Priority Health

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 Eligibile 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

Medications	Coverage Level	Restrictions
Alternative Therapy		
Alternative Therapy - Unclassified		
creatine monohydrate powder (rx)	Formulary	
ubiquinol powder	Formulary	
ubiquinol powder (rx)	Formulary	
Analgesic, Anti-Inflammatory Or Antipyretic		
Analgesic - Opioid Antagonists		
LOTREXONE	State Carve Out	
NALTREX	State Carve Out	
Analgesic Opioid Agonists		
codeine sulfate 15 mg tablet	Formulary	PDL Preferred; QL (180 tablets per 30 days); Age Limit (Min 12 Years)
codeine sulfate 30 mg tablet	Formulary	PDL Preferred; QL (180 tablets per 30 days); Age Limit (Min 12 Years)
codeine sulfate 60 mg tablet	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	
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)
DISKETS 40 MG TABLET DISPR	Formulary	PA; PDL Non-Preferred
fentanyl 100 mcg/hr patch	Formulary	PDL Preferred; QL (10 patches per 1 claim)

Medications	Coverage Level	Restrictions
fentanyl 100 mcg/hr patch outer	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 12 mcg/hr patch	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 12 mcg/hr patch outer	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 25 mcg/hr patch	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 25 mcg/hr patch outer	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 37.5 mcg/hr patch	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
fentanyl 37.5 mcg/hr patch outer	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
fentanyl 50 mcg/hr patch	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 50 mcg/hr patch outer	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 62.5 mcg/hr patch	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
fentanyl 62.5 mcg/hr patch outer	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
fentanyl 75 mcg/hr patch	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 75 mcg/hr patch outer	Formulary	PDL Preferred; QL (10 patches per 1 claim)
fentanyl 87.5 mcg/hr patch outer	Formulary	PA; PDL Non-Preferred; QL (10 patches per 1 claim)
fentanyl cit 400 mcg buccal tb outer	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
fentanyl cit 600 mcg buccal tb outer	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
fentanyl cit 800 mcg buccal tb outer	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
fentanyl cit otfc 1,200 mcg outer	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
fentanyl cit otfc 1,600 mcg outer	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
fentanyl citrate otfc 200 mcg outer	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)

Medications	Coverage Level	Restrictions
fentanyl citrate otfc 400 mcg outer	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
fentanyl citrate otfc 600 mcg outer	Formulary	PA; PDL Non-Preferred; QL (120 lozenges per 30 days)
fentanyl citrate otfc 800 mcg outer	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)
hydrocodone er 10 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 100 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 120 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 15 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 20 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 20 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 30 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 30 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 40 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 40 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 50 mg capsule	Formulary	PA; PDL Non-Preferred
hydrocodone er 60 mg tablet	Formulary	PA; PDL Non-Preferred
hydrocodone er 80 mg tablet	Formulary	PA; PDL Non-Preferred
hydromorphone 1 mg/ml solution	Formulary	PDL Preferred; QL (120 ML per 30 days)
hydromorphone 2 mg tablet	Formulary	PDL Preferred; QL (180 tablets per 30 days)
hydromorphone 2 mg tablet outer	Formulary	PDL Preferred; QL (180 tablets per 30 days)
hydromorphone 2 mg tablet u-d	Formulary	PDL Preferred; QL (180 tablets per 30 days)
hydromorphone 3 mg suppos	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
hydromorphone 4 mg tablet	Formulary	PDL Preferred; QL (135 tablets per 30 days)
hydromorphone 4 mg tablet outer	Formulary	PDL Preferred; QL (135 tablets per 30 days)
hydromorphone 4 mg tablet u-d	Formulary	PDL Preferred; QL (135 tablets per 30 days)
hydromorphone 5 mg/5 ml soln	Formulary	PDL Preferred; QL (120 ML per 30 days)
hydromorphone 5 mg/5 ml solution cup outer	Formulary	PDL Preferred; QL (120 ML per 30 days)
hydromorphone 8 mg tablet	Formulary	PDL Preferred; QL (67 tablets per 30 days)
hydromorphone hcl er 12 mg tab	Formulary	PA; PDL Non-Preferred
hydromorphone hcl er 16 mg tab	Formulary	PA; PDL Non-Preferred
hydromorphone hcl er 32 mg tab	Formulary	PA; PDL Non-Preferred
hydromorphone hcl er 8 mg tab	Formulary	PA; PDL Non-Preferred
hydromorphone injection syringe 0.5 mg/0.5 ml, 1 mg/ml, 2 mg/ml, 4 mg/ml	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
levorphanol 2 mg tablet	Formulary	PA; PDL Non-Preferred
levorphanol 3 mg tablet	Formulary	PA; PDL Non-Preferred
meperidine 50 mg tablet	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
meperidine 50 mg/5 ml solution	Formulary	PA; PDL Non-Preferred; QL (240 ML per 30 days)
methadone 10 mg/5 ml solution	Formulary	PA; PDL Non-Preferred
methadone 10 mg/ml oral conc	Formulary	PA; PDL Non-Preferred
methadone 10 mg/ml oral conc cherry	Formulary	PA; PDL Non-Preferred
methadone 10 mg/ml oral conc d/f, unflavored	Formulary	PA; PDL Non-Preferred
methadone 40 mg tablet dispr dispersable	Formulary	PA; PDL Non-Preferred
methadone 40 mg tablet dispr disprsbl	Formulary	PA; PDL Non-Preferred
methadone 5 mg/5 ml solution	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
methadone 5 mg/5 ml solution cup inner	Formulary	PA; PDL Non-Preferred
methadone 5 mg/5 ml solution cup outer	Formulary	PA; PDL Non-Preferred
methadone hcl 10 mg tablet	Formulary	PA; PDL Non-Preferred
methadone hcl 10 mg tablet 10x10, outer	Formulary	PA; PDL Non-Preferred
methadone hcl 10 mg tablet inner	Formulary	PA; PDL Non-Preferred
methadone hcl 5 mg tablet	Formulary	PA; PDL Non-Preferred
methadone hcl 5 mg tablet 10x10, outer	Formulary	PA; PDL Non-Preferred
methadone hcl 5 mg tablet inner	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
morphine 10 mg/0.5 ml oral syringe inner	Formulary	PDL Preferred; QL (4 ml per 1 day)
morphine 10 mg/0.5 ml oral syringe outer	Formulary	PDL Preferred; QL (4 ml per 1 day)
morphine 20 mg/ml oral syringe outer	Formulary	PDL Preferred; QL (4 ML per 1 day)
morphine injection syringe 2 mg/ml, 4 mg/ml	Non-Formulary	
morphine sulf 10 mg suppos	Formulary	PDL Preferred
morphine sulf 10 mg/5 ml soln	Formulary	PDL Preferred; QL (140 ML per 30 days)
morphine sulf 10 mg/5 ml soln	Formulary	PDL Preferred; QL (240 ML per 30 days)
morphine sulf 10 mg/5 ml soln dosing cup	Formulary	PDL Preferred; QL (240 ML per 30 days)
morphine sulf 10 mg/5 ml solution cup inner	Formulary	PDL Preferred; QL (240 ML per 30 days)
morphine sulf 10 mg/5 ml solution cup outer	Formulary	PDL Preferred; QL (240 ML per 30 days)
morphine sulf 100 mg/5 ml conc	Formulary	PDL Preferred; QL (120 ML per 30 days)
morphine sulf 100 mg/5 ml conc added color	Formulary	PDL Preferred; QL (120 ML per 30 days)
morphine sulf 20 mg suppos	Formulary	PDL Preferred
morphine sulf 20 mg/5 ml soln	Formulary	PDL Preferred; QL (240 ML per 30 days)

Medications	Coverage Level	Restrictions
morphine sulf 20 mg/5 ml soln dosing cup	Formulary	PDL Preferred; QL (240 ML per 30 days)
morphine sulf 30 mg suppos	Formulary	PDL Preferred
morphine sulf 5 mg suppos	Formulary	PDL Preferred
morphine sulf er 100 mg tablet	Formulary	PDL Preferred
morphine sulf er 100 mg tablet 10x10, outer	Formulary	PDL Preferred
morphine sulf er 100 mg tablet f/c	Formulary	PDL Preferred
morphine sulf er 100 mg tablet inner	Formulary	PDL Preferred
morphine sulf er 15 mg tablet	Formulary	PDL Preferred
morphine sulf er 15 mg tablet 10x10, outer	Formulary	PDL Preferred
morphine sulf er 15 mg tablet f/c	Formulary	PDL Preferred
morphine sulf er 15 mg tablet inner	Formulary	PDL Preferred
morphine sulf er 15 mg tablet outer	Formulary	PDL Preferred
morphine sulf er 200 mg tablet	Formulary	PDL Preferred
morphine sulf er 30 mg tablet	Formulary	PDL Preferred
morphine sulf er 30 mg tablet 10x10, outer	Formulary	PDL Preferred
morphine sulf er 30 mg tablet f/c	Formulary	PDL Preferred
morphine sulf er 30 mg tablet inner	Formulary	PDL Preferred
morphine sulf er 30 mg tablet outer	Formulary	PDL Preferred
morphine sulf er 60 mg tablet	Formulary	PDL Preferred
morphine sulf er 60 mg tablet 10x10, outer	Formulary	PDL Preferred
morphine sulf er 60 mg tablet f/c	Formulary	PDL Preferred
morphine sulf er 60 mg tablet inner	Formulary	PDL Preferred
morphine sulfate er 10 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 100 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 120 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 20 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 30 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 45 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 50 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 60 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 75 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 80 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate er 90 mg cap	Formulary	PA; PDL Non-Preferred
morphine sulfate ir 15 mg tab	Formulary	PDL Preferred; QL (180 tablets per 30 days)

Medications	Coverage Level	Restrictions
morphine sulfate ir 15 mg tab outer	Formulary	PDL Preferred; QL (180 tablets per 30 days)
morphine sulfate ir 30 mg tab	Formulary	PDL Preferred; QL (90 tablets per 30 days)
morphine sulfate ir 30 mg tab outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)
morphine sulfate ir 30 mg tab u-d 4x25, blister	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
oxycodone hcl (ir) 10 mg tab	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 10 mg tab outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 15 mg tab	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 15 mg tab inner	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 15 mg tab outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 15 mg tab u-d, 10x10, outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 20 mg tab	Formulary	PA; PDL Non-Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 30 mg tab	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
oxycodone hcl (ir) 30 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
oxycodone hcl (ir) 30 mg tab u-d, 10x10, outer	Formulary	PA; PDL Non-Preferred; QL (60 tablets per 30 days)
oxycodone hcl (ir) 5 mg cap	Formulary	PA; PDL Non-Preferred; QL (90 capsules per 30 days)
oxycodone hcl (ir) 5 mg tablet	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 5 mg tablet 10x10, outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)

Medications	Coverage Level	Restrictions
oxycodone hcl (ir) 5 mg tablet inner	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl (ir) 5 mg tablet u-d, 10x10, outer	Formulary	PDL Preferred; QL (90 tablets per 30 days)
oxycodone hcl 100 mg/5 ml conc	Formulary	PA; PDL Non-Preferred; QL (90 ML per 30 days)
oxycodone hcl 5 mg/5 ml soln	Formulary	PDL Preferred; QL (8 ML per 1 day)
oxycodone hcl 5 mg/5 ml soln w/calibrated cup	Formulary	PDL Preferred; QL (8 ML per 1 day)
oxycodone hcl 5 mg/5 ml solution cup inner	Formulary	PDL Preferred; QL (8 ML per 1 day)
oxycodone hcl 5 mg/5 ml solution cup outer	Formulary	PDL Preferred; QL (8 ML per 1 day)
oxycodone hcl er 10 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 tablets per 1 day)
oxycodone hcl er 20 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (3 tablets per 1 day)
oxycodone hcl er 40 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (45 tablets per 30 days)
oxycodone hcl er 80 mg tablet	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)

Medications	Coverage Level	Restrictions
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)
oxymorphone hcl 10 mg tablet	Formulary	PA; PDL Non-Preferred; QL (90 tablets per 30 days)
oxymorphone hcl 5 mg tablet	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days)
oxymorphone hcl er 10 mg tab	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 15 mg tab	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 20 mg tab	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 30 mg tab	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 40 mg tab	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 5 mg tablet	Formulary	PA; PDL Non-Preferred
oxymorphone hcl er 7.5 mg tab	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)
tramadol er 100 mg tablet coated	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol er 200 mg tablet coated	Formulary	PDL Preferred; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
tramadol er 300 mg tablet coated	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 100 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 25 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 25 mg/5 ml cup outer	Formulary	PA; PDL Non-Preferred; QL (80 ML per 1 day); Age Limit (Min 12 Years)
tramadol hcl 5 mg/ml solution	Formulary	PA; PDL Non-Preferred; QL (80 ML per 1 day); Age Limit (Min 12 Years)
tramadol hcl 50 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 50 mg tablet f/c	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 50 mg tablet outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl 75 mg tablet	Formulary	PDL Preferred
tramadol hcl er 100 mg capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
tramadol hcl er 100 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl er 100 mg tablet coated	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl er 200 mg capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
tramadol hcl er 200 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol hcl er 300 mg capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
tramadol hcl er 300 mg tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
Analgesic Opioid Codeine Combinations		
acetaminophen-cod #2 tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-cod #3 tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-cod #3 tablet 10x10, outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
acetaminophen-cod #3 tablet inner	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-cod #4 tablet	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-codeine 120 mg-12 mg/5 ml solution	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-codeine 120-12 mg/5 ml cup outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)
acetaminophen-codeine 300-30 mg/12.5 ml cup outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)
asa-butalb-caff-cod #3 capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
ASCOMP WITH CODEINE CAPSULE	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
butalbital-acetaminophen-caffeine-codeine 50-300-40-30 mg cp	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
butalbital-acetaminophen-caffeine-codeine 50-325-40-30 mg cp	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)
Analgesic Opioid Dihydrocodeine Combinations		
acetaminophen-caffeine-dihydrocodeine 320.5-30-16 mg capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
Analgesic Opioid Dihydrocodeine, Non-Salicylate Analgesic,Xanthine		
acetaminophen-caffeine-dihydrocodeine 320.5-30-16 mg capsule	Formulary	PA; PDL Non-Preferred; Age Limit (Min 12 Years)
Analgesic Opioid Hydrocodone And Non-Salicylate Combinations		
hydrocodone-acetaminophen 10 mg-300 mg/15 ml solution	Formulary	PDL Preferred
hydrocodone-acetaminophen 10 mg-325 mg/15 ml solution	Formulary	PDL Preferred
hydrocodone-acetaminophen 10-300 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 10-325 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 10-325 mg tablet outer	Formulary	PDL Preferred

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

Medications	Coverage Level	Restrictions
hydrocodone-acetaminophen 2.5-325 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 5 mg-217 mg/10 ml solution cup outer	Formulary	PDL Preferred
hydrocodone-acetaminophen 5-300 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 5-325 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 5-325 mg tablet outer	Formulary	PDL Preferred
hydrocodone-acetaminophen 7.5-300 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 7.5-325 mg tablet	Formulary	PDL Preferred
hydrocodone-acetaminophen 7.5-325 mg tablet outer	Formulary	PDL Preferred
hydrocodone-acetaminophen 7.5-325 mg/15 ml solution	Formulary	PDL Preferred
hydrocodone-acetaminophen 7.5-325 mg/15 ml solution cup outer	Formulary	PDL Preferred
hydrocodone-ibuprofen 10-200	Formulary	PA; PDL Non-Preferred
hydrocodone-ibuprofen 5-200 mg	Formulary	PA; PDL Non-Preferred
hydrocodone-ibuprofen 7.5-200	Formulary	PA; PDL Non-Preferred
Analgesic Opioid Oxycodone And Non-Salicylate 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
oxycodone-acetaminophen 10-325 mg tab	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tab 10x10, outer	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tab inner	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tab outer	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tablet outer	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
oxycodone-acetaminophen 2.5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab 10x10, outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab inner	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tablet outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg/5 ml solution	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet 10x10, outer	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet inner	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet outer	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
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
oxycodone-acetaminophen 10-325 mg tab	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tab 10x10, outer	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
oxycodone-acetaminophen 10-325 mg tab inner	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tab outer	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 10-325 mg tablet outer	Formulary	PDL Preferred
oxycodone-acetaminophen 2.5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab 10x10, outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab inner	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tab outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg tablet outer	Formulary	PDL Preferred
oxycodone-acetaminophen 5-325 mg/5 ml solution	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet 10x10, outer	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet inner	Formulary	PDL Preferred
oxycodone-acetaminophen 7.5-325 mg tablet outer	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
PROLATE 7.5-300 MG TABLET	Formulary	PA; PDL Non-Preferred
Analgesic Opioid Partial-Mixed Agonists		
BELBUCA 150 MCG FILM INNER	Formulary	PA; PDL Non-Preferred; QL (2 films per 1 day)

Medications	Coverage Level	Restrictions
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)
buprenorphine 10 mcg/hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 10 mcg/hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 15 mcg/hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 15 mcg/hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 20 mcg/hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)

Medications	Coverage Level	Restrictions
buprenorphine 20 mcg/hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 5 mcg/hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 5 mcg/hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 7.5 mcg/hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
buprenorphine 7.5 mcg/hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (6 patches per 28 days)
butorphanol 10 mg/ml spray	Formulary	PA; PDL Non-Preferred; QL (15 ML per 30 days)
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)
pentazocine-naloxone tablet	Formulary	PA; PDL Non-Preferred
Analgesic Opioid Tramadol And Non-Salicylate Combinations		
tramadol-acetaminophen 37.5-325 mg tab	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol-acetaminophen 37.5-325 mg tab f/c	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol-acetaminophen 37.5-325 mg tab outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)
Analgesic Opioid Tramadol And Nsaid Combinations		
SEGLENTIS 56 MG-44 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (120 tablets per 30 days); Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
Analgesic Opioid Tramadol Combinations		
tramadol-acetaminophen 37.5-325 mg tab	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol-acetaminophen 37.5-325 mg tab f/c	Formulary	PDL Preferred; Age Limit (Min 12 Years)
tramadol-acetaminophen 37.5-325 mg tab outer	Formulary	PDL Preferred; Age Limit (Min 12 Years)
Analgesic Or Antipyretic Non-Opioid Combinations Other		
TENSION HEADACHE	Non-Formulary	Dual Eligible Covered; OTC
Analgesic Or Antipyretic Non-Opioid/Sedative Combinations		
butalb-acetaminophen-caff 50-325-40 tab	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
butalbital-acetaminophen 50-325 mg tab	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
butalbital-acetaminophen oral capsule	Non-Formulary	
butalbital-acetaminophen oral tablet 50-300 mg	Non-Formulary	
butalbital-acetaminophen-caff oral capsule	Non-Formulary	
butalbital-acetaminophen-caffeine 50-325-40 mg tablet	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
butalbital-acetaminophen-caffeine 50-325-40 mg tablet outer	Formulary	QL (6 tablets per 1 day); Age Limit (Min 10 Years and Max 64 Years)
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
Analgesic Or Antipyretic Non-Opioid		
8 HOUR ACETAMINOPHEN ER 650 MG	Formulary	Dual Eligible Covered; OTC
acetaminophen 120 mg suppos	Formulary	Dual Eligible Covered; OTC
acetaminophen 120 mg suppos outer	Formulary	Dual Eligible Covered; OTC
acetaminophen 160 mg/5 ml liq	Formulary	OTC
acetaminophen 160 mg/5 ml soln	Formulary	OTC

Medications	Coverage Level	Restrictions
acetaminophen 160 mg/5 ml solution cup outer	Formulary	OTC
acetaminophen 160 mg/5 ml solution cup outer	Formulary	Dual Eligible Covered; OTC
acetaminophen 160 mg/5 ml suspension cup inner	Formulary	OTC
acetaminophen 160 mg/5 ml suspension cup outer	Formulary	Dual Eligible Covered; OTC
acetaminophen 325 mg gelcap	Formulary	Dual Eligible Covered; OTC
acetaminophen 325 mg tablet	Formulary	OTC
acetaminophen 325 mg tablet	Formulary	Dual Eligible Covered; OTC
acetaminophen 325 mg tablet u-d,10x10,asa-free	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg caplet	Formulary	OTC
acetaminophen 500 mg caplet	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg caplet caplet,ex-strength	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg gelcap	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg tablet	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg tablet asa-free,ex-str	Formulary	Dual Eligible Covered; OTC
acetaminophen 500 mg tablet aspirin free, u/d	Formulary	Dual Eligible Covered; OTC
acetaminophen 650 mg suppos	Formulary	Dual Eligible Covered; OTC
acetaminophen 650 mg suppos outer	Formulary	Dual Eligible Covered; OTC
acetaminophen er 650 mg caplet	Formulary	OTC
acetaminophen er 650 mg caplet	Formulary	Dual Eligible Covered; OTC
acetaminophen er 650 mg tablet	Formulary	Dual Eligible Covered; OTC
acetaminophen er 650 mg tablet outer	Formulary	Dual Eligible Covered; OTC
acetaminophen oral solution 325 mg/10.15 ml, 650 mg/20.3 ml	Non-Formulary	OTC
acetaminophen oral suspension 325 mg/10.15 ml, 650 mg/20.3 ml	Non-Formulary	OTC
acetaminophen oral syringe	Non-Formulary	OTC
acetaminophen oral tablet,chewable 160 mg	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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
Anti-Inflammatory - Complement (C5) Receptor Inhibitors		
TAVNEOS	State Carve Out	
Anti-Inflammatory - Interleukin-1 Beta Blockers		
ILARIS (PF)	State Carve Out	
Anti-Inflammatory - Interleukin-1 Receptor Antagonist		
ARCALYST	State Carve Out	
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Seiective		
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
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

Medications	Coverage Level	Restrictions
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Tnf-Alpha Sel		
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
adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)	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
adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ai/box, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 10 mg/0.1 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, p/f, suv	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 10 mg/0.2 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 20 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.8 ml syringe	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
adalimumab-adbm(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) pen 40 mg/0.8 ml	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 ml syringe	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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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
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)

Medications	Coverage Level	Restrictions
Dmard - Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents		
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
adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)	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
adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ai/box, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 10 mg/0.1 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, p/f, suv	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 10 mg/0.2 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 20 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.8 ml syringe	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
adalimumab-adbm(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) pen 40 mg/0.8 ml	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 ml syringe	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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
Dmard - Antimalarials		
hydroxychloroquine 100 mg tab	Formulary	
hydroxychloroquine 200 mg tab	Formulary	
hydroxychloroquine 200 mg tab f/c	Formulary	
hydroxychloroquine 200 mg tab outer	Formulary	
hydroxychloroquine 200 mg tab u-d,10x10,outer	Formulary	
hydroxychloroquine 300 mg tab	Formulary	
hydroxychloroquine 400 mg tab	Formulary	
SOVUNA	Non-Formulary	
Dmard - Antimetabolites		
JYLAMVO 2 MG/ML ORAL SOLUTION	Formulary	
methotrexate 1 gram/40 ml vial p/f, sdv	Formulary	
methotrexate 1 gram/40 ml vial p/f, suv	Formulary	
methotrexate 1 gram/40 ml vial p/f,sdv	Formulary	
methotrexate 2.5 mg tablet	Formulary	
methotrexate 2.5 mg tablet outer	Formulary	
methotrexate 2.5 mg tablet u-d,10x10,blisters	Formulary	
methotrexate 2.5 mg tablet u-d,2x10,outer	Formulary	
methotrexate 25 mg/ml vial p/f	Formulary	
methotrexate 250 mg/10 ml vial	Formulary	
methotrexate 250 mg/10 ml vial p/f, sdv	Formulary	
methotrexate 50 mg/2 ml vial	Formulary	
methotrexate 50 mg/2 ml vial outer	Formulary	
methotrexate 50 mg/2 ml vial outer, p/f, sdv	Formulary	
methotrexate 50 mg/2 ml vial p/f, sdv	Formulary	

Medications	Coverage Level	Restrictions
methotrexate 50 mg/2 ml vial p/f, suv	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	
Dmard - Antinflammatory, Select. Costimulation Modulator,T-Cell Inhib.		
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
Dmard - Gold Compounds		
RIDAURA	Non-Formulary	
Dmard - Immunosuppressives		
AZASAN 100 MG TABLET	Formulary	
AZASAN 75 MG TABLET	Formulary	
azathioprine 100 mg tablet	Formulary	
azathioprine 50 mg tablet	Formulary	
azathioprine 50 mg tablet outer	Formulary	
azathioprine 75 mg tablet	Formulary	
CELLCEPT 200 MG/ML ORAL SUSP	Formulary	
CELLCEPT 250 MG CAPSULE	Formulary	
CELLCEPT 500 MG TABLET F/C	Formulary	
cyclophosphamide 25 mg capsule	Formulary	
cyclophosphamide 50 mg capsule	Formulary	
cyclophosphamide 50 mg tablet outer	Formulary	
cyclosporine 100 mg capsule	Formulary	
cyclosporine 100 mg capsule outer	Formulary	
cyclosporine 25 mg capsule	Formulary	

Medications	Coverage Level	Restrictions
cyclosporine 25 mg capsule outer	Formulary	
cyclosporine modified 100 mg	Formulary	
cyclosporine modified 100 mg outer	Formulary	
cyclosporine modified 100 mg softgel,outer	Formulary	
cyclosporine modified 100 mg/ml	Formulary	
cyclosporine modified 25 mg	Formulary	
cyclosporine modified 25 mg outer	Formulary	
cyclosporine modified 25 mg outer, softgel	Formulary	
cyclosporine modified 50 mg	Formulary	
cyclosporine modified 50 mg outer	Formulary	
GENGRAF 100 MG CAPSULE	Formulary	
GENGRAF 100 MG/ML SOLUTION	Formulary	
GENGRAF 25 MG CAPSULE	Formulary	
IMURAN 50 MG TABLET	Formulary	
mycophenolate 200 mg/ml susp	Formulary	
mycophenolate 250 mg capsule	Formulary	
mycophenolate 250 mg capsule outer	Formulary	
mycophenolate 250 mg capsule u-d,10x10,outer	Formulary	
mycophenolate 500 mg tablet	Formulary	
mycophenolate 500 mg tablet f/c	Formulary	
mycophenolate 500 mg tablet outer	Formulary	
mycophenolate 500 mg tablet u-d,10x10,outer,f/c	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	
SANDIMMUNE 100 MG CAPSULE U-D, SANDOPAK,OUTER	Formulary	
SANDIMMUNE 100 MG CAPSULE U-D,INNER	Formulary	
SANDIMMUNE 100 MG/ML SOLN	Formulary	

Medications	Coverage Level	Restrictions
SANDIMMUNE 25 MG CAPSULE U-D, SANDOPAK,OUTER	Formulary	
SANDIMMUNE 25 MG CAPSULE U-D,INNER	Formulary	
Dmard - Interleukin-1 Receptor Antagonist (Il-1Ra)		
KINERET	State Carve Out	
Dmard - Interleukin-6 (Il-6) Receptor Inhibitors, Monoclonal Antibody		
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
Dmard - Janus Kinase (Jak) Inhibitors		
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
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
Dmard - Other		
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	
minocycline 100 mg capsule	Formulary	
minocycline 100 mg capsule outer	Formulary	

Medications	Coverage Level	Restrictions
minocycline 50 mg capsule	Formulary	
minocycline 75 mg capsule	Formulary	
minocycline oral tablet	Non-Formulary	
penicillamine	Non-Formulary	
sulfasalazine 500 mg tablet	Formulary	PDL Preferred
sulfasalazine dr 500 mg tab	Formulary	PDL Preferred
Dmard - Phosphodiesterase-4 (Pde4) Inhibitors		
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
Dmard - Pyrimidine Synthesis Inhibitors		
ARAVA	Non-Formulary	
leflunomide 10 mg tablet	Formulary	QL (1 tablet per 1 day)
leflunomide 10 mg tablet outer	Formulary	QL (1 tablet per 1 day)
leflunomide 20 mg tablet	Formulary	
leflunomide 20 mg tablet outer	Formulary	
Immunomodulator - Rho Kinase Inhibitor		
REZUROCK 200 MG TABLET	Formulary	
Immunomodulator B-Lymphocyte Stimulator (Blys)-Specific Inhibitor Mcab		
BENLYSTA SUBCUTANEOUS	Non-Formulary	
Nsaid Analgesic And Histamine H2 Receptor Antagonist Combinations		
ibuprofen-famotidin 800-26.6 mg	Formulary	PA; PDL Non-Preferred
Nsaid Analgesic And Non-Salicylate Analgesic Combination		
acetaminophen-ibuprofen 250-125 mg caplet	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
gnp acetaminophen-ibuprofen 250-125 mg tablet	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

Medications	Coverage Level	Restrictions
diclofenac-misoprostol dr 50-0.2 mg tablet	Formulary	PA; PDL Non-Preferred
diclofenac-misoprostol dr 75-0.2 mg tablet	Formulary	PA; PDL Non-Preferred
Nsaid Analgesic And Proton Pump Inhibitor Combinations		
naproxen-esomepraz dr 375-20 mg	Formulary	PA; PDL Non-Preferred
naproxen-esomepraz dr 500-20 mg	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)
celecoxib 100 mg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day)
celecoxib 100 mg capsule outer	Formulary	PDL Preferred; QL (2 capsules per 1 day)
celecoxib 200 mg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day)
celecoxib 200 mg capsule outer	Formulary	PDL Preferred; QL (2 capsules per 1 day)
celecoxib 400 mg capsule	Formulary	PDL Preferred; QL (1 capsule per 1 day)
celecoxib 50 mg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day)
Nsaid Analgesics (Cox Non-Specific) - Anthranilic Acid Derivatives		
meclofenamate 100 mg capsule	Formulary	PA; PDL Non-Preferred
meclofenamate 50 mg capsule	Formulary	PA; PDL Non-Preferred
mefenamic acid 250 mg capsule	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Nsaid Analgesics (Cox Non-Specific) - Other		
ketorolac 10 mg tablet	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
ketorolac 10 mg tablet f/c	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
ketorolac 10 mg tablet outer	Formulary	PDL Preferred; QL (21 tablets per 1 claim)
ketorolac injection syringe 30 mg/ml	Non-Formulary	
ketorolac intramuscular syringe	Non-Formulary	
nabumetone 500 mg tablet	Formulary	PDL Preferred
nabumetone 500 mg tablet f/c	Formulary	PDL Preferred
nabumetone 500 mg tablet outer	Formulary	PDL Preferred
nabumetone 750 mg tablet	Formulary	PDL Preferred
nabumetone 750 mg tablet f/c	Formulary	PDL Preferred
RELAFEN DS 1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
sulindac 150 mg tablet	Formulary	PDL Preferred
sulindac 200 mg tablet	Formulary	PDL Preferred
TOLECTIN 600 MG TABLET	Formulary	PA; PDL Non-Preferred
tolmetin sodium 400 mg cap	Formulary	PA; PDL Non-Preferred
tolmetin sodium 600 mg tab	Formulary	PA; PDL Non-Preferred
Nsaid Analgesics (Cox Non-Specific) - Oxicam Derivatives		
FELDENE 10 MG CAPSULE	Formulary	PA; PDL Non-Preferred
meloxicam 10 mg capsule	Formulary	PA; PDL Non-Preferred
meloxicam 15 mg tablet	Formulary	PDL Preferred
meloxicam 15 mg tablet outer	Formulary	PDL Preferred
meloxicam 5 mg capsule	Formulary	PA; PDL Non-Preferred
meloxicam 7.5 mg tablet	Formulary	PDL Preferred
meloxicam 7.5 mg tablet outer	Formulary	PDL Preferred
piroxicam 10 mg capsule	Formulary	PA; PDL Non-Preferred
piroxicam 20 mg capsule	Formulary	PA; PDL Non-Preferred
Nsaid Analgesics (Cox Non-Specific) - Phenylacetic Acid Derivatives		
CAMBIA	Non-Formulary	
diclofenac pot 25 mg tablet	Formulary	PA; PDL Non-Preferred
diclofenac pot 50 mg tablet	Formulary	PA; PDL Non-Preferred
diclofenac pot 50 mg tablet f/c	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
diclofenac potassium 25 mg cap	Formulary	PA; PDL Non-Preferred
diclofenac potassium oral powder in packet	Non-Formulary	
diclofenac sod dr 25 mg tab	Formulary	PDL Preferred
diclofenac sod dr 50 mg tab	Formulary	PDL Preferred
diclofenac sod dr 75 mg tab	Formulary	PDL Preferred
diclofenac sod dr 75 mg tab outer	Formulary	PDL Preferred
diclofenac sod ec 25 mg tab	Formulary	PDL Preferred
diclofenac sod ec 50 mg tab	Formulary	PDL Preferred
diclofenac sod ec 50 mg tab outer	Formulary	PDL Preferred
diclofenac sod ec 75 mg tab	Formulary	PDL Preferred
diclofenac sod er 100 mg tab	Formulary	PA; PDL Non-Preferred
diclofenac sod er 100 mg tab f/c	Formulary	PA; PDL Non-Preferred
LOFENA 25 MG TABLET	Formulary	PA; PDL Non-Preferred
Nsaid Analgesics (Cox Non-Specific) - Propionic Acid Derivatives		
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
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 INNER, D/F	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 CUP OUTER	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML CUP OUTER, D/F	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML CUP U-D	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CHILD IBUPROFEN 100 MG/5 ML CUP U-D,100'S,HOSP USE	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
CHILD IBUPROFEN 100 MG/5 ML CUP U-D,30'S,HOSP USE	Formulary	PDL Preferred; Dual Eligible Covered; 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 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
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
fenoprofen 400 mg capsule	Formulary	PA; PDL Non-Preferred
fenoprofen 600 mg tablet	Formulary	PA; PDL Non-Preferred
FENOPRON 300 MG CAPSULE	Formulary	PA; PDL Non-Preferred
flurbiprofen 100 mg tablet	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
ft ibuprofen 200 mg caplet	Formulary	PDL Preferred; OTC
ft ibuprofen 200 mg mini sfgl	Formulary	PDL Preferred; OTC
ft ibuprofen 200 mg softgel	Formulary	PDL Preferred; OTC
ft ibuprofen 200 mg tablet	Formulary	PDL Preferred; OTC
FT IBUPROFEN IB 100 MG CHEW TB	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
FT INF IBUPROFEN 50 MG/1.25 ML	Formulary	PDL Preferred; OTC
ft naproxen sodium 220 mg cap	Formulary	PDL Preferred; OTC
FT PAIN RELIEF 200 MG TABLET	Formulary	PDL Preferred; OTC
gnp ibuprofen 100 mg chew tab	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gnp ibuprofen 200 mg mini sfgl	Formulary	PDL Preferred; OTC
gnp ibuprofen 200 mg mini sfgl	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gnp ibuprofen 200 mg softgel	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gnp ibuprofen 200 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gnp naproxen sod 220 mg caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gnp naproxen sod 220 mg tablet	Formulary	PDL Preferred; OTC
gnp naproxen sod 220 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS CHILD IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs ibuprofen 100 mg chew tab	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs ibuprofen 200 mg caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs ibuprofen 200 mg liquid gel	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs ibuprofen 200 mg tablet	Formulary	PDL Preferred; OTC
gs ibuprofen 200 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
GS INF IBUPROFEN 50 MG/1.25 ML	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs naproxen sod 220 mg caplet	Formulary	PDL Preferred; OTC
gs naproxen sod 220 mg caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
gs naproxen sod 220 mg tablet	Formulary	PDL Preferred; OTC
gs naproxen sod 220 mg tablet	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

Medications	Coverage Level	Restrictions
IBU-200 200 MG TABLET	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 100 mg/5 ml susp (rx)	Formulary	PDL Preferred; OTC
ibuprofen 100 mg/5 ml susp (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 100 mg/5 ml susp cup outer (rx)	Formulary	PDL Preferred; OTC
ibuprofen 200 mg caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg caplet caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg caplet coated caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg capsule	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg softgel	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg tablet	Formulary	PDL Preferred; OTC
ibuprofen 200 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg tablet coated	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg tablet outer	Formulary	PDL Preferred; OTC
ibuprofen 200 mg/10 ml suspension cup 100's, u-d cups (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg/10 ml suspension cup 30's, u-d cups (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 200 mg/10 ml suspension cup outer (rx)	Formulary	PDL Preferred; OTC
ibuprofen 200 mg/10 ml suspension cup u-d (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ibuprofen 400 mg tablet	Formulary	PDL Preferred
ibuprofen 400 mg tablet f/c	Formulary	PDL Preferred
ibuprofen 400 mg tablet outer	Formulary	PDL Preferred
ibuprofen 600 mg tablet	Formulary	PDL Preferred
ibuprofen 600 mg tablet f/c	Formulary	PDL Preferred
ibuprofen 600 mg tablet outer	Formulary	PDL Preferred
ibuprofen 800 mg tablet	Formulary	PDL Preferred
ibuprofen 800 mg tablet f/c	Formulary	PDL Preferred
ibuprofen 800 mg tablet outer	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
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
ketoprofen 50 mg capsule	Formulary	PA; PDL Non-Preferred
ketoprofen 75 mg capsule	Formulary	PA; PDL Non-Preferred
ketoprofen er 200 mg capsule	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
naproxen 125 mg/5 ml suspen	Formulary	PA; PDL Non-Preferred
naproxen 250 mg tablet	Formulary	PDL Preferred
naproxen 250 mg tablet outer	Formulary	PDL Preferred
naproxen 375 mg tablet	Formulary	PDL Preferred
naproxen 375 mg tablet outer	Formulary	PDL Preferred
naproxen 500 mg tablet	Formulary	PDL Preferred
naproxen 500 mg tablet outer	Formulary	PDL Preferred
naproxen dr 375 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen dr 500 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod cr 375 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod cr 500 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod cr 500 mg tablet f/c	Formulary	PA; PDL Non-Preferred
naproxen sod cr 750 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod er 375 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod er 500 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sod er 750 mg tablet	Formulary	PA; PDL Non-Preferred
naproxen sodium 220 mg capsule	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
naproxen sodium 220 mg tablet	Formulary	PDL Preferred; OTC
naproxen sodium 220 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
naproxen sodium 275 mg tab	Formulary	PA; PDL Non-Preferred
naproxen sodium 275 mg tab f/c	Formulary	PA; PDL Non-Preferred
naproxen sodium 275 mg tab outer	Formulary	PA; PDL Non-Preferred
naproxen sodium 550 mg tab	Formulary	PA; PDL Non-Preferred
naproxen sodium 550 mg tab f/c	Formulary	PA; PDL Non-Preferred
oxaprozin 600 mg caplet caplet, f/c	Formulary	PA; PDL Non-Preferred
oxaprozin 600 mg tablet	Formulary	PA; PDL Non-Preferred
oxaprozin 600 mg tablet f/c	Formulary	PA; PDL Non-Preferred
SM CHILD IBUPROFEN 100 MG/5 ML	Formulary	PDL Preferred; OTC
sm ibuprofen 200 mg caplet caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
sm ibuprofen 200 mg softgel	Formulary	PDL Preferred; Dual Eligible Covered; OTC
sm ibuprofen 200 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM IBUPROFEN IB 100 MG CHEW TB	Formulary	PDL Preferred; Dual Eligible Covered; OTC
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
sm naproxen sod 220 mg caplet gluten free, caplet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
Nsaid Analgesics (Cyclooxygenase Inhibitors-Non-Selective)		
CAMBIA	Non-Formulary	
diclofenac potassium oral powder in packet	Non-Formulary	
Nsaid Analgesics, (Cox Non-Specific) - Indole Acetic Acid Derivatives		
etodolac 200 mg capsule	Formulary	PA; PDL Non-Preferred
etodolac 300 mg capsule	Formulary	PA; PDL Non-Preferred
etodolac 400 mg tablet	Formulary	PA; PDL Non-Preferred
etodolac 400 mg tablet f/c	Formulary	PA; PDL Non-Preferred
etodolac 500 mg tablet	Formulary	PA; PDL Non-Preferred
etodolac 500 mg tablet f/c	Formulary	PA; PDL Non-Preferred
etodolac er 400 mg tablet	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
etodolac er 400 mg tablet f/c	Formulary	PA; PDL Non-Preferred
etodolac er 500 mg tablet	Formulary	PA; PDL Non-Preferred
etodolac er 500 mg tablet f/c	Formulary	PA; PDL Non-Preferred
etodolac er 600 mg tablet	Formulary	PA; PDL Non-Preferred
etodolac er 600 mg tablet f/c	Formulary	PA; PDL Non-Preferred
indomethacin 25 mg capsule	Formulary	PDL Preferred
indomethacin 25 mg capsule outer	Formulary	PDL Preferred
indomethacin 25 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
indomethacin 50 mg capsule	Formulary	PDL Preferred
indomethacin 50 mg capsule outer	Formulary	PDL Preferred
indomethacin er 75 mg capsule	Formulary	PA; PDL Non-Preferred
indomethacin er 75 mg capsule outer	Formulary	PA; PDL Non-Preferred
Salicylate Analgesic And Sedative Combinations		
butalbital-aspirin-caffeine 50-325-40 mg capsule	Formulary	QL (6 capsules per 1 day); Age Limit (Max 64 Years)
butalbital-aspirin-caffeine oral tablet	Non-Formulary	
Salicylate Analgesics, Buffered		
buffered aspirin 325 mg tb	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		
aspirin 300 mg suppository	Formulary	Dual Eligible Covered; OTC
aspirin 325 mg tablet	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin 325 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin 325 mg tablet micro-coated	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin 81 mg chewable tablet	Formulary	OTC; QL (2 tablets per 1 day)
aspirin 81 mg chewable tablet	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
aspirin 81 mg chewable tablet gluten-free, orange	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
aspirin 81 mg chewable tablet low dose	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
aspirin 81 mg chewable tablet low dose, cherry	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
aspirin ec 325 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin ec 325 mg tablet safety-coated	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin ec 81 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
aspirin ec 81 mg tablet low dose	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)
diflunisal 500 mg tablet	Formulary	PA; PDL Non-Preferred
diflunisal 500 mg tablet f/c	Formulary	PA; PDL Non-Preferred
DISALCID	Non-Formulary	
DOLOBID 250 MG TABLET	Formulary	PA; PDL Non-Preferred
DOLOBID 375 MG TABLET	Formulary	PA; PDL Non-Preferred
ft aspirin 325 mg tablet	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
ft aspirin 81 mg chewable tab	Formulary	OTC; QL (2 tablets per 1 day)
ft aspirin ec 325 mg tablet	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
ft aspirin ec 81 mg tablet	Formulary	OTC; QL (3 tablets per 1 day)
gnp aspirin 325 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
gnp aspirin ec 81 mg tablet	Formulary	OTC; QL (3 tablets per 1 day)
gnp aspirin ec 81 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
gs aspirin 81 mg chewable tab	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
hm aspirin 81 mg chewable tab adlt low dose,orange	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)
hm aspirin ec 81 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
salsalate	Non-Formulary	
sm aspirin 81 mg chewable tab	Formulary	Dual Eligible Covered; OTC; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
sm aspirin ec 325 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
sm aspirin ec 81 mg tablet	Formulary	OTC; QL (3 tablets per 1 day)
sm aspirin ec 81 mg tablet adult low strength	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day)
Anesthetics		
General Anesthetic Adjuncts - Neuroleptic, Butyrophenone Derivative		
droperidol injection solution	State Carve Out	
Local Anesthetic - Amides		
lidocaine hcl laryngotracheal	Non-Formulary	
Anorectal Preparations		
Anal Fissure Pain/Treatment Agents - Nitrates		
nitroglycerin rectal	Non-Formulary	
RECTIV	Non-Formulary	
Anorectal - Glucocorticoids		
hydrocortisone 2.5% cream	Formulary	
hydrocortisone acetate rectal suppository 30 mg	Non-Formulary	
hydrocortisone topical cream with perineal applicator 1 %	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	
hydrocortisone-pramoxine rectal cream 1-1 %, 2.5-1 %	Non-Formulary	
lidocaine hcl-hydrocortison ac rectal cream	Non-Formulary	
lidocaine hcl-hydrocortison ac rectal kit	Non-Formulary	
lidocaine-hydrocortisone-aloe	Non-Formulary	
PROCTOFOAM HC	Non-Formulary	

Medications	Coverage Level	Restrictions
Antidotes And Other Reversal Agents		
Antidote - Acetaminophen Poisoning		
acetylcysteine 10% vial (not for injection) inner	Formulary	
acetylcysteine 10% vial (not for injection) outer	Formulary	
acetylcysteine 10% vial (not for injection) p/f, outer	Formulary	
acetylcysteine 20% vial (not for injection) inner	Formulary	
acetylcysteine 20% vial (not for injection) outer	Formulary	
Antidote Others		
GALZIN	Non-Formulary	
Chelating Agents - Copper		
CUPRIMINE	Non-Formulary	
DEPEN TITRATABS	Non-Formulary	
penicillamine	Non-Formulary	
SYPRINE	Non-Formulary	
trientine oral capsule 250 mg	Non-Formulary	
Chelating Agents - Iron		
deferasirox	Non-Formulary	
deferiprone	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		
alvimopan	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

Medications	Coverage Level	Restrictions
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)
naloxone 0.4 mg/ml carpuject outer, p/f, suv	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml syringe outer, suv, p/f	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial outer	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial outer, sdv	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial outer, suv, p/f	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial sdv,outer	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial suv, outer	Formulary	QL (6 ML per 90 days)
naloxone 0.4 mg/ml vial suv,outer	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe outer, suv	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe outer, suv, p/f	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe p/f, sdv	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe p/f, suv	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe p/f,sdv	Formulary	QL (6 ML per 90 days)
naloxone 2 mg/2 ml syringe suv, p/f, outer	Formulary	QL (6 ML per 90 days)
naloxone 4 mg/10 ml vial muv, outer	Formulary	QL (6 ML per 90 days)
naloxone 4 mg/10 ml vial muv,outer	Formulary	QL (6 ML per 90 days)
naloxone 4 mg/10 ml vial outer, muv	Formulary	QL (6 ML per 90 days)
naloxone 4 mg/10 ml vial outer,mdv	Formulary	QL (6 ML per 90 days)
naloxone hcl 4 mg nasal spray outer (otc)	Formulary	OTC; QL (3 boxes per 90 days)
naloxone hcl 4 mg nasal spray outer (rx)	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		
paromomycin 250 mg capsule	Formulary	
Aminoglycoside Antibiotic		
neomycin 500 mg tablet	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
tobramycin 1,200 mg/30 ml vial mdv	Formulary	
tobramycin 1,200 mg/30 ml vial outer, muv	Formulary	
tobramycin 1.2 gram/30 ml vial mdv,outer	Formulary	
tobramycin 40 mg/ml vial mdv	Formulary	
tobramycin 80 mg/2 ml vial mdv,outer	Formulary	
tobramycin 80 mg/2 ml vial muv	Formulary	
tobramycin 80 mg/2 ml vial muv, outer	Formulary	
tobramycin 80 mg/2 ml vial outer,mdv	Formulary	
Aminomethylcycline Antibiotics		
NUZYRA ORAL	Non-Formulary	
Aminopenicillin Antibiotic - Beta-Lactamase Inhibitor Combinations		
amox-clav 200-28.5 mg tab chew	Formulary	
amox-clav 200-28.5 mg/5 ml sus	Formulary	
amox-clav 250-125 mg tablet	Formulary	
amox-clav 250-125 mg tablet f/c	Formulary	
amox-clav 250-125 mg tablet outer	Formulary	
amox-clav 250-62.5 mg/5 ml sus	Formulary	
amox-clav 400-57 mg tab chew	Formulary	
amox-clav 400-57 mg/5 ml susp	Formulary	
amox-clav 500-125 mg tablet	Formulary	
amox-clav 500-125 mg tablet f/c	Formulary	
amox-clav 500-125 mg tablet outer	Formulary	
amox-clav 600-42.9 mg/5 ml sus	Formulary	
amox-clav 875-125 mg tablet	Formulary	
amox-clav 875-125 mg tablet f/c	Formulary	
amox-clav 875-125 mg tablet outer	Formulary	
amoxicillin-pot clavulanate oral tablet extended release 12 hr	Non-Formulary	
AUGMENTIN XR	Non-Formulary	
Aminopenicillin Antibiotic		
amoxicillin 125 mg tab chew	Formulary	3 Months Allowed
amoxicillin 125 mg/5 ml susp	Formulary	3 Months Allowed
amoxicillin 200 mg/5 ml susp	Formulary	3 Months Allowed
amoxicillin 250 mg capsule	Formulary	3 Months Allowed
amoxicillin 250 mg tab chew	Formulary	3 Months Allowed
amoxicillin 250 mg/5 ml susp	Formulary	3 Months Allowed

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

Medications	Coverage Level	Restrictions
nitrofurantoin macrocrystal oral capsule 25 mg	Non-Formulary	
nitrofurantoin mcr 100 mg cap	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 100 mg cap outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 50 mg cap	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 50 mg cap outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg u-d,outer,10x10	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin oral suspension 25 mg/5 ml	Non-Formulary	
Antibacterial Other		
fosfomycin tromethamine	Non-Formulary	
Antifungal - Allylamines		
terbinafine hcl 250 mg tablet	Formulary	PDL Preferred; QL (84 tablets per 1 claim)
terbinafine hcl 250 mg tablet	Formulary	PDL Preferred; QL (84 tablets per 1 Fill)
Antifungal - Amphoteric Polyene Macrolides		
nystatin 500,000 unit oral tab	Formulary	PDL Preferred
nystatin 500,000 unit oral tab oral	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
flucytosine 250 mg capsule	Formulary	PA; PDL Non-Preferred
flucytosine 250 mg capsule outer	Formulary	PA; PDL Non-Preferred
flucytosine 500 mg capsule	Formulary	PA; PDL Non-Preferred
flucytosine 500 mg capsule outer	Formulary	PA; PDL Non-Preferred
Antifungal - Glucan Synthesis Inhibitor, Triterpenoid		
BREXAFEMME 150 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 1 Fill)

Medications	Coverage Level	Restrictions
Antifungal - Glucan Synthesis Inhibitors		
BREXAFEMME 150 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 1 Fill)
Antifungal - Imidazoles		
ketoconazole 200 mg tablet	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
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
DIFLUCAN 40 MG/ML SUSPENSION	Formulary	PA; PDL Non-Preferred
fluconazole 10 mg/ml susp	Formulary	PDL Preferred
fluconazole 100 mg tablet	Formulary	PDL Preferred
fluconazole 100 mg tablet outer	Formulary	PDL Preferred
fluconazole 150 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
fluconazole 150 mg tablet inner	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
fluconazole 150 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 claim)
fluconazole 200 mg tablet	Formulary	PDL Preferred
fluconazole 200 mg tablet outer	Formulary	PDL Preferred
fluconazole 40 mg/ml susp	Formulary	PDL Preferred
fluconazole 50 mg tablet	Formulary	PDL Preferred
itraconazole 10 mg/ml solution	Formulary	PA; PDL Non-Preferred; QL (840 mL per 1 claim)
itraconazole 100 mg capsule	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
itraconazole 100 mg capsule outer	Formulary	PA; PDL Non-Preferred; QL (4 capsules per 1 day)
itraconazole 100 mg/10 ml cup outer	Formulary	PA; PDL Non-Preferred; QL (840 ML per 1 claim)

Medications	Coverage Level	Restrictions
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
posaconazole 200 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
posaconazole dr 100 mg tablet	Formulary	PA; PDL Non-Preferred
posaconazole dr 100 mg tablet outer	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
VFEND 50 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
voriconazole 200 mg tablet	Formulary	PA; PDL Non-Preferred
voriconazole 200 mg tablet f/c	Formulary	PA; PDL Non-Preferred
voriconazole 200 mg tablet outer	Formulary	PA; PDL Non-Preferred
voriconazole 40 mg/ml susp	Formulary	PA; PDL Non-Preferred
voriconazole 50 mg tablet	Formulary	PA; PDL Non-Preferred
voriconazole 50 mg tablet f/c	Formulary	PA; PDL Non-Preferred
voriconazole 50 mg tablet outer	Formulary	PA; PDL Non-Preferred
Antifungal Other		
griseofulvin 125 mg/5 ml susp	Formulary	PDL Preferred
griseofulvin micro 500 mg tab	Formulary	PA; PDL Non-Preferred
griseofulvin ultra 125 mg tab	Formulary	PA; PDL Non-Preferred
griseofulvin ultra 250 mg tab	Formulary	PA; PDL Non-Preferred
Antileprotic - Immunomodulators		
THALOMID 100 MG CAPSULE	Formulary	
THALOMID 200 MG CAPSULE	Formulary	
THALOMID 50 MG CAPSULE	Formulary	
Antileprotic - Sulfone Agents		
dapsone 100 mg tablet	Formulary	
dapsone 25 mg tablet	Formulary	
Antimalarial Combinations		
atovaquone-proguanil	Non-Formulary	
COARTEM	Non-Formulary	

Medications	Coverage Level	Restrictions
MALARONE	Non-Formulary	
MALARONE PEDIATRIC	Non-Formulary	
Antimalarials		
chloroquine ph 250 mg tablet	Formulary	QL (1 tablet per 1 day)
chloroquine ph 250 mg tablet f/c	Formulary	QL (1 tablet per 1 day)
chloroquine ph 500 mg tablet	Formulary	QL (1 tablet per 1 day)
chloroquine ph 500 mg tablet f/c	Formulary	QL (1 tablet per 1 day)
DARAPRIM	Non-Formulary	
hydroxychloroquine 100 mg tab	Formulary	
hydroxychloroquine 200 mg tab	Formulary	
hydroxychloroquine 200 mg tab f/c	Formulary	
hydroxychloroquine 200 mg tab outer	Formulary	
hydroxychloroquine 200 mg tab u-d,10x10,outer	Formulary	
hydroxychloroquine 300 mg tab	Formulary	
hydroxychloroquine 400 mg tab	Formulary	
KRINTAFEL 150 MG TABLET	Formulary	QL (2 tablets per 1 year); Age Limit (Min 16 Years)
mefloquine hcl 250 mg tablet	Formulary	QL (5 tablets per 30 days)
mefloquine hcl 250 mg tablet outer	Formulary	QL (5 tablets per 30 days)
primaquine 26.3 mg tablet	Formulary	
pyrimethamine 25 mg tablet	Formulary	PA; QL (3 tablets per 1 day)
QUALAQUIN	Non-Formulary	
quinine sulfate	Non-Formulary	
SOVUNA	Non-Formulary	
Antiprotozoal Agents - Nitrofuran Derivatives		
LAMPIT	Non-Formulary	
Antiprotozoal Agents - Nitroimidazole Derivatives		
benznidazole 100 mg tablet	Formulary	PA
benznidazole 12.5 mg tablet	Formulary	PA
Antiprotozoal Agents - Other		
atovaquone 750 mg/5 ml susp	Formulary	
atovaquone 750 mg/5 ml susp cup outer	Formulary	
atovaquone 750 mg/5 ml susp outer	Formulary	

Medications	Coverage Level	Restrictions
atovaquone 750 mg/5 ml suspension cup outer	Formulary	
MEPRON	Non-Formulary	
Antiprotozoal Agents (Antiparasitic) - 5-Nitrothiazolyl Derivatives		
nitazoxanide 500 mg tablet	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
LIKMEZ 500 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred; QL (400 ML per 10 days)
metronidazole 125 mg tablet	Formulary	PA; PDL Non-Preferred
metronidazole 250 mg tablet	Formulary	PDL Preferred
metronidazole 250 mg tablet f/c	Formulary	PDL Preferred
metronidazole 250 mg tablet outer	Formulary	PDL Preferred
metronidazole 375 mg capsule	Formulary	PA; PDL Non-Preferred
metronidazole 500 mg tablet	Formulary	PDL Preferred
metronidazole 500 mg tablet f/c	Formulary	PDL Preferred
metronidazole 500 mg tablet outer	Formulary	PDL Preferred
Antiprotozoal-Antibacterial 2Nd Generation 2-Methyl-5-Nitroimidazole		
SOLOSEC	Non-Formulary	
tinidazole 250 mg tablet	Formulary	PDL Preferred
tinidazole 500 mg tablet	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		
maraviroc	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	

Medications	Coverage Level	Restrictions
Antiretroviral - Hiv-1 Integrase Strand Transfer Inhibitors		
APRETUDE	State Carve Out	
cabotegravir intramuscular suspension,extended release 600 mg/3 ml (200 mg/ml)	State Carve Out	
ISENTRESS	State Carve Out	
ISENTRESS HD	State Carve Out	
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	
EDURANT PED	State Carve Out	
efavirenz	State Carve Out	
etravirine	State Carve Out	
INTELENCE	State Carve Out	
nevirapine	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	
emtricitabine-tenofovir (tdf)	State Carve Out	
TEMIXYS	State Carve Out	
TRUVADA	State Carve Out	
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (Nrti)		
abacavir	State Carve Out	

Medications	Coverage Level	Restrictions
didanosine oral capsule,delayed release(dr/ec) 250 mg, 400 mg	State Carve Out	
emtricitabine	State Carve Out	
EMTRIVA	State Carve Out	
EPIVIR	State Carve Out	
lamivudine oral solution	State Carve Out	
lamivudine oral tablet 150 mg, 300 mg	State Carve Out	
RETROVIR INTRAVENOUS	State Carve Out	
RETROVIR ORAL CAPSULE	State Carve Out	
RETROVIR ORAL SYRUP	State Carve Out	
stavudine oral capsule 15 mg, 20 mg, 40 mg	State Carve Out	
ZIAGEN	State Carve Out	
zidovudine	State Carve Out	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors		
tenofovir disoproxil fumarate	State Carve Out	
VIREAD	State Carve Out	
Antiretroviral Combinations - Protease Inhibitors		
EVOTAZ	State Carve Out	
KALETRA	State Carve Out	
lopinavir-ritonavir	State Carve Out	
PREZCOBIX	State Carve Out	
Antiretroviral- Nucleoside And Nucleotide Analogs,Protease Inhibitors		
SYMTUZA	State Carve Out	
Antiretroviral-Integrase Inhibitor,Nucleoside And Nucleotide Rtis 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	

Medications	Coverage Level	Restrictions
Antiretroviral-Nucleoside Reverse Transcriptase Inhibitors (Nrti) Comb		
abacavir-lamivudine	State Carve Out	
abacavir-lamivudine-zidovudine	State Carve Out	
COMBIVIR	State Carve Out	
EPZICOM	State Carve Out	
lamivudine-zidovudine	State Carve Out	
TRIZIVIR	State Carve Out	
Antiretroviral-Nucleoside, Nucleotide Analogs And Non-Nucleoside Rti		
ATRIPLA	State Carve Out	
COMPLERA	State Carve Out	
DELSTRIGO	State Carve Out	
efavirenz-emtricitabin-tenofov	State Carve Out	
efavirenz-lamivu-tenofov disop	State Carve Out	
emtricita-rilpivirine-tenof df	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		
cycloserine 250 mg capsule outer	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		
isoniazid 100 mg tablet	Formulary	
isoniazid 300 mg tablet	Formulary	
isoniazid 300 mg tablet outer	Formulary	
isoniazid 300 mg tablet u-d,10x10,outer	Formulary	
isoniazid 50 mg/5 ml solution	Formulary	Age Limit (Max 12 Years)
Antitubercular - Niacinamide Derivatives		
pyrazinamide 500 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
pyrazinamide 500 mg tablet outer	Formulary	
Antitubercular - Nitroimidazole Derivatives		
pretomanid 200 mg tablet	Formulary	PA
Antitubercular - Rifamycin And Derivatives		
MYCOBUTIN	Non-Formulary	
PRIFTIN 150 MG TABLET OUTER	Formulary	QL (24 tablets per 28 days)
rifabutin 150 mg capsule	Formulary	
rifampin 150 mg capsule	Formulary	
rifampin 150 mg capsule outer	Formulary	
rifampin 300 mg capsule	Formulary	
rifampin 300 mg capsule outer	Formulary	
Antitubercular Agents Other		
ethambutol hcl 100 mg tablet	Formulary	
ethambutol hcl 400 mg tablet	Formulary	
ethambutol hcl 400 mg tablet f/c	Formulary	
ethambutol hcl 400 mg tablet u-d, 10x10, outer	Formulary	
TRECATOR 250 MG TABLET	Formulary	
Cephalosporin Antibiotics - 1St Generation		
cefadroxil 1 gm tablet	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
cefadroxil 250 mg/5 ml susp	Formulary	PDL Preferred
cefadroxil 500 mg capsule	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
cefadroxil 500 mg/5 ml susp	Formulary	PDL Preferred
cephalexin 125 mg/5 ml susp	Formulary	PDL Preferred
cephalexin 250 mg capsule	Formulary	PDL Preferred
cephalexin 250 mg capsule outer	Formulary	PDL Preferred
cephalexin 250 mg tablet	Formulary	PDL Preferred
cephalexin 250 mg/5 ml susp	Formulary	PDL Preferred
cephalexin 500 mg capsule	Formulary	PDL Preferred
cephalexin 500 mg capsule outer	Formulary	PDL Preferred
cephalexin 500 mg tablet	Formulary	PDL Preferred
cephalexin 750 mg capsule	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
Cephalosporin Antibiotics - 2Nd Generation		
cefaclor 125 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
cefaclor 250 mg capsule	Formulary	PA; PDL Non-Preferred; QL (42 capsules per 1 claim)
cefaclor 375 mg/5 ml suspen	Formulary	PA; PDL Non-Preferred
cefaclor 500 mg capsule	Formulary	PA; PDL Non-Preferred; QL (42 capsules per 1 claim)
cefaclor er 500 mg tablet film coated	Formulary	PA; PDL Non-Preferred; QL (42 tablets per 1 claim)
cefprozil 125 mg/5 ml susp	Formulary	PDL Preferred
cefprozil 250 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
cefprozil 250 mg tablet f/c	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
cefprozil 250 mg/5 ml susp	Formulary	PDL Preferred
cefprozil 500 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
cefuroxime axetil 250 mg tab	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
cefuroxime axetil 250 mg tab f/c	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
cefuroxime axetil 250 mg tab outer	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
cefuroxime axetil 500 mg tab	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
cefuroxime axetil 500 mg tab f/c	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
cefuroxime axetil 500 mg tab outer	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
Cephalosporin Antibiotics - 3Rd Generation		
cefdinir 125 mg/5 ml susp	Formulary	PDL Preferred
cefdinir 250 mg/5 ml susp	Formulary	PDL Preferred
cefdinir 300 mg capsule	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
cefdinir 300 mg capsule outer	Formulary	PDL Preferred; QL (28 capsules per 1 claim)
cefixime 100 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
cefixime 200 mg/5 ml susp	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
cefixime 400 mg capsule	Formulary	PDL Preferred
cefpodoxime 100 mg tablet	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
cefpodoxime 100 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
cefpodoxime 200 mg tablet	Formulary	PA; PDL Non-Preferred; QL (28 tablets per 1 claim)
cefpodoxime 50 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
Cmv Antiviral Agent - Nucleoside Analogs		
VALCYTE	Non-Formulary	
valganciclovir 450 mg tablet	Formulary	QL (2 tablets per 1 day)
valganciclovir 450 mg tablet f/c	Formulary	QL (2 tablets per 1 day)
valganciclovir 450 mg tablet f/c, outer	Formulary	QL (2 tablets per 1 day)
valganciclovir 450 mg tablet outer	Formulary	QL (2 tablets per 1 day)
valganciclovir oral recon soln	Non-Formulary	
Cmv Antiviral Agent - Protein Kinase Inhibitors		
LIVTENCITY 200 MG TABLET	Formulary	
Cmv Antiviral Agent - Terminase Complex Inhibitors		
PREVYMIS 120 MG PELLET PACKET OUTER	Formulary	
PREVYMIS 20 MG PELLET PACKET OUTER	Formulary	
PREVYMIS 240 MG TABLET OUTER	Formulary	
PREVYMIS 480 MG TABLET OUTER	Formulary	
PREVYMIS INTRAVENOUS	Non-Formulary	
Fluoroquinolone Antibiotics		
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)
ciprofloxacin 250 mg/5 ml susp	Formulary	PDL Preferred
ciprofloxacin 500 mg/5 ml susp	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
ciprofloxacin hcl 250 mg tab	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 250 mg tab f/c	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 500 mg tab	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 500 mg tab f/c	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 500 mg tab outer	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 750 mg tab	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
ciprofloxacin hcl 750 mg tab f/c	Formulary	PDL Preferred; QL (42 tablets per 1 claim)
levofloxacin 25 mg/ml solution	Formulary	PDL Preferred
levofloxacin 250 mg tablet	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
levofloxacin 250 mg tablet f/c	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
levofloxacin 500 mg tablet	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
levofloxacin 500 mg tablet f/c	Formulary	PDL Preferred; QL (14 tablets per 1 claim)
levofloxacin 750 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
levofloxacin 750 mg tablet f/c	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
moxifloxacin hcl 400 mg tablet	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
moxifloxacin hcl 400 mg tablet f/c	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
moxifloxacin hcl 400 mg tablet f/c, outer	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
moxifloxacin hcl 400 mg tablet outer	Formulary	PA; PDL Non-Preferred; QL (14 tablets per 1 claim)
ofloxacin 300 mg tablet	Formulary	PA; PDL Non-Preferred
ofloxacin 400 mg tablet	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
VANCOCIN HCL 125 MG CAPSULE	Formulary	PA; PDL Non-Preferred
VANCOCIN HCL 250 MG CAPSULE	Formulary	PA; PDL Non-Preferred
vancomycin 1 gm vial inner, suv, p/f	Formulary	
vancomycin 1 gm vial outer	Formulary	
vancomycin 1 gm vial outer, p/f	Formulary	
vancomycin 1 gm vial outer, p/f, suv	Formulary	
vancomycin 1 gm vial outer, suv, p/f	Formulary	
vancomycin 1 gm vial p/f	Formulary	
vancomycin 1 gm vial p/f, muv, outer	Formulary	
vancomycin 1 gm vial p/f, outer	Formulary	
vancomycin 1 gm vial p/f, suv	Formulary	
vancomycin 1 gm vial p/f, suv, outer	Formulary	
vancomycin 1 gm vial p/f,outer	Formulary	
vancomycin 1 gm vial suv, outer	Formulary	
vancomycin 1 gm vial suv, p/f, outer	Formulary	
vancomycin 25 mg/ml oral soln	Formulary	PDL Preferred
vancomycin 250 mg/5 ml oral sol	Formulary	PDL Preferred
vancomycin 50 mg/ml oral soln	Formulary	PDL Preferred
vancomycin 50 mg/ml oral soln outer	Formulary	PDL Preferred
vancomycin 500 mg vial	Formulary	
vancomycin 500 mg vial outer	Formulary	
vancomycin 500 mg vial outer, p/f	Formulary	
vancomycin 500 mg vial outer, p/f, suv	Formulary	
vancomycin 500 mg vial outer, suv, p/f	Formulary	
vancomycin 500 mg vial outer,p/f	Formulary	
vancomycin 500 mg vial p/f	Formulary	
vancomycin 500 mg vial p/f, outer	Formulary	
vancomycin 500 mg vial p/f,outer	Formulary	
vancomycin 500 mg vial suv, p/f, outer	Formulary	
vancomycin 750 mg add-van vial outer, suv	Formulary	
vancomycin hcl 10 gm vial mdv	Formulary	
vancomycin hcl 10 gm vial muv	Formulary	
vancomycin hcl 10 gm vial muv, p/f	Formulary	
vancomycin hcl 10 gm vial p/f, mdv	Formulary	
vancomycin hcl 10 gm vial p/f, muv	Formulary	
vancomycin hcl 10 gm vial p/f,mdv	Formulary	

Medications	Coverage Level	Restrictions
vancomycin hcl 125 mg capsule	Formulary	PDL Preferred
vancomycin hcl 125 mg capsule 2x10, outer	Formulary	PDL Preferred
vancomycin hcl 125 mg capsule 2x10, u-d	Formulary	PDL Preferred
vancomycin hcl 250 mg capsule	Formulary	PDL Preferred
vancomycin hcl 250 mg capsule 2x10, outer	Formulary	PDL Preferred
vancomycin hcl 250 mg capsule 2x10, u-d	Formulary	PDL Preferred
vancomycin hcl 5 gm vial mdv	Formulary	
vancomycin hcl 5 gm vial muv, p/f	Formulary	
vancomycin hcl 5 gm vial p/f, mdv	Formulary	
vancomycin hcl 5 gm vial p/f, muv	Formulary	
vancomycin hcl 5 gm vial p/f,mdv	Formulary	
vancomycin hcl 750 mg vial outer, suv, p/f	Formulary	
vancomycin hcl 750 mg vial outer,suv	Formulary	
vancomycin hcl 750 mg vial p/f, outer	Formulary	
vancomycin hcl 750 mg vial p/f, suv, outer	Formulary	
vancomycin hcl 750 mg vial suv, outer	Formulary	
vancomycin intravenous recon soln 1.5 gram, 1.75 gram, 2 gram	Non-Formulary	
Hepatitis B Treatment- Nucleoside Analogs (Antiviral)		
BARACLUDE	Non-Formulary	
entecavir 0.5 mg tablet	Formulary	QL (1 tablet per 1 day)
entecavir 0.5 mg tablet f/c	Formulary	QL (1 tablet per 1 day)
entecavir 0.5 mg tablet outer	Formulary	QL (1 tablet per 1 day)
entecavir 1 mg tablet	Formulary	QL (1 tablet per 1 day)
lamivudine hbv 100 mg tablet	Formulary	QL (1 tablet per 1 day)
Hepatitis B Treatment- Nucleotide Analogs (Antiviral)		
adefovir dipivoxil 10 mg tab	Formulary	QL (1 tablet per 1 day)
tenofovir disoproxil fumarate	State Carve Out	
VEMLIDY 25 MG TABLET	Formulary	PA; QL (1 tablet per 1 day); Age Limit (Min 6 Years)
VIREAD	State Carve Out	
Hepatitis C - Interferons		
PEGASYS	State Carve Out	

Medications	Coverage Level	Restrictions
Hepatitis C - Ns5a Inhibitor And Ns3/4A Protease Inhibitor Combination		
MAVYRET	State Carve Out	
TECHNIVIE	State Carve Out	
ZEPATIER	State Carve Out	
Hepatitis C - Ns5a Replication Complex Inhibitors		
DAKLINZA	State Carve Out	
Hepatitis C - Ns5a, Ns3/4A Protease, Nucleo.Ns5b Polymerase Inhib Comb		
VOSEVI	State Carve Out	
Hepatitis C - Ns5b Polymerase And Ns5a Inhibitor Combinations		
EPCLUSA	State Carve Out	
HARVONI	State Carve Out	
ledipasvir-sofosbuvir	State Carve Out	
sofosbuvir-velpatasvir	State Carve Out	
Hepatitis C - Nucleos(T)Ide Analog Ns5b Polymerase Inhibitors		
SOVALDI	State Carve Out	
Hepatitis C - Nucleoside Analogs		
ribavirin oral capsule	State Carve Out	
ribavirin oral tablet 200 mg	State Carve Out	
Hepatitis C- Ns5a, Ns3/4A Protease And Non-Nucleo.Ns5b Poly Inh. Comb		
VIEKIRA PAK	State Carve Out	
VIEKIRA XR	State Carve Out	
Herpes Antiviral Agent - Purine Analogs		
acyclovir 200 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 200 mg capsule 10x10	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 200 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 200 mg/5 ml susp	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 400 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
acyclovir 400 mg tablet 10x10	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 400 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 800 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 800 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 1 gram tablet	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 1 gram tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 1 gram tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 1 gram tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 500 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 500 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valacyclovir hcl 500 mg tablet u-d,outer,5x6,f/c	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
Herpes Antiviral Agent - Thymidine Analogs		
famciclovir 125 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
famciclovir 125 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
famciclovir 250 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
famciclovir 250 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
famciclovir 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
famciclovir 500 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
Influenza Antiviral Agents - Neuraminidase Inhibitors		
oseltamivir 6 mg/ml suspension	Formulary	PDL Preferred; QL (120 ML per 1 claim)
oseltamivir 6 mg/ml suspension	Formulary	PDL Preferred; QL (120 mL per 1 claim)
oseltamivir phos 30 mg capsule	Formulary	PDL Preferred; QL (14 capsules per 1 claim)
oseltamivir phos 45 mg capsule	Formulary	PDL Preferred; QL (14 capsules per 1 claim)
oseltamivir phos 75 mg capsule	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)
Influenza Antiviral Agents - Pa Endonuclease Inhibitor		
XOFLUZA 40 MG TABLET	Formulary	PDL Preferred
XOFLUZA 80 MG TABLET	Formulary	PDL Preferred
Influenza-A Antiviral Agents		
FLUMADINE 100 MG TABLET F/C	Formulary	PA; PDL Non-Preferred
rimantadine hcl 100 mg tablet	Formulary	PDL Preferred
Lincosamide Antibiotics		
CLEOCIN HCL	Non-Formulary	
CLEOCIN PEDIATRIC	Non-Formulary	
clindamycin (pedi) 75 mg/5 ml	Formulary	Age Limit (Max 12 Years)
CLINDAMYCIN (PEDI) 75 MG/5 ML	Formulary	Age Limit (Max 12 Years)

Medications	Coverage Level	Restrictions
clindamycin hcl 150 mg capsule	Formulary	
clindamycin hcl 150 mg capsule 10x10,u-d,outer	Formulary	
clindamycin hcl 150 mg capsule u-d,10x10	Formulary	
clindamycin hcl 300 mg capsule	Formulary	
clindamycin hcl 300 mg capsule 10x10,u-d,outer	Formulary	
clindamycin hcl 300 mg capsule outer	Formulary	
clindamycin hcl 75 mg capsule	Formulary	
Macrolide Antibiotics		
azithromycin 1 gm pwd packet outer	Formulary	PDL Preferred; QL (2 packets per 1 claim)
azithromycin 100 mg/5 ml susp	Formulary	PDL Preferred
azithromycin 200 mg/5 ml susp	Formulary	PDL Preferred
azithromycin 250 mg tablet	Formulary	PDL Preferred
azithromycin 250 mg tablet f/c	Formulary	PDL Preferred
azithromycin 250 mg tablet inner	Formulary	PDL Preferred
azithromycin 250 mg tablet outer	Formulary	PDL Preferred
azithromycin 500 mg tablet	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
azithromycin 500 mg tablet 3's, f/c	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
azithromycin 500 mg tablet f/c	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
azithromycin 500 mg tablet inner	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
azithromycin 500 mg tablet outer	Formulary	PDL Preferred; QL (3 tablets per 1 claim)
azithromycin 600 mg tablet	Formulary	PDL Preferred; QL (12 tablets per 1 claim)
azithromycin 600 mg tablet f/c	Formulary	PDL Preferred; QL (12 tablets per 1 claim)
clarithromycin 125 mg/5 ml sus	Formulary	PDL Preferred
clarithromycin 250 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin 250 mg tablet f/c	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin 250 mg tablet outer	Formulary	PDL Preferred; QL (28 tablets per 1 claim)

Medications	Coverage Level	Restrictions
clarithromycin 250 mg/5 ml sus	Formulary	PDL Preferred
clarithromycin 500 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin 500 mg tablet f/c	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin 500 mg tablet f/c, outer	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin 500 mg tablet outer	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
clarithromycin er 500 mg tab	Formulary	PA; PDL Non-Preferred
clarithromycin er 500 mg tab f/c	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
erythromycin 200 mg/5 ml susp	Formulary	PDL Preferred
erythromycin 250 mg tablet	Formulary	PA; PDL Non-Preferred
erythromycin 400 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
erythromycin 500 mg tablet	Formulary	PA; PDL Non-Preferred
erythromycin dr 250 mg cap	Formulary	PA; PDL Non-Preferred
erythromycin dr 250 mg tablet	Formulary	PA; PDL Non-Preferred
erythromycin dr 333 mg tablet	Formulary	PA; PDL Non-Preferred
erythromycin dr 500 mg tablet	Formulary	PA; PDL Non-Preferred
erythromycin es 400 mg tab	Formulary	PDL Preferred
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

Medications	Coverage Level	Restrictions
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 TRI-PAK 500 MG TAB F/C, TRI-PAK, 3X3	Formulary	PA; PDL Non-Preferred; QL (3 tablets per 1 claim)
Misc Anti-Infective Combinations		
MB CAPS	Non-Formulary	
methen-sod phos-meth blue-hyos	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	
Misc Anti-Infective		
methenamine hipp 1 gm tablet	Formulary	
methenamine hipp 1 gm tablet outer	Formulary	
methenamine mand 1 gm tablet	Formulary	
methenamine mand 500 mg tablet	Formulary	
NEBUPENT	Non-Formulary	
pentamidine inhalation	Non-Formulary	
Oxazolidinone Antibiotics		
linezolid 100 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
linezolid 600 mg tablet	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
linezolid 600 mg tablet f/c	Formulary	PDL Preferred; QL (28 tablets per 1 claim)
linezolid 600 mg tablet outer	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

Medications	Coverage Level	Restrictions
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	
penicillin vk 125 mg/5 ml soln	Formulary	3 Months Allowed
penicillin vk 250 mg tablet	Formulary	3 Months Allowed
penicillin vk 250 mg tablet f/c	Formulary	3 Months Allowed
penicillin vk 250 mg/5 ml soln	Formulary	3 Months Allowed
penicillin vk 500 mg tablet	Formulary	3 Months Allowed
penicillin vk 500 mg tablet f/c	Formulary	3 Months Allowed
Penicillin Antibiotic - Penicillinase-Resistant		
dicloxacillin 250 mg capsule	Formulary	
dicloxacillin 500 mg capsule	Formulary	
Penicillin Natural Antibiotic Combinations - Extended Release		
BICILLIN C-R	Non-Formulary	
Protease Inhibitors (Non-Peptidic) Antiretroviral		
APTIVUS	State Carve Out	
darunavir	State Carve Out	
darunavir propylene glycolate	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		
atazanavir	State Carve Out	
EVOTAZ	State Carve Out	
fosamprenavir	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	
ritonavir	State Carve Out	
VIRACEPT ORAL TABLET	State Carve Out	
Rifamycins And Related Derivative Antibiotics		
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)
rifabutin 150 mg capsule	Formulary	
rifampin 150 mg capsule	Formulary	
rifampin 150 mg capsule outer	Formulary	
rifampin 300 mg capsule	Formulary	
rifampin 300 mg capsule outer	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)
Sars-Cov-2 Antiviral Agent - Main Protease (Mpro) Inhibitors		
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	
Sulfonamide Antibiotic		
sulfadiazine	Non-Formulary	
Tetracycline Antibiotics		
demeclocycline	Non-Formulary	
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 200 MG, 80 MG	Non-Formulary	
doxycycline 25 mg/5 ml susp	Formulary	
doxycycline hyclate 100 mg cap	Formulary	
doxycycline hyclate 100 mg cap outer	Formulary	

Medications	Coverage Level	Restrictions
doxycycline hyclate 100 mg tab	Formulary	
doxycycline hyclate 100 mg tab coated, outer	Formulary	
doxycycline hyclate 100 mg tab f/c	Formulary	
doxycycline hyclate 100 mg tab outer	Formulary	
doxycycline hyclate 50 mg cap	Formulary	
doxycycline hyclate 50 mg cap outer	Formulary	
doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg	Non-Formulary	
doxycycline hyclate oral tablet,delayed release (dr/ec)	Non-Formulary	
doxycycline mono 100 mg cap	Formulary	
doxycycline mono 100 mg cap outer	Formulary	
doxycycline mono 100 mg tablet	Formulary	
doxycycline mono 100 mg tablet f/c	Formulary	
doxycycline mono 100 mg tablet outer	Formulary	
doxycycline mono 50 mg cap	Formulary	
doxycycline mono 50 mg cap outer	Formulary	
doxycycline mono 50 mg tablet	Formulary	
doxycycline monohydrate oral capsule 150 mg, 75 mg	Non-Formulary	
doxycycline monohydrate oral capsule,ir - delay rel,biphase	Non-Formulary	
doxycycline monohydrate oral tablet 150 mg, 75 mg	Non-Formulary	
minocycline 100 mg capsule	Formulary	
minocycline 100 mg capsule outer	Formulary	
minocycline 50 mg capsule	Formulary	
minocycline 75 mg capsule	Formulary	
minocycline oral tablet	Non-Formulary	
minocycline oral tablet extended release 24 hr	Non-Formulary	
MORGIDOX 1X 50	Non-Formulary	
MORGIDOX 50 MG CAPSULE	Formulary	
NUZYRA ORAL	Non-Formulary	
ORACEA	Non-Formulary	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 65 MG, 80 MG	Non-Formulary	

Medications	Coverage Level	Restrictions
tetracycline oral capsule	Non-Formulary	
Antineoplastics		
Antineoplasic-Epiderm.Growth Factor-Egfr (Erbb1),Her-2 (Erbb2)R.Inhib		
EXKIVITY	State Carve Out	
lapatinib	State Carve Out	
TYKERB	State Carve Out	
Antineoplastic - Cyp17 (17 Alpha-Hydroxylase/C17,20-Lyase) Inhibitor		
abiraterone acetate 250 mg tab	Formulary	
abiraterone acetate 250 mg tab outer	Formulary	
abiraterone acetate 500 mg tab	Formulary	
ABIRTEGA 250 MG TABLET	Formulary	
YONSA 125 MG TABLET	Formulary	
ZYTIGA 250 MG TABLET	Formulary	
ZYTIGA 500 MG TABLET	Formulary	
Antineoplastic - 1St Generation Egfr Tyrosine Kinase Inhibitor		
erlotinib	State Carve Out	
gefitinib	State Carve Out	
IRESSA	State Carve Out	
TARCEVA	State Carve Out	
Antineoplastic - 2Nd Generation Egfr Tyrosine Kinase Inhibitor		
GILOTRIF	State Carve Out	
NERLYNX	State Carve Out	
VIZIMPRO	State Carve Out	
Antineoplastic - 3Rd Generation Egfr Tyrosine Kinase Inhibitor		
LAZCLUZE	State Carve Out	
TAGRISSO	State Carve Out	
Antineoplastic - Akt (Protein Kinase B (Pkb)) Inhibitor		
TRUQAP	State Carve Out	
Antineoplastic - Alkylating Agent - Methylhydrazines		
MATULANE 50 MG CAPSULE	Formulary	

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

Medications	Coverage Level	Restrictions
ERLEADA 240 MG TABLET	Formulary	
ERLEADA 60 MG TABLET	Formulary	
nilutamide 150 mg tablet	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	
Antineoplastic - Antimetabolite - Folic Acid Analogs		
JYLAMVO 2 MG/ML ORAL SOLUTION	Formulary	
methotrexate 1 gm vial p/f,lyophili,sdv	Formulary	
methotrexate 1 gm vial p/f,sdv	Formulary	
methotrexate 1 gm vial p/f,suv	Formulary	
methotrexate 1 gm vial suv, p/f	Formulary	
methotrexate 1 gram/40 ml vial p/f, sdv	Formulary	
methotrexate 1 gram/40 ml vial p/f, suv	Formulary	
methotrexate 1 gram/40 ml vial p/f,sdv	Formulary	
methotrexate 2.5 mg tablet	Formulary	
methotrexate 2.5 mg tablet outer	Formulary	
methotrexate 2.5 mg tablet u-d,10x10,blisters	Formulary	
methotrexate 2.5 mg tablet u-d,2x10,outer	Formulary	
methotrexate 25 mg/ml vial p/f	Formulary	
methotrexate 250 mg/10 ml vial	Formulary	
methotrexate 250 mg/10 ml vial p/f, sdv	Formulary	
methotrexate 50 mg/2 ml vial	Formulary	
methotrexate 50 mg/2 ml vial outer	Formulary	
methotrexate 50 mg/2 ml vial outer, p/f, sdv	Formulary	
methotrexate 50 mg/2 ml vial p/f, sdv	Formulary	
methotrexate 50 mg/2 ml vial p/f, suv	Formulary	
TREXALL 10 MG TABLET	Formulary	
TREXALL 15 MG TABLET	Formulary	
TREXALL 5 MG TABLET	Formulary	
TREXALL 7.5 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
XATMEP 2.5 MG/ML ORAL SOLUTION	Formulary	
Antineoplastic - Antimetabolite - Purine Analogs		
mercaptopurine 20 mg/ml suspen	Formulary	
mercaptopurine 50 mg tablet	Formulary	
PURIXAN 20 MG/ML ORAL SUSP OUTER	Formulary	
TABLOID 40 MG TABLET	Formulary	
Antineoplastic - Antimetabolite - Pyrimidine Analogs		
capecitabine 150 mg tablet	Formulary	
capecitabine 500 mg tablet	Formulary	
capecitabine 500 mg tablet f/c	Formulary	
capecitabine 500 mg tablet outer	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
hydroxyurea 500 mg capsule	Formulary	3 Months Allowed
hydroxyurea 500 mg capsule u-d,10x10,outer	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		
anastrozole 1 mg tablet	Formulary	
anastrozole 1 mg tablet coated	Formulary	
anastrozole 1 mg tablet f/c	Formulary	
anastrozole 1 mg tablet outer	Formulary	
ARIMIDEX 1 MG TABLET	Formulary	
AROMASIN 25 MG TABLET	Formulary	
exemestane 25 mg tablet	Formulary	
exemestane 25 mg tablet f/c	Formulary	
FEMARA 2.5 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
letrozole 2.5 mg tablet	Formulary	
letrozole 2.5 mg tablet f/c	Formulary	
letrozole 2.5 mg tablet never launched	Formulary	
letrozole 2.5 mg tablet outer	Formulary	
Antineoplastic - B-Cell Lymphoma-2 (Bcl-2) Inhibitors		
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	
Antineoplastic - Braf Kinase Inhibitors		
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	
Antineoplastic - Bruton's Tyrosine Kinase (Btk) Inhibitor		
BRUKINSA	State Carve Out	
CALQUENCE	State Carve Out	
CALQUENCE (ACALABRUTINIB MAL)	State Carve Out	
IMBRUVICA	State Carve Out	
JAYPIRCA	State Carve Out	
Antineoplastic - Cyclin-Dependent Kinase (Cdk) 4/6 Inhibitors		
IBRANCE	State Carve Out	
KISQALI	State Carve Out	
VERZENIO	State Carve Out	
Antineoplastic - Epidermal Growth Factor Receptor-2 (Her2) Inhibitor		
TUKYSA	State Carve Out	
Antineoplastic - Epipodophyllotoxins		
etoposide 50 mg capsule outer	Formulary	

Medications	Coverage Level	Restrictions
Antineoplastic - Exportin-1 (Xpo1) Inhibitors		
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 - Ezh2 Histone Methyltransferase (Hmt) Inhibitor		
TAZVERIK 200 MG TABLET	Formulary	
Antineoplastic - Fibroblast Growth Factor Receptor (Fgfr) Kinase Inhib		
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	
Antineoplastic - Fms-Like Tyrosine Kinase 3 (Flt3) Inhibitors		
VANFLYTA	State Carve Out	
XOSPATA	State Carve Out	
Antineoplastic - Gamma-Secretase Inhibitor (Gsi)		
OGSIVEO	State Carve Out	
Antineoplastic - Hedgehog Pathway Inhibitor		
DAURISMO 100 MG TABLET	Formulary	
DAURISMO 25 MG TABLET	Formulary	
ERIVEDGE 150 MG CAPSULE	Formulary	
ODOMZO 200 MG CAPSULE	Formulary	

Medications	Coverage Level	Restrictions
Antineoplastic - Histone Deacetylase (Hdac) Inhibitors		
ZOLINZA 100 MG CAPSULE	Formulary	
Antineoplastic - Hypoxia Inducible Factor (Hif) Inhibitors		
WELIREG	State Carve Out	
Antineoplastic - Interferons		
BESREMI 500 MCG/ML SYRINGE	Formulary	
Antineoplastic - Janus Kinase (Jak) Inhibitors		
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	
Antineoplastic - Janus Kinase (Jak), Acvr1/Alk2 Inhibitors		
OJJAARA	State Carve Out	
Antineoplastic - Janus Kinase(Jak),Fms-Like Tyrosine Kinase(Flt) Inhib		
INREBIC	State Carve Out	
VONJO	State Carve Out	
Antineoplastic - Kinase Inhibitor And Aromatase Inhibitor Combination		
KISQALI FEMARA 200 MG CO-PACK	Formulary	
KISQALI FEMARA 400 MG CO-PACK	Formulary	
KISQALI FEMARA 600 MG CO-PACK	Formulary	
Antineoplastic - Kirsten Rat Sarcoma (Kras) Protein Inhibitor		
KRAZATI 200 MG TABLET	Formulary	
LUMAKRAS 120 MG TABLET INNER	Formulary	
LUMAKRAS 120 MG TABLET OUTER	Formulary	
LUMAKRAS 240 MG TABLET	Formulary	
LUMAKRAS 320 MG TABLET	Formulary	
Antineoplastic - Lhrh (Gnrh) Agonist Analog Pituitary Suppressants		
CAMCEVI 42 MG SYRINGE	Formulary	

Medications	Coverage Level	Restrictions
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	
leuprolide 2wk 14 mg/2.8 ml kt mdv	Formulary	
leuprolide 2wk 14 mg/2.8 ml kt muv	Formulary	
leuprolide 2wk 14 mg/2.8 ml kt outer, muv	Formulary	
leuprolide 2wk 14 mg/2.8 ml kt outer,mdv	Formulary	
leuprolide depot 22.5 mg vial outer, suv	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	
LUTRATE DEPOT 22.5 MG VIAL OUTER, SUV	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	
Antineoplastic - Mast Cell Stabilizers		
cromolyn 100 mg/5 ml oral conc	Formulary	
cromolyn 100 mg/5 ml oral conc outer	Formulary	

Medications	Coverage Level	Restrictions
GASTROCROM 100 MG/5 ML CONC OUTER	Formulary	
Antineoplastic - Mek 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	
everolimus 10 mg tablet	Formulary	
everolimus 10 mg tablet outer	Formulary	
everolimus 2 mg tab for susp outer	Formulary	
everolimus 2.5 mg tablet	Formulary	
everolimus 2.5 mg tablet outer	Formulary	
everolimus 3 mg tab for susp outer	Formulary	
everolimus 5 mg tab for susp outer	Formulary	
everolimus 5 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
everolimus 5 mg tablet outer	Formulary	
everolimus 7.5 mg tablet	Formulary	
everolimus 7.5 mg tablet outer	Formulary	
TORPENZ 10 MG TABLET	Formulary	
TORPENZ 2.5 MG TABLET	Formulary	
TORPENZ 5 MG TABLET	Formulary	
TORPENZ 7.5 MG TABLET	Formulary	
Antineoplastic - Multikinase Inhibitors		
CABOMETYX	State Carve Out	
COMETRIQ	State Carve Out	
ICLUSIG	State Carve Out	
NEXAVAR	State Carve Out	
sorafenib	State Carve Out	
STIVARGA	State Carve Out	
UKONIQ	State Carve Out	
Antineoplastic - Mutant Isocitrate Dehydrogenase 1 (Midh1) Inhibitors		
REZLIDHIA 150 MG CAPSULE	Formulary	
TIBSOVO 250 MG TABLET	Formulary	
Antineoplastic - Mutant Isocitrate Dehydrogenase 2 (Midh2) Inhibitors		
IDHIFA 100 MG TABLET	Formulary	
IDHIFA 50 MG TABLET	Formulary	
Antineoplastic - Ornithine Decarboxylase (Odc) Inhibitors		
IWILFIN	State Carve Out	
Antineoplastic - Pan-Class I Pi3k Inhibitors		
ALIQOPA	State Carve Out	
Antineoplastic - Parp Inhibitor And Antiandrogen Combinations		
AKEEGA 100-500 MG TABLET	Formulary	
AKEEGA 50-500 MG TABLET	Formulary	
Antineoplastic - Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors		
ALIQOPA	State Carve Out	
COPIKTRA	State Carve Out	
ZYDELIG	State Carve Out	

Medications	Coverage Level	Restrictions
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	
CALQUENCE	State Carve Out	
CALQUENCE (ACALABRUTINIB MAL)	State Carve Out	
CAPRELSA	State Carve Out	
DANZITEN	State Carve Out	
dasatinib	State Carve Out	

Medications	Coverage Level	Restrictions
FOTIVDA	State Carve Out	
FRUZAQLA	State Carve Out	
GLEEVEC	State Carve Out	
imatinib	State Carve Out	
IMBRUVICA	State Carve Out	
IMKELDI	State Carve Out	
INLYTA	State Carve Out	
JAYPIRCA	State Carve Out	
LENVIMA	State Carve Out	
nilotinib hcl	State Carve Out	
OFEV	Non-Formulary	
pazopanib	State Carve Out	
QINLOCK	State Carve Out	
ROMVIMZA	State Carve Out	
ROZLYTREK	State Carve Out	
RYDAPT	State Carve Out	
SCEMBLIX	State Carve Out	
SPRYCEL	State Carve Out	
sunitinib malate	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	
Antineoplastic - Retinoids		
tretinoin 10 mg capsule	Formulary	
tretinoin 10 mg capsule 3x10, outer	Formulary	
Antineoplastic - Selective Estrogen Receptor Degraders (Serds)		
ORSERDU 345 MG TABLET	Formulary	
ORSERDU 86 MG TABLET	Formulary	
Antineoplastic - Selective Estrogen Receptor Modulators (Serms)		
FARESTON 60 MG TABLET	Formulary	
SOLTAMOX 20 MG/10 ML SOLN	Formulary	
tamoxifen 10 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
tamoxifen 10 mg tablet 15.2mg tamoxifen cit	Formulary	
tamoxifen 20 mg tablet	Formulary	
tamoxifen 20 mg tablet 30.4mg tamoxifen cit	Formulary	
toremifene citrate 60 mg tab	Formulary	
Antineoplastic - Selective Inhibitiors 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		
bexarotene 75 mg capsule	Formulary	
TARGRETIN 75 MG CAPSULE	Formulary	
Antineoplastic - Systemic Enzyme Inhibitors Combinations		
AVMAPKI-FAKZYNJA	State Carve Out	
Antineoplastic - Telomerase Inhibitors		
RYTELO	State Carve Out	
Antineoplastic - Thalidomide Analogs		
lenalidomide 10 mg capsule	Formulary	
lenalidomide 15 mg capsule	Formulary	
lenalidomide 2.5 mg capsule	Formulary	
lenalidomide 20 mg capsule	Formulary	
lenalidomide 25 mg capsule	Formulary	

Medications	Coverage Level	Restrictions
lenalidomide 5 mg capsule	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	
Antineoplastic - Topoisomerase I Inhibitors		
HYCAMTIN 0.25 MG CAPSULE	Formulary	
HYCAMTIN 1 MG CAPSULE	Formulary	
Antineoplastic - Tropomyosin Receptor Kinase (Trk) Inhibitor		
VITRAKVI	State Carve Out	
Antineoplastic-Anti-Programmed Cell Death Receptor-1 (Pd-1) Mc Antib.		
OPDIVO INTRAVENOUS SOLUTION 240 MG/24 ML	Non-Formulary	
Antineoplastic-Isocitrate Dehydrogenase-1 And -2 (Idh1 And Idh2) Inhib		
VORANIGO 10 MG TABLET	Formulary	
VORANIGO 40 MG TABLET	Formulary	
Antineoplastic-Pyrimidine Analog And Cytidine Deaminase Inhibitor Comb		
INQOVI 35 MG-100 MG TABLET	Formulary	
Bone Marrow Protective Agents Used In Conjunction With Chemotherapy		
COSELA	State Carve Out	
Methotrexate Rescue Agents - Folic Acid Antagonist Type		
leucovorin calcium 10 mg tab	Formulary	

Medications	Coverage Level	Restrictions
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
ALCOHOL PREP PADS	Formulary	OTC
alcohol swab sterile, two ply	Formulary	OTC
alcohol swabs	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

Medications	Coverage Level	Restrictions
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
gnp alcohol swab sterile, two ply	Formulary	OTC
HM ALCOHOL 70% PREP PADS	Formulary	OTC
INCONTROL ALCOHOL PADS	Non-Formulary	OTC
pharm choice alcohol prep pads	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
ra alcohol swabs health care, 70%	Formulary	OTC
RA ISOPROPYL ALCOHOL 70% WIPES	Formulary	OTC
relion alcohol 70% swabs	Formulary	OTC
saps alcohol 70% prep pads	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
WEBCOL ALCOHOL PREPS 20'S,LARGE,2-PLY	Formulary	OTC
WEBCOL ALCOHOL PREPS 20'S,MEDIUM,2-PLY	Formulary	OTC
Antiseptic - Iodine/Iodophores		
LUGOLS TOPICAL	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
Biologicals		
Allergenic Extracts - Grass Pollen		
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	Non-Formulary	
Antiviral Monoclonal Antibodies - Respiratory Syncytial Virus (Rsv)		
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
Hepatitis A And Hepatitis B Vaccine Combinations		
TWINRIX (PF)	Formulary	QL (4 doses per 1 lifetime); Age Limit (Min 19 Years)
Hepatitis A Vaccine - Single Agents		
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)
Hepatitis B Vaccines - Single Agents		
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)
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)

Medications	Coverage Level	Restrictions
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)
Immune Globulin - Rho(D)		
HYPERRHO S/D	Non-Formulary	
RHOGAM ULTRA-FILTERED PLUS	Non-Formulary	
RHOPHYLAC	Non-Formulary	
Live Vaccine And Live Virus Formulations		
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)
VIVOTIF	Formulary	QL (4 capsules per 1 lifetime); Age Limit (Min 6 Years)
YF-VAX (PF)	Formulary	QL (1 dose per 1 lifetime)
Peanut Desensitization Agents		
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)

Medications	Coverage Level	Restrictions
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)
Toxoid Vaccine Combinations		
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)
TENIVAC (PF)	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Bacterial - Gram Negative Bacilli (Non-Enteric)		
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)

Medications	Coverage Level	Restrictions
Vaccine Bacterial - Gram Negative Cocci		
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)
Vaccine Bacterial - Gram Positive Cocci		
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)
Vaccine Bacterial - Meningococcal Group B Vaccines		
BEXSERO	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
TRUMENBA	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Bacterial - Toxin-Producing Bacilli		
VAXCHORA VACCINE	Formulary	QL (1 dose per 1 lifetime); Age Limit (Min 2 Years and Max 64 Years)
Vaccine Viral - Chikungunya Virus (Chikv)		
IXCHIQ (PF)	Formulary	Age Limit (Min 18 Years)
VIMKUNYA	Formulary	Age Limit (Min 12 Years)
Vaccine Viral - Covid-19 (Sars-Cov-2)		
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)

Medications	Coverage Level	Restrictions
SPIKEVAX 2024-2025(12Y UP)(PF)	Formulary	QL (1 rx per 1 Year); Age Limit (Min 19 Years)
Vaccine Viral - Human Papillomavirus (Hpv) Vaccines		
GARDASIL 9 (PF)	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Viral - Influenza A And B		
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)
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)
Vaccine Viral - Japanese Encephalitis		
IXIARO (PF)	Formulary	QL (2 doses per 1 lifetime)
Vaccine Viral - Measles		
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)

Medications	Coverage Level	Restrictions
Vaccine Viral - Mpox		
JYNNEOS (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Viral - Mumps And Related		
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)
Vaccine Viral - Poliomyelitis		
IPOL	Formulary	QL (3 doses per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Viral - Respiratory Syncytial Virus (Rsv)		
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)
Vaccine Viral - Rubella		
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)
Vaccine Viral - Smallpox		
JYNNEOS (PF)	Formulary	QL (2 doses per 1 lifetime); Age Limit (Min 19 Years)
Vaccine Viral - Varicella		
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)
Vaccine Viral - Yellow Fever		
YF-VAX (PF)	Formulary	QL (1 dose per 1 lifetime)
Vaccine Viral Combinations		
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)

Medications	Coverage Level	Restrictions
Vaccine Viral- Tick-Borne Encephalitis		
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		
Ace Inhibitor And Calcium Channel Blocker Combinations		
amlodipine-benazepril 10-20 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-benazepril 10-40 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-benazepril 2.5-10	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-benazepril 5-10 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-benazepril 5-20 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-benazepril 5-40 mg	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
trandolapril-verapamil er 1-240 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
trandolapril-verapamil er 2-180 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
trandolapril-verapamil er 2-240 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
trandolapril-verapamil er 4-240 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Ace Inhibitor And Diuretic Combinations		
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

Medications	Coverage Level	Restrictions
ACCURETIC 20-25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
benazepril-hydrochlorothiazide 10-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
benazepril-hydrochlorothiazide 20-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
benazepril-hydrochlorothiazide 20-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
benazepril-hydrochlorothiazide 5-6.25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
captopril-hydrochlorothiazide 25-15 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril-hydrochlorothiazide 25-25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril-hydrochlorothiazide 50-15 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril-hydrochlorothiazide 50-25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
enalapril-hydrochlorothiazide 10-25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
enalapril-hydrochlorothiazide 5-12.5 mg tab tablet	Formulary	PDL Preferred; 3 Months Allowed
fosinopril-hydrochlorothiazide 10-12.5 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fosinopril-hydrochlorothiazide 20-12.5 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
lisinopril-hydrochlorothiazide 10-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
lisinopril-hydrochlorothiazide 20-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
lisinopril-hydrochlorothiazide 20-25 mg tab	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
quinapril-hydrochlorothiazide 10-12.5 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
quinapril-hydrochlorothiazide 20-12.5 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril-hydrochlorothiazide 20-25 mg tab	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
Ace Inhibitors		
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
benazepril hcl 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 10 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 20 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 20 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
benazepril hcl 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 5 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
benazepril hcl 5 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
captopril 100 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 12.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 12.5 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 12.5 mg tablet u-d, outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 25 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 25 mg tablet u-d, outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
captopril 50 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
enalapril 1 mg/ml oral soln	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
enalapril maleate 10 mg tab	Formulary	PDL Preferred; 3 Months Allowed
enalapril maleate 10 mg tab for repackaging only	Formulary	PDL Preferred; 3 Months Allowed
enalapril maleate 2.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
enalapril maleate 2.5 mg tab for repackaging only	Formulary	PDL Preferred; 3 Months Allowed
enalapril maleate 20 mg tab	Formulary	PDL Preferred; 3 Months Allowed

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

Medications	Coverage Level	Restrictions
moexipril hcl 15 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
moexipril hcl 7.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
perindopril erbumine 2 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
perindopril erbumine 4 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
perindopril erbumine 8 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
QBRELIS 1 MG/ML SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 20 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 40 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 40 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
quinapril 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ramipril 1.25 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
ramipril 10 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
ramipril 2.5 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
ramipril 5 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
trandolapril 1 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
trandolapril 2 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
trandolapril 4 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VASOTEC 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
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
Aldosterone Receptor Antagonists		
ALDACTONE	Non-Formulary	
CAROSPIR	Non-Formulary	
eplerenone 25 mg tablet	Formulary	
eplerenone 25 mg tablet f/c	Formulary	
eplerenone 25 mg tablet inner	Formulary	
eplerenone 25 mg tablet outer	Formulary	
eplerenone 50 mg tablet	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)
spironolactone 100 mg tablet	Formulary	
spironolactone 100 mg tablet f/c	Formulary	
spironolactone 100 mg tablet outer	Formulary	
spironolactone 25 mg tablet	Formulary	
spironolactone 25 mg tablet f/c	Formulary	
spironolactone 25 mg tablet f/c,u-d,10x10	Formulary	
spironolactone 25 mg tablet outer	Formulary	
spironolactone 25 mg tablet u-d,10x10,outer	Formulary	

Medications	Coverage Level	Restrictions
spironolactone 50 mg tablet	Formulary	
spironolactone 50 mg tablet f/c	Formulary	
spironolactone 50 mg tablet f/c,u-d,10x10	Formulary	
spironolactone 50 mg tablet f/c,u-d,10x10,outer	Formulary	
spironolactone 50 mg tablet outer	Formulary	
spironolactone oral suspension	Non-Formulary	
Alpha-Beta Blockers		
carvedilol 12.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 12.5 mg tablet 12's	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 12.5 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 12.5 mg tablet f/c, u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 12.5 mg tablet f/c,outer,10x10,u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 25 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 25 mg tablet f/c, u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 25 mg tablet f/c,outer,10x10,u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 3.125 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 3.125 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 3.125 mg tablet f/c, u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 6.25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 6.25 mg tablet 12's	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 6.25 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
carvedilol 6.25 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
carvedilol 6.25 mg tablet f/c, u-d	Formulary	PDL Preferred; 3 Months Allowed
carvedilol er 10 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carvedilol er 20 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carvedilol er 40 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carvedilol er 80 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
labetalol hcl 100 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 100 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 100 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 200 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 200 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 200 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 300 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 300 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 300 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
labetalol hcl 400 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
Angiotensin Ii Receptor Blocker (Arb)-Calcium Channel Blocker Comb.		
amlodipine-olmesartan 10-20 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-olmesartan 10-40 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-olmesartan 5-20 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-olmesartan 5-40 mg	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
amlodipine-valsartan 10-160 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan 10-320 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan 5-160 mg	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan 5-320 mg	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
telmisartan-amlodipine 40-10	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-amlodipine 40-5 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-amlodipine 80-10	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-amlodipine 80-5 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Angiotensin Ii Receptor Blocker (Arb)-Calcium Channel Blocker-Diuretic		
amlodipine-valsartan-hydrochlorothiazide 10-160-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan-hydrochlorothiazide 10-160-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan-hydrochlorothiazide 10-320-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
amlodipine-valsartan-hydrochlorothiazide 5-160-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine-valsartan-hydrochlorothiazide 5-160-25 mg tab	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
olmsrtn-amldpn-hydrochlorothiazide 20-5-12.5	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
olmsrtn-amldpn-hydrochlorothiazide 40-10-12.5	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
olmsrtn-amldpn-hydrochlorothiazide 40-10-25 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
olmsrtn-amldpn-hydrochlorothiazide 40-5-12.5	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
olmsrtn-amldpn-hydrochlorothiazide 40-5-25 mg	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
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
Angiotensin Ii Receptor Blocker (Arb)-Diuretic Combinations		
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

Medications	Coverage Level	Restrictions
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
candesartan-hydrochlorothiazide 16-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan-hydrochlorothiazide 32-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan-hydrochlorothiazide 32-25 mg tab	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
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
irbesartan-hydrochlorothiazide 150-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
irbesartan-hydrochlorothiazide 150-12.5 mg tb f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan-hydrochlorothiazide 300-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan-hydrochlorothiazide 300-12.5 mg tb f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 100-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 100-12.5 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 100-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 100-25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 50-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
losartan-hydrochlorothiazide 50-12.5 mg tab f/c	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
olmesartan-hydrochlorothiazide 20-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
olmesartan-hydrochlorothiazide 40-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
olmesartan-hydrochlorothiazide 40-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
telmisartan-hydrochlorothiazide 40-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-hydrochlorothiazide 40-12.5 mg tb outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-hydrochlorothiazide 80-12.5 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-hydrochlorothiazide 80-12.5 mg tb outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan-hydrochlorothiazide 80-25 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
telmisartan-hydrochlorothiazide 80-25 mg tab outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 160-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 160-12.5 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 160-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 160-25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 320-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 320-12.5 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 320-25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 320-25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 80-12.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
valsartan-hydrochlorothiazide 80-12.5 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
Angiotensin Ii Receptor Blocker-Neprilysin 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)
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 PELLET	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

Medications	Coverage Level	Restrictions
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
candesartan cilexetil 16 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 16 mg tb outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 32 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 32 mg tb outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 4 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 8 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
candesartan cilexetil 8 mg tab outer	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

Medications	Coverage Level	Restrictions
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
eprosartan mesylate 600 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 150 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 150 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 150 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 300 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 300 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 300 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 75 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 75 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
irbesartan 75 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
losartan potassium 100 mg tab	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 100 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 100 mg tab f/c,10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 100 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 25 mg tab	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
losartan potassium 25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 25 mg tab f/c,10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 25 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 50 mg tab	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 50 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 50 mg tab f/c,10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
losartan potassium 50 mg tab outer	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
olmesartan medoxomil 20 mg tab	Formulary	PDL Preferred; 3 Months Allowed
olmesartan medoxomil 40 mg tab	Formulary	PDL Preferred; 3 Months Allowed
olmesartan medoxomil 5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
telmisartan 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan 20 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan 40 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan 40 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan 80 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
telmisartan 80 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
valsartan 160 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
valsartan 160 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan 160 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valsartan 20 mg/5 ml solution	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
valsartan 320 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
valsartan 320 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan 320 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valsartan 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
valsartan 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
valsartan 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
valsartan 80 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
valsartan 80 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
Antianginal - Coronary Vasodilators (Nitrates)		
GONITRO	Non-Formulary	
ISORDIL	Non-Formulary	
ISORDIL TITRADOSE ORAL TABLET 5 MG	Non-Formulary	
isosorbide dinitrate 10 mg tab	Formulary	
isosorbide dinitrate 10 mg tab outer	Formulary	
isosorbide dinitrate 20 mg tab	Formulary	
isosorbide dinitrate 20 mg tab outer	Formulary	
isosorbide dinitrate 30 mg tab	Formulary	
isosorbide dinitrate 5 mg tab	Formulary	
isosorbide dinitrate 5 mg tab outer	Formulary	
isosorbide dinitrate oral tablet 40 mg	Non-Formulary	
isosorbide mononit 10 mg tab	Formulary	
isosorbide mononit 20 mg tab	Formulary	

Medications	Coverage Level	Restrictions
isosorbide mononit er 120 mg	Formulary	QL (2 tablets per 1 day)
isosorbide mononit er 120 mg f/c	Formulary	QL (2 tablets per 1 day)
isosorbide mononit er 30 mg tb	Formulary	QL (1 tablet per 1 day)
isosorbide mononit er 30 mg tb f/c	Formulary	QL (1 tablet per 1 day)
isosorbide mononit er 30 mg tb outer	Formulary	QL (1 tablet per 1 day)
isosorbide mononit er 60 mg tb	Formulary	QL (2 tablets per 1 day)
isosorbide mononit er 60 mg tb f/c	Formulary	QL (2 tablets per 1 day)
isosorbide mononit er 60 mg tb outer	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	
nitroglycerin 0.1 mg/hr patch	Formulary	QL (1 patch per 1 day)
nitroglycerin 0.1 mg/hr patch outer	Formulary	QL (1 patch per 1 day)
nitroglycerin 0.2 mg/hr patch outer	Formulary	QL (1 patch per 1 day)
nitroglycerin 0.3 mg tablet sl	Formulary	
nitroglycerin 0.4 mg tablet sl	Formulary	
nitroglycerin 0.4 mg tablet sl outer	Formulary	
nitroglycerin 0.4 mg/hr patch outer	Formulary	QL (1 patch per 1 day)
nitroglycerin 0.6 mg tablet sl	Formulary	
nitroglycerin 0.6 mg/hr patch	Formulary	QL (1 patch per 1 day)
nitroglycerin 0.6 mg/hr patch outer	Formulary	QL (1 patch per 1 day)
nitroglycerin 400 mcg spray	Formulary	
nitroglycerin 400 mcg spray 200-dose, pumpspray	Formulary	
nitroglycerin 400 mcg spray 60-dose, pumpspray	Formulary	
NITROLINGUAL	Non-Formulary	
NITROSTAT	Non-Formulary	
Antianginal And Anti-Ischemic Agents, Non-Hemodynamic		
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)
ranolazine er 1,000 mg tablet	Formulary	PA; QL (2 tablets per 1 day)
ranolazine er 1,000 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
ranolazine er 500 mg tablet	Formulary	PA; QL (2 tablets per 1 day)
ranolazine er 500 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day)
Antianginal And Anti-Ischemic Agents		
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)
Antiarrhythmic - Class Ia		
disopyramide 100 mg capsule	Formulary	Age Limit (Max 64 Years)
disopyramide 150 mg capsule	Formulary	Age Limit (Max 64 Years)
NORPACE	Non-Formulary	
NORPACE CR	Non-Formulary	
quinidine gluconate oral	Non-Formulary	
quinidine sulfate 200 mg tab	Formulary	
quinidine sulfate 300 mg tab	Formulary	
Antiarrhythmic - Class Ib		
mexiletine 150 mg capsule	Formulary	
mexiletine 150 mg capsule outer	Formulary	
mexiletine 200 mg capsule	Formulary	
mexiletine 250 mg capsule	Formulary	
phenytoin sodium	State Carve Out	
Antiarrhythmic - Class Ic		
flecainide acetate 100 mg tab	Formulary	
flecainide acetate 100 mg tab outer	Formulary	
flecainide acetate 150 mg tab	Formulary	
flecainide acetate 50 mg tab	Formulary	
flecainide acetate 50 mg tab outer	Formulary	
propafenone hcl 150 mg tablet	Formulary	
propafenone hcl 150 mg tablet f/c	Formulary	
propafenone hcl 150 mg tablet outer	Formulary	

Medications	Coverage Level	Restrictions
propafenone hcl 225 mg tab	Formulary	
propafenone hcl 225 mg tab f/c	Formulary	
propafenone hcl 300 mg tab	Formulary	
propafenone oral capsule,extended release 12 hr	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
sotalol 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 120 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
sotalol 160 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 240 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 80 mg tablet outer	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
Antiarrhythmic - Class Iii		
amiodarone hcl 100 mg tablet	Formulary	QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
amiodarone hcl 100 mg tablet outer	Formulary	QL (1 tablet per 1 day)
amiodarone hcl 200 mg tablet	Formulary	
amiodarone hcl 200 mg tablet outer	Formulary	
amiodarone hcl 400 mg tablet	Formulary	
dofetilide 125 mcg capsule	Formulary	
dofetilide 250 mcg capsule	Formulary	
dofetilide 500 mcg capsule	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	
Antiarrhythmic - Class Iv		
verapamil 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 120 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 80 mg tablet f/c	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

Medications	Coverage Level	Restrictions
CHOLESTYRAMINE LIGHT POWDER	Formulary	PDL Preferred; 3 Months Allowed
cholestyramine packet	Formulary	PDL Preferred; 3 Months Allowed
cholestyramine packet outer	Formulary	PDL Preferred; 3 Months Allowed
cholestyramine powder	Formulary	PDL Preferred; 3 Months Allowed
colesevelam 625 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
colesevelam 625 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
colesevelam hcl 3.75 g packet	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
colestipol hcl 1 gm tablet	Formulary	PDL Preferred; 3 Months Allowed
colestipol hcl 1 gm tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
colestipol hcl 1 gm tablet outer	Formulary	PDL Preferred; 3 Months Allowed
colestipol hcl granules	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
colestipol hcl granules packet	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

Medications	Coverage Level	Restrictions
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
Antihyperlipidemic - Fibric Acid Derivatives		
fenofibrate 120 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 130 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 134 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 145 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 145 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 145 mg tablet f/c, 10x10, outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 145 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 150 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 160 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 160 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 160 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 200 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 200 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 40 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 43 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 48 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
fenofibrate 48 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 48 mg tablet f/c, 10x10, outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 48 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 50 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibrate 54 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 54 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 54 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 67 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
fenofibrate 90 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibric acid 105 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibric acid 35 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibric acid dr 135 mg cap	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fenofibric acid dr 45 mg cap	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
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
gemfibrozil 600 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
gemfibrozil 600 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
gemfibrozil 600 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
LIPOFEN 150 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
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
Antihyperlipidemic - Hmg Coa Reductase Inhibitors (Statins)		
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)
atorvastatin 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 10 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 10 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 10 mg tablet f/c,u-d	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 20 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 20 mg tablet f/c, 10x10, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
atorvastatin 20 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 20 mg tablet f/c,u-d	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 20 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 40 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 80 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 80 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 80 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
atorvastatin 80 mg tablet u-d, 5x6, outer	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)
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)

Medications	Coverage Level	Restrictions
EZALLOR SPRINKLE 5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
fluvastatin er 80 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
fluvastatin sodium 20 mg cap	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 capsule per 1 day)
fluvastatin sodium 40 mg cap	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)
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)

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

Medications	Coverage Level	Restrictions
pravastatin sodium 80 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 10 mg tab	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 10 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 20 mg tab	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 20 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 40 mg tab	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 40 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 5 mg tab	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
rosuvastatin calcium 5 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 10 mg tablet 10x10, u-d, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 10 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 10 mg tablet f/c,u-d,10x10	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 20 mg tablet 10x10, u-d, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 20 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 20 mg tablet f/c,u-d,10x30	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 40 mg tablet f/c, u-d, 10x10	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
simvastatin 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 5 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 5 mg tablet f/c, 10x10	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
simvastatin 80 mg tablet f/c	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)
ZYPITAMAG 4 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
Antihyperlipidemic - Nicotinic Acid Derivatives		
niacin 500 mg tablet (rx)	Formulary	PDL Preferred; 3 Months Allowed; OTC
niacin er 1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
niacin er 1,000 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
niacin er 500 mg tablet (rx)	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
niacin er 500 mg tablet f/c (rx)	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
niacin er 500 mg tablet outer (rx)	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
niacin er 750 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperlipidemic - Omega-3 Fatty Acid Type		
icosapent ethyl 0.5 gm capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
icosapent ethyl 1 gram capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
icosapent ethyl 1 gram capsule outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
icosapent ethyl 500 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
omega-3 ethyl esters 1 gm cap	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
omega-3 ethyl esters 1 gm cap outer	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)
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)
Antihyperlipidemic - Pcsk9 Inhibitors		
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)

Medications	Coverage Level	Restrictions
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)
Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor		
ezetimibe 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ezetimibe 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ZETIA 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperlipidemic- Atp-Citrate Lyase And Cholesterol Absorption Inhib		
NEXLIZET 180-10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
Antihyperlipidemic Hmg Coa Reduct Inhib And Calcium Channel Blocker		
amlodipine-atorvast 10-10 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 10-20 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 10-40 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 10-80 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 2.5-10 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 2.5-20 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 2.5-40 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
amlodipine-atorvast 5-10 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 5-20 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 5-40 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
amlodipine-atorvast 5-80 mg	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)
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)
Antihyperlipidemic-Hmg Coa Reduct Inhib And Cholesterol Absorp Inhibit		
ezetimibe-simvastatin 10-10 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ezetimibe-simvastatin 10-20 mg	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)

Medications	Coverage Level	Restrictions
ezetimibe-simvastatin 10-40 mg	Formulary	PDL Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
ezetimibe-simvastatin 10-80 mg	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)
Antihyperlipidemic-Microsomal Triglyceride Transfer Protein (Mtp)Inhib		
JUXTAPID	Non-Formulary	
Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity		
acebutolol 200 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
acebutolol 200 mg capsule outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
acebutolol 400 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Beta Blockers Cardiac Selective		
atenolol 100 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
atenolol 100 mg tablet u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
atenolol 25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
atenolol 25 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
atenolol 25 mg tablet u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
atenolol 50 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
atenolol 50 mg tablet u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
betaxolol 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
betaxolol 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
bisoprolol fumarate 10 mg tab	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol fumarate 2.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol fumarate 5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol fumarate 5 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol fumarate 5 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
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
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
metoprolol succ er 100 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 100 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
metoprolol succ er 100 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 200 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 200 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 200 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 25 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 50 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 50 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol succ er 50 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 100 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 100 mg tab 10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 100 mg tab 12's	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 100 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 100 mg tab u-d,robot ready,outr	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 25 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 25 mg tab u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 37.5 mg tb	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
metoprolol tartrate 50 mg tab	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 50 mg tab 10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 50 mg tab 12's	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 50 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 50 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
metoprolol tartrate 75 mg tab	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 2.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nebivolol 5 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
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

Medications	Coverage Level	Restrictions
Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity		
pindolol 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pindolol 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Beta Blockers Non-Cardiac Selective		
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
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
nadolol 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
nadolol 20 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nadolol 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nadolol 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nadolol 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
propranolol 20 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol 20 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
propranolol 20 mg/5 ml soln	Formulary	PDL Preferred; 3 Months Allowed
propranolol 20 mg/5 ml solution cup outer	Formulary	PDL Preferred; 3 Months Allowed
propranolol 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol 40 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
propranolol 40 mg/5 ml soln	Formulary	PDL Preferred; 3 Months Allowed
propranolol 60 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
propranolol er 120 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
propranolol er 160 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
propranolol er 60 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
propranolol er 60 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
propranolol er 80 mg capsule	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
propranolol er 80 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
sotalol 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 120 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
sotalol 160 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 240 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
sotalol 80 mg tablet outer	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
timolol maleate 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
timolol maleate 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
timolol maleate 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Bradykinin B2 Receptor Antagonists		
FIRAZYR	Non-Formulary	
icatibant	Non-Formulary	
SAJAZIR	Non-Formulary	
Calcium Channel Blockers - Benzothiazepines		
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

Medications	Coverage Level	Restrictions
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
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
diltiazem 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 12hr er 120 mg cap	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
diltiazem 12hr er 120 mg cap u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 12hr er 60 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 12hr er 60 mg cap u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 12hr er 90 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 12hr er 90 mg cap u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 120 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 120 mg cp outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 180 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 180 mg cp outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 240 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 240 mg cp outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 300 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 300 mg cp once a day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 300 mg cp outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(cd) 360 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(la) 120 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
diltiazem 24h er(la) 180 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
diltiazem 24h er(la) 240 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
diltiazem 24h er(la) 300 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
diltiazem 24h er(la) 360 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
diltiazem 24h er(la) 420 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
diltiazem 24h er(xr) 120 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(xr) 180 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24h er(xr) 240 mg cp	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 120 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 120 mg cap once-a-day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 120 mg cap once-a-day-dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 180 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 180 mg cap once-a-day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 240 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 240 mg cap once-a-day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 300 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 300 mg cap once-a-day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 360 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 360 mg cap once-a-day dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 360 mg cap once-a-day-dosage	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 24hr er 420 mg cap	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 30 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 30 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 60 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
diltiazem 60 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
diltiazem 90 mg tablet	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
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

Medications	Coverage Level	Restrictions
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
Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific		
nimodipine 30 mg capsule	Formulary	QL (252 capsules per 365 days)
nimodipine 30 mg capsule outer	Formulary	QL (252 capsules per 365 days)
nimodipine 30 mg capsule u-d, 25x4, outer	Formulary	QL (252 capsules per 365 days)
nimodipine 30 mg capsule u-d, 5x6	Formulary	QL (252 capsules per 365 days)
NYMALIZE ORAL SYRINGE	Non-Formulary	
Calcium Channel Blockers - Dihydropyridines		
amlodipine besylate 10 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine besylate 10 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
amlodipine besylate 2.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine besylate 5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
amlodipine besylate 5 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
felodipine er 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
felodipine er 10 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
felodipine er 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
felodipine er 2.5 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
felodipine er 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
felodipine er 5 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
isradipine 2.5 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
isradipine 5 mg capsule	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)
levamlodipine 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levamlodipine maleate 5 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nicardipine 20 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nicardipine 30 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nifedipine 10 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
nifedipine 10 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
nifedipine 20 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 30 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 30 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 30 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 60 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 60 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 60 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 90 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nifedipine er 90 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
nifedipine er 90 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nisoldipine er 17 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 25.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 30 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 34 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 40 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
nisoldipine er 8.5 mg tablet	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
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

Medications	Coverage Level	Restrictions
SULAR ER 8.5 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Calcium Channel Blockers - Phenylakylamines		
verapamil 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 120 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil 40 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 40 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil 80 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil 80 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 120 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil er 120 mg capsule u-d,10x10,outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil er 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 120 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 180 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil er 180 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 180 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 240 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil er 240 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
verapamil er 240 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
verapamil er pm 100 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil er pm 200 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
verapamil er pm 300 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil sr 120 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil sr 180 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil sr 240 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
verapamil sr 360 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 100 MG CAP PELLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 200 MG CAP PELLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VERELAN PM 300 MG CAP PELLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Cardiac Inotropes - Phosphodiesterase Inhibitors		
milrinone in 5 % dextrose	Non-Formulary	
Cardiac Myosin Inhibitor		
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)
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.		
atenolol-chlorthalidone 100-25	Formulary	PDL Preferred; 3 Months Allowed
atenolol-chlorthalidone 50-25	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol-hydrochlorothiazide 10-6.25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol-hydrochlorothiazide 10-6.25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol-hydrochlorothiazide 2.5-6.25 mg tb	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
bisoprolol-hydrochlorothiazide 2.5-6.25 mg tb f/c	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol-hydrochlorothiazide 5-6.25 mg tab	Formulary	PDL Preferred; 3 Months Allowed
bisoprolol-hydrochlorothiazide 5-6.25 mg tab f/c	Formulary	PDL Preferred; 3 Months Allowed
metoprolol-hydrochlorothiazide 100-25 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metoprolol-hydrochlorothiazide 100-50 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metoprolol-hydrochlorothiazide 50-25 mg tab	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)
epinephrine 0.15 mg auto-injct outer, suv	Formulary	PDL Preferred; QL (4 pens per 1 claim)
epinephrine 0.3 mg auto-inject outer, suv	Formulary	PDL Preferred; QL (4 pens per 1 claim)
epinephrine 0.3 mg auto-inject outer, suv,	Formulary	PDL Preferred; QL (4 pens per 1 claim)
epinephrine 0.3 mg auto-inject suv, outer	Formulary	PDL Preferred; QL (4 pens per 1 claim)
EPIPEN 2-PAK 0.3 MG AUTO-INJCT 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)

Medications	Coverage Level	Restrictions
NEFFY 2 MG/0.1 ML NASAL SPRAY	Formulary	PA; PDL Non-Preferred; QL (2 boxes per 1 claim)
Cardiovascular Sympathomimetics		
dobutamine in d5w intravenous parenteral solution 500 mg/250 ml (2,000 mcg/ml)	Non-Formulary	
droxidopa	Non-Formulary	
midodrine hcl 10 mg tablet	Formulary	
midodrine hcl 10 mg tablet outer	Formulary	
midodrine hcl 2.5 mg tablet	Formulary	
midodrine hcl 2.5 mg tablet outer	Formulary	
midodrine hcl 5 mg tablet	Formulary	
midodrine hcl 5 mg tablet outer	Formulary	
midodrine hcl 5 mg tablet u-d, 10x10, inner	Formulary	
midodrine hcl 5 mg tablet u-d, 10x10, outer	Formulary	
midodrine hcl 5 mg tablet u-d,10x10,outer	Formulary	
NORTHERA	Non-Formulary	
Central Alpha-2 Agonists-Thiazide Diuretic And Related Comb.		
methyldopa-hydrochlorothiazide 250-15 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
methyldopa-hydrochlorothiazide 250-25 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Central Alpha-2 Receptor Agonists		
clonidine 0.1 mg/day patch	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
clonidine 0.1 mg/day patch outer	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
clonidine 0.2 mg/day patch	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
clonidine 0.2 mg/day patch outer	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
clonidine 0.3 mg/day patch	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)

Medications	Coverage Level	Restrictions
clonidine 0.3 mg/day patch outer	Formulary	PDL Preferred; 3 Months Allowed; QL (4 patches per 28 days)
clonidine hcl 0.1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl 0.1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl 0.2 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl 0.2 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl 0.3 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl 0.3 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
clonidine hcl er 0.17 mg tab	Formulary	PDL Preferred; 3 Months Allowed
guanfacine 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
guanfacine 1 mg tablet inner	Formulary	PDL Preferred; 3 Months Allowed
guanfacine 1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
guanfacine 2 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
guanfacine 2 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
methyldopa 250 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
methyldopa 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
NEXICLON XR 0.17 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
Digitalis Glycosides		
digoxin 0.125 mg tablet	Formulary	
digoxin 0.125 mg tablet outer	Formulary	
digoxin 0.25 mg tablet	Formulary	
digoxin 0.25 mg tablet outer	Formulary	
digoxin 125 mcg tablet	Formulary	
digoxin 125 mcg tablet outer	Formulary	

Medications	Coverage Level	Restrictions
digoxin 250 mcg tablet	Formulary	
digoxin 250 mcg tablet outer	Formulary	
digoxin oral solution	Non-Formulary	
digoxin oral tablet 62.5 mcg (0.0625 mg)	Non-Formulary	
Direct Acting Vasodilators		
hydralazine 10 mg tablet	Formulary	
hydralazine 10 mg tablet outer	Formulary	
hydralazine 10 mg tablet u-d, 10x10, outer	Formulary	
hydralazine 10 mg tablet u-d,10x10,outer	Formulary	
hydralazine 100 mg tablet	Formulary	
hydralazine 100 mg tablet f/c	Formulary	
hydralazine 25 mg tablet	Formulary	
hydralazine 25 mg tablet f/c	Formulary	
hydralazine 25 mg tablet f/c, outer	Formulary	
hydralazine 25 mg tablet outer	Formulary	
hydralazine 25 mg tablet u-d,10x10,outer	Formulary	
hydralazine 50 mg tablet	Formulary	
hydralazine 50 mg tablet 10x10,u-d,f/c,outer	Formulary	
hydralazine 50 mg tablet f/c	Formulary	
hydralazine 50 mg tablet outer	Formulary	
hydralazine 50 mg tablet u-d,10x10,outer	Formulary	
minoxidil 10 mg tablet	Formulary	
minoxidil 10 mg tablet outer	Formulary	
minoxidil 2.5 mg tablet	Formulary	
minoxidil 2.5 mg tablet outer	Formulary	
Diuretic - Aldosterone Receptor Antagonist, Non-Selective		
ALDACTONE	Non-Formulary	
CAROSPIR	Non-Formulary	
spironolactone 100 mg tablet	Formulary	
spironolactone 100 mg tablet f/c	Formulary	
spironolactone 100 mg tablet outer	Formulary	
spironolactone 25 mg tablet	Formulary	
spironolactone 25 mg tablet f/c	Formulary	
spironolactone 25 mg tablet f/c,u-d,10x10	Formulary	
spironolactone 25 mg tablet outer	Formulary	

Medications	Coverage Level	Restrictions
spironolactone 25 mg tablet u-d,10x10,outer	Formulary	
spironolactone 50 mg tablet	Formulary	
spironolactone 50 mg tablet f/c	Formulary	
spironolactone 50 mg tablet f/c,u-d,10x10	Formulary	
spironolactone 50 mg tablet f/c,u-d,10x10,outer	Formulary	
spironolactone 50 mg tablet outer	Formulary	
spironolactone oral suspension	Non-Formulary	
Diuretic - Aldosterone Receptor Antagonist, Selective		
eplerenone 25 mg tablet	Formulary	
eplerenone 25 mg tablet f/c	Formulary	
eplerenone 25 mg tablet inner	Formulary	
eplerenone 25 mg tablet outer	Formulary	
eplerenone 50 mg tablet	Formulary	
INSPRA	Non-Formulary	
Diuretic - Carbonic Anhydrase Inhibitors		
acetazolamide 125 mg tablet	Formulary	QL (4 tablets per 1 day)
acetazolamide 250 mg tablet	Formulary	QL (4 tablets per 1 day)
acetazolamide 250 mg tablet outer	Formulary	QL (4 tablets per 1 day)
acetazolamide er 500 mg cap	Formulary	QL (2 capsules per 1 day)
acetazolamide er 500 mg cap outer	Formulary	QL (2 capsules per 1 day)
dichlorphenamide	Non-Formulary	
methazolamide	Non-Formulary	
Diuretic - Loop		
bumetanide 0.5 mg tablet	Formulary	Step Therapy
bumetanide 0.5 mg tablet outer	Formulary	Step Therapy
bumetanide 1 mg tablet	Formulary	Step Therapy
bumetanide 1 mg tablet outer	Formulary	Step Therapy
bumetanide 2 mg tablet	Formulary	Step Therapy
bumetanide 2 mg tablet outer	Formulary	Step Therapy
EDECRIN	Non-Formulary	
ethacrynic acid	Non-Formulary	
furosemide 10 mg/ml solution	Formulary	
furosemide 20 mg tablet	Formulary	
furosemide 40 mg tablet	Formulary	
furosemide 40 mg/5 ml soln	Formulary	Age Limit (Max 12 Years)

Medications	Coverage Level	Restrictions
furosemide 40 mg/5 ml solution cup inner	Formulary	Age Limit (Max 12 Years)
furosemide 40 mg/5 ml solution cup outer	Formulary	Age Limit (Max 12 Years)
furosemide 80 mg tablet	Formulary	
furosemide oral solution 40 mg/4 ml	Non-Formulary	
LASIX	Non-Formulary	
torsemide 10 mg tablet	Formulary	
torsemide 10 mg tablet outer	Formulary	
torsemide 100 mg tablet	Formulary	
torsemide 100 mg tablet outer	Formulary	
torsemide 20 mg tablet	Formulary	
torsemide 20 mg tablet 10x10, u-d, outer	Formulary	
torsemide 20 mg tablet outer	Formulary	
torsemide 5 mg tablet	Formulary	
torsemide 5 mg tablet outer	Formulary	
Diuretic - Potassium Sparing		
amiloride hcl 5 mg tablet	Formulary	
triamterene	Non-Formulary	
Diuretic - Potassium Sparing-Thiazide And Related Combinations		
amiloride hcl-hydrochlorothiazide 5-50 mg tab	Formulary	
spironolactone-hydrochlorothiazide 25-25 tab	Formulary	
spironolactone-hydrochlorothiazide 25-25 tab outer	Formulary	
triamterene-hydrochlorothiazide 37.5-25 mg cp	Formulary	
triamterene-hydrochlorothiazide 37.5-25 mg tb	Formulary	
triamterene-hydrochlorothiazide 37.5-25 mg tb outer	Formulary	
triamterene-hydrochlorothiazide 75-50 mg tab	Formulary	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists		
SAMSCA	Non-Formulary	
tolvaptan	Non-Formulary	
Diuretic - Thiazides And Related		
chlorthalidone 25 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
chlorthalidone 25 mg tablet outer	Formulary	
chlorthalidone 25 mg tablet u-d, outer	Formulary	
chlorthalidone 50 mg tablet	Formulary	
DIURIL 250 MG/5 ML ORAL SUSP	Formulary	Age Limit (Max 12 Years)
hydrochlorothiazide 12.5 mg cp	Formulary	
hydrochlorothiazide 12.5 mg cp outer	Formulary	
hydrochlorothiazide 12.5 mg tb	Formulary	
hydrochlorothiazide 25 mg tab	Formulary	
hydrochlorothiazide 25 mg tab outer	Formulary	
hydrochlorothiazide 50 mg tab	Formulary	
indapamide 1.25 mg tablet	Formulary	
indapamide 1.25 mg tablet f/c	Formulary	
indapamide 2.5 mg tablet	Formulary	
indapamide 2.5 mg tablet f/c	Formulary	
metolazone 10 mg tablet	Formulary	
metolazone 2.5 mg tablet	Formulary	
metolazone 2.5 mg tablet outer	Formulary	
metolazone 2.5 mg tablet u-d,10x10,outer	Formulary	
metolazone 5 mg tablet	Formulary	
metolazone 5 mg tablet outer	Formulary	
metolazone 5 mg tablet u-d,10x10,outer	Formulary	
THALITONE	Non-Formulary	
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	
ivabradine hcl 5 mg tablet	Formulary	PA
ivabradine hcl 7.5 mg tablet	Formulary	PA
Muscarinic Receptor Antagonists (Anticholinergic)		
atropine injection syringe 0.1 mg/ml	Non-Formulary	

Medications	Coverage Level	Restrictions
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb.		
propranolol-hydrochlorothiazide 40-25 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
propranolol-hydrochlorothiazide 80-25 mg tab	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
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	
Pah-Endothelin Receptor Antagonist-Selective Cgmp Pde5 Inhibitor Comb		
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)

Medications	Coverage Level	Restrictions
Peripheral Alpha-1 Receptor Blockers		
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
doxazosin mesylate 1 mg tab	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 1 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 2 mg tab	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 2 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 4 mg tab	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 4 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 8 mg tab	Formulary	PDL Preferred; 3 Months Allowed
doxazosin mesylate 8 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
phenoxybenzamine	Non-Formulary	
prazosin 1 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
prazosin 1 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
prazosin 1 mg capsule u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
prazosin 2 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
prazosin 2 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
prazosin 2 mg capsule u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
prazosin 5 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
prazosin 5 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
prazosin 5 mg capsule u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
terazosin 1 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
terazosin 1 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
terazosin 10 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
terazosin 10 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
terazosin 2 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
terazosin 2 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
terazosin 5 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
terazosin 5 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
Pheochromocytoma, Agents To Treat		
DEMSER	Non-Formulary	
metyrosine	Non-Formulary	
Plasma Kallikrein Inhibitor Agents, Recombinant Monoclonal Antibody		
TAKHZYRO	State Carve Out	
Plasma Kallikrein Inhibitor Agents, Recombinant Protein		
KALBITOR	State Carve Out	
Plasma Kallikrein Inhibitor Agents, Small Molecule		
ORLADEYO	State Carve Out	
Pulmonary Antihypertensive Agent - Activin Receptor Iia-Fc (Actriia)		
WINREVAIR 45 MG ONE-VIAL KIT OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
WINREVAIR 45 MG TWO-VIAL KIT	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	Formulary	PA; PDL Non-Preferred
Pulmonary Antihypertensive Agents - Prostacyclin-Type		
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
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
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

Medications	Coverage Level	Restrictions
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
VENTAVIS 20 MCG/1 ML SOLUTION SNGLE-USE,P/F,INNER	Formulary	PA; PDL Preferred; 3 Months Allowed
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator		
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
Pulmonary Arterial Hypertension - Endothelin Receptor Antagonists		
ambrisentan 10 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed
ambrisentan 5 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed
bosentan 125 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
bosentan 62.5 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
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
TRACLEER 62.5 MG TABLET F/C, U-D, 10X3	Formulary	PA; PDL Preferred; 3 Months Allowed
Pulmonary Arterial Hypertension - Selective Cgmp-Pde5 Inhibitors		
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
sildenafil 10 mg/ml oral susp	Formulary	PA; PDL Preferred; 3 Months Allowed
sildenafil 20 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed
sildenafil 20 mg tablet f/c	Formulary	PA; PDL Preferred; 3 Months Allowed
sildenafil 20 mg tablet outer	Formulary	PA; PDL Preferred; 3 Months Allowed
tadalafil 20 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
TADLIQ 20 MG/5 ML SUSPENSION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
Renin Inhibitor, Direct		
aliskiren 150 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
aliskiren 300 mg tablet	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
Vasodilator Combinations		
BIDIL	Non-Formulary	
isosorbide-hydralazine	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		
hydroxyzine 10 mg/5 ml soln	Formulary	
hydroxyzine 10 mg/5 ml syrup	Formulary	
hydroxyzine hcl 10 mg tablet	Formulary	
hydroxyzine hcl 10 mg tablet coated	Formulary	
hydroxyzine hcl 10 mg tablet coated,u-d,10x10	Formulary	
hydroxyzine hcl 10 mg tablet f/c	Formulary	
hydroxyzine hcl 10 mg tablet outer	Formulary	
hydroxyzine hcl 25 mg tablet	Formulary	
hydroxyzine hcl 25 mg tablet coated	Formulary	
hydroxyzine hcl 25 mg tablet coated,u-d,10x10	Formulary	
hydroxyzine hcl 25 mg tablet f/c	Formulary	
hydroxyzine hcl 25 mg tablet outer	Formulary	
hydroxyzine hcl 50 mg tablet	Formulary	
hydroxyzine hcl 50 mg tablet coated	Formulary	
hydroxyzine hcl 50 mg tablet f/c	Formulary	

Medications	Coverage Level	Restrictions
hydroxyzine pam 100 mg cap	Formulary	
hydroxyzine pam 25 mg cap	Formulary	
hydroxyzine pam 25 mg cap outer	Formulary	
hydroxyzine pam 50 mg cap	Formulary	
hydroxyzine pam 50 mg cap outer	Formulary	
VISTARIL ORAL CAPSULE 25 MG	Non-Formulary	
Antianxiety Agent - Benzodiazepines		
alprazolam	State Carve Out	
ALPRAZOLAM INTENSOL	State Carve Out	
ATIVAN ORAL	State Carve Out	
chlordiazepoxide hcl	State Carve Out	
clonazepam	State Carve Out	
clorazepate dipotassium	State Carve Out	
diazepam injection	State Carve Out	
DIAZEPAM INTENSOL	State Carve Out	
diazepam oral	State Carve Out	
KLONOPIN	State Carve Out	
LORAZEPAM INTENSOL	State Carve Out	
lorazepam oral	State Carve Out	
LOREEV XR	State Carve Out	
oxazepam	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	
Antianxiety Agent - Dicarbamate Type		
meprobamate	State Carve Out	
Antianxiety Agent - Non-Benzodiazepine		
BUCAPSOL	State Carve Out	
buspirone	State Carve Out	
Anticonvulsant - Ampa-Type Glutamate Receptor Antagonists		
FYCOMPA	State Carve Out	
perampanel	State Carve Out	
Anticonvulsant - Barbiturates And Derivatives		
MYSOLINE	State Carve Out	

Medications	Coverage Level	Restrictions
phenobarbital	State Carve Out	
phenobarbital sodium injection solution	State Carve Out	
primidone	State Carve Out	
SEZABY	State Carve Out	
Anticonvulsant - Benzodiazepines		
clobazam oral suspension	State Carve Out	
clobazam oral tablet	State Carve Out	
clonazepam	State Carve Out	
DIASTAT	State Carve Out	
DIASTAT ACUDIAL	State Carve Out	
diazepam rectal	State Carve Out	
KLONOPIN	State Carve Out	
LIBERVANT	State Carve Out	
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		
felbamate	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	
divalproex	State Carve Out	
valproate sodium	State Carve Out	
valproic acid	State Carve Out	
valproic acid (as sodium salt)	State Carve Out	
Anticonvulsant - Functionalized Amino Acid		
lacosamide	State Carve Out	
MOTPOLY XR	State Carve Out	
VIMPAT	State Carve Out	

Medications	Coverage Level	Restrictions
Anticonvulsant - Gaba Analogs		
gabapentin oral capsule	State Carve Out	
gabapentin oral solution	State Carve Out	
gabapentin oral tablet 600 mg, 800 mg	State Carve Out	
GABARONE	State Carve Out	
LYRICA	State Carve Out	
NEURONTIN	State Carve Out	
pregabalin oral capsule	State Carve Out	
pregabalin oral solution	State Carve Out	
Anticonvulsant - Gaba Re-Uptake Inhibitor, Nipecotic Acid Derivatives		
GABITRIL	State Carve Out	
tiagabine	State Carve Out	
Anticonvulsant - Gaba Transaminase (Gaba-T) Inhibitor		
SABRIL	State Carve Out	
vigabatrin	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	
fosphenytoin	State Carve Out	
PHENYTEK	State Carve Out	
phenytoin oral suspension	State Carve Out	
phenytoin oral tablet,chewable	State Carve Out	
phenytoin sodium	State Carve Out	
phenytoin sodium extended	State Carve Out	
Anticonvulsant - Iminostilbene Derivatives		
APTIOM	State Carve Out	
carbamazepine	State Carve Out	
CARBATROL	State Carve Out	

Medications	Coverage Level	Restrictions
EPITOL	State Carve Out	
EQUETRO	State Carve Out	
eslicarbazepine	State Carve Out	
oxcarbazepine	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	
topiramate	State Carve Out	
TROKENDI XR	State Carve Out	
Anticonvulsant - Neuroactive Steroid Gaba-A Receptor Modulator		
ZTALMY	State Carve Out	
Anticonvulsant - Phenyltriazine Derivatives		
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	
lamotrigine	State Carve Out	
SUBVENITE	State Carve Out	

Medications	Coverage Level	Restrictions
SUBVENITE STARTER (BLUE) KIT	State Carve Out	
SUBVENITE STARTER (GREEN) KIT	State Carve Out	
SUBVENITE STARTER (ORANGE) KIT	State Carve Out	
Anticonvulsant - Pyrrolidine Derivatives		
BRIVIACT	State Carve Out	
ELEPSIA XR	State Carve Out	
KEPPRA	State Carve Out	
KEPPRA XR	State Carve Out	
levetiracetam in nacl (iso-os)	State Carve Out	
levetiracetam intravenous	State Carve Out	
levetiracetam oral solution	State Carve Out	
levetiracetam oral tablet	State Carve Out	
levetiracetam oral tablet extended release 24 hr	State Carve Out	
ROWEEPRA	State Carve Out	
ROWEEPRA XR	State Carve Out	
SPRITAM	State Carve Out	
Anticonvulsant - Succinimides		
CELONTIN ORAL CAPSULE 300 MG	State Carve Out	
ethosuximide	State Carve Out	
methsuximide	State Carve Out	
ZARONTIN	State Carve Out	
Anticonvulsant - Sulfonamide Derivatives		
ZONISADE	State Carve Out	
zonisamide	State Carve Out	
Anticonvulsant - Triazole Derivatives		
BANZEL	State Carve Out	
rufinamide	State Carve Out	
Anticonvulsant Others		
DIACOMIT	State Carve Out	
FINTEPLA	State Carve Out	
XCOPRI	State Carve Out	
XCOPRI MAINTENANCE PACK	State Carve Out	
XCOPRI TITRATION PACK	State Carve Out	
Antidepressant - Alpha-2 Receptor Antagonists (Nassa)		
mirtazapine	State Carve Out	

Medications	Coverage Level	Restrictions
REMERON	State Carve Out	
REMERON SOLTAB	State Carve Out	
Antidepressant - Mao Inhibitor Nonselective And Irreversible-Types A,B		
EMSAM	State Carve Out	
MARPLAN	State Carve Out	
NARDIL	State Carve Out	
phenelzine	State Carve Out	
tranylcypromine	State Carve Out	
Antidepressant - Ndma Receptor Antagonist And Ndri Combinations		
AUVELITY	State Carve Out	
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	
citalopram	State Carve Out	
escitalopram oxalate	State Carve Out	
fluoxetine	State Carve Out	
fluvoxamine	State Carve Out	
LEXAPRO	State Carve Out	
paroxetine hcl	State Carve Out	
PAXIL	State Carve Out	
PAXIL CR	State Carve Out	
PEXEVA	State Carve Out	
PROZAC ORAL CAPSULE	State Carve Out	
sertraline	State Carve Out	
ZOLOFT	State Carve Out	

Medications	Coverage Level	Restrictions
Antidepressant - Serotonin-2 Antagonist-Reuptake Inhibitors (Saris)		
nefazodone	State Carve Out	
RALDESY	State Carve Out	
trazodone	State Carve Out	
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (Snris)		
CYMBALTA	State Carve Out	
desvenlafaxine	State Carve Out	
desvenlafaxine succinate	State Carve Out	
DRIZALMA SPRINKLE	State Carve Out	
duloxetine	State Carve Out	
DULOXICAINE	State Carve Out	
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
venlafaxine	State Carve Out	
venlafaxine besylate	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	
vilazodone	State Carve Out	
Antidepressant - Ssri And Serotonin (5-Ht) Receptor Modulator		
TRINTELLIX	State Carve Out	

Medications	Coverage Level	Restrictions
Antidepressant - Tricyclic And Antipsychotic, Phenothiazine Comb		
perphenazine-amitriptyline	State Carve Out	
Antidepressant - Tricyclic-Benzodiazepine Combinations		
amitriptyline-chlordiazepoxide	State Carve Out	
Antidepressant- Ssri And Atypical Antipsych,Dopamine,Serotonin Antagon		
olanzapine-fluoxetine	State Carve Out	
SYMBYAX	State Carve Out	
Antidepressant-Norepinephrine And Dopamine Reuptake Inhibitors (Ndris)		
APLENZIN	State Carve Out	
bupropion hcl	State Carve Out	
FORFIVO XL	State Carve Out	
WELLBUTRIN	State Carve Out	
WELLBUTRIN SR	State Carve Out	
WELLBUTRIN XL	State Carve Out	
Antidepressant-Tricyclics And Related (Non-Select Reuptake Inhibitors)		
amitriptyline	State Carve Out	
amoxapine	State Carve Out	
ANAFRANIL	State Carve Out	
clomipramine	State Carve Out	
desipramine	State Carve Out	
doxepin oral capsule	State Carve Out	
doxepin oral concentrate	State Carve Out	
imipramine hcl	State Carve Out	
imipramine pamoate	State Carve Out	
maprotiline	State Carve Out	
NORPRAMIN ORAL TABLET 10 MG, 25 MG	State Carve Out	
nortriptyline	State Carve Out	
PAMELOR	State Carve Out	
protriptyline	State Carve Out	
trimipramine	State Carve Out	

Medications	Coverage Level	Restrictions
Antiparkinson - Dopaminergic-Periph Comt-Dopa-Decarboxylase Inhib Comb		
carbidopa-levodopa-entacapone 12.5-50-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levodopa-entacapone 18.75-75-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levodopa-entacapone 25-100-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levodopa-entacapone 31.25-125-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levodopa-entacapone 37.5-150-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levodopa-entacapone 50-200-200 mg tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson - Dopaminerg-Peripheral Dopa-Decarboxylase Inhibit Comb		
carbidopa-levo 10-100 mg odt	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levo 25-100 mg odt	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levo 25-250 mg odt	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
carbidopa-levo er 25-100 tab	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levo er 25-100 tab outer	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levo er 25-100 tab u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levo er 50-200 tab	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levo er 50-200 tab u-d, outer	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levo er 50-200 tab u-d,10x10,outer	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levodopa 10-100 tab	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levodopa 25-100 tab	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levodopa 25-100 tab outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
carbidopa-levodopa 25-250 tab	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levodopa 25-250 tab outer	Formulary	PDL Preferred; 3 Months Allowed
carbidopa-levodopa 25-250 tab u-d,10x10,outer	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
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)
Antiparkinson Adjuvant - Adenosine Receptor Antagonist		
NOURIANZ 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
NOURIANZ 40 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Antiparkinson Adjuvant - Central/Peripheral Comt Inhibitors		
TASMAR 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
tolcapone 100 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson Adjuvant - Peripheral Comt Inhibitors		
entacapone 200 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
entacapone 200 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
entacapone 200 mg tablet outer	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
Antiparkinson Adjuvant - Peripheral Dopa-Decarboxylase Inhibitors		
carbidopa 25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
LODOSYN 25 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antiparkinson Therapy - Anticholinergic Agents		
benztropine	State Carve Out	
COGENTIN	State Carve Out	
trihexyphenidyl	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		
bromocriptine 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
bromocriptine 5 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
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)
rasagiline mesylate 0.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
rasagiline mesylate 1 mg tab	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Min 18 Years)
selegiline hcl 5 mg capsule	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
selegiline hcl 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
XADAGO 100 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
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
Antiparkinson Therapy - Non-Ergot Dopamine Agonist Agents		
amantadine 100 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
amantadine 100 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
amantadine 100 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
amantadine 100 mg tablet inner	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
amantadine 100 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
amantadine 100 mg/10 ml solution cup	Formulary	PDL Preferred; 3 Months Allowed
amantadine 100 mg/10 ml solution cup outer	Formulary	PDL Preferred; 3 Months Allowed
amantadine 50 mg/5 ml solution	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
amantadine 50 mg/5 ml solution d/f	Formulary	PDL Preferred; 3 Months Allowed
APOKYN	Non-Formulary	
apomorphine	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)
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
pramipexole 0.125 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 0.25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 0.25 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 0.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 0.5 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 0.75 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
pramipexole 1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
pramipexole 1.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pramipexole er 0.375 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 0.75 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 1.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 2.25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 3 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 3.75 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
pramipexole er 4.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ropinirole hcl 0.25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 0.25 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 0.25 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 0.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 0.5 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 0.5 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 1 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 2 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 2 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ropinirole hcl 2 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 3 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 3 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 4 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 4 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl 5 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ropinirole hcl er 12 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ropinirole hcl er 2 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ropinirole hcl er 4 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ropinirole hcl er 6 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ropinirole hcl er 8 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles		
asenapine maleate	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	
lurasidone	State Carve Out	
ziprasidone hcl	State Carve Out	
ziprasidone mesylate	State Carve Out	
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv		
ERZOFRI	State Carve Out	
FANAPT	State Carve Out	

Medications	Coverage Level	Restrictions
INVEGA	State Carve Out	
INVEGA HAFYERA	State Carve Out	
INVEGA SUSTENNA	State Carve Out	
INVEGA TRINZA	State Carve Out	
paliperidone	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	
risperidone microspheres	State Carve Out	
risperidone oral solution	State Carve Out	
risperidone oral tablet	State Carve Out	
risperidone oral tablet,disintegrating	State Carve Out	
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		
clozapine	State Carve Out	
CLOZARIL	State Carve Out	
VERSACLOZ	State Carve Out	
Antipsychotic - Butyrophenone Derivatives		
HALDOL DECANOATE	State Carve Out	
haloperidol	State Carve Out	
haloperidol decanoate	State Carve Out	
haloperidol lactate	State Carve Out	
Antipsychotic - Dibenzoxazepine Derivatives		
loxapine succinate	State Carve Out	
Antipsychotic - Dihydroindolones		
molindone	State Carve Out	
Antipsychotic - Diphenylbutylpiperidine Derivatives		
pimozide	State Carve Out	

Medications	Coverage Level	Restrictions
Antipsychotic - Muscarinic Agonist/Antagonist Combinations		
COBENFY	State Carve Out	
COBENFY STARTER PACK	State Carve Out	
Antipsychotic - Phenothiazines, Aliphatic		
chlorpromazine	State Carve Out	
Antipsychotic - Phenothiazines, Piperazine		
fluphenazine hcl oral	State Carve Out	
perphenazine	State Carve Out	
prochlorperazine 10 mg tab	Formulary	
prochlorperazine 10 mg tab f/c	Formulary	
prochlorperazine 10 mg tab outer	Formulary	
prochlorperazine 5 mg tablet	Formulary	
prochlorperazine 5 mg tablet f/c	Formulary	
prochlorperazine 5 mg tablet outer	Formulary	
trifluoperazine	State Carve Out	
Antipsychotic - Phenothiazines, Piperidine		
thioridazine	State Carve Out	
Antipsychotic - Thioxanthenes		
thiothixene	State Carve Out	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der		
quetiapine	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	
olanzapine	State Carve Out	
olanzapine-fluoxetine	State Carve Out	
SYMBYAX	State Carve Out	
ZYPREXA	State Carve Out	
ZYPREXA RELPREVV	State Carve Out	
ZYPREXA ZYDIS	State Carve Out	

Medications	Coverage Level	Restrictions
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	
aripiprazole	State Carve Out	
ARISTADA	State Carve Out	
ARISTADA INITIO	State Carve Out	
OPIPZA	State Carve Out	
REXULTI ORAL TABLET	State Carve Out	
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		
clonidine hcl oral tablet extended release 12 hr	State Carve Out	
guanfacine oral tablet extended release 24 hr	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	
amphetamine	State Carve Out	
amphetamine sulfate	State Carve Out	
APTENSIO XR	State Carve Out	

Medications	Coverage Level	Restrictions
AZSTARYS	State Carve Out	
CONCERTA	State Carve Out	
COTEMPLA XR-ODT	State Carve Out	
DAYTRANA	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
dexmethylphenidate	State Carve Out	
dextroamphetamine sulfate oral capsule, extended release	State Carve Out	
dextroamphetamine sulfate oral tablet	State Carve Out	
dextroamphetamine-amphetamine	State Carve Out	
DYANAVEL XR	State Carve Out	
EVEKEO	State Carve Out	
EVEKEO ODT	State Carve Out	
FOCALIN	State Carve Out	
FOCALIN XR	State Carve Out	
JORNAY PM	State Carve Out	
lisdexamfetamine	State Carve Out	
METADATE CD	State Carve Out	
METHYLIN ORAL SOLUTION	State Carve Out	
methylphenidate	State Carve Out	
methylphenidate hcl	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		
atomoxetine	State Carve Out	
QELBREE	State Carve Out	
STRATTERA	State Carve Out	
Benzodiazepines		
alprazolam	State Carve Out	

Medications	Coverage Level	Restrictions
ALPRAZOLAM INTENSOL	State Carve Out	
amitriptyline-chlordiazepoxide	State Carve Out	
ATIVAN	State Carve Out	
chlordiazepoxide hcl	State Carve Out	
chlordiazepoxide-clidinium	Non-Formulary	
clobazam oral suspension	State Carve Out	
clobazam oral tablet	State Carve Out	
clonazepam	State Carve Out	
clorazepate dipotassium	State Carve Out	
DIASTAT	State Carve Out	
DIASTAT ACUDIAL	State Carve Out	
diazepam	State Carve Out	
DIAZEPAM INTENSOL	State Carve Out	
estazolam	State Carve Out	
flurazepam	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	
lorazepam	State Carve Out	
LORAZEPAM INTENSOL	State Carve Out	
LOREEV XR	State Carve Out	
midazolam oral	State Carve Out	
NAYZILAM	State Carve Out	
ONFI	State Carve Out	
oxazepam	State Carve Out	
RESTORIL	State Carve Out	
SYMPAZAN	State Carve Out	
temazepam	State Carve Out	
TRANXENE T-TAB	State Carve Out	
triazolam	State Carve Out	
VALIUM ORAL TABLET 10 MG	State Carve Out	
VALTOCO	State Carve Out	
XANAX	State Carve Out	
XANAX XR	State Carve Out	

Medications	Coverage Level	Restrictions
Bipolar Therapy Agents - Anticonvulsant Type		
carbamazepine	State Carve Out	
CARBATROL	State Carve Out	
DEPAKOTE	State Carve Out	
DEPAKOTE ER	State Carve Out	
DEPAKOTE SPRINKLES	State Carve Out	
divalproex	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	
LAMICTAL STARTER (GREEN) KIT	State Carve Out	
LAMICTAL STARTER (ORANGE) KIT	State Carve Out	
lamotrigine oral tablet disintegrating, dose pk	State Carve Out	
lamotrigine oral tablet,disintegrating	State Carve Out	
lamotrigine oral tablets,dose pack	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	
valproic acid	State Carve Out	
valproic acid (as sodium salt)	State Carve Out	
Bipolar Therapy Agents - Atypical Antipsychotics		
ABILIFY MYCITE MAINTENANCE KIT	State Carve Out	
ABILIFY MYCITE STARTER KIT	State Carve Out	
ABILIFY ORAL TABLET	State Carve Out	
aripiprazole	State Carve Out	
asenapine maleate	State Carve Out	
GEODON	State Carve Out	
LYBALVI	State Carve Out	

Medications	Coverage Level	Restrictions
olanzapine	State Carve Out	
olanzapine-fluoxetine	State Carve Out	
OPIPZA	State Carve Out	
quetiapine	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	
risperidone oral solution	State Carve Out	
risperidone oral tablet	State Carve Out	
risperidone oral tablet,disintegrating	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	
VRAYLAR	State Carve Out	
ziprasidone hcl	State Carve Out	
ziprasidone mesylate	State Carve Out	
ZYPREXA	State Carve Out	
ZYPREXA ZYDIS	State Carve Out	
Bipolar Therapy Agents - Lithium		
lithium carbonate	State Carve Out	
lithium citrate	State Carve Out	
LITHOBID	State Carve Out	
Cannabis And Cannabinoids		
dronabinol 10 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule outer	Formulary	PA
dronabinol 5 mg capsule	Formulary	PA
dronabinol 5 mg capsule outer	Formulary	PA
MARINOL	Non-Formulary	
Cns Stimulant - Amphetamine Combinations		
ADDERALL	State Carve Out	
ADDERALL XR	State Carve Out	
ADZENYS ER	State Carve Out	
ADZENYS XR-ODT	State Carve Out	

Medications	Coverage Level	Restrictions
amphetamine	State Carve Out	
dextroamphetamine-amphetamine	State Carve Out	
DYANAVEL XR	State Carve Out	
MYDAYIS	State Carve Out	
Cns Stimulant - Amphetamines		
amphetamine sulfate	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
dextroamphetamine sulfate	State Carve Out	
EVEKEO	State Carve Out	
EVEKEO ODT	State Carve Out	
PROCENTRA	State Carve Out	
XELSTRYM	State Carve Out	
ZENZEDI	State Carve Out	
Cns Stimulant - Analeptics, Methylxanthine-Type		
caffeine cit 60 mg/3 ml oral	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral 10's,sdv,p/f	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral inner	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral outer	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral p/f	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral p/f, sdv, outer	Formulary	Age Limit (Max 1 Years)
caffeine cit 60 mg/3 ml oral suv, outer	Formulary	Age Limit (Max 1 Years)
Diabetic Peripheral Neuropathy Agents		
LYRICA CR	State Carve Out	
pregabalin oral tablet extended release 24 hr	State Carve Out	
Fibromyalgia Agents - Gaba Analogs		
LYRICA	State Carve Out	
pregabalin oral capsule	State Carve Out	
pregabalin oral solution	State Carve Out	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (Snris)		
CYMBALTA	State Carve Out	
DRIZALMA SPRINKLE	State Carve Out	
duloxetine	State Carve Out	
DULOXICAINE	State Carve Out	
IRENKA	State Carve Out	
SAVELLA 100 MG TABLET	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
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
melatonin 1 mg/ml liquid	Non-Formulary	CSHCS Covered
Hypnotics - Melatonin M1/M2 Receptor Agonists		
HETLIOZ	State Carve Out	
HETLIOZ LQ	State Carve Out	
ramelteon	State Carve Out	
ROZEREM	State Carve Out	
tasimelteon	State Carve Out	
Migraine Therapy - Carboxylic Acid Derivatives		
DEPAKOTE ER	State Carve Out	
divalproex oral tablet extended release 24 hr	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)

Medications	Coverage Level	Restrictions
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)
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)
Migraine Therapy - Ergot Alkaloids And Derivatives		
dihydroergotamine	Non-Formulary	
MIGRANAL	Non-Formulary	
Migraine Therapy - Ergot Combinations		
MIGERGOT	Non-Formulary	
Migraine Therapy - Nsaid Analgesics (Cyclooxygenase Inhibitor)		
CAMBIA	Non-Formulary	
diclofenac potassium oral powder in packet	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)

Medications	Coverage Level	Restrictions
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1)		
almotriptan malate 12.5 mg tab f/c, outer	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
almotriptan malate 12.5 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
almotriptan malate 12.5 mg tab outer, f/c	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
almotriptan malate 6.25 mg tab f/c, outer	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
almotriptan malate 6.25 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
almotriptan malate 6.25 mg tab outer, f/c	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
eletriptan hbr 20 mg tablet	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
eletriptan hbr 20 mg tablet outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
eletriptan hbr 40 mg tablet	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
eletriptan hbr 40 mg tablet outer	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)
frovatriptan succ 2.5 mg tab	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)

Medications	Coverage Level	Restrictions
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)
naratriptan hcl 1 mg tablet	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
naratriptan hcl 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
naratriptan hcl 2.5 mg tablet outer	Formulary	PA; PDL Non-Preferred; QL (9 tablets per 1 claim)
RELPAX 20 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
RELPAX 40 MG TABLET OUTER	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
rizatriptan 10 mg odt	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg odt inner	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg odt outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg tablet	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg tablet 4x3, outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg tablet inner	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 10 mg tablet outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg odt	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg odt inner	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg odt outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg tablet	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg tablet 4x3, outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
rizatriptan 5 mg tablet inner	Formulary	PDL Preferred; QL (18 tablets per 1 claim)

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

Medications	Coverage Level	Restrictions
sumatriptan succ 100 mg tablet	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 100 mg tablet f/c	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 100 mg tablet outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 100 mg tablet u-d	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 25 mg tablet	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 25 mg tablet f/c	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 25 mg tablet outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 25 mg tablet u-d	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 50 mg tablet	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 50 mg tablet f/c	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 50 mg tablet outer	Formulary	PDL Preferred; QL (18 tablets per 1 claim)
sumatriptan succ 50 mg tablet u-d	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
zolmitriptan 2.5 mg odt	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5 mg odt 1x6, outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5 mg odt outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)

Medications	Coverage Level	Restrictions
zolmitriptan 2.5 mg tablet f/c	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5 mg tablet f/c, outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5 mg tablet outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 2.5mg nasal spray	Formulary	PA; PDL Non-Preferred
zolmitriptan 5 mg nasal spray	Formulary	PA; PDL Non-Preferred
zolmitriptan 5 mg nasal spray outer	Formulary	PA; PDL Non-Preferred
zolmitriptan 5 mg odt	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg odt 1x3, outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg odt outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg tablet	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg tablet f/c	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg tablet f/c, outer	Formulary	PA; PDL Non-Preferred; QL (12 tablets per 1 claim)
zolmitriptan 5 mg tablet outer	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)
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1F)		
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)
Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Comb.		
sumatriptan-naproxen 85-500 mg	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Movement Disorder Drug Therapy		
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)
tetrabenazine	Non-Formulary	
XENAZINE	Non-Formulary	
Movement Disorder Therapy - Huntington's Disease		
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)

Medications	Coverage Level	Restrictions
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)
tetrabenazine	Non-Formulary	
XENAZINE	Non-Formulary	
Movement Disorder Therapy - Restless Legs Syndrome		
HORIZANT ER 300 MG TABLET	Formulary	PDL Preferred
HORIZANT ER 600 MG TABLET	Formulary	PDL Preferred
Movement Disorder Therapy - Tardive Dyskinesia		
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)

Medications	Coverage Level	Restrictions
Narcolepsy And Cataplexy Therapy Agents - Sedative-Type		
sodium oxybate 0.5 g/ml soln	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)
Narcolepsy Therapy Agents - Dopamine And Ne Reuptake Inhibitor (Dnri)		
SUNOSI	State Carve Out	
Narcolepsy Therapy Agents - H3-Receptor Antagonist/Inverse Agonist		
WAKIX	State Carve Out	
Narcolepsy Therapy Agents - Non-Sympathomimetic		
armodafinil	State Carve Out	
modafinil	State Carve Out	
NUVIGIL	State Carve Out	
PROVIGIL	State Carve Out	
Narcolepsy Therapy Agents - Stimulant-Type, Piperadine Derivative		
METHYLIN ORAL SOLUTION	State Carve Out	
methylphenidate hcl oral solution	State Carve Out	
methylphenidate hcl oral tablet	State Carve Out	
methylphenidate hcl oral tablet,chewable	State Carve Out	
RITALIN	State Carve Out	
Narcolepsy Therapy Agents- Stimulant-Type,Sympathomimetic,Amphetamines		
ADDERALL	State Carve Out	
amphetamine sulfate	State Carve Out	
DEXEDRINE SPANSULE	State Carve Out	
dextroamphetamine sulfate oral capsule, extended release	State Carve Out	
dextroamphetamine sulfate oral tablet	State Carve Out	
dextroamphetamine-amphetamine oral tablet	State Carve Out	
EVEKEO	State Carve Out	
ZENZEDI	State Carve Out	

Medications	Coverage Level	Restrictions
Neuropathic Pain Therapy		
LYRICA CR	State Carve Out	
pregabalin oral tablet extended release 24 hr	State Carve Out	
Postherpetic Neuralgia Agents		
DULOXICAINE	State Carve Out	
gabapentin er 300 mg tablet	Formulary	PDL Preferred
gabapentin er 600 mg tablet	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
GRALISE ER 750 MG TABLET	Formulary	PDL Preferred
GRALISE ER 900 MG TABLET	Formulary	PDL Preferred
LYRICA CR	State Carve Out	
pregabalin oral tablet extended release 24 hr	State Carve Out	
Pseudobulbar Affect (Pba) Agents, Nmda Antagonists Type		
NUEDEXTA	Non-Formulary	
Sedative-Hypnotic - Antihistamines		
ALKA-SELTZER PLUS ALLERGY	State Carve Out	OTC
diphenhydramine 25 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet inner	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet outer	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg capsule u-d, 10x10 (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
NIGHTIME 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

Medications	Coverage Level	Restrictions
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
WAL-SOM (DOXYLAMINE)	State Carve Out	OTC
Sedative-Hypnotic - Barbiturates		
phenobarbital	State Carve Out	
phenobarbital sodium injection solution	State Carve Out	
SECONAL SODIUM	State Carve Out	
Sedative-Hypnotic - Benzodiazepines		
ATIVAN INJECTION	State Carve Out	
estazolam	State Carve Out	
flurazepam	State Carve Out	
HALCION ORAL TABLET 0.25 MG	State Carve Out	
lorazepam injection	State Carve Out	
midazolam oral	State Carve Out	
RESTORIL	State Carve Out	
temazepam	State Carve Out	
triazolam	State Carve Out	
Sedative-Hypnotic - Gaba-Receptor Modulators		
AMBIEN	State Carve Out	
AMBIEN CR	State Carve Out	
EDLUAR	State Carve Out	
eszopiclone	State Carve Out	
LUNESTA	State Carve Out	
zaleplon	State Carve Out	
zolpidem	State Carve Out	

Medications	Coverage Level	Restrictions
Sedative-Hypnotic - Orexin Receptor Antagonist		
BELSOMRA	State Carve Out	
DAYVIGO	State Carve Out	
QUVIVIQ	State Carve Out	
Sedative-Hypnotic - Selective Alpha2-Adrenoreceptor Agonists		
dexmedetomidine	State Carve Out	
dexmedetomidine in 0.9 % nacl intravenous syringe 20 mcg/5 ml (4 mcg/ml), 40 mcg/10 ml	State Carve Out	
IGALMI	State Carve Out	
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	
Sedative-Hypnotic - Tricyclic Antidepressant Type		
doxepin oral tablet	State Carve Out	
SILENOR	State Carve Out	
Chemical Dependency, Agents To Treat		
Agents For Opioid Withdrawal, Central Alpha-2 Adrenergic Agonist-Type		
lofexidine 0.18 mg tablet	Formulary	PDL Preferred
LUCEMYRA 0.18 MG TABLET	Formulary	PDL Preferred
Agents For Opioid Withdrawal, Opioid-Type		
BRIXADI	State Carve Out	
buprenorphine hcl sublingual	State Carve Out	
buprenorphine-naloxone	State Carve Out	
SUBLOCADE	State Carve Out	
SUBOXONE	State Carve Out	
ZUBSOLV	State Carve Out	
Alcohol Abstinence Therapy - Glutamate And Gaba System Type		
acamprosate	State Carve Out	
Alcohol Abstinence Therapy - Opioid Receptor Antagonist-Type		
naltrexone	State Carve Out	

Medications	Coverage Level	Restrictions
VIVITROL	State Carve Out	
Alcohol Deterrents		
disulfiram	State Carve Out	
Smoking Deterrents - Ne And Dopamine Reuptake Inhibitor (Ndri)-Type		
bupropion hcl sr 150 mg tablet	Formulary	QL (2 tablets per 1 day)
bupropion hcl sr 150 mg tablet f/c	Formulary	QL (2 tablets per 1 day)
bupropion hcl sr 150 mg tablet f/c, starter kit	Formulary	QL (2 tablets per 1 day)
Smoking Deterrents - Nicotine-Type		
ft nicotine 14 mg/24hr patch (otc)	Formulary	OTC; QL (1 patch per 1 day)
ft nicotine 2 mg chewing gum	Formulary	OTC; QL (30 pieces per 1 day)
ft nicotine 2 mg lozenge	Formulary	OTC; QL (20 lozenges per 1 day)
ft nicotine 21 mg/24hr patch (otc)	Formulary	OTC; QL (1 patch per 1 day)
ft nicotine 4 mg chewing gum	Formulary	OTC; QL (24 pieces per 1 day)
ft nicotine 4 mg lozenge	Formulary	OTC; QL (20 lozenges per 1 day)
ft nicotine 7 mg/24hr patch (otc)	Formulary	OTC; QL (1 patch per 1 day)
gnp nicotine 2 mg chewing gum	Formulary	OTC; QL (30 pieces per 1 day)
gnp nicotine 2 mg chewing gum	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
gnp nicotine 2 mg lozenge outer	Formulary	OTC; QL (20 lozenges per 1 day)
gnp nicotine 2 mg mini lozenge	Formulary	OTC; QL (20 lozenges per 1 day)
gnp nicotine 21 mg/24hr patch (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
gnp nicotine 4 mg chewing gum	Formulary	OTC; QL (24 pieces per 1 day)
gnp nicotine 4 mg chewing gum	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
gnp nicotine 4 mg mini lozenge	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
gs nicotine 2 mg chewing gum	Formulary	OTC; QL (30 pieces per 1 day)
gs nicotine 2 mg chewing gum	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
gs nicotine 2 mg chewing gum original	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
gs nicotine 2 mg lozenge	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)

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

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

Medications	Coverage Level	Restrictions
nicotine 4 mg mini lozenge	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
nicotine 4 mg mini lozenge inner	Formulary	OTC; QL (20 lozenges per 1 day)
nicotine 4 mg mini lozenge outer	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
nicotine 7 mg/24hr patch (otc)	Formulary	OTC; QL (1 patch per 1 day)
nicotine 7 mg/24hr patch (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
nicotine 7 mg/24hr patch inner (otc)	Formulary	OTC; QL (1 patch per 1 day)
nicotine 7 mg/24hr patch outer (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
nicotine 7 mg/24hr patch outer, clear, step 3 (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
nicotine 7 mg/24hr patch step 3 (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
nicotine transdermal system step 1,2,3	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
NICOTROL NS 10 MG/ML SPRAY	Formulary	QL (40 ML per 30 days)
sm nicotine 14 mg/24hr patch (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
sm nicotine 2 mg chewing gum	Formulary	Dual Eligible Covered; OTC; QL (30 pieces per 1 day)
sm nicotine 2 mg lozenge	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
sm nicotine 21 mg/24hr patch (otc)	Formulary	Dual Eligible Covered; OTC; QL (1 patch per 1 day)
sm nicotine 4 mg chewing gum	Formulary	Dual Eligible Covered; OTC; QL (24 pieces per 1 day)
sm nicotine 4 mg lozenge	Formulary	Dual Eligible Covered; OTC; QL (20 lozenges per 1 day)
sm nicotine 7 mg/24hr patch (otc)	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	
varenicline 0.5 mg tablet	Formulary	QL (2 tablets per 1 day)
varenicline 1 mg cont month bx	Formulary	QL (2 tablets per 1 day)
varenicline 1 mg tablet	Formulary	QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
varenicline 1 mg tablet outer	Formulary	QL (2 tablets per 1 day)
varenicline starting month box	Formulary	QL (2 tablets per 1 day)
varenicline starting month box outer	Formulary	QL (2 tablets per 1 day)
Chemicals-Pharmaceutical Adjuvants		
Bulk Chemicals		
arginine 100% crystals	Formulary	
arginine hcl powder usp (rx)	Formulary	OTC
arginine hcl powder usp,ep (rx)	Formulary	OTC
BASE, PCCA POLYPEG WAX	Formulary	
cherry artificial flavor liq oil miscible (rx)	Formulary	
cherry concentrate flavor liq natural & artificial (rx)	Formulary	
cherry flavor conc liquid colorless (rx)	Formulary	
cherry flavor liquid (rx)	Formulary	
cherry flavor liquid artificial (rx)	Formulary	
cherry flavor liquid artificial flavor (rx)	Formulary	
cherry flavor liquid concentrate, red (rx)	Formulary	
cherry syrup (rx)	Formulary	
coenzyme q-10 powder (rx)	Formulary	
coenzyme q-10 powder (water dispersible) (rx)	Formulary	
creatine monohydrate powder (rx)	Formulary	
glutamine powder (rx)	Formulary	OTC
l-arginine hcl powder usp (rx)	Formulary	OTC
l-arginine mono-hcl powder usp (rx)	Formulary	OTC
l-citrulline powder	Formulary	
L-CITRULLINE POWDER (RX)	Formulary	
l-glutamine powder (rx)	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
l-glutamine powder usp (rx)	Formulary	OTC
l-ornithine hcl powder (rx)	Formulary	OTC
lysine hcl powder (rx)	Formulary	
ornithine (l) hcl powder (rx)	Formulary	OTC
PCCA BASE ANHYDROUS OINT	Formulary	
PCCA VANISHING BASE CREAM	Formulary	
polyethylene glycol 1450 powd base a (rx)	Formulary	

Medications	Coverage Level	Restrictions
sodium benzoate powder nf (rx)	Formulary	
sodium bicarbonate powder usp (rx)	Formulary	OTC
sodium bicarbonate powder usp,ep,jp (rx)	Formulary	OTC
sodium phenylbutyrate powder	Formulary	
sodium phenylbutyrate powder spb	Formulary	
sodium phenylbutyrate powder usp	Formulary	
ubiquinol powder	Formulary	
ubiquinol powder (rx)	Formulary	
urea powder	Formulary	
vitamin d3 100,000 unit/gm pwd (rx)	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
sodium chloride 0.9% inhal vl 100's, u-d, suv, p/f (rx)	Formulary	
sodium chloride 0.9% inhal vl 50's, u-d, suv, p/f (rx)	Formulary	
sodium chloride 3% vial	Non-Formulary	CSHCS Covered
sodium chloride 3% vial p/f	Non-Formulary	CSHCS Covered
sodium chloride 7% vial	Non-Formulary	CSHCS Covered
sodium chloride 7% vial 60's, suv, p/f	Non-Formulary	CSHCS Covered
sodium chloride 7% vial 60's, suv, p/f, u-d	Non-Formulary	CSHCS Covered
sodium chloride inhalation solution for nebulization 10 %	Non-Formulary	
Pharmaceutical Adjuvant - Liquid Vehicles Other		
PCCA NATAPRES LIQUID	Formulary	
PCCA SUSPENDIT ANHYDROUS	Formulary	

Medications	Coverage Level	Restrictions
Pharmaceutical Adjuvant - Oral Vehicles		
BASE, PCCA SYRUP VEHICLE	Formulary	
cherry artificial flavor liq oil miscible (rx)	Formulary	
cherry concentrate flavor liq natural & artificial (rx)	Formulary	
cherry flavor conc liquid colorless (rx)	Formulary	
cherry flavor liquid (rx)	Formulary	
cherry flavor liquid artificial (rx)	Formulary	
cherry flavor liquid artificial flavor (rx)	Formulary	
cherry flavor liquid concentrate, red (rx)	Formulary	
cherry syrup (rx)	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	
simple syrup (rx)	Formulary	
simple syrup nf (rx)	Formulary	

Medications	Coverage Level	Restrictions
simple syrup usp (rx)	Formulary	
SOSWEET SYRUP VEHICLE	Formulary	
SUSPENDRX ANHYDROUS SWEET SUSP	Formulary	
SUSPENDRX ANHYDRS UNSWEET SUSP	Formulary	
suspension vehicle natural	Formulary	
SWEET-SF SYRUP	Formulary	
SYRPALTA SYRUP	Formulary	
SYRSPEND SF ALKA POWDER	Formulary	
SYRSPEND SF LIQUID (RX)	Formulary	
SYRSPEND SF LIQUID CHERRY (RX)	Formulary	
SYRSPEND SF LIQUID GRAPE (RX)	Formulary	
SYRSPEND SF PH4 POWDER	Formulary	
SYRSPEND SF POWDER DRY & UNFLAVORED (RX)	Formulary	
syrup vehicle (rx)	Formulary	
SYRUP VEHICLE SF	Formulary	
UNISPEND ANHYDROUS SWEET SUSP	Formulary	
VERSA FREE SF SYRUP VEHICLE	Formulary	
VERSA PLUS SUSPENSION VEHICLE	Formulary	
Pharmaceutical Adjuvant - Preservatives		
sodium benzoate powder nf (rx)	Formulary	
Pharmaceutical Adjuvant - Troche/Soft Lozenge Base		
polyethylene glycol 1450 powd base a (rx)	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
donepezil hcl 10 mg tablet	Formulary	PDL Preferred
donepezil hcl 10 mg tablet f/c	Formulary	PDL Preferred
donepezil hcl 10 mg tablet outer	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
donepezil hcl 23 mg tablet	Formulary	PA; PDL Non-Preferred
donepezil hcl 5 mg tablet	Formulary	PDL Preferred
donepezil hcl 5 mg tablet f/c	Formulary	PDL Preferred
donepezil hcl 5 mg tablet outer	Formulary	PDL Preferred
donepezil hcl odt 10 mg tablet	Formulary	PDL Preferred
donepezil hcl odt 10 mg tablet outer	Formulary	PDL Preferred
donepezil hcl odt 5 mg tablet	Formulary	PDL Preferred
donepezil hcl odt 5 mg tablet outer	Formulary	PDL Preferred
EXELON 13.3 MG/24HR PATCH INNER	Formulary	PDL Preferred
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
galantamine 4 mg/ml oral soln	Formulary	PA; PDL Non-Preferred
galantamine er 16 mg capsule	Formulary	PA; PDL Non-Preferred
galantamine er 24 mg capsule	Formulary	PA; PDL Non-Preferred
galantamine er 8 mg capsule	Formulary	PA; PDL Non-Preferred
galantamine hbr 12 mg tablet	Formulary	PDL Preferred
galantamine hbr 12 mg tablet f/c	Formulary	PDL Preferred
galantamine hbr 4 mg tablet	Formulary	PDL Preferred
galantamine hbr 4 mg tablet f/c	Formulary	PDL Preferred
galantamine hbr 4 mg tablet f/c, outer	Formulary	PDL Preferred
galantamine hbr 8 mg tablet	Formulary	PDL Preferred
galantamine hbr 8 mg tablet f/c	Formulary	PDL Preferred
rivastigmine 1.5 mg capsule	Formulary	PDL Preferred
rivastigmine 1.5 mg capsule outer	Formulary	PDL Preferred
rivastigmine 13.3 mg/24hr ptch	Formulary	PA; Brand Preferred; PDL Non-Preferred
rivastigmine 13.3 mg/24hr ptch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred
rivastigmine 3 mg capsule	Formulary	PDL Preferred
rivastigmine 4.5 mg capsule	Formulary	PDL Preferred
rivastigmine 4.6 mg/24hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred
rivastigmine 4.6 mg/24hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred

Medications	Coverage Level	Restrictions
rivastigmine 6 mg capsule	Formulary	PDL Preferred
rivastigmine 9.5 mg/24hr patch	Formulary	PA; Brand Preferred; PDL Non-Preferred
rivastigmine 9.5 mg/24hr patch outer	Formulary	PA; Brand Preferred; PDL Non-Preferred
Alzheimer's Disease Therapy - Nmda Receptor Antagonists		
memantine 5-10 mg titration pk	Formulary	PDL Preferred
memantine hcl 10 mg tablet	Formulary	PDL Preferred
memantine hcl 10 mg tablet f/c	Formulary	PDL Preferred
memantine hcl 10 mg tablet f/c, outer	Formulary	PDL Preferred
memantine hcl 10 mg tablet outer	Formulary	PDL Preferred
memantine hcl 2 mg/ml solution	Formulary	PDL Preferred
memantine hcl 5 mg tablet	Formulary	PDL Preferred
memantine hcl 5 mg tablet f/c	Formulary	PDL Preferred
memantine hcl 5 mg tablet f/c, outer	Formulary	PDL Preferred
memantine hcl 5 mg tablet outer	Formulary	PDL Preferred
memantine hcl er 14 mg capsule	Formulary	PA; PDL Non-Preferred
memantine hcl er 21 mg capsule	Formulary	PA; PDL Non-Preferred
memantine hcl er 28 mg capsule	Formulary	PA; PDL Non-Preferred
memantine hcl er 7 mg capsule	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
Alzheimer's Thx - Nmda Receptor Antag. And Cholinesterase Inhib. Comb		
memantine-donepezil er 21-10 mg	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
Cognitive Disorder Therapy - Cerebral Vasodilators		
ergoloid	Non-Formulary	
Rett Syndrome Agents - Glypromate (Gpe) Analogs		
DAYBUE	State Carve Out	

Medications	Coverage Level	Restrictions
Contraceptives		
Contraceptive - Vaginal Ph Modulator		
PHEXXI 1.8-1-0.4% VAGINAL GEL	Formulary	QL (180 GM per 30 days)
Contraceptive Injectable - Progestin		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	Non-Formulary	
DEPO-PROVERA INTRAMUSCULAR SYRINGE	Non-Formulary	
DEPO-SUBQ PROVERA 104	Non-Formulary	
medroxyprogesterone 150 mg/ml	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml inner, suv, p/f	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml inner,suv	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml outer, suv, p/f	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml outer,suv	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml sdv,inner	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml sdv,outer	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml suv	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml suv, outer	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml suv, p/f	Formulary	QL (1 ML per 75 days)
medroxyprogesterone 150 mg/ml terumo ndl, suv	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	
desogestr-eth estrad eth estra	Formulary	12 Months Allowed
JAIMIESS	Non-Formulary	
KARIVA 28 DAY TABLET OUTER	Formulary	12 Months Allowed
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)	Non-Formulary	
LO LOESTRIN FE	Non-Formulary	

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
CRYSELLE-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
drospirenone-e.estradiol-lm.fa	Non-Formulary	
drospirenone-ee 3-0.02 mg tab f/c, outer	Formulary	12 Months Allowed
drospirenone-ee 3-0.02 mg tab outer	Formulary	12 Months Allowed
drospirenone-ee 3-0.03 mg tab	Formulary	12 Months Allowed
drospirenone-ee 3-0.03 mg tab outer	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
ethynodiol-eth estra 1 mg-35 mcg outer	Formulary	12 Months Allowed
ethynodiol-eth estra 1 mg-50 mcg outer	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
GALBRIELA 0.8-0.025 MG CHEW TB 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

Medications	Coverage Level	Restrictions
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
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
levonor-eth estra 0.09-0.02 mg outer, f/c	Formulary	12 Months Allowed
levonor-eth estrad 0.1-0.02 mg inner	Formulary	12 Months Allowed
levonor-eth estrad 0.1-0.02 mg outer	Formulary	12 Months Allowed
levonor-eth estrad 0.15-0.03 outer	Formulary	12 Months Allowed
levonorgest-eth.estradiol-iron	Non-Formulary	
levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet	Formulary	12 Months Allowed
levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet 3x91 wallets,outer	Formulary	12 Months Allowed
levonorgestrel-eth estrad 0.15 mg-0.03 mg tablet outer	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

Medications	Coverage Level	Restrictions
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
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
noret-estr-fe 0.4-0.035(21)-75 outer	Formulary	12 Months Allowed
noreth-ee-fe 1.5-0.03 mg(21)-75 outer	Formulary	12 Months Allowed
noreth-ee-fe 1-0.02(21)-75 tab outer	Formulary	12 Months Allowed
noreth-ee-fe 1-0.02(24)-75 chw outer	Formulary	12 Months Allowed
norethind-eth estrad 1-0.02 mg outer	Formulary	12 Months Allowed
norethindrone-e.estradiol-iron oral capsule	Non-Formulary	
norethin-ee 1.5-0.03 mg(21) tb outer	Formulary	12 Months Allowed
norethin-estra-fe 0.8-0.025 mg chewable tab,outer	Formulary	12 Months Allowed
norg-ethin estra 0.25-0.035 mg 3x28, outer	Formulary	12 Months Allowed
norg-ethin estra 0.25-0.035 mg outer	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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
ZUMANDIMINE 3 MG-0.03 MG TAB OUTER	Formulary	12 Months Allowed
Contraceptive Oral - Progestin		
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
LYZA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
MELEYA 0.35 MG TABLET OUTER	Formulary	12 Months Allowed
NORA-BE TABLET OUTER	Formulary	12 Months Allowed
norethindrone 0.35 mg tablet outer	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 - Quadraphasic		
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	Non-Formulary	
NATAZIA	Non-Formulary	
RIVELSA	Non-Formulary	
ROSYRAH	Non-Formulary	
Contraceptive Oral - Triphasic		
ALYACEN 7-7-7-28 TABLET OUTER	Formulary	12 Months Allowed
ARANELLE 28 TABLET OUTER	Formulary	12 Months Allowed
CAZIANT 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
levonor-eth estrad triphasic outer	Formulary	12 Months Allowed

Medications	Coverage Level	Restrictions
noreth-ee-fe 1 mg/20-30-35 mcg outer	Formulary	12 Months Allowed
norg-ee 0.18-0.215-0.25/0.035 outer	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
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.		
norelgestrom-ee 150-35 mcg/day outer	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)
etonogestrel-ee vaginal ring outer	Formulary	12 Months Allowed; QL (1 ring per 28 days)

Medications	Coverage Level	Restrictions
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
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
levonorgestrel 1.5 mg tablet (otc)	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
Emergency Contraceptives		
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
ELLA 30 MG TABLET	Formulary	12 Months Allowed
HER STYLE 1.5 MG TABLET	Formulary	12 Months Allowed; OTC
levonorgestrel 1.5 mg tablet (otc)	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
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)
isotretinoin 10 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 10 mg capsule inner	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 10 mg capsule inner	Non-Formulary	
isotretinoin 10 mg capsule outer	Formulary	PA; QL (2 capsules per 1 day)

Medications	Coverage Level	Restrictions
isotretinoin 10 mg capsule outer	Non-Formulary	
isotretinoin 20 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 20 mg capsule inner	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 20 mg capsule inner	Non-Formulary	
isotretinoin 20 mg capsule outer	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 20 mg capsule outer	Non-Formulary	
isotretinoin 30 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 30 mg capsule inner	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 30 mg capsule inner	Non-Formulary	
isotretinoin 30 mg capsule outer	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 30 mg capsule outer	Non-Formulary	
isotretinoin 40 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 40 mg capsule inner	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 40 mg capsule inner	Non-Formulary	
isotretinoin 40 mg capsule outer	Formulary	PA; QL (2 capsules per 1 day)
isotretinoin 40 mg capsule outer	Non-Formulary	
isotretinoin oral capsule 25 mg, 35 mg	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)
Acne Therapy Systemic - Tetracycline Antibiotic		
minocycline oral tablet extended release 24 hr	Non-Formulary	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 65 MG, 80 MG	Non-Formulary	
Acne Therapy Topical - Androgen Receptor Inhibitors		
WINLEVI	Non-Formulary	

Medications	Coverage Level	Restrictions
Acne Therapy Topical - Anti-Infective Combinations Other		
CLINDACIN ETZ TOPICAL KIT	Non-Formulary	
CLINDACIN PAC	Non-Formulary	
Acne Therapy Topical - Anti-Infective		
azelaic acid	Non-Formulary	
CLEOCIN T TOPICAL LOTION	Non-Formulary	
CLINDACIN ETZ 1% PLEDGET OUTER	Formulary	
CLINDACIN P 1% PLEDGETS	Formulary	
clindamycin ph 1% solution	Formulary	QL (180 ML per 30 days)
clindamycin phos 1% pledget	Formulary	
clindamycin phosphate topical foam	Non-Formulary	
clindamycin phosphate topical gel	Non-Formulary	
clindamycin phosphate topical gel, once daily	Non-Formulary	
clindamycin phosphate topical lotion	Non-Formulary	
dapsone topical gel 5 %	Non-Formulary	
dapsone topical gel with pump	Non-Formulary	
ERY PADS	Non-Formulary	
ERYGEL	Non-Formulary	
erythromycin 2% solution	Formulary	
erythromycin with ethanol topical gel	Non-Formulary	
EVOCLIN	Non-Formulary	
FINACEA TOPICAL FOAM	Non-Formulary	
KLARON	Non-Formulary	
sulfacetamide sodium (acne)	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	
clind ph-benzoyl pero 1.2-2.5%	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
clind ph-benzoyl perox 1.2-5%	Formulary	PDL Preferred
clindamyc-bnz perox 1.2-3.75%	Formulary	PA; PDL Non-Preferred
clindamycin-benzoyl perox 1-5%	Formulary	PDL Preferred
clindamycin-benzoyl perox 1-5% outer	Formulary	PDL Preferred
clindamycin-bnz perox 1-5% pmp	Formulary	PDL Preferred
clindamycin-bnz perox 1-5% pmp outer	Formulary	PDL Preferred
erythromycin-benzoyl gel	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	
sod sulfacet-sulfur 10-5% clsr	Formulary	
SSS 10-5	Non-Formulary	
sulfacetamide sodium-sulfur topical cleanser 10-2 %, 9-4 %, 9-4.5 %, 9.8-4.8 %	Non-Formulary	
sulfacetamide sodium-sulfur topical cream 10-2 %, 10-5 % (w/w)	Non-Formulary	
sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w)	Non-Formulary	
sulfacetamide sodium-sulfur topical pads, medicated 10-4 %	Non-Formulary	
sulfacetamide sodium-sulfur topical suspension 10-5 %, 8-4 %	Non-Formulary	
sulfacetamide sod-sulfur-urea	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
clindamycin-tretinoin	Non-Formulary	
ZIANA	Non-Formulary	
Acne Therapy Topical - Keratolytic		
ACNE MEDICATION 10% GEL	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)

Medications	Coverage Level	Restrictions
ACNE MEDICATION TOPICAL GEL 2.5 %, 5 %	Non-Formulary	OTC
ACNE MEDICATION TOPICAL LOTION 10 %	Non-Formulary	OTC
benzoyl peroxide 10% gel (otc)	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)
benzoyl peroxide 10% gel aqueous (otc)	Formulary	Dual Eligible Covered; OTC; QL (4 GM per 1 day)
benzoyl peroxide 10% wash (otc)	Formulary	OTC
benzoyl peroxide 5% gel (otc)	Formulary	Dual Eligible Covered; OTC
benzoyl peroxide 5% gel aqueous (otc)	Formulary	Dual Eligible Covered; OTC
benzoyl peroxide 5% wash (otc)	Formulary	OTC
benzoyl peroxide 5% wash (otc)	Formulary	Dual Eligible Covered; OTC
benzoyl peroxide topical gel 2.5 %	Non-Formulary	OTC
Acne Therapy Topical - Retinoid Combinations Other		
adapalene-benzoyl peroxide topical gel with pump 0.3-2.5 %	Non-Formulary	
adapalene-bnzyl perox 0.1-2.5%	Formulary	QL (45 GM per 30 days)
EPIDUO FORTE	Non-Formulary	
Acne Therapy Topical - Retinoids And Derivatives		
adapalene 0.1% gel (otc)	Formulary	OTC; QL (45 GM per 30 days)
adapalene 0.1% gel (otc)	Formulary	Dual Eligible Covered; OTC; QL (45 GM per 30 days)
adapalene 0.3% gel	Formulary	QL (45 GM per 30 days)
adapalene 0.3% gel	Formulary	Dual Eligible Covered; QL (45 GM per 30 days)
adapalene topical cream	Non-Formulary	
adapalene topical gel with pump	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

Medications	Coverage Level	Restrictions
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
tazarotene topical foam	Non-Formulary	
tretinoin 0.025% cream	Formulary	QL (20 GM per 30 days)
tretinoin 0.025% cream	Formulary	Dual Eligible Covered; QL (20 GM per 30 days)
tretinoin 0.05% cream	Formulary	QL (20 GM per 30 days)
tretinoin 0.05% cream	Formulary	Dual Eligible Covered; QL (20 GM per 30 days)
tretinoin microspheres topical gel	Non-Formulary	Dual Eligible Covered
tretinoin microspheres topical gel with pump 0.04 %, 0.1 %	Non-Formulary	Dual Eligible Covered
tretinoin microspheres topical gel with pump 0.08 %	Non-Formulary	
tretinoin topical cream 0.1 %	Non-Formulary	Dual Eligible Covered
tretinoin topical gel 0.01 %, 0.025 %	Non-Formulary	Dual Eligible Covered
tretinoin topical gel 0.05 %	Non-Formulary	
Antipsoriatic - Retinoid (Vitamin A Derivative) - Glucocorticoid		
DUOBRII	Non-Formulary	
Antipsoriatic - Vitamin D Analog - Glucocorticoid Combinations		
calcipotriene-betamethasone	Non-Formulary	
ENSTILAR	Non-Formulary	
TACLONEX TOPICAL SUSPENSION	Non-Formulary	
Antipsoriatic Agents - Interleukin 12 And Il-23 Inhibitors,Mc Antibody		
OTULFI 45 MG/0.5 ML SYRINGE	Formulary	PA
OTULFI 90 MG/ML SYRINGE	Formulary	PA
PYZCHIVA 45 MG/0.5 ML SYRINGE	Formulary	PA
PYZCHIVA 90 MG/ML SYRINGE	Formulary	PA

Medications	Coverage Level	Restrictions
SELARSDI 45 MG/0.5 ML SYRINGE	Formulary	PA
SELARSDI 90 MG/ML SYRINGE	Formulary	PA
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
STEQEYMA 45 MG/0.5 ML SYRINGE	Formulary	PA
STEQEYMA 90 MG/ML SYRINGE	Formulary	PA
ustekinumab 45 mg/0.5 ml syringe	Formulary	PA
ustekinumab 90 mg/ml syringe	Formulary	PA
ustekinumab-aekn 45 mg/0.5 ml	Formulary	PA
ustekinumab-aekn 90 mg/ml syr	Formulary	PA
ustekinumab-ttwe 45 mg/0.5 ml syringe	Formulary	PA
ustekinumab-ttwe 90 mg/ml syr	Formulary	PA
YESINTEK 45 MG/0.5 ML SYRINGE	Formulary	PA
YESINTEK 90 MG/ML SYRINGE	Formulary	PA
Antipsoriatic Agents - Interleukin-23 (Il-23) Antagonist, Mc Antibody		
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 ONE-PRESS	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
Antipsoriatic Agents - Tyrosine Kinase 2 (Tyk2) Inhibitor		
SOTYKTU 6 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day); Age Limit (Min 18 Years)
Antipsoriatic Agents-Interleukin-17 (Il-17) Antagonist, Mc Antibody		
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

Medications	Coverage Level	Restrictions
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
Dermatitis - Janus Kinase (Jak) Inhibitors		
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)
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

Medications	Coverage Level	Restrictions
Dermatitis Agents, Systemic - Interleukin-13 Inhibitors Mab		
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)
Dermatitis Agents,Systemic - Il-31 Receptor Alpha Antagonist Mab		
NEMLUVIO 30 MG PEN	Formulary	PA; PDL Non-Preferred; QL (1 pen per 28 days)
Dermatitis Agents,Systemic-Il-4 Receptor Alpha Antagonist (Il-4Ra) Mab		
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
Dermatitis Or Eczema Agents, Topical - Phosphodiesterase-4 Inhibitors		
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)
Dermatological - Antibacterial Aminoglycosides		
gentamicin 0.1% cream	Formulary	
gentamicin 0.1% ointment	Formulary	
Dermatological - Antibacterial Mixtures		
FT TRIPLE ANTIBIOTIC OINTMENT	Formulary	OTC
SM TRIPLE ANTIBIOTIC OINTMENT	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
TRIPLE ANTIBIOTIC OINTMENT	Formulary	OTC
TRIPLE ANTIBIOTIC OINTMENT	Formulary	Dual Eligible Covered; OTC
Dermatological - Antibacterial Other		
CENTANY 2% OINTMENT	Formulary	PA; PDL Non-Preferred
CENTANY AT 2% OINTMENT KIT	Formulary	PA; PDL Non-Preferred
mupirocin 2% cream	Formulary	PA; PDL Non-Preferred
mupirocin 2% ointment	Formulary	PDL Preferred
mupirocin 2% ointment outer	Formulary	PDL Preferred
silver nitrate topical solution 0.5 %	Non-Formulary	
Dermatological - Antibacterial Povidone-Iodine Preparations		
FIRST AID ANTISEPTIC(POVIDONE) TOPICAL OINTMENT	Non-Formulary	Dual Eligible Covered; OTC
povidone-iodine topical ointment	Non-Formulary	Dual Eligible Covered; OTC
Dermatological - Antibacterial Quinolones		
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)
Dermatological - Antibacterial-Glucocorticoid Combinations		
NEO-SYNALAR	Non-Formulary	
NEO-SYNALAR KIT	Non-Formulary	
Dermatological - Anticholinergic Hyperhidrosis Treatment Agents		
SOFDRA	Non-Formulary	
Dermatological - Antifungal Allylamines		
naftifine hcl 1% cream	Formulary	PA; PDL Non-Preferred
naftifine hcl 2% cream	Formulary	PA; PDL Non-Preferred
naftifine hcl 2% gel	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
terbinafine 1% cream	Formulary	OTC
terbinafine 1% cream antifungal	Formulary	OTC
Dermatological - Antifungal Amphoteric Polyene Macrolides		
KLAYESTA 100,000 UNIT/GM POWD	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
NYAMYC 100,000 UNIT/GM POWDER	Formulary	PDL Preferred
nystatin 100,000 unit/gm cream	Formulary	PDL Preferred
nystatin 100,000 unit/gm oint	Formulary	PDL Preferred
nystatin 100,000 unit/gm powd	Formulary	PDL Preferred
NYSTOP 100,000 UNIT/GM POWDER	Formulary	PDL Preferred
Dermatological - Antifungal Benzylamines		
butenafine hcl 1% cream	Formulary	PA; PDL Non-Preferred; OTC
Dermatological - Antifungal Hydroxypyridinone		
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
ciclopirox 0.77% cream	Formulary	PDL Preferred
ciclopirox 0.77% gel	Formulary	PA; PDL Non-Preferred
ciclopirox 0.77% topical susp	Formulary	PA; PDL Non-Preferred
ciclopirox 1% shampoo	Formulary	PA; PDL Non-Preferred
ciclopirox 8% solution	Formulary	PDL Preferred
ciclopirox 8% treatment kit	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
Dermatological - Antifungal Imidazole And Related Agents		
ANTIFUNGAL 1% TOPICAL CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; OTC
ATHLETE'S FOOT 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
ATHLETE'S FOOT 1% SOLUTION	Formulary	PDL Preferred; OTC
clotrimazole 1% solution (otc)	Formulary	PDL Preferred; OTC
clotrimazole 1% solution (rx)	Formulary	PA; PDL Non-Preferred; OTC
clotrimazole 1% topical cream (otc)	Formulary	PDL Preferred; OTC
clotrimazole 1% topical cream (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
clotrimazole 1% topical cream (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
clotrimazole 1% topical cream 2 x 45gm tubes (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
econazole nitrate 1% cream	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
ketoconazole 2% cream	Formulary	PDL Preferred
ketoconazole 2% foam	Formulary	PA; PDL Non-Preferred
ketoconazole 2% shampoo	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
luliconazole 1% cream	Formulary	PA; PDL Non-Preferred
LUZU 1% CREAM	Formulary	PA; PDL Non-Preferred
miconazole 2% topical cream	Formulary	PDL Preferred; OTC
miconazole 2% topical cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
miconazole nitrate 2% solution	Formulary	PDL Preferred; OTC
miconazole-zinc-petro 0.25-15%	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
oxiconazole nitrate 1% cream	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
sm miconazole 2% topical cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
tm-clotrimazole 1% top cream (otc)	Formulary	PDL Preferred; OTC
VUSION OINTMENT	Formulary	PA; PDL Non-Preferred; Age Limit (Max 16 Years)

Medications	Coverage Level	Restrictions
Dermatological - Antifungal Oxaborole		
tavaborole 5% topical solution	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
Dermatological - Antifungal Thiocarbamate		
FT ANTIFUNGAL 1% CREAM	Formulary	PDL Preferred; OTC
SM ANTIFUNGAL 1% CREAM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
tolnaftate 1% cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
tolnaftate 1% powder	Formulary	PDL Preferred; OTC
Dermatological - Antifungal Triazole		
JUBLIA 10% TOPICAL SOLUTION	Formulary	PA; PDL Non-Preferred; Age Limit (Min 6 Years)
Dermatological - Antifungal-Glucocorticoid Combinations		
clotrimazole-betamethasone crm	Formulary	PDL Preferred
clotrimazole-betamethasone lot	Formulary	PA; PDL Non-Preferred
hydrocortisone-iodoquinol	Non-Formulary	
nystatin-triamcinolone cream	Formulary	PDL Preferred
nystatin-triamcinolone ointm	Formulary	PDL Preferred
nystatin-triamcinolone ointment	Formulary	PDL Preferred
Dermatological - Antineoplastic Alkylating Agents		
VALCHLOR 0.016% GEL	Formulary	
Dermatological - Antineoplastic Antimetabolites		
CARAC 0.5% CREAM	Formulary	
EFUDEX 5% CREAM	Formulary	
fluorouracil 0.5% cream	Formulary	
fluorouracil 2% topical soln	Formulary	
fluorouracil 5% cream	Formulary	
fluorouracil 5% topical soln	Formulary	
Dermatological - Antineoplastic Or Premalignant Lesions - Nsaid's		
diclofenac sodium 3% gel	Formulary	
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist		
bexarotene 1% gel	Formulary	

Medications	Coverage Level	Restrictions
TARGRETIN 1% GEL	Formulary	
Dermatological - Antiperspirants		
DRYSOL DAB-O-MATIC	Benefit Exclusion	
Dermatological - Antipsoriatic Agents Systemic, Photosensitizing		
methoxsalen	Non-Formulary	
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives		
acitretin 10 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
acitretin 17.5 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
acitretin 25 mg capsule	Formulary	PA; QL (2 capsules per 1 day)
Dermatological - Antipsoriatic Agents Topical		
BRYHALI 0.01% LOTION	Formulary	PA; PDL Non-Preferred
calcipotriene 0.005% cream	Formulary	QL (400 GM per 30 days); Age Limit (Min 2 Years)
calcipotriene 0.005% ointment	Formulary	QL (400 GM per 30 days); Age Limit (Min 2 Years)
calcipotriene 0.005% solution	Formulary	Age Limit (Min 2 Years)
calcipotriene topical foam	Non-Formulary	
calcitriol 3 mcg/g ointment	Formulary	PA; Age Limit (Min 2 Years)
clobetasol 0.025% cream	Formulary	PA; PDL Non-Preferred
halobetasol prop 0.05% foam	Formulary	PA; PDL Non-Preferred
SORILUX	Non-Formulary	
tazarotene 0.05% cream	Formulary	PA
tazarotene 0.05% gel	Formulary	PA; Age Limit (Min 12 Years)
tazarotene 0.1% cream	Formulary	PA
tazarotene 0.1% gel	Formulary	PA; Age Limit (Min 12 Years)
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)
Dermatological - Antipsoriatics Systemic, Phosphodiesterase 4 Inhib.		
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

Medications	Coverage Level	Restrictions
OTEZLA 30 MG TABLET	Formulary	PA; PDL Non-Preferred
Dermatological - Antiseborrheic		
OVACE	Non-Formulary	
OVACE PLUS	Non-Formulary	
OVACE PLUS SHAMPOO	Non-Formulary	
OVACE PLUS WASH	Non-Formulary	
PROMISEB	Non-Formulary	
selenium sulfide 2.5% lotion	Formulary	
selenium sulfide topical shampoo 2.25 %	Non-Formulary	
sulfacetamide sodium topical cleanser	Non-Formulary	
sulfacetamide sodium topical cleanser, gel	Non-Formulary	
sulfacetamide sodium topical shampoo 10 %	Non-Formulary	
ZORYVE 0.3% FOAM	Formulary	PA; Age Limit (Min 9 Years)
Dermatological - Antiviral, Herpes		
acyclovir 5% cream	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 5% ointment	Formulary	PDL Preferred; 3 Months Allowed
acyclovir 5% ointment outer	Formulary	PDL Preferred; 3 Months Allowed
DENAVIR 1% CREAM	Formulary	PDL Preferred; 3 Months Allowed
docosanol 10% cream	Formulary	OTC
gnp docosanol 10% cream	Formulary	OTC
penciclovir 1% cream	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
ZOVIRAX 5% CREAM	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZOVIRAX 5% OINTMENT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Dermatological - Antiviral-Glucocorticoid Combinations		
XERESE 5%-1% CREAM	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Dermatological - Burn Products Anti-Infective		
mafenide acetate	Non-Formulary	
SILVADENE	Non-Formulary	
silver sulfadiazine 1% cream	Formulary	

Medications	Coverage Level	Restrictions
SSD 1% CREAM	Formulary	
SULFAMYLON TOPICAL CREAM	Non-Formulary	
Dermatological - Calcineurin Inhibitors		
ELIDEL 1% CREAM	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
pimecrolimus 1% cream	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
tacrolimus 0.03% ointment	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 2 Years)
tacrolimus 0.03% ointment	Formulary	PA; PDL Preferred; QL (30 grams per 30 days); Age Limit (Min 2 Years)
tacrolimus 0.1% ointment	Formulary	PA; PDL Preferred; QL (30 GM per 30 days); Age Limit (Min 16 Years)
tacrolimus 0.1% ointment	Formulary	PA; PDL Preferred; QL (30 grams per 30 days); Age Limit (Min 16 Years)
Dermatological - Depigmenting Agents		
hydroquinone	Non-Formulary	
Dermatological - Depigmenting Combinations		
TRI-LUMA	Non-Formulary	
Dermatological - Emollient Mixtures		
PROMISEB	Non-Formulary	
Dermatological - Emollients		
ammonium lactate 12% cream (rx)	Formulary	OTC; QL (140 GM per 30 days)
ammonium lactate 12% cream (rx)	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
ammonium lactate 12% cream 2x140gm (rx)	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
ammonium lactate 12% cream outer, 2x140gm (rx)	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
ammonium lactate 12% cream w/pump (rx)	Formulary	Dual Eligible Covered; OTC; QL (140 GM per 30 days)
ammonium lactate 12% lotion (rx)	Formulary	Dual Eligible Covered; OTC; QL (225 GM per 30 days)

Medications	Coverage Level	Restrictions
PCCA BASE ANHYDROUS OINT	Formulary	
Dermatological - Enzymes		
SANTYL	Non-Formulary	
Dermatological - Glucocorticoid		
alclometasone dipr 0.05% oint	Formulary	PA; PDL Non-Preferred
alclometasone dipro 0.05% crm	Formulary	PA; PDL Non-Preferred
amcinonide 0.1% cream	Formulary	PA; PDL Non-Preferred
APEXICON E 0.05% CREAM	Formulary	PA; PDL Non-Preferred
BESER 0.05% LOTION	Formulary	PA; PDL Non-Preferred
betamethasone dp 0.05% crm	Formulary	PDL Preferred
betamethasone dp 0.05% lot	Formulary	PDL Preferred
betamethasone dp 0.05% oint	Formulary	PDL Preferred
betamethasone dp 0.05% oint carton	Formulary	PDL Preferred
betamethasone dp aug 0.05% crm	Formulary	PA; PDL Non-Preferred
betamethasone dp aug 0.05% gel	Formulary	PA; PDL Non-Preferred
betamethasone dp aug 0.05% lot	Formulary	PA; PDL Non-Preferred
betamethasone dp aug 0.05% oin	Formulary	PA; PDL Non-Preferred
betamethasone dp aug 0.05% oin augmented	Formulary	PA; PDL Non-Preferred
betamethasone va 0.1% cream	Formulary	PDL Preferred
betamethasone va 0.1% cream carton	Formulary	PDL Preferred
betamethasone va 0.1% lotion	Formulary	PDL Preferred
betamethasone valer 0.1% ointm	Formulary	PDL Preferred
betamethasone valer 0.12% foam	Formulary	PA; PDL Non-Preferred
BRYHALI 0.01% LOTION	Formulary	PA; PDL Non-Preferred
CAPEX SHAMPOO	Formulary	PA; PDL Non-Preferred
clobetasol 0.025% cream	Formulary	PA; PDL Non-Preferred
clobetasol 0.05% cream	Formulary	PDL Preferred
clobetasol 0.05% gel	Formulary	PA; PDL Non-Preferred
clobetasol 0.05% ointment	Formulary	PDL Preferred
clobetasol 0.05% shampoo	Formulary	PA; PDL Non-Preferred
clobetasol 0.05% solution	Formulary	PDL Preferred
clobetasol 0.05% topical lotn	Formulary	PA; PDL Non-Preferred
clobetasol emollient 0.05% crm	Formulary	PA; PDL Non-Preferred
clobetasol emollnt 0.05% foam	Formulary	PA; PDL Non-Preferred
clobetasol emulsion 0.05% foam	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
clobetasol prop 0.05% foam	Formulary	PA; PDL Non-Preferred
clobetasol prop 0.05% spray	Formulary	PA; PDL Non-Preferred
CLOBEX 0.05% SHAMPOO	Formulary	PA; PDL Non-Preferred
CLOBEX 0.05% SPRAY	Formulary	PA; PDL Non-Preferred
clocortolone pivalate 0.1% crm	Formulary	PA; PDL Non-Preferred
CLODAN 0.05% SHAMPOO	Formulary	PA; PDL Non-Preferred
DERMA-SMOOTHE-FS BODY OIL	Formulary	PA; PDL Non-Preferred
DERMA-SMOOTHE-FS SCALP OIL	Formulary	PA; PDL Non-Preferred
desonide 0.05% cream	Formulary	PA; PDL Non-Preferred
desonide 0.05% lotion	Formulary	PA; PDL Non-Preferred
desonide 0.05% ointment	Formulary	PA; PDL Non-Preferred
desoximetasone 0.05% cream	Formulary	PA; PDL Non-Preferred
desoximetasone 0.05% gel	Formulary	PA; PDL Non-Preferred
desoximetasone 0.05% ointment	Formulary	PA; PDL Non-Preferred
desoximetasone 0.25% cream	Formulary	PA; PDL Non-Preferred
desoximetasone 0.25% cream usp	Formulary	PA; PDL Non-Preferred
desoximetasone 0.25% ointment	Formulary	PA; PDL Non-Preferred
desoximetasone 0.25% spray	Formulary	PA; PDL Non-Preferred
diflorasone 0.05% cream	Formulary	PA; PDL Non-Preferred
diflorasone 0.05% ointment	Formulary	PA; PDL Non-Preferred
DIPROLENE 0.05% OINTMENT	Formulary	PA; PDL Non-Preferred
fluocinolone 0.01% body oil	Formulary	PA; PDL Non-Preferred
fluocinolone 0.01% cream	Formulary	PA; PDL Non-Preferred
fluocinolone 0.01% scalp oil	Formulary	PA; PDL Non-Preferred
fluocinolone 0.01% solution	Formulary	PA; PDL Non-Preferred
fluocinolone 0.025% cream	Formulary	PA; PDL Non-Preferred
fluocinolone 0.025% ointment	Formulary	PA; PDL Non-Preferred
fluocinonide 0.05% cream	Formulary	PDL Preferred
fluocinonide 0.05% gel	Formulary	PDL Preferred
fluocinonide 0.05% ointment	Formulary	PDL Preferred
fluocinonide 0.05% solution	Formulary	PDL Preferred
fluocinonide 0.1% cream	Formulary	PDL Preferred
fluocinonide-e 0.05% cream	Formulary	PA; PDL Non-Preferred
FLUOCINONIDE-E 0.05% CREAM	Formulary	PA; PDL Non-Preferred
flurandrenolide 0.05% lotion	Formulary	PA; PDL Non-Preferred
flurandrenolide 0.05% ointment	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
fluticasone prop 0.005% oint	Formulary	PDL Preferred
fluticasone prop 0.05% cream	Formulary	PDL Preferred
fluticasone prop 0.05% lotion	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
halcinonide 0.1% cream	Formulary	PA; PDL Non-Preferred
halcinonide 0.1% solution	Formulary	PA; PDL Non-Preferred
halobetasol prop 0.05% cream	Formulary	PDL Preferred
halobetasol prop 0.05% foam	Formulary	PA; PDL Non-Preferred
halobetasol prop 0.05% ointmnt	Formulary	PDL Preferred
HALOG 0.1% CREAM	Formulary	PA; PDL Non-Preferred
HALOG 0.1% OINTMENT	Formulary	PA; PDL Non-Preferred
hm hydrocortisone 1% cream (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 0.5% cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 0.5% cream (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream carton (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream max str, w/aloe (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream maximum strength (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% cream moisturizer,max. str (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% ointment	Formulary	PDL Preferred; OTC
hydrocortisone 1% ointment (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% ointment (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
hydrocortisone 1% ointment maximum strength (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
hydrocortisone 2.5% cream	Formulary	
hydrocortisone 2.5% cream	Formulary	PDL Preferred
hydrocortisone 2.5% cream carton	Formulary	PDL Preferred
hydrocortisone 2.5% lotion	Formulary	PDL Preferred
hydrocortisone 2.5% ointment	Formulary	PDL Preferred
hydrocortisone 2.5% solution	Formulary	PA; PDL Non-Preferred
hydrocortisone buty 0.1% cream	Formulary	PA; PDL Non-Preferred
hydrocortisone butyr 0.1% lotn	Formulary	PA; PDL Non-Preferred
hydrocortisone butyr 0.1% oint	Formulary	PA; PDL Non-Preferred
hydrocortisone butyr 0.1% soln	Formulary	PA; PDL Non-Preferred
hydrocortisone topical cream with perineal applicator 1 %	Non-Formulary	
hydrocortisone val 0.2% cream	Formulary	PA; PDL Non-Preferred
hydrocortisone val 0.2% ointmt	Formulary	PA; PDL Non-Preferred
hydrocortisone-pramoxine topical cream 2.5-1 %	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
mometasone furoate 0.1% cream	Formulary	PDL Preferred
mometasone furoate 0.1% oint	Formulary	PDL Preferred
mometasone furoate 0.1% soln 27.5 gram	Formulary	PDL Preferred
mometasone furoate 0.1% soln 55 gram	Formulary	PDL Preferred
OLUX 0.05% FOAM	Formulary	PA; PDL Non-Preferred
PANDEL 0.1% CREAM	Formulary	PA; PDL Non-Preferred
prednicarbate 0.1% cream	Formulary	PA; PDL Non-Preferred
prednicarbate 0.1% ointment	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	
sm hydrocortisone 1% ointment maximum strength (otc)	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

Medications	Coverage Level	Restrictions
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
triamcinolone 0.025% cream	Formulary	PDL Preferred
triamcinolone 0.025% lotion	Formulary	PDL Preferred
triamcinolone 0.025% oint	Formulary	PDL Preferred
triamcinolone 0.05% ointment	Formulary	PDL Preferred
triamcinolone 0.1% cream	Formulary	PDL Preferred
triamcinolone 0.1% lotion	Formulary	PDL Preferred
triamcinolone 0.1% ointment	Formulary	PDL Preferred
triamcinolone 0.147 mg/g spray	Formulary	PA; PDL Non-Preferred
triamcinolone 0.5% cream	Formulary	PDL Preferred
triamcinolone 0.5% ointment	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
Dermatological - Glucocorticoid-Emollient Combinations		
BESER 0.05% KIT	Formulary	PA; PDL Non-Preferred
FT ITCH RLF WITH ALOE 1% CREAM	Formulary	PDL Preferred; OTC
hydrocortisone-aloe 1% cream	Formulary	PDL Preferred; OTC
hydrocortisone-aloe 1% cream	Formulary	PDL Preferred; Dual Eligible Covered; OTC
SM HYDROCORTISONE PLUS 1% CRM	Formulary	PDL Preferred; Dual Eligible Covered; OTC
sm hydrocortisone-aloe 1% crm	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

Medications	Coverage Level	Restrictions
Dermatological - Glucocorticoid-Local Anesthetic Combinations		
EPIFOAM	Non-Formulary	
lidocaine hcl-hydrocortison ac topical	Non-Formulary	
LIDOCORT	Non-Formulary	
PRAMOSONE TOPICAL CREAM 1-1 %	Non-Formulary	
PRAMOSONE TOPICAL LOTION 1-1 %	Non-Formulary	
PRAMOSONE TOPICAL OINTMENT	Non-Formulary	
Dermatological - Glucocorticoid-Skin Cleanser Combinations		
CLODAN 0.05% KIT	Formulary	PA; PDL Non-Preferred
SYNALAR TS 0.01% KIT	Formulary	PA; PDL Non-Preferred
Dermatological - Immunomodulator - Catechins - Genital Wart/Hpv Tx		
VEREGEN	Non-Formulary	
Dermatological - Immunomodulator - Imidazoquinolinamines		
imiquimod 5% cream packet 12x0.25gm packet	Formulary	
imiquimod 5% cream packet 24x0.25gm packet	Formulary	
imiquimod 5% cream packet inner	Formulary	
imiquimod 5% cream packet inner, single use	Formulary	
imiquimod 5% cream packet outer	Formulary	
imiquimod 5% cream packet outer, single use	Formulary	
imiquimod 5% cream packet outer,0.25gx24pkt	Formulary	
imiquimod topical cream in metered-dose pump	Non-Formulary	
imiquimod topical cream in packet 3.75 %	Non-Formulary	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	Non-Formulary	
Dermatological - Keratolytic-Antimitotic Single Agents		
CONDYLOX TOPICAL GEL	Non-Formulary	
PODOCON	Non-Formulary	
podofilox 0.5% topical soln	Formulary	
salicylic acid topical cream	Non-Formulary	

Medications	Coverage Level	Restrictions
salicylic acid topical film forming liquid w/appl	Non-Formulary	
salicylic acid topical foam	Non-Formulary	
salicylic acid topical gel	Non-Formulary	
salicylic acid topical lotion	Non-Formulary	
salicylic acid topical ointment	Non-Formulary	
URAMAXIN TOPICAL FOAM	Non-Formulary	
urea powder	Formulary	
urea topical cream 39 %, 40 %, 41 %	Non-Formulary	
urea topical foam	Non-Formulary	
Dermatological - Local Anesthetic Combinations		
lidocaine-prilocaine 2.5%-2.5% cream	Formulary	QL (1 GM per 1 day)
lidocaine-prilocaine 2.5%-2.5% cream outer	Formulary	QL (1 GM per 1 day)
lidocaine-prilocaine 2.5%-2.5% cream outer, p/f	Formulary	QL (1 GM per 1 day)
lidocaine-prilocaine topical kit	Non-Formulary	
Dermatological - Mammalian Target Of Rapamycin (Mtor) Inhibitors		
HYFTOR 0.2% GEL	Formulary	PA; QL (20 GM per 30 days); Age Limit (Min 6 Years)
Dermatological - Nsaid Single Agents		
ARTHRITIS PAIN RELIEVER 1% GEL	Formulary	PDL Preferred; OTC
diclofenac 1.5% topical soln	Formulary	PDL Preferred
diclofenac 2% solution pump	Formulary	PA; PDL Non-Preferred
diclofenac epolamine 1.3% ptch outer	Formulary	PA; PDL Non-Preferred; QL (2 patches per 1 day)
diclofenac sodium 1% gel (otc)	Formulary	PDL Preferred; OTC
diclofenac sodium 1% gel (rx)	Formulary	PDL Preferred; OTC
FT ARTHRITIS PAIN 1% GEL	Formulary	PDL Preferred; OTC
gnp diclofenac sodium 1% gel (otc)	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
Dermatological - Photodynamic Therapy Agents Topical		
AMELUZ	Non-Formulary	
LEVULAN	Non-Formulary	

Medications	Coverage Level	Restrictions
Dermatological - Retinoids (Vitamin A Derivatives) - Topical Cosmetic		
RENOVA TOPICAL CREAM 0.02 %	Non-Formulary	Dual Eligible Covered
tazarotene 0.1% cream	Formulary	PA
Dermatological - Rosacea Therapy, Systemic		
doxycycline monohydrate oral capsule,ir - delay rel,biphase	Non-Formulary	
ORACEA	Non-Formulary	
Dermatological - Rosacea Therapy, Topical		
azelaic acid	Non-Formulary	
CLEANSING WASH TOPICAL CLEANSER	Non-Formulary	
FINACEA TOPICAL FOAM	Non-Formulary	
ivermectin topical cream	Non-Formulary	
METROCREAM	Non-Formulary	
METROGEL TOPICAL GEL 1 %	Non-Formulary	
metronidazole 0.75% cream	Formulary	
metronidazole topical 0.75% gl	Formulary	
metronidazole topical gel 1 %	Non-Formulary	
metronidazole topical gel with pump	Non-Formulary	
metronidazole topical lotion	Non-Formulary	
MIRVASO	Non-Formulary	
NORITATE	Non-Formulary	
RHOFADE	Non-Formulary	
ROSADAN 0.75% CREAM	Formulary	
ROSADAN TOPICAL GEL	Non-Formulary	
ROSADAN TOPICAL KIT, CLEANSER AND GEL	Non-Formulary	
ROSADAN TOPICAL KIT,CLEANSER AND CREAM	Non-Formulary	
SOOLANTRA	Non-Formulary	
sulfacetamide sod-sulfur-urea	Non-Formulary	
SUMADAN XLT	Non-Formulary	
Dermatological - Tissue/Wound Adhesives - Fibrin Sealants		
ARTISS	Non-Formulary	

Medications	Coverage Level	Restrictions
Dermatological - Topical Local Anesthetic Amides		
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	
lidocaine 3% cream (rx)	Formulary	QL (85 GM per 30 days)
lidocaine 4% patch outer	Formulary	OTC; QL (1 patch per 1 day)
lidocaine 5% ointment	Formulary	QL (100 GM per 30 days)
lidocaine 5% patch	Formulary	PA; QL (3 patches per 1 day)
lidocaine 5% patch outer	Formulary	PA; QL (3 patches per 1 day)
lidocaine hcl 2% jel urojet ac uro-jet ac, p/f, suv	Formulary	
lidocaine hcl 2% jelly uro-jet uro-jet, p/f, suv	Formulary	
lidocaine hcl 2% jelly uro-jet uro-jet,p/f, suv	Formulary	
lidocaine hcl 2% jelly uro-jet uro-jet,single use	Formulary	
lidocaine pain relief 4% patch	Formulary	OTC; QL (1 patch per 1 day)
LIDOCAINE PAIN RELIEF 4% PATCH	Formulary	OTC; QL (1 patch per 1 day)
lidocaine topical cream 4 %	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)
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	
Dermatological Antipruritics - Antihistamines		
doxepin topical	Non-Formulary	
PRUDOXIN	Non-Formulary	
ZONALON	Non-Formulary	

Medications	Coverage Level	Restrictions
Hair Growth Agents - Kinase Inhibitor		
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
Scabicide And Pediculicide Combinations		
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
Scabicide And Pediculicide Single Agents		
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)
ivermectin 0.5% lotion (otc)	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)
malathion 0.5% lotion	Formulary	QL (2 ML per 1 day); Age Limit (Min 2 Years)
NATROBA	Non-Formulary	
OVIDE	Non-Formulary	
permethrin 5% cream	Formulary	QL (60 GM per 30 days)
PRURADIK	Non-Formulary	
SKLICE	Non-Formulary	OTC
spinosad 0.9% topical susp	Formulary	QL (240 ML per 180 days); Age Limit (Min 6 Months)
Wound Care Combinations Other		
balsam peru-castor oil topical ointment in packet	Non-Formulary	

Medications	Coverage Level	Restrictions
Diagnostic Agents		
Diagnostic Drugs - Metabolic Function		
METOPIRONE	Non-Formulary	
Diagnostic Drugs - Pituitary Function		
CORTROSYN	State Carve Out	
cosyntropin	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	
sildenafil	Benefit Exclusion	
STENDRA	Benefit Exclusion	
tadalafil	Benefit Exclusion	
vardenafil	Benefit Exclusion	
VIAGRA	Benefit Exclusion	
Electrolyte Balance-Nutritional Products		
Amino Acid - Carnitine Derivatives		
levocarnitine oral tablet	State Carve Out	OTC
Amino Acids, Single Ingredient, Oral (Non-Injectable)		
ENDARI	Non-Formulary	
l-glutamine 5 gram powder pkt outer	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
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	

Medications	Coverage Level	Restrictions
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
B-Complex Vitamins And Combinations		
DIALYVITE WITH ZINC TABLET	Formulary	Dual Eligible Covered
NEPHPLEX RX TABLET	Formulary	Dual Eligible Covered
Dietary Product - Dietary Supplements		
coenzyme q-10 powder (rx)	Formulary	
coenzyme q-10 powder (water dispersible) (rx)	Formulary	
Diluents - Sodium Chloride		
sodium chloride 0.9 % injection	Non-Formulary	
Electrolyte Depleters - Ion Exchange Resin		
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
sodium polystyrene sulf powder	Formulary	
sodium polystyrene sulf powder inner	Formulary	
sodium polystyrene sulf powder outer	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

Medications	Coverage Level	Restrictions
Electrolyte Depleters - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitors		
XPHOZAH 20 MG TABLET	Formulary	PA; PDL Non-Preferred
XPHOZAH 30 MG TABLET	Formulary	PA; PDL Non-Preferred
Irrigation Solutions		
PHYSIOLYTE	Non-Formulary	
PHYSIOSOL IRRIGATION	Non-Formulary	
sodium chloride 1 gm tablet (otc)	Non-Formulary	CSHCS Covered; OTC
sodium chloride 1 gm tablet (rx)	Non-Formulary	CSHCS Covered; OTC
sodium chloride irrigation	Non-Formulary	
Minerals And Electrolytes - Bicarbonate Producing Or Containing Agents		
sodium bicarbonate powder usp (rx)	Formulary	OTC
sodium bicarbonate powder usp,ep,jp (rx)	Formulary	OTC
Minerals And Electrolytes - Calcium Replacement/Vitamin D Combinations		
calcium 250 mg-vit d3 3 mcg tb	Formulary	
CALCIUM 250-D TABLET OYSTER SHELL (RX)	Formulary	
CALCIUM 500 + D ORAL TABLET,CHEWABLE	Non-Formulary	
calcium 500 mg-vit d3 5 mcg tb (rx)	Formulary	
CALCIUM 500-VIT D3 200 TABLET (RX)	Formulary	
CALCIUM 500-VIT D3 200 TABLET 10X10, U-D (RX)	Formulary	
calcium 600-vit d3 400 tablet (rx)	Formulary	
CALCIUM 600-VIT D3 400 TABLET INNER (RX)	Formulary	
CALCIUM 600-VIT D3 400 TABLET OUTER (RX)	Formulary	
calcium 600-vit d3 800 tablet (rx)	Formulary	
calcium 600-vit d3 800 tablet inner (rx)	Formulary	
calcium 600-vit d3 800 tablet outer (rx)	Formulary	
calcium carbonate-vitamin d3 oral tablet,chewable 500 mg-10 mcg (400 unit)	Non-Formulary	
calcium cit 315-vit d3 250 tab outer (rx)	Formulary	
calcium citrate-vit d3 tablet (rx)	Formulary	
gnp calcium 500-vit d3 600 tab	Formulary	

Medications	Coverage Level	Restrictions
OS-CAL 500 + D3 ORAL TABLET 500 MG-5 MCG (200 UNIT)	Non-Formulary	
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	
ultra calc 600 mg-vit d3 10 mcg (rx)	Formulary	
Minerals And Electrolytes - Calcium Replacement		
calcium 600 mg tablet (rx)	Formulary	
calcium carb 1,250 mg/5 ml sus n (otc)	Formulary	Dual Eligible Covered; OTC
calcium carbonate 1,250 mg/5 ml suspension cup 40's,u-d (otc)	Formulary	Dual Eligible Covered; OTC
calcium citrate 250 mg caplet	Non-Formulary	CSHCS Covered
calcium citrate 250 mg tablet	Non-Formulary	CSHCS Covered
calcium gluc 1,000 mg/10 ml vl outer, suv, p/f	Non-Formulary	CSHCS Covered
calcium gluc 1,000 mg/10 ml vl sdv,outer,p/f	Non-Formulary	CSHCS Covered
calcium gluc 10,000 mg/100 ml mdv,outer,p/f	Non-Formulary	CSHCS Covered
calcium gluc 10,000 mg/100 ml muv, p/f	Non-Formulary	CSHCS Covered
calcium gluc 10,000 mg/100 ml muv, p/f, outer	Non-Formulary	CSHCS Covered
calcium gluc 10,000 mg/100 ml outer, muv, p/f	Non-Formulary	CSHCS Covered
calcium gluc 5,000 mg/50 ml vl outer, suv, p/f	Non-Formulary	CSHCS Covered
calcium gluc 5,000 mg/50 ml vl sdv,outer,p/f	Non-Formulary	CSHCS Covered
calcium gluc 5,000 mg/50 ml vl suv, p/f, outer	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	

Medications	Coverage Level	Restrictions
OYSTER SHELL CALCIUM 500 MG TB U-D, 10X10 (RX)	Formulary	
TRUE OYSTER CALCIUM 500 MG TAB (RX)	Formulary	
Minerals And Electrolytes - Iron Combinations		
ACTIVE FE	Non-Formulary	
CORVITA 150	Non-Formulary	
CORVITE 150	Non-Formulary	
CORVITE FE	Non-Formulary	
FERIVA 21-7 ORAL TABLET 75 MG IRON-175 MG-12 MCG-1 MG	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	
Minerals And Electrolytes - Iron		
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	
ferric citrate 210 mg tablet	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	
ferrous gluconate 324 mg tab (rx)	Formulary	
ferrous sulf 15 mg iron/ml drp (rx)	Formulary	
ferrous sulf 220 mg/5 ml elix (rx)	Formulary	Age Limit (Max 12 Years)
ferrous sulf 44 mg iron/5 ml lq (rx)	Formulary	Age Limit (Max 12 Years)
ferrous sulf ec 324 mg tablet	Formulary	
ferrous sulf ec 325 mg tablet (rx)	Formulary	
ferrous sulf ec 325 mg tablet u-d, inner (rx)	Formulary	

Medications	Coverage Level	Restrictions
ferrous sulf ec 325 mg tablet u-d, outer (rx)	Formulary	
ferrous sulfate 300 mg/5 ml cup	Formulary	Age Limit (Max 12 Years)
ferrous sulfate 300 mg/5 ml cup 100's, u-d	Formulary	Age Limit (Max 12 Years)
ferrous sulfate 300 mg/5 ml cup outer	Formulary	Age Limit (Max 12 Years)
ferrous sulfate 325 mg tablet (rx)	Formulary	
ferrous sulfate 325 mg tablet f/c, green (rx)	Formulary	
ferrous sulfate 325 mg tablet f/c, red (rx)	Formulary	
ferrous sulfate 325 mg tablet u-d,10x10, film coat (rx)	Formulary	
infant iron 15 mg/ml drop (rx)	Formulary	
infant iron 15 mg/ml drop (rx)	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
pharm chc ped iron 15 mg/ml drp (rx)	Non-Formulary	CSHCS Covered
true ferrous sulf ec 324 mg tb	Formulary	
Minerals And Electrolytes - Magnesium Combinations		
BEELITH TABLET	Formulary	
Minerals And Electrolytes - Magnesium		
magnesium chelated 100 mg tab	Non-Formulary	CSHCS Covered
magnesium chl 200 mg/ml vial	Formulary	
magnesium citrate 100 mg tab	Non-Formulary	CSHCS Covered
magnesium gluconate tablet y/f,gluten/f (rx)	Non-Formulary	CSHCS Covered
magnesium oxide 400 mg tablet (otc)	Non-Formulary	CSHCS Covered; OTC
magnesium oxide 400 mg tablet (otc)	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
magnesium oxide 400 mg tablet (rx)	Formulary	OTC
magnesium oxide 400 mg tablet (rx)	Non-Formulary	CSHCS Covered; OTC
magnesium oxide 400 mg tablet inner (rx)	Formulary	OTC
magnesium oxide 400 mg tablet outer (rx)	Formulary	OTC
magnesium oxide 420 mg tablet (rx)	Formulary	Dual Eligible Covered
magnesium oxide 440 mg tablet	Non-Formulary	CSHCS Covered; OTC
magnesium oxide 500 mg tablet p/f,lactose-free (rx)	Formulary	

Medications	Coverage Level	Restrictions
magnesium sulfate 50% 1 g/2 ml sdv, p/f, outer	Formulary	
magnesium sulfate 50% 1 g/2 ml suv, p/f, outer	Formulary	
magnesium sulfate 50% 10g/20 ml outer, suv, p/f	Formulary	
magnesium sulfate 50% 10g/20 ml p/f, suv, outer	Formulary	
magnesium sulfate 50% 25g/50 ml outer, suv, p/f	Formulary	
magnesium sulfate 50% 5 g/10 ml p/f, sdv, outer	Formulary	
magnesium sulfate 50% 5 g/10 ml sdv, p/f, outer	Formulary	
magnesium sulfate injection syringe	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
true magnesium oxide 400 mg tb (rx)	Formulary	OTC
true magnesium oxide 500 mg tb	Non-Formulary	CSHCS Covered
well magnesium oxide 400 mg tb (rx)	Formulary	OTC
Minerals And Electrolytes - Oral Electrolytes		
ORALYTE SOLUTION	Formulary	
PEDIALYTE ELECTROLYTE SINGLES 4'S (RX)	Formulary	
PEDIALYTE FREEZER POPS	Formulary	
PEDIALYTE SOLUTION (RX)	Formulary	
PEDIALYTE SOLUTION READY-TO-USE (RX)	Formulary	
SM PEDIATRIC ELECTROLYTE SOLN (RX)	Formulary	
Minerals And Electrolytes - Phosphate		
K-PHOS NEUTRAL TABLET	Formulary	
PHOS-NAK PACKET OUTER	Non-Formulary	CSHCS Covered
PHOSPHA 250 NEUTRAL TABLET	Formulary	
PHOSPHOROUS 250 MG TABLET	Formulary	

Medications	Coverage Level	Restrictions
PHOSPHOROUS POWDER PACKET OUTER	Non-Formulary	CSHCS Covered
phosphorus-sodium-potassium	Non-Formulary	CSHCS Covered
PHOSPHO-TRIN 250 NEUTRAL TAB	Formulary	
sodium phosphate 15 mmol/5 ml sdv, inner	Formulary	
sodium phosphate 15 mmol/5 ml sdv, outer	Formulary	
sodium phosphate 15 mmol/5 ml suv, inner	Formulary	
sodium phosphate 15 mmol/5 ml suv, outer	Formulary	
sodium phosphate 150 mmol/50 ml inner, suv, p/f	Formulary	
sodium phosphate 150 mmol/50 ml outer, suv, p/f	Formulary	
sodium phosphate 150 mmol/50 ml suv, inner	Formulary	
sodium phosphate 150 mmol/50 ml suv, outer	Formulary	
sodium phosphate 45 mmol/15 ml inner, p/f, suv	Formulary	
sodium phosphate 45 mmol/15 ml inner, sdv	Formulary	
sodium phosphate 45 mmol/15 ml outer, p/f, suv	Formulary	
sodium phosphate 45 mmol/15 ml outer, sdv	Formulary	
sodium phosphate 45 mmol/15 ml suv, inner	Formulary	
sodium phosphate 45 mmol/15 ml suv, outer	Formulary	
sodium-potassium-phos powder	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	

Medications	Coverage Level	Restrictions
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	
potassium chloride oral liquid	Non-Formulary	
potassium chloride oral packet	Non-Formulary	
potassium chloride oral tablet,er particles/crystals 15 meq	Non-Formulary	
potassium cl er 10 meq capsule	Formulary	
potassium cl er 10 meq capsule outer	Formulary	
potassium cl er 10 meq tablet	Formulary	
potassium cl er 10 meq tablet f/c	Formulary	
potassium cl er 10 meq tablet inner	Formulary	
potassium cl er 10 meq tablet outer	Formulary	
potassium cl er 20 meq tablet	Formulary	
potassium cl er 20 meq tablet outer	Formulary	
potassium cl er 8 meq capsule	Formulary	
potassium cl er 8 meq tablet	Formulary	
potassium cl er 8 meq tablet f/c	Formulary	
Minerals And Electrolytes - Sodium Chloride, Oral		
sodium chloride 1 gm tablet (otc)	Non-Formulary	CSHCS Covered; OTC
sodium chloride 1 gm tablet (rx)	Non-Formulary	CSHCS Covered; OTC
Minerals And Electrolytes - Zinc		
ORAZINC 110 MG TABLET	Non-Formulary	CSHCS Covered
ORAZINC 220 MG CAPSULE	Non-Formulary	CSHCS Covered
zinc 50 mg tablet (rx)	Non-Formulary	CSHCS Covered
zinc gluconate 100 mg tablet (rx)	Non-Formulary	CSHCS Covered
zinc sulfate 220 mg (50 mg) cap (rx)	Non-Formulary	CSHCS Covered
zinc sulfate 220 mg capsule (rx)	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
zinc sulfate 50 mg (220 mg) tb (rx)	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	
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	
NESTABS ONE	Non-Formulary	
ONCOVITE TABLET	Formulary	
ONE DAILY MEN'S 50+ TABLET	Formulary	
PRENATE AM	Non-Formulary	

Medications	Coverage Level	Restrictions
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	
l-glutamine 5 gram powder pkt outer	Formulary	PA; 3 Months Allowed; QL (6 packets per 1 day); Age Limit (Min 5 Years)
Nutritional Product - Protein Replacements		
arginine 100% crystals	Formulary	
arginine hcl powder usp (rx)	Formulary	OTC
arginine hcl powder usp,ep (rx)	Formulary	OTC
glutamine powder (rx)	Formulary	OTC
l-arginine hcl powder usp (rx)	Formulary	OTC
l-arginine mono-hcl powder usp (rx)	Formulary	OTC
l-citrulline powder	Formulary	
L-CITRULLINE POWDER (RX)	Formulary	
l-glutamine powder (rx)	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
l-glutamine powder usp (rx)	Formulary	OTC
l-ornithine hcl powder (rx)	Formulary	OTC
lysine hcl powder (rx)	Formulary	
ornithine (l) hcl powder (rx)	Formulary	OTC
Pediatric Vitamins And Mineral Combinations		
CHILDREN'S CHEWABLE COMPLETE	Non-Formulary	
DEKAS PLUS LIQUID	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
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
NANOVM 9-18 POWDER	Non-Formulary	CSHCS Covered
NANOVM T-F POWDER	Non-Formulary	CSHCS Covered
Pediatric Vitamins With Fluoride And Minerals Combinations		
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)
Pediatric Vitamins With Fluoride Combinations		
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)
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)

Medications	Coverage Level	Restrictions
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)
VIT A,C,D-FLUORIDE 0.5 MG/ML	Formulary	Dual Eligible Covered; Age Limit (Max 12 Years)
Pediatric Vitamins		
CHILDREN'S CHEWABLES EXTRA C	Non-Formulary	
MVW COMPLETE FORM MULTIVI SFGL	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL D3000 SFGL	Non-Formulary	CSHCS Covered
MVW COMPLETE FORMUL D5000 SFGL	Non-Formulary	CSHCS Covered
Prenatal Vitamins And Minerals		
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)

Medications	Coverage Level	Restrictions
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	
PRENATAL VITAMINS TABLET W/ FOLIC ACID (RX)	Formulary	
PRENATE ENHANCE	Non-Formulary	
PRENATE RESTORE	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 ULTRA	Non-Formulary	

Medications	Coverage Level	Restrictions
VITAFOL-OB	Non-Formulary	
VITAFOL-OB+DHA	Non-Formulary	
VITAFOL-ONE	Non-Formulary	
WESTAB PLUS TABLET	Formulary	
WESTGEL DHA	Non-Formulary	
Prenatal Vitamins With Low Or No Iron (Less Than 27 Mg)		
PRENATE DHA (FERR ASP GLYCIN)	Non-Formulary	
PRENATE ELITE (IRON ASP GLYC)	Non-Formulary	
PRENATE MINI (FERR ASP GLYCIN)	Non-Formulary	
PRENATE PIXIE	Non-Formulary	
PRENATE STAR	Non-Formulary	
VITAFOL GUMMIES	Non-Formulary	
Sodium Chloride Flushes		
sodium chloride 0.9 % injection	Non-Formulary	
Sodium Chloride Solutions, Concentrated		
sodium chloride 120 meq/30 ml p/f, outer, suv	Formulary	Age Limit (Max 6 Years)
sodium chloride 400 meq/100 ml muv, outer	Formulary	Age Limit (Max 6 Years)
sodium chloride 400 meq/100 ml outer, muv, p/f	Formulary	Age Limit (Max 6 Years)
sodium chloride 800 meq/200 ml outer, muv, p/f	Formulary	Age Limit (Max 6 Years)
Sodium Chloride, Parenteral		
sodium chloride 0.9 % intravenous parenteral solution	Non-Formulary	
sodium chloride 120 meq/30 ml p/f, outer, suv	Formulary	Age Limit (Max 6 Years)
sodium chloride 400 meq/100 ml muv, outer	Formulary	Age Limit (Max 6 Years)
sodium chloride 400 meq/100 ml outer, muv, p/f	Formulary	Age Limit (Max 6 Years)
sodium chloride 800 meq/200 ml outer, muv, p/f	Formulary	Age Limit (Max 6 Years)
Sterile Water For Injection		
water for injection, sterile intravenous	Non-Formulary	
Vitamins - A		
beta carotene 7,500 mcg sfgl (rx)	Non-Formulary	CSHCS Covered
beta-carotene 25,000 unit sfgl softgel (rx)	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
vitamin a 10,000 unit softgel outer (rx)	Non-Formulary	CSHCS Covered
vitamin a 3,000 mcg softgel (rx)	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		
vitamin b-1 100 mg tablet (rx)	Formulary	
Vitamins - B-12 And Folic Acid Combinations		
FOLTRATE	Non-Formulary	
Vitamins - B-12, Cyanocobalamin And Derivatives		
cyanocobalamin (vitamin b-12) nasal	Non-Formulary	
cyanocobalamin 1,000 mcg/ml vl inner, muv	Formulary	
cyanocobalamin 1,000 mcg/ml vl mdv,inner	Formulary	Dual Eligible Covered
cyanocobalamin 1,000 mcg/ml vl muv	Formulary	
cyanocobalamin 1,000 mcg/ml vl muv, outer	Formulary	
cyanocobalamin 1,000 mcg/ml vl muv, outer	Formulary	Dual Eligible Covered
cyanocobalamin 1,000 mcg/ml vl outer	Formulary	Dual Eligible Covered
cyanocobalamin 1,000 mcg/ml vl outer, muv	Formulary	
cyanocobalamin 1,000 mcg/ml vl outer, muv	Formulary	Dual Eligible Covered
cyanocobalamin 1,000 mcg/ml vl outer, muv, p/f	Formulary	
cyanocobalamin 1,000 mcg/ml vl outer,mdv	Formulary	Dual Eligible Covered
cyanocobalamin 10,000 mcg/10 ml mdv, outer	Formulary	Dual Eligible Covered
cyanocobalamin 10,000 mcg/10 ml mdv,outer	Formulary	Dual Eligible Covered
cyanocobalamin 10,000 mcg/10 ml outer, muv	Formulary	
cyanocobalamin 10,000 mcg/10 ml outer, muv	Formulary	Dual Eligible Covered
cyanocobalamin 10,000 mcg/10 ml outer,mdv	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml inner, muv	Formulary	
cyanocobalamin 30,000 mcg/30 ml inner,mdv	Formulary	

Medications	Coverage Level	Restrictions
cyanocobalamin 30,000 mcg/30 ml mdv, outer	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml muv	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml muv, inner	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml muv, outer	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml outer, muv	Formulary	
cyanocobalamin 30,000 mcg/30 ml outer,mdv	Formulary	Dual Eligible Covered
cyanocobalamin 30,000 mcg/30 ml outer,muv	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	
NASCOBAL	Non-Formulary	
Vitamins - B-2, Riboflavin And Derivatives		
cvs vitamin b-2 100 mg tablet	Non-Formulary	CSHCS Covered
riboflavin 100 mg tablet	Non-Formulary	CSHCS Covered
riboflavin 50 mg tablet	Non-Formulary	CSHCS Covered
true vitamin b2 100 mg tablet	Non-Formulary	CSHCS Covered
true vitamin b2 25 mg tablet	Non-Formulary	CSHCS Covered
true vitamin b2 50 mg tablet	Non-Formulary	CSHCS Covered
vitamin b-2 100 mg tablet	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
Vitamins - B-3, Niacin And Derivatives		
niacin 100 mg tablet outer (rx)	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
niacin 500 mg capsule sa (rx)	Formulary	PDL Preferred; 3 Months Allowed; Dual Eligible Covered
niacin 500 mg tablet (rx)	Formulary	PDL Preferred; 3 Months Allowed; OTC
niacin er 500 mg tablet outer (rx)	Formulary	PDL Preferred; 3 Months Allowed
SLO-NIACIN 500 MG TABLET (RX)	Formulary	PDL Preferred; 3 Months Allowed
SLO-NIACIN 750 MG TABLET	Formulary	PDL Preferred
true vitamin b3 500 mg tablet (rx)	Formulary	
Vitamins - B-6, Pyridoxine And Derivatives		
pyridoxine (vitamin b6) oral tablet 50 mg	Non-Formulary	
VITAMIN B-6 ORAL TABLET 100 MG, 50 MG	Non-Formulary	
Vitamins - C, Ascorbic Acid And Derivatives		
vitamin c 500 mg tablet (rx)	Non-Formulary	CSHCS Covered
VITAMIN C 500 MG TABLET (RX)	Non-Formulary	CSHCS Covered
Vitamins - D Derivatives		
CALCIDOL DROPS	Non-Formulary	CSHCS Covered
calcitriol 0.25 mcg capsule	Formulary	
calcitriol 0.25 mcg capsule outer	Formulary	
calcitriol 0.5 mcg capsule	Formulary	
calcitriol 1 mcg/ml solution	Formulary	Age Limit (Max 12 Years)
cholecalciferol (vitamin d3) oral capsule 10 mcg (400 unit)	Non-Formulary	
cvs vitamin d3 50 mcg softgel	Non-Formulary	CSHCS Covered
cvs vitamin d3 50 mcg tablet (rx)	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	
ergocalciferol 200 mcg/ml drop (rx)	Non-Formulary	CSHCS Covered
ergocalciferol 8,000 unit/ml (rx)	Non-Formulary	CSHCS Covered
ft vitamin d3 50 mcg softgel	Non-Formulary	CSHCS Covered
ft vitamin d3 50 mcg tablet (rx)	Non-Formulary	CSHCS Covered

Medications	Coverage Level	Restrictions
infant vitamin d 10 mcg/ml drp (rx)	Non-Formulary	CSHCS Covered
PEDIATRIC D-VITE 10 MCG/ML LIQ	Non-Formulary	CSHCS Covered
ROCALTROL ORAL SOLUTION	Non-Formulary	
true vitamin d3 1,250 mcg tab	Formulary	
true vitamin d3 10 mcg tablet	Formulary	
true vitamin d3 125 mcg cap (rx)	Formulary	
true vitamin d3 125 mcg tablet	Formulary	
true vitamin d3 25 mcg capsule (rx)	Formulary	
true vitamin d3 25 mcg tablet (rx)	Formulary	
true vitamin d3 50 mcg capsule	Formulary	
true vitamin d3 50 mcg tablet (rx)	Formulary	
VITAL-D RX TABLET	Formulary	Dual Eligible Covered
vitamin d2 1.25 mg(50,000 unit)	Formulary	
vitamin d2 1.25 mg(50,000 unit)	Formulary	Dual Eligible Covered
VITAMIN D2 1.25 MG(50,000 UNIT) CAPSULE	Formulary	Dual Eligible Covered
vitamin d2 1.25 mg(50,000 unit) inner	Formulary	
vitamin d2 1.25 mg(50,000 unit) outer	Formulary	Dual Eligible Covered
vitamin d2 1.25 mg(50,000 unit) softgel	Formulary	Dual Eligible Covered
vitamin d3 1,000 unit softgel softgel (rx)	Formulary	
VITAMIN D3 1,000 UNIT TABLET (RX)	Formulary	
VITAMIN D3 1,000 UNIT TABLET (RX)	Non-Formulary	CSHCS Covered
vitamin d3 10 mcg tablet inner	Formulary	
vitamin d3 10 mcg tablet outer	Formulary	
vitamin d3 10 mcg/ml drop (rx)	Formulary	
vitamin d3 10 mcg/ml liquid w/dropper (rx)	Formulary	
vitamin d3 10,000 unit tablet	Non-Formulary	CSHCS Covered
vitamin d3 100,000 unit/gm pwd (rx)	Formulary	
vitamin d3 2,000 unit softgel	Non-Formulary	CSHCS Covered
vitamin d3 2,000 unit softgel inner	Formulary	
vitamin d3 2,000 unit softgel outer	Formulary	
VITAMIN D3 2,000 UNIT SOFTGEL P/F,N,SOFTGEL (RX)	Non-Formulary	CSHCS Covered
vitamin d3 2,000 unit softgel softgel	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	

Medications	Coverage Level	Restrictions
vitamin d3 2,000 unit tablet inner (rx)	Formulary	
vitamin d3 2,000 unit tablet outer (rx)	Formulary	
vitamin d3 25 mcg tablet (rx)	Non-Formulary	CSHCS Covered
VITAMIN D3 25 MCG TABLET P/F, EX-STRENGTH (RX)	Non-Formulary	CSHCS Covered
vitamin d3 400 unit tablet outer	Formulary	
VITAMIN D3 400 UNIT TABLET P/F (RX)	Formulary	
vitamin d3 5,000 unit softgel inner (rx)	Formulary	
vitamin d3 5,000 unit softgel outer (rx)	Formulary	
vitamin d3 5,000 unit tablet outer	Formulary	
vitamin d3 50 mcg capsule	Non-Formulary	CSHCS Covered
vitamin d3 50 mcg softgel	Formulary	
vitamin d3 50 mcg softgel	Non-Formulary	CSHCS Covered
vitamin d3 50 mcg tablet (rx)	Non-Formulary	CSHCS Covered
vitamin d3 50,000 unit capsule (rx)	Formulary	
VITAMIN D3 ORAL CAPSULE 10 MCG (400 UNIT)	Non-Formulary	
WEEKLY-D 1,250 MCG SOFTGEL	Formulary	
well vitamin d3 125 mcg softgl (rx)	Formulary	
well vitamin d3 25 mcg softgel (rx)	Formulary	
well vitamin d3 50 mcg softgel	Formulary	
Vitamins - E		
true vitamin e 180 mg capsule (rx)	Non-Formulary	CSHCS Covered
true vitamin e 450 mg capsule (rx)	Formulary	
true vitamin e 90 mg capsule	Non-Formulary	CSHCS Covered
vitamin e 100 unit tablet	Non-Formulary	CSHCS Covered
vitamin e 100 unit tablet y/f,gluten/f (rx)	Non-Formulary	CSHCS Covered
vitamin e 15 unit/0.3 ml drop	Formulary	
vitamin e 180 mg softgel outer (rx)	Non-Formulary	CSHCS Covered
vitamin e 180 mg(400 unit) sfgl (rx)	Non-Formulary	CSHCS Covered
vitamin e 450 mg softgel (rx)	Formulary	
Vitamins - Folic Acid And Derivatives		
folic acid 1 mg tablet (rx)	Formulary	OTC
folic acid 1 mg tablet (rx)	Formulary	Dual Eligible Covered; OTC
folic acid 1 mg tablet outer (rx)	Formulary	OTC
folic acid 1,000 mcg tablet inner (rx)	Formulary	OTC
folic acid 1,000 mcg tablet outer (rx)	Formulary	OTC

Medications	Coverage Level	Restrictions
folic acid 400 mcg tablet (rx)	Formulary	QL (1 tablet per 1 day)
folic acid 400 mcg tablet outer (rx)	Formulary	QL (1 tablet per 1 day)
folic acid 800 mcg tablet outer (rx)	Formulary	
levomefolate calcium	Benefit Exclusion	
L-METHYLFOLATE FORTE	Benefit Exclusion	
true folic acid 1,600 mcg dfe tb (rx)	Formulary	OTC
Vitamins - Folic Acid Combinations		
ENLYTE	Non-Formulary	
NIVA-FOL TABLET	Non-Formulary	CSHCS Covered; Dual Eligible Covered
WESTAB MAX TABLET	Formulary	Dual Eligible Covered
Vitamins - K, Phytonadione And Derivatives		
phytonadione (vitamin k1) injection solution 10 mg/ml	Non-Formulary	Dual Eligible Covered
phytonadione (vitamin k1) injection syringe	Non-Formulary	
phytonadione 5 mg tablet	Formulary	QL (3 tablets per 30 days)
phytonadione 5 mg tablet	Formulary	Dual Eligible Covered; QL (3 tablets per 30 days)
phytonadione 5 mg tablet outer	Formulary	Dual Eligible Covered; QL (3 tablets per 30 days)
VITAMIN K1 INJECTION	Non-Formulary	Dual Eligible Covered
Endocrine		
Abortifacients Or Cervical Ripening Agents - Prostaglandin Analogs		
CERVIDIL	Non-Formulary	
PREPIDIL	Non-Formulary	
Adrenal Steroid Inhibitors		
ISTURISA ORAL TABLET 1 MG, 5 MG	Non-Formulary	
Adrenocorticotrophic Hormones		
ACTHAR	State Carve Out	
ACTHAR SELFJECT	State Carve Out	
CORTROPHIN GEL	State Carve Out	
Agents To Treat Hypoglycemia (Hyperglycemics)		
BAQSIMI 3 MG SPRAY ONE PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 packs per 30 days)

Medications	Coverage Level	Restrictions
BAQSIMI 3 MG SPRAY TWO PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (1 packs per 30 days)
BAQSIMI 3 MG SPRAY TWO PACK OUTER	Formulary	PDL Preferred; 3 Months Allowed; QL (2 packs per 30 days)
diazoxide 50 mg/ml oral susp	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

Medications	Coverage Level	Restrictions
Amyloidosis Agents- Transthyretin (Ttr) Stabilizer		
VYNDAMAX 61 MG CAPSULE OUTER	Formulary	PA; QL (1 capsule per 1 day); Age Limit (Min 18 Years)
VYNDAQEL 20 MG CAPSULE OUTER	Formulary	PA; QL (4 capsules per 1 day); Age Limit (Min 18 Years)
Amyloidosis Agents-Ttr Suppression, Antisense Oligonucleotide-Based		
TEGSEDI	Non-Formulary	
WAINUA	Non-Formulary	
Androgen - Single Agents		
ANDROGEL 1.62% GEL PUMP	Formulary	PA; PDL Non-Preferred
DEPO-TESTOSTERONE	Non-Formulary	
JATENZO	Non-Formulary	
METHITEST	Non-Formulary	
methyltestosterone oral capsule	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	
testosteron enan 1,000 mg/5 ml mdv	Formulary	QL (5 ML per 28 days)
testosterone 1% (25 mg/2.5 g) pk	Formulary	PA; PDL Non-Preferred
testosterone 1% (25 mg/2.5 g) pk outer	Formulary	PA; PDL Non-Preferred
testosterone 1% (50 mg/5 g) pk	Formulary	PA; PDL Non-Preferred
testosterone 1% (50 mg/5 g) pk outer	Formulary	PA; PDL Non-Preferred
testosterone 1.62% (2.5 g) pkt outer	Formulary	PA; PDL Non-Preferred
testosterone 1.62% gel pump	Formulary	PA; PDL Preferred
testosterone 1.62%(1.25 g) pkt outer	Formulary	PA; PDL Non-Preferred
testosterone 10 mg gel pump	Formulary	PA; PDL Non-Preferred
testosterone 12.5 mg/1.25 gram	Formulary	PA; PDL Non-Preferred
testosterone 12.5 mg/1.25 gram outer	Formulary	PA; PDL Non-Preferred
testosterone 30 mg/1.5 ml pump	Formulary	PA; PDL Non-Preferred
testosterone 50 mg/5 gram gel outer	Formulary	PA; PDL Non-Preferred
testosterone 50 mg/5 gram pkt outer	Formulary	PA; PDL Non-Preferred
testosterone cyp 1,000 mg/10 ml mdv	Formulary	
testosterone cyp 1,000 mg/10 ml muv	Formulary	
testosterone cyp 2,000 mg/10 ml mdv	Formulary	
testosterone cyp 2,000 mg/10 ml muv	Formulary	

Medications	Coverage Level	Restrictions
testosterone cyp 2,000 mg/10 ml muv, outer, in oil	Formulary	
testosterone cyp 200 mg/ml sdv	Formulary	
testosterone cyp 200 mg/ml suv	Formulary	
testosterone cyp 200 mg/ml suv, in oil	Formulary	
testosterone enan 200 mg/ml mdv	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	
Antidiuretic And Vasopressor Hormones		
DDAVP ORAL	Non-Formulary	
desmopressin 0.01% solution 50 doses	Formulary	PA
desmopressin 10 mcg/0.1 ml spr	Formulary	PA
desmopressin acetate 0.1 mg tb	Formulary	QL (6 tablets per 1 day)
desmopressin acetate 0.1 mg tb outer	Formulary	QL (6 tablets per 1 day)
desmopressin acetate 0.2 mg tb	Formulary	QL (6 tablets per 1 day)
desmopressin acetate 0.2 mg tb outer	Formulary	QL (6 tablets per 1 day)
NOCDURNA (MEN)	Non-Formulary	
NOCDURNA (WOMEN)	Non-Formulary	
Antihyperglycemic - Alpha-Glucosidase Inhibitors		
acarbose 100 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
acarbose 25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
acarbose 50 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
miglitol 100 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
miglitol 25 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
miglitol 50 mg tablet	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
Antihyperglycemic - Amylin Analog-Type		
SYMLINPEN 120 PEN INJECTOR SUV	Formulary	PDL Preferred; 3 Months Allowed
SYMLINPEN 60 PEN INJECTOR SUV	Formulary	PDL Preferred; 3 Months Allowed
Antihyperglycemic - Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors		
alogliptin 12.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin 25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin 6.25 mg tablet	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
saxagliptin hcl 2.5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
saxagliptin hcl 5 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin 100 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin 25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin 50 mg tablet	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
Antihyperglycemic - Dopamine Receptor Agonists		
CYCLOSET	Non-Formulary	
Antihyperglycemic - Dual Gip And Glp-1 Receptor Agonists		
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)
Antihyperglycemic - Dual Sglt1 And Sglt2 Inhibitors		
INPEFA 200 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
INPEFA 400 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperglycemic - Glucagon-Like Peptide-1 (Glp-1) Receptor Agonists		
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)
exenatide 10 mcg dose pen inj	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2.4 ML per 30 days)
exenatide 5 mcg dose pen inj	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1.2 ML per 30 days)
liraglutide 2-pak 18 mg/3 ml outer, suv	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (6 ML per 30 days)
liraglutide 3-pak 18 mg/3 ml outer, suv	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)

Medications	Coverage Level	Restrictions
RYBELSUS 14 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 tablet per 1 day)
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)
Antihyperglycemic - Glucocorticoid (Cortisol) Receptor Blocker (Gr-li)		
KORLYM	Non-Formulary	
mifepristone oral tablet 300 mg	Non-Formulary	
Antihyperglycemic - Meglitinide Analogs		
nateglinide 120 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nateglinide 120 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
nateglinide 60 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
nateglinide 60 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
repaglinide 0.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
repaglinide 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
repaglinide 1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
repaglinide 2 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
Antihyperglycemic - Sglt-2 Inhibitor And Biguanide Combinations		
dapagliflozin-metformin er 10-1,000 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
dapagliflozin-metformin er 5-1,000 mg tablet	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

Medications	Coverage Level	Restrictions
SYNJARDY XR 10-1,000 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed
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
Antihyperglycemic - Sglt-2 Inhibitor And Dpp-4 Inhibitor Combinations		
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
Antihyperglycemic - Sodium Glucose Cotransporter-2 (Sglt2) Inhibitors		
dapagliflozin 10 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
dapagliflozin 5 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
FARXIGA 10 MG TABLET	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
FARXIGA 10 MG TABLET F/C	Formulary	PDL Preferred; 3 Months Allowed
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
Antihyperglycemic - Sulfonylurea And Biguanide Combinations		
glipizide-metformin 2.5-250 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
glipizide-metformin 2.5-500 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
glipizide-metformin 5-500 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
glyburide-metformin 1.25 mg-250 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
glyburide-metformin 2.5-500 mg f/c	Formulary	PDL Preferred; 3 Months Allowed
glyburide-metformin 5-500 mg f/c	Formulary	PDL Preferred; 3 Months Allowed
glyburid-metformin 1.25-250 mg f/c	Formulary	PDL Preferred; 3 Months Allowed
Antihyperglycemic - Sulfonylurea Derivatives		
glimepiride 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
glimepiride 1 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed

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

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

Medications	Coverage Level	Restrictions
Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibit And Thiazolidinedione		
alogliptin-pioglit 12.5-30 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin-pioglit 25-15 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin-pioglit 25-30 mg tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin-pioglit 25-45 mg tb	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
Antihyperglycemic-Dipeptidyl Peptidase-4(Dpp-4)Inhibitor And Biguanide		
alogliptin-metformin 12.5-1000	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
alogliptin-metformin 12.5-500	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
saxagliptin-metformin er 2.5-1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
saxagliptin-metformin er 5-1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
saxagliptin-metformin er 5-500 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin-metformin 50 mg-1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin-metformin 50 mg-500 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin-metformin er 100 mg-1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin-metformin er 50 mg-1,000 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sitagliptin-metformin er 50 mg-500 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIMET 50-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIMET 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ZITUVIMET XR 100-1,000 MG TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIMET XR 50-1,000 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ZITUVIMET XR 50-500 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Antihyperglycemic-Insulin, Long Acting And Glp-1 Receptor Agonist Comb		
SOLIQUA 100 UNIT-33 MCG/ML PEN	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (15 ML per 25 days)
XULTOPHY 100 UNIT-3.6 MG/ML PEN	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (15 ML per 30 days)
Antihyperglycemic-Sglt-2 Inhibitor, Dpp-4 Inhibitor And Biguanide Comb		
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
Antithyroid Agents, Thionamides - Imidazole Derivatives		
methimazole 10 mg tablet	Formulary	
methimazole 10 mg tablet outer	Formulary	
methimazole 5 mg tablet	Formulary	
methimazole 5 mg tablet outer	Formulary	
Antithyroid Agents, Thionamides - Thiouracil Derivatives		
propylthiouracil 50 mg tablet	Formulary	
propylthiouracil 50 mg tablet bulk package	Formulary	
propylthiouracil 50 mg tablet outer	Formulary	
Bone Formation Stimulating Agents - Natriuretic Peptide		
VOXZOGO	State Carve Out	

Medications	Coverage Level	Restrictions
Bone Formation Stimulating Agents - Parathyroid Hormone Rel Peptides		
TYMLOS 80 MCG DOSE PEN INJECTR OUTER, SUV	Formulary	PA; PDL Non-Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type		
BONSITY 560 MCG/2.24 ML PEN	Formulary	PA; PDL Non-Preferred
FORTEO 560 MCG/2.24 ML PEN INJ SUV	Formulary	PA; PDL Non-Preferred
teriparatide 560 mcg/2.24 ml pen	Formulary	PA; PDL Non-Preferred
teriparatide 620 mcg/2.48 ml	Formulary	PA; PDL Non-Preferred
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)
alendronate sod 70 mg/75 ml	Formulary	PA; PDL Non-Preferred
alendronate sodium 10 mg tab	Formulary	PDL Preferred
alendronate sodium 35 mg tab	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
alendronate sodium 35 mg tab once weekly	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
alendronate sodium 35 mg tab u-u	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
alendronate sodium 5 mg tablet	Formulary	PDL Preferred
alendronate sodium 70 mg tab	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
alendronate sodium 70 mg tab once weekly	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
alendronate sodium 70 mg tab outer	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)

Medications	Coverage Level	Restrictions
alendronate sodium 70 mg tab u-u	Formulary	PDL Preferred; QL (0.15 tablets per 1 day)
ATELVIA 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)
ibandronate sodium 150 mg tab	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
ibandronate sodium 150 mg tab f/c, inner	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
ibandronate sodium 150 mg tab f/c, outer	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
ibandronate sodium 150 mg tab once monthly, u-d	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
ibandronate sodium 150 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (0.04 tablets per 1 day)
risedronate sod dr 35 mg tab	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sod dr 35 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 150 mg tab	Formulary	PA; PDL Non-Preferred
risedronate sodium 150 mg tab f/c, once-a-month	Formulary	PA; PDL Non-Preferred
risedronate sodium 150 mg tab f/c,once-a-month	Formulary	PA; PDL Non-Preferred
risedronate sodium 150 mg tab outer	Formulary	PA; PDL Non-Preferred
risedronate sodium 30 mg tab	Formulary	PA; PDL Non-Preferred
risedronate sodium 35 mg tab	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 35 mg tab f/c, once-a-week	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 35 mg tab outer	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 35 mg tablet	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 35 mg tablet f/c, once-a-week	Formulary	PA; PDL Non-Preferred; QL (4 tablets per 28 days)
risedronate sodium 5 mg tablet	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer		
cinacalcet hcl 30 mg tablet	Formulary	PA; QL (2 tablets per 1 day)
cinacalcet hcl 30 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day)
cinacalcet hcl 60 mg tablet	Formulary	PA; QL (2 tablets per 1 day)
cinacalcet hcl 90 mg tablet	Formulary	PA; QL (4 tablets per 1 day)
SENSIPAR	Non-Formulary	
Calcitonins		
calcitonin-salmon 200 unit spr	Formulary	PDL Preferred
calcitonin-salmon 200 unit spr 30 dose bottle	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		
estrogens-methyltestosterone	Non-Formulary	
Estrogen-Progestin		
ACTIVELLA	Non-Formulary	
BIJUVA ORAL CAPSULE 1-100 MG	Non-Formulary	
CLIMARA PRO	Non-Formulary	
COMBIPATCH	Non-Formulary	
estradiol-noreth 0.5-0.1 mg tb coated	Formulary	Age Limit (Max 64 Years)
estradiol-noreth 0.5-0.1 mg tb inner	Formulary	Age Limit (Max 64 Years)
estradiol-noreth 0.5-0.1 mg tb outer	Formulary	Age Limit (Max 64 Years)
estradiol-noreth 1-0.5 mg tab f/c	Formulary	Age Limit (Max 64 Years)
estradiol-noreth 1-0.5 mg tab inner	Formulary	Age Limit (Max 64 Years)
estradiol-noreth 1-0.5 mg tab outer	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	
norethind-eth estrad 0.5-2.5 outer	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
norethin-eth estrad 1 mg-5 mcg	Formulary	Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
norethin-eth estrad 1 mg-5 mcg outer	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)
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	
estradiol 0.025 mg patch(1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.025 mg patch(2/wk) outer	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.0375 mg patch(1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
estradiol 0.0375 mg patch(2/wk) outer	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.05 mg patch (1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.05 mg patch (2/wk) outer	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.06 mg patch (1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.075 mg patch(1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.075 mg patch(2/wk) outer	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.1 mg patch (1/wk) outer	Formulary	QL (4 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.1 mg patch (2/wk) outer	Formulary	QL (8 patches per 28 days); Age Limit (Max 64 Years)
estradiol 0.5 mg tablet	Formulary	Age Limit (Max 64 Years)
estradiol 1 mg tablet	Formulary	Age Limit (Max 64 Years)
estradiol 2 mg tablet	Formulary	Age Limit (Max 64 Years)
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 %)	Non-Formulary	
estradiol valerate 100 mg/5 ml muv	Formulary	
estradiol valerate 200 mg/5 ml muv	Formulary	
estradiol valerate 50 mg/5 ml muv	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)

Medications	Coverage Level	Restrictions
PREMARIN 1.25 MG TABLET	Formulary	QL (1 tablet per 1 day); Age Limit (Max 64 Years)
VIVELLE-DOT	Non-Formulary	
Fertility Enhancer - Luteal Phase Supporting, Progesterone-Type		
CRINONE 8% GEL OUTER	Formulary	PA; PDL Non-Preferred
Glucocorticoid Salt Combinations		
betamethasone acet,sod phos	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	
cortisone	Non-Formulary	
deflazacort 18 mg tablet	Formulary	
deflazacort 22.75 mg/ml susp	Formulary	
deflazacort 30 mg tablet	Formulary	
deflazacort 36 mg tablet	Formulary	
deflazacort 6 mg tablet	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	
dexamethasone 0.5 mg tablet	Formulary	
dexamethasone 0.5 mg tablet u-d, 10x10, blister	Formulary	
dexamethasone 0.5 mg/5 ml elx	Formulary	
dexamethasone 0.5 mg/5 ml liq	Formulary	
dexamethasone 0.75 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
dexamethasone 0.75 mg tablet u-d, 10x10, blister	Formulary	
dexamethasone 1 mg tablet	Formulary	
dexamethasone 1.5 mg tablet	Formulary	
dexamethasone 10 day 1.5 mg tb	Formulary	
dexamethasone 10 mg/ml syringe outer, suv, p/f	Formulary	
dexamethasone 10 mg/ml syringe suv, p/f	Formulary	
dexamethasone 10 mg/ml vial 25's,inner	Formulary	
dexamethasone 10 mg/ml vial 25's,outer	Formulary	
dexamethasone 10 mg/ml vial outer	Formulary	
dexamethasone 100 mg/10 ml vl 10's,mdv	Formulary	
dexamethasone 100 mg/10 ml vl mdv,outer	Formulary	
dexamethasone 100 mg/10 ml vl outer, muv	Formulary	
dexamethasone 100 mg/10 ml vl outer,muv	Formulary	
dexamethasone 120 mg/30 ml vl mdv	Formulary	
dexamethasone 120 mg/30 ml vl mdv, outer	Formulary	
dexamethasone 120 mg/30 ml vl outer, muv	Formulary	
dexamethasone 13 day 1.5 mg tb	Formulary	
dexamethasone 2 mg tablet	Formulary	
dexamethasone 2 mg tablet outer	Formulary	
dexamethasone 20 mg/5 ml vial mdv	Formulary	
dexamethasone 20 mg/5 ml vial mdv, outer	Formulary	
dexamethasone 20 mg/5 ml vial muv	Formulary	
dexamethasone 20 mg/5 ml vial outer	Formulary	
dexamethasone 20 mg/5 ml vial outer, muv	Formulary	
dexamethasone 20 mg/5 ml vial outer,muv	Formulary	
dexamethasone 4 mg tablet	Formulary	
dexamethasone 4 mg tablet outer	Formulary	
dexamethasone 4 mg/ml syringe outer, suv	Formulary	
dexamethasone 4 mg/ml syringe p/f, suv	Formulary	
dexamethasone 4 mg/ml vial outer	Formulary	
dexamethasone 4 mg/ml vial outer, muv	Formulary	
dexamethasone 4 mg/ml vial outer, sdv	Formulary	
dexamethasone 4 mg/ml vial outer, suv	Formulary	
dexamethasone 4 mg/ml vial sdv	Formulary	
dexamethasone 4 mg/ml vial sdv,outer	Formulary	

Medications	Coverage Level	Restrictions
dexamethasone 4 mg/ml vial suv	Formulary	
dexamethasone 6 day 1.5 mg tab	Formulary	
dexamethasone 6 mg tablet	Formulary	
dexamethasone 6 mg tablet outer	Formulary	
dexamethasone 6 mg tablet u-d, 10x10, blister	Formulary	
DEXAMETHASONE INTENSOL 1 MG/ML	Formulary	
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	
hydrocortisone 10 mg tablet	Formulary	
hydrocortisone 10 mg tablet outer	Formulary	
hydrocortisone 20 mg tablet	Formulary	
hydrocortisone 20 mg tablet outer	Formulary	
hydrocortisone 5 mg tablet	Formulary	
hydrocortisone 5 mg tablet outer	Formulary	
hydrocortisone ss 100 mg vial	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	
methylprednisolone 16 mg tab	Formulary	
methylprednisolone 200 mg/5 ml muv	Formulary	
methylprednisolone 32 mg tab	Formulary	
methylprednisolone 4 mg dosepk	Formulary	

Medications	Coverage Level	Restrictions
methylprednisolone 4 mg dosepk dosepack	Formulary	
methylprednisolone 4 mg dosepk dosepak	Formulary	
methylprednisolone 4 mg tablet	Formulary	
methylprednisolone 4 mg tablet outer	Formulary	
methylprednisolone 40 mg/ml vl inner, suv	Formulary	
methylprednisolone 40 mg/ml vl outer, suv	Formulary	
methylprednisolone 400 mg/10 ml inner, muv	Formulary	
methylprednisolone 400 mg/10 ml muv	Formulary	
methylprednisolone 400 mg/10 ml outer, muv	Formulary	
methylprednisolone 400 mg/5 ml inner, muv	Formulary	
methylprednisolone 400 mg/5 ml muv	Formulary	
methylprednisolone 400 mg/5 ml outer, muv	Formulary	
methylprednisolone 8 mg tablet	Formulary	
methylprednisolone 80 mg/ml vl inner, suv	Formulary	
methylprednisolone 80 mg/ml vl outer, suv	Formulary	
methylprednisolone ss 1 gm vl mdv	Formulary	
methylprednisolone ss 1 gm vl muv	Formulary	
methylprednisolone ss 125 mg outer, suv	Formulary	
methylprednisolone ss 125 mg sdv,outer	Formulary	
methylprednisolone ss 40 mg vl outer, suv	Formulary	
methylprednisolone ss 40 mg vl sdv,outer	Formulary	
methylprednisolone ss 500 mg muv	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	
prednisolone 10 mg/5 ml soln	Formulary	
prednisolone 15 mg/5 ml soln	Formulary	
prednisolone 15 mg/5 ml soln	Formulary	
prednisolone 15 mg/5 ml soln cup outer	Formulary	
prednisolone 15 mg/5 ml soln d/f	Formulary	
prednisolone 15 mg/5 ml solution cup outer	Formulary	
prednisolone 20 mg/5 ml soln	Formulary	
prednisolone 5 mg tablet	Formulary	
prednisolone 5 mg/5 ml soln	Formulary	
prednisolone 5 mg/5 ml soln outer	Formulary	

Medications	Coverage Level	Restrictions
prednisolone odt 10 mg tablet	Formulary	
prednisolone odt 15 mg tablet	Formulary	
prednisolone odt 30 mg tablet	Formulary	
prednisolone sod ph 25 mg/5 ml	Formulary	
prednisone 1 mg tablet	Formulary	
prednisone 10 mg tab dose pack	Formulary	
prednisone 10 mg tab dose pack dose pack	Formulary	
prednisone 10 mg tablet	Formulary	
prednisone 10 mg tablet outer	Formulary	
prednisone 2.5 mg tablet	Formulary	
prednisone 20 mg tablet	Formulary	
prednisone 20 mg tablet outer	Formulary	
prednisone 5 mg tab dose pack	Formulary	
prednisone 5 mg tab dose pack dose-pack	Formulary	
prednisone 5 mg tablet	Formulary	
prednisone 5 mg tablet outer	Formulary	
prednisone 5 mg/5 ml solution	Formulary	
prednisone 50 mg tablet	Formulary	
prednisone 50 mg tablet outer	Formulary	
prednisone 50 mg tablet u-d, 10x10	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	

Medications	Coverage Level	Restrictions
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	
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	
triamcinolone acet 200 mg/5 ml inner, muv	Formulary	
triamcinolone acet 200 mg/5 ml mdv	Formulary	
triamcinolone acet 200 mg/5 ml muv	Formulary	
triamcinolone acet 200 mg/5 ml outer, muv	Formulary	
triamcinolone acet 40 mg/ml vl inner, suv	Formulary	
triamcinolone acet 40 mg/ml vl outer, suv	Formulary	
triamcinolone acet 40 mg/ml vl outer,suv	Formulary	
triamcinolone acet 40 mg/ml vl suv	Formulary	
triamcinolone acet 40 mg/ml vl suv, outer	Formulary	
triamcinolone acet 40 mg/ml vl suv,outer	Formulary	
triamcinolone acet 400 mg/10 ml inner, muv	Formulary	
triamcinolone acet 400 mg/10 ml mdv	Formulary	
triamcinolone acet 400 mg/10 ml muv	Formulary	
triamcinolone acet 400 mg/10 ml outer, muv	Formulary	
Gonadotropin Inhibitor Pituitary Suppressants		
danazol 100 mg capsule	Formulary	
danazol 200 mg capsule	Formulary	
danazol 50 mg capsule	Formulary	

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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
Human Insulins - Fixed Combinations		
HUMULIN 70/30 KWIKPEN INNER, SINGLE USE	Formulary	PDL Preferred; 3 Months Allowed; OTC; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
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)
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)
Human Insulins - Intermediate Acting		
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)
Human Insulins - Rapid Acting		
AFREZZA ((REGULAR INSULIN) 8 UNIT CARTRIDGE	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
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
AFREZZA (REGULAR INSULIN) 90-8 UNIT / 90-12 UNIT	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Human Insulins - Short Acting		
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)
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)
Insulin Analogs - Fixed Combinations		
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)

Medications	Coverage Level	Restrictions
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)
insulin aspart protamine-insulin aspart mix 70-30 flexpen outer,suv	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin aspart protamine-insulin aspart mix 70-30 vial	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin lispro mix 75-25 kwkpn suv, outer	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)
Insulin Analogs - Long Acting		
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)
insulin degludec 100 unit/ml vial	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin degludec flextouch 100 unit/ml pen suv, outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)

Medications	Coverage Level	Restrictions
insulin degludec flextouch 200 unit/ml pen suv, outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin glargine max solo u300 outer, suv	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin glargine solostar u300 outer, suv	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin glargine-yfgn u100 pen outer, suv	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin glargine-yfgn u100 vl	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)

Medications	Coverage Level	Restrictions
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)
TRESIBA FLEXTOUCH 200 UNIT/ML SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
Insulin Analogs - Rapid Acting		
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)

Medications	Coverage Level	Restrictions
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)
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)
insulin aspart 100 unit/ml vl	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin aspart flexpen 100 unit/ml pen outer,suv	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin aspart penfill 100 unit/ml cartridge outer,suv	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin lispro 100 unit/ml kwikpen suv, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin lispro 100 unit/ml vl	Formulary	PDL Preferred; 3 Months Allowed; QL (90 ML per 30 days)
insulin lispro jr 100 unit/ml kwikpen suv, outer	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)

Medications	Coverage Level	Restrictions
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)
MERILOG 100 UNIT/ML VIAL	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
MERILOG SOLOSTAR 100 UNIT/ML INNER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
MERILOG SOLOSTAR 100 UNIT/ML OUTER, SUV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (90 ML per 30 days)
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)
Insulin Response Enhancers - Biguanides		
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
metformin er 1,000 mg gastr-tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin er 1,000 mg osm-tab	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin er 1,000 mg osm-tab f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
metformin er 500 mg gastrc-tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin er 500 mg osmotic tb	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin hcl 1,000 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 1,000 mg tablet 12's, f/c	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 1,000 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 1,000 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 1,000 mg tablet f/c,blackberry scent	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 500 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 500 mg tablet f/c,blackberry scent	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 500 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 500 mg/5 ml soln	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin hcl 500 mg/5 ml solution cup outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin hcl 625 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin hcl 750 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
metformin hcl 850 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 850 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 850 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl 850 mg tablet f/c,blackberry scent	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl er 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
metformin hcl er 500 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl er 750 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
metformin hcl er 750 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
RIOMET 500 MG/5 ML SOLUTION	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Insulin Response Enhancers - Thiazolidinediones (Ppar-Gamma Agonists)		
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
pioglitazone hcl 15 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pioglitazone hcl 15 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
pioglitazone hcl 30 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
pioglitazone hcl 45 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
Insulin-Like Growth Factor-1 (Igf-1)		
INCRELEX 40 MG/4 ML VIAL	Formulary	PA
Leptin Hormone Analogs		
MYALEPT	State Carve Out	
Lhrh (Gnrh) Agonist Analog Pit Suppres - Central Precocious Puberty		
FENSOLVI	Non-Formulary	
LUPRON DEPOT-PED (3 MONTH)	Non-Formulary	
LUPRON DEPOT-PED INTRAMUSCULAR KIT	Non-Formulary	
TRIPTODUR	Non-Formulary	
Lhrh (Gnrh) Agonist Analog Pituitary Suppressants		
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	Non-Formulary	

Medications	Coverage Level	Restrictions
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	Non-Formulary	
SYNAREL	Non-Formulary	
Lhrh (Gnrh) Antagonist, Estrogen And Progestin Combinations		
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)
Lhrh (Gnrh) Antagonists		
ORILISSA 150 MG TABLET	Formulary	PA; PDL Preferred; QL (28 tablets per 28 days); Age Limit (Min 18 Years)
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	
paroxetine mesylate(menop.sym)	State Carve Out	
Mineralocorticoids		
fludrocortisone 0.1 mg tablet	Formulary	
fludrocortisone 0.1 mg tablet outer	Formulary	
Oxytocic - Ergot Alkaloids		
methylergonovine 0.2 mg tablet	Formulary	QL (28 tablets per 180 days); Age Limit (Min 12 Years)
methylergonovine 0.2 mg tablet outer	Formulary	QL (28 tablets per 180 days); Age Limit (Min 12 Years)

Medications	Coverage Level	Restrictions
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
medroxyprogesterone 10 mg tab	Formulary	PDL Preferred; 3 Months Allowed
medroxyprogesterone 10 mg tab outer	Formulary	PDL Preferred; 3 Months Allowed
medroxyprogesterone 2.5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
medroxyprogesterone 5 mg tab	Formulary	PDL Preferred; 3 Months Allowed
norethindrone 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
progesterone 100 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
progesterone 200 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
progesterone 500 mg/10 ml vial mdv,in sesame oil	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
progesterone 500 mg/10 ml vial mdv,sesame oil	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
progesterone 500 mg/10 ml vial muv	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

Medications	Coverage Level	Restrictions
Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists		
cabergoline 0.5 mg tablet	Formulary	
Selective Estrogen Receptor Modulators (Serms)		
EVISTA 60 MG TABLET	Formulary	PA; PDL Non-Preferred
raloxifene hcl 60 mg tablet	Formulary	PDL Preferred
raloxifene hcl 60 mg tablet f/c	Formulary	PDL Preferred
raloxifene hcl 60 mg tablet outer	Formulary	PDL Preferred
Somatostatic Agents		
lanreotide subcutaneous syringe 120 mg/0.5 ml	Non-Formulary	
MYCAPSSA	Non-Formulary	
octreotide 1,000 mcg/5 ml vial mdv	Formulary	PA
octreotide 1,000 mcg/5 ml vial muv	Formulary	PA
octreotide 5,000 mcg/5 ml vial mdv	Formulary	PA
octreotide 5,000 mcg/5 ml vial muv	Formulary	PA
octreotide acet 100 mcg/ml vl inner, p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl outer, p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl outer, suv, p/f	Formulary	PA
octreotide acet 100 mcg/ml vl p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl sdv, outer	Formulary	PA
octreotide acet 100 mcg/ml vl suv, p/f	Formulary	PA
octreotide acet 50 mcg/ml vial 10's,suv	Formulary	PA
octreotide acet 50 mcg/ml vial inner, p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial outer, p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial outer, p/f, suv	Formulary	PA
octreotide acet 50 mcg/ml vial p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial sdv	Formulary	PA
octreotide acet 50 mcg/ml vial suv, p/f	Formulary	PA
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	

Medications	Coverage Level	Restrictions
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 20 MG, 30 MG, 60 MG	Non-Formulary	
SOMATULINE DEPOT	Non-Formulary	
Thyroid Hormones - Animal Source (Porcine)		
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	
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	

Medications	Coverage Level	Restrictions
RENTHYROID 60 MG TABLET	Formulary	
RENTHYROID 90 MG TABLET	Formulary	
thyroid 120 mg tablet	Formulary	
thyroid 15 mg tablet	Formulary	
thyroid 30 mg tablet	Formulary	
thyroid 60 mg tablet	Formulary	
thyroid 90 mg tablet	Formulary	
Thyroid Hormones - Synthetic T3 (Triiodothyronine)		
CYTOMEL 25 MCG TABLET	Formulary	
CYTOMEL 5 MCG TABLET	Formulary	
CYTOMEL 50 MCG TABLET	Formulary	
liothyronine sod 25 mcg tab	Formulary	
liothyronine sod 5 mcg tab	Formulary	
liothyronine sod 50 mcg tab	Formulary	
Thyroid Hormones - Synthetic T4 (Thyroxine)		
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	

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

Medications	Coverage Level	Restrictions
levothyroxine 50 mcg tablet outer	Formulary	
levothyroxine 50 mcg tablet u-d,outer,10x10	Formulary	
levothyroxine 75 mcg capsule	Formulary	
levothyroxine 75 mcg tablet	Formulary	
levothyroxine 75 mcg tablet outer	Formulary	
levothyroxine 75 mcg tablet u-d,outer,10x10	Formulary	
levothyroxine 88 mcg capsule	Formulary	
levothyroxine 88 mcg tablet	Formulary	
levothyroxine 88 mcg tablet outer	Formulary	
LEVOXYL 100 MCG TABLET	Formulary	
LEVOXYL 112 MCG TABLET	Formulary	
LEVOXYL 125 MCG TABLET	Formulary	
LEVOXYL 137 MCG TABLET	Formulary	
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	

Medications	Coverage Level	Restrictions
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	
UNITHROID 88 MCG TABLET	Formulary	
Gastrointestinal Therapy Agents		
Agents To Treat Chaple Disease		
VEOPOZ	State Carve Out	
Antacid - Aluminum		
aluminum hydroxide gel	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		
sodium bicarb 325 mg tablet	Formulary	Dual Eligible Covered; OTC
sodium bicarb 650 mg tablet	Formulary	OTC
sodium bicarb 650 mg tablet 10 gr	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

Medications	Coverage Level	Restrictions
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
calcium carb 1,250 mg/5 ml sus n (otc)	Formulary	Dual Eligible Covered; OTC
calcium carbonate 1,250 mg/5 ml suspension cup 40's,u-d (otc)	Formulary	Dual Eligible Covered; OTC
calcium carbonate oral tablet 260 mg calcium (648 mg)	Non-Formulary	OTC
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
Antacid - Magnesium		
magnesium oxide 400 mg tablet (otc)	Non-Formulary	CSHCS Covered; OTC
magnesium oxide 400 mg tablet (otc)	Non-Formulary	CSHCS Covered; Dual Eligible Covered; OTC
magnesium oxide 400 mg tablet (rx)	Formulary	OTC
magnesium oxide 400 mg tablet (rx)	Non-Formulary	CSHCS Covered; OTC
magnesium oxide 400 mg tablet inner (rx)	Formulary	OTC
magnesium oxide 400 mg tablet outer (rx)	Formulary	OTC
true magnesium oxide 400 mg tb (rx)	Formulary	OTC
well magnesium oxide 400 mg tb (rx)	Formulary	OTC
Antacid - Simethicone Combinations		
ALMACONE-2 LIQUID	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
alum-mag hydroxide-simeth 1,200-1,200-120 mg/30 ml cup outer	Formulary	OTC
alum-mag hydroxide-simeth 2,400-2,400-240 mg/30 ml cup outer	Formulary	OTC
alum-mag hydroxide-simeth cup outer	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
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

Medications	Coverage Level	Restrictions
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
loperamide 1 mg/7.5 ml soln	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loperamide 1 mg/7.5 ml solution cup inner	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loperamide 1 mg/7.5 ml solution cup outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loperamide 2 mg capsule (rx)	Formulary	PDL Preferred
loperamide 2 mg capsule (rx)	Formulary	PDL Preferred; Dual Eligible Covered
loperamide 2 mg capsule outer (rx)	Formulary	PDL Preferred
loperamide 2 mg capsule outer (rx)	Formulary	PDL Preferred; Dual Eligible Covered
loperamide 2 mg capsule u-d,10x10,outer (rx)	Formulary	PDL Preferred; Dual Eligible Covered
loperamide 2 mg/15 ml solution cup inner	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loperamide 2 mg/15 ml solution cup outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
opium tincture	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
Antidiarrheal - Bismuth Agents		
bismuth 262 mg tablet chew	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

Medications	Coverage Level	Restrictions
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
Antidiarrheal - Gastrointestinal Chloride Channel Inhibitors		
MYTESI	Non-Formulary	
Antidiarrheal Antiperistaltic-Anticholinergic Combinations		
diphenoxylate-atropine 2.5-0.025 mg tablet	Formulary	PDL Preferred
diphenoxylate-atropine 2.5-0.025 mg/5 ml liquid w/dropper	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
loperamide-simethicone	Non-Formulary	OTC
Antidiarrheal Opioid Agents		
opium tincture	Non-Formulary	
Antiemetic - Anticholinergics		
scopolamine base	Non-Formulary	
TRANSDERM-SCOP	Non-Formulary	
Antiemetic - Antihistamines		
ANTIVERT ORAL TABLET 50 MG	Non-Formulary	
ANTIVERT ORAL TABLET,CHEWABLE	Non-Formulary	
FT MOTION SICKNESS 25 MG TAB	Formulary	OTC
meclizine 12.5 mg caplet (otc)	Formulary	OTC
meclizine 12.5 mg tablet (otc)	Formulary	OTC
meclizine 12.5 mg tablet (rx)	Formulary	OTC
meclizine 12.5 mg tablet outer (rx)	Formulary	OTC
meclizine 25 mg tablet (rx)	Formulary	OTC

Medications	Coverage Level	Restrictions
meclizine 25 mg tablet chew	Formulary	OTC
meclizine 25 mg tablet chew raspberry	Formulary	OTC
meclizine 25 mg tablet outer (rx)	Formulary	OTC
meclizine oral tablet 50 mg	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	
doxylamine-pyridoxine (vit b6)	Non-Formulary	
Antiemetic - Cannabinoid Type		
dronabinol 10 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule outer	Formulary	PA
dronabinol 5 mg capsule	Formulary	PA
dronabinol 5 mg capsule outer	Formulary	PA
MARINOL	Non-Formulary	
Antiemetic - Dopamine (D2) Antagonists		
droperidol injection solution	State Carve Out	
Antiemetic - Dopamine (D2)/5-Ht3 Antagonists		
TIGAN ORAL CAPSULE 300 MG	Non-Formulary	
trimethobenzamide oral	Non-Formulary	
Antiemetic - Phenothiazines		
COMPRO	Non-Formulary	
prochlorperazine 10 mg tab	Formulary	
prochlorperazine 10 mg tab f/c	Formulary	
prochlorperazine 10 mg tab outer	Formulary	
prochlorperazine 25 mg supp	Formulary	QL (2 suppositories per 1 day)
prochlorperazine 25 mg supp outer	Formulary	QL (2 suppositories per 1 day)
prochlorperazine 5 mg tablet	Formulary	
prochlorperazine 5 mg tablet f/c	Formulary	
prochlorperazine 5 mg tablet outer	Formulary	

Medications	Coverage Level	Restrictions
promethazine 12.5 mg suppos	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg suppos outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet outer	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg suppository inner	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg suppository outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet outer	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 6.25 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml solution cup outer	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml syrp	Formulary	Age Limit (Max 64 Years)
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)

Medications	Coverage Level	Restrictions
Antiemetic - Selective Serotonin 5-Ht3 Antagonists		
ANZEMET 50 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (10 tablets per 1 claim)
granisetron hcl 1 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 day)
granisetron hcl 1 mg tablet f/c, 2x10, outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
granisetron hcl 1 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
granisetron hcl 1 mg tablet u-d, f/c	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron 4 mg/5 ml soln cup outer	Formulary	PDL Preferred; QL (75 ML per 1 claim)
ondansetron 4 mg/5 ml solution	Formulary	PDL Preferred; QL (75 mL per 1 claim)
ondansetron 4 mg/5 ml solution cup inner	Formulary	PDL Preferred; QL (75 mL per 1 claim)
ondansetron 4 mg/5 ml solution cup outer	Formulary	PDL Preferred; QL (75 mL per 1 claim)
ondansetron hcl 4 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 4 mg tablet f/c	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 4 mg tablet f/c, 1x3, u-d	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 4 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 8 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 8 mg tablet f/c	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 8 mg tablet f/c, 1x3, u-d	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron hcl 8 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 16 mg tablet	Formulary	PA; PDL Non-Preferred; QL (1 tablet per 1 day)
ondansetron odt 4 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 day)

Medications	Coverage Level	Restrictions
ondansetron odt 4 mg tablet 3x10	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 4 mg tablet 3x10, outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 4 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 8 mg tablet	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 8 mg tablet 3x10	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 8 mg tablet 3x10, outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 8 mg tablet inner	Formulary	PDL Preferred; QL (2 tablets per 1 day)
ondansetron odt 8 mg tablet outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
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		
aprepitant 125 mg capsule outer	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
aprepitant 125-80-80 mg pack	Formulary	PA; PDL Non-Preferred; QL (3 capsules per 1 claim); Age Limit (Min 12 Years)
aprepitant 40 mg capsule inner	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
aprepitant 40 mg capsule outer	Formulary	PDL Preferred; QL (1 capsule per 1 claim); Age Limit (Min 12 Years)
aprepitant 80 mg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 claim); Age Limit (Min 12 Years)
aprepitant 80 mg capsule outer	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)

Medications	Coverage Level	Restrictions
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)
EMEND TRIPACK	Formulary	PA; PDL Non-Preferred; QL (3 capsules per 1 claim); Age Limit (Min 12 Years)
Antiemetic - Substance P-Neurokinin 1 And 5-Ht3 Recept Antagonist Comb		
AKYNZEO 300-0.5 MG CAPSULE	Formulary	PA; PDL Non-Preferred; QL (1 capsule per 1 claim)
Bile Acids		
CHOLBAM	Non-Formulary	
Chronic Idiopathic Const. Agents - Guanylate Cyclase-C (Gc-C) Agonists		
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
Colonic Acidifier (Ammonia Inhibitor)		
ENULOSE	State Carve Out	
GENERLAC	State Carve Out	
lactulose 10 gm/15 ml solution	Formulary	
lactulose 10 gm/15 ml solution	State Carve Out	
Digestive Enzyme Mixtures		
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

Medications	Coverage Level	Restrictions
DIGESTIVE ENZYME (ACIDOPH,PEC)	State Carve Out	
GASTRACID	State Carve Out	
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
Digestive Enzymes		
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	

Medications	Coverage Level	Restrictions
ENZYME DIGEST	State Carve Out	
LACTAID	State Carve Out	
LACTAID FAST ACT	State Carve Out	
lactase	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	
Gallstone Solubilizing (Litholysis) Agents		
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
ursodiol 250 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
ursodiol 250 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
ursodiol 250 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
ursodiol 300 mg capsule	Formulary	PDL Preferred; 3 Months Allowed
ursodiol 300 mg capsule outer	Formulary	PDL Preferred; 3 Months Allowed
ursodiol 500 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
Gastric Acid Secretion Reducer - Histamine H2-Receptor Antagonists		
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
cimetidine 200 mg tablet (rx)	Formulary	OTC
cimetidine 200 mg tablet (rx)	Formulary	Dual Eligible Covered; OTC
cimetidine 300 mg tablet	Formulary	

Medications	Coverage Level	Restrictions
cimetidine 300 mg/5 ml cup outer	Formulary	
cimetidine 300 mg/5 ml soln	Formulary	
cimetidine 400 mg tablet	Formulary	
cimetidine 800 mg tablet	Formulary	
cimetidine 800 mg tablet f/c	Formulary	
famotidine 10 mg tablet	Formulary	OTC
famotidine 10 mg tablet	Formulary	Dual Eligible Covered; OTC
famotidine 20 mg tablet (otc)	Formulary	OTC
famotidine 20 mg tablet (otc)	Formulary	Dual Eligible Covered; OTC
famotidine 20 mg tablet (rx)	Formulary	OTC
famotidine 20 mg tablet (rx)	Formulary	Dual Eligible Covered; OTC
famotidine 20 mg tablet 12's (rx)	Formulary	Dual Eligible Covered; OTC
famotidine 20 mg tablet f/c (rx)	Formulary	Dual Eligible Covered; OTC
famotidine 20 mg tablet inner (otc)	Formulary	OTC
famotidine 20 mg tablet outer (otc)	Formulary	OTC
famotidine 20 mg tablet outer (rx)	Formulary	OTC
famotidine 20 mg tablet outer (rx)	Formulary	Dual Eligible Covered; OTC
famotidine 40 mg tablet	Formulary	
famotidine 40 mg tablet	Formulary	Dual Eligible Covered
famotidine 40 mg tablet f/c	Formulary	
famotidine 40 mg tablet outer	Formulary	
famotidine 40 mg/5 ml susp	Formulary	QL (5 ML per 1 day); Age Limit (Max 6 Years)
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
nizatidine oral capsule	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

Medications	Coverage Level	Restrictions
SM ACID REDUCER 20 MG TABLET MAXIMUM STRENGTH	Formulary	Dual Eligible Covered; OTC
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
dexlansoprazole dr 30 mg cap	Formulary	PA; PDL Non-Preferred
dexlansoprazole dr 60 mg cap	Formulary	PA; PDL Non-Preferred
esomeprazole dr 10 mg packet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 2.5 mg packet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 20 mg packet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 20 mg packet outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 40 mg packet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 40 mg packet outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole dr 5 mg packet	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
esomeprazole mag dr 20 mg cap (otc)	Formulary	PA; PDL Non-Preferred; OTC
esomeprazole mag dr 20 mg cap (rx)	Formulary	PA; PDL Non-Preferred; OTC
esomeprazole mag dr 20 mg cap outer (otc)	Formulary	PA; PDL Non-Preferred; OTC
esomeprazole mag dr 20 mg tab	Formulary	PA; PDL Non-Preferred; OTC
esomeprazole mag dr 40 mg cap	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
FT ACID REDUCER DR 15 MG CAP	Formulary	PA; PDL Non-Preferred; OTC
FT ACID REDUCER DR 20 MG CAP	Formulary	PA; PDL Non-Preferred; OTC
ft omeprazole dr 20 mg tablet	Formulary	PA; PDL Non-Preferred; OTC
gnp esomeprazole mag dr 20 mg (otc)	Formulary	PA; PDL Non-Preferred; OTC
gnp lansoprazole dr 15 mg cap (otc)	Formulary	PA; PDL Non-Preferred; OTC
gnp omeprazole dr 20 mg tablet	Formulary	PA; PDL Non-Preferred; OTC
gnp omeprazole mag dr 20 mg cp	Formulary	PA; PDL Non-Preferred; OTC
gs esomeprazole mag dr 20 mg (otc)	Formulary	PA; PDL Non-Preferred; OTC
gs lansoprazole dr 15 mg cap (otc)	Formulary	PA; PDL Non-Preferred; OTC
gs lansoprazole dr 15 mg cap (otc)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
gs lansoprazole dr 15 mg odt (otc)	Formulary	PA; PDL Non-Preferred; OTC
gs omeprazole dr 20 mg odt	Formulary	PA; PDL Non-Preferred; OTC
gs omeprazole dr 20 mg tablet	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
gs omeprazole dr 20 mg tablet 14 day course	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
hm esomeprazole mag dr 20 mg (otc)	Formulary	PA; PDL Non-Preferred; OTC
lansoprazole dr 15 mg capsule (otc)	Formulary	PA; PDL Non-Preferred; OTC
lansoprazole dr 15 mg capsule (otc)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
lansoprazole dr 15 mg capsule (rx)	Formulary	PA; PDL Non-Preferred; OTC
lansoprazole dr 15 mg capsule (rx)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
lansoprazole dr 15 mg capsule outer (otc)	Formulary	PA; PDL Non-Preferred; OTC
lansoprazole dr 15 mg capsule outer (rx)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
lansoprazole dr 15 mg odt outer (rx)	Formulary	PA; PDL Non-Preferred; OTC
lansoprazole dr 30 mg capsule	Formulary	PA; PDL Non-Preferred
lansoprazole dr 30 mg capsule outer	Formulary	PA; PDL Non-Preferred
lansoprazole dr 30 mg capsule u-d, 10x10	Formulary	PA; PDL Non-Preferred
lansoprazole dr 30 mg capsule u-d,8x10,outer	Formulary	PA; PDL Non-Preferred
lansoprazole dr 30 mg odt outer	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)

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

Medications	Coverage Level	Restrictions
omeprazole mag dr 20.6 mg cap one 14-day course	Formulary	PA; PDL Non-Preferred; OTC
omeprazole mag dr 20.6 mg cap three 14-day course	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
omeprazole mag dr 20.6 mg cap two 14-day course	Formulary	PA; PDL Non-Preferred; OTC
pantoprazole dr 40 mg susp pkt inner	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
pantoprazole dr 40 mg susp pkt outer	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 packets per 1 day)
pantoprazole in 0.9% sod chlor	Non-Formulary	
pantoprazole intravenous	Non-Formulary	
pantoprazole sod dr 20 mg tab	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 20 mg tab f/c	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 20 mg tab outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab enteric-coated	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab f/c	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab outer	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab u-d,10x10	Formulary	PDL Preferred; QL (2 tablets per 1 day)
pantoprazole sod dr 40 mg tab u-d,outer,f/c,10x10	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)

Medications	Coverage Level	Restrictions
PROTONIX DR 20 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day)
PROTONIX DR 40 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day)
PROTONIX INTRAVENOUS	Non-Formulary	
rabeprazole sod dr 20 mg tab	Formulary	PA; PDL Non-Preferred
sm esomeprazole mag dr 20 mg (otc)	Formulary	PA; PDL Non-Preferred; OTC
sm lansoprazole dr 15 mg cap (otc)	Formulary	PA; PDL Non-Preferred; OTC
sm omeprazole dr 20 mg tablet	Formulary	PA; PDL Non-Preferred; OTC
sm omeprazole dr 20 mg tablet 2x14 day course	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
sm omeprazole dr 20 mg tablet 3x14 day course	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		
gs omeprazole-bicarb 20-1,100 (otc)	Formulary	PA; PDL Non-Preferred; OTC
KONVOMEP 2-84 MG/ML ORAL SUSP OUTER	Formulary	PA; PDL Non-Preferred
omeprazole-bicarb 20-1,100 cap (rx)	Formulary	PA; PDL Non-Preferred; OTC
omeprazole-bicarb 20-1,680 pkt	Formulary	PA; PDL Non-Preferred
omeprazole-bicarb 20-1,680 pkt outer	Formulary	PA; PDL Non-Preferred
omeprazole-bicarb 40-1,100 cap	Formulary	PA; PDL Non-Preferred
omeprazole-bicarb 40-1,680 pkt	Formulary	PA; PDL Non-Preferred
omeprazole-bicarb 40-1,680 pkt outer	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	
misoprostol 100 mcg tablet	Formulary	

Medications	Coverage Level	Restrictions
misoprostol 100 mcg tablet outer	Formulary	
misoprostol 200 mcg tablet	Formulary	
misoprostol 200 mcg tablet inner	Formulary	
misoprostol 200 mcg tablet outer	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
prucalopride 1 mg tablet	Formulary	PA; PDL Non-Preferred
prucalopride 2 mg tablet	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	
metoclopramide 10 mg tablet	Formulary	
metoclopramide 10 mg tablet outer	Formulary	
metoclopramide 10 mg/10 ml solution cup	Formulary	
metoclopramide 10 mg/10 ml solution cup outer	Formulary	
metoclopramide 5 mg tablet	Formulary	
metoclopramide 5 mg tablet outer	Formulary	
metoclopramide 5 mg/5 ml soln	Formulary	
REGLAN ORAL	Non-Formulary	
Gi Antispasmodic - Belladonna Alkaloids		
ANASPAZ 0.125 MG TABLET ODT	Formulary	Age Limit (Max 64 Years)
atropine injection syringe 0.1 mg/ml	Non-Formulary	
ED-SPAZ 0.125 MG ODT	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg odt	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg tab sl	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg/5 ml elix	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg/ml drop	Formulary	Age Limit (Max 64 Years)
hyoscyamine er 0.375 mg tab	Formulary	Age Limit (Max 64 Years)
hyoscyamine sulf 0.125 mg tab	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	
methscopolamine	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	
Gi Antispasmodic - Quaternary Ammonium Compounds		
GLYCATE	Non-Formulary	
glycopyrrolate 1 mg tablet	Formulary	
glycopyrrolate 2 mg tablet	Formulary	
ROBINUL FORTE	Non-Formulary	
ROBINUL ORAL	Non-Formulary	
Gi Antispasmodic - Synthetic Tertiary Amines		
dicyclomine 10 mg capsule	Formulary	Age Limit (Max 64 Years)
dicyclomine 10 mg capsule outer	Formulary	Age Limit (Max 64 Years)
dicyclomine 10 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
dicyclomine 20 mg tablet	Formulary	Age Limit (Max 64 Years)
dicyclomine 20 mg tablet outer	Formulary	Age Limit (Max 64 Years)
Gi Antispasmodic And Benzodiazepine Combinations		
chlordiazepoxide-clidinium	Non-Formulary	
LIBRAX (WITH CLIDINIUM)	Non-Formulary	
Gi Antispasmodic And Opioid Combinations		
belladonna alkaloids-opium	Non-Formulary	
Gi Antispasmodic Combinations Other		
belladonna alkaloids-opium	Non-Formulary	
chlordiazepoxide-clidinium	Non-Formulary	
LIBRAX (WITH CLIDINIUM)	Non-Formulary	
H. Pylori Therapy - Bismuth And Antibiotics Combinations		
bismuth-metronidazole-tetracycline 140-125-125 mg capsule	Formulary	PA; Brand Preferred; PDL Non-Preferred

Medications	Coverage Level	Restrictions
bismuth-metronidazole-tetracycline 140-125-125 mg capsule outer	Formulary	PA; Brand Preferred; PDL Non-Preferred
PYLERA CAPSULE	Formulary	PDL Preferred
H. Pylori Therapy - Proton Pump Inhibitor And Antibiotics Combinations		
lansoprazol-amoxicil-clarithro outer	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
H.Pylori Therapy-Potassium-Competitive Acid Blocker And Antibiotics		
VOQUEZNA DUAL PAK OUTER	Formulary	PA; PDL Non-Preferred
VOQUEZNA TRIPLE PAK OUTER	Formulary	PA; PDL Non-Preferred
Ibs Agent - Gastrointestinal Chloride Channel Activator Agents		
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)
lubiprostone 24 mcg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 24 mcg capsule outer	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 8 mcg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 8 mcg capsule outer	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists		
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
Ibs Agent - Mixed Opioid Receptor Agonist And Antagonist		
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)
Ibs Agent - Selective 5-Ht3 Receptor Antagonists		
alosetron hcl 0.5 mg tablet	Formulary	PA; PDL Non-Preferred
alosetron hcl 1 mg tablet	Formulary	PA; PDL Non-Preferred
LOTRONEX 0.5 MG TABLET	Formulary	PA; PDL Non-Preferred
LOTRONEX 1 MG TABLET	Formulary	PA; PDL Non-Preferred
Ibs Agent - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitor		
IBSRELA 50 MG TABLET	Formulary	PA; PDL Non-Preferred; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
Inflammatory Bowel Agent - Interleukin-12 And Il-23 Inhibitors, Mc Ab		
OTULFI 90 MG/ML SYRINGE	Formulary	PA
PYZCHIVA 90 MG/ML SYRINGE	Formulary	PA
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
STEQEYMA 90 MG/ML SYRINGE	Formulary	PA
ustekinumab 90 mg/ml syringe	Formulary	PA
ustekinumab-ttwe 90 mg/ml syr	Formulary	PA
YESINTEK 90 MG/ML SYRINGE	Formulary	PA
Inflammatory Bowel Agent - Interleukin-23 (Il-23) Inhibitor, Mc Ab		
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)

Medications	Coverage Level	Restrictions
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
SKYRIZI 360 MG/2.4 ML ON-BODY OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
TREMFYA 100 MG/ML ONE-PRESS	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
Inflammatory Bowel Agent - Aminosalicylates And Related Agents		
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
balsalazide disodium 750 mg cp	Formulary	PA; PDL Non-Preferred
balsalazide disodium 750 mg cp outer	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
mesalamine 4 gm/60 ml enema 7x60ml, outer	Formulary	
mesalamine 4 gm/60 ml enema outer	Formulary	
mesalamine 800 mg dr tablet	Formulary	PA; PDL Non-Preferred
mesalamine 800 mg dr tablet outer	Formulary	PA; PDL Non-Preferred
mesalamine dr 1.2 gm tablet	Formulary	PDL Preferred
mesalamine dr 1.2 gm tablet outer	Formulary	PDL Preferred
mesalamine dr 400 mg capsule	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
mesalamine dr 400 mg capsule outer	Formulary	PA; PDL Non-Preferred
mesalamine er 0.375 gram cap	Formulary	PA; Brand Preferred; PDL Non-Preferred
mesalamine er 0.375 gram cap outer	Formulary	PA; Brand Preferred; PDL Non-Preferred
mesalamine er 500 mg capsule	Formulary	PA; Brand Preferred; PDL Non-Preferred
mesalamine rectal suppository	Non-Formulary	
mesalamine with cleansing wipe	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	
sulfasalazine 500 mg tablet	Formulary	PDL Preferred
sulfasalazine dr 500 mg tab	Formulary	PDL Preferred
Inflammatory Bowel Agent - Glucocorticoids		
budesonide dr 3 mg capsule	Formulary	PA; QL (3 capsules per 1 day)
budesonide dr 3 mg capsule outer	Formulary	PA; QL (3 capsules per 1 day)
budesonide ec 3 mg capsule	Formulary	PA; QL (3 capsules per 1 day)
budesonide er 9 mg tablet	Formulary	PA; PDL Non-Preferred
budesonide rectal	Non-Formulary	
CORTENEMA	Non-Formulary	
CORTIFOAM	Non-Formulary	
hydrocortisone rectal	Non-Formulary	
UCERIS 9 MG ER TABLET	Formulary	PA; PDL Non-Preferred
UCERIS RECTAL	Non-Formulary	
Inflammatory Bowel Agent - Integrin Receptor Antagonist, Mc Antibody		
ENTYVIO 108 MG/0.68 ML PEN SUV, OUTER	Formulary	PA; PDL Non-Preferred
Inflammatory Bowel Agent - Janus Kinase (Jak) Inhibitors		
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
adalimumab-aacf(cf) 40 mg/0.8 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aacf(cf) pen 40 mg/0.8 ml (2 pack)	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
adalimumab-aaty(cf) 20 mg/0.2 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector (2 pack) 2 ai/box, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml autoinjector suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 40 mg/0.4 ml syringe (2 pack)	Formulary	PA; PDL Non-Preferred
adalimumab-aaty(cf) 80 mg/0.8 ml autoinjector	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-AATY(CF) AUTOINJ CROHN'S-UC-HS START 80 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 20 mg/0.2 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
adalimumab-adaz(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adaz(cf) pen 80 mg/0.8 ml outer, p/f, suv	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 20 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.4 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) 40 mg/0.8 ml syringe	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) pen 40 mg/0.4 ml	Formulary	PA; PDL Non-Preferred
adalimumab-adbm(cf) pen 40 mg/0.8 ml	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.4 ML	Formulary	PA; PDL Non-Preferred
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS START 40 MG/0.8 ML	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 20 mg/0.4 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) 40 mg/0.8 ml syringe suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml outer, suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-fkjp(cf) pen 40 mg/0.8 ml suv, p/f	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 ml autoinjector	Formulary	PA; PDL Non-Preferred
adalimumab-ryvk(cf) 40 mg/0.4 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
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) 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) 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
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)
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)

Medications	Coverage Level	Restrictions
Intestinal Flora Modifiers		
CULTURELLE 10B CELL CAPSULE OUTER (RX)	Non-Formulary	CSHCS Covered
CULTURELLE HLTH-WELL 15B CELL	Non-Formulary	CSHCS Covered
Irritable Bowel Syndrome (Ibs) Agents		
alosetron hcl 0.5 mg tablet	Formulary	PA; PDL Non-Preferred
alosetron hcl 1 mg tablet	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
lubiprostone 24 mcg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 24 mcg capsule outer	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 8 mcg capsule	Formulary	PDL Preferred; QL (2 capsules per 1 day); Age Limit (Min 18 Years)
lubiprostone 8 mcg capsule outer	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)
Laxative - Lubricant		
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
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	

Medications	Coverage Level	Restrictions
FT CLEARLAX POWDER	Formulary	OTC
ft magnesium citrate solution	Formulary	OTC
GAVILAX POWDER 14 DAY	Formulary	OTC
GAVILAX POWDER 30 DAY	Formulary	OTC
gnp magnesium citrate solution	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	
lactulose 10 gm/15 ml solution	Formulary	
lactulose 10 gm/15 ml solution	State Carve Out	
lactulose 10 gm/15 ml solution cup inner	Formulary	
lactulose 10 gm/15 ml solution cup outer	Formulary	
lactulose 20 gm/30 ml solution cup inner	Formulary	
lactulose 20 gm/30 ml solution cup outer	Formulary	
magnesium citrate solution	Formulary	OTC
milk of magnesia susp 2,400 mg/30 ml cup inner	Formulary	OTC
MILK OF MAGNESIA SUSP 2,400 MG/30 ML CUP INNER	Formulary	OTC
milk of magnesia susp 2,400 mg/30 ml cup outer	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
polyethylene glycol 3350 oral powder in packet 17 gram	Non-Formulary	Dual Eligible Covered; OTC
polyethylene glycol 3350 powd (otc)	Formulary	OTC
polyethylene glycol 3350 powd 14 once-daily doses (otc)	Formulary	OTC
polyethylene glycol 3350 powd 30 once-daily doses (otc)	Formulary	OTC
polyethylene glycol 3350 powd 7 once-daily doses (otc)	Formulary	OTC

Medications	Coverage Level	Restrictions
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
Laxative - Saline/Osmotic Mixtures		
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	
peg 3350-electrolyte solution	Formulary	
peg 3350-electrolyte solution lemon	Formulary	
peg-3350 and electrolytes soln	Formulary	
peg3350-sod sul-nacl-kcl-asb-c	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

Medications	Coverage Level	Restrictions
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
sod sul-potass sul-mag sul sol	Formulary	QL (354 ML per 30 days)
sod sul-potass sul-mag sul sol 2-6oz+mix cont,outer	Formulary	QL (354 ML per 30 days)
sod sul-potass sul-mag sul sol inner	Formulary	QL (354 ML per 30 days)
sod sul-potass sul-mag sul sol outer	Formulary	QL (354 ML per 30 days)
SUTAB	Non-Formulary	
Laxative - Stimulant And Surfactant Combinations		
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
SENNA PLUS 8.6-50 MG TABLET	Formulary	OTC
SENNA PLUS ORAL CAPSULE	Non-Formulary	OTC
SENNA PLUS TABLET	Formulary	OTC
SENNA PLUS TABLET U-D, 10X10	Formulary	OTC
SENNA-S 8.6-50 MG TABLET	Formulary	OTC
SENNA-TIME S TABLET	Formulary	OTC
sennosides-docusate sodium tab	Formulary	OTC
sennosides-docusate sodium tab outer	Formulary	OTC
SENOKOT-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 LAXAT ORAL CAPSULE	Non-Formulary	OTC
Laxative - Stimulant		
bisacodyl 10 mg suppository	Formulary	OTC
bisacodyl 10 mg suppository	Formulary	Dual Eligible Covered; OTC
bisacodyl ec 5 mg tablet	Formulary	OTC
bisacodyl ec 5 mg tablet	Formulary	Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
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
senna 176 mg/5 ml syrup	Formulary	
SENNA 176 MG/5 ML SYRUP	Formulary	
senna 26.4 mg/15 ml syrup cup outer	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
senna 8.8 mg/5 ml syrup	Formulary	OTC
SENNA 8.8 MG/5 ML SYRUP	Formulary	OTC
senna 8.8 mg/5 ml syrup cup outer	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
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

Medications	Coverage Level	Restrictions
docusate cal 240 mg softgel	Formulary	Dual Eligible Covered; OTC
docusate sod 100 mg/10 ml cup outer	Formulary	OTC
docusate sod 100 mg/10 ml cup outer	Formulary	Dual Eligible Covered; OTC
docusate sod 100 mg/10 ml liquid cup outer	Formulary	OTC
docusate sodium 100 mg softgel	Formulary	OTC
docusate sodium 100 mg softgel	Formulary	Dual Eligible Covered; OTC
docusate sodium 100 mg softgel outer, softgel	Formulary	Dual Eligible Covered; OTC
docusate sodium 100 mg softgel softgel	Formulary	Dual Eligible Covered; OTC
docusate sodium 250 mg softgel	Formulary	OTC
docusate sodium 250 mg softgel outer	Formulary	Dual Eligible Covered; OTC
docusate sodium 50 mg/5 ml cup outer	Formulary	Dual Eligible Covered; OTC
docusate sodium 50 mg/5 ml liq	Formulary	Dual Eligible Covered; OTC
docusate sodium mini enema	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
STOOL SOFTENER 100 MG SOFTGEL	Formulary	Dual Eligible Covered; OTC
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives		
CARAFATE	Non-Formulary	
sucralfate 1 gm tablet	Formulary	

Medications	Coverage Level	Restrictions
sucralfate 1 gm tablet outer	Formulary	
sucralfate oral suspension	Non-Formulary	
Short Bowel Syndrome (Sbs) - Glucagon-Like Peptide-2 (Glp-2) Analog		
GATTEX 30-VIAL	Non-Formulary	
Short Bowel Syndrome (Sbs) Agents		
octreotide 1,000 mcg/5 ml vial mdv	Formulary	PA
octreotide 1,000 mcg/5 ml vial muv	Formulary	PA
octreotide 5,000 mcg/5 ml vial mdv	Formulary	PA
octreotide 5,000 mcg/5 ml vial muv	Formulary	PA
octreotide acet 100 mcg/ml vl inner, p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl outer, p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl outer, suv, p/f	Formulary	PA
octreotide acet 100 mcg/ml vl p/f, sdv	Formulary	PA
octreotide acet 100 mcg/ml vl sdv, outer	Formulary	PA
octreotide acet 100 mcg/ml vl suv, p/f	Formulary	PA
octreotide acet 50 mcg/ml vial 10's,suv	Formulary	PA
octreotide acet 50 mcg/ml vial inner, p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial outer, p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial outer, p/f, suv	Formulary	PA
octreotide acet 50 mcg/ml vial p/f, sdv	Formulary	PA
octreotide acet 50 mcg/ml vial sdv	Formulary	PA
octreotide acet 50 mcg/ml vial suv, p/f	Formulary	PA
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	
Genitourinary Therapy		
Bph Agent- 5-Alpha Reductase Inhib And Alpha-1 Adrenoceptor Antag Comb		
dutasteride-tamsulosin 0.5-0.4	Formulary	PA; PDL Non-Preferred
Cystinosis Therapy (Cystine Depleting Agents)		
CYSTAGON	State Carve Out	
PROCYSBI	State Carve Out	

Medications	Coverage Level	Restrictions
G.U. Irrigants - Anti-Infective		
neomycin-polymyxin b gu	Non-Formulary	
G.U. Irrigants		
acetic acid irrigation	Non-Formulary	
sorbitol-mannitol	Non-Formulary	
Interstitial Cystitis Agents		
ELMIRON 100 MG CAPSULE	Formulary	QL (3 capsules per 1 day)
Kidney Stone Agents		
THIOLA	Non-Formulary	
THIOLA EC	Non-Formulary	
tiopronin	Non-Formulary	
VENXXIVA	Non-Formulary	
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist		
GEMTESA 75 MG TABLET	Formulary	PA; PDL Non-Preferred
mirabegron er 25 mg tablet	Formulary	PA; PDL Non-Preferred
mirabegron er 50 mg tablet	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
Oxalosis Agent - Oxalate Inhibitor, Small Interfering Rna Directed		
RIVFLOZA	State Carve Out	
Phosphate Binders - Calcium-Based		
calcium acetate 667 mg capsule	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg capsule inner	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg capsule outer	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg gelcap	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg gelcap gelcap	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
Phosphate Binders - Iron-Based		
AURYXIA 210 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ferric citrate 210 mg tablet	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
calcium acetate 667 mg capsule	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg capsule inner	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg capsule outer	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg gelcap	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg gelcap gelcap	Formulary	PA; PDL Preferred; 3 Months Allowed
calcium acetate 667 mg tablet	Formulary	PA; PDL Preferred; 3 Months Allowed
ferric citrate 210 mg tablet	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
FOSRENOL 750 MG TABLET CHEW OUTER PK, 6X15 TABS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
lanthanum carb 1,000 mg tb chw outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
lanthanum carb 500 mg tab chew outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
lanthanum carb 750 mg tab chew outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
RENVELA 0.8 GM POWDER PACKET INNER,90 X 0.8G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RENVELA 0.8 GM POWDER PACKET OUTER,90 X 0.8G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RENVELA 2.4 GM POWDER PACKET INNER,90 X 2.4G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RENVELA 2.4 GM POWDER PACKET OUTER,90 X 2.4G PKTS	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
RENVELA 800 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer 0.8 gm powder packet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer 0.8 gm powder packet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer 2.4 gm powder packet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer 2.4 gm powder packet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer carbonate 800 mg tab	Formulary	PA; PDL Preferred; 3 Months Allowed
sevelamer carbonate 800 mg tab inner	Formulary	PA; PDL Preferred; 3 Months Allowed
sevelamer carbonate 800 mg tab outer	Formulary	PA; PDL Preferred; 3 Months Allowed
sevelamer hcl 400 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer hcl 800 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
sevelamer hcl 800 mg tablet outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
VELPHORO 500 MG CHEWABLE TAB	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
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)

Medications	Coverage Level	Restrictions
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)
tolvaptan 15 mg tablet	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 15 mg-15 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 30 mg tablet	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 30 mg-15 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 45 mg-15 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 60 mg-30 mg tablet outer	Formulary	PA; QL (2 tablets per 1 day); Age Limit (Min 18 Years)
tolvaptan 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		
alfuzosin hcl er 10 mg tablet	Formulary	PDL Preferred
alfuzosin hcl er 10 mg tablet f/c	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
silodosin 4 mg capsule	Formulary	PA; PDL Non-Preferred
silodosin 8 mg capsule	Formulary	PA; PDL Non-Preferred
tamsulosin hcl 0.4 mg capsule	Formulary	PDL Preferred
tamsulosin hcl 0.4 mg capsule outer	Formulary	PDL Preferred
tamsulosin hcl 0.4 mg capsule u-d, 10x10	Formulary	PDL Preferred
Prostatic Hypertrophy Agent - Type Ii 5-Alpha Reductase Inhibitors		
finasteride 5 mg tablet	Formulary	PDL Preferred
finasteride 5 mg tablet f/c	Formulary	PDL Preferred
finasteride 5 mg tablet outer	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
PROSCAR 5 MG TABLET	Formulary	PA; PDL Non-Preferred
Prostatic Hypertrophy Agent-Sel.Cgmp Phosphodiesterase Type5 Inhibitor		
CIALIS ORAL TABLET 5 MG	Benefit Exclusion	
tadalafil oral tablet 2.5 mg, 5 mg	Benefit Exclusion	
Prostatic Hypertrophy Agent-Type I And Ii 5-Alpha Reductase Inhibitors		
dutasteride 0.5 mg capsule	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	
pot,sodium citrate-citric acid	Non-Formulary	
potassium cit-citric acid soln	Formulary	
potassium citrate er 10 meq tb	Formulary	
potassium citrate er 10 meq tb outer	Formulary	
potassium citrate er 15 meq tb	Formulary	
potassium citrate er 5 meq tab	Formulary	
sod citrate-citric acid soln (rx)	Formulary	
sod citrate-citric acid solution 1.5-1 gm/15 ml cup outer (rx)	Formulary	
sod citrate-citric acid solution 3-2 gm/30 ml cup outer (rx)	Formulary	
TRICITRATES	Non-Formulary	
UROCIT-K 10	Non-Formulary	
UROCIT-K 15	Non-Formulary	
Urinary Analgesics		
phenazopyridine 100 mg tab	Formulary	

Medications	Coverage Level	Restrictions
phenazopyridine 100 mg tab f/c	Formulary	
phenazopyridine 200 mg tab	Formulary	
phenazopyridine 200 mg tab f/c	Formulary	
PYRIDIUM	Non-Formulary	
Urinary Antibacterial - Methenamine And Salts		
methenamine hipp 1 gm tablet	Formulary	
methenamine hipp 1 gm tablet outer	Formulary	
methenamine mand 1 gm tablet	Formulary	
methenamine mand 500 mg tablet	Formulary	
Urinary Antibacterial - Nitrofuran Derivatives		
FURADANTIN	Non-Formulary	
MACROBID	Non-Formulary	
nitrofurantoin macrocrystal oral capsule 25 mg	Non-Formulary	
nitrofurantoin mcr 100 mg cap	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 100 mg cap outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 50 mg cap	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mcr 50 mg cap outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg outer	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin mono-mcr 100 mg u-d,outer,10x10	Formulary	QL (2 capsules per 1 day); Age Limit (Max 64 Years)
nitrofurantoin oral suspension 25 mg/5 ml	Non-Formulary	
Urinary Antibacterials Other		
fosfomycin tromethamine	Non-Formulary	
Urinary Anti-Infective Methenamine-Antispas-Analg Combinations		
MB CAPS	Non-Formulary	
URELLE	Non-Formulary	
URIBEL	Non-Formulary	
URIBEL TABS	Non-Formulary	

Medications	Coverage Level	Restrictions
URIMAR-T ORAL TABLET	Non-Formulary	
URO-458	Non-Formulary	
URO-MP	Non-Formulary	
Urinary Anti-Infective Methenamine-Antispasmodic Combinations		
methen-sod phos-meth blue-hyos	Non-Formulary	
UROGESIC-BLUE	Non-Formulary	
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)		
darifenacin er 15 mg tablet	Formulary	PA; PDL Non-Preferred
darifenacin er 7.5 mg tablet	Formulary	PA; PDL Non-Preferred
solifenacin 10 mg tablet	Formulary	PDL Preferred
solifenacin 5 mg tablet	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)
hyoscyamine 0.125 mg odt	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg tab sl	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg/5 ml elix	Formulary	Age Limit (Max 64 Years)
hyoscyamine 0.125 mg/ml drop	Formulary	Age Limit (Max 64 Years)
hyoscyamine er 0.375 mg tab	Formulary	Age Limit (Max 64 Years)
hyoscyamine sulf 0.125 mg tab	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	

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

Medications	Coverage Level	Restrictions
tolterodine tartrate 2 mg tab f/c,outer	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
trospium chloride 20 mg tablet	Formulary	PA; PDL Non-Preferred
trospium chloride er 60 mg cap	Formulary	PA; PDL Non-Preferred
Urinary Retention Therapy - Parasympathomimetic Agents		
bethanechol 10 mg tablet	Formulary	QL (4 tablets per 1 day)
bethanechol 10 mg tablet outer	Formulary	QL (4 tablets per 1 day)
bethanechol 10 mg tablet u-d, 10x10, inner	Formulary	QL (4 tablets per 1 day)
bethanechol 10 mg tablet u-d, 10x10, outer	Formulary	QL (4 tablets per 1 day)
bethanechol 25 mg tablet	Formulary	QL (4 tablets per 1 day)
bethanechol 25 mg tablet outer	Formulary	QL (4 tablets per 1 day)
bethanechol 25 mg tablet u-d, 10x10, inner	Formulary	QL (4 tablets per 1 day)
bethanechol 25 mg tablet u-d, 10x10, outer	Formulary	QL (4 tablets per 1 day)
bethanechol 5 mg tablet	Formulary	QL (4 tablets per 1 day)
bethanechol 50 mg tablet	Formulary	QL (4 tablets per 1 day)
bethanechol 50 mg tablet u-d, 10x10, inner	Formulary	QL (4 tablets per 1 day)
bethanechol 50 mg tablet u-d, 10x10, outer	Formulary	QL (4 tablets per 1 day)
Gout And Hyperuricemia Therapy		
Gout Acute Therapy - Antimitotics		
colchicine 0.6 mg capsule	Formulary	PA; PDL Non-Preferred
colchicine 0.6 mg capsule outer	Formulary	PA; PDL Non-Preferred
colchicine 0.6 mg tablet	Formulary	PDL Preferred
colchicine 0.6 mg tablet outer	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		
probenecid-colchicine tablet	Formulary	PDL Preferred
Hyperuricemia Therapy - Uricosurics		
probenecid 500 mg tablet	Formulary	PDL Preferred
probenecid 500 mg tablet film coated	Formulary	PDL Preferred
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors		
allopurinol 100 mg tablet	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
allopurinol 100 mg tablet outer	Formulary	PDL Preferred
allopurinol 100 mg tablet u-d, outer	Formulary	PDL Preferred
allopurinol 200 mg tablet	Formulary	PDL Preferred
allopurinol 300 mg tablet	Formulary	PDL Preferred
allopurinol 300 mg tablet outer	Formulary	PDL Preferred
allopurinol 300 mg tablet u-d, outer	Formulary	PDL Preferred
febuxostat 40 mg tablet	Formulary	PA; PDL Non-Preferred
febuxostat 40 mg tablet outer	Formulary	PA; PDL Non-Preferred
febuxostat 80 mg tablet	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		
Agents To Treat Attp- Anti Von Willebrand Factor (Vwf) A1 Domain		
CABLIVI INJECTION KIT	Non-Formulary	
Agents To Treat Cold Agglutinin Disease (Cad)		
ENJAYMO	State Carve Out	
Agents To Treat Paroxysmal Nocturnal Hemoglobinuria (Pnh)		
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	
Anticoagulants - Coumarin		
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
warfarin sodium 1 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 2 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 2 mg tablet 10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 2.5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 2.5 mg tablet 10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 3 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 4 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 5 mg tablet 10x10,u-d,outer	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 6 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
warfarin sodium 7.5 mg tablet	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	

Medications	Coverage Level	Restrictions
Cad - Complement (C1) Inhibitors		
ENJAYMO	State Carve Out	
Cxcr4 Chemokine Receptor Antagonists		
MOZOBIL	Non-Formulary	
plerixafor	Non-Formulary	
XOLREMDI	State Carve Out	
Direct Factor Xa Inhibitors		
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)
rivaroxaban 2.5 mg tablet	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)

Medications	Coverage Level	Restrictions
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)
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)
Erythropoietins		
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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
Factor Ix Complex (Prothrombin Complex Concentrate) Preparations		
BALFAXAR	State Carve Out	
KCENTRA	State Carve Out	
Factor Ix Preparations		
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	
Factor Vii Preparations		
NOVOSEVEN RT	State Carve Out	
SEVENFACT	State Carve Out	
Factor Viii Preparations (Ahf)		
ADVATE	State Carve Out	
ADYNOVATE	State Carve Out	
AFSTYLA	State Carve Out	
ALPHANATE	State Carve Out	

Medications	Coverage Level	Restrictions
ALTUVIIIO	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	
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	
Factor X Preparations		
COAGADEX	State Carve Out	
Factor Xiii Preparations		
CORIFACT	State Carve Out	
TRETTEN	State Carve Out	
Gene Therapy Agents - Cd34+ Hematopoietic Stem Cells (Hscs)		
CASGEVY	State Carve Out	
LYFGENIA	State Carve Out	
ZYNTEGLO	State Carve Out	
Granulocyte Colony-Stimulating Factor (G-Csf)		
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)

Medications	Coverage Level	Restrictions
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
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

Medications	Coverage Level	Restrictions
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
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)
Granulocyte-Macrophage Colony-Stimulating Factor (Gm-Csf)		
LEUKINE 250 MCG VIAL OUTER, SUV, P/F	Formulary	PA; PDL Non-Preferred
Hematopoietic Agents - Hypoxia Inducible Factor Prolyl Hydroxylase Inh		
VAFSEO 150 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
VAFSEO 300 MG TABLET	Formulary	PA; PDL Non-Preferred; Age Limit (Min 18 Years)
Hematorheologic Agents		
pentoxifylline er 400 mg tab	Formulary	
pentoxifylline er 400 mg tab f/c	Formulary	
pentoxifylline er 400 mg tab u-d,10x10,f/c	Formulary	
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	
aminocaproic acid	State Carve Out	
CYKLOKAPRON	State Carve Out	
FIBRYGA	State Carve Out	
LYSTEDA	State Carve Out	
RIASTAP	State Carve Out	
tranexamic acid	State Carve Out	
tranexamic acid in nacl,iso-os	State Carve Out	
Hemostatic Systemic- Von Willebrand Factor (Vwf) Preparations		
VONVENDI	State Carve Out	
Heparin Flush Formulations		
heparin (porcine) in nacl (pf) intravenous parenteral solution	Non-Formulary	
heparin lock flush (porcine) intravenous solution 10 unit/ml	Non-Formulary	
heparin, porcine (pf) intravenous syringe 1 unit/ml, 100 unit/ml	Non-Formulary	
Heparins		
heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)	Non-Formulary	

Medications	Coverage Level	Restrictions
heparin (porcine) in nacl (pf) intravenous parenteral solution	Non-Formulary	
heparin (porcine) injection cartridge	Non-Formulary	
heparin (porcine) injection solution 1,000 unit/ml, 20,000 unit/ml	Non-Formulary	
heparin (porcine) injection syringe 5,000 unit/ml	Non-Formulary	
heparin lock flush (porcine) intravenous solution 10 unit/ml	Non-Formulary	
heparin sodium 10,000 unit/ml vial	Formulary	
heparin sodium 10,000 unit/ml vial muv, outer	Formulary	
heparin sodium 10,000 unit/ml vial outer	Formulary	
heparin sodium 10,000 unit/ml vial outer, mdv	Formulary	
heparin sodium 10,000 unit/ml vial outer, suv	Formulary	
heparin sodium 10,000 unit/ml vial suv, outer	Formulary	
heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv	Formulary	
heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv,25's	Formulary	
heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial mdv,outer	Formulary	
heparin sodium 40,000 unit/4 ml (10,000 unit/ml) vial muv, outer	Formulary	
heparin sodium 5,000 unit/ml vial	Formulary	
heparin sodium 5,000 unit/ml vial mdv, outer	Formulary	
heparin sodium 5,000 unit/ml vial mdv,25's	Formulary	
heparin sodium 5,000 unit/ml vial mdv,outer	Formulary	
heparin sodium 5,000 unit/ml vial muv, outer	Formulary	
heparin sodium 5,000 unit/ml vial muv,outer	Formulary	
heparin sodium 5,000 unit/ml vial outer	Formulary	
heparin sodium 5,000 unit/ml vial outer, muv	Formulary	
heparin sodium 5,000 unit/ml vial outer, suv	Formulary	
heparin sodium 5,000 unit/ml vial suv, outer	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial inner,muv	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mdv,25's	Formulary	

Medications	Coverage Level	Restrictions
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial mdv,outer	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial muv, outer	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial muv,outer	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer, muv	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer,mdv	Formulary	
heparin sodium 50,000 unit/10 ml (5,000 unit/ml) vial outer,muv	Formulary	
heparin sodium 50,000 unit/5 ml (10,000 unit/ml) vial muv, inner	Formulary	
heparin sodium 50,000 unit/5 ml (10,000 unit/ml) vial muv, outer	Formulary	
heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml	Non-Formulary	
heparin, porcine (pf) injection	Non-Formulary	
heparin, porcine (pf) intravenous syringe 1 unit/ml, 100 unit/ml	Non-Formulary	
heparin, porcine (pf) subcutaneous	Non-Formulary	
Human Albumin		
ALBUKED-25	State Carve Out	
ALBUKED-5	State Carve Out	
albumin, human 25 %	State Carve Out	
albumin, human 5 %	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	

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

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

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

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

Medications	Coverage Level	Restrictions
enoxaparin 60 mg/0.6 ml syr p/f, suv, outer	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 60 mg/0.6 ml syr suv, p/f	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 60 mg/0.6 ml syr suv, p/f, outer	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 60 mg/0.6 ml syr suv,p/f,inner	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 60 mg/0.6 ml syr suv,p/f,outer	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr auto dev, sdv	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr outer, suv, p/f	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr outer,p/f,suv	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr outer,suv	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr p/f, outer, suv	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr suv, p/f	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr suv, p/f, outer	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr suv,p/f,inner	Formulary	PDL Preferred; 3 Months Allowed
enoxaparin 80 mg/0.8 ml syr suv,p/f,outer	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

Medications	Coverage Level	Restrictions
FRAGMIN 5,000 UNIT/0.2 ML SYR P/F, OUTER, SDV	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
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
Plasma Fractions		
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
ticagrelor 60 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
ticagrelor 90 mg tablet	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed
Platelet Aggregation Inhibitor Combinations		
aspirin-dipyridam er 25-200 mg	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Platelet Aggregation Inhibitors - Phosphodiesterase Iii Inhibitors		
cilostazol 100 mg tablet	Formulary	
cilostazol 100 mg tablet outer	Formulary	
cilostazol 50 mg tablet	Formulary	
cilostazol 50 mg tablet outer	Formulary	
Platelet Aggregation Inhibitors - Quinazoline Agents		
AGRYLIN	Non-Formulary	
anagrelide hcl 0.5 mg capsule	Formulary	
anagrelide hcl 1 mg capsule	Formulary	
Platelet Aggregation Inhibitors - Salicylates		
aspirin 325 mg tablet	Formulary	OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)
aspirin 325 mg tablet	Formulary	Dual Eligible Covered; OTC; QL (3 tablets per 1 day); Age Limit (Min 40 Years)

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

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

Medications	Coverage Level	Restrictions
prasugrel 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
prasugrel 5 mg tablet	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 75 Years)
Platelet Aggregation Inhib-Pdesterase And Adenosine Deaminase Inhibitr		
dipyridamole 25 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
dipyridamole 25 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
dipyridamole 50 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
dipyridamole 50 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
dipyridamole 75 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
dipyridamole 75 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Pnh - Complement (C3) Inhibitors		
EMPAVELI	State Carve Out	
Pnh - Complement Factor B Inhibitors		
FABHALTA	State Carve Out	
Pnh - Complement Factor D Inhibitors		
VOYDEYA	State Carve Out	
Pnh - Human Monoclonal Antibody Complement (C5) Inhibitors		
BKEMV	State Carve Out	
EPYSQLI	State Carve Out	
PIASKY	State Carve Out	
SOLIRIS	State Carve Out	
ULTOMIRIS	State Carve Out	
Pyruvate Kinase (Pk) Activators		
PYRUKYND	State Carve Out	
Sickle Cell Anemia Agents - Cell/Gene Therapy		
CASGEVY	State Carve Out	
LYFGENIA	State Carve Out	

Medications	Coverage Level	Restrictions
Sickle Cell Anemia Agents, Others		
DROXIA 200 MG CAPSULE	Formulary	3 Months Allowed
DROXIA 300 MG CAPSULE	Formulary	3 Months Allowed
DROXIA 400 MG CAPSULE	Formulary	3 Months Allowed
ENDARI	Non-Formulary	
glutamine powder (rx)	Formulary	OTC
l-glutamine 5 gram powder pkt outer	Formulary	PA; 3 Months Allowed; QL (6 packets per 1 day); Age Limit (Min 5 Years)
l-glutamine powder (rx)	Formulary	OTC
L-GLUTAMINE POWDER FCC	Formulary	
L-GLUTAMINE POWDER USP	Formulary	
l-glutamine powder usp (rx)	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)
Sickle Hemoglobin (Hbs) Polymerization Inhibitor		
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)
Thrombin Inhibitor - Selective Direct And Reversible		
dabigatran etexilate 110 mg cp	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
dabigatran etexilate 110 mg cp	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (4 capsules per 1 day)
dabigatran etexilate 110 mg cp inner	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (4 capsules per 1 day)

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

Medications	Coverage Level	Restrictions
PRADAXA 50 MG PELLET PACK	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 11 Years)
PRADAXA 75 MG CAPSULE	Formulary	PDL Preferred; 3 Months Allowed; QL (2 capsules per 1 day)
Thrombopoietin Receptor Agonists		
DOPTELET (10 TAB PACK)	Non-Formulary	
DOPTELET (15 TAB PACK)	Non-Formulary	
DOPTELET (30 TAB PACK)	Non-Formulary	
eltrombopag olamine	Non-Formulary	
MULPLETA	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	
LIVMARLI ORAL TABLET	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	
cyclosporine 100 mg capsule	Formulary	
cyclosporine 100 mg capsule outer	Formulary	
cyclosporine 25 mg capsule	Formulary	
cyclosporine 25 mg capsule outer	Formulary	
cyclosporine modified 100 mg	Formulary	
cyclosporine modified 100 mg outer	Formulary	
cyclosporine modified 100 mg softgel,outer	Formulary	
cyclosporine modified 100 mg/ml	Formulary	
cyclosporine modified 25 mg	Formulary	
cyclosporine modified 25 mg outer	Formulary	
cyclosporine modified 25 mg outer, softgel	Formulary	

Medications	Coverage Level	Restrictions
cyclosporine modified 50 mg	Formulary	
cyclosporine modified 50 mg outer	Formulary	
ENVARSUS XR 0.75 MG TABLET	Formulary	
ENVARSUS XR 1 MG TABLET	Formulary	
ENVARSUS 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	
tacrolimus 0.5 mg capsule (immediate release)	Formulary	
tacrolimus 0.5 mg capsule (immediate release) 10x10, outer	Formulary	
tacrolimus 0.5 mg capsule (immediate release) u-d, 10x10, outer	Formulary	
tacrolimus 1 mg capsule (immediate release)	Formulary	

Medications	Coverage Level	Restrictions
tacrolimus 1 mg capsule (immediate release) 10x10, outer	Formulary	
tacrolimus 1 mg capsule (immediate release) u-d, 10x10, outer	Formulary	
tacrolimus 5 mg capsule (immediate release)	Formulary	
tacrolimus 5 mg capsule (immediate release) 10x10, outer	Formulary	
tacrolimus 5 mg capsule (immediate release) u-d, 10x10, outer	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	
mycophenolate 200 mg/ml susp	Formulary	
mycophenolate 250 mg capsule	Formulary	
mycophenolate 250 mg capsule outer	Formulary	
mycophenolate 250 mg capsule u-d,10x10,outer	Formulary	
mycophenolate 500 mg tablet	Formulary	
mycophenolate 500 mg tablet f/c	Formulary	
mycophenolate 500 mg tablet outer	Formulary	
mycophenolate 500 mg tablet u-d,10x10,outer,f/c	Formulary	
mycophenolic acid dr 180 mg tb	Formulary	
mycophenolic acid dr 180 mg tb f/c	Formulary	
mycophenolic acid dr 180 mg tb outer	Formulary	
mycophenolic acid dr 360 mg tb	Formulary	
mycophenolic acid dr 360 mg tb enteric coated	Formulary	
mycophenolic acid dr 360 mg tb enteric coated,outer	Formulary	
mycophenolic acid dr 360 mg tb f/c	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		
everolimus 0.25 mg tablet	Formulary	
everolimus 0.25 mg tablet outer	Formulary	
everolimus 0.5 mg tablet	Formulary	
everolimus 0.5 mg tablet outer	Formulary	
everolimus 0.75 mg tablet	Formulary	
everolimus 0.75 mg tablet outer	Formulary	
everolimus 1 mg tablet	Formulary	
everolimus 1 mg tablet outer	Formulary	
RAPAMUNE 1 MG TABLET	Formulary	
RAPAMUNE 2 MG TABLET	Formulary	
sirolimus 0.5 mg tablet	Formulary	
sirolimus 1 mg tablet	Formulary	
sirolimus 1 mg tablet outer	Formulary	
sirolimus 1 mg/ml solution	Formulary	
sirolimus 1 mg/ml solution outer	Formulary	
sirolimus 2 mg tablet	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	
azathioprine 100 mg tablet	Formulary	
azathioprine 50 mg tablet	Formulary	
azathioprine 50 mg tablet outer	Formulary	
azathioprine 75 mg tablet	Formulary	
IMURAN 50 MG TABLET	Formulary	
Locomotor System		
Agents To Treat Periodic Paralysis - Carbonic Anhydrase Inhibitors		
dichlorphenamide	Non-Formulary	
KEVEYIS	Non-Formulary	
Als Agents - Antioxidants/Anti-Inflammatories		
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 - Benzathiazoles		
RILUTEK	Non-Formulary	
riluzole 50 mg tablet	Formulary	
riluzole 50 mg tablet f/c	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	
pyridostigmine br 60 mg tablet	Formulary	
pyridostigmine br 60 mg tablet outer	Formulary	
pyridostigmine bromide oral syrup	Non-Formulary	
pyridostigmine bromide oral tablet 30 mg	Non-Formulary	
pyridostigmine er 180 mg tab	Formulary	
Antimyasthenic Agents Other		
ZILBRYSQ	State Carve Out	
Duchenne Muscular Dystrophy - Exon Skipping Antisense Oligonucleotide		
AMONDYS-45	State Carve Out	
EXONDYS-51	State Carve Out	

Medications	Coverage Level	Restrictions
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
orphenad-asa-caff 50-770-60 mg	Formulary	PA; PDL Non-Preferred
orphenadrine-aspirin-caffeine 25-385-30 mg tablet	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
baclofen 10 mg tablet	Formulary	PDL Preferred
baclofen 10 mg tablet outer	Formulary	PDL Preferred
baclofen 10 mg/5 ml solution	Formulary	PA; PDL Preferred
baclofen 15 mg tablet	Formulary	PDL Preferred
baclofen 20 mg tablet	Formulary	PDL Preferred
baclofen 20 mg tablet outer	Formulary	PDL Preferred
baclofen 25 mg/5 ml suspension	Formulary	PA; PDL Non-Preferred
baclofen 5 mg tablet	Formulary	PDL Preferred
baclofen 5 mg tablet outer	Formulary	PDL Preferred
baclofen 5 mg/5 ml solution	Formulary	PA; PDL Preferred
chlorzoxazone 250 mg tablet	Formulary	PA; PDL Non-Preferred
chlorzoxazone 375 mg tablet	Formulary	PA; PDL Non-Preferred
chlorzoxazone 500 mg tablet	Formulary	PA; PDL Non-Preferred
chlorzoxazone 750 mg tablet	Formulary	PA; PDL Non-Preferred
cyclobenzaprine 10 mg tablet	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
cyclobenzaprine 10 mg tablet f/c	Formulary	PDL Preferred
cyclobenzaprine 10 mg tablet outer	Formulary	PDL Preferred
cyclobenzaprine 5 mg tablet	Formulary	PDL Preferred
cyclobenzaprine 5 mg tablet f/c	Formulary	PDL Preferred
cyclobenzaprine 5 mg tablet outer	Formulary	PDL Preferred
cyclobenzaprine 7.5 mg tablet	Formulary	PDL Preferred
cyclobenzaprine 7.5 mg tablet f/c	Formulary	PDL Preferred
cyclobenzaprine er 15 mg cap	Formulary	PA; PDL Non-Preferred
cyclobenzaprine er 30 mg cap	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
metaxalone 400 mg tablet	Formulary	PA; PDL Non-Preferred
metaxalone 640 mg tablet	Formulary	PA; PDL Non-Preferred
metaxalone 800 mg tablet	Formulary	PA; PDL Non-Preferred
metaxalone 800 mg tablet outer	Formulary	PA; PDL Non-Preferred
methocarbamol 1,000 mg tablet	Formulary	PDL Preferred
methocarbamol 500 mg tablet	Formulary	PDL Preferred
methocarbamol 500 mg tablet outer	Formulary	PDL Preferred
methocarbamol 750 mg tablet	Formulary	PDL Preferred
methocarbamol 750 mg tablet outer	Formulary	PDL Preferred
orphenadrine er 100 mg tablet	Formulary	PDL Preferred
TANLOR 1,000 MG TABLET	Formulary	PA; PDL Non-Preferred
tizanidine hcl 2 mg capsule	Formulary	PA; PDL Non-Preferred
tizanidine hcl 2 mg tablet	Formulary	PDL Preferred
tizanidine hcl 2 mg tablet outer	Formulary	PDL Preferred
tizanidine hcl 4 mg capsule	Formulary	PA; PDL Non-Preferred
tizanidine hcl 4 mg tablet	Formulary	PDL Preferred
tizanidine hcl 4 mg tablet outer	Formulary	PDL Preferred
tizanidine hcl 6 mg capsule	Formulary	PA; PDL Non-Preferred
ZANAFLEX 2 MG CAPSULE	Formulary	PA; PDL Non-Preferred
ZANAFLEX 4 MG CAPSULE	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
ZANAFLEX 4 MG TABLET	Formulary	PA; PDL Non-Preferred
ZANAFLEX 6 MG CAPSULE	Formulary	PA; PDL Non-Preferred
Skeletal Muscle Relaxant - Direct Muscle Relaxants		
DANTRIUM 25 MG CAPSULE	Formulary	PA; PDL Non-Preferred
dantrolene sodium 100 mg cap	Formulary	PA; PDL Non-Preferred
dantrolene sodium 25 mg cap	Formulary	PA; PDL Non-Preferred
dantrolene sodium 25 mg cap outer	Formulary	PA; PDL Non-Preferred
dantrolene sodium 25 mg cap u-d,3x10,outer	Formulary	PA; PDL Non-Preferred
dantrolene sodium 50 mg cap	Formulary	PA; PDL Non-Preferred
Spinal Muscular Atrophy - Exon Inclusion Antisense Oligonucleotide		
SPINRAZA (PF)	State Carve Out	
Spinal Muscular Atrophy - Motor Neuron 2 (Smn2) Splicing Modifier		
EVRYSDI	State Carve Out	
Medical Supplies And Durable Medical Equipment (Dme)		
Medical Supplies And Dme - Blood Glucose Tests		
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)
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)

Medications	Coverage Level	Restrictions
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)
Medical Supplies And Dme - Cervical Caps		
FEMCAP 22 MM CERVICAL CAP	Formulary	
FEMCAP 26 MM CERVICAL CAP	Formulary	
FEMCAP 30 MM CERVICAL CAP	Formulary	
Medical Supplies And Dme - Diaphragms		
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	
Medical Supplies And Dme - Female Condoms		
FC2 FEMALE CONDOM	Formulary	OTC; QL (36 condoms per 30 days)
Medical Supplies And Dme - Glucose Monitoring Test Supplies		
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
ACTI-LANCE LITE 28G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS	Formulary	OTC
ACTI-LANCE SPECIAL 17G LANCETS STERILE, SINGLE-USE	Formulary	OTC

Medications	Coverage Level	Restrictions
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
AGAMATRIX ULTRA-THIN 33G LANCT	Formulary	OTC
ALTERNATE SITE 26G LANCETS RECAPPABLE	Formulary	OTC
assure comfort 28g lancets	Formulary	OTC
assure comfort 30g lancets	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
blood lancets 30g easy twist	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
CLEVER CHEK ULTRA THIN 30G	Formulary	OTC
COAGUCHEK LANCETS	Formulary	OTC
cvs micro thin 33g lancets	Formulary	OTC
CVS MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC

Medications	Coverage Level	Restrictions
cvs thin 26g lancets	Formulary	OTC
cvs ultra thin 30g lancets	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
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

Medications	Coverage Level	Restrictions
E-ZJECT SUPER THIN 30G LANCETS SUPER THIN	Formulary	OTC
e-zject thin lancets 26 gauge	Formulary	OTC
FIFTY50 UNILET 33G LANCETS	Formulary	OTC
FINGERSTIX LANCETS	Formulary	OTC
fora 30g lancets twist off,single use	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
kroger lancets	Formulary	OTC
KROGER SUPER THIN LANCETS	Formulary	OTC
lancets	Formulary	OTC
lancets 26g x 1.8mm yellow	Formulary	OTC
lancets 28g lancets	Formulary	OTC
lancets 30g	Formulary	OTC
lancets 30g twist top,single use	Formulary	OTC
lancets 33g	Formulary	OTC
lancets ultra fine 28g	Formulary	OTC
LONGS THIN LANCETS 26G 26G	Formulary	OTC
LONGS THIN LANCETS 30G 30G	Formulary	OTC

Medications	Coverage Level	Restrictions
MEDISENSE THIN 28G LANCETS	Formulary	OTC
medisense thin lancets	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
meijer lancets 30g	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
PC SUPER THIN 30G LANCETS	Formulary	OTC
PHARMACIST CHOICE 28G LANCETS ULTRA THIN	Formulary	OTC
pharmacist choice 30g lancets ultra thin	Formulary	OTC

Medications	Coverage Level	Restrictions
pharmacist choice 33g lancets	Formulary	OTC
preferred plus lancets super thin	Formulary	OTC
preferred plus thin lancets	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
relion thin 26g lancets	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
SAFETY SEAL 30G LANCETS	Formulary	OTC
SAFETY-LET 30G LANCETS	Formulary	OTC
saps twist top 30g lancet	Formulary	OTC

Medications	Coverage Level	Restrictions
saps twist top 30g lancets	Formulary	OTC
SINGLE-LET LANCETS	Formulary	OTC
SM COLOR LANCETS 21G	Formulary	OTC
sm lancets 21g	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 RECAPPABLE	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
TECHLITE 28G LANCETS	Formulary	OTC
TECHLITE 30G LANCETS	Formulary	OTC
TELCARE ULTRA THIN 30G LANCETS	Formulary	OTC

Medications	Coverage Level	Restrictions
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
twist lancets 28g	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 RECAPPABLE	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
ULTRALANCE 26G LANCETS	Formulary	OTC
ULTRALANCE 28G LANCETS	Formulary	OTC
ULTRA-THIN II 28G LANCETS	Formulary	OTC
ULTRA-THIN II 30G LANCETS	Formulary	OTC
ULTRATLC LANCETS	Formulary	OTC
UNILET COMFORTOUCH 26G LANCETS	Formulary	OTC
UNILET COMFORTOUCH LANCET	Formulary	OTC
UNILET GP LANCET	Formulary	OTC

Medications	Coverage Level	Restrictions
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
Medical Supplies And Dme - Insulin Needles-Syringes And Admin Supplies		
1ST TIER UNIFINE PENTP 5MM 31G	Formulary	OTC
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

Medications	Coverage Level	Restrictions
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
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
aq insulin syr 0.5 ml 30g 8mm (rx)	Formulary	OTC
aq insulin syr 1 ml 31g 8mm (rx)	Formulary	OTC
aq insulin syrin 1 ml 29g 12mm (rx)	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
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

Medications	Coverage Level	Restrictions
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
bd insulin syr 1 ml 28gx1/2" (otc)	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
ca ins syr 0.3 ml 30gx5/16" short	Formulary	OTC
ca ins syr 0.3 ml 31gx5/16" short	Formulary	OTC
ca ins syr 0.5 ml 30gx5/16" short (otc)	Formulary	OTC
ca ins syr 0.5 ml 31gx5/16" short (otc)	Formulary	OTC
ca insulin syr 0.3 ml 29gx1/2"	Formulary	OTC

Medications	Coverage Level	Restrictions
ca insulin syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ca insulin syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ca insulin syr 1 ml 30gx5/16" short (otc)	Formulary	OTC
ca insulin syr 1 ml 31gx5/16" short (otc)	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
careone syr 0.3 ml 30gx1/2" regular, hri	Formulary	OTC
careone syr 0.5 ml 30gx1/2" regular, hri (otc)	Formulary	OTC
careone syr 1 ml 30gx1/2" regular, hri (otc)	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
CLICKFINE 31G X 1/4" NEEDLES 6MM, UNIVERSAL	Formulary	OTC

Medications	Coverage Level	Restrictions
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
COMFORT EZ PEN NEEDLES 6MM 33G	Formulary	OTC
COMFORT EZ PEN NEEDLES 8MM 31G	Formulary	OTC

Medications	Coverage Level	Restrictions
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
comfort point pen ndl 29gx1/2" 12mm	Formulary	OTC
comfort point pen ndl 31gx1/3"	Formulary	OTC
comfort point pen ndl 31gx1/4" 6mm	Formulary	OTC
comfort point pen ndl 31gx1/6"	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
DROPLET PEN NEEDLE 32G 4MM	Formulary	OTC
DROPLET PEN NEEDLE 32G 5MM	Formulary	OTC

Medications	Coverage Level	Restrictions
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
EASY TOUCH INSULIN SYR 1 ML	Formulary	OTC

Medications	Coverage Level	Restrictions
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
eql ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
eql insul syr 0.3 ml 31gx5/16"	Formulary	OTC
eql insul syr 0.5 ml 31gx5/16" (otc)	Formulary	OTC
eql insulin 0.3 ml syringe	Formulary	OTC
eql insulin 0.3 ml syringe short needle	Formulary	OTC
eql insulin 0.5 ml syringe	Formulary	OTC
eql insulin 0.5 ml syringe short needle	Formulary	OTC
eql insulin 1 ml syringe short needle	Formulary	OTC

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

Medications	Coverage Level	Restrictions
gnp pen needle 32g 6mm	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
gs pen needle 31g x 5/16"	Formulary	OTC
gs pen needle 31g x 5mm	Formulary	OTC
gs pen needle 31g x 6mm	Formulary	OTC
gs pen needle 31g x 8mm	Formulary	OTC
gs pen needle 32g x 4mm	Formulary	OTC
gs pen needle 32g x 6mm	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 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
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 ULTICARE NDL 31G 6MM	Formulary	OTC

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

Medications	Coverage Level	Restrictions
insulin syrin 0.5 ml 31g 5/16" outer (rx)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" (otc)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" hri (otc)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" short (otc)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" short needle,thin ii	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" short needle,thin ii (otc)	Formulary	OTC
insulin syrin 0.5 ml 31gx5/16" ultra comfort (otc)	Formulary	OTC
INSULIN SYRIN 1 ML 29GX1/2"	Formulary	OTC
insulin syring 0.5 ml 27g 1/2"	Formulary	
insulin syring 0.5 ml 27g 1/2" inner	Formulary	
insulin syring 0.5 ml 27g 1/2" outer	Formulary	
insulin syring 0.5 ml 27g 13mm	Formulary	
insulin syring 0.5 ml 28g 1/2" inner (rx)	Formulary	OTC
insulin syring 0.5 ml 29g 1/2" inner (rx)	Formulary	OTC
insulin syring 0.5 ml 29g 1/2" outer (rx)	Formulary	OTC
insulin syring 0.5 ml 29gx1/2" (otc)	Formulary	OTC
INSULIN SYRINGE 0.3 ML	Formulary	OTC
insulin syringe 0.3 ml 31gx1/4	Formulary	OTC
insulin syringe 0.3 ml short	Formulary	OTC
INSULIN SYRINGE 0.5 ML	Formulary	OTC
insulin syringe 0.5 ml 31g 6mm(only for 500 unit/ml insulin)	Formulary	
insulin syringe 0.5 ml 31gx1/4	Formulary	OTC
INSULIN SYRINGE 1 ML	Formulary	OTC
insulin syringe 1 ml 27g 1/2" inner	Formulary	
insulin syringe 1 ml 27g 1/2" outer	Formulary	
insulin syringe 1 ml 27g 13mm inner	Formulary	
insulin syringe 1 ml 27g 16mm	Formulary	OTC
insulin syringe 1 ml 27gx1/2" outer	Formulary	
insulin syringe 1 ml 28g 1/2" inner (rx)	Formulary	OTC
insulin syringe 1 ml 28g 1/2" outer (rx)	Formulary	OTC
insulin syringe 1 ml 28g 12.7mm (otc)	Formulary	OTC

Medications	Coverage Level	Restrictions
insulin syringe 1 ml 28g 13mm inner (rx)	Formulary	OTC
insulin syringe 1 ml 28g 13mm outer (rx)	Formulary	OTC
insulin syringe 1 ml 28gx1/2" (otc)	Formulary	OTC
insulin syringe 1 ml 29g 1/2" inner (rx)	Formulary	OTC
insulin syringe 1 ml 29g 1/2" outer (rx)	Formulary	OTC
insulin syringe 1 ml 29gx1/2" (otc)	Formulary	OTC
insulin syringe 1 ml 30g 1/2" (otc)	Formulary	OTC
insulin syringe 1 ml 30g 1/2" inner (rx)	Formulary	OTC
insulin syringe 1 ml 30g 1/2" outer (rx)	Formulary	OTC
insulin syringe 1 ml 30g 5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx1/2" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx1/2" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" short (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 31g 5/16" inner (rx)	Formulary	OTC
insulin syringe 1 ml 31g 5/16" outer (rx)	Formulary	OTC
insulin syringe 1 ml 31gx1/4"	Formulary	OTC
insulin syringe 1 ml 31gx5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" hri (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short needle,thin ii (otc)	Formulary	OTC
insulin syringe 1 ml short	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

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

Medications	Coverage Level	Restrictions
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
MONOJECT INSULIN SYR U-100	Formulary	

Medications	Coverage Level	Restrictions
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
ms ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ms ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ms ins syringe 1 ml 30gx1/2" (otc)	Formulary	OTC
ms insul syr 0.3 ml 31gx5/16"	Formulary	OTC
ms insul syr 0.5 ml 30gx1/2" (otc)	Formulary	OTC
ms insul syr 0.5 ml 31gx5/16" (otc)	Formulary	OTC
ms insulin syr 0.3 ml 29gx1/2"	Formulary	OTC
ms insulin syr 1 ml 31gx5/16" (otc)	Formulary	OTC
ms insulin syringe 0.3 ml	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
pen needle 29g 12mm	Formulary	OTC
pen needle 30g 5mm inner	Formulary	OTC
pen needle 30g 5mm outer	Formulary	OTC
PEN NEEDLE 30G X 5/16"	Formulary	
pen needle 31g 5mm	Formulary	OTC
pen needle 31g 5mm inner	Formulary	OTC
pen needle 31g 5mm outer	Formulary	OTC
pen needle 31g 6mm	Formulary	OTC

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

Medications	Coverage Level	Restrictions
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
pref plus ins 0.3 ml 29gx1/2"	Formulary	OTC
pref plus syr 0.5 ml 30gx5/16" (otc)	Formulary	OTC
pref plus syring 1 ml 29gx1/2" (otc)	Formulary	OTC
preferred plus 0.3 ml 30gx5/16	Formulary	OTC
preferred plus 0.5 ml 29gx1/2" (otc)	Formulary	OTC
preferred plus syringe 0.5 ml	Formulary	OTC
preferred plus syringe 1 ml	Formulary	OTC
prefpls ins syr 1 ml 30gx5/16" (otc)	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
pub ins syrin 0.3 ml 30gx1/2" regular needle	Formulary	OTC
pub ins syringe 1 ml 30gx1/2" regular needle (otc)	Formulary	OTC
pub insul syr 0.3 ml 31gx5/16" short needle	Formulary	OTC

Medications	Coverage Level	Restrictions
pub insul syr 0.5 ml 30gx1/2" regular needle (otc)	Formulary	OTC
pub insul syr 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
pub insulin syr 1 ml 31gx5/16" short needle (otc)	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 PNTP 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
ra ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ra ins syr 0.5 ml 30gx5/16" (otc)	Formulary	OTC
ra ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ra ins syringe 1 ml 30gx5/16" (otc)	Formulary	OTC
RA PEN NEEDLE 31GX3/16" 5MM (OTC)	Formulary	OTC
RA PEN NEEDLE 31GX5/16" 8MM (OTC)	Formulary	OTC
relion ins syr 0.3 ml 29gx1/2"	Formulary	OTC
relion ins syr 0.3 ml 31gx6mm	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
relion ins syr 0.5 ml 31gx6mm	Formulary	OTC
relion ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
relion ins syr 1 ml 31gx15/64"	Formulary	OTC
relion ins syr 1 ml 31gx5/16" (otc)	Formulary	OTC
relion ins syr 1 ml 31gx5/16" inner (otc)	Formulary	OTC

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

Medications	Coverage Level	Restrictions
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
sm ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
sm ins syr 0.5 ml 30gx5/16" short needle (otc)	Formulary	OTC
sm ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
sm ins syring 0.3 ml 30gx5/16" short needle	Formulary	OTC
sm ins syringe 1 ml 28gx1/2" (otc)	Formulary	OTC
sm ins syringe 1 ml 30gx5/16" short needle (otc)	Formulary	OTC
sm insul syr 0.3 ml 31gx5/16" short needle	Formulary	OTC
sm insul syr 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
sm insulin syr 0.3 ml 29gx1/2"	Formulary	OTC
sm insulin syr 0.5 ml 28gx1/2" (otc)	Formulary	OTC
sm insulin syr 1 ml 31gx5/16" short needle (otc)	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 3/10 ML SYRINGE	Formulary	OTC

Medications	Coverage Level	Restrictions
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
terumo ins syr 0.3 ml 29gx1/2"	Formulary	OTC
terumo ins syringe u100-1 ml	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

Medications	Coverage Level	Restrictions
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
ultcare ins syr 1 ml 31gx5/16" 31gx5/16" (otc)	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
ulticare ins safety 1 ml 29x1/2 (rx)	Formulary	OTC
ulticare ins syr 0.3 ml 30g 8mm	Formulary	OTC
ulticare ins syr 0.3 ml 31g 8mm	Formulary	OTC
ulticare ins syr 0.5 ml 30g 8mm (otc)	Formulary	OTC
ULTICARE INS SYR 0.5 ML 31G 6MM	Formulary	OTC

Medications	Coverage Level	Restrictions
ulticare ins syr 0.5 ml 31g 8mm (otc)	Formulary	OTC
ulticare ins syr 1 ml 28gx1/2" 28gx1/2" (otc)	Formulary	OTC
ulticare ins syr 1 ml 29gx1/2" 29gx1/2" (otc)	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
ulticare safety 0.5 ml 29gx1/2 (rx)	Formulary	OTC
ULTICARE SAFETY PEN NEEDLE	Non-Formulary	OTC
ulticare syr 0.3 ml 29g 12.7mm	Formulary	OTC
ULTICARE SYR 0.3 ML 30GX1/2"	Formulary	OTC
ulticare syr 0.3 ml 30gx5/16" 30gx5/16"	Formulary	OTC
ulticare syr 0.3 ml 31gx5/16"	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL	Formulary	OTC
ulticare syr 0.5 ml 29g 12.7mm (otc)	Formulary	OTC
ulticare syr 0.5 ml 29gx1/2" 29gx1/2" (otc)	Formulary	OTC
ULTICARE SYR 0.5 ML 30GX1/2"	Formulary	OTC
ulticare syr 0.5 ml 30gx5/16" 30gx5/16" (otc)	Formulary	OTC
ulticare syr 0.5 ml 31gx5/16" 31gx5/16" (otc)	Formulary	OTC

Medications	Coverage Level	Restrictions
ULTICARE SYR 0.5 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL	Formulary	OTC
ulticare syr 1 ml 30gx5/16" 30gx5/16" (otc)	Formulary	OTC
ULTICARE SYR 1 ML 31GX5/16"	Formulary	OTC
ulticare syrin 0.3 ml 29gx1/2" 29gx1/2"	Formulary	OTC
ulticare syrin 0.5 ml 28gx1/2" 28gx1/2" (otc)	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
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

Medications	Coverage Level	Restrictions
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
UNIFINE PENTIPS 12MM 29G 29GX12MM,STRL,ORIGNL	Formulary	OTC
UNIFINE PENTIPS 12MM 29G ORIGINAL	Formulary	OTC

Medications	Coverage Level	Restrictions
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
UNIFINE PENTIPS 8MM 31G SHORT	Formulary	OTC
UNIFINE PENTIPS 8MM NEEDLE SHORT	Formulary	OTC
UNIFINE PENTIPS MAXFLOW	Non-Formulary	OTC

Medications	Coverage Level	Restrictions
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
WM UNIFINE PENTIP PLUS 8MM 31G W/ SAFETY CLICK	Formulary	OTC
YOURX ULTICARE PEN NDL 4MM 32G	Formulary	OTC

Medications	Coverage Level	Restrictions
YOURX ULTICARE PEN NDL 6MM 31G	Formulary	OTC
YOURX ULTICARE PEN NDL 8MM 31G	Formulary	OTC
Medical Supplies And Dme - Male Condoms		
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)
TROJAN ULTRA THIN-SPERMICIDAL	Formulary	OTC; QL (36 condoms per 30 days)

Medications	Coverage Level	Restrictions
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)
Medical Supplies And Dme - Needles And Syringes		
ALLERGIST TRAY 1/2 ML 27GX3/8"	Non-Formulary	

Medications	Coverage Level	Restrictions
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
exel huber 22gx3/4" needle	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	
syringe (disposable) syringe 3 ml	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
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"	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
tuberculin-allergy syringes	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
Medical Supplies And Dme - Peak Flow Meters		
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)
Medical Supplies And Dme - Respiratory Therapy Supplies		
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)
LITEAIRE 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	
Medical Supplies And Dme - Subcutaneous Insulin Delivery Devices		
V-GO 20 DISPOSABLE DEVICE	Formulary	
V-GO 30 DISPOSABLE DEVICE	Formulary	
V-GO 40 DISPOSABLE DEVICE	Formulary	
Medical Supplies And Dme - Urine Ketone Tests		
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		
Medical Supply, Fdb Superset		
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)
AGAMATRIX ULTRA-THIN 33G LANCT	Formulary	OTC
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 RECAPPABLE	Formulary	OTC
aq insulin syr 0.5 ml 30g 8mm (rx)	Formulary	OTC
aq insulin syr 1 ml 31g 8mm (rx)	Formulary	OTC
aq insulin syrin 1 ml 29g 12mm (rx)	Formulary	OTC

Medications	Coverage Level	Restrictions
assure comfort 28g lancets	Formulary	OTC
assure comfort 30g lancets	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

Medications	Coverage Level	Restrictions
bd insulin syr 1 ml 28gx1/2" (otc)	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 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
blood lancets 30g easy twist	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
ca ins syr 0.3 ml 30gx5/16" short	Formulary	OTC
ca ins syr 0.3 ml 31gx5/16" short	Formulary	OTC
ca ins syr 0.5 ml 30gx5/16" short (otc)	Formulary	OTC
ca ins syr 0.5 ml 31gx5/16" short (otc)	Formulary	OTC
ca insulin syr 0.3 ml 29gx1/2"	Formulary	OTC
ca insulin syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ca insulin syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ca insulin syr 1 ml 30gx5/16" short (otc)	Formulary	OTC
ca insulin syr 1 ml 31gx5/16" short (otc)	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
careone syr 0.3 ml 30gx1/2" regular, hri	Formulary	OTC
careone syr 0.5 ml 30gx1/2" regular, hri (otc)	Formulary	OTC
careone syr 1 ml 30gx1/2" regular, hri (otc)	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
comfort point pen ndl 29gx1/2" 12mm	Formulary	OTC
comfort point pen ndl 31gx1/3"	Formulary	OTC
comfort point pen ndl 31gx1/4" 6mm	Formulary	OTC
comfort point pen ndl 31gx1/6"	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
cvs micro thin 33g lancets	Formulary	OTC
CVS MICRO THIN 33G LANCETS UNIVERSAL 1	Formulary	OTC
cvs thin 26g lancets	Formulary	OTC
cvs ultra thin 30g lancets	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)
eql ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
eql insul syr 0.3 ml 31gx5/16"	Formulary	OTC
eql insul syr 0.5 ml 31gx5/16" (otc)	Formulary	OTC
eql insulin 0.3 ml syringe	Formulary	OTC
eql insulin 0.3 ml syringe short needle	Formulary	OTC
eql insulin 0.5 ml syringe	Formulary	OTC
eql insulin 0.5 ml syringe short needle	Formulary	OTC
eql insulin 1 ml syringe short needle	Formulary	OTC
eql insulin syr 1 ml 31gx5/16" (otc)	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
exel huber 22gx3/4" needle	Formulary	OTC
exel ins syr u100 1 ml 28gx1/2 (otc)	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
exel u100 0.3 ml 30gx5/16"	Formulary	OTC
EXEL U100 0.5 ML 28GX1/2"	Formulary	OTC
exel u100 0.5 ml 29gx1/2" (otc)	Formulary	OTC
EXEL U100 0.5 ML 30GX5/16"	Formulary	OTC
EXEL U100 1 ML 30GX5/16"	Formulary	OTC
exel u100 ins syr 1 ml 29gx1/2 (otc)	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
e-zject thin lancets 26 gauge	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	
fifty50 ins 0.3 ml 31gx5/16" short needle	Formulary	OTC
fifty50 ins 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
fifty50 ins syr 1 ml 31gx5/16" short needle (otc)	Formulary	OTC
FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)	Formulary	OTC
fifty50 pen 31g x 3/16" needle 5mm	Formulary	OTC
FIFTY50 PEN 31G X 5/16" NEEDLE (OTC)	Formulary	OTC
fifty50 pen 31g x 5/16" needle 8mm	Formulary	OTC
fifty50 pen needle 32g x 1/4"	Formulary	OTC
fifty50 pen needle 32g x 5/32" 4mm	Formulary	OTC
FIFTY50 UNILET 33G LANCETS	Formulary	OTC
FINGERSTIX LANCETS	Formulary	OTC
FLEXICHAMBER	Formulary	QL (4 spacers per 365 days)
fora 30g lancets twist off,single use	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
gnp ins syr 0.3 ml 29gx1/2"	Formulary	OTC
gnp ins syringe 1 ml 28g 1/2" (otc)	Formulary	OTC
gnp insul syr 0.3 ml 31gx5/16"	Formulary	OTC
gnp insul syr 0.5 ml 31gx5/16" (otc)	Formulary	OTC
gnp insulin syr 1 ml 31gx5/16" (otc)	Formulary	OTC
gnp pen needle 31g 5mm	Formulary	OTC
gnp pen needle 31g 8mm	Formulary	OTC
gnp pen needle 32g 4mm	Formulary	OTC
gnp pen needle 32g 6mm	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
gs pen needle 31g x 5/16"	Formulary	OTC
gs pen needle 31g x 5mm	Formulary	OTC
gs pen needle 31g x 6mm	Formulary	OTC
gs pen needle 31g x 8mm	Formulary	OTC
gs pen needle 32g x 4mm	Formulary	OTC

Medications	Coverage Level	Restrictions
gs pen needle 32g x 6mm	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
insulin 1 ml syringe	Formulary	OTC
insulin 1/2 ml syringe	Formulary	OTC
insulin 3/10 ml syringe	Formulary	OTC
insulin syr 0.3 ml 30gx5/16"	Formulary	OTC
insulin syr 0.5 ml 28g 12.7mm (otc)	Formulary	OTC
insulin syr/ndl u100 half mark	Non-Formulary	OTC

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

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

Medications	Coverage Level	Restrictions
insulin syringe 1 ml 30g 1/2" outer (rx)	Formulary	OTC
insulin syringe 1 ml 30g 5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx1/2" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx1/2" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" short (otc)	Formulary	OTC
insulin syringe 1 ml 30gx5/16" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 31g 5/16" inner (rx)	Formulary	OTC
insulin syringe 1 ml 31g 5/16" outer (rx)	Formulary	OTC
insulin syringe 1 ml 31gx1/4"	Formulary	OTC
insulin syringe 1 ml 31gx5/16" (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" hri (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short needle (otc)	Formulary	OTC
insulin syringe 1 ml 31gx5/16" short needle,thin ii (otc)	Formulary	OTC
insulin syringe 1 ml short	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)
kinray ins syr 1 ml 31gx5/16" preferred plus (otc)	Formulary	OTC
kinray syring 0.3 ml 31gx5/16" preferred plus	Formulary	OTC
kinray syring 0.5 ml 31gx5/16" preferred plus (otc)	Formulary	OTC
kmart valu plus syr 1/2 ml	Formulary	OTC
kro ins syr 0.3 ml 29gx1/2"	Formulary	OTC
kro ins syrin 0.5 ml 31gx5/16" (otc)	Formulary	OTC
kro insulin syr 1 ml 30gx5/16" (otc)	Formulary	OTC
kro pen needle 4mm x 32g	Formulary	OTC
kro pen needle 4mm x 33g	Formulary	OTC
kro pen needle 5mm x 31g	Formulary	OTC
kro pen needle 6mm x 31g	Formulary	OTC
kro pen needle 8mm x 31g	Formulary	OTC
KRO UNIVERSAL 1 THIN 26G LANCT	Formulary	OTC
kroger ins syr 0.3 ml 30gx5/16 short needle	Formulary	OTC
kroger ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
kroger ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
kroger ins syr 1 ml 31gx5/16" (otc)	Formulary	OTC
kroger lancets	Formulary	OTC
KROGER PEN NEEDLES 31G X 5/16" (OTC)	Formulary	OTC
KROGER SUPER THIN LANCETS	Formulary	OTC
kroger syr 0.5 ml 30gx5/16" (otc)	Formulary	OTC
kroger syring 0.3 ml 31gx5/16"	Formulary	OTC
lancets	Formulary	OTC
lancets 26g x 1.8mm yellow	Formulary	OTC
lancets 28g lancets	Formulary	OTC
lancets 30g	Formulary	OTC
lancets 30g twist top,single use	Formulary	OTC

Medications	Coverage Level	Restrictions
lancets 33g	Formulary	OTC
lancets ultra fine 28g	Formulary	OTC
leader ins syr 0.3 ml 29gx1/2"	Formulary	OTC
leader ins syr 0.5 ml 28gx1/2" (otc)	Formulary	OTC
leader ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
leader ins syr 0.5 ml 30gx1/2" (otc)	Formulary	OTC
leader ins syr 1 ml 28gx1/2" (otc)	Formulary	OTC
leader ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
leader ins syr 1 ml 30gx5/16" (otc)	Formulary	OTC
leader ins syr 1 ml 31gx5/16" (otc)	Formulary	OTC
leader insulin syringe 0.3 ml	Formulary	OTC
leader pen needles 12mm 29g	Formulary	OTC
leader syring 0.3 ml 31gx5/16"	Formulary	OTC
leader syring 0.5 ml 31gx5/16" (otc)	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
medisense thin lancets	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
meijer lancets 30g	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
ms ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ms ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ms ins syringe 1 ml 30gx1/2" (otc)	Formulary	OTC
ms insul syr 0.3 ml 31gx5/16"	Formulary	OTC
ms insul syr 0.5 ml 30gx1/2" (otc)	Formulary	OTC
ms insul syr 0.5 ml 31gx5/16" (otc)	Formulary	OTC
ms insulin syr 0.3 ml 29gx1/2"	Formulary	OTC
ms insulin syr 1 ml 31gx5/16" (otc)	Formulary	OTC
ms insulin syringe 0.3 ml	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)
pen needle 29g 12mm	Formulary	OTC
pen needle 30g 5mm inner	Formulary	OTC
pen needle 30g 5mm outer	Formulary	OTC
PEN NEEDLE 30G X 5/16"	Formulary	
pen needle 31g 5mm	Formulary	OTC
pen needle 31g 5mm inner	Formulary	OTC
pen needle 31g 5mm outer	Formulary	OTC
pen needle 31g 6mm	Formulary	OTC
pen needle 31g 8mm	Formulary	OTC
pen needle 31g 8mm inner	Formulary	OTC
pen needle 31g 8mm outer	Formulary	OTC
pen needle 31g x 1/4"	Formulary	OTC
pen needle 31g x 1/4" 6mm	Formulary	OTC
pen needle 31g x 1/4" hri	Formulary	OTC
pen needle 31g x 3/16"	Formulary	OTC
PEN NEEDLE 31G X 3/16" (RX)	Formulary	OTC
pen needle 31g x 3/16" hri	Formulary	OTC

Medications	Coverage Level	Restrictions
pen needle 31g x 5/16"	Formulary	OTC
PEN NEEDLE 31G X 5/16" (RX)	Formulary	OTC
pen needle 31g x 5/16" 8mm	Formulary	OTC
pen needle 31g x 5/16" hri	Formulary	OTC
pen needle 32g 4mm	Formulary	OTC
pen needle 32g 4mm inner	Formulary	OTC
pen needle 32g 4mm outer	Formulary	OTC
pen needle 32g x 1/4"	Formulary	OTC
pen needle 32g x 3/16"	Formulary	OTC
pen needle 32g x 5/32"	Formulary	OTC
pen needle 32g x 5/32" 4mm	Formulary	OTC
pen needle 32g x 5/32" hri	Formulary	OTC
pen needle 33g 4mm	Formulary	OTC
PEN NEEDLE 6MM 31G 6MM	Formulary	OTC
pen needle, diabetic needle 30 gauge x 5/16"	Non-Formulary	OTC
PEN NEEDLES 12MM 29G	Formulary	OTC
pen needles 12mm 29g 29gx12mm, strl	Formulary	OTC
PEN NEEDLES 12MM 29G 29GX12MM,STRL	Formulary	OTC
pen needles 12mm 29g strl	Formulary	OTC
PEN NEEDLES 4MM 32G	Formulary	OTC
PEN NEEDLES 5MM 31G 31GX5MM,STRL,MINI (OTC)	Formulary	OTC
pen needles 6mm 31g 31gx6mm, strl	Formulary	OTC
pen needles 6mm 31g strl	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
pharmacist choice 30g lancets ultra thin	Formulary	OTC
pharmacist choice 33g lancets	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)
pref plus ins 0.3 ml 29gx1/2"	Formulary	OTC
pref plus syr 0.5 ml 30gx5/16" (otc)	Formulary	OTC
pref plus syring 1 ml 29gx1/2" (otc)	Formulary	OTC
preferred plus 0.3 ml 30gx5/16	Formulary	OTC
preferred plus 0.5 ml 29gx1/2" (otc)	Formulary	OTC

Medications	Coverage Level	Restrictions
preferred plus lancets super thin	Formulary	OTC
preferred plus syringe 0.5 ml	Formulary	OTC
preferred plus syringe 1 ml	Formulary	OTC
preferred plus thin lancets	Formulary	OTC
prefpls ins syr 1 ml 30gx5/16" (otc)	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
pub ins syrin 0.3 ml 30gx1/2" regular needle	Formulary	OTC
pub ins syringe 1 ml 30gx1/2" regular needle (otc)	Formulary	OTC
pub insul syr 0.3 ml 31gx5/16" short needle	Formulary	OTC
pub insul syr 0.5 ml 30gx1/2" regular needle (otc)	Formulary	OTC
pub insul syr 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
pub insulin syr 1 ml 31gx5/16" short needle (otc)	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 PNTP 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
ra ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
ra ins syr 0.5 ml 30gx5/16" (otc)	Formulary	OTC
ra ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
ra ins syringe 1 ml 30gx5/16" (otc)	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
relion ins syr 0.3 ml 29gx1/2"	Formulary	OTC
relion ins syr 0.3 ml 31gx6mm	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
relion ins syr 0.5 ml 31gx6mm	Formulary	OTC
relion ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
relion ins syr 1 ml 31gx15/64"	Formulary	OTC
relion ins syr 1 ml 31gx5/16" (otc)	Formulary	OTC
relion ins syr 1 ml 31gx5/16" inner (otc)	Formulary	OTC
relion ins syr 1 ml 31gx5/16" outer,10x10 (otc)	Formulary	OTC
relion insulin syr 0.5 ml	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
relion pen needle 29gx1/2"	Formulary	OTC
RELION PEN NEEDLE 29GX1/2"	Formulary	OTC
relion pen needle 31g 6mm	Formulary	OTC
relion pen needle 31gx1/4"	Formulary	OTC
relion pen needle 31gx5/16"	Formulary	OTC
relion pen needle 31gx5/16" short	Formulary	OTC
RELION PEN NEEDLE 31GX5/16" SHORT (OTC)	Formulary	OTC
relion pen needle 32gx5/32"	Formulary	OTC
relion syring 0.3 ml 31gx5/16"	Formulary	OTC
relion syring 0.3 ml 31gx5/16" inner	Formulary	OTC
relion syring 0.3 ml 31gx5/16" outer,10x10	Formulary	OTC
relion syring 0.5 ml 31gx5/16" (otc)	Formulary	OTC
relion syring 0.5 ml 31gx5/16" inner (otc)	Formulary	OTC
relion syring 0.5 ml 31gx5/16" outer,10x10 (otc)	Formulary	OTC
relion thin 26g lancets	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
saps twist top 30g lancet	Formulary	OTC
saps twist top 30g lancets	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
sm ins syr 0.5 ml 29gx1/2" (otc)	Formulary	OTC
sm ins syr 0.5 ml 30gx5/16" short needle (otc)	Formulary	OTC
sm ins syr 1 ml 29gx1/2" (otc)	Formulary	OTC
sm ins syring 0.3 ml 30gx5/16" short needle	Formulary	OTC
sm ins syringe 1 ml 28gx1/2" (otc)	Formulary	OTC
sm ins syringe 1 ml 30gx5/16" short needle (otc)	Formulary	OTC
sm insul syr 0.3 ml 31gx5/16" short needle	Formulary	OTC
sm insul syr 0.5 ml 31gx5/16" short needle (otc)	Formulary	OTC
sm insulin syr 0.3 ml 29gx1/2"	Formulary	OTC
sm insulin syr 0.5 ml 28gx1/2" (otc)	Formulary	OTC
sm insulin syr 1 ml 31gx5/16" short needle (otc)	Formulary	OTC
sm lancets 21g	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 RECAPPABLE	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	
syringe (disposable) syringe 3 ml	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
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"	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
terumo ins syr 0.3 ml 29gx1/2"	Formulary	OTC
terumo ins syringe u100-1 ml	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
tuberculin-allergy syringes	Non-Formulary	OTC
twist lancets 28g	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
ultcare ins syr 1 ml 31gx5/16" 31gx5/16" (otc)	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
ulticare ins safety 1 ml 29x1/2 (rx)	Formulary	OTC
ulticare ins syr 0.3 ml 30g 8mm	Formulary	OTC
ulticare ins syr 0.3 ml 31g 8mm	Formulary	OTC
ulticare ins syr 0.5 ml 30g 8mm (otc)	Formulary	OTC
ULTICARE INS SYR 0.5 ML 31G 6MM	Formulary	OTC
ulticare ins syr 0.5 ml 31g 8mm (otc)	Formulary	OTC
ulticare ins syr 1 ml 28gx1/2" 28gx1/2" (otc)	Formulary	OTC
ulticare ins syr 1 ml 29gx1/2" 29gx1/2" (otc)	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
ulticare safety 0.5 ml 29gx1/2 (rx)	Formulary	OTC
ULTICARE SAFETY PEN NEEDLE	Non-Formulary	OTC
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 23 GAUGE X 1"	Non-Formulary	OTC
ulticare syr 0.3 ml 29g 12.7mm	Formulary	OTC
ULTICARE SYR 0.3 ML 30GX1/2"	Formulary	OTC
ulticare syr 0.3 ml 30gx5/16" 30gx5/16"	Formulary	OTC

Medications	Coverage Level	Restrictions
ulticare syr 0.3 ml 31gx5/16"	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL	Formulary	OTC
ulticare syr 0.5 ml 29g 12.7mm (otc)	Formulary	OTC
ulticare syr 0.5 ml 29gx1/2" 29gx1/2" (otc)	Formulary	OTC
ULTICARE SYR 0.5 ML 30GX1/2"	Formulary	OTC
ulticare syr 0.5 ml 30gx5/16" 30gx5/16" (otc)	Formulary	OTC
ulticare syr 0.5 ml 31gx5/16" 31gx5/16" (otc)	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT	Formulary	OTC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL	Formulary	OTC
ulticare syr 1 ml 30gx5/16" 30gx5/16" (otc)	Formulary	OTC
ULTICARE SYR 1 ML 31GX5/16"	Formulary	OTC
ulticare syrin 0.3 ml 29gx1/2" 29gx1/2"	Formulary	OTC
ulticare syrin 0.5 ml 28gx1/2" 28gx1/2" (otc)	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 RECAPPABLE	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 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

Medications	Coverage Level	Restrictions
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		
Metabolic Disease Enzyme Replacement, Alpha-Mannosidosis		
LAMZEDE	State Carve Out	
Metabolic Disease Enzyme Replacement, Fabry's Disease		
ELFABRIO	State Carve Out	
FABRAZYME	State Carve Out	
Metabolic Disease Enzyme Replacement, Gaucher's Disease		
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	State Carve Out	
ELELYSO	State Carve Out	
VPRIV	State Carve Out	
Metabolic Disease Enzyme Replacement, Hypophosphatasia		
STRENSIQ	State Carve Out	
Metabolic Disease Enzyme Replacement, Mucopolysaccharidosis		
ALDURAZYME	State Carve Out	
ELAPRASE	State Carve Out	

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

Medications	Coverage Level	Restrictions
Metabolic Modifier - Hereditary Tyrosinemia Treatment Agents		
nitisinone	State Carve Out	
NITYR	State Carve Out	
ORFADIN	State Carve Out	
Metabolic Modifier - Homocystinuria Treatment Agents		
betaine	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	
sodium benzoate-sod phenylacet	State Carve Out	
sodium phenylbutyrate	State Carve Out	
sodium phenylbutyrate powder	Formulary	
sodium phenylbutyrate powder spb	Formulary	
sodium phenylbutyrate powder usp	Formulary	
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (Cps 1) Activator		
CARBAGLU	State Carve Out	
carglumic acid	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	
sapropterin	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	
fluoride (sodium) dental solution	Non-Formulary	
fluoride 0.25 mg tablet chew (rx)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
fluoride 0.25 mg tablet chew cherry flavor (rx)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
fluoride 0.5 mg tablet chew (rx)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
fluoride 0.5 mg tablet chew grape flavor (rx)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
fluoride 1 mg tablet chewable (rx)	Formulary	QL (1 tablet per 1 day); Age Limit (Max 16 Years)
fluoride 1 mg tablet chewable orange flavor (rx)	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	
sod fluoride enam prot 5000ppm	Formulary	

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

Medications	Coverage Level	Restrictions
Mouth And Throat - Saliva Stimulants		
cevimeline	Non-Formulary	
EVOXAC	Non-Formulary	
pilocarpine hcl 5 mg tablet	Formulary	
pilocarpine hcl 5 mg tablet f/c	Formulary	
pilocarpine hcl 5 mg tablet outer	Formulary	
pilocarpine hcl 7.5 mg tablet	Formulary	
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors		
doxycycline hyclate 20 mg tab	Formulary	
doxycycline hyclate 20 mg tab f/c	Formulary	
Therapy For Drooling- Primary Or Secondary Sialorrhea-Anticholinergic		
CUVPOSA	Non-Formulary	
glycopyrrolate 1 mg/5 ml oral solution	Formulary	Age Limit (Max 12 Years)
Multiple Sclerosis Agents		
Multiple Sclerosis Agent - Cd20 Specific Monoclonal Antibody		
KESIMPTA 20 MG/0.4 ML PEN SUV, P/F	Formulary	PDL Preferred
Multiple Sclerosis Agent - Interferons		
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 SYRING 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, OUTERM, 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
dimethyl fumarate 30d start pk	Formulary	PDL Preferred
dimethyl fumarate dr 120 mg cp	Formulary	PDL Preferred
dimethyl fumarate dr 240 mg cp	Formulary	PDL Preferred
glatiramer 20 mg/ml syringe outer,suv	Formulary	PA; Brand Preferred; PDL Non-Preferred
glatiramer 40 mg/ml syringe outer,sdv	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	
dalfampridine er 10 mg tablet	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
teriflunomide 14 mg tablet	Formulary	PDL Preferred
teriflunomide 7 mg tablet	Formulary	PDL Preferred
Multiple Sclerosis Agent - Sphingosine 1-Phosphate Receptor Modulator		
fingolimod 0.5 mg capsule	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		
carboxymethylcell 0.5% eye drp	Formulary	OTC
carboxymethylcell 0.5% eye drp	Formulary	Dual Eligible Covered; OTC
carboxymethylcell 0.5% eye drp inner	Formulary	OTC
carboxymethylcell 0.5% eye drp outer	Formulary	OTC
carboxymethylcell 1% eye gel	Formulary	OTC
carboxymethylcellulose sodium ophthalmic (eye) dropperette	Non-Formulary	Dual Eligible Covered; OTC
carboxymethylcellulose sodium ophthalmic (eye) drops, liquid gel	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)
polyvinyl alcohol 1.4% eyedrop	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
Miotics - Cholinesterase Inhibitors		
PHOSPHOLINE IODIDE 0.125% DROP OUTER	Formulary	
Miotics - Direct Acting		
MIOCHOL-E	Non-Formulary	
pilocarpine 1% eye drops	Formulary	
pilocarpine 2% eye drops	Formulary	
pilocarpine 4% eye drops	Formulary	
Mydriatic And Cycloplegic Combinations		
CYCLOMYDRIL	Non-Formulary	
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations		
SIMBRINZA 1%-0.2% EYE DROP	Formulary	PDL Preferred
Ophthalmic - Antibacterial-Glucocorticoid Combinations		
MAXITROL	Non-Formulary	
neo-bacit-poly-hc eye ointment	Formulary	
neomycin-polymyxin-hc ophthalmic (eye)	Non-Formulary	
neomyc-polym-dexamet eye ointm	Formulary	
neomyc-polym-dexameth eye drop	Formulary	
NEO-POLYCIN HC	Non-Formulary	
sulf-pred 10-0.23% eye drops	Formulary	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	Non-Formulary	
TOBRADEX ST	Non-Formulary	
tobramycin-dexameth ophth susp	Formulary	

Medications	Coverage Level	Restrictions
ZYLET	Non-Formulary	
Ophthalmic - Anticholinergics		
atropine 1% eye drops	Formulary	
atropine 1% eye ointment	Formulary	
CYCLOGYL	Non-Formulary	
cyclopentolate 1% eye drop	Formulary	
cyclopentolate 1% eye drops	Formulary	
ISOPTO ATROPINE	Non-Formulary	
MYDRIACYL	Non-Formulary	
tropicamide 0.5% eye drop	Formulary	
tropicamide 0.5% eye drops	Formulary	
tropicamide 1% eye drop	Formulary	
tropicamide 1% eye drops	Formulary	
Ophthalmic - Antihistamines		
ALAWAY 0.025% EYE DROPS	Formulary	PDL Preferred; Dual Eligible Covered; OTC
azelastine hcl 0.05% drops	Formulary	PDL Preferred
azelastine hcl 0.05% drops sterile	Formulary	PDL Preferred
azelastine hcl 0.05% drops strl	Formulary	PDL Preferred
bepotastine 1.5% eye drop	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
epinastine hcl 0.05% eye drops	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
gnp olopatadine 0.1% eye drops (otc)	Formulary	PDL Preferred; OTC
gnp olopatadine 0.2% eye drop (otc)	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
ketotifen fum 0.025% eye drops (otc)	Formulary	PDL Preferred; OTC
ketotifen fum 0.025% eye drops (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
ketotifen fum 0.035% eye drops (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
LASTACAFT ONCE DAILY 0.25% DRP	Formulary	PA; PDL Non-Preferred; OTC
olopatadine hcl 0.1% eye drop (otc)	Formulary	PDL Preferred; OTC
olopatadine hcl 0.1% eye drops (otc)	Formulary	PDL Preferred; OTC
olopatadine hcl 0.1% eye drops (rx)	Formulary	PA; PDL Non-Preferred; OTC
olopatadine hcl 0.2% eye drop (otc)	Formulary	PDL Preferred; OTC
olopatadine hcl 0.2% eye drop (rx)	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
sm olopatadine 0.2% eye drop (otc)	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
Ophthalmic - Anti-Inflammatory, Glucocorticoids		
ALREX 0.2% EYE DROPS	Formulary	PA; PDL Non-Preferred
dexamethasone 0.1% eye drop	Formulary	
difluprednate	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	
fluorometholone 0.1% eye drop	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	
loteprednol etabonate 0.2% drp	Formulary	PA; PDL Non-Preferred
loteprednol etabonate ophthalmic (eye) drops,gel	Non-Formulary	
loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %	Non-Formulary	
MAXIDEX	Non-Formulary	
PRED FORTE	Non-Formulary	
PRED MILD	Non-Formulary	

Medications	Coverage Level	Restrictions
prednisolone ac 1% eye drop	Formulary	
prednisolone sod 1% eye drop	Formulary	
TRIESENCE (PF)	Non-Formulary	
XIPERE (PF)	Non-Formulary	
Ophthalmic - Anti-Inflammatory, Immunomodulators		
CEQUA 0.09% SOLUTION	Formulary	PA; PDL Non-Preferred; QL (60 ampules per 30 days)
cyclosporine 0.05% eye emulsion	Formulary	PA; Brand Preferred; PDL Non-Preferred; QL (2 ampules per 1 day)
cyclosporine 0.05% eye emulsion outer	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)
Ophthalmic - Anti-Inflammatory, Lfa-1 Antagonists		
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)
Ophthalmic - Anti-Inflammatory, Nsaids		
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
bromfenac sod 0.075% eye drop	Formulary	PA; PDL Non-Preferred
bromfenac sodium 0.07% eye drp	Formulary	PA; PDL Non-Preferred
bromfenac sodium 0.09% eye drp	Formulary	PA; PDL Non-Preferred
BROMSITE 0.075% EYE DROPS	Formulary	PA; PDL Non-Preferred
diclofenac 0.1% eye drops	Formulary	PDL Preferred
flurbiprofen 0.03% eye drop	Formulary	PDL Preferred
ILEVRO 0.3% OPHTH DROPS	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
ketorolac 0.4% ophth solution	Formulary	PA; PDL Non-Preferred
ketorolac 0.5% ophth solution	Formulary	PDL Preferred
NEVANAC 0.1% EYE DROP	Formulary	PA; PDL Non-Preferred
PROLENSA 0.07% EYE DROPS	Formulary	PA; PDL Non-Preferred
Ophthalmic - Beta Blockers-Adrenergic Combinations		
brimonidine-timolol 0.2%-0.5%	Formulary	PA; Brand Preferred; PDL Non-Preferred
COMBIGAN 0.2%-0.5% EYE DROPS	Formulary	PDL Preferred
Ophthalmic - Beta Blockers-Carbonic Anhydrase Inhibitor Combinations		
COSOPT EYE DROPS	Formulary	PA; PDL Non-Preferred
COSOPT PF EYE DROPS OUTER	Formulary	PA; PDL Non-Preferred
dorzolamide-timolol 2%-0.5% outer	Formulary	PA; PDL Non-Preferred
dorzolamide-timolol 2%-0.5% outer, plf	Formulary	PA; PDL Non-Preferred
dorzolamide-timolol eye drops	Formulary	PDL Preferred
Ophthalmic - Carbonic Anhydrase Inhibitors		
AZOPT 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
brinzolamide 1% eye drops	Formulary	PDL Preferred
dorzolamide hcl 2% eye drops	Formulary	PDL Preferred
Ophthalmic - Cystine Depleting Agents		
CYSTADROPS	Non-Formulary	
CYSTARAN	Non-Formulary	
Ophthalmic - Decongestants		
phenylephrine 2.5% eye drop	Formulary	
phenylephrine hcl ophthalmic (eye) drops 10 %	Non-Formulary	
Ophthalmic - Diagnostic Agents		
fluorescein-benoxinate	Non-Formulary	
Ophthalmic - Human Nerve Growth Factor (Hngf)		
OXERVATE 0.002% EYE DROP	Formulary	PA; QL (28 ML per 28 days); Age Limit (Min 2 Years)
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-Blockers		
betaxolol hcl 0.5% eye drop	Formulary	PA; PDL Non-Preferred
BETIMOL 0.25% EYE DROPS	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
BETIMOL 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
BETOPTIC S 0.25% EYE DROP	Formulary	PDL Preferred
carteolol hcl 1% eye drops	Formulary	PDL Preferred
ISTALOL 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
levobunolol 0.5% eye drops	Formulary	PA; PDL Non-Preferred
timolol 0.25% gel-solution	Formulary	PDL Preferred
timolol 0.5% eye drop	Formulary	PA; PDL Non-Preferred
timolol 0.5% eye drops	Formulary	PA; PDL Non-Preferred
timolol 0.5% gel-solution	Formulary	PDL Preferred
timolol 0.5% gfs gel-solution	Formulary	PDL Preferred
timolol maleate 0.25% eye drop	Formulary	PDL Preferred
timolol maleate 0.25% eye drop outer	Formulary	PA; PDL Non-Preferred
timolol maleate 0.5% eye drop	Formulary	PA; PDL Non-Preferred
timolol maleate 0.5% eye drop outer	Formulary	PA; PDL Non-Preferred
timolol maleate 0.5% eye drop outer, p/f	Formulary	PA; PDL Non-Preferred
timolol maleate 0.5% eye drops	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 - Local Anesthetic Combinations		
fluorescein-benoxinate	Non-Formulary	
Ophthalmic - Local Anesthetic Esters		
ALCAINE	Non-Formulary	
proparacaine 0.5% eye drops	Formulary	
tetracaine hcl	Non-Formulary	
tetracaine hcl (pf) ophthalmic (eye)	Non-Formulary	
Ophthalmic - Local Anesthetic, Amides		
AKTEN (PF)	Non-Formulary	
Ophthalmic - Mast Cell Stabilizers		
ALOMIDE 0.1% EYE DROP	Formulary	PA; PDL Non-Preferred
cromolyn 4% eye drops	Formulary	PDL Preferred
Ophthalmic - Rho Kinase Inhibitor And Prostaglandin Analog Combination		
ROCKLATAN 0.02%-0.005% EYE DRP	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
Ophthalmic - Surgical Aids Other		
GELFILM OPHTHALMIC (EYE)	Non-Formulary	
Ophthalmic Antibacterial Mixtures		
bacitracin-polymyxin eye oint	Formulary	
neomyc-bacit-polymix eye oint	Formulary	
neomyc-polym-gramicid eye drop formerly ocutricin	Formulary	
NEO-POLYCIN EYE OINTMENT	Formulary	
POLYCIN EYE OINTMENT	Formulary	
polymyxin b-tmp eye drops	Formulary	
Ophthalmic Antibiotic - Aminoglycosides		
gentamicin 0.3% eye drop	Formulary	
tobramycin 0.3% eye drop	Formulary	
TOBREX OPHTHALMIC (EYE) OINTMENT	Non-Formulary	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors		
bacitracin 500 unit/gm ophthalmic ointment sterile	Formulary	
Ophthalmic Antibiotic - Fluoroquinolones		
BESIVANCE 0.6% SUSP	Formulary	PA; PDL Non-Preferred
CILOXAN 0.3% OINTMENT	Formulary	PA; PDL Non-Preferred
ciprofloxacin 0.3% eye drop	Formulary	PDL Preferred
gatifloxacin 0.5% eye drops	Formulary	PA; PDL Non-Preferred
levofloxacin 0.5% eye drop	Formulary	PA; PDL Non-Preferred
moxifloxacin 0.5% eye drop (viscous) (twice daily)	Formulary	PA; PDL Non-Preferred
moxifloxacin 0.5% eye drops	Formulary	PDL Preferred
OCUFLOX 0.3% EYE DROPS	Formulary	PA; PDL Non-Preferred
ofloxacin 0.3% eye drops	Formulary	PDL Preferred
VIGAMOX 0.5% EYE DROPS	Formulary	PA; PDL Non-Preferred
Ophthalmic Antibiotic - Macrolides		
AZASITE 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
erythromycin 0.5% eye ointment	Formulary	PDL Preferred
erythromycin 0.5% eye ointment 50's, u-d	Formulary	PDL Preferred
erythromycin 0.5% eye ointment outer	Formulary	PDL Preferred
Ophthalmic Antibiotic - Sulfonamides		
sulfacetamide 10% eye drops	Formulary	

Medications	Coverage Level	Restrictions
sulfacetamide 10% eye ointment	Formulary	
Ophthalmic Antifungals - Tetraene Polyene-Type		
NATACYN	Non-Formulary	
Ophthalmic Antifungals		
NATACYN	Non-Formulary	
Ophthalmic Antiseptics		
BETADINE OPHTHALMIC PREP	Non-Formulary	
Ophthalmic Antivirals		
trifluridine	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
apraclonidine hcl 0.5% drops	Formulary	PDL Preferred
brimonidine 0.2% eye drop	Formulary	PDL Preferred
brimonidine tartrate 0.1% drop	Formulary	PA; PDL Non-Preferred
brimonidine tartrate 0.15% drp	Formulary	PA; PDL Non-Preferred
IOPIDINE 1% EYE DROPS	Formulary	PA; PDL Non-Preferred
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs		
bimatoprost 0.03% eye drops	Formulary	PA; PDL Non-Preferred
IYUZEH 0.005% EYE DROP OUTER	Formulary	PA; PDL Non-Preferred
latanoprost 0.005% eye drops	Formulary	PDL Preferred
latanoprost 0.005% eye drops 3's, multi-pack	Formulary	PDL Preferred
LUMIGAN 0.01% EYE DROPS	Formulary	PA; PDL Non-Preferred
tafluprost 0.0015% eye drop outer	Formulary	PA; PDL Non-Preferred
TRAVATAN Z 0.004% EYE DROP	Formulary	PA; PDL Non-Preferred
travoprost 0.004% eye drop	Formulary	PA; PDL Non-Preferred
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
Ophthalmic-Intraocular Pressure Reducing Agents, Rho Kinase Inhibitors		
RHOPRESSA 0.02% OPHTH SOLUTION	Formulary	PDL Preferred

Medications	Coverage Level	Restrictions
Otic (Ear)		
Otic (Ear) - Anti-Infective-Glucocorticoid Combinations		
CIPRO HC OTIC SUSPENSION	Formulary	PA; PDL Non-Preferred
ciproflox-dexameth otic susp	Formulary	PDL Preferred
ciproflox-fluocinln 0.3-0.025%	Formulary	PA; PDL Non-Preferred
CORTISPORIN-TC	Non-Formulary	
neomycin-polymyxin-hc ear soln w/dropper	Formulary	PDL Preferred
neomycin-polymyxin-hc ear susp	Formulary	PDL Preferred
neomycin-polymyxin-hc ear susp w/dropper	Formulary	PDL Preferred
Otic (Ear) - Anti-Infectives Other		
acetic acid 2% ear solution	Formulary	
Otic (Ear) - Fluoroquinolones		
ciprofloxacin 0.2% otic soln	Formulary	PA; PDL Non-Preferred
ofloxacin 0.3% ear drops	Formulary	PDL Preferred
Otic (Ear) - Glucocorticoids		
DERMOTIC OIL	Non-Formulary	
FLAC OTIC OIL	Non-Formulary	
fluocinolone acetonide oil	Non-Formulary	
hydrocortisone 1%-acetic acid 2% ear drop	Formulary	
Respiratory Therapy Agents		
Antihistamine - 1St Generation - Alkylamines		
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
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

Medications	Coverage Level	Restrictions
Antihistamine - 1St Generation - Ethanolamines		
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)
carbinoxamine 4 mg/5 ml liquid	Formulary	
carbinoxamine maleate 4 mg tab	Formulary	
CHILD ALLERGY RLF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHILDREN'S ALLERGY (DIPHENHYD) ORAL TABLET,CHEWABLE	Non-Formulary	OTC
clemastine oral tablet	Non-Formulary	
DIPHEDRYL 12.5 MG/5 ML ELIXIR	Formulary	Dual Eligible Covered; OTC
diphenhydramine 12.5 mg/5 ml	Formulary	OTC
diphenhydramine 12.5 mg/5 ml	Formulary	Dual Eligible Covered; OTC
diphenhydramine 12.5 mg/5 ml cup outer	Formulary	OTC
diphenhydramine 12.5 mg/5 ml cup outer	Formulary	Dual Eligible Covered; OTC
diphenhydramine 25 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet inner	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet outer	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
diphenhydramine 25 mg/10 ml cup outer	Formulary	OTC
diphenhydramine 25 mg/10 ml cup outer	Formulary	Dual Eligible Covered; OTC
diphenhydramine 50 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg capsule u-d, 10x10 (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml syrng suv	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial mdv	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv, p/f	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv, p/f, outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv,outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine hcl oral elixir	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
NYTOL	State Carve Out	OTC
REST SIMPLY NIGHTTIME SLEEP	State Carve Out	OTC
RYVENT	Non-Formulary	
SIMPLY SLEEP	State Carve Out	OTC

Medications	Coverage Level	Restrictions
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		
promethazine 12.5 mg suppos	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg suppos outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet outer	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg suppository inner	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg suppository outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet outer	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 6.25 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml solution cup outer	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml syrp	Formulary	Age Limit (Max 64 Years)
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)
Antihistamine - 1St Generation - Piperidines		
cyproheptadine 2 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
cyproheptadine 2 mg/5 ml syrup	Formulary	Age Limit (Max 64 Years)
cyproheptadine 4 mg tablet	Formulary	Age Limit (Max 64 Years)
cyproheptadine 4 mg tablet outer	Formulary	Age Limit (Max 64 Years)
Antihistamine - 1St Generation - Propylamines		
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
triprolidine hcl	Non-Formulary	OTC
Antihistamines - 1St Generation		
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
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)

Medications	Coverage Level	Restrictions
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)
carbinoxamine 4 mg/5 ml liquid	Formulary	
carbinoxamine maleate 4 mg tab	Formulary	
CHILD ALLERGY RLF 12.5 MG/5 ML	Formulary	Dual Eligible Covered; OTC
CHILDREN'S ALLERGY (DIPHENHYD) ORAL TABLET,CHEWABLE	Non-Formulary	OTC
clemastine oral tablet	Non-Formulary	
cyproheptadine 2 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
cyproheptadine 2 mg/5 ml syrup	Formulary	Age Limit (Max 64 Years)
cyproheptadine 4 mg tablet	Formulary	Age Limit (Max 64 Years)
cyproheptadine 4 mg tablet outer	Formulary	Age Limit (Max 64 Years)
DIPHEDRYL 12.5 MG/5 ML ELIXIR	Formulary	Dual Eligible Covered; OTC
diphenhydramine 12.5 mg/5 ml	Formulary	OTC
diphenhydramine 12.5 mg/5 ml	Formulary	Dual Eligible Covered; OTC
diphenhydramine 12.5 mg/5 ml cup outer	Formulary	OTC
diphenhydramine 12.5 mg/5 ml cup outer	Formulary	Dual Eligible Covered; OTC
diphenhydramine 25 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet inner	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg tablet outer	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 25 mg/10 ml cup outer	Formulary	OTC
diphenhydramine 25 mg/10 ml cup outer	Formulary	Dual Eligible Covered; OTC
diphenhydramine 50 mg capsule (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg capsule u-d, 10x10 (otc)	Formulary	Dual Eligible Covered; OTC; Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml syrng suv	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial mdv	Formulary	Age Limit (Max 64 Years)

Medications	Coverage Level	Restrictions
diphenhydramine 50 mg/ml vial outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv, p/f	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv, p/f, outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine 50 mg/ml vial suv,outer	Formulary	Age Limit (Max 64 Years)
diphenhydramine hcl oral elixir	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
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

Medications	Coverage Level	Restrictions
PEDIAVENT ORAL LIQUID	Non-Formulary	OTC
promethazine 12.5 mg suppos	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg suppos outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 12.5 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 12.5 mg tablet outer	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg suppository inner	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg suppository outer	Formulary	QL (4 suppositories per 1 day); Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 25 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 25 mg tablet outer	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Max 64 Years)
promethazine 50 mg tablet	Formulary	Age Limit (Min 2 Years and Max 64 Years)
promethazine 6.25 mg/5 ml soln	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml solution cup outer	Formulary	Age Limit (Max 64 Years)
promethazine 6.25 mg/5 ml syrp	Formulary	Age Limit (Max 64 Years)
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)

Medications	Coverage Level	Restrictions
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
triprolidine hcl	Non-Formulary	OTC
UNISOM SLEEPGELS	State Carve Out	OTC
WAL-SOM (DIPHENHYDRAMINE)	State Carve Out	OTC
Antihistamines - 2Nd Generation - Piperazines		
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 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
cetirizine hcl 1 mg/ml soln (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln (rx)	Formulary	PDL Preferred; OTC
cetirizine hcl 1 mg/ml soln (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln children, grape (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln children's (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml syrup (rx)	Formulary	PDL Preferred; OTC

Medications	Coverage Level	Restrictions
cetirizine hcl 10 mg chew tab outer	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet	Formulary	PDL Preferred; OTC
cetirizine hcl 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet f/c,u-d,10x10,outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet indoor & outdoor	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet indoor-outdoor,24hr	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg chew tab children's,outer,u-d	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg tablet indoor & outdoor	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg/5 ml solution cup inner	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg/5 ml solution cup outer	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
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

Medications	Coverage Level	Restrictions
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
levocetirizine 2.5 mg/5 ml sol	Formulary	PA; PDL Non-Preferred
levocetirizine 5 mg tablet (otc)	Formulary	PDL Preferred; OTC
levocetirizine 5 mg tablet (rx)	Formulary	PDL Preferred; OTC
levocetirizine 5 mg tablet f/c (rx)	Formulary	PDL Preferred; OTC
SM ALL DAY ALLERGY 10 MG TAB	Formulary	PDL Preferred; OTC
Antihistamines - 2Nd Generation - Piperidines		
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
child loratadine 5 mg/5 ml sol	Formulary	PDL Preferred; Dual Eligible Covered; OTC
child loratadine 5 mg/5 ml syr grape	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CLARINEX 5 MG TABLET	Formulary	PA; PDL Non-Preferred
desloratadine 2.5 mg odt outer	Formulary	PA; PDL Non-Preferred; Age Limit (Max 11 Years)
desloratadine 5 mg odt outer	Formulary	PA; PDL Non-Preferred

Medications	Coverage Level	Restrictions
desloratadine 5 mg tablet	Formulary	PA; PDL Non-Preferred
desloratadine 5 mg tablet f/c	Formulary	PA; PDL Non-Preferred
fexofenadine hcl 180 mg tablet (otc)	Formulary	PDL Preferred; OTC
fexofenadine hcl 180 mg tablet (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
fexofenadine hcl 180 mg tablet non-drowsy, 24hr (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
fexofenadine hcl 60 mg tablet (otc)	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
gnp fexofenadine hcl 180 mg tb (otc)	Formulary	PDL Preferred; OTC
gnp loratadine 10 mg odt	Formulary	PDL Preferred; OTC
gnp loratadine 10 mg tablet	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
hm loratadine 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 10 mg odt	Formulary	PDL Preferred; OTC
loratadine 10 mg odt	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 10 mg tablet	Formulary	PDL Preferred; OTC
loratadine 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
loratadine 10 mg tablet 10x10, outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 10 mg tablet 10x10,u-d,outer	Formulary	PDL Preferred; OTC
loratadine 10 mg tablet outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 5 mg/5 ml solution	Formulary	PDL Preferred; OTC
loratadine 5 mg/5 ml syrup children's	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 5 mg/5 ml syrup children's, d/f	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine allergy 5 mg/5 ml d/f	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
sm fexofenadine hcl 180 mg tab (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
sm loratadine 5 mg/5 ml syrup	Formulary	PDL Preferred; Dual Eligible Covered; OTC
Antihistamines - 2Nd Generation		
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
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

Medications	Coverage Level	Restrictions
ALLERGY RLF (FEXO) 60 MG TAB	Formulary	PDL Preferred; OTC
ALLERGY RLF(CETRZN) 10 MG SFGL	Formulary	PA; PDL Non-Preferred; OTC
cetirizine hcl 1 mg/ml soln (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln (rx)	Formulary	PDL Preferred; OTC
cetirizine hcl 1 mg/ml soln (rx)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln children, grape (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml soln children's (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 1 mg/ml syrup (rx)	Formulary	PDL Preferred; OTC
cetirizine hcl 10 mg chew tab outer	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet	Formulary	PDL Preferred; OTC
cetirizine hcl 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet f/c,u-d,10x10,outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet indoor & outdoor	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet indoor-outdoor,24hr	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 10 mg tablet outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg chew tab children's,outer,u-d	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg tablet indoor & outdoor	Formulary	PDL Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg/5 ml solution cup inner	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
cetirizine hcl 5 mg/5 ml solution cup outer	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

Medications	Coverage Level	Restrictions
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
child loratadine 5 mg/5 ml sol	Formulary	PDL Preferred; Dual Eligible Covered; OTC
child loratadine 5 mg/5 ml syr grape	Formulary	PDL Preferred; Dual Eligible Covered; OTC
CLARINEX 5 MG TABLET	Formulary	PA; PDL Non-Preferred
desloratadine 2.5 mg odt outer	Formulary	PA; PDL Non-Preferred; Age Limit (Max 11 Years)
desloratadine 5 mg odt outer	Formulary	PA; PDL Non-Preferred
desloratadine 5 mg tablet	Formulary	PA; PDL Non-Preferred
desloratadine 5 mg tablet f/c	Formulary	PA; PDL Non-Preferred
fexofenadine hcl 180 mg tablet (otc)	Formulary	PDL Preferred; OTC
fexofenadine hcl 180 mg tablet (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
fexofenadine hcl 180 mg tablet non-drowsy, 24hr (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
fexofenadine hcl 60 mg tablet (otc)	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
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

Medications	Coverage Level	Restrictions
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
gnp fexofenadine hcl 180 mg tb (otc)	Formulary	PDL Preferred; OTC
gnp loratadine 10 mg odt	Formulary	PDL Preferred; OTC
gnp loratadine 10 mg tablet	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
hm loratadine 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
levocetirizine 2.5 mg/5 ml sol	Formulary	PA; PDL Non-Preferred
levocetirizine 5 mg tablet (otc)	Formulary	PDL Preferred; OTC
levocetirizine 5 mg tablet (rx)	Formulary	PDL Preferred; OTC
levocetirizine 5 mg tablet f/c (rx)	Formulary	PDL Preferred; OTC
loratadine 10 mg odt	Formulary	PDL Preferred; OTC
loratadine 10 mg odt	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 10 mg tablet	Formulary	PDL Preferred; OTC
loratadine 10 mg tablet	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 10 mg tablet 10x10, outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC

Medications	Coverage Level	Restrictions
loratadine 10 mg tablet 10x10,u-d,outer	Formulary	PDL Preferred; OTC
loratadine 10 mg tablet outer	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 5 mg/5 ml solution	Formulary	PDL Preferred; OTC
loratadine 5 mg/5 ml syrup children's	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine 5 mg/5 ml syrup children's, d/f	Formulary	PDL Preferred; Dual Eligible Covered; OTC
loratadine allergy 5 mg/5 ml d/f	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
sm fexofenadine hcl 180 mg tab (otc)	Formulary	PDL Preferred; Dual Eligible Covered; OTC
sm loratadine 5 mg/5 ml syrup	Formulary	PDL Preferred; Dual Eligible Covered; OTC
Antitussives - Non-Opioid		
benzonatate	Benefit Exclusion	
Asthma Therapy - 5-Lipoxygenase Inhibitors		
zileuton er 600 mg tablet	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		
epinephrine injection syringe 0.1 mg/ml	Non-Formulary	
Asthma Therapy - Immunoglobulin E (Ige) Inhibitors, Mab		
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)

Medications	Coverage Level	Restrictions
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	
Asthma Therapy - Inhaled Corticosteroids (Glucocorticoids)		
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
ARNUITY ELLIPTA 100 MCG INH	Formulary	PDL Preferred; 3 Months Allowed
ARNUITY ELLIPTA 200 MCG INH	Formulary	PDL Preferred; 3 Months Allowed
ARNUITY 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)
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)

Medications	Coverage Level	Restrictions
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)
budesonide 0.25 mg/2 ml susp	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.25 mg/2 ml susp outer	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.25 mg/2 ml susp outer, single-dose	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.25 mg/2 ml susp outer,u-d,sdv,30's	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.5 mg/2 ml susp	Formulary	PDL Preferred; 3 Months Allowed; QL (2 aampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.5 mg/2 ml susp	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.5 mg/2 ml susp 30's,sdv, outer	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 0.5 mg/2 ml susp outer	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)

Medications	Coverage Level	Restrictions
budesonide 0.5 mg/2 ml susp outer,single-dose	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
budesonide 1 mg/2 ml inh susp outer	Formulary	PDL Preferred; 3 Months Allowed; QL (2 ampules (4ml) per 1 day); Age Limit (Max 8 Years)
fluticasone prop 100 mcg diskus	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fluticasone prop 250 mcg disk	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fluticasone prop 50 mcg diskus	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
fluticasone propionate hfa 110 mcg inhaler	Formulary	PDL Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone propionate hfa 220 mcg inhaler	Formulary	PDL Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
fluticasone propionate hfa 44 mcg inhaler	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)
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 REDIHALER 40 MCG	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
QVAR REDIHALER 80 MCG	Formulary	PDL Preferred; 3 Months Allowed
Asthma Therapy - Interleukin-4 (Il-4) Receptor Alpha Antagonists, Mab		
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
Asthma Therapy - Interleukin-5 (Il-5) Inhibitors, Mab		
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)
Asthma Therapy - Interleukin-5 (Il-5) Receptor Alpha Antagonists, Mab		
FASENRA PEN 30 MG/ML SUV	Formulary	PA; PDL Preferred; Age Limit (Min 6 Years)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	Non-Formulary	
Asthma Therapy - Leukotriene Receptor Antagonists		
ACCOLATE 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
ACCOLATE 20 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
montelukast sod 10 mg tablet	Formulary	PDL Preferred; 3 Months Allowed
montelukast sod 10 mg tablet 15+ yrs, f/c	Formulary	PDL Preferred; 3 Months Allowed
montelukast sod 10 mg tablet f/c	Formulary	PDL Preferred; 3 Months Allowed
montelukast sod 10 mg tablet f/c, outer	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
montelukast sod 10 mg tablet outer	Formulary	PDL Preferred; 3 Months Allowed
montelukast sod 4 mg granules	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 4 mg granules outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 4 mg granules outer, foil pkt	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 4 mg tab chew	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 4 mg tab chew 2-5 yrs old	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 4 mg tab chew outer	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 5 Years)
montelukast sod 5 mg tab chew	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
montelukast sod 5 mg tab chew 6-14 yrs old	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
montelukast sod 5 mg tab chew outer	Formulary	PDL Preferred; 3 Months Allowed; Age Limit (Max 14 Years)
SINGULAIR 10 MG TABLET	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
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)
zafirlukast 10 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
zafirlukast 20 mg tablet	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
zafirlukast 20 mg tablet f/c	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
zafirlukast 20 mg tablet f/c, outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Asthma Therapy - Mast Cell Stabilizers		
cromolyn inhalation	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	
theophylline 80 mg/15 ml soln	Formulary	
theophylline 80 mg/15 ml solution cup outer	Formulary	
theophylline er 100 mg tablet	Formulary	
theophylline er 200 mg tablet	Formulary	
theophylline er 300 mg tablet	Formulary	
theophylline er 400 mg tablet	Formulary	
theophylline er 450 mg tablet	Formulary	
theophylline er 600 mg tablet	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
DALIRESP 500 MCG TABLET	Formulary	PA; PDL Non-Preferred
roflumilast 250 mcg tablet	Formulary	PA; PDL Preferred
roflumilast 250 mcg tablet outer	Formulary	PA; PDL Preferred
roflumilast 500 mcg tablet	Formulary	PA; PDL Preferred
roflumilast 500 mcg tablet outer	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)

Medications	Coverage Level	Restrictions
SPIRIVA HANDIHALER 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)
tiotropium 18 mcg cap-inhaler outer	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)
ipratropium br 0.02% soln	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 25's,p/f,u-d	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 30's	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 30's,p/f	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 30's,p/f,u-d	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 30's,u-d	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 60's	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln 60's,p/f,u-d	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln outer	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln outer, p/f	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ipratropium br 0.02% soln p/f, outer	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln p/f,outer	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln sdv, p/f	Formulary	PDL Preferred; 3 Months Allowed
ipratropium br 0.02% soln sdv, p/f, outer	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		
arformoterol 15 mcg/2 ml soln outer	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
formoterol 20 mcg/2 ml neb vl	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
formoterol 20 mcg/2 ml neb vl outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
PERFOROMIST 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)
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting		
albuterol 2.5 mg/0.5 ml sol	Formulary	PDL Preferred; 3 Months Allowed
albuterol hfa 90 mcg inhaler	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)
albuterol sul 0.63 mg/3 ml sol	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 0.63 mg/3 ml sol 30's,p/f,strl	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
albuterol sul 0.63 mg/3 ml sol outer	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 0.63 mg/3 ml sol u-d, 25's	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 1.25 mg/3 ml sol	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 1.25 mg/3 ml sol outer	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 1.25 mg/3 ml sol p/f,pedia,25's,u-d	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 1.25 mg/3 ml sol p/f,pedia,30's,u-d	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 1.25 mg/3 ml sol u-d, 25's	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln 25's, u-d, p/f	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln 30's, p/f	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln 30's, u-d, p/f	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln 60's, u-d, p/f	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln outer	Formulary	PDL Preferred; 3 Months Allowed
albuterol sul 2.5 mg/3 ml soln p/f, outer	Formulary	PDL Preferred; 3 Months Allowed
levalbuterol 0.31 mg/3 ml sol	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol 0.31 mg/3 ml sol outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol 0.63 mg/3 ml sol	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol 0.63 mg/3 ml sol outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol 1.25 mg/3 ml sol	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol 1.25 mg/3 ml sol outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
levalbuterol conc 1.25 mg/0.5 outer	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol conc 1.25 mg/0.5 outer, p/f	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
levalbuterol tar hfa 45 mcg inh	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)
Asthma/Copd Therapy - Beta Adrenergic Agents		
albuterol sulfate oral	Non-Formulary	
terbutaline sulfate 2.5 mg tab	Formulary	
terbutaline sulfate 5 mg tab	Formulary	
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
ipratropium-albuterol 0.5-3(2.5) mg/3 ml	Formulary	PDL Preferred; 3 Months Allowed

Medications	Coverage Level	Restrictions
ipratropium-albuterol 0.5-3(2.5) mg/3 ml outer	Formulary	PDL Preferred; 3 Months Allowed
ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 30's, 1vl/pouch	Formulary	PDL Preferred; 3 Months Allowed
ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d, 30's,single vl	Formulary	PDL Preferred; 3 Months Allowed
ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d,30's,5 vls/pouch	Formulary	PDL Preferred; 3 Months Allowed
ipratropium-albuterol 0.5-3(2.5) mg/3 ml u-d,60's,5vls/pouch	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)
umeclidinium-vilanterol ellipta 62.5-25 mcg inh	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)
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)

Medications	Coverage Level	Restrictions
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)
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)
budesonide-formoterol 160-4.5	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (2 inhalers per 30 days)

Medications	Coverage Level	Restrictions
budesonide-formoterol 80-4.5	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)
fluticasone-salmeterol 100-50	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 113-14	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 115-21	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 230-21	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 232-14	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 250-50	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 45-21	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 500-50	Formulary	PA; Brand Preferred; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-salmeterol 55-14	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
fluticasone-vilanterol 100-25	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)

Medications	Coverage Level	Restrictions
fluticasone-vilanterol 200-25	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)
Asthma/Copd Tx - Beta-Adrenergic-Anticholinergic-Glucocorticoid Comb,		
BREZTRI AEROSPHERE INHALER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed; QL (1 inhaler per 30 days)
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
tobramycin 300 mg/4 ml ampule	Formulary	PA; Brand Preferred; PDL Non-Preferred

Medications	Coverage Level	Restrictions
tobramycin 300 mg/4 ml ampule outer	Formulary	PA; Brand Preferred; PDL Non-Preferred
tobramycin 300 mg/5 ml ampule outer	Formulary	PDL Preferred
tobramycin 300 mg/5 ml ampule p/f	Formulary	PDL Preferred
tobramycin 300 mg/5 ml ampule p/f, single use	Formulary	PDL Preferred
tobramycin 300 mg/5 ml ampule single use,p/f,outer	Formulary	PDL Preferred
tobramycin pak 300 mg/5 ml	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	
SYMDEKO	State Carve Out	
TRIKAFTA	State Carve Out	
Lung Surfactants		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5 ML	Non-Formulary	
SURVANTA	Non-Formulary	
Mucolytics		
acetylcysteine 10% vial (not for injection) inner	Formulary	
acetylcysteine 10% vial (not for injection) outer	Formulary	
acetylcysteine 10% vial (not for injection) p/f, outer	Formulary	
acetylcysteine 20% vial (not for injection) inner	Formulary	
acetylcysteine 20% vial (not for injection) outer	Formulary	

Medications	Coverage Level	Restrictions
PULMOZYME 1 MG/ML AMPUL 30'S, OUTER	Formulary	PA; QL (1 ampule per 1 day)
Nasal Anticholinergics		
ipratropium 0.03% spray	Formulary	PDL Preferred
ipratropium 0.06% spray	Formulary	PDL Preferred
Nasal Antihistamine And Anti-Inflammatory Steroid Combinations		
azelastin-flutic 137-50 mcg spr	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		
azelastine 0.1% (137 mcg) spry	Formulary	PDL Preferred
azelastine 0.15% nasal spray (rx)	Formulary	PDL Preferred; OTC
olopatadine 665 mcg nasal spry	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
budesonide 32 mcg nasal spray (otc)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
flunisolide 0.025% spray	Formulary	PA; PDL Non-Preferred
fluticasone prop 50 mcg spray (otc)	Formulary	PA; PDL Non-Preferred; OTC
fluticasone prop 50 mcg spray (otc)	Formulary	PA; PDL Non-Preferred; Dual Eligible Covered; OTC
fluticasone prop 50 mcg spray (rx)	Formulary	PDL Preferred; OTC
fluticasone prop 50 mcg spray 120 metered sprays (rx)	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
gnp fluticasone prop 50 mcg sp (otc)	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
mometasone furoate 50 mcg spry (otc)	Formulary	PA; PDL Non-Preferred; OTC
mometasone furoate 50 mcg spry (rx)	Formulary	PA; PDL Non-Preferred; OTC
NASAL ALLERGY 24HR SPRAY	Formulary	PA; PDL Non-Preferred; OTC

Medications	Coverage Level	Restrictions
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
triamcinolone 55 mcg nasal spr (otc)	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
Nasal Mast Cell Stabilizers		
cromolyn sodium nasal spray	Formulary	Dual Eligible Covered; OTC
Nasal Preparations - Nicotinic Receptor Partial Agonist		
TYRVAYA 0.03 MG NASAL SPRAY OUTER	Formulary	PA; PDL Non-Preferred; QL (8.4 ML per 30 days)
Pulmonary Fibrosis Treatment Agents - Antifibrotic Therapy		
ESBRIET	Non-Formulary	
pirfenidone oral capsule	Non-Formulary	
pirfenidone oral tablet 267 mg, 801 mg	Non-Formulary	
Pulmonary Fibrosis Treatment Agents - Multikinase Inhibitors		
OFEV	Non-Formulary	
Systemic Sympathomimetic Decongestants		
pseudoephedrine hcl oral tablet 60 mg	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
clindamycin 2% vaginal cream	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)

Medications	Coverage Level	Restrictions
Vaginal Antifungal - Imidazoles		
3-DAY VAGINAL CREAM	Formulary	Dual Eligible Covered; OTC
clotrimazole 1% vaginal cream	Formulary	OTC
clotrimazole 1% vaginal cream	Formulary	Dual Eligible Covered; OTC
CLOTRIMAZOLE-3 2% CREAM	Formulary	Dual Eligible Covered; OTC
ft clotrimazole 1% vag cream	Formulary	OTC
FT CLOTRIMAZOLE-3 2% CREAM	Formulary	OTC
FT MICONAZOLE 3 COMBO PACK	Formulary	OTC
ft miconazole 7 cream	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	
miconazole 2% vaginal cream	Formulary	Dual Eligible Covered; OTC
miconazole 3 combo pack	Formulary	OTC
MICONAZOLE 3 COMBO PACK 3 SUPP W/9GM CREAM	Formulary	Dual Eligible Covered; OTC
miconazole 7 100 mg vag supp	Formulary	OTC
miconazole 7 cream	Formulary	Dual Eligible Covered; OTC
MICONAZOLE 7 CREAM	Formulary	Dual Eligible Covered; OTC
miconazole nitrate vaginal kit 1,200-2 mg-%	Non-Formulary	Dual Eligible Covered; OTC
MICONAZOLE-3 VAGINAL SUPPOSITORY	Non-Formulary	
miconazole-7 cream	Formulary	Dual Eligible Covered; OTC
SM 3-DAY VAGINAL CREAM	Formulary	Dual Eligible Covered; OTC
sm clotrimazole 1% vag cream	Formulary	Dual Eligible Covered; OTC
sm miconazole 2% vaginal cream w/disp applicators	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
tioconazole	Non-Formulary	Dual Eligible Covered; OTC
TIOCONAZOLE-1	Non-Formulary	Dual Eligible Covered; OTC
Vaginal Antifungal - Triazoles		
terconazole 0.4% cream	Formulary	
terconazole 0.8% cream	Formulary	

Medications	Coverage Level	Restrictions
terconazole 0.8% cream 3-day therapy	Formulary	
terconazole vaginal suppository	Non-Formulary	
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives		
metronidazole vaginal 0.75% gl	Formulary	PDL Preferred
NUVESSA VAGINAL 1.3% GEL	Formulary	PDL Preferred
VANDAZOLE VAGINAL 0.75% GEL	Formulary	PA; PDL Non-Preferred
Vaginal Antiseptic Mixtures		
FEM PH	Non-Formulary	
Vaginal Estrogens		
ESTRACE VAGINAL	Non-Formulary	
estradiol 0.01% cream	Formulary	QL (42.5 GM per 30 days)
estradiol 10 mcg vaginal insrt outer	Formulary	
ESTRING	Non-Formulary	
FEMRING	Non-Formulary	
PREMARIN VAGINAL	Non-Formulary	
VAGIFEM 10 MCG VAGINAL TAB	Formulary	
YUVAFEM 10 MCG VAGINAL INSERT	Formulary	
Vaginal Progestins		
CRINONE 4% GEL OUTER	Formulary	PA; PDL Non-Preferred; 3 Months Allowed
Weight Loss/Gain Agents		
Anorexiant Combinations		
phentermine-topiramate er 11.25-69 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 12 Years)
phentermine-topiramate er 15-92 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 12 Years)
phentermine-topiramate er 3.75-23 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 12 Years)
phentermine-topiramate er 7.5-46 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 12 Years)
Anorexiants		
ADIPEX-P 37.5 MG TABLET	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
benzphetamine hcl 50 mg tablet (rx)	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)

Medications	Coverage Level	Restrictions
diethylpropion 25 mg tablet	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
diethylpropion 25 mg tablet	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
diethylpropion er 75 mg tablet	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
diethylpropion er 75 mg tablet	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)
phendimetrazine 35 mg tablet	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
phendimetrazine 35 mg tablet	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 18 Years)
phendimetrazine er 105 mg cap	Formulary	PA; PDL Preferred; Age Limit (Min 18 Years)
phentermine 15 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
phentermine 15 mg capsule	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
phentermine 30 mg capsule	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
phentermine 30 mg capsule	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
phentermine 37.5 mg capsule	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)
phentermine 37.5 mg tablet	Formulary	PA; PDL Preferred; Age Limit (Min 17 Years)
phentermine 37.5 mg tablet	Formulary	PA; PDL Preferred; Dual Eligible Covered; Age Limit (Min 17 Years)

Medications	Coverage Level	Restrictions
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		
orlistat 120 mg capsule	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)
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)

Medications	Coverage Level	Restrictions
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		
dronabinol 10 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule	Formulary	PA
dronabinol 2.5 mg capsule outer	Formulary	PA
dronabinol 5 mg capsule	Formulary	PA
dronabinol 5 mg capsule outer	Formulary	PA
MARINOL	Non-Formulary	
Appetite Stimulants - Progestin Hormone Type		
megestrol 400 mg/10 ml cup inner	Formulary	PDL Preferred
megestrol 400 mg/10 ml cup outer	Formulary	PDL Preferred
megestrol 400 mg/10 ml suspension cup outer	Formulary	PDL Preferred
megestrol 625 mg/5 ml susp	Formulary	PA; PDL Non-Preferred
megestrol 800 mg/20 ml suspension cup inner	Formulary	PDL Preferred
megestrol 800 mg/20 ml suspension cup outer	Formulary	PDL Preferred
megestrol acet 40 mg/ml susp	Formulary	PDL Preferred
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