



**April 2024 - June 2024**

**Molina Healthcare of Illinois Medicaid**

**Preferred Drug List  
(Formulary)**

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Email: [Civil.Rights@MolinaHealthcare.com](mailto:Civil.Rights@MolinaHealthcare.com)

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200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
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Molina Healthcare of Illinois, Inc.

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# Molina Healthcare of Illinois Preferred Drug List (Formulary)

(04/01/2024)

## INTRODUCTION

We are pleased to provide the 2024 *Molina Healthcare of Illinois 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.

This Formulary is up to date through its date of publication, April 1, 2024. Please notify Molina Healthcare of Illinois at [mhilpharmacy@molinahealthcare.com](mailto:mhilpharmacy@molinahealthcare.com) or 1-855-866-5462 with any mistakes in the formulary.

Molina Healthcare of Illinois only covers drugs made by a manufacturer that participates in the Federal Medicaid drug rebate program. Drugs obtained through the Molina Healthcare of Illinois prescription drug benefit are covered at no cost to the member.

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.

## 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 the particular drug.
- If both 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 for the brand name product. 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.

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.

## CATEGORIES OF CONSIDERATION

### OPIOID ANALGESICS, BENZODIAZEPINES, MUSCLE RELAXANTS

- All Opioid Analgesics are subject to a Morphine Equivalent Dose of 90 mg per day, Acute Pain Duration Limits, and ER Opioid Step Therapy.
- Concurrent use of Opioid Analgesics, Benzodiazepines, and/or Muscle Relaxants may be subject to clinical review.

## NON-COVERED MEDICATIONS

Please note that certain medications are not covered. These include, but are not limited to:

- Appetite Suppressants / Anorexiant for weight loss
- Drugs for Cosmetic Purposes
- Drugs to treat infertility
- Drugs to treat erectile dysfunction
- Experimental or Investigational Medications
- Convenience Dosage Forms not listed on the Formulary
- 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 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 Molina at (855) 365-8112. The forms may be obtained by logging into the website [www.molinahealthcare.com](http://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 MHIL Pharmacy Department, please provide clinical documentation with the Prior Authorization request. The following are examples:

### Class of Medication/Diagnosis

Cholesterol Lowering

Diabetes

Non-Formulary/Non-Preferred Medication

### Requested Clinical Information

Lipid Panel, Cardiovascular risk factors

A1c Report

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

## LEGEND

<b>AGE</b>	Age Limit
<b>OTC</b>	Over-the-counter, covered benefit with a prescription
<b>PA</b>	Prior Authorization
<b>PA, QL</b>	Quantity Limit is applied after Prior Authorization approval
<b>QL</b>	Quantity Limit
<b>SP</b>	Specialty Drug; these drugs must be obtained through a specialty pharmacy
<b>ST</b>	Step Therapy
<b>Preferred</b>	Preferred product, may require Prior Authorization
<b>Non-preferred</b>	Non-Preferred product, requires Prior Authorization and documentation of medical necessity

## URGENT AND AFTER-HOURS MEDICATION POLICY

To prevent a member's condition from worsening in an urgent situation, it may be necessary to dispense a 72-hour supply of an acute medication before prior authorization may be obtained from Molina Healthcare. (e.g., a member is discharged from a hospital after regular business hours with a special antibiotic prescription). Pharmacies are instructed to use their professional judgment. Molina Healthcare will reimburse pharmacies for a 72-hour supply of an acute medication at contracted rates for these prescriptions. Pharmacies may contact CVS Caremark Help Desk at (800) 364-6331 to obtain an override for a 72-hour supply.

Pharmacies may call Molina Healthcare at (855) 866-5462 on the following business day to obtain authorization to allow the urgent or after-hours prescription to process on-line. It is advised and expected that the pharmacy will provide reasonable documentation of cases where medications were dispensed under these urgent circumstances.

## NOTICE

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

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Drug Name	Formulary Status	Requirements/Limits
<b>*ACE INHIBITORS*** - DRUGS FOR THE HEART</b>		
<b>*ANTIHYPERTENSIVES* - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>enalapril maleate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<b>*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>clonidine hcl er tablet extended release 12 hour 0.1 mg oral</i>	Preferred	AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 2 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 3 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 4 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 1 MG ORAL ( <i>guanfacine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 2 MG ORAL ( <i>guanfacine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL ( <i>guanfacine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL ( <i>guanfacine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<b>*ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
STRATTERA CAPSULE 10 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
STRATTERA CAPSULE 100 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
STRATTERA CAPSULE 18 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
STRATTERA CAPSULE 25 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
STRATTERA CAPSULE 40 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
STRATTERA CAPSULE 60 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
STRATTERA CAPSULE 80 MG ORAL ( <i>atomoxetine hcl</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>atomoxetine hcl capsule 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 100 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 18 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
<i>atomoxetine hcl capsule 80 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years); Max 90-day supply per fill
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>viloxazine hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>viloxazine hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>viloxazine hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<b>*AMPHETAMINE MIXTURES*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 12.5 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphetamine-dextroamphetamine tablet 7.5 mg oral</i>	Preferred	QL (5 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>amphet-dextroamphetamine 3-bead er capsule extended release 24 hour 12.5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 25 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 37.5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 10 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 12.5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 15 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 20 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 30 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL TABLET 7.5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (5 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>amphetamine-dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<b>*AMPHETAMINES*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
DYANAVEL XR SUSPENSION EXTENDED RELEASE 2.5 MG/ML ORAL ( <i>amphetamine</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 10 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 20 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 30 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 40 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 50 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 60 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE CAPSULE 70 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 10 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 20 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 30 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 40 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 50 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
VYVANSE TABLET CHEWABLE 60 MG ORAL ( <i>lisdexamfetamine dimesylate</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
<i>amphetamine sulfate tablet 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>amphetamine sulfate tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate solution 5 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 10 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 15 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 2.5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate tablet 7.5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 40 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 50 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 60 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate capsule 70 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 40 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 50 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>lisdexamfetamine dimesylate tablet chewable 60 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>methamphetamine hcl tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 15.7 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 18.8 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 3.1 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 6.3 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 9.4 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DESOXYN TABLET 5 MG ORAL ( <i>methamphetamine hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>dextroamphetamine sulfate</i> )	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>dextroamphetamine sulfate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 10 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 15 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 20 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 5 MG ORAL ( <i>amphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO ODT TABLET DISPERSIBLE 10 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO ODT TABLET DISPERSIBLE 15 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO ODT TABLET DISPERSIBLE 20 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO ODT TABLET DISPERSIBLE 5 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO TABLET 10 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
EVEKEO TABLET 5 MG ORAL ( <i>amphetamine sulfate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Procentra Solution 5 Mg/5MI Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
XELSTRYM PATCH 13.5 MG/9HR TRANSDERMAL ( <i>dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
XELSTRYM PATCH 18 MG/9HR TRANSDERMAL ( <i>dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
XELSTRYM PATCH 4.5 MG/9HR TRANSDERMAL ( <i>dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
XELSTRYM PATCH 9 MG/9HR TRANSDERMAL ( <i>dextroamphetamine</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 10 Mg Oral)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 15 Mg Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 2.5 Mg Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 20 Mg Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 30 Mg Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 5 Mg Oral)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Tablet 7.5 Mg Oral)	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<b>*ANALEPTICS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>caffeine citrate oral solution 20 mg/ml</i>	Preferred	Max 120 ML Per Lifetime; AGE (Max 1 Years)
<i>caffeine citrate oral solution 60 mg/3ml</i>	Preferred	QL (120 ML per 1 Lifetime); AGE (Max 1 Years)
<b>*DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)*** - DRUGS FOR SLEEP DISORDER</b>		
SUNOSI TABLET 150 MG ORAL ( <i>solriamfetol hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
SUNOSI TABLET 75 MG ORAL ( <i>solriamfetol hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<b>*HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS*** - DRUGS FOR SLEEP DISORDER</b>		
WAKIX TABLET 17.8 MG ORAL ( <i>pitolisant hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)
WAKIX TABLET 4.45 MG ORAL ( <i>pitolisant hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)
<b>*STIMULANT COMBINATIONS*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
AZSTARYS CAPSULE 26.1-5.2 MG ORAL ( <i>serdexmethylphen-dexmethylphen</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
AZSTARYS CAPSULE 39.2-7.8 MG ORAL ( <i>serdexmethylphen-dexmethylphen</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
AZSTARYS CAPSULE 52.3-10.4 MG ORAL ( <i>serdexmethylphen-dexmethylphen</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<b>*STIMULANTS - MISC.*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>dexmethylphenidate hcl tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>modafinil tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 17 Years)
<i>modafinil tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 17 Years)
CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
DAYTRANA PATCH 10 MG/9HR TRANSDERMAL ( <i>methylphenidate</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DAYTRANA PATCH 15 MG/9HR TRANSDERMAL ( <i>methylphenidate</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
DAYTRANA PATCH 20 MG/9HR TRANSDERMAL ( <i>methylphenidate</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
DAYTRANA PATCH 30 MG/9HR TRANSDERMAL ( <i>methylphenidate</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 35 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Preferred	AGE (Min 6 Years and Max 18 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>methylphenidate hcl</i> )	Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>armodafinil tablet 150 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
<i>armodafinil tablet 200 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
<i>armodafinil tablet 250 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
<i>armodafinil tablet 50 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 25 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>dexmethylphenidate hcl er capsule extended release 24 hour 35 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 50 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (cd) capsule extended release 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 18 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 36 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 36 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl er (osm) tablet extended release 45 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 54 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 54 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 63 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (osm) tablet extended release 72 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 18 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 27 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 36 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 54 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl solution 10 mg/5ml oral</i>	Non Preferred	PA; QL (30 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl solution 5 mg/5ml oral</i>	Non Preferred	PA; QL (15 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl tablet chewable 10 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate hcl tablet chewable 2.5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl tablet chewable 5 mg oral</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate patch 10 mg/9hr transdermal</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate patch 15 mg/9hr transdermal</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate patch 20 mg/9hr transdermal</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
<i>methylphenidate patch 30 mg/9hr transdermal</i>	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG ORAL ( <i>methylphenidate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 25.9 MG ORAL ( <i>methylphenidate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 8.6 MG ORAL ( <i>methylphenidate</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
FOCALIN TABLET 10 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
FOCALIN TABLET 2.5 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
FOCALIN TABLET 5 MG ORAL ( <i>dexmethylphenidate hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
METHYLIN SOLUTION 10 MG/5ML ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; QL (30 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
METHYLIN SOLUTION 5 MG/5ML ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; QL (15 ML per 1 day); AGE (Min 6 Years and Max 18 Years)
NUVIGIL TABLET 150 MG ORAL ( <i>armodafinil</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
NUVIGIL TABLET 200 MG ORAL ( <i>armodafinil</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
NUVIGIL TABLET 250 MG ORAL ( <i>armodafinil</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
NUVIGIL TABLET 50 MG ORAL ( <i>armodafinil</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
PROVIGIL TABLET 100 MG ORAL ( <i>modafinil</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 17 Years)
PROVIGIL TABLET 200 MG ORAL ( <i>modafinil</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 20 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 30 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 40 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
QUILLIVANT XR SUSPENSION RECONSTITUTED ER 25 MG/5ML ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 18 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 27 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 36 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 54 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; AGE (Min 6 Years and Max 18 Years)
RITALIN TABLET 10 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
RITALIN TABLET 20 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
RITALIN TABLET 5 MG ORAL ( <i>methylphenidate hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 6 Years and Max 18 Years)
<b>*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*GENITOURINARY AGENTS - MISCELLANEOUS* - DRUGS FOR THE PROSTATE</b>		
<i>tamsulosin hcl capsule 0.4 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<b>*ALTERNATIVE MEDICINES* - VITAMINS AND MINERALS</b>		
<b>*ALTERNATIVE MEDICINE - ME'S*** - VITAMINS AND MINERALS</b>		
<i>melatonin oral tablet 3 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm melatonin oral tablet 3 mg</i>	Preferred	QL (1 EA per 1 day)
<b>*AMEBICIDES* - DRUGS FOR INFECTIONS</b>		
<b>*AMEBICIDES*** - DRUGS FOR PARASITES</b>		
SOLOSEC PACKET 2 GM ORAL ( <i>secnidazole</i> )	Non Preferred	PA
<b>*AMINOGLYCOSIDES* - DRUGS FOR INFECTIONS</b>		
<b>*AMINOGLYCOSIDES*** - ANTIBIOTICS</b>		
<i>neomycin sulfate tablet 500 mg oral</i>	Preferred	
<i>paromomycin sulfate capsule 250 mg oral</i>	Preferred	
KITABIS PAK NEBULIZATION SOLUTION 300 MG/5ML INHALATION ( <i>tobramycin</i> )	Preferred	
<i>tobramycin nebulization solution 300 mg/4ml inhalation</i>	Non Preferred	PA
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non Preferred	PA
ARIKAYCE SUSPENSION 590 MG/8.4ML INHALATION ( <i>amikacin sulfate liposome</i> )	Non Preferred	PA
BETHKIS NEBULIZATION SOLUTION 300 MG/4ML INHALATION ( <i>tobramycin</i> )	Non Preferred	PA
TOBI NEBULIZATION SOLUTION 300 MG/5ML INHALATION ( <i>tobramycin</i> )	Non Preferred	PA
TOBI PODHALER CAPSULE 28 MG INHALATION ( <i>tobramycin</i> )	Non Preferred	PA
<b>*ANALGESICS - ANTI-INFLAMMATORY* - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
XELJANZ SOLUTION 1 MG/ML ORAL ( <i>tofacitinib citrate</i> )	Preferred	PA
XELJANZ TABLET 10 MG ORAL ( <i>tofacitinib citrate</i> )	Preferred	PA
XELJANZ TABLET 5 MG ORAL ( <i>tofacitinib citrate</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
XELJANZ XR TABLET EXTENDED RELEASE 24 HOUR 11 MG ORAL ( <i>tofacitinib citrate</i> )	Preferred	PA
XELJANZ XR TABLET EXTENDED RELEASE 24 HOUR 22 MG ORAL ( <i>tofacitinib citrate</i> )	Preferred	PA
OLUMIANT TABLET 1 MG ORAL ( <i>baricitinib</i> )	Non Preferred	PA
OLUMIANT TABLET 2 MG ORAL ( <i>baricitinib</i> )	Non Preferred	PA
OLUMIANT TABLET 4 MG ORAL ( <i>baricitinib</i> )	Non Preferred	PA
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>upadacitinib</i> )	Non Preferred	PA
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>upadacitinib</i> )	Non Preferred	PA
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 45 MG ORAL ( <i>upadacitinib</i> )	Non Preferred	PA
XELJANZ SOLUTION 1 MG/ML ORAL ( <i>tofacitinib citrate</i> )	Non Preferred	PA
<b>*ANTIRHEUMATIC ANTIMETABOLITES*** - ARTHRITIS AND PAIN DRUGS</b>		
OTREXUP SOLUTION AUTO-INJECTOR 10 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 12.5 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 15 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 17.5 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 22.5 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 25 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 10 MG/0.2ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 15 MG/0.3ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RASUVO SOLUTION AUTO-INJECTOR 25 MG/0.5ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 30 MG/0.6ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML SUBCUTANEOUS ( <i>methotrexate (anti-rheumatic)</i> )	Non Preferred	PA
<b>*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS</b>		
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA (2 PEN) PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA (2 PEN) PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA-CD/UC/HS STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA-PED<40KG CROHNS STARTER PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA-PED>/=40KG CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA; QL (0.072 EA per 1 day)
HUMIRA-PED>/=40KG UC STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA-PS/UV/ADOL HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
HUMIRA-PSORIASIS/UVEIT STARTER PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS ( <i>adalimumab</i> )	Preferred	PA
<i>adalimumab-aacf (2 pen) auto-injector kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adaz solution auto-injector 40 mg/0.4ml subcutaneous</i>	Non Preferred	PA; Max 150-day supply per fill
<i>adalimumab-adaz solution prefilled syringe 40 mg/0.4ml subcutaneous</i>	Non Preferred	PA; Max 150-day supply per fill
<i>adalimumab-fkjp auto-injector kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>adalimumab-fkjp prefilled syringe kit 20 mg/0.4ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-fkjp prefilled syringe kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
ABRILADA (1 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-afzb</i> )	Non Preferred	PA
ABRILADA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-afzb</i> )	Non Preferred	PA
ABRILADA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-afzb</i> )	Non Preferred	PA
ABRILADA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-afzb</i> )	Non Preferred	PA
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA-PED 10KG TO <15KG SOLUTION PREFILLED SYRINGE 10 MG/0.2ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
AMJEVITA-PED 15KG TO <30KG SOLUTION PREFILLED SYRINGE 20 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-atto</i> )	Non Preferred	PA
CYLTEZO (2 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.2ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
CYLTEZO-CD/UC/HS STARTER AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
CYLTEZO-PSORIASIS/UV STARTER AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adbm</i> )	Non Preferred	PA
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-bwwd</i> )	Non Preferred	PA; Max 150-day supply per fill
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-bwwd</i> )	Non Preferred	PA; Max 150-day supply per fill
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-bwwd</i> )	Non Preferred	PA; Max 150-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-bwwd</i> )	Non Preferred	PA; Max 150-day supply per fill
HULIO (2 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-fkjp</i> )	Non Preferred	PA
HULIO (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-fkjp</i> )	Non Preferred	PA
HULIO (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-fkjp</i> )	Non Preferred	PA
HYRIMOZ SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ-CROHNS/UC STARTER SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ-PED<40KG CROHN STARTER SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ-PED>/=40KG CROHN START SOLUTION PREFILLED SYRINGE 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
HYRIMOZ-PLAQUE PSORIASIS START SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-adaz</i> )	Non Preferred	PA; Max 150-day supply per fill
IDACIO (2 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aacf</i> )	Non Preferred	PA
IDACIO (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aacf</i> )	Non Preferred	PA
IDACIO-CROHNS/UC STARTER AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aacf</i> )	Non Preferred	PA
IDACIO-PSORIASIS STARTER AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aacf</i> )	Non Preferred	PA
SIMPONI ARIA SOLUTION 50 MG/4ML INTRAVENOUS ( <i>golimumab</i> )	Non Preferred	PA
SIMPONI SOLUTION AUTO-INJECTOR 100 MG/ML SUBCUTANEOUS ( <i>golimumab</i> )	Non Preferred	PA
SIMPONI SOLUTION AUTO-INJECTOR 50 MG/0.5ML SUBCUTANEOUS ( <i>golimumab</i> )	Non Preferred	PA
SIMPONI SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS ( <i>golimumab</i> )	Non Preferred	PA
SIMPONI SOLUTION PREFILLED SYRINGE 50 MG/0.5ML SUBCUTANEOUS ( <i>golimumab</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
YUFLYMA (1 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-aaty</i> )	Non Preferred	PA
YUFLYMA (1 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aaty</i> )	Non Preferred	PA
YUFLYMA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-aaty</i> )	Non Preferred	PA
YUFLYMA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS ( <i>adalimumab-aaty</i> )	Non Preferred	PA
YUFLYMA-CD/UC/HS STARTER AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aaty</i> )	Non Preferred	PA
YUSIMRY SOLUTION PEN-INJECTOR 40 MG/0.8ML SUBCUTANEOUS ( <i>adalimumab-aqvh</i> )	Non Preferred	PA; Max 150-day supply per fill
<b>*CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>celecoxib capsule 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>celecoxib capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>celecoxib capsule 400 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>celecoxib capsule 50 mg oral</i>	Preferred	Max 90-day supply per fill
CELEBREX CAPSULE 100 MG ORAL ( <i>celecoxib</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CELEBREX CAPSULE 200 MG ORAL ( <i>celecoxib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CELEBREX CAPSULE 400 MG ORAL ( <i>celecoxib</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CELEBREX CAPSULE 50 MG ORAL ( <i>celecoxib</i> )	Non Preferred	PA
<b>*GOLD COMPOUNDS*** - ARTHRITIS AND PAIN DRUGS</b>		
RIDAURA CAPSULE 3 MG ORAL ( <i>auranofin</i> )	Non Preferred	PA
<b>*INTERLEUKIN-1 BLOCKERS*** - ARTHRITIS AND PAIN DRUGS</b>		
ARCALYST SOLUTION RECONSTITUTED 220 MG SUBCUTANEOUS ( <i>rilonacept</i> )	Non Preferred	PA
<b>*INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)*** - ARTHRITIS AND PAIN DRUGS</b>		
KINERET SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS ( <i>anakinra</i> )	Non Preferred	PA
<b>*INTERLEUKIN-1BETA BLOCKERS*** - ARTHRITIS AND PAIN DRUGS</b>		
ILARIS SOLUTION 150 MG/ML SUBCUTANEOUS ( <i>canakinumab</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*INTERLEUKIN-6 RECEPTOR INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
ACTEMRA ACTPEN SOLUTION AUTO-INJECTOR 162 MG/0.9ML SUBCUTANEOUS ( <i>tocilizumab</i> )	Non Preferred	PA
ACTEMRA SOLUTION 200 MG/10ML INTRAVENOUS ( <i>tocilizumab</i> )	Non Preferred	PA
ACTEMRA SOLUTION 400 MG/20ML INTRAVENOUS ( <i>tocilizumab</i> )	Non Preferred	PA
ACTEMRA SOLUTION 80 MG/4ML INTRAVENOUS ( <i>tocilizumab</i> )	Non Preferred	PA
ACTEMRA SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS ( <i>tocilizumab</i> )	Non Preferred	PA
KEVZARA SOLUTION AUTO-INJECTOR 150 MG/1.14ML SUBCUTANEOUS ( <i>sarilumab</i> )	Non Preferred	PA
KEVZARA SOLUTION AUTO-INJECTOR 200 MG/1.14ML SUBCUTANEOUS ( <i>sarilumab</i> )	Non Preferred	PA
KEVZARA SOLUTION PREFILLED SYRINGE 150 MG/1.14ML SUBCUTANEOUS ( <i>sarilumab</i> )	Non Preferred	PA
KEVZARA SOLUTION PREFILLED SYRINGE 200 MG/1.14ML SUBCUTANEOUS ( <i>sarilumab</i> )	Non Preferred	PA
<b>*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>diclofenac-misoprostol tablet delayed release 50-0.2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>diclofenac-misoprostol tablet delayed release 75-0.2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ibuprofen-famotidine tablet 800-26.6 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>naproxen-esomeprazole mg tablet delayed release 375-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>naproxen-esomeprazole mg tablet delayed release 500-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ARTHROTEC TABLET DELAYED RELEASE 50-0.2 MG ORAL ( <i>diclofenac-misoprostol</i> )	Non Preferred	PA
ARTHROTEC TABLET DELAYED RELEASE 75-0.2 MG ORAL ( <i>diclofenac-misoprostol</i> )	Non Preferred	PA
DUEXIS TABLET 800-26.6 MG ORAL ( <i>ibuprofen-famotidine</i> )	Non Preferred	PA
VIMOVO TABLET DELAYED RELEASE 375-20 MG ORAL ( <i>naproxen-esomeprazole</i> )	Non Preferred	PA
VIMOVO TABLET DELAYED RELEASE 500-20 MG ORAL ( <i>naproxen-esomeprazole</i> )	Non Preferred	PA
<b>*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>all day pain relief oral tablet 220 mg</i>	Preferred	
<i>all day relief oral tablet 220 mg</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>diclofenac potassium tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>diclofenac sodium er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diclofenac sodium tablet delayed release 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>diclofenac sodium tablet delayed release 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>diclofenac sodium tablet delayed release 75 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>ec-naproxen tablet delayed release 375 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>ec-naproxen tablet delayed release 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>etodolac capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac capsule 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac er tablet extended release 24 hour 400 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac er tablet extended release 24 hour 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac er tablet extended release 24 hour 600 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac tablet 400 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>etodolac tablet 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>flurbiprofen tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ft all day pain relief oral tablet 220 mg</i>	Preferred	
<i>ft ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>ft ibuprofen ib childrens oral tablet chewable 100 mg</i>	Preferred	
<i>ft ibuprofen minis oral capsule 200 mg</i>	Preferred	
<i>ft ibuprofen oral capsule 200 mg</i>	Preferred	
<i>ft ibuprofen oral tablet 200 mg</i>	Preferred	
<i>gnp childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>gnp ibuprofen childrens oral tablet chewable 100 mg</i>	Preferred	
<i>gnp ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	
<i>gnp ibuprofen oral capsule 200 mg</i>	Preferred	
<i>gnp ibuprofen oral tablet 200 mg</i>	Preferred	
<i>gnp naproxen sodium oral tablet 220 mg</i>	Preferred	
<i>goodsense ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>goodsense ibuprofen childrens oral tablet chewable 100 mg</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>goodsense ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	
<i>goodsense ibuprofen junior st oral tablet chewable 100 mg</i>	Preferred	
<i>goodsense ibuprofen oral capsule 200 mg</i>	Preferred	
<i>goodsense ibuprofen oral tablet 200 mg</i>	Preferred	
<i>goodsense naproxen sodium oral tablet 220 mg</i>	Preferred	
<i>hm ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>hm ibuprofen oral capsule 200 mg</i>	Preferred	
<i>ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	
<i>ibuprofen junior strength oral tablet chewable 100 mg</i>	Preferred	
<i>ibuprofen oral capsule 200 mg</i>	Preferred	
<i>ibuprofen oral tablet 200 mg</i>	Preferred	
<i>ibuprofen tablet 400 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ibuprofen tablet 600 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ibuprofen tablet 800 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>indomethacin capsule 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>indomethacin capsule 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>indomethacin er capsule extended release 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>indomethacin suppository 50 mg rectal</i>	Preferred	
<i>indomethacin suspension 25 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>infants ibuprofen oral suspension 50 mg/1.25ml</i>	Preferred	
<i>ketoprofen capsule 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ketoprofen capsule 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ketorolac tromethamine tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 5-day supply per fill
<i>meloxicam tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>meloxicam tablet 7.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nabumetone tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>nabumetone tablet 750 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>naproxen dr tablet delayed release 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>naproxen sodium oral tablet 220 mg</i>	Preferred	

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<i>naproxen sodium tablet 275 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen sodium tablet 550 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen suspension 125 mg/5ml oral</i>	Preferred	QL (100 ML per 1 day); Max 90-day supply per fill
<i>naproxen tablet 250 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>naproxen tablet 375 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>naproxen tablet 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>naproxen tablet delayed release 375 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>naproxen tablet delayed release 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>sm childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	QL (160 ML per 1 day); Max 90-day supply per fill
<i>sm ibuprofen ib childrens oral tablet chewable 100 mg</i>	Preferred	
<i>sm ibuprofen ib oral tablet 200 mg</i>	Preferred	
<i>sm ibuprofen jr oral tablet 100 mg</i>	Preferred	
<i>sm ibuprofen oral capsule 200 mg</i>	Preferred	
<i>sm ibuprofen oral tablet 200 mg</i>	Preferred	
<i>sm infants ibuprofen oral suspension 50 mg/1.25ml</i>	Preferred	
<i>sm naproxen sodium oral tablet 220 mg</i>	Preferred	
<i>sulindac tablet 150 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>sulindac tablet 200 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 400 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 600 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 800 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>diclofenac potassium capsule 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>diclofenac potassium tablet 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fenoprofen calcium capsule 400 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fenoprofen calcium tablet 600 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ibuprofen suspension 100 mg/5ml oral (rx)</i>	Non Preferred	PA; QL (160 ML per 1 day); Max 90-day supply per fill
<i>ketoprofen er capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>ketorolac tromethamine solution 15.75 mg/spray nasal</i>	Non Preferred	PA
<i>meclofenamate sodium capsule 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>meclofenamate sodium capsule 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>mefenamic acid capsule 250 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>meloxicam capsule 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>meloxicam capsule 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>naproxen sodium er tablet extended release 24 hour 375 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>naproxen sodium er tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>naproxen sodium er tablet extended release 24 hour 750 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>oxaprozin tablet 600 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day); Max 90-day supply per fill
<i>piroxicam capsule 10 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 90-day supply per fill
<i>piroxicam capsule 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>tolmetin sodium capsule 400 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tolmetin sodium tablet 600 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
DAYPRO TABLET 600 MG ORAL ( <i>oxaprozin</i> )	Non Preferred	PA; QL (3 EA per 1 day)
FELDENE CAPSULE 10 MG ORAL ( <i>piroxicam</i> )	Non Preferred	PA; QL (4 EA per 1 day)
FELDENE CAPSULE 20 MG ORAL ( <i>piroxicam</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<i>diclofenac potassium</i> (Lofena Tablet 25 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
MOBIC TABLET 7.5 MG ORAL ( <i>meloxicam</i> )	Non Preferred	PA; QL (2 EA per 1 day)
NALFON CAPSULE 400 MG ORAL ( <i>fenoprofen calcium</i> )	Non Preferred	PA
NALFON TABLET 600 MG ORAL ( <i>fenoprofen calcium</i> )	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 375 MG ORAL ( <i>naproxen sodium</i> )	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL ( <i>naproxen sodium</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL ( <i>naproxen sodium</i> )	Non Preferred	PA
RELAFEN DS TABLET 1000 MG ORAL ( <i>nabumetone</i> )	Non Preferred	PA
<b>*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
OTEZLA TABLET 30 MG ORAL ( <i>apremilast</i> )	Non Preferred	PA
OTEZLA TABLET THERAPY PACK 10 & 20 & 30 MG ORAL ( <i>apremilast</i> )	Non Preferred	PA
<b>*PYRIMIDINE SYNTHESIS INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>leflunomide tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>leflunomide tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
ARAVA TABLET 10 MG ORAL ( <i>leflunomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ARAVA TABLET 20 MG ORAL ( <i>leflunomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*SELECTIVE COSTIMULATION MODULATORS*** - ARTHRITIS AND PAIN DRUGS</b>		
ORENCIA CLICKJECT SOLUTION AUTO-INJECTOR 125 MG/ML SUBCUTANEOUS ( <i>abatacept</i> )	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 125 MG/ML SUBCUTANEOUS ( <i>abatacept</i> )	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 50 MG/0.4ML SUBCUTANEOUS ( <i>abatacept</i> )	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML SUBCUTANEOUS ( <i>abatacept</i> )	Non Preferred	PA
ORENCIA SOLUTION RECONSTITUTED 250 MG INTRAVENOUS ( <i>abatacept</i> )	Non Preferred	PA
<b>*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS*** - ARTHRITIS AND PAIN DRUGS</b>		
ENBREL MINI SOLUTION CARTRIDGE 50 MG/ML SUBCUTANEOUS ( <i>etanercept</i> )	Preferred	PA
ENBREL SOLUTION 25 MG/0.5ML SUBCUTANEOUS ( <i>etanercept</i> )	Preferred	PA
ENBREL SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS ( <i>etanercept</i> )	Preferred	PA
ENBREL SOLUTION PREFILLED SYRINGE 50 MG/ML SUBCUTANEOUS ( <i>etanercept</i> )	Preferred	PA
ENBREL SURECLICK SOLUTION AUTO-INJECTOR 50 MG/ML SUBCUTANEOUS ( <i>etanercept</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANALGESICS - NONNARCOTIC* - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANALGESICS OTHER*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	Preferred	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	Preferred	QL (6 EA per 1 day)
<i>acetaminophen er oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>acetaminophen extra strength oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	Preferred	
<i>acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	Preferred	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	Preferred	
<i>acetaminophen oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>acetaminophen oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>acetaminophen oral tablet chewable 160 mg</i>	Preferred	QL (6 EA per 1 day)
<i>acetaminophen rectal suppository 120 mg</i>	Preferred	QL (34 EA per 1 day)
<i>acetaminophen rectal suppository 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>childrens acetaminophen oral suspension 160 mg/5ml</i>	Preferred	
<i>childrens silapap oral liquid 160 mg/5ml</i>	Preferred	
<i>ed-apap oral liquid 160 mg/5ml</i>	Preferred	
<i>ft 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft children's pain/fever oral tablet chewable 160 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft pain &amp; fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>ft pain relief adult extra st oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>ft pain relief oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>ft pain reliever ex str adult oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp acetaminophen oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>gnp acetaminophen oral tablet chewable 160 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp childrens easy-melts oral tablet dispersible 80 mg</i>	Preferred	QL (50 EA per 1 day)
<i>gnp infants pain/fever oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain &amp; fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain &amp; fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain relief extra strength oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp pain relief oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>goodsense arthritis pain oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>goodsense pain &amp; fever child oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain &amp; fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain relief extra st oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>goodsense pain relief oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>goodsense pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>hm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>hm pain &amp; fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>hm pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>liquid acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>mapap oral capsule 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>m-pap oral liquid 160 mg/5ml</i>	Preferred	
<i>pain &amp; fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>pain &amp; fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm pain &amp; fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain &amp; fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain relief extra strength oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>sm pain reliever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain reliever ex st oral tablet 500 mg</i>	Preferred	QL (8 EA per 1 day)
<i>sm pain reliever oral tablet 325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>sm rapid melts junior oral tablet dispersible 160 mg</i>	Preferred	QL (25 EA per 1 day)
FEVERALL ADULTS RECTAL SUPPOSITORY 650 MG (acetaminophen)	Preferred	QL (6 EA per 1 day)
FEVERALL CHILDRENS RECTAL SUPPOSITORY 120 MG (acetaminophen)	Preferred	QL (34 EA per 1 day)
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (acetaminophen)	Preferred	QL (50 EA per 1 day)
MAPAP ACETAMINOPHEN EXTRA STR ORAL LIQUID 500 MG/15ML (acetaminophen)	Preferred	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG, 80 MG (acetaminophen)	Preferred	QL (6 EA per 1 day)
<b>*ANALGESICS-SEDATIVES*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>butalbital-acetaminophen tablet 50-300 mg oral</i>	Preferred	
<i>butalbital-acetaminophen tablet 50-325 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>butalbital-apap-caffeine capsule 50-300-40 mg oral</i>	Preferred	
<i>butalbital-apap-caffeine capsule 50-325-40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>butalbital-apap-caffeine tablet 50-325-40 mg oral</i>	Preferred	QL (6 EA per 1 day)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>butalbital-aspirin-caffeine capsule 50-325-40 mg oral</i>	Preferred	
<i>butalbital-apap-caffeine (Bac Tablet 50-325-40 Mg Oral)</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-acetaminophen (Bupap Tablet 50-300 Mg Oral)</i>	Preferred	
<i>butalbital-apap-caffeine (Esgic Capsule 50-325-40 Mg Oral)</i>	Preferred	QL (2 EA per 1 day)
<i>butalbital-apap-caffeine (Zebutal Capsule 50-325-40 Mg Oral)</i>	Preferred	QL (2 EA per 1 day)
<i>butalbital-acetaminophen capsule 50-300 mg oral</i>	Non Preferred	PA
<i>butalbital-acetaminophen tablet 25-325 mg oral</i>	Non Preferred	PA
ESGIC TABLET 50-325-40 MG ORAL ( <i>butalbital-apap-caffeine</i> )	Non Preferred	PA; QL (6 EA per 1 day)
FIORICET CAPSULE 50-300-40 MG ORAL ( <i>butalbital-apap-caffeine</i> )	Non Preferred	PA
<b>*SALICYLATES*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	
<i>aspirin oral tablet 325 mg</i>	Preferred	
<i>aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin oral tablet delayed release 325 mg, 81 mg</i>	Preferred	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	Preferred	
<i>diflunisal tablet 500 mg oral</i>	Preferred	
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	
<i>ft aspirin oral tablet 325 mg</i>	Preferred	
<i>ft enteric coated aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	Preferred	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	
<i>gnp aspirin oral tablet 325 mg</i>	Preferred	
<i>gnp aspirin oral tablet delayed release 325 mg, 81 mg</i>	Preferred	
<i>goodsense aspirin adult low st oral tablet chewable 81 mg</i>	Preferred	
<i>goodsense aspirin adults oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	
<i>goodsense aspirin oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>hm adult aspirin oral tablet 325 mg</i>	Preferred	
<i>hm aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>salsalate tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>salsalate tablet 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	Preferred	
<i>sm aspirin ec low strength oral tablet delayed release 81 mg</i>	Preferred	
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
<b>*ANALGESICS - OPIOID* - DRUGS FOR PAIN AND FEVER</b>		
<b>*CODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>acetaminophen-codeine solution 120-12 mg/5ml oral</i>	Preferred	QL (3750 ML per 25 days); AGE (Min 18 Years)
<i>acetaminophen-codeine solution 120-12 mg/5ml oral</i>	Preferred	QL (3750 ML per 30 days); AGE (Min 18 Years)
<i>acetaminophen-codeine tablet 300-15 mg oral</i>	Preferred	QL (6 EA per 1 day); AGE (Min 18 Years)
<i>acetaminophen-codeine tablet 300-30 mg oral</i>	Preferred	QL (6 EA per 1 day); AGE (Min 18 Years)
<i>acetaminophen-codeine tablet 300-60 mg oral</i>	Preferred	QL (6 EA per 1 day); AGE (Min 18 Years)
<i>butalbital-asa-caff-codeine capsule 50-325-40-30 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>butalbital-asa-caff-codeine (Ascomp-Codeine Capsule 50-325-40-30 Mg Oral)</i>	Preferred	AGE (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-300-40-30 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-325-40-30 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); AGE (Min 18 Years)
FIORICET/CODEINE CAPSULE 50-300-40-30 MG ORAL ( <i>butalbital-apap-caff-cod</i> )	Non Preferred	PA; AGE (Min 18 Years)
<b>*DIHYDROCODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>apap-caff-dihydrocodeine capsule 320.5-30-16 mg oral</i>	Non Preferred	PA
<b>*HYDROCODONE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>hydrocodone-acetaminophen solution 2.5-108 mg/5ml oral</i>	Preferred	QL (3750 ML per 30 days)
<i>hydrocodone-acetaminophen solution 5-217 mg/10ml oral</i>	Preferred	QL (3750 ML per 30 days)
<i>hydrocodone-acetaminophen solution 7.5-325 mg/15ml oral</i>	Preferred	QL (3750 ML per 30 days)
<i>hydrocodone-acetaminophen tablet 10-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 7.5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 10-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 5-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 7.5-200 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*OPIOID AGONISTS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>codeine sulfate tablet 15 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>codeine sulfate tablet 30 mg oral</i>	Preferred	QL (12 EA per 1 day); AGE (Min 18 Years)
<i>codeine sulfate tablet 60 mg oral</i>	Preferred	QL (8 EA per 1 day); AGE (Min 18 Years)
<i>hydromorphone hcl liquid 1 mg/ml oral</i>	Preferred	
<i>hydromorphone hcl suppository 3 mg rectal</i>	Preferred	
<i>hydromorphone hcl tablet 2 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydromorphone hcl tablet 4 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydromorphone hcl tablet 8 mg oral</i>	Preferred	
<i>morphine sulfate (concentrate) solution 10 mg/0.5ml oral</i>	Preferred	
<i>morphine sulfate (concentrate) solution 100 mg/5ml oral</i>	Preferred	
<i>morphine sulfate (concentrate) solution 20 mg/ml oral</i>	Preferred	
<i>morphine sulfate er tablet extended release 100 mg oral</i>	Preferred	ST; QL (3 EA per 1 day)
<i>morphine sulfate er tablet extended release 15 mg oral</i>	Preferred	ST; QL (3 EA per 1 day)
<i>morphine sulfate er tablet extended release 200 mg oral</i>	Preferred	ST
<i>morphine sulfate er tablet extended release 30 mg oral</i>	Preferred	ST; QL (3 EA per 1 day)
<i>morphine sulfate er tablet extended release 60 mg oral</i>	Preferred	ST; QL (3 EA per 1 day)
<i>morphine sulfate solution 10 mg/5ml oral</i>	Preferred	
<i>morphine sulfate solution 20 mg/5ml oral</i>	Preferred	
<i>morphine sulfate suppository 10 mg rectal</i>	Preferred	
<i>morphine sulfate suppository 20 mg rectal</i>	Preferred	
<i>morphine sulfate suppository 30 mg rectal</i>	Preferred	
<i>morphine sulfate suppository 5 mg rectal</i>	Preferred	
<i>morphine sulfate tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>morphine sulfate tablet 30 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl capsule 5 mg oral</i>	Preferred	
<i>oxycodone hcl concentrate 100 mg/5ml oral</i>	Preferred	
<i>oxycodone hcl solution 5 mg/5ml oral</i>	Preferred	
<i>oxycodone hcl tablet 10 mg oral</i>	Preferred	
<i>oxycodone hcl tablet 15 mg oral</i>	Preferred	
<i>oxycodone hcl tablet 20 mg oral</i>	Preferred	
<i>oxycodone hcl tablet 30 mg oral</i>	Preferred	
<i>oxycodone hcl tablet 5 mg oral</i>	Preferred	
<i>tramadol hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); AGE (Min 18 Years)
<i>fentanyl citrate lozenge on a handle 1200 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg buccal</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>fentanyl citrate lozenge on a handle 200 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 400 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 600 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 800 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 100 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 200 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 400 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 600 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 800 mcg buccal</i>	Non Preferred	PA
<i>fentanyl patch 72 hour 100 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 12 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 25 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 37.5 mcg/hr transdermal</i>	Non Preferred	PA
<i>fentanyl patch 72 hour 50 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 62.5 mcg/hr transdermal</i>	Non Preferred	PA
<i>fentanyl patch 72 hour 75 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 87.5 mcg/hr transdermal</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 10 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 15 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 20 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 30 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 40 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er capsule extended release 12 hour 50 mg oral</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 100 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 120 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 20 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 30 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 40 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 60 mg oral</i>	Non Preferred	PA
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 80 mg oral</i>	Non Preferred	PA
<i>hydromorphone hcl er tablet extended release 24 hour 12 mg oral</i>	Non Preferred	PA
<i>hydromorphone hcl er tablet extended release 24 hour 16 mg oral</i>	Non Preferred	PA
<i>hydromorphone hcl er tablet extended release 24 hour 32 mg oral</i>	Non Preferred	PA
<i>hydromorphone hcl er tablet extended release 24 hour 8 mg oral</i>	Non Preferred	PA
<i>levorphanol tartrate tablet 2 mg oral</i>	Non Preferred	PA
<i>levorphanol tartrate tablet 3 mg oral</i>	Non Preferred	PA
<i>meperidine hcl solution 50 mg/5ml oral</i>	Non Preferred	PA; QL (500 ML per 30 days)
<i>meperidine hcl tablet 50 mg oral</i>	Non Preferred	PA; QL (10 EA per 1 day)
<i>methadone hcl concentrate 10 mg/ml oral</i>	Non Preferred	PA
<i>methadone hcl solution 10 mg/5ml oral</i>	Non Preferred	PA
<i>methadone hcl solution 5 mg/5ml oral</i>	Non Preferred	PA
<i>methadone hcl tablet 10 mg oral</i>	Non Preferred	PA
<i>methadone hcl tablet 5 mg oral</i>	Non Preferred	PA
<i>methadone hcl tablet soluble 40 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er beads capsule extended release 24 hour 120 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er beads capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>morphine sulfate er beads capsule extended release 24 hour 45 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er beads capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er beads capsule extended release 24 hour 75 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er beads capsule extended release 24 hour 90 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA
<i>morphine sulfate er capsule extended release 24 hour 80 mg oral</i>	Non Preferred	PA
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 10 mg oral</i>	Non Preferred	PA
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 20 mg oral</i>	Non Preferred	PA
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 40 mg oral</i>	Non Preferred	PA
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 80 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 10 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 15 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 20 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 30 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 40 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 5 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl er tablet extended release 12 hour 7.5 mg oral</i>	Non Preferred	PA
<i>oxymorphone hcl tablet 10 mg oral</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>oxymorphone hcl tablet 5 mg oral</i>	Non Preferred	PA
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 300 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 200 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 300 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl er tablet extended release 24 hour 200 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl er tablet extended release 24 hour 300 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl solution 5 mg/ml oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl tablet 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tramadol hcl tablet 25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
ACTIQ LOZENGE ON A HANDLE 1200 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
ACTIQ LOZENGE ON A HANDLE 200 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
ACTIQ LOZENGE ON A HANDLE 400 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
ACTIQ LOZENGE ON A HANDLE 600 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
ACTIQ LOZENGE ON A HANDLE 800 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>tramadol hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>tramadol hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>tramadol hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)
DILAUDID LIQUID 1 MG/ML ORAL ( <i>hydromorphone hcl</i> )	Non Preferred	PA
DILAUDID TABLET 2 MG ORAL ( <i>hydromorphone hcl</i> )	Non Preferred	PA; QL (12 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
DILAUDID TABLET 4 MG ORAL ( <i>hydromorphone hcl</i> )	Non Preferred	PA; QL (12 EA per 1 day)
DILAUDID TABLET 8 MG ORAL ( <i>hydromorphone hcl</i> )	Non Preferred	PA
FENTORA TABLET 100 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
FENTORA TABLET 200 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
FENTORA TABLET 400 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
FENTORA TABLET 600 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
FENTORA TABLET 800 MCG BUCCAL ( <i>fentanyl citrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 120 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 30 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 40 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 60 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 80 MG ORAL ( <i>hydrocodone bitartrate</i> )	Non Preferred	PA
<i>methadone hcl</i> (Methadone Hcl Intensol Concentrate 10 Mg/ML Oral)	Non Preferred	PA
METHADOSE CONCENTRATE 10 MG/ML ORAL ( <i>methadone hcl</i> )	Non Preferred	PA
METHADOSE SUGAR-FREE CONCENTRATE 10 MG/ML ORAL ( <i>methadone hcl</i> )	Non Preferred	PA
<i>methadone hcl</i> (Methadose Tablet Soluble 40 Mg Oral)	Non Preferred	PA
MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL ( <i>morphine sulfate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL ( <i>morphine sulfate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL ( <i>morphine sulfate</i> )	Non Preferred	PA
MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL ( <i>morphine sulfate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL ( <i>morphine sulfate</i> )	Non Preferred	PA; QL (3 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 150 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 250 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 50 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA TABLET 100 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA TABLET 50 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
NUCYNTA TABLET 75 MG ORAL ( <i>tapentadol hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 15 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 20 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 30 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 60 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 80 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXICODONE TABLET 15 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXICODONE TABLET 30 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXICODONE TABLET 5 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXYBOND TABLET ABUSE-DETERRENT 15 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXYBOND TABLET ABUSE-DETERRENT 30 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
ROXYBOND TABLET ABUSE-DETERRENT 5 MG ORAL ( <i>oxycodone hcl</i> )	Non Preferred	PA
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG ORAL ( <i>oxycodone</i> )	Non Preferred	PA
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 18 MG ORAL ( <i>oxycodone</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 27 MG ORAL ( <i>oxycodone</i> )	Non Preferred	PA
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG ORAL ( <i>oxycodone</i> )	Non Preferred	PA
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 9 MG ORAL ( <i>oxycodone</i> )	Non Preferred	PA
<b>*OPIOID COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>oxycodone-acetaminophen solution 5-325 mg/5ml oral</i>	Preferred	
<i>oxycodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen tablet 2.5-325 mg oral</i>	Preferred	
<i>oxycodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>oxycodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen (Endocet Tablet 10-325 Mg Oral)</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen (Endocet Tablet 5-325 Mg Oral)</i>	Preferred	QL (8 EA per 1 day)
<i>oxycodone-acetaminophen (Endocet Tablet 7.5-325 Mg Oral)</i>	Preferred	QL (6 EA per 1 day)
<i>nalocet tablet 2.5-300 mg oral</i>	Non Preferred	PA
PERCOCET TABLET 10-325 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA; QL (6 EA per 1 day)
PERCOCET TABLET 2.5-325 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PERCOCET TABLET 5-325 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA; QL (8 EA per 1 day)
PERCOCET TABLET 7.5-325 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA; QL (6 EA per 1 day)
PRIMLEV TABLET 10-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PRIMLEV TABLET 5-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PRIMLEV TABLET 7.5-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PROLATE SOLUTION 10-300 MG/5ML ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PROLATE TABLET 10-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PROLATE TABLET 5-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
PROLATE TABLET 7.5-300 MG ORAL ( <i>oxycodone-acetaminophen</i> )	Non Preferred	PA
<b>*OPIOID PARTIAL AGONISTS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>buprenorphine hcl tablet sublingual 2 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl tablet sublingual 8 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl film 12-3 mg sublingual</i>	Preferred	QL (3 EA per 1 day)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>buprenorphine hcl-naloxone hcl film 2-0.5 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl film 4-1 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl film 8-2 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl tablet sublingual 2-0.5 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
<i>buprenorphine hcl-naloxone hcl tablet sublingual 8-2 mg sublingual</i>	Preferred	QL (3 EA per 1 day)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 16 MG/0.32ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (1.28 ML per 28 days)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 24 MG/0.48ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (1.92 ML per 28 days)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 32 MG/0.64ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (2.56 ML per 28 days)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 8 MG/0.16ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (0.64 ML per 28 days)
BRIXADI SOLUTION PREFILLED SYRINGE 128 MG/0.36ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (0.36 ML per 30 days)
BRIXADI SOLUTION PREFILLED SYRINGE 64 MG/0.18ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (0.18 ML per 30 days)
BRIXADI SOLUTION PREFILLED SYRINGE 96 MG/0.27ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	QL (0.27 ML per 30 days)
SUBLOCADE SOLUTION PREFILLED SYRINGE 100 MG/0.5ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	
SUBLOCADE SOLUTION PREFILLED SYRINGE 300 MG/1.5ML SUBCUTANEOUS ( <i>buprenorphine</i> )	Preferred	
SUBOXONE FILM 12-3 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
SUBOXONE FILM 2-0.5 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
SUBOXONE FILM 4-1 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
SUBOXONE FILM 8-2 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 0.7-0.18 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 1.4-0.36 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 11.4-2.9 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 2.9-0.71 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 5.7-1.4 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)
ZUBSOLV TABLET SUBLINGUAL 8.6-2.1 MG SUBLINGUAL ( <i>buprenorphine hcl-naloxone hcl</i> )	Preferred	QL (3 EA per 1 day)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>buprenorphine patch weekly 10 mcg/hr transdermal</i>	Non Preferred	PA
<i>buprenorphine patch weekly 15 mcg/hr transdermal</i>	Non Preferred	PA
<i>buprenorphine patch weekly 20 mcg/hr transdermal</i>	Non Preferred	PA
<i>buprenorphine patch weekly 5 mcg/hr transdermal</i>	Non Preferred	PA
<i>buprenorphine patch weekly 7.5 mcg/hr transdermal</i>	Non Preferred	PA
<i>butorphanol tartrate solution 10 mg/ml nasal</i>	Non Preferred	PA
<i>pentazocine-naloxone hcl tablet 50-0.5 mg oral</i>	Non Preferred	PA
BELBUCA FILM 150 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 300 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 450 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 600 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 75 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 750 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BELBUCA FILM 900 MCG BUCCAL ( <i>buprenorphine hcl</i> )	Non Preferred	PA
BUTRANS PATCH WEEKLY 10 MCG/HR TRANSDERMAL ( <i>buprenorphine</i> )	Non Preferred	PA
BUTRANS PATCH WEEKLY 15 MCG/HR TRANSDERMAL ( <i>buprenorphine</i> )	Non Preferred	PA
BUTRANS PATCH WEEKLY 20 MCG/HR TRANSDERMAL ( <i>buprenorphine</i> )	Non Preferred	PA
BUTRANS PATCH WEEKLY 5 MCG/HR TRANSDERMAL ( <i>buprenorphine</i> )	Non Preferred	PA
BUTRANS PATCH WEEKLY 7.5 MCG/HR TRANSDERMAL ( <i>buprenorphine</i> )	Non Preferred	PA
<b>*TRAMADOL COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>tramadol-acetaminophen tablet 37.5-325 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
SEGLENTIS TABLET 56-44 MG ORAL ( <i>celecoxib-tramadol hcl</i> )	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANALGESICS-SEDATIVES*** - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANALGESICS - NONNARCOTIC* - ARTHRITIS AND PAIN DRUGS</b>		
<i>butalbital-apap-caffeine tablet 50-325-40 mg oral</i>	Preferred	QL (6 EA per 1 day)
<b>*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER</b>		
<i>abiraterone acetate tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>*ANDROGENS-ANABOLIC* - HORMONES</b>		
<b>*ANDROGENS*** - DRUGS FOR MEN</b>		
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	Preferred	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	Preferred	
<i>testosterone cypionate (Depo-Testosterone Intramuscular Solution 100 Mg/ML, 200 Mg/ML)</i>	Preferred	
<b>*ANORECTAL AND RELATED PRODUCTS* - RECTAL PREPARATIONS</b>		
<b>*INTRARECTAL STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>hydrocortisone enema 100 mg/60ml rectal</i>	Preferred	QL (60 ML per 1 day)
<i>budesonide foam 2 mg rectal</i>	Non Preferred	PA
CORTENEMA ENEMA 100 MG/60ML RECTAL ( <i>hydrocortisone</i> )	Non Preferred	PA; QL (60 ML per 1 day)
CORTIFOAM FOAM 10 % EXTERNAL ( <i>hydrocortisone acetate</i> )	Non Preferred	PA
UCERIS FOAM 2 MG/ACT RECTAL ( <i>budesonide</i> )	Non Preferred	PA
<b>*NITRATE VASODILATING AGENTS*** - RECTAL PREPARATIONS</b>		
RECTIV OINTMENT 0.4 % RECTAL ( <i>nitroglycerin</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*RECTAL ANESTHETIC COMBINATIONS*** - RECTAL PREPARATIONS</b>		
<i>hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<b>*RECTAL ANESTHETIC/STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>lidocaine-hydrocort (perianal) cream 3-0.5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>lidocaine-hydrocortisone ace gel 2.8-0.55 % rectal</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone ace kit 2-2 % rectal</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>lidocaine-hydrocortisone ace kit 3-0.5 % rectal</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone ace kit 3-1 % rectal</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone ace kit 3-2.5 % rectal</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone ace (Ana-Lex Kit 2-2 % Rectal)</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone ace (Lidocort Cream 3-0.5 % External)</i>	Non Preferred	PA; Max 60-day supply per fill
PROCTOFOAM HC FOAM 1-1 % EXTERNAL ( <i>hydrocortisone ace-pramoxine</i> )	Non Preferred	PA
<b>*RECTAL LOCAL ANESTHETICS*** - RECTAL PREPARATIONS</b>		
<i>dibucaine (perianal) external ointment 1 %</i>	Preferred	
<b>*RECTAL STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>hydrocortisone (perianal) cream 1 % external</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone (perianal) cream 2.5 % external</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone (Procto-Med Hc Cream 2.5 % External)</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone (Proctosol Hc Cream 2.5 % External)</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone (Proctozone-Hc Cream 2.5 % External)</i>	Preferred	Max 60-day supply per fill
ANUSOL-HC CREAM 2.5 % EXTERNAL ( <i>hydrocortisone</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTACIDS* - DRUGS FOR THE STOMACH</b>		
<b>*ANTACID &amp; SIMETHICONE*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>alum &amp; mag hydroxide-simeth oral suspension 1200-1200-120 mg/30ml</i>	Preferred	
<i>antacid &amp; antigas oral suspension 2400-2400-240 mg/30ml</i>	Preferred	
<i>antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml</i>	Preferred	
<i>antacid oral suspension 400-400-40 mg/10ml</i>	Preferred	
<i>antacid plus anti-gas relief oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid/antigas oral suspension 400-400-40 mg/10ml</i>	Preferred	
<i>ft antacid &amp; antigas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>gnp antacid &amp; anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>gnp antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	Preferred	
<i>mag-al plus xs oral liquid 400-400-40 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>magnesium-aluminum-simethicone oral suspension 2400-2400-240 mg/30ml</i>	Preferred	
<i>mintox maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid advanced max st oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid advanced oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid oral suspension 400-400-40 mg/10ml</i>	Preferred	
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML ( <i>alum &amp; mag hydroxide-simeth</i> )	Preferred	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG ( <i>alum &amp; mag hydroxide-simeth</i> )	Preferred	
<b>*ANTACID COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>antacid extra strength oral tablet chewable 160-105 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 160-105 mg</i>	Preferred	
ACID GONE ORAL SUSPENSION 95-358 MG/15ML ( <i>alum hydroxide-mag carbonate</i> )	Preferred	
ACID GONE ORAL TABLET CHEWABLE 160-105 MG ( <i>alum hydroxide-mag carbonate</i> )	Preferred	
<b>*ANTACIDS - BICARBONATE*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>sodium bicarbonate oral tablet 325 mg, 650 mg</i>	Preferred	
<b>*ANTACIDS - CALCIUM SALTS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>antacid calcium oral tablet chewable 500 mg</i>	Preferred	
<i>antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>antacid oral tablet chewable 750 mg</i>	Preferred	
<i>antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>calcium antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>calcium antacid ultra max st oral tablet chewable 1000 mg</i>	Preferred	
<i>calcium carbonate antacid oral suspension 1250 mg/5ml</i>	Preferred	
<i>calcium carbonate antacid oral tablet 648 mg</i>	Preferred	
<i>ft antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>ft antacid regular strength oral tablet chewable 500 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>gnp antacid oral tablet chewable 500 mg</i>	Preferred	
<i>gnp antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>hm antacid extra strength oral tablet chewable 750 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm calcium antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>sm calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm smooth antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>smooth antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG (calcium carbonate antacid)	Preferred	
<b>*ANTACIDS - MAGNESIUM SALTS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>magnesium oxide oral tablet 400 mg</i>	Preferred	
<b>*ANTHELMINTICS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTHELMINTICS*** - DRUGS FOR PARASITES</b>		
<i>praziquantel tablet 600 mg oral</i>	Preferred	
<i>albendazole tablet 200 mg oral</i>	Non Preferred	PA
<i>benznidazole tablet 100 mg oral</i>	Non Preferred	PA
<i>benznidazole tablet 12.5 mg oral</i>	Non Preferred	PA
<i>ivermectin tablet 3 mg oral</i>	Non Preferred	PA; QL (10 EA per 1 day)
BILTRICIDE TABLET 600 MG ORAL ( <i>praziquantel</i> )	Non Preferred	PA
EGATEN TABLET 250 MG ORAL ( <i>triclabendazole</i> )	Non Preferred	PA
EMVERM TABLET CHEWABLE 100 MG ORAL ( <i>mebendazole</i> )	Non Preferred	PA
STROMECTOL TABLET 3 MG ORAL ( <i>ivermectin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
<b>*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR THE HEART</b>		
<b>*ANTIHYPERTENSIVES* - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>clonidine patch weekly 0.1 mg/24hr transdermal</i>	Preferred	
<i>clonidine patch weekly 0.2 mg/24hr transdermal</i>	Preferred	
<i>clonidine patch weekly 0.3 mg/24hr transdermal</i>	Preferred	
<b>*ANTIANGINAL AGENTS* - DRUGS FOR THE HEART</b>		
<b>*ANTIANGINALS-OTHER*** - DRUGS FOR ANGINA</b>		
<i>ranolazine er tablet extended release 12 hour 1000 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>ranolazine er tablet extended release 12 hour 500 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
ASPRUZYO SPRINKLE PACKET 1000 MG ORAL ( <i>ranolazine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ASPRUZYO SPRINKLE PACKET 500 MG ORAL ( <i>ranolazine</i> )	Non Preferred	PA
RANEXA TABLET EXTENDED RELEASE 12 HOUR 1000 MG ORAL ( <i>ranolazine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
RANEXA TABLET EXTENDED RELEASE 12 HOUR 500 MG ORAL ( <i>ranolazine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*NITRATES*** - DRUGS FOR ANGINA</b>		
<i>isosorbide dinitrate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>isosorbide dinitrate tablet 20 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>isosorbide dinitrate tablet 30 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>isosorbide dinitrate tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>isosorbide dinitrate tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate er tablet extended release 24 hour 120 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate er tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate er tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nitroglycerin patch 24 hour 0.1 mg/hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin patch 24 hour 0.2 mg/hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin patch 24 hour 0.4 mg/hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin patch 24 hour 0.6 mg/hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin tablet sublingual 0.3 mg sublingual</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>nitroglycerin tablet sublingual 0.4 mg sublingual</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>nitroglycerin tablet sublingual 0.6 mg sublingual</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
NITRO-BID OINTMENT 2 % TRANSDERMAL ( <i>nitroglycerin</i> )	Preferred	Max 60-day supply per fill
<i>nitroglycerin solution 0.4 mg/spray translingual</i>	Non Preferred	PA
GONITRO PACKET 400 MCG SUBLINGUAL ( <i>nitroglycerin</i> )	Non Preferred	PA
ISORDIL TITRADOSE TABLET 40 MG ORAL ( <i>isosorbide dinitrate</i> )	Non Preferred	PA
ISORDIL TITRADOSE TABLET 5 MG ORAL ( <i>isosorbide dinitrate</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
NITRO-DUR PATCH 24 HOUR 0.1 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NITRO-DUR PATCH 24 HOUR 0.2 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NITRO-DUR PATCH 24 HOUR 0.3 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA
NITRO-DUR PATCH 24 HOUR 0.4 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NITRO-DUR PATCH 24 HOUR 0.6 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NITRO-DUR PATCH 24 HOUR 0.8 MG/HR TRANSDERMAL ( <i>nitroglycerin</i> )	Non Preferred	PA
NITROLINGUAL SOLUTION 0.4 MG/SPRAY TRANSLINGUAL ( <i>nitroglycerin</i> )	Non Preferred	PA
NITROSTAT TABLET SUBLINGUAL 0.3 MG SUBLINGUAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NITROSTAT TABLET SUBLINGUAL 0.4 MG SUBLINGUAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NITROSTAT TABLET SUBLINGUAL 0.6 MG SUBLINGUAL ( <i>nitroglycerin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
<b>*ANTIANXIETY AGENTS - MISC.*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIANXIETY AGENTS* - DRUGS FOR ANXIETY</b>		
<i>hydroxyzine hcl syrup 10 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
<b>*ANTIANXIETY AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIANXIETY AGENTS - MISC.*** - DRUGS FOR ANXIETY</b>		
<i>bupirone hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>bupirone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bupirone hcl tablet 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupirone hcl tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>bupirone hcl tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hydroxyzine hcl syrup 10 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
<i>hydroxyzine hcl tablet 10 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>hydroxyzine hcl tablet 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>hydroxyzine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>hydroxyzine pamoate capsule 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>hydroxyzine pamoate capsule 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>hydroxyzine pamoate capsule 50 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>meprobamate tablet 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>meprobamate tablet 400 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
VISTARIL CAPSULE 25 MG ORAL ( <i>hydroxyzine pamoate</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>alprazolam tablet 0.25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>alprazolam tablet 0.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>alprazolam tablet 1 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>alprazolam tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>chlordiazepoxide hcl capsule 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>chlordiazepoxide hcl capsule 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>chlordiazepoxide hcl capsule 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 3.75 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 7.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>diazepam concentrate 5 mg/ml oral</i>	Preferred	QL (3 ML per 1 day)
<i>diazepam solution 5 mg/5ml oral</i>	Preferred	QL (4 ML per 1 day)
<i>diazepam tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diazepam tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diazepam tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>lorazepam concentrate 2 mg/ml oral</i>	Preferred	QL (3 ML per 1 day)
<i>lorazepam tablet 0.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>lorazepam tablet 1 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>lorazepam tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxazepam capsule 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxazepam capsule 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxazepam capsule 30 mg oral</i>	Preferred	QL (4 EA per 1 day)
ALPRAZOLAM INTENSOL CONCENTRATE 1 MG/ML ORAL ( <i>alprazolam</i> )	Preferred	
<i>diazepam (Diazepam Intensol Concentrate 5 Mg/MI Oral)</i>	Preferred	QL (3 ML per 1 day)
<i>lorazepam (Lorazepam Intensol Concentrate 2 Mg/MI Oral)</i>	Preferred	QL (3 ML per 1 day)
<i>alprazolam er tablet extended release 24 hour 0.5 mg oral</i>	Non Preferred	PA

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<i>alprazolam er tablet extended release 24 hour 1 mg oral</i>	Non Preferred	PA
<i>alprazolam er tablet extended release 24 hour 2 mg oral</i>	Non Preferred	PA
<i>alprazolam er tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA
<i>alprazolam tablet dispersible 0.25 mg oral</i>	Non Preferred	PA
<i>alprazolam tablet dispersible 0.5 mg oral</i>	Non Preferred	PA
<i>alprazolam tablet dispersible 1 mg oral</i>	Non Preferred	PA
<i>alprazolam tablet dispersible 2 mg oral</i>	Non Preferred	PA
<i>alprazolam xr tablet extended release 24 hour 0.5 mg oral</i>	Non Preferred	PA
<i>alprazolam xr tablet extended release 24 hour 1 mg oral</i>	Non Preferred	PA
<i>alprazolam xr tablet extended release 24 hour 2 mg oral</i>	Non Preferred	PA
<i>alprazolam xr tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA
ATIVAN TABLET 0.5 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ATIVAN TABLET 1 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ATIVAN TABLET 2 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LOREEV XR CAPSULE ER 24 HOUR SPRINKLE 1 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA
LOREEV XR CAPSULE ER 24 HOUR SPRINKLE 1.5 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA
LOREEV XR CAPSULE ER 24 HOUR SPRINKLE 2 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA
LOREEV XR CAPSULE ER 24 HOUR SPRINKLE 3 MG ORAL ( <i>lorazepam</i> )	Non Preferred	PA
XANAX TABLET 0.25 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
XANAX TABLET 0.5 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
XANAX TABLET 1 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
XANAX TABLET 2 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
XANAX XR TABLET EXTENDED RELEASE 24 HOUR 0.5 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
XANAX XR TABLET EXTENDED RELEASE 24 HOUR 1 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA
XANAX XR TABLET EXTENDED RELEASE 24 HOUR 2 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA
XANAX XR TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL ( <i>alprazolam</i> )	Non Preferred	PA
<b>*ANTIARRHYTHMICS* - DRUGS FOR THE HEART</b>		
<b>*ANTIARRHYTHMICS TYPE I-A*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>disopyramide phosphate capsule 100 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>disopyramide phosphate capsule 150 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>quinidine gluconate er tablet extended release 324 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinidine sulfate tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinidine sulfate tablet 300 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
NORPACE CR CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>disopyramide phosphate</i> )	Preferred	
NORPACE CR CAPSULE EXTENDED RELEASE 12 HOUR 150 MG ORAL ( <i>disopyramide phosphate</i> )	Preferred	
NORPACE CAPSULE 100 MG ORAL ( <i>disopyramide phosphate</i> )	Non Preferred	PA; QL (8 EA per 1 day)
NORPACE CAPSULE 150 MG ORAL ( <i>disopyramide phosphate</i> )	Non Preferred	PA; QL (5 EA per 1 day)
<b>*ANTIARRHYTHMICS TYPE I-B*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>mexiletine hcl capsule 150 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>mexiletine hcl capsule 200 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>mexiletine hcl capsule 250 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<b>*ANTIARRHYTHMICS TYPE I-C*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>flecainide acetate tablet 100 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>flecainide acetate tablet 150 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>flecainide acetate tablet 50 mg oral</i>	Preferred	QL (7 EA per 1 day); Max 90-day supply per fill
<i>propafenone hcl tablet 150 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propafenone hcl tablet 225 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>propafenone hcl tablet 300 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>propafenone hcl er capsule extended release 12 hour 225 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>propafenone hcl er capsule extended release 12 hour 325 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>propafenone hcl er capsule extended release 12 hour 425 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
RYTHMOL SR CAPSULE EXTENDED RELEASE 12 HOUR 225 MG ORAL ( <i>propafenone hcl</i> )	Non Preferred	PA
RYTHMOL SR CAPSULE EXTENDED RELEASE 12 HOUR 325 MG ORAL ( <i>propafenone hcl</i> )	Non Preferred	PA
RYTHMOL SR CAPSULE EXTENDED RELEASE 12 HOUR 425 MG ORAL ( <i>propafenone hcl</i> )	Non Preferred	PA
<b>*ANTIARRHYTHMICS TYPE III*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>amiodarone hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amiodarone hcl tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>amiodarone hcl tablet 400 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dofetilide capsule 125 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>dofetilide capsule 250 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>dofetilide capsule 500 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>amiodarone hcl (Pacerone Tablet 100 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>amiodarone hcl (Pacerone Tablet 200 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>amiodarone hcl (Pacerone Tablet 400 Mg Oral)</i>	Preferred	Max 90-day supply per fill
MULTAQ TABLET 400 MG ORAL ( <i>dronedarone hcl</i> )	Non Preferred	PA
TIKOSYN CAPSULE 125 MCG ORAL ( <i>dofetilide</i> )	Non Preferred	PA
TIKOSYN CAPSULE 250 MCG ORAL ( <i>dofetilide</i> )	Non Preferred	PA
TIKOSYN CAPSULE 500 MCG ORAL ( <i>dofetilide</i> )	Non Preferred	PA
<b>*ANTIASTHMATIC AND BRONCHODILATOR AGENTS* - DRUGS FOR THE LUNGS</b>		
<b>*5-LIPOXYGENASE INHIBITORS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>zileuton er tablet extended release 12 hour 600 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ZYFLO TABLET 600 MG ORAL ( <i>zileuton</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ADRENERGIC COMBINATIONS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>ipratropium-albuterol solution 0.5-2.5 (3) mg/3ml inhalation</i>	Preferred	QL (360 ML per 30 days)
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (2 EA per 1 day)
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (2 EA per 1 day)
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (2 EA per 1 day)
ADVAIR HFA AEROSOL 115-21 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	
ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	
ADVAIR HFA AEROSOL 45-21 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol(sensor)</i> )	Preferred	
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol(sensor)</i> )	Preferred	
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol(sensor)</i> )	Preferred	
AIRDUO RESPICLICK 113/14 AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (0.04 EA per 1 day)
AIRDUO RESPICLICK 232/14 AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (0.04 EA per 1 day)
AIRDUO RESPICLICK 55/14 AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT INHALATION ( <i>fluticasone-salmeterol</i> )	Preferred	QL (0.04 EA per 1 day)
ANORO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT INHALATION ( <i>umeclidinium-vilanterol</i> )	Preferred	QL (2 EA per 1 day)
DULERA AEROSOL 100-5 MCG/ACT INHALATION ( <i>mometasone furo-formoterol fum</i> )	Preferred	
DULERA AEROSOL 200-5 MCG/ACT INHALATION ( <i>mometasone furo-formoterol fum</i> )	Preferred	
DULERA AEROSOL 50-5 MCG/ACT INHALATION ( <i>mometasone furo-formoterol fum</i> )	Preferred	
SYMBICORT AEROSOL 160-4.5 MCG/ACT INHALATION ( <i>budesonide-formoterol fumarate</i> )	Preferred	QL (20.6 GM per 30 days)
SYMBICORT AEROSOL 80-4.5 MCG/ACT INHALATION ( <i>budesonide-formoterol fumarate</i> )	Preferred	QL (20.6 GM per 30 days)
<i>budesonide-formoterol fumarate aerosol 160-4.5 mcg/act inhalation</i>	Non Preferred	PA; QL (20.6 GM per 30 days)

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Drug Name	Formulary Status	Requirements/Limits
<i>budesonide-formoterol fumarate aerosol 80-4.5 mcg/act inhalation</i>	Non Preferred	PA; QL (20.6 GM per 30 days)
<i>fluticasone furoate-vilanterol aerosol powder breath activated 100-25 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone furoate-vilanterol aerosol powder breath activated 200-25 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol 115-21 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol 230-21 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol 45-21 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/act inhalation</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation</i>	Non Preferred	PA; QL (0.04 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation</i>	Non Preferred	PA; QL (0.04 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/act inhalation</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/act inhalation</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation</i>	Non Preferred	PA; QL (0.04 EA per 1 day)
AIRSUPRA AEROSOL 90-80 MCG/ACT INHALATION ( <i>albuterol-budesonide</i> )	Non Preferred	PA
BEVESPI AEROSPHERE AEROSOL 9-4.8 MCG/ACT INHALATION ( <i>glycopyrrolate-formoterol</i> )	Non Preferred	PA
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT INHALATION ( <i>fluticasone furoate-vilanterol</i> )	Non Preferred	PA
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT INHALATION ( <i>fluticasone furoate-vilanterol</i> )	Non Preferred	PA
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH INHALATION ( <i>fluticasone furoate-vilanterol</i> )	Non Preferred	PA
<i>budesonide-formoterol fumarate (Breyna Aerosol 160-4.5 Mcg/Act Inhalation)</i>	Non Preferred	PA; QL (20.6 GM per 30 days)
<i>budesonide-formoterol fumarate (Breyna Aerosol 80-4.5 Mcg/Act Inhalation)</i>	Non Preferred	PA; QL (20.6 GM per 30 days)
BREZTRI AEROSPHERE AEROSOL 160-9-4.8 MCG/ACT INHALATION ( <i>budeson-glycopyrrol-formoterol</i> )	Non Preferred	PA
COMBIVENT RESPIMAT AEROSOL SOLUTION 20-100 MCG/ACT INHALATION ( <i>ipratropium-albuterol</i> )	Non Preferred	PA
DUAKLIR PRESSAIR AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT INHALATION ( <i>aclidinium br-formoterol fum</i> )	Non Preferred	PA
STIOLTO RESPIMAT AEROSOL SOLUTION 2.5-2.5 MCG/ACT INHALATION ( <i>tiotropium bromide-olodaterol</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT INHALATION ( <i>fluticasone-umeclidin-vilant</i> )	Non Preferred	PA
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT INHALATION ( <i>fluticasone-umeclidin-vilant</i> )	Non Preferred	PA
<i>fluticasone-salmeterol</i> (Wixela Inhub Aerosol Powder Breath Activated 100-50 Mcg/Act Inhalation)	Non Preferred	PA; QL (2 EA per 1 day)
<i>fluticasone-salmeterol</i> (Wixela Inhub Aerosol Powder Breath Activated 250-50 Mcg/Act Inhalation)	Non Preferred	PA; QL (2 EA per 1 day)
<i>fluticasone-salmeterol</i> (Wixela Inhub Aerosol Powder Breath Activated 500-50 Mcg/Act Inhalation)	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ANTI-IGE MONOCLONAL ANTIBODIES*** - DRUGS FOR ASTHMA/COPD</b>		
XOLAIR SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>omalizumab</i> )	Preferred	PA
XOLAIR SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS ( <i>omalizumab</i> )	Preferred	PA
XOLAIR SOLUTION RECONSTITUTED 150 MG SUBCUTANEOUS ( <i>omalizumab</i> )	Preferred	PA
<b>*ANTI-INFLAMMATORY AGENTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>cromolyn sodium nebulization solution 20 mg/2ml inhalation</i>	Preferred	QL (26 ML per 1 day)
<b>*BETA ADRENERGICS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	QL (18 GM per 30 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	QL (6.7 GM per 30 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	QL (8.5 GM per 30 days)
<i>albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 0.63 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 1.25 mg/3ml inhalation</i>	Preferred	QL (9 ML per 1 day)
<i>albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation</i>	Preferred	QL (6 EA per 1 day)
<i>terbutaline sulfate tablet 2.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>terbutaline sulfate tablet 5 mg oral</i>	Preferred	QL (6 EA per 1 day)
PROAIR HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate</i> )	Preferred	QL (8.5 GM per 30 days)
PROVENTIL HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate</i> )	Preferred	QL (6.7 GM per 30 days)
SEREVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION ( <i>salmeterol xinafoate</i> )	Preferred	
<i>albuterol sulfate syrup 2 mg/5ml oral</i>	Non Preferred	PA; QL (150 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>albuterol sulfate tablet 2 mg oral</i>	Non Preferred	PA
<i>albuterol sulfate tablet 4 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day)
<i>arformoterol tartrate nebulization solution 15 mcg/2ml inhalation</i>	Non Preferred	PA
<i>formoterol fumarate nebulization solution 20 mcg/2ml inhalation</i>	Non Preferred	PA
<i>levalbuterol hcl nebulization solution 0.31 mg/3ml inhalation</i>	Non Preferred	PA (Eligible for auto-PA)
<i>levalbuterol hcl nebulization solution 0.63 mg/3ml inhalation</i>	Non Preferred	PA (Eligible for auto-PA)
<i>levalbuterol hcl nebulization solution 1.25 mg/0.5ml inhalation</i>	Non Preferred	PA (Eligible for auto-PA)
<i>levalbuterol hcl nebulization solution 1.25 mg/3ml inhalation</i>	Non Preferred	PA (Eligible for auto-PA)
<i>levalbuterol tartrate aerosol 45 mcg/act inhalation</i>	Non Preferred	PA (Eligible for auto-PA)
BROVANA NEBULIZATION SOLUTION 15 MCG/2ML INHALATION ( <i>arformoterol tartrate</i> )	Non Preferred	PA
PERFORMIST NEBULIZATION SOLUTION 20 MCG/2ML INHALATION ( <i>formoterol fumarate</i> )	Non Preferred	PA
PROAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate (sensor)</i> )	Non Preferred	PA
PROAIR RESPICLICK AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate</i> )	Non Preferred	PA
STRIVERDI RESPIMAT AEROSOL SOLUTION 2.5 MCG/ACT INHALATION ( <i>olodaterol hcl</i> )	Non Preferred	PA; QL (2 GM per 1 day)
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate</i> )	Non Preferred	PA; QL (18 GM per 30 days)
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION ( <i>albuterol sulfate</i> )	Non Preferred	PA; QL (8 GM per 30 days)
XOPENEX HFA AEROSOL 45 MCG/ACT INHALATION ( <i>levalbuterol tartrate</i> )	Non Preferred	PA (Eligible for auto-PA)
<b>*BRONCHODILATORS - ANTICHOLINERGICS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>ipratropium bromide solution 0.02 % inhalation</i>	Preferred	QL (10 ML per 1 day)
<i>tiotropium bromide monohydrate capsule 18 mcg inhalation</i>	Preferred	
ATROVENT HFA AEROSOL SOLUTION 17 MCG/ACT INHALATION ( <i>ipratropium bromide hfa</i> )	Preferred	QL (12.9 GM per 30 days)
INCRUSE ELLIPTA AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT INHALATION ( <i>umeclidinium bromide</i> )	Preferred	QL (1 EA per 1 day)
SPIRIVA HANDIHALER CAPSULE 18 MCG INHALATION ( <i>tiotropium bromide monohydrate</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25 MCG/ACT INHALATION ( <i>tiotropium bromide monohydrate</i> )	Preferred	AGE (Min 6 Years and Max 17 Years)
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5 MCG/ACT INHALATION ( <i>tiotropium bromide monohydrate</i> )	Preferred	
TUDORZA PRESSAIR AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT INHALATION ( <i>aclidinium bromide</i> )	Non Preferred	PA
YUPELRI SOLUTION 175 MCG/3ML INHALATION ( <i>revefenacin</i> )	Non Preferred	PA
<b>*INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA)*** - DRUGS FOR ASTHMA/COPD</b>		
FASENRA PEN SOLUTION AUTO-INJECTOR 30 MG/ML SUBCUTANEOUS ( <i>benralizumab</i> )	Preferred	PA
FASENRA SOLUTION PREFILLED SYRINGE 30 MG/ML SUBCUTANEOUS ( <i>benralizumab</i> )	Preferred	PA
NUCALA SOLUTION AUTO-INJECTOR 100 MG/ML SUBCUTANEOUS ( <i>mepolizumab</i> )	Preferred	PA
NUCALA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS ( <i>mepolizumab</i> )	Preferred	PA
NUCALA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS ( <i>mepolizumab</i> )	Preferred	PA
NUCALA SOLUTION RECONSTITUTED 100 MG SUBCUTANEOUS ( <i>mepolizumab</i> )	Preferred	PA
<b>*INTERLEUKIN-5 ANTAGONISTS (IGG4 KAPPA)*** - DRUGS FOR ASTHMA/COPD</b>		
CINQAIR SOLUTION 100 MG/10ML INTRAVENOUS ( <i>reslizumab</i> )	Non Preferred	PA
<b>*LEUKOTRIENE RECEPTOR ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>montelukast sodium packet 4 mg oral</i>	Preferred	Max 90-day supply per fill
<i>montelukast sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>montelukast sodium tablet chewable 4 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>montelukast sodium tablet chewable 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>zafirlukast tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>zafirlukast tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
ACCOLATE TABLET 10 MG ORAL ( <i>zafirlukast</i> )	Non Preferred	PA
ACCOLATE TABLET 20 MG ORAL ( <i>zafirlukast</i> )	Non Preferred	PA
SINGULAIR PACKET 4 MG ORAL ( <i>montelukast sodium</i> )	Non Preferred	PA
SINGULAIR TABLET 10 MG ORAL ( <i>montelukast sodium</i> )	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
SINGULAIR TABLET CHEWABLE 4 MG ORAL ( <i>montelukast sodium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SINGULAIR TABLET CHEWABLE 5 MG ORAL ( <i>montelukast sodium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>roflumilast tablet 250 mcg oral</i>	Non Preferred	PA
<i>roflumilast tablet 500 mcg oral</i>	Non Preferred	PA
DALIRESP TABLET 250 MCG ORAL ( <i>roflumilast</i> )	Non Preferred	PA
DALIRESP TABLET 500 MCG ORAL ( <i>roflumilast</i> )	Non Preferred	PA
<b>*STEROID INHALANTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>budesonide suspension 0.25 mg/2ml inhalation</i>	Preferred	QL (4 ML per 1 day); AGE (Max 7 Years)
<i>budesonide suspension 0.5 mg/2ml inhalation</i>	Preferred	QL (4 ML per 1 day); AGE (Max 7 Years)
<i>budesonide suspension 1 mg/2ml inhalation</i>	Preferred	AGE (Max 7 Years)
<i>fluticasone propionate hfa aerosol 110 mcg/act inhalation</i>	Preferred	PA; QL (0.4 GM per 1 day)
<i>fluticasone propionate hfa aerosol 220 mcg/act inhalation</i>	Preferred	PA
<i>fluticasone propionate hfa aerosol 44 mcg/act inhalation</i>	Preferred	PA; QL (0.354 GM per 1 day)
ASMANEX (120 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Preferred	
ASMANEX (14 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Preferred	
ASMANEX (30 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Preferred	
ASMANEX (30 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Preferred	
ASMANEX (60 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Preferred	
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION ( <i>fluticasone propionate (inhal)</i> )	Preferred	
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250 MCG/ACT INHALATION ( <i>fluticasone propionate (inhal)</i> )	Preferred	
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION ( <i>fluticasone propionate (inhal)</i> )	Preferred	
FLOVENT HFA AEROSOL 110 MCG/ACT INHALATION ( <i>fluticasone propionate hfa</i> )	Preferred	QL (0.4 GM per 1 day)
FLOVENT HFA AEROSOL 220 MCG/ACT INHALATION ( <i>fluticasone propionate hfa</i> )	Preferred	
FLOVENT HFA AEROSOL 44 MCG/ACT INHALATION ( <i>fluticasone propionate hfa</i> )	Preferred	QL (0.354 GM per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>fluticasone propionate diskus aerosol powder breath activated 100 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone propionate diskus aerosol powder breath activated 250 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone propionate diskus aerosol powder breath activated 50 mcg/act inhalation</i>	Non Preferred	PA
ALVESCO AEROSOL SOLUTION 160 MCG/ACT INHALATION ( <i>ciclesonide</i> )	Non Preferred	PA
ALVESCO AEROSOL SOLUTION 80 MCG/ACT INHALATION ( <i>ciclesonide</i> )	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 113 MCG/ACT INHALATION ( <i>fluticasone propionate(sensor)</i> )	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 232 MCG/ACT INHALATION ( <i>fluticasone propionate(sensor)</i> )	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 55 MCG/ACT INHALATION ( <i>fluticasone propionate(sensor)</i> )	Non Preferred	PA
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION ( <i>fluticasone furoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200 MCG/ACT INHALATION ( <i>fluticasone furoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION ( <i>fluticasone furoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ASMANEX HFA AEROSOL 100 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Non Preferred	PA
ASMANEX HFA AEROSOL 200 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Non Preferred	PA
ASMANEX HFA AEROSOL 50 MCG/ACT INHALATION ( <i>mometasone furoate</i> )	Non Preferred	PA
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT INHALATION ( <i>budesonide</i> )	Non Preferred	PA
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 90 MCG/ACT INHALATION ( <i>budesonide</i> )	Non Preferred	PA
PULMICORT SUSPENSION 0.25 MG/2ML INHALATION ( <i>budesonide</i> )	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 7 Years)
PULMICORT SUSPENSION 0.5 MG/2ML INHALATION ( <i>budesonide</i> )	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 7 Years)
PULMICORT SUSPENSION 1 MG/2ML INHALATION ( <i>budesonide</i> )	Non Preferred	PA; AGE (Max 7 Years)
QVAR REDIHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION ( <i>beclomethasone diprop hfa</i> )	Non Preferred	PA; QL (0.354 GM per 1 day)
QVAR REDIHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION ( <i>beclomethasone diprop hfa</i> )	Non Preferred	PA; QL (0.354 GM per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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Drug Name	Formulary Status	Requirements/Limits
<b>*THYMIC STROMAL LYMPHOPOIETIN (TSLP) ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD</b>		
TEZSPIRE SOLUTION AUTO-INJECTOR 210 MG/1.91ML SUBCUTANEOUS ( <i>tezepelumab-ekko</i> )	Non Preferred	PA
TEZSPIRE SOLUTION PREFILLED SYRINGE 210 MG/1.91ML SUBCUTANEOUS ( <i>tezepelumab-ekko</i> )	Non Preferred	PA
<b>*XANTHINES*** - DRUGS FOR ASTHMA/COPD</b>		
<i>theophylline elixir 80 mg/15ml oral</i>	Preferred	
<i>theophylline er tablet extended release 12 hour 100 mg oral</i>	Preferred	
<i>theophylline er tablet extended release 12 hour 200 mg oral</i>	Preferred	
<i>theophylline er tablet extended release 12 hour 300 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>theophylline er tablet extended release 12 hour 450 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>theophylline er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>theophylline er tablet extended release 24 hour 600 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>theophylline solution 80 mg/15ml oral</i>	Preferred	
THEO-24 CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>theophylline</i> )	Preferred	
THEO-24 CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>theophylline</i> )	Preferred	
THEO-24 CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>theophylline</i> )	Preferred	
THEO-24 CAPSULE EXTENDED RELEASE 24 HOUR 400 MG ORAL ( <i>theophylline</i> )	Preferred	
<b>*ANTICOAGULANTS* - DRUGS FOR THE BLOOD</b>		
<b>*COUMARIN ANTICOAGULANTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>warfarin sodium tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 2.5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 3 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 4 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 6 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium tablet 7.5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 1 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 10 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 2 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 2.5 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 3 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 4 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium (Jantoven Tablet 5 Mg Oral)</i>	Preferred	QL (10 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>warfarin sodium</i> (Jantoven Tablet 6 Mg Oral)	Preferred	QL (10 EA per 1 day)
<i>warfarin sodium</i> (Jantoven Tablet 7.5 Mg Oral)	Preferred	QL (10 EA per 1 day)
<b>*DIRECT FACTOR XA INHIBITORS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
ELIQUIS DVT/PE STARTER PACK TABLET THERAPY PACK 5 MG ORAL ( <i>apixaban</i> )	Preferred	PA
ELIQUIS TABLET 2.5 MG ORAL ( <i>apixaban</i> )	Preferred	PA
ELIQUIS TABLET 5 MG ORAL ( <i>apixaban</i> )	Preferred	PA
XARELTO STARTER PACK TABLET THERAPY PACK 15 & 20 MG ORAL ( <i>rivaroxaban</i> )	Preferred	PA
XARELTO TABLET 10 MG ORAL ( <i>rivaroxaban</i> )	Preferred	PA; QL (1 EA per 1 day)
XARELTO TABLET 15 MG ORAL ( <i>rivaroxaban</i> )	Preferred	PA; QL (2 EA per 1 day)
XARELTO TABLET 2.5 MG ORAL ( <i>rivaroxaban</i> )	Preferred	PA
XARELTO TABLET 20 MG ORAL ( <i>rivaroxaban</i> )	Preferred	PA; QL (1 EA per 1 day)
SAVAYSA TABLET 15 MG ORAL ( <i>edoxaban tosylate</i> )	Non Preferred	PA
SAVAYSA TABLET 30 MG ORAL ( <i>edoxaban tosylate</i> )	Non Preferred	PA
SAVAYSA TABLET 60 MG ORAL ( <i>edoxaban tosylate</i> )	Non Preferred	PA
XARELTO SUSPENSION RECONSTITUTED 1 MG/ML ORAL ( <i>rivaroxaban</i> )	Non Preferred	PA
<b>*HEPARINS AND HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>heparin sodium (porcine) pf solution 1000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) pf solution 5000 unit/0.5ml injection</i>	Preferred	
<i>heparin sodium (porcine) pf solution 5000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 1000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 10000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 20000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 5000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution prefilled syringe 5000 unit/0.5ml injection</i>	Preferred	
<b>*LOW MOLECULAR WEIGHT HEPARINS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>enoxaparin sodium solution 300 mg/3ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 100 mg/ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 120 mg/0.8ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 150 mg/ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 30 mg/0.3ml injection</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>enoxaparin sodium solution prefilled syringe 40 mg/0.4ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 60 mg/0.6ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 80 mg/0.8ml injection</i>	Preferred	
FRAGMIN SOLUTION 10000 UNIT/4ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION 95000 UNIT/3.8ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 10000 UNIT/ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 12500 UNIT/0.5ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 15000 UNIT/0.6ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 18000 UNT/0.72ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 5000 UNIT/0.2ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
FRAGMIN SOLUTION PREFILLED SYRINGE 7500 UNIT/0.3ML SUBCUTANEOUS ( <i>dalteparin sodium</i> )	Preferred	
LOVENOX SOLUTION 300 MG/3ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 100 MG/ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 120 MG/0.8ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 150 MG/ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 30 MG/0.3ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 40 MG/0.4ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 60 MG/0.6ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 80 MG/0.8ML INJECTION ( <i>enoxaparin sodium</i> )	Non Preferred	PA
<b>*SYNTHETIC HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>fondaparinux sodium solution 10 mg/0.8ml subcutaneous</i>	Preferred	
<i>fondaparinux sodium solution 2.5 mg/0.5ml subcutaneous</i>	Preferred	
<i>fondaparinux sodium solution 5 mg/0.4ml subcutaneous</i>	Preferred	
<i>fondaparinux sodium solution 7.5 mg/0.6ml subcutaneous</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ARIXTRA SOLUTION 10 MG/0.8ML SUBCUTANEOUS ( <i>fondaparinux sodium</i> )	Non Preferred	PA
ARIXTRA SOLUTION 2.5 MG/0.5ML SUBCUTANEOUS ( <i>fondaparinux sodium</i> )	Non Preferred	PA
ARIXTRA SOLUTION 5 MG/0.4ML SUBCUTANEOUS ( <i>fondaparinux sodium</i> )	Non Preferred	PA
ARIXTRA SOLUTION 7.5 MG/0.6ML SUBCUTANEOUS ( <i>fondaparinux sodium</i> )	Non Preferred	PA
<b>*THROMBIN INHIBITORS - SELECTIVE DIRECT &amp; REVERSIBLE*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>dabigatran etexilate mesylate capsule 150 mg oral</i>	Non Preferred	PA
<i>dabigatran etexilate mesylate capsule 75 mg oral</i>	Non Preferred	PA
PRADAXA CAPSULE 110 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA CAPSULE 150 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA CAPSULE 75 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 110 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 150 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 20 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 30 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 40 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
PRADAXA PACKET 50 MG ORAL ( <i>dabigatran etexilate mesylate</i> )	Non Preferred	PA
<b>*ANTICONVULSANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*AMPA GLUTAMATE RECEPTOR ANTAGONISTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
FYCOMPA SUSPENSION 0.5 MG/ML ORAL ( <i>perampanel</i> )	Non Preferred	PA
FYCOMPA TABLET 10 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA
FYCOMPA TABLET 12 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA
FYCOMPA TABLET 2 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
FYCOMPA TABLET 4 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA
FYCOMPA TABLET 6 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA
FYCOMPA TABLET 8 MG ORAL ( <i>perampanel</i> )	Non Preferred	PA
<b>*ANTICONVULSANTS - BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>clonazepam tablet 0.5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>clonazepam tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>clonazepam tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>diazepam gel 10 mg rectal</i>	Preferred	QL (0.2 EA per 1 day)
<i>diazepam gel 2.5 mg rectal</i>	Preferred	QL (0.2 EA per 1 day)
<i>diazepam gel 20 mg rectal</i>	Preferred	QL (0.2 EA per 1 day)
DIASTAT ACUDIAL GEL 10 MG RECTAL ( <i>diazepam</i> )	Preferred	QL (0.2 EA per 1 day)
<i>clobazam suspension 2.5 mg/ml oral</i>	Non Preferred	PA
<i>clobazam tablet 10 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>clobazam tablet 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>clonazepam tablet dispersible 0.125 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 0.25 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 0.5 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 1 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 2 mg oral</i>	Non Preferred	PA
KLONOPIN TABLET 0.5 MG ORAL ( <i>clonazepam</i> )	Non Preferred	PA; QL (10 EA per 1 day)
KLONOPIN TABLET 1 MG ORAL ( <i>clonazepam</i> )	Non Preferred	PA; QL (10 EA per 1 day)
KLONOPIN TABLET 2 MG ORAL ( <i>clonazepam</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NAYZILAM SOLUTION 5 MG/0.1ML NASAL ( <i>midazolam (anticonvulsant)</i> )	Non Preferred	PA
ONFI SUSPENSION 2.5 MG/ML ORAL ( <i>clobazam</i> )	Non Preferred	PA
ONFI TABLET 10 MG ORAL ( <i>clobazam</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ONFI TABLET 20 MG ORAL ( <i>clobazam</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
SYMPAZAN FILM 10 MG ORAL ( <i>clobazam</i> )	Non Preferred	PA
SYMPAZAN FILM 20 MG ORAL ( <i>clobazam</i> )	Non Preferred	PA
SYMPAZAN FILM 5 MG ORAL ( <i>clobazam</i> )	Non Preferred	PA
VALTOCO 10 MG DOSE LIQUID 10 MG/0.1ML NASAL ( <i>diazepam</i> )	Non Preferred	PA; QL (10 EA per 30 days)
VALTOCO 15 MG DOSE LIQUID THERAPY PACK 7.5 MG/0.1ML NASAL ( <i>diazepam</i> )	Non Preferred	PA; QL (10 EA per 30 days)
VALTOCO 20 MG DOSE LIQUID THERAPY PACK 10 MG/0.1ML NASAL ( <i>diazepam</i> )	Non Preferred	PA; QL (10 EA per 28 days)
VALTOCO 5 MG DOSE LIQUID 5 MG/0.1ML NASAL ( <i>diazepam</i> )	Non Preferred	PA; QL (10 EA per 30 days)
<b>*ANTICONVULSANTS - MISC.*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine suspension 100 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
<i>carbamazepine tablet 200 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine tablet chewable 100 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>gabapentin capsule 100 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>gabapentin capsule 300 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>gabapentin capsule 400 mg oral</i>	Preferred	QL (9 EA per 1 day); Max 90-day supply per fill
<i>gabapentin solution 250 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>gabapentin solution 300 mg/6ml oral</i>	Preferred	Max 90-day supply per fill
<i>gabapentin tablet 600 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>gabapentin tablet 800 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine tablet 100 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine tablet 150 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>lamotrigine tablet 25 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine tablet chewable 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine tablet chewable 5 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam solution 100 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>levetiracetam tablet 1000 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam tablet 250 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam tablet 750 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>oxcarbazepine suspension 300 mg/5ml oral</i>	Preferred	QL (16.667 ML per 1 day); Max 90-day supply per fill
<i>oxcarbazepine tablet 150 mg oral</i>	Preferred	QL (16 EA per 1 day); Max 90-day supply per fill
<i>oxcarbazepine tablet 300 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>oxcarbazepine tablet 600 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 150 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 200 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 225 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 50 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>pregabalin capsule 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pregabalin solution 20 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>primidone tablet 125 mg oral</i>	Preferred	Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>primidone tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>primidone tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>topiramate capsule sprinkle 15 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>topiramate capsule sprinkle 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>topiramate tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>topiramate tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>topiramate tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>topiramate tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>zonisamide capsule 100 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>zonisamide capsule 25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>zonisamide capsule 50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine (Epilex Tablet 200 Mg Oral)</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>levetiracetam (Roweepra Tablet 500 Mg Oral)</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine (Subvenite Tablet 100 Mg Oral)</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine (Subvenite Tablet 150 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine (Subvenite Tablet 200 Mg Oral)</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine (Subvenite Tablet 25 Mg Oral)</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine er capsule extended release 12 hour 100 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine er capsule extended release 12 hour 200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbamazepine er capsule extended release 12 hour 300 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>lacosamide solution 10 mg/ml oral</i>	Non Preferred	PA (Eligible for auto-PA); QL (40 ML per 1 day); Max 90-day supply per fill
<i>lacosamide solution 10 mg/ml oral</i>	Non Preferred	PA; QL (40 ML per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>lacosamide tablet 100 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>lacosamide tablet 150 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>lacosamide tablet 200 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>lacosamide tablet 50 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 250 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 300 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine kit 21 x 25 mg &amp; 7 x 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine kit 25 &amp; 50 &amp; 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine kit 42 x 50 mg &amp; 14x100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine starter kit-blue kit 35 x 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine starter kit-green kit 84 x 25 mg &amp; 14x100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine starter kit-orange kit 42 x 25 mg &amp; 7 x 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine tablet dispersible 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine tablet dispersible 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine tablet dispersible 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine tablet dispersible 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>rufinamide suspension 40 mg/ml oral</i>	Non Preferred	PA; QL (80 ML per 1 day); Max 90-day supply per fill
<i>rufinamide tablet 200 mg oral</i>	Non Preferred	PA (Eligible for auto-PA); QL (16 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>rufinamide tablet 200 mg oral</i>	Non Preferred	PA; QL (16 EA per 1 day); Max 90-day supply per fill
<i>rufinamide tablet 400 mg oral</i>	Non Preferred	PA (Eligible for auto-PA); QL (8 EA per 1 day); Max 90-day supply per fill
<i>rufinamide tablet 400 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule extended release 24 hour 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate er capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
APTIO <sup>M</sup> TABLET 200 MG ORAL ( <i>eslicarbazepine acetate</i> )	Non Preferred	PA
APTIO <sup>M</sup> TABLET 400 MG ORAL ( <i>eslicarbazepine acetate</i> )	Non Preferred	PA
APTIO <sup>M</sup> TABLET 600 MG ORAL ( <i>eslicarbazepine acetate</i> )	Non Preferred	PA
APTIO <sup>M</sup> TABLET 800 MG ORAL ( <i>eslicarbazepine acetate</i> )	Non Preferred	PA
BANZEL SUSPENSION 40 MG/ML ORAL ( <i>rufinamide</i> )	Non Preferred	PA; QL (80 ML per 1 day)
BANZEL TABLET 200 MG ORAL ( <i>rufinamide</i> )	Non Preferred	PA; QL (16 EA per 1 day)
BANZEL TABLET 400 MG ORAL ( <i>rufinamide</i> )	Non Preferred	PA; QL (8 EA per 1 day)
BRIVIACT SOLUTION 10 MG/ML ORAL ( <i>brivaracetam</i> )	Non Preferred	PA
BRIVIACT TABLET 10 MG ORAL ( <i>brivaracetam</i> )	Non Preferred	PA
BRIVIACT TABLET 100 MG ORAL ( <i>brivaracetam</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
BRIVIACT TABLET 25 MG ORAL ( <i>brivaracetam</i> )	Non Preferred	PA
BRIVIACT TABLET 50 MG ORAL ( <i>brivaracetam</i> )	Non Preferred	PA
BRIVIACT TABLET 75 MG ORAL ( <i>brivaracetam</i> )	Non Preferred	PA
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
DIACOMIT CAPSULE 250 MG ORAL ( <i>stiripentol</i> )	Non Preferred	PA
DIACOMIT CAPSULE 500 MG ORAL ( <i>stiripentol</i> )	Non Preferred	PA
DIACOMIT PACKET 250 MG ORAL ( <i>stiripentol</i> )	Non Preferred	PA
DIACOMIT PACKET 500 MG ORAL ( <i>stiripentol</i> )	Non Preferred	PA
ELEPSIA XR TABLET EXTENDED RELEASE 24 HOUR 1000 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
ELEPSIA XR TABLET EXTENDED RELEASE 24 HOUR 1500 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
EPIDIOLEX SOLUTION 100 MG/ML ORAL ( <i>cannabidiol</i> )	Non Preferred	PA
EPRONTIA SOLUTION 25 MG/ML ORAL ( <i>topiramate</i> )	Non Preferred	PA
FINTEPLA SOLUTION 2.2 MG/ML ORAL ( <i>fenfluramine hcl</i> )	Non Preferred	PA
KEPPRA SOLUTION 100 MG/ML ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (30 ML per 1 day)
KEPPRA TABLET 1000 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (3 EA per 1 day)
KEPPRA TABLET 250 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (6 EA per 1 day)
KEPPRA TABLET 500 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (6 EA per 1 day)
KEPPRA TABLET 750 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (4 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (6 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA; QL (4 EA per 1 day)
LAMICTAL ODT KIT 21 X 25 MG & 7 X 50 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LAMICTAL ODT KIT 25 & 50 & 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL ODT KIT 42 X 50 MG & 14X100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL ODT TABLET DISPERSIBLE 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL ODT TABLET DISPERSIBLE 200 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL ODT TABLET DISPERSIBLE 25 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL ODT TABLET DISPERSIBLE 50 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL STARTER KIT 35 X 25 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL STARTER KIT 42 X 25 MG & 7 X 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL STARTER KIT 84 X 25 MG & 14X100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL TABLET 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
LAMICTAL TABLET 150 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (4 EA per 1 day)
LAMICTAL TABLET 200 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (4 EA per 1 day)
LAMICTAL TABLET 25 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (10 EA per 1 day)
LAMICTAL TABLET CHEWABLE 25 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
LAMICTAL TABLET CHEWABLE 5 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
LAMICTAL XR KIT 21 X 25 MG & 7 X 50 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR KIT 25 & 50 & 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR KIT 50 & 100 & 200 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 250 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>lamotrigine</i> )	Non Preferred	PA
LYRICA CAPSULE 100 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LYRICA CAPSULE 150 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (4 EA per 1 day)
LYRICA CAPSULE 200 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LYRICA CAPSULE 225 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (2 EA per 1 day)
LYRICA CAPSULE 25 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LYRICA CAPSULE 300 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (2 EA per 1 day)
LYRICA CAPSULE 50 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA; QL (6 EA per 1 day)
LYRICA CAPSULE 75 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA
LYRICA SOLUTION 20 MG/ML ORAL ( <i>pregabalin</i> )	Non Preferred	PA
MOTPOLY XR CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA (Eligible for auto-PA)
MOTPOLY XR CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA (Eligible for auto-PA)
MOTPOLY XR CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA (Eligible for auto-PA)
MYSOLINE TABLET 250 MG ORAL ( <i>primidone</i> )	Non Preferred	PA; QL (4 EA per 1 day)
MYSOLINE TABLET 50 MG ORAL ( <i>primidone</i> )	Non Preferred	PA; QL (4 EA per 1 day)
NEURONTIN CAPSULE 100 MG ORAL ( <i>gabapentin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NEURONTIN CAPSULE 300 MG ORAL ( <i>gabapentin</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NEURONTIN CAPSULE 400 MG ORAL ( <i>gabapentin</i> )	Non Preferred	PA; QL (9 EA per 1 day)
NEURONTIN SOLUTION 250 MG/5ML ORAL ( <i>gabapentin</i> )	Non Preferred	PA
NEURONTIN TABLET 600 MG ORAL ( <i>gabapentin</i> )	Non Preferred	PA; QL (6 EA per 1 day)
NEURONTIN TABLET 800 MG ORAL ( <i>gabapentin</i> )	Non Preferred	PA; QL (4 EA per 1 day)
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 600 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 100 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 150 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 200 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 25 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 50 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL ( <i>levetiracetam</i> )	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Blue Kit 35 X 25 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine</i> (Subvenite Starter Kit-Green Kit 84 X 25 Mg & 14X100 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine</i> (Subvenite Starter Kit-Orange Kit 42 X 25 Mg & 7 X 100 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
TEGRETOL SUSPENSION 100 MG/5ML ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (60 ML per 1 day)
TEGRETOL TABLET 200 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL ( <i>carbamazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TOPAMAX SPRINKLE CAPSULE SPRINKLE 15 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TOPAMAX SPRINKLE CAPSULE SPRINKLE 25 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TOPAMAX TABLET 100 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TOPAMAX TABLET 200 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TOPAMAX TABLET 25 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
TOPAMAX TABLET 50 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TRILEPTAL SUSPENSION 300 MG/5ML ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA; QL (16.667 ML per 1 day)
TRILEPTAL TABLET 150 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA; QL (16 EA per 1 day)
TRILEPTAL TABLET 300 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
TRILEPTAL TABLET 600 MG ORAL ( <i>oxcarbazepine</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>topiramate</i> )	Non Preferred	PA
VIMPAT SOLUTION 10 MG/ML ORAL ( <i>lacosamide</i> )	Non Preferred	PA; QL (40 ML per 1 day)
VIMPAT TABLET 100 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VIMPAT TABLET 150 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VIMPAT TABLET 200 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VIMPAT TABLET 50 MG ORAL ( <i>lacosamide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZONISADE SUSPENSION 100 MG/5ML ORAL ( <i>zonisamide</i> )	Non Preferred	PA
ZTALMY SUSPENSION 50 MG/ML ORAL ( <i>ganaxolone</i> )	Non Preferred	PA
<b>*CARBAMATES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET 100 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET 150 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET 200 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET 50 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL ( <i>cenobamate</i> )	Preferred	
XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL ( <i>cenobamate</i> )	Preferred	

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL ( <i>cenobamate</i> )	Preferred	
<i>felbamate suspension 600 mg/5ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>felbamate tablet 400 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>felbamate tablet 600 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
FELBATOL SUSPENSION 600 MG/5ML ORAL ( <i>felbamate</i> )	Non Preferred	PA
FELBATOL TABLET 400 MG ORAL ( <i>felbamate</i> )	Non Preferred	PA
FELBATOL TABLET 600 MG ORAL ( <i>felbamate</i> )	Non Preferred	PA
<b>*GABA MODULATORS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>tiagabine hcl tablet 12 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tiagabine hcl tablet 16 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tiagabine hcl tablet 2 mg oral</i>	Non Preferred	PA; QL (28 EA per 1 day); Max 90-day supply per fill
<i>tiagabine hcl tablet 4 mg oral</i>	Non Preferred	PA; QL (14 EA per 1 day); Max 90-day supply per fill
<i>vigabatrin packet 500 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
<i>vigabatrin tablet 500 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
GABITRIL TABLET 12 MG ORAL ( <i>tiagabine hcl</i> )	Non Preferred	PA
GABITRIL TABLET 16 MG ORAL ( <i>tiagabine hcl</i> )	Non Preferred	PA
GABITRIL TABLET 2 MG ORAL ( <i>tiagabine hcl</i> )	Non Preferred	PA; QL (28 EA per 1 day)
GABITRIL TABLET 4 MG ORAL ( <i>tiagabine hcl</i> )	Non Preferred	PA; QL (14 EA per 1 day)
SABRIL PACKET 500 MG ORAL ( <i>vigabatrin</i> )	Non Preferred	PA; QL (6 EA per 1 day)
SABRIL TABLET 500 MG ORAL ( <i>vigabatrin</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<i>vigabatrin (Vigadrone Packet 500 Mg Oral)</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
<i>vigabatrin (Vigadrone Tablet 500 Mg Oral)</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*HYDANTOINS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>phenytoin sodium extended capsule 100 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>phenytoin sodium extended capsule 200 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>phenytoin sodium extended capsule 300 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>phenytoin suspension 100 mg/4ml oral</i>	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
<i>phenytoin suspension 125 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
<i>phenytoin tablet chewable 50 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>phenytoin sodium extended (Phenytek Capsule 200 Mg Oral)</i>	Preferred	QL (6 EA per 1 day)
<i>phenytoin sodium extended (Phenytek Capsule 300 Mg Oral)</i>	Preferred	QL (6 EA per 1 day)
<i>phenytoin (Phenytoin Infatabs Tablet Chewable 50 Mg Oral)</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
DILANTIN CAPSULE 100 MG ORAL ( <i>phenytoin sodium extended</i> )	Non Preferred	PA; QL (6 EA per 1 day)
DILANTIN CAPSULE 30 MG ORAL ( <i>phenytoin sodium extended</i> )	Non Preferred	PA; QL (6 EA per 1 day)
DILANTIN INFATABS TABLET CHEWABLE 50 MG ORAL ( <i>phenytoin</i> )	Non Preferred	PA; QL (5 EA per 1 day)
DILANTIN SUSPENSION 125 MG/5ML ORAL ( <i>phenytoin</i> )	Non Preferred	PA; QL (20 ML per 1 day)
<b>*SUCCINIMIDES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>ethosuximide capsule 250 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>ethosuximide solution 250 mg/5ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>methsuximide capsule 300 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CELONTIN CAPSULE 300 MG ORAL ( <i>methsuximide</i> )	Non Preferred	PA
ZARONTIN CAPSULE 250 MG ORAL ( <i>ethosuximide</i> )	Non Preferred	PA; QL (6 EA per 1 day)
ZARONTIN SOLUTION 250 MG/5ML ORAL ( <i>ethosuximide</i> )	Non Preferred	PA; QL (30 ML per 1 day)
<b>*VALPROIC ACID*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>divalproex sodium capsule delayed release sprinkle 125 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>divalproex sodium er tablet extended release 24 hour 250 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>divalproex sodium er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 125 mg oral</i>	Preferred	QL (15 EA per 1 day); Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 250 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 500 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>valproic acid capsule 250 mg oral</i>	Preferred	QL (20 EA per 1 day); Max 90-day supply per fill
<i>valproic acid solution 250 mg/5ml oral</i>	Preferred	QL (100 ML per 1 day); Max 90-day supply per fill
DEPAKOTE ER TABLET EXTENDED RELEASE 24 HOUR 250 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (10 EA per 1 day)
DEPAKOTE ER TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (10 EA per 1 day)
DEPAKOTE SPRINKLES CAPSULE DELAYED RELEASE SPRINKLE 125 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (10 EA per 1 day)
DEPAKOTE TABLET DELAYED RELEASE 125 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (15 EA per 1 day)
DEPAKOTE TABLET DELAYED RELEASE 250 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (10 EA per 1 day)
DEPAKOTE TABLET DELAYED RELEASE 500 MG ORAL ( <i>divalproex sodium</i> )	Non Preferred	PA; QL (10 EA per 1 day)
<b>*ANTIDEPRESSANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)** - DRUGS FOR DEPRESSION</b>		
<i>mirtazapine tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>mirtazapine tablet 30 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>mirtazapine tablet 45 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>mirtazapine tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 45 mg oral</i>	Preferred	Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 15 MG ORAL ( <i>mirtazapine</i> )	Non Preferred	PA
REMERON SOLTAB TABLET DISPERSIBLE 30 MG ORAL ( <i>mirtazapine</i> )	Non Preferred	PA
REMERON SOLTAB TABLET DISPERSIBLE 45 MG ORAL ( <i>mirtazapine</i> )	Non Preferred	PA
REMERON TABLET 15 MG ORAL ( <i>mirtazapine</i> )	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
REMERON TABLET 30 MG ORAL ( <i>mirtazapine</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*ANTIDEPRESSANT - MISCELLANEOUS COMBINATIONS*** - DRUGS FOR DEPRESSION</b>		
AUVELITY TABLET EXTENDED RELEASE 45-105 MG ORAL ( <i>dextromethorphan-bupropion</i> )	Non Preferred	PA
<b>*ANTIDEPRESSANTS - MISC.*** - DRUGS FOR DEPRESSION</b>		
<i>bupropion hcl er (sr) tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl er (sr) tablet extended release 12 hour 150 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl er (sr) tablet extended release 12 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bupropion hcl tablet 75 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL ( <i>bupropion hbr</i> )	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL ( <i>bupropion hbr</i> )	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL ( <i>bupropion hbr</i> )	Non Preferred	PA
FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 150 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>bupropion hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID*** - DRUGS FOR DEPRESSION</b>		
ZURZUVAE CAPSULE 20 MG ORAL ( <i>zuranolone</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ZURZUVAE CAPSULE 25 MG ORAL ( <i>zuranolone</i> )	Non Preferred	PA
ZURZUVAE CAPSULE 30 MG ORAL ( <i>zuranolone</i> )	Non Preferred	PA
<b>*MONOAMINE OXIDASE INHIBITORS (MAOIS)*** - DRUGS FOR DEPRESSION</b>		
<i>phenelzine sulfate tablet 15 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>tranylcypromine sulfate tablet 10 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
EMSAM PATCH 24 HOUR 12 MG/24HR TRANSDERMAL ( <i>selegiline</i> )	Non Preferred	PA
EMSAM PATCH 24 HOUR 6 MG/24HR TRANSDERMAL ( <i>selegiline</i> )	Non Preferred	PA
EMSAM PATCH 24 HOUR 9 MG/24HR TRANSDERMAL ( <i>selegiline</i> )	Non Preferred	PA
MARPLAN TABLET 10 MG ORAL ( <i>isocarboxazid</i> )	Non Preferred	PA
NARDIL TABLET 15 MG ORAL ( <i>phenelzine sulfate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR DEPRESSION</b>		
SPRAVATO (56 MG DOSE) SOLUTION THERAPY PACK 28 MG/DEVICE NASAL ( <i>esketamine hcl</i> )	Non Preferred	PA
SPRAVATO (84 MG DOSE) SOLUTION THERAPY PACK 28 MG/DEVICE NASAL ( <i>esketamine hcl</i> )	Non Preferred	PA
<b>*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)*** - DRUGS FOR DEPRESSION</b>		
<i>citalopram hydrobromide solution 10 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
<i>citalopram hydrobromide tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>citalopram hydrobromide tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>citalopram hydrobromide tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>escitalopram oxalate solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>escitalopram oxalate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>escitalopram oxalate tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>escitalopram oxalate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fluoxetine hcl capsule 10 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>fluoxetine hcl capsule 20 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>fluoxetine hcl capsule 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl solution 20 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl tablet 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluvoxamine maleate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>fluvoxamine maleate tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>fluvoxamine maleate tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>paroxetine hcl suspension 10 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>paroxetine hcl tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>paroxetine hcl tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>paroxetine hcl tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>paroxetine hcl tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sertraline hcl concentrate 20 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>sertraline hcl tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sertraline hcl tablet 25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>sertraline hcl tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>citalopram hydrobromide capsule 30 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluoxetine hcl capsule delayed release 90 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluvoxamine maleate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluvoxamine maleate er capsule extended release 24 hour 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>paroxetine hcl er tablet extended release 24 hour 12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>paroxetine hcl er tablet extended release 24 hour 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>paroxetine hcl er tablet extended release 24 hour 37.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>sertraline hcl capsule 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>sertraline hcl capsule 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CELEXA TABLET 10 MG ORAL ( <i>citalopram hydrobromide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CELEXA TABLET 20 MG ORAL ( <i>citalopram hydrobromide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CELEXA TABLET 40 MG ORAL ( <i>citalopram hydrobromide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
LEXAPRO TABLET 10 MG ORAL ( <i>escitalopram oxalate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LEXAPRO TABLET 20 MG ORAL ( <i>escitalopram oxalate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LEXAPRO TABLET 5 MG ORAL ( <i>escitalopram oxalate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 12.5 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 37.5 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA
PAXIL SUSPENSION 10 MG/5ML ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA
PAXIL TABLET 10 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PAXIL TABLET 20 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PAXIL TABLET 30 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PAXIL TABLET 40 MG ORAL ( <i>paroxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PEXEVA TABLET 10 MG ORAL ( <i>paroxetine mesylate</i> )	Non Preferred	PA
PEXEVA TABLET 20 MG ORAL ( <i>paroxetine mesylate</i> )	Non Preferred	PA
PEXEVA TABLET 30 MG ORAL ( <i>paroxetine mesylate</i> )	Non Preferred	PA
PEXEVA TABLET 40 MG ORAL ( <i>paroxetine mesylate</i> )	Non Preferred	PA
PROZAC CAPSULE 10 MG ORAL ( <i>fluoxetine hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
PROZAC CAPSULE 20 MG ORAL ( <i>fluoxetine hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
PROZAC CAPSULE 40 MG ORAL ( <i>fluoxetine hcl</i> )	Non Preferred	PA
ZOLOFT CONCENTRATE 20 MG/ML ORAL ( <i>sertraline hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ZOLOFT TABLET 100 MG ORAL ( <i>sertraline hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZOLOFT TABLET 25 MG ORAL ( <i>sertraline hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZOLOFT TABLET 50 MG ORAL ( <i>sertraline hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*SEROTONIN MODULATORS*** - DRUGS FOR DEPRESSION</b>		
<i>trazodone hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trazodone hcl tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trazodone hcl tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trazodone hcl tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nefazodone hcl tablet 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nefazodone hcl tablet 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nefazodone hcl tablet 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nefazodone hcl tablet 250 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nefazodone hcl tablet 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>vilazodone hcl tablet 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>vilazodone hcl tablet 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>vilazodone hcl tablet 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
TRINTELLIX TABLET 10 MG ORAL ( <i>vortioxetine hbr</i> )	Non Preferred	PA
TRINTELLIX TABLET 20 MG ORAL ( <i>vortioxetine hbr</i> )	Non Preferred	PA
TRINTELLIX TABLET 5 MG ORAL ( <i>vortioxetine hbr</i> )	Non Preferred	PA
VIIBRYD TABLET 10 MG ORAL ( <i>vilazodone hcl</i> )	Non Preferred	PA
VIIBRYD TABLET 20 MG ORAL ( <i>vilazodone hcl</i> )	Non Preferred	PA
VIIBRYD TABLET 40 MG ORAL ( <i>vilazodone hcl</i> )	Non Preferred	PA
<b>*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)*** - DRUGS FOR DEPRESSION</b>		
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine besylate er tablet extended release 24 hour 112.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl er capsule extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl er capsule extended release 24 hour 37.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl er capsule extended release 24 hour 75 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl tablet 37.5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl tablet 75 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>desvenlafaxine er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine er tablet extended release 24 hour 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>venlafaxine hcl er tablet extended release 24 hour 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>venlafaxine hcl er tablet extended release 24 hour 225 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>venlafaxine hcl er tablet extended release 24 hour 37.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>venlafaxine hcl er tablet extended release 24 hour 75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 40 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 60 MG ORAL ( <i>duloxetine hcl</i> )	Non Preferred	PA
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>venlafaxine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG ORAL ( <i>venlafaxine hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 75 MG ORAL ( <i>venlafaxine hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>levomilnacipran hcl</i> )	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>levomilnacipran hcl</i> )	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>levomilnacipran hcl</i> )	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>levomilnacipran hcl</i> )	Non Preferred	PA
FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL ( <i>levomilnacipran hcl</i> )	Non Preferred	PA
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>desvenlafaxine succinate</i> )	Non Preferred	PA
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>desvenlafaxine succinate</i> )	Non Preferred	PA
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>desvenlafaxine succinate</i> )	Non Preferred	PA
<b>*TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION</b>		
<i>amitriptyline hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>amitriptyline hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>amitriptyline hcl tablet 150 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>amitriptyline hcl tablet 25 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>amitriptyline hcl tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>amitriptyline hcl tablet 75 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>clomipramine hcl capsule 25 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>clomipramine hcl capsule 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>clomipramine hcl capsule 75 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 50 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>desipramine hcl tablet 75 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 10 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl capsule 75 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>doxepin hcl concentrate 10 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>imipramine hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>imipramine hcl tablet 25 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>imipramine hcl tablet 50 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>nortriptyline hcl capsule 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>nortriptyline hcl capsule 25 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>nortriptyline hcl capsule 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>nortriptyline hcl capsule 75 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nortriptyline hcl solution 10 mg/5ml oral</i>	Preferred	Max 90-day supply per fill

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>protriptyline hcl tablet 10 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>protriptyline hcl tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>amoxapine tablet 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>imipramine pamoate capsule 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>imipramine pamoate capsule 125 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>imipramine pamoate capsule 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>imipramine pamoate capsule 75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>trimipramine maleate capsule 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>trimipramine maleate capsule 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>trimipramine maleate capsule 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ANAFRANIL CAPSULE 25 MG ORAL ( <i>clomipramine hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
ANAFRANIL CAPSULE 50 MG ORAL ( <i>clomipramine hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ANAFRANIL CAPSULE 75 MG ORAL ( <i>clomipramine hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
NORPRAMIN TABLET 10 MG ORAL ( <i>desipramine hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
NORPRAMIN TABLET 25 MG ORAL ( <i>desipramine hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
PAMELOR CAPSULE 10 MG ORAL ( <i>nortriptyline hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
PAMELOR CAPSULE 25 MG ORAL ( <i>nortriptyline hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
PAMELOR CAPSULE 50 MG ORAL ( <i>nortriptyline hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
PAMELOR CAPSULE 75 MG ORAL ( <i>nortriptyline hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIDIABETICS* - HORMONES</b>		
<b>*ALPHA-GLUCOSIDASE INHIBITORS*** - DRUGS FOR DIABETES</b>		
<i>acarbose tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>acarbose tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>acarbose tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>miglitol tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>miglitol tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>miglitol tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<b>*ANTIDIABETIC - AMYLIN ANALOGS*** - DRUGS FOR DIABETES</b>		
SYMLINPEN 120 SOLUTION PEN-INJECTOR 2700 MCG/2.7ML SUBCUTANEOUS ( <i>pramlintide acetate</i> )	Non Preferred	PA
SYMLINPEN 60 SOLUTION PEN-INJECTOR 1500 MCG/1.5ML SUBCUTANEOUS ( <i>pramlintide acetate</i> )	Non Preferred	PA
<b>*BIGUANIDES*** - DRUGS FOR DIABETES</b>		
<i>metformin hcl er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>metformin hcl er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>metformin hcl tablet 1000 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>metformin hcl tablet 500 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>metformin hcl tablet 850 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metformin hcl er (mod) tablet extended release 24 hour 1000 mg oral</i>	Non Preferred	Max 90-day supply per fill
<i>metformin hcl er (mod) tablet extended release 24 hour 1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>metformin hcl er (mod) tablet extended release 24 hour 500 mg oral</i>	Non Preferred	Max 90-day supply per fill
<i>metformin hcl er (mod) tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>metformin hcl er (osm) tablet extended release 24 hour 1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>metformin hcl er (osm) tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>metformin hcl solution 500 mg/5ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>metformin hcl tablet 625 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 1000 MG ORAL ( <i>metformin hcl</i> )	Non Preferred	PA
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL ( <i>metformin hcl</i> )	Non Preferred	PA
RIOMET ER SUSPENSION RECONSTITUTED ER 500 MG/5ML ORAL ( <i>metformin hcl</i> )	Non Preferred	PA
<b>*DIABETIC OTHER - COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>sm glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<b>*DIABETIC OTHER*** - DRUGS FOR DIABETES</b>		
<i>diazoxide suspension 50 mg/ml oral</i>	Preferred	
BAQSIMI ONE PACK POWDER 3 MG/DOSE NASAL ( <i>glucagon</i> )	Preferred	QL (2 EA per 30 days)
BAQSIMI TWO PACK POWDER 3 MG/DOSE NASAL ( <i>glucagon</i> )	Preferred	QL (2 EA per 30 days)
GVOKE HYPOPEN 1-PACK SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
GVOKE HYPOPEN 1-PACK SOLUTION AUTO-INJECTOR 1 MG/0.2ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
GVOKE HYPOPEN 2-PACK SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
GVOKE HYPOPEN 2-PACK SOLUTION AUTO-INJECTOR 1 MG/0.2ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
GVOKE KIT SOLUTION 1 MG/0.2ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
GVOKE PFS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML SUBCUTANEOUS ( <i>glucagon</i> )	Preferred	
PROGLYCEM SUSPENSION 50 MG/ML ORAL ( <i>diazoxide</i> )	Preferred	
ZEGALOGUE SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML SUBCUTANEOUS ( <i>dasiglucagon hcl</i> )	Preferred	
ZEGALOGUE SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML SUBCUTANEOUS ( <i>dasiglucagon hcl</i> )	Preferred	
<i>glucagon emergency kit 1 mg injection</i>	Non Preferred	PA; QL (2 EA per 30 days)
<i>glucagon emergency solution reconstituted 1 mg/ml injection</i>	Non Preferred	PA
GLUCAGEN HYPOKIT SOLUTION RECONSTITUTED 1 MG INJECTION ( <i>glucagon hcl (rdna)</i> )	Non Preferred	PA; QL (2 EA per 30 days)
<b>*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** - DRUGS FOR DIABETES</b>		
JANUVIA TABLET 100 MG ORAL ( <i>sitagliptin phosphate</i> )	Preferred	
JANUVIA TABLET 25 MG ORAL ( <i>sitagliptin phosphate</i> )	Preferred	
JANUVIA TABLET 50 MG ORAL ( <i>sitagliptin phosphate</i> )	Preferred	
TRADJENTA TABLET 5 MG ORAL ( <i>linagliptin</i> )	Preferred	
<i>alogliptin benzoate tablet 12.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>alogliptin benzoate tablet 25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>alogliptin benzoate tablet 6.25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>saxagliptin hcl tablet 2.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>saxagliptin hcl tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>zituvio tablet 100 mg oral</i>	Non Preferred	PA
<i>zituvio tablet 25 mg oral</i>	Non Preferred	PA
<i>zituvio tablet 50 mg oral</i>	Non Preferred	PA
NESINA TABLET 12.5 MG ORAL ( <i>alogliptin benzoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NESINA TABLET 25 MG ORAL ( <i>alogliptin benzoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NESINA TABLET 6.25 MG ORAL ( <i>alogliptin benzoate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ONGLYZA TABLET 2.5 MG ORAL ( <i>saxagliptin hcl</i> )	Non Preferred	PA
ONGLYZA TABLET 5 MG ORAL ( <i>saxagliptin hcl</i> )	Non Preferred	PA
<b>*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>alogliptin-metformin hcl tablet 12.5-1000 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>alogliptin-metformin hcl tablet 12.5-500 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>saxagliptin-metformin er tablet extended release 24 hour 2.5-1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>saxagliptin-metformin er tablet extended release 24 hour 5-1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>saxagliptin-metformin er tablet extended release 24 hour 5-500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
JANUMET TABLET 50-1000 MG ORAL ( <i>sitagliptin-metformin hcl</i> )	Non Preferred	PA
JANUMET TABLET 50-500 MG ORAL ( <i>sitagliptin-metformin hcl</i> )	Non Preferred	PA
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL ( <i>sitagliptin-metformin hcl</i> )	Non Preferred	PA
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL ( <i>sitagliptin-metformin hcl</i> )	Non Preferred	PA
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL ( <i>sitagliptin-metformin hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
JENTADUETO TABLET 2.5-1000 MG ORAL ( <i>linagliptin-metformin hcl</i> )	Non Preferred	PA
JENTADUETO TABLET 2.5-500 MG ORAL ( <i>linagliptin-metformin hcl</i> )	Non Preferred	PA
JENTADUETO TABLET 2.5-850 MG ORAL ( <i>linagliptin-metformin hcl</i> )	Non Preferred	PA
JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL ( <i>linagliptin-metformin hcl</i> )	Non Preferred	PA
JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL ( <i>linagliptin-metformin hcl</i> )	Non Preferred	PA
KAZANO TABLET 12.5-1000 MG ORAL ( <i>alogliptin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
KAZANO TABLET 12.5-500 MG ORAL ( <i>alogliptin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL ( <i>saxagliptin-metformin</i> )	Non Preferred	PA
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL ( <i>saxagliptin-metformin</i> )	Non Preferred	PA
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-500 MG ORAL ( <i>saxagliptin-metformin</i> )	Non Preferred	PA
<b>*DOPAMINE RECEPTOR AGONISTS - ERGOT DERIVATIVES*** - DRUGS FOR DIABETES</b>		
CYCLOSET TABLET 0.8 MG ORAL ( <i>bromocriptine mesylate</i> )	Non Preferred	PA
<b>*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>alogliptin-pioglitazone tablet 12.5-30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>alogliptin-pioglitazone tablet 25-15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>alogliptin-pioglitazone tablet 25-30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>alogliptin-pioglitazone tablet 25-45 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
OSENI TABLET 12.5-30 MG ORAL ( <i>alogliptin-pioglitazone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
OSENI TABLET 25-15 MG ORAL ( <i>alogliptin-pioglitazone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
OSENI TABLET 25-30 MG ORAL ( <i>alogliptin-pioglitazone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
OSENI TABLET 25-45 MG ORAL ( <i>alogliptin-pioglitazone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*HUMAN INSULIN*** - DRUGS FOR DIABETES</b>		
<i>insulin lispro (1 unit dial) solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>insulin lispro junior kwikpen solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin lispro prot &amp; lispro suspension pen-injector (75-25) 100 unit/ml subcutaneous</i>	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
<i>insulin lispro solution 100 unit/ml injection</i>	Preferred	Max 90-day supply per fill
HUMALOG JUNIOR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Preferred	Max 90-day supply per fill
HUMALOG MIX 50/50 KWIKPEN SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro prot &amp; lispro</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMALOG MIX 50/50 SUSPENSION (50-50) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro prot &amp; lispro</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMALOG MIX 75/25 KWIKPEN SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro prot &amp; lispro</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMALOG MIX 75/25 SUSPENSION (75-25) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro prot &amp; lispro</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMALOG SOLUTION 100 UNIT/ML INJECTION ( <i>insulin lispro</i> )	Preferred	Max 90-day supply per fill
HUMALOG SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Preferred	Max 90-day supply per fill
HUMULIN 70/30 KWIKPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMULIN 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMULIN N KWIKPEN SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph human (isophane)</i> )	Preferred	Max 90-day supply per fill
HUMULIN N SUSPENSION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph human (isophane)</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMULIN R SOLUTION 100 UNIT/ML INJECTION ( <i>insulin regular human</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
HUMULIN R U-500 (CONCENTRATED) SOLUTION 500 UNIT/ML SUBCUTANEOUS ( <i>insulin regular human</i> )	Preferred	QL (1 ML per 1 day); Max 90-day supply per fill
HUMULIN R U-500 KWIKPEN SOLUTION PEN-INJECTOR 500 UNIT/ML SUBCUTANEOUS ( <i>insulin regular human</i> )	Preferred	Max 90-day supply per fill
LANTUS SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Preferred	QL (1.34 ML per 1 day); Max 90-day supply per fill
LANTUS SOLUTION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Preferred	Max 90-day supply per fill
LEVEMIR FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin detemir</i> )	Preferred	Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
LEVEMIR FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin detemir</i> )	Preferred	Max 90-day supply per fill
LEVEMIR SOLUTION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin detemir</i> )	Preferred	Max 90-day supply per fill
<i>insulin asp prot &amp; asp flexpen suspension pen-injector (70-30) 100 unit/ml subcutaneous</i>	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
<i>insulin aspart flexpen solution pen-injector 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin aspart penfill solution cartridge 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin aspart prot &amp; aspart suspension (70-30) 100 unit/ml subcutaneous</i>	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
<i>insulin aspart solution 100 unit/ml injection</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin degludec flextouch solution pen-injector 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin degludec flextouch solution pen-injector 200 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin degludec solution 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin glargine max solostar solution pen-injector 300 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin glargine solostar solution pen-injector 100 unit/ml subcutaneous</i>	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
<i>insulin glargine solostar solution pen-injector 300 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin glargine solution 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin glargine-yfgn solution 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
<i>insulin glargine-yfgn solution pen-injector 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
ADMELOG SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Non Preferred	PA; Max 90-day supply per fill
ADMELOG SOLUTION 100 UNIT/ML INJECTION ( <i>insulin lispro</i> )	Non Preferred	PA; Max 90-day supply per fill
AFREZZA POWDER 12 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
AFREZZA POWDER 4 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
AFREZZA POWDER 60X4 & 60X8 & 60X12 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
AFREZZA POWDER 8 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
AFREZZA POWDER 90 X 4 UNIT & 90X8 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
AFREZZA POWDER 90 X 8 UNIT & 90X12 UNIT INHALATION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
APIDRA SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glulisine</i> )	Non Preferred	PA; Max 90-day supply per fill
APIDRA SOLUTION 100 UNIT/ML INJECTION ( <i>insulin glulisine</i> )	Non Preferred	PA; Max 90-day supply per fill
BASAGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
BASAGLAR TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Non Preferred	PA; Max 90-day supply per fill
FIASP FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart (w/niacinamide)</i> )	Non Preferred	PA; Max 90-day supply per fill
FIASP PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart (w/niacinamide)</i> )	Non Preferred	PA; Max 90-day supply per fill
FIASP PUMPCART SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart (w/niacinamide)</i> )	Non Preferred	PA; Max 90-day supply per fill
FIASP SOLUTION 100 UNIT/ML INJECTION ( <i>insulin aspart (w/niacinamide)</i> )	Non Preferred	PA; Max 90-day supply per fill
HUMALOG TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro</i> )	Non Preferred	PA; Max 90-day supply per fill
LYUMJEV KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro-aabc</i> )	Non Preferred	PA; Max 90-day supply per fill
LYUMJEV KWIKPEN SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro-aabc</i> )	Non Preferred	PA; Max 90-day supply per fill
LYUMJEV SOLUTION 100 UNIT/ML INJECTION ( <i>insulin lispro- aabc</i> )	Non Preferred	PA; Max 90-day supply per fill
LYUMJEV TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin lispro-aabc</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN 70/30 FLEXPEN RELION SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN 70/30 FLEXPEN SUSPENSION PEN-INJECTOR (70- 30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph isophane &amp; regular</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN N FLEXPEN RELION SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph human (isophane)</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN N FLEXPEN SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (OTC) ( <i>insulin nph human (isophane)</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN N RELION SUSPENSION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph human (isophane)</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN N SUSPENSION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin nph human (isophane)</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
NOVOLIN R FLEXPEN RELION SOLUTION PEN-INJECTOR 100 UNIT/ML INJECTION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN R FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML INJECTION ( <i>insulin regular human</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN R RELION SOLUTION 100 UNIT/ML INJECTION ( <i>insulin regular human</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLIN R SOLUTION 100 UNIT/ML INJECTION ( <i>insulin regular human</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLOG 70/30 FLEXPEN RELION SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart prot &amp; aspart</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLOG FLEXPEN RELION SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG MIX 70/30 FLEXPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart prot &amp; aspart</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLOG MIX 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart prot &amp; aspart</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLOG MIX 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart prot &amp; aspart</i> )	Non Preferred	PA; QL (1.34 ML per 1 day); Max 90-day supply per fill
NOVOLOG PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS ( <i>insulin aspart</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG RELION SOLUTION 100 UNIT/ML INJECTION ( <i>insulin aspart</i> )	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG SOLUTION 100 UNIT/ML INJECTION ( <i>insulin aspart</i> )	Non Preferred	PA; Max 90-day supply per fill
REZVOGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine-aglr</i> )	Non Preferred	PA; Max 90-day supply per fill
SEMGLEE (YFGN) SOLUTION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine-yfgn</i> )	Non Preferred	PA; Max 90-day supply per fill
SEMGLEE (YFGN) SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine-yfgn</i> )	Non Preferred	PA; Max 90-day supply per fill
TOUJEO MAX SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Non Preferred	PA; Max 90-day supply per fill
TOUJEO SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS ( <i>insulin glargine</i> )	Non Preferred	PA; Max 90-day supply per fill
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS ( <i>insulin degludec</i> )	Non Preferred	PA; Max 90-day supply per fill
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS ( <i>insulin degludec</i> )	Non Preferred	PA; Max 90-day supply per fill
TRESIBA SOLUTION 100 UNIT/ML SUBCUTANEOUS ( <i>insulin degludec</i> )	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*INCRETIN MIMETIC AGENTS (GIP &amp; GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES</b>		
MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS ( <i>tirzepatide</i> )	Non Preferred	PA
<b>*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES</b>		
RYBELSUS TABLET 14 MG ORAL ( <i>semaglutide</i> )	Preferred	PA
RYBELSUS TABLET 3 MG ORAL ( <i>semaglutide</i> )	Preferred	PA
RYBELSUS TABLET 7 MG ORAL ( <i>semaglutide</i> )	Preferred	PA
TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS ( <i>dulaglutide</i> )	Preferred	QL (0.072 ML per 1 day)
TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS ( <i>dulaglutide</i> )	Preferred	QL (0.072 ML per 1 day)
TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS ( <i>dulaglutide</i> )	Preferred	QL (0.072 ML per 1 day)
TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS ( <i>dulaglutide</i> )	Preferred	QL (0.072 ML per 1 day)
VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS ( <i>liraglutide</i> )	Preferred	
BYDUREON BCISE AUTO-INJECTOR 2 MG/0.85ML SUBCUTANEOUS ( <i>exenatide</i> )	Non Preferred	PA
BYETTA 10 MCG PEN SOLUTION PEN-INJECTOR 10 MCG/0.04ML SUBCUTANEOUS ( <i>exenatide</i> )	Non Preferred	PA
BYETTA 5 MCG PEN SOLUTION PEN-INJECTOR 5 MCG/0.02ML SUBCUTANEOUS ( <i>exenatide</i> )	Non Preferred	PA
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/1.5ML SUBCUTANEOUS ( <i>semaglutide</i> )	Non Preferred	PA
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS ( <i>semaglutide</i> )	Non Preferred	PA
OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS ( <i>semaglutide</i> )	Non Preferred	PA
OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS ( <i>semaglutide</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*INSULIN-INCRETIN MIMETIC COMBINATIONS*** - DRUGS FOR DIABETES</b>		
SOLIQUA SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML SUBCUTANEOUS ( <i>insulin glargine-lixisenatide</i> )	Non Preferred	PA
XULTOPHY SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML SUBCUTANEOUS ( <i>insulin degludec-liraglutide</i> )	Non Preferred	PA
<b>*MEGLITINIDE ANALOGUES*** - DRUGS FOR DIABETES</b>		
<i>nateglinide tablet 120 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>nateglinide tablet 60 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>repaglinide tablet 0.5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
<i>repaglinide tablet 1 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
<i>repaglinide tablet 2 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
<b>*PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR DIABETES</b>		
<i>mifepristone tablet 300 mg oral</i>	Non Preferred	PA
KORLYM TABLET 300 MG ORAL ( <i>mifepristone</i> )	Non Preferred	PA
<b>*SGLT2 INHIBITOR - DPP-4 INHIBITOR - BIGUANIDE COMB*** - DRUGS FOR DIABETES</b>		
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG ORAL ( <i>empagliflozin-linagliptin-metform</i> )	Non Preferred	PA
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG ORAL ( <i>empagliflozin-linagliptin-metform</i> )	Non Preferred	PA
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-5-1000 MG ORAL ( <i>empagliflozin-linagliptin-metform</i> )	Non Preferred	PA
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-2.5-1000 MG ORAL ( <i>empagliflozin-linagliptin-metform</i> )	Non Preferred	PA
<b>*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS*** - DRUGS FOR DIABETES</b>		
GLYXAMBI TABLET 10-5 MG ORAL ( <i>empagliflozin-linagliptin</i> )	Non Preferred	PA
GLYXAMBI TABLET 25-5 MG ORAL ( <i>empagliflozin-linagliptin</i> )	Non Preferred	PA
QTERN TABLET 10-5 MG ORAL ( <i>dapagliflozin-saxagliptin</i> )	Non Preferred	PA
QTERN TABLET 5-5 MG ORAL ( <i>dapagliflozin-saxagliptin</i> )	Non Preferred	PA
STEGLUJAN TABLET 15-100 MG ORAL ( <i>ertugliflozin-sitagliptin</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
STEGLUJAN TABLET 5-100 MG ORAL ( <i>ertugliflozin-sitagliptin</i> )	Non Preferred	PA
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS*** - DRUGS FOR DIABETES</b>		
FARXIGA TABLET 10 MG ORAL ( <i>dapagliflozin propanediol</i> )	Preferred	
FARXIGA TABLET 5 MG ORAL ( <i>dapagliflozin propanediol</i> )	Preferred	
INVOKANA TABLET 100 MG ORAL ( <i>canagliflozin</i> )	Preferred	
INVOKANA TABLET 300 MG ORAL ( <i>canagliflozin</i> )	Preferred	
JARDIANCE TABLET 10 MG ORAL ( <i>empagliflozin</i> )	Preferred	
JARDIANCE TABLET 25 MG ORAL ( <i>empagliflozin</i> )	Preferred	PA
JARDIANCE TABLET 25 MG ORAL ( <i>empagliflozin</i> )	Preferred	
<i>dapagliflozin propanediol tablet 10 mg oral</i>	Non Preferred	PA
<i>dapagliflozin propanediol tablet 5 mg oral</i>	Non Preferred	PA
JARDIANCE TABLET 10 MG ORAL ( <i>empagliflozin</i> )	Non Preferred	PA
STEGLATRO TABLET 15 MG ORAL ( <i>ertugliflozin l-pyroglutamicac</i> )	Non Preferred	PA; QL (1 EA per 1 day)
STEGLATRO TABLET 5 MG ORAL ( <i>ertugliflozin l-pyroglutamicac</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - DRUGS FOR DIABETES</b>		
<i>dapagliflozin pro-metformin er tablet extended release 24 hour 10-1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>dapagliflozin pro-metformin er tablet extended release 24 hour 5-1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
INVOKAMET TABLET 150-1000 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET TABLET 150-500 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET TABLET 50-1000 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET TABLET 50-500 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL ( <i>canagliflozin-metformin hcl</i> )	Non Preferred	PA
SEGLUROMET TABLET 2.5-1000 MG ORAL ( <i>ertugliflozin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
SEGLUROMET TABLET 2.5-500 MG ORAL ( <i>ertugliflozin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SEGLUROMET TABLET 7.5-1000 MG ORAL ( <i>ertugliflozin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SEGLUROMET TABLET 7.5-500 MG ORAL ( <i>ertugliflozin-metformin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNJARDY TABLET 12.5-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY TABLET 12.5-500 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY TABLET 5-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY TABLET 5-500 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL ( <i>empagliflozin-metformin hcl</i> )	Non Preferred	PA
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL ( <i>dapagliflozin prop-metformin</i> )	Non Preferred	PA
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 10-500 MG ORAL ( <i>dapagliflozin prop-metformin</i> )	Non Preferred	PA
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL ( <i>dapagliflozin prop-metformin</i> )	Non Preferred	PA
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL ( <i>dapagliflozin prop-metformin</i> )	Non Preferred	PA
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 5-500 MG ORAL ( <i>dapagliflozin prop-metformin</i> )	Non Preferred	PA
<b>*SULFONYLUREA-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>glipizide-metformin hcl tablet 2.5-250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>glipizide-metformin hcl tablet 2.5-500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>glipizide-metformin hcl tablet 5-500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>glyburide-metformin tablet 1.25-250 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glyburide-metformin tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glyburide-metformin tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<b>*SULFONYLUREAS*** - DRUGS FOR DIABETES</b>		
<i>glimepiride tablet 1 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>glimepiride tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glimepiride tablet 4 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glipizide tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glipizide tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>glipizide tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>glyburide micronized tablet 1.5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glyburide micronized tablet 3 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glyburide micronized tablet 6 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glyburide tablet 1.25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glyburide tablet 2.5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>glyburide tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>glipizide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 2.5 MG ORAL ( <i>glipizide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL ( <i>glipizide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
GLYNASE TABLET 1.5 MG ORAL ( <i>glyburide micronized</i> )	Non Preferred	PA; QL (4 EA per 1 day)
GLYNASE TABLET 3 MG ORAL ( <i>glyburide micronized</i> )	Non Preferred	PA; QL (4 EA per 1 day)
GLYNASE TABLET 6 MG ORAL ( <i>glyburide micronized</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl-glimepiride tablet 30-2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pioglitazone hcl-glimepiride tablet 30-4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
DUETACT TABLET 30-2 MG ORAL ( <i>pioglitazone hcl-glimepiride</i> )	Non Preferred	PA
DUETACT TABLET 30-4 MG ORAL ( <i>pioglitazone hcl-glimepiride</i> )	Non Preferred	PA
<b>*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl-metformin hcl tablet 15-500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pioglitazone hcl-metformin hcl tablet 15-850 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ACTOPLUS MET TABLET 15-850 MG ORAL ( <i>pioglitazone hcl-metformin hcl</i> )	Non Preferred	PA
<b>*THIAZOLIDINEDIONES*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pioglitazone hcl tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pioglitazone hcl tablet 45 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ACTOS TABLET 15 MG ORAL ( <i>pioglitazone hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACTOS TABLET 30 MG ORAL ( <i>pioglitazone hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACTOS TABLET 45 MG ORAL ( <i>pioglitazone hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTIDIARRHEAL/PROBIOTIC AGENTS* - DRUGS FOR THE STOMACH</b>		
<b>*ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.*** - DRUGS FOR DIARRHEA</b>		
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	Preferred	
<i>ft stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>ft stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>gnp pink bismuth oral tablet 262 mg</i>	Preferred	
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>gnp pink bismuth ultra str oral suspension 525 mg/15ml</i>	Preferred	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>goodsense stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>hm stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>hm stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>sm stomach relief oral tablet 262 mg</i>	Preferred	
<i>sm stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	Preferred	
<i>stomach relief max st oral suspension 525 mg/15ml</i>	Preferred	
<i>stomach relief oral suspension 262 mg/15ml, 525 mg/30ml</i>	Preferred	
<i>stomach relief oral tablet 262 mg</i>	Preferred	
<i>stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	
<b>*ANTIPERISTALTIC AGENTS*** - DRUGS FOR DIARRHEA</b>		
<i>anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>anti-diarrheal oral tablet 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Preferred	QL (8 EA per 1 day)
<i>ft anti-diarrheal oral capsule 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>ft anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>ft anti-diarrheal oral tablet 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>gnp anti-diarrheal oral capsule 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>gnp anti-diarrheal oral tablet 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>gnp loperamide hcl oral solution 1 mg/7.5ml</i>	Preferred	
<i>goodsense anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>hm anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral capsule 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>loperamide hcl oral solution 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral suspension 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral tablet 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>sm anti-diarrheal oral capsule 2 mg</i>	Preferred	QL (8 EA per 1 day)
<i>sm anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>sm anti-diarrheal oral tablet 2 mg</i>	Preferred	QL (8 EA per 1 day)
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS* - DRUGS FOR OVERDOSE OR POISONING</b>		
<b>*ANTIDOTES - CHELATING AGENTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
CHEMET CAPSULE 100 MG ORAL ( <i>succimer</i> )	Preferred	
<i>deferasirox granules packet 180 mg oral</i>	Non Preferred	PA
<i>deferasirox granules packet 360 mg oral</i>	Non Preferred	PA
<i>deferasirox granules packet 90 mg oral</i>	Non Preferred	PA
<i>deferasirox packet 180 mg oral</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>deferasirox packet 360 mg oral</i>	Non Preferred	PA
<i>deferasirox packet 90 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet 180 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet 360 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet 90 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet soluble 125 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet soluble 250 mg oral</i>	Non Preferred	PA
<i>deferasirox tablet soluble 500 mg oral</i>	Non Preferred	PA
<i>deferiprone tablet 1000 mg oral</i>	Non Preferred	PA
<i>deferiprone tablet 500 mg oral</i>	Non Preferred	PA
EXJADE TABLET SOLUBLE 125 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
EXJADE TABLET SOLUBLE 250 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
EXJADE TABLET SOLUBLE 500 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
FERRIPROX SOLUTION 100 MG/ML ORAL ( <i>deferiprone</i> )	Non Preferred	PA
FERRIPROX TABLET 1000 MG ORAL ( <i>deferiprone</i> )	Non Preferred	PA
FERRIPROX TABLET 500 MG ORAL ( <i>deferiprone</i> )	Non Preferred	PA
FERRIPROX TWICE-A-DAY TABLET 1000 MG ORAL ( <i>deferiprone</i> )	Non Preferred	PA
JADENU SPRINKLE PACKET 180 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
JADENU SPRINKLE PACKET 360 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
JADENU SPRINKLE PACKET 90 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
JADENU TABLET 180 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
JADENU TABLET 360 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA
JADENU TABLET 90 MG ORAL ( <i>deferasirox</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*OPIOID ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>lifems naloxone prefilled syringe kit 2 mg/2ml injection</i>	Preferred	
<i>nalmefene hcl solution 1 mg/ml injection</i>	Preferred	
<i>naloxone hcl liquid 4 mg/0.1ml nasal (otc)</i>	Preferred	
<i>naloxone hcl liquid 4 mg/0.1ml nasal (rx)</i>	Preferred	
<i>naloxone hcl solution 0.4 mg/ml injection</i>	Preferred	
<i>naloxone hcl solution 4 mg/10ml injection</i>	Preferred	
<i>naloxone hcl solution cartridge 0.4 mg/ml injection</i>	Preferred	
<i>naloxone hcl solution prefilled syringe 2 mg/2ml injection</i>	Preferred	
<i>naltrexone hcl tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
KLOXXADO LIQUID 8 MG/0.1ML NASAL ( <i>naloxone hcl</i> )	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (OTC) ( <i>naloxone hcl</i> )	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (RX) ( <i>naloxone hcl</i> )	Preferred	
OPVEE SOLUTION 2.7 MG/0.1ML NASAL ( <i>nalmefene hcl</i> )	Preferred	
VIVITROL SUSPENSION RECONSTITUTED 380 MG INTRAMUSCULAR ( <i>naltrexone</i> )	Preferred	
ZIMHI SOLUTION PREFILLED SYRINGE 5 MG/0.5ML INJECTION ( <i>naloxone hcl</i> )	Preferred	
<b>*ANTIEMETICS* - DRUGS FOR THE STOMACH</b>		
<b>*5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>ondansetron hcl solution 4 mg/5ml oral</i>	Preferred	
<i>ondansetron hcl tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>ondansetron hcl tablet 8 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ondansetron tablet dispersible 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>ondansetron tablet dispersible 8 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>granisetron hcl tablet 1 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
ANZEMET TABLET 50 MG ORAL ( <i>dolasetron mesylate</i> )	Non Preferred	PA
SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL ( <i>granisetron</i> )	Non Preferred	PA
<b>*ANTIEMETIC COMBINATIONS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>doxylamine-pyridoxine tablet delayed release 10-10 mg oral</i>	Non Preferred	PA
AKYNZEO CAPSULE 300-0.5 MG ORAL ( <i>netupitant-palonosetron</i> )	Non Preferred	PA
BONJESTA TABLET EXTENDED RELEASE 20-20 MG ORAL ( <i>doxylamine-pyridoxine</i> )	Non Preferred	PA
DICLEGIS TABLET DELAYED RELEASE 10-10 MG ORAL ( <i>doxylamine-pyridoxine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIEMETICS - ANTICHOLINERGIC*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>ft motion sickness oral tablet 50 mg</i>	Preferred	
<i>gnp motion sickness relief oral tablet 50 mg</i>	Preferred	
<i>meclizine hcl oral tablet chewable 25 mg</i>	Preferred	
<i>meclizine hcl tablet 12.5 mg oral (rx)</i>	Preferred	QL (4 EA per 1 day)
<i>meclizine hcl tablet 25 mg oral (rx)</i>	Preferred	QL (4 EA per 1 day)
<i>meclizine hcl tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>motion sickness relief oral tablet 50 mg</i>	Preferred	
<i>motion-time oral tablet chewable 25 mg</i>	Preferred	
<i>scopolamine patch 72 hour 1 mg/3days transdermal</i>	Preferred	
<i>sm motion sickness oral tablet 50 mg</i>	Preferred	
<i>travel sickness oral tablet chewable 25 mg</i>	Preferred	
DRIMINATE ORAL TABLET 50 MG ( <i>dimenhydrinate</i> )	Preferred	
TRANSDERM-SCOP PATCH 72 HOUR 1 MG/3DAYS TRANSDERMAL ( <i>scopolamine base</i> )	Preferred	
<i>trimethobenzamide hcl capsule 300 mg oral</i>	Non Preferred	PA
ANTIVERT TABLET 50 MG ORAL ( <i>meclizine hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ANTIVERT TABLET CHEWABLE 25 MG ORAL ( <i>meclizine hcl</i> )	Non Preferred	PA
<b>*ANTIEMETICS - MISCELLANEOUS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>dronabinol capsule 10 mg oral</i>	Non Preferred	PA
<i>dronabinol capsule 2.5 mg oral</i>	Non Preferred	PA
<i>dronabinol capsule 5 mg oral</i>	Non Preferred	PA
MARINOL CAPSULE 2.5 MG ORAL ( <i>dronabinol</i> )	Non Preferred	PA
<b>*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>aprepitant 80 &amp; 125 mg oral</i>	Preferred	
<i>aprepitant capsule 125 mg oral</i>	Preferred	
<i>aprepitant capsule 40 mg oral</i>	Preferred	
<i>aprepitant capsule 80 &amp; 125 mg oral</i>	Preferred	
<i>aprepitant capsule 80 mg oral</i>	Preferred	
EMEND CAPSULE 80 MG ORAL ( <i>aprepitant</i> )	Non Preferred	PA
EMEND SUSPENSION RECONSTITUTED 125 MG/5ML ORAL ( <i>aprepitant</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
EMEND TRI-PACK CAPSULE 80 & 125 MG ORAL ( <i>aprepitant</i> )	Non Preferred	PA
<b>*ANTIFUNGALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (TRITERPENOID)*** - ANTIBIOTICS</b>		
BREXAFEMME TABLET 150 MG ORAL ( <i>ibrexafungerp citrate</i> )	Non Preferred	PA
<b>*ANTIFUNGALS*** - DRUGS FOR FUNGUS</b>		
<i>griseofulvin microsize suspension 125 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>griseofulvin microsize tablet 500 mg oral</i>	Preferred	
<i>griseofulvin ultramicrosize tablet 125 mg oral</i>	Preferred	
<i>griseofulvin ultramicrosize tablet 250 mg oral</i>	Preferred	
<i>nystatin tablet 500000 unit oral</i>	Preferred	QL (8 EA per 1 day)
<i>terbinafine hcl tablet 250 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>flucytosine capsule 250 mg oral</i>	Non Preferred	PA
<i>flucytosine capsule 500 mg oral</i>	Non Preferred	PA
ANCOBON CAPSULE 250 MG ORAL ( <i>flucytosine</i> )	Non Preferred	PA
ANCOBON CAPSULE 500 MG ORAL ( <i>flucytosine</i> )	Non Preferred	PA
<b>*IMIDAZOLES*** - DRUGS FOR FUNGUS</b>		
<i>ketoconazole tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>*TETRAZOLES*** - DRUGS FOR FUNGUS</b>		
VIVJOA CAPSULE THERAPY PACK 150 MG ORAL ( <i>oteseconazole</i> )	Non Preferred	PA
<b>*TRIAZOLES*** - DRUGS FOR FUNGUS</b>		
<i>fluconazole suspension reconstituted 10 mg/ml oral</i>	Preferred	QL (3 ML per 1 day)
<i>fluconazole suspension reconstituted 40 mg/ml oral</i>	Preferred	QL (5 ML per 1 day)
<i>fluconazole tablet 100 mg oral</i>	Preferred	
<i>fluconazole tablet 150 mg oral</i>	Preferred	
<i>fluconazole tablet 200 mg oral</i>	Preferred	
<i>fluconazole tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>itraconazole capsule 100 mg oral</i>	Preferred	
<i>itraconazole solution 10 mg/ml oral</i>	Non Preferred	PA
<i>posaconazole suspension 40 mg/ml oral</i>	Non Preferred	PA
<i>posaconazole tablet delayed release 100 mg oral</i>	Non Preferred	PA
<i>tolsura capsule 65 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>voriconazole suspension reconstituted 40 mg/ml oral</i>	Non Preferred	PA
<i>voriconazole tablet 200 mg oral</i>	Non Preferred	PA
<i>voriconazole tablet 50 mg oral</i>	Non Preferred	PA
CRESEMBA CAPSULE 186 MG ORAL ( <i>isavuconazonium sulfate</i> )	Non Preferred	PA
CRESEMBA CAPSULE 74.5 MG ORAL ( <i>isavuconazonium sulfate</i> )	Non Preferred	PA
DIFLUCAN SUSPENSION RECONSTITUTED 10 MG/ML ORAL ( <i>fluconazole</i> )	Non Preferred	PA; QL (3 ML per 1 day)
DIFLUCAN SUSPENSION RECONSTITUTED 40 MG/ML ORAL ( <i>fluconazole</i> )	Non Preferred	PA; QL (5 ML per 1 day)
DIFLUCAN TABLET 100 MG ORAL ( <i>fluconazole</i> )	Non Preferred	PA
DIFLUCAN TABLET 200 MG ORAL ( <i>fluconazole</i> )	Non Preferred	PA
NOXAFIL PACKET 300 MG ORAL ( <i>posaconazole</i> )	Non Preferred	PA
NOXAFIL SUSPENSION 40 MG/ML ORAL ( <i>posaconazole</i> )	Non Preferred	PA
NOXAFIL TABLET DELAYED RELEASE 100 MG ORAL ( <i>posaconazole</i> )	Non Preferred	PA
SPORANOX CAPSULE 100 MG ORAL ( <i>itraconazole</i> )	Non Preferred	PA
SPORANOX SOLUTION 10 MG/ML ORAL ( <i>itraconazole</i> )	Non Preferred	PA
VFEND SUSPENSION RECONSTITUTED 40 MG/ML ORAL ( <i>voriconazole</i> )	Non Preferred	PA
VFEND TABLET 200 MG ORAL ( <i>voriconazole</i> )	Non Preferred	PA
VFEND TABLET 50 MG ORAL ( <i>voriconazole</i> )	Non Preferred	PA
<b>*ANTIHISTAMINES* - DRUGS FOR THE LUNGS</b>		
<b>*ANTIHISTAMINES - ALKYLAMINES*** - DRUGS FOR ALLERGIES</b>		
<i>aller-chlor oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>allergy oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>allergy relief oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	Preferred	
<i>ft allergy relief oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp allergy relief oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTI-HISTAMINES - ETHANOLAMINES*** - DRUGS FOR ALLERGIES</b>		
<i>allergy oral capsule 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>allergy relief oral capsule 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>allergy relief oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	Preferred	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Preferred	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Preferred	AGE (Max 64 Years)
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	Preferred	QL (80 ML per 1 day); AGE (Max 12 Years)
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml, 25 mg/10ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>diphenhydramine hcl oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>ft allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>ft allergy relief oral capsule 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>ft allergy relief oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>gnp allergy oral capsule 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>gnp allergy oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>gnp allergy relief oral capsule 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>gnp allergy relief oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 12 Years)
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>m-dryl oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 12 Years)
<i>sm allergy relief oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
BANOPHEN ORAL CAPSULE 25 MG, 50 MG ( <i>diphenhydramine hcl</i> )	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
BANOPHEN ORAL TABLET 25 MG ( <i>diphenhydramine hcl</i> )	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
DAYHIST ALLERGY 12 HOUR RELIEF ORAL TABLET 1.34 MG ( <i>clemastine fumarate</i> )	Preferred	QL (2 EA per 1 day)
<b>*ANTIHIISTAMINES - NON-SEDATING*** - DRUGS FOR ALLERGIES</b>		
<i>all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>all day allergy oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>allergy rel child (loratadine) oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>allergy relief (loratadine) oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy relief cetirizine oral tablet 10 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy relief childrens oral solution 1 mg/ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>allergy relief oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy relief/indoor/outdoor oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>cetirizine hcl allergy child oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>cetirizine hcl childrens alrgy oral solution 1 mg/ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>cetirizine hcl oral tablet 10 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day)
<i>childrens loratadine oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>ft all day allergy 24 hour oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ft all day allergy oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ft all day allergy relief oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ft allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>ft allergy relief childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>gnp all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>gnp all day allergy oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp loratadine childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>gnp loratadine oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>gnp loratadine oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp loratadine oral tablet dispersible 10 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Max 12 Years)
<i>goodsense all day allergy oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>goodsense all day allergy oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>goodsense allergy relief child oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>goodsense allergy relief oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>hm all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>hm loratadine childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>hm loratadine oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>loratadine childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>loratadine oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>loratadine oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>loratadine oral tablet dispersible 10 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Max 12 Years)
<i>sm all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>sm all day allergy oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm all day allergy relief oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm allergy childrens oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>sm allergy relief oral tablet dispersible 10 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Max 12 Years)
<i>sm childrens loratadine oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>sm loratadine allergy relief oral tablet dispersible 10 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Max 12 Years)
<i>sm loratadine oral solution 5 mg/5ml</i>	Preferred	QL (10 ML per 1 day); AGE (Max 12 Years)
<i>sm loratadine oral tablet 10 mg</i>	Preferred	QL (1 EA per 1 day)
KLS ALLERCLEAR ORAL TABLET 10 MG ( <i>loratadine</i> )	Preferred	QL (1 EA per 1 day)
KLS ALLER-TEC ORAL TABLET 10 MG ( <i>cetirizine hcl</i> )	Preferred	QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTI-HISTAMINES - PHENOTHIAZINES*** - DRUGS FOR ALLERGIES</b>		
<i>promethazine hcl injection solution 25 mg/ml</i>	Preferred	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl injection solution 50 mg/ml</i>	Preferred	QL (50 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	Preferred	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	Preferred	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>	Preferred	QL (2 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl oral tablet 25 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	Preferred	QL (8 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl (Phenadoz Rectal Suppository 12.5 Mg, 25 Mg)</i>	Preferred	QL (8 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<i>promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)</i>	Preferred	QL (8 EA per 1 day); AGE (Min 2 Years and Max 64 Years)
<b>*ANTI-HISTAMINES - PIPERIDINES*** - DRUGS FOR ALLERGIES</b>		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	Preferred	QL (20 ML per 1 day); AGE (Max 64 Years)
<i>cyproheptadine hcl oral tablet 4 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 64 Years)
<b>*ANTIHYPERLIPIDEMICS* - DRUGS FOR THE HEART</b>		
<b>*ACL INHIB-INTestinal CHOLESTEROL ABSORPTION INHIB COMB*** - DRUGS FOR CHOLESTEROL</b>		
NEXLIZET TABLET 180-10 MG ORAL ( <i>bempedoic acid-ezetimibe</i> )	Non Preferred	PA
<b>*ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
NEXLETOL TABLET 180 MG ORAL ( <i>bempedoic acid</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIHYPERLIPIDEMICS - MISC.*** - DRUGS FOR CHOLESTEROL</b>		
<i>icosapent ethyl capsule 0.5 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>icosapent ethyl capsule 1 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>omega-3-acid ethyl esters capsule 1 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
LOVAZA CAPSULE 1 GM ORAL ( <i>omega-3-acid ethyl esters</i> )	Non Preferred	PA
VASCEPA CAPSULE 0.5 GM ORAL ( <i>icosapent ethyl</i> )	Non Preferred	PA
VASCEPA CAPSULE 1 GM ORAL ( <i>icosapent ethyl</i> )	Non Preferred	PA
<b>*BILE ACID SEQUESTRANTS*** - DRUGS FOR CHOLESTEROL</b>		
<i>cholestyramine light packet 4 gm oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine light powder 4 gm/dose oral</i>	Preferred	QL (8 GM per 1 day); Max 90-day supply per fill
<i>cholestyramine packet 4 gm oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine powder 4 gm/dose oral</i>	Preferred	QL (48 GM per 1 day); Max 90-day supply per fill
<i>cholestyramine light</i> (Prevalite Packet 4 Gm Oral)	Preferred	Max 90-day supply per fill
<i>cholestyramine light</i> (Prevalite Powder 4 Gm/Dose Oral)	Preferred	QL (8 GM per 1 day); Max 90-day supply per fill
<i>colesevelam hcl packet 3.75 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>colesevelam hcl tablet 625 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>colestipol hcl granules 5 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>colestipol hcl packet 5 gm oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>colestipol hcl tablet 1 gm oral</i>	Non Preferred	PA; QL (16 EA per 1 day); Max 90-day supply per fill
COLESTID FLAVORED GRANULES 5 GM ORAL ( <i>colestipol hcl</i> )	Non Preferred	PA
COLESTID FLAVORED PACKET 5 GM ORAL ( <i>colestipol hcl</i> )	Non Preferred	PA
COLESTID GRANULES 5 GM ORAL ( <i>colestipol hcl</i> )	Non Preferred	PA
COLESTID PACKET 5 GM ORAL ( <i>colestipol hcl</i> )	Non Preferred	PA
COLESTID TABLET 1 GM ORAL ( <i>colestipol hcl</i> )	Non Preferred	PA; QL (16 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
QUESTRAN LIGHT POWDER 4 GM/DOSE ORAL ( <i>cholestyramine light</i> )	Non Preferred	PA; QL (8 GM per 1 day)
QUESTRAN PACKET 4 GM ORAL ( <i>cholestyramine</i> )	Non Preferred	PA
QUESTRAN POWDER 4 GM/DOSE ORAL ( <i>cholestyramine</i> )	Non Preferred	PA; QL (48 GM per 1 day)
WELCHOL PACKET 3.75 GM ORAL ( <i>colesevelam hcl</i> )	Non Preferred	PA
WELCHOL TABLET 625 MG ORAL ( <i>colesevelam hcl</i> )	Non Preferred	PA
<b>*FIBRIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL</b>		
<i>fenofibrate capsule 134 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate capsule 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate capsule 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate capsule 67 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 130 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 134 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 43 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 67 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate micronized capsule 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate tablet 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate tablet 145 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fenofibrate tablet 160 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fenofibrate tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate tablet 48 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fenofibrate tablet 54 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fenofibric acid capsule delayed release 135 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibric acid capsule delayed release 45 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gemfibrozil tablet 600 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>fenofibric acid tablet 105 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fenofibric acid tablet 35 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ANTARA CAPSULE 30 MG ORAL ( <i>fenofibrate micronized</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FENOGLIDE TABLET 120 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA
FENOGLIDE TABLET 40 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA
LIPOFEN CAPSULE 150 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA
LIPOFEN CAPSULE 50 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA
LOPID TABLET 600 MG ORAL ( <i>gemfibrozil</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TRICOR TABLET 145 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TRICOR TABLET 48 MG ORAL ( <i>fenofibrate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TRILIPIX CAPSULE DELAYED RELEASE 135 MG ORAL ( <i>choline fenofibrate</i> )	Non Preferred	PA
TRILIPIX CAPSULE DELAYED RELEASE 45 MG ORAL ( <i>choline fenofibrate</i> )	Non Preferred	PA
<b>*HMG COA REDUCTASE INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
<i>atorvastatin calcium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atorvastatin calcium tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atorvastatin calcium tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atorvastatin calcium tablet 80 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lovastatin tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lovastatin tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lovastatin tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pravastatin sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pravastatin sodium tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pravastatin sodium tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pravastatin sodium tablet 80 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>rosuvastatin calcium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>rosuvastatin calcium tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>rosuvastatin calcium tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>rosuvastatin calcium tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>simvastatin tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>simvastatin tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>simvastatin tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>simvastatin tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>simvastatin tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluvastatin sodium capsule 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluvastatin sodium capsule 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluvastatin sodium er tablet extended release 24 hour 80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pitavastatin calcium tablet 1 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pitavastatin calcium tablet 2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pitavastatin calcium tablet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>lovastatin</i> )	Non Preferred	PA
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>lovastatin</i> )	Non Preferred	PA
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 60 MG ORAL ( <i>lovastatin</i> )	Non Preferred	PA
ATORVALIQ SUSPENSION 20 MG/5ML ORAL ( <i>atorvastatin calcium</i> )	Non Preferred	PA
CRESTOR TABLET 10 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CRESTOR TABLET 20 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CRESTOR TABLET 5 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EZALLOR SPRINKLE CAPSULE SPRINKLE 10 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA
EZALLOR SPRINKLE CAPSULE SPRINKLE 20 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA
EZALLOR SPRINKLE CAPSULE SPRINKLE 40 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
EZALLOR SPRINKLE CAPSULE SPRINKLE 5 MG ORAL ( <i>rosuvastatin calcium</i> )	Non Preferred	PA
LESCOL XL TABLET EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>fluvastatin sodium</i> )	Non Preferred	PA
LIPITOR TABLET 10 MG ORAL ( <i>atorvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LIPITOR TABLET 20 MG ORAL ( <i>atorvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LIPITOR TABLET 40 MG ORAL ( <i>atorvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LIPITOR TABLET 80 MG ORAL ( <i>atorvastatin calcium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LIVALO TABLET 1 MG ORAL ( <i>pitavastatin calcium</i> )	Non Preferred	PA
LIVALO TABLET 2 MG ORAL ( <i>pitavastatin calcium</i> )	Non Preferred	PA
LIVALO TABLET 4 MG ORAL ( <i>pitavastatin calcium</i> )	Non Preferred	PA
ZOCOR TABLET 10 MG ORAL ( <i>simvastatin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZOCOR TABLET 20 MG ORAL ( <i>simvastatin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZOCOR TABLET 40 MG ORAL ( <i>simvastatin</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZYPITAMAG TABLET 2 MG ORAL ( <i>pitavastatin magnesium</i> )	Non Preferred	PA
ZYPITAMAG TABLET 4 MG ORAL ( <i>pitavastatin magnesium</i> )	Non Preferred	PA
<b>*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB*** - DRUGS FOR CHOLESTEROL</b>		
<i>ezetimibe-simvastatin tablet 10-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ezetimibe-simvastatin tablet 10-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ezetimibe-simvastatin tablet 10-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ezetimibe-simvastatin tablet 10-80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
VYTORIN TABLET 10-10 MG ORAL ( <i>ezetimibe-simvastatin</i> )	Non Preferred	PA
VYTORIN TABLET 10-20 MG ORAL ( <i>ezetimibe-simvastatin</i> )	Non Preferred	PA
VYTORIN TABLET 10-40 MG ORAL ( <i>ezetimibe-simvastatin</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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Drug Name	Formulary Status	Requirements/Limits
VYTORIN TABLET 10-80 MG ORAL ( <i>ezetimibe-simvastatin</i> )	Non Preferred	PA
<b>*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
<i>ezetimibe tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ZETIA TABLET 10 MG ORAL ( <i>ezetimibe</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
JUXTAPID CAPSULE 10 MG ORAL ( <i>lomitapide mesylate</i> )	Non Preferred	PA
JUXTAPID CAPSULE 20 MG ORAL ( <i>lomitapide mesylate</i> )	Non Preferred	PA
JUXTAPID CAPSULE 30 MG ORAL ( <i>lomitapide mesylate</i> )	Non Preferred	PA
JUXTAPID CAPSULE 5 MG ORAL ( <i>lomitapide mesylate</i> )	Non Preferred	PA
<b>*NICOTINIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL</b>		
<i>niacin er (antihyperlipidemic) tablet extended release 1000 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>niacin er (antihyperlipidemic) tablet extended release 500 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>niacin er (antihyperlipidemic) tablet extended release 750 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<b>*PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
PRALUENT SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS ( <i>alirocumab</i> )	Non Preferred	PA
PRALUENT SOLUTION AUTO-INJECTOR 75 MG/ML SUBCUTANEOUS ( <i>alirocumab</i> )	Non Preferred	PA
REPATHA PUSHTRONEX SYSTEM SOLUTION CARTRIDGE 420 MG/3.5ML SUBCUTANEOUS ( <i>evolocumab</i> )	Non Preferred	PA
REPATHA SOLUTION PREFILLED SYRINGE 140 MG/ML SUBCUTANEOUS ( <i>evolocumab</i> )	Non Preferred	PA
REPATHA SURECLICK SOLUTION AUTO-INJECTOR 140 MG/ML SUBCUTANEOUS ( <i>evolocumab</i> )	Non Preferred	PA
<b>*SMALL INTERFERING RNA (SIRNA) PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
LEQVIO SOLUTION PREFILLED SYRINGE 284 MG/1.5ML SUBCUTANEOUS ( <i>inclisiran sodium</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIHYPERTENSIVES* - DRUGS FOR THE HEART</b>		
<b>*ACE INHIBITOR &amp; CALCIUM CHANNEL BLOCKER COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besy-benazepril hcl capsule 10-20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 10-40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 2.5-10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>trandolapril-verapamil hcl er tablet extended release 1-240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trandolapril-verapamil hcl er tablet extended release 2-180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trandolapril-verapamil hcl er tablet extended release 2-240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trandolapril-verapamil hcl er tablet extended release 4-240 mg oral</i>	Preferred	Max 90-day supply per fill
LOTREL CAPSULE 10-20 MG ORAL ( <i>amlodipine besy-benazepril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTREL CAPSULE 10-40 MG ORAL ( <i>amlodipine besy-benazepril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTREL CAPSULE 5-10 MG ORAL ( <i>amlodipine besy-benazepril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTREL CAPSULE 5-20 MG ORAL ( <i>amlodipine besy-benazepril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ACE INHIBITORS &amp; THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>benazepril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 5-6.25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>captopril-hydrochlorothiazide tablet 25-15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>captopril-hydrochlorothiazide tablet 25-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>captopril-hydrochlorothiazide tablet 50-15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>captopril-hydrochlorothiazide tablet 50-25 mg oral</i>	Preferred	Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>enalapril-hydrochlorothiazide tablet 10-25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>enalapril-hydrochlorothiazide tablet 5-12.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>fosinopril sodium-hctz tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fosinopril sodium-hctz tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>quinapril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>quinapril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>quinapril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ACCURETIC TABLET 10-12.5 MG ORAL ( <i>quinapril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACCURETIC TABLET 20-12.5 MG ORAL ( <i>quinapril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACCURETIC TABLET 20-25 MG ORAL ( <i>quinapril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTENSIN HCT TABLET 10-12.5 MG ORAL ( <i>benazepril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTENSIN HCT TABLET 20-12.5 MG ORAL ( <i>benazepril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LOTENSIN HCT TABLET 20-25 MG ORAL ( <i>benazepril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VASERETIC TABLET 10-25 MG ORAL ( <i>enalapril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZESTORETIC TABLET 10-12.5 MG ORAL ( <i>lisinopril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZESTORETIC TABLET 20-12.5 MG ORAL ( <i>lisinopril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZESTORETIC TABLET 20-25 MG ORAL ( <i>lisinopril-hydrochlorothiazide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ACE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>benazepril hcl tablet 10 mg oral</i>	Preferred	QL (1.5 EA per 1 day); Max 90-day supply per fill
<i>benazepril hcl tablet 20 mg oral</i>	Preferred	QL (1.5 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>benazepril hcl tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>benazepril hcl tablet 5 mg oral</i>	Preferred	QL (1.5 EA per 1 day); Max 90-day supply per fill
<i>captopril tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>captopril tablet 12.5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>captopril tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>captopril tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>enalapril maleate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>enalapril maleate tablet 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>enalapril maleate tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>enalapril maleate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fosinopril sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fosinopril sodium tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fosinopril sodium tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lisinopril tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>moexipril hcl tablet 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>moexipril hcl tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinapril hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>quinapril hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>quinapril hcl tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>quinapril hcl tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>ramipril capsule 1.25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>ramipril capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>ramipril capsule 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>ramipril capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>trandolapril tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>trandolapril tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>trandolapril tablet 4 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>enalapril maleate solution 1 mg/ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>perindopril erbumine tablet 2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>perindopril erbumine tablet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>perindopril erbumine tablet 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ACCUPRIL TABLET 10 MG ORAL ( <i>quinapril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACCUPRIL TABLET 20 MG ORAL ( <i>quinapril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ACCUPRIL TABLET 40 MG ORAL ( <i>quinapril hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ACCUPRIL TABLET 5 MG ORAL ( <i>quinapril hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALTACE CAPSULE 1.25 MG ORAL ( <i>ramipril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALTACE CAPSULE 10 MG ORAL ( <i>ramipril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALTACE CAPSULE 2.5 MG ORAL ( <i>ramipril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALTACE CAPSULE 5 MG ORAL ( <i>ramipril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EPANED SOLUTION 1 MG/ML ORAL ( <i>enalapril maleate</i> )	Non Preferred	PA
LOTENSIN TABLET 10 MG ORAL ( <i>benazepril hcl</i> )	Non Preferred	PA; QL (1.5 EA per 1 day)
LOTENSIN TABLET 20 MG ORAL ( <i>benazepril hcl</i> )	Non Preferred	PA; QL (1.5 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
LOTENSIN TABLET 40 MG ORAL ( <i>benazepril hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
QBRELIS SOLUTION 1 MG/ML ORAL ( <i>lisinopril</i> )	Non Preferred	PA
VASOTEC TABLET 10 MG ORAL ( <i>enalapril maleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VASOTEC TABLET 2.5 MG ORAL ( <i>enalapril maleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VASOTEC TABLET 20 MG ORAL ( <i>enalapril maleate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VASOTEC TABLET 5 MG ORAL ( <i>enalapril maleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZESTRIL TABLET 10 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZESTRIL TABLET 2.5 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZESTRIL TABLET 20 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZESTRIL TABLET 30 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZESTRIL TABLET 40 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZESTRIL TABLET 5 MG ORAL ( <i>lisinopril</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*AGENTS FOR PHEOCHROMOCYTOMA*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>metyrosine capsule 250 mg oral</i>	Preferred	Max 90-day supply per fill
DEMSEER CAPSULE 250 MG ORAL ( <i>metyrosine</i> )	Preferred	
<i>phenoxybenzamine hcl capsule 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<b>*ANGIOTENSIN II RECEPTOR ANTAG &amp; CA CHANNEL BLOCKER COMB*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besylate-valsartan tablet 10-160 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 10-320 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 5-160 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 5-320 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 10-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 10-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>amlodipine-olmesartan tablet 5-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 5-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-amlodipine tablet 40-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-amlodipine tablet 40-5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-amlodipine tablet 80-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-amlodipine tablet 80-5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
AZOR TABLET 10-20 MG ORAL ( <i>amlodipine-olmesartan</i> )	Non Preferred	PA
AZOR TABLET 10-40 MG ORAL ( <i>amlodipine-olmesartan</i> )	Non Preferred	PA
AZOR TABLET 5-20 MG ORAL ( <i>amlodipine-olmesartan</i> )	Non Preferred	PA
AZOR TABLET 5-40 MG ORAL ( <i>amlodipine-olmesartan</i> )	Non Preferred	PA
EXFORGE TABLET 10-160 MG ORAL ( <i>amlodipine besylate-valsartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EXFORGE TABLET 10-320 MG ORAL ( <i>amlodipine besylate-valsartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EXFORGE TABLET 5-160 MG ORAL ( <i>amlodipine besylate-valsartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EXFORGE TABLET 5-320 MG ORAL ( <i>amlodipine besylate-valsartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANGIOTENSIN II RECEPTOR ANTAG &amp; THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>irbesartan-hydrochlorothiazide tablet 150-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>irbesartan-hydrochlorothiazide tablet 300-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium-hctz tablet 100-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium-hctz tablet 100-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium-hctz tablet 50-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 160-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 160-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>valsartan-hydrochlorothiazide tablet 320-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 320-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 80-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>candesartan cilexetil-hctz tablet 16-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>candesartan cilexetil-hctz tablet 32-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>candesartan cilexetil-hctz tablet 32-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil-hctz tablet 20-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil-hctz tablet 40-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil-hctz tablet 40-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-hctz tablet 40-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-hctz tablet 80-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan-hctz tablet 80-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ATACAND HCT TABLET 16-12.5 MG ORAL ( <i>candesartan cilexetil-hctz</i> )	Non Preferred	PA
ATACAND HCT TABLET 32-12.5 MG ORAL ( <i>candesartan cilexetil-hctz</i> )	Non Preferred	PA
ATACAND HCT TABLET 32-25 MG ORAL ( <i>candesartan cilexetil-hctz</i> )	Non Preferred	PA
AVALIDE TABLET 150-12.5 MG ORAL ( <i>irbesartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AVALIDE TABLET 300-12.5 MG ORAL ( <i>irbesartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
BENICAR HCT TABLET 20-12.5 MG ORAL ( <i>olmesartan medoxomil-hctz</i> )	Non Preferred	PA
BENICAR HCT TABLET 40-12.5 MG ORAL ( <i>olmesartan medoxomil-hctz</i> )	Non Preferred	PA
BENICAR HCT TABLET 40-25 MG ORAL ( <i>olmesartan medoxomil-hctz</i> )	Non Preferred	PA
DIOVAN HCT TABLET 160-12.5 MG ORAL ( <i>valsartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
DIOVAN HCT TABLET 160-25 MG ORAL ( <i>valsartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
DIOVAN HCT TABLET 320-12.5 MG ORAL ( <i>valsartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
DIOVAN HCT TABLET 320-25 MG ORAL ( <i>valsartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
DIOVAN HCT TABLET 80-12.5 MG ORAL ( <i>valsartan-hydrochlorothiazide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EDARBYCLOR TABLET 40-12.5 MG ORAL ( <i>azilsartan-chlorthalidone</i> )	Non Preferred	PA
EDARBYCLOR TABLET 40-25 MG ORAL ( <i>azilsartan-chlorthalidone</i> )	Non Preferred	PA
HYZAAR TABLET 100-12.5 MG ORAL ( <i>losartan potassium-hctz</i> )	Non Preferred	PA; QL (1 EA per 1 day)
HYZAAR TABLET 100-25 MG ORAL ( <i>losartan potassium-hctz</i> )	Non Preferred	PA; QL (1 EA per 1 day)
HYZAAR TABLET 50-12.5 MG ORAL ( <i>losartan potassium-hctz</i> )	Non Preferred	PA; QL (1 EA per 1 day)
MICARDIS HCT TABLET 40-12.5 MG ORAL ( <i>telmisartan-hctz</i> )	Non Preferred	PA
MICARDIS HCT TABLET 80-12.5 MG ORAL ( <i>telmisartan-hctz</i> )	Non Preferred	PA
MICARDIS HCT TABLET 80-25 MG ORAL ( <i>telmisartan-hctz</i> )	Non Preferred	PA
<b>*ANGIOTENSIN II RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>irbesartan tablet 150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>irbesartan tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>irbesartan tablet 75 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium tablet 25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>losartan potassium tablet 50 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>valsartan solution 4 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan tablet 160 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>valsartan tablet 320 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>valsartan tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>valsartan tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>candesartan cilexetil tablet 16 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>candesartan cilexetil tablet 32 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>candesartan cilexetil tablet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>candesartan cilexetil tablet 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil tablet 20 mg oral</i>	Non Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil tablet 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil tablet 40 mg oral</i>	Non Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil tablet 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan medoxomil tablet 5 mg oral</i>	Non Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan tablet 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan tablet 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>telmisartan tablet 80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ATACAND TABLET 16 MG ORAL ( <i>candesartan cilexetil</i> )	Non Preferred	PA
ATACAND TABLET 32 MG ORAL ( <i>candesartan cilexetil</i> )	Non Preferred	PA
ATACAND TABLET 4 MG ORAL ( <i>candesartan cilexetil</i> )	Non Preferred	PA
ATACAND TABLET 8 MG ORAL ( <i>candesartan cilexetil</i> )	Non Preferred	PA
AVAPRO TABLET 150 MG ORAL ( <i>irbesartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AVAPRO TABLET 300 MG ORAL ( <i>irbesartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AVAPRO TABLET 75 MG ORAL ( <i>irbesartan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
BENICAR TABLET 20 MG ORAL ( <i>olmesartan medoxomil</i> )	Non Preferred	PA
BENICAR TABLET 40 MG ORAL ( <i>olmesartan medoxomil</i> )	Non Preferred	PA
BENICAR TABLET 5 MG ORAL ( <i>olmesartan medoxomil</i> )	Non Preferred	PA
COZAAR TABLET 100 MG ORAL ( <i>losartan potassium</i> )	Non Preferred	PA; QL (1 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
COZAAR TABLET 25 MG ORAL ( <i>losartan potassium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
COZAAR TABLET 50 MG ORAL ( <i>losartan potassium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
DIOVAN TABLET 160 MG ORAL ( <i>valsartan</i> )	Non Preferred	PA; QL (2 EA per 1 day)
DIOVAN TABLET 320 MG ORAL ( <i>valsartan</i> )	Non Preferred	PA; QL (2 EA per 1 day)
DIOVAN TABLET 40 MG ORAL ( <i>valsartan</i> )	Non Preferred	PA; QL (2 EA per 1 day)
DIOVAN TABLET 80 MG ORAL ( <i>valsartan</i> )	Non Preferred	PA; QL (2 EA per 1 day)
EDARBI TABLET 40 MG ORAL ( <i>azilsartan medoxomil</i> )	Non Preferred	PA
EDARBI TABLET 80 MG ORAL ( <i>azilsartan medoxomil</i> )	Non Preferred	PA
MICARDIS TABLET 20 MG ORAL ( <i>telmisartan</i> )	Non Preferred	PA
MICARDIS TABLET 40 MG ORAL ( <i>telmisartan</i> )	Non Preferred	PA
MICARDIS TABLET 80 MG ORAL ( <i>telmisartan</i> )	Non Preferred	PA
<b>*ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine-valsartan-hctz tablet 10-160-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-valsartan-hctz tablet 10-160-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-valsartan-hctz tablet 10-320-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-valsartan-hctz tablet 5-160-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-valsartan-hctz tablet 5-160-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 20-5-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 40-10-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 40-10-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 40-5-12.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 40-5-25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EXFORGE HCT TABLET 10-160-12.5 MG ORAL ( <i>amlodipine-valsartan-hctz</i> )	Non Preferred	PA
EXFORGE HCT TABLET 10-160-25 MG ORAL ( <i>amlodipine-valsartan-hctz</i> )	Non Preferred	PA
EXFORGE HCT TABLET 10-320-25 MG ORAL ( <i>amlodipine-valsartan-hctz</i> )	Non Preferred	PA
EXFORGE HCT TABLET 5-160-12.5 MG ORAL ( <i>amlodipine-valsartan-hctz</i> )	Non Preferred	PA
EXFORGE HCT TABLET 5-160-25 MG ORAL ( <i>amlodipine-valsartan-hctz</i> )	Non Preferred	PA
TRIBENZOR TABLET 20-5-12.5 MG ORAL ( <i>olmesartan-amlodipine-hctz</i> )	Non Preferred	PA
TRIBENZOR TABLET 40-10-12.5 MG ORAL ( <i>olmesartan-amlodipine-hctz</i> )	Non Preferred	PA
TRIBENZOR TABLET 40-10-25 MG ORAL ( <i>olmesartan-amlodipine-hctz</i> )	Non Preferred	PA
TRIBENZOR TABLET 40-5-12.5 MG ORAL ( <i>olmesartan-amlodipine-hctz</i> )	Non Preferred	PA
TRIBENZOR TABLET 40-5-25 MG ORAL ( <i>olmesartan-amlodipine-hctz</i> )	Non Preferred	PA
<b>*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>clonidine hcl tablet 0.1 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>clonidine hcl tablet 0.2 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>clonidine hcl tablet 0.3 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>clonidine patch weekly 0.1 mg/24hr transdermal</i>	Preferred	
<i>clonidine patch weekly 0.2 mg/24hr transdermal</i>	Preferred	
<i>clonidine patch weekly 0.3 mg/24hr transdermal</i>	Preferred	
<i>guanfacine hcl tablet 1 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>guanfacine hcl tablet 2 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>methyldopa tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>methyldopa tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>clonidine hcl er tablet extended release 24 hour 0.17 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIADRENERGICS - PERIPHERALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>doxazosin mesylate tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>doxazosin mesylate tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>doxazosin mesylate tablet 4 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>doxazosin mesylate tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>prazosin hcl capsule 1 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>prazosin hcl capsule 2 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>prazosin hcl capsule 5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>terazosin hcl capsule 1 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>terazosin hcl capsule 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>terazosin hcl capsule 2 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>terazosin hcl capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
CARDURA TABLET 1 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDURA TABLET 2 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDURA TABLET 4 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDURA TABLET 8 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
MINIPRESS CAPSULE 1 MG ORAL ( <i>prazosin hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
MINIPRESS CAPSULE 2 MG ORAL ( <i>prazosin hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
MINIPRESS CAPSULE 5 MG ORAL ( <i>prazosin hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*BETA BLOCKER &amp; DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>atenolol-chlorthalidone tablet 100-25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atenolol-chlorthalidone tablet 50-25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bisoprolol-hydrochlorothiazide tablet 10-6.25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bisoprolol-hydrochlorothiazide tablet 2.5-6.25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>bisoprolol-hydrochlorothiazide tablet 5-6.25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol-hydrochlorothiazide tablet 100-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol-hydrochlorothiazide tablet 100-50 mg oral</i>	Preferred	Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>metoprolol-hydrochlorothiazide tablet 50-25 mg oral</i>	Preferred	Max 90-day supply per fill
TENORETIC 100 TABLET 100-25 MG ORAL ( <i>atenolol-chlorthalidone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TENORETIC 50 TABLET 50-25 MG ORAL ( <i>atenolol-chlorthalidone</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZIAC TABLET 10-6.25 MG ORAL ( <i>bisoprolol-hydrochlorothiazide</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ZIAC TABLET 2.5-6.25 MG ORAL ( <i>bisoprolol-hydrochlorothiazide</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ZIAC TABLET 5-6.25 MG ORAL ( <i>bisoprolol-hydrochlorothiazide</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*DIRECT RENIN INHIBITORS &amp; THIAZIDE/THIAZIDE-LIKE COMB*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
TEKTURNA HCT TABLET 300-12.5 MG ORAL ( <i>aliskiren-hydrochlorothiazide</i> )	Non Preferred	PA
TEKTURNA HCT TABLET 300-25 MG ORAL ( <i>aliskiren-hydrochlorothiazide</i> )	Non Preferred	PA
<b>*DIRECT RENIN INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>aliskiren fumarate tablet 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>aliskiren fumarate tablet 300 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
TEKTURNA TABLET 150 MG ORAL ( <i>aliskiren fumarate</i> )	Non Preferred	PA
TEKTURNA TABLET 300 MG ORAL ( <i>aliskiren fumarate</i> )	Non Preferred	PA
<b>*SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>eplerenone tablet 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>eplerenone tablet 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
INSPRA TABLET 25 MG ORAL ( <i>eplerenone</i> )	Non Preferred	PA
INSPRA TABLET 50 MG ORAL ( <i>eplerenone</i> )	Non Preferred	PA
<b>*VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>hydralazine hcl tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>hydralazine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>hydralazine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
<i>hydralazine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>minoxidil tablet 10 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>minoxidil tablet 2.5 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<b>*ANTI-INFECTIVE AGENTS - MISC.* - DRUGS FOR INFECTIONS</b>		
<b>*ANTI-INFECTIVE AGENTS - MISC.*** - DRUGS FOR INFECTIONS</b>		
<i>metronidazole tablet 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>metronidazole tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>pentamidine isethionate solution reconstituted 300 mg inhalation</i>	Preferred	
<i>trimethoprim tablet 100 mg oral</i>	Preferred	QL (6 EA per 1 day)
NEBUPENT SOLUTION RECONSTITUTED 300 MG INHALATION ( <i>pentamidine isethionate</i> )	Preferred	
<i>metronidazole capsule 375 mg oral</i>	Non Preferred	PA
<i>tinidazole tablet 250 mg oral</i>	Non Preferred	PA
<i>tinidazole tablet 500 mg oral</i>	Non Preferred	PA
AEMCOLO TABLET DELAYED RELEASE 194 MG ORAL ( <i>rifamycin sodium</i> )	Non Preferred	PA
FLAGYL CAPSULE 375 MG ORAL ( <i>metronidazole</i> )	Non Preferred	PA
LIKMEZ SUSPENSION 500 MG/5ML ORAL ( <i>metronidazole</i> )	Non Preferred	PA
XIFAXAN TABLET 200 MG ORAL ( <i>rifaximin</i> )	Non Preferred	PA
XIFAXAN TABLET 550 MG ORAL ( <i>rifaximin</i> )	Non Preferred	PA
<b>*ANTI-INFECTIVE MISC. - COMBINATIONS*** - ANTIBIOTICS</b>		
<i>sulfamethoxazole-trimethoprim suspension 200-40 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>sulfamethoxazole-trimethoprim tablet 400-80 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>sulfamethoxazole-trimethoprim tablet 800-160 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>sulfamethoxazole-trimethoprim (Sulfatrim Pediatric Suspension 200-40 Mg/5MI Oral)</i>	Preferred	QL (40 ML per 1 day)
BACTRIM DS TABLET 800-160 MG ORAL ( <i>sulfamethoxazole-trimethoprim</i> )	Non Preferred	PA; QL (4 EA per 1 day)
BACTRIM TABLET 400-80 MG ORAL ( <i>sulfamethoxazole-trimethoprim</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIPROTOZOAL AGENTS*** - DRUGS FOR PARASITES</b>		
<i>atovaquone suspension 750 mg/5ml oral</i>	Preferred	
<i>nitazoxanide tablet 500 mg oral</i>	Non Preferred	PA
LAMPIT TABLET 120 MG ORAL ( <i>nifurtimox</i> )	Non Preferred	PA
LAMPIT TABLET 30 MG ORAL ( <i>nifurtimox</i> )	Non Preferred	PA
MEPRON SUSPENSION 750 MG/5ML ORAL ( <i>atovaquone</i> )	Non Preferred	PA
<b>*CARBAPENEMS*** - ANTIBIOTICS</b>		
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	Preferred	Max 14-day supply per fill
<i>meropenem intravenous solution reconstituted 500 mg</i>	Preferred	Max 14-day supply per fill
<b>*GLYCOPEPTIDES*** - ANTIBIOTICS</b>		
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	
<i>vancomycin hcl capsule 250 mg oral</i>	Preferred	
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 1.25 gm, 1.5 gm, 10 gm, 250 mg, 5 gm, 500 mg, 750 mg</i>	Preferred	
<i>vancomycin hcl solution reconstituted 25 mg/ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>vancomycin hcl solution reconstituted 250 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>vancomycin hcl solution reconstituted 50 mg/ml oral</i>	Preferred	QL (40 ML per 1 day)
FIRVANQ SOLUTION RECONSTITUTED 25 MG/ML ORAL ( <i>vancomycin hcl</i> )	Non Preferred	PA; QL (40 ML per 1 day)
FIRVANQ SOLUTION RECONSTITUTED 50 MG/ML ORAL ( <i>vancomycin hcl</i> )	Non Preferred	PA; QL (40 ML per 1 day)
VANCOGIN CAPSULE 125 MG ORAL ( <i>vancomycin hcl</i> )	Non Preferred	PA
VANCOGIN CAPSULE 250 MG ORAL ( <i>vancomycin hcl</i> )	Non Preferred	PA
<b>*LEPROSTATICS*** - ANTIBIOTICS</b>		
<i>dapsone tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>dapsone tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<b>*LINCOSAMIDES*** - ANTIBIOTICS</b>		
<i>clindamycin hcl capsule 150 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>clindamycin hcl capsule 300 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>clindamycin hcl capsule 75 mg oral</i>	Preferred	
<i>clindamycin palmitate hcl solution reconstituted 75 mg/5ml oral</i>	Preferred	
CLEOCIN CAPSULE 150 MG ORAL ( <i>clindamycin hcl</i> )	Non Preferred	PA; QL (8 EA per 1 day)
CLEOCIN CAPSULE 300 MG ORAL ( <i>clindamycin hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
CLEOCIN CAPSULE 75 MG ORAL ( <i>clindamycin hcl</i> )	Non Preferred	PA
CLEOCIN SOLUTION RECONSTITUTED 75 MG/5ML ORAL ( <i>clindamycin palmitate hcl</i> )	Non Preferred	PA
<b>*MONOBACTAMS*** - ANTIBIOTICS</b>		
CAYSTON SOLUTION RECONSTITUTED 75 MG INHALATION ( <i>aztreonam lysine</i> )	Non Preferred	PA
<b>*OXAZOLIDINONES*** - ANTIBIOTICS</b>		
<i>linezolid suspension reconstituted 100 mg/5ml oral</i>	Non Preferred	PA
<i>linezolid tablet 600 mg oral</i>	Non Preferred	PA
SIVEXTRO TABLET 200 MG ORAL ( <i>tedizolid phosphate</i> )	Non Preferred	PA
ZYVOX SUSPENSION RECONSTITUTED 100 MG/5ML ORAL ( <i>linezolid</i> )	Non Preferred	PA
ZYVOX TABLET 600 MG ORAL ( <i>linezolid</i> )	Non Preferred	PA
<b>*URINARY ANTI-INFECTIVES*** - ANTIBIOTICS</b>		
<i>fosfomycin tromethamine packet 3 gm oral</i>	Preferred	
<i>methenamine hippurate tablet 1 gm oral</i>	Preferred	
<i>methenamine mandelate tablet 0.5 gm oral</i>	Preferred	
<i>methenamine mandelate tablet 1 gm oral</i>	Preferred	
<i>nitrofurantoin macrocrystal capsule 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>nitrofurantoin macrocrystal capsule 25 mg oral</i>	Preferred	
<i>nitrofurantoin macrocrystal capsule 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>nitrofurantoin monohyd macro capsule 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>nitrofurantoin suspension 25 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>nitrofurantoin suspension 50 mg/5ml oral</i>	Preferred	
HIPREX TABLET 1 GM ORAL ( <i>methenamine hippurate</i> )	Non Preferred	PA
MACROBID CAPSULE 100 MG ORAL ( <i>nitrofurantoin monohyd macro</i> )	Non Preferred	PA; QL (2 EA per 1 day)
MACRODANTIN CAPSULE 100 MG ORAL ( <i>nitrofurantoin macrocrystal</i> )	Non Preferred	PA; QL (4 EA per 1 day)
MACRODANTIN CAPSULE 25 MG ORAL ( <i>nitrofurantoin macrocrystal</i> )	Non Preferred	PA
MACRODANTIN CAPSULE 50 MG ORAL ( <i>nitrofurantoin macrocrystal</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*URINARY ANTISEPTIC-ANTISPASMODIC &amp;/OR ANALGESICS*** - DRUGS FOR INFECTIONS</b>		
<i>me/naphos/mb/hyo1 tablet 81.6 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>uro-mp capsule 118 mg oral</i>	Non Preferred	PA
HYOPHEN TABLET 81.6 MG ORAL ( <i>meth-hyo-m bl-benz acd-ph sal</i> )	Non Preferred	PA
<i>meth-hyo-m bl-na phos-ph sal</i> (Phosphasal Tablet 81.6 Mg Oral)	Non Preferred	PA
URIBEL TABLET 81.6 MG ORAL ( <i>meth-hyo-m bl-benz acd-ph sal</i> )	Non Preferred	PA
<i>meth-hyo-m bl-na phos-ph sal</i> (Urimar-T Capsule 120 Mg Oral)	Non Preferred	PA
URIMAR-T TABLET 120 MG ORAL ( <i>meth-hyo-m bl-na phos-ph sal</i> )	Non Preferred	PA
UROGESIC-BLUE TABLET 81.6 MG ORAL ( <i>methen-hyosc-meth blue-na phos</i> )	Non Preferred	PA
<i>meth-hyo-m bl-na phos-ph sal</i> (Ustell Capsule 120 Mg Oral)	Non Preferred	PA
<b>*ANTIMALARIALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIMALARIAL COMBINATIONS*** - DRUGS FOR PARASITES</b>		
<i>atovaquone-proguanil hcl tablet 250-100 mg oral</i>	Preferred	Max 100-day supply per fill
<i>atovaquone-proguanil hcl tablet 62.5-25 mg oral</i>	Preferred	Max 100-day supply per fill
COARTEM TABLET 20-120 MG ORAL ( <i>artemether-lumefantrine</i> )	Non Preferred	PA
MALARONE TABLET 250-100 MG ORAL ( <i>atovaquone-proguanil hcl</i> )	Non Preferred	PA; Max 100-day supply per fill
MALARONE TABLET 62.5-25 MG ORAL ( <i>atovaquone-proguanil hcl</i> )	Non Preferred	PA; Max 100-day supply per fill
<b>*ANTIMALARIALS*** - DRUGS FOR PARASITES</b>		
<i>chloroquine phosphate tablet 250 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>chloroquine phosphate tablet 500 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>hydroxychloroquine sulfate tablet 100 mg oral</i>	Preferred	
<i>hydroxychloroquine sulfate tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxychloroquine sulfate tablet 300 mg oral</i>	Preferred	
<i>hydroxychloroquine sulfate tablet 400 mg oral</i>	Preferred	
<i>mefloquine hcl tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 100-day supply per fill
<i>primaquine phosphate tablet 26.3 (15 base) mg oral</i>	Preferred	Max 100-day supply per fill
<i>pyrimethamine tablet 25 mg oral</i>	Non Preferred	PA
<i>quinine sulfate capsule 324 mg oral</i>	Non Preferred	PA
DARAPRIM TABLET 25 MG ORAL ( <i>pyrimethamine</i> )	Non Preferred	PA
KRINTAFEL TABLET 150 MG ORAL ( <i>tafenoquine succinate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
QUALAQUIN CAPSULE 324 MG ORAL ( <i>quinine sulfate</i> )	Non Preferred	PA
<b>*ANTIMYASTHENIC/CHOLINERGIC AGENTS* - DRUGS FOR NERVES AND MUSCLES</b>		
<b>*ANTIMYASTHENIC/CHOLINERGIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>pyridostigmine bromide er tablet extended release 180 mg oral</i>	Preferred	
<i>pyridostigmine bromide solution 60 mg/5ml oral</i>	Preferred	
<i>pyridostigmine bromide tablet 30 mg oral</i>	Preferred	
<i>pyridostigmine bromide tablet 60 mg oral</i>	Preferred	QL (6 EA per 1 day)
FIRDAPSE TABLET 10 MG ORAL ( <i>amifampridine phosphate</i> )	Non Preferred	PA
MESTINON SOLUTION 60 MG/5ML ORAL ( <i>pyridostigmine bromide</i> )	Non Preferred	PA
MESTINON TABLET 60 MG ORAL ( <i>pyridostigmine bromide</i> )	Non Preferred	PA; QL (6 EA per 1 day)
MESTINON TABLET EXTENDED RELEASE 180 MG ORAL ( <i>pyridostigmine bromide</i> )	Non Preferred	PA
<b>*ANTIMYCOBACTERIAL AGENTS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIMYCOBACTERIAL AGENTS*** - ANTIBIOTICS</b>		
<i>cycloserine capsule 250 mg oral</i>	Preferred	
<i>ethambutol hcl tablet 100 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>ethambutol hcl tablet 400 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>isoniazid syrup 50 mg/5ml oral</i>	Preferred	QL (30 ML per 1 day)
<i>isoniazid tablet 100 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>isoniazid tablet 300 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>pyrazinamide tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>rifabutin capsule 150 mg oral</i>	Preferred	
<i>rifampin capsule 150 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>rifampin capsule 300 mg oral</i>	Preferred	QL (4 EA per 1 day)
PRIFTIN TABLET 150 MG ORAL ( <i>rifapentine</i> )	Preferred	QL (1.143 EA per 1 day)
TRECTOR TABLET 250 MG ORAL ( <i>ethionamide</i> )	Preferred	
<i>pretomanid tablet 200 mg oral</i>	Non Preferred	PA
MYAMBUTOL TABLET 400 MG ORAL ( <i>ethambutol hcl</i> )	Non Preferred	PA; QL (5 EA per 1 day)
MYCOBUTIN CAPSULE 150 MG ORAL ( <i>rifabutin</i> )	Non Preferred	PA
SIRTURO TABLET 100 MG ORAL ( <i>bedaquiline fumarate</i> )	Non Preferred	PA
SIRTURO TABLET 20 MG ORAL ( <i>bedaquiline fumarate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER</b>		
<i>everolimus tablet 7.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER</b>		
<b>*ALKYLATING AGENTS*** - DRUGS FOR CANCER</b>		
MYLERAN TABLET 2 MG ORAL ( <i>busulfan</i> )	Preferred	
<b>*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>abiraterone acetate tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>abiraterone acetate tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
YONSA TABLET 125 MG ORAL ( <i>abiraterone acetate micronized</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ZYTIGA TABLET 250 MG ORAL ( <i>abiraterone acetate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ZYTIGA TABLET 500 MG ORAL ( <i>abiraterone acetate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ANTIADRENALS*** - DRUGS FOR CANCER</b>		
LYSODREN TABLET 500 MG ORAL ( <i>mitotane</i> )	Preferred	
<b>*ANTIANDROGENS*** - DRUGS FOR CANCER</b>		
<i>bicalutamide tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>flutamide capsule 125 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>nilutamide tablet 150 mg oral</i>	Preferred	
CASODEX TABLET 50 MG ORAL ( <i>bicalutamide</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ERLEADA TABLET 240 MG ORAL ( <i>apalutamide</i> )	Non Preferred	PA
ERLEADA TABLET 60 MG ORAL ( <i>apalutamide</i> )	Non Preferred	PA; QL (4 EA per 1 day)
NUBEQA TABLET 300 MG ORAL ( <i>darolutamide</i> )	Non Preferred	PA; QL (4 EA per 1 day)
XTANDI CAPSULE 40 MG ORAL ( <i>enzalutamide</i> )	Non Preferred	PA; QL (4 EA per 1 day)
XTANDI TABLET 40 MG ORAL ( <i>enzalutamide</i> )	Non Preferred	PA
XTANDI TABLET 80 MG ORAL ( <i>enzalutamide</i> )	Non Preferred	PA
<b>*ANTIESTROGENS*** - DRUGS FOR CANCER</b>		
<i>tamoxifen citrate tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>tamoxifen citrate tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>toremifene citrate tablet 60 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SOLTAMOX SOLUTION 10 MG/5ML ORAL ( <i>tamoxifen citrate</i> )	Preferred	
FARESTON TABLET 60 MG ORAL ( <i>toremifene citrate</i> )	Non Preferred	PA
<b>*ANTIMETABOLITES*** - DRUGS FOR CANCER</b>		
<i>mercaptopurine tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	Preferred	QL (0.4 ML per 1 day)
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	Preferred	QL (0.4 ML per 1 day)
<i>methotrexate sodium tablet 2.5 mg oral</i>	Preferred	QL (24 EA per 1 day)
TABLOID TABLET 40 MG ORAL ( <i>thioguanine</i> )	Preferred	
TREXALL TABLET 10 MG ORAL ( <i>methotrexate sodium</i> )	Preferred	
TREXALL TABLET 15 MG ORAL ( <i>methotrexate sodium</i> )	Preferred	
TREXALL TABLET 5 MG ORAL ( <i>methotrexate sodium</i> )	Preferred	
TREXALL TABLET 7.5 MG ORAL ( <i>methotrexate sodium</i> )	Preferred	
<i>capecitabine tablet 150 mg oral</i>	Non Preferred	PA
<i>capecitabine tablet 500 mg oral</i>	Non Preferred	PA
JYLAMVO SOLUTION 2 MG/ML ORAL ( <i>methotrexate</i> )	Non Preferred	PA
ONUREG TABLET 200 MG ORAL ( <i>azacitidine</i> )	Non Preferred	PA
ONUREG TABLET 300 MG ORAL ( <i>azacitidine</i> )	Non Preferred	PA
PURIXAN SUSPENSION 2000 MG/100ML ORAL ( <i>mercaptopurine</i> )	Non Preferred	PA
XATMEP SOLUTION 2.5 MG/ML ORAL ( <i>methotrexate</i> )	Non Preferred	PA
XELODA TABLET 150 MG ORAL ( <i>capecitabine</i> )	Non Preferred	
XELODA TABLET 150 MG ORAL ( <i>capecitabine</i> )	Non Preferred	PA
XELODA TABLET 500 MG ORAL ( <i>capecitabine</i> )	Non Preferred	
XELODA TABLET 500 MG ORAL ( <i>capecitabine</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - ALK INHIBITORS*** - DRUGS FOR CANCER</b>		
ALECENSA CAPSULE 150 MG ORAL ( <i>alectinib hcl</i> )	Non Preferred	PA; QL (8 EA per 1 day)
ALUNBRIG TABLET 180 MG ORAL ( <i>brigatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALUNBRIG TABLET 30 MG ORAL ( <i>brigatinib</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
ALUNBRIG TABLET 90 MG ORAL ( <i>brigatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ALUNBRIG TABLET THERAPY PACK 90 & 180 MG ORAL ( <i>brigatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LORBRENA TABLET 100 MG ORAL ( <i>lorlatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LORBRENA TABLET 25 MG ORAL ( <i>lorlatinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TRUQAP TABLET 160 MG ORAL ( <i>capivasertib</i> )	Non Preferred	PA
TRUQAP TABLET 200 MG ORAL ( <i>capivasertib</i> )	Non Preferred	PA
XALKORI CAPSULE 200 MG ORAL ( <i>crizotinib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
XALKORI CAPSULE 250 MG ORAL ( <i>crizotinib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
XALKORI CAPSULE SPRINKLE 150 MG ORAL ( <i>crizotinib</i> )	Non Preferred	PA
XALKORI CAPSULE SPRINKLE 20 MG ORAL ( <i>crizotinib</i> )	Non Preferred	PA
XALKORI CAPSULE SPRINKLE 50 MG ORAL ( <i>crizotinib</i> )	Non Preferred	PA
ZYKADIA TABLET 150 MG ORAL ( <i>ceritinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*ANTINEOPLASTIC - ANTI-HER2 AGENTS*** - DRUGS FOR CANCER</b>		
TUKYSA TABLET 150 MG ORAL ( <i>tucatinib</i> )	Non Preferred	PA
TUKYSA TABLET 50 MG ORAL ( <i>tucatinib</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - BCL-2 INHIBITORS*** - DRUGS FOR CANCER</b>		
VENCLEXTA STARTING PACK TABLET THERAPY PACK 10 & 50 & 100 MG ORAL ( <i>venetoclax</i> )	Non Preferred	PA; QL (1.5 EA per 1 day)
VENCLEXTA TABLET 10 MG ORAL ( <i>venetoclax</i> )	Non Preferred	PA; QL (4 EA per 1 day)
VENCLEXTA TABLET 100 MG ORAL ( <i>venetoclax</i> )	Non Preferred	PA; QL (6 EA per 1 day)
VENCLEXTA TABLET 50 MG ORAL ( <i>venetoclax</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>imatinib mesylate tablet 100 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>imatinib mesylate tablet 400 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)

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BOSULIF CAPSULE 100 MG ORAL ( <i>bosutinib</i> )	Non Preferred	PA
BOSULIF CAPSULE 50 MG ORAL ( <i>bosutinib</i> )	Non Preferred	PA
BOSULIF TABLET 100 MG ORAL ( <i>bosutinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
BOSULIF TABLET 400 MG ORAL ( <i>bosutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
BOSULIF TABLET 500 MG ORAL ( <i>bosutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
GLEEVEC TABLET 100 MG ORAL ( <i>imatinib mesylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
GLEEVEC TABLET 400 MG ORAL ( <i>imatinib mesylate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ICLUSIG TABLET 10 MG ORAL ( <i>ponatinib hcl</i> )	Non Preferred	PA
ICLUSIG TABLET 15 MG ORAL ( <i>ponatinib hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ICLUSIG TABLET 30 MG ORAL ( <i>ponatinib hcl</i> )	Non Preferred	PA
ICLUSIG TABLET 45 MG ORAL ( <i>ponatinib hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SCSEMBLIX TABLET 20 MG ORAL ( <i>asciminib hcl</i> )	Non Preferred	PA
SCSEMBLIX TABLET 40 MG ORAL ( <i>asciminib hcl</i> )	Non Preferred	PA
SPRYCEL TABLET 100 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SPRYCEL TABLET 140 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SPRYCEL TABLET 20 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
SPRYCEL TABLET 50 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SPRYCEL TABLET 70 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
SPRYCEL TABLET 80 MG ORAL ( <i>dasatinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TASIGNA CAPSULE 150 MG ORAL ( <i>nilotinib hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TASIGNA CAPSULE 200 MG ORAL ( <i>nilotinib hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TASIGNA CAPSULE 50 MG ORAL ( <i>nilotinib hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<b>*ANTINEOPLASTIC - BRAF KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
BRAFTOVI CAPSULE 75 MG ORAL ( <i>encorafenib</i> )	Non Preferred	PA; QL (6 EA per 1 day)
TAFINLAR CAPSULE 50 MG ORAL ( <i>dabrafenib mesylate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TAFINLAR CAPSULE 75 MG ORAL ( <i>dabrafenib mesylate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TAFINLAR TABLET SOLUBLE 10 MG ORAL ( <i>dabrafenib mesylate</i> )	Non Preferred	PA
ZELBORAF TABLET 240 MG ORAL ( <i>vemurafenib</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*ANTINEOPLASTIC - BTK INHIBITORS*** - DRUGS FOR CANCER</b>		
BRUKINSA CAPSULE 80 MG ORAL ( <i>zanubrutinib</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CALQUENCE CAPSULE 100 MG ORAL ( <i>acalabrutinib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CALQUENCE TABLET 100 MG ORAL ( <i>acalabrutinib maleate</i> )	Non Preferred	PA
IMBRUVICA CAPSULE 140 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
IMBRUVICA CAPSULE 70 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IMBRUVICA SUSPENSION 70 MG/ML ORAL ( <i>ibrutinib</i> )	Non Preferred	PA
IMBRUVICA TABLET 140 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IMBRUVICA TABLET 280 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IMBRUVICA TABLET 420 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IMBRUVICA TABLET 560 MG ORAL ( <i>ibrutinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
JAYPIRCA TABLET 100 MG ORAL ( <i>pirtobrutinib</i> )	Non Preferred	PA
JAYPIRCA TABLET 50 MG ORAL ( <i>pirtobrutinib</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - EGFR INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>erlotinib hcl tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>erlotinib hcl tablet 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>erlotinib hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>gefitinib tablet 250 mg oral</i>	Preferred	
IRESSA TABLET 250 MG ORAL ( <i>gefitinib</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
EXKIVITY CAPSULE 40 MG ORAL ( <i>mobocertinib succinate</i> )	Non Preferred	PA
GILOTRIF TABLET 20 MG ORAL ( <i>afatinib dimaleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
GILOTRIF TABLET 30 MG ORAL ( <i>afatinib dimaleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
GILOTRIF TABLET 40 MG ORAL ( <i>afatinib dimaleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TAGRISSE TABLET 40 MG ORAL ( <i>osimertinib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TAGRISSE TABLET 80 MG ORAL ( <i>osimertinib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TARCEVA TABLET 100 MG ORAL ( <i>erlotinib hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TARCEVA TABLET 150 MG ORAL ( <i>erlotinib hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
TARCEVA TABLET 25 MG ORAL ( <i>erlotinib hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
VIZIMPRO TABLET 15 MG ORAL ( <i>dacomitinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VIZIMPRO TABLET 30 MG ORAL ( <i>dacomitinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VIZIMPRO TABLET 45 MG ORAL ( <i>dacomitinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTINEOPLASTIC - FGFR KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
BALVERSA TABLET 3 MG ORAL ( <i>erdafitinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
BALVERSA TABLET 4 MG ORAL ( <i>erdafitinib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BALVERSA TABLET 5 MG ORAL ( <i>erdafitinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LYTGOBI (12 MG DAILY DOSE) TABLET THERAPY PACK 4 MG ORAL ( <i>futibatinib</i> )	Non Preferred	PA
LYTGOBI (16 MG DAILY DOSE) TABLET THERAPY PACK 4 MG ORAL ( <i>futibatinib</i> )	Non Preferred	PA
LYTGOBI (20 MG DAILY DOSE) TABLET THERAPY PACK 4 MG ORAL ( <i>futibatinib</i> )	Non Preferred	PA
PEMAZYRE TABLET 13.5 MG ORAL ( <i>pemigatinib</i> )	Non Preferred	PA
PEMAZYRE TABLET 4.5 MG ORAL ( <i>pemigatinib</i> )	Non Preferred	PA
PEMAZYRE TABLET 9 MG ORAL ( <i>pemigatinib</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS*** - DRUGS FOR CANCER</b>		
ERIVEDGE CAPSULE 150 MG ORAL ( <i>vismodegib</i> )	Preferred	
DAURISMO TABLET 100 MG ORAL ( <i>glasdegib maleate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
DAURISMO TABLET 25 MG ORAL ( <i>glasdegib maleate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ODOMZO CAPSULE 200 MG ORAL ( <i>sonidegib phosphate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS*** - DRUGS FOR CANCER</b>		
ZOLINZA CAPSULE 100 MG ORAL ( <i>vorinostat</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*ANTINEOPLASTIC - HORMONAL AND RELATED AGENT COMBINATIONS*** - DRUGS FOR CANCER</b>		
AKEEGA TABLET 100-500 MG ORAL ( <i>niraparib-abiraterone acetate</i> )	Non Preferred	PA
AKEEGA TABLET 50-500 MG ORAL ( <i>niraparib-abiraterone acetate</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - IMMUNOMODULATORS*** - DRUGS FOR CANCER</b>		
POMALYST CAPSULE 1 MG ORAL ( <i>pomalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
POMALYST CAPSULE 2 MG ORAL ( <i>pomalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
POMALYST CAPSULE 3 MG ORAL ( <i>pomalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
POMALYST CAPSULE 4 MG ORAL ( <i>pomalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTINEOPLASTIC - KRAS INHIBITORS*** - DRUGS FOR CANCER</b>		
KRAZATI TABLET 200 MG ORAL ( <i>adagrasib</i> )	Non Preferred	PA
LUMAKRAS TABLET 120 MG ORAL ( <i>sotorasib</i> )	Non Preferred	PA
LUMAKRAS TABLET 320 MG ORAL ( <i>sotorasib</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - MEK INHIBITORS*** - DRUGS FOR CANCER</b>		
COTELLIC TABLET 20 MG ORAL ( <i>cobimetinib fumarate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
KOSELUGO CAPSULE 10 MG ORAL ( <i>selumetinib sulfate</i> )	Non Preferred	PA
KOSELUGO CAPSULE 25 MG ORAL ( <i>selumetinib sulfate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MEKINIST SOLUTION RECONSTITUTED 0.05 MG/ML ORAL ( <i>trametinib dimethyl sulfoxide</i> )	Non Preferred	PA
MEKINIST TABLET 0.5 MG ORAL ( <i>trametinib dimethyl sulfoxide</i> )	Non Preferred	PA; QL (3 EA per 1 day)
MEKINIST TABLET 2 MG ORAL ( <i>trametinib dimethyl sulfoxide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
MEKTOVI TABLET 15 MG ORAL ( <i>binimetinib</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*ANTINEOPLASTIC - MET INHIBITORS*** - DRUGS FOR CANCER</b>		
TABRECTA TABLET 150 MG ORAL ( <i>capmatinib hcl</i> )	Non Preferred	PA
TABRECTA TABLET 200 MG ORAL ( <i>capmatinib hcl</i> )	Non Preferred	PA
TEPMETKO TABLET 225 MG ORAL ( <i>tepotinib hcl</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS*** - DRUGS FOR CANCER</b>		
TAZVERIK TABLET 200 MG ORAL ( <i>tazemetostat hbr</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>everolimus tablet 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>everolimus tablet 2.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>everolimus tablet 5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>everolimus tablet 7.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>everolimus tablet soluble 2 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>everolimus tablet soluble 3 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>everolimus tablet soluble 5 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
AFINITOR DISPERZ TABLET SOLUBLE 2 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (2 EA per 1 day)
AFINITOR DISPERZ TABLET SOLUBLE 3 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (3 EA per 1 day)
AFINITOR DISPERZ TABLET SOLUBLE 5 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (2 EA per 1 day)
AFINITOR TABLET 10 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AFINITOR TABLET 2.5 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
AFINITOR TABLET 5 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AFINITOR TABLET 7.5 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ANTINEOPLASTIC - MULTIKINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>pazopanib hcl tablet 200 mg oral</i>	Preferred	
<i>sorafenib tosylate tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>sunitinib malate capsule 12.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>sunitinib malate capsule 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>sunitinib malate capsule 37.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 50 mg oral</i>	Preferred	QL (1 EA per 1 day)
CAPRELSA TABLET 100 MG ORAL ( <i>vandetanib</i> )	Preferred	
CAPRELSA TABLET 300 MG ORAL ( <i>vandetanib</i> )	Preferred	
NEXAVAR TABLET 200 MG ORAL ( <i>sorafenib tosylate</i> )	Preferred	QL (4 EA per 1 day)
SUTENT CAPSULE 12.5 MG ORAL ( <i>sunitinib malate</i> )	Preferred	QL (4 EA per 1 day)
SUTENT CAPSULE 25 MG ORAL ( <i>sunitinib malate</i> )	Preferred	QL (2 EA per 1 day)
SUTENT CAPSULE 37.5 MG ORAL ( <i>sunitinib malate</i> )	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 50 MG ORAL ( <i>sunitinib malate</i> )	Preferred	QL (1 EA per 1 day)
VOTRIENT TABLET 200 MG ORAL ( <i>pazopanib hcl</i> )	Preferred	
<i>lapatinib ditosylate tablet 250 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
CABOMETYX TABLET 20 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CABOMETYX TABLET 40 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CABOMETYX TABLET 60 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
COMETRIQ (100 MG DAILY DOSE) KIT 80 & 20 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
COMETRIQ (140 MG DAILY DOSE) KIT 3 X 20 MG & 80 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
COMETRIQ (60 MG DAILY DOSE) KIT 20 MG ORAL ( <i>cabozantinib s-malate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
FOTIVDA CAPSULE 0.89 MG ORAL ( <i>tivozanib hcl</i> )	Non Preferred	PA
FOTIVDA CAPSULE 1.34 MG ORAL ( <i>tivozanib hcl</i> )	Non Preferred	PA
NERLYNX TABLET 40 MG ORAL ( <i>neratinib maleate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
QINLOCK TABLET 50 MG ORAL ( <i>ripretinib</i> )	Non Preferred	PA
RYDAPT CAPSULE 25 MG ORAL ( <i>midostaurin</i> )	Non Preferred	PA; QL (8 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
STIVARGA TABLET 40 MG ORAL ( <i>regorafenib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TURALIO CAPSULE 125 MG ORAL ( <i>pexidartinib hcl</i> )	Non Preferred	PA
TYKERB TABLET 250 MG ORAL ( <i>lapatinib ditosylate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
VANFLYTA TABLET 17.7 MG ORAL ( <i>quizartinib dihydrochloride</i> )	Non Preferred	PA
VANFLYTA TABLET 26.5 MG ORAL ( <i>quizartinib dihydrochloride</i> )	Non Preferred	PA
XOSPATA TABLET 40 MG ORAL ( <i>gilteritinib fumarate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS*** - DRUGS FOR CANCER</b>		
AYVAKIT TABLET 100 MG ORAL ( <i>avapritinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AYVAKIT TABLET 200 MG ORAL ( <i>avapritinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AYVAKIT TABLET 25 MG ORAL ( <i>avapritinib</i> )	Non Preferred	PA
AYVAKIT TABLET 300 MG ORAL ( <i>avapritinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AYVAKIT TABLET 50 MG ORAL ( <i>avapritinib</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - PROTEASOME INHIBITORS*** - DRUGS FOR CANCER</b>		
NINLARO CAPSULE 2.3 MG ORAL ( <i>ixazomib citrate</i> )	Non Preferred	PA; QL (3 EA per 20 days)
NINLARO CAPSULE 3 MG ORAL ( <i>ixazomib citrate</i> )	Non Preferred	PA; QL (3 EA per 20 days)
NINLARO CAPSULE 4 MG ORAL ( <i>ixazomib citrate</i> )	Non Preferred	PA; QL (3 EA per 20 days)
<b>*ANTINEOPLASTIC - RET INHIBITORS*** - DRUGS FOR CANCER</b>		
GAVRETO CAPSULE 100 MG ORAL ( <i>pralsetinib</i> )	Non Preferred	PA
RETEVMO CAPSULE 40 MG ORAL ( <i>selpercatinib</i> )	Non Preferred	PA
RETEVMO CAPSULE 80 MG ORAL ( <i>selpercatinib</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
AUGTYRO CAPSULE 40 MG ORAL ( <i>reprotrectinib</i> )	Non Preferred	PA
ROZLYTREK CAPSULE 100 MG ORAL ( <i>entrectinib</i> )	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
ROZLYTREK CAPSULE 200 MG ORAL ( <i>entrectinib</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ROZLYTREK PACKET 50 MG ORAL ( <i>entrectinib</i> )	Non Preferred	PA
VITRAKVI CAPSULE 100 MG ORAL ( <i>larotrectinib sulfate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VITRAKVI CAPSULE 25 MG ORAL ( <i>larotrectinib sulfate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
VITRAKVI SOLUTION 20 MG/ML ORAL ( <i>larotrectinib sulfate</i> )	Non Preferred	PA; QL (10 ML per 1 day)
<b>*ANTINEOPLASTIC - XPO1 INHIBITORS*** - DRUGS FOR CANCER</b>		
XPOVIO (100 MG ONCE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA; QL (20 EA per 28 days)
XPOVIO (100 MG ONCE WEEKLY) TABLET THERAPY PACK 50 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (40 MG ONCE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (40 MG ONCE WEEKLY) TABLET THERAPY PACK 40 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (40 MG TWICE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (40 MG TWICE WEEKLY) TABLET THERAPY PACK 40 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (60 MG ONCE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA; QL (12 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) TABLET THERAPY PACK 60 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (60 MG TWICE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (80 MG ONCE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA; QL (16 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) TABLET THERAPY PACK 40 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA
XPOVIO (80 MG TWICE WEEKLY) TABLET THERAPY PACK 20 MG ORAL ( <i>selinexor</i> )	Non Preferred	PA; QL (32 EA per 28 days)
<b>*ANTINEOPLASTIC COMBINATIONS*** - DRUGS FOR CANCER</b>		
INQOVI TABLET 35-100 MG ORAL ( <i>decitabine-cedazuridine</i> )	Non Preferred	PA
KISQALI FEMARA (200 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL ( <i>ribociclib-letrozole</i> )	Non Preferred	PA; QL (49 EA per 28 days)
KISQALI FEMARA (400 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL ( <i>ribociclib-letrozole</i> )	Non Preferred	PA; QL (70 EA per 28 days)
KISQALI FEMARA (600 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL ( <i>ribociclib-letrozole</i> )	Non Preferred	PA; QL (91 EA per 28 days)

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Drug Name	Formulary Status	Requirements/Limits
LONSURF TABLET 15-6.14 MG ORAL ( <i>trifluridine-tipiracil</i> )	Non Preferred	PA; QL (100 EA per 28 days)
LONSURF TABLET 20-8.19 MG ORAL ( <i>trifluridine-tipiracil</i> )	Non Preferred	PA; QL (100 EA per 28 days)
<b>*ANTINEOPLASTICS MISC.*** - DRUGS FOR CANCER</b>		
<i>hydroxyurea capsule 500 mg oral</i>	Preferred	
MATULANE CAPSULE 50 MG ORAL ( <i>procarbazine hcl</i> )	Preferred	
HYDREA CAPSULE 500 MG ORAL ( <i>hydroxyurea</i> )	Non Preferred	PA
<b>*AROMATASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>anastrozole tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 40 Years)
<i>exemestane tablet 25 mg oral</i>	Preferred	AGE (Min 40 Years)
<i>letrozole tablet 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 40 Years)
ARIMIDEX TABLET 1 MG ORAL ( <i>anastrozole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 40 Years)
AROMASIN TABLET 25 MG ORAL ( <i>exemestane</i> )	Non Preferred	PA; AGE (Min 40 Years)
FEMARA TABLET 2.5 MG ORAL ( <i>letrozole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 40 Years)
<b>*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER</b>		
IBRANCE CAPSULE 100 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IBRANCE CAPSULE 125 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IBRANCE CAPSULE 75 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IBRANCE TABLET 100 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA
IBRANCE TABLET 125 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA
IBRANCE TABLET 75 MG ORAL ( <i>palbociclib</i> )	Non Preferred	PA
KISQALI (200 MG DOSE) TABLET THERAPY PACK 200 MG ORAL ( <i>ribociclib succinate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
KISQALI (400 MG DOSE) TABLET THERAPY PACK 200 MG ORAL ( <i>ribociclib succinate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
KISQALI (600 MG DOSE) TABLET THERAPY PACK 200 MG ORAL ( <i>ribociclib succinate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
VERZENIO TABLET 100 MG ORAL ( <i>abemaciclib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VERZENIO TABLET 150 MG ORAL ( <i>abemaciclib</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
VERZENIO TABLET 200 MG ORAL ( <i>abemaciclib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
VERZENIO TABLET 50 MG ORAL ( <i>abemaciclib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ESTROGENS-ANTINEOPLASTIC*** - DRUGS FOR CANCER</b>		
EMCYT CAPSULE 140 MG ORAL ( <i>estramustine phosphate sodium</i> )	Preferred	
<b>*FOLIC ACID ANTAGONISTS RESCUE AGENTS*** - DRUGS FOR CANCER</b>		
<i>leucovorin calcium tablet 10 mg oral</i>	Preferred	
<i>leucovorin calcium tablet 15 mg oral</i>	Preferred	
<i>leucovorin calcium tablet 25 mg oral</i>	Preferred	
<i>leucovorin calcium tablet 5 mg oral</i>	Preferred	
<b>*GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS*** - DRUGS FOR CANCER</b>		
ORGOVYX TABLET 120 MG ORAL ( <i>relugolix</i> )	Non Preferred	PA
<b>*IMIDAZOTETRAZINES*** - DRUGS FOR CANCER</b>		
<i>temozolomide capsule 100 mg oral</i>	Preferred	
<i>temozolomide capsule 140 mg oral</i>	Preferred	
<i>temozolomide capsule 180 mg oral</i>	Preferred	
<i>temozolomide capsule 20 mg oral</i>	Preferred	
<i>temozolomide capsule 250 mg oral</i>	Preferred	
<i>temozolomide capsule 5 mg oral</i>	Preferred	
<b>*ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS*** - DRUGS FOR CANCER</b>		
REZLIDHIA CAPSULE 150 MG ORAL ( <i>olutasidenib</i> )	Non Preferred	PA
TIBSOVO TABLET 250 MG ORAL ( <i>ivosidenib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ISOCITRATE DEHYDROGENASE-2 (IDH2) INHIBITORS*** - DRUGS FOR CANCER</b>		
IDHIFA TABLET 100 MG ORAL ( <i>enasidenib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
IDHIFA TABLET 50 MG ORAL ( <i>enasidenib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*JANUS ASSOCIATED KINASE (JAK) INHIBITORS*** - DRUGS FOR CANCER</b>		
JAKAFI TABLET 10 MG ORAL ( <i>ruxolitinib phosphate</i> )	Preferred	
JAKAFI TABLET 15 MG ORAL ( <i>ruxolitinib phosphate</i> )	Preferred	
JAKAFI TABLET 20 MG ORAL ( <i>ruxolitinib phosphate</i> )	Preferred	
JAKAFI TABLET 25 MG ORAL ( <i>ruxolitinib phosphate</i> )	Preferred	
JAKAFI TABLET 5 MG ORAL ( <i>ruxolitinib phosphate</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
INREBIC CAPSULE 100 MG ORAL ( <i>fedratinib hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
OJJAARA TABLET 100 MG ORAL ( <i>momelotinib dihydrochloride</i> )	Non Preferred	PA
OJJAARA TABLET 150 MG ORAL ( <i>momelotinib dihydrochloride</i> )	Non Preferred	PA
OJJAARA TABLET 200 MG ORAL ( <i>momelotinib dihydrochloride</i> )	Non Preferred	PA
VONJO CAPSULE 100 MG ORAL ( <i>pacritinib citrate</i> )	Non Preferred	PA
<b>*MITOTIC INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>etoposide capsule 50 mg oral</i>	Preferred	
<b>*NITROGEN MUSTARDS AND RELATED ANALOGUES*** - DRUGS FOR CANCER</b>		
<i>cyclophosphamide capsule 25 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>cyclophosphamide capsule 50 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>cyclophosphamide tablet 25 mg oral</i>	Preferred	
<i>cyclophosphamide tablet 50 mg oral</i>	Preferred	
<i>melphalan tablet 2 mg oral</i>	Preferred	
LEUKERAN TABLET 2 MG ORAL ( <i>chlorambucil</i> )	Preferred	QL (8 EA per 1 day)
<b>*ORNITHINE DECARBOXYLASE (ODC) INHIBITORS*** - DRUGS FOR CANCER</b>		
IWILFIN TABLET 192 MG ORAL ( <i>eflornithine hcl</i> )	Non Preferred	PA
<b>*PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS*** - DRUGS FOR CANCER</b>		
COPIKTRA CAPSULE 15 MG ORAL ( <i>duvelisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
COPIKTRA CAPSULE 25 MG ORAL ( <i>duvelisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PIQRAY (200 MG DAILY DOSE) TABLET THERAPY PACK 200 MG ORAL ( <i>alpelisib</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PIQRAY (250 MG DAILY DOSE) TABLET THERAPY PACK 200 & 50 MG ORAL ( <i>alpelisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PIQRAY (300 MG DAILY DOSE) TABLET THERAPY PACK 2 X 150 MG ORAL ( <i>alpelisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZYDELIG TABLET 100 MG ORAL ( <i>idelalisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ZYDELIG TABLET 150 MG ORAL ( <i>idelalisib</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS*** - DRUGS FOR CANCER</b>		
LYNPARZA TABLET 100 MG ORAL ( <i>olaparib</i> )	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
LYNPARZA TABLET 150 MG ORAL ( <i>olaparib</i> )	Non Preferred	PA; QL (4 EA per 1 day)
RUBRACA TABLET 200 MG ORAL ( <i>rucaparib camsylate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
RUBRACA TABLET 250 MG ORAL ( <i>rucaparib camsylate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
RUBRACA TABLET 300 MG ORAL ( <i>rucaparib camsylate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
TALZENNA CAPSULE 0.1 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA
TALZENNA CAPSULE 0.25 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TALZENNA CAPSULE 0.35 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA
TALZENNA CAPSULE 0.5 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA
TALZENNA CAPSULE 0.75 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA
TALZENNA CAPSULE 1 MG ORAL ( <i>talazoparib tosylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZEJULA CAPSULE 100 MG ORAL ( <i>niraparib tosylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
ZEJULA TABLET 100 MG ORAL ( <i>niraparib tosylate</i> )	Non Preferred	PA
ZEJULA TABLET 200 MG ORAL ( <i>niraparib tosylate</i> )	Non Preferred	PA
ZEJULA TABLET 300 MG ORAL ( <i>niraparib tosylate</i> )	Non Preferred	PA
<b>*PROGESTINS-ANTINEOPLASTIC*** - DRUGS FOR CANCER</b>		
<i>megestrol acetate suspension 40 mg/ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>megestrol acetate suspension 400 mg/10ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>megestrol acetate suspension 800 mg/20ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>megestrol acetate tablet 20 mg oral</i>	Preferred	QL (40 EA per 1 day)
<i>megestrol acetate tablet 40 mg oral</i>	Preferred	QL (20 EA per 1 day)
<b>*RETINOIDS*** - DRUGS FOR CANCER</b>		
<i>tretinoin capsule 10 mg oral</i>	Preferred	
<b>*SELECTIVE ESTROGEN RECEPTOR DEGRADERS*** - DRUGS FOR CANCER</b>		
ORSERDU TABLET 345 MG ORAL ( <i>elacestrant hydrochloride</i> )	Preferred	
ORSERDU TABLET 86 MG ORAL ( <i>elacestrant hydrochloride</i> )	Preferred	
<b>*SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR CANCER</b>		
<i>bexarotene capsule 75 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TARGRETIN CAPSULE 75 MG ORAL ( <i>bexarotene</i> )	Non Preferred	PA
<b>*TOPOISOMERASE I INHIBITORS*** - DRUGS FOR CANCER</b>		
HYCANTIN CAPSULE 0.25 MG ORAL ( <i>topotecan hcl</i> )	Preferred	
HYCANTIN CAPSULE 1 MG ORAL ( <i>topotecan hcl</i> )	Preferred	
<b>*URINARY TRACT PROTECTIVE AGENTS*** - DRUGS FOR CANCER</b>		
MESNEX TABLET 400 MG ORAL ( <i>mesna</i> )	Preferred	
<b>*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS*** - DRUGS FOR CANCER</b>		
FRUZAQLA CAPSULE 1 MG ORAL ( <i>fruquintinib</i> )	Non Preferred	PA
FRUZAQLA CAPSULE 5 MG ORAL ( <i>fruquintinib</i> )	Non Preferred	PA
INLYTA TABLET 1 MG ORAL ( <i>axitinib</i> )	Non Preferred	PA; QL (6 EA per 1 day)
INLYTA TABLET 5 MG ORAL ( <i>axitinib</i> )	Non Preferred	PA; QL (4 EA per 1 day)
LENVIMA (10 MG DAILY DOSE) CAPSULE THERAPY PACK 10 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LENVIMA (12 MG DAILY DOSE) CAPSULE THERAPY PACK 3 X 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LENVIMA (14 MG DAILY DOSE) CAPSULE THERAPY PACK 10 & 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
LENVIMA (18 MG DAILY DOSE) CAPSULE THERAPY PACK 10 MG & 2 X 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LENVIMA (20 MG DAILY DOSE) CAPSULE THERAPY PACK 2 X 10 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
LENVIMA (24 MG DAILY DOSE) CAPSULE THERAPY PACK 2 X 10 MG & 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LENVIMA (4 MG DAILY DOSE) CAPSULE THERAPY PACK 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
LENVIMA (8 MG DAILY DOSE) CAPSULE THERAPY PACK 2 X 4 MG ORAL ( <i>lenvatinib mesylate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*ANTIPARKINSON AND RELATED THERAPY AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ADENOSINE RECEPTOR ANTAGONIST*** - DRUGS FOR PARKINSON</b>		
NOURIANZ TABLET 20 MG ORAL ( <i>istradefylline</i> )	Non Preferred	PA
NOURIANZ TABLET 40 MG ORAL ( <i>istradefylline</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIPARKINSON ANTICHOLINERGICS*** - DRUGS FOR PARKINSON</b>		
<i>benztropine mesylate tablet 0.5 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>benztropine mesylate tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>benztropine mesylate tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>trihexyphenidyl hcl solution 0.4 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>trihexyphenidyl hcl tablet 2 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>trihexyphenidyl hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<b>*ANTIPARKINSON DOPAMINERGICS*** - DRUGS FOR PARKINSON</b>		
<i>amantadine hcl capsule 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>amantadine hcl solution 50 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>amantadine hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bromocriptine mesylate capsule 5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>bromocriptine mesylate tablet 2.5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
GOCOVRI CAPSULE EXTENDED RELEASE 24 HOUR 137 MG ORAL ( <i>amantadine hcl</i> )	Non Preferred	PA
GOCOVRI CAPSULE EXTENDED RELEASE 24 HOUR 68.5 MG ORAL ( <i>amantadine hcl</i> )	Non Preferred	PA
INBRIJA CAPSULE 42 MG INHALATION ( <i>levodopa</i> )	Non Preferred	PA
OSMOLEX ER TABLET EXTENDED RELEASE 24 HOUR 129 MG ORAL ( <i>amantadine hcl</i> )	Non Preferred	PA
OSMOLEX ER TABLET EXTENDED RELEASE 24 HOUR 193 MG ORAL ( <i>amantadine hcl</i> )	Non Preferred	PA
PARLODEL CAPSULE 5 MG ORAL ( <i>bromocriptine mesylate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
PARLODEL TABLET 2.5 MG ORAL ( <i>bromocriptine mesylate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>selegiline hcl capsule 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>selegiline hcl tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>rasagiline mesylate tablet 0.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>rasagiline mesylate tablet 1 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
AZILECT TABLET 0.5 MG ORAL ( <i>rasagiline mesylate</i> )	Non Preferred	PA
AZILECT TABLET 1 MG ORAL ( <i>rasagiline mesylate</i> )	Non Preferred	PA
XADAGO TABLET 100 MG ORAL ( <i>safinamide mesylate</i> )	Non Preferred	PA
XADAGO TABLET 50 MG ORAL ( <i>safinamide mesylate</i> )	Non Preferred	PA
ZELAPAR TABLET DISPERSIBLE 1.25 MG ORAL ( <i>selegiline hcl</i> )	Non Preferred	PA
<b>*CENTRAL/PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>tolcapone tablet 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
TASMAR TABLET 100 MG ORAL ( <i>tolcapone</i> )	Non Preferred	PA
<b>*DECARBOXYLASE INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>carbidopa tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
LODOSYN TABLET 25 MG ORAL ( <i>carbidopa</i> )	Non Preferred	PA
<b>*LEVODOPA COMBINATIONS*** - DRUGS FOR PARKINSON</b>		
<i>carbidopa-levodopa er tablet extended release 25-100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa er tablet extended release 50-200 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa tablet 10-100 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa tablet 25-100 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa tablet 25-250 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa tablet dispersible 10-100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbidopa-levodopa tablet dispersible 25-100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbidopa-levodopa tablet dispersible 25-250 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone tablet 12.5-50-200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone tablet 18.75-75-200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>carbidopa-levodopa-entacapone tablet 25-100-200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone tablet 31.25-125-200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone tablet 37.5-150-200 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 day); Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone tablet 50-200-200 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
DHIVY TABLET 25-100 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA; QL (12 EA per 1 day)
RYTARY CAPSULE EXTENDED RELEASE 23.75-95 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA
RYTARY CAPSULE EXTENDED RELEASE 36.25-145 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA
RYTARY CAPSULE EXTENDED RELEASE 48.75-195 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA
RYTARY CAPSULE EXTENDED RELEASE 61.25-245 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA
SINEMET TABLET 10-100 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA; QL (8 EA per 1 day)
SINEMET TABLET 25-100 MG ORAL ( <i>carbidopa-levodopa</i> )	Non Preferred	PA; QL (12 EA per 1 day)
STALEVO 100 TABLET 25-100-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
STALEVO 125 TABLET 31.25-125-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
STALEVO 150 TABLET 37.5-150-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
STALEVO 200 TABLET 50-200-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (6 EA per 1 day)
STALEVO 50 TABLET 12.5-50-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
STALEVO 75 TABLET 18.75-75-200 MG ORAL ( <i>carbidopa-levodopa-entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*NONERGOLINE DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR PARKINSON</b>		
<i>pramipexole dihydrochloride tablet 0.125 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.75 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 1 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>pramipexole dihydrochloride tablet 1.5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 0.25 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 0.5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 1 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 2 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 3 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 4 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>ropinirole hcl tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>apomorphine hcl solution cartridge 30 mg/3ml subcutaneous</i>	Non Preferred	PA
<i>pramipexole dihydrochloride er tablet extended release 24 hour 0.375 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 0.75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 1.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 2.25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 3.75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 4.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ropinirole hcl er tablet extended release 24 hour 12 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ropinirole hcl er tablet extended release 24 hour 2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ropinirole hcl er tablet extended release 24 hour 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ropinirole hcl er tablet extended release 24 hour 6 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>ropinirole hcl er tablet extended release 24 hour 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
APOKYN SOLUTION CARTRIDGE 30 MG/3ML SUBCUTANEOUS ( <i>apomorphine hcl</i> )	Non Preferred	PA
KYNMOBI TITRATION KIT KIT 10&15&20&25&30 MG SUBLINGUAL ( <i>apomorphine hcl</i> )	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 0.375 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 0.75 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 2.25 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 3.75 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 4.5 MG ORAL ( <i>pramipexole dihydrochloride</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL ( <i>rotigotine</i> )	Non Preferred	PA
<b>*PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>entacapone tablet 200 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
COMTAN TABLET 200 MG ORAL ( <i>entacapone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
ONGENTYS CAPSULE 25 MG ORAL ( <i>opicapone</i> )	Non Preferred	PA
ONGENTYS CAPSULE 50 MG ORAL ( <i>opicapone</i> )	Non Preferred	PA
<b>*ANTIPSYCHOTICS/ANTIMANIC AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIMANIC AGENTS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>lithium carbonate capsule 150 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>lithium carbonate capsule 300 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>lithium carbonate capsule 600 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>lithium carbonate er tablet extended release 300 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>lithium carbonate er tablet extended release 450 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lithium carbonate tablet 300 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>lithium solution 8 meq/5ml oral</i>	Preferred	Max 90-day supply per fill
LITHOBID TABLET EXTENDED RELEASE 300 MG ORAL ( <i>lithium carbonate</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*ANTIPSYCHOTICS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>lurasidone hcl tablet 120 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 20 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 40 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 60 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 80 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 20 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 60 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 80 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>ziprasidone mesylate solution reconstituted 20 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
CAPLYTA CAPSULE 10.5 MG ORAL ( <i>lumateperone tosylate</i> )	Non Preferred	PA; AGE (Min 8 Years)
CAPLYTA CAPSULE 21 MG ORAL ( <i>lumateperone tosylate</i> )	Non Preferred	PA; AGE (Min 8 Years)
CAPLYTA CAPSULE 42 MG ORAL ( <i>lumateperone tosylate</i> )	Non Preferred	PA; AGE (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL ( <i>carbamazepine (antipsychotic)</i> )	Non Preferred	PA; AGE (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL ( <i>carbamazepine (antipsychotic)</i> )	Non Preferred	PA; AGE (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL ( <i>carbamazepine (antipsychotic)</i> )	Non Preferred	PA; AGE (Min 8 Years)
GEODON CAPSULE 20 MG ORAL ( <i>ziprasidone hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)

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Drug Name	Formulary Status	Requirements/Limits
GEODON CAPSULE 40 MG ORAL ( <i>ziprasidone hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
GEODON CAPSULE 60 MG ORAL ( <i>ziprasidone hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
GEODON CAPSULE 80 MG ORAL ( <i>ziprasidone hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
GEODON SOLUTION RECONSTITUTED 20 MG INTRAMUSCULAR ( <i>ziprasidone mesylate</i> )	Non Preferred	PA; AGE (Min 18 Years)
LATUDA TABLET 120 MG ORAL ( <i>lurasidone hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
LATUDA TABLET 20 MG ORAL ( <i>lurasidone hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
LATUDA TABLET 40 MG ORAL ( <i>lurasidone hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
LATUDA TABLET 60 MG ORAL ( <i>lurasidone hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
LATUDA TABLET 80 MG ORAL ( <i>lurasidone hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
NUPLAZID CAPSULE 34 MG ORAL ( <i>pimavanserin tartrate</i> )	Non Preferred	PA; AGE (Min 8 Years)
NUPLAZID TABLET 10 MG ORAL ( <i>pimavanserin tartrate</i> )	Non Preferred	PA; AGE (Min 8 Years)
VRAYLAR CAPSULE 1.5 MG ORAL ( <i>cariprazine hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
VRAYLAR CAPSULE 3 MG ORAL ( <i>cariprazine hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
VRAYLAR CAPSULE 4.5 MG ORAL ( <i>cariprazine hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
VRAYLAR CAPSULE 6 MG ORAL ( <i>cariprazine hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL ( <i>cariprazine hcl</i> )	Non Preferred	PA; AGE (Min 8 Years)
<b>*BENZISOXAZOLES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>risperidone solution 1 mg/ml oral</i>	Preferred	QL (16 ML per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>risperidone tablet 2 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet 3 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
INVEGA HAFYERA SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA HAFYERA SUSPENSION PREFILLED SYRINGE 1560 MG/5ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 156 MG/ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML INTRAMUSCULAR ( <i>paliperidone palmitate</i> )	Preferred	PA; AGE (Min 18 Years)
PERSERIS PREFILLED SYRINGE 120 MG SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
PERSERIS PREFILLED SYRINGE 90 MG SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
UZEDY SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML SUBCUTANEOUS ( <i>risperidone</i> )	Preferred	PA; AGE (Min 18 Years)
<i>paliperidone er tablet extended release 24 hour 1.5 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>paliperidone er tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>paliperidone er tablet extended release 24 hour 6 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>paliperidone er tablet extended release 24 hour 9 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone microspheres er suspension reconstituted er 12.5 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>risperidone microspheres er suspension reconstituted er 25 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>risperidone microspheres er suspension reconstituted er 37.5 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>risperidone microspheres er suspension reconstituted er 50 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>risperidone tablet dispersible 0.25 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 0.5 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 1 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 2 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 3 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 4 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
FANAPT TABLET 1 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TABLET 10 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TABLET 12 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TABLET 2 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TABLET 4 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)

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Drug Name	Formulary Status	Requirements/Limits
FANAPT TABLET 6 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TABLET 8 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL ( <i>iloperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL ( <i>paliperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL ( <i>paliperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL ( <i>paliperidone</i> )	Non Preferred	PA; AGE (Min 8 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 12.5 MG INTRAMUSCULAR ( <i>risperidone microspheres</i> )	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 25 MG INTRAMUSCULAR ( <i>risperidone microspheres</i> )	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 37.5 MG INTRAMUSCULAR ( <i>risperidone microspheres</i> )	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 50 MG INTRAMUSCULAR ( <i>risperidone microspheres</i> )	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL SOLUTION 1 MG/ML ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (16 ML per 1 day); AGE (Min 8 Years)
RISPERDAL TABLET 0.5 MG ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
RISPERDAL TABLET 1 MG ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
RISPERDAL TABLET 2 MG ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
RISPERDAL TABLET 3 MG ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
RISPERDAL TABLET 4 MG ORAL ( <i>risperidone</i> )	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 8 Years)
RYKINDO SUSPENSION RECONSTITUTED ER 25 MG INTRAMUSCULAR ( <i>risperidone</i> )	Non Preferred	PA; AGE (Min 18 Years)
RYKINDO SUSPENSION RECONSTITUTED ER 37.5 MG INTRAMUSCULAR ( <i>risperidone</i> )	Non Preferred	PA; AGE (Min 18 Years)
RYKINDO SUSPENSION RECONSTITUTED ER 50 MG INTRAMUSCULAR ( <i>risperidone</i> )	Non Preferred	PA; AGE (Min 18 Years)
<b>*BUTYROPHENONES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	Preferred	AGE (Min 6 Years)
<i>haloperidol lactate concentrate 2 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>haloperidol tablet 0.5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>haloperidol tablet 1 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>haloperidol tablet 10 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>haloperidol tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>haloperidol tablet 20 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>haloperidol tablet 5 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<b>*DIBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>clozapine tablet 100 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet 200 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet 25 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet dispersible 100 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet dispersible 12.5 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet dispersible 150 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet dispersible 200 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>clozapine tablet dispersible 25 mg oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
CLOZARIL TABLET 100 MG ORAL ( <i>clozapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
CLOZARIL TABLET 25 MG ORAL ( <i>clozapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
VERSACLOZ SUSPENSION 50 MG/ML ORAL ( <i>clozapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
<b>*DIBENZO-OXEPINO PYRROLES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>asenapine maleate tablet sublingual 10 mg sublingual</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>asenapine maleate tablet sublingual 2.5 mg sublingual</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>asenapine maleate tablet sublingual 5 mg sublingual</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL ( <i>asenapine maleate</i> )	Non Preferred	PA; AGE (Min 8 Years)
SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL ( <i>asenapine maleate</i> )	Non Preferred	PA; AGE (Min 8 Years)
SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL ( <i>asenapine maleate</i> )	Non Preferred	PA; AGE (Min 8 Years)
SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL ( <i>asenapine</i> )	Non Preferred	PA; AGE (Min 18 Years)
SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL ( <i>asenapine</i> )	Non Preferred	PA; AGE (Min 18 Years)
SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL ( <i>asenapine</i> )	Non Preferred	PA; AGE (Min 18 Years)
<b>*DIBENZOTHIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>quetiapine fumarate er tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 150 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 400 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>quetiapine fumarate tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
SEROQUEL TABLET 100 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL TABLET 200 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL TABLET 25 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL TABLET 300 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL TABLET 400 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL TABLET 50 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>quetiapine fumarate</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
<b>*DIBENZOXAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>loxapine succinate capsule 10 mg oral</i>	Preferred	QL (15 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 25 mg oral</i>	Preferred	QL (6 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 5 mg oral</i>	Preferred	QL (15 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 50 mg oral</i>	Preferred	QL (15 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION ( <i>loxapine</i> )	Non Preferred	PA; AGE (Min 18 Years)
<b>*DIHYDROINDOLONES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>molindone hcl tablet 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>molindone hcl tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*PHENOTHIAZINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>chlorpromazine hcl concentrate 100 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>chlorpromazine hcl concentrate 30 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>chlorpromazine hcl tablet 10 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 100 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 200 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 25 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 50 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	Preferred	
<i>fluphenazine hcl concentrate 5 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>fluphenazine hcl elixir 2.5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>fluphenazine hcl tablet 1 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>fluphenazine hcl tablet 2.5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>fluphenazine hcl tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>perphenazine tablet 16 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>perphenazine tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>perphenazine tablet 4 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>perphenazine tablet 8 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>prochlorperazine maleate tablet 10 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>prochlorperazine maleate tablet 5 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>prochlorperazine suppository 25 mg rectal</i>	Preferred	QL (12 EA per 1 day)
<i>thioridazine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>thioridazine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>thioridazine hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>thioridazine hcl tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 2 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>prochlorperazine (Compro Suppository 25 Mg Rectal)</i>	Preferred	QL (12 EA per 1 day)
<b>*QUINOLINONE DERIVATIVES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>aripiprazole tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
ABILIFY ASIMTUFII PREFILLED SYRINGE 720 MG/2.4ML INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ABILIFY ASIMTUFII PREFILLED SYRINGE 960 MG/3.2ML INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ABILIFY MAINTENA PREFILLED SYRINGE 300 MG INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ABILIFY MAINTENA PREFILLED SYRINGE 400 MG INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 300 MG INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 400 MG INTRAMUSCULAR ( <i>aripiprazole</i> )	Preferred	PA; AGE (Min 18 Years)
ARISTADA INITIO PREFILLED SYRINGE 675 MG/2.4ML INTRAMUSCULAR ( <i>aripiprazole lauroxil</i> )	Preferred	PA; AGE (Min 18 Years)
ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR ( <i>aripiprazole lauroxil</i> )	Preferred	PA; AGE (Min 18 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR ( <i>aripiprazole lauroxil</i> )	Preferred	PA; AGE (Min 18 Years)
ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR ( <i>aripiprazole lauroxil</i> )	Preferred	PA; AGE (Min 18 Years)
ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR ( <i>aripiprazole lauroxil</i> )	Preferred	PA; AGE (Min 18 Years)
<i>aripiprazole solution 1 mg/ml oral</i>	Non Preferred	PA; AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet dispersible 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>aripiprazole tablet dispersible 15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 10 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 15 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 2 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 20 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 30 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 5 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 10 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 15 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 2 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 20 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 30 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 5 MG ORAL ( <i>aripiprazole w/ sens-strip-pod</i> )	Non Preferred	PA; AGE (Min 8 Years)
ABILIFY TABLET 10 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ABILIFY TABLET 15 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ABILIFY TABLET 2 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ABILIFY TABLET 20 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ABILIFY TABLET 30 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ABILIFY TABLET 5 MG ORAL ( <i>aripiprazole</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
REXULTI TABLET 0.25 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
REXULTI TABLET 0.5 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
REXULTI TABLET 1 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
REXULTI TABLET 2 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
REXULTI TABLET 3 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
REXULTI TABLET 4 MG ORAL ( <i>brexpiprazole</i> )	Non Preferred	PA; AGE (Min 8 Years)
<b>*THIENBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>olanzapine tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet 7.5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 10 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 15 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 20 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 5 mg oral</i>	Preferred	AGE (Min 8 Years); Max 90-day supply per fill
<i>olanzapine solution reconstituted 10 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 210 MG INTRAMUSCULAR ( <i>olanzapine pamoate</i> )	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 300 MG INTRAMUSCULAR ( <i>olanzapine pamoate</i> )	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 405 MG INTRAMUSCULAR ( <i>olanzapine pamoate</i> )	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA SOLUTION RECONSTITUTED 10 MG INTRAMUSCULAR ( <i>olanzapine</i> )	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA TABLET 10 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA TABLET 15 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA TABLET 2.5 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA TABLET 20 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA TABLET 5 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA TABLET 7.5 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 8 Years)
ZYPREXA ZYDIS TABLET DISPERSIBLE 10 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
ZYPREXA ZYDIS TABLET DISPERSIBLE 15 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
ZYPREXA ZYDIS TABLET DISPERSIBLE 20 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
ZYPREXA ZYDIS TABLET DISPERSIBLE 5 MG ORAL ( <i>olanzapine</i> )	Non Preferred	PA; AGE (Min 8 Years)
<b>*THIOXANTHENES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>thiothixene capsule 1 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>thiothixene capsule 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>thiothixene capsule 2 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>thiothixene capsule 5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<b>*ANTISEPTICS &amp; DISINFECTANTS* - ANTISEPTICS AND DISINFECTANTS</b>		
<b>*CHLORINE ANTISEPTICS*** - ANTISEPTICS AND DISINFECTANTS</b>		
BETASEPT SURGICAL SCRUB EXTERNAL LIQUID 4 % ( <i>chlorhexidine gluconate</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANALGESICS - ANTI-INFLAMMATORY* - ARTHRITIS AND PAIN DRUGS</b>		
<i>adalimumab-adbm (2 pen) auto-injector kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adbm (2 syringe) prefilled syringe kit 10 mg/0.2ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adbm (2 syringe) prefilled syringe kit 20 mg/0.4ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adbm (2 syringe) prefilled syringe kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adbm(cd/uc/hs strt) auto-injector kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adbm(ps/uv starter) auto-injector kit 40 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<b>*ANTIVIRALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIRETROVIRAL COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>abacavir sulfate-lamivudine tablet 600-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-emtricitab-tenofo df tablet 600-200-300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 100-150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 133-200 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 167-250 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 200-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lamivudine-zidovudine tablet 150-300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir solution 400-100 mg/5ml oral</i>	Preferred	QL (16 ML per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir tablet 100-25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir tablet 200-50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ATRIPLA TABLET 600-200-300 MG ORAL (efavirenz-emtricitab-tenofo df)</i>	Preferred	Max 90-day supply per fill
<i>BIKTARVY TABLET 30-120-15 MG ORAL (bictegravir-emtricitab-tenofov)</i>	Preferred	Max 90-day supply per fill
<i>BIKTARVY TABLET 50-200-25 MG ORAL (bictegravir-emtricitab-tenofov)</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>CABENUVA SUSPENSION EXTENDED RELEASE 400 &amp; 600 MG/2ML INTRAMUSCULAR (cabotegravir &amp; rilpivirine)</i>	Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
CABENUVA SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML INTRAMUSCULAR ( <i>cabotegravir &amp; rilpivirine</i> )	Preferred	PA; Max 90-day supply per fill
COMPLERA TABLET 200-25-300 MG ORAL ( <i>emtricitabine-rilpivirine-tenofovir</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DELSTRIGO TABLET 100-300-300 MG ORAL ( <i>doravirine-lamivudine-tenofovir df</i> )	Preferred	Max 90-day supply per fill
DESCOVY TABLET 120-15 MG ORAL ( <i>emtricitabine-tenofovir af</i> )	Preferred	Max 90-day supply per fill
DESCOVY TABLET 200-25 MG ORAL ( <i>emtricitabine-tenofovir af</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DOVATO TABLET 50-300 MG ORAL ( <i>dolutegravir-lamivudine</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
GENVOYA TABLET 150-150-200-10 MG ORAL ( <i>elvitegravir-cobicistat-emtricitabine-tenofovir</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
KALETRA TABLET 100-25 MG ORAL ( <i>lopinavir-ritonavir</i> )	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
KALETRA TABLET 200-50 MG ORAL ( <i>lopinavir-ritonavir</i> )	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
ODEFSEY TABLET 200-25-25 MG ORAL ( <i>emtricitabine-rilpivirine-tenofovir af</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMFI LO TABLET 400-300-300 MG ORAL ( <i>efavirenz-lamivudine-tenofovir</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMFI TABLET 600-300-300 MG ORAL ( <i>efavirenz-lamivudine-tenofovir</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMTUZA TABLET 800-150-200-10 MG ORAL ( <i>darunavir-cobicistat-emtricitabine-tenofovir</i> )	Preferred	Max 90-day supply per fill
TRIUMEQ PD TABLET SOLUBLE 60-5-30 MG ORAL ( <i>abacavir-dolutegravir-lamivudine</i> )	Preferred	Max 90-day supply per fill
TRIUMEQ TABLET 600-50-300 MG ORAL ( <i>abacavir-dolutegravir-lamivudine</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 100-150 MG ORAL ( <i>emtricitabine-tenofovir df</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 133-200 MG ORAL ( <i>emtricitabine-tenofovir df</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 167-250 MG ORAL ( <i>emtricitabine-tenofovir df</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 200-300 MG ORAL ( <i>emtricitabine-tenofovir df</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-lamivudine-tenofovir tablet 400-300-300 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-lamivudine-tenofovir tablet 600-300-300 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
CIMDUO TABLET 300-300 MG ORAL ( <i>lamivudine-tenofovir</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
COMBIVIR TABLET 150-300 MG ORAL ( <i>lamivudine-zidovudine</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
EPZICOM TABLET 600-300 MG ORAL ( <i>abacavir sulfate-lamivudine</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
EVOTAZ TABLET 300-150 MG ORAL ( <i>atazanavir-cobicistat</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
JULUCA TABLET 50-25 MG ORAL ( <i>dolutegravir-rilpivirine</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
KALETRA SOLUTION 400-100 MG/5ML ORAL ( <i>lopinavir-ritonavir</i> )	Non Preferred	PA; QL (16 ML per 1 day); Max 90-day supply per fill
PREZCOBIX TABLET 800-150 MG ORAL ( <i>darunavir-cobicistat</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRIBILD TABLET 150-150-200-300 MG ORAL ( <i>elviteg-cobic-emtricit-tenofdf</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
TRIZIVIR TABLET 300-150-300 MG ORAL ( <i>abacavir-lamivudine-zidovudine</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - CAPSID INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
SUNLENCA SOLUTION 463.5 MG/1.5ML SUBCUTANEOUS ( <i>lenacapavir sodium</i> )	Preferred	PA; Max 90-day supply per fill
SUNLENCA TABLET THERAPY PACK 4 X 300 MG ORAL ( <i>lenacapavir sodium</i> )	Preferred	PA; Max 90-day supply per fill
SUNLENCA TABLET THERAPY PACK 5 X 300 MG ORAL ( <i>lenacapavir sodium</i> )	Preferred	PA; Max 90-day supply per fill
<b>*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>maraviroc tablet 150 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>maraviroc tablet 300 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY SOLUTION 20 MG/ML ORAL ( <i>maraviroc</i> )	Non Preferred	PA; Max 90-day supply per fill
SELZENTRY TABLET 150 MG ORAL ( <i>maraviroc</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 25 MG ORAL ( <i>maraviroc</i> )	Non Preferred	PA; Max 90-day supply per fill
SELZENTRY TABLET 300 MG ORAL ( <i>maraviroc</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 75 MG ORAL ( <i>maraviroc</i> )	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR*** - DRUGS FOR VIRAL INFECTIONS</b>		
TROGARZO SOLUTION 200 MG/1.33ML INTRAVENOUS ( <i>ibalizumab-uiyk</i> )	Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIRETROVIRALS - FUSION INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
FUZEON SOLUTION RECONSTITUTED 90 MG SUBCUTANEOUS ( <i>enfuvirtide</i> )	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR*** - DRUGS FOR VIRAL INFECTIONS</b>		
RUKOBIA TABLET EXTENDED RELEASE 12 HOUR 600 MG ORAL ( <i>fostemsavir tromethamine</i> )	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIRETROVIRALS - INTEGRASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR ( <i>cabotegravir</i> )	Preferred	Max 90-day supply per fill
ISENTRESS HD TABLET 600 MG ORAL ( <i>raltegravir potassium</i> )	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS PACKET 100 MG ORAL ( <i>raltegravir potassium</i> )	Preferred	Max 90-day supply per fill
ISENTRESS TABLET 400 MG ORAL ( <i>raltegravir potassium</i> )	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 100 MG ORAL ( <i>raltegravir potassium</i> )	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 25 MG ORAL ( <i>raltegravir potassium</i> )	Preferred	Max 90-day supply per fill
TIVICAY PD TABLET SOLUBLE 5 MG ORAL ( <i>dolutegravir sodium</i> )	Preferred	Max 90-day supply per fill
TIVICAY TABLET 10 MG ORAL ( <i>dolutegravir sodium</i> )	Preferred	Max 90-day supply per fill
TIVICAY TABLET 25 MG ORAL ( <i>dolutegravir sodium</i> )	Preferred	Max 90-day supply per fill
TIVICAY TABLET 50 MG ORAL ( <i>dolutegravir sodium</i> )	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR ( <i>cabotegravir</i> )	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIRETROVIRALS - PROTEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>atazanavir sulfate capsule 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>atazanavir sulfate capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>atazanavir sulfate capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>darunavir tablet 600 mg oral</i>	Preferred	Max 90-day supply per fill
<i>darunavir tablet 800 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fosamprenavir calcium tablet 700 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>ritonavir tablet 100 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
APTIVUS CAPSULE 250 MG ORAL ( <i>tipranavir</i> )	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
INVIRASE TABLET 500 MG ORAL ( <i>saquinavir mesylate</i> )	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
LEXIVA SUSPENSION 50 MG/ML ORAL ( <i>fosamprenavir calcium</i> )	Preferred	Max 90-day supply per fill
LEXIVA TABLET 700 MG ORAL ( <i>fosamprenavir calcium</i> )	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
NORVIR PACKET 100 MG ORAL ( <i>ritonavir</i> )	Preferred	Max 90-day supply per fill
NORVIR TABLET 100 MG ORAL ( <i>ritonavir</i> )	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
PREZISTA SUSPENSION 100 MG/ML ORAL ( <i>darunavir</i> )	Preferred	Max 90-day supply per fill
PREZISTA TABLET 150 MG ORAL ( <i>darunavir</i> )	Preferred	Max 90-day supply per fill
PREZISTA TABLET 600 MG ORAL ( <i>darunavir</i> )	Preferred	Max 90-day supply per fill
PREZISTA TABLET 75 MG ORAL ( <i>darunavir</i> )	Preferred	Max 90-day supply per fill
PREZISTA TABLET 800 MG ORAL ( <i>darunavir</i> )	Preferred	Max 90-day supply per fill
REYATAZ CAPSULE 200 MG ORAL ( <i>atazanavir sulfate</i> )	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
REYATAZ CAPSULE 300 MG ORAL ( <i>atazanavir sulfate</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
REYATAZ PACKET 50 MG ORAL ( <i>atazanavir sulfate</i> )	Preferred	Max 90-day supply per fill
VIRACEPT TABLET 250 MG ORAL ( <i>nelfinavir mesylate</i> )	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
VIRACEPT TABLET 625 MG ORAL ( <i>nelfinavir mesylate</i> )	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>efavirenz capsule 200 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>efavirenz capsule 50 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>efavirenz tablet 600 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>etravirine tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>etravirine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nevirapine er tablet extended release 24 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nevirapine er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nevirapine suspension 50 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day); Max 90-day supply per fill
<i>nevirapine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
EDURANT TABLET 25 MG ORAL ( <i>rilpivirine hcl</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 100 MG ORAL ( <i>etravirine</i> )	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
INTELENCE TABLET 200 MG ORAL ( <i>etravirine</i> )	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 25 MG ORAL ( <i>etravirine</i> )	Preferred	Max 90-day supply per fill
PIFELTRO TABLET 100 MG ORAL ( <i>doravirine</i> )	Non Preferred	PA; Max 90-day supply per fill
VIRAMUNE XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL ( <i>nevirapine</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>abacavir sulfate solution 20 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>abacavir sulfate tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>didanosine capsule delayed release 250 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>didanosine capsule delayed release 400 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ZIAGEN SOLUTION 20 MG/ML ORAL ( <i>abacavir sulfate</i> )	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
ZIAGEN TABLET 300 MG ORAL ( <i>abacavir sulfate</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>emtricitabine capsule 200 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lamivudine solution 10 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>lamivudine tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lamivudine tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EMTRIVA CAPSULE 200 MG ORAL ( <i>emtricitabine</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EMTRIVA SOLUTION 10 MG/ML ORAL ( <i>emtricitabine</i> )	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
EPIVIR SOLUTION 10 MG/ML ORAL ( <i>lamivudine</i> )	Non Preferred	PA; QL (30 ML per 1 day); Max 90-day supply per fill
EPIVIR TABLET 150 MG ORAL ( <i>lamivudine</i> )	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
EPIVIR TABLET 300 MG ORAL ( <i>lamivudine</i> )	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>stavudine capsule 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>stavudine capsule 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>stavudine capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>zidovudine capsule 100 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>zidovudine syrup 50 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
<i>zidovudine tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
RETROVIR CAPSULE 100 MG ORAL ( <i>zidovudine</i> )	Non Preferred	PA; QL (6 EA per 1 day); Max 90-day supply per fill
RETROVIR SYRUP 50 MG/5ML ORAL ( <i>zidovudine</i> )	Non Preferred	PA; QL (60 ML per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>tenofovir disoproxil fumarate tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD POWDER 40 MG/GM ORAL ( <i>tenofovir disoproxil fumarate</i> )	Preferred	QL (7.5 GM per 1 day); Max 90-day supply per fill
VIREAD TABLET 150 MG ORAL ( <i>tenofovir disoproxil fumarate</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 200 MG ORAL ( <i>tenofovir disoproxil fumarate</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 250 MG ORAL ( <i>tenofovir disoproxil fumarate</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 300 MG ORAL ( <i>tenofovir disoproxil fumarate</i> )	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<b>*ANTIRETROVIRALS ADJUVANTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
TYBOST TABLET 150 MG ORAL ( <i>cobicistat</i> )	Non Preferred	PA; Max 90-day supply per fill
<b>*ANTIVIRAL COMBINATIONS*** - DRUGS FOR INFECTIONS</b>		
PAXLOVID (150/100) TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG ORAL ( <i>nirmatrelvir-ritonavir</i> )	Preferred	AGE (Min 12 Years); Max 5-day supply per fill
PAXLOVID (300/100) TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG ORAL ( <i>nirmatrelvir-ritonavir</i> )	Preferred	AGE (Min 12 Years); Max 5-day supply per fill
<b>*CMV AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>valganciclovir hcl tablet 450 mg oral</i>	Preferred	
LIVTENCITY TABLET 200 MG ORAL ( <i>maribavir</i> )	Preferred	PA
PREVYMIS TABLET 240 MG ORAL ( <i>letermovir</i> )	Preferred	PA
PREVYMIS TABLET 480 MG ORAL ( <i>letermovir</i> )	Preferred	PA
<i>valganciclovir hcl solution reconstituted 50 mg/ml oral</i>	Non Preferred	PA
VALCYTE SOLUTION RECONSTITUTED 50 MG/ML ORAL ( <i>valganciclovir hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
VALCYTE TABLET 450 MG ORAL ( <i>valganciclovir hcl</i> )	Non Preferred	PA
<b>*HEPATITIS B AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>entecavir tablet 0.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>entecavir tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>adefovir dipivoxil tablet 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lamivudine tablet 100 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
BARACLUDE SOLUTION 0.05 MG/ML ORAL ( <i>entecavir</i> )	Non Preferred	PA; QL (30 ML per 1 day)
BARACLUDE TABLET 0.5 MG ORAL ( <i>entecavir</i> )	Non Preferred	PA; QL (1 EA per 1 day)
BARACLUDE TABLET 1 MG ORAL ( <i>entecavir</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EPIVIR HBV SOLUTION 5 MG/ML ORAL ( <i>lamivudine</i> )	Non Preferred	PA
EPIVIR HBV TABLET 100 MG ORAL ( <i>lamivudine</i> )	Non Preferred	PA; QL (3 EA per 1 day)
VEMLIDY TABLET 25 MG ORAL ( <i>tenofovir alafenamide fumarate</i> )	Non Preferred	PA
<b>*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>sofosbuvir-velpatasvir tablet 400-100 mg oral</i>	Preferred	QL (1 EA per 1 day)
MAVYRET PACKET 50-20 MG ORAL ( <i>glecaprevir-pibrentasvir</i> )	Preferred	
MAVYRET TABLET 100-40 MG ORAL ( <i>glecaprevir-pibrentasvir</i> )	Preferred	
<i>ledipasvir-sofosbuvir tablet 90-400 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
EPCLUSA PACKET 150-37.5 MG ORAL ( <i>sofosbuvir-velpatasvir</i> )	Non Preferred	PA
EPCLUSA PACKET 200-50 MG ORAL ( <i>sofosbuvir-velpatasvir</i> )	Non Preferred	PA
EPCLUSA TABLET 200-50 MG ORAL ( <i>sofosbuvir-velpatasvir</i> )	Non Preferred	PA
EPCLUSA TABLET 400-100 MG ORAL ( <i>sofosbuvir-velpatasvir</i> )	Non Preferred	PA; QL (1 EA per 1 day)
HARVONI PACKET 33.75-150 MG ORAL ( <i>ledipasvir-sofosbuvir</i> )	Non Preferred	PA
HARVONI PACKET 45-200 MG ORAL ( <i>ledipasvir-sofosbuvir</i> )	Non Preferred	PA
HARVONI TABLET 45-200 MG ORAL ( <i>ledipasvir-sofosbuvir</i> )	Non Preferred	PA
HARVONI TABLET 90-400 MG ORAL ( <i>ledipasvir-sofosbuvir</i> )	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
VOSEVI TABLET 400-100-100 MG ORAL ( <i>sofosbuv-velpatasv-voxilaprev</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ZEPATIER TABLET 50-100 MG ORAL ( <i>elbasvir-grazoprevir</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*HEPATITIS C AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>ribavirin capsule 200 mg oral</i>	Preferred	
<i>ribavirin tablet 200 mg oral</i>	Preferred	
PEGASYS SOLUTION 180 MCG/ML SUBCUTANEOUS ( <i>peginterferon alfa-2a</i> )	Non Preferred	PA
PEGASYS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML SUBCUTANEOUS ( <i>peginterferon alfa-2a</i> )	Non Preferred	PA
SOVALDI PACKET 150 MG ORAL ( <i>sofosbuvir</i> )	Non Preferred	PA
SOVALDI PACKET 200 MG ORAL ( <i>sofosbuvir</i> )	Non Preferred	PA
SOVALDI TABLET 200 MG ORAL ( <i>sofosbuvir</i> )	Non Preferred	PA
SOVALDI TABLET 400 MG ORAL ( <i>sofosbuvir</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*HERPES AGENTS - PURINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>acyclovir capsule 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>acyclovir suspension 200 mg/5ml oral</i>	Preferred	QL (25 ML per 1 day)
<i>acyclovir tablet 400 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>acyclovir tablet 800 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>valacyclovir hcl tablet 1 gm oral</i>	Preferred	QL (8 EA per 1 day)
<i>valacyclovir hcl tablet 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
SITAVIG TABLET 50 MG BUCCAL ( <i>acyclovir</i> )	Non Preferred	PA
VALTREX TABLET 1 GM ORAL ( <i>valacyclovir hcl</i> )	Non Preferred	PA; QL (8 EA per 1 day)
VALTREX TABLET 500 MG ORAL ( <i>valacyclovir hcl</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*HERPES AGENTS - THYMIDINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>famciclovir tablet 125 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>famciclovir tablet 250 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>famciclovir tablet 500 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
<b>*INFLUENZA AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>rimantadine hcl tablet 100 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<b>*MISC. ANTIVIRALS*** - DRUGS FOR VIRAL INFECTIONS</b>		
LAGEVRIO CAPSULE 200 MG ORAL ( <i>molnupiravir</i> )	Preferred	AGE (Min 18 Years); Max 5-day supply per fill
<b>*NEURAMINIDASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>oseltamivir phosphate capsule 30 mg oral</i>	Preferred	Max 10-day supply per fill
<i>oseltamivir phosphate capsule 45 mg oral</i>	Preferred	Max 10-day supply per fill
<i>oseltamivir phosphate capsule 75 mg oral</i>	Preferred	Max 10-day supply per fill
<i>oseltamivir phosphate suspension reconstituted 6 mg/ml oral</i>	Preferred	Max 10-day supply per fill
RELENZA DISKHALER AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT INHALATION ( <i>zanamivir</i> )	Preferred	Max 10-day supply per fill
TAMIFLU CAPSULE 30 MG ORAL ( <i>oseltamivir phosphate</i> )	Non Preferred	PA; Max 10-day supply per fill
TAMIFLU CAPSULE 45 MG ORAL ( <i>oseltamivir phosphate</i> )	Non Preferred	PA; Max 10-day supply per fill
TAMIFLU CAPSULE 75 MG ORAL ( <i>oseltamivir phosphate</i> )	Non Preferred	PA; Max 10-day supply per fill
TAMIFLU SUSPENSION RECONSTITUTED 6 MG/ML ORAL ( <i>oseltamivir phosphate</i> )	Non Preferred	PA; Max 10-day supply per fill
<b>*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
XOFLUZA (40 MG DOSE) TABLET THERAPY PACK 1 X 40 MG ORAL ( <i>baloxavir marboxil</i> )	Non Preferred	PA
XOFLUZA (40 MG DOSE) TABLET THERAPY PACK 2 X 20 MG ORAL ( <i>baloxavir marboxil</i> )	Non Preferred	PA
XOFLUZA (80 MG DOSE) TABLET THERAPY PACK 1 X 80 MG ORAL ( <i>baloxavir marboxil</i> )	Non Preferred	PA
XOFLUZA (80 MG DOSE) TABLET THERAPY PACK 2 X 40 MG ORAL ( <i>baloxavir marboxil</i> )	Non Preferred	PA
<b>*RSV AGENTS - NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>ribavirin solution reconstituted 6 gm inhalation</i>	Preferred	
VIRAZOLE SOLUTION RECONSTITUTED 6 GM INHALATION ( <i>ribavirin</i> )	Non Preferred	PA
<b>*BETA ADRENERGICS*** - DRUGS FOR THE LUNGS</b>		
<b>*ANTIASTHMATIC AND BRONCHODILATOR AGENTS* - DRUGS FOR ASTHMA/COPD</b>		
<i>arformoterol tartrate nebulization solution 15 mcg/2ml inhalation</i>	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<b>*BETA BLOCKERS* - DRUGS FOR THE HEART</b>		
<b>*ALPHA-BETA BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>carvedilol tablet 12.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>carvedilol tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>carvedilol tablet 3.125 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>carvedilol tablet 6.25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>labetalol hcl tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>labetalol hcl tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>labetalol hcl tablet 300 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL ( <i>carvedilol phosphate</i> )	Non Preferred	PA
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL ( <i>carvedilol phosphate</i> )	Non Preferred	PA
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL ( <i>carvedilol phosphate</i> )	Non Preferred	PA
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>carvedilol phosphate</i> )	Non Preferred	PA
COREG TABLET 12.5 MG ORAL ( <i>carvedilol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
COREG TABLET 25 MG ORAL ( <i>carvedilol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
COREG TABLET 3.125 MG ORAL ( <i>carvedilol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
COREG TABLET 6.25 MG ORAL ( <i>carvedilol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*BETA BLOCKERS CARDIO-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>acebutolol hcl capsule 200 mg oral</i>	Preferred	QL (16 EA per 1 day); Max 90-day supply per fill

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>acebutolol hcl capsule 400 mg oral</i>	Preferred	QL (16 EA per 1 day); Max 90-day supply per fill
<i>atenolol tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>atenolol tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>atenolol tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>betaxolol hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>betaxolol hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bisoprolol fumarate tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bisoprolol fumarate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>metoprolol tartrate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol tartrate tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol tartrate tablet 37.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>metoprolol tartrate tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nebivolol hcl tablet 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nebivolol hcl tablet 2.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nebivolol hcl tablet 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nebivolol hcl tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
BYSTOLIC TABLET 10 MG ORAL ( <i>nebivolol hcl</i> )	Non Preferred	PA
BYSTOLIC TABLET 2.5 MG ORAL ( <i>nebivolol hcl</i> )	Non Preferred	PA
BYSTOLIC TABLET 20 MG ORAL ( <i>nebivolol hcl</i> )	Non Preferred	PA
BYSTOLIC TABLET 5 MG ORAL ( <i>nebivolol hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FIRST - METOPROLOL SOLUTION 10 MG/ML ORAL ( <i>metoprolol tartrate</i> )	Non Preferred	PA
FIRST-ATENOLOL SOLUTION 10 MG/ML ORAL ( <i>atenolol</i> )	Non Preferred	PA
FIRST-ATENOLOL SOLUTION 2 MG/ML ORAL ( <i>atenolol</i> )	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 100 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 200 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 25 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 50 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA
LOPRESSOR TABLET 100 MG ORAL ( <i>metoprolol tartrate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LOPRESSOR TABLET 50 MG ORAL ( <i>metoprolol tartrate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TENORMIN TABLET 100 MG ORAL ( <i>atenolol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TENORMIN TABLET 25 MG ORAL ( <i>atenolol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TENORMIN TABLET 50 MG ORAL ( <i>atenolol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>metoprolol succinate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*BETA BLOCKERS NON-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>nadolol tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>nadolol tablet 40 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>nadolol tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>pindolol tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pindolol tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 160 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>propranolol hcl er capsule extended release 24 hour 60 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 80 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl solution 20 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
<i>propranolol hcl solution 40 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl tablet 20 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl tablet 40 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl tablet 60 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propranolol hcl tablet 80 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl tablet 120 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl tablet 160 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl tablet 240 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>timolol maleate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>timolol maleate tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>timolol maleate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
HEMANGEOL SOLUTION 4.28 MG/ML ORAL ( <i>propranolol hcl</i> )	Preferred	PA; AGE (Max 1 Years)
<i>sotalol hcl (Sorine Tablet 120 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 160 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 240 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 80 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (af) tablet 120 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (af) tablet 160 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>sotalol hcl (af) tablet 80 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
BETAPACE AF TABLET 120 MG ORAL ( <i>sotalol hcl af</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
BETAPACE AF TABLET 160 MG ORAL ( <i>sotalol hcl af</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BETAPACE AF TABLET 80 MG ORAL ( <i>sotalol hcl af</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BETAPACE TABLET 120 MG ORAL ( <i>sotalol hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BETAPACE TABLET 160 MG ORAL ( <i>sotalol hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BETAPACE TABLET 80 MG ORAL ( <i>sotalol hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CORGARD TABLET 20 MG ORAL ( <i>nadolol</i> )	Non Preferred	PA; QL (3 EA per 1 day)
CORGARD TABLET 40 MG ORAL ( <i>nadolol</i> )	Non Preferred	PA; QL (3 EA per 1 day)
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>propranolol hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 160 MG ORAL ( <i>propranolol hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL ( <i>propranolol hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>propranolol hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
INDERAL XL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>propranolol hcl sr beads</i> )	Non Preferred	PA
INDERAL XL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>propranolol hcl sr beads</i> )	Non Preferred	PA
INNOPRAN XL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>propranolol hcl sr beads</i> )	Non Preferred	PA
INNOPRAN XL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>propranolol hcl sr beads</i> )	Non Preferred	PA
SOTYLIZE SOLUTION 5 MG/ML ORAL ( <i>sotalol hcl</i> )	Non Preferred	PA
<b>*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR THE EYE</b>		
<b>*OPHTHALMIC AGENTS* - DRUGS FOR GLAUCOMA</b>		
<i>timolol maleate</i> (Timolol Maleate Oculdose Solution 0.5 % Ophthalmic)	Non Preferred	PA
<b>*BILE ACID SEQUESTRANTS*** - DRUGS FOR THE HEART</b>		
<b>*ANTIHYPERLIPIDEMICS* - DRUGS FOR CHOLESTEROL</b>		
<i>cholestyramine light powder 4 gm/dose oral</i>	Preferred	QL (8 GM per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*CALCIUM CHANNEL BLOCKERS* - DRUGS FOR THE HEART</b>		
<b>*CALCIUM CHANNEL BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besylate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besylate tablet 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>amlodipine besylate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 420 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 360 mg oral</i>	Preferred	Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>diltiazem hcl er tablet extended release 24 hour 420 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl tablet 120 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl tablet 60 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl tablet 90 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>felodipine er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>felodipine er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>felodipine er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nifedipine capsule 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>nifedipine capsule 20 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 90 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 90 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>nimodipine capsule 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>verapamil hcl er tablet extended release 120 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>verapamil hcl er tablet extended release 180 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>verapamil hcl er tablet extended release 240 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>verapamil hcl tablet 120 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>verapamil hcl tablet 40 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>verapamil hcl tablet 80 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl coated beads (Cartia Xt Capsule Extended Release 24 Hour 120 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl coated beads (Cartia Xt Capsule Extended Release 24 Hour 180 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl coated beads (Cartia Xt Capsule Extended Release 24 Hour 240 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl coated beads (Cartia Xt Capsule Extended Release 24 Hour 300 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 180 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 240 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 300 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 360 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 420 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 120 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 180 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 240 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 300 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 360 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 120 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 180 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 240 Mg Oral)</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>diltiazem hcl er beads</i> (Tiadylt Er Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadylt Er Capsule Extended Release 24 Hour 360 Mg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadylt Er Capsule Extended Release 24 Hour 420 Mg Oral)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>isradipine capsule 2.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>isradipine capsule 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levamlodipine maleate tablet 2.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levamlodipine maleate tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nicardipine hcl capsule 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nicardipine hcl capsule 30 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 17 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 25.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 30 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 34 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 8.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>diltiazem hcl coated beads</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL ( <i>diltiazem hcl coated beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL ( <i>diltiazem hcl coated beads</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>diltiazem hcl coated beads</i> )	Non Preferred	PA; QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL ( <i>diltiazem hcl coated beads</i> )	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 180 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 240 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 360 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 420 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA
CARDIZEM TABLET 120 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CARDIZEM TABLET 30 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)
CARDIZEM TABLET 60 MG ORAL ( <i>diltiazem hcl</i> )	Non Preferred	PA; QL (4 EA per 1 day)
KATERZIA SUSPENSION 1 MG/ML ORAL ( <i>amlodipine benzoate</i> )	Non Preferred	PA
NORLIQVA SOLUTION 1 MG/ML ORAL ( <i>amlodipine besylate</i> )	Non Preferred	PA
NORVASC TABLET 10 MG ORAL ( <i>amlodipine besylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NORVASC TABLET 2.5 MG ORAL ( <i>amlodipine besylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NORVASC TABLET 5 MG ORAL ( <i>amlodipine besylate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
NYMALIZE SOLUTION 6 MG/ML ORAL ( <i>nimodipine</i> )	Non Preferred	PA
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>nifedipine</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 60 MG ORAL ( <i>nifedipine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 90 MG ORAL ( <i>nifedipine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SULAR TABLET EXTENDED RELEASE 24 HOUR 17 MG ORAL ( <i>nisoldipine</i> )	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 34 MG ORAL ( <i>nisoldipine</i> )	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 8.5 MG ORAL ( <i>nisoldipine</i> )	Non Preferred	PA
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL ( <i>diltiazem hcl er beads</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL ( <i>verapamil hcl</i> )	Non Preferred	PA
<b>*CARDIOTONICS* - DRUGS FOR THE HEART</b>		
<b>*CARDIAC GLYCOSIDES*** - DRUGS FOR THE HEART</b>		
<i>digoxin solution 0.05 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>digoxin tablet 125 mcg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>digoxin tablet 250 mcg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>digoxin</i> (Digox Tablet 125 Mcg Oral)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>digoxin</i> (Digox Tablet 250 Mcg Oral)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>digoxin tablet 62.5 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<b>*CARDIOVASCULAR AGENTS - MISC.* - DRUGS FOR THE HEART</b>		
<b>*CALCIUM CHANNEL BLOCKER &amp; HMG COA REDUCTASE INHIBIT COMB*** - DRUGS FOR CHOLESTEROL</b>		
<i>amlodipine-atorvastatin tablet 10-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 10-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 10-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 10-80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 2.5-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>amlodipine-atorvastatin tablet 2.5-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 2.5-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 5-10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 5-20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 5-40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amlodipine-atorvastatin tablet 5-80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CADUET TABLET 10-10 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 10-20 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 10-40 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 10-80 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 5-10 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 5-20 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 5-40 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
CADUET TABLET 5-80 MG ORAL ( <i>amlodipine-atorvastatin</i> )	Non Preferred	PA
<b>*CARDIAC MYOSIN INHIBITORS*** - DRUGS FOR THE HEART</b>		
CAMZYOS CAPSULE 10 MG ORAL ( <i>mavacamten</i> )	Non Preferred	PA
CAMZYOS CAPSULE 15 MG ORAL ( <i>mavacamten</i> )	Non Preferred	PA
CAMZYOS CAPSULE 2.5 MG ORAL ( <i>mavacamten</i> )	Non Preferred	PA
CAMZYOS CAPSULE 5 MG ORAL ( <i>mavacamten</i> )	Non Preferred	PA
<b>*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
ENTRESTO TABLET 24-26 MG ORAL ( <i>sacubitril-valsartan</i> )	Preferred	
ENTRESTO TABLET 49-51 MG ORAL ( <i>sacubitril-valsartan</i> )	Preferred	
ENTRESTO TABLET 97-103 MG ORAL ( <i>sacubitril-valsartan</i> )	Preferred	
<b>*NITRATE &amp; VASODILATOR COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>isosorb dinitrate-hydralazine tablet 20-37.5 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
BIDIL TABLET 20-37.5 MG ORAL ( <i>isosorb dinitrate-hydralazine</i> )	Preferred	
<b>*PROSTAGLANDIN VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>epoprostenol sodium solution reconstituted 0.5 mg intravenous</i>	Preferred	PA
<i>epoprostenol sodium solution reconstituted 1.5 mg intravenous</i>	Preferred	PA
FLOLAN SOLUTION RECONSTITUTED 0.5 MG INTRAVENOUS ( <i>epoprostenol sodium</i> )	Preferred	PA
FLOLAN SOLUTION RECONSTITUTED 1.5 MG INTRAVENOUS ( <i>epoprostenol sodium</i> )	Preferred	PA
<i>treprostinil solution 100 mg/20ml injection</i>	Non Preferred	PA
<i>treprostinil solution 20 mg/20ml injection</i>	Non Preferred	PA
<i>treprostinil solution 200 mg/20ml injection</i>	Non Preferred	PA
<i>treprostinil solution 50 mg/20ml injection</i>	Non Preferred	PA
ORENITRAM MONTH 1 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM MONTH 2 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM MONTH 3 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 0.125 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 0.25 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 1 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 2.5 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 5 MG ORAL ( <i>treprostinil diolamine</i> )	Non Preferred	PA
REMODULIN SOLUTION 100 MG/20ML INJECTION ( <i>treprostinil</i> )	Non Preferred	PA
REMODULIN SOLUTION 20 MG/20ML INJECTION ( <i>treprostinil</i> )	Non Preferred	PA
REMODULIN SOLUTION 200 MG/20ML INJECTION ( <i>treprostinil</i> )	Non Preferred	PA
REMODULIN SOLUTION 50 MG/20ML INJECTION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 112 X 32MCG & 112 X 48MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 16 MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TYVASO DPI MAINTENANCE KIT POWDER 32 MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 48 MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 64 MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI TITRATION KIT POWDER 112 X 16MCG & 84 X 32MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO DPI TITRATION KIT POWDER 16 & 32 & 48 MCG INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO REFILL SOLUTION 0.6 MG/ML INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO SOLUTION 0.6 MG/ML INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
TYVASO STARTER SOLUTION 0.6 MG/ML INHALATION ( <i>treprostinil</i> )	Non Preferred	PA
VELETRI SOLUTION RECONSTITUTED 0.5 MG INTRAVENOUS ( <i>epoprostenol sodium</i> )	Non Preferred	PA
VELETRI SOLUTION RECONSTITUTED 1.5 MG INTRAVENOUS ( <i>epoprostenol sodium</i> )	Non Preferred	PA
VENTAVIS SOLUTION 10 MCG/ML INHALATION ( <i>iloprost</i> )	Non Preferred	PA
VENTAVIS SOLUTION 20 MCG/ML INHALATION ( <i>iloprost</i> )	Non Preferred	PA
<b>*PULM HYPERTEN-SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
ADEMPAS TABLET 0.5 MG ORAL ( <i>riociguat</i> )	Non Preferred	PA
ADEMPAS TABLET 1 MG ORAL ( <i>riociguat</i> )	Non Preferred	PA
ADEMPAS TABLET 1.5 MG ORAL ( <i>riociguat</i> )	Non Preferred	PA
ADEMPAS TABLET 2 MG ORAL ( <i>riociguat</i> )	Non Preferred	PA
ADEMPAS TABLET 2.5 MG ORAL ( <i>riociguat</i> )	Non Preferred	PA
<b>*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
LETAIRIS TABLET 10 MG ORAL ( <i>ambrisentan</i> )	Preferred	PA; QL (1 EA per 1 day)
LETAIRIS TABLET 5 MG ORAL ( <i>ambrisentan</i> )	Preferred	PA; QL (1 EA per 1 day)
TRACLEER TABLET 125 MG ORAL ( <i>bosentan</i> )	Preferred	PA; QL (2 EA per 1 day)
TRACLEER TABLET 62.5 MG ORAL ( <i>bosentan</i> )	Preferred	PA; QL (2 EA per 1 day)
TRACLEER TABLET SOLUBLE 32 MG ORAL ( <i>bosentan</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>ambrisentan tablet 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>ambrisentan tablet 5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>bosentan tablet 125 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>bosentan tablet 62.5 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
OPSUMIT TABLET 10 MG ORAL ( <i>macitentan</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>sildenafil citrate tablet 20 mg oral</i>	Preferred	PA; QL (3 EA per 1 day)
<i>tadalafil (pah) tablet 20 mg oral</i>	Preferred	PA
ADCIRCA TABLET 20 MG ORAL ( <i>tadalafil (pah)</i> )	Preferred	PA
<i>tadalafil (pah)</i> (Alyq Tablet 20 Mg Oral)	Preferred	PA
REVATIO SUSPENSION RECONSTITUTED 10 MG/ML ORAL ( <i>sildenafil citrate</i> )	Preferred	PA
<i>sildenafil citrate solution 10 mg/12.5ml intravenous</i>	Non Preferred	PA
<i>sildenafil citrate suspension reconstituted 10 mg/ml oral</i>	Non Preferred	PA
LIQREV SUSPENSION 10 MG/ML ORAL ( <i>sildenafil citrate</i> )	Non Preferred	PA
REVATIO SOLUTION 10 MG/12.5ML INTRAVENOUS ( <i>sildenafil citrate</i> )	Non Preferred	PA
REVATIO TABLET 20 MG ORAL ( <i>sildenafil citrate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
TADLIQ SUSPENSION 20 MG/5ML ORAL ( <i>tadalafil (pah)</i> )	Non Preferred	PA
<b>*PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
UPTRAVI SOLUTION RECONSTITUTED 1800 MCG INTRAVENOUS ( <i>selexipag</i> )	Non Preferred	PA
UPTRAVI TABLET 1000 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 1200 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 1400 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 1600 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 200 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
UPTRAVI TABLET 400 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 600 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TABLET 800 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA; QL (2 EA per 1 day)
UPTRAVI TITRATION TABLET THERAPY PACK 200 & 800 MCG ORAL ( <i>selexipag</i> )	Non Preferred	PA
<b>*SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS*** - DRUGS FOR THE HEART</b>		
<i>tadalafil tablet 5 mg oral</i>	Non Preferred	PA
CIALIS TABLET 5 MG ORAL ( <i>tadalafil</i> )	Non Preferred	PA
<b>*SINUS NODE INHIBITORS** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
CORLANOR SOLUTION 5 MG/5ML ORAL ( <i>ivabradine hcl</i> )	Non Preferred	PA
CORLANOR TABLET 5 MG ORAL ( <i>ivabradine hcl</i> )	Non Preferred	PA
CORLANOR TABLET 7.5 MG ORAL ( <i>ivabradine hcl</i> )	Non Preferred	PA
<b>*TRANSTHYRETIN STABILIZERS*** - DRUGS FOR THE HEART</b>		
VYNDAMAX CAPSULE 61 MG ORAL ( <i>tafamidis</i> )	Non Preferred	PA
VYNDAQEL CAPSULE 20 MG ORAL ( <i>tafamidis meglumine (cardiac)</i> )	Non Preferred	PA
<b>*VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)*** - DRUGS FOR ANGINA</b>		
VERQUVO TABLET 10 MG ORAL ( <i>vericiguat</i> )	Preferred	PA
VERQUVO TABLET 2.5 MG ORAL ( <i>vericiguat</i> )	Preferred	PA
VERQUVO TABLET 5 MG ORAL ( <i>vericiguat</i> )	Preferred	PA
VERQUVO TABLET 10 MG ORAL ( <i>vericiguat</i> )	Non Preferred	PA
VERQUVO TABLET 2.5 MG ORAL ( <i>vericiguat</i> )	Non Preferred	PA
VERQUVO TABLET 5 MG ORAL ( <i>vericiguat</i> )	Non Preferred	PA
<b>*CEPHALOSPORINS* - DRUGS FOR INFECTIONS</b>		
<b>*CEPHALOSPORINS - 1ST GENERATION*** - ANTIBIOTICS</b>		
<i>cefadroxil capsule 500 mg oral</i>	Preferred	
<i>cefadroxil suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cefadroxil suspension reconstituted 500 mg/5ml oral</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>cefadroxil tablet 1 gm oral</i>	Preferred	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm</i>	Preferred	Max 14-day supply per fill
<i>cephalexin capsule 250 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>cephalexin capsule 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>cephalexin capsule 750 mg oral</i>	Preferred	
<i>cephalexin suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cephalexin suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cephalexin tablet 250 mg oral</i>	Preferred	
<i>cephalexin tablet 500 mg oral</i>	Preferred	
<b>*CEPHALOSPORINS - 2ND GENERATION*** - ANTIBIOTICS</b>		
<i>cefaclor capsule 250 mg oral</i>	Preferred	
<i>cefaclor capsule 500 mg oral</i>	Preferred	
<i>cefaclor suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cefaclor suspension reconstituted 375 mg/5ml oral</i>	Preferred	
<i>cefprozil suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cefprozil suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cefuroxime axetil tablet 250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>cefuroxime axetil tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>cefaclor er tablet extended release 12 hour 500 mg oral</i>	Non Preferred	PA
<i>cefprozil tablet 250 mg oral</i>	Non Preferred	PA
<i>cefprozil tablet 500 mg oral</i>	Non Preferred	PA
<b>*CEPHALOSPORINS - 3RD GENERATION*** - ANTIBIOTICS</b>		
<i>cefdinir capsule 300 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>cefdinir suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cefdinir suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cefixime capsule 400 mg oral</i>	Preferred	
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm</i>	Preferred	Max 14-day supply per fill
<i>cefixime suspension reconstituted 100 mg/5ml oral</i>	Non Preferred	PA
<i>cefixime suspension reconstituted 200 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil suspension reconstituted 100 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil suspension reconstituted 50 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil tablet 100 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>cefepime proxetil tablet 200 mg oral</i>	Non Preferred	PA
SUPRAX SUSPENSION RECONSTITUTED 100 MG/5ML ORAL ( <i>cefixime</i> )	Non Preferred	PA
<b>*CEPHALOSPORINS - 4TH GENERATION*** - ANTIBIOTICS</b>		
<i>cefepime hcl injection solution reconstituted 1 gm</i>	Preferred	Max 14-day supply per fill
MAXIPIME INTRAVENOUS SOLUTION RECONSTITUTED 1 GM ( <i>cefepime hcl</i> )	Preferred	Max 14-day supply per fill
<b>*CHEMICALS*</b>		
<b>*FIXED OILS***</b>		
<i>sesame oil oil</i>	Preferred	
<b>*LIQUIDS***</b>		
<i>benzyl benzoate liquid</i>	Preferred	AGE (Min 16 Years and Max 60 Years)
<b>*COMBINATION CONTRACEPTIVES - ORAL*** - DRUGS FOR WOMEN</b>		
<b>*CONTRACEPTIVES* - BIRTH CONTROL PILLS</b>		
<i>levonorgest-eth estradiol-iron tablet 0.1-20 mg-mcg(21) oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*CONTRACEPTIVES* - DRUGS FOR WOMEN</b>		
<b>*BIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>desogestrel-ethinyl estradiol tablet 0.15-0.02/0.01 mg (21/5) oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>viorele tablet 0.15-0.02/0.01 mg (21/5) oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol (Azurette Tablet 0.15-0.02/0.01 Mg (21/5) Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol (Bekyree Tablet 0.15-0.02/0.01 Mg (21/5) Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol (Kariva Tablet 0.15-0.02/0.01 Mg (21/5) Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
LO LOESTRIN FE TABLET 1 MG-10 MCG / 10 MCG ORAL ( <i>norethin-eth estrad-fe biphaz</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
MIRCETTE TABLET 0.15-0.02/0.01 MG (21/5) ORAL ( <i>desogestrel-ethinyl estradiol</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Pimtreea Tablet 0.15-0.02/0.01 Mg (21/5) Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Simliya Tablet 0.15-0.02/0.01 Mg (21/5) Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Volnea Tablet 0.15-0.02/0.01 Mg (21/5) Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*COMBINATION CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>alyacen 1/35 tablet 1-35 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>briellyn tablet 0.4-35 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol tablet 0.15-30 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospiren-eth estrad-levomefol tablet 3-0.02-0.451 mg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospiren-eth estrad-levomefol tablet 3-0.03-0.451 mg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol tablet 3-0.02 mg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol tablet 3-0.03 mg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>ethynodiol diac-eth estradiol tablet 1-35 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>ethynodiol diac-eth estradiol tablet 1-50 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estradiol-iron tablet 0.1-20 mg-mcg(21) oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad tablet 0.1-20 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad tablet 0.15-30 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>marlissa tablet 0.15-30 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe capsule 1-20 mg-mcg(24) oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe tablet 1.5-30 mg-mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe tablet 1-20 mg-mcg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe tablet chewable 1-20 mg-mcg(24) oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est tablet 1.5-30 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est tablet 1-20 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estradiol-fe tablet chewable 0.4-35 mg-mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estradiol-fe tablet chewable 0.8-25 mg-mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol tablet 0.25-35 mg-mcg oral</i>	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Altavera Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Apri Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Aviane Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
BALCOLTRA TABLET 0.1-20 MG-MCG(21) ORAL ( <i>levonorgestrel-eth estrad-fe bisg</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Balziva Tablet 0.4-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
BEYAZ TABLET 3-0.02-0.451 MG ORAL ( <i>drospiren-eth estrad-levomefol</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Tablet Chewable 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Tablet 0.3-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Elinest Tablet 0.3-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Enskyce Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Estarylla Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
FALESSA KIT 20-1-0.1 MCG-MG ORAL ( <i>levonorgestrel-eth estrad &amp; fa</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<i>levonorgestrel-ethinyl estrad</i> (Falmina Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Finzala Tablet Chewable 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Gemmy Capsule 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Gianvi Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Isibloom Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad-fe bisg</i> (Joyeaux Tablet 0.1-20 Mg-Mcg(21) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Juleber Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Tablet Chewable 0.8-25 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Kalliga Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Tablet 1-50 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estradiol-fe</i> (Layolis Fe Tablet Chewable 0.8-25 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Lessina Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1.5/30 (21) Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1/20 (21) Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Loryna Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Tablet 0.3-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Lutera Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Melodetta 24 Fe Tablet Chewable 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>norethin ace-eth estrad-fe</i> (Merzee Capsule 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Tablet Chewable 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Microgestin 24 Fe Tablet 1-20 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Tablet 1.5-30 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Mili Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
MINASTRIN 24 FE TABLET CHEWABLE 1-20 MG-MCG(24) ORAL ( <i>norethin ace-eth estrad-fe</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Mono-Linyah Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Tablet 0.5-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NEXTSTELLIS TABLET 3-14.2 MG ORAL ( <i>drospirenone-estetrol</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Nikki Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Tablet 0.5-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Nymyo Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Ocella Tablet 3-0.03 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Philith Tablet 0.4-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Pirmella 1/35 Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Previfem Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Tablet 0.15-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SAFYRAL TABLET 3-0.03-0.451 MG ORAL ( <i>drospiren-eth estrad-levomefol</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Sprintec 28 Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Syeda Tablet 3-0.03 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Tablet 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Tablet 1-20 Mg-Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Taysofy Capsule 1-20 Mg-Mcg(24) Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TAYTULLA CAPSULE 1-20 MG-MCG(24) ORAL ( <i>norethin ace-eth estrad-fe</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Turqoz Tablet 0.3-30 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TYBLUME TABLET CHEWABLE 0.1-20 MG-MCG ORAL ( <i>levonorgestrel-ethinyl estrad</i> )	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospiren-eth estrad-levomefol</i> (Tydemy Tablet 3-0.03-0.451 Mg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Vestura Tablet 3-0.02 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Vienva Tablet 0.1-20 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone-eth estradiol</i> (Vyfemla Tablet 0.4-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestimate-eth estradiol</i> (Vylibra Tablet 0.25-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>norethindrone-eth estradiol</i> (Wera Tablet 0.5-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Tablet Chewable 0.4-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
YASMIN 28 TABLET 3-0.03 MG ORAL ( <i>drospirenone-ethinyl estradiol</i> )	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
YAZ TABLET 3-0.02 MG ORAL ( <i>drospirenone-ethinyl estradiol</i> )	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Tablet 1-35 Mg-Mcg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Tablet 3-0.03 Mg Oral)	Preferred	QL (1.34 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*COMBINATION CONTRACEPTIVES - TRANSDERMAL*** - BIRTH CONTROL PILLS</b>		
<i>norelgestromin-eth estradiol patch weekly 150-35 mcg/24hr transdermal</i>	Preferred	QL (0.143 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TWIRLA PATCH WEEKLY 120-30 MCG/24HR TRANSDERMAL ( <i>levonorgestrel-eth estradiol</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norelgestromin-eth estradiol</i> (Xulane Patch Weekly 150-35 Mcg/24Hr Transdermal)	Preferred	QL (0.143 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norelgestromin-eth estradiol</i> (Zafemy Patch Weekly 150-35 Mcg/24Hr Transdermal)	Preferred	QL (0.143 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*COMBINATION CONTRACEPTIVES - VAGINAL*** - BIRTH CONTROL PILLS</b>		
<i>etonogestrel-ethinyl estradiol ring 0.12-0.015 mg/24hr vaginal</i>	Preferred	QL (0.05 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
ANNOVERA RING 0.013-0.15 MG/24HR VAGINAL ( <i>segesterone-ethinyl estradiol</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Ring 0.12-0.015 Mg/24Hr Vaginal)	Preferred	QL (0.05 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Ring 0.12-0.015 Mg/24Hr Vaginal)	Preferred	QL (0.05 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>etonogestrel-ethinyl estradiol</i> (Haloette Ring 0.12-0.015 Mg/24Hr Vaginal)	Preferred	QL (0.05 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NUVARING RING 0.12-0.015 MG/24HR VAGINAL ( <i>etonogestrel-ethinyl estradiol</i> )	Preferred	QL (0.05 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*CONTINUOUS CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>levonorgestrel-ethinyl estrad tablet 90-20 mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Tablet 90-20 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Tablet 90-20 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*EMERGENCY CONTRACEPTIVES*** - BIRTH CONTROL PILLS</b>		
<i>levonorgestrel tablet 1.5 mg oral (otc)</i>	Preferred	QL (4 EA per 28 days)
<i>levonorgestrel tablet 1.5 mg oral (otc)</i>	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
CURAE TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
ECONTRA ONE-STEP TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
ELLA TABLET 30 MG ORAL ( <i>ulipristal acetate</i> )	Preferred	QL (4 EA per 28 days); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
HER STYLE TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
MY CHOICE TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
MY WAY TABLET 1.5 MG ORAL (OTC) ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
NEW DAY TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
OPTION 2 TABLET 1.5 MG ORAL ( <i>levonorgestrel</i> )	Preferred	QL (4 EA per 28 days); Max 100-day supply per fill
<b>*EXTENDED-CYCLE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>levonorgest-eth est &amp; eth est tablet 42-21-21-7 days oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day tablet 0.1-0.02 &amp; 0.01 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 &amp; 0.01 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Amethia Tablet 0.15-0.03 &amp; 0.01 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Ashlyna Tablet 0.15-0.03 &amp; 0.01 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Camrese Lo Tablet 0.1-0.02 &amp; 0.01 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Camrese Tablet 0.15-0.03 &amp; 0.01 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Daysee Tablet 0.15-0.03 &amp; 0.01 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Fayosim Tablet 42-21-21-7 Days Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day (Iclevia Tablet 0.15-0.03 Mg Oral)</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
<i>levonorgest-eth estrad 91-day</i> (Introvale Tablet 0.15-0.03 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Tablet 0.15-0.03 & 0.01 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Jolessa Tablet 0.15-0.03 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Tablet 0.1-0.02 & 0.01 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
LOSEASONIQUE TABLET 0.1-0.02 & 0.01 MG ORAL ( <i>levonorgest-eth estrad 91-day</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
QUARTETTE TABLET 42-21-21-7 DAYS ORAL ( <i>levonorgest-eth estrad 91-day</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Tablet 42-21-21-7 Days Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SEASONIQUE TABLET 0.15-0.03 & 0.01 MG ORAL ( <i>levonorgest-eth estrad 91-day</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Setlakin Tablet 0.15-0.03 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Simpesse Tablet 0.15-0.03 & 0.01 Mg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*FOUR PHASE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
NATAZIA TABLET 3/2-2/2-3/1 MG ORAL ( <i>estradiol valerate-dienogest</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<b>*PROGESTIN CONTRACEPTIVES - INJECTABLE*** - BIRTH CONTROL PILLS</b>		
<i>medroxyprogesterone acetate suspension 150 mg/ml intramuscular</i>	Preferred	QL (1 ML per 71 days); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>medroxyprogesterone acetate suspension 150 mg/ml intramuscular</i>	Preferred	QL (1 ML per 84 days); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>medroxyprogesterone acetate suspension prefilled syringe 150 mg/ml intramuscular</i>	Preferred	QL (0.012 ML per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
DEPO-PROVERA SUSPENSION 150 MG/ML INTRAMUSCULAR ( <i>medroxyprogesterone acetate</i> )	Preferred	QL (1 ML per 84 days); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
DEPO-PROVERA SUSPENSION PREFILLED SYRINGE 150 MG/ML INTRAMUSCULAR ( <i>medroxyprogesterone acetate</i> )	Preferred	QL (0.012 ML per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
DEPO-SUBQ PROVERA 104 SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML SUBCUTANEOUS ( <i>medroxyprogesterone acetate</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*PROGESTIN CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>norethindrone tablet 0.35 mg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Camila Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Deblitane Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Errin Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Heather Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Incassia Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone (Jencycla Tablet 0.35 Mg Oral)</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>norethindrone</i> (Lyleq Tablet 0.35 Mg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone</i> (Nora-Be Tablet 0.35 Mg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindrone</i> (Norlyda Tablet 0.35 Mg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
OPILL ORAL TABLET 0.075 MG ( <i>norgestrel</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>norethindrone</i> (Sharobel Tablet 0.35 Mg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SLYND TABLET 4 MG ORAL ( <i>drospirenone</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*TRIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>alyacen 7/7/7 tablet 0.5/0.75/1-35 mg-mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorg-eth estrad triphasic tablet 50-30/75-40/ 125-30 mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindron-ethinyl estrad-fe tablet 1-20/1-30/1-35 mg-mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic tablet 0.18/0.215/0.25 mg-35 mcg oral</i>	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estrad triphasic</i> (Aranelle Tablet 0.5/1/0.5-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Tablet 0.5/0.75/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Tablet 50-30/75-40/ 125-30 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estrad triphasic</i> (Leena Tablet 0.5/1/0.5-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorg-eth estrad triphasic</i> (Levonest Tablet 50-30/75-40/ 125-30 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Tablet 0.5/0.75/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Tablet 0.5/0.75/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Tablet 0.5/0.75/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Tablet 1-20/1-30/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri Femynor Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Tablet 1-20/1-30/1-35 Mg-Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Tablet 0.18/0.215/0.25 Mg-25 Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Tablet 0.18/0.215/0.25 Mg-25 Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Tablet 0.18/0.215/0.25 Mg-25 Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Tablet 0.18/0.215/0.25 Mg-25 Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Nymyo Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Tablet 50-30/75-40/ 125-30 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Tablet 0.18/0.215/0.25 Mg-25 Mcg Oral)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Tablet 0.18/0.215/0.25 Mg-35 Mcg Oral)	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VELIVET TABLET 0.1/0.125/0.15 -0.025 MG ORAL ( <i>desogestrel-ethinyl estradiol</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*CORTICOSTEROIDS* - HORMONES</b>		
<b>*GLUCOCORTICOSTEROIDS*** - DRUGS FOR INFLAMMATION</b>		
<i>dexamethasone elixir 0.5 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day)
<i>dexamethasone solution 0.5 mg/5ml oral</i>	Preferred	
<i>dexamethasone tablet 0.5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>dexamethasone tablet 0.75 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 1.5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 4 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 6 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet therapy pack 1.5 mg (21) oral</i>	Preferred	
<i>dexamethasone tablet therapy pack 1.5 mg (35) oral</i>	Preferred	
<i>dexamethasone tablet therapy pack 1.5 mg (51) oral</i>	Preferred	
<i>hydrocortisone tablet 10 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocortisone tablet 20 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>hydrocortisone tablet 5 mg oral</i>	Preferred	QL (24 EA per 1 day)
<i>methylprednisolone tablet 16 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>methylprednisolone tablet 32 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>methylprednisolone tablet 4 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>methylprednisolone tablet 8 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>methylprednisolone tablet therapy pack 4 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>prednisolone sodium phosphate solution 10 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 20 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 25 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral</i>	Preferred	
<i>prednisolone solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone tablet 5 mg oral</i>	Preferred	
<i>prednisone solution 5 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>prednisone tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>prednisone tablet 10 mg oral</i>	Preferred	QL (9 EA per 1 day)
<i>prednisone tablet 2.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>prednisone tablet 20 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>prednisone tablet 5 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>prednisone tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>prednisone tablet therapy pack 10 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (48) oral</i>	Preferred	
<i>prednisone tablet therapy pack 5 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 5 mg (48) oral</i>	Preferred	
DEXAMETHASONE INTENSOL CONCENTRATE 1 MG/ML ORAL ( <i>dexamethasone</i> )	Preferred	
<i>prednisolone (Millipred Tablet 5 Mg Oral)</i>	Preferred	
PREDNISONE INTENSOL CONCENTRATE 5 MG/ML ORAL ( <i>prednisone</i> )	Preferred	
<i>budesonide capsule delayed release particles 3 mg oral</i>	Non Preferred	PA
<i>budesonide er tablet extended release 24 hour 9 mg oral</i>	Non Preferred	PA
<i>cortisone acetate tablet 25 mg oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate tablet dispersible 10 mg oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate tablet dispersible 15 mg oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate tablet dispersible 30 mg oral</i>	Non Preferred	PA
AGAMREE SUSPENSION 40 MG/ML ORAL ( <i>vamorolone</i> )	Non Preferred	PA
ALKINDI SPRINKLE CAPSULE SPRINKLE 0.5 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA
ALKINDI SPRINKLE CAPSULE SPRINKLE 1 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA
ALKINDI SPRINKLE CAPSULE SPRINKLE 2 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA
ALKINDI SPRINKLE CAPSULE SPRINKLE 5 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA
CORTEF TABLET 10 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA; QL (12 EA per 1 day)
CORTEF TABLET 20 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA; QL (6 EA per 1 day)
CORTEF TABLET 5 MG ORAL ( <i>hydrocortisone</i> )	Non Preferred	PA; QL (24 EA per 1 day)
EMFLAZA SUSPENSION 22.75 MG/ML ORAL ( <i>deflazacort</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
EMFLAZA TABLET 18 MG ORAL ( <i>deflazacort</i> )	Non Preferred	PA
EMFLAZA TABLET 30 MG ORAL ( <i>deflazacort</i> )	Non Preferred	PA
EMFLAZA TABLET 36 MG ORAL ( <i>deflazacort</i> )	Non Preferred	PA
EMFLAZA TABLET 6 MG ORAL ( <i>deflazacort</i> )	Non Preferred	PA
HEMADY TABLET 20 MG ORAL ( <i>dexamethasone</i> )	Non Preferred	PA
MEDROL TABLET 16 MG ORAL ( <i>methylprednisolone</i> )	Non Preferred	PA; QL (4 EA per 1 day)
MEDROL TABLET 2 MG ORAL ( <i>methylprednisolone</i> )	Non Preferred	PA
MEDROL TABLET 4 MG ORAL ( <i>methylprednisolone</i> )	Non Preferred	PA; QL (12 EA per 1 day)
MEDROL TABLET 8 MG ORAL ( <i>methylprednisolone</i> )	Non Preferred	PA; QL (6 EA per 1 day)
MEDROL TABLET THERAPY PACK 4 MG ORAL ( <i>methylprednisolone</i> )	Non Preferred	PA; QL (12 EA per 1 day)
RAYOS TABLET DELAYED RELEASE 1 MG ORAL ( <i>prednisone</i> )	Non Preferred	PA
RAYOS TABLET DELAYED RELEASE 2 MG ORAL ( <i>prednisone</i> )	Non Preferred	PA
RAYOS TABLET DELAYED RELEASE 5 MG ORAL ( <i>prednisone</i> )	Non Preferred	PA
TAPERDEX 12-DAY TABLET THERAPY PACK 1.5 MG (49) ORAL ( <i>dexamethasone</i> )	Non Preferred	PA
<i>dexamethasone</i> (Taperdex 6-Day Tablet Therapy Pack 1.5 Mg (21) Oral)	Non Preferred	PA
<i>dexamethasone</i> (Taperdex 6-Day Tablet Therapy Pack 1.5 Mg Oral)	Non Preferred	PA
TAPERDEX 7-DAY TABLET THERAPY PACK 1.5 MG (27) ORAL ( <i>dexamethasone</i> )	Non Preferred	PA
TARPEYO CAPSULE DELAYED RELEASE 4 MG ORAL ( <i>budesonide</i> )	Non Preferred	PA
UCERIS TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL ( <i>budesonide</i> )	Non Preferred	PA
<b>*MINERALOCORTICOID*** - DRUGS FOR INFLAMMATION</b>		
<i>fludrocortisone acetate tablet 0.1 mg oral</i>	Preferred	QL (5 EA per 1 day)
<b>*COUGH/COLD/ALLERGY* - DRUGS FOR THE LUNGS</b>		
<b>*ANTITUSSIVE - NONNARCOTIC*** - DRUGS FOR ALLERGIES</b>		
<i>benzonatate oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day)
<i>benzonatate oral capsule 200 mg</i>	Preferred	QL (5 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp cough relief oral liquid 15 mg/5ml</i>	Preferred	
<b>*ANTITUSSIVE-EXPECTORANT*** - DRUGS FOR COUGH AND COLD</b>		
<i>chest congestion relief dm oral syrup 10-100 mg/5ml</i>	Preferred	QL (180 ML per 30 days)
<i>chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>dextromethorphan-guaifenesin oral liquid 10-100 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>dextromethorphan-guaifenesin oral liquid 5-100 mg/5ml</i>	Preferred	
<i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml, 20-200 mg/10ml</i>	Preferred	QL (180 ML per 30 days)
<i>dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>ft chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>ft mucus relief dm oral tablet extended release 12 hour 1200-60 mg</i>	Preferred	
<i>ft mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ft tussin dm max adult oral liquid 20-400 mg/20ml</i>	Preferred	
<i>gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>gnp mucus relief dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp tab tussin dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp tussin dm cough oral liquid 100-10 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>gnp tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>goodsense mucus dm oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>goodsense tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	Preferred	QL (60 ML per 1 day); AGE (Min 2 Years)
<i>guaifenesin-dm oral syrup 100-10 mg/5ml</i>	Preferred	QL (180 ML per 30 days)
<i>mucus relief cough childrens oral liquid 5-100 mg/5ml</i>	Preferred	
<i>mucus relief dm cough oral tablet 20-400 mg</i>	Preferred	
<i>mucus relief dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>mucus relief dm oral liquid 20-400 mg/20ml</i>	Preferred	
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>siltussin dm das oral liquid 100-10 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>sm chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>sm tussin cough/chest congest oral liquid 20-200 mg/10ml</i>	Preferred	QL (240 ML per 30 days)
<i>sm tussin cough/chest congest oral syrup 100-10 mg/5ml</i>	Preferred	QL (180 ML per 30 days)

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Drug Name	Formulary Status	Requirements/Limits
<i>sm tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>sm tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	QL (180 ML per 30 days)
<i>tusnel diabetic oral liquid 10-100 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>tussin dm cough + chest oral liquid 10-100 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>tussin dm cough + chest oral liquid 20-400 mg/20ml</i>	Preferred	
<i>tussin dm max adult oral liquid 10-200 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>tussin dm oral liquid 100-10 mg/5ml</i>	Preferred	QL (240 ML per 30 days)
<i>tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	QL (180 ML per 30 days)
DELSYM CGH/CHEST CONG DM CHILD ORAL LIQUID 5-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	Preferred	
DELSYM COUGH/CHEST CONGEST DM ORAL LIQUID 5-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	Preferred	
MUCINEX COUGH CHILDRENS ORAL LIQUID 5-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	Preferred	
MUCINEX FAST-MAX DM MAX ORAL LIQUID 20-400 MG/20ML ( <i>dextromethorphan-guaifenesin</i> )	Preferred	
<b>*ANTITUSSIVE-EXPECTORANTS-DECONGESTANT*** - DRUGS FOR COUGH AND COLD</b>		
<i>guaifenesin dac oral solution 30-10-100 mg/5ml</i>	Preferred	QL (60 ML per 1 day)
<b>*DECONGESTANT &amp; ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>allergy relief d-12 oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>allergy relief d-24 oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy relief/nasal decongest oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>allergy relief/nasal decongest oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>ft all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>ft allergy relief-d oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>gnp allergy &amp; congestion oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp allergy/congestion relief oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>goodsense all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>hm allergy relief/nasal decong oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>loratadine-d 12hr oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Max 64 Years)
<i>rynex pse oral liquid 1-15 mg/5ml</i>	Preferred	QL (480 ML per 30 days)
<i>sm all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
<i>sm cold &amp; allergy childrens oral elixir 1-15 mg/5ml</i>	Preferred	QL (480 ML per 30 days)
<i>sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm lorata-dine d oral tablet extended release 24 hour 10-240 mg</i>	Preferred	QL (1 EA per 1 day)
<b>*DECONGESTANT W/ EXPECTORANT*** - DRUGS FOR COUGH AND COLD</b>		
<i>ft mucus relief d 12 hour oral tablet extended release 12 hour 60-600 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 4 Years)
<i>mucus d oral tablet extended release 12 hour 60-600 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 4 Years)
<i>mucus relief d oral tablet extended release 12 hour 60-600 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 4 Years)
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 60-600 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 4 Years)
<b>*EXPECTORANTS*** - DRUGS FOR COUGH AND COLD</b>		
<i>chest congestion relief oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>chest congestion relief oral tablet 400 mg</i>	Preferred	AGE (Min 4 Years)
<i>ft chest congestion relief oral tablet 400 mg</i>	Preferred	AGE (Min 4 Years)
<i>ft mucus relief 12hr oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ft tussin adult oral liquid 200 mg/10ml</i>	Preferred	AGE (Min 4 Years)
<i>gnp mucus er oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gnp mucus relief oral tablet 400 mg</i>	Preferred	AGE (Min 4 Years)
<i>gnp tab tussin oral tablet 400 mg</i>	Preferred	AGE (Min 4 Years)
<i>gnp tussin mucus &amp; chest cong oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>goodsense mucus er oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>guaifenesin er oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>guaifenesin oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>guaifenesin oral tablet 200 mg</i>	Preferred	AGE (Min 4 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>mucus relief er oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>siltussin sa oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>sm chest congestion relief oral tablet 400 mg</i>	Preferred	AGE (Min 4 Years)
<i>sm mucus relief childrens oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>sm mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm tussin mucus+chest congest oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>tussin mucus &amp; chest congest oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
<i>tussin mucus+chest congestion oral liquid 100 mg/5ml</i>	Preferred	AGE (Min 4 Years)
MUCINEX FAST-MAX CHEST CONG MS ORAL LIQUID 400 MG/20ML ( <i>guaifenesin</i> )	Preferred	AGE (Min 4 Years)
TUSNEL-EX ORAL LIQUID 100 MG/5ML ( <i>guaifenesin</i> )	Preferred	AGE (Min 4 Years)
<b>*MISC. RESPIRATORY INHALANTS*** - DRUGS FOR ALLERGIES</b>		
<i>sodium chloride inhalation nebulization solution 0.9 %, 3 %, 7 %</i>	Preferred	
<i>sodium chloride (Nebusal Inhalation Nebulization Solution 3 %)</i>	Preferred	
<i>sodium chloride (Pulmosal Inhalation Nebulization Solution 7 %)</i>	Preferred	
<b>*MUCOLYTICS*** - DRUGS FOR THE LUNGS</b>		
<i>acetylcysteine inhalation solution 20 %</i>	Preferred	QL (120 ML per 1 day)
<b>*NON-NARC ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	Preferred	QL (180 ML per 30 days); AGE (Min 4 Years and Max 64 Years)
<b>*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	Preferred	QL (60 ML per 1 day)
<b>*OPIOID ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	Preferred	QL (240 ML per 30 days); AGE (Min 2 Years and Max 64 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	Preferred	QL (240 ML per 30 days); AGE (Min 2 Years and Max 64 Years)
<b>*OPIOID ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5ml</i>	Preferred	QL (60 ML per 1 day); AGE (Min 2 Years and Max 64 Years)

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Drug Name	Formulary Status	Requirements/Limits
<b>*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE</b>		
<b>*OPHTHALMIC AGENTS* - DRUGS FOR THE EYE</b>		
<i>atropine sulfate solution 1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<b>*DERMATOLOGICALS* - DRUGS FOR THE SKIN</b>		
<b>*ACNE ANTIBIOTICS*** - DRUGS FOR THE SKIN</b>		
<i>clindamycin phosphate gel 1 % external</i>	Preferred	QL (2 GM per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate lotion 1 % external</i>	Preferred	QL (10 ML per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate solution 1 % external</i>	Preferred	QL (2 ML per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate swab 1 % external</i>	Preferred	QL (2 EA per 1 day); AGE (Min 10 Years)
<i>erythromycin gel 2 % external</i>	Preferred	QL (1 GM per 1 day); AGE (Min 10 Years)
<i>erythromycin solution 2 % external</i>	Preferred	QL (15 ML per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate (Clindacin Etz Swab 1 % External)</i>	Preferred	QL (2 EA per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate (Clindacin-P Swab 1 % External)</i>	Preferred	QL (2 EA per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate foam 1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>dapsone gel 5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>dapsone gel 7.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>ery pad 2 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium (acne) lotion 10 % external</i>	Non Preferred	PA; QL (118 ML per 30 days); AGE (Min 10 Years and Max 20 Years)
CLEOCIN-T LOTION 1 % EXTERNAL ( <i>clindamycin phosphate</i> )	Non Preferred	PA; QL (10 ML per 1 day); AGE (Min 10 Years)
<i>clindamycin phosphate (Clindacin Foam 1 % External)</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
CLINDAGEL GEL 1 % EXTERNAL ( <i>clindamycin phosphate</i> )	Non Preferred	PA; QL (2 ML per 1 day); AGE (Min 10 Years)
ERYGEL GEL 2 % EXTERNAL ( <i>erythromycin</i> )	Non Preferred	PA; QL (1 GM per 1 day); AGE (Min 10 Years)
KLARON LOTION 10 % EXTERNAL ( <i>sulfacetamide sodium (acne)</i> )	Non Preferred	PA; QL (118 ML per 30 days); AGE (Min 10 Years and Max 20 Years)
<b>*ACNE COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>benzoyl peroxide-erythromycin gel 5-3 % external</i>	Preferred	QL (1.6 GM per 1 day); AGE (Min 10 Years)

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<i>adapalene-benzoyl peroxide gel 0.1-2.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>adapalene-benzoyl peroxide gel 0.3-2.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>adapalene-benzoyl peroxide pad 0.1-2.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>bp 10-1 emulsion 10-1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>bp cleansing wash emulsion 10-4 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin phos-benzoyl perox gel 1.2-2.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin phos-benzoyl perox gel 1.2-3.75 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin phos-benzoyl perox gel 1.2-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin phos-benzoyl perox gel 1-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin-tretinoin gel 1.2-0.025 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sss 10-5 cream 10-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years); Max 60-day supply per fill
<i>sss 10-5 foam 10-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur cream 10-2 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years); Max 60-day supply per fill
<i>sulfacetamide sodium-sulfur cream 10-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years); Max 60-day supply per fill
<i>sulfacetamide sodium-sulfur liquid 10-2 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur liquid 10-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur liquid 9.8-4.8 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur pad 10-4 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur suspension 8-4 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sod-sulfur wash liquid 9-4.5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>sulfacetamide-sulfur in urea emulsion 10-5 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ACANYA GEL 1.2-2.5 % EXTERNAL ( <i>clindamycin phos-benzoyl perox</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar Cleanser Liquid 10-5 % External)	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
BENZAMYCIN GEL 5-3 % EXTERNAL ( <i>benzoyl peroxide-erythromycin</i> )	Non Preferred	PA; QL (1.6 GM per 1 day); AGE (Min 10 Years)
CABTREO GEL 0.15-3.1-1.2 % EXTERNAL ( <i>adapalene-benzoyl per-clindamy</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
CLINDACIN ETZ KIT 1 % EXTERNAL ( <i>clindamycin phos &amp; cleanser</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
CLINDACIN PAC KIT 1 % EXTERNAL ( <i>clindamycin phos &amp; cleanser</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>clindamycin-benzoyl per (refr)</i> (Neuac Gel 1.2-5 % External)	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
NEUAC KIT 1.2-5 % EXTERNAL ( <i>clindamycin-benzoyl per-moist</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ONEXTON GEL 1.2-3.75 % EXTERNAL ( <i>clindamycin phos-benzoyl perox</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMADAN KIT 9-4.5 % EXTERNAL ( <i>sulfacetamide-sulfur-cleanser</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMADAN WASH LIQUID 9-4.5 % EXTERNAL ( <i>sulfacetamide sodium-sulfur</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMADAN XLT KIT 9-4.5 % EXTERNAL ( <i>sulfacetamide-sulfur-sunscreen</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMAXIN CP KIT 10-4 % EXTERNAL ( <i>sulfacetamide-sulfur-cleanser</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMAXIN PAD 10-4 % EXTERNAL ( <i>sulfacetamide sodium-sulfur</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
SUMAXIN WASH LIQUID 9-4 % EXTERNAL ( <i>sulfacetamide sodium-sulfur</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ZIANA GEL 1.2-0.025 % EXTERNAL ( <i>clindamycin-tretinoin</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ZMA CLEAR SUSPENSION 9-4.5 % EXTERNAL ( <i>sulfacetamide sodium-sulfur</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<b>*ACNE PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>adapalene external gel 0.1 %</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years)
<i>tretinoin cream 0.025 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill
<i>tretinoin cream 0.05 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>tretinoin cream 0.1 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill
<i>tretinoin gel 0.01 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
<i>tretinoin gel 0.025 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
<i>tretinoin gel 0.05 % external</i>	Preferred	QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
<i>adapalene cream 0.1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years); Max 60-day supply per fill
<i>adapalene gel 0.3 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>isotretinoin capsule 10 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin capsule 20 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin capsule 25 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin capsule 30 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin capsule 35 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin capsule 40 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tazarotene foam 0.1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere gel 0.04 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere gel 0.08 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere gel 0.1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere pump gel 0.04 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere pump gel 0.08 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>tretinoin microsphere pump gel 0.1 % external</i>	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ABSORICA CAPSULE 10 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ABSORICA CAPSULE 20 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)
ABSORICA CAPSULE 25 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)
ABSORICA CAPSULE 30 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)
ABSORICA CAPSULE 35 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)
ABSORICA CAPSULE 40 MG ORAL ( <i>isotretinoin</i> )	Non Preferred	PA; AGE (Min 12 Years)
ABSORICA LD CAPSULE 16 MG ORAL ( <i>isotretinoin micronized</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ABSORICA LD CAPSULE 24 MG ORAL ( <i>isotretinoin micronized</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ABSORICA LD CAPSULE 32 MG ORAL ( <i>isotretinoin micronized</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ABSORICA LD CAPSULE 8 MG ORAL ( <i>isotretinoin micronized</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ALTRENO LOTION 0.05 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
<i>isotretinoin</i> (Amnesteem Capsule 10 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Amnesteem Capsule 20 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Amnesteem Capsule 40 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
ARAZLO LOTION 0.045 % EXTERNAL ( <i>tazarotene</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
ATRALIN GEL 0.05 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
<i>isotretinoin</i> (Claravis Capsule 10 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Claravis Capsule 20 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Claravis Capsule 30 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Claravis Capsule 40 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
FABIOR FOAM 0.1 % EXTERNAL ( <i>tazarotene</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A CREAM 0.025 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill

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RETIN-A CREAM 0.05 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill
RETIN-A CREAM 0.1 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years); Max 60-day supply per fill
RETIN-A GEL 0.01 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
RETIN-A GEL 0.025 % EXTERNAL ( <i>tretinoin</i> )	Non Preferred	PA; QL (1.5 GM per 1 day); AGE (Min 10 Years and Max 35 Years)
RETIN-A MICRO GEL 0.04 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A MICRO GEL 0.1 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A MICRO PUMP GEL 0.04 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A MICRO PUMP GEL 0.06 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A MICRO PUMP GEL 0.08 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
RETIN-A MICRO PUMP GEL 0.1 % EXTERNAL ( <i>tretinoin microsphere</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years)
WINLEVI CREAM 1 % EXTERNAL ( <i>clascoterone</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 20 Years); Max 60-day supply per fill
<i>isotretinoin</i> (Zenatane Capsule 10 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Zenatane Capsule 20 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Zenatane Capsule 30 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<i>isotretinoin</i> (Zenatane Capsule 40 Mg Oral)	Non Preferred	PA; AGE (Min 12 Years)
<b>*AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS*** - DRUGS FOR THE SKIN</b>		
VEREGEN OINTMENT 15 % EXTERNAL ( <i>sinecatechins</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTIBIOTIC MIXTURES TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>first aid antibiotic external ointment 3.5-400-5000 mg-unit</i>	Preferred	
<i>gnp triple antibiotic external ointment</i>	Preferred	
<i>gnp triple antibiotic plus external ointment 1 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense first aid antibiotic external ointment</i>	Preferred	
<i>poly bacitracin external ointment 500-10000 unit/gm</i>	Preferred	
<i>sm double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>sm triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>sm triple antibiotic max st external ointment 1 %</i>	Preferred	
<i>sm triple antibiotic original external ointment 3.5-400-5000</i>	Preferred	
<i>triple antibiotic external ointment , 3.5-400-5000 , 5-400-5000</i>	Preferred	
<i>triple antibiotic plus external ointment 1 %</i>	Preferred	
<i>triple antibiotic+pain relief external ointment 1 %</i>	Preferred	
<b>*ANTIBIOTIC STEROID COMBINATIONS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
NEO-SYNALAR CREAM 0.5-0.025 % EXTERNAL ( <i>neomycin-fluocinolone</i> )	Non Preferred	PA; Max 60-day supply per fill
NEO-SYNALAR KIT 0.5-0.025 % EXTERNAL ( <i>neo-fluocinolone &amp; emollient</i> )	Non Preferred	PA
<b>*ANTIBIOTICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc-aloe external ointment 500 unit/gm</i>	Preferred	
<i>gentamicin sulfate cream 0.1 % external</i>	Preferred	QL (1 GM per 1 day); Max 60-day supply per fill
<i>gentamicin sulfate ointment 0.1 % external</i>	Preferred	QL (1 GM per 1 day); Max 60-day supply per fill
<i>gnp bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>mupirocin ointment 2 % external</i>	Preferred	Max 60-day supply per fill
<i>sm antibiotic external ointment 500 unit/gm</i>	Preferred	
<i>mupirocin calcium cream 2 % external</i>	Non Preferred	PA; AGE (Max 20 Years); Max 60-day supply per fill
CENTANY AT KIT 2 % EXTERNAL ( <i>mupirocin</i> )	Non Preferred	PA
CENTANY OINTMENT 2 % EXTERNAL ( <i>mupirocin</i> )	Non Preferred	PA; Max 60-day supply per fill
XEPI CREAM 1 % EXTERNAL ( <i>ozenoxacin</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTIFUNGALS - TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>clotrimazole-betamethasone cream 1-0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>clotrimazole-betamethasone lotion 1-0.05 % external</i>	Non Preferred	PA
<i>miconazole-zinc oxide-petrolat ointment 0.25-15-81.35 % external</i>	Non Preferred	PA; Max 60-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-% external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>nystatin-triamcinolone ointment 100000-0.1 unit/gm-% external</i>	Non Preferred	PA; Max 60-day supply per fill
MYCOZYL HC LIQUID 1-0.667 % EXTERNAL ( <i>tolnaftate-hydrocortisone</i> )	Non Preferred	PA
VUSION OINTMENT 0.25-15-81.35 % EXTERNAL ( <i>miconazole-zinc oxide-petrolat</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>antifungal (tolnaftate) external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>athletes foot (terbinafine) external cream 1 %</i>	Preferred	
<i>athletes foot powder spray external aerosol powder 1 %</i>	Preferred	QL (133 GM per 30 days)
<i>ft antifungal external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>ft athletes foot (terbinafine) external cream 1 %</i>	Preferred	
<i>gnp terbinafine hydrochloride external cream 1 %</i>	Preferred	
<i>gnp tolnaftate external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>jock itch spray external aerosol powder 1 %</i>	Preferred	QL (133 GM per 30 days)
<i>nystatin cream 100000 unit/gm external</i>	Preferred	Max 60-day supply per fill
<i>nystatin ointment 100000 unit/gm external</i>	Preferred	Max 60-day supply per fill
<i>nystatin powder 100000 unit/gm external</i>	Preferred	QL (30 GM per 30 days)
<i>sm antifungal tolnaftate external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>sm athletes foot external cream 1 %</i>	Preferred	
<i>terbinafine hcl external cream 1 %</i>	Preferred	
<i>tolnaftate antifungal external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>tolnaftate external cream 1 %</i>	Preferred	QL (60 GM per 30 days)
<i>tolnaftate external powder 1 %</i>	Preferred	QL (67.5 GM per 30 days)
<i>nystatin (Klayesta Powder 100000 Unit/Gm External)</i>	Preferred	QL (30 GM per 30 days)
<i>nystatin (Nyamyc Powder 100000 Unit/Gm External)</i>	Preferred	QL (30 GM per 30 days)
<i>nystatin (Nystop Powder 100000 Unit/Gm External)</i>	Preferred	QL (30 GM per 30 days)
<i>ciclopirox gel 0.77 % external</i>	Non Preferred	PA
<i>ciclopirox olamine cream 0.77 % external</i>	Non Preferred	PA; QL (180 GM per 30 days); Max 60-day supply per fill
<i>ciclopirox olamine suspension 0.77 % external</i>	Non Preferred	PA; QL (60 ML per 30 days)
<i>ciclopirox shampoo 1 % external</i>	Non Preferred	PA
<i>ciclopirox solution 8 % external</i>	Non Preferred	PA; QL (6.6 ML per 30 days)
<i>ciclopirox treatment kit 8 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>naftifine hcl cream 1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>naftifine hcl cream 2 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>naftifine hcl gel 2 % external</i>	Non Preferred	PA
<i>ciclopirox (Ciclodan Solution 8 % External)</i>	Non Preferred	PA; QL (6.6 ML per 30 days)
LOPROX CREAM 0.77 % EXTERNAL ( <i>ciclopirox olamine</i> )	Non Preferred	PA; QL (180 GM per 30 days); Max 60-day supply per fill
LOPROX KIT 0.77 % (SUSP) EXTERNAL ( <i>ciclopirox olamine-cleanser</i> )	Non Preferred	PA
LOPROX KIT 0.77 % EXTERNAL ( <i>ciclopirox olamine-cleanser</i> )	Non Preferred	PA
LOPROX SUSPENSION 0.77 % EXTERNAL ( <i>ciclopirox olamine</i> )	Non Preferred	PA; QL (60 ML per 30 days)
MYCOZYL AL SOLUTION 1 % EXTERNAL (RX) ( <i>tolnaftate</i> )	Non Preferred	PA
NAFTIN GEL 1 % EXTERNAL ( <i>naftifine hcl</i> )	Non Preferred	PA
NAFTIN GEL 2 % EXTERNAL ( <i>naftifine hcl</i> )	Non Preferred	PA
<b>*ANTI-INFLAMMATORY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>arthritis pain reliever external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>cvs diclofenac sodium external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>diclofenac sodium external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>eq arthritis pain external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>eq arthritis pain reliever external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>ft arthritis pain external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>gnp arthritis pain external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>gnp diclofenac sodium external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>goodsense arthritis pain external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>kls diclofenac sodium external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>qc diclofenac sodium external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
<i>sm arthritis pain external gel 1 %</i>	Preferred	QL (100 GM per 30 days)
ASPERCREME ARTHRITIS PAIN EXTERNAL GEL 1 % ( <i>diclofenac sodium</i> )	Preferred	QL (100 GM per 30 days)
MOTRIN ARTHRITIS PAIN EXTERNAL GEL 1 % ( <i>diclofenac sodium</i> )	Preferred	QL (100 GM per 30 days)
VOLTAREN ARTHRITIS PAIN EXTERNAL GEL 1 % ( <i>diclofenac sodium</i> )	Preferred	QL (100 GM per 30 days)
<i>diclofenac epolamine patch 1.3 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>diclofenac sodium gel 1 % external (rx)</i>	Non Preferred	PA
<i>diclofenac sodium gel 1 % external (rx)</i>	Non Preferred	PA; QL (100 GM per 30 days)
<i>diclofenac sodium solution 1.5 % external</i>	Non Preferred	PA
<i>diclofenac sodium solution 2 % external</i>	Non Preferred	PA
FLECTOR PATCH 1.3 % EXTERNAL ( <i>diclofenac epolamine</i> )	Non Preferred	PA
LICART PATCH 24 HOUR 1.3 % EXTERNAL ( <i>diclofenac epolamine</i> )	Non Preferred	PA
PENNSAID SOLUTION 2 % EXTERNAL ( <i>diclofenac sodium</i> )	Non Preferred	PA
<b>*ANTI-INFLAMMATORY COMBINATIONS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>diclofenac sodium-capsaicin (Lextol Therapy Pack 1.5 &amp; 0.025 % External)</i>	Non Preferred	PA
<b>*ANTINEOPLASTIC ALKYLATING AGENTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
VALCHLOR GEL 0.016 % EXTERNAL ( <i>mechlorethamine hcl (topical)</i> )	Non Preferred	PA
<b>*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>fluorouracil cream 0.5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>fluorouracil cream 5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>fluorouracil solution 2 % external</i>	Non Preferred	PA
<i>fluorouracil solution 5 % external</i>	Non Preferred	PA
CARAC CREAM 0.5 % EXTERNAL ( <i>fluorouracil</i> )	Non Preferred	PA; Max 60-day supply per fill
EFUDEX CREAM 5 % EXTERNAL ( <i>fluorouracil</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S*** - DRUGS FOR THE SKIN</b>		
<i>diclofenac sodium gel 3 % external</i>	Non Preferred	PA
<b>*ANTIPRURITICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>doxepin hcl cream 5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
PRUDOXIN CREAM 5 % EXTERNAL ( <i>doxepin hcl (antipruritic)</i> )	Non Preferred	PA; Max 60-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ZONALON CREAM 5 % EXTERNAL ( <i>doxepin hcl (antipruritic)</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTIPSORIATICS - SYSTEMIC*** - DRUGS FOR THE SKIN</b>		
COSENTYX (300 MG DOSE) SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
COSENTYX SENSOREADY (300 MG) SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
COSENTYX SENSOREADY PEN SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
COSENTYX UNOREADY SOLUTION AUTO-INJECTOR 300 MG/2ML SUBCUTANEOUS ( <i>secukinumab</i> )	Preferred	PA
<i>acitretin capsule 10 mg oral</i>	Non Preferred	PA
<i>acitretin capsule 17.5 mg oral</i>	Non Preferred	PA
<i>acitretin capsule 25 mg oral</i>	Non Preferred	PA
<i>methoxsalen rapid capsule 10 mg oral</i>	Non Preferred	PA
BIMZELX SOLUTION AUTO-INJECTOR 160 MG/ML SUBCUTANEOUS ( <i>bimekizumab-bkzx</i> )	Non Preferred	PA
BIMZELX SOLUTION PREFILLED SYRINGE 160 MG/ML SUBCUTANEOUS ( <i>bimekizumab-bkzx</i> )	Non Preferred	PA
ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS ( <i>tildrakizumab-asmn</i> )	Non Preferred	PA
SILIQ SOLUTION PREFILLED SYRINGE 210 MG/1.5ML SUBCUTANEOUS ( <i>brodalumab</i> )	Non Preferred	PA
SKYRIZI (150 MG DOSE) PREFILLED SYRINGE KIT 75 MG/0.83ML SUBCUTANEOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
SKYRIZI PEN SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
SKYRIZI SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
SOTYKTU TABLET 6 MG ORAL ( <i>deucravacitinib</i> )	Non Preferred	PA
STELARA SOLUTION 45 MG/0.5ML SUBCUTANEOUS ( <i>ustekinumab</i> )	Non Preferred	PA
STELARA SOLUTION PREFILLED SYRINGE 45 MG/0.5ML SUBCUTANEOUS ( <i>ustekinumab</i> )	Non Preferred	PA
STELARA SOLUTION PREFILLED SYRINGE 90 MG/ML SUBCUTANEOUS ( <i>ustekinumab</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TALTZ SOLUTION AUTO-INJECTOR 80 MG/ML SUBCUTANEOUS ( <i>ixekizumab</i> )	Non Preferred	PA
TALTZ SOLUTION PREFILLED SYRINGE 80 MG/ML SUBCUTANEOUS ( <i>ixekizumab</i> )	Non Preferred	PA
TREMFYA SOLUTION PEN-INJECTOR 100 MG/ML SUBCUTANEOUS ( <i>guselkumab</i> )	Non Preferred	PA
TREMFYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS ( <i>guselkumab</i> )	Non Preferred	PA
<b>*ANTIPSORIATICS*** - DRUGS FOR THE SKIN</b>		
<i>calcipotriene cream 0.005 % external</i>	Preferred	Max 60-day supply per fill
<i>calcipotriene ointment 0.005 % external</i>	Preferred	Max 60-day supply per fill
<i>calcipotriene solution 0.005 % external</i>	Preferred	
<i>calcipotriene foam 0.005 % external</i>	Non Preferred	PA
<i>calcitriol ointment 3 mcg/gm external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>tazarotene cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>tazarotene gel 0.05 % external</i>	Non Preferred	PA
<i>tazarotene gel 0.1 % external</i>	Non Preferred	PA
SORILUX FOAM 0.005 % EXTERNAL ( <i>calcipotriene</i> )	Non Preferred	PA
VTAMA CREAM 1 % EXTERNAL ( <i>tapinarof</i> )	Non Preferred	PA; Max 60-day supply per fill
ZORYVE CREAM 0.3 % EXTERNAL ( <i>roflumilast</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTISEBORRHEIC PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>anti-dandruff external shampoo 1 %</i>	Preferred	
<i>dandruff shampoo external lotion 1 %</i>	Preferred	
<i>selenium sulfide lotion 2.5 % external</i>	Preferred	
<i>selenium sulfide shampoo 2.25 % external</i>	Non Preferred	PA
<i>sodium sulfacetamide wash liquid 10 % external</i>	Non Preferred	PA
<i>sulfacetamide sodium (cleans) gel 10 % external</i>	Non Preferred	PA
<i>sulfacetamide sodium liquid 10 % external</i>	Non Preferred	PA
ZORYVE FOAM 0.3 % EXTERNAL ( <i>roflumilast (antiseborrheic)</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTIVIRAL TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
XERESE CREAM 5-1 % EXTERNAL ( <i>acyclovir-hydrocortisone</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ANTIVIRALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>acyclovir cream 5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>acyclovir ointment 5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>penciclovir cream 1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
DENAVIR CREAM 1 % EXTERNAL ( <i>penciclovir</i> )	Non Preferred	PA; Max 60-day supply per fill
ZOVIRAX CREAM 5 % EXTERNAL ( <i>acyclovir</i> )	Non Preferred	PA; Max 60-day supply per fill
ZOVIRAX OINTMENT 5 % EXTERNAL ( <i>acyclovir</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ASTRINGENTS*** - DRUGS FOR THE SKIN</b>		
XERAC AC SOLUTION 6.25 % EXTERNAL ( <i>aluminum chloride in alcohol</i> )	Non Preferred	PA
<b>*ATOPIC DERMATITIS - JANUS KINASE (JAK) INHIBITORS*** - DRUGS FOR THE SKIN</b>		
CIBINQO TABLET 100 MG ORAL ( <i>abrocitinib</i> )	Non Preferred	PA
CIBINQO TABLET 200 MG ORAL ( <i>abrocitinib</i> )	Non Preferred	PA
CIBINQO TABLET 50 MG ORAL ( <i>abrocitinib</i> )	Non Preferred	PA
OPZELURA CREAM 1.5 % EXTERNAL ( <i>ruxolitinib phosphate</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE SKIN</b>		
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS ( <i>dupilumab</i> )	Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS ( <i>dupilumab</i> )	Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS ( <i>dupilumab</i> )	Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 200 MG/1.14ML SUBCUTANEOUS ( <i>dupilumab</i> )	Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 300 MG/2ML SUBCUTANEOUS ( <i>dupilumab</i> )	Preferred	PA
ADBRY SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>tralokinumab-ldrm</i> )	Non Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS ( <i>dupilumab</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS ( <i>dupilumab</i> )	Non Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS ( <i>dupilumab</i> )	Non Preferred	PA
<b>*BURN PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>mafenide acetate packet 5 % external</i>	Preferred	
<i>silver sulfadiazine cream 1 % external</i>	Preferred	Max 60-day supply per fill
<i>silver sulfadiazine (Ssd Cream 1 % External)</i>	Preferred	Max 60-day supply per fill
SULFAMYLON CREAM 85 MG/GM EXTERNAL ( <i>mafenide acetate</i> )	Preferred	Max 60-day supply per fill
SILVADENE CREAM 1 % EXTERNAL ( <i>silver sulfadiazine</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*CAUTERIZING AGENT COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>grafco silver nit applicator 75-25 % external</i>	Non Preferred	PA
ARZOL SILVER NIT APPLICATORS 75-25 % EXTERNAL ( <i>silver nitrate-pot nitrate</i> )	Non Preferred	PA
<b>*CAUTERIZING AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>silver nitrate solution 0.5 % external</i>	Non Preferred	PA
<b>*CORTICOSTEROIDS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>alclometasone dipropionate cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>alclometasone dipropionate ointment 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone valerate cream 0.1 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone valerate lotion 0.1 % external</i>	Preferred	QL (60 ML per 30 days)
<i>betamethasone valerate ointment 0.1 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>clobetasol prop emollient base cream 0.05 % external</i>	Preferred	Max 60-day supply per fill
<i>clobetasol propionate cream 0.05 % external</i>	Preferred	Max 60-day supply per fill
<i>clobetasol propionate e cream 0.05 % external</i>	Preferred	Max 60-day supply per fill
<i>clobetasol propionate gel 0.05 % external</i>	Preferred	
<i>clobetasol propionate ointment 0.05 % external</i>	Preferred	Max 60-day supply per fill
<i>clobetasol propionate solution 0.05 % external</i>	Preferred	QL (50 ML per 30 days)
<i>desonide cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>desonide ointment 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>diflorasone diacetate cream 0.05 % external</i>	Preferred	QL (60 GM per 30 days); Max 60-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>diflorasone diacetate ointment 0.05 % external</i>	Preferred	QL (60 GM per 30 days); Max 60-day supply per fill
<i>fluocinolone acetonide body oil 0.01 % external</i>	Preferred	QL (4 ML per 1 day)
<i>fluocinolone acetonide cream 0.01 % external</i>	Preferred	Max 60-day supply per fill
<i>fluocinolone acetonide cream 0.025 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluocinolone acetonide ointment 0.025 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluocinolone acetonide scalp oil 0.01 % external</i>	Preferred	QL (4 ML per 1 day)
<i>fluocinolone acetonide solution 0.01 % external</i>	Preferred	
<i>fluocinonide cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluocinonide cream 0.1 % external</i>	Preferred	Max 60-day supply per fill
<i>fluocinonide emulsified base cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluocinonide gel 0.05 % external</i>	Preferred	QL (2 GM per 1 day)
<i>fluocinonide ointment 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluocinonide solution 0.05 % external</i>	Preferred	QL (60 ML per 30 days)
<i>fluticasone propionate cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>fluticasone propionate ointment 0.005 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>gnp hydrocortisone external cream 0.5 %</i>	Preferred	
<i>halobetasol propionate cream 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>halobetasol propionate ointment 0.05 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone cream 2.5 % external</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone external cream 0.5 %</i>	Preferred	
<i>hydrocortisone external ointment 0.5 %</i>	Preferred	
<i>hydrocortisone lotion 2.5 % external</i>	Preferred	QL (60 ML per 30 days)
<i>hydrocortisone ointment 1 % external (rx)</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone ointment 2.5 % external</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone valerate cream 0.2 % external</i>	Preferred	Max 60-day supply per fill
<i>hydrocortisone valerate ointment 0.2 % external</i>	Preferred	Max 60-day supply per fill
<i>mometasone furoate cream 0.1 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>mometasone furoate ointment 0.1 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>mometasone furoate solution 0.1 % external</i>	Preferred	QL (60 ML per 30 days)
<i>sm hydrocortisone external cream 0.5 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm hydrocortisone external ointment 0.5 %</i>	Preferred	
<i>triamcinolone acetonide cream 0.025 % external</i>	Preferred	Max 60-day supply per fill
<i>triamcinolone acetonide cream 0.1 % external</i>	Preferred	Max 60-day supply per fill
<i>triamcinolone acetonide cream 0.5 % external</i>	Preferred	Max 60-day supply per fill
<i>triamcinolone acetonide lotion 0.025 % external</i>	Preferred	
<i>triamcinolone acetonide lotion 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.025 % external</i>	Preferred	Max 60-day supply per fill
<i>triamcinolone acetonide ointment 0.1 % external</i>	Preferred	Max 60-day supply per fill
<i>triamcinolone acetonide ointment 0.5 % external</i>	Preferred	Max 60-day supply per fill
AQUANIL HC EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	Preferred	
<i>amcinonide cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>betamethasone dipropionate aug cream 0.05 % external</i>	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone dipropionate aug gel 0.05 % external</i>	Non Preferred	PA; QL (2 GM per 1 day)
<i>betamethasone dipropionate aug lotion 0.05 % external</i>	Non Preferred	PA; QL (60 ML per 30 days)
<i>betamethasone dipropionate aug ointment 0.05 % external</i>	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone dipropionate cream 0.05 % external</i>	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone dipropionate lotion 0.05 % external</i>	Non Preferred	PA; QL (60 ML per 30 days)
<i>betamethasone dipropionate ointment 0.05 % external</i>	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
<i>betamethasone valerate foam 0.12 % external</i>	Non Preferred	PA
<i>clobetasol propionate emulsion foam 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate foam 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate liquid 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate lotion 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate shampoo 0.05 % external</i>	Non Preferred	PA
<i>clocortolone pivalate cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>desonide lotion 0.05 % external</i>	Non Preferred	PA
<i>desoximetasone cream 0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>desoximetasone cream 0.25 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>desoximetasone gel 0.05 % external</i>	Non Preferred	PA
<i>desoximetasone liquid 0.25 % external</i>	Non Preferred	PA
<i>desoximetasone ointment 0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>desoximetasone ointment 0.25 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>flurandrenolide cream 0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>flurandrenolide lotion 0.05 % external</i>	Non Preferred	PA
<i>fluticasone propionate lotion 0.05 % external</i>	Non Preferred	PA
<i>halcinonide cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>halobetasol propionate foam 0.05 % external</i>	Non Preferred	PA
<i>hydrocortisone butyr lipo base cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>hydrocortisone butyrate cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>hydrocortisone butyrate lotion 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone butyrate ointment 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>hydrocortisone butyrate solution 0.1 % external</i>	Non Preferred	PA
<i>prednicarbate cream 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>prednicarbate ointment 0.1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>triamcinolone acetonide aerosol solution 0.147 mg/gm external</i>	Non Preferred	PA
<i>triamcinolone acetonide ointment 0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>triamcinolone in absorbase ointment 0.05 % external</i>	Non Preferred	PA; Max 60-day supply per fill
APEXICON E CREAM 0.05 % EXTERNAL ( <i>diflorasone diacet emoll base</i> )	Non Preferred	PA; Max 60-day supply per fill
<i>fluticasone propionate (Beser Lotion 0.05 % External)</i>	Non Preferred	PA
BRYHALI LOTION 0.01 % EXTERNAL ( <i>halobetasol propionate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>clobetasol propionate</i> (Clodan Shampoo 0.05 % External)	Non Preferred	PA
CLODERM CREAM 0.1 % EXTERNAL ( <i>clocortolone pivalate</i> )	Non Preferred	PA; Max 60-day supply per fill
DERMA-SMOOTH/FS BODY OIL 0.01 % EXTERNAL ( <i>fluocinolone acetonide</i> )	Non Preferred	PA; QL (4 ML per 1 day)
DERMA-SMOOTH/FS SCALP OIL 0.01 % EXTERNAL ( <i>fluocinolone acetonide</i> )	Non Preferred	PA; QL (4 ML per 1 day)
DIPROLENE OINTMENT 0.05 % EXTERNAL ( <i>betamethasone dipropionate aug</i> )	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
HALOG CREAM 0.1 % EXTERNAL ( <i>halcinonide</i> )	Non Preferred	PA; Max 60-day supply per fill
HALOG OINTMENT 0.1 % EXTERNAL ( <i>halcinonide</i> )	Non Preferred	PA; Max 60-day supply per fill
HALOG SOLUTION 0.1 % EXTERNAL ( <i>halcinonide</i> )	Non Preferred	PA
HYDROXYM GEL 2 % EXTERNAL ( <i>hydrocortisone</i> )	Non Preferred	PA
LEXETTE FOAM 0.05 % EXTERNAL ( <i>halobetasol propionate</i> )	Non Preferred	PA
LOCOID LIPOCREAM CREAM 0.1 % EXTERNAL ( <i>hydrocortisone butyr lipo base</i> )	Non Preferred	PA; Max 60-day supply per fill
LOCOID LOTION 0.1 % EXTERNAL ( <i>hydrocortisone butyrate</i> )	Non Preferred	PA
PANDEL CREAM 0.1 % EXTERNAL ( <i>hydrocortisone probutate</i> )	Non Preferred	PA; Max 60-day supply per fill
SYNALAR CREAM 0.025 % EXTERNAL ( <i>fluocinolone acetonide</i> )	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
SYNALAR OINTMENT 0.025 % EXTERNAL ( <i>fluocinolone acetonide</i> )	Non Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
SYNALAR SOLUTION 0.01 % EXTERNAL ( <i>fluocinolone acetonide</i> )	Non Preferred	PA
TEXACORT SOLUTION 2.5 % EXTERNAL ( <i>hydrocortisone</i> )	Non Preferred	PA
TOPICORT CREAM 0.25 % EXTERNAL ( <i>desoximetasone</i> )	Non Preferred	PA; Max 60-day supply per fill
TOPICORT GEL 0.05 % EXTERNAL ( <i>desoximetasone</i> )	Non Preferred	PA
<i>clobetasol propionate emulsion</i> (Tovet Foam 0.05 % External)	Non Preferred	PA
TOVET KIT 0.05 % EXTERNAL ( <i>clobetasol emul foam w/moistcr</i> )	Non Preferred	PA
ULTRAVATE LOTION 0.05 % EXTERNAL ( <i>halobetasol propionate</i> )	Non Preferred	PA
VANOS CREAM 0.1 % EXTERNAL ( <i>fluocinonide</i> )	Non Preferred	PA; Max 60-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*EMOLLIENT/KERATOLYTIC AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>urea cream 39 % external</i>	Preferred	Max 60-day supply per fill
<i>urea cream 39.5 % external</i>	Preferred	Max 60-day supply per fill
<i>urea cream 40 % external</i>	Preferred	Max 60-day supply per fill
<i>urea lotion 40 % external</i>	Preferred	
<i>urea (Dermacinrx Urea Cream 41 % External)</i>	Preferred	Max 60-day supply per fill
<b>*EMOLLIENT/KERATOLYTIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>urea hydrating foam 35 % external</i>	Non Preferred	PA
<b>*EMOLLIENTS*** - DRUGS FOR THE SKIN</b>		
<i>ammonium lactate lotion 12 % external (rx)</i>	Preferred	QL (225 GM per 30 days)
<i>ammonium lactate cream 12 % external (rx)</i>	Non Preferred	PA; Max 60-day supply per fill
<b>*EYELID CLEANSERS &amp; LUBRICANTS*** - DRUGS FOR THE SKIN</b>		
<i>HYPOCYN SOLUTION EXTERNAL (eyelid cleansers)</i>	Non Preferred	PA
<b>*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>antifungal external cream 2 %</i>	Preferred	
<i>antifungal external powder 2 %</i>	Preferred	QL (90 GM per 30 days)
<i>athletes foot powder spray external aerosol powder 2 %</i>	Preferred	QL (133 GM per 30 days)
<i>clotrimazole cream 1 % external (rx)</i>	Preferred	QL (60 GM per 30 days); Max 60-day supply per fill
<i>econazole nitrate cream 1 % external</i>	Preferred	Max 60-day supply per fill
<i>ft antifungal external cream 2 %</i>	Preferred	
<i>gnp athletes foot external aerosol powder 2 %</i>	Preferred	QL (133 GM per 30 days)
<i>gnp miconazorb af external powder 2 %</i>	Preferred	QL (90 GM per 30 days)
<i>ketoconazole cream 2 % external</i>	Preferred	QL (2 GM per 1 day); Max 60-day supply per fill
<i>ketoconazole shampoo 2 % external</i>	Preferred	QL (4 ML per 1 day)
<i>miconazole nitrate external cream 2 %</i>	Preferred	
<i>sm antifungal miconazole external cream 2 %</i>	Preferred	
<i>MICOTRIN AP EXTERNAL POWDER 2 % (miconazole nitrate)</i>	Preferred	QL (90 GM per 30 days)
<i>MYCOZYL AP EXTERNAL POWDER 2 % (miconazole nitrate)</i>	Preferred	QL (90 GM per 30 days)
<i>clotrimazole solution 1 % external (rx)</i>	Non Preferred	PA; QL (60 ML per 30 days)
<i>ketoconazole foam 2 % external</i>	Non Preferred	PA
<i>luliconazole cream 1 % external</i>	Non Preferred	PA; Max 60-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>oxiconazole nitrate cream 1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
ERTACZO CREAM 2 % EXTERNAL ( <i>sertaconazole nitrate</i> )	Non Preferred	PA; Max 60-day supply per fill
JUBLIA SOLUTION 10 % EXTERNAL ( <i>efinaconazole</i> )	Non Preferred	PA
<i>ketoconazole</i> (Ketodan Foam 2 % External)	Non Preferred	PA
KETODAN KIT 2 % EXTERNAL ( <i>ketoconazole-cleanser</i> )	Non Preferred	PA
LUZU CREAM 1 % EXTERNAL ( <i>luliconazole</i> )	Non Preferred	PA; Max 60-day supply per fill
OXISTAT LOTION 1 % EXTERNAL ( <i>oxiconazole nitrate</i> )	Non Preferred	PA
<b>*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>imiquimod cream 5 % external</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years); Max 60-day supply per fill
<i>imiquimod cream 3.75 % external</i>	Non Preferred	PA; AGE (Min 10 Years); Max 60-day supply per fill
<i>imiquimod pump cream 3.75 % external</i>	Non Preferred	PA; AGE (Min 10 Years); Max 60-day supply per fill
ZYCLARA CREAM 3.75 % EXTERNAL ( <i>imiquimod</i> )	Non Preferred	PA; AGE (Min 10 Years); Max 60-day supply per fill
ZYCLARA PUMP CREAM 2.5 % EXTERNAL ( <i>imiquimod</i> )	Non Preferred	PA; AGE (Min 10 Years); Max 60-day supply per fill
ZYCLARA PUMP CREAM 3.75 % EXTERNAL ( <i>imiquimod</i> )	Non Preferred	PA; AGE (Min 10 Years); Max 60-day supply per fill
<b>*KERATOLYTIC AND/OR ANTIMITOTIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
UREA-SALICYLIC ACID CREAM 39.5-2 % EXTERNAL ( <i>salicylic acid-urea</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*KERATOLYTIC/ANTIMITOTIC AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>podofilox gel 0.5 % external</i>	Preferred	
<i>podofilox solution 0.5 % external</i>	Preferred	QL (7 ML per 180 days)
<i>salicylic acid gel 6 % external</i>	Preferred	
<i>salicylic acid ointment 3 % external</i>	Preferred	Max 60-day supply per fill
<i>salicylic acid wart remover liquid 27.5 % external</i>	Preferred	
CONDYLOX GEL 0.5 % EXTERNAL ( <i>podofilox</i> )	Preferred	
<i>bensal hp ointment 3 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>salicylic acid foam 6 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PODOCON-25 SOLUTION 25 % EXTERNAL ( <i>podophyllum resin</i> )	Non Preferred	PA
SALICATE LIQUID 10 % EXTERNAL ( <i>salicylic acid</i> )	Non Preferred	PA
SALYCIM CREAM 6 % EXTERNAL ( <i>salicylic acid</i> )	Non Preferred	PA; Max 60-day supply per fill
YCANTH SOLUTION 0.7 % EXTERNAL ( <i>cantharidin</i> )	Non Preferred	PA
<b>*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>arthritis pain relieving external cream 0.075 %</i>	Preferred	
<i>capsaicin external cream 0.025 %, 0.1 %</i>	Preferred	
<i>capsaicin pain relief external cream 0.1 %</i>	Preferred	
<i>ft pain relief max strength external patch 4 %</i>	Preferred	
<i>gnp lidocaine pain relief external patch 4 %</i>	Preferred	
<i>lidocaine external cream 4 %</i>	Preferred	
<i>lidocaine hcl cream 3 % external (rx)</i>	Preferred	Max 60-day supply per fill
<i>lidocaine hcl solution 4 % external</i>	Preferred	
<i>lidocaine hcl urethral/mucosal prefilled syringe 2 % external</i>	Preferred	
<i>lidocaine ointment 5 % external</i>	Preferred	Max 60-day supply per fill
<i>lidocaine pain relief external patch 4 %</i>	Preferred	
<i>lidocaine pain relief max st external patch 4 %</i>	Preferred	
<i>lidocaine pain relieving external patch 4 %</i>	Preferred	
<i>lidocaine patch 5 % external</i>	Preferred	QL (3 EA per 1 day)
DERMACINRX PENETRAL EXTERNAL CREAM 0.025 % ( <i>capsaicin</i> )	Preferred	
<i>lidocaine hcl (Glydo Prefilled Syringe 2 % External)</i>	Preferred	
<i>lidocaine (Lidocan Patch 5 % External)</i>	Preferred	QL (3 EA per 1 day)
<i>lidocaine hcl cream 4.12 % external</i>	Non Preferred	PA; Max 60-day supply per fill
DERMACINRX LIDOGEL GEL 2.8 % EXTERNAL ( <i>lidocaine hcl</i> )	Non Preferred	PA
LIDODERM PATCH 5 % EXTERNAL ( <i>lidocaine</i> )	Non Preferred	PA; QL (3 EA per 1 day)
LIDOREX GEL 2.8 % EXTERNAL ( <i>lidocaine hcl</i> )	Non Preferred	PA
LIDOTRAL CREAM 3.88 % EXTERNAL ( <i>lidocaine hcl</i> )	Non Preferred	PA; Max 60-day supply per fill
LIDOTRAN CREAM 3.88 % EXTERNAL ( <i>lidocaine hcl</i> )	Non Preferred	PA; Max 60-day supply per fill
LYDEXA CREAM 4.12 % EXTERNAL ( <i>lidocaine hcl</i> )	Non Preferred	PA; Max 60-day supply per fill
QUTENZA (2 PATCH) KIT 8 % EXTERNAL ( <i>capsaicin-cleansing gel</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
QUTENZA (4 PATCH) KIT 8 % EXTERNAL ( <i>capsaicin-cleansing gel</i> )	Non Preferred	PA
QUTENZA KIT 8 % EXTERNAL ( <i>capsaicin-cleansing gel</i> )	Non Preferred	PA
ZTLIDO PATCH 1.8 % EXTERNAL ( <i>lidocaine</i> )	Non Preferred	PA
<b>*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>pimecrolimus cream 1 % external</i>	Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
<i>tacrolimus ointment 0.03 % external</i>	Preferred	PA; Max 60-day supply per fill
<i>tacrolimus ointment 0.1 % external</i>	Preferred	PA; Max 60-day supply per fill
ELIDEL CREAM 1 % EXTERNAL ( <i>pimecrolimus</i> )	Preferred	PA; QL (2 GM per 1 day); Max 60-day supply per fill
PROTOPIC OINTMENT 0.03 % EXTERNAL ( <i>tacrolimus</i> )	Preferred	PA; Max 60-day supply per fill
HYFTOR GEL 0.2 % EXTERNAL ( <i>sirolimus</i> )	Non Preferred	PA
PROTOPIC OINTMENT 0.1 % EXTERNAL ( <i>tacrolimus</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*MISC. DERMATOLOGICAL PRODUCTS*** - DRUGS FOR THE SKIN</b>		
ALADERM PLUS EMULSION EXTERNAL ( <i>dermatological products, misc.</i> )	Non Preferred	PA
HYLATOPIC PLUS CREAM EXTERNAL ( <i>dermatological products, misc.</i> )	Non Preferred	PA; Max 60-day supply per fill
NUVAIL SOLUTION EXTERNAL ( <i>dermatological products, misc.</i> )	Non Preferred	PA
TETRIX CREAM EXTERNAL ( <i>dermatological products, misc.</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*OXABOROLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>tavaborole solution 5 % external</i>	Non Preferred	PA
<b>*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
EUCRISA OINTMENT 2 % EXTERNAL ( <i>crisaborole</i> )	Preferred	PA (Eligible for auto-PA); Max 60-day supply per fill
<b>*PHOTODYNAMIC THERAPY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
LEVULAN KERASTICK SOLUTION RECONSTITUTED 20 % EXTERNAL ( <i>aminolevulinic acid hcl</i> )	Preferred	
AMELUZ GEL 10 % EXTERNAL ( <i>aminolevulinic acid hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ROSACEA AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>metronidazole cream 0.75 % external</i>	Preferred	Max 60-day supply per fill
<i>metronidazole gel 0.75 % external</i>	Preferred	
<i>metronidazole gel 1 % external</i>	Preferred	
<i>metronidazole lotion 0.75 % external</i>	Preferred	
<i>metronidazole (Rosadan Cream 0.75 % External)</i>	Preferred	Max 60-day supply per fill
<i>metronidazole (Rosadan Gel 0.75 % External)</i>	Preferred	
<i>azelaic acid gel 15 % external</i>	Non Preferred	PA
<i>brimonidine tartrate gel 0.33 % external</i>	Non Preferred	PA
<i>doxycycline capsule delayed release 40 mg oral</i>	Non Preferred	PA
<i>ivermectin cream 1 % external</i>	Non Preferred	PA; Max 60-day supply per fill
FINACEA FOAM 15 % EXTERNAL ( <i>azelaic acid</i> )	Non Preferred	PA
FINACEA GEL 15 % EXTERNAL ( <i>azelaic acid</i> )	Non Preferred	PA
NORITATE CREAM 1 % EXTERNAL ( <i>metronidazole</i> )	Non Preferred	PA; Max 60-day supply per fill
RHOFADE CREAM 1 % EXTERNAL ( <i>oxymetazoline hcl</i> )	Non Preferred	PA; Max 60-day supply per fill
ROSADAN KIT 0.75 % CREAM EXTERNAL ( <i>metronidazole-cleanser</i> )	Non Preferred	PA
ROSADAN KIT 0.75 % GEL EXTERNAL ( <i>metronidazole-cleanser</i> )	Non Preferred	PA
<b>*SCABICIDE COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>gnp lice treatment shampoo 0.33-4 % external</i>	Preferred	
<i>lice killing maximum strength shampoo 0.33-4 % external</i>	Preferred	
<i>sm lice killing external shampoo 0.33-4 %</i>	Preferred	
<i>sm lice killing max strength shampoo 0.33-4 % external</i>	Preferred	
<b>*SCABICIDES &amp; PEDICULICIDES*** - DRUGS FOR THE SKIN</b>		
<i>gnp home lice/bedbug/dust mite aerosol 0.5 %</i>	Preferred	
<i>gnp lice treatment liquid 1 % external</i>	Preferred	
<i>goodsense lice killing liquid 1 % external</i>	Preferred	
<i>permethrin cream 5 % external</i>	Preferred	Max 60-day supply per fill
<i>sm bedding lice treatment aerosol 0.5 %</i>	Preferred	
<i>sm lice treatment liquid 1 % external</i>	Preferred	
NATROBA SUSPENSION 0.9 % EXTERNAL ( <i>spinosad</i> )	Preferred	QL (8 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>ivermectin lotion 0.5 % external (rx)</i>	Non Preferred	PA
<i>malathion lotion 0.5 % external</i>	Non Preferred	PA
<i>spinosad suspension 0.9 % external</i>	Non Preferred	PA; QL (8 ML per 1 day)
CROTAN LOTION 10 % EXTERNAL ( <i>crotamiton</i> )	Non Preferred	PA
<b>*SKIN CLEANSERS*** - DRUGS FOR THE SKIN</b>		
HYCLODEX SOLUTION 0.012 % EXTERNAL ( <i>hypochlorous acid</i> )	Non Preferred	PA
<b>*SKIN PROTECTANTS*** - DRUGS FOR THE SKIN</b>		
MINERIN CREME EXTERNAL CREAM ( <i>skin protectants, misc.</i> )	Preferred	
<b>*STEROID-LOCAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
EPIFOAM FOAM 1-1 % EXTERNAL ( <i>pramoxine-hc</i> )	Non Preferred	PA
RADIAURA CREAM 3-0.5 % EXTERNAL ( <i>lidocaine-hydrocortisone ace</i> )	Non Preferred	PA; Max 60-day supply per fill
<b>*TOPICAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>lidocaine-prilocaine cream 2.5-2.5 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>lidocaine-prilocaine kit 2.5-2.5 % external</i>	Non Preferred	PA
LIDOTRAL-MENTHOL LIQUID 5-3 % EXTERNAL ( <i>lidocaine-menthol</i> )	Non Preferred	PA
XYLIDERM KIT 5 % EXTERNAL ( <i>lidocaine-adhesive sheets</i> )	Non Preferred	PA
<b>*TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR THE SKIN</b>		
TARGRETIN GEL 1 % EXTERNAL ( <i>bexarotene</i> )	Preferred	
<i>bexarotene gel 1 % external</i>	Non Preferred	PA
<b>*TOPICAL STEROID COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>calcipotriene-betameth diprop ointment 0.005-0.064 % external</i>	Non Preferred	PA; Max 60-day supply per fill
<i>calcipotriene-betameth diprop suspension 0.005-0.064 % external</i>	Non Preferred	PA
<i>hydrocortisone complete kit therapy pack 2 % external</i>	Non Preferred	PA
BESER KIT 0.05 % EXTERNAL ( <i>fluticasone-emollient</i> )	Non Preferred	PA
CLODAN KIT 0.05 % EXTERNAL ( <i>clobetasol prop &amp; cleanser</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
DUOBRII LOTION 0.01-0.045 % EXTERNAL ( <i>halobetasol prop-tazarotene</i> )	Non Preferred	PA
ENSTILAR FOAM 0.005-0.064 % EXTERNAL ( <i>calcipotriene-betameth diprop</i> )	Non Preferred	PA
SYNALAR (CREAM) KIT 0.025 % EXTERNAL ( <i>fluocinolone-emollient</i> )	Non Preferred	PA
SYNALAR (OINTMENT) KIT 0.025 % EXTERNAL ( <i>fluocinolone-emollient</i> )	Non Preferred	PA
SYNALAR TS KIT 0.01 % EXTERNAL ( <i>fluocinolone &amp; cleanser</i> )	Non Preferred	PA
TACLONEX OINTMENT 0.005-0.064 % EXTERNAL ( <i>calcipotriene-betameth diprop</i> )	Non Preferred	PA; Max 60-day supply per fill
TACLONEX SUSPENSION 0.005-0.064 % EXTERNAL ( <i>calcipotriene-betameth diprop</i> )	Non Preferred	PA
<b>*WOUND CARE COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>bpc ointment external</i>	Non Preferred	PA; Max 60-day supply per fill
<b>*WOUND TREATMENT - GENE THERAPY*** - DRUGS FOR THE SKIN</b>		
VYJUVEK GEL 5000000000 PFU/2.5ML EXTERNAL ( <i>beremagene geperpavec-svdt</i> )	Non Preferred	PA
<b>*DIAGNOSTIC PRODUCTS*</b>		
<b>*DIAGNOSTIC TESTS***</b>		
<i>ketone test in vitro strip</i>	Preferred	
CHEMSTRIP K IN VITRO STRIP ( <i>acetone (urine) test</i> )	Preferred	
KETOSTIX IN VITRO STRIP ( <i>acetone (urine) test</i> )	Preferred	
RELION KETONE TEST IN VITRO STRIP ( <i>acetone (urine) test</i> )	Preferred	
<b>GLUCOSE MONITORING SUPPLIES : TEST STRIPS</b>		
ONETOUCH ULTRA STRIP IN VITRO ( <i>glucose blood</i> )	Preferred	QL (4 EA per 1 day); Max 100-day supply per fill
ONETOUCH ULTRA TEST STRIP IN VITRO ( <i>glucose blood</i> )	Preferred	QL (4 EA per 1 day); Max 100-day supply per fill
ONETOUCH VERIO STRIP IN VITRO ( <i>glucose blood</i> )	Preferred	QL (4 EA per 1 day); Max 100-day supply per fill
<i>blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>blood glucose test strips 333 strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>cvs glucose meter test strips strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>diatrue plus test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>easy plus ii glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>easy talk blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>easy talk plus ii test strips strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>easy trak blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>easy trak ii glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>element compact test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>eq blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>ge100 blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>ght test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>glucose meter test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>gnp easy touch glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>goodsense blood glucose strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>groger blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>groger premium glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>groger test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>liberty test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>meijer blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>meijer essential glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>meijer premium glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>one drop test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>pharmacist choice no coding strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>premium blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>pro voice v8/v9 glucose strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>tgt blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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<i>true focus blood glucose strip strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<i>verasens blood glucose test strip in vitro</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ACCU-CHEK AVIVA PLUS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ACCU-CHEK COMPACT PLUS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ACCU-CHEK GUIDE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ACCU-CHEK SMARTVIEW STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ACCU-TREND GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ADVANCE INTUITION TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ADVANCE MICRO-DRAW TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ADVOCATE REDI-CODE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ADVOCATE REDI-CODE+ TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ADVOCATE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
AGAMATRIX AMP TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
AGAMATRIX JAZZ TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
AGAMATRIX KEYNOTE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
AGAMATRIX PRESTO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE 3 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE 4 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE II CHECK STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE II STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE PLATINUM STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE PRISM MULTI TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ASSURE PRO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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BIOSCANNER GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
BIOTEL CARE TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
BLULINK GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CAREONE BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CARESENS N GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CARETOUCH TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHEK AUTO-CODE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHEK AUTO-CODE VOICE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHEK TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHOICE AUTO-CODE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHOICE MICRO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHOICE NO CODING STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CLEVER CHOICE TALK SYSTEM STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CONTOUR NEXT TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CONTOUR TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
COOL BLOOD GLUCOSE TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
CVS ADVANCED GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
D-CARE BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
DIATHRIVE BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
DIATHRIVE GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
DIATHRIVE+ GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
DUO-CARE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASY STEP TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASY TOUCH TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYGLUCO PLUS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYGLUCO STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYMAX 15 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYMAX TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYPRO BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EASYPRO PLUS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ELEMENT TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EMBRACE BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EMBRACE EVO BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EMBRACE PRO GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EMBRACE TALK GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EMBRACE WAVE BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE + BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE G2 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE G3 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE MINI GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVENCARE PROVIEW GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EVOLUTION AUTOCODE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EXACTECH R-S-G TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
EXACTECH TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
FIFTY50 GLUCOSE TEST 2.0 STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA 6 CONNECT STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA 6 CONNECT/GTEL TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA D15G BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA D20 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA D40/G31 BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA G20 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA G30/PREM V10 GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA GD20 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA GD50 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA GTEL BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA TN'G ADVANCE PRO STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA TN'G/TN'G VOICE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA V10 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA V12 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA V20 BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORA V30A BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORACARE GD40 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORACARE PREMIUM V10 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORACARE TEST N GO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORTISCARE G1 TEST STRIP STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FORTISCARE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
FREESTYLE INSULINX TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FREESTYLE LITE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FREESTYLE PRECISION NEO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
FREESTYLE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GENULTIMATE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCO PERFECT 3 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCARD 01 SENSOR PLUS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCARD EXPRESSION TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCARD SHINE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCARD VITAL TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCARD X-SENSOR STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCOCOM TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GLUCONAVII BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GNP TRUE METRIX GLUCOSE STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GNP TRUETRACK SMART SYSTEM STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GNP TRUETRACK TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GOJJI BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
GOJJI BLOOD TEST STRIP/LANCETS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
HARMONY BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
HW EMBRACE PRO GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
HW EMBRACE TALK GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
IGLUCOSE TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
IN TOUCH BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
INFINITY BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
INFINITY VOICE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
KROGER HEALTHPRO GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
LIBERTY NEXT GENERATION TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
MEIJER TRUETEST TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
MEIJER TRUETRACK TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
MICRODOT TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
MM EASY TOUCH GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
MYGLUCOHEALTH TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
NEUTEK 2TEK TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
NOVA MAX GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ON CALL EXPRESS BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ON CALL PLUS BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ON CALL VIVID BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ONETOUCH VERIO STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
OPTIUM TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
OPTIUMEZ TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
OPTUMRX BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PHARMACIST CHOICE AUTOCODE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PIP BLOOD GLUCOSE TEST STRIP STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
POCKETCHEM EZ TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRECISION PCX PLUS TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRECISION PCX STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PRECISION POINT OF CARE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRECISION QID TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRECISION SOF-TACT TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRECISION XTRA BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PRODIGY NO CODING BLOOD GLUC STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PTS PANELS EGLU TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
PTS PANELS GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
QUICKTEK TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
QUINTET AC BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
QUINTET BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
REFUAH PLUS BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION CONFIRM/MICRO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION PREMIER TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION PRIME TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION TRUE METRIX TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RELION ULTIMA TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
REVEAL BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
REXALL BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RIGHTEST GS100 BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RIGHTEST GS300 BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RIGHTEST GS550 BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
RIGHTEST GT333 BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
RIGHTEST GT333 GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SMART SENSE PREMIUM TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SMART SENSE VALUE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SMARTEST BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SOLUS V2 TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SUPREME TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SURE EDGE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SURECHEK BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
SURE-TEST EASYPLUS MINI TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
TRUE METRIX PRO BLOOD GLUCOSE STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
TRUETEST TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
TRUETRACK TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ULTRATRAK PRO TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
ULTRATRAK ULTIMATE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
UNISTRIP1 GENERIC STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
VIVAGUARD INO TEST STRIPS STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
VOCAL POINT BLOOD GLUCOSE TEST STRIP IN VITRO ( <i>glucose blood</i> )	Non Preferred	PA; QL (4 EA per 1 day); Max 100-day supply per fill
<b>*DIGESTIVE AIDS* - DRUGS FOR THE STOMACH</b>		
<b>*DIGESTIVE ENZYMES*** - DRUGS FOR THE STOMACH</b>		
CREON CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
CREON CAPSULE DELAYED RELEASE PARTICLES 24000-76000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
CREON CAPSULE DELAYED RELEASE PARTICLES 3000-9500 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
CREON CAPSULE DELAYED RELEASE PARTICLES 6000-19000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 24000-76000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 15000-47000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 20000-63000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 25000-79000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 3000-10000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 40000-126000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 5000-24000 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	QL (6 EA per 1 day)
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 60000-189600 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Preferred	
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 24000-86250 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 4000-14375 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 8000-28750 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
VIOKACE TABLET 10440-39150 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
VIOKACE TABLET 20880-78300 UNIT ORAL ( <i>pancrelipase (lip-prot-amyl)</i> )	Non Preferred	PA
<b>*DIURETICS* - DRUGS FOR THE HEART</b>		
<b>*CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>acetazolamide er capsule extended release 12 hour 500 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>acetazolamide tablet 125 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>acetazolamide tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>methazolamide tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>methazolamide tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dichlorphenamide tablet 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
KEVEYIS TABLET 50 MG ORAL ( <i>dichlorphenamide</i> )	Non Preferred	PA
<b>*DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amiloride-hydrochlorothiazide tablet 5-50 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>spironolactone-hctz tablet 25-25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>triamterene-hctz capsule 37.5-25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>triamterene-hctz tablet 37.5-25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>triamterene-hctz tablet 75-50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
ALDACTAZIDE TABLET 50-50 MG ORAL ( <i>spironolactone-hctz</i> )	Non Preferred	PA; QL (2 EA per 1 day)
MAXZIDE TABLET 75-50 MG ORAL ( <i>triamterene-hctz</i> )	Non Preferred	PA; QL (4 EA per 1 day)
MAXZIDE-25 TABLET 37.5-25 MG ORAL ( <i>triamterene-hctz</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*LOOP DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>bumetanide tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bumetanide tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>bumetanide tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>ethacrynic acid tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>furosemide solution 10 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>furosemide solution 8 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>furosemide tablet 20 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>furosemide tablet 40 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>furosemide tablet 80 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>torseamide tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>torseamide tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>torseamide tablet 20 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>torseamide tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
BUMEX TABLET 0.5 MG ORAL ( <i>bumetanide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BUMEX TABLET 1 MG ORAL ( <i>bumetanide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
BUMEX TABLET 2 MG ORAL ( <i>bumetanide</i> )	Non Preferred	PA; QL (5 EA per 1 day)
EDECIN TABLET 25 MG ORAL ( <i>ethacrynic acid</i> )	Non Preferred	PA
LASIX TABLET 20 MG ORAL ( <i>furosemide</i> )	Non Preferred	PA; QL (6 EA per 1 day)
LASIX TABLET 40 MG ORAL ( <i>furosemide</i> )	Non Preferred	PA; QL (6 EA per 1 day)
LASIX TABLET 80 MG ORAL ( <i>furosemide</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*POTASSIUM SPARING DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amiloride hcl tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>spironolactone tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>spironolactone tablet 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>spironolactone tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>triamterene capsule 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>triamterene capsule 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>spironolactone suspension 25 mg/5ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
ALDACTONE TABLET 100 MG ORAL ( <i>spironolactone</i> )	Non Preferred	PA; QL (2 EA per 1 day)
ALDACTONE TABLET 25 MG ORAL ( <i>spironolactone</i> )	Non Preferred	PA; QL (8 EA per 1 day)
ALDACTONE TABLET 50 MG ORAL ( <i>spironolactone</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CAROSPIR SUSPENSION 25 MG/5ML ORAL ( <i>spironolactone</i> )	Non Preferred	PA
<b>*THIAZIDES AND THIAZIDE-LIKE DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>chlorthalidone tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>chlorthalidone tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>hydrochlorothiazide capsule 12.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>hydrochlorothiazide tablet 12.5 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>hydrochlorothiazide tablet 25 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<i>hydrochlorothiazide tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>indapamide tablet 1.25 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>indapamide tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>metolazone tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>metolazone tablet 2.5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>metolazone tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
DIURIL SUSPENSION 250 MG/5ML ORAL ( <i>chlorothiazide</i> )	Preferred	
THALITONE TABLET 15 MG ORAL ( <i>chlorthalidone</i> )	Non Preferred	PA
<b>*ENDOCRINE AND METABOLIC AGENTS - MISC.* - HORMONES</b>		
<b>*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR WOMEN</b>		
<i>mifepristone tablet 200 mg oral</i>	Preferred	PA
MIFEPREX TABLET 200 MG ORAL ( <i>mifepristone</i> )	Preferred	PA
<b>*BISPHOSPHONATES*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>alendronate sodium solution 70 mg/75ml oral</i>	Preferred	Max 90-day supply per fill
<i>alendronate sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>alendronate sodium tablet 35 mg oral</i>	Preferred	QL (0.1429 EA per 1 day); Max 90-day supply per fill
<i>alendronate sodium tablet 70 mg oral</i>	Preferred	QL (0.1429 EA per 1 day); Max 90-day supply per fill
<i>ibandronate sodium tablet 150 mg oral</i>	Non Preferred	PA; QL (0.0358 EA per 1 day); Max 90-day supply per fill
<i>risedronate sodium tablet 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>risedronate sodium tablet 30 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>risedronate sodium tablet 35 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>risedronate sodium tablet 5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>risedronate sodium tablet delayed release 35 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ACTONEL TABLET 150 MG ORAL ( <i>risedronate sodium</i> )	Non Preferred	PA
ACTONEL TABLET 35 MG ORAL ( <i>risedronate sodium</i> )	Non Preferred	PA
AELVIA TABLET DELAYED RELEASE 35 MG ORAL ( <i>risedronate sodium</i> )	Non Preferred	PA
BINOSTO TABLET EFFERVESCENT 70 MG ORAL ( <i>alendronate sodium</i> )	Non Preferred	PA
FOSAMAX PLUS D TABLET 70-2800 MG-UNIT ORAL ( <i>alendronate-cholecalciferol</i> )	Non Preferred	PA
FOSAMAX PLUS D TABLET 70-5600 MG-UNIT ORAL ( <i>alendronate-cholecalciferol</i> )	Non Preferred	PA
FOSAMAX TABLET 70 MG ORAL ( <i>alendronate sodium</i> )	Non Preferred	PA; QL (0.1429 EA per 1 day)
<b>*CALCIMIMETIC AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>cinacalcet hcl tablet 30 mg oral</i>	Non Preferred	PA
<i>cinacalcet hcl tablet 60 mg oral</i>	Non Preferred	PA
<i>cinacalcet hcl tablet 90 mg oral</i>	Non Preferred	PA
SENSIPAR TABLET 30 MG ORAL ( <i>cinacalcet hcl</i> )	Non Preferred	PA
SENSIPAR TABLET 60 MG ORAL ( <i>cinacalcet hcl</i> )	Non Preferred	PA
SENSIPAR TABLET 90 MG ORAL ( <i>cinacalcet hcl</i> )	Non Preferred	PA
<b>*CALCITONINS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>calcitonin (salmon) solution 200 unit/act nasal</i>	Preferred	QL (1 ML per 1 day)
<b>*CARNITINE REPLENISHER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>levocarnitine sf solution 1 gm/10ml oral</i>	Non Preferred	PA; QL (60 ML per 1 day)
<i>levocarnitine solution 1 gm/10ml oral</i>	Non Preferred	PA; QL (60 ML per 1 day)
<i>levocarnitine tablet 330 mg oral</i>	Non Preferred	PA; QL (18 EA per 1 day)
CARNITOR SF SOLUTION 1 GM/10ML ORAL ( <i>levocarnitine</i> )	Non Preferred	PA; QL (60 ML per 1 day)
CARNITOR SOLUTION 1 GM/10ML ORAL ( <i>levocarnitine</i> )	Non Preferred	PA; QL (60 ML per 1 day)
CARNITOR TABLET 330 MG ORAL ( <i>levocarnitine</i> )	Non Preferred	PA; QL (18 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*CORTISOL SYNTHESIS INHIBITORS*** - HORMONES</b>		
ISTURISA TABLET 1 MG ORAL ( <i>osilodrostat phosphate</i> )	Non Preferred	PA
ISTURISA TABLET 10 MG ORAL ( <i>osilodrostat phosphate</i> )	Non Preferred	PA
ISTURISA TABLET 5 MG ORAL ( <i>osilodrostat phosphate</i> )	Non Preferred	PA
RECORLEV TABLET 150 MG ORAL ( <i>levoketoconazole</i> )	Non Preferred	PA
<b>*DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR WOMEN</b>		
<i>cabergoline tablet 0.5 mg oral</i>	Preferred	
<b>*FABRY DISEASE - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
GALAFOLD CAPSULE 123 MG ORAL ( <i>migalastat hcl</i> )	Non Preferred	PA
<b>*GNRH/LHRH ANTAGONISTS*** - DRUGS FOR WOMEN</b>		
ORLISSA TABLET 150 MG ORAL ( <i>elagolix sodium</i> )	Preferred	PA
ORLISSA TABLET 200 MG ORAL ( <i>elagolix sodium</i> )	Preferred	PA
<b>*GROWTH HORMONE RELEASING HORMONES (GHRH)*** - DRUGS FOR GROWTH</b>		
EGRIFTA SV SOLUTION RECONSTITUTED 2 MG SUBCUTANEOUS ( <i>tesamorelin acetate</i> )	Non Preferred	PA
<b>*GROWTH HORMONES*** - DRUGS FOR GROWTH</b>		
GENOTROPIN CARTRIDGE 12 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN CARTRIDGE 5 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.2 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.4 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.6 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.8 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.2 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.4 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.6 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.8 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
GENOTROPIN MINIQUICK PREFILLED SYRINGE 2 MG SUBCUTANEOUS ( <i>somatropin</i> )	Preferred	PA
HUMATROPE CARTRIDGE 12 MG INJECTION ( <i>somatropin</i> )	Non Preferred	PA
HUMATROPE CARTRIDGE 24 MG INJECTION ( <i>somatropin</i> )	Non Preferred	PA
HUMATROPE CARTRIDGE 6 MG INJECTION ( <i>somatropin</i> )	Non Preferred	PA
NGENLA SOLUTION PEN-INJECTOR 24 MG/1.2ML SUBCUTANEOUS ( <i>somatrogon-ghla</i> )	Non Preferred	PA
NGENLA SOLUTION PEN-INJECTOR 60 MG/1.2ML SUBCUTANEOUS ( <i>somatrogon-ghla</i> )	Non Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 30 MG/3ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NUTROPIN AQ NUSPIN 10 SOLUTION PEN-INJECTOR 10 MG/2ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NUTROPIN AQ NUSPIN 20 SOLUTION PEN-INJECTOR 20 MG/2ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
NUTROPIN AQ NUSPIN 5 SOLUTION PEN-INJECTOR 5 MG/2ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 10 MG/1.5ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 5 MG/1.5ML SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
OMNITROPE SOLUTION RECONSTITUTED 5.8 MG SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 5 MG INJECTION ( <i>somatropin (non-refrigerated)</i> )	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 8.8 MG INJECTION ( <i>somatropin (non-refrigerated)</i> )	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 4 MG SUBCUTANEOUS ( <i>somatropin (non-refrigerated)</i> )	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS ( <i>somatropin (non-refrigerated)</i> )	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 6 MG SUBCUTANEOUS ( <i>somatropin (non-refrigerated)</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 11 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 13.3 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SKYTROFA CARTRIDGE 3 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 3.6 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 4.3 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 5.2 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 6.3 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 7.6 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SKYTROFA CARTRIDGE 9.1 MG SUBCUTANEOUS ( <i>lonapegsomatropin-tcgd</i> )	Non Preferred	PA
SOGROYA SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS ( <i>somapacitan-beco</i> )	Non Preferred	PA
SOGROYA SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS ( <i>somapacitan-beco</i> )	Non Preferred	PA
SOGROYA SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS ( <i>somapacitan-beco</i> )	Non Preferred	PA
ZOMACTON SOLUTION RECONSTITUTED 10 MG SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
ZOMACTON SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS ( <i>somatropin</i> )	Non Preferred	PA
<b>*HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>nitisinone capsule 10 mg oral</i>	Preferred	
<i>nitisinone capsule 2 mg oral</i>	Preferred	
<i>nitisinone capsule 20 mg oral</i>	Preferred	
<i>nitisinone capsule 5 mg oral</i>	Preferred	
ORFADIN CAPSULE 10 MG ORAL ( <i>nitisinone</i> )	Preferred	
ORFADIN CAPSULE 2 MG ORAL ( <i>nitisinone</i> )	Preferred	
ORFADIN CAPSULE 20 MG ORAL ( <i>nitisinone</i> )	Preferred	
ORFADIN CAPSULE 5 MG ORAL ( <i>nitisinone</i> )	Preferred	
NITYR TABLET 10 MG ORAL ( <i>nitisinone</i> )	Non Preferred	PA
NITYR TABLET 2 MG ORAL ( <i>nitisinone</i> )	Non Preferred	PA
NITYR TABLET 5 MG ORAL ( <i>nitisinone</i> )	Non Preferred	PA
ORFADIN SUSPENSION 4 MG/ML ORAL ( <i>nitisinone</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*HOMOCYSTINURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>betaine powder oral</i>	Non Preferred	PA
CYSTADANE POWDER ORAL ( <i>betaine</i> )	Non Preferred	PA
<b>*HYPERAMMONEMIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>carglumic acid tablet soluble 200 mg oral</i>	Preferred	PA
<i>carglumic acid tablet soluble 200 mg oral</i>	Non Preferred	PA
CARBAGLU TABLET SOLUBLE 200 MG ORAL ( <i>carglumic acid</i> )	Non Preferred	PA
<b>*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>calcitriol capsule 0.25 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>calcitriol capsule 0.5 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>calcitriol solution 1 mcg/ml oral</i>	Preferred	
<i>doxercalciferol capsule 0.5 mcg oral</i>	Preferred	
<i>doxercalciferol capsule 1 mcg oral</i>	Preferred	
<i>doxercalciferol capsule 2.5 mcg oral</i>	Preferred	
<i>paricalcitol capsule 1 mcg oral</i>	Non Preferred	PA
<i>paricalcitol capsule 2 mcg oral</i>	Non Preferred	PA
<i>paricalcitol capsule 4 mcg oral</i>	Non Preferred	PA
RAYALDEE CAPSULE EXTENDED RELEASE 30 MCG ORAL ( <i>calcifediol</i> )	Non Preferred	PA
ROCALTROL CAPSULE 0.25 MCG ORAL ( <i>calcitriol</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ROCALTROL CAPSULE 0.5 MCG ORAL ( <i>calcitriol</i> )	Non Preferred	PA; QL (4 EA per 1 day)
ROCALTROL SOLUTION 1 MCG/ML ORAL ( <i>calcitriol</i> )	Non Preferred	PA
ZEMPLAR CAPSULE 1 MCG ORAL ( <i>paricalcitol</i> )	Non Preferred	PA
ZEMPLAR CAPSULE 2 MCG ORAL ( <i>paricalcitol</i> )	Non Preferred	PA
<b>*INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)*** - HORMONES</b>		
INCRELEX SOLUTION 40 MG/4ML SUBCUTANEOUS ( <i>mecasermin</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS*** - DRUGS FOR WOMEN</b>		
SYNAREL SOLUTION 2 MG/ML NASAL ( <i>nafarelin acetate</i> )	Non Preferred	PA
<b>*NON-STEROIDAL MINERALOCORTICOID RECEPTOR ANTAGONISTS*** - HORMONES</b>		
KERENDIA TABLET 10 MG ORAL ( <i>finerenone</i> )	Preferred	PA
KERENDIA TABLET 20 MG ORAL ( <i>finerenone</i> )	Preferred	PA
KERENDIA TABLET 10 MG ORAL ( <i>finerenone</i> )	Non Preferred	PA
KERENDIA TABLET 20 MG ORAL ( <i>finerenone</i> )	Non Preferred	PA
<b>*PHENYLKETONURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>sapropterin dihydrochloride packet 100 mg oral</i>	Non Preferred	PA
<i>sapropterin dihydrochloride packet 500 mg oral</i>	Non Preferred	PA
<i>sapropterin dihydrochloride tablet 100 mg oral</i>	Non Preferred	PA
<i>sapropterin dihydrochloride (Javygtor Packet 100 Mg Oral)</i>	Non Preferred	PA
<i>sapropterin dihydrochloride (Javygtor Packet 500 Mg Oral)</i>	Non Preferred	PA
<i>sapropterin dihydrochloride (Javygtor Tablet 100 Mg Oral)</i>	Non Preferred	PA
KUVAN PACKET 100 MG ORAL ( <i>sapropterin dihydrochloride</i> )	Non Preferred	PA
KUVAN PACKET 500 MG ORAL ( <i>sapropterin dihydrochloride</i> )	Non Preferred	PA
KUVAN TABLET 100 MG ORAL ( <i>sapropterin dihydrochloride</i> )	Non Preferred	PA
<b>*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>raloxifene hcl tablet 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
EVISTA TABLET 60 MG ORAL ( <i>raloxifene hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
OSPHENA TABLET 60 MG ORAL ( <i>ospemifene</i> )	Non Preferred	PA
<b>*SELECTIVE VASOPRESSIN V2-RECEPTOR ANTAGONISTS*** - HORMONES</b>		
<i>tolvaptan tablet 15 mg oral</i>	Non Preferred	PA
<i>tolvaptan tablet 30 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
JYNARQUE TABLET 15 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET 30 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET THERAPY PACK 15 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET THERAPY PACK 30 & 15 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET THERAPY PACK 45 & 15 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET THERAPY PACK 60 & 30 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
JYNARQUE TABLET THERAPY PACK 90 & 30 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
SAMSCA TABLET 15 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
SAMSCA TABLET 30 MG ORAL ( <i>tolvaptan</i> )	Non Preferred	PA
<b>*SOMATOSTATIC AGENTS*** - DRUGS FOR GROWTH</b>		
<i>lanreotide acetate solution 120 mg/0.5ml subcutaneous</i>	Non Preferred	PA
<i>octreotide acetate solution 100 mcg/ml injection</i>	Non Preferred	PA
<i>octreotide acetate solution 1000 mcg/ml injection</i>	Non Preferred	PA
<i>octreotide acetate solution 200 mcg/ml injection</i>	Non Preferred	PA
<i>octreotide acetate solution 50 mcg/ml injection</i>	Non Preferred	PA
<i>octreotide acetate solution 500 mcg/ml injection</i>	Non Preferred	PA
<i>octreotide acetate solution prefilled syringe 100 mcg/ml subcutaneous</i>	Non Preferred	PA
<i>octreotide acetate solution prefilled syringe 50 mcg/ml subcutaneous</i>	Non Preferred	PA
<i>octreotide acetate solution prefilled syringe 500 mcg/ml subcutaneous</i>	Non Preferred	PA
BYNFEZIA PEN SOLUTION PEN-INJECTOR 2500 MCG/ML SUBCUTANEOUS ( <i>octreotide acetate</i> )	Non Preferred	PA
MYCAPSSA CAPSULE DELAYED RELEASE 20 MG ORAL ( <i>octreotide acetate</i> )	Non Preferred	PA
SANDOSTATIN LAR DEPOT KIT 10 MG INTRAMUSCULAR ( <i>octreotide acetate</i> )	Non Preferred	PA
SANDOSTATIN LAR DEPOT KIT 20 MG INTRAMUSCULAR ( <i>octreotide acetate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SANDOSTATIN LAR DEPOT KIT 30 MG INTRAMUSCULAR ( <i>octreotide acetate</i> )	Non Preferred	PA
SANDOSTATIN SOLUTION 100 MCG/ML INJECTION ( <i>octreotide acetate</i> )	Non Preferred	PA
SANDOSTATIN SOLUTION 50 MCG/ML INJECTION ( <i>octreotide acetate</i> )	Non Preferred	PA
SANDOSTATIN SOLUTION 500 MCG/ML INJECTION ( <i>octreotide acetate</i> )	Non Preferred	PA
SIGNIFOR LAR SUSPENSION RECONSTITUTED ER 10 MG INTRAMUSCULAR ( <i>pasireotide pamoate</i> )	Non Preferred	PA
SIGNIFOR LAR SUSPENSION RECONSTITUTED ER 20 MG INTRAMUSCULAR ( <i>pasireotide pamoate</i> )	Non Preferred	PA
SIGNIFOR LAR SUSPENSION RECONSTITUTED ER 30 MG INTRAMUSCULAR ( <i>pasireotide pamoate</i> )	Non Preferred	PA
SIGNIFOR LAR SUSPENSION RECONSTITUTED ER 40 MG INTRAMUSCULAR ( <i>pasireotide pamoate</i> )	Non Preferred	PA
SIGNIFOR LAR SUSPENSION RECONSTITUTED ER 60 MG INTRAMUSCULAR ( <i>pasireotide pamoate</i> )	Non Preferred	PA
SIGNIFOR SOLUTION 0.3 MG/ML SUBCUTANEOUS ( <i>pasireotide diaspertate</i> )	Non Preferred	PA
SIGNIFOR SOLUTION 0.6 MG/ML SUBCUTANEOUS ( <i>pasireotide diaspertate</i> )	Non Preferred	PA
SIGNIFOR SOLUTION 0.9 MG/ML SUBCUTANEOUS ( <i>pasireotide diaspertate</i> )	Non Preferred	PA
SOMATULINE DEPOT SOLUTION 120 MG/0.5ML SUBCUTANEOUS ( <i>lanreotide acetate</i> )	Non Preferred	PA
SOMATULINE DEPOT SOLUTION 60 MG/0.2ML SUBCUTANEOUS ( <i>lanreotide acetate</i> )	Non Preferred	PA
SOMATULINE DEPOT SOLUTION 90 MG/0.3ML SUBCUTANEOUS ( <i>lanreotide acetate</i> )	Non Preferred	PA
<b>*UREA CYCLE DISORDER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>sodium phenylbutyrate powder 3 gm/tsp oral</i>	Non Preferred	PA
<i>sodium phenylbutyrate tablet 500 mg oral</i>	Non Preferred	PA
BUPHENYL POWDER 3 GM/TSP ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
BUPHENYL TABLET 500 MG ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
OLPRUVA (2 GM DOSE) THERAPY PACK 2 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
OLPRUVA (3 GM DOSE) THERAPY PACK 3 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
OLPRUVA (4 GM DOSE) THERAPY PACK 2 & 2 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
OLPRUVA (5 GM DOSE) THERAPY PACK 2 & 3 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
OLPRUVA (6 GM DOSE) THERAPY PACK 3 & 3 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
OLPRUVA (6.67 GM DOSE) THERAPY PACK 3 & 3.67 GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
PHEBURANE PELLETT 483 MG/GM ORAL ( <i>sodium phenylbutyrate</i> )	Non Preferred	PA
RAVICTI LIQUID 1.1 GM/ML ORAL ( <i>glycerol phenylbutyrate</i> )	Non Preferred	PA
<b>*VASOPRESSIN*** - HORMONES</b>		
<i>desmopressin ace spray refrig solution 0.01 % nasal</i>	Preferred	
<i>desmopressin acetate spray solution 0.01 % nasal</i>	Preferred	
<i>desmopressin acetate tablet 0.1 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>desmopressin acetate tablet 0.2 mg oral</i>	Preferred	QL (5 EA per 1 day)
DDAVP TABLET 0.1 MG ORAL ( <i>desmopressin acetate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
DDAVP TABLET 0.2 MG ORAL ( <i>desmopressin acetate</i> )	Non Preferred	PA; QL (5 EA per 1 day)
NOCDURNA TABLET SUBLINGUAL 27.7 MCG SUBLINGUAL ( <i>desmopressin acetate</i> )	Non Preferred	PA
NOCDURNA TABLET SUBLINGUAL 55.3 MCG SUBLINGUAL ( <i>desmopressin acetate</i> )	Non Preferred	PA
<b>*ESTROGENS* - HORMONES</b>		
<b>*ESTROGEN &amp; ANDROGEN*** - DRUGS FOR WOMEN</b>		
<i>est estrogens-methyltest ds tablet 1.25-2.5 mg oral</i>	Preferred	
<i>est estrogens-methyltest hs tablet 0.625-1.25 mg oral</i>	Preferred	
<b>*ESTROGEN &amp; PROGESTIN*** - DRUGS FOR WOMEN</b>		
<i>estradiol-norethindrone acet tablet 0.5-0.1 mg oral</i>	Preferred	
<i>estradiol-norethindrone acet tablet 1-0.5 mg oral</i>	Preferred	
<i>estradiol-norethindrone acet</i> (Amabelz Tablet 0.5-0.1 Mg Oral)	Preferred	
<i>estradiol-norethindrone acet</i> (Amabelz Tablet 1-0.5 Mg Oral)	Preferred	
COMBIPATCH PATCH TWICE WEEKLY 0.05-0.14 MG/DAY TRANSDERMAL ( <i>estradiol-norethindrone acet</i> )	Preferred	
COMBIPATCH PATCH TWICE WEEKLY 0.05-0.25 MG/DAY TRANSDERMAL ( <i>estradiol-norethindrone acet</i> )	Preferred	
<i>estradiol-norethindrone acet</i> (Mimvey Tablet 1-0.5 Mg Oral)	Preferred	
PREMPHASE TABLET 0.625-5 MG ORAL ( <i>conj estrog-medroxyprogest ace</i> )	Preferred	
PREMPRO TABLET 0.3-1.5 MG ORAL ( <i>conj estrog-medroxyprogest ace</i> )	Preferred	
PREMPRO TABLET 0.45-1.5 MG ORAL ( <i>conj estrog-medroxyprogest ace</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
PREMPRO TABLET 0.625-2.5 MG ORAL ( <i>conj estrogen-medroxyprogesterone</i> )	Preferred	
PREMPRO TABLET 0.625-5 MG ORAL ( <i>conj estrogen-medroxyprogesterone</i> )	Preferred	
<i>norethindrone-eth estradiol tablet 0.5-2.5 mg-mcg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>norethindrone-eth estradiol tablet 1-5 mg-mcg oral</i>	Non Preferred	PA
ACTIVELLA TABLET 1-0.5 MG ORAL ( <i>estradiol-norethindrone acetate</i> )	Non Preferred	PA
ANGELIQ TABLET 0.25-0.5 MG ORAL ( <i>drospirenone-estradiol</i> )	Non Preferred	PA
ANGELIQ TABLET 0.5-1 MG ORAL ( <i>drospirenone-estradiol</i> )	Non Preferred	PA
BIJUVA CAPSULE 0.5-100 MG ORAL ( <i>estradiol-progesterone</i> )	Non Preferred	PA
BIJUVA CAPSULE 1-100 MG ORAL ( <i>estradiol-progesterone</i> )	Non Preferred	PA
CLIMARA PRO PATCH WEEKLY 0.045-0.015 MG/DAY TRANSDERMAL ( <i>estradiol-levonorgestrel</i> )	Non Preferred	PA
<i>norethindrone-eth estradiol (Fyavolv Tablet 0.5-2.5 Mg-Mcg Oral)</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>norethindrone-eth estradiol (Fyavolv Tablet 1-5 Mg-Mcg Oral)</i>	Non Preferred	PA
<i>norethindrone-eth estradiol (Jinteli Tablet 1-5 Mg-Mcg Oral)</i>	Non Preferred	PA
PREFEST TABLET 1/1-0.09 MG (15/15) ORAL ( <i>estradiol-norgestimate</i> )	Non Preferred	PA
<b>*ESTROGEN-PROGESTIN-GNRH ANTAGONIST*** - DRUGS FOR WOMAN</b>		
MYFEMBREE TABLET 40-1-0.5 MG ORAL ( <i>relugolix-estradiol-norethindrone</i> )	Preferred	PA
ORIAHNN CAPSULE THERAPY PACK 300-1-0.5 & 300 MG ORAL ( <i>elagolix-estradiol-norethindrone</i> )	Preferred	PA
<b>*ESTROGENS*** - DRUGS FOR WOMEN</b>		
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.025 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.0375 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.05 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.06 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.075 mg/24hr transdermal</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>estradiol patch weekly 0.1 mg/24hr transdermal</i>	Preferred	
<i>estradiol tablet 0.5 mg oral</i>	Preferred	
<i>estradiol tablet 1 mg oral</i>	Preferred	
<i>estradiol tablet 2 mg oral</i>	Preferred	
<i>estradiol (Dotti Patch Twice Weekly 0.025 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Dotti Patch Twice Weekly 0.0375 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Dotti Patch Twice Weekly 0.05 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Dotti Patch Twice Weekly 0.075 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Dotti Patch Twice Weekly 0.1 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Lyllana Patch Twice Weekly 0.025 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Lyllana Patch Twice Weekly 0.0375 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Lyllana Patch Twice Weekly 0.05 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Lyllana Patch Twice Weekly 0.075 Mg/24Hr Transdermal)</i>	Preferred	
<i>estradiol (Lyllana Patch Twice Weekly 0.1 Mg/24Hr Transdermal)</i>	Preferred	
MENEST TABLET 0.3 MG ORAL ( <i>esterified estrogens</i> )	Preferred	
MENEST TABLET 0.625 MG ORAL ( <i>esterified estrogens</i> )	Preferred	
MENEST TABLET 1.25 MG ORAL ( <i>esterified estrogens</i> )	Preferred	
MENEST TABLET 2.5 MG ORAL ( <i>esterified estrogens</i> )	Preferred	
PREMARIN TABLET 0.3 MG ORAL ( <i>estrogens conjugated</i> )	Preferred	
PREMARIN TABLET 0.45 MG ORAL ( <i>estrogens conjugated</i> )	Preferred	
PREMARIN TABLET 0.625 MG ORAL ( <i>estrogens conjugated</i> )	Preferred	
PREMARIN TABLET 0.9 MG ORAL ( <i>estrogens conjugated</i> )	Preferred	
PREMARIN TABLET 1.25 MG ORAL ( <i>estrogens conjugated</i> )	Preferred	
<i>estradiol gel 0.25 mg/0.25gm transdermal</i>	Non Preferred	PA
<i>estradiol gel 0.5 mg/0.5gm transdermal</i>	Non Preferred	PA
<i>estradiol gel 0.75 mg/0.75gm transdermal</i>	Non Preferred	PA
<i>estradiol gel 1 mg/gm transdermal</i>	Non Preferred	PA
<i>estradiol gel 1.25 mg/1.25gm transdermal</i>	Non Preferred	PA
<i>estradiol valerate oil 10 mg/ml intramuscular</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>estradiol valerate oil 20 mg/ml intramuscular</i>	Non Preferred	PA
<i>estradiol valerate oil 40 mg/ml intramuscular</i>	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.025 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.0375 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.05 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.06 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.075 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
CLIMARA PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
DELESTROGEN OIL 10 MG/ML INTRAMUSCULAR ( <i>estradiol valerate</i> )	Non Preferred	PA
DELESTROGEN OIL 20 MG/ML INTRAMUSCULAR ( <i>estradiol valerate</i> )	Non Preferred	PA
DELESTROGEN OIL 40 MG/ML INTRAMUSCULAR ( <i>estradiol valerate</i> )	Non Preferred	PA
DEPO-ESTRADIOL OIL 5 MG/ML INTRAMUSCULAR ( <i>estradiol cypionate</i> )	Non Preferred	PA
DIVIGEL GEL 0.25 MG/0.25GM TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
DIVIGEL GEL 0.5 MG/0.5GM TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
DIVIGEL GEL 0.75 MG/0.75GM TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
DIVIGEL GEL 1 MG/GM TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
DIVIGEL GEL 1.25 MG/1.25GM TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
ELESTRIN GEL 0.52 MG/0.87 GM (0.06%) TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
ESTRACE TABLET 0.5 MG ORAL ( <i>estradiol</i> )	Non Preferred	PA
ESTRACE TABLET 1 MG ORAL ( <i>estradiol</i> )	Non Preferred	PA
ESTRACE TABLET 2 MG ORAL ( <i>estradiol</i> )	Non Preferred	PA
EVAMIST SOLUTION 1.53 MG/SPRAY TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
MENOSTAR PATCH WEEKLY 14 MCG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MINIVELLE PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
MINIVELLE PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
MINIVELLE PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
MINIVELLE PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
MINIVELLE PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
VIVELLE-DOT PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
VIVELLE-DOT PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
VIVELLE-DOT PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
VIVELLE-DOT PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
VIVELLE-DOT PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL ( <i>estradiol</i> )	Non Preferred	PA
<b>*ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MODULATOR COMB*** - DRUGS FOR WOMEN</b>		
DUAVEE TABLET 0.45-20 MG ORAL ( <i>conj estrogens-bazedoxifene</i> )	Non Preferred	PA
<b>*FLUOROQUINOLONES* - DRUGS FOR INFECTIONS</b>		
<b>*FLUOROQUINOLONES*** - ANTIBIOTICS</b>		
<i>ciprofloxacin hcl tablet 100 mg oral</i>	Preferred	AGE (Min 16 Years)
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years)
<i>ciprofloxacin hcl tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years)
<i>ciprofloxacin hcl tablet 750 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years)
<i>ciprofloxacin suspension reconstituted 250 mg/5ml (5%) oral</i>	Preferred	AGE (Min 16 Years)
<i>ciprofloxacin suspension reconstituted 500 mg/5ml (10%) oral</i>	Preferred	AGE (Min 16 Years)
<i>levofloxacin solution 25 mg/ml oral</i>	Preferred	AGE (Min 16 Years)
<i>levofloxacin tablet 250 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 16 Years)
<i>levofloxacin tablet 500 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 16 Years)
<i>levofloxacin tablet 750 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 16 Years)
<i>moxifloxacin hcl tablet 400 mg oral</i>	Preferred	AGE (Min 16 Years)
<i>ofloxacin tablet 300 mg oral</i>	Non Preferred	PA; AGE (Min 16 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>ofloxacin tablet 400 mg oral</i>	Non Preferred	PA; AGE (Min 16 Years)
BAXDELA TABLET 450 MG ORAL ( <i>delafloxacin meglumine</i> )	Non Preferred	PA; AGE (Min 16 Years)
CIPRO SUSPENSION RECONSTITUTED 250 MG/5ML (5%) ORAL ( <i>ciprofloxacin</i> )	Non Preferred	PA; AGE (Min 16 Years)
CIPRO SUSPENSION RECONSTITUTED 500 MG/5ML (10%) ORAL ( <i>ciprofloxacin</i> )	Non Preferred	PA; AGE (Min 16 Years)
CIPRO TABLET 250 MG ORAL ( <i>ciprofloxacin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
CIPRO TABLET 500 MG ORAL ( <i>ciprofloxacin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
<b>*GASTROINTESTINAL AGENTS - MISC.* - DRUGS FOR THE STOMACH</b>		
<b>*5-HT4 RECEPTOR AGONISTS*** - DRUGS FOR THE STOMACH</b>		
MOTEGRITY TABLET 1 MG ORAL ( <i>prucalopride succinate</i> )	Non Preferred	PA
MOTEGRITY TABLET 2 MG ORAL ( <i>prucalopride succinate</i> )	Non Preferred	PA
<b>*ANTIFLATULENTS*** - DRUGS FOR THE STOMACH</b>		
<i>ft gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>ft gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>ft gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>ft gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>ft gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>gnp anti-gas oral capsule 180 mg</i>	Preferred	
<i>gnp gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gnp gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gnp gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gnp infant gas relief oral suspension 20 mg/0.3ml</i>	Preferred	
<i>infants simethicone oral suspension 20 mg/0.3ml</i>	Preferred	
<i>simethicone drops infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>simethicone oral suspension 40 mg/0.6ml</i>	Preferred	
<i>simethicone oral tablet chewable 80 mg</i>	Preferred	
<i>simethicone ultra strength oral capsule 180 mg</i>	Preferred	
<i>sm gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>sm gas relief infants drops oral suspension 40 mg/0.6ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>sm gas relief oral capsule 180 mg</i>	Preferred	
<i>sm gas relief oral tablet chewable 125 mg, 80 mg</i>	Preferred	
<b>*BILE ACID SYNTHESIS DISORDER AGENTS*** - DRUGS FOR THE STOMACH</b>		
CHOLBAM CAPSULE 250 MG ORAL ( <i>cholic acid</i> )	Non Preferred	PA
CHOLBAM CAPSULE 50 MG ORAL ( <i>cholic acid</i> )	Non Preferred	PA
<b>*CIC AGENTS - GUANYLATE CYCLASE-C (GC-C) AGONISTS*** - DRUGS FOR CONSTIPATION</b>		
TRULANCE TABLET 3 MG ORAL ( <i>plecanatide</i> )	Non Preferred	PA
<b>*FARNESOID X RECEPTOR (FXR) AGONISTS*** - DRUGS FOR THE STOMACH</b>		
OCALIVA TABLET 10 MG ORAL ( <i>obeticholic acid</i> )	Non Preferred	PA
OCALIVA TABLET 5 MG ORAL ( <i>obeticholic acid</i> )	Non Preferred	PA
<b>*GALLSTONE SOLUBILIZING AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>ursodiol capsule 300 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ursodiol tablet 250 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>ursodiol tablet 500 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
CHENODAL TABLET 250 MG ORAL ( <i>chenodiol</i> )	Non Preferred	PA
RELTONE CAPSULE 200 MG ORAL ( <i>ursodiol</i> )	Non Preferred	PA
RELTONE CAPSULE 400 MG ORAL ( <i>ursodiol</i> )	Non Preferred	PA
URSO 250 TABLET 250 MG ORAL ( <i>ursodiol</i> )	Non Preferred	PA; QL (4 EA per 1 day)
URSO FORTE TABLET 500 MG ORAL ( <i>ursodiol</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*GASTROINTESTINAL ANTIALLERGY AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>cromolyn sodium concentrate 100 mg/5ml oral</i>	Preferred	
GASTROCROM CONCENTRATE 100 MG/5ML ORAL ( <i>cromolyn sodium</i> )	Non Preferred	PA
<b>*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
<i>lubiprostone capsule 24 mcg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>lubiprostone capsule 8 mcg oral</i>	Non Preferred	PA
AMITIZA CAPSULE 24 MCG ORAL ( <i>lubiprostone</i> )	Non Preferred	PA
AMITIZA CAPSULE 8 MCG ORAL ( <i>lubiprostone</i> )	Non Preferred	PA
<b>*GASTROINTESTINAL STIMULANTS*** - DRUGS FOR THE STOMACH</b>		
<i>metoclopramide hcl solution 10 mg/10ml oral</i>	Preferred	
<i>metoclopramide hcl solution 5 mg/5ml oral</i>	Preferred	
<i>metoclopramide hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>metoclopramide hcl tablet 5 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>metoclopramide hcl tablet dispersible 10 mg oral</i>	Non Preferred	PA
GIMOTI SOLUTION 15 MG/ACT NASAL ( <i>metoclopramide hcl</i> )	Non Preferred	PA
REGLAN TABLET 10 MG ORAL ( <i>metoclopramide hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
REGLAN TABLET 5 MG ORAL ( <i>metoclopramide hcl</i> )	Non Preferred	PA; QL (6 EA per 1 day)
<b>*GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS*** - DRUGS FOR THE STOMACH</b>		
GATTEX KIT 5 MG SUBCUTANEOUS ( <i>teduglutide (rdna)</i> )	Non Preferred	PA
<b>*IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS*** - DRUGS FOR CONSTIPATION</b>		
LINZESS CAPSULE 145 MCG ORAL ( <i>linaclotide</i> )	Non Preferred	PA
LINZESS CAPSULE 290 MCG ORAL ( <i>linaclotide</i> )	Non Preferred	PA
LINZESS CAPSULE 72 MCG ORAL ( <i>linaclotide</i> )	Non Preferred	PA
<b>*IBS AGENT - MU-OPIOID RECEPTOR AGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
VIBERZI TABLET 100 MG ORAL ( <i>eluxadoline</i> )	Non Preferred	PA
VIBERZI TABLET 75 MG ORAL ( <i>eluxadoline</i> )	Non Preferred	PA
<b>*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
<i>alosetron hcl tablet 0.5 mg oral</i>	Non Preferred	PA
<i>alosetron hcl tablet 1 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LOTRONEX TABLET 0.5 MG ORAL ( <i>alosetron hcl</i> )	Non Preferred	PA
LOTRONEX TABLET 1 MG ORAL ( <i>alosetron hcl</i> )	Non Preferred	PA
<b>*IBS AGENT - SODIUM/HYDROGEN EXCHANGER 3 (NHE3) INHIBITOR*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
IBSRELA TABLET 50 MG ORAL ( <i>tenapanor hcl</i> )	Non Preferred	PA
<b>*INFLAMMATORY BOWEL AGENTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
<i>balsalazide disodium capsule 750 mg oral</i>	Preferred	
<i>mesalamine enema 4 gm rectal</i>	Preferred	
<i>mesalamine er capsule extended release 500 mg oral</i>	Preferred	
<i>mesalamine suppository 1000 mg rectal</i>	Preferred	
<i>sulfasalazine tablet 500 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>sulfasalazine tablet delayed release 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
PENTASA CAPSULE EXTENDED RELEASE 250 MG ORAL ( <i>mesalamine</i> )	Preferred	
PENTASA CAPSULE EXTENDED RELEASE 500 MG ORAL ( <i>mesalamine</i> )	Preferred	
SFROWASA ENEMA 4 GM/60ML RECTAL ( <i>mesalamine</i> )	Preferred	
<i>mesalamine capsule delayed release 400 mg oral</i>	Non Preferred	PA
<i>mesalamine er capsule extended release 24 hour 0.375 gm oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>mesalamine tablet delayed release 1.2 gm oral</i>	Non Preferred	PA
<i>mesalamine tablet delayed release 800 mg oral</i>	Non Preferred	PA
<i>mesalamine-cleanser kit 4 gm rectal</i>	Non Preferred	PA
APRISO CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM ORAL ( <i>mesalamine</i> )	Non Preferred	PA; QL (4 EA per 1 day)
AZULFIDINE EN-TABS TABLET DELAYED RELEASE 500 MG ORAL ( <i>sulfasalazine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
AZULFIDINE TABLET 500 MG ORAL ( <i>sulfasalazine</i> )	Non Preferred	PA; QL (10 EA per 1 day)
CANASA SUPPOSITORY 1000 MG RECTAL ( <i>mesalamine</i> )	Non Preferred	PA
COLAZAL CAPSULE 750 MG ORAL ( <i>balsalazide disodium</i> )	Non Preferred	PA
DELZICOL CAPSULE DELAYED RELEASE 400 MG ORAL ( <i>mesalamine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
DIPENTUM CAPSULE 250 MG ORAL ( <i>olsalazine sodium</i> )	Non Preferred	PA
LIALDA TABLET DELAYED RELEASE 1.2 GM ORAL ( <i>mesalamine</i> )	Non Preferred	PA
ROWASA KIT 4 GM RECTAL ( <i>mesalamine-cleanser</i> )	Non Preferred	PA
<b>*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
ENTYVIO SOLUTION PEN-INJECTOR 108 MG/0.68ML SUBCUTANEOUS ( <i>vedolizumab</i> )	Non Preferred	PA
ENTYVIO SOLUTION RECONSTITUTED 300 MG INTRAVENOUS ( <i>vedolizumab</i> )	Non Preferred	PA
<b>*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
OMVOH SOLUTION 300 MG/15ML INTRAVENOUS ( <i>mirikizumab-mrkz</i> )	Non Preferred	PA
OMVOH SOLUTION AUTO-INJECTOR 100 MG/ML SUBCUTANEOUS ( <i>mirikizumab-mrkz</i> )	Non Preferred	PA
SKYRIZI SOLUTION 600 MG/10ML INTRAVENOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
SKYRIZI SOLUTION CARTRIDGE 180 MG/1.2ML SUBCUTANEOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
SKYRIZI SOLUTION CARTRIDGE 360 MG/2.4ML SUBCUTANEOUS ( <i>risankizumab-rzaa</i> )	Non Preferred	PA
STELARA SOLUTION 130 MG/26ML INTRAVENOUS ( <i>ustekinumab</i> )	Non Preferred	PA
<b>*INTESTINAL ACIDIFIERS*** - DRUGS FOR THE STOMACH</b>		
<i>enulose solution 10 gm/15ml oral</i>	Preferred	QL (180 ML per 1 day)
<i>generlac solution 10 gm/15ml oral</i>	Preferred	QL (180 ML per 1 day)
<i>lactulose encephalopathy solution 10 gm/15ml oral</i>	Preferred	QL (180 ML per 1 day)
<b>*PERIPHERAL OPIOID RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<i>alvimopan capsule 12 mg oral</i>	Non Preferred	PA
ENTEREG CAPSULE 12 MG ORAL ( <i>alvimopan</i> )	Non Preferred	PA
MOVANTIK TABLET 12.5 MG ORAL ( <i>naloxegol oxalate</i> )	Non Preferred	PA
MOVANTIK TABLET 25 MG ORAL ( <i>naloxegol oxalate</i> )	Non Preferred	PA
RELISTOR SOLUTION 12 MG/0.6ML SUBCUTANEOUS ( <i>methylnaltrexone bromide</i> )	Non Preferred	PA
RELISTOR SOLUTION 8 MG/0.4ML SUBCUTANEOUS ( <i>methylnaltrexone bromide</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RELISTOR TABLET 150 MG ORAL ( <i>methylnaltrexone bromide</i> )	Non Preferred	PA
SYMPROIC TABLET 0.2 MG ORAL ( <i>naldemedine tosylate</i> )	Non Preferred	PA
<b>*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>calcium acetate (phos binder) capsule 667 mg oral</i>	Preferred	
<i>calcium acetate (phos binder) tablet 667 mg oral (rx)</i>	Preferred	
<i>calcium acetate tablet 667 mg oral</i>	Preferred	
<i>lanthanum carbonate tablet chewable 1000 mg oral</i>	Preferred	
<i>lanthanum carbonate tablet chewable 500 mg oral</i>	Preferred	
<i>lanthanum carbonate tablet chewable 750 mg oral</i>	Preferred	
<i>sevelamer carbonate tablet 800 mg oral</i>	Preferred	
<i>sevelamer hcl tablet 400 mg oral</i>	Preferred	
<i>sevelamer hcl tablet 800 mg oral</i>	Preferred	
FOSRENOL PACKET 1000 MG ORAL ( <i>lanthanum carbonate</i> )	Preferred	
FOSRENOL PACKET 750 MG ORAL ( <i>lanthanum carbonate</i> )	Preferred	
<i>sevelamer carbonate packet 0.8 gm oral</i>	Non Preferred	PA
<i>sevelamer carbonate packet 2.4 gm oral</i>	Non Preferred	PA
AURYXIA TABLET 1 GM 210 MG(FE) ORAL ( <i>ferric citrate</i> )	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 1000 MG ORAL ( <i>lanthanum carbonate</i> )	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 500 MG ORAL ( <i>lanthanum carbonate</i> )	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 750 MG ORAL ( <i>lanthanum carbonate</i> )	Non Preferred	PA
PHOSLYRA SOLUTION 667 MG/5ML ORAL ( <i>calcium acetate (phos binder)</i> )	Non Preferred	PA
RENVELA PACKET 0.8 GM ORAL ( <i>sevelamer carbonate</i> )	Non Preferred	PA
RENVELA PACKET 2.4 GM ORAL ( <i>sevelamer carbonate</i> )	Non Preferred	PA
RENVELA TABLET 800 MG ORAL ( <i>sevelamer carbonate</i> )	Non Preferred	PA
VELPHORO TABLET CHEWABLE 500 MG ORAL ( <i>sucroferric oxyhydroxide</i> )	Non Preferred	PA
<b>*TRYPTOPHAN HYDROXYLASE INHIBITORS*** - DRUGS FOR DIARRHEA</b>		
XERMELO TABLET 250 MG ORAL ( <i>telotristat etiprate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*TUMOR NECROSIS FACTOR ALPHA BLOCKERS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
CIMZIA (2 SYRINGE) PREFILLED SYRINGE KIT 200 MG/ML SUBCUTANEOUS ( <i>certolizumab pegol</i> )	Preferred	PA
CIMZIA STARTER KIT PREFILLED SYRINGE KIT 6 X 200 MG/ML SUBCUTANEOUS ( <i>certolizumab pegol</i> )	Preferred	PA
<i>infliximab solution reconstituted 100 mg intravenous</i>	Non Preferred	PA
AVSOLA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS ( <i>infliximab-axxq</i> )	Non Preferred	PA
CIMZIA KIT 2 X 200 MG SUBCUTANEOUS ( <i>certolizumab pegol</i> )	Non Preferred	PA
INFLECTRA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS ( <i>infliximab-dyyb</i> )	Non Preferred	PA
REMICADE SOLUTION RECONSTITUTED 100 MG INTRAVENOUS ( <i>infliximab</i> )	Non Preferred	PA
RENFLEXIS SOLUTION RECONSTITUTED 100 MG INTRAVENOUS ( <i>infliximab-abda</i> )	Non Preferred	PA
<b>*GENITOURINARY AGENTS - MISCELLANEOUS* - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE PROSTATE</b>		
<i>finasteride tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>dutasteride capsule 0.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
AVODART CAPSULE 0.5 MG ORAL ( <i>dutasteride</i> )	Non Preferred	PA
PROSCAR TABLET 5 MG ORAL ( <i>finasteride</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE PROSTATE</b>		
<i>alfuzosin hcl er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>tamsulosin hcl capsule 0.4 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>silodosin capsule 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>silodosin capsule 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CARDURA XL TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA
CARDURA XL TABLET EXTENDED RELEASE 24 HOUR 8 MG ORAL ( <i>doxazosin mesylate</i> )	Non Preferred	PA
FLOMAX CAPSULE 0.4 MG ORAL ( <i>tamsulosin hcl</i> )	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
RAPAFLO CAPSULE 4 MG ORAL ( <i>silodosin</i> )	Non Preferred	PA
RAPAFLO CAPSULE 8 MG ORAL ( <i>silodosin</i> )	Non Preferred	PA
<b>*CITRATES*** - DRUGS FOR INFECTIONS</b>		
<i>sod citrate-citric acid solution 1.5-1 gm/15ml oral</i>	Preferred	
<i>sod citrate-citric acid solution 3-2 gm/30ml oral</i>	Preferred	
<i>sod citrate-citric acid solution 500-334 mg/5ml oral (rx)</i>	Preferred	
ORACIT SOLUTION 490-640 MG/5ML ORAL ( <i>sod citrate-citric acid</i> )	Preferred	
<i>cytra k crystals packet 3300-1002 mg oral</i>	Non Preferred	PA
<i>pot &amp; sod cit-cit ac solution 550-500-334 mg/5ml oral</i>	Non Preferred	PA
<i>potassium citrate er tablet extended release 10 meq (1080 mg) oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>potassium citrate er tablet extended release 15 meq (1620 mg) oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>potassium citrate er tablet extended release 5 meq (540 mg) oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>potassium citrate-citric acid solution 1100-334 mg/5ml oral</i>	Non Preferred	PA
<i>tricitrates solution 550-500-334 mg/5ml oral</i>	Non Preferred	PA
<i>potassium citrate-citric acid (Taron-Crystals Packet 3300-1002 Mg Oral)</i>	Non Preferred	PA
UROCI-K 10 TABLET EXTENDED RELEASE 10 MEQ (1080 MG) ORAL ( <i>potassium citrate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
UROCI-K 15 TABLET EXTENDED RELEASE 15 MEQ (1620 MG) ORAL ( <i>potassium citrate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
UROCI-K 5 TABLET EXTENDED RELEASE 5 MEQ (540 MG) ORAL ( <i>potassium citrate</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*CYSTINOSIS AGENTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
CYSTAGON CAPSULE 150 MG ORAL ( <i>cysteamine bitartrate</i> )	Preferred	
CYSTAGON CAPSULE 50 MG ORAL ( <i>cysteamine bitartrate</i> )	Preferred	
PROCYSBI CAPSULE DELAYED RELEASE 25 MG ORAL ( <i>cysteamine bitartrate</i> )	Non Preferred	PA
PROCYSBI CAPSULE DELAYED RELEASE 75 MG ORAL ( <i>cysteamine bitartrate</i> )	Non Preferred	PA
PROCYSBI PACKET 300 MG ORAL ( <i>cysteamine bitartrate</i> )	Non Preferred	PA
PROCYSBI PACKET 75 MG ORAL ( <i>cysteamine bitartrate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*INTERSTITIAL CYSTITIS AGENTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
ELMIRON CAPSULE 100 MG ORAL ( <i>pentosan polysulfate sodium</i> )	Non Preferred	PA
<b>*PHOSPHATES*** - DRUGS FOR INFECTIONS</b>		
K-PHOS NO 2 TABLET 305-700 MG ORAL ( <i>pot &amp; sod ac phosphates</i> )	Non Preferred	PA
<b>*PROSTATIC HYPERTROPHY AGENT COMBINATIONS*** - DRUGS FOR THE PROSTATE</b>		
<i>dutasteride-tamsulosin hcl capsule 0.5-0.4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ENTADFI CAPSULE 5-5 MG ORAL ( <i>finasteride-tadalafil</i> )	Non Preferred	PA
JALYN CAPSULE 0.5-0.4 MG ORAL ( <i>dutasteride-tamsulosin hcl</i> )	Non Preferred	PA
<b>*URINARY ANALGESICS*** - DRUGS FOR INFECTIONS</b>		
<i>phenazopyridine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>phenazopyridine hcl tablet 200 mg oral</i>	Preferred	QL (3 EA per 1 day)
PYRIDIUM TABLET 100 MG ORAL ( <i>phenazopyridine hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
PYRIDIUM TABLET 200 MG ORAL ( <i>phenazopyridine hcl</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*URINARY STONE AGENTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
<i>tiopronin tablet 100 mg oral</i>	Non Preferred	PA
LITHOSTAT TABLET 250 MG ORAL ( <i>acetohydroxamic acid</i> )	Non Preferred	PA
THIOLA EC TABLET DELAYED RELEASE 100 MG ORAL ( <i>tiopronin</i> )	Non Preferred	PA
THIOLA EC TABLET DELAYED RELEASE 300 MG ORAL ( <i>tiopronin</i> )	Non Preferred	PA
THIOLA TABLET 100 MG ORAL ( <i>tiopronin</i> )	Non Preferred	PA
<b>*GLUCOCORTICOSTEROIDS*** - HORMONES</b>		
<b>*CORTICOSTEROIDS* - DRUGS FOR INFLAMMATION</b>		
<i>dexamethasone tablet 1.5 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 4 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dexamethasone tablet 6 mg oral</i>	Preferred	QL (10 EA per 1 day)
<b>*GOUT AGENTS* - DRUGS FOR PAIN AND FEVER</b>		
<b>*GOUT AGENT COMBINATIONS*** - GOUT DRUGS</b>		
<i>colchicine-probenecid tablet 0.5-500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*GOUT AGENTS*** - GOUT DRUGS</b>		
<i>allopurinol tablet 100 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>allopurinol tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>allopurinol tablet 300 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>colchicine capsule 0.6 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>colchicine tablet 0.6 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>febuxostat tablet 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>febuxostat tablet 80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
COLCRYS TABLET 0.6 MG ORAL ( <i>colchicine</i> )	Non Preferred	PA
MITIGARE CAPSULE 0.6 MG ORAL ( <i>colchicine</i> )	Non Preferred	PA
ULORIC TABLET 40 MG ORAL ( <i>febuxostat</i> )	Non Preferred	PA
ULORIC TABLET 80 MG ORAL ( <i>febuxostat</i> )	Non Preferred	PA
<b>*URICOSURICS*** - GOUT DRUGS</b>		
<i>probenecid tablet 500 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<b>*H-2 ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<b>*ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS* - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>famotidine suspension reconstituted 40 mg/5ml oral</i>	Preferred	QL (5 ML per 1 day)
<b>*HEMATOLOGICAL AGENTS - MISC.* - DRUGS FOR THE BLOOD</b>		
<b>*AGENTS FOR CONGENITAL THROMBOTIC THROMBOCYTOPENIC PURPURA* - DRUGS FOR THE BLOOD</b>		
<i>adzynma kit 1500 unit intravenous</i>	Non Preferred	PA
<i>adzynma kit 500 unit intravenous</i>	Non Preferred	PA
<b>*ANTIHEMOPHILIC PRODUCTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD</b>		
HEMLIBRA SOLUTION 105 MG/0.7ML SUBCUTANEOUS ( <i>emicizumab-kxwh</i> )	Preferred	PA
HEMLIBRA SOLUTION 150 MG/ML SUBCUTANEOUS ( <i>emicizumab-kxwh</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
HEMLIBRA SOLUTION 30 MG/ML SUBCUTANEOUS ( <i>emicizumab-kxwh</i> )	Preferred	PA
HEMLIBRA SOLUTION 300 MG/2ML SUBCUTANEOUS ( <i>emicizumab-kxwh</i> )	Preferred	PA
HEMLIBRA SOLUTION 60 MG/0.4ML SUBCUTANEOUS ( <i>emicizumab-kxwh</i> )	Preferred	PA
<b>*ANTIHEMOPHILIC PRODUCTS*** - DRUGS TO PREVENT BLEEDING</b>		
<i>adynovate solution reconstituted 1000 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 1500 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 2000 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 250 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 3000 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 500 unit intravenous</i>	Preferred	PA
<i>adynovate solution reconstituted 750 unit intravenous</i>	Preferred	PA
<i>obizur solution reconstituted 500 unit intravenous</i>	Preferred	PA
<i>rixubis solution reconstituted 1000 unit intravenous</i>	Preferred	PA
<i>rixubis solution reconstituted 2000 unit intravenous</i>	Preferred	PA
<i>rixubis solution reconstituted 250 unit intravenous</i>	Preferred	PA
<i>rixubis solution reconstituted 3000 unit intravenous</i>	Preferred	PA
<i>rixubis solution reconstituted 500 unit intravenous</i>	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
ADVATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
AFSTYLA KIT 1000 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
AFSTYLA KIT 1500 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
AFSTYLA KIT 2000 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
AFSTYLA KIT 250 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA

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AFSTYLA KIT 2500 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
AFSTYLA KIT 3000 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
AFSTYLA KIT 500 UNIT INTRAVENOUS ( <i>antihemophil fact single chain</i> )	Preferred	PA
ALPHANATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
ALPHANATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
ALPHANATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
ALPHANATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
ALPHANATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
ALPHANINE SD SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix</i> )	Preferred	PA
ALPHANINE SD SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>coagulation factor ix</i> )	Preferred	PA
ALPHANINE SD SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor ix</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
ALPROLIX SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor ix (rfixfc)</i> )	Preferred	PA
BENEFIX KIT 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
BENEFIX KIT 2000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
BENEFIX KIT 250 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
BENEFIX KIT 3000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
BENEFIX KIT 500 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
COAGADEX SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>coagulation factor x (human)</i> )	Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
COAGADEX SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor x (human)</i> )	Preferred	PA
CORIFACT KIT 1000-1600 UNIT INTRAVENOUS ( <i>factor xiii concentrate human</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 5000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 6000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ELOCTATE SOLUTION RECONSTITUTED 750 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviiiifc)</i> )	Preferred	PA
ESPEROCT SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemoph fact rcmb gpeg-exei</i> )	Preferred	PA
ESPEROCT SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihemoph fact rcmb gpeg-exei</i> )	Preferred	PA
ESPEROCT SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihemoph fact rcmb gpeg-exei</i> )	Preferred	PA
ESPEROCT SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihemoph fact rcmb gpeg-exei</i> )	Preferred	PA
ESPEROCT SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemoph fact rcmb gpeg-exei</i> )	Preferred	PA
FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antiinhibitor coagulant cmplx</i> )	Preferred	PA
FEIBA SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS ( <i>antiinhibitor coagulant cmplx</i> )	Preferred	PA
FEIBA SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antiinhibitor coagulant cmplx</i> )	Preferred	PA
HEMOPIL M SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
HEMOPIL M SOLUTION RECONSTITUTED 1700 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
HEMOPIL M SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
HEMOPIL M SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
HUMATE-P SOLUTION RECONSTITUTED 1000-2400 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
HUMATE-P SOLUTION RECONSTITUTED 250-600 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
HUMATE-P SOLUTION RECONSTITUTED 500-1200 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
IDELVION SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rix-fp)</i> )	Preferred	PA
IDELVION SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>coagulation factor ix (rix-fp)</i> )	Preferred	PA
IDELVION SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>coagulation factor ix (rix-fp)</i> )	Preferred	PA
IDELVION SOLUTION RECONSTITUTED 3500 UNIT INTRAVENOUS ( <i>coagulation factor ix (rix-fp)</i> )	Preferred	PA
IDELVION SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor ix (rix-fp)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
IXINITY SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor ix (recomb)</i> )	Preferred	PA
JIVI SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>ahf (bdd-rfviii peg-aucl)</i> )	Preferred	PA
JIVI SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>ahf (bdd-rfviii peg-aucl)</i> )	Preferred	PA
JIVI SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>ahf (bdd-rfviii peg-aucl)</i> )	Preferred	PA
JIVI SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>ahf (bdd-rfviii peg-aucl)</i> )	Preferred	PA
KOATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
KOATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
KOATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA
KOATE-DVI SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophilic factor</i> )	Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
KOGENATE FS KIT 1000 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
KOGENATE FS KIT 2000 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
KOGENATE FS KIT 250 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
KOGENATE FS KIT 3000 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
KOGENATE FS KIT 500 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
KOVALTRY SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
KOVALTRY SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
KOVALTRY SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
KOVALTRY SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
KOVALTRY SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophil factor (rahf-pfm)</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOEIGHT SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihemophil fact bd truncated</i> )	Preferred	PA
NOVOSEVEN RT SOLUTION RECONSTITUTED 1 MG INTRAVENOUS ( <i>coagulation factor viia recomb</i> )	Preferred	PA
NOVOSEVEN RT SOLUTION RECONSTITUTED 2 MG INTRAVENOUS ( <i>coagulation factor viia recomb</i> )	Preferred	PA
NOVOSEVEN RT SOLUTION RECONSTITUTED 5 MG INTRAVENOUS ( <i>coagulation factor viia recomb</i> )	Preferred	PA
NOVOSEVEN RT SOLUTION RECONSTITUTED 8 MG INTRAVENOUS ( <i>coagulation factor viia recomb</i> )	Preferred	PA
NUWIIQ KIT 1000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIIQ KIT 1500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIIQ KIT 2000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NUWIQ KIT 250 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ KIT 2500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ KIT 3000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ KIT 4000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ KIT 500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
NUWIQ SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,sim)</i> )	Preferred	PA
PROFILNINE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>factor ix complex</i> )	Preferred	PA
PROFILNINE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS ( <i>factor ix complex</i> )	Preferred	PA
PROFILNINE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>factor ix complex</i> )	Preferred	PA
REBINYN SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS ( <i>coagulation factor ix glycopeg</i> )	Preferred	PA
REBINYN SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS ( <i>coagulation factor ix glycopeg</i> )	Preferred	PA
REBINYN SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS ( <i>coagulation factor ix glycopeg</i> )	Preferred	PA
REBINYN SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>coagulation factor ix glycopeg</i> )	Preferred	PA
RECOMBINATE SOLUTION RECONSTITUTED 1241-1800 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
RECOMBINATE SOLUTION RECONSTITUTED 1801-2400 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
RECOMBINATE SOLUTION RECONSTITUTED 220-400 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RECOMBINATE SOLUTION RECONSTITUTED 401-800 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
RECOMBINATE SOLUTION RECONSTITUTED 801-1240 UNIT INTRAVENOUS ( <i>antihem factor recomb (rfviii)</i> )	Preferred	PA
SEVENFACT SOLUTION RECONSTITUTED 1 MG INTRAVENOUS ( <i>coagulation factor viia-jncw</i> )	Preferred	PA
SEVENFACT SOLUTION RECONSTITUTED 5 MG INTRAVENOUS ( <i>coagulation factor viia-jncw</i> )	Preferred	PA
TRETTEN SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS ( <i>coagulation factor xiii a-sub</i> )	Preferred	PA
VONVENDI SOLUTION RECONSTITUTED 1300 UNIT INTRAVENOUS ( <i>von willebrand factor (recomb)</i> )	Preferred	PA
VONVENDI SOLUTION RECONSTITUTED 650 UNIT INTRAVENOUS ( <i>von willebrand factor (recomb)</i> )	Preferred	PA
WILATE KIT 1000-1000 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
WILATE KIT 500-500 UNIT INTRAVENOUS ( <i>antihemophilic factor-vwf</i> )	Preferred	PA
XYNTHA KIT 1000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA KIT 2000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA KIT 250 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA KIT 500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA SOLOFUSE KIT 1000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA SOLOFUSE KIT 2000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA SOLOFUSE KIT 250 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA SOLOFUSE KIT 3000 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
XYNTHA SOLOFUSE KIT 500 UNIT INTRAVENOUS ( <i>antihem fact (bdd-rfviii,mor)</i> )	Preferred	PA
<b>*BRADYKININ B2 RECEPTOR ANTAGONISTS*** - DRUGS FOR THE BLOOD</b>		
<i>icatibant acetate solution prefilled syringe 30 mg/3ml subcutaneous</i>	Non Preferred	PA
FIRAZYR SOLUTION PREFILLED SYRINGE 30 MG/3ML SUBCUTANEOUS ( <i>icatibant acetate</i> )	Non Preferred	PA
<i>icatibant acetate</i> (Sajazir Solution Prefilled Syringe 30 Mg/3MI Subcutaneous)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*C1 ESTERASE INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
BERINERT KIT 500 UNIT INTRAVENOUS ( <i>c1 esterase inhibitor (human)</i> )	Preferred	PA
CINRYZE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS ( <i>c1 esterase inhibitor (human)</i> )	Non Preferred	PA
HAEGARDA SOLUTION RECONSTITUTED 2000 UNIT SUBCUTANEOUS ( <i>c1 esterase inhibitor (human)</i> )	Non Preferred	PA
HAEGARDA SOLUTION RECONSTITUTED 3000 UNIT SUBCUTANEOUS ( <i>c1 esterase inhibitor (human)</i> )	Non Preferred	PA
RUCONEST SOLUTION RECONSTITUTED 2100 UNIT INTRAVENOUS ( <i>c1 esterase inhibitor (recomb)</i> )	Non Preferred	PA
<b>*COMPLEMENT C1 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
ENJAYMO SOLUTION 1100 MG/22ML INTRAVENOUS ( <i>sutimlimab-jome</i> )	Non Preferred	PA
<b>*COMPLEMENT C3 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
EMPAVELI SOLUTION 1080 MG/20ML SUBCUTANEOUS ( <i>pegcetacoplan</i> )	Non Preferred	PA
<b>*COMPLEMENT C5 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
SOLIRIS SOLUTION 300 MG/30ML INTRAVENOUS ( <i>eculizumab</i> )	Non Preferred	PA
ULTOMIRIS SOLUTION 1100 MG/11ML INTRAVENOUS ( <i>ravulizumab-cwvz</i> )	Non Preferred	PA
ULTOMIRIS SOLUTION 300 MG/3ML INTRAVENOUS ( <i>ravulizumab-cwvz</i> )	Non Preferred	PA
VEOPOZ SOLUTION 400 MG/2ML INJECTION ( <i>pezelimab-bbfg</i> )	Non Preferred	PA
ZILBRYSQ SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML SUBCUTANEOUS ( <i>zilucoplan sodium</i> )	Non Preferred	PA
ZILBRYSQ SOLUTION PREFILLED SYRINGE 23 MG/0.574ML SUBCUTANEOUS ( <i>zilucoplan sodium</i> )	Non Preferred	PA
ZILBRYSQ SOLUTION PREFILLED SYRINGE 32.4 MG/0.81ML SUBCUTANEOUS ( <i>zilucoplan sodium</i> )	Non Preferred	PA
<b>*COMPLEMENT C5A RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
TAVNEOS CAPSULE 10 MG ORAL ( <i>avacopan</i> )	Non Preferred	PA
<b>*COMPLEMENT FACTOR B INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
FABHALTA CAPSULE 200 MG ORAL ( <i>iptacopan hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
BRILINTA TABLET 60 MG ORAL ( <i>ticagrelor</i> )	Preferred	
BRILINTA TABLET 90 MG ORAL ( <i>ticagrelor</i> )	Preferred	
<b>*HEMATORHEOLOGIC AGENTS*** - DRUGS FOR THE BLOOD</b>		
<i>pentoxifylline er tablet extended release 400 mg oral</i>	Preferred	QL (4 EA per 1 day)
<b>*PHOSPHODIESTERASE III INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<i>cilostazol tablet 100 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>cilostazol tablet 50 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<b>*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD</b>		
TAKHZYRO SOLUTION 300 MG/2ML SUBCUTANEOUS ( <i>lanadelumab-flyo</i> )	Non Preferred	PA
TAKHZYRO SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS ( <i>lanadelumab-flyo</i> )	Non Preferred	PA
TAKHZYRO SOLUTION PREFILLED SYRINGE 300 MG/2ML SUBCUTANEOUS ( <i>lanadelumab-flyo</i> )	Non Preferred	PA
<b>*PLASMA KALLIKREIN INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
KALBITOR SOLUTION 10 MG/ML SUBCUTANEOUS ( <i>ecallantide</i> )	Non Preferred	PA
ORLADEYO CAPSULE 110 MG ORAL ( <i>berotralstat hcl</i> )	Non Preferred	PA
ORLADEYO CAPSULE 150 MG ORAL ( <i>berotralstat hcl</i> )	Non Preferred	PA
<b>*PLATELET AGGREGATION INHIBITOR COMBINATIONS*** - DRUGS FOR THE BLOOD</b>		
<i>aspirin-dipyridamole er capsule extended release 12 hour 25-200 mg oral</i>	Preferred	
<b>*PLATELET AGGREGATION INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<i>dipyridamole tablet 25 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>dipyridamole tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>dipyridamole tablet 75 mg oral</i>	Preferred	QL (4 EA per 1 day)
<b>*QUINAZOLINE AGENTS*** - DRUGS FOR THE BLOOD</b>		
<i>anagrelide hcl capsule 0.5 mg oral</i>	Preferred	
<i>anagrelide hcl capsule 1 mg oral</i>	Preferred	
AGRYLIN CAPSULE 0.5 MG ORAL ( <i>anagrelide hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*SPLEEN TYROSINE KINASE (SYK) INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
TAVALISSE TABLET 100 MG ORAL ( <i>fostamatinib disodium</i> )	Non Preferred	PA
TAVALISSE TABLET 150 MG ORAL ( <i>fostamatinib disodium</i> )	Non Preferred	PA
<b>*THIENOPYRIDINE DERIVATIVES*** - DRUGS FOR THE BLOOD</b>		
<i>clopidogrel bisulfate tablet 300 mg oral</i>	Preferred	
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>prasugrel hcl tablet 10 mg oral</i>	Non Preferred	PA
<i>prasugrel hcl tablet 5 mg oral</i>	Non Preferred	PA
EFFIENT TABLET 10 MG ORAL ( <i>prasugrel hcl</i> )	Non Preferred	PA
EFFIENT TABLET 5 MG ORAL ( <i>prasugrel hcl</i> )	Non Preferred	PA
PLAVIX TABLET 75 MG ORAL ( <i>clopidogrel bisulfate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*HEMATOPOIETIC AGENTS* - DRUGS FOR NUTRITION</b>		
<b>*AGENTS FOR SICKLE CELL DISEASE - AUTOLOGOUS GENE THERAPY*** - DRUGS FOR NUTRITION</b>		
CASGEVY SUSPENSION INTRAVENOUS ( <i>exagamglogene autotemcel</i> )	Non Preferred	PA
LYFGENIA SUSPENSION INTRAVENOUS ( <i>lovotibeglogene autotemcel</i> )	Non Preferred	PA
<b>*AMINO ACIDS*** - DRUGS FOR NUTRITION</b>		
ENDARI PACKET 5 GM ORAL ( <i>glutamine (sickle cell)</i> )	Preferred	
<b>*COBALAMINS*** - DRUGS FOR NUTRITION</b>		
<i>sm vitamin b-12 oral tablet 100 mcg, 500 mcg</i>	Preferred	
<i>true vitamin b12 oral tablet 1000 mcg, 500 mcg</i>	Preferred	
<i>vitamin b-12 oral tablet 100 mcg, 1000 mcg, 250 mcg, 500 mcg</i>	Preferred	
<b>*CYTOTOXIC AGENTS*** - DRUGS FOR NUTRITION</b>		
DROXIA CAPSULE 200 MG ORAL ( <i>hydroxyurea</i> )	Preferred	
DROXIA CAPSULE 300 MG ORAL ( <i>hydroxyurea</i> )	Preferred	
DROXIA CAPSULE 400 MG ORAL ( <i>hydroxyurea</i> )	Preferred	
SIKLOS TABLET 100 MG ORAL ( <i>hydroxyurea</i> )	Non Preferred	PA
SIKLOS TABLET 1000 MG ORAL ( <i>hydroxyurea</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ERYTHROID MATURATION AGENTS*** - DRUGS FOR NUTRITION</b>		
REBLOZYL SOLUTION RECONSTITUTED 25 MG SUBCUTANEOUS ( <i>luspatercept-aamt</i> )	Non Preferred	PA
REBLOZYL SOLUTION RECONSTITUTED 75 MG SUBCUTANEOUS ( <i>luspatercept-aamt</i> )	Non Preferred	PA
<b>*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)*** - DRUGS FOR NUTRITION</b>		
EPOGEN SOLUTION 10000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
EPOGEN SOLUTION 2000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
EPOGEN SOLUTION 20000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
EPOGEN SOLUTION 3000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
EPOGEN SOLUTION 4000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 10000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 2000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 20000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 3000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 4000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
PROCRIT SOLUTION 40000 UNIT/ML INJECTION ( <i>epoetin alfa</i> )	Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 100 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 200 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 25 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 40 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 60 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 25 MCG/0.42ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 40 MCG/0.4ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 500 MCG/ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 60 MCG/0.3ML INJECTION ( <i>darbepoetin alfa</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 120 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 200 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 30 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 50 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 75 MCG/0.3ML INJECTION ( <i>methoxy peg-epoetin beta</i> )	Non Preferred	PA
RETACRIT SOLUTION 10000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
RETACRIT SOLUTION 2000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
RETACRIT SOLUTION 20000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
RETACRIT SOLUTION 3000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
RETACRIT SOLUTION 4000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
RETACRIT SOLUTION 40000 UNIT/ML INJECTION ( <i>epoetin alfa-epbx</i> )	Non Preferred	PA
<b>*FOLIC ACID/FOLATES*** - DRUGS FOR NUTRITION</b>		
<i>folic acid oral tablet 1 mg</i>	Preferred	QL (5 EA per 1 day)
<i>sm folic acid oral tablet 400 mcg</i>	Preferred	
<i>true folic acid oral tablet 1 mg</i>	Preferred	QL (5 EA per 1 day)
<i>true folic acid oral tablet 400 mcg</i>	Preferred	
<b>*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)*** - DRUGS FOR NUTRITION</b>		
NEUPOGEN SOLUTION 300 MCG/ML INJECTION ( <i>filgrastim</i> )	Preferred	
NEUPOGEN SOLUTION 480 MCG/1.6ML INJECTION ( <i>filgrastim</i> )	Preferred	
NEUPOGEN SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION ( <i>filgrastim</i> )	Preferred	
NEUPOGEN SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION ( <i>filgrastim</i> )	Preferred	
<i>releuko solution 480 mcg/1.6ml injection</i>	Non Preferred	PA
<i>releuko solution prefilled syringe 300 mcg/0.5ml subcutaneous</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>releuko solution prefilled syringe 480 mcg/0.8ml subcutaneous</i>	Non Preferred	PA
FULPHILA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-jmdb</i> )	Non Preferred	PA; QL (0.043 ML per 1 day)
FYLNETRA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-pbbk</i> )	Non Preferred	PA
GRANIX SOLUTION 300 MCG/ML SUBCUTANEOUS ( <i>tbo-filgrastim</i> )	Non Preferred	PA
GRANIX SOLUTION 480 MCG/1.6ML SUBCUTANEOUS ( <i>tbo-filgrastim</i> )	Non Preferred	PA
GRANIX SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML SUBCUTANEOUS ( <i>tbo-filgrastim</i> )	Non Preferred	PA
GRANIX SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML SUBCUTANEOUS ( <i>tbo-filgrastim</i> )	Non Preferred	PA
NEULASTA ONPRO PREFILLED SYRINGE KIT 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim</i> )	Non Preferred	PA; QL (0.6 ML per 14 days)
NEULASTA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim</i> )	Non Preferred	PA; QL (0.043 ML per 1 day)
NIVESTYM SOLUTION 300 MCG/ML INJECTION ( <i>filgrastim-aafi</i> )	Non Preferred	PA
NIVESTYM SOLUTION 480 MCG/1.6ML INJECTION ( <i>filgrastim-aafi</i> )	Non Preferred	PA
NIVESTYM SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION ( <i>filgrastim-aafi</i> )	Non Preferred	PA
NIVESTYM SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION ( <i>filgrastim-aafi</i> )	Non Preferred	PA
NYVEPRIA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-apgf</i> )	Non Preferred	PA
RELEUKO SOLUTION 300 MCG/ML INJECTION ( <i>filgrastim-ayow</i> )	Non Preferred	PA
ROLVEDON SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML SUBCUTANEOUS ( <i>eflapegrastim-xnst</i> )	Non Preferred	PA
STIMUFEND SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-fpgk</i> )	Non Preferred	PA
UDENYCA ONBODY SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-cbqv</i> )	Non Preferred	PA
UDENYCA SOLUTION AUTO-INJECTOR 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-cbqv</i> )	Non Preferred	PA
UDENYCA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-cbqv</i> )	Non Preferred	PA; QL (0.043 ML per 1 day)
ZARXIO SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML INJECTION ( <i>filgrastim-sndz</i> )	Non Preferred	PA
ZARXIO SOLUTION PREFILLED SYRINGE 480 MCG/0.8ML INJECTION ( <i>filgrastim-sndz</i> )	Non Preferred	PA
ZIEXTENZO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS ( <i>pegfilgrastim-bmez</i> )	Non Preferred	PA; QL (0.043 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*GRANULOCYTE/MACROPHAGE COLONY-STIMULATING FACTOR(GM-CSF)*** - DRUGS FOR NUTRITION</b>		
LEUKINE SOLUTION RECONSTITUTED 250 MCG INJECTION ( <i>sargramostim</i> )	Preferred	
<b>*HEMOGLOBIN S (HBS) POLYMERIZATION INHIBITORS*** - DRUGS FOR NUTRITION</b>		
OXBRYTA TABLET 300 MG ORAL ( <i>voxelotor</i> )	Non Preferred	PA
OXBRYTA TABLET 500 MG ORAL ( <i>voxelotor</i> )	Non Preferred	PA
OXBRYTA TABLET SOLUBLE 300 MG ORAL ( <i>voxelotor</i> )	Non Preferred	PA
<b>*HYPOXIA-INDUCIBLE FACTOR PROLYL HYDROXYLASE INHIBITORS*** - DRUGS FOR NUTRITION</b>		
JESDUVROQ TABLET 1 MG ORAL ( <i>daprodustat</i> )	Non Preferred	PA
JESDUVROQ TABLET 2 MG ORAL ( <i>daprodustat</i> )	Non Preferred	PA
JESDUVROQ TABLET 4 MG ORAL ( <i>daprodustat</i> )	Non Preferred	PA
JESDUVROQ TABLET 6 MG ORAL ( <i>daprodustat</i> )	Non Preferred	PA
JESDUVROQ TABLET 8 MG ORAL ( <i>daprodustat</i> )	Non Preferred	PA
<b>*IRON*** - DRUGS FOR NUTRITION</b>		
<i>ferrous fumarate oral tablet 324 mg</i>	Preferred	
<i>ferrous gluconate oral tablet 324 (37.5 fe) mg, 324 (38 fe) mg</i>	Preferred	
<i>ferrous sulfate oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	
<i>ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 325 (65 fe) mg</i>	Preferred	
<i>gnp iron oral tablet 200 (65 fe) mg</i>	Preferred	
<i>gnp iron oral tablet extended release 142 (45 fe) mg</i>	Preferred	
<i>iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron infant/toddler oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron supplement childrens oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>polysaccharide iron complex oral capsule 150 mg</i>	Preferred	
<i>sm iron oral tablet 325 (65 fe) mg</i>	Preferred	
<i>sm iron slow release oral tablet extended release 160 (50 fe) mg</i>	Preferred	
<i>true ferrous sulfate oral tablet delayed release 324 mg</i>	Preferred	
FERATE ORAL TABLET 240 (27 FE) MG ( <i>ferrous gluconate</i> )	Preferred	
FEROSUL ORAL ELIXIR 220 (44 FE) MG/5ML ( <i>ferrous sulfate</i> )	Preferred	
FEROSUL ORAL TABLET 325 (65 FE) MG ( <i>ferrous sulfate</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
FERREX 150 ORAL CAPSULE 150 MG ( <i>polysaccharide iron complex</i> )	Preferred	
FERROCITE ORAL TABLET 324 MG ( <i>ferrous fumarate</i> )	Preferred	
NU-IRON ORAL CAPSULE 150 MG ( <i>polysaccharide iron complex</i> )	Preferred	
<b>*SELECTIN BLOCKERS*** - DRUGS FOR NUTRITION</b>		
ADAKVEO SOLUTION 100 MG/10ML INTRAVENOUS ( <i>crizanlizumab-tmca</i> )	Non Preferred	PA
<b>*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS*** - DRUGS FOR NUTRITION</b>		
DOPTELET TABLET 20 MG ORAL ( <i>avatrombopag maleate</i> )	Non Preferred	PA
MULPLETA TABLET 3 MG ORAL ( <i>lusutrombopag</i> )	Non Preferred	PA
NPLATE SOLUTION RECONSTITUTED 125 MCG SUBCUTANEOUS ( <i>romiplostim</i> )	Non Preferred	PA
NPLATE SOLUTION RECONSTITUTED 250 MCG SUBCUTANEOUS ( <i>romiplostim</i> )	Non Preferred	PA
NPLATE SOLUTION RECONSTITUTED 500 MCG SUBCUTANEOUS ( <i>romiplostim</i> )	Non Preferred	PA
PROMACTA PACKET 12.5 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
PROMACTA PACKET 25 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
PROMACTA TABLET 12.5 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
PROMACTA TABLET 25 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
PROMACTA TABLET 50 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
PROMACTA TABLET 75 MG ORAL ( <i>eltrombopag olamine</i> )	Non Preferred	PA
<b>*HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTI-HISTAMINE HYPNOTICS*** - DRUGS FOR INSOMNIA</b>		
<i>ft nighttime sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ft sleep aid (doxylamine) oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>nighttime sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sleep tabs oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sleep-aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>sm nighttime sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm sleep aid oral tablet 25 mg</i>	Preferred	QL (1 EA per 1 day)
<b>*BARBITURATE HYPNOTICS*** - DRUGS FOR INSOMNIA</b>		
<i>phenobarbital elixir 20 mg/5ml oral</i>	Preferred	QL (50 ML per 1 day)
<i>phenobarbital tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 16.2 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 32.4 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 60 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>phenobarbital tablet 64.8 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>phenobarbital tablet 97.2 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>*BENZODIAZEPINE HYPNOTICS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>estazolam tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>estazolam tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>quazepam tablet 15 mg oral</i>	Preferred	
<i>temazepam capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 22.5 mg oral</i>	Preferred	
<i>temazepam capsule 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 7.5 mg oral</i>	Preferred	
<i>triazolam tablet 0.125 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>triazolam tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>flurazepam hcl capsule 15 mg oral</i>	Non Preferred	PA
<i>flurazepam hcl capsule 30 mg oral</i>	Non Preferred	PA
<i>midazolam hcl syrup 2 mg/ml oral</i>	Non Preferred	PA
DORAL TABLET 15 MG ORAL ( <i>quazepam</i> )	Non Preferred	PA
HALCION TABLET 0.25 MG ORAL ( <i>triazolam</i> )	Non Preferred	PA; QL (2 EA per 1 day)
RESTORIL CAPSULE 15 MG ORAL ( <i>temazepam</i> )	Non Preferred	PA; QL (1 EA per 1 day)
RESTORIL CAPSULE 22.5 MG ORAL ( <i>temazepam</i> )	Non Preferred	PA
RESTORIL CAPSULE 30 MG ORAL ( <i>temazepam</i> )	Non Preferred	PA; QL (1 EA per 1 day)
RESTORIL CAPSULE 7.5 MG ORAL ( <i>temazepam</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*HYPNOTICS - TRICYCLIC AGENTS*** - DRUGS FOR INSOMNIA</b>		
<i>doxepin hcl tablet 3 mg oral</i>	Non Preferred	PA
<i>doxepin hcl tablet 6 mg oral</i>	Non Preferred	PA
<b>*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR INSOMNIA</b>		
<i>zolpidem tartrate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>zolpidem tartrate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>eszopiclone tablet 1 mg oral</i>	Non Preferred	PA
<i>eszopiclone tablet 2 mg oral</i>	Non Preferred	PA
<i>eszopiclone tablet 3 mg oral</i>	Non Preferred	PA
<i>zaleplon capsule 10 mg oral</i>	Non Preferred	PA
<i>zaleplon capsule 5 mg oral</i>	Non Preferred	PA
<i>zolpidem tartrate capsule 7.5 mg oral</i>	Non Preferred	PA
<i>zolpidem tartrate er tablet extended release 12.5 mg oral</i>	Non Preferred	PA
<i>zolpidem tartrate er tablet extended release 6.25 mg oral</i>	Non Preferred	PA
<i>zolpidem tartrate tablet sublingual 1.75 mg sublingual</i>	Non Preferred	PA
<i>zolpidem tartrate tablet sublingual 3.5 mg sublingual</i>	Non Preferred	PA
AMBIEN CR TABLET EXTENDED RELEASE 12.5 MG ORAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA
AMBIEN CR TABLET EXTENDED RELEASE 6.25 MG ORAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA
AMBIEN TABLET 10 MG ORAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
AMBIEN TABLET 5 MG ORAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
EDLUAR TABLET SUBLINGUAL 10 MG SUBLINGUAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA
EDLUAR TABLET SUBLINGUAL 5 MG SUBLINGUAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA
LUNESTA TABLET 1 MG ORAL ( <i>eszopiclone</i> )	Non Preferred	PA
LUNESTA TABLET 2 MG ORAL ( <i>eszopiclone</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LUNESTA TABLET 3 MG ORAL ( <i>eszopiclone</i> )	Non Preferred	PA
ZOLPIMIST SOLUTION 5 MG/ACT ORAL ( <i>zolpidem tartrate</i> )	Non Preferred	PA
<b>*OREXIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INSOMNIA</b>		
BELSOMRA TABLET 10 MG ORAL ( <i>suvorexant</i> )	Non Preferred	PA
BELSOMRA TABLET 15 MG ORAL ( <i>suvorexant</i> )	Non Preferred	PA
BELSOMRA TABLET 20 MG ORAL ( <i>suvorexant</i> )	Non Preferred	PA
BELSOMRA TABLET 5 MG ORAL ( <i>suvorexant</i> )	Non Preferred	PA
DAYVIGO TABLET 10 MG ORAL ( <i>lemborexant</i> )	Non Preferred	PA
DAYVIGO TABLET 5 MG ORAL ( <i>lemborexant</i> )	Non Preferred	PA
QUVIVIQ TABLET 25 MG ORAL ( <i>daridorexant hcl</i> )	Non Preferred	PA
QUVIVIQ TABLET 50 MG ORAL ( <i>daridorexant hcl</i> )	Non Preferred	PA
<b>*SELECTIVE MELATONIN RECEPTOR AGONISTS*** - DRUGS FOR INSOMNIA</b>		
<i>ramelteon tablet 8 mg oral</i>	Non Preferred	PA
<i>tasimelteon capsule 20 mg oral</i>	Non Preferred	PA
HETLIOZ CAPSULE 20 MG ORAL ( <i>tasimelteon</i> )	Non Preferred	PA
HETLIOZ LQ SUSPENSION 4 MG/ML ORAL ( <i>tasimelteon</i> )	Non Preferred	PA
ROZEREM TABLET 8 MG ORAL ( <i>ramelteon</i> )	Non Preferred	PA
<b>*IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS</b>		
<b>*MISCELLANEOUS THERAPEUTIC CLASSES* - VITAMINS AND MINERALS</b>		
<i>lenalidomide capsule 15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*LAXATIVES* - DRUGS FOR THE STOMACH</b>		
<b>*BOWEL EVACUANT COMBINATIONS*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>peg 3350/electrolytes oral solution reconstituted 240 gm</i>	Preferred	QL (4000 ML per 1 day)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	Preferred	QL (4000 ML per 1 day)
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	Preferred	QL (4000 ML per 1 day)
<i>peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)</i>	Preferred	QL (4000 ML per 1 day)
<i>bisacodyl-peg-kcl-nabicar-nacl (Gavilyte-H Oral Kit 5-210 Mg-Gm)</i>	Preferred	QL (1 EA per 1 day)
<i>GOLYTELY ORAL SOLUTION RECONSTITUTED 227.1 GM (peg 3350-kcl-nabcb-nacl-nasulf)</i>	Preferred	QL (1 EA per 1 day)
<b>*BULK LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>fiber laxative + calcium oral tablet 625 mg</i>	Preferred	
<i>fiber oral tablet 625 mg</i>	Preferred	
<i>fiber-lax oral tablet 625 mg</i>	Preferred	
<i>ft fiber laxative oral tablet 500 mg, 625 mg</i>	Preferred	
<i>gnp best fiber oral powder</i>	Preferred	
<i>gnp fiber therapy oral tablet 500 mg</i>	Preferred	
<i>gnp fiber-caps oral tablet 625 mg</i>	Preferred	
<i>gnp natural fiber oral capsule 0.52 gm</i>	Preferred	
<i>gnp natural fiber oral powder 28.3 %</i>	Preferred	
<i>konsyl daily fiber oral packet 100 %, 28.3 %</i>	Preferred	
<i>konsyl daily fiber oral powder 28.3 %</i>	Preferred	
<i>qc natural vegetable oral powder 95 %</i>	Preferred	
<i>sm fiber laxative oral tablet 500 mg</i>	Preferred	
<i>sm fiber oral powder 28.3 %, 48.57 %, 58.6 %</i>	Preferred	
<i>sm fiber oral tablet 625 mg</i>	Preferred	
<i>KONSYL FIBER ORAL TABLET 625 MG (calcium polycarbophil)</i>	Preferred	
<i>KONSYL ORAL POWDER 30.9 % (psyllium)</i>	Preferred	
<i>KONSYL-D ORAL POWDER 52.3 % (psyllium)</i>	Preferred	
<i>REGULOID ORAL POWDER 48.57 %, 58.6 % (psyllium)</i>	Preferred	
<b>*LAXATIVES - MISCELLANEOUS*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>constulose oral solution 10 gm/15ml</i>	Preferred	QL (180 ML per 1 day)
<i>ft clearlax oral powder 17 gm/scoop</i>	Preferred	QL (34 GM per 1 day)
<i>gavilax oral powder 17 gm/scoop</i>	Preferred	QL (34 GM per 1 day)
<i>glycerin (adult) rectal suppository 2 gm</i>	Preferred	
<i>glycerin adult rectal suppository 2 gm</i>	Preferred	
<i>glycerin childrens rectal suppository 1.2 gm</i>	Preferred	
<i>gnp glycerin (adult) rectal suppository 2.1 gm</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp glycerin child rectal suppository 1.2 gm</i>	Preferred	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	Preferred	QL (180 ML per 1 day)
<i>peg 3350 oral powder 17 gm/scoop</i>	Preferred	QL (34 GM per 1 day)
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	Preferred	QL (34 GM per 1 day)
<i>sm glycerin pediatric rectal suppository 1.2 gm, 80.7 %</i>	Preferred	
CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
GLYCOLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
GOODSENSE CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
HM CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
SM CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	Preferred	QL (34 GM per 1 day)
<b>*LAXATIVES &amp; DSS*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>ft senna-s oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft stool softener oral tablet 50-8.6 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp senna plus oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>hm stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>senexon-s oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>senna plus oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>senna-docusate sodium oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>senna-time s oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sennosides-docusate sodium oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm senna-s oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>stimulant laxative oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
<i>stool softener plus laxative oral tablet 8.6-50 mg</i>	Preferred	QL (6 EA per 1 day)
COLACE 2-IN-1 ORAL TABLET 8.6-50 MG ( <i>sennosides-docusate sodium</i> )	Preferred	QL (6 EA per 1 day)
<b>*LUBRICANT LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>enema mineral oil rectal enema</i>	Preferred	
<i>ft mineral oil oral oil</i>	Preferred	
<i>gnp mineral oil oral oil</i>	Preferred	
<i>gnp mineral oil rectal enema</i>	Preferred	
<i>hm enema mineral oil rectal enema</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>mineral oil oral oil</i>	Preferred	
<i>sm mineral oil rectal enema</i>	Preferred	
<b>*SALINE LAXATIVE MIXTURES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>enema ready-to-use rectal enema 7-19 gm/118ml</i>	Preferred	
<i>enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>hm enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>sm enema rectal enema , 7-19 gm/118ml</i>	Preferred	
<b>*SALINE LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>ft magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>ft milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>gnp magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>gnp milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>hm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>milk of magnesia concentrate oral suspension 2400 mg/10ml</i>	Preferred	
<i>milk of magnesia oral suspension 1200 mg/15ml, 2400 mg/30ml, 400 mg/5ml, 7.75 %</i>	Preferred	
<i>sm magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>sm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<b>*STIMULANT LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>bisacodyl ec oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>bisacodyl rectal suppository 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>chocolated laxative oral tablet chewable 15 mg</i>	Preferred	
<i>ft gentle laxative rectal suppository 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ft laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>ft senna laxatives oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gentle laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>gentle laxative rectal suppository 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp gentle laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>gnp gentle laxative rectal suppository 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp senna lax oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gnp womens gentle laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>laxative max str oral tablet 25 mg</i>	Preferred	
<i>qc chocolated laxative oral tablet chewable 15 mg</i>	Preferred	
<i>senna oral liquid 8.8 mg/5ml</i>	Preferred	
<i>senna oral syrup 8.8 mg/5ml</i>	Preferred	
<i>senna oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)
<i>senna-lax oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>senna-time oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm gentle laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<i>sm laxative maximum strength oral tablet 25 mg</i>	Preferred	
<i>sm laxative rectal suppository 10 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm senna laxative oral tablet 8.6 mg</i>	Preferred	QL (2 EA per 1 day)
<i>womens laxative oral tablet delayed release 5 mg</i>	Preferred	QL (3 EA per 1 day)
<b>*SURFACTANT LAXATIVES*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>docusate calcium oral capsule 240 mg</i>	Preferred	QL (2 EA per 1 day)
<i>docusate sodium oral capsule 100 mg, 250 mg</i>	Preferred	QL (6 EA per 1 day)
<i>docusate sodium oral liquid 100 mg/10ml, 50 mg/5ml</i>	Preferred	QL (30 ML per 1 day)
<i>ft stool softener oral capsule 100 mg, 250 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft stool softener oral tablet 100 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp stool softener oral capsule 100 mg, 250 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp stool softener oral capsule 240 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gnp stool softener oral syrup 60 mg/15ml</i>	Preferred	QL (30 ML per 1 day)
<i>hm stool softener oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm docusate calcium oral capsule 240 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm stool softener oral capsule 100 mg, 250 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm stool softener oral tablet 100 mg</i>	Preferred	QL (6 EA per 1 day)
<i>stool softener laxative oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day)
<i>stool softener oral capsule 100 mg, 250 mg</i>	Preferred	QL (6 EA per 1 day)
<i>stool softener oral capsule 240 mg</i>	Preferred	QL (2 EA per 1 day)
DOCUSOL PLUS MINI-ENEMA RECTAL ENEMA 20-283 MG ( <i>benzocaine-docusate sodium</i> )	Preferred	
DOK ORAL TABLET 100 MG ( <i>docusate sodium</i> )	Preferred	QL (6 EA per 1 day)
ENEMEEZ PLUS RECTAL ENEMA 20-283 MG ( <i>benzocaine-docusate sodium</i> )	Preferred	
PEDIA-LAX ORAL LIQUID 50 MG/15ML ( <i>docusate sodium</i> )	Preferred	QL (30 ML per 1 day)
<b>*LINCOSAMIDES*** - DRUGS FOR INFECTIONS</b>		
<b>*ANTI-INFECTIVE AGENTS - MISC.* - ANTIBIOTICS</b>		
<i>clindamycin palmitate hcl solution reconstituted 75 mg/5ml oral</i>	Preferred	
<b>*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<b>*DERMATOLOGICALS* - DRUGS FOR THE SKIN</b>		
<i>lidocaine hcl solution 4 % external</i>	Preferred	
<b>*MACROLIDES* - DRUGS FOR INFECTIONS</b>		
<b>*AZITHROMYCIN*** - ANTIBIOTICS</b>		
<i>azithromycin packet 1 gm oral</i>	Preferred	QL (1 EA per 1 day)
<i>azithromycin suspension reconstituted 100 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>azithromycin suspension reconstituted 200 mg/5ml oral</i>	Preferred	QL (30 ML per 1 day)
<i>azithromycin tablet 250 mg oral</i>	Preferred	
<i>azithromycin tablet 500 mg oral</i>	Preferred	
<i>azithromycin tablet 600 mg oral</i>	Preferred	QL (1 EA per 1 day)
ZITHROMAX PACKET 1 GM ORAL ( <i>azithromycin</i> )	Preferred	QL (1 EA per 1 day)
ZITHROMAX SUSPENSION RECONSTITUTED 100 MG/5ML ORAL ( <i>azithromycin</i> )	Non Preferred	PA; QL (20 ML per 1 day)
ZITHROMAX SUSPENSION RECONSTITUTED 200 MG/5ML ORAL ( <i>azithromycin</i> )	Non Preferred	PA; QL (30 ML per 1 day)
ZITHROMAX TABLET 250 MG ORAL ( <i>azithromycin</i> )	Non Preferred	PA
ZITHROMAX TABLET 500 MG ORAL ( <i>azithromycin</i> )	Non Preferred	PA
ZITHROMAX TRI-PAK TABLET 500 MG ORAL ( <i>azithromycin</i> )	Non Preferred	PA
ZITHROMAX Z-PAK TABLET 250 MG ORAL ( <i>azithromycin</i> )	Non Preferred	PA
<b>*CLARITHROMYCIN*** - ANTIBIOTICS</b>		
<i>clarithromycin er tablet extended release 24 hour 500 mg oral</i>	Preferred	
<i>clarithromycin suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>clarithromycin suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>clarithromycin tablet 250 mg oral</i>	Preferred	
<i>clarithromycin tablet 500 mg oral</i>	Preferred	
<b>*ERYTHROMYCINS*** - ANTIBIOTICS</b>		
<i>erythromycin base capsule delayed release particles 250 mg oral</i>	Preferred	
<i>erythromycin base tablet 250 mg oral</i>	Preferred	
<i>erythromycin base tablet 500 mg oral</i>	Preferred	
<i>erythromycin base tablet delayed release 250 mg oral</i>	Preferred	
<i>erythromycin base tablet delayed release 333 mg oral</i>	Preferred	
<i>erythromycin base tablet delayed release 500 mg oral</i>	Preferred	
<i>erythromycin ethylsuccinate suspension reconstituted 200 mg/5ml oral</i>	Preferred	
<i>erythromycin ethylsuccinate suspension reconstituted 400 mg/5ml oral</i>	Preferred	
<i>erythromycin ethylsuccinate tablet 400 mg oral</i>	Preferred	
<i>erythromycin tablet delayed release 250 mg oral</i>	Preferred	
<i>erythromycin tablet delayed release 333 mg oral</i>	Preferred	
<i>erythromycin tablet delayed release 500 mg oral</i>	Preferred	
E.E.S. 400 TABLET 400 MG ORAL ( <i>erythromycin ethylsuccinate</i> )	Preferred	
E.E.S. GRANULES SUSPENSION RECONSTITUTED 200 MG/5ML ORAL ( <i>erythromycin ethylsuccinate</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ERYPED 200 SUSPENSION RECONSTITUTED 200 MG/5ML ORAL ( <i>erythromycin ethylsuccinate</i> )	Preferred	
ERYPED 400 SUSPENSION RECONSTITUTED 400 MG/5ML ORAL ( <i>erythromycin ethylsuccinate</i> )	Preferred	
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 250 Mg Oral)	Preferred	
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 333 Mg Oral)	Preferred	
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 500 Mg Oral)	Preferred	
ERYTHROCIN STEARATE TABLET 250 MG ORAL ( <i>erythromycin stearate</i> )	Preferred	
<b>*FIDAXOMICIN*** - ANTIBIOTICS</b>		
DIFICID SUSPENSION RECONSTITUTED 40 MG/ML ORAL ( <i>fidaxomicin</i> )	Preferred	
DIFICID TABLET 200 MG ORAL ( <i>fidaxomicin</i> )	Preferred	
<b>*MEDICAL DEVICES AND SUPPLIES* - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<b>*APPLICATORS,COTTON BALLS,ETC*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>alcohol pads pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>alcohol prep pad , 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>alcohol prep pads pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>alcohol swabs pad , 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>alcoh-wipe sheet</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>cvs alcohol prep pads pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>cvs prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>easy comfort alcohol pads pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>eql alcohol swabs pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>essentra wipes 9x9" sheet 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>global alcohol prep ease pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>gnp alcohol swabs pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>h-e-b incontrol alcohol pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill

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<i>hm sterile alcohol prep pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>meijer alcohol swabs pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>pro comfort alcohol pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>pure comfort alcohol prep pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>qc alcohol swabs pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>ra alcohol swabs pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>reality swabs pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>saps care alcohol prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>saps health alcohol prep pad , 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>saps health care alcohol prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>sb alcohol prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>sm alcohol prep pad , 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>sure comfort alcohol prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>true comfort alcohol prep pads pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>true comfort pro alcohol prep pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>ultilet alcohol swabs pad</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>ultra-care alcohol prep pads pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<i>zevrx sterile alcohol prep pad pad 70 %</i>	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
ADVOCATE ALCOHOL PREP PADS PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
ALCOH-GLOVE CONTOURED WIPE PAD ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
ALCOHOL SWABSTICK PAD ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
BD SWAB SINGLE USE REGULAR PAD ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
CARETOUCH ALCOHOL PREP PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill

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COMFORT TOUCH ALCOHOL PREP PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
CURITY ALCOHOL PREPS PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
DROPSAFE ALCOHOL PREP PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
FIFTY50 ALCOHOL PREP PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
PHARMACIST CHOICE ALCOHOL PAD ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
RELION ALCOHOL SWABS PAD , 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
ULTICARE ALCOHOL SWABS PAD , 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
WEBCOL ALCOHOL PREP LARGE PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
WEBCOL ALCOHOL PREP MEDIUM PAD 70 % ( <i>alcohol swabs</i> )	Preferred	QL (8 EA per 1 day); Max 100-day supply per fill
<b>*CERVICAL CAPS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
FEMCAP VAGINAL DEVICE 30 MM ( <i>cervical caps</i> )	Preferred	
<b>*CONDOMS - FEMALE*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
FC2 FEMALE CONDOM ( <i>condoms - female</i> )	Preferred	
<b>*CONDOMS - MALE*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>aimsco lubricated</i>	Preferred	QL (12 EA per 1 Fill)
<i>condoms</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono micro thin</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono micro thin plus</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono plus</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono ps</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono ps plus</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono sensation</i>	Preferred	QL (12 EA per 1 Fill)
<i>kimono sensation plus</i>	Preferred	QL (12 EA per 1 Fill)
<i>maxx</i>	Preferred	QL (12 EA per 1 Fill)
<i>maxx plus</i>	Preferred	QL (12 EA per 1 Fill)
<i>premium condoms lubricated</i>	Preferred	QL (12 EA per 1 Fill)
DUREX EXTRA SENSITIVE THIN DEVICE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
FANTASY LUBRICATED ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
FANTASY LUBRICATED/SPERMICIDE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
KAMELEON LUBRICATED ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
KIMONO COLORS DEVICE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
KIMONO MAXX-LARGE FLARE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
KIMONO SPECIAL DEVICE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
REALITY LATEX CONDOMS ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
REALITY LATEX/ULTRA TEXTURED DEVICE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
REALITY LATEX/ULTRA THIN DEVICE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX COLOR CONDOMS + LUBE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUB/RIBBED/STUDED ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUB/SPERMICIDE EX ST ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUB/SPERMICIDE XL ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUBRICATED ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUBRICATED EX LARGE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUBRICATED EXTRA ST ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX LUBRICATED/SPERMICIDE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX NATURAL CONDOMS + LUBE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX NON-LUBRICATED ( <i>condoms latex non-lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX RIA LUB/SPERMICIDE ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX RIA LUBRICATED ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX RIA NON-LUBRICATED ( <i>condoms latex non-lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
TRUSTEX-NONOXYNOL-9/RIB/STUD ( <i>condoms latex lubricated</i> )	Preferred	QL (12 EA per 1 Fill)
<b>*GLUCOSE MONITORING TEST SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>acti-lance 28g</i>	Preferred	Max 100-day supply per fill
<i>acti-lance lite lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>acti-lance special lancets 17g</i>	Preferred	Max 100-day supply per fill
<i>acti-lance universal 23g</i>	Preferred	Max 100-day supply per fill
<i>advanced mobile lancet</i>	Preferred	Max 100-day supply per fill
<i>aimsco twist lancets 32g</i>	Preferred	Max 100-day supply per fill
<i>assure comfort lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>aurora lancet super thin 30g</i>	Preferred	Max 100-day supply per fill
<i>aurora lancet thin 23g</i>	Preferred	Max 100-day supply per fill
<i>careone lancet thin 23g</i>	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>comfort assured lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>comfort assured lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets 21g</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets micro thin 33g</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets original</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets thin 26g</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets ultra thin 30g</i>	Preferred	Max 100-day supply per fill
<i>cvs lancets ultra-thin 30g</i>	Preferred	Max 100-day supply per fill
<i>cvs ultra thin lancets</i>	Preferred	Max 100-day supply per fill
<i>drug mart lancets thin 26g</i>	Preferred	Max 100-day supply per fill
<i>easy comfort lancets</i>	Preferred	Max 100-day supply per fill
<i>easy comfort lancets twist top</i>	Preferred	Max 100-day supply per fill
<i>eql color lancets 21g</i>	Preferred	Max 100-day supply per fill
<i>eql color lancets micro 33g</i>	Preferred	Max 100-day supply per fill
<i>eql super thin lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>eql thin lancets 26g</i>	Preferred	Max 100-day supply per fill
<i>global inject ease lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>global inject ease lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>gnp lancets 21g</i>	Preferred	Max 100-day supply per fill
<i>gnp lancets thin 26g</i>	Preferred	Max 100-day supply per fill
<i>gnp sterile lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>gnp sterile lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>gnp sterile lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>goodsense color lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>goodsense lancets 26g univ</i>	Preferred	Max 100-day supply per fill
<i>goodsense lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>goodsense lancets 30g univ</i>	Preferred	Max 100-day supply per fill
<i>goodsense lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>goodsense lancets 33g univ</i>	Preferred	Max 100-day supply per fill
<i>h-e-b incontrol lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>h-e-b incontrol lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>h-e-b incontrol lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>hy-vee thin lancets</i>	Preferred	Max 100-day supply per fill
<i>kinney lancets</i>	Preferred	Max 100-day supply per fill
<i>kinney thin lancets</i>	Preferred	Max 100-day supply per fill
<i>kroger lancets</i>	Preferred	Max 100-day supply per fill
<i>kroger lancets 21g</i>	Preferred	Max 100-day supply per fill
<i>kroger lancets micro thin 33g</i>	Preferred	Max 100-day supply per fill
<i>kroger lancets super thin</i>	Preferred	Max 100-day supply per fill
<i>kroger lancets thin</i>	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>croger lancets thin 26g</i>	Preferred	Max 100-day supply per fill
<i>croger lancets ultrathin 30g</i>	Preferred	Max 100-day supply per fill
<i>lancets</i>	Preferred	Max 100-day supply per fill
<i>lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>lancets micro thin 33g</i>	Preferred	Max 100-day supply per fill
<i>lancets super thin 28g</i>	Preferred	Max 100-day supply per fill
<i>lancets thin</i>	Preferred	Max 100-day supply per fill
<i>lancets ultra thin 30g</i>	Preferred	Max 100-day supply per fill
<i>lite touch lancets</i>	Preferred	Max 100-day supply per fill
<i>live better lancet super thin</i>	Preferred	Max 100-day supply per fill
<i>longs lancets standard</i>	Preferred	Max 100-day supply per fill
<i>longs lancets thin</i>	Preferred	Max 100-day supply per fill
<i>longs lancets ultra thin</i>	Preferred	Max 100-day supply per fill
<i>medichoice safety lancet</i>	Preferred	Max 100-day supply per fill
<i>medichoice safety lancet extra</i>	Preferred	Max 100-day supply per fill
<i>medichoice safety lancet norm</i>	Preferred	Max 100-day supply per fill
<i>pip lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>pip lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>preferred plus lancets colored</i>	Preferred	Max 100-day supply per fill
<i>preferred plus lancets thin</i>	Preferred	Max 100-day supply per fill
<i>pro comfort lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>pro comfort lancets 31g</i>	Preferred	Max 100-day supply per fill
<i>pro comfort safety lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>pure comfort lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>px lancets microthin 33g</i>	Preferred	Max 100-day supply per fill
<i>px lancets ultra thin 28g</i>	Preferred	Max 100-day supply per fill
<i>qc lancets super thin 30g</i>	Preferred	Max 100-day supply per fill
<i>qc lancets ultra thin</i>	Preferred	Max 100-day supply per fill
<i>qc unilet lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>qc unilet lancets micro thin</i>	Preferred	Max 100-day supply per fill
<i>reality lancets</i>	Preferred	Max 100-day supply per fill
<i>reality trigger lancets</i>	Preferred	Max 100-day supply per fill
<i>safety lancet 30g/pressure act</i>	Preferred	Max 100-day supply per fill
<i>safety lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>saps health plus lancets</i>	Preferred	Max 100-day supply per fill
<i>saps health twist top lancets</i>	Preferred	Max 100-day supply per fill
<i>saps twist top lancets</i>	Preferred	Max 100-day supply per fill
<i>saps care twist top lancets</i>	Preferred	Max 100-day supply per fill
<i>sb lancets thin</i>	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>sb lancets ultra thin</i>	Preferred	Max 100-day supply per fill
<i>select-lite device/lancets kit</i>	Preferred	Max 100-day supply per fill
<i>sm lancets 33g</i>	Preferred	Max 100-day supply per fill
<i>super thin lancets</i>	Preferred	Max 100-day supply per fill
<i>sure comfort lancets 18g</i>	Preferred	Max 100-day supply per fill
<i>sure comfort lancets 21g</i>	Preferred	Max 100-day supply per fill
<i>sure comfort lancets 23g</i>	Preferred	Max 100-day supply per fill
<i>sure comfort lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>sure comfort lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>tgt lancet micro thin 33g</i>	Preferred	Max 100-day supply per fill
<i>tgt lancet thin 26g</i>	Preferred	Max 100-day supply per fill
<i>tgt lancet ultra thin 30g</i>	Preferred	Max 100-day supply per fill
<i>todays health thin lancets 28g</i>	Preferred	Max 100-day supply per fill
<i>todays health thin lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>topcare lancets micro-thin 33g</i>	Preferred	Max 100-day supply per fill
<i>true comfort safety lancets</i>	Preferred	Max 100-day supply per fill
<i>true comfort twist top lancets</i>	Preferred	Max 100-day supply per fill
<i>twist top lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>ultra thin lancets 31g</i>	Preferred	Max 100-day supply per fill
<i>ultra-care lancets 30g</i>	Preferred	Max 100-day supply per fill
<i>value plus lancet standard 21g</i>	Preferred	Max 100-day supply per fill
<i>value plus lancets super thin</i>	Preferred	Max 100-day supply per fill
<i>value plus lancets thin 26g</i>	Preferred	Max 100-day supply per fill
<i>walgreens lancets micro thin</i>	Preferred	Max 100-day supply per fill
<i>walgreens lancets super thin</i>	Preferred	Max 100-day supply per fill
<i>zevrx twist top lancets 30g</i>	Preferred	Max 100-day supply per fill
ACCU-CHEK FASTCLIX LANCET KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
ACCU-CHEK FASTCLIX LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ACCU-CHEK SAFE-T PRO LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ACCU-CHEK SOFTCLIX LANCET DEV KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
ACCU-CHEK SOFTCLIX LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ADVOCATE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ADVOCATE LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ADVOCATE SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ADVOCATE SAFETY LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
AGAMATRIX ULTRA-THIN LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
AIMSCO TWIST LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
AQUALANCE LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE HAEMOLANCE PLUS HIGH ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE HAEMOLANCE PLUS LOW ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ASSURE HAEMOLANCE PLUS MICRO ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE HAEMOLANCE PLUS NORMAL ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE HAEMOLANCE PLUS PED ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE LANCE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE LANCE LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE LANCE PLUS SAFETY 25G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE LANCE PLUS SAFETY 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ASSURE LANCE SAFETY LANCET 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
AUTOLET II CLINISAFE KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
AUTOLET LITE CLINISAFE KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
AUTOLET LITE STARTER PACK KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
BD MICROTAINER LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CAREONE LANCET SUPER THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARESENS LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARESENS LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH SAFETY LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH TWIST LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH TWIST LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH TWIST LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CARETOUCH TWIST MC LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEANLET LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEVER CHEK LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEVER CHOICE COMFORT EZ ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEVER CHOICE LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEVER CHOICE LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
CLEVER CHOICE LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
COAGUCHEK LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
COMFORT TOUCH LANCETS 31G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
COMFORT TOUCH PLUS LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
COMFORT TOUCH PLUS LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DIATHRIVE LANCET ULTRA THIN 30 ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DIATHRIVE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DROPLET LANCETS ULTRA THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DROPLET PERSONAL LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DRUG MART ON-THE-GO LANCET 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DRUG MART UNILET LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DRUG MART UNILET LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
DRUG MART UNILET LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EASY TOUCH LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 28G/TWIST ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 30G/TWIST ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 32G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 32G/TWIST ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH LANCETS 33G/TWIST ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH SAFETY LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH SAFETY LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH SAFETY LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EASY TOUCH SAFETY LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EMBRACE LANCETS ULTRA THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EMBRACE PRESSURE ACTIVATED 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EMBRACE PRESSURE ACTIVATED 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
E-Z JECT LANCET MICRO-THIN 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
E-Z JECT LANCET SUPER THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
E-Z JECT LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
E-Z JECT LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
E-Z JECT LANCETS THIN 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EZ-LETS LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EZ-LETS LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EZ-LETS LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
EZ-LETS LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FIFTY50 SAFETY SEAL LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FIFTY50 UNILET LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FINGERSTIX LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FORA LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FREESTYLE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
FREESTYLE UNISTICK II LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GENTEEL BUTTERFLY TOUCH LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GENTEEL LANCING KIT (BLUE) KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
GENTLE-LET GP LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GENTLE-LET LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GLUCOCOM LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GLUCOCOM LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GLUCOCOM LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
GOJJI STERILE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
HAEMOLANCE LOW FLOW LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE PLUS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE PLUS HIGH FLOW ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE PLUS LOW FLOW ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE PLUS MAX FLOW ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HAEMOLANCE PLUS PEDIATRIC FLOW ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
HYPOLANCE AST LANCING KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
HY-VEE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
IN TOUCH STERILE LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
KROGER HEALTHPRO LANCET 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
LANCETS ULTRA THIN ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
LIBERTY MEDICAL LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
LITETOUCH LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEDLANCE PLUS EXTRA 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEDLANCE PLUS LITE 25G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEDLANCE PLUS SPECIAL 0.8MM ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEDLANCE PLUS SUPERLITE 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEDLANCE PLUS UNIVERSAL 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER LANCETS THIN ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER LANCETS UNIVERSAL 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER LANCETS UNIVERSAL 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER LANCETS UNIVERSAL 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MEIJER SUPER THIN LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MICROLET LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MM TWIST LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MONOLET LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MONOLET OPD LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MONOLETTOR SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
MULTI-LANCET DEVICE 2 KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
MYGLUCOHEALTH LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
NOVA SAFETY LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
NOVA SAFETY LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
NOVA SUREFLEX LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ONETOUCH DELICA PLUS LANCET30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ONETOUCH DELICA PLUS LANCET33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ONETOUCH ULTRASOFT 2 LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PERFECT LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PERFECT LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PHARMACIST CHOICE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PHARMACY COUNTER LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PRECISION THINS GP LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PRODIGY LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PRODIGY SAFETY LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PRODIGY TWIST TOP LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PSS SELECT GP LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
PSS SELECT SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RA E-ZJECT LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RA E-ZJECT LANCETS THIN 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RA E-ZJECT LANCETS THIN 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RA E-ZJECT LANCETS ULTRA THIN ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
READYLANCE SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RELION LANCETS MICRO-THIN 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RELION LANCETS THIN 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RELION LANCETS ULTRA-THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RELION LANCING DEVICE KIT ( <i>lancets misc.</i> )	Preferred	Max 100-day supply per fill
RELION ULTRA THIN LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RELION ULTRA THIN PLUS LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
REXALL LANCETS ULTRA THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
RIGHTTEST GL300 LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SAFE-T-LANCE ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SAFE-T-LANCE PLUS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SAFETY LANCETS 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SAFETY LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SINGLE-LET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SMART SENSE COLOR LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SMART SENSE STANDARD LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SMART SENSE SUPER THIN LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SMART SENSE THIN LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SMARTTEST LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SOLUS V2 LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SOLUS V2 TWIST LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
STERILANCE TL ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
SURELITE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TECHLITE AST LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TECHLITE LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TECHLITE LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TECHLITE LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
THINLETS GP LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
TRAVEL LANCETS ADVANCED 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TRUEPLUS LANCETS 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TRUEPLUS LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TRUEPLUS LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TRUEPLUS LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
TRUEPLUS SAFETY LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTILET CLASSIC LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTILET LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTILET SAFETY LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTILET SAFETY LANCETS 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTRA-THIN II AUTO LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
ULTRA-THIN II LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET COMFORTOUCH LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET EXCELITE ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET EXCELITE II ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET G.P. LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET G.P. SUPERLITE LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET GP 28 ULTRA THIN ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET MICRO-THIN 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET SUPERLITE LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET SUPER-THIN 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNILET ULTRA-THIN 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK 3 GENTLE ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK PRO SAFETY LANCET ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK SAFETY LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK SAFETY LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK TOUCH SAFETY LANC 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK TOUCH SAFETY LANC 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK TOUCH SAFETY LANC 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNISTIK TOUCH SAFETY LANC 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNIVERSAL 1 LANCETS THIN 26G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNIVERSAL 1 LANCETS THIN 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
UNIVERSAL 1 LANCETS ULTRA THIN ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE SAFE LANCET MINI 21G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE SAFE LANCET MINI 23G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE SAFE LANCET MINI 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE SAFE LANCET MINI 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE UNIVERSAL LANCETS 28G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VERIFINE UNIVERSAL LANCETS 30G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
VERIFINE UNIVERSAL LANCETS 33G ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
VIVAGUARD LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
WALGREENS LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
WALGREENS THIN LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
WALGREENS ULTRA THIN LANCETS ( <i>lancets</i> )	Preferred	Max 100-day supply per fill
<b>*MEDICAL WASTE DISPOSAL SYSTEMS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>bd sharps container home</i>	Preferred	
<i>cvs needle collection/disposal</i>	Preferred	
<i>easy comfort sharps container</i>	Preferred	
<i>sharps collector</i>	Preferred	
<i>sharps container</i>	Preferred	
<i>sharps disposal by mail system</i>	Preferred	
BD PHLEBOTOMY SHARPS COLLECTOR ( <i>sharps container</i> )	Preferred	
BD SHARPS COLLECTOR ( <i>sharps container</i> )	Preferred	
COMPLETE NEEDLE COLLECTION SYS ( <i>sharps container</i> )	Preferred	
MONOJECT SHARPS CONTAINER ( <i>sharps container</i> )	Preferred	
ULTILET SHARPS CONTAINER 1QT ( <i>sharps container</i> )	Preferred	
ULTILET SHARPS CONTAINER 2QT ( <i>sharps container</i> )	Preferred	
VERIFINE SHARPS CONTAINER ( <i>sharps container</i> )	Preferred	
<b>*NEEDLES &amp; SYRINGES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>carepoint poly hub needle 18g x 1-1/2"</i>	Preferred	
<i>carepoint syringe luer lock 3 ml</i>	Preferred	
<i>hypodermic needle 18g x 1-1/2"</i>	Preferred	
<i>poly hub needle 18g x 1-1/2"</i>	Preferred	
<i>syringe luer lock 21g x 1" 5 ml, 22g x 1" 10 ml, 22g x 1" 3 ml, 25g x 1" 3 ml, 25g x 5/8" 3 ml, 3 ml</i>	Preferred	
<i>syringe luer slip 3 ml</i>	Preferred	
BD BLUNT FILL NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD BLUNT FILTER NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD DISP NEEDLES 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD ECLIPSE NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD ECLIPSE SHIELDED NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD ECLIPSE SYRINGE 25G X 1" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
BD ECLIPSE SYRINGE/NEEDLE 22G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
BD HYPODERMIC NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD INTEGRA SYRINGE 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
BD LUER-LOK SYRINGE 20G X 1" 1 ML ( <i>syringe/needle (disp)</i> )	Preferred	QL (100 EA per 90 days)

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Drug Name	Formulary Status	Requirements/Limits
BD LUER-LOK SYRINGE 21G X 1" 5 ML, 22G X 1" 10 ML, 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
BD NOKOR ADMIX NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD PLASTIPAK SYRINGE 3 ML ( <i>syringe (disposable)</i> )	Preferred	
BD SAFETYGLIDE NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
BD SAFETYGLIDE SYRINGE/NEEDLE 25G X 1" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
BD SYRINGE LUER-LOK 3 ML ( <i>syringe (disposable)</i> )	Preferred	
BD SYRINGE SLIP TIP 3 ML ( <i>syringe (disposable)</i> )	Preferred	
BD SYRINGE/NEEDLE 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
CAREPOINT SAFETY1ST SYR/NEEDLE 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
CAREPOINT SYRINGE LUER LOCK 22G X 1" 3 ML, 25G X 1" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
CARETOUCH HYPODERMIC NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
CARETOUCH LUER LOCK 3 ML ( <i>syringe (disposable)</i> )	Preferred	
CARETOUCH LUER LOCK SYR/NEEDLE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
CARETOUCH LUER SLIP 3 ML ( <i>syringe (disposable)</i> )	Preferred	
EASY GLIDE LUER LOCK SYRINGE 3 ML ( <i>syringe (disposable)</i> )	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
EASY TOUCH FLIPLOCK SAFETY SYR 21G X 1" 5 ML, 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
EASY TOUCH SAFETY SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
EASYPOINT NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
EASYPOINT NEEDLE/SYRINGE 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
LUER LOCK SAFETY SYRINGES 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
LUER LOCK SAFETY SYRINGES 3 ML ( <i>syringe (disposable)</i> )	Preferred	
MONOJECT BLUNTIP SYR/CANNULA 3 ML ( <i>syringe (disposable)</i> )	Preferred	
MONOJECT HYPODERMIC NEEDLE 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
MONOJECT MAGELLAN SAFETY NDL 18G X 1-1/2" ( <i>needle (disp)</i> )	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MONOJECT PHARMACY TRAY 3 ML ( <i>syringe (disposable)</i> )	Preferred	
MONOJECT SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
MONOJECT SYRINGE 3 ML ( <i>syringe (disposable)</i> )	Preferred	
MONOJECT SYRINGE REG LUER 3 ML ( <i>syringe (disposable)</i> )	Preferred	
MONOJECT SYRINGE REGULAR TIP 3 ML ( <i>syringe (disposable)</i> )	Preferred	
SECURESAFE SYRINGE/NEEDLE 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
VANISHPOINT SAFETY SYRINGE 21G X 1" 5 ML, 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
VANISHPOINT SYRINGE 22G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	Preferred	
<b>*PEAK FLOW METERS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>breathe ease peak flow meter device</i>	Preferred	
<i>lung perform peak flow meter device</i>	Preferred	
<i>peak a-i-r flow meter device</i>	Preferred	
<i>peak flow meter universal rang device</i>	Preferred	
<i>pure comfort flow meter adult device</i>	Preferred	
<i>pure comfort flow meter child device</i>	Preferred	
AIRZONE PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
ASSESS PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
CLEVER CHOICE PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
MICROLIFE DIGITAL PEAK FLOW DEVICE ( <i>peak flow meter</i> )	Preferred	
MINI WRIGHT PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
PEAK AIR PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
PERSONAL BEST FULL RANGE DEVICE ( <i>peak flow meter</i> )	Preferred	
PIKO 1 DEVICE ( <i>peak flow meter</i> )	Preferred	
POCKET PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
POCKETPEAK PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	Preferred	
<b>*RESPIRATORY THERAPY SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>adult aerosol mask</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>adult mask device</i>	Preferred	
<i>adult mask large</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>breathe ease neb mask/child</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>breathe ease neb mask/infant</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>co monitor device</i>	Preferred	

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>co monitor replacement pieces</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>filter air pp</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>full kit nebulizer set</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>nebulizer air tube/plugs</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>nebulizer cup/tubing device</i>	Preferred	
<i>nebulizer mask adult</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>nebulizer mask child</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>nose clip</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pediatric mouthpiece</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pharmacist choice mask wipes</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pillow mask/adult</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pillow mask/child</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pillow mask/pediatric</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>pure comfort 3-ball breathe ex device</i>	Preferred	
<i>replacement air filter</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>replacement filters</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>silicone mask/adult</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>silicone mask/infant</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>silicone mask/pediatric</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>sootheneb nbl 100 adult mask</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>sootheneb nbl 100 child mask</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>sootheneb nbl 100 med cup</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>sootheneb nbl 100 mesh cap</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>spiro pd device</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>tubing/wing tip</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<i>ultra neb accessories kit</i>	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
ACE AEROSOL CLOUD ENHANCER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
ACTIVITY POUCH ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AEROBIKA DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
AEROECLIPSE EZ TWIST TUBING ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AEROECLIPSE MASK LARGE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AEROECLIPSE MASK MEDIUM ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AEROECLIPSE MASK SMALL ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AEROTRACH PLUS ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
AIRS PEDIATRIC AEROSOL MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
ALL FLOW 1000 PFT FILTER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
ALL FLOW 1000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 2000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 3000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 4000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 5000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 6000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ALL FLOW 7000 PFT FILTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
BUBBLES THE FISH II PEDI MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
CARETOUCH 2 CPAP HOSE HANGER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
CARETOUCH CPAP & BIPAP HOSE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
CARETOUCH CPAP MASK WIPES ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
CARETOUCH CPAP PRE-WASH SOLN ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 ML per 365 days); Max 365-day supply per fill
CARETOUCH CPAP TUBE BRUSH ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
CARETOUCH UNIVERSL CPAP FILTER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
EASY FLOW 300 MM HOSE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
EASY FLOW 400 MM HOSE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
EASY FLOW AIR NOZZLE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
EASY FLOW BLACK/BLUE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW BLACK/ORANGE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW BLACK/RED DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW BLACK/WHITE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW BLACK/YELLOW DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW HEPA FILTER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
EASY FLOW WHITE/BLUE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW WHITE/GREEN DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW WHITE/PINK DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW WHITE/WHITE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EASY FLOW WHITE/YELLOW DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
EBASE CONTROLLER KIT ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
FLYP HYPERSONIQ CARTRIDGE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
IN-CHECK DIAL FLOW TRAINER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
IN-CHECK INSPIRATORY FLOW MTR DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
INNOSPIRE REPLACEMENT FILTER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
LITETOUCH MASK LARGE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
LITETOUCH MASK MEDIUM ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
LITETOUCH MASK SMALL ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
MINIELITE FILTER REPLACEMENTS ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
OMBRA COMPRESSOR AIR FILTERS ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
OMBRA TABLE TOP COMPRESSOR DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
ONE FLOW SPIROMETER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
PARI ALTERA NEBULIZER HANDSET ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI BABY CONVERSION KIT ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI ERAPID NEBULIZER HANDSET ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI EXPIRATORY FILTER SET DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI MANUAL INTERRUPTER DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
PARI MASK SET ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI SMARTMASK BABY/ELBOW ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI SOFT PLASTIC ADULT MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI SOFT PLASTIC PED MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI TREK S COMBO PACK DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
PFLEX ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PRONEB ULTRA FILTER SET ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
QUAKE DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
REUSABLE COMFORTSEAL MASK-LRG ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
REUSABLE COMFORTSEAL MASK-MED ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
REUSABLE COMFORTSEAL MASK-SML ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
SAMI THE SEAL FILTERS ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
SIDESTREAM ADULT FACE MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
SIDESTREAM PEDIATRIC FACE MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
SIDESTREAM PLS ADULT FACE MASK ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
THRESHOLD IMT ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
THRESHOLD PEP DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
VERSAPAP DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
VERSAPAP W/UNIVERSAL TUBING DEVICE ( <i>respiratory therapy supplies</i> )	Preferred	
WINDMILL TRAINER ( <i>respiratory therapy supplies</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
<b>*SPACER/AEROSOL-HOLDING CHAMBERS &amp; SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>breathe comfort chamber/adult device</i>	Preferred	QL (1 EA per 365 days)
<i>breathe comfort chamber/child device</i>	Preferred	QL (1 EA per 365 days)
<i>breathe ease large device</i>	Preferred	QL (1 EA per 365 days)
<i>breathe ease medium device</i>	Preferred	QL (1 EA per 365 days)
<i>breathe ease small device</i>	Preferred	QL (1 EA per 365 days)
<i>eq space chamber anti-static device</i>	Preferred	QL (1 EA per 365 days)
<i>eq space chamber anti-static l device</i>	Preferred	QL (1 EA per 365 days)
<i>eq space chamber anti-static m device</i>	Preferred	QL (1 EA per 365 days)
<i>eq space chamber anti-static s device</i>	Preferred	QL (1 EA per 365 days)
<i>pro comfort spacer adult</i>	Preferred	QL (1 EA per 365 days)
<i>pro comfort spacer child</i>	Preferred	QL (1 EA per 365 days)
<i>pro comfort spacer infant device</i>	Preferred	QL (1 EA per 365 days)
<i>procare spacer/adult mask device</i>	Preferred	QL (1 EA per 365 days)
<i>procare spacer/child mask device</i>	Preferred	QL (1 EA per 365 days)
<i>prochamber vhc device</i>	Preferred	QL (1 EA per 365 days)
<i>pure comfort spacer chamber device</i>	Preferred	QL (1 EA per 365 days)
AEROCHAMBER HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER MINI CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER MV ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU INTERM DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU LARGE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
AEROCHAMBER PLUS FLO-VU LARGE DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU MEDIUM ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER PLUS FLOW VU ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER W/FLOWSIGNAL ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER Z-STAT PLUS ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER Z-STAT PLUS CHAMBR ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER Z-STAT PLUS/LARGE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER Z-STAT PLUS/MEDIUM ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROCHAMBER Z-STAT PLUS/SMALL ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
AEROVENT PLUS DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
BREATHERITE VALVED MDI CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
CLEVER CHOICE HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
COMPACT SPACE CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
COMPACT SPACE CHAMBER/LG MASK DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
COMPACT SPACE CHAMBER/MED MASK DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
COMPACT SPACE CHAMBER/SM MASK DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
EASIVENT ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
EASIVENT MASK LARGE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
EASIVENT MASK MEDIUM ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
EASIVENT MASK SMALL ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
FLEXICHAMBER ADULT MASK/SMALL ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
FLEXICHAMBER CHILD MASK/LARGE ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
FLEXICHAMBER CHILD MASK/SMALL ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
FLEXICHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
INSPIREASE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
MASK VORTEX/CHILD/FROG ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
MASK VORTEX/TODDLER/LADYBUG ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
MICROCHAMBER ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
MICROCHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
MICROSPACER ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
OPTICHAMBER DIAMOND ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
OPTICHAMBER DIAMOND DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
OPTICHAMBER DIAMOND-LG MASK DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
OPTICHAMBER DIAMOND-MD MASK ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
OPTICHAMBER DIAMOND-SM MASK ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
PANDA MASK LARGE ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PANDA MASK MEDIUM ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PANDA MASK SMALL ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PARI VORTEX ADULT MASK ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
PEDIATRIC PANDA MASK ( <i>spacer/aero-hold chamber mask</i> )	Preferred	QL (1 EA per 365 days); Max 365-day supply per fill
POCKET CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
POCKET SPACER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
RITEFLO DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
VORTEX HOLD CHMBR/MASK/CHILD DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
VORTEX HOLD CHMBR/MASK/TODDLER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
VORTEX VALVED HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	Preferred	QL (1 EA per 365 days)
<b>GLUCOSE MONITORING SUPPLIES : CGMS - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
DEXCOM G6 RECEIVER DEVICE ( <i>continuous glucose receiver</i> )	Preferred	PA
DEXCOM G6 SENSOR ( <i>continuous glucose sensor</i> )	Preferred	PA
DEXCOM G6 TRANSMITTER ( <i>continuous glucose transmitter</i> )	Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
DEXCOM G7 RECEIVER DEVICE ( <i>continuous glucose receiver</i> )	Preferred	PA
DEXCOM G7 SENSOR ( <i>continuous glucose sensor</i> )	Preferred	PA
FREESTYLE LIBRE 14 DAY READER DEVICE ( <i>continuous glucose receiver</i> )	Preferred	PA
FREESTYLE LIBRE 14 DAY SENSOR ( <i>continuous glucose sensor</i> )	Preferred	PA
FREESTYLE LIBRE 2 READER DEVICE ( <i>continuous glucose receiver</i> )	Preferred	PA
FREESTYLE LIBRE 2 SENSOR ( <i>continuous glucose sensor</i> )	Preferred	PA
FREESTYLE LIBRE 3 READER DEVICE ( <i>continuous glucose receiver</i> )	Preferred	PA
FREESTYLE LIBRE 3 SENSOR ( <i>continuous glucose sensor</i> )	Preferred	PA
<i>guardian sensor 3</i>	Non Preferred	PA
<i>oval tape</i>	Non Preferred	PA
<i>transmitter tape</i>	Non Preferred	PA
CGMS REPLACEMENT CABLE ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
CGMS SOFTWARE ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
DEXCOM G4 PLAT PED RCV/SHARE DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
DEXCOM G4 PLAT PED RECEIVER DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
DEXCOM G4 PLATINUM RCV/SHARE DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
DEXCOM G4 PLATINUM RECEIVER DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
DEXCOM G4 PLATINUM TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
DEXCOM G4 SENSOR ( <i>continuous glucose sensor</i> )	Non Preferred	PA
DEXCOM G5 MOB/G4 PLAT SENSOR ( <i>continuous glucose sensor</i> )	Non Preferred	PA
DEXCOM G5 MOBILE RECEIVER DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
DEXCOM G5 MOBILE TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
DEXCOM G5 RECEIVER KIT DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
ENLITE GLUCOSE SENSOR ( <i>continuous glucose sensor</i> )	Non Preferred	PA
EVERSENSE E3 SENSOR/HOLDER ( <i>continuous glucose sensor</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EVERSENSE E3 SMART TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
EVERSENSE SENSOR/HOLDER ( <i>continuous glucose sensor</i> )	Non Preferred	PA
EVERSENSE SMART TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
FREESTYLE LIBRE READER DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
FREESTYLE LIBRE SENSOR SYSTEM ( <i>continuous glucose sensor</i> )	Non Preferred	PA
GUARDIAN 4 GLUCOSE SENSOR ( <i>continuous glucose sensor</i> )	Non Preferred	PA
GUARDIAN 4 TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
GUARDIAN CONNECT TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
GUARDIAN LINK 3 TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
GUARDIAN REAL-TIME CHARGER ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN REAL-TIME REPLACE PED DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
GUARDIAN REAL-TIME REPLACEMENT DEVICE ( <i>continuous glucose receiver</i> )	Non Preferred	PA
GUARDIAN REAL-TIME STARTER KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN REAL-TIME SYSTEM KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN REAL-TIME SYSTEM PED KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN REAL-TIME TEST PLUG ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN RT SOFTWARE ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN RT STARTER KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN RT SYSTEM KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
GUARDIAN SENSOR (3) ( <i>continuous glucose sensor</i> )	Non Preferred	PA
GUARDIAN TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
MINILINK REAL-TIME TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
MINIMED 630G GUARDIAN PRESS ( <i>continuous glucose transmitter</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PARADIGM REAL-TIME STARTER KIT ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
PARADIGM REAL-TIME TRANSMITTER ( <i>continuous glucose transmitter</i> )	Non Preferred	PA
SOF-SENSOR ( <i>continuous glucose sensor</i> )	Non Preferred	PA
TEST PLUG ( <i>continuous glucose monitor sup</i> )	Non Preferred	PA
<b>GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
ONETOUCH ULTRA 2 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Preferred	QL (1 EA per 365 days)
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Preferred	QL (1 EA per 365 days)
<i>blood glucose monitor system kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>blood glucose monitoring 333 device</i>	Non Preferred	PA
<i>blood glucose system pak kit</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>diabetes monitor digit add-on kit</i>	Non Preferred	PA
<i>diabetes monitor digit soln kit</i>	Non Preferred	PA
<i>diatrue plus blood glucose device</i>	Non Preferred	PA
<i>easy plus ii glucose system device</i>	Non Preferred	PA
<i>easy talk blood glucose system device</i>	Non Preferred	PA
<i>easy trak blood glucose system device</i>	Non Preferred	PA
<i>easy trak ii blood glucose sys device</i>	Non Preferred	PA
<i>element compact glucose system device</i>	Non Preferred	PA
<i>element compact v glucose sys device</i>	Non Preferred	PA
<i>ge100 blood glucose system device</i>	Non Preferred	PA
<i>ge100 blood glucose system kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>ght blood glucose monitor kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>goodsense blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>kroger blood glucose kit</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>kroger blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>kroger premium blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>ldr blood glucose truetest kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>liberty blood glucose meter device</i>	Non Preferred	PA
<i>meijer blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>meijer essential blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>meijer premium blood glucose kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>one drop blood glucose monitor kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>pro voice v8 glucose system device</i>	Non Preferred	PA
<i>pro voice v9 glucose system device</i>	Non Preferred	PA
<i>tgt blood glucose monitoring kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
<i>verasens blood glucose meter device</i>	Non Preferred	PA
<i>verasens blood glucose system kit w/device</i>	Non Preferred	PA; QL (1 EA per 365 days)
ACCU-CHEK AVIVA PLUS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ACCU-CHEK GUIDE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ACCU-CHEK GUIDE ME KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ADVANCE INTUITION METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ADVANCE INTUITION MONITOR KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ADVANCE MICRO-DRAW METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ADVOCATE BLOOD GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ADVOCATE BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ADVOCATE REDI-CODE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ADVOCATE REDI-CODE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ADVOCATE REDI-CODE+ DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ADVOCATE REDI-CODE+ TALKING KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
AGAMATRIX AMP DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
AGAMATRIX JAZZ WIRELESS 2 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
AGAMATRIX PRESTO KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
AGAMATRIX PRESTO PRO METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ASSURE 3 METER KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ASSURE 4 METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ASSURE PLATINUM METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ASSURE PRISM MULTI METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ASSURE PRO BLOOD GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
BAYER CONTOUR LINK 2.4 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BD LATITUDE DIABETES KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BD LATITUDE DIABETES SYSTEM KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BD LOGIC BLOOD GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BIGFOOT UNITY PROGRAM KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
BIOTEL CARE BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BIOTEL CARE BLOOD GLUCOSE SYST KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
BLULINK GLUCOSE MONITORING SYS DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CAREONE BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CARESENS N FELIZ BT DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
CARESENS N FELIZ DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CARESENS N GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CARESENS N VOICE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CARETOUCH MONITOR SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CLEVER CHEK AUTO-CODE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CLEVER CHEK AUTO-CODE VOICE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CLEVER CHEK SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CLEVER CHOICE AUTO-CODE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CLEVER CHOICE MICRO SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CLEVER CHOICE MINI SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CLEVER CHOICE TALK SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CONTOUR BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CONTOUR MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CONTOUR NEXT EZ KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CONTOUR NEXT GEN MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CONTOUR NEXT GEN MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CONTOUR NEXT LINK KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CONTOUR NEXT MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CONTOUR NEXT ONE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
CONTOUR NEXT ONE KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
COOL MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
COOL MONITOR KIT KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
CVS BLOOD GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
D-CARE GLUCOMETER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
DIATHRIVE BLOOD GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
DIATHRIVE+ GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EASY STEP GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EASY TOUCH GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EASY TOUCH HEALTHPRO GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EASYGLUCO KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EASYMAX NG BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EASYMAX NG BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EASYMAX V BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EASYPRO BLOOD GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EASYPRO PLUS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ELEMENT AUTOCODE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ELEMENT PLUS DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE BLOOD GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE EVO GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE EVO GLUCOSE MONITORING KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EMBRACE PRO GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE TALK BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE TALK MONITORING SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
EMBRACE WAVE BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EMBRACE WAVE GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EVENCARE G2 MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EVENCARE G3 MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EVENCARE GLUCOSE MONITORING KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EVENCARE MINI MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
EVOLUTION AUTOCODE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FIFTY50 GLUCOSE METER 2.0 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FORA G20 BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FORA G30A BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA GD20 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA GD50 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA GTEL BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA PREMIUM V10 BLE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA TEST N' GO MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA TN'G VOICE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FORA V10 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA V10/V12/D10/D20 TEST KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA V12 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA V20 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA V30A BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORA V30A BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FORACARE GD40 MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORACARE PREMIUM V10 DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORACARE TEST N GO MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FORTISCARE T1 GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
FREESTYLE FREEDOM KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FREESTYLE FREEDOM LITE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FREESTYLE INSULINX SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LITE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
FREESTYLE LITE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FREESTYLE PRECISION NEO SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
FREESTYLE SIDEKICK II KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCO PERFECT 3 METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
GLUCOCARD 01 BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
GLUCOCARD 01 BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD 01-MINI GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD EXPRESSION MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD SHINE CONNEX KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD SHINE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
GLUCOCARD SHINE EXPRESS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD SHINE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD SHINE XL DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
GLUCOCARD VITAL MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCARD X-METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCOCOM BLOOD GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
GLUCOCOM MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GLUCONAVII BLOOD GLUCOSE SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GNP EASY TOUCH GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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GNP TRUE METRIX AIR METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
GNP TRUE METRIX GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
HEALTHPRO BLOOD GLUCOSE MONITO KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
HM EMBRACE TALK SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
HW EMBRACE PRO GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
HW EMBRACE TALK BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
IGLUCOSE MONITORING SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
IN TOUCH DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
INFINITY BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
INFINITY VOICE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
LIBERTY NXT GENERATION MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
MEIJER TRUE2GO BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
MEIJER TRUERESULT GLUCOSE SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
MEIJER TRUETRACK GLUCOSE SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
MICRODOT BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
MM EASY TOUCH GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
MYGLUCOHEALTH BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
NOVA MAX BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
NOVA MAX BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ON CALL EXPRESS GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ON CALL EXPRESS MONITORING SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ON CALL PLUS METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ON CALL PLUS METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ON CALL PLUS MONITORING SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ON CALL VIVID GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ON CALL VIVID METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ON CALL VIVID MONITORING KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ON CALL VIVID PAL METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ON CALL VIVID PAL METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH SOLUTIONS STARTER KIT KIT W/ WELL DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ONETOUCH ULTRA 2 KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH ULTRA MINI KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH ULTRALINK KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH VERIO FLEX SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH VERIO IQ SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH VERIO KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH VERIO REFLECT KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ONETOUCH VERIO SYNC SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
OPTIUM BLOOD GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
OPTIUM GLUCOSE MONITOR SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
OPTUMRX BLOOD GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
OPTUMRX BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PARADIGM LINK GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PHARMACIST CHOICE AUTOCODE SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PHARMACIST CHOICE MINI SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PIP BLOOD GLUCOSE MONITORING DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
POCKETCHEM EZ SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
POGO AUTOMATIC BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRECISION LINK KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PRECISION QID MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRECISION SOF-TACT MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRECISION XTRA DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRECISION XTRA KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRECISION XTRA KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PRECISION XTRA MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRODIGY AUTOCODE BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
PRODIGY AUTOCODE BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PRODIGY NO CODING BLOOD GLUC KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PRODIGY POCKET BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
PRODIGY VOICE BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
QUICKTEK KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
QUICKTEK/METER KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
QUINTET AC BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
QUINTET BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
REFUAH PLUS MONITORING SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RELION ALL-IN-ONE DEVICE ( <i>blood gluc meter disp-strips</i> )	Non Preferred	PA
RELION CONFIRM GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RELION MICRO KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
RELION PREMIER BLU MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
RELION PREMIER CLASSIC DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
RELION PREMIER COMPACT SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RELION PREMIER VOICE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
RELION PRIME MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
RELION TRUE MET AIR GLUC METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RELION ULTIMA GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
REVEAL BLOOD GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
REXALL BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RIGHTEST GM100 BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RIGHTEST GM300 BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RIGHTEST GM550 BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
RIGHTEST GT333 BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SMART SENSE PREMIUM SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SMART SENSE VALUE GLUCOSE SYS KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SMARTEST EJECT DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SMARTEST EJECT STARTER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SMARTEST PERSONA STARTER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SMARTEST PRONTO STARTER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SMARTEST PROTEGE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SMARTEST PROTEGE STARTER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SOLUS V2 BLOOD GLUCOSE SYSTEM DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SOLUS V2 BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
SURE EDGE GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SURECHEK BLOOD GLUCOSE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
SURECHEK BLOOD GLUCOSE MONITOR KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
SURE-TEST EASYPLUS MINI METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TELCARE BLOOD GLUCOSE SYSTEM KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TEMPO REFILL KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TEMPO WELCOME KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUE FOCUS BLOOD GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TRUE METRIX AIR GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TRUE METRIX AIR GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUE METRIX GO GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUE METRIX METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TRUE METRIX METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUERESULT BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUETRACK BLOOD GLUCOSE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
TRUETRACK BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
TRUETRACK SMART SYSTEM KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ULTIMA KIT ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ULTRA TRAK PRO BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
ULTRATRAK ACTIVE DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ULTRATRAK PRO DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
ULTRATRAK ULTIMATE MONITOR DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
VIVAGUARD INO GLUCOSE METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
VIVAGUARD INO SMART GLUC METER DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
VOCAL POINT BLOOD GLUCOSE SYS DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA
WAVESENSE AMP KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	Non Preferred	PA; QL (1 EA per 365 days)
<b>GLUCOSE MONITORING SUPPLIES : INSULIN INFUSION DISPOSABLE PUMP - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
OMNIPOD 5 G6 INTRO (GEN 5) KIT ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD 5 G6 PODS (GEN 5) ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD 5 G7 INTRO (GEN 5) KIT ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD 5 G7 PODS (GEN 5) ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD CLASSIC PDM (GEN 3) KIT ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD CLASSIC PODS (GEN 3) ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD DASH INTRO (GEN 4) KIT ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD DASH PDM (GEN 4) KIT ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD DASH PODS (GEN 4) ( <i>insulin disposable pump</i> )	Preferred	PA
OMNIPOD GO KIT 10 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 15 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 20 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 25 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 30 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 35 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
OMNIPOD GO KIT 40 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
V-GO 20 KIT 20 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
V-GO 30 KIT 30 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
V-GO 40 KIT 40 UNIT/24HR ( <i>insulin disposable pump</i> )	Non Preferred	PA
<b>GLUCOSE MONITORING SUPPLIES : INSULIN PEN NEEDLES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Preferred	
TRUEPLUS PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Preferred	
<i>1st tier unifine pentips 29g x 12mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 31g x 6 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 31g x 8 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 32g x 6 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips 33g x 4 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 29g x 12mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 31g x 5 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 31g x 6 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 31g x 8 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 32g x 4 mm</i>	Non Preferred	PA
<i>1st tier unifine pentips plus 33g x 4 mm</i>	Non Preferred	PA
<i>aqinject pen needle 31g x 5 mm</i>	Non Preferred	PA
<i>aqinject pen needle 32g x 4 mm</i>	Non Preferred	PA
<i>aum insulin safety pen needle 31g x 4 mm</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>aum insulin safety pen needle 31g x 5 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 32g x 4 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 32g x 5 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 32g x 6 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 32g x 8 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 33g x 4 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 33g x 5 mm</i>	Non Preferred	PA
<i>aum mini insulin pen needle 33g x 6 mm</i>	Non Preferred	PA
<i>aum pen needle 32g x 4 mm</i>	Non Preferred	PA
<i>aum pen needle 32g x 5 mm</i>	Non Preferred	PA
<i>aum pen needle 32g x 6 mm</i>	Non Preferred	PA
<i>aum pen needle 33g x 4 mm</i>	Non Preferred	PA
<i>aum pen needle 33g x 5 mm</i>	Non Preferred	PA
<i>aum pen needle 33g x 6 mm</i>	Non Preferred	PA
<i>aurora pen needles 29g x 12mm</i>	Non Preferred	PA
<i>aurora pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>aurora pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>aurora unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>aurora unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>careone unifine pentips 29g x 12mm</i>	Non Preferred	PA
<i>careone unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>careone unifine pentips 31g x 6 mm</i>	Non Preferred	PA
<i>careone unifine pentips 31g x 8 mm</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>careone unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 29g x 12mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 31g x 5 mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 31g x 6 mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 31g x 8 mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 32g x 4 mm</i>	Non Preferred	PA
<i>careone unifine pentips plus 33g x 4 mm</i>	Non Preferred	PA
<i>clickfine pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>dropsafe safety pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>dropsafe safety pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>dropsafe safety pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>drug mart unifine pentips 29g x 12mm</i>	Non Preferred	PA
<i>drug mart unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>drug mart unifine pentips 31g x 6 mm</i>	Non Preferred	PA
<i>drug mart unifine pentips 31g x 8 mm</i>	Non Preferred	PA
<i>drug mart unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>drug mart unifine pentips plus 32g x 4 mm</i>	Non Preferred	PA
<i>easy comfort insulin syringe 31g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>easy comfort pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>easy comfort pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>easy comfort pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>easy comfort pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>easy comfort pen needles 33g x 4 mm</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>easy comfort pen needles 33g x 5 mm</i>	Non Preferred	PA
<i>easy comfort pen needles 33g x 6 mm</i>	Non Preferred	PA
<i>easy glide pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>freds pharmacy unifine pentip+ 31g x 5 mm</i>	Non Preferred	PA
<i>freds pharmacy unifine pentip+ 31g x 8 mm</i>	Non Preferred	PA
<i>freds pharmacy unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>global ease inject pen needles 29g x 12mm</i>	Non Preferred	PA
<i>global ease inject pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>global ease inject pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>global ease inject pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>global easy glide pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>gnp clickfine pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>gnp clickfine pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>gnp ulticare pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>gnp ulticare pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>gnp ulticare pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>gnp ulticare pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>goodsense clickfine pen needle 31g x 5 mm</i>	Non Preferred	PA
<i>healthwise micron pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>healthwise mini pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>healthwise pen needles 29g x 12mm</i>	Non Preferred	PA
<i>healthwise short pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>healthwise short pen needles 31g x 8 mm</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>healthwise unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>healthy accents unifine pentip 29g x 12mm</i>	Non Preferred	PA
<i>healthy accents unifine pentip 31g x 5 mm</i>	Non Preferred	PA
<i>healthy accents unifine pentip 31g x 6 mm</i>	Non Preferred	PA
<i>healthy accents unifine pentip 31g x 8 mm</i>	Non Preferred	PA
<i>healthy accents unifine pentip 32g x 4 mm</i>	Non Preferred	PA
<i>h-e-b incontrol pen needles 29g x 12mm</i>	Non Preferred	PA
<i>h-e-b incontrol pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>h-e-b incontrol pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>h-e-b incontrol pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>h-e-b incontrol pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>insupen pen needles 29g x 12mm</i>	Non Preferred	PA
<i>insupen pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>insupen pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>insupen pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>insupen pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>kroger pen needles 29g x 12mm</i>	Non Preferred	PA
<i>kroger pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>kroger pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>kroger pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>kroger pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>kroger pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>medicine shoppe pen needles 29g x 12mm</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>medicine shoppe pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>medicine shoppe pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>meijer pen needles 29g x 12mm</i>	Non Preferred	PA
<i>meijer pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>meijer pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>pc unifine pentips 29g x 12mm</i>	Non Preferred	PA
<i>pc unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>pc unifine pentips 31g x 6 mm</i>	Non Preferred	PA
<i>pc unifine pentips 31g x 8 mm</i>	Non Preferred	PA
<i>pen needles 1/2" 29g x 12mm</i>	Non Preferred	PA
<i>pen needles 29g x 12mm</i>	Non Preferred	PA
<i>pen needles 3/16" 31g x 5 mm</i>	Non Preferred	PA
<i>pen needles 30g x 5 mm (otc)</i>	Non Preferred	PA
<i>pen needles 30g x 5 mm (rx)</i>	Non Preferred	PA
<i>pen needles 30g x 8 mm</i>	Non Preferred	PA
<i>pen needles 31g x 5 mm (otc)</i>	Non Preferred	PA
<i>pen needles 31g x 5 mm (rx)</i>	Non Preferred	PA
<i>pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>pen needles 31g x 8 mm (otc)</i>	Non Preferred	PA
<i>pen needles 31g x 8 mm (rx)</i>	Non Preferred	PA
<i>pen needles 32g x 4 mm (otc)</i>	Non Preferred	PA
<i>pen needles 32g x 4 mm (rx)</i>	Non Preferred	PA
<i>pen needles 32g x 5 mm</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>pen needles 5/16" 30g x 8 mm</i>	Non Preferred	PA
<i>pen needles 5/16" 31g x 8 mm</i>	Non Preferred	PA
<i>pip pen needles 31g x 5mm 31g x 5 mm</i>	Non Preferred	PA
<i>pip pen needles 32g x 4mm 32g x 4 mm</i>	Non Preferred	PA
<i>preferred plus unifine pentips 29g x 12mm</i>	Non Preferred	PA
<i>preferred plus unifine pentips 31g x 5 mm</i>	Non Preferred	PA
<i>preferred plus unifine pentips 31g x 6 mm</i>	Non Preferred	PA
<i>preferred plus unifine pentips 31g x 8 mm</i>	Non Preferred	PA
<i>preferred plus unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>pro comfort pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>pro comfort pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>pro comfort pen needles 32g x 5 mm</i>	Non Preferred	PA
<i>pro comfort pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>pure comfort pen needle 32g x 4 mm</i>	Non Preferred	PA
<i>pure comfort pen needle 32g x 5 mm</i>	Non Preferred	PA
<i>pure comfort pen needle 32g x 6 mm</i>	Non Preferred	PA
<i>pure comfort pen needle 32g x 8 mm</i>	Non Preferred	PA
<i>pure comfort safety pen needle 31g x 5 mm</i>	Non Preferred	PA
<i>pure comfort safety pen needle 31g x 6 mm</i>	Non Preferred	PA
<i>pure comfort safety pen needle 32g x 4 mm</i>	Non Preferred	PA
<i>px extra short pen needles 31g x 6 mm</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>px mini pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>px pen needle 29g x 12mm</i>	Non Preferred	PA
<i>px pen needle 31g x 8 mm</i>	Non Preferred	PA
<i>px shortlength pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>qc pen needles 29g x 12mm</i>	Non Preferred	PA
<i>qc pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>qc pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>qc unifine pentips 32g x 4 mm</i>	Non Preferred	PA
<i>ra pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>ra pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>raya sure pen needle 29g x 12mm</i>	Non Preferred	PA
<i>raya sure pen needle 31g x 4 mm</i>	Non Preferred	PA
<i>raya sure pen needle 31g x 5 mm</i>	Non Preferred	PA
<i>raya sure pen needle 31g x 6 mm</i>	Non Preferred	PA
<i>raya sure pen needle 31g x 8 mm</i>	Non Preferred	PA
<i>safety pen needles 30g x 5 mm</i>	Non Preferred	PA
<i>safety pen needles 30g x 8 mm</i>	Non Preferred	PA
<i>sure comfort pen needles 29g x 12.7mm</i>	Non Preferred	PA
<i>sure comfort pen needles 30g x 8 mm</i>	Non Preferred	PA
<i>sure comfort pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>sure comfort pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>sure comfort pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>sure comfort pen needles 32g x 4 mm (otc)</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>sure comfort pen needles 32g x 4 mm (rx)</i>	Non Preferred	PA
<i>sure comfort pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>todays health mini pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>todays health pen needles 29g x 12mm</i>	Non Preferred	PA
<i>todays health short pen needle 31g x 8 mm</i>	Non Preferred	PA
<i>topcare clickfine pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>topcare clickfine pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>true comfort pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>true comfort pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>true comfort pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 32g x 4 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 32g x 5 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 33g x 5 mm</i>	Non Preferred	PA
<i>true comfort pro pen needles 33g x 6 mm</i>	Non Preferred	PA
<i>ultracare pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>ultracare pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>ultracare pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>ultracare pen needles 32g x 4 mm</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>ultracare pen needles 32g x 5 mm</i>	Non Preferred	PA
<i>ultracare pen needles 32g x 6 mm</i>	Non Preferred	PA
<i>ultracare pen needles 33g x 4 mm</i>	Non Preferred	PA
<i>valumark pen needles 29g x 12mm</i>	Non Preferred	PA
<i>valumark pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>valumark pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>wegmans unifine pentips plus 31g x 5 mm</i>	Non Preferred	PA
<i>wegmans unifine pentips plus 31g x 6 mm</i>	Non Preferred	PA
<i>wegmans unifine pentips plus 31g x 8 mm</i>	Non Preferred	PA
<i>wegmans unifine pentips plus 32g x 4 mm</i>	Non Preferred	PA
<i>zevrx pen needles 31g x 5 mm</i>	Non Preferred	PA
<i>zevrx pen needles 31g x 6 mm</i>	Non Preferred	PA
<i>zevrx pen needles 31g x 8 mm</i>	Non Preferred	PA
<i>zevrx pen needles 32g x 4 mm</i>	Non Preferred	PA
ABOUTTIME PEN NEEDLE 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ABOUTTIME PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ABOUTTIME PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ABOUTTIME PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ASSURE ID PRO PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ASSURE ID SAFETY PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ASSURE ID SAFETY PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
AUM SAFETY PEN NEEDLE 31G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
AUM SAFETY PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD AUTOSHIELD 29G X 5MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD AUTOSHIELD 29G X 8MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD AUTOSHIELD DUO 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE MICRO U/F 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE MINI U/F 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE NANO U/F 32G X 4 MM (OTC) ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE NANO U/F 32G X 4 MM (RX) ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
BD PEN NEEDLE SHORT U/F 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CAREFINE PEN NEEDLES 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
CAREFINE PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CARETOUCH PEN NEEDLES 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CLEVER CHOICE COMFORT EZ 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CLEVER CHOICE COMFORT EZ 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CLICKFINE PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CLICKFINE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
CLICKFINE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ MICRO PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 32G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 33G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
COMFORT EZ PEN NEEDLES 33G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PEN NEEDLES 33G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA; Max 150-day supply per fill
COMFORT EZ PRO PEN NEEDLES 31G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA; Max 150-day supply per fill
COMFORT EZ PRO PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA; Max 150-day supply per fill
COMFORT EZ SHORT PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 33G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
COMFORT TOUCH INSULIN PEN NEED 33G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DIATHRIVE PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DIATHRIVE PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DIATHRIVE PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DIATHRIVE PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET MICRON 34G X 3.5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 29G X 10MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
DROPLET PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
DROPLET PEN NEEDLES 32G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 30G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EMBRACE PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EMBRACE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EXEL COMFORT POINT PEN NEEDLE 31G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EXEL COMFORT POINT PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
EXEL COMFORT POINT PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
FIFTY50 PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
FIFTY50 PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
FIFTY50 PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
FIFTY50 PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GNP ULTIGUARD SAFEPACK NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GNP ULTIGUARD SAFEPACK NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GNP ULTIGUARD SAFEPACK NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GNP ULTIGUARD SAFEPACK NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GOODSENSE PEN NEEDLE PENFINE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GOODSENSE PEN NEEDLE PENFINE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GOODSENSE PEN NEEDLE PENFINE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
GOODSENSE PEN NEEDLE PENFINE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
H-E-B INCONTROL UNIFINE PENTIP 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
H-E-B INCONTROL UNIFINE PENTIP 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
H-E-B INCONTROL UNIFINE PENTIP 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
H-E-B INCONTROL UNIFINE PENTIP 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
HM ULTICARE MINI PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN SENSITIVE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN SENSITIVE 32G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN ULTRAFIN 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN ULTRAFIN 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN ULTRAFIN 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
INSUPEN ULTRAFIN 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LEADER UNIFINE PENTIPS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LEADER UNIFINE PENTIPS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LEADER UNIFINE PENTIPS PLUS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LEADER UNIFINE PENTIPS PLUS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LEADER UNIFINE PENTIPS PLUS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LITETOUCH PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LITETOUCH PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LITETOUCH PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
LITETOUCH PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
LITETOUCH PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MARATHON MEDICAL PENTIPS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MARATHON MEDICAL PENTIPS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MARATHON MEDICAL PENTIPS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MARATHON MEDICAL PENTIPS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MAXICOMFORT II PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MICRODOT PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MICRODOT PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MICRODOT PEN NEEDLE 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MM PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MM PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MM PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
MM PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
NOVOFINE PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
NOVOTWIST PEN NEEDLE 32G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 29G X 12MM (OTC) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 29G X 12MM (RX) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 31G X 5 MM (OTC) ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PENTIPS 31G X 5 MM (RX) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 31G X 8 MM (OTC) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 31G X 8 MM (RX) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 32G X 4 MM (OTC) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 32G X 4 MM (RX) ( <i>insulin pen needle</i> )	Non Preferred	PA
PENTIPS 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PREVENT SAFETY PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
PREVENT SAFETY PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION MINI PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
RELION SHORT PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS PLUS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
SHOPKO UNIFINE PENTIPS PLUS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS PLUS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SHOPKO UNIFINE PENTIPS PLUS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SURE-FINE PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SURE-FINE PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
SURE-FINE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 29G X 10MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PEN NEEDLES 32G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
TECHLITE PLUS PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MICRO PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MICRO PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MICRO PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MINI PEN NEEDLES 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MINI PEN NEEDLES 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE MINI PEN NEEDLES 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ULTICARE SHORT PEN NEEDLES 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTICARE SHORT PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTILET PEN NEEDLE 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTILET PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTILET PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTILET PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA FLO INSULIN PEN NEEDLES 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA THIN PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
ULTRA-THIN II PEN NEEDLES 29G X 12.7MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
UNIFINE PENTIPS 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PENTIPS PLUS 33G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PROTECT PEN NEEDLE 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE PROTECT PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE ULTRA PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE ULTRA PEN NEEDLE 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
UNIFINE ULTRA PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
UNIFINE ULTRA PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE INSULIN PEN NEEDLE 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE INSULIN PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE INSULIN PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE INSULIN PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE PLUS PEN NEEDLE 31G X 5 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE PLUS PEN NEEDLE 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VERIFINE PLUS PEN NEEDLE 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VIDA MIA UNIFINE PENTIPS 29G X 12MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VIDA MIA UNIFINE PENTIPS 31G X 6 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VIDA MIA UNIFINE PENTIPS 31G X 8 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
VIDA MIA UNIFINE PENTIPS 32G X 4 MM ( <i>insulin pen needle</i> )	Non Preferred	PA
<b>GLUCOSE MONITORING SUPPLIES : INSULIN SYRINGES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Preferred	
<i>aq insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>aq insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>aq insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>careone insulin syringe 30g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>careone insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>careone insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>careone insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>careone insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>careone insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 32g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>easy comfort insulin syringe 32g x 5/16" 1 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>elite-thin insulin syringe 28g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 28g x 5/16" 1 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 29g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 29g x 5/16" 1 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>elite-thin insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>eql insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>eql insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>eql insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>eql insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>eql insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>eql insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>eql insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>eql insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>eql insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>global easy glide insulin syr 31g x 15/64" 0.3 ml</i>	Non Preferred	PA
<i>global easy glide insulin syr 31g x 15/64" 0.5 ml</i>	Non Preferred	PA
<i>global easy glide insulin syr 31g x 15/64" 1 ml</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>global easy glide insulin syr 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>global inject ease insulin syr 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>global insulin syringes 30g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>global insulin syringes 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>gnp insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>gnp insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 28gx1/2" 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 29gx1/2" 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 29gx1/2" 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 30gx5/16" 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>gnp insulin syringes 31gx5/16" 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>gnp ultra com insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>healthwise insulin syr/needle 31g x 5/16" 1 ml</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe 29g x 1" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>insulin syringe/needle 27g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe/needle 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe/needle 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (rx)</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 1/4" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 1/4" 0.5 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 1/4" 1 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (rx)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (otc)</i>	Non Preferred	PA
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (rx)</i>	Non Preferred	PA
<i>kinray insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>kinray insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>kinray insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>kinray insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>kmart valu insulin syringe 29g u-100 0.5 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>kmart valu insulin syringe 29g u-100 1 ml</i>	Non Preferred	PA
<i>kmart valu insulin syringe 30g u-100 0.3 ml</i>	Non Preferred	PA
<i>kmart valu insulin syringe 30g u-100 0.5 ml</i>	Non Preferred	PA
<i>kmart valu insulin syringe 30g u-100 1 ml</i>	Non Preferred	PA
<i>croger insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>croger insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>croger insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>croger insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>croger insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>croger insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>croger insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>croger insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>croger insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>leader insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>leader insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>leader insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>leader insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>leader insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>leader insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>leader insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>leader insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>leader insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>leader insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>leader insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>longs insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>medic insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>medic insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>mm insulin syringe/needle 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>ms insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>ms insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>ms insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>preferred plus insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>px insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>ra insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>ra insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>ra insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>ra insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>reality insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>reality insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>reality insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>reality insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>safety insulin syringes 27g x 1/2" 1 ml</i>	Non Preferred	PA
<i>safety insulin syringes 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>safety insulin syringes 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>safety insulin syringes 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>safety insulin syringes 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>sb insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>sb insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>sb insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>sb insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>sb insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 28g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 28g x 1/2" 1 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 1/2" 0.3 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (otc)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (rx)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (otc)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (rx)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (otc)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (rx)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 1 ml (otc)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 30g x 5/16" 1 ml (rx)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 1/4" 0.3 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 1/4" 0.5 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 1/4" 1 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (otc)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (rx)</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>sure comfort insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 30g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>techlite insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 15/64" 0.3 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 15/64" 0.5 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 15/64" 1 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>techlite insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>topcare ultra comfort ins syr 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>true comfort insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>true comfort insulin syringe 32g x 5/16" 1 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 32g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>true comfort pro insulin syr 32g x 5/16" 1 ml</i>	Non Preferred	PA
<i>ultra comfort insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 30g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 30g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 30g x 5/16" 1 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 31g x 5/16" 0.3 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 31g x 5/16" 0.5 ml</i>	Non Preferred	PA
<i>ultracare insulin syringe 31g x 5/16" 1 ml</i>	Non Preferred	PA
<i>value health insulin syringe 29g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>value health insulin syringe 29g x 1/2" 1 ml</i>	Non Preferred	PA
<i>vp insulin syringe 29g x 1/2" 0.3 ml</i>	Non Preferred	PA
<i>zevrx insulin syringe 30g x 1/2" 0.5 ml</i>	Non Preferred	PA
<i>zevrx insulin syringe 30g x 1/2" 1 ml</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
zevrx insulin syringe 30g x 5/16" 0.5 ml	Non Preferred	PA
zevrx insulin syringe 30g x 5/16" 1 ml	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ADVOCATE INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 0.5 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 0.5 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 25G X 1" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 25G X 5/8" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 26G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 27.5G X 5/8" 2 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 27G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
BD INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE HALF-UNIT 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 1/2UNIT 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U/F 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE U-100 1 ML ( <i>insulin syringes (disposable)</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug



Drug Name	Formulary Status	Requirements/Limits
BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD SAFETY-LOK INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 28G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 29G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
CARETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT ASSIST INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
DROPLET INSULIN SYRINGE 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
EXEL COMFORT POINT INSULIN SYR 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
EXEL COMFORT POINT INSULIN SYR 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FIFTY50 SUPERIOR COMFORT SYR 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FREESTYLE PRECISION INS SYR 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FREESTYLE PRECISION INS SYR 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FREESTYLE PRECISION INS SYR 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
FREESTYLE PRECISION INS SYR 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT INSULIN SYRINGE U-100 1 ML ( <i>insulin syringes (disposable)</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SUREDOSE PLUS SYR 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PRECISION SUREDOSE PLUS SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SURE-DOSE SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SURE-DOSE SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SURE-DOSE SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SURE-DOSE SYRINGE 30G X 3/8" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 15/64" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
RELION INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SAFESNAP INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
SAFESNAP INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SAFESNAP INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SAFESNAP INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SAFESNAP INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SECURESAFE INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SECURESAFE INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
SURE-JECT INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ULTILET INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 1/4" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 1/4" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 15/64" 0.3 ML (OTC) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 15/64" 0.3 ML (RX) ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 15/64" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTILET INSULIN SYRINGE SHORT 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 30G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 30G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VANISHPOINT INSULIN SYRINGE 30G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.5 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
VERIFINE INSULIN SYRINGE 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	Non Preferred	PA
<b>*MIGRAINE PRODUCTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAG (CGRP)*** - DRUGS FOR MIGRAINE HEADACHES</b>		
NURTEC TABLET DISPERSIBLE 75 MG ORAL ( <i>rimegepant sulfate</i> )	Preferred	PA
QULIPTA TABLET 10 MG ORAL ( <i>atogepant</i> )	Preferred	PA
QULIPTA TABLET 30 MG ORAL ( <i>atogepant</i> )	Preferred	PA
QULIPTA TABLET 60 MG ORAL ( <i>atogepant</i> )	Preferred	PA
UBRELVY TABLET 100 MG ORAL ( <i>ubrogepant</i> )	Preferred	PA
UBRELVY TABLET 50 MG ORAL ( <i>ubrogepant</i> )	Preferred	PA
ZAVZPRET SOLUTION 10 MG/ACT NASAL ( <i>zavegepant hcl</i> )	Non Preferred	PA
<b>*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MIGRAINE HEADACHES</b>		
AIMOVIG SOLUTION AUTO-INJECTOR 140 MG/ML SUBCUTANEOUS ( <i>erenumab-aooe</i> )	Preferred	PA
AIMOVIG SOLUTION AUTO-INJECTOR 70 MG/ML SUBCUTANEOUS ( <i>erenumab-aooe</i> )	Preferred	PA
AJOVY SOLUTION AUTO-INJECTOR 225 MG/1.5ML SUBCUTANEOUS ( <i>fremanezumab-vfrm</i> )	Preferred	PA
AJOVY SOLUTION PREFILLED SYRINGE 225 MG/1.5ML SUBCUTANEOUS ( <i>fremanezumab-vfrm</i> )	Preferred	PA
EMGALITY (300 MG DOSE) SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS ( <i>galcanezumab-gnlm</i> )	Preferred	PA
EMGALITY SOLUTION AUTO-INJECTOR 120 MG/ML SUBCUTANEOUS ( <i>galcanezumab-gnlm</i> )	Preferred	PA
EMGALITY SOLUTION PREFILLED SYRINGE 120 MG/ML SUBCUTANEOUS ( <i>galcanezumab-gnlm</i> )	Preferred	PA
VYEPTI SOLUTION 100 MG/ML INTRAVENOUS ( <i>eptinezumab-jjmr</i> )	Non Preferred	PA
<b>*ERGOT COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
MIGERGOT SUPPOSITORY 2-100 MG RECTAL ( <i>ergotamine-caffeine</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*MIGRAINE PRODUCTS - CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
ELYXYB SOLUTION 120 MG/4.8ML ORAL ( <i>celecoxib (migraine)</i> )	Non Preferred	PA
<b>*MIGRAINE PRODUCTS - NSAIDS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>diclofenac potassium(migraine) packet 50 mg oral</i>	Non Preferred	PA
<b>*MIGRAINE PRODUCTS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>dihydroergotamine mesylate solution 4 mg/ml nasal</i>	Non Preferred	PA
<i>dihydroergotamine mesylate solution 4 mg/ml nasal</i>	Non Preferred	PA; Max 150-day supply per fill
MIGRANAL SOLUTION 4 MG/ML NASAL ( <i>dihydroergotamine mesylate</i> )	Non Preferred	PA
TRUDHESA AEROSOL SOLUTION 0.725 MG/ACT NASAL ( <i>dihydroergotamine mesylate hfa</i> )	Non Preferred	PA
<b>*SELECTIVE SEROTONIN AGONIST-NSAID COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>sumatriptan-naproxen sodium tablet 85-500 mg oral</i>	Non Preferred	PA
<b>*SELECTIVE SEROTONIN AGONISTS 5-HT(1)*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>rizatriptan benzoate tablet 10 mg oral</i>	Preferred	QL (12 EA per 30 days)
<i>rizatriptan benzoate tablet 5 mg oral</i>	Preferred	QL (12 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 10 mg oral</i>	Preferred	QL (12 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 5 mg oral</i>	Preferred	QL (12 EA per 30 days)
<i>sumatriptan solution 20 mg/act nasal</i>	Preferred	QL (0.2 EA per 1 day)
<i>sumatriptan solution 5 mg/act nasal</i>	Preferred	QL (0.2 EA per 1 day)
<i>sumatriptan succinate refill solution cartridge 4 mg/0.5ml subcutaneous</i>	Preferred	
<i>sumatriptan succinate refill solution cartridge 6 mg/0.5ml subcutaneous</i>	Preferred	
<i>sumatriptan succinate solution 6 mg/0.5ml subcutaneous</i>	Preferred	QL (4 ML per 30 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml subcutaneous</i>	Preferred	
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous</i>	Preferred	
<i>sumatriptan succinate tablet 100 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 25 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 50 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>almotriptan malate tablet 12.5 mg oral</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>almotriptan malate tablet 6.25 mg oral</i>	Non Preferred	PA
<i>eletriptan hydrobromide tablet 20 mg oral</i>	Non Preferred	PA
<i>eletriptan hydrobromide tablet 40 mg oral</i>	Non Preferred	PA
<i>frovatriptan succinate tablet 2.5 mg oral</i>	Non Preferred	PA
<i>naratriptan hcl tablet 1 mg oral</i>	Non Preferred	PA; QL (9 EA per 30 days)
<i>naratriptan hcl tablet 2.5 mg oral</i>	Non Preferred	PA; QL (9 EA per 30 days)
<i>zolmitriptan solution 2.5 mg nasal</i>	Non Preferred	PA
<i>zolmitriptan solution 5 mg nasal</i>	Non Preferred	PA
<i>zolmitriptan tablet 2.5 mg oral</i>	Non Preferred	PA
<i>zolmitriptan tablet 5 mg oral</i>	Non Preferred	PA
<i>zolmitriptan tablet dispersible 2.5 mg oral</i>	Non Preferred	PA
<i>zolmitriptan tablet dispersible 5 mg oral</i>	Non Preferred	PA
FROVA TABLET 2.5 MG ORAL ( <i>frovatriptan succinate</i> )	Non Preferred	PA
IMITREX SOLUTION 20 MG/ACT NASAL ( <i>sumatriptan</i> )	Non Preferred	PA; QL (0.2 EA per 1 day)
IMITREX SOLUTION 5 MG/ACT NASAL ( <i>sumatriptan</i> )	Non Preferred	PA; QL (0.2 EA per 1 day)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS ( <i>sumatriptan succinate</i> )	Non Preferred	PA
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS ( <i>sumatriptan succinate</i> )	Non Preferred	PA
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS ( <i>sumatriptan succinate</i> )	Non Preferred	PA
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS ( <i>sumatriptan succinate</i> )	Non Preferred	PA
IMITREX TABLET 100 MG ORAL ( <i>sumatriptan succinate</i> )	Non Preferred	PA; QL (9 EA per 30 days)
IMITREX TABLET 25 MG ORAL ( <i>sumatriptan succinate</i> )	Non Preferred	PA; QL (9 EA per 30 days)
IMITREX TABLET 50 MG ORAL ( <i>sumatriptan succinate</i> )	Non Preferred	PA; QL (9 EA per 30 days)
MAXALT TABLET 10 MG ORAL ( <i>rizatriptan benzoate</i> )	Non Preferred	PA; QL (12 EA per 30 days)

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Drug Name	Formulary Status	Requirements/Limits
MAXALT-MLT TABLET DISPERSIBLE 10 MG ORAL ( <i>rizatriptan benzoate</i> )	Non Preferred	PA; QL (12 EA per 30 days)
RELPAX TABLET 20 MG ORAL ( <i>eletriptan hydrobromide</i> )	Non Preferred	PA
RELPAX TABLET 40 MG ORAL ( <i>eletriptan hydrobromide</i> )	Non Preferred	PA
TOSYMRA SOLUTION 10 MG/ACT NASAL ( <i>sumatriptan</i> )	Non Preferred	PA
ZEMBRACE SYMTOUCH SOLUTION AUTO-INJECTOR 3 MG/0.5ML SUBCUTANEOUS ( <i>sumatriptan succinate</i> )	Non Preferred	PA
ZOMIG SOLUTION 2.5 MG NASAL ( <i>zolmitriptan</i> )	Non Preferred	PA
ZOMIG SOLUTION 5 MG NASAL ( <i>zolmitriptan</i> )	Non Preferred	PA
ZOMIG TABLET 2.5 MG ORAL ( <i>zolmitriptan</i> )	Non Preferred	PA
ZOMIG TABLET 5 MG ORAL ( <i>zolmitriptan</i> )	Non Preferred	PA
ZOMIG ZMT TABLET DISPERSIBLE 2.5 MG ORAL ( <i>zolmitriptan</i> )	Non Preferred	PA
ZOMIG ZMT TABLET DISPERSIBLE 5 MG ORAL ( <i>zolmitriptan</i> )	Non Preferred	PA
<b>*SELECTIVE SEROTONIN AGONISTS 5-HT(1F)*** - DRUGS FOR MIGRAINE HEADACHES</b>		
REYVOW TABLET 100 MG ORAL ( <i>lasmiditan succinate</i> )	Non Preferred	PA
REYVOW TABLET 50 MG ORAL ( <i>lasmiditan succinate</i> )	Non Preferred	PA
<b>*MINERALS &amp; ELECTROLYTES* - DRUGS FOR NUTRITION</b>		
<b>*CALCIUM COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<i>calcium + vitamin d3 oral tablet 500-5 mg-mcg</i>	Preferred	
<i>calcium 600-d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>calcium carb-cholecalciferol oral tablet 600-5 mg-mcg</i>	Preferred	
<i>calcium carbonate-vitamin d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg</i>	Preferred	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>oyster shell calcium w/d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium/vit d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>risacal-d oral tablet 105-81-120 mg-mg-unit</i>	Preferred	
<i>sm calcium 500/vitamin d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>sm calcium 600/vitamin d oral tablet 600-10 mg-mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm calcium citrate-vit d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>sm calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>sm oyster shell calcium/vit d oral tablet 500-10 mg-mcg</i>	Preferred	
<i>sm oyster shell calcium/vit d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>ultra calcium + vitamin d3 oral tablet 600-10 mg-mcg</i>	Preferred	
CALCITRATE ORAL TABLET 315-6.25 MG-MCG ( <i>calcium citrate-vitamin d</i> )	Preferred	
OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	Preferred	
OS-CAL ORAL TABLET CHEWABLE 500-15 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	Preferred	
OYSCO 500+D ORAL TABLET 500-5 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	Preferred	
<b>*CALCIUM*** - DRUGS FOR NUTRITION</b>		
<i>calcium 600 oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>gnp calcium oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>oyster shell calcium oral tablet 500 mg</i>	Preferred	
CALCITRATE ORAL TABLET 950 (200 CA) MG ( <i>calcium citrate</i> )	Preferred	
OYSCO 500 ORAL TABLET 500 MG ( <i>oyster shell</i> )	Preferred	
<b>*ELECTROLYTES ORAL*** - DRUGS FOR NUTRITION</b>		
<i>gnp electrolyte solution oral solution</i>	Preferred	
<i>gnp pediatric electrolyte oral solution</i>	Preferred	
<i>sm pediatric electrolyte oral solution</i>	Preferred	
REHYDRALYTE ORAL SOLUTION ( <i>oral electrolytes</i> )	Preferred	
<b>*FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	Preferred	QL (1 EA per 1 day)
<b>*MAGNESIUM*** - DRUGS FOR NUTRITION</b>		
<i>magnesium oxide -mg supplement oral tablet 400 (240 mg) mg, 500 mg</i>	Preferred	
<i>sm magnesium oral tablet 250 mg</i>	Preferred	
<i>true magnesium oxide oral tablet 400 mg, 500 mg</i>	Preferred	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG ( <i>magnesium oxide</i> )	Preferred	
<b>*PHOSPHATE*** - DRUGS FOR NUTRITION</b>		
<i>phosphorous oral tablet 155-852-130 mg</i>	Preferred	QL (4 EA per 1 day)
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	Preferred	QL (4 EA per 1 day)
<i>k phos mono-sod phos di &amp; mono</i> (Phospha 250 Neutral Oral Tablet 155-852-130 Mg)	Preferred	QL (4 EA per 1 day)
<i>k phos mono-sod phos di &amp; mono</i> (Phospho-Trin 250 Neutral Oral Tablet 155-852-130 Mg)	Preferred	QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<b>*POTASSIUM*** - DRUGS FOR NUTRITION</b>		
<i>potassium chloride crys er oral tablet extended release 10 meq</i>	Preferred	QL (4 EA per 1 day)
<i>potassium chloride crys er oral tablet extended release 20 meq</i>	Preferred	QL (5 EA per 1 day)
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	Preferred	QL (4 EA per 1 day)
<i>potassium chloride er oral tablet extended release 10 meq, 8 meq</i>	Preferred	QL (4 EA per 1 day)
<i>potassium chloride er oral tablet extended release 20 meq</i>	Preferred	QL (5 EA per 1 day)
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	Preferred	
<i>potassium bicarbonate (Effer-K Oral Tablet Effervescent 25 Meq)</i>	Preferred	QL (2 EA per 1 day)
<i>potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	QL (4 EA per 1 day)
<i>potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	QL (4 EA per 1 day)
<i>potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)</i>	Preferred	QL (5 EA per 1 day)
<i>potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)</i>	Preferred	QL (4 EA per 1 day)
<i>potassium bicarbonate (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)</i>	Preferred	QL (2 EA per 1 day)
<b>*SODIUM*** - DRUGS FOR NUTRITION</b>		
<i>sodium chloride oral tablet 1 gm</i>	Preferred	
<b>*MISCELLANEOUS THERAPEUTIC CLASSES* - VITAMINS AND MINERALS</b>		
<b>*ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME AGENT*** - VITAMINS AND MINERALS</b>		
JOENJA TABLET 70 MG ORAL ( <i>leniolisib phosphate</i> )	Non Preferred	PA
<b>*ANTILEPROTICS*** - VITAMINS AND MINERALS</b>		
THALOMID CAPSULE 100 MG ORAL ( <i>thalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
THALOMID CAPSULE 150 MG ORAL ( <i>thalidomide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
THALOMID CAPSULE 200 MG ORAL ( <i>thalidomide</i> )	Non Preferred	PA; QL (2 EA per 1 day)
THALOMID CAPSULE 50 MG ORAL ( <i>thalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS*** - VITAMINS AND MINERALS</b>		
BENLYSTA SOLUTION AUTO-INJECTOR 200 MG/ML SUBCUTANEOUS ( <i>belimumab</i> )	Non Preferred	PA
BENLYSTA SOLUTION PREFILLED SYRINGE 200 MG/ML SUBCUTANEOUS ( <i>belimumab</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*CHELATING AGENTS*** - VITAMINS AND MINERALS</b>		
<i>penicillamine capsule 250 mg oral</i>	Preferred	
<i>penicillamine tablet 250 mg oral</i>	Preferred	
<i>trientine hcl capsule 250 mg oral</i>	Preferred	
<i>trientine hcl capsule 500 mg oral</i>	Preferred	
DEPEN TITRATABS TABLET 250 MG ORAL ( <i>penicillamine</i> )	Preferred	
CUPRIMINE CAPSULE 250 MG ORAL ( <i>penicillamine</i> )	Non Preferred	PA
CUVRIOR TABLET 300 MG ORAL ( <i>trientine tetrahydrochloride</i> )	Non Preferred	PA
SYPRINE CAPSULE 250 MG ORAL ( <i>trientine hcl</i> )	Non Preferred	PA
<b>*CYCLOSPORINE ANALOGS*** - VITAMINS AND MINERALS</b>		
<i>cyclosporine capsule 100 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>cyclosporine capsule 25 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>cyclosporine modified capsule 100 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>cyclosporine modified capsule 25 mg oral</i>	Preferred	QL (15 EA per 1 day)
<i>cyclosporine modified capsule 50 mg oral</i>	Preferred	QL (15 EA per 1 day)
<i>cyclosporine modified solution 100 mg/ml oral</i>	Preferred	QL (10 ML per 1 day)
<i>cyclosporine modified</i> (Gengraf Capsule 100 Mg Oral)	Preferred	QL (10 EA per 1 day)
<i>cyclosporine modified</i> (Gengraf Capsule 25 Mg Oral)	Preferred	QL (15 EA per 1 day)
<i>cyclosporine modified</i> (Gengraf Solution 100 Mg/ML Oral)	Preferred	QL (10 ML per 1 day)
SANDIMMUNE SOLUTION 100 MG/ML ORAL ( <i>cyclosporine</i> )	Preferred	
LUPKYNIS CAPSULE 7.9 MG ORAL ( <i>voclosporin</i> )	Non Preferred	PA
NEORAL CAPSULE 100 MG ORAL ( <i>cyclosporine modified</i> )	Non Preferred	PA; QL (10 EA per 1 day)
NEORAL CAPSULE 25 MG ORAL ( <i>cyclosporine modified</i> )	Non Preferred	PA; QL (15 EA per 1 day)
NEORAL SOLUTION 100 MG/ML ORAL ( <i>cyclosporine modified</i> )	Non Preferred	PA; QL (10 ML per 1 day)
SANDIMMUNE CAPSULE 100 MG ORAL ( <i>cyclosporine</i> )	Non Preferred	PA; QL (5 EA per 1 day)
SANDIMMUNE CAPSULE 25 MG ORAL ( <i>cyclosporine</i> )	Non Preferred	PA; QL (16 EA per 1 day)
<b>*IMMUNOMODULATORS - COMBINATIONS*** - VITAMINS AND MINERALS</b>		
VYVGART HYTRULO SOLUTION 180-2000 MG-UNIT/ML SUBCUTANEOUS ( <i>efgartigimod alfa-hyalur-qvfc</i> )	Non Preferred	PA
<b>*IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS</b>		
<i>lenalidomide capsule 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>lenalidomide capsule 15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 2.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>lenalidomide capsule 5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 10 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 15 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 2.5 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 20 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 25 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
REVLIMID CAPSULE 5 MG ORAL ( <i>lenalidomide</i> )	Non Preferred	PA; QL (1 EA per 1 day)
<b>*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS*** - VITAMINS AND MINERALS</b>		
<i>mycophenolate mofetil capsule 250 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>mycophenolate mofetil suspension reconstituted 200 mg/ml oral</i>	Preferred	
<i>mycophenolate mofetil tablet 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>mycophenolate sodium tablet delayed release 180 mg oral</i>	Preferred	
<i>mycophenolate sodium tablet delayed release 360 mg oral</i>	Preferred	
<i>mycophenolic acid tablet delayed release 180 mg oral</i>	Preferred	
<i>mycophenolic acid tablet delayed release 360 mg oral</i>	Preferred	
CELLCEPT CAPSULE 250 MG ORAL ( <i>mycophenolate mofetil</i> )	Non Preferred	PA; QL (12 EA per 1 day)
CELLCEPT SUSPENSION RECONSTITUTED 200 MG/ML ORAL ( <i>mycophenolate mofetil</i> )	Non Preferred	PA
CELLCEPT TABLET 500 MG ORAL ( <i>mycophenolate mofetil</i> )	Non Preferred	PA; QL (8 EA per 1 day)
MYFORTIC TABLET DELAYED RELEASE 180 MG ORAL ( <i>mycophenolate sodium</i> )	Non Preferred	PA
MYFORTIC TABLET DELAYED RELEASE 360 MG ORAL ( <i>mycophenolate sodium</i> )	Non Preferred	PA
<b>*MACROLIDE IMMUNOSUPPRESSANTS*** - VITAMINS AND MINERALS</b>		
<i>sirolimus solution 1 mg/ml oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sirolimus tablet 0.5 mg oral</i>	Preferred	
<i>sirolimus tablet 1 mg oral</i>	Preferred	
<i>sirolimus tablet 2 mg oral</i>	Preferred	
<i>tacrolimus capsule 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>tacrolimus capsule 1 mg oral</i>	Preferred	QL (14 EA per 1 day)
<i>tacrolimus capsule 5 mg oral</i>	Preferred	
<i>everolimus tablet 0.25 mg oral</i>	Non Preferred	
<i>everolimus tablet 0.25 mg oral</i>	Non Preferred	PA
<i>everolimus tablet 0.5 mg oral</i>	Non Preferred	
<i>everolimus tablet 0.5 mg oral</i>	Non Preferred	PA
<i>everolimus tablet 0.75 mg oral</i>	Non Preferred	
<i>everolimus tablet 0.75 mg oral</i>	Non Preferred	PA
<i>everolimus tablet 1 mg oral</i>	Non Preferred	PA
ASTAGRAF XL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
ASTAGRAF XL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
ASTAGRAF XL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
ENVARUSUS XR TABLET EXTENDED RELEASE 24 HOUR 0.75 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
ENVARUSUS XR TABLET EXTENDED RELEASE 24 HOUR 1 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
ENVARUSUS XR TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
PROGRAF CAPSULE 0.5 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PROGRAF CAPSULE 1 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA; QL (14 EA per 1 day)
PROGRAF CAPSULE 5 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
PROGRAF PACKET 0.2 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
PROGRAF PACKET 1 MG ORAL ( <i>tacrolimus</i> )	Non Preferred	PA
RAPAMUNE SOLUTION 1 MG/ML ORAL ( <i>sirolimus</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RAPAMUNE TABLET 0.5 MG ORAL ( <i>sirolimus</i> )	Non Preferred	PA
RAPAMUNE TABLET 1 MG ORAL ( <i>sirolimus</i> )	Non Preferred	PA
RAPAMUNE TABLET 2 MG ORAL ( <i>sirolimus</i> )	Non Preferred	PA
ZORTRESS TABLET 0.25 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA
ZORTRESS TABLET 0.5 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA
ZORTRESS TABLET 0.75 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA
ZORTRESS TABLET 1 MG ORAL ( <i>everolimus</i> )	Non Preferred	PA
<b>*NEONATAL FC RECEPTOR (FCRN) ANTAGONISTS*** - VITAMINS AND MINERALS</b>		
RYSTIGGO SOLUTION 280 MG/2ML SUBCUTANEOUS ( <i>rozanolixizumab-noli</i> )	Non Preferred	PA
VYVGART SOLUTION 400 MG/20ML INTRAVENOUS ( <i>efgartigimod alfa-fcab</i> )	Non Preferred	PA
<b>*POTASSIUM REMOVING AGENTS*** - VITAMINS AND MINERALS</b>		
<i>sodium polystyrene sulfonate powder oral</i>	Preferred	
LOKELMA PACKET 10 GM ORAL ( <i>sodium zirconium cyclosilicate</i> )	Non Preferred	PA
LOKELMA PACKET 5 GM ORAL ( <i>sodium zirconium cyclosilicate</i> )	Non Preferred	PA
SPS SUSPENSION 15 GM/60ML ORAL ( <i>sodium polystyrene sulfonate</i> )	Non Preferred	PA
VELTASSA PACKET 16.8 GM ORAL ( <i>patiromer sorbitex calcium</i> )	Non Preferred	PA
VELTASSA PACKET 25.2 GM ORAL ( <i>patiromer sorbitex calcium</i> )	Non Preferred	PA
VELTASSA PACKET 8.4 GM ORAL ( <i>patiromer sorbitex calcium</i> )	Non Preferred	PA
<b>*PURINE ANALOGS*** - VITAMINS AND MINERALS</b>		
<i>azathioprine tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>azathioprine tablet 100 mg oral</i>	Non Preferred	
<i>azathioprine tablet 100 mg oral</i>	Non Preferred	PA
<i>azathioprine tablet 75 mg oral</i>	Non Preferred	
<i>azathioprine tablet 75 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>azathioprine</i> (Azasan Tablet 100 Mg Oral)	Non Preferred	PA
<i>azathioprine</i> (Azasan Tablet 75 Mg Oral)	Non Preferred	PA
IMURAN TABLET 50 MG ORAL ( <i>azathioprine</i> )	Non Preferred	PA; QL (8 EA per 1 day)
<b>*ROCK INHIBITORS*** - VITAMINS AND MINERALS</b>		
REZUROCK TABLET 200 MG ORAL ( <i>belumosudil mesylate</i> )	Non Preferred	PA
<b>*MOUTH/THROAT/DENTAL AGENTS* - DRUGS FOR THE MOUTH AND THROAT</b>		
<b>*ANESTHETICS TOPICAL ORAL*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>lidocaine hcl solution 4 % mouth/throat</i>	Preferred	
<i>lidocaine viscous hcl solution 2 % mouth/throat</i>	Preferred	
<b>*ANTI-INFECTIVES - THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>clotrimazole troche 10 mg mouth/throat</i>	Preferred	QL (5 EA per 1 day)
<i>nystatin suspension 100000 unit/ml mouth/throat</i>	Preferred	QL (120 ML per 1 day)
ORAVIG TABLET 50 MG BUCCAL ( <i>miconazole</i> )	Non Preferred	PA
<b>*ANTISEPTICS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>chlorhexidine gluconate solution 0.12 % mouth/throat</i>	Preferred	Max 150-day supply per fill
<i>chlorhexidine gluconate solution 0.12 % mouth/throat</i>	Preferred	
<b>*DENTAL PRODUCTS - COMBINATIONS*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>sodium fluoride 5000 enamel gel 1.1-5 % dental</i>	Non Preferred	PA
<i>sodium fluoride 5000 sensitive gel 1.1-5 % dental</i>	Non Preferred	PA
<b>*DRY MOUTH AGENTS AND ARTIFICIAL SALIVA*** - DRUGS FOR THE MOUTH AND THROAT</b>		
AQUORAL SOLUTION MOUTH/THROAT ( <i>artificial saliva</i> )	Non Preferred	PA
<b>*FLUORIDE DENTAL PRODUCTS*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>sodium fluoride 5000 plus cream 1.1 % dental</i>	Non Preferred	PA; Max 60-day supply per fill
<i>sodium fluoride 5000 ppm cream 1.1 % dental</i>	Non Preferred	PA; Max 60-day supply per fill
<i>sodium fluoride 5000 ppm gel 1.1 % dental</i>	Non Preferred	PA
<i>sodium fluoride 5000 ppm paste 1.1 % dental</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>sodium fluoride gel 1.1 % dental</i>	Non Preferred	PA
<i>sodium fluoride solution 0.2 % mouth/throat</i>	Non Preferred	PA
<i>sodium fluoride (Denta 5000 Plus Cream 1.1 % Dental)</i>	Non Preferred	PA; Max 60-day supply per fill
<i>sodium fluoride (Dentagel Gel 1.1 % Dental)</i>	Non Preferred	PA
<b>*PROTECTANTS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
GELX GEL MOUTH/THROAT ( <i>oral wound care products</i> )	Non Preferred	PA
<b>*SALIVA STIMULANTS*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>pilocarpine hcl tablet 5 mg oral</i>	Preferred	
<i>pilocarpine hcl tablet 7.5 mg oral</i>	Preferred	
<i>cevimeline hcl capsule 30 mg oral</i>	Non Preferred	PA
EVOXAC CAPSULE 30 MG ORAL ( <i>cevimeline hcl</i> )	Non Preferred	PA
<b>*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>triamcinolone acetonide paste 0.1 % mouth/throat</i>	Preferred	
<i>triamcinolone acetonide (Oralene Paste 0.1 % Mouth/Throat)</i>	Preferred	
<b>*MULTIVITAMINS* - DRUGS FOR NUTRITION</b>		
<b>*B-COMPLEX W/ C &amp; FOLIC ACID*** - DRUGS FOR NUTRITION</b>		
<i>folika-bc oral tablet 1 mg</i>	Preferred	
<i>rena-vite rx oral tablet 1 mg</i>	Preferred	
<i>vita-bee/c oral tablet</i>	Preferred	
<i>west-vite w/folic acid oral tablet 0.8 mg</i>	Preferred	
DIALYVITE 800 ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	Preferred	
NEPHRO-VITE ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	Preferred	
<b>*MULTIPLE VITAMINS W/ IRON*** - DRUGS FOR NUTRITION</b>		
<i>daily-vite/iron/beta-carotene oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>sm multiple vitamins/iron oral tablet</i>	Preferred	QL (1 EA per 1 day)
<b>*MULTIPLE VITAMINS W/ MINERALS*** - DRUGS FOR NUTRITION</b>		
<i>dialyvite 800/ultra d oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>eye multivitamin/lutein oral capsule</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
<i>glucoten oral capsule</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)

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<i>gnp healthy eyes oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp mega multi for men oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp mega multi for women oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp one daily mens health 50+ oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp one daily mens/lycopene oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp one daily womens 50+ oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>gnp one daily womens oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>i-vite oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>multivit/multimineral adult oral liquid</i>	Preferred	QL (1 ML per 1 day)
<i>multivitamin oral liquid</i>	Preferred	QL (1 ML per 1 day)
<i>one-daily multi caps oral capsule</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
<i>sm complete advanced formula oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>sm complete oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>sm complete senior formula oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>sm daily diet support oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>sm opti-vitamins oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>v-c forte oral capsule</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
CEROVITE SENIOR ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
CERTAVITE/ANTIOXIDANTS ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
COMPETE ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
DEXATRAN ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
ICAPS LUTEIN & OMEGA-3 ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
ICAPS MV ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
ICAPS ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
MENATROL ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
<i>multiple vitamins-minerals</i> (Nutrifac Zx Oral Tablet)	Preferred	QL (1 EA per 1 day)
OCUVITE ADULT 50+ ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
OCUVITE ADULT FORMULA ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
OCUVITE EXTRA ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
OCUVITE EYE + MULTI ORAL TABLET ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day)
OCUVITE EYE HEALTH FORMULA ORAL CAPSULE ( <i>multiple vitamins-minerals</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)

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Drug Name	Formulary Status	Requirements/Limits
OCUVITE EYE HEALTH GUMMIES ORAL TABLET CHEWABLE (multiple vitamins-minerals)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
OCUVITE-LUTEIN ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
OCUVITE-LUTEIN ORAL TABLET (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day)
PRESERVISION AREDS 2 ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
PRESERVISION AREDS 2 ORAL TABLET CHEWABLE (multiple vitamins-minerals)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
PRESERVISION AREDS 2+MULTI VIT ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
PRESERVISION AREDS ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
PRESERVISION/LUTEIN ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
PRORENAL + D W/ OMEGA-3 ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
PROSIGHT ORAL TABLET (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day)
RENAPLEX ORAL TABLET (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day)
SYSTANE ICAPS AREDS2 ORAL CAPSULE (multiple vitamins-minerals)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years)
SYSTANE ICAPS AREDS2 ORAL TABLET CHEWABLE (multiple vitamins-minerals)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years)
multiple vitamins-minerals (Vita S Forte Oral Tablet)	Preferred	QL (1 EA per 1 day)
<b>*MULTIVITAMINS*** - DRUGS FOR NUTRITION</b>		
daily-vite oral tablet	Preferred	
gnp essential one daily oral tablet	Preferred	
sm multiple vitamins essential oral tablet	Preferred	
stress formula oral tablet	Preferred	
tm-daily vite oral tablet	Preferred	
true multivitamin oral tablet	Preferred	
TAB-A-VITE/BETA CAROTENE ORAL TABLET (multiple vitamin)	Preferred	
THERA ORAL TABLET (multiple vitamin)	Preferred	
<b>*PED MULTI VITAMINS W/FL &amp; FE*** - DRUGS FOR NUTRITION</b>		
multi-vit/iron/fluoride oral solution 0.25-10 mg/ml	Preferred	QL (1.67 ML per 1 day)
multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml	Preferred	QL (1.67 ML per 1 day)
POLY-VI-FLOR/IRON ORAL SUSPENSION 0.25-7 MG/ML (ped multivitamins-fl-iron)	Preferred	
POLY-VI-FLOR/IRON ORAL TABLET CHEWABLE 0.5-10 MG (ped multivitamins-fl-iron)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*PED MULTIPLE VITAMINS W/ MINERALS*** - DRUGS FOR NUTRITION</b>		
<i>abdek pediatric oral solution</i>	Preferred	QL (1 ML per 1 day); AGE (Max 3 Years)
<b>*PED MV W/ FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>multivitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<i>POLY-VI-FLOR FS ORAL STRIP 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins-fl)</i>	Preferred	
<i>POLY-VI-FLOR ORAL SUSPENSION 0.25 MG/ML (pediatric multivitamins-fl)</i>	Preferred	
<b>*PED MV W/ IRON*** - DRUGS FOR NUTRITION</b>		
<i>chewable vite/iron childrens oral tablet chewable 15 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp childrens chewables/iron oral tablet chewable 15 mg</i>	Preferred	QL (1 EA per 1 day)
<b>*PED VITAMINS ACD W/ FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>adc/f (0.5mg/ml) oral solution 0.5 mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<i>tri-vite/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	Preferred	QL (1.67 ML per 1 day)
<b>*PRENATAL MV &amp; MIN W/FE-FA*** - DRUGS FOR NUTRITION</b>		
<i>classic prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>completenate tablet chewable 29-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>gnp prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>m-natal plus tablet 27-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>prenatal oral tablet 27-0.8 mg</i>	Preferred	
<i>prenatal plus vitamin/mineral tablet 27-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>prenatal tablet 27-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>se-natal 19 tablet 29-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<i>se-natal 19 tablet chewable 29-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>sm prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>thrivite rx tablet 29-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>trinatal rx 1 tablet 60-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>westab plus tablet 27-1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
ELITE-OB TABLET 50-1.25 MG ORAL ( <i>prenatal vit-iron carbonyl-fa</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NIVA-PLUS TABLET 27-1 MG ORAL ( <i>prenatal vit-fe fumarate-fa</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
OB COMPLETE TABLET 50-1.25 MG ORAL ( <i>prenatal vit-iron carbonyl-fa</i> )	Preferred	AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TRICARE TABLET ORAL ( <i>prenatal vit-fe fumarate-fa</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL-OB TABLET ORAL ( <i>prenatal vit-fe fumarate-fa</i> )	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>c-nate dha capsule 28-1-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>multi-mac tablet 15-0.75-1 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>natal pnv tablet 6-0.5 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>pnv-omega capsule 28-0.6-0.4-340 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>pnv-select tablet 27-0.6-0.4 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>relnate dha capsule 28-1-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>tri-tabs dha 32-1 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>virt-nate dha capsule 28-1-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>wescap-c dha capsule 53.5-38-1 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>wesnate dha capsule 28-1-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL B-CALM 20-1 MG & 2 X 25 MG ORAL ( <i>prenat w/o a fecbnfeglu-fa &amp;b6</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL BLOOM TABLET 90-1 MG ORAL ( <i>prenatal-dss-fecb-fegl-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
DERMACINRX PRETRATE TABLET 1 MG ORAL ( <i>prenatal multivit-min-fe-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
ENBRACE HR CAPSULE ORAL ( <i>prenat vit-fe gly cys-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
FOLIVANE-OB CAPSULE 85-1 MG ORAL ( <i>prenat w/o a vit-fefum-fepo-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NESTABS DHA 32-1 MG ORAL ( <i>prenat-w/oa-fe bisgly-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NESTABS TABLET 32-1 MG ORAL ( <i>prenat-fe bisgly-fa-w/o vit a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
OB COMPLETE ONE CAPSULE 50-1-476 MG ORAL ( <i>prenat-fecbn-feaspgl-fa-fish</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
OB COMPLETE PETITE CAPSULE 35-5-1-200 MG ORAL ( <i>prenat-fecbn-feaspgl-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
OB COMPLETE PREMIER TABLET 30-20-1 MG ORAL ( <i>prenatal-fe cbn-fe asp gly-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
OB COMPLETE/DHA CAPSULE 30-10-1-200 MG ORAL ( <i>prenat-fecbn-feaspgl-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE ELITE TABLET 20-0.6-0.4 MG ORAL ( <i>prenatal-feaspgly-methylfol-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATRIX TABLET 27-1 MG ORAL ( <i>prenatal vit-fe fumarate-fa</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATRYL TABLET 27-1 MG ORAL ( <i>prenatal vit-fe fumarate-fa</i> )	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRIMACARE CAPSULE 30-1-470 MG ORAL ( <i>pren-fe-meth-fa-omeg w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SELECT-OB TABLET CHEWABLE 29-0.6-0.4 MG ORAL ( <i>prenat vit-fepoly-methylfol-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SELECT-OB TABLET CHEWABLE 29-1 MG ORAL ( <i>prenatal vit-fe psac cmplx-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TARON-C DHA CAPSULE 35-1 MG ORAL ( <i>prenat-fefum-fepo-fa-omega 3</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VINATE DHA RF CAPSULE 27-1.13 MG ORAL ( <i>prenat w/oa-fefum-methf-omegas</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL GUMMIES TABLET CHEWABLE 3.33-0.333-34.8 MG ORAL ( <i>prenatal vit-fe phos-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL-NANO TABLET 18-0.6-0.4 MG ORAL ( <i>prenatal-fe fum-methf-fa w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAPEARL CAPSULE EXTENDED RELEASE 30-1.4-200 MG ORAL ( <i>prenat-fefum-fered-fa-dha w/oa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
ZATEAN-PN PLUS CAPSULE 28-0.6-0.4-340 MG ORAL ( <i>prenat w/o a-fe-methf-fa-omega</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*PRENATAL MV &amp; MIN W/FE-FA-CA-OMEGA 3 FISH OIL*** - DRUGS FOR NUTRITION</b>		
<i>complete natal dha 29-1-200 &amp; 200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>wesnatal dha complete 29-1-200 &amp; 200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*PRENATAL MV &amp; MIN W/FE-FA-DHA*** - DRUGS FOR NUTRITION</b>		
<i>pnv-dha capsule 27-0.6-0.4-300 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>pnv-dha+docusate capsule 27-1.25-300 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>prenaissance capsule 29-1.25-325 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>prenaissance plus capsule 28-1-250 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>tristart dha capsule 31-0.6-0.4-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>virt-pn dha capsule 27-0.6-0.4-300 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>wescap-pn dha capsule 27-0.6-0.4-300 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<i>westgel dha capsule 31-0.6-0.4-200 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL 90 DHA 90-1 & 300 MG ORAL ( <i>prenat w/o a-fecbgl-dss-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL ASSURE 35-1 & 300 MG ORAL ( <i>prenat w/o a-fecbgl-dss-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL HARMONY CAPSULE 27-1-260 MG ORAL ( <i>prenat-fefmcb-dss-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
CITRANATAL MEDLEY CAPSULE 27-1-200 MG ORAL ( <i>prenat-fecb-fefum-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
NESTABS ONE CAPSULE 38-1-225 MG ORAL ( <i>prenat-fe-methylfol-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE DHA CAPSULE 18-0.6-0.4-300 MG ORAL ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE ENHANCE CAPSULE 28-0.6-0.4-400 MG ORAL ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
PRENATE ESSENTIAL CAPSULE 18-0.6-0.4-300 MG ORAL ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE MINI CAPSULE 18-0.6-0.4-350 MG ORAL ( <i>prenat-fecfn-feasp-meth-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE PIXIE CAPSULE 10-0.6-0.4-200 MG ORAL ( <i>prenat-feasp-meth-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE RESTORE CAPSULE 27-0.6-0.4-400 MG ORAL ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
SELECT-OB+DHA 29-1 & 250 MG ORAL ( <i>prenatal vit-fepoly-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TARON-PREX CAPSULE 30-1.2-265 MG ORAL ( <i>prenat-fefum-dss-fa-dha w/o a</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TRISTART FREE CAPSULE 33-1 MG ORAL ( <i>prenat w/o a-fecfn-meth-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
TRISTART ONE CAPSULE 35-1-215 MG ORAL ( <i>prenat w/o a-fecfn-meth-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL FE+ CAPSULE 90-0.6-0.4-200 MG ORAL ( <i>prenat-fepoly-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL FE+ CAPSULE THERAPY PACK 90-1-200 & 50 MG ORAL ( <i>prenat-fepoly-metf-fa-dha-dss</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL ULTRA CAPSULE 29-0.6-0.4-200 MG ORAL ( <i>prenat-fepoly-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL-OB+DHA 65-1 & 250 MG ORAL ( <i>prenatal mv-min-fefum-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL-ONE CAPSULE 29-1-200 MG ORAL ( <i>prenatal vit-fepoly-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAMEDMD ONE RX/QUATREFOLIC CAPSULE 30-0.6-0.4-200 MG ORAL ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
ZATEAN-PN DHA CAPSULE 27-0.6-0.4-300 MG ORAL ( <i>prenat w/o a-fe-methfol-fa-dha</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*PRENATAL MV &amp; MINERALS W/FA WITHOUT IRON*** - DRUGS FOR NUTRITION</b>		
PRENATE TABLET CHEWABLE 0.6-0.4 MG ORAL ( <i>prenat mv-min-methylfolate-fa</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*PRENATAL VITAMINS*** - DRUGS FOR NUTRITION</b>		
PREMESISRX TABLET 1 MG ORAL ( <i>prenatal ca-b6-b12-fa-ginger</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
PRENATE AM TABLET 1 MG ORAL ( <i>prenatal ca-b6-b12-fa-ginger</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
VITAFOL STRIPS FILM 1 MG ORAL ( <i>prenatal-b6-b12-d3-folic acid</i> )	Non Preferred	PA; AGE (Min 10 Years and Max 55 Years); Max 100-day supply per fill
<b>*MUSCULOSKELETAL THERAPY AGENTS* - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<b>*CENTRAL MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>baclofen suspension 25 mg/5ml oral</i>	Preferred	
<i>baclofen tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>baclofen tablet 20 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>baclofen tablet 5 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 250 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 375 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>chlorzoxazone tablet 750 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 7.5 mg oral</i>	Preferred	
<i>methocarbamol tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>methocarbamol tablet 750 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>orphenadrine citrate er tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>tizanidine hcl tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>tizanidine hcl tablet 4 mg oral</i>	Preferred	QL (9 EA per 1 day)
<i>cyclobenzaprine hcl (Fexmid Tablet 7.5 Mg Oral)</i>	Preferred	
<i>chlorzoxazone (Lorzone Tablet 375 Mg Oral)</i>	Preferred	
<i>chlorzoxazone (Lorzone Tablet 750 Mg Oral)</i>	Preferred	
<i>baclofen solution 10 mg/5ml oral</i>	Non Preferred	
<i>baclofen solution 5 mg/5ml oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>carisoprodol tablet 250 mg oral</i>	Non Preferred	PA
<i>carisoprodol tablet 350 mg oral</i>	Non Preferred	PA
<i>cyclobenzaprine hcl er capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA
<i>cyclobenzaprine hcl er capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA
<i>metaxalone tablet 400 mg oral</i>	Non Preferred	PA
<i>metaxalone tablet 800 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl capsule 2 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl capsule 4 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl capsule 6 mg oral</i>	Non Preferred	PA
AMRIX CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL ( <i>cyclobenzaprine hcl</i> )	Non Preferred	PA
AMRIX CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL ( <i>cyclobenzaprine hcl</i> )	Non Preferred	PA
FLEQSUVY SUSPENSION 25 MG/5ML ORAL ( <i>baclofen</i> )	Non Preferred	PA
LYVISPAH PACKET 10 MG ORAL ( <i>baclofen</i> )	Non Preferred	PA
LYVISPAH PACKET 20 MG ORAL ( <i>baclofen</i> )	Non Preferred	PA
LYVISPAH PACKET 5 MG ORAL ( <i>baclofen</i> )	Non Preferred	PA
SOMA TABLET 250 MG ORAL ( <i>carisoprodol</i> )	Non Preferred	PA
SOMA TABLET 350 MG ORAL ( <i>carisoprodol</i> )	Non Preferred	PA
ZANAFLEX CAPSULE 2 MG ORAL ( <i>tizanidine hcl</i> )	Non Preferred	PA
ZANAFLEX CAPSULE 4 MG ORAL ( <i>tizanidine hcl</i> )	Non Preferred	PA
ZANAFLEX CAPSULE 6 MG ORAL ( <i>tizanidine hcl</i> )	Non Preferred	PA
ZANAFLEX TABLET 4 MG ORAL ( <i>tizanidine hcl</i> )	Non Preferred	PA; QL (9 EA per 1 day)
<b>*DIRECT MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>dantrolene sodium capsule 100 mg oral</i>	Preferred	
<i>dantrolene sodium capsule 25 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>dantrolene sodium capsule 50 mg oral</i>	Preferred	
DANTRIUM CAPSULE 25 MG ORAL ( <i>dantrolene sodium</i> )	Non Preferred	PA
<b>*FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
SOHONOS CAPSULE 1 MG ORAL ( <i>palovarotene</i> )	Non Preferred	PA
SOHONOS CAPSULE 1.5 MG ORAL ( <i>palovarotene</i> )	Non Preferred	PA
SOHONOS CAPSULE 10 MG ORAL ( <i>palovarotene</i> )	Non Preferred	PA
SOHONOS CAPSULE 2.5 MG ORAL ( <i>palovarotene</i> )	Non Preferred	PA
SOHONOS CAPSULE 5 MG ORAL ( <i>palovarotene</i> )	Non Preferred	PA
<b>*MUSCLE RELAXANT COMBINATIONS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>orphenadrine-aspirin-caffeine tablet 25-385-30 mg oral</i>	Preferred	
<i>orphenadrine-aspirin-caffeine tablet 50-770-60 mg oral</i>	Preferred	
<i>orphenadrine-aspirin-caffeine</i> (Norgesic Tablet 25-385-30 Mg Oral)	Preferred	
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Tablet 50-770-60 Mg Oral)	Preferred	
<i>norgesic forte tablet 50-770-60 mg oral</i>	Non Preferred	PA
ORPHENGESIC FORTE TABLET 770-60-50 MG ORAL ( <i>orphenadrine-aspirin-caffeine</i> )	Non Preferred	PA
<b>*NASAL AGENTS - SYSTEMIC AND TOPICAL* - DRUGS FOR THE NOSE</b>		
<b>*ANTI-HISTAMINE-STERIOD*** - ALLERGY</b>		
<i>azelastine-fluticasone suspension 137-50 mcg/act nasal</i>	Non Preferred	PA
DYMISTA SUSPENSION 137-50 MCG/ACT NASAL ( <i>azelastine-fluticasone</i> )	Non Preferred	PA
RYALTRIS SUSPENSION 665-25 MCG/ACT NASAL ( <i>olopatadine-mometasone</i> )	Non Preferred	PA
<b>*NASAL AGENTS - MISC.*** - ALLERGY</b>		
<i>deep sea nasal spray nasal solution 0.65 %</i>	Preferred	
<i>saline mist spray nasal solution 0.65 %</i>	Preferred	
<i>saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>sm nasal spray saline nasal solution 0.65 %</i>	Preferred	
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % ( <i>saline</i> )	Preferred	
OCEAN FOR KIDS NASAL SOLUTION 0.65 % ( <i>saline</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*NASAL ANTICHOLINERGICS*** - ALLERGY</b>		
<i>ipratropium bromide solution 0.03 % nasal</i>	Non Preferred	PA
<i>ipratropium bromide solution 0.06 % nasal</i>	Non Preferred	PA
<b>*NASAL ANTIHISTAMINES*** - ALLERGY</b>		
<i>azelastine hcl solution 0.1 % nasal</i>	Preferred	QL (1.2 ML per 1 day)
<i>azelastine hcl solution 0.15 % nasal</i>	Preferred	
<i>azelastine hcl solution 137 mcg/spray nasal</i>	Preferred	QL (1.2 ML per 1 day)
<i>olopatadine hcl solution 0.6 % nasal</i>	Preferred	
<b>*NASAL MAST CELL STABILIZERS*** - ALLERGY</b>		
<i>cromolyn sodium nasal aerosol solution 5.2 mg/act</i>	Preferred	QL (52 ML per 30 days)
<b>*NASAL STEROIDS*** - ALLERGY</b>		
<i>flunisolide solution 25 mcg/act (0.025%) nasal</i>	Preferred	
<i>fluticasone propionate suspension 50 mcg/act nasal (rx)</i>	Preferred	QL (16 GM per 30 days)
<i>mometasone furoate suspension 50 mcg/act nasal (rx)</i>	Non Preferred	PA
BECONASE AQ SUSPENSION 42 MCG/SPRAY NASAL ( <i>beclomethasone diprop monohyd</i> )	Non Preferred	PA
OMNARIS SUSPENSION 50 MCG/ACT NASAL ( <i>ciclesonide</i> )	Non Preferred	PA
PROPEL MINI SDS IMPLANT 370 MCG NASAL ( <i>mometasone furoate</i> )	Non Preferred	PA
QNASL AEROSOL SOLUTION 80 MCG/ACT NASAL ( <i>beclomethasone diprop (nasal)</i> )	Non Preferred	PA
QNASL CHILDRENS AEROSOL SOLUTION 40 MCG/ACT NASAL ( <i>beclomethasone diprop (nasal)</i> )	Non Preferred	PA
SINUVA IMPLANT 1350 MCG NASAL ( <i>mometasone furoate</i> )	Non Preferred	PA
XHANCE EXHALER SUSPENSION 93 MCG/ACT NASAL ( <i>fluticasone propionate</i> )	Non Preferred	PA
ZETONNA AEROSOL SOLUTION 37 MCG/ACT NASAL ( <i>ciclesonide</i> )	Non Preferred	PA
<b>*SYSTEMIC DECONGESTANTS*** - ALLERGY</b>		
<i>12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ft nasal decongestant max str oral tablet 30 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ft nasal decongestant max str oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ft nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>gnp nasal decongestant oral tablet 30 mg</i>	Preferred	QL (6 EA per 1 day)
<i>gnp nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp suphedrin oral liquid 15 mg/5ml</i>	Preferred	QL (40 ML per 1 day)
<i>nasal decongestant oral tablet 30 mg</i>	Preferred	QL (6 EA per 1 day)
<i>nasal decongestant pe max st oral tablet 10 mg</i>	Preferred	
<i>nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>phenylephrine hcl oral tablet 10 mg</i>	Preferred	
<i>pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sinus 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sinus congestion max strength oral tablet 30 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm nasal decongestant max st oral tablet 30 mg</i>	Preferred	QL (6 EA per 1 day)
<i>sm nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>sudogest 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
<i>suphedrine 12hour oral tablet extended release 12 hour 120 mg</i>	Preferred	QL (2 EA per 1 day)
SUDOGEST MAXIMUM STRENGTH ORAL TABLET 30 MG ( <i>pseudoephedrine hcl</i> )	Preferred	QL (6 EA per 1 day)
SUDOGEST ORAL TABLET 30 MG, 60 MG ( <i>pseudoephedrine hcl</i> )	Preferred	QL (6 EA per 1 day)
<b>*TOPICAL DECONGESTANTS*** - ALLERGY</b>		
<i>12 hour nasal decongestant nasal solution 0.05 %</i>	Preferred	
<i>12 hour nasal spray nasal solution 0.05 %</i>	Preferred	
<i>ft nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp nasal spray extra moist nasal solution 0.05 %</i>	Preferred	
<i>gnp nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp no drip nasal spray nasal solution 0.05 %</i>	Preferred	
<i>nasal decongestant spray nasal solution 0.05 %</i>	Preferred	
<i>nasal relief nasal solution 0.05 %</i>	Preferred	
<i>nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>nasal spray extra moisturizing nasal solution 0.05 %</i>	Preferred	
<i>nasal spray no drip nasal solution 0.05 %</i>	Preferred	
<i>sinus nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray sinus nasal solution 0.05 %</i>	Preferred	
MUCINEX SINUS-MAX CLEAR & COOL NASAL SOLUTION 0.05 % ( <i>oxymetazoline hcl</i> )	Preferred	
MUCINEX SINUS-MAX SINUS/ALLRGY NASAL SOLUTION 0.05 % ( <i>oxymetazoline hcl</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*NEUROMUSCULAR AGENTS* - DRUGS FOR NERVES AND MUSCLES</b>		
<b>*ALS AGENT COMBINATIONS*** - DRUGS FOR NERVES AND MUSCLES</b>		
RELYVRIO PACKET 3-1 GM ORAL ( <i>phenylbutyrate-taurursodiol</i> )	Non Preferred	PA
<b>*ALS AGENTS - MISCELLANEOUS*** - DRUGS FOR NERVES AND MUSCLES</b>		
RADICAVA ORS STARTER KIT SUSPENSION 105 MG/5ML ORAL ( <i>edaravone</i> )	Non Preferred	PA
RADICAVA ORS SUSPENSION 105 MG/5ML ORAL ( <i>edaravone</i> )	Non Preferred	PA
<b>*BENZATHIAZOLES*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>riluzole tablet 50 mg oral</i>	Preferred	
EXSERVAN FILM 50 MG ORAL ( <i>riluzole</i> )	Non Preferred	PA
RILUTEK TABLET 50 MG ORAL ( <i>riluzole</i> )	Non Preferred	PA
TEGLUTIK SUSPENSION 50 MG/10ML ORAL ( <i>riluzole</i> )	Non Preferred	PA
TIGLUTIK SUSPENSION 50 MG/10ML ORAL ( <i>riluzole</i> )	Non Preferred	PA
<b>*RETT SYNDROME AGENTS - GLYCINE-PROLINE-GLUTAMATE ANALOGS*** - DRUGS FOR NERVES AND MUSCLES</b>		
DAYBUE SOLUTION 200 MG/ML ORAL ( <i>trofinetide</i> )	Non Preferred	PA
<b>*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS* - DRUGS FOR INSOMNIA</b>		
<i>zolpidem tartrate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>zolpidem tartrate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>*NUTRIENTS* - DRUGS FOR NUTRITION</b>		
<b>*MISC. NUTRITIONAL SUBSTANCES*** - DRUGS FOR NUTRITION</b>		
<i>enteric fish oil oral capsule delayed release 1000 mg</i>	Preferred	
<i>fish oil high potency oral capsule 1000 mg</i>	Preferred	
<i>fish oil oral capsule 1000 mg, 500 mg</i>	Preferred	
<i>sm fish oil oral capsule 1000 mg</i>	Preferred	
<i>sm omega-3 fish oil oral capsule 1200 mg</i>	Preferred	
SEA-OMEGA 30 ORAL CAPSULE 1200 MG ( <i>omega-3 fatty acids</i> )	Preferred	
SEA-OMEGA ORAL CAPSULE 1000 MG ( <i>omega-3 fatty acids</i> )	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*OPHTHALMIC AGENTS* - DRUGS FOR THE EYE</b>		
<b>*ALPHA ADRENERGIC AGONIST &amp; CARBONIC ANHYDRASE INHIB COMB*** - DRUGS FOR GLAUCOMA</b>		
SIMBRINZA SUSPENSION 1-0.2 % OPHTHALMIC (brinzolamide-brimonidine)	Non Preferred	PA
<b>*ARTIFICIAL TEAR AND LUBRICANT COMBINATIONS*** - DRUGS FOR THE EYE</b>		
artificial tears ophthalmic solution 0.5-0.6 %	Preferred	
dry eye relief drops ophthalmic solution 0.2-0.2-1 %	Preferred	
ft lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
gnp artificial tears ophthalmic solution 5-6 mg/ml	Preferred	
gnp eye drops long lasting ophthalmic solution 0.4-0.3 %	Preferred	
gnp eye drops ophthalmic solution 0.2-0.2-1 %	Preferred	
gnp nighttime relief lub eye ophthalmic ointment 57.3-42.5 %	Preferred	
goodsense lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %	Preferred	
lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
lubricant eye nighttime ophthalmic ointment	Preferred	
lubricating eye drops ophthalmic solution 0.4-0.3 %	Preferred	
lubrifresh p.m. ophthalmic ointment	Preferred	
sm dry eye relief ophthalmic solution 0.2-0.2-1 %	Preferred	
sm lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
sm lubricating tears ophthalmic solution 0.4-0.3 %	Preferred	
ultra lubricating eye drops ophthalmic solution 0.4-0.3 %	Preferred	
ultra lubricating eye drops pf ophthalmic solution 0.4-0.3 %	Preferred	
GENTEAL TEARS NIGHT-TIME OPHTHALMIC OINTMENT (white petrolatum-mineral oil)	Preferred	
GENTEAL TEARS OPHTHALMIC SOLUTION 0.1-0.3 % (dextran 70-hypromellose)	Preferred	
REFRESH LACRI-LUBE OPHTHALMIC OINTMENT (white petrolatum-mineral oil)	Preferred	
REFRESH P.M. OPHTHALMIC OINTMENT (white petrolatum-mineral oil)	Preferred	
SYSTANE NIGHTTIME OPHTHALMIC OINTMENT (white petrolatum-mineral oil)	Preferred	
<b>*ARTIFICIAL TEAR INSERTS*** - DRUGS FOR THE EYE</b>		
LACRISERT INSERT 5 MG OPHTHALMIC (artificial tear insert)	Preferred	
<b>*ARTIFICIAL TEAR SOLUTIONS*** - DRUGS FOR THE EYE</b>		
artificial tears ophthalmic solution	Preferred	
sm artificial tears ophthalmic solution	Preferred	
GENTEAL TEARS OPHTHALMIC SOLUTION 0.1-0.2-0.3 % (artificial tear solution)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SYSTANE CONTACTS OPHTHALMIC SOLUTION ( <i>artificial tear solution</i> )	Preferred	
<b>*ARTIFICIAL TEARS AND LUBRICANTS*** - DRUGS FOR THE EYE</b>		
<i>artificial tears ophthalmic solution 1.4 %</i>	Preferred	
<i>carboxymethylcellulose sodium ophthalmic solution 0.5 %</i>	Preferred	
<i>ft lubricant eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>gnp eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>gnp lubricant eye drops (pf) ophthalmic solution 0.5 %</i>	Preferred	
<i>gnp lubricating plus eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>goodsense lubricating eye drop ophthalmic solution 0.5 %</i>	Preferred	
<i>lubricant eye drops pf ophthalmic solution 0.5 %</i>	Preferred	
<i>polyvinyl alcohol ophthalmic solution 1.4 %</i>	Preferred	
<i>sm lubricating plus ophthalmic solution 0.5 %</i>	Preferred	
<i>ventiva tears ophthalmic solution 0.5 %</i>	Preferred	
<b>*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS*** - DRUGS FOR GLAUCOMA</b>		
<i>dorzolamide hcl-timolol mal solution 2-0.5 % ophthalmic</i>	Preferred	QL (10 ML per 25 days)
<i>dorzolamide hcl-timolol mal solution 2-0.5 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>brimonidine tartrate-timolol solution 0.2-0.5 % ophthalmic</i>	Non Preferred	PA
<i>dorzolamide hcl-timolol mal pf solution 2-0.5 % ophthalmic</i>	Non Preferred	PA
COMBIGAN SOLUTION 0.2-0.5 % OPHTHALMIC ( <i>brimonidine tartrate-timolol</i> )	Non Preferred	PA
COSOPT PF SOLUTION 2-0.5 % OPHTHALMIC ( <i>dorzolamide hcl-timolol mal</i> )	Non Preferred	PA
COSOPT SOLUTION 2-0.5 % OPHTHALMIC ( <i>dorzolamide hcl-timolol mal</i> )	Non Preferred	PA; QL (10 ML per 30 days)
<b>*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA</b>		
<i>betaxolol hcl solution 0.5 % ophthalmic</i>	Preferred	
<i>carteolol hcl solution 1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>levobunolol hcl solution 0.5 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>timolol maleate (once-daily) solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.25 % ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate pf solution 0.25 % ophthalmic</i>	Non Preferred	PA
<i>timolol maleate pf solution 0.5 % ophthalmic</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
BETIMOL SOLUTION 0.25 % OPHTHALMIC ( <i>timolol hemihydrate</i> )	Non Preferred	PA
BETIMOL SOLUTION 0.5 % OPHTHALMIC ( <i>timolol hemihydrate</i> )	Non Preferred	PA
BETOPTIC-S SUSPENSION 0.25 % OPHTHALMIC ( <i>betaxolol hcl</i> )	Non Preferred	PA
ISTALOL SOLUTION 0.5 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
<i>timolol maleate</i> (Timolol Maleate OcuDose Solution 0.5 % Ophthalmic)	Non Preferred	PA
TIMOPTIC OCUDOSE SOLUTION 0.25 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
TIMOPTIC OCUDOSE SOLUTION 0.5 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
TIMOPTIC SOLUTION 0.25 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
TIMOPTIC SOLUTION 0.5 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
TIMOPTIC-XE GEL FORMING SOLUTION 0.25 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
TIMOPTIC-XE GEL FORMING SOLUTION 0.5 % OPHTHALMIC ( <i>timolol maleate</i> )	Non Preferred	PA
<b>*CYCLOPLEGIC MYDRIATIC COMBINATIONS*** - DRUGS FOR THE EYE</b>		
CYCLOMYDRIL SOLUTION 0.2-1 % OPHTHALMIC ( <i>cyclopentolate-phenylephrine</i> )	Preferred	
<b>*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE</b>		
<i>atropine sulfate ointment 1 % ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>atropine sulfate solution 1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>cyclopentolate hcl solution 1 % ophthalmic</i>	Preferred	
<i>tropicamide solution 0.5 % ophthalmic</i>	Preferred	
<i>tropicamide solution 1 % ophthalmic</i>	Preferred	
<i>phenylephrine hcl solution 10 % ophthalmic</i>	Non Preferred	PA
<i>phenylephrine hcl solution 2.5 % ophthalmic</i>	Non Preferred	PA
CYCLOGYL SOLUTION 0.5 % OPHTHALMIC ( <i>cyclopentolate hcl</i> )	Non Preferred	PA
CYCLOGYL SOLUTION 1 % OPHTHALMIC ( <i>cyclopentolate hcl</i> )	Non Preferred	PA
CYCLOGYL SOLUTION 2 % OPHTHALMIC ( <i>cyclopentolate hcl</i> )	Non Preferred	PA
MYDRIACYL SOLUTION 1 % OPHTHALMIC ( <i>tropicamide</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
XIIDRA SOLUTION 5 % OPHTHALMIC ( <i>lifitegrast</i> )	Non Preferred	PA
<b>*MIOTICS - CHOLINESTERASE INHIBITORS*** - DRUGS FOR GLAUCOMA</b>		
PHOSPHOLINE IODIDE SOLUTION RECONSTITUTED 0.125 % OPHTHALMIC ( <i>echothiophate iodide</i> )	Non Preferred	PA
<b>*MIOTICS - DIRECT ACTING*** - DRUGS FOR GLAUCOMA</b>		
<i>pilocarpine hcl solution 1 % ophthalmic</i>	Preferred	
<i>pilocarpine hcl solution 2 % ophthalmic</i>	Preferred	
<i>pilocarpine hcl solution 4 % ophthalmic</i>	Preferred	
VUITY SOLUTION 1.25 % OPHTHALMIC ( <i>pilocarpine hcl</i> )	Non Preferred	PA
<b>*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR ITCHY EYE</b>		
<i>azelastine hcl solution 0.05 % ophthalmic</i>	Preferred	QL (0.28 ML per 1 day)
<i>cromolyn sodium solution 4 % ophthalmic</i>	Preferred	
<i>eye itch relief ophthalmic solution 0.025 %, 0.035 %</i>	Preferred	
<i>ketotifen fumarate ophthalmic solution 0.025 %, 0.035 %</i>	Preferred	
<i>sm eye itch relief ophthalmic solution 0.035 %</i>	Preferred	
ALAWAY CHILDRENS ALLERGY OPHTHALMIC SOLUTION 0.035 % ( <i>ketotifen fumarate</i> )	Preferred	
ALAWAY OPHTHALMIC SOLUTION 0.035 % ( <i>ketotifen fumarate</i> )	Preferred	
<i>bepotastine besilate solution 1.5 % ophthalmic</i>	Non Preferred	PA
<i>epinastine hcl solution 0.05 % ophthalmic</i>	Non Preferred	PA
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Non Preferred	PA; QL (5 ML per 30 days)
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Non Preferred	PA; QL (2.5 ML per 30 days)
ALOMIDE SOLUTION 0.1 % OPHTHALMIC ( <i>lodoxamide tromethamine</i> )	Non Preferred	PA
BEPREVE SOLUTION 1.5 % OPHTHALMIC ( <i>bepotastine besilate</i> )	Non Preferred	PA
ZERVIAE SOLUTION 0.24 % OPHTHALMIC ( <i>cetirizine hcl</i> )	Non Preferred	PA
<b>*OPHTHALMIC ANTIBIOTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bacitracin ointment 500 unit/gm ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>ciprofloxacin hcl solution 0.3 % ophthalmic</i>	Preferred	

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<i>erythromycin ointment 5 mg/gm ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>gentamicin sulfate solution 0.3 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>ofloxacin solution 0.3 % ophthalmic</i>	Preferred	
<i>tobramycin solution 0.3 % ophthalmic</i>	Preferred	
CILOXAN OINTMENT 0.3 % OPHTHALMIC ( <i>ciprofloxacin hcl</i> )	Preferred	Max 60-day supply per fill
TOBEX OINTMENT 0.3 % OPHTHALMIC ( <i>tobramycin</i> )	Preferred	Max 60-day supply per fill
<i>gatifloxacin solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>moxifloxacin hcl (2x day) solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>moxifloxacin hcl solution 0.5 % ophthalmic</i>	Non Preferred	PA
AZASITE SOLUTION 1 % OPHTHALMIC ( <i>azithromycin</i> )	Non Preferred	PA
BESIVANCE SUSPENSION 0.6 % OPHTHALMIC ( <i>besifloxacin hcl</i> )	Non Preferred	PA
OCUFLOX SOLUTION 0.3 % OPHTHALMIC ( <i>ofloxacin</i> )	Non Preferred	PA
VIGAMOX SOLUTION 0.5 % OPHTHALMIC ( <i>moxifloxacin hcl</i> )	Non Preferred	PA
ZYMAXID SOLUTION 0.5 % OPHTHALMIC ( <i>gatifloxacin</i> )	Non Preferred	PA
<b>*OPHTHALMIC ANTIFUNGAL*** - DRUGS FOR THE EYE</b>		
NATACYN SUSPENSION 5 % OPHTHALMIC ( <i>natamycin</i> )	Non Preferred	PA
<b>*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bacitracin-polymyxin b ointment 500-10000 unit/gm ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>neomycin-bacitracin zn-polymyx ointment 3.5-400-10000 ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>neomycin-bacitracin zn-polymyx ointment 5-400-10000 ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>neomycin-polymyxin-gramicidin solution 1.75-10000-.025 ophthalmic</i>	Preferred	
<i>polymyxin b-trimethoprim solution 10000-0.1 unit/ml-% ophthalmic</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx (Neo-Polycin Ointment 3.5-400-10000 Ophthalmic)</i>	Preferred	Max 60-day supply per fill
<i>bacitracin-polymyxin b (Polycin Ointment 500-10000 Unit/Gm Ophthalmic)</i>	Preferred	Max 60-day supply per fill
<b>*OPHTHALMIC ANTISEPTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
BETADINE OPHTHALMIC PREP SOLUTION 5 % OPHTHALMIC ( <i>povidone-iodine</i> )	Non Preferred	PA

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<b>*OPHTHALMIC ANTIVIRALS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>trifluridine solution 1 % ophthalmic</i>	Preferred	QL (7.5 ML per 30 days)
ZIRGAN GEL 0.15 % OPHTHALMIC ( <i>ganciclovir</i> )	Preferred	
<b>*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR GLAUCOMA</b>		
<i>dorzolamide hcl solution 2 % ophthalmic</i>	Preferred	
<i>brinzolamide suspension 1 % ophthalmic</i>	Non Preferred	PA
AZOPT SUSPENSION 1 % OPHTHALMIC ( <i>brinzolamide</i> )	Non Preferred	PA
<b>*OPHTHALMIC DIAGNOSTIC PRODUCTS*** - DRUGS FOR THE EYE</b>		
<i>fluorescein sodium/benoxinate solution 0.3-0.4 % ophthalmic</i>	Non Preferred	PA
GLOSTRIPS STRIP 1 MG OPHTHALMIC ( <i>fluorescein sodium</i> )	Non Preferred	PA
<b>*OPHTHALMIC ECTOPARASITICIDE** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
XDEMVY SOLUTION 0.25 % OPHTHALMIC ( <i>lotilaner</i> )	Non Preferred	PA
<b>*OPHTHALMIC HYPEROSMOLAR PRODUCTS*** - DRUGS FOR THE EYE</b>		
<i>sodium chloride (hypertonic) ophthalmic ointment 5 %</i>	Preferred	
<i>sodium chloride (hypertonic) ophthalmic solution 5 %</i>	Preferred	
<b>*OPHTHALMIC IMMUNOMODULATORS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	Non Preferred	PA
CEQUA SOLUTION 0.09 % OPHTHALMIC ( <i>cyclosporine</i> )	Non Preferred	PA
RESTASIS EMULSION 0.05 % OPHTHALMIC ( <i>cyclosporine</i> )	Non Preferred	PA
RESTASIS MULTIDOSE EMULSION 0.05 % OPHTHALMIC ( <i>cyclosporine</i> )	Non Preferred	PA
VERKAZIA EMULSION 0.1 % OPHTHALMIC ( <i>cyclosporine</i> )	Non Preferred	PA
VEVYE SOLUTION 0.1 % OPHTHALMIC ( <i>cyclosporine</i> )	Non Preferred	PA
<b>*OPHTHALMIC KINASE INHIBITORS - COMBINATIONS*** - DRUGS FOR GLAUCOMA</b>		
ROCKLATAN SOLUTION 0.02-0.005 % OPHTHALMIC ( <i>netarsudil-latanoprost</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*OPHTHALMIC LOCAL ANESTHETICS*** - DRUGS FOR THE EYE</b>		
<i>proparacaine hcl solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>tetracaine hcl solution 0.5 % ophthalmic</i>	Non Preferred	PA
AKTEN GEL 3.5 % OPHTHALMIC ( <i>lidocaine hcl</i> )	Non Preferred	PA
ALCAINE SOLUTION 0.5 % OPHTHALMIC ( <i>proparacaine hcl</i> )	Non Preferred	PA
IHEEZO GEL 3 % OPHTHALMIC ( <i>chloroprocaine hcl</i> )	Non Preferred	PA
<b>*OPHTHALMIC NERVE GROWTH FACTORS*** - DRUGS FOR THE EYE</b>		
OXERVATE SOLUTION 0.002 % OPHTHALMIC ( <i>cenegermin-bkbj</i> )	Non Preferred	PA
<b>*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>diclofenac sodium solution 0.1 % ophthalmic</i>	Preferred	
<i>flurbiprofen sodium solution 0.03 % ophthalmic</i>	Preferred	
<i>ketorolac tromethamine solution 0.4 % ophthalmic</i>	Preferred	
<i>ketorolac tromethamine solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>bromfenac sodium (once-daily) solution 0.09 % ophthalmic</i>	Non Preferred	PA
<i>bromfenac sodium solution 0.07 % ophthalmic</i>	Non Preferred	PA
ACULAR LS SOLUTION 0.4 % OPHTHALMIC ( <i>ketorolac tromethamine</i> )	Non Preferred	PA
ACULAR SOLUTION 0.5 % OPHTHALMIC ( <i>ketorolac tromethamine</i> )	Non Preferred	PA; QL (10 ML per 30 days)
ACUVAIL SOLUTION 0.45 % OPHTHALMIC ( <i>ketorolac tromethamine</i> )	Non Preferred	PA
BROMSITE SOLUTION 0.075 % OPHTHALMIC ( <i>bromfenac sodium</i> )	Non Preferred	PA
ILEVRO SUSPENSION 0.3 % OPHTHALMIC ( <i>nepafenac</i> )	Non Preferred	PA
NEVANAC SUSPENSION 0.1 % OPHTHALMIC ( <i>nepafenac</i> )	Non Preferred	PA
PROLENSA SOLUTION 0.07 % OPHTHALMIC ( <i>bromfenac sodium</i> )	Non Preferred	PA
<b>*OPHTHALMIC RHO KINASE INHIBITORS*** - DRUGS FOR GLAUCOMA</b>		
RHOPRESSA SOLUTION 0.02 % OPHTHALMIC ( <i>netarsudil dimesylate</i> )	Non Preferred	PA

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<b>*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR GLAUCOMA</b>		
<i>brimonidine tartrate solution 0.1 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.15 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.2 % ophthalmic</i>	Preferred	
ALPHAGAN P SOLUTION 0.1 % OPTHALMIC ( <i>brimonidine tartrate</i> )	Preferred	
ALPHAGAN P SOLUTION 0.15 % OPTHALMIC ( <i>brimonidine tartrate</i> )	Preferred	
<i>apraclonidine hcl solution 0.5 % ophthalmic</i>	Non Preferred	PA
IOPIDINE SOLUTION 1 % OPTHALMIC ( <i>apraclonidine hcl</i> )	Non Preferred	PA
<b>*OPHTHALMIC STEROID COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bacitra-neomycin-polymyxin-hc ointment 1 % ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>neomycin-polymyxin-dexameth ointment 3.5-10000-0.1 ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>neomycin-polymyxin-dexameth suspension 3.5-10000-0.1 ophthalmic</i>	Preferred	
<i>neomycin-polymyxin-hc suspension 3.5-10000-1 ophthalmic</i>	Preferred	
<i>tobramycin-dexamethasone suspension 0.3-0.1 % ophthalmic</i>	Preferred	
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ointment 1 % Ophthalmic)	Preferred	Max 60-day supply per fill
<i>sulfacetamide-prednisolone solution 10-0.23 % ophthalmic</i>	Non Preferred	PA
MAXITROL OINTMENT 3.5-10000-0.1 OPTHALMIC ( <i>neomycin-polymyxin-dexameth</i> )	Non Preferred	PA; Max 60-day supply per fill
MAXITROL SUSPENSION 0.1 % OPTHALMIC ( <i>neomycin-polymyxin-dexameth</i> )	Non Preferred	PA
MAXITROL SUSPENSION 3.5-10000-0.1 OPTHALMIC ( <i>neomycin-polymyxin-dexameth</i> )	Non Preferred	PA
TOBRADEX OINTMENT 0.3-0.1 % OPTHALMIC ( <i>tobramycin-dexamethasone</i> )	Non Preferred	PA; Max 60-day supply per fill
TOBRADEX ST SUSPENSION 0.3-0.05 % OPTHALMIC ( <i>tobramycin-dexamethasone</i> )	Non Preferred	PA
TOBRADEX SUSPENSION 0.3-0.1 % OPTHALMIC ( <i>tobramycin-dexamethasone</i> )	Non Preferred	PA
ZYLET SUSPENSION 0.5-0.3 % OPTHALMIC ( <i>loteprednol-tobramycin</i> )	Non Preferred	PA
<b>*OPHTHALMIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>dexamethasone sodium phosphate solution 0.1 % ophthalmic</i>	Preferred	
<i>fluorometholone suspension 0.1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>loteprednol etabonate suspension 0.5 % ophthalmic</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>prednisolone acetate suspension 1 % ophthalmic</i>	Preferred	
<i>prednisolone sodium phosphate solution 1 % ophthalmic</i>	Preferred	
ALREX SUSPENSION 0.2 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Preferred	
FLAREX SUSPENSION 0.1 % OPHTHALMIC ( <i>fluorometholone acetate</i> )	Preferred	
FML FORTE SUSPENSION 0.25 % OPHTHALMIC ( <i>fluorometholone</i> )	Preferred	
MAXIDEX SUSPENSION 0.1 % OPHTHALMIC ( <i>dexamethasone</i> )	Preferred	
PRED MILD SUSPENSION 0.12 % OPHTHALMIC ( <i>prednisolone acetate</i> )	Preferred	
<i>difluprednate emulsion 0.05 % ophthalmic</i>	Non Preferred	PA
<i>loteprednol etabonate gel 0.5 % ophthalmic</i>	Non Preferred	PA
DEXTENZA INSERT 0.4 MG OPHTHALMIC ( <i>dexamethasone</i> )	Non Preferred	PA
DUREZOL EMULSION 0.05 % OPHTHALMIC ( <i>difluprednate</i> )	Non Preferred	PA
EYSUVIS SUSPENSION 0.25 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA
FML LIQUIFILM SUSPENSION 0.1 % OPHTHALMIC ( <i>fluorometholone</i> )	Non Preferred	PA; QL (15 ML per 30 days)
INVELTYS SUSPENSION 1 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA
LOTEMAX GEL 0.5 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA
LOTEMAX OINTMENT 0.5 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA; Max 60-day supply per fill
LOTEMAX SM GEL 0.38 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA
LOTEMAX SUSPENSION 0.5 % OPHTHALMIC ( <i>loteprednol etabonate</i> )	Non Preferred	PA
PRED FORTE SUSPENSION 1 % OPHTHALMIC ( <i>prednisolone acetate</i> )	Non Preferred	PA
<b>*OPHTHALMIC SULFONAMIDES*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>sulfacetamide sodium ointment 10 % ophthalmic</i>	Preferred	Max 60-day supply per fill
<i>sulfacetamide sodium solution 10 % ophthalmic</i>	Preferred	
<b>*OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE</b>		
CYSTADROPS SOLUTION 0.37 % OPHTHALMIC ( <i>cysteamine hcl</i> )	Non Preferred	PA
CYSTARAN SOLUTION 0.44 % OPHTHALMIC ( <i>cysteamine hcl</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*PROSTAGLANDINS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA</b>		
<i>latanoprost solution 0.005 % ophthalmic</i>	Preferred	QL (0.17 ML per 1 day)
<i>bimatoprost solution 0.03 % ophthalmic</i>	Non Preferred	PA
<i>tafluprost (pf) solution 0.0015 % ophthalmic</i>	Non Preferred	PA
<i>travoprost (bak free) solution 0.004 % ophthalmic</i>	Non Preferred	PA; QL (5 ML per 30 days)
IYUZEH SOLUTION 0.005 % OPHTHALMIC ( <i>latanoprost</i> )	Non Preferred	PA
LUMIGAN SOLUTION 0.01 % OPHTHALMIC ( <i>bimatoprost</i> )	Non Preferred	PA
TRAVATAN Z SOLUTION 0.004 % OPHTHALMIC ( <i>travoprost</i> )	Non Preferred	PA; QL (5 ML per 30 days)
VYZULTA SOLUTION 0.024 % OPHTHALMIC ( <i>latanoprostene bunod</i> )	Non Preferred	PA
XALATAN SOLUTION 0.005 % OPHTHALMIC ( <i>latanoprost</i> )	Non Preferred	PA; QL (0.17 ML per 1 day)
XELPROS EMULSION 0.005 % OPHTHALMIC ( <i>latanoprost</i> )	Non Preferred	PA
ZIOPTAN SOLUTION 0.0015 % OPHTHALMIC ( <i>tafluprost</i> )	Non Preferred	PA
<b>*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR THE EYE</b>		
<b>*OPHTHALMIC AGENTS* - DRUGS FOR ITCHY EYE</b>		
<i>bepotastine besilate solution 1.5 % ophthalmic</i>	Non Preferred	PA
<b>*OPHTHALMIC ANTIBIOTICS*** - DRUGS FOR THE EYE</b>		
<b>*OPHTHALMIC AGENTS* - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>ofloxacin solution 0.3 % ophthalmic</i>	Preferred	
<b>*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR THE EYE</b>		
<b>*OPHTHALMIC AGENTS* - DRUGS FOR GLAUCOMA</b>		
<i>brinzolamide suspension 1 % ophthalmic</i>	Non Preferred	PA
<b>*OPIOID AGONISTS*** - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANALGESICS - OPIOID* - ARTHRITIS AND PAIN DRUGS</b>		
<i>tramadol hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); AGE (Min 18 Years)
<b>*OTIC AGENTS* - DRUGS FOR THE EAR</b>		
<b>*OTIC AGENTS - MISCELLANEOUS*** - WAX REMOVAL</b>		
<i>acetic acid solution 2 % otic</i>	Preferred	QL (20 ML per 30 days)
<i>ear drops otic solution 6.5 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>earwax removal otic solution 6.5 %</i>	Preferred	
<i>ft earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>ft earwax removal otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal drops otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>sm ear drops otic solution 6.5 %</i>	Preferred	
<b>*OTIC ANTI-INFECTIVES*** - ANTIBIOTICS</b>		
<i>ofloxacin solution 0.3 % otic</i>	Preferred	QL (5 ML per 30 days)
<i>ciprofloxacin hcl solution 0.2 % otic</i>	Non Preferred	PA; QL (14 EA per 30 days)
<b>*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic</i>	Preferred	QL (7.5 ML per 30 days)
<i>neomycin-polymyxin-hc solution 1 % otic</i>	Preferred	
<i>neomycin-polymyxin-hc solution 3.5-10000-1 otic</i>	Preferred	
<i>neomycin-polymyxin-hc suspension 3.5-10000-1 otic</i>	Preferred	
CIPRODEX SUSPENSION 0.3-0.1 % OTIC ( <i>ciprofloxacin-dexamethasone</i> )	Preferred	QL (7.5 ML per 30 days)
<i>ciprofloxacin-fluocinolone pf solution 0.3-0.025 % otic</i>	Non Preferred	PA
CORTISPORIN-TC SUSPENSION 3.3-3-10-0.5 MG/ML OTIC ( <i>neomycin-colist-hc-thonzonium</i> )	Non Preferred	PA
<b>*OTIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>fluocinolone acetonide oil 0.01 % otic</i>	Non Preferred	PA
<i>hydrocortisone-acetic acid solution 1-2 % otic</i>	Non Preferred	PA
DERMOTIC OIL 0.01 % OTIC ( <i>fluocinolone acetonide</i> )	Non Preferred	PA
<i>fluocinolone acetonide</i> (Flac Oil 0.01 % Otic)	Non Preferred	PA
<b>*OXYTOCICS* - HORMONES</b>		
<b>*OXYTOCICS*** - DRUGS FOR WOMEN</b>		
<i>methylergonovine maleate oral tablet 0.2 mg</i>	Preferred	QL (7 EA per 1 day)
<i>methylergonovine maleate</i> (Methergine Oral Tablet 0.2 Mg)	Preferred	QL (7 EA per 1 day)
<b>*PENICILLINS* - DRUGS FOR INFECTIONS</b>		
<b>*AMINOPENICILLINS*** - ANTIBIOTICS</b>		
<i>amoxicillin capsule 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>amoxicillin capsule 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>amoxicillin suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>amoxicillin suspension reconstituted 200 mg/5ml oral</i>	Preferred	
<i>amoxicillin suspension reconstituted 250 mg/5ml oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>amoxicillin suspension reconstituted 400 mg/5ml oral</i>	Preferred	
<i>amoxicillin tablet 500 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>amoxicillin tablet 875 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>amoxicillin tablet chewable 125 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>amoxicillin tablet chewable 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>ampicillin capsule 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
<b>*NATURAL PENICILLINS*** - ANTIBIOTICS</b>		
<i>penicillin v potassium solution reconstituted 125 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>penicillin v potassium solution reconstituted 250 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>penicillin v potassium tablet 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>penicillin v potassium tablet 500 mg oral</i>	Preferred	QL (8 EA per 1 day)
<b>*PENICILLIN COMBINATIONS*** - ANTIBIOTICS</b>		
<i>amoxicillin-pot clavulanate suspension reconstituted 200-28.5 mg/5ml oral</i>	Preferred	
<i>amoxicillin-pot clavulanate suspension reconstituted 250-62.5 mg/5ml oral</i>	Preferred	
<i>amoxicillin-pot clavulanate suspension reconstituted 400-57 mg/5ml oral</i>	Preferred	
<i>amoxicillin-pot clavulanate suspension reconstituted 600-42.9 mg/5ml oral</i>	Preferred	
<i>amoxicillin-pot clavulanate tablet 250-125 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>amoxicillin-pot clavulanate tablet 500-125 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>amoxicillin-pot clavulanate tablet 875-125 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>amoxicillin-pot clavulanate tablet chewable 200-28.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>amoxicillin-pot clavulanate tablet chewable 400-57 mg oral</i>	Preferred	QL (4 EA per 1 day)
AUGMENTIN SUSPENSION RECONSTITUTED 125-31.25 MG/5ML ORAL ( <i>amoxicillin-pot clavulanate</i> )	Preferred	
<i>amoxicillin-pot clavulanate er tablet extended release 12 hour 1000-62.5 mg oral</i>	Non Preferred	PA
AUGMENTIN ES-600 SUSPENSION RECONSTITUTED 600-42.9 MG/5ML ORAL ( <i>amoxicillin-pot clavulanate</i> )	Non Preferred	PA
<b>*PENICILLINASE-RESISTANT PENICILLINS*** - ANTIBIOTICS</b>		
<i>dicloxacillin sodium capsule 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>dicloxacillin sodium capsule 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<b>*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH</b>		
<b>*GASTROINTESTINAL AGENTS - MISC.* - DRUGS FOR THE STOMACH</b>		
RENVELA TABLET 800 MG ORAL ( <i>sevelamer carbonate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*PROGESTINS* - HORMONES</b>		
<b>*PROGESTINS*** - DRUGS FOR WOMEN</b>		
<i>medroxyprogesterone acetate tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>medroxyprogesterone acetate tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>medroxyprogesterone acetate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>progesterone capsule 100 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>progesterone capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>progesterone oil 50 mg/ml intramuscular</i>	Preferred	
<i>megestrol acetate suspension 625 mg/5ml oral</i>	Non Preferred	PA
<i>norethindrone acetate tablet 5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
AYGESTIN TABLET 5 MG ORAL ( <i>norethindrone acetate</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PROMETRIUM CAPSULE 100 MG ORAL ( <i>progesterone</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PROMETRIUM CAPSULE 200 MG ORAL ( <i>progesterone</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PROVERA TABLET 10 MG ORAL ( <i>medroxyprogesterone acetate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PROVERA TABLET 2.5 MG ORAL ( <i>medroxyprogesterone acetate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PROVERA TABLET 5 MG ORAL ( <i>medroxyprogesterone acetate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*AGENTS FOR OPIOID WITHDRAWAL*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
LUCEMYRA TABLET 0.18 MG ORAL ( <i>lofexidine hcl</i> )	Preferred	
<b>*ALCOHOL DETERRENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>acamprosate calcium tablet delayed release 333 mg oral</i>	Preferred	
<i>disulfiram tablet 250 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>disulfiram tablet 500 mg oral</i>	Preferred	QL (1 EA per 1 day)
<b>*ALZHEIMER'S TREATMENT - ANTI-AMYLOID ANTIBODIES*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
ADUHELM SOLUTION 170 MG/1.7ML INTRAVENOUS ( <i>aducanumab-avwa</i> )	Non Preferred	PA
ADUHELM SOLUTION 300 MG/3ML INTRAVENOUS ( <i>aducanumab-avwa</i> )	Non Preferred	PA
LEQEMBI SOLUTION 200 MG/2ML INTRAVENOUS ( <i>lecanemab-irmb</i> )	Non Preferred	PA
LEQEMBI SOLUTION 500 MG/5ML INTRAVENOUS ( <i>lecanemab-irmb</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ANTI-CATAPLECTIC AGENTS*** - DRUGS FOR SLEEP DISORDER</b>		
<i>sodium oxybate solution 500 mg/ml oral</i>	Non Preferred	PA
<i>sodium oxybate solution 500 mg/ml oral</i>	Non Preferred	PA; Max 150-day supply per fill
XYREM SOLUTION 500 MG/ML ORAL ( <i>sodium oxybate</i> )	Non Preferred	PA
<b>*ANTI-CATAPLECTIC COMBINATIONS*** - DRUGS FOR SLEEP DISORDER</b>		
XYWAV SOLUTION 500 MG/ML ORAL ( <i>ca, mg, k, and na oxybates</i> )	Non Preferred	PA
<b>*ANTIDEMENTIA AGENT COMBINATIONS*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
NAMZARIC CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG ORAL ( <i>memantine hcl-donepezil hcl</i> )	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG ORAL ( <i>memantine hcl-donepezil hcl</i> )	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 21-10 MG ORAL ( <i>memantine hcl-donepezil hcl</i> )	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 28-10 MG ORAL ( <i>memantine hcl-donepezil hcl</i> )	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 7-10 MG ORAL ( <i>memantine hcl-donepezil hcl</i> )	Non Preferred	PA
<b>*ANTISENSE OLIGONUCLEOTIDE (ASO) INHIBITOR AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
TEGSEDI SOLUTION PREFILLED SYRINGE 284 MG/1.5ML SUBCUTANEOUS ( <i>inotersen sodium</i> )	Non Preferred	PA
WAINUA SOLUTION AUTO-INJECTOR 45 MG/0.8ML SUBCUTANEOUS ( <i>eplontersen sodium</i> )	Non Preferred	PA
<b>*BENZODIAZEPINES &amp; TRICYCLIC AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>chlordiazepoxide-amitriptyline tablet 10-25 mg oral</i>	Preferred	
<i>chlordiazepoxide-amitriptyline tablet 5-12.5 mg oral</i>	Preferred	
<b>*CHOLINOMIMETICS - ACHE INHIBITORS*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
<i>donepezil hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>donepezil hcl tablet 23 mg oral</i>	Preferred	Max 90-day supply per fill
<i>donepezil hcl tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>donepezil hcl tablet dispersible 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>donepezil hcl tablet dispersible 5 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>galantamine hydrobromide er capsule extended release 24 hour 16 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide er capsule extended release 24 hour 24 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide er capsule extended release 24 hour 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide solution 4 mg/ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide tablet 12 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide tablet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide tablet 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>rivastigmine patch 24 hour 13.3 mg/24hr transdermal</i>	Non Preferred	PA
<i>rivastigmine patch 24 hour 4.6 mg/24hr transdermal</i>	Non Preferred	PA
<i>rivastigmine patch 24 hour 9.5 mg/24hr transdermal</i>	Non Preferred	PA
<i>rivastigmine tartrate capsule 1.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>rivastigmine tartrate capsule 3 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>rivastigmine tartrate capsule 4.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>rivastigmine tartrate capsule 6 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ADLARITY PATCH WEEKLY 10 MG/DAY TRANSDERMAL ( <i>donepezil hcl</i> )	Non Preferred	PA
ADLARITY PATCH WEEKLY 5 MG/DAY TRANSDERMAL ( <i>donepezil hcl</i> )	Non Preferred	PA
ARICEPT TABLET 10 MG ORAL ( <i>donepezil hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
ARICEPT TABLET 23 MG ORAL ( <i>donepezil hcl</i> )	Non Preferred	PA
ARICEPT TABLET 5 MG ORAL ( <i>donepezil hcl</i> )	Non Preferred	PA; QL (1 EA per 1 day)
EXELON PATCH 24 HOUR 13.3 MG/24HR TRANSDERMAL ( <i>rivastigmine</i> )	Non Preferred	PA
EXELON PATCH 24 HOUR 4.6 MG/24HR TRANSDERMAL ( <i>rivastigmine</i> )	Non Preferred	PA
EXELON PATCH 24 HOUR 9.5 MG/24HR TRANSDERMAL ( <i>rivastigmine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*FIBROMYALGIA AGENT - SNRIS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
SAVELLA TABLET 100 MG ORAL ( <i>milnacipran hcl</i> )	Non Preferred	PA
SAVELLA TABLET 12.5 MG ORAL ( <i>milnacipran hcl</i> )	Non Preferred	PA
SAVELLA TABLET 25 MG ORAL ( <i>milnacipran hcl</i> )	Non Preferred	PA
SAVELLA TABLET 50 MG ORAL ( <i>milnacipran hcl</i> )	Non Preferred	PA
SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL ( <i>milnacipran hcl</i> )	Non Preferred	PA
<b>*MOVEMENT DISORDER DRUG THERAPY*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
AUSTEDO TABLET 12 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO TABLET 6 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO TABLET 9 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO XR PATIENT TITRATION TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 12 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 24 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL ( <i>deutetrabenazine</i> )	Preferred	PA
INGREZZA CAPSULE 40 MG ORAL ( <i>valbenazine tosylate</i> )	Preferred	PA
INGREZZA CAPSULE 60 MG ORAL ( <i>valbenazine tosylate</i> )	Preferred	PA
INGREZZA CAPSULE 80 MG ORAL ( <i>valbenazine tosylate</i> )	Preferred	PA
INGREZZA CAPSULE THERAPY PACK 40 & 80 MG ORAL ( <i>valbenazine tosylate</i> )	Preferred	PA
<i>tetrabenazine tablet 12.5 mg oral</i>	Non Preferred	PA
<i>tetrabenazine tablet 25 mg oral</i>	Non Preferred	PA
AUSTEDO PATIENT TITRATION KIT TABLET THERAPY PACK 6 & 9 & 12 MG ORAL ( <i>deutetrabenazine</i> )	Non Preferred	PA
XENAZINE TABLET 12.5 MG ORAL ( <i>tetrabenazine</i> )	Non Preferred	PA
XENAZINE TABLET 25 MG ORAL ( <i>tetrabenazine</i> )	Non Preferred	PA
<b>*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<i>teriflunomide tablet 14 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>teriflunomide tablet 7 mg oral</i>	Non Preferred	PA
AUBAGIO TABLET 14 MG ORAL ( <i>teriflunomide</i> )	Non Preferred	PA
AUBAGIO TABLET 7 MG ORAL ( <i>teriflunomide</i> )	Non Preferred	PA
<b>*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
MAVENCLAD (10 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (4 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (5 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (6 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (7 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (8 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
MAVENCLAD (9 TABS) TABLET THERAPY PACK 10 MG ORAL ( <i>cladribine</i> )	Non Preferred	PA
<b>*MULTIPLE SCLEROSIS AGENTS - INTERFERONS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
BETASERON KIT 0.3 MG SUBCUTANEOUS ( <i>interferon beta-1b</i> )	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
REBIF REBIDOSE TITRATION PACK SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
REBIF SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
REBIF SOLUTION PREFILLED SYRINGE 44 MCG/0.5ML SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
REBIF TITRATION PACK SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG SUBCUTANEOUS ( <i>interferon beta-1a</i> )	Preferred	
AVONEX PEN AUTO-INJECTOR KIT 30 MCG/0.5ML INTRAMUSCULAR ( <i>interferon beta-1a</i> )	Non Preferred	PA
AVONEX PREFILLED PREFILLED SYRINGE KIT 30 MCG/0.5ML INTRAMUSCULAR ( <i>interferon beta-1a</i> )	Non Preferred	PA
EXTAVIA KIT 0.3 MG SUBCUTANEOUS ( <i>interferon beta-1b</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PLEGRIDY SOLUTION PEN-INJECTOR 125 MCG/0.5ML SUBCUTANEOUS ( <i>peginterferon beta-1a</i> )	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML INTRAMUSCULAR ( <i>peginterferon beta-1a</i> )	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML SUBCUTANEOUS ( <i>peginterferon beta-1a</i> )	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML SUBCUTANEOUS ( <i>peginterferon beta-1a</i> )	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML SUBCUTANEOUS ( <i>peginterferon beta-1a</i> )	Non Preferred	PA
<b>*MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
BRIUMVI SOLUTION 150 MG/6ML INTRAVENOUS ( <i>ublituximab-xiyy</i> )	Non Preferred	PA
KESIMPTA SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS ( <i>ofatumumab</i> )	Non Preferred	PA
LEMTRADA SOLUTION 12 MG/1.2ML INTRAVENOUS ( <i>alemtuzumab</i> )	Non Preferred	PA
OCREVUS SOLUTION 300 MG/10ML INTRAVENOUS ( <i>ocrelizumab</i> )	Non Preferred	PA
TYSABRI CONCENTRATE 300 MG/15ML INTRAVENOUS ( <i>natalizumab</i> )	Non Preferred	PA
<b>*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate starter pack capsule delayed release therapy pack 120 &amp; 240 mg oral</i>	Preferred	
TECFIDERA CAPSULE DELAYED RELEASE 120 MG ORAL ( <i>dimethyl fumarate</i> )	Preferred	QL (2 EA per 1 day)
TECFIDERA CAPSULE DELAYED RELEASE 240 MG ORAL ( <i>dimethyl fumarate</i> )	Preferred	QL (2 EA per 1 day)
TECFIDERA CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG ORAL ( <i>dimethyl fumarate</i> )	Preferred	
BAFIERTAM CAPSULE DELAYED RELEASE 95 MG ORAL ( <i>monomethyl fumarate</i> )	Non Preferred	PA
VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL ( <i>diroximel fumarate</i> )	Non Preferred	PA
<b>*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<i>dalfampridine er tablet extended release 12 hour 10 mg oral</i>	Non Preferred	PA
AMPYRA TABLET EXTENDED RELEASE 12 HOUR 10 MG ORAL ( <i>dalfampridine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*MULTIPLE SCLEROSIS AGENTS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS ( <i>glatiramer acetate</i> )	Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS ( <i>glatiramer acetate</i> )	Preferred	
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	Non Preferred	PA
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	Non Preferred	PA
<i>glatiramer acetate</i> (Glatopa Solution Prefilled Syringe 20 Mg/ML Subcutaneous)	Non Preferred	PA
<i>glatiramer acetate</i> (Glatopa Solution Prefilled Syringe 40 Mg/ML Subcutaneous)	Non Preferred	PA
<b>*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
<i>memantine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>memantine hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 14 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 21 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 28 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 7 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl solution 2 mg/ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl tablet 28 x 5 mg &amp; 21 x 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
NAMENDA TABLET 10 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
NAMENDA TABLET 5 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
NAMENDA TITRATION PAK TABLET 28 X 5 MG & 21 X 10 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
NAMENDA XR CAPSULE EXTENDED RELEASE 24 HOUR 14 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
NAMENDA XR CAPSULE EXTENDED RELEASE 24 HOUR 21 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
NAMENDA XR CAPSULE EXTENDED RELEASE 24 HOUR 28 MG ORAL ( <i>memantine hcl</i> )	Non Preferred	PA
<b>*PHENOTHIAZINES &amp; TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION</b>		
<i>perphenazine-amitriptyline tablet 2-10 mg oral</i>	Preferred	
<i>perphenazine-amitriptyline tablet 2-25 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>perphenazine-amitriptyline tablet 4-10 mg oral</i>	Preferred	
<i>perphenazine-amitriptyline tablet 4-25 mg oral</i>	Preferred	
<i>perphenazine-amitriptyline tablet 4-50 mg oral</i>	Preferred	
<b>*POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>gabapentin (once-daily) tablet 300 mg oral</i>	Non Preferred	PA
<i>gabapentin (once-daily) tablet 600 mg oral</i>	Non Preferred	PA
<i>pregabalin er tablet extended release 24 hour 165 mg oral</i>	Non Preferred	PA
<i>pregabalin er tablet extended release 24 hour 330 mg oral</i>	Non Preferred	PA
<i>pregabalin er tablet extended release 24 hour 82.5 mg oral</i>	Non Preferred	PA
GRALISE 300 (9) & 600(24) MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
GRALISE TABLET 300 MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
GRALISE TABLET 450 MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
GRALISE TABLET 600 MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
GRALISE TABLET 750 MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
GRALISE TABLET 900 MG ORAL ( <i>gabapentin (once-daily)</i> )	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 165 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 330 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 82.5 MG ORAL ( <i>pregabalin</i> )	Non Preferred	PA
<b>*PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS*** - DRUGS FOR DEPRESSION</b>		
<i>fluoxetine hcl (pmdd) tablet 10 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl (pmdd) tablet 20 mg oral</i>	Non Preferred	PA
<b>*PSEUDOBULBAR AFFECT AGENT COMBINATIONS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
NUEDEXTA CAPSULE 20-10 MG ORAL ( <i>dextromethorphan-quinidine</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>ergoloid mesylates tablet 1 mg oral</i>	Preferred	
<i>pimozide tablet 1 mg oral</i>	Preferred	
<i>pimozide tablet 2 mg oral</i>	Preferred	
<b>*RESTLESS LEG SYNDROME (RLS) AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
HORIZANT TABLET EXTENDED RELEASE 300 MG ORAL ( <i>gabapentin enacarbil</i> )	Non Preferred	PA
HORIZANT TABLET EXTENDED RELEASE 600 MG ORAL ( <i>gabapentin enacarbil</i> )	Non Preferred	PA
<b>*SMALL INTERFERING RIBONUCLEIC ACID (SIRNA) AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
AMVUTTRA SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS ( <i>vutrisiran sodium</i> )	Non Preferred	PA
<b>*SMOKING DETERRENTS*** - DRUGS FOR DEPRESSION</b>		
<i>bupropion hcl er (smoking det) tablet extended release 12 hour 150 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>ft nicotine lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine gum 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>gnp nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>gnp nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>goodsense nicotine gum 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>goodsense nicotine gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>goodsense nicotine lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>goodsense nicotine lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>hm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>hm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>hm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>hm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>hm nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine kit 21-14-7 mg/24hr transdermal</i>	Preferred	
<i>nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>nicotine patch 24 hour 14 mg/24hr transdermal (otc)</i>	Preferred	QL (1 EA per 1 day)
<i>nicotine patch 24 hour 21 mg/24hr transdermal (otc)</i>	Preferred	QL (1 EA per 1 day)
<i>nicotine patch 24 hour 7 mg/24hr transdermal (otc)</i>	Preferred	QL (1 EA per 1 day)
<i>nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine polacrilex mini lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>nicotine step 1 patch 24 hour 21 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nicotine step 2 patch 24 hour 14 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>nicotine step 3 patch 24 hour 7 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>sm nicotine gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>sm nicotine lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>sm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	QL (1 EA per 1 day)
<i>sm nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>sm nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>sm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>sm nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	QL (8 EA per 1 day)
<i>varenicline tartrate (starter) tablet therapy pack 0.5 mg x 11 &amp; 1 mg x 42 oral</i>	Preferred	QL (2 EA per 1 day)
<i>varenicline tartrate tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>varenicline tartrate tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>varenicline tartrate(continue) tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day)
CHANTIX CONTINUING MONTH PAK TABLET 1 MG ORAL ( <i>varenicline tartrate</i> )	Preferred	QL (2 EA per 1 day)
CHANTIX STARTING MONTH PAK TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 ORAL ( <i>varenicline tartrate</i> )	Preferred	QL (2 EA per 1 day)
CHANTIX TABLET 0.5 MG ORAL ( <i>varenicline tartrate</i> )	Preferred	QL (2 EA per 1 day)
CHANTIX TABLET 1 MG ORAL ( <i>varenicline tartrate</i> )	Preferred	QL (2 EA per 1 day)
NICOTROL INHALER 10 MG INHALATION ( <i>nicotine</i> )	Preferred	
NICOTROL NS SOLUTION 10 MG/ML NASAL ( <i>nicotine</i> )	Preferred	
<b>*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
GILENYA CAPSULE 0.5 MG ORAL ( <i>fingolimod hcl</i> )	Preferred	PA
<i>fingolimod hcl capsule 0.5 mg oral</i>	Non Preferred	PA
GILENYA CAPSULE 0.25 MG ORAL ( <i>fingolimod hcl</i> )	Non Preferred	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 12 X 0.25 MG ORAL ( <i>siponimod fumarate</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MAYZENT STARTER PACK TABLET THERAPY PACK 7 X 0.25 MG ORAL ( <i>siponimod fumarate</i> )	Non Preferred	PA
MAYZENT TABLET 0.25 MG ORAL ( <i>siponimod fumarate</i> )	Non Preferred	PA
MAYZENT TABLET 1 MG ORAL ( <i>siponimod fumarate</i> )	Non Preferred	PA
MAYZENT TABLET 2 MG ORAL ( <i>siponimod fumarate</i> )	Non Preferred	PA
PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL ( <i>ponesimod</i> )	Non Preferred	PA
PONVORY TABLET 20 MG ORAL ( <i>ponesimod</i> )	Non Preferred	PA
TASCENSO ODT TABLET DISPERSIBLE 0.25 MG ORAL ( <i>fingolimod lauryl sulfate</i> )	Non Preferred	PA
TASCENSO ODT TABLET DISPERSIBLE 0.5 MG ORAL ( <i>fingolimod lauryl sulfate</i> )	Non Preferred	PA
ZEPOSIA 7-DAY STARTER PACK CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG ORAL ( <i>ozanimod hcl</i> )	Non Preferred	PA
ZEPOSIA CAPSULE 0.92 MG ORAL ( <i>ozanimod hcl</i> )	Non Preferred	PA
ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0.23MG & 0.46MG & 0.92MG ORAL ( <i>ozanimod hcl</i> )	Non Preferred	PA
ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) ORAL ( <i>ozanimod hcl</i> )	Non Preferred	
<b>*THIENBENZODIAZEPINES &amp; OPIOID ANTAGONISTS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
LYBALVI TABLET 10-10 MG ORAL ( <i>olanzapine-samidorphan</i> )	Non Preferred	PA
LYBALVI TABLET 15-10 MG ORAL ( <i>olanzapine-samidorphan</i> )	Non Preferred	PA
LYBALVI TABLET 20-10 MG ORAL ( <i>olanzapine-samidorphan</i> )	Non Preferred	PA
LYBALVI TABLET 5-10 MG ORAL ( <i>olanzapine-samidorphan</i> )	Non Preferred	PA
<b>*THIENBENZODIAZEPINES &amp; SSRIS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>olanzapine-fluoxetine hcl capsule 12-25 mg oral</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl capsule 12-50 mg oral</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl capsule 3-25 mg oral</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl capsule 6-25 mg oral</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl capsule 6-50 mg oral</i>	Non Preferred	PA

**AGE** - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug  
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Drug Name	Formulary Status	Requirements/Limits
SYMBYAX CAPSULE 3-25 MG ORAL ( <i>olanzapine-fluoxetine hcl</i> )	Non Preferred	PA
SYMBYAX CAPSULE 6-25 MG ORAL ( <i>olanzapine-fluoxetine hcl</i> )	Non Preferred	PA
<b>*VASOMOTOR SYMPTOM AGENTS - SSRIS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>paroxetine mesylate capsule 7.5 mg oral</i>	Non Preferred	PA
<b>*RESPIRATORY AGENTS - MISC.* - DRUGS FOR THE LUNGS</b>		
<b>*CFTR POTENTIATORS*** - DRUGS FOR CYSTIC FIBROSIS</b>		
KALYDECO PACKET 13.4 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
KALYDECO PACKET 25 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
KALYDECO PACKET 5.8 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
KALYDECO PACKET 50 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
KALYDECO PACKET 75 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
KALYDECO TABLET 150 MG ORAL ( <i>ivacaftor</i> )	Non Preferred	PA
<b>*CYSTIC FIBROSIS AGENT - COMBINATIONS*** - DRUGS FOR CYSTIC FIBROSIS</b>		
ORKAMBI PACKET 100-125 MG ORAL ( <i>lumacaftor-ivacaftor</i> )	Non Preferred	PA
ORKAMBI PACKET 150-188 MG ORAL ( <i>lumacaftor-ivacaftor</i> )	Non Preferred	PA
ORKAMBI PACKET 75-94 MG ORAL ( <i>lumacaftor-ivacaftor</i> )	Non Preferred	PA
ORKAMBI TABLET 100-125 MG ORAL ( <i>lumacaftor-ivacaftor</i> )	Non Preferred	PA
ORKAMBI TABLET 200-125 MG ORAL ( <i>lumacaftor-ivacaftor</i> )	Non Preferred	PA
SYMDEKO TABLET THERAPY PACK 100-150 & 150 MG ORAL ( <i>tezacaftor-ivacaftor</i> )	Non Preferred	PA
SYMDEKO TABLET THERAPY PACK 50-75 & 75 MG ORAL ( <i>tezacaftor-ivacaftor</i> )	Non Preferred	PA
TRIKAFTA TABLET THERAPY PACK 100-50-75 & 150 MG ORAL ( <i>elexacaftor-tezacaftor-ivacaft</i> )	Non Preferred	PA
TRIKAFTA TABLET THERAPY PACK 50-25-37.5 & 75 MG ORAL ( <i>elexacaftor-tezacaftor-ivacaft</i> )	Non Preferred	PA
TRIKAFTA THERAPY PACK 100-50-75 & 75 MG ORAL ( <i>elexacaftor-tezacaftor-ivacaft</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TRIKAFTA THERAPY PACK 80-40-60 & 59.5 MG ORAL ( <i>elexacaftor-tezacaftor-ivacaft</i> )	Non Preferred	PA
<b>*CYSTIC FIBROSIS AGENTS - MISCELLANEOUS*** - DRUGS FOR CYSTIC FIBROSIS</b>		
BRONCHITOL CAPSULE 40 MG INHALATION ( <i>mannitol (cystic fibrosis)</i> )	Non Preferred	PA
BRONCHITOL TOLERANCE TEST CAPSULE 40 MG INHALATION ( <i>mannitol (cystic fibrosis)</i> )	Non Preferred	PA
<b>*HYDROLYTIC ENZYMES*** - DRUGS FOR THE LUNGS</b>		
PULMOZYME SOLUTION 2.5 MG/2.5ML INHALATION ( <i>dornase alfa</i> )	Preferred	QL (2.5 ML per 1 day)
<b>*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR THE LUNGS</b>		
OFEV CAPSULE 100 MG ORAL ( <i>nintedanib esylate</i> )	Non Preferred	PA
OFEV CAPSULE 150 MG ORAL ( <i>nintedanib esylate</i> )	Non Preferred	PA
<b>*PULMONARY FIBROSIS AGENTS*** - DRUGS FOR THE LUNGS</b>		
<i>pirfenidone capsule 267 mg oral</i>	Non Preferred	PA
<i>pirfenidone tablet 267 mg oral</i>	Non Preferred	PA
<i>pirfenidone tablet 534 mg oral</i>	Non Preferred	PA
<i>pirfenidone tablet 801 mg oral</i>	Non Preferred	PA
ESBRIET CAPSULE 267 MG ORAL ( <i>pirfenidone</i> )	Non Preferred	PA
ESBRIET TABLET 267 MG ORAL ( <i>pirfenidone</i> )	Non Preferred	PA
ESBRIET TABLET 801 MG ORAL ( <i>pirfenidone</i> )	Non Preferred	PA
<b>*SULFONAMIDES* - DRUGS FOR INFECTIONS</b>		
<b>*SULFONAMIDES*** - ANTIBIOTICS</b>		
<i>sulfadiazine tablet 500 mg oral</i>	Preferred	
<b>*TETRACYCLINES* - DRUGS FOR INFECTIONS</b>		
<b>*AMINOMETHYLCYCLINES*** - ANTIBIOTICS</b>		
NUZYRA TABLET 150 MG ORAL ( <i>omadacycline tosylate</i> )	Non Preferred	PA
<b>*TETRACYCLINES*** - ANTIBIOTICS</b>		
<i>demeclocycline hcl tablet 150 mg oral</i>	Preferred	
<i>demeclocycline hcl tablet 300 mg oral</i>	Preferred	
<i>doxycycline hyclate capsule 100 mg oral</i>	Preferred	
<i>doxycycline hyclate capsule 50 mg oral</i>	Preferred	

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>doxycycline hyclate tablet 100 mg oral</i>	Preferred	
<i>doxycycline hyclate tablet 150 mg oral</i>	Preferred	
<i>doxycycline hyclate tablet 20 mg oral</i>	Preferred	
<i>doxycycline hyclate tablet 50 mg oral</i>	Preferred	
<i>doxycycline hyclate tablet 75 mg oral</i>	Preferred	
<i>doxycycline monohydrate capsule 100 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>doxycycline monohydrate capsule 150 mg oral</i>	Preferred	
<i>doxycycline monohydrate capsule 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>doxycycline monohydrate capsule 75 mg oral</i>	Preferred	
<i>doxycycline monohydrate suspension reconstituted 25 mg/5ml oral</i>	Preferred	
<i>doxycycline monohydrate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>doxycycline monohydrate tablet 150 mg oral</i>	Preferred	
<i>doxycycline monohydrate tablet 50 mg oral</i>	Preferred	
<i>doxycycline monohydrate tablet 75 mg oral</i>	Preferred	
<i>minocycline hcl capsule 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>minocycline hcl capsule 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>minocycline hcl capsule 75 mg oral</i>	Preferred	
<i>minocycline hcl tablet 100 mg oral</i>	Preferred	
<i>minocycline hcl tablet 50 mg oral</i>	Preferred	
<i>minocycline hcl tablet 75 mg oral</i>	Preferred	
<i>tetracycline hcl capsule 250 mg oral</i>	Preferred	
<i>tetracycline hcl capsule 500 mg oral</i>	Preferred	
<i>doxycycline hyclate (Morgidox Capsule 100 Mg Oral)</i>	Preferred	
<i>doxycycline hyclate tablet delayed release 100 mg oral</i>	Non Preferred	PA
<i>doxycycline hyclate tablet delayed release 150 mg oral</i>	Non Preferred	PA
<i>doxycycline hyclate tablet delayed release 200 mg oral</i>	Non Preferred	PA
<i>doxycycline hyclate tablet delayed release 50 mg oral</i>	Non Preferred	PA
<i>doxycycline hyclate tablet delayed release 75 mg oral</i>	Non Preferred	PA
<i>doxycycline hyclate tablet delayed release 80 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 105 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 115 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 135 mg oral</i>	Non Preferred	PA

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>minocycline hcl er tablet extended release 24 hour 45 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 55 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 65 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 80 mg oral</i>	Non Preferred	PA
<i>minocycline hcl er tablet extended release 24 hour 90 mg oral</i>	Non Preferred	PA
DORYX MPC TABLET DELAYED RELEASE 120 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
DORYX MPC TABLET DELAYED RELEASE 60 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
DORYX TABLET DELAYED RELEASE 200 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
DORYX TABLET DELAYED RELEASE 50 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
DORYX TABLET DELAYED RELEASE 80 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
MINOLIRA TABLET EXTENDED RELEASE 24 HOUR 105 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
MINOLIRA TABLET EXTENDED RELEASE 24 HOUR 135 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
MORGIDOX KIT 1 X 100 MG COMBINATION ( <i>doxycycline hyclate-cleanser</i> )	Non Preferred	PA
MORGIDOX KIT 2 X 100 MG COMBINATION ( <i>doxycycline hyclate-cleanser</i> )	Non Preferred	PA
SOLODYN TABLET EXTENDED RELEASE 24 HOUR 105 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
SOLODYN TABLET EXTENDED RELEASE 24 HOUR 115 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
SOLODYN TABLET EXTENDED RELEASE 24 HOUR 55 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
SOLODYN TABLET EXTENDED RELEASE 24 HOUR 65 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
SOLODYN TABLET EXTENDED RELEASE 24 HOUR 80 MG ORAL ( <i>minocycline hcl</i> )	Non Preferred	PA
VIBRAMYCIN CAPSULE 100 MG ORAL ( <i>doxycycline hyclate</i> )	Non Preferred	PA
<b>*TETRACYCLINES*** - DRUGS FOR INFECTIONS</b>		
<b>*TETRACYCLINES* - ANTIBIOTICS</b>		
<i>doxycycline hyclate</i> (Lymepak Tablet 100 Mg Oral)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<b>*THYROID AGENTS* - HORMONES</b>		
<b>*ANTITHYROID AGENTS*** - DRUGS FOR THYROID</b>		
<i>methimazole tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>methimazole tablet 5 mg oral</i>	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>propylthiouracil tablet 50 mg oral</i>	Preferred	QL (20 EA per 1 day); Max 90-day supply per fill
<b>*THYROID HORMONES*** - DRUGS FOR THYROID</b>		
<i>levothyroxine sodium tablet 100 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 112 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 125 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 137 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 150 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 175 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 200 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 25 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 300 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 50 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 75 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium tablet 88 mcg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>liothyronine sodium tablet 25 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>liothyronine sodium tablet 5 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>liothyronine sodium tablet 50 mcg oral</i>	Preferred	Max 90-day supply per fill
<i>niva thyroid tablet 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>niva thyroid tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>niva thyroid tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>niva thyroid tablet 60 mg oral</i>	Preferred	
<i>niva thyroid tablet 90 mg oral</i>	Preferred	
<i>thyroid tablet 120 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>thyroid tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>thyroid tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>thyroid tablet 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>thyroid tablet 90 mg oral</i>	Preferred	Max 90-day supply per fill
ADTHYZA TABLET 120 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 130 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 15 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 16.25 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 30 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 32.5 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 60 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 65 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 90 MG ORAL ( <i>thyroid</i> )	Preferred	
ADTHYZA TABLET 97.5 MG ORAL ( <i>thyroid</i> )	Preferred	
ARMOUR THYROID TABLET 120 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 15 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 180 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 240 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 30 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 300 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
ARMOUR THYROID TABLET 60 MG ORAL ( <i>thyroid</i> )	Preferred	
ARMOUR THYROID TABLET 90 MG ORAL ( <i>thyroid</i> )	Preferred	
<i>levothyroxine sodium</i> (Euthyrox Tablet 100 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 112 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 125 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 137 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 150 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 175 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 200 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 25 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 50 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Euthyrox Tablet 75 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>levothyroxine sodium</i> (Euthyrox Tablet 88 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 100 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 112 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 125 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 137 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 150 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 175 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 200 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 25 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 300 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 50 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 75 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Tablet 88 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 100 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 112 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 125 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 137 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 150 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 175 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 200 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 25 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 50 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Tablet 75 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>levothyroxine sodium</i> (Levoxyl Tablet 88 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
NP THYROID TABLET 120 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
NP THYROID TABLET 15 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
NP THYROID TABLET 30 MG ORAL ( <i>thyroid</i> )	Preferred	QL (1 EA per 1 day)
NP THYROID TABLET 60 MG ORAL ( <i>thyroid</i> )	Preferred	
NP THYROID TABLET 90 MG ORAL ( <i>thyroid</i> )	Preferred	
<i>levothyroxine sodium</i> (Unithroid Tablet 100 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 112 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 125 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 137 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 150 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 175 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 200 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 25 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 300 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 50 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 75 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium</i> (Unithroid Tablet 88 Mcg Oral)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>levothyroxine sodium capsule 100 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 112 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 125 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 13 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 137 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 150 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 175 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>levothyroxine sodium capsule 200 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 25 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 50 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 75 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>levothyroxine sodium capsule 88 mcg oral</i>	Non Preferred	PA; Max 90-day supply per fill
CYTOMEL TABLET 25 MCG ORAL ( <i>liothyronine sodium</i> )	Non Preferred	PA
CYTOMEL TABLET 5 MCG ORAL ( <i>liothyronine sodium</i> )	Non Preferred	PA
CYTOMEL TABLET 50 MCG ORAL ( <i>liothyronine sodium</i> )	Non Preferred	PA
ERMEZA SOLUTION 150 MCG/5ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
SYNTHROID TABLET 100 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 112 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 125 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 137 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 150 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 175 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 200 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 25 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 300 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 50 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 75 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
SYNTHROID TABLET 88 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
THYQUIDITY SOLUTION 100 MCG/5ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 100 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA

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**PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
TIROSINT CAPSULE 112 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 125 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 13 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 137 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 150 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 175 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 200 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 25 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 37.5 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 44 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 50 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 62.5 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 75 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT CAPSULE 88 MCG ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 100 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 112 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 125 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 13 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 137 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 150 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 175 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 200 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 25 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TIROSINT-SOL SOLUTION 37.5 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 44 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 50 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 62.5 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 75 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
TIROSINT-SOL SOLUTION 88 MCG/ML ORAL ( <i>levothyroxine sodium</i> )	Non Preferred	PA
<b>*TOXOIDS* - BIOLOGICAL AGENTS</b>		
<b>*TOXOID COMBINATIONS*** - VACCINES</b>		
<i>tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml</i>	Preferred	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	Preferred	AGE (Min 19 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	Preferred	AGE (Min 19 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	Preferred	AGE (Min 19 Years)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML ( <i>tetanus-diphtheria toxoids td</i> )	Preferred	
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU ( <i>tetanus-diphtheria toxoids td</i> )	Preferred	
<b>*TRICYCLIC AGENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIDEPRESSANTS* - DRUGS FOR DEPRESSION</b>		
<i>amoxapine tablet 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>amoxapine tablet 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<b>*ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS* - DRUGS FOR THE STOMACH</b>		
<b>*ANTICHOLINERGIC COMBINATIONS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>belladonna alkaloids-opium suppository 16.2-30 mg rectal</i>	Preferred	
<i>belladonna alkaloids-opium suppository 16.2-60 mg rectal</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>chlordiazepoxide-clidinium capsule 5-2.5 mg oral</i>	Non Preferred	PA
LIBRAX CAPSULE 5-2.5 MG ORAL ( <i>chlordiazepoxide-clidinium</i> )	Non Preferred	PA
<b>*ANTISPASMODICS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>dicyclomine hcl capsule 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>dicyclomine hcl solution 10 mg/5ml oral</i>	Preferred	QL (80 ML per 1 day)
<i>dicyclomine hcl tablet 20 mg oral</i>	Preferred	QL (8 EA per 1 day)
<b>*BELLADONNA ALKALOIDS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>ed-spaz tablet dispersible 0.125 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hyoscyamine sulfate elixir 0.125 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day)
<i>hyoscyamine sulfate er tablet extended release 12 hour 0.375 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hyoscyamine sulfate solution 0.125 mg/ml oral</i>	Preferred	
<i>hyoscyamine sulfate tablet 0.125 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hyoscyamine sulfate tablet dispersible 0.125 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hyoscyamine sulfate tablet sublingual 0.125 mg sublingual</i>	Preferred	QL (12 EA per 1 day)
<i>oscimin tablet 0.125 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>oscimin tablet sublingual 0.125 mg sublingual</i>	Preferred	QL (12 EA per 1 day)
<i>hyoscyamine sulfate (Nulev Tablet Dispersible 0.125 Mg Oral)</i>	Preferred	QL (12 EA per 1 day)
LEVSIN TABLET 0.125 MG ORAL ( <i>hyoscyamine sulfate</i> )	Non Preferred	PA; QL (12 EA per 1 day)
LEVSIN/SL TABLET SUBLINGUAL 0.125 MG SUBLINGUAL ( <i>hyoscyamine sulfate</i> )	Non Preferred	PA; QL (12 EA per 1 day)
<b>*H-2 ANTAGONISTS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>acid reducer oral tablet 10 mg</i>	Preferred	
<i>cimetidine tablet 200 mg oral (rx)</i>	Preferred	QL (4 EA per 1 day)
<i>cimetidine tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>cimetidine tablet 400 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>cimetidine tablet 800 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>famotidine oral tablet 10 mg</i>	Preferred	
<i>famotidine orig st oral tablet 10 mg</i>	Preferred	
<i>famotidine suspension reconstituted 40 mg/5ml oral</i>	Preferred	QL (5 ML per 1 day)
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	QL (2 EA per 1 day)
<i>famotidine tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>ft acid reducer oral tablet 10 mg</i>	Preferred	
<i>gnp acid reducer oral tablet 10 mg</i>	Preferred	
<i>heartburn relief oral tablet 10 mg</i>	Preferred	
<i>kls acid reducer oral tablet 75 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>nizatidine capsule 150 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>nizatidine capsule 300 mg oral</i>	Preferred	
<i>sm acid reducer oral tablet 10 mg</i>	Preferred	
PEPCID TABLET 20 MG ORAL ( <i>famotidine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
PEPCID TABLET 40 MG ORAL ( <i>famotidine</i> )	Non Preferred	PA; QL (2 EA per 1 day)
<b>*MISC. ANTI-ULCER*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>sucralfate suspension 1 gm/10ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>sucralfate tablet 1 gm oral</i>	Preferred	QL (4 EA per 1 day)
CARAFATE SUSPENSION 1 GM/10ML ORAL ( <i>sucralfate</i> )	Preferred	QL (40 ML per 1 day)
CARAFATE TABLET 1 GM ORAL ( <i>sucralfate</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*PROTON PUMP INHIBITOR-ANTACID COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>omeprazole-sodium bicarbonate capsule 20-1100 mg oral (rx)</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate capsule 40-1100 mg oral</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate packet 20-1680 mg oral</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate packet 40-1680 mg oral</i>	Non Preferred	PA
KONVOMEF SUSPENSION RECONSTITUTED 2-84 MG/ML ORAL ( <i>omeprazole-sodium bicarbonate</i> )	Non Preferred	PA
ZEGERID CAPSULE 20-1100 MG ORAL ( <i>omeprazole-sodium bicarbonate</i> )	Non Preferred	PA
ZEGERID CAPSULE 40-1100 MG ORAL ( <i>omeprazole-sodium bicarbonate</i> )	Non Preferred	PA
ZEGERID PACKET 20-1680 MG ORAL ( <i>omeprazole-sodium bicarbonate</i> )	Non Preferred	PA
ZEGERID PACKET 40-1680 MG ORAL ( <i>omeprazole-sodium bicarbonate</i> )	Non Preferred	PA
<b>*PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>lansoprazole tablet delayed release dispersible 15 mg oral (rx)</i>	Preferred	AGE (Max 10 Years)
<i>lansoprazole tablet delayed release dispersible 30 mg oral</i>	Preferred	AGE (Max 10 Years)
<i>omeprazole capsule delayed release 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>omeprazole capsule delayed release 20 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>omeprazole capsule delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Preferred	QL (3 EA per 1 day)

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<b>Drug Name</b>	<b>Formulary Status</b>	<b>Requirements/Limits</b>
<i>dexlansoprazole capsule delayed release 30 mg oral</i>	Non Preferred	PA
<i>dexlansoprazole capsule delayed release 60 mg oral</i>	Non Preferred	PA
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 40 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium packet 10 mg oral</i>	Non Preferred	PA
<i>esomeprazole magnesium packet 20 mg oral</i>	Non Preferred	PA
<i>esomeprazole magnesium packet 20 mg oral</i>	Non Preferred	PA; AGE (Max 20 Years)
<i>esomeprazole magnesium packet 40 mg oral</i>	Non Preferred	PA
<i>esomeprazole magnesium packet 40 mg oral</i>	Non Preferred	PA; AGE (Max 20 Years)
<i>lansoprazole capsule delayed release 15 mg oral (rx)</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>lansoprazole capsule delayed release 30 mg oral</i>	Non Preferred	PA
<i>pantoprazole sodium packet 40 mg oral</i>	Non Preferred	PA; AGE (Max 20 Years)
<i>rabeprazole sodium tablet delayed release 20 mg oral</i>	Non Preferred	PA
ACIPHEX TABLET DELAYED RELEASE 20 MG ORAL ( <i>rabeprazole sodium</i> )	Non Preferred	PA
DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL ( <i>dexlansoprazole</i> )	Non Preferred	PA
DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL ( <i>dexlansoprazole</i> )	Non Preferred	PA
FIRST PANTOPRAZOLE SUSPENSION 4 MG/ML ORAL ( <i>pantoprazole sodium</i> )	Non Preferred	PA
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM PACKET 10 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA
NEXIUM PACKET 2.5 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA
NEXIUM PACKET 20 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA
NEXIUM PACKET 40 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NEXIUM PACKET 5 MG ORAL ( <i>esomeprazole magnesium</i> )	Non Preferred	PA
PREVACID CAPSULE DELAYED RELEASE 30 MG ORAL ( <i>lansoprazole</i> )	Non Preferred	PA
PREVACID SOLUTAB TABLET DELAYED RELEASE DISPERSIBLE 15 MG ORAL ( <i>lansoprazole</i> )	Non Preferred	PA; AGE (Max 10 Years)
PREVACID SOLUTAB TABLET DELAYED RELEASE DISPERSIBLE 30 MG ORAL ( <i>lansoprazole</i> )	Non Preferred	PA; AGE (Max 10 Years)
PRILOSEC PACKET 10 MG ORAL ( <i>omeprazole magnesium</i> )	Non Preferred	PA
PRILOSEC PACKET 2.5 MG ORAL ( <i>omeprazole magnesium</i> )	Non Preferred	PA
PROTONIX PACKET 40 MG ORAL ( <i>pantoprazole sodium</i> )	Non Preferred	PA; AGE (Max 20 Years)
PROTONIX TABLET DELAYED RELEASE 20 MG ORAL ( <i>pantoprazole sodium</i> )	Non Preferred	PA; QL (1 EA per 1 day)
PROTONIX TABLET DELAYED RELEASE 40 MG ORAL ( <i>pantoprazole sodium</i> )	Non Preferred	PA; QL (3 EA per 1 day)
<b>*QUATERNARY ANTICHOLINERGICS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>glycopyrrolate solution 1 mg/5ml oral</i>	Preferred	
<i>glycopyrrolate tablet 1 mg oral</i>	Preferred	
<i>glycopyrrolate tablet 2 mg oral</i>	Preferred	
<i>methscopolamine bromide tablet 2.5 mg oral</i>	Non Preferred	PA
<i>methscopolamine bromide tablet 5 mg oral</i>	Non Preferred	PA
CUVPOSA SOLUTION 1 MG/5ML ORAL ( <i>glycopyrrolate</i> )	Non Preferred	PA
DARTISLA ODT TABLET DISPERSIBLE 1.7 MG ORAL ( <i>glycopyrrolate</i> )	Non Preferred	PA
GLYCATE TABLET 1.5 MG ORAL ( <i>glycopyrrolate</i> )	Non Preferred	PA
ROBINUL TABLET 1 MG ORAL ( <i>glycopyrrolate</i> )	Non Preferred	PA
ROBINUL-FORTE TABLET 2 MG ORAL ( <i>glycopyrrolate</i> )	Non Preferred	PA
<b>*ULCER ANTI-INFECTIVE W/ BISMUTH COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>bis subcit-metronid-tetracyc capsule 140-125-125 mg oral</i>	Non Preferred	PA
<i>bismuth/metronidaz/tetracyclin capsule 140-125-125 mg oral</i>	Non Preferred	PA
PYLERA CAPSULE 140-125-125 MG ORAL ( <i>bis subcit-metronid-tetracyc</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*ULCER ANTI-INFECTIVE W/ PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>amoxicill-clarithro-lansopraz therapy pack 500 &amp; 500 &amp; 30 mg oral</i>	Non Preferred	PA
TALICIA CAPSULE DELAYED RELEASE 250-12.5-10 MG ORAL ( <i>amoxicill-rifabutin-omeprazole</i> )	Non Preferred	PA
<b>*ULCER DRUGS - PROSTAGLANDINS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>misoprostol tablet 100 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>misoprostol tablet 200 mcg oral</i>	Preferred	QL (4 EA per 1 day)
CYTOTEC TABLET 100 MCG ORAL ( <i>misoprostol</i> )	Non Preferred	PA; QL (4 EA per 1 day)
CYTOTEC TABLET 200 MCG ORAL ( <i>misoprostol</i> )	Non Preferred	PA; QL (4 EA per 1 day)
<b>*URINARY ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS</b>		
<b>*ANTI-INFECTIVE AGENTS - MISC.* - ANTIBIOTICS</b>		
<i>nitrofurantoin suspension 25 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<b>*URINARY ANTISPASMODICS* - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)*** - DRUGS FOR THE BLADDER</b>		
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>oxybutynin chloride solution 5 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day); Max 90-day supply per fill
<i>oxybutynin chloride solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>solifenacin succinate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>solifenacin succinate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>darifenacin hydrobromide er tablet extended release 24 hour 15 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>darifenacin hydrobromide er tablet extended release 24 hour 7.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fesoterodine fumarate er tablet extended release 24 hour 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fesoterodine fumarate er tablet extended release 24 hour 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>tolterodine tartrate er capsule extended release 24 hour 2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tolterodine tartrate er capsule extended release 24 hour 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tolterodine tartrate tablet 1 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>tolterodine tartrate tablet 2 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>tropium chloride er capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tropium chloride tablet 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
DETROL LA CAPSULE EXTENDED RELEASE 24 HOUR 2 MG ORAL ( <i>tolterodine tartrate</i> )	Non Preferred	PA
DETROL LA CAPSULE EXTENDED RELEASE 24 HOUR 4 MG ORAL ( <i>tolterodine tartrate</i> )	Non Preferred	PA
DETROL TABLET 1 MG ORAL ( <i>tolterodine tartrate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
DETROL TABLET 2 MG ORAL ( <i>tolterodine tartrate</i> )	Non Preferred	PA; QL (2 EA per 1 day)
GELNIQUE GEL 10 % TRANSDERMAL ( <i>oxybutynin chloride</i> )	Non Preferred	PA
OXYTROL PATCH TWICE WEEKLY 3.9 MG/24HR TRANSDERMAL ( <i>oxybutynin</i> )	Non Preferred	PA
TOVIAZ TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL ( <i>fesoterodine fumarate</i> )	Non Preferred	PA
TOVIAZ TABLET EXTENDED RELEASE 24 HOUR 8 MG ORAL ( <i>fesoterodine fumarate</i> )	Non Preferred	PA
VESICARE LS SUSPENSION 5 MG/5ML ORAL ( <i>solifenacin succinate</i> )	Non Preferred	PA
VESICARE TABLET 10 MG ORAL ( <i>solifenacin succinate</i> )	Non Preferred	PA
VESICARE TABLET 5 MG ORAL ( <i>solifenacin succinate</i> )	Non Preferred	PA
<b>*URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER</b>		
GEMTESA TABLET 75 MG ORAL ( <i>vibegron</i> )	Non Preferred	PA
MYRBETRIQ SUSPENSION RECONSTITUTED ER 8 MG/ML ORAL ( <i>mirabegron</i> )	Non Preferred	PA
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL ( <i>mirabegron</i> )	Non Preferred	PA
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL ( <i>mirabegron</i> )	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<b>*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** - DRUGS FOR THE BLADDER</b>		
<i>bethanechol chloride tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bethanechol chloride tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bethanechol chloride tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>bethanechol chloride tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<b>*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** - DRUGS FOR THE BLADDER</b>		
<i>flavoxate hcl tablet 100 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day); Max 90-day supply per fill
<b>*VACCINES* - BIOLOGICAL AGENTS</b>		
<b>*BACTERIAL VACCINES*** - VACCINES</b>		
PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML ( <i>pneumococcal vac polyvalent</i> )	Preferred	QL (2 ML per 1 Lifetime)
PREVNAR 13 INTRAMUSCULAR SUSPENSION ( <i>pneumococcal 13-val conj vacc</i> )	Preferred	QL (1 ML per 1 Lifetime)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 20-val conj vacc</i> )	Preferred	QL (1 ML per 1 Lifetime)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 15-val conj vacc</i> )	Preferred	QL (1 ML per 1 Lifetime); AGE (Min 19 Years)
<b>*VIRAL VACCINE COMBINATIONS*** - VACCINES</b>		
M-M-R II INJECTION SOLUTION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	Preferred	QL (3 EA per 1 Lifetime); AGE (Min 19 Years)
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	Preferred	QL (3 EA per 1 Lifetime); AGE (Min 19 Years)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML ( <i>hepatitis a-hep b recomb vac</i> )	Preferred	
<b>*VIRAL VACCINES*** - VACCINES</b>		
<i>pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.3ml</i>	Preferred	AGE (Min 19 Years)
ABRYSCO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML ( <i>rsv pre-fusion f a&amp;b vac rcmb</i> )	Preferred	QL (1 EA per 1 Lifetime); AGE (Min 60 Years)
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML ( <i>rsvpref3 vac recomb adjuvanted</i> )	Preferred	QL (1 EA per 1 Lifetime); AGE (Min 60 Years)
COMIRNATY INTRAMUSCULAR SUSPENSION 30 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)

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Drug Name	Formulary Status	Requirements/Limits
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	Preferred	
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	Preferred	
FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML ( <i>influenza vac a&amp;b sa adj quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 65 Years)
FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac recomb ha quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 19 Years)
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac subunit quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac subunit quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
FLUMIST QUADRIVALENT NASAL SUSPENSION ( <i>influenza virus vac live quad</i> )	Preferred	QL (1 EA per 180 days); AGE (Min 4 Years and Max 49 Years)
FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.7 ML ( <i>influenza vac high-dose quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 65 Years)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split quad</i> )	Preferred	QL (1 ML per 180 days); AGE (Min 4 Years)
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML ( <i>hepatitis a vaccine</i> )	Preferred	AGE (Min 19 Years)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML ( <i>hepatitis b vac recomb adj</i> )	Preferred	
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION 25 MCG/0.25ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)
PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	Preferred	
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	Preferred	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML ( <i>zoster vac recomb adjuvanted</i> )	Preferred	QL (2 EA per 1 Lifetime); AGE (Min 18 Years)
SPIKEVAX INTRAMUSCULAR SUSPENSION 50 MCG/0.5ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML ( <i>covid-19 mrna virus vaccine</i> )	Preferred	AGE (Min 19 Years)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML ( <i>hepatitis a vaccine</i> )	Preferred	AGE (Min 19 Years)

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Drug Name	Formulary Status	Requirements/Limits
<b>*VAGINAL AND RELATED PRODUCTS* - DRUGS FOR WOMEN</b>		
<b>*IMIDAZOLE-RELATED ANTIFUNGALS*** - DRUGS FOR INFECTIONS</b>		
<i>3 day vaginal vaginal cream 2 %</i>	Preferred	
<i>clotrimazole vaginal cream 1 %</i>	Preferred	
<i>ft miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>gnp clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>gnp miconazole 3 vaginal kit 200 &amp; 2 mg-% (9gm)</i>	Preferred	
<i>gnp miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>gnp tioconazole 1 vaginal ointment 6.5 %</i>	Preferred	
<i>miconazole 3 combo-supp vaginal kit 200 &amp; 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 3 suppository 200 mg vaginal</i>	Preferred	
<i>miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>miconazole 7 vaginal suppository 100 mg</i>	Preferred	
<i>miconazole nitrate vaginal cream 2 %</i>	Preferred	
<i>qc 3 day vaginal cream 4 %</i>	Preferred	
<i>sm 3-day vaginal vaginal cream 2 %</i>	Preferred	
<i>sm clotrimazole vaginal vaginal cream 1 %</i>	Preferred	
<i>sm miconazole 3 applicator vaginal kit 200 &amp; 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 3 vaginal kit 200 &amp; 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>sm miconazole 7 vaginal suppository 100 mg</i>	Preferred	
<i>sm tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>terconazole cream 0.4 % vaginal</i>	Preferred	Max 60-day supply per fill
<i>terconazole cream 0.8 % vaginal</i>	Preferred	Max 60-day supply per fill
<i>terconazole suppository 80 mg vaginal</i>	Preferred	QL (1 EA per 1 day)
<i>tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>GYNAZOLE-1 CREAM 2 % VAGINAL (butoconazole nitrate (1 dose))</i>	Non Preferred	PA; Max 60-day supply per fill
<b>*MISCELLANEOUS VAGINAL COMBINATIONS*** - DRUGS FOR INFECTIONS</b>		
<i>TRIMO-SAN GEL 0.025-0.01 % VAGINAL (oxyquinoline-sod lauryl sulf)</i>	Non Preferred	PA
<b>*MISCELLANEOUS VAGINAL PRODUCTS*** - DRUGS FOR WOMEN</b>		
<i>INTRAROSA INSERT 6.5 MG VAGINAL (prasterone)</i>	Non Preferred	PA
<b>*VAGINAL ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS</b>		
<i>clindamycin phosphate cream 2 % vaginal</i>	Preferred	Max 60-day supply per fill
<i>metronidazole gel 0.75 % vaginal</i>	Preferred	QL (70 GM per 5 days)

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Drug Name	Formulary Status	Requirements/Limits
<i>metronidazole gel 0.75 % vaginal</i>	Preferred	QL (70 GM per 7 days)
CLEOCIN SUPPOSITORY 100 MG VAGINAL ( <i>clindamycin phosphate</i> )	Preferred	
CLEOCIN CREAM 2 % VAGINAL ( <i>clindamycin phosphate</i> )	Non Preferred	PA; Max 60-day supply per fill
CLINDESSE CREAM 2 % VAGINAL ( <i>clindamycin phosphate (1 dose)</i> )	Non Preferred	PA; Max 60-day supply per fill
NUVESSA GEL 1.3 % VAGINAL ( <i>metronidazole</i> )	Non Preferred	PA
VANAZOLE GEL 0.75 % VAGINAL ( <i>metronidazole</i> )	Non Preferred	PA; QL (70 GM per 7 days)
XACIATO GEL 2 % VAGINAL ( <i>clindamycin phosphate</i> )	Non Preferred	PA
<b>*VAGINAL CONTRACEPTIVE PH MODULATOR - COMBINATIONS*** - DRUGS FOR WOMEN</b>		
PHEXXI GEL 1.8-1-0.4 % VAGINAL ( <i>lactic ac-citric ac-pot bitart</i> )	Preferred	
<b>*VAGINAL ESTROGENS*** - DRUGS FOR WOMEN</b>		
<i>estradiol cream 0.1 mg/gm vaginal</i>	Preferred	QL (1.42 GM per 1 day); Max 90-day supply per fill
PREMARIN CREAM 0.625 MG/GM VAGINAL ( <i>estrogens, conjugated</i> )	Preferred	Max 90-day supply per fill
<i>estradiol tablet 10 mcg vaginal</i>	Non Preferred	PA; Max 90-day supply per fill
ESTRACE CREAM 0.1 MG/GM VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; QL (1.42 GM per 1 day); Max 90-day supply per fill
ESTRING RING 2 MG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
ESTRING RING 7.5 MCG/24HR VAGINAL ( <i>estradiol</i> )	Non Preferred	Max 90-day supply per fill
FEMRING RING 0.05 MG/24HR VAGINAL ( <i>estradiol acetate</i> )	Non Preferred	PA; Max 90-day supply per fill
FEMRING RING 0.1 MG/24HR VAGINAL ( <i>estradiol acetate</i> )	Non Preferred	PA; Max 90-day supply per fill
IMVEXXY MAINTENANCE PACK INSERT 10 MCG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
IMVEXXY MAINTENANCE PACK INSERT 4 MCG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
IMVEXXY STARTER PACK INSERT 10 MCG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
IMVEXXY STARTER PACK INSERT 4 MCG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
VAGIFEM TABLET 10 MCG VAGINAL ( <i>estradiol</i> )	Non Preferred	PA; Max 90-day supply per fill
<i>estradiol (YuvaFem Tablet 10 Mcg Vaginal)</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<b>*VAGINAL PROGESTINS*** - DRUGS FOR WOMEN</b>		
ENDOMETRIN INSERT 100 MG VAGINAL ( <i>progesterone</i> )	Preferred	
CRINONE GEL 4 % VAGINAL ( <i>progesterone</i> )	Non Preferred	PA
CRINONE GEL 8 % VAGINAL ( <i>progesterone</i> )	Non Preferred	PA
<b>*VALPROIC ACID*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTICONSULSANTS* - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>divalproex sodium capsule delayed release sprinkle 125 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<b>*VASODILATORS*** - DRUGS FOR THE HEART</b>		
<b>*ANTIHYPERTENSIVES* - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>hydralazine hcl tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>hydralazine hcl tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>hydralazine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>hydralazine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
<b>*VASOPRESSORS* - DRUGS FOR THE HEART</b>		
<b>*ANAPHYLAXIS THERAPY AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION</b>		
<i>epinephrine solution auto-injector 0.15 mg/0.15ml injection</i>	Preferred	QL (2 EA per 30 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml injection</i>	Preferred	QL (2 EA per 30 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml injection</i>	Preferred	QL (2 EA per 30 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML INJECTION ( <i>epinephrine</i> )	Preferred	
AUVI-Q SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML INJECTION ( <i>epinephrine</i> )	Preferred	QL (2 EA per 30 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION ( <i>epinephrine</i> )	Preferred	QL (2 EA per 30 days)
EPIPEN 2-PAK SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION ( <i>epinephrine</i> )	Non Preferred	PA; QL (2 EA per 30 days)
EPIPEN JR 2-PAK SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML INJECTION ( <i>epinephrine</i> )	Non Preferred	PA; QL (2 EA per 30 days)
<b>*NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION</b>		
<i>droxidopa capsule 100 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>droxidopa capsule 200 mg oral</i>	Non Preferred	PA
<i>droxidopa capsule 300 mg oral</i>	Non Preferred	PA
NORTHERA CAPSULE 100 MG ORAL ( <i>droxidopa</i> )	Non Preferred	PA
NORTHERA CAPSULE 200 MG ORAL ( <i>droxidopa</i> )	Non Preferred	PA
NORTHERA CAPSULE 300 MG ORAL ( <i>droxidopa</i> )	Non Preferred	PA
<b>*VASOPRESSORS*** - DRUGS FOR SERIOUS ALLERGIC REACTION</b>		
<i>midodrine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>midodrine hcl tablet 2.5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>midodrine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<b>*VITAMINS* - DRUGS FOR NUTRITION</b>		
<b>*VITAMIN B-1*** - DRUGS FOR NUTRITION</b>		
<i>vitamin b1 oral tablet 100 mg</i>	Preferred	
<b>*VITAMIN B-2*** - DRUGS FOR NUTRITION</b>		
<i>true vitamin b2 oral tablet 100 mg</i>	Preferred	
<b>*VITAMIN B-3*** - DRUGS FOR NUTRITION</b>		
<i>niacin er oral capsule extended release 250 mg, 500 mg</i>	Preferred	
<i>niacin er oral tablet extended release 500 mg, 750 mg</i>	Preferred	
<i>niacin oral tablet 100 mg, 500 mg</i>	Preferred	
<i>niacinamide oral tablet 500 mg</i>	Preferred	
<i>true vitamin b3 oral tablet 100 mg, 50 mg, 500 mg</i>	Preferred	
<b>*VITAMIN B-6*** - DRUGS FOR NUTRITION</b>		
<i>sm vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>true vitamin b6 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>vitamin b-6 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
<b>*VITAMIN C*** - DRUGS FOR NUTRITION</b>		
<i>ascorbic acid oral tablet 500 mg</i>	Preferred	
<i>sm vitamin c/rose hips oral tablet 500 mg</i>	Preferred	
<i>true vitamin c oral tablet 500 mg</i>	Preferred	
<i>vitamin c oral tablet 500 mg</i>	Preferred	
<b>*VITAMIN D*** - DRUGS FOR NUTRITION</b>		
<i>aqueous vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>d3 vitamin oral liquid 10 mcg/ml</i>	Preferred	
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	Preferred	QL (6 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>sm vitamin d3 oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>true vitamin d3 oral capsule 1.25 mg (50000 ut), 125 mcg (5000 ut), 25 mcg (1000 ut), 250 mcg (10000 ut)</i>	Preferred	
<i>true vitamin d3 oral tablet 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut)</i>	Preferred	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	Preferred	QL (6 EA per 1 day)
<i>vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>vitamin d oral tablet 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d3 oral capsule 1.25 mg (50000 ut), 125 mcg (5000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d3 oral tablet 10 mcg (400 unit)</i>	Preferred	
DECARA ORAL CAPSULE 1.25 MG (50000 UT), 250 MCG (10000 UT) ( <i>cholecalciferol</i> )	Preferred	
DIALYVITE VITAMIN D 5000 ORAL CAPSULE 125 MCG (5000 UT) ( <i>cholecalciferol</i> )	Preferred	
WEEKLY-D ORAL CAPSULE 1.25 MG (50000 UT) ( <i>cholecalciferol</i> )	Preferred	

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