

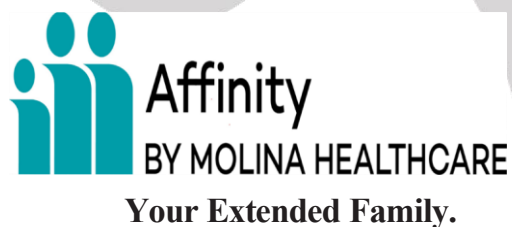
Preferred Drug List

Affinity by Molina Healthcare of New York, Inc
CHP



2026

*Affinity by Molina mandates the use of generic drugs, if available. Brand names listed are for reference only. THIS LIST IS SUBJECT TO CHANGE. You can get more information and updates to this document on our website at www.molinahealthcare.com



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 - Qualified sign language interpreters
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- Phone: (866) 606-3889 (for TTY/TDD services, call 711)
- Fax: (718) 536-3358
- In person: 2900 Exterior Street Suite 202, Bronx, NY 10463
- Email: Civil.Rights@MolinaHealthcare.com

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- Web: Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

This notice is available at Affinity's website: AffinityPlan.com.

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call (800) 223-7242 (TTY:711).	English
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请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 (800) 223- 7242 (TTY:711)。	Chinese
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ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру (800) 223- 7242 (TTY:711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il (800) 223- 7242 (TTY:711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le (800) 223- 7242 (TTY:711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele (800) 223- 7242 (TTY:711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר איין אומזיסט. רופט (800) 223-7242 (TTY:711).	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: (800) 223- 7242 (TTY:711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa (800) 223- 7242 (TTY:711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। (800) 223-7242 (TTY:711)-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi (800) 223- 7242 (TTY:711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο (800) 223- 7242 (TTY:711).	Greek
توجہ: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بال معاوضہ دستیاب ہیں۔ کال کریں (800) 223-7242 (TTY:711)۔	Urdu

Affinity by Molina Healthcare of New York Preferred Drug List (Formulary)

(10/01/2026)

INTRODUCTION

We are pleased to provide the Affinity by *Molina Healthcare of New York Preferred Drug List (Formulary)* as a useful reference and informational tool. This document can assist medical providers in selecting clinically-appropriate and cost-effective products for their patients.

The drugs represented have been reviewed by a Pharmacy and Therapeutics (P&T) Committee and are approved for inclusion. The document is reflective of current medical practice as of the date of review.

The information contained in this document and its appendices is provided solely for the convenience of medical providers. We do not warrant or assure accuracy of such information nor is it intended to be comprehensive in nature. All the information in the document is provided as a reference for drug therapy selection.

The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

We assume no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

PREFACE

The document is organized by sections. Each section is divided by therapeutic drug class primarily defined by mechanism of action.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The services of a Pharmacy and Therapeutics Committee ("P&T Committee") are utilized to approve safe and clinically effective drug therapies. The P&T Committee is an advisory body of clinical professionals. The P&T Committee's voting members include physicians and pharmacists, all of whom have a broad background of clinical and academic expertise regarding prescription drugs. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

DRUG LIST PRODUCT DESCRIPTIONS

To assist in understanding which specific strengths and dosage forms on the document are covered, general principles are noted below.

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g., *atorvastatin*).
- The second column (Requirements/Limits) contains any special requirements for coverage of your drug.
- If the OTC and Prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms on the document will be consistent with the category and use where listed.

GENERIC SUBSTITUTION

Generic substitution is a pharmacy action whereby a generic version is dispensed rather than a prescribed brand-name product. In this document, *lowercase italicized* type indicates generic availability. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product to the market. However, the document is subject to state specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Generic drugs are usually priced lower than their brand-name equivalents. Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drug.
- Manufactured in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

The document represents a closed formulary plan design. The medications listed on the document are covered by the plan as represented. Certain medications on the list are covered if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.); requests for use of such medications outside of their listed criteria will be reviewed for medical necessity. If a medication is not listed on the document, a formulary exception may be requested for coverage. Medical necessity or formulary exception requests will be reviewed based on drug-specific prior authorization criteria or standard nonformulary prescription request criteria. Log in to **www.molinahealthcare.com** to check coverage.

CLASSES OF CONSIDERATION

OPIOID ANALGESICS

All Opioid Analgesics are subject to a Morphine Equivalent Dose of 90 mg per day. Concurrent use of opioids with benzodiazepines or muscle relaxants is excluded.

NON-COVERED MEDICATIONS

Please note that certain medications are not covered. This includes, but is not limited to:

- Pharmaceuticals determined by the Federal Drug Administration (FDA) to be less than effective and identical, related or similar drugs (frequently referred to as “DESI 5 and 6” drugs)

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Affinity by Molina Drug Formulary may be approved when medically necessary and when formulary options have demonstrated ineffectiveness. When these exceptional situations arise, the physician may fax a completed drug prior authorization form to Affinity by Molina at (844) 823-5479. The forms may be obtained by logging into the website **www.molinahealthcare.com**. Trials of pharmaceutical samples will not be considered as rationale for approving a prior authorization request.

PRIOR AUTHORIZATION HELPFUL HINTS

To ensure the quickest response possible from Affinity by Molina Pharmacy Department, please provide relevant information with the Prior Authorization request. The following are examples:

Class of Medication/Diagnosis

Cholesterol Lowering

Diabetes

Non-Formulary/Non-Preferred
Medication Formulary

Requested Clinical Information

Lipid Panel, Cardiovascular risk factors

A1c Report

Medication Log and/or Progress Notes documenting previous use
of medications

LEGEND

AGE	Age Limit
MED	Max 90 mg Morphine Equivalent Dose per day
GNDR	Gender Edit
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit
SP	Specialty Drug; these drugs must be obtained through a specialty
ST	pharmacy Step Therapy

lowercase Indicates generic availability

UPPERCASE Indicates brand availability

REQUESTING FORMULARY CHANGES

If you are a prescriber and would like to request a formulary change, please submit your request and rationale to Affinity by Molina's Pharmacy Department with your contact information.

Fax: (866) 879-4742

NOTICE

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This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers

Lista de Medicamentos Preferidos de Affinity de Molina Healthcare of New York (Formulario)

(10/01/2026)

INTRODUCCIÓN

Nos complace proporcionar la *Lista de Medicamentos Preferidos (Formulario) de Affinity de Molina Healthcare of New York* como una herramienta útil de referencia e información. Este documento puede ayudar a los proveedores médicos a seleccionar los productos clínicamente adecuados y rentables para sus pacientes.

Los medicamentos representados fueron revisados por un Comité de Farmacia y Terapia (P&T) y fueron aprobados para su inclusión. El documento refleja la práctica médica actual desde la fecha de revisión.

La información contenida en este documento y sus apéndices se proporciona únicamente para la conveniencia de los proveedores médicos. Nosotros no garantizamos ni aseguramos la exactitud de dicha información, ni tampoco tiene la intención de ser exhaustiva. Toda la información que figura en el documento se proporciona como referencia para la selección de tratamiento con medicamentos.

El documento está sujeto a las reglas y normas específicas del estado, que incluyen, entre otras, las relativas a la sustitución de genéricos, las listas de sustancias controladas, la preferencia por marcas y los genéricos obligatorios cuando corresponda.

No asumimos ninguna responsabilidad por las acciones u omisiones de cualquier proveedor médico sobre la base de la confianza, total o parcial, en esta información. El proveedor médico debe consultar la bibliografía de productos del fabricante de medicamentos o las referencias estándar para obtener información más detallada.

PREFACIO

El documento está organizado por secciones. Cada sección se divide por clase de fármacos terapéuticos definida principalmente por el mecanismo de acción.

COMITÉ DE FARMACIA Y TERAPÉUTICA (P&T)

Se utilizan los servicios de un Comité de Farmacia y Terapéutica ("Comité P&T") para aprobar terapias farmacológicas seguras y clínicamente eficaces. El Comité P&T es un órgano consultivo de profesionales clínicos. Los miembros con derecho a voto del Comité P&T incluyen médicos y farmacéuticos, todos los cuales tienen una amplia experiencia clínica y académica con respecto a medicamentos recetados. Los miembros del Comité P&T deben revelar toda relación financiera o conflicto de interés con cualquier fabricante de productos farmacéuticos.

DESCRIPCIÓN DE LOS PRODUCTOS DE LA LISTA DE MEDICAMENTOS

Para ayudarle a entender qué fortalezas y formas de dosificación específicas en el documento están cubiertas, se indican los principios generales a continuación.

- La primera columna del gráfico indica el nombre del medicamento. Los medicamentos de marca aparecen en mayúsculas (p. ej., LIPITOR). Los medicamentos genéricos figuran en cursiva y minúsculas (p. ej., *atorvastatin*).
- La segunda columna (Requisitos/Límites) contiene todos los requisitos especiales para la cobertura de su medicamento.
- Si las versiones del producto de venta libre (OTC) y con receta están cubiertas, ambas aparecen en la lista.
- Los productos de liberación extendida y de liberación prolongada requieren su propia entrada.
- Las formas farmacéuticas en el documento serán consistentes con la categoría y el uso donde se mencione.

SUSTITUCIÓN POR GENÉRICOS

La sustitución por genéricos es una acción en una farmacia en la que se dispensa una versión genérica en lugar de un producto de marca recetado. En este documento, la fuente *en cursiva y minúsculas* indica la disponibilidad de genéricos. En la mayoría de los casos, un medicamento de marca para el cual se pone a disposición un producto genérico pasa a ser un medicamento que no está incluido en el formulario y el producto genérico queda cubierto en su lugar tras su comercialización. Sin embargo, el documento está sujeto a normas y reglas estatales específicas relativas a la sustitución por genéricos y a las normas obligatorias relativas a los genéricos, cuando corresponda.

Los medicamentos genéricos suelen tener un precio menor que sus equivalentes de marca. Los medicamentos genéricos recetados cumplen con lo siguiente:

- Aprobados por la Administración de Alimentos y Medicamentos de los EE. UU. para su seguridad y eficacia, y fabricados según las mismas normas estrictas que se aplican a los medicamentos de marca.
- Probado en humanos para garantizar que el genérico se absorba en el torrente sanguíneo a un ritmo similar y con una extensión similar en comparación con el medicamento de marca (bioequivalencia). Los genéricos pueden ser diferentes de los medicamentos de marca en tamaño, color e ingredientes inactivos, pero esto no modifica su eficacia o capacidad de absorberse al igual que el medicamento de marca.
- Fabricados con la misma concentración y forma de dosificación que los medicamentos de marca.

Cuando se sustituye un medicamento de marca por uno genérico, se puede esperar que el medicamento genérico produzca el mismo efecto clínico con el mismo perfil de seguridad que el medicamento de marca (equivalencia terapéutica).

DISEÑO DEL PLAN

El documento representa el diseño de un plan de formulario cerrado. Los medicamentos que figuran en el documento están cubiertos por el plan como se presentan. Ciertos medicamentos de la lista están cubiertos si se cumplen los criterios de administración de la utilización (es decir, terapia escalonada, autorización previa, límites de cantidad, etc.); se revisarán las solicitudes de uso de estos medicamentos fuera de los criterios indicados según la necesidad médica. Si un medicamento no está incluido en el documento, es posible que se solicite una excepción al formulario para la cobertura. Las solicitudes de excepción del formulario o necesidad médica se revisarán en función de los criterios de autorización previa específica para cada medicamento o los criterios estándar para solicitar una receta que no se encuentra en el formulario. Inicie sesión en www.molinahealthcare.com para verificar la cobertura.

CLASES DE CONSIDERACIÓN

ANALGÉSICOS OPIOIDES

Todos los analgésicos opioides están sujetos a una dosis equivalente de morfina de 90 mg por día. Se excluye el uso simultáneo de opioides con benzodiazepinas o relajantes musculares.

MEDICAMENTOS SIN COBERTURA

Tenga en cuenta que determinados medicamentos no están cubiertos. Esto incluye, entre otros, los siguientes:

- Los productos farmacéuticos determinados por la Administración de Alimentos y Medicamentos (FDA) como medicamentos menos eficaces, y medicamentos idénticos, relacionados o similares (con frecuencia denominados medicamentos “DESI 5 y 6”).

PROCEDIMIENTO DE SOLICITUD DE AUTORIZACIÓN PREVIA

Las recetas de medicamentos que requieren aprobación previa o medicamentos no incluidos en el Formulario de Medicamentos de Affinity de Molina pueden aprobarse cuando sea médicamente necesario y cuando las opciones del formulario hayan demostrado ser ineficaces. Cuando se presentan estas situaciones excepcionales, el médico puede enviar por fax un formulario de autorización previa de medicamentos lleno a Affinity de Molina al (844) 823-5479. Los formularios se pueden obtener iniciando sesión en el sitio web www.molinahealthcare.com. Los ensayos de muestras farmacéuticas no se considerarán como justificación para aprobar una solicitud de autorización previa.

CONSEJOS ÚTILES PARA LA AUTORIZACIÓN PREVIA

Para garantizar la respuesta más rápida posible del Departamento de Farmacia de Affinity de Molina, proporcione la información pertinente con la solicitud de autorización previa. Estos son algunos ejemplos:

Clase de medicamento/diagnóstico

Reducción del colesterol

Diabetes

Formulario de medicamentos
no preferidos/fuera del formulario

Información clínica solicitada

Panel de lípidos, Factores de riesgo cardiovascular

Informe de A1c

Informe del medicamento o notas sobre el progreso que
documentan el uso previo de medicamentos

LEYENDA

EDAD	Límite de edad
MED	Dosis máxima equivalente de morfina de 90 mg por día
GNDR	Editar sexo
OTC	Beneficio cubierto de venta libre con receta
PA	Autorización previa
PA, QL	El límite de cantidad se aplica después de la aprobación de la autorización previa
QL	Límite en la cantidad
SP	Medicamento especializado, estos medicamentos deben obtenerse a través de una farmacia especializada
ST	Terapia escalonada

minúscula Indica la disponibilidad del medicamento genérico

MAYÚSCULAS Indica la disponibilidad de medicamento de marca

SOLICITAR CAMBIOS EN EL FORMULARIO

Si usted es un profesional que emite recetas y desea solicitar un cambio en el formulario, envíe su solicitud y justificación al Departamento de Farmacia de Affinity de Molina con su información de contacto.

Fax: (866) 879-4742

AVISO

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Este documento contiene referencias a medicamentos recetados de marca comercial que son marcas comerciales o marcas registradas de fabricantes farmacéuticos.

FORMULARY UPDATES

Key			
AL= Age Limit	ST= Step Therapy	OTC= Over the Counter	PA Prior Authorization
PA, QL= Quantity Limit is applied after Prior Authorization approval	QL= Quantity Limit	SP= Specialty Drugs; these drugs must be obtained through a specialty pharmacy	

Date Effective	Product Name	Change	Notes
10/1/2026	Duloxetine Cap 80mg, 90mg, and 120mg	Added to Formulary	Max quantity 1 per day
10/1/2026	Ozempic Tablets 1.5mg, 4mg, 9mg	Added to Formulary	Max quantity 1 per day
10/1/2026	Uptravi tablets 100mcg, 150mcg,	Added to Formulary	PA required

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Drug Name	Drug Tier	Requirements/Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
*ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS***		
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR***		
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
*AMPHETAMINE MIXTURES***		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine oral tablet 7.5 mg</i>	COVERED - sPDL	QL (5 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
*AMPHETAMINES***		
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 3 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years)
*ANALEPTICS***		
<i>caffeine citrate oral solution 60 mg/3ml</i>	COVERED - sPDL	QL (120 ML per 1 Fill); AGE (Max 1 Years)
*STIMULANTS - MISC.***		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 17 Years)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
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Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	COVERED - sPDL	QL (15 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>modafinil oral tablet 100 mg, 200 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 17 Years)
ALTERNATIVE MEDICINES		
*ALTERNATIVE MEDICINE COMBINATIONS - TWO INGREDIENTS***		
<i>melatonin/vitamin b-6 ex st oral tablet 3-1 mg</i>	COVERED - sPDL	
AMINOGLYCOSIDES		
*AMINOGLYCOSIDES***		
<i>neomycin sulfate oral tablet 500 mg</i>	COVERED - sPDL	
<i>paromomycin sulfate oral capsule 250 mg</i>	COVERED - sPDL	

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ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS - ANTI-INFLAMMATORY		
*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS***		
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	COVERED - sPDL	PA
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	COVERED - sPDL	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	COVERED - sPDL	PA
*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES***		
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	COVERED - sPDL	PA; QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	COVERED - sPDL	PA; QL (2 EA per 28 days)
<i>adalimumab-fkjp subcutaneous auto-injector kit 40 mg/0.8ml</i>	COVERED - sPDL	PA; QL (2 EA per 28 days)
<i>adalimumab-fkjp subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	COVERED - sPDL	PA; QL (2 EA per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	COVERED - sPDL	PA; QL (2 EA per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	COVERED - sPDL	PA; QL (2 EA per 28 days)
*CYCLOOXYGENASE 2 (COX-2) INHIBITORS***		
<i>celecoxib oral capsule 100 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>celecoxib oral capsule 200 mg, 400 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*INTERLEUKIN-6 RECEPTOR INHIBITORS***		
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	COVERED - sPDL	PA
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)***		
<i>childrens ibuprofen 100 oral suspension 100 mg/5ml</i>	COVERED - sPDL	QL (160 ML per 1 day)
<i>diclofenac potassium oral tablet 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>etodolac oral tablet 400 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>etodolac oral tablet 500 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>ibuprofen 100 junior strength oral tablet chewable 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>ibuprofen infants oral suspension 50 mg/1.25ml</i>	COVERED - sPDL	QL (160 ML per 1 day)
<i>ibuprofen junior strength oral tablet 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>ibuprofen oral capsule 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>ibuprofen oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>indomethacin oral capsule 25 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>ketoprofen oral capsule 50 mg, 75 mg</i>	COVERED - sPDL	
<i>ketorolac tromethamine injection solution 15 mg/ml, 30 mg/ml</i>	COVERED - sPDL	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	COVERED - sPDL	
<i>ketorolac tromethamine oral tablet 10 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>nabumetone oral tablet 500 mg, 750 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>naproxen oral suspension 125 mg/5ml</i>	COVERED - sPDL	QL (100 ML per 1 day)
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>naproxen sodium oral tablet 220 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>oxaprozin oral tablet 600 mg</i>	COVERED - sPDL	PA; QL (3 EA per 1 day)
<i>piroxicam oral capsule 10 mg</i>	COVERED - sPDL	PA; QL (4 EA per 1 day)
<i>piroxicam oral capsule 20 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day)
<i>sulindac oral tablet 150 mg, 200 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS***		
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (apremilast)	COVERED - sPDL	PA
*PYRIMIDINE SYNTHESIS INHIBITORS***		
leflunomide oral tablet 10 mg, 20 mg	COVERED - sPDL	QL (1 EA per 1 day)
*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS***		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (etanercept)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (etanercept)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (etanercept)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG (etanercept)	COVERED - sPDL	
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (etanercept)	COVERED - sPDL	PA; QL (4 ML per 24 days)
ANALGESICS - NONNARCOTIC		
*ANALGESICS OTHER***		
acetaminophen 8 hour oral tablet extended release 650 mg	COVERED - sPDL	QL (6 EA per 1 day)
acetaminophen extra strength oral liquid 500 mg/15ml	COVERED - sPDL	
acetaminophen extra strength oral tablet 500 mg	COVERED - sPDL	QL (8 EA per 1 day)
acetaminophen infants oral suspension 160 mg/5ml	COVERED - sPDL	
acetaminophen junior strength oral tablet dispersible 160 mg	COVERED - sPDL	
acetaminophen oral liquid 160 mg/5ml	COVERED - sPDL	
acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml	COVERED - sPDL	
acetaminophen oral tablet 325 mg	COVERED - sPDL	QL (12 EA per 1 day)
acetaminophen rapid tabs child oral tablet dispersible 80 mg	Not Covered	
acetaminophen rectal suppository 650 mg	COVERED - sPDL	QL (6 EA per 1 day)
childrens aspirin free oral elixir 80 mg/2.5ml	COVERED - sPDL	
childrens non-aspirin oral tablet chewable 80 mg	COVERED - sPDL	QL (6 EA per 1 day)
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (acetaminophen)	COVERED - sPDL	QL (50 EA per 1 day)
non-aspirin jr strength oral tablet chewable 160 mg	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>pain reliever/fever reducer rectal suppository 120 mg</i>	COVERED - sPDL	QL (34 EA per 1 day)
*ANALGESICS-SEDATIVES***		
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	COVERED - sPDL	QL (10 EA per 1 day); AGE (Max 64 Years)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
*SALICYLATES***		
<i>aspirin 81 oral tablet chewable 81 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>aspirin 81 oral tablet delayed release 81 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>aspirin oral tablet 325 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>aspirin oral tablet delayed release 325 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>salsalate oral tablet 500 mg, 750 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
ANALGESICS - OPIOID		
*CODEINE COMBINATIONS***		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml</i>	COVERED - sPDL	QL (3750 ML per 25 days); AGE (Min 12 Years); MED; Max 7 day supply for initial fill or PA required
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 12 Years); MED; Max 7 day supply for initial fill or PA required
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
*HYDROCODONE COMBINATIONS***		
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	COVERED - sPDL	QL (3750 ML per 25 days); MED; Max 7 day supply for initial fill or PA required
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
*OPIOID AGONISTS***		
<i>codeine sulfate oral tablet 30 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Min 12 Years); MED; Max 7 day supply for initial fill or PA required
<i>codeine sulfate oral tablet 60 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 12 Years); MED; Max 7 day supply for initial fill or PA required

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Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	COVERED - sPDL	QL (0.334 EA per 1 day); MED
<i>hydromorphone hcl oral tablet 2 mg, 4 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	MED; Max 7 day supply for initial fill or PA required
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	COVERED - sPDL	MED; Max 7 day supply for initial fill or PA required
<i>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg</i>	COVERED - sPDL	ST; QL (3 EA per 1 day); Requires prior use of IR Opioid; MED
<i>morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml</i>	COVERED - sPDL	MED; Max 7 day supply for initial fill or PA required
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
<i>oxycodone hcl oral solution 5 mg/5ml</i>	COVERED - sPDL	MED; Max 7 day supply for initial fill or PA required
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	COVERED - sPDL	QL(120); MED; Max 7 day supply for initial fill or PA required
<i>tramadol hcl oral tablet 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 12 Years); MED; Max 7 day supply for initial fill or PA required
*OPIOID COMBINATIONS***		
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
<i>oxycodone-acetaminophen oral tablet 5-325 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); MED; Max 7 day supply for initial fill or PA required
*OPIOID PARTIAL AGONISTS***		
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML, 24 MG/0.48ML, 32 MG/0.64ML, 8 MG/0.16ML (<i>buprenorphine</i>)	COVERED - sPDL	MAX 4 fills per 25 days
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML, 64 MG/0.18ML, 96 MG/0.27ML (<i>buprenorphine</i>)	COVERED - sPDL	MAX 4 fills per 25 days
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</i>	COVERED - sPDL	PA; QL (4 EA per 23 days)
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (<i>buprenorphine</i>)	COVERED - sPDL	MAX 4 fills per 25 days
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 2.9-0.71 MG, 5.7-1.4 MG (<i>buprenorphine hcl-naloxone hcl</i>)	COVERED - sPDL	QL (3 EA per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG (<i>buprenorphine hcl-naloxone hcl</i>)	COVERED - sPDL	QL (1 EA per 1 day)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	COVERED - sPDL	QL (2 EA per 1 day)
ANDROGENS-ANABOLIC		
*ANDROGENS***		
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	COVERED - sPDL	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	COVERED - sPDL	
ANORECTAL AND RELATED PRODUCTS		
*INTRARECTAL STEROIDS***		
<i>hydrocortisone rectal enema 100 mg/60ml</i>	COVERED - sPDL	QL (1680 ML per 25 days)
*RECTAL ANESTHETIC COMBINATIONS***		
<i>hemorrhoidal external cream 1-0.25-14.4-15 %</i>	COVERED - sPDL	
*RECTAL LOCAL ANESTHETICS***		
<i>dibucaine (perianal) external ointment 1 %</i>	COVERED - sPDL	
*RECTAL STEROIDS***		
<i>anucort-hc rectal suppository 25 mg</i>	COVERED - sPDL	
<i>anumed-hc suppository 25 mg</i>	COVERED - sPDL	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (<i>hydrocortisone acetate</i>)	COVERED - sPDL	
<i>grx hicort 25 rectal suppository 25 mg</i>	COVERED - sPDL	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG, 30 MG (<i>hydrocortisone acetate</i>)	COVERED - sPDL	
<i>hemorrhoidal-hc rectal suppository 25 mg</i>	COVERED - sPDL	
<i>hydrocortisone acetate (Hemril-30 Rectal Suppository 30 Mg)</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone (perianal) external cream 1 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>hydrocortisone acetate rectal suppository 25 mg</i>	COVERED - sPDL	QL (7 EA per 1 day)
<i>hydrocortisone acetate rectal suppository 30 mg</i>	COVERED - sPDL	
PROCTOCORT RECTAL SUPPOSITORY 30 MG (<i>hydrocortisone acetate</i>)	COVERED - sPDL	
<i>hydrocortisone acetate (Proctosert Hc Suppository 30 Mg)</i>	COVERED - sPDL	
<i>hydrocortisone (Proctosol Hc External Cream 2.5 %)</i>	COVERED - sPDL	
<i>rectacort-hc rectal suppository 25 mg</i>	COVERED - sPDL	
ANTACIDS		
*ANTACID & SIMETHICONE***		
<i>antacid anti-gas max strength oral suspension 400-400-40 mg/5ml</i>	COVERED - sPDL	
<i>antacid plus oral tablet chewable 200-200-25 mg</i>	COVERED - sPDL	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	COVERED - sPDL	
*ANTACID COMBINATIONS***		
ACID GONE ORAL SUSPENSION 95-358 MG/15ML (<i>alum hydroxide-mag carbonate</i>)	COVERED - sPDL	
<i>antacid extra strength oral tablet chewable 675-135 mg</i>	COVERED - sPDL	
<i>cvs antacid supreme oral suspension 400-135 mg/5ml</i>	COVERED - sPDL	
<i>heartburn antacid ex st oral tablet chewable 160-105 mg</i>	COVERED - sPDL	
*ANTACIDS - BICARBONATE***		
<i>sodium bicarbonate oral tablet 325 mg, 650 mg</i>	COVERED - sPDL	
*ANTACIDS - CALCIUM SALTS***		
<i>antacid maximum oral tablet chewable 1000 mg</i>	COVERED - sPDL	
<i>antacid oral tablet chewable 500 mg, 750 mg</i>	COVERED - sPDL	
<i>calcium carbonate antacid oral tablet 648 mg</i>	COVERED - sPDL	
CHILDRENS SOOTHE ORAL TABLET CHEWABLE 400 MG (<i>calcium carbonate antacid</i>)	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*ANTACIDS - MAGNESIUM SALTS***		
<i>magnesium oxide oral tablet 250 mg, 420 mg</i>	COVERED - sPDL	
ANTHELMINTICS		
*ANTHELMINTICS***		
<i>albendazole oral tablet 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>ivermectin oral tablet 3 mg</i>	COVERED - sPDL	QL (16 EA per 2 days); Max 1 fill per 30 days
<i>pinworm medicine oral suspension 144 (50 base) mg/ml</i>	COVERED - sPDL	
ANTIANGINAL AGENTS		
*ANTIANGINALS-OTHER***		
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); Prior use BB/CCBs & long-acting nitrate
*NITRATES***		
<i>isosorbide dinitrate oral tablet 10 mg, 30 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>isosorbide dinitrate oral tablet 20 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>isosorbide mononitrate oral tablet 10 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>isosorbide mononitrate oral tablet 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	COVERED - sPDL	QL (1 EA per 1 day)
ANTIANXIETY AGENTS		
*ANTIANXIETY AGENTS - MISC.***		
<i>buspirone hcl oral tablet 10 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>buspirone hcl oral tablet 15 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years)
<i>buspirone hcl oral tablet 5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 6 Years)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day); AGE (Max 64 Years)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Max 64 Years)
<i>hydroxyzine pamoate oral capsule 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)

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Drug Name	Drug Tier	Requirements/Limits
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Max 64 Years)
*BENZODIAZEPINES***		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 18 Years)
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
<i>diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)</i>	COVERED - sPDL	PA; QL (3 ML per 1 day); AGE (Max 64 Years)
<i>diazepam oral solution 5 mg/5ml</i>	COVERED - sPDL	QL (4 ML per 1 day); AGE (Max 64 Years)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/ML)</i>	COVERED - sPDL	QL (3 ML per 1 day); AGE (Min 12 Years)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 12 Years)
<i>oxazepam oral capsule 10 mg, 15 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years)
<i>oxazepam oral capsule 30 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years)
ANTIARRHYTHMICS		
*ANTIARRHYTHMICS TYPE I-A***		
<i>disopyramide phosphate oral capsule 100 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>disopyramide phosphate oral capsule 150 mg</i>	COVERED - sPDL	QL (5 EA per 1 day); AGE (Max 64 Years)
<i>quinidine sulfate oral tablet 300 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*ANTIARRHYTHMICS TYPE I-B***		
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*ANTIARRHYTHMICS TYPE I-C***		
<i>flecainide acetate oral tablet 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>flecainide acetate oral tablet 150 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>flecainide acetate oral tablet 50 mg</i>	COVERED - sPDL	QL (7 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>propafenone hcl oral tablet 150 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>propafenone hcl oral tablet 225 mg, 300 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*ANTIARRHYTHMICS TYPE III***		
<i>amiodarone hcl (Pacerone Oral Tablet 200 Mg)</i>	COVERED - sPDL	QL (4 EA per 1 day)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
*ADRENERGIC COMBINATIONS***		
<i>ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (umeclidinium-vilanterol)</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>budesonide-formoterol fumarate (Breyna Inhalation Aerosol 160-4.5 Mcg/Act, 80-4.5 Mcg/Act)</i>	COVERED - sPDL	QL (20.6 GM per 25 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	COVERED - sPDL	QL (20.4 GM per 25 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	COVERED - sPDL	QL (0.04 EA per 1 day)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	COVERED - sPDL	QL (360 ML per 25 days)
<i>TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (fluticasone-umeclidin-vilant)</i>	COVERED - sPDL	QL (2 EA per 1 day)
*ANTI-IGE MONOCLONAL ANTIBODIES***		
<i>XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (omalizumab)</i>	COVERED - sPDL	PA; QL (5 ML per 24 days)
<i>XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (omalizumab)</i>	COVERED - sPDL	PA; QL (2.5 ML per 24 days)
<i>XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (omalizumab)</i>	COVERED - sPDL	PA; QL (5 EA per 24 days)
*ANTI-INFLAMMATORY AGENTS***		
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	COVERED - sPDL	QL (26 ML per 1 day)
*BETA ADRENERGICS***		
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	COVERED - sPDL	QL (13.4 GM per 24 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	COVERED - sPDL	QL (17 GM per 24 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	COVERED - sPDL	QL (36 GM per 24 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	COVERED - sPDL	QL (6.7 GM per 24 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	COVERED - sPDL	QL (8.5 GM per 24 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%</i>	COVERED - sPDL	QL (225 ML per 25 days)
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml</i>	COVERED - sPDL	QL (300 ML per 25 days)
<i>albuterol sulfate inhalation nebulization solution 1.25 mg/3ml</i>	COVERED - sPDL	QL (150 ML per 25 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	COVERED - sPDL	QL (150 EA per 25 days)
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	COVERED - sPDL	QL (150 ML per 1 day)
<i>albuterol sulfate oral tablet 4 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>olodaterol hcl</i>)	COVERED - sPDL	QL (2 GM per 1 day)
<i>terbutaline sulfate oral tablet 2.5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>terbutaline sulfate oral tablet 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*BRONCHODILATORS - ANTICHOLINERGICS***		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	COVERED - sPDL	QL (12.9 GM per 25 days)
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>umeclidinium bromide</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>ipratropium bromide inhalation solution 0.02 %</i>	COVERED - sPDL	QL (10 ML per 1 day)
*INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA)***		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	COVERED - sPDL	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (<i>benralizumab</i>)	COVERED - sPDL	PA
*LEUKOTRIENE RECEPTOR ANTAGONISTS***		
<i>montelukast sodium oral tablet 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*STEROID INHALANTS***		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT, 80 MCG/ACT (<i>ciclesonide</i>)	COVERED - sPDL	QL (6.1 GM per 25 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	COVERED - sPDL	QL (4 ML per 1 day); AGE (Max 9 Years)
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act</i>	COVERED - sPDL	QL (0.4 GM per 1 day); AGE (Max 11 Years)
<i>fluticasone propionate hfa inhalation aerosol 44 mcg/act</i>	COVERED - sPDL	QL (0.354 GM per 1 day); AGE (Max 11 Years)

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Drug Name	Drug Tier	Requirements/Limits
*XANTHINES***		
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>theophylline er oral tablet extended release 12 hour 450 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>theophylline oral elixir 80 mg/15ml</i>	COVERED - sPDL	
<i>theophylline oral solution 80 mg/15ml</i>	COVERED - sPDL	
ANTICOAGULANTS		
*COUMARIN ANTICOAGULANTS***		
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
*DIRECT FACTOR XA INHIBITORS***		
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	COVERED - sPDL	QL (600 ML per 30 days); AGE (Max 17 Years)
XARELTO ORAL TABLET 10 MG, 20 MG (<i>rivaroxaban</i>)	COVERED - sPDL	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG (<i>rivaroxaban</i>)	COVERED - sPDL	QL (42 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG (<i>rivaroxaban</i>)	COVERED - sPDL	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	COVERED - sPDL	QL (51 EA per 28 days)
*HEPARINS AND HEPARINOID-LIKE AGENTS***		
BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML (<i>heparin sod (pork) lock flush</i>)	COVERED - sPDL	
<i>hep flush-10 intravenous solution 10 unit/ml</i>	COVERED - sPDL	
<i>heparin (porcine) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	COVERED - sPDL	
<i>heparin lock flush intravenous solution 100 unit/ml</i>	COVERED - sPDL	
<i>heparin na (pork) lock flsh pf intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml</i>	COVERED - sPDL	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	COVERED - sPDL	
<i>heparin sodium lock flush intravenous solution 10 unit/ml</i>	COVERED - sPDL	
<i>hep-lock flush intravenous solution 100 unit/ml</i>	COVERED - sPDL	
<i>heparin lock flush (Hep-Lock Intravenous Solution 10 Unit/ML, 100 Unit/ML)</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>heparin lock flush</i> (Monoject Flush Syr/Hep Lock Intravenous Solution 10 Unit/ML, 100 Unit/ML)	COVERED - sPDL	
<i>heparin lock flush</i> (Monoject Prefill Adv Heparin Intravenous Solution 10 Unit/ML, 100 Unit/ML)	COVERED - sPDL	
<i>heparin lock flush</i> (Monoject Prefill Heparin Sod Intravenous Solution 10 Unit/ML, 100 Unit/ML)	COVERED - sPDL	
<i>heparin lock flush</i> (Monoject Prefill Intravenous Solution 10 Unit/ML, 100 Unit/ML)	COVERED - sPDL	
*LOW MOLECULAR WEIGHT HEPARINS***		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	COVERED - sPDL	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml</i>	COVERED - sPDL	QL (2 ML per 1 day)
<i>enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml</i>	COVERED - sPDL	QL (1.6 ML per 1 day)
<i>enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml</i>	COVERED - sPDL	QL (0.6 ML per 1 day)
<i>enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml</i>	COVERED - sPDL	QL (0.8 ML per 1 day)
<i>enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml</i>	COVERED - sPDL	QL (1.2 ML per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (<i>dalteparin sodium</i>)	COVERED - sPDL	PA
*SYNTHETIC HEPARINOID-LIKE AGENTS***		
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	COVERED - sPDL	PA
ANTICONVULSANTS		
*ANTICONVULSANTS - BENZODIAZEPINES***		
<i>clobazam oral tablet 10 mg, 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	COVERED - sPDL	QL (2 EA per 25 days)
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 12 Years)
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (<i>diazepam</i>)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 2 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (<i>diazepam</i>)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 2 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (<i>diazepam</i>)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 2 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (<i>diazepam</i>)	COVERED - sPDL	QL (10 EA per 25 days); AGE (Min 2 Years)

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Drug Name	Drug Tier	Requirements/Limits
*ANTICONVULSANTS - MISC.***		
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>carbamazepine oral suspension 100 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>carbamazepine oral tablet chewable 100 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>carbamazepine (Eitol Oral Tablet 200 Mg)</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>gabapentin oral capsule 100 mg, 300 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>gabapentin oral capsule 400 mg</i>	COVERED - sPDL	QL (9 EA per 1 day)
<i>gabapentin oral solution 250 mg/5ml</i>	COVERED - sPDL	
<i>gabapentin oral tablet 600 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>gabapentin oral tablet 800 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>lacosamide oral solution 10 mg/ml</i>	COVERED - sPDL	QL (20 ML per 1 day)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>lamotrigine oral tablet 100 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>lamotrigine oral tablet 150 mg, 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>lamotrigine oral tablet 25 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>levetiracetam er oral tablet extended release 24 hour 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>levetiracetam er oral tablet extended release 24 hour 750 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>levetiracetam oral solution 100 mg/ml, 500 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
<i>levetiracetam oral tablet 1000 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>levetiracetam oral tablet 250 mg, 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>levetiracetam oral tablet 750 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	COVERED - sPDL	QL (16.667 ML per 1 day)
<i>oxcarbazepine oral tablet 150 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>oxcarbazepine oral tablet 300 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>oxcarbazepine oral tablet 600 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg</i>	COVERED - sPDL	PA; QL (3 EA per 1 day)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day)
<i>pregabalin oral capsule 50 mg</i>	COVERED - sPDL	PA; QL (6 EA per 1 day)
<i>pregabalin oral capsule 75 mg</i>	COVERED - sPDL	PA; QL (8 EA per 1 day)
<i>primidone oral tablet 250 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>rufinamide oral suspension 40 mg/ml</i>	COVERED - sPDL	QL (80 ML per 1 day)
<i>rufinamide oral tablet 200 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>rufinamide oral tablet 400 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>topiramate oral tablet 100 mg, 200 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>topiramate oral tablet 25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>zonisamide oral capsule 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>zonisamide oral capsule 25 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*GABA MODULATORS***		
<i>tiagabine hcl oral tablet 12 mg</i>	COVERED - sPDL	QL (4.67 EA per 1 day)
<i>tiagabine hcl oral tablet 16 mg</i>	COVERED - sPDL	QL (3.5 EA per 1 day)
<i>tiagabine hcl oral tablet 2 mg</i>	COVERED - sPDL	QL (28 EA per 1 day)
<i>tiagabine hcl oral tablet 4 mg</i>	COVERED - sPDL	QL (14 EA per 1 day)
<i>vigabatrin oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>vigabatrin (Vigadrone Oral Packet 500 Mg)</i>	COVERED - sPDL	QL (6 EA per 1 day)
*HYDANTOINS***		
<i>DILANTIN ORAL CAPSULE 30 MG (phenytoin sodium extended)</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>phenytoin oral suspension 100 mg/4ml</i>	COVERED - sPDL	QL (20 ML per 1 day)
<i>phenytoin oral tablet chewable 50 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*SUCCINIMIDES***		
<i>ethosuximide oral capsule 250 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>ethosuximide oral solution 250 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
*VALPROIC ACID***		
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>divalproex sodium oral tablet delayed release 125 mg</i>	COVERED - sPDL	QL (15 EA per 1 day)
<i>divalproex sodium oral tablet delayed release 250 mg, 500 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>valproic acid oral capsule 250 mg</i>	COVERED - sPDL	QL (20 EA per 1 day)
<i>valproic acid oral solution 250 mg/5ml</i>	COVERED - sPDL	QL (100 ML per 1 day)
ANTIDEPRESSANTS		
*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)***		
<i>mirtazapine oral tablet 15 mg, 45 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>mirtazapine oral tablet 30 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*ANTIDEPRESSANTS - MISC.***		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>maprotiline hcl oral tablet 25 mg, 50 mg, 75 mg</i>	COVERED - sPDL	
*MONOAMINE OXIDASE INHIBITORS (MAOIS)***		
<i>phenelzine sulfate oral tablet 15 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>tranylcypromine sulfate oral tablet 10 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)***		
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	COVERED - sPDL	QL (20 ML per 1 day)
<i>citalopram hydrobromide oral tablet 10 mg</i>	COVERED - sPDL	QL (1.5 EA per 1 day)
<i>citalopram hydrobromide oral tablet 20 mg, 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	COVERED - sPDL	
<i>escitalopram oxalate oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (1.5 EA per 1 day)
<i>escitalopram oxalate oral tablet 20 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>fluoxetine hcl oral capsule 10 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>fluoxetine hcl oral capsule 20 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>fluoxetine hcl oral capsule 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	COVERED - sPDL	
<i>fluvoxamine maleate oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>fluvoxamine maleate oral tablet 25 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>sertraline hcl oral concentrate 20 mg/ml</i>	COVERED - sPDL	
<i>sertraline hcl oral tablet 100 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>sertraline hcl oral tablet 25 mg</i>	COVERED - sPDL	QL (1.5 EA per 1 day)
*SEROTONIN MODULATORS***		
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	COVERED - sPDL	

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ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)***		
<i>duloxetine hcl oral capsule delayed release particles 120 mg, 80 mg, 90 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*TRICYCLIC AGENTS***		
<i>amitriptyline hcl oral tablet 10 mg, 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>amitriptyline hcl oral tablet 100 mg, 150 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>amitriptyline hcl oral tablet 50 mg, 75 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>clomipramine hcl oral capsule 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>clomipramine hcl oral capsule 50 mg, 75 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>desipramine hcl oral tablet 10 mg, 50 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>desipramine hcl oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>desipramine hcl oral tablet 150 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>desipramine hcl oral tablet 25 mg, 75 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>doxepin hcl oral capsule 10 mg, 100 mg, 25 mg, 50 mg, 75 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>doxepin hcl oral capsule 150 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Max 64 Years)
<i>doxepin hcl oral concentrate 10 mg/ml</i>	COVERED - sPDL	QL (30 ML per 1 day); AGE (Max 64 Years)
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>nortriptyline hcl oral capsule 10 mg, 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>nortriptyline hcl oral capsule 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>nortriptyline hcl oral capsule 75 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
ANTIDIABETICS		
*ALPHA-GLUCOSIDASE INHIBITORS***		
<i>acarbose oral tablet 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>acarbose oral tablet 25 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*BIGUANIDES***		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>metformin hcl oral tablet 1000 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>metformin hcl oral tablet 500 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>metformin hcl oral tablet 850 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*DIABETIC OTHER - COMBINATIONS***		
<i>glucose oral tablet chewable 4-6 gm-mg</i>	COVERED - sPDL	
*DIABETIC OTHER***		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	COVERED - sPDL	QL (2 EA per 25 days)
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (<i>glucagon hcl</i>)	COVERED - sPDL	QL (2 EA per 25 days)
<i>glucagon emergency injection kit 1 mg</i>	COVERED - sPDL	QL (2 EA per 25 days)
<i>glucagon emergency injection solution reconstituted 1 mg</i>	COVERED - sPDL	QL (2 EA per 25 days)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML (<i>glucagon</i>)	COVERED - sPDL	QL (0.2 ML per 25 days)
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1 MG/0.2ML (<i>glucagon</i>)	COVERED - sPDL	QL (0.4 ML per 25 days)
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (<i>glucagon</i>)	COVERED - sPDL	QL (0.4 ML per 25 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML (<i>glucagon</i>)	COVERED - sPDL	QL (0.2 ML per 25 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	COVERED - sPDL	QL (0.4 ML per 25 days)
*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS***		
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	COVERED - sPDL	ST; QL (1 EA per 1 day); PRIOR USE OF METFORMIN
<i>saxagliptin hcl oral tablet 2.5 mg, 5 mg</i>	COVERED - sPDL	ST; PA

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Drug Name	Drug Tier	Requirements/Limits
*DIIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS***		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); PRIOR USE OF METFORMIN AND SULFON
<i>alogliptin-metformin hcl oral tablet 12.5-500 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); PRIOR USE OF METFORMIN AND SULFON
*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS***		
<i>alogliptin-pioglitazone oral tablet 12.5-15 mg, 12.5-30 mg, 12.5-45 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	COVERED - sPDL	ST; QL (1 EA per 1 day); PRIOR USE OF METFORMIN AND SULFON
*HUMAN INSULIN***		
ADMELOG INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro</i>)	COVERED - sPDL	QL (30 ML per 25 days)
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	COVERED - sPDL	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	COVERED - sPDL	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	COVERED - sPDL	QL (30 ML per 25 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (<i>insulin regular human</i>)	COVERED - sPDL	QL (20 ML per 25 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	COVERED - sPDL	QL (18 ML per 25 days)
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	COVERED - sPDL	QL (30 ML per 25 days)
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	COVERED - sPDL	QL (30 ML per 25 days)
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	COVERED - sPDL	QL (30 ML per 25 days)
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	COVERED - sPDL	QL (30 ML per 25 days)
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart</i>)	COVERED - sPDL	QL (30 ML per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine-aglr</i>)	COVERED - sPDL	QL (30 ML per 30 days)
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine-yfgn</i>)	COVERED - sPDL	QL (30 ML per 25 days)
*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)***		
<i>liraglutide subcutaneous solution pen-injector 18 mg/3ml</i>	COVERED - sPDL	QL (9 ML per 30 days); AGE (Min 10 Years)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (1.5 ML per 25 days); AGE (Min 18 Years); PRIOR USE OF METFORMIN
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (3 ML per 25 days); AGE (Min 18 Years); PRIOR USE OF METFORMIN
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (1.5 ML per 25 days); AGE (Min 18 Years); PRIOR USE OF METFORMIN
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (3 ML per 25 days); AGE (Min 18 Years); PRIOR USE OF METFORMIN
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (3 ML per 25 days); AGE (Min 18 Years); PRIOR USE OF METFORMIN
OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (1 EA per 1 day); AGE (Min 18 Years)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</i>)	COVERED - sPDL	ST; QL (1 EA per 1 day); AGE (Min 18 Years); PRIOR USE OF METFORMIN
*MEGLITINIDE ANALOGUES***		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS***		
<i>dapagliflozin propanediol oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	ST; QL (1 EA per 1 day)
STEGLATRO ORAL TABLET 15 MG, 5 MG (<i>ertugliflozin l-pyrogutamicac</i>)	COVERED - sPDL	ST; PRIOR USE OF METFORMIN
*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB***		
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG (<i>ertugliflozin-metformin hcl</i>)	COVERED - sPDL	ST; PRIOR USE OF METFORMIN
*SULFONYLUREA-BIGUANIDE COMBINATIONS***		
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>glyburide-metformin oral tablet 5-500 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*SULFONYLUREAS***		
<i>glimepiride oral tablet 1 mg, 4 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>glimepiride oral tablet 2 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>glipizide oral tablet 10 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>glipizide oral tablet 5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>tolbutamide oral tablet 500 mg</i>	COVERED - sPDL	
*THIAZOLIDINEDIONES***		
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
ANTIDIARRHEAL/PROBIOTIC AGENTS		
*ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.***		
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	COVERED - sPDL	
<i>pink bismuth oral suspension 262 mg/15ml</i>	COVERED - sPDL	
<i>sb bismuth oral tablet 262 mg</i>	COVERED - sPDL	
*ANTIPERISTALTIC AGENTS***		
<i>anti-diarrheal oral tablet 2 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>loperamide hcl oral capsule 2 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>loperamide hcl oral liquid 1 mg/7.5ml</i>	COVERED - sPDL	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
*ANTIDOTES - CHELATING AGENTS***		
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	COVERED - sPDL	PA; QL (8 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	COVERED - sPDL	PA; QL (8 EA per 1 day)
<i>deferasirox oral tablet soluble 125 mg</i>	COVERED - sPDL	PA; QL (28 EA per 1 day)
<i>deferasirox oral tablet soluble 250 mg</i>	COVERED - sPDL	PA; QL (14 EA per 1 day)
<i>deferasirox oral tablet soluble 500 mg</i>	COVERED - sPDL	PA; QL (7 EA per 1 day)
<i>deferiprone oral tablet 1000 mg</i>	COVERED - sPDL	PA; QL (10 EA per 1 day)
<i>deferiprone oral tablet 500 mg</i>	COVERED - sPDL	PA; QL (14 EA per 1 day)
*OPIOID ANTAGONISTS***		
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	COVERED - sPDL	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	COVERED - sPDL	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	COVERED - sPDL	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	COVERED - sPDL	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	COVERED - sPDL	
<i>naltrexone hcl oral tablet 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	COVERED - sPDL	
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (<i>nalmefene hcl</i>)	COVERED - sPDL	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	COVERED - sPDL	QL (1 EA per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	COVERED - sPDL	
ANTIEMETICS		
*5-HT3 RECEPTOR ANTAGONISTS***		
<i>granisetron hcl oral tablet 1 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); PRIOR USE OF ONDANSETRON
<i>ondansetron hcl injection solution 40 mg/20ml</i>	COVERED - sPDL	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	COVERED - sPDL	PA
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	COVERED - sPDL	QL (90 EA per 25 days)
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	COVERED - sPDL	QL (90 EA per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
ZOFRAN INJECTION SOLUTION 40 MG/20ML (<i>ondansetron hcl</i>)	COVERED - sPDL	
*ANTIEMETIC COMBINATIONS***		
<i>anti-nausea oral solution 1.87-1.87-21.5</i>	COVERED - sPDL	
*ANTIEMETICS - ANTICHOLINERGIC***		
<i>dimenhydrinate oral tablet 50 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>motion sickness relief oral tablet chewable 25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	COVERED - sPDL	QL (0.34 EA per 1 day)
ANTIFUNGALS		
*ANTIFUNGALS***		
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>nystatin oral tablet 500000 unit</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>terbinafine hcl oral tablet 250 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*IMIDAZOLES***		
<i>ketoconazole oral tablet 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*TRIAZOLES***		
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	COVERED - sPDL	QL (35 ML per 25 days); AGE (Max 12 Years)
<i>fluconazole oral tablet 100 mg, 200 mg</i>	COVERED - sPDL	QL (21 EA per 25 days)
<i>fluconazole oral tablet 150 mg</i>	COVERED - sPDL	QL (2 EA per 25 days)
<i>fluconazole oral tablet 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>itraconazole oral capsule 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 18 Years)
ANTI HISTAMINES		
*ANTI HISTAMINES - ALKYLAMINES***		
<i>aller-chlor oral syrup 2 mg/5ml</i>	COVERED - sPDL	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>chlorpheniramine maleate oral tablet 4 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*ANTI HISTAMINES - ETHANOLAMINES***		
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	COVERED - sPDL	QL (80 ML per 1 day); AGE (Max 12 Years)
<i>allergy relief childrens oral tablet dispersible 12.5 mg</i>	COVERED - sPDL	
<i>allergy relief oral capsule 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>allergy relief oral tablet 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	COVERED - sPDL	
<i>carbinoxamine maleate oral tablet 4 mg</i>	COVERED - sPDL	
<i>clemastine fumarate oral tablet 1.34 mg</i>	COVERED - sPDL	
<i>clemastine fumarate oral tablet 2.68 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	COVERED - sPDL	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule 50 mg</i>	COVERED - sPDL	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	COVERED - sPDL	QL (80 ML per 1 day); AGE (Max 12 Years)
<i>diphenhydramine hcl oral tablet 25 mg, 50 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*ANTI HISTAMINES - NON-SEDATING***		
<i>cetirizine hcl childrens oral solution 5 mg/5ml</i>	COVERED - sPDL	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>cetirizine hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>loratadine childrens oral solution 5 mg/5ml</i>	COVERED - sPDL	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>loratadine oral tablet 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>loratadine oral tablet dispersible 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Max 12 Years)
*ANTI HISTAMINES - PHENOTHIAZINES***		
<i>promethazine hcl injection solution 25 mg/ml</i>	COVERED - sPDL	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl injection solution 50 mg/ml</i>	COVERED - sPDL	QL (50 ML per 1 day); AGE (Min 2 Years and Max 64 Years)

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	COVERED - sPDL	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	COVERED - sPDL	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral tablet 12.5 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral tablet 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)</i>	COVERED - sPDL	QL (24 EA per 30 days); AGE (Min 2 Years and Max 64 Years)
*ANTI HISTAMINES - PIPERIDINES***		
<i>cycloheptadine hcl oral syrup 2 mg/5ml</i>	COVERED - sPDL	QL (20 ML per 1 day); AGE (Max 64 Years)
<i>cycloheptadine hcl oral tablet 4 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
ANTI HYPERLIPIDEMICS		
*ACL INHIB-INTestinal CHOLESTEROL ABSORPTION INHIB COMB***		
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	COVERED - sPDL	PA
*ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS***		
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	COVERED - sPDL	PA
*BILE ACID SEQUESTRANTS***		
<i>cholestyramine oral powder 4 gm/dose</i>	COVERED - sPDL	QL (48 GM per 1 day)
<i>colestipol hcl oral tablet 1 gm</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)</i>	COVERED - sPDL	QL (8 GM per 1 day)
*FIBRIC ACID DERIVATIVES***		
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>gemfibrozil oral tablet 600 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*HMG COA REDUCTASE INHIBITORS***		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS***		
<i>ezetimibe oral tablet 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*PCSK9 INHIBITORS***		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (<i>evolocumab</i>)	COVERED - sPDL	PA; QL (3.5 ML per 24 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	COVERED - sPDL	PA; QL (2 ML per 24 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	COVERED - sPDL	PA; QL (2 ML per 24 days)
ANTIHYPERTENSIVES		
*ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS***		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE***		
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ACE INHIBITORS***		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (1.5 EA per 1 day)
<i>benazepril hcl oral tablet 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>enalapril maleate oral solution 1 mg/ml</i>	COVERED - sPDL	AGE (Max 12 Years)
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>enalapril maleate oral tablet 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>lisinopril oral tablet 30 mg, 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
QBRELIS ORAL SOLUTION 1 MG/ML (<i>lisinopril</i>)	COVERED - sPDL	AGE (Min 6 Years and Max 12 Years)
<i>quinapril hcl oral tablet 10 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>quinapril hcl oral tablet 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAG & CA CHANNEL BLOCKER COMB***		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE***		
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAGONISTS***		
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*ANTIADRENERGICS - CENTRALLY ACTING***		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>clonidine hcl oral tablet 0.3 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>guanfacine hcl oral tablet 1 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>guanfacine hcl oral tablet 2 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>methyldopa oral tablet 250 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>methyldopa oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
*ANTIADRENERGICS - PERIPHERALLY ACTING***		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>doxazosin mesylate oral tablet 8 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>terazosin hcl oral capsule 1 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>terazosin hcl oral capsule 10 mg, 2 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*BETA BLOCKER & DIURETIC COMBINATIONS***		
<i>atenolol-chlorthalidone oral tablet 100-25 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>atenolol-chlorthalidone oral tablet 50-25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet 2.5-6.25 mg, 5-6.25 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*VASODILATORS***		
<i>hydralazine hcl oral tablet 10 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>hydralazine hcl oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>hydralazine hcl oral tablet 25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>hydralazine hcl oral tablet 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
ANTI-INFECTIVE AGENTS - MISC.		
*ANTI-INFECTIVE AGENTS - MISC.***		
<i>metronidazole oral tablet 250 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>metronidazole oral tablet 500 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>trimethoprim oral tablet 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*ANTI-INFECTIVE MISC. - COMBINATIONS***		
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml, 800-160 mg/20ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*ANTIPROTOZOAL AGENTS***		
<i>atovaquone oral suspension 750 mg/5ml</i>	COVERED - sPDL	PA
*GLYCOPEPTIDES***		
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
*LEPROSTATICS***		
<i>dapsone oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>dapsone oral tablet 25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*LINCOSAMIDES***		
<i>clindamycin hcl oral capsule 150 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>clindamycin hcl oral capsule 300 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	COVERED - sPDL	AGE (Max 18 Years)
*OXAZOLIDINONES***		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	COVERED - sPDL	PA
<i>linezolid oral tablet 600 mg</i>	COVERED - sPDL	PA
*URINARY ANTI-INFECTIVES***		
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Max 64 Years)
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day); AGE (Max 12 Years)
ANTIMALARIALS		
*ANTIMALARIALS***		
<i>chloroquine phosphate oral tablet 250 mg</i>	COVERED - sPDL	QL (10 EA per 3 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	COVERED - sPDL	QL (5 EA per 3 days)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>mefloquine hcl oral tablet 250 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
*ANTIMYASTHENIC/CHOLINERGIC AGENTS***		
<i>pyridostigmine bromide oral tablet 60 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
ANTIMYCOBACTERIAL AGENTS		
*ANTIMYCOBACTERIAL AGENTS***		
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>isoniazid oral syrup 50 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
<i>isoniazid oral tablet 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>isoniazid oral tablet 300 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	COVERED - sPDL	QL (1.143 EA per 1 day)
<i>pyrazinamide oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>rifampin oral capsule 150 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>rifampin oral capsule 300 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
*ANDROGEN BIOSYNTHESIS INHIBITORS***		
<i>abiraterone acetate oral tablet 250 mg</i>	COVERED - sPDL	PA; QL (4 EA per 1 day); 15
*ANTIADRENALS***		
LYSODREN ORAL TABLET 500 MG (<i>mitotane</i>)	COVERED - sPDL	
*ANTIANDROGENS***		
<i>bicalutamide oral tablet 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>flutamide oral capsule 125 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*ANTIESTROGENS***		
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*ANTIMETABOLITES***		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	COVERED - sPDL	PA
<i>mercaptopurine oral tablet 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>methotrexate oral tablet 2.5 mg</i>	COVERED - sPDL	QL (24 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	COVERED - sPDL	QL (10 ML per 25 days)
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	COVERED - sPDL	QL (10 ML per 25 days)
*ANTINEOPLASTIC - ALK INHIBITORS***		
ALECENSA ORAL CAPSULE 150 MG (<i>alectinib hcl</i>)	COVERED - sPDL	PA; QL (8 EA per 1 day)
*ANTINEOPLASTIC - BCL-2 INHIBITORS***		
VENCLEXTA ORAL TABLET 10 MG (<i>venetoclax</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
VENCLEXTA ORAL TABLET 100 MG (<i>venetoclax</i>)	COVERED - sPDL	PA; QL (6 EA per 1 day)
VENCLEXTA ORAL TABLET 50 MG (<i>venetoclax</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (<i>venetoclax</i>)	COVERED - sPDL	PA; QL (1 Pack per 28 days)
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS***		
<i>imatinib mesylate oral tablet 100 mg</i>	COVERED - sPDL	PA; QL (3 EA per 1 day); 15
<i>imatinib mesylate oral tablet 400 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day); 15
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (<i>dasatinib</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day); 15
SPRYCEL ORAL TABLET 20 MG (<i>dasatinib</i>)	COVERED - sPDL	PA; QL (3 EA per 1 day); 15
*ANTINEOPLASTIC - BTK INHIBITORS***		
BRUKINSA ORAL CAPSULE 80 MG (<i>zanubrutinib</i>)	COVERED - sPDL	PA; QL (4 EA per 1 day)
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	COVERED - sPDL	PA; QL (3 EA per 1 day)
IMBRUVICA ORAL TABLET 420 MG, 560 MG (<i>ibrutinib</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
*ANTINEOPLASTIC - EGFR INHIBITORS***		
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day); 15
<i>erlotinib hcl oral tablet 25 mg</i>	COVERED - sPDL	PA; QL (3 EA per 1 day); 15
TAGRISSO ORAL TABLET 40 MG, 80 MG (<i>osimertinib mesylate</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day); 15
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS***		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
<i>lapatinib ditosylate oral tablet 250 mg</i>	COVERED - sPDL	PA; QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>pazopanib hcl oral tablet 200 mg</i>	COVERED - sPDL	PA; QL (4 EA per 1 day)
<i>sorafenib tosylate oral tablet 200 mg</i>	COVERED - sPDL	PA; QL (4 EA per 1 day); 15
<i>sunitinib malate oral capsule 12.5 mg</i>	COVERED - sPDL	PA; QL (4 EA per 1 day); 14
<i>sunitinib malate oral capsule 25 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day); 14
<i>sunitinib malate oral capsule 37.5 mg, 50 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day); 14
*ANTINEOPLASTICS MISC.***		
<i>hydroxyurea oral capsule 500 mg</i>	COVERED - sPDL	
INTRON A INJECTION SOLUTION 10000000 UNIT/ML (<i>interferon alfa-2b</i>)	COVERED - sPDL	
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT (<i>interferon alfa-2b</i>)	COVERED - sPDL	
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	COVERED - sPDL	PA
*AROMATASE INHIBITORS***		
<i>anastrozole oral tablet 1 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>letrozole oral tablet 2.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS***		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>abemaciclib</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
*FOLIC ACID ANTAGONISTS RESCUE AGENTS***		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	COVERED - sPDL	
*IMIDAZOTETRAZINES***		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	COVERED - sPDL	PA
*JANUS ASSOCIATED KINASE (JAK) INHIBITORS***		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
*LHRH ANALOGS***		
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	COVERED - sPDL	PA
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate</i> (6 month))	COVERED - sPDL	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate</i>)	COVERED - sPDL	PA
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	COVERED - sPDL	PA
*MITOTIC INHIBITORS***		
<i>etoposide oral capsule 50 mg</i>	COVERED - sPDL	PA
*NITROGEN MUSTARDS AND RELATED ANALOGUES***		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	COVERED - sPDL	QL (8 EA per 1 day)
<i>melphalan oral tablet 2 mg</i>	COVERED - sPDL	
*NITROSOUREAS***		
<i>lomustine oral capsule 100 mg, 40 mg</i>	Not Covered	
*PROGESTINS-ANTINEOPLASTIC***		
<i>megestrol acetate oral suspension 400 mg/10ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>megestrol acetate oral tablet 20 mg</i>	COVERED - sPDL	QL (40 EA per 1 day)
<i>megestrol acetate oral tablet 40 mg</i>	COVERED - sPDL	QL (20 EA per 1 day)
*RETINOIDS***		
<i>tretinoin oral capsule 10 mg</i>	COVERED - sPDL	PA
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS***		
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (3 EA per 1 day)
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (3 EA per 1 day)
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	QL (3 EA per 1 day)
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG (<i>lenvatinib mesylate</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)
ANTIPARKINSON AND RELATED THERAPY AGENTS		
*ANTIPARKINSON ANTICHOLINERGICS***		
<i>benztropine mesylate oral tablet 0.5 mg</i>	COVERED - sPDL	QL (5 EA per 1 day); AGE (Max 64 Years)
<i>benztropine mesylate oral tablet 1 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>benztropine mesylate oral tablet 2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	COVERED - sPDL	PA
<i>trihexyphenidyl hcl oral tablet 2 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Max 64 Years)
<i>trihexyphenidyl hcl oral tablet 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
*ANTIPARKINSON DOPAMINERGICS***		
<i>amantadine hcl oral capsule 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>amantadine hcl oral solution 50 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>bromocriptine mesylate oral capsule 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS***		
<i>selegiline hcl oral capsule 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>selegiline hcl oral tablet 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*LEVODOPA COMBINATIONS***		
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>carbidopa-levodopa er oral tablet extended release 50-200 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-250 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>carbidopa-levodopa oral tablet 25-100 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg</i>	COVERED - sPDL	ST; QL (8 EA per 1 day); prior use of LEVODOPA/CARBIDOPA
<i>carbidopa-levodopa-entacapone oral tablet 50-200-200 mg</i>	COVERED - sPDL	ST; QL (6 EA per 1 day); prior use of LEVODOPA/CARBIDOPA

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Drug Name	Drug Tier	Requirements/Limits
*NONERGOLINE DOPAMINE RECEPTOR AGONISTS***		
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 1.5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>pramipexole dihydrochloride oral tablet 0.75 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>ropinirole hcl oral tablet 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>ropinirole hcl oral tablet 0.5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*PERIPHERAL COMT INHIBITORS***		
<i>entacapone oral tablet 200 mg</i>	COVERED - sPDL	ST; QL (8 EA per 1 day); prior use of LEVODOPA/CARBIDOPA
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
*ANTIMANIC AGENTS***		
<i>lithium carbonate er oral tablet extended release 300 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>lithium carbonate er oral tablet extended release 450 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years)
<i>lithium carbonate oral capsule 150 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Min 6 Years)
<i>lithium carbonate oral capsule 300 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>lithium carbonate oral capsule 600 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>lithium carbonate oral tablet 300 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>lithium oral solution 8 meq/5ml</i>	COVERED - sPDL	
*ANTIPSYCHOTICS - MISC.***		
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	COVERED - sPDL	AGE (Min 18 Years)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG (<i>cariprazine hcl</i>)	COVERED - sPDL	AGE (Min 18 Years)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years)
*BENZISOXAZOLES***		
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML (<i>paliperidone palmitate</i>)	COVERED - sPDL	QL (1 Syringe per 168 days); AGE (Min 18 Years)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML (<i>paliperidone palmitate</i>)	COVERED - sPDL	QL (1 Syringe per 25 days); AGE (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML (<i>paliperidone palmitate</i>)	COVERED - sPDL	QL (1 Syringe per 71 days); AGE (Min 18 Years)

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Drug Name	Drug Tier	Requirements/Limits
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg</i>	COVERED - sPDL	PA; AGE (Min 6 Years)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (<i>risperidone microspheres</i>)	COVERED - sPDL	QL (2 EA per 25 days); AGE (Min 18 Years)
<i>risperidone oral solution 1 mg/ml</i>	COVERED - sPDL	QL (16 ML per 1 day); AGE (Min 5 Years)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 5 Years)
<i>risperidone oral tablet 4 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 5 Years)
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 5 Years)
<i>risperidone oral tablet dispersible 4 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 5 Years)
*BUTYROPHENONES***		
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	COVERED - sPDL	AGE (Min 6 Years)
<i>haloperidol lactate injection solution 5 mg/ml</i>	COVERED - sPDL	AGE (Min 6 Years)
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	COVERED - sPDL	AGE (Min 6 Years)
<i>haloperidol oral tablet 0.5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>haloperidol oral tablet 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	COVERED - sPDL	QL (5 EA per 1 day); AGE (Min 6 Years)
*DIBENZODIAZEPINES***		
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg</i>	COVERED - sPDL	AGE (Min 6 Years)
<i>clozapine oral tablet 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years)
*DIBENZO-OXEPINO PYRROLES***		
<i>asenapine maleate sublingual tablet sublingual 10 mg, 5 mg</i>	COVERED - sPDL	AGE (Min 6 Years)
*DIBENZOTHIAZEPINES***		
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 6 Years)
*DIBENZOXAZEPINES***		
<i>loxapine succinate oral capsule 10 mg, 5 mg, 50 mg</i>	COVERED - sPDL	QL (15 EA per 1 day); AGE (Min 6 Years)
<i>loxapine succinate oral capsule 25 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)

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Drug Name	Drug Tier	Requirements/Limits
*PHENOTHIAZINES***		
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Min 6 Years)
<i>prochlorperazine (Compro Rectal Suppository 25 Mg)</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	COVERED - sPDL	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	COVERED - sPDL	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years)
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Min 6 Years and Max 64 Years)
<i>prochlorperazine edisylate injection solution 10 mg/2ml</i>	COVERED - sPDL	
<i>prochlorperazine maleate oral tablet 10 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Min 6 Years)
<i>prochlorperazine maleate oral tablet 5 mg</i>	COVERED - sPDL	QL (10 EA per 1 day); AGE (Min 6 Years)
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>trifluoperazine hcl oral tablet 1 mg, 2 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>trifluoperazine hcl oral tablet 10 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 6 Years)
*QUINOLINONE DERIVATIVES***		
ABILIFY ASIMTUFI INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (<i>aripiprazole</i>)	COVERED - sPDL	QL (1 Syringe per 50 days); AGE (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (<i>aripiprazole</i>)	COVERED - sPDL	QL (1 Syringe per 25 days); AGE (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (<i>aripiprazole</i>)	COVERED - sPDL	QL (1 EA per 25 days); AGE (Min 18 Years)
<i>aripiprazole oral solution 1 mg/ml</i>	COVERED - sPDL	PA; AGE (Min 6 Years)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 6 Years)
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (<i>aripiprazole lauroxil</i>)	COVERED - sPDL	QL (1 Syringe per 28 days); AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (<i>aripiprazole lauroxil</i>)	COVERED - sPDL	QL (3.9 ML per 50 days); AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML (<i>aripiprazole lauroxil</i>)	COVERED - sPDL	QL (1.6 ML per 25 days); AGE (Min 18 Years)

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Drug Name	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML (<i>aripiprazole lauroxil</i>)	COVERED - sPDL	QL (2.4 ML per 25 days); AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML (<i>aripiprazole lauroxil</i>)	COVERED - sPDL	QL (3.2 ML per 25 days); AGE (Min 18 Years)
*THIENBENZODIAZEPINES***		
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	COVERED - sPDL	ST; QL (1 EA per 1 day); AGE (Min 6 Years); Requires trial of risperidone or quetiapine or clozapine
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG (<i>olanzapine pamoate</i>)	COVERED - sPDL	QL (2 EA per 25 days); AGE (Min 18 Years)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG (<i>olanzapine pamoate</i>)	COVERED - sPDL	QL (1 EA per 25 days); AGE (Min 18 Years)
*THIOXANTHENES***		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Min 6 Years)
ANTISEPTICS & DISINFECTANTS		
*CHLORINE ANTISEPTICS***		
BETASEPT SURGICAL SCRUB EXTERNAL LIQUID 4 % (<i>chlorhexidine gluconate</i>)	COVERED - sPDL	
BETASEPT SURGICAL SCRUB EXTERNAL SOLUTION 4 % (<i>chlorhexidine gluconate</i>)	COVERED - sPDL	
ANTIVIRALS		
*ANTIRETROVIRAL COMBINATIONS***		
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
BIKTARVY ORAL TABLET 30-120-15 MG (<i>bictegravir-emtricitab-tenofovir</i>)	COVERED - sPDL	QL (1 EA per 1 day); AGE (Max 12 Years)
BIKTARVY ORAL TABLET 50-200-25 MG (<i>bictegravir-emtricitab-tenofovir</i>)	COVERED - sPDL	QL (1 EA per 1 day)
CIMDUO ORAL TABLET 300-300 MG (<i>lamivudine-tenofovir</i>)	COVERED - sPDL	QL (1 EA per 1 day)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	COVERED - sPDL	QL (1 EA per 1 day)
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofovir df</i>)	COVERED - sPDL	QL (1 EA per 1 day)
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (<i>emtricitabine-tenofovir af</i>)	COVERED - sPDL	QL (1 EA per 1 day)
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>efavirenz-emtricitab-tenofovir df oral tablet 600-200-300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	COVERED - sPDL	QL (1 EA per 1 day)
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	COVERED - sPDL	QL (1 EA per 1 day)
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	COVERED - sPDL	QL (17.5 ML per 1 day)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofov af</i>)	COVERED - sPDL	QL (1 EA per 1 day)
PREZCOBIX ORAL TABLET 800-150 MG (<i>darunavir-cobicistat</i>)	COVERED - sPDL	QL (1 EA per 1 day)
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	COVERED - sPDL	QL (1 EA per 1 day)
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	COVERED - sPDL	QL (1 EA per 1 day)
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivud</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>trumeq pd oral tablet soluble 60-5-30 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
TRIZIVIR ORAL TABLET 300-150-300 MG (<i>abacavir-lamivudine-zidovudine</i>)	COVERED - sPDL	QL (2 EA per 1 day)
TRUVADA ORAL TABLET 200-300 MG (<i>emtricitabine-tenofovir df</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)***		
<i>maraviroc oral tablet 150 mg, 300 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	COVERED - sPDL	QL (60 ML per 1 day)
SELZENTRY ORAL TABLET 25 MG (<i>maraviroc</i>)	COVERED - sPDL	QL (48 EA per 1 day)
SELZENTRY ORAL TABLET 75 MG (<i>maraviroc</i>)	COVERED - sPDL	QL (16 EA per 1 day)
*ANTIRETROVIRALS - FUSION INHIBITORS***		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (<i>enfuvirtide</i>)	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR***		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	COVERED - sPDL	QL (2 EA per 1 day)
*ANTIRETROVIRALS - INTEGRASE INHIBITORS***		
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	COVERED - sPDL	QL (2 EA per 1 day)
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	COVERED - sPDL	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	COVERED - sPDL	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (<i>raltegravir potassium</i>)	COVERED - sPDL	QL (12 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (<i>raltegravir potassium</i>)	COVERED - sPDL	QL (6 EA per 1 day)
TIVICAY ORAL TABLET 10 MG, 25 MG, 50 MG (<i>dolutegravir sodium</i>)	COVERED - sPDL	QL (2 EA per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	COVERED - sPDL	QL (6 EA per 1 day)
*ANTIRETROVIRALS - PROTEASE INHIBITORS***		
APTIVUS ORAL CAPSULE 250 MG (<i>tipranavir</i>)	COVERED - sPDL	QL (4 EA per 1 day)
APTIVUS ORAL SOLUTION 100 MG/ML (<i>tipranavir</i>)	COVERED - sPDL	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>atazanavir sulfate oral capsule 300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG (<i>indinavir sulfate</i>)	COVERED - sPDL	
<i>darunavir oral tablet 600 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>darunavir oral tablet 800 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>fosamprenavir calcium oral tablet 700 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
INVIRASE ORAL TABLET 500 MG (<i>saquinavir mesylate</i>)	COVERED - sPDL	
LEXIVA ORAL SUSPENSION 50 MG/ML (<i>fosamprenavir calcium</i>)	COVERED - sPDL	QL (56 ML per 1 day)
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	COVERED - sPDL	PA
NORVIR ORAL SOLUTION 80 MG/ML (<i>ritonavir</i>)	COVERED - sPDL	QL (15 ML per 1 day)
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	COVERED - sPDL	QL (8 ML per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
PREZISTA ORAL TABLET 150 MG (<i>darunavir</i>)	COVERED - sPDL	QL (8 EA per 1 day)
PREZISTA ORAL TABLET 75 MG (<i>darunavir</i>)	COVERED - sPDL	QL (16 EA per 1 day)
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	COVERED - sPDL	QL (6 EA per 1 day)
<i>ritonavir oral tablet 100 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
VIRACEPT ORAL TABLET 250 MG (<i>nelfinavir mesylate</i>)	COVERED - sPDL	QL (10 EA per 1 day)
VIRACEPT ORAL TABLET 625 MG (<i>nelfinavir mesylate</i>)	COVERED - sPDL	QL (4 EA per 1 day)
*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES***		
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>efavirenz oral capsule 200 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>efavirenz oral capsule 50 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>efavirenz oral tablet 600 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>etravirine oral tablet 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>etravirine oral tablet 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	COVERED - sPDL	QL (4 EA per 1 day)
<i>nevirapine er oral tablet extended release 24 hour 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>nevirapine oral suspension 50 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>nevirapine oral tablet 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
PIFELTRO ORAL TABLET 100 MG (<i>doravirine</i>)	COVERED - sPDL	QL (1 EA per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES***		
<i>abacavir sulfate oral solution 20 mg/ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
<i>abacavir sulfate oral tablet 300 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>didanosine oral capsule delayed release 200 mg, 250 mg, 400 mg</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES***		
<i>emtricitabine oral capsule 200 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	COVERED - sPDL	QL (20 ML per 1 day)
<i>lamivudine oral solution 10 mg/ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
<i>lamivudine oral tablet 150 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>lamivudine oral tablet 300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES***		
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML (<i>zidovudine</i>)	COVERED - sPDL	QL (100 ML per 1 day)
<i>stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>zidovudine oral capsule 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>zidovudine oral syrup 50 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>zidovudine oral tablet 300 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES***		
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
VIREAD ORAL POWDER 40 MG/GM (<i>tenofovir disoproxil fumarate</i>)	COVERED - sPDL	QL (7.5 GM per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	COVERED - sPDL	QL (1 EA per 1 day)
*ANTIRETROVIRALS ADJUVANTS***		
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	COVERED - sPDL	QL (1 EA per 1 day)
*ANTIVIRAL COMBINATIONS***		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	COVERED - sPDL	QL (30 EA per 25 days); AGE (Min 18 Years); Max 5 day supply
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	COVERED - sPDL	QL (30 EA per 25 days); AGE (Min 18 Years); Max 5 day supply
*CMV AGENTS***		
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
<i>valganciclovir hcl oral tablet 450 mg</i>	COVERED - sPDL	PA
*HEPATITIS B AGENTS***		
<i>adefovir dipivoxil oral tablet 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>lamivudine oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
VEMLIDY ORAL TABLET 25 MG (<i>tenofovir alafenamide fumarate</i>)	COVERED - sPDL	PA
*HEPATITIS C AGENT - COMBINATIONS***		
<i>ledipasvir-sofosbuvir oral tablet 90-400 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	COVERED - sPDL	PA
*HEPATITIS C AGENTS***		
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	COVERED - sPDL	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	COVERED - sPDL	PA; SP
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5ML (<i>peginterferon alfa-2b</i>)	COVERED - sPDL	PA
<i>ribavirin oral capsule 200 mg</i>	COVERED - sPDL	PA
<i>ribavirin oral tablet 200 mg</i>	COVERED - sPDL	PA
SOVALDI ORAL TABLET 400 MG (<i>sofosbuvir</i>)	COVERED - sPDL	PA
*HERPES AGENTS - PURINE ANALOGUES***		
<i>acyclovir oral capsule 200 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>acyclovir oral suspension 200 mg/5ml</i>	COVERED - sPDL	QL (25 ML per 1 day)
<i>acyclovir oral tablet 400 mg, 800 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*HERPES AGENTS - THYMIDINE ANALOGUES***		
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*INFLUENZA AGENTS***		
<i>rimantadine hcl oral tablet 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*NEURAMINIDASE INHIBITORS***		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	COVERED - sPDL	
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	COVERED - sPDL	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>zanamivir</i>)	COVERED - sPDL	
BETA BLOCKERS		
*ALPHA-BETA BLOCKERS***		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>labetalol hcl oral tablet 100 mg, 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>labetalol hcl oral tablet 300 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*BETA BLOCKERS CARDIO-SELECTIVE***		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 25 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>metoprolol succinate er oral tablet extended release 24 hour 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>metoprolol succinate er oral tablet extended release 24 hour 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*BETA BLOCKERS NON-SELECTIVE***		
<i>nadolol oral tablet 20 mg, 40 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>nadolol oral tablet 80 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 60 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 160 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 80 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>propranolol hcl oral solution 20 mg/5ml</i>	COVERED - sPDL	QL (20 ML per 1 day)
<i>propranolol hcl oral solution 40 mg/5ml</i>	COVERED - sPDL	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
CALCIUM CHANNEL BLOCKERS		
*CALCIUM CHANNEL BLOCKERS***		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 240 mg, 300 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>felodipine er oral tablet extended release 24 hour 10 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
KATERZIA ORAL SUSPENSION 1 MG/ML (<i>amlodipine benzoate</i>)	COVERED - sPDL	AGE (Min 6 Years and Max 12 Years)
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 90 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg, 90 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>nifedipine oral capsule 10 mg, 20 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	COVERED - sPDL	AGE (Min 6 Years and Max 12 Years)
<i>verapamil hcl er oral tablet extended release 120 mg, 240 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>verapamil hcl er oral tablet extended release 180 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>verapamil hcl oral tablet 120 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>verapamil hcl oral tablet 40 mg, 80 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
CARDIOTONICS		
*CARDIAC GLYCOSIDES***		
<i>digoxin oral solution 0.05 mg/ml</i>	COVERED - sPDL	AGE (Max 12 Years)
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>digoxin oral tablet 62.5 mcg</i>	COVERED - sPDL	QL (8 EA per 1 day)
CARDIOVASCULAR AGENTS - MISC.		
*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB***		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (<i>sacubitril-valsartan</i>)	COVERED - sPDL	PA; QL (8 EA per 1 day)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (<i>sacubitril-valsartan</i>)	COVERED - sPDL	PA
*PERIPHERAL VASODILATORS***		
<i>niacin flush free oral capsule 500 mg</i>	COVERED - sPDL	
*PROSTAGLANDIN VASODILATORS***		
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	COVERED - sPDL	PA
*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS***		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day)
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	COVERED - sPDL	PA
*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS***		
<i>sildenafil citrate oral tablet 20 mg</i>	COVERED - sPDL	PA; QL (3 EA per 1 day)
*PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST***		
UPTRAVI ORAL TABLET 100 MCG, 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	COVERED - sPDL	PA; QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
UPTRAVI ORAL TABLET 150 MCG (<i>selexipag</i>)	COVERED - SPDL	PA; QL (6 EA per 1 day)
SINUS NODE INHIBITORS		
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	COVERED - SPDL	PA
CEPHALOSPORINS		
*CEPHALOSPORINS - 1ST GENERATION***		
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	COVERED - SPDL	AGE (Max 12 Years)
<i>cephalexin oral capsule 250 mg, 500 mg</i>	COVERED - SPDL	QL (6 EA per 1 day)
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	COVERED - SPDL	AGE (Max 12 Years)
*CEPHALOSPORINS - 2ND GENERATION***		
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	COVERED - SPDL	AGE (Max 12 Years)
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	COVERED - SPDL	QL (2 EA per 1 day)
*CEPHALOSPORINS - 3RD GENERATION***		
<i>cefdinir oral capsule 300 mg</i>	COVERED - SPDL	QL (2 EA per 1 day)
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	COVERED - SPDL	AGE (Max 12 Years)
CHEMICALS		
*BULK CHEMICALS - BU'S***		
<i>budesonide powder</i>	COVERED - SPDL	
*BULK CHEMICALS - ET'S***		
<i>ethyl oleate liquid</i>	COVERED - SPDL	
*BULK CHEMICALS - PR'S***		
<i>progesterone micronized powder</i>	COVERED - SPDL	
*FIXED OILS***		
<i>sesame oil oil</i>	COVERED - SPDL	
*LIQUIDS***		
<i>benzyl benzoate liquid</i>	COVERED - SPDL	AGE (Min 16 Years and Max 60 Years)
CONTRACEPTIVES		
*BIPHASIC CONTRACEPTIVES - ORAL***		
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	COVERED - SPDL	QL (1.34 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*COMBINATION CONTRACEPTIVES - ORAL***		
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>drospirenone-ethinyl estradiol oral tablet 3-0.03 mg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	COVERED - sPDL	QL (1.34 EA per 1 day)
*COMBINATION CONTRACEPTIVES - TRANSDERMAL***		
<i>norelgestromin-eth estradiol</i> (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	COVERED - sPDL	QL (0.143 EA per 1 day)
*COMBINATION CONTRACEPTIVES - VAGINAL***		
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	COVERED - sPDL	QL (0.05 EA per 1 day)
*EMERGENCY CONTRACEPTIVES***		
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	COVERED - sPDL	QL (6 EA per 365 days)
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	COVERED - sPDL	QL (6 EA per 365 days); Max 1 per fill
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL***		
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	COVERED - sPDL	QL (1.08 EA per 1 day)
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	COVERED - sPDL	QL (1.08 EA per 1 day)
<i>levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg</i>	COVERED - sPDL	QL (1.08 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*PROGESTIN CONTRACEPTIVES - INJECTABLE***		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	COVERED - sPDL	QL (2.6 ML per 284 days)
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	COVERED - sPDL	QL (4 ML per 284 days)
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	COVERED - sPDL	QL (4 ML per 284 days)
*PROGESTIN CONTRACEPTIVES - IUD***		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	COVERED - sPDL	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	COVERED - sPDL	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	COVERED - sPDL	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (<i>levonorgestrel</i>)	COVERED - sPDL	
*PROGESTIN CONTRACEPTIVES - ORAL***		
<i>norethindrone oral tablet 0.35 mg</i>	COVERED - sPDL	QL (1.34 EA per 1 day)
*TRIPHASIC CONTRACEPTIVES - ORAL***		
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	COVERED - sPDL	QL (1.34 EA per 1 day)
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	COVERED - sPDL	QL (1.34 EA per 1 day)
CORTICOSTEROIDS		
*GLUCOCORTICOSTEROIDS***		
<i>methylprednisolone sodium succ</i> (A-Methapred Injection Solution Reconstituted 125 Mg, 40 Mg)	COVERED - sPDL	
<i>budesonide oral capsule delayed release particles 3 mg</i>	COVERED - sPDL	
DEPO-MEDROL INJECTION SUSPENSION 40 MG/ML, 80 MG/ML (<i>methylprednisolone acetate</i>)	COVERED - sPDL	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>dexamethasone oral solution 0.5 mg/5ml</i>	COVERED - sPDL	
<i>dexamethasone oral tablet 0.5 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>dexamethasone oral tablet 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>dexamethasone sod phos + rfid injection solution prefilled syringe 4 mg/ml</i>	COVERED - sPDL	
<i>dexamethasone sodium phosphate injection solution 4 mg/ml</i>	COVERED - sPDL	
<i>dexamethasone sodium phosphate injection solution prefilled syringe 4 mg/ml</i>	COVERED - sPDL	
<i>hydrocortisone oral tablet 10 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>hydrocortisone oral tablet 20 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>hydrocortisone oral tablet 5 mg</i>	COVERED - sPDL	QL (24 EA per 1 day)
<i>hydrocortisone sod suc (pf) injection solution reconstituted 100 mg</i>	COVERED - sPDL	
<i>methylprednisolone acetate injection suspension 40 mg/ml, 50 mg/ml, 80 mg/ml</i>	COVERED - sPDL	
<i>methylprednisolone acetate powder</i>	COVERED - sPDL	
<i>methylprednisolone oral tablet 16 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>methylprednisolone oral tablet 32 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>methylprednisolone oral tablet 4 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>methylprednisolone oral tablet 8 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>methylprednisolone powder</i>	COVERED - sPDL	
<i>methylprednisolone sodium succ injection solution reconstituted 1 gm, 1000 mg, 125 mg, 40 mg, 500 mg</i>	COVERED - sPDL	
<i>prednisolone oral solution 15 mg/5ml</i>	COVERED - sPDL	
<i>prednisolone oral syrup 15 mg/5ml</i>	COVERED - sPDL	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml</i>	COVERED - sPDL	
<i>prednisone oral solution 5 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>prednisone oral tablet 1 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>prednisone oral tablet 10 mg</i>	COVERED - sPDL	QL (9 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>prednisone oral tablet 2.5 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>prednisone oral tablet 20 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>prednisone oral tablet 5 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>prednisone oral tablet 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	COVERED - sPDL	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED 100 MG (<i>hydrocortisone sod succinate</i>)	COVERED - sPDL	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED 1000 MG, 125 MG, 40 MG, 500 MG (<i>methylprednisolone sodium succ</i>)	COVERED - sPDL	
*MINERALOCORTICOIDS***		
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
COUGH/COLD/ALLERGY		
*ANTITUSSIVE - NONNARCOTIC***		
<i>benzonatate oral capsule 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>benzonatate oral capsule 200 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>tussin cough long-acting oral liquid 15 mg/5ml</i>	COVERED - sPDL	
*ANTITUSSIVE-EXPECTORANT***		
<i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml</i>	COVERED - sPDL	QL (180 ML Max Qty Per Fill Retail)
DIABETIC TUSSIN DM MAX ST ORAL LIQUID 10-200 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	COVERED - sPDL	
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>tussin dm oral liquid 100-10 mg/5ml</i>	COVERED - sPDL	QL (240 ML per 25 days)
*DECONGESTANT & ANTIHISTAMINE***		
<i>allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>childs cold/allergy oral elixir 1-15 mg/5ml</i>	COVERED - sPDL	
<i>diphenhydramine-phenylephrine oral tablet 25-10 mg</i>	COVERED - sPDL	
<i>loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>night time cough/cold child oral liquid 6.25-2.5 mg/5ml</i>	COVERED - sPDL	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day); AGE (Max 64 Years)
*DECONGESTANT W/ EXPECTORANT***		
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 60-600 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Min 4 Years)
*EXPECTORANTS***		
<i>chest congestion relief child oral liquid 100 mg/5ml</i>	COVERED - sPDL	
<i>chest congestion relief oral tablet 400 mg</i>	COVERED - sPDL	AGE (Min 4 Years)
<i>geri-tussin oral syrup 100 mg/5ml</i>	COVERED - sPDL	AGE (Min 4 Years)
<i>guaifenesin er oral tablet extended release 12 hour 600 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>guaifenesin oral tablet 200 mg</i>	COVERED - sPDL	AGE (Min 4 Years)
*MISC. RESPIRATORY INHALANTS***		
<i>sodium chloride inhalation nebulization solution 0.9 %, 3 %, 7 %</i>	COVERED - sPDL	
*MUCOLYTICS***		
<i>acetylcysteine inhalation solution 20 %</i>	COVERED - sPDL	QL (120 ML per 1 day)
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTI-HISTAMINE***		
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
DERMATOLOGICALS		
*ACNE ANTIBIOTICS***		
<i>clindamycin phos (once-daily) external gel 1 %</i>	COVERED - sPDL	ST; QL (60 ML per 25 days); PRIOR USE DIFFERIN, CLINDA SOLN, OR ERYTHRO SOLN
<i>clindamycin phos (twice-daily) external gel 1 %</i>	COVERED - sPDL	ST; QL (60 GM per 25 days); PRIOR USE DIFFERIN, CLINDA SOLN, OR ERYTHRO SOLN
<i>clindamycin phosphate external gel 1 %</i>	COVERED - sPDL	ST; QL (60 GM per 25 days); PRIOR USE DIFFERIN, CLINDA SOLN, OR ERYTHRO SOLN
<i>clindamycin phosphate external lotion 1 %</i>	COVERED - sPDL	ST; QL (10 ML per 1 day); PRIOR USE DIFFERIN, CLINDA SOLN, OR ERYTHRO SOLN

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Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate external solution 1 %</i>	COVERED - sPDL	QL (60 ML per 25 days)
<i>erythromycin external solution 2 %</i>	COVERED - sPDL	QL (15 ML per 1 day)
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	COVERED - sPDL	PA; QL (118 ML per 25 days)
*ACNE PRODUCTS***		
<i>acne medication 10 external lotion 10 %</i>	COVERED - sPDL	
<i>acne medication 5 external lotion 5 %</i>	COVERED - sPDL	
<i>adapalene external gel 0.1 %</i>	COVERED - sPDL	QL (45 GM per 25 days)
<i>benzoyl peroxide external gel 10 %, 5 %</i>	COVERED - sPDL	
<i>benzoyl peroxide external gel 2.5 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	COVERED - sPDL	PA
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	COVERED - sPDL	ST; QL (45 GM per 25 days); AGE (Max 35 Years); PRIOR USE DIFFERIN OTC AND CLINDA SOLN OR ERYTHRO SOLN
<i>tretinoin external gel 0.01 %, 0.025 %</i>	COVERED - sPDL	ST; QL (45 GM per 25 days); AGE (Max 35 Years); PRIOR USE DIFFERIN OTC AND CLINDA SOLN OR ERYTHRO SOLN
*ANTIBIOTIC MIXTURES TOPICAL***		
<i>double antibiotic external ointment 500-10000 unit/gm</i>	COVERED - sPDL	
<i>first aid antibiotic external ointment 3.5-400-5000 mg-unit</i>	COVERED - sPDL	
<i>goodsense first aid antibiotic external ointment</i>	COVERED - sPDL	
<i>triple antibiotic pain relief external ointment 1 %</i>	COVERED - sPDL	
*ANTIBIOTICS - TOPICAL***		
<i>bacitracin external ointment 500 unit/gm</i>	COVERED - sPDL	
<i>bacitracin zinc external ointment 500 unit/gm</i>	COVERED - sPDL	
<i>gentamicin sulfate external cream 0.1 %</i>	COVERED - sPDL	QL (30 GM per 25 days)
<i>gentamicin sulfate external ointment 0.1 %</i>	COVERED - sPDL	QL (30 GM per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>mupirocin external ointment 2 %</i>	COVERED - sPDL	QL (44 GM per 25 days)
*ANTIFUNGALS - TOPICAL***		
<i>athletes foot (terbinafine) external cream 1 %</i>	COVERED - sPDL	QL (30 GM per 25 days)
BLIS-TO-SOL EXTERNAL LIQUID 1 % (<i>tolnaftate</i>)	COVERED - sPDL	QL (151 ML per 30 days)
<i>ciclopirox external solution 8 %</i>	COVERED - sPDL	QL (6.6 ML per 25 days)
<i>ciclopirox olamine external cream 0.77 %</i>	COVERED - sPDL	QL (20 GM per 1 day)
<i>ciclopirox olamine external suspension 0.77 %</i>	COVERED - sPDL	QL (60 ML per 25 days)
<i>jock itch spray powder external aerosol powder 1 %</i>	COVERED - sPDL	QL (133 GM per 30 days)
<i>nystatin external cream 100000 unit/gm</i>	COVERED - sPDL	QL (90 GM per 25 days)
<i>nystatin external ointment 100000 unit/gm</i>	COVERED - sPDL	QL (90 GM per 25 days)
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	COVERED - sPDL	QL (30 GM per 25 days)
<i>tolnaftate external cream 1 %</i>	COVERED - sPDL	QL (60 GM per 30 days)
<i>tolnaftate external powder 1 %</i>	COVERED - sPDL	QL (67.5 GM per 30 days)
*ANTI-INFLAMMATORY AGENTS - TOPICAL***		
<i>diclofenac sodium external gel 1 %</i>	COVERED - sPDL	QL (200 GM per 25 days)
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL***		
<i>fluorouracil external cream 5 %</i>	COVERED - sPDL	
*ANTIPSORIATICS - SYSTEMIC***		
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (2 ML per 24 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (2 ML per 24 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (1 ML per 24 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (1 ML per 24 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (0.5 ML per 24 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	COVERED - sPDL	PA; QL (2 ML per 23 days)
PYZCHIVA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-ttwe</i>)	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (ustekinumab-kfce)	COVERED - sPDL	PA
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (ustekinumab-kfce)	COVERED - sPDL	PA
*ANTIPSORIATICS***		
calcipotriene external cream 0.005 %	COVERED - sPDL	QL (120 GM per 25 days)
calcipotriene external ointment 0.005 %	COVERED - sPDL	QL (120 GM per 25 days)
calcipotriene external solution 0.005 %	COVERED - sPDL	QL (60 ML per 25 days)
*ANTIVIRALS - TOPICAL***		
acyclovir external ointment 5 %	COVERED - sPDL	PA
docosanol external cream 10 %	COVERED - sPDL	
*BURN PRODUCTS***		
silver sulfadiazine (Ssd External Cream 1 %)	COVERED - sPDL	
*CORTICOSTEROIDS - TOPICAL***		
alclometasone dipropionate external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
alclometasone dipropionate external ointment 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
anti-itch maximum strength external cream 1 %	COVERED - sPDL	QL (60 GM per 25 days)
betamethasone dipropionate aug external cream 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
betamethasone dipropionate aug external gel 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
betamethasone dipropionate aug external lotion 0.05 %	COVERED - sPDL	QL (60 ML per 25 days)
betamethasone dipropionate aug external ointment 0.05 %	COVERED - sPDL	QL (50 GM per 25 days)
betamethasone dipropionate external cream 0.05 %	COVERED - sPDL	QL (60 GM per 25 days)
betamethasone dipropionate external lotion 0.05 %	COVERED - sPDL	QL (60 ML per 25 days)
betamethasone dipropionate external ointment 0.05 %	COVERED - sPDL	QL (45 GM per 25 days)
betamethasone valerate external cream 0.1 %	COVERED - sPDL	QL (45 GM per 25 days)
betamethasone valerate external lotion 0.1 %	COVERED - sPDL	QL (60 ML per 25 days)
betamethasone valerate external ointment 0.1 %	COVERED - sPDL	QL (45 GM per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>clobetasol propionate external solution 0.05 %</i>	COVERED - sPDL	QL (50 ML per 25 days)
<i>cvs cortisone cooling relief external gel 1 %</i>	COVERED - sPDL	
<i>desonide external cream 0.05 %</i>	COVERED - sPDL	ST; QL (60 GM per 25 days); REQ TRY ANY 3 PREFERRED LOW POTENCY
<i>desonide external ointment 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinolone acetonide body external oil 0.01 %</i>	COVERED - sPDL	QL (120 ML per 25 days)
<i>fluocinolone acetonide external cream 0.025 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinolone acetonide external ointment 0.025 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	COVERED - sPDL	QL (120 ML per 25 days)
<i>fluocinonide emulsified base external cream 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinonide external cream 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinonide external gel 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinonide external ointment 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluocinonide external solution 0.05 %</i>	COVERED - sPDL	QL (60 ML per 25 days)
<i>fluticasone propionate external cream 0.05 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>fluticasone propionate external ointment 0.005 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>halobetasol propionate external cream 0.05 %</i>	COVERED - sPDL	QL (50 GM per 25 days)
<i>halobetasol propionate external ointment 0.05 %</i>	COVERED - sPDL	QL (50 GM per 25 days)
<i>hydrocortisone acetate external cream 1 %</i>	COVERED - sPDL	
<i>hydrocortisone external cream 0.5 %, 2.5 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>hydrocortisone external lotion 1 %</i>	COVERED - sPDL	
<i>hydrocortisone external lotion 2.5 %</i>	COVERED - sPDL	QL (60 ML per 25 days)
<i>hydrocortisone external ointment 0.5 %, 2.5 %</i>	COVERED - sPDL	QL (60 GM per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone external ointment 1 %</i>	COVERED - sPDL	
<i>mometasone furoate external cream 0.1 %</i>	COVERED - sPDL	QL (45 GM per 25 days)
<i>mometasone furoate external ointment 0.1 %</i>	COVERED - sPDL	QL (45 GM per 25 days)
<i>mometasone furoate external solution 0.1 %</i>	COVERED - sPDL	QL (60 ML per 25 days)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	COVERED - sPDL	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	COVERED - sPDL	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	COVERED - sPDL	
<i>triamcinolone acetonide powder</i>	COVERED - sPDL	
*EMOLLIENTS***		
<i>ammonium lactate external lotion 12 %</i>	COVERED - sPDL	QL (225 GM per 25 days)
HYDROLATUM EXTERNAL OINTMENT (<i>emollient</i>)	COVERED - sPDL	
*ENZYMES - TOPICAL***		
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	COVERED - sPDL	PA; QL (2 GM per 1 day)
*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL***		
<i>antifungal clotrimazole external cream 1 %</i>	COVERED - sPDL	
<i>antifungal external powder 2 %</i>	COVERED - sPDL	
<i>athletes foot powder spray external aerosol powder 2 %</i>	COVERED - sPDL	
<i>clotrimazole external solution 1 %</i>	COVERED - sPDL	QL (60 ML per 30 days)
<i>ketoconazole external cream 2 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
<i>ketoconazole external shampoo 2 %</i>	COVERED - sPDL	QL (120 ML per 25 days)
<i>miconazole nitrate external cream 2 %</i>	COVERED - sPDL	QL (150 GM per 25 days)
TRIPLE PASTE AF EXTERNAL OINTMENT 2 % (<i>miconazole nitrate</i>)	COVERED - sPDL	
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL***		
<i>imiquimod external cream 5 %</i>	COVERED - sPDL	PA; QL (24 EA per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
*INSECT REPELLENTS***		
NATRAPEL EXTERNAL LIQUID 20 % (<i>picaridin</i>)	COVERED - sPDL	
REPEL 100 EXTERNAL LIQUID 98.11 % (<i>diethyltoluamide</i>)	COVERED - sPDL	
REPEL FAMILY EXTERNAL AEROSOL 15 % (<i>diethyltoluamide</i>)	COVERED - sPDL	
REPEL LEMON EUCALYPTUS EXTERNAL AEROSOL (<i>insect repellent</i>)	COVERED - sPDL	
REPEL SPORTSMEN MAX EXTERNAL LOTION 40 % (<i>diethyltoluamide</i>)	COVERED - sPDL	
REPEL TICK DEFENSE EXTERNAL AEROSOL 15 % (<i>picaridin</i>)	COVERED - sPDL	
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS***		
<i>podofilox external solution 0.5 %</i>	COVERED - sPDL	QL (7 ML per 180 days)
*LOCAL ANESTHETICS - TOPICAL***		
<i>arthritis pain relieving external cream 0.075 %</i>	COVERED - sPDL	
<i>capsaicin external cream 0.025 %</i>	COVERED - sPDL	
<i>capsaicin external cream 0.1 %</i>	COVERED - sPDL	QL (85 GM per 25 days)
CAPZASIN-P EXTERNAL CREAM 0.035 % (<i>capsaicin</i>)	COVERED - sPDL	
CIRCATA EXTERNAL CREAM 0.05 % (<i>capsaicin</i>)	COVERED - sPDL	
<i>dibucaine external ointment 1 %</i>	COVERED - sPDL	
<i>lidocaine hcl</i> (Glydo External Prefilled Syringe 2 %)	COVERED - sPDL	
<i>lidocaine external cream 4 %</i>	COVERED - sPDL	
<i>lidocaine external patch 5 %</i>	COVERED - sPDL	PA; QL (3 EA per 1 day)
<i>lidocaine hcl external solution 4 %</i>	COVERED - sPDL	
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	COVERED - sPDL	
<i>lidocaine pain relief max st external patch 4 %</i>	COVERED - sPDL	QL (4 EA per 1 day)
PROXIVOL EXTERNAL GEL 2 % (<i>lidocaine hcl</i>)	COVERED - sPDL	
ZOSTRIX NATURAL PAIN RELIEF EXTERNAL CREAM 0.033 % (<i>capsaicin</i>)	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL***		
<i>pimecrolimus external cream 1 %</i>	COVERED - sPDL	QL (100 GM per 25 days)
<i>tacrolimus external ointment 0.03 %</i>	COVERED - sPDL	QL (100 GM per 25 days)
<i>tacrolimus external ointment 0.1 %</i>	COVERED - sPDL	QL (100 GM per 25 days); AGE (Min 16 Years)
*MISC. TOPICAL COMBINATIONS***		
ZINC-OXYDE PLUS EXTERNAL OINTMENT 0.44-20 % (<i>menthol-zinc oxide</i>)	COVERED - sPDL	
*MISC. TOPICAL***		
DRYSOL EXTERNAL SOLUTION 20 % (<i>aluminum chloride</i>)	COVERED - sPDL	
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL***		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	COVERED - sPDL	PA; QL (100 GM per 25 days)
*ROSACEA AGENTS***		
<i>metronidazole external cream 0.75 %</i>	COVERED - sPDL	
<i>metronidazole external gel 0.75 %</i>	COVERED - sPDL	
<i>metronidazole external lotion 0.75 %</i>	COVERED - sPDL	
*SCABICIDE COMBINATIONS***		
<i>lice killing maximum strength external shampoo 0.33-4 %</i>	COVERED - sPDL	
<i>stop lice complete treatment combination kit 0.33-4-0.5 %</i>	COVERED - sPDL	
<i>stop lice maximum strength external liquid 0.33-4 %</i>	COVERED - sPDL	
*SCABICIDES & PEDICULICIDES***		
CROTAN EXTERNAL LOTION 10 % (<i>crotamiton</i>)	COVERED - sPDL	
<i>lice treatment creme rinse external liquid 1 %</i>	COVERED - sPDL	
<i>lice treatment external liquid 1 %</i>	COVERED - sPDL	
<i>lice treatment external lotion 1 %</i>	COVERED - sPDL	
<i>malathion external lotion 0.5 %</i>	COVERED - sPDL	QL (59 ML per 25 days)
<i>permethrin external cream 5 %</i>	COVERED - sPDL	

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
<i>spinosad external suspension 0.9 %</i>	COVERED - sPDL	QL (120 ML per 25 days)
<i>stop lice aerosol 0.5 %</i>	COVERED - sPDL	
*SKIN PROTECTANTS***		
MINERIN CREME EXTERNAL CREAM (<i>skin protectants, misc.</i>)	COVERED - sPDL	
*TOPICAL ANESTHETIC COMBINATIONS***		
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	COVERED - sPDL	QL (60 GM per 25 days)
*TOPICAL STEROID COMBINATIONS***		
<i>hydrocortisone-aloe external cream 0.5 %, 1 %</i>	COVERED - sPDL	
*WOUND CARE COMBINATIONS***		
XEROFORM PETROLAT PATCH 2"X2" EXTERNAL PAD (<i>bismuth tribromoph-petrolatum</i>)	COVERED - sPDL	
*WOUND DRESSINGS***		
DUODERM CGF DRESSING EXTERNAL (<i>control gel formula dressing</i>)	COVERED - sPDL	
INTRASITE GEL APPLIPAK EXTERNAL GEL (<i>wound dressings</i>)	COVERED - sPDL	
DIAGNOSTIC PRODUCTS		
*DIAGNOSTIC DRUGS***		
THYROGEN INTRAMUSCULAR SOLUTION RECONSTITUTED 0.9 MG (<i>thyrotropin alfa</i>)	COVERED - sPDL	PA; QL (2 EA per 180 days)
*DIAGNOSTIC INFECTION TEST COMBINATIONS***		
BD VERITOR SARS-COV-2/FLU A+B IN VITRO KIT (<i>influenza-sars antigen test</i>)	COVERED - sPDL	
*DIAGNOSTIC TESTS***		
KETOSTIX IN VITRO STRIP (<i>acetone (urine) test</i>)	COVERED - sPDL	
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (<i>glucose blood</i>)	COVERED - sPDL	Max of #100/month for non-insulin users. Max of #200/month for insulin users and pregnant members filling prenatal vitamins
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (<i>glucose blood</i>)	COVERED - sPDL	Max of #100/month for non-insulin users. Max of #200/month for insulin users and pregnant members filling prenatal vitamins. Max 300 strips/month for type 1 if submitted with Dx code or PA required without Dx

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Drug Name	Drug Tier	Requirements/Limits
*INFECTION TESTS***		
BD VERITOR SYSTEM SARS-COV-2 IN VITRO KIT (<i>covid-19 antigen test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
<i>covid-19 at-home test in vitro kit</i>	COVERED - sPDL	QL (2 EA per 28 days)
<i>covid-19 testing by pharmacist kit</i>	COVERED - sPDL	QL (2 EA per 28 days)
CUE COVID-19 TEST IN VITRO CARTRIDGE (<i>covid-19 at home test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
CUE HEALTH MONITORING SYSTEM IN VITRO (<i>covid-19 at home test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
ID NOW COVID-19 2.0 TEST IN VITRO KIT (<i>covid-19 test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
ID NOW COVID-19 CONTROL IN VITRO KIT (<i>covid-19 control test</i>)	COVERED - sPDL	
ID NOW COVID-19 IN VITRO KIT (<i>covid-19 test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
LUCIRA COVID-19 ALL-IN-ONE IN VITRO KIT (<i>covid-19 at home test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
PIXEL COVID-19 PCR HOME TEST IN VITRO KIT (<i>covid-19 home test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
RAPID RESPONSE COVID-19 IN VITRO KIT (<i>covid-19 antibody test</i>)	COVERED - sPDL	QL (2 EA per 28 days)
DIGESTIVE AIDS		
*DIGESTIVE ENZYMES***		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	COVERED - sPDL	QL (6 EA per 1 day)
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	COVERED - sPDL	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	COVERED - sPDL	QL (6 EA per 1 day)
DIURETICS		
*CARBONIC ANHYDRASE INHIBITORS***		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*DIURETIC COMBINATIONS***		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>spironolactone-hctz oral tablet 25-25 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*LOOP DIURETICS***		
<i>bumetanide oral tablet 0.5 mg, 1 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>bumetanide oral tablet 2 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	COVERED - sPDL	AGE (Max 12 Years)
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>torsemide oral tablet 10 mg, 20 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>torsemide oral tablet 100 mg, 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*POTASSIUM SPARING DIURETICS***		
<i>amiloride hcl oral tablet 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>spironolactone oral tablet 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>spironolactone oral tablet 25 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>spironolactone oral tablet 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*THIAZIDES AND THIAZIDE-LIKE DIURETICS***		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>hydrochlorothiazide oral tablet 25 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>hydrochlorothiazide oral tablet 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>metolazone oral tablet 10 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>metolazone oral tablet 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
ENDOCRINE AND METABOLIC AGENTS - MISC.		
*BISPHOSPHONATES***		
<i>alendronate sodium oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	COVERED - sPDL	QL (0.1429 EA per 1 day)
<i>ibandronate sodium oral tablet 150 mg</i>	COVERED - sPDL	QL (0.0358 EA per 1 day)
*CALCIMIMETIC AGENTS***		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>cinacalcet hcl oral tablet 90 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*CALCITONINS***		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	COVERED - sPDL	QL (1 ML per 1 day); AGE (Min 50 Years)
*CARNITINE REPLENISHER - AGENTS***		
<i>levocarnitine oral solution 1 gm/10ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>levocarnitine oral tablet 330 mg</i>	COVERED - sPDL	QL (18 EA per 1 day)
*DOPAMINE RECEPTOR AGONISTS***		
<i>cabergoline oral tablet 0.5 mg</i>	COVERED - sPDL	
*GROWTH HORMONES***		
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (<i>somatropin</i>)	COVERED - sPDL	PA
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS***		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)***		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML (<i>mecasermin</i>)	COVERED - sPDL	PA
*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS***		
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (<i>leuprolide acetate</i>)	COVERED - sPDL	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG (<i>leuprolide acetate (3 month)</i>)	COVERED - sPDL	PA
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	COVERED - sPDL	PA
*MUCOPOLYSACCHARIDOSIS II (MPS II) - AGENTS***		
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML (<i>idursulfase</i>)	COVERED - sPDL	PA
*OVULATION STIMULANTS-SYNTHETIC***		
<i>clomiphene citrate oral tablet 50 mg</i>	COVERED - sPDL	AGE (Min 21 Years)

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Drug Name	Drug Tier	Requirements/Limits
*PARATHYROID HORMONE AND DERIVATIVES***		
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	COVERED - sPDL	PA
*PHENYLKETONURIA TREATMENT - AGENTS***		
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	COVERED - sPDL	PA
*RANK LIGAND (RANKL) INHIBITORS***		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML (<i>denosumab</i>)	COVERED - sPDL	PA
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)***		
<i>raloxifene hcl oral tablet 60 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 50 Years)
*SOMATOSTATIC AGENTS***		
<i>octreotide acetate injection solution 100 mcg/ml</i>	COVERED - sPDL	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml</i>	COVERED - sPDL	PA
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG (<i>octreotide acetate</i>)	COVERED - sPDL	PA
*UREA CYCLE DISORDER - AGENTS***		
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	COVERED - sPDL	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	COVERED - sPDL	PA
*VASOPRESSIN***		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	COVERED - sPDL	PA
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	COVERED - sPDL	PA
<i>desmopressin acetate oral tablet 0.1 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>desmopressin acetate oral tablet 0.2 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>desmopressin acetate spray nasal solution 0.01 %</i>	COVERED - sPDL	PA
ESTROGENS		
*ESTROGEN & PROGESTIN***		
<i>norethindrone-eth estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg)</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>norethindrone-eth estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ESTROGENS***		
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	COVERED - sPDL	AGE (Max 64 Years)

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Drug Name	Drug Tier	Requirements/Limits
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr</i>	COVERED - sPDL	QL (8 Patches per 28 days); AGE (Min 18 Years)
<i>estradiol transdermal patch weekly 0.025 mg/24hr</i>	COVERED - sPDL	QL (4 Patches per 28 days); AGE (Min 18 Years)
FLUOROQUINOLONES		
*FLUOROQUINOLONES***		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>levofloxacin oral solution 25 mg/ml</i>	COVERED - sPDL	PA
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>moxifloxacin hcl oral tablet 400 mg</i>	COVERED - sPDL	
GASTROINTESTINAL AGENTS - MISC.		
*ANTIFLATULENTS***		
<i>gas relief extra strength oral capsule 125 mg</i>	COVERED - sPDL	
<i>gas relief extra strength oral tablet chewable 125 mg</i>	COVERED - sPDL	
<i>gas relief oral tablet chewable 80 mg</i>	COVERED - sPDL	
<i>goodsense gas relief extra st oral capsule 125 mg</i>	COVERED - sPDL	
<i>infants gas relief oral suspension 40 mg/0.6ml</i>	COVERED - sPDL	
<i>simethicone drops infants oral liquid 20 mg/0.3ml</i>	COVERED - sPDL	
<i>simethicone oral tablet chewable 80 mg</i>	COVERED - sPDL	
<i>simethicone ultra strength oral capsule 180 mg</i>	COVERED - sPDL	
*GALLSTONE SOLUBILIZING AGENTS***		
<i>ursodiol oral capsule 300 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>ursodiol oral tablet 250 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>ursodiol oral tablet 500 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*GASTROINTESTINAL STIMULANTS***		
<i>metoclopramide hcl oral solution 10 mg/10ml</i>	COVERED - sPDL	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*INFLAMMATORY BOWEL AGENTS***		
<i>balsalazide disodium oral capsule 750 mg</i>	COVERED - sPDL	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>sulfasalazine oral tablet 500 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>sulfasalazine oral tablet delayed release 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*INTERLEUKIN ANTAGONISTS***		
PYZCHIVA INTRAVENOUS SOLUTION 130 MG/26ML (ustekinumab-ttwe (iv))	COVERED - sPDL	PA
*INTESTINAL ACIDIFIERS***		
<i>enulose oral solution 10 gm/15ml</i>	COVERED - sPDL	QL (180 ML per 1 day)
*PHOSPHATE BINDER AGENTS***		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	COVERED - sPDL	
<i>sevelamer carbonate oral tablet 800 mg</i>	COVERED - sPDL	ST; PRIOR USE OF calcium acetate
GENITOURINARY AGENTS - MISCELLANEOUS		
*5-ALPHA REDUCTASE INHIBITORS***		
<i>finasteride oral tablet 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ALPHA 1-ADRENOCEPTOR ANTAGONISTS***		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>tamsulosin hcl oral capsule 0.4 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*CITRATES***		
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>potassium citrate er oral tablet extended release 15 meq (1620 mg)</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	COVERED - sPDL	
<i>sod citrate-citric acid oral solution 500-334 mg/5ml</i>	COVERED - sPDL	
*GENITOURINARY IRRIGANTS***		
<i>acetic acid irrigation solution 0.25 %</i>	COVERED - sPDL	
<i>sodium chloride irrigation solution 0.9 %</i>	COVERED - sPDL	QL (10000 ML per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
*URINARY ANALGESICS***		
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
GOUT AGENTS		
*GOUT AGENT COMBINATIONS***		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*GOUT AGENTS***		
<i>allopurinol oral tablet 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>allopurinol oral tablet 300 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>colchicine oral tablet 0.6 mg</i>	COVERED - sPDL	QL (30 EA per 90 days)
*URICOSURICS***		
<i>probenecid oral tablet 500 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
HEMATOLOGICAL AGENTS - MISC.		
*ANTIHEMOPHILIC PRODUCTS***		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 4000 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	COVERED - sPDL	PA
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>coagulation factor ix (recomb)</i>)	COVERED - sPDL	PA
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 500-1200 UNIT (<i>antihemophilic factor-vwf</i>)	COVERED - sPDL	PA
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihem factor recomb (rfviii)</i>)	COVERED - sPDL	PA
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	COVERED - sPDL	PA
NUWIK INTRAVENOUS KIT 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	COVERED - sPDL	PA
<i>rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit</i>	COVERED - sPDL	PA
*HEMATORHEOLOGIC AGENTS***		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*PHOSPHODIESTERASE III INHIBITORS***		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*PLATELET AGGREGATION INHIBITOR COMBINATIONS***		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
*PLATELET AGGREGATION INHIBITORS***		
<i>dipyridamole oral tablet 25 mg</i>	COVERED - sPDL	QL (10 EA per 1 day)
<i>dipyridamole oral tablet 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>dipyridamole oral tablet 75 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*THIENOPYRIDINE DERIVATIVES***		
<i>clopidogrel bisulfate oral tablet 75 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
HEMATOPOIETIC AGENTS		
*COBALAMINS***		
<i>b-12 oral tablet 250 mcg</i>	COVERED - sPDL	
<i>b-12 quick dissolve sublingual tablet sublingual 1000 mcg</i>	COVERED - sPDL	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	COVERED - sPDL	
<i>vitamin b-12 er oral tablet extended release 1000 mcg</i>	COVERED - sPDL	
<i>vitamin b-12 oral tablet 100 mcg, 1000 mcg, 500 mcg</i>	COVERED - sPDL	
<i>vitamin b-12 sublingual tablet sublingual 1000 mcg, 2500 mcg, 500 mcg</i>	COVERED - sPDL	
*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)***		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	COVERED - sPDL	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	COVERED - sPDL	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	COVERED - sPDL	PA
*FOLIC ACID/FOLATES***		
<i>folic acid oral tablet 1 mg, 400 mcg, 800 mcg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>kp folic acid oral tablet 800 mcg</i>	COVERED - sPDL	QL (5 EA per 1 day)
*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)***		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-jmdb</i>)	COVERED - sPDL	PA; QL (0.6 ML per 11 days)
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-bmez</i>)	COVERED - sPDL	PA; QL (0.6 ML per 11 days)
*IRON COMBINATIONS***		
<i>foltrin oral capsule</i>	COVERED - sPDL	QL (2 EA per 1 day)
HEMATOGEN ORAL CAPSULE (<i>iron combinations</i>)	COVERED - sPDL	QL (2 EA per 1 day)
<i>polysaccharide iron forte oral capsule 150-25-1 mg-mcg-mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*IRON***		
FERATE ORAL TABLET 240 (27 FE) MG (<i>ferrous gluconate</i>)	COVERED - sPDL	
FERROCITE ORAL TABLET 324 MG (<i>ferrous fumarate</i>)	COVERED - sPDL	
<i>ferrous gluconate oral tablet 324 (37.5 fe) mg, 324 (38 fe) mg</i>	COVERED - sPDL	
<i>ferrous sulfate oral elixir 220 (44 fe) mg/5ml</i>	COVERED - sPDL	
<i>ferrous sulfate oral liquid 220 (44 fe) mg/5ml</i>	COVERED - sPDL	
<i>ferrous sulfate oral solution 220 (44 fe) mg/5ml</i>	COVERED - sPDL	
<i>ferrous sulfate oral tablet 325 (65 fe) mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 325 (65 fe) mg</i>	COVERED - sPDL	
<i>iron infant/toddler oral solution 75 (15 fe) mg/ml</i>	COVERED - sPDL	
NU-IRON ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	COVERED - sPDL	QL (2 EA per 1 day)
<i>px iron oral tablet 200 (65 fe) mg</i>	COVERED - sPDL	
<i>slow release iron oral tablet extended release 160 (50 fe) mg, 50 mg</i>	COVERED - sPDL	
<i>sm slow release dried iron oral tablet extended release 45 mg</i>	COVERED - sPDL	
<i>sm slow release iron oral tablet extended release 142 (45 fe) mg, 45 mg</i>	COVERED - sPDL	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
*ANTI HISTAMINE HYPNOTICS***		
<i>cvs sleep-aid (doxylamine) oral tablet 25 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>diphenhydramine hcl (sleep) oral tablet 25 mg, 50 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Max 64 Years)

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ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
*BARBITURATE HYPNOTICS***		
<i>phenobarbital oral elixir 20 mg/5ml</i>	COVERED - sPDL	QL (50 ML per 1 day); AGE (Max 12 Years)
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 97.2 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>phenobarbital oral tablet 64.8 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
*BENZODIAZEPINE HYPNOTICS***		
<i>estazolam oral tablet 1 mg, 2 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 15 Years and Max 64 Years)
<i>temazepam oral capsule 15 mg, 30 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>triazolam oral tablet 0.125 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>triazolam oral tablet 0.25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 18 Years)
*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS***		
<i>zolpidem tartrate oral tablet 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate oral tablet 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day); AGE (Min 18 Years)
LAXATIVES		
*BOWEL EVACUANT COMBINATIONS***		
<i>GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (peg 3350-kcl-nabcb-nacl-nasulf)</i>	COVERED - sPDL	QL (4000 ML per 1 day)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	COVERED - sPDL	QL (4000 ML per 1 day)
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	COVERED - sPDL	QL (4000 ML per 1 day)
<i>PEG-PREP ORAL KIT 5-210 MG-GM (bisacodyl-peg-kcl-nabicar-nacl)</i>	COVERED - sPDL	
*BULK LAXATIVES***		
<i>BENEFIBER DRINK MIX ORAL PACKET (wheat dextrin)</i>	COVERED - sPDL	
<i>clear soluble fiber oral powder</i>	COVERED - sPDL	
<i>cvs daily fiber oral packet 58.6 %</i>	COVERED - sPDL	
<i>fiber (corn dextrin) oral powder</i>	COVERED - sPDL	
<i>fiber therapy oral tablet 500 mg</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>fiber-lax oral tablet 625 mg</i>	COVERED - sPDL	
<i>konsyl daily fiber oral packet 28.3 %</i>	COVERED - sPDL	
<i>konsyl original daily fiber oral packet 100 %</i>	COVERED - sPDL	
KONSYL-D ORAL POWDER 52.3 % (<i>psyllium</i>)	COVERED - sPDL	
METAMUCIL 4 IN 1 FIBER ORAL PACKET 25 %, 51.7 % (<i>psyllium</i>)	COVERED - sPDL	
METAMUCIL MULTIHEALTH FIBER ORAL PACKET 58.12 % (<i>psyllium</i>)	COVERED - sPDL	
METAMUCIL ORAL PACKET 28 % (<i>psyllium</i>)	COVERED - sPDL	
METAMUCIL ORAL WAFER (<i>psyllium</i>)	COVERED - sPDL	
<i>natural fiber oral powder 58.6 %</i>	COVERED - sPDL	
<i>natural fiber therapy oral powder 28.3 %</i>	COVERED - sPDL	
<i>natural psyllium seed oral powder 100 %</i>	COVERED - sPDL	
<i>psyllium fiber oral capsule 0.52 gm</i>	COVERED - sPDL	
<i>qc natural vegetable oral powder 95 %</i>	COVERED - sPDL	
<i>sb fib lax orange oral powder 33 %</i>	COVERED - sPDL	
UNIFIBER ORAL POWDER (<i>cellulose</i>)	COVERED - sPDL	
WAL-MUCIL ORAL POWDER 43 %, 48.57 % (<i>psyllium</i>)	COVERED - sPDL	
*ELECTROLYTE-BASED OSMOTIC LAXATIVE MIXTURES***		
<i>enema pediatric rectal enema 3.5-9.5 gm/59ml</i>	COVERED - sPDL	
<i>enema rectal enema 7-19 gm/118ml</i>	COVERED - sPDL	
*ELECTROLYTE-BASED OSMOTIC LAXATIVES***		
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	COVERED - sPDL	
<i>milk of magnesia concentrate oral suspension 2400 mg/10ml</i>	COVERED - sPDL	
<i>milk of magnesia oral suspension 7.75 %</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*LAXATIVES - MISCELLANEOUS***		
<i>glycerin (adult) rectal suppository 2 gm, 2.1 gm, 80.7 %</i>	COVERED - sPDL	
<i>glycerin (pediatric) rectal suppository 1.2 gm</i>	COVERED - sPDL	
<i>lactulose oral solution 10 gm/15ml</i>	COVERED - sPDL	QL (180 ML per 1 day)
<i>peg 3350 oral powder 17 gm/scoop</i>	COVERED - sPDL	QL (34 GM per 1 day)
*LAXATIVES & DSS***		
<i>easy-lax plus oral tablet 8.6-50 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
*LUBRICANT LAXATIVES***		
<i>enema mineral oil rectal enema</i>	COVERED - sPDL	
<i>mineral oil oral oil</i>	COVERED - sPDL	
*STIMULANT LAXATIVES***		
<i>bisacodyl laxative oral tablet delayed release 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>chocolated laxative oral tablet chewable 15 mg</i>	COVERED - sPDL	
<i>gentle laxative rectal suppository 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>natural senna laxative oral tablet 8.6 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>senna laxative oral tablet 25 mg</i>	COVERED - sPDL	
<i>senna oral syrup 8.8 mg/5ml</i>	COVERED - sPDL	
*SURFACTANT LAXATIVES***		
<i>cvs stool softener oral capsule 50 mg</i>	COVERED - sPDL	
<i>docusate calcium oral capsule 240 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>docusate sodium oral capsule 100 mg</i>	COVERED - sPDL	
<i>docusate sodium oral capsule 250 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>docusate sodium oral liquid 50 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day)
<i>docusate sodium oral syrup 60 mg/15ml</i>	COVERED - sPDL	
<i>docusate sodium oral tablet 100 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
PEDIA-LAX ORAL LIQUID 50 MG/15ML (<i>docusate sodium</i>)	COVERED - sPDL	QL (30 ML per 1 day)
MACROLIDES		
*AZITHROMYCIN***		
<i>azithromycin oral packet 1 gm</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>azithromycin oral suspension reconstituted 100 mg/5ml</i>	COVERED - sPDL	QL (20 ML per 1 day); AGE (Max 12 Years)
<i>azithromycin oral suspension reconstituted 200 mg/5ml</i>	COVERED - sPDL	QL (30 ML per 1 day); AGE (Max 12 Years)
<i>azithromycin oral tablet 250 mg</i>	COVERED - sPDL	QL (12 EA per 25 days)
<i>azithromycin oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 25 days)
<i>azithromycin oral tablet 600 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*CLARITHROMYCIN***		
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	COVERED - sPDL	AGE (Max 12 Years)
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	COVERED - sPDL	
*ERYTHROMYCINS***		
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</i>	COVERED - sPDL	AGE (Max 12 Years)
MEDICAL DEVICES AND SUPPLIES		
*ADHESIVE BANDAGES***		
LEUKOSTRIP 1/8"X1-1/2" (<i>adhesive bandages</i>)	COVERED - sPDL	QL (30 EA per 25 days)
*ADHESIVE TAPE***		
SCANPOR TAPE TAPE (<i>adhesive tape</i>)	COVERED - sPDL	QL (120 EA per 25 days)
*APPLICATORS,COTTON BALLS,ETC***		
<i>alcohol swabs pad 70 %</i>	COVERED - sPDL	QL (200 EA per 25 days)
<i>essentra wipes 9x9" sheet 70 %</i>	COVERED - sPDL	QL (200 EA per 25 days)
*CONDOMS - MALE***		
<i>condoms</i>	COVERED - sPDL	
TRUSTEX RIA NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	COVERED - sPDL	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>condoms latex lubricated</i>)	COVERED - sPDL	QL (108 EA per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
*DISPOSABLE GLOVES***		
SECURE GLOVES (<i>disposable gloves</i>)	COVERED - sPDL	QL (100 EA per 25 days)
*GAUZE PADS & DRESSINGS***		
AMD FOAM DRESSING PAD 4"X4" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (30 EA per 25 days)
CURITY COVER SPONGE PAD 3"X3" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (120 EA per 25 days)
CURITY GAUZE SPONGE PAD 2"X2" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (120 EA per 25 days)
CURITY NON-ADHERING DRESSING PAD 5"X9" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (30 EA per 25 days)
PRIMAPORE 2-7/8"X2" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (120 EA per 25 days)
TELF A NON-ADHERENT DESSING PAD 2"X3" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (180 EA per 25 days)
TELF A NON-ADHERENT PAD 3"X4" (<i>gauze pads & dressings</i>)	COVERED - sPDL	QL (180 EA per 25 days)
*GLUCOSE MONITORING TEST SUPPLIES***		
DEXCOM G5 MOB/G4 PLAT SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	PA; QL (4 EA per 23 days); (except ages 2-17 with history of insulin)
DEXCOM G5 MOBILE RECEIVER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
DEXCOM G5 MOBILE TRANSMITTER (<i>continuous glucose transmitter</i>)	COVERED - sPDL	QL (1 EA per 76 days); (except ages 2-17 with history of insulin)
DEXCOM G5 RECEIVER KIT DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	PA; QL (3 EA per 23 days); (except ages 2-17 with history of insulin)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	COVERED - sPDL	QL (1 EA per 76 days); (except ages 2-17 with history of insulin)
DEXCOM G7 15 DAY SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 25 days)
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)

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Drug Name	Drug Tier	Requirements/Limits
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	PA; QL (3 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (8 EA per 1 day); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	COVERED - sPDL	QL (2 EA per 23 days); (except ages 2-17 with history of insulin)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	COVERED - sPDL	QL (1 EA per 310 days); (except ages 2-17 with history of insulin)
<i>lancets thin</i>	COVERED - sPDL	
TRUE METRIX AIR GLUCOSE METER KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	COVERED - sPDL	QL (1 EA per 1 Fill)
TRUE METRIX METER KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	COVERED - sPDL	QL (1 EA per 1 Fill)
*HUMIDIFIERS***		
<i>personal ultrasonic humidifier</i>	COVERED - sPDL	QL (1 EA per 365 days)
*INCONTINENCE SUPPLIES***		
BARD DISPOZ-A-BAG LEG BAG (<i>incontinence supply disposable</i>)	COVERED - sPDL	QL (10 EA per 25 days)
BARDIA URINARY DRAINAGE BAG (<i>incontinence supplies</i>)	COVERED - sPDL	QL (50 EA per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
washable pants kit	COVERED - sPDL	QL (10 EA per 25 days)
*NEBULIZERS***		
AEROECLIPSE II NEBULIZER (<i>nebulizers</i>)	COVERED - sPDL	QL (2 EA per 1 Fill)
*NEEDLES & SYRINGES***		
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (<i>insulin syringe/needle u-500</i>)	COVERED - sPDL	QL (5 EA per 1 day)
careone unifine pentips 29g x 12mm	COVERED - sPDL	QL (200 EA per 25 days)
careone unifine pentips 31g x 8 mm	COVERED - sPDL	QL (1 EA per 25 days)
INSUPEN SENSITIVE 32G X 8 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (4 EA per 25 days)
MONOJECT HYPODERMIC NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	COVERED - sPDL	
MONOJECT SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	COVERED - sPDL	
MONOJECT SYRINGE REGULAR TIP 3 ML (<i>syringe (disposable)</i>)	COVERED - sPDL	
NOVOFINE PEN NEEDLE 32G X 6 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
pc unifine pentips 31g x 5 mm , 31g x 6 mm	COVERED - sPDL	QL (200 EA per 25 days)
techlite insulin syringe 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 1/2" 0.3 ml, 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 15/64" 0.3 ml, 31g x 15/64" 0.5 ml, 31g x 15/64" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml	COVERED - sPDL	QL (5 EA per 1 day)
TECHLITE PEN NEEDLES 29G X 10MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 29G X 10MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 29G X 12MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 31G X 6 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TECHLITE PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)

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Drug Name	Drug Tier	Requirements/Limits
TECHLITE PEN NEEDLES 32G X 6 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
TECHLITE PEN NEEDLES 32G X 8 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (1 EA per 25 days)
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	COVERED - sPDL	QL (5 EA per 1 day)
ULTICARE PEN NEEDLES 29G X 12.7MM (<i>insulin pen needle</i>)	COVERED - sPDL	QL (200 EA per 25 days)
*OSTOMY SUPPLIES***		
<i>adapt stoma powder</i>	COVERED - sPDL	
ALLKARE PROTECT BARRIER WIPES (<i>ostomy supplies</i>)	COVERED - sPDL	QL (25 EA per 25 days)
FEATHER-LITE UROSTOMY POUCH (<i>ostomy supplies</i>)	COVERED - sPDL	QL (50 EA per 25 days)
<i>ostomy belt large</i>	COVERED - sPDL	QL (510 EA per 25 days)
<i>ostomy belt medium</i>	COVERED - sPDL	QL (5 EA per 25 days)
SKIN PREP WIPES (<i>ostomy supplies</i>)	COVERED - sPDL	QL (15 EA per 25 days)
<i>stoma lubricant paste</i>	COVERED - sPDL	QL (10 ML per 25 days)
SUR-FIT NATURA DURAHESIVE WAFER (<i>ostomy supplies</i>)	COVERED - sPDL	QL (10 EA per 25 days)
*PEAK FLOW METERS***		
TRUZONE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	COVERED - sPDL	QL (1 EA per 365 days)
*RESPIRATORY THERAPY SUPPLIES***		
ACE AEROSOL CLOUD ENHANCER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
ACTIVITY POUCH (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>adult aerosol mask</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>adult mask large</i>	COVERED - sPDL	QL (1 EA per 365 days)
AEROECLIPSE EZ TWIST TUBING (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
AEROECLIPSE MASK LARGE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
AEROECLIPSE MASK MEDIUM (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
AEROECLIPSE MASK SMALL (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
AEROTRACH PLUS (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
AIRS PEDIATRIC AEROSOL MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
ALL FLOW 1000 PFT FILTER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>breathe ease neb mask/child</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>breathe ease neb mask/infant</i>	COVERED - sPDL	QL (1 EA per 365 days)
BUBBLES THE FISH II PEDI MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
CARETOUCH 2 CPAP HOSE HANGER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
CARETOUCH CPAP & BIPAP HOSE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
CARETOUCH CPAP MASK WIPES (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
CARETOUCH CPAP PRE-WASH SOLN (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (354.8 ML per 365 days)
CARETOUCH CPAP TUBE BRUSH (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
CARETOUCH UNIVERSL CPAP FILTER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>co monitor replacement pieces</i>	COVERED - sPDL	QL (1 EA per 365 days)
EASY FLOW 300 MM HOSE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
EASY FLOW 400 MM HOSE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
EASY FLOW AIR NOZZLE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
EASY FLOW HEPA FILTER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
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Drug Name	Drug Tier	Requirements/Limits
<i>filter air pp</i>	COVERED - sPDL	QL (1 EA per 365 days)
FLYP HYPERSONIQ CARTRIDGE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>full kit nebulizer set</i>	COVERED - sPDL	QL (1 EA per 365 days)
INNOSPIRE REPLACEMENT FILTER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
LITETOUCH MASK LARGE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
LITETOUCH MASK MEDIUM (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
LITETOUCH MASK SMALL (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
MINIELITE FILTER REPLACEMENTS (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>nebulizer air tube/plugs</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>nebulizer mask adult</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>nebulizer mask child</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>nose clip</i>	COVERED - sPDL	QL (1 EA per 365 days)
OMBRA COMPRESSOR AIR FILTERS (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI BABY CONVERSION KIT (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI EXPIRATORY FILTER SET DEVICE (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI MASK SET (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI SMARTMASK BABY/ELBOW (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI SOFT PLASTIC ADULT MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
PARI SOFT PLASTIC PED MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>pediatric mouthpiece</i>	COVERED - sPDL	QL (1 EA per 365 days)
PFLEX (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>pharmacist choice mask wipes</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>pillow mask/adult</i>	COVERED - sPDL	QL (1 EA per 365 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>pillow mask/child</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>pillow mask/pediatric</i>	COVERED - sPDL	QL (1 EA per 365 days)
PRONEB ULTRA FILTER SET (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>replacement air filter</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>replacement filters</i>	COVERED - sPDL	QL (1 EA per 365 days)
REUSABLE COMFORTSEAL MASK-LRG (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
REUSABLE COMFORTSEAL MASK-MED (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
REUSABLE COMFORTSEAL MASK-SML (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
SAMI THE SEAL FILTERS (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
SIDESTREAM ADULT FACE MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
SIDESTREAM PEDIATRIC FACE MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
SIDESTREAM PLS ADULT FACE MASK (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>silicone mask/adult</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>silicone mask/infant</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>silicone mask/pediatric</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>sootheneb nbl 100 adult mask</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>sootheneb nbl 100 child mask</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>sootheneb nbl 100 med cup</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>sootheneb nbl 100 mesh cap</i>	COVERED - sPDL	QL (1 EA per 365 days)
THRESHOLD IMT (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (1 EA per 365 days)
<i>tubing/wing tip</i>	COVERED - sPDL	QL (1 EA per 365 days)
<i>ultra neb accessories kit</i>	COVERED - sPDL	QL (1 EA per 365 days)
WINDMILL TRAINER (<i>respiratory therapy supplies</i>)	COVERED - sPDL	QL (5 EA per 365 days)

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Drug Name	Drug Tier	Requirements/Limits
*SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES***		
INSPIREASE (<i>spacer/aero-holding chambers</i>)	COVERED - sPDL	QL (2 EA per 180 days)
PEDIATRIC PANDA MASK (<i>spacer/aero-hold chamber mask</i>)	COVERED - sPDL	QL (3 EA per 365 days)
*THERMOMETERS***		
KP FAST READ FLEX-TIP THERM (<i>electronic thermometer</i>)	COVERED - sPDL	
VICKS BABY THERMOMETER (<i>rectal thermometer</i>)	COVERED - sPDL	QL (2 EA per 365 days)
VICKS PACIFIER THERMOMETER (<i>infant thermometer</i>)	COVERED - sPDL	QL (2 EA per 365 days)
MIGRAINE PRODUCTS		
*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES***		
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>galcanezumab-gnlm</i>)	COVERED - sPDL	PA
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (<i>galcanezumab-gnlm</i>)	COVERED - sPDL	PA
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>galcanezumab-gnlm</i>)	COVERED - sPDL	PA
*SELECTIVE SEROTONIN AGONISTS 5-HT(1)***		
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	COVERED - sPDL	QL (9 EA per 25 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (12 EA per 25 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	COVERED - sPDL	QL (12 EA per 25 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	COVERED - sPDL	QL (9 EA per 25 days)
MINERALS & ELECTROLYTES		
*CALCIUM COMBINATIONS***		
<i>calcium 500 + d oral tablet 500-3.125 mg-mcg</i>	COVERED - sPDL	
<i>calcium 600/vitamin d oral tablet chewable 600-10 mg-mcg</i>	COVERED - sPDL	
<i>calcium 600+d oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	COVERED - sPDL	
<i>calcium 600+d plus minerals oral tablet chewable 600-400 mg-unit</i>	COVERED - sPDL	
<i>calcium 600+d3 oral tablet 600-20 mg-mcg</i>	COVERED - sPDL	
<i>calcium carb-cholecalciferol oral tablet 600-5 mg-mcg</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>calcium carb-cholecalciferol oral tablet chewable 500-10 mg-mcg</i>	COVERED - sPDL	
<i>calcium carbonate-vitamin d oral tablet 500-3.125 mg-mcg</i>	COVERED - sPDL	
<i>calcium citrate + d3 oral tablet 250-5 mg-mcg, 315-6.25 mg-mcg</i>	COVERED - sPDL	
<i>calcium citrate-vitamin d oral tablet 315-5 mg-mcg</i>	COVERED - sPDL	
<i>calcium magnesium zinc oral tablet 333-133-5 mg</i>	COVERED - sPDL	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg, 600-3.125 mg-mcg</i>	COVERED - sPDL	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	COVERED - sPDL	
<i>liquid calcium/vitamin d oral capsule 600-5 mg-mcg</i>	COVERED - sPDL	
<i>oscal 500 d-3 oral tablet 500-5 mg-mcg</i>	COVERED - sPDL	
OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG (<i>calcium carb-cholecalciferol</i>)	COVERED - sPDL	
OS-CAL ORAL TABLET CHEWABLE 500-15 MG-MCG (<i>calcium carb-cholecalciferol</i>)	COVERED - sPDL	
<i>oyster shell calcium/d oral tablet 250-3.125 mg-mcg, 500-10 mg-mcg</i>	COVERED - sPDL	
<i>risacal-d oral tablet 105-81-120 mg-mg-unit</i>	COVERED - sPDL	
*CALCIUM***		
<i>calcium 600 oral tablet 1500 (600 ca) mg, 600 mg</i>	COVERED - sPDL	
<i>calcium citrate oral tablet 950 (200 ca) mg</i>	COVERED - sPDL	
<i>calcium oyster shell oral tablet 1250 (500 ca) mg</i>	COVERED - sPDL	
<i>oyster shell calcium oral tablet 500 mg</i>	COVERED - sPDL	
*ELECTROLYTES & DEXTROSE***		
<i>dextrose in lactated ringers intravenous solution 5 %</i>	COVERED - sPDL	
*ELECTROLYTES ORAL***		
REHYDRALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	COVERED - sPDL	
*ELECTROLYTES PARENTERAL***		
<i>lactated ringers intravenous solution</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*FLUORIDE***		
FLURA-DROPS ORAL SOLUTION 0.55 (0.25 F) MG/DROP (sodium fluoride)	COVERED - sPDL	
sodium fluoride (Nafrinse Oral Tablet Chewable 2.2 (1 F) Mg)	COVERED - sPDL	QL (1 EA per 1 day)
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	COVERED - sPDL	QL (1.67 ML per 1 day)
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg	COVERED - sPDL	QL (1 EA per 1 day)
*MAGNESIUM***		
magnesium chloride oral tablet delayed release 64 mg	COVERED - sPDL	
magnesium gluconate oral tablet 27.5 mg, 500 (27 mg) mg	COVERED - sPDL	
magnesium oral tablet 250 mg, 400 mg	COVERED - sPDL	
magnesium oxide -mg supplement oral capsule 500 mg	COVERED - sPDL	
magnesium oxide -mg supplement oral tablet 250 mg, 400 (240 mg) mg, 500 mg	COVERED - sPDL	
*PHOSPHATE***		
PHOSPHO-TRIN 250 NEUTRAL ORAL TABLET 155-852-130 MG (k phos mono-sod phos di & mono)	COVERED - sPDL	QL (4 EA per 1 day)
*POTASSIUM***		
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	COVERED - sPDL	QL (4 EA per 1 day)
potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	COVERED - sPDL	QL (4 EA per 1 day)
potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	COVERED - sPDL	QL (5 EA per 1 day)
potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)	COVERED - sPDL	QL (4 EA per 1 day)
potassium bicarbonate (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)	COVERED - sPDL	QL (2 EA per 1 day)
potassium chloride er oral capsule extended release 10 meq, 8 meq	COVERED - sPDL	QL (4 EA per 1 day)
potassium chloride er oral tablet extended release 20 meq	COVERED - sPDL	QL (5 EA per 1 day)
potassium chloride oral solution 10 %, 40 meq/15ml (20%)	COVERED - sPDL	
*SODIUM***		
AQUASTAT INTRAVENOUS SOLUTION 0.9 % (sodium chloride flush)	COVERED - sPDL	
AQUASTAT SFR INTRAVENOUS SOLUTION 0.9 % (sodium chloride flush)	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
BD POSIFLUSH INTRAVENOUS SOLUTION 0.9 % (<i>sodium chloride flush</i>)	COVERED - sPDL	
BD POSIFLUSH SAFESCRUB INTRAVENOUS SOLUTION 0.9 % (<i>sodium chloride flush</i>)	COVERED - sPDL	
<i>sodium chloride flush</i> (Kendall Sodium Chloride Flush Intravenous Solution 0.9 %)	COVERED - sPDL	
MONOJECT FLUSH SYRINGE INTRAVENOUS SOLUTION 0.9 % (<i>sodium chloride flush</i>)	COVERED - sPDL	
MONOJECT SODIUM CHLORIDE FLUSH INTRAVENOUS SOLUTION 0.9 % (<i>sodium chloride flush</i>)	COVERED - sPDL	
<i>normal saline flush intravenous solution 0.9 %</i>	COVERED - sPDL	
<i>saline flush intravenous solution 0.9 %</i>	COVERED - sPDL	
<i>sodium chloride flush</i> (Saline Flush Zr Intravenous Solution 0.9 %)	COVERED - sPDL	
<i>sodium chloride flush intravenous solution 0.9 %</i>	COVERED - sPDL	
<i>sodium chloride intravenous solution 0.9 %</i>	COVERED - sPDL	
<i>sodium chloride oral tablet 1 gm</i>	COVERED - sPDL	
<i>sodium chloride flush</i> (Swabflush Saline Flush Intravenous Solution 0.9 %)	COVERED - sPDL	
*ZINC***		
ORAZINC ORAL CAPSULE 220 (50 ZN) MG (<i>zinc sulfate</i>)	COVERED - sPDL	
MISCELLANEOUS THERAPEUTIC CLASSES		
*ANTILEPROTICS***		
THALOMID ORAL CAPSULE 100 MG (<i>thalidomide</i>)	COVERED - sPDL	PA; QL (1 EA per 1 day)
*B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS***		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML (<i>belimumab</i>)	COVERED - sPDL	PA
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML (<i>belimumab</i>)	COVERED - sPDL	PA
*CHELATING AGENTS***		
<i>penicillamine oral tablet 250 mg</i>	COVERED - sPDL	PA
*CYCLOSPORINE ANALOGS***		
<i>cyclosporine modified oral capsule 50 mg</i>	COVERED - sPDL	QL (15 EA per 1 day)
<i>cyclosporine oral capsule 100 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>cyclosporine oral capsule 25 mg</i>	COVERED - sPDL	QL (16 EA per 1 day)
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg)	COVERED - sPDL	QL (10 EA per 1 day)
<i>cyclosporine modified</i> (Gengraf Oral Capsule 25 Mg)	COVERED - sPDL	QL (15 EA per 1 day)
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	COVERED - sPDL	QL (10 ML per 1 day)
NEORAL ORAL CAPSULE 100 MG (<i>cyclosporine modified</i>)	COVERED - sPDL	QL (10 EA per 1 day)
NEORAL ORAL CAPSULE 25 MG (<i>cyclosporine modified</i>)	COVERED - sPDL	QL (15 EA per 1 day)
NEORAL ORAL SOLUTION 100 MG/ML (<i>cyclosporine modified</i>)	COVERED - sPDL	QL (10 ML per 1 day)
SANDIMMUNE ORAL SOLUTION 100 MG/ML (<i>cyclosporine</i>)	COVERED - sPDL	
*IMMUNOMODULATORS FOR MYELOYDYSPLASTIC SYNDROMES***		
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	COVERED - sPDL	PA; QL (1 EA per 1 day)
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS***		
<i>mycophenolate mofetil oral capsule 250 mg</i>	COVERED - sPDL	QL (12 EA per 1 day)
<i>mycophenolate mofetil oral tablet 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*IRRIGATION SOLUTIONS***		
<i>sterile water for irrigation irrigation solution</i>	COVERED - sPDL	
*MACROLIDE IMMUNOSUPPRESSANTS***		
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG (<i>tacrolimus</i>)	COVERED - sPDL	
<i>tacrolimus oral capsule 0.5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>tacrolimus oral capsule 1 mg</i>	COVERED - sPDL	QL (14 EA per 1 day)
<i>tacrolimus oral capsule 5 mg</i>	COVERED - sPDL	
*POTASSIUM REMOVING AGENTS***		
LOKELMA ORAL PACKET 10 GM, 5 GM (<i>sodium zirconium cyclosilicate</i>)	COVERED - sPDL	QL (3 EA per 1 day)
<i>sodium polystyrene sulfonate oral powder</i>	COVERED - sPDL	
<i>sodium polystyrene sulfonate</i> (Sps (Sodium Polystyrene Sulf) Combination Suspension 15 Gm/60ML)	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (<i>sodium polystyrene sulfonate</i>)	COVERED - sPDL	
<i>sodium polystyrene sulfonate</i> (Sps Oral Suspension 15 Gm/60ML)	COVERED - sPDL	
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (<i>patiromer sorbitex calcium</i>)	COVERED - sPDL	QL (1 EA per 1 day)
*PURINE ANALOGS***		
<i>azathioprine oral tablet 50 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
MOUTH/THROAT/DENTAL AGENTS		
*ANESTHETICS TOPICAL ORAL***		
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	COVERED - sPDL	
*ANTI-INFECTIVES - THROAT***		
<i>clotrimazole mouth/throat troche 10 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	COVERED - sPDL	QL (120 ML per 1 day)
*ANTISEPTICS - MOUTH/THROAT***		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	COVERED - sPDL	
*FLUORIDE DENTAL PRODUCTS***		
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	COVERED - sPDL	
<i>sodium fluoride dental gel 1.1 %</i>	COVERED - sPDL	
*SALIVA STIMULANTS***		
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	COVERED - sPDL	
*STEROIDS - MOUTH/THROAT/DENTAL***		
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	COVERED - sPDL	
MULTIVITAMINS		
*B-COMPLEX W/ C & FOLIC ACID***		
<i>b complex-c-folic acid oral tablet</i>	COVERED - sPDL	
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	COVERED - sPDL	
DIALYVITE ORAL TABLET (<i>b complex-c-folic acid</i>)	COVERED - sPDL	
<i>folbee plus oral tablet</i>	COVERED - sPDL	
<i>triphrocaps oral capsule 1 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*MULTIPLE VITAMINS W/ IRON***		
<i>multi-vitamin/iron oral tablet</i>	COVERED - sPDL	QL (1 EA per 1 day)
*MULTIPLE VITAMINS W/ MINERALS***		
COMPETE ORAL TABLET (<i>multiple vitamins-minerals</i>)	COVERED - sPDL	QL (1 EA per 1 day)
ICAPS MV ORAL TABLET (<i>multiple vitamins-minerals</i>)	COVERED - sPDL	QL (1 EA per 1 day)
ICAPS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	COVERED - sPDL	
<i>multivitamin & mineral oral liquid</i>	COVERED - sPDL	QL (1 ML per 1 day)
*MULTIVITAMINS***		
<i>daily-vite oral tablet</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>mv-one oral capsule</i>	COVERED - sPDL	
*PED MULTI VITAMINS W/FL & FE***		
<i>multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml</i>	COVERED - sPDL	QL (1.67 ML per 1 day)
*PED MULTIPLE VITAMINS W/ MINERALS***		
<i>childrens gummies oral tablet chewable</i>	COVERED - sPDL	
<i>pediatric multivit-minerals</i> (Vitamax Pediatric Oral Solution)	COVERED - sPDL	
*PED MV W/ FLUORIDE***		
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	COVERED - sPDL	QL (1.67 ML per 1 day)
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>multivitamin/fluoride oral tablet chewable 1 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
*PED MV W/ IRON***		
LAND BEFORE TIME MULTIVITAMIN ORAL TABLET CHEWABLE 15 MG (<i>pediatric multivitamins-iron</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>multivitamins plus iron child oral tablet chewable 18 mg</i>	COVERED - sPDL	
POLY-VI-SOL/IRON ORAL SOLUTION 11 MG/ML (<i>pediatric multivitamins-iron</i>)	COVERED - sPDL	QL (50 ML per 25 days)
<i>poly-vita/iron oral solution 10 mg/ml</i>	COVERED - sPDL	
*PED VITAMINS ACD W/ FLUORIDE***		
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	COVERED - sPDL	QL (1.67 ML per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*PEDIATRIC MULTIPLE VITAMINS W/ C & FA***		
<i>multiple vitamins oral tablet chewable</i>	COVERED - sPDL	QL (1 EA per 1 day)
*PEDIATRIC MULTIPLE VITAMINS W/ EXTRA C & FA***		
<i>childrens multi vits/extra c oral tablet chewable</i>	COVERED - sPDL	
*PEDIATRIC MULTIPLE VITAMINS***		
<i>childrens chewable vitamins oral tablet chewable</i>	COVERED - sPDL	QL (1 EA per 1 day)
POLY-VI-SOL ORAL SOLUTION (<i>pediatric multiple vitamins</i>)	COVERED - sPDL	QL (50 EA per 25 days)
*PEDIATRIC VITAMINS A & D W/ C***		
TRI-VI-SOL A/C/D ORAL SOLUTION 250-50-10 (<i>pediatric vitamins adc</i>)	COVERED - sPDL	QL (50 ML per 25 days)
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	COVERED - sPDL	
*PRENATAL MV & MIN W/FE-FA***		
CLINICAL NUTRIENTS PRENATAL ORAL TABLET 7.5-0.2 MG (<i>prenatal vit-fe succinate-fa</i>)	COVERED - sPDL	
HEALTHY MAMA BE WELL ROUNDED ORAL THERAPY PACK 28-0.8 & 450 MG (<i>prenatal-fe bisgly-fa-omega 3</i>)	COVERED - sPDL	
<i>kpn prenatal oral tablet 0.1 mg</i>	COVERED - sPDL	
<i>mynate 90 plus oral tablet extended release</i>	COVERED - sPDL	
NATALVIT ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	COVERED - sPDL	QL (1 EA per 1 day)
O-CAL PRENATAL ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	COVERED - sPDL	
ONE-A-DAY WOMENS PRENATAL ORAL 28-0.8 & 223 MG (<i>prenatal vit-fe fum-fa-omega</i>)	COVERED - sPDL	
PERRY PRENATAL ORAL CAPSULE 13.5-0.4 MG (<i>prenatal vit-fe fumarate-fa</i>)	COVERED - sPDL	
<i>prenatal (w/iron & fa) oral tablet 27-0.8 mg</i>	COVERED - sPDL	
<i>prenatal complete oral tablet 14-0.4 mg</i>	COVERED - sPDL	
<i>prenatal formula a-free oral tablet 9-0.267 mg</i>	COVERED - sPDL	
<i>prenatal formula oral capsule 28-0.8-235 mg</i>	COVERED - sPDL	
<i>prenatal multi +dha oral capsule 27-0.8-228 mg</i>	COVERED - sPDL	
<i>prenatal oral tablet 27-0.8 mg, 28-0.8 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>prenatal oral tablet 6.75-0.2 mg</i>	COVERED - sPDL	
<i>prenatal/omega-3/fa/iron oral capsule 28-0.8-530 mg</i>	COVERED - sPDL	
<i>se-natal 19 oral tablet 29-1 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>se-natal 19 oral tablet chewable 29-1 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>sm one daily prenatal oral 28-0.8 & 440 mg</i>	COVERED - sPDL	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	COVERED - sPDL	QL (1 EA per 1 day)
<i>trinatal rx 1 oral tablet 60-1 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
VINATE II ORAL TABLET 29-1 MG (<i>prenatal vit w/ fe bisg-fa</i>)	COVERED - sPDL	QL (1 EA per 1 day)
VITAFOL-OB ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	COVERED - sPDL	QL (1 EA per 1 day)
*PRENATAL MV & MIN W/FE-FA-DHA***		
BRAINSTRONG PRENATAL ORAL 33-0.8 & 350 MG (<i>prenatal mv-min-fe cbn-fa-dha</i>)	COVERED - sPDL	
CENTRUM SPECIALIST PRENATAL ORAL 27-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	COVERED - sPDL	
ENFAMIL EXPECTA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	COVERED - sPDL	
<i>prenatal multi +dha oral capsule 27-0.8-250 mg</i>	COVERED - sPDL	
<i>prenatal+dha oral 28-0.975 & 200 mg</i>	COVERED - sPDL	
*PRENATAL MV & MINERALS W/ FA-OMEGA FATTY ACIDS W/O IRON***		
<i>cvs prenatal gummy oral tablet chewable 0.4-113.5 mg</i>	COVERED - sPDL	
*PRENATAL MV & MINERALS W/FA WITHOUT IRON***		
<i>prenatal + complete multi oral therapy pack 0.267 & 373 mg</i>	COVERED - sPDL	
*PRENATAL VITAMINS***		
<i>calna oral tablet</i>	COVERED - sPDL	
MUSCULOSKELETAL THERAPY AGENTS		
*CENTRAL MUSCLE RELAXANTS***		
<i>baclofen oral tablet 10 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>baclofen oral tablet 20 mg, 5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>chlorzoxazone oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>methocarbamol oral tablet 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>methocarbamol oral tablet 750 mg</i>	COVERED - sPDL	QL (10 EA per 1 day); AGE (Max 64 Years)
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>tizanidine hcl oral tablet 2 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 64 Years)
<i>tizanidine hcl oral tablet 4 mg</i>	COVERED - sPDL	QL (9 EA per 1 day); AGE (Max 64 Years)
NASAL AGENTS - SYSTEMIC AND TOPICAL		
*NASAL AGENTS - MISC.***		
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % (<i>saline</i>)	COVERED - sPDL	
*NASAL ANTICHOLINERGICS***		
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	COVERED - sPDL	
*NASAL ANTIHISTAMINES***		
<i>azelastine hcl nasal solution 0.1 %</i>	COVERED - sPDL	QL (30 ML per 25 days)
*NASAL MAST CELL STABILIZERS***		
<i>cromolyn sodium nasal aerosol solution 5.2 mg/act</i>	COVERED - sPDL	QL (52 ML per 25 days)
*NASAL STEROIDS***		
<i>budesonide nasal suspension 32 mcg/act</i>	COVERED - sPDL	QL (8.43 ML per 25 days); AGE (Min 6 Years)
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	COVERED - sPDL	QL (16 GM per 25 days); AGE (Min 4 Years)
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	COVERED - sPDL	AGE (Min 2 Years)
*SYSTEMIC DECONGESTANTS***		
<i>childrens nasal decongestant oral liquid† 15 mg/5ml</i>	COVERED - sPDL	
<i>nasal decongestant oral tablet 30 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>nasal decongestant pe max st oral tablet 10 mg</i>	COVERED - sPDL	
<i>pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>pseudoephedrine hcl oral tablet 60 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
SUDAFED PE CHILDRENS ORAL SOLUTION 2.5 MG/5ML (phenylephrine hcl)	COVERED - sPDL	
*TOPICAL DECONGESTANTS***		
epinephrine hcl (nasal) nasal solution 0.1 %	COVERED - sPDL	
nasal spray extra moisturizing nasal solution 0.05 %	COVERED - sPDL	
OPHTHALMIC AGENTS		
*ARTIFICIAL TEAR AND LUBRICANT COMBINATIONS***		
artificial tears ophthalmic solution 0.5-0.6 %, 1-0.3 %	COVERED - sPDL	
artificial tears pf ophthalmic solution 0.1-0.3 %	COVERED - sPDL	
cvs lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %	COVERED - sPDL	
dry eye relief drops ophthalmic solution 0.2-0.2-1 %	COVERED - sPDL	
lubricating eye drops ophthalmic solution 0.4-0.3 %	COVERED - sPDL	
lubricating tears eye drops ophthalmic solution 0.1-0.3 %	COVERED - sPDL	
REFRESH LACRI-LUBE OPHTHALMIC OINTMENT (white petrolatum-mineral oil)	COVERED - sPDL	
*ARTIFICIAL TEAR SOLUTIONS***		
SYSTANE CONTACTS OPHTHALMIC SOLUTION (artificial tear solution)	COVERED - sPDL	
*ARTIFICIAL TEARS AND LUBRICANTS***		
lubricant eye drops ophthalmic solution 0.5 %	COVERED - sPDL	
lubricating plus eye drops ophthalmic solution 0.5 %	COVERED - sPDL	
polyvinyl alcohol ophthalmic solution 1.4 %	COVERED - sPDL	
*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS***		
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	COVERED - sPDL	QL (10 ML per 25 days)
*BETA-BLOCKERS - OPHTHALMIC***		
carteolol hcl ophthalmic solution 1 %	COVERED - sPDL	QL (15 ML per 25 days)
levobunolol hcl ophthalmic solution 0.5 %	COVERED - sPDL	QL (15 ML per 25 days)
timolol maleate ophthalmic solution 0.25 %, 0.5 %	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
*CYCLOPLEGIC MYDRIATICS***		
<i>atropine sulfate ophthalmic solution 1 %</i>	COVERED - sPDL	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	COVERED - sPDL	QL (15 ML per 25 days)
*MIOTICS - DIRECT ACTING***		
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	COVERED - sPDL	
*OPHTHALMIC ANTIALLERGIC***		
<i>azelastine hcl ophthalmic solution 0.05 %</i>	COVERED - sPDL	PA; QL (6 ML per 25 days)
<i>cromolyn sodium ophthalmic solution 4 %</i>	COVERED - sPDL	
<i>eye itch relief ophthalmic solution 0.025 %</i>	COVERED - sPDL	QL (10 ML per 25 days)
<i>olopatadine hcl ophthalmic solution 0.1 %</i>	COVERED - sPDL	QL (5 ML per 30 days)
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	COVERED - sPDL	QL (2.5 ML per 30 days)
PATADAY OPHTHALMIC SOLUTION 0.1 % (<i>olopatadine hcl</i>)	COVERED - sPDL	QL (5 ML per 30 days)
PATADAY OPHTHALMIC SOLUTION 0.2 % (<i>olopatadine hcl</i>)	COVERED - sPDL	QL (2.5 ML per 30 days)
*OPHTHALMIC ANTIBIOTICS***		
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	COVERED - sPDL	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	COVERED - sPDL	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	COVERED - sPDL	
GENTAK OPHTHALMIC OINTMENT 0.3 % (<i>gentamicin sulfate</i>)	COVERED - sPDL	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	COVERED - sPDL	QL (10 ML per 30 days)
<i>levofloxacin ophthalmic solution 0.5 %</i>	COVERED - sPDL	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	COVERED - sPDL	QL (3 ML per 25 days)
<i>ofloxacin ophthalmic solution 0.3 %</i>	COVERED - sPDL	
<i>tobramycin ophthalmic solution 0.3 %</i>	COVERED - sPDL	
*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS***		
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-bacitracin zn-polymyx (Neo-Polycin Ophthalmic Ointment 3.5-400-10000)</i>	COVERED - sPDL	
<i>bacitracin-polymyxin b (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)</i>	COVERED - sPDL	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	COVERED - sPDL	
*OPHTHALMIC ANTIVIRALS***		
<i>trifluridine ophthalmic solution 1 %</i>	COVERED - sPDL	QL (7.5 ML per 25 days)
*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS***		
<i>dorzolamide hcl ophthalmic solution 2 %</i>	COVERED - sPDL	
*OPHTHALMIC HYPEROSMOLAR PRODUCTS***		
<i>sodium chloride (hypertonic) ophthalmic ointment 5 %</i>	COVERED - sPDL	
*OPHTHALMIC LOCAL ANESTHETICS***		
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	COVERED - sPDL	
*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS***		
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	COVERED - sPDL	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	COVERED - sPDL	
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	COVERED - sPDL	QL (10 ML per 25 days)
*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS***		
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	COVERED - sPDL	
*OPHTHALMIC STEROID COMBINATIONS***		
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	COVERED - sPDL	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	COVERED - sPDL	
<i>bacitracin-polymyx-neo-hc (Neo-Polycin Hc Ophthalmic Ointment 1 %)</i>	COVERED - sPDL	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	COVERED - sPDL	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	COVERED - sPDL	
*OPHTHALMIC STEROIDS***		
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
<i>fluorometholone ophthalmic suspension 0.1 %</i>	COVERED - sPDL	QL (15 ML per 25 days)
<i>prednisolone acetate ophthalmic suspension 1 %</i>	COVERED - sPDL	
*OPHTHALMIC SULFONAMIDES***		
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	COVERED - sPDL	
*PROSTAGLANDINS - OPTHALMIC***		
<i>bimatoprost ophthalmic solution 0.03 %</i>	COVERED - sPDL	ST; Please use Latanoprost
<i>latanoprost ophthalmic solution 0.005 %</i>	COVERED - sPDL	QL (5 ML per 25 days)
OTIC AGENTS		
*OTIC AGENTS - MISCELLANEOUS***		
<i>acetic acid otic solution 2 %</i>	COVERED - sPDL	QL (20 ML per 25 days)
<i>ear drops otic solution 6.5 %</i>	COVERED - sPDL	
<i>ra ear drying agent otic liquid 95-5 %</i>	COVERED - sPDL	
*OTIC ANTI-INFECTIVES***		
<i>ciprofloxacin hcl otic solution 0.2 %</i>	COVERED - sPDL	QL (14 EA per 25 days)
<i>ofloxacin otic solution 0.3 %</i>	COVERED - sPDL	QL (5 ML per 25 days)
*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS***		
<i>neomycin-polymyxin-hc otic solution 1 %</i>	COVERED - sPDL	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	COVERED - sPDL	
*OTIC STEROIDS***		
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	COVERED - sPDL	
OXYTOCICS		
*OXYTOCICS***		
<i>methylergonovine maleate oral tablet 0.2 mg</i>	COVERED - sPDL	QL (7 EA per 1 day)
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
*ANTIVIRAL MONOCLONAL ANTIBODIES***		
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (<i>palivizumab</i>)	COVERED - sPDL	PA
*IMMUNE SERUMS***		
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT (<i>rho d immune globulin</i>)	COVERED - sPDL	

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Drug Name	Drug Tier	Requirements/Limits
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (<i>rho d immune globulin</i>)	COVERED - sPDL	
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE 1500 UNIT/2ML (<i>rho d immune globulin</i>)	COVERED - sPDL	
PENICILLINS		
*AMINOPENICILLINS***		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	COVERED - sPDL	
<i>amoxicillin oral tablet 500 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)
<i>amoxicillin oral tablet 875 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>amoxicillin oral tablet chewable 125 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>amoxicillin oral tablet chewable 250 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>ampicillin oral capsule 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*NATURAL PENICILLINS***		
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	COVERED - sPDL	QL (40 ML per 1 day)
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
*PENICILLIN COMBINATIONS***		
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	COVERED - sPDL	AGE (Max 12 Years)
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day); AGE (Max 12 Years)
<i>amoxicillin-pot clavulanate oral tablet chewable 400-57 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 12 Years)
*PENICILLINASE-RESISTANT PENICILLINS***		
<i>dicloxacillin sodium oral capsule 250 mg</i>	COVERED - sPDL	QL (8 EA per 1 day)
<i>dicloxacillin sodium oral capsule 500 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
PHARMACEUTICAL ADJUVANTS		
*ANTIMICROBIAL AGENTS***		
<i>benzyl alcohol liquid</i>	COVERED - sPDL	AGE (Min 16 Years and Max 60 Years)

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Drug Name	Drug Tier	Requirements/Limits
PROGESTINS		
*PROGESTINS***		
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>norethindrone acetate oral tablet 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>progesterone oral capsule 100 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>progesterone oral capsule 200 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
*ALCOHOL DETERRENTS***		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	COVERED - sPDL	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
*ANTI-CATAPLECTIC AGENTS***		
<i>sodium oxybate oral solution 500 mg/ml</i>	COVERED - sPDL	PA
*CHOLINOMIMETICS - ACHE INHIBITORS***		
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>donepezil hcl oral tablet dispersible 10 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>donepezil hcl oral tablet dispersible 5 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	COVERED - sPDL	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	COVERED - sPDL	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	COVERED - sPDL	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	COVERED - sPDL	PA
*MOVEMENT DISORDER DRUG THERAPY***		
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	COVERED - sPDL	PA
*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS***		
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	COVERED - sPDL	PA
*MULTIPLE SCLEROSIS AGENTS - INTERFERONS***		
<i>AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (interferon beta-1a)</i>	COVERED - sPDL	PA

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Drug Name	Drug Tier	Requirements/Limits
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	COVERED - sPDL	PA
EXTAVIA SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	COVERED - sPDL	PA
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	COVERED - sPDL	PA
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	COVERED - sPDL	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	COVERED - sPDL	PA
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	COVERED - sPDL	PA
*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS***		
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	COVERED - sPDL	PA; QL (2 EA per 1 day)
*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS***		
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	COVERED - sPDL	PA
*MULTIPLE SCLEROSIS AGENTS***		
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i>	COVERED - sPDL	PA
*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS***		
<i>memantine hcl oral solution 2 mg/ml</i>	COVERED - sPDL	
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg</i>	COVERED - sPDL	
*SMOKING DETERRENTS***		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>goodsense nicotine mouth/throat gum 2 mg</i>	COVERED - sPDL	QL (24 EA per 1 day); AGE (Min 18 Years)
<i>nicotine mini mouth/throat lozenge 4 mg</i>	COVERED - sPDL	QL (20 EA per 1 day); AGE (Min 18 Years)
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	COVERED - sPDL	QL (24 EA per 1 day); AGE (Min 18 Years)
<i>nicotine polacrilex mouth/throat lozenge 2 mg</i>	COVERED - sPDL	QL (20 EA per 1 day); AGE (Min 18 Years)
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	COVERED - sPDL	QL (1 EA per 1 day); AGE (Min 18 Years)
NICOTROL INHALATION INHALER 10 MG (<i>nicotine</i>)	COVERED - sPDL	QL (168 EA per 26 days); AGE (Min 18 Years)

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Drug Name	Drug Tier	Requirements/Limits
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	COVERED - sPDL	QL (40 ML per 26 days); AGE (Min 18 Years)
<i>varenicline tartrate oral 0.5 mg x 11 & 1 mg x 42</i>	COVERED - sPDL	
<i>varenicline tartrate oral tablet 0.5 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>varenicline tartrate oral tablet 1 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>varenicline tartrate oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	COVERED - sPDL	
*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS***		
<i>fingolimod hcl oral capsule 0.5 mg</i>	COVERED - sPDL	PA
RESPIRATORY AGENTS - MISC.		
*ALPHA-PROTEINASE INHIBITOR (HUMAN)***		
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML (<i>alpha1-proteinase inhibitor</i>)	COVERED - sPDL	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG (<i>alpha1-proteinase inhibitor</i>)	COVERED - sPDL	PA
*CFTR POTENTIATORS***		
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (<i>ivacaftor</i>)	COVERED - sPDL	PA
KALYDECO ORAL TABLET 150 MG (<i>ivacaftor</i>)	COVERED - sPDL	PA
*CYSTIC FIBROSIS AGENT - COMBINATIONS***		
ORKAMBI ORAL PACKET 150-188 MG (<i>lumacaftor-ivacaftor</i>)	COVERED - sPDL	PA
ORKAMBI ORAL TABLET 100-125 MG (<i>lumacaftor-ivacaftor</i>)	COVERED - sPDL	PA; QL (4 EA per 1 day); AGE (Min 6 Years and Max 11 Years)
ORKAMBI ORAL TABLET 200-125 MG (<i>lumacaftor-ivacaftor</i>)	COVERED - sPDL	PA; QL (4 EA per 1 day); AGE (Min 11 Years)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	COVERED - sPDL	PA
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	COVERED - sPDL	PA
*HYDROLYTIC ENZYMES***		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	COVERED - sPDL	QL (5 ML per 1 day)
TETRACYCLINES		
*TETRACYCLINES***		
<i>doxycycline hyclate oral capsule 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline hyclate oral capsule 50 mg</i>	COVERED - sPDL	
<i>doxycycline hyclate oral tablet 100 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>doxycycline monohydrate oral tablet 100 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>minocycline hcl oral capsule 100 mg, 50 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
THYROID AGENTS		
*ANTITHYROID AGENTS***		
<i>methimazole oral tablet 10 mg, 5 mg</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>propylthiouracil oral tablet 50 mg</i>	COVERED - sPDL	QL (20 EA per 1 day)
*THYROID HORMONES***		
ARMOUR THYROID ORAL TABLET 120 MG, 180 MG, 240 MG, 300 MG (<i>thyroid</i>)	COVERED - sPDL	QL (1 EA per 1 day); AGE (Max 64 Years)
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	COVERED - sPDL	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG (<i>levothyroxine sodium</i>)	COVERED - sPDL	QL (2 EA per 1 day)
<i>thyroid oral tablet 15 mg, 30 mg, 60 mg, 90 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
TOXOIDS		
*TOXOID COMBINATIONS***		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 (<i>diphth-acell pertussis-tetanus</i>)	COVERED - sPDL	AGE (Max 6 Years); QL, (5 per Lifetime)
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10 (<i>diphth-acell pertussis-tetanus</i>)	COVERED - sPDL	AGE (Max 6 Years); QL, (5 per Lifetime)
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>dtap-ipv vaccine</i>)	COVERED - sPDL	AGE (Min 4 Years and Max 6 Years); QL, (1 per Lifetime)

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Drug Name	Drug Tier	Requirements/Limits
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	COVERED - sPDL	AGE (Max 6 Years); QL, (3 per Lifetime)
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	COVERED - sPDL	AGE (Max 4 Years); QL, (4 per Lifetime)
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	COVERED - sPDL	AGE (Min 4 Years and Max 6 Years); QL, (1 per Lifetime)
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>dtap-ipv vaccine</i>)	COVERED - sPDL	AGE (Min 4 Years and Max 6 Years); QL, (1 per Lifetime)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
<i>tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml</i>	COVERED - sPDL	AGE (Min 7 Years); QL, (1 per Lifetime)
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recmb</i>)	COVERED - sPDL	AGE (Max 4 Years); QL, (3 per Lifetime)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	COVERED - sPDL	AGE (Max 4 Years); QL, (3 per Lifetime)
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
*ANTISPASMODICS***		
<i>dicyclomine hcl oral capsule 10 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	COVERED - sPDL	QL (80 ML per 1 day); AGE (Max 64 Years)
<i>dicyclomine hcl oral tablet 20 mg</i>	COVERED - sPDL	QL (8 EA per 1 day); AGE (Max 64 Years)
*BELLADONNA ALKALOIDS***		
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	COVERED - sPDL	QL (4 EA per 1 day); AGE (Max 64 Years)
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day); AGE (Max 64 Years)
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	COVERED - sPDL	QL (60 ML per 1 day); AGE (Max 64 Years)
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Max 64 Years)
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Max 64 Years)
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	COVERED - sPDL	QL (12 EA per 1 day); AGE (Max 64 Years)
*H-2 ANTAGONISTS***		
<i>acid reducer maximum strength oral tablet 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>acid reducer oral tablet 10 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
<i>cimetidine 200 oral tablet 200 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
<i>cimetidine hcl oral solution 300 mg/5ml</i>	COVERED - sPDL	QL (60 ML per 1 day)
<i>cimetidine oral tablet 300 mg, 400 mg, 800 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>famotidine intravenous solution 40 mg/4ml</i>	COVERED - sPDL	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	COVERED - sPDL	QL (5 ML per 1 day); AGE (Max 6 Years)
<i>famotidine oral tablet 40 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>famotidine premixed intravenous solution 20-0.9 mg/50ml-%</i>	COVERED - sPDL	
<i>nizatidine oral capsule 150 mg</i>	COVERED - sPDL	ST; QL (4 EA per 1 day); T/F of Famotidine
<i>nizatidine oral solution 15 mg/ml</i>	COVERED - sPDL	ST; T/F of Famotidine
PEPCID PREMIXED INTRAVENOUS SOLUTION 20-0.9 MG/50ML-% (<i>famotidine in nacl</i>)	COVERED - sPDL	
*MISC. ANTI-ULCER***		
<i>sucralfate oral suspension 1 gm/10ml</i>	COVERED - sPDL	QL (40 ML per 1 day); AGE (Max 18 Years)
<i>sucralfate oral tablet 1 gm</i>	COVERED - sPDL	QL (4 EA per 1 day)
*PROTON PUMP INHIBITORS***		
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>lansoprazole oral capsule delayed release 15 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>omeprazole magnesium oral tablet delayed release 20 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>omeprazole oral capsule delayed release 40 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>omeprazole oral tablet delayed release 20 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>pantoprazole sodium oral tablet delayed release 20 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>pantoprazole sodium oral tablet delayed release 40 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)

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Drug Name	Drug Tier	Requirements/Limits
*QUATERNARY ANTICHOLINERGICS***		
<i>glycopyrrolate oral solution 1 mg/5ml</i>	COVERED - sPDL	PA
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	COVERED - sPDL	
*ULCER DRUGS - PROSTAGLANDINS***		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	COVERED - sPDL	QL (4 EA per 1 day)
URINARY ANTISPASMODICS		
*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)***		
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	COVERED - sPDL	ST; QL (1 EA per 1 day); Prior use of oxybutynin required
<i>oxybutynin chloride oral syrup 5 mg/5ml</i>	COVERED - sPDL	QL (20 ML per 1 day)
<i>oxybutynin chloride oral tablet 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); Prior use of oxybutynin required
<i>tropium chloride oral tablet 20 mg</i>	COVERED - sPDL	ST; QL (2 EA per 1 day); Prior use of oxybutynin required
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS***		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS***		
<i>flavoxate hcl oral tablet 100 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
VACCINES		
*BACTERIAL VACCINES***		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	COVERED - sPDL	QL, (4 per Lifetime)
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b recomb omv adj</i>)	COVERED - sPDL	QL, (3 per Lifetime)
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (<i>haemophilus b polysac conj vac</i>)	COVERED - sPDL	QL, (4 per Lifetime)
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (<i>mening acy&w-135 tetanus conj</i>)	COVERED - sPDL	AGE (Min 2 Years); QL, (2 per Lifetime)
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	COVERED - sPDL	QL, (4 per Lifetime)
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	COVERED - sPDL	QL, (4 per Lifetime)

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Drug Name	Drug Tier	Requirements/Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (<i>haemophilus b polysac conj vac</i>)	COVERED - sPDL	QL, (4 per Lifetime)
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	COVERED - sPDL	AGE (Min 10 Years); QL, (2 per Lifetime)
<i>penmenvy intramuscular suspension reconstituted</i>	COVERED - sPDL	AGE (Min 10 Years); QL, (2 per Lifetime)
PNEUMOVAX 23 INJECTION SOLUTION 25 MCG/0.5ML (<i>pneumococcal vac polyvalent</i>)	COVERED - sPDL	AGE (Min 2 Years); QL, (1 per Lifetime)
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>pneumococcal vac polyvalent</i>)	COVERED - sPDL	AGE (Min 2 Years); QL, (1 per Lifetime)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 20-val conj vacc</i>)	COVERED - sPDL	QL, (4 per Lifetime)
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b vac (recomb)</i>)	COVERED - sPDL	QL, (3 per Lifetime)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 15-val conj vacc</i>)	COVERED - sPDL	QL, (4 per Lifetime)
*VIRAL VACCINE COMBINATIONS***		
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	COVERED - sPDL	QL, (2 per Lifetime)
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	COVERED - sPDL	QL, (2 per Lifetime)
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	COVERED - sPDL	AGE (Min 2 Years and Max 12 Years); QL, (2 per Lifetime)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (<i>hepatitis a-hep b recomb vac</i>)	COVERED - sPDL	AGE (Min 18 Years); QL, (3 per Lifetime)
*VIRAL VACCINES***		
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	COVERED - sPDL	QL, (1 per 180 days)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	COVERED - sPDL	QL, (1 per 180 days)
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
COMIRNATY INTRAMUSCULAR SUSPENSION 30 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
ENGRIX-B INJECTION SUSPENSION 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	COVERED - sPDL	QL, (3 per Lifetime)
ENGRIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	COVERED - sPDL	QL, (3 per Lifetime)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	COVERED - sPDL	QL, (1 per 180 days)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>influenza vac recombinant ha</i>)	COVERED - sPDL	AGE (Min 9 Years); QL, (1 per 180 days)

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Drug Name	Drug Tier	Requirements/Limits
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>influenza vac tiss-cult subunt</i>)	COVERED - sPDL	QL, (1 per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac tiss-cult subunt</i>)	COVERED - sPDL	QL, (1 per 180 days)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	COVERED - sPDL	QL, (1 per 180 days)
FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	COVERED - sPDL	AGE (Min 12 Years); QL, (1 per 180 days)
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	COVERED - sPDL	QL, (1 per 180 days)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	COVERED - sPDL	QL, (1 per 180 days)
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	COVERED - sPDL	AGE (Min 9 Years); QL, (3 per Lifetime)
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	COVERED - sPDL	AGE (Min 9 Years); QL, (3 per Lifetime)
HAVRIX INTRAMUSCULAR SUSPENSION 720 EL U/0.5ML (<i>hepatitis a vaccine</i>)	COVERED - sPDL	QL, (2 per Lifetime)
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (<i>hepatitis a vaccine</i>)	COVERED - sPDL	QL, (2 per Lifetime)
IPOLE INJECTION SUSPENSION (<i>poliovirus vaccine inactivated</i>)	COVERED - sPDL	QL, (4 per Lifetime)
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
<i>moderna covid-19 vac (booster) intramuscular suspension 50 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
<i>moderna covid-19 vacc 6-11y intramuscular suspension 50 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>moderna covid-19 vacc 6m-5y intramuscular suspension 25 mcg/0.25ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>moderna covid-19 vaccine intramuscular suspension 100 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>novavax covid-19 vaccine intramuscular suspension 5 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>novavax covid-19 vaccine intramuscular suspension prefilled syringe 5 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>nuvaxovid covid-19 vaccine intramuscular suspension prefilled syringe 5 mcg/0.5ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>pfizer covid-19 vac-tris 5-11y intramuscular suspension 10 mcg/0.2ml</i>	COVERED - sPDL	QL, (1 per 180 days)

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Drug Name	Drug Tier	Requirements/Limits
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
<i>pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.2ml, 3 mcg/0.3ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>pfizer-biont covid-19 vac-tris intramuscular suspension 30 mcg/0.3ml</i>	COVERED - sPDL	QL, (1 per 180 days)
<i>pfizer-biontech covid-19 vacc intramuscular suspension 30 mcg/0.3ml</i>	COVERED - sPDL	QL, (1 per 180 days)
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	COVERED - sPDL	QL, (3 per Lifetime)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	COVERED - sPDL	QL, (3 per Lifetime)
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	COVERED - sPDL	QL, "2 per Lifetime"
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	COVERED - sPDL	QL, "3 per Lifetime"
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
SPIKEVAX COVID-19 VACCINE INTRAMUSCULAR SUSPENSION 100 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
SPIKEVAX INTRAMUSCULAR SUSPENSION 50 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	COVERED - sPDL	QL, (1 per 180 days)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	COVERED - sPDL	QL, (2 per Lifetime)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML, 50 UNIT/ML (<i>hepatitis a vaccine</i>)	COVERED - sPDL	QL, (2 per Lifetime)
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (<i>varicella virus vaccine live</i>)	COVERED - sPDL	QL, (2 per Lifetime)
VAGINAL AND RELATED PRODUCTS		
*IMIDAZOLE-RELATED ANTIFUNGALS***		
<i>clotrimazole 3 vaginal cream 2 %</i>	COVERED - sPDL	
<i>clotrimazole-7 vaginal cream 1 %</i>	COVERED - sPDL	
<i>miconazole 3 combo pack app vaginal kit 200 & 2 mg-% (9gm)</i>	COVERED - sPDL	
<i>miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)</i>	COVERED - sPDL	
<i>miconazole 7 vaginal cream 2 %</i>	COVERED - sPDL	
<i>miconazole 7 vaginal suppository 100 mg</i>	COVERED - sPDL	

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
<i>qc 3 day vaginal cream 4 %</i>	COVERED - sPDL	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	COVERED - sPDL	
<i>terconazole vaginal suppository 80 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>tioconazole-1 vaginal ointment 6.5 %</i>	COVERED - sPDL	
*VAGINAL ANTI-INFECTIVES***		
<i>clindamycin phosphate vaginal cream 2 %</i>	COVERED - sPDL	
<i>metronidazole vaginal gel 0.75 %</i>	COVERED - sPDL	QL (70 GM per 5 days)
*VAGINAL ESTROGENS***		
<i>estradiol vaginal cream 0.01 %, 0.1 mg/gm</i>	COVERED - sPDL	QL (1.42 GM per 1 day)
<i>estradiol vaginal tablet 10 mcg</i>	COVERED - sPDL	
VASOPRESSORS		
*ANAPHYLAXIS THERAPY AGENTS***		
<i>epinephrine injection solution 1 mg/ml</i>	COVERED - sPDL	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	COVERED - sPDL	QL (2 EA per 25 days)
SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	COVERED - sPDL	QL (2 EA per 25 days)
*VASOPRESSORS***		
<i>epinephrine injection solution 1 mg/ml</i>	COVERED - sPDL	
<i>epinephrine injection solution prefilled syringe 0.2 mg/0.2ml, 1 mg/ml</i>	COVERED - sPDL	
<i>epinephrine intravenous solution 1 mg/10ml</i>	COVERED - sPDL	
<i>epinephrine intravenous solution prefilled syringe 1 mg/10ml</i>	COVERED - sPDL	
<i>epinephrine pf injection solution 1 mg/ml</i>	COVERED - sPDL	
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	COVERED - sPDL	QL (3 EA per 1 day)
VITAMINS		
*VITAMIN B-1***		
<i>sm vitamin b1 oral tablet 100 mg</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>vitamin b-1 oral tablet 50 mg</i>	COVERED - sPDL	

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
*VITAMIN B-2***		
<i>vitamin b-2 oral tablet 100 mg</i>	COVERED - sPDL	
*VITAMIN B-3***		
<i>niacin er oral capsule extended release 250 mg, 500 mg</i>	COVERED - sPDL	
<i>niacin er oral tablet extended release 500 mg, 750 mg</i>	COVERED - sPDL	
<i>niacin oral tablet 100 mg, 250 mg, 50 mg, 500 mg</i>	COVERED - sPDL	
<i>niacinamide oral tablet 500 mg</i>	COVERED - sPDL	
<i>sm niacin cr oral tablet extended release 250 mg</i>	COVERED - sPDL	
*VITAMIN B-6***		
<i>b-6 oral tablet 100 mg</i>	COVERED - sPDL	
<i>vitamin b-6 er oral tablet extended release 200 mg</i>	COVERED - sPDL	
<i>vitamin b-6 oral tablet 25 mg</i>	COVERED - sPDL	QL (2 EA per 1 day)
<i>vitamin b-6 oral tablet 50 mg</i>	COVERED - sPDL	QL (4 EA per 1 day)
*VITAMIN C***		
<i>ascorbic acid oral tablet 500 mg</i>	COVERED - sPDL	
*VITAMIN D***		
<i>d 10000 oral capsule 250 mcg (10000 ut)</i>	COVERED - sPDL	
<i>d3 kids oral tablet chewable 10 mcg (400 unit)</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>d3 maximum strength oral liquid 125 mcg/ml</i>	COVERED - sPDL	
<i>vitamin d (cholecalciferol) oral capsule 50 mcg (2000 ut)</i>	COVERED - sPDL	QL (1 EA per 1 day); OTC
<i>vitamin d (cholecalciferol) oral tablet 10 mcg (400 unit), 25 mcg (1000 ut)</i>	COVERED - sPDL	QL (6 EA per 1 day); OTC
<i>vitamin d (ergocalciferol) oral capsule 50000 unit</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>vitamin d oral liquid 10 mcg/ml</i>	COVERED - sPDL	QL (6 ML per 1 day)
<i>vitamin d3 oral capsule 1.25 mg (50000 ut), 125 mcg (5000 ut)</i>	COVERED - sPDL	QL (1 EA per 1 day)
<i>vitamin d-3 oral capsule 25 mcg (1000 ut)</i>	COVERED - sPDL	QL (1 EA per 1 day)

AGE - Age Limit **MED** - Max 90 mg Morphine EQ Dose Per Day **PA** - Prior Authorization **QL** - Quantity Limits
ST - Step Therapy

Drug Name	Drug Tier	Requirements/Limits
<i>vitamin d3 oral tablet 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	COVERED - sPDL	QL (6 EA per 1 day)
<i>vitamin d-3 oral tablet 125 mcg (5000 ut)</i>	COVERED - sPDL	
<i>vitamin d3 oral tablet chewable 25 mcg (1000 ut)</i>	COVERED - sPDL	
*VITAMIN K***		
<i>phytonadione oral tablet 5 mg</i>	COVERED - sPDL	QL (5 EA per 1 day)

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