 50 mg tablet u-d</i>	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
TOSYMRA 10 MG NASAL SPRAY INNER	Formulary	PA; PDL Non-Preferred; QL (6 EA per 1 claim)
TOSYMRA 10 MG NASAL SPRAY OUTER	Formulary	PA; PDL Non-Preferred; QL (6 EA per 1 claim)
ZEMBRACE SYMTOUCH 3 MG/0.5 ML INNER, SUV	Formulary	PA; PDL Non-Preferred
ZEMBRACE SYMTOUCH 3 MG/0.5 ML OUTER, SUV	Formulary	PA; PDL Non-Preferred
<i>zolmitriptan 2.5 mg odt</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg odt 1x6, outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg tablet f/c, outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 2.5mg nasal spray</i>	Formulary	PA; PDL Non-Preferred
<i>zolmitriptan 5 mg nasal spray</i>	Formulary	PA; PDL Non-Preferred
<i>zolmitriptan 5 mg nasal spray outer</i>	Formulary	PA; PDL Non-Preferred
<i>zolmitriptan 5 mg odt</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)

Medications	Coverage Level	Restrictions
<i>zolmitriptan 5 mg odt 1x3, outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 5 mg tablet flc</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 5 mg tablet flc, outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>zolmitriptan 5 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
ZOMIG 2.5 MG NASAL SPRAY	Formulary	PA; PDL Non-Preferred
ZOMIG 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
ZOMIG 5 MG NASAL SPRAY	Formulary	PA; PDL Non-Preferred
ZOMIG 5 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
<i>Migraine Therapy - Selective Serotonin Agonists 5-Ht(1F)</i>		
REYVOW 100 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (8 tablets per 30 days); Age Limit (Min 18 Years)
REYVOW 50 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (8 tablets per 30 days); Age Limit (Min 18 Years)
<i>Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Comb.</i>		
<i>sumatriptan-naproxen 85-500 mg</i>	Formulary	PA; PDL Non-Preferred
<i>Movement Disorder Drug Therapy</i>		
AUSTEDO 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 9 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 18 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 24 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 30 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 36 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 42 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 48 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
AUSTEDO XR 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR KT(6-12-24 MG)	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR(12-18-24-30 MG)	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40-80 MG INITIATION PACK (TARDIVE)	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
<i>tetrabenazine</i>	Non-Formulary	
XENAZINE	Non-Formulary	
<i>Movement Disorder Therapy - Huntington's Disease</i>		
AUSTEDO 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 9 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 18 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 24 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 30 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 36 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 42 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 48 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR KT(6-12-24 MG)	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR(12-18-24-30 MG)	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
<i>tetrabenazine</i>	Non-Formulary	
XENAZINE	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>Movement Disorder Therapy - Restless Legs Syndrome</i>		
HORIZANT ER 300 MG TABLET	Formulary	PDL Preferred
HORIZANT ER 600 MG TABLET	Formulary	PDL Preferred
<i>Movement Disorder Therapy - Tardive Dyskinesia</i>		
AUSTEDO 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO 9 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 12 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 18 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 24 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 30 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 36 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 42 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 48 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR 6 MG TABLET	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR KT(6-12-24 MG)	Formulary	PA; Age Limit (Min 18 Years)
AUSTEDO XR TITR(12-18-24-30 MG)	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 40-80 MG INITIATION PACK (TARDIVE)	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 60 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG CAPSULE	Formulary	PA; Age Limit (Min 18 Years)
INGREZZA 80 MG SPRINKLE CAP	Formulary	PA; Age Limit (Min 18 Years)
<i>Narcolepsy And Cataplexy Therapy Agents - Sedative-Type</i>		
<i>sodium oxybate 0.5 g/ml soln</i>	Formulary	PA; QL (18 ML per 1 day); Age Limit (Min 7 Years)
XYREM	Non-Formulary	
XYWAV 0.5 GM/ML ORAL SOLUTION	Formulary	PA; QL (9 gm (18ml) per 1 day); Age Limit (Min 7 Years)
<i>Narcolepsy Therapy Agents - Dopamine And Ne Reuptake Inhibitor (Dnri)</i>		
SUNOSI	State Carve Out	

Medications	Coverage Level	Restrictions
Narcolepsy Therapy Agents - H3-Receptor Antagonist/Inverse Agonist		
WAKIX	State Carve Out	
Narcolepsy Therapy Agents - Non-Sympathomimetic		
<i>armodafinil</i>	State Carve Out	
<i>modafinil</i>	State Carve Out	
NUVIGIL	State Carve Out	
PROVIGIL	State Carve Out	
Narcolepsy Therapy Agents - Stimulant-Type, Piperadine Derivative		
METHYLIN ORAL SOLUTION	State Carve Out	
<i>methylphenidate hcl oral solution</i>	State Carve Out	
<i>methylphenidate hcl oral tablet</i>	State Carve Out	
<i>methylphenidate hcl oral tablet, chewable</i>	State Carve Out	
RITALIN	State Carve Out	
Narcolepsy Therapy Agents- Stimulant-Type, Sympathomimetic, Amphetamines		
ADDERALL	State Carve Out	
<i>amphetamine sulfate</i>	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
<i>dextroamphetamine sulfate oral capsule, extended release</i>	State Carve Out	
<i>dextroamphetamine sulfate oral tablet</i>	State Carve Out	
<i>dextroamphetamine-amphetamine oral tablet</i>	State Carve Out	
EVEKEO	State Carve Out	
ZENZEDI	State Carve Out	
Neuropathic Pain Therapy		
LYRICA CR	State Carve Out	
<i>pregabalin oral tablet extended release 24 hr</i>	State Carve Out	
Postherpetic Neuralgia Agents		
DULOXICAININE	State Carve Out	
<i>gabapentin er 300 mg tablet</i>	Formulary	PDL Preferred
<i>gabapentin er 600 mg tablet</i>	Formulary	PDL Preferred
GRALISE ER 300 MG TABLET	Formulary	PDL Preferred
GRALISE ER 450 MG TABLET	Formulary	PDL Preferred
GRALISE ER 600 MG TABLET	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
GRALISE ER 750 MG TABLET	Formulary	PDL Preferred
GRALISE ER 900 MG TABLET	Formulary	PDL Preferred
LYRICA CR	State Carve Out	
<i>pregabalin oral tablet extended release 24 hr</i>	State Carve Out	
<i>Pseudobulbar Affect (Pba) Agents, Nmda Antagonists Type</i>		
NUDEXTA	Non-Formulary	
<i>Sedative-Hypnotic - Antihistamines</i>		
ALKA-SELTZER PLUS ALLERGY	State Carve Out	OTC
<i>diphenhydramine 25 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet inner</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet outer</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg capsule u-d, 10x10 (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
NIGHTTIME SLEEP	State Carve Out	OTC
NIGHTTIME SLEEP AID (DIPHEN) ORAL CAPSULE 50 MG	State Carve Out	OTC
NIGHTTIME SLEEP AID (DIPHEN) ORAL TABLET	State Carve Out	OTC
NIGHTTIME SLEEP-AID (DOXYLAMN)	State Carve Out	OTC
NYTOL	State Carve Out	OTC
REST SIMPLY NIGHTTIME SLEEP	State Carve Out	OTC
SIMPLY SLEEP	State Carve Out	OTC
SLEEP AID (DIPHENHYDRAMINE) ORAL CAPSULE 50 MG	State Carve Out	OTC
SLEEP AID (DIPHENHYDRAMINE) ORAL TABLET	State Carve Out	OTC
SLEEP AID (DOXYLAMINE)	State Carve Out	OTC
SOMINEX	State Carve Out	OTC
UNISOM (DOXYLAMINE)	State Carve Out	OTC
UNISOM SLEEPGELS	State Carve Out	OTC
WAL-SOM (DIPHENHYDRAMINE)	State Carve Out	OTC

Medications	Coverage Level	Restrictions
WAL-SOM (DOXYLAMINE)	State Carve Out	OTC
<i>Sedative-Hypnotic - Barbiturates</i>		
<i>phenobarbital</i>	State Carve Out	
<i>phenobarbital sodium injection solution</i>	State Carve Out	
SECONAL SODIUM	State Carve Out	
<i>Sedative-Hypnotic - Benzodiazepines</i>		
ATIVAN INJECTION	State Carve Out	
<i>estazolam</i>	State Carve Out	
<i>flurazepam</i>	State Carve Out	
HALCION ORAL TABLET 0.25 MG	State Carve Out	
<i>lorazepam injection</i>	State Carve Out	
<i>midazolam oral</i>	State Carve Out	
RESTORIL	State Carve Out	
<i>temazepam</i>	State Carve Out	
<i>triazolam</i>	State Carve Out	
<i>Sedative-Hypnotic - Gaba-Receptor Modulators</i>		
AMBIEN	State Carve Out	
AMBIEN CR	State Carve Out	
EDLUAR	State Carve Out	
<i>eszopiclone</i>	State Carve Out	
LUNESTA	State Carve Out	
<i>zaleplon</i>	State Carve Out	
<i>zolpidem</i>	State Carve Out	
<i>Sedative-Hypnotic - Orexin Receptor Antagonist</i>		
BELSOMRA	State Carve Out	
DAYVIGO	State Carve Out	
QUVIVIQ	State Carve Out	
<i>Sedative-Hypnotic - Selective Alpha2-Adrenoreceptor Agonists</i>		
<i>dexmedetomidine</i>	State Carve Out	
<i>dexmedetomidine in 0.9 % nacl intravenous syringe 20 mcg/5 ml (4 mcg/ml), 40 mcg/10 ml</i>	State Carve Out	
IGALMI	State Carve Out	

Medications	Coverage Level	Restrictions
PRECEDEX IN 0.9 % SODIUM CHLOR INTRAVENOUS SOLUTION 1,000 MCG/250ML (4 MCG/ML), 200 MCG/50 ML (4 MCG/ML), 400 MCG/100 ML (4 MCG/ML)	State Carve Out	
<i>Sedative-Hypnotic - Tricyclic Antidepressant Type</i>		
<i>doxepin oral tablet</i>	State Carve Out	
SILENOR	State Carve Out	
Chemical Dependency, Agents To Treat		
<i>Agents For Opioid Withdrawal, Central Alpha-2 Adrenergic Agonist-Type</i>		
<i>lofexidine 0.18 mg tablet</i>	Formulary	PDL Preferred
LUCEMYRA 0.18 MG TABLET	Formulary	PDL Preferred
<i>Agents For Opioid Withdrawal, Opioid-Type</i>		
BRIXADI	State Carve Out	
<i>buprenorphine hcl sublingual</i>	State Carve Out	
<i>buprenorphine-naloxone</i>	State Carve Out	
SUBLOCADE	State Carve Out	
SUBOXONE	State Carve Out	
ZUBSOLV	State Carve Out	
<i>Alcohol Abstinence Therapy - Glutamate And Gaba System Type</i>		
<i>acamprosate</i>	State Carve Out	
<i>Alcohol Abstinence Therapy - Opioid Receptor Antagonist-Type</i>		
<i>naltrexone</i>	State Carve Out	
VIVITROL	State Carve Out	
<i>Alcohol Deterrents</i>		
<i>disulfiram</i>	State Carve Out	
<i>Smoking Deterrents - Ne And Dopamine Reuptake Inhibitor (Ndri)-Type</i>		
<i>bupropion hcl sr 150 mg tablet</i>	Formulary	QL (2 tablets per 1 day)
<i>bupropion hcl sr 150 mg tablet f/c</i>	Formulary	QL (2 tablets per 1 day)
<i>bupropion hcl sr 150 mg tablet f/c, starter kit</i>	Formulary	QL (2 tablets per 1 day)
<i>Smoking Deterrents - Nicotine-Type</i>		
<i>ft nicotine 14 mg/24hr patch (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>ft nicotine 2 mg chewing gum</i>	Formulary	OTC; QL (30 pieces per 1 day)

Medications	Coverage Level	Restrictions
<i>ft nicotine 2 mg lozenge</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>ft nicotine 21 mg/24hr patch (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>ft nicotine 4 mg chewing gum</i>	Formulary	OTC; QL (24 pieces per 1 day)
<i>ft nicotine 4 mg lozenge</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>ft nicotine 7 mg/24hr patch (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>gnp nicotine 2 mg chewing gum</i>	Formulary	OTC; QL (30 pieces per 1 day)
<i>gnp nicotine 2 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>gnp nicotine 2 mg lozenge outer</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>gnp nicotine 2 mg mini lozenge</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>gnp nicotine 21 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>gnp nicotine 4 mg chewing gum</i>	Formulary	OTC; QL (24 pieces per 1 day)
<i>gnp nicotine 4 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>gnp nicotine 4 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>gs nicotine 2 mg chewing gum</i>	Formulary	OTC; QL (30 pieces per 1 day)
<i>gs nicotine 2 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>gs nicotine 2 mg chewing gum original</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>gs nicotine 2 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>gs nicotine 2 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>gs nicotine 4 mg chewing gum</i>	Formulary	OTC; QL (24 pieces per 1 day)
<i>gs nicotine 4 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>gs nicotine 4 mg chewing gum original</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>gs nicotine 4 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>gs nicotine 4 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)

Medications	Coverage Level	Restrictions
<i>hm nicotine 14 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>hm nicotine 2 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>hm nicotine 2 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>hm nicotine 21 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>hm nicotine 4 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 14 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 14 mg/24hr patch clear, step 2, outer (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 14 mg/24hr patch inner (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>nicotine 14 mg/24hr patch outer (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 14 mg/24hr patch step 2 (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 2 mg chewing gum</i>	Formulary	OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg chewing gum coated</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg chewing gum coated fruit</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg chewing gum coated,cinnamon</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg chewing gum outer</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>nicotine 2 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 2 mg lozenge inner</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>nicotine 2 mg lozenge inner</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 2 mg lozenge outer</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 2 mg mini lozenge inner</i>	Formulary	OTC; QL (20 lozenges per 1 day)

Medications	Coverage Level	Restrictions
<i>nicotine 2 mg mini lozenge outer</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 21 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 21 mg/24hr patch inner (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>nicotine 21 mg/24hr patch outer (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 21 mg/24hr patch outer, clear, step 1 (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 4 mg chewing gum</i>	Formulary	OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum coated</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum coated fruit</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum coated, cinnamon</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum outer</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum refill. outer</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg chewing gum starter kit, outer</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>nicotine 4 mg lozenge inner</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 4 mg lozenge mint, 3 quittube</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 4 mg lozenge outer</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 4 mg mini lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 4 mg mini lozenge inner</i>	Formulary	OTC; QL (20 lozenges per 1 day)
<i>nicotine 4 mg mini lozenge outer</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>nicotine 7 mg/24hr patch (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>nicotine 7 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 7 mg/24hr patch inner (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)

Medications	Coverage Level	Restrictions
<i>nicotine 7 mg/24hr patch outer (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 7 mg/24hr patch outer, clear, step 3 (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine 7 mg/24hr patch step 3 (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>nicotine transdermal system step 1,2,3</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
NICOTROL NS 10 MG/ML SPRAY	Formulary	QL (40 ML per 30 days)
<i>sm nicotine 14 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>sm nicotine 2 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
<i>sm nicotine 2 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>sm nicotine 21 mg/24hr patch (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
<i>sm nicotine 4 mg chewing gum</i>	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
<i>sm nicotine 4 mg lozenge</i>	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
<i>sm nicotine 7 mg/24hr patch (otc)</i>	Formulary	OTC; QL (1 patch per 1 day)
Smoking Deterrents - Nicotinic Receptor Partial Agonist, Alpha4beta2		
CHANTIX CONTINUING MONTH BOX	Non-Formulary	
CHANTIX ORAL TABLET 1 MG	Non-Formulary	
CHANTIX STARTING MONTH BOX	Non-Formulary	
<i>varenicline 0.5 mg tablet</i>	Formulary	QL (2 tablets per 1 day)
<i>varenicline 1 mg cont month bx</i>	Formulary	QL (2 tablets per 1 day)
<i>varenicline 1 mg tablet</i>	Formulary	QL (2 tablets per 1 day)
<i>varenicline 1 mg tablet outer</i>	Formulary	QL (2 tablets per 1 day)
<i>varenicline starting month box</i>	Formulary	QL (2 tablets per 1 day)
<i>varenicline starting month box outer</i>	Formulary	QL (2 tablets per 1 day)
Chemicals-Pharmaceutical Adjuvants		
Bulk Chemicals		
<i>arginine 100% crystals</i>	Formulary	
<i>arginine hcl powder usp (rx)</i>	Formulary	OTC
<i>arginine hcl powder usp,ep (rx)</i>	Formulary	OTC
BASE, PCCA POLYPEG WAX	Formulary	

Medications	Coverage Level	Restrictions
<i>cherry artificial flavor liq oil miscible (rx)</i>	Formulary	
<i>cherry concentrate flavor liq natural & artificial (rx)</i>	Formulary	
<i>cherry flavor conc liquid colorless (rx)</i>	Formulary	
<i>cherry flavor liquid (rx)</i>	Formulary	
<i>cherry flavor liquid artificial (rx)</i>	Formulary	
<i>cherry flavor liquid artificial flavor (rx)</i>	Formulary	
<i>cherry flavor liquid concentrate, red (rx)</i>	Formulary	
<i>cherry syrup (rx)</i>	Formulary	
<i>coenzyme q-10 powder (rx)</i>	Formulary	
<i>coenzyme q-10 powder (water dispersible) (rx)</i>	Formulary	
<i>creatine monohydrate powder (rx)</i>	Formulary	
<i>glutamine powder (rx)</i>	Formulary	OTC
<i>l-arginine hcl powder usp (rx)</i>	Formulary	OTC
<i>l-arginine mono-hcl powder usp (rx)</i>	Formulary	OTC
<i>l-citrulline powder</i>	Formulary	
L-CITRULLINE POWDER (RX)	Formulary	
<i>l-glutamine powder (rx)</i>	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
<i>l-glutamine powder usp (rx)</i>	Formulary	OTC
<i>l-ornithine hcl powder (rx)</i>	Formulary	OTC
<i>lysine hcl powder (rx)</i>	Formulary	
<i>ornithine (l) hcl powder (rx)</i>	Formulary	OTC
PCCA BASE ANHYDROUS OINT	Formulary	
PCCA VANISHING BASE CREAM	Formulary	
<i>polyethylene glycol 1450 powd base a (rx)</i>	Formulary	
<i>sodium benzoate powder nf (rx)</i>	Formulary	
<i>sodium bicarbonate powder usp (rx)</i>	Formulary	OTC
<i>sodium bicarbonate powder usp,ep,jp (rx)</i>	Formulary	OTC
<i>sodium phenylbutyrate powder</i>	Formulary	
<i>sodium phenylbutyrate powder spb</i>	Formulary	
<i>sodium phenylbutyrate powder usp</i>	Formulary	
<i>ubiquinol powder</i>	Formulary	
<i>ubiquinol powder (rx)</i>	Formulary	
<i>urea powder</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>vitamin d3 100,000 unit/gm pwd (rx)</i>	Formulary	
Pharmaceutical Adjuvant - Cream/Ointment Vehicles		
PCCA VANISHING BASE CREAM	Formulary	
Pharmaceutical Adjuvant - External Vehicles		
BASE, PCCA POLYPEG WAX	Formulary	
Pharmaceutical Adjuvant - Inhalation Vehicles		
HYPER-SAL 3.5% VIAL	Non-Formulary	CSHCS Covered
HYPER-SAL 7% VIAL SUV, P/F	Non-Formulary	CSHCS Covered
NEBUSAL 3% VIAL	Non-Formulary	CSHCS Covered
NEBUSAL 6% VIAL	Non-Formulary	CSHCS Covered
PULMOSAL 7% VIAL	Non-Formulary	CSHCS Covered
<i>sodium chloride 0.9% inhal vl 100's, u-d, suv, p/f (rx)</i>	Formulary	
<i>sodium chloride 0.9% inhal vl 50's, u-d, suv, p/f (rx)</i>	Formulary	
<i>sodium chloride 3% vial</i>	Non-Formulary	CSHCS Covered
<i>sodium chloride 3% vial p/f</i>	Non-Formulary	CSHCS Covered
<i>sodium chloride 7% vial</i>	Non-Formulary	CSHCS Covered
<i>sodium chloride 7% vial 60's, suv, p/f</i>	Non-Formulary	CSHCS Covered
<i>sodium chloride 7% vial 60's, suv, p/f, u-d</i>	Non-Formulary	CSHCS Covered
<i>sodium chloride inhalation solution for nebulization 10 %</i>	Non-Formulary	
Pharmaceutical Adjuvant - Liquid Vehicles Other		
PCCA NATAPRES LIQUID	Formulary	
PCCA SUSPENDIT ANHYDROUS	Formulary	
Pharmaceutical Adjuvant - Oral Vehicles		
BASE, PCCA SYRUP VEHICLE	Formulary	
<i>cherry artificial flavor liq oil miscible (rx)</i>	Formulary	
<i>cherry concentrate flavor liq natural & artificial (rx)</i>	Formulary	
<i>cherry flavor conc liquid colorless (rx)</i>	Formulary	
<i>cherry flavor liquid (rx)</i>	Formulary	
<i>cherry flavor liquid artificial (rx)</i>	Formulary	
<i>cherry flavor liquid artificial flavor (rx)</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>cherry flavor liquid concentrate, red (rx)</i>	Formulary	
<i>cherry syrup (rx)</i>	Formulary	
FLAVOR BLEND 2 IN 1 SUSPENSION	Formulary	
FLAVOR PLUS SUSP	Formulary	
FLAVOR SWEET SYRUP	Formulary	
FLAVOR SWEET-SF SYRUP	Formulary	
MX-SOL BLEND	Formulary	
MX-SOL BLEND SF	Formulary	
MX-SOL SF SYRUP	Formulary	
MX-SOL SUSPEND	Formulary	
MX-SOL SYRUP	Formulary	
ORA PLUS SUSPENSION	Formulary	
ORA SWEET ORAL SYRUP	Formulary	
ORA-BLEND SF SUSPENSION	Formulary	
ORA-BLEND SUSPENSION	Formulary	
ORAL MIX SF VEHICLE	Formulary	
ORAL MIX VEHICLE	Formulary	
ORAL SUSPEND VEHICLE	Formulary	
ORAL SYRUP SF VEHICLE	Formulary	
ORAL SYRUP VEHICLE	Formulary	
ORA-PLUS SUSPENDING VEHICLE	Formulary	
ORA-SWEET ORAL SYRUP	Formulary	
ORA-SWEET SF SYRUP	Formulary	
ORA-SWEET-SF SYRUP	Formulary	
PCCA-PLUS ORAL SUSP VEHICLE	Formulary	
<i>simple syrup (rx)</i>	Formulary	
<i>simple syrup nf (rx)</i>	Formulary	
<i>simple syrup usp (rx)</i>	Formulary	
SOSWEET SYRUP VEHICLE	Formulary	
SUSPENDRX ANHYDROUS SWEET SUSP	Formulary	
SUSPENDRX ANHYDRS UNSWEET SUSP	Formulary	
<i>suspension vehicle natural</i>	Formulary	
SWEET-SF SYRUP	Formulary	
SYRPALTA SYRUP	Formulary	
SYRSPEND SF ALKA POWDER	Formulary	
SYRSPEND SF LIQUID (RX)	Formulary	

Medications	Coverage Level	Restrictions
SYRSPEND SF LIQUID CHERRY (RX)	Formulary	
SYRSPEND SF LIQUID GRAPE (RX)	Formulary	
SYRSPEND SF PH4 POWDER	Formulary	
SYRSPEND SF POWDER DRY & UNFLAVORED (RX)	Formulary	
<i>syrup vehicle (rx)</i>	Formulary	
SYRUP VEHICLE SF	Formulary	
UNISPEND ANHYDROUS SWEET SUSP	Formulary	
VERSA FREE SF SYRUP VEHICLE	Formulary	
VERSA PLUS SUSPENSION VEHICLE	Formulary	
Pharmaceutical Adjuvant - Preservatives		
<i>sodium benzoate powder nf (rx)</i>	Formulary	
Pharmaceutical Adjuvant - Troche/Soft Lozenge Base		
<i>polyethylene glycol 1450 powd base a (rx)</i>	Formulary	
Cognitive Disorder Therapy		
Alzheimer's Disease Therapy - Cholinesterase Inhibitors		
ADLARITY 10 MG/DAY WEEKLY PATCH OUTER	Formulary	PA; PDL Non-Preferred
ADLARITY 5 MG/DAY WEEKLY PATCH OUTER	Formulary	PA; PDL Non-Preferred
ARICEPT 10 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
ARICEPT 23 MG TABLET	Formulary	PA; PDL Non-Preferred
ARICEPT 5 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
<i>donepezil hcl 10 mg tablet</i>	Formulary	PDL Preferred
<i>donepezil hcl 10 mg tablet f/c</i>	Formulary	PDL Preferred
<i>donepezil hcl 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>donepezil hcl 23 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>donepezil hcl 5 mg tablet</i>	Formulary	PDL Preferred
<i>donepezil hcl 5 mg tablet f/c</i>	Formulary	PDL Preferred
<i>donepezil hcl 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>donepezil hcl odt 10 mg tablet</i>	Formulary	PDL Preferred
<i>donepezil hcl odt 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>donepezil hcl odt 5 mg tablet</i>	Formulary	PDL Preferred
<i>donepezil hcl odt 5 mg tablet outer</i>	Formulary	PDL Preferred
EXELON 13.3 MG/24HR PATCH INNER	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
EXELON 13.3 MG/24HR PATCH OUTER	Formulary	PDL Preferred
EXELON 4.6 MG/24HR PATCH INNER	Formulary	PDL Preferred
EXELON 4.6 MG/24HR PATCH OUTER	Formulary	PDL Preferred
EXELON 9.5 MG/24HR PATCH INNER	Formulary	PDL Preferred
EXELON 9.5 MG/24HR PATCH OUTER	Formulary	PDL Preferred
<i>galantamine 4 mg/ml oral soln</i>	Formulary	PA; PDL Non-Preferred
<i>galantamine er 16 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>galantamine er 24 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>galantamine er 8 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>galantamine hbr 12 mg tablet</i>	Formulary	PDL Preferred
<i>galantamine hbr 12 mg tablet f/c</i>	Formulary	PDL Preferred
<i>galantamine hbr 4 mg tablet</i>	Formulary	PDL Preferred
<i>galantamine hbr 4 mg tablet f/c</i>	Formulary	PDL Preferred
<i>galantamine hbr 4 mg tablet f/c, outer</i>	Formulary	PDL Preferred
<i>galantamine hbr 8 mg tablet</i>	Formulary	PDL Preferred
<i>galantamine hbr 8 mg tablet f/c</i>	Formulary	PDL Preferred
<i>rivastigmine 1.5 mg capsule</i>	Formulary	PDL Preferred
<i>rivastigmine 1.5 mg capsule outer</i>	Formulary	PDL Preferred
<i>rivastigmine 13.3 mg/24hr ptch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>rivastigmine 13.3 mg/24hr ptch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>rivastigmine 3 mg capsule</i>	Formulary	PDL Preferred
<i>rivastigmine 4.5 mg capsule</i>	Formulary	PDL Preferred
<i>rivastigmine 4.6 mg/24hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>rivastigmine 4.6 mg/24hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>rivastigmine 6 mg capsule</i>	Formulary	PDL Preferred
<i>rivastigmine 9.5 mg/24hr patch</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>rivastigmine 9.5 mg/24hr patch outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
Alzheimer's Disease Therapy - Nmda Receptor Antagonists		
<i>memantine 5-10 mg titration pk</i>	Formulary	PDL Preferred
<i>memantine hcl 10 mg tablet</i>	Formulary	PDL Preferred
<i>memantine hcl 10 mg tablet f/c</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>memantine hcl 10 mg tablet f/c, outer</i>	Formulary	PDL Preferred
<i>memantine hcl 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>memantine hcl 2 mg/ml solution</i>	Formulary	PDL Preferred
<i>memantine hcl 5 mg tablet</i>	Formulary	PDL Preferred
<i>memantine hcl 5 mg tablet f/c</i>	Formulary	PDL Preferred
<i>memantine hcl 5 mg tablet f/c, outer</i>	Formulary	PDL Preferred
<i>memantine hcl 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>memantine hcl er 14 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>memantine hcl er 21 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>memantine hcl er 28 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>memantine hcl er 7 mg capsule</i>	Formulary	PA; PDL Non-Preferred
NAMENDA 5-10 MG TITRATION PK	Formulary	PA; PDL Non-Preferred
NAMENDA XR 7 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NAMENDA XR TITRATION PACK	Formulary	PA; PDL Non-Preferred
<i>Alzheimer's Thx - Nmda Receptor Antag. And Cholinesterase Inhib. Comb</i>		
<i>memantine-donepezil er 21-10 mg</i>	Formulary	PA; PDL Non-Preferred
NAMZARIC 14 MG-10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NAMZARIC 21 MG-10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NAMZARIC 28 MG-10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NAMZARIC 7 MG-10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
NAMZARIC TITRATION PACK	Formulary	PA; PDL Non-Preferred
<i>Cognitive Disorder Therapy - Cerebral Vasodilators</i>		
<i>ergoloid</i>	Non-Formulary	
<i>Rett Syndrome Agents - Glypromate (Gpe) Analogs</i>		
DAYBUE	State Carve Out	
Contraceptives		
<i>Contraceptive - Vaginal Ph Modulator</i>		
PHEXXI 1.8-1-0.4% VAGINAL GEL	Formulary	QL (180 GM per 30 days)
<i>Contraceptive Injectable - Progestin</i>		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	Non-Formulary	
DEPO-PROVERA INTRAMUSCULAR SYRINGE	Non-Formulary	
DEPO-SUBQ PROVERA 104	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>medroxyprogesterone 150 mg/ml</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml inner, suv, p/f</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml inner,suv</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml outer, suv, p/f</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml outer,suv</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml sdv,inner</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml sdv,outer</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml suv</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml suv, outer</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml suv, p/f</i>	Formulary	QL (1 ML per 75 days)
<i>medroxyprogesterone 150 mg/ml terumo ndl, suv</i>	Formulary	QL (1 ML per 75 days)
Contraceptive Oral - Biphasic		
AMETHIA	Non-Formulary	
ASHLYNA	Non-Formulary	
AZURETTE 28 DAY TABLET OUTER	Formulary	12 Months Allowed
CAMRESE	Non-Formulary	
CAMRESE LO	Non-Formulary	
DAYSEE	Non-Formulary	
<i>desogestr-eth estrad eth estra</i>	Formulary	12 Months Allowed
JAIMIESS	Non-Formulary	
KARIVA 28 DAY TABLET OUTER	Formulary	12 Months Allowed
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	Non-Formulary	
LO LOESTRIN FE	Non-Formulary	
LOJAIMIESS	Non-Formulary	
PIMTREA 28 DAY TABLET OUTER	Formulary	12 Months Allowed
SIMLIYA 28 DAY TABLET OUTER	Formulary	12 Months Allowed
SIMPESSE	Non-Formulary	
VIORELE 28 DAY TABLET OUTER	Formulary	12 Months Allowed
VOLNEA 0.15-0.02-0.01 MG TAB OUTER	Formulary	12 Months Allowed
Contraceptive Oral - Monophasic		
AFIRMELLE-28 TABLET OUTER	Formulary	12 Months Allowed
ALTAVERA-28 TABLET OUTER	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
ALYACEN 1-35 28 TABLET OUTER	Formulary	12 Months Allowed
AMETHYST 90-20 MCG TABLET	Formulary	12 Months Allowed
APRI 28 DAY TABLET OUTER	Formulary	12 Months Allowed
AUBRA EQ-28 TABLET INNER	Formulary	12 Months Allowed
AUBRA EQ-28 TABLET OUTER	Formulary	12 Months Allowed
AUBRA-28 TABLET INNER	Formulary	12 Months Allowed
AUBRA-28 TABLET OUTER	Formulary	12 Months Allowed
AUROVELA 1 MG-20 MCG TABLET OUTER	Formulary	12 Months Allowed
AUROVELA 21 1.5-30 TABLET OUTER	Formulary	12 Months Allowed
AUROVELA 24 FE 1 MG-20 MCG TAB OUTER	Formulary	12 Months Allowed
AUROVELA FE 1.5 MG-30 MCG TAB OUTER	Formulary	12 Months Allowed
AUROVELA FE 1-20 TABLET OUTER	Formulary	12 Months Allowed
AVIANE-28 TABLET OUTER	Formulary	12 Months Allowed
AYUNA-28 TABLET OUTER	Formulary	12 Months Allowed
BALCOLTRA	Non-Formulary	
BALZIVA 28 TABLET OUTER	Formulary	12 Months Allowed
BEYAZ	Non-Formulary	
BLISOVI 24 FE TABLET OUTER	Formulary	12 Months Allowed
BLISOVI FE 1.5-30 TABLET OUTER	Formulary	12 Months Allowed
BLISOVI FE 1-20 TABLET OUTER	Formulary	12 Months Allowed
BRIELLYN TABLET	Formulary	12 Months Allowed
CHARLOTTE 24 FE CHEWABLE TAB OUTER	Formulary	12 Months Allowed
CHATEAL EQ-28 TABLET INNER	Formulary	12 Months Allowed
CHATEAL EQ-28 TABLET OUTER	Formulary	12 Months Allowed
CRYSSELLE-28 TABLET OUTER	Formulary	12 Months Allowed
CYRED 28 DAY TABLET OUTER	Formulary	12 Months Allowed
CYRED EQ 28 DAY TABLET INNER	Formulary	12 Months Allowed
CYRED EQ 28 DAY TABLET OUTER	Formulary	12 Months Allowed
DASETTA 1-35-28 TABLET 6'S, OUTER	Formulary	12 Months Allowed
DOLISHALE 90-20 MCG TABLET INNER	Formulary	12 Months Allowed
DOLISHALE 90-20 MCG TABLET OUTER	Formulary	12 Months Allowed
<i>drospirenone-e.estradiol-lm.fa</i>	Non-Formulary	
<i>drospirenone-ee 3-0.02 mg tab f/c, outer</i>	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
<i>drospirenone-ee 3-0.02 mg tab outer</i>	Formulary	12 Months Allowed
<i>drospirenone-ee 3-0.03 mg tab</i>	Formulary	12 Months Allowed
<i>drospirenone-ee 3-0.03 mg tab outer</i>	Formulary	12 Months Allowed
ELINEST-28 TABLET OUTER	Formulary	12 Months Allowed
ENSKYCE 28 TABLET OUTER	Formulary	
ENSKYCE 28 TABLET OUTER	Formulary	12 Months Allowed
ESTARYLLA 0.25-0.035 MG TABLET OUTER	Formulary	12 Months Allowed
<i>ethynodiol-eth estra 1 mg-35 mcg outer</i>	Formulary	12 Months Allowed
<i>ethynodiol-eth estra 1 mg-50 mcg outer</i>	Formulary	12 Months Allowed
FALMINA-28 TABLET OUTER	Formulary	12 Months Allowed
FEIRZA 1 MG-20 MCG TABLET OUTER	Formulary	12 Months Allowed
FEIRZA 1.5 MG-30 MCG TABLET OUTER	Formulary	12 Months Allowed
GEMMILY	Non-Formulary	
HAILEY 21 1.5 MG-30 MCG TAB OUTER	Formulary	12 Months Allowed
HAILEY 24 FE 1 MG-20 MCG TAB OUTER	Formulary	12 Months Allowed
HAILEY FE 1.5-30 TABLET OUTER	Formulary	12 Months Allowed
HAILEY FE 1-20 TABLET OUTER	Formulary	12 Months Allowed
ICLEVIA 0.15 MG-0.03 MG TABLET OUTER	Formulary	12 Months Allowed
ISIBLOOM 28 DAY TABLET OUTER	Formulary	12 Months Allowed
JASMIEL 3 MG-0.02 MG TABLET INNER	Formulary	12 Months Allowed
JASMIEL 3 MG-0.02 MG TABLET OUTER	Formulary	12 Months Allowed
JOLESSA 0.15 MG-0.03 MG TABLET	Formulary	12 Months Allowed
JOYEAUX	Non-Formulary	
JULEBER 28 DAY TABLET OUTER	Formulary	12 Months Allowed
JUNEL 1 MG-20 MCG TABLET 3X21	Formulary	12 Months Allowed
JUNEL 1.5 MG-30 MCG TABLET 3'S	Formulary	12 Months Allowed
JUNEL FE 1 MG-20 MCG TABLET	Formulary	12 Months Allowed
JUNEL FE 1.5 MG-30 MCG TABLET	Formulary	12 Months Allowed
JUNEL FE 24 TABLET OUTER	Formulary	12 Months Allowed
KAITLIB FE 0.8-0.025 MG CHEW TB OUTER	Formulary	12 Months Allowed
KALLIGA 28 DAY TABLET OUTER	Formulary	12 Months Allowed
KELNOR 1-35 28 TABLET OUTER	Formulary	12 Months Allowed
KELNOR 1-50 TABLET OUTER	Formulary	12 Months Allowed
KURVELO-28 TABLET OUTER	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
LARIN 1.5 MG-30 MCG TABLET OUTER	Formulary	12 Months Allowed
LARIN 21 1-20 TABLET OUTER	Formulary	12 Months Allowed
LARIN 24 FE 1 MG-20 MCG TABLET OUTER	Formulary	12 Months Allowed
LARIN FE 1.5-30 TABLET OUTER	Formulary	12 Months Allowed
LARIN FE 1-20 TABLET OUTER	Formulary	12 Months Allowed
LAYOLIS FE CHEWABLE TABLET	Formulary	12 Months Allowed
LESSINA-28 TABLET OUTER	Formulary	12 Months Allowed
<i>levonor-eth estra 0.09-0.02 mg outer, f/c</i>	Formulary	12 Months Allowed
<i>levonor-eth estrad 0.1-0.02 mg inner</i>	Formulary	12 Months Allowed
<i>levonor-eth estrad 0.1-0.02 mg outer</i>	Formulary	12 Months Allowed
<i>levonor-eth estrad 0.15-0.03 outer</i>	Formulary	12 Months Allowed
<i>levonorgest-eth.estradiol-iron</i>	Non-Formulary	
<i>levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet</i>	Formulary	12 Months Allowed
<i>levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet 3x91 wallets,outer</i>	Formulary	12 Months Allowed
<i>levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet outer</i>	Formulary	12 Months Allowed
LEVORA-28 TABLET OUTER	Formulary	12 Months Allowed
LOESTRIN 1.5/30 (21)	Non-Formulary	
LOESTRIN 1/20 (21)	Non-Formulary	
LOESTRIN FE 1.5/30 (28-DAY)	Non-Formulary	
LOESTRIN FE 1/20 (28-DAY)	Non-Formulary	
LORYNA 3 MG-0.02 MG TABLET OUTER	Formulary	12 Months Allowed
LOW-OGESTREL-28 TABLET OUTER	Formulary	12 Months Allowed
LO-ZUMANDIMINE 3 MG-0.02 MG TB OUTER	Formulary	12 Months Allowed
LUTERA-28 TABLET OUTER	Formulary	12 Months Allowed
MARLISSA-28 TABLET 3X28, OUTER	Formulary	12 Months Allowed
MERZEE	Non-Formulary	
MIBELAS 24 FE CHEWABLE TABLET OUTER	Formulary	12 Months Allowed
MICROGESTIN 21 1.5-30 TAB OUTER	Formulary	12 Months Allowed
MICROGESTIN 21 1-20 TABLET OUTER	Formulary	
MICROGESTIN 21 1-20 TABLET OUTER	Formulary	12 Months Allowed
MICROGESTIN FE 1.5-30 TAB OUTER	Formulary	12 Months Allowed
MICROGESTIN FE 1-20 TABLET OUTER	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
MILI 0.25-0.035 MG TABLET OUTER	Formulary	12 Months Allowed
MINZOYA	Non-Formulary	
MONO-LINYAH 28 TABLET OUTER	Formulary	12 Months Allowed
NECON 0.5-35-28 TABLET OUTER	Formulary	12 Months Allowed
NEXTSTELLIS	Non-Formulary	
NIKKI 3 MG-0.02 MG TABLET OUTER	Formulary	12 Months Allowed
<i>noret-estr-fe 0.4-0.035(21)-75 outer</i>	Formulary	12 Months Allowed
<i>noreth-ee-fe 1.5-0.03 mg(21)-75 outer</i>	Formulary	12 Months Allowed
<i>noreth-ee-fe 1-0.02(21)-75 tab outer</i>	Formulary	12 Months Allowed
<i>noreth-ee-fe 1-0.02(24)-75 chw outer</i>	Formulary	12 Months Allowed
<i>norethind-eth estrad 1-0.02 mg outer</i>	Formulary	12 Months Allowed
<i>norethindrone-e.estradiol-iron oral capsule</i>	Non-Formulary	
<i>norethin-ee 1.5-0.03 mg(21) tb outer</i>	Formulary	12 Months Allowed
<i>norethin-estra-fe 0.8-0.025 mg chewable tab,outer</i>	Formulary	12 Months Allowed
<i>norg-ethin estra 0.25-0.035 mg 3x28, outer</i>	Formulary	12 Months Allowed
<i>norg-ethin estra 0.25-0.035 mg outer</i>	Formulary	12 Months Allowed
NORTREL 0.5-35-28 TABLET OUTER	Formulary	12 Months Allowed
NORTREL 1-35 21 TABLET OUTER	Formulary	
NORTREL 1-35 28 TABLET OUTER	Formulary	12 Months Allowed
NYLIA 1-35 28 TABLET OUTER	Formulary	12 Months Allowed
OCELLA 3 MG-0.03 MG TABLET 3'S, F/C, INNER	Formulary	12 Months Allowed
OCELLA 3 MG-0.03 MG TABLET 3'S, F/C, OUTER	Formulary	12 Months Allowed
PHILITH 0.4-0.035 MG TABLET 6X28,OUTER	Formulary	12 Months Allowed
PORTIA-28 TABLET OUTER	Formulary	12 Months Allowed
RECLIPSEN 28 DAY TABLET OUTER	Formulary	12 Months Allowed
SAFYRAL	Non-Formulary	
SETLAKIN 0.15 MG-0.03 MG TAB OUTER	Formulary	12 Months Allowed
SPRINTEC 28 DAY TABLET	Formulary	12 Months Allowed
SRONYX 0.10-0.02 MG TABLET OUTER	Formulary	12 Months Allowed
SYEDA 28 TABLET OUTER	Formulary	12 Months Allowed
TARINA 24 FE 1 MG-20 MCG TAB INNER	Formulary	12 Months Allowed
TARINA 24 FE 1 MG-20 MCG TAB OUTER	Formulary	12 Months Allowed
TARINA FE 1-20 EQ TABLET INNER	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
TARINA FE 1-20 EQ TABLET OUTER	Formulary	12 Months Allowed
TARINA FE 1-20 TABLET INNER	Formulary	12 Months Allowed
TARINA FE 1-20 TABLET OUTER	Formulary	12 Months Allowed
TAYTULLA	Non-Formulary	
TURQOZ-28 TABLET OUTER	Formulary	12 Months Allowed
TYBLUME	Non-Formulary	
TYDEMY	Non-Formulary	
VALTYA 1 MG-50 MCG TABLET OUTER	Formulary	12 Months Allowed
VESTURA 3 MG-0.02 MG TABLET OUTER	Formulary	
VESTURA 3 MG-0.02 MG TABLET OUTER	Formulary	12 Months Allowed
VIENVA-28 TABLET OUTER	Formulary	12 Months Allowed
VYFEMLA 0.4 MG-0.035 MG TABLET OUTER	Formulary	12 Months Allowed
VYLIBRA 28 TABLET INNER	Formulary	12 Months Allowed
VYLIBRA 28 TABLET OUTER	Formulary	12 Months Allowed
WERA 0.5/0.035 MG 28 TABLET 3X28, OUTER	Formulary	12 Months Allowed
WYMZYA FE 0.4-0.035 MG CHEW TB OUTER	Formulary	12 Months Allowed
XELRIA FE 0.4-0.035 MG CHEW TB OUTER	Formulary	12 Months Allowed
YASMIN (28)	Non-Formulary	
YAZ (28)	Non-Formulary	
ZARAH TABLET OUTER	Formulary	12 Months Allowed
ZOVIA 1-35 TABLET OUTER	Formulary	12 Months Allowed
ZUMANDIMINE 3 MG-0.03 MG TAB OUTER	Formulary	12 Months Allowed
<i>Contraceptive Oral - Progestin</i>		
CAMILA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
DEBLITANE 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
EMZAHH 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
ERRIN 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
HEATHER 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
INCASSIA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
JENCYCLA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
LYLEQ 0.35 MG TABLET INNER	Formulary	12 Months Allowed
LYLEQ 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
LYZA 0.35 MG TABLET INNER	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
LYZA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
NORA-BE TABLET OUTER	Formulary	12 Months Allowed
<i>norethindrone 0.35 mg tablet outer</i>	Formulary	12 Months Allowed
OPILL 0.075 MG TABLET	Formulary	12 Months Allowed; OTC
SHAROBEL 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
SLYND	Non-Formulary	
TULANA 0.35 MG TABLET INNER	Formulary	12 Months Allowed
TULANA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
Contraceptive Oral - Quadrphasic		
<i>l norgestle.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	Non-Formulary	
NATAZIA	Non-Formulary	
RIVELSA	Non-Formulary	
Contraceptive Oral - Triphasic		
ALYACEN 7-7-7-28 TABLET OUTER	Formulary	12 Months Allowed
ARANELLE 28 TABLET OUTER	Formulary	12 Months Allowed
CAZIAN 28 DAY TABLET OUTER	Formulary	12 Months Allowed
DASETTA 7/7/7-28 TABLET 6X28, OUTER	Formulary	12 Months Allowed
ENPRESSE-28 TABLET 6'S	Formulary	12 Months Allowed
LEENA 28 TABLET OUTER	Formulary	12 Months Allowed
LEVONEST-28 TABLET 6X28, OUTER	Formulary	12 Months Allowed
<i>levonor-eth estrad triphasic outer</i>	Formulary	12 Months Allowed
<i>noreth-ee-fe 1 mg/20-30-35 mcg outer</i>	Formulary	12 Months Allowed
<i>norg-ee 0.18-0.215-0.25/0.035 outer</i>	Formulary	12 Months Allowed
NORTREL 7-7-7-28 TABLET OUTER	Formulary	12 Months Allowed
NYLIA 7-7-7-28 TABLET OUTER	Formulary	12 Months Allowed
TILIA FE 28 TABLET OUTER	Formulary	12 Months Allowed
TRI-ESTARYLLA TABLET OUTER	Formulary	12 Months Allowed
TRI-LEGEST FE-28 DAY TABLET	Formulary	12 Months Allowed
TRI-LINYAH TABLET OUTER	Formulary	12 Months Allowed
TRI-LO-ESTARYLLA TABLET OUTER	Formulary	12 Months Allowed
TRI-LO-MARZIA TABLET OUTER	Formulary	12 Months Allowed
TRI-LO-MILI TABLET OUTER	Formulary	12 Months Allowed
TRI-LO-SPRINTEC TABLET OUTER	Formulary	12 Months Allowed
TRI-MILI 28 TABLET OUTER	Formulary	12 Months Allowed
TRI-SPRINTEC TABLET	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
TRIVORA-28 TABLET OUTER	Formulary	12 Months Allowed
TRI-VYLIBRA 28 TABLET INNER	Formulary	12 Months Allowed
TRI-VYLIBRA 28 TABLET OUTER	Formulary	12 Months Allowed
TRI-VYLIBRA LO TABLET INNER	Formulary	12 Months Allowed
TRI-VYLIBRA LO TABLET OUTER	Formulary	12 Months Allowed
VELIVET 28 DAY TABLET OUTER	Formulary	12 Months Allowed
XARAH FE 1 MG/20-30-35 MCG TAB OUTER	Formulary	12 Months Allowed
Contraceptive Transdermal Combinations - Estrogen And Progestin Comb.		
<i>norelgestrom-ee 150-35 mcg/day outer</i>	Formulary	12 Months Allowed
TWIRLA	Non-Formulary	
XULANE 150-35 MCG/DAY PATCH OUTER	Formulary	12 Months Allowed
ZAFEMY 150-35 MCG/DAY PATCH OUTER	Formulary	12 Months Allowed
Contraceptives - Intravaginal, Systemic - Estrogen And Progestin Comb.		
ANNOVERA	Non-Formulary	
ELURYNG VAGINAL RING OUTER	Formulary	12 Months Allowed; QL (1 ring per 28 days)
ENILLORING VAGINAL RING OUTER	Formulary	12 Months Allowed; QL (1 ring per 28 days)
<i>etonogestrel-ee vaginal ring outer</i>	Formulary	12 Months Allowed; QL (1 ring per 28 days)
HALOETTE VAGINAL RING OUTER	Formulary	12 Months Allowed; QL (1 ring per 28 days)
NUVARING	Non-Formulary	
Emergency Contraceptives - Progesterone Agonist/Antagonist Type		
ELLA 30 MG TABLET	Formulary	12 Months Allowed
Emergency Contraceptives - Progestin Type		
ECONTRA EZ 1.5 MG TABLET INNER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA EZ 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA ONE-STEP 1.5 MG TABLET INNER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA ONE-STEP 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; OTC

Medications	Coverage Level	Restrictions
ECONTRA ONE-STEP 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
HER STYLE 1.5 MG TABLET	Formulary	12 Months Allowed; OTC
<i>levonorgestrel 1.5 mg tablet (otc)</i>	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
MY CHOICE 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
MY WAY 1.5 MG TABLET (OTC)	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
NEW DAY 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
OPCICON ONE-STEP 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
OPTION 2 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
<i>Emergency Contraceptives</i>		
ECONTRA EZ 1.5 MG TABLET INNER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA EZ 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA ONE-STEP 1.5 MG TABLET INNER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ECONTRA ONE-STEP 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; OTC
ECONTRA ONE-STEP 1.5 MG TABLET OUTER	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
ELLA 30 MG TABLET	Formulary	12 Months Allowed
HER STYLE 1.5 MG TABLET	Formulary	12 Months Allowed; OTC
<i>levonorgestrel 1.5 mg tablet (otc)</i>	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
MY CHOICE 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
MY WAY 1.5 MG TABLET (OTC)	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
NEW DAY 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
OPCICON ONE-STEP 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC
OPTION 2 1.5 MG TABLET	Formulary	12 Months Allowed; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
Dermatological		
Acne Therapy Systemic - Retinoids And Derivatives		
ABSORICA	Non-Formulary	
ABSORICA LD	Non-Formulary	
AMNESTEEM 10 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 10 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 20 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 20 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 30 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 40 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
AMNESTEEM 40 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 10 MG CAPSULE 3X10	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 10 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 20 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 30 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 30 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
CLARAVIS 40 MG CAPSULE OUTER	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 10 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 10 mg capsule inner</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 10 mg capsule inner</i>	Non-Formulary	
<i>isotretinoin 10 mg capsule outer</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 10 mg capsule outer</i>	Non-Formulary	
<i>isotretinoin 20 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 20 mg capsule inner</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 20 mg capsule inner</i>	Non-Formulary	
<i>isotretinoin 20 mg capsule outer</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 20 mg capsule outer</i>	Non-Formulary	
<i>isotretinoin 30 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 30 mg capsule inner</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 30 mg capsule inner</i>	Non-Formulary	
<i>isotretinoin 30 mg capsule outer</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 30 mg capsule outer</i>	Non-Formulary	
<i>isotretinoin 40 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 40 mg capsule inner</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 40 mg capsule inner</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>isotretinoin 40 mg capsule outer</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>isotretinoin 40 mg capsule outer</i>	Non-Formulary	
<i>isotretinoin oral capsule 25 mg, 35 mg</i>	Non-Formulary	
ZENATANE 10 MG CAPSULE 3X10, OUTER	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 10 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 20 MG CAPSULE 3X10, OUTER	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 20 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 30 MG CAPSULE OUTER, 3X10	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 40 MG CAPSULE 3X10, OUTER	Formulary	PA; QL (2 capsules per 1 day)
ZENATANE 40 MG CAPSULE INNER	Formulary	PA; QL (2 capsules per 1 day)
<i>Acne Therapy Systemic - Tetracycline Antibiotic</i>		
<i>minocycline oral tablet extended release 24 hr</i>	Non-Formulary	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 65 MG, 80 MG	Non-Formulary	
<i>Acne Therapy Topical - Androgen Receptor Inhibitors</i>		
WINLEVI	Non-Formulary	
<i>Acne Therapy Topical - Anti-Infective Combinations Other</i>		
CLINDACIN ETZ TOPICAL KIT	Non-Formulary	
CLINDACIN PAC	Non-Formulary	
<i>Acne Therapy Topical - Anti-Infective</i>		
<i>azelaic acid</i>	Non-Formulary	
CLEOCIN T TOPICAL LOTION	Non-Formulary	
CLINDACIN ETZ 1% PLEDGET OUTER	Formulary	
CLINDACIN P 1% PLEDGETS	Formulary	
<i>clindamycin ph 1% solution</i>	Formulary	QL (180 ML per 30 days)
<i>clindamycin phos 1% pledget</i>	Formulary	
<i>clindamycin phosphate topical foam</i>	Non-Formulary	
<i>clindamycin phosphate topical gel</i>	Non-Formulary	
<i>clindamycin phosphate topical gel, once daily</i>	Non-Formulary	
<i>clindamycin phosphate topical lotion</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>dapsone topical gel 5 %</i>	Non-Formulary	
<i>dapsone topical gel with pump</i>	Non-Formulary	
ERY PADS	Non-Formulary	
ERYGEL	Non-Formulary	
<i>erythromycin 2% solution</i>	Formulary	
<i>erythromycin with ethanol topical gel</i>	Non-Formulary	
EVOCLIN	Non-Formulary	
FINACEA TOPICAL FOAM	Non-Formulary	
KLARON	Non-Formulary	
<i>sulfacetamide sodium (acne)</i>	Non-Formulary	
Acne Therapy Topical - Anti-Infective-Keratolytic Combinations		
ACANYA GEL PUMP	Formulary	PA; PDL Non-Preferred
AVAR CLEANSER 12'S	Formulary	
AVAR LS	Non-Formulary	
AVAR-E	Non-Formulary	
AVAR-E GREEN	Non-Formulary	
AVAR-E LS	Non-Formulary	
BENZAMYCIN	Non-Formulary	
BP 10-1	Non-Formulary	
CLEANSING WASH TOPICAL CLEANSER	Non-Formulary	
<i>clind ph-benzoyl pero 1.2-2.5%</i>	Formulary	PDL Preferred
<i>clind ph-benzoyl perox 1.2-5%</i>	Formulary	PDL Preferred
<i>clindamyc-bnz perox 1.2-3.75%</i>	Formulary	PA; PDL Non-Preferred
<i>clindamycin-benzoyl perox 1-5%</i>	Formulary	PDL Preferred
<i>clindamycin-benzoyl perox 1-5% outer</i>	Formulary	PDL Preferred
<i>clindamycin-bnz perox 1-5% pmp</i>	Formulary	PDL Preferred
<i>clindamycin-bnz perox 1-5% pmp outer</i>	Formulary	PDL Preferred
<i>erythromycin-benzoyl gel</i>	Formulary	
NEUAC 1.2-5% KIT	Formulary	PA; PDL Non-Preferred
NEUAC GEL	Formulary	PA; PDL Non-Preferred
ONEXTON GEL PUMP	Formulary	PA; PDL Non-Preferred
ROSULA	Non-Formulary	
ROSULA CLEANSING CLOTHS	Non-Formulary	
<i>sod sulfacet-sulfur 10-5% clsr</i>	Formulary	
SSS 10-5	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>sulfacetamide sodium-sulfur topical cleanser 10-2 %, 9-4 %, 9-4.5 %, 9.8-4.8 %</i>	Non-Formulary	
<i>sulfacetamide sodium-sulfur topical cream 10-2 %, 10-5 % (w/w)</i>	Non-Formulary	
<i>sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w)</i>	Non-Formulary	
<i>sulfacetamide sodium-sulfur topical pads, medicated 10-4 %</i>	Non-Formulary	
<i>sulfacetamide sodium-sulfur topical suspension 10-5 %, 8-4 %</i>	Non-Formulary	
<i>sulfacetamide sod-sulfur-urea</i>	Non-Formulary	
SUMADAN	Non-Formulary	
SUMADAN XLT	Non-Formulary	
SUMAXIN	Non-Formulary	
SUMAXIN CP	Non-Formulary	
SUMAXIN TS	Non-Formulary	
Acne Therapy Topical - Anti-Infective-Retinoid Combinations		
CABTREO 1.2%-0.15%-3.15% GEL	Formulary	PA; PDL Non-Preferred
<i>clindamycin-tretinoin</i>	Non-Formulary	
ZIANA	Non-Formulary	
Acne Therapy Topical - Keratolytic		
ACNE MEDICATION 10% GEL	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)
ACNE MEDICATION TOPICAL GEL 2.5 %, 5 %	Non-Formulary	OTC
ACNE MEDICATION TOPICAL LOTION 10 %	Non-Formulary	OTC
<i>benzoyl peroxide 10% gel (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)
<i>benzoyl peroxide 10% gel aqueous (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)
<i>benzoyl peroxide 10% wash (otc)</i>	Formulary	OTC
<i>benzoyl peroxide 5% gel (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>benzoyl peroxide 5% gel aqueous (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>benzoyl peroxide 5% wash (otc)</i>	Formulary	OTC
<i>benzoyl peroxide 5% wash (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>benzoyl peroxide topical gel 2.5 %</i>	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
Acne Therapy Topical - Retinoid Combinations Other		
<i>adapalene-benzoyl peroxide topical gel with pump 0.3-2.5 %</i>	Non-Formulary	
<i>adapalene-bnzyl perox 0.1-2.5%</i>	Formulary	QL (45 GM per 30 days)
EPIDUO FORTE	Non-Formulary	
Acne Therapy Topical - Retinoids And Derivatives		
<i>adapalene 0.1% gel (otc)</i>	Formulary	OTC; QL (45 GM per 30 days)
<i>adapalene 0.1% gel (otc)</i>	Formulary	Dual Eligible Covered; OTC; QL (45 GM per 30 days)
<i>adapalene 0.3% gel</i>	Formulary	QL (45 GM per 30 days)
<i>adapalene 0.3% gel</i>	Formulary	Dual Eligible Covered; QL (45 GM per 30 days)
<i>adapalene topical cream</i>	Non-Formulary	
<i>adapalene topical gel with pump</i>	Non-Formulary	
ALTRENO	Non-Formulary	
ARAZLO	Non-Formulary	
ATRALIN	Non-Formulary	
AVITA TOPICAL GEL	Non-Formulary	Dual Eligible Covered
DIFFERIN 0.1% GEL (OTC)	Formulary	OTC; QL (45 GM per 30 days)
DIFFERIN TOPICAL CREAM	Non-Formulary	
DIFFERIN TOPICAL GEL WITH PUMP	Non-Formulary	
DIFFERIN TOPICAL LOTION	Non-Formulary	Dual Eligible Covered
FABIOR	Non-Formulary	
RETIN-A MICRO	Non-Formulary	Dual Eligible Covered
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.04 %, 0.1 %	Non-Formulary	Dual Eligible Covered
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	Non-Formulary	
RETIN-A TOPICAL CREAM 0.025 %	Non-Formulary	
RETIN-A TOPICAL CREAM 0.05 %, 0.1 %	Non-Formulary	Dual Eligible Covered
RETIN-A TOPICAL GEL	Non-Formulary	Dual Eligible Covered
<i>tazarotene topical foam</i>	Non-Formulary	
<i>tretinoin 0.025% cream</i>	Formulary	QL (20 GM per 30 days)
<i>tretinoin 0.025% cream</i>	Formulary	Dual Eligible Covered; QL (20 GM per 30 days)
<i>tretinoin 0.05% cream</i>	Formulary	QL (20 GM per 30 days)

Medications	Coverage Level	Restrictions
<i>tretinoin 0.05% cream</i>	Formulary	Dual Eligible Covered; QL (20 GM per 30 days)
<i>tretinoin microspheres topical gel</i>	Non-Formulary	Dual Eligible Covered
<i>tretinoin microspheres topical gel with pump 0.04 %, 0.1 %</i>	Non-Formulary	Dual Eligible Covered
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	Non-Formulary	
<i>tretinoin topical cream 0.1 %</i>	Non-Formulary	Dual Eligible Covered
<i>tretinoin topical gel 0.01 %, 0.025 %</i>	Non-Formulary	Dual Eligible Covered
<i>tretinoin topical gel 0.05 %</i>	Non-Formulary	
<i>Antipsoriatic - Retinoid (Vitamin A Derivative) - Glucocorticoid</i>		
DUOBRII	Non-Formulary	
<i>Antipsoriatic - Vitamin D Analog - Glucocorticoid Combinations</i>		
<i>calcipotriene-betamethasone</i>	Non-Formulary	
ENSTILAR	Non-Formulary	
TACLONEX TOPICAL SUSPENSION	Non-Formulary	
<i>Antipsoriatic Agents - Interleukin 12 And Il-23 Inhibitors, Mc Antibody</i>		
STELARA 45 MG/0.5 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
STELARA 45 MG/0.5 ML VIAL SDV, P/F	Formulary	PA; PDL Non-Preferred
STELARA 90 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>Antipsoriatic Agents - Interleukin-23 (Il-23) Antagonist, Mc Antibody</i>		
ILUMYA 100 MG/ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SKYRIZI 150 MG/ML PEN	Formulary	PA; PDL Non-Preferred
SKYRIZI 150 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML INJECTOR	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
<i>Antipsoriatic Agents - Tyrosine Kinase 2 (Tyk2) Inhibitor</i>		
SOTYKTU 6 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
<i>Antipsoriatic Agents-Interleukin-17 (Il-17) Antagonist, Mc Antibody</i>		
BIMZELX 160 MG/ML AUTOINJECTOR	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
BIMZELX 160 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
BIMZELX 320 MG/2 ML AUTOINJECT	Formulary	PA; PDL Non-Preferred
BIMZELX 320 MG/2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
COSENTYX (150 MG/ML) 300 MG DOSE-2 SYRINGES	Formulary	PDL Preferred
COSENTYX 150 MG/ML SYRINGE	Formulary	PDL Preferred
COSENTYX 75 MG/0.5 ML SYRINGE	Formulary	PDL Preferred
COSENTYX SENSOREADY 150 MG/ML PEN	Formulary	PDL Preferred
COSENTYX SENSOREADY 300 MG DOSE/2 PENS (150 MG/PEN)	Formulary	PDL Preferred
COSENTYX UNOREADY 300 MG/2 ML PEN (1 PEN) SUV,P/F, 1 PEN=300MG	Formulary	PDL Preferred
SILIQ 210 MG/1.5 ML SYRINGE OUTER,P/F,SDV	Formulary	PA; PDL Non-Preferred
TALTZ 20 MG/0.25 ML SYRINGE	Formulary	PA; PDL Non-Preferred
TALTZ 40 MG/0.5 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML AUTOINJECTOR (2-PACK)	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML AUTOINJECTOR (3-PACK)	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML AUTOINJECTOR P/F,SDV,INNER	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML AUTOINJECTOR P/F,SDV,OUTER	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML SYRINGE P/F,SUV,INNER	Formulary	PA; PDL Non-Preferred
TALTZ 80 MG/ML SYRINGE P/F,SUV,OUTER	Formulary	PA; PDL Non-Preferred
<i>Dermatitis - Janus Kinase (Jak) Inhibitors</i>		
CIBINQO 100 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
CIBINQO 200 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
CIBINQO 50 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
OPZELURA 1.5% CREAM	Formulary	PA; PDL Non-Preferred; QL (240 GM per 30 days); Age Limit (Min 12 Years)
RINVOQ ER 15 MG TABLET	Formulary	PA; PDL Non-Preferred
RINVOQ ER 30 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Dermatitis Agents, Systemic - Interleukin-13 Inhibitors Mab</i>		
ADBRY 150 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred; QL (4 ML per 28 days)
ADBRY 150 MG/ML SYRINGE SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (4 ML per 28 days)
ADBRY 300 MG/2 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (4 ML per 28 days)
EBGLYSS 250 MG/2 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; QL (2 ML per 28 days); Age Limit (Min 12 Years)
EBGLYSS 250 MG/2 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; QL (2 ML per 28 days); Age Limit (Min 12 Years)
<i>Dermatitis Agents, Systemic - Il-31 Receptor Alpha Antagonist Mab</i>		
NEMLUVIO 30 MG PEN	Formulary	PA; PDL Non-Preferred; QL (1 pen per 28 days)
<i>Dermatitis Agents, Systemic - Il-4 Receptor Alpha Antagonist (Il-4Ra) Mab</i>		
DUPIXENT 200 MG/1.14 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Preferred; Age Limit (Min 2 Years)
DUPIXENT 200 MG/1.14 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Preferred
DUPIXENT 300 MG/2 ML PEN OUTER, SUV	Formulary	PA; PDL Preferred; Age Limit (Min 2 Years)
DUPIXENT 300 MG/2 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Preferred
<i>Dermatitis Or Eczema Agents, Topical - Phosphodiesterase-4 Inhibitors</i>		
EUCRISA 2% OINTMENT	Formulary	PA; PDL Preferred; QL (100 GM per 30 days); Age Limit (Min 3 Months)
ZORYVE 0.15% CREAM	Formulary	PA; Age Limit (Min 6 Years)

Medications	Coverage Level	Restrictions
<i>Dermatological - Antibacterial Aminoglycosides</i>		
<i>gentamicin 0.1% cream</i>	Formulary	
<i>gentamicin 0.1% ointment</i>	Formulary	
<i>Dermatological - Antibacterial Mixtures</i>		
FT TRIPLE ANTIBIOTIC OINTMENT	Formulary	OTC
SM TRIPLE ANTIBIOTIC OINTMENT	Formulary	Dual Eligible Covered; OTC
TRIPLE ANTIBIOTIC OINTMENT	Formulary	OTC
TRIPLE ANTIBIOTIC OINTMENT	Formulary	Dual Eligible Covered; OTC
<i>Dermatological - Antibacterial Other</i>		
CENTANY 2% OINTMENT	Formulary	PA; PDL Non-Preferred
CENTANY AT 2% OINTMENT KIT	Formulary	PA; PDL Non-Preferred
<i>mupirocin 2% cream</i>	Formulary	PA; PDL Non-Preferred
<i>mupirocin 2% ointment</i>	Formulary	PDL Preferred
<i>mupirocin 2% ointment outer</i>	Formulary	PDL Preferred
<i>silver nitrate topical solution 0.5 %</i>	Non-Formulary	
<i>Dermatological - Antibacterial Povidone-Iodine Preparations</i>		
BETADINE TOPICAL SOLUTION	Non-Formulary	Dual Eligible Covered; OTC
FIRST AID ANTISEPTIC(POVIDONE) TOPICAL OINTMENT	Non-Formulary	Dual Eligible Covered; OTC
<i>povidone-iodine topical ointment</i>	Non-Formulary	Dual Eligible Covered; OTC
<i>povidone-iodine topical solution 10 %</i>	Non-Formulary	Dual Eligible Covered; OTC
<i>Dermatological - Antibacterial Quinolones</i>		
XEPI 1% CREAM INNER	Formulary	PA; PDL Non-Preferred; QL (60 GM per 30 days)
XEPI 1% CREAM OUTER	Formulary	PA; PDL Non-Preferred; QL (60 GM per 30 days)
<i>Dermatological - Antibacterial-Glucocorticoid Combinations</i>		
NEO-SYNALAR	Non-Formulary	
NEO-SYNALAR KIT	Non-Formulary	
<i>Dermatological - Anticholinergic Hyperhidrosis Treatment Agents</i>		
SOFDRA	Non-Formulary	
<i>Dermatological - Antifungal Allylamines</i>		
<i>naftifine hcl 1% cream</i>	Formulary	PA; PDL Non-Preferred
<i>naftifine hcl 2% cream</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>naftifine hcl 2% gel</i>	Formulary	PA; PDL Non-Preferred
NAFTIN 1% GEL	Formulary	PA; PDL Non-Preferred
NAFTIN 2% GEL	Formulary	PA; PDL Non-Preferred
SM ATHLETE'S 1% FOOT CREAM	Formulary	OTC
<i>terbinafine 1% cream</i>	Formulary	OTC
<i>terbinafine 1% cream antifungal</i>	Formulary	OTC
<i>Dermatological - Antifungal Amphoteric Polyene Macrolides</i>		
KLAYESTA 100,000 UNIT/GM POWD	Formulary	PDL Preferred
NYAMYC 100,000 UNIT/GM POWDER	Formulary	PDL Preferred
<i>nystatin 100,000 unit/gm cream</i>	Formulary	PDL Preferred
<i>nystatin 100,000 unit/gm oint</i>	Formulary	PDL Preferred
<i>nystatin 100,000 unit/gm powd</i>	Formulary	PDL Preferred
NYSTOP 100,000 UNIT/GM POWDER	Formulary	PDL Preferred
<i>Dermatological - Antifungal Benzylamines</i>		
<i>butenafine hcl 1% cream</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>Dermatological - Antifungal Hydroxypyridinone</i>		
CICLODAN 0.77% CREAM	Formulary	PA; PDL Non-Preferred
CICLODAN 0.77% CREAM KIT	Formulary	PA; PDL Non-Preferred
CICLODAN 8% KIT	Formulary	PA; PDL Non-Preferred
CICLODAN 8% SOLUTION	Formulary	PA; PDL Non-Preferred
<i>ciclopirox 0.77% cream</i>	Formulary	PDL Preferred
<i>ciclopirox 0.77% gel</i>	Formulary	PA; PDL Non-Preferred
<i>ciclopirox 0.77% topical susp</i>	Formulary	PA; PDL Non-Preferred
<i>ciclopirox 1% shampoo</i>	Formulary	PA; PDL Non-Preferred
<i>ciclopirox 8% solution</i>	Formulary	PDL Preferred
<i>ciclopirox 8% treatment kit</i>	Formulary	PA; PDL Non-Preferred
LOPROX 0.77% CREAM	Formulary	PA; PDL Non-Preferred
LOPROX 0.77% CREAM KIT	Formulary	PA; PDL Non-Preferred
LOPROX 0.77% SUSPENSION KIT	Formulary	PA; PDL Non-Preferred
LOPROX 0.77% TOPICAL SUSP	Formulary	PA; PDL Non-Preferred
<i>Dermatological - Antifungal Imidazole And Related Agents</i>		
ANTIFUNGAL 1% TOPICAL CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ATHLETE'S FOOT 1% SOLUTION	Formulary	PDL Preferred; OTC
<i>clotrimazole 1% solution (otc)</i>	Formulary	PDL Preferred; OTC
<i>clotrimazole 1% solution (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>clotrimazole 1% topical cream (otc)</i>	Formulary	PDL Preferred; OTC
<i>clotrimazole 1% topical cream (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>clotrimazole 1% topical cream (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>clotrimazole 1% topical cream 2 x 45gm tubes (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>econazole nitrate 1% cream</i>	Formulary	PA; PDL Non-Preferred
ERTACZO 2% CREAM	Formulary	PA; PDL Non-Preferred
EXTINA 2% FOAM	Formulary	PA; PDL Non-Preferred
FT ANTIFUNGAL 2% TOPICAL CREAM	Formulary	OTC
FT ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; OTC
FUNGOID TINCTURE	Non-Formulary	OTC
GNP ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ketoconazole 2% cream</i>	Formulary	PDL Preferred
<i>ketoconazole 2% foam</i>	Formulary	PA; PDL Non-Preferred
<i>ketoconazole 2% shampoo</i>	Formulary	PDL Preferred
KETODAN 2% FOAM	Formulary	PA; PDL Non-Preferred
KETODAN 2% FOAM KIT	Formulary	PA; PDL Non-Preferred
LOTRIMIN AF 1% CREAM	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>luliconazole 1% cream</i>	Formulary	PA; PDL Non-Preferred
LUZU 1% CREAM	Formulary	PA; PDL Non-Preferred
<i>miconazole 2% topical cream</i>	Formulary	PDL Preferred; OTC
<i>miconazole 2% topical cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>miconazole nitrate 2% solution</i>	Formulary	PDL Preferred; OTC
<i>miconazole-zinc-petro 0.25-15%</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
MICOTRIN AC 1% TOPICAL CREAM	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
MYCOZYL AC 1% TOPICAL CREAM	Formulary	PA; PDL Non-Preferred; OTC

Medications	Coverage Level	Restrictions
<i>oxiconazole nitrate 1% cream</i>	Formulary	PA; PDL Non-Preferred
OXISTAT 1% LOTION	Formulary	PA; PDL Non-Preferred
SM ANTIFUNGAL 1% TOPICAL CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm miconazole 2% topical cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>tm-clotrimazole 1% top cream (otc)</i>	Formulary	PDL Preferred; OTC
VUSION OINTMENT	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
<i>Dermatological - Antifungal Oxaborole</i>		
<i>tavaborole 5% topical solution</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
<i>Dermatological - Antifungal Thiocarbamate</i>		
FT ANTIFUNGAL 1% CREAM	Formulary	PDL Preferred; OTC
SM ANTIFUNGAL 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>tolnaftate 1% cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>tolnaftate 1% powder</i>	Formulary	PDL Preferred; OTC
<i>Dermatological - Antifungal Triazole</i>		
JUBLIA 10% TOPICAL SOLUTION	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
<i>Dermatological - Antifungal-Glucocorticoid Combinations</i>		
<i>clotrimazole-betamethasone crm</i>	Formulary	PDL Preferred
<i>clotrimazole-betamethasone lot</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone-iodoquinol</i>	Non-Formulary	
<i>nystatin-triamcinolone cream</i>	Formulary	PDL Preferred
<i>nystatin-triamcinolone ointm</i>	Formulary	PDL Preferred
<i>nystatin-triamcinolone ointment</i>	Formulary	PDL Preferred
<i>Dermatological - Antineoplastic Alkylating Agents</i>		
VALCHLOR 0.016% GEL	Formulary	
<i>Dermatological - Antineoplastic Antimetabolites</i>		
CARAC 0.5% CREAM	Formulary	
EFUDEX 5% CREAM	Formulary	
<i>fluorouracil 0.5% cream</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>fluorouracil 2% topical soln</i>	Formulary	
<i>fluorouracil 5% cream</i>	Formulary	
<i>fluorouracil 5% topical soln</i>	Formulary	
Dermatological - Antineoplastic Or Premalignant Lesions - Nsaid's		
<i>diclofenac sodium 3% gel</i>	Formulary	
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist		
<i>bexarotene 1% gel</i>	Formulary	
TARGRETIN 1% GEL	Formulary	
Dermatological - Antiperspirants		
DRYSOL DAB-O-MATIC	Benefit Exclusion	
XERAC AC	Non-Formulary	OTC
Dermatological - Antipsoriatic Agents Systemic, Photosensitizing		
<i>methoxsalen</i>	Non-Formulary	
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives		
<i>acitretin 10 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>acitretin 17.5 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
<i>acitretin 25 mg capsule</i>	Formulary	PA; QL (2 capsules per 1 day)
Dermatological - Antipsoriatic Agents Topical		
BRYHALI 0.01% LOTION	Formulary	PA; PDL Non-Preferred
<i>calcipotriene 0.005% cream</i>	Formulary	QL (400 GM per 30 days); Age Limit (Min 2 Years)
<i>calcipotriene 0.005% ointment</i>	Formulary	QL (400 GM per 30 days); Age Limit (Min 2 Years)
<i>calcipotriene 0.005% solution</i>	Formulary	Age Limit (Min 2 Years)
<i>calcipotriene topical foam</i>	Non-Formulary	
<i>calcitriol 3 mcg/g ointment</i>	Formulary	PA; Age Limit (Min 2 Years)
<i>clobetasol 0.025% cream</i>	Formulary	PA; PDL Non-Preferred
<i>halobetasol prop 0.05% foam</i>	Formulary	PA; PDL Non-Preferred
SORILUX	Non-Formulary	
<i>tazarotene 0.05% cream</i>	Formulary	PA
<i>tazarotene 0.05% gel</i>	Formulary	PA; Age Limit (Min 12 Years)
<i>tazarotene 0.1% cream</i>	Formulary	PA
<i>tazarotene 0.1% gel</i>	Formulary	PA; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
ULTRAVATE 0.05% LOTION INNER	Formulary	PA; PDL Non-Preferred
ULTRAVATE 0.05% LOTION OUTER	Formulary	PA; PDL Non-Preferred
VECTICAL	Non-Formulary	
VTAMA 1% CREAM	Formulary	PA; Age Limit (Min 18 Years)
ZORYVE 0.3% CREAM	Formulary	PA; Age Limit (Min 6 Years)
<i>Dermatological - Antipsoriatics Systemic, Phosphodiesterase 4 Inhib.</i>		
OTEZLA 10-20 MG STARTER 28 DAY	Formulary	PA; PDL Non-Preferred
OTEZLA 10-20-30 MG START 28 DAY	Formulary	PA; PDL Non-Preferred
OTEZLA 20 MG TABLET	Formulary	PA; PDL Non-Preferred
OTEZLA 30 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Dermatological - Antiseborrheic</i>		
OVACE	Non-Formulary	
OVACE PLUS	Non-Formulary	
OVACE PLUS SHAMPOO	Non-Formulary	
OVACE PLUS WASH	Non-Formulary	
PROMISEB	Non-Formulary	
<i>selenium sulfide 2.5% lotion</i>	Formulary	
<i>selenium sulfide topical shampoo 2.25 %</i>	Non-Formulary	
<i>sulfacetamide sodium topical cleanser</i>	Non-Formulary	
<i>sulfacetamide sodium topical cleanser, gel</i>	Non-Formulary	
<i>sulfacetamide sodium topical shampoo 10 %</i>	Non-Formulary	
ZORYVE 0.3% FOAM	Formulary	PA; Age Limit (Min 9 Years)
<i>Dermatological - Antiviral, Herpes</i>		
<i>acyclovir 5% cream</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 5% ointment</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acyclovir 5% ointment outer</i>	Formulary	PDL Preferred; 3 Months Allowed
DENAVIR 1% CREAM	Formulary	PDL Preferred; 3 Months Allowed
<i>docosanol 10% cream</i>	Formulary	OTC
<i>gnp docosanol 10% cream</i>	Formulary	OTC
<i>penciclovir 1% cream</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
ZOVIRAX 5% CREAM	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ZOVIRAX 5% OINTMENT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Dermatological - Antiviral-Glucocorticoid Combinations</i>		
XERESE 5%-1% CREAM	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Dermatological - Burn Products Anti-Infective</i>		
<i>mafenide acetate</i>	Non-Formulary	
SILVADENE	Non-Formulary	
<i>silver sulfadiazine 1% cream</i>	Formulary	
SSD 1% CREAM	Formulary	
SULFAMYLLON TOPICAL CREAM	Non-Formulary	
<i>Dermatological - Calcineurin Inhibitors</i>		
ELIDEL 1% CREAM	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
<i>pimecrolimus 1% cream</i>	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
<i>tacrolimus 0.03% ointment</i>	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
<i>tacrolimus 0.03% ointment</i>	Formulary	PA; PDL Preferred; QL (30 grams per 30 days); Age Limit (Min 2 Years)
<i>tacrolimus 0.1% ointment</i>	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 16 Years)
<i>tacrolimus 0.1% ointment</i>	Formulary	PA; PDL Preferred; QL (30 grams per 30 days); Age Limit (Min 16 Years)
<i>Dermatological - Depigmenting Agents</i>		
<i>hydroquinone</i>	Non-Formulary	
<i>Dermatological - Depigmenting Combinations</i>		
TRI-LUMA	Non-Formulary	
<i>Dermatological - Emollient Mixtures</i>		
PROMISEB	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>Dermatological - Emollients</i>		
<i>ammonium lactate 12% cream (rx)</i>	Formulary	OTC; QL (140 GM per 30 days)
<i>ammonium lactate 12% cream (rx)</i>	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
<i>ammonium lactate 12% cream 2x140gm (rx)</i>	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
<i>ammonium lactate 12% cream outer, 2x140gm (rx)</i>	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
<i>ammonium lactate 12% cream w/pump (rx)</i>	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
<i>ammonium lactate 12% lotion (rx)</i>	Formulary	Dual Eligible Covered; OTC; QL (225 GM per 30 days)
PCCA BASE ANHYDROUS OINT	Formulary	
<i>Dermatological - Enzymes</i>		
SANTYL	Non-Formulary	
<i>Dermatological - Glucocorticoid</i>		
<i>alclometasone dipr 0.05% oint</i>	Formulary	PA; PDL Non-Preferred
<i>alclometasone dipro 0.05% crm</i>	Formulary	PA; PDL Non-Preferred
<i>amcinonide 0.1% cream</i>	Formulary	PA; PDL Non-Preferred
APEXICON E 0.05% CREAM	Formulary	PA; PDL Non-Preferred
BESER 0.05% LOTION	Formulary	PA; PDL Non-Preferred
<i>betamethasone dp 0.05% crm</i>	Formulary	PDL Preferred
<i>betamethasone dp 0.05% lot</i>	Formulary	PDL Preferred
<i>betamethasone dp 0.05% oint</i>	Formulary	PDL Preferred
<i>betamethasone dp 0.05% oint carton</i>	Formulary	PDL Preferred
<i>betamethasone dp aug 0.05% crm</i>	Formulary	PA; PDL Non-Preferred
<i>betamethasone dp aug 0.05% gel</i>	Formulary	PA; PDL Non-Preferred
<i>betamethasone dp aug 0.05% lot</i>	Formulary	PA; PDL Non-Preferred
<i>betamethasone dp aug 0.05% oin</i>	Formulary	PA; PDL Non-Preferred
<i>betamethasone dp aug 0.05% oin augmented</i>	Formulary	PA; PDL Non-Preferred
<i>betamethasone va 0.1% cream</i>	Formulary	PDL Preferred
<i>betamethasone va 0.1% cream carton</i>	Formulary	PDL Preferred
<i>betamethasone va 0.1% lotion</i>	Formulary	PDL Preferred
<i>betamethasone valer 0.1% ointm</i>	Formulary	PDL Preferred
<i>betamethasone valer 0.12% foam</i>	Formulary	PA; PDL Non-Preferred
BRYHALI 0.01% LOTION	Formulary	PA; PDL Non-Preferred
CAPEX SHAMPOO	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>clobetasol 0.025% cream</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol 0.05% cream</i>	Formulary	PDL Preferred
<i>clobetasol 0.05% gel</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol 0.05% ointment</i>	Formulary	PDL Preferred
<i>clobetasol 0.05% shampoo</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol 0.05% solution</i>	Formulary	PDL Preferred
<i>clobetasol 0.05% topical lotn</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol emollient 0.05% crm</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol emollnt 0.05% foam</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol emulsion 0.05% foam</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol prop 0.05% foam</i>	Formulary	PA; PDL Non-Preferred
<i>clobetasol prop 0.05% spray</i>	Formulary	PA; PDL Non-Preferred
CLOBEX 0.05% SHAMPOO	Formulary	PA; PDL Non-Preferred
CLOBEX 0.05% SPRAY	Formulary	PA; PDL Non-Preferred
<i>clocortolone pivalate 0.1% crm</i>	Formulary	PA; PDL Non-Preferred
CLODAN 0.05% SHAMPOO	Formulary	PA; PDL Non-Preferred
DERMA-SMOOTH-FS BODY OIL	Formulary	PA; PDL Non-Preferred
DERMA-SMOOTH-FS SCALP OIL	Formulary	PA; PDL Non-Preferred
<i>desonide 0.05% cream</i>	Formulary	PA; PDL Non-Preferred
<i>desonide 0.05% lotion</i>	Formulary	PA; PDL Non-Preferred
<i>desonide 0.05% ointment</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.05% cream</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.05% gel</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.05% ointment</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.25% cream</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.25% cream usp</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.25% ointment</i>	Formulary	PA; PDL Non-Preferred
<i>desoximetasone 0.25% spray</i>	Formulary	PA; PDL Non-Preferred
<i>diflorasone 0.05% cream</i>	Formulary	PA; PDL Non-Preferred
<i>diflorasone 0.05% ointment</i>	Formulary	PA; PDL Non-Preferred
DIPROLENE 0.05% OINTMENT	Formulary	PA; PDL Non-Preferred
<i>fluocinolone 0.01% body oil</i>	Formulary	PA; PDL Non-Preferred
<i>fluocinolone 0.01% cream</i>	Formulary	PA; PDL Non-Preferred
<i>fluocinolone 0.01% scalp oil</i>	Formulary	PA; PDL Non-Preferred
<i>fluocinolone 0.01% solution</i>	Formulary	PA; PDL Non-Preferred
<i>fluocinolone 0.025% cream</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>fluocinolone 0.025% ointment</i>	Formulary	PA; PDL Non-Preferred
<i>fluocinonide 0.05% cream</i>	Formulary	PDL Preferred
<i>fluocinonide 0.05% gel</i>	Formulary	PDL Preferred
<i>fluocinonide 0.05% ointment</i>	Formulary	PDL Preferred
<i>fluocinonide 0.05% solution</i>	Formulary	PDL Preferred
<i>fluocinonide 0.1% cream</i>	Formulary	PDL Preferred
<i>fluocinonide-e 0.05% cream</i>	Formulary	PA; PDL Non-Preferred
FLUOCINONIDE-E 0.05% CREAM	Formulary	PA; PDL Non-Preferred
<i>flurandrenolide 0.05% lotion</i>	Formulary	PA; PDL Non-Preferred
<i>flurandrenolide 0.05% ointment</i>	Formulary	PA; PDL Non-Preferred
<i>fluticasone prop 0.005% oint</i>	Formulary	PDL Preferred
<i>fluticasone prop 0.05% cream</i>	Formulary	PDL Preferred
<i>fluticasone prop 0.05% lotion</i>	Formulary	PA; PDL Non-Preferred
FT ITCH RELIEF 1% OINTMENT	Formulary	PDL Preferred; OTC
GS ANTI-ITCH 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>halcinonide 0.1% cream</i>	Formulary	PA; PDL Non-Preferred
<i>halcinonide 0.1% solution</i>	Formulary	PA; PDL Non-Preferred
<i>halobetasol prop 0.05% cream</i>	Formulary	PDL Preferred
<i>halobetasol prop 0.05% foam</i>	Formulary	PA; PDL Non-Preferred
<i>halobetasol prop 0.05% ointmnt</i>	Formulary	PDL Preferred
HALOG 0.1% CREAM	Formulary	PA; PDL Non-Preferred
HALOG 0.1% OINTMENT	Formulary	PA; PDL Non-Preferred
<i>hm hydrocortisone 1% cream (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 0.5% cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 0.5% cream (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream carton (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
<i>hydrocortisone 1% cream max str, w/aloe (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream maximum strength (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% cream moisturizer, max. str (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% ointment</i>	Formulary	PDL Preferred; OTC
<i>hydrocortisone 1% ointment (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% ointment (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 1% ointment maximum strength (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hydrocortisone 2.5% cream</i>	Formulary	
<i>hydrocortisone 2.5% cream</i>	Formulary	PDL Preferred
<i>hydrocortisone 2.5% cream carton</i>	Formulary	PDL Preferred
<i>hydrocortisone 2.5% lotion</i>	Formulary	PDL Preferred
<i>hydrocortisone 2.5% ointment</i>	Formulary	PDL Preferred
<i>hydrocortisone 2.5% solution</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone buty 0.1% cream</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone butyr 0.1% lotn</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone butyr 0.1% oint</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone butyr 0.1% soln</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	Non-Formulary	
<i>hydrocortisone val 0.2% cream</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone val 0.2% ointmt</i>	Formulary	PA; PDL Non-Preferred
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	Non-Formulary	
KENALOG 0.147 MG/GRAM SPRAY	Formulary	PA; PDL Non-Preferred
LOCOID 0.1% LIPOCREAM	Formulary	PA; PDL Non-Preferred
LOCOID 0.1% LOTION	Formulary	PA; PDL Non-Preferred
<i>mometasone furoate 0.1% cream</i>	Formulary	PDL Preferred
<i>mometasone furoate 0.1% oint</i>	Formulary	PDL Preferred
<i>mometasone furoate 0.1% soln 27.5 gram</i>	Formulary	PDL Preferred
<i>mometasone furoate 0.1% soln 55 gram</i>	Formulary	PDL Preferred
OLUX 0.05% FOAM	Formulary	PA; PDL Non-Preferred
PANDEL 0.1% CREAM	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>prednicarbate 0.1% cream</i>	Formulary	PA; PDL Non-Preferred
<i>prednicarbate 0.1% ointment</i>	Formulary	PA; PDL Non-Preferred
PROCTO-MED HC 2.5% CREAM	Formulary	
PROCTO-PAK	Non-Formulary	
PROCTOSOL-HC 2.5% CREAM	Formulary	
PROCTOZONE-HC 2.5% CREAM	Formulary	
<i>sm hydrocortisone 1% ointment maximum strength (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM HYDROCORTISONE PLUS 1% CRM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SYNALAR 0.01% SOLUTION	Formulary	PA; PDL Non-Preferred
SYNALAR 0.025% CREAM	Formulary	PA; PDL Non-Preferred
SYNALAR 0.025% OINTMENT	Formulary	PA; PDL Non-Preferred
TEXACORT 2.5% SOLUTION	Formulary	PA; PDL Non-Preferred
TOPICORT 0.05% CREAM	Formulary	PA; PDL Non-Preferred
TOPICORT 0.05% GEL	Formulary	PA; PDL Non-Preferred
TOPICORT 0.05% OINTMENT	Formulary	PA; PDL Non-Preferred
TOPICORT 0.25% CREAM	Formulary	PA; PDL Non-Preferred
TOPICORT 0.25% OINTMENT	Formulary	PA; PDL Non-Preferred
TOPICORT 0.25% SPRAY	Formulary	PA; PDL Non-Preferred
TOVET EMOLLIENT 0.05% FOAM	Formulary	PA; PDL Non-Preferred
<i>triamcinolone 0.025% cream</i>	Formulary	PDL Preferred
<i>triamcinolone 0.025% lotion</i>	Formulary	PDL Preferred
<i>triamcinolone 0.025% oint</i>	Formulary	PDL Preferred
<i>triamcinolone 0.05% ointment</i>	Formulary	PDL Preferred
<i>triamcinolone 0.1% cream</i>	Formulary	PDL Preferred
<i>triamcinolone 0.1% lotion</i>	Formulary	PDL Preferred
<i>triamcinolone 0.1% ointment</i>	Formulary	PDL Preferred
<i>triamcinolone 0.147 mg/g spray</i>	Formulary	PA; PDL Non-Preferred
<i>triamcinolone 0.5% cream</i>	Formulary	PDL Preferred
<i>triamcinolone 0.5% ointment</i>	Formulary	PDL Preferred
ULTRAVATE 0.05% LOTION INNER	Formulary	PA; PDL Non-Preferred
ULTRAVATE 0.05% LOTION OUTER	Formulary	PA; PDL Non-Preferred
VANOS 0.1% CREAM	Formulary	PA; PDL Non-Preferred
<i>Dermatological - Glucocorticoid-Emollient Combinations</i>		
BESER 0.05% KIT	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
FT ITCH RLF WITH ALOE 1% CREAM	Formulary	PDL Preferred; OTC
<i>hydrocortisone-aloe 1% cream</i>	Formulary	PDL Preferred; OTC
<i>hydrocortisone-aloe 1% cream</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM HYDROCORTISONE PLUS 1% CRM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm hydrocortisone-aloe 1% crm</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SYNALAR 0.025% CREAM KIT	Formulary	PA; PDL Non-Preferred
SYNALAR 0.025% OINTMENT KIT	Formulary	PA; PDL Non-Preferred
TOVET 0.05% FOAM KIT	Formulary	PA; PDL Non-Preferred
<i>Dermatological - Glucocorticoid-Local Anesthetic Combinations</i>		
EPIFOAM	Non-Formulary	
<i>lidocaine hcl-hydrocortison ac topical</i>	Non-Formulary	
LIDOCORT	Non-Formulary	
PRAMOSONE TOPICAL CREAM 1-1 %	Non-Formulary	
PRAMOSONE TOPICAL LOTION 1-1 %	Non-Formulary	
PRAMOSONE TOPICAL OINTMENT	Non-Formulary	
<i>Dermatological - Glucocorticoid-Skin Cleanser Combinations</i>		
CLODAN 0.05% KIT	Formulary	PA; PDL Non-Preferred
SYNALAR TS 0.01% KIT	Formulary	PA; PDL Non-Preferred
<i>Dermatological - Immunomodulator - Catechins - Genital Wart/Hpv Tx</i>		
VEREGEN	Non-Formulary	
<i>Dermatological - Immunomodulator - Imidazoquinolinamines</i>		
<i>imiquimod 5% cream packet 12x0.25gm packet</i>	Formulary	
<i>imiquimod 5% cream packet 24x0.25gm packet</i>	Formulary	
<i>imiquimod 5% cream packet inner</i>	Formulary	
<i>imiquimod 5% cream packet inner, single use</i>	Formulary	
<i>imiquimod 5% cream packet outer</i>	Formulary	
<i>imiquimod 5% cream packet outer, single use</i>	Formulary	
<i>imiquimod 5% cream packet outer,0.25gx24pkt</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>imiquimod topical cream in metered-dose pump</i>	Non-Formulary	
<i>imiquimod topical cream in packet 3.75 %</i>	Non-Formulary	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	Non-Formulary	
<i>Dermatological - Keratolytic-Antimitotic Single Agents</i>		
CONDYLOX TOPICAL GEL	Non-Formulary	
PODOCON	Non-Formulary	
<i>podofilox 0.5% topical soln</i>	Formulary	
<i>salicylic acid topical cream</i>	Non-Formulary	
<i>salicylic acid topical film forming liquid w/appl</i>	Non-Formulary	
<i>salicylic acid topical foam</i>	Non-Formulary	
<i>salicylic acid topical gel</i>	Non-Formulary	
<i>salicylic acid topical lotion</i>	Non-Formulary	
<i>salicylic acid topical ointment</i>	Non-Formulary	
URAMAXIN TOPICAL FOAM	Non-Formulary	
<i>urea powder</i>	Formulary	
<i>urea topical cream 39 %, 40 %, 41 %</i>	Non-Formulary	
<i>urea topical foam</i>	Non-Formulary	
<i>Dermatological - Local Anesthetic Combinations</i>		
<i>lidocaine-prilocaine 2.5%-2.5% cream</i>	Formulary	QL (1 GM per 1 day)
<i>lidocaine-prilocaine 2.5%-2.5% cream outer</i>	Formulary	QL (1 GM per 1 day)
<i>lidocaine-prilocaine 2.5%-2.5% cream outer, plf</i>	Formulary	QL (1 GM per 1 day)
<i>lidocaine-prilocaine topical kit</i>	Non-Formulary	
<i>Dermatological - Mammalian Target Of Rapamycin (Mtor) Inhibitors</i>		
HYFTOR 0.2% GEL	Formulary	PA; QL (20 GM per 30 days); Age Limit (Min 6 Years)
<i>Dermatological - Nsaid Single Agents</i>		
ARTHRITIS PAIN RELIEVER 1% GEL	Formulary	PDL Preferred; OTC
<i>diclofenac 1.5% topical soln</i>	Formulary	PDL Preferred
<i>diclofenac 2% solution pump</i>	Formulary	PA; PDL Non-Preferred
<i>diclofenac epolamine 1.3% ptch outer</i>	Formulary	PA; PDL Non-Preferred; QL (2 patches per 1 day)
<i>diclofenac sodium 1% gel (otc)</i>	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>diclofenac sodium 1% gel (rx)</i>	Formulary	PDL Preferred; OTC
FT ARTHRITIS PAIN 1% GEL	Formulary	PDL Preferred; OTC
<i>gnp diclofenac sodium 1% gel (otc)</i>	Formulary	PDL Preferred; OTC
GS ARTHRITIS PAIN 1% GEL	Formulary	PDL Preferred; OTC
PENNSAID 2% PUMP	Formulary	PA; PDL Non-Preferred
SM ARTHRITIS PAIN 1% GEL	Formulary	PDL Preferred; OTC
<i>Dermatological - Photodynamic Therapy Agents Topical</i>		
AMELUZ	Non-Formulary	
LEVULAN	Non-Formulary	
<i>Dermatological - Retinoids (Vitamin A Derivatives) - Topical Cosmetic</i>		
RENOVA TOPICAL CREAM 0.02 %	Non-Formulary	Dual Eligible Covered
<i>tazarotene 0.1% cream</i>	Formulary	PA
<i>Dermatological - Rosacea Therapy, Systemic</i>		
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase</i>	Non-Formulary	
ORACEA	Non-Formulary	
<i>Dermatological - Rosacea Therapy, Topical</i>		
<i>azelaic acid</i>	Non-Formulary	
CLEANSING WASH TOPICAL CLEANSER	Non-Formulary	
FINACEA TOPICAL FOAM	Non-Formulary	
<i>ivermectin topical cream</i>	Non-Formulary	
METROCREAM	Non-Formulary	
METROGEL TOPICAL GEL 1 %	Non-Formulary	
<i>metronidazole 0.75% cream</i>	Formulary	
<i>metronidazole topical 0.75% gl</i>	Formulary	
<i>metronidazole topical gel 1 %</i>	Non-Formulary	
<i>metronidazole topical gel with pump</i>	Non-Formulary	
<i>metronidazole topical lotion</i>	Non-Formulary	
MIRVASO	Non-Formulary	
NORITATE	Non-Formulary	
RHOFADE	Non-Formulary	
ROSADAN 0.75% CREAM	Formulary	
ROSADAN TOPICAL GEL	Non-Formulary	

Medications	Coverage Level	Restrictions
ROSADAN TOPICAL KIT, CLEANSER AND GEL	Non-Formulary	
ROSADAN TOPICAL KIT,CLEANSER AND CREAM	Non-Formulary	
SOOLANTRA	Non-Formulary	
<i>sulfacetamide sod-sulfur-urea</i>	Non-Formulary	
SUMADAN XLT	Non-Formulary	
<i>Dermatological - Tissue/Wound Adhesives - Fibrin Sealants</i>		
ARTISS	Non-Formulary	
<i>Dermatological - Topical Local Anesthetic Amides</i>		
ASPERFLEX (LIDOCAINE) TOPICAL CREAM	Non-Formulary	OTC
DERMACINRX LIDOCAN 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
GLYDO 2% JELLY SYRINGE	Formulary	
<i>lidocaine 3% cream (rx)</i>	Formulary	QL (85 GM per 30 days)
<i>lidocaine 4% patch outer</i>	Formulary	OTC; QL (1 patch per 1 day)
<i>lidocaine 5% ointment</i>	Formulary	QL (100 GM per 30 days)
<i>lidocaine 5% patch</i>	Formulary	PA; QL (3 patches per 1 day)
<i>lidocaine 5% patch outer</i>	Formulary	PA; QL (3 patches per 1 day)
<i>lidocaine hcl 2% jel urojet ac uro-jet ac, plf, suv</i>	Formulary	
<i>lidocaine hcl 2% jelly uro-jet uro-jet, plf, suv</i>	Formulary	
<i>lidocaine hcl 2% jelly uro-jet uro-jet,plf, suv</i>	Formulary	
<i>lidocaine hcl 2% jelly uro-jet uro-jet,single use</i>	Formulary	
<i>lidocaine pain relief 4% patch</i>	Formulary	OTC; QL (1 patch per 1 day)
LIDOCAINE PAIN RELIEF 4% PATCH	Formulary	OTC; QL (1 patch per 1 day)
<i>lidocaine topical cream 4 %</i>	Non-Formulary	OTC
LIDOCAN III 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
LIDOCAN IV 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
LIDOCAN V 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
LIDODERM	Non-Formulary	
LIDOTRAL	Non-Formulary	
TRIDACAINE 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
TRIDACAINE II 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)

Medications	Coverage Level	Restrictions
TRIDACAINE III 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
TRIDACAINE XL 5% PATCH OUTER	Formulary	PA; QL (3 patches per 1 day)
ZTLIDO	Non-Formulary	
<i>Dermatological Antipruritics - Antihistamines</i>		
<i>doxepin topical</i>	Non-Formulary	
PRUDOXIN	Non-Formulary	
ZONALON	Non-Formulary	
<i>Hair Growth Agents - Kinase Inhibitor</i>		
LITFULO 50 MG CAPSULE	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 12 Years)
OLUMIANT 1 MG TABLET	Formulary	PA; PDL Non-Preferred
OLUMIANT 2 MG TABLET	Formulary	PA; PDL Non-Preferred
OLUMIANT 4 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Scabicide And Pediculicide Combinations</i>		
FT LICE KILLING SHAMPOO	Formulary	OTC; QL (118 ML per 30 days)
GNP LICE KILLING SHAMPOO	Formulary	OTC; QL (118 ML per 30 days)
GS LICE KILLING SHAMPOO W/NIT COMB	Formulary	Dual Eligible Covered; OTC; QL (118 ML per 30 days)
LICE KILLING SHAMPOO	Formulary	OTC; QL (118 ML per 30 days)
LICE KILLING SHAMPOO W/NIT COMB	Formulary	Dual Eligible Covered; OTC; QL (118 ML per 30 days)
SB LICE KILLING SHAMPOO MAXIMUM STRENGTH	Formulary	Dual Eligible Covered; OTC; QL (118 ML per 30 days)
VANALICE	Non-Formulary	OTC
<i>Scabicide And Pediculicide Single Agents</i>		
CROTAN	Non-Formulary	
ELIMITE	Non-Formulary	
EURAX	Non-Formulary	
GS LICE KILLING 1 % CRM RINSE	Formulary	Dual Eligible Covered; OTC; QL (59 ML per 30 days)
<i>ivermectin 0.5% lotion (otc)</i>	Formulary	OTC; Age Limit (Min 6 Months)
LICE TREATMENT 1% CREME RINSE 1 NIT REMOVAL COMB	Formulary	Dual Eligible Covered; OTC; QL (59 ML per 30 days)
<i>malathion 0.5% lotion</i>	Formulary	QL (2 ML per 1 day); Age Limit (Min 2 Years)
NATROBA	Non-Formulary	
OVIDE	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>permethrin 5% cream</i>	Formulary	QL (60 GM per 30 days)
SKLICE	Non-Formulary	OTC
<i>spinosad 0.9% topical susp</i>	Formulary	QL (240 ML per 180 days); Age Limit (Min 6 Months)
Wound Care Combinations Other		
<i>balsam peru-castor oil topical ointment in packet</i>	Non-Formulary	
Diagnostic Agents		
Diagnostic Drugs - Metabolic Function		
METOPIRONE	Non-Formulary	
Diagnostic Drugs - Pituitary Function		
CORTROSYN	State Carve Out	
<i>cosyntropin</i>	State Carve Out	
Drugs To Treat Erectile Dysfunction		
Erectile Dysfunction (Ed) Drugs - Prostaglandins		
CAVERJECT IMPULSE	Benefit Exclusion	
EDEX	Benefit Exclusion	
Erectile Dysfunction (Ed) Drugs-Sel.Cgmp Phosphodiesterase Type5 Inhib		
CIALIS ORAL TABLET 10 MG, 20 MG, 5 MG	Benefit Exclusion	
<i>sildenafil</i>	Benefit Exclusion	
STENDRA	Benefit Exclusion	
<i>tadalafil</i>	Benefit Exclusion	
<i>vardeafil</i>	Benefit Exclusion	
VIAGRA	Benefit Exclusion	
Electrolyte Balance-Nutritional Products		
Amino Acid - Carnitine Derivatives		
<i>levocarnitine oral tablet</i>	State Carve Out	OTC
Amino Acids, Single Ingredient, Oral (Non-Injectable)		
ENDARI	Non-Formulary	
<i>l-glutamine 5 gram powder pkt outer</i>	Formulary	PA; 3 Months Allowed; QL (6 packets per 1 day); Age Limit (Min 5 Years)
B-Complex Vitamin Combinations		
DIALYVITE 3,000 TABLET	Formulary	Dual Eligible Covered

Medications	Coverage Level	Restrictions
DIALYVITE 800 ORAL TABLET,CHEWABLE	Non-Formulary	
DIALYVITE 800 TABLET	Formulary	
DIALYVITE SUPREME D TABLET	Formulary	Dual Eligible Covered
DIALYVITE TABLET	Formulary	Dual Eligible Covered
NEPHRON FA TABLET	Non-Formulary	CSHCS Covered
NEPHRO-VITE TABLET (RX)	Formulary	
RENAL CAPS SOFTGEL	Non-Formulary	CSHCS Covered; Dual Eligible Covered
RENAL-VITE TABLET	Formulary	
RENO CAPS SOFTGEL	Non-Formulary	CSHCS Covered
TRIPHROCAPS SOFTGEL SOFTGEL (RX)	Formulary	Dual Eligible Covered
VIRT-CAPS SOFTGEL (RX)	Formulary	Dual Eligible Covered
WESCAPS CAPSULE	Formulary	Dual Eligible Covered
<i>B-Complex Vitamins And Combinations</i>		
DIALYVITE WITH ZINC TABLET	Formulary	Dual Eligible Covered
NEPHPLEX RX TABLET	Formulary	Dual Eligible Covered
<i>B-Complex Vitamins</i>		
B-COMPLEX 100 INJECTION	Formulary	
<i>Dextrose And Lactated Ringer's Solutions</i>		
<i>dextrose 5 %-lactated ringers</i>	Non-Formulary	
<i>Dextrose And Sodium Chloride Solutions</i>		
<i>d10 %-0.45 % sodium chloride</i>	Non-Formulary	
<i>d2.5 %-0.45 % sodium chloride</i>	Non-Formulary	
<i>d5 % and 0.9 % sodium chloride</i>	Non-Formulary	
<i>d5 %-0.45 % sodium chloride</i>	Non-Formulary	
<i>dextrose 5%-0.2 % sod chloride</i>	Non-Formulary	
<i>Dextrose Solutions, Concentrated</i>		
<i>dextrose 20 % in water (d20w)</i>	Non-Formulary	
<i>dextrose 25 % in water (d25w)</i>	Non-Formulary	
<i>dextrose 30 % in water (d30w)</i>	Non-Formulary	
<i>dextrose 50 % in water (d50w)</i>	Non-Formulary	
<i>dextrose 70 % in water (d70w)</i>	Non-Formulary	
<i>Dextrose Solutions</i>		
<i>dextrose 10 % in water (d10w)</i>	Non-Formulary	
<i>dextrose 20 % in water (d20w)</i>	Non-Formulary	
<i>dextrose 25 % in water (d25w)</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>dextrose 30 % in water (d30w)</i>	Non-Formulary	
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	Non-Formulary	
<i>dextrose 50 % in water (d50w)</i>	Non-Formulary	
<i>dextrose 70 % in water (d70w)</i>	Non-Formulary	
<i>Dietary Product - Dietary Supplements</i>		
<i>coenzyme q-10 powder (rx)</i>	Formulary	
<i>coenzyme q-10 powder (water dispersible) (rx)</i>	Formulary	
<i>Diluents - Sodium Chloride</i>		
<i>sodium chlor 0.9% bacteriostat</i>	Non-Formulary	
<i>sodium chloride 0.9 % injection</i>	Non-Formulary	
<i>Electrolyte Depleters - Ion Exchange Resin</i>		
KIONEX 15 GM/60 ML SUSPENSION OUTER	Formulary	PDL Preferred; 3 Months Allowed
LOKELMA 10 GRAM POWDER PACKET OUTER	Formulary	PDL Preferred
LOKELMA 5 GRAM POWDER PACKET OUTER	Formulary	PDL Preferred
<i>sodium polystyrene sulf powder</i>	Formulary	
<i>sodium polystyrene sulf powder inner</i>	Formulary	
<i>sodium polystyrene sulf powder outer</i>	Formulary	
SPS 15 GM/60 ML SUSPENSION	Formulary	PDL Preferred
SPS 30 GM/120 ML ENEMA SUSP	Formulary	PDL Preferred
VELTASSA 1 GM POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELTASSA 16.8 GM POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELTASSA 25.2 GM POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELTASSA 8.4 GM POWDER PACKET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELTASSA 8.4 GM POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Electrolyte Depleters - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitors</i>		
XPHOZAH 20 MG TABLET	Formulary	PA; PDL Non-Preferred
XPHOZAH 30 MG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Irrigation Solutions		
PHYSIOLYTE	Non-Formulary	
PHYSIOSOL IRRIGATION	Non-Formulary	
<i>sodium chloride 1 gm tablet (otc)</i>	Non-Formulary	CSHCS Covered; OTC
<i>sodium chloride 1 gm tablet (rx)</i>	Non-Formulary	CSHCS Covered; OTC
<i>sodium chloride irrigation</i>	Non-Formulary	
Minerals And Electrolytes - Bicarbonate Producing Or Containing Agents		
<i>sodium acetate intravenous solution 2 meq/ml</i>	Non-Formulary	
<i>sodium bicarbonate intravenous</i>	Non-Formulary	
<i>sodium bicarbonate powder usp (rx)</i>	Formulary	OTC
<i>sodium bicarbonate powder usp,ep,jp (rx)</i>	Formulary	OTC
Minerals And Electrolytes - Calcium Replacement/Vitamin D Combinations		
<i>calcium 250 mg-vit d3 3 mcg tb</i>	Formulary	
CALCIUM 250-D TABLET OYSTER SHELL (RX)	Formulary	
CALCIUM 500 + D ORAL TABLET,CHEWABLE	Non-Formulary	
<i>calcium 500 mg-vit d3 5 mcg tb (rx)</i>	Formulary	
CALCIUM 500-VIT D3 200 TABLET (RX)	Formulary	
CALCIUM 500-VIT D3 200 TABLET 10X10, U-D (RX)	Formulary	
<i>calcium 600-vit d3 400 tablet (rx)</i>	Formulary	
CALCIUM 600-VIT D3 400 TABLET INNER (RX)	Formulary	
CALCIUM 600-VIT D3 400 TABLET OUTER (RX)	Formulary	
<i>calcium 600-vit d3 800 tablet (rx)</i>	Formulary	
<i>calcium 600-vit d3 800 tablet inner (rx)</i>	Formulary	
<i>calcium 600-vit d3 800 tablet outer (rx)</i>	Formulary	
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500 mg-10 mcg (400 unit)</i>	Non-Formulary	
<i>calcium cit 315-vit d3 250 tab outer (rx)</i>	Formulary	
<i>calcium citrate-vit d3 tablet (rx)</i>	Formulary	
<i>gnp calcium 500-vit d3 600 tab</i>	Formulary	
OS-CAL 500 + D3 ORAL TABLET 500 MG-5 MCG (200 UNIT)	Non-Formulary	

Medications	Coverage Level	Restrictions
OS-CAL 500-VIT D3 600 CAPLET	Formulary	
OYSCO 500-VIT D3 200 TABLET	Formulary	
OYSTER SHELL 500-VIT D3 200 TB (RX)	Formulary	
OYSTER SHELL 500-VIT D3 200 TB (RX)	Formulary	Dual Eligible Covered
OYSTER SHELL-D 250 MG TABLET U-D, 10X10 (RX)	Formulary	
<i>ultra calc 600 mg-vit d3 10 mcg (rx)</i>	Formulary	
Minerals And Electrolytes - Calcium Replacement		
<i>calcium 600 mg tablet (rx)</i>	Formulary	
<i>calcium carb 1,250 mg/5 ml sus n (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>calcium carbonate 1,250 mg/5 ml suspension cup 40's,u-d (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>calcium citrate 250 mg caplet</i>	Non-Formulary	CSHCS Covered
<i>calcium citrate 250 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 1,000 mg/10 ml vl outer, suv, plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 1,000 mg/10 ml vl sdv,outer,plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 10,000 mg/100 ml mdv,outer,plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 10,000 mg/100 ml mov, plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 10,000 mg/100 ml mov, plf, outer</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 10,000 mg/100 ml outer, mov, plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 5,000 mg/50 ml vl outer, suv, plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 5,000 mg/50 ml vl sdv,outer,plf</i>	Non-Formulary	CSHCS Covered
<i>calcium gluc 5,000 mg/50 ml vl suv, plf, outer</i>	Non-Formulary	CSHCS Covered
CALPHRON 667 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
OYSTER SHELL CALCIUM 500 MG TB (RX)	Formulary	
OYSTER SHELL CALCIUM 500 MG TB 500MG ELEMENTAL (RX)	Formulary	
OYSTER SHELL CALCIUM 500 MG TB 500MG ELEMENTAL CA (RX)	Formulary	
OYSTER SHELL CALCIUM 500 MG TB OYSTER SHELL (RX)	Formulary	
OYSTER SHELL CALCIUM 500 MG TB U-D, 10X10 (RX)	Formulary	

Medications	Coverage Level	Restrictions
TRUE OYSTER CALCIUM 500 MG TAB (RX)	Formulary	
<i>Minerals And Electrolytes - Electrolytes And Dextrose</i>		
<i>electrolyte-48 in d5w</i>	Non-Formulary	
IONOSOL-MB IN D5W	Non-Formulary	
ISOLYTE-P IN 5 % DEXTROSE	Non-Formulary	
NORMOSOL-M IN 5 % DEXTROSE	Non-Formulary	
NORMOSOL-R IN 5 % DEXTROSE	Non-Formulary	
<i>Minerals And Electrolytes - Iron Combinations</i>		
ACTIVE FE	Non-Formulary	
CORVITA 150	Non-Formulary	
CORVITE 150	Non-Formulary	
CORVITE FE	Non-Formulary	
FERIVA 21-7	Non-Formulary	
FERIVA FA (WITH SUMALATE)	Non-Formulary	
FOLIVANE-F	Non-Formulary	
IROSPAN 24/6	Non-Formulary	
NUFERA	Non-Formulary	
TARON FORTE	Non-Formulary	
TRIGELS-F FORTE	Non-Formulary	
<i>Minerals And Electrolytes - Iron</i>		
AURYXIA 210 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FERATE 27 MG TABLET	Formulary	
FERGON 27 MG TABLET (RX)	Formulary	
FEROSUL 325 MG TABLET (RX)	Formulary	
FEROSUL 325 MG TABLET F/C,BLISTER PACK (RX)	Formulary	
<i>ferric citrate 210 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FERRO-TIME 325 MG TABLET F/C, GREEN	Formulary	
FERRO-TIME 325 MG TABLET F/C, RED	Formulary	
<i>ferrous gluconate 324 mg tab (rx)</i>	Formulary	
<i>ferrous sulf 15 mg iron/ml drp (rx)</i>	Formulary	
<i>ferrous sulf 220 mg/5 ml elix (rx)</i>	Formulary	Age Limit (Max 12 Years)

Medications	Coverage Level	Restrictions
<i>ferrous sulf 44 mg iron/5 ml lq (rx)</i>	Formulary	Age Limit (Max 12 Years)
<i>ferrous sulf ec 324 mg tablet</i>	Formulary	
<i>ferrous sulf ec 325 mg tablet (rx)</i>	Formulary	
<i>ferrous sulf ec 325 mg tablet u-d, inner (rx)</i>	Formulary	
<i>ferrous sulf ec 325 mg tablet u-d, outer (rx)</i>	Formulary	
<i>ferrous sulfate 300 mg/5 ml cup</i>	Formulary	Age Limit (Max 12 Years)
<i>ferrous sulfate 300 mg/5 ml cup 100's, u-d</i>	Formulary	Age Limit (Max 12 Years)
<i>ferrous sulfate 300 mg/5 ml cup outer</i>	Formulary	Age Limit (Max 12 Years)
<i>ferrous sulfate 325 mg tablet (rx)</i>	Formulary	
<i>ferrous sulfate 325 mg tablet f/c, green (rx)</i>	Formulary	
<i>ferrous sulfate 325 mg tablet f/c, red (rx)</i>	Formulary	
<i>ferrous sulfate 325 mg tablet u-d,10x10, film coat (rx)</i>	Formulary	
<i>infant iron 15 mg/ml drop (rx)</i>	Formulary	
<i>infant iron 15 mg/ml drop (rx)</i>	Non-Formulary	CSHCS Covered
INFED	Non-Formulary	
IRON 65 MG TABLET (RX)	Formulary	
IRON CHEWS 15 MG TABLET CHEW	Formulary	
PEDIA IRON 15 MG/ML DROP	Non-Formulary	CSHCS Covered
PEDIATRIC FE-VITE 15 MG/ML DRP	Non-Formulary	CSHCS Covered
<i>pharm chc ped iron 15 mg/ml drp (rx)</i>	Non-Formulary	CSHCS Covered
TRIFERIC HEMODIALYSIS SOLUTION	Non-Formulary	
<i>true ferrous sulf ec 324 mg tb</i>	Formulary	
Minerals And Electrolytes - Magnesium Combinations		
BEELITH TABLET	Formulary	
Minerals And Electrolytes - Magnesium		
<i>magnesium chelated 100 mg tab</i>	Non-Formulary	CSHCS Covered
<i>magnesium chl 200 mg/ml vial</i>	Formulary	
<i>magnesium citrate 100 mg tab</i>	Non-Formulary	CSHCS Covered
<i>magnesium gluconate tablet y/f,gluten/f (rx)</i>	Non-Formulary	CSHCS Covered
<i>magnesium oxide 400 mg tablet (otc)</i>	Non-Formulary	CSHCS Covered; OTC
<i>magnesium oxide 400 mg tablet (otc)</i>	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
<i>magnesium oxide 400 mg tablet (rx)</i>	Formulary	OTC
<i>magnesium oxide 400 mg tablet (rx)</i>	Non-Formulary	CSHCS Covered; OTC
<i>magnesium oxide 400 mg tablet inner (rx)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>magnesium oxide 400 mg tablet outer (rx)</i>	Formulary	OTC
<i>magnesium oxide 420 mg tablet (rx)</i>	Formulary	Dual Eligible Covered
<i>magnesium oxide 440 mg tablet</i>	Non-Formulary	CSHCS Covered; OTC
<i>magnesium oxide 500 mg tablet plf,lactose-free (rx)</i>	Formulary	
<i>magnesium sulfate 50% 1 g/2 ml sdv, plf, outer</i>	Formulary	
<i>magnesium sulfate 50% 1 g/2 ml suv, plf, outer</i>	Formulary	
<i>magnesium sulfate 50% 10g/20 ml outer, suv, plf</i>	Formulary	
<i>magnesium sulfate 50% 10g/20 ml plf, suv, outer</i>	Formulary	
<i>magnesium sulfate 50% 25g/50 ml outer, suv, plf</i>	Formulary	
<i>magnesium sulfate 50% 5 g/10 ml plf, sdv, outer</i>	Formulary	
<i>magnesium sulfate 50% 5 g/10 ml sdv, plf, outer</i>	Formulary	
<i>magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml</i>	Non-Formulary	
<i>magnesium sulfate in water</i>	Non-Formulary	
<i>magnesium sulfate injection syringe</i>	Non-Formulary	
MG-PLUS-PROTEIN TABLET (RX)	Non-Formulary	CSHCS Covered
NU-MAG 71.5 MG TABLET	Formulary	Dual Eligible Covered
SLOWMAG 71.5 MG TABLET	Formulary	
SLOW-MAG 71.5 MG TABLET	Formulary	Dual Eligible Covered
<i>true magnesium oxide 400 mg tb (rx)</i>	Formulary	OTC
<i>true magnesium oxide 500 mg tb</i>	Non-Formulary	CSHCS Covered
<i>well magnesium oxide 400 mg tb (rx)</i>	Formulary	OTC
Minerals And Electrolytes - Manganese		
<i>manganese chloride</i>	Non-Formulary	Dual Eligible Covered
Minerals And Electrolytes - Oral Electrolytes		
ORALYTE SOLUTION	Formulary	
PEDIALYTE ELECTROLYTE SINGLES 4'S (RX)	Formulary	
PEDIALYTE FREEZER POPS	Formulary	
PEDIALYTE SOLUTION (RX)	Formulary	

Medications	Coverage Level	Restrictions
PEDIALYTE SOLUTION READY-TO-USE (RX)	Formulary	
SM PEDIATRIC ELECTROLYTE SOLN (RX)	Formulary	
<i>Minerals And Electrolytes - Parenteral Electrolyte Combinations</i>		
ISOLYTE S PH 7.4	Non-Formulary	
ISOLYTE-S	Non-Formulary	
NORMOSOL-R	Non-Formulary	
NORMOSOL-R PH 7.4	Non-Formulary	
TPN ELECTROLYTES	Non-Formulary	
<i>Minerals And Electrolytes - Phosphate</i>		
K-PHOS NEUTRAL TABLET	Formulary	
PHOS-NAK PACKET OUTER	Non-Formulary	CSHCS Covered
PHOSPHA 250 NEUTRAL TABLET	Formulary	
PHOSPHOROUS 250 MG TABLET	Formulary	
PHOSPHOROUS POWDER PACKET OUTER	Non-Formulary	CSHCS Covered
<i>phosphorus-sodium-potassium</i>	Non-Formulary	CSHCS Covered
PHOSPHO-TRIN 250 NEUTRAL TAB	Formulary	
<i>sodium phosphate 15 mmol/5 ml sdv, inner</i>	Formulary	
<i>sodium phosphate 15 mmol/5 ml sdv, outer</i>	Formulary	
<i>sodium phosphate 15 mmol/5 ml suv, inner</i>	Formulary	
<i>sodium phosphate 15 mmol/5 ml suv, outer</i>	Formulary	
<i>sodium phosphate 150 mmol/50 ml inner, suv, plf</i>	Formulary	
<i>sodium phosphate 150 mmol/50 ml outer, suv, plf</i>	Formulary	
<i>sodium phosphate 150 mmol/50 ml suv, inner</i>	Formulary	
<i>sodium phosphate 150 mmol/50 ml suv, outer</i>	Formulary	
<i>sodium phosphate 45 mmol/15 ml inner, plf, suv</i>	Formulary	
<i>sodium phosphate 45 mmol/15 ml inner, sdv</i>	Formulary	
<i>sodium phosphate 45 mmol/15 ml outer, plf, suv</i>	Formulary	
<i>sodium phosphate 45 mmol/15 ml outer, sdv</i>	Formulary	
<i>sodium phosphate 45 mmol/15 ml suv, inner</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>sodium phosphate 45 mmol/15 ml sol, outer</i>	Formulary	
<i>sodium-potassium-phos powder</i>	Non-Formulary	CSHCS Covered
WES-PHOS 250 MG NEUTRAL TABLET	Formulary	
Minerals And Electrolytes - Potassium, Oral		
EFFER-K 25 MEQ TABLET EFF	Formulary	
EFFER-K 25 MEQ TABLET EFF OUTER	Formulary	
EFFER-K ORAL TABLET, EFFERVESCENT 10 MEQ, 20 MEQ	Non-Formulary	
KLOR-CON	Non-Formulary	
KLOR-CON 10 MEQ TABLET	Formulary	
KLOR-CON 10 MEQ TABLET INNER	Formulary	
KLOR-CON 10 MEQ TABLET OUTER	Formulary	
KLOR-CON 8 MEQ TABLET	Formulary	
KLOR-CON 8 MEQ TABLET INNER	Formulary	
KLOR-CON 8 MEQ TABLET OUTER	Formulary	
KLOR-CON M10 TABLET	Formulary	
KLOR-CON M10 TABLET INNER	Formulary	
KLOR-CON M10 TABLET OUTER	Formulary	
KLOR-CON M15	Non-Formulary	
KLOR-CON M20 TABLET	Formulary	
KLOR-CON M20 TABLET INNER	Formulary	
KLOR-CON M20 TABLET OUTER	Formulary	
KLOR-CON-EF 25 MEQ TAB EFF OUTER	Formulary	
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ	Non-Formulary	
<i>potassium chloride oral liquid</i>	Non-Formulary	
<i>potassium chloride oral packet</i>	Non-Formulary	
<i>potassium chloride oral tablet, er particles/crystals 15 meq</i>	Non-Formulary	
<i>potassium chloride 10 meq capsule</i>	Formulary	
<i>potassium chloride 10 meq capsule outer</i>	Formulary	
<i>potassium chloride 10 meq tablet</i>	Formulary	
<i>potassium chloride 10 meq tablet f/c</i>	Formulary	
<i>potassium chloride 10 meq tablet inner</i>	Formulary	
<i>potassium chloride 10 meq tablet outer</i>	Formulary	
<i>potassium chloride 20 meq tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>potassium chloride 20 meq tablet outer</i>	Formulary	
<i>potassium chloride 8 meq capsule</i>	Formulary	
<i>potassium chloride 8 meq tablet</i>	Formulary	
<i>potassium chloride 8 meq tablet f/c</i>	Formulary	
Minerals And Electrolytes - Sodium Chloride, Oral		
<i>sodium chloride 1 gm tablet (otc)</i>	Non-Formulary	CSHCS Covered; OTC
<i>sodium chloride 1 gm tablet (rx)</i>	Non-Formulary	CSHCS Covered; OTC
Minerals And Electrolytes - Trace Minerals		
<i>chromium chloride</i>	Non-Formulary	Dual Eligible Covered
Minerals And Electrolytes - Zinc		
ORAZINC 110 MG TABLET	Non-Formulary	CSHCS Covered
ORAZINC 220 MG CAPSULE	Non-Formulary	CSHCS Covered
<i>zinc 50 mg tablet (rx)</i>	Non-Formulary	CSHCS Covered
<i>zinc gluconate 100 mg tablet (rx)</i>	Non-Formulary	CSHCS Covered
<i>zinc sulfate 220 mg (50 mg) cap (rx)</i>	Non-Formulary	CSHCS Covered
<i>zinc sulfate 220 mg capsule (rx)</i>	Non-Formulary	CSHCS Covered
<i>zinc sulfate 50 mg (220 mg) tb (rx)</i>	Non-Formulary	CSHCS Covered
ZINC-220 CAPSULE (RX)	Non-Formulary	CSHCS Covered
Multivitamin And Mineral Combinations		
BACMIN CAPLET	Formulary	Dual Eligible Covered
CERTAVITE SENIOR TABLET	Formulary	
CORVITA	Non-Formulary	
CORVITE	Non-Formulary	
DEKAS PLUS CHEWABLE TABLET	Non-Formulary	CSHCS Covered
DEKAS PLUS SOFTGEL	Non-Formulary	CSHCS Covered
DIALYVITE 5000 TABLET	Formulary	Dual Eligible Covered
ELITE-OB	Non-Formulary	
FOLIVANE-OB	Non-Formulary	
MEGA MULTI FOR MEN TABLET HIGH POTENCY (RX)	Formulary	
MEGA MULTI FOR WOMEN TAB	Formulary	
OB COMPLETE	Non-Formulary	
ONE DAILY TABLET	Formulary	
ONE DAILY WOMEN'S HEALTH TAB	Formulary	
PNV-OMEGA	Non-Formulary	
PRORENAL QD SOFTGEL	Formulary	

Medications	Coverage Level	Restrictions
SENTRY SENIOR TABLET INNER	Formulary	
SENTRY SENIOR TABLET OUTER	Formulary	
STROVITE FORTE	Non-Formulary	
STROVITE ONE	Non-Formulary	
TARON-C DHA	Non-Formulary	
VITAL-D RX TABLET	Formulary	Dual Eligible Covered
ZATEAN-PN PLUS	Non-Formulary	
Multivitamins		
CERTAVITE-ANTIOXIDANT TABLET (RX)	Formulary	
DEKAS ESSENTIAL CAPSULE	Non-Formulary	CSHCS Covered
DEKAS ESSENTIAL LIQUID	Non-Formulary	CSHCS Covered
ENBRACE HR	Non-Formulary	
INFUVITE ADULT	Non-Formulary	
NESTABS ONE	Non-Formulary	
ONCOVITE TABLET	Formulary	
ONE DAILY MEN'S 50+ TABLET	Formulary	
PRENATE AM	Non-Formulary	
PRENATE CHEWABLE	Non-Formulary	
PRENATE ESSENTIAL(IRON-ASP-GL)	Non-Formulary	
PUREVIT DUALFE PLUS	Non-Formulary	
SE-TAN PLUS	Non-Formulary	
TAB-A-VITE TABLET	Formulary	
TANDEM PLUS	Non-Formulary	
THERA TABLET	Formulary	
VIT 3	Non-Formulary	
Nutritional Product - Lipid Others		
DOJOLVI	Non-Formulary	
Nutritional Product - Medical Condition Specific Formulation		
ENDARI	Non-Formulary	
<i>l-glutamine 5 gram powder pkt outer</i>	Formulary	PA; 3 Months Allowed; QL (6 packets per 1 day); Age Limit (Min 5 Years)
Nutritional Product - Protein Replacements		
<i>arginine 100% crystals</i>	Formulary	
<i>arginine hcl powder usp (rx)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>arginine hcl powder usp,ep (rx)</i>	Formulary	OTC
<i>glutamine powder (rx)</i>	Formulary	OTC
<i>l-arginine hcl powder usp (rx)</i>	Formulary	OTC
<i>l-arginine mono-hcl powder usp (rx)</i>	Formulary	OTC
<i>l-citrulline powder</i>	Formulary	
L-CITRULLINE POWDER (RX)	Formulary	
<i>l-glutamine powder (rx)</i>	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
<i>l-glutamine powder usp (rx)</i>	Formulary	OTC
<i>l-ornithine hcl powder (rx)</i>	Formulary	OTC
<i>lysine hcl powder (rx)</i>	Formulary	
<i>ornithine (l) hcl powder (rx)</i>	Formulary	OTC
<i>Pediatric Vitamins And Mineral Combinations</i>		
CHILDREN'S CHEWABLE COMPLETE	Non-Formulary	
NANOVM 9-18 POWDER	Non-Formulary	CSHCS Covered
NANOVM T-F POWDER	Non-Formulary	CSHCS Covered
<i>Pediatric Vitamins With Fluoride And Minerals Combinations</i>		
MULTIVIT-FLUOR-IRON 0.25 MG/ML (RX)	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
MULTIVIT-IRON-FLUOR 0.25 MG/ML (RX)	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
<i>Pediatric Vitamins With Fluoride Combinations</i>		
FLORIVA ORAL TABLET,CHEWABLE 0.25MG FLUORIDE (0.55 MG)	Non-Formulary	
MULTIVIT-FLUOR 0.25 MG TAB CHW (RX)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.25 MG TAB CHW (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.25 MG TAB CHW GRAPE FLAVOR (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)

Medications	Coverage Level	Restrictions
MULTIVIT-FLUOR 0.25 MG/ML DROP (RX)	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.5 MG TAB CHEW (RX)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.5 MG TAB CHEW (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.5 MG TAB CHEW GRAPE FLAVOR (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR 0.5 MG/ML DROP (RX)	Formulary	QL (2 ML per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUORIDE 1 MG TAB CHW (RX)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUORIDE 1 MG TAB CHW (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUORIDE 1 MG TAB CHW GRAPE FLAVOR (RX)	Formulary	Dual Eligible Covered; QL (1 tablet per 1 day); Age Limit (Max 12 Years)
MULTIVIT-FLUOR-IRON 0.25 MG/ML (RX)	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
MULTIVIT-IRON-FLUOR 0.25 MG/ML (RX)	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
QUFLORA	Non-Formulary	
QUFLORA FE	Non-Formulary	Dual Eligible Covered
QUFLORA FE (FERROUS SULFATE)	Non-Formulary	
QUFLORA PEDIATRIC	Non-Formulary	
QUFLORA PEDIATRIC DROPS	Non-Formulary	
SOLUVITA A,C,D-FLUOR 0.25 MG/ML	Formulary	QL (2 ML per 1 day); Age Limit (Max 12 Years)
TRI-VITE-FLUORIDE 0.25 MG/ML	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)
TRI-VITE-FLUORIDE 0.5 MG/ML	Formulary	Dual Eligible Covered; Age Limit (Max 12 Years)
VIT A,C,D-FLUORIDE 0.25 MG/ML	Formulary	Dual Eligible Covered; QL (2 ML per 1 day); Age Limit (Max 12 Years)

Medications	Coverage Level	Restrictions
VIT A,C,D-FLUORIDE 0.5 MG/ML	Formulary	Dual Eligible Covered; Age Limit (Max 12 Years)
<i>Pediatric Vitamins</i>		
CHILDREN'S CHEWABLES EXTRA C	Non-Formulary	
DEKAS PLUS LIQUID	Non-Formulary	CSHCS Covered
MVW COMPLETE FORM MULTIVI SFGL	Non-Formulary	CSHCS Covered
MVW COMPLETE FORM MULTIVIT CHW	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL D3000 CHEW	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL D3000 SFGL	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL D5000 SFGL	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL PEDIA DRPS	Non-Formulary	CSHCS Covered
NANO VM 1-3 POWDER	Non-Formulary	CSHCS Covered
NANO VM 4-8 POWDER	Non-Formulary	CSHCS Covered
<i>Prenatal Vitamins And Minerals</i>		
C-NATE DHA	Non-Formulary	
COMPLETE NATAL DHA	Non-Formulary	
COMPLETENATE TABLET CHEW	Formulary	QL (1 tablet per 1 day); Age Limit (Min 12 Years and Max 55 Years)
DERMACINRX PRENATRIX	Non-Formulary	
DERMACINRX PRENATRYL	Non-Formulary	
DERMACINRX PRETRATE	Non-Formulary	
MARNATAL-F	Non-Formulary	
M-NATAL PLUS TABLET	Formulary	
NESTABS ABC	Non-Formulary	
NESTABS DHA	Non-Formulary	
NESTABS TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Min 12 Years and Max 55 Years)
OB COMPLETE ONE	Non-Formulary	
OB COMPLETE PETITE	Non-Formulary	
OB COMPLETE PREMIER	Non-Formulary	
OB COMPLETE WITH DHA	Non-Formulary	
PNV-SELECT	Non-Formulary	
PRENATAL VITAMIN PLUS LOW IRON	Formulary	
PRENATAL VITAMINS TABLET PHOSPHORUS FREE (RX)	Formulary	

Medications	Coverage Level	Restrictions
PRENATAL VITAMINS TABLET W/ FOLIC ACID (RX)	Formulary	
PRENATE DHA (FERR ASP GLYCIN)	Non-Formulary	
PRENATE ELITE (IRON ASP GLYC)	Non-Formulary	
PRENATE ENHANCE	Non-Formulary	
PRENATE MINI (FERR ASP GLYCIN)	Non-Formulary	
PRENATE PIXIE	Non-Formulary	
PRENATE RESTORE	Non-Formulary	
PRENATE STAR	Non-Formulary	
PRIMACARE	Non-Formulary	
SELECT-OB	Non-Formulary	
SELECT-OB (FOLIC ACID)	Non-Formulary	
SELECT-OB + DHA	Non-Formulary	
SE-NATAL 19 CHEWABLE	Non-Formulary	
SE-NATAL 19 TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Min 12 Years and Max 55 Years)
THRIVITE RX TABLET	Formulary	
TRICARE PRENATAL TABLET (RX)	Formulary	QL (1 tablet per 1 day)
TRINATAL RX 1 TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Min 12 Years and Max 55 Years)
TRISTART DHA	Non-Formulary	
VITAFOL FE PLUS	Non-Formulary	
VITAFOL GUMMIES	Non-Formulary	
VITAFOL ULTRA	Non-Formulary	
VITAFOL-OB	Non-Formulary	
VITAFOL-OB+DHA	Non-Formulary	
VITAFOL-ONE	Non-Formulary	
WESTAB PLUS TABLET	Formulary	
WESTGEL DHA	Non-Formulary	
<i>Ringer's And Lactated Ringer's Solutions</i>		
<i>lactated ringers intravenous</i>	Non-Formulary	
<i>Sodium Chloride Flushes</i>		
<i>sodium chlor 0.9% bacteriostat</i>	Non-Formulary	
<i>sodium chloride 0.9 % injection</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
Sodium Chloride Solutions, Concentrated		
<i>sodium chloride 120 meq/30 ml p/f, outer, suv</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 400 meq/100 ml muv, outer</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 400 meq/100 ml outer, muv, p/f</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 5 % hypertonic</i>	Non-Formulary	
<i>sodium chloride 800 meq/200 ml outer, muv, p/f</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride intravenous solution 2.5 meq/ml</i>	Non-Formulary	
Sodium Chloride, Parenteral		
<i>sodium chloride 0.45 % intravenous</i>	Non-Formulary	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	Non-Formulary	
<i>sodium chloride 120 meq/30 ml p/f, outer, suv</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 400 meq/100 ml muv, outer</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 400 meq/100 ml outer, muv, p/f</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride 5 % hypertonic</i>	Non-Formulary	
<i>sodium chloride 800 meq/200 ml outer, muv, p/f</i>	Formulary	Age Limit (Max 6 Years)
<i>sodium chloride intravenous solution 2.5 meq/ml</i>	Non-Formulary	
Sterile Water For Injection		
<i>water for injection, sterile intravenous</i>	Non-Formulary	
Vitamins - A		
<i>beta carotene 7,500 mcg sfgl (rx)</i>	Non-Formulary	CSHCS Covered
<i>beta-carotene 25,000 unit sfgl softgel (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin a 10,000 unit softgel outer (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin a 3,000 mcg softgel (rx)</i>	Non-Formulary	CSHCS Covered
Vitamins - B Preparation Combinations		
NIVA-FOL TABLET	Non-Formulary	CSHCS Covered; Dual Eligible Covered
WESTAB MAX TABLET	Formulary	Dual Eligible Covered
Vitamins - B-1, Thiamine And Derivatives		
<i>thiamine hcl (vitamin b1) injection</i>	Non-Formulary	Dual Eligible Covered
<i>vitamin b-1 100 mg tablet (rx)</i>	Formulary	

Medications	Coverage Level	Restrictions
Vitamins - B-12 And Folic Acid Combinations		
FOLTRATE	Non-Formulary	
Vitamins - B-12, Cyanocobalamin And Derivatives		
<i>cyanocobalamin (vitamin b-12) nasal</i>	Non-Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl inner, mov</i>	Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl mdv,inner</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 1,000 mcg/ml vl mov</i>	Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl mov, outer</i>	Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl mov, outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 1,000 mcg/ml vl outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 1,000 mcg/ml vl outer, mov</i>	Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl outer, mov</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 1,000 mcg/ml vl outer, mov, plf</i>	Formulary	
<i>cyanocobalamin 1,000 mcg/ml vl outer,mdv</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 10,000 mcg/10 ml mdv, outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 10,000 mcg/10 ml mdv,outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 10,000 mcg/10 ml outer, mov</i>	Formulary	
<i>cyanocobalamin 10,000 mcg/10 ml outer, mov</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 10,000 mcg/10 ml outer,mdv</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml inner, mov</i>	Formulary	
<i>cyanocobalamin 30,000 mcg/30 ml inner,mdv</i>	Formulary	
<i>cyanocobalamin 30,000 mcg/30 ml mdv, outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml mov</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml mov, inner</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml mov, outer</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml outer, mov</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>cyanocobalamin 30,000 mcg/30 ml outer,mdv</i>	Formulary	Dual Eligible Covered
<i>cyanocobalamin 30,000 mcg/30 ml outer,muv</i>	Formulary	Dual Eligible Covered
DODEX 1,000 MCG/ML VIAL MUV, OUTER	Formulary	
DODEX 10,000 MCG/10 ML VIAL MUV	Formulary	
DODEX 30,000 MCG/30 ML VIAL MUV	Formulary	
<i>hydroxocobalamin</i>	Non-Formulary	Dual Eligible Covered
NASCOBAL	Non-Formulary	
<i>Vitamins - B-2, Riboflavin And Derivatives</i>		
<i>cvs vitamin b-2 100 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>riboflavin 100 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>riboflavin 50 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>true vitamin b2 100 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>true vitamin b2 25 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>true vitamin b2 50 mg tablet</i>	Non-Formulary	CSHCS Covered
<i>vitamin b-2 100 mg tablet</i>	Non-Formulary	CSHCS Covered
VITAMIN B-2 100 MG TABLET COATED,P/F (RX)	Non-Formulary	CSHCS Covered
VITAMIN B-2 100 MG TABLET GLUTEN-FREE (RX)	Non-Formulary	CSHCS Covered
VITAMIN B-2 100 MG TABLET P/F (RX)	Non-Formulary	CSHCS Covered
VITAMIN B-2 100 MG TABLET P/F, LACTOSE-F (RX)	Non-Formulary	CSHCS Covered
VITAMIN B-2 100 MG TABLET Y/F,GLUTEN/F (RX)	Non-Formulary	CSHCS Covered
VITAMIN B-2 25 MG TABLET	Non-Formulary	CSHCS Covered
VITAMIN B-2 50 MG TABLET (RX)	Non-Formulary	CSHCS Covered
<i>Vitamins - B-3, Niacin And Derivatives</i>		
<i>niacin 100 mg tablet outer (rx)</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>niacin 500 mg capsule sa (rx)</i>	Formulary	PDL Preferred; 3 Months Allowed; Dual Eligible Covered
<i>niacin 500 mg tablet (rx)</i>	Formulary	PDL Preferred; 3 Months Allowed; OTC
<i>niacin er 500 mg tablet outer (rx)</i>	Formulary	PDL Preferred; 3 Months Allowed
SLO-NIACIN 500 MG TABLET (RX)	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
SLO-NIACIN 750 MG TABLET	Formulary	PDL Preferred
<i>true vitamin b3 500 mg tablet (rx)</i>	Formulary	
Vitamins - B-6, Pyridoxine And Derivatives		
<i>pyridoxine (vitamin b6) injection</i>	Non-Formulary	Dual Eligible Covered
<i>pyridoxine (vitamin b6) oral tablet 50 mg</i>	Non-Formulary	
VITAMIN B-6 ORAL TABLET 100 MG, 50 MG	Non-Formulary	
Vitamins - C, Ascorbic Acid And Derivatives		
<i>vitamin c 500 mg tablet (rx)</i>	Non-Formulary	CSHCS Covered
VITAMIN C 500 MG TABLET (RX)	Non-Formulary	CSHCS Covered
Vitamins - D Derivatives		
CALCIDOL DROPS	Non-Formulary	CSHCS Covered
<i>calcitriol 0.25 mcg capsule</i>	Formulary	
<i>calcitriol 0.25 mcg capsule outer</i>	Formulary	
<i>calcitriol 0.5 mcg capsule</i>	Formulary	
<i>calcitriol 1 mcg/ml solution</i>	Formulary	Age Limit (Max 12 Years)
<i>calcitriol intravenous solution 1 mcg/ml</i>	Non-Formulary	
<i>cholecalciferol (vitamin d3) oral capsule 10 mcg (400 unit)</i>	Non-Formulary	
<i>cvs vitamin d3 50 mcg softgel</i>	Non-Formulary	CSHCS Covered
<i>cvs vitamin d3 50 mcg tablet (rx)</i>	Non-Formulary	CSHCS Covered
DECARA 50,000 UNIT SOFTGEL	Formulary	
DECARA ORAL CAPSULE 625 MCG (25,000 UNIT)	Non-Formulary	
DIALYVITE VIT D3 50,000 UNIT	Formulary	
DIALYVITE VITAMIN D 5,000 UNIT	Formulary	
<i>ergocalciferol 200 mcg/ml drop (rx)</i>	Non-Formulary	CSHCS Covered
<i>ergocalciferol 8,000 unit/ml (rx)</i>	Non-Formulary	CSHCS Covered
<i>ft vitamin d3 50 mcg softgel</i>	Non-Formulary	CSHCS Covered
<i>ft vitamin d3 50 mcg tablet (rx)</i>	Non-Formulary	CSHCS Covered
<i>infant vitamin d 10 mcg/ml drp (rx)</i>	Non-Formulary	CSHCS Covered
PEDIATRIC D-VITE 10 MCG/ML LIQ	Non-Formulary	CSHCS Covered
ROCALTROL ORAL SOLUTION	Non-Formulary	
<i>true vitamin d3 1,250 mcg tab</i>	Formulary	
<i>true vitamin d3 10 mcg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>true vitamin d3 125 mcg cap (rx)</i>	Formulary	
<i>true vitamin d3 125 mcg tablet</i>	Formulary	
<i>true vitamin d3 25 mcg capsule (rx)</i>	Formulary	
<i>true vitamin d3 25 mcg tablet (rx)</i>	Formulary	
<i>true vitamin d3 50 mcg capsule</i>	Formulary	
<i>true vitamin d3 50 mcg tablet (rx)</i>	Formulary	
VITAL-D RX TABLET	Formulary	Dual Eligible Covered
<i>vitamin d2 1.25 mg(50,000 unit)</i>	Formulary	
<i>vitamin d2 1.25 mg(50,000 unit)</i>	Formulary	Dual Eligible Covered
VITAMIN D2 1.25 MG(50,000 UNIT) CAPSULE	Formulary	Dual Eligible Covered
<i>vitamin d2 1.25 mg(50,000 unit) inner</i>	Formulary	
<i>vitamin d2 1.25 mg(50,000 unit) outer</i>	Formulary	Dual Eligible Covered
<i>vitamin d2 1.25 mg(50,000 unit) softgel</i>	Formulary	Dual Eligible Covered
<i>vitamin d3 1,000 unit softgel softgel (rx)</i>	Formulary	
VITAMIN D3 1,000 UNIT TABLET (RX)	Formulary	
VITAMIN D3 1,000 UNIT TABLET (RX)	Non-Formulary	CSHCS Covered
<i>vitamin d3 10 mcg tablet inner</i>	Formulary	
<i>vitamin d3 10 mcg tablet outer</i>	Formulary	
<i>vitamin d3 10 mcg/ml drop (rx)</i>	Formulary	
<i>vitamin d3 10 mcg/ml liquid w/dropper (rx)</i>	Formulary	
<i>vitamin d3 10,000 unit tablet</i>	Non-Formulary	CSHCS Covered
<i>vitamin d3 100,000 unit/gm pwd (rx)</i>	Formulary	
<i>vitamin d3 2,000 unit softgel</i>	Non-Formulary	CSHCS Covered
<i>vitamin d3 2,000 unit softgel inner</i>	Formulary	
<i>vitamin d3 2,000 unit softgel outer</i>	Formulary	
VITAMIN D3 2,000 UNIT SOFTGEL P/F,N,SOFTGEL (RX)	Non-Formulary	CSHCS Covered
<i>vitamin d3 2,000 unit softgel softgel</i>	Non-Formulary	CSHCS Covered
VITAMIN D3 2,000 UNIT SOFTGEL SOFTGEL, P/F (RX)	Non-Formulary	CSHCS Covered
VITAMIN D3 2,000 UNIT TABLET (RX)	Formulary	
<i>vitamin d3 2,000 unit tablet inner (rx)</i>	Formulary	
<i>vitamin d3 2,000 unit tablet outer (rx)</i>	Formulary	
<i>vitamin d3 25 mcg tablet (rx)</i>	Non-Formulary	CSHCS Covered
VITAMIN D3 25 MCG TABLET P/F, EX-STRENGTH (RX)	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
<i>vitamin d3 400 unit tablet outer</i>	Formulary	
VITAMIN D3 400 UNIT TABLET P/F (RX)	Formulary	
<i>vitamin d3 5,000 unit softgel inner (rx)</i>	Formulary	
<i>vitamin d3 5,000 unit softgel outer (rx)</i>	Formulary	
<i>vitamin d3 5,000 unit tablet outer</i>	Formulary	
<i>vitamin d3 50 mcg capsule</i>	Non-Formulary	CSHCS Covered
<i>vitamin d3 50 mcg softgel</i>	Formulary	
<i>vitamin d3 50 mcg softgel</i>	Non-Formulary	CSHCS Covered
<i>vitamin d3 50 mcg tablet (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin d3 50,000 unit capsule (rx)</i>	Formulary	
VITAMIN D3 ORAL CAPSULE 10 MCG (400 UNIT)	Non-Formulary	
WEEKLY-D 1,250 MCG SOFTGEL	Formulary	
<i>well vitamin d3 125 mcg softgl (rx)</i>	Formulary	
<i>well vitamin d3 25 mcg softgel (rx)</i>	Formulary	
<i>well vitamin d3 50 mcg softgel</i>	Formulary	
Vitamins - E		
<i>true vitamin e 180 mg capsule (rx)</i>	Non-Formulary	CSHCS Covered
<i>true vitamin e 450 mg capsule (rx)</i>	Formulary	
<i>true vitamin e 90 mg capsule</i>	Non-Formulary	CSHCS Covered
<i>vitamin e 100 unit tablet</i>	Non-Formulary	CSHCS Covered
<i>vitamin e 100 unit tablet y/f,gluten/f (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin e 15 unit/0.3 ml drop</i>	Formulary	
<i>vitamin e 180 mg softgel outer (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin e 180 mg(400 unit) sfgl (rx)</i>	Non-Formulary	CSHCS Covered
<i>vitamin e 450 mg softgel (rx)</i>	Formulary	
Vitamins - Folic Acid And Derivatives		
<i>folic acid 1 mg tablet (rx)</i>	Formulary	OTC
<i>folic acid 1 mg tablet (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>folic acid 1 mg tablet outer (rx)</i>	Formulary	OTC
<i>folic acid 1,000 mcg tablet inner (rx)</i>	Formulary	OTC
<i>folic acid 1,000 mcg tablet outer (rx)</i>	Formulary	OTC
<i>folic acid 400 mcg tablet (rx)</i>	Formulary	QL (1 tablet per 1 day)
<i>folic acid 400 mcg tablet outer (rx)</i>	Formulary	QL (1 tablet per 1 day)
<i>folic acid 800 mcg tablet outer (rx)</i>	Formulary	
<i>folic acid injection</i>	Non-Formulary	Dual Eligible Covered

Medications	Coverage Level	Restrictions
<i>levomefolate calcium</i>	Benefit Exclusion	
L-METHYLFOLATE FORTE	Benefit Exclusion	
<i>true folic acid 1,600 mcg dfe tb (rx)</i>	Formulary	OTC
<i>Vitamins - Folic Acid Combinations</i>		
ENLYTE	Non-Formulary	
NIVA-FOL TABLET	Non-Formulary	CSHCS Covered; Dual Eligible Covered
WESTAB MAX TABLET	Formulary	Dual Eligible Covered
<i>Vitamins - K, Phytonadione And Derivatives</i>		
<i>phytonadione (vitamin k1) injection solution 10 mg/ml</i>	Non-Formulary	Dual Eligible Covered
<i>phytonadione (vitamin k1) injection syringe</i>	Non-Formulary	
<i>phytonadione 5 mg tablet</i>	Formulary	QL (3 tablets per 30 days)
<i>phytonadione 5 mg tablet</i>	Formulary	Dual Eligible Covered; QL (3 tablets per 30 days)
<i>phytonadione 5 mg tablet outer</i>	Formulary	Dual Eligible Covered; QL (3 tablets per 30 days)
VITAMIN K1 INJECTION	Non-Formulary	Dual Eligible Covered
Endocrine		
<i>Abortifacients Or Cervical Ripening Agents - Prostaglandin Analogs</i>		
CERVIDIL	Non-Formulary	
PREPIDIL	Non-Formulary	
<i>Adrenal Steroid Inhibitors</i>		
ISTURISA ORAL TABLET 1 MG, 5 MG	Non-Formulary	
<i>Adrenocorticotrophic Hormones</i>		
ACTHAR	State Carve Out	
ACTHAR SELFJECT	State Carve Out	
CORTROPHIN GEL	State Carve Out	
<i>Agents To Treat Hypoglycemia (Hyperglycemics)</i>		
BAQSIMI 3 MG SPRAY ONE PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 packs per 30 days)
BAQSIMI 3 MG SPRAY TWO PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 packs per 30 days)

Medications	Coverage Level	Restrictions
BAQSIMI 3 MG SPRAY TWO PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 packs per 30 days)
<i>diazoxide 50 mg/ml oral susp</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
GLUCAGON 1 MG EMERGENCY KIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GLUCAGON 1 MG EMERGENCY KIT SUV	Formulary	PA; PDL Non-Preferred
GLUCAGON 1 MG EMERGENCY KIT SUV, OUTER	Formulary	PA; PDL Non-Preferred
GVOKE 1 MG/0.2 ML KIT OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 1PK 0.5 MG/0.1 ML	Formulary	PDL Preferred; 3 Months Allowed; QL (0.2 ML per 30 days)
GVOKE HYPOPEN 1-PK 1 MG/0.2 ML	Formulary	PDL Preferred; 3 Months Allowed; QL (0.4 ML per 30 days)
GVOKE HYPOPEN 2PK 0.5 MG/0.1 ML	Formulary	PDL Preferred; 3 Months Allowed; QL (0.2 ML per 30 days)
GVOKE HYPOPEN 2-PK 1 MG/0.2 ML	Formulary	PDL Preferred; 3 Months Allowed; QL (0.4 ML per 30 days)
GVOKE PFS 1-PK 1 MG/0.2 ML SYR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (0.4 ML per 30 days)
GVOKE PFS 2-PK 1 MG/0.2 ML SYR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (0.4 ML per 30 days)
PROGLYCEM 50 MG/ML ORAL SUSP	Formulary	PDL Preferred; 3 Months Allowed
ZEGALOGUE 0.6 MG/0.6 ML AUTOINJ	Formulary	PDL Preferred; 3 Months Allowed
ZEGALOGUE 0.6 MG/0.6 ML SYRING	Formulary	PDL Preferred; 3 Months Allowed
<i>Amyloidosis Agents- Transthyretin (Ttr) Stabilizer</i>		
VYNDAMAX 61 MG CAPSULE OUTER	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
VYNDAQEL 20 MG CAPSULE OUTER	Formulary	PA; QL (4 capsules per 1 day); Age Limit (Min 18 Years)
<i>Amyloidosis Agents-Ttr Suppression, Antisense Oligonucleotide-Based</i>		
TEGSEDI	Non-Formulary	
WAINUA	Non-Formulary	
<i>Androgen - Single Agents</i>		
ANDROGEL 1.62% GEL PUMP	Formulary	PA; PDL Non-Preferred
DEPO-TESTOSTERONE	Non-Formulary	
JATENZO	Non-Formulary	
METHITEST	Non-Formulary	
<i>methyltestosterone oral capsule</i>	Non-Formulary	
NATESTO NASAL 5.5 MG/0.122 GM	Formulary	PA; PDL Non-Preferred
TESTIM 1% (50 MG) GEL OUTER	Formulary	PA; PDL Non-Preferred
TESTOPEL	Non-Formulary	
<i>testosteron enan 1,000 mg/5 ml mdv</i>	Formulary	QL (5 ML per 28 days)
<i>testosterone 1% (25 mg/2.5 g) pk</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 1% (25 mg/2.5 g) pk outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 1% (50 mg/5 g) pk</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 1% (50 mg/5 g) pk outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 1.62% (2.5 g) pkt outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 1.62% gel pump</i>	Formulary	PA; PDL Preferred
<i>testosterone 1.62%(1.25 g) pkt outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 10 mg gel pump</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 12.5 mg/1.25 gram</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 12.5 mg/1.25 gram outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 30 mg/1.5 ml pump</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 50 mg/5 gram gel outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone 50 mg/5 gram pkt outer</i>	Formulary	PA; PDL Non-Preferred
<i>testosterone cyp 1,000 mg/10 ml mdv</i>	Formulary	
<i>testosterone cyp 1,000 mg/10 ml muv</i>	Formulary	
<i>testosterone cyp 2,000 mg/10 ml mdv</i>	Formulary	
<i>testosterone cyp 2,000 mg/10 ml muv</i>	Formulary	
<i>testosterone cyp 2,000 mg/10 ml muv, outer, in oil</i>	Formulary	
<i>testosterone cyp 200 mg/ml sdv</i>	Formulary	
<i>testosterone cyp 200 mg/ml suv</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>testosterone cyp 200 mg/ml suv, in oil</i>	Formulary	
<i>testosterone enan 200 mg/ml mdv</i>	Formulary	QL (5 ML per 28 days)
UNDECATREX	Non-Formulary	
VOGELXO 12.5 MG/1.25 GRAM PUMP OUTER	Formulary	PA; PDL Non-Preferred
VOGELXO 50 MG/5 GRAM GEL OUTER	Formulary	PA; PDL Non-Preferred
VOGELXO 50 MG/5 GRAM GEL PACKT OUTER	Formulary	PA; PDL Non-Preferred
XYOSTED	Non-Formulary	
<i>Antidiuretic And Vasopressor Hormones</i>		
DDAVP INJECTION	Non-Formulary	
DDAVP ORAL	Non-Formulary	
<i>desmopressin 0.01% solution 50 doses</i>	Formulary	PA
<i>desmopressin 10 mcg/0.1 ml spr</i>	Formulary	PA
<i>desmopressin acetate 0.1 mg tb</i>	Formulary	QL (6 tablets per 1 day)
<i>desmopressin acetate 0.1 mg tb outer</i>	Formulary	QL (6 tablets per 1 day)
<i>desmopressin acetate 0.2 mg tb</i>	Formulary	QL (6 tablets per 1 day)
<i>desmopressin acetate 0.2 mg tb outer</i>	Formulary	QL (6 tablets per 1 day)
<i>desmopressin injection</i>	Non-Formulary	
NOCDURNA (MEN)	Non-Formulary	
NOCDURNA (WOMEN)	Non-Formulary	
VASOSTRICT INTRAVENOUS SOLUTION 0.2 UNIT/ML, 0.4 UNIT/ML	Non-Formulary	
<i>Antihyperglycemic - Alpha-Glucosidase Inhibitors</i>		
<i>acarbose 100 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acarbose 25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>acarbose 50 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>miglitol 100 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>miglitol 25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>miglitol 50 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
PRECOSE 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
PRECOSE 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PRECOSE 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Amylin Analog-Type</i>		
SYMLINPEN 120 PEN INJECTOR SUV	Formulary	PDL Preferred; 3 Months Allowed
SYMLINPEN 60 PEN INJECTOR SUV	Formulary	PDL Preferred; 3 Months Allowed
<i>Antihyperglycemic - Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors</i>		
<i>alogliptin 12.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin 6.25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
JANUVIA 100 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 100 MG TABLET F/C, BULK PACKAGE	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 100 MG TABLET U-D, F/C, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 25 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 25 MG TABLET U-D,F/C,OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 50 MG TABLET F/C	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUVIA 50 MG TABLET OUTER, F/C	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
NESINA 12.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NESINA 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
NESINA 6.25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>saxagliptin hcl 2.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>saxagliptin hcl 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sitagliptin 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sitagliptin 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sitagliptin 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRADJENTA 5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
TRADJENTA 5 MG TABLET 10X10, U-D	Formulary	PDL Preferred; 3 Months Allowed
TRADJENTA 5 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
ZITUVIO 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIO 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIO 50 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Dopamine Receptor Agonists</i>		
CYCLOSET	Non-Formulary	
<i>Antihyperglycemic - Dual Gip And Glp-1 Receptor Agonists</i>		
MOUNJARO 10 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)
MOUNJARO 12.5 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)
MOUNJARO 15 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)
MOUNJARO 2.5 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)

Medications	Coverage Level	Restrictions
MOUNJARO 5 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)
MOUNJARO 7.5 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ML per 28 days)
<i>Antihyperglycemic - Dual SglT1 And SglT2 Inhibitors</i>		
INPEFA 200 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INPEFA 400 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Glucagon-Like Peptide-1 (Glp-1) Receptor Agonists</i>		
BYDUREON BCISE 2 MG AUTOINJECT OUTER,SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (3.4 ML per 28 days)
BYETTA 10 MCG DOSE PEN INJ SINGLE USE	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2.4 ML per 30 days)
BYETTA 5 MCG DOSE PEN INJ SINGLE USE	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (1.2 ML per 30 days)
<i>exenatide 10 mcg dose pen inj</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2.4 ML per 30 days)
<i>liraglutide 2-pak 18 mg/3 ml outer, suv</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (6 ML per 30 days)
<i>liraglutide 3-pak 18 mg/3 ml outer, suv</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (9 ML per 30 days)
OZEMPIC 0.25-0.5 MG/DOSE (2 MG/3 ML) PEN OUTER, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (3 ML per 28 days)
OZEMPIC 1 MG/DOSE (4 MG/3 ML) PEN OUTER, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (3 ML per 28 days)
OZEMPIC 2 MG/DOSE (8 MG/3 ML) PEN OUTER, SUV	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (3 ML per 28 days)
RYBELSUS 14 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
RYBELSUS 3 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
RYBELSUS 7 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
TRULICITY 0.75 MG/0.5 ML PEN SDV, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
TRULICITY 1.5 MG/0.5 ML PEN SDV, OUTER	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
TRULICITY 3 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
TRULICITY 4.5 MG/0.5 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (2 ML per 28 days)
VICTOZA 2-PAK 18 MG/3 ML PEN	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (6 ML per 30 days)
VICTOZA 3-PAK 18 MG/3 ML PEN	Formulary	PA; PDL Preferred; 3 Months Allowed; QL (9 ML per 30 days)
<i>Antihyperglycemic - Glucocorticoid (Cortisol) Receptor Blocker (Gr-I)</i>		
KORLYM	Non-Formulary	
<i>mifepristone oral tablet 300 mg</i>	Non-Formulary	
<i>Antihyperglycemic - Meglitinide Analogs</i>		
<i>nateglinide 120 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nateglinide 120 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nateglinide 60 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>nateglinide 60 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>repaglinide 0.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>repaglinide 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>repaglinide 1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>repaglinide 2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>Antihyperglycemic - SglT-2 Inhibitor And Biguanide Combinations</i>		
<i>dapagliflozin-metformin er 10-1,000 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
<i>dapagliflozin-metformin er 5-1,000 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
INVOKAMET 150-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET 150-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET 50-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET XR 150-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET XR 150-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET XR 50-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKAMET XR 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SEGLUROMET 2.5-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SEGLUROMET 2.5-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SEGLUROMET 7.5-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SEGLUROMET 7.5-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SYNJARDY 12.5-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY 12.5-500 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY 5-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY 5-500 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY XR 10-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
SYNJARDY XR 12.5-1,000 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY XR 25-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
SYNJARDY XR 5-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
XIGDUO XR 10 MG-1,000 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
XIGDUO XR 10 MG-500 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
XIGDUO XR 2.5 MG-1,000 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
XIGDUO XR 5 MG-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
XIGDUO XR 5 MG-500 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
<i>Antihyperglycemic - Sglt-2 Inhibitor And Dpp-4 Inhibitor Combinations</i>		
GLYXAMBI 10 MG-5 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GLYXAMBI 25 MG-5 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QTERN 10 MG-5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QTERN 5 MG-5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
STEGLUJAN 15-100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
STEGLUJAN 5-100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Sodium Glucose Cotransporter-2 (Sglt2) Inhibitors</i>		
<i>dapagliflozin 10 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
<i>dapagliflozin 5 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
FARXIGA 10 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
FARXIGA 10 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
FARXIGA 5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
FARXIGA 5 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
INVOKANA 100 MG TABLET F/C	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INVOKANA 300 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
JARDIANCE 10 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
JARDIANCE 25 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
STEGLATRO 15 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
STEGLATRO 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Sulfonylurea And Biguanide Combinations</i>		
<i>glipizide-metformin 2.5-250 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>glipizide-metformin 2.5-500 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>glipizide-metformin 5-500 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>glyburide-metformin 1.25 mg-250 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide-metformin 2.5-500 mg f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide-metformin 5-500 mg f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburid-metformin 1.25-250 mg f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Antihyperglycemic - Sulfonylurea Derivatives</i>		
<i>glimepiride 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 1 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>glimepiride 2 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 2 mg tablet u-d, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 3 mg tablet</i>	Formulary	PDL Preferred
<i>glimepiride 4 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 4 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glimepiride 4 mg tablet u-d, 10x10, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide 5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 10 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 2.5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 2.5 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 5 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide er 5 mg tablet f/c,u-d,10x10,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide xl 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glipizide xl 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>glipizide xl 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
GLUCOTROL XL 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GLUCOTROL XL 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GLUCOTROL XL 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>glyburide 1.25 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide micro 1.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide micro 3 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>glyburide micro 6 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Antihyperglycemic - Thiazolidinedione And Biguanide Combinations</i>		
ACTOPLUS MET 15 MG-850 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pioglitazone-metformin 15-500</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pioglitazone-metformin 15-850</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic - Thiazolidinedione And Sulfonylurea Combinations</i>		
DUETACT 30-2 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
DUETACT 30-4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pioglitazone-glimepiride 30-2</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>pioglitazone-glimepiride 30-4</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibit And Thiazolidinedione</i>		
<i>alogliptin-pioglit 12.5-30 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin-pioglit 25-15 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin-pioglit 25-30 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin-pioglit 25-45 mg tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
OSENI 12.5-30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
OSENI 25-15 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
OSENI 25-30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
OSENI 25-45 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antihyperglycemic-Dipeptidyl Peptidase-4(Dpp-4)Inhibitor And Biguanide</i>		
<i>alogliptin-metformin 12.5-1000</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>alogliptin-metformin 12.5-500</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
JANUMET 50-1,000 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUMET 50-1,000 MG TABLET F/C, BULK PACKAGE	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUMET 50-500 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUMET 50-500 MG TABLET F/C, BULK PACKAGE	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
JANUMET XR 100-1,000 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
JANUMET XR 100-1,000 MG TABLET F/C, BULK	Formulary	PDL Preferred; 3 Months Allowed
JANUMET XR 50-1,000 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
JANUMET XR 50-1,000 MG TABLET F/C, BULK	Formulary	PDL Preferred; 3 Months Allowed
JANUMET XR 50-500 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
JANUMET XR 50-500 MG TABLET F/C, BULK	Formulary	PDL Preferred; 3 Months Allowed
JENTADUETO 2.5 MG-1,000 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
JENTADUETO 2.5 MG-500 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
JENTADUETO 2.5 MG-850 MG TAB	Formulary	PDL Preferred; 3 Months Allowed
JENTADUETO XR 2.5 MG-1,000 MG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
JENTADUETO XR 5 MG-1,000 MG TB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KAZANO 12.5-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
KAZANO 12.5-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>saxagliptin-metformin er 2.5-1,000 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>saxagliptin-metformin er 5-1,000 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>saxagliptin-metformin er 5-500 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sitagliptin-metformin 50 mg-1,000 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>sitagliptin-metformin 50 mg-500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
ZITUVIMET 50-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
ZITUVIMET 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred
ZITUVIMET XR 100-1,000 MG TAB	Formulary	PA; PDL Non-Preferred
ZITUVIMET XR 50-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
ZITUVIMET XR 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Antihyperglycemic-Insulin, Long Acting And Glp-1 Receptor Agonist Comb</i>		
SOLIQUA 100 UNIT-33 MCG/ML PEN	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (15 ML per 25 days)

Medications	Coverage Level	Restrictions
XULTOPHY 100 UNIT-3.6 MG/ML PEN	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (15 ML per 30 days)
<i>Antihyperglycemic-Sglt-2 Inhibitor, Dpp-4 Inhibitor And Biguanide Comb</i>		
TRIJARDY XR 10-5-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIJARDY XR 12.5-2.5-1,000 MG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIJARDY XR 25-5-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
TRIJARDY XR 5-2.5-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Antithyroid Agents, Thionamides - Imidazole Derivatives</i>		
<i>methimazole 10 mg tablet</i>	Formulary	
<i>methimazole 10 mg tablet outer</i>	Formulary	
<i>methimazole 5 mg tablet</i>	Formulary	
<i>methimazole 5 mg tablet outer</i>	Formulary	
<i>Antithyroid Agents, Thionamides - Thiouracil Derivatives</i>		
<i>propylthiouracil 50 mg tablet</i>	Formulary	
<i>propylthiouracil 50 mg tablet bulk package</i>	Formulary	
<i>propylthiouracil 50 mg tablet outer</i>	Formulary	
<i>Bone Formation Stimulating Agents - Natriuretic Peptide</i>		
VOXZOGO	State Carve Out	
<i>Bone Formation Stimulating Agents - Parathyroid Hormone Rel Peptides</i>		
TYMLOS 80 MCG DOSE PEN INJECTR OUTER, SUV	Formulary	PA; PDL Non-Preferred
<i>Bone Formation Stimulating Agents - Parathyroid Hormone-Type</i>		
FORTEO 560 MCG/2.24 ML PEN INJ SUV	Formulary	PA; PDL Non-Preferred
<i>teriparatide 560 mcg/2.24 ml pen</i>	Formulary	PA; PDL Non-Preferred
<i>teriparatide 620 mcg/2.48 ml</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Bone Resorption Inhibitors - Bisphosphonate And Vitamin D Combinations		
FOSAMAX PLUS D 70 MG-2800 UNIT	Formulary	PA; PDL Non-Preferred; QL (0.15 tablets per 1 day)
FOSAMAX PLUS D 70 MG-5600 UNIT	Formulary	PA; PDL Non-Preferred; QL (0.15 tablets per 1 day)
Bone Resorption Inhibitors - Bisphosphonates		
ACTONEL 150 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
ACTONEL 150 MG TABLET F/C, ONCE-A-MONTH	Formulary	PA; PDL Non-Preferred
ACTONEL 35 MG TABLET F/C, DOSEPACK	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>alendronate sod 70 mg/75 ml</i>	Formulary	PA; PDL Non-Preferred
<i>alendronate sodium 10 mg tab</i>	Formulary	PDL Preferred
<i>alendronate sodium 35 mg tab</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 35 mg tab once weekly</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 35 mg tab u-u</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 5 mg tablet</i>	Formulary	PDL Preferred
<i>alendronate sodium 70 mg tab</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 70 mg tab once weekly</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 70 mg tab outer</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
<i>alendronate sodium 70 mg tab u-u</i>	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
AELVIA DR 35 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
BINOSTO 70 MG EFFERVESCENT TAB OUTER	Formulary	PA; PDL Non-Preferred
FOSAMAX 70 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (0.15 tablets per 1 day)
<i>ibandronate sodium 150 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
<i>ibandronate sodium 150 mg tab f/c, inner</i>	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)

Medications	Coverage Level	Restrictions
<i>ibandronate sodium 150 mg tab f/c, outer</i>	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
<i>ibandronate sodium 150 mg tab once monthly, u-d</i>	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
<i>ibandronate sodium 150 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
RECLAST	Non-Formulary	
<i>risedronate sod dr 35 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sod dr 35 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 150 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>risedronate sodium 150 mg tab f/c, once-a-month</i>	Formulary	PA; PDL Non-Preferred
<i>risedronate sodium 150 mg tab f/c,once-a-month</i>	Formulary	PA; PDL Non-Preferred
<i>risedronate sodium 150 mg tab outer</i>	Formulary	PA; PDL Non-Preferred
<i>risedronate sodium 30 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>risedronate sodium 35 mg tab</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 35 mg tab f/c, once-a-week</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 35 mg tab outer</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 35 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 35 mg tablet f/c, once-a-week</i>	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
<i>risedronate sodium 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>zoledronic acid</i>	Non-Formulary	
<i>zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml</i>	Non-Formulary	
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer		
<i>cinacalcet hcl 30 mg tablet</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>cinacalcet hcl 30 mg tablet outer</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>cinacalcet hcl 60 mg tablet</i>	Formulary	PA; QL (2 tablets per 1 day)
<i>cinacalcet hcl 90 mg tablet</i>	Formulary	PA; QL (4 tablets per 1 day)
SENSIPAR	Non-Formulary	

Medications	Coverage Level	Restrictions
Calcitonins		
<i>calcitonin-salmon 200 unit spr</i>	Formulary	PDL Preferred
<i>calcitonin-salmon 200 unit spr 30 dose bottle</i>	Formulary	PDL Preferred
Estrogen And Progestin With Antimineralocorticoid Activity, Combination		
ANGELIQ	Non-Formulary	
Estrogen And Selective Estrogen Receptor Modulator (Serm) Combinations		
DUAVEE	Non-Formulary	
Estrogen-Androgen		
<i>estrogens-methyltestosterone</i>	Non-Formulary	
Estrogen-Progestin		
ACTIVELLA	Non-Formulary	
BIJUVA ORAL CAPSULE 1-100 MG	Non-Formulary	
CLIMARA PRO	Non-Formulary	
COMBIPATCH	Non-Formulary	
<i>estradiol-noreth 0.5-0.1 mg tb coated</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol-noreth 0.5-0.1 mg tb inner</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol-noreth 0.5-0.1 mg tb outer</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol-noreth 1-0.5 mg tab f/c</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol-noreth 1-0.5 mg tab inner</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol-noreth 1-0.5 mg tab outer</i>	Formulary	Age Limit (Max 64 Years)
FYAVOLV 0.5 MG-2.5 MCG TABLET F/C	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
FYAVOLV 0.5 MG-2.5 MCG TABLET OUTER	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
JINTELI	Non-Formulary	
<i>norethind-eth estrad 0.5-2.5 outer</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
<i>norethin-eth estrad 1 mg-5 mcg</i>	Formulary	Age Limit (Max 64 Years)
<i>norethin-eth estrad 1 mg-5 mcg outer</i>	Formulary	Age Limit (Max 64 Years)
PREMPHASE 0.625-5 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMPRO 0.3 MG-1.5 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMPRO 0.45-1.5 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
PREMPRO 0.625-2.5 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMPRO 0.625-5 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
Estrogens		
CLIMARA	Non-Formulary	
DELESTROGEN 100 MG/5 ML VIAL IN OIL, MUV	Formulary	
DELESTROGEN 200 MG/5 ML VIAL IN OIL, MUV	Formulary	
DELESTROGEN 50 MG/5 ML VIAL IN OIL, MUV	Formulary	
DEPO-ESTRADIOL 5 MG/ML VIAL	Formulary	
DIVIGEL	Non-Formulary	
DOTTI 0.025 MG PATCH OUTER	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
DOTTI 0.0375 MG PATCH OUTER	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
DOTTI 0.05 MG PATCH OUTER	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
DOTTI 0.075 MG PATCH OUTER	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
DOTTI 0.1 MG PATCH OUTER	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
ELESTRIN	Non-Formulary	
ESTRACE ORAL	Non-Formulary	
<i>estradiol 0.025 mg patch(1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.025 mg patch(2/wk) outer</i>	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.0375 mg patch(1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.0375 mg patch(2/wk) outer</i>	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.05 mg patch (1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.05 mg patch (2/wk) outer</i>	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.06 mg patch (1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
<i>estradiol 0.075 mg patch(1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.075 mg patch(2/wk) outer</i>	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.1 mg patch (1/wk) outer</i>	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.1 mg patch (2/wk) outer</i>	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
<i>estradiol 0.5 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol 1 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol 2 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>estradiol transdermal gel in packet 0.75 mg/0.75 gram (0.1%), 1 mg/gram (0.1 %), 1.25 mg/1.25 gram (0.1 %)</i>	Non-Formulary	
<i>estradiol valerate 100 mg/5 ml muv</i>	Formulary	
<i>estradiol valerate 200 mg/5 ml muv</i>	Formulary	
<i>estradiol valerate 50 mg/5 ml muv</i>	Formulary	
EVAMIST	Non-Formulary	
MENEST 0.3 MG TABLET	Formulary	Age Limit (Max 64 Years)
MENEST 0.625 MG TABLET	Formulary	Age Limit (Max 64 Years)
MENEST 1.25 MG TABLET	Formulary	Age Limit (Max 64 Years)
MENEST 2.5 MG TABLET	Formulary	Age Limit (Max 64 Years)
MENOSTAR	Non-Formulary	
MINIVELLE	Non-Formulary	
PREMARIN 0.3 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMARIN 0.45 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMARIN 0.625 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMARIN 0.9 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
PREMARIN 1.25 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
VIVELLE-DOT	Non-Formulary	
<i>Fertility Enhancer - Luteal Phase Supporting, Progesterone-Type</i>		
CRINONE 8% GEL OUTER	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Glucocorticoid Salt Combinations		
<i>betamethasone acet,sod phos</i>	Non-Formulary	
CELESTONE SOLUSPAN	Non-Formulary	
Glucocorticoids		
AGAMREE 40 MG/ML SUSPENSION	Formulary	
ALKINDI SPRINKLE 0.5 MG CAP	Formulary	
ALKINDI SPRINKLE 1 MG CAPSULE	Formulary	
ALKINDI SPRINKLE 2 MG CAPSULE	Formulary	
ALKINDI SPRINKLE 5 MG CAPSULE	Formulary	
CORTEF 10 MG TABLET	Formulary	
CORTEF 20 MG TABLET	Formulary	
CORTEF 5 MG TABLET	Formulary	
<i>cortisone</i>	Non-Formulary	
<i>deflazacort 18 mg tablet</i>	Formulary	
<i>deflazacort 22.75 mg/ml susp</i>	Formulary	
<i>deflazacort 30 mg tablet</i>	Formulary	
<i>deflazacort 36 mg tablet</i>	Formulary	
<i>deflazacort 6 mg tablet</i>	Formulary	
DEPO-MEDROL 100 MG/5 ML VIAL	Formulary	
DEPO-MEDROL 200 MG/5 ML VIAL MDV	Formulary	
DEPO-MEDROL 40 MG/ML VIAL SDV	Formulary	
DEPO-MEDROL 40 MG/ML VIAL SDV, 25'S	Formulary	
DEPO-MEDROL 400 MG/10 ML VIAL MDV	Formulary	
DEPO-MEDROL 400 MG/5 ML VIAL MDV	Formulary	
DEPO-MEDROL 80 MG/ML VIAL SDV	Formulary	
<i>dexamethasone 0.5 mg tablet</i>	Formulary	
<i>dexamethasone 0.5 mg tablet u-d, 10x10, blister</i>	Formulary	
<i>dexamethasone 0.5 mg/5 ml elx</i>	Formulary	
<i>dexamethasone 0.5 mg/5 ml liq</i>	Formulary	
<i>dexamethasone 0.75 mg tablet</i>	Formulary	
<i>dexamethasone 0.75 mg tablet u-d, 10x10, blister</i>	Formulary	
<i>dexamethasone 1 mg tablet</i>	Formulary	
<i>dexamethasone 1.5 mg tablet</i>	Formulary	
<i>dexamethasone 10 day 1.5 mg tb</i>	Formulary	
<i>dexamethasone 10 mg/ml syringe suv, plf</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>dexamethasone 10 mg/ml vial 25's,inner</i>	Formulary	
<i>dexamethasone 10 mg/ml vial 25's,outer</i>	Formulary	
<i>dexamethasone 10 mg/ml vial outer</i>	Formulary	
<i>dexamethasone 100 mg/10 ml vl 10's,mdv</i>	Formulary	
<i>dexamethasone 100 mg/10 ml vl mdv,outer</i>	Formulary	
<i>dexamethasone 100 mg/10 ml vl outer, muv</i>	Formulary	
<i>dexamethasone 100 mg/10 ml vl outer,muv</i>	Formulary	
<i>dexamethasone 120 mg/30 ml vl mdv</i>	Formulary	
<i>dexamethasone 120 mg/30 ml vl mdv, outer</i>	Formulary	
<i>dexamethasone 120 mg/30 ml vl outer, muv</i>	Formulary	
<i>dexamethasone 13 day 1.5 mg tb</i>	Formulary	
<i>dexamethasone 2 mg tablet</i>	Formulary	
<i>dexamethasone 2 mg tablet outer</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial mdv</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial mdv, outer</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial muv</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial outer</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial outer, muv</i>	Formulary	
<i>dexamethasone 20 mg/5 ml vial outer,muv</i>	Formulary	
<i>dexamethasone 4 mg tablet</i>	Formulary	
<i>dexamethasone 4 mg tablet outer</i>	Formulary	
<i>dexamethasone 4 mg/ml syringe outer, suv</i>	Formulary	
<i>dexamethasone 4 mg/ml syringe plf, suv</i>	Formulary	
<i>dexamethasone 4 mg/ml vial outer</i>	Formulary	
<i>dexamethasone 4 mg/ml vial outer, muv</i>	Formulary	
<i>dexamethasone 4 mg/ml vial outer, sdv</i>	Formulary	
<i>dexamethasone 4 mg/ml vial outer, suv</i>	Formulary	
<i>dexamethasone 4 mg/ml vial sdv</i>	Formulary	
<i>dexamethasone 4 mg/ml vial sdv,outer</i>	Formulary	
<i>dexamethasone 4 mg/ml vial suv</i>	Formulary	
<i>dexamethasone 6 day 1.5 mg tab</i>	Formulary	
<i>dexamethasone 6 mg tablet</i>	Formulary	
<i>dexamethasone 6 mg tablet outer</i>	Formulary	
<i>dexamethasone 6 mg tablet u-d, 10x10, blister</i>	Formulary	
DEXAMETHASONE INTENSOL 1 MG/ML	Formulary	

Medications	Coverage Level	Restrictions
EMFLAZA 18 MG TABLET	Formulary	
EMFLAZA 22.75 MG/ML ORAL SUSP	Formulary	
EMFLAZA 30 MG TABLET	Formulary	
EMFLAZA 36 MG TABLET	Formulary	
EMFLAZA 6 MG TABLET	Formulary	
EOHILIA 2 MG/10 ML STICK PACK OUTER	Formulary	PA; QL (20 ML per 1 day); Age Limit (Min 11 Years)
HEMADY 20 MG TABLET	Formulary	
HEXATRIONE	Non-Formulary	
<i>hydrocortisone 10 mg tablet</i>	Formulary	
<i>hydrocortisone 10 mg tablet outer</i>	Formulary	
<i>hydrocortisone 20 mg tablet</i>	Formulary	
<i>hydrocortisone 20 mg tablet outer</i>	Formulary	
<i>hydrocortisone 5 mg tablet</i>	Formulary	
<i>hydrocortisone 5 mg tablet outer</i>	Formulary	
<i>hydrocortisone ss 100 mg vial</i>	Formulary	
KENALOG-10 50 MG/5 ML VIAL MDV	Formulary	
KENALOG-40 200 MG/5 ML VIAL MDV	Formulary	
KENALOG-40 40 MG/ML VIAL SUV	Formulary	
KENALOG-40 400 MG/10 ML VIAL MUV	Formulary	
KENALOG-80	Non-Formulary	
MEDROL 16 MG TABLET	Formulary	
MEDROL 2 MG TABLET	Formulary	
MEDROL 4 MG DOSEPAK	Formulary	
MEDROL 4 MG TABLET	Formulary	
MEDROL 8 MG TABLET	Formulary	
<i>methylprednisolone 16 mg tab</i>	Formulary	
<i>methylprednisolone 200 mg/5 ml muv</i>	Formulary	
<i>methylprednisolone 32 mg tab</i>	Formulary	
<i>methylprednisolone 4 mg dosepk</i>	Formulary	
<i>methylprednisolone 4 mg dosepk dosepack</i>	Formulary	
<i>methylprednisolone 4 mg dosepk dosepak</i>	Formulary	
<i>methylprednisolone 4 mg tablet</i>	Formulary	
<i>methylprednisolone 4 mg tablet outer</i>	Formulary	
<i>methylprednisolone 40 mg/ml vl inner, suv</i>	Formulary	
<i>methylprednisolone 40 mg/ml vl outer, suv</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>methylprednisolone 400 mg/10 ml inner, mov</i>	Formulary	
<i>methylprednisolone 400 mg/10 ml mov</i>	Formulary	
<i>methylprednisolone 400 mg/10 ml outer, mov</i>	Formulary	
<i>methylprednisolone 400 mg/5 ml inner, mov</i>	Formulary	
<i>methylprednisolone 400 mg/5 ml mov</i>	Formulary	
<i>methylprednisolone 400 mg/5 ml outer, mov</i>	Formulary	
<i>methylprednisolone 8 mg tablet</i>	Formulary	
<i>methylprednisolone 80 mg/ml vl inner, suv</i>	Formulary	
<i>methylprednisolone 80 mg/ml vl outer, suv</i>	Formulary	
<i>methylprednisolone ss 1 gm vl mdv</i>	Formulary	
<i>methylprednisolone ss 1 gm vl mov</i>	Formulary	
<i>methylprednisolone ss 125 mg outer, suv</i>	Formulary	
<i>methylprednisolone ss 125 mg sdv,outer</i>	Formulary	
<i>methylprednisolone ss 40 mg vl outer, suv</i>	Formulary	
<i>methylprednisolone ss 40 mg vl sdv,outer</i>	Formulary	
<i>methylprednisolone ss 500 mg mov</i>	Formulary	
MILLIPRED 5 MG TABLET	Formulary	
MILLIPRED DP 5 MG 12-DAY PACK DOSE PACK, 12 DAY	Formulary	
MILLIPRED DP 5 MG 6-DAY PACK DOSE PACK, 6 DAY	Formulary	
<i>prednisolone 10 mg/5 ml soln</i>	Formulary	
<i>prednisolone 15 mg/5 ml soln</i>	Formulary	
<i>prednisolone 15 mg/5 ml soln</i>	Formulary	
<i>prednisolone 15 mg/5 ml soln cup outer</i>	Formulary	
<i>prednisolone 15 mg/5 ml soln d/f</i>	Formulary	
<i>prednisolone 15 mg/5 ml solution cup outer</i>	Formulary	
<i>prednisolone 20 mg/5 ml soln</i>	Formulary	
<i>prednisolone 5 mg tablet</i>	Formulary	
<i>prednisolone 5 mg/5 ml soln</i>	Formulary	
<i>prednisolone 5 mg/5 ml soln outer</i>	Formulary	
<i>prednisolone odt 10 mg tablet</i>	Formulary	
<i>prednisolone odt 15 mg tablet</i>	Formulary	
<i>prednisolone odt 30 mg tablet</i>	Formulary	
<i>prednisolone sod ph 25 mg/5 ml</i>	Formulary	
<i>prednisone 1 mg tablet</i>	Formulary	
<i>prednisone 10 mg tab dose pack</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>prednisone 10 mg tab dose pack dose pack</i>	Formulary	
<i>prednisone 10 mg tablet</i>	Formulary	
<i>prednisone 10 mg tablet outer</i>	Formulary	
<i>prednisone 2.5 mg tablet</i>	Formulary	
<i>prednisone 20 mg tablet</i>	Formulary	
<i>prednisone 20 mg tablet outer</i>	Formulary	
<i>prednisone 5 mg tab dose pack</i>	Formulary	
<i>prednisone 5 mg tab dose pack dose-pack</i>	Formulary	
<i>prednisone 5 mg tablet</i>	Formulary	
<i>prednisone 5 mg tablet outer</i>	Formulary	
<i>prednisone 5 mg/5 ml solution</i>	Formulary	
<i>prednisone 50 mg tablet</i>	Formulary	
<i>prednisone 50 mg tablet outer</i>	Formulary	
<i>prednisone 50 mg tablet u-d, 10x10</i>	Formulary	
PREDNISONE INTENSOL 5 MG/ML	Formulary	
RAYOS DR 1 MG TABLET	Formulary	
RAYOS DR 2 MG TABLET	Formulary	
RAYOS DR 5 MG TABLET	Formulary	
SOLU-CORTEF 1,000 MG ACT-O-VL	Formulary	
SOLU-CORTEF 100 MG ACT-O-VIAL INNER,SDV, P/F	Formulary	
SOLU-CORTEF 100 MG ACT-O-VIAL OUTER,25'S, SDV, P/F	Formulary	
SOLU-CORTEF 100 MG VIAL	Formulary	
SOLU-CORTEF 250 MG ACT-O-VIAL INNER,SDV, P/F	Formulary	
SOLU-CORTEF 250 MG ACT-O-VIAL OUTER,25'S, SDV, P/F	Formulary	
SOLU-CORTEF 500 MG ACT-O-VIAL	Formulary	
SOLU-MEDROL 1 GRAM VIAL	Formulary	
SOLU-MEDROL 1,000 MG VIAL	Formulary	
SOLU-MEDROL 125 MG VIAL P/F, SDV, OUTER	Formulary	
SOLU-MEDROL 125 MG VIAL SDV, ACTO- VIAL, P/F	Formulary	
SOLU-MEDROL 125 MG VIAL SDV, P/F, OUTER	Formulary	
SOLU-MEDROL 2,000 MG VIAL	Formulary	

Medications	Coverage Level	Restrictions
SOLU-MEDROL 40 MG VIAL P/F, SDV, OUTER	Formulary	
SOLU-MEDROL 40 MG VIAL SDV, ACTO-VIAL, P/F	Formulary	
SOLU-MEDROL 40 MG VIAL SDV, P/F, OUTER	Formulary	
SOLU-MEDROL 500 MG VIAL	Formulary	
SOLU-MEDROL 500 MG VIAL	Formulary	
TAPERDEX 12 DAY 1.5 MG TABLET	Formulary	
TAPERDEX 6 DAY 1.5 MG TABLET	Formulary	
TAPERDEX 7 DAY 1.5 MG TAB PACK	Formulary	
<i>triamcinolone acet 200 mg/5 ml inner, muv</i>	Formulary	
<i>triamcinolone acet 200 mg/5 ml mdv</i>	Formulary	
<i>triamcinolone acet 200 mg/5 ml muv</i>	Formulary	
<i>triamcinolone acet 200 mg/5 ml outer, muv</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl inner, suv</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl outer, suv</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl outer, suv</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl suv</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl suv, outer</i>	Formulary	
<i>triamcinolone acet 40 mg/ml vl suv, outer</i>	Formulary	
<i>triamcinolone acet 400 mg/10 ml inner, muv</i>	Formulary	
<i>triamcinolone acet 400 mg/10 ml mdv</i>	Formulary	
<i>triamcinolone acet 400 mg/10 ml muv</i>	Formulary	
<i>triamcinolone acet 400 mg/10 ml outer, muv</i>	Formulary	
Gonadotropin Inhibitor Pituitary Suppressants		
<i>danazol 100 mg capsule</i>	Formulary	
<i>danazol 200 mg capsule</i>	Formulary	
<i>danazol 50 mg capsule</i>	Formulary	
Growth Hormone Receptor Antagonists		
SOMAVERT	Non-Formulary	
Growth Hormone Releasing Hormones (Ghrh)		
EGRIFTA SV	Non-Formulary	
Growth Hormones		
GENOTROPIN 12 MG CARTRIDGE SINGLE USE	Formulary	PA; PDL Preferred

Medications	Coverage Level	Restrictions
GENOTROPIN 5 MG CARTRIDGE SINGLE USE	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 0.2 MG OUTER, P/F, SUV	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 0.4 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 0.6 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 0.8 MG P/F, SUV	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 1 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 1.2 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 1.4 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 1.6 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 1.8 MG	Formulary	PA; PDL Preferred
GENOTROPIN MINIQUICK 2 MG	Formulary	PA; PDL Preferred
HUMATROPE 12 MG CARTRIDGE W/DILUENT, SUV	Formulary	PA; PDL Non-Preferred
HUMATROPE 24 MG CARTRIDGE W/DILUENT, SUV	Formulary	PA; PDL Non-Preferred
HUMATROPE 6 MG CARTRIDGE W/DILUENT, SUV	Formulary	PA; PDL Non-Preferred
NGENLA PEN 24 MG/1.2 ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
NGENLA PEN 60 MG/1.2 ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
NORDITROPIN FLEXPRO 10 MG/1.5	Formulary	PA; PDL Preferred
NORDITROPIN FLEXPRO 15 MG/1.5	Formulary	PA; PDL Preferred
NORDITROPIN FLEXPRO 30 MG/3 ML	Formulary	PA; PDL Preferred
NORDITROPIN FLEXPRO 5 MG/1.5	Formulary	PA; PDL Preferred
NUTROPIN AQ NUSPIN 10 INJECTOR	Formulary	PA; PDL Non-Preferred
NUTROPIN AQ NUSPIN 20 INJECTOR	Formulary	PA; PDL Non-Preferred
NUTROPIN AQ NUSPIN 5 INJECTOR	Formulary	PA; PDL Non-Preferred
OMNITROPE 10 MG/1.5 ML CRTG SINGLE USE	Formulary	PA; PDL Non-Preferred
OMNITROPE 5 MG/1.5 ML CRTG SINGLE USE	Formulary	PA; PDL Non-Preferred
OMNITROPE 5.8 MG VIAL OUTER, SUV	Formulary	PA; PDL Non-Preferred
SEROSTIM 4 MG VIAL OUTER, W/1ML DIL,MDV	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
SEROSTIM 5 MG VIAL OUTER, W/1ML DIL,SDV	Formulary	PA; PDL Non-Preferred
SEROSTIM 6 MG VIAL OUTER, W/1ML DIL,SDV	Formulary	PA; PDL Non-Preferred
SKYTROFA 11 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 13.3 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 3 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 3.6 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 4.3 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 5.2 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 6.3 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 7.6 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SKYTROFA 9.1 MG CARTRIDGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)
SOGROYA 10 MG/1.5 ML PEN	Formulary	PA; PDL Non-Preferred
SOGROYA 15 MG/1.5 ML PEN	Formulary	PA; PDL Non-Preferred
SOGROYA 5 MG/1.5 ML PEN	Formulary	PA; PDL Non-Preferred
ZOMACTON 10 MG VIAL	Formulary	PA; PDL Non-Preferred
ZOMACTON 5 MG VIAL	Formulary	PA; PDL Non-Preferred
<i>Human Insulins - Fixed Combinations</i>		
HUMULIN 70/30 KWIKPEN INNER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
HUMULIN 70/30 KWIKPEN OUTER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
HUMULIN 70-30 VIAL	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
NOVOLIN 70-30 100 UNIT/ML VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
NOVOLIN 70-30 FLEXPEN OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN 70-30 FLEXPEN OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN 70-30 VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
<i>Human Insulins - Intermediate Acting</i>		
HUMULIN N 100 UNIT/ML KWIKPEN INNER, SINGLE USE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
HUMULIN N 100 UNIT/ML KWIKPEN OUTER, SINGLE USE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
HUMULIN N 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
NOVOLIN N 100 UNIT/ML FLEXPEN	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
NOVOLIN N 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN N 100 UNIT/ML	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN N 100 UNIT/ML FLEXPEN	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
<i>Human Insulins - Rapid Acting</i>		
AFREZZA ((REGULAR INSULIN) 8 UNIT CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AFREZZA (REGULAR INSULIN) 12 UNIT CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AFREZZA (REGULAR INSULIN) 4 UNIT CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AFREZZA (REGULAR INSULIN) 60-4 UNIT/60-8 UNIT/60-12 UNIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
AFREZZA (REGULAR INSULIN) 90-4 UNIT / 90-8 UNIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
AFREZZA (REGULAR INSULIN) 90-8 UNIT / 90-12 UNIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Human Insulins - Short Acting</i>		
HUMULIN R 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
HUMULIN R 500 UNIT/ML KWIKPEN OUTER,SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMULIN R 500 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
MYXREDLIN	Non-Formulary	
NOVOLIN R 100 UNIT/ML FLEXPEN SUV, OUTER	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
NOVOLIN R 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN R 100 UNIT/ML	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
RELION NOVOLIN R 100 UNIT/ML FLEXPEN SUV	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)
<i>Insulin Analogs - Fixed Combinations</i>		
HUMALOG MIX 50-50 KWIKPEN INNER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG MIX 50-50 KWIKPEN OUTER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG MIX 75-25 KWIKPEN INNER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG MIX 75-25 KWIKPEN OUTER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG MIX 75-25 VIAL	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
<i>insulin aspart protamine-insulin aspart mix 70-30 flexpen outer,suv</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin aspart protamine-insulin aspart mix 70-30 vial</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin lispro mix 75-25 kwkpn suv, outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
NOVOLOG MIX 70-30 FLEXPEN SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
NOVOLOG MIX 70-30 VIAL MUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
RELION NOVOLOG MIX 70-30 FLXPN SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
RELION NOVOLOG MIX 70-30 VIAL MDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>Insulin Analogs - Long Acting</i>		
BASAGLAR 100 UNIT/ML KWIKPEN INNER , SDV	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
BASAGLAR 100 UNIT/ML KWIKPEN OUTER, SDV	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
BASAGLAR TEMPO PEN 100 UNIT/ML OUTER, SUV	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin degludec 100 unit/ml vial</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin degludec flextouch 100 unit/ml pen suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin degludec flextouch 200 unit/ml pen suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin glargine max solo u300 outer, suv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
<i>insulin glargine solostar u300 outer, suv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin glargine-yfgn u100 pen outer, suv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin glargine-yfgn u100 vl</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LANTUS 100 UNIT/ML VIAL MUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LANTUS SOLOSTAR 100 UNIT/ML OUTER,SUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LEVEMIR 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LEVEMIR FLEXPEN 100 UNIT/ML OUTER, SUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
REZVOGLAR 100 UNIT/ML KWIKPEN OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
SEMGLEE (YFGN) 100 UNIT/ML PEN OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
SEMGLEE (YFGN) 100 UNIT/ML VL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
TOUJEO MAX SOLOSTR 300 UNIT/ML OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
TOUJEO SOLOSTAR 300 UNIT/ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
TRESIBA 100 UNIT/ML VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
TRESIBA FLEXTOUCH 100 UNIT/ML SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
TRESIBA FLEXTOUCH 200 UNIT/ML SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>Insulin Analogs - Rapid Acting</i>		
ADMELOG 100 UNIT/ML VIAL MDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
ADMELOG 100 UNIT/ML VIAL MUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
ADMELOG SOLOSTAR 100 UNIT/ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
APIDRA 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
APIDRA SOLOSTAR 100 UNIT/ML OUTER, SUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
FIASP 100 UNIT/ML FLEXTOUCH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
FIASP 100 UNIT/ML VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
FIASP PENFILL 100 UNIT/ML CART OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
FIASP PUMPCART 100 UNIT/ML SINGLE USE, OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
HUMALOG 100 UNIT/ML CARTRIDGE OUTER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG 100 UNIT/ML KWIKPEN INNER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG 100 UNIT/ML KWIKPEN OUTER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG 100 UNIT/ML VIAL	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
HUMALOG 200 UNIT/ML KWIKPEN INNER, SINGLE USE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG 200 UNIT/ML KWIKPEN OUTER, SINGLE USE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG JR 100 UNIT/ML KWIKPEN OUTER, SUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
HUMALOG TEMPO PEN 100 UNIT/ML OUTER, SUV	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin aspart 100 unit/ml vl</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin aspart flexpen 100 unit/ml pen outer,suv</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin aspart penfill 100 unit/ml cartridge outer,suv</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin lispro 100 unit/ml kwikpen suv, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin lispro 100 unit/ml vl</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>insulin lispro jr 100 unit/ml kwikpen suv, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LYUMJEV 100 UNIT/ML KWIKPEN OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LYUMJEV 100 UNIT/ML VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LYUMJEV 200 UNIT/ML KWIKPEN OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
LYUMJEV TEMPO PEN 100 UNIT/ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
NOVOLOG 100 UNIT/ML FLEXPEN SINGLE USE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
NOVOLOG 100 UNIT/ML VIAL MUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
NOVOLOG PENFILL 100 UNIT/ML	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
RELION NOVOLOG 100 UNIT/ML FLEXPEN OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
RELION NOVOLOG 100 UNIT/ML VL MDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
<i>Insulin Response Enhancers - Biguanides</i>		
GLUMETZA ER 1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
GLUMETZA ER 500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin er 1,000 mg gastr-tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin er 1,000 mg osm-tab</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin er 1,000 mg osm-tab f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin er 500 mg gastrc-tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin er 500 mg osmotic tb</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin hcl 1,000 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 1,000 mg tablet 12's, f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 1,000 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 1,000 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 1,000 mg tablet f/c,blackberry scent</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>metformin hcl 500 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 500 mg tablet f/c,blackberry scent</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 500 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 500 mg/5 ml soln</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin hcl 500 mg/5 ml solution cup outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin hcl 625 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin hcl 750 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>metformin hcl 850 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 850 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 850 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl 850 mg tablet f/c,blackberry scent</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl er 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl er 500 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl er 750 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>metformin hcl er 750 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
RIOMET 500 MG/5 ML SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Insulin Response Enhancers - Thiazolidinediones (Ppar-Gamma Agonists)</i>		
ACTOS 15 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACTOS 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACTOS 45 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>pioglitazone hcl 15 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pioglitazone hcl 15 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pioglitazone hcl 30 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>pioglitazone hcl 45 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Insulin-Like Growth Factor-1 (Igf-1)</i>		
INCRELEX 40 MG/4 ML VIAL	Formulary	PA
<i>Leptin Hormone Analogs</i>		
MYALEPT	State Carve Out	
<i>Lhrh (Gnrh) Agonist Analog Pit Suppres - Central Precocious Puberty</i>		
FENSOLVI	Non-Formulary	
LUPRON DEPOT-PED (3 MONTH)	Non-Formulary	
LUPRON DEPOT-PED INTRAMUSCULAR KIT	Non-Formulary	
TRIPTODUR	Non-Formulary	
<i>Lhrh (Gnrh) Agonist Analog Pituitary Suppressants</i>		
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	Non-Formulary	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	Non-Formulary	
SYNAREL	Non-Formulary	
<i>Lhrh (Gnrh) Antagonist, Estrogen And Progestin Combinations</i>		
MYFEMBREE 40 MG-1 MG-0.5 MG TB	Formulary	PA; PDL Preferred; QL (28 tablets per 28 days); Age Limit (Min 18 Years)
ORIAHNN 300-1-0.5 MG/300 MG CAPS	Formulary	PA; PDL Preferred; QL (56 capsules per 28 days); Age Limit (Min 18 Years)
<i>Lhrh (Gnrh) Antagonists</i>		
ORILISSA 150 MG TABLET	Formulary	PA; PDL Preferred; QL (28 tablets per 28 days); Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
ORILISSA 200 MG TABLET	Formulary	PA; PDL Preferred; QL (56 tablets per 28 days); Age Limit (Min 18 Years)
Menopausal Symptoms Suppressant - Hormonal Agents		
IMVEXXY MAINTENANCE PACK	Non-Formulary	
IMVEXXY STARTER PACK	Non-Formulary	
INTRAROSA	Non-Formulary	
Menopausal Symptoms Suppressant-Selective Estrogen Receptor Modulators		
OSPHENA	Non-Formulary	
Menopausal Symptoms Suppressant-Ssri Antidepressant Type		
BRISDELLE	State Carve Out	
<i>paroxetine mesylate(menop.sym)</i>	State Carve Out	
Mineralocorticoids		
<i>fludrocortisone 0.1 mg tablet</i>	Formulary	
<i>fludrocortisone 0.1 mg tablet outer</i>	Formulary	
Oxytocic - Ergot Alkaloids		
<i>methylergonovine 0.2 mg tablet</i>	Formulary	QL (28 tablets per 180 days); Age Limit (Min 12 Years)
<i>methylergonovine 0.2 mg tablet outer</i>	Formulary	QL (28 tablets per 180 days); Age Limit (Min 12 Years)
<i>methylergonovine injection</i>	Non-Formulary	
Parathyroid Hormones And Analogs		
YORVIPATH 168 MCG/0.56 ML PEN SUV, OUTER	Formulary	PA; QL (2 pens per 28 days); Age Limit (Min 18 Years)
YORVIPATH 294 MCG/0.98 ML PEN SUV, OUTER	Formulary	PA; QL (2 pens per 28 days); Age Limit (Min 18 Years)
YORVIPATH 420 MCG/1.4 ML PEN SUV, OUTER	Formulary	PA; QL (2 pens per 28 days); Age Limit (Min 18 Years)
Progestins		
GALLIFREY 5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
<i>medroxyprogesterone 10 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>medroxyprogesterone 10 mg tab outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>medroxyprogesterone 2.5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>medroxyprogesterone 5 mg tab</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>norethindrone 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>progesterone 100 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>progesterone 200 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>progesterone 500 mg/10 ml vial mdv, in sesame oil</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>progesterone 500 mg/10 ml vial mdv, sesame oil</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>progesterone 500 mg/10 ml vial muv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROMETRIUM 100 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROMETRIUM 200 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROVERA 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROVERA 2.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PROVERA 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists</i>		
<i>cabergoline 0.5 mg tablet</i>	Formulary	
<i>Selective Estrogen Receptor Modulators (Serms)</i>		
EVISTA 60 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>raloxifene hcl 60 mg tablet</i>	Formulary	PDL Preferred
<i>raloxifene hcl 60 mg tablet f/c</i>	Formulary	PDL Preferred
<i>raloxifene hcl 60 mg tablet outer</i>	Formulary	PDL Preferred
<i>Somatostatic Agents</i>		
<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i>	Non-Formulary	
MYCAPSSA	Non-Formulary	
<i>octreotide 1,000 mcg/5 ml vial mdv</i>	Formulary	PA
<i>octreotide 1,000 mcg/5 ml vial muv</i>	Formulary	PA
<i>octreotide 5,000 mcg/5 ml vial mdv</i>	Formulary	PA

Medications	Coverage Level	Restrictions
<i>octreotide 5,000 mcg/5 ml vial muv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl inner, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl outer, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl outer, suv, p/f</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl sdv, outer</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl suv, p/f</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial 10's, suv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial inner, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial outer, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial outer, p/f, suv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial suv, p/f</i>	Formulary	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	Non-Formulary	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	Non-Formulary	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 10 MG	Non-Formulary	
SIGNIFOR	Non-Formulary	
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 20 MG, 30 MG, 60 MG	Non-Formulary	
SOMATULINE DEPOT	Non-Formulary	
<i>Thyroid Hormones - Animal Source (Porcine)</i>		
ADTHYZA 120 MG TABLET	Formulary	
ADTHYZA 130 MG TABLET	Formulary	
ADTHYZA 15 MG TABLET	Formulary	
ADTHYZA 16.25 MG TABLET	Formulary	
ADTHYZA 30 MG TABLET	Formulary	
ADTHYZA 32.5 MG TABLET	Formulary	
ADTHYZA 60 MG TABLET	Formulary	
ADTHYZA 65 MG TABLET	Formulary	
ADTHYZA 90 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
ADTHYZA 97.5 MG TABLET	Formulary	
ARMOUR THYROID 120 MG TABLET	Formulary	
ARMOUR THYROID 15 MG TABLET	Formulary	
ARMOUR THYROID 180 MG TABLET	Formulary	
ARMOUR THYROID 240 MG TABLET	Formulary	
ARMOUR THYROID 30 MG TABLET	Formulary	
ARMOUR THYROID 300 MG TABLET	Formulary	
ARMOUR THYROID 60 MG TABLET	Formulary	
ARMOUR THYROID 90 MG TABLET	Formulary	
NIVA THYROID 120 MG TABLET	Formulary	
NIVA THYROID 15 MG TABLET	Formulary	
NIVA THYROID 30 MG TABLET	Formulary	
NIVA THYROID 60 MG TABLET	Formulary	
NIVA THYROID 90 MG TABLET	Formulary	
NP THYROID 120 MG TABLET	Formulary	
NP THYROID 15 MG TABLET	Formulary	
NP THYROID 30 MG TABLET	Formulary	
NP THYROID 60 MG TABLET	Formulary	
NP THYROID 90 MG TABLET	Formulary	
RENTHYROID 120 MG TABLET	Formulary	
RENTHYROID 15 MG TABLET	Formulary	
RENTHYROID 30 MG TABLET	Formulary	
RENTHYROID 60 MG TABLET	Formulary	
RENTHYROID 90 MG TABLET	Formulary	
<i>thyroid 120 mg tablet</i>	Formulary	
<i>thyroid 15 mg tablet</i>	Formulary	
<i>thyroid 30 mg tablet</i>	Formulary	
<i>thyroid 60 mg tablet</i>	Formulary	
<i>thyroid 90 mg tablet</i>	Formulary	
<i>Thyroid Hormones - Synthetic T3 (Triiodothyronine)</i>		
CYTOMEL 25 MCG TABLET	Formulary	
CYTOMEL 5 MCG TABLET	Formulary	
CYTOMEL 50 MCG TABLET	Formulary	
<i>liothyronine sod 25 mcg tab</i>	Formulary	
<i>liothyronine sod 5 mcg tab</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>liothyronine sod 50 mcg tab</i>	Formulary	
<i>Thyroid Hormones - Synthetic T4 (Thyroxine)</i>		
ERMEZA 150 MCG/5 ML SOLUTION	Formulary	
EUTHYROX 100 MCG TABLET	Formulary	
EUTHYROX 112 MCG TABLET	Formulary	
EUTHYROX 125 MCG TABLET	Formulary	
EUTHYROX 137 MCG TABLET	Formulary	
EUTHYROX 150 MCG TABLET	Formulary	
EUTHYROX 175 MCG TABLET	Formulary	
EUTHYROX 200 MCG TABLET	Formulary	
EUTHYROX 25 MCG TABLET	Formulary	
EUTHYROX 50 MCG TABLET	Formulary	
EUTHYROX 75 MCG TABLET	Formulary	
EUTHYROX 88 MCG TABLET	Formulary	
LEVO-T 100 MCG TABLET	Formulary	
LEVO-T 112 MCG TABLET	Formulary	
LEVO-T 125 MCG TABLET	Formulary	
LEVO-T 137 MCG TABLET	Formulary	
LEVO-T 150 MCG TABLET	Formulary	
LEVO-T 175 MCG TABLET	Formulary	
LEVO-T 200 MCG TABLET	Formulary	
LEVO-T 25 MCG TABLET	Formulary	
LEVO-T 300 MCG TABLET	Formulary	
LEVO-T 50 MCG TABLET	Formulary	
LEVO-T 75 MCG TABLET	Formulary	
LEVO-T 88 MCG TABLET	Formulary	
<i>levothyroxine 100 mcg capsule</i>	Formulary	
<i>levothyroxine 100 mcg tablet</i>	Formulary	
<i>levothyroxine 100 mcg tablet outer</i>	Formulary	
<i>levothyroxine 100 mcg tablet u-d,outer,10x10</i>	Formulary	
<i>levothyroxine 112 mcg capsule</i>	Formulary	
<i>levothyroxine 112 mcg tablet</i>	Formulary	
<i>levothyroxine 112 mcg tablet outer</i>	Formulary	
<i>levothyroxine 125 mcg capsule</i>	Formulary	
<i>levothyroxine 125 mcg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>levothyroxine 125 mcg tablet outer</i>	Formulary	
<i>levothyroxine 125 mcg tablet u-d,outer,10x10</i>	Formulary	
<i>levothyroxine 13 mcg capsule</i>	Formulary	
<i>levothyroxine 137 mcg capsule</i>	Formulary	
<i>levothyroxine 137 mcg tablet</i>	Formulary	
<i>levothyroxine 137 mcg tablet outer</i>	Formulary	
<i>levothyroxine 150 mcg capsule</i>	Formulary	
<i>levothyroxine 150 mcg tablet</i>	Formulary	
<i>levothyroxine 150 mcg tablet outer</i>	Formulary	
<i>levothyroxine 150 mcg tablet u-d,10x10,outer</i>	Formulary	
<i>levothyroxine 175 mcg capsule</i>	Formulary	
<i>levothyroxine 175 mcg tablet</i>	Formulary	
<i>levothyroxine 175 mcg tablet outer</i>	Formulary	
<i>levothyroxine 200 mcg capsule</i>	Formulary	
<i>levothyroxine 200 mcg tablet</i>	Formulary	
<i>levothyroxine 200 mcg tablet outer</i>	Formulary	
<i>levothyroxine 25 mcg capsule</i>	Formulary	
<i>levothyroxine 25 mcg tablet</i>	Formulary	
<i>levothyroxine 25 mcg tablet outer</i>	Formulary	
<i>levothyroxine 25 mcg tablet u-d,10x10,outer</i>	Formulary	
<i>levothyroxine 300 mcg tablet</i>	Formulary	
<i>levothyroxine 50 mcg capsule</i>	Formulary	
<i>levothyroxine 50 mcg tablet</i>	Formulary	
<i>levothyroxine 50 mcg tablet outer</i>	Formulary	
<i>levothyroxine 50 mcg tablet u-d,outer,10x10</i>	Formulary	
<i>levothyroxine 75 mcg capsule</i>	Formulary	
<i>levothyroxine 75 mcg tablet</i>	Formulary	
<i>levothyroxine 75 mcg tablet outer</i>	Formulary	
<i>levothyroxine 75 mcg tablet u-d,outer,10x10</i>	Formulary	
<i>levothyroxine 88 mcg capsule</i>	Formulary	
<i>levothyroxine 88 mcg tablet</i>	Formulary	
<i>levothyroxine 88 mcg tablet outer</i>	Formulary	
LEVOXYL 100 MCG TABLET	Formulary	
LEVOXYL 112 MCG TABLET	Formulary	
LEVOXYL 125 MCG TABLET	Formulary	
LEVOXYL 137 MCG TABLET	Formulary	

Medications	Coverage Level	Restrictions
LEVOXYL 150 MCG TABLET	Formulary	
LEVOXYL 175 MCG TABLET	Formulary	
LEVOXYL 200 MCG TABLET	Formulary	
LEVOXYL 25 MCG TABLET	Formulary	
LEVOXYL 50 MCG TABLET	Formulary	
LEVOXYL 75 MCG TABLET	Formulary	
LEVOXYL 88 MCG TABLET	Formulary	
SYNTHROID 100 MCG TABLET	Formulary	
SYNTHROID 100 MCG TABLET U-D	Formulary	
SYNTHROID 112 MCG TABLET	Formulary	
SYNTHROID 125 MCG TABLET	Formulary	
SYNTHROID 125 MCG TABLET U-D	Formulary	
SYNTHROID 137 MCG TABLET	Formulary	
SYNTHROID 150 MCG TABLET	Formulary	
SYNTHROID 150 MCG TABLET U-D	Formulary	
SYNTHROID 175 MCG TABLET	Formulary	
SYNTHROID 200 MCG TABLET	Formulary	
SYNTHROID 25 MCG TABLET	Formulary	
SYNTHROID 300 MCG TABLET	Formulary	
SYNTHROID 50 MCG TABLET	Formulary	
SYNTHROID 50 MCG TABLET U-D	Formulary	
SYNTHROID 75 MCG TABLET	Formulary	
SYNTHROID 75 MCG TABLET U-D	Formulary	
SYNTHROID 88 MCG TABLET	Formulary	
THYQUIDITY 100 MCG/5 ML SOLN OUTER	Formulary	
UNITHROID 100 MCG TABLET	Formulary	
UNITHROID 112 MCG TABLET	Formulary	
UNITHROID 125 MCG TABLET	Formulary	
UNITHROID 137 MCG TABLET	Formulary	
UNITHROID 150 MCG TABLET	Formulary	
UNITHROID 175 MCG TABLET	Formulary	
UNITHROID 200 MCG TABLET	Formulary	
UNITHROID 25 MCG TABLET	Formulary	
UNITHROID 300 MCG TABLET	Formulary	
UNITHROID 50 MCG TABLET	Formulary	
UNITHROID 75 MCG TABLET	Formulary	

Medications	Coverage Level	Restrictions
UNITHROID 88 MCG TABLET	Formulary	
Gastrointestinal Therapy Agents		
<i>Agents To Treat Chapple Disease</i>		
VEOPOZ	State Carve Out	
Antacid - Aluminum		
<i>aluminum hydroxide gel</i>	Formulary	Dual Eligible Covered; OTC
Antacid - Antacid Combinations		
ACID GONE ANTACID LIQUID	Formulary	Dual Eligible Covered; OTC
GAVISCON EXTRA STRENGTH ORAL SUSPENSION	Non-Formulary	OTC
GAVISCON LIQUID	Formulary	OTC
HEARTBURN RELIEF ORAL SUSPENSION	Non-Formulary	OTC
MAG-AL	Non-Formulary	OTC
Antacid - Bicarbonate		
<i>sodium bicarb 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
<i>sodium bicarb 650 mg tablet</i>	Formulary	OTC
<i>sodium bicarb 650 mg tablet 10 gr</i>	Formulary	Dual Eligible Covered; OTC
Antacid - Calcium		
ANTACID 500 MG CHEW TABLET ASST FRUIT FLAVORED	Formulary	Dual Eligible Covered; OTC
ANTACID 500 MG CHEWABLE TABLET OUTER	Formulary	Dual Eligible Covered; OTC
ANTACID 750 MG CHEWABLE TABLET	Formulary	Dual Eligible Covered; OTC
ANTACID EX-STR 750 MG TAB CHEW	Formulary	OTC
ANTACID EX-STR 750 MG TAB CHEW	Formulary	Dual Eligible Covered; OTC
ANTACID ULTRA STR 1,000 MG CHW	Formulary	Dual Eligible Covered; OTC
ANTACID XTRA STRENGTH CHEW TAB EXTRA STRENGTH	Formulary	Dual Eligible Covered; OTC
CALCIUM ANTACID 500 MG CHW TAB ASSORTED FRUIT	Formulary	Dual Eligible Covered; OTC
CALCIUM ANTACID 500 MG CHW TAB GLUTEN-F, PEPPERMINT	Formulary	Dual Eligible Covered; OTC
CALCIUM ANTACID 750 MG CHEW TAB	Formulary	Dual Eligible Covered; OTC
<i>calcium carb 1,250 mg/5 ml sus n (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>calcium carbonate 1,250 mg/5 ml suspension cup 40's,u-d (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>calcium carbonate oral tablet 260 mg calcium (648 mg)</i>	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
CAL-GEST 500 MG TABLET CHEW	Formulary	Dual Eligible Covered; OTC
FT ANTACID 500 MG CHEW TABLET	Formulary	OTC
FT ANTACID EX-STR 750 MG CHEW	Formulary	OTC
GNP ANTACID EX-STR 750 MG CHEW	Formulary	Dual Eligible Covered; OTC
HM ANTACID 500 MG CHEW TABLET	Formulary	OTC
HM CAL ANTACID 750 MG CHEW TAB EX-STR, ORANGE	Formulary	Dual Eligible Covered; OTC
SM ANTACID 500 MG CHEW TABLET	Formulary	OTC
SM ANTACID 500 MG CHEW TABLET	Formulary	Dual Eligible Covered; OTC
SM ANTACID 750 MG CHEW TABLET	Formulary	Dual Eligible Covered; OTC
SMOOTH ANTACID 750 MG CHEW TAB	Formulary	OTC
<i>Antacid - Magnesium</i>		
<i>magnesium oxide 400 mg tablet (otc)</i>	Non-Formulary	CSHCS Covered; OTC
<i>magnesium oxide 400 mg tablet (otc)</i>	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
<i>magnesium oxide 400 mg tablet (rx)</i>	Formulary	OTC
<i>magnesium oxide 400 mg tablet (rx)</i>	Non-Formulary	CSHCS Covered; OTC
<i>magnesium oxide 400 mg tablet inner (rx)</i>	Formulary	OTC
<i>magnesium oxide 400 mg tablet outer (rx)</i>	Formulary	OTC
<i>true magnesium oxide 400 mg tb (rx)</i>	Formulary	OTC
<i>well magnesium oxide 400 mg tb (rx)</i>	Formulary	OTC
<i>Antacid - Simethicone Combinations</i>		
ALMACONE-2 LIQUID	Formulary	Dual Eligible Covered; OTC
<i>alum-mag hydroxide-simeth 1,200-1,200-120 mg/30 ml cup outer</i>	Formulary	OTC
<i>alum-mag hydroxide-simeth 2,400-2,400-240 mg/30 ml cup outer</i>	Formulary	OTC
<i>alum-mag hydroxide-simeth cup outer</i>	Formulary	OTC
ANTACID ANTI-GAS LIQUID	Formulary	Dual Eligible Covered; OTC
ANTACID ANTI-GAS MAX STR LIQ	Formulary	Dual Eligible Covered; OTC
ANTACID LIQUID	Formulary	Dual Eligible Covered; OTC
ANTACID-ANTIGAS LIQUID	Formulary	Dual Eligible Covered; OTC
ANTACID-ANTIGAS SUSPENSION	Formulary	Dual Eligible Covered; OTC
FT ANTACID-ANTIGAS LIQUID	Formulary	OTC
FT ANTACID-ANTIGAS MAX STR	Formulary	OTC
HM ANTACID ANTI-GAS SUSPENSION ORIGINAL, MAX STR	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
HM ANTACID-ANTIGAS SUSPENSION	Formulary	Dual Eligible Covered; OTC
MAG-AL PLUS SUSPENS 30 ML CUP 100'S,U-D,10X10	Formulary	Dual Eligible Covered; OTC
MAG-AL PLUS SUSPENS 30 ML CUP OUTER	Formulary	OTC
MAG-AL PLUS XS SUSP 30 ML CUP	Formulary	Dual Eligible Covered; OTC
MINTOX MAXIMUM STRENGTH SUSP MAX STR, LEMON CREME	Formulary	Dual Eligible Covered; OTC
SM ADV ANTACID-ANTIGAS LIQUID	Formulary	Dual Eligible Covered; OTC
SM ADV ANTACID-ANTIGAS SUSP MAX STRENGTH, CHERRY	Formulary	Dual Eligible Covered; OTC
SM ANTACID MAX STRENGTH SUSP ORIGINAL	Formulary	Dual Eligible Covered; OTC
SM ANTACID-ANTIGAS LIQUID	Formulary	Dual Eligible Covered; OTC
Antidiarrheal - Antiperistaltic Agents		
ANTI-DIARRHEAL 1 MG/7.5 ML SOL	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ANTI-DIARRHEAL 2 MG CAPLET	Formulary	PDL Preferred; OTC
ANTI-DIARRHEAL 2 MG CAPLET CAPLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ANTI-DIARRHEAL 2 MG SOFTGEL	Formulary	PDL Preferred; Dual Eligible Covered; OTC
FT ANTI-DIARRHEAL 1 MG/7.5 ML	Formulary	PDL Preferred; OTC
FT ANTI-DIARRHEAL 2 MG CAPLET	Formulary	PDL Preferred; OTC
FT ANTI-DIARRHEAL 2 MG SOFTGEL	Formulary	PDL Preferred; OTC
GNP ANTI-DIARRHEAL 2 MG TABLET	Formulary	PDL Preferred; OTC
GS ANTI-DIARRHEAL 1 MG/7.5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ANTI-DIARRHEAL 2 MG CAPLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loperamide 1 mg/7.5 ml soln</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loperamide 1 mg/7.5 ml solution cup inner</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loperamide 1 mg/7.5 ml solution cup outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loperamide 2 mg capsule (rx)</i>	Formulary	PDL Preferred
<i>loperamide 2 mg capsule (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered
<i>loperamide 2 mg capsule outer (rx)</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>loperamide 2 mg capsule outer (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered
<i>loperamide 2 mg capsule u-d,10x10,outer (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered
<i>loperamide 2 mg/15 ml solution cup inner</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loperamide 2 mg/15 ml solution cup outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>opium tincture</i>	Non-Formulary	
SM ANTI-DIARRHEAL 1 MG/7.5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM ANTI-DIARRHEAL 2 MG CAPLET CAPLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM ANTI-DIARRHEAL 2 MG SOFTGEL	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>Antidiarrheal - Bismuth Agents</i>		
<i>bismuth 262 mg tablet chew</i>	Formulary	OTC
FT STOMACH RELIEF 525 MG/30 ML	Formulary	OTC
FT STOMACH RLF 262 MG CAPLET	Formulary	OTC
FT STOMACH RLF 262 MG CHEW TAB	Formulary	OTC
GNP PINK BISMUTH 262 MG TB CHW	Formulary	OTC
GNP PINK BISMUTH 525 MG/15 ML	Formulary	OTC
GNP STOMACH RLF 525 MG/30 ML	Formulary	Dual Eligible Covered; OTC
HM STOMACH RLF 262 MG CHEW TAB	Formulary	Dual Eligible Covered; OTC
KAOPECTATE 262 MG/15 ML SUSP	Formulary	Dual Eligible Covered; OTC
PINK BISMUTH 262 MG TAB CHEW	Formulary	Dual Eligible Covered; OTC
PINK BISMUTH CAPLET	Formulary	Dual Eligible Covered; OTC
SM STOMACH RLF 262 MG CAPLET	Formulary	Dual Eligible Covered; OTC
SM STOMACH RLF 262 MG CHEW TAB	Formulary	Dual Eligible Covered; OTC
STOMACH RELIEF 262 MG CAPLET	Formulary	OTC
STOMACH RELIEF 262 MG CHEW TAB	Formulary	Dual Eligible Covered; OTC
STOMACH RELIEF 525 MG/15 ML	Formulary	Dual Eligible Covered; OTC
STOMACH RLF 525 MG/30 ML SUSP	Formulary	Dual Eligible Covered; OTC
<i>Antidiarrheal - Gastrointestinal Chloride Channel Inhibitors</i>		
MYTESI	Non-Formulary	

Medications	Coverage Level	Restrictions
Antidiarrheal Antiperistaltic-Anticholinergic Combinations		
<i>diphenoxylate-atropine 2.5-0.025 mg tablet</i>	Formulary	PDL Preferred
<i>diphenoxylate-atropine 2.5-0.025 mg/5 ml liquid w/dropper</i>	Formulary	PDL Preferred
LOMOTIL 2.5-0.025 MG TABLET	Formulary	
MOTOFEN	Non-Formulary	
Antidiarrheal Antiperistaltic-Antiflatulent Combinations		
ANTI-DIARRHEAL (LOPE)-ANTI-GAS	Non-Formulary	OTC
<i>loperamide-simethicone</i>	Non-Formulary	OTC
Antidiarrheal Opioid Agents		
<i>opium tincture</i>	Non-Formulary	
Antiemetic - Anticholinergics		
<i>scopolamine base</i>	Non-Formulary	
TRANSDERM-SCOP	Non-Formulary	
Antiemetic - Antihistamines		
ANTIVERT ORAL TABLET 50 MG	Non-Formulary	
ANTIVERT ORAL TABLET,CHEWABLE	Non-Formulary	
<i>dimenhydrinate injection solution</i>	Non-Formulary	
FT MOTION SICKNESS 25 MG TAB	Formulary	OTC
<i>meclizine 12.5 mg caplet (otc)</i>	Formulary	OTC
<i>meclizine 12.5 mg tablet (otc)</i>	Formulary	OTC
<i>meclizine 12.5 mg tablet (rx)</i>	Formulary	OTC
<i>meclizine 12.5 mg tablet outer (rx)</i>	Formulary	OTC
<i>meclizine 25 mg tablet (rx)</i>	Formulary	OTC
<i>meclizine 25 mg tablet chew</i>	Formulary	OTC
<i>meclizine 25 mg tablet chew raspberry</i>	Formulary	OTC
<i>meclizine 25 mg tablet outer (rx)</i>	Formulary	OTC
<i>meclizine oral tablet 50 mg</i>	Non-Formulary	
MOTION SICKNESS RLF 25 MG TAB	Formulary	OTC
MOTION-TIME 25 MG TABLET CHEW	Formulary	OTC
SM MOTION SICKNESS 25 MG TAB	Formulary	OTC
Antiemetic - Antihistamine-Vitamin Combinations		
BONJESTA	Non-Formulary	
DICLEGIS	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>doxylamine-pyridoxine (vit b6)</i>	Non-Formulary	
Antiemetic - Cannabinoid Type		
<i>dronabinol 10 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule outer</i>	Formulary	PA
<i>dronabinol 5 mg capsule</i>	Formulary	PA
<i>dronabinol 5 mg capsule outer</i>	Formulary	PA
MARINOL	Non-Formulary	
Antiemetic - Dopamine (D2) Antagonists		
<i>droperidol injection solution</i>	State Carve Out	
Antiemetic - Dopamine (D2)/5-Ht3 Antagonists		
TIGAN ORAL CAPSULE 300 MG	Non-Formulary	
<i>trimethobenzamide oral</i>	Non-Formulary	
Antiemetic - Phenothiazines		
COMPRO	Non-Formulary	
PHENERGAN INJECTION	Non-Formulary	
<i>prochlorperazine 10 mg tab</i>	Formulary	
<i>prochlorperazine 10 mg tab f/c</i>	Formulary	
<i>prochlorperazine 10 mg tab outer</i>	Formulary	
<i>prochlorperazine 25 mg supp</i>	Formulary	QL (2 suppositories per 1 day)
<i>prochlorperazine 25 mg supp outer</i>	Formulary	QL (2 suppositories per 1 day)
<i>prochlorperazine 5 mg tablet</i>	Formulary	
<i>prochlorperazine 5 mg tablet f/c</i>	Formulary	
<i>prochlorperazine 5 mg tablet outer</i>	Formulary	
<i>prochlorperazine edisylate injection solution 5 mg/ml</i>	Non-Formulary	
<i>promethazine 12.5 mg suppos</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg suppos outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
<i>promethazine 25 mg suppository inner</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg suppository outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet outer</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 6.25 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 6.25 mg/5 ml solution cup outer</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 6.25 mg/5 ml syrup</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine injection solution</i>	Non-Formulary	
PROMETHEGAN 12.5 MG SUPPOS OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 25 MG SUPPOSITORY OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY INNER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY OUTER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>Antiemetic - Selective Serotonin 5-Ht3 Antagonists</i>		
ANZEMET 50 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (10 tablets per 1 claim)
<i>granisetron (pf) intravenous solution 100 mcg/ml</i>	Non-Formulary	
<i>granisetron hcl 1 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>granisetron hcl 1 mg tablet flc, 2x10, outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
<i>granisetron hcl 1 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>granisetron hcl 1 mg tablet u-d, f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>granisetron hcl intravenous</i>	Non-Formulary	
<i>ondansetron 4 mg/5 ml soln cup outer</i>	Formulary	PDL Preferred; QL (75 ML per 1 claim)
<i>ondansetron 4 mg/5 ml solution</i>	Formulary	PDL Preferred; QL (75 mL per 1 claim)
<i>ondansetron 4 mg/5 ml solution cup inner</i>	Formulary	PDL Preferred; QL (75 mL per 1 claim)
<i>ondansetron 4 mg/5 ml solution cup outer</i>	Formulary	PDL Preferred; QL (75 mL per 1 claim)
<i>ondansetron hcl (pf) injection solution</i>	Non-Formulary	
<i>ondansetron hcl 4 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 4 mg tablet f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 4 mg tablet f/c, 1x3, u-d</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 4 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 8 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 8 mg tablet f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 8 mg tablet f/c, 1x3, u-d</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl 8 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron hcl intravenous</i>	Non-Formulary	
<i>ondansetron odt 16 mg tablet</i>	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)
<i>ondansetron odt 4 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 4 mg tablet 3x10</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 4 mg tablet 3x10, outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 4 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
<i>ondansetron odt 8 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 8 mg tablet 3x10</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 8 mg tablet 3x10, outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 8 mg tablet inner</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>ondansetron odt 8 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>palonosetron intravenous solution 0.25 mg/2 ml</i>	Non-Formulary	
SANCUSO 3.1 MG/24 HR PATCH	Formulary	PA; PDL Non-Preferred; QL (0.2 EA per 1 day)
SUSTOL	Non-Formulary	
Antiemetic - Substance P-Neurokinin 1 (Nk1) Receptor Antagonists		
<i>aprepitant 125 mg capsule outer</i>	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
<i>aprepitant 125-80-80 mg pack</i>	Formulary	PA; PDL Non-Preferred; QL (3 capsules per 1 claim); Age Limit (Min 12 Years)
<i>aprepitant 40 mg capsule inner</i>	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
<i>aprepitant 40 mg capsule outer</i>	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
<i>aprepitant 80 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 claim); Age Limit (Min 12 Years)
<i>aprepitant 80 mg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 claim); Age Limit (Min 12 Years)
EMEND 125 MG POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
EMEND 80 MG CAPSULE BI-FOLD PACK, U-U	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 claim); Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
EMEND TRIPACK	Formulary	PA; PDL Non-Preferred; QL (3 capsules per 1 claim); Age Limit (Min 12 Years)
<i>Antiemetic - Substance P-Neurokinin 1 And 5-Ht3 Recept Antagonist Comb</i>		
AKYNZEO 300-0.5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (1 capsule per 1 claim)
<i>Bile Acids</i>		
CHOLBAM	Non-Formulary	
<i>Chronic Idiopathic Const. Agents - Guanylate Cyclase-C (Gc-C) Agonists</i>		
LINZESS 145 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)
LINZESS 290 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)
LINZESS 72 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)
TRULANCE 3 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Colonic Acidifier (Ammonia Inhibitor)</i>		
ENULOSE	State Carve Out	
GENERLAC	State Carve Out	
<i>lactulose 10 gm/15 ml solution</i>	Formulary	
<i>lactulose 10 gm/15 ml solution</i>	State Carve Out	
<i>Digestive Enzyme Mixtures</i>		
CREON DR 12,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
CREON DR 24,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
CREON DR 3,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
CREON DR 36,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
CREON DR 6,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
DIGESTIVE ENZYME (ACIDOPH,PEC)	State Carve Out	
GASTRACID	State Carve Out	

Medications	Coverage Level	Restrictions
PERTZYE DR 16,000 UNIT CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PERTZYE DR 24,000 UNIT CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PERTZYE DR 4,000 UNIT CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PERTZYE DR 8,000 UNIT CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SUPERIOR DIGESTIVE ENZYME	State Carve Out	
VIOKACE 10,440-39,150 UNIT TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VIOKACE 20,880-78,300 UNITS TB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZENPEP DR 10,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 15,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 20,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 25,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 3,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 40,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 5,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
ZENPEP DR 60,000 UNIT CAPSULE	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>Digestive Enzymes</i>		
DAIRY AID	State Carve Out	
DAIRY DIGESTIVE ORAL TABLET	State Carve Out	
DAIRY RELIEF ORAL TABLET 3,000 UNIT, 9,000 UNIT	State Carve Out	
DAIRY RELIEF ORAL TABLET,CHEWABLE	State Carve Out	
DAIRY-AID	State Carve Out	
DIGESTIVE ENZYMES(MAL,LAC,INV)	State Carve Out	
ENZYME DIGEST	State Carve Out	
LACTAID	State Carve Out	

Medications	Coverage Level	Restrictions
LACTAID FAST ACT	State Carve Out	
<i>lactase</i>	State Carve Out	
LACTASE FAST ACTING ORAL TABLET	State Carve Out	
LACTOSE FAST ACTING RELIEF	State Carve Out	
SUCRAID	State Carve Out	
XYMOZYME	State Carve Out	
<i>Gallstone Solubilizing (Litholysis) Agents</i>		
CHENODAL	Non-Formulary	
RELTONE 200 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RELTONE 400 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
URSO FORTE 500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ursodiol 250 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ursodiol 250 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ursodiol 250 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ursodiol 300 mg capsule</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ursodiol 300 mg capsule outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ursodiol 500 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>Gastric Acid Secretion Reducer - Histamine H2-Receptor Antagonists</i>		
ACID REDUCER 10 MG TABLET	Formulary	Dual Eligible Covered; OTC
ACID REDUCER 20 MG TABLET	Formulary	OTC
ACID REDUCER 20 MG TABLET	Formulary	Dual Eligible Covered; OTC
ACID REDUCER 20 MG TABLET MAXIMUM STRENGTH	Formulary	Dual Eligible Covered; OTC
ACID REDUCER 20 MG TABLET MAX-STR	Formulary	Dual Eligible Covered; OTC
<i>cimetidine 200 mg tablet (rx)</i>	Formulary	OTC
<i>cimetidine 200 mg tablet (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>cimetidine 300 mg tablet</i>	Formulary	
<i>cimetidine 300 mg/5 ml cup outer</i>	Formulary	
<i>cimetidine 300 mg/5 ml soln</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>cimetidine 400 mg tablet</i>	Formulary	
<i>cimetidine 800 mg tablet</i>	Formulary	
<i>cimetidine 800 mg tablet f/c</i>	Formulary	
<i>famotidine 10 mg tablet</i>	Formulary	OTC
<i>famotidine 10 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 20 mg tablet (otc)</i>	Formulary	OTC
<i>famotidine 20 mg tablet (otc)</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 20 mg tablet (rx)</i>	Formulary	OTC
<i>famotidine 20 mg tablet (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 20 mg tablet 12's (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 20 mg tablet f/c (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 20 mg tablet inner (otc)</i>	Formulary	OTC
<i>famotidine 20 mg tablet outer (otc)</i>	Formulary	OTC
<i>famotidine 20 mg tablet outer (rx)</i>	Formulary	OTC
<i>famotidine 20 mg tablet outer (rx)</i>	Formulary	Dual Eligible Covered; OTC
<i>famotidine 40 mg tablet</i>	Formulary	
<i>famotidine 40 mg tablet</i>	Formulary	Dual Eligible Covered
<i>famotidine 40 mg tablet f/c</i>	Formulary	
<i>famotidine 40 mg tablet outer</i>	Formulary	
<i>famotidine 40 mg/5 ml susp</i>	Formulary	QL (5 ML per 1 day); Age Limit (Max 6 Years)
<i>famotidine intravenous</i>	Non-Formulary	
FT ACID REDUCER 10 MG TABLET	Formulary	OTC
FT ACID REDUCER 20 MG TABLET	Formulary	OTC
GNP ACID REDUCER 10 MG TABLET	Formulary	OTC
GNP ACID REDUCER 20 MG TABLET	Formulary	OTC
GS ACID REDUCER 10 MG TABLET	Formulary	Dual Eligible Covered; OTC
GS ACID REDUCER 20 MG TABLET	Formulary	Dual Eligible Covered; OTC
HEARTBURN RELIEF 10 MG TABLET	Formulary	Dual Eligible Covered; OTC
HEARTBURN RELIEF 20 MG TABLET	Formulary	Dual Eligible Covered; OTC
<i>nizatidine oral capsule</i>	Non-Formulary	
PEPCID ORAL TABLET 20 MG	Non-Formulary	Dual Eligible Covered
PEPCID ORAL TABLET 40 MG	Non-Formulary	
SM ACID REDUCER 10 MG TABLET	Formulary	Dual Eligible Covered; OTC
SM ACID REDUCER 20 MG TABLET	Formulary	Dual Eligible Covered; OTC
SM ACID REDUCER 20 MG TABLET MAXIMUM STRENGTH	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
Gastric Acid Secretion Reducer - Potassium-Competitive Acid Blockers		
VOQUEZNA 10 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
VOQUEZNA 20 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
Gastric Acid Secretion Reducer - Proton Pump Inhibitors (Ppis)		
ACID REDUCER DR 20 MG CAP	Formulary	PA; PDL Non-Preferred; OTC
DEXILANT DR 30 MG CAPSULE	Formulary	PA; PDL Non-Preferred
DEXILANT DR 60 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>dexlansoprazole dr 30 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>dexlansoprazole dr 60 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>esomeprazole dr 10 mg packet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 2.5 mg packet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 20 mg packet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 20 mg packet outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 40 mg packet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 40 mg packet outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole dr 5 mg packet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>esomeprazole mag dr 20 mg cap (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>esomeprazole mag dr 20 mg cap (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>esomeprazole mag dr 20 mg cap outer (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>esomeprazole mag dr 20 mg tab</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>esomeprazole mag dr 40 mg cap</i>	Formulary	PA; PDL Non-Preferred
FT ACID REDUCER DR 15 MG CAP	Formulary	PA; PDL Non-Preferred; OTC

Medications	Coverage Level	Restrictions
FT ACID REDUCER DR 20 MG CAP	Formulary	PA; PDL Non-Preferred; OTC
<i>ft omeprazole dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp esomeprazole mag dr 20 mg (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp lansoprazole dr 15 mg cap (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp omeprazole dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp omeprazole mag dr 20 mg cp</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gs esomeprazole mag dr 20 mg (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gs lansoprazole dr 15 mg cap (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gs lansoprazole dr 15 mg cap (otc)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>gs lansoprazole dr 15 mg odt (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gs omeprazole dr 20 mg odt</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>gs omeprazole dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>gs omeprazole dr 20 mg tablet 14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>hm esomeprazole mag dr 20 mg (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>lansoprazole dr 15 mg capsule (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>lansoprazole dr 15 mg capsule (otc)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>lansoprazole dr 15 mg capsule (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>lansoprazole dr 15 mg capsule (rx)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>lansoprazole dr 15 mg capsule outer (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>lansoprazole dr 15 mg capsule outer (rx)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>lansoprazole dr 15 mg odt outer (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>lansoprazole dr 30 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>lansoprazole dr 30 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred
<i>lansoprazole dr 30 mg capsule u-d, 10x10</i>	Formulary	PA; PDL Non-Preferred
<i>lansoprazole dr 30 mg capsule u-d, 8x10, outer</i>	Formulary	PA; PDL Non-Preferred
<i>lansoprazole dr 30 mg odt outer</i>	Formulary	PA; PDL Non-Preferred
NEXIUM DR 10 MG PACKET	Formulary	PDL Preferred; QL (2 packets per 1 day)
NEXIUM DR 2.5 MG PACKET	Formulary	PDL Preferred; QL (2 packets per 1 day)
NEXIUM DR 20 MG CAPSULE DELAYED-RELEASE	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
NEXIUM DR 20 MG PACKET	Formulary	PDL Preferred; QL (2 packets per 1 day)
NEXIUM DR 40 MG CAPSULE DELAYED-RELEASE	Formulary	PA; PDL Non-Preferred
NEXIUM DR 40 MG PACKET	Formulary	PDL Preferred; QL (2 packets per 1 day)
NEXIUM DR 5 MG PACKET	Formulary	PDL Preferred; QL (2 packets per 1 day)
<i>omeprazole dr 10 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 20 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 20 mg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 20 mg capsule u-d</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 20 mg capsule u-d,10x10,outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 20 mg odt</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>omeprazole dr 20 mg tablet 1x14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>omeprazole dr 20 mg tablet 2x14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>omeprazole dr 20 mg tablet 3x14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>omeprazole dr 20 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole dr 40 mg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 40 mg capsule never launched</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole dr 40 mg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day)
<i>omeprazole mag dr 20 mg cap</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole mag dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole mag dr 20 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole mag dr 20.6 mg cap one 14-day course</i>	Formulary	PA; PDL Non-Preferred; OTC

Medications	Coverage Level	Restrictions
<i>omeprazole mag dr 20.6 mg cap three 14-day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>omeprazole mag dr 20.6 mg cap two 14-day course</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>pantoprazole dr 40 mg susp pkt inner</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>pantoprazole dr 40 mg susp pkt outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
<i>pantoprazole in 0.9% sod chlor</i>	Non-Formulary	
<i>pantoprazole intravenous</i>	Non-Formulary	
<i>pantoprazole sod dr 20 mg tab</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 20 mg tab f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 20 mg tab outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab enteric-coated</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab outer</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab u-d,10x10</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
<i>pantoprazole sod dr 40 mg tab u-d,outer,f/c,10x10</i>	Formulary	PDL Preferred; QL (2 tablets per 1 day)
PREVACID 24HR DR 15 MG CAPSULE	Formulary	PA; PDL Non-Preferred; OTC
PREVACID DR 15 MG SOLUTAB OUTER	Formulary	PA; PDL Non-Preferred
PREVACID DR 30 MG CAPSULE	Formulary	PA; PDL Non-Preferred
PREVACID DR 30 MG SOLUTAB OUTER	Formulary	PA; PDL Non-Preferred
PRILOSEC DR 10 MG SUSPENSION	Formulary	PA; PDL Non-Preferred
PRILOSEC DR 2.5 MG SUSPENSION	Formulary	PA; PDL Non-Preferred
PROTONIX 40 MG SUSPENSION OUTER	Formulary	PDL Preferred; QL (2 packets per 1 day)
PROTONIX DR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
PROTONIX DR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day)
PROTONIX INTRAVENOUS	Non-Formulary	
<i>rabeprazole sod dr 20 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>sm esomeprazole mag dr 20 mg (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>sm lansoprazole dr 15 mg cap (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>sm omeprazole dr 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>sm omeprazole dr 20 mg tablet 2x14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>sm omeprazole dr 20 mg tablet 3x14 day course</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
Gastric Acid Secretion Reducer-H2 Antagonist And Antacid Combinations		
ACID REDUCER COMPLETE (FAMOT)	Non-Formulary	OTC
DUAL ACTION COMPLETE	Non-Formulary	OTC
Gastric Acid Secretion Reducer-Proton Pump Inhibitor And Antacid Comb		
<i>gs omeprazole-bicarb 20-1,100 (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
KONVOMEK 2-84 MG/ML ORAL SUSP OUTER	Formulary	PA; PDL Non-Preferred
<i>omeprazole-bicarb 20-1,100 cap (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>omeprazole-bicarb 20-1,680 pkt</i>	Formulary	PA; PDL Non-Preferred
<i>omeprazole-bicarb 20-1,680 pkt outer</i>	Formulary	PA; PDL Non-Preferred
<i>omeprazole-bicarb 40-1,100 cap</i>	Formulary	PA; PDL Non-Preferred
<i>omeprazole-bicarb 40-1,680 pkt</i>	Formulary	PA; PDL Non-Preferred
<i>omeprazole-bicarb 40-1,680 pkt outer</i>	Formulary	PA; PDL Non-Preferred
ZEGERID 20 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ZEGERID 20 MG PACKET INNER	Formulary	PA; PDL Non-Preferred
ZEGERID 20 MG PACKET OUTER	Formulary	PA; PDL Non-Preferred
ZEGERID 40 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ZEGERID 40 MG PACKET INNER	Formulary	PA; PDL Non-Preferred
ZEGERID 40 MG PACKET OUTER	Formulary	PA; PDL Non-Preferred
Gastric Mucosa - Cytoprotective Prostaglandin Analogs		
CYTOTEC	Non-Formulary	
<i>misoprostol 100 mcg tablet</i>	Formulary	
<i>misoprostol 100 mcg tablet outer</i>	Formulary	
<i>misoprostol 200 mcg tablet</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>misoprostol 200 mcg tablet inner</i>	Formulary	
<i>misoprostol 200 mcg tablet outer</i>	Formulary	
Gastrointestinal - Prokinetic Agents - 5-Ht4 Receptor Agonists		
MOTEGRITY 1 MG TABLET	Formulary	PA; PDL Non-Preferred
MOTEGRITY 2 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>prucalopride 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>prucalopride 2 mg tablet</i>	Formulary	PA; PDL Non-Preferred
Gastrointestinal Antiflatulents		
ANTI-GAS	State Carve Out	
BEANO ORAL TABLET	State Carve Out	
GAS RELIEF-PREVENTION	State Carve Out	
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-Ht4 Agonists		
GIMOTI	Non-Formulary	
<i>metoclopramide 10 mg tablet</i>	Formulary	
<i>metoclopramide 10 mg tablet outer</i>	Formulary	
<i>metoclopramide 10 mg/10 ml solution cup</i>	Formulary	
<i>metoclopramide 10 mg/10 ml solution cup outer</i>	Formulary	
<i>metoclopramide 5 mg tablet</i>	Formulary	
<i>metoclopramide 5 mg tablet outer</i>	Formulary	
<i>metoclopramide 5 mg/5 ml soln</i>	Formulary	
<i>metoclopramide hcl injection solution</i>	Non-Formulary	
REGLAN ORAL	Non-Formulary	
Gi Antispasmodic - Belladonna Alkaloids		
ANASPAZ 0.125 MG TABLET ODT	Formulary	Age Limit (Max 64 Years)
<i>atropine injection solution</i>	Non-Formulary	
<i>atropine injection syringe 0.1 mg/ml</i>	Non-Formulary	
ED-SPAZ 0.125 MG ODT	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg odt</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg tab sl</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg/5 ml elix</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg/ml drop</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine er 0.375 mg tab</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine sulf 0.125 mg tab</i>	Formulary	Age Limit (Max 64 Years)
HYOSYNE 125 MCG/5 ML ELIXIR	Formulary	Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
HYOSYNE ORAL DROPS	Non-Formulary	
LEVSIN ORAL	Non-Formulary	
LEVSIN/SL	Non-Formulary	
<i>methscopolamine</i>	Non-Formulary	
NULEV	Non-Formulary	
OSCIMIN 0.125 MG TABLET	Formulary	Age Limit (Max 64 Years)
OSCIMIN SL	Non-Formulary	
SYMAX FASTABS 0.125 MG TABLET	Formulary	Age Limit (Max 64 Years)
SYMAX-SL	Non-Formulary	
<i>Gi Antispasmodic - Quaternary Ammonium Compounds</i>		
GLYCATE	Non-Formulary	
<i>glycopyrrolate 1 mg tablet</i>	Formulary	
<i>glycopyrrolate 2 mg tablet</i>	Formulary	
ROBINUL FORTE	Non-Formulary	
ROBINUL ORAL	Non-Formulary	
<i>Gi Antispasmodic - Synthetic Tertiary Amines</i>		
<i>dicyclomine 10 mg capsule</i>	Formulary	Age Limit (Max 64 Years)
<i>dicyclomine 10 mg capsule outer</i>	Formulary	Age Limit (Max 64 Years)
<i>dicyclomine 10 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>dicyclomine 20 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>dicyclomine 20 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)
<i>Gi Antispasmodic And Benzodiazepine Combinations</i>		
<i>chlordiazepoxide-clidinium</i>	Non-Formulary	
LIBRAX (WITH CLIDINIUM)	Non-Formulary	
<i>Gi Antispasmodic And Opioid Combinations</i>		
<i>belladonna alkaloids-opium</i>	Non-Formulary	
<i>Gi Antispasmodic Combinations Other</i>		
<i>belladonna alkaloids-opium</i>	Non-Formulary	
<i>chlordiazepoxide-clidinium</i>	Non-Formulary	
LIBRAX (WITH CLIDINIUM)	Non-Formulary	
<i>H. Pylori Therapy - Bismuth And Antibiotics Combinations</i>		
<i>bismuth-metronidazole-tetracycline 140-125-125 mg capsule</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>bismuth-metronidazole-tetracycline 140-125-125 mg capsule outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
PYLERA CAPSULE	Formulary	PDL Preferred
<i>H. Pylori Therapy - Proton Pump Inhibitor And Antibiotics Combinations</i>		
<i>lansoprazol-amoxicil-clarithro outer</i>	Formulary	PA; PDL Non-Preferred; QL (224 capsules per 1 claim)
OMECLAMOX-PAK COMBO PACK OUTER	Formulary	PA; PDL Non-Preferred
TALICIA DR 10-250-12.5 MG CAP OUTER	Formulary	PA; PDL Non-Preferred
<i>H.Pylori Therapy-Potassium-Competitive Acid Blocker And Antibiotics</i>		
VOQUEZNA DUAL PAK OUTER	Formulary	PA; PDL Non-Preferred
VOQUEZNA TRIPLE PAK OUTER	Formulary	PA; PDL Non-Preferred
<i>Ibs Agent - Gastrointestinal Chloride Channel Activator Agents</i>		
AMITIZA 24 MCG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
AMITIZA 8 MCG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 24 mcg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 24 mcg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 8 mcg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 8 mcg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists</i>		
LINZESS 145 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)
LINZESS 290 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)

Medications	Coverage Level	Restrictions
LINZESS 72 MCG CAPSULE	Formulary	PDL Preferred; QL (1 capsule per 1 day); Age Limit (Min 6 Years)
TRULANCE 3 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Ibs Agent - Mixed Opioid Receptor Agonist And Antagonist</i>		
VIBERZI 100 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
VIBERZI 75 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
<i>Ibs Agent - Selective 5-Ht3 Receptor Antagonists</i>		
<i>alosetron hcl 0.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>alosetron hcl 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred
LOTRONEX 0.5 MG TABLET	Formulary	PA; PDL Non-Preferred
LOTRONEX 1 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>Ibs Agent - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitor</i>		
IBSRELA 50 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
<i>Inflammatory Bowel Agent - Interleukin-12 And Il-23 Inhibitors, Mc Ab</i>		
STELARA 130 MG/26 ML VIAL SDV, P/F	Formulary	PA; PDL Non-Preferred
STELARA 45 MG/0.5 ML VIAL SDV, P/F	Formulary	PA; PDL Non-Preferred
STELARA 90 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>Inflammatory Bowel Agent - Interleukin-23 (Il-23) Inhibitor, Mc Ab</i>		
OMVOH 100 MG/ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
OMVOH 100 MG/ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
OMVOH 300 MG DOSE (100 MG/ML-200 MG/2 ML)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
OMVOH INTRAVENOUS	Non-Formulary	
OMVOH PEN 300 MG DOSE (100 MG/ML-200 MG/2 ML)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
SKYRIZI 180 MG/1.2 ML ON-BODY OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
SKYRIZI 360 MG/2.4 ML ON-BODY OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML INJECTOR	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
TREMFYA 200 MG/2 ML PEN INDCT PK	Formulary	PA; PDL Non-Preferred
TREMFYA 200 MG/2 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA 200 MG/2 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA INTRAVENOUS	Non-Formulary	
<i>Inflammatory Bowel Agent - Aminosalicylates And Related Agents</i>		
APRISO ER 0.375 GRAM CAPSULE	Formulary	PDL Preferred
AZULFIDINE 500 MG TABLET	Formulary	PA; PDL Non-Preferred
AZULFIDINE ENTAB 500 MG	Formulary	PA; PDL Non-Preferred
<i>balsalazide disodium 750 mg cp</i>	Formulary	PA; PDL Non-Preferred
<i>balsalazide disodium 750 mg cp outer</i>	Formulary	PA; PDL Non-Preferred
CANASA	Non-Formulary	
COLAZAL 750 MG CAPSULE	Formulary	PA; PDL Non-Preferred
DELZICOL DR 400 MG CAPSULE	Formulary	PA; PDL Non-Preferred
DIPENTUM 250 MG CAPSULE	Formulary	PA; PDL Non-Preferred
LIALDA DR 1.2 GM TABLET F/C	Formulary	PA; PDL Non-Preferred
LIALDA DR 1.2 GM TABLET FEDERAL SUPPLY	Formulary	PA; PDL Non-Preferred
<i>mesalamine 4 gml/60 ml enema 7x60ml, outer</i>	Formulary	
<i>mesalamine 4 gml/60 ml enema outer</i>	Formulary	
<i>mesalamine 800 mg dr tablet</i>	Formulary	PA; PDL Non-Preferred
<i>mesalamine 800 mg dr tablet outer</i>	Formulary	PA; PDL Non-Preferred
<i>mesalamine dr 1.2 gm tablet</i>	Formulary	PDL Preferred
<i>mesalamine dr 1.2 gm tablet outer</i>	Formulary	PDL Preferred
<i>mesalamine dr 400 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>mesalamine dr 400 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred
<i>mesalamine er 0.375 gram cap</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>mesalamine er 0.375 gram cap outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>mesalamine er 500 mg capsule</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>mesalamine rectal suppository</i>	Non-Formulary	
<i>mesalamine with cleansing wipe</i>	Non-Formulary	
PENTASA 250 MG CAPSULE	Formulary	PDL Preferred
PENTASA 500 MG CAPSULE	Formulary	PDL Preferred
ROWASA RECTAL ENEMA KIT	Non-Formulary	
SFROWASA	Non-Formulary	
<i>sulfasalazine 500 mg tablet</i>	Formulary	PDL Preferred
<i>sulfasalazine dr 500 mg tab</i>	Formulary	PDL Preferred
<i>Inflammatory Bowel Agent - Glucocorticoids</i>		
<i>budesonide dr 3 mg capsule</i>	Formulary	PA; QL (3 capsules per 1 day)
<i>budesonide dr 3 mg capsule outer</i>	Formulary	PA; QL (3 capsules per 1 day)
<i>budesonide ec 3 mg capsule</i>	Formulary	PA; QL (3 capsules per 1 day)
<i>budesonide er 9 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>budesonide rectal</i>	Non-Formulary	
CORTENEMA	Non-Formulary	
CORTIFOAM	Non-Formulary	
<i>hydrocortisone rectal</i>	Non-Formulary	
UCERIS 9 MG ER TABLET	Formulary	PA; PDL Non-Preferred
UCERIS RECTAL	Non-Formulary	
<i>Inflammatory Bowel Agent - Integrin Receptor Antagonist, Mc Antibody</i>		
ENTYVIO 108 MG/0.68 ML PEN SUV, OUTER	Formulary	PA; PDL Non-Preferred
<i>Inflammatory Bowel Agent - Janus Kinase (Jak) Inhibitors</i>		
RINVOQ ER 45 MG TABLET	Formulary	PA; PDL Non-Preferred
XELJANZ 10 MG TABLET	Formulary	PA; PDL Non-Preferred
XELJANZ 5 MG TABLET	Formulary	PA; PDL Non-Preferred
XELJANZ XR 11 MG TABLET	Formulary	PA; PDL Non-Preferred
XELJANZ XR 22 MG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Inflammatory Bowel Agent - Sphingosine 1-Phosphate Receptor Modulator		
VELSIPITY 2 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZEPOSIA 0.92 MG CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZEPOSIA STARTER KIT (28-DAY)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZEPOSIA STARTER PACK (7-DAY)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers		
ABRILADA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML (2 PACK) 2 PEN/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
ABRILADA(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN CROHN'S-UC-HS 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AACF(CF) PEN PSORIASIS-UV 40 MG/0.8 ML (4 PACK)	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ailbox, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, plf</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>adalimumab-adaz(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, p/f, suv</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 20 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) 40 mg/0.8 ml syringe</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.4 ml</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-adbm(cf) pen 40 mg/0.8 ml</i>	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADB(M)CF PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector</i>	Formulary	PA; PDL Non-Preferred
<i>adalimumab-ryvk(cf) 40 mg/0.4 ml syringe</i>	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.2 ML SYRING	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.4 ML SYRING SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR INNER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, INNER	Formulary	PA; PDL Non-Preferred
AMJEVITA(CF) 80 MG/0.8 ML AUTOINJECTOR SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG VIAL KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML SYRINGE KIT	Formulary	PA; PDL Non-Preferred
CIMZIA 2X200 MG/ML(X3)START KT	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 20 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) 40 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HADLIMA 40 MG/0.8 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA PUSHTOUCH 40 MG/0.8 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HADLIMA(CF) 40 MG/0.4 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
HADLIMA(CF) PUSH TOUCH 40 MG/0.4 ML OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 20 MG/0.4 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) 40 MG/0.8 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
HULIO(CF) PEN 40 MG/0.8 ML SUV, P/F	Formulary	PA; PDL Non-Preferred
HUMIRA 40 MG/0.8 ML SYRINGE P/F, SUV	Formulary	PDL Preferred
HUMIRA PEN 40 MG/0.8 ML P/F, SUV	Formulary	PDL Preferred
HUMIRA(CF) 20 MG/0.2 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) 40 MG/0.4 ML SYRINGE	Formulary	PDL Preferred
HUMIRA(CF) PEN 40 MG/0.4 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN 80 MG/0.8 ML SUV, P/F	Formulary	PDL Preferred
HUMIRA(CF) PEN CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML	Formulary	PDL Preferred
HUMIRA(CF) PEN PS-UV-ADOL HS START 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PDL Preferred
HYRIMOZ	Non-Formulary	
HYRIMOZ PEN	Non-Formulary	
HYRIMOZ(CF) 20 MG/0.2 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) 40 MG/0.4 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEDIATRIC CROHNS START 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SYRINGE	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN 40 MG/0.4 ML P/F, SUV	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
HYRIMOZ(CF) PEN CROHNS-ULCERATIVE COLITIS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
HYRIMOZ(CF) PEN PSORIASIS STARTER 80 MG/0.8 ML-40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
IDACIO(CF) 40 MG/0.8 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN 40 MG/0.8 ML (2 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN CROHN'S-UC START 40 MG/0.8 ML (6 PACK)	Formulary	PA; PDL Non-Preferred
IDACIO(CF) PEN PLAQUE PSORIASIS STARTER 40 MG/0.8 ML (4PK)	Formulary	PA; PDL Non-Preferred
INFLECTRA	Non-Formulary	
RENFLEXIS	Non-Formulary	
SIMLANDI(CF) 20 MG/0.2 ML SYRINGE SUV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, OUTER	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 40 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 80 MG/0.8 ML AUTOINJECTOR OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
SIMLANDI(CF) 80 MG/0.8 ML SYRINGE SUV,P/F, OUTER	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML PEN INJECTOR	Formulary	PA; PDL Non-Preferred
SIMPONI 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 20 MG/0.2 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR (2 PACK) 2 AI/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML AUTOINJECTOR SUV, P/F	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 40 MG/0.4 ML SYRINGE (2 PACK)	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) 80 MG/0.8 ML AUTOINJECTOR	Formulary	PA; PDL Non-Preferred
YUFLYMA(CF) AUTOINJECTOR CROHN'S-UC-HS STARTER 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
YUSIMRY(CF) 40 MG/0.8 ML PEN	Formulary	PA; PDL Non-Preferred
ZYMFENTRA 120 MG/ML PEN KIT (2 PACK) 2 PEN/BOX, SUV, P/F	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
ZYMFENTRA 120 MG/ML PEN KIT SUV, P/F	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZYMFENTRA 120 MG/ML SYRINGE KIT (2 PACK)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
<i>Intestinal Flora Modifiers</i>		
CULTURELLE 10B CELL CAPSULE OUTER (RX)	Non-Formulary	CSHCS Covered
CULTURELLE HLTH-WELL 15B CELL	Non-Formulary	CSHCS Covered
<i>Irritable Bowel Syndrome (Ibs) Agents</i>		
<i>alosetron hcl 0.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>alosetron hcl 1 mg tablet</i>	Formulary	PA; PDL Non-Preferred
AMITIZA 24 MCG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
AMITIZA 8 MCG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
LOTRONEX 0.5 MG TABLET	Formulary	PA; PDL Non-Preferred
LOTRONEX 1 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>lubiprostone 24 mcg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 24 mcg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 8 mcg capsule</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
<i>lubiprostone 8 mcg capsule outer</i>	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
VIBERZI 100 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
VIBERZI 75 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
<i>Laxative - Lubricant</i>		
FLEET MINERAL OIL ENEMA	Formulary	OTC
FT READY TO USE MIN OIL ENEMA	Formulary	OTC
HM READY TO USE MIN OIL ENEMA	Formulary	OTC
SM READY TO USE MIN OIL ENEMA	Non-Formulary	CSHCS Covered; OTC

Medications	Coverage Level	Restrictions
Laxative - Saline And Osmotic		
CLEARLAX ORAL POWDER IN PACKET	Non-Formulary	Dual Eligible Covered; OTC
CLEARLAX POWDER	Formulary	OTC
CONSTULOSE 10 GM/15 ML SOLN	Formulary	
FT CLEARLAX POWDER	Formulary	OTC
<i>ft magnesium citrate solution</i>	Formulary	OTC
GAVILAX POWDER 14 DAY	Formulary	OTC
GAVILAX POWDER 30 DAY	Formulary	OTC
<i>gnp magnesium citrate solution</i>	Formulary	OTC
GS CLEARLAX POWDER	Formulary	OTC
HEALTHYLAX	Non-Formulary	Dual Eligible Covered; OTC
HM CLEARLAX POWDER	Formulary	OTC
HM CLEARLAX POWDER 7 ONCE-DAILY DOSES	Formulary	OTC
KRISTALOSE	Non-Formulary	
<i>lactulose 10 gm/15 ml solution</i>	Formulary	
<i>lactulose 10 gm/15 ml solution</i>	State Carve Out	
<i>lactulose 10 gm/15 ml solution cup inner</i>	Formulary	
<i>lactulose 10 gm/15 ml solution cup outer</i>	Formulary	
<i>lactulose 20 gm/30 ml solution cup inner</i>	Formulary	
<i>lactulose 20 gm/30 ml solution cup outer</i>	Formulary	
<i>magnesium citrate solution</i>	Formulary	OTC
<i>milk of magnesia susp 2,400 mg/30 ml cup inner</i>	Formulary	OTC
MILK OF MAGNESIA SUSP 2,400 MG/30 ML CUP INNER	Formulary	OTC
<i>milk of magnesia susp 2,400 mg/30 ml cup outer</i>	Formulary	OTC
MILK OF MAGNESIA SUSP 2,400 MG/30 ML CUP OUTER	Formulary	OTC
MILK OF MAGNESIA SUSPENSION	Formulary	OTC
MILK OF MAGNESIA SUSPENSION 100'S, U-D	Formulary	OTC
NATURA-LAX	Non-Formulary	OTC
<i>polyethylene glycol 3350 oral powder in packet 17 gram</i>	Non-Formulary	Dual Eligible Covered; OTC
<i>polyethylene glycol 3350 powd (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>polyethylene glycol 3350 powd 14 once-daily doses (otc)</i>	Formulary	OTC
<i>polyethylene glycol 3350 powd 30 once-daily doses (otc)</i>	Formulary	OTC
<i>polyethylene glycol 3350 powd 7 once-daily doses (otc)</i>	Formulary	OTC
SM CLEARLAX POWDER	Formulary	OTC
SM CLEARLAX POWDER 7 ONCE-DAILY DOSES	Formulary	OTC
SM MILK OF MAGNESIA SUSPENSION	Formulary	OTC
SM MILK OF MAGNESIA SUSPENSION MINT	Formulary	OTC
SMOOTHLAX ORAL POWDER IN PACKET	Non-Formulary	Dual Eligible Covered; OTC
TRUE LAXATIVE PEG 3350 POWDER	Formulary	OTC
<i>Laxative - Saline/Osmotic Mixtures</i>		
ENEMA DISPOSABLE	Formulary	Dual Eligible Covered; OTC
ENEMA READY TO USE	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
ENEMA READY TO USE	Formulary	Dual Eligible Covered; OTC
FLEET ENEMA	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
FLEET ENEMA 2X133ML, TWIN PACK	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
FLEET ENEMA 4X133ML	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
FLEET PEDIATRIC	Non-Formulary	Dual Eligible Covered; OTC
FT ENEMA READY TO USE	Formulary	OTC
FT ENEMA READY TO USE TWIN PAK	Formulary	OTC
GAVILYTE-C SOLUTION	Formulary	
GAVILYTE-G SOLUTION	Formulary	
GAVILYTE-N SOLUTION	Formulary	
GOLYTELY	Non-Formulary	
HM ENEMA READY TO USE	Formulary	Dual Eligible Covered; OTC
HM ENEMA READY TO USE TWIN PAK	Formulary	Dual Eligible Covered; OTC
MOVIPREP	Non-Formulary	
<i>peg 3350-electrolyte solution</i>	Formulary	
<i>peg 3350-electrolyte solution lemon</i>	Formulary	
<i>peg-3350 and electrolytes soln</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	Non-Formulary	
PLENVU	Non-Formulary	
QC READY TO USE ENEMA	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
QC READY TO USE ENEMA TWIN PACK	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
SM ENEMA READY TO USE	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
SM ENEMA READY TO USE TWIN PAK	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
<i>sod sul-potass sul-mag sul sol</i>	Formulary	QL (354 ML per 30 days)
<i>sod sul-potass sul-mag sul sol 2-6oz+mix cont,outer</i>	Formulary	QL (354 ML per 30 days)
<i>sod sul-potass sul-mag sul sol inner</i>	Formulary	QL (354 ML per 30 days)
<i>sod sul-potass sul-mag sul sol outer</i>	Formulary	QL (354 ML per 30 days)
SUTAB	Non-Formulary	
<i>Laxative - Stimulant And Surfactant Combinations</i>		
COLACE 2-IN-1	Non-Formulary	OTC
FT SENNA-S 8.6-50 MG TABLET	Formulary	OTC
FT STOOL SOFTENER-STIM LAX TAB	Formulary	OTC
GNP SENNA PLUS 8.6-50 MG TAB	Formulary	OTC
GNP STOOL SOFTENER-STIM LAX TB	Formulary	OTC
SENEXON-S 50-8.6 MG TABLET	Formulary	OTC
SENNAPLUS 8.6-50 MG TABLET	Formulary	OTC
SENNAPLUS ORAL CAPSULE	Non-Formulary	OTC
SENNAPLUS TABLET	Formulary	OTC
SENNAPLUS TABLET U-D, 10X10	Formulary	OTC
SENNAPLUS 8.6-50 MG TABLET	Formulary	OTC
SENNAPLUS-TIME S TABLET	Formulary	OTC
<i>sennosides-docusate sodium tab</i>	Formulary	OTC
<i>sennosides-docusate sodium tab outer</i>	Formulary	OTC
SENNAPLUS-TIME S TABLET	Formulary	OTC
SM STOOL SOFTENER-LAXATIVE TAB	Formulary	OTC
STIMULANT LAXATIVE PLUS TABLET	Formulary	OTC
STOOL SOFTENER-STIM LAX TABLET	Formulary	OTC
STOOL SOFTENER-STIMULANT LAXATIVE ORAL CAPSULE	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
<i>Laxative - Stimulant</i>		
<i>bisacodyl 10 mg suppository</i>	Formulary	OTC
<i>bisacodyl 10 mg suppository</i>	Formulary	Dual Eligible Covered; OTC
<i>bisacodyl ec 5 mg tablet</i>	Formulary	OTC
<i>bisacodyl ec 5 mg tablet</i>	Formulary	Dual Eligible Covered; OTC
CHOCOLATED LAXATIVE	Formulary	OTC
FLEET BISACODYL EC 5 MG TAB	Formulary	OTC
FT GENTLE LAXATIVE 10 MG SUPP	Formulary	OTC
FT LAXATIVE EC 5 MG TABLET	Formulary	OTC
FT SENNA LAXATIVE 8.6 MG TAB	Formulary	OTC
GENTLE LAXATIVE 10 MG SUPPOSIT	Formulary	Dual Eligible Covered; OTC
GENTLE LAXATIVE EC 5 MG TABLET	Formulary	Dual Eligible Covered; OTC
GNP GENTLE LAXATIVE 10 MG SUPP	Formulary	Dual Eligible Covered; OTC
GNP GENTLE LAXATIVE EC 5 MG TB	Formulary	OTC
GNP SENNA LAX 8.6 MG TABLET	Formulary	OTC
HM GENTLE LAXATIVE 10 MG SUPP	Formulary	Dual Eligible Covered; OTC
HM LAXATIVE EC 5 MG TABLET	Formulary	Dual Eligible Covered; OTC
HM SENNA 8.6 MG TABLET	Formulary	OTC
LAXATIVE 15 MG TABLET	Formulary	OTC
LAXATIVE 25 MG TABLET	Formulary	OTC
LAXATIVE EC 5 MG TABLET	Formulary	Dual Eligible Covered; OTC
<i>senna 176 mg/5 ml syrup</i>	Formulary	
SENNA 176 MG/5 ML SYRUP	Formulary	
<i>senna 26.4 mg/15 ml syrup cup outer</i>	Formulary	OTC
SENNA 528 MG/15 ML CUP	Formulary	
SENNA 8.6 MG SOFTGEL	Formulary	OTC
SENNA 8.6 MG TABLET	Formulary	OTC
SENNA 8.8 MG/5 ML LIQUID	Formulary	OTC
<i>senna 8.8 mg/5 ml syrup</i>	Formulary	OTC
SENNA 8.8 MG/5 ML SYRUP	Formulary	OTC
<i>senna 8.8 mg/5 ml syrup cup outer</i>	Formulary	OTC
SENNA-LAX 8.6 MG TABLET	Formulary	OTC
SENNA-TIME 8.6 MG TABLET	Formulary	OTC
SENOKOT 8.6 MG TABLET	Formulary	OTC
SENOKOT EXTRA STR 17.2 MG TAB	Formulary	OTC
SM GENTLE LAXATIVE EC 5 MG TAB	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
SM SENNA LAXATIVE 8.6 MG TAB	Formulary	OTC
WOMEN'S GENTLE LAX EC 5 MG TAB	Formulary	Dual Eligible Covered; OTC
Laxative - Surfactant		
COLACE	Non-Formulary	OTC
COLACE CLEAR 50 MG SOFTGEL	Formulary	OTC
<i>docusate cal 240 mg softgel</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sod 100 mg/10 ml cup outer</i>	Formulary	OTC
<i>docusate sod 100 mg/10 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sod 100 mg/10 ml liquid cup outer</i>	Formulary	OTC
<i>docusate sodium 100 mg softgel</i>	Formulary	OTC
<i>docusate sodium 100 mg softgel</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium 100 mg softgel outer, softgel</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium 100 mg softgel softgel</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium 250 mg softgel</i>	Formulary	OTC
<i>docusate sodium 250 mg softgel outer</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium 50 mg/5 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium 50 mg/5 ml liq</i>	Formulary	Dual Eligible Covered; OTC
<i>docusate sodium mini enema</i>	Formulary	OTC
ENEMEEZ MINI ENEMA	Formulary	OTC
ENEMEEZ MINI ENEMA 5CC TUBES, OUTER	Formulary	OTC
ENEMEEZ PLUS MINI ENEMA	Formulary	OTC
ENEMEEZ PLUS MINI ENEMA OUTER	Formulary	OTC
FLEET DOCUSATE 100 MG SOFTGEL	Formulary	OTC
FT STOOL SOFTENER 100 MG SFTGL	Formulary	OTC
FT STOOL SOFTENER 100 MG TAB	Formulary	OTC
FT STOOL SOFTENER 250 MG SFTGL	Formulary	OTC
GNP STOOL SOFTENER 100 MG SFGL	Formulary	Dual Eligible Covered; OTC
GNP STOOL SOFTENER 240 MG SFGL	Formulary	Dual Eligible Covered; OTC
GNP STOOL SOFTENER 250 MG SFGL	Formulary	Dual Eligible Covered; OTC
HM STOOL SOFTENER 100 MG SFTGL	Formulary	OTC
HM STOOL SOFTENER 100 MG SFTGL	Formulary	Dual Eligible Covered; OTC
HM STOOL SOFTENER 250 MG SFTGL	Formulary	Dual Eligible Covered; OTC
SM STOOL SOFTENER 100 MG SFTGL	Formulary	Dual Eligible Covered; OTC
SM STOOL SOFTENER 100 MG TAB	Formulary	OTC
SOF-LAX	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
STOOL SOFTENER 100 MG SOFTGEL	Formulary	Dual Eligible Covered; OTC
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives		
CARAFATE	Non-Formulary	
<i>sucralfate 1 gm tablet</i>	Formulary	
<i>sucralfate 1 gm tablet outer</i>	Formulary	
<i>sucralfate oral suspension</i>	Non-Formulary	
Short Bowel Syndrome (Sbs) - Glucagon-Like Peptide-2 (Glp-2) Analog		
GATTEX 30-VIAL	Non-Formulary	
Short Bowel Syndrome (Sbs) Agents		
<i>octreotide 1,000 mcg/5 ml vial mdv</i>	Formulary	PA
<i>octreotide 1,000 mcg/5 ml vial muv</i>	Formulary	PA
<i>octreotide 5,000 mcg/5 ml vial mdv</i>	Formulary	PA
<i>octreotide 5,000 mcg/5 ml vial muv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl inner, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl outer, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl outer, suv, p/f</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl p/f, sdv</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl sdv, outer</i>	Formulary	PA
<i>octreotide acet 100 mcg/ml vl suv, p/f</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial 10's, suv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial inner, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial outer, p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial outer, p/f, suv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial p/f, sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial sdv</i>	Formulary	PA
<i>octreotide acet 50 mcg/ml vial suv, p/f</i>	Formulary	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	Non-Formulary	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	Non-Formulary	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 10 MG	Non-Formulary	

Medications	Coverage Level	Restrictions
Genitourinary Therapy		
<i>Bph Agent- 5-Alpha Reductase Inhib And Alpha-1 Adrenoceptor Antag Comb</i>		
<i>dutasteride-tamsulosin 0.5-0.4</i>	Formulary	PA; PDL Non-Preferred
<i>Cystinosis Therapy (Cystine Depleting Agents)</i>		
CYSTAGON	State Carve Out	
PROCYSBI	State Carve Out	
<i>G.U. Irrigants - Anti-Infective</i>		
<i>neomycin-polymyxin b gu</i>	Non-Formulary	
<i>G.U. Irrigants</i>		
<i>acetic acid irrigation</i>	Non-Formulary	
<i>sorbitol-mannitol</i>	Non-Formulary	
<i>Interstitial Cystitis Agents</i>		
ELMIRON 100 MG CAPSULE	Formulary	QL (3 capsules per 1 day)
<i>Kidney Stone Agents</i>		
THIOLA	Non-Formulary	
THIOLA EC	Non-Formulary	
<i>tiopronin</i>	Non-Formulary	
VENXXIVA	Non-Formulary	
<i>Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist</i>		
GEMTESA 75 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>mirabegron er 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>mirabegron er 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred
MYRBETRIQ ER 25 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
MYRBETRIQ ER 50 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
MYRBETRIQ ER 8 MG/ML SUSP	Formulary	PA; PDL Non-Preferred
<i>Oxalosis Agent - Oxalate Inhibitor, Small Interfering Rna Directed</i>		
OXLUMO	Non-Formulary	
RIVFLOZA	State Carve Out	
<i>Phosphate Binders - Calcium-Based</i>		
<i>calcium acetate 667 mg capsule</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg capsule inner</i>	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>calcium acetate 667 mg capsule outer</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg gelcap</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg gelcap gelcap</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
Phosphate Binders - Iron-Based		
AURYXIA 210 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ferric citrate 210 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELPHORO 500 MG CHEWABLE TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Phosphate Binders		
AURYXIA 210 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>calcium acetate 667 mg capsule</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg capsule inner</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg capsule outer</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg gelcap</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg gelcap gelcap</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>calcium acetate 667 mg tablet</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>ferric citrate 210 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FOSRENOL 1,000 MG POWDER PACK OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FOSRENOL 1,000 MG TABLET CHEW OUTER PK, 9X10 TABS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FOSRENOL 500 MG TABLET CHEW OUTER PK, 2X45 TABS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FOSRENOL 750 MG POWDER PACKET OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
FOSRENOL 750 MG TABLET CHEW OUTER PK, 6X15 TABS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>lanthanum carb 1,000 mg tb chw outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>lanthanum carb 500 mg tab chew outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>lanthanum carb 750 mg tab chew outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVELA 0.8 GM POWDER PACKET INNER,90 X 0.8G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVELA 0.8 GM POWDER PACKET OUTER,90 X 0.8G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVELA 2.4 GM POWDER PACKET INNER,90 X 2.4G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVELA 2.4 GM POWDER PACKET OUTER,90 X 2.4G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
REVELA 800 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer 0.8 gm powder packet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer 0.8 gm powder packet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer 2.4 gm powder packet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer 2.4 gm powder packet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer carbonate 800 mg tab</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sevelamer carbonate 800 mg tab inner</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sevelamer carbonate 800 mg tab outer</i>	Formulary	PA; PDL Preferred; 3 Months Allowed
<i>sevelamer hcl 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer hcl 800 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>sevelamer hcl 800 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELPHORO 500 MG CHEWABLE TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Polycystic Kidney Disease - Vasopressin V2 Receptor Antagonists		
JYNARQUE 15 MG TABLET	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 15 MG-15 MG TABLET OUTER	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 30 MG TABLET	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 30 MG-15 MG TABLET OUTER	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 45 MG-15 MG TABLET OUTER	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 60 MG-30 MG TABLET OUTER	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
JYNARQUE 90 MG-30 MG TABLET OUTER	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
Prostatic Hypertrophy Agent - Alpha-1-Adrenoceptor Antagonists		
<i>alfuzosin hcl er 10 mg tablet</i>	Formulary	PDL Preferred
<i>alfuzosin hcl er 10 mg tablet f/c</i>	Formulary	PDL Preferred
FLOMAX 0.4 MG CAPSULE	Formulary	PA; PDL Non-Preferred
RAPAFLO 4 MG CAPSULE	Formulary	PA; PDL Non-Preferred
RAPAFLO 8 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>silodosin 4 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>silodosin 8 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>tamsulosin hcl 0.4 mg capsule</i>	Formulary	PDL Preferred
<i>tamsulosin hcl 0.4 mg capsule outer</i>	Formulary	PDL Preferred
<i>tamsulosin hcl 0.4 mg capsule u-d, 10x10</i>	Formulary	PDL Preferred
Prostatic Hypertrophy Agent - Type II 5-Alpha Reductase Inhibitors		
<i>finasteride 5 mg tablet</i>	Formulary	PDL Preferred
<i>finasteride 5 mg tablet f/c</i>	Formulary	PDL Preferred
<i>finasteride 5 mg tablet outer</i>	Formulary	PDL Preferred
PROSCAR 5 MG TABLET	Formulary	PA; PDL Non-Preferred
Prostatic Hypertrophy Agent-Sel.Cgmp Phosphodiesterase Type5 Inhibitor		
CIALIS ORAL TABLET 5 MG	Benefit Exclusion	
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	Benefit Exclusion	

Medications	Coverage Level	Restrictions
Prostatic Hypertrophy Agent-Type I And II 5-Alpha Reductase Inhibitors		
<i>dutasteride 0.5 mg capsule</i>	Formulary	PDL Preferred
Urinary Acidifier - Bacterial Urease Inhibitor		
LITHOSTAT	State Carve Out	
Urinary Acidifier - Phosphates		
K-PHOS #2 TABLET	Formulary	
K-PHOS NEUTRAL TABLET	Formulary	
K-PHOS ORIGINAL TABLET	Formulary	Dual Eligible Covered
PHOSPHA 250 NEUTRAL TABLET	Formulary	
PHOSPHOROUS 250 MG TABLET	Formulary	
PHOSPHO-TRIN 250 NEUTRAL TAB	Formulary	
WES-PHOS 250 MG NEUTRAL TABLET	Formulary	
Urinary Alkalinizer - Citrates		
ORACIT	Non-Formulary	
<i>pot,sodium citrate-citric acid</i>	Non-Formulary	
<i>potassium cit-citric acid soln</i>	Formulary	
<i>potassium citrate er 10 meq tb</i>	Formulary	
<i>potassium citrate er 10 meq tb outer</i>	Formulary	
<i>potassium citrate er 15 meq tb</i>	Formulary	
<i>potassium citrate er 5 meq tab</i>	Formulary	
<i>sod citrate-citric acid soln (rx)</i>	Formulary	
<i>sod citrate-citric acid solution 1.5-1 gm/15 ml cup outer (rx)</i>	Formulary	
<i>sod citrate-citric acid solution 3-2 gm/30 ml cup outer (rx)</i>	Formulary	
TRICITRATES	Non-Formulary	
UROCIT-K 10	Non-Formulary	
UROCIT-K 15	Non-Formulary	
Urinary Analgesics		
<i>phenazopyridine 100 mg tab</i>	Formulary	
<i>phenazopyridine 100 mg tab f/c</i>	Formulary	
<i>phenazopyridine 200 mg tab</i>	Formulary	
<i>phenazopyridine 200 mg tab f/c</i>	Formulary	
PYRIDIDIUM	Non-Formulary	

Medications	Coverage Level	Restrictions
Urinary Antibacterial - Methenamine And Salts		
<i>methenamine hipp 1 gm tablet</i>	Formulary	
<i>methenamine hipp 1 gm tablet outer</i>	Formulary	
<i>methenamine mand 1 gm tablet</i>	Formulary	
<i>methenamine mand 500 mg tablet</i>	Formulary	
Urinary Antibacterial - Nitrofurantoin Derivatives		
FURADANTIN	Non-Formulary	
MACROBID	Non-Formulary	
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	Non-Formulary	
<i>nitrofurantoin mcr 100 mg cap</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 100 mg cap outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 50 mg cap</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mcr 50 mg cap outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg outer</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin mono-mcr 100 mg u-d,outer, 10x10</i>	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	Non-Formulary	
Urinary Antibacterials Other		
<i>fosfomicin tromethamine</i>	Non-Formulary	
Urinary Anti-Infective Methenamine-Antispas-Analg Combinations		
MB CAPS	Non-Formulary	
URELLE	Non-Formulary	
URIBEL	Non-Formulary	
URIBEL TABS	Non-Formulary	
URIMAR-T ORAL TABLET	Non-Formulary	
URO-458	Non-Formulary	
URO-MP	Non-Formulary	

Medications	Coverage Level	Restrictions
Urinary Anti-Infective Methenamine-Antispasmodic Combinations		
<i>methen-sod phos-meth blue-hyos</i>	Non-Formulary	
UROGESIC-BLUE	Non-Formulary	
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)		
<i>darifenacin er 15 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>darifenacin er 7.5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>solifenacin 10 mg tablet</i>	Formulary	PDL Preferred
<i>solifenacin 5 mg tablet</i>	Formulary	PDL Preferred
VESICARE 10 MG TABLET	Formulary	PA; PDL Non-Preferred
VESICARE 5 MG TABLET	Formulary	PA; PDL Non-Preferred
VESICARE LS 5 MG/5 ML SUSP	Formulary	PA; PDL Non-Preferred
Urinary Antispasmodic - Anticholinergics, Non-Selective		
ANASPAZ 0.125 MG TABLET ODT	Formulary	Age Limit (Max 64 Years)
ED-SPAZ 0.125 MG ODT	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg odt</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg tab sl</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg/5 ml elix</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine 0.125 mg/ml drop</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine er 0.375 mg tab</i>	Formulary	Age Limit (Max 64 Years)
<i>hyoscyamine sulf 0.125 mg tab</i>	Formulary	Age Limit (Max 64 Years)
HYOSYNE 125 MCG/5 ML ELIXIR	Formulary	Age Limit (Max 64 Years)
HYOSYNE ORAL DROPS	Non-Formulary	
LEVSIN ORAL	Non-Formulary	
LEVSIN/SL	Non-Formulary	
NULEV	Non-Formulary	
OSCIMIN 0.125 MG TABLET	Formulary	Age Limit (Max 64 Years)
OSCIMIN SL	Non-Formulary	
SYMAX FASTABS 0.125 MG TABLET	Formulary	Age Limit (Max 64 Years)
SYMAX-SL	Non-Formulary	
Urinary Antispasmodic - Smooth Muscle Relaxants		
DETROL 1 MG TABLET	Formulary	PA; PDL Non-Preferred
DETROL 2 MG TABLET	Formulary	PA; PDL Non-Preferred
DETROL LA 2 MG CAPSULE	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
DETROL LA 4 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>fesoterodine er 4 mg tablet</i>	Formulary	PDL Preferred
<i>fesoterodine er 8 mg tablet</i>	Formulary	PDL Preferred
<i>flavoxate hcl 100 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>flavoxate hcl 100 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>oxybutynin 2.5 mg tablet</i>	Formulary	PDL Preferred
<i>oxybutynin 5 mg tablet</i>	Formulary	PDL Preferred
<i>oxybutynin 5 mg tablet inner</i>	Formulary	PDL Preferred
<i>oxybutynin 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxybutynin 5 mg/5 ml solution</i>	Formulary	PDL Preferred
<i>oxybutynin 5 mg/5 ml syrup</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 10 mg tablet</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 10 mg tablet coated</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 15 mg tablet</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 15 mg tablet coated</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 15 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 5 mg tablet</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 5 mg tablet coated</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 5 mg tablet u-d,10x10,outer</i>	Formulary	PDL Preferred
<i>oxybutynin cl er 5 mg tablet u-d,3x10</i>	Formulary	PDL Preferred
OXYTROL 3.9 MG/24HR PATCH OUTER	Formulary	PA; PDL Non-Preferred
<i>tolterodine tart er 2 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tart er 2 mg cap outer</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tart er 4 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tart er 4 mg cap outer</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tartrate 1 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tartrate 1 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tartrate 2 mg tab</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tartrate 2 mg tab f/c</i>	Formulary	PA; PDL Non-Preferred
<i>tolterodine tartrate 2 mg tab f/c,outer</i>	Formulary	PA; PDL Non-Preferred
TOVIAZ ER 4 MG TABLET	Formulary	PA; PDL Non-Preferred
TOVIAZ ER 8 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>tropium chloride 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>tropium chloride er 60 mg cap</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Urinary Retention Therapy - Parasympathomimetic Agents		
<i>bethanechol 10 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 10 mg tablet outer</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 10 mg tablet u-d, 10x10, inner</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 10 mg tablet u-d, 10x10, outer</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 25 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 25 mg tablet outer</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 25 mg tablet u-d, 10x10, inner</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 25 mg tablet u-d, 10x10, outer</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 5 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 50 mg tablet</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 50 mg tablet u-d, 10x10, inner</i>	Formulary	QL (4 tablets per 1 day)
<i>bethanechol 50 mg tablet u-d, 10x10, outer</i>	Formulary	QL (4 tablets per 1 day)
Gout And Hyperuricemia Therapy		
Gout Acute Therapy - Antimitotics		
<i>colchicine 0.6 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>colchicine 0.6 mg capsule outer</i>	Formulary	PA; PDL Non-Preferred
<i>colchicine 0.6 mg tablet</i>	Formulary	PDL Preferred
<i>colchicine 0.6 mg tablet outer</i>	Formulary	PDL Preferred
COLCRYS 0.6 MG TABLET	Formulary	PA; PDL Non-Preferred
GLOPERBA 0.6 MG/5 ML SOLUTION	Formulary	PA; PDL Non-Preferred
MITIGARE 0.6 MG CAPSULE	Formulary	PA; PDL Non-Preferred
Gout And Hyperuricemia - Antimitotic-Uricosuric Combinations		
<i>probenecid-colchicine tablet</i>	Formulary	PDL Preferred
Hyperuricemia Therapy - Uricosurics		
<i>probenecid 500 mg tablet</i>	Formulary	PDL Preferred
<i>probenecid 500 mg tablet film coated</i>	Formulary	PDL Preferred
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors		
<i>allopurinol 100 mg tablet</i>	Formulary	PDL Preferred
<i>allopurinol 100 mg tablet outer</i>	Formulary	PDL Preferred
<i>allopurinol 100 mg tablet u-d, outer</i>	Formulary	PDL Preferred
<i>allopurinol 200 mg tablet</i>	Formulary	PDL Preferred
<i>allopurinol 300 mg tablet</i>	Formulary	PDL Preferred
<i>allopurinol 300 mg tablet outer</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>allopurinol 300 mg tablet u-d, outer</i>	Formulary	PDL Preferred
<i>febuxostat 40 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>febuxostat 40 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred
<i>febuxostat 80 mg tablet</i>	Formulary	PA; PDL Non-Preferred
ULORIC 40 MG TABLET	Formulary	PA; PDL Non-Preferred
ULORIC 80 MG TABLET	Formulary	PA; PDL Non-Preferred
ZYLOPRIM 100 MG TABLET	Formulary	PA; PDL Non-Preferred
Hematological Agents		
<i>Agents To Treat Attp- Anti Von Willebrand Factor (Vwf) A1 Domain</i>		
CABLIVI INJECTION KIT	Non-Formulary	
<i>Agents To Treat Cold Agglutinin Disease (Cad)</i>		
ENJAYMO	State Carve Out	
<i>Agents To Treat Paroxysmal Nocturnal Hemoglobinuria (Pnh)</i>		
BKEMV	State Carve Out	
EMPAVELI	State Carve Out	
EPYSQLI	State Carve Out	
FABHALTA	State Carve Out	
PIASKY	State Carve Out	
SOLIRIS	State Carve Out	
ULTOMIRIS	State Carve Out	
VOYDEYA	State Carve Out	
<i>Anticoagulants - Coumarin</i>		
JANTOVEN 1 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 1 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 1 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 10 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 10 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 10 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 2 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
JANTOVEN 2 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 2 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 2.5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 2.5 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 2.5 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 3 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 3 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 3 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 4 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 4 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 4 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 5 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 5 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 6 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 6 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 6 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 7.5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 7.5 MG TABLET U-D,10X10, INNER	Formulary	PDL Preferred; 3 Months Allowed
JANTOVEN 7.5 MG TABLET U-D,10X10, OUTER	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>warfarin sodium 1 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 2 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 2 mg tablet 10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 2.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 2.5 mg tablet 10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 3 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 4 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 5 mg tablet 10x10,u-d,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 6 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>warfarin sodium 7.5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
Anti-Inhibitor Coagulation Complex		
FEIBA NF	State Carve Out	
Blood Cell And Platelet Disorder Tx- Spleen Tyrosine Kinase Inhibitors		
TAVALISSE	Non-Formulary	
C1 Esterase Inhibitor Agents		
BERINERT INTRAVENOUS KIT	State Carve Out	
CINRYZE	State Carve Out	
HAEGARDA	State Carve Out	
RUCONEST	State Carve Out	
Cad - Complement (C1) Inhibitors		
ENJAYMO	State Carve Out	
Cxcr4 Chemokine Receptor Antagonists		
MOZOBIL	Non-Formulary	
<i>plerixafor</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
XOLREMDI	State Carve Out	
<i>Direct Factor Xa Inhibitors</i>		
ELIQUIS 2.5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
ELIQUIS 5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed; QL (218 tablets per 102 days)
ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG PACK	Formulary	PDL Preferred; 3 Months Allowed; QL (74 tablets per 30 days)
<i>rivaroxaban 2.5 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
SAVAYSA 15 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SAVAYSA 30 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SAVAYSA 60 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
XARELTO 1 MG/ML SUSPENSION	Formulary	PDL Preferred; 3 Months Allowed; QL (20 ML per 1 day)
XARELTO 10 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 10 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 10 MG TABLET OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 15 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 15 MG TABLET OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 2.5 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
XARELTO 2.5 MG TABLET OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 tablets per 1 day)
XARELTO 20 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO 20 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
XARELTO 20 MG TABLET OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
XARELTO DVT-PE TREATMENT 30-DAY STARTER 15-20 MG PACK	Formulary	PDL Preferred; 3 Months Allowed; QL (51 tablets per 30 days)
<i>Erythropoietins</i>		
ARANESP 10 MCG/0.4 ML SYRINGE P/F, INNER, SUV	Formulary	PA; PDL Preferred
ARANESP 10 MCG/0.4 ML SYRINGE P/F, OUTER, SUV	Formulary	PA; PDL Preferred
ARANESP 100 MCG/0.5 ML SYRINGE P/F, SDV, INNER	Formulary	PA; PDL Preferred
ARANESP 100 MCG/0.5 ML SYRINGE P/F, SDV, OUTER	Formulary	PA; PDL Preferred
ARANESP 100 MCG/ML VIAL P/F, 4'S, SDV	Formulary	PA; PDL Preferred
ARANESP 100 MCG/ML VIAL P/F, SDV	Formulary	PA; PDL Preferred
ARANESP 150 MCG/0.3 ML SYRINGE P/F, SDV, INNER	Formulary	PA; PDL Preferred
ARANESP 150 MCG/0.3 ML SYRINGE P/F, SDV, OUTER	Formulary	PA; PDL Preferred
ARANESP 200 MCG/0.4 ML SYRINGE P/F, SDV	Formulary	PA; PDL Preferred
ARANESP 200 MCG/ML VIAL	Formulary	PA; PDL Preferred
ARANESP 25 MCG/0.42 ML SYRING P/F,SDV,INNER	Formulary	PA; PDL Preferred
ARANESP 25 MCG/0.42 ML SYRING P/F,SDV,OUTER	Formulary	PA; PDL Preferred
ARANESP 25 MCG/ML VIAL P/F,SDV,INNER	Formulary	PA; PDL Preferred
ARANESP 25 MCG/ML VIAL P/F,SDV,OUTER	Formulary	PA; PDL Preferred
ARANESP 300 MCG/0.6 ML SYRINGE	Formulary	PA; PDL Preferred
ARANESP 40 MCG/0.4 ML SYRINGE P/F, INNER, SDV	Formulary	PA; PDL Preferred
ARANESP 40 MCG/0.4 ML SYRINGE P/F,SDV,OUTER	Formulary	PA; PDL Preferred
ARANESP 40 MCG/ML VIAL P/F,SDV,INNER	Formulary	PA; PDL Preferred
ARANESP 40 MCG/ML VIAL P/F,SDV,OUTER	Formulary	PA; PDL Preferred

Medications	Coverage Level	Restrictions
ARANESP 500 MCG/1 ML SYRINGE	Formulary	PA; PDL Preferred
ARANESP 60 MCG/0.3 ML SYRINGE P/F,SDV, OUTER	Formulary	PA; PDL Preferred
ARANESP 60 MCG/0.3 ML SYRINGE P/F,SDV,INNER	Formulary	PA; PDL Preferred
ARANESP 60 MCG/ML VIAL P/F,SDV,INNER	Formulary	PA; PDL Preferred
ARANESP 60 MCG/ML VIAL P/F,SDV,OUTER	Formulary	PA; PDL Preferred
EPOGEN 10,000 UNITS/ML VIAL SDV, P/F, INNER	Formulary	PA; PDL Preferred
EPOGEN 10,000 UNITS/ML VIAL SDV, P/F, OUTER	Formulary	PA; PDL Preferred
EPOGEN 2,000 UNITS/ML VIAL SDV, P/F, INNER	Formulary	PA; PDL Preferred
EPOGEN 2,000 UNITS/ML VIAL SDV, P/F, OUTER	Formulary	PA; PDL Preferred
EPOGEN 20,000 UNIT/2 ML VIAL MDV, INNER	Formulary	PA; PDL Preferred
EPOGEN 20,000 UNIT/2 ML VIAL MDV, OUTER	Formulary	PA; PDL Preferred
EPOGEN 20,000 UNITS/ML VIAL INNER, MDV	Formulary	PA; PDL Preferred
EPOGEN 20,000 UNITS/ML VIAL MDV, OUTER	Formulary	PA; PDL Preferred
EPOGEN 3,000 UNITS/ML VIAL SDV, P/F, INNER	Formulary	PA; PDL Preferred
EPOGEN 3,000 UNITS/ML VIAL SDV, P/F, OUTER	Formulary	PA; PDL Preferred
EPOGEN 4,000 UNITS/ML VIAL SDV, P/F, INNER	Formulary	PA; PDL Preferred
EPOGEN 4,000 UNITS/ML VIAL SDV, P/F, OUTER	Formulary	PA; PDL Preferred
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 150 MCG/0.3 ML, 200 MCG/0.3 ML, 30 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	Non-Formulary	
PROCRIT 10,000 UNITS/ML VIAL 25'S,SDV,P/F	Formulary	PA; PDL Non-Preferred
PROCRIT 10,000 UNITS/ML VIAL SDV,P/F,OUTER	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
PROCRIT 2,000 UNITS/ML VIAL SDV,P/F, OUTER	Formulary	PA; PDL Non-Preferred
PROCRIT 20,000 UNIT/2 ML VIAL 4'S, MDV, OUTER	Formulary	PA; PDL Non-Preferred
PROCRIT 20,000 UNITS/ML VIAL 4'S,MDV, OUTER	Formulary	PA; PDL Non-Preferred
PROCRIT 3,000 UNITS/ML VIAL SDV,P/F, OUTER	Formulary	PA; PDL Non-Preferred
PROCRIT 4,000 UNITS/ML VIAL SDV, P/F, OUTER	Formulary	PA; PDL Non-Preferred
PROCRIT 40,000 UNITS/ML VIAL OUTER, SDV,P/F	Formulary	PA; PDL Non-Preferred
RETACRIT 10,000 UNIT/ML VIAL P/F, OUTER, SDV	Formulary	PA; PDL Preferred
RETACRIT 10,000 UNIT/ML VIAL SUV, P/F, INNER	Formulary	PA; PDL Preferred
RETACRIT 10,000 UNIT/ML VIAL SUV, P/F, OUTER	Formulary	PA; PDL Preferred
RETACRIT 2,000 UNIT/ML VIAL P/F, OUTER, SDV	Formulary	PA; PDL Preferred
RETACRIT 2,000 UNIT/ML VIAL SUV, P/F, INNER	Formulary	PA; PDL Preferred
RETACRIT 2,000 UNIT/ML VIAL SUV, P/F, OUTER	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/2 ML VIAL MUV, INNER	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/2 ML VIAL MUV, OUTER	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/2 ML VIAL OUTER, MUV	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/ML VIAL MUV,INNER	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/ML VIAL MUV,OUTER	Formulary	PA; PDL Preferred
RETACRIT 20,000 UNIT/ML VIAL OUTER, MUV	Formulary	PA; PDL Preferred
RETACRIT 3,000 UNIT/ML VIAL P/F, OUTER, SDV	Formulary	PA; PDL Preferred
RETACRIT 3,000 UNIT/ML VIAL SUV, P/F, INNER	Formulary	PA; PDL Preferred

Medications	Coverage Level	Restrictions
RETACRIT 3,000 UNIT/ML VIAL SUV, P/F, OUTER	Formulary	PA; PDL Preferred
RETACRIT 4,000 UNIT/ML VIAL P/F, OUTER, SDV	Formulary	PA; PDL Preferred
RETACRIT 4,000 UNIT/ML VIAL SUV, P/F, INNER	Formulary	PA; PDL Preferred
RETACRIT 4,000 UNIT/ML VIAL SUV, P/F, OUTER	Formulary	PA; PDL Preferred
RETACRIT 40,000 UNIT/ML VIAL P/F, OUTER, SDV	Formulary	PA; PDL Preferred
<i>Factor Ix Complex (Prothrombin Complex Concentrate) Preparations</i>		
BALFAXAR	State Carve Out	
KCENTRA	State Carve Out	
<i>Factor Ix Preparations</i>		
ALPHANINE SD	State Carve Out	
ALPROLIX	State Carve Out	
BENEFIX	State Carve Out	
IDELVION	State Carve Out	
IXINITY	State Carve Out	
PROFILNINE	State Carve Out	
REBINYN	State Carve Out	
RIXUBIS	State Carve Out	
<i>Factor Vii Preparations</i>		
NOVOSEVEN RT	State Carve Out	
SEVENFACT	State Carve Out	
<i>Factor Viii Preparations (Ahf)</i>		
ADVATE	State Carve Out	
ADYNOVATE	State Carve Out	
AFSTYLA	State Carve Out	
ALPHANATE	State Carve Out	
ALTUVIIIIO	State Carve Out	
ELOCTATE	State Carve Out	
ESPEROCT	State Carve Out	
HEMOFIL M HIGH	State Carve Out	
HEMOFIL M LOW	State Carve Out	
HEMOFIL M MID	State Carve Out	
HEMOFIL M SUPER HIGH	State Carve Out	

Medications	Coverage Level	Restrictions
HUMATE-P	State Carve Out	
JIVI	State Carve Out	
KOATE	State Carve Out	
KOGENATE FS	State Carve Out	
KOVALTRY	State Carve Out	
NOVOEIGHT	State Carve Out	
NUWIQ INTRAVENOUS RECON SOLN 1000 UNIT, 2,000 UNIT, 2,500 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT	State Carve Out	
OBIZUR	State Carve Out	
RECOMBINATE	State Carve Out	
WILATE	State Carve Out	
XYNTHA	State Carve Out	
XYNTHA SOLOFUSE	State Carve Out	
<i>Factor X Preparations</i>		
COAGADEX	State Carve Out	
<i>Factor Xiii Preparations</i>		
CORIFACT	State Carve Out	
TRETTEN	State Carve Out	
<i>Gene Therapy Agents - Cd34+ Hematopoietic Stem Cells (Hscs)</i>		
CASGEVY	State Carve Out	
LYFGENIA	State Carve Out	
ZYNTGLO	State Carve Out	
<i>Granulocyte Colony-Stimulating Factor (G-Csf)</i>		
FULPHILA 6 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
FYLNETRA 6 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
GRANIX 300 MCG/0.5 ML SAFE SYR P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred
GRANIX 300 MCG/0.5 ML SYRINGE P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred
GRANIX 300 MCG/ML VIAL SUV, OUTER	Formulary	PA; PDL Non-Preferred
GRANIX 480 MCG/0.8 ML SAFE SYR P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred
GRANIX 480 MCG/0.8 ML SYRINGE P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
GRANIX 480 MCG/1.6 ML VIAL SUV, OUTER	Formulary	PA; PDL Non-Preferred
NEULASTA 6 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
NEULASTA ONPRO 6 MG/0.6 ML KIT	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
NEUPOGEN 300 MCG/0.5 ML SYR P/F, INNER, SUV	Formulary	PDL Preferred
NEUPOGEN 300 MCG/0.5 ML SYR P/F, OUTER, SUV	Formulary	PDL Preferred
NEUPOGEN 300 MCG/0.5 ML SYR P/F, SUV	Formulary	PDL Preferred
NEUPOGEN 300 MCG/ML VIAL SUV, INNER	Formulary	PDL Preferred
NEUPOGEN 300 MCG/ML VIAL SUV, OUTER	Formulary	PDL Preferred
NEUPOGEN 480 MCG/0.8 ML SYR 10'S,P/F, SUV	Formulary	PDL Preferred
NEUPOGEN 480 MCG/0.8 ML SYR P/F, SUV	Formulary	PDL Preferred
NEUPOGEN 480 MCG/1.6 ML VIAL SUV, INNER	Formulary	PDL Preferred
NEUPOGEN 480 MCG/1.6 ML VIAL SUV, OUTER	Formulary	PDL Preferred
NIVESTYM 300 MCG/0.5 ML SYRING P/F, SUV, INNER	Formulary	PA; PDL Non-Preferred
NIVESTYM 300 MCG/0.5 ML SYRING P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
NIVESTYM 300 MCG/ML VIAL P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
NIVESTYM 480 MCG/0.8 ML SYRING P/F, SUV, INNER	Formulary	PA; PDL Non-Preferred
NIVESTYM 480 MCG/0.8 ML SYRING P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
NIVESTYM 480 MCG/1.6 ML VIAL P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
NYVEPRIA 6 MG/0.6 ML SYRINGE	Formulary	PDL Preferred; QL (0.6 ML per 14 days)
RELEUKO 300 MCG/0.5 ML SYRINGE P/F, SUV, INNER	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
RELEUKO 300 MCG/0.5 ML SYRINGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
RELEUKO 480 MCG/0.8 ML SYRINGE P/F, SUV, INNER	Formulary	PA; PDL Non-Preferred
RELEUKO 480 MCG/0.8 ML SYRINGE P/F, SUV, OUTER	Formulary	PA; PDL Non-Preferred
STIMUFEND 6 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
UDENYCA 6 MG/0.6 ML AUTOINJECT	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
UDENYCA 6 MG/0.6 ML ONBODY	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
UDENYCA 6 MG/0.6 ML SYRINGE	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
ZARXIO 300 MCG/0.5 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred; QL (45 ML per 30 days)
ZARXIO 300 MCG/0.5 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred; QL (45 ML per 30 days)
ZARXIO 480 MCG/0.8 ML SYRINGE OUTER, P/F, SUV	Formulary	PA; PDL Non-Preferred; QL (45 ML per 30 days)
ZARXIO 480 MCG/0.8 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred; QL (45 ML per 30 days)
ZIEXTENZO 6 MG/0.6 ML SYRINGE P/F, SUV	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
ZIEXTENZO 6 MG/0.6 ML SYRINGE SUV, P/F	Formulary	PA; PDL Non-Preferred; QL (0.6 ML per 14 days)
<i>Granulocyte-Macrophage Colony-Stimulating Factor (Gm-Csf)</i>		
LEUKINE 250 MCG VIAL OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
<i>Hematopoietic Agents - Hypoxia Inducible Factor Prolyl Hydroxylase Inh</i>		
VAFSEO 150 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
VAFSEO 300 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
<i>Hematorheologic Agents</i>		
<i>pentoxifylline er 400 mg tab</i>	Formulary	
<i>pentoxifylline er 400 mg tab f/c</i>	Formulary	
<i>pentoxifylline er 400 mg tab u-d,10x10,f/c</i>	Formulary	

Medications	Coverage Level	Restrictions
Hemophilia Treatment Agents - Monoclonal Antibody		
ALHEMO PEN	State Carve Out	
HEMLIBRA	State Carve Out	
HYMPAVZI PEN	State Carve Out	
Hemophilia Treatment Agents - Small Interfering Rna (Sirna)		
QFITLIA	State Carve Out	
QFITLIA PEN	State Carve Out	
Hemostatic Systemic - Antifibrinolytic Agents		
AMICAR	State Carve Out	
<i>aminocaproic acid</i>	State Carve Out	
CYKLOKAPRON	State Carve Out	
FIBRYGA	State Carve Out	
LYSTEDA	State Carve Out	
RIASTAP	State Carve Out	
<i>tranexamic acid</i>	State Carve Out	
<i>tranexamic acid in nacl,iso-os</i>	State Carve Out	
Hemostatic Systemic- Von Willebrand Factor (Vwf) Preparations		
VONVENDI	State Carve Out	
Heparin Flush Formulations		
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution</i>	Non-Formulary	
<i>heparin lock flush (porcine) intravenous solution 10 unit/ml</i>	Non-Formulary	
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml, 100 unit/ml</i>	Non-Formulary	
Heparins		
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	Non-Formulary	
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution</i>	Non-Formulary	
<i>heparin (porcine) injection cartridge</i>	Non-Formulary	
<i>heparin (porcine) injection solution 1,000 unit/ml, 20,000 unit/ml</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>heparin (porcine) injection syringe 5,000 unit/ml</i>	Non-Formulary	
<i>heparin lock flush (porcine) intravenous solution 10 unit/ml</i>	Non-Formulary	
<i>heparin sodium 10,000 unit/ml vial</i>	Formulary	
<i>heparin sodium 10,000 unit/ml vial mov, outer</i>	Formulary	
<i>heparin sodium 10,000 unit/ml vial outer</i>	Formulary	
<i>heparin sodium 10,000 unit/ml vial outer, mdv</i>	Formulary	
<i>heparin sodium 10,000 unit/ml vial outer, suv</i>	Formulary	
<i>heparin sodium 10,000 unit/ml vial suv, outer</i>	Formulary	
<i>heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv</i>	Formulary	
<i>heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv,25's</i>	Formulary	
<i>heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv,outer</i>	Formulary	
<i>heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mov, outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial mdv, outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial mdv,25's</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial mdv,outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial mov, outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial mov,outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial outer</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial outer, mov</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial outer, suv</i>	Formulary	
<i>heparin sodium 5,000 unit/ml vial suv, outer</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial inner,mov</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mdv,25's</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mdv,outer</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mov, outer</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mov,outer</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer, mov</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer,mdv</i>	Formulary	
<i>heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer,muv</i>	Formulary	
<i>heparin sodium 50,000 unit/5 ml (10,000 unit/ml) vial mov, inner</i>	Formulary	
<i>heparin sodium 50,000 unit/5 ml (10,000 unit/ml) vial mov, outer</i>	Formulary	
<i>heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml</i>	Non-Formulary	
<i>heparin, porcine (pf) injection</i>	Non-Formulary	
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml, 100 unit/ml</i>	Non-Formulary	
<i>heparin, porcine (pf) subcutaneous</i>	Non-Formulary	
Human Albumin		
ALBUKED-25	State Carve Out	
ALBUKED-5	State Carve Out	
<i>albumin, human 25 %</i>	State Carve Out	
<i>albumin, human 5 %</i>	State Carve Out	
ALBUMINAR 25 %	State Carve Out	
ALBUMINEX 25 %	State Carve Out	
ALBUMINEX 5 %	State Carve Out	
ALBURX (HUMAN) 25 %	State Carve Out	
ALBURX (HUMAN) 5 %	State Carve Out	
ALBUTEIN 25 %	State Carve Out	
ALBUTEIN 5 %	State Carve Out	
FLEXBUMIN 25 %	State Carve Out	
FLEXBUMIN 5 %	State Carve Out	
PLASBUMIN 25 %	State Carve Out	
PLASBUMIN 5 %	State Carve Out	
Indirect Factor Xa Inhibitors		
ARIXTRA 10 MG/0.8 ML SYRINGE P/F, OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ARIXTRA 2.5 MG/0.5 ML SYRINGE P/F, OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ARIXTRA 5 MG/0.4 ML SYRINGE P/F, OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ARIXTRA 7.5 MG/0.6 ML SYRINGE P/F, OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr outer, p/f, sdv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr p/f, suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr p/f,suv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr sdv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr sdv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr sdv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 10 mg/0.8 ml syr suv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr outer, p/f, sdv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr p/f, suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr p/f,suv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr sdv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr sdv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 2.5 mg/0.5 ml syr suv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 5 mg/0.4 ml syr outer, p/f, sdv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 5 mg/0.4 ml syr p/f, suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 5 mg/0.4 ml syr p/f,suv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 5 mg/0.4 ml syr sdv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>fondaparinux 5 mg/0.4 ml syr sdv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 5 mg/0.4 ml syr suv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr outer, p/f, sdv</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr p/f, suv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr p/f,suv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr sdv, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr sdv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr sdv,outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fondaparinux 7.5 mg/0.6 ml syr suv, p/f, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Low Molecular Weight Heparins		
<i>enoxaparin 100 mg/ml syringe auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe outer, p/f, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe outer, suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe outer,p/f,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe p/f, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe suv, p/f, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe suv,p/f,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 100 mg/ml syringe suv,p/f,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr outer, suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>enoxaparin 120 mg/0.8 ml syr outer,p/f,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr outer,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr p/f, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr suv, p/f, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr suv,p/f,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 120 mg/0.8 ml syr suv,p/f,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe outer, suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe outer,p/f,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe p/f, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe suv,p/f,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 150 mg/ml syringe suv,p/f,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr outer, p/f, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr outer, suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr outer,p/f,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr p/f, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr suv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>enoxaparin 30 mg/0.3 ml syr suv, plf, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr suv,plf,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 30 mg/0.3 ml syr suv,plf,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 300 mg/3 ml vial mdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 300 mg/3 ml vial muv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr outer, plf, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr outer, suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr outer,plf,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr plf, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr suv, plf, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 40 mg/0.4 ml syr suv,plf,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr outer, plf, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr outer, suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr outer,plf,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr outer,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr plf, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr plf, suv, outer</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>enoxaparin 60 mg/0.6 ml syr suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr suv, plf, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr suv,plf,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 60 mg/0.6 ml syr suv,plf,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr auto dev, sdv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr outer, suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr outer,plf,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr outer,suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr plf, outer, suv</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr suv, plf</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr suv, plf, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr suv,plf,inner</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>enoxaparin 80 mg/0.8 ml syr suv,plf,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
FRAGMIN 10,000 UNIT/4 ML VIAL OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 10,000 UNIT/ML SYRINGE P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 12,500 UNIT/0.5 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 15,000 UNIT/0.6 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 18,000 UNIT/0.72 ML P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 2,500 UNIT/0.2 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 5,000 UNIT/0.2 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
FRAGMIN 7,500 UNIT/0.3 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
FRAGMIN 95,000 UNIT/3.8 ML VL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 100 MG/ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 100 MG/ML SYRINGE OUTER,SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 120 MG/0.8 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 150 MG/ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 30 MG/0.3 ML SYRINGE OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 30 MG/0.3 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 300 MG/3 ML VIAL MDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 300 MG/3 ML VIAL MULTI USE VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 40 MG/0.4 ML SYRINGE OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 40 MG/0.4 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 60 MG/0.6 ML SYRINGE OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 60 MG/0.6 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 80 MG/0.8 ML SYRINGE OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LOVENOX 80 MG/0.8 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Plasma Fractions</i>		
OCTAPLAS (BLOOD GROUP A)	State Carve Out	
OCTAPLAS (BLOOD GROUP AB)	State Carve Out	
OCTAPLAS (BLOOD GROUP B)	State Carve Out	
OCTAPLAS (BLOOD GROUP O)	State Carve Out	
PLASMANATE	State Carve Out	

Medications	Coverage Level	Restrictions
Plasma Proteins Which Facilitate Anticoagulation		
RYPLAZIM	State Carve Out	
THROMBATE III	State Carve Out	
Platelet Aggregation Inhib - Cyclopentyl-Triazolo-Pyrimidines (Cptps)		
BRILINTA 60 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
BRILINTA 90 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
BRILINTA 90 MG TABLET F/C, U-D	Formulary	PDL Preferred; 3 Months Allowed
<i>ticagrelor 90 mg tablet</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
Platelet Aggregation Inhibitor Combinations		
<i>aspirin-dipyridam er 25-200 mg</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Platelet Aggregation Inhibitors - Phosphodiesterase Iii Inhibitors		
<i>cilostazol 100 mg tablet</i>	Formulary	
<i>cilostazol 100 mg tablet outer</i>	Formulary	
<i>cilostazol 50 mg tablet</i>	Formulary	
<i>cilostazol 50 mg tablet outer</i>	Formulary	
Platelet Aggregation Inhibitors - Quinazoline Agents		
AGRYLIN	Non-Formulary	
<i>anagrelide hcl 0.5 mg capsule</i>	Formulary	
<i>anagrelide hcl 1 mg capsule</i>	Formulary	
Platelet Aggregation Inhibitors - Salicylates		
<i>aspirin 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 325 mg tablet micro-coated</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin 81 mg chewable tablet</i>	Formulary	OTC; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
<i>aspirin 81 mg chewable tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet gluten-free, orange</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet low dose</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin 81 mg chewable tablet low dose, cherry</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>aspirin ec 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin ec 325 mg tablet safety-coated</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>aspirin ec 81 mg tablet low dose</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
ASPIRIN REGIMEN 81 MG EC TAB	Formulary	OTC; QL (3 tablets per 1 day)
<i>ft aspirin 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>ft aspirin 81 mg chewable tab</i>	Formulary	OTC; QL (2 tablets per 1 day)
<i>ft aspirin ec 325 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>ft aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>gnp aspirin 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>gnp aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>gnp aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>gnp aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>gs aspirin 81 mg chewable tab</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>hm aspirin 81 mg chewable tab adlt low dose, orange</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
<i>hm aspirin ec 81 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
<i>sm aspirin 81 mg chewable tab</i>	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
<i>sm aspirin ec 325 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
<i>sm aspirin ec 81 mg tablet</i>	Formulary	OTC; QL (3 tablets per 1 day)
<i>sm aspirin ec 81 mg tablet adult low strength</i>	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
Platelet Aggregation Inhibitors - Thienopyridine Agents		
<i>clopidogrel 300 mg tablet</i>	Formulary	PDL Preferred; QL (2 tablets per 30 days)
<i>clopidogrel 300 mg tablet f/c</i>	Formulary	PDL Preferred; QL (2 tablets per 30 days)
<i>clopidogrel 300 mg tablet f/c, u-d,5x6,outer</i>	Formulary	PDL Preferred; QL (2 tablets per 30 days)
<i>clopidogrel 300 mg tablet outer</i>	Formulary	PDL Preferred; QL (2 tablets per 30 days)
<i>clopidogrel 75 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>clopidogrel 75 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>clopidogrel 75 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>clopidogrel 75 mg tablet f/c,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>clopidogrel 75 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
EFFIENT 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
EFFIENT 5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
PLAVIX 75 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
<i>prasugrel 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
<i>prasugrel 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 75 Years)

Medications	Coverage Level	Restrictions
<i>prasugrel 5 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
<i>Platelet Aggregation Inhib-Pdesterase And Adenosine Deaminase Inhibitr</i>		
<i>dipyridamole 25 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>dipyridamole 25 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>dipyridamole 50 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>dipyridamole 50 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>dipyridamole 75 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>dipyridamole 75 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>Pnh - Complement (C3) Inhibitors</i>		
EMPAVELI	State Carve Out	
<i>Pnh - Complement Factor B Inhibitors</i>		
FABHALTA	State Carve Out	
<i>Pnh - Complement Factor D Inhibitors</i>		
VOYDEYA	State Carve Out	
<i>Pnh - Human Monoclonal Antibody Complement (C5) Inhibitors</i>		
BKEMV	State Carve Out	
EPYSQLI	State Carve Out	
PIASKY	State Carve Out	
SOLIRIS	State Carve Out	
ULTOMIRIS	State Carve Out	
<i>Pyruvate Kinase (Pk) Activators</i>		
PYRUKYND	State Carve Out	
<i>Sickle Cell Anemia Agents - Cell/Gene Therapy</i>		
CASGEVY	State Carve Out	
LYFGENIA	State Carve Out	
<i>Sickle Cell Anemia Agents, Others</i>		
DROXIA 200 MG CAPSULE	Formulary	3 Months Allowed
DROXIA 300 MG CAPSULE	Formulary	3 Months Allowed

Medications	Coverage Level	Restrictions
DROXIA 400 MG CAPSULE	Formulary	3 Months Allowed
ENDARI	Non-Formulary	
<i>glutamine powder (rx)</i>	Formulary	OTC
<i>l-glutamine 5 gram powder pkt outer</i>	Formulary	PA; 3 Months Allowed; QL (6 packets per 1 day); Age Limit (Min 5 Years)
<i>l-glutamine powder (rx)</i>	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
<i>l-glutamine powder usp (rx)</i>	Formulary	OTC
SIKLOS 1,000 MG TABLET	Formulary	3 Months Allowed; Age Limit (Min 2 Years and Max 14 Years)
SIKLOS 100 MG TABLET	Formulary	3 Months Allowed; Age Limit (Min 2 Years and Max 14 Years)
<i>Sickle Hemoglobin (Hbs) Polymerization Inhibitor</i>		
OXBRYTA 300 MG TABLET	Formulary	PA; 3 Months Allowed; QL (3 tablets per 1 day); Age Limit (Min 4 Years)
OXBRYTA 300 MG TABLET FOR SUSP	Formulary	PA; 3 Months Allowed; QL (3 tablets per 1 day); Age Limit (Min 4 Years)
OXBRYTA 500 MG TABLET	Formulary	PA; 3 Months Allowed; QL (3 tablets per 1 day); Age Limit (Min 12 Years)
<i>Thrombin Inhibitor - Selective Direct And Reversible</i>		
<i>dabigatran etexilate 110 mg cp</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 110 mg cp</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (4 capsules per 1 day)
<i>dabigatran etexilate 110 mg cp inner</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (4 capsules per 1 day)
<i>dabigatran etexilate 110 mg cp outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (4 capsules per 1 day)

Medications	Coverage Level	Restrictions
<i>dabigatran etexilate 150 mg cp</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 150 mg cp inner</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 150 mg cp outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 75 mg cap</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 75 mg cap inner</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
<i>dabigatran etexilate 75 mg cap outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
PRADAXA 110 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed; QL (4 capsules per 1 day)
PRADAXA 110 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 150 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
PRADAXA 150 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 20 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 30 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 40 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 50 MG PELLETT PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)

Medications	Coverage Level	Restrictions
PRADAXA 75 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
Thrombolytic - Tissue Plasminogen Activators		
CATHFLO ACTIVASE	Non-Formulary	
Thrombopoietin Receptor Agonists		
DOPTELET (10 TAB PACK)	Non-Formulary	
DOPTELET (15 TAB PACK)	Non-Formulary	
DOPTELET (30 TAB PACK)	Non-Formulary	
MULPLETA	Non-Formulary	
NPLATE SUBCUTANEOUS RECON SOLN 250 MCG, 500 MCG	Non-Formulary	
PROMACTA	Non-Formulary	
Hepatobiliary System Treatment Agents		
Farnesoid X Receptor (Fxr) Agonist, Bile Acid Analog		
OCALIVA	Non-Formulary	
Ileal Bile Acid Transporter (Ibat) Inhibitor		
BYLVAY	State Carve Out	
LIVMARLI ORAL SOLUTION 19 MG/ML	State Carve Out	
Immunosuppressive Agents		
Immunosuppressive - Calcineurin Inhibitors		
ASTAGRAF XL 0.5 MG CAPSULE	Formulary	
ASTAGRAF XL 1 MG CAPSULE	Formulary	
ASTAGRAF XL 5 MG CAPSULE	Formulary	
<i>cyclosporine 100 mg capsule</i>	Formulary	
<i>cyclosporine 100 mg capsule outer</i>	Formulary	
<i>cyclosporine 25 mg capsule</i>	Formulary	
<i>cyclosporine 25 mg capsule outer</i>	Formulary	
<i>cyclosporine modified 100 mg</i>	Formulary	
<i>cyclosporine modified 100 mg outer</i>	Formulary	
<i>cyclosporine modified 100 mg softgel,outer</i>	Formulary	
<i>cyclosporine modified 100 mg/ml</i>	Formulary	
<i>cyclosporine modified 25 mg</i>	Formulary	
<i>cyclosporine modified 25 mg outer</i>	Formulary	
<i>cyclosporine modified 25 mg outer, softgel</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>cyclosporine modified 50 mg</i>	Formulary	
<i>cyclosporine modified 50 mg outer</i>	Formulary	
ENVARBUS XR 0.75 MG TABLET	Formulary	
ENVARBUS XR 1 MG TABLET	Formulary	
ENVARBUS XR 4 MG TABLET	Formulary	
GENGRAF 100 MG CAPSULE	Formulary	
GENGRAF 100 MG/ML SOLUTION	Formulary	
GENGRAF 25 MG CAPSULE	Formulary	
LUPKYNIS	Non-Formulary	
NEORAL 100 MG GELATIN CAPSULE INNER, U-D	Formulary	
NEORAL 100 MG GELATIN CAPSULE OUTER, U-D	Formulary	
NEORAL 100 MG/ML SOLUTION	Formulary	
NEORAL 25 MG GELATIN CAPSULE INNER, U-D	Formulary	
NEORAL 25 MG GELATIN CAPSULE OUTER, U-D	Formulary	
PROGRAF 0.2 MG GRANULE PACKET	Formulary	
PROGRAF 0.5 MG CAPSULE	Formulary	
PROGRAF 1 MG CAPSULE	Formulary	
PROGRAF 1 MG GRANULE PACKET	Formulary	
PROGRAF 5 MG CAPSULE	Formulary	
SANDIMMUNE 100 MG CAPSULE U-D, SANDOPAK, OUTER	Formulary	
SANDIMMUNE 100 MG CAPSULE U-D, INNER	Formulary	
SANDIMMUNE 100 MG/ML SOLN	Formulary	
SANDIMMUNE 25 MG CAPSULE U-D, SANDOPAK, OUTER	Formulary	
SANDIMMUNE 25 MG CAPSULE U-D, INNER	Formulary	
<i>tacrolimus 0.5 mg capsule (immediate release)</i>	Formulary	
<i>tacrolimus 0.5 mg capsule (immediate release) 10x10, outer</i>	Formulary	
<i>tacrolimus 0.5 mg capsule (immediate release) u-d, 10x10, outer</i>	Formulary	
<i>tacrolimus 1 mg capsule (immediate release)</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>tacrolimus 1 mg capsule (immediate release) 10x10, outer</i>	Formulary	
<i>tacrolimus 1 mg capsule (immediate release) u-d, 10x10, outer</i>	Formulary	
<i>tacrolimus 5 mg capsule (immediate release)</i>	Formulary	
<i>tacrolimus 5 mg capsule (immediate release) 10x10, outer</i>	Formulary	
<i>tacrolimus 5 mg capsule (immediate release) u-d, 10x10, outer</i>	Formulary	
Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors		
CELLCEPT 200 MG/ML ORAL SUSP	Formulary	
CELLCEPT 250 MG CAPSULE	Formulary	
CELLCEPT 500 MG TABLET F/C	Formulary	
<i>mycophenolate 200 mg/ml susp</i>	Formulary	
<i>mycophenolate 250 mg capsule</i>	Formulary	
<i>mycophenolate 250 mg capsule outer</i>	Formulary	
<i>mycophenolate 250 mg capsule u-d, 10x10, outer</i>	Formulary	
<i>mycophenolate 500 mg tablet</i>	Formulary	
<i>mycophenolate 500 mg tablet f/c</i>	Formulary	
<i>mycophenolate 500 mg tablet outer</i>	Formulary	
<i>mycophenolate 500 mg tablet u-d, 10x10, outer, f/c</i>	Formulary	
<i>mycophenolic acid dr 180 mg tb</i>	Formulary	
<i>mycophenolic acid dr 180 mg tb f/c</i>	Formulary	
<i>mycophenolic acid dr 180 mg tb outer</i>	Formulary	
<i>mycophenolic acid dr 360 mg tb</i>	Formulary	
<i>mycophenolic acid dr 360 mg tb enteric coated</i>	Formulary	
<i>mycophenolic acid dr 360 mg tb enteric coated, outer</i>	Formulary	
<i>mycophenolic acid dr 360 mg tb f/c</i>	Formulary	
MYFORTIC 180 MG TABLET	Formulary	
MYFORTIC 360 MG TABLET	Formulary	
MYHIBBIN 200 MG/ML SUSPENSION	Formulary	

Medications	Coverage Level	Restrictions
Immunosuppressive - Interleukin-6 (Il-6) Receptor Inhibitors		
ENSPRYNG 120 MG/ML SYRINGE	Formulary	PA; QL (1 ML per 28 days); Age Limit (Min 18 Years)
Immunosuppressive - Mammalian Target Of Rapamycin (Mtor) Inhibitors		
<i>everolimus 0.25 mg tablet</i>	Formulary	
<i>everolimus 0.25 mg tablet outer</i>	Formulary	
<i>everolimus 0.5 mg tablet</i>	Formulary	
<i>everolimus 0.5 mg tablet outer</i>	Formulary	
<i>everolimus 0.75 mg tablet</i>	Formulary	
<i>everolimus 0.75 mg tablet outer</i>	Formulary	
<i>everolimus 1 mg tablet</i>	Formulary	
<i>everolimus 1 mg tablet outer</i>	Formulary	
RAPAMUNE 1 MG TABLET	Formulary	
RAPAMUNE 2 MG TABLET	Formulary	
<i>sirolimus 0.5 mg tablet</i>	Formulary	
<i>sirolimus 1 mg tablet</i>	Formulary	
<i>sirolimus 1 mg tablet outer</i>	Formulary	
<i>sirolimus 1 mg/ml solution</i>	Formulary	
<i>sirolimus 1 mg/ml solution outer</i>	Formulary	
<i>sirolimus 2 mg tablet</i>	Formulary	
ZORTRESS 0.25 MG TABLET 6X10, U-D, INNER	Formulary	
ZORTRESS 0.25 MG TABLET 6X10, U-D, OUTER	Formulary	
ZORTRESS 0.5 MG TABLET 6X10, U-D, INNER	Formulary	
ZORTRESS 0.5 MG TABLET 6X10, U-D, OUTER	Formulary	
ZORTRESS 0.75 MG TABLET 6X10, U-D, INNER	Formulary	
ZORTRESS 0.75 MG TABLET 6X10, U-D, OUTER	Formulary	
ZORTRESS 1 MG TABLET INNER	Formulary	
ZORTRESS 1 MG TABLET OUTER	Formulary	
Immunosuppressive - Purine Analogs		
AZASAN 100 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
AZASAN 75 MG TABLET	Formulary	
<i>azathioprine 100 mg tablet</i>	Formulary	
<i>azathioprine 50 mg tablet</i>	Formulary	
<i>azathioprine 50 mg tablet outer</i>	Formulary	
<i>azathioprine 75 mg tablet</i>	Formulary	
<i>azathioprine sodium</i>	Non-Formulary	
IMURAN 50 MG TABLET	Formulary	
Locomotor System		
Agents To Treat Periodic Paralysis - Carbonic Anhydrase Inhibitors		
<i>dichlorphenamide</i>	Non-Formulary	
KEVEYIS	Non-Formulary	
Als Agents - Antioxidants/Anti-Inflammatories		
<i>edaravone</i>	Non-Formulary	
RADICAVA	Non-Formulary	
RADICAVA ORS 105 MG/5 ML SUSP	Formulary	PA; QL (50 ML per 28 days); Age Limit (Min 20 Years)
RADICAVA ORS STARTER KIT SUSP OUTER	Formulary	PA; QL (50 ML per 28 days); Age Limit (Min 20 Years)
Amyotrophic Lateral Sclerosis (Als) Agents - Benzothiazoles		
RILUTEK	Non-Formulary	
<i>riluzole 50 mg tablet</i>	Formulary	
<i>riluzole 50 mg tablet f/c</i>	Formulary	
TIGLUTIK 50 MG/10 ML SUSP OUTER	Formulary	PA; Age Limit (Min 18 Years)
Antimyasthenic Agent - Reversible Cholinesterase Inhibitors		
MESTINON ORAL	Non-Formulary	
MESTINON TIMESPAN	Non-Formulary	
<i>pyridostigmine br 60 mg tablet</i>	Formulary	
<i>pyridostigmine br 60 mg tablet outer</i>	Formulary	
<i>pyridostigmine bromide oral syrup</i>	Non-Formulary	
<i>pyridostigmine bromide oral tablet 30 mg</i>	Non-Formulary	
<i>pyridostigmine er 180 mg tab</i>	Formulary	
Antimyasthenic Agents Other		
ZILBRYSQ	State Carve Out	

Medications	Coverage Level	Restrictions
Duchenne Muscular Dystrophy - Exon Skipping Antisense Oligonucleotide		
AMONDYS-45	State Carve Out	
EXONDYS-51	State Carve Out	
VILTEPSO	State Carve Out	
VYONDYS-53	State Carve Out	
Duchenne Muscular Dystrophy - Histone Deacetylase (Hdac) Inhibitor		
DUVYZAT	State Carve Out	
Fibrodysplasia Ossificans Progressiva-Retinoic Acid Receptor Agonists		
SOHONOS	State Carve Out	
Friedreich Ataxia-Nuclear Factor Erythroid-Rel.Factor2(Nrf2) Activator		
SKYCLARYS	State Carve Out	
Skeletal Muscle Relaxant - Analgesic Salicylate Combinations		
NORGESIC 25-385-30 MG TABLET	Formulary	PA; PDL Non-Preferred
NORGESIC FORTE 50-770-60 MG TB	Formulary	PA; PDL Non-Preferred
<i>orphenad-asa-caff 50-770-60 mg</i>	Formulary	PA; PDL Non-Preferred
<i>orphenadrine-aspirin-caffeine 25-385-30 mg tablet</i>	Formulary	PA; PDL Non-Preferred
ORPHENGESIC FORTE 50-770-60 MG	Formulary	PA; PDL Non-Preferred
Skeletal Muscle Relaxant - Central Muscle Relaxants		
AMRIX ER 15 MG CAPSULE	Formulary	PA; PDL Non-Preferred
AMRIX ER 30 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>baclofen 10 mg tablet</i>	Formulary	PDL Preferred
<i>baclofen 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>baclofen 10 mg/5 ml solution</i>	Formulary	PA; PDL Preferred
<i>baclofen 15 mg tablet</i>	Formulary	PDL Preferred
<i>baclofen 20 mg tablet</i>	Formulary	PDL Preferred
<i>baclofen 20 mg tablet outer</i>	Formulary	PDL Preferred
<i>baclofen 25 mg/5 ml suspension</i>	Formulary	PA; PDL Non-Preferred
<i>baclofen 5 mg tablet</i>	Formulary	PDL Preferred
<i>baclofen 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>baclofen 5 mg/5 ml solution</i>	Formulary	PA; PDL Preferred
<i>chlorzoxazone 250 mg tablet</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>chlorzoxazone 375 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>chlorzoxazone 500 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>chlorzoxazone 750 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>cyclobenzaprine 10 mg tablet</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 10 mg tablet flc</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 10 mg tablet outer</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 5 mg tablet</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 5 mg tablet flc</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 5 mg tablet outer</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 7.5 mg tablet</i>	Formulary	PDL Preferred
<i>cyclobenzaprine 7.5 mg tablet flc</i>	Formulary	PDL Preferred
<i>cyclobenzaprine er 15 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>cyclobenzaprine er 30 mg cap</i>	Formulary	PA; PDL Non-Preferred
FEXMID 7.5 MG TABLET	Formulary	PA; PDL Non-Preferred
FLEQSUVY 25 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred
LORZONE 375 MG TABLET	Formulary	PA; PDL Non-Preferred
LORZONE 750 MG TABLET	Formulary	PA; PDL Non-Preferred
LYVISPAH 10 MG GRANULE PACKET	Formulary	PA; PDL Non-Preferred
LYVISPAH 20 MG GRANULE PACKET	Formulary	PA; PDL Non-Preferred
LYVISPAH 5 MG GRANULE PACKET	Formulary	PA; PDL Non-Preferred
<i>metaxalone 400 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>metaxalone 640 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>metaxalone 800 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>metaxalone 800 mg tablet outer</i>	Formulary	PA; PDL Non-Preferred
<i>methocarbamol 1,000 mg tablet</i>	Formulary	PDL Preferred
<i>methocarbamol 500 mg tablet</i>	Formulary	PDL Preferred
<i>methocarbamol 500 mg tablet outer</i>	Formulary	PDL Preferred
<i>methocarbamol 750 mg tablet</i>	Formulary	PDL Preferred
<i>methocarbamol 750 mg tablet outer</i>	Formulary	PDL Preferred
<i>orphenadrine er 100 mg tablet</i>	Formulary	PDL Preferred
TANLOR 1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>tizanidine hcl 2 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>tizanidine hcl 2 mg tablet</i>	Formulary	PDL Preferred
<i>tizanidine hcl 2 mg tablet outer</i>	Formulary	PDL Preferred
<i>tizanidine hcl 4 mg capsule</i>	Formulary	PA; PDL Non-Preferred
<i>tizanidine hcl 4 mg tablet</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>tizanidine hcl 4 mg tablet outer</i>	Formulary	PDL Preferred
<i>tizanidine hcl 6 mg capsule</i>	Formulary	PA; PDL Non-Preferred
ZANAFLEX 2 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ZANAFLEX 4 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ZANAFLEX 4 MG TABLET	Formulary	PA; PDL Non-Preferred
ZANAFLEX 6 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>Skeletal Muscle Relaxant - Direct Muscle Relaxants</i>		
DANTRIUM 25 MG CAPSULE	Formulary	PA; PDL Non-Preferred
<i>dantrolene sodium 100 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>dantrolene sodium 25 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>dantrolene sodium 25 mg cap outer</i>	Formulary	PA; PDL Non-Preferred
<i>dantrolene sodium 25 mg cap u-d,3x10,outer</i>	Formulary	PA; PDL Non-Preferred
<i>dantrolene sodium 50 mg cap</i>	Formulary	PA; PDL Non-Preferred
<i>Spinal Muscular Atrophy - Exon Inclusion Antisense Oligonucleotide</i>		
SPINRAZA (PF)	State Carve Out	
<i>Spinal Muscular Atrophy - Motor Neuron 2 (Smn2) Splicing Modifier</i>		
EVRYSDI	State Carve Out	
Medical Supplies And Durable Medical Equipment (Dme)		
<i>Medical Supplies And Dme - Blood Glucose Tests</i>		
CONTOUR NEXT TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
CONTOUR TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE INSULINX STRIP NFRS NO CODE, NFRS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE INSULINX TEST STRIP NO CODE	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE INSULINX TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE LITE TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE LITE TEST STRIP NFRS	Formulary	OTC; QL (200 test strips per 30 days)

Medications	Coverage Level	Restrictions
FREESTYLE TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE TEST STRIPS NFRS NOT FOR RETAIL SALE	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION PCX PLUS TEST STR	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION PCX TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION POINT OF CARE STR	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION Q-I-D TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION XTRA TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION XTRA TEST STRIPS NOT FOR RETAIL SALE	Formulary	OTC; QL (200 test strips per 30 days)
<i>Medical Supplies And Dme - Cervical Caps</i>		
FEMCAP 22 MM CERVICAL CAP	Formulary	
FEMCAP 26 MM CERVICAL CAP	Formulary	
FEMCAP 30 MM CERVICAL CAP	Formulary	
<i>Medical Supplies And Dme - Diaphragms</i>		
CAYA CONTOURED DIAPHRAGM	Formulary	
WIDE SEAL DIAPHRAGM 60MM	Formulary	
WIDE SEAL DIAPHRAGM 65MM	Formulary	
WIDE SEAL DIAPHRAGM 70MM	Formulary	
WIDE SEAL DIAPHRAGM 75MM	Formulary	
WIDE SEAL DIAPHRAGM 80MM	Formulary	
WIDE SEAL DIAPHRAGM 85MM	Formulary	
WIDE SEAL DIAPHRAGM 90MM	Formulary	
WIDE SEAL DIAPHRAGM 95MM	Formulary	
<i>Medical Supplies And Dme - Female Condoms</i>		
FC2 FEMALE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
<i>Medical Supplies And Dme - Glucose Monitoring Test Supplies</i>		
ACCU-CHEK FASTCLIX LANCET DRUM	Formulary	OTC
ACCU-CHEK SAFE-T-PRO 23G LANCT	Formulary	OTC

Medications	Coverage Level	Restrictions
ACCU-CHEK SAFE-T-PRO PLUS 23G	Formulary	OTC
ACCU-CHEK SOFTCLIX LANCETS	Formulary	OTC
ACTI-LANCE LITE 28G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS STERILE, SINGLE-USE	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS STERILE,SINGLE-USE	Formulary	OTC
ACTI-LANCE UNIVERS 23G LANCETS	Formulary	OTC
ADVANCED TRAVEL 28G LANCETS SINGLE-USE,STERILE	Formulary	OTC
ADVOCATE 26G LANCETS 26 G,STERILE	Formulary	OTC
ADVOCATE 26G LANCETS STERILE	Formulary	OTC
ADVOCATE 30G LANCETS PULL TOP	Formulary	OTC
ADVOCATE 30G LANCETS THIN, STERILE	Formulary	OTC
ADVOCATE 30G LANCETS TWIST TOP	Formulary	OTC
ADVOCATE SAFETY 21G LANCET	Formulary	OTC
ADVOCATE SAFETY 23G LANCET	Formulary	OTC
ADVOCATE SAFETY 28G LANCET	Formulary	OTC
ALTERNATE SITE 26G LANCETS RECAPABLE	Formulary	OTC
<i>assure comfort 28g lancets</i>	Formulary	OTC
<i>assure comfort 30g lancets</i>	Formulary	OTC
ASSURE LANCE 25G LANCETS	Formulary	OTC
ASSURE LANCE 28G LANCETS	Formulary	OTC
ASSURE LANCE 28G SAFETY LANCET	Formulary	OTC
ASSURE LANCE PLUS 21G LANCETS	Formulary	OTC
ASSURE LANCE PLUS 25G LANCETS	Formulary	OTC
ASSURE LANCE PLUS 30G LANCETS	Formulary	OTC
BD MICROTAINER 21G LANCETS	Formulary	OTC
BD MICROTAINER 30G LANCETS	Formulary	OTC
<i>blood lancets 30g easy twist</i>	Formulary	OTC
BULLSEYE MINI SAFETY 21G	Formulary	OTC
BULLSEYE MINI SAFETY 25G LANCT	Formulary	OTC
BULLSEYE MINI SAFETY 28G LANCT	Formulary	OTC
CAREONE ULTRA THIN LANCET	Formulary	OTC

Medications	Coverage Level	Restrictions
CLEVER CHEK ULTRA THIN 30G	Formulary	OTC
COAGUCHEK LANCETS	Formulary	OTC
<i>cvs micro thin 33g lancets</i>	Formulary	OTC
CVS MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC
<i>cvs thin 26g lancets</i>	Formulary	OTC
<i>cvs ultra thin 30g lancets</i>	Formulary	OTC
CVS ULTRA THIN 30G LANCETS	Formulary	OTC
CVS ULTRA THIN 30G LANCETS STERILE	Formulary	OTC
DROPLET 30G LANCETS	Formulary	OTC
EASY COMFORT 30G LANCETS	Formulary	OTC
EASY COMFORT 30G LANCETS 30G,PULL TOP,STERILE	Formulary	OTC
EASY COMFORT 30G LANCETS 30G,TWIST TOP,STRL	Formulary	OTC
EASY COMFORT 30G LANCETS THIN TOP, SINGLE USE	Formulary	OTC
EASY TOUCH PULL-TOP 26G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 28G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 30G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 32G LANCET	Formulary	OTC
EASY TOUCH SAFETY 21G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 23G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 26G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 28G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 30G LANCETS STRL	Formulary	OTC
EASY TOUCH SAFETY 32G LANCETS	Formulary	OTC
EASY TOUCH TWIST 26G LANCETS	Formulary	OTC
EASY TOUCH TWIST 28G LANCETS	Formulary	OTC
EASY TOUCH TWIST 30G LANCETS	Formulary	OTC
EASY TOUCH TWIST 32G LANCETS	Formulary	OTC
EASY TOUCH TWIST 33G LANCETS	Formulary	OTC
EASY TWIST & CAP 28G LANCETS	Formulary	OTC
EMBRACE 30G LANCETS	Formulary	OTC
EQL MICRO THIN 33G LANCETS COLOR	Formulary	OTC
E-Z JECT COLORED LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
E-Z JECT LANCETS	Formulary	OTC
EZ SMART 28G LANCETS	Formulary	OTC
E-ZJECT COLOR 32G LANCETS	Formulary	OTC
E-ZJECT COLOR 33G LANCETS	Formulary	OTC
E-ZJECT SUPER THIN 30G LANCETS SUPER THIN	Formulary	OTC
<i>e-zject thin lancets 26 gauge</i>	Formulary	OTC
FIFTY50 UNILET 33G LANCETS	Formulary	OTC
FINGERSTIX LANCETS	Formulary	OTC
<i>fora 30g lancets twist off, single use</i>	Formulary	OTC
FORACARE 30G LANCETS	Formulary	OTC
FREESTYLE 28G LANCETS	Formulary	OTC
FREESTYLE UNISTIK 2 LANCETS	Formulary	OTC
GLUCOCOM 28G LANCETS	Formulary	OTC
GLUCOCOM 30G LANCETS	Formulary	OTC
GLUCOCOM 33G LANCETS	Formulary	OTC
GNP UNIVERSAL 1 STANDARD 21G	Formulary	OTC
GNP UNIVERSAL 1 THIN 26G LANCT	Formulary	OTC
GOJJI LANCETS 30G	Formulary	OTC
GS UNIVERSAL 1 MICRO THIN 33G	Formulary	OTC
GS UNIVERSAL 1 THIN 26G LANCET	Formulary	OTC
GS UNIVERSAL 1 ULTRA THIN 30G	Formulary	OTC
HEB MICRO THIN 33G LANCETS SINGLE- USE,STERILE	Formulary	OTC
INCONTROL SUPER THIN 30G LANCT	Formulary	OTC
INCONTROL ULTRA THIN 28G LANCT	Formulary	OTC
INJECT EASE 28G LANCETS	Formulary	OTC
INJECT EASE 30G LANCETS	Formulary	OTC
INVACARE 30G LANCETS	Formulary	OTC
KRO UNIVERSAL 1 THIN 26G LANCT	Formulary	OTC
<i>kroger lancets</i>	Formulary	OTC
KROGER SUPER THIN LANCETS	Formulary	OTC
<i>lancets</i>	Formulary	OTC
<i>lancets 26g x 1.8mm yellow</i>	Formulary	OTC
<i>lancets 28g lancets</i>	Formulary	OTC
<i>lancets 30g</i>	Formulary	OTC
<i>lancets 30g twist top, single use</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>lancets 33g</i>	Formulary	OTC
<i>lancets ultra fine 28g</i>	Formulary	OTC
LONGS THIN LANCETS 26G 26G	Formulary	OTC
LONGS THIN LANCETS 30G 30G	Formulary	OTC
MEDISENSE THIN 28G LANCETS	Formulary	OTC
<i>medisense thin lancets</i>	Formulary	OTC
MEDLANCE PLUS 21G LANCETS UNIVERSAL	Formulary	OTC
MEDLANCE PLUS 21G LANCETS UNIVERSAL, 1.8MM	Formulary	OTC
MEDLANCE PLUS 30G LANCETS SUPERLITE	Formulary	OTC
MEDLANCE PLUS 30G LANCETS SUPERLITE, 1.2MM	Formulary	OTC
MEDLANCE PLUS EXTRA 21G LANCET 2.4MM	Formulary	OTC
MEDLANCE PLUS LITE 25G LANCETS 1.5MM	Formulary	OTC
MEDLANCE PLUS LITE 25G LANCETS 25G	Formulary	OTC
<i>meijer lancets 30g</i>	Formulary	OTC
MEIJER UNIVERSAL 1 26G LANCETS	Formulary	OTC
MICRO THIN 33G LANCETS	Formulary	OTC
MICRO THIN 33G LANCETS FOR WALGREENS	Formulary	OTC
MICRO THIN 33G LANCETS STERILE	Formulary	OTC
MICRO THIN 33G LANCETS TRUE PLUS, WALGREENS	Formulary	OTC
MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC
MICROLET LANCETS	Formulary	OTC
MONOLET 21G LANCETS	Formulary	OTC
MONOLET THIN 28G LANCETS	Formulary	OTC
MYGLUCOHEALTH 30G LANCETS	Formulary	OTC
NOVA SAFETY 23G LANCETS	Formulary	OTC
NOVA SAFETY 28G LANCETS	Formulary	OTC
NOVA SUREFLEX THIN LANCETS	Formulary	OTC
ON CALL 30G LANCET	Formulary	OTC
ON-THE-GO 30G LANCETS GENTLE, 1.5MM	Formulary	OTC

Medications	Coverage Level	Restrictions
PC SUPER THIN 30G LANCETS	Formulary	OTC
PHARMACIST CHOICE 28G LANCETS ULTRA THIN	Formulary	OTC
<i>pharmacist choice 30g lancets ultra thin</i>	Formulary	OTC
<i>pharmacist choice 33g lancets</i>	Formulary	OTC
<i>preferred plus lancets super thin</i>	Formulary	OTC
<i>preferred plus thin lancets</i>	Formulary	OTC
PRESSURE ACTIVATED 21G LANCETS	Formulary	OTC
PRESSURE ACTIVATED 28G LANCETS	Formulary	OTC
PRODIGY PRESSURE ACTIVATED 28G	Formulary	OTC
PRODIGY SAFETY 26G LANCETS	Formulary	OTC
PRODIGY TWIST TOP 28G LANCET	Formulary	OTC
PUB MICRO THIN 33G LANCET	Formulary	OTC
PV UNILET MICRO THIN 33G LANCT	Formulary	OTC
PV UNILET SUPER THIN 30G LANCT	Formulary	OTC
QC UNILET SUPER THIN 30G LANCT	Formulary	OTC
QC UNILET ULTRA THIN 28G LANCT	Formulary	OTC
RA E-ZJECT 26G LANCETS	Formulary	OTC
RA E-ZJECT 28G LANCETS	Formulary	OTC
RA E-ZJECT 30G LANCETS ULTRA THIN	Formulary	OTC
RA E-ZJECT COLOR 33G LANCETS	Formulary	OTC
RELIAMED 28G LANCETS	Formulary	OTC
RELIAMED 30G LANCETS	Formulary	OTC
RELIAMED SAFETY SEAL 28G LANCT	Formulary	OTC
RELIAMED SAFETY SEAL 30G LANCT	Formulary	OTC
RELION MICRO THIN 33G LANCET	Formulary	OTC
<i>relion thin 26g lancets</i>	Formulary	OTC
RELION THIN 26G LANCETS	Formulary	OTC
RELION ULTRA THIN 30G LANCETS	Formulary	OTC
RELION ULTRA THIN 30G LANCETS 5 COLORS	Formulary	OTC
RELION ULTRA THIN PLUS 33G	Formulary	OTC
REXALL UNIVERSAL 1 30G LANCETS	Formulary	OTC
RIGHTEST GL300 30G LANCETS	Formulary	OTC
SAFETY 21G LANCETS	Formulary	OTC
SAFETY 28G LANCETS	Formulary	OTC
SAFETY SEAL 28G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
SAFETY SEAL 30G LANCETS	Formulary	OTC
SAFETY-LET 30G LANCETS	Formulary	OTC
<i>saps twist top 30g lancet</i>	Formulary	OTC
<i>saps twist top 30g lancets</i>	Formulary	OTC
SINGLE-LET LANCETS	Formulary	OTC
SM COLOR LANCETS 21G	Formulary	OTC
<i>sm lancets 21g</i>	Formulary	OTC
SM MICRO THIN 33G LANCETS	Formulary	OTC
SM SUPER THIN 30G LANCETS STERILE TIP	Formulary	OTC
SM THIN LANCETS 26G	Formulary	OTC
SMART SENSE COLOR 33G LANCETS	Formulary	OTC
SMART SENSE STANDARD 21G	Formulary	OTC
SMART SENSE SUPER THIN 30G	Formulary	OTC
SMART SENSE THIN 26G LANCETS	Formulary	OTC
SMARTEST LANCET	Formulary	OTC
SOLUS V2 28G LANCETS	Formulary	OTC
SOLUS V2 30G TWIST LANCETS	Formulary	OTC
STERILANCE TL TWIST 30G LANCET	Formulary	OTC
STERILANCE TL TWIST 32G LANCET	Formulary	OTC
SUPER THIN 28G LANCETS 28G, COMFORT ASSURED	Formulary	OTC
SUPER THIN 28G LANCETS STERILE	Formulary	OTC
SUPER THIN 30G LANCETS	Formulary	OTC
SUPER THIN 30G LANCETS RECAPABLE	Formulary	OTC
SURE COMFORT 18G LANCETS	Formulary	OTC
SURE COMFORT 21G LANCETS	Formulary	OTC
SURE COMFORT 23G LANCETS	Formulary	OTC
SURE COMFORT 28G LANCETS	Formulary	OTC
SURE COMFORT 30G LANCETS	Formulary	OTC
SURE-LANCE 26G LANCETS	Formulary	OTC
SURE-LANCE FLAT LANCETS	Formulary	OTC
SURE-LANCE THIN 28G LANCETS	Formulary	OTC
SURE-LANCE ULTRA THIN 30G	Formulary	OTC
SURE-TOUCH LANCET	Formulary	OTC
TECHLITE 26G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
TECHLITE 28G LANCETS	Formulary	OTC
TECHLITE 30G LANCETS	Formulary	OTC
TELCARE ULTRA THIN 30G LANCETS	Formulary	OTC
THIN 26G LANCETS	Formulary	OTC
THIN LANCETS 28G	Formulary	OTC
TOPCARE UNIVERSAL1 THIN LANCET THIN, 26G	Formulary	OTC
TOPCARE UNIVERSAL1 THIN LANCET ULTRA THIN, 30G	Formulary	OTC
TRUEPLUS 33G LANCETS	Formulary	OTC
TRUEPLUS SAFETY 28G LANCET	Formulary	OTC
TRUEPLUS SAFETY 28G LANCETS	Formulary	OTC
TRUEPLUS SUPER THIN 28G LANCET	Formulary	OTC
TRUEPLUS ULTRA THIN 30G LANCET	Formulary	OTC
<i>twist lancets 28g</i>	Formulary	OTC
ULTILET 28G LANCETS	Formulary	OTC
ULTILET 30G LANCETS	Formulary	OTC
ULTILET 33G LANCETS	Formulary	OTC
ULTILET BASIC 30G LANCETS	Formulary	OTC
ULTILET CLASSIC 26G LANCETS	Formulary	OTC
ULTILET CLASSIC 28G LANCETS	Formulary	OTC
ULTILET CLASSIC 30G LANCETS	Formulary	OTC
ULTILET CLASSIC 33G LANCETS	Formulary	OTC
ULTILET SAFETY 23G LANCETS	Formulary	OTC
ULTRA THIN 28G LANCETS 28G, STRL	Formulary	OTC
ULTRA THIN 28G LANCETS RECAPABLE	Formulary	OTC
ULTRA THIN 28G LANCETS ULTRA THIN	Formulary	OTC
ULTRA THIN 30G LANCETS	Formulary	OTC
ULTRA THIN 30G LANCETS STERILE	Formulary	OTC
ULTRA THIN 31G LANCET	Formulary	OTC
ULTRA THIN 31G LANCETS	Formulary	OTC
ULTRA THIN 33G LANCETS	Formulary	OTC
ULTRALANCE 26G LANCETS	Formulary	OTC
ULTRALANCE 28G LANCETS	Formulary	OTC
ULTRA-THIN II 28G LANCETS	Formulary	OTC
ULTRA-THIN II 30G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTRATLC LANCETS	Formulary	OTC
UNILET COMFORTOUCH 26G LANCETS	Formulary	OTC
UNILET COMFORTOUCH LANCET	Formulary	OTC
UNILET GP LANCET	Formulary	OTC
UNILET GP LANCET SUPERLITE	Formulary	OTC
UNILET MICRO THIN 33G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS SINGLE-USE,STERILE	Formulary	OTC
UNILET SUPER THIN 30G LANCETS SUPER THIN	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS 28G,ULTRA THIN,STRL	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS SINGLE-USE,STERILE	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS UNIVERSAL FIT	Formulary	OTC
UNISTIK 3 COMFORT 28G LANCET	Formulary	OTC
UNISTIK 3 EXTRA 21G LANCETS	Formulary	OTC
UNISTIK 3 GENTLE 30G LANCETS	Formulary	OTC
UNISTIK 3 GENTLE ON-THE-GO 30G	Formulary	OTC
UNISTIK 3 NORMAL 23G LANCETS	Formulary	OTC
UNISTIK CZT COMFORT 28G LANCET	Formulary	OTC
UNISTIK CZT NORMAL 23G LANCETS	Formulary	OTC
UNISTIK SAFETY 28G LANCET	Formulary	OTC
UNISTIK SAFETY 30G LANCETS	Formulary	OTC
UNISTIK TOUCH 21G LANCETS	Formulary	OTC
UNISTIK TOUCH 23G LANCETS	Formulary	OTC
UNISTIK TOUCH 28G LANCETS	Formulary	OTC
UNISTIK TOUCH 30G LANCETS	Formulary	OTC
UNIVERSAL 1 33G LANCETS	Formulary	OTC
WALGREENS THIN LANCETS THIN	Formulary	OTC
WALGREENS ULTRA THIN LANCETS	Formulary	OTC
<i>Medical Supplies And Dme - Insulin Needles-Syringes And Admin Supplies</i>		
1ST TIER UNIFINE PENTP 5MM 31G	Formulary	OTC

Medications	Coverage Level	Restrictions
1ST TIER UNIFINE PNTIP 4MM 32G	Formulary	OTC
1ST TIER UNIFINE PNTIP 6MM 31G	Formulary	OTC
1ST TIER UNIFINE PNTIP 8MM 31G STRL, SINGLE USE	Formulary	OTC
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT	Formulary	OTC
1ST TIER UNIFINE PNTIP 12MM 29G	Formulary	OTC
1ST TIER UNIFINE PNTIP 29GX1/2"	Formulary	OTC
1ST TIER UNIFINE PNTIP 31GX1/4"	Formulary	OTC
1ST TIER UNIFINE PNTIP 31GX3/16	Formulary	OTC
1ST TIER UNIFINE PNTIP 31GX5/16	Formulary	OTC
1ST TIER UNIFINE PNTIP 32GX5/32	Formulary	OTC
ADVOCATE INS 0.3 ML 30GX5/16"	Formulary	OTC
ADVOCATE INS 0.3 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS 0.5 ML 30GX5/16"	Formulary	OTC
ADVOCATE INS 0.5 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS 1 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS SYR 1 ML 30GX5/16	Formulary	OTC
ADVOCATE PEN NEEDLE 32G 4MM	Formulary	OTC
ADVOCATE PEN NEEDLE 4MM 33G	Formulary	OTC
ADVOCATE PEN NEEDLES 5MM 31G	Formulary	OTC
ADVOCATE PEN NEEDLES 8MM 31G	Formulary	OTC
<i>aq insulin syr 0.5 ml 30g 8mm (rx)</i>	Formulary	OTC
<i>aq insulin syr 1 ml 31g 8mm (rx)</i>	Formulary	OTC
<i>aq insulin syrin 1 ml 29g 12mm (rx)</i>	Formulary	OTC
ASSURE ID PEN NEEDLE	Non-Formulary	OTC
AUTOSHIELD DUO PEN NDL 30G 5MM	Formulary	OTC
BD ECLIPSE 30GX1/2" SYRINGE	Formulary	OTC
BD INS SYR 0.3 ML 8MMX31G(1/2)	Formulary	OTC
BD INS SYR UF 0.3 ML 12.7MMX30G	Formulary	OTC
BD INS SYR UF 0.5 ML 12.7MMX30G	Formulary	OTC
BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE	Formulary	OTC
BD INS SYRN UF 1 ML 12.7MMX30G	Formulary	OTC
BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE	Formulary	OTC
BD INS SYRN UF 1 ML 30G 12.7MM	Formulary	OTC

Medications	Coverage Level	Restrictions
BD INS SYRNG 0.3 ML 29GX12.7MM	Formulary	OTC
BD INS SYRNG 0.5 ML 29GX12.7MM	Formulary	OTC
BD INS SYRNG UF 0.3 ML 8MMX31G	Formulary	OTC
BD INS SYRNG UF 0.5 ML 8MMX31G	Formulary	OTC
BD INSULIN SYR 0.5 ML 28GX1/2"	Formulary	OTC
BD INSULIN SYR 0.5 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 27GX12.7MM	Formulary	OTC
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE	Formulary	OTC
<i>bd insulin syr 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
BD INSULIN SYR 1 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 29GX12.7MM	Formulary	OTC
BD INSULIN SYR UF 1 ML 8MMX31G	Formulary	OTC
BD NANO 2 GEN PEN NDL 32G 4MM	Formulary	OTC
BD SAFETGLD INS 0.3 ML 29G 13MM	Formulary	OTC
BD SAFETGLD INS 0.5 ML 13MMX29G	Formulary	OTC
BD SAFETYGLD INS 0.3 ML 31G 8MM	Formulary	OTC
BD SAFETYGLD INS 0.5 ML 30G 8MM	Formulary	OTC
BD SAFETYGLD INS 1 ML 29G 13MM	Formulary	OTC
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64"	Non-Formulary	OTC
BD SAFETYGLIDE SYRINGE 27GX5/8	Formulary	OTC
BD UF MICRO PEN NEEDLE 6MMX32G	Formulary	OTC
BD UF MINI PEN NEEDLE 5MMX31G	Formulary	OTC
BD UF NANO PEN NEEDLE 4MMX32G	Formulary	OTC
BD UF ORIG PEN NDL 12.7MMX29G	Formulary	OTC
BD UF SHORT PEN NEEDLE 8MMX31G	Formulary	OTC
BD VEO INS 0.3 ML 6MMX31G (1/2)	Formulary	OTC
BD VEO INS SYRING 1 ML 6MMX31G	Formulary	OTC
BD VEO INS SYRN 0.3 ML 6MMX31G	Formulary	OTC
BD VEO INS SYRN 0.5 ML 6MMX31G	Formulary	OTC
<i>ca ins syr 0.3 ml 30gx5/16" short</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>ca ins syr 0.3 ml 31gx5/16" short</i>	Formulary	OTC
<i>ca ins syr 0.5 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>ca ins syr 0.5 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>ca insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>ca insulin syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 31gx5/16" short (otc)</i>	Formulary	OTC
CAREFINE PEN NEEDLE 12.7MM 29G HRI	Formulary	OTC
CAREFINE PEN NEEDLE 4MM 32G	Formulary	OTC
CAREFINE PEN NEEDLE 5MM 32G	Formulary	OTC
CAREFINE PEN NEEDLE 6MM 31G HRI	Formulary	OTC
CAREFINE PEN NEEDLE 8MM 30G HRI	Formulary	OTC
CAREFINE PEN NEEDLES 6MM 32G	Formulary	OTC
CAREFINE PEN NEEDLES 8MM 31G	Formulary	OTC
<i>careone syr 0.3 ml 30gx1/2" regular, hri</i>	Formulary	OTC
<i>careone syr 0.5 ml 30gx1/2" regular, hri (otc)</i>	Formulary	OTC
<i>careone syr 1 ml 30gx1/2" regular, hri (otc)</i>	Formulary	OTC
CAREONE UNIFINE PENTIP 4MM 32G STERILE, SINGLE USE	Formulary	OTC
CAREONE UNIFINE PENTIP 5MM 31G SINGLE USE, STERILE	Formulary	OTC
CAREONE UNIFINE PENTIP 6MM 31G 31GX6MM,MINI,STRL	Formulary	OTC
CAREONE UNIFINE PENTIP 8MM 31G 31GX8MM,SHORT,STRL	Formulary	OTC
CAREONE UNIFINE PENTP 29GX1/2" ORIGINAL, 12MM	Formulary	OTC
CAREONE UNIFINE PENTP 31GX1/4" ULTRA SHORT, 6MM	Formulary	OTC
CAREONE UNIFINE PNTP 12MM 29G 29GX12MM,ORIGNL,STRL	Formulary	OTC
CAREONE UNIFINE PNTP 31GX3/16" MINI, 5MM	Formulary	OTC
CAREONE UNIFINE PNTP 31GX5/16" SHORT, 8MM	Formulary	OTC
CAREONE UNIFINE PNTP 32GX5/32"	Formulary	OTC
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16"	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
CARETOUCH PEN NEEDLE	Non-Formulary	OTC
CLICKFINE 31G X 1/4" NEEDLES 6MM, UNIVERSAL	Formulary	OTC
CLICKFINE 31G X 5/16" NEEDLES 8MM, UNIVERSAL	Formulary	OTC
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE	Formulary	OTC
CLICKFINE PEN NEEDLE 32GX5/32" UNIVERSAL CLICK	Formulary	OTC
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND	Formulary	OTC
COMFORT EZ 0.3 ML 31G 15/64"	Formulary	OTC
COMFORT EZ 0.5 ML 31G 15/64"	Formulary	OTC
COMFORT EZ INS 0.3 ML 30GX1/2"	Formulary	OTC
COMFORT EZ INS 0.3 ML 30GX5/16"	Formulary	OTC
COMFORT EZ INS 0.5 ML 31GX5/16"	Formulary	OTC
COMFORT EZ INS 1 ML 31G 15/64"	Formulary	OTC
COMFORT EZ INS 1 ML 31GX5/16"	Formulary	OTC
COMFORT EZ INSULIN SYR 0.3 ML	Formulary	OTC
COMFORT EZ INSULIN SYR 0.5 ML	Formulary	OTC
COMFORT EZ PEN NEEDLE 12MM 29G	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G MICRO	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 32G MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 6MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 6MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
COMFORT EZ PEN NEEDLES 6MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G SHORT	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 32G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 33G	Formulary	OTC
COMFORT EZ SYR 0.3 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 28GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 30GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 28GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 30GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 30GX5/16"	Formulary	OTC
<i>comfort point pen ndl 29gx1/2" 12mm</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/3"</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/4" 6mm</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/6"</i>	Formulary	OTC
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16"	Non-Formulary	OTC
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	Non-Formulary	OTC
DROPLET MICRON PEN NEEDLE	Non-Formulary	OTC
DROPLET PEN NEEDLE 29G 10MM	Formulary	OTC
DROPLET PEN NEEDLE 29G 12MM	Formulary	OTC
DROPLET PEN NEEDLE 30G 8MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 5MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 6MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 8MM	Formulary	OTC

Medications	Coverage Level	Restrictions
DROPLET PEN NEEDLE 32G 4MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 5MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 6MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 8MM	Formulary	OTC
DROPSAFE PEN NEEDLE	Non-Formulary	OTC
DRUG MART ULTRA COMFORT SYR	Formulary	OTC
EASY COMFORT 0.3 ML 31G 1/2"	Formulary	OTC
EASY COMFORT 0.3 ML 31G 5/16"	Formulary	OTC
EASY COMFORT 0.5 ML 30GX1/2"	Formulary	OTC
EASY COMFORT 0.5 ML 31GX5/16"	Formulary	OTC
EASY COMFORT 0.5 ML 32GX5/16"	Formulary	OTC
EASY COMFORT 0.5 ML SYRINGE	Formulary	OTC
EASY COMFORT 1 ML 31GX5/16"	Formulary	OTC
EASY COMFORT 1 ML 32GX5/16"	Formulary	OTC
EASY COMFORT INSULIN 1 ML SYR	Formulary	OTC
EASY COMFORT PEN NDL 31GX1/4"	Formulary	OTC
EASY COMFORT PEN NDL 31GX3/16"	Formulary	OTC
EASY COMFORT PEN NDL 31GX5/16"	Formulary	OTC
EASY COMFORT PEN NDL 32GX5/32"	Formulary	OTC
EASY COMFORT PEN NDL 33G 4MM	Formulary	OTC
EASY COMFORT PEN NDL 33G 5MM	Formulary	OTC
EASY COMFORT PEN NDL 33G 6MM	Formulary	OTC
EASY COMFORT SYR 1 ML 30GX1/2"	Formulary	OTC
EASY TOUCH 0.3 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 27GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 29GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 30GX5/16	Formulary	OTC
EASY TOUCH 1 ML SYR 27GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 29GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH INSULIN 1 ML 29GX1/2	Formulary	OTC
EASY TOUCH INSULIN 1 ML 30GX1/2	Formulary	OTC
EASY TOUCH INSULIN SYR 0.3 ML	Formulary	OTC
EASY TOUCH INSULIN SYR 0.5 ML	Formulary	OTC

Medications	Coverage Level	Restrictions
EASY TOUCH INSULIN SYR 1 ML	Formulary	OTC
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE	Formulary	OTC
EASY TOUCH INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8"	Non-Formulary	OTC
EASY TOUCH INSULN 1 ML 29GX1/2"	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX1/2"	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 31GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 31GX5/16	Formulary	OTC
EASY TOUCH LUER LOK INSUL 1 ML	Formulary	OTC
EASY TOUCH PEN NEEDLE 29GX1/2"	Formulary	OTC
EASY TOUCH PEN NEEDLE 30GX5/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX1/4"	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX3/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX5/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX1/4"	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX3/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX5/32	Formulary	OTC
EASY TOUCH SAFETY PEN NEEDLE	Non-Formulary	OTC
EASY TOUCH SYR 0.5 ML 27G 12.7MM	Formulary	OTC
EASY TOUCH SYR 0.5 ML 28G 12.7MM	Formulary	OTC
EASY TOUCH SYR 0.5 ML 29G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 27G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 28G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 29G 12.7MM	Formulary	OTC
EASY TOUCH UNI-SLIP SYR 1 ML	Formulary	OTC
EASY-TOUCH INS 1 ML 31GX5/16" EASY-TOUCH	Formulary	OTC
<i>eql ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>eql insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>eql insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>eql insulin 0.3 ml syringe</i>	Formulary	OTC
<i>eql insulin 0.3 ml syringe short needle</i>	Formulary	OTC
<i>eql insulin 0.5 ml syringe</i>	Formulary	OTC
<i>eql insulin 0.5 ml syringe short needle</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>eql insulin 1 ml syringe short needle</i>	Formulary	OTC
<i>eql insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
EQL PEN 8MM 31G X 5/16" NEEDLE STERILE,SINGLE USE (OTC)	Formulary	OTC
<i>exel ins syr u100 1 ml 28gx1/2 (otc)</i>	Formulary	OTC
EXEL U100 0.3 ML 29GX1/2"	Formulary	OTC
<i>exel u100 0.3 ml 30gx5/16"</i>	Formulary	OTC
EXEL U100 0.5 ML 28GX1/2"	Formulary	OTC
<i>exel u100 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
EXEL U100 0.5 ML 30GX5/16"	Formulary	OTC
EXEL U100 1 ML 30GX5/16"	Formulary	OTC
<i>exel u100 ins syr 1 ml 29gx1/2 (otc)</i>	Formulary	OTC
<i>fifty50 ins 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>fifty50 ins 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>fifty50 ins syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)	Formulary	OTC
<i>fifty50 pen 31g x 3/16" needle 5mm</i>	Formulary	OTC
FIFTY50 PEN 31G X 5/16" NEEDLE (OTC)	Formulary	OTC
<i>fifty50 pen 31g x 5/16" needle 8mm</i>	Formulary	OTC
<i>fifty50 pen needle 32g x 1/4"</i>	Formulary	OTC
<i>fifty50 pen needle 32g x 5/32" 4mm</i>	Formulary	OTC
FREESTYLE PREC 0.5 ML 30GX5/16	Formulary	OTC
FREESTYLE PREC 0.5 ML 31GX5/16	Formulary	OTC
FREESTYLE PREC 1 ML 30GX5/16"	Formulary	OTC
FREESTYLE PREC 1 ML 31GX5/16"	Formulary	OTC
GNP CLICKFINE 31G X 1/4" NDL 6MM, UNIVERSAL	Formulary	OTC
GNP CLICKFINE 31G X 5/16" NDL 8MM, UNIVERSAL	Formulary	OTC
<i>gnp ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>gnp ins syringe 1 ml 28g 1/2" (otc)</i>	Formulary	OTC
<i>gnp insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>gnp insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>gnp insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>gnp pen needle 31g 5mm</i>	Formulary	OTC
<i>gnp pen needle 31g 8mm</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>gnp pen needle 32g 4mm</i>	Formulary	OTC
<i>gnp pen needle 32g 6mm</i>	Formulary	OTC
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT	Formulary	OTC
GNP ULT CMFRT 0.5 ML 29GX1/2"	Formulary	OTC
GNP ULTICARE PEN NDL 31G 5MM	Formulary	OTC
GNP ULTICARE PEN NDL 31G 8MM	Formulary	OTC
GNP ULTICARE PEN NDL 32G 4MM	Formulary	OTC
GNP ULTICARE PEN NDL 32G 6MM	Formulary	OTC
GNP ULTIGUARD SAFEPAK 32G 4MM	Formulary	OTC
GNP ULTR CMFRT 0.5 ML 28GX1/2"	Formulary	OTC
GNP ULTR COMFORT 1 ML 29GX1/2"	Formulary	OTC
GNP ULTRA COMFORT 0.5 ML SYR	Formulary	OTC
GNP ULTRA COMFORT 1 ML SYRINGE	Formulary	OTC
GNP ULTRA COMFORT 3/10 ML SYR	Formulary	OTC
GNP ULTRA COMFRT 1 ML 28GX1/2"	Formulary	OTC
<i>gs pen needle 31g x 5/16"</i>	Formulary	OTC
<i>gs pen needle 31g x 5mm</i>	Formulary	OTC
<i>gs pen needle 31g x 6mm</i>	Formulary	OTC
<i>gs pen needle 31g x 8mm</i>	Formulary	OTC
<i>gs pen needle 32g x 4mm</i>	Formulary	OTC
<i>gs pen needle 32g x 6mm</i>	Formulary	OTC
HEALTHWISE PEN NEEDLE	Non-Formulary	OTC
HEALTHY ACCENTS PENTIP 5MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTIP 6MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTIP 8MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTP 12MM 29G	Formulary	OTC
HEB UNIFINE PNTPLUS 31GX3/16 5MM	Formulary	OTC
HM ULTICARE PEN NEEDLE 4MM 32G	Formulary	OTC
HM ULTICARE PEN NEEDLE 5MM 31G	Formulary	OTC
HM ULTICARE PEN NEEDLE 6MM 31G	Formulary	OTC
HM ULTICARE PEN NEEDLE 8MM 31G	Formulary	OTC
INCONTROL PEN NEEDLE 12MM 29G	Formulary	OTC
INCONTROL PEN NEEDLE 4MM 32G	Formulary	OTC
INCONTROL PEN NEEDLE 5MM 31G	Formulary	OTC
INCONTROL PEN NEEDLE 6MM 31G	Formulary	OTC
INCONTROL PEN NEEDLE 8MM 31G	Formulary	OTC

Medications	Coverage Level	Restrictions
INCONTROL ULTICARE NDL 31G 6MM	Formulary	OTC
INCONTROL ULTICARE NDL 31G 8MM	Formulary	OTC
INCONTROL ULTICARE NDL 32G 4MM	Formulary	OTC
<i>insulin 1 ml syringe</i>	Formulary	OTC
<i>insulin 1/2 ml syringe</i>	Formulary	OTC
<i>insulin 3/10 ml syringe</i>	Formulary	OTC
<i>insulin syr 0.3 ml 30gx5/16"</i>	Formulary	OTC
<i>insulin syr 0.5 ml 28g 12.7mm (otc)</i>	Formulary	OTC
<i>insulin syr/ndl u100 half mark</i>	Non-Formulary	OTC
<i>insulin syrin 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx1/2"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx1/2" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" hri</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" short</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short needle,thin ii</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" ultra comfort</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 28g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx1/2" short needle (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>insulin syrin 0.5 ml 31g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short needle,thin ii</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short needle,thin ii (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" ultra comfort (otc)</i>	Formulary	OTC
INSULIN SYRIN 1 ML 29GX1/2"	Formulary	OTC
<i>insulin syring 0.5 ml 27g 1/2"</i>	Formulary	
<i>insulin syring 0.5 ml 27g 1/2" inner</i>	Formulary	
<i>insulin syring 0.5 ml 27g 1/2" outer</i>	Formulary	
<i>insulin syring 0.5 ml 27g 13mm</i>	Formulary	
<i>insulin syring 0.5 ml 28g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syring 0.5 ml 29g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syring 0.5 ml 29g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syring 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
INSULIN SYRINGE 0.3 ML	Formulary	OTC
<i>insulin syringe 0.3 ml 31gx1/4</i>	Formulary	OTC
<i>insulin syringe 0.3 ml short</i>	Formulary	OTC
INSULIN SYRINGE 0.5 ML	Formulary	OTC
<i>insulin syringe 0.5 ml 31g 6mm(only for 500 unit/ml insulin)</i>	Formulary	
<i>insulin syringe 0.5 ml 31gx1/4</i>	Formulary	OTC
INSULIN SYRINGE 1 ML	Formulary	OTC
<i>insulin syringe 1 ml 27g 1/2" inner</i>	Formulary	
<i>insulin syringe 1 ml 27g 1/2" outer</i>	Formulary	
<i>insulin syringe 1 ml 27g 13mm inner</i>	Formulary	
<i>insulin syringe 1 ml 27g 16mm</i>	Formulary	OTC
<i>insulin syringe 1 ml 27gx1/2" outer</i>	Formulary	
<i>insulin syringe 1 ml 28g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 1/2" outer (rx)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>insulin syringe 1 ml 28g 12.7mm (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 13mm inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 13mm outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx1/2" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx1/4"</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short needle,thin ii (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml short</i>	Formulary	OTC
INSUPEN PEN NEEDLE 29GX1/2"	Formulary	OTC
INSUPEN PEN NEEDLE 29GX12MM	Formulary	OTC
INSUPEN PEN NEEDLE 31G 5MM	Formulary	OTC
INSUPEN PEN NEEDLE 31G 8MM	Formulary	OTC
INSUPEN PEN NEEDLE 31GX3/16"	Formulary	OTC
INSUPEN PEN NEEDLE 31GX5/16"	Formulary	OTC
INSUPEN PEN NEEDLE 31GX8MM	Formulary	OTC
INSUPEN PEN NEEDLE 32G 4MM	Formulary	OTC

Medications	Coverage Level	Restrictions
INSUPEN PEN NEEDLE 32GX4MM	Formulary	OTC
INSUPEN PEN NEEDLE 32GX5/32"	Formulary	OTC
<i>kinray ins syr 1 ml 31gx5/16" preferred plus (otc)</i>	Formulary	OTC
<i>kinray syring 0.3 ml 31gx5/16" preferred plus</i>	Formulary	OTC
<i>kinray syring 0.5 ml 31gx5/16" preferred plus (otc)</i>	Formulary	OTC
<i>kmart valu plus syr 1/2 ml</i>	Formulary	OTC
<i>kro ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>kro ins syrin 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>kro insulin syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>kro pen needle 4mm x 32g</i>	Formulary	OTC
<i>kro pen needle 4mm x 33g</i>	Formulary	OTC
<i>kro pen needle 5mm x 31g</i>	Formulary	OTC
<i>kro pen needle 6mm x 31g</i>	Formulary	OTC
<i>kro pen needle 8mm x 31g</i>	Formulary	OTC
<i>kroger ins syr 0.3 ml 30gx5/16 short needle</i>	Formulary	OTC
<i>kroger ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>kroger ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>kroger ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
KROGER PEN NEEDLES 31G X 5/16" (OTC)	Formulary	OTC
<i>kroger syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>kroger syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>leader ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>leader insulin syringe 0.3 ml</i>	Formulary	OTC
<i>leader pen needles 12mm 29g</i>	Formulary	OTC
<i>leader syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>leader syring 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
LIVE BETTER PEN NEEDLES 8MM 31G (OTC)	Formulary	OTC
MAGELLAN INSUL SYRINGE 0.3 ML	Formulary	
MAGELLAN INSUL SYRINGE 0.5 ML	Formulary	
MAGELLAN INSULIN SYR 0.3 ML	Formulary	
MAGELLAN INSULIN SYR 0.5 ML	Formulary	
MAGELLAN INSULIN SYRINGE 1 ML	Formulary	
MAXICOMFORT II PEN NEEDLE	Non-Formulary	OTC
MAXI-COMFORT INS 0.5 ML 28G	Formulary	OTC
MAXI-COMFORT INS 1 ML 28GX1/2"	Formulary	OTC
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16"	Non-Formulary	OTC
MINI ULTRA-THIN II PEN NDL 31G STERILE	Formulary	OTC
MONOJECT 0.5 ML SYRN 28GX1/2"	Formulary	
MONOJECT 1 ML SYRN 27X1/2"	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" (OTC)	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" 28GX1/2" (OTC)	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" SOFTPACK (RX)	Formulary	OTC
MONOJECT INSUL SYR U100 (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 0.5 ML (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 0.3 ML	Formulary	
MONOJECT INSULIN SYR 0.3 ML (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 0.5 ML	Formulary	
MONOJECT INSULIN SYR 0.5 ML (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 1 ML (RX)	Formulary	OTC
MONOJECT INSULIN SYR 1 ML 3'S (OTC)	Formulary	OTC

Medications	Coverage Level	Restrictions
MONOJECT INSULIN SYR U-100	Formulary	
MONOJECT INSULIN SYR U-100	Formulary	OTC
MONOJECT INSULIN SYRN 3/10 ML	Formulary	OTC
MONOJECT SYRINGE 0.3 ML	Formulary	OTC
MONOJECT SYRINGE 0.5 ML	Formulary	OTC
MONOJECT SYRINGE 1 ML	Formulary	OTC
MONOJECT SYRINGE 1 ML SOFTPK, REG LUER TIP (RX)	Formulary	OTC
<i>ms ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ms ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ms ins syringe 1 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>ms insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>ms insul syr 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>ms insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>ms insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>ms insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>ms insulin syringe 0.3 ml</i>	Formulary	OTC
MS PEN NEEDLE 6MM 31G SHORT, SINGLE USE	Formulary	OTC
NANO 2 GEN PEN NEEDLE 32G 4MM	Formulary	OTC
NANO PEN NEEDLE 32G 4MM	Formulary	OTC
NOVOFINE 32G NEEDLES	Formulary	OTC
NOVOFINE PLUS PEN NDL 32GX1/6"	Formulary	OTC
PARADIGM RESERVOIR	Non-Formulary	
PC UNIFINE PENTIPS 12MM NEEDLE ORIGINAL	Formulary	OTC
PC UNIFINE PENTIPS 6MM NEEDLE ULTRA SHORT	Formulary	OTC
PC UNIFINE PENTIPS 8MM NEEDLE SHORT	Formulary	OTC
<i>pen needle 29g 12mm</i>	Formulary	OTC
<i>pen needle 30g 5mm inner</i>	Formulary	OTC
<i>pen needle 30g 5mm outer</i>	Formulary	OTC
PEN NEEDLE 30G X 5/16"	Formulary	
<i>pen needle 31g 5mm</i>	Formulary	OTC
<i>pen needle 31g 5mm inner</i>	Formulary	OTC
<i>pen needle 31g 5mm outer</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>pen needle 31g 6mm</i>	Formulary	OTC
<i>pen needle 31g 8mm</i>	Formulary	OTC
<i>pen needle 31g 8mm inner</i>	Formulary	OTC
<i>pen needle 31g 8mm outer</i>	Formulary	OTC
<i>pen needle 31g x 1/4"</i>	Formulary	OTC
<i>pen needle 31g x 1/4" 6mm</i>	Formulary	OTC
<i>pen needle 31g x 1/4" hri</i>	Formulary	OTC
<i>pen needle 31g x 3/16"</i>	Formulary	OTC
PEN NEEDLE 31G X 3/16" (RX)	Formulary	OTC
<i>pen needle 31g x 3/16" hri</i>	Formulary	OTC
<i>pen needle 31g x 5/16"</i>	Formulary	OTC
PEN NEEDLE 31G X 5/16" (RX)	Formulary	OTC
<i>pen needle 31g x 5/16" 8mm</i>	Formulary	OTC
<i>pen needle 31g x 5/16" hri</i>	Formulary	OTC
<i>pen needle 32g 4mm</i>	Formulary	OTC
<i>pen needle 32g 4mm inner</i>	Formulary	OTC
<i>pen needle 32g 4mm outer</i>	Formulary	OTC
<i>pen needle 32g x 1/4"</i>	Formulary	OTC
<i>pen needle 32g x 3/16"</i>	Formulary	OTC
<i>pen needle 32g x 5/32"</i>	Formulary	OTC
<i>pen needle 32g x 5/32" 4mm</i>	Formulary	OTC
<i>pen needle 32g x 5/32" hri</i>	Formulary	OTC
<i>pen needle 33g 4mm</i>	Formulary	OTC
PEN NEEDLE 6MM 31G 6MM	Formulary	OTC
<i>pen needle, diabetic needle 30 gauge x 5/16"</i>	Non-Formulary	OTC
PEN NEEDLES 12MM 29G	Formulary	OTC
<i>pen needles 12mm 29g 29gx12mm, strl</i>	Formulary	OTC
PEN NEEDLES 12MM 29G 29GX12MM,STRL	Formulary	OTC
<i>pen needles 12mm 29g strl</i>	Formulary	OTC
PEN NEEDLES 4MM 32G	Formulary	OTC
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)	Formulary	OTC
<i>pen needles 6mm 31g 31gx6mm, strl</i>	Formulary	OTC
<i>pen needles 6mm 31g strl</i>	Formulary	OTC
PEN NEEDLES 8MM 31G (OTC)	Formulary	OTC

Medications	Coverage Level	Restrictions
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)	Formulary	OTC
PENTIPS PEN NEEDLE 29G 1/2"	Formulary	OTC
PENTIPS PEN NEEDLE 29G 12MM	Formulary	OTC
PENTIPS PEN NEEDLE 29GX1/2"	Formulary	OTC
PENTIPS PEN NEEDLE 31G 1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 31G 3/16" MINI, 5MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 5/16" SHORT, 8MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 5MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 6MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 8MM	Formulary	OTC
PENTIPS PEN NEEDLE 31GX1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 31GX3/16"	Formulary	OTC
PENTIPS PEN NEEDLE 31GX5/16"	Formulary	OTC
PENTIPS PEN NEEDLE 32G 1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 32G 4MM	Formulary	OTC
PENTIPS PEN NEEDLE 32G 5/32" 4MM	Formulary	OTC
PENTIPS PEN NEEDLE 32GX5/32"	Formulary	OTC
PIP PEN NEEDLE	Non-Formulary	OTC
<i>pref plus ins 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>pref plus syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>pref plus syring 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>preferred plus 0.3 ml 30gx5/16</i>	Formulary	OTC
<i>preferred plus 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>preferred plus syringe 0.5 ml</i>	Formulary	OTC
<i>preferred plus syringe 1 ml</i>	Formulary	OTC
<i>prefpls ins syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
PREVENT DROPSAFE PEN NEEDLE	Non-Formulary	OTC
PRO COMFORT INSULIN SYRINGE	Non-Formulary	OTC
PRO COMFORT PEN NEEDLE	Non-Formulary	OTC
PRODIGY INS SYR 1 ML 28GX1/2"	Formulary	OTC
PRODIGY SYRNG 0.5 ML 31GX5/16"	Formulary	OTC
PRODIGY SYRNGE 0.3 ML 31GX5/16"	Formulary	OTC
<i>pub ins syrin 0.3 ml 30gx1/2" regular needle</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>pub ins syringe 1 ml 30gx1/2" regular needle (otc)</i>	Formulary	OTC
<i>pub insul syr 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>pub insul syr 0.5 ml 30gx1/2" regular needle (otc)</i>	Formulary	OTC
<i>pub insul syr 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>pub insulin syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
PUB PEN 12MM 29G NEEDLES STANDARD LENGTH	Formulary	OTC
PUB PEN 8MM 31G NEEDLES SHORT LENGTH (OTC)	Formulary	OTC
PUB PEN NEEDLE 6MM 31G EXTRA SHORT, 6MM	Formulary	OTC
PUB UNIFINE PNTIP PLUS 31GX3/16 MINI, 5MM	Formulary	OTC
PURE COMFORT PEN NEEDLE	Non-Formulary	OTC
PV UNIFINE PENTIP PLUS 31GX5MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 31GX6MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 31GX8MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 32GX4MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 33GX4MM	Formulary	OTC
QC UNIFINE PENTIPS 32GX5/32" STERILE	Formulary	OTC
QC UNIFINE PENTIPS 4MM 32G STERILE	Formulary	OTC
<i>ra ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ra ins syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>ra ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ra ins syringe 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
RA PEN NEEDLE 31GX3/16" 5MM (OTC)	Formulary	OTC
RA PEN NEEDLE 31GX5/16" 8MM (OTC)	Formulary	OTC
<i>relion ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>relion ins syr 0.3 ml 31gx6mm</i>	Formulary	OTC
RELION INS SYR 0.5 ML 29GX1/2" 29GX1/2,INNER	Formulary	OTC
RELION INS SYR 0.5 ML 29GX1/2" OUTER	Formulary	OTC
<i>relion ins syr 0.5 ml 31gx6mm</i>	Formulary	OTC
<i>relion ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>relion ins syr 1 ml 31gx15/64"</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" inner (otc)</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" outer, 10x10 (otc)</i>	Formulary	OTC
<i>relion insulin syr 0.5 ml</i>	Formulary	OTC
RELION MINI PEN 31G X 1/4" NDL	Formulary	OTC
RELION PEN 29G NEEDLE 12MM	Formulary	OTC
RELION PEN 31G NEEDLE 8MM (OTC)	Formulary	OTC
<i>relion pen needle 29gx1/2"</i>	Formulary	OTC
RELION PEN NEEDLE 29GX1/2"	Formulary	OTC
<i>relion pen needle 31g 6mm</i>	Formulary	OTC
<i>relion pen needle 31gx1/4"</i>	Formulary	OTC
<i>relion pen needle 31gx5/16"</i>	Formulary	OTC
<i>relion pen needle 31gx5/16" short</i>	Formulary	OTC
RELION PEN NEEDLE 31GX5/16" SHORT (OTC)	Formulary	OTC
<i>relion pen needle 32gx5/32"</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16" inner</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16" outer, 10x10</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" inner (otc)</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" outer, 10x10 (otc)</i>	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16", 10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2", 10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16", 10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2"	Formulary	OTC

Medications	Coverage Level	Restrictions
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10	Formulary	OTC
SAFETY PEN NEEDLE	Non-Formulary	OTC
SECURESAFE PEN NEEDLE	Non-Formulary	OTC
SHOPKO UNIFINE PENTIPS 4MM 32G	Formulary	OTC
SHOPKO UNIFINE PENTIPS 4MM 32G MICRO, STERILE	Formulary	OTC
SHOPKO UNIFINE PENTIPS 5MM 31G	Formulary	OTC
SHOPKO UNIFINE PENTIPS 5MM 31G MINI, STERILE	Formulary	OTC
SHOPKO UNIFINE PENTIPS 8MM 31G	Formulary	OTC
SHOPKO UNIFINE PENTIPS 8MM 31G SHORT, STERILE	Formulary	OTC
SHOPKO UNIFINE PNTIPS 12MM 29G	Formulary	OTC
SHOPKO UNIFINE PNTIPS 12MM 29G ORIGINAL, STERILE	Formulary	OTC
<i>sm ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syr 0.5 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syringe 0.3 ml 30gx5/16" short needle</i>	Formulary	OTC
<i>sm ins syringe 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syringe 1 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm insul syr 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>sm insul syr 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>sm insulin syr 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>sm insulin syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
SURE COMFORT 0.3 ML SYRINGE SHORT NDL	Formulary	OTC
SURE COMFORT 0.5 ML SYRINGE	Formulary	OTC
SURE COMFORT 0.5 ML SYRINGE	Formulary	OTC

Medications	Coverage Level	Restrictions
SURE COMFORT 1 ML SYRINGE	Formulary	OTC
SURE COMFORT 3/10 ML SYRINGE	Formulary	OTC
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE	Formulary	OTC
SURE COMFORT 30G PEN NEEDLE	Formulary	OTC
SURE COMFORT PEN NDL 29GX1/2" 12.7MM	Formulary	OTC
SURE COMFORT PEN NDL 31G 5MM	Formulary	OTC
SURE COMFORT PEN NDL 31G 8MM	Formulary	OTC
SURE COMFORT PEN NDL 32G 4MM	Formulary	OTC
SURE COMFORT PEN NDL 32G 6MM	Formulary	OTC
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4"	Non-Formulary	OTC
SURE-FINE PEN NEEDLES 12.7MM	Formulary	OTC
SURE-FINE PEN NEEDLES 5MM	Formulary	OTC
SURE-FINE PEN NEEDLES 8MM	Formulary	OTC
SURE-JECT INS 0.3 ML 31GX5/16"	Formulary	OTC
SURE-JECT INS 0.5 ML 31GX5/16"	Formulary	OTC
SURE-JECT INSU SYR U100 0.3 ML	Formulary	OTC
SURE-JECT INSU SYR U100 0.5 ML	Formulary	OTC
SURE-JECT INSU SYR U100 1 ML	Formulary	OTC
SURE-JECT INSUL SYR U100 1 ML	Formulary	OTC
SURE-JECT INSULIN SYRINGE 1 ML	Formulary	OTC
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	Non-Formulary	OTC
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16"	Non-Formulary	OTC
TECHLITE PEN NEEDLE 29GX1/2"	Formulary	OTC
TECHLITE PEN NEEDLE 31GX3/16"	Formulary	OTC
TECHLITE PEN NEEDLE 31GX5/16"	Formulary	OTC
TECHLITE PEN NEEDLE 32GX1/4"	Formulary	OTC
TECHLITE PEN NEEDLE 32GX5/32"	Formulary	OTC
<i>terumo ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>terumo ins syringe u100-1 ml</i>	Formulary	OTC
TERUMO INS SYRINGE U100-1 ML	Formulary	OTC
TERUMO INS SYRINGE U100-1/2 ML	Formulary	OTC

Medications	Coverage Level	Restrictions
TERUMO INS SYRINGE U100-1/3 ML	Formulary	OTC
TERUMO INS SYRNG U100-1/2 ML	Formulary	OTC
THINPRO INS SYRIN U100-0.3 ML	Formulary	OTC
THINPRO INS SYRIN U100-0.5 ML	Formulary	OTC
THINPRO INS SYRIN U100-1 ML	Formulary	OTC
TODAY'S HLTH PN NEEDLE 6MM 31G 31GX6MM,STRL,MINI	Formulary	OTC
TOPCARE CLICKFINE 31G X 1/4"	Formulary	OTC
TOPCARE CLICKFINE 31G X 5/16"	Formulary	OTC
TOPCARE ULTRA COMFORT SYRINGE	Formulary	OTC
TRUE COMFORT INSULIN SYRINGE	Non-Formulary	OTC
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32"	Non-Formulary	OTC
TRUE COMFORT PRO INS SYRINGE	Non-Formulary	OTC
TRUEPLUS PEN NEEDLE	Non-Formulary	OTC
TRUEPLUS SYR 0.3 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.3 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.3 ML 31GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 28GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 31GX5/16"	Formulary	OTC
TRUEPLUS SYR 1 ML 28GX1/2"	Formulary	OTC
TRUEPLUS SYR 1 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 1 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 1 ML 31GX5/16"	Formulary	OTC
ULT CFT 0.3 ML 29GX1/2" (1/2) 1/2 UNIT	Formulary	OTC
ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT	Formulary	OTC
<i>ulticare ins syr 1 ml 31gx5/16" 31gx5/16" (otc)</i>	Formulary	OTC
ULTICARE INS 0.3 ML 30GX1/2"	Formulary	OTC
ULTICARE INS 0.5 ML 30GX1/2"	Formulary	OTC
ULTICARE INS 0.5 ML 31GX1/4"	Formulary	OTC
<i>ulticare ins safety 1 ml 29x1/2 (rx)</i>	Formulary	OTC
<i>ulticare ins syr 0.3 ml 30g 8mm</i>	Formulary	OTC
<i>ulticare ins syr 0.3 ml 31g 8mm</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>ulticare ins syr 0.5 ml 30g 8mm (otc)</i>	Formulary	OTC
ULTICARE INS SYR 0.5 ML 31G 6MM	Formulary	OTC
<i>ulticare ins syr 0.5 ml 31g 8mm (otc)</i>	Formulary	OTC
<i>ulticare ins syr 1 ml 28gx1/2" 28gx1/2" (otc)</i>	Formulary	OTC
<i>ulticare ins syr 1 ml 29gx1/2" 29gx1/2" (otc)</i>	Formulary	OTC
ULTICARE INS SYR 1 ML 30GX1/2"	Formulary	OTC
ULTICARE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 1/4"	Non-Formulary	OTC
ULTICARE INSULN SYR(HALF UNIT)	Non-Formulary	OTC
ULTICARE PEN NDL 12.7 MM 29G	Formulary	OTC
ULTICARE PEN NEEDLE 31GX3/16"	Formulary	OTC
ULTICARE PEN NEEDLE 4MM 32G	Formulary	OTC
ULTICARE PEN NEEDLE 6MM 31G	Formulary	OTC
ULTICARE PEN NEEDLE 8 MM 31G	Formulary	OTC
ULTICARE PEN NEEDLE 8MM 31G	Formulary	OTC
ULTICARE PEN NEEDLES 12MM 29G	Formulary	OTC
ULTICARE PEN NEEDLES 31G 8MM	Formulary	OTC
ULTICARE PEN NEEDLES 4MM 32G MICRO	Formulary	OTC
ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM	Formulary	OTC
ULTICARE PEN NEEDLES 6MM 31G	Formulary	OTC
ULTICARE PEN NEEDLES 6MM 32G	Formulary	OTC
ULTICARE PEN NEEDLES 8MM 31G	Formulary	OTC
<i>ulticare safety 0.5 ml 29gx1/2 (rx)</i>	Formulary	OTC
ULTICARE SAFETY PEN NEEDLE	Non-Formulary	OTC
<i>ulticare syr 0.3 ml 29g 12.7mm</i>	Formulary	OTC
ULTICARE SYR 0.3 ML 30GX1/2"	Formulary	OTC
<i>ulticare syr 0.3 ml 30gx5/16" 30gx5/16"</i>	Formulary	OTC
<i>ulticare syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL	Formulary	OTC
<i>ulticare syr 0.5 ml 29g 12.7mm (otc)</i>	Formulary	OTC
<i>ulticare syr 0.5 ml 29gx1/2" 29gx1/2" (otc)</i>	Formulary	OTC
ULTICARE SYR 0.5 ML 30GX1/2"	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>ulticare syr 0.5 ml 30gx5/16" 30gx5/16" (otc)</i>	Formulary	OTC
<i>ulticare syr 0.5 ml 31gx5/16" 31gx5/16" (otc)</i>	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL	Formulary	OTC
<i>ulticare syr 1 ml 30gx5/16" 30gx5/16" (otc)</i>	Formulary	OTC
ULTICARE SYR 1 ML 31GX5/16"	Formulary	OTC
<i>ulticare syrin 0.3 ml 29gx1/2" 29gx1/2"</i>	Formulary	OTC
<i>ulticare syrin 0.5 ml 28gx1/2" 28gx1/2" (otc)</i>	Formulary	OTC
ULTICARE SYRINGE 1 ML 30GX1/2"	Formulary	OTC
ULTIGUARD SAFEPACK 32G 4MM	Formulary	OTC
ULTIGUARD SAFEPACK-INSULIN SYR SYRINGE 1/2 ML 31 X 5/16"	Non-Formulary	OTC
ULTIGUARD SAFEPACK-PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4"	Non-Formulary	OTC
ULTILET INSULIN SYRINGE 0.3 ML	Formulary	OTC
ULTILET INSULIN SYRINGE 0.5 ML	Formulary	OTC
ULTILET INSULIN SYRINGE 1 ML	Formulary	OTC
ULTILET PEN NEEDLE	Formulary	OTC
ULTILET PEN NEEDLE 4MM 32G	Formulary	OTC
ULTRA COMFORT 0.3 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 0.3 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 0.5 ML 28GX1/2"	Formulary	OTC
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G	Formulary	OTC
ULTRA COMFORT 0.5 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 0.5 ML 31GX5/16"	Formulary	OTC
ULTRA COMFORT 0.5 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 0.5 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 1 ML 28GX1/2"	Formulary	OTC
ULTRA COMFORT 1 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 1 ML 30GX5/16"	Formulary	OTC
ULTRA COMFORT 1 ML 31GX5/16"	Formulary	OTC
ULTRA COMFORT 1 ML SYRINGE	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	Non-Formulary	OTC
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	Non-Formulary	OTC
ULTRA FLO PEN NEEDLE	Non-Formulary	OTC
ULTRA THIN PEN NEEDLE	Non-Formulary	OTC
ULTRACARE PEN NEEDLE	Non-Formulary	OTC
ULTRA-FINE 0.3 ML 30G 12.7MM	Formulary	OTC
ULTRA-FINE 0.3 ML 31G 6MM (1/2)	Formulary	OTC
ULTRA-FINE 0.3 ML 31G 8MM (1/2)	Formulary	OTC
ULTRA-FINE 0.5 ML 30G 12.7MM	Formulary	OTC
ULTRA-FINE INS SYR 1 ML 31G 6MM	Formulary	OTC
ULTRA-FINE INS SYR 1 ML 31G 8MM	Formulary	OTC
ULTRA-FINE PEN NDL 29G 12.7MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 31G 5MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 31G 8MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 32G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.3 ML 31G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.3 ML 31G 8MM	Formulary	OTC
ULTRA-FINE SYR 0.5 ML 31G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.5 ML 31G 8MM	Formulary	OTC
ULTRA-FINE SYR 1 ML 30G 12.7MM	Formulary	OTC
ULTRA-THIN II 1 ML 31GX5/16"	Formulary	OTC
ULTRA-THIN II INS 0.3 ML 30G	Formulary	OTC
ULTRA-THIN II INS 0.3 ML 31G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 29G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 30G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 31G	Formulary	OTC
ULTRA-THIN II INS SYR 1 ML 29G	Formulary	OTC
ULTRA-THIN II INS SYR 1 ML 30G	Formulary	OTC
ULTRA-THIN II PEN NDL 29GX1/2"	Formulary	OTC
ULTRA-THIN II PEN NDL 31GX5/16	Formulary	OTC
UNIFINE PENTIPS 12MM 29G	Formulary	OTC
UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL	Formulary	OTC

Medications	Coverage Level	Restrictions
UNIFINE PENTIPS 12MM 29G 29GX12MM,STRL,ORIGNL	Formulary	OTC
UNIFINE PENTIPS 12MM 29G ORIGINAL	Formulary	OTC
UNIFINE PENTIPS 29G 12MM	Formulary	OTC
UNIFINE PENTIPS 31G 5MM	Formulary	OTC
UNIFINE PENTIPS 31G 6MM	Formulary	OTC
UNIFINE PENTIPS 31G 8MM	Formulary	OTC
UNIFINE PENTIPS 31GX3/16"	Formulary	OTC
UNIFINE PENTIPS 31GX3/16" 31GX5MM, STERILE	Formulary	OTC
UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI	Formulary	OTC
UNIFINE PENTIPS 32G 4MM	Formulary	OTC
UNIFINE PENTIPS 32G 6MM	Formulary	OTC
UNIFINE PENTIPS 32GX1/4"	Formulary	OTC
UNIFINE PENTIPS 32GX5/32"	Formulary	OTC
UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO	Formulary	OTC
UNIFINE PENTIPS 32GX5/32" STERILE, SINGLE USE	Formulary	OTC
UNIFINE PENTIPS 33GX5/32"	Formulary	OTC
UNIFINE PENTIPS 6MM 31G	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM, STRL	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM,MINI,STRL	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM,STRL,MINI	Formulary	OTC
UNIFINE PENTIPS 6MM 31G ULTRA SHORT	Formulary	OTC
UNIFINE PENTIPS 6MM NEEDLE ULTRA SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM 31G	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM, STRL	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM,SHORT,STRL	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM,STRL,SHORT	Formulary	OTC

Medications	Coverage Level	Restrictions
UNIFINE PENTIPS 8MM 31G SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM NEEDLE SHORT	Formulary	OTC
UNIFINE PENTIPS MAXFLOW	Non-Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2"	Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2" 12MM	Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2" ORIGINAL, 12MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31G 5MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX1/4"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI, 5MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI,5MM,STRL	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT, 8MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT,8MM,STRL	Formulary	OTC
UNIFINE PENTIPS PLUS 32GX5/32"	Formulary	OTC
UNIFINE PENTIPS PLUS 33GX5/32"	Formulary	OTC
UNIFINE PENTIPS PLUS MAXFLOW	Non-Formulary	OTC
UNIFINE SAFECONTROL PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16"	Non-Formulary	OTC
UNIFINE ULTRA PEN NEEDLE	Non-Formulary	OTC
VANISHPOINT 0.5 ML 30GX1/2" SY INNER	Formulary	OTC
VANISHPOINT INSULIN SYRINGE	Non-Formulary	OTC
VANISHPOINT U-100 29X1/2 SYR	Formulary	OTC
WM UNIFINE PENTIP PLUS 4MM 32G	Formulary	OTC
WM UNIFINE PENTIP PLUS 5MM 31G W/ SAFETY CLICK	Formulary	OTC
WM UNIFINE PENTIP PLUS 6MM 31G W/ SAFETY CLICK	Formulary	OTC

Medications	Coverage Level	Restrictions
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK	Formulary	OTC
YOURX ULTICARE PEN NDL 4MM 32G	Formulary	OTC
YOURX ULTICARE PEN NDL 6MM 31G	Formulary	OTC
YOURX ULTICARE PEN NDL 8MM 31G	Formulary	OTC
<i>Medical Supplies And Dme - Male Condoms</i>		
AIMSCO LATEX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
DUREX AVANTI REAL FEEL CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
DUREX EXTRA SENSITIVE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
DUREX TROPICAL CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
FANTASY CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MAXX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MICROTHIN AQUA LUBE	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MICROTHIN CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MICROTHIN LARGE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO TEXTURED CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO THIN LUBRICATED CONDOMS	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ENZ CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ENZ CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ENZ SPERMICIDE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN MAGNUM CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ULTRA RIBBED CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ULTRA THIN CONDOM	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
TROJAN ULTRA THIN-SPERMICIDAL	Formulary	OTC; QL (36 condoms per 30 days)
TRUE COVER CONDOM INNER	Formulary	OTC; QL (36 condoms per 30 days)
TRUE COVER CONDOM OUTER	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, RESERVOIR TIP	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, W/NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, W-NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,EXTRA STRENGTH	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,W/NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,W-NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX LATEX CONDOM 12'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX LATEX CONDOM 48'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S, NON-LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S,W/SPERMICIDE	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S, NON-LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S,W/SPERMICIDE	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
<i>Medical Supplies And Dme - Needles And Syringes</i>		
ALLERGIST TRAY 1/2 ML 27GX3/8"	Non-Formulary	
ALLERGIST TRAY INTRADERMAL BEV	Non-Formulary	
ALLERGIST TRAY REGULAR BEVEL	Non-Formulary	
ALLERGY SYRINGE	Non-Formulary	OTC
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 27 X 1/2"	Non-Formulary	
BD ALLERGIST TRAY REG BEVEL TRAY	Non-Formulary	
BD ALLERGY SYRINGE	Non-Formulary	OTC
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2", 3 ML 23 X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1"	Non-Formulary	OTC
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1", 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2", 3 ML, 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2", 3 ML 25 X 5/8", 3 ML 26 X 5/8", 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1"	Non-Formulary	OTC
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8"	Non-Formulary	OTC
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 27 X 1/2"	Non-Formulary	
BD SAFETYGLIDE SHIELDING REG	Non-Formulary	OTC
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
BD SAFETYGLIDE TB REG BEVEL	Non-Formulary	OTC
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 26 GAUGE X 3/8"	Non-Formulary	OTC
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8", 3 ML	Non-Formulary	OTC
BD TUBERCULIN SYRINGE	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2", 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
EASY TOUCH FLURINGE	Non-Formulary	OTC
EASY TOUCH FLURINGE FLIPLOCK	Non-Formulary	OTC
EASY TOUCH FLURINGE SHEATHLOCK	Non-Formulary	OTC
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML	Non-Formulary	OTC
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML	Non-Formulary	OTC
EASY TOUCH SYRINGE	Non-Formulary	OTC
EASY TOUCH TUBERCULIN FLIPLOCK	Non-Formulary	OTC
EASY TOUCH TUBERCULIN SHEATHLK	Non-Formulary	OTC
EASY TOUCH UNI-SLIP SYRINGE 3 ML	Non-Formulary	OTC
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1"	Non-Formulary	
EXCEL SYRINGE	Non-Formulary	OTC
<i>exel huber 22gx3/4" needle</i>	Formulary	OTC
EXEL SYRINGE SYRINGE 3 ML 27 GAUGE X 1 1/4"	Non-Formulary	OTC
INTEGRA SYRINGE	Non-Formulary	
LIFESHIELD BLUNT CANNULA SYRINGE	Non-Formulary	OTC
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2"	Non-Formulary	

Medications	Coverage Level	Restrictions
MONOJECT ALLERGY TRAY	Non-Formulary	OTC
MONOJECT ALLERGY TRAY DETACH	Non-Formulary	OTC
MONOJECT LUER-LOCK TIP SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT MAGELLAN SYRINGE	Non-Formulary	
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT SAFETY LUER LOCK TIP	Non-Formulary	OTC
MONOJECT SAFETY SYRINGES SYRINGE , 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 22 GAUGE X 1 1/2"	Non-Formulary	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML	Non-Formulary	
MONOJECT SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 20 X 3/4", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4"	Non-Formulary	OTC
MONOJECT TB	Non-Formulary	OTC
MONOJECT TB SAFETY SYRINGE	Non-Formulary	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2", 1 ML 28 GAUGE X 1/2", 1/2 ML 28 X 1/2"	Non-Formulary	OTC
SURGUARD2 SAFETY SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	
<i>syringe (disposable) syringe 3 ml</i>	Non-Formulary	OTC
SYRINGE 3CC/20GX1"	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
SYRINGE 3CC/21GX1"	Non-Formulary	OTC
SYRINGE 3CC/21GX1-1/2"	Non-Formulary	OTC
SYRINGE 3CC/22GX1"	Non-Formulary	OTC
SYRINGE 3CC/22GX3/4"	Non-Formulary	OTC
SYRINGE 3CC/25GX1"	Non-Formulary	OTC
<i>syringe with needle syringe 1 ml 25 gauge x 1", 3 ml 20 gauge x 1 1/2", 3 ml 22 x 1 1/2"</i>	Non-Formulary	OTC
TERUMO ALLERGY SYRINGE	Non-Formulary	OTC
TERUMO HYPODERMIC NEEDLE/SYRIN	Non-Formulary	OTC
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1"	Non-Formulary	
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2"	Non-Formulary	OTC
<i>tuberculin-allergy syringes</i>	Non-Formulary	OTC
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 23 GAUGE X 1"	Non-Formulary	OTC
ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8"	Non-Formulary	
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2"	Non-Formulary	OTC
VANISHPOINT TUBERCULIN SYRINGE	Non-Formulary	OTC
<i>Medical Supplies And Dme - Peak Flow Meters</i>		
AIRZONE PEAK FLOW METER ADULTS & CHILDREN	Formulary	OTC; QL (4 spacers per 365 days)
ASTHMA CHECK PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
CLEVER CHOICE PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)
IN-CHECK NASAL WITH MASK	Formulary	OTC; QL (4 units per 365 days)
IN-CHECK ORAL FLOW METER	Formulary	OTC; QL (4 units per 365 days)

Medications	Coverage Level	Restrictions
MICROLIFE PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)
MINI WRIGHT PEAK FLOW METER AFS, (30-400)	Formulary	QL (4 spacers per 365 days)
MINI WRIGHT PEAK FLOW METER STANDARD, (60-800)	Formulary	QL (4 spacers per 365 days)
PEAK-AIR PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)
PERSONAL BEST PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
PERSONAL BEST PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
PIKO 1 FLOW METER	Formulary	OTC; QL (4 units per 365 days)
POCKET PEAK FLOW METER 12'S	Formulary	OTC; QL (4 spacers per 365 days)
PURECOMFORT PEAK FLOW MTR ADLT	Formulary	OTC; QL (4 spacers per 365 days)
PURECOMFORT PEAK FLOW MTR CHLD	Formulary	OTC; QL (4 spacers per 365 days)
STRIVE DUAL ZONE PEAK FLOW METER	Formulary	QL (4 spacers per 365 days)
TRUZONE PEAK FLOW METER ADULT/PEDIATRIC	Formulary	QL (4 spacers per 365 days)
<i>Medical Supplies And Dme - Respiratory Therapy Supplies</i>		
ACE AEROSOL CLOUD ENHANCER	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER MECHANICAL VENT	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER MINI	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER MV HOLD CHAMBER	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU LARGE	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU MED	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU SMALL	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS LARGE W/MASK, LARGE	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS W-FLOW	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS W-FLOW W/FLOWSIGNAL	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS-MED W/MASK-MED,CMFT SEAL	Formulary	QL (4 spacers per 365 days)

Medications	Coverage Level	Restrictions
AEROCHAMBER Z-STAT PLUS-SMALL W/MASK-SM,CMFT SEAL	Formulary	QL (4 spacers per 365 days)
AEROTRACH HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
AEROVENT PLUS HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
BREATHERITE MDI SPACER	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-ADULT MASK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-INFANT MASK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-LG CHLD MSK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-NEONATE MSK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-SM CHLD MSK	Formulary	QL (4 spacers per 365 days)
BREATHRITE VALVED MDI CHAMBER	Formulary	QL (4 spacers per 365 days)
BREATHRITE VALVED MDI SPACER	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE CHAMBER-LRG MASK	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE CHAMBER-MED MASK	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE CHAMBER-SM MASK	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-LRG MASK	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-MED MASK	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-SM MASK	Formulary	QL (4 spacers per 365 days)
EASIVENT HOLDING CHAMBER HOSPITAL PACK	Formulary	QL (4 spacers per 365 days)
EASIVENT HOLDING CHAMBER RETAIL PACK	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER-LARGE MASK	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER-MEDIUM MASK	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER-SMALL MASK	Formulary	QL (4 spacers per 365 days)
FLEXICHAMBER	Formulary	QL (4 spacers per 365 days)
LITIAIRE MDI CHAMBER	Formulary	QL (4 spacers per 365 days)
MICROCHAMBER	Formulary	QL (4 spacers per 365 days)
MICROSPACER FOR AEROSOL DEVICE	Formulary	QL (4 spacers per 365 days)
ONE WAY VALVED MOUTHPIECE	Formulary	OTC; QL (4 spacers per 365 days)
ONE WAY VALVED MOUTHPIECE INSPIRATORY	Formulary	OTC; QL (4 spacers per 365 days)
OPTICHAMBER ADULT MASK-LARGE	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND VHC	Formulary	QL (4 spacers per 365 days)

Medications	Coverage Level	Restrictions
OPTICHAMBER DIAMOND W-LRG MASK	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND W-MED MASK	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND W-SML MASK	Formulary	QL (4 spacers per 365 days)
POCKET CHAMBER	Formulary	QL (4 spacers per 365 days)
PRIMEAIRE CHAMBER	Formulary	QL (4 spacers per 365 days)
PRO COMFORT SPACER-ADULT MASK	Formulary	OTC; QL (4 spacers per 365 days)
PRO COMFORT SPACER-CHILD MASK	Formulary	OTC; QL (4 spacers per 365 days)
PRO COMFORT SPACER-INFANT MASK	Formulary	OTC; QL (4 spacers per 365 days)
PROCARE SPACER WITH ADULT MASK	Formulary	QL (4 spacers per 365 days)
PROCARE SPACER WITH CHILD MASK	Formulary	QL (4 spacers per 365 days)
PROCHAMBER HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
PURE COMFORT SPACER-ADULT MASK	Formulary	OTC; QL (4 spacers per 365 days)
RITEFLO SPACER	Formulary	QL (4 spacers per 365 days)
VORTEX HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
VORTEX HOLDING CHAMBER HRI	Formulary	QL (4 spacers per 365 days)
VORTEX VHC FROG CHILD MASK HRI	Formulary	
VORTEX VHC LADYBUG TODDLER MSK HRI	Formulary	
<i>Medical Supplies And Dme - Subcutaneous Insulin Delivery Devices</i>		
V-GO 20 DISPOSABLE DEVICE	Formulary	
V-GO 30 DISPOSABLE DEVICE	Formulary	
V-GO 40 DISPOSABLE DEVICE	Formulary	
<i>Medical Supplies And Dme - Urine Ketone Tests</i>		
CVS KETONE CARE TEST STRIP	Formulary	OTC
KETONE TEST STRIP	Formulary	OTC
KETOSTIX REAGENT STRIP	Formulary	OTC
RELION KETONE TEST STRIP	Formulary	OTC
TRUEPLUS KETONE TEST STRIP	Formulary	OTC
Medical Supply, Fdb Superset		
<i>Medical Supply, Fdb Superset</i>		
1ST TIER UNIFINE PENTP 5MM 31G	Formulary	OTC
1ST TIER UNIFINE PNTIP 4MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
1ST TIER UNIFINE PNTIP 6MM 31G	Formulary	OTC
1ST TIER UNIFINE PNTIP 8MM 31G STRL, SINGLE USE	Formulary	OTC
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT	Formulary	OTC
1ST TIER UNIFINE PNTP 12MM 29G	Formulary	OTC
1ST TIER UNIFINE PNTP 29GX1/2"	Formulary	OTC
1ST TIER UNIFINE PNTP 31GX1/4"	Formulary	OTC
1ST TIER UNIFINE PNTP 31GX3/16	Formulary	OTC
1ST TIER UNIFINE PNTP 31GX5/16	Formulary	OTC
1ST TIER UNIFINE PNTP 32GX5/32	Formulary	OTC
ACCU-CHEK FASTCLIX LANCET DRUM	Formulary	OTC
ACCU-CHEK SAFE-T-PRO 23G LANCT	Formulary	OTC
ACCU-CHEK SAFE-T-PRO PLUS 23G	Formulary	OTC
ACCU-CHEK SOFTCLIX LANCETS	Formulary	OTC
ACE AEROSOL CLOUD ENHANCER	Formulary	QL (4 spacers per 365 days)
ACTI-LANCE LITE 28G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS STERILE, SINGLE-USE	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS STERILE,SINGLE-USE	Formulary	OTC
ACTI-LANCE UNIVERS 23G LANCETS	Formulary	OTC
ADVANCED TRAVEL 28G LANCETS SINGLE-USE,STERILE	Formulary	OTC
ADVOCATE 26G LANCETS 26 G,STERILE	Formulary	OTC
ADVOCATE 26G LANCETS STERILE	Formulary	OTC
ADVOCATE 30G LANCETS PULL TOP	Formulary	OTC
ADVOCATE 30G LANCETS THIN, STERILE	Formulary	OTC
ADVOCATE 30G LANCETS TWIST TOP	Formulary	OTC
ADVOCATE INS 0.3 ML 30GX5/16"	Formulary	OTC
ADVOCATE INS 0.3 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS 0.5 ML 30GX5/16"	Formulary	OTC
ADVOCATE INS 0.5 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS 1 ML 31GX5/16"	Formulary	OTC
ADVOCATE INS SYR 1 ML 30GX5/16	Formulary	OTC
ADVOCATE PEN NEEDLE 32G 4MM	Formulary	OTC

Medications	Coverage Level	Restrictions
ADVOCATE PEN NEEDLE 4MM 33G	Formulary	OTC
ADVOCATE PEN NEEDLES 5MM 31G	Formulary	OTC
ADVOCATE PEN NEEDLES 8MM 31G	Formulary	OTC
ADVOCATE SAFETY 21G LANCET	Formulary	OTC
ADVOCATE SAFETY 23G LANCET	Formulary	OTC
ADVOCATE SAFETY 28G LANCET	Formulary	OTC
AEROCHAMBER MECHANICAL VENT	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER MINI	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER MV HOLD CHAMBER	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU LARGE	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU MED	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER PLUS FLOW-VU SMALL	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS LARGE W/MASK, LARGE	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS W-FLOW	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS W-FLOW W/FLOWSIGNAL	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS-MED W/MASK-MED,CMFT SEAL	Formulary	QL (4 spacers per 365 days)
AEROCHAMBER Z-STAT PLUS-SMALL W/MASK-SM,CMFT SEAL	Formulary	QL (4 spacers per 365 days)
AEROTRACH HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
AEROVENT PLUS HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
AIMSCO LATEX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
AIRZONE PEAK FLOW METER ADULTS & CHILDREN	Formulary	OTC; QL (4 spacers per 365 days)
ALLERGIST TRAY 1/2 ML 27GX3/8"	Non-Formulary	
ALLERGIST TRAY INTRADERMAL BEV	Non-Formulary	
ALLERGIST TRAY REGULAR BEVEL	Non-Formulary	
ALLERGY SYRINGE	Non-Formulary	OTC
ALTERNATE SITE 26G LANCETS RECAPABLE	Formulary	OTC
<i>aq insulin syr 0.5 ml 30g 8mm (rx)</i>	Formulary	OTC
<i>aq insulin syr 1 ml 31g 8mm (rx)</i>	Formulary	OTC
<i>aq insulin syrin 1 ml 29g 12mm (rx)</i>	Formulary	OTC
<i>assure comfort 28g lancets</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>assure comfort 30g lancets</i>	Formulary	OTC
ASSURE ID PEN NEEDLE	Non-Formulary	OTC
ASSURE LANCE 25G LANCETS	Formulary	OTC
ASSURE LANCE 28G LANCETS	Formulary	OTC
ASSURE LANCE 28G SAFETY LANCET	Formulary	OTC
ASSURE LANCE PLUS 21G LANCETS	Formulary	OTC
ASSURE LANCE PLUS 25G LANCETS	Formulary	OTC
ASSURE LANCE PLUS 30G LANCETS	Formulary	OTC
ASTHMA CHECK PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
AUTOSHIELD DUO PEN NDL 30G 5MM	Formulary	OTC
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 27 X 1/2"	Non-Formulary	
BD ALLERGIST TRAY REG BEVEL TRAY	Non-Formulary	
BD ALLERGY SYRINGE	Non-Formulary	OTC
BD ECLIPSE 30GX1/2" SYRINGE	Formulary	OTC
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2", 3 ML 23 X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
BD INS SYR 0.3 ML 8MMX31G(1/2)	Formulary	OTC
BD INS SYR UF 0.3 ML 12.7MMX30G	Formulary	OTC
BD INS SYR UF 0.5 ML 12.7MMX30G	Formulary	OTC
BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE	Formulary	OTC
BD INS SYRN UF 1 ML 12.7MMX30G	Formulary	OTC
BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE	Formulary	OTC
BD INS SYRN UF 1 ML 30G 12.7MM	Formulary	OTC
BD INS SYRNG 0.3 ML 29GX12.7MM	Formulary	OTC
BD INS SYRNG 0.5 ML 29GX12.7MM	Formulary	OTC
BD INS SYRNG UF 0.3 ML 8MMX31G	Formulary	OTC
BD INS SYRNG UF 0.5 ML 8MMX31G	Formulary	OTC
BD INSULIN SYR 0.5 ML 28GX1/2"	Formulary	OTC
BD INSULIN SYR 0.5 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 27GX12.7MM	Formulary	OTC
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE	Formulary	OTC
<i>bd insulin syr 1 ml 28gx1/2" (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
BD INSULIN SYR 1 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 28GX1/2" MICRO-FINE IV PERM N	Formulary	OTC
BD INSULIN SYR 1 ML 29GX12.7MM	Formulary	OTC
BD INSULIN SYR UF 1 ML 8MMX31G	Formulary	OTC
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1"	Non-Formulary	OTC
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1", 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2", 3 ML, 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2", 3 ML 25 X 5/8", 3 ML 26 X 5/8", 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1"	Non-Formulary	OTC
BD MICROTAINER 21G LANCETS	Formulary	OTC
BD MICROTAINER 30G LANCETS	Formulary	OTC
BD NANO 2 GEN PEN NDL 32G 4MM	Formulary	OTC
BD SAFETGLD INS 0.3 ML 29G 13MM	Formulary	OTC
BD SAFETGLD INS 0.5 ML 13MMX29G	Formulary	OTC
BD SAFETYGLD INS 0.3 ML 31G 8MM	Formulary	OTC
BD SAFETYGLD INS 0.5 ML 30G 8MM	Formulary	OTC
BD SAFETYGLD INS 1 ML 29G 13MM	Formulary	OTC
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8"	Non-Formulary	OTC
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 27 X 1/2"	Non-Formulary	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64"	Non-Formulary	OTC
BD SAFETYGLIDE SHIELDING REG	Non-Formulary	OTC
BD SAFETYGLIDE SYRINGE 27GX5/8	Formulary	OTC
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
BD SAFETYGLIDE TB REG BEVEL	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 26 GAUGE X 3/8"	Non-Formulary	OTC
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8", 3 ML	Non-Formulary	OTC
BD TUBERCULIN SYRINGE	Non-Formulary	OTC
BD UF MICRO PEN NEEDLE 6MMX32G	Formulary	OTC
BD UF MINI PEN NEEDLE 5MMX31G	Formulary	OTC
BD UF NANO PEN NEEDLE 4MMX32G	Formulary	OTC
BD UF ORIG PEN NDL 12.7MMX29G	Formulary	OTC
BD UF SHORT PEN NEEDLE 8MMX31G	Formulary	OTC
BD VEO INS 0.3 ML 6MMX31G (1/2)	Formulary	OTC
BD VEO INS SYRING 1 ML 6MMX31G	Formulary	OTC
BD VEO INS SYRN 0.3 ML 6MMX31G	Formulary	OTC
BD VEO INS SYRN 0.5 ML 6MMX31G	Formulary	OTC
<i>blood lancets 30g easy twist</i>	Formulary	OTC
BREATHERITE MDI SPACER	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-ADULT MASK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-INFANT MASK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-LG CHLD MSK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-NEONATE MSK	Formulary	QL (4 spacers per 365 days)
BREATHERITE SPACER-SM CHLD MSK	Formulary	QL (4 spacers per 365 days)
BREATHRITE VALVED MDI CHAMBER	Formulary	QL (4 spacers per 365 days)
BREATHRITE VALVED MDI SPACER	Formulary	QL (4 spacers per 365 days)
BULLSEYE MINI SAFETY 21G	Formulary	OTC
BULLSEYE MINI SAFETY 25G LANCT	Formulary	OTC
BULLSEYE MINI SAFETY 28G LANCT	Formulary	OTC
<i>ca ins syr 0.3 ml 30gx5/16" short</i>	Formulary	OTC
<i>ca ins syr 0.3 ml 31gx5/16" short</i>	Formulary	OTC
<i>ca ins syr 0.5 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>ca ins syr 0.5 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>ca insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>ca insulin syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>ca insulin syr 1 ml 31gx5/16" short (otc)</i>	Formulary	OTC
CAREFINE PEN NEEDLE 12.7MM 29G HRI	Formulary	OTC
CAREFINE PEN NEEDLE 4MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
CAREFINE PEN NEEDLE 5MM 32G	Formulary	OTC
CAREFINE PEN NEEDLE 6MM 31G HRI	Formulary	OTC
CAREFINE PEN NEEDLE 8MM 30G HRI	Formulary	OTC
CAREFINE PEN NEEDLES 6MM 32G	Formulary	OTC
CAREFINE PEN NEEDLES 8MM 31G	Formulary	OTC
<i>careone syr 0.3 ml 30gx1/2" regular, hri</i>	Formulary	OTC
<i>careone syr 0.5 ml 30gx1/2" regular, hri (otc)</i>	Formulary	OTC
<i>careone syr 1 ml 30gx1/2" regular, hri (otc)</i>	Formulary	OTC
CAREONE ULTRA THIN LANCET	Formulary	OTC
CAREONE UNIFINE PENTIP 4MM 32G STERILE, SINGLE USE	Formulary	OTC
CAREONE UNIFINE PENTIP 5MM 31G SINGLE USE, STERILE	Formulary	OTC
CAREONE UNIFINE PENTIP 6MM 31G 31GX6MM,MINI,STRL	Formulary	OTC
CAREONE UNIFINE PENTIP 8MM 31G 31GX8MM,SHORT,STRL	Formulary	OTC
CAREONE UNIFINE PENTP 29GX1/2" ORIGINAL, 12MM	Formulary	OTC
CAREONE UNIFINE PENTP 31GX1/4" ULTRA SHORT, 6MM	Formulary	OTC
CAREONE UNIFINE PNTP 12MM 29G 29GX12MM,ORIGNL,STRL	Formulary	OTC
CAREONE UNIFINE PNTP 31GX3/16" MINI, 5MM	Formulary	OTC
CAREONE UNIFINE PNTP 31GX5/16" SHORT, 8MM	Formulary	OTC
CAREONE UNIFINE PNTP 32GX5/32"	Formulary	OTC
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16"	Non-Formulary	OTC
CARETOUCH PEN NEEDLE	Non-Formulary	OTC
CAYA CONTOURED DIAPHRAGM	Formulary	
CLEVER CHEK ULTRA THIN 30G	Formulary	OTC
CLEVER CHOICE CHAMBER-LRG MASK	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE CHAMBER-MED MASK	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE CHAMBER-SM MASK	Formulary	QL (4 spacers per 365 days)
CLEVER CHOICE PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)

Medications	Coverage Level	Restrictions
CLICKFINE 31G X 1/4" NEEDLES 6MM, UNIVERSAL	Formulary	OTC
CLICKFINE 31G X 5/16" NEEDLES 8MM, UNIVERSAL	Formulary	OTC
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE	Formulary	OTC
CLICKFINE PEN NEEDLE 32GX5/32" UNIVERSAL CLICK	Formulary	OTC
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND	Formulary	OTC
COAGUCHEK LANCETS	Formulary	OTC
COMFORT EZ 0.3 ML 31G 15/64"	Formulary	OTC
COMFORT EZ 0.5 ML 31G 15/64"	Formulary	OTC
COMFORT EZ INS 0.3 ML 30GX1/2"	Formulary	OTC
COMFORT EZ INS 0.3 ML 30GX5/16"	Formulary	OTC
COMFORT EZ INS 0.5 ML 31GX5/16"	Formulary	OTC
COMFORT EZ INS 1 ML 31G 15/64"	Formulary	OTC
COMFORT EZ INS 1 ML 31GX5/16"	Formulary	OTC
COMFORT EZ INSULIN SYR 0.3 ML	Formulary	OTC
COMFORT EZ INSULIN SYR 0.5 ML	Formulary	OTC
COMFORT EZ PEN NEEDLE 12MM 29G	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G MICRO	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO	Formulary	OTC
COMFORT EZ PEN NEEDLES 4MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 31G MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 32G MINI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI	Formulary	OTC
COMFORT EZ PEN NEEDLES 5MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 6MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 6MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
COMFORT EZ PEN NEEDLES 6MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G SHORT	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 32G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 33G	Formulary	OTC
COMFORT EZ SYR 0.3 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 28GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 0.5 ML 30GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 28GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 29GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 30GX1/2"	Formulary	OTC
COMFORT EZ SYR 1 ML 30GX5/16"	Formulary	OTC
<i>comfort point pen ndl 29gx1/2" 12mm</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/3"</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/4" 6mm</i>	Formulary	OTC
<i>comfort point pen ndl 31gx1/6"</i>	Formulary	OTC
COMPACT SPACE CHAMBER	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-LRG MASK	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-MED MASK	Formulary	QL (4 spacers per 365 days)
COMPACT SPACE CHAMBER-SM MASK	Formulary	QL (4 spacers per 365 days)
CONTOUR NEXT TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
CONTOUR TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
CVS KETONE CARE TEST STRIP	Formulary	OTC
<i>cvs micro thin 33g lancets</i>	Formulary	OTC
CVS MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC
<i>cvs thin 26g lancets</i>	Formulary	OTC
<i>cvs ultra thin 30g lancets</i>	Formulary	OTC
CVS ULTRA THIN 30G LANCETS	Formulary	OTC
CVS ULTRA THIN 30G LANCETS STERILE	Formulary	OTC
DROPLET 30G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16"	Non-Formulary	OTC
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	Non-Formulary	OTC
DROPLET MICRON PEN NEEDLE	Non-Formulary	OTC
DROPLET PEN NEEDLE 29G 10MM	Formulary	OTC
DROPLET PEN NEEDLE 29G 12MM	Formulary	OTC
DROPLET PEN NEEDLE 30G 8MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 5MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 6MM	Formulary	OTC
DROPLET PEN NEEDLE 31G 8MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 4MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 5MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 6MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 8MM	Formulary	OTC
DROPSAFE PEN NEEDLE	Non-Formulary	OTC
DRUG MART ULTRA COMFORT SYR	Formulary	OTC
DUREX AVANTI REAL FEEL CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
DUREX EXTRA SENSITIVE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
DUREX TROPICAL CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
EASIVENT HOLDING CHAMBER HOSPITAL PACK	Formulary	QL (4 spacers per 365 days)
EASIVENT HOLDING CHAMBER RETAIL PACK	Formulary	QL (4 spacers per 365 days)
EASY COMFORT 0.3 ML 31G 1/2"	Formulary	OTC
EASY COMFORT 0.3 ML 31G 5/16"	Formulary	OTC
EASY COMFORT 0.5 ML 30GX1/2"	Formulary	OTC
EASY COMFORT 0.5 ML 31GX5/16"	Formulary	OTC
EASY COMFORT 0.5 ML 32GX5/16"	Formulary	OTC

Medications	Coverage Level	Restrictions
EASY COMFORT 0.5 ML SYRINGE	Formulary	OTC
EASY COMFORT 1 ML 31GX5/16"	Formulary	OTC
EASY COMFORT 1 ML 32GX5/16"	Formulary	OTC
EASY COMFORT 30G LANCETS	Formulary	OTC
EASY COMFORT 30G LANCETS 30G,PULL TOP,STERILE	Formulary	OTC
EASY COMFORT 30G LANCETS 30G,TWIST TOP,STRL	Formulary	OTC
EASY COMFORT 30G LANCETS THIN TOP, SINGLE USE	Formulary	OTC
EASY COMFORT INSULIN 1 ML SYR	Formulary	OTC
EASY COMFORT PEN NDL 31GX1/4"	Formulary	OTC
EASY COMFORT PEN NDL 31GX3/16"	Formulary	OTC
EASY COMFORT PEN NDL 31GX5/16"	Formulary	OTC
EASY COMFORT PEN NDL 32GX5/32"	Formulary	OTC
EASY COMFORT PEN NDL 33G 4MM	Formulary	OTC
EASY COMFORT PEN NDL 33G 5MM	Formulary	OTC
EASY COMFORT PEN NDL 33G 6MM	Formulary	OTC
EASY COMFORT SYR 1 ML 30GX1/2"	Formulary	OTC
EASY TOUCH 0.3 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 27GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 29GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 0.5 ML SYR 30GX5/16	Formulary	OTC
EASY TOUCH 1 ML SYR 27GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 29GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH 1 ML SYR 30GX1/2"	Formulary	OTC
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2", 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
EASY TOUCH FLURINGE	Non-Formulary	OTC
EASY TOUCH FLURINGE FLIPLOCK	Non-Formulary	OTC
EASY TOUCH FLURINGE SHEATHLOCK	Non-Formulary	OTC
EASY TOUCH INSULIN 1 ML 29GX1/2	Formulary	OTC
EASY TOUCH INSULIN 1 ML 30GX1/2	Formulary	OTC
EASY TOUCH INSULIN SYR 0.3 ML	Formulary	OTC
EASY TOUCH INSULIN SYR 0.5 ML	Formulary	OTC
EASY TOUCH INSULIN SYR 1 ML	Formulary	OTC
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE	Formulary	OTC
EASY TOUCH INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8"	Non-Formulary	OTC
EASY TOUCH INSULN 1 ML 29GX1/2"	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX1/2"	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 30GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 31GX5/16	Formulary	OTC
EASY TOUCH INSULN 1 ML 31GX5/16	Formulary	OTC
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML	Non-Formulary	OTC
EASY TOUCH LUER LOK INSUL 1 ML	Formulary	OTC
EASY TOUCH PEN NEEDLE 29GX1/2"	Formulary	OTC
EASY TOUCH PEN NEEDLE 30GX5/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX1/4"	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX3/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 31GX5/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX1/4"	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX3/16	Formulary	OTC
EASY TOUCH PEN NEEDLE 32GX5/32	Formulary	OTC
EASY TOUCH PULL-TOP 26G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 28G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 30G LANCET	Formulary	OTC
EASY TOUCH PULL-TOP 32G LANCET	Formulary	OTC
EASY TOUCH SAFETY 21G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 23G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 26G LANCETS	Formulary	OTC
EASY TOUCH SAFETY 28G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
EASY TOUCH SAFETY 30G LANCETS STRL	Formulary	OTC
EASY TOUCH SAFETY 32G LANCETS	Formulary	OTC
EASY TOUCH SAFETY PEN NEEDLE	Non-Formulary	OTC
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML	Non-Formulary	OTC
EASY TOUCH SYR 0.5 ML 27G 12.7MM	Formulary	OTC
EASY TOUCH SYR 0.5 ML 28G 12.7MM	Formulary	OTC
EASY TOUCH SYR 0.5 ML 29G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 27G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 28G 12.7MM	Formulary	OTC
EASY TOUCH SYR 1 ML 29G 12.7MM	Formulary	OTC
EASY TOUCH SYRINGE	Non-Formulary	OTC
EASY TOUCH TUBERCULIN FLIPLOCK	Non-Formulary	OTC
EASY TOUCH TUBERCULIN SHEATHLK	Non-Formulary	OTC
EASY TOUCH TWIST 26G LANCETS	Formulary	OTC
EASY TOUCH TWIST 28G LANCETS	Formulary	OTC
EASY TOUCH TWIST 30G LANCETS	Formulary	OTC
EASY TOUCH TWIST 32G LANCETS	Formulary	OTC
EASY TOUCH TWIST 33G LANCETS	Formulary	OTC
EASY TOUCH UNI-SLIP SYR 1 ML	Formulary	OTC
EASY TOUCH UNI-SLIP SYRINGE 3 ML	Non-Formulary	OTC
EASY TWIST & CAP 28G LANCETS	Formulary	OTC
EASY-TOUCH INS 1 ML 31GX5/16" EASY-TOUCH	Formulary	OTC
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1"	Non-Formulary	
EMBRACE 30G LANCETS	Formulary	OTC
EQ SPACE CHAMBER	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER-LARGE MASK	Formulary	QL (4 spacers per 365 days)
EQ SPACE CHAMBER-MEDIUM MASK	Formulary	QL (4 spacers per 365 days)

Medications	Coverage Level	Restrictions
EQ SPACE CHAMBER-SMALL MASK	Formulary	QL (4 spacers per 365 days)
<i>eql ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>eql insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>eql insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>eql insulin 0.3 ml syringe</i>	Formulary	OTC
<i>eql insulin 0.3 ml syringe short needle</i>	Formulary	OTC
<i>eql insulin 0.5 ml syringe</i>	Formulary	OTC
<i>eql insulin 0.5 ml syringe short needle</i>	Formulary	OTC
<i>eql insulin 1 ml syringe short needle</i>	Formulary	OTC
<i>eql insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
EQL MICRO THIN 33G LANCETS COLOR	Formulary	OTC
EQL PEN 8MM 31G X 5/16" NEEDLE STERILE,SINGLE USE (OTC)	Formulary	OTC
EXCEL SYRINGE	Non-Formulary	OTC
<i>exel huber 22gx3/4" needle</i>	Formulary	OTC
<i>exel ins syr u100 1 ml 28gx1/2 (otc)</i>	Formulary	OTC
EXEL SYRINGE SYRINGE 3 ML 27 GAUGE X 1 1/4"	Non-Formulary	OTC
EXEL U100 0.3 ML 29GX1/2"	Formulary	OTC
<i>exel u100 0.3 ml 30gx5/16"</i>	Formulary	OTC
EXEL U100 0.5 ML 28GX1/2"	Formulary	OTC
<i>exel u100 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
EXEL U100 0.5 ML 30GX5/16"	Formulary	OTC
EXEL U100 1 ML 30GX5/16"	Formulary	OTC
<i>exel u100 ins syr 1 ml 29gx1/2 (otc)</i>	Formulary	OTC
E-Z JECT COLORED LANCETS	Formulary	OTC
E-Z JECT LANCETS	Formulary	OTC
EZ SMART 28G LANCETS	Formulary	OTC
E-ZJECT COLOR 32G LANCETS	Formulary	OTC
E-ZJECT COLOR 33G LANCETS	Formulary	OTC
E-ZJECT SUPER THIN 30G LANCETS SUPER THIN	Formulary	OTC
<i>e-zject thin lancets 26 gauge</i>	Formulary	OTC
FANTASY CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
FC2 FEMALE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
FEMCAP 22 MM CERVICAL CAP	Formulary	
FEMCAP 26 MM CERVICAL CAP	Formulary	
FEMCAP 30 MM CERVICAL CAP	Formulary	
<i>fifty50 ins 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>fifty50 ins 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>fifty50 ins syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)	Formulary	OTC
<i>fifty50 pen 31g x 3/16" needle 5mm</i>	Formulary	OTC
FIFTY50 PEN 31G X 5/16" NEEDLE (OTC)	Formulary	OTC
<i>fifty50 pen 31g x 5/16" needle 8mm</i>	Formulary	OTC
<i>fifty50 pen needle 32g x 1/4"</i>	Formulary	OTC
<i>fifty50 pen needle 32g x 5/32" 4mm</i>	Formulary	OTC
FIFTY50 UNILET 33G LANCETS	Formulary	OTC
FINGERSTIX LANCETS	Formulary	OTC
FLEXICHAMBER	Formulary	QL (4 spacers per 365 days)
<i>fora 30g lancets twist off, single use</i>	Formulary	OTC
FORACARE 30G LANCETS	Formulary	OTC
FREESTYLE 28G LANCETS	Formulary	OTC
FREESTYLE INSULINX STRIP NFRS NO CODE, NFRS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE INSULINX TEST STRIP NO CODE	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE INSULINX TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE LITE TEST STRIP	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE LITE TEST STRIP NFRS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE PREC 0.5 ML 30GX5/16	Formulary	OTC
FREESTYLE PREC 0.5 ML 31GX5/16	Formulary	OTC
FREESTYLE PREC 1 ML 30GX5/16"	Formulary	OTC
FREESTYLE PREC 1 ML 31GX5/16"	Formulary	OTC
FREESTYLE TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE TEST STRIPS NFRS NOT FOR RETAIL SALE	Formulary	OTC; QL (200 test strips per 30 days)
FREESTYLE UNISTIK 2 LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
GLUCOCOM 28G LANCETS	Formulary	OTC
GLUCOCOM 30G LANCETS	Formulary	OTC
GLUCOCOM 33G LANCETS	Formulary	OTC
GNP CLICKFINE 31G X 1/4" NDL 6MM, UNIVERSAL	Formulary	OTC
GNP CLICKFINE 31G X 5/16" NDL 8MM, UNIVERSAL	Formulary	OTC
<i>gnp ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>gnp ins syringe 1 ml 28g 1/2" (otc)</i>	Formulary	OTC
<i>gnp insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>gnp insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>gnp insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>gnp pen needle 31g 5mm</i>	Formulary	OTC
<i>gnp pen needle 31g 8mm</i>	Formulary	OTC
<i>gnp pen needle 32g 4mm</i>	Formulary	OTC
<i>gnp pen needle 32g 6mm</i>	Formulary	OTC
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT	Formulary	OTC
GNP ULT CMFRT 0.5 ML 29GX1/2"	Formulary	OTC
GNP ULTICARE PEN NDL 31G 5MM	Formulary	OTC
GNP ULTICARE PEN NDL 31G 8MM	Formulary	OTC
GNP ULTICARE PEN NDL 32G 4MM	Formulary	OTC
GNP ULTICARE PEN NDL 32G 6MM	Formulary	OTC
GNP ULTIGUARD SAFEPACK 32G 4MM	Formulary	OTC
GNP ULTR CMFRT 0.5 ML 28GX1/2"	Formulary	OTC
GNP ULTR COMFORT 1 ML 29GX1/2"	Formulary	OTC
GNP ULTRA COMFORT 0.5 ML SYR	Formulary	OTC
GNP ULTRA COMFORT 1 ML SYRINGE	Formulary	OTC
GNP ULTRA COMFORT 3/10 ML SYR	Formulary	OTC
GNP ULTRA COMFRT 1 ML 28GX1/2"	Formulary	OTC
GNP UNIVERSAL 1 STANDARD 21G	Formulary	OTC
GNP UNIVERSAL 1 THIN 26G LANCT	Formulary	OTC
GOJJI LANCETS 30G	Formulary	OTC
<i>gs pen needle 31g x 5/16"</i>	Formulary	OTC
<i>gs pen needle 31g x 5mm</i>	Formulary	OTC
<i>gs pen needle 31g x 6mm</i>	Formulary	OTC
<i>gs pen needle 31g x 8mm</i>	Formulary	OTC
<i>gs pen needle 32g x 4mm</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>gs pen needle 32g x 6mm</i>	Formulary	OTC
GS UNIVERSAL 1 MICRO THIN 33G	Formulary	OTC
GS UNIVERSAL 1 THIN 26G LANCET	Formulary	OTC
GS UNIVERSAL 1 ULTRA THIN 30G	Formulary	OTC
HEALTHWISE PEN NEEDLE	Non-Formulary	OTC
HEALTHY ACCENTS PENTIP 5MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTIP 6MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTIP 8MM 31G	Formulary	OTC
HEALTHY ACCENTS PENTP 12MM 29G	Formulary	OTC
HEB MICRO THIN 33G LANCETS SINGLE-USE,STERILE	Formulary	OTC
HEB UNIFINE PNTP PLUS 31GX3/16 5MM	Formulary	OTC
HM ULTICARE PEN NEEDLE 4MM 32G	Formulary	OTC
HM ULTICARE PEN NEEDLE 5MM 31G	Formulary	OTC
HM ULTICARE PEN NEEDLE 6MM 31G	Formulary	OTC
HM ULTICARE PEN NEEDLE 8MM 31G	Formulary	OTC
IN-CHECK NASAL WITH MASK	Formulary	OTC; QL (4 units per 365 days)
IN-CHECK ORAL FLOW METER	Formulary	OTC; QL (4 units per 365 days)
INCONTROL PEN NEEDLE 12MM 29G	Formulary	OTC
INCONTROL PEN NEEDLE 4MM 32G	Formulary	OTC
INCONTROL PEN NEEDLE 5MM 31G	Formulary	OTC
INCONTROL PEN NEEDLE 6MM 31G	Formulary	OTC
INCONTROL PEN NEEDLE 8MM 31G	Formulary	OTC
INCONTROL SUPER THIN 30G LANCT	Formulary	OTC
INCONTROL ULTICARE NDL 31G 6MM	Formulary	OTC
INCONTROL ULTICARE NDL 31G 8MM	Formulary	OTC
INCONTROL ULTICARE NDL 32G 4MM	Formulary	OTC
INCONTROL ULTRA THIN 28G LANCT	Formulary	OTC
INJECT EASE 28G LANCETS	Formulary	OTC
INJECT EASE 30G LANCETS	Formulary	OTC
<i>insulin 1 ml syringe</i>	Formulary	OTC
<i>insulin 1/2 ml syringe</i>	Formulary	OTC
<i>insulin 3/10 ml syringe</i>	Formulary	OTC
<i>insulin syr 0.3 ml 30gx5/16"</i>	Formulary	OTC
<i>insulin syr 0.5 ml 28g 12.7mm (otc)</i>	Formulary	OTC
<i>insulin syr/ndl u100 half mark</i>	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
<i>insulin syrin 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx1/2"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx1/2" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" hri</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" short</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 30gx5/16" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" short needle,thin ii</i>	Formulary	OTC
<i>insulin syrin 0.3 ml 31gx5/16" ultra comfort</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 28g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx1/2" short needle (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" short needle,thin ii</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>insulin syrin 0.5 ml 31gx5/16" short needle,thin ii (otc)</i>	Formulary	OTC
<i>insulin syrin 0.5 ml 31gx5/16" ultra comfort (otc)</i>	Formulary	OTC
INSULIN SYRIN 1 ML 29GX1/2"	Formulary	OTC
<i>insulin syringe 0.5 ml 27g 1/2"</i>	Formulary	
<i>insulin syringe 0.5 ml 27g 1/2" inner</i>	Formulary	
<i>insulin syringe 0.5 ml 27g 1/2" outer</i>	Formulary	
<i>insulin syringe 0.5 ml 27g 13mm</i>	Formulary	
<i>insulin syringe 0.5 ml 28g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 0.5 ml 29g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 0.5 ml 29g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
INSULIN SYRINGE 0.3 ML	Formulary	OTC
<i>insulin syringe 0.3 ml 31gx1/4</i>	Formulary	OTC
<i>insulin syringe 0.3 ml short</i>	Formulary	OTC
INSULIN SYRINGE 0.5 ML	Formulary	OTC
<i>insulin syringe 0.5 ml 31g 6mm(only for 500 unit/ml insulin)</i>	Formulary	
<i>insulin syringe 0.5 ml 31gx1/4</i>	Formulary	OTC
INSULIN SYRINGE 1 ML	Formulary	OTC
<i>insulin syringe 1 ml 27g 1/2" inner</i>	Formulary	
<i>insulin syringe 1 ml 27g 1/2" outer</i>	Formulary	
<i>insulin syringe 1 ml 27g 13mm inner</i>	Formulary	
<i>insulin syringe 1 ml 27g 16mm</i>	Formulary	OTC
<i>insulin syringe 1 ml 27gx1/2" outer</i>	Formulary	
<i>insulin syringe 1 ml 28g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 12.7mm (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 13mm inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28g 13mm outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29g 1/2" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 1/2" inner (rx)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>insulin syringe 1 ml 30g 1/2" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30g 5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx1/2" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31g 5/16" inner (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31g 5/16" outer (rx)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx1/4"</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" hri (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml 31gx5/16" short needle,thin ii (otc)</i>	Formulary	OTC
<i>insulin syringe 1 ml short</i>	Formulary	OTC
INSUPEN PEN NEEDLE 29GX1/2"	Formulary	OTC
INSUPEN PEN NEEDLE 29GX12MM	Formulary	OTC
INSUPEN PEN NEEDLE 31G 5MM	Formulary	OTC
INSUPEN PEN NEEDLE 31G 8MM	Formulary	OTC
INSUPEN PEN NEEDLE 31GX3/16"	Formulary	OTC
INSUPEN PEN NEEDLE 31GX5/16"	Formulary	OTC
INSUPEN PEN NEEDLE 31GX8MM	Formulary	OTC
INSUPEN PEN NEEDLE 32G 4MM	Formulary	OTC
INSUPEN PEN NEEDLE 32GX4MM	Formulary	OTC
INSUPEN PEN NEEDLE 32GX5/32"	Formulary	OTC
INTEGRA SYRINGE	Non-Formulary	
INVACARE 30G LANCETS	Formulary	OTC
KETONE TEST STRIP	Formulary	OTC
KETOSTIX REAGENT STRIP	Formulary	OTC
KIMONO MAXX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MICROTHIN AQUA LUBE	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
KIMONO MICROTHIN CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO MICROTHIN LARGE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO TEXTURED CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
KIMONO THIN LUBRICATED CONDOMS	Formulary	OTC; QL (36 condoms per 30 days)
<i>kinray ins syr 1 ml 31gx5/16" preferred plus (otc)</i>	Formulary	OTC
<i>kinray syring 0.3 ml 31gx5/16" preferred plus</i>	Formulary	OTC
<i>kinray syring 0.5 ml 31gx5/16" preferred plus (otc)</i>	Formulary	OTC
<i>kmart valu plus syr 1/2 ml</i>	Formulary	OTC
<i>kro ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>kro ins syrin 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>kro insulin syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>kro pen needle 4mm x 32g</i>	Formulary	OTC
<i>kro pen needle 4mm x 33g</i>	Formulary	OTC
<i>kro pen needle 5mm x 31g</i>	Formulary	OTC
<i>kro pen needle 6mm x 31g</i>	Formulary	OTC
<i>kro pen needle 8mm x 31g</i>	Formulary	OTC
KRO UNIVERSAL 1 THIN 26G LANCT	Formulary	OTC
<i>croger ins syr 0.3 ml 30gx5/16 short needle</i>	Formulary	OTC
<i>croger ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>croger ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>croger ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>croger lancets</i>	Formulary	OTC
KROGER PEN NEEDLES 31G X 5/16" (OTC)	Formulary	OTC
KROGER SUPER THIN LANCETS	Formulary	OTC
<i>croger syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>croger syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>lancets</i>	Formulary	OTC
<i>lancets 26g x 1.8mm yellow</i>	Formulary	OTC
<i>lancets 28g lancets</i>	Formulary	OTC
<i>lancets 30g</i>	Formulary	OTC
<i>lancets 30g twist top, single use</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>lancets 33g</i>	Formulary	OTC
<i>lancets ultra fine 28g</i>	Formulary	OTC
<i>leader ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>leader ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>leader insulin syringe 0.3 ml</i>	Formulary	OTC
<i>leader pen needles 12mm 29g</i>	Formulary	OTC
<i>leader syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>leader syring 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
LIFESHIELD BLUNT CANNULA SYRINGE	Non-Formulary	OTC
LITEAIRE MDI CHAMBER	Formulary	QL (4 spacers per 365 days)
LIVE BETTER PEN NEEDLES 8MM 31G (OTC)	Formulary	OTC
LONGS THIN LANCETS 26G 26G	Formulary	OTC
LONGS THIN LANCETS 30G 30G	Formulary	OTC
MAGELLAN INSUL SYRINGE 0.3 ML	Formulary	
MAGELLAN INSUL SYRINGE 0.5 ML	Formulary	
MAGELLAN INSULIN SYR 0.3 ML	Formulary	
MAGELLAN INSULIN SYR 0.5 ML	Formulary	
MAGELLAN INSULIN SYRINGE 1 ML	Formulary	
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2"	Non-Formulary	
MAXICOMFORT II PEN NEEDLE	Non-Formulary	OTC
MAXI-COMFORT INS 0.5 ML 28G	Formulary	OTC
MAXI-COMFORT INS 1 ML 28GX1/2"	Formulary	OTC
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16"	Non-Formulary	OTC
MEDISENSE THIN 28G LANCETS	Formulary	OTC
<i>medisense thin lancets</i>	Formulary	OTC
MEDLANCE PLUS 21G LANCETS UNIVERSAL	Formulary	OTC

Medications	Coverage Level	Restrictions
MEDLANCE PLUS 21G LANCETS UNIVERSAL, 1.8MM	Formulary	OTC
MEDLANCE PLUS 30G LANCETS SUPERLITE	Formulary	OTC
MEDLANCE PLUS 30G LANCETS SUPERLITE, 1.2MM	Formulary	OTC
MEDLANCE PLUS EXTRA 21G LANCET 2.4MM	Formulary	OTC
MEDLANCE PLUS LITE 25G LANCETS 1.5MM	Formulary	OTC
MEDLANCE PLUS LITE 25G LANCETS 25G	Formulary	OTC
<i>meijer lancets 30g</i>	Formulary	OTC
MEIJER UNIVERSAL 1 26G LANCETS	Formulary	OTC
MICRO THIN 33G LANCETS	Formulary	OTC
MICRO THIN 33G LANCETS FOR WALGREENS	Formulary	OTC
MICRO THIN 33G LANCETS STERILE	Formulary	OTC
MICRO THIN 33G LANCETS TRUE PLUS, WALGREENS	Formulary	OTC
MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC
MICROCHAMBER	Formulary	QL (4 spacers per 365 days)
MICROLET LANCETS	Formulary	OTC
MICROLIFE PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)
MICROSPACER FOR AEROSOL DEVICE	Formulary	QL (4 spacers per 365 days)
MINI ULTRA-THIN II PEN NDL 31G STERILE	Formulary	OTC
MINI WRIGHT PEAK FLOW METER AFS, (30-400)	Formulary	QL (4 spacers per 365 days)
MINI WRIGHT PEAK FLOW METER STANDARD, (60-800)	Formulary	QL (4 spacers per 365 days)
MONOJECT 0.5 ML SYRN 28GX1/2"	Formulary	
MONOJECT 1 ML SYRN 27X1/2"	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" (OTC)	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" 28GX1/2" (OTC)	Formulary	OTC
MONOJECT 1 ML SYRN 28GX1/2" SOFTPACK (RX)	Formulary	OTC
MONOJECT ALLERGY TRAY	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
MONOJECT ALLERGY TRAY DETACH	Non-Formulary	OTC
MONOJECT INSUL SYR U100 (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 0.5 ML (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)	Formulary	OTC
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 0.3 ML	Formulary	
MONOJECT INSULIN SYR 0.3 ML (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 0.5 ML	Formulary	
MONOJECT INSULIN SYR 0.5 ML (OTC)	Formulary	OTC
MONOJECT INSULIN SYR 1 ML (RX)	Formulary	OTC
MONOJECT INSULIN SYR 1 ML 3'S (OTC)	Formulary	OTC
MONOJECT INSULIN SYR U-100	Formulary	
MONOJECT INSULIN SYR U-100	Formulary	OTC
MONOJECT INSULIN SYRN 3/10 ML	Formulary	OTC
MONOJECT LUER-LOCK TIP SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT MAGELLAN SYRINGE	Non-Formulary	
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML	Non-Formulary	OTC
MONOJECT SAFETY LUER LOCK TIP	Non-Formulary	OTC
MONOJECT SAFETY SYRINGES SYRINGE , 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	OTC
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 22 GAUGE X 1 1/2"	Non-Formulary	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML	Non-Formulary	
MONOJECT SYRINGE 0.3 ML	Formulary	OTC

Medications	Coverage Level	Restrictions
MONOJECT SYRINGE 0.5 ML	Formulary	OTC
MONOJECT SYRINGE 1 ML	Formulary	OTC
MONOJECT SYRINGE 1 ML SOFTPK, REG LUER TIP (RX)	Formulary	OTC
MONOJECT SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 20 X 3/4", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4"	Non-Formulary	OTC
MONOJECT TB	Non-Formulary	OTC
MONOJECT TB SAFETY SYRINGE	Non-Formulary	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2", 1 ML 28 GAUGE X 1/2", 1/2 ML 28 X 1/2"	Non-Formulary	OTC
MONOLET 21G LANCETS	Formulary	OTC
MONOLET THIN 28G LANCETS	Formulary	OTC
<i>ms ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ms ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ms ins syringe 1 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>ms insul syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>ms insul syr 0.5 ml 30gx1/2" (otc)</i>	Formulary	OTC
<i>ms insul syr 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>ms insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>ms insulin syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>ms insulin syringe 0.3 ml</i>	Formulary	OTC
MS PEN NEEDLE 6MM 31G SHORT, SINGLE USE	Formulary	OTC
MYGLUCOHEALTH 30G LANCETS	Formulary	OTC
NANO 2 GEN PEN NEEDLE 32G 4MM	Formulary	OTC
NANO PEN NEEDLE 32G 4MM	Formulary	OTC
NOVA SAFETY 23G LANCETS	Formulary	OTC
NOVA SAFETY 28G LANCETS	Formulary	OTC
NOVA SUREFLEX THIN LANCETS	Formulary	OTC
NOVOFINE 32G NEEDLES	Formulary	OTC
NOVOFINE PLUS PEN NDL 32GX1/6"	Formulary	OTC
ON CALL 30G LANCET	Formulary	OTC

Medications	Coverage Level	Restrictions
ONE WAY VALVED MOUTHPIECE	Formulary	OTC; QL (4 spacers per 365 days)
ONE WAY VALVED MOUTHPIECE INSPIRATORY	Formulary	OTC; QL (4 spacers per 365 days)
ON-THE-GO 30G LANCETS GENTLE, 1.5MM	Formulary	OTC
OPTICHAMBER ADULT MASK-LARGE	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND VHC	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND W-LRG MASK	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND W-MED MASK	Formulary	QL (4 spacers per 365 days)
OPTICHAMBER DIAMOND W-SML MASK	Formulary	QL (4 spacers per 365 days)
PARADIGM RESERVOIR	Non-Formulary	
PC SUPER THIN 30G LANCETS	Formulary	OTC
PC UNIFINE PENTIPS 12MM NEEDLE ORIGINAL	Formulary	OTC
PC UNIFINE PENTIPS 6MM NEEDLE ULTRA SHORT	Formulary	OTC
PC UNIFINE PENTIPS 8MM NEEDLE SHORT	Formulary	OTC
PEAK-AIR PEAK FLOW METER	Formulary	OTC; QL (4 spacers per 365 days)
<i>pen needle 29g 12mm</i>	Formulary	OTC
<i>pen needle 30g 5mm inner</i>	Formulary	OTC
<i>pen needle 30g 5mm outer</i>	Formulary	OTC
PEN NEEDLE 30G X 5/16"	Formulary	
<i>pen needle 31g 5mm</i>	Formulary	OTC
<i>pen needle 31g 5mm inner</i>	Formulary	OTC
<i>pen needle 31g 5mm outer</i>	Formulary	OTC
<i>pen needle 31g 6mm</i>	Formulary	OTC
<i>pen needle 31g 8mm</i>	Formulary	OTC
<i>pen needle 31g 8mm inner</i>	Formulary	OTC
<i>pen needle 31g 8mm outer</i>	Formulary	OTC
<i>pen needle 31g x 1/4"</i>	Formulary	OTC
<i>pen needle 31g x 1/4" 6mm</i>	Formulary	OTC
<i>pen needle 31g x 1/4" hri</i>	Formulary	OTC
<i>pen needle 31g x 3/16"</i>	Formulary	OTC
PEN NEEDLE 31G X 3/16" (RX)	Formulary	OTC
<i>pen needle 31g x 3/16" hri</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>pen needle 31g x 5/16"</i>	Formulary	OTC
PEN NEEDLE 31G X 5/16" (RX)	Formulary	OTC
<i>pen needle 31g x 5/16" 8mm</i>	Formulary	OTC
<i>pen needle 31g x 5/16" hri</i>	Formulary	OTC
<i>pen needle 32g 4mm</i>	Formulary	OTC
<i>pen needle 32g 4mm inner</i>	Formulary	OTC
<i>pen needle 32g 4mm outer</i>	Formulary	OTC
<i>pen needle 32g x 1/4"</i>	Formulary	OTC
<i>pen needle 32g x 3/16"</i>	Formulary	OTC
<i>pen needle 32g x 5/32"</i>	Formulary	OTC
<i>pen needle 32g x 5/32" 4mm</i>	Formulary	OTC
<i>pen needle 32g x 5/32" hri</i>	Formulary	OTC
<i>pen needle 33g 4mm</i>	Formulary	OTC
PEN NEEDLE 6MM 31G 6MM	Formulary	OTC
<i>pen needle, diabetic needle 30 gauge x 5/16"</i>	Non-Formulary	OTC
PEN NEEDLES 12MM 29G	Formulary	OTC
<i>pen needles 12mm 29g 29gx12mm, strl</i>	Formulary	OTC
PEN NEEDLES 12MM 29G 29GX12MM,STRL	Formulary	OTC
<i>pen needles 12mm 29g strl</i>	Formulary	OTC
PEN NEEDLES 4MM 32G	Formulary	OTC
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)	Formulary	OTC
<i>pen needles 6mm 31g 31gx6mm, strl</i>	Formulary	OTC
<i>pen needles 6mm 31g strl</i>	Formulary	OTC
PEN NEEDLES 8MM 31G (OTC)	Formulary	OTC
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)	Formulary	OTC
PENTIPS PEN NEEDLE 29G 1/2"	Formulary	OTC
PENTIPS PEN NEEDLE 29G 12MM	Formulary	OTC
PENTIPS PEN NEEDLE 29GX1/2"	Formulary	OTC
PENTIPS PEN NEEDLE 31G 1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 31G 3/16" MINI, 5MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 5/16" SHORT, 8MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 5MM	Formulary	OTC

Medications	Coverage Level	Restrictions
PENTIPS PEN NEEDLE 31G 6MM	Formulary	OTC
PENTIPS PEN NEEDLE 31G 8MM	Formulary	OTC
PENTIPS PEN NEEDLE 31GX1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 31GX3/16"	Formulary	OTC
PENTIPS PEN NEEDLE 31GX5/16"	Formulary	OTC
PENTIPS PEN NEEDLE 32G 1/4"	Formulary	OTC
PENTIPS PEN NEEDLE 32G 4MM	Formulary	OTC
PENTIPS PEN NEEDLE 32G 5/32" 4MM	Formulary	OTC
PENTIPS PEN NEEDLE 32GX5/32"	Formulary	OTC
PERSONAL BEST PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
PERSONAL BEST PEAK FLOW MTR	Formulary	OTC; QL (4 spacers per 365 days)
PHARMACIST CHOICE 28G LANCETS ULTRA THIN	Formulary	OTC
<i>pharmacist choice 30g lancets ultra thin</i>	Formulary	OTC
<i>pharmacist choice 33g lancets</i>	Formulary	OTC
PIKO 1 FLOW METER	Formulary	OTC; QL (4 units per 365 days)
PIP PEN NEEDLE	Non-Formulary	OTC
POCKET CHAMBER	Formulary	QL (4 spacers per 365 days)
POCKET PEAK FLOW METER 12'S	Formulary	OTC; QL (4 spacers per 365 days)
PRECISION PCX PLUS TEST STR	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION PCX TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION POINT OF CARE STR	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION Q-I-D TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION XTRA TEST STRIPS	Formulary	OTC; QL (200 test strips per 30 days)
PRECISION XTRA TEST STRIPS NOT FOR RETAIL SALE	Formulary	OTC; QL (200 test strips per 30 days)
<i>pref plus ins 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>pref plus syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>pref plus syring 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>preferred plus 0.3 ml 30gx5/16</i>	Formulary	OTC
<i>preferred plus 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>preferred plus lancets super thin</i>	Formulary	OTC
<i>preferred plus syringe 0.5 ml</i>	Formulary	OTC
<i>preferred plus syringe 1 ml</i>	Formulary	OTC
<i>preferred plus thin lancets</i>	Formulary	OTC
<i>prefpls ins syr 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
PRESSURE ACTIVATED 21G LANCETS	Formulary	OTC
PRESSURE ACTIVATED 28G LANCETS	Formulary	OTC
PREVENT DROPSAFE PEN NEEDLE	Non-Formulary	OTC
PRIMEAIRE CHAMBER	Formulary	QL (4 spacers per 365 days)
PRO COMFORT INSULIN SYRINGE	Non-Formulary	OTC
PRO COMFORT PEN NEEDLE	Non-Formulary	OTC
PRO COMFORT SPACER-ADULT MASK	Formulary	OTC; QL (4 spacers per 365 days)
PRO COMFORT SPACER-CHILD MASK	Formulary	OTC; QL (4 spacers per 365 days)
PRO COMFORT SPACER-INFANT MASK	Formulary	OTC; QL (4 spacers per 365 days)
PROCARE SPACER WITH ADULT MASK	Formulary	QL (4 spacers per 365 days)
PROCARE SPACER WITH CHILD MASK	Formulary	QL (4 spacers per 365 days)
PROCHAMBER HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
PRODIGY INS SYR 1 ML 28GX1/2"	Formulary	OTC
PRODIGY PRESSURE ACTIVATED 28G	Formulary	OTC
PRODIGY SAFETY 26G LANCETS	Formulary	OTC
PRODIGY SYRNG 0.5 ML 31GX5/16"	Formulary	OTC
PRODIGY SYRNGE 0.3 ML 31GX5/16"	Formulary	OTC
PRODIGY TWIST TOP 28G LANCET	Formulary	OTC
<i>pub ins syrin 0.3 ml 30gx1/2" regular needle</i>	Formulary	OTC
<i>pub ins syringe 1 ml 30gx1/2" regular needle (otc)</i>	Formulary	OTC
<i>pub insul syr 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>pub insul syr 0.5 ml 30gx1/2" regular needle (otc)</i>	Formulary	OTC
<i>pub insul syr 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>pub insulin syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
PUB MICRO THIN 33G LANCET	Formulary	OTC

Medications	Coverage Level	Restrictions
PUB PEN 12MM 29G NEEDLES STANDARD LENGTH	Formulary	OTC
PUB PEN 8MM 31G NEEDLES SHORT LENGTH (OTC)	Formulary	OTC
PUB PEN NEEDLE 6MM 31G EXTRA SHORT, 6MM	Formulary	OTC
PUB UNIFINE PNTIP PLUS 31GX3/16 MINI, 5MM	Formulary	OTC
PURE COMFORT PEN NEEDLE	Non-Formulary	OTC
PURE COMFORT SPACER-ADULT MASK	Formulary	OTC; QL (4 spacers per 365 days)
PURECOMFORT PEAK FLOW MTR ADLT	Formulary	OTC; QL (4 spacers per 365 days)
PURECOMFORT PEAK FLOW MTR CHLD	Formulary	OTC; QL (4 spacers per 365 days)
PV UNIFINE PENTIP PLUS 31GX5MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 31GX6MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 31GX8MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 32GX4MM	Formulary	OTC
PV UNIFINE PENTIP PLUS 33GX4MM	Formulary	OTC
PV UNILET MICRO THIN 33G LANCT	Formulary	OTC
PV UNILET SUPER THIN 30G LANCT	Formulary	OTC
QC UNIFINE PENTIPS 32GX5/32" STERILE	Formulary	OTC
QC UNIFINE PENTIPS 4MM 32G STERILE	Formulary	OTC
QC UNILET SUPER THIN 30G LANCT	Formulary	OTC
QC UNILET ULTRA THIN 28G LANCT	Formulary	OTC
RA E-ZJECT 26G LANCETS	Formulary	OTC
RA E-ZJECT 28G LANCETS	Formulary	OTC
RA E-ZJECT 30G LANCETS ULTRA THIN	Formulary	OTC
RA E-ZJECT COLOR 33G LANCETS	Formulary	OTC
<i>ra ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ra ins syr 0.5 ml 30gx5/16" (otc)</i>	Formulary	OTC
<i>ra ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>ra ins syringe 1 ml 30gx5/16" (otc)</i>	Formulary	OTC
RA PEN NEEDLE 31GX3/16" 5MM (OTC)	Formulary	OTC
RA PEN NEEDLE 31GX5/16" 8MM (OTC)	Formulary	OTC
RELIAMED 28G LANCETS	Formulary	OTC
RELIAMED 30G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
RELIAMED SAFETY SEAL 28G LANCT	Formulary	OTC
RELIAMED SAFETY SEAL 30G LANCT	Formulary	OTC
<i>relion ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>relion ins syr 0.3 ml 31gx6mm</i>	Formulary	OTC
RELION INS SYR 0.5 ML 29GX1/2" 29GX1/2,INNER	Formulary	OTC
RELION INS SYR 0.5 ML 29GX1/2" OUTER	Formulary	OTC
<i>relion ins syr 0.5 ml 31gx6mm</i>	Formulary	OTC
<i>relion ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx15/64"</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" inner (otc)</i>	Formulary	OTC
<i>relion ins syr 1 ml 31gx5/16" outer,10x10 (otc)</i>	Formulary	OTC
<i>relion insulin syr 0.5 ml</i>	Formulary	OTC
RELION KETONE TEST STRIP	Formulary	OTC
RELION MICRO THIN 33G LANCET	Formulary	OTC
RELION MINI PEN 31G X 1/4" NDL	Formulary	OTC
RELION PEN 29G NEEDLE 12MM	Formulary	OTC
RELION PEN 31G NEEDLE 8MM (OTC)	Formulary	OTC
<i>relion pen needle 29gx1/2"</i>	Formulary	OTC
RELION PEN NEEDLE 29GX1/2"	Formulary	OTC
<i>relion pen needle 31g 6mm</i>	Formulary	OTC
<i>relion pen needle 31gx1/4"</i>	Formulary	OTC
<i>relion pen needle 31gx5/16"</i>	Formulary	OTC
<i>relion pen needle 31gx5/16" short</i>	Formulary	OTC
RELION PEN NEEDLE 31GX5/16" SHORT (OTC)	Formulary	OTC
<i>relion pen needle 32gx5/32"</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16"</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16" inner</i>	Formulary	OTC
<i>relion syring 0.3 ml 31gx5/16" outer,10x10</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" (otc)</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" inner (otc)</i>	Formulary	OTC
<i>relion syring 0.5 ml 31gx5/16" outer,10x10 (otc)</i>	Formulary	OTC
<i>relion thin 26g lancets</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
RELION THIN 26G LANCETS	Formulary	OTC
RELION ULTRA THIN 30G LANCETS	Formulary	OTC
RELION ULTRA THIN 30G LANCETS 5 COLORS	Formulary	OTC
RELION ULTRA THIN PLUS 33G	Formulary	OTC
REXALL UNIVERSAL 1 30G LANCETS	Formulary	OTC
RIGHTEST GL300 30G LANCETS	Formulary	OTC
RITEFLO SPACER	Formulary	QL (4 spacers per 365 days)
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2"	Formulary	OTC
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10	Formulary	OTC
SAFETY 21G LANCETS	Formulary	OTC
SAFETY 28G LANCETS	Formulary	OTC
SAFETY PEN NEEDLE	Non-Formulary	OTC
SAFETY SEAL 28G LANCETS	Formulary	OTC
SAFETY SEAL 30G LANCETS	Formulary	OTC
SAFETY-LET 30G LANCETS	Formulary	OTC
<i>saps twist top 30g lancet</i>	Formulary	OTC
<i>saps twist top 30g lancets</i>	Formulary	OTC
SECURESAFE PEN NEEDLE	Non-Formulary	OTC
SHOPKO UNIFINE PENTIPS 4MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
SHOPKO UNIFINE PENTIPS 4MM 32G MICRO, STERILE	Formulary	OTC
SHOPKO UNIFINE PENTIPS 5MM 31G	Formulary	OTC
SHOPKO UNIFINE PENTIPS 5MM 31G MINI, STERILE	Formulary	OTC
SHOPKO UNIFINE PENTIPS 8MM 31G	Formulary	OTC
SHOPKO UNIFINE PENTIPS 8MM 31G SHORT, STERILE	Formulary	OTC
SHOPKO UNIFINE PNTIPS 12MM 29G	Formulary	OTC
SHOPKO UNIFINE PNTIPS 12MM 29G ORIGINAL, STERILE	Formulary	OTC
SINGLE-LET LANCETS	Formulary	OTC
SM COLOR LANCETS 21G	Formulary	OTC
<i>sm ins syr 0.5 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syr 0.5 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm ins syr 1 ml 29gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syringe 0.3 ml 30gx5/16" short needle</i>	Formulary	OTC
<i>sm ins syringe 1 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>sm ins syringe 1 ml 30gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm insul syr 0.3 ml 31gx5/16" short needle</i>	Formulary	OTC
<i>sm insul syr 0.5 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm insulin syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>sm insulin syr 0.5 ml 28gx1/2" (otc)</i>	Formulary	OTC
<i>sm insulin syr 1 ml 31gx5/16" short needle (otc)</i>	Formulary	OTC
<i>sm lancets 21g</i>	Formulary	OTC
SM MICRO THIN 33G LANCETS	Formulary	OTC
SM SUPER THIN 30G LANCETS STERILE TIP	Formulary	OTC
SM THIN LANCETS 26G	Formulary	OTC
SMART SENSE COLOR 33G LANCETS	Formulary	OTC
SMART SENSE STANDARD 21G	Formulary	OTC
SMART SENSE SUPER THIN 30G	Formulary	OTC
SMART SENSE THIN 26G LANCETS	Formulary	OTC
SMARTEST LANCET	Formulary	OTC

Medications	Coverage Level	Restrictions
SOLUS V2 28G LANCETS	Formulary	OTC
SOLUS V2 30G TWIST LANCETS	Formulary	OTC
STERILANCE TL TWIST 30G LANCET	Formulary	OTC
STERILANCE TL TWIST 32G LANCET	Formulary	OTC
STRIVE DUAL ZONE PEAK FLOW METER	Formulary	QL (4 spacers per 365 days)
SUPER THIN 28G LANCETS 28G, COMFORT ASSURED	Formulary	OTC
SUPER THIN 28G LANCETS STERILE	Formulary	OTC
SUPER THIN 30G LANCETS	Formulary	OTC
SUPER THIN 30G LANCETS RECAPABLE	Formulary	OTC
SURE COMFORT 0.3 ML SYRINGE SHORT NDL	Formulary	OTC
SURE COMFORT 0.5 ML SYRINGE	Formulary	OTC
SURE COMFORT 0.5 ML SYRINGE	Formulary	OTC
SURE COMFORT 1 ML SYRINGE	Formulary	OTC
SURE COMFORT 18G LANCETS	Formulary	OTC
SURE COMFORT 21G LANCETS	Formulary	OTC
SURE COMFORT 23G LANCETS	Formulary	OTC
SURE COMFORT 28G LANCETS	Formulary	OTC
SURE COMFORT 3/10 ML SYRINGE	Formulary	OTC
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE	Formulary	OTC
SURE COMFORT 30G LANCETS	Formulary	OTC
SURE COMFORT 30G PEN NEEDLE	Formulary	OTC
SURE COMFORT PEN NDL 29GX1/2" 12.7MM	Formulary	OTC
SURE COMFORT PEN NDL 31G 5MM	Formulary	OTC
SURE COMFORT PEN NDL 31G 8MM	Formulary	OTC
SURE COMFORT PEN NDL 32G 4MM	Formulary	OTC
SURE COMFORT PEN NDL 32G 6MM	Formulary	OTC
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4"	Non-Formulary	OTC
SURE-FINE PEN NEEDLES 12.7MM	Formulary	OTC
SURE-FINE PEN NEEDLES 5MM	Formulary	OTC
SURE-FINE PEN NEEDLES 8MM	Formulary	OTC
SURE-JECT INS 0.3 ML 31GX5/16"	Formulary	OTC
SURE-JECT INS 0.5 ML 31GX5/16"	Formulary	OTC

Medications	Coverage Level	Restrictions
SURE-JECT INSU SYR U100 0.3 ML	Formulary	OTC
SURE-JECT INSU SYR U100 0.5 ML	Formulary	OTC
SURE-JECT INSU SYR U100 1 ML	Formulary	OTC
SURE-JECT INSUL SYR U100 1 ML	Formulary	OTC
SURE-JECT INSULIN SYRINGE 1 ML	Formulary	OTC
SURE-LANCE 26G LANCETS	Formulary	OTC
SURE-LANCE FLAT LANCETS	Formulary	OTC
SURE-LANCE THIN 28G LANCETS	Formulary	OTC
SURE-LANCE ULTRA THIN 30G	Formulary	OTC
SURE-TOUCH LANCET	Formulary	OTC
SURGUARD2 SAFETY SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8"	Non-Formulary	
<i>syringe (disposable) syringe 3 ml</i>	Non-Formulary	OTC
SYRINGE 3CC/20GX1"	Non-Formulary	OTC
SYRINGE 3CC/21GX1"	Non-Formulary	OTC
SYRINGE 3CC/21GX1-1/2"	Non-Formulary	OTC
SYRINGE 3CC/22GX1"	Non-Formulary	OTC
SYRINGE 3CC/22GX3/4"	Non-Formulary	OTC
SYRINGE 3CC/25GX1"	Non-Formulary	OTC
<i>syringe with needle syringe 1 ml 25 gauge x 1", 3 ml 20 gauge x 1 1/2", 3 ml 22 x 1 1/2"</i>	Non-Formulary	OTC
TECHLITE 26G LANCETS	Formulary	OTC
TECHLITE 28G LANCETS	Formulary	OTC
TECHLITE 30G LANCETS	Formulary	OTC
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	Non-Formulary	OTC
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16"	Non-Formulary	OTC
TECHLITE PEN NEEDLE 29GX1/2"	Formulary	OTC
TECHLITE PEN NEEDLE 31GX3/16"	Formulary	OTC
TECHLITE PEN NEEDLE 31GX5/16"	Formulary	OTC

Medications	Coverage Level	Restrictions
TECHLITE PEN NEEDLE 32GX1/4"	Formulary	OTC
TECHLITE PEN NEEDLE 32GX5/32"	Formulary	OTC
TELCARE ULTRA THIN 30G LANCETS	Formulary	OTC
TERUMO ALLERGY SYRINGE	Non-Formulary	OTC
TERUMO HYPODERMIC NEEDLE/SYRIN	Non-Formulary	OTC
<i>terumo ins syr 0.3 ml 29gx1/2"</i>	Formulary	OTC
<i>terumo ins syringe u100-1 ml</i>	Formulary	OTC
TERUMO INS SYRINGE U100-1 ML	Formulary	OTC
TERUMO INS SYRINGE U100-1/2 ML	Formulary	OTC
TERUMO INS SYRINGE U100-1/3 ML	Formulary	OTC
TERUMO INS SYRNG U100-1/2 ML	Formulary	OTC
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8"	Non-Formulary	OTC
THIN 26G LANCETS	Formulary	OTC
THIN LANCETS 28G	Formulary	OTC
THINPRO INS SYRIN U100-0.3 ML	Formulary	OTC
THINPRO INS SYRIN U100-0.5 ML	Formulary	OTC
THINPRO INS SYRIN U100-1 ML	Formulary	OTC
TODAY'S HLTH PN NEEDLE 6MM 31G 31GX6MM,STRL,MINI	Formulary	OTC
TOPCARE CLICKFINE 31G X 1/4"	Formulary	OTC
TOPCARE CLICKFINE 31G X 5/16"	Formulary	OTC
TOPCARE ULTRA COMFORT SYRINGE	Formulary	OTC
TOPCARE UNIVERSAL1 THIN LANCET THIN, 26G	Formulary	OTC
TOPCARE UNIVERSAL1 THIN LANCET ULTRA THIN, 30G	Formulary	OTC
TROJAN ENZ CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ENZ CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ENZ SPERMICIDE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN MAGNUM CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ULTRA RIBBED CONDOM	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
TROJAN ULTRA THIN CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TROJAN ULTRA THIN-SPERMICIDAL	Formulary	OTC; QL (36 condoms per 30 days)
TRUE COMFORT INSULIN SYRINGE	Non-Formulary	OTC
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32"	Non-Formulary	OTC
TRUE COMFORT PRO INS SYRINGE	Non-Formulary	OTC
TRUE COVER CONDOM INNER	Formulary	OTC; QL (36 condoms per 30 days)
TRUE COVER CONDOM OUTER	Formulary	OTC; QL (36 condoms per 30 days)
TRUEPLUS 33G LANCETS	Formulary	OTC
TRUEPLUS KETONE TEST STRIP	Formulary	OTC
TRUEPLUS PEN NEEDLE	Non-Formulary	OTC
TRUEPLUS SAFETY 28G LANCET	Formulary	OTC
TRUEPLUS SAFETY 28G LANCETS	Formulary	OTC
TRUEPLUS SUPER THIN 28G LANCET	Formulary	OTC
TRUEPLUS SYR 0.3 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.3 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.3 ML 31GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 28GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 0.5 ML 31GX5/16"	Formulary	OTC
TRUEPLUS SYR 1 ML 28GX1/2"	Formulary	OTC
TRUEPLUS SYR 1 ML 29GX1/2"	Formulary	OTC
TRUEPLUS SYR 1 ML 30GX5/16"	Formulary	OTC
TRUEPLUS SYR 1 ML 31GX5/16"	Formulary	OTC
TRUEPLUS ULTRA THIN 30G LANCET	Formulary	OTC
TRUSTEX CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, RESERVOIR TIP	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
TRUSTEX CONDOM 12'S, W/NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S, W-NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,EXTRA STRENGTH	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,W/NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX CONDOM 12'S,W-NONOXYNOL-9	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX LATEX CONDOM 12'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX LATEX CONDOM 48'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S,NON-LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 12'S,W/SPERMICIDE	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S,NON-LUBRICATED	Formulary	OTC; QL (36 condoms per 30 days)
TRUSTEX-RIA CONDOM 48'S,W/SPERMICIDE	Formulary	OTC; QL (36 condoms per 30 days)
TRUZONE PEAK FLOW METER ADULT/PEDIATRIC	Formulary	QL (4 spacers per 365 days)
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1"	Non-Formulary	
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2"	Non-Formulary	OTC
<i>tuberculin-allergy syringes</i>	Non-Formulary	OTC
<i>twist lancets 28g</i>	Formulary	OTC
ULT CFT 0.3 ML 29GX1/2" (1/2) 1/2 UNIT	Formulary	OTC
ULT CFT 0.3 ML 31GX5/16" (1/2) 1/2 UNIT	Formulary	OTC
<i>ultcare ins syr 1 ml 31gx5/16" 31gx5/16" (otc)</i>	Formulary	OTC
ULTICARE INS 0.3 ML 30GX1/2"	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTICARE INS 0.5 ML 30GX1/2"	Formulary	OTC
ULTICARE INS 0.5 ML 31GX1/4"	Formulary	OTC
<i>ulticare ins safety 1 ml 29x1/2 (rx)</i>	Formulary	OTC
<i>ulticare ins syr 0.3 ml 30g 8mm</i>	Formulary	OTC
<i>ulticare ins syr 0.3 ml 31g 8mm</i>	Formulary	OTC
<i>ulticare ins syr 0.5 ml 30g 8mm (otc)</i>	Formulary	OTC
ULTICARE INS SYR 0.5 ML 31G 6MM	Formulary	OTC
<i>ulticare ins syr 0.5 ml 31g 8mm (otc)</i>	Formulary	OTC
<i>ulticare ins syr 1 ml 28gx1/2" 28gx1/2" (otc)</i>	Formulary	OTC
<i>ulticare ins syr 1 ml 29gx1/2" 29gx1/2" (otc)</i>	Formulary	OTC
ULTICARE INS SYR 1 ML 30GX1/2"	Formulary	OTC
ULTICARE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 1/4"	Non-Formulary	OTC
ULTICARE INSULN SYR(HALF UNIT)	Non-Formulary	OTC
ULTICARE PEN NDL 12.7 MM 29G	Formulary	OTC
ULTICARE PEN NEEDLE 31GX3/16"	Formulary	OTC
ULTICARE PEN NEEDLE 4MM 32G	Formulary	OTC
ULTICARE PEN NEEDLE 6MM 31G	Formulary	OTC
ULTICARE PEN NEEDLE 8 MM 31G	Formulary	OTC
ULTICARE PEN NEEDLE 8MM 31G	Formulary	OTC
ULTICARE PEN NEEDLES 12MM 29G	Formulary	OTC
ULTICARE PEN NEEDLES 31G 8MM	Formulary	OTC
ULTICARE PEN NEEDLES 4MM 32G MICRO	Formulary	OTC
ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM	Formulary	OTC
ULTICARE PEN NEEDLES 6MM 31G	Formulary	OTC
ULTICARE PEN NEEDLES 6MM 32G	Formulary	OTC
ULTICARE PEN NEEDLES 8MM 31G	Formulary	OTC
<i>ulticare safety 0.5 ml 29gx1/2 (rx)</i>	Formulary	OTC
ULTICARE SAFETY PEN NEEDLE	Non-Formulary	OTC
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 23 GAUGE X 1"	Non-Formulary	OTC
<i>ulticare syr 0.3 ml 29g 12.7mm</i>	Formulary	OTC
ULTICARE SYR 0.3 ML 30GX1/2"	Formulary	OTC
<i>ulticare syr 0.3 ml 30gx5/16" 30gx5/16"</i>	Formulary	OTC

Medications	Coverage Level	Restrictions
<i>ulticare syr 0.3 ml 31gx5/16"</i>	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL	Formulary	OTC
<i>ulticare syr 0.5 ml 29g 12.7mm (otc)</i>	Formulary	OTC
<i>ulticare syr 0.5 ml 29gx1/2" 29gx1/2" (otc)</i>	Formulary	OTC
ULTICARE SYR 0.5 ML 30GX1/2"	Formulary	OTC
<i>ulticare syr 0.5 ml 30gx5/16" 30gx5/16" (otc)</i>	Formulary	OTC
<i>ulticare syr 0.5 ml 31gx5/16" 31gx5/16" (otc)</i>	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL	Formulary	OTC
<i>ulticare syr 1 ml 30gx5/16" 30gx5/16" (otc)</i>	Formulary	OTC
ULTICARE SYR 1 ML 31GX5/16"	Formulary	OTC
<i>ulticare syrin 0.3 ml 29gx1/2" 29gx1/2"</i>	Formulary	OTC
<i>ulticare syrin 0.5 ml 28gx1/2" 28gx1/2" (otc)</i>	Formulary	OTC
ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8"	Non-Formulary	
ULTICARE SYRINGE 1 ML 30GX1/2"	Formulary	OTC
ULTIGUARD SAFEPACK 32G 4MM	Formulary	OTC
ULTIGUARD SAFEPACK-INSULIN SYR SYRINGE 1/2 ML 31 X 5/16"	Non-Formulary	OTC
ULTIGUARD SAFEPACK-PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4"	Non-Formulary	OTC
ULTILET 28G LANCETS	Formulary	OTC
ULTILET 30G LANCETS	Formulary	OTC
ULTILET 33G LANCETS	Formulary	OTC
ULTILET BASIC 30G LANCETS	Formulary	OTC
ULTILET CLASSIC 26G LANCETS	Formulary	OTC
ULTILET CLASSIC 28G LANCETS	Formulary	OTC
ULTILET CLASSIC 30G LANCETS	Formulary	OTC
ULTILET CLASSIC 33G LANCETS	Formulary	OTC
ULTILET INSULIN SYRINGE 0.3 ML	Formulary	OTC
ULTILET INSULIN SYRINGE 0.5 ML	Formulary	OTC
ULTILET INSULIN SYRINGE 1 ML	Formulary	OTC
ULTILET PEN NEEDLE	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTILET PEN NEEDLE 4MM 32G	Formulary	OTC
ULTILET SAFETY 23G LANCETS	Formulary	OTC
ULTRA COMFORT 0.3 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 0.3 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 0.5 ML 28GX1/2"	Formulary	OTC
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G	Formulary	OTC
ULTRA COMFORT 0.5 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 0.5 ML 31GX5/16"	Formulary	OTC
ULTRA COMFORT 0.5 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 0.5 ML SYRINGE	Formulary	OTC
ULTRA COMFORT 1 ML 28GX1/2"	Formulary	OTC
ULTRA COMFORT 1 ML 29GX1/2"	Formulary	OTC
ULTRA COMFORT 1 ML 30GX5/16"	Formulary	OTC
ULTRA COMFORT 1 ML 31GX5/16"	Formulary	OTC
ULTRA COMFORT 1 ML SYRINGE	Formulary	OTC
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	Non-Formulary	OTC
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	Non-Formulary	OTC
ULTRA FLO PEN NEEDLE	Non-Formulary	OTC
ULTRA THIN 28G LANCETS 28G, STRL	Formulary	OTC
ULTRA THIN 28G LANCETS RECAPABLE	Formulary	OTC
ULTRA THIN 28G LANCETS ULTRA THIN	Formulary	OTC
ULTRA THIN 30G LANCETS	Formulary	OTC
ULTRA THIN 30G LANCETS STERILE	Formulary	OTC
ULTRA THIN 31G LANCET	Formulary	OTC
ULTRA THIN 31G LANCETS	Formulary	OTC
ULTRA THIN 33G LANCETS	Formulary	OTC
ULTRA THIN PEN NEEDLE	Non-Formulary	OTC
ULTRACARE PEN NEEDLE	Non-Formulary	OTC
ULTRA-FINE 0.3 ML 30G 12.7MM	Formulary	OTC
ULTRA-FINE 0.3 ML 31G 6MM (1/2)	Formulary	OTC
ULTRA-FINE 0.3 ML 31G 8MM (1/2)	Formulary	OTC
ULTRA-FINE 0.5 ML 30G 12.7MM	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTRA-FINE INS SYR 1 ML 31G 6MM	Formulary	OTC
ULTRA-FINE INS SYR 1 ML 31G 8MM	Formulary	OTC
ULTRA-FINE PEN NDL 29G 12.7MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 31G 5MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 31G 8MM	Formulary	OTC
ULTRA-FINE PEN NEEDLE 32G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.3 ML 31G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.3 ML 31G 8MM	Formulary	OTC
ULTRA-FINE SYR 0.5 ML 31G 6MM	Formulary	OTC
ULTRA-FINE SYR 0.5 ML 31G 8MM	Formulary	OTC
ULTRA-FINE SYR 1 ML 30G 12.7MM	Formulary	OTC
ULTRALANCE 26G LANCETS	Formulary	OTC
ULTRALANCE 28G LANCETS	Formulary	OTC
ULTRA-THIN II 1 ML 31GX5/16"	Formulary	OTC
ULTRA-THIN II 28G LANCETS	Formulary	OTC
ULTRA-THIN II 30G LANCETS	Formulary	OTC
ULTRA-THIN II INS 0.3 ML 30G	Formulary	OTC
ULTRA-THIN II INS 0.3 ML 31G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 29G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 30G	Formulary	OTC
ULTRA-THIN II INS 0.5 ML 31G	Formulary	OTC
ULTRA-THIN II INS SYR 1 ML 29G	Formulary	OTC
ULTRA-THIN II INS SYR 1 ML 30G	Formulary	OTC
ULTRA-THIN II PEN NDL 29GX1/2"	Formulary	OTC
ULTRA-THIN II PEN NDL 31GX5/16	Formulary	OTC
ULTRATLC LANCETS	Formulary	OTC
UNIFINE PENTIPS 12MM 29G	Formulary	OTC
UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL	Formulary	OTC
UNIFINE PENTIPS 12MM 29G 29GX12MM,STRL,ORIGNL	Formulary	OTC
UNIFINE PENTIPS 12MM 29G ORIGINAL	Formulary	OTC
UNIFINE PENTIPS 29G 12MM	Formulary	OTC
UNIFINE PENTIPS 31G 5MM	Formulary	OTC
UNIFINE PENTIPS 31G 6MM	Formulary	OTC
UNIFINE PENTIPS 31G 8MM	Formulary	OTC
UNIFINE PENTIPS 31GX3/16"	Formulary	OTC

Medications	Coverage Level	Restrictions
UNIFINE PENTIPS 31GX3/16" 31GX5MM, STERILE	Formulary	OTC
UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI	Formulary	OTC
UNIFINE PENTIPS 32G 4MM	Formulary	OTC
UNIFINE PENTIPS 32G 6MM	Formulary	OTC
UNIFINE PENTIPS 32GX1/4"	Formulary	OTC
UNIFINE PENTIPS 32GX5/32"	Formulary	OTC
UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO	Formulary	OTC
UNIFINE PENTIPS 32GX5/32" STERILE, SINGLE USE	Formulary	OTC
UNIFINE PENTIPS 33GX5/32"	Formulary	OTC
UNIFINE PENTIPS 6MM 31G	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM, STRL	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM,MINI,STRL	Formulary	OTC
UNIFINE PENTIPS 6MM 31G 31GX6MM,STRL,MINI	Formulary	OTC
UNIFINE PENTIPS 6MM 31G ULTRA SHORT	Formulary	OTC
UNIFINE PENTIPS 6MM NEEDLE ULTRA SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM 31G	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM, STRL	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM,SHORT,STRL	Formulary	OTC
UNIFINE PENTIPS 8MM 31G 31GX8MM,STRL,SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM 31G SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM NEEDLE SHORT	Formulary	OTC
UNIFINE PENTIPS MAXFLOW	Non-Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2"	Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2" 12MM	Formulary	OTC
UNIFINE PENTIPS PLUS 29GX1/2" ORIGINAL, 12MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31G 5MM	Formulary	OTC

Medications	Coverage Level	Restrictions
UNIFINE PENTIPS PLUS 31GX1/4"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI, 5MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX3/16" MINI,5MM,STRL	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16"	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT, 8MM	Formulary	OTC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT,8MM,STRL	Formulary	OTC
UNIFINE PENTIPS PLUS 32GX5/32"	Formulary	OTC
UNIFINE PENTIPS PLUS 33GX5/32"	Formulary	OTC
UNIFINE PENTIPS PLUS MAXFLOW	Non-Formulary	OTC
UNIFINE SAFECONTROL PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16"	Non-Formulary	OTC
UNIFINE ULTRA PEN NEEDLE	Non-Formulary	OTC
UNILET COMFORTOUCH 26G LANCETS	Formulary	OTC
UNILET COMFORTOUCH LANCET	Formulary	OTC
UNILET GP LANCET	Formulary	OTC
UNILET GP LANCET SUPERLITE	Formulary	OTC
UNILET MICRO THIN 33G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS	Formulary	OTC
UNILET SUPER THIN 30G LANCETS SINGLE-USE,STERILE	Formulary	OTC
UNILET SUPER THIN 30G LANCETS SUPER THIN	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS 28G,ULTRA THIN,STRL	Formulary	OTC
UNILET ULTRA THIN 28G LANCETS SINGLE-USE,STERILE	Formulary	OTC

Medications	Coverage Level	Restrictions
UNILET ULTRA THIN 28G LANCETS UNIVERSAL FIT	Formulary	OTC
UNISTIK 3 COMFORT 28G LANCET	Formulary	OTC
UNISTIK 3 EXTRA 21G LANCETS	Formulary	OTC
UNISTIK 3 GENTLE 30G LANCETS	Formulary	OTC
UNISTIK 3 GENTLE ON-THE-GO 30G	Formulary	OTC
UNISTIK 3 NORMAL 23G LANCETS	Formulary	OTC
UNISTIK CZT COMFORT 28G LANCET	Formulary	OTC
UNISTIK CZT NORMAL 23G LANCETS	Formulary	OTC
UNISTIK SAFETY 28G LANCET	Formulary	OTC
UNISTIK SAFETY 30G LANCETS	Formulary	OTC
UNISTIK TOUCH 21G LANCETS	Formulary	OTC
UNISTIK TOUCH 23G LANCETS	Formulary	OTC
UNISTIK TOUCH 28G LANCETS	Formulary	OTC
UNISTIK TOUCH 30G LANCETS	Formulary	OTC
UNIVERSAL 1 33G LANCETS	Formulary	OTC
VANISHPOINT 0.5 ML 30GX1/2" SY INNER	Formulary	OTC
VANISHPOINT INSULIN SYRINGE	Non-Formulary	OTC
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2"	Non-Formulary	OTC
VANISHPOINT TUBERCULIN SYRINGE	Non-Formulary	OTC
VANISHPOINT U-100 29X1/2 SYR	Formulary	OTC
V-GO 20 DISPOSABLE DEVICE	Formulary	
V-GO 30 DISPOSABLE DEVICE	Formulary	
V-GO 40 DISPOSABLE DEVICE	Formulary	
VORTEX HOLDING CHAMBER	Formulary	QL (4 spacers per 365 days)
VORTEX HOLDING CHAMBER HRI	Formulary	QL (4 spacers per 365 days)
VORTEX VHC FROG CHILD MASK HRI	Formulary	
VORTEX VHC LADYBUG TODDLER MSK HRI	Formulary	
WALGREENS THIN LANCETS THIN	Formulary	OTC
WALGREENS ULTRA THIN LANCETS	Formulary	OTC
WIDE SEAL DIAPHRAGM 60MM	Formulary	

Medications	Coverage Level	Restrictions
WIDE SEAL DIAPHRAGM 65MM	Formulary	
WIDE SEAL DIAPHRAGM 70MM	Formulary	
WIDE SEAL DIAPHRAGM 75MM	Formulary	
WIDE SEAL DIAPHRAGM 80MM	Formulary	
WIDE SEAL DIAPHRAGM 85MM	Formulary	
WIDE SEAL DIAPHRAGM 90MM	Formulary	
WIDE SEAL DIAPHRAGM 95MM	Formulary	
WM UNIFINE PENTIP PLUS 4MM 32G	Formulary	OTC
WM UNIFINE PENTIP PLUS 5MM 31G W/ SAFETY CLICK	Formulary	OTC
WM UNIFINE PENTIP PLUS 6MM 31G W/ SAFETY CLICK	Formulary	OTC
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK	Formulary	OTC
YOURX ULTICARE PEN NDL 4MM 32G	Formulary	OTC
YOURX ULTICARE PEN NDL 6MM 31G	Formulary	OTC
YOURX ULTICARE PEN NDL 8MM 31G	Formulary	OTC
Metabolic Disease Enzyme Replacement Agents		
<i>Metabolic Disease Enzyme Replacement, Alpha-Mannosidosis</i>		
LAMZEDE	State Carve Out	
<i>Metabolic Disease Enzyme Replacement, Fabry's Disease</i>		
ELFABRIO	State Carve Out	
FABRAZYME	State Carve Out	
<i>Metabolic Disease Enzyme Replacement, Gaucher's Disease</i>		
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	State Carve Out	
ELELYSO	State Carve Out	
VPRIV	State Carve Out	
<i>Metabolic Disease Enzyme Replacement, Hypophosphatasia</i>		
STRENSIQ	State Carve Out	
<i>Metabolic Disease Enzyme Replacement, Mucopolysaccharidosis</i>		
ALDURAZYME	State Carve Out	
ELAPRASE	State Carve Out	

Medications	Coverage Level	Restrictions
MEPSEVII	State Carve Out	
NAGLAZYME	State Carve Out	
VIMIZIM	State Carve Out	
<i>Metabolic Disease Enzyme Replacement, Pompe Disease</i>		
LUMIZYME	State Carve Out	
NEXVIAZYME	State Carve Out	
POMBILITI	State Carve Out	
<i>Metabolic Dx Enzyme Replacement, Severe Combined Immune Deficiency</i>		
REVCOVI	State Carve Out	
Metabolic Modifiers		
<i>Hyperparathyroid Treatment Agents - Vitamin D Analog-Type</i>		
<i>calcitriol 0.25 mcg capsule</i>	Formulary	
<i>calcitriol 0.25 mcg capsule outer</i>	Formulary	
<i>calcitriol 0.5 mcg capsule</i>	Formulary	
<i>calcitriol 1 mcg/ml solution</i>	Formulary	Age Limit (Max 12 Years)
<i>calcitriol intravenous solution 1 mcg/ml</i>	Non-Formulary	
<i>doxercalciferol oral</i>	Non-Formulary	
<i>paricalcitol oral</i>	Non-Formulary	
RAYALDEE	Non-Formulary	
ROCALTROL ORAL SOLUTION	Non-Formulary	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	Non-Formulary	
<i>Metabolic Modifier - Carnitine Replenisher Agents</i>		
CARNITOR	State Carve Out	
CARNITOR (SUGAR-FREE)	State Carve Out	
<i>levocarnitine (with sugar)</i>	State Carve Out	
<i>levocarnitine intravenous</i>	State Carve Out	
<i>levocarnitine oral solution 100 mg/ml</i>	State Carve Out	
<i>levocarnitine oral tablet</i>	State Carve Out	OTC
<i>Metabolic Modifier - Gaucher's Disease, Type-1, Substrate Reduction Tx</i>		
CERDELGA	State Carve Out	
<i>miglustat</i>	State Carve Out	
YARGESA	State Carve Out	

Medications	Coverage Level	Restrictions
ZAVESCA	State Carve Out	
Metabolic Modifier - Hereditary Tyrosinemia Treatment Agents		
<i>nitisinone</i>	State Carve Out	
NITYR	State Carve Out	
ORFADIN	State Carve Out	
Metabolic Modifier - Homocystinuria Treatment Agents		
<i>betaine</i>	State Carve Out	
CYSTADANE	State Carve Out	
Metabolic Modifier - Neimann Pick Disease Type C (Npc)		
MIPLYFFA	State Carve Out	
Metabolic Modifier - Phosphatidylinositol-3-Kinase (Pi3k) Inhibitors		
VIJOICE	State Carve Out	
Metabolic Modifier - Pompe Disease - Gcs Inhibitor		
OPFOLDA	State Carve Out	
Metabolic Modifier - Urea Cycle Disorder Agents-Conjugating Agents		
AMMONUL	State Carve Out	
BUPHENYL	State Carve Out	
OLPRUVA	State Carve Out	
PHEBURANE	State Carve Out	
RAVICTI	State Carve Out	
<i>sodium benzoate-sod phenylacet</i>	State Carve Out	
<i>sodium phenylbutyrate</i>	State Carve Out	
<i>sodium phenylbutyrate powder</i>	Formulary	
<i>sodium phenylbutyrate powder spb</i>	Formulary	
<i>sodium phenylbutyrate powder usp</i>	Formulary	
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (Cps 1) Activator		
CARBAGLU	State Carve Out	
<i>carglumic acid</i>	State Carve Out	
Pharmacoenhancer - Cytochrome P450 Inhibitors		
TYBOST	State Carve Out	

Medications	Coverage Level	Restrictions
Pharmacological Chaperone Tx - Alpha-Galactosidase A Enzyme Stabilizer		
GALAFOLD	State Carve Out	
Phenylketonuria(Pku) Tx Agents - Cofactor Of Phenylalanine Hydroxylase		
JAVYGTOR ORAL POWDER IN PACKET 500 MG	State Carve Out	
JAVYGTOR ORAL TABLET,SOLUBLE	State Carve Out	
KUVAN	State Carve Out	
<i>sapropterin</i>	State Carve Out	
Phenylketonuria(Pku) Tx Agents - Phenylalanine Ammonia Lyase		
PALYNZIQ	Non-Formulary	
Progeria Syndrome Treatment Agents - Farnyltransferase Inhibitor		
ZOKINVY	State Carve Out	
Mouth-Throat-Dental - Preparations		
Dental Product - Fluoride Preparations		
DENTA 5000 PLUS CREAM	Formulary	
DENTA 5000 PLUS SENSITIV PASTE	Formulary	
DENTAGEL 1.1% GEL	Formulary	
FLORIVA (FLUORIDE-VITAMIN D3)	Non-Formulary	
<i>fluoride (sodium) dental solution</i>	Non-Formulary	
<i>fluoride 0.25 mg tablet chew (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>fluoride 0.25 mg tablet chew cherry flavor (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>fluoride 0.5 mg tablet chew (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>fluoride 0.5 mg tablet chew grape flavor (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>fluoride 1 mg tablet chewable (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>fluoride 1 mg tablet chewable orange flavor (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
FRAICHE 5000 1.1 % DENTAL GEL	Formulary	
PREVIDENT 5000 ENAMEL PROTECT	Non-Formulary	
PREVIDENT 5000 SENSITIVE	Non-Formulary	
<i>sod fluoride enam prot 5000ppm</i>	Formulary	

Medications	Coverage Level	Restrictions
<i>sodium fluoride 0.25 (0.55) mg (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>sodium fluoride 0.5 mg(1.1 mg) (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>sodium fluoride 0.5 mg/ml drop (rx)</i>	Formulary	QL (4 ML per 1 day); Age Limit (Max 16 Years)
<i>sodium fluoride 1 mg (2.2 mg) (rx)</i>	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
<i>sodium fluoride 1.1% gel</i>	Formulary	
<i>sodium fluoride 1.1%-potassium nitrate 5% sensitive paste</i>	Formulary	
SODIUM FLUORIDE 5000 PLUS CRM	Formulary	
<i>sodium fluoride 5000 ppm cream</i>	Formulary	
<i>sodium fluoride sensstv 5000ppm</i>	Formulary	
SOLUVITA 0.5 MG/ML DROP	Formulary	QL (4 ML per 1 day); Age Limit (Max 16 Years)
Mouth And Throat - Antifungals		
<i>clotrimazole 10 mg lozenge</i>	Formulary	PDL Preferred
<i>clotrimazole 10 mg troche</i>	Formulary	PDL Preferred
<i>nystatin 100,000 unit/ml susp</i>	Formulary	PDL Preferred
<i>nystatin 500,000 unit/5 ml cup 40's, u-d</i>	Formulary	PDL Preferred
<i>nystatin 500,000 unit/5 ml cup outer</i>	Formulary	PDL Preferred
Mouth And Throat - Antiseptics		
<i>chlorhexidine 0.12% rinse</i>	Formulary	
<i>chlorhexidine 0.12% rinse 15 ml cup outer</i>	Formulary	
Mouth And Throat - Glucocorticoids		
ORALONE	Non-Formulary	
<i>triamcinolone 0.1% paste</i>	Formulary	QL (5 GM per 30 days)
Mouth And Throat - Local Anesthetic Amides		
<i>lidocaine 2% viscous soln</i>	Formulary	
LIDOCAINE 2% VISCOUS SOLN	Formulary	
<i>lidocaine 2% viscous solution 15 ml cup outer</i>	Formulary	
LIDOCAINE 2% VISCOUS SOLUTION 15 ML CUP OUTER	Formulary	
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>Mouth And Throat - Saliva Stimulants</i>		
<i>cevimeline</i>	Non-Formulary	
EVOXAC	Non-Formulary	
<i>pilocarpine hcl 5 mg tablet</i>	Formulary	
<i>pilocarpine hcl 5 mg tablet f/c</i>	Formulary	
<i>pilocarpine hcl 5 mg tablet outer</i>	Formulary	
<i>pilocarpine hcl 7.5 mg tablet</i>	Formulary	
<i>Periodontal Product - Tetracycline-Type, Collagenase Inhibitors</i>		
<i>doxycycline hyclate 20 mg tab</i>	Formulary	
<i>doxycycline hyclate 20 mg tab f/c</i>	Formulary	
<i>Therapy For Drooling- Primary Or Secondary Sialorrhea-Anticholinergic</i>		
CUVPOSA	Non-Formulary	
<i>glycopyrrolate 1 mg/5 ml oral solution</i>	Formulary	Age Limit (Max 12 Years)
Multiple Sclerosis Agents		
<i>Multiple Sclerosis Agent - Cd20 Specific Monoclonal Antibody</i>		
KESIMPTA 20 MG/0.4 ML PEN SUV, P/F	Formulary	PDL Preferred
<i>Multiple Sclerosis Agent - Interferons</i>		
AVONEX 30 MCG/0.5 ML SYRINGE KIT (4 PACK) 4 SYR/BOX, SUV, OUTER	Formulary	PDL Preferred; QL (2 mL per 28 days)
AVONEX PEN 30 MCG/0.5 ML KIT (4 PACK) 4 PEN/BOX, SUV, OUTER	Formulary	PDL Preferred
BETASERON 0.3 MG KIT INNER, SUV, P/F	Formulary	PDL Preferred
BETASERON 0.3 MG KIT OUTER, SUV, P/F	Formulary	PDL Preferred
PLEGRIDY 125 MCG/0.5 ML PEN P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred
PLEGRIDY 125 MCG/0.5 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
PLEGRIDY PEN INJ STARTER PACK	Formulary	PA; PDL Non-Preferred
PLEGRIDY SYRINGE STARTER PACK	Formulary	PA; PDL Non-Preferred
REBIF 22 MCG/0.5 ML SYRINGE P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred
REBIF 44 MCG/0.5 ML SYRINGE P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred; QL (0.25 ML per 1 day)
REBIF REBIDOSE 22 MCG/0.5 ML P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
REBIF REBIDOSE 44 MCG/0.5 ML P/F, OUTER, SUV	Formulary	PA; PDL Non-Preferred
REBIF REBIDOSE TITRATION PACK	Formulary	PA; PDL Non-Preferred
REBIF TITRATION PACK	Formulary	PA; PDL Non-Preferred
Multiple Sclerosis Agent - Others		
BAFIERTAM DR 95 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
COPAXONE 20 MG/ML SYRINGE	Formulary	PDL Preferred
COPAXONE 40 MG/ML SYRINGE SUV	Formulary	PA; PDL Non-Preferred
<i>dimethyl fumarate 30d start pk</i>	Formulary	PDL Preferred
<i>dimethyl fumarate dr 120 mg cp</i>	Formulary	PDL Preferred
<i>dimethyl fumarate dr 240 mg cp</i>	Formulary	PDL Preferred
<i>glatiramer 20 mg/ml syringe outer,suv</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>glatiramer 40 mg/ml syringe outer,sdv</i>	Formulary	PA; PDL Non-Preferred
GLATOPA 20 MG/ML SYRINGE OUTER, SUV	Formulary	PA; Brand Preferred; PDL Non-Preferred
GLATOPA 40 MG/ML SYRINGE OUTER,SUV	Formulary	PA; PDL Non-Preferred
TECFIDERA DR 120 MG CAPSULE	Formulary	PA; PDL Non-Preferred
TECFIDERA DR 240 MG CAPSULE	Formulary	PA; PDL Non-Preferred
TECFIDERA STARTER PACK	Formulary	PA; PDL Non-Preferred
VUMERITY DR 231 MG CAPSULE	Formulary	PA; PDL Non-Preferred
Multiple Sclerosis Agent - Potassium Channel Blocker		
AMPYRA	Non-Formulary	
<i>dalfampridine er 10 mg tablet</i>	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years and Max 70 Years)
Multiple Sclerosis Agent - Purine Nucleoside Analogs		
MAVENCLAD 10 MG X 10 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 4 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 5 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 6 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 7 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 8 TABLET PK	Formulary	PA; PDL Non-Preferred
MAVENCLAD 10 MG X 9 TABLET PK	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors		
AUBAGIO 14 MG TABLET	Formulary	PA; PDL Non-Preferred
AUBAGIO 7 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>teriflunomide 14 mg tablet</i>	Formulary	PDL Preferred
<i>teriflunomide 7 mg tablet</i>	Formulary	PDL Preferred
Multiple Sclerosis Agent - Sphingosine 1-Phosphate Receptor Modulator		
<i>fingolimod 0.5 mg capsule</i>	Formulary	PDL Preferred
GILENYA 0.25 MG CAPSULE	Formulary	PA; PDL Non-Preferred
GILENYA 0.5 MG CAPSULE	Formulary	PA; PDL Non-Preferred
MAYZENT 0.25 MG STARTER PK(FOR 1 MG MAINTENANCE DOSE)(7 TAB)	Formulary	PA; PDL Non-Preferred
MAYZENT 0.25 MG STARTER PK(FOR 2MG MAINTENANCE DOSE)(12 TAB)	Formulary	PA; PDL Non-Preferred
MAYZENT 0.25 MG TABLET	Formulary	PA; PDL Non-Preferred
MAYZENT 1 MG TABLET	Formulary	PA; PDL Non-Preferred
MAYZENT 2 MG TABLET	Formulary	PA; PDL Non-Preferred
PONVORY 14-DAY STARTER PACK	Formulary	PA; PDL Non-Preferred
PONVORY 14-DAY STARTER PACK	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years and Max 55 Years)
PONVORY 20 MG TABLET	Formulary	PA; PDL Non-Preferred
PONVORY 20 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years and Max 55 Years)
TASCENSO ODT 0.25 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 10 Years)
TASCENSO ODT 0.5 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 10 Years)
ZEPOSIA 0.92 MG CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZEPOSIA STARTER KIT (28-DAY)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
ZEPOSIA STARTER PACK (7-DAY)	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
Ophthalmic Agents		
Artificial Tears And Lubricant Combinations		
ARTIFICIAL TEARS DROPS	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
GENTEAL TEARS SEVERE(PETROLAT)	Non-Formulary	OTC
LUBRICANT EYE OPHTHALMIC (EYE) OINTMENT 57.3-42.5 %	Non-Formulary	OTC
LUBRIFRESH PM	Non-Formulary	OTC
REFRESH LACRI-LUBE OINTMENT	Formulary	Dual Eligible Covered; OTC
REFRESH OPTIVE OPHTHALMIC (EYE) DROPS	Non-Formulary	OTC
REFRESH P.M. OINTMENT	Formulary	OTC
REFRESH P.M. OINTMENT	Formulary	Dual Eligible Covered; OTC
REFRESH RELIEVA	Non-Formulary	OTC
REFRESH RELIEVA PF	Non-Formulary	OTC
SYSTANE (PF)	Non-Formulary	OTC
SYSTANE HYDRATION (PF) OPHTHALMIC (EYE) DROPPERETTE	Non-Formulary	OTC
SYSTANE NIGHTTIME	Non-Formulary	OTC
SYSTANE ULTRA (PF) OPHTHALMIC (EYE) DROPPERETTE	Non-Formulary	OTC
Artificial Tears And Lubricant Single Agents		
<i>carboxymethylcell 0.5% eye drp</i>	Formulary	OTC
<i>carboxymethylcell 0.5% eye drp</i>	Formulary	Dual Eligible Covered; OTC
<i>carboxymethylcell 0.5% eye drp inner</i>	Formulary	OTC
<i>carboxymethylcell 0.5% eye drp outer</i>	Formulary	OTC
<i>carboxymethylcell 1% eye gel</i>	Formulary	OTC
<i>carboxymethylcellulose sodium ophthalmic (eye) dropperette</i>	Non-Formulary	Dual Eligible Covered; OTC
<i>carboxymethylcellulose sodium ophthalmic (eye) drops, liquid gel</i>	Non-Formulary	OTC
FT LUBRICANT 0.5% EYE DROP	Formulary	OTC
GENTEAL TEARS SEVERE GEL	Non-Formulary	OTC
GNP LUBRICANT 0.5% EYE DROP	Formulary	OTC
GS LUBRICAT PLUS 0.5% EYE DRPS P/F, 30X0.4ML	Formulary	Dual Eligible Covered; OTC
LACRISERT	Non-Formulary	
LUBRICANT 0.5% EYE DROP	Formulary	OTC
LUBRICANT 0.5% EYE DROPS	Formulary	Dual Eligible Covered; OTC
LUBRICANT EYE (PROPYL GLYCOL) OPHTHALMIC (EYE) DROPS 0.6 %	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
MIEBO 100% EYE DROP	Formulary	PA; PDL Non-Preferred; QL (0.1 ML per 1 day); Age Limit (Min 18 Years)
<i>polyvinyl alcohol 1.4% eyedrop</i>	Formulary	OTC
REFRESH CELLUVISC 1% EYE GEL	Formulary	Dual Eligible Covered; OTC
REFRESH CONTACTS	Non-Formulary	OTC
REFRESH LIQUIGEL 1% EYE DROP	Formulary	Dual Eligible Covered; OTC
REFRESH PLUS	Non-Formulary	Dual Eligible Covered; OTC
SYSTANE BALANCE	Non-Formulary	OTC
SYSTANE COMPLETE	Non-Formulary	OTC
SYSTANE GEL OPHTHALMIC (EYE) GEL	Non-Formulary	OTC
TEARS LUBRICANT EYE DROP	Non-Formulary	OTC
<i>Miotics - Cholinesterase Inhibitors</i>		
PHOSPHOLINE IODIDE 0.125% DROP OUTER	Formulary	
<i>Miotics - Direct Acting</i>		
MIOCHOL-E	Non-Formulary	
MIOSTAT	Non-Formulary	
<i>pilocarpine 1% eye drops</i>	Formulary	
<i>pilocarpine 2% eye drops</i>	Formulary	
<i>pilocarpine 4% eye drops</i>	Formulary	
<i>Mydriatic And Cycloplegic Combinations</i>		
CYCLOMYDRIL	Non-Formulary	
<i>Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations</i>		
SIMBRINZA 1%-0.2% EYE DROP	Formulary	PDL Preferred
<i>Ophthalmic - Antibacterial-Glucocorticoid Combinations</i>		
MAXITROL	Non-Formulary	
<i>neo-bacit-poly-hc eye ointment</i>	Formulary	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	Non-Formulary	
<i>neomyc-polym-dexamet eye ointm</i>	Formulary	
<i>neomyc-polym-dexameth eye drop</i>	Formulary	
NEO-POLYCIN HC	Non-Formulary	
<i>sulf-pred 10-0.23% eye drops</i>	Formulary	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	Non-Formulary	
TOBRADEX ST	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>tobramycin-dexameth ophth susp</i>	Formulary	
ZYLET	Non-Formulary	
Ophthalmic - Anticholinergics		
<i>atropine 1% eye drops</i>	Formulary	
<i>atropine 1% eye ointment</i>	Formulary	
CYCLOGYL	Non-Formulary	
<i>cyclopentolate 1% eye drop</i>	Formulary	
<i>cyclopentolate 1% eye drops</i>	Formulary	
ISOPTO ATROPINE	Non-Formulary	
MYDRIACYL	Non-Formulary	
<i>tropicamide 0.5% eye drop</i>	Formulary	
<i>tropicamide 0.5% eye drops</i>	Formulary	
<i>tropicamide 1% eye drop</i>	Formulary	
<i>tropicamide 1% eye drops</i>	Formulary	
Ophthalmic - Antihistamines		
ALAWAY 0.025% EYE DROPS	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>azelastine hcl 0.05% drops</i>	Formulary	PDL Preferred
<i>azelastine hcl 0.05% drops sterile</i>	Formulary	PDL Preferred
<i>azelastine hcl 0.05% drops strl</i>	Formulary	PDL Preferred
<i>bepotastine 1.5% eye drop</i>	Formulary	PA; PDL Non-Preferred
BEPREVE 1.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
CHILD'S ALAWAY 0.025% EYE DROP	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>epinastine hcl 0.05% eye drops</i>	Formulary	PA; PDL Non-Preferred
EYE ALLERGY ITCH RLF 0.2% DROP	Formulary	PDL Preferred; OTC
EYE ALLERGY ITCH-RED 0.1% DROP	Formulary	PDL Preferred; OTC
EYE ITCH RELIEF 0.025% DROPS	Formulary	PDL Preferred; Dual Eligible Covered; OTC
FT EYE ALLERGY ITCH RLF 0.2%	Formulary	PDL Preferred; OTC
FT EYE ALLERGY ITCH-RED 0.1%	Formulary	PDL Preferred; OTC
<i>gnp olopatadine 0.1% eye drops (otc)</i>	Formulary	PDL Preferred; OTC
<i>gnp olopatadine 0.2% eye drop (otc)</i>	Formulary	PDL Preferred; OTC
HM EYE ALLERGY ITCH RLF 0.2%	Formulary	PDL Preferred; OTC
HM EYE ALLERGY ITCH-RED 0.1%	Formulary	PDL Preferred; OTC
<i>ketotifen fum 0.025% eye drops (otc)</i>	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>ketotifen fum 0.025% eye drops (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>ketotifen fum 0.035% eye drops (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
LASTACRAFT ONCE DAILY 0.25% DRP	Formulary	PA; PDL Non-Preferred; OTC
<i>olopatadine hcl 0.1% eye drop (otc)</i>	Formulary	PDL Preferred; OTC
<i>olopatadine hcl 0.1% eye drops (otc)</i>	Formulary	PDL Preferred; OTC
<i>olopatadine hcl 0.1% eye drops (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>olopatadine hcl 0.2% eye drop (otc)</i>	Formulary	PDL Preferred; OTC
<i>olopatadine hcl 0.2% eye drop (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
PATADAY ONCE DAILY 0.2% DROPS	Formulary	PA; PDL Non-Preferred; OTC
PATADAY ONCE DAILY 0.7% DROPS	Formulary	PA; PDL Non-Preferred; OTC
PATADAY TWICE DAILY 0.1% DROPS	Formulary	PA; PDL Non-Preferred; OTC
<i>sm olopatadine 0.2% eye drop (otc)</i>	Formulary	PDL Preferred; OTC
ZADITOR 0.025% (0.035%) DROPS UP TO 12 HRS (OTC)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
ZERVIATE 0.24% EYE DROP	Formulary	PA; PDL Non-Preferred
<i>Ophthalmic - Anti-Inflammatory, Glucocorticoids</i>		
ALREX 0.2% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>dexamethasone 0.1% eye drop</i>	Formulary	
<i>difluprednate</i>	Non-Formulary	
DUREZOL	Non-Formulary	
EYSUVIS 0.25% EYE DROPS	Formulary	PA; PDL Non-Preferred; QL (8.3 ML per 14 days)
FLAREX	Non-Formulary	
<i>fluorometholone 0.1% eye drop</i>	Formulary	QL (15 ML per 30 days)
FML FORTE	Non-Formulary	
FML LIQUIFILM	Non-Formulary	
INVELTYS	Non-Formulary	
LOTEMAX	Non-Formulary	
LOTEMAX SM	Non-Formulary	
<i>loteprednol etabonate 0.2% drp</i>	Formulary	PA; PDL Non-Preferred
<i>loteprednol etabonate ophthalmic (eye) drops,gel</i>	Non-Formulary	
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %</i>	Non-Formulary	
MAXIDEX	Non-Formulary	

Medications	Coverage Level	Restrictions
OZURDEX	Non-Formulary	
PRED FORTE	Non-Formulary	
PRED MILD	Non-Formulary	
<i>prednisolone ac 1% eye drop</i>	Formulary	
<i>prednisolone sod 1% eye drop</i>	Formulary	
RETISERT	Non-Formulary	
TRIESENCE (PF)	Non-Formulary	
XIPERE (PF)	Non-Formulary	
<i>Ophthalmic - Anti-Inflammatory, Immunomodulators</i>		
CEQUA 0.09% SOLUTION	Formulary	PA; PDL Non-Preferred; QL (60 ampules per 30 days)
<i>cyclosporine 0.05% eye emulsion</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 ampules per 1 day)
<i>cyclosporine 0.05% eye emulsion outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 ampules per 1 day)
RESTASIS 0.05% EYE EMULSION SUV,P/F, 0.4ML VIAL	Formulary	PDL Preferred; QL (2 ampules per 1 day)
RESTASIS 0.05% EYE EMULSION SUV,P/F,0.4ML VIAL	Formulary	PDL Preferred; QL (2 ampules per 1 day)
RESTASIS MULTIDOSE 0.05% EYE P/F	Formulary	PA; PDL Non-Preferred; QL (5.5 ML per 30 days)
VEVYE 0.1% EYE DROP	Formulary	PA; PDL Non-Preferred; QL (2 ML per 30 days); Age Limit (Min 18 Years)
<i>Ophthalmic - Anti-Inflammatory, Lfa-1 Antagonists</i>		
XIIDRA 5% EYE DROPS OUTER	Formulary	PDL Preferred; QL (2 ampules per 1 day)
XIIDRA 5% EYE DROPS OUTER, P/F	Formulary	PDL Preferred; QL (2 ampules per 1 day)
<i>Ophthalmic - Anti-Inflammatory, Nsaids</i>		
ACULAR 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
ACULAR LS 0.4% OPHTH SOL	Formulary	PA; PDL Non-Preferred
ACUVAIL 0.45% OPHTH SOLUTION	Formulary	PA; PDL Non-Preferred
<i>bromfenac sod 0.075% eye drop</i>	Formulary	PA; PDL Non-Preferred
<i>bromfenac sodium 0.07% eye drp</i>	Formulary	PA; PDL Non-Preferred
<i>bromfenac sodium 0.09% eye drp</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
BROMSITE 0.075% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>diclofenac 0.1% eye drops</i>	Formulary	PDL Preferred
<i>flurbiprofen 0.03% eye drop</i>	Formulary	PDL Preferred
ILEVRO 0.3% OPHTH DROPS	Formulary	PA; PDL Non-Preferred
<i>ketorolac 0.4% ophth solution</i>	Formulary	PA; PDL Non-Preferred
<i>ketorolac 0.5% ophth solution</i>	Formulary	PDL Preferred
NEVANAC 0.1% EYE DROP	Formulary	PA; PDL Non-Preferred
PROLENSA 0.07% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>Ophthalmic - Beta Blockers-Adrenergic Combinations</i>		
<i>brimonidine-timolol 0.2%-0.5%</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
COMBIGAN 0.2%-0.5% EYE DROPS	Formulary	PDL Preferred
<i>Ophthalmic - Beta Blockers-Carbonic Anhydrase Inhibitor Combinations</i>		
COSOPT EYE DROPS	Formulary	PA; PDL Non-Preferred
COSOPT PF EYE DROPS OUTER	Formulary	PA; PDL Non-Preferred
<i>dorzolamide-timolol 2%-0.5% outer</i>	Formulary	PA; PDL Non-Preferred
<i>dorzolamide-timolol 2%-0.5% outer, plf</i>	Formulary	PA; PDL Non-Preferred
<i>dorzolamide-timolol eye drops</i>	Formulary	PDL Preferred
<i>Ophthalmic - Carbonic Anhydrase Inhibitors</i>		
AZOPT 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>brinzolamide 1% eye drops</i>	Formulary	PDL Preferred
<i>dorzolamide hcl 2% eye drops</i>	Formulary	PDL Preferred
<i>Ophthalmic - Cystine Depleting Agents</i>		
CYSTADROPS	Non-Formulary	
CYSTARAN	Non-Formulary	
<i>Ophthalmic - Decongestants</i>		
<i>phenylephrine 2.5% eye drop</i>	Formulary	
<i>phenylephrine hcl ophthalmic (eye) drops 10 %</i>	Non-Formulary	
<i>Ophthalmic - Diagnostic Agents</i>		
<i>fluorescein-benoxinate</i>	Non-Formulary	
<i>Ophthalmic - Human Nerve Growth Factor (Hngf)</i>		
OXERVATE 0.002% EYE DROP	Formulary	PA; QL (28 ML per 28 days); Age Limit (Min 2 Years)

Medications	Coverage Level	Restrictions
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-Blockers		
<i>betaxolol hcl 0.5% eye drop</i>	Formulary	PA; PDL Non-Preferred
BETIMOL 0.25% EYE DROPS	Formulary	PA; PDL Non-Preferred
BETIMOL 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
BETOPTIC S 0.25% EYE DROP	Formulary	PDL Preferred
<i>carteolol hcl 1% eye drops</i>	Formulary	PDL Preferred
ISTALOL 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>levobunolol 0.5% eye drops</i>	Formulary	PA; PDL Non-Preferred
<i>timolol 0.25% gel-solution</i>	Formulary	PDL Preferred
<i>timolol 0.5% eye drop</i>	Formulary	PA; PDL Non-Preferred
<i>timolol 0.5% eye drops</i>	Formulary	PA; PDL Non-Preferred
<i>timolol 0.5% gel-solution</i>	Formulary	PDL Preferred
<i>timolol 0.5% gfs gel-solution</i>	Formulary	PDL Preferred
<i>timolol maleate 0.25% eye drop</i>	Formulary	PDL Preferred
<i>timolol maleate 0.25% eye drop outer</i>	Formulary	PA; PDL Non-Preferred
<i>timolol maleate 0.5% eye drop</i>	Formulary	PA; PDL Non-Preferred
<i>timolol maleate 0.5% eye drop outer</i>	Formulary	PA; PDL Non-Preferred
<i>timolol maleate 0.5% eye drop outer, p/f</i>	Formulary	PA; PDL Non-Preferred
<i>timolol maleate 0.5% eye drops</i>	Formulary	PDL Preferred
TIMOPTIC 0.25% OCUDOSE DROP	Formulary	PA; PDL Non-Preferred
TIMOPTIC 0.25% OCUDOSE DROP P/F, OCUDOSE	Formulary	PA; PDL Non-Preferred
TIMOPTIC 0.5% OCUDOSE DROP P/F	Formulary	PA; PDL Non-Preferred
Ophthalmic - Irrigation Solutions		
BALANCED SALT	Non-Formulary	
BSS	Non-Formulary	
BSS PLUS	Non-Formulary	
Ophthalmic - Local Anesthetic Combinations		
<i>fluorescein-benoxinate</i>	Non-Formulary	
Ophthalmic - Local Anesthetic Esters		
ALCAINE	Non-Formulary	
<i>proparacaine 0.5% eye drops</i>	Formulary	
<i>tetracaine hcl</i>	Non-Formulary	
<i>tetracaine hcl (pf) ophthalmic (eye)</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
Ophthalmic - Local Anesthetic, Amides		
AKTEN (PF)	Non-Formulary	
Ophthalmic - Mast Cell Stabilizers		
ALOMIDE 0.1% EYE DROP	Formulary	PA; PDL Non-Preferred
<i>cromolyn 4% eye drops</i>	Formulary	PDL Preferred
Ophthalmic - Rho Kinase Inhibitor And Prostaglandin Analog Combination		
ROCKLATAN 0.02%-0.005% EYE DRP	Formulary	PDL Preferred
Ophthalmic - Surgical Aids Other		
GELFILM OPHTHALMIC (EYE)	Non-Formulary	
Ophthalmic Antibacterial Mixtures		
<i>bacitracin-polymyxin eye oint</i>	Formulary	
<i>neomyc-bacit-polymix eye oint</i>	Formulary	
<i>neomyc-polym-gramicid eye drop formerly ocutricin</i>	Formulary	
NEO-POLYCIN EYE OINTMENT	Formulary	
POLYCIN EYE OINTMENT	Formulary	
<i>polymyxin b-tmp eye drops</i>	Formulary	
Ophthalmic Antibiotic - Aminoglycosides		
<i>gentamicin 0.3% eye drop</i>	Formulary	
<i>tobramycin 0.3% eye drop</i>	Formulary	
TOBREX OPHTHALMIC (EYE) OINTMENT	Non-Formulary	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors		
<i>bacitracin 500 unit/gm ophthalmic ointment sterile</i>	Formulary	
Ophthalmic Antibiotic - Fluoroquinolones		
BESIVANCE 0.6% SUSP	Formulary	PA; PDL Non-Preferred
CILOXAN 0.3% OINTMENT	Formulary	PA; PDL Non-Preferred
<i>ciprofloxacin 0.3% eye drop</i>	Formulary	PDL Preferred
<i>gatifloxacin 0.5% eye drops</i>	Formulary	PA; PDL Non-Preferred
<i>moxifloxacin 0.5% eye drop (viscous) (twice daily)</i>	Formulary	PA; PDL Non-Preferred
<i>moxifloxacin 0.5% eye drops</i>	Formulary	PDL Preferred
OCUFLOX 0.3% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>ofloxacin 0.3% eye drops</i>	Formulary	PDL Preferred
VIGAMOX 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Ophthalmic Antibiotic - Macrolides		
AZASITE 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>erythromycin 0.5% eye ointment</i>	Formulary	PDL Preferred
<i>erythromycin 0.5% eye ointment 50's, u-d</i>	Formulary	PDL Preferred
<i>erythromycin 0.5% eye ointment outer</i>	Formulary	PDL Preferred
Ophthalmic Antibiotic - Sulfonamides		
<i>sulfacetamide 10% eye drops</i>	Formulary	
<i>sulfacetamide 10% eye ointment</i>	Formulary	
Ophthalmic Antifungals - Tetraene Polyene-Type		
NATACYN	Non-Formulary	
Ophthalmic Antifungals		
NATACYN	Non-Formulary	
Ophthalmic Antiseptics		
BETADINE OPHTHALMIC PREP	Non-Formulary	
Ophthalmic Antivirals		
<i>trifluridine</i>	Non-Formulary	
ZIRGAN	Non-Formulary	
Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists		
ALPHAGAN P 0.1% DROPS	Formulary	PA; PDL Non-Preferred
ALPHAGAN P 0.15% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>apraclonidine hcl 0.5% drops</i>	Formulary	PDL Preferred
<i>brimonidine 0.2% eye drop</i>	Formulary	PDL Preferred
<i>brimonidine tartrate 0.1% drop</i>	Formulary	PA; PDL Non-Preferred
<i>brimonidine tartrate 0.15% drp</i>	Formulary	PA; PDL Non-Preferred
IOPIDINE 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs		
<i>bimatoprost 0.03% eye drops</i>	Formulary	PA; PDL Non-Preferred
IYUZEH 0.005% EYE DROP OUTER	Formulary	PA; PDL Non-Preferred
<i>latanoprost 0.005% eye drops</i>	Formulary	PDL Preferred
<i>latanoprost 0.005% eye drops 3's, multi-pack</i>	Formulary	PDL Preferred
LUMIGAN 0.01% EYE DROPS	Formulary	PA; PDL Non-Preferred
<i>tafluprost 0.0015% eye drop outer</i>	Formulary	PA; PDL Non-Preferred
TRAVATAN Z 0.004% EYE DROP	Formulary	PA; PDL Non-Preferred
<i>travoprost 0.004% eye drop</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
VYZULTA 0.024% OPHTH SOLUTION	Formulary	PA; PDL Non-Preferred
XALATAN 0.005% EYE DROPS	Formulary	PA; PDL Non-Preferred
XELPROS 0.005% EYE DROP	Formulary	PA; PDL Non-Preferred
ZIOPTAN 0.0015% EYE DROP OUTER	Formulary	PA; PDL Non-Preferred
<i>Ophthalmic-Intraocular Pressure Reducing Agents, Rho Kinase Inhibitors</i>		
RHOPRESSA 0.02% OPHTH SOLUTION	Formulary	PDL Preferred
Otic (Ear)		
<i>Otic (Ear) - Anti-Infective-Glucocorticoid Combinations</i>		
CIPRO HC OTIC SUSPENSION	Formulary	PA; PDL Non-Preferred
<i>ciproflox-dexameth otic susp</i>	Formulary	PDL Preferred
<i>ciproflox-fluocinln 0.3-0.025%</i>	Formulary	PA; PDL Non-Preferred
CORTISPORIN-TC	Non-Formulary	
<i>neomycin-polymyxin-hc ear soln w/dropper</i>	Formulary	PDL Preferred
<i>neomycin-polymyxin-hc ear susp</i>	Formulary	PDL Preferred
<i>neomycin-polymyxin-hc ear susp w/dropper</i>	Formulary	PDL Preferred
<i>Otic (Ear) - Anti-Infectives Other</i>		
<i>acetic acid 2% ear solution</i>	Formulary	
<i>Otic (Ear) - Fluoroquinolones</i>		
<i>ciprofloxacin 0.2% otic soln</i>	Formulary	PA; PDL Non-Preferred
<i>ofloxacin 0.3% ear drops</i>	Formulary	PDL Preferred
<i>Otic (Ear) - Glucocorticoids</i>		
DERMOTIC OIL	Non-Formulary	
FLAC OTIC OIL	Non-Formulary	
<i>fluocinolone acetonide oil</i>	Non-Formulary	
<i>hydrocortisone 1%-acetic acid 2% ear drop</i>	Formulary	
Respiratory Therapy Agents		
<i>Antihistamine - 1St Generation - Alkylamines</i>		
ALA-HIST IR	Non-Formulary	OTC
ALLER-CHLOR 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLERGY 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLERGY-TIME 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ED CHLORPED JR	Non-Formulary	OTC
FT ALLERGY (CHLORPHEN) 4 MG TB	Formulary	OTC

Medications	Coverage Level	Restrictions
GNP ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
HM ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
PEDIAVENT ORAL LIQUID	Non-Formulary	OTC
RYCLORA	Non-Formulary	
SM ALLERGY 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
<i>Antihistamine - 1St Generation - Ethanolamines</i>		
ALKA-SELTZER PLUS ALLERGY	State Carve Out	OTC
ALLER-G-TIME 25 MG CAPLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY 25 MG CAPSULE	Formulary	OTC; Age Limit (Max 64 Years)
ALLERGY 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY 50 MG/20 ML SOLUTION	Formulary	Dual Eligible Covered; OTC
ALLERGY RELIEF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
ALLERGY RELIEF 25 MG CAPSULE	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY RELIEF 25 MG SOFTGEL	Formulary	OTC; Age Limit (Max 64 Years)
ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
BANOPHEN 25 MG CAPSULE	Formulary	OTC; Age Limit (Max 64 Years)
BANOPHEN 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
BANOPHEN 50 MG CAPSULE	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>carbinoxamine 4 mg/5 ml liquid</i>	Formulary	
<i>carbinoxamine maleate 4 mg tab</i>	Formulary	
CHILD ALLERGY RLF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHILDREN'S ALLERGY (DIPHENHYD) ORAL TABLET,CHEWABLE	Non-Formulary	OTC
<i>clemastine oral tablet</i>	Non-Formulary	
DIPHEDRYL 12.5 MG/5 ML ELIXIR	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 12.5 mg/5 ml</i>	Formulary	OTC
<i>diphenhydramine 12.5 mg/5 ml</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 12.5 mg/5 ml cup outer</i>	Formulary	OTC
<i>diphenhydramine 12.5 mg/5 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 25 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
<i>diphenhydramine 25 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet inner</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet outer</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg/10 ml cup outer</i>	Formulary	OTC
<i>diphenhydramine 25 mg/10 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 50 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg capsule u-d, 10x10 (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml syrng suv</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial mdv</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv, p/f</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv, p/f, outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv,outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine hcl oral elixir</i>	Non-Formulary	OTC
FT ALLERGY (DIPHEN) 25 MG CAP	Formulary	OTC; Age Limit (Max 64 Years)
FT ALLERGY (DIPHEN) 25 MG TAB	Formulary	OTC; Age Limit (Max 64 Years)
FT CHILD ALLERGY 12.5 MG/5 ML	Formulary	OTC
GNP ALLERGY RELIEF 25 MG SFGL	Formulary	OTC; Age Limit (Max 64 Years)
GNP ALLERGY RELIEF 25 MG TAB	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
GNP ALLERGY RELIEF 50 MG/20 ML	Formulary	Dual Eligible Covered; OTC
GNP CHILD ALLERGY 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
GS ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
GS CHILD ALLERGY 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
HM ALLERGY RELIEF 25 MG CAP	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
HM ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
KARBINAL ER	Non-Formulary	
M-DRYL 12.5 MG/5 ML SOLUTION	Formulary	Dual Eligible Covered; OTC
NIGHTTIME SLEEP AID (DIPHEN) ORAL TABLET	State Carve Out	OTC

Medications	Coverage Level	Restrictions
NYTOL	State Carve Out	OTC
REST SIMPLY NIGHTTIME SLEEP	State Carve Out	OTC
RYVENT	Non-Formulary	
SIMPLY SLEEP	State Carve Out	OTC
SLEEP AID (DIPHENHYDRAMINE) ORAL TABLET	State Carve Out	OTC
SM ALLERGY (DIPHEN) 25 MG TAB	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
SM CHILD ALLERGY 12.5 MG/5 ML	Formulary	OTC
SOMINEX	State Carve Out	OTC
Antihistamine - 1St Generation - Phenothiazines		
PHENERGAN INJECTION	Non-Formulary	
<i>promethazine 12.5 mg suppos</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg suppos outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 25 mg suppository inner</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg suppository outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet outer</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 6.25 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 6.25 mg/5 ml solution cup outer</i>	Formulary	Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
<i>promethazine 6.25 mg/5 ml syrup</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine injection solution</i>	Non-Formulary	
PROMETHEGAN 12.5 MG SUPPOS OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 25 MG SUPPOSITORY OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY INNER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY OUTER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>Antihistamine - 1St Generation - Piperidines</i>		
<i>cyproheptadine 2 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 2 mg/5 ml syrup</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 4 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 4 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)
<i>Antihistamine - 1St Generation - Propylamines</i>		
HISTEX (TRIPROLIDINE)	Non-Formulary	OTC
HISTEX PD ORAL DROPS 0.938 MG/ML	Non-Formulary	OTC
HISTEX PDX	Non-Formulary	OTC
PEDIACLEAR PD	Non-Formulary	OTC
<i>triprolidine hcl</i>	Non-Formulary	OTC
<i>Antihistamines - 1St Generation</i>		
ALA-HIST IR	Non-Formulary	OTC
ALKA-SELTZER PLUS ALLERGY	State Carve Out	OTC
ALLER-CHLOR 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLER-G-TIME 25 MG CAPLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY 25 MG CAPSULE	Formulary	OTC; Age Limit (Max 64 Years)
ALLERGY 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLERGY 50 MG/20 ML SOLUTION	Formulary	Dual Eligible Covered; OTC
ALLERGY RELIEF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
ALLERGY RELIEF 25 MG CAPSULE	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY RELIEF 25 MG SOFTGEL	Formulary	OTC; Age Limit (Max 64 Years)
ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
ALLERGY-TIME 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
BANOPHEN 25 MG CAPSULE	Formulary	OTC; Age Limit (Max 64 Years)
BANOPHEN 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
BANOPHEN 50 MG CAPSULE	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>carbinoxamine 4 mg/5 ml liquid</i>	Formulary	
<i>carbinoxamine maleate 4 mg tab</i>	Formulary	
CHILD ALLERGY RLF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHILDREN'S ALLERGY (DIPHENHYD) ORAL TABLET,CHEWABLE	Non-Formulary	OTC
<i>clemastine oral tablet</i>	Non-Formulary	
<i>cyproheptadine 2 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 2 mg/5 ml syrup</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 4 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>cyproheptadine 4 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)
DIPHEDRYL 12.5 MG/5 ML ELIXIR	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 12.5 mg/5 ml</i>	Formulary	OTC
<i>diphenhydramine 12.5 mg/5 ml</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 12.5 mg/5 ml cup outer</i>	Formulary	OTC
<i>diphenhydramine 12.5 mg/5 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 25 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet inner</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg tablet outer</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 25 mg/10 ml cup outer</i>	Formulary	OTC
<i>diphenhydramine 25 mg/10 ml cup outer</i>	Formulary	Dual Eligible Covered; OTC
<i>diphenhydramine 50 mg capsule (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
<i>diphenhydramine 50 mg capsule u-d, 10x10 (otc)</i>	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml syrng suv</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial mdv</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv, plf</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv, plf, outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine 50 mg/ml vial suv,outer</i>	Formulary	Age Limit (Max 64 Years)
<i>diphenhydramine hcl oral elixir</i>	Non-Formulary	OTC
ED CHLORPED JR	Non-Formulary	OTC
FT ALLERGY (CHLORPHEN) 4 MG TB	Formulary	OTC
FT ALLERGY (DIPHEN) 25 MG CAP	Formulary	OTC; Age Limit (Max 64 Years)
FT ALLERGY (DIPHEN) 25 MG TAB	Formulary	OTC; Age Limit (Max 64 Years)
FT CHILD ALLERGY 12.5 MG/5 ML	Formulary	OTC
GNP ALLERGY RELIEF 25 MG SFGL	Formulary	OTC; Age Limit (Max 64 Years)
GNP ALLERGY RELIEF 25 MG TAB	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
GNP ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
GNP ALLERGY RELIEF 50 MG/20 ML	Formulary	Dual Eligible Covered; OTC
GNP CHILD ALLERGY 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
GS ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
GS CHILD ALLERGY 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
HISTEX (TRIPROLIDINE)	Non-Formulary	OTC
HISTEX PD ORAL DROPS 0.938 MG/ML	Non-Formulary	OTC
HISTEX PDX	Non-Formulary	OTC
HM ALLERGY RELIEF 25 MG CAP	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
HM ALLERGY RELIEF 25 MG TABLET	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
HM ALLERGY RELIEF 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
KARBINAL ER	Non-Formulary	
M-DRYL 12.5 MG/5 ML SOLUTION	Formulary	Dual Eligible Covered; OTC
NIGHTIME SLEEP	State Carve Out	OTC
NIGHTTIME SLEEP AID (DIPHEN) ORAL CAPSULE 50 MG	State Carve Out	OTC

Medications	Coverage Level	Restrictions
NIGHTTIME SLEEP AID (DIPHEN) ORAL TABLET	State Carve Out	OTC
NYTOL	State Carve Out	OTC
PEDIACLEAR PD	Non-Formulary	OTC
PEDIACLEAR-8	Non-Formulary	OTC
PEDIAVENT ORAL LIQUID	Non-Formulary	OTC
PHENERGAN INJECTION	Non-Formulary	
<i>promethazine 12.5 mg suppos</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg suppos outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 12.5 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 12.5 mg tablet outer</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 25 mg suppository inner</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg suppository outer</i>	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 25 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 25 mg tablet outer</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 50 mg tablet</i>	Formulary	Age Limit (Min 2 Years and Max 64 Years)
<i>promethazine 6.25 mg/5 ml soln</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 6.25 mg/5 ml solution cup outer</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine 6.25 mg/5 ml syrp</i>	Formulary	Age Limit (Max 64 Years)
<i>promethazine injection solution</i>	Non-Formulary	
PROMETHEGAN 12.5 MG SUPPOS OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)

Medications	Coverage Level	Restrictions
PROMETHEGAN 25 MG SUPPOSITORY OUTER	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY INNER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
PROMETHEGAN 50 MG SUPPOSITORY OUTER	Formulary	QL (2 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
REST SIMPLY NIGHTTIME SLEEP	State Carve Out	OTC
RYCLORA	Non-Formulary	
RYVENT	Non-Formulary	
SIMPLY SLEEP	State Carve Out	OTC
SLEEP AID (DIPHENHYDRAMINE) ORAL CAPSULE 50 MG	State Carve Out	OTC
SLEEP AID (DIPHENHYDRAMINE) ORAL TABLET	State Carve Out	OTC
SM ALLERGY (DIPHEN) 25 MG TAB	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
SM ALLERGY 4 MG TABLET	Formulary	Dual Eligible Covered; OTC
SM CHILD ALLERGY 12.5 MG/5 ML	Formulary	OTC
SOMINEX	State Carve Out	OTC
<i>triprolidine hcl</i>	Non-Formulary	OTC
UNISOM SLEEPGELS	State Carve Out	OTC
WAL-SOM (DIPHENHYDRAMINE)	State Carve Out	OTC
<i>Antihistamines - 2Nd Generation - Piperazines</i>		
24HR ALLERGY(LEVOCETIRZLN) 5 MG	Formulary	PDL Preferred; OTC
ALL DAY ALLERGY 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALL DAY ALLERGY 10 MG TABLET INDOOR/OUTDOOR 24 HR	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RLF (CETRZN) 10 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF (CETRZN) 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RLF (CETRZN) 5 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF(CETRZN) 10 MG SFGL	Formulary	PA; PDL Non-Preferred; OTC
<i>cetirizine hcl 1 mg/ml soln (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln (rx)</i>	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>cetirizine hcl 1 mg/ml soln (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln children, grape (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln children's (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml syrup (rx)</i>	Formulary	PDL Preferred; OTC
<i>cetirizine hcl 10 mg chew tab outer</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>cetirizine hcl 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet f/c,u-d,10x10,outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet indoor & outdoor</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet indoor-outdoor,24hr</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg chew tab children's,outer,u-d</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg tablet indoor & outdoor</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg/5 ml solution cup inner</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg/5 ml solution cup outer</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
CHILD ALL DAY ALLERGY 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALL DAY ALLERGY 1 MG/ML BUBBLE GUM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALLERGY RELIEF 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD CETIRIZINE 10 MG CHEW TB CHEWABLE, ALLERGY	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
CHILD CETIRIZINE HCL 1 MG/ML	Formulary	PDL Preferred; OTC
CHILD CETIRIZINE HCL 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
FT AD ALLERGY (CETRZN) 10 MG TB	Formulary	PDL Preferred; OTC
FT ALLERGY (CETRZN) 10 MG TAB	Formulary	PDL Preferred; OTC
FT CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY RLF 1 MG/ML	Formulary	PDL Preferred; OTC
GNP ALL DAY ALLERGY 10 MG SFGL	Formulary	PA; PDL Non-Preferred; OTC
GNP ALLERGY RELIEF 5 MG TABLET	Formulary	PDL Preferred; OTC
GS ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>levocetirizine 2.5 mg/5 ml sol</i>	Formulary	PA; PDL Non-Preferred
<i>levocetirizine 5 mg tablet (otc)</i>	Formulary	PDL Preferred; OTC
<i>levocetirizine 5 mg tablet (rx)</i>	Formulary	PDL Preferred; OTC
<i>levocetirizine 5 mg tablet f/c (rx)</i>	Formulary	PDL Preferred; OTC
SM ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; OTC
<i>Antihistamines - 2Nd Generation - Piperidines</i>		
ALLERGY (LORATADINE) 10 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY (LORATADINE) 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; OTC
ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RELIEF 180 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RELIEF 5 MG/5 ML SOLN	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RLF (FEXO) 60 MG TAB	Formulary	PDL Preferred; OTC
CHILD ALLERGY (FEXO) 30 MG/5 ML	Formulary	PDL Preferred; OTC
CHILD ALLERGY 5 MG/5 ML SOLN	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALLERGY RELIEF 5 MG/5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD LORATADINE 5 MG TAB CHEW	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>child loratadine 5 mg/5 ml sol</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>child loratadine 5 mg/5 ml syr grape</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CLARINEX 5 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>desloratadine 2.5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Max 11 Years)
<i>desloratadine 5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred
<i>desloratadine 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>desloratadine 5 mg tablet flc</i>	Formulary	PA; PDL Non-Preferred
<i>fexofenadine hcl 180 mg tablet (otc)</i>	Formulary	PDL Preferred; OTC
<i>fexofenadine hcl 180 mg tablet (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>fexofenadine hcl 180 mg tablet non-drowsy, 24hr (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>fexofenadine hcl 60 mg tablet (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
FT AD ALLERGY (LORAT) 10 MG TB	Formulary	PDL Preferred; OTC
FT ALLERGY (FEXO) 180 MG TAB	Formulary	PDL Preferred; OTC
FT ALLERGY (FEXO) 60 MG TABLET	Formulary	PDL Preferred; OTC
FT ALLERGY (LORAT) 10 MG TAB	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY 5 MG/5 ML SOL	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY RLF 5 MG CHEW	Formulary	PDL Preferred; OTC
GNP ALLERGY RELIEF 180 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>gnp fexofenadine hcl 180 mg tb (otc)</i>	Formulary	PDL Preferred; OTC
<i>gnp loratadine 10 mg odt</i>	Formulary	PDL Preferred; OTC
<i>gnp loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ALLER-EASE 180 MG TABLET	Formulary	PDL Preferred; OTC
GS ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ALLERGY RELIEF 10 MG TABLET NON-DROWSY	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD ALLERGY RLF 5 MG/5 ML	Formulary	PDL Preferred; OTC
HM ALLERGY RELIEF 180 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM ALLERGY RELIEF 60 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
<i>hm loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg odt</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg odt</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet 10x10, outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet 10x10,u-d,outer</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg tablet outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 5 mg/5 ml solution</i>	Formulary	PDL Preferred; OTC
<i>loratadine 5 mg/5 ml syrup children's</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 5 mg/5 ml syrup children's, dlf</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine allergy 5 mg/5 ml dlf</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
QC ALLERGY (LORAT) 10 MG TAB	Formulary	PDL Preferred; OTC
SM ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; OTC
SM CHILD ALLERGY 5 MG/5 ML SOL	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm fexofenadine hcl 180 mg tab (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm loratadine 5 mg/5 ml syrup</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>Antihistamines - 2Nd Generation</i>		
24HR ALLERGY(LEVOCETIRZN) 5 MG	Formulary	PDL Preferred; OTC
ALL DAY ALLERGY 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALL DAY ALLERGY 10 MG TABLET INDOOR/OUTDOOR 24 HR	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY (LORATADINE) 10 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY (LORATADINE) 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; OTC
ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
ALLERGY RELIEF 180 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RELIEF 5 MG/5 ML SOLN	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RLF (CETRZN) 10 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF (CETRZN) 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ALLERGY RLF (CETRZN) 5 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF (FEXO) 60 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF(CETRZN) 10 MG SFGL	Formulary	PA; PDL Non-Preferred; OTC
<i>cetirizine hcl 1 mg/ml soln (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln (rx)</i>	Formulary	PDL Preferred; OTC
<i>cetirizine hcl 1 mg/ml soln (rx)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln children, grape (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml soln children's (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 1 mg/ml syrup (rx)</i>	Formulary	PDL Preferred; OTC
<i>cetirizine hcl 10 mg chew tab outer</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>cetirizine hcl 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet f1c,u-d,10x10,outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet indoor & outdoor</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet indoor-outdoor,24hr</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 10 mg tablet outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg chew tab children's,outer,u-d</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg tablet indoor & outdoor</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
<i>cetirizine hcl 5 mg/5 ml solution cup inner</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>cetirizine hcl 5 mg/5 ml solution cup outer</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
CHILD ALL DAY ALLERGY 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALL DAY ALLERGY 1 MG/ML BUBBLE GUM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALLERGY (FEXO) 30 MG/5 ML	Formulary	PDL Preferred; OTC
CHILD ALLERGY 5 MG/5 ML SOLN	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALLERGY RELIEF 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD ALLERGY RELIEF 5 MG/5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD CETIRIZINE 10 MG CHEW TB CHEWABLE, ALLERGY	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
CHILD CETIRIZINE HCL 1 MG/ML	Formulary	PDL Preferred; OTC
CHILD CETIRIZINE HCL 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD LORATADINE 5 MG TAB CHEW	Formulary	PDL Preferred; OTC
<i>child loratadine 5 mg/5 ml sol</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>child loratadine 5 mg/5 ml syr grape</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CLARINEX 5 MG TABLET	Formulary	PA; PDL Non-Preferred
<i>desloratadine 2.5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred; Age Limit (Max 11 Years)
<i>desloratadine 5 mg odt outer</i>	Formulary	PA; PDL Non-Preferred
<i>desloratadine 5 mg tablet</i>	Formulary	PA; PDL Non-Preferred
<i>desloratadine 5 mg tablet f/c</i>	Formulary	PA; PDL Non-Preferred
<i>fexofenadine hcl 180 mg tablet (otc)</i>	Formulary	PDL Preferred; OTC
<i>fexofenadine hcl 180 mg tablet (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>fexofenadine hcl 180 mg tablet non-drowsy, 24hr (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>fexofenadine hcl 60 mg tablet (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
FT AD ALLERGY (CETRZN) 10 MG TB	Formulary	PDL Preferred; OTC
FT AD ALLERGY (LORAT) 10 MG TB	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
FT ALLERGY (CETRZN) 10 MG TAB	Formulary	PDL Preferred; OTC
FT ALLERGY (FEXO) 180 MG TAB	Formulary	PDL Preferred; OTC
FT ALLERGY (FEXO) 60 MG TABLET	Formulary	PDL Preferred; OTC
FT ALLERGY (LORAT) 10 MG TAB	Formulary	PDL Preferred; OTC
FT CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY 5 MG/5 ML SOL	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY RLF 1 MG/ML	Formulary	PDL Preferred; OTC
FT CHILD ALLERGY RLF 5 MG CHEW	Formulary	PDL Preferred; OTC
GNP ALL DAY ALLERGY 10 MG SFGL	Formulary	PA; PDL Non-Preferred; OTC
GNP ALLERGY RELIEF 180 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GNP ALLERGY RELIEF 5 MG TABLET	Formulary	PDL Preferred; OTC
<i>gnp fexofenadine hcl 180 mg tb (otc)</i>	Formulary	PDL Preferred; OTC
<i>gnp loratadine 10 mg odt</i>	Formulary	PDL Preferred; OTC
<i>gnp loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ALLER-EASE 180 MG TABLET	Formulary	PDL Preferred; OTC
GS ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS ALLERGY RELIEF 10 MG TABLET NON-DROWSY	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD ALLERGY RLF 5 MG/5 ML	Formulary	PDL Preferred; OTC
HM ALLERGY RELIEF 10 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM ALLERGY RELIEF 180 MG TAB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM ALLERGY RELIEF 60 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
HM CHILD ALL DAY ALLER 1 MG/ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>hm loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>levocetirizine 2.5 mg/5 ml sol</i>	Formulary	PA; PDL Non-Preferred
<i>levocetirizine 5 mg tablet (otc)</i>	Formulary	PDL Preferred; OTC
<i>levocetirizine 5 mg tablet (rx)</i>	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
<i>levocetirizine 5 mg tablet f/c (rx)</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg odt</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg odt</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg tablet</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet 10x10, outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 10 mg tablet 10x10,u-d,outer</i>	Formulary	PDL Preferred; OTC
<i>loratadine 10 mg tablet outer</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 5 mg/5 ml solution</i>	Formulary	PDL Preferred; OTC
<i>loratadine 5 mg/5 ml syrup children's</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine 5 mg/5 ml syrup children's, d/f</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>loratadine allergy 5 mg/5 ml d/f</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
QC ALLERGY (LORAT) 10 MG TAB	Formulary	PDL Preferred; OTC
SM ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; OTC
SM ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; OTC
SM CHILD ALLERGY 5 MG/5 ML SOL	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm fexofenadine hcl 180 mg tab (otc)</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
<i>sm loratadine 5 mg/5 ml syrup</i>	Formulary	PDL Preferred; Dual Eligible Covered; OTC
Antitussives - Non-Opioid		
<i>benzonatate</i>	Benefit Exclusion	
Asthma Therapy - 5-Lipoxygenase Inhibitors		
<i>zileuton er 600 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZYFLO 600 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Asthma Therapy - Alpha/Beta Adrenergic Agents		
<i>epinephrine injection syringe 0.1 mg/ml</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>Asthma Therapy - Immunoglobulin E (Ige) Inhibitors, Mab</i>		
XOLAIR 150 MG/ML AUTOINJECTOR	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR 150 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred
XOLAIR 150 MG/ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR 300 MG/2 ML AUTOINJECT SUV, P/F	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR 300 MG/2 ML SYRINGE SUV, P/F	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR 75 MG/0.5 ML AUTOINJECT	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR 75 MG/0.5 ML SYRINGE	Formulary	PA; PDL Preferred
XOLAIR 75 MG/0.5 ML SYRINGE	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
XOLAIR SUBCUTANEOUS RECON SOLN	Non-Formulary	
<i>Asthma Therapy - Inhaled Corticosteroids (Glucocorticoids)</i>		
ALVESCO 160 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed
ALVESCO 80 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed
ARMONAIR DIGIHALER 113 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ARMONAIR DIGIHALER 232 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ARNUIITY ELLIPTA 100 MCG INH	Formulary	PDL Preferred; 3 Months Allowed
ARNUIITY ELLIPTA 200 MCG INH	Formulary	PDL Preferred; 3 Months Allowed
ARNUIITY ELLIPTA 50 MCG INH	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
ASMANEX HFA 100 MCG INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ASMANEX HFA 200 MCG INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
ASMANEX HFA 50 MCG INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days); Age Limit (Max 12 Years)
ASMANEX TWISTHALER 110 MCG #30	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days); Age Limit (Max 11 Years)
ASMANEX TWISTHALER 220 MCG #14	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ASMANEX TWISTHALER 220 MCG #30	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ASMANEX TWISTHALER 220 MCG #60	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ASMANEX TWISTHALR 220 MCG #120	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>budesonide 0.25 mg/2 ml susp</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.25 mg/2 ml susp outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.25 mg/2 ml susp outer, single-dose</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.25 mg/2 ml susp outer,u-d,sv,30's</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.5 mg/2 ml susp</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 aampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.5 mg/2 ml susp</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)

Medications	Coverage Level	Restrictions
<i>budesonide 0.5 mg/2 ml susp 30's, sdv, outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.5 mg/2 ml susp outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 0.5 mg/2 ml susp outer, single-dose</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>budesonide 1 mg/2 ml inh susp outer</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
<i>fluticasone prop 100 mcg diskus</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fluticasone prop 250 mcg disk</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fluticasone prop 50 mcg diskus</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>fluticasone propionate hfa 110 mcg inhaler</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone propionate hfa 220 mcg inhaler</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
<i>fluticasone propionate hfa 44 mcg inhaler</i>	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
PULMICORT 0.25 MG/2 ML RESPUL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
PULMICORT 0.5 MG/2 ML RESPULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
PULMICORT 1 MG/2 ML RESPULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)

Medications	Coverage Level	Restrictions
PULMICORT 180 MCG FLEXHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
PULMICORT 90 MCG FLEXHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
QVAR REDHALER 40 MCG	Formulary	PDL Preferred; 3 Months Allowed
QVAR REDHALER 80 MCG	Formulary	PDL Preferred; 3 Months Allowed
<i>Asthma Therapy - Interleukin-4 (Il-4) Receptor Alpha Antagonists, Mab</i>		
DUPIXENT 200 MG/1.14 ML PEN OUTER, SUV, P/F	Formulary	PA; PDL Preferred; Age Limit (Min 2 Years)
DUPIXENT 200 MG/1.14 ML SYRING OUTER, SUV, P/F	Formulary	PA; PDL Preferred
DUPIXENT 300 MG/2 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Age Limit (Min 2 Years)
DUPIXENT 300 MG/2 ML SYRINGE OUTER, SUV, P/F	Formulary	PA; PDL Preferred
<i>Asthma Therapy - Interleukin-5 (Il-5) Inhibitors, Mab</i>		
NUCALA 100 MG/ML AUTO-INJECTOR P/F, SUV	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
NUCALA 100 MG/ML SYRINGE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
NUCALA 40 MG/0.4 ML SYRINGE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years and Max 11 Years)
NUCALA SUBCUTANEOUS RECON SOLN	Non-Formulary	
<i>Asthma Therapy - Interleukin-5 (Il-5) Receptor Alpha Antagonists, Mab</i>		
FASENRA PEN 30 MG/ML SUV	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	Non-Formulary	
<i>Asthma Therapy - Leukotriene Receptor Antagonists</i>		
ACCOLATE 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ACCOLATE 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>montelukast sod 10 mg tablet</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>montelukast sod 10 mg tablet 15+ yrs, f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>montelukast sod 10 mg tablet f/c</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>montelukast sod 10 mg tablet f/c, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>montelukast sod 10 mg tablet outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>montelukast sod 4 mg granules</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 4 mg granules outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 4 mg granules outer, foil pkt</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 4 mg tab chew</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 4 mg tab chew 2-5 yrs old</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 4 mg tab chew outer</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
<i>montelukast sod 5 mg tab chew</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
<i>montelukast sod 5 mg tab chew 6-14 yrs old</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
<i>montelukast sod 5 mg tab chew outer</i>	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
SINGULAIR 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
SINGULAIR 4 MG GRANULES	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
SINGULAIR 4 MG TABLET CHEW	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
SINGULAIR 5 MG TABLET CHEW	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
<i>zafirlukast 10 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>zafirlukast 20 mg tablet</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>zafirlukast 20 mg tablet flc</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>zafirlukast 20 mg tablet flc, outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Asthma Therapy - Mast Cell Stabilizers		
<i>cromolyn inhalation</i>	Non-Formulary	
Asthma Therapy - Thymic Stromal Lymphopoietin Inhibitor, Mab		
TEZSPIRE 210 MG/1.91 ML PEN	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
Asthma Therapy - Xanthines		
THEO-24	Non-Formulary	
<i>theophylline 80 mg/15 ml soln</i>	Formulary	
<i>theophylline 80 mg/15 ml solution cup outer</i>	Formulary	
<i>theophylline er 100 mg tablet</i>	Formulary	
<i>theophylline er 200 mg tablet</i>	Formulary	
<i>theophylline er 300 mg tablet</i>	Formulary	
<i>theophylline er 400 mg tablet</i>	Formulary	
<i>theophylline er 450 mg tablet</i>	Formulary	
<i>theophylline er 600 mg tablet</i>	Formulary	
Asthma/Copd - Phosphodiesterase-3 And -4 (Pde3 And Pde4) Inhibitors		
OHTUVAYRE 3 MG/2.5 ML INHAL SUS OUTER	Formulary	PA; QL (2 ampules per 1 day); Age Limit (Min 18 Years)
Asthma/Copd - Phosphodiesterase-4 (Pde4) Inhibitors		
DALIRESP 250 MCG TABLET	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
DALIRESP 500 MCG TABLET	Formulary	PA; PDL Non-Preferred
<i>roflumilast 250 mcg tablet</i>	Formulary	PA; PDL Preferred
<i>roflumilast 250 mcg tablet outer</i>	Formulary	PA; PDL Preferred
<i>roflumilast 500 mcg tablet</i>	Formulary	PA; PDL Preferred
<i>roflumilast 500 mcg tablet outer</i>	Formulary	PA; PDL Preferred
Asthma/Copd - Anticholinergic Agents, Inhaled Long Acting		
INCRUSE ELLIPTA 62.5 MCG INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
SPIRIVA HANDHALER 18 MCG CAP	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
SPIRIVA RESPIMAT 1.25 MCG INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
SPIRIVA RESPIMAT 2.5 MCG INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>tiotropium 18 mcg cap-inhaler outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
TUDORZA PRESSAIR 400 MCG INHAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
YUPELRI 175 MCG/3 ML SOLUTION OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Asthma/Copd - Anticholinergic Agents, Inhaled Short Acting		
ATROVENT 17 MCG HFA INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
<i>ipratropium br 0.02% soln</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 25's,p/f,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 30's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 30's,p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 30's,p/f,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>ipratropium br 0.02% soln 30's,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 60's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln 60's,p/f,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln outer, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln p/f, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln p/f,outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln sdv, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium br 0.02% soln sdv, p/f, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
Asthma/Copd - Beta 2-Adrenergic Agents, Inhaled, Ultra-Long Acting		
STRIVERDI RESPIMAT INHAL SPRAY	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Long Acting		
<i>arformoterol 15 mcg/2 ml soln outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BROVANA 15 MCG/2 ML SOLUTION 30'S, OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
BROVANA 15 MCG/2 ML SOLUTION OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>formoterol 20 mcg/2 ml neb vl</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>formoterol 20 mcg/2 ml neb vl outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PERFORMIST 20 MCG/2 ML SOLN OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
SEREVENT DISKUS 50 MCG	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting		
<i>albuterol 2.5 mg/0.5 ml sol</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol hfa 90 mcg inhaler</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
<i>albuterol sul 0.63 mg/3 ml sol</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 0.63 mg/3 ml sol 30's,pf,stri</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 0.63 mg/3 ml sol outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 0.63 mg/3 ml sol u-d, 25's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 1.25 mg/3 ml sol</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 1.25 mg/3 ml sol outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,25's,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 1.25 mg/3 ml sol p/f,pedia,30's,u-d</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 1.25 mg/3 ml sol u-d, 25's</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln 25's, u-d, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln 30's, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln 30's, u-d, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln 60's, u-d, p/f</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>albuterol sul 2.5 mg/3 ml soln p/f, outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>levalbuterol 0.31 mg/3 ml sol</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
<i>levalbuterol 0.31 mg/3 ml sol outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol 0.63 mg/3 ml sol</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol 0.63 mg/3 ml sol outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol 1.25 mg/3 ml sol</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol 1.25 mg/3 ml sol outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol conc 1.25 mg/0.5 outer</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol conc 1.25 mg/0.5 outer, p/f</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>levalbuterol tar hfa 45 mcg inh</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
PROAIR DIGIHALER 90 MCG INHALR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
PROAIR RESPICLICK 90 MCG INHLR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
VENTOLIN HFA 90 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
VENTOLIN HFA 90 MCG INHALER DOSE COUNTER,200 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
XOPENEX HFA 45 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhaler per 30 days)
<i>Asthma/Copd Therapy - Beta Adrenergic Agents</i>		
<i>albuterol sulfate oral</i>	Non-Formulary	
<i>terbutaline subcutaneous</i>	Non-Formulary	
<i>terbutaline sulfate 2.5 mg tab</i>	Formulary	
<i>terbutaline sulfate 5 mg tab</i>	Formulary	

Medications	Coverage Level	Restrictions
Asthma/Copd Therapy - Beta Adrenergic-Anticholinergic Combinations		
ANORO ELLIPTA 62.5-25 MCG INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
BEVESPI AEROSPHERE INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
COMBIVENT RESPIMAT 20-100 MCG	Formulary	PDL Preferred; 3 Months Allowed; QL (5 inhalers per 90 days)
DUAKLIR PRESSAIR 400-12MCG INH	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml outer</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 30's, 1vll/pouch</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 30's, single vl</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 30's, 5 vls/pouch</i>	Formulary	PDL Preferred; 3 Months Allowed
<i>ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 60's, 5vls/pouch</i>	Formulary	PDL Preferred; 3 Months Allowed
STIOLTO RESPIMAT INHALER (10)	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
STIOLTO RESPIMAT INHALER (60)	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>umeclidinium-vilanterol ellipta 62.5-25 mcg inh</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
Asthma/Copd Therapy - Beta Adrenergic-Glucocorticoid Combinations		
ADVAIR 100-50 DISKUS	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR 250-50 DISKUS	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
ADVAIR 500-50 DISKUS	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 115-21 MCG INHALER DOSE COUNTER, 60 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 115-21 MCG INHALER DOSE COUNTER,120 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 230-21 MCG INHALER DOSE COUNTER, 60 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 230-21 MCG INHALER DOSE COUNTER,120 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 45-21 MCG INHALER DOSE COUNTER, 60 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
ADVAIR HFA 45-21 MCG INHALER DOSE COUNTER,120 INH	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRDUO DIGIHALER 113-14 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRDUO DIGIHALER 232-14 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK 113-14 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK 232-14 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRDUO RESPICLICK 55-14 MCG	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
AIRSUPRA 90-80 MCG INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
BREO ELLIPTA 100-25 MCG INHALR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
BREO ELLIPTA 200-25 MCG INHALR	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
BREO ELLIPTA 50-25 MCG INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days); Age Limit (Max 11 Years)
BREYNA 160-4.5 MCG INHALER	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
BREYNA 80-4.5 MCG INHALER	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
<i>budesonide-formoterol 160-4.5</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
<i>budesonide-formoterol 80-4.5</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
DULERA 100 MCG-5 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
DULERA 200 MCG-5 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
DULERA 50 MCG-5 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days); Age Limit (Max 11 Years)
<i>fluticasone-salmeterol 100-50</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 113-14</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 115-21</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 230-21</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
<i>fluticasone-salmeterol 232-14</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 250-50</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 45-21</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 500-50</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol 55-14</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-vilanterol 100-25</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>fluticasone-vilanterol 200-25</i>	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
SYMBICORT 160-4.5 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
SYMBICORT 80-4.5 MCG INHALER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
WIXELA 100-50 INHUB	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
WIXELA 250-50 INHUB	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
WIXELA 500-50 INHUB	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
<i>Asthma/Copd Tx - Beta-Adrenergic-Anticholinergic-Glucocorticoid Comb,</i>		
BREZTRI AEROSPHERE INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
TRELEGY ELLIPTA 100-62.5-25	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
TRELEGY ELLIPTA 200-62.5-25	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
Cystic Fibrosis - Inhaled Aminoglycosides		
BETHKIS 300 MG/4 ML AMPULE P/F	Formulary	PDL Preferred
BETHKIS 300 MG/4 ML AMPULE P/F, OUTER	Formulary	PDL Preferred
KITABIS PAK 300 MG/5 ML	Formulary	PDL Preferred
TOBI 300 MG/5 ML SOLUTION OUTER	Formulary	PA; PDL Non-Preferred
TOBI PODHALER 28 MG INHALE CAP 1 DAY,W/DEVICE	Formulary	PDL Preferred
TOBI PODHALER 28 MG INHALE CAP OUTER	Formulary	PDL Preferred
<i>tobramycin 300 mg/4 ml ampule</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>tobramycin 300 mg/4 ml ampule outer</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
<i>tobramycin 300 mg/5 ml ampule outer</i>	Formulary	PDL Preferred
<i>tobramycin 300 mg/5 ml ampule plf</i>	Formulary	PDL Preferred
<i>tobramycin 300 mg/5 ml ampule plf, single use</i>	Formulary	PDL Preferred
<i>tobramycin 300 mg/5 ml ampule single use,plf,outer</i>	Formulary	PDL Preferred
<i>tobramycin pak 300 mg/5 ml</i>	Formulary	PA; Brand Preferred; PDL Non-Preferred
Cystic Fibrosis - Inhaled Monobactams		
CAYSTON 75 MG INHAL SOLUTION	Formulary	PDL Preferred
Cystic Fibrosis - Inhaled Osmotic Agents		
BRONCHITOL 40 MG INHALE CAP OUTER	Formulary	PA; QL (560 capsules per 28 days); Age Limit (Min 18 Years)
Cystic Fibrosis-Transmembrane Conductance Regulator (Cftr) Potentiator		
KALYDECO	State Carve Out	
Cystic Fib-Transmemb Conduct. Reg.(Cftr) Potentiator And Corrector Cmb		
ALYFTREK	State Carve Out	
ORKAMBI	State Carve Out	

Medications	Coverage Level	Restrictions
SYMDEKO	State Carve Out	
TRIKAFTA	State Carve Out	
Lung Surfactants		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5 ML	Non-Formulary	
SURVANTA	Non-Formulary	
Mucolytics		
<i>acetylcysteine 10% vial (not for injection) inner</i>	Formulary	
<i>acetylcysteine 10% vial (not for injection) outer</i>	Formulary	
<i>acetylcysteine 10% vial (not for injection) p/f, outer</i>	Formulary	
<i>acetylcysteine 20% vial (not for injection) inner</i>	Formulary	
<i>acetylcysteine 20% vial (not for injection) outer</i>	Formulary	
PULMOZYME 1 MG/ML AMPUL 30'S, OUTER	Formulary	PA; QL (1 ampule per 1 day)
Nasal Anticholinergics		
<i>ipratropium 0.03% spray</i>	Formulary	PDL Preferred
<i>ipratropium 0.06% spray</i>	Formulary	PDL Preferred
Nasal Antihistamine And Anti-Inflammatory Steroid Combinations		
<i>azelastin-flutic 137-50 mcg spr</i>	Formulary	PA; PDL Non-Preferred
DYMISTA NASAL SPRAY	Formulary	PA; PDL Non-Preferred
RYALTRIS 665-25 MCG SPRAY	Formulary	PA; PDL Non-Preferred
Nasal Antihistamines		
<i>azelastine 0.1% (137 mcg) spry</i>	Formulary	PDL Preferred
<i>azelastine 0.15% nasal spray (rx)</i>	Formulary	PDL Preferred; OTC
<i>olopatadine 665 mcg nasal spry</i>	Formulary	PA; PDL Non-Preferred
Nasal Corticosteroids		
24H NASAL ALLERGY 55 MCG SPRAY	Formulary	PA; PDL Non-Preferred; OTC
ALLERGY NASAL 50 MCG SPRAY	Formulary	PA; PDL Non-Preferred; OTC
ALLERGY RELIEF 50 MCG SPRAY	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>budesonide 32 mcg nasal spray (otc)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>flunisolide 0.025% spray</i>	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
<i>fluticasone prop 50 mcg spray (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>fluticasone prop 50 mcg spray (otc)</i>	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>fluticasone prop 50 mcg spray (rx)</i>	Formulary	PDL Preferred; OTC
<i>fluticasone prop 50 mcg spray 120 metered sprays (rx)</i>	Formulary	PDL Preferred; OTC
FT 24H NASAL ALLERGY 55 MCG SPR	Formulary	PA; PDL Non-Preferred; OTC
FT ALLERGY RELIEF 50 MCG SPRAY	Formulary	PA; PDL Non-Preferred; OTC
<i>gnp fluticasone prop 50 mcg sp (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
GS 24 HOUR ALLERGY 50 MCG SPRY	Formulary	PA; PDL Non-Preferred; OTC
GS NASAL ALLERGY 24HR SPRAY	Formulary	PA; PDL Non-Preferred; OTC
HM 24H NASAL ALLERGY 55 MCG SPR	Formulary	PA; PDL Non-Preferred; OTC
<i>mometasone furoate 50 mcg spry (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
<i>mometasone furoate 50 mcg spry (rx)</i>	Formulary	PA; PDL Non-Preferred; OTC
NASAL ALLERGY 24HR SPRAY	Formulary	PA; PDL Non-Preferred; OTC
NASONEX 24HR ALLERGY 50 MCG NASAL SPRAY	Formulary	PA; PDL Non-Preferred; OTC
OMNARIS 50 MCG NASAL SPRAY	Formulary	PA; PDL Non-Preferred
QNASL 80 MCG NASAL SPRAY	Formulary	PA; PDL Non-Preferred
QNASL CHILDREN'S 40 MCG SPRAY	Formulary	PA; PDL Non-Preferred
SM ALLERGY RELIEF 50 MCG SPRAY	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
<i>triamcinolone 55 mcg nasal spr (otc)</i>	Formulary	PA; PDL Non-Preferred; OTC
XHANCE 93 MCG EXHALATION DELIVERY NASAL SPRAY EXHALATION DELIVERY	Formulary	PA; PDL Non-Preferred
ZETONNA 37 MCG NASAL SPRAY	Formulary	PA; PDL Non-Preferred
<i>Nasal Mast Cell Stabilizers</i>		
<i>cromolyn sodium nasal spray</i>	Formulary	Dual Eligible Covered; OTC
<i>Nasal Preparations - Nicotinic Receptor Partial Agonist</i>		
TYRVAYA 0.03 MG NASAL SPRAY OUTER	Formulary	PA; PDL Non-Preferred; QL (8.4 ML per 30 days)
<i>Pulmonary Fibrosis Treatment Agents - Antifibrotic Therapy</i>		
ESBRIET	Non-Formulary	
<i>pirfenidone oral capsule</i>	Non-Formulary	
<i>pirfenidone oral tablet 267 mg, 801 mg</i>	Non-Formulary	

Medications	Coverage Level	Restrictions
Pulmonary Fibrosis Treatment Agents - Multikinase Inhibitors		
OFEV	Non-Formulary	
Systemic Sympathomimetic Decongestants		
<i>pseudoephedrine hcl oral tablet 60 mg</i>	Benefit Exclusion	OTC
SUDOGEST ORAL TABLET 60 MG	Benefit Exclusion	OTC
Vaginal Products		
Vaginal Antibacterial - Lincosamides		
CLEOCIN 100 MG VAGINAL OVULE	Formulary	PDL Preferred
CLEOCIN 2% VAGINAL CREAM W/7 APPLICATORS	Formulary	PA; PDL Non-Preferred
<i>clindamycin 2% vaginal cream</i>	Formulary	PDL Preferred
CLINDESSE 2% VAGINAL CREAM	Formulary	PDL Preferred
XACIATO 2% VAGINAL GEL OUTER	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
Vaginal Antifungal - Imidazoles		
3-DAY VAGINAL CREAM	Formulary	Dual Eligible Covered; OTC
<i>clotrimazole 1% vaginal cream</i>	Formulary	OTC
<i>clotrimazole 1% vaginal cream</i>	Formulary	Dual Eligible Covered; OTC
CLOTRIMAZOLE-3 2% CREAM	Formulary	Dual Eligible Covered; OTC
<i>ft clotrimazole 1% vag cream</i>	Formulary	OTC
FT CLOTRIMAZOLE-3 2% CREAM	Formulary	OTC
FT MICONAZOLE 3 COMBO PACK	Formulary	OTC
<i>ft miconazole 7 cream</i>	Formulary	OTC
GS MICONAZOLE 3 COMBO PACK	Formulary	Dual Eligible Covered; OTC
GS MICONAZOLE 7 CREAM	Formulary	Dual Eligible Covered; OTC
GYNAZOLE-1	Non-Formulary	
<i>miconazole 2% vaginal cream</i>	Formulary	Dual Eligible Covered; OTC
<i>miconazole 3 combo pack</i>	Formulary	OTC
MICONAZOLE 3 COMBO PACK 3 SUPP W/9GM CREAM	Formulary	Dual Eligible Covered; OTC
<i>miconazole 7 100 mg vag supp</i>	Formulary	OTC
<i>miconazole 7 cream</i>	Formulary	Dual Eligible Covered; OTC
MICONAZOLE 7 CREAM	Formulary	Dual Eligible Covered; OTC
<i>miconazole nitrate vaginal kit 1,200-2 mg-%</i>	Non-Formulary	Dual Eligible Covered; OTC
MICONAZOLE-3 VAGINAL SUPPOSITORY	Non-Formulary	

Medications	Coverage Level	Restrictions
<i>miconazole-7 cream</i>	Formulary	Dual Eligible Covered; OTC
SM 3-DAY VAGINAL CREAM	Formulary	Dual Eligible Covered; OTC
<i>sm clotrimazole 1% vag cream</i>	Formulary	Dual Eligible Covered; OTC
<i>sm miconazole 2% vaginal cream w/disp applicators</i>	Formulary	Dual Eligible Covered; OTC
SM MICONAZOLE 3 COMBO PACK	Formulary	OTC
SM MICONAZOLE 3 COMBO PACK W/DISPOSABLE APPLICA	Formulary	Dual Eligible Covered; OTC
SM MICONAZOLE 7 100 MG VAG SUP	Formulary	Dual Eligible Covered; OTC
SM MICONAZOLE 7 CREAM W/REUSABLE APPLIC	Formulary	Dual Eligible Covered; OTC
<i>tioconazole</i>	Non-Formulary	Dual Eligible Covered; OTC
TIOCONAZOLE-1	Non-Formulary	Dual Eligible Covered; OTC
<i>Vaginal Antifungal - Triazoles</i>		
<i>terconazole 0.4% cream</i>	Formulary	
<i>terconazole 0.8% cream</i>	Formulary	
<i>terconazole 0.8% cream 3-day therapy</i>	Formulary	
<i>terconazole vaginal suppository</i>	Non-Formulary	
<i>Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives</i>		
<i>metronidazole vaginal 0.75% gl</i>	Formulary	PDL Preferred
NUVESSA VAGINAL 1.3% GEL	Formulary	PDL Preferred
VANDAZOLE VAGINAL 0.75% GEL	Formulary	PA; PDL Non-Preferred
<i>Vaginal Antiseptic Mixtures</i>		
FEM PH	Non-Formulary	
<i>Vaginal Estrogens</i>		
ESTRACE VAGINAL	Non-Formulary	
<i>estradiol 0.01% cream</i>	Formulary	QL (42.5 GM per 30 days)
<i>estradiol 10 mcg vaginal insrt outer</i>	Formulary	
ESTRING	Non-Formulary	
FEMRING	Non-Formulary	
PREMARIN VAGINAL	Non-Formulary	
VAGIFEM 10 MCG VAGINAL TAB	Formulary	
YUVAFEM 10 MCG VAGINAL INSERT	Formulary	
<i>Vaginal Progestins</i>		
CRINONE 4% GEL OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Weight Loss/Gain Agents		
Anorexiant Combinations		
QSYMIA	Benefit Exclusion	
Anorexiants		
ADIPEX-P 37.5 MG TABLET	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
<i>benzphetamine hcl 50 mg tablet (rx)</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
<i>diethylpropion 25 mg tablet</i>	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
<i>diethylpropion 25 mg tablet</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
<i>diethylpropion er 75 mg tablet</i>	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
<i>diethylpropion er 75 mg tablet</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
LOMAIRA 8 MG TABLET	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
<i>phendimetrazine 35 mg tablet</i>	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
<i>phendimetrazine 35 mg tablet</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
<i>phendimetrazine er 105 mg cap</i>	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
<i>phentermine 15 mg capsule</i>	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
<i>phentermine 15 mg capsule</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
<i>phentermine 30 mg capsule</i>	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
<i>phentermine 30 mg capsule</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)

Medications	Coverage Level	Restrictions
<i>phentermine 37.5 mg capsule</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
<i>phentermine 37.5 mg tablet</i>	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
<i>phentermine 37.5 mg tablet</i>	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
Anti-Obesity - Dual Gip And Glp-1 Receptor Agonists		
ZEPBOUND 10 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
ZEPBOUND 12.5 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
ZEPBOUND 15 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
ZEPBOUND 2.5 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
ZEPBOUND 5 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
ZEPBOUND 7.5 MG/0.5 ML PEN SUV, P/F, OUTER	Formulary	PA; PDL Preferred; QL (2 ML per 28 days); Age Limit (Min 18 Years)
Anti-Obesity - Fat Absorption Decreasing Agents		
<i>orlistat 120 mg capsule</i>	Formulary	PA; PDL Preferred; QL (3 capsules per 1 day); Age Limit (Min 12 Years)
XENICAL 120 MG CAPSULE	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (3 capsules per 1 day); Age Limit (Min 12 Years)
Anti-Obesity - Glucagon-Like Peptide-1 (Glp-1) Receptor Agonists		
SAXENDA 18 MG/3 ML PEN	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (15 ML per 30 days); Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
WEGOVY 0.25 MG/0.5 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (2 ML per 28 days); Age Limit (Min 12 Years)
WEGOVY 0.5 MG/0.5 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (2 ML per 28 days); Age Limit (Min 12 Years)
WEGOVY 1 MG/0.5 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (2 ML per 28 days); Age Limit (Min 12 Years)
WEGOVY 1.7 MG/0.75 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (3 ML per 28 days); Age Limit (Min 12 Years)
WEGOVY 2.4 MG/0.75 ML PEN OUTER,SUV	Formulary	PA; PDL Preferred; Dual Eligible Covered; QL (3 ML per 28 days); Age Limit (Min 12 Years)
Anti-Obesity-Opioid Antag/Norepinephrine And Dopamine Reuptake Inhibit		
CONTRAVE	Benefit Exclusion	
Appetite Stimulants - Cannabinoids		
<i>dronabinol 10 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule</i>	Formulary	PA
<i>dronabinol 2.5 mg capsule outer</i>	Formulary	PA
<i>dronabinol 5 mg capsule</i>	Formulary	PA
<i>dronabinol 5 mg capsule outer</i>	Formulary	PA
MARINOL	Non-Formulary	
Appetite Stimulants - Progestin Hormone Type		
<i>megestrol 400 mg/10 ml cup inner</i>	Formulary	PDL Preferred
<i>megestrol 400 mg/10 ml cup outer</i>	Formulary	PDL Preferred
<i>megestrol 400 mg/10 ml suspension cup outer</i>	Formulary	PDL Preferred
<i>megestrol 625 mg/5 ml susp</i>	Formulary	PA; PDL Non-Preferred
<i>megestrol 800 mg/20 ml suspension cup inner</i>	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
<i>megestrol 800 mg/20 ml suspension cup outer</i>	Formulary	PDL Preferred
<i>megestrol acet 40 mg/ml susp</i>	Formulary	PDL Preferred
<i>Melanocortin 4 (Mc4) Receptor Agonist</i>		
IMCIVREE	State Carve Out	

Index

- 1ST TIER UNIFINE PENTIPS**..... 405, 406, 441, 442
1ST TIER UNIFINE PENTIPS PLUS.....406, 442
24 HOUR ALLERGY RELIEF.....536
24 HOUR NASAL ALLERGY..... 535, 536
24HR ALLERGY RELIEF.....511, 515
3-DAY VAGINAL.....537, 538
8 HOUR PAIN RELIEVER.....22, 24
abacavir.....64
abacavir-lamivudine.....65
abacavir-lamivudine-zidovudine.....65
ABELCET.....58
ABILIFY.....187, 191
ABILIFY ASIMTUFII.....187
ABILIFY MAINTENA.....187
ABILIFY MYCITE MAINTENANCE KIT... 187, 191
ABILIFY MYCITE STARTER KIT..... 187, 191
abiraterone..... 84, 85
ABIRTEGA.....84, 85
ABRILADA(CF).....26, 31, 342
ABRILADA(CF) PEN.....26, 31, 342
ABRYSVO (PF).....105
ABSORICA.....226
ABSORICA LD.....226
acamprosate.....206
ACANYA.....228
acarbose.....276
ACCOLATE.....523, 524
ACCU-CHEK FASTCLIX LANCET DRUM..... 397, 442
ACCU-CHEK SAFE-T-PRO.....397, 442
ACCU-CHEK SAFE-T-PRO PLUS.....398, 442
ACCU-CHEK SOFTCLIX LANCETS.....398, 442
ACCUPRIL.....108
ACCURETIC.....107
ACE AEROSOL CLOUD ENHANCER..... 439, 442
acebutolol..... 140, 141
acetaminophen.....22, 23
acetaminophen-caff-dihydrocod..... 14, 15
acetaminophen-codeine..... 14
acetazolamide..... 160
acetic acid.....354, 503
acetylcysteine.....53, 535
ACID GONE ANTACID..... 318
ACID REDUCER (ESOMEPRAZOLE)..... 332
ACID REDUCER (FAMOTIDINE).....329, 330
ACID REDUCER (LANSOPRAZOLE)..... 331
ACID REDUCER (OMEPRAZOLE).....331
ACID REDUCER COMPLETE (FAMOT)..... 335
acitretin.....238
ACNE MEDICATION.....229
ACTEMRA.....39
ACTEMRA ACTPEN.....39
ACTHAR.....273
ACTHAR SELFJECT.....273
ACTHIB (PF).....103
ACTI-LANCE LANCETS.....398, 442
ACTIMMUNE.....61
ACTIVE FE.....256
ACTIVELLA.....291
ACTONEL.....289
ACTOPLUS MET.....285
ACTOS.....309
ACULAR.....498
ACULAR LS.....498
ACUVAIL (PF).....498
acyclovir.....74, 75, 239
acyclovir sodium.....75
ADACEL(TDAP ADOLESN/ADULT)(PF).....102
adalimumab-aacf..... 26, 31, 342
ADALIMUMAB-AACF(CF) PEN CROHNS.....26, 31, 342
ADALIMUMAB-AACF(CF) PEN PS-UV..... 26, 31, 342
adalimumab-aaty..... 26, 31, 342
ADALIMUMAB-AATY(CF) AI CROHNS..... 26, 31, 342
adalimumab-adaz.....26, 27, 31, 32, 342, 343
adalimumab-adbm...27, 32, 343
ADALIMUMAB-ADBM(CF) PEN CROHNS.....27, 32, 343
ADALIMUMAB-ADBM(CF) PEN PS-UV..... 27, 32, 343
adalimumab-fkjp..... 27, 32, 343
adalimumab-ryvk..... 27, 32, 343
adapalene.....230
*adapalene-benzoyl peroxide*230
ADBRY.....233
ADCIRCA.....169
ADDERALL..... 188, 192, 203
ADDERALL XR.....188, 192
ADDYI.....193
adefovir.....73
ADEMPAS.....168
ADHANSIA XR.....188
ADIPEX-P.....539
ADLARITY.....214
ADMELOG SOLOSTAR U-100 INSULIN.....306
ADMELOG U-100 INSULIN LISPRO.....306
ADTHYZA.....313, 314
ADULT ASPIRIN REGIMEN.....50, 384
ADVAIR DISKUS.....530, 531
ADVAIR HFA.....531
ADVANCED ANTACID-ANTIGAS.....320
ADVANCED TRAVEL LANCETS.....398, 442
ADVATE.....370
ADVOCATE LANCET.....398, 442, 443
ADVOCATE PEN NEEDLE.....406, 442, 443
ADVOCATE SYRINGES.....406, 442
ADYNOVATE.....370
ADZENYS ER.....188, 192
ADZENYS XR-ODT.....188, 192
AEMCOLO.....82
AEROCHAMBER MECHANICAL VENT..439, 443

AEROCHAMBER MINI 439, 443	ALBUKED-5 376 <i>albumin, human 25 %</i> 376 <i>albumin, human 5 %</i> 376	ALLERGY (DIPHENHYDRAMINE) 504, 505, 507, 509
AEROCHAMBER MV. 439, 443	ALBUMINAR 25 % 376	ALLERGY NASAL
AEROCHAMBER PLUS	ALBUMINEX 25 % 376	(MOMETASONE) 535
FLOW-VU 439, 443	ALBUMINEX 5 % 376	ALLERGY RELIEF
AEROCHAMBER PLUS	ALBURX (HUMAN) 25 % 376	(CETIRIZINE) 511, 513, 516, 518
FLOW-VU,L MSK 439, 443	ALBURX (HUMAN) 5 % 376	ALLERGY RELIEF
AEROCHAMBER PLUS	ALBUTEIN 25 % 376	(FEXOFENADINE) 513, 514, 516, 518
FLOW-VU,M MSK 439, 443	ALBUTEIN 5 % 376	ALLERGY RELIEF
AEROCHAMBER PLUS	<i>albuterol sulfate</i> 528, 529	(FLUTICASONE) 535, 536
FLOW-VU,S MSK 439, 443	ALCAINE 500	ALLERGY RELIEF
AEROCHAMBER PLUS Z	<i>alclometasone</i> 241	(LEVOCETIRIZIN) 513, 518
STAT 439, 443	ALCOHOL PADS 99	ALLERGY RELIEF
AEROCHAMBER PLUS Z	ALCOHOL PREP PADS 98, 99	(LORATADINE) 513, 514, 515, 516, 517, 518, 519
STAT LG MSK 439, 443	<i>alcohol swabs</i> 98, 99	ALLERGY
AEROCHAMBER PLUS Z	ALCOHOL WIPES 99	RELIEF(CHLORPHENIRAM
STAT MD MSK 439, 443	ALDACTONE 112, 160	N) 503, 504, 508, 509
AEROCHAMBER PLUS Z	ALDURAZYME 486	ALLERGY
STAT SM MSK 440, 443	ALECENSA 85	RELIEF(DIPHENHYDRAMIN
AEROCHAMBER Z-STAT	<i>alendronate</i> 289	N) 504, 505, 506, 507, 508, 509, 511
PLUS-FLW SG 439, 443	<i>alfuzosin</i> 357	ALLERGY SYRINGE .. 435, 443
AEROTRACH PLUS ... 440, 443	ALHEMO PEN 374	ALLERGY-TIME 503, 508
AEROVENT PLUS 440, 443	ALIQOPA 93, 94	<i>allopurinol</i> 362, 363
AFINITOR 92	<i>aliskiren</i> 169	ALMACONE-2 319
AFINITOR DISPERZ 92	ALKA-SELTZER PLUS	<i>almotriptan malate</i> 195, 196
AFIRMELLE 217	ALLERGY 204, 504, 507	<i>alogliptin</i> 277
AFLURIA TRIV 2024-2025 104	ALKINDI SPRINKLE 294	<i>alogliptin-metformin</i> 286
AFLURIA TRIV 2024-2025	ALL DAY ALLERGY	<i>alogliptin-pioglitazone</i> 286
(PF) 104	(CETIRIZINE) 511, 513, 515, 517, 518, 519	ALOMIDE 501
AFREZZA 302, 303	ALL DAY PAIN RELIEF .. 43, 44	<i>alosepron</i> 339, 347
AFSTYLA 370	ALL DAY RELIEF 44, 45	ALPHAGAN P 502
AGAMREE 294	ALLER-CHLOR 503, 507	ALPHANATE 370
AGRYLIN 383	ALLER-EASE 514, 518	ALPHANINE SD 370
AIMOVIG AUTOINJECTOR 194	ALLERGIST TRAY 1/2 ML	<i>alprazolam</i> 170, 189
AIMSCO LATEX CONDOM	27GX3/8" 435, 443	ALPRAZOLAM INTENSOL 170, 189
..... 433, 443	ALLERGIST TRAY	ALPROLIX 370
AIRDUO DIGIHALER 531	INTRADERMAL BEV .. 435, 443	ALREX 497
AIRDUO RESPICLICK 531	ALLERGIST TRAY	ALTACE 108
AIRSUPRA 531	REGULAR BEVEL 435, 443	ALTAVERA (28) 217
AIRZONE PEAK FLOW	ALLER-G-TIME 504, 507	ALTERNATE SITE
METER 438, 443	ALLERGY 504, 507	LANCET 398, 443
AJOVY AUTOINJECTOR ... 194	ALLERGY	ALTOPREV 131
AJOVY SYRINGE 194	(CHLORPHENIRAMINE) 503, 504, 507, 511	
AKEEGA 93		
AKTEN (PF) 501		
AKYNZEO (NETUPITANT) .. 327		
ALA-HIST IR 503, 507		
ALAWAY 496		
<i>albendazole</i> 57		
ALBUKED-25 376		

ALTRENO	230	<i>amoxicillin-pot clavulanate</i>	56	ANUSOL-HC	53
ALTUVIII	370	<i>amphetamine</i>	188, 192	ANZEMET	324
<i>aluminum hydroxide gel</i>	318	<i>amphetamine sulfate</i>	188, 192, 203	APEXICON E	241
<i>alum-mag hydroxide-simeth</i>	319	<i>amphotericin b</i>	58	APIDRA SOLOSTAR U-100	
ALUNBRIG	85	<i>amphotericin b liposome</i>	58	INSULIN	306
ALVESCO	520	<i>ampicillin</i>	57	APIDRA U-100 INSULIN	306
<i>alvimopan</i>	54	<i>ampicillin sodium</i>	57	APLENZIN	177
ALYACEN 1/35 (28)	218	<i>ampicillin-sulbactam</i>	56	APOKYN	182
ALYACEN 7/17 (28)	223	AMPYRA	492	<i>apomorphine</i>	182
ALYFTREK	534	AMRIX	394	<i>apraclonidine</i>	502
ALYQ	169	ANAFRANIL	178	<i>aprepitant</i>	326
<i>amantadine hcl</i>	182	<i>anagrelide</i>	383	APRETUDE	63
AMBIEN	205	ANA-LEX KIT	53	APRI	218
AMBIEN CR	205	ANALPRAM-HC	53	APRISO	340
AMBISOME	58	ANASPAZ	336, 360	APTENSIO XR	188
<i>ambriasantan</i>	168	<i>anastrozole</i>	87	APTIOM	173
<i>amcinonide</i>	241	ANCOBON	58	APTIVUS	81
AMELUZ	248	ANDROGEL	275	ARANELLE (28)	223
AMETHIA	217	ANGELIQ	291	ARANESP (IN	
AMETHYST (28)	218	ANNOVERA	224	POLYSORBATE)	367, 368
AMICAR	374	ANORO ELLIPTA	530	ARAVA	40
<i>amiloride</i>	161	ANTACID (CALCIUM		ARAZLO	230
<i>amiloride-</i>		CARBONATE)	318, 319	ARCALYST	25
<i>hydrochlorothiazide</i>	161	ANTACID ANTI-GAS	319	AREXVY (PF)	105
<i>aminocaproic acid</i>	374	ANTACID EXT STR		<i>arformoterol</i>	527
<i>amiodarone</i>	127	(CALCIUM CARB)	318, 319	<i>arginine (l-arginine) (bulk)</i>	210, 262
AMITIZA	338, 347	ANTACID EXTRA-		<i>arginine hcl(l-arginine)(bulk)</i>	210, 211, 262, 263
<i>amitriptyline</i>	178	STRENGTH	318	ARICEPT	214
<i>amitriptyline-</i>		ANTACID MAXIMUM		ARIMIDEX	87
<i>chlordiazepoxide</i>	177, 189	STRENGTH	320	<i>aripiprazole</i>	187, 191
AMJEVITA(CF)		ANTACID REGULAR		ARISTADA	187
.....	27, 28, 32, 33, 343, 344	STRENGTH	319	ARISTADA INITIO	187
AMJEVITA(CF)		ANTACID ULTRA		ARIXTRA	376, 377
AUTOINJECTOR		STRENGTH	318	<i>armodafinil</i>	203
.....	27, 28, 32, 33, 343, 344	ANTACID-ANTIGAS ... 319, 320		ARMONAIR DIGHALER ... 520	
<i>amlodipine</i>	151, 152	ANTI-DIARRHEAL (LOPE)-		ARMOUR THYROID	314
<i>amlodipine-atorvastatin</i>	138, 139	ANTI-GAS	322	ARNUITY ELLIPTA	520
<i>amlodipine-benazepril</i>	106	ANTI-DIARRHEAL		AROMASIN	87
<i>amlodipine-olmesartan</i>	115	(LOPERAMIDE)	320, 321	ARTHRITIS PAIN	
<i>amlodipine-valsartan</i>	115	ANTIFUNGAL		(DICLOFENAC)	247, 248
<i>amlodipine-valsartan-</i>		(CLOTRIMAZOLE)	235, 237	ARTHRITIS PAIN RELIEF	
<i>hcthiazid</i>	116	ANTIFUNGAL		(ACETAM)	23, 24
<i>ammonium lactate</i>	241	(MICONAZOLE)	236	ARTHROTEC 50	41
AMMONUL	488	ANTIFUNGAL		ARTHROTEC 75	41
AMNESTEEM	226	(TOLNAFTATE)	237	ARTIFICIAL	
AMONDYS-45	394	ANTI-GAS	336	TEARS(PVALCH-POVID) ... 493	
<i>amoxapine</i>	178	ANTI-ITCH (HC)	243	ARTISS	249
<i>amoxicil-clarithromy-</i>		ANTIVERT	322	ASCOMP WITH CODEINE ... 14	
<i>lansopraz</i>	338	ANUCORT-HC	53		
<i>amoxicillin</i>	56, 57				

<i>ascorbic acid (vitamin c)</i>	270	AUSTEDO	200, 201, 202	<i>balsalazide</i>	340
<i>asenapine maleate</i>	185, 191	AUSTEDO XR	200, 201, 202	<i>balsam peru-castor oil</i>	251
ASHLYNA	217	AUSTEDO XR TITRATION		BALVERSA	89
ASMANEX HFA	520, 521	KT(WK1-4)	201, 202	BALZIVA (28)	218
ASMANEX TWISTHALER ..	521	AUTOSHIELD DUO PEN		BANOPHEN	504, 508
ASPERFLEX (LIDOCAINE)	249	NEEDLE	406, 444	BANZEL	175
<i>aspirin</i>	50, 51, 383, 384, 385	AUVELITY	175	BAQSIMI	273, 274
<i>aspirin,buffd-calcium carb-</i>		AUVI-Q	156	BARACLUE	73
<i>mag</i>	50	AVALIDE	117	BASAGLAR KWIKPEN U-	
<i>aspirin-dipyridamole</i>	383	AVAPRO	120	100 INSULIN	304
ASPRUZYO SPRINKLE	125	AVAR	228	BASAGLAR TEMPO	
ASSURE ID PEN NEEDLE		AVAR LS	228	PEN(U-100)INSLN	304
.....	406, 444	AVAR-E	228	BASE, PCCA POLYPEG	
ASSURE LANCE	398, 444	AVAR-E GREEN	228	.....	210, 212
ASSURE LANCE PLUS		AVAR-E LS	228	BASE, PCCA SYRUP	
.....	398, 444	AVELOX IN NACL (ISO-		VEHICLE	212
ASTAGRAF XL	389	OSMOTIC)	70	BAXDELA	70
ASTHMA CHECK METER		AVIANE	218	BD ALCOHOL SWABS	99
.....	438, 444	AVITA	230	BD ALLERGIST TRAY REG	
ATACAND	120	AVONEX	491	BEVEL	435, 444
ATACAND HCT	117	AYUNA	218	BD ALLERGY SYRINGE	
<i>atazanavir</i>	81	AYVAKIT	94	.....	435, 444
ATELVIA	289	AZACTAM	80	BD ECLIPSE LUER-LOK	
<i>atenolol</i>	141	AZASAN	37, 392, 393	.....	406, 435, 444
<i>atenolol-chlorthalidone</i>	156	AZASITE	502	BD INSULIN SYRINGE	
ATHLETE'S FOOT		<i>azathioprine</i>	37, 38, 393	.....	407, 444, 445
(CLOTRIMAZOLE)	235, 236	<i>azathioprine sodium</i>	38, 393	BD INSULIN SYRINGE	
ATHLETE'S FOOT		<i>azelaic acid</i>	227, 248	(HALF UNIT)	406, 444
(TERBINAFINE)	235	<i>azelastine</i>	496, 535	BD INSULIN SYRINGE	
ATIVAN	170, 189, 205	<i>azelastine-fluticasone</i>	535	MICRO-FINE	407, 445
<i>atomoxetine</i>	189	AZILECT	181	BD INSULIN SYRINGE	
ATORVALIQ	131	<i>azithromycin</i>	77, 78	ULTRA-FINE	
<i>atorvastatin</i>	131, 132	AZOPT	499	.....	406, 407, 444, 445
<i>atovaquone</i>	62	AZOR	115	BD INTEGRA SYRINGE	
<i>atovaquone-proguanil</i>	61	AZSTARYS	188	.....	435, 445
ATRALIN	230	<i>aztreonam</i>	80	BD LO-DOSE MICRO-FINE	
ATRIPLA	65	AZULFIDINE	40, 340	IV	407, 444
<i>atropine</i>	163, 336, 496	AZULFIDINE EN-TABS	40, 340	BD LUER-LOK SYRINGE	
ATROVENT HFA	526	AZURETTE (28)	217	.....	435, 445
AUBAGIO	493	B COMPLEX 100	252	BD MICROTAINER	
AUBRA	218	<i>bacitracin</i>	501	LANCET	398, 445
AUBRA EQ	218	<i>bacitracin-polymyxin b</i>	501	BD NANO 2ND GEN PEN	
AUGMENTIN XR	56	<i>baclofen</i>	394	NEEDLE	407, 445
AUGTYRO	94	BACMIN	261	BD SAFETYGLIDE	
AUROVELA 1.5/30 (21)	218	BACTRIM	57	ALLERGIST TRAY	435, 445
AUROVELA 1/20 (21)	218	BACTRIM DS	57	BD SAFETYGLIDE	
AUROVELA 24 FE	218	BAFIERTAM	492	INSULIN SYRINGE	407, 445
AUROVELA FE 1.5/30 (28)	218	BALANCED SALT	500	BD SAFETYGLIDE	
AUROVELA FE 1-20 (28) ...	218	BALCOLTRA	218	SHIELDING REG	435, 445
AURYXIA	256, 355	BALFAXAR	370		

BD SAFETYGLIDE		BETADINE	234	BOSULIF	94
SYRINGE	407, 435, 445	BETADINE OPHTHALMIC		BP 10-1	228
BD SAFETYGLIDE TB REG		PREP	502	BRAFTOVI	88
BEVEL	435, 445	<i>betaine</i>	488	BREATHERITE MDI	
BD SAFETYGLIDE		<i>betamethasone acet,sod</i>		SPACER	440, 446
TUBERCULIN	435, 446	<i>phos</i>	294	BREATHERITE SPACER-	
BD SLIP TIP SYRINGE		<i>betamethasone dipropionate</i>		MASK, NEO	440, 446
.....	435, 446	.....	241	BREATHERITE SPACER-	
BD TUBERCULIN		<i>betamethasone valerate</i>	241	MASK,ADULT	440, 446
SYRINGE	435, 446	<i>betamethasone, augmented</i>	241	BREATHERITE SPACER-	
BD ULTRA-FINE MICRO		BETAPACE	126, 144	MASK,CHILD	440, 446
PEN NEEDLE	407, 446	BETAPACE AF	126, 144	BREATHERITE SPACER-	
BD ULTRA-FINE MINI PEN		BETASERON	491	MASK,INFANT	440, 446
NEEDLE	407, 446	<i>betaxolol</i>	141, 500	BREATHERITE SPACER-	
BD ULTRA-FINE NANO		<i>bethanechol chloride</i>	362	MASK,S.CHLD	440, 446
PEN NEEDLE	407, 446	BETHKIS	534	BREATHERITE VALVED	
BD ULTRA-FINE ORIG		BETIMOL	500	MDI CHAMBER	440, 446
PEN NEEDLE	407, 446	BETOPTIC S	500	BREATHERITE VALVED	
BD ULTRA-FINE SHORT		BEVESPI AEROSPHERE ...	530	MDI SPACER	440, 446
PEN NEEDLE	407, 446	<i>bexarotene</i>	96, 238	BREO ELLIPTA	531, 532
BD VEO INSULIN SYR		BEXSERO	103	BREXAFEMME	59
(HALF UNIT)	407, 446	BEYAZ	218	BREYNA	532
BD VEO INSULIN		BEYFORTUS	100	BREZTRI AEROSPHERE ...	533
SYRINGE UF	407, 446	<i>bicalutamide</i>	85, 86	BRIELLYN	218
BEANO	336	BICILLIN C-R	81	BRILINTA	383
BEELITH	257	BICILLIN L-A	80	<i>brimonidine</i>	502
BELBUCA	19	BIDIL	169	<i>brimonidine-timolol</i>	499
<i>belladonna alkaloids-opium</i>	337	BIJUVA	291	<i>brinzolamide</i>	499
BELSOMRA	205	BIKTARVY	65	BRISDELLE	311
<i>benazepril</i>	109	BILTRICIDE	57	BRIVIACT	174
<i>benazepril-</i>		<i>bimatoprost</i>	502	BRIXADI	206
<i>hydrochlorothiazide</i>	107	BIMZELX	232	<i>bromfenac</i>	498
BENEFIX	370	BIMZELX AUTOINJECTOR	232	<i>bromocriptine</i>	181
BENICAR	120	BINOSTO	289	BROMSITE	499
BENICAR HCT	117	<i>bisacodyl</i>	351	BRONCHITOL	534
BENLYSTA	40	<i>bismuth subcit k-metronidz-</i>		BROVANA	527
BENZAMYCIN	228	<i>tcn</i>	337, 338	BRUKINSA	88, 94
<i>benznidazole</i>	62	<i>bismuth subsalicylate</i>	321	BRYHALI	238, 241
<i>benzonatate</i>	519	<i>bisoprolol fumarate</i>	141	BSS	500
<i>benzoyl peroxide</i>	229	<i>bisoprolol-</i>		BSS PLUS	500
<i>benzphetamine</i>	539	<i>hydrochlorothiazide</i>	156	<i>budesonide</i> ..	341, 521, 522, 535
<i>benztropine</i>	181	BKEMV	363, 386	<i>budesonide-formoterol</i>	532
<i>bepotastine besilate</i>	496	BLISOVI 24 FE	218	BULLSEYE MINI SAFETY	
BEPREVE	496	BLISOVI FE 1.5/30 (28)	218	LANCETS	398, 446
BERINERT	365	BLISOVI FE 1/20 (28)	218	<i>bumetanide</i>	160, 161
BESER	241	BONJESTA	322	BUPHENYL	488
BESER KIT	245	BOOSTRIX TDAP	102	<i>bupivacaine (pf)</i>	51
BESIVANCE	501	<i>bortezomib</i>	94	<i>bupivacaine hcl</i>	51
BESREMI	90	BORUZU	94	<i>bupivacaine-dextrose-</i>	
<i>beta carotene</i>	267	<i>bosentan</i>	168	<i>water(pf)</i>	51

<i>bupivacaine-epinephrine</i>	52	CALQUENCE	88, 95	CARNITOR	487
<i>bupivacaine-epinephrine (pf)</i>	52	CALQUENCE		CARNITOR (SUGAR-FREE)	
<i>buprenorphine</i>	19, 20	(ACALABRUTINIB MAL)	88, 95	.....	487
<i>buprenorphine hcl</i>	206	CAMBIA	43, 49, 195	CAROSPIR	112, 160
<i>buprenorphine-naloxone</i>	206	CAMCEVI (6 MONTH)	91	<i>carteolol</i>	500
<i>bupropion hcl</i>	177	CAMILA	222	CARTIA XT	147, 148
<i>bupropion hcl (smoking</i>		CAMRESE	217	<i>carvedilol</i>	113, 114
<i>deter)</i>	206	CAMRESE LO	217	<i>carvedilol phosphate</i>	114
<i>buspirone</i>	171	CAMZYOS	155, 156	CASGEVY	371, 386
<i>butalbital-acetaminop-caf-</i>		CANASA	340	CASODEX	86
<i>cod</i>	14	CANCIDAS	59	<i>caspofungin</i>	59
<i>butalbital-acetaminophen</i>	21	<i>candesartan</i>	120, 121	CATHFLO ACTIVASE	389
<i>butalbital-acetaminophen-</i>		<i>candesartan-</i>		CAVERJECT IMPULSE	251
<i>caff</i>	21	<i>hydrochlorothiazid</i>	117	CAYA CONTOURED ..	397, 447
<i>butalbital-aspirin-caffeine</i>	49	<i>capecitabine</i>	87	CAYSTON	534
<i>butenafine</i>	235	CAPEX	241	CAZANT (28)	223
<i>butorphanol</i>	20	CAPLYTA	186	<i>cefaclor</i>	68
BUTRANS	20	CAPRELSA	95	<i>cefadroxil</i>	67
BYDUREON BCISE	279	<i>captopril</i>	109	<i>cefazolin</i>	67
BYETTA	279	<i>captopril-hydrochlorothiazide</i>		<i>cefazolin in dextrose (iso-os)</i>	67
BYLVAY	389	.....	107	<i>cefdinir</i>	69
BYSTOLIC	141	CAPVAXIVE	103	<i>cefepime</i>	69
CABENUVA	64	CARAC	237	<i>cefepime in dextrose 5 %</i>	69
<i>cabergoline</i>	312	CARAFATE	353	<i>cefepime in dextrose, iso-</i>	
CABLIVI	363	CARBAGLU	488	<i>osm</i>	69
CABOMETYX	93	<i>carbamazepine</i>	173, 190	<i>cefixime</i>	69
<i>cabotegravir</i>	63	CARBATROL	173, 190	CEFOTAN	68
CABTREO	229	<i>carbidopa</i>	181	<i>cefotaxime</i>	69
CADUET	139, 140	<i>carbidopa-levodopa</i>	178, 179	<i>cefotetan</i>	68
CAFCIT	193	<i>carbidopa-levodopa-</i>		<i>cefoxitin</i>	68
<i>caffeine citrate</i>	193	<i>entacapone</i>	178	<i>cefoxitin in dextrose, iso-</i>	
CALCIDOL	270	<i>carbinoxamine maleate</i>	504, 508	<i>osm</i>	68
<i>calcipotriene</i>	238	<i>carboxymethylcellulose</i>		<i>cefpodoxime</i>	69
<i>calcipotriene-betamethasone</i>		<i>sodium</i>	494	<i>cefprozil</i>	68
.....	231	CARDIZEM	147	<i>ceftazidime</i>	69
<i>calcitonin (salmon)</i>	291	CARDIZEM CD	147	<i>ceftriaxone</i>	69
<i>calcitriol</i>	238, 270, 487	CARDIZEM LA	147	<i>cefuroxime axetil</i>	68
CALCIUM 500 + D	254	CARDURA	164	<i>cefuroxime sodium</i>	69
CALCIUM 600 + D(3)	254	CARDURA XL	164	CELEBREX	41
<i>calcium acetate(phosphat</i>		CAREFINE PEN NEEDLE		<i>celecoxib</i>	41, 42
<i>bind)</i>	354, 355	.....	408, 446, 447	CELESTONE SOLUSPAN ..	294
CALCIUM ANTACID	318, 319	CAREONE ULTRA THIN		CELEXA	176
<i>calcium carbonate</i>	255, 318	LANCET	398, 447	CELLCEPT	38, 391
<i>calcium carbonate-vitamin</i>		CARETOUCH ALCOHOL		CELONTIN	175
<i>d3</i>	254, 255	PREP PAD	99	CENTANY	234
<i>calcium citrate</i>	255	CARETOUCH INSULIN		CENTANY AT	234
<i>calcium citrate-vitamin d3</i>	254	SYRINGE	408, 447	<i>cephalexin</i>	67, 68
<i>calcium gluconate</i>	255	CARETOUCH PEN		CEQUA	498
CAL-GEST ANTACID	319	NEEDLE	409, 447	CERDELGA	487
CALPHRON	255	<i>carglumic acid</i>	488	CEREBYX	173

CEREZYME	486	CHILD'S ALL DAY		<i>ciprofloxacin-fluocinolone</i>	503
CERTAVITE SENIOR	261	ALLERGY(CETIR)		<i>citalopram</i>	176
CERTAVITE-ANTIOXIDANT		.....	512, 513, 517, 518	<i>citrulline (bulk)</i>	211, 263
.....	262	<i>chlordiazepoxide hcl</i>		CLARAVIS	226
CERVIDIL	273	<i>chlordiazepoxide-clidinium</i>		CLARINEX	514, 517
<i>cetirizine</i>	511, 512, 516, 517	.....	189, 337	<i>clarithromycin</i>	78
<i>cevimeline</i>	491	<i>chlorhexidine gluconate</i>	490	CLEANSING WASH ...	228, 248
CHANTIX	210	<i>chlorprocaine (pf)</i>	52	CLEARLAX	348, 349
CHANTIX CONTINUING		<i>chloroquine phosphate</i>	61	<i>clemastine</i>	504, 508
MONTH BOX	210	<i>chlorpromazine</i>	186	CLEOCIN	76, 537
CHANTIX STARTING		<i>chlorthalidone</i>	162	CLEOCIN HCL	76
MONTH BOX	210	<i>chlorzoxazone</i>	394, 395	CLEOCIN PEDIATRIC	77
CHARLOTTE 24 FE	218	CHOCOLATE LAXATIVE ...	351	CLEOCIN T	227
CHATEAL EQ (28)	218	CHOLBAM	327	CLEVER CHEK LANCETS	
CHEMET	54	<i>cholecalciferol (vit d3)(bulk)</i>		.....	399, 447
CHENODAL	329	.....	212, 271	CLEVER CHOICE	
<i>cherry flavor (bulk)</i>		<i>cholecalciferol (vitamin d3)</i>		CHAMBER-LRG MASK	
.....	211, 212, 213	.....	270, 271, 272	.....	440, 447
CHILD ALLERGY		<i>cholestyramine (with sugar)</i> .128		CLEVER CHOICE	
RELF(CETIRIZINE)		CHOLESTYRAMINE LIGHT		CHAMBER-MED MASK	
.....	512, 513, 517, 518	.....	128	.....	440, 447
CHILDREN'S		<i>chromium chloride</i>	261	CLEVER CHOICE	
ACETAMINOPHEN	23	CIALIS	251, 357	CHAMBER-SM MASK	440, 447
CHILDREN'S ALAWAY	496	CIBINQO	232, 233	CLEVER CHOICE PEAK	
CHILDREN'S ALLERGY		CICLODAN	235	FLOW METER	438, 447
(DIPHENHYD)		CICLODAN KIT	235	CLICKFINE PEN NEEDLE	
.....	504, 505, 506, 508, 509, 511	<i>ciclopirox</i>	235	.....	409, 413, 448, 456
CHILDREN'S ALLERGY		<i>ciclopirox-ure-camph-menth-</i>		CLIMARA	292
RELIEF(FEX)	513, 517	<i>euc</i>	235	CLIMARA PRO	291
CHILDREN'S ALLERGY		<i>cidofovir</i>	70	CLINDACIN ETZ	227
RELIEF(LOR)		<i>cilostazol</i>	383	CLINDACIN P	227
.....	513, 514, 515, 517, 518, 519	CILOXAN	501	CLINDACIN PAC	227
CHILDREN'S CETIRIZINE		CIMDUO	64	<i>clindamycin hcl</i>	77
.....	512, 517	<i>cimetidine</i>	329, 330	<i>clindamycin in 0.9 % sod</i>	
CHILDREN'S CHEWABLE		<i>cimetidine hcl</i>	329	<i>chlor</i>	77
COMPLETE	263	CIMZIA	28, 33, 344	<i>clindamycin in 5 % dextrose</i> ..	77
CHILDREN'S CHEWABLES		CIMZIA POWDER FOR		<i>clindamycin palmitate hcl</i>	77
EXTRA C	265	RECONST	28, 33, 344	CLINDAMYCIN PEDIATRIC .77	
CHILDREN'S IBUPROFEN		CIMZIA STARTER KIT		<i>clindamycin phosphate</i>	
.....	44, 45, 48	.....	28, 33, 344	.....	77, 227, 537
CHILDREN'S		<i>cinacalcet</i>	290	<i>clindamycin-benzoyl</i>	
LORATADINE	513, 517	CINRYZE	365	<i>peroxide</i>	228
CHILDREN'S MAPAP	23	CIPRO	70	<i>clindamycin-tretinoin</i>	229
CHILDREN'S PAIN		CIPRO HC	503	CLINDESSE	537
RELIEVER	23	<i>ciprofloxacin</i>	70	<i>clobazam</i>	171, 189
CHILDREN'S PAIN-FEVER		<i>ciprofloxacin hcl</i>		<i>clobetasol</i>	238, 242
RELIEF	23, 24	.....	70, 71, 501, 503	<i>clobetasol-emollient</i>	242
		<i>ciprofloxacin in 5 % dextrose</i> .71		CLOBEX	242
		<i>ciprofloxacin-</i>		<i>clocortolone pivalate</i>	242
		<i>dexamethasone</i>	503	CLODAN	242

CLODAN KIT	246	COMPACT SPACE		COTEMPLA XR-ODT	188
<i>clomipramine</i>	178	CHAMBER	440, 449	COZAAR	121
<i>clonazepam</i>	171, 189	COMPACT SPACE		<i>cpd vehicle susp.sugar-free</i>	
<i>clonidine</i>	158	CHAMBER-LRG MASK		<i>12</i>	213
<i>clonidine hcl</i>	158, 188	.....	440, 449	<i>creatine monohydrate (bulk)</i>	
<i>clopidogrel</i>	385	COMPACT SPACE		.....	4, 211
<i>clorazepate dipotassium</i>		CHAMBER-MED MASK		CREON	327
.....	171, 189	.....	440, 449	CRESEMBA	59
<i>clotrimazole</i>		COMPACT SPACE		CRESTOR	132, 133
.....	236, 237, 490, 537, 538	CHAMBER-SM MASK	440, 449	CREXONT	179
CLOTTRIMAZOLE-3	537	COMPLERA	66	CRINONE	293, 538
<i>clotrimazole-betamethasone</i>	237	COMPLETE NATAL DHA ...	265	<i>cromolyn</i>	92, 501, 525, 536
<i>clozapine</i>	186	COMPLETENATE	265	CROTAN	250
CLOZARIL	186	COMPRO	323	CRYSSELLE (28)	218
C-NATE DHA	265	CONCERTA	188	CULTURELLE	347
COAGADEx	371	CONDYLOX	247	CUPRIMINE	40, 54
COAGUCHEK LANCETS		CONSTULOSE	348	CURITY ALCOHOL	
.....	399, 448	CONTOUR NEXT TEST		SWABS	99
COARTEM	61	STRIPS	396, 449	CUROSURF	535
COBENFY	186	CONTOUR TEST STRIPS		CUTAQUIG	101
COBENFY STARTER		.....	396, 449	CUVPOSA	491
PACK	186	CONTRAVE	541	<i>cyanocobalamin (vitamin b-</i>	
<i>codeine sulfate</i>	4	CONZIP	4	<i>12)</i>	268, 269
<i>codeine-butalbital-asa-caff</i> ...	14	COPAXONE	492	<i>cyclobenzaprine</i>	395
<i>coenzyme q10 (bulk)</i> ...	211, 253	COPIKTRA	94	CYCLOGYL	496
COGENTIN	181	CORIFACT	371	CYCLOMYDRIL	495
COLACE	352	CORLANOR	163	<i>cyclopentolate</i>	496
COLACE 2-IN-1	350	CORTEF	294	<i>cyclophosphamide</i>	38, 85
COLACE CLEAR	352	CORTENEMA	341	<i>cycloserine</i>	66
COLAZAL	340	CORTIFOAM	341	CYCLOSET	278
<i>colchicine</i>	362	<i>cortisone</i>	294	<i>cyclosporine</i>	38, 389, 498
COLCRYS	362	CORTISPORIN-TC	503	<i>cyclosporine modified</i>	
<i>colesevelam</i>	128	CORTROPHIN GEL	273	.....	38, 389, 390
COLESTID	128	CORTROSYN	251	CYKLOKAPRON	374
<i>colestipol</i>	128, 129	CORVITA	261	CYLTEZO(CF)	28, 33, 344
<i>colistin (colistimethate na)</i>	81	CORVITA 150	256	CYLTEZO(CF) PEN	28, 33, 344
COLOR LANCETS	403, 473	CORVITE	261	CYLTEZO(CF) PEN	
COLY-MYCIN M		CORVITE 150	256	CROHN'S-UC-HS	28, 33, 344
PARENTERAL	81	CORVITE FE	256	CYLTEZO(CF) PEN	
COMBIGAN	499	COSELA	98	PSORIASIS-UV	28, 33, 344
COMBIPATCH	291	COSENTYX	232	CYMBALTA	176, 193
COMBIVENT RESPIMAT ...	530	COSENTYX (2 SYRINGES)	232	<i>cyproheptadine</i>	507, 508
COMBIVIR	65	COSENTYX PEN	232	CYRED	218
COMETRIQ	93	COSENTYX PEN (2 PENS)	232	CYRED EQ	218
COMFORT EZ INSULIN		COSENTYX UNOREADY		CYSTADANE	488
SYRINGE	409, 410, 448, 449	PEN	232	CYSTADROPS	499
COMFORT EZ PEN		COSOPT	499	CYSTAGON	354
NEEDLES	409, 410, 448, 449	COSOPT (PF)	499	CYSTARAN	499
COMIRNATY 2024-25 (12Y		<i>cosyntropin</i>	251	CYTOMEL	314
UP)(PF)	104	COTELIC	92	CYTOTEC	335

CYTOVENE.....69	DEKAS PLUS (FOLIC ACID).....261	DEXAMETHASONE INTENSOL 295
<i>d10 %-0.45 % sodium chloride</i> 252	DEKAS PLUS LIQUID 265	<i>dexamethasone sodium phos (pf)</i> 294
<i>d2.5 %-0.45 % sodium chloride</i> 252	DELESTROGEN 292	<i>dexamethasone sodium phosphate</i>.....295, 497
<i>d5 % and 0.9 % sodium chloride</i> 252	DELSTRIGO.....66	DEXEDRINE SPANSULE 188, 192, 203
<i>d5 %-0.45 % sodium chloride</i> 252	<i>demeclocycline</i> 82	DEXILANT.....331
<i>dabigatran etexilate</i> 387, 388	DEMEROL.....4	<i>dexlansoprazole</i> 331
DAIRY AID 328	DEMEROL (PF).....4	<i>dexmedetomidine</i> 205
DAIRY DIGESTIVE 328	DEMSE 166	<i>dexmedetomidine in 0.9 % nacl</i> 205
DAIRY RELIEF.....328	DENAVIR 239	<i>dexmethylphenidate</i> 188
DAIRY-AID 328	DENTA 5000 PLUS.....489	<i>dextroamphetamine sulfate</i> 188, 192, 203
DAKLINZA 74	DENTA 5000 PLUS SENSITIVE.....489	<i>dextroamphetamine-amphetamine</i> 188, 192, 203
<i>dalfampridine</i> 492	DENTAGEL.....489	<i>dextrose 10 % in water (d10w)</i>.....252
DALIRESP 525, 526	DEPAKOTE.....172, 190	<i>dextrose 20 % in water (d20w)</i>.....252
<i>danazol</i>.....299	DEPAKOTE ER ...172, 190, 194	<i>dextrose 25 % in water (d25w)</i>.....252
DANTRIUM 396	DEPAKOTE SPRINKLES.....172, 190	<i>dextrose 30 % in water (d30w)</i>.....252, 253
<i>dantrolene</i>.....396	DEPEN TITRATABS.....40, 54	<i>dextrose 5 % in water (d5w)</i> 253
DANZITEN 95	DEPO-ESTRADIOL 292	<i>dextrose 5 %-lactated ringers</i>.....252
<i>dapaglifloz propaned-metformin</i>.....281	DEPO-MEDROL.....294	<i>dextrose 5%-0.2 % sod chloride</i> 252
<i>dapagliflozin propanediol</i>....282	DEPO-PROVERA 216	<i>dextrose 50 % in water (d50w)</i>.....252, 253
<i>dapsone</i>.....61, 228	DEPO-SUBQ PROVERA 104.....216	<i>dextrose 70 % in water (d70w)</i>.....252, 253
<i>daptomycin</i> 70	DEPO-TESTOSTERONE ...275	DHIVY.....179
DARAPRIM 61	DERMACINRX LIDOCAN ...249	DIACOMIT 175
<i>darifenacin</i>.....360	DERMACINRX PRENATRIX.....265	DIALYVITE.....252
<i>darunavir</i>.....81	DERMACINRX PRENATRYL.....265	DIALYVITE 3000.....251
<i>darunavir propylene glycolate</i> 81	DERMACINRX PRETRATE 265	DIALYVITE 5000.....261
<i>dasatinib</i> 95	DERMA-SMOOTH/FS BODY OIL 242	DIALYVITE 800.....252
DASETTA 1/35 (28) 218	DERMA-SMOOTH/FS SCALP OIL 242	DIALYVITE SUPREME D ... 252
DASETTA 7/7/7 (28) 223	DERMOTIC OIL 503	DIALYVITE VITAMIN D 270
DAURISMO 90	DESCOVY 64	DIALYVITE VITAMIN D3 MAX.....270
DAYBUE 216	DESFERAL 54	DIASTAT 171, 189
DAYPRO 45	<i>desipramine</i> 178	DIASTAT ACUDIAL 171, 189
DAYSEE.....217	<i>desloratadine</i> 514, 517	<i>diazepam</i> 171, 189
DAYTRANA 188	<i>desmopressin</i> 276	
DAYVIGO.....205	<i>desog-e.estradiolle.estradiol</i> 217	
DDAVP.....276	<i>desonide</i>.....242	
DEBLITANE 222	<i>desoximetasone</i> 242	
DECARA.....270	<i>desvenlafaxine</i>.....176	
<i>deferasirox</i>.....54	<i>desvenlafaxine succinate</i> 176	
<i>deferiprone</i> 54	DETROL.....360	
<i>deferoxamine</i>.....54	DETROL LA.....360, 361	
<i>deflazacort</i>.....294	<i>dexamethasone</i> 294, 295	
DEHYDRATED ALCOHOL....4		
DEKAS ESSENTIAL.....262		

DIAZEPAM INTENSOL		DIURIL.....162	DROPSAFE PEN NEEDLE
.....171, 189		<i>divalproex</i>.....172, 190, 194	.....411, 450
<i>diazoxide</i>.....274		DIVIGEL.....292	<i>drospirenone-e.estradiol-</i>
<i>dichlorphenamide</i>.....160, 393		<i>dobutamine</i>.....157	<i>lm.fa</i>.....218
DICLEGIS.....322		<i>dobutamine in d5w</i>.....157	<i>drospirenone-ethinyl</i>
<i>diclofenac epolamine</i>.....247		<i>docosanol</i>.....239	<i>estradiol</i>.....218, 219
<i>diclofenac potassium</i>		<i>docusate calcium</i>.....352	DROXIA.....386, 387
.....43, 49, 195		<i>docusate sodium</i>.....352	<i>droxidopa</i>.....157
<i>diclofenac sodium</i>		DODEX.....269	DRYSOL DAB-O-MATIC ...238
.....43, 238, 247, 248, 499		<i>dofetilide</i>.....127	DUAKLIR PRESSAIR.....530
<i>diclofenac-misoprostol</i>.....41		DOJOLVI.....262	DUAL ACTION COMPLETE
<i>dicloxacillin</i>.....80		DOLISHALE.....218	.....335
<i>dicyclomine</i>.....337		DOLOBID.....50	DUAL ACTION PAIN
<i>didanosine</i>.....64		<i>donepezil</i>.....214	RELIEVER.....41
<i>diethylpropion</i>.....539		DOPTELET (10 TAB PACK)	DUAVEE.....291
DIFFERIN.....230		.....389	DUETACT.....285
DIFICID.....78		DOPTELET (15 TAB PACK)	DULERA.....532
<i>diflorasone</i>.....242		.....389	<i>duloxetine</i>.....176, 193
DIFLUCAN.....59, 60		DOPTELET (30 TAB PACK)	DULOXICAIN ...176, 193, 203
<i>diflunisal</i>.....50		.....389	DUOBRII.....231
<i>difluprednate</i>.....497		DORYX.....82	DUOPA.....179
DIGESTIVE ENZYME		<i>dorzolamide</i>.....499	DUPIXENT PEN.....233, 523
(ACIDOPH,PEC).....327		<i>dorzolamide-timolol</i>.....499	DUPIXENT SYRINGE .233, 523
DIGESTIVE		<i>dorzolamide-timolol (pf)</i>.....499	DURAMORPH (PF).....5
ENZYMES(MAL,LAC,INV) ..328		DOTTI.....292	DUREX AVANTI BARE
<i>digoxin</i>.....159		DOVATO.....64	REAL FEEL.....433, 450
<i>dihydroergotamine</i>.....195		<i>doxazosin</i>.....164, 165	DUREX EXTRA SENSITIVE
DILANTIN.....173		<i>doxepin</i>.....178, 206, 250	CONDOM.....433, 450
DILANTIN EXTENDED.....173		<i>doxercalciferol</i>.....487	DUREX TROPICAL
DILANTIN INFATABS.....173		DOXY-100.....82	CONDOM.....433, 450
DILANTIN-125.....173		<i>doxycycline hyclate</i>.....83, 491	DUREZOL.....497
DILAUDID.....4		<i>doxycycline monohydrate</i>	<i>dutasteride</i>.....358
<i>diltiazem hcl</i>.....148, 149, 150		.....83, 248	<i>dutasteride-tamsulosin</i>.....354
DILT-XR.....148		<i>doxylamine-pyridoxine (vit</i>	DUVYZAT.....394
<i>dimenhydrinate</i>.....322		<i>b6)</i>.....323	DYANAVAL XR.....188, 192
<i>dimethyl fumarate</i>.....492		DRIZALMA SPRINKLE	DYMISTA.....535
DIOVAN.....121		.....176, 193	E.E.S. 400.....78
DIOVAN HCT.....117		<i>dronabinol</i>.....192, 323, 541	E.E.S. GRANULES.....78
DIPENTUM.....340		<i>droperidol</i>.....51, 323	EASIVENT HOLDING
DIPHEDRYL.....504, 508		DROPLET INSULIN	CHAMBER.....440, 450
<i>diphenhydramine hcl</i>		SYR(HALF UNIT).....410, 450	EASY COMFORT
.....204, 504, 505, 508, 509		DROPLET INSULIN	ALCOHOL PAD.....99
<i>diphenoxylate-atropine</i>.....322		SYRINGE.....410, 450	EASY COMFORT INSULIN
DIPROLENE		DROPLET LANCETS .399, 449	SYRINGE.....411, 450, 451
(AUGMENTED).....242		DROPLET MICRON PEN	EASY COMFORT
<i>dipyridamole</i>.....386		NEEDLE.....410, 450	LANCETS.....399, 451
DISALCID.....50		DROPLET PEN NEEDLE	EASY COMFORT PEN
DISKETS.....5		.....410, 411, 450	NEEDLES.....411, 451
<i>disopyramide phosphate</i>.....125		DROPSAFE ALCOHOL	
<i>disulfiram</i>.....206		PREP PADS.....99	

EASY TOUCH 412, 436, 452, 453	EASY TOUCH UNI-SLIP 412, 436, 453	ELOCTATE 370
EASY TOUCH ALCOHOL PREP PADS.....99	EASY TWIST AND CAP LANCETS.....399, 453	ELURYNG 224
EASY TOUCH FLIPLOCK INSULIN 412, 452	EBGLYSS PEN 233	ELYXYB 195
EASY TOUCH FLIPLOCK SYRINGE 436, 451	EBGLYSS SYRINGE 233	EMBRACE LANCETS 399, 453
EASY TOUCH FLURINGE 436, 452	ECLIPSE SYRINGE ... 436, 453	EMEND.....326, 327
EASY TOUCH FLURINGE FLIPLOCK.....436, 452	<i>econazole nitrate</i> 236	EMFLAZA 296
EASY TOUCH FLURINGE SHEATHLOCK.....436, 452	ECONTRA EZ 224, 225	EMGALITY PEN 194
EASY TOUCH INSULIN SAFETY SYR 411, 451	ECONTRA ONE-STEP 224, 225	EMGALITY SYRINGE .170, 194
EASY TOUCH INSULIN SYRINGE.....411, 412, 451, 452, 453	ED CHLORPED JR 503, 509	EMPAVELI 363, 386
EASY TOUCH LANCETS 399, 452	ED-APAP 23	EMSAM 175
EASY TOUCH LUER LOCK INSULIN 412, 452	<i>edaravone</i>.....393	<i>emtricitabine</i> 64
EASY TOUCH LUER LOCK SYRINGE 436, 452	EDARBI.....121	<i>emtricitabine-tenofovir (tdf)</i> 64
EASY TOUCH PEN NEEDLE 412, 452	EDARBYCLOR 117, 118	EMTRIVA 64
EASY TOUCH SAFETY LANCETS.....399, 452, 453	EDECRIN 161	EMVERM.....57
EASY TOUCH SAFETY PEN NEEDLE.....412, 453	EDEX.....251	EMZAHH 222
EASY TOUCH SHEATHLOCK INSULIN 411, 412, 452	EDLUAR.....205	<i>enalapril maleate</i> 110
EASY TOUCH SHEATHLOCK SYRG-NDL 436, 453	ED-SPAZ 336, 360	<i>enalapril-hydrochlorothiazide</i> 107
EASY TOUCH SHEATHLOCK SYRINGE 436, 453	EDURANT 64	ENBRACE HR.....262
EASY TOUCH TUBERCULIN FLIPLOCK 436, 453	<i>efavirenz</i> 64	ENBREL.....25, 26, 33, 34
EASY TOUCH TUBERCULIN SHEATHLK 436, 453	<i>efavirenz-emtricitabin- tenofov</i>.....66	ENBREL MINI 25, 26, 34
EASY TOUCH TWIST LANCETS.....399, 453	<i>efavirenz-lamivu-tenofov</i> <i>disop</i> 66	ENBREL SURECLICK ...26, 34
	EFFER-K.....260	ENDARI.....251, 262, 387
	EFFEXOR XR.....177	ENDOCET 16, 17, 18
	EFFIENT.....385	ENEMA.....349, 350
	EFUDEX 237	ENEMA DISPOSABLE 349
	EGRIFTA SV 299	ENEMEEZ 352
	ELAPRASE 486	ENEMEEZ PLUS.....352
	<i>electrolyte-48 in d5w</i>.....256	ENGERIX-B (PF).....100
	ELELYSO.....486	ENGERIX-B PEDIATRIC (PF).....100
	ELEPSIA XR 174	ENILLORING 224
	ELESTRIN.....292	ENJAYMO.....363, 365
	<i>eletriptan</i> 196	ENLYTE 273
	ELFABRIO 486	<i>enoxaparin</i> ...378, 379, 380, 381
	ELIDEL.....240	ENPRESSE 223
	ELIGARD 91	ENSKYCE 219
	ELIGARD (3 MONTH) 91	ENSPRYNG 392
	ELIGARD (4 MONTH) 91	ENSTILAR.....231
	ELIGARD (6 MONTH) 91	<i>entacapone</i> 180
	ELIMITE 250	<i>entecavir</i> 73
	ELINEST 219	ENTEREG 54
	ELIQUIS 366	ENTRESTO 119, 120
	ELIQUIS DVT-PE TREAT 30D START 366	ENTRESTO SPRINKLE 120
	ELITE-OB.....261	ENTYVIO PEN 341
	ELLA 224, 225	ENULOSE 327
	ELMIRON 354	ENVARUSUS XR.....390
		ENZYM DIGEST 328
		EOHILIA 296
		EPANED 110

EPCLUSA	74	<i>estazolam</i>	189, 205	EYSUVIS	497
EPIDIOLEX	172	ESTRACE	292, 538	E-Z JECT LANCETS	
EPIDUO FORTE	230	<i>estradiol</i>	292, 293, 538	.....	399, 400, 402, 454, 470
EPIFOAM	246	<i>estradiol valerate</i>	293	E-Z JECT THIN LANCETS	
<i>epinastine</i>	496	<i>estradiol-norethindrone acet</i>	291	.....	402, 470
<i>epinephrine</i>	157, 519	ESTRING	538	EZ SMART LANCETS	400, 454
EPIPEN 2-PAK	157	<i>estrogens-</i>		EZALLOR SPRINKLE	133
EPIPEN JR 2-PAK	157	<i> methyltestosterone</i>	291	<i>ezetimibe</i>	138
EPITOL	173, 190	<i>eszopiclone</i>	205	<i>ezetimibe-simvastatin</i>	140
EPIVIR	64	<i>ethacrynic acid</i>	161	FABHALTA	363, 386
<i>eplerenone</i>	112, 160	<i>ethambutol</i>	67	FABIOR	230
EPOGEN	368	<i>ethosuximide</i>	175	FABRAZYME	486
EPRONTIA	173	<i>ethynodiol diac-eth estradiol</i>	219	FALMINA (28)	219
<i>eprosartan</i>	121	<i>etodolac</i>	49	<i>famciclovir</i>	75, 76
EPYSQLI	363, 386	<i>etonogestrel-ethinyl estradiol</i>		<i>famotidine</i>	330
EPZICOM	65	.....	224	FANAPT	185
EQUETRO	173, 190	<i>etoposide</i>	89	FANTASY CONDOM ..	433, 454
ERAXIS(WATER DILUENT) ..	59	<i>etravirine</i>	64	FARESTON	96
<i>ergocalciferol (vitamin d2)</i>		EUCRISA	233	FARXIGA	282, 283
.....	270, 271	EURAX	250	FASENRA	523
<i>ergoloid</i>	216	EUTHYROX	315	FASENRA PEN	523
ERIVEDGE	90	EVAMIST	293	FC2 FEMALE CONDOM	
ERLEADA	86	EVEKEO	188, 192, 203	.....	397, 454
<i>erlotinib</i>	84	EVEKEO ODT	188, 192	<i>febuxostat</i>	363
ERMEZA	315	<i>everolimus (antineoplastic)</i>		FEIBA NF	365
ERRIN	222	.....	92, 93	FEIRZA	219
ERTACZO	236	<i>everolimus</i>		<i>felbamate</i>	172
ERY PADS	228	<i>(immunosuppressive)</i>	392	FELBATOL	172
ERYGEL	228	EVISTA	312	FELDENE	43
ERYPED 200	78	EVOCLIN	228	<i>felodipine</i>	152
ERYPED 400	78	EVOTAZ	65, 81	FEM PH	538
ERY-TAB	78	EVOXAC	491	FEMARA	88
ERYTHROCIN	78	EVRYSDI	396	FEMCAP	397, 455
ERYTHROCIN (AS		EXCEL SYRINGE	436, 454	FEMRING	538
 STEARATE)	78	EXEL INSULIN	413, 454	<i>fenofibrate</i>	129, 130
<i>erythromycin</i>	79, 502	EXEL SYRINGE	436, 454	<i>fenofibrate micronized</i> ..	129, 130
<i>erythromycin ethylsuccinate</i>		EXELON PATCH	214, 215	<i>fenofibrate nanocrystallized</i>	
.....	78, 79	<i>exemestane</i>	87, 88	.....	129, 130
<i>erythromycin lactobionate</i>	79	<i>exenatide</i>	279	<i>fenofibric acid</i>	130
<i>erythromycin with ethanol</i>	228	EXFORGE	115	<i>fenofibric acid (choline)</i>	130
<i>erythromycin-benzoyl</i>		EXFORGE HCT	116	FENOGLIDE	131
<i> peroxide</i>	228	EXJADE	54	<i>fenopropfen</i>	45
ERZOFRI	185	EXKIVITY	84	FENOPRON	45
ESBRIET	536	EXONDYS-51	394	FENSOLVI	310
<i>escitalopram oxalate</i>	176	EXTINA	236	<i>fentanyl</i>	5
ESGIC	22	EYE ALLERGY ITCH		<i> fentanyl citrate</i>	5, 6
<i>esomeprazole magnesium</i>		 RELIEF	496	<i> fentanyl citrate (pf)</i>	6, 51
.....	331, 332, 335	EYE ALLERGY ITCH-		FENTORA	6
ESPEROCT	370	 REDNESS RLF	496	FERATE	256
ESTARYLLA	219	EYE ITCH RELIEF	496	FERGON	256

FERIVA 21-7	256	FLEET ENEMA	349	<i>fluticasone propionate</i>	.....243, 522, 536
FERIVA FA (WITH SUMALATE)	256	FLEET MINERAL OIL	347	<i>fluticasone propion-salmeterol</i>	532, 533
FEROSUL	256	FLEET PEDIATRIC	349	<i>fluvastatin</i>	133
<i>ferric citrate</i>	256, 355	FLEQSUVY	395	<i>fluvoxamine</i>	176
FERRIPROX	54	FLEXBUMIN 25 %	376	FLUZONE HIGH-DOSE TRIV 24-25	105
FERRIPROX (2 TIMES A DAY)	54	FLEXBUMIN 5 %	376	FLUZONE TRIV 2024-2025	105
FERRO-TIME	256	FLEXICHAMBER	440, 455	FLUZONE TRIV 2024-2025 (PF)	105
<i>ferrous gluconate</i>	256	FLOMAX	357	FML FORTE	497
<i>ferrous sulfate</i>	256, 257	FLORIVA	263	FML LIQUIFILM	497
<i>fesoterodine</i>	361	FLORIVA (FLUORIDE-VITAMIN D3)	489	FOCALIN	188
FETZIMA	177	FLUAD TRIV 2024-25(65Y UP)(PF)	104	FOCALIN XR	188
FEVERALL	23, 24	FLUARIX TRIV 2024-2025 (PF)	104	<i>folic acid</i>	272, 273
FE-VITE	257	FLUBLOK TRIV 2024-2025 (PF)	104	FOLIVANE-F	256
FEXMID	395	FLUCELVAX TRIV 2024-2025	104	FOLIVANE-OB	261
<i>fexofenadine</i>	.....514, 515, 517, 518, 519	FLUCELVAX TRIV 2024-2025 (PF)	104	FOLTRATE	268
FIASP FLEXTOUCH U-100 INSULIN	306	<i>fluconazole</i>	60	<i>fondaparinux</i>	377, 378
FIASP PENFILL U-100 INSULIN	306	<i>fluconazole in nacl (iso-osm)</i>	60	FORACARE LANCETS	.....400, 455
FIASP PUMPCART	306	<i>flucytosine</i>	58, 59	FORFIVO XL	177
FIASP U-100 INSULIN	306	<i>fludrocortisone</i>	311	<i>formoterol fumarate</i>	527
FIBRICOR	131	FLULAVAL TRIV 2024-2025 (PF)	104	FORTEO	288
FIBRYGA	374	FLUMADINE	76	FOSAMAX	289
FINACEA	228, 248	FLUMIST TRIVALENT 2024-2025	101, 104	FOSAMAX PLUS D	289
<i>finasteride</i>	357	<i>flunisolide</i>	535	<i>fosamprenavir</i>	81
FINGERSTIX LANCETS	.....400, 455	<i>fluocinolone</i>	242, 243	<i>foscarnet</i>	69
<i>ingolimod</i>	493	<i>fluocinolone acetonide oil</i>	503	<i>fosfomycin tromethamine</i>	.....58, 359
FINTEPLA	175	<i>fluocinolone and shower cap</i>	.....242	<i>fosinopril</i>	110
FIORICET	22	<i>fluocinonide</i>	243	<i>fosinopril-hydrochlorothiazide</i>	107
FIORICET WITH CODEINE ..	14	FLUOCINONIDE-E	243	<i>fosphenytoin</i>	173
FIRAZYR	147	<i>fluocinonide-emollient</i>	243	FOSRENOL	355, 356
FIRST AID ANTISEPTIC(POVIDONE) ..	234	<i>fluorescein-benoxinate</i>	499, 500	FOTIVDA	95
FIRVANQ	71	<i>fluoride (sodium)</i>	489, 490	FRAGMIN	381, 382
FLAC OTIC OIL	503	<i>fluorometholone</i>	497	FRAICHE 5000	489
FLAGYL	62	<i>fluorouracil</i>	237, 238	FREESTYLE INSULINX	.....396, 455
FLAREX	497	<i>fluoxetine</i>	176	FREESTYLE INSULINX TEST STRIPS	396, 455
FLAVOR BLEND 2 IN 1	213	<i>fluphenazine hcl</i>	186	FREESTYLE LANCETS	.....400, 455
FLAVOR PLUS	213	<i>flurandrenolide</i>	243	FREESTYLE LITE STRIPS	.....396, 455
FLAVOR SWEET	213	<i>flurazepam</i>	190, 205	FREESTYLE PRECISION	.....413, 455
FLAVOR SWEET-SF	213	<i>flurbiprofen</i>	45	FREESTYLE TEST	397, 455
<i>flavoxate</i>	361	<i>flurbiprofen sodium</i>	499		
FLEBOGAMMA DIF	101	<i>fluticasone furoate-vilanterol</i>	533		
<i>flecainide</i>	126				
FLEET BISACODYL	351				
FLEET DOCUSATE	352				

FREESTYLE UNISTIK 2		GENTLE LAXATIVE		GVOKE PFS 1-PACK	
.....	400, 455	(BISACODYL)	351	SYRINGE	274
FROVA	196	GENVOYA	65	GVOKE PFS 2-PACK	
<i>frovatriptan</i>	196	GEODON	185, 191	SYRINGE	274
FRUZAQLA	95	GILENYA	493	GYNAZOLE-1	537
FULPHILA	371	GILOTRIF	84	HADLIMA	28, 34, 344
FUNGOID TINCTURE	236	GIMOTI	336	HADLIMA PUSHTOUCH	
FURADANTIN	57, 359	<i>glatiramer</i>	492	.....	29, 34, 344
<i>furosemide</i>	161	GLATOPA	492	HADLIMA(CF)	29, 34, 344
FUZEON	63	GLEEVEC	95	HADLIMA(CF)	
FYAVOLV	291	<i>glimepiride</i>	283, 284	PUSHTOUCH	29, 34, 345
FYCOMPA	171	<i>glipizide</i>	284, 285	HAEGARDA	365
FYLNETRA	371	<i>glipizide-metformin</i>	283	HAILEY	219
<i>gabapentin</i>	172, 203	GLOPERBA	362	HAILEY 24 FE	219
GABARONE	172	GLUCAGON (HCL)		HAILEY FE 1.5/30 (28)	219
GABITRIL	172	EMERGENCY KIT	274	HAILEY FE 1/20 (28)	219
GALAFOLD	489	GLUCAGON EMERGENCY		<i>halcinonide</i>	243
<i>galantamine</i>	215	KIT (HUMAN)	274	HALCION	190, 205
GALLIFREY	311	GLUCOCOM LANCETS		HALDOL DECANOATE	186
GALZIN	54	.....	400, 456	<i>halobetasol propionate</i>	238, 243
<i>ganciclovir sodium</i>	69	GLUCOTROL XL	285	HALOETTE	224
GARDASIL 9 (PF)	104	GLUMETZA	308	HALOG	243
GAS RELIEF-PREVENTION		<i>glutamine (bulk)</i> ... 211, 263, 387		<i>haloperidol</i>	186
.....	336	<i>glutamine (sickle cell)</i>		<i>haloperidol decanoate</i>	186
GASTRACID	327	.....	251, 262, 387	<i>haloperidol lactate</i>	186
GASTROCROM	92	<i>glyburide</i>	285	HARVONI	74
<i>gatifloxacin</i>	501	<i>glyburide micronized</i>	285	HAVRIX (PF)	100
GATTEX 30-VIAL	353	<i>glyburide-metformin</i>	283	HEALTHWISE PEN	
GAVILAX	348	GLYCATE	337	NEEDLE	414, 457
GAVILYTE-C	349	<i>glycopyrrolate</i>	337, 491	HEALTHY ACCENTS	
GAVILYTE-G	349	GLYDO	249	UNIFINE PENTIP	414, 457
GAVILYTE-N	349	GLYXAMBI	282	HEALTHYLAX	348
GAVICON	318	GOCOVRI	182	HEARTBURN RELIEF	318
GAVICON EXTRA		GOJJI LANCETS	400, 456	HEARTBURN RELIEF	
STRENGTH	318	GOLYTELY	349	(FAMOTIDINE)	330
GAVRETO	96	GOMEKLI	92	HEATHER	222
<i>gefitinib</i>	84	GONITRO	123	HEMADY	296
GELFILM	501	GRALISE	203, 204	HEMANGEOL	144
<i>gemfibrozil</i>	131	<i>granisetron (pf)</i>	324	HEMLIBRA	374
GEMMILY	219	<i>granisetron hcl</i>	324, 325	HEMOFIL M HIGH	370
GEMTESA	354	GRANIX	371, 372	HEMOFIL M LOW	370
GENERLAC	327	<i>griseofulvin microsize</i>	61	HEMOFIL M MID	370
GENGRAF	38, 390	<i>griseofulvin ultramicrosize</i>	61	HEMOFIL M SUPER HIGH	370
GENOTROPIN	299, 300	<i>guanfacine</i>	158, 159, 188	<i>heparin (porcine)</i>	374, 375, 376
GENOTROPIN MINIQUICK	300	GVOKE	274	<i>heparin (porcine) in 5 % dex</i>	374
<i>gentamicin</i>	55, 234, 501	GVOKE HYOPEN 1-PACK		<i>heparin (porcine) in nacl (pf)</i>	374
GENTEAL TEARS SEVERE		.....	274	<i>heparin lock flush (porcine)</i>	
GEL	494	GVOKE HYOPEN 2-PACK		.....	374, 375
GENTEAL TEARS		.....	274	<i>heparin(porcine) in 0.45%</i>	
SEVERE(PETROLAT)	494			<i>nacl</i>	376

<i>heparin, porcine (pf)</i>	374, 376	HUMULIN R REGULAR U-100 INSULN	303	HYRIMOZ(CF) PEDI CROHN STARTER.	29, 35, 345
HEPLISAV-B (PF)	100	HUMULIN R U-500 (CONC) INSULIN	303	HYRIMOZ(CF) PEN	30, 35, 345
HER STYLE	225	HUMULIN R U-500 (CONC) KWIKPEN	303	HYSINGLA ER	7
HETLIOZ	194	HYCAMTIN	97	HYZAAR	118
HETLIOZ LQ	194	<i>hydralazine</i>	159	<i>ibandronate</i>	289, 290
HEXATRIONE	296	HYDREA	87	IBRANCE	88
HIBERIX (PF)	103	<i>hydrochlorothiazide</i>	162	IBSRELA	339
HISTAFLEX	22	<i>hydrocodone bitartrate</i>	6	IBU	46
HISTEX (TRIPROLIDINE)	507, 509	<i>hydrocodone-acetaminophen</i>	15, 16	IBU-200	46
.....	507, 509	<i>hydrocodone-ibuprofen</i>	15, 16	<i>ibuprofen</i>	45, 46, 47, 48
HISTEX PD	507, 509	<i>hydrocortisone</i>	53, 243, 244, 245, 296, 341	IBUPROFEN IB	45, 48
HISTEX PDX	507, 509	<i>hydrocortisone acetate</i>	53, 243, 244	IBUPROFEN JR STRENGTH	47
HORIZANT	202	<i>hydrocortisone butyrate</i>	244	<i>ibuprofen-acetaminophen</i>	41
<i>huber safety needles (disp.)</i>	436, 454	HYDROCORTISONE PLUS	245, 246	<i>ibuprofen-famotidine</i>	41
HULIO(CF)	29, 34, 345	<i>hydrocortisone sod succinate</i>	296	<i>icatibant</i>	147
HULIO(CF) PEN	29, 34, 345	<i>hydrocortisone valerate</i>	244	ICLEVIA	219
HUMALOG JUNIOR KWIKPEN U-100	307	<i>hydrocortisone-acetic acid</i> ...	503	ICLUSIG	93
HUMALOG KWIKPEN INSULIN	306, 307	<i>hydrocortisone-aloe vera</i>	246	<i>icosapent ethyl</i>	137
HUMALOG MIX 50-50 KWIKPEN	303	<i>hydrocortisone-iodoquinol</i> ...	237	IDACIO(CF)	30, 35, 346
HUMALOG MIX 75-25 KWIKPEN	303	<i>hydrocortisone-pramoxine</i>	53, 244	IDACIO(CF) PEN	30, 35, 346
HUMALOG MIX 75-25(U-100)INSULN	303	<i>hydromorphone</i>	6, 7	IDACIO(CF) PEN CROHN-UC STARTR	30, 35, 346
HUMALOG TEMPO PEN(U-100)INSULN	307	<i>hydromorphone (pf)</i>	6	IDACIO(CF) PEN PSORIASIS START	30, 35, 346
HUMALOG U-100 INSULIN	306	<i>hydroquinone</i>	240	IDELVION	370
HUMATE-P	371	<i>hydroxocobalamin</i>	269	IDHIFA	93
HUMATROPE	300	<i>hydroxychloroquine</i>	36, 62	IGALMI	205
HUMIRA	29, 34, 345	<i>hydroxyurea</i>	87	ILARIS (PF)	25
HUMIRA PEN	29, 34, 345	<i>hydroxyzine hcl</i>	170	ILEVRO	499
HUMIRA(CF)	29, 34, 35, 345	<i>hydroxyzine pamoate</i>	170	ILUMYA	231
HUMIRA(CF) PEN ...	29, 35, 345	HYFTOR	247	<i>imatinib</i>	95
HUMIRA(CF) PEN CROHNS-UC-HS	29, 35, 345	HYMPAVZI PEN	374	IMBRUVICA	88, 95
HUMIRA(CF) PEN PEDIATRIC UC	29, 35, 345	<i>hyoscyamine sulfate</i>	336, 360	IMCIVREE	542
HUMIRA(CF) PEN PSOR-UV-ADOL HS	29, 35, 345	HYOSYNE	336, 337, 360	IMFINZI	97
HUMULIN 70/30 U-100 INSULIN	301	HYPERRHO S/D	101	<i>imipenem-cilastatin</i>	67
HUMULIN 70/30 U-100 KWIKPEN	301	HYPERSAL	212	<i>imipramine hcl</i>	178
HUMULIN N NPH INSULIN KWIKPEN	302	HYRIMOZ	29, 35, 345	<i>imipramine pamoate</i>	178
HUMULIN N NPH U-100 INSULIN	302	HYRIMOZ PEN	29, 35, 345	<i>imiquimod</i>	246, 247
		HYRIMOZ PEN CROHN'S-UC STARTER	30, 35, 345	IMITREX	196
		HYRIMOZ PEN PSORIASIS STARTER	30, 35, 346	IMITREX STATDOSE PEN	196
		HYRIMOZ(CF)	29, 35, 345	IMITREX STATDOSE REFILL	196

INCASSIA	222	<i>insulin syrlndl u100 half</i>	ISOLYTE-P IN 5 %
IN-CHECK NASAL WITH		<i>mark</i>	DEXTROSE
MASK	438, 457		256
IN-CHECK ORAL FLOW		INSULIN SYRINGE	ISOLYTE-S
METER	438, 457	....	259
INCONTROL ALCOHOL		407, 416, 423, 445, 459, 471	<i>isoniazid</i>
PADS	99	INSULIN SYRINGE	66
INCONTROL PEN NEEDLE		MICROFINE	ISOPTO ATROPINE
.....	414, 415, 457	407, 444	496
INCONTROL SUPER THIN		<i>insulin syringe-needle u-100</i>	ISORDIL
LANCETS	400, 457	406, 407, 408, 412, 413, 415,	124
INCONTROL ULTRA THIN		416, 417, 418, 420, 422, 423,	ISORDIL TITRADOSE
LANCETS	400, 457	424, 425, 426, 427, 428, 429,	124
INCRELEX	310	443, 444, 446, 447, 454, 455,	<i>isosorbide dinitrate</i>
INCRUSE ELLIPTA	526	456, 457, 458, 459, 460, 461,	124
<i>indapamide</i>	162	462, 465, 468, 469, 470, 471,	<i>isosorbide mononitrate</i>
INDERAL LA	144, 145	473, 476, 478, 479, 480	124
INDERAL XL	145	<i>insulin u-500 syringe-needle</i>	<i>isotretinoin</i>
<i>indomethacin</i>	49	.....	226, 227
<i>indomethacin sodium</i>	164	416, 459	<i>isradipine</i>
INFANT PAIN RELIEVER	24	INSUPEN PEN NEEDLE	152
INFANT'S IBUPROFEN		.....	ISTALOL
.....	45, 46, 47, 49	417, 418, 460	500
INFANTS' PAIN AND		INTEGRA SYRINGE ... 436, 460	ISTURISA
FEVER	24	INTELENCE	273
INFED	257	64	ITCH RELIEF (HC)
INFLECTRA	30, 35, 346	INTRAROSA	243
INFUMORPH P/F	7	311	ITCH RELIEF (HC) WITH
INFUVITE ADULT	262	INTUNIV ER	ALOE
INGREZZA	201, 202	188	246
INGREZZA INITIATION		INVACARE LANCETS 400, 460	ITOVEBI
PK(TARDIV)	201, 202	INVEGA	94
INGREZZA SPRINKLE		185	<i>itraconazole</i>
.....	201, 202	INVEGA HAFYERA	60
INJECT EASE LANCETS		INVEGA SUSTENNA	<i>ivabradine</i>
.....	400, 457	185	163
INLYTA	95	INVEGA TRINZA	<i>ivermectin</i>
INNOPRAN XL	145	185	57, 248, 250
INPEFA	279	INVELTYS	IWILFIN
INQOVI	97	497	93
INREBIC	90	INVIRASE	IXCHIQ (PF)
INSPIRA	112, 160	81	101, 104
<i>insulin asp prt-insulin aspart</i> 304		INVOKAMET	IXIARO (PF)
<i>insulin aspart u-100</i>	307	281	105
<i>insulin degludec</i>	304	INVOKAMET XR	IXINITY
<i>insulin glargine u-300 conc</i>		281	370
.....	304, 305	INVOKANA	IYUZEH (PF)
<i>insulin glargine-yfgn</i>	305	283	502
<i>insulin lispro</i>	307	IONOSOL-MB IN D5W	JADENU
<i>insulin lispro protamin-lispro</i> 304		256	54
		IOPIDINE	JADENU SPRINKLE
		502	54
		IPOL	JAIMIESS
		105	217
		<i>ipratropium bromide</i>	JAKAFI
		.....	90
		526, 527, 535	JANTOVEN
		<i>ipratropium-albuterol</i>	363, 364
		530	JANUMET
		<i>irbesartan</i>	286
		121, 122	JANUMET XR
		<i>irbesartan-</i>	286, 287
		<i>hydrochlorothiazide</i>	JANUVIA
		118	277
		IRENKA	JARDIANCE
		177, 193	283
		IRESSA	JASMIEL (28)
		84	219
		IRON	JATENZO
		257	275
		IRON CHEWS	JAVYGTOR
		257	489
		IROSPAN 24/6	JAYPIRCA
		256	88, 95
		ISENTRESS	JEMPERLI
		63	97
		ISENTRESS HD	JENCYCLA
		63	222
		ISIBLOOM	JENTADUETO
		219	287
		ISOLYTE S PH 7.4	JENTADUETO XR
		259	287
			JINTELI
			291
			JIVI
			371
			JOLESSA
			219
			JORNAY PM
			189
			JOYEAUX
			219
			JUBLIA
			237
			JULEBER
			219

JULUCA.....	64	KIMONO MICROTHIN		LACTASE FAST ACTING..	329
JUNEL 1.5/30 (21).....	219	LARGE CONDOMS....	433, 461	<i>lactated ringers</i>	266
JUNEL 1/20 (21).....	219	KIMONO TEXTURED		LACTOSE FAST ACTING	
JUNEL FE 1.5/30 (28).....	219	CONDOMS.....	433, 461	RELIEF.....	329
JUNEL FE 1/20 (28).....	219	KIMONO THIN		<i>lactulose</i>	327, 348
JUNEL FE 24.....	219	LUBRICATED CONDOMS		LAMICTAL.....	174
JUXTAPID.....	140	.....	433, 461	LAMICTAL ODT.....	174, 190
JYLAMVO.....	36, 86	KINERET.....	39	LAMICTAL ODT STARTER	
JYNARQUE.....	357	KIONEX (WITH SORBITOL)		(BLUE).....	174, 190
JYNNEOS (PF).....	101, 105	.....	253	LAMICTAL ODT STARTER	
KAITLIB FE.....	219	KIPROFEN.....	47	(GREEN).....	174, 190
KALBITOR.....	166	KISQALI.....	88	LAMICTAL ODT STARTER	
KALETRA.....	65	KISQALI FEMARA CO-		(ORANGE).....	174, 190
KALLIGA.....	219	PACK.....	90	LAMICTAL STARTER	
KALYDECO.....	534	KITABIS PAK.....	534	(BLUE) KIT.....	174, 190
KAOPECTATE (BISMUTH		KLARON.....	228	LAMICTAL STARTER	
SUBSALICY).....	321	KLAYESTA.....	235	(GREEN) KIT.....	174, 191
KAPSPARGO SPRINKLE..	142	KLONOPIN.....	171, 190	LAMICTAL STARTER	
KARBINAL ER.....	505, 509	KLOR-CON.....	260	(ORANGE) KIT.....	174, 191
KARIVA (28).....	217	KLOR-CON 10.....	260	LAMICTAL XR.....	174
KATERZIA.....	152	KLOR-CON 8.....	260	LAMICTAL XR STARTER	
KAZANO.....	287	KLOR-CON M10.....	260	(BLUE).....	174
KCENTRA.....	370	KLOR-CON M15.....	260	LAMICTAL XR STARTER	
KELNOR 1/35 (28).....	219	KLOR-CON M20.....	260	(GREEN).....	174
KELNOR 1/50 (28).....	219	KLOR-CON/EF.....	260	LAMICTAL XR STARTER	
KENALOG.....	244, 296	KLOXXADO.....	54	(ORANGE).....	174
KENALOG-80.....	296	KOATE.....	371	<i>lamivudine</i>	64, 73
KEPPRA.....	174	KOGENATE FS.....	371	<i>lamivudine-zidovudine</i>	65
KEPPRA XR.....	174	KONVOMEF.....	335	<i>lamotrigine</i>	174, 191
KERENDIA.....	112	KORLYM.....	280	LAMPIT.....	62
KESIMPTA PEN.....	491	KOSELUGO.....	92	LAMZEDE.....	486
<i>ketoconazole</i>	59, 236	KOVALTRY.....	371	<i>lancets</i>	
KETODAN.....	236	K-PHOS NO 2.....	358	398, 399, 400, 401, 402, 403,	
KETODAN KIT.....	236	K-PHOS ORIGINAL.....	358	404, 443, 444, 446, 449, 454,	
KETONE CARE.....	441, 449	K-PHOS-NEUTRAL....	259, 358	455, 461, 462, 463, 468, 469,	
KETONE URINE TEST		KRAZATI.....	90	471, 472, 473, 478	
.....	441, 460, 471	KRINTAFEL.....	62	LANCETS, SUPER THIN	
<i>ketoprofen</i>	47	KRISTALOSE.....	348	.....	400, 461
<i>ketorolac</i>	42, 499	K-TAB.....	260	LANCETS, THIN	
KETOSTIX.....	441, 460	KURVELO (28).....	219	....	401, 404, 405, 462, 476, 485
<i>ketotifen fumarate</i>	496, 497	KUVAN.....	489	LANCETS, ULTRA THIN	
KEVEYIS.....	393	KYPROLIS.....	94	.....	405, 485
KEVZARA.....	39	<i>l norgest/le.estradiol-e.estrad</i>		<i>lanreotide</i>	312
KIMMTRAK.....	98	.....	217, 223	<i>lansoprazole</i>	332, 335
KIMONO LUBRICATED		<i>labetalol</i>	114	<i>lanthanum</i>	356
CONDOMS.....	433, 460	<i>lacosamide</i>	172	LANTUS SOLOSTAR U-	
KIMONO MICROTHIN		LACRISERT.....	494	100 INSULIN.....	305
AQUA LUBE CON.....	433, 460	LACTAID.....	328	LANTUS U-100 INSULIN....	305
KIMONO MICROTHIN		LACTAID FAST ACT.....	329	<i>lapatinib</i>	84
CONDOMS.....	433, 461	<i>lactase</i>	329	LARIN 1.5/30 (21).....	220

LARIN 1/20 (21)	220	<i>levorphanol tartrate</i>	7	<i>lisinopril-hydrochlorothiazide</i>	107, 108
LARIN 24 FE	220	LEVO-T	315	LITEAIRE MDI CHAMBER	440, 462
LARIN FE 1.5/30 (28)	220	<i>levothyroxine</i>	315, 316	LITFULO	250
LARIN FE 1/20 (28)	220	LEVOXYL	316, 317	<i>lithium carbonate</i>	192
LASIX	161	LEVSIN	337, 360	<i>lithium citrate</i>	192
LASTACAFT ONCE DAILY RELIEF	497	LEVSIN/SL	337, 360	LITHOBID	192
<i>latanoprost</i>	502	LEVULAN	248	LITHOSTAT	358
LATUDA	185	LEXAPRO	176	LIVALO	134
LAXATIVE (BISACODYL) ..	351	LEXIVA	81	LIVMARLI	389
LAXATIVE (SENNOSIDES)	351	L-GLUTAMINE	211, 263, 387	LIVTENCITY	70
LAXATIVE PEG 3350	349	LIALDA	340	L-METHYLFOLATE FORTE	273
LAYOLIS FE	220	LIBERVANT	171, 190	LO LOESTRIN FE	217
LAZCLUZE	84	LIBRAX (WITH CLIDINIUM)	190, 337	LOCOID	244
L-CITRULLINE	211, 263	LICE KILLING	250	LOCOID LIPOCREAM	244
<i>ledipasvir-sofosbuvir</i>	74	LICE KILLING (PERMETHRIN)	250	LODOSYN	181
LEENA 28	223	LICE TREATMENT	250	LOESTRIN 1.5/30 (21)	220
<i>leflunomide</i>	40	<i>lidocaine</i>	249	LOESTRIN 1/20 (21)	220
<i>lenalidomide</i>	96, 97	<i>lidocaine (pf)</i>	51	LOESTRIN FE 1.5/30 (28-DAY)	220
LENVIMA	95	<i>lidocaine hcl</i>	52, 249, 490	LOESTRIN FE 1/20 (28-DAY)	220
LESCOL XL	133	<i>lidocaine hcl-hydrocortison ac</i>	53, 246	LOFENA	43
LESSINA	220	LIDOCAINE PAIN RELIEF	249	<i>lofexidine</i>	206
LETAIRIS	168	LIDOCAINE VISCOUS	490	LOJAIMIESS	217
<i>letrozole</i>	88	<i>lidocaine-epinephrine</i>	52	LOKELMA	253
<i>leucovorin calcium</i>	98	<i>lidocaine-epinephrine (pf)</i>	52	LOMAIRA	539
LEUKINE	373	<i>lidocaine-hydrocortisone-aloe</i>	53	LOMOTIL	322
<i>leuprolide</i>	91	<i>lidocaine-prilocaine</i>	247	LONSURF	87
<i>leuprolide (3 month)</i>	91	LIDOCAN III	249	<i>loperamide</i>	320, 321
<i>levabuterol hcl</i>	528, 529	LIDOCAN IV	249	<i>loperamide-simethicone</i>	322
<i>levabuterol tartrate</i>	529	LIDOCAN V	249	LOPID	131
<i>levamlodipine</i>	152	LIDOCORT	246	<i>lopinavir-ritonavir</i>	65
LEVEMIR FLEXPEN	305	LIDODERM	249	LOPRESSOR	142
LEVEMIR U-100 INSULIN ..	305	LIDOTRAL	249	LOPROX (AS OLAMINE) ...	235
<i>levetiracetam</i>	174	LIFESHIELD BLUNT CANNULA	436, 462	LOPROX KIT	235
<i>levetiracetam in nacl (iso-os)</i>	174	LIKMEZ	63	<i>loratadine</i>	514, 515, 517, 518, 519
<i>levobunolol</i>	500	LINCOCIN	77	<i>lorazepam</i>	171, 190, 205
<i>levocarnitine</i>	251, 487	<i>lincomycin</i>	77	LORAZEPAM INTENSOL	171, 190
<i>levocarnitine (with sugar)</i>	487	<i>linezolid</i>	80	LORBRENA	85
<i>levocetirizine</i>	513, 518, 519	LINZESS	327, 338, 339	LOREEV XR	171, 190
<i>levofloxacin</i>	71	<i>liothyronine</i>	314, 315	LORYNA (28)	220
<i>levomefolate calcium</i>	273	LIPITOR	133, 134	LORZONE	395
LEVONEST (28)	223	LIPOFEN	131	<i>losartan</i>	122
<i>levonorgest-eth.estradiol-iron</i>	220	LIQREV	169	<i>losartan-hydrochlorothiazide</i>	118
<i>levonorgestrel</i>	225	<i>liraglutide</i>	279	LOTEMAX	497
<i>levonorgestrel-ethinyl estrad</i>	220	<i>lisdexamfetamine</i>	189		
<i>levonorg-eth estrad triphasic</i>	223	<i>lisinopril</i>	110, 111		
LEVORA-28	220				

LOTEMAX SM	497	LYSTEDA	374	MATZIM LA	150
LOTENSIN	111	LYTGOBI	89	MAVENCLAD (10 TABLET PACK)	492
LOTENSIN HCT	108	LYUMJEV KWIKPEN U-100 INSULIN	307	MAVENCLAD (4 TABLET PACK)	492
<i>loteprednol etabonate</i>	497	LYUMJEV KWIKPEN U-200 INSULIN	307	MAVENCLAD (5 TABLET PACK)	492
LOTREL	106	LYUMJEV TEMPO PEN(U- 100)INSULN	307	MAVENCLAD (6 TABLET PACK)	492
LOTREXONE	4	LYUMJEV U-100 INSULIN	307	MAVENCLAD (7 TABLET PACK)	492
LOTRIMIN AF (CLOTRIMAZOLE)	236	LYVISPAH	395	MAVENCLAD (8 TABLET PACK)	492
LOTRONEX	339, 347	LYZA	222, 223	MAVENCLAD (9 TABLET PACK)	492
<i>lovastatin</i>	134	MACROBID	58, 359	MAVYRET	74
LOVENOX	382	<i>mafenide acetate</i>	240	MAX SLEEP JUNIOR	193
LOW-OGESTREL (28)	220	MAG-AL	318	MAXALT	196
<i>loxapine succinate</i>	186	MAG-AL PLUS	320	MAXALT-MLT	196
LO-ZUMANDIMINE (28)	220	MAG-AL PLUS EXTRA STRENGTH	320	MAXICOMFORT II PEN NEEDLE	419, 462
<i>lubiprostone</i>	338, 347	MAGELLAN INSULIN SAFETY SYRNG	419, 462	MAXI-COMFORT INSULIN SYRINGE	419, 462
LUBRICANT EYE	494	MAGELLAN SYRINGE	419, 436, 462	MAXICOMFORT SAFETY PEN NEEDLE	419, 462
LUBRICANT EYE (PROPYL GLYCOL)	494	<i>magnesium amino acid chelate</i>	257	MAXIDEX	497
LUBRICANT EYE DROPS	494	<i>magnesium chloride</i>	257	MAXITROL	495
LUBRICATING PLUS	494	<i>magnesium citrate</i>	257, 348	MAYZENT	493
LUBRIFRESH PM	494	<i>magnesium gluconate</i>	257	MAYZENT STARTER(FOR 1MG MAINT)	493
LUCEMYRA	206	<i>magnesium hydroxide</i>	348	MAYZENT STARTER(FOR 2MG MAINT)	493
LUGOLS	100	<i>magnesium oxide</i>	257, 258, 319	MB CAPS	79, 359
<i>luliconazole</i>	236	<i>magnesium sulfate</i>	258	M-DRYL	505, 509
LUMAKRAS	90, 91	<i>magnesium sulfate in d5w</i>	258	<i>meclizine</i>	322
LUMIGAN	502	<i>magnesium sulfate in water</i>	258	<i>meclofenamate</i>	42
LUMIZYME	487	MALARONE	61	MEDISENSE THIN LANCETS	401, 462
LUNESTA	205	MALARONE PEDIATRIC	61	MEDLANCE PLUS LANCETS	401, 462, 463
LUPKYNIS	390	<i>malathion</i>	250	MEDROL	296
LUPRON DEPOT	91, 310	<i>manganese chloride</i>	258	MEDROL (PAK)	296
LUPRON DEPOT (3 MONTH)	91, 310	MAPAP (ACETAMINOPHEN)	25	<i>medroxyprogesterone</i>	217, 311, 312
LUPRON DEPOT (4 MONTH)	91	<i>maprotiline</i>	178	<i>mefenamic acid</i>	42
LUPRON DEPOT (6 MONTH)	91	<i>maraviroc</i>	63	<i>mefloquine</i>	62
LUPRON DEPOT-PED	310	MARCAINE	52	MEGA MULTI FOR WOMEN	261
LUPRON DEPOT-PED (3 MONTH)	310	MARCAINE (PF)	52	MEGA MULTIVITAMIN FOR MEN	261
<i>lurasidone</i>	185	MARCAINE SPINAL (PF)	52		
LUTERA (28)	220	MARCAINE-EPINEPHRINE	52		
LUZU	236	MARCAINE-EPINEPHRINE (PF)	52		
LYBALVI	187, 188, 191	MARINOL	192, 323, 541		
LYFGENIA	371, 386	MARLISSA (28)	220		
LYLEQ	222	MARNATAL-F	265		
LYNPARZA	94	MARPLAN	175		
LYRICA	172, 193	MATULANE	85		
LYRICA CR	193, 203, 204				
<i>lysine hcl (bulk)</i>	211, 263				
LYSODREN	85				

<i>megestrol</i>	94, 541, 542	<i>methotrexate sodium (pf)</i>	36, 37, 86	MICROCHAMBER	440, 463
MEKINIST	92	<i>methoxsalen</i>	238	MICROGESTIN 1.5/30 (21) ..	220
MEKTOVI	92	<i>methscopolamine</i>	337	MICROGESTIN 1/20 (21)	220
<i>melatonin</i>	193	<i>methsuximide</i>	175	MICROGESTIN FE 1.5/30	
<i>meloxicam</i>	43	<i>methyldopa</i>	159	(28)	220
<i>meloxicam submicronized</i>	43	<i>methyldopa-</i>		MICROGESTIN FE 1/20	
<i>memantine</i>	215, 216	<i>hydrochlorothiazide</i>	157	(28)	220
<i>memantine-donepezil</i>	216	<i>methylergonovine</i>	311	MICROLET LANCET ..	401, 463
MENACTRA (PF)	103	METHYLIN	189, 203	MICROLIFE PEAK FLOW	
MENEST	293	<i>methylphenidate</i>	189	METER	439, 463
MENOSTAR	293	<i>methylphenidate hcl</i>	189, 203	MICROSPACER	440, 463
MENQUADFI (PF)	103	<i>methylprednisolone</i>	296, 297	<i>midazolam</i>	190, 205
MENSTRUAL		<i>methylprednisolone acetate</i>		<i>midodrine</i>	157
RELIEF(PAMABR-PYRIL)	22	.....	296, 297	MIEBO (PF)	495
MENVEO A-C-Y-W-135-DIP		<i>methylprednisolone sodium</i>		<i>mifepristone</i>	280
(PF)	103	<i>succ</i>	297	MIGERGOT	195
<i>mepерidine</i>	8	<i>methyltestosterone</i>	275	<i>miglitol</i>	276
<i>mepерidine (pf)</i>	7	<i>metoclopramide hcl</i>	336	<i>miglustat</i>	487
<i>meprobamate</i>	171	METOLAZONE	162	MIGRANAL	195
MEPRON	62	METOPIRON	251	MILI	221
MEPSEVII	487	<i>metoprolol succinate</i>	142	MILK OF MAGNESIA ..	348, 349
<i>mercaptopurine</i>	87	<i>metoprolol ta-</i>		MILLIPRED	297
<i>meropenem</i>	67	<i>hydrochlorothiaz</i>	156	MILLIPRED DP	297
<i>meropenem-0.9% sodium</i>		<i>metoprolol tartrate</i>	142, 143	<i>milrinone</i>	155
<i>chloride</i>	67	METRO I.V.	63	<i>milrinone in 5 % dextrose</i>	155
MERZEE	220	METROCREAM	248	MINI ULTRA-THIN II ..	419, 463
<i>mesalamine</i>	340, 341	METROGEL	248	MINI WRIGHT PEAK FLOW	
<i>mesalamine with cleansing</i>		<i>metronidazole</i>	63, 248, 538	METER	439, 463
<i>wipe</i>	341	<i>metronidazole in nacl (iso-</i>		MINIVELLE	293
<i>mesna</i>	98	<i>os)</i>	63	<i>minocycline</i>	40, 83, 227
MESNEX	98	<i>metyrosine</i>	166	<i>minoxidil</i>	159, 160
MESTINON	393	<i>mexiletine</i>	125, 126	MINTOX MAXIMUM	
MESTINON TIMESPAN	393	MG-PLUS-PROTEIN	258	STRENGTH	320
METADATE CD	189	MIBELAS 24 FE	220	MINZOYA	221
<i>metaxalone</i>	395	<i>micafungin</i>	59	MIOCHOL-E	495
<i>metformin</i>	308, 309	<i>micafungin in 0.9 % sodium</i>		MIOSTAT	495
<i>methadone</i>	8	<i>chl</i>	59	MIPLYFFA	488
METHADONE INTENSOL	8	MICARDIS	122	<i>mirabegron</i>	354
METHADOSE	8	MICARDIS HCT	118	MIRCERA	368
<i>methazolamide</i>	160	<i>miconazole nitrate</i>		<i>mirtazapine</i>	175
<i>methenamine hippurate</i> ..	79, 359	.....	236, 237, 537, 538	MIRVASO	248
<i>methenamine mandelate</i>		<i>miconazole nitrate-zinc ox-</i>		<i>misoprostol</i>	335, 336
.....	79, 359	<i>pet</i>	236	MITIGARE	362
<i>methen-sod phos-meth blue-</i>		MICONAZOLE-3	537, 538	MITIGO (PF)	8
<i>hyos</i>	79, 360	MICONAZOLE-7	537, 538	M-M-R II (PF)	101, 105, 106
<i>methimazole</i>	288	MICOTRIN AC	236	M-NATAL PLUS	265
METHITEST	275	MICRO THIN LANCETS		<i>modafinil</i>	203
<i>methocarbamol</i>	395	399, 400, 401, 402, 403, 449,		<i>moexipril</i>	111
<i>methotrexate sodium</i> ..	36, 37, 86	454, 457, 463, 469, 471, 473		<i>molindone</i>	186
				<i>mometasone</i>	244, 536

MONOJECT ALLERGY TRAY	437, 463	MOUNJARO	278, 279	MYXREDLIN	303
MONOJECT ALLERGY TRAY DETACH	437, 464	MOVANTIK	54	NABI-HB	101
MONOJECT INSULIN SAFETY SYRINGE	419, 420, 464	MOVIPREP	349	<i>nabumetone</i>	42
MONOJECT INSULIN SYRINGE	419, 420, 463, 464, 465	<i>moxifloxacin</i>	71, 501	<i>nadolol</i>	145
MONOJECT LUER-LOCK TIP	437, 464	<i>moxifloxacin-sod.chloride(iso)</i>	71	<i>nafcillin</i>	81
MONOJECT MAGELLAN SYRINGE	437, 464	MOZOBIL	365	<i>nafcillin in dextrose iso-osm.</i> ..	80
MONOJECT PHARMACY TRAY LUER	437, 464	M-PAP	25	<i>naftifine</i>	234, 235
MONOJECT REG TIP NON-STERILE	437, 464	MRESVIA (PF)	105	NAFTIN	235
MONOJECT SAFETY LUER LOCK TIP	437, 464	MS CONTIN	10	NAGLAZYME	487
MONOJECT SAFETY SYRINGES	437, 464	MULPLETA	389	<i>nalbuphine</i>	20
MONOJECT SMARTIP CANNULA	437, 464	MULTAQ	127	NALFON	47
MONOJECT SYRINGE	419, 437, 463, 465	MULTI-VIT WITH FLUORIDE-IRON	263, 264	NALOCET	17, 18
MONOJECT TB	437, 465	MULTI-VITAMIN WITH FLUORIDE	263, 264	<i>naloxone</i>	54, 55
MONOJECT TB SAFETY SYRINGE	437, 465	<i>mupirocin</i>	234	NALTREX	4
MONOJECT TUBERCULIN SYRINGE	437, 465	<i>mupirocin calcium</i>	234	<i>naltrexone</i>	206
MONOJECT ULTRA COMFORT INSULIN ...	429, 481	MVW COMPLETE FORMUL MULTIVIT	265	NAMENDA TITRATION PAK	216
MONOLET LANCETS	401, 465	MVW COMPLETE FORMUL PEDIATRIC	265	NAMENDA XR	216
MONOLET THIN LANCETS	401, 465	MVW COMPLETE FORMULATION D3000	265	NAMZARIC	216
MONO-LINYAH	221	MVW COMPLETE FORMULATION D5000	265	NANO 2ND GEN PEN NEEDLE	420, 465
<i>montelukast</i>	524	MX-SOL	213	NANO PEN NEEDLE ..	420, 465
MORGIDOX	83	MX-SOL BLEND	213	NANO VM 1-3	265
MORGIDOX 1X 50	83	MX-SOL BLEND SF	213	NANO VM 4-8	265
<i>morphine</i>	8, 9, 10	MX-SOL SF	213	NANOVM 9-18	263
<i>morphine (pf)</i>	8	MX-SOL SUSPEND	213	NANOVM T-F	263
<i>morphine concentrate</i>	8, 9	MY CHOICE	225	NAPRELAN CR	47
MOTEGRITY	336	MY WAY	225	NAPROSYN	47
MOTION SICKNESS (MECLIZINE)	322	MYALEPT	310	<i>naproxen</i>	47, 48
MOTION SICKNESS RELIEF(MECLIZ)	322	MYCAMINE	59	<i>naproxen sodium</i> ..	45, 46, 48, 49
MOTION-TIME	322	MYCAPSSA	312	<i>naproxen-esomeprazole</i>	41
MOTOFEN	322	MYCOBUTIN	66, 82	<i>naratriptan</i>	196
MOTPOLY XR	172	<i>mycophenolate mofetil</i> ...38, 391		NARCAN	55
		<i>mycophenolate sodium</i>	391	NARDIL	175
		MYCOZYL AC	236	NAROPIN (PF)	52
		MYDAYIS	189, 192	NASAL ALLERGY	536
		MYDRIACYL	496	NASCOBAL	269
		MYFEMBREE	310	NASONEX 24HR ALLERGY	536
		MYFORTIC	391	NATACYN	502
		MYGLUCOHEALTH LANCETS	401, 465	NATAZIA	223
		MYHIBBIN	391	<i>nateglinide</i>	280
		MYRBETRIQ	354	NATESTO	275
		MYSOLINE	171	NATROBA	250
		MYTESI	321	NATURA-LAX	348
				NAYZILAM	172, 190
				<i>nebivolol</i>	143
				NEBUPENT	79
				NEBUSAL	212
				NECON 0.5/35 (28)	221

<i>nefazodone</i>	176	<i>niacinamide</i>	270	<i>norgestimate-ethinyl</i>	
NEFFY	157	<i>nicardipine</i>	152	<i>estradiol</i>	221, 223
NEMLUVIO	233	<i>nicotine</i> 206, 207, 208, 209, 210		NORITATE	248
<i>neomycin</i>	55	<i>nicotine (polacrilex)</i>		NORLIQVA	153
<i>neomycin-bacitracin-poly-hc</i>	495	.....206, 207, 208, 209, 210		NORMOSOL-M IN 5 %	
<i>neomycin-bacitracin-</i>		NICOTROL NS	210	DEXTROSE	256
<i>polymyxin</i>	501	<i>nifedipine</i>	152, 153	NORMOSOL-R	259
<i>neomycin-polymyxin b gu</i>	354	NIGHTTIME SLEEP	204, 509	NORMOSOL-R IN 5 %	
<i>neomycin-polymyxin b-</i>		NIGHTTIME SLEEP AID		DEXTROSE	256
<i>dexameth</i>	495	(DIPHEN)	204, 505, 509, 510	NORMOSOL-R PH 7.4	259
<i>neomycin-polymyxin-</i>		NIGHTTIME SLEEP-AID		NORPACE	125
<i>gramicidin</i>	501	(DOXYLAMN)	204	NORPACE CR	125
<i>neomycin-polymyxin-hc</i>		NIKKI (28)	221	NORPRAMIN	178
.....	495, 503	<i>nilutamide</i>	86	NORTHERA	157
NEO-POLYCIN	501	<i>nimodipine</i>	151	NORTREL 0.5/35 (28)	221
NEO-POLYCIN HC	495	NINLARO	94	NORTREL 1/35 (21)	221
NEORAL	39, 390	<i>nisoldipine</i>	153	NORTREL 1/35 (28)	221
NEO-SYNALAR	234	<i>nitazoxanide</i>	62	NORTREL 7/7/7 (28)	223
NEO-SYNALAR KIT	234	<i>nitisinone</i>	488	<i>nortriptyline</i>	178
NEPHPLEX RX	252	NITRO-BID	124	NORVASC	153, 154
NEPHRON FA	252	NITRO-DUR	124	NORVIR	81
NEPHRO-VITE	252	<i>nitrofurantoin</i>	58, 359	NOURIANZ	180
NERLYNX	84	<i>nitrofurantoin macrocrystal</i>		NOVA SAFETY LANCETS	
NESACAINE	52	.....	58, 359	.....	401, 465
NESACAINE-MPF	52	<i>nitrofurantoin monohydr/m-</i>		NOVA SUREFLEX	
NESINA	277, 278	<i>cryst</i>	58, 359	LANCETS	401, 465
NESTABS	265	<i>nitroglycerin</i>	53, 124, 125	NOVAVAX COVID 2024-	
NESTABS ABC	265	NITROLINGUAL	125	25(PF)(EUA)	104
NESTABS DHA	265	NITROSTAT	125	NOVOEIGHT	371
NESTABS ONE	262	NITYR	488	NOVOFINE 32	420, 465
NEUAC	228	NIVA THYROID	314	NOVOFINE PLUS	420, 465
NEUAC KIT	228	NIVA-FOL	267, 273	NOVOLIN 70/30 U-100	
NEULASTA	372	NIVESTYM	372	INSULIN	301, 302
NEULASTA ONPRO	372	<i>nizatidine</i>	330	NOVOLIN 70-30 FLEXPEN	
NEUPOGEN	372	NOCDURNA (MEN)	276	U-100	302
NEUPRO	182, 183	NOCDURNA (WOMEN)	276	NOVOLIN N FLEXPEN	302
NEURONTIN	172	NORA-BE	223	NOVOLIN N NPH U-100	
NEVANAC	499	NORDITROPIN FLEXPEN	300	INSULIN	302
<i>nevirapine</i>	64	<i>norelgestromin-</i>		NOVOLIN R FLEXPEN	303
NEW DAY	225	<i>ethin.estradiol</i>	224	NOVOLIN R REGULAR	
NEXAVAR	93	<i>noreth-ethinyl estradiol-iron</i>	221	U100 INSULIN	303
NEXICLON XR	159	<i>norethindrone</i>		NOVOLOG FLEXPEN U-	
NEXIUM	332, 333	<i>(contraceptive)</i>	223	100 INSULIN	308
NEXIUM PACKET	332, 333	<i>norethindrone acetate</i>	312	NOVOLOG MIX 70-30 U-	
NEXLETOL	128	<i>norethindrone ac-eth</i>		100 INSULN	304
NEXLIZET	138	<i>estradiol</i>	221, 291	NOVOLOG MIX 70-	
NEXTSTELLIS	221	<i>norethindrone-e.estradiol-</i>		30FLEXPEN U-100	304
NEXVIAZYME	487	<i>iron</i>	221, 223	NOVOLOG PENFILL U-100	
NGENLA	300	NORGESIC	394	INSULIN	308
<i>niacin</i>	137, 269	NORGESIC FORTE	394		

NOVOLOG U-100 INSULIN		OFEV.....95, 537	OPFOLDA.....488
ASPART.....308		<i>ofloxacin</i>.....71, 501, 503	OPILL.....223
NOVOSEVEN RT.....370		OGSIVEO.....89	OPIPZA.....187, 191
NOXAFIL.....60		OHTUVAYRE.....525	<i>opium tincture</i>.....321, 322
NP THYROID.....314		OJEMDA.....88	OPSUMIT.....168
NPLATE.....389		OJJAARA.....90	OPSYNVI.....164
NUBEQA.....86		<i>olanzapine</i>.....187, 191	OPTICHAMBER ADULT
NUCALA.....523		<i>olanzapine-fluoxetine</i>	MASK-LARGE.....440, 466
NUDEXTA.....204		.....177, 187, 191	OPTICHAMBER DIAMOND
NUFERA.....256		<i>olmesartan</i>.....122	LG MASK.....441, 466
NULEV.....337, 360		<i>olmesartan-amlodipin-</i>	OPTICHAMBER DIAMOND
NU-MAG.....258		<i>hcthiamid</i>.....116	VHC.....440, 466
NUPLAZID.....187		<i>olmesartan-</i>	OPTICHAMBER DIAMOND-
NURTEC ODT.....194		<i>hydrochlorothiazide</i>.....118	MED MSK.....441, 466
NUTROPIN AQ NUSPIN.....300		<i>olopatadine</i>.....496, 497, 535	OPTICHAMBER DIAMOND-
NUVARING.....224		OLPRUVA.....488	SML MASK.....441, 466
NUVESSA.....538		OLUMIANT.....39, 250	OPTION-2.....225
NUVIGIL.....203		OLUX.....244	OPVEE.....55
NUWIQ.....371		OMECLAMOX-PAK.....338	OPZELURA.....233
NUZYRA.....56, 83		<i>omega-3 acid ethyl esters</i> ...137	ORA-BLEND.....213
NYAMYC.....235		<i>omeprazole</i>.....332, 333, 335	ORA-BLEND SF.....213
NYLIA 1/35 (28).....221		<i>omeprazole magnesium</i>	ORACEA.....84, 248
NYLIA 7/7 (28).....223		.....332, 333, 334	ORACIT.....358
NYMALIZE.....151		<i>omeprazole-sodium</i>	ORAL MIX.....213
<i>nystatin</i>.....58, 235, 490		<i>bicarbonate</i>.....335	ORAL MIX SF.....213
<i>nystatin-triamcinolone</i>.....237		OMNARIS.....536	ORAL SUSPEND.....213
NYSTOP.....235		OMNITROPE.....300	ORAL SYRUP.....213
NYTOL.....204, 506, 510		OMVOH.....339	ORAL SYRUP SF.....213
NYVEPRIA.....372		OMVOH PEN.....339	ORALAIR.....100
OB COMPLETE.....261		ON CALL LANCET.....401, 465	ORALONE.....490
OB COMPLETE ONE.....265		ONCOVITE.....262	ORALYTE.....258
OB COMPLETE PETITE.....265		<i>ondansetron</i>.....325, 326	ORA-PLUS.....213
OB COMPLETE PREMIER.....265		<i>ondansetron hcl</i>.....325	ORA-SWEET.....213
OB COMPLETE WITH DHA		<i>ondansetron hcl (pf)</i>.....325	ORA-SWEET SF.....213
.....265		ONE DAILY.....261	ORAVIG.....59
OBIZUR.....371		ONE DAILY MEN'S 50	ORAZINC.....261
OCALIVA.....389		PLUS MEMORY.....262	ORENCIA.....37
OCELLA.....221		ONE DAILY WOMEN'S	ORENCIA (WITH
OCTAPLAS (BLOOD		HEALTH.....261	MALTOSE).....37
GROUP A).....382		ONE WAY VALVED	ORENCIA CLICKJECT.....37
OCTAPLAS (BLOOD		MOUTHPIECE.....440, 466	ORENITRAM.....166
GROUP AB).....382		ONEXTON.....228	ORENITRAM MONTH 1
OCTAPLAS (BLOOD		ONFI.....172, 190	TITRATION KT.....166
GROUP B).....382		ONGENTYS.....180	ORENITRAM MONTH 2
OCTAPLAS (BLOOD		ON-THE-GO LANCETS	TITRATION KT.....167
GROUP O).....382		.....401, 466	ORENITRAM MONTH 3
<i>octreotide acetate</i> 312, 313, 353		ONUREG.....87	TITRATION KT.....167
OCUFLOX.....501		ONYDA XR.....188	ORFADIN.....488
ODEFSEY.....66		OPCICON ONE-STEP.....225	ORGOVYX.....91
ODOMZO.....90		OPDIVO.....97	ORIAHNN.....310

ORLISSA	310, 311	OYSTER SHELL		PASER	66
ORKAMBI	534	CALCIUM-VIT D3	255	PATADAY ONCE DAILY	
ORLADEYO	166	OZEMPIC	279	RELIEF	497
<i>orlistat</i>	540	OZURDEX	498	PATADAY TWICE DAILY	
<i>ornithine hydrochloride</i>		PACERONE	127	RELIEF	497
<i>(bulk)</i>	211, 263	PAIN RELIEF		PAXIL	176
<i>orphenadrine citrate</i>	395	(ACETAMINOPHEN)	24, 25	PAXIL CR	176
<i>orphenadrine-asa-caffeine</i>	394	PAIN RELIEF		PAXLOVID	82
ORPHENGESIC FORTE	394	(IBUPROFEN)	45	<i>pazopanib</i>	95
ORSERDU	95	PAIN RELIEF ES		PCCA BASE ANHYDROUS	
OS-CAL 500 + D3	254, 255	(ACETAMINOPHEN)	24, 25	.....	211, 241
OSCIMIN	337, 360	PAIN RELIEVER		PCCA NATAPRES	212
OSCIMIN SL	337, 360	(ACETAMINOPHEN)	24, 25	PCCA SUSPENDIT	
<i>oseltamivir</i>	76	PAIN RELIEVER		ANHYDROUS	212
OSENI	286	ES(ACETAMINOPHN)	24, 25	PCCA VANISHING BASE	
OSMOLEX ER	183	PALFORZIA (LEVEL 0)	102	.....	211, 212
OSPHENA	311	PALFORZIA (LEVEL 1)	102	PCCA-PLUS BASE	213
OTEZLA	40, 239	PALFORZIA (LEVEL 2)	102	PEAK AIR PEAK FLOW	
OTEZLA STARTER	40, 239	PALFORZIA (LEVEL 3)	102	METER	439, 466
OTREXUP (PF)	37	PALFORZIA (LEVEL 4)	102	PEDIA IRON	257
OVACE	239	PALFORZIA (LEVEL 5)	102	PEDIACLEAR PD	507, 510
OVACE PLUS	239	PALFORZIA (LEVEL 6)	102	PEDIACLEAR-8	510
OVACE PLUS SHAMPOO	239	PALFORZIA (LEVEL 7)	102	PEDIALYTE	258, 259
OVACE PLUS WASH	239	PALFORZIA (LEVEL 8)	102	PEDIALYTE FREEZER	
OVIDE	250	PALFORZIA (LEVEL 9)	102	POPS	258
<i>oxacillin</i>	81	PALFORZIA (LEVEL 10)	102	PEDIALYTE SINGLES	258
<i>oxacillin in dextrose(iso-</i>		PALFORZIA (LEVEL 11		PEDIATRIC D-VITE	270
<i>osm)</i>	81	UP-DOSE)	102	PEDIATRIC	
<i>oxaprozin</i>	48	PALFORZIA INITIAL (1-3		ELECTROLYTE	259
<i>oxazepam</i>	171, 190	YRS)	102	PEDIAVENT	504, 510
OXBRYTA	387	PALFORZIA INITIAL (4-17		PEDVAX HIB (PF)	103
<i>oxcarbazepine</i>	173	YRS)	102	<i>peg 3350-electrolytes</i>	349
OXERVATE	499	PALFORZIA LEVEL 11		<i>peg3350-sod sul-nacl-kcl-</i>	
<i>oxiconazole</i>	237	MAINTENANCE	102	<i>asb-c</i>	350
OXISTAT	237	<i>paliperidone</i>	185	PEGASYS	74
OXLUMO	354	<i>palonosetron</i>	326	<i>peg-electrolyte soln</i>	349
OXTELLAR XR	173	PALYNZIQ	489	PEMAZYRE	89
<i>oxybutynin chloride</i>	361	PAMELOR	178	PEN NEEDLE	
<i>oxycodone</i>	10, 11, 12	PANDEL	244	413, 418, 419, 420, 421, 422,	
<i>oxycodone-acetaminophen</i>		<i>pantoprazole</i>	334	423, 424, 427, 454, 455, 461,	
.....	17, 18	<i>pantoprazole in 0.9% sod</i>		462, 465, 466, 467, 470, 471,	
OXYCONTIN	12	<i>chlor</i>	334	476	
<i>oxymorphone</i>	12, 13	PANZYGA	101	<i>pen needle, diabetic</i>	
OXYTROL	361	PARADIGM RESERVOIR		410, 413, 414, 418, 420, 421,	
OYSCO 500/D	255	.....	420, 466	424, 449, 455, 456, 457, 461,	
OYSTER SHELL + D3	254, 255	<i>paricalcitol</i>	487	462, 466, 467, 471	
OYSTER SHELL CALCIUM	255	<i>paromomycin</i>	55	PENBRAYA (PF)	103
OYSTER SHELL CALCIUM		<i>paroxetine hcl</i>	176	<i> penciclovir</i>	239
500	255, 256	<i>paroxetine</i>		<i>penicillamine</i>	40, 54
		<i>mesylate(menop.sym)</i>	311	<i>penicillin g pot in dextrose</i>	80

<i>penicillin g potassium</i>	80	PHOSPHO-TRIN 250		PONVORY	493
<i>penicillin g sodium</i>	80	NEUTRAL	259, 358	PONVORY 14-DAY	
<i>penicillin v potassium</i>	80	PHYSIOLYTE	254	STARTER PACK	493
PENNSAID	248	PHYSIOSOL IRRIGATION	254	PORTIA 28	221
PENTAM	79	<i>phytonadione (vitamin k1)</i> ...	273	<i>posaconazole</i>	60
<i>pentamidine</i>	80	PIASKY	363, 386	<i>pot,sodium citrate-citric acid</i>	358
PENTASA	341	PIFELTRO	64	<i>potassium chloride</i>	260, 261
<i>pentazocine-naloxone</i>	20	PIKO 1	439, 468	<i>potassium citrate</i>	358
PENTIPS PEN NEEDLE		<i>pilocarpine hcl</i>	491, 495	<i>potassium citrate-citric acid</i>	358
.....	422, 467, 468	<i>pimecrolimus</i>	240	<i>potassium, sodium</i>	
<i>pentoxifylline</i>	373	<i>pimozide</i>	186	<i>phosphates</i>	259, 260
PEPCID	330	PIMTREA (28)	217	<i>povidone-iodine</i>	234
PERCOCET	17, 18, 19	<i>pindolol</i>	144	PRADAXA	388, 389
PERFOROMIST	527	PINK BISMUTH	321	PRALUENT PEN	137, 138
<i>perindopril erbumine</i>	111	<i>pioglitazone</i>	310	<i>pramipexole</i>	183, 184
<i>permethrin</i>	251	<i>pioglitazone-glimepiride</i>	285	PRAMOSONE	246
<i>perphenazine</i>	186	<i>pioglitazone-metformin</i>	285	<i>prasugrel hcl</i>	385, 386
<i>perphenazine-amitriptyline</i> ..	177	PIP PEN NEEDLE	422, 468	<i>pravastatin</i>	134, 135
PERSERIS	185	<i>piperacillin-tazobactam</i>	81	<i>praziquantel</i>	57
PERSONAL BEST FULL		PIQRAY	94	<i>prazosin</i>	165
RANGE	439, 468	<i>pirfenidone</i>	536	PRECEDEX IN 0.9 %	
PERSONAL BEST LOW		<i>piroxicam</i>	43	SODIUM CHLOR	206
RANGE	439, 468	<i>pitavastatin calcium</i>	134	PRECISION PCX PLUS	
PERTZYE	328	PLASBUMIN 25 %	376	TEST	397, 468
PEXEVA	176	PLASBUMIN 5 %	376	PRECISION PCX TEST	
PFIZERPEN-G	80	PLASMANATE	382	.....	397, 468
PHEBURANE	488	PLAVIX	385	PRECISION POINT OF	
<i>phenazopyridine</i>	358	PLEGRIDY	491	CARE TEST	397, 468
<i>phendimetrazine tartrate</i>	539	PLENVU	350	PRECISION Q-I-D TEST	
<i>phenelzine</i>	175	<i>plerixafor</i>	365	.....	397, 468
PHENERGAN	323, 506, 510	PNEUMOVAX-23	103	PRECISION XTRA TEST	
<i>phenobarbital</i>	171, 205	PNV-OMEGA	261	.....	397, 468
<i>phenobarbital sodium</i> ..	171, 205	PNV-SELECT	265	PRECOSE	276, 277
<i>phenoxybenzamine</i>	165	POCKET CHAMBER ..	441, 468	PRED FORTE	498
<i>phentermine</i>	539, 540	POCKET PEAK FLOW		PRED MILD	498
<i>phenylephrine hcl</i>	499	METER	439, 468	<i>prednicarbate</i>	245
PHENYTEK	173	PODOCON	247	<i>prednisolone</i>	297
<i>phenytoin</i>	173	<i>podofilox</i>	247	<i>prednisolone acetate</i>	498
<i>phenytoin sodium</i>	126, 173	POLOCAINE-MPF	52	<i>prednisolone sodium</i>	
<i>phenytoin sodium extended</i> ..	173	POLYCIN	501	<i>phosphate</i>	297, 498
PHEXXI	216	<i>polyethylene glycol</i>		<i>prednisone</i>	297, 298
PHILITH	221	<i>1450(bulk)</i>	211, 214	PREDNISONE INTENSOL ..	298
PHOS-NAK	259	<i>polyethylene glycol 3350</i>		<i>pregabalin</i>	172, 193, 203, 204
PHOSPHA 250 NEUTRAL		.....	348, 349	PREHEVBRIO (PF)	100
.....	259, 358	<i>polymyxin b sulfate</i>	81	PREMARIN	293, 538
PHOSPHOLINE IODIDE	495	<i>polymyxin b sulf-</i>		PREMPHASE	291
PHOSPHOROUS	259, 358	<i>trimethoprim</i>	501	PREMPRO	291, 292
PHOSPHOROUS		<i>polyvinyl alcohol</i>	495	PRENATAL	265, 266
SUPPLEMENT	259	POMALYST	97	PRENATAL VITAMIN PLUS	
		POMBILITI	487	LOW IRON	265

PRENATE AM	262	PRO COMFORT SPACER-ADULT MASK	441, 469	<i>propranolol</i>	145, 146
PRENATE CHEWABLE	262	PRO COMFORT SPACER-CHILD MASK	441, 469	<i>propranolol-hydrochlorothiazid</i>	163
PRENATE DHA (FERR ASP GLYCIN)	266	PRO COMFORT SPACER-INFANT MASK	441, 469	<i>propylthiouracil</i>	288
PRENATE ELITE (IRON ASP GLYC)	266	PROAIR DIGIHALER	529	PRORENAL QD	261
PRENATE ENHANCE	266	PROAIR RESPICLICK	529	PROSCAR	357
PRENATE ESSENTIAL(IRON-ASP-GL)	262	<i>probenecid</i>	362	PROTONIX	334, 335
PRENATE MINI (FERR ASP GLYCIN)	266	<i>probenecid-colchicine</i>	362	<i>protriptyline</i>	178
PRENATE PIXIE	266	PROCARDIA XL	154	PROVERA	312
PRENATE RESTORE	266	PROCARE SPACER WITH ADULT MASK	441, 469	PROVIGIL	203
PRENATE STAR	266	PROCARE SPACER WITH CHILD MASK	441, 469	PROZAC	176
PREPIDIL	273	PROCENTRA	192	<i>prucalopride</i>	336
PRESSURE ACTIVATED LANCETS	402, 469	PROCHAMBER	441, 469	PRUDOXIN	250
<i>pretomanid</i>	66	<i>prochlorperazine</i>	323	<i>pseudoephedrine hcl</i>	537
PREVACID	334	<i>prochlorperazine edisylate</i>	323	PULMICORT	522
PREVACID 24HR	334	.....	186, 187, 323	PULMICORT FLEXHALER	523
PREVACID SOLUTAB	334	PROCRIT	368, 369	PULMOSAL	212
PREVALITE	129	PROCTOCORT	53	PULMOZYME	535
PREVENT DROPSAFE		PROCTOFOAM HC	53	PURE COMFORT ALCOHOL PADS	99
PEN NEEDLE	422, 469	PROCTO-MED HC	53, 245	PURE COMFORT PEN NEEDLE	423, 470
PREVIDENT 5000 ENAMEL		PROCTO-PAK	245	PURE COMFORT SPACER-ADULT MASK	441, 470
PROTECT	489	PROCTOSOL HC	53, 245	PURECOMFORT PEAK FLOW METER	439, 470
PREVIDENT 5000 SENSITIVE	489	PROCTOZONE-HC	53, 245	PUREVIT DUALFE PLUS	262
PREVNAR 13 (PF)	103	PROCYSBI	354	PURIXAN	87
PREVNAR 20 (PF)	103	PRODIGY INSULIN SYRINGE	422, 469	PYLERA	338
PREVYMIS	70	PRODIGY LANCETS	402, 469	<i>pyrazinamide</i>	66
PREZCOBIX	65, 81	PRODIGY TWIST TOP LANCET	402, 469	PYRIDIDIUM	358
PREZISTA	81	PROFILNINE	370	<i>pyridostigmine bromide</i>	393
PRIFTIN	66, 82	<i>progesterone</i>	312	<i>pyridoxine (vitamin b6)</i>	270
PRILOSEC	334	<i>progesterone micronized</i>	312	<i>pyrimethamine</i>	62
PRIMACARE	266	PROGLYCEM	274	PYRUKYND	386
<i>primaquine</i>	62	PROGRAF	390	QBRELIS	111
PRIMAXIN IV	67	PROLATE	17, 18, 19	QELBREE	189
PRIMEAIRE	441, 469	PROLENSA	499	QFITLIA	374
<i>primidone</i>	171	PROMACTA	389	QFITLIA PEN	374
PRIORIX (PF)	101, 105, 106	<i>promethazine</i>	323, 324, 506, 507, 510	QINLOCK	95
PRISTIQ	177	PROMETHEGAN	324, 507, 510, 511	QNASL	536
PRO COMFORT ALCOHOL PADS	99	PROMETRIUM	312	QSYMIA	539
PRO COMFORT INSULIN SYRINGE	422, 469	PROMISEB	239, 240	QTERN	282
PRO COMFORT PEN NEEDLE	422, 469	<i>propafenone</i>	126	QUALAQUIN	62
		<i>proparacaine</i>	500	QUDEXY XR	173
				QUESTRAN	129
				QUESTRAN LIGHT	129
				<i>quetiapine</i>	187, 191
				QUFLORA	264

QUFLORA FE	264	REFRESH LACRI-LUBE	494	REXULTI	187
QUFLORA FE (FERROUS SULFATE)	264	REFRESH LIQUIGEL	495	REYATAZ	81, 82
QUFLORA PEDIATRIC	264	REFRESH OPTIVE	494	REYVOW	200
QUFLORA PEDIATRIC DROPS	264	REFRESH P.M.	494	REZLIDHIA	93
QUILLICHEW ER	189	REFRESH PLUS	495	REZUROCK	40
QUILLIVANT XR	189	REFRESH RELIEVA	494	REZVOGLAR KWIKPEN ...	305
<i>quinapril</i>	111	REFRESH RELIEVA PF	494	RHOFADE	248
<i>quinapril-hydrochlorothiazide</i>	108	REGLAN	336	RHOGAM ULTRA-FILTERED PLUS	101
<i>quinidine gluconate</i>	125	RELAFEN DS	42	RHOPHYLAC	101
<i>quinidine sulfate</i>	125	RELENZA DISKHALER	76	RHOPRESSA	503
<i>quinine sulfate</i>	62	RELEUKO	372, 373	RIASTAP	374
QULIPTA	194, 195	RELEXXII	189	<i>ribavirin</i>	74
QUVIVIQ	205	RELIAMED LANCET ..	402, 470	<i>riboflavin (vitamin b2)</i>	269
QVAR REDIHALER	523	RELIAMED SAFETY SEAL LANCETS	402, 471	RIDAURA	37
<i>rabeprazole</i>	335	RELISTOR	54	<i>rifabutin</i>	66, 82
RADICAVA	393	REL PAX	197	RIFADIN	66, 82
RADICAVA ORS	393	RELTONE	329	<i>rifampin</i>	66, 67, 82
RADICAVA ORS STARTER KIT SUSP	393	REMERON	175	RIGHTEST GL300 LANCETS	402, 472
RALDESY	176	REMERON SOLTAB	175	RILUTEK	393
<i>raloxifene</i>	312	REMODULIN	167	<i>riluzole</i>	393
<i>ramelteon</i>	194	RENAL CAPS	252	<i>rimantadine</i>	76
<i>ramipril</i>	111, 112	RENAL-VITE	252	RINVOQ	39, 40, 233, 341
<i>ranolazine</i>	125	REN FLEXIS	30, 35, 346	RINVOQ LQ	40
RAPAFLO	357	RENO CAPS	252	RIOMET	309
RAPAMUNE	392	RENOVA	248	<i>risedronate</i>	290
<i>rasagiline</i>	181	RENTHYROID	314	RISPERDAL	185, 191
RASUVO (PF)	37	REVELA	356	RISPERDAL CONSTA	185
RAVICTI	488	<i>repaglinide</i>	280	<i>risperidone</i>	185, 191
RAYALDEE	487	REPATHA PUSHTRONEX ..	138	<i>risperidone microspheres</i>	185
RAYOS	298	REPATHA SURECLICK	137, 138	RITALIN	189, 203
READY-TO-USE ENEMA	349, 350	REPATHA SYRINGE	138	RITALIN LA	189
READY-TO-USE ENEMA (MIN OIL)	347	REST SIMPLY NIGHTTIME SLEEP	204, 506, 511	RITEFLO AEROCHAMBER	441, 472
REBIF (WITH ALBUMIN) ...	491	RESTASIS	498	<i>ritonavir</i>	82
REBIF REBIDOSE	491, 492	RESTASIS MULTIDOSE	498	<i>rivaroxaban</i>	366
REBIF TITRATION PACK ..	492	RESTORIL	190, 205	<i>rivastigmine</i>	215
REBINYN	370	RETACRIT	369, 370	<i>rivastigmine tartrate</i>	215
RECARBRIO	67	RETEVMO	96	RIVELSA	223
RECLAST	290	RETIN-A	230	RIVFLOZA	354
RECLIPSEN (28)	221	RETIN-A MICRO	230	RIXUBIS	370
RECOMBINATE	371	RETIN-A MICRO PUMP	230	<i>rizatriptan</i>	197
RECOMBIVAX HB (PF)	101	RETISERT	498	ROBINUL	337
RECTIV	53	RETROVIR	64, 65	ROBINUL FORTE	337
REFRESH CELLUVISC	495	REVATIO	169	ROCALTROL	270, 487
REFRESH CONTACTS	495	REVCovi	487	ROCKLATAN	501
		REVLIMID	97	<i>roflumilast</i>	526
		REVUFORJ	92	ROMVIMZA	95
		REXTOVY	55	<i>ropinirole</i>	184, 185

<i>ropivacaine (pf)</i>	52	SAVAYSA	366	SEREVENT DISKUS	527
ROSADAN	248, 249	SAVELLA	177, 193	SEROQUEL	187, 191
ROSULA	228	<i>saxagliptin</i>	278	SEROQUEL XR	187, 191
ROSULA CLEANSING		<i>saxagliptin-metformin</i>	287	SEROSTIM	300, 301
CLOTHS	228	SAXENDA	540	<i>sertraline</i>	176
<i>rosuvastatin</i>	135	SCEMBLIX	95	SE-TAN PLUS	262
ROWASA	341	<i>scopolamine base</i>	322	SETLAKIN	221
ROWEEPRA	175	SECONAL SODIUM	205	<i>sevelamer carbonate</i>	356
ROWEEPRA XR	175	SECUADO	185	<i>sevelamer hcl</i>	356
ROXICODONE	13	SECURESAFE PEN		SEVENFACT	370
ROXYBOND	13	NEEDLE	425, 472	SEZABY	171
ROZEREM	194	SEGLENTIS	21	SFROWASA	341
ROZLYTREK	95	SEGLUROMET	281	SHAROBEL	223
RUBRACA	94	SELECT-OB	266	SHINGRIX (PF)	106
RUCONEST	365	SELECT-OB (FOLIC ACID)	266	SIGNIFOR	313
<i>rufinamide</i>	175	SELECT-OB + DHA	266	SIGNIFOR LAR	313
RUKOBIA	63	<i>selegiline hcl</i>	181	SIKLOS	387
RUXIENCE	37, 88	<i>selenium sulfide</i>	239	<i>sildenafil</i>	251
RYALTRIS	535	SELZENTRY	63	<i>sildenafil</i>	
RYBELSUS	279, 280	SEMGLEE(INSULIN		<i>(pulm.hypertension)</i>	169
RYCLORA	504, 511	GLARGINE-YFGN)	305	SILENOR	206
RYDAPT	95	SEMGLEE(INSULIN		SILIQ	232
RYKINDO	186	GLARG-YFGN)PEN	305	<i>silodosin</i>	357
RYPLAZIM	383	SE-NATAL 19	266	SILVADENE	240
RYTARY	180	SE-NATAL 19 CHEWABLE	266	<i>silver nitrate</i>	234
RYTELO	96	SENEXON-S	350	<i>silver sulfadiazine</i>	240
RYVENT	506, 511	SENNA	351	SIMBRINZA	495
SABRIL	173	SENNA LAX	351	SIMLANDI(CF) ..	30, 35, 36, 346
SAFESNAP INSULIN		SENNA LAXATIVE	351, 352	SIMLANDI(CF)	
SYRINGE	424, 425, 472	<i>senna leaf extract</i>	351	AUTOINJECTOR	
SAFETY LANCETS	402, 472	SENNA PLUS	350	.....	30, 35, 36, 346
SAFETY PEN NEEDLE		SENNA-S	350	SIMLIYA (28)	217
.....	425, 472	SENNA-TIME S	350	SIMPESSE	217
SAFETY SEAL LANCETS		<i>sennosides</i>	351	<i>simple syrup</i>	213, 214
.....	402, 403, 472	<i>sennosides-docusate</i>		SIMPLY SLEEP ..	204, 506, 511
SAFETY-LET LANCETS		<i>sodium</i>	350	SIMPONI	30, 36, 346
.....	403, 472	SENOKOT	351	SIMPONI ARIA	30, 36
SAFYRAL	221	SENOKOT EXTRA		<i>simvastatin</i>	135, 136
SAJAZIR	147	STRENGTH	351	SINEMET	180
<i>salicylic acid</i>	247	SENOKOT-S	350	SINGLE-LET	403, 473
<i>salsalate</i>	51	SENSIPAR	290	SINGULAIR	524, 525
SAMSCA	162	SENSORCAINE	52	<i>sirolimus</i>	392
SANCUSO	326	SENSORCAINE-		SIRTURO	66
SANDIMMUNE	39, 390	EPINEPHRINE	52	<i>sitagliptin</i>	278
SANDOSTATIN	313, 353	SENSORCAINE-MPF	52	<i>sitagliptin-metformin</i>	287
SANDOSTATIN LAR		SENSORCAINE-MPF		SIVEXTRO	80
DEPOT	313, 353	SPINAL	52	SKLICE	251
SANTYL	241	SENSORCAINE-		SKYCLARYS	394
SAPHRIS	185, 191	MPF/EPINEPHRINE	52	SKYRIZI	231, 339, 340
<i>sapropterin</i>	489	SENTRY SENIOR	262	SKYTROFA	301

SLEEP AID (DIPHENHYDRAMINE)	SOLIQUA 100/33	SPRYCEL
..... 204, 506, 511	..... 287	..... 95
SLEEP AID (DOXYLAMINE)	SOLIRIS	SPS (WITH SORBITOL)
..... 204	..... 363, 386	..... 253
SLO-NIACIN	SOLODYN	SRONYX
..... 269, 270	..... 84, 227	..... 221
SLOW-MAG	SOLOSEC	SSD
..... 258	..... 63	..... 240
SLYND	SOLTAMOX	SSS 10-5
..... 223	..... 96	..... 228
SMART SENSE LANCETS	SOLU-CORTEF	<i>stavudine</i>
..... 403, 473	..... 298	..... 65
SMARTEST LANCET	SOLU-CORTEF ACT-O- VIAL (PF)	STEGLATRO
..... 403, 473	..... 298, 299	..... 283
SMOOTH ANTACID	SOLU-MEDROL	STEGLUJAN
..... 319	..... 298, 299	..... 282
SMOOTHLAX	SOLUS V2 LANCETS	STELARA
..... 349	..... 403, 474	..... 231, 339
<i>sodium acetate</i>	SOLUVITA	STENDRA
..... 254	..... 490	..... 251
<i>sodium benzoate (bulk)</i>	SOLUVITA A,C,D WITH FLUORIDE	STERILANCE TL
..... 211, 214	..... 264	..... 403, 474
<i>sodium benzoate-sod phenylacet</i>	SOMATULINE DEPOT	STIMUFEND
..... 488	..... 313	..... 373
<i>sodium bicarbonate</i>	SOMAVERT	STIMULANT LAXATIVE PLUS
..... 254, 318	..... 299	..... 350
<i>sodium bicarbonate (bulk)</i>	SOMINEX	STIOLTO RESPIMAT
..... 211, 254	..... 204, 506, 511	..... 530
<i>sodium chlor 0.9% bacteriostat</i>	SOOLANTRA	STIVARGA
..... 253, 266	..... 249	..... 93
<i>sodium chloride</i>	<i>sorafenib</i>	STOMACH RELIEF
..... 212, 254, 261, 267	..... 93	..... 321
<i>sodium chloride 0.45 %</i>	<i>sorbitol-mannitol</i>	STOOL SOFTENER
..... 267	..... 354	..... 352, 353
<i>sodium chloride 0.9 %</i>	SORILUX	STOOL SOFTENER (DOCUSATE CAL)
..... 253, 266, 267	..... 238	..... 352
<i>sodium chloride 5 % hypertonic</i>	SOSWEET SYRUP VEHICLE	STOOL SOFTENER- LAXATIVE
..... 267	..... 213	..... 350
<i>sodium citrate-citric acid</i>	<i>sotalol</i>	STOOL SOFTENER- STIMULANT LAXAT
..... 358	..... 126, 127, 146	..... 350
SODIUM FLUORIDE 5000 PLUS	SOTALOL AF	STRATTERA
..... 490	..... 127, 146	..... 189
<i>sodium fluoride-pot nitrate</i>	SOTYKTU	STRENSIQ
..... 489, 490	..... 231	..... 486
<i>sodium oxybate</i>	SOTYLIZE	<i>streptomycin</i>
..... 202	..... 127, 146	..... 55
<i>sodium phenylbutyrate</i>	SOVALDI	STRIBILD
..... 488	..... 74	..... 65
<i>sodium phenylbutyrate (bulk)</i>	SOVUNA	STRIVE PEAK FLOW METER
..... 211, 488	..... 36, 62	..... 439, 474
<i>sodium phosphate</i>	SPACE CHAMBER	STRIVERDI RESPIMAT
..... 259, 260	..... 440, 453	..... 527
<i>sodium polystyrene sulfonate</i>	SPACE CHAMBER WITH LARGE MASK	STROMECTOL
..... 253	..... 440, 453	..... 57
<i>sodium,potassium,mag sulfates</i>	SPACE CHAMBER WITH MEDIUM MASK	STROVITE FORTE
..... 350	..... 440, 453	..... 262
SOFDRA	SPACE CHAMBER WITH SMALL MASK	STROVITE ONE
..... 234	..... 440, 454	..... 262
SOF-LAX	SPIKEVAX 2024-2025(12Y UP)(PF)	SUBLOCADE
..... 352	..... 104	..... 206
<i>sofosbuvir-velpatasvir</i>	<i>spinosad</i>	SUBOXONE
..... 74	..... 251	..... 206
SOGROYA	SPINRAZA (PF)	SUBVENITE
..... 301	..... 396	..... 174
SOHONOS	SPIRIVA RESPIMAT	SUBVENITE STARTER (BLUE) KIT
..... 394	..... 526	..... 174, 191
<i>solifenacin</i>	SPIRIVA WITH HANDIHALER	SUBVENITE STARTER (GREEN) KIT
..... 360	..... 526	..... 174, 191
	<i>spironolactone</i>	SUBVENITE STARTER (ORANGE) KIT
	..... 112, 113, 160	..... 174, 191
	<i>spironolacton- hydrochlorothiaz</i>	SUCRAID
	..... 161	..... 329
	SPORANOX	<i>sucrafate</i>
	..... 60	..... 353
	SPRAVATO	SUDOGEST
	..... 176	..... 537
	SPRINTEC (28)	SULAR
	..... 221	..... 154
	SPRITAM	<i>sulfacetamide sodium</i>
	..... 175	..... 239, 502

<i>sulfacetamide sodium (acne)</i>	SURE-TOUCH LANCET	SYRINGE 3CC/25GX1"
.....228	.....403, 475	.....438, 475
<i>sulfacetamide sodium-sulfur</i>	SURGUARD2 SAFETY	<i>syringe with needle</i>.....438, 475
.....228, 229	.....437, 475	SYRPALTA VEHICLE.....213
<i>sulfacetamide sod-sulfur-</i>	SURVANTA.....535	SYRSPEND SF.....214
<i>urea</i>.....229, 249	SUSPENDRX	SYRSPEND SF ALKA.....213
<i>sulfacetamide-prednisolone</i>.....495	ANHYDROUS	SYRSPEND SF LIQUID
<i>sulfadiazine</i>.....82	SWEETENED.....213	.....213, 214
<i>sulfamethoxazole-</i>	SUSPENDRX	SYRSPEND SF PH4.....214
<i>trimethoprim</i>.....57	ANHYDROUS UNSWEET ..213	SYRUP VEHICLE SF.....214
SULFAMYLON.....240	SUSTIVA.....64	SYSTANE (PF).....494
<i>sulfasalazine</i>.....40, 341	SUSTOL.....326	SYSTANE BALANCE.....495
SULFATRIM.....57	SUTAB.....350	SYSTANE COMPLETE.....495
<i>sulindac</i>.....42	SUTENT.....95	SYSTANE GEL.....495
SUMADAN.....229	SWEET-SF.....213	SYSTANE HYDRATION
SUMADAN XLT.....229, 249	SYEDA.....221	(PF).....494
<i>sumatriptan</i>.....197, 198	SYMAX FASTABS.....337, 360	SYSTANE NIGHTTIME.....494
<i>sumatriptan succinate</i> ..198, 199	SYMAX-SL.....337, 360	SYSTANE ULTRA (PF).....494
<i>sumatriptan-naproxen</i>.....200	SYMBICORT.....533	TAB-A-VITE.....262
SUMAXIN.....229	SYMBYAX.....177, 187, 191	TABLOID.....87
SUMAXIN CP.....229	SYMDEKO.....535	TABRECTA.....95
SUMAXIN TS.....229	SYMFI.....66	TACLONEX.....231
<i>sunitinib malate</i>.....95	SYMFI LO.....66	<i>tacrolimus</i>.....240, 390, 391
SUNLENCA.....63	SYMLINPEN 120.....277	<i>tadalafil</i>.....251, 357
SUNOSI.....202	SYMLINPEN 60.....277	<i>tadalafil (pulm. hypertension)</i>
SUPER THIN LANCETS	SYMPAZAN.....172, 190	.....169
.....402, 403, 466, 473, 474	SYMPROIC.....54	TADLIQ.....169
SUPERIOR DIGESTIVE	SYMTOZA.....65	TAFINLAR.....88
ENZYME.....328	SYNAGIS.....100	<i>tafluprost (pf)</i>.....502
SURE COMFORT	SYNALAR.....245	TAGRISSO.....84
ALCOHOL PREP PADS.....99	SYNALAR CREAM KIT.....246	TAKHZYRO.....166
SURE COMFORT INS.	SYNALAR OINTMENT KIT.....246	TALICIA.....338
SYR. U-100.....425, 474	SYNALAR TS.....246	TALTZ AUTOINJECTOR ...232
SURE COMFORT INSULIN	SYNAREL.....310	TALTZ AUTOINJECTOR (2
SYRINGE.....425, 426, 474	SYNJARDY.....281	PACK).....232
SURE COMFORT	SYNJARDY XR.....281, 282	TALTZ AUTOINJECTOR (3
LANCETS.....403, 474	SYNTHROID.....317	PACK).....232
SURE COMFORT PEN	SYPRINE.....54	TALTZ SYRINGE.....232
NEEDLE.....426, 474	<i>syringe (disposable)</i>....437, 475	TALZENNA.....94
SURE COMFORT SAFETY	SYRINGE 3CC/20GX1"	TAMIFLU.....76
PEN NEEDLE.....426, 474	.....437, 475	<i>tamoxifen</i>.....96
SURE-FINE PEN NEEDLES	SYRINGE 3CC/21GX1"	<i>tamsulosin</i>.....357
.....426, 474	.....438, 475	TANDEM PLUS.....262
SURE-JECT INSULIN	SYRINGE 3CC/21GX1-1/2"	TANLOR.....395
SYRINGE.....426, 474, 475	.....438, 475	TAPERDEX.....299
SURE-LANCE.....403, 475	SYRINGE 3CC/22GX1"	TARCEVA.....84
SURE-LANCE ULTRA THIN	.....438, 475	TARGRETIN.....96, 238
.....403, 475	SYRINGE 3CC/22GX3/4"	TARINA 24 FE.....221
SURE-PREP ALCOHOL	.....438, 475	TARINA FE 1/20 (28).....222
PREP PADS.....99		

TARINA FE 1-20 EQ (28)	<i>terbinafine hcl</i> 58, 235	TILIA FE 223
..... 221, 222	<i>terbutaline</i> 529	<i>timolol</i> 500
TARON FORTE 256	<i>terconazole</i> 538	<i>timolol maleate</i> 146, 147, 500
TARON-C DHA 262	<i>teriflunomide</i> 493	<i>timolol maleate (pf)</i> 500
TASCENSO ODT 493	<i>teriparatide</i> 288	TIMOPTIC OCUDOSE (PF) 500
TASIGNA 95	TERUMO ALLERGY	<i>tinidazole</i> 63
<i>tasimelteon</i> 194	SYRINGE 438, 476	<i>tioconazole</i> 538
TASMAR 180	TERUMO HYPODERMIC	TIOCONAZOLE-1 538
<i>tavaborole</i> 237	NEEDLE/SYRIN 438, 476	<i>tiopronin</i> 354
TAVALISSE 365	TERUMO INSULIN	<i>tiotropium bromide</i> 526
TAVNEOS 25	SYRINGE 426, 427, 476	TIVICAY 64
TAYTULLA 222	TERUMO SYRINGE ... 438, 476	TIVICAY PD 64
<i>tazarotene</i> 230, 238, 248	TESTIM 275	<i>tizanidine</i> 395, 396
TAZICEF 69	TESTOPEL 275	TOBI 534
TAZTIA XT 150	<i>testosterone</i> 275	TOBI PODHALER 534
TAZVERIK 89	<i>testosterone cypionate</i> 275, 276	TOBRADEX 495
TDVAX 102	<i>testosterone enanthate</i> 275, 276	TOBRADEX ST 495
TEARS LUBRICANT EYE	<i>tetrabenazine</i> 201	<i>tobramycin</i> 501, 534
DROP 495	<i>tetracaine hcl</i> 500	<i>tobramycin in 0.225 % nacl</i> 534
TECFIDERA 492	<i>tetracaine hcl (pf)</i> 52, 500	<i>tobramycin sulfate</i> 55, 56
TECHLITE INSULIN	<i>tetracycline</i> 84	<i>tobramycin with nebulizer</i> 534
SYRINGE 426, 475	TEXACORT 245	<i>tobramycin-dexamethasone</i> 496
TECHLITE INSULN	TEZSPIRE 525	TOBREX 501
SYR(HALF UNIT) 426, 475	THALITONE 162	<i>tolcapone</i> 180
TECHLITE LANCETS	THALOMID 61, 97	TOLECTIN 600 42
..... 403, 404, 475	THEO-24 525	<i>tolmetin</i> 42
TECHLITE PEN NEEDLE	<i>theophylline</i> 525	<i>tolnaftate</i> 237
..... 426, 475, 476	THERA 262	TOLSURA 60
TECHNIVIE 74	<i>thiamine hcl (vitamin b1)</i> 267	<i>tolterodine</i> 361
TEGRETOL 173, 191	THIN LANCETS	<i>tolvaptan</i> 162
TEGRETOL XR 173, 191	..... 402, 403, 404, 472, 473, 476	TOPAMAX 173
TEGSEDI 275	THINPRO INSULIN	TOPCARE CLICKFINE
TEKTRUNA 169	SYRINGE 427, 476	..... 427, 476
TELCARE LANCETS .. 404, 476	THIOLA 354	TOPCARE ULTRA
<i>telmisartan</i> 122, 123	THIOLA EC 354	COMFORT 427, 476
<i>telmisartan-amlodipine</i> 115, 116	<i>thioridazine</i> 187	TOPCARE UNIVERSAL1
<i>telmisartan-</i>	<i>thiothixene</i> 187	LANCET 404, 476
<i>hydrochlorothiazid</i> 119	THRIVITE RX 266	TOPICORT 245
<i>temazepam</i> 190, 205	THROMBATE III 383	<i>topiramate</i> 174
TEMIXYS 64	THYQUIDITY 317	TOPROL XL 144
<i>temozolomide</i> 85	<i>thyroid (pork)</i> 314	<i>toremifene</i> 96
TENIVAC (PF) 103	TIADYLT ER 150, 151	TORPENZ 93
<i>tenofovir disoproxil fumarate</i>	<i>tiagabine</i> 172	<i>torseamide</i> 161
..... 65, 73	TIAZAC 151	TOSYMRA 199
TENORETIC 100 156	TIBSOVO 93	TOUJEO MAX U-300
TENORETIC 50 156	<i>ticagrelor</i> 383	SOLOSTAR 305
TENORMIN 144	TICOVAC 106	TOUJEO SOLOSTAR U-
TENSION HEADACHE 21	TIGAN 323	300 INSULIN 305
TEPMETKO 95	TIGLUTIK 393	TOVET EMOLLIENT 245
<i>terazosin</i> 165, 166	TIKOSYN 127	TOVET KIT 246

TOVIAZ	361	<i>trientine</i>	54	TROJAN-ENZ	
TPN ELECTROLYTES	259	TRIESENCE (PF)	498	LUBRICATED CONDOMS	
TRACLEER	168, 169	TRI-ESTARYLLA	223	.....	433, 476
TRADJENTA	278	TRIFERIC	257	TROJAN-	
<i>tramadol</i>	13, 14	<i>trifluoperazine</i>	187	ENZ/SPERMICIDAL	
<i>tramadol-acetaminophen</i>	21	<i>trifluridine</i>	502	CONDOMS	433, 476
<i>trandolapril</i>	112	TRIGELS-F FORTE	256	TROKENDI XR	174
<i>trandolapril-verapamil</i>	107	<i>trihexyphenidyl</i>	181	<i>tropicamide</i>	496
<i>tranexamic acid</i>	374	TRIJARDY XR	288	<i>tropium</i>	361
<i>tranexamic acid in nacl, iso-</i>		TRIKAFTA	535	TRUE COMFORT	
<i>os</i>	374	TRI-LEGEST FE	223	ALCOHOL PADS	99
TRANSDERM-SCOP	322	TRILEPTAL	173	TRUE COMFORT INSULIN	
TRANXENE T-TAB	171, 190	TRI-LINYAH	223	SYRINGE	427, 477
<i>tranylcypromine</i>	175	TRILIPIX	131	TRUE COMFORT PEN	
TRAVATAN Z	502	TRI-LO-ESTARYLLA	223	NEEDLE	427, 477
<i>travoprost</i>	502	TRI-LO-MARZIA	223	TRUE COMFORT PRO	
<i>trazodone</i>	176	TRI-LO-MILI	223	ALCOHOL PADS	99
TRECTOR	67	TRI-LO-SPRINTEC	223	TRUE COMFORT PRO INS	
TRELEGY ELLIPTA	534	TRI-LUMA	240	SYRINGE	427, 477
TRELSTAR	91	<i>trimethobenzamide</i>	323	TRUE COVER CONDOM	
TREMFYA	231, 340	<i>trimethoprim</i>	57	.....	434, 477
TREMFYA PEN	231, 340	TRI-MILI	223	TRUEPLUS INSULIN	427, 477
TREMFYA PEN		<i>trimipramine</i>	178	TRUEPLUS KETONE	441, 477
INDUCTION PK-CROHN	340	TRINATAL RX 1	266	TRUEPLUS LANCETS	
<i>treprostinil sodium</i>	167	TRINTELLIX	177	.....	404, 477
TRESIBA FLEXTOUCH U-		TRIPHROCAPS	252	TRUEPLUS PEN NEEDLE	
100	305	TRIPLE ANTIBIOTIC	234	.....	427, 477
TRESIBA FLEXTOUCH U-		<i>triprolidine hcl</i>	507, 511	TRULANCE	327, 339
200	306	TRIPTODUR	310	TRULICITY	280
TRESIBA U-100 INSULIN	305	TRI-SPRINTEC (28)	223	TRUMENBA	104
<i>tretinoin</i>	230, 231	TRISTART DHA	266	TRUQAP	84
<i>tretinoin (antineoplastic)</i>	95	TRIUMEQ	65	TRUSELTIQ	89
<i>tretinoin microspheres</i>	231	TRIUMEQ PD	65	TRUSTEX LATEX	
TRETEN	371	TRI-VITE WITH FLUORIDE	264	CONDOM	434, 478
TREXALL	37, 86, 87	TRIVORA (28)	224	TRUSTEX LUBRICATED	
<i>triamcinolone acetonide</i>		TRI-VYLIBRA	224	CONDOMS	434, 477, 478
.....	245, 299, 490, 536	TRI-VYLIBRA LO	224	TRUSTEX NON-LUB	
<i>triamterene</i>	161	TRIZIVIR	65	CONDOMS	434, 477
<i>triamterene-</i>		TROGARZO	63	TRUSTEX-RIA	
<i>hydrochlorothiazid</i>	162	TROJAN MAGNUM		LUB/SPERMICIDE	434, 478
<i>triazolam</i>	190, 205	CONDOMS	433, 476	TRUSTEX-RIA	
TRIBENZOR	116, 117	TROJAN ULTRA RIBBED		LUBRICATED CONDOMS	
TRI-BUFFERED ASPIRIN	50	CONDOM	433, 476	.....	434, 478
TRICARE	266	TROJAN ULTRA THIN		TRUSTEX-RIA NON-LUB	
TRICITRATES	358	SPERMICIDAL	434, 477	CONDOMS	434, 478
TRICOR	131	TROJAN VERY THIN LUB		TRUVADA	64
TRIDACAINE	249	CONDOMS	433, 477	TRUZONE PEAK FLOW	
TRIDACAINE II	249	TROJAN-ENZ (NON-LUB)		METER	439, 478
TRIDACAINE III	250	CONDOMS	433, 476	TRYVIO	163
TRIDACAINE XL	250				

TUBERCULIN SYRINGE 438, 478 <i>tuberculin-allergy syringes</i> 438, 478	ULTIGUARD SAFEPACK- INSULIN SYR 429, 480	ULTRALANCE LANCETS 404, 482
TUDORZA PRESSAIR 526	ULTIGUARD SAFEPACK- PEN NEEDLE 414, 429, 456, 480	ULTRA-THIN II (SHORT) INS SYR 430, 482
TUKYSA 89	ULTILET ALCOHOL SWAB 99	ULTRA-THIN II (SHORT) PEN NDL 430, 482
TULANA 223	ULTILET BASIC LANCETS 404, 480	ULTRA-THIN II INS PEN NEEDLES 430, 482
TURALIO 95	ULTILET CLASSIC LANCETS 404, 480	ULTRA-THIN II INSULIN SYRINGE 430, 482
TURQOZ (28) 222	ULTILET INSULIN SYRINGE ... 416, 429, 459, 480	ULTRA-THIN II LANCETS 404, 482
TWINRIX (PF) 100	ULTILET LANCETS ... 404, 480	ULTRAVATE 239, 245 <i>umeclidinium-vilanterol</i> 530
TWIRLA 224	ULTILET PEN NEEDLE 429, 480, 481	UNASYN 56
TYBLUME 222	ULTILET SAFETY LANCETS 404, 481	UNDECATREX 276
TYBOST 488	ULTOMIRIS 363, 386	UNIFINE PENTIPS 408, 420, 423, 425, 430, 431, 432, 447, 466, 470, 473, 482, 483
TYDEMY 222	ULTRA CMFT INS SYR (HALF UNIT) 414, 427, 456, 478	UNIFINE PENTIPS MAXFLOW 432, 483
TYENNE 39	ULTRA COMFORT INSULIN SYRINGE 411, 414, 429, 450, 456, 481	UNIFINE PENTIPS PLUS 408, 414, 423, 425, 432, 433, 447, 457, 470, 472, 473, 483, 484, 486
TYENNE AUTOINJECTOR ... 39	ULTRA FLO INSUL SYR(HALF UNIT) 430, 481	UNIFINE PENTIPS PLUS MAXFLOW 432, 484
TYKERB 84	ULTRA FLO INSULIN SYRINGE 430, 481	UNIFINE SAFECONTROL PEN NEEDLE 432, 484
TYMLOS 288	ULTRA FLO PEN NEEDLE 430, 481	UNIFINE ULTRA PEN NEEDLE 432, 484
TYPHIM VI 103	ULTRA THIN II LANCETS 404, 482	UNILET COMFORTOUCH LANCET 405, 484
TYRVAYA 536	ULTRA THIN LANCETS 399, 402, 404, 449, 468, 472, 481	UNILET GP LANCET .. 405, 484
TYVASO 167	ULTRA THIN PEN NEEDLE 430, 481	UNILET LANCET 400, 402, 405, 455, 470, 484, 485
TYVASO DPI 167	ULTRA THIN PLUS LANCETS 402, 472	UNILET LANCETS 405, 484
TYVASO INSTITUTIONAL START KIT 167	ULTRA TLC LANCETS 405, 482	UNILET SUPER THIN LANCETS ... 402, 405, 470, 484
TYVASO REFILL KIT 167	ULTRACARE PEN NEEDLE 430, 481	UNISOM (DOXYLAMINE) ... 204
TYVASO STARTER KIT 167 <i>ubiquinol (bulk)</i> 4, 211	ULTRA-FINE INS SYR (HALF UNIT) 430, 481	UNISOM SLEEPGELS 204, 511
UBRELVY 195	ULTRA-FINE INSULIN SYRINGE 430, 481, 482	UNISPEND ANHYDROUS SWEET 214
UCERIS 341	ULTRA-FINE PEN NEEDLE 430, 482	UNISTIK 3 COMFORT LANCET 405, 485
UDENYCA 373		UNISTIK 3 EXTRA LANCET 405, 485
UDENYCA AUTOINJECTOR 373		UNISTIK 3 GENTLE ... 405, 485
UDENYCA ONBODY 373		
UKONIQ 93		
ULORIC 363		
ULTICARE 427, 428, 429, 438, 478, 479, 480		
ULTICARE INSULIN SYRINGE 427, 428, 479		
ULTICARE INSULN SYR(HALF UNIT) 428, 479		
ULTICARE PEN NEEDLE 414, 428, 433, 456, 457, 479, 486		
ULTICARE SAFETY PEN NEEDLE 428, 479		
ULTICARE SAFETY SYRINGE 438, 479		

UNISTIK 3 NORMAL		VANFLYTA	89	VFEND IV	61
LANCET	405, 485	VANISHPOINT INSULIN		V-GO 20	441, 485
UNISTIK CZT LANCET		SYRINGE	432, 485	V-GO 30	441, 485
.....	405, 485	VANISHPOINT SYRINGE		V-GO 40	441, 485
UNISTIK SAFETY	405, 485	.....	432, 438, 485	VIAGRA	251
UNISTIK TOUCH LANCETS		VANISHPOINT		VIBERZI	339, 347
.....	405, 485	TUBERCULIN SYRINGE		VICTOZA 2-PAK	280
UNITHROID	317, 318	.....	438, 485	VICTOZA 3-PAK	280
UNIVERSAL 1 LANCETS		VANOS	245	VIEKIRA PAK	74
400, 401, 402, 405, 456, 457,		VAQTA (PF)	100	VIEKIRA XR	74
461, 463, 472, 485		<i>ildenafil</i>	251	VIENVA	222
UPTRAVI	163, 164	<i>varenicline tartrate</i>	210	<i>vigabatrin</i>	173
URAMAXIN	247	VARIVAX (PF)	101, 106	VIGADRONE	173
<i>urea</i>	247	VASERETIC	108	VIGAFYDE	173
<i>urea (bulk)</i>	211, 247	VASOSTRICT	276	VIGAMOX	501
URELLE	79, 359	VASOTEC	112	VIGPODER	173
URIBEL	79, 359	VAXCHORA VACCINE		VIIBRYD	177
URIBEL TABS	79, 359	.....	101, 104	VIJOICE	488
URIMAR-T	79, 359	VAXNEUVANCE (PF)	103	<i>vilazodone</i>	177
URO-458	79, 359	VECTICAL	239	VILTEPSO	394
UROCI-K 10	358	VELCADE	94	VIMIZIM	487
UROCI-K 15	358	VELIVET TRIPHASIC		VIMKUNYA	104
UROGESIC-BLUE	79, 360	REGIMEN (28)	224	VIMOVO	41
URO-MP	79, 359	VELPHORO	355, 356	VIMPAT	172
URSO FORTE	329	VELSIPIITY	342	VIOKACE	328
<i>ursodiol</i>	329	VELTASSA	253	VIORELE (28)	217
UZEDY	186	VEMLIDY	73	VIRACEPT	82
VAFSEO	373	VENCLEXTA	88	VIRAMUNE	64
VAGIFEM	538	VENCLEXTA STARTING		VIREAD	65, 73
<i>valacyclovir</i>	75	PACK	88	VIRT-CAPS	252
VALCHLOR	237	<i>venlafaxine</i>	177	VISTARIL	170
VALCYTE	70	<i>venlafaxine besylate</i>	177	VIT 3	262
<i>valganciclovir</i>	70	VENTAVIS	167, 168	VITAFOL FE PLUS	266
VALIUM	171, 190	VENTOLIN HFA	529	VITAFOL GUMMIES	266
<i>valproate sodium</i>	172	VENXXIVA	354	VITAFOL ULTRA	266
<i>valproic acid</i>	172, 191	VEOPOZ	318	VITAFOL-OB	266
<i>valproic acid (as sodium</i>		<i>verapamil</i>	127, 128, 154, 155	VITAFOL-OB+DHA	266
<i>salt)</i>	172, 191	VEREGEN	246	VITAFOL-ONE	266
<i>valsartan</i>	123	VERELAN PM	155	VITAL-D RX	262, 271
<i>valsartan-</i>		VERQUVO	125	<i>vitamin a</i>	267
<i>hydrochlorothiazide</i>	119	VERSA FREE	214	<i>vitamin a palmitate</i>	267
VALTOCO	172, 190	VERSA PLUS	214	VITAMIN B-2	269
VALTRESX	75	VERSACLOZ	186	VITAMIN B-6	270
VALTYA	222	VERZENIO	88	VITAMIN C	270
VANALICE	250	VESICARE	360	VITAMIN D2	271
VANOCOCIN	72	VESICARE LS	360	VITAMIN D3	271, 272
<i>vancomycin</i>	72, 73	VESTURA (28)	222	<i>vitamin e (dl, acetate)</i>	272
<i>vancomycin in 0.9 % sodium</i>		VEVYE	498	<i>vitamin e mixed</i>	272
<i>chl</i>	73	VFEND	60, 61	<i>vitamin e succinate</i>	272
<i>vancomycin in dextrose 5 %</i> ..	73			VITAMIN K1	273

VITAMINS A,C,D AND FLUORIDE	264, 265	WAL-SOM (DIPHENHYDRAMINE)	204, 511	XANAX XR	171, 190
VITRAKVI	97	WAL-SOM (DOXYLAMINE)	205	XARAH FE	224
VIVELLE-DOT	293	<i>warfarin</i>	365	XARELTO	366, 367
VIVITROL	206	<i>water for injection, sterile</i>	267	XARELTO DVT-PE TREAT 30D START	367
VIVJOA	59	WEBCOL	99, 100	XATMEP	37, 87
VIVOTIF	102, 103	WEEKLY-D	272	XCOPRI	175
VIZIMPRO	84	WEGOVY	541	XCOPRI MAINTENANCE PACK	175
VOGELXO	276	WELCHOL	129	XCOPRI TITRATION PACK	175
VOLNEA (28)	217	WELIREG	90	XELJANZ	40, 341
VONJO	90	WELLBUTRIN	178	XELJANZ XR	40, 341
VONVENDI	374	WELLBUTRIN SR	178	XELODA	87
VOQUEZNA	331	WELLBUTRIN XL	178	XELPROS	503
VOQUEZNA DUAL PAK	338	WERA (28)	222	XELRIA FE	222
VOQUEZNA TRIPLE PAK	338	WESCAPS	252	XELSTRYM	189, 192
VORANIGO	97	WES-PHOS 250 NEUTRAL	260, 358	XENAZINE	201
<i>voriconazole</i>	61	WESTAB MAX	267, 273	XENICAL	540
VORTEX HOLDING CHAMBER	441, 485	WESTAB PLUS	266	XEPI	234
VORTEX VHC FROG MASK-CHILD	441, 485	WESTAB DHA	266	XERAC AC	238
VORTEX VHC LADYBUG MASK-TODDLR	441, 485	WIDE-SEAL DIAPHRAGM 60	397, 485	XERESE	240
VOSEVI	74	WIDE-SEAL DIAPHRAGM 65	397, 486	XHANCE	536
VOTRIENT	95	WIDE-SEAL DIAPHRAGM 70	397, 486	XIFAXAN	82
VOXZOGO	288	WIDE-SEAL DIAPHRAGM 75	397, 486	XIGDUO XR	282
VOYDEYA	363, 386	WIDE-SEAL DIAPHRAGM 80	397, 486	XIIDRA	498
VPRIV	486	WIDE-SEAL DIAPHRAGM 85	397, 486	XIPERE (PF)	498
VRAYLAR	188, 192	WIDE-SEAL DIAPHRAGM 90	397, 486	XOFLUZA	76
VTAMA	239	WIDE-SEAL DIAPHRAGM 95	397, 486	XOLAIR	520
VUMERITY	492	WILATE	371	XOLREMDI	366
VUSION	237	WINLEVI	227	XOPENEX HFA	529
VYALEV	180	WINREVAIR	166	XOSPATA	89
VYFEMLA (28)	222	WINRHO SDF	101	XPHOZAH	253
VYLIBRA	222	WIXELA INHUB	533	XPOVIO	89, 96
VYNDAMAX	274	WOMEN'S GENTLE LAXATIVE(BISAC)	352	XTANDI	86
VYNDAQEL	275	WYMZYA FE	222	XULANE	224
VYONDYS-53	394	XACIATO	537	XULTOPHY 100/3.6	288
VYTORIN 10-10	140	XADAGO	181, 182	XYLOCAINE	52
VYTORIN 10-20	140	XALATAN	503	XYLOCAINE WITH EPINEPHRINE	52
VYTORIN 10-40	140	XALKORI	85	XYLOCAINE-MPF	52
VYTORIN 10-80	140	XANAX	171, 190	XYLOCAINE- MPF/EPINEPHRINE	52
VYVANSE	189			XYMOZYME	329
VYZULTA	503			XYNTHA	371
WAINUA	275			XYNTHA SOLOFUSE	371
WAKIX	203			XYOSTED	276
				XYREM	202
				XYWAV	202
				YARGESA	487
				YASMIN (28)	222

YAZ (28)	222	<i>zidovudine</i>	65	ZYMFENTRA	31, 346, 347
YF-VAX (PF)	102, 106	ZIEXTENZO	373	ZYNTEGLO	371
YONSA	84, 86	ZILBRYSQ	393	ZYPITAMAG	136, 137
YORVIPATH	311	<i>zileuton</i>	519	ZYPREXA	187, 192
YUFLYMA(CF)	30, 36, 346	ZIMHI	55	ZYPREXA RELPREVV	187
YUFLYMA(CF) AI		<i>zinc gluconate</i>	261	ZYPREXA ZYDIS	187, 192
CROHN'S-UC-HS	31, 36, 346	<i>zinc sulfate</i>	261	ZYTIGA	84, 86
YUFLYMA(CF)		ZINC-220	261	ZYVOX	80
AUTOINJECTOR		ZIOPTAN (PF)	503		
.....	30, 31, 36, 346	<i>ziprasidone hcl</i>	185, 192		
YUPELRI	526	<i>ziprasidone mesylate</i> ...	185, 192		
YUSIMRY(CF) PEN	31, 36, 346	ZIRGAN	502		
YUVAFEM	538	ZITHROMAX	79		
ZADITOR	497	ZITHROMAX TRI-PAK	79		
ZAFEMY	224	ZITHROMAX Z-PAK	79		
<i>zafirlukast</i>	525	ZITUVIMET	287		
<i>zaleplon</i>	205	ZITUVIMET XR	287		
ZANAFLEX	396	ZITUVIO	278		
ZARAH	222	ZOCOR	136		
ZARONTIN	175	ZOKINVY	489		
ZARXIO	373	<i>zoledronic acid</i>	290		
ZATEAN-PN PLUS	262	<i>zoledronic acid-mannitol-</i>			
ZAVESCA	488	<i>water</i>	290		
ZAVZPRET	195	ZOLINZA	90		
ZEGALOGUE		<i>zolmitriptan</i>	199, 200		
AUTOINJECTOR	274	ZOLOFT	176		
ZEGALOGUE SYRINGE	274	<i>zolpidem</i>	205		
ZEGERID	335	ZOMACTON	301		
ZEJULA	94	ZOMIG	200		
ZELAPAR	182	ZONALON	250		
ZELBORAF	88	ZONISADE	175		
ZEMBRACE SYMTOUCH ...	199	<i>zonisamide</i>	175		
ZEMPLAR	487	ZORTRESS	392		
ZENATANE	227	ZORYVE	233, 239		
ZENPEP	328	ZOSYN IN DEXTROSE			
ZENZEDI	189, 192, 203	(ISO-OSM)	81		
ZEPATIER	74	ZOVIA 1-35 (28)	222		
ZEPBOUND	540	ZOVIRAX	239, 240		
ZEPOSIA	342, 493	ZTALMY	174		
ZEPOSIA STARTER KIT		ZTLIDO	250		
(28-DAY)	342, 493	ZUBSOLV	206		
ZEPOSIA STARTER PACK		ZULRESSO	176		
(7-DAY)	342, 493	ZUMANDIMINE (28)	222		
ZERVIAE	497	ZURZUVAE	176		
ZESTORETIC	108	ZYCLARA	247		
ZESTRIL	112	ZYDELIG	94		
ZETIA	138	ZYFLO	519		
ZETONNA	536	ZYKADIA	85		
ZIAGEN	65	ZYLET	496		
ZIANA	229	ZYLOPRIM	363		

