

Comprehensive Formulary

(List of Covered Drugs)

2023



**Wellcare Giveback Boost (HMO),
Wellcare Giveback Open (PPO),
Wellcare No Premium (HMO),
Wellcare No Premium Essentials (HMO),
Wellcare No Premium Medicare (HMO),
Wellcare No Premium Open (PPO),
Wellcare Premium Ultra Open (PPO)**

21



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

HPMS Approved Formulary File Submission ID 23318, Version Number 18

This formulary was updated on 12/01/2023. For more recent information or other questions, please contact Wellcare Member Services at the telephone number or website for your state listed on the inside front and back covers of this formulary.

- **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible*. Call Member Services for more information.
- **Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible*.

***Please refer to your Evidence of Coverage and other plan materials for any deductible that may apply.**

We're Just a Phone Call Away

ARKANSAS

+ HMO, HMO D-SNP

📞 1-855-565-9518

💻 Or visit www.wellcare.com/allwellAR

ARIZONA

+ HMO, HMO C-SNP, HMO D-SNP

📞 1-800-977-7522

💻 Or visit www.wellcare.com/allwellAZ

CALIFORNIA

+ HMO, HMO C-SNP, PPO

📞 1-800-275-4737

+ HMO D-SNP

📞 1-800-431-9007

💻 Or visit www.wellcare.com/healthnetCA

FLORIDA

+ HMO D-SNP

📞 1-877-935-8022

💻 Or visit www.wellcare.com/allwellFL

GEORGIA

+ HMO

📞 1-844-890-2326

+ HMO D-SNP

📞 1-877-725-7748

💻 Or visit www.wellcare.com/allwellGA

INDIANA

+ HMO, PPO

📞 1-855-766-1541

+ HMO D-SNP, PPO D-SNP

📞 1-833-202-4704

💻 Or visit www.wellcare.com/allwellIN

KANSAS

+ HMO

📞 1-855-565-9519

+ PPO

📞 1-833-696-0634

+ HMO D-SNP, PPO D-SNP

📞 1-833-402-6707

💻 Or visit www.wellcare.com/allwellKS

LOUISIANA

+ HMO

📞 1-855-766-1572

+ HMO D-SNP

📞 1-833-541-0767

💻 Or visit www.wellcare.com/allwellLA

MISSOURI

+ HMO

📞 1-855-766-1452

+ HMO D-SNP

📞 1-833-298-3361

💻 Or visit www.wellcare.com/allwellMO

MISSISSIPPI

+ HMO

📞 1-844-786-7711

+ HMO D-SNP

📞 1-833-260-4124

💻 Or visit www.wellcare.com/allwellMS

NEBRASKA

+ HMO, PPO

📞 1-833-542-0693

+ HMO D-SNP, PPO D-SNP

1-833-853-0864

💻 Or visit www.wellcare.com/NE

NEVADA

+ HMO, HMO C-SNP, PPO

📞 1-833-854-4766

+ HMO D-SNP

📞 1-833-717-0806

💻 Or visit www.wellcare.com/allwellNV

NEW MEXICO

+ HMO, PPO

📞 1-833-543-0246

+ HMO D-SNP

📞 1-844-810-7965

💻 Or visit www.wellcare.com/allwellNM

NEW YORK

+ HMO, HMO-POS, HMO D-SNP

📞 1-800-247-1447

💻 Or visit www.wellcare.com/fidelisNY

OHIO

+ HMO, PPO

📞 1-855-766-1851

+ HMO D-SNP, PPO D-SNP

📞 1-866-389-7690

💻 Or visit www.wellcare.com/allwellOH

OKLAHOMA

+ HMO, PPO

📞 1-833-853-0865

+ HMO D-SNP, PPO D-SNP

📞 1-833-853-0866

💻 Or visit www.wellcare.com/OK

OREGON

+ HMO, PPO

📞 1-888-445-8913

💻 Or visit www.wellcare.com/healthnetOR

+ HMO D-SNP

📞 1-844-867-1156

💻 Or visit www.wellcare.com/trilliumOR

PENNSYLVANIA

+ HMO, PPO

📞 1-855-766-1456

+ HMO D-SNP, PPO D-SNP

📞 1-866-330-9368

💻 Or visit www.wellcare.com/allwellPA

SOUTH CAROLINA

+ HMO, HMO D-SNP

📞 1-855-766-1497

💻 Or visit www.wellcare.com/allwellSC

TEXAS

 HMO

 1-844-796-6811

 HMO D-SNP

 1-877-935-8023

 Or visit www.wellcare.com/allwellTX

WISCONSIN

 HMO D-SNP

 1-877-935-8024

 Or visit www.wellcare.com/allwellWI

WASHINGTON

 PPO

 1-888-445-8913

 Or visit www.wellcare.com/healthnetOR

TTY FOR ALL STATES: 711

HOURS OF OPERATION

 **October 1 to March 31:** Monday–Sunday, 8 a.m. to 8 p.m.

 **April 1 to September 30:** Monday–Friday, 8 a.m. to 8 p.m.

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to “we,” “us” or “our,” it means Wellcare. When it refers to “plan” or “our plan,” it means Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO).

This document includes a list of the drugs (formulary) for our plan which is current as of 12/01/2023. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the inside front and back cover pages.

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

What is the Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO) Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO)’s Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO)’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 12/01/2023. To get updated information about the drugs covered by our plan please contact us. Our contact information appears on the inside front and back cover pages.

The formulary will be updated monthly and posted on our website. To get an updated printed formulary or to get information about the drugs covered by our plan, please visit our website or call Member Services at our contact information on the inside front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular.” If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page INDEX-1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 18 tablets per prescription for rizatriptan 5mg. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the inside front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO)'s formulary?" on page V for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Wellcare Giveback Boost (HMO), Wellcare Giveback Open (PPO), Wellcare No Premium (HMO), Wellcare No Premium Essentials (HMO), Wellcare No Premium Medicare (HMO), Wellcare No Premium Open (PPO), Wellcare Premium Ultra Open (PPO)'s Formulary?

You can ask our plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a level of care change (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can call our Provider Service Center and request a one-time override. This one-time override will be up to a 31-day supply (unless you have a prescription written for fewer days).

For more information

For more detailed information about your plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the inside front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (**1-800-633-4227**) 24 hours a day/7 days a week. TTY users should call **1-877-486-2048**. Or, visit **<http://www.medicare.gov>**.

Our plan's Formulary

The formulary below provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page INDEX-1.

The first column of the chart lists the drug name. Brand-name drugs are **capitalized** (e.g., **ELIQUIS**) and generic drugs are listed in lower-case italics (e.g., *simvastatin*).

The information in the Requirements/Limits column tells you if our plan has any special requirements for coverage of your drug.

- **GC** stands for Gap Coverage: We provide additional coverage of this prescription drug in the coverage gap. Please refer to your Evidence of Coverage for more information about this coverage.
- **NT** stands for Not Part D: This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count toward your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving Extra Help to pay for your prescriptions, you will not get any Extra Help to pay for this drug.
- **NM** means the drug is not available via your monthly mail service benefit. This is noted in the Requirements/ Limits column of your formulary. You may be able to receive more than one month's supply of most of the drugs on your formulary via mail service at a reduced cost share. Please see Chapter 5 of your Evidence of Coverage for more information.
- **PA** stands for Prior Authorization: Please see page IV for details.
- **PA-NS** stands for Prior Authorization for New Starts: This means that if this drug is new to you, you will need to get approval from us before you fill your prescription. If you are taking this drug at the time of enrollment, you will not be required to meet criteria for approval.
- **B/D** stands for Covered under Medicare B or D: This drug may be eligible for payment under Medicare Part B or Part D. You (or your physician) are required to get prior authorization from us to determine that this drug is covered under Medicare Part D before you fill your prescription for this drug. Without prior approval, we may not cover this drug.

- **QL** stands for Quantity Limits: Please see page IV for details.
- **LA** stands for Limited Access medication. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Service at the telephone number listed on the inside front and back covers of this formulary.
- **ST** stands for Step Therapy: Please see page IV for details.
- **^** stands for Drug may be available for up to a 30-day supply only.

Drug tier copayment/coinsurance amounts

Prescription drugs are grouped into one of six tiers. To find out which tier your drug is in, look in the Drug Tier column of the formulary that begins on page 1. For more detailed information about your out-of-pocket costs for prescriptions, including any deductible that may apply, please refer to your Evidence of Coverage and other plan materials.

- **Tier 1 (Preferred Generic Drugs)** includes preferred generic drugs and may include some brand drugs.
 - **Preferred** Copayment range: \$0 - \$5
 - **Standard** Copayment range: \$5 - \$15
- **Tier 2 (Generic Drugs)** includes generic drugs and may include some brand drugs.
 - **Preferred** Copayment range: \$5 - \$15
 - **Standard** Copayment range: \$10 - \$20
- **Tier 3 (Preferred Brand Drugs)** includes preferred brand drugs and may include some generic drugs.
 - **Preferred** Copayment: \$37
 - **Standard** Copayment: \$47
- **Tier 4 (Non-Preferred Drugs)** includes non-preferred brand and non-preferred generic drugs.
 - **Preferred** Copayment/Coinsurance range: \$90 / 43% - 48%
 - **Standard** Copayment/Coinsurance range: \$100 / 45% - 50%
- **Tier 5 (Specialty Tier)** includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.
 - **Preferred** Coinsurance range: 27% - 33%
 - **Standard** Coinsurance range: 27% - 33%
- **Tier 6 (Select Care Drugs)** includes some generic and brand drugs commonly used to treat specific chronic conditions or to prevent disease (vaccines).
 - **Preferred** Copayment: \$0
 - **Standard** Copayment: \$0

Consult your Evidence of Coverage or Summary of Benefits for your applicable co-pays/coinsurance and amounts.

Table of Contents

ANALGESICS	3
ANESTHETICS	5
ANTI-INFECTIVES	5
ANTINEOPLASTIC AGENTS	16
CARDIOVASCULAR	25
CENTRAL NERVOUS SYSTEM	33
ENDOCRINE AND METABOLIC	49
GASTROINTESTINAL	63
GENITOURINARY	67
HEMATOLOGIC	68
IMMUNOLOGIC AGENTS	70
NUTRITIONAL/SUPPLEMENTS	76
OPHTHALMIC	79
OTIC	81
PHOSPHODIESTERASE TYPE 5 INHIBITORS	82
RESPIRATORY	82
TOPICAL	86

Drug Name	Drug Tier	Requirements / Limits
ANALGESICS		
GOUT		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	
<i>colchicine oral tablet 0.6 mg</i>	4	QL (120 EA per 30 days)
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	3	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	4	PA
MITIGARE ORAL CAPSULE 0.6 MG	3	QL (60 EA per 30 days)
<i>probenecid oral tablet 500 mg</i>	3	
NSAIDS		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	3	QL (60 EA per 30 days)
<i>celecoxib oral capsule 400 mg</i>	3	QL (30 EA per 30 days)
<i>diclofenac potassium oral tablet 50 mg</i>	3	QL (120 EA per 30 days)
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	3	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	2	
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	4	
<i>diflunisal oral tablet 500 mg</i>	3	
<i>ec-naproxen oral tablet delayed release 375 mg</i>	2	QL (120 EA per 30 days)
<i>ec-naproxen oral tablet delayed release 500 mg</i>	4	QL (90 EA per 30 days)
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	2	
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	2	
<i>flurbiprofen oral tablet 100 mg</i>	3	
<i>ibu oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	3	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	2	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen oral tablet delayed release 375 mg</i>	2	QL (120 EA per 30 days)
<i>naproxen oral tablet delayed release 500 mg</i>	4	QL (90 EA per 30 days)
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>oxaprozin oral tablet 600 mg</i>	4	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	3	
<i>sulindac oral tablet 150 mg, 200 mg</i>	2	
OPIOID ANALGESICS, LONG-ACTING		
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	PA; QL (10 EA per 30 days)
<i>HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG, 120 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG</i>	3	PA; QL (30 EA per 30 days)
<i>methadone hcl intensol oral concentrate 10 mg/ml</i>	3	PA; QL (90 ML per 30 days)
<i>methadone hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	3	PA; QL (450 ML per 30 days)
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	3	PA; QL (90 EA per 30 days)
<i>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	3	PA; QL (90 EA per 30 days)
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	3	QL (2700 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	3	QL (400 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-30 mg</i>	3	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	3	QL (180 EA per 30 days)
<i>butorphanol tartrate injection solution 1 mg/ml, 2 mg/ml</i>	4	
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	3	QL (10 ML per 30 days)
<i>endocet oral tablet 10-325 mg</i>	3	QL (180 EA per 30 days)
<i>endocet oral tablet 2.5-325 mg, 5-325 mg</i>	3	QL (360 EA per 30 days)
<i>endocet oral tablet 7.5-325 mg</i>	3	QL (240 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	5^	PA; QL (120 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	4	PA; QL (120 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	4	QL (2700 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg</i>	3	QL (180 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 5-325 mg</i>	3	QL (240 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	3	QL (150 EA per 30 days)
<i>hydromorphone hcl oral liquid 1 mg/ml</i>	4	QL (600 ML per 30 days)
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	3	QL (180 EA per 30 days)
<i>morphine sulfate (concentrate) oral solution 20 mg/ml</i>	3	QL (180 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
MORPHINE SULFATE (PF) INJECTION SOLUTION 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML, 8 MG/ML	4	B/D
MORPHINE SULFATE (PF) INTRAVENOUS SOLUTION 1 MG/ML, 10 MG/ML, 2 MG/ML, 4 MG/ML, 8 MG/ML	4	B/D
<i>morphine sulfate intravenous solution 10 mg/ml, 4 mg/ml, 8 mg/ml</i>	4	B/D
<i>morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml</i>	3	QL (900 ML per 30 days)
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	3	QL (180 EA per 30 days)
<i>nalbuphine hcl injection solution 10 mg/ml, 20 mg/ml</i>	4	
<i>oxycodone hcl oral capsule 5 mg</i>	4	QL (180 EA per 30 days)
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	4	QL (180 ML per 30 days)
<i>oxycodone hcl oral solution 5 mg/5ml</i>	4	QL (900 ML per 30 days)
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	3	QL (180 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	3	QL (180 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	3	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	3	QL (240 EA per 30 days)
<i>tramadol hcl oral tablet 50 mg</i>	2	QL (240 EA per 30 days)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	3	QL (240 EA per 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
<i>lidocaine hcl (pf) injection solution 0.5 %, 1 %, 1.5 %</i>	3	B/D
<i>lidocaine hcl injection solution 0.5 %, 1 %, 2 %</i>	3	B/D
ANTI-INFECTIVES		
ANTIFUNGALS		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	4	B/D
<i>amphotericin b intravenous solution reconstituted 50 mg</i>	4	B/D
<i>amphotericin b liposome intravenous suspension reconstituted 50 mg</i>	5^	B/D
<i>caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg</i>	4	
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</i>	3	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	2	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	5^	PA
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	4	
<i>griseofulvin microsize oral tablet 500 mg</i>	4	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	4	
<i>itraconazole oral capsule 100 mg</i>	4	PA
<i>ketoconazole oral tablet 200 mg</i>	3	PA
<i>micafungin sodium intravenous solution reconstituted 100 mg, 50 mg</i>	5^	
NOXAFIL ORAL SUSPENSION 40 MG/ML	5^	PA; QL (630 ML per 30 days)
<i>nystatin oral tablet 500000 unit</i>	3	
<i>posaconazole oral suspension 40 mg/ml</i>	5^	PA; QL (630 ML per 30 days)
<i>posaconazole oral tablet delayed release 100 mg</i>	5^	PA; QL (93 EA per 30 days)
<i>terbinafine hcl oral tablet 250 mg</i>	1	QL (90 EA per 365 days)
<i>voriconazole intravenous solution reconstituted 200 mg</i>	5^	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	5^	PA
<i>voriconazole oral tablet 200 mg</i>	4	PA; QL (120 EA per 30 days)
<i>voriconazole oral tablet 50 mg</i>	4	PA; QL (480 EA per 30 days)
ANTI-INFECTIVES - MISCELLANEOUS		
<i>albendazole oral tablet 200 mg</i>	5^	
<i>amikacin sulfate injection solution 1 gm/4ml, 500 mg/2ml</i>	4	
<i>atovaquone oral suspension 750 mg/5ml</i>	4	
<i>aztreonam injection solution reconstituted 1 gm, 2 gm</i>	4	
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5^	PA; LA
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	2	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	4	
<i>clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml, 900 mg/50ml</i>	4	
CLINDAMYCIN PHOSPHATE IN NAACL INTRAVENOUS SOLUTION 300-0.9 MG/50ML-%, 600-0.9 MG/50ML-%, 900-0.9 MG/50ML-%	4	
<i>clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml, 9000 mg/60ml</i>	3	
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>dapsone oral tablet 100 mg, 25 mg</i>	3	
<i>daptomycin intravenous solution reconstituted 350 mg, 500 mg</i>	5^	
DAPTOMYCIN SOLUTION RECONSTITUTED 350 MG INTRAVENOUS	5^	
EMVERM ORAL TABLET CHEWABLE 100 MG	5^	QL (12 EA per 365 days)
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	4	
<i>gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%, 2-0.9 mg/ml-%</i>	3	
<i>gentamicin sulfate injection solution 10 mg/ml, 40 mg/ml</i>	3	
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	4	
<i>ivermectin oral tablet 3 mg</i>	3	PA; QL (12 EA per 90 days)
<i>linezolid in sodium chloride intravenous solution 600-0.9 mg/300ml-%</i>	4	
<i>linezolid intravenous solution 600 mg/300ml</i>	4	
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	5^	QL (1800 ML per 30 days)
<i>linezolid oral tablet 600 mg</i>	4	QL (60 EA per 30 days)
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	4	
<i>methenamine hippurate oral tablet 1 gm</i>	4	
<i>metronidazole intravenous solution 500 mg/100ml</i>	3	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	
<i>neomycin sulfate oral tablet 500 mg</i>	2	
<i>nitazoxanide oral tablet 500 mg</i>	5^	QL (6 EA per 30 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	3	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	3	
<i>paromomycin sulfate oral capsule 250 mg</i>	4	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	4	B/D
<i>pentamidine isethionate injection solution reconstituted 300 mg</i>	4	
<i>praziquantel oral tablet 600 mg</i>	4	
SIVEXTRO INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	5^	
SIVEXTRO ORAL TABLET 200 MG	5^	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	4	
<i>sulfadiazine oral tablet 500 mg</i>	4	
<i>sulfamethoxazole-trimethoprim intravenous solution 400-80 mg/5ml</i>	4	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	3	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	3	
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	5^	PA
<i>tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 2 gm/50ml, 80 mg/2ml</i>	3	
<i>trimethoprim oral tablet 100 mg</i>	3	
VANCOMYCIN HCL IN NAACL INTRAVENOUS SOLUTION 1-0.9 GM/200ML-%, 500-0.9 MG/100ML-%, 750-0.9 MG/150ML-%	4	
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 5 gm, 500 mg, 750 mg</i>	4	
<i>vancomycin hcl oral capsule 125 mg</i>	4	QL (80 EA per 180 days)
<i>vancomycin hcl oral capsule 250 mg</i>	4	QL (160 EA per 180 days)
ANTIMALARIALS		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	4	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	4	
COARTEM ORAL TABLET 20-120 MG	4	
<i>mefloquine hcl oral tablet 250 mg</i>	3	
PRIMAQUINE PHOSPHATE ORAL TABLET 26.3 (15 BASE) MG	3	
<i>primaquine phosphate tablet 26.3 (15 base) mg oral</i>	3	
<i>quinine sulfate oral capsule 324 mg</i>	4	PA
ANTIRETROVIRAL AGENTS		
<i>abacavir sulfate oral solution 20 mg/ml</i>	4	
<i>abacavir sulfate oral tablet 300 mg</i>	3	
APTIVUS ORAL CAPSULE 250 MG	5^	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	4	
EDURANT ORAL TABLET 25 MG	5^	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>efavirenz oral capsule 200 mg, 50 mg</i>	4	
<i>efavirenz oral tablet 600 mg</i>	4	
<i>emtricitabine oral capsule 200 mg</i>	3	
EMTRIVA ORAL SOLUTION 10 MG/ML	4	
<i>etravirine oral tablet 100 mg, 200 mg</i>	5^	
<i>fosamprenavir calcium oral tablet 700 mg</i>	5^	
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	5^	
INTELENCE ORAL TABLET 25 MG	4	
ISENTRESS HD ORAL TABLET 600 MG	5^	
ISENTRESS ORAL PACKET 100 MG	5^	
ISENTRESS ORAL TABLET 400 MG	5^	
ISENTRESS ORAL TABLET CHEWABLE 100 MG	5^	
ISENTRESS ORAL TABLET CHEWABLE 25 MG	4	
<i>lamivudine oral solution 10 mg/ml</i>	3	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	3	
LEXIVA ORAL SUSPENSION 50 MG/ML	4	
<i>maraviroc oral tablet 150 mg, 300 mg</i>	5^	
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	4	
<i>nevirapine oral suspension 50 mg/5ml</i>	4	
<i>nevirapine oral tablet 200 mg</i>	2	
NORVIR ORAL PACKET 100 MG	4	
PIFELTRO ORAL TABLET 100 MG	5^	
PREZISTA ORAL SUSPENSION 100 MG/ML	5^	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	5^	QL (240 EA per 30 days)
PREZISTA ORAL TABLET 600 MG	5^	QL (60 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	QL (480 EA per 30 days)
PREZISTA ORAL TABLET 800 MG	5^	QL (30 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	5^	
<i>ritonavir oral tablet 100 mg</i>	3	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	5^	
SELZENTRY ORAL SOLUTION 20 MG/ML	5^	
SELZENTRY ORAL TABLET 25 MG	4	
SELZENTRY ORAL TABLET 75 MG	5^	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG	5^	LA
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	3	
TIVICAY ORAL TABLET 10 MG	3	
TIVICAY ORAL TABLET 25 MG, 50 MG	5^	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	5^	
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	5^	LA
TYBOST ORAL TABLET 150 MG	3	
VIRACEPT ORAL TABLET 250 MG, 625 MG	5^	
VIREAD ORAL POWDER 40 MG/GM	5^	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5^	
<i>zidovudine oral capsule 100 mg</i>	4	
<i>zidovudine oral syrup 50 mg/5ml</i>	4	
<i>zidovudine oral tablet 300 mg</i>	3	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	3	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5^	
CIMDUO ORAL TABLET 300-300 MG	5^	
COMPLERA ORAL TABLET 200-25-300 MG	5^	
DELSTRIGO ORAL TABLET 100-300-300 MG	5^	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5^	QL (30 EA per 30 days)
DOVATO ORAL TABLET 50-300 MG	5^	
<i>efavirenz-emtricitabine-tenofovir disoproxil fumarate oral tablet 600-200-300 mg</i>	5^	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate oral tablet 400-300-300 mg, 600-300-300 mg</i>	5^	
<i>emtricitabine-tenofovir disoproxil fumarate oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg</i>	5^	QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	5^	
GENVOYA ORAL TABLET 150-150-200-10 MG	5^	
JULUCA ORAL TABLET 50-25 MG	5^	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	4	
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	4	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	4	
ODEFSEY ORAL TABLET 200-25-25 MG	5^	
PREZCOBIX ORAL TABLET 800-150 MG	5^	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
STRIBILD ORAL TABLET 150-150-200-300 MG	5^	
SYMTUZA ORAL TABLET 800-150-200-10 MG	5^	
TRIUMEQ ORAL TABLET 600-50-300 MG	5^	
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	5^	
TRIZIVIR ORAL TABLET 300-150-300 MG	5^	
ANTITUBERCULAR AGENTS		
<i>cycloserine oral capsule 250 mg</i>	5^	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	3	
<i>isoniazid oral syrup 50 mg/5ml</i>	4	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	
PRIFTIN ORAL TABLET 150 MG	4	
<i>pyrazinamide oral tablet 500 mg</i>	4	
<i>rifabutin oral capsule 150 mg</i>	4	
<i>rifampin intravenous solution reconstituted 600 mg</i>	4	
<i>rifampin oral capsule 150 mg, 300 mg</i>	3	
SIRTURO ORAL TABLET 100 MG, 20 MG	5^	PA; LA
TRECTOR ORAL TABLET 250 MG	4	
ANTIVIRALS		
<i>acyclovir oral capsule 200 mg</i>	2	
<i>acyclovir oral suspension 200 mg/5ml</i>	4	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	2	
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	4	B/D
<i>adefovir dipivoxil oral tablet 10 mg</i>	5^	
BARACLUDE ORAL SOLUTION 0.05 MG/ML	5^	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	4	
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG	5^	PA
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG	5^	PA
EPIVIR HBV ORAL SOLUTION 5 MG/ML	4	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	3	
<i>ganciclovir sodium intravenous solution reconstituted 500 mg</i>	4	B/D
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG	5^	PA
HARVONI ORAL TABLET 45-200 MG, 90-400 MG	5^	PA
<i>lamivudine oral tablet 100 mg</i>	4	
MAVYRET ORAL PACKET 50-20 MG	5^	PA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
MAVYRET ORAL TABLET 100-40 MG	5^	PA
<i>oseltamivir phosphate oral capsule 30 mg</i>	3	QL (168 EA per 365 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	3	QL (84 EA per 365 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	3	QL (1080 ML per 365 days)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5^	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	5^	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG	5^	PA; QL (28 EA per 28 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	3	QL (120 EA per 365 days)
<i>ribavirin oral capsule 200 mg</i>	3	
<i>ribavirin oral tablet 200 mg</i>	4	
<i>rimantadine hcl oral tablet 100 mg</i>	4	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	3	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	5^	
<i>valganciclovir hcl oral tablet 450 mg</i>	3	
VEMLIDY ORAL TABLET 25 MG	5^	
VOSEVI ORAL TABLET 400-100-100 MG	5^	PA
CEPHALOSPORINS		
CEFACTOR ER ORAL TABLET EXTENDED RELEASE 12 HOUR 500 MG	4	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	3	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	4	
<i>cefadroxil oral capsule 500 mg</i>	2	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	3	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 500 mg</i>	3	
<i>cefazolin sodium intravenous solution reconstituted 1 gm</i>	3	
CEFAZOLIN SODIUM INTRAVENOUS SOLUTION RECONSTITUTED 2 GM, 3 GM	4	
CEFAZOLIN SODIUM-DEXTROSE INTRAVENOUS SOLUTION 1-4 GM/50ML-%, 2-4 GM/100ML-%	4	
<i>cefdinir oral capsule 300 mg</i>	2	

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	3
<i>cefepime hcl injection solution reconstituted 1 gm</i>	4
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	4
<i>cefixime oral capsule 400 mg</i>	4
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	4
<i>cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	4
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	4
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	3
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	3
<i>cefprozil oral tablet 250 mg, 500 mg</i>	3
<i>ceftazidime injection solution reconstituted 1 gm, 6 gm</i>	4
<i>ceftazidime intravenous solution reconstituted 2 gm</i>	4
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	4
<i>ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	4
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	3
<i>cefuroxime sodium injection solution reconstituted 750 mg</i>	3
<i>cefuroxime sodium intravenous solution reconstituted 1.5 gm</i>	3
<i>cephalexin oral capsule 250 mg, 500 mg</i>	2
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	3
<i>tazicef injection solution reconstituted 1 gm</i>	4
<i>tazicef intravenous solution reconstituted 1 gm, 2 gm, 6 gm</i>	4
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5^
ERYTHROMYCINS/MACROLIDES	
<i>azithromycin intravenous solution reconstituted 500 mg</i>	3
<i>azithromycin oral packet 1 gm</i>	3
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	3

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg</i>	1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	3	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	4	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	3	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5^	
DIFICID ORAL TABLET 200 MG	5^	
<i>e.e.s. 400 oral tablet 400 mg</i>	4	
<i>ery-tab oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	4	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	
<i>erythrocin stearate oral tablet 250 mg</i>	4	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	4	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	4	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	4	
<i>erythromycin lactobionate intravenous solution reconstituted 500 mg</i>	4	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	4	
FLUOROQUINOLONES		
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%)	4	
<i>ciprofloxacin hcl oral tablet 100 mg</i>	4	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml, 400 mg/200ml</i>	3	
<i>levofloxacin in d5w intravenous solution 250 mg/50ml, 500 mg/100ml, 750 mg/150ml</i>	3	
<i>levofloxacin intravenous solution 25 mg/ml</i>	4	
<i>levofloxacin oral solution 25 mg/ml</i>	4	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	4	
PENICILLINS		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	2
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	4
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	3
<i>amoxicillin-pot clavulanate oral suspension reconstituted 250-62.5 mg/5ml</i>	4
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg</i>	3
<i>amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg</i>	2
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	4
<i>ampicillin oral capsule 500 mg</i>	2
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg, 2 gm, 250 mg, 500 mg</i>	4
<i>ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	4
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	4
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm</i>	4
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML	4
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	3
<i>nafcillin sodium injection solution reconstituted 1 gm, 2 gm</i>	4
<i>nafcillin sodium intravenous solution reconstituted 10 gm</i>	5^
<i>oxacillin sodium injection solution reconstituted 1 gm, 2 gm</i>	4
<i>oxacillin sodium intravenous solution reconstituted 10 gm</i>	4
PENICILLIN G POT IN DEXTROSE INTRAVENOUS SOLUTION 40000 UNIT/ML, 60000 UNIT/ML	4
<i>penicillin g potassium injection solution reconstituted 20000000 unit, 5000000 unit</i>	4
PENICILLIN G PROCAINE INTRAMUSCULAR SUSPENSION 600000 UNIT/ML	4

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	4	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
<i>pfizerpen injection solution reconstituted 20000000 unit, 5000000 unit</i>	4	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted 13.5 (12-1.5) gm, 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm</i>	4	
TETRACYCLINES		
<i>doxy 100 intravenous solution reconstituted 100 mg</i>	4	
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	4	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	3	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	3	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	3	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	3	
NUZYRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5^	LA
NUZYRA ORAL TABLET 150 MG	5^	LA
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	4	PA
<i>tigecycline intravenous solution reconstituted 50 mg</i>	5^	
TIGECYCLINE SOLUTION RECONSTITUTED 50 MG INTRAVENOUS	5^	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA INTRAVENOUS SOLUTION 100 MG/4ML	5^	B/D; LA
<i>carboplatin intravenous solution 150 mg/15ml, 450 mg/45ml, 50 mg/5ml, 600 mg/60ml</i>	3	B/D
<i>cisplatin intravenous solution 100 mg/100ml, 200 mg/200ml, 50 mg/50ml</i>	3	B/D
<i>cyclophosphamide injection solution reconstituted 1 gm, 2 gm, 500 mg</i>	5^	B/D
CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION 1 GM/5ML, 2 GM/10ML, 500 MG/2.5ML, 500 MG/ML	5^	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	3	B/D
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 50 MG	4	B/D
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	4	
GLEOSTINE ORAL CAPSULE 100 MG	5^	
LEUKERAN ORAL TABLET 2 MG	4	
<i>oxaliplatin intravenous solution 100 mg/20ml, 200 mg/40ml, 50 mg/10ml</i>	4	B/D
<i>oxaliplatin intravenous solution reconstituted 100 mg, 50 mg</i>	5^	B/D
<i>paraplatin intravenous solution 1000 mg/100ml</i>	3	B/D
ANTIBIOTICS		
<i>doxorubicin hcl intravenous solution 2 mg/ml</i>	4	B/D
<i>doxorubicin hcl liposomal intravenous injectable 2 mg/ml</i>	5^	B/D
ELLECE INTRAVENOUS SOLUTION 200 MG/100ML, 50 MG/25ML	4	B/D
ANTIMETABOLITES		
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	5^	B/D
<i>azacitidine injection suspension reconstituted 100 mg</i>	5^	B/D
<i>cytarabine injection solution 20 mg/ml</i>	3	B/D
<i>fluorouracil intravenous solution 1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml</i>	3	B/D
<i>gemcitabine hcl intravenous solution 1 gm/26.3ml, 2 gm/52.6ml, 200 mg/5.26ml</i>	4	B/D
<i>gemcitabine hcl intravenous solution reconstituted 1 gm, 2 gm, 200 mg</i>	4	B/D
INQOVI ORAL TABLET 35-100 MG	5^	PA-NS; LA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5^	PA-NS; LA
<i>mercaptopurine oral tablet 50 mg</i>	3	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	3	B/D
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	3	B/D
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	3	B/D
ONUREG ORAL TABLET 200 MG, 300 MG	5^	PA-NS; LA
<i>pemetrexed disodium intravenous solution reconstituted 100 mg, 1000 mg, 500 mg, 750 mg</i>	5^	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
PURIXAN ORAL SUSPENSION 2000 MG/100ML	5^	
TABLOID ORAL TABLET 40 MG	4	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate oral tablet 250 mg, 500 mg</i>	5^	PA-NS
<i>anastrozole oral tablet 1 mg</i>	2	
<i>bicalutamide oral tablet 50 mg</i>	2	
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	4	PA-NS
EMCYT ORAL CAPSULE 140 MG	5^	
ERLEADA ORAL TABLET 240 MG, 60 MG	5^	PA-NS; LA
EULEXIN ORAL CAPSULE 125 MG	5^	
<i>exemestane oral tablet 25 mg</i>	4	
<i>fulvestrant intramuscular solution prefilled syringe 250 mg/5ml</i>	5^	B/D
<i>letrozole oral tablet 2.5 mg</i>	2	
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	4	PA-NS
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG	5^	PA-NS
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG	5^	PA-NS
LYSODREN ORAL TABLET 500 MG	5^	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	3	
<i>nilutamide oral tablet 150 mg</i>	5^	
NUBEQA ORAL TABLET 300 MG	5^	PA-NS; LA
ORGOVYX ORAL TABLET 120 MG	5^	PA-NS; LA
ORSERDU ORAL TABLET 345 MG, 86 MG	5^	PA-NS; LA
SOLTAMOX ORAL SOLUTION 10 MG/5ML	5^	
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	2	
<i>toremifene citrate oral tablet 60 mg</i>	5^	
XTANDI ORAL CAPSULE 40 MG	5^	PA-NS; LA
XTANDI ORAL TABLET 40 MG, 80 MG	5^	PA-NS; LA
IMMUNOMODULATORS		
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 5 mg</i>	5^	PA-NS; LA; QL (28 EA per 28 days)
<i>lenalidomide oral capsule 20 mg, 25 mg</i>	5^	PA-NS; LA; QL (21 EA per 28 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG	5^	PA-NS; LA; QL (28 EA per 28 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
REVLIMID ORAL CAPSULE 20 MG, 25 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
THALOMID ORAL CAPSULE 100 MG, 50 MG	5^	PA-NS; LA; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5^	PA-NS; LA; QL (56 EA per 28 days)
MISCELLANEOUS		
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	5^	PA-NS; LA
<i>bexarotene oral capsule 75 mg</i>	5^	PA-NS
<i>hydroxyurea oral capsule 500 mg</i>	2	
<i>irinotecan hcl intravenous solution 100 mg/5ml, 300 mg/15ml, 40 mg/2ml, 500 mg/25ml</i>	4	B/D
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5^	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5^	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5^	PA-NS; QL (91 EA per 28 days)
MATULANE ORAL CAPSULE 50 MG	5^	LA
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG	5^	PA-NS
<i>tretinoin oral capsule 10 mg</i>	5^	
WELIREG ORAL TABLET 40 MG	5^	PA-NS; LA
MITOTIC INHIBITORS		
DOCETAXEL CONCENTRATE 160 MG/8ML INTRAVENOUS	5^	B/D
DOCETAXEL CONCENTRATE 80 MG/4ML INTRAVENOUS	5^	B/D
<i>docetaxel intravenous concentrate 160 mg/8ml, 80 mg/4ml</i>	5^	B/D
<i>docetaxel intravenous concentrate 20 mg/ml</i>	4	B/D
<i>docetaxel intravenous solution 160 mg/16ml, 20 mg/2ml, 80 mg/8ml</i>	5^	B/D
DOCETAXEL SOLUTION 160 MG/16ML INTRAVENOUS	5^	B/D
DOCETAXEL SOLUTION 20 MG/2ML INTRAVENOUS	5^	B/D
DOCETAXEL SOLUTION 80 MG/8ML INTRAVENOUS	5^	B/D
<i>etoposide intravenous solution 1 gm/50ml, 100 mg/5ml, 500 mg/25ml</i>	3	B/D
<i>paclitaxel intravenous concentrate 100 mg/16.7ml, 150 mg/25ml, 30 mg/5ml, 300 mg/50ml</i>	4	B/D
<i>paclitaxel protein-bound part intravenous suspension reconstituted 100 mg</i>	5^	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>vincristine sulfate intravenous solution 1 mg/ml</i>	2	B/D
<i>vinorelbine tartrate intravenous solution 10 mg/ml, 50 mg/5ml</i>	4	B/D
MOLECULAR TARGET AGENTS		
ALECENSA ORAL CAPSULE 150 MG	5^	PA-NS; LA
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG	5^	PA-NS; LA
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5^	PA-NS; LA
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5^	PA-NS; LA
BORTEZOMIB INJECTION SOLUTION RECONSTITUTED 1 MG, 2.5 MG	5^	PA-NS
<i>bortezomib injection solution reconstituted 3.5 mg</i>	5^	PA-NS
BORTEZOMIB INTRAVENOUS SOLUTION RECONSTITUTED 3.5 MG	5^	PA-NS
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG	5^	PA-NS
BRAFTOVI ORAL CAPSULE 75 MG	5^	PA-NS; LA
BRUKINSA ORAL CAPSULE 80 MG	5^	PA-NS; LA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
CALQUENCE ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
CALQUENCE ORAL TABLET 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG, 300 MG	5^	PA-NS; LA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5^	PA-NS; LA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5^	PA-NS; LA
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5^	PA-NS; LA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5^	PA-NS; LA
COTELLIC ORAL TABLET 20 MG	5^	PA-NS; LA
DAURISMO ORAL TABLET 100 MG, 25 MG	5^	PA-NS; LA
ERIVEDGE ORAL CAPSULE 150 MG	5^	PA-NS; LA
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
<i>erlotinib hcl oral tablet 25 mg</i>	5^	PA-NS; QL (90 EA per 30 days)
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
<i>everolimus oral tablet soluble 2 mg</i>	5^	PA-NS; QL (150 EA per 30 days)
<i>everolimus oral tablet soluble 3 mg</i>	5^	PA-NS; QL (90 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>everolimus oral tablet soluble 5 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
EXKIVITY ORAL CAPSULE 40 MG	5^	PA-NS; LA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
GAVRETO ORAL CAPSULE 100 MG	5^	PA-NS; LA
<i>gefitinib oral tablet 250 mg</i>	5^	PA-NS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5^	PA-NS; LA
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600-10000 MG-UNT/5ML	5^	PA-NS; LA
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED 150 MG	5^	PA-NS; LA
HERZUMA INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5^	PA-NS; LA
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5^	PA-NS; LA; QL (21 EA per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
IDHIFA ORAL TABLET 100 MG, 50 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>imatinib mesylate oral tablet 100 mg</i>	5^	PA-NS; QL (90 EA per 30 days)
<i>imatinib mesylate oral tablet 400 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5^	PA-NS; LA; QL (216 ML per 27 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
INLYTA ORAL TABLET 1 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
INLYTA ORAL TABLET 5 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
INREBIC ORAL CAPSULE 100 MG	5^	PA-NS; LA
IRESSA ORAL TABLET 250 MG	5^	PA-NS; LA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	5^	B/D; LA
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5^	PA-NS; LA
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	5^	PA-NS; LA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5^	PA-NS; QL (21 EA per 28 days)
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5^	PA-NS; QL (42 EA per 28 days)
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5^	PA-NS; QL (63 EA per 28 days)
KRAZATI ORAL TABLET 200 MG	5^	PA-NS; LA
<i>lapatinib ditosylate oral tablet 250 mg</i>	5^	PA-NS
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5^	PA-NS; LA; QL (60 EA per 30 days)
LORBRENA ORAL TABLET 100 MG, 25 MG	5^	PA-NS; LA
LUMAKRAS ORAL TABLET 120 MG, 320 MG	5^	PA-NS; LA
LYNPARZA ORAL TABLET 100 MG, 150 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5^	PA-NS; LA
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5^	PA-NS; LA
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	5^	PA-NS; LA
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	5^	PA-NS; LA
MEKINIST ORAL TABLET 0.5 MG, 2 MG	5^	PA-NS; LA
MEKTOVI ORAL TABLET 15 MG	5^	PA-NS; LA
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	5^	PA-NS; LA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
MVASI INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	5^	PA-NS; LA
NERLYNX ORAL TABLET 40 MG	5^	PA-NS; LA
NEXAVAR ORAL TABLET 200 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5^	PA-NS; QL (3 EA per 28 days)
ODOMZO ORAL CAPSULE 200 MG	5^	PA-NS; LA
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5^	PA-NS; LA
ONTRUZANT INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5^	PA-NS; LA
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5^	PA-NS; LA
PHESGO SUBCUTANEOUS SOLUTION 60-60-2000 MG-MG-U/ML, 80-40-2000 MG-MG-U/ML	5^	PA-NS; LA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5^	PA-NS
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5^	PA-NS
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5^	PA-NS
QINLOCK ORAL TABLET 50 MG	5^	PA-NS; LA
RETEVMO ORAL CAPSULE 40 MG, 80 MG	5^	PA-NS; LA
REZLIDHIA ORAL CAPSULE 150 MG	5^	PA-NS; LA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5^	PA-NS; LA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
RYDAPT ORAL CAPSULE 25 MG	5^	PA-NS
SCEMBLIX ORAL TABLET 20 MG	5^	PA-NS; QL (60 EA per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5^	PA-NS; QL (300 EA per 30 days)
<i>sorafenib tosylate oral tablet 200 mg</i>	5^	PA-NS; QL (120 EA per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	5^	PA-NS
STIVARGA ORAL TABLET 40 MG	5^	PA-NS; LA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	5^	PA-NS; QL (30 EA per 30 days)
TABRECTA ORAL TABLET 150 MG, 200 MG	5^	PA-NS
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5^	PA-NS; LA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	5^	PA-NS; LA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
TAGRISSO ORAL TABLET 40 MG, 80 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	5^	PA-NS
TAZVERIK ORAL TABLET 200 MG	5^	PA-NS; LA
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	5^	PA-NS; LA
TEPMETKO ORAL TABLET 225 MG	5^	PA-NS; LA
TIBSOVO ORAL TABLET 250 MG	5^	PA-NS; LA
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	5^	PA-NS
TRUSELTIQ (100MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 MG	5^	PA-NS; LA
TRUSELTIQ (125MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 & 25 MG	5^	PA-NS; LA
TRUSELTIQ (50MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5^	PA-NS; LA
TRUSELTIQ (75MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	5^	PA-NS; LA
TRUXIMA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	5^	PA-NS
TUKYSA ORAL TABLET 150 MG, 50 MG	5^	PA-NS; LA
TURALIO ORAL CAPSULE 125 MG, 200 MG	5^	PA-NS; LA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	5^	PA-NS; LA
VENCLEXTA ORAL TABLET 10 MG	4	PA-NS; LA; QL (112 EA per 28 days)
VENCLEXTA ORAL TABLET 100 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5^	PA-NS; LA; QL (112 EA per 28 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5^	PA-NS; LA; QL (42 EA per 28 days)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5^	PA-NS; LA; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG, 25 MG	5^	PA-NS; LA
VITRAKVI ORAL SOLUTION 20 MG/ML	5^	PA-NS; LA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5^	PA-NS; LA
VONJO ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
VOTRIENT ORAL TABLET 200 MG	5^	PA-NS; LA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
XALKORI ORAL CAPSULE 200 MG, 250 MG	5^	PA-NS; LA
XOSPATA ORAL TABLET 40 MG	5^	PA-NS; LA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5^	PA-NS; LA; QL (8 EA per 28 days)
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5^	PA-NS; LA; QL (4 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5^	PA-NS; LA; QL (8 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5^	PA-NS; LA; QL (4 EA per 28 days)
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5^	PA-NS; LA; QL (24 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5^	PA-NS; LA; QL (8 EA per 28 days)
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5^	PA-NS; LA; QL (32 EA per 28 days)
ZEJULA ORAL CAPSULE 100 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
ZELBORAF ORAL TABLET 240 MG	5^	PA-NS; LA
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	5^	PA-NS; LA
ZOLINZA ORAL CAPSULE 100 MG	5^	PA-NS
ZYDELIG ORAL TABLET 100 MG, 150 MG	5^	PA-NS; LA
ZYKADIA ORAL TABLET 150 MG	5^	PA-NS; LA
PROTECTIVE AGENTS		
<i>leucovorin calcium injection solution 500 mg/50ml</i>	4	B/D
<i>leucovorin calcium injection solution reconstituted 100 mg, 200 mg, 350 mg, 50 mg, 500 mg</i>	4	B/D
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 5 mg</i>	3	
<i>leucovorin calcium oral tablet 25 mg</i>	4	
MESNEX ORAL TABLET 400 MG	5^	
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	6	GC; QL (30 EA per 30 days)
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	6	GC

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	6	GC
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	6	GC
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	6	GC
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	6	GC
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	6	GC
ACE INHIBITORS		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	GC
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	6	GC
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	6	GC
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	6	GC
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	6	GC
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	6	GC
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	6	GC
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	GC
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	6	GC
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	6	GC
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	3	
KERENDIA ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
ALPHA BLOCKERS		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	3	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	2	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	6	GC; QL (30 EA per 30 days)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	6	GC; QL (30 EA per 30 days)
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg</i>	6	GC; QL (60 EA per 30 days)
<i>candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg</i>	6	GC; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	4	QL (30 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	6	GC; QL (60 EA per 30 days)
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	6	GC; QL (30 EA per 30 days)
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	6	GC
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	6	GC; QL (30 EA per 30 days)
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	6	GC; QL (30 EA per 30 days)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	6	GC; QL (30 EA per 30 days)
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-25 mg</i>	6	GC; QL (30 EA per 30 days)
<i>telmisartan-hctz oral tablet 80-12.5 mg</i>	6	GC; QL (60 EA per 30 days)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	6	GC; QL (30 EA per 30 days)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg</i>	6	GC; QL (60 EA per 30 days)
<i>candesartan cilexetil oral tablet 32 mg</i>	6	GC; QL (30 EA per 30 days)
EDARBI ORAL TABLET 40 MG, 80 MG	4	QL (30 EA per 30 days)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	6	GC; QL (30 EA per 30 days)
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	6	GC
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg</i>	6	GC; QL (30 EA per 30 days)
<i>olmesartan medoxomil oral tablet 5 mg</i>	6	GC; QL (60 EA per 30 days)
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	6	GC; QL (30 EA per 30 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	6	GC; QL (60 EA per 30 days)
<i>valsartan oral tablet 320 mg</i>	6	GC; QL (30 EA per 30 days)
ANTIARRHYTHMICS		
<i>amiodarone hcl intravenous solution 150 mg/3ml, 450 mg/9ml, 900 mg/18ml</i>	4	
<i>amiodarone hcl oral tablet 100 mg, 400 mg</i>	4	
<i>amiodarone hcl oral tablet 200 mg</i>	1	
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	4	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	4	
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	3	
MULTAQ ORAL TABLET 400 MG	4	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG	4	
<i>pacerone oral tablet 100 mg, 400 mg</i>	4	
<i>pacerone oral tablet 200 mg</i>	1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	4	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	3	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	3	
<i>sorine oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	3	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	2	
ANTIPEMICS, FIBRATES		
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	2	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	2	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	2	
<i>gemfibrozil oral tablet 600 mg</i>	1	
ANTIPEMICS, HMG-COA REDUCTASE INHIBITORS		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG	5^	ST; QL (30 EA per 30 days)
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	6	GC; QL (30 EA per 30 days)
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG	4	ST; QL (30 EA per 30 days)
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	6	GC; QL (30 EA per 30 days)
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	6	GC; QL (60 EA per 30 days)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	4	ST; QL (30 EA per 30 days)
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	6	GC; QL (60 EA per 30 days)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	6	GC; QL (30 EA per 30 days)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	6	GC; QL (30 EA per 30 days)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	6	GC; QL (30 EA per 30 days)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG	4	ST; QL (30 EA per 30 days)
ANTIPEMICS, MISCELLANEOUS		
<i>cholestyramine light oral packet 4 gm</i>	3	
<i>cholestyramine light oral powder 4 gm/dose</i>	3	
<i>cholestyramine oral packet 4 gm</i>	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>cholestyramine oral powder 4 gm/dose</i>	3	
<i>colesevelam hcl oral packet 3.75 gm</i>	4	
<i>colesevelam hcl oral tablet 625 mg</i>	4	
<i>colestipol hcl oral granules 5 gm</i>	4	
<i>colestipol hcl oral packet 5 gm</i>	4	
<i>colestipol hcl oral tablet 1 gm</i>	3	
<i>ezetimibe oral tablet 10 mg</i>	1	
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	6	GC
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	3	QL (60 EA per 30 days)
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML	3	PA
<i>prevalite oral packet 4 gm</i>	3	
<i>prevalite oral powder 4 gm/dose</i>	3	
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM	4	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	2	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	3	
BETA-BLOCKERS		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	3	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate intravenous solution 5 mg/5ml</i>	4	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	2	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	3	QL (30 EA per 30 days)
<i>nebivolol hcl oral tablet 20 mg</i>	3	QL (60 EA per 30 days)
<i>pindolol oral tablet 10 mg, 5 mg</i>	3	

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	3
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	2
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	4
CALCIUM CHANNEL BLOCKERS	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1
<i>cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	2
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	4
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	4
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	4
<i>diltiazem hcl intravenous solution 125 mg/25ml, 25 mg/5ml, 50 mg/10ml</i>	3
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	2
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	3
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	2
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	4
<i>matzim la oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	4
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	4
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	3
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	2
<i>nimodipine oral capsule 30 mg</i>	4
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	4

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
NYMALIZE ORAL SOLUTION 6 MG/ML	5^
<i>taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	2
<i>tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	2
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	3
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg</i>	4
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	2
<i>verapamil hcl intravenous solution 2.5 mg/ml</i>	4
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1
DIURETICS	
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	4
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	3
<i>amiloride hcl oral tablet 5 mg</i>	2
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	2
<i>bumetanide injection solution 0.25 mg/ml</i>	3
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	3
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2
<i>furosemide injection solution 10 mg/ml</i>	3
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	2
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1
<i>methazolamide oral tablet 25 mg, 50 mg</i>	4
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	3
<i>spironolactone-hctz oral tablet 25-25 mg</i>	2
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	2
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1
MISCELLANEOUS	
ADRENALIN INJECTION SOLUTION 1 MG/ML	4

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	4	
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	6	GC
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	2	
CORLANOR ORAL SOLUTION 5 MG/5ML	4	
CORLANOR ORAL TABLET 5 MG, 7.5 MG	4	
<i>digoxin injection solution 0.25 mg/ml</i>	4	
<i>digoxin oral solution 0.05 mg/ml</i>	4	
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	2	QL (30 EA per 30 days)
<i>droxidopa oral capsule 100 mg</i>	5^	PA; QL (90 EA per 30 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	5^	PA; QL (180 EA per 30 days)
<i>epinephrine (anaphylaxis) injection solution 1 mg/ml</i>	4	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	3	PA; PA if 70 years and older
<i>hydralazine hcl injection solution 20 mg/ml</i>	4	
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	2	
<i>metirosine oral capsule 250 mg</i>	5^	PA
<i>midodrine hcl oral tablet 10 mg</i>	4	
<i>midodrine hcl oral tablet 2.5 mg, 5 mg</i>	3	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	2	
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	4	
NITRATES		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	3	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	2	
NITRO-BID TRANSDERMAL OINTMENT 2 %	3	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	3	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	3	
PULMONARY ARTERIAL HYPERTENSION		
ADCIRCA ORAL TABLET 20 MG	5^	PA-NS; QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5^	PA-NS; LA; QL (90 EA per 30 days)
<i>alyq oral tablet 20 mg</i>	5^	PA-NS; QL (60 EA per 30 days)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	5^	PA-NS; LA; QL (60 EA per 30 days)
OPSUMIT ORAL TABLET 10 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	3	PA-NS; generic for Revatio; QL (360 EA per 30 days)
<i>tadalafil (pah) oral tablet 20 mg</i>	5^	PA-NS; generic for Adcirca; QL (60 EA per 30 days)
TADLIQ ORAL SUSPENSION 20 MG/5ML	5^	PA-NS; QL (300 ML per 30 days)
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	5^	PA-NS; LA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	5^	PA-NS; LA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	QL (150 EA per 30 days)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 5 mg</i>	2	
<i>buspirone hcl oral tablet 30 mg, 7.5 mg</i>	3	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	3	
<i>lorazepam injection solution 2 mg/ml, 4 mg/ml</i>	2	
<i>lorazepam intensol oral concentrate 2 mg/ml</i>	3	QL (150 ML per 30 days)
<i>lorazepam oral concentrate 2 mg/ml</i>	3	QL (150 ML per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	2	QL (150 EA per 30 days)
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG	5^	QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	5^	QL (60 EA per 30 days)
BRIVIACT INTRAVENOUS SOLUTION 50 MG/5ML	4	PA-NS
BRIVIACT ORAL SOLUTION 10 MG/ML	5^	PA-NS; QL (600 ML per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	5^	PA-NS; QL (60 EA per 30 days)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	4	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	4	
<i>carbamazepine oral suspension 100 mg/5ml</i>	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>carbamazepine oral tablet 200 mg</i>	3	
<i>carbamazepine oral tablet chewable 100 mg</i>	3	
CELONTIN ORAL CAPSULE 300 MG	4	
<i>clobazam oral suspension 2.5 mg/ml</i>	4	PA-NS; QL (480 ML per 30 days)
<i>clobazam oral tablet 10 mg, 20 mg</i>	4	PA-NS; QL (60 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	3	QL (90 EA per 30 days)
<i>clonazepam oral tablet dispersible 2 mg</i>	3	QL (300 EA per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	4	PA-NS; PA if 65 years and older; QL (180 EA per 30 days)
DIACOMIT ORAL CAPSULE 250 MG	5^	PA-NS; LA; QL (360 EA per 30 days)
DIACOMIT ORAL CAPSULE 500 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
DIACOMIT ORAL PACKET 250 MG	5^	PA-NS; LA; QL (360 EA per 30 days)
DIACOMIT ORAL PACKET 500 MG	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>diazepam injection solution 5 mg/ml</i>	4	
<i>diazepam intensol oral concentrate 5 mg/ml</i>	3	PA-NS; PA if 65 years and older; QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5ml</i>	3	PA-NS; PA if 65 years and older; QL (1200 ML per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	2	PA-NS; PA if 65 years and older; QL (120 EA per 30 days)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	4	
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG	4	
DILANTIN ORAL CAPSULE 100 MG, 30 MG	4	
DILANTIN ORAL SUSPENSION 125 MG/5ML	4	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	3	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	4	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	3	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	5^	PA-NS; LA; QL (600 ML per 30 days)
<i>epitol oral tablet 200 mg</i>	3	
EPRONTIA ORAL SOLUTION 25 MG/ML	4	PA-NS; QL (480 ML per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>ethosuximide oral capsule 250 mg</i>	4	
<i>ethosuximide oral solution 250 mg/5ml</i>	3	
<i>felbamate oral suspension 600 mg/5ml</i>	5^	
<i>felbamate oral tablet 400 mg, 600 mg</i>	4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML	5^	PA-NS; LA; QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	5^	PA-NS; QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5^	PA-NS; QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	PA-NS; QL (60 EA per 30 days)
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	2	QL (180 EA per 30 days)
<i>gabapentin oral solution 250 mg/5ml, 300 mg/6ml</i>	3	QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	2	QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)
<i>lacosamide intravenous solution 200 mg/20ml</i>	5^	
<i>lacosamide oral solution 10 mg/ml</i>	4	QL (1200 ML per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	4	QL (60 EA per 30 days)
<i>lacosamide oral tablet 50 mg</i>	4	QL (120 EA per 30 days)
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	4	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	3	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	4	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	3	
<i>levetiracetam in nacl intravenous solution 1000 mg/100ml, 1500 mg/100ml, 500 mg/100ml</i>	4	
<i>levetiracetam intravenous solution 500 mg/5ml</i>	4	
<i>levetiracetam oral solution 100 mg/ml</i>	3	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	3	
<i>methsuximide oral capsule 300 mg</i>	4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	4	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	3	
<i>phenobarbital oral elixir 20 mg/5ml</i>	4	PA-NS; PA if 70 years and older

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	3	PA-NS; PA if 70 years and older
<i>phenobarbital sodium injection solution 130 mg/ml, 65 mg/ml</i>	4	PA-NS; PA if 70 years and older
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	2	
<i>phenytoin oral suspension 125 mg/5ml</i>	3	
<i>phenytoin oral tablet chewable 50 mg</i>	3	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	3	
<i>phenytoin sodium injection solution 50 mg/ml</i>	3	
<i>pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	3	QL (120 EA per 30 days)
<i>pregabalin oral capsule 200 mg</i>	3	QL (90 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	3	QL (60 EA per 30 days)
<i>pregabalin oral solution 20 mg/ml</i>	4	QL (900 ML per 30 days)
<i>primidone oral tablet 125 mg, 250 mg, 50 mg</i>	2	
<i>roweepra oral tablet 500 mg</i>	3	
<i>rufinamide oral suspension 40 mg/ml</i>	5^	PA-NS; QL (2400 ML per 30 days)
<i>rufinamide oral tablet 200 mg</i>	4	PA-NS; QL (480 EA per 30 days)
<i>rufinamide oral tablet 400 mg</i>	5^	PA-NS; QL (240 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG	4	QL (90 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG	4	QL (360 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 500 MG	4	QL (180 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG	4	QL (120 EA per 30 days)
<i>subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG	5^	PA-NS; QL (60 EA per 30 days)
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	4	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	3	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>valproate sodium intravenous solution 100 mg/ml</i>	4	
<i>valproic acid oral capsule 250 mg</i>	3	
<i>valproic acid oral solution 250 mg/5ml</i>	3	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	4	
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	4	
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	4	
<i>vigabatrin oral packet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigabatrin oral tablet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigadrone oral packet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
<i>vigadrone oral tablet 500 mg</i>	5^	PA-NS; LA; QL (180 EA per 30 days)
VIMPAT ORAL SOLUTION 10 MG/ML	5^	QL (1200 ML per 30 days)
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	5^	QL (56 EA per 28 days)
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	5^	QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG, 50 MG	5^	QL (30 EA per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	5^	QL (60 EA per 30 days)
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG	4	QL (28 EA per 28 days)
XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG	5^	QL (28 EA per 28 days)
ZONISADE ORAL SUSPENSION 100 MG/5ML	4	PA-NS; QL (900 ML per 30 days)
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	2	
ZTALMY ORAL SUSPENSION 50 MG/ML	5^	PA-NS; LA; QL (1100 ML per 30 days)
ANTIDEMENTIA		
<i>donepezil hcl oral tablet 10 mg</i>	1	
<i>donepezil hcl oral tablet 5 mg</i>	1	QL (30 EA per 30 days)
<i>donepezil hcl oral tablet dispersible 10 mg</i>	2	
<i>donepezil hcl oral tablet dispersible 5 mg</i>	2	QL (30 EA per 30 days)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	3	QL (30 EA per 30 days)
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	4	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	3	QL (60 EA per 30 days)
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	4	PA; PA if < 30 yrs
<i>memantine hcl oral solution 2 mg/ml</i>	4	PA; PA if < 30 yrs
<i>memantine hcl oral tablet 10 mg, 5 mg</i>	3	PA; PA if < 30 yrs
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	4	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	3	QL (60 EA per 30 days)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	4	QL (30 EA per 30 days)
ANTIDEPRESSANTS		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	3	
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	4	PA-NS; QL (60 EA per 30 days)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	3	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	2	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	3	
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	3	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	4	PA-NS
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	4	
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	4	PA-NS; QL (30 EA per 30 days)
<i>doxepin hcl oral capsule 10 mg, 100 mg, 25 mg, 50 mg, 75 mg</i>	3	
<i>doxepin hcl oral capsule 150 mg</i>	4	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	3	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	4	PA-NS; QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	2	QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	4	QL (60 EA per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5^	PA-NS; QL (30 EA per 30 days)
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	4	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	1	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG	4	PA-NS; QL (30 EA per 30 days)
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 40 MG	4	PA-NS; QL (60 EA per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	4	PA-NS
<i>fluoxetine hcl oral capsule 10 mg, 20 mg</i>	1	
<i>fluoxetine hcl oral capsule 40 mg</i>	2	
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	3	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	2	
MARPLAN ORAL TABLET 10 MG	4	QL (180 EA per 30 days)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	2	
<i>mirtazapine oral tablet 7.5 mg</i>	3	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	3	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	4	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	2	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	4	
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	4	QL (60 EA per 30 days)
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	4	QL (900 ML per 30 days)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	2	
<i>phenelzine sulfate oral tablet 15 mg</i>	3	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	4	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	3	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	4	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>trimipramine maleate oral capsule 100 mg</i>	4	QL (60 EA per 30 days)
<i>trimipramine maleate oral capsule 25 mg, 50 mg</i>	4	QL (120 EA per 30 days)
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	QL (30 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	2	
<i>venlafaxine hcl oral tablet 100 mg</i>	3	
<i>venlafaxine hcl oral tablet 25 mg, 37.5 mg, 50 mg, 75 mg</i>	2	
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG	4	QL (30 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
VIIBRYD STARTER PACK ORAL KIT 10 & 20 MG	4	
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	4	QL (30 EA per 30 days)
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl oral capsule 100 mg</i>	3	QL (120 EA per 30 days)
<i>amantadine hcl oral solution 50 mg/5ml</i>	3	
<i>amantadine hcl oral tablet 100 mg</i>	4	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML	5^	PA; LA; QL (60 ML per 30 days)
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	5^	PA; QL (60 ML per 30 days)
<i>benztropine mesylate injection solution 1 mg/ml</i>	4	
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	4	PA; PA if 70 years and older
<i>bromocriptine mesylate oral capsule 5 mg</i>	4	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	4	
<i>carbidopa oral tablet 25 mg</i>	4	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	2	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	2	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	4	
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	4	
<i>entacapone oral tablet 200 mg</i>	4	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR	4	
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	4	
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	4	QL (30 EA per 30 days)
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	4	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	2	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>selegiline hcl oral capsule 5 mg</i>	3	
<i>selegiline hcl oral tablet 5 mg</i>	3	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	3	PA; PA if 70 years and older
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	3	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	5^	QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	5^	QL (1 EA per 28 days)
<i>aripiprazole oral solution 1 mg/ml</i>	4	QL (900 ML per 30 days)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	4	QL (30 EA per 30 days)
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	5^	QL (60 EA per 30 days)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	5^	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	5^	QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	5^	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	5^	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	5^	QL (3.2 ML per 28 days)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	4	QL (60 EA per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	4	QL (30 EA per 30 days)
<i>chlorpromazine hcl injection solution 25 mg/ml, 50 mg/2ml</i>	4	
CHLORPROMAZINE HCL ORAL CONCENTRATE 100 MG/ML, 30 MG/ML	4	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	4	
<i>clozapine oral tablet 100 mg</i>	4	QL (270 EA per 30 days)
<i>clozapine oral tablet 200 mg</i>	4	QL (120 EA per 30 days)
<i>clozapine oral tablet 25 mg, 50 mg</i>	3	
<i>clozapine oral tablet dispersible 100 mg</i>	4	PA-NS; QL (270 EA per 30 days)
<i>clozapine oral tablet dispersible 12.5 mg, 25 mg</i>	4	PA-NS
<i>clozapine oral tablet dispersible 150 mg</i>	4	PA-NS; QL (180 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>clozapine oral tablet dispersible 200 mg</i>	5^	PA-NS; QL (120 EA per 30 days)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	4	PA-NS; QL (60 EA per 30 days)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	4	PA-NS
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	4	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	4	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	4	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	4	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	4	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml(1ml)</i>	4	
<i>haloperidol lactate injection solution 5 mg/ml</i>	3	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	3	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	3	
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML	5^	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML	5^	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	5^	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5^	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	5^	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	5^	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML	5^	QL (0.88 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML	5^	QL (1.32 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	5^	QL (1.75 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML	5^	QL (2.63 ML per 90 days)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	4	QL (30 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
LATUDA ORAL TABLET 80 MG	4	QL (60 EA per 30 days)
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	3	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	QL (30 EA per 30 days)
<i>lurasidone hcl oral tablet 80 mg</i>	4	QL (60 EA per 30 days)
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	4	
NUPLAZID ORAL CAPSULE 34 MG	4	PA-NS; LA; QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	4	PA-NS; LA; QL (30 EA per 30 days)
<i>olanzapine intramuscular solution reconstituted 10 mg</i>	4	QL (3 EA per 1 day)
<i>olanzapine oral tablet 10 mg, 2.5 mg, 5 mg</i>	3	QL (60 EA per 30 days)
<i>olanzapine oral tablet 15 mg, 20 mg, 7.5 mg</i>	3	QL (30 EA per 30 days)
<i>olanzapine oral tablet dispersible 10 mg</i>	4	QL (60 EA per 30 days)
<i>olanzapine oral tablet dispersible 15 mg, 20 mg, 5 mg</i>	4	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	4	QL (30 EA per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	4	QL (60 EA per 30 days)
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	4	
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	5^	QL (1 EA per 30 days)
<i>pimozide oral tablet 1 mg, 2 mg</i>	4	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	4	PA-NS; QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	4	PA-NS; QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 150 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	3	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG	4	QL (60 EA per 30 days)
REXULTI ORAL TABLET 3 MG, 4 MG	4	QL (30 EA per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG	4	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 37.5 MG, 50 MG	5^	QL (2 EA per 28 days)
<i>risperidone oral solution 1 mg/ml</i>	3	QL (240 ML per 30 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	2	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg</i>	4	QL (90 EA per 30 days)
<i>risperidone oral tablet dispersible 1 mg, 2 mg, 3 mg</i>	4	QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>risperidone oral tablet dispersible 4 mg</i>	4	QL (120 EA per 30 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	4	QL (30 EA per 30 days)
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	3	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	4	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	3	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	4	PA-NS; QL (600 ML per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG	4	QL (60 EA per 30 days)
VRAYLAR ORAL CAPSULE 3 MG, 4.5 MG, 6 MG	4	QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	4	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	4	QL (60 EA per 30 days)
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	4	QL (6 EA per 3 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	4	PA-NS; QL (2 EA per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 300 MG	5^	PA-NS; QL (2 EA per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG	5^	PA-NS; QL (1 EA per 28 days)
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	4	PA; QL (30 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	3	PA; QL (60 EA per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 20 mg</i>	3	PA; QL (90 EA per 30 days)
<i>atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg</i>	4	QL (120 EA per 30 days)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	4	QL (30 EA per 30 days)
<i>atomoxetine hcl oral capsule 40 mg</i>	4	QL (60 EA per 30 days)
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	3	PA; QL (60 EA per 30 days)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (120 EA per 30 days)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 4 mg</i>	3	PA; PA if 70 years and older; QL (30 EA per 30 days)
<i>guanfacine hcl er oral tablet extended release 24 hour 3 mg</i>	3	PA; PA if 70 years and older; QL (60 EA per 30 days)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	4	PA; QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	4	PA; QL (30 EA per 30 days)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	4	PA; QL (60 EA per 30 days)
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	4	PA; QL (30 EA per 30 days)
<i>metadate er oral tablet extended release 20 mg</i>	4	PA; QL (90 EA per 30 days)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	4	PA; QL (90 EA per 30 days)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	4	PA; QL (900 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	4	PA; QL (1800 ML per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	3	PA; QL (180 EA per 30 days)
<i>methylphenidate hcl oral tablet 20 mg</i>	3	PA; QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	4	PA; QL (180 EA per 30 days)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG	4	PA; QL (60 EA per 30 days)
VYVANSE ORAL CAPSULE 40 MG, 50 MG, 60 MG, 70 MG	4	PA; QL (30 EA per 30 days)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG	4	PA; QL (60 EA per 30 days)
VYVANSE ORAL TABLET CHEWABLE 40 MG, 50 MG, 60 MG	4	PA; QL (30 EA per 30 days)
HYPNOTICS		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	QL (30 EA per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG	4	QL (30 EA per 30 days)
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	3	QL (30 EA per 30 days)
<i>tasimelteon oral capsule 20 mg</i>	5^	PA; QL (30 EA per 30 days)
<i>temazepam oral capsule 15 mg</i>	4	PA; PA if 65 years and older; QL (60 EA per 30 days)
<i>temazepam oral capsule 30 mg, 7.5 mg</i>	4	PA; PA if 65 years and older; QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	2	PA; PA applies if 70 years and older after a 90 day supply in a calendar year; QL (30 EA per 30 days)
MIGRAINE		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA; QL (1 ML per 30 days)
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	5^	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	5^	PA; QL (8 ML per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5^	PA; QL (3 ML per 30 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	3	PA; QL (2 ML per 30 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	3	PA; QL (2 ML per 30 days)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	PA; QL (40 EA per 28 days)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	3	QL (12 EA per 30 days)
NURTEC ORAL TABLET DISPERSIBLE 75 MG	5^	PA; QL (16 EA per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	3	QL (18 EA per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	3	QL (18 EA per 30 days)
<i>sumatriptan nasal solution 20 mg/act</i>	4	QL (12 EA per 30 days)
<i>sumatriptan nasal solution 5 mg/act</i>	4	QL (24 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	2	QL (12 EA per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml</i>	4	QL (9 ML per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml</i>	4	QL (6 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	4	QL (6 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	4	QL (9 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	4	QL (6 ML per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	4	QL (12 EA per 30 days)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	4	QL (12 EA per 30 days)
MISCELLANEOUS		
AUSTEDO ORAL TABLET 12 MG, 9 MG	5^	PA; LA; QL (120 EA per 30 days)
AUSTEDO ORAL TABLET 6 MG	5^	PA; LA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG	5^	PA; QL (120 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 24 MG	5^	PA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 6 MG	5^	PA; QL (90 EA per 30 days)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG	5^	PA; QL (84 EA per 365 days)
GRALISE ORAL TABLET 300 MG	4	PA; QL (180 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
GRALISE ORAL TABLET 450 MG	4	PA; QL (120 EA per 30 days)
GRALISE ORAL TABLET 600 MG	4	PA; QL (90 EA per 30 days)
GRALISE ORAL TABLET 750 MG, 900 MG	4	PA; QL (60 EA per 30 days)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG	5^	PA; LA; QL (30 EA per 30 days)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG	5^	PA; LA; QL (28 EA per 28 days)
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	2	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	
<i>lithium carbonate oral tablet 300 mg</i>	2	
LITHIUM ORAL SOLUTION 8 MEQ/5ML	4	
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 82.5 MG	3	PA; QL (90 EA per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 330 MG	3	PA; QL (60 EA per 30 days)
NUDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (60 EA per 30 days)
<i>pyridostigmine bromide oral tablet 60 mg</i>	3	
<i>riluzole oral tablet 50 mg</i>	4	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	4	PA; QL (60 EA per 30 days)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	4	PA
<i>tetrabenazine oral tablet 12.5 mg</i>	5^	PA; QL (90 EA per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	5^	PA; QL (120 EA per 30 days)
MULTIPLE SCLEROSIS AGENTS		
AUBAGIO ORAL TABLET 14 MG, 7 MG	5^	PA-NS; LA; QL (30 EA per 30 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG	5^	PA-NS; QL (14 EA per 28 days)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	3	PA
<i>fingolimod hcl oral capsule 0.5 mg</i>	5^	PA-NS; QL (28 EA per 28 days)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	5^	PA-NS; QL (30 ML per 30 days)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	5^	PA-NS; QL (12 ML per 28 days)
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	5^	PA-NS; QL (30 ML per 30 days)
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	5^	PA-NS; QL (12 ML per 28 days)
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML	5^	PA-NS; LA
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG	5^	PA-NS; LA; QL (14 EA per 7 days)
TECFIDERA ORAL CAPSULE DELAYED RELEASE 240 MG	5^	PA-NS; LA; QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG	5^	PA-NS; LA
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG	5^	PA-NS; LA; QL (120 EA per 30 days)
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	3	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	2	PA; PA if 70 years and older
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	4	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	2	
NARCOLEPSY/CATAPLEXY		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	3	PA; QL (30 EA per 30 days)
<i>armodafinil oral tablet 50 mg</i>	3	PA; QL (60 EA per 30 days)
<i>modafinil oral tablet 100 mg</i>	4	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 200 mg</i>	4	PA; QL (60 EA per 30 days)
SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	5^	PA; LA; QL (540 ML per 30 days)
XYREM ORAL SOLUTION 500 MG/ML	5^	PA; LA; QL (540 ML per 30 days)
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	4	
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	3	PA; QL (90 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	4	QL (60 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	4	QL (90 EA per 30 days)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	3	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	3	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	2	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	2	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	2	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	3	
<i>naltrexone hcl oral tablet 50 mg</i>	3	
NICOTROL INHALATION INHALER 10 MG	4	
NICOTROL NS NASAL SOLUTION 10 MG/ML	4	
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	4	QL (56 EA per 28 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5^	
ENDOCRINE AND METABOLIC		
ANDROGENS		
<i>depo-testosterone intramuscular solution 100 mg/ml, 200 mg/ml</i>	3	
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	3	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	3	
<i>testosterone transdermal gel 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)</i>	4	PA; QL (300 GM per 30 days)
ANTIDIABETICS, INSULINS		
ALCOHOL SWABS PAD 70 %	3	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP INJECTION SOLUTION 100 UNIT/ML	3	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
FIASP PUMPCART SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	B/D
GAUZE PADS 2" X 2" PAD 2"X2"	3	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	5^	B/D
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	5^	
INSULIN PEN NEEDLE 29G X 12MM	2	
INSULIN SYRINGE (DISP) U-100 0.3 ML 29G 0.3 ML	2	
INSULIN SYRINGE (DISP) U-100 1 ML 29G X 1/2" 1 ML	2	
INSULIN SYRINGE (DISP) U-100 1/2 ML 28G X 1/2" 0.5 ML	2	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
NEEDLES, INSULIN DISP., SAFETY 29G X 1/2" 1 ML	2	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	3	(brand RELION not covered)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	(brand RELION not covered)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	(brand RELION not covered)
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	3	(brand RELION not covered)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	(brand RELION not covered)
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	(brand RELION not covered)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	(brand RELION not covered)
OMNIPOD 5 G6 INTRO (GEN 5) KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD 5 G6 POD (GEN 5)	4	PA; QL (15 EA per 30 days)
OMNIPOD CLASSIC PDM (GEN 3) KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD CLASSIC PODS (GEN 3)	4	PA; QL (15 EA per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	4	PA; QL (15 EA per 30 days)
OMNIPOD GO KIT 10 UNIT/24HR, 15 UNIT/24HR, 20 UNIT/24HR, 25 UNIT/24HR, 30 UNIT/24HR, 35 UNIT/24HR, 40 UNIT/24HR	4	PA; QL (15 EA per 30 days)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	QL (15 ML per 25 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
V-GO 20 KIT 20 UNIT/24HR	4	PA; QL (30 EA per 30 days)
V-GO 30 KIT 30 UNIT/24HR	4	PA; QL (30 EA per 30 days)
V-GO 40 KIT 40 UNIT/24HR	4	PA; QL (30 EA per 30 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML	3	QL (15 ML per 30 days)
ANTIDIABETICS		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	6	GC
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML	3	PA-NS; QL (3.4 ML per 28 days)
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	4	PA-NS; QL (2.4 ML per 30 days)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	4	PA-NS; QL (1.2 ML per 30 days)
FARXIGA ORAL TABLET 10 MG, 5 MG	3	QL (30 EA per 30 days)
<i>glimepiride oral tablet 1 mg, 2 mg</i>	6	GC; QL (90 EA per 30 days)
<i>glimepiride oral tablet 4 mg</i>	6	GC; QL (60 EA per 30 days)
<i>glipizide er oral tablet extended release 24 hour 10 mg</i>	6	GC; QL (60 EA per 30 days)
<i>glipizide er oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	6	GC; QL (90 EA per 30 days)
<i>glipizide oral tablet 10 mg</i>	6	GC; QL (120 EA per 30 days)
<i>glipizide oral tablet 5 mg</i>	6	GC; QL (240 EA per 30 days)
<i>glipizide xl oral tablet extended release 24 hour 10 mg</i>	6	GC; QL (60 EA per 30 days)
<i>glipizide xl oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	6	GC; QL (90 EA per 30 days)
<i>glipizide-metformin hcl oral tablet 2.5-250 mg</i>	6	GC; QL (240 EA per 30 days)
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg</i>	6	GC; QL (120 EA per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 EA per 30 days)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG	4	QL (60 EA per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	4	QL (120 EA per 30 days)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG	4	QL (60 EA per 30 days)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-500 MG	4	QL (120 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
INVOKANA ORAL TABLET 100 MG	4	QL (60 EA per 30 days)
INVOKANA ORAL TABLET 300 MG	4	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG	3	QL (60 EA per 30 days)
JARDIANCE ORAL TABLET 25 MG	3	QL (30 EA per 30 days)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	3	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	3	QL (30 EA per 30 days)
<i>metformin hcl er oral tablet extended release 24 hour 500 mg</i>	6	GC; (generic of GLUCOPHAGE XR); QL (120 EA per 30 days)
<i>metformin hcl er oral tablet extended release 24 hour 750 mg</i>	6	GC; (generic of GLUCOPHAGE XR); QL (60 EA per 30 days)
<i>metformin hcl oral tablet 1000 mg</i>	6	GC; QL (75 EA per 30 days)
<i>metformin hcl oral tablet 500 mg</i>	6	GC; QL (150 EA per 30 days)
<i>metformin hcl oral tablet 850 mg</i>	6	GC; QL (90 EA per 30 days)
<i>nateglinide oral tablet 120 mg, 60 mg</i>	6	GC; QL (90 EA per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	3	PA-NS; QL (1.5 ML per 28 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML	3	PA-NS; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML	3	PA-NS; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML	3	PA-NS; QL (3 ML per 28 days)
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	6	GC; QL (30 EA per 30 days)
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	6	GC; QL (30 EA per 30 days)
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	6	GC; QL (90 EA per 30 days)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	6	GC; QL (120 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>repaglinide oral tablet 2 mg</i>	6	GC; QL (240 EA per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	PA-NS; QL (30 EA per 30 days)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG	3	QL (60 EA per 30 days)
SYNJARDY ORAL TABLET 5-500 MG	3	QL (120 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG	3	QL (30 EA per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG	3	QL (30 EA per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG	3	QL (60 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	PA-NS; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	3	PA-NS; QL (9 ML per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG	3	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG, 5-500 MG	3	QL (60 EA per 30 days)
CALCIUM REGULATORS		
<i>alendronate sodium oral solution 70 mg/75ml</i>	4	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	3	B/D
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 600 MCG/2.4ML	5^	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT	4	ST
<i>ibandronate sodium intravenous solution 3 mg/3ml</i>	4	B/D; QL (3 ML per 90 days)
<i>ibandronate sodium oral tablet 150 mg</i>	1	B/D
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	5^	PA; LA
<i>pamidronate disodium intravenous solution 30 mg/10ml, 90 mg/10ml</i>	3	B/D
PAMIDRONATE DISODIUM INTRAVENOUS SOLUTION 6 MG/ML	3	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	4	QL (1 ML per 180 days)
<i>risedronate sodium oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	3	
<i>risedronate sodium oral tablet 30 mg</i>	4	
<i>risedronate sodium oral tablet delayed release 35 mg</i>	4	
TERIPARATIDE (RECOMBINANT) SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML	5^	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5^	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5^	PA
<i>zoledronic acid intravenous concentrate 4 mg/5ml</i>	4	B/D
<i>zoledronic acid intravenous solution 4 mg/100ml, 5 mg/100ml</i>	4	B/D
CHELATING AGENTS		
CHEMET ORAL CAPSULE 100 MG	4	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	5^	PA
<i>deferasirox oral tablet 180 mg, 360 mg</i>	5^	PA
<i>deferasirox oral tablet 90 mg</i>	4	PA
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	5^	PA
LOKELMA ORAL PACKET 10 GM, 5 GM	3	
<i>penicillamine oral tablet 250 mg</i>	5^	
<i>sodium polystyrene sulfonate oral powder</i>	3	
<i>sps oral suspension 15 gm/60ml</i>	3	
<i>trientine hcl oral capsule 250 mg</i>	5^	PA
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM	3	
CONTRACEPTIVES		
<i>afirmelle oral tablet 0.1-20 mg-mcg</i>	2	
<i>altavera oral tablet 0.15-30 mg-mcg</i>	3	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	3	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	3	
<i>apri oral tablet 0.15-30 mg-mcg</i>	2	
<i>aranelle oral tablet 0.5/1/0.5-35 mg-mcg</i>	3	
<i>aubra eq oral tablet 0.1-20 mg-mcg</i>	2	
<i>aurovela 1/20 oral tablet 1-20 mg-mcg</i>	3	

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>aurovela fe 1/20 oral tablet 1-20 mg-mcg</i>	2
<i>aviane oral tablet 0.1-20 mg-mcg</i>	2
<i>ayuna oral tablet 0.15-30 mg-mcg</i>	3
<i>azurette oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>balziva oral tablet 0.4-35 mg-mcg</i>	3
<i>blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	3
<i>camila oral tablet 0.35 mg</i>	2
<i>chateal oral tablet 0.15-30 mg-mcg</i>	3
<i>cryselle-28 oral tablet 0.3-30 mg-mcg</i>	3
<i>cyred eq oral tablet 0.15-30 mg-mcg</i>	2
<i>dasetta 1/35 oral tablet 1-35 mg-mcg</i>	3
<i>dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	3
<i>deblitane oral tablet 0.35 mg</i>	2
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg</i>	2
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	3
<i>elinest oral tablet 0.3-30 mg-mcg</i>	3
<i>eluryng vaginal ring 0.12-0.015 mg/24hr</i>	4
<i>emoquette oral tablet 0.15-30 mg-mcg</i>	2
<i>enilloring vaginal ring 0.12-0.015 mg/24hr</i>	4
<i>enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg</i>	2
<i>enskyce oral tablet 0.15-30 mg-mcg</i>	2
<i>errin oral tablet 0.35 mg</i>	2
<i>estarylla oral tablet 0.25-35 mg-mcg</i>	2
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg</i>	2
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	3
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	4
<i>falmina oral tablet 0.1-20 mg-mcg</i>	2
<i>femynor oral tablet 0.25-35 mg-mcg</i>	2
<i>hailey 1.5/30 oral tablet 1.5-30 mg-mcg</i>	3

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>haloette vaginal ring 0.12-0.015 mg/24hr</i>	4
<i>heather oral tablet 0.35 mg</i>	2
<i>iclevia oral tablet 0.15-0.03 mg</i>	3
<i>incassia oral tablet 0.35 mg</i>	2
<i>introvale oral tablet 0.15-0.03 mg</i>	3
<i>isibloom oral tablet 0.15-30 mg-mcg</i>	2
<i>jasmiel oral tablet 3-0.02 mg</i>	3
<i>jolessa oral tablet 0.15-0.03 mg</i>	3
<i>juleber oral tablet 0.15-30 mg-mcg</i>	2
<i>junel 1.5/30 oral tablet 1.5-30 mg-mcg</i>	3
<i>junel 1/20 oral tablet 1-20 mg-mcg</i>	3
<i>junel fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>junel fe 1/20 oral tablet 1-20 mg-mcg</i>	2
<i>kariva oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>kelnor 1/35 oral tablet 1-35 mg-mcg</i>	2
<i>kelnor 1/50 oral tablet 1-50 mg-mcg</i>	3
<i>kurvelo oral tablet 0.15-30 mg-mcg</i>	3
<i>larin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	3
<i>larin 1/20 oral tablet 1-20 mg-mcg</i>	3
<i>larin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>larin fe 1/20 oral tablet 1-20 mg-mcg</i>	2
<i>leena oral tablet 0.5/1/0.5-35 mg-mcg</i>	3
<i>lessina oral tablet 0.1-20 mg-mcg</i>	2
<i>levonest oral tablet 50-30/75-40/ 125-30 mcg</i>	2
<i>levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg</i>	3
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg</i>	2
<i>levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg</i>	3
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	2
<i>levora 0.15/30 (28) oral tablet 0.15-30 mg-mcg</i>	3
<i>loestrin 1.5/30 (21) oral tablet 1.5-30 mg-mcg</i>	3
<i>loestrin 1/20 (21) oral tablet 1-20 mg-mcg</i>	3
<i>loestrin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>loestrin fe 1/20 oral tablet 1-20 mg-mcg</i>	2
<i>loryna oral tablet 3-0.02 mg</i>	3

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>low-ogestrel oral tablet 0.3-30 mg-mcg</i>	3
<i>luta oral tablet 0.1-20 mg-mcg</i>	2
<i>lyleq oral tablet 0.35 mg</i>	2
<i>lyza oral tablet 0.35 mg</i>	2
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	3
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	3
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	3
<i>microgestin 1.5/30 oral tablet 1.5-30 mg-mcg</i>	3
<i>microgestin 1/20 oral tablet 1-20 mg-mcg</i>	3
<i>microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg</i>	2
<i>microgestin fe 1/20 oral tablet 1-20 mg-mcg</i>	2
<i>mili oral tablet 0.25-35 mg-mcg</i>	2
<i>mono-linyah oral tablet 0.25-35 mg-mcg</i>	2
<i>necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	3
<i>nikki oral tablet 3-0.02 mg</i>	3
<i>nora-be oral tablet 0.35 mg</i>	2
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg</i>	2
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	3
<i>norethindrone oral tablet 0.35 mg</i>	2
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	4
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	2
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>norlyroc oral tablet 0.35 mg</i>	2
<i>nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg</i>	3
<i>nortrel 1/35 (21) oral tablet 1-35 mg-mcg</i>	3
<i>nortrel 1/35 (28) oral tablet 1-35 mg-mcg</i>	3
<i>nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	3
<i>nylia 1/35 oral tablet 1-35 mg-mcg</i>	3
<i>nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	3
<i>nymyo oral tablet 0.25-35 mg-mcg</i>	2

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>ocella oral tablet 3-0.03 mg</i>	3
<i>philith oral tablet 0.4-35 mg-mcg</i>	3
<i>pimtree oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>pirmella 1/35 oral tablet 1-35 mg-mcg</i>	3
<i>portia-28 oral tablet 0.15-30 mg-mcg</i>	3
<i>reclipsen oral tablet 0.15-30 mg-mcg</i>	2
<i>setlakin oral tablet 0.15-0.03 mg</i>	3
<i>sharobel oral tablet 0.35 mg</i>	2
<i>simliya oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>sprintec 28 oral tablet 0.25-35 mg-mcg</i>	2
<i>sronyx oral tablet 0.1-20 mg-mcg</i>	2
<i>syeda oral tablet 3-0.03 mg</i>	3
<i>tarina fe 1/20 eq oral tablet 1-20 mg-mcg</i>	2
<i>tilia fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	4
<i>tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	4
<i>tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	3
<i>tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	3
<i>tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	3
<i>tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	3
<i>tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>trivora (28) oral tablet 50-30/75-40/ 125-30 mcg</i>	2
<i>tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	3
<i>tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	3
<i>velivet oral tablet 0.1/0.125/0.15 -0.025 mg</i>	3
<i>vestura oral tablet 3-0.02 mg</i>	3
<i>vienva oral tablet 0.1-20 mg-mcg</i>	2
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	3
<i>vyfemla oral tablet 0.4-35 mg-mcg</i>	3
<i>vylibra oral tablet 0.25-35 mg-mcg</i>	2
<i>wera oral tablet 0.5-35 mg-mcg</i>	3

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	4
<i>zafemy transdermal patch weekly 150-35 mcg/24hr</i>	4
<i>zovia 1/35 (28) oral tablet 1-35 mg-mcg</i>	2
<i>zumandimine oral tablet 3-0.03 mg</i>	3
ENDOMETRIOSIS	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	4
SYNAREL NASAL SOLUTION 2 MG/ML	5^
ESTROGENS	
<i>amabelz oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	3
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML	4
<i>dotti transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	3
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	3
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	3
<i>estradiol vaginal cream 0.1 mg/gm</i>	3
<i>estradiol vaginal tablet 10 mcg</i>	4
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	4
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	3
<i>fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	3
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG	3
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG	3
<i>jinteli oral tablet 1-5 mg-mcg</i>	3
<i>lyllana transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	3
<i>mimvey oral tablet 1-0.5 mg</i>	3
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	3

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>yuvaferm vaginal tablet 10 mcg</i>	4
GLUCOCORTICOIDS	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	4
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	3
<i>dexamethasone oral solution 0.5 mg/5ml</i>	3
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	3
<i>dexamethasone sod phosphate pf injection solution 10 mg/ml</i>	3
<i>dexamethasone sodium phosphate injection solution 10 mg/ml, 100 mg/10ml, 120 mg/30ml, 20 mg/5ml, 4 mg/ml</i>	3
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	2
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	3
<i>methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml</i>	3
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	3
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	2
<i>methylprednisolone sodium succ injection solution reconstituted 1000 mg, 125 mg, 40 mg</i>	3
<i>prednisolone oral solution 15 mg/5ml</i>	2
<i>prednisolone sodium phosphate oral solution 15 mg/5ml</i>	2
<i>prednisolone sodium phosphate oral solution 25 mg/5ml</i>	3
<i>prednisolone sodium phosphate oral solution 6.7 (5 base) mg/5ml</i>	4
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	4
<i>prednisone oral solution 5 mg/5ml</i>	4
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	2
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	3
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED 100 MG, 1000 MG, 250 MG, 500 MG	4
GLUCOSE ELEVATING AGENTS	
<i>diazoxide oral suspension 50 mg/ml</i>	5^
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	3

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	3	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML	3	
MISCELLANEOUS		
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5ML	5^	PA; LA
<i>betaine oral powder</i>	5^	LA
<i>cabergoline oral tablet 0.5 mg</i>	3	
<i>carglumic acid oral tablet soluble 200 mg</i>	5^	PA; LA
CERDELGA ORAL CAPSULE 84 MG	5^	PA; LA
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT	5^	PA; LA
<i>cinacalcet hcl oral tablet 30 mg</i>	4	B/D; QL (60 EA per 30 days)
<i>cinacalcet hcl oral tablet 60 mg</i>	5^	B/D; QL (60 EA per 30 days)
<i>cinacalcet hcl oral tablet 90 mg</i>	5^	B/D; QL (120 EA per 30 days)
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA; LA
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	4	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	5^	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	3	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	5^	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	4	
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG, 5 MG	5^	PA; LA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG	5^	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG	5^	PA
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5^	PA; LA
<i>javygtor oral packet 100 mg, 500 mg</i>	5^	PA; LA
<i>javygtor oral tablet 100 mg</i>	5^	PA; LA
KORLYM ORAL TABLET 300 MG	5^	PA; LA
<i>levocarnitine oral solution 1 gm/10ml</i>	4	B/D
<i>levocarnitine oral tablet 330 mg</i>	4	B/D
LUMIZYME INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	5^	PA; LA
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG	5^	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED), 30 MG	5^	PA
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG	5^	PA
<i>miglustat oral capsule 100 mg</i>	5^	PA; QL (90 EA per 30 days)
NAGLAZYME INTRAVENOUS SOLUTION 1 MG/ML	5^	PA; LA
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	5^	PA
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA
<i>octreotide acetate injection solution 1000 mcg/ml, 500 mcg/ml</i>	5^	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml</i>	4	PA
<i>octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml</i>	5^	PA
<i>raloxifene hcl oral tablet 60 mg</i>	2	
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	5^	PA
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	5^	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	5^	PA; LA
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	5^	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	5^	PA
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML	5^	PA-NS; LA
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 60 MG/0.2ML, 90 MG/0.3ML	5^	PA; LA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5^	PA; LA
PHOSPHATE BINDER AGENTS		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	3	QL (360 EA per 30 days)
<i>calcium acetate oral tablet 667 mg</i>	3	QL (360 EA per 30 days)
<i>sevelamer carbonate oral packet 0.8 gm</i>	5^	QL (540 EA per 30 days)
<i>sevelamer carbonate oral packet 2.4 gm</i>	5^	QL (180 EA per 30 days)
<i>sevelamer carbonate oral tablet 800 mg</i>	4	QL (540 EA per 30 days)
VELPHORO ORAL TABLET CHEWABLE 500 MG	4	QL (180 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
PROGESTINS		
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>megestrol acetate oral suspension 40 mg/ml</i>	3	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	4	PA
<i>norethindrone acetate oral tablet 5 mg</i>	3	
THYROID AGENTS		
<i>euthyrox oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levo-t oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	3	
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	3	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	4	
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
VITAMIN D ANALOGS		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	2	B/D
<i>calcitriol oral solution 1 mcg/ml</i>	4	B/D
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	4	B/D
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	4	B/D
RAYALDEE ORAL CAPSULE EXTENDED RELEASE 30 MCG	5^	
GASTROINTESTINAL		
ANTIEMETICS		
<i>aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg</i>	4	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>compro rectal suppository 25 mg</i>	4	
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	4	B/D; QL (60 EA per 30 days)
<i>granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml</i>	4	
<i>granisetron hcl oral tablet 1 mg</i>	4	B/D
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	2	
<i>metoclopramide hcl injection solution 5 mg/ml</i>	3	
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	3	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
<i>ondansetron hcl injection solution 4 mg/2ml, 40 mg/20ml</i>	3	
<i>ondansetron hcl injection solution prefilled syringe 4 mg/2ml</i>	3	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	4	
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	3	
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	3	
<i>prochlorperazine edisylate injection solution 10 mg/2ml</i>	4	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	2	
<i>prochlorperazine rectal suppository 25 mg</i>	4	
<i>promethazine hcl injection solution 25 mg/ml, 50 mg/ml</i>	3	PA; PA if 70 years and older
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	3	PA; PA if 70 years and older
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	3	PA; PA if 70 years and older
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	4	PA; PA if 70 years and older; QL (10 EA per 30 days)

ANTISPASMODICS

<i>dicyclomine hcl oral capsule 10 mg</i>	3	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	4	
<i>dicyclomine hcl oral tablet 20 mg</i>	3	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	3	

H2-RECEPTOR ANTAGONISTS

<i>famotidine (pf) intravenous solution 20 mg/2ml</i>	3	
<i>famotidine intravenous solution 200 mg/20ml, 40 mg/4ml</i>	3	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	4	QL (300 ML per 30 days)
<i>famotidine oral tablet 20 mg</i>	1	QL (120 EA per 30 days)
<i>famotidine oral tablet 40 mg</i>	1	QL (60 EA per 30 days)
<i>famotidine premixed intravenous solution 20-0.9 mg/50ml-%</i>	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
nizatidine oral capsule 150 mg, 300 mg	4	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium oral capsule 750 mg	3	
budesonide er oral tablet extended release 24 hour 9 mg	5^	PA; QL (30 EA per 30 days)
budesonide oral capsule delayed release particles 3 mg	4	PA; QL (90 EA per 30 days)
hydrocortisone rectal enema 100 mg/60ml	4	
mesalamine er oral capsule extended release 24 hour 0.375 gm	4	QL (120 EA per 30 days)
mesalamine oral capsule delayed release 400 mg	4	QL (180 EA per 30 days)
mesalamine oral tablet delayed release 1.2 gm, 800 mg	4	
mesalamine rectal enema 4 gm	4	
mesalamine rectal suppository 1000 mg	4	
mesalamine-cleanser rectal kit 4 gm	4	
sulfasalazine oral tablet 500 mg	2	
sulfasalazine oral tablet delayed release 500 mg	3	
LAXATIVES		
constulose oral solution 10 gm/15ml	3	
enulose oral solution 10 gm/15ml	3	
gavilyte-c oral solution reconstituted 240 gm	2	
gavilyte-g oral solution reconstituted 236 gm	2	
generlac oral solution 10 gm/15ml	3	
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM	3	
lactulose encephalopathy oral solution 10 gm/15ml	3	
lactulose oral solution 10 gm/15ml	3	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml	4	
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	2	
peg-3350/electrolytes oral solution reconstituted 236 gm	2	
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM	4	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML	4	
MISCELLANEOUS		
alosetron hcl oral tablet 0.5 mg, 1 mg	5^	PA; QL (60 EA per 30 days)
CARAFATE ORAL SUSPENSION 1 GM/10ML	4	PA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	4	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	4	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	3	
GATTEX SUBCUTANEOUS KIT 5 MG	5^	PA; LA
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	4	QL (30 EA per 30 days)
<i>loperamide hcl oral capsule 2 mg</i>	3	
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	4	QL (60 EA per 30 days)
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	3	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 EA per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 12 MG/0.6ML (0.6ML SYRINGE), 8 MG/0.4ML	5^	PA
<i>sucralfate oral suspension 1 gm/10ml</i>	4	PA
<i>sucralfate oral tablet 1 gm</i>	3	
<i>ursodiol oral capsule 300 mg</i>	3	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	4	
XERMELO ORAL TABLET 250 MG	5^	PA; LA; QL (90 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5^	PA
PANCREATIC ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	3	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT	4	
PROTON PUMP INHIBITORS		
<i>dexlansoprazole oral capsule delayed release 30 mg, 60 mg</i>	4	
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	4	ST
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	3	
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	4	ST
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	
<i>pantoprazole sodium intravenous solution reconstituted 40 mg</i>	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	3	
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	2	QL (30 EA per 30 days)
<i>dutasteride oral capsule 0.5 mg</i>	2	QL (30 EA per 30 days)
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	4	QL (30 EA per 30 days)
<i>finasteride oral tablet 5 mg</i>	1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	3	QL (30 EA per 30 days)
<i>tamsulosin hcl oral capsule 0.4 mg</i>	2	
MISCELLANEOUS		
<i>acetic acid irrigation solution 0.25 %</i>	2	
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	3	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	4	
URINARY ANTISPASMODICS		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	4	ST; QL (30 EA per 30 days)
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	4	QL (30 EA per 30 days)
GEMTESA ORAL TABLET 75 MG	4	QL (30 EA per 30 days)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	4	QL (300 ML per 28 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	4	QL (30 EA per 30 days)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg</i>	2	QL (60 EA per 30 days)
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg</i>	2	QL (30 EA per 30 days)
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	2	
<i>oxybutynin chloride oral tablet 5 mg</i>	2	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	3	QL (30 EA per 30 days)
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	4	ST; QL (30 EA per 30 days)
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	4	QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>trospium chloride er oral capsule extended release 24 hour 60 mg</i>	4	QL (30 EA per 30 days)
<i>trospium chloride oral tablet 20 mg</i>	3	QL (60 EA per 30 days)
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal cream 2 %</i>	3	
<i>metronidazole vaginal gel 0.75 %</i>	3	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	3	
<i>terconazole vaginal suppository 80 mg</i>	3	
HEMATOLOGIC		
ANTICOAGULANTS		
<i>dabigatran etexilate mesylate oral capsule 150 mg, 75 mg</i>	4	QL (60 EA per 30 days)
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (74 EA per 30 days)
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	4	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</i>	4	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	5^	
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	4	
HEPARIN (PORCINE) IN NAACL INTRAVENOUS SOLUTION 12500-0.45 UT/250ML-%, 25000-0.45 UT/250ML-%, 25000-0.45 UT/500ML-%	3	
<i>heparin sod (porcine) in d5w intravenous solution 100 unit/ml, 25000-5 ut/500ml-%, 40-5 unit/ml-%</i>	3	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	3	B/D
<i>jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
PRADAXA ORAL CAPSULE 110 MG	4	QL (120 EA per 30 days)
PRADAXA ORAL CAPSULE 150 MG, 75 MG	4	QL (60 EA per 30 days)
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	3	QL (620 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	QL (51 EA per 30 days)
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	3	PA
PROCRIT INJECTION SOLUTION 20000 UNIT/ML, 40000 UNIT/ML	5^	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5^	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5^	PA
MISCELLANEOUS		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	4	
BERINERT INTRAVENOUS KIT 500 UNIT	5^	PA; LA; QL (24 EA per 30 days)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	2	
DOPTELET ORAL TABLET 20 MG, 20 MG (10 PACK), 20 MG(15 PACK)	5^	PA; LA
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	3	
ENDARI ORAL PACKET 5 GM	5^	PA; LA
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT	5^	PA; LA; QL (30 EA per 30 days)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT	5^	PA; LA; QL (20 EA per 30 days)
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	5^	PA; QL (27 ML per 30 days)
<i>pentoxifylline er oral tablet extended release 400 mg</i>	2	
PROMACTA ORAL PACKET 12.5 MG	5^	PA; LA; QL (360 EA per 30 days)
PROMACTA ORAL PACKET 25 MG	5^	PA; LA; QL (180 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5^	PA; LA; QL (30 EA per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5^	PA; LA; QL (60 EA per 30 days)
<i>sajazir subcutaneous solution prefilled syringe 30 mg/3ml</i>	5^	PA; LA; QL (27 ML per 30 days)
<i>tranexamic acid intravenous solution 1000 mg/10ml</i>	4	
<i>tranexamic acid oral tablet 650 mg</i>	3	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	4	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	3	PA; PA if 70 years and older
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	3	
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML	5^	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML, 200 MG/1.14ML, 300 MG/2ML	5^	PA
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5^	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5^	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML	5^	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5^	PA; QL (16 EA per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5^	PA; QL (8 ML per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML	5^	PA
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5^	PA; QL (6 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5^	PA; QL (4 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML	5^	PA
HUMIRA PEN-PEDIATRIC UC START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5^	PA
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5^	PA
HUMIRA PEN-PSOR/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5^	PA
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML	5^	PA; QL (2 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML	5^	PA; QL (6 EA per 28 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5^	PA; LA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	5^	PA; QL (2.28 ML per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	5^	PA; QL (2.28 ML per 28 days)
OTEZLA ORAL TABLET 30 MG	5^	PA; QL (60 EA per 30 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	5^	PA; QL (110 EA per 365 days)
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5^	PA; LA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5^	PA; LA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG	5^	PA; QL (30 EA per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG	5^	PA; QL (168 EA per 365 days)
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	5^	PA; QL (60 ML per 365 days)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5^	PA; QL (6 ML per 365 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	5^	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	5^	PA; QL (2.4 ML per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5^	PA; QL (6 ML per 365 days)
STELARA INTRAVENOUS SOLUTION 130 MG/26ML	5^	PA; LA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5^	PA; LA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5^	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5^	PA; QL (1 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	5^	PA; LA; QL (3 ML per 28 days)
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	5^	PA; LA; QL (3 ML per 28 days)
XELJANZ ORAL SOLUTION 1 MG/ML	5^	PA; QL (480 ML per 24 days)
XELJANZ ORAL TABLET 10 MG, 5 MG	5^	PA; QL (60 EA per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG	5^	PA; QL (30 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	3	QL (30 EA per 30 days)
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	4	
XATMEP ORAL SOLUTION 2.5 MG/ML	4	
IMMUNOGLOBULINS		
BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML, 5 GM/50ML	5^	PA; LA
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 2.5 GM/50ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML	5^	PA
GAMASTAN INTRAMUSCULAR INJECTABLE	4	B/D; LA
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5^	PA
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	5^	PA
GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML	5^	PA
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML	5^	PA; LA
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5^	PA
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 2.5 GM/50ML, 20 GM/200ML, 25 GM/500ML, 30 GM/300ML, 5 GM/100ML, 5 GM/50ML	5^	PA
PANZYGA INTRAVENOUS SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5^	PA
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	5^	PA
IMMUNOMODULATORS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML	5^	PA-NS; LA

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	5^	PA; LA
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT	5^	B/D; LA
IMMUNOSUPPRESSANTS		
<i>azathioprine oral tablet 50 mg</i>	3	B/D
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG	5^	PA; LA
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5^	PA; LA; QL (8 ML per 28 days)
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5^	PA; LA; QL (8 ML per 28 days)
<i>cyclosporine intravenous solution 50 mg/ml</i>	4	B/D
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	4	B/D
<i>cyclosporine modified oral solution 100 mg/ml</i>	4	B/D
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	4	B/D
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	5^	B/D
<i>engraft oral capsule 100 mg, 25 mg</i>	4	B/D
<i>engraft oral solution 100 mg/ml</i>	4	B/D
<i>mycophenolate mofetil oral capsule 250 mg</i>	3	B/D
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	5^	B/D
<i>mycophenolate mofetil oral tablet 500 mg</i>	3	B/D
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	4	B/D
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	5^	B/D
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	B/D
REZUROCK ORAL TABLET 200 MG	5^	PA; LA
SANDIMMUNE ORAL SOLUTION 100 MG/ML	4	B/D
<i>sirolimus oral solution 1 mg/ml</i>	5^	B/D
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	4	B/D
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	4	B/D
VACCINES		
ABRYSCO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML	6	NM; IRA \$0 for age 60 and older or pregnant during 32-36 weeks

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	6	NM
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	6	NM
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML	6	NM; IRA \$0 for age 60 and older only
BCG VACCINE INJECTION SOLUTION RECONSTITUTED 50 MG	3	NM
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	NM
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF- MCG/0.5	6	NM
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	6	NM
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	6	NM
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	NM
DIPHThERIA-TETANUS TOXOIDS DT INTRAMUSCULAR SUSPENSION 25-5 LFU/0.5ML	6	B/D; NM
ENGRIX-B INJECTION SUSPENSION 20 MCG/ML	6	B/D; NM
ENGRIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML	6	B/D; NM
GARDASIL 9 INTRAMUSCULAR SUSPENSION	6	NM
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	NM
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML	6	NM
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML	6	B/D; NM
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	6	NM
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	6	B/D; NM
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	6	NM
IPOLE INJECTION INJECTABLE	6	NM
IXIARO INTRAMUSCULAR SUSPENSION	6	NM
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	NM
MENACTRA INTRAMUSCULAR SOLUTION	6	NM
MENQUADFI INTRAMUSCULAR SOLUTION	6	NM

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
MENVEO INTRAMUSCULAR SOLUTION	6	NM
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	6	NM
M-M-R II INJECTION SOLUTION RECONSTITUTED	6	NM
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	NM
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	6	NM
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	NM
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML	6	B/D; NM
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	NM
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	6	NM
QUADRACEL INTRAMUSCULAR SUSPENSION , (58 UNT/ML)	6	NM
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	6	NM
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	6	B/D; NM
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	6	B/D; NM
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML	6	B/D; NM
ROTARIX ORAL SUSPENSION	6	NM
ROTARIX ORAL SUSPENSION RECONSTITUTED	6	NM
ROTATEQ ORAL SOLUTION	6	NM
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	6	NM; A third dose may be considered in post-transplant members (PA required); QL (2 EA per 999 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML	6	B/D; NM
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)	6	B/D; NM
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML	6	NM
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	6	NM
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	6	NM
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	6	NM

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	6	NM
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	6	NM
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	6	NM
YF-VAX SUBCUTANEOUS INJECTABLE , (2.5 ML IN 1 VIAL, MULTI-DOSE)	6	NM
NUTRITIONAL/SUPPLEMENTS		
<i>ELECTROLYTES/MINERALS, INJECTABLE</i>		
DEXTROSE 5%/ELECTROLYTE #48 INTRAVENOUS SOLUTION	4	
<i>dextrose in lactated ringers intravenous solution 5 %</i>	3	
DEXTROSE-NACL INTRAVENOUS SOLUTION 10-0.2 %	3	
<i>dextrose-nacl intravenous solution 10-0.45 %, 5-0.2 %, 5-0.45 %, 5-0.9 %</i>	3	
DEXTROSE-NACL INTRAVENOUS SOLUTION 2.5-0.45 %	4	
<i>dextrose-sodium chloride intravenous solution 2.5-0.45 %, 5-0.225 %, 5-0.3 %</i>	3	
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	4	
ISOLYTE-S INTRAVENOUS SOLUTION	4	
ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION	4	
<i>kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%</i>	3	
KCL IN DEXTROSE-NACL SOLUTION 40-5-0.9 MEQ/L-%-% INTRAVENOUS	4	
<i>lactated ringers intravenous solution</i>	3	
<i>magnesium sulfate in d5w intravenous solution 1-5 gm/100ml-%</i>	3	
MAGNESIUM SULFATE IN D5W SOLUTION 1-5 GM/100ML-% INTRAVENOUS	3	
<i>magnesium sulfate injection solution 50 %, 50 % (10ml syringe)</i>	3	
<i>magnesium sulfate intravenous solution 2 gm/50ml, 20 gm/500ml, 4 gm/100ml, 4 gm/50ml, 40 gm/1000ml</i>	3	
MAGNESIUM SULFATE SOLUTION 2 GM/50ML INTRAVENOUS	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
MAGNESIUM SULFATE SOLUTION 20 GM/500ML INTRAVENOUS	3	
MAGNESIUM SULFATE SOLUTION 4 GM/100ML INTRAVENOUS	3	
MAGNESIUM SULFATE SOLUTION 4 GM/50ML INTRAVENOUS	3	
MAGNESIUM SULFATE SOLUTION 40 GM/1000ML INTRAVENOUS	3	
<i>multiple electro type 1 ph 5.5 intravenous solution</i>	4	
<i>multiple electro type 1 ph 7.4 intravenous solution</i>	4	
PLASMA-LYTE 148 INTRAVENOUS SOLUTION	4	
PLASMA-LYTE A INTRAVENOUS SOLUTION	4	
<i>potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%</i>	3	
POTASSIUM CHLORIDE IN NACL SOLUTION 20-0.45 MEQ/L-% INTRAVENOUS	4	
POTASSIUM CHLORIDE IN NACL SOLUTION 20-0.9 MEQ/L-% INTRAVENOUS	3	
POTASSIUM CHLORIDE IN NACL SOLUTION 40-0.9 MEQ/L-% INTRAVENOUS	4	
POTASSIUM CHLORIDE INTRAVENOUS SOLUTION 10 MEQ/50ML, 20 MEQ/50ML	4	
<i>potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml)</i>	3	
<i>potassium chloride solution 10 meq/100ml intravenous</i>	4	
<i>potassium chloride solution 20 meq/100ml intravenous</i>	4	
<i>potassium chloride solution 20 meq/50ml intravenous</i>	4	
<i>potassium chloride solution 40 meq/100ml intravenous</i>	4	
<i>potassium cl in dextrose 5% intravenous solution 20 meq/l</i>	3	
<i>sodium chloride injection solution 2.5 meq/ml</i>	3	
<i>sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %</i>	3	
TPN ELECTROLYTES INTRAVENOUS CONCENTRATE	4	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
<i>klor-con 10 oral tablet extended release 10 meq</i>	2	
<i>klor-con m10 oral tablet extended release 10 meq</i>	2	
<i>klor-con m15 oral tablet extended release 15 meq</i>	3	
<i>klor-con m20 oral tablet extended release 20 meq</i>	2	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>klor-con oral packet 20 meq</i>	4	
<i>klor-con oral tablet extended release 8 meq</i>	2	
M-NATAL PLUS ORAL TABLET 27-1 MG	3	
<i>potassium chloride crys er oral tablet extended release 10 meq, 20 meq</i>	2	
<i>potassium chloride crys er oral tablet extended release 15 meq</i>	3	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	3	
<i>potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq</i>	2	
<i>potassium chloride oral packet 20 meq</i>	4	
<i>potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	4	
PRENATAL VITAMIN WITH FOLIC ACID GREATER THAN 0.8 MG ORAL TABLET ORAL TABLET 27-1 MG	3	
<i>sodium fluoride chew, tab, 1.1 (0.5 f) mg/ml soln oral tablet 2.2 (1 f) mg</i>	2	
IV NUTRITION		
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	4	B/D
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	4	B/D
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	4	B/D
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	4	B/D
CLINIMIX/DEXTROSE (6/5) INTRAVENOUS SOLUTION 6 %	4	B/D
CLINIMIX/DEXTROSE (8/10) INTRAVENOUS SOLUTION 8 %	4	B/D
CLINIMIX/DEXTROSE (8/14) INTRAVENOUS SOLUTION 8 %	4	B/D
<i>clinisol sf intravenous solution 15 %</i>	4	B/D
CLINOLIPID INTRAVENOUS EMULSION 20 %	4	B/D
<i>dextrose intravenous solution 10 %, 5 %</i>	3	
<i>dextrose intravenous solution 50 %, 70 %</i>	3	B/D
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	B/D
NUTRILIPID INTRAVENOUS EMULSION 20 %	4	B/D
<i>plenamine intravenous solution 15 %</i>	4	B/D
PREMASOL INTRAVENOUS SOLUTION 10 %	5^	B/D

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
PROSOL INTRAVENOUS SOLUTION 20 %	4	B/D
TRAVASOL INTRAVENOUS SOLUTION 10 %	4	B/D
TROPHAMINE INTRAVENOUS SOLUTION 10 %	4	B/D
OPHTHALMIC		
ANTIALLERGICS		
<i>azelastine hcl ophthalmic solution 0.05 %</i>	3	
<i>cromolyn sodium ophthalmic solution 4 %</i>	2	
<i>olopatadine hcl ophthalmic solution 0.1 %</i>	3	
ZERVIAE OPHTHALMIC SOLUTION 0.24 %	4	
ANTI GLAUCOMA		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	3	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	3	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 %	3	
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	4	
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	1	
<i>brinzolamide ophthalmic suspension 1 %</i>	4	
<i>carteolol hcl ophthalmic solution 1 %</i>	2	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 %	3	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	2	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	2	
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	2	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	3	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %	4	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	4	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	4	
VYZULTA OPHTHALMIC SOLUTION 0.024 %	4	
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	3	

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12/01/2023

Drug Name	Drug Tier Requirements / Limits
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	2
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	2
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	4
<i>neo-polycin hc ophthalmic ointment 1 %</i>	3
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	2
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	3
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 %	3
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	4
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 %	3
ANTI-INFECTIVES	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	3
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	2
BESIVANCE OPHTHALMIC SUSPENSION 0.6 %	3
CILOXAN OPHTHALMIC OINTMENT 0.3 %	3
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	2
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	2
<i>gatifloxacin ophthalmic solution 0.5 %</i>	2
<i>gentak ophthalmic ointment 0.3 %</i>	3
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	2
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	3
NATACYN OPHTHALMIC SUSPENSION 5 %	4
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000</i>	3
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	3
<i>neo-polycin ophthalmic ointment 3.5-400-10000</i>	3
<i>ofloxacin ophthalmic solution 0.3 %</i>	2
<i>polycin ophthalmic ointment 500-10000 unit/gm</i>	2
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	3
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	3

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>tobramycin ophthalmic solution 0.3 %</i>	1	
<i>trifluridine ophthalmic solution 1 %</i>	4	
ZIRGAN OPHTHALMIC GEL 0.15 %	4	
ANTI-INFLAMMATORIES		
ALREX OPHTHALMIC SUSPENSION 0.2 %	3	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	4	
BROMSITE OPHTHALMIC SOLUTION 0.075 %	4	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	3	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	2	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	4	
FLAREX OPHTHALMIC SUSPENSION 0.1 %	4	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	3	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	3	
ILEVRO OPHTHALMIC SUSPENSION 0.3 %	3	
<i>ketorolac tromethamine ophthalmic solution 0.4 %</i>	3	
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	2	
LOTEMAX OPHTHALMIC OINTMENT 0.5 %	3	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	3	
PREDNISOLONE SODIUM PHOSPHATE OPHTHALMIC SOLUTION 1 %	3	
PROLENSA OPHTHALMIC SOLUTION 0.07 %	3	
MISCELLANEOUS		
<i>atropine sulfate ophthalmic solution 1 %</i>	3	
ATROPINE SULFATE SOLUTION 1 % OPHTHALMIC	3	
CYSTADROPS OPHTHALMIC SOLUTION 0.37 %	5^	PA; LA
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	5^	PA; LA
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	3	
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 %	3	
RESTASIS OPHTHALMIC EMULSION 0.05 %	3	
TYRVAYA NASAL SOLUTION 0.03 MG/ACT	4	
OTIC		
OTIC AGENTS		
<i>acetic acid otic solution 2 %</i>	3	
CIPRO HC OTIC SUSPENSION 0.2-1 %	4	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
CIPRODEX OTIC SUSPENSION 0.3-0.1 %	3	
<i>flac otic oil 0.01 %</i>	2	
<i>fluocinolone acetonide otic oil 0.01 %</i>	2	
<i>neomycin-polymyxin-hc otic solution 1 %</i>	3	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	3	
<i>ofloxacin otic solution 0.3 %</i>	4	
PHOSPHODIESTERASE TYPE 5 INHIBITORS		
PHOSPHODIESTERASE TYPE 5 INHIBITORS		
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	NT; QL (6 EA per 30 days)
<i>vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	NT; QL (6 EA per 30 days)
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT	3	QL (10.7 GM per 30 days)
BREZTRI AEROSPHERE AEROSOL 160-9-4.8 MCG/ACT INHALATION	3	Institutional Pack (5.9g inhaler containing 28 inhalations); QL (23.6 GM per 28 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	3	Retail Inhalation Canister (10.7g inhaler containing 120 inhalations); QL (10.7 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	4	QL (8 GM per 30 days)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	3	B/D
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
ANTICHOLINERGICS		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	4	QL (25.8 GM per 30 days)
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT	3	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	2	B/D
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	3	
ANTI-HISTAMINES		
<i>azelastine hcl nasal solution 0.1 %, 0.15 %</i>	3	

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>cetirizine hcl oral solution 1 mg/ml</i>	2	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	3	PA; PA if 70 years and older
<i>cyproheptadine hcl oral tablet 4 mg</i>	3	PA; PA if 70 years and older
<i>desloratadine oral tablet 5 mg</i>	3	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	3	
<i>hydroxyzine hcl intramuscular solution 25 mg/ml, 50 mg/ml</i>	4	PA; PA if 70 years and older
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	3	PA; PA if 70 years and older
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	3	PA; PA if 70 years and older
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	3	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	4	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	3	
<i>olopatadine hcl nasal solution 0.6 %</i>	4	
BETA AGONISTS		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act inhalation aerosol solution 108 (90 base) mcg/act</i>	3	(generic of Proair HFA); QL (17 GM per 30 days)
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act inhalation aerosol solution 108 (90 base) mcg/act (nda020503)</i>	3	(generic of Proventil HFA); QL (13.4 GM per 30 days)
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act inhalation aerosol solution 108 (90 base) mcg/act (nda020983)</i>	3	(generic of Ventolin HFA); QL (36 GM per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%</i>	2	B/D
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	3	B/D
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	3	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	4	
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	4	B/D
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	5^	B/D
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	4	B/D
<i>levalbuterol tartrate inhalation aerosol 45 mcg/act</i>	3	ST; QL (30 GM per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	3	QL (60 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	4	
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION	3	QL (48 GM per 30 days)
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	QL (36 GM per 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium oral packet 4 mg</i>	4	
<i>montelukast sodium oral tablet 10 mg</i>	1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	3	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	3	
MISCELLANEOUS		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	4	B/D
ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG	5^	PA; LA
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	3	B/D
<i>epinephrine injection solution 0.3 mg/0.3ml</i>	3	(generic of Adrenaclick)
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml</i>	3	(generic of Adrenaclick)
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	3	(generic of EpiPen)
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML	5^	PA; LA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML	5^	PA; LA
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 50 MG, 75 MG	5^	PA; LA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET 150 MG	5^	PA; LA; QL (60 EA per 30 days)
OFEV ORAL CAPSULE 100 MG, 150 MG	5^	PA; LA; QL (60 EA per 30 days)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG	5^	PA; LA; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5^	PA; LA; QL (112 EA per 28 days)
<i>pirfenidone oral capsule 267 mg</i>	5^	PA; QL (270 EA per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	5^	PA; QL (270 EA per 30 days)
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	5^	PA; QL (90 EA per 30 days)
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML	5^	PA; LA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5^	PA; LA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5^	PA
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	4	
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5^	PA; LA; QL (56 EA per 28 days)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG	4	
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	4	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	3	
<i>theophylline oral elixir 80 mg/15ml</i>	4	
<i>theophylline oral solution 80 mg/15ml</i>	4	
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5^	PA; LA; QL (84 EA per 28 days)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	5^	PA; LA; QL (56 EA per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML	5^	PA; LA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5^	PA; LA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5^	PA; LA
NASAL STEROIDS		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	3	QL (75 ML per 30 days)
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	2	QL (16 GM per 30 days)
<i>mometasone furoate nasal suspension 50 mcg/act</i>	4	ST; QL (34 GM per 30 days)
OMNARIS NASAL SUSPENSION 50 MCG/ACT	4	ST; QL (12.5 GM per 30 days)
XHANCE NASAL EXHALER SUSPENSION 93 MCG/ACT	4	PA; QL (32 ML per 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	QL (30 EA per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	4	B/D
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 250 MCG/ACT	3	QL (240 EA per 30 days)
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	3	QL (180 EA per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT	3	QL (24 GM per 30 days)
FLOVENT HFA INHALATION AEROSOL 44 MCG/ACT	3	QL (21.2 GM per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT	4	QL (2 EA per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 90 MCG/ACT	4	QL (3 EA per 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	3	QL (60 EA per 30 days)
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	QL (12 GM per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	3	QL (60 EA per 30 days)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT	3	QL (30.6 GM per 30 days)
TOPICAL		
DERMATOLOGY, ACNE		
<i>accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	PA
<i>amnestem oral capsule 10 mg, 20 mg, 40 mg</i>	4	PA
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	4	QL (46.6 GM per 30 days)
<i>claravis oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	PA
<i>clindamycin phosphate external gel 1 %</i>	4	QL (75 GM per 30 days)
<i>clindamycin phosphate external lotion 1 %</i>	3	QL (60 ML per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	3	QL (60 ML per 30 days)
<i>ery external pad 2 %</i>	3	QL (60 EA per 30 days)
<i>erythromycin external solution 2 %</i>	3	QL (60 ML per 30 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	PA
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	4	QL (118 ML per 30 days)
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	4	PA; QL (45 GM per 30 days)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	4	PA; QL (45 GM per 30 days)
<i>zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	PA
DERMATOLOGY, ANTIBIOTICS		
<i>gentamicin sulfate external cream 0.1 %</i>	4	QL (30 GM per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>gentamicin sulfate external ointment 0.1 %</i>	3	QL (30 GM per 30 days)
<i>mupirocin external ointment 2 %</i>	2	QL (220 GM per 30 days)
<i>silver sulfadiazine external cream 1 %</i>	2	
<i>ssd external cream 1 %</i>	2	
SULFAMYLON EXTERNAL CREAM 85 MG/GM	4	QL (453.6 GM per 30 days)
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox olamine external cream 0.77 %</i>	3	QL (90 GM per 30 days)
<i>ciclopirox olamine external suspension 0.77 %</i>	3	QL (60 ML per 30 days)
<i>clotrimazole external cream 1 %</i>	3	QL (45 GM per 30 days)
<i>clotrimazole external solution 1 %</i>	3	QL (30 ML per 30 days)
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	3	QL (45 GM per 30 days)
<i>ketoconazole external cream 2 %</i>	3	QL (60 GM per 30 days)
<i>nyamyc external powder 100000 unit/gm</i>	3	QL (60 GM per 30 days)
<i>nystatin external cream 100000 unit/gm</i>	3	QL (30 GM per 30 days)
<i>nystatin external ointment 100000 unit/gm</i>	3	QL (30 GM per 30 days)
<i>nystatin external powder 100000 unit/gm</i>	3	QL (60 GM per 30 days)
<i>nystop external powder 100000 unit/gm</i>	3	QL (60 GM per 30 days)
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	4	PA
<i>calcipotriene external ointment 0.005 %</i>	4	PA; QL (120 GM per 30 days)
<i>calcipotriene external solution 0.005 %</i>	4	PA; QL (120 ML per 30 days)
<i>calcitrene external ointment 0.005 %</i>	4	PA; QL (120 GM per 30 days)
<i>tazarotene external cream 0.1 %</i>	3	PA; QL (60 GM per 30 days)
TAZORAC EXTERNAL CREAM 0.05 %	4	PA; QL (60 GM per 30 days)
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole external shampoo 2 %</i>	2	QL (120 ML per 30 days)
<i>selenium sulfide external lotion 2.5 %</i>	2	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort external cream 1 %</i>	1	
<i>ala-cort external cream 2.5 %</i>	2	
<i>alclometasone dipropionate external cream 0.05 %</i>	3	QL (60 GM per 30 days)
<i>alclometasone dipropionate external ointment 0.05 %</i>	3	QL (60 GM per 30 days)
<i>betamethasone dipropionate aug external cream 0.05 %</i>	2	QL (120 GM per 30 days)
<i>betamethasone dipropionate aug external gel 0.05 %</i>	4	QL (120 GM per 30 days)

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12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	4	QL (120 ML per 30 days)
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	4	QL (120 GM per 30 days)
<i>betamethasone dipropionate external cream 0.05 %</i>	3	QL (120 GM per 30 days)
<i>betamethasone dipropionate external lotion 0.05 %</i>	3	QL (120 ML per 30 days)
<i>betamethasone dipropionate external ointment 0.05 %</i>	4	QL (120 GM per 30 days)
<i>betamethasone valerate external cream 0.1 %</i>	3	QL (120 GM per 30 days)
<i>betamethasone valerate external lotion 0.1 %</i>	3	QL (120 ML per 30 days)
<i>betamethasone valerate external ointment 0.1 %</i>	3	QL (120 GM per 30 days)
<i>clobetasol propionate e external cream 0.05 %</i>	3	QL (60 GM per 30 days)
<i>clobetasol propionate external cream 0.05 %</i>	3	QL (60 GM per 30 days)
<i>clobetasol propionate external gel 0.05 %</i>	4	QL (60 GM per 30 days)
<i>clobetasol propionate external ointment 0.05 %</i>	3	QL (60 GM per 30 days)
<i>clobetasol propionate external solution 0.05 %</i>	3	QL (50 ML per 30 days)
<i>desonide external cream 0.05 %</i>	3	QL (60 GM per 30 days)
<i>desonide external ointment 0.05 %</i>	4	QL (60 GM per 30 days)
ENSTILAR EXTERNAL FOAM 0.005-0.064 %	4	PA; QL (120 GM per 30 days)
<i>fluocinolone acetonide body external oil 0.01 %</i>	3	QL (118.28 ML per 30 days)
<i>fluocinolone acetonide external cream 0.01 %</i>	4	QL (60 GM per 30 days)
<i>fluocinolone acetonide external cream 0.025 %</i>	4	QL (120 GM per 30 days)
<i>fluocinolone acetonide external ointment 0.025 %</i>	3	QL (120 GM per 30 days)
<i>fluocinolone acetonide external solution 0.01 %</i>	4	QL (90 ML per 30 days)
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	3	QL (118.28 ML per 30 days)
<i>fluocinonide emulsified base external cream 0.05 %</i>	3	QL (120 GM per 30 days)
<i>fluocinonide external cream 0.05 %</i>	3	QL (120 GM per 30 days)
<i>fluocinonide external gel 0.05 %</i>	4	QL (60 GM per 30 days)
<i>fluocinonide external ointment 0.05 %</i>	4	QL (60 GM per 30 days)
<i>fluocinonide external solution 0.05 %</i>	3	QL (60 ML per 30 days)
<i>fluticasone propionate external cream 0.05 %</i>	3	
<i>fluticasone propionate external ointment 0.005 %</i>	3	
<i>halobetasol propionate external cream 0.05 %</i>	4	QL (50 GM per 30 days)
<i>halobetasol propionate external ointment 0.05 %</i>	4	QL (50 GM per 30 days)
<i>hydrocortisone external cream 1 %</i>	1	
<i>hydrocortisone external cream 2.5 %</i>	2	
<i>hydrocortisone external lotion 2.5 %</i>	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>hydrocortisone external ointment 2.5 %</i>	2	
<i>mometasone furoate external cream 0.1 %</i>	3	
<i>mometasone furoate external ointment 0.1 %</i>	3	
<i>mometasone furoate external solution 0.1 %</i>	3	
<i>triamcinolone acetonide external cream 0.025 %, 0.5 %</i>	2	
<i>triamcinolone acetonide external cream 0.1 %</i>	2	QL (454 GM per 30 days)
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	3	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	2	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo external prefilled syringe 2 %</i>	4	PA; QL (60 ML per 30 days)
<i>lidocaine external ointment 5 %</i>	4	PA; QL (50 GM per 30 days)
<i>lidocaine external patch 5 %</i>	3	PA; QL (3 EA per 1 day)
<i>lidocaine hcl external solution 4 %</i>	3	PA; QL (50 ML per 30 days)
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	3	PA; QL (30 GM per 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>ammonium lactate external cream 12 %</i>	2	
<i>ammonium lactate external lotion 12 %</i>	3	
<i>azelaic acid external gel 15 %</i>	4	QL (50 GM per 30 days)
<i>bexarotene external gel 1 %</i>	5^	PA-NS; QL (60 GM per 30 days)
<i>diclofenac sodium external gel 1 %</i>	3	QL (1000 GM per 30 days)
FINACEA EXTERNAL FOAM 15 %	4	QL (50 GM per 30 days)
<i>fluorouracil external cream 5 %</i>	4	QL (40 GM per 30 days)
<i>fluorouracil external solution 2 %, 5 %</i>	3	QL (10 ML per 30 days)
<i>hydrocortisone (perianal) external cream 1 %</i>	3	
<i>hydrocortisone (perianal) external cream 2.5 %</i>	2	
<i>imiquimod external cream 5 %</i>	3	QL (24 EA per 30 days)
<i>metronidazole external cream 0.75 %</i>	4	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	3	QL (45 GM per 30 days)
<i>metronidazole external lotion 0.75 %</i>	4	QL (59 ML per 30 days)
NORITATE EXTERNAL CREAM 1 %	5^	QL (60 GM per 30 days)
PANRETIN EXTERNAL GEL 0.1 %	5^	PA-NS; QL (60 GM per 30 days)
<i>podofilox external solution 0.5 %</i>	3	QL (7 ML per 28 days)
<i>procto-med hc external cream 2.5 %</i>	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Drug Name	Drug Tier	Requirements / Limits
<i>proctosol hc external cream 2.5 %</i>	3	
<i>proctozone-hc external cream 2.5 %</i>	3	
RECTIV RECTAL OINTMENT 0.4 %	4	QL (30 GM per 30 days)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	4	QL (100 GM per 30 days)
VALCHLOR EXTERNAL GEL 0.016 %	5^	PA-NS; LA; QL (60 GM per 30 days)
ZYCLARA PUMP EXTERNAL CREAM 2.5 %	5^	QL (7.5 GM per 28 days)
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion external lotion 0.5 %</i>	4	QL (59 ML per 30 days)
<i>permethrin external cream 5 %</i>	3	QL (60 GM per 30 days)
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX EXTERNAL GEL 0.01 %	5^	PA; QL (30 GM per 30 days)
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	4	QL (180 GM per 30 days)
<i>sodium chloride irrigation solution 0.9 %</i>	3	
<i>sterile water for irrigation irrigation solution</i>	2	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl oral capsule 30 mg</i>	4	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
<i>clotrimazole mouth/throat troche 10 mg</i>	4	QL (150 EA per 30 days)
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	2	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	3	
<i>periogard mouth/throat solution 0.12 %</i>	1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	3	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

12/01/2023

Index of Drugs

<i>abacavir sulfate</i>	8	ALREX.....	81	<i>arformoterol tartrate</i>	83
<i>abacavir sulfate-lamivudine</i>	10	<i>altavera</i>	54	<i>aripiprazole</i>	41
ABELCET.....	5	ALTOPREV.....	28	ARISTADA.....	41
ABILIFY MAINTENA.....	41	ALUNBRIG.....	20	ARISTADA INITIO.....	41
<i>abiraterone acetate</i>	18	<i>alyacen 1/35</i>	54	<i>armodafinil</i>	48
ABRYSVO.....	73	<i>alyacen 7/7/7</i>	54	ARNUITY ELLIPTA.....	85
<i>acamprosate calcium</i>	48	<i>alyq</i>	33	<i>asenapine maleate</i>	41
<i>acarbose</i>	51	<i>amabelz</i>	59	<i>aspirin-dipyridamole er</i>	69
<i>accutane</i>	86	<i>amantadine hcl</i>	40	<i>atazanavir sulfate</i>	8
<i>acebutolol hcl</i>	29	<i>ambrisentan</i>	33	<i>atenolol</i>	29
<i>acetaminophen-codeine</i>	4	<i>amikacin sulfate</i>	6	<i>atenolol-chlorthalidone</i>	29
<i>acetazolamide</i>	31	<i>amiloride hcl</i>	31	<i>atomoxetine hcl</i>	44
<i>acetazolamide er</i>	31	<i>amiloride-hydrochlorothiazide</i> ...	31	<i>atorvastatin calcium</i>	28
<i>acetic acid</i>	67, 81	<i>amiodarone hcl</i>	27	<i>atovaquone</i>	6
<i>acetylcysteine</i>	84	<i>amitriptyline hcl</i>	38	<i>atovaquone-proguanil hcl</i>	8
<i>acitretin</i>	87	<i>amlodipine besy-benazepril hcl</i> ..	25	<i>atropine sulfate</i>	81
ACTHIB.....	74	<i>amlodipine besylate</i>	30	ATROPINE SULFATE.....	81
ACTIMMUNE.....	72	<i>amlodipine besylate-valsartan</i> ...	26	ATROVENT HFA.....	82
<i>acyclovir</i>	11	<i>amlodipine-atorvastatin</i>	32	AUBAGIO.....	47
<i>acyclovir sodium</i>	11	<i>amlodipine-olmesartan</i>	26	<i>aubra eq</i>	54
ADACEL.....	74	<i>ammonium lactate</i>	89	<i>aurovela 1/20</i>	54
ADCIRCA.....	32	<i>amnesteem</i>	86	<i>aurovela fe 1.5/30</i>	55
<i>adefovir dipivoxil</i>	11	<i>amoxapine</i>	38	<i>aurovela fe 1/20</i>	55
ADEMPAS.....	33	<i>amoxicillin</i>	14, 15	AUSTEDO.....	46
ADRENALIN.....	31	<i>amoxicillin-pot clavulanate</i>	15	AUSTEDO XR.....	46
ADVAIR DISKUS.....	86	<i>amoxicillin-pot clavulanate er</i>	15	AUSTEDO XR PATIENT	
ADVAIR HFA.....	86	<i>amphetamine-dextroamphet er</i> ..	44	TITRATION.....	46
<i>afirmelle</i>	54	<i>amphetamine-</i>		AUVELITY.....	38
AIMOVIG.....	45	<i>dextroamphetamine</i>	44	<i>aviane</i>	55
<i>ala-cort</i>	87	<i>amphotericin b</i>	5	<i>ayuna</i>	55
<i>albendazole</i>	6	<i>amphotericin b liposome</i>	5	AYVAKIT.....	20
<i>albuterol sulfate</i>	83	<i>ampicillin</i>	15	<i>azacitidine</i>	17
<i>albuterol sulfate hfa inhalation</i>		<i>ampicillin sodium</i>	15	<i>azathioprine</i>	73
<i>aerosol solution 108 (90 base)</i>		<i>ampicillin-sulbactam sodium</i>	15	<i>azelaic acid</i>	89
<i>mcg/act</i>	83	<i>anagrelide hcl</i>	69	<i>azelastine hcl</i>	79, 82
<i>alclometasone dipropionate</i>	87	<i>anastrozole</i>	18	<i>azithromycin</i>	13, 14
ALCOHOL SWABS.....	49	ANORO ELLIPTA.....	82	<i>aztreonam</i>	6
ALDURAZYME.....	61	APOKYN.....	40	<i>azurette</i>	55
ALECENSA.....	20	<i>apomorphine hcl</i>	40	<i>bacitracin</i>	80
<i>alendronate sodium</i>	53	<i>aprepitant</i>	63	<i>bacitracin-polymyxin b</i>	80
<i>alfuzosin hcl er</i>	67	<i>apri</i>	54	<i>bacitra-neomycin-polymyxin-hc</i> ..	79
ALIMTA.....	17	APTIOM.....	33	<i>baclofen</i>	48
<i>aliskiren fumarate</i>	32	APTIVUS.....	8	<i>balsalazide disodium</i>	65
<i>allopurinol</i>	3	ARALAST NP.....	84	BALVERSA.....	20
<i>alosectron hcl</i>	65	<i>aranelle</i>	54	<i>balziva</i>	55
ALPHAGAN P.....	79	ARCALYST.....	73	BARACLUDE.....	11
<i>alprazolam</i>	33	AREXVY.....	74	BASAGLAR KWIKPEN.....	49

12/01/2023

BCG VACCINE.....	74	budesonide er.....	65	CEFAZOLIN SODIUM.....	12
BELSOMRA.....	45	bumetanide.....	31	CEFAZOLIN SODIUM-DEXTROSE..	12
benazepril hcl.....	26	buprenorphine hcl.....	48	cefdinir.....	12, 13
benazepril-hydrochlorothiazide..	25	buprenorphine hcl-naloxone hcl.	48	cefepime hcl.....	13
BENDEKA.....	16	bupropion hcl.....	38	cefixime.....	13
BENLYSTA.....	73	bupropion hcl er (smoking det)...	48	cefoxitin sodium.....	13
benzoyl peroxide-erythromycin..	86	bupropion hcl er (sr).....	38	cefpodoxime proxetil.....	13
benztropine mesylate.....	40	bupropion hcl er (xl).....	38	cefprozil.....	13
BERINERT.....	69	buspirone hcl.....	33	ceftazidime.....	13
BESIVANCE.....	80	butorphanol tartrate.....	4	ceftriaxone sodium.....	13
BESREMI.....	19	BYDUREON BCISE.....	51	cefuroxime axetil.....	13
betaine.....	61	BYETTA 10 MCG PEN.....	51	cefuroxime sodium.....	13
betamethasone dipropionate.....	88	cabergoline.....	61	celecoxib.....	3
betamethasone dipropionate		CABOMETYX.....	20	CELONTIN.....	34
aug.....	87, 88	calcipotriene.....	87	cephalexin.....	13
betamethasone valerate.....	88	calcitonin (salmon).....	53	CERDELGA.....	61
BETASERON.....	47	calcitrene.....	87	CEREZYME.....	61
betaxolol hcl.....	79	calcitriol.....	63	cetirizine hcl.....	83
bethanechol chloride.....	67	calcium acetate.....	62	cevimeline hcl.....	90
BETOPTIC-S.....	79	calcium acetate (phos binder)....	62	chateal.....	55
BEVESPI AEROSPHERE.....	82	CALQUENCE.....	20	CHEMET.....	54
bexarotene.....	19, 89	camila.....	55	chlorhexidine gluconate.....	90
BEXSERO.....	74	candesartan cilexetil.....	27	chloroquine phosphate.....	8
bicalutamide.....	18	candesartan cilexetil-hctz.....	26	chlorpromazine hcl.....	41
BICILLIN L-A.....	15	CAPLYTA.....	41	CHLORPROMAZINE HCL.....	41
BIKTARVY.....	10	CAPRELSA.....	20	chlorthalidone.....	31
bisoprolol fumarate.....	29	captopril.....	26	cholestyramine.....	28, 29
bisoprolol-hydrochlorothiazide..	29	captopril-hydrochlorothiazide....	26	cholestyramine light.....	28
BIVIGAM.....	72	CARAFATE.....	65	ciclopirox olamine.....	87
blisovi fe 1.5/30.....	55	carbamazepine.....	33, 34	cilostazol.....	69
BOOSTRIX.....	74	carbamazepine er.....	33	CILOXAN.....	80
BORTEZOMIB.....	20	carbidopa.....	40	CIMDUO.....	10
bortezomib.....	20	carbidopa-levodopa.....	40	cinacalcet hcl.....	61
bosentan.....	33	carbidopa-levodopa er.....	40	CIPRO.....	14
BOSULIF.....	20	carbidopa-levodopa-		CIPRO HC.....	81
BRAFTOVI.....	20	entacapone.....	40	CIPRODEX.....	82
BREO ELLIPTA.....	86	carboplatin.....	16	ciprofloxacin hcl.....	14, 80
BREZTRI AEROSPHERE.....	82	carglumic acid.....	61	ciprofloxacin in d5w.....	14
briellyn.....	55	carteolol hcl.....	79	cisplatin.....	16
BRILINTA.....	70	cartia xt.....	30	citalopram hydrobromide.....	38
brimonidine tartrate.....	79	carvedilol.....	29	claravis.....	86
brinzolamide.....	79	caspofungin acetate.....	5	clarithromycin.....	14
BRIVIACT.....	33	CAYSTON.....	6	clarithromycin er.....	14
bromfenac sodium (once-daily)..	81	cefaclor.....	12	clindamycin hcl.....	6
bromocriptine mesylate.....	40	CEFACTOR ER.....	12	clindamycin palmitate hcl.....	6
BROMSITE.....	81	cefadroxil.....	12	clindamycin phosphate.....	6, 68, 86
BRUKINSA.....	20	cefazolin sodium.....	12	clindamycin phosphate in d5w.....	6
budesonide.....	65, 85				

CLINDAMYCIN PHOSPHATE IN NACL.....	6	CYCLOPHOSPHAMIDE	16, 17	dextrose.....	78
CLINIMIX/DEXTROSE (4.25/10)...	78	cycloserine	11	DEXTROSE 5%/ELECTROLYTE #48.....	76
CLINIMIX/DEXTROSE (4.25/5).....	78	cyclosporine	73	dextrose in lactated ringers	76
CLINIMIX/DEXTROSE (5/15).....	78	cyclosporine modified	73	DEXTROSE-NACL.....	76
CLINIMIX/DEXTROSE (5/20).....	78	cyproheptadine hcl.....	83	dextrose-nacl.....	76
CLINIMIX/DEXTROSE (6/5).....	78	cyred eq.....	55	dextrose-sodium chloride.....	76
CLINIMIX/DEXTROSE (8/10).....	78	CYSTADROPS.....	81	DIACOMIT	34
CLINIMIX/DEXTROSE (8/14).....	78	CYSTAGON.....	61	diazepam.....	34
clinisol sf.....	78	CYSTARAN	81	diazepam intensol.....	34
CLINOLIPID.....	78	cytarabine	17	diazoxide	60
clobazam	34	dabigatran etexilate mesylate	68	diclofenac potassium.....	3
clobetasol propionate	88	dalfampridine er.....	47	diclofenac sodium	3, 81, 89
clobetasol propionate e.....	88	danazol	59	diclofenac sodium er.....	3
clomipramine hcl.....	38	dantrolene sodium.....	48	diclofenac-misoprostol.....	3
clonazepam	34	dapsone	7	dicloxacillin sodium.....	15
clonidine	32	DAPTACEL.....	74	dicyclomine hcl.....	64
clonidine hcl.....	32	daptomycin	7	DIFICID.....	14
clopidogrel bisulfate	70	DAPTOMYCIN	7	diflunisal	3
clorazepate dipotassium	34	darifenacin hydrobromide er.....	67	difluprednate.....	81
clotrimazole.....	87, 90	dasetta 1/35.....	55	digoxin.....	32
clotrimazole-betamethasone	87	dasetta 7/7/7.....	55	dihydroergotamine mesylate	45
clozapine	41, 42	DAURISMO	20	DILANTIN.....	34
COARTEM.....	8	DAYVIGO	45	DILANTIN INFATABS.....	34
colchicine	3	deblitane	55	diltiazem hcl.....	30
colchicine-probenecid	3	deferasirox.....	54	diltiazem hcl er.....	30
colesevelam hcl.....	29	deferasirox granules	54	diltiazem hcl er beads.....	30
colestipol hcl.....	29	DELESTROGEN.....	59	diltiazem hcl er coated beads	30
colistimethate sodium (cba).....	6	DELSTRIGO.....	10	dilt-xr.....	30
COMBIGAN.....	79	DENGVAIXA.....	74	diphenhydramine hcl.....	83
COMBIVENT RESPIMAT	82	depo-testosterone	49	diphenoxylate-atropine.....	66
COMETRIQ (100 MG DAILY DOSE).....	20	DESCOVY	10	DIPHThERIA-TETANUS TOXOIDS DT.....	74
COMETRIQ (140 MG DAILY DOSE).....	20	desipramine hcl.....	38	dipyridamole	70
COMETRIQ (60 MG DAILY DOSE).....	20	desloratadine	83	disopyramide phosphate.....	27
COMPLERA.....	10	desmopressin ace spray refrig....	61	disulfiram	48
compro.....	64	desmopressin acetate	61	divalproex sodium.....	34
constulose	65	desmopressin acetate pf.....	61	divalproex sodium er.....	34
COPIKTRA.....	20	desmopressin acetate spray.....	61	DOCETAXEL.....	19
CORLANOR.....	32	desogestrel-ethinyl estradiol.....	55	docetaxel.....	19
COTELLIC.....	20	desonide	88	dofetilide	27
CREON	66	desvenlafaxine succinate er.....	38	donepezil hcl.....	37
cromolyn sodium	66, 79, 84	dexamethasone	60	DOPTelet	69
cryselle-28.....	55	DEXAMETHASONE INTENSOL.....	60	dorzolamide hcl.....	79
cyclobenzaprine hcl.....	48	dexamethasone sod phosphate pf.....	60	dorzolamide hcl-timolol mal.....	79
cyclophosphamide.....	16, 17	dexamethasone sodium phosphate	60, 81	dotti.....	59
		dexlansoprazole	66	DOVATO.....	10
		dexmethylphenidate hcl.....	44	doxazosin mesylate.....	26

<i>doxepin hcl</i>	38, 45	<i>enoxaparin sodium</i>	68	<i>exemestane</i>	18
<i>doxercalciferol</i>	63	<i>enpresse-28</i>	55	EXKIVITY	21
<i>doxorubicin hcl</i>	17	<i>enskyce</i>	55	EZALLOR SPRINKLE	28
<i>doxorubicin hcl liposomal</i>	17	ENSTILAR	88	<i>ezetimibe</i>	29
<i>doxy 100</i>	16	<i>entacapone</i>	40	<i>ezetimibe-simvastatin</i>	29
<i>doxycycline hyclate</i>	16	<i>entecavir</i>	11	FABRAZYME	61
<i>doxycycline monohydrate</i>	16	ENTRESTO	27	<i>falmina</i>	55
DRIZALMA SPRINKLE	38	<i>enulose</i>	65	<i>famciclovir</i>	11
<i>dronabinol</i>	64	EPCLUSA	11	<i>famotidine</i>	64
<i>drospirenone-ethinyl estradiol</i> ...	55	EPIDIOLEX	34	<i>famotidine (pf)</i>	64
DROXIA	69	<i>epinephrine</i>	84	<i>famotidine premixed</i>	64
<i>droxidopa</i>	32	<i>epinephrine (anaphylaxis)</i>	32	FANAPT	42
<i>duloxetine hcl</i>	38	<i>epitol</i>	34	FANAPT TITRATION PACK	42
DUPIXENT	70	EPIVIR HBV	11	FARXIGA	51
<i>dutasteride</i>	67	<i>eplerenone</i>	26	FASENRA	84
<i>dutasteride-tamsulosin hcl</i>	67	EPRONTIA	34	FASENRA PEN	84
<i>e.e.s. 400</i>	14	<i>ergotamine-caffeine</i>	46	<i>febuxostat</i>	3
<i>ec-naproxen</i>	3	ERIVEDGE	20	<i>felbamate</i>	35
EDARBI	27	ERLEADA	18	<i>felodipine er</i>	30
EDARBYCLOR	27	<i>erlotinib hcl</i>	20	<i>femynor</i>	55
EDURANT	8	<i>errin</i>	55	<i>fenofibrate</i>	28
<i>efavirenz</i>	9	<i>ertapenem sodium</i>	7	<i>fenofibrate micronized</i>	28
<i>efavirenz-emtricitab-tenofo df</i> ... 10		<i>ery</i>	86	<i>fenofibric acid</i>	28
<i>efavirenz-lamivudine-tenofovir</i> ...10		<i>ery-tab</i>	14	<i>fentanyl</i>	4
ELIGARD	18	ERYTHROCIN LACTOBIONATE	14	<i>fentanyl citrate</i>	4
<i>elinest</i>	55	<i>erythrocine stearate</i>	14	<i>fesoterodine fumarate er</i>	67
ELIQUIS	68	<i>erythromycin</i>	14, 80, 86	FETZIMA	39
ELIQUIS DVT/PE STARTER PACK ..	68	<i>erythromycin base</i>	14	FETZIMA TITRATION	39
ELLECE	17	<i>erythromycin ethylsuccinate</i>	14	FIASP	49
<i>eluryng</i>	55	<i>erythromycin lactobionate</i>	14	FIASP FLEXTOUCH	49
EMCYT	18	<i>escitalopram oxalate</i>	38	FIASP PENFILL	49
EMGALITY	46	<i>esomeprazole magnesium</i>	66	FIASP PUMPCART	49
EMGALITY (300 MG DOSE)	46	<i>estarylla</i>	55	FINACEA	89
<i>emoquette</i>	55	<i>estradiol</i>	59	<i>finasteride</i>	67
EMSAM	38	<i>estradiol valerate</i>	59	<i>ingolimod hcl</i>	47
<i>emtricitabine</i>	9	<i>estradiol-norethindrone acet</i>	59	FINTEPLA	35
<i>emtricitabine-tenofovir df</i>	10	<i>ethambutol hcl</i>	11	<i>flac</i>	82
EMTRIVA	9	<i>ethosuximide</i>	35	FLAREX	81
EMVERM	7	<i>ethynodiol diac-eth estradiol</i>	55	FLEBOGAMMA DIF	72
<i>enalapril maleate</i>	26	<i>etodolac</i>	3	<i>flecainide acetate</i>	27
<i>enalapril-hydrochlorothiazide</i>	26	<i>etodolac er</i>	3	FLOVENT DISKUS	85
ENBREL	70	<i>etonogestrel-ethinyl estradiol</i>	55	FLOVENT HFA	86
ENBREL MINI	70	<i>etoposide</i>	19	<i>fluconazole</i>	5, 6
ENBREL SURECLICK	70	<i>etravirine</i>	9	<i>fluconazole in sodium chloride</i>	5
ENDARI	69	EULEXIN	18	<i>flucytosine</i>	6
<i>endocet</i>	4	<i>euthyrox</i>	63	<i>fludrocortisone acetate</i>	60
ENGERIX-B	74	<i>everolimus</i>	20, 21, 73	<i>flunisolide</i>	85
<i>enilloring</i>	55	EVOTAZ	10	<i>fluocinolone acetonide</i>	82, 88

<i>fluocinolone acetonide body</i>88	GEMTESA..... 67	HIBERIX..... 74
<i>fluocinolone acetonide scalp</i> 88	<i>generlac</i> 65	HUMIRA..... 70
<i>fluocinonide</i> 88	<i>gengraf</i> 73	HUMIRA PEDIATRIC CROHNS
<i>fluocinonide emulsified base</i> 88	GENOTROPIN..... 61	START..... 70
<i>fluorometholone</i> 81	GENOTROPIN MINIQUICK..... 61	HUMIRA PEN..... 70
<i>fluorouracil</i> 17, 89	<i>gentak</i> 80	HUMIRA PEN-CD/UC/HS
<i>fluoxetine hcl</i> 39	<i>gentamicin in saline</i> 7	STARTER..... 70
<i>fluphenazine decanoate</i> 42	<i>gentamicin sulfate</i> 7, 80, 86, 87	HUMIRA PEN-PEDIATRIC UC
<i>fluphenazine hcl</i> 42	GENVOYA..... 10	START..... 70
<i>flurbiprofen</i> 3	GILOTRIF..... 21	HUMIRA PEN-PS/UV/ADOL HS
<i>flurbiprofen sodium</i> 81	<i>glatiramer acetate</i> 47	START..... 70
<i>fluticasone propionate</i> 85, 88	<i>glatopa</i> 47	HUMIRA PEN-PSOR/UEIT
<i>fluvastatin sodium</i> 28	GLEOSTINE..... 17	STARTER..... 70
<i>fluvastatin sodium er</i> 28	<i>glimepiride</i> 51	HUMULIN R U-500
<i>fluvoxamine maleate</i> 33	<i>glipizide</i> 51	(CONCENTRATED)..... 49
<i>fondaparinux sodium</i> 68	<i>glipizide er</i> 51	HUMULIN R U-500 KWIKPEN..... 49
<i>formoterol fumarate</i> 83	<i>glipizide xl</i> 51	<i>hydralazine hcl</i> 32
FORTEO..... 53	<i>glipizide-metformin hcl</i> 51	<i>hydrochlorothiazide</i> 31
FOSAMAX PLUS D..... 53	<i>glycopyrrolate</i> 64	<i>hydrocodone-acetaminophen</i> 4
<i>fosamprenavir calcium</i> 9	<i>glydo</i> 89	<i>hydrocodone-ibuprofen</i> 4
<i>fosinopril sodium</i> 26	GLYXAMBI..... 51	<i>hydrocortisone</i> 60, 65, 88, 89
<i>fosinopril sodium-hctz</i> 26	GOLYTELY..... 65	<i>hydrocortisone (perianal)</i> 89
FOTIVDA..... 21	GRALISE..... 46, 47	<i>hydromorphone hcl</i> 4
<i>fulvestrant</i> 18	<i>granisetron hcl</i> 64	<i>hydroxychloroquine sulfate</i> 72
<i>furosemide</i> 31	<i>griseofulvin microsize</i> 6	<i>hydroxyurea</i> 19
FUZEON..... 9	<i>griseofulvin ultramicrosize</i> 6	<i>hydroxyzine hcl</i> 83
<i>fyavolv</i> 59	<i>guanfacine hcl</i> 32	<i>hydroxyzine pamoate</i> 83
FYCOMPA..... 35	<i>guanfacine hcl er</i> 44	HYSINGLA ER..... 4
<i>gabapentin</i> 35	GVOKE HYOPEN 2-PACK..... 60	<i>ibandronate sodium</i> 53
<i>galantamine hydrobromide</i> 37	GVOKE KIT..... 61	IBRANCE..... 21
<i>galantamine hydrobromide er</i> 37	GVOKE PFS..... 61	<i>ibu</i> 3
GAMASTAN..... 72	HAEGARDA..... 69	<i>ibuprofen</i> 3
GAMMAGARD..... 72	<i>hailey 1.5/30</i> 55	<i>icatibant acetate</i> 69
GAMMAGARD S/D LESS IGA..... 72	<i>halobetasol propionate</i> 88	<i>iclevia</i> 56
GAMMAKED..... 72	<i>haloette</i> 56	ICLUSIG..... 21
GAMMAPLEX..... 72	<i>haloperidol</i> 42	IDHIFA..... 21
GAMUNEX-C..... 72	<i>haloperidol decanoate</i> 42	ILEVRO..... 81
<i>ganciclovir sodium</i> 11	<i>haloperidol lactate</i> 42	<i>imatinib mesylate</i> 21
GARDASIL 9..... 74	HARVONI..... 11	IMBRUVICA..... 21
<i>gatifloxacin</i> 80	HAVRIX..... 74	<i>imipenem-cilastatin</i> 7
GATTEX..... 66	<i>heather</i> 56	<i>imipramine hcl</i> 39
GAUZE PADS 2" X 2"..... 49	HEPARIN (PORCINE) IN NACL..... 68	<i>imiquimod</i> 89
<i>gavilyte-c</i> 65	<i>heparin sod (porcine) in d5w</i> 68	IMOVAX RABIES..... 74
<i>gavilyte-g</i> 65	<i>heparin sodium (porcine)</i> 68	IMVEXXY MAINTENANCE PACK.. 59
GAVRETO..... 21	HEPLISAV-B..... 74	IMVEXXY STARTER PACK..... 59
<i>gefitinib</i> 21	HERCEPTIN..... 21	<i>incassia</i> 56
<i>gemcitabine hcl</i> 17	HERCEPTIN HYLECTA..... 21	INCRELEX..... 61
<i>gemfibrozil</i> 28	HERZUMA..... 21	INCRUSE ELLIPTA..... 82

<i>indapamide</i>	31	JANUMET.....	52	<i>labetalol hcl</i>	29
INFANRIX.....	74	JANUMET XR.....	52	<i>lacosamide</i>	35
INFLIXIMAB.....	71	JANUVIA.....	52	<i>lactated ringers</i>	76
INGREZZA.....	47	JARDIANCE.....	52	<i>lactulose</i>	65
INLYTA.....	21	<i>jasmiel</i>	56	<i>lactulose encephalopathy</i>	65
INQOVI.....	17	<i>javygtor</i>	61	<i>lamivudine</i>	9, 11
INREBIC.....	21	JAYPIRCA.....	21	<i>lamivudine-zidovudine</i>	10
INSULIN PEN NEEDLE.....	49	JENTADUETO.....	52	<i>lamotrigine</i>	35
INSULIN SYRINGE (DISP) U-100		JENTADUETO XR.....	52	<i>lamotrigine er</i>	35
0.3 ML.....	49	<i>jinteli</i>	59	<i>lansoprazole</i>	66
INSULIN SYRINGE (DISP) U-100		<i>jolessa</i>	56	LANTUS.....	49
1 ML.....	49	<i>juleber</i>	56	LANTUS SOLOSTAR.....	49
INSULIN SYRINGE (DISP) U-100		JULUCA.....	10	<i>lapatinib ditosylate</i>	22
1/2 ML.....	49	<i>junel 1.5/30</i>	56	<i>larin 1.5/30</i>	56
INTELENCE.....	9	<i>junel 1/20</i>	56	<i>larin 1/20</i>	56
INTRALIPID.....	78	<i>junel fe 1.5/30</i>	56	<i>larin fe 1.5/30</i>	56
INTRON A.....	73	<i>junel fe 1/20</i>	56	<i>larin fe 1/20</i>	56
<i>introvale</i>	56	KADCYLA.....	21	<i>latanoprost</i>	79
INVEGA HAFYERA.....	42	KALYDECO.....	84	LATUDA.....	42, 43
INVEGA SUSTENNA.....	42	KANJINTI.....	21	<i>leena</i>	56
INVEGA TRINZA.....	42	<i>kariva</i>	56	<i>leflunomide</i>	72
INVOKAMET.....	51	<i>kcl in dextrose-nacl</i>	76	<i>lenalidomide</i>	18
INVOKAMET XR.....	51	KCL IN DEXTROSE-NACL.....	76	LENVIMA (10 MG DAILY DOSE)...	22
INVOKANA.....	52	<i>kelnor 1/35</i>	56	LENVIMA (12 MG DAILY DOSE)...	22
IPOL.....	74	<i>kelnor 1/50</i>	56	LENVIMA (14 MG DAILY DOSE)...	22
<i>ipratropium bromide</i>	82	KERENDIA.....	26	LENVIMA (18 MG DAILY DOSE)...	22
<i>ipratropium-albuterol</i>	82	<i>ketoconazole</i>	6, 87	LENVIMA (20 MG DAILY DOSE)...	22
<i>irbesartan</i>	27	<i>ketorolac tromethamine</i>	81	LENVIMA (24 MG DAILY DOSE)...	22
<i>irbesartan-hydrochlorothiazide</i> ..	27	KEVZARA.....	71	LENVIMA (4 MG DAILY DOSE)....	22
IRESSA.....	21	KEYTRUDA.....	21	LENVIMA (8 MG DAILY DOSE)....	22
<i>irinotecan hcl</i>	19	KINRIX.....	74	<i>lessina</i>	56
ISENTRESS.....	9	KISQALI (200 MG DOSE).....	22	<i>letrozole</i>	18
ISENTRESS HD.....	9	KISQALI (400 MG DOSE).....	22	<i>leucovorin calcium</i>	25
<i>isibloom</i>	56	KISQALI (600 MG DOSE).....	22	LEUKERAN.....	17
ISOLYTE-P IN D5W.....	76	KISQALI FEMARA (200 MG		<i>leuprolide acetate</i>	18
ISOLYTE-S.....	76	DOSE).....	19	<i>levalbuterol hcl</i>	83
ISOLYTE-S PH 7.4.....	76	KISQALI FEMARA (400 MG		<i>levalbuterol tartrate</i>	83
<i>isoniazid</i>	11	DOSE).....	19	LEVEMIR.....	50
<i>isosorbide dinitrate</i>	32	KISQALI FEMARA (600 MG		LEVEMIR FLEXPEN.....	49
<i>isosorbide mononitrate</i>	32	DOSE).....	19	LEVEMIR FLEXTOUCH.....	50
<i>isosorbide mononitrate er</i>	32	<i>klor-con</i>	78	<i>levetiracetam</i>	35
<i>isotretinoin</i>	86	<i>klor-con 10</i>	77	<i>levetiracetam er</i>	35
<i>isradipine</i>	30	<i>klor-con m10</i>	77	<i>levetiracetam in nacl</i>	35
<i>itraconazole</i>	6	<i>klor-con m15</i>	77	<i>levobunolol hcl</i>	79
<i>ivermectin</i>	7	<i>klor-con m20</i>	77	<i>levocarnitine</i>	61
IXIARO.....	74	KORLYM.....	61	<i>levocetirizine dihydrochloride</i>	83
JAKAFI.....	21	KRAZATI.....	22	<i>levofloxacin</i>	14
<i>jantoven</i>	68	<i>kurvelo</i>	56	<i>levofloxacin in d5w</i>	14

<i>levonest</i>	56	LUPRON DEPOT (1-MONTH)	18	MESNEX.....	25
<i>levonorgest-eth estrad 91-day</i> ...	56	LUPRON DEPOT (3-MONTH)	18	<i>metadate er</i>	45
<i>levonorgestrel-ethinyl estrad</i>	56	LUPRON DEPOT-PED (1-		<i>metformin hcl</i>	52
<i>levonorg-eth estrad triphasic</i>	56	MONTH).....	61	<i>metformin hcl er</i>	52
<i>levora 0.15/30 (28)</i>	56	LUPRON DEPOT-PED (3-		<i>methadone hcl</i>	4
<i>levo-t</i>	63	MONTH).....	62	<i>methadone hcl intensol</i>	4
<i>levothyroxine sodium</i>	63	LUPRON DEPOT-PED (6-		<i>methazolamide</i>	31
<i>levoxyl</i>	63	MONTH).....	62	<i>methenamine hippurate</i>	7
LEXIVA.....	9	<i>lurasidone hcl</i>	43	<i>methimazole</i>	63
<i>lidocaine</i>	89	<i>luter</i>	57	<i>methotrexate sodium</i>	17, 72
<i>lidocaine hcl</i>	5, 89	<i>lyleq</i>	57	<i>methotrexate sodium (pf)</i>	17
<i>lidocaine hcl (pf)</i>	5	<i>lyllana</i>	59	<i>methsuximide</i>	35
<i>lidocaine viscous hcl</i>	90	LYNPARZA.....	22	<i>methylphenidate hcl</i>	45
<i>lidocaine-prilocaine</i>	89	LYRICA CR.....	47	<i>methylphenidate hcl er</i>	45
<i>linezolid</i>	7	LYSODREN.....	18	<i>methylprednisolone</i>	60
<i>linezolid in sodium chloride</i>	7	LYTGOBI (12 MG DAILY DOSE)....	22	<i>methylprednisolone acetate</i>	60
LINZESS.....	66	LYTGOBI (16 MG DAILY DOSE)....	22	<i>methylprednisolone sodium</i>	
<i>liothyronine sodium</i>	63	LYTGOBI (20 MG DAILY DOSE)....	22	<i>succ</i>	60
<i>lisdexamfetamine dimesylate</i>		<i>lyza</i>	57	<i>metoclopramide hcl</i>	64
.....	44, 45	<i>magnesium sulfate</i>	76	<i>metolazone</i>	31
<i>lisinopril</i>	26	MAGNESIUM SULFATE.....	76, 77	<i>metoprolol succinate er</i>	29
<i>lisinopril-hydrochlorothiazide</i>	26	<i>magnesium sulfate in d5w</i>	76	<i>metoprolol tartrate</i>	29
LITHIUM.....	47	MAGNESIUM SULFATE IN D5W..	76	<i>metoprolol-hydrochlorothiazide</i> ..	29
<i>lithium carbonate</i>	47	<i>malathion</i>	90	<i>metronidazole</i>	7, 68, 89
<i>lithium carbonate er</i>	47	<i>maraviroc</i>	9	<i>metyrosine</i>	32
LIVALO.....	28	<i>marlissa</i>	57	<i>micafungin sodium</i>	6
<i>loestrin 1.5/30 (21)</i>	56	MARPLAN.....	39	<i>microgestin 1.5/30</i>	57
<i>loestrin 1/20 (21)</i>	56	MATULANE.....	19	<i>microgestin 1/20</i>	57
<i>loestrin fe 1.5/30</i>	56	<i>matzim la</i>	30	<i>microgestin fe 1.5/30</i>	57
<i>loestrin fe 1/20</i>	56	MAVYRET.....	11, 12	<i>microgestin fe 1/20</i>	57
LOKELMA.....	54	<i>meclizine hcl</i>	64	<i>midodrine hcl</i>	32
LONSURF.....	17	<i>medroxyprogesterone acetate</i>		<i>miglustat</i>	62
<i>loperamide hcl</i>	66		57, 63	<i>mili</i>	57
<i>lopinavir-ritonavir</i>	10	<i>mefloquine hcl</i>	8	<i>mimvey</i>	59
<i>lorazepam</i>	33	<i>megestrol acetate</i>	18, 63	<i>minocycline hcl</i>	16
<i>lorazepam intensol</i>	33	MEKINIST.....	22	<i>minoxidil</i>	32
LORBRENA.....	22	MEKTOVI.....	22	<i>mirtazapine</i>	39
<i>loryna</i>	56	<i>meloxicam</i>	3	<i>misoprostol</i>	66
<i>losartan potassium</i>	27	<i>memantine hcl</i>	37	MITIGARE.....	3
<i>losartan potassium-hctz</i>	27	<i>memantine hcl er</i>	37	M-M-R II.....	75
LOTEMAX.....	81	MENACTRA.....	74	M-NATAL PLUS.....	78
<i>lovastatin</i>	28	MENQUADFI.....	74	<i>modafinil</i>	48
<i>low-ogestrel</i>	57	MENVEO.....	75	<i>moexipril hcl</i>	26
<i>loxapine succinate</i>	43	<i>mercaptopurine</i>	17	<i>molindone hcl</i>	43
<i>lubiprostone</i>	66	<i>meropenem</i>	7	<i>mometasone furoate</i>	85, 89
LUMAKRAS.....	22	<i>mesalamine</i>	65	MONJUVI.....	22
LUMIGAN.....	79	<i>mesalamine er</i>	65	<i>mono-lynyah</i>	57
LUMIZYME.....	61	<i>mesalamine-cleanser</i>	65	<i>montelukast sodium</i>	84

<i>morphine sulfate</i>5	<i>niacin er (antihyperlipidemic)</i> 29	NUBEQA.....18
<i>morphine sulfate (concentrate)</i> 4	<i>nicardipine hcl</i>30	NUDEXTA..... 47
MORPHINE SULFATE (PF).....5	NICOTROL..... 48	NULOJIX..... 73
<i>morphine sulfate er</i> 4	NICOTROL NS..... 48	NUPLAZID..... 43
MOVANTIK.....66	<i>nifedipine er</i> 30	NURTEC.....46
<i>moxifloxacin hcl</i> 14, 80	<i>nifedipine er osmotic release</i> 30	NUTRILIPID.....78
MULTAQ..... 27	<i>nikki</i> 57	NUZYRA.....16
<i>multiple electro type 1 ph 5.5</i> 77	<i>nilutamide</i>18	<i>nyamyc</i> 87
<i>multiple electro type 1 ph 7.4</i> 77	<i>nimodipine</i> 30	<i>nylia 1/35</i>57
<i>mupirocin</i>87	NINLARO..... 23	<i>nylia 7/7/7</i> 57
MVASI..... 23	<i>nisoldipine er</i> 30	NYMALIZE..... 31
<i>mycophenolate mofetil</i>73	<i>nitazoxanide</i> 7	<i>nymyo</i> 57
<i>mycophenolate sodium</i> 73	<i>nitisinone</i> 62	<i>nystatin</i> 6, 87, 90
MYRBETRIQ.....67	NITRO-BID.....32	<i>nystop</i> 87
<i>na sulfate-k sulfate-mg sulf</i> 65	<i>nitrofurantoin macrocrystal</i>7	<i>ocella</i> 58
<i>nabumetone</i> 3	<i>nitrofurantoin monohyd macro</i> 7	OCREVUS..... 47
<i>nadolol</i>29	<i>nitroglycerin</i>32	OCTAGAM.....72
<i>nafcillin sodium</i>15	<i>nizatidine</i> 65	<i>octreotide acetate</i> 62
NAGLAZYME..... 62	<i>nora-be</i> 57	ODEFSEY..... 10
<i>nalbuphine hcl</i> 5	<i>norethin ace-eth estrad-fe</i> 57	ODOMZO..... 23
<i>naloxone hcl</i>48	<i>norethindrone</i>57	OFEV..... 84
<i>naltrexone hcl</i>48	<i>norethindrone acetate</i>63	<i>ofloxacin</i> 80, 82
NAMZARIC..... 37, 38	<i>norethindrone acet-ethinyl est</i> ... 57	OGIVRI..... 23
<i>naproxen</i>3	<i>norethindrone-eth estradiol</i> 59	<i>olanzapine</i> 43
<i>naproxen sodium</i> 3	<i>norethindron-ethinyl estrad-fe</i> ... 57	<i>olmesartan medoxomil</i>27
<i>naratriptan hcl</i>46	<i>norgestimate-eth estradiol</i>57	<i>olmesartan medoxomil-hctz</i> 27
NATACYN..... 80	<i>norgestim-eth estrad triphasic</i> ... 57	<i>olmesartan-amlodipine-hctz</i>27
<i>nateglinide</i>52	NORITATE..... 89	<i>olopatadine hcl</i> 79, 83
NATPARA..... 53	<i>norlyroc</i>57	<i>omeprazole</i> 66
NAYZILAM.....35	NORPACE CR.....28	OMNARIS..... 85
<i>nebivolol hcl</i>29	<i>nortrel 0.5/35 (28)</i> 57	OMNIPOD 5 G6 INTRO (GEN 5).. 50
<i>necon 0.5/35 (28)</i> 57	<i>nortrel 1/35 (21)</i> 57	OMNIPOD 5 G6 POD (GEN 5).....50
NEEDLES, INSULIN DISP., SAFETY..... 50	<i>nortrel 1/35 (28)</i> 57	OMNIPOD CLASSIC PDM (GEN 3).....50
<i>nefazodone hcl</i>39	<i>nortrel 7/7/7</i> 57	OMNIPOD CLASSIC PODS (GEN 3).....50
<i>neomycin sulfate</i>7	<i>nortriptyline hcl</i> 39	OMNIPOD DASH INTRO (GEN 4). 50
<i>neomycin-bacitracin zn-</i> <i>polymyx</i>80	NORVIR..... 9	OMNIPOD DASH PODS (GEN 4).. 50
<i>neomycin-polymyxin-dexameth</i> ..80	NOVOLIN 70/30..... 50	OMNIPOD GO..... 50
<i>neomycin-polymyxin-gramicidin</i> .80	NOVOLIN 70/30 FLEXPEN..... 50	<i>ondansetron</i>64
<i>neomycin-polymyxin-hc</i> 80, 82	NOVOLIN N..... 50	<i>ondansetron hcl</i> 64
<i>neo-polycin</i> 80	NOVOLIN N FLEXPEN..... 50	ONTRUZANT..... 23
<i>neo-polycin hc</i>80	NOVOLIN R.....50	ONUREG.....17
NERLYNX.....23	NOVOLIN R FLEXPEN.....50	OPSUMIT.....33
NEUPRO..... 40	NOVOLOG..... 50	ORGOVYX.....18
<i>nevirapine</i> 9	NOVOLOG FLEXPEN..... 50	ORKAMBI..... 84
<i>nevirapine er</i> 9	NOVOLOG MIX 70/30..... 50	ORSERDU..... 18
NEXAVAR..... 23	NOVOLOG MIX 70/30 FLEXPEN.. 50	<i>oseltamivir phosphate</i> 12
	NOVOLOG PENFILL..... 50	
	NOXAFIL..... 6	

OTEZLA.....	71	<i>pfizerpen</i>	16	<i>pravastatin sodium</i>	28
<i>oxacillin sodium</i>	15	<i>phenelzine sulfate</i>	39	<i>praziquantel</i>	7
<i>oxaliplatin</i>	17	<i>phenobarbital</i>	35, 36	<i>prazosin hcl</i>	26
<i>oxaprozin</i>	4	<i>phenobarbital sodium</i>	36	<i>prednisolone</i>	60
<i>oxcarbazepine</i>	35	PHENYTEK.....	36	<i>prednisolone acetate</i>	81
<i>oxybutynin chloride</i>	67	<i>phenytoin</i>	36	<i>prednisolone sodium phosphate</i>	60
<i>oxybutynin chloride er</i>	67	<i>phenytoin sodium</i>	36	PREDNISOLONE SODIUM	
<i>oxycodone hcl</i>	5	<i>phenytoin sodium extended</i>	36	PHOSPHATE.....	81
<i>oxycodone-acetaminophen</i>	5	PHESGO	23	<i>prednisone</i>	60
OZEMPIC (0.25 OR 0.5		<i>philith</i>	58	PREDNISONE INTENSOL.....	60
MG/DOSE)	52	PIFELTRO	9	<i>pregabalin</i>	36
OZEMPIC (1 MG/DOSE)	52	<i>pilocarpine hcl</i>	79, 90	PREHEVBRIO	75
OZEMPIC (2 MG/DOSE)	52	<i>pimozide</i>	43	PREMASOL	78
<i>pacerone</i>	28	<i>pimtrea</i>	58	PRENATAL VITAMIN WITH	
<i>paclitaxel</i>	19	<i>pindolol</i>	29	FOLIC ACID GREATER THAN 0.8	
<i>paclitaxel protein-bound part</i>	19	<i>pioglitazone hcl</i>	52	MG ORAL TABLET	78
<i>paliperidone er</i>	43	<i>pioglitazone hcl-glimepiride</i>	52	<i>prevalite</i>	29
<i>pamidronate disodium</i>	53	<i>pioglitazone hcl-metformin hcl</i>	52	PREVYMIS.....	12
PAMIDRONATE DISODIUM	53	<i>piperacillin sod-tazobactam so</i>	16	PREZCOBIX.....	10
PANRETIN	89	PIQRAY (200 MG DAILY DOSE)	23	PREZISTA.....	9
<i>pantoprazole sodium</i>	66, 67	PIQRAY (250 MG DAILY DOSE)	23	PRIFTIN.....	11
PANZYGA	72	PIQRAY (300 MG DAILY DOSE)	23	PRIMAQUINE PHOSPHATE	8
<i>paraplatin</i>	17	<i>pirfenidone</i>	84	<i>primaquine phosphate</i>	8
<i>paricalcitol</i>	63	<i>pirmella 1/35</i>	58	<i>primidone</i>	36
<i>paromomycin sulfate</i>	7	<i>piroxicam</i>	4	PRIORIX.....	75
<i>paroxetine hcl</i>	39	PLASMA-LYTE 148.....	77	PRIVIGEN.....	72
<i>paroxetine hcl er</i>	39	PLASMA-LYTE A.....	77	<i>probenecid</i>	3
PEDIARIX	75	<i>plenamine</i>	78	<i>prochlorperazine</i>	64
PEDVAX HIB.....	75	PLENVU	65	<i>prochlorperazine edisylate</i>	64
<i>peg 3350-kcl-na bicarb-nacl</i>	65	<i>podofilox</i>	89	<i>prochlorperazine maleate</i>	64
<i>peg-3350/electrolytes</i>	65	<i>polycin</i>	80	PROCRIT	69
PEGASYS.....	12	<i>polymyxin b-trimethoprim</i>	80	<i>procto-med hc</i>	89
PEMAZYRE	23	POMALYST	18	<i>proctosol hc</i>	90
<i>pemetrexed disodium</i>	17	<i>portia-28</i>	58	<i>proctozone-hc</i>	90
<i>penicillamine</i>	54	<i>posaconazole</i>	6	PROGRAF.....	73
PENICILLIN G POT IN DEXTROSE. 15		POTASSIUM CHLORIDE	77	PROLASTIN-C.....	84
<i>penicillin g potassium</i>	15	<i>potassium chloride</i>	77, 78	PROLENSA.....	81
PENICILLIN G PROCAINE	15	<i>potassium chloride crys er</i>	78	PROLIA.....	54
<i>penicillin g sodium</i>	16	<i>potassium chloride er</i>	78	PROMACTA.....	69
<i>penicillin v potassium</i>	16	<i>potassium chloride in nacl</i>	77	<i>promethazine hcl</i>	64
PENTACEL	75	POTASSIUM CHLORIDE IN NACL. 77		<i>propafenone hcl</i>	28
<i>pentamidine isethionate</i>	7	<i>potassium citrate er</i>	67	<i>propafenone hcl er</i>	28
<i>pentoxifylline er</i>	69	<i>potassium cl in dextrose 5%</i>	77	<i>proparacaine hcl</i>	81
<i>perindopril erbumine</i>	26	PRADAXA.....	68	<i>propranolol hcl</i>	30
<i>periogard</i>	90	PRALUENT	29	<i>propranolol hcl er</i>	30
<i>permethrin</i>	90	<i>pramipexole dihydrochloride</i>	40	<i>propylthiouracil</i>	63
<i>perphenazine</i>	43	<i>pramipexole dihydrochloride er</i>	40	PROQUAD.....	75
PERSERIS.....	43	<i>prasugrel hcl</i>	70	PROSOL.....	79

<i>protriptyline hcl</i>	39	<i>ritonavir</i>	9	<i>sodium chloride</i>	77, 90
PULMICORT FLEXHALER.....	86	<i>rivastigmine</i>	38	<i>sodium fluoride chew, tab, 1.1</i>	
PULMOZYME.....	85	<i>rivastigmine tartrate</i>	38	<i>(0.5 f) mg/ml soln</i>	78
PURIXAN.....	18	<i>rizatriptan benzoate</i>	46	SODIUM OXYBATE.....	48
<i>pyrazinamide</i>	11	ROCKLATAN.....	79	<i>sodium phenylbutyrate</i>	62
<i>pyridostigmine bromide</i>	47	<i>roflumilast</i>	85	<i>sodium polystyrene sulfonate</i>	54
QINLOCK.....	23	<i>ropinirole hcl</i>	40	<i>solifenacin succinate</i>	67
QUADRACEL.....	75	<i>ropinirole hcl er</i>	40	SOLQUA.....	50
<i>quetiapine fumarate</i>	43	<i>rosuvastatin calcium</i>	28	SOLTAMOX.....	18
<i>quetiapine fumarate er</i>	43	ROTARIX.....	75	SOLU-CORTEF.....	60
<i>quinapril hcl</i>	26	ROTATEQ.....	75	SOMATULINE DEPOT.....	62
<i>quinapril-hydrochlorothiazide</i>	26	<i>roweepra</i>	36	SOMAVERT.....	62
<i>quinidine sulfate</i>	28	ROZLYTREK.....	23	<i>sorafenib tosylate</i>	23
<i>quinine sulfate</i>	8	RUBRACA.....	23	<i>sorine</i>	28
RABAVERT.....	75	<i>rufinamide</i>	36	<i>sotalol hcl</i>	28
<i>rabeprazole sodium</i>	67	RUKOBIA.....	9	<i>sotalol hcl (af)</i>	28
<i>raloxifene hcl</i>	62	RYBELSUS.....	53	<i>spironolactone</i>	26
<i>ramipril</i>	26	RYDAPT.....	23	<i>spironolactone-hctz</i>	31
<i>ranolazine er</i>	32	<i>sajazir</i>	69	<i>sprintec 28</i>	58
<i>rasagiline mesylate</i>	40	SANDIMMUNE.....	73	SPRITAM.....	36
RAYALDEE.....	63	SANTYL.....	90	SPRYCEL.....	23
<i>reclipsen</i>	58	<i>sapropterin dihydrochloride</i>	62	<i>sps</i>	54
RECOMBIVAX HB.....	75	SAVELLA.....	47	<i>sronyx</i>	58
RECTIV.....	90	SAVELLA TITRATION PACK.....	47	<i>ssd</i>	87
REGRANEX.....	90	SCEMBLIX.....	23	STELARA.....	71
RELENZA DISKHALER.....	12	<i>scopolamine</i>	64	<i>sterile water for irrigation</i>	90
RELISTOR.....	66	SECUADO.....	44	STIVARGA.....	23
REMICADE.....	71	<i>selegiline hcl</i>	41	<i>streptomycin sulfate</i>	8
RENFLEXIS.....	71	<i>selenium sulfide</i>	87	STRIBILD.....	11
<i>repaglinide</i>	52, 53	SELZENTRY.....	9	<i>subvenite</i>	36
RESTASIS.....	81	SEREVENT DISKUS.....	83	<i>sucrafate</i>	66
RESTASIS MULTIDOSE.....	81	<i>sertraline hcl</i>	39	<i>sulfacetamide sodium</i>	80
RETEVMO.....	23	<i>setlakin</i>	58	<i>sulfacetamide sodium (acne)</i>	86
REVLIMID.....	18, 19	<i>sevelamer carbonate</i>	62	<i>sulfacetamide-prednisolone</i>	80
REXULTI.....	43	<i>sharobel</i>	58	<i>sulfadiazine</i>	8
REYATAZ.....	9	SHINGRIX.....	75	<i>sulfamethoxazole-trimethoprim</i> ...	8
REZLIDHIA.....	23	SIGNIFOR.....	62	SULFAMYLON.....	87
REZUROCK.....	73	<i>sildenafil citrate</i>	33, 82	<i>sulfasalazine</i>	65
RHOPRESSA.....	79	<i>silodosin</i>	67	<i>sulindac</i>	4
<i>ribavirin</i>	12	<i>silver sulfadiazine</i>	87	<i>sumatriptan</i>	46
<i>rifabutin</i>	11	SIMBRINZA.....	79	<i>sumatriptan succinate</i>	46
<i>rifampin</i>	11	<i>simliya</i>	58	<i>sumatriptan succinate refill</i>	46
<i>riluzole</i>	47	<i>simvastatin</i>	28	<i>sunitinib malate</i>	23
<i>rimantadine hcl</i>	12	<i>sirolimus</i>	73	SUNLENCA.....	10
RINVOQ.....	71	SIRTURO.....	11	SUPREP BOWEL PREP KIT.....	65
<i>risedronate sodium</i>	54	SIVEXTRO.....	7	<i>syeda</i>	58
RISPERDAL CONSTA.....	43	SKYRIZI.....	71	SYMBICORT.....	86
<i>risperidone</i>	43, 44	SKYRIZI PEN.....	71	SYMDEKO.....	85

SYMPAZAN.....	36	THEO-24.....	85	<i>triamterene-hctz</i>	31
SYMTUZA.....	11	<i>theophylline</i>	85	<i>trientine hcl</i>	54
SYNAREL.....	59	<i>theophylline er</i>	85	<i>tri-estarylla</i>	58
SYNJARDY.....	53	<i>thioridazine hcl</i>	44	<i>trifluoperazine hcl</i>	44
SYNJARDY XR.....	53	<i>thiothixene</i>	44	<i>trifluridine</i>	81
SYNRIBO.....	19	<i>tiadylt er</i>	31	<i>trihexyphenidyl hcl</i>	41
SYNTHROID.....	63	<i>tiagabine hcl</i>	36	TRIJARDY XR.....	53
TABLOID.....	18	TIBSOVO.....	24	TRIKAFTA.....	85
TABRECTA.....	23	TICOVAC.....	75	<i>tri-legest fe</i>	58
<i>tacrolimus</i>	73, 90	<i>tigecycline</i>	16	<i>tri-lynyah</i>	58
<i>tadalafil (pah)</i>	33	TIGECYCLINE.....	16	<i>tri-lo-estarylla</i>	58
TADLIQ.....	33	<i>tilia fe</i>	58	<i>tri-lo-marzia</i>	58
TAFINLAR.....	23	<i>timolol maleate</i>	30, 79	<i>tri-lo-mili</i>	58
TAGRISSO.....	24	<i>tinidazole</i>	8	<i>tri-lo-sprintec</i>	58
TALTZ.....	71	TIVICAY.....	10	<i>trimethoprim</i>	8
TALZENNA.....	24	TIVICAY PD.....	10	<i>tri-mili</i>	58
<i>tamoxifen citrate</i>	18	<i>tizanidine hcl</i>	48	<i>trimipramine maleate</i>	39
<i>tamsulosin hcl</i>	67	TOBRADEX.....	80	TRINTELLIX.....	39
<i>tarina fe 1/20 eq</i>	58	TOBRADEX ST.....	80	<i>tri-nymyo</i>	58
TASIGNA.....	24	<i>tobramycin</i>	8, 81	<i>tri-sprintec</i>	58
<i>tasimelteon</i>	45	<i>tobramycin sulfate</i>	8	TRIUMEQ.....	11
<i>tazarotene</i>	87	<i>tobramycin-dexamethasone</i>	80	TRIUMEQ PD.....	11
<i>tazicef</i>	13	<i>tolterodine tartrate</i>	67	<i>trivora (28)</i>	58
TAZORAC.....	87	<i>tolterodine tartrate er</i>	67	<i>tri-vylibra</i>	58
<i>taztia xt</i>	31	<i>topiramate</i>	36	<i>tri-vylibra lo</i>	58
TAZVERIK.....	24	<i>toremifene citrate</i>	18	TRIZIVIR.....	11
TDVAX.....	75	<i>torse mide</i>	31	TROGARZO.....	10
TECENTRIQ.....	24	TOUJEO MAX SOLOSTAR.....	50	TROPHAMINE.....	79
TECFIDERA.....	47, 48	TOUJEO SOLOSTAR.....	50	<i>trospium chloride</i>	68
TEFLARO.....	13	TPN ELECTROLYTES.....	77	<i>trospium chloride er</i>	68
<i>telmisartan</i>	27	TRADJENTA.....	53	TRULICITY.....	53
<i>telmisartan-amlodipine</i>	27	<i>tramadol hcl</i>	5	TRUMENBA.....	75
<i>telmisartan-hctz</i>	27	<i>tramadol-acetaminophen</i>	5	TRUSELTIQ (100MG DAILY DOSE).....	24
<i>temazepam</i>	45	<i>trandolapril</i>	26	TRUSELTIQ (125MG DAILY DOSE).....	24
TENIVAC.....	75	<i>tranexamic acid</i>	69	TRUSELTIQ (50MG DAILY DOSE).....	24
<i>tenofovir disoproxil fumarate</i>	10	<i>tranylcypromine sulfate</i>	39	TRUSELTIQ (75MG DAILY DOSE).....	24
TEPMETKO.....	24	TRAVASOL.....	79	TRUXIMA.....	24
<i>terazosin hcl</i>	26	<i>travoprost (bak free)</i>	79	TUKYSA.....	24
<i>terbinafine hcl</i>	6	TRAZIMERA.....	24	TURALIO.....	24
<i>terbutaline sulfate</i>	84	<i>trazodone hcl</i>	39	TWINRIX.....	75
<i>terconazole</i>	68	TRECTOR.....	11	TYBOST.....	10
TERIPARATIDE (RECOMBINANT).....	54	TRELEGY ELLIPTA.....	82	TYMLOS.....	54
<i>testosterone</i>	49	<i>treprostinil</i>	33	TYPHIM VI.....	75, 76
<i>testosterone cypionate</i>	49	TRESIBA.....	51	TYRVAYA.....	81
<i>testosterone enanthate</i>	49	TRESIBA FLEXTOUCH.....	51	<i>unithroid</i>	63
<i>tetrabenazine</i>	47	<i>tretinoin</i>	19, 86	<i>ursodiol</i>	66
<i>tetracycline hcl</i>	16	TREXALL.....	72		
THALOMID.....	19	<i>triamcinolone acetonide</i>	89, 90		

<i>valacyclovir hcl</i>	12	<i>viorele</i>	58	XULTOPHY.....	51
VALCHLOR.....	90	VIRACEPT.....	10	XYREM.....	48
<i>valganciclovir hcl</i>	12	VIREAD.....	10	YF-VAX.....	76
<i>valproate sodium</i>	36	VITRAKVI.....	24	<i>yuvaferm</i>	60
<i>valproic acid</i>	36	VIVITROL.....	49	<i>zafemy</i>	59
<i>valsartan</i>	27	VIZIMPRO.....	24	<i>zafirlukast</i>	84
<i>valsartan-hydrochlorothiazide</i>	27	VONJO.....	24	ZARXIO.....	69
VALTOCO 10 MG DOSE.....	36	<i>voriconazole</i>	6	ZEJULA.....	25
VALTOCO 15 MG DOSE.....	36	VOSEVI.....	12	ZELBORAF.....	25
VALTOCO 20 MG DOSE.....	37	VOTRIENT.....	24	ZEMAIRA.....	85
VALTOCO 5 MG DOSE.....	37	VRAYLAR.....	44	<i>zenatane</i>	86
<i>vancomycin hcl</i>	8	VUMERITY.....	48	ZENPEP.....	66
VANCOMYCIN HCL IN NACL.....	8	<i>vyfemla</i>	58	ZERVIAE.....	79
VANFLYTA.....	24	<i>vylibra</i>	58	<i>zidovudine</i>	10
VAQTA.....	76	VYVANSE.....	45	ZIEXTENZO.....	69
<i>vardenafil hcl</i>	82	VYZULTA.....	79	<i>ziprasidone hcl</i>	44
<i>varenicline tartrate</i>	49	<i>warfarin sodium</i>	68	<i>ziprasidone mesylate</i>	44
<i>varenicline tartrate (starter)</i>	48	WELIREG.....	19	ZIRABEV.....	25
VARIVAX.....	76	<i>wera</i>	58	ZIRGAN.....	81
VASCEPA.....	29	XALKORI.....	25	<i>zoledronic acid</i>	54
<i>velivet</i>	58	XARELTO.....	68, 69	ZOLINZA.....	25
VELPHORO.....	62	XARELTO STARTER PACK.....	69	<i>zolmitriptan</i>	46
VELTASSA.....	54	XATMEP.....	72	<i>zolpidem tartrate</i>	45
VEMLIDY.....	12	XCOPRI.....	37	ZONISADE.....	37
VENCLEXTA.....	24	XCOPRI (250 MG DAILY DOSE)....	37	<i>zonisamide</i>	37
VENCLEXTA STARTING PACK.....	24	XCOPRI (350 MG DAILY DOSE)....	37	<i>zovia 1/35 (28)</i>	59
<i>venlafaxine hcl</i>	39	XELJANZ.....	71	ZTALMY.....	37
<i>venlafaxine hcl er</i>	39	XELJANZ XR.....	71	<i>zumandimine</i>	59
VENTAVIS.....	33	XERMELO.....	66	ZYCLARA PUMP.....	90
VENTOLIN HFA.....	84	XGEVA.....	54	ZYDELIG.....	25
<i>verapamil hcl</i>	31	XHANCE.....	85	ZYKADIA.....	25
<i>verapamil hcl er</i>	31	XIFAXAN.....	66	ZYLET.....	80
VERSACLOZ.....	44	XIGDUO XR.....	53	ZYPITAMAG.....	28
VERZENIO.....	24	XOLAIR.....	85	ZYPREXA RELPREVV.....	44
<i>vestura</i>	58	XOSPATA.....	25		
V-GO 20.....	51	XPOVIO (100 MG ONCE			
V-GO 30.....	51	WEEKLY).....	25		
V-GO 40.....	51	XPOVIO (40 MG ONCE WEEKLY). 25			
VICTOZA.....	53	XPOVIO (40 MG TWICE			
<i>vienva</i>	58	WEEKLY).....	25		
<i>vigabatrin</i>	37	XPOVIO (60 MG ONCE WEEKLY). 25			
<i>vigadrone</i>	37	XPOVIO (60 MG TWICE			
VIIBRYD.....	39	WEEKLY).....	25		
VIIBRYD STARTER PACK.....	40	XPOVIO (80 MG ONCE WEEKLY). 25			
<i>vilazodone hcl</i>	40	XPOVIO (80 MG TWICE			
VIMPAT.....	37	WEEKLY).....	25		
<i>vincristine sulfate</i>	20	XTANDI.....	18		
<i>vinorelbine tartrate</i>	20	<i>xulane</i>	59		

‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

Please contact your plan for details.

For plans that offer preferred pharmacies

WellCare’s pharmacy network includes limited lower-cost, preferred pharmacies in rural areas of MO and NE. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **1-833-444-9088 (TTY 711)** for Wellcare No Premium (HMO) and Wellcare Giveback (HMO) in MO or consult the online pharmacy directory at **www.wellcare.com/medicare**, and **1-833-542-0693 (TTY 711)** for Wellcare No Premium (HMO), Wellcare Giveback (HMO) and Wellcare No Premium Open (PPO) in NE or consult the online pharmacy directory at **www.wellcare.com/NE**.

For NM Dual Eligible Plans

For New Mexico (NM) Dual-Special Needs Population (D-SNP) Members: As an Allwell D-SNP member, you have coverage from both Medicare and Medicaid. Medicaid services are funded in part by the state of New Mexico. NM Medicaid benefits may be limited to payment of Medicare premiums for some members.

For LA Dual Eligible Plans

For Louisiana D-SNP members: As a WellCare HMO D-SNP member, you have coverage from both Medicare and Medicaid. You receive your Medicare health care and prescription drug coverage through WellCare and are also eligible to receive additional health care services and coverage through Louisiana Medicaid. Learn more about providers who participate in Louisiana Medicaid by visiting **<https://www.myplan.healthy.la.gov/en/find-provider>**. For detailed information about Louisiana Medicaid benefits, please visit the Medicaid website at **<https://ldh.la.gov/medicaid>** and select the “Learn about Medicaid Services” link.

For TN Dual Eligible plans

Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any benefits above and beyond traditional Medicare benefits are applicable to Wellcare Medicare Advantage only and do not indicate increased Medicaid benefits.

Health Net Life Insurance Company is contracted with Medicare for PPO plans. “Wellcare by Health Net” is issued by Health Net Life Insurance Company.

“Wellcare” is issued by Wellcare of Washington, Inc.

“Wellcare” is issued by WellCare Health Insurance Company of Washington, Inc.

“Wellcare” is issued by WellCare Prescription Insurance, Inc.

Do you think Trillium Community Health Plan (Trillium) has treated you unfairly?

Trillium must follow state and federal civil rights laws. It cannot treat people unfairly in any of its programs or activities because of a person's:

- Age
- Sexual orientation
- Religion
- National Origin
- Gender identity
- Color
- Disability
- Sex
- Race
- Marital status
- Health Status

You have a right to enter, exit, and use buildings and services. You have the right to get information in a way you understand. Trillium will make reasonable changes to policies, practices, and procedures by talking with you about your needs.

To report concerns or to get more information, please contact Member Services at **1-541-485-2155**; Toll Free: **1-877-600-5472**; TTY: **1-877-600-5473**, Monday through Friday, 8:00 a.m. to 5:00 p.m. You can leave a message at other times, including weekends and federal holidays. We will return your call the next business day. The call is free.

If you believe you have been discriminated against, you may also contact:

Emily Farrell, Non-Discrimination Coordinator

555 International Way, Building B
Springfield, OR 97477

Phone: **1-541-214-3948**

Toll-free: **1-844-867-1156** (TTY **711**)

Email: **emilyann.farrell@TrilliumCHP.com**

Web: **<https://wellcare.trilliumadvantage.com/legal/nondiscrimination-notice.html>**

You have a right to file a civil rights complaint with these organizations:

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

Web: **<https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>**

Phone: **1-800-368-1019, 1-800-537-7697** (TDD)

Email: **OCRComplaint@hhs.gov**

Mail: Office for Civil Rights, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

Oregon Health Authority (OHA) Civil Rights

Web: **www.oregon.gov/OHA/OEI**

Phone: **1-844-882-7889**, (TTY **711**)

Email: **OHA.PublicCivilRights@odhsoha.oregon.gov**

Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204

Bureau of Labor and Industries Civil Rights Division

Phone: **1-971-673-0764**

Email: **crdemail@boli.state.or.us**

Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045, Portland, OR 97232

You can get this letter in another language, large print, or another way that is best for you. You can also have a language interpreter. This help is free. Call **1-844-867-1156** (TTY/TDD **711**).

Puede recibir esta carta en otro idioma, en letra grande o en otro formato que sea más conveniente para usted. También puede acceder a servicios de interpretación. Esta asistencia es gratuita. Llame al **1-844-867-1156** (TTY/TDD **711**).

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-844-867-1156**; TTY: **1-877-600-5473**

Español (Spanish)

ATENCIÓN: Si no habla Inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-867-1156**; TTY: **1-877-600-5473**

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị không nói tiếng Anh, có các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-844-867-1156**; TTY: **1-877-600-5473**

繁體中文 (Chinese)

注意：如果您不會講英語，我們有提供免費的語言協助服務。請致電 **1-844-867-1156**；TTY：**1-877-600-5473**

Русский (Russian)

ВНИМАНИЕ! Если вы не говорите по-английски, вы можете бесплатно получить помощь переводчика. Позвоните по номеру **1-844-867-1156**; TTY: **1-877-600-5473**

한국어 (Korean)

주의: 영어 외 다른 언어를 사용하시는 분은 무료로 언어 지원 서비스를 이용할 수 있습니다. 전화: **1-844-867-1156**; TTY: **1-877-600-5473**

Українська (Ukrainian)

УВАГА: якщо ви не володієте англійською мовою, вам доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером **1-844-867-1156**; TTY: **1-877-600-5473**

日本語 (Japanese)

注意：英語を話さない方は、無料で言語支援サービスを利用できます。**1-844-867-1156**（TTY: **1-877-600-5473**）までお電話ください。

العربية (Arabic):

ملاحظة: إذا كنت لا تجيد التحدث باللغة الإنجليزية، فنحن نوفر لك خدمات مساعدة لغوية مجانية. اتصل بالرقم **1-844-867-1156**؛ الهاتف النصي: **1-877-600-5473**

Română (Romanian)

ATENȚIE: Dacă nu vorbiți limba engleză, aveți la dispoziție gratuit servicii de asistență lingvistică. Apelați numărul de telefon **1-844-867-1156**; TTY: **1-877-600-5473**

ខ្មែរ (Cambodian)

ចំណាំ៖ បុរសិនបីអ្នកមិននិយាយភាសាអង់គ្លេសទេ នោះមានសេវាជំនួយផ្លូវភាសាដោយឥតគិតថ្លៃ សម្រាប់អ្នក។ សូមទូរសព្ទទៅលេខ **1-844-867-1156**; TTY: **1-877-600-5473**

Afaan Oromoo (Oromo)

XIYYEEFFANNO: Afaan Ingiliffaa hin dubbattu taanan, gargaarsi tajaajiloota afaanii, kan kaffaltii irraa bilisaa siif jira. **1-844-867-1156** irratti bilbila; TTY: **1-877-600-5473**

Deutsch (German)

ACHTUNG: Wenn Sie kein Englisch sprechen, stehen Ihnen kostenlos Sprachdienstleistungen zur Verfügung. Rufen Sie dazu folgende Nummer an: **++1-844-867-1156**; TTY: **++1-877-600-5473**

فارسی (Farsi)

توجه: اگر به زبان انگلیسی صحبت نمی‌کنید، خدمات کمک‌زبانی به صورت رایگان در اختیار شما قرار می‌گیرد. با شماره **1-844-867-1156** تماس بگیرید؛ شماره برای ناشنویان: **1-877-600-5473**

Français (French)

ATTENTION : si vous ne parlez pas anglais, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le **1-844-867-1156** ; TTY : **1-877-600-5473**.

ภาษาไทย (Thai)

หมายเหตุ: หากคุณใช้ภาษาอังกฤษไม่ได้ เรามีความช่วยเหลือด้านภาษาฟรีพร้อมให้บริการแก่คุณ โทร **1-844-867-1156**; TTY: **1-877-600-5473**

Discrimination is Against the Law

Arizona Complete Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Arizona Complete Health:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides language services at no cost to people whose primary language is not English, such as: qualified interpreters and information written in other languages

If you need these services, contact Member Services at:

Arizona Complete Health: **1-800-977-7522** (TTY/TDD: **711**)

If you believe that Arizona Complete Health failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Chief Compliance Officer. You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your grievance to:

Wellcare By Allwell - Appeals & Grievances - Medicare Operations

P.O. Box 279410 Sacramento, CA 95827

Fax: **1-844-273-2671**

Email: **Arizona_Medicare@CENTENE.COM**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: **1-800-368-1019, 1-800-537-7697** (TTY/TDD).

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**

La Discriminación es un Delito

Arizona Complete Health cumple con las leyes de derechos civiles Federales vigentes y no discrimina por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo. Arizona Complete Health no excluye a personas ni las trata de forma diferente por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo.

Arizona Complete Health proporciona lo siguiente:

- Asistencia y servicios sin costo alguno a las personas con discapacidades para comunicarse de manera eficaz con nosotros, tales como intérpretes calificados de lengua de señas
- Información escrita en otros formatos (letra grande, audios, formatos electrónicos accesibles y otros formatos)
- Servicios de idiomas sin costo alguno a personas cuyo idioma principal no es el inglés, tales como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, llame a Servicios para Miembros al siguiente número:

Arizona Complete Health: **1-800-977-7522** (TTY/TDD: **711**)

Si considera que Arizona Complete Health no le brindó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo, puede presentar una queja ante el Oficial de Cumplimiento. Puede presentar una queja en persona, por correo, fax o correo electrónico. Su queja se debe realizar por escrito y se debe enviar en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja toma conocimiento de lo que se considera como discriminación.

Envíe su queja a la siguiente dirección:

Wellcare By Allwell - Appeals & Grievances - Medicare Operations

P.O. Box 279410 Sacramento, CA 95827

Fax: **1-844-273-2671**

Correo electrónico: **Arizona_Medicare@CENTENE.COM**

También puede presentar una queja de derechos civiles a la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, el cual se encuentra disponible en **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, o puede enviarla por correo a U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D. C. 20201. Asimismo, puede presentar dicha queja por teléfono llamando al **1-800-368-1019** o al **1-800-537-7697** (TTY/TDD).

Los formularios de queja están disponibles en **<http://www.hhs.gov/ocr/office/file/index.html>**

ATTENTION: If you speak a language other than English, oral interpretation and written translation are available to you at no cost to understand the information provided. Call **1-800-977-7522** (TTY:TDD **711**)

Spanish	Si habla español, contamos con servicios de interpretación oral y traducción escrita, disponibles para usted de manera gratuita, para que pueda comprender la información. Llame al 1-800-977-7522 (TTY:TDD 711).
Navajo	Dine k'ehji yanilti go ata' hane' ná hólo doo naaltsoos t'aa Dine k'ehji bee bik'e'ashchiigo nich'' adoolniilgo bee haz'a aldo ako dii t'a at'e t'aajik'e kot'eegol nich'' sa'até. Koji holne 1-800-977-7522 (TTY:TDD 711).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。请致电 1-800-977-7522 (TTY:TDD 711)。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 1-800-977-7522 (TTY:TDD 711)。
Vietnamese	Nếu quý vị nói tiếng Việt, quý vị được cung cấp dịch vụ phiên dịch và biên dịch, miễn phí, để quý vị hiểu được thông tin. Hãy gọi 1-800-977-7522 (TTY:TDD 711).
Arabic	إذا كنت تتحدث لغة غير الإنكليزية، تتوفر لك ترجمة شفوية وترجمة كتابية مجاناً لكي تفهم المعلومات الموقرة. اتصل على الرقم 1-800-977-7522 (TTY:TDD 711).
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, may oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin nang wala kang babayaran para maunawaan ang impormasyong ibinigay. Tumawag sa 1-800-977-7522 (TTY:TDD 711).
Korean	한국어를 하실 경우, 제공된 정보의 이해를 위한 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-800-977-7522 (TTY:TDD 711) 번으로 전화하십시오.
French	Si vous parlez français, vous disposez, sans frais, d'une interprétation orale et d'une traduction écrite pour pouvoir comprendre les informations fournies. Appelez le 1-800-977-7522 (TTY:TDD 711).
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-800-977-7522 (TTY:TDD 711).
Russian	Если вы говорите по-русски, вам бесплатно доступны услуги устного и письменного перевода предоставляемой информации. Звоните по телефону 1-800-977-7522 (TTY:TDD 711).
Japanese	日本語を話される方は、提供された情報を理解するための通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。電話番号 1-800-977-7522 (TTY:TDD 711)。

[illegible]

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que hable español puede ayudarle. Este es un servicio gratuito.

Chinese Mandarin: 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯系我們。會說中文普通話的人員可以協助您。此為免費服務。

Chinese Cantonese: 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯絡我們。會說粵語的人員可以協助您。此為免費服務。

Tagalog: Meron kaming libreng serbisyo ng interpreter para sagutin anumang tanong na meron ka tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa sumusunod na mga pahina. Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser au sujet de notre régime de soins médicaux ou de notre régime d'assurance-médicaments. Pour bénéficier des services d'un interprète, il suffit de nous appeler aux numéros de régime indiqués dans les pages suivantes. Quelqu'un qui parle français peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ phiên dịch viên miễn phí để trả lời bất kỳ câu hỏi nào quý vị có về chương trình y tế hoặc thuốc của chúng tôi. Để nhận được dịch vụ phiên dịch, chỉ cần gọi cho chúng tôi theo số điện thoại của chương trình trong các trang sau. Người nào đó nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Um einen Dolmetscher zu finden, rufen Sie uns einfach unter den auf den folgenden Seiten angegebenen Plan-Nummern an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist für Sie kostenlos.

Korean: 저희의 건강 또는 약품 플랜에 대한 질문에 답해 드릴 수 있는 무료 통역 서비스를 제공합니다. 통역사에게 연결하려면 다음 페이지에 있는 플랜 번호로 전화하시기 바랍니다. 한국어를 하는 분이 도와드릴 수 있습니다. 이 통화는 무료 서비스입니다.

Russian: Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы, которые могут возникнуть у вас о нашем плане медицинского страхования или страхового покрытия лекарственных препаратов. Чтобы получить устного переводчика, просто позвоните нам по номерам планов, указанным на следующих страницах. Вам поможет тот, кто говорит по-русски. Эта услуга предоставляется бесплатно.

Arabic: نوفر خدمات مترجم فوري للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للاستعانة بمترجم، ما عليك سوى الاتصال بنا على أرقام الخطة في الصفحات التالية. شخص يتحدث العربية يمكنه مساعدتك. هذه الخدمة تقدم مجاناً.

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके होने वाले किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया प्राप्त करने के लिए, हमें निम्नलिखित पृष्ठों पर दिए गए प्लान नंबरों पर कॉल करें। कोई हिंदी भाषी व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Disponiamo di servizi di interpretariato gratuiti per rispondere ad eventuali domande in merito al nostro piano sanitario o farmaceutico. Per ottenere un interprete, chiami i recapiti del piano disponibili nelle pagine successive. Qualcuno che parla italiano Le sarà d'aiuto. Si tratta di un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder quaisquer perguntas que você possa ter sobre nossos planos de saúde ou de medicamentos. Para solicitar um intérprete, ligue para nós através dos números do plano nas páginas a seguir. Um funcionário que fala português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante ouwa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan nimewo plan yo ki sou paj annapre yo. Yon moun ki pale Kreyòl Franse kapab ede ou. Se yon sèvis gratis li ye.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe w przypadku pytań dotyczących naszego planu zdrowotnego i lekowego. Aby skorzystać z tłumacza, prosimy zadzwonić do nas pod numery podane na kolejnych stronach. Pomocą posłużą osoby mówiące po polsku. Usługa jest bezpłatna.

Japanese: 当社の医療プランまたは処方薬プランについての質問にお答えする無料の通訳サービスをご利用いただけます。通訳サービスをご利用になるには、以降のページにおけるプランの番号までお電話ください。日本語を話すスタッフが対応いたします。これは無料のサービスです。

Hawaiian: Aia iā mākou he mau lawelawe māhele 'ōlelo manuahi e pane i nā 'ano nīnau āu no ka mākou papahana mālama olakino a ho'olako lā'au. No ka 'imi i mea māhele 'ōlelo, e kelepona wale mai iā mākou ma nā helu kelepona e waiho nei ma kēia mau 'ao'ao e koe nei. Na kekahi māhele 'ōlelo Hawai'i e kōkua iā 'oe. He lawelawe manuahi kēia.

Ilocano: Addaankami kadagiti libre a serbisio ti panagipatarus tapno masungbatan dagiti aniaman a saludsodmo maipapan iti salun-at wenno plano iti agas. Tapno makaala iti tagaipatarus, tawagannakami laeng kadagiti numero ti plano kadagiti sumaganad a panid. Matulongannaka ti maysa a tao nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai a matou auaunaga fa'aliliu upu fua e tali ai so'o se fesili e te ono iai e uiga i la matou fuafuaga fa'alesoifua maloloina po'o vaila'au. Mo le mauaina o se fa'aliliu upu, na'o le vala'au mai i numera o fuafuaga o lo'o i itulau nei. E mafai e se tasi e tautala i le gagana Samoa ona fesoasoani ia te oe. Ose auaunaga e leai se totogi.

We're Just a Phone Call Away

ARKANSAS

+ HMO, HMO D-SNP

📞 1-855-565-9518

💻 Or visit www.wellcare.com/allwellAR

ARIZONA

+ HMO, HMO C-SNP, HMO D-SNP

📞 1-800-977-7522

💻 Or visit www.wellcare.com/allwellAZ

CALIFORNIA

+ HMO, HMO C-SNP, PPO

📞 1-800-275-4737

+ HMO D-SNP

📞 1-800-431-9007

💻 Or visit www.wellcare.com/healthnetCA

FLORIDA

+ HMO D-SNP

📞 1-877-935-8022

💻 Or visit www.wellcare.com/allwellFL

GEORGIA

+ HMO

📞 1-844-890-2326

+ HMO D-SNP

📞 1-877-725-7748

💻 Or visit www.wellcare.com/allwellGA

INDIANA

+ HMO, PPO

📞 1-855-766-1541

+ HMO D-SNP, PPO D-SNP

📞 1-833-202-4704

💻 Or visit www.wellcare.com/allwellIN

KANSAS

+ HMO

📞 1-855-565-9519

+ PPO

📞 1-833-696-0634

+ HMO D-SNP, PPO D-SNP

📞 1-833-402-6707

💻 Or visit www.wellcare.com/allwellKS

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📞 1-855-766-1572

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📞 1-833-541-0767

💻 Or visit www.wellcare.com/allwellLA

MISSOURI

+ HMO

📞 1-855-766-1452

+ HMO D-SNP

📞 1-833-298-3361

💻 Or visit www.wellcare.com/allwellMO

MISSISSIPPI

+ HMO

📞 1-844-786-7711

+ HMO D-SNP

📞 1-833-260-4124

💻 Or visit www.wellcare.com/allwellMS

NEBRASKA

+ HMO, PPO

📞 1-833-542-0693

+ HMO D-SNP, PPO D-SNP

1-833-853-0864

💻 Or visit www.wellcare.com/NE

NEVADA

+ HMO, HMO C-SNP, PPO

📞 1-833-854-4766

+ HMO D-SNP

📞 1-833-717-0806

💻 Or visit www.wellcare.com/allwellNV

NEW MEXICO

+ HMO, PPO

📞 1-833-543-0246

+ HMO D-SNP

📞 1-844-810-7965

💻 Or visit www.wellcare.com/allwellNM

NEW YORK

+ HMO, HMO-POS, HMO D-SNP

📞 1-800-247-1447

💻 Or visit www.wellcare.com/fidelisNY

OHIO

+ HMO, PPO

📞 1-855-766-1851

+ HMO D-SNP, PPO D-SNP

📞 1-866-389-7690

💻 Or visit www.wellcare.com/allwellOH

OKLAHOMA

+ HMO, PPO

📞 1-833-853-0865

+ HMO D-SNP, PPO D-SNP

📞 1-833-853-0866

💻 Or visit www.wellcare.com/OK

OREGON

+ HMO, PPO

📞 1-888-445-8913

💻 Or visit www.wellcare.com/healthnetOR

+ HMO D-SNP

📞 1-844-867-1156

💻 Or visit www.wellcare.com/trilliumOR

PENNSYLVANIA

+ HMO, PPO

📞 1-855-766-1456

+ HMO D-SNP, PPO D-SNP

📞 1-866-330-9368

💻 Or visit www.wellcare.com/allwellPA

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+ HMO, HMO D-SNP

📞 1-855-766-1497

💻 Or visit www.wellcare.com/allwellSC

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 HMO

 1-844-796-6811

 HMO D-SNP

 1-877-935-8023

 Or visit www.wellcare.com/allwellTX

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 HMO D-SNP

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 Or visit www.wellcare.com/allwellWI

WASHINGTON

 PPO

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TTY FOR ALL STATES: 711

HOURS OF OPERATION

 **October 1 to March 31:** Monday–Sunday, 8 a.m. to 8 p.m.

 **April 1 to September 30:** Monday–Friday, 8 a.m. to 8 p.m.



This formulary was updated on 12/01/2023.

For more recent information or other questions, please contact Wellcare Member Services at the telephone number or website for your state listed on the inside front and back covers of this formulary.

12/01/2023

Medicare^{Rx}
Prescription Drug Coverage