



**Keystone 65 Rx HMO**  
**Personal Choice 65<sup>SM</sup> Rx PPO**  
**Select Option<sup>®</sup> Rx PDP**

**2022 Utilization Management Criteria: Step Therapy**

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

This document was updated on 10/19/2021. For more recent information or other questions, please contact our Member Help Team: Keystone 65 at 1-844-352-1699, Personal Choice 65 at 1-888-879-4293, Select Option at 1-888-678-7009 or, for TTY/TDD users, 711, seven days a week from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, visit [www.ibxmedicare.com](http://www.ibxmedicare.com) to use our *Formulary (List of Covered Drugs)* search tool or view a downloadable document.

When this document refers to “we,” “us,” or “our,” it means Independence Blue Cross. When it refers to “plan” or “our plan,” it means Keystone 65 Rx, Personal Choice 65 Rx, and Select Option Rx.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

Independence Blue Cross offers Medicare Advantage plans with a Medicare contract. Enrollment in Independence Medicare Advantage plans depends on contract renewal.

Keystone 65: Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

Personal Choice 65 and Select Option: Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

## There may be restrictions to your drug coverage

Some covered drugs may have additional requirements or limits on coverage. We call this “utilization management.” These requirements and limits may include:

- **Prior Authorization (PA):** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don’t get approval, our plan may not cover the drug. Drugs that require prior authorization are listed in *2022 Utilization Management Criteria: Prior Authorization*.
- **Step Therapy (ST):** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs that require step therapy are listed in this document.
- **Quantity Limits (QL):** For certain drugs, our plan limits the amount of the drug that our plan will cover. Drugs that have quantity limits are listed in the *Keystone 65 Rx, Personal Choice 65 Rx, and Select Option Rx Formulary (List of Covered Drugs)*.

You can find out if your drug has any additional requirements or limits by looking in your plan *Formulary (List of Covered Drugs)*. You can also get more information about the restrictions applied to specific covered drugs by visiting [www.ibxmedicare.com](http://www.ibxmedicare.com).

You can ask our plan to make an exception to these restrictions or limits, or for a list of other similar drugs that may treat your health condition. Your *Formulary (List of Covered Drugs)* and *Evidence of Coverage* will have more information about the exception request process.

### How to use this document

This document, along with *2022 Utilization Management Criteria: Prior Authorization*, is intended to be used with your *Formulary (List of Covered Drugs)*. If your prescription drug has the note “ST” in the “Requirements” column of the *Keystone 65 Rx, Personal Choice 65 Rx, and Select Option Rx Formulary (List of Covered Drugs)*, you can find more information on the restriction(s) in this document.

Locate your drug in the index on page 31. The restriction information includes step therapy criteria.

Be sure to read all the information listed for your affected drug. If you have any questions or need assistance with the information contained in this document, please call our Member Help Team: Keystone 65 at 1-844-352-1699, Personal Choice 65 at 1-888-879-4293, Select Option at 1-888-678-7009.

# ALBUTEROL 2022

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## Products Affected

- PROAIR DIGIHALER AEROSOL POWDER  
BREATH ACTIVATED 108 (90 BASE) MCG/ACT  
INHALATION

## Details

<b>Criteria</b>	Trial of Proair HFA or Proair Respiclick. Always Applies.
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# ANTIDEPRESSANTS [SNRIS] 2022

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## Products Affected

- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL
- FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL

## Details

<b>Criteria</b>	Trial of two generic formulary serotonin-norepinephrine reuptake Inhibitor (SNRI). Applies to new starts.
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# BENZODIAZEPINES 2022

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## Products Affected

- ATIVAN TABLET 0.5 MG ORAL
- ATIVAN TABLET 1 MG ORAL
- ATIVAN TABLET 2 MG ORAL

## Details

<b>Criteria</b>	Trial of two generic formulary benzodiazepines. Always Applies.
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# BRAND ANTIPSYCHOTICS 2022

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## Products Affected

- ABILIFY TABLET 10 MG ORAL
- ABILIFY TABLET 15 MG ORAL
- ABILIFY TABLET 2 MG ORAL
- ABILIFY TABLET 20 MG ORAL
- ABILIFY TABLET 30 MG ORAL
- ABILIFY TABLET 5 MG ORAL
- CAPLYTA CAPSULE 42 MG ORAL
- FANAPT TABLET 1 MG ORAL
- FANAPT TABLET 10 MG ORAL
- FANAPT TABLET 12 MG ORAL
- FANAPT TABLET 2 MG ORAL
- FANAPT TABLET 4 MG ORAL
- FANAPT TABLET 6 MG ORAL
- FANAPT TABLET 8 MG ORAL
- FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL
- REXULTI TABLET 0.25 MG ORAL
- REXULTI TABLET 0.5 MG ORAL
- REXULTI TABLET 1 MG ORAL
- REXULTI TABLET 2 MG ORAL
- REXULTI TABLET 3 MG ORAL
- REXULTI TABLET 4 MG ORAL
- SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL
- SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL
- VRAYLAR CAPSULE 1.5 MG ORAL
- VRAYLAR CAPSULE 3 MG ORAL
- VRAYLAR CAPSULE 4.5 MG ORAL
- VRAYLAR CAPSULE 6 MG ORAL
- VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL

## Details

Details	
<b>Criteria</b>	Trial of two generic antipsychotic products. Applies to new starts.

# BRAND BUPROPION PRODUCTS 2022

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## Products Affected

- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL
- FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL
- WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL
- WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL

## Details

<b>Criteria</b>	Trial of one generic formulary bupropion product. Applies to new starts.
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# BRAND ORAL NSAIDS 2022

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## Products Affected

- RELAFEN DS TABLET 1000 MG ORAL

## Details

<b>Criteria</b>	Trial of two generic formulary non-steroidal anti-inflammatory drugs (NSAIDs). Always applies.
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# BUDESONIDE CAPSULES 2022

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## Products Affected

- ORTIKOS CAPSULE EXTENDED RELEASE 24 HOUR 6 MG ORAL
- ORTIKOS CAPSULE EXTENDED RELEASE 24 HOUR 9 MG ORAL

## Details

<b>Criteria</b>	Trial of generic budesonide capsule DR 3mg (generic Entocort EC). Always applies.
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# CUPRIMINE 2022

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## Products Affected

- CUPRIMINE CAPSULE 250 MG ORAL

## Details

<b>Criteria</b>	Trial of penicillamine or brand Depen. Always applies.
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# DRIZALMA 2022

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## Products Affected

- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 40 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 60 MG ORAL

## Details

<b>Criteria</b>	Trial of generic formulary duloxetine. Applies to new starts.
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# DYMISTA 2022

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## Products Affected

- *azelastine-fluticasone suspension 137-50 mcg/act nasal*

## Details

<b>Criteria</b>	Trial of both generic fluticasone nasal spray and azelastine nasal spray. Always applies.
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# GIMOTI 2022

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## Products Affected

- GIMOTI SOLUTION 15 MG/ACT NASAL

## Details

<b>Criteria</b>	Trial of generic oral metoclopramide. Always applies.
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# GLOPERBA 2022

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## Products Affected

- GLOPERBA SOLUTION 0.6 MG/5ML ORAL

## Details

<b>Criteria</b>	Trial of generic formulary colchicine. Always applies.
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# GOUT AGENTS 2022

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## Products Affected

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*

## Details

<b>Criteria</b>	Trial of generic allopurinol. Always applies.
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# IMPETIGO AGENTS 2022

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## Products Affected

- ALTABAX OINTMENT 1 % EXTERNAL

## Details

<b>Criteria</b>	Trial of generic formulary mupirocin ointment. Always applies
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# INSULIN GLARGINE 2022

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## Products Affected

- BASAGLAR KWIKPEN SOLUTION PEN-INJECTOR  
100 UNIT/ML SUBCUTANEOUS

## Details

Criteria	Trial of two of the following: Lantus, Levemir, Toujeo, Tresiba. Always applies.
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# LONHALA STEP THERAPY 2022

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## Products Affected

- LONHALA MAGNAIR REFILL KIT SOLUTION 25 MCG/ML INHALATION

## Details

<b>Criteria</b>	Trial of Spiriva or Spiriva Respimat or Incruse Ellipta. Always applies.
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# MIGRAINE AGENTS 2022-Pending CMS Review

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## Products Affected

- NURTEC TABLET DISPERSIBLE 75 MG ORAL
- TOSYMRA SOLUTION 10 MG/ACT NASAL

## Details

<b>Criteria</b>	Trial of two generic formulary triptans. Always applies.
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# MULTIPLE SCLEROSIS AGENTS 2022-Pending CMS Review

## Products Affected

- BAFIERTAM CAPSULE DELAYED RELEASE 95 MG ORAL
- COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS
- COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS
- KESIMPTA SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS
- MAVENCLAD (10 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (4 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (5 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (6 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (7 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (8 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAVENCLAD (9 TABS) TABLET THERAPY PACK 10 MG ORAL
- MAYZENT STARTER PACK TABLET THERAPY PACK 12 X 0.25 MG ORAL
- MAYZENT TABLET 0.25 MG ORAL
- MAYZENT TABLET 2 MG ORAL
- PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL
- PONVORY TABLET 20 MG ORAL
- VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL
- ZEPOSIA 7-DAY STARTER PACK CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG ORAL
- ZEPOSIA CAPSULE 0.92 MG ORAL
- ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0.23MG & 0.46MG & 0.92MG ORAL

## Details

<b>Criteria</b>	Trial of two of the following medications: (1) Avonex (interferon beta-1a), (2) Plegridy (peginterferon beta-1a), (3) Betaseron (interferon beta-1b), (4) Glatopa (glatiramer acetate), (5) Tecfidera (Dimethyl Fumarate), (6) Gilenya (fingolimod), (7) Aubagio (teriflunomide), or (8) Rebif (interferon beta 1a). Applies to new starts.
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# OIC AGENTS 2022-Pending CMS Review

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**Products Affected**

- RELISTOR SOLUTION 12 MG/0.6ML SUBCUTANEOUS
- RELISTOR SOLUTION 8 MG/0.4ML
- RELISTOR TABLET 150 MG ORAL

**Details**

<b>Criteria</b>	Trial of Amitiza (lubiprostone). Always Applies.
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# OPHTHALMIC PROSTAGLANDINS 2022-Pending CMS Review

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## Products Affected

- RHOPRESSA SOLUTION 0.02 % OPHTHALMIC

## Details

<b>Criteria</b>	Trial of three from the following: generic formulary ophthalmic prostaglandin products, brand Lumigan 0.01%. Always applies.
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# PROTON PUMP INHIBITORS (PPIs) 2022

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## Products Affected

- *omeprazole-sodium bicarbonate packet 20-1680 mg oral*
- *omeprazole-sodium bicarbonate packet 40-1680 mg oral*
- *rabeprazole sodium tablet delayed release 20 mg oral*

## Details

<b>Criteria</b>	Trial of two generic formulary proton pump inhibitors. Always applies.
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# RELTONE 2022

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## Products Affected

- RELTONE CAPSULE 200 MG ORAL
- RELTONE CAPSULE 400 MG ORAL

## Details

<b>Criteria</b>	Trial of generic formulary ursodiol capsules. Always applies.
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# RENIN INHIBITORS 2022

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## Products Affected

- TEKTURNA HCT TABLET 150-12.5 MG ORAL
- TEKTURNA HCT TABLET 150-25 MG ORAL
- TEKTURNA HCT TABLET 300-12.5 MG ORAL
- TEKTURNA HCT TABLET 300-25 MG ORAL

## Details

<b>Criteria</b>	Trial of Aliskiren or two from the following: generic formulary Angiotensin-converting-enzyme (ACE) inhibitors OR generic formulary angiotensin II receptor blockers (ARB). Always Applies.
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# SANCUSO 2022

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## Products Affected

- SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL

## Details

<b>Criteria</b>	Trial of (a) ondansetron or granisetron and (b) aprepitant. Always applies.
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# SAVELLA 2022

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## Products Affected

- SAVELLA TABLET 100 MG ORAL
- SAVELLA TABLET 12.5 MG ORAL
- SAVELLA TABLET 25 MG ORAL
- SAVELLA TABLET 50 MG ORAL
- SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL

## Details

<b>Criteria</b>	Trial of generic formulary duloxetine. Applies to new starts.
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# TRULANCE 2022

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## Products Affected

- TRULANCE TABLET 3 MG ORAL

## Details

<b>Criteria</b>	Trial of both of the following: (1) lactulose and (2) Linzess or Amitiza (lubiprostone). Always applies.
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# VIIBRYD 2022

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## Products Affected

- VIIBRYD STARTER PACK KIT 10 & 20 MG ORAL
- VIIBRYD TABLET 10 MG ORAL
- VIIBRYD TABLET 20 MG ORAL
- VIIBRYD TABLET 40 MG ORAL

## Details

<b>Criteria</b>	Trial of two generic formulary selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors. Applies to new starts.
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# XCOPRI 2022

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## Products Affected

- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL
- XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL
- XCOPRI TABLET 100 MG ORAL
- XCOPRI TABLET 150 MG ORAL
- XCOPRI TABLET 200 MG ORAL
- XCOPRI TABLET 50 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL

## Details

Details	
<b>Criteria</b>	Trial of two generic formulary anticonvulsants. Applies to new starts.

## Index

ABILIFY TABLET 10 MG ORAL.....	6	<i>febuxostat tablet 80 mg oral</i> .....	15
ABILIFY TABLET 15 MG ORAL.....	6	FETZIMA CAPSULE EXTENDED RELEASE 24	
ABILIFY TABLET 2 MG ORAL.....	6	HOUR 120 MG ORAL.....	4
ABILIFY TABLET 20 MG ORAL.....	6	FETZIMA CAPSULE EXTENDED RELEASE 24	
ABILIFY TABLET 30 MG ORAL.....	6	HOUR 20 MG ORAL.....	4
ABILIFY TABLET 5 MG ORAL.....	6	FETZIMA CAPSULE EXTENDED RELEASE 24	
ALTABAX OINTMENT 1 % EXTERNAL.....	16	HOUR 40 MG ORAL.....	4
APLENZIN TABLET EXTENDED RELEASE 24		FETZIMA CAPSULE EXTENDED RELEASE 24	
HOUR 174 MG ORAL.....	7	HOUR 80 MG ORAL.....	4
APLENZIN TABLET EXTENDED RELEASE 24		FETZIMA TITRATION CAPSULE ER 24 HOUR	
HOUR 348 MG ORAL.....	7	THERAPY PACK 20 & 40 MG ORAL.....	4
APLENZIN TABLET EXTENDED RELEASE 24		FORFIVO XL TABLET EXTENDED RELEASE 24	
HOUR 522 MG ORAL.....	7	HOUR 450 MG ORAL.....	7
ATIVAN TABLET 0.5 MG ORAL.....	5	GIMOTI SOLUTION 15 MG/ACT NASAL.....	13
ATIVAN TABLET 1 MG ORAL.....	5	GLOPERBA SOLUTION 0.6 MG/5ML ORAL.....	14
ATIVAN TABLET 2 MG ORAL.....	5	KESIMPTA SOLUTION AUTO-INJECTOR 20	
<i>azelastine-fluticasone suspension 137-50</i>		MG/0.4ML SUBCUTANEOUS.....	20
<i>mcg/act nasal</i> .....	12	LONHALA MAGNAIR REFILL KIT SOLUTION 25	
BAFIERTAM CAPSULE DELAYED RELEASE 95		MCG/ML INHALATION.....	18
MG ORAL.....	20	MAVENCLAD (10 TABS) TABLET THERAPY	
BASAGLAR KWIKPEN SOLUTION PEN-		PACK 10 MG ORAL.....	20
INJECTOR 100 UNIT/ML SUBCUTANEOUS.....	17	MAVENCLAD (4 TABS) TABLET THERAPY	
CAPLYTA CAPSULE 42 MG ORAL.....	6	PACK 10 MG ORAL.....	20
COPAXONE SOLUTION PREFILLED SYRINGE		MAVENCLAD (5 TABS) TABLET THERAPY	
20 MG/ML SUBCUTANEOUS.....	20	PACK 10 MG ORAL.....	20
COPAXONE SOLUTION PREFILLED SYRINGE		MAVENCLAD (6 TABS) TABLET THERAPY	
40 MG/ML SUBCUTANEOUS.....	20	PACK 10 MG ORAL.....	20
CUPRIMINE CAPSULE 250 MG ORAL.....	10	MAVENCLAD (7 TABS) TABLET THERAPY	
DRIZALMA SPRINKLE CAPSULE DELAYED		PACK 10 MG ORAL.....	20
RELEASE SPRINKLE 20 MG ORAL.....	11	MAVENCLAD (8 TABS) TABLET THERAPY	
DRIZALMA SPRINKLE CAPSULE DELAYED		PACK 10 MG ORAL.....	20
RELEASE SPRINKLE 30 MG ORAL.....	11	MAVENCLAD (9 TABS) TABLET THERAPY	
DRIZALMA SPRINKLE CAPSULE DELAYED		PACK 10 MG ORAL.....	20
RELEASE SPRINKLE 40 MG ORAL.....	11	MAYZENT STARTER PACK TABLET THERAPY	
DRIZALMA SPRINKLE CAPSULE DELAYED		PACK 12 X 0.25 MG ORAL.....	20
RELEASE SPRINKLE 60 MG ORAL.....	11	MAYZENT TABLET 0.25 MG ORAL.....	20
FANAPT TABLET 1 MG ORAL.....	6	MAYZENT TABLET 2 MG ORAL.....	20
FANAPT TABLET 10 MG ORAL.....	6	NURTEC TABLET DISPERSIBLE 75 MG ORAL.....	19
FANAPT TABLET 12 MG ORAL.....	6	<i>omeprazole-sodium bicarbonate packet 20-</i>	
FANAPT TABLET 2 MG ORAL.....	6	<i>1680 mg oral</i> .....	23
FANAPT TABLET 4 MG ORAL.....	6	<i>omeprazole-sodium bicarbonate packet 40-</i>	
FANAPT TABLET 6 MG ORAL.....	6	<i>1680 mg oral</i> .....	23
FANAPT TABLET 8 MG ORAL.....	6	ORTIKOS CAPSULE EXTENDED RELEASE 24	
FANAPT TITRATION PACK TABLET 1 & 2 & 4		HOUR 6 MG ORAL.....	9
& 6 MG ORAL.....	6	ORTIKOS CAPSULE EXTENDED RELEASE 24	
<i>febuxostat tablet 40 mg oral</i> .....	15	HOUR 9 MG ORAL.....	9

PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL.....	20	TOSYMRA SOLUTION 10 MG/ACT NASAL.....	19
PONVORY TABLET 20 MG ORAL.....	20	TRULANCE TABLET 3 MG ORAL.....	28
PROAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION.....	3	VIIBRYD STARTER PACK KIT 10 & 20 MG ORAL.....	29
<i>rabeprazole sodium tablet delayed release 20 mg oral.....</i>	23	VIIBRYD TABLET 10 MG ORAL.....	29
RELAFEN DS TABLET 1000 MG ORAL.....	8	VIIBRYD TABLET 20 MG ORAL.....	29
RELISTOR SOLUTION 12 MG/0.6ML SUBCUTANEOUS.....	21	VIIBRYD TABLET 40 MG ORAL.....	29
RELISTOR SOLUTION 8 MG/0.4ML SUBCUTANEOUS.....	21	VRAYLAR CAPSULE 1.5 MG ORAL.....	6
RELISTOR TABLET 150 MG ORAL.....	21	VRAYLAR CAPSULE 3 MG ORAL.....	6
RELTONE CAPSULE 200 MG ORAL.....	24	VRAYLAR CAPSULE 4.5 MG ORAL.....	6
RELTONE CAPSULE 400 MG ORAL.....	24	VRAYLAR CAPSULE 6 MG ORAL.....	6
REXULTI TABLET 0.25 MG ORAL.....	6	VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL.....	6
REXULTI TABLET 0.5 MG ORAL.....	6	VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL.....	20
REXULTI TABLET 1 MG ORAL.....	6	WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL.....	7
REXULTI TABLET 2 MG ORAL.....	6	WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL.....	7
REXULTI TABLET 3 MG ORAL.....	6	XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL.....	30
REXULTI TABLET 4 MG ORAL.....	6	XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL.....	30
RHOPRESSA SOLUTION 0.02 % OPHTHALMIC.	22	XCOPRI TABLET 100 MG ORAL.....	30
SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL.....	26	XCOPRI TABLET 150 MG ORAL.....	30
SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL.....	6	XCOPRI TABLET 200 MG ORAL.....	30
SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL.....	6	XCOPRI TABLET 50 MG ORAL.....	30
SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL.....	6	XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL.....	30
SAVELLA TABLET 100 MG ORAL.....	27	XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG ORAL.....	30
SAVELLA TABLET 12.5 MG ORAL.....	27	XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL.....	30
SAVELLA TABLET 25 MG ORAL.....	27	ZEPOSIA 7-DAY STARTER PACK CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG ORAL.....	20
SAVELLA TABLET 50 MG ORAL.....	27	ZEPOSIA CAPSULE 0.92 MG ORAL.....	20
SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL.....	27	ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0.23MG & 0.46MG & 0.92MG ORAL.....	20
SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL.....	6		
SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL.....	6		
SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL.....	6		
TEKTURNA HCT TABLET 150-12.5 MG ORAL...	25		
TEKTURNA HCT TABLET 150-25 MG ORAL.....	25		
TEKTURNA HCT TABLET 300-12.5 MG ORAL...	25		
TEKTURNA HCT TABLET 300-25 MG ORAL.....	25		